A Descriptive Exploratory Study of Health Promotion Among Men and Women Released From a County Detention Center

A DISSERTATION

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By

Theresa A. Kapetanovic

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A Descriptive Exploratory Study of Health Promotion Among Men and Women Released From a County Detention Center

Theresa A. Kapetanovic PhD RN CPHQ, CMCN

Director: Janice Agazio, PhD, CRNP, FAANP, FAAN

The national agenda, Healthy People 2020, continues to support and encourage public health of the American people through primary, secondary and tertiary goals of disease prevention (U.S. Department of Health and Human Services, 2008). More than 10,000 men and women returning daily back to communities after release from county detention centers nationwide have health histories of infectious and chronic diseases, substance abuse, and mental health problems (National Commission on Correctional Healthcare, 2002). Studies that explore health promotion among the correctional population returning to communities are limited.

The purpose of this study was twofold, to explore 1) health and health promotion of men and women released 5 days to eighteen months after incarceration in an adult county detention center, and 2) the personal, social and community factors that may act as barriers and facilitators in health promotion among men and women released from an adult county detention facility. Research questions for the study include: 1) How is health described by men and women recently released from an adult county detention center? 2) How do men and women experience health after recent release from an adult county detention center? 3) What personal strategies to promote, maintain or restore health are described by men and women released from an adult county detention center? 4) What personal, social or community factors influencing health promotion are described by men and women released from an adult county detention facility? 5) What barriers and facilitating influences to health promotion are described by men and women released from an adult county detention center?

Thirty-five men and women were recruited from a day homeless shelter program and a
community agency that provides vocational, educational services and community referral for men and women released from a county detention center. Each data collection site was located in different states in the mid-Atlantic region of the United States. Study approval was obtained from the university Institutional Review Board (IRB) Committee for the Protection of Human Research Subjects.

A semi-structured interview guide and a demographic survey were used to obtain information from thirty-five men and women released from a county adult detention facility within last eighteen months. Each interview was tape-recorded, and transcribed. Demographic information was entered into SPSS software and an iterative coding process and content analysis was used with the assistance of analytical software. Results of the study suggest health promotion among men and women who have been recently released from a county detention facility is a transformative process. Health promotion occurs along a continuum - first unhealthy, then incarceration, then striving toward health, both mentally and physically.

The overall theme was Health Promotion and A Time of Change. Five sub-themes contribute to this continuum of change that included 1) Toward a healthy me, 2) Continuing challenges - physical and/or mental health maintenance, 3) Changing Lifestyles – we want to be healthy, 4) Dealing with life on life’s terms – resilience to adversity and 5) Survival – overcoming the obstacles. As an increasing number of men and women go through the doors of a county detention centers each year and return to communities’ nationwide, factors that influence the health of this population has been largely unexamined. Nursing research that explores health and influencing factors associated with primary, secondary and tertiary health prevention among this returning population is important in ensuring return to, and maintenance of, health promotion for these individuals.
This dissertation by Theresa A. Kapetanovic fulfills the dissertation requirement for the doctoral degree in Nursing approved by Janice Agazio, PhD, CRNP, FAANP, FAAN, as Director, and by Rebecca Robert, Ph.D., PNP-BC, FNP-BC, and Deborah Shelton, PhD, RN, NE-BC, CCHP, FAAN as Readers.

Janice Agazio, PhD, CRNP, FAANP, FAAN, Director

Rebecca Robert, Ph.D., PNP-BC, FNP-BC, Reader

Deborah Shelton, PhD, RN, NE-BC, CCHP, FAAN, Reader
Dedication

To all the men and women who took the time to share their personal stories with me; my hope is that this work provides one small voice to the everyday struggles and challenges in health and health promotion faced by those living in communities everywhere.
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CHAPTER I: INTRODUCTION

Background

Health promotion in the United States is a national focus. Since 1990, the United States federal government has supported a major health initiative, Healthy People, which emphasizes healthy living habits and disease reduction among all Americans (U.S. Department of Health and Human Services, 2011). Health promotion is “the process of enabling people to increase control over, and to improve, their health …a state of complete physical mental and social wellbeing” (Ottawa Charter for Health Promotion, 1986).

The national agenda, Healthy People 2020, continues to support and encourage public health of the American people through primary, secondary and tertiary goals of disease prevention. Goals for primary prevention include prevention of unhealthy lifestyle practices that can lead to health problems, e.g. obesity, poor nutrition, tobacco cessation, substance and alcohol use, and physical activity. The importance of personal awareness in maintaining health through everyday preventive health behavior, i.e. good nutrition, exercise, stress reduction and periodic health screening for early detection of health problems is emphasized. Focus on secondary and tertiary prevention includes national goals in early detection and the reduction of continuing morbidity or complications associated with chronic disease, e.g. diabetes, heart disease, asthma, infectious and other diseases (Healthy People.gov, 2012).

National health priorities include 1) overall reduction in the number of cancer deaths through increasing the number of persons screened for cervical, breast, prostate and skin cancer, 2) improved prevention behaviors among individuals at high risk for diabetes, pre-diabetes, hypertension, and cardiovascular risk, 3) reduction of new cases related to infectious disease, e.g. HIV/AIDS, Hepatitis B, influenza, sexually transmitted disease, 4) reduction in the number
of adults who are obese and 5) reduction in the number of adults who smoke tobacco, use excessive alcohol or illegal drugs (Healthy People.gov, 2012).

In continuing to advance the nation’s public health agenda that began 30 years ago, Healthy People 2020 specifically addresses the importance of alleviating health disparity, or “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage” and “adversely affects groups of people who have systematically experienced greater obstacles to health based on their racial, or ethnic group, socioeconomic status, mental health, geographic location, or other characteristics historically linked to discrimination or exclusion” (Healthy People.gov, 2010; National Partnership for Action to End Health Disparities (2011).

National studies examining the nation’s health with regard to disease prevention and the status of chronic illness among Americans have included only non-institutionalized men and women, and not those in jails and prisons throughout the United States. The federal government and individual states have collected health information about Americans at various time intervals over the past several decades through the administration of surveys that have included the National Health and Nutrition Examination survey (NHANES), the Behavioral Health Risk Factor Surveillance system (BHRFSS) and the National Survey on Drug Use and Health (Centers for Disease Control and Prevention, 2013; Centers for Disease Control and Prevention 2014b; Substance Abuse and Mental Health Services Administration, 2013).

In conducting each survey, a representative sample of men and women, randomly selected from across the United States, participated in telephone interviews, to answer questions regarding personal health, disease prevention, healthcare access and status of chronic illness. The
results of these surveys and several other large surveys have provided valuable data regarding the incidence and prevalence of health conditions and preventive health behavior of the American people; as well, these surveys have provided data to develop national goals for improvement of our nation’s health, as evidenced by the *Healthy People 2020* (HealthyPeople.gov, 2013).

Men and women in federal or state prisons or local jails have not been included in the above referenced surveys. Demographic information collected in each survey has not included whether the person interviewed may have a history of incarceration. Limited data are available that describe the health of men and women who are in federal or state prison and local jails, and is published primarily by the Office of Justice Programs, Bureau of Justice Statistics (Bureau of Justice Statistics, 2014). Much of the health status data regarding inmates has been collected retrospectively from administrative records of federal and state prisons or county jails nationwide. Studies have included inmate interviews, although limited. To date, data are limited that enable an improved understanding regarding preventive health behavior among the correctional population.

Studies are also limited that explore preventive health among the correctional population returning to communities. In fact, studies have not examined factors - personal or otherwise - that are associated with preventive health practices, such as periodic health screening or maintenance of a healthy lifestyle, early disease detection or personal efforts to curtail the effects of chronic illness. The focus of this study was to explore and describe health and preventive health behaviors that are reported by men and women recently released from county jails located in a suburban community outside of a major metropolitan area in the United States.
The Correctional Population

The correctional population includes men and women court-sentenced to federal and state prison, or in county jails, for a crime committed; court sentencing can also include court-ordered participation in a community correctional program that can include community service, parole or probation (supervised or unsupervised) (Freudenberg, 2001). More than 2 million people are incarcerated in the United States (Pew Center on the States, 2008). Every year more than 12 million men and women pass through federal, state, and county jails and prisons (Gondles, 2005; Pew Center on the States, 2008; Stojkovic, 2007). Differences in inmate demographics and length of average stay are described among inmates at each type of facility – federal or state prison vs. local and county jails.

Approximately, 1.6 million men and women are sentenced to federal and state prisons across the United States. These individuals are serving lengthier sentences, of usually more than one year. In 2009, men accounted for 93% of the total population, most men and women are of black non-Hispanic origin (45%), and more than 50% are between the ages of 20 and 39 years old (Bureau of Justice Statistics, 2010).

In contrast to those in federal and state prisons, about 750,000 men and women reside in local and county jails on any given day. Many have been arrested for an alleged offense and may be awaiting arraignment and/or court date for trial (61%), may be serving a court-imposed sentence of incarceration for one year or less, or are awaiting transfer to a federal or state facility (39%) (Freudenberg, 2001). County jails in the United States have more men (87%) than women, and most individuals are white (44%), followed by African American (37%), and Hispanics (15%) (Minton, 2011). Most men and women in county jails are between the ages of
18 to 34 years, a rate more than two times that of those between the ages of 35 to 49 years and those over the age of 50 (Cunniff, 2002).

Many men and women who are in county jails, come from socioeconomically disadvantaged urban communities; Chicago, Philadelphia and New York are among the top five county jails in the country where more than 10,000 inmates reside on a daily basis (Bureau of Justice Statistics, 2010; Report of the Re-Entry Policy Council, 2005). Annually, more than 10 million men and women are released from local county jails.

Community correctional programs nationwide include men and women who are released from incarceration (end of sentence), and those who continue to serve a court-imposed sentence (probation or parole or community service) while living in the community. More than 50% of men and women participating in community correction programs nationwide have felony convictions associated with drug-related sentencing (Arditti & McClintock, 2001). In 2009, more than 22 percent of 1.7 million adults (18 or older) released from prison in the same year had histories of illegal drug use, and approximately 28 percent of 5.1 million persons on probation reported illegal drug use (Substance Abuse and Mental Health Services Administration, 2010).

Laws enacted in response to the “war on drugs” declared by President Nixon in 1972 have had a direct effect on the number of persons in jail and prisons in the United States. After passage of the Anti-Drug Abuse Acts of 1986 and 1988 signed by President Reagan, prisons and jails experienced an unprecedented growth in number of inmates. Sixty percent of individuals in United States prisons and jails are non-violent offenders and 25 percent of men and women are behind bars because of drug-related convictions (Schmitt, Warner, & Gupta, 2010). Although drug use is reported to be high, only 7 to 17% of drug-using jail inmates in the United States
have participated in a treatment program in jail or prison (National Institute on Drug Abuse, 2011).

Among men and women continuing on parole or probation who commit another crime, 50 percent of the time, the individual is under the influence of drugs. Illegal substance users may have histories of impulsive decision-making which can affect personal behavior, self-control and deviance (Mooney, et al, 2008). As men and women continue to reoffend and have repeated convictions, drug use is a frequent factor (French, Fang, & Fretz, 2010). Forty – five to sixty-five percent of inmates have a history of substance use and the chances for repeat incarceration (recidivism) is doubled in this group when compared to those without a substance use history (National Re-entry Resource Center, 2012). Approximately two of every three persons leaving prisons and jails go back within 3 years of release (Bales & Mears, 2008; Codd, 2007).

In addition to illegal substance use, men and women participating in community corrections may have court-imposed sentencing related to convictions for driving while intoxicated (DWI) or other traffic criminal violations (18%) or for committing violent crimes and/or other offenses (13 %) (Pew Center on the States, 2009). Sixty-five percent of the women in jails report having minor children. The majority of these women are in their 20's or 30's, unmarried, and without a high school education.

Demographics of men and women on probation in communities across the United States include those of all ethnic backgrounds, with most individuals who are white (50%), followed by African-Americans (30%), and Hispanic (12%) (Primm, Oscher & Gomez, 2005). Of those who have a history of incarceration either in federal and state prisons or in county jails, 10 % of men and women have a history of homelessness and more than 20 % of individuals have a mental
health disorder, a rate six times higher than the general population (Greenberg & Rosenheck, 2008a; McCoy, Roberts, Hanrahan, Clay, & Luchins, 2004).

More than 40% of those released from prison or jails are without a high school education. Many lack job skills or have been unemployed prior to incarceration (Bureau of Justice Statistics, 2003; Freudenberg, 2005; National Re-Entry Resource Center, 2012, Pew Center for the States, 2011). Twenty-two percent of men and women in jail are reported to have a learning disorder that may include dyslexia or an attention deficit disorder (Marushak, 2006). Degree of health literacy may affect the ability to understand health-related information among the community correctional population (Kutner, Greenberg, Jin, & Paulsen, 2006, p. 2).

**Health and the Correctional Population**

**Chronic Illness.** Wilper, et al. (2009) found more than 750,000 inmates have at least one chronic medical condition and persistent medical problems were reported by 14% of federal and 20% of state inmates. Data collected from the 2002 Survey of Inmates in County Jail, indicated more than 229,300 inmates reported presence of medical problems. Female inmates (50%) when compared to male inmates (35%) report a higher number of medical problems (Marushak, 2006).

Men and women returning to communities nationwide have health histories of infectious and chronic diseases, substance abuse, and mental health problems (National Commission on Correctional Health Care, 2002). Rates of tuberculosis (TB) and Acquired Immune Deficiency Syndrome (AIDS) are four to ten times higher in persons living in jails and prisons compared to the general population (Golembeski & Fullilove, 2005). Prevalence of hepatitis B virus is five times greater among the incarcerated than in the general population, particularly among those having a history of at-risk sexual and drug-use behaviors (Gupta & Altice, 2009).
Malik-Kane & Visher (2008) conducted a longitudinal study that included interviews with more than 1000 returning offenders in several states, and found 54% of the women and 77% of the men had one or more chronic health conditions at the time of their release from prison. Human immunodeficiency virus (HIV) infection and sexually transmitted diseases (STDs) are described in increased numbers among women, subsequent to personal histories of violence, substance abuse, promiscuity, prostitution, and exchange of sex for drugs, when compared to community populations (Bonney, Rose, Clarke, Hebert, Rosengard & Stein, 2007; Fickenscher, Lapidus, Silk-Walker, Becker, 2001; Fogel & Belyea, 1999; McClelland, Teplin, Abram, & Jacobs, 2002; Vik & Ross, 2003).

**Mental Health.** Mental health disorders are prevalent among the correctional population, with many individuals having more than one mental health condition (Steadman, Osher, Robbins, Case, & Samuels, 2009). More women, in comparison with men, have used multiple substances, i.e. crack and powdered cocaine, experienced sexual / physical abuse and have a co-occurring mental health conditions, i.e. anxiety and depression. (Staton-Tindall, Havens, Oser, Prendergast & Leukefield, 2009). Scott, Lewis & McDermott (2006) describe the prevalence of “co-morbid substance use disorder[s] in offenders with mental illness is the rule, not the exception” (p.35).

Prevalence estimates of major depression are reported between eight and fifteen percent (National Commission on Correctional Health Care, 2002). Among women inmates in particular, the prevalence of depressive or dysthymic disorder is reported between 20 and 27 percent and major depression is recognized as a continuing prevalent co-morbid condition among substance use among women, more frequently than among men (Conner, Pinquart, & Duberstein, 2008;
Johnson & Zlotnick, 2008). In addition, psychiatric disorders related to Drugs and Alcohol, Post Traumatic Stress Disorder, Alcohol Abuse, Major Depression and Antisocial Personality Disorder and Borderline Personality Disorder is found proportionately higher among female inmates in jails when compared to male inmates (Jordan, et al., 2002; Lewis, 2006, Teplin, 1994).

In addition to the mental health disorders mentioned, approximately 1% of men and women in jail are schizophrenic or have other psychotic disorder, and 2-3% are diagnosed with bipolar disorder (National Commission on Correctional Health Care, 2002). Inmates with co-occurring disorders, i.e. substance abuse with depression, bipolar disorder, and schizophrenia, are at higher risk for repeated incarcerations when compared to inmates with either a psychiatric disorder alone or a substance use disorder alone (Baillargeon, et al., 2010). Non-adherence to psychotropic medication among inmates with psychosis, schizophrenia, and other serious mental illness is associated with violent crime and continuing recidivism (Shelton, Ehret, Wakai, Kapetanovic & Moran, 2010).

Many men and women in the criminal justice system have histories of personal violence, sexual abuse, and post-traumatic stress disorder (Fickenscher, Lapidus, Silk-Walker, & Becker, 2001; Mullings, Hartley, & Marquart, 2004; Singer, Bussey, Song, & Lunghofer, 1995). Post-traumatic stress disorder (PTSD) is found among men and women with a correctional history, and is associated with prior experiences of domestic and sexual abuse - personal histories reported in this population (Richie, Tsenin, & Widom, 2000). More than two thirds of inmates may not have received treatment for known mental disorders while incarcerated in accordance with national guidelines for treatment of mental health conditions (Baillargeon, Penn, Knight,
Hartzke & Baillargeon, 2010; Fazel, Hope, O'Donnell, Piper, & Jacoby, 2001; National Commission on Correctional Health Care, 2002). The status of offender mental health is one of continuing morbidity and co-morbidity and is associated with continued criminal behavior (Freudenberg, Daniels, Crum, Perkins, & Richie, 2005; Greenberg & Rosenheck, 2008b).

**Disease Prevention.** Studies that explore health, either describing health-related behavior that emphasizes a healthy lifestyle or behavior that indicates personal understanding of the importance of early detection, treatment, or efforts to reduce the effects of chronic disease, is limited in correctional health literature. Health behavior pertinent to this population has predominately been described in relation to risk behavior or behavior that may cause self or others health harm. Risk-behavior includes having unprotected sex thus increasing HIV risk (Clements-Nolle, et al., 2008; Daniels, Crum, Ramaswamy, & Freudenberg, 2011; Martin, O'Connell, Inciardi, Surratt, & Maiden, 2009), tattooing with reused needles increasing risk for hepatitis C (Pena-Orellana, Hernandez-Viver, Caraballo-Correa, & Albizu-Garcia, 2011), and alcohol use and risky sexual behavior (Clarke, Anderson & Stein, 2011).

The use of drugs, e.g. marijuana, cocaine, and methyl amphetamine, continues to be a public health concern as men and women return to communities nationwide (Daniels, et al, 2011; Durrah, 2005). Additionally, seventy to eighty percent of men and women in jail or prison smoke tobacco — a percentage four times the national average of non-institutionalized men and women (Thibodeau, Jorenby, Seal, Su-Young, & Sosman, 2010; Voglewede & Noel, 2004). Data describing the correctional population indicate excessive alcohol intake is associated with risky sexual behavior, among both men and women (Staton-Tindall et al., 2007; Stein et al., 2009; Stuewig, Tangney, Mashek, Forkner, & Dearing, 2009), heroin and other drug use
(Phillips, Nixon, & Pfefferbaum, 2002; Seal et al., 2001), violent crime (Weizmann-Henelius, Putkonen, Naukkarinen, & Eronen, 2009) and domestic violence (Parker, 2004) – all conditions found in this population.

**Social Factors related to Health.** Housing, employment and substance treatment are three predominant areas of concern for released men and women returning to communities and can affect health (van Olphen, Freudenberg, Fortin, & Galea, 2006). As men and women return to communities nationwide after jail or prison, they seek living arrangements, look for employment, and again attempt to reestablish relationships with family and friends. Multiple challenges exist in the lives of these men and women who now have a criminal history that can act as a stigma and limit access to governmental programs for housing, employment and healthcare.

**Summary**

To date, data regarding men and women in the criminal justice system have provided indices of chronic illness, infectious disease, and mental health disorders. Information regarding the personal, social or community factors that may have relevance to individual health and health promotion, among this population is particularly limited. Healthy People 2020 is a national agenda and serves as a blueprint for continuing support of clinical, educational and multi-disciplinary research efforts that encourage public health of all people in the United States. This study will provide information regarding factors that influence personal health and health promotion, defined as primary, secondary and tertiary health prevention among men and women who have a history of incarceration, having served time at a county detention center. As the prevalence of mental health, physical health and at-risk health behavior is higher in this population when compared to men and women living in the community not having a history of
incarceration, this study will contribute to nursing knowledge applicable to correctional health, public and community health nursing.

**Statement of the Problem**

Research studies have provided some insight regarding the personal and socio-economic status and concerns of men and women reentering the community after incarceration, in either state or federal prison or county jails (Alemagno, 2001; Arditti & Few, 2006; Freudenberg, Daniels, Crum, Perkins, & Richie, 2008; Loeb & Steffensmeier, 2006; Loeb, Steffensmeier & Myco, 2007; McBurney, 1989; Sered & Norton-Hawk, 2008). As men and women are released, we know little about how these individuals perceive their own health, what views they may have regarding their own ability to maintain health, or what factors are associated with individual health-related behavior.

More than ten million men and women go through county jail doors each year. Pollack, Khoshnood & Altice (1999) describe community health challenges that exist for men and women returning to communities after incarceration. These challenges include individual relapse to previous lifestyle that may pose numerous health risks, such as continued drug or alcohol use; in addition, continuity and coordination of care that promotes mental and physical health or other needed treatment for continuing chronic illness is lacking (Golembeski & Fullilove, 2005; MacNeil, Lobato & Moore, 2005).

As health problems continue at seemingly higher rates than in general community populations, - e.g. chronic illness, mental illness, risk behavior associated with communicable disease, substance / alcohol use – little is known about the individual who is reentering the community after incarceration. Empirical research is absent to provide an understanding of
individual views regarding one’s own health or factors that influence personal health promotion among the re-entering population.

Studies have documented increased prevalence of chronic health problems among the correctional population when compared to non-institutional residing community population; and yet, views of men and women regarding disease prevention, early diagnosis and treatment or continuing care of chronic illness are not known. Additional study that explores health and levels of disease prevention among the correctional community population is needed.

As demographic differences exist between men and women in county jails as contrasted with federal and state prison inmates – predominance of white men and women vs. non-Hispanic Black, shorter stay vs. longer incarceration usually more than 1 year - it is important to understand the needs of this unique population. Community health among the county detention population is only one aspect of understanding the health needs of the larger correctional population.

This study obtained information concerning health promotion among men and women reentering the community after release from county detention, thus, enabling a better understanding of this population. The importance of this information is consistent with national goals for a healthier nation, stated in *Healthy People 2020*.

**Theoretical Framework**

Two nursing models underpinning this qualitative study were *Rediscovery of Self-Care: A Model for Nursing Care of Persons with an Incarceration Experience* (Shelton, Barta & Anderson, 2010) and *Nola Pender’s Health Promotion Model (HPM)* (Pender, Murdaugh & Parsons, 2011).
Rediscovery of Self-Care: A Model for Nursing Care of Persons with an Incarceration Experience (See Figure 1). This model describes individual transitional stages found among persons who have an incarceration experience (Shelton, 2010a). Four specific time periods are described: 1) Community environment – prior to incarceration, 2) Prison Environment, 3) Initial Re-Entry and 4) Re-integration. Orem’s Self-care Model, which describes the nurse’s role in assisting clients who have or have had an incarceration experience to meet self-care requirements that may result from loss, illness, injury or life events, is an

Figure 1: Rediscovery of Self-Care: A Model for Nursing Care of Persons with an Incarceration Experience

underlying nursing framework in this study. At any transition time, an individual is vulnerable to stressors that can negatively affect personal adaptation and may result in the need for nursing assistance with management of self-care.

**Community environment.** Prior to incarceration, an individual lives in a community and is responding to differing life events that can have a negative or positive effect on personal functioning. Positive life events might include maintaining adequate housing, sufficient income, and attending safe schools; negative life events might include living in a drug-ridden community where violence is an everyday problem. Prior to an incarceration experience, individuals acquire life history and experiences that can influence personal mental and physical health, vocational skills, and interpersonal skills. Personal adaptation is dependent on individual level of self-efficacy, personal planning ability, and degree of motivation, control and beliefs – all factors that can affect individual self-care.

**Prison environment.** After sentencing for a civil or criminal offense committed, an incarceration experience can result for an individual. During this time, men and women experience a controlled environment, have a lack of autonomy, and have restrictions in self-care. He or she is expected to adapt to incarceration that can cause stress resulting in a change in cognitive functioning. Social support by family and friends is limited.

**Initial re-entry.** After serving a period of incarceration, as men and women reenter the community, each may attempt to re-establish housing, employment, and reconnection with family and friends. Personal challenges may be present to positively re-establish a crime free life and achieve positive adaptation in maintaining personal responsibilities of self-care. Personal
situational awareness, goal setting, problem solving, emotional control ability and other environmental factors may influence individual adaptation.

Re-integration. Reintegration is the final phase of immediate personal restoration after an incarceration experience. Men and women continue to learn / relearn self-care behavior, become more goal oriented and engage in positive lifestyle promotion (or not). Each person may successfully (or unsuccessfully) be able to negotiate life demands, remain out of incarceration, and meet their own needs to enable functioning as an independent adult.

Men and women who participated in this study were those in an “initial re-entry period”, defined as the time individual efforts are directed toward increasing self-awareness and goal directed behavior. This study explored personal self-awareness of health, barriers and facilitating circumstances associated with health promotion during this initial stage after incarceration.

Pender’s Health Promotion Model (See Figure 2). Pender's Health Promotion Model (HPM) served as a guide in development of methodology using a focused interview format in this study. Pender’s model, first published in 1987, was influenced by two theories of behavior: expectancy value theory and social cognitive theory (McCullagh, 2009; Pender, et al., 2011). Expectancy value theory describes human behavior as goal-oriented and is motivated by expectations that one has and the value one places on the goal to be achieved (Pender, et al., 2011).
Figure 2: Penders’s Health Promotion Model


Underlying Pender’s model is social cognitive theory that describes how we as human beings learn from the world around us. Human behavior is viewed as an interaction of personal factors, behavior, and the environment; and also, personal self-efficacy influences knowledge acquisition and the sense of control that a person has to manage or adhere to a prescribed treatment plan or to participate in positive change of behavior (Evangelista, 2008; Jones, Harris, Waller, & Coggins, 2005; Schoenthaler, Ogedegbe, & Allegrante, 2009).
Pender’s theory includes three (3) major relationships, e.g. individual characteristics and experiences, behavior-specific cognitions and affect and behavioral outcomes. Individual characteristics include personal factors referring to any biological, psychological or socio-cultural factors. (Pender, Bar-Or, Wilk, & Mitchell, 2002). Behavior – Specific Cognitions represent a grouping of factors influencing individual health promotion, i.e. perceived benefits of action, perceived barriers to action, perceived self-efficacy, activity-related affect, interpersonal influences and situational influences (Pender, et al., 2011). In particular, self-efficacy or the degree of perceived competence regarding a health behavior will increase the likelihood of health behavior action (Robbins, Pender, Ronis, Kazanis, & Pis, 2004; Robbins, Pis, Pender, & Kazanis, 2004; Shin, Jang, & Pender, 2001; Shin et al., 2006).

Health behavior can also be influenced by positive emotions that may be associated with the behavior. In addition, health behavior can be affected by interactions with significant others who support or model the desired health behavior, or by family and friends who can positively or negatively affect individual commitment and engagement in health-promoting behavior (Wu & Pender, 2005; Wu, Pender, & Noureddine, 2003). The effect of interpersonal influence and social support is not consistently documented as an influencing factor as seen in studies which involve physical activity among adolescents (Duffy, 1993; Shin, Jang, & Pender et al., 2001; Wu & Pender, 2005).

**Application of Nursing Theory to Population of Interest.** The focus of study included men and women who are returning to communities after a recent incarceration experience at local county detention centers, and within a time frame defined as “initial re-entry” (Shelton, 2010a; Shelton, Barta & Anderson, 2010b). Individual focus during this time includes
development or rediscovery of self-awareness, personal goal setting and problem solving in daily life after incarceration. Personal self-awareness of one’s own health and preventive health behaviors is an important area to explore and is consistent with aspects of self-development important during this time. Factors that may influence goal setting and problem solving among men and women concerning their own health is important.

In addition, Pender's Health Promotion Model was used as a guide to explore personal factors, barriers or facilitators, and the influence of situational or interpersonal factors that can influence health promotion consistent with social learning theory. Knowledge gained through this study provided an initial understanding of health and factors that influence health as described by men and women post- release from a county detention center.

**Statement of Purpose**

The overall purpose of study was to 1) explore health and health promotion of men and women recently released five days to eighteen months prior from an adult county detention center, and 2) explore the personal, social and community factors that may act as barriers and facilitators in health promotion among men and women released from an adult county detention center.

**Research Questions**

The main questions for this study were

1.) How is health described by men and women recently released from an adult county detention center?

2.) How do men and women experience health after recent release from an adult county detention center?
3.) What personal strategies to promote, maintain or restore health are described among men and women recently released from an adult county detention center?

4.) What personal, social or community factors influence health promotion, i.e. primary, secondary and tertiary prevention as described by men and women recently released from an adult county detention facility?

5.) What barriers or facilitating influences to health promotion, i.e. primary, secondary and tertiary prevention, as described by men and women recently released from an adult county detention center?

**Definition of Terms**

**Health promotion.** Health promotion was theoretically defined as “increasing the level of well-being and self-actualization of a given individual or group” and included activities related to primary, secondary and tertiary health prevention (McCollugh, 2009, p. 292). Health promotion was operationally defined as information obtained in response to questions included on a focused interview guide and demographic survey (See Appendix A and B).

**Primary health prevention** was theoretically defined as “specific practices for the prevention of disease or mental disorders in susceptible individuals or populations.” (National Library of Medicine, 2011a). Primary health prevention was operationally defined as information obtained in response to questions included on a focused interview guide and demographic survey.

**Secondary health prevention** was theoretically defined as health measures that stop or slow progress of disease. Health measures included health screening such as mammography to detect breast cancer, and blood pressure screening to detect hypertension treatment (AHRQ, 2012).
Secondary health prevention was operationally defined as information obtained in response to questions included on a focused interview guide and demographic survey.

*Tertiary health prevention* was theoretically defined as "measures aimed at providing appropriate supportive and rehabilitative services to minimize morbidity and maximize quality of life after a long-term disease or injury is present" (National Library of Medicine, 2011b). Tertiary health prevention was operationally defined as information obtained in response to questions included on a focused interview guide and demographic survey.

**Personal factors.** Personal factors were theoretically defined as biological, psychological or socio-cultural factors that can affect action or inaction toward individual health promotion (Pender, 2011). Personal factors which may affect action toward health also included own life history and experiences pre-incarceration, vocational skills, self-efficacy, personal planning ability, degree of motivation, control and beliefs, and during time of initial re-entry, personal situational awareness, problem-solving, goal-setting, and emotional control (Shelton, et al., 2010a). Personal factors were operationally defined as responses obtained in response to questions included on a focused interview guide and items listed on a demographic survey (See Appendix A and B).

**Interpersonal Influence.** Interpersonal influence was theoretically defined as “interpersonal influences (family, peers, providers): norms, social support, role models – perceptions concerning the behaviors, beliefs, or attitudes of relevant others” that influence preventive health practices (Pender, 2011, p. 3). Interpersonal influence was operationally defined by responses obtained in response to questions included in a focused interview and items listed on a demographic survey (See Appendix A and B).
Situational influence. Situational influence was theoretically defined as environmental factors that can influence the outcome of preventive health practices (Pender, 2011). Situational influence was operationally defined by responses obtained in response to questions included in a focused interview and items listed on a demographic survey (See Appendix A and B.).

Perceived benefits. A perceived benefit was theoretically defined as the “perceptions of the positive or reinforcing consequences of undertaking a health behavior” (Pender, 2011). Perceived benefits was operationally defined by responses obtained in response to questions included in a focused interview and items listed on a demographic survey (See Appendix A and B).

Perceived barriers. Perceived barriers were theoretically defined as “perceptions of the blocks, hurdles, and personal costs of undertaking a health behavior” (Pender, 2011). Perceived barriers were operationally defined by responses obtained in response to questions included in a focused interview and items listed on a demographic survey (See Appendix A and B).

Recent release from an adult county detention center. Recent release from an adult county detention center was theoretically defined as release from a county detention center where men and women over the age of eighteen are detained after arrest; a county detention center provides 24 hour supervision of men and women who are awaiting charges for a criminal or civil offense, or serving sentence imposed by a court judge for civil or criminal offense. Recent release from an adult county detention center was operationally defined as release of a man or woman from an adult detention center located in a mid-Atlantic state; such person has been incarcerated for least five days and no longer than two years, and released five days to no longer than eighteen months prior to the time of study.
Assumptions

Assumptions underlying the study were formulated in review of assumptions associated with each of two nursing models, *Pender’s Health Promotion Model*, and *Rediscovery of Self-Care: A Model for Nursing Care of Persons with an Incarceration Experience* (Pender, et al., 2011; Shelton, et al., 2010a) as stated:

Men and women released from a county detention center and living in the community

1. can respond honestly to verbal questions.
2. are reflective and can assess own competencies accurately.
3. seek opportunities for growth in personal transition while seeking equilibrium between change and stability.
4. seek opportunities for wellness and have the capacity to care for self.
5. interact and respond to their current environment, influenced by prior personal experience; such interaction can change with new experience and understanding.
6. can respond positively throughout a lifespan to nursing assistance directly toward promotion and maintenance of personal well-being.
7. have the capacity to change while interacting in relationships with other human beings.

Significance of the Problem

This study explored health among men and women who were recently released from an adult county detention center. Men and women in the study included those who had been incarcerated anywhere from five days to two years while serving a court-assigned sentence and since have returned to a community to live independent lives. As increasing number of men and women go through the doors of a county detention center each year and return to communities
nationwide. Factors that influence the health of this population have been largely unexamined. Nursing research that explores health and influencing factors associated with primary, secondary and tertiary health prevention among this returning population is important.

Knowledge gained through this study can be applied to individual one-to-one effort working with individuals, or support organizational design/ redesign of appropriate health programs for the returning population nationwide. This study was only a beginning inquiry to explore health among the lives of men and women with a county detention center incarceration experience. Information gained through study can add to the sparse amount of knowledge that exists regarding health and factors that affect health among this population.
CHAPTER II: REVIEW OF THE LITERATURE

Introduction

Research in correctional health has described an increased prevalence of health problems among men and women in federal and state prisons and local jails when compared to the general population – these health problems include mental health disorders, infectious disease, chronic illness, substance and excessive alcohol use, and smoking tobacco. Studies conducted retrospectively have described health statistics with regard to medical and mental health conditions prevalent among federal, state and county jail inmates. Although there is an increased prevalence of health problems in the correctional population, factors that may affect personal decision-making regarding personal health and health promotion have largely been unexamined.

National focus has included study of the correctional population returning to communities after incarceration. The Second Chance Act of 2007 signed by President Bush in 2008 provides a national focus of the importance of the re-entry process and offers financial support to states to develop programs that support community programs that may assist to decrease recidivism among the returning population (Spjeldnes & Goodkind, 2009). Studies that describe personal challenges faced by returning men and women in community re-entry continue to be qualitative in nature describing personal, social, and socioeconomic conditions reported among this population.

Health promotion, emphasizing and encouraging lifestyle changes to improve or maintain health began to appear in the mid 1980’s. Researchers both in nursing and in non-nursing began to develop instruments to assess personal characteristics that may influence a health – promoting life style. (Pender, Bar-Or, Wilk, & Mitchell, 2002; Pender, Walker, Sechrist, & Stromborg,
Variables of study included demographics of age, sex, marital status, income, education, religious preference, intrinsic vs. extrinsic motivation, perceived social support, self-reported health status, and perceived social support. Factors associated with preventive health behavior and health promotion have not been studied among the correctional population.

Additional factors that may influence personal behavior and health promotion include 1) recognized personal need and motivation to receive the information; 2) the capacity for self-efficacy to integrate the cognitive, affective or psycho-motor skills necessary to adopt a revised way of thinking about an aspect of health or integrate a life style behavior change and 3) be free of barriers to access or integrate the new information (Arras, Ogletree, & Welshimer, 2006; Becker & Stuifbergen, 2004; Kaewthummanukul & Brown, 2006; Shin, et al., 2006). To date, study of these factors relevant to the correctional population leaving county jails and living in communities has not been conducted.

Although the prevalence of health conditions is known regarding the correctional population, it is not clear what understanding of health, or of factors associated with health promotion, is found among the returning population. Differences may also exist regarding influencing factors affecting men and women who have been incarcerated for shorter time periods (county detention) as compared to those having served longer sentences in federal and state prisons. In either case, prison or county detention centers, empirical research to date has sparsely examined health or preventive health behavior – e.g. personal behavior directed toward early detection and screening, diagnosis and treatment, and restorative or rehabilitative in nature and what meaning is assigned to these concepts by the returning population.
This literature review includes studies that examine health promotion defined as any aspect of primary, secondary or tertiary health prevention, found among men and women who are or have been incarcerated in county jails in the United States. This review is divided into sections that describe studies relevant to the health promotion of men and women who have spent time in county jails. Studies include those that address: 1) current health status and factors influencing health; 2) primary prevention associated with lifestyle; 3) secondary prevention or those studies that describe factors associated with health screening, early diagnosis and treatment of health concerns, including treatment adherence; and finally 4) mental health, or studies that describe substance use or other mental health – related concerns found among this population.

**Health of the Correctional Population**

**Health Status.** Men and women in county detention centers are more likely to be less healthy when compared to those without a history of incarceration. Conklin, Lincoln & Tuthill (2000) conducted interviews with 1198 men (90 %) and women (10 %) inmates on day 3 of incarceration at a county correctional facility that included those detained for 3 days or less, or 4 days to 3 months, and those detained anywhere from 91 days to 2 years. More than 50 % of the inmates were younger than 30 years old, most were Hispanic (40 %), or non-Hispanic white (33%), and less than 50 % of men and women had a high school / Graduate Education Diploma (GED).

Data reported by the inmates included health status and health problems, use of tobacco, alcohol or drugs, and sexual behavior and other lifestyle behavior. Fifty percent of all men and women stated their health to be good, fair or poor. The most reported health problems (in addition to substance use), were dental concerns and conditions associated with bones, back,
neck and mental health. Only 33% of men and women saw a health provider at least once within one year and the primary reason for non-healthcare was cost. Drug and alcohol use were the most frequently reported problems and more than 75% of men and women reported tobacco use. Women more frequently reported sexually transmitted disease, e.g. Chlamydia, gonorrhea, syphilis, - a rate two times that of men. Conklin, et al.’s (2000) study points out a lack of positive health among county inmates; also, barriers to health include limited access to health providers related to cost. The need for disease prevention at all levels of services, whether preventive, diagnostic, or restorative, was reported.

Schnittker & John (2007) discussed the effects of incarceration on health and suggested that spending time in jail or prison may have a negative effect on individual health post-release, both short and long term. The investigators described the results of data collected using the National Longitudinal Survey of Youth ages 14 – 21 among a representative sample of more than 11,000 incarcerated male and female inmates; 50% male and 50% female) who were either in jail or prison, during the years 1979 to 2000. Approximately 20% of female inmates, when compared to 14% male inmates, reported severe health limitations. Generally, more African Americans and female inmates were more likely to report functional limitations (ability to work) resulting from a health condition. Men and women who spent a longer time in jail tended to have less education, scored lower on intelligence, and were two times as likely to use drugs. Functional and physical limitations were reported twice increased among those spending more time in jail when compared to men and women who spent less time in jail.

**Discharge planning.** Hammett, Roberts & Kennedy (2001) discussed the numerous factors that can affect post-release adherence to medical treatment among released inmates.
Discharge planning and community referral to county clinics prior to release can assist in obtaining needed preventive services. Other factors include exclusion from entitlement programs, the lack of coordination in the transfer of pertinent medical information, and having insufficient medication and or needed supplies upon release.

Discharge planning to meet the health needs of offenders prior to community release is not well documented. As men and women are released with numerous health problems – both mental and physical health related - effective assistance in promoting healthcare services continues to be lacking nationwide. Flanagan (2004) conducted a study using a mail survey sent to 33 chief medical officers of prison facilities within the United States, asking each to complete information related to transitional health care for inmates with varied health issues, i.e. AIDS, TB, hepatitis, mental illness, and substance abuse. She found that transitional health-care programs for ex-offenders vary widely across the country. All respondents reported some type of planning, most frequently at one or six months prior to release and usually registered nurses were involved.

Only one study was found that explored case management or discharge planning implementation related to treatment adherence among the correctional population. Wohl, et al (2010) conducted a randomized control study to explore if continuing case management of HIV – infected men and women released from a state prison had an improved effect in treatment adherence. Continuing access to care at 4, 12, 24 and 48 weeks was compared among 104 inmates in state facilities after release. Each inmate was already enrolled in one of several participating clinics statewide where follow up care was delivered. At time of recruitment, inmates were randomly assigned to one of two treatments - case management or pre-release discharge planning. For those assigned to case management, periodic meetings with released
clients were held after release, and for those assigned to the discharge planning intervention, nurses worked with each client 3 – 6 months during incarceration, prior to release.

In review of findings of 89 participants continuing throughout the study (n=43 in case management and n= 46 in discharge planning), no statistical difference was observed in access to care between each group. Results indicated both groups continuing to access care at 4 weeks (65 % of those case managed and 54% of those in the discharge planning treatment), at 12 weeks (88.4 % of those case managed and 78 % in discharge planning treatment), at 24 weeks (90 % of those in case management and 89 % in discharge planning treatment).

Even though no difference was found between those, who were case managed continuing after jail when compared to discharge planning only in jail, the study does point to the positive effect of case management on treatment adherence among HIV clients released from a correctional setting. With both discharge planning and case management, men and women in jail continued to access needed medical care in treatment of HIV.

Research describing the use of case management models for care, treatment and coordination of those persons with mental illness, for instance, is described with mixed results as related to decreasing recidivism, stabilization on medication, improvement in social functioning, less relapse due to substance abuse, and increased quality of life (Essock et al., 2006; Kleinpeter, Deschenes, Blanks, Lepage, & Knox, 2006; Loveland & Boyle, 2007).

Community / Social Factors Affecting Health. A focus on how one’s health is affected can be related to a number of social factors an individual is dealing with at the same time.

Freudenberg, et al. (2008) in a study conducted in an urban area of returning citizens within 1 year of release from a New York city jail, described circumstances affecting adult
women and adolescent males within 1 year of release. The study focused on describing living conditions and other factors post release, i.e. drug use, criminal activity, and health status, which affected the lives of returning citizens. Intake interviews were conducted with 706 adolescents males and 704 women at time of release between 1997 and 2001; 69 % of the adolescents and women completing the intake surveys also completed follow up interviews 9 – 18 months after release.

Most women in the sample were African American (66%), and approximately one-third had completed high school, a Graduate Education Diploma (GED) program or some college (36 %). Most women had children (80 %), about one-third were homeless (34 %) in the past year, and 63% reported histories of physical or sexual abuse. Only 27 % had worked during the six months prior to arrest; 38 % had benefited from illegal income, and 26 % were receiving public assistance prior to their arrest.

During the year prior to arrest, half of the women reported participation in drug or alcohol treatment programs and 14 % reported participation in mental health treatment. Almost 25 % of the women were pregnant in the year prior to arrest, and, of those, 28 % reported pregnancy-related medical complications. At first interview at time of jail release, women identified housing (71%), substance abuse (69 %), inadequate income (65%), education (27%), and having family problems with their children as major issues.

Fragmentation of healthcare services continues to be a concern for men and women leaving jails. Hoyt (2006) explored how formerly incarcerated women perceived their healthcare encounters, using grounded theory method. She interviewed 16 formerly incarcerated women, through focus group and individual interviews, at two different community sites. Women
described, “going back-and-forth” in a fragmented healthcare system as they sought care for their health problems. The lack of money, health insurance, literacy, and knowledge and prison stigmatization acted as barriers in achieving successful healthcare encounters. A successful healthcare encounter was influenced by having friends, nurses, and/or caring providers present. Self-persistence also influenced whether their health care needs were met.

In another study, Alemagno (2001) described the self-perceived needs among 156 women living in a female housing unit upon release from jail. Most were African Americans (72%), between the ages of 18 and 40 years old (78%). A little over half of the women (56%) were high school graduates, 53% had three or more children and 56% of the women had been in jail three or more times. Among those women reporting the need for drug abuse services (n=83), the need for community services was also reported. These women were more likely to require housing/place to stay, medical care, education/training, mental health services, family support, and parenting assistance.

Similar findings are described for both men and women. Marlow, White and Chesla (2010) in a phenomenological study, described barriers and facilitators to healthcare reported among 17 chronically ill male parolees living in a community-based residential drug and alcohol treatment program. Participants between the ages of 40 and 65 had more than one chronic mental/physical illness, and had been incarcerated at least two times. Barriers regarding access and utilization of healthcare services were reported by most participants to include financial, administrative and provider-related factors.

Financial barriers included the lack of insurance and poverty – most were using county hospitals and clinics that affected choice and decision-making of needed services. Administrative
barriers included long waiting times and paperwork procedures and coordination of care after incarceration. In addition, most of the chronically ill men saw healthcare providers as unempathetic, uncaring and “cursory” in their approach (p. 54). The result of these barriers was limited access for many who had been interviewed.

In a study that included both men and women, Wu, et al. (2012) examined if differences are found between men and women regarding barriers to receiving medical and psychiatric services. Eighty-three women and 239 men were recruited who participated in an alternative to incarceration program for at least 30 days. Of the total number of men and women, the average age was 30, most were African-American (58 %), single (75 %) and less than one-half (47 %) were high school graduates. Only 14 % of men and women were employed and more than 50 % had no insurance. The most frequent illegal drug use reported was marijuana (61%), and about one-third reported at least one binge drink experience in the last 30 days.

In this study, similar to others described, the most frequent barriers to healthcare reported by both men and women included lack of provider accommodation to personal schedules and obligations (34.9 % of women vs. 30.5 % of men), limited access to public transportation (30.1 % of women vs. 31 % of men), and limited funds for travel (28.9 % women vs. 27 % of the men). Lack of trust in the provider to act in their best interests was a significant finding among more women (25 %) than men (21.8%), and the availability of childcare was viewed as a significant barrier among women (9.6%) when compared to men (3.3%).

Sered & Norton- Hawk (2008) conducted a mixed methods study that explored the lives of 33 women after release from incarceration from a state prison and living in transitional housing one day to three months post release. Interviews conducted with each woman explored personal
health and healthcare experiences that included access to healthcare services. The overall theme reported is that of fragmentation – of individual lives, of health care, and healthcare access. Each participating woman had described experiences of physical illness present (chronic or acute) and the prevalence of hepatitis C was most frequently reported.

More than 75% of the women took prescription drugs regularly. Healthcare for these women was fragmented with many going to different providers and lacking continuity of care, as each shifted between state Medicaid and non-Medicaid coverage. Almost 90% of the women described participation in detoxification and drug treatment programs, delivered in an uncoordinated fashion as compelled by law enforcement, correctional staff or their own family. Fragmentation of individual personal lives continued due to disruption of family processes related to crises, lack of employment, housing and other concerns. Drug use was central as to why many women who participated in the study neglected their health.

Regarding healthcare service access, the women described their own vulnerabilities – healthcare providers who did not listen as they described their symptoms and concerns. Access to health programs was curtailed in some cases related to changing legislation, i.e. men and women with need of substance use treatment are no longer covered under the Supplemental Security Income (SSI) legislation; and, with a felony conviction, men and women in some states are not eligible for support through state programs such as Aid to Families with Dependent Children.

**Primary Prevention**

Primary prevention includes health measures taken that will prevent disease. Measures may include health vaccinations, well-adult visits, or early education in health hazards
associated with tobacco use or excess alcohol intake. In a recent issue of *Mortality and Morbidity Weekly Reports* (2012), results were described regarding pandemic preparedness among state and federal prisons and local jails to administer the influenza A (H1N1) virus vaccine during the 2009 – 2010 flu season. A random selection of large and small jails, federal and state prisons across the county included in the study, described more than 50% of jails (as contrasted with only 14% of federal prisons and 11% of state prisons) not receiving the vaccine for inmate administration. As men and women with a correctional history have increased prevalence of chronic infectious disease when compared to community populations, efforts to control incidence of acute episodes of flu by flu vaccine administration appear to be hampered among the inmate population, - and in particular, the jail population.

**Lifestyle.** Lifestyle among the correctional population includes a higher rate of tobacco and alcohol use when compared to the general population. Seventy to eighty percent of men and women in jail or prison, or four times the national average of community-residing men and women, smoke tobacco (Thibodeau, Jorenby, Seal, Su-Young, & Sosman, 2010). The prevalence of excessive alcohol intake among women in particular is estimated as at least five times higher than among women without a history of incarceration and living in the community (Clark, Anderson & Stein, 2011). Little is known regarding factors involved with tobacco or alcohol use among men and women who have been released from county detention.

**Tobacco Use.** Vogelwede & Noel (2004) explored independent variables associated with smoking behavior among 150 male inmates in one county jail located in the southeast United States. Interviews were conducted with each inmate regarding smoking behavior 12 months prior to incarceration. The mean age of the men was 28 years old, most were lifetime smokers
(94%), and the average education level among those who participated was less than high school completion. Results of the study showed the men had smoked an average of 11.5 years and an average of 23 cigarettes daily. About one-third of the inmates tried to quit 2.5 times (mean) which lasted 43.4 days (mean).

In another study, Thibodeau, et al. (2010) examined the effect of a smoking ban implemented in a state prison in Wisconsin. A convenience sample of 49 men who reported a daily smoking history prior to incarceration were recruited one month prior to release, and interviews were conducted one month prior and one month post release. Results among 90% of inmates continuing in the study post-release, indicated two significant relationships: 1) more white men (41%) when compared to other ethnic groups were significantly more likely to relapse to smoking post release (p< .05); and, 2) pre-release intent to quit strongly correlated (p = .001) with post release quitting smoking. The investigators discussed the role of stress in smoking behavior, and although many stresses are present post release, i.e. employment, return to same communities, housing needs, 67.3 % of the men post-release did not smoke. This study suggests that health prevention measures implemented in county jails can assist in positive health habits continuing after release. Studies were not found that described smoking tobacco among women having a history of county detention.

**Excessive alcohol use.** Alcohol use while driving is associated with time in jail and recidivism. Everyday nationwide, men and women are convicted of Driving under the Influence (DUI) or Driving While Intoxicated (DWI) (Wells-Parker, et al., 1991; Wells-Parker, et. al, 1988). In one study, Wells-Parker, Cosby & Landrum (1986) described demographics found among 353 male and female arrestees found guilty of driving under the influence (DUI) offenses
who were participating in a Mississippi DUI probation follow-up. The mean age of the men and women was 38 years old at time of offense. Non-white men and women accounted for only 22% of the sample and the mean educational level reported was 10 years, or less than that of a high school graduate. Sixty four percent of the men and women earned less than $10,000 annually, and less than half (42%) were married. The men and women had a total of 2750 cumulative offenses which included approximately 20% traffic-related violations (moving violations), 17.2% for public drunkenness behavior, and 8.3% had driver’s license violations.

In another study, Wells-Parker, et al (1991) explored gender–related demographics associated with Drinking under the Influence (DUI). Among over 3000 men (n = 3151) and women (n = 274) arrested for DUI, more men than women (43.1 % vs. 33.3%; p < .01) were under the age of 30 when arrested. Significant gender-related differences were found in level of education (only 30 % of men vs. 37.4 % of women were high school graduates); marital status differed among men and women with more women being divorced or separated (50%) as compared to men (25%). Sixty-three percent of the men had no prior DUI arrest as compared to 81 % of the women.

Woodall et al. (2004) described demographics found among men and women attending a 28 – day in jail treatment program for first time offenders convicted of driving while intoxicated (DWI). Among men and women having a history of alcohol-related crashes (n = 269), the number of individual prior arrests a person had was a significant risk factor for continuing history of car crashes. Nineteen percent of alcohol-related car crashes were associated with persons having had one arrest, and more than 28.3 % of alcohol – related crashes occurred by men and women having two or more time episode of arrest.
In review of the alcohol-related studies, men and women who are under the age of 30 appear to be at greater risk of alcohol-related driving behavior. Many arrested for alcohol-related driving are those men and women with less education and are of a lower income. It is unclear if either men or women who participate in alcohol-related driving identify excessive drinking as a health risk that can affect themselves and others. Studies are absent that explore health and drinking behavior among men and women released from jail.

Wang, et al (2009) examined data collected during a five-year longitudinal study using the survey, Coronary Artery Risk Development in Young Adults (CARDIA) among over 4300 men and women living in 4 metropolitan areas in the United States. Seven percent (n = 288) of the sample reported episode/s of incarceration and all participants were between the ages of 18 and 30 years old at the start of study. Among the men and women having a history of incarceration, a greater number were African American, less educated, and had earnings 200% below poverty (p < .001) when compared to those with no incarceration history. Smoking behavior (p < .001), drug use (cocaine use; p < .001) and excess alcohol use (p < .001) were significantly higher among these men and women. In addition, by year 5, a higher mean systolic blood pressure was observed among those who were formerly incarcerated compared to those with no history. Men and women were also more likely to develop incident hypertension, or elevated blood pressure not present at beginning of study. In particular, black men with a history of incarceration who were less educated showed a significant difference in the incidence of hypertension, being without health insurance, and having less access to healthcare when compared to those not incarcerated.
Secondary Prevention

Health Screening. As more men and women in prison and jails have a variety of health problems, efforts to provide health screening vary state to state. For instance, Seal (2005) reviewed 43 articles related to HIV/AIDS and the correctional population, published from January 2004 through March 2005, and found only two studies that addressed HIV prevention interventions.

McIntyre, Studzinski, Beidinger & Rabins (2009) in a study of 81 adult county jails in Illinois found the availability of health screening services for sexually transmitted disease (STD), HIV, AIDS and hepatitis among inmates varied across the state; only 49% of the county jails in Illinois provided on-site testing for these conditions, and only if symptoms were present. Routine screening for infectious disease was reported by four jails only. As contrasted with Illinois, data collected in Florida, Louisiana, New York and Wisconsin over a two-and-a-half year period indicated state health departments working with jails to provide voluntary rapid HIV testing programs affecting more than 30,000 inmates who requested the service or were referred.

Empirical evidence indicates that if health screening services were offered in jails, inmates would participate. For instance, the Rhode Island Department of Corrections, in a study involving rapid HIV testing, invited a random sample of jail detainees (n = 113) to complete a health questionnaire that included a survey of individual HIV risk behavior, incarceration history, HIV testing history, and attitudes toward routine HIV testing in jail and toward partner notification services (Beckwith, et al., 2007). Of 100 inmates who participated, ninety-five percent consented to rapid HIV testing. The majority of inmates (96%) supported rapid HIV testing in jail; also, partner notification was supported among inmates if results indicated positive
status. Of interest, 44% of the inmates reported sexual activity with multiple partners or having a history of injection drug use and/or shared needle use (23%), but only 25% of the inmates tested perceived themselves to be at risk for HIV.

In addition to studies that examine screening for infectious disease among inmates, only two studies have examined cancer screening among men and women who have a history of time spent in county jails. Ramaswamy, Kelly, Loblit, Kimminau & Engelman (2011) conducted a cross-sectional study to explore cervical cancer screening among 204 women in a Kansas City jail who may have a history of abuse or intimate violence. The mean age of the women was 34 years old; 48% were African American, most graduated from high school or had completed a GED (64%), less than half (45.4%) had health insurance, and only 43% of all women had a primary care health provider.

Survey results indicated 38% of the women were victims of sexual abuse and almost two-thirds (61.8%) reported physical abuse occurring before the age of 16; almost half of the women (49%) reported intimate partner violence in the year prior to incarceration. Overall, most of the women (84%) participating in the study, reported having a pap smear in the last 3 years and, more than one-third of the women (40.1%) reported an abnormal Pap in their lifetime, a rate six times higher than the general population. Women in the study who reported histories of physical abuse were six times more likely, and women who reported intimate partner violence were two times more likely, to report an abnormal pap smear, when compared to women not reporting personal histories of violence.

Binswanger, White, Perez-Stable, Goldenson & Tulsky, (2005) explored knowledge and frequency of cancer screening among 133 men and women at two large county jail facilities.
located in San Francisco. Overall findings indicated 90% of the women (n = 82) had a Papanicolaou (Pap) test within 3 years, and for women aged 40 years and older, only 41% reported having had a mammogram within 2 years. Women who were incarcerated between the ages of 40 and 49 years of age were less likely to have had a mammogram, when compared to California data obtained through the Behavioral Risk Factor Surveillance Survey (BRFSS) of same age non-institutionalized women. Both men and women in the study (75% of the inmates), had limited or no knowledge of colon cancer screening and knowledge about colon cancer screening was associated with being white and having insurance.

Results of the limited number of health screening-related studies suggest individual participation in health screening behavior among men and women before or after incarceration may be related to several factors - health insurance, and access to a primary care provider. As these studies suggest the influence of factors such as limited access and cost on individual health screening participation, there may also be additional personal, social or environmental factors which can influence health behavior, yet unexplored. As thousands of men and women pass through county jails each year, exploring both positive and negative factors that may be present regarding individual preventive behavior is important.

**Diagnosis and treatment.** Diagnosis and treatment of infectious disease appears inconsistent in jails. In a study of 20 correctional facilities, Reichard, Lobato, Roberts, Bazerman, & Hammett (2003) reviewed medical records of over 400 inmates who had been evaluated, diagnosed with tuberculosis (TB), or confirmed as having latent TB. They found chest x rays not performed or otherwise documented in approximately 25% of inmates (n = 98); in addition, sputum collection as a diagnostic test was not documented in approximately 20% of
inmates who were not receiving treatment for TB when admitted to jail. The investigators found an average delay of 3.1 days occurred before an inmate with reported symptoms was provided respiratory isolation. Documentation regarding discharge planning or community follow up was lacking in more than 80% of medical records of those inmates with latent TB.

The lack of health information available has been identified as a barrier among men and women with infectious disease leaving county detention. For instance, Catz et al. (2012) in a study that included interviews with 30 HIV-infected men and women who were awaiting release, found that individual lack of information was reported a barrier affecting HIV risk reduction behavior. Both men and women wanted information regarding viral loads and transmission modes of the disease. In addition, both men and women identified barriers associated with risk reduction that included partners' attitudes toward condom use, HIV disclosure and related fears of rejection, presence of depression, and substance use upon release. Both men and women expressed interest in learning more about safe behaviors with partners, how to communicate disclosure of HIV status, and the opportunity to acquire clean needles or condoms upon release. Stigma and privacy concerns were viewed as major prison barriers to delivering HIV prevention services during incarceration.

Zucker (2006) conducted a pilot study of women diagnosed with hepatitis C to explore health beliefs and level of understanding regarding personal health and illness. Data were collected from women in three focus groups; one group was recruited from specialty physician offices (n = 5), another group of women recruited through a church that offered support for women with HIV/Hepatitis C (n = 5), and one group was recruited from a county correctional facility (n = 6). Women in the county correctional focus group reported that although each
maintained an active interest in their own health, each sought medical services only when they were sick. A knowledge gap regarding HIV or Hepatitis C was reported among the women, who also wanted to know more about their illness. Overall results of the three focus groups of women with hepatitis C indicated that women belonged to one of two groups - those with and those without access to knowledge and Hepatitis C services. Women in all groups wanted more information and worried about transmission of the virus.

**Treatment Adherence.** Treatment adherence by men and women returning to communities who have medical conditions has not been widely studied. In particular, the study of medical treatment adherence has predominately centered on those with infectious disease – hepatitis C (Butt, Wagener, Shakil & Ahmad, 2005), HIV/AIDS (Arnsten, et al., 2007; Williams, et al., 2006) and Tuberculosis (TB) (Mitty, et al., 2005; White, et al., 2002). In mental health, medication adherence among psychotic and schizophrenic men and women has been a focus of study (Baillargeon, Contreras, Grady, et al., 2000; Bressington, Gray, Lathlean, et al., 2008; Shelton, et. al, 2010c). In addition, studies that explored drug treatment program adherence among released offenders were also found (Blitz, Wolff, Ko-Yu, & Pogorzelski, 2005; Oser, et. al, 2009; Rounds-Bryant, Motivans & Pelissier, 2004; Skeem, Eno Louden, Manchak, Vidal, & Haddad, 2009).

Kim & Crittenden (2007) conducted a retrospective study to examine demographic, behavioral risk, incarceration, and direct observation therapy (DOT) associated with tuberculosis (TB) treatment completion in over 400 inmates diagnosed with tuberculosis detained in a large county jail in Illinois in 1992 to 1998. Inmate follow-up was conducted after release to assess treatment completion. Demographic variables included age, ethnicity, gender, education and
marital status. Treatment completion was measured either by self-administration of medications or medication adherence of those participating in DOT, where healthcare workers administered medication either in the community or health clinic.

Overall results indicated a 38% treatment completion rate (n = 441). Men and women completed TB treatment in both the self-administered group (20%) and in the group who participated in DOT (59%). No significant differences were found based on gender, education, alcohol or drug use, or employment status. Men and women who had children were significantly more likely (p < .01) to complete treatment when compared to those without children. Those who were monitored by a healthcare worker (DOT method) were significantly more likely (p < .01) to be treatment adherent when compared to those who self-administered their medication.

Fontana and Beckerman (2007), in a descriptive exploratory study of 105 HIV/AIDS-affected men and women released one year from a county jail, described individual and service-related characteristics that affected use of health care services. The average age of men and women participating in the study was 41 years old, most were unemployed (82%), male (77%), single (73%), African American (57%) and had less than a high school education (47%).

Among the 105 men and women in the study, 73% reported receipt of routine medical care as needed. Those less likely to have received medical care were white (p = .02), and had less than a high school education (p = .02). Homeless men and women were less likely to see a physician, have routine lab tests, or be taking HIV/AIDS medication. Individuals with minor children were more likely to participate in own health. Obstacles that influenced men and women to seek healthcare included fear of others knowing about HIV status (25%), limited access to transportation (24%), experience of unpleasant medical side effects (22%), provider attitudes
(13 %) and pessimism regarding healthcare benefit (18 %). The amount of paperwork was identified as an obstacle by 19 % of the men and women.

In another study, Samet, et. al. (2003) examined 198 HIV/AIDS men and women who left primary care treatment within six months of beginning treatment. The investigators found the probability of discontinuing treatment was two times higher among those with less than a high school education (O.R. = 2.3; 95% C.I 1.1 – 5.0) , and also, in men and women who have a history of incarceration within 10 years (O.R. = 2.2;95%  C.I. 1.1 – 5.0) as compared to those with no history. Those who were enrolled at one of two clinic sites also were less likely to continue treatment.

Individual level of education appears to affect treatment adherence in the studies described. Those with less than a high school education were less likely to continue treatment. Facilitating factors to treatment adherence noted by men and women in Fontana and Beckermen’s study included having confidence in their healthcare provider (81 %), access at a nominal cost (77 %), pleasantness among providers (81 %), and less time wasting in provider offices (70 %). Spiritual beliefs were reported to influence the choice to continue needed healthcare (71 %) and the importance of staying healthy as a family member (62 %) was an important factor.

Mental Health

Substance Use. Substance use is a prevalent mental health disorder found among county jail inmates. Men and women with pre-morbid diagnoses of Antisocial Personality Disorder and Conduct Disorder are at greater risk for substance use disorder (Mueser et al., 2006). Psychopathy, or a “syndrome of personality pathology characterized by interpersonal manipulation, callousness, and impulsive antisocial behavior” has been described among substance users
(Walsh, Allen & Kosson, 2007). As many men and women are in jail have a history of substance use, the relationship between substance use and psychopathy has been studied among jail inmates.

Walsh, et al., (2007) examined the relationship between psychopathic personality and substance use among 190 African American and 209 European American men sentenced to a county jail for less than one year. A semi-structured interview and the Hare Psychopathy checklist was used to collect information regarding symptoms found among the men with Antisocial Personality Disorder. Substance use was assessed by reported use of alcohol, cannabis, cocaine and opioids and diagnosis was determined using the DSM-IV criteria.

Results of the study indicated a significant correlation between the use of any of four substances (alcohol, cannabis, opioid and cocaine) and presence of psychopathy, among both African and European Americans. A significant relationship was reported between interpersonal, affective, impulsive and irresponsible lifestyle, and antisocial behavior and drug use.

Grella and Rodriquez (2011) explored personal factors associated with community aftercare among women participating in substance use programs. Pre-release attitudes, motivation for treatment and after care participation were explored by the investigators who hypothesized that motivation for treatment would vary based on drug use and child welfare involvement. Women who were participating in a custody treatment program at four state prisons for women (n = 1158) completed surveys to assess treatment motivation. Inclusion criteria included those women released at least 12 months. Results indicated more than two-thirds of the women had plans for aftercare and treatment motivation was influenced by several factors. Those who scored higher in treatment motivation tended to have a child, had prior treatment, and/or had a history of using
cocaine, meth or opiates vs. alcohol or marijuana. Lower motivation was associated with African-American ethnicity or other minority status.

Studies, which involve men and women leaving county jails with mental health needs associated with drug use and/or other mental health disorders, suggest a willingness to participate in treatment yet opportunities for mental health treatment appear to be limited. Green, Miranda, Daroowalla, & Siddique (2005) conducted a quantitative descriptive study that included 100 female inmate volunteers housed in a Prince George’s county correctional facility in Maryland to examine characteristics of risky sexual behavior and parenting capacity. Information was obtained through participant self-report regarding the perceptions of service needs women would find useful while incarcerated. Results indicated a high rate of trauma exposure among the women. Ninety-eight percent of the women had been exposed to trauma, most frequently because of violence by husband or boyfriend. Seventy-two percent of the women reported recent illegal substance use and 74% reporting a current alcohol or substance abuse problem.

The women in Green, et al study (2005) expressed an interest in drug education/treatment (75%), alcohol treatment (45%), GED preparation (50%), stress management (88%), individual mental health counseling (80%), anger management (76%), parenting skills (79%), communication skills (83%), problem-solving skills (91%) and health education (82%). The most frequent service need identified by these women was for substance abuse treatment.

**Clinical Depression.** Depression is present among men and women leaving correctional facilities. Visher, LeVigne & Travis, (2004) published findings of a pilot study conducted in Maryland, which looked at the healthcare needs of released prisoners. Surveys were
administered at three time periods to 324 male and female prisoners, approximately 30 to 90 days prior to expected release date, another within 30 to 90 days after release, and one approximately 4 to 6 months after their release. The mean age of men and women was 33 years old, most were African American (90%) and male (72%). At post release of 30 to 90 days, depression or anxiety was reported by 25 % of both men and women. Thirty eight percent of women as compared to 20.5 % of men reported depression symptoms at 30 to 90 days. Among the men and women participating in the study, only 10 % had health insurance, e.g. health plan, and less than 5 % were covered under a government entitlement program, i.e. Medicaid or Medicare. Little change in findings was noted at 4 to 6 months after release.

In another study, Arditti and Few (2008) described findings that supported the presence of ongoing depression as a clinically significant variable affecting the lives of individual women post-release. Stories of distress with heterosexual relationships, family loss and relationships with children, was an ongoing theme. Women identified personal histories of violence linked with substance use. Drinking and substance use was reported by the women to be a means to deal with stresses and emotional pain and was identified as a factor in increasing parental challenges.

Arditti and Few (2006) explored the experiences of 28 women who were mothers and reentering the community. Each woman had at least one child younger than 18 years old and had spent at least 2 months in jail. Findings indicated “mental health risks” among the women which included inadequacy of resources and parenting stress. Resource adequacy was significantly correlated with parental stress and lower levels of resources associated with higher levels of parental stress. At least 40% of the women were described as clinically depressed, and a little over 25% of the women reported a decline in health since release. More than one-half of the
women were looking for work and those who were employed, were in low-paying, service-oriented jobs (92.3%).

**Self-efficacy.** Self-efficacy is a predictor that can influence behavioral change and/or new skill development (Evangelista, 2008; Jones, Harris, Waller, & Coggins, 2005; Schoenthaler, Ogedegbe, & Allegrante, 2009). Only one study was found that looked at the influence of self-efficacy and health promotion among the correctional population. Loeb & Steffensmeier (2006) conducted a pilot study with a convenience sample of 51 older male inmates, age 50 or older, who were incarcerated at a state correctional facility, to explore how older men who are incarcerated describe their health status, self-efficacy beliefs, and health-promoting behaviors. Chronic conditions were present among the study participants, ranging from two to thirteen health conditions. Vision problems (84.3%) were the most common reported condition. Approximately 60% of the male inmates reported feeling very confident in their ability to manage their health, and about 40% expressed only some or little confidence. When asked about level of confidence to care for self after release, a slightly higher percentage (62.7%) reported feeling very confident in their ability to manage their health on release. Inmates who reported greater self-efficacy for managing their health on release from prison tended to have better health, or reported more improved health since incarceration.

This study focused on older men’s health who were incarcerated in a state facility. Studies that describe a younger population of men, the predominant age group in county correctional settings who reenter communities nationwide, and their ability to care for own health needs have not been found.
Summary

Although literature was found that describes the increased health problems found among the released county detention population when compared to the general community population without history of incarceration, information is limited regarding individual views these men and women have of their own health. In addition, studies are lacking with regard to factors that may or may not influence men and women in their everyday lives in caring for their own health.

In the review of studies, it appears that educational level may be associated with health promotion – those with less education than a high school diploma/ GED tend to have increased rates of excessive alcohol and tobacco use. In addition, younger men and women, as compared with those who are older, are in county jails in greater numbers, having varied physical and mental health disorders, and are socio-economically disadvantaged, having less income and a history of unemployment. Additionally, limitations regarding provider access, lack of care coordination and lack of health education have been identified as barriers.

Although information exists regarding varied demographic characteristics, an understanding as to the extent of how various personal, social or other environmental factors, for instance, affect an individual’s ability to care for themselves have not been described. This study was a beginning inquiry to explore relevant factors that have reported influence in health and health promotion among men and women living in the community after release from county detention.
CHAPTER III: METHODOLOGY

Statement of Purpose

The overall purpose of study was to 1) explore health and health promotion of men and women recently released five days to one year from an adult county detention center, and 2) explore the personal, social and community factors that may be reported as barriers and facilitators in health promotion among men and women released from an adult county detention center. This chapter will describe the methodology used to collect data in this study. The description will include the research design, setting and sample, human subject protections, instrumentation, procedure for data collection and pilot testing, data analysis, and limitations of the study.

Design

This descriptive exploratory study used a qualitative approach to explore preventive health behavior among men and women recently released from a county adult detention facility. This descriptive study provides information regarding health and health promotion. Health promotion had not been previously studied among the correctional population who are reentering communities after incarceration in a county detention facility. This study was exploratory, as a review of literature has indicated a lack of empirical evidence regarding the concepts of health and health promotion among men and women who are released from a county detention center after a period of incarceration. As this population has numerous health risks related to primary, secondary, and tertiary health concerns, this study provided valuable information in understanding factors associated with health promotion among this population.
Sample

A non-probability purposive sample of 35 volunteers were recruited to participate in the study. Each participant met approved inclusion criteria that included, 1) the ability to understand and speak English, - as indicated by self-report, 2) be over the age of 18 and have been released after incarceration of at least 5 days from a county detention center, and 3) living in the community for at least five days to eighteen months after a most recent release.

Exclusion criteria included 1) non-English speaking persons 2) men and women whose most recent incarceration is at a non-county facility, i.e. federal or state prison, and 3) those persons with documented psychiatric disorder of schizophrenia, psychosis or mental behavior that indicates difficulty in maintaining attention span, normal motor movement, or other behavioral characteristic of altered mental status.

Setting

Data were collected by conducting an interview with men and women, located in two states of the mid-Atlantic region of the United States. In one state, interviews were conducted at a day shelter homeless program and in the other state, interviews were conducted at a community not-for-profit agency whose mission is to provide vocational, housing and other services for men and women released from county detention centers at two different sites, located in two states.

**Site 1: Community non-profit agency.** The community non-profit agency from where men and women were referred as potential participants for the study is located in one of 95 counties in the mid-Atlantic state. In the particular state, there are seventy-six counties that each have a county detention center and more than 25,000 men and women are detained on an everyday basis. In this state, more than 50,000 men and women are on probation, after serving time in a
county detention center or not, and continue to be supervised in the community under the state
department of corrections. Similar to county detention centers nationwide, men and women
(over the age of 18) who are suspected of committing a criminal or civil offense are arrested, and
held in local county adult detention centers. Each person may be awaiting arraignment or trial,
serving a court-imposed sentence of less than two years, or are awaiting transfer to a state or
federal prison.

As men and women are released from county detention centers across the United States,
community-based service and referral agencies may be available in local counties to provide
client services after release. The community agency where referrals of clients to participate in the
study occurred, works primarily with one county detention facility, located in a county in the
northern section of the state. Men and women who live in the agency catchment area and who
may have been incarcerated out of state or in other parts of the state are eligible to receive
services.

In FY 2011, the adult detention center geographically near the community agency had more
than six thousand admissions and releases of men and women. The average length of stay for an
inmate was thirty-one days. Offenses of male and female inmates at the facility ranged from
petty larceny and check fraud to 1st degree murder. Demographic information regarding clients
served by the community agency in Virginia was not available. Men and women who qualify to
receive services at the community agency are based on need and income level.

**Site 2: Homeless day and resource center program.** Men and women in the study were
recruited as each was attending a day shelter program for the homeless located in a state in the
Mid-Atlantic region. The homeless day shelter program is one of four programs for men and
women living in the state county, and uniquely offers a volunteer medical clinic for men and women attending the shelter. Services of the program include daytime shelter, coffee and snacks, restroom and shower facilities, and use of telephone or mailbox. Men and women participate in case management that includes services in housing search, and referral to other community agencies for mental health, job counseling, and other services.

A state level department of public safety and correctional services is responsible for community safety in the state. This state department has operational and oversight responsibilities for offenders sentenced to jail or prisons, and those who are on parole or probation after incarceration. A specific division of parole and probation works with parolees, those on probation and those released to the community subsequent to an imposed sentence for a crime committed. Approximately 22 adult county detention centers are located within the state. In 2008, the state Division of Parole and Probation continues to monitor more than 70,000 offenders in community supervision that include men and women on probation, parole, or in a mandatory drinking driving oversight program.

**Instrumentation**

A semi-structured focused interview guide and a demographic survey using selected items from the national Behavioral Health Risk Surveillance System was used in the study (Centers for Disease Control and Prevention, 2013) (See Appendix C and Appendix D).

**Focused Interview Guide.** A semi-structured focused interview guide developed by the nurse researcher was used to explore responses regarding the research questions. Items for inclusion to the interview guide were guided by Pender’s Health Promotion model. Open – ended questions were included that explored health, preventive health care including primary/secondary/tertiary
prevention, perceived barriers and facilitators to health promotion, and self-efficacy. The focused interview guide was reviewed with three registered nurses prepared at least at a Master’s level in nursing who had familiarity with Pender's Health Promotion model. Additionally, the instrument was piloted with two individuals who met inclusion criteria for study. Minimal modifications to the interview guide were made based on the results of the pilot study.

**Demographic Survey.** The Demographic Survey includes selected items, both related to demographic information and aspects of health promotion found on the Behavioral Health Risk Surveillance System. The federal government and individual states have used the Behavioral Health Risk Surveillance System (BHRSS) since the early 1980’s to collect risk-health information through telephonic interview with randomly selected men and women on a yearly basis (Centers for Disease Control and Prevention, 2014a).

In addition to incorporated items from the BHRSS, individual demographic information included: (a) age (b) ethnicity (c) education (d) socioeconomic status (e) health status (f) health care access (g) chronic health conditions – mental and medical (h) number of previous incarcerations (i) length of most recent incarceration, (j) housing arrangements (k) local zip code (l) reason for most recent incarceration and (m) time since last jail release (n) employment status (o) history of alcohol use, (p) history of tobacco use. The nurse researcher recorded this information at time of interview with each participant. (See Appendix B).

**Permission and Protection of Human Subjects.**

Prior to participation in the pilot study or actual study, human subject approval was obtained from The Catholic University of America Committee for the Protection of Human Research Subjects for 35 men and women to participate in the study. Potential volunteers were
informed in writing that a signed consent form is a requirement for participation and that participation is totally voluntary, will not be considered in probation decisions, risks of participating in the study are the same as for any member in the community, and that he/she is free to withdraw at any time without penalty. Each person was informed of the confidentiality of his/her responses and that data collected would only be shared in the aggregate without use of any individual identifying information.

Information provided verbally and in writing to each participant included the following: 1) the study is part of a doctoral dissertation for a student at The Catholic University of America and is not connected with the United States Department of Criminal Justice or the local Department of Corrections; 2) confidentiality would be maintained of all collected information, 3) only aggregate data would be shared with the referring agency, helpful to plan and implement improved services, 4) the risks involved in the research were minimal, 5) the criminal justice system will not take into account participation in the research when making decisions about probation or other sentencing and 6) personal decision to participate or not in the study would not interfere with usual treatment or access to services at either facility (U.S Department of Health and Human Services, 2009). Confidentiality was maintained in the administration of all instruments. All data was kept confidential and secure at all times, using a locked file cabinet, only accessible to the nurse researcher.

**Procedure**

The procedure for data collection included the following:
1. The Nurse researcher met with key personnel in each agency to provide an overview of the study, how staff members can help refer individuals meeting study criteria, and method for contacting the nurse researcher with potential study volunteers.

2. Flyers and a letter of invitation were available for agency personnel for distribution to men and women who might express interest. Flyers included Nurse Researcher contact information.

3. As men and women were interested in learning more about the study, each person contacted the nurse researcher to obtain additional information and/or set up a time for interview at either site; at the homeless day program, individuals who were interested could also contact nurse researcher when on-site.

4. At time of the scheduled interview, nurse researcher met with the interested volunteer using an office provided by each agency that allowed for privacy and confidentiality. As individual men and women expressed interest in wanting to participate in the study and met inclusion criteria, the purpose and informed consent requirements were explained in full and written information provided.

5. Each participant was requested to sign an information and consent document that served as evidence the individual understood the study and consented to participate. A copy of the written consent was offered and/or provided to each volunteer.

6. After the individual consent was obtained, the nurse researcher conducted interviews with each volunteer that included the use of two instruments (See Appendix B and Appendix C); the time required for the interview was approximately 20 to 35 minutes.
7. Each interview conducted with a volunteer was tape-recorded and then transcribed. After transcription, each interview was downloaded to NVivo 10 qualitative data analysis software to facilitate content analysis as described by Miles and Huberman (1994).

8. At time of interview completion, each volunteer was thanked verbally and given a note card envelope that included a twenty-dollar gift card to either Target® stores or local metro transit access.

9. Immediately after each interview, the nurse researcher recorded contextual summary information describing personal reactions or observations, regarding the interview.

10. A codebook was created a priori of approximately 105 codes; a priori coding was guided by concepts identified in Pender’s Health Promotion model and/or the Rediscovery of Self Care; the addition of codes was a continuous iterative process. Definitions and citations, as applicable, were included for each code created to ensure uniformity and exclusivity of codes (Saldana, 2009).

11. Interviews were conducted with men and women at each agency until the desired sample size was obtained.

Pilot Testing. A pilot test was conducted prior to the beginning of the study to gain information regarding the ease in administering and using the selected research instruments. Approval for implementation of the pilot study was obtained through the Institutional Review Board (IRB) process from The Catholic University of America Committee for the Protection of Human Research Subjects and all required consents were incorporated during the pilot study.

The pilot study included two persons, recruited in the same manner as described. After volunteer consent was obtained, the two study instruments were used to obtain information from
each participant. Results were reviewed with the dissertation committee director and changes incorporated. Pilot testing resulted in minor edit changes in text of both instruments.

After pilot study, a request was made to the Institutional Review Board (IRB) to incorporate a change to extend the inclusion criteria to men and women released up to eighteen months at the time of the study (vs. twelve months as initially requested) and to add additional data collection sites as needed ensure sample size. This request was approved by the IRB.

**Analysis**

Participant responses to the Demographic survey were recorded in the statistical program, IBM SPSS Statistics®. Responses of participants were aggregated using descriptive statistics functions found in the program.

Qualitative data obtained through the semi-structured focused interview survey were transcribed and each interview was entered in NVivo 10 qualitative data analysis software.

An iterative coding process continued that resulted in ongoing modification of text coding as described by Lincoln and Guba (Miles &Huberman, 1994). These approaches included “fitting in” of the process of adding, modifying, changing codes as information continued to be reviewed; “extension” or the process or the review of previously coded information to reclassify into new extensions of codes, or relationships; “bridging” or looking at the data to see linkages to other codes which may lead to categories of codes; and “surfacing” or identifying categories from code groupings (p. 62).

After assignment of text to codes determined a priori, reliability of coder assignment was established by review of a ten percent sample of coded interviews by another registered nurse, having familiarity with the underlying nursing models. Review of text assigned to individual
codes continued until ninety-five percent reliability of the text assignment was achieved.

As initial coding was completed and modifications occurred, categories emerged. Categories represent homogeneous codes and contain information that is mutually exclusive to other categories. According to Graneheim & Lundman (2004), category assignment is the “core feature of content analysis” (p. 107). As categories are determined, patterns emerge or “emergent theme, configuration, or explanation” into a “smaller number of sets, themes or constructs” (Miles & Huberman, 1994, p. 69). For instance, coding may include data guided by either model of nursing that underlies this study, with subcategories / categories identified and collapsed to identify overarching themes. Relationships and interrelationships of codes were constructed as noted from information collected. Graneheim and Lundman (2004) provided an example of data display in a table format that would include the following:

*Table 1. Coding Scheme*

(Graneheim and Lundman, 2004, p. 107; adapted)

<table>
<thead>
<tr>
<th>Theme</th>
<th>Category</th>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subcategory</td>
<td>Subcategory 1</td>
<td>Subcategory 2</td>
<td>Subcategory 3</td>
<td>Subcategory 4</td>
</tr>
<tr>
<td>Codes</td>
<td>Code 1</td>
<td>Code 2</td>
<td>Code 3</td>
<td>Code 4</td>
</tr>
<tr>
<td>Data</td>
<td>Data</td>
<td>Data</td>
<td>Data</td>
<td>Data</td>
</tr>
<tr>
<td>Data</td>
<td>Data</td>
<td>Data</td>
<td>Data</td>
<td>Data</td>
</tr>
<tr>
<td>......</td>
<td>......</td>
<td>......</td>
<td>......</td>
<td>......</td>
</tr>
</tbody>
</table>

Study credibility is determined by the degree the results can be deemed dependable, transferable and trustworthy (Rolfe, 2006). Credibility of the study was maintained by ensuring adherence to the procedures described in this study; most importantly, the study sample includes those men and women identified as re-entering individuals after an experience of incarceration.
All persons wishing to participate and meeting inclusion criteria were accepted in the study. Additionally, the focused interview guide was approved by faculty familiar with *Pender's Health Promotion Model* and *Rediscovery of Self-Care: A Model for Nursing Care of Persons with an Incarceration Experience* (Pender, et al., 2011; Shelton, et al., 2010a). Credibility was also maintained through the review of coded data by two persons familiar with qualitative coding methodology to ensure reliability of information coding, to single units, categories and themes.

Dependability was be ensured by continuous and consistent use of the focused interview guide. The probing questions elicited information consistently across all persons interviewed. Transferability of study results may be limited in application to those persons who decide to seek services using voluntary agencies that assist in post-incarceration transition.

**Limitations**

Limitations include: 1) instrument administration took place at one point in time for individuals volunteering to participate in this study; a second interview did not occur to validate results of first testing; 2) findings are limited to men and women who are receiving services or require assistance in returning to the community after incarceration. Eligibility to receive services in the agency is based on financial need and those who may be above specific requirements based on income are excluded. Transferability of study results is limited to men and women having financial support, with reduced or limited income, who have reentered the community from county detention.

**Summary**

As more and more individuals are released from prison each year, various areas of health concern pertinent to this population have yet been examined, or are incomplete. Though this
population may reflect similarity to other “vulnerable” populations, there are distinct differences and challenges that result from having the experience of incarceration and finding oneself released back into the community. Released men and women, having the experience of incarceration, have lived in an environment focused on maintaining safety. Self-choice was limited regarding leisure time, meals, sleep time, telephone time, etc.; as well, men and women in county detention centers have limited opportunity for health-focused self-care. As men and women return to communities, they are beginning to care for themselves and their health, in a less restrictive setting. The study of health and individual factors associated with maintaining and promoting health promotion after transitioning to the community is an important concern.

Health, while a national goal, has received limited study among this population. Although health risk behavior has been studied related to varied prevalence of infectious disease and drug use among this population, preventive health practices regarding nutrition and diet, smoking behaviors, use of alcohol, exercise and other healthy lifestyle aspects has not been studied. Additionally, if men and women have chronic illnesses, little is known regarding their capacity to care for themselves.

The study of returning men and women offers many opportunities for nursing research. Nursing research conducted to date, has more so focused on the inmate or person, living in a state, federal prison or local jail and has just barely focused on understanding the health needs of individuals returning to communities nationwide. Nurses are involved in community health efforts and the exploration of factors that may be associated with health promotion among this population is important.
CHAPTER IV - PRESENTATION OF FINDINGS

Introduction

The purpose of this study was to: 1) explore health and health promotion of men and women recently released five days to eighteen months from an adult county detention center, and 2) explore the personal, social and community factors that may act as barriers and facilitators in health promotion among men and women released from an adult county detention center. The research questions guiding the study were 1) How is health described by men and women recently released from an adult county detention center? 2) How do men and women experience health after recent release from an adult county detention center? 3) What personal strategies to promote, maintain or restore health are described among men and women recently released from an adult county detention center? 4) What personal, social or community factors influence health promotion, i.e. primary, secondary and tertiary prevention as described by men and women recently released from an adult county detention facility?, and 5) What barriers or facilitating influences to health promotion, i.e. primary, secondary and tertiary prevention, are described by men and women recently released from an adult county detention center?

A pilot study was conducted with two participants using the semi structured interview format and demographic survey designed for the study. Each person who participated met predetermined inclusion criteria for the study. The informed consent form was reviewed with each participant and time allowed each participant to review the form prior to signature. Each interview required about 25 minutes and completion of the demographic survey with each participant required an additional five to eight minutes. The pilot study resulted in minimal
changes to both instruments. Participant results from the pilot study were included in the actual study.

This chapter is organized in three main sections: (a) setting and participants, (b) analysis of descriptive and qualitative data related to each research questions and (c) summary of subcategories, categories and emergent themes resulting from data analysis.

**Setting and Participants**

A purposive sample of 35 men and women who were released from a county correctional facility within 18 months of the scheduled interview were included in the study. Approved inclusion criteria initially included men and women who were released from a facility within 12 months of the study and access to men and women would include posting of a flyer at a community agency where released men and women seek referral and access to community services post – release from local county detention centers. These criteria were extended per IRB approval to include men and women released up to 18 months (vs. 12 months) from a county detention center and to written flyer posting at a homeless shelter day program located in a neighboring state.

Fifty men and women contacted the investigator to indicate interest in the study and 35 men and women, who met inclusion criteria, were included in the study. Of the 15 men and women who were not included in the study, eight did not respond to phone or email contact when return calls were made to discuss the study, and, seven men and women did not meet inclusion criteria. Of these, one person was excluded because of the agency staff’s determination that he would not be a candidate related to his psychological status and the inability to be interviewed; one person requested an opportunity to be interviewed again, and five men and women were
excluded because of having been recently incarcerated at a state or federal prison, or having been released greater than 18 months from a county facility at the time of the study.

**Data Analysis**

**Descriptive data.** Thirty-five men and women participated in the study; 71% were men (n = 25) and 29% were women (n = 10). The average age of the participants was 43 years old (range = 24 – 61; SD = 9.173). More than 50% of the participants were white (n = 20; 57%), followed by 37% who were Black or African American (n = 13). Eighty percent of men and women were not married (n = 28); of these, 37% had never been married (n = 13) and 40% were divorced or separated. Thirty-one percent of participants were either, high school graduates (n = 11) or had some high school (n = 11), and 29% of participants (n = 10) had attended some college. Regarding employment, 37% of men and women described themselves as unable to work (n = 13) and 31% of participants had been out of work for more than one year (n = 11). The majority of participants had an annual income of less than $10,000 (n = 31; 89%).

Seventy-four percent of men and women described themselves as homeless (n = 26) and the same number of men and women described themselves as having been in jail or prison more than four times in their lifetime (n = 26). Seventy-one percent of men and women described their most recent incarceration as related to a conviction for a misdemeanor (n = 25); the average number of days since release to time of study participation was 172 days, or between five and six months (Range 5 – 525 days; standard deviation = 146.27) (See Table 2).

**Qualitative data.** After transcription of each interview, text was imported to NVivo 10 qualitative data analysis software. One hundred and five codes were identified a priori, guided by
the nursing models underlying the study – Pender’ Health Promotion model and Nursing Care of
the Person with an Incarceration Experience. A definition for each code, a priori or subsequent

Table 2.

Frequency and Mean of Demographic Characteristics of Men and Women with a Recent
History of Incarceration

<table>
<thead>
<tr>
<th>Variables</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>25</td>
<td>71 %</td>
</tr>
<tr>
<td>Female</td>
<td>10</td>
<td>29 %</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>20</td>
<td>57 %</td>
</tr>
<tr>
<td>Black or African American</td>
<td>13</td>
<td>37 %</td>
</tr>
<tr>
<td>Mixed Race</td>
<td>2</td>
<td>5.6 %</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>7</td>
<td>20 %</td>
</tr>
<tr>
<td>Divorced</td>
<td>6</td>
<td>17.1 %</td>
</tr>
<tr>
<td>Widowed</td>
<td>1</td>
<td>2.9 %</td>
</tr>
<tr>
<td>Separated</td>
<td>8</td>
<td>23 %</td>
</tr>
<tr>
<td>Never Married</td>
<td>13</td>
<td>37 %</td>
</tr>
<tr>
<td>Educational Level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary school</td>
<td>3</td>
<td>8.6 %</td>
</tr>
<tr>
<td>Some high school</td>
<td>11</td>
<td>31.4 %</td>
</tr>
<tr>
<td>High school graduate</td>
<td>11</td>
<td>31.4 %</td>
</tr>
<tr>
<td>Some college or technical school</td>
<td>10</td>
<td>28.6 %</td>
</tr>
<tr>
<td>Employment status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed for wages</td>
<td>3</td>
<td>8.6 %</td>
</tr>
<tr>
<td>Self-employed</td>
<td>1</td>
<td>2.9 %</td>
</tr>
<tr>
<td>Out of work more than one year</td>
<td>11</td>
<td>31.4 %</td>
</tr>
<tr>
<td>Out of work for less than one year</td>
<td>7</td>
<td>20 %</td>
</tr>
<tr>
<td>Unable to work</td>
<td>13</td>
<td>37.1 %</td>
</tr>
</tbody>
</table>
Table 2.

*Frequency and Mean of Demographic Characteristics of Men and Women with a Recent History of Incarceration (continued)*

<table>
<thead>
<tr>
<th>Annual Income</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $10,000</td>
<td>31</td>
<td>88.6%</td>
</tr>
<tr>
<td>Less than $15,000</td>
<td>2</td>
<td>5.7%</td>
</tr>
<tr>
<td>Less than $20,000</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Less than $50,000</td>
<td>1</td>
<td>2.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Homeless</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>26</td>
<td>74%</td>
</tr>
<tr>
<td>No</td>
<td>9</td>
<td>26%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Offense</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Felony</td>
<td>4</td>
<td>11.4%</td>
</tr>
<tr>
<td>Misdemeanor</td>
<td>25</td>
<td>71.4%</td>
</tr>
<tr>
<td>Combination</td>
<td>4</td>
<td>11.4%</td>
</tr>
<tr>
<td>Not sure</td>
<td>2</td>
<td>5.7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of times incarcerated (Lifetime)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 time only</td>
<td>2</td>
<td>5.7%</td>
</tr>
<tr>
<td>2 – 3 times</td>
<td>7</td>
<td>20%</td>
</tr>
<tr>
<td>4 – 6 times</td>
<td>10</td>
<td>28.6%</td>
</tr>
<tr>
<td>More than 6 times</td>
<td>16</td>
<td>45.7%</td>
</tr>
</tbody>
</table>

coding was determined and recorded. As coding continued, start codes were modified and other codes were added according to the approaches described by Lincoln and Guba (Miles & Huberman, 1994). Approaches included “fitting in” of the process of adding, modifying, changing codes as information continued to be reviewed. An iterative coding process continued that included “extension” of current coding or the review of previously coded information to reclassify into new codes or extensions of codes, and “bridging” or looking at the text data to see linkages to other codes (Miles and Huberman, p. 62).
Coding integrity was established through review of the code definitions; in addition, the Dissertation Director reviewed a ten percent sample of coded interviews. As coding continued, each code and associated text was assigned to a related research question, as text within the assigned code answered the particular research question. Content analysis was conducted by determining the frequency of interviews related to pertinent text associated with particular code. Text continued to be reviewed and/or reassigned to codes until all coding of interview text was complete. Subsequent to coding of text, relevant subcategories were determined from groups of codes while noting the total number of relevant interviews included. Each subcategory was mutually exclusive in the identification of categories, and categories subsequently were collapsed to describe major themes relative to health promotion described by participating men and women (Miles & Huberman, 1994).

**What Is Health?**

To answer the first research question, “How is health described by men and women recently released from an adult county detention center” relevant questions on the interview guide included “what is health?”, “how would you describe a healthy person?” and “how would you describe an unhealthy person?” As participants provided descriptions, probe questions were used to explore each response. In response to the question, “What is health?” coding of text resulted in the development of six subcategories to answer the research question.

*Health includes mental health and/or physical health (n = 14).* Fourteen participant comments described health as “overall well-being”. Mental health may be influenced by factors such as stress, thinking ability and the importance of positive social interaction. Physical health is a measure of how a person feels, if they have symptoms of illness, how they look (healthy or
not). If someone is healthy, a person has “vitality”, is “mentally and physically able to do things”, is sleeping good, and not worrying about going back and forth to the hospital.

“Your mental health, your thinking ability and your stress levels ....” (P28)

“It should be a good thing, make sure your health is good, so you can live a longer and happy life.” (P21)

“If you are feeling bad, that’s usually a symptom of some type of health problem, or something like that you know.” (P19)

**Health is described as good health or bad health (n = 13).** Thirteen participants described health as measurable. Terms used included “good” or “bad” health. If a person had “bad” health, he or she might suffer from health issues; with “good” health, health issues tend to be diminished. Additional descriptions included health as “positive” or “negative”, or a person has health or does not have health. Health is a “measuring stick of how well or not well a person is”; it is a “device” to measure how a person is feeling, and how they are getting along, according to three participants. A description of body function status, or how your body is working, was a descriptor of health, i.e. your breathing, your heart or basic physical health.

“Health to me would be a state or condition, that you are physically and mentally that you can actually measure on a scale of good to bad; and as you lean toward the ‘bad’ health, you suffer issues, and as you lean toward the ‘good’ health, those issues tend to diminish, and you know, things become a little bit better for you. It’s like a positive and negative scale.” (P30)

“I think it is a measuring stick for telling how well or how, not bad, but it is a device to measure how you are feeling or how your life is going.” (P13)

**Mental health and physical health are related (n = 9).** Nine participants described mental health and physical health as related to each other, i.e. one can affect the other. Stress was described as a factor that can influence physical health (n=3), by “putting disease inward”, and is
“one of the biggest causes of disease”. Holistic health, to include “mind, body and spirit”, was mentioned (n = 1) as well as the influence of spiritual health on physical health (n = 1).

“You take two people, they might have the same ailment...one might be stressed to the hilt, and the other has a means of releasing their stress. The one who is stressed out, their health is worse than the other one”. (P5)

“Some people think healthy is fitness; some people simply think it as nutrition. I think of it as a more holistic complete health, - mind, body and soul,” (P24)

“I believe a good mental health, helps with your physical health............If you are thinking right, you are more likely to do things right with your life, such as your health and things of that nature.” (P004s)

**Health is important. (n = 8).** When asked to describe health, the importance of health was the immediate response by eight participants, as seen in comments below.

“I think health is very important, without you being healthy or caring about yourself, nobody else will.” (03)

“I believe it is very important. To me health is your vitality... I mean, I guess like your life force, maybe. ” (P27)

“Health is something very important; to me it is something you have to take care, in order to live.” (P32sr)

“It’s an important part of life, your health is, I think.” (P07)

**Self-care influences health. (n = 8).** Eight participants described self-care and its relationship to maintaining health. Self-care included “taking care of your body”, “not smoking”, “keeping yourself in shape” [“being in shape’]. For one person, personal health status was medication-related - “not taking medication for a health condition” or “or not taking so many medications” or “taking the right medication”. The ability to maintain one’s own self-care and “being able to do things on your own” is related to health.

“Keeping yourself in shape” (P29)
“you know if you have health issues, I think I think you should address them, and honestly follow up on whatever health issues you have, instead of letting them go, because the longer you let them go, the worse off you will end up being.” (P33sr)
“I would say it’s taking care of yourself, how you take care of yourself.” (P16)

**Diet influences health (n = 6).** Six participants described the type of dietary intake, i.e. healthy foods, to influence health. For instance, in not eating the right foods, there may be “differences in health related to body weight”.

“If you are eating right, you are definitely healthy” (P35)

“... eating the right foods, pretty much it.” (P29)

**Healthy Person Description**

To answer the first research question, participants were also asked the question, “How would you describe a healthy person?” Thirty-three participants provided a response. Coding of text resulted in the following subcategory descriptions; a person who is healthy is someone who maintains: 1) positive mental health, 2) a healthy diet, 3) self-maintenance ability, 4) physical appearance, 5) positive lifestyle, 6) physical health and 7) an exercise regime.

**Positive mental health (n=14).** Fourteen participants described positive mental health as a characteristic of a healthy person. Attributes of positive mental health were mentioned twenty-two times and included descriptions such as someone who has “positive thinking” (n = 2), and can “think clearly”, and maintain “proper decision making (n=2). Someone who is healthy is “feeling good” and has a “positive demeanor that is happy”, is “vibrant”, “has energy, is not sluggish” and would be “upbeat about life”.

A healthy person is able to “deal with life… handle things” and demonstrates “inner happiness” (n = 3).
“I feel if those areas in your life are positive [mental health status, family environment, employment], then you would tend to have a more healthy life.” (P004S)

“Also promoting good mental health and positive thinking, and healthy choices that they make to live their life, not just physically, but mentally.” (P022)

“Positive, happy, health goes along with a certain inner happiness too. Someone who is healthy, someone whose body and mind is functioning appropriately, how it is supposed to... effectively.” (P018)

One young man described,

“If you are healthy from the inside, it shows on the outside, automatically physically and mentally, emotionally as well. I think that plays a big part as far as your health.” (P32S)

In addition to personal mental health, a person has “positive social relationships” with family, and has “positive social reinforcement” concerning health, and “makes healthy choices”.

Participants (n = 2) described a synergistic relationship that exists “between mental, physical and spiritual health” when talking about a healthy person.

“I think the components work together; I think your physical health, your mental health, and spiritual health, they have to work in conjunction,... and if one is lacking, the other is going to lack somewhere” (P006)

“I think everybody has something going on with them, so your overall health reflects in your mood, your happiness. If you have something wrong with you and it is managed properly, it gives you a better quality of life.” (P34)

A Healthy Diet (n=13). Thirteen participants described maintenance of a healthy diet as a characteristic of a healthy person. A healthy person was someone whose dietary intake included “proper nutrients, vitamins and minerals (n = 2), “watched what they eat (amount and type), (n = 2) and is “eating right” (n=2) or “eating properly” (n =2).

“They probably eat right, that’s the main thing, and giving their body the nutrients that it needs ... you know all the vitamins and minerals and everything. I guess eating healthy would be the first thing (P014)
“They watch what they eat. They particularly watch what they eat, paying attention to the amount of food they eat, what types of food they eat.” (P22)

“A person that is healthy is a person that eats right” (P003)

“Someone who is healthy? Eat right, watch what you eat ... “(P007)

“If and you are eating properly. That’s healthy.” (P023sr)

Physical Fitness and Exercise (n = 11). Eleven participants described positive physical fitness as a characteristic of a healthy person, alone or in combination with other characteristics. Both men and women described a healthy person as someone maintaining a “good exercise regimen, probably maybe like each day or multiple times a week” (P01), or one who “exercises” (n=2) or someone who “exercises regularly” (P22) and is “in good physical fitness, good physical shape (n = 3).

Physical fitness was oftentimes viewed with healthy eating and/or one of several characteristics (n = 3).

“Like no sugar, no unrefined sugars, no caffeine, no alcohol, a person who exercises moderately, a person who has positive reinforcements, socially, yeah. [Healthy person]” (P06)

“Getting at least 6 to 8 hours sleep. Eating good, three meals a day, eating right, exercising”. (P31)

“Someone, basically to me healthy is from the inside, you know eating properly, getting rest, exercising, looking vibrant, I feel like it comes from the inside and not just on the outside” (P32)

Positive self-maintenance (n = 11). Eleven participants described one or more aspects of positive self-maintenance as a function of a healthy person. Healthy persons maintain a healthy diet, attend “doctor’s appointments”, “take prescribed medication”, and “seek medical attention
when needed”. They are “knowing” about their body, maintain “cleanliness/ hygiene” and seek resources as needed. As several persons remarked,

“I guess just the way they take care of themselves.” (P12)

“....maybe proper doctor appointments, just taking care of themselves as they know to do. (P030)

“A person who knows what is going on with their body. That makes you healthy because you know what you need to do in order to get better. So knowing, that is the most important for a healthy person” (P05)

“‘Feeling good, eats right, exercises. Takes care of them self.” (P26)

Positive self-maintenance was described as someone who “does not have bad habits,” or “not putting anything in your body, like cigarettes, anything like that” (P14) or someone who is “not using drugs, not drinking, stuff like that” (P29). A healthy person is someone who “takes care of their body” (P10), or “takes care of themselves” (P12; P 26) or “takes care of their diet” (P12). “Good physical fitness” (P16) would indicate self-maintenance. One gentleman, as he was having a hard time with disabilities and his own self-care, viewed someone who is healthy as able to seek medical attention and otherwise getting treated, or, are those with “an apartment, … they have money in their pocket”. Two participants mentioned cigarette smoking as a bad habit. One older woman who was forced into homelessness after losing her home and being incarcerated after misuse of opiates, described

“A healthy person would [be]maintaining a healthy perspective or health at a certain level and if not trying to get better and better, at least maintaining a state of good health, as people would think of it.... And ““based on what they know as their own constitution, I guess, what to eat, how much to eat, maybe proper doctor appointments, just taking care of themselves as they know to do.” (P30)
Physical health (n = 11). Eleven men and women described a healthy person as one who demonstrates physical health, both outwardly and inwardly. A healthy person was described as having characteristics of a positive outward physical appearance that included skin tone (n = 3), cleanliness (n = 4), and the obvious ability to walk (n = 4) or having mobility. If you are healthy from the inside, it shows on the outside (n = 3).

Outward manifestations of positive health included “they look fit, don’t really walk with a limp, stand up straight, they walk faster like they have more energy” (P25), “your body is in good shape”. (P27). “People who are in good health, are usually pretty spry and have a lot of agility and able to move well, without a lot of effort.” (P5).

“They look all right. They look good. “(P11)

“As far as physical health anyway, the only thing that pops in my mind, skin says a lot. Often times, skin and eyes.” (P24)

“Well, the first thing is how they look”. (P19)

“The way their appearance is; the way you look and carry yourself… ” (P 17)

“I think like energy wise. If they have a lot of energy, they are not sluggish. You see them moving slow around, and stuff like that, I would say so” (P21)

Descriptions of a healthy person included someone “whose body is functioning appropriately, how it is supposed to work “effectively” or it is “functioning properly” (n = 2). A healthy person is “not sick”, is “feeling good” and is free of illness (n = 2).

Healthy Lifestyle (n = 6). Six participants described the relevance of a healthy lifestyle if someone is a healthy person. The “way they live” or the “person’s lifestyle” is relevant to health (n = 2). A person does not have “bad habits” such as smoking (n = 2) and “are not drugging, and
they are not using…. or abusing alcohol, drugs or anything like that” (n = 2). A healthy person has “structure” in one’s life, and “tame about their daily activities”.

**Unhealthy Person Description**

To answer the first research question, participants were also asked, “How would you describe an unhealthy person?” Thirty-two participants provided a response. Coding resulted in the following subcategories, a person who is unhealthy is described as someone who 1) does not maintain a healthy diet, 2) may have mental health problems, 3) physical appearance is affected 4) is unable to choose to care for self, 5) is affected by drug use and/or addiction, or excessive use of alcohol, 6) has difficulty with day to day life activities and 7) has existing chronic illness.

**Unhealthy eating (n = 11).** Unhealthy eating was described as a factor as to whether someone is healthy or not. Descriptions of unhealthy eating included being a “fast food junkie” (P04), “not eating the proper foods everyday” (P012), or just “not eating healthy” (P014). Obesity and being overweight was mentioned as an indication of unhealthy eating (n = 2). As one woman remarked, who was living at home with an elderly father who did not eat right and who had lost weight,

“…not eating properly... depends how you are eating, because what you are eating is what you are putting in your body... they are losing weight like my dad. My dad is unhealthy; he doesn’t take care of himself. He is like a skeleton; he doesn’t take care of himself. He got all these problems and he is taking his pills but, he is not eating the right stuff.” (P035)

A few men and women (n = 2), when mentioning not eating healthy, also mentioned, “not exercising” as a factor with not eating that would also be unhealthy.

**Mental health (n = 9).** Nine participants described mental health status as an influencing factor as to whether someone is unhealthy. Description of mental health status as an influence
included the negative effect it can have on one’s everyday activities. As well, the connection between mental, spiritual, and physical health was noted.

“I think your physical health, your mental health, and spiritual health, they have to work in conjunction..., and if one is lacking, the other is going to lack somewhere. (P006)

Someone who is unhealthy may not be “addressing any issues that they have mentally, if they have addiction problems, family problems, anything of that nature. “ (P10)

One man, who has been homeless for three years, talked about the break up with a fiancée prior to incarceration and his dad’s death that triggered his addiction behavior:

“I think that would be sad, I see a minus sign or unhappy face with that, both emotionally and physically. Yeah, yeah, I think that someone who is unhealthy, both physically and mentally or emotionally is sad. I think physical pain causes you to feel poorly, in here, in your heart, your emotional heart. (P18)

Another gentleman who is homeless yet meets up daily with his wife and baby as they lived apart, noted

“Someone who is not healthy is ill, sort of broken, needs could be medical help, or mental help, pretty much” (P27)

Remarks included a description of a perceived relationship between the lack of mental health and one’s physical health. A forty-three year old homeless man who is faced with untreated chronic illness and years of addiction remarked,

“Mental health as well, because being a bad state of mental health causes your body to break down as well.” (P034)

Similarly, a thirty-six year old African American man who grew up on the streets in a neighborhood ridden with crime remarked,

“If one of those is missing, such as no family structure or lack of job, it would draw and bring depression and stress and things of that nature, into your life, that causes hypertension and things of that nature. (P04)
Observable physical symptoms and negative appearance \((n = 8)\). Eight men and women described various characteristics that would be observable if someone were unhealthy. Such characteristics included “jitters” (P019), vocal characteristics such as having a “raspy or hoarse voice, slurred speech” (P019), “walk with a cane, coughing” (P029), or “impaired mobility” \((n = 2)\). In particular, skin condition \((n = 4)\) and eyes \((n = 3)\) were noted as being observable signs of an unhealthy person.

“Usually your eyes, can tell you if there is some kind of a health problem, if they are blood shot, or something like that you know. ........ Your skin, if your skin is pale or something like that,... that is usually a symptom, bumps or blotches, something like that.” (P019)

“Either limping, or walking hunched over, or you can see it in their face like skin, skin color, or sunken in skin.” (P25)

“They might need assistance, like I was saying. Walk with a cane, can’t walk very far, cough a lot, stuff like that.” (P29)

“Not looking well... eyes sunken, not bright and vibrant... skin don’t look healthy; it’s dark, scaly, and ashy. Eyes discolored, fingernails as well, and your weight, teeth. You can look at a person all the time, and tell their health as well, I can.” (P03)

Inability for self-care \((n = 8)\). Eight participants described that an unhealthy person had difficulty in caring for one self and managing one’s every day routines that may be due to drug and or excessive alcohol use.

“I would look at it as not taking care of yourself; possibly on drugs, drinking alcohol, you know that is not healthy.” (P031)

“Partly from diseases, and the other part is from not taking care of yourself. I am talking about mental health as well, because being a bad state of mental health causes your body to break down as well.” (P034)

Two participants described not taking prescribed medications as an aspect of self-care that may be lacking among unhealthy individuals. In addition, underlying the inability for self-care,
there may be a lack of concern for self, where men and women may not “really care too much about their everyday activities.” (P003) or

“Someone who just does not care about any aspect of their life, and their well-being, -- physically or mentally.” (P022)

“I guess it depends on how they take care of themselves physically.” (P006)

As one person stated, an unhealthy person may be

“Strung out, usually unhealthy to me, people up and around have been drug addicts, alcoholics, people that don’t eat right, don’t take care of them self...just basically those that let their health go.” (P 016)

Lack of self-care may include “not going to the doctor” (P 035).

**Drug or excessive alcohol use and/or addiction (n = 7).** Seven participants described drug or excessive alcohol use to be unhealthy. An unhealthy person may be someone who

“... don’t care what you put in your body. You are more likely to be using some type of alcohol or other vices” (P04)

“... they are not watching how much alcohol they consume. “ (P012)

A person may not be able to care for self, leading to unhealthiness; comments included

“Strung out, ............ usually unhealthy to me, people up and around have been drug addicts, alcoholics, people that don’t eat right, don’t take care of themselves... just basically those that let their health go.” (P016)

“I would look at it as not taking care of yourself; possibly on drugs, drinking alcohol, you know that is not healthy.” (P031)

**Difficulty with day-to-day routines (n = 4).** Four participants described an unhealthy person as having difficulty with day-to-day routines. A thirty-four year old homeless and disabled man who had been incarcerated more than six times stated,

“If you have trouble carrying on just basic day to day, I guess routines that would be unhealthy.” (P13)
“Yeah, they need help eating, walking or moving around, just basic thinking processes.”  (P28)

“Doesn’t eat right, doesn’t sleep well, and doesn’t take care of themselves.”  (P26)

**Presence of chronic illness (n = 3).** Three men and women mentioned having a chronic illness while describing an unhealthy person. For instance, someone might have “high blood pressure, sugar diabetes, um, type 2” or other “physical illness” (P013). It may be that someone is “having hard times with health issues” (P21). A forty-two year old African American with a number of chronic illnesses that included diabetes, hepatitis C, epilepsy and blindness in his right eye related to trauma discussed this connection:

“It depends on what kind of health problems they got. Like if you take somebody with HIV, you can look at them [sic] and not know it. If you look at someone with full-blown AIDS, you can tell it. So it depends on what kind of health issues you actually have.”  (P033)

**Physical Health before Incarceration**

To begin to answer the second research question, “How do men and women experience health after recent release from an adult county detention center?” interview questions included asking men and women to describe their physical and mental health status before and after most recent incarceration. Questions included “how would you describe your physical health status before going to jail”, and “how would you describe your physical health today” and, “how would you describe your mental health status before going to jail?” and “how would you describe your mental health today?”

Table 3 describes responses among 35 participants when describing their physical health status before their most recent incarceration.
Descriptions of physical health prior to incarceration ranged from having “excellent” or “good” physical health, to stories of poor health related to drug and alcohol use. Men and women who described positive health prior to jail (n = 7), used words such as “it was good” (P11), or “good…. excellent” (P2) or described themselves to be a healthy person prior to incarceration. A fifty-three year old man released in the past 90 days and who was homeless, having a rough time because of having been robbed of his wallet while living in a tent, described “I was healthy. … “Yeah, I was. I was eating good, taking care of myself. I was doing pretty good. (P23S).

Table 3.

Physical Health of Men and Women before most recent Incarceration (N = 35)

<table>
<thead>
<tr>
<th>Category</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health was “good”, “excellent”</td>
<td>7</td>
<td>20%</td>
</tr>
<tr>
<td>Experienced negative health effects from Alcohol or drug use</td>
<td>10</td>
<td>28%</td>
</tr>
<tr>
<td>Physically feeling better before going to jail vs. after release</td>
<td>8</td>
<td>23%</td>
</tr>
<tr>
<td>No difference in health status before jail or after release</td>
<td>7</td>
<td>20%</td>
</tr>
<tr>
<td>Health decline described as occurring after release when compared to prior to jail</td>
<td>4</td>
<td>11%</td>
</tr>
</tbody>
</table>

Seven participants described no difference in their health before incarceration as compared to after, indicating a similar lifestyle before and after. As one forty-three year old homeless man living on the streets described his health as
“Kind of similar, because of financial reasons... inadequate job situation, to have the time and money to buy the right food, as well as access to exercise, equipment.” (P24)

For some, chronic health problems prior to incarceration were present, but after incarceration, individuals may be taking better care of themselves. For instance, one man described himself as a Type II diabetic also diagnosed with a seizure disorder and high blood pressure, who is maintained on medication. His health

“...was pretty much the same, because a lot of this stuff I have known about for years. I have had a lot of these conditions for years. (P33S)

More than 30 % (n = 11) of the participants described the negative effect that addiction to alcohol, and/or drug use had on their physical health prior to incarceration. Personal stories included not eating right, a lack of exercise, smoking cigarettes with alcohol use, poor hygiene and “not living right” related to efforts to obtain drugs.

“Most of the time it was like not in good shape, not eating right, not taking showers all the time because I was running around looking for drugs, just real bad looking, lost a lot of weight’ [before jail] (P16)

“I think it was almost poor ... my entire existence was poor, alcohol, unemployed, homeless, wrong people, wrong places. There was no diet, it was a lot of junk food mainly, [prior to jail] (P 006)

“When I am partying and stuff like that, my health is not that good.” (P28).

I wasn’t a real heavy drinker, but apparently, as some pointed out.... With the drugs, and not resting or whatever... it took a toll on me.” (P32sr)

“Well, I was using drugs real bad, so actually I was being chased and I got caught, so, and I guess I wasn’t in too good a shape, you know. .... I sold something and I couldn’t run. They caught me.” (P14)

One man described hitting rock bottom prior to incarceration, physically, because of his drug use.
“I was emaciated from drug usage, I was dying. I wasn’t eating, I wasn’t seeing any doctors for any reason what so ever. I was living in the woods, I was covered with abscesses, from just being dirty, boils, it was nasty. I was literally dying living in the woods. ...no food, no money...no, no hope.” (P34)

Men and women also described feeling better physically prior to incarceration (n =8), than after release.

“I was better by far [before jail]... I was still broken up and everything but I had a routine, I was constantly moving, I was constantly exercising. I was drinking water. I was feeding myself. I was able to take care of myself. (P13)

“Yeah, I was. I was eating good, taking care of myself. I was doing pretty good. Since I got out, it has been tough, these last couple months. It has been tough...I got my disability; I was eating good because I had an apartment then.” (P23 SR)

“Before... it was better. I did not have this many dental issues [before jail]. I did not have a head and back injury [before jail]; I was not having stomach problems, like I am now (P008)

One man described the effect of sleeping on hard bunks while in jail, that affected his back and legs.

“Yeah, it was kind of the same. It makes it worse when you are sleeping on that still. That could be another reason to make it worse. ..... Like I say, some mornings when I wake up, my back can go out at any time, or my leg gets stiff. I am now getting numbness in my foot, my left foot (P20)

Another person who used drugs prior to jail described his health to be the same; yet, since the age of sixteen, his drug use prevented the experience of ongoing back pain from spinal bifida, also beginning at that time.

“I would say my health is the same, but my ability to do stuff is limited. You know, pain medicine obviously hides the pain, so you can keep going.” (P25)

Four participants described decline in physical health after release as contrasted to their personal health before incarceration. (P26). As one man remarked, his health was “probably better than it is now, because I have been going downhill” (P26). One participant had hip
surgery before he went to jail, that continued to be a health problem, “Well, I had an operation before I went to jail, so my health was declining, before I went to jail. It was on the decline.” (P007). Another participant after being released, was experiencing pain in his joints due to arthritis,

“I was ok…. [before jail] I had my sicknesses by then, but I wasn’t hurting. I wasn’t feeling no pain. Now all of a sudden I started feeling these pains, and whoa buddy”. (P009)

**Mental health before incarceration**

Table 4.

*Mental Health status before most recent incarceration*

<table>
<thead>
<tr>
<th>Category</th>
<th>n = 26</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No problems with Mental health</td>
<td>7</td>
<td>20%</td>
</tr>
<tr>
<td>No difference before and after jail</td>
<td>1</td>
<td>9%</td>
</tr>
<tr>
<td>Changes in mental health status after jail</td>
<td>18</td>
<td>53%</td>
</tr>
<tr>
<td>compared to prior to jail</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative change</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Positive change</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Not sure</td>
<td>1</td>
<td>3%</td>
</tr>
</tbody>
</table>

Table 4 describes responses of men and women when asked, “How would you describe your mental health status before going to jail?” Fifty-three percent of men and women described changes in their mental health status before and after their most recent incarceration (n = 18). Of these, more than 75 % of the men and women described a positive mental health change occurring (n = 14).
Personal stories involving positive change after incarceration were related to prior life histories involving addiction to illicit drugs or excessive alcohol intake (n = 7), as each described their successes, challenges and/or their failures associated with use. For some, drug use was secondary to pain control and for others, incarceration broke the cycle of personal addiction.

“I wouldn’t say I was much better, because I was on drugs, and stuff. Heroin, because it would help with the pain too, but I just started abusing it like I said.” (P025)

“Next month, in July, I will be one year clean. I was a heroin addict... Yes, I used [heroin] for about 30 years. Today I feel great, my health has gotten to the point, where it is not perfect, but I feel better than I did 11 months ago, a year ago. Before I got incarcerated, I was so tired; I went and turned myself in. You know, I was just at a point, at my rock bottom, I couldn’t take it anymore.” (P032)

“No, I was really into crack, running the streets, and jail actually saved me.” (P026)

“I was emaciated from drug usage, I was dying.... I was literally dying living in the woods. No food, no money, no, no hope.” (P034)

For others, their mental health needs required medication, that they lacked prior to incarceration,

“Sometimes I be out there, because eventually I would not be taking my medication sometimes and I would be basically... basically anxious about things, my anxiety level would be up there. Sometimes I be depressed, you know, Lithium and Klonopin for anxiety. I would stop taking them, I would end up just being... just not thinking right, from all the drugs, and not being on my medication. I would just be a confused person, you know.” (P016)

Several men and women described the choices they made and some of the challenges they had faced prior to jail.

“I didn’t mean to say so much fine. I was stressing before, I was coping with a considerable amount of stress, from trying to maintain stability with poor resources, being incarcerated cut off those, I am not working anymore, trying to maintain that situation and now I have to start all over again. (P024)
“Well, see the circumstances that put me in jail... my entire existence was poor, alcohol, unemployed, homeless, wrong people, wrong places; before going to jail, it was poor, it was pretty poor.” (006)

Men and women who described negative changes in mental health after incarceration also shared,

“I did not get mad at people as much. Took longer for someone to get me to getagrivated, and want to hit somebody.” (P015)

“Yeah, I was comfortable. I had a house, a kitty cat.” [teary eyed]. [and your mental status today?] Not good, not good at all, I am stuck in the woods, but I will get it back, I will get it back, I will get it back “[teary]”. (P022)

“Ok, I was able to think clearly, clearer than I can think now. I didn’t have... My focus was different. I did not have as much major issues to deal with. I had minors, lots of minors; lots of little ones, in comparison to what I have now, [which are] are majors. (P030)

“Was not having OCD symptoms, or trouble focusing on tasks. [before jail]” (P008)

Among those men and women who did not describe any mental health concerns was a 41 year old male, who was one of the few participants who had an income and was self-employed,

“I think my mental health was always been pretty good. I deal with issues (P018)

Another example was a 35-year-old male, who was currently going to school with the goal of becoming a computer software analyst

“Mental state of being is always pretty good. You know, I am very, how would I would say, not humble, but it takes a lot... (P003)

Mental health history. Thirty percent of men and women (n = 10) described personal experiences with own mental health conditions before and/ or after incarceration.

“Well, I had, they are called emotional breakdowns, because of going homeless... Now, I was admitted and committed about two years ago, I had like an emotional breakdown. I went to the mental unit in the hospital; they put me on their psychiatric unit for a couple of days” (P012)

“There was a lot of stuff to do with stuff that was going on in my life went I went to jail, stuff that happened while I was in jail, and now stuff that is happening now that I am out of jail.” (P13)
“My problems started when I was a kid..., yeah, basically the anger problem and seeing certain things, and stuff, like paranoia and things like that. I always been paranoid all of my life I guess.” (P20)

“I was living in the woods homeless, and it was a cold rainy night, and I had two choices; one, I was either going to kill myself that night or go into a psychiatric hospital, and I chose the psychiatric hospital that night.” (P22)

“But back to jail, that really contributed to a lot of anxiety and PTSD ordeals, because now any time I hear keys jingling, or a loud noise or a door slam, or someone yelling out orders at someone, it kinda [sic] sends me back to jail, in my mind.” (P2)

**Illicit substance and/or drug use.** Sixty-three percent ($n = 22$) of men and women reported histories of illicit drug or excessive alcohol use. Among the men and women using, the most frequently used substance was marijuana and cocaine (See Table 5).

Table 5

**Drug use among men and women prior to incarceration**

<table>
<thead>
<tr>
<th>Drug</th>
<th>$n = 22$</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana</td>
<td>7</td>
<td>20 %</td>
</tr>
<tr>
<td>Alcohol</td>
<td>6</td>
<td>18 %</td>
</tr>
<tr>
<td>Drugs (non-specific)</td>
<td>6</td>
<td>18 %</td>
</tr>
<tr>
<td>Cocaine</td>
<td>7</td>
<td>20 %</td>
</tr>
<tr>
<td>PCP</td>
<td>3</td>
<td>9 %</td>
</tr>
<tr>
<td>LSD</td>
<td>1</td>
<td>3 %</td>
</tr>
<tr>
<td>Opiates</td>
<td>4</td>
<td>13 %</td>
</tr>
<tr>
<td>Heroin</td>
<td>4</td>
<td>13 %</td>
</tr>
</tbody>
</table>

Note = participants may use more than one substance; equals > 100 %

The use of marijuana was described as a means to stress reduction and a drug that was less addictive than some of the other drugs

“Just having to deal with the stress of it all, that is when I was smoking weed, and that is how I ended getting locked up, for the weed, so.... and that is when I was doing it to relieve the stress a little bit, so.” (P21)
“I not going to do, what’s the other one, like dope? I am not going to do that stuff, because I know if you do it, and you get addicted, you are going to have to maintain it. All these other drugs, like marijuana, you don’t have to maintain.” (P11)

“I still smoke marijuana, but…. and I am trying to stop that to. Right now I smoke marijuana to stay mellow, and that is illegal…..Yeah, I honestly just do it to take away my anxiety.” (P14)

Men and women described the difficulty and challenges of breaking a cycle of addiction, i.e. to the use of cocaine.

“Cocaine….because cocaine there is never an end to that. Did anyone ever tell you that? I am telling you that. If you pick up one time, you will pick up, and pick up and pick up, and you are going to pick up until the money is gone. (P9)

Men and women once released continued to make choices while recognizing the court-imposed consequences that can happen with continued use.

“Yeah….I am telling you, but I need to stop because you know, I am in drug class right now. …. So I am trying, I am shying away from that [drug use] a little bit, now. I am not going to jail anymore, especially for dumb stuff like that. If I want to do drugs, I am not gonna [sic] do no drugs that will really harm me, like PCP, I am not going to do that stuff.” (P11)

The use of illicit drugs as described by several men and women created negative health consequences. A fifty-two year old woman who began using illicit drugs in high school led to overdose and physical harm;

“….mini strokes, but they are from prior drug use. [Your mini strokes occurred result from drug use?] Yes, ma’am… from PCP, when I was younger. I got high when I was 17, I started doing drugs when I was 15 and also I was drinking”. (P12)

A 45-year-old man released from incarceration a little over one year ago commented,

“Most of the time it was like not in good shape, not eating right, not taking showers all the time because I was running around looking for drugs, just real bad looking. lost a lot of weight” (P 16)
For a forty-one year old previously self-employed man who began using opiates while trying
to cope with grief and loss in his life described,

[Your addiction is opiates?] “Yes.” [When did this stop? [steady employment] ] “About 3
years ago. I lost my fiancée and my father just a few months apart. I guess I used that as an
excuse to give up and use drugs more ... prolifically?” (P18)

For several gentleman, medical treatment of a back injury led to the use of opiates and then
to the use of heroin,

“I have a prior use of heroin, and that is two reasons. One was initially leading up to my
back surgery, I was initially prescribed heavy pain killers because of the issues I have had with
back injuries and that soon progressed to opiate addiction, leading to heroin addiction. Then
once I discovered that opiate addiction kind of took away a lot of the different pains besides
physical but also covered up the mental pain. Once it has a grasp, and a hold of you, you can’t
escape it, so.” (P22)

[What kind of drugs did you use?] “Heroin, because it would help with the pain too, but I
just started abusing it like I said.” (P25)

For many, illicit drug use was a way of life for more than 20 years (n = 3).

“Yes. 28 years of drug abuse, on and off. I had a six or seven year period where I was clean
but, for the most part, I have never had more than a year of sobriety....... starting back in the
early 80’s with marijuana, LSD, PCP, going to crack cocaine, Heroin pills. I ran the whole
gammit [sic]. Crack cocaine made me homeless, made me lose everything. It was the one that I
was addicted to. (P34)

Health after Release

Several questions, both on the demographic survey and through interview, obtained
participant descriptions of their health status. In review of transcribed interviews, relevant
coding included two major categories of response: physical health condition and mental health
condition. Interview questions included asking participants to describe their health after having
spent time in jail. In addition, the demographic survey included several questions asking
participants to choose the best answer among four or five responses.
**General health status.** Table 6 describes responses of participants through use of the demographic survey. A question is asked, “Would you say that in general your health is—?”

### Table 6

**General Health Status**

<table>
<thead>
<tr>
<th>Rating</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Very Good</td>
<td>7</td>
<td>20%</td>
</tr>
<tr>
<td>Good</td>
<td>10</td>
<td>29%</td>
</tr>
<tr>
<td>Fair</td>
<td>12</td>
<td>34%</td>
</tr>
<tr>
<td>Poor</td>
<td>4</td>
<td>11%</td>
</tr>
</tbody>
</table>

In addition, participants were asked to describe their perceived general health status after the interview. Text analysis included varying descriptions used by participants to describe their health status. In some cases, it was difficult to determine congruence between the interview response and responses of participants as noted above. Some examples of text in response to the question, ‘how would you describe your general health status today?’ included ‘with no illness’ (n = 1), “in perfect health” (n = 1), “generally healthy (n = 2), “very healthy (n = 2), “pretty good” (n = 3), “not healthy” (n = 5), “fair (n = 2), and “above average” (n = 3). Overall, there appeared to be general congruence between survey responses and interview responses recorded.

**Reported physical health conditions.** Eighty-six percent of men and women described the presence of personal health problems (n = 30). The type and frequency of specific health problems reported are described. See Table 7.

Cardiovascular and heart disease were reported by more than 50% of participants. A history of hypertension was described by 29% (n = 10) of men and women. Fifty-four percent of men
and women described having been diagnosed as having hepatitis (n = 18); in particular, hepatitis C was described by 34% of men and women (n = 12).

Table 7

_Type and Frequency of Reported Physical Health Problems after Release_

<table>
<thead>
<tr>
<th>Category</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>30</td>
<td>85.7 %</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
<td>14.3 %</td>
</tr>
<tr>
<td>Physical Health Problems (n=30)</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Allergies</td>
<td>5</td>
<td>14%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>5</td>
<td>14%</td>
</tr>
<tr>
<td>Asthma or COPD</td>
<td>8</td>
<td>23%</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>18</td>
<td>54%</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>12</td>
<td>34%</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>5</td>
<td>14%</td>
</tr>
<tr>
<td>Hepatitis D</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Hepatitis E</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Cardiovascular and heart disease</td>
<td></td>
<td>more than 50%</td>
</tr>
<tr>
<td>History of heart attacks</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Heart disease</td>
<td>3</td>
<td>9%</td>
</tr>
<tr>
<td>Chest pain</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>10</td>
<td>29%</td>
</tr>
<tr>
<td>Circulatory problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In any extremity</td>
<td>3</td>
<td>9%</td>
</tr>
<tr>
<td>Increased cholesterol</td>
<td>6</td>
<td>17%</td>
</tr>
<tr>
<td>History of stroke</td>
<td>3</td>
<td>9%</td>
</tr>
<tr>
<td>Transient Ischemic Attack, (TIA)</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Muscular skeletal /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthopedic disorders</td>
<td>17</td>
<td>49%</td>
</tr>
<tr>
<td>Arthritis</td>
<td>3</td>
<td>9%</td>
</tr>
<tr>
<td>Chronic ankle pain</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Back injury</td>
<td>6</td>
<td>19%</td>
</tr>
<tr>
<td>Carpal tunnel syndrome</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Knee related injury</td>
<td>4</td>
<td>13%</td>
</tr>
<tr>
<td>Hip replacement / continuing pain</td>
<td>2</td>
<td>6%</td>
</tr>
</tbody>
</table>
Table 7
Type and Frequency of Reported Physical Health Problems after Release (continued)

<table>
<thead>
<tr>
<th>Category</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broken jaw</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Pain, persistent / chronic</td>
<td>12</td>
<td>34%</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>3</td>
<td>9%</td>
</tr>
<tr>
<td>Skin condition</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Trauma related injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gunshot to leg</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Trauma to both legs</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Toe infection</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Gynecological conditions</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Hyperthyroid</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Neuropathy</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Glaucoma</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Blindness</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Gastrointestinal problems</td>
<td>4</td>
<td>12%</td>
</tr>
</tbody>
</table>

Forty-nine percent of participants (n = 17) reported conditions related to various muscular skeletal / orthopedic disorders; the most frequently reported muscular skeletal conditions were back injury (n = 6; 19%) and knee-related injury (n = 4; 13%). Among men and women with muscular skeletal conditions, persistent and/or chronic pain was described among 34% of the men and women (n = 12). Other chronic illness among participants included 14% of men and women with diabetes (n = 5) and 23% having asthma or COPD (n = 8).

**Acute and chronic illness.** Thirty-one percent of men and women described their experiences with acute illness (n = 11), with most episodes due to acquiring an infection (n = 9; 29%), that was treated by visit to the Emergency Room, medication, or overnight stay in the hospital. Acquired-infection episodes included bronchitis or pneumonia, inner ear infection, and/or injury to an extremity resulting in an infected condition.
Men and women talked about their experience of having other chronic conditions (not pain-related) \( n = 10 \). For instance, one 46 year old woman with a history of excessive alcohol intake and drug use, states the effects of her former life style,

"I have low sugar, I have microcytic anemia, and it affects my low blood pressure and it affects my eyes. The anemia was the result of the alcohol over the years, so I take supplements". (P06)

A homeless 41-year-old man having a history of cocaine use is now living with hepatitis C and believed he ‘will probably have complications with that later on in life (P14).

A fifty–five year old woman released seven months prior to the study and who is living in transitional housing after a long history of heroin addiction, described the chronicity of her medical conditions as she continues to receive treatment,

"I am HIV +, I am a diabetic. I have neuropathy and glaucoma and what not. ... I got the neuropathy in both of my feet, and arthritis in my knees, carpal tunnel in my hands, glaucoma in my left eye. Right now, I am on top of that, I have hepatitis, A, and B, A and C, no A, B and C. So I am getting treated for that [hepatitis A, B and C] as well." (P 32)

**Pain.** Sixty percent of participants described having continuing pain of some type and duration after release \( n = 22 \) and half of these men and women \( n = 11 \) described pain as severe in nature.

For one 48-year-old African American man, who had had several repeat hip replacement surgeries, pain continued with little relief.

"I don’t know if they will give me another hip. I don’t know if it is defective. It will never be the same .... the same, the leg is not the same, I hurt all the time”. [post hip replacement] (P07)

For a 58-year-old African-American man, diagnosed with HIV +, hypertension, hepatitis C, heart disease and having a history of heroin use, severe pain caused by arthritis was setting in.
Table 8

Type and location of pain described by men and women after release (n = 22)

<table>
<thead>
<tr>
<th>Type and Location</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persistent ankle pain</td>
<td>2</td>
<td>9%</td>
</tr>
<tr>
<td>Back pain / injury</td>
<td>7</td>
<td>32%</td>
</tr>
<tr>
<td>Knees soreness or injury</td>
<td>3</td>
<td>14%</td>
</tr>
<tr>
<td>Wrist pain/carpal tunnel</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Pain in feet limits walking</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Joint pains</td>
<td>2</td>
<td>9%</td>
</tr>
<tr>
<td>Hip pain</td>
<td>2</td>
<td>9%</td>
</tr>
<tr>
<td>Leg pain / injury</td>
<td>2</td>
<td>9%</td>
</tr>
<tr>
<td>Jaw pain chronic</td>
<td>1</td>
<td>5%</td>
</tr>
</tbody>
</table>

“Let me tell you something, I never knew or had any idea that it is that painful, because my mother would moan, and groan and grunt and stuff like that, and I would say ‘what’s wrong with you..... Now all of a sudden I started feeling these pains, and whoa buddy. .... Man, ache all night long. When I lay on my shoulder it hurts, lay on my other shoulder, it hurts... my joints, whoa! I never knew....” (P09)

Several participants described having long-standing back pain that resulted from injury or car accident involvement, and are awaiting disability benefits. As one gentleman described,

“I am 34 years old and I am just now getting my disability. I have a broken back, since I was 14, so I been in and out of the system... I’ve have worked very hard for 30 some years, even with my disability.” (P13)

A 39 year old homeless man with a history of bipolar and explosive personality disorder who has been unable to work, describes continuing back and hip pain present over a 5-year period,

“Yeah, I am in a lot of pain right now. That is why I am leaning towards this way [leans to the right sitting] the left side of my hip, there is a lot of pain in it right now. ... This is the longest it has been with me [pain in hip]. .... Sometimes it gets to where I can’t move, and like now when I lift this leg up [right leg], it is the farthest I can lift it... To me it feels like it is getting ready to be permanent because it is not getting any better” (P20)
For a 24-year-old white male high school drop-out, born with Spina Bifida, back pain has been present since the age of sixteen.

“I was on pain medicine, I was, I guess, abusing it. ….. [Now] my ability to do stuff is limited …. I am trying for disability because in 2011 I broke my back, it made the pain worse, on top of the Spina Bifida”. (P25)

With the experience of pain, participants described the effects in limiting their physical activity (n = 4).

“My ankle hurting, like it was, I been walking all around, got no way to go nowhere and the more I walk, the more it hurts, the more it swells up ….has been hurting all my life [ankle]. I am kind of used to the pain.” (P10)

“I go 'If I am healthy why do my feet hurt?’ One foot, just this one. It stays swollen all the time. You know if I walk a lot, my hands will get swollen….Not only my feet.. I can tell, because when I do this, if I squeeze my hands together, they hurt. So I already know, I know either my blood pressure is high, or what do you call that, water on?” (P11)

“Like I said, when I put this leg down, the pain is just unbearable. I don’t exercise anymore, because it hurts me, too. I can walk with a cane, for two or three blocks, and then I have to sit down (P07)

**Accident-related injury.** Approximately 25 % (n = 9) of participants described having experienced an accident – related injury, and, for eight of the nine men (88 %) and women, involvement in a car accident resulted in continuing disability and /or the inability to work. As several gentleman described,

“When I flipped my jeep, I messed my L5 up. I can’t really lift anything anymore. When I do, it pops a certain way, and I am done for a week. Between that and my mental health issues I am waiting for disability actually, so.” (P16)

“Before jail, actually I had been involved in several car accidents, also work related accidents... That led to my addiction which also caused further physical decline.” (P22)

[You said you were hit by a car] “About 5, 6 years ago. That is why I got this cane. I can’t walk too far without it. I got hit by a car, and the car broke my legs. Hit and run driver” (P15)
“1985 I was hit by a car and I had both of my legs crushed. I did not get my disability until a couple years ago. For 20 some years, I had to work and do anything I could, on these bad legs, until finally they grant me my disability”. (P 23)

In addition to involvement in a car accident as a source of injury, one man describes a history of trauma as he got in the middle of a fight between two others that resulted in loss of eyesight in one eye.

“I was actually stabbed in my face about 10 years ago. A friend of mine was going through some stuff. He was about to be involved in an altercation with somebody else, and I stepped in the middle of it, and he stabbed me in my face. As a result, you know, I only got vision in my right eye.” (P33)

Aging. Eight men and women described the influence of aging, or getting older has had on their health. For one 48 year old gentleman with hypertension and bronchitis, health was ‘not as good as it used to be” (P02), and for a 46 year old woman with a past history of alcohol and substance use,

“I am generally healthy, but I have noticed some things as I am getting older. Things are not like they used to be... I used to be able to eat almost everything. Drink a soda, or coffee, there were no limitations to what I could do. Now everything I do to myself physically affects me. “(P 06)

A 55 year old homeless man, chooses nightly to sleep under the eave of a building where there is heat coming through the vent system downward.

“I am sure the weather has taken its toll on me, the aches and pains that you have dealing with the weather, the changes in the weather, and stuff like that, I was kind of in little better health then, you know (P019)

A man with multiple mental health diagnoses admits, “it’s like the older I get, the worse my mind gets, I don’t know. … but some things I cannot help, because the older I get, the worse it can get.” (P020)

For several men and women, aging may have increased a focus on personal health,
“I am 46 years old. I don’t want to, in 5 years from now go to the hospital all the time, because I haven’t taken care of myself, you know.” (P 029)

“My mental health status is something new to me. I have always had like an attitude problem, never really realized. I always thought it was because how I grew up, or the fact that I had been in the Marine Corps, and the stuff that I learned there. All that just plays a part now that I am older...it is something I just learned about, so still ... I read up on it on the computer. I do a lot of research on stuff. I read every ... every health issue I have, I do research on it.” (P33)

Mental health after release

In addition to medical conditions, 80 % of men and women (n = 28) reported having at least one mental health condition currently or in their lifetime. Sixty – three percent of men and women described having histories of substance/ drug or excessive alcohol use (n = 22). More than 50 % of men and women had been diagnosed with mental depression (n = 18; 51 %).

Table 9

<table>
<thead>
<tr>
<th>Reported Mental Health Problems</th>
<th>n = 28</th>
<th>80%</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Depression</td>
<td>18</td>
<td>51%</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>6</td>
<td>18%</td>
</tr>
<tr>
<td>History of substance / drug use</td>
<td>22</td>
<td>63%</td>
</tr>
<tr>
<td>PTSD</td>
<td>4</td>
<td>11%</td>
</tr>
<tr>
<td>Insomnia</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Explosive personality disorder</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Anti-social personality</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>7</td>
<td>20%</td>
</tr>
<tr>
<td>Paranoia</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Mood Disorder</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Sexual addiction</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Obsessive Compulsive Disorder</td>
<td>1</td>
<td>3%</td>
</tr>
</tbody>
</table>
Men and women spoke openly about their mental health conditions and how their mental health status affected their lives.

“I am bipolar, I have explosive disorder, that means when I get upset with myself, I might run my head into a wall. Yeah, if I am not doing anything, or something, I am liable to probably go off for no apparent reason. I can easily get agitated... I guess, yelling at me, or talking down to me, is a trigger, I get agitated with that. I get confused. Getting confused is a trigger.” (P20)

“.... PTSD, general anxiety disorder, and paranoia. That kind of, now that I look at, I can see over the many years, reasons why I didn’t follow through with things, why I didn’t like leaving places, because I was uncomfortable going places because of anxiety issues.” (P22)

“I had a good job there and lost it. I guess because of my bipolar, I was not able to control my anger and my actions. I lost my job over it, and again relapsed, started using drugs again. That was all during that 7 or 8 year period” (P34)

**Mental Depression.** More than 50% of participants (n = 18) described a history of mental depression, continuing and/or prior to incarceration. For some, depression occurred with the illicit use of drugs and with intermittent anxiety.

[How would you describe your mental health status before going to jail?] “Sometimes I be out there, because eventually I would not be taking my medication sometimes and I would be basically ... basically anxious about things, my anxiety level would be up there. Sometimes I be depressed, you know, but... “. (P16)

“I am putting my drinking first at the top of my list over anything else and I shouldn’t do that. I guess I am very depressed right now. I still wake up depressed, after I pass out; I wake back up, with a drink.” (P23)

“I guess I am a lot more depressed and have a lot more anxiety now, ‘cause I just got out of jail with nothing. (P25)

For one 61-year-old woman, becoming homeless was a major event, after years living in her own home, having raised her family, and then losing everything subsequent to eviction and opioid use.
“I have downsized my expectations. I don’t expect myself to be as happy as I was [before jail], dealing with the depression, just with the situation, of living in a tent, as opposed to living in a house.” (P30)

**Anxiety.** Twenty-six percent of men and women (n = 9) described having anxiety as they continued to seek ways to take care of themselves and/or their families after release. For some, anxiety was related to finding work after release and now having a criminal record. For others, anxiety appeared to be related to making progress in personal concerns after incarceration.

“More, right now the biggest stress in my life is looking for work; someone let me in the door. That is my biggest thing [getting a job], because I want certain things to happen right now. Right now, I need a job; I don’t care what I would be doing. I could sweep floors, I don’t care. Just let me get a job.” (P04)

“Yes, I am taking anti-anxiety medication. It definitely helps, it is definitely helping. With all the stuff going on, my mind, I can’t sleep cause all these thoughts keep racing in my head of how I can fix it and do things, it is kind of crazy, and it is kind of slows me down, get me where I can focus.” (P10)

“I have different anxieties which make it real hard to classify. I have anxieties where I need to be getting something done, or I have to come up with a plan about tomorrow of getting something done.” (P13)

“I have high anxiety. Like I can’t sleep. Up until last night, I slept six hours, the whole time I was out, I only slept six hours. I had no desire to go to sleep, don’t even want to go to sleep” (P14)

For several men (n = 2), having anxiety is the reason for continued use of marijuana.

[You said you smoke marijuana?] “Yeah, I honestly just do it to take away my anxiety. “I was mellow, more mellow [on Elavil]. Right now I smoke marijuana to stay mellow, and that is illegal.” (P14)

“Just having to deal with the stress of it all, that is when I was smoking weed, and that is how I ended getting locked up, for the weed, so..... and that is when I was doing it to relieve the stress a little bit, so.” (P21)

**Stress.** More than 35% of men and women (n = 13) described varied sources of stress in their lives after release. The most frequent sources of stress were homelessness or the lack of
stable housing (n = 7) and the lack of personal income (n = 5). Other sources of stress included living in an unsafe environment (n = 1), family concerns (n= 4), and other people (n = 2),

A 36 year old woman who had been a victim of domestic violence and had children who are not living with her describes ‘I don’t want to be homeless, I hate it” and staying with friends on a temporary basis is stressful as they were ‘judgmental’. For a 55-year-old man, time spent in the correctional facility was better than being homeless

“Even though I didn’t have my freedom to do the things I wanted to do, it was a type of structure there, where you know, I had access to things to three meals a day, a cot to sleep on, a bed to sleep on [and] dealing with you know, some of the issues I have, like not having a place, a consistent place to stay and stuff like that, is a stressful thing.” (P19)

A 61-year-old woman, who had been incarcerated after abusing pain medication, described homelessness as one source of much stress.

“The constant state of adrenalinization, [laughter] has got to take its toll. Yeah, I mean you are constantly squirting out the ‘fight or flight’; you are gonna [sic] run out eventually; and, just staying in the state, is not a good way. Your body just doesn’t like that.” (P30)

For a 58 year old man having a long history of cocaine addiction and who is now ‘trying to stay clean and keep clean’ and also, care for himself having several chronic medical conditions, e.g. hypertension, congestive heart failure, and HIV +, daily living was a challenge.

“Then you have your everyday trials and tribulations, the things you go through through the course of the day, like you are dealing with the bills and sometimes I am going, when is this going to end, when is this ever end?. The main thing is I am still trying, ok, and I will continue to try until I am out of here. that is the positive and good part, I am trying to stay positive in the course of that, but it’s hard, it’s hard.” (P09)

Unemployment was a source of stress for several men. One 36-year-old stated

“The most stress I have right now I have right now is looking for work. And that is going to come through, optimistic.... right now the biggest stress in my life is looking for work, someone let me in the door.” (P04)
Lastly, family relationships were important but were a source of stress, complicated by being homeless. As one 36 year old mother shared,

“Not being able to live at home with my mom and my children, that’s a stress. That is something I have to deal with, ’cause it is never going to happen [living with her children]. If I get approved for my disability and get a house, and get my children back, and that won’t be a stressor anymore. So I am praying on that.” (P17)

Several persons had family members with a history of mental illness themselves, who they stayed in contact with. For one 38 year old man, having a history of depression, anxiety, and substance use himself, continues to be contacted by a former girlfriend,

“One of my ex’s hinders me mentally health wise, constantly calling me because she constantly wants money or she wants me to give her some of my medications. One of my medications, particularly Klonopine, what they call Benzodiazepine, which is also, like Xanax, which is something she is addicted to” (P22)

For another 29-year-old homeless man who also has mental health issues, continuing contact with his mother after release was described as ‘really stressful’ (P08) For others, getting help from others to learn about services or resources available was a source of stress.

“I mean, I need help from other people, and waiting on them, stresses me out, because I don’t know if they really trying to help or not, you know. There’s a place up here, a housing authority. There is another place; I got the card in my wallet. They help you; it is a community place, where they try to get you some kind of housing. But the county ... county for homeless people, there is really nothing, so basically trying to get what you can get done on your own.” (P16)

Coping ability. Men and women were asked about their mental health status after release; descriptions in response provided insight of individual coping ability to life post release. Among 27 men and women who described sources of stress in their life post release, 31 % seemed to have difficulty with coping with everyday challenges (n = 11). A 59-year-old African American man with a history of congestive heart failure, HIV, hypertension and cocaine use noted
“…trying to stay clean and keep clean... like it is a fight, believe me, it is a fight. Then you have your everyday trials and tribulations, the things you go through the course of the day, like you are dealing with the bills and sometimes I am going, when is this going to end, when is this ever end?. The main thing is I am still trying, ok, and I will continue to try until I am out of here. That is the positive and good part, I am trying to stay positive in the course of that, but it’s hard, it’s hard.” (P09)

A 47-year-old man having been homeless and living on the streets for at least 5 years stated,

“Yeah, I get angry a lot, a lot now. At first, I used to laugh that off, laugh it off [mimic laughter times two]. ...... Now since I have been on the streets, six years straight or five years or whatever, I pay attention to stuff now, you know the least little thing you are trying to do, I automatically put in my head. You are trying to get me, you trying to get over on me.” (P11)

A 54-year-old white male, having been divorced four times and having attended some high school explained,

“I did not get mad at people as much [before going to jail]. Took a longer for someone to get me to get aggravated, and want to hit somebody. It don’t take much to make me go off the handle to where I want to hit somebody. But I have learned to control that, walk away from people.” (P15)

It is hard to explain, I just avoid people in general. I don’t know why I do that. ...... Sometimes you want to give up. If I do, nothing [will turn up] it is like a roller coaster. Some days I want to give up, and then I know if I give up, nothing good will happen. (P17)

For some, existing mental health disorders still are part of everyday life,

“Things I really freak out about and struggle with, especially paranoia and anxiety issue..., probably the longest term of employment I have had a job is three months. I struggle with being around people. I struggle with even catching a bus.” (P22)

“I don’t know. I think crazy things some time. I obviously do, because I keep making mistakes that send me back to jail, so, I need some kind of help, maybe, I don’t know... I am all right today. There isn’t a day that goes by, that I don’t think about using drugs though. I just try not to.” (P29)

Twenty-three percent seemed to be coping with their challenges of re-entry (n = 8) as they described their present status.
“I think my mental health is the strongest it has been all my life... today. I am more aware of things today, about myself than I was before.” (P06)

“Yeah, I have stressors now, but I have been rejuvenated [after incarceration], I guess. I said a few times already, [I am] rather buoyant.” (P24)

“Yes there is a big difference. I think better, I think more clearly. I behave more, more rationally. It seems like I grew up a little bit. I always known [sic] what was the right thing to do, but I just kind of made bad choices, so now I make better choices now, before I do something... I think about the consequences, I think of the consequences of making the bad choices, and I think about the benefits of making good choices.” (P33)

Lastly, 23 % of men and women talked about their mental health status as they were dealing with challenges (n = 8) such as caring for self and family, staying ‘clean’, obtaining state or military benefits that would help financially, or adjusting to challenges while maintaining a positive and/or optimistic attitude.

“I know where to go to find out information, but I don’t, with my illness and my disability, you know sometimes, sometimes you don’t get to see what is right in front of you all the time and you need to find someone else who can help you.” (P13)

“I just basically, I am just trying to keep myself clean, you know... I think you have a better outlook on things when you are clean you know, and it makes you more proud of yourself, I should say, I guess.” (P16)

“Well, actually, since I got these things, getting ready to come about, mentally I am in a better place. I get some veteran’s benefits that I am taking advantage of. I am getting ready to start my CDL class, plus I got a little job that I go to, on a regular basis. I don’t have no pending charges hanging over me, or nothing like that, so that’s all good.” (P19)

“I have to take care of my mental health in order to handle my physical health. If I don’t take care of my mental health and get depressed, I don’t’ care about the rest. I have to stay with a positive mental attitude, so I can keep getting through everything I got to do.”(P34)

One twenty-nine year old gentleman who is homeless, and expecting a child with his wife, described

“I think I am doing pretty good, considering the situations I am going through, you know what I mean... When you do get upset, it’s ok to get upset sometimes because we all do. You got
to take your time out, and then move past it. You can’t let it burden you, if you do, that will just slow you down. That is what I try to do, not let stuff bother me too much. There is time to deal with it, and there is time to get over it and move on, so it’s nothing that bad.” (P21)

A 40-year-old man who has a history of incarceration of at least a half dozen times and who is currently attending a methadone clinic after years of heroin use offered,

“I just go with the flow. I am one of those happy go lucky people, I don’t stress over stuff. They always have a saying, ‘spilled milk, why sit there and cry about it, and then clean it up? Why don’t you just clean it up, and go about your business?’ [humor] Why stress over it? You are either going to do two things, you can either let it sit there, or clean it up. Why go through all that hassle in the middle of it?” (P28)

Health Promotion

To answer the third research question ‘What personal strategies to promote, maintain or restore health are described among men and women recently released from an adult county detention center?’, iterative coding of text and responses on the demographic survey resulted in a description of subcategories of health promotion based on levels of health promotion, i.e. primary, secondary or tertiary prevention. Questioning related to primary prevention included asking the participant about receiving a flu vaccine, or measures taken to prevent sexually transmitted disease. Participant inquiry regarding secondary prevention strategies included descriptions of whether they had a recent physical examination and/or other health screening or diagnostic testing, mammogram or pap smears, and the use of health care resources. Lastly, questions regarding participant participation in tertiary prevention included the use of medication to treat existing physical or mental health problems.

Primary prevention. Men and women described varied strategies in primary prevention. Table 10 describes health strategies mentioned by men and women, to stay healthy.
Table 10

*Primary prevention strategies described by men and women after release*

<table>
<thead>
<tr>
<th>Primary prevention strategy</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exercise</td>
<td>14</td>
<td>40 %</td>
</tr>
<tr>
<td>Walking</td>
<td>33</td>
<td>95 %</td>
</tr>
<tr>
<td>Eating healthy</td>
<td>19</td>
<td>54%</td>
</tr>
<tr>
<td>Structuring of activities</td>
<td>13</td>
<td>38 %</td>
</tr>
<tr>
<td>Interest in health maintenance</td>
<td>9</td>
<td>26 %</td>
</tr>
<tr>
<td>Recent intended weight loss</td>
<td>5</td>
<td>14 %</td>
</tr>
<tr>
<td>Abstinence of illicit drug use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Or excessive alcohol</td>
<td>3</td>
<td>8 %</td>
</tr>
<tr>
<td>Smoking reduction</td>
<td>3</td>
<td>8 %</td>
</tr>
<tr>
<td>Proper hygiene</td>
<td>2</td>
<td>6 %</td>
</tr>
<tr>
<td>Positive social interaction</td>
<td>2</td>
<td>6 %</td>
</tr>
<tr>
<td>Prayer</td>
<td>2</td>
<td>6 %</td>
</tr>
</tbody>
</table>

**Physical Activity.** Men and women described daily physical activity to include walking, exercise or both. Walking was the primary physical activity for 95% (n = 33) of the participants. Many men and women stated that they “do a lot of walking” (P004) and that walking was “the most exercise that I get (P 004S). Men and women who are homeless tended to walk every day, frequently ‘every day, all day’ (P16), and ‘from the time I get up to the time I go to bed, I am walking (P17), ‘an average two or three miles a day, at least (P19).

**Walking.** Twenty percent of men and women described walking as their main mode of transportation (n = 7). For some who used public transportation, there was walking to and from bus stop / metro stop to home.

“….that is about a quarter of a mile to my school. I don’t get a bus, I walk, when the weather allows.” (P 004s)
“Oh, I walk a lot; I walk and ride a bicycle a lot. I don’t have a car, so anywhere I get, I either walk or ride a bike. I know today I already rode about 4 miles, and it is early yet, so. By the time the day is out, I have ridden at least 8 miles” [walk or ride a bike] “Yep, everywhere I go.” (P029)

For a 36-year-old unemployed woman with diabetes, hypertension and COPD, walking is a primary means of transportation, combined with the rail and bus system.

“that is like, because I take public transportation, so I walk everywhere I go... to the bus stop, from the bus stop to the metro station” walking comes naturally, because I have to get around” (P001)

“I go to NA meetings in the evening; the average is 5 miles round trip. That's a good evening walk.” (P018)

Exercise. In addition to walking, 40 % of men and women described their experience with exercise as a physical activity (n = 14). For some (n = 2) bike riding was a way to get around,

“Yeah, yeah, I ride a bike too, a pedal bike, all the time, whenever I travel...... that’s how I get around.... maybe an average of 5 to 10 miles a day, dependent on where I am going. I just got the bike. Before that, I walked all the time. I walk for miles and miles, I walk so much that my feet will be swollen at the end of the day.” (P003)

For others, workouts and body building exercises were a daily activity (n = 6).

“Once a week, I will do some calisthenics in the house, but it is not where I would like to be at. I try to do 50 push-ups” (P004s)

“I lift weights, I body build. I have a very intense body building /cardio/stretching, stomach; I kind of do it all. It’s all one routine, it only takes me about 25 minutes and it is very intense.” (P0 10)

“I do other things, push-ups, pull ups or sit ups. I try to avoid sit-ups; I understand it is not the best for your lower back. That motion is not the best for your lower back, so crunches are better for the lower back, so.... .” (P018)

“Working out, I am big into working out...... Exercise, one of the main things. .... sometimes I go to the gym, depends if I am working. I am pretty much, between the walking and the work I do, and what exercise I get in.” (P 28)
“I exercise. I don’t exercise as much as I used to. When I was in the military, we exercise every single day, and twice on Sundays. So now, I exercise every few days, do moderate exercise...... I do like some mild weight lifting. I get on the machines, like I get on the bike, and I do the rowing and the peddling and stuff. I do like a bow flex, I do various exercises on the bow flex. Leg, legwork, and stuff like that. I jog a little bit every so often.” (P33)

A few men and women described general physical activities that included “carrying weighted stuff” (P008), staying active (P009), moving and hauling large furniture, being employed (P10). Still others described, “throwing a football around, play[ing] basketball.”(P021)

**Healthy Eating.** More than 50% of men and women - when asked about ‘the things you do to stay healthy? What can you describe as things that you do to stay healthy?’ - described personal dietary-related strategies helpful to staying healthy. Descriptions of healthy food choices included staying away from fried foods and red meat and eating fruits and vegetables.

“Since I say, late December [2012; started vitamins, juicing fruit]. I would say it is a lifestyle change. ..... Don’t do too much red meat anymore. Mostly turkey, chicken, fish...breakfast I eat oatmeal, things of that nature... some fruit, a juice, new drink with green vegetables with fruit mixed in, every morning, one for lunch and one for dinner. I am going to try it” (P004)

“I eat salad; I don’t eat a lot of red meat. I eat chicken. I don’t eat a lot of fried foods, baked chicken. Very seldom, do I eat fried food... I have tried to bake things, and boil things more, instead of frying, or whatever.” (P07)

“I am on very nutritious meals that I take... Yes, I eat all fresh fruits, if I can’t eat fresh foods because it’s expensive, I eat frozen. ...... Vegetables, I try to eat fresh foods, vegetables. Lean meats, a lot of whole grain cereals, a lot of water, I try to drink a lot of milk. I try to eliminate any processed food “. (P10)

“No, it is more of a general, a total life thing In general I do whatever I can to lower negative things in my diet. I try to avoid potato chips too as a snack, because e super-heated potatoes turn into a compound commonly found in plastic. (P18)

“I think being active, eating the right foods mainly, pretty much that is the best thing a person can do for their health... I try to eat healthy... I eat a lot of fruit, dried fruit and stuff.” (P29)

The importance of vitamin intake affecting health was mentioned by four women.
“She [the primary care doctor] said take some prenatal vitamins for a while, and you will be ok. So I was doing that for a while... and I ran out of those a while ago. I would like to start up taking vitamins, I think a multi probably, would be a good thing to do.” (P30)

“I take my vitamins every day, and just eat the right stuff. Don’t put all that poison in your body.” 35

“The anemia was the result of the alcohol over the years, so I take supplements .... Iron, B 12, folic acid.” (P06)

**Recreational and structured activities.** Thirty-seven percent of men and women described the importance of daily routines and recreational activities as a means of staying healthy (n = 13). For one 56-year-old woman, with a history of PTSD and substance use, after having served as a military contractor in Afghanistan and Iraq, recreation was important.

“Listen to music, get with family members, you know recreation. Enjoy family gatherings and things of that sort ... outings maybe, shopping. We have a great time, dinner and things of that sort.... just being with family, we might play games, we have a good time” (P05)

For another 46 year old woman who associated with the wrong friends, drank excessive alcohol, and described past drug use,

“I spend a lot more quiet time and meditation with myself, and I think a lot about what it is I want to do, that is positive. So I do a lot of quiet time and meditation, to try to retrain my mind into thinking something else [escape for craving], even though my body feels one thing I will pick up the Bible, I will pick up a novel, or I will go to the library to get my brain not to feed the physical urge. “(P06)

For two men who have a history of bipolar disorder and other psychiatric co- morbidities and taking medication, keeping busy with leisure time was important.

[Are there any other activities that you have, that help you take care of yourself?] “Actually, I listen to the radio, read, you know, do like little puzzles, like crossword puzzles that occupy my time some time, just get tired and go to sleep and what not. That’s about it basically.” (P16)

“Well, basically, on Facebook to help ease my mind, and listening to music, that’s it. I guess it keeps me sane, or whatever, in the right state of mind” (P20)
For men and women, having a daily plan and keeping busy was a way of taking care of their health.

“My mental status is what my plan is, as long as I keep having a plan, I am able to work my mind in a positive way. When I don’t have anything to do, don’t have anything to complete, or something to work for, my mind wonders in all sorts of different directions.” (P13)

[What helps you take care of your health?] “Is basically, having structure in my life, uh, getting out walking as much as I possibly can and I use public transportation as well, so that helps as well” (P 32)

**Interest in health maintenance.** Twenty-two percent of men and women described their interest in personal health and self-maintenance (n = 9). One 36-year-old man with no existing health problems stated

“I never knew you can cook with olive oil. I always thought it was something you dip bread in, or something like that. It is interesting to learn” (P04)

Several women over the age of 40 described aspects of self-care, as they grow older,

“A person who knows what is going on with their body. That makes you healthy because you know what you need to do in order to get better. So knowing, that is the most important for a healthy person…. I know everything that is going on with me. I exercise; I eat properly, the best I can.” (P05)

“at my age I am 46, there are things that I know as a 46 year old female, that I should be doing to supplement things in my health that I did not have to do 20 years ago, like fiber, vitamins, exercise and things like that”. (P06)

Health information sources included the use of the internet, friends and healthcare providers.

“The Internet is an awesome means of information. As far as television is concerned, Dr. Oz has a lot of good tips. He tells you some things that is amazing. I get a lot from that show. I like his show, it is very good. It is informative.” (P05)

“And she [ex-wife] was talking about arthritis, and she said let me tell you something. She said everything you eat is meat, you eat no vegetables. You know what meat is, it is protein, ands he said what happens is protein is crystallized on your bone. So that is where is arthritis comes from. What you got to do, is start eating vegetables, lot of vegetables, eat a lot of salads. So now, I always fix a lot of salad. (P9)
“People say I got fluid on my feet, or whatever. One nurse told me that if I elevate my feet higher than my heart, then it would go down. I tried that. It works, it works.” (P 11)

“Well, I read. Every now and then, I come down here to see what flyers they have. I will read up on them and stuff like that” (P 19)

**Alcohol Non-use.** More than 80% of men and women (n = 29) reported non-use of alcohol in past 30 days. When asked during an interview “do you drink alcohol?” Eight men and women stated that each was an “ex drinker”. One person quit drinking alcohol after serving jail time for Driving While Intoxicated and two others were recovering alcoholics.

Table 11

*Alcohol intake of men and women after release*

<table>
<thead>
<tr>
<th>Current Status</th>
<th>N = 35</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex drinker</td>
<td>8</td>
<td>23%</td>
</tr>
<tr>
<td>Does not drink</td>
<td>13</td>
<td>37%</td>
</tr>
<tr>
<td>Occasional drinker</td>
<td>12</td>
<td>34%</td>
</tr>
<tr>
<td>Drinks everyday</td>
<td>2</td>
<td>6%</td>
</tr>
</tbody>
</table>

Eleven men and women stated they “occasionally” drank alcoholic beverage, one person described himself to be a “sometime drinker”, and three men stated they “drink everyday.

One person who stated that he is an ex drinker, is a recovering alcoholic (P12). Others had a history of drinking early in their teen years,

“I used to drink; I was an alcoholic when I was a kid, before I discovered drugs. I did not go to school anything drunk or anything like that, but when I drank, it wasn’t a good thing. (P13)

“When people would normally stop and get a loaf of bread and milk, I would get a six pack of beer, and I drank quite heavily for years. “ (P30)
One young man who quit drinking after a conviction and jail time for Driving While Intoxicated (DWI) stated

“Drinking and smoking marijuana, partying. It is nil right now; don’t drink anymore. .... to scared they will put me back in.” (P04)

Another man stated that he does not drink anymore, after he became aware of having Hepatitis C, as he knows that continued drinking can accelerate his condition.

“I have learned to stay away from alcohol. Even though I walk past four liquor stores every day, I just walk right on by. I think it is better healthy wise to stay away from it.”(P15)

For two men who were both homeless, drinking continues to be an everyday event. As one person described, “I drink every day, every morning. That’s like coffee to me.” (P11). In particular, a 53-year-old man who grew up in a family of alcohol drinkers and is now ‘living in a tent’ and having recently been robbed described,

“Yeah, I do. Yeah... to put up with what I am putting up with back in the woods, I shouldn’t but I do... yeah I do. “Oh  yeah, yeah, yeah, yeah, drink every day. “Beer, vodka ... depends on my mood.” (P23SR).

Similar feelings were shared by another young man who recently became homeless, in stating, “he absolutely drinks more than before.” (P24)

**Tobacco Use.**  Survey questions included questions regarding their use of tobacco, i.e. cigarette smoking. More than 90% of the participants (n = 32) currently smoked cigarettes; among this group more than two – thirds of men and women smoke cigarettes (tobacco) every day, and 63% of men and women have tried to quit in the past year.

More than 90% of men and women interviewed smoked cigarettes in their lifetime, and 69% continued to smoke cigarettes every day. When asked about the time since last having a cigarette, 80% of men and women stated within the past month, and more specifically on the
Table 12

**Tobacco Use**

<table>
<thead>
<tr>
<th>User status</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tobacco Use in lifetime</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>32</td>
<td>91%</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>9%</td>
</tr>
<tr>
<td><strong>Current Smoker (frequency)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Every day</td>
<td>24</td>
<td>69%</td>
</tr>
<tr>
<td>Some days</td>
<td>4</td>
<td>11%</td>
</tr>
<tr>
<td>Not at all</td>
<td>7</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Tried quitting to smoke in past year (n = 32)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>22</td>
<td>63%</td>
</tr>
<tr>
<td>No</td>
<td>10</td>
<td>29%</td>
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<tr>
<td>Has not smoked in 12 months (not included)</td>
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<td></td>
</tr>
<tr>
<td><strong>Time since last smoked</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within past month</td>
<td>28</td>
<td>80%</td>
</tr>
<tr>
<td>Six months &lt; 1 year</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>1 year &lt; 5 years</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>10 years or more</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Don’t know / not sure</td>
<td>1</td>
<td>3%</td>
</tr>
</tbody>
</table>

same day of the study. Twenty percent of men and women described that they have been smoking since they were teen agers, (n = 5); other descriptions included “for 25 years”, (n = 1), ‘for 20 years’ (n = 1), for “30 years (n = 1), or about ’27 years’ (n = 1). When asked ‘how much did you smoke’ (n =19), 23 % of men and women smoked ¼ to ½ pack a day (n = 8), or three to five cigarettes a day (n = 3). Five participants described smoking a “pack a day” and two reported, “smoking a pack every few days” or “10 cigarettes a day”.
A 41-year-old male, who had been in jail multiple times, with one sentence lasting eight years, stated he did not smoke during this time in prison. Also, a 61-year-old divorced woman who had been incarcerated most recently for only 7 days, recalled,

“In jail, it was a funny thing, if you want to equate it to that, that is a different situation, where you, it is not a personal decision. You can’t smoke, and that is that... so you say ‘shucks’, when you know you can’t. When you are out here, like I said, that’s a personal decision, so I am able to make that decision, ‘no I don’t want to smoke’.” (P30)

Several men and women described smoking as personally unhealthy (n = 5).

“I am a cigarette smoker, and I definitely put my lungs through their paces over the years.” (P013)

“I smoke for a very long time, for years... by now, I probably messed my lungs up by now, so I don’t know.” (P 020)

“I smoke, I have COPD, I am a recovering drug addict. And I don’t take very good care of myself.” (P 026)

Smoking cessation. More than 60 % of men and women (n=22) tried to quit smoking in the last year. One person tried medication, (n = 1)

“I have stopped smoking then I started back. I was on this Chantix, and I really swore by that medication at one time, but I started back smoking; yeah, you can smoke when you first take it, then it takes away the craving, but you have to take it after you stop smoking” (P001)

Other men and women were in the process of quitting smoking as they were concerned about their health (n = 4).

“I notice I don’t breathe as heavy anymore, since I have cut back on the cigarettes. I still smoke about 5 every day, I don’t buy them.” (P29)

“Yes, trying to cut back on that. I know once I get in the gym, I am not going to want to smoke. You know what I am saying, in that type of environment, I am going to want to go full force with my health.” (P31)

“I am smoking less and less, because I am seeing the benefit of doing that, while walking.” (P30)
“.... if I buy a whole pack of cigarettes, I am liable to smoke a whole pack of cigarettes. I am concerned about my health.” (P029)

For others, they were just tired of smoking and were trying to quit (n = 5)

“I probably will quit smoking, because they are starting to taste real nasty to me. That is just where I am at with that.” (P33)

“I am smoking like 3 a day now. I am cutting down on them. I used to smoke two packs a day. I am trying to quit though.” (P035)

So I quit smoking, I quit drinking, and that eliminated a particular group of people that I was around. I don’t know that that will go away [drinking and smoking], but some days are better than others ....” (P006)

I am really literally over the past few months, I am trying not to [smoke], and physically don’t want to, but there is a craving there.....” (P30)

“I am smoking now, but I am trying to quit. I don’t want to really smoke anymore, so” (P16)

Quitting to smoke was difficult and challenging (n = 5).

“Sometimes people give me a cigarette. Sometimes I walk around, if I find enough money to get me a pack, it will last me a week. Even if there is sometimes that I do not find anything, and I really need a cigarette, if I see a decent size cigarette lying on the ground, I will pick it up and smoke it.” (P015)

Yet, there were men and women who described having quit smoking early in their lifetime (n = 5). For some, smoking was associated with drinking behavior (n = 3),

“Yeah, if I didn’t drink, I didn’t smoke. When I started drinking, after about the third drink in me, then I started smoking. I could smoke a pack or two packs a night.....” (P023)

“Put it this way. I was in jail for 8 months and did not miss smoking. Smoking is really something I would do, if I go to a bar, if I am drinking, I would like to have a smoke.” (P024)

“It took years for me to come to the point where I would actually buy a pack of cigarettes. The thing is I am never smoking unless I am drinking. I drink more now that I am in the street.” (P 024)
Influenza Vaccine. During the interview, a question was asked, ‘have you had a flu vaccine'? Results indicated 50% (n = 16) of men and women had received the vaccine and 50% of men and women (n = 16) did not receive the vaccine.

Among those that did not have the vaccine, reasons were varied,

“I don’t believe in a flu vaccine. Key reasons, because you are giving me the virus, to fight off the virus. I don’t want the virus at all. If I get it, then let it come naturally, and not put it in me, even though it is supposed to be a dead virus, just totally against it.” (P04)

“I actually don’t do flu shots. I just let my body fight it off naturally, so.” ..... “I don’t know, it is weird. If you believe it, sometimes don’t even get sick, so, it’s weird.” (P21)

“No, I don’t oftentimes get sick. I guess it is a diet thing or whatever. I have not had the flu in I don’t know how long exactly, for years, maybe 15 maybe more. I haven’t had the flu, and I just can’t remember.”  (P24)

“No, I don’t take the flu vaccine. I see too many people getting sick from it. The baby got it, and was put in the hospital twice with pneumonia, because it was a two part, and both times got pneumonia.” (P34)

Men and women also described having received other vaccinations to guard against disease, with 14% having received a pneumonia vaccine (n = 5). One man, who was a new grandfather, was familiar with the more recent CDC guidelines regarding infant protection against the Pertussis virus; he felt strongly about the importance of himself and other adults receiving the vaccine to provide a safeguard from his new grandchild.

“Right. As soon as it came out, I went to my doctor and he said, ‘well how old is your daughter now?’ and I said, she is right to turn a year old. He said, ‘you want this shot now?’ and I took it. I told her mother, I had her mother go and get a shot. I had her grandmother go get it; I had her grandfather go get it... and I said ‘if you don’t get it, I don’t want to hear about you holding my daughter’.” (P33)

Protected Sex. In exploring primary prevention strategies among men and women, probe questions included a focus on prevention of sexually transmitted disease; questioning included a
focus on protected sex if sexually active. Thirty-six percent of men (or women concerning their partner) described condom use (n = 9) when sexually active; similarly, 36% did not use a condom (n = 9) when sexually active. Among those that did not use a condom, two out of three (n = 6) men and women were in a monogamous relationship. Other responses indicated “sometimes” (n = 2), and not being sexually active / abstinence (n = 5).

One 36-year-old gentleman unmarried, who had only been incarcerated one time, stated,

“Yes, of course, yes, not to say it like everyone does... but it is dangerous out here right now. (P04)

Another person described a decision to use or not used based on the nature of the relationship.

“I do.... there is a long history as to what that means. In certain situations, my last sustained relationship, no we didn’t. That was a relationship of seven, really more than that year, we will just describe it as a 7-year relationship, and no of course we didn’t. I don’t want to say of course, but no, we didn’t. In a shorter term relationship that you are not so sure, or comfortable, there is no clear destiny, or whatever, yes.” (P 24)

Other men and women described being in a relationship, that influenced their decision, not to use a condom,

“I am not out there sleeping around; I am with the same person, more or less, you know. Not to say that she can’t you know.” (P19)

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having sex. I am classic old tradition; I don’t just have random sex. “Sometimes I would, sometimes I didn’t.” (P22)

A 42-year-old gentleman who had recently returned to a relationship with a woman after three years apart and who now has hepatitis C, described,

“In the three years that we weren’t together, she was involved in another relationship; and, he had hepatitis C and he never told her. She didn’t really have a choice in the matter of how she got it. She told me when we got back together, that she had it [hepatitis C], that she contracted it, and I was like ok, it doesn’t matter, I am not going to turn my back on you, so I made a choice to take that risk with her…. You know, we are in a monogamous relationship” (P33)

**Other primary prevention strategies.** Additional strategies related to primary health promotion included recognition that weight loss, cutting down smoking and staying off drugs and excessive alcohol use.

Men and women described their recent efforts in weight loss that was associated with maintaining health.

“Yea, it shows, I have lost about 10 lbs. not a lot, but to me it is a lot. I was at 260, I am down to 244. It is more of wanting to get myself healthy. I do want to lose some weight. I have felt myself getting sluggish, different pains that were not there before” (P04)

“I am pretty much a vegetarian, put it like that. I probably eat red meat once a month. That is just how my diet has changed dramatically. As the result, I lost ………………50 pounds, I went from 300 to 250, which is good.” (P33)

Men and women realized the relationship smoking cigarettes has to positive health.

“3 packs…. I have come down. I could go through a carton a week, in my worst time smoking that is 10 packs.” (P04)

Also, men and women with histories of drug and excessive alcohol use recognized the health hazards of continued use. Several men and women commented,

“Stay away from illegal drugs and alcohol, and if you are going to drink try not to drink excessively” (P 04)
What helps you take care of your health? “Basically, listen to what my doctor tells me, actually stay off of drugs, I been off of drugs for a long time... maybe a couple years, (P20)

Secondary Prevention

National health priority goals include a focus on secondary health prevention that includes increasing the number of persons screened for cervical and breast cancer (Healthy People.gov, 2010). Items included on the demographic survey, taken from the national Behavioral Health Surveillance Risk System Survey (BHSRS) included whether a woman has had a recent Pap test or mammogram. Additionally, men and women were asked ‘how long has it been that you saw a doctor for a routine check-up?’ and ‘how long has it been that you saw a dentist for a routine check – up?’. Table 13 describes a summary of responses regarding participants having had a routine check – up or dental exam within the last 12 months.

Sixty percent of men and women (n = 21) confirmed having had a physical exam within the last 12 months; in response to the question as to the last time each had a dental check-up, 60% of participants had a routine dental check sometime less than 5 years (n = 21). Additional findings indicated an equal number of participants having had a routine dental check less than 12 months and also those having one 5 or more years ago (n = 13; 37 %) See Table 13.

Table 13

Time frame of most recent physical and dental exam among participants

<table>
<thead>
<tr>
<th>Time frame</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Routine Physical exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 12 months ago</td>
<td>21</td>
<td>60%</td>
</tr>
<tr>
<td>1 year and less than 2 years ago</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>2 years but less than 5 years ago</td>
<td>6</td>
<td>17%</td>
</tr>
<tr>
<td>5 or more years ago</td>
<td>5</td>
<td>14%</td>
</tr>
<tr>
<td>Never</td>
<td>1</td>
<td>3%</td>
</tr>
</tbody>
</table>
Table 13

*Time frame of most recent physical and dental exam among participants (continued)*

<table>
<thead>
<tr>
<th>Time frame</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Routine Dental Check</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 12 months ago</td>
<td>13</td>
<td>37%</td>
</tr>
<tr>
<td>One year but less than 2 years ago</td>
<td>3</td>
<td>9%</td>
</tr>
<tr>
<td>2 years but less than 5 years ago</td>
<td>5</td>
<td>14%</td>
</tr>
<tr>
<td>5 or more years ago</td>
<td>13</td>
<td>37%</td>
</tr>
<tr>
<td>Don’t know / not sure</td>
<td>1</td>
<td>3%</td>
</tr>
</tbody>
</table>

**Physical Exam.** Responses regarding having had a physical exam were varied. Most men and women described having had a physical exam ‘when they were inside’ (P04) (n = 6); other circumstances that resulted in a physical exam included starting a methadone program (n = 3), or a new job (n = 3). Several participants described having had a ‘physical’ as they were hospitalized for an acute condition (n = 2), or when starting insurance coverage (n = 1) or seeing a doctor routinely (n = 3).

Five participants disclosed not having a recent physical exam. One person who has been homeless for 20 years, described not having ‘had an exam for “about 30 years” (P12). Still others stated (n = 3), it has been ‘a few years ago’ (P 17), or ‘no, not really’ (P 23), or ‘not yet’ (P02). One person states, “I never have [had a physical exam]. (P7)

Among men and women who had a physical exam while incarcerated, descriptions included a ‘cursory physical’ by medical personnel.

“I got a physical... county detention center. ‘Can you lift 50 pounds, arms straight out, lift your legs, and basically you were sent you on your way.” (P13)

“.... I mean it is a cursory physical that you get in jail so I don’t know how much is a physical....Well, they do ask a couple questions, but mostly it is managing health risk in the
general population [correctional population], and is not your own health. So I guess I would say in that vein, let’s say three years.” (P24)

“They do a physical there, but that’s all they do is take your blood pressure, and touch on your stomach a little bit and that’s it” (P25)

“Just in jail, and it was a basic physical.”….included where they checked my knee, made me turn my head and cough, held my nuts, [sic] [laugh] all that stuff. I was good on all that. “(P29)

Others recounted having had a physical exam in meeting requirements for employment,

“I am a CDO driver, I take the DOT, I had that. As far as blood work, no.”(P10)

“Yeah, well February, was my last. I needed to be clear to drive, so I had to take a DOT (Department of Transportation) physical for that, blood pressure and whatever that consisted of, right. I passed that with flying colors” (P19)

Among those who described having a physical exam as they began treatment at a local methadone clinic, their experience was that the exam was very thorough. One women describes,

“When I first went into the Health Department for the Methadone treatment, December 19, that week…. That’s right, Laura the nurse, that was about the most comprehensive physical, I have had in a long time. I mean they did everything, top to bottom. She even knows I have a mole…. You know, they mapped everything. She was just terrific. Yeah, there’s [sic] records out there that show me inside and out.” (P30)

Several men and women (n=3) described recently becoming insured; and, only one person took advantage of the coverage and another was unsure as to whether the insurance plan covered a health physical.

“I do know that I need to make an appointment with my primary care [doctor] because I know since I have gotten [sic] insurance, that is usually one of the first things that you are supposed to do, is go get a physical exam, which I failed to follow through with because I have higher priorities than that right now.” (P22)

Men and women who had a relationship with a primary care physician (n = 3) described a physical exam as an annual health activity.
“I had one in December…. I get a physical every year. This last year I had two physicals. I had one in June of last year, and then I had another one in December”. (P05)

“I have had a prostate exam, a rectal exam, a thyroid check, all came back negative. A stool check came back negative... vision, hearing, stuff like that. (P08)

“When I go to the doctor next week, she always do [sic] a thorough check, like a complete physical, I am talking about head to toe, she checks it all.” (P09)

**Health screening and diagnostic testing.** As men and women were asked as to whether they had had recent health screening, such as having had laboratory blood work or other work-ups to detect presence of disease, 45% of men and women stated that they did (n = 15) have other screening.

The one person who described having a colonoscopy has celiac disease and had a colonoscopy because of his gastric work up (P01). Regarding having had a prostate exam or colonoscopy, one 54 year old African American male with a strong history of prostate cancer in his family among his brothers and father and also his mother died of ovarian cancer expressed,

“I need to be on top of that, maybe a little more than I am. I have had a couple of PSA’s, they were pretty good, but it has been almost..... they told me, I really need to get done every six months, it has been pretty close to a year and a half, since I had my last PSA done. Like I said, I tried to get through the PAC thing. That stuff I need to get on.” (P19)

“....have not had a colonoscopy yet, that is the one thing I need to get done... I am in that age bracket, like you know, colon cancer does not really have a lot of symptoms, and till it gets beyond the point that they can’t help you.” (P19)

Several men and women (n = 5) described having had HIV and other testing as routine screening process when becoming incarcerated.

“Yes, you mean the HIV positive. Yeah, um um.... I think I was diagnosed....matter of fact, I did not know I was HIV positive, until I was over in [x] jail. (P09)
“...other than the medical clinic and jail. I don’t know if it is the TB tine anymore, they do a blurb, TB, HIV, Hepatitis C, those are the three. It was negative. Yes, they do the three. All those are negative.” (P18)

“Yeah, you know when you go to jail, they give you all that stuff. I had a couple little things. They do TB shot, AIDS test and all that. AIDS test was negative, TB test was negative. I don’t have none [sic] of that stuff.” (P11)

Cervical cancer screening. Women participants were asked as to whether each had a recent pap smear. Of eight women questioned, five women indicated that they had, although four of the five were non-specific as to when or how long ago; one woman admitted ‘it was a couple of years ago. Among women who said they did not have a recent pap smear (n = 3), one person stated,

“I don’t have cancer anywhere in me. But I haven’t had like a pap smear or they have not done a breast exam or anything.” (P12)

Two other women stated,

“Yeah, couple years ago too. I don’t have one as often as I should.” (P17)

“No, I didn’t do any of that. No, I really should do that. [You have not had a mammogram. How about a Pap smear?] “Last one was probably when I was 40 or 45, about 20 years.” (30)

Breast cancer screening. Fifty percent of women over the age of forty (n = 6) of women in the study expressed not having had a recent mammogram.

“No, I didn’t do any of that. No, I really should do that. I am very cystic, I have got these little, what do you call them, fibromas everywhere, and I have a uterus full of them, and I have one on my breast, but I have had that for years, it hasn’t grown, I know how to look at it, and I do self-breast exam myself. It seems to me if I went for a mammogram, they probably would want to biopsy everything. I should. Last one was probably when I was 40 or 45, about 20 years.” (P30)

“I was scheduled to have one and I did not go, I have breast implants, and I was kind of scared to have it done, but my doctor, she gave me a referral but I hadn’t gone yet. It is still in my purse. I can go at any time, but yeah I do have a referral.” (P31)
Illness remedy and use of over-the-counter medication. Men and women were asked ‘if you are sick, how do you restore your health?’ Probe questions included, ‘for instance if you have a cold, or are not feeling well?’ or ‘do you take any over the counter medicine?’ or ‘do you use over the counter drugs for any reason?’

Table 14

Over the counter medication or other remedies use when ill by men and women

<table>
<thead>
<tr>
<th>Use of over the counter remedies</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-use of over the counter meds</td>
<td>15</td>
<td>42%</td>
</tr>
<tr>
<td>Pain medication, i.e. Tylenol, Advil, other</td>
<td>13</td>
<td>37%</td>
</tr>
<tr>
<td>Cold medicine</td>
<td>8</td>
<td>23%</td>
</tr>
</tbody>
</table>

Other remedies

| Rest                                                      | 8  | 23% |
| Go to the doctor or Emergency Room                       | 7  | 20% |
| Drink fluids                                             | 4  | 11% |
| Make a hot toddy (liquor and tea)                        | 4  | 11% |
| Take vitamins                                            | 3  | 9%  |

Other remedies described were antihistamine use for allergies (n = 1), Epson salt for feet soaks (n = 1), and eating soup when having a cold (n = 1).

Forty-two percent of men and women did not use any over-the-counter medication for any reason when sick. The use of pain medication over the counter was mentioned most frequently followed by taking medication when cold or flu symptoms are present. Other non-medication remedies included rest, drinking fluids, making home brew like a hot toddy and taking vitamins.

Varied home remedies were described by men and women,
“I drink a hot toddy. You know if I got a cold, I don’t get colds, because I am out on the streets constantly, I don’t get sick. When I sick is like every three or four years, I get really sick. I know what to do with that. I grab a hot toddy, tea... you know a cup of tea, a shot of Old Grand Dad, and lemon or honey. Go in the house somewhere, get under the blankets. By the time the next morning, I am like ‘bing’, I am up and running. Yeah, I’m good.” (P11)

“I guess I usually, if I am feeling under the weather, I drink more orange juice, Vitamin C consumption, vitamins in general, I try to take my vitamins. Typically I try to give my body the tools and resources it needs to do its own work.” (P24)

“By taking my medication, maybe about once a month or so, I will try to drink some green tea, or Alovera, or something, to release the toxins that is in my body from the pills that I take... I have used this toxin pad that you put at the bottom of your feet. You go to sleep and you wake up, and it’s black. I guess it is pulling something out of me. You feel a lot better as well. I drink a lot of tea now, relaxing tea.” (P32)

“I get some over the counter medication. Use some of my grandmother’s remedies. Things like that, she cut an onion up, put it in water and let it, something like a syrup, let it simmer and settle down to a syrup. Put the garlic and onion bag to your chest. Vicks vapor rub. (P07)

“Tylenol don’t [sic] even get rid of a headache. Now, there is this thing called BC powder, or goodie powder. One envelope cures a headache real quick. It is over the counter, it is mainly for headaches.” (P15)

“I restore my health either by home remedies, like I was saying, by brandy and bourbon, mixed up with some Nyquil, Stamina pill, let it come to a simmer. Stamina, Nyquil and some brandy, and you can mix that together. You could put it in a tad bit of water and let it all melt together, and mix that, and it knocks it right out. So if you are sick and trying to get more energy, you take one of those pills... but you have to take the remedy with it,” (P 03)

### Dietary restrictions.

Four men and women had chronic conditions that required maintenance by dietary restrictions. i.e. irritable bowel syndrome, celiac disease, chronic mandibular malfunction, Type II diabetes and hypertension.

“If I don’t eat enough, my stomach will start to bother me as well, so it is like a balancing trick like diabetes, but for my stomach [has Irritable bowel syndrome].” (P8)

“I make smoothies, yogurt smoothies. I can’t eat meat, so I eat beans and rice, peas and eggs. I add strawberries and banana in them. For lunch, I will have typical rice and peas. I eat rice all the time. Mashed potatoes stuff like that. Noodles, Last night I had buttered noodles with parmesan cheese.” (P17)
“I can lose a lot of weight real fast, and get sick. If I eat gluten, I go to the hospital. Health is a big question. With my issues, celiac disease “its wheat, wheat is like a poison in my body. Celiac is like my lower intestinal tract, got small bowel hairs in your lower intestinal tract, get your nutrients into your body. Wheat kills them, shuts me down. I get really sick, really sick.”” (P23)

”. Like in the morning, it would probably be up 110, 120, which mean I could only eat light. Now it is in the low 90’s, or mid 80’s, so I could eat whatever I want if I choose, but I don’t. .... I buy what I am supposed to eat. I buy a lot of vegetables; I buy a lot of fruit, chicken, turkey, fish, stuff like that. I stay away, I try to stay away from as much beef as possible, eat once a month” (P33)

Health Resource Utilization

To explore secondary prevention strategies found among men and women recently released from incarceration, participants were asked questions regarding the use of healthcare resources. Questioning included asking each participant if he or she ‘required healthcare within the last year?’, and if he or she has “one person you think of as a personal doctor or health care provider?” Questions also included the type of resource utilized, i.e. physician office, community clinic, emergency room and/or hospital if needed.

Primary care. More than 75 % of men and women needed healthcare within the last year and two out of three participants (n = 23; 66 %) did not think of anyone as their personal doctor or health care provider. For additional clarity regarding whether someone had a personal doctor or not, the following question was asked, “Is there more than one, or is there no one person who you think of as your personal doctor or health care provider?” Responses further clarified that 51% of men and women (n = 18) did not have a physician or other healthcare provider.

Health resource utilization was most frequently seen through use of the Emergency Room (46%) or a physician office visits (43%). Among participants who described one person they had
Table 15.

*Healthcare need and resource utilization by men and women within last year*

<table>
<thead>
<tr>
<th>Healthcare need and utilization</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Healthcare need within last year</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>27</td>
<td>77%</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
<td>23%</td>
</tr>
<tr>
<td><strong>Type of health resource utilization</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician office visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>15</td>
<td>43%</td>
</tr>
<tr>
<td>No</td>
<td>20</td>
<td>57%</td>
</tr>
<tr>
<td>Community clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>8</td>
<td>23%</td>
</tr>
<tr>
<td>No</td>
<td>27</td>
<td>77%</td>
</tr>
<tr>
<td>Emergency Room visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>16</td>
<td>46%</td>
</tr>
<tr>
<td>No</td>
<td>19</td>
<td>54%</td>
</tr>
<tr>
<td>Hospital visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>7</td>
<td>20%</td>
</tr>
<tr>
<td>No</td>
<td>28</td>
<td>80%</td>
</tr>
</tbody>
</table>

as a physician or other health provider, responses were favorable, in describing the relationship.

“Yeah, I do have a doctor. Last time I saw him, I think it was November. I got my blood checked because I thought I had diabetes or something.....When I would eat something, I would crave something sweet, and then I would eat something and I would be fine, so I thought maybe I was hypoglycemic, but he said no, its fine.”  (P27)

One gentleman, a former heroin addict now with diabetes and HIV, talked about having a primary care doctor at a university and attending a specialized clinic for HIV care, and others, i.e. ophthalmologist, podiatrist, all the diabetic care” (P032).

“I am with U. healthcare. They’re good... and then I have Medicaid. Matter of fact, when I go to the doctor next week, she always do [sic] a thorough check, like a complete physical, I am talking about head to toe, she checks it all. (P009)
Another man with irritable bowel syndrome, stated, “yes, a doctor and a lot of medication, and diet” (P08) and another described, “I see my doctor like once every other month, just for anything (P33). Others were in the process of either signing on for PAC insurance, or went to a doctor when sick.

[Do you have a health care provider, a doctor?] “PAC, I use government insurance.” [Do you have a particular physician that you see?] “Not yet.” [Did just sign on?] “Yeah, I haven’t needed to. Other than the dental, I haven’t needed to see a doctor for anything.” (P018)

If ill, one person explained he would

“Call up my insurance group, Am..., I would call and ask for a general practitioner or urgent care facility locally so I can go there.” (P018)

For one person with diabetes, the involvement of a primary care physician was described,

“Yeah, once I got diagnosed with diabetes, he told me I need you to do this and I need you to do that. The biggest issue with doctors and their diabetic patients is the feet. …… Having diabetes for some reason or another, it causes cracks on your heels. Like your feet get dry and you get cracks on your heels. If they open up, you are susceptible to bacteria and infection, so they try to make you take care of them.” (P033)

**Emergency room care.** Among men and women who utilized the Emergency Room, some had no insurance. Others viewed the Emergency Room as the place of care for physical ailments and mental health concerns (n = 5).

“I actually don’t really get sick that much, I haven’t since I was younger. If I do, like this, I go to the Emergency Room, because obviously I have no health insurance.” (P025)

[Other resources you use?] “The emergency room, other than that… I haven’t been to a doctor’s office probably all my life. I always go to the hospital.” (P014)

“The hernia, a couple times. [went to the Emergency Room] A couple times, I had suicidal thoughts, I don’t have them anymore.” (P014)

“In the past, years ago, [visited Emergency Room] through my divorce, you know. I experienced a lot of depression due to being married to a crazy man.” (P3)
In some cases, men and women who went to the Emergency Room for care had a primary care physician. For some, a visit to the Emergency Room was determined by the severity of their illness (n = 5).

“Right now, if I need be, I can go see my doctor, or if it is really bad, I go to the emergency room. If I am sick or something I just go to the doctors, you know what I mean. If it is something, like I said major, needs done right away, I will go right away to the Emergency Room, but usually I set up an appointment with my doctor, I go in if I want, and get checked up or something.” (P016)

“My tooth got infected, so I had to get some Penicillin, to clear the infection out of my tooth. I need to get a couple of teeth pulled that are really bothering me right now, cause my fillings fell out, and my teeth are rotted out right now.” [So you went to the ER, for Penicillin...for dental problem] “They looked at me, and they gave me not Penicillin but Ampicillin. (P23)

For more urgent health care needs and routine care, the Emergency Room is also a source of care.

“If I get too bad, if I feel really bad, I will go over to the [A] Hospital which is the [A] medical center. I will go there and I will see a licensed physician or nurse, they will examine me and all. And if I am really sick, if have migraines, which I have had headaches before, and all, they will write me out a prescription.” (P012)

“Usually I have to go to the hospital. Like coming to this clinic here, it takes about 3 weeks to get an appointment, so by the time you get here, you are already better.” (P034)

For others, Emergency Room care served as a means for routine health screening (n = 3).

[Pap smear]. I had one in the Emergency room about 4 months ago, because I was having pains, infection?” (P017)

“Yeah, I had a pap smear. [You had a pap smear when you went to the Emergency room?] Yeah, because I told them something was wrong with me and they checked, and there was nothing wrong.” (P0 35)

Hospital care. Twenty percent of men and women responded ‘yes’ to having been hospitalized in the last year (n = 7).
“Now when I went to the hospital, they did a lot of tests on me to check/see if I had cancer, and I tested negative, and they already did that one test to see if I have cancer in the rectum.” (P 012)

A man described going to a city hospital and receiving “free care” for a surgical procedure (P014). When asked regarding having had a recent physical exam, a 41 year old man with an elementary school education who has been incarcerated more than six times states, “I was at the hospital, cause they kept checking my blood pressure every day, twice a day; listening to my heart and lungs every day, twice a day.” (P015). As noted earlier, presence of infection was one reason for hospitalization,

“I just got out Monday. They kept me for three days for infection in my legs.” (P 015)

“I have been walking lately, but I just had surgery in my leg, because I had an infection in it. .... I think I had walked past a nail or something, and might have scratched it. [There was] a little cut there or something and it started to heal, then an infection came in it, set in pretty bad, you know, it swelled up pretty big. I just was in the hospital for four days I think, while they were draining it and pumping me full of antibiotics.” (P025)

For others, pain management (n = 2) or medication adjustment was needed.

“I had to wind up being in the hospital for three days because of it. Turned to find out, the medicine I was taking, wasn’t working, and I was taking it on a daily basis. They said, sometimes the medicine just stops working.” (P33)

**Mental health services.** Men and women with histories of mental health disorders described strategies they sought in treatment of mental health and/or addiction. Among the 28 men and women who described histories or addiction or mental health disorders, 50 % percent (n = 14) described past or current participation in individual treatment modalities. Modalities included participation in drug treatment and counseling programs (n = 5) and/or treatment for mental health disorders (n = 12). For several men and women, treatment was now occurring, after years of addiction and/or the presence of other mental health problems.
“Upon talking with these doctors, I got diagnosed with major depressive disorder, PTSD, general anxiety disorder, and paranoia. I am now addressing with certain doctors [mental health], and certain medications help me address these issues, which now is starting to turn my life around and live a healthier life” (P 22)

“Now with me being clean and sober, I have not maintained my drug dependency, being clean and sober; I started talking about a lot of issues that went on in my childhood. That was something that I never did before. So this time, I feel I am making a difference in my life, as far as that. I am into, I go to a psychologist, and I do therapy, and I am also on medication for that.” (P 32)

“Yes, I actually see a Dr. D, a psychiatrist here, once a month. I just signed up for another one, where the psychiatrist will come to... I stay at ... Center, it is a program, it is a house, it is a transitional house of sorts, but they have an intense program, where you work on your health and your mental hygiene.” (P34)

Methadone clinic. In addition to individual or group therapy, men and women with a history of cocaine, heroin or opiate use and/or the need for pain management described their involvement in a methadone treatment program (n = 6).

“Well, the methadone is given for two reasons, one to prevent my taking of heroin again. Methadone is also used as a painkiller. So, lot of them are switching over to methadone, because it is single dose, once a day, and it doesn’t make you get high, like most people think. (P22)

“Yeah, I just got in a Methadone clinic; that way to stay off of heroin, I just got in a Methadone clinic a week and a half ago. I got 3 days in clean right now. No opiates.” (P28)

“I am chained unfortunately to a Methadone clinic. I got, both my daughter and myself, we got hung up in pain management. I am with the health department, and my daughter is with another Methadone clinic. We had gone up to a certain level, and now we are kind of on our way back down.” (P30)

Tertiary Prevention

Chronic illness. Health promotion as defined in this study includes all levels of health - primary, secondary and tertiary prevention. Eighty two percent of men and women in the study described taking prescribed medication for a chronic illness (n = 29), either medical or mental
health conditions. Forty-two percent of men and women described having been prescribed psychotropic medication (n = 15) and 52% were taking medication for a medical condition (n = 18).

Table 16

*Prescribed medication use among men and women*

<table>
<thead>
<tr>
<th>Reported Diagnosis</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No medication used</td>
<td>6</td>
<td>18%</td>
</tr>
<tr>
<td>Use of medication for medical conditions</td>
<td>18</td>
<td>52%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>9</td>
<td>27%</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>3</td>
<td>9%</td>
</tr>
<tr>
<td>Acid reflux</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>3</td>
<td>9%</td>
</tr>
<tr>
<td>COPD / bronchitis</td>
<td>4</td>
<td>12%</td>
</tr>
<tr>
<td>Pain medication- non-narcotic</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Anti-spasmodic</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Antibiotic</td>
<td>3</td>
<td>9%</td>
</tr>
<tr>
<td>HIV</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Cardiac</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Seizure</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Muscle relaxant</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Pain</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Thyroid</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>1</td>
<td>3%</td>
</tr>
</tbody>
</table>

Among men and women who took medication to treat mental health conditions, side effects were experienced

“I gained a lot of weight over the past year or so, um, it has been due to some of the psychiatric medication I am taking. I run the risk of my mental health being controlled, like it is now with medication and having to deal with the weight gain, or to continue to try different things and run the risk of being unstable” (P01)
Table 17

*Prescribed psychotropic medication use among men and women*

<table>
<thead>
<tr>
<th>Reported Diagnosis</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of Medication for Mental Health conditions</td>
<td>15</td>
<td>42%</td>
</tr>
<tr>
<td>Methadone clinic</td>
<td>6</td>
<td>19%</td>
</tr>
<tr>
<td>Bipolar</td>
<td>5</td>
<td>14%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>6</td>
<td>18%</td>
</tr>
<tr>
<td>Depression</td>
<td>10</td>
<td>28%</td>
</tr>
<tr>
<td>Insomnia</td>
<td>4</td>
<td>13%</td>
</tr>
<tr>
<td>PTSD</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Mood stabilizer</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Non – specific</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Paranoia</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Anti-psychotic</td>
<td>2</td>
<td>6%</td>
</tr>
</tbody>
</table>

“The Vistaril and Zoloft I am supposed to take at night 100 Vistaril at night, and 50 of the Zoloft and 50 of Vistaril during the day, but I don’t usually take the nighttime medicine because I have trouble getting up in the morning and I feel really out of it, and my body aches.” (P08)

One 46-year-old woman described making a conscious choice not to take medication, as she viewed anti-depressants not helping her.

“One of the reasons I did that [stop taking psych meds], is because I begin to notice that they were more of a substitute for me, and a crutch, as opposed to me using it as a tool to deal with things. It was as if, if I had always had something to lean on, then I am not going to do anything different to get better. They made me feel worse, they made me feel lower [antidepressants]. I cannot even begin to explain to you what it made me feel like.” (P06)

For others, medication worked positively in helping them cope with day-to-day challenges.

“Yes, I am taking anti-anxiety medication. It definitely helps, it is definitely helping. With all the stuff going on, my mind, I can’t sleep cause all these thoughts keep racing in my head of how I can fix it and do things, it is kind of crazy, and it is kind of slows me down, get me where I can focus.” (P10)

“I am on medication. I am alert. I get tired, sometimes from the medication. I am basically all right I feel good. I feel ok.” (P16)
“[psychotropic medication] Yes, it is working for me. Like this morning, it helps me to basically function. Kind of think a little bit, and get my mind together. Actually, without taking it, I probably wouldn’t be actually talking with you right now. It would be like I am staring off to space, and I would go ‘huh’, ‘what’?” (P20)

Men and women with chronic conditions described taking their medication after release.

“I have hepatitis, A, and B, A and C, no A, B and C. ... I am getting treated for that as well. I take my meds now on a daily basis and I feel a lot better than I did a year ago, at least 11 months ago. And I am to the point now, like I said, my health is not perfect, but the medication I am taking as far as with my HIV, I take my Atripla every day. I take Metformin twice a day, plus I take Insulin once a day.”(P32)

“I am a diabetic; I have Type II diabetes, which I take medicine for on a daily basis. I have a seizure disorder, caused by what you call nocturnal frontal lobe epilepsy. I take medicine for that on a daily basis. I have high blood pressure. I got some mild heart problems, one of the chambers in my heart, the walls are a little thicker than normal, but I take medicine and I take baby aspirin on a daily basis for that, so I won’t have a heart attack, to decrease the risk of heart attack.” (P33)

Seven men and women, who were prescribed either psychotropic or other medication to treat a physical illness, described their non-adherence. Reasons included hearsay about side effects (P14), cost (P14, P15), not wanting to take pain pills (P19), forgetfulness (P02), decision-making not to take an anti-depressant (P27), and not having a doctor to prescribe psychotropic medication (P31).

[Do you take your medication for high blood pressure?] “As much as I can remember, there are days when that I forget, sometimes there been two days that I forget to take my medicine, overall I do take them .... Because I get in I am tired, I go to sleep... and, I might have to repeat that same thing, again. Sometimes it has been two days, I can’t quite remember why I forgot the second day, but it has happened, but, it was not intentional” (P02)

“I was to continue with my psych meds, it was here actually, I didn’t show up. I made the decision to stop taking the Lithium, and so there was no reason to come, if I was going to stop that.” (P14)

“I used to take Corgard and SerApAs. It got to the point I could not afford it anymore [When did you stop taking the medication?] “About 8 years ago.”(P15)
[Do you take medication?] “Supposed to.” [Do you take it every day?] “Supposed to, but I haven’t been on it due to not having a doctor” (P31)

“Yes, depression I was treated for, but after a short period of time, they stopped it, I was taking Paxil for that. They thought it would be better treated with counseling which I never followed through with, because I went out and started using drugs again.” (P34)

**Chronic pain (n = 12).** Probe questions included asking each to describe measures they took to alleviate continuing pain. For some, pain medication was restricted because of other health conditions,

“The doctor told me I can’t take too many Aleve, because it is bad on my kidney. I just go through a lot. I have asked them if they can give me something for pain management, like cortisone, or something like that, they have to get back to me on that.” (P007)

For men and women (n = 5), medication was used as prescribed to control pain, which included the use of Percocet or Methadone. For others with chronic pain, comfort and effective pain control with medication or other treatment was still being sought,

“I am trying to get my physical doctor to get me on something stable for my pain. It is not that I want pain medication; I am hooked on it or anything. I just want something to stop the pain, fix me, or operate on me whatever. This pain I feel like ... is like killing me, you know” (P20)

“And that goes for like, I have a pinched nerve in my back, I need pain management for that and they don’t do pain management either. So I have to find a health clinic that is going to accept my insurance and take care of everything right there.” (P34)

“Well I go to the hospital when it gets bad [pain in back] ... He has given me non-narcotic stuff. .... No, just Aleve for my back, but occasionally, that doctor, he will give me the 800 mgs of it. He’s given me Tramadol, its non-narcotic. I don’t have a prescription for it. If I don’t have anything, I take a couple of Aleves.” (P34)

**Factors Influencing Health Promotion**

To answer research question 4, “What personal, social or community factors influence health promotion, i.e. primary, secondary and tertiary prevention as described by men and
women recently released from an adult county detention facility?’, during the interview men and women were asked to describe factors they perceived to influence their health. In review of the text coding from all interviews, personal, social and community factors were identified influencing health promotion among men and women recently released.

**Personal Factors**

*Socioeconomic status.* Over two-thirds of the men and women reported they were unable to work ($n = 13; 37\%$) and/or that they were out of work for more than one year ($n = 11; 31\%$). One in five reported ($n = 7; 20\%$) being out of work for less than 1 year and only 4 men and women were employed for wages ($n = 3; 9\%$) or self-employed ($n = 1; 3\%$).

The majority of participants had an annual income of less than $10,000 ($n = 31; 89\%$). Other income levels included those with an annual income of less than $15,000 ($n = 2; 6\%$), one person reported an income between $10,000 and $20,000 (3\%) and one person reported an annual income between $10,000 and $50,000 (3\%). Two-thirds of the participants reported being homeless ($n = 23; 66\%$).

*Unemployment.* Men and women described their efforts in looking for work. For a 36-year-old African American male first time offender, having been incarcerated 3 months ago for five days, looking for a job was a challenge.

“The most stress I have right now is looking for work...and that is going to come through, optimistic. Right now, the biggest stress in my life is looking for work, someone let me in the door. That is my biggest thing [getting a job], because I want certain things to happen right now.” (P04)

Several men and women describe the difficulty of finding employment because of their criminal records ($n = 5$). A 41-year-old gentleman, out of work for less than a year, states,
“Because of my record, and everything, I am having a hell of a time getting a job, but it just makes me want it more so.” (P10)

“I am trying. It is hard to find a job, with the background being in jail; it is hard to find a job. I worked for Motor Vehicles, I worked for MCI... really good jobs. [now] I can’t get a job at McDonalds.” (P17)

A 54-year-old man with multiple handicaps, that included being in a car accident that resulted in bone replacement of both legs, continues to look for work in spite of his handicaps,

“I force myself to walk, to I look for work. Sometimes I find it [work], sometimes I don’t. Sometimes I walk for the exercise... Like I said, I walk around looking for work, cleaning parking lots, taking trash out of buildings.” (P15)

For others, both their physical condition and mental health disorders affected the ability to seek employment.

[Are you presently looking for a job?] “No, I can’t really. When I flipped my jeep, I messed my L5 up. I can’t really lift anything anymore. When I do, it pops a certain way, and I am done for a week. Between that and my mental health issues I am waiting for disability” (P16)

“No, right now I currently have filed for disability, cause of my mental problem, I feel I can’t work. I haven’t worked since 2005. Like I said, even working around a lot of people, agitates me, I get into fights and stuff like that. So I can’t keep a job, because of my mental” (P20)

“No, I am unemployed; I have been unemployed for a long time. Actually my mental conditions, I realize have kept me from maintaining a job when I get one. Over the last twelve years, probably the longest term of employment I have had a job is three months.” (P22)

One 46-year-old woman who most recently had spent two months in jail admits,

“Well, see the circumstances that put me in jail... my entire existence was poor, alcohol, unemployed, homeless, wrong people, wrong places (P06)

For a 46-year-old man who had been released 3 months prior, the ability to eat healthy or do exercise was affected as he was trying to sort out priorities after release,

“I don’t have a job right now. Things are in a transitional period right now. There is no baseline to go from (ability to follow a healthy diet or do exercise) necessarily. Everything is still
in a whirlwind kind of situation. I was not released into a stable situation. I am trying now to put my life back together and reach that ability.”

**Incarceration history.** Almost 75% of the participants (n = 26) reported having been in jail or prison more than four times in their lifetime, and almost half of the men and women had been in jail or prison more than 6 times in their lifetime (46%). Men and women described both positive and negative effects of incarceration on their health.

Negative effects of incarceration included the lack of mental health services / proper medication (P10; P20), lack of personal control (P13), lack of exercise (P13; P24; P29), an unhealthy diet (P13; P23; P07), victim violence (P22; P35) and sleeping conditions believed to have negatively affected bones and joints (P19; P22; P29).

As men and women described aspects of incarceration, positive health behaviors occurring during incarceration were also described. For instance, one gentleman in jail for Driving While Intoxicated (DWI) admitted he no longer drinks because he is “scared they will put me back in.”

“For a gentleman most recently in jail for 15 days and homeless,

“So I am trying, I am shying away from that [drug use] a little bit, now. I am not going to jail anymore, especially for dumb stuff like that. (P11)

For a 36 year old, a victim of domestic violence that resulted in chronic pain and depression, psychotropic medication and proper pain management was viewed important to positively affecting her behavior,

“I don’t want to get to a point where I do something stupid, that I will be locked up again. I really don’t like jail... at all.” (P17)
A 54-year-old man who had recently been incarcerated for 30 days and had a history of repeat incarcerations, ‘incarceration’ was described as a healthy break in his life.

“Actually, going to jail kind of helped me a little bit, cause at the time, I was dealing with some issues, like say homelessness, stuff like that, you know, Going to jail, gave me a place to sleep, a balanced diet more or less, three meals a day, that type of thing you know. It gave me access to bathing, and stuff like that on a consistent basis, things like that you know.... and it gave me a chance to rest properly, so it kind of helped a little you know.” (P19)

Several others felt the same way,

“I guess the time in jail, actually I used it, unlike most of my contemporaries, [smile] ... I used it to focus on rest, focus, rejuvenation and planning. My spirit is rather buoyant, compared to prior to going in. “(P24)

“Anytime in jail, I work out, and stay pretty healthy. I am eating three meals a day. The food is not that good but I am always healthy when I come home. In the process of going to jail, I think a little more clearer when I come home, because all the time I am in there, I say I need to do this, I need to do that, and I really want to get myself together.,” (P28)

Men and women also described ‘incarceration’ as an unhealthy experience. A 38 year old with a history of mental health and addiction disorders describes

“But back to jail, that really contributed to a lot of anxiety and PTSD ordeals, because now any time I hear keys jingling, or a loud noise or a door slam, or someone yelling out orders at someone, it kind of sends me back to jail, in my mind.” (P22)

A 63-year-old woman incarcerated 2 -3 times describes the jail environment as a most unhealthy environment, and that she is more conscious now than before regarding personal infection control and sanitation.

“When I did, it seemed like everyone else in there [jail] was focused on everything else, except their health. They didn’t seem to think that that was an issue. I remember being worried about the toilet seat, and being worried literally about the bars, you know and all that, and not knowing what to do about it,’ cause nobody else seemed worried about it..... You are thinking about your health in a major way, like how to survive, as opposed to maintaining a healthy state. You are trying to literally stay alive. (P30)
Addiction recovery. More than 50% of participants (n = 18) described their journey in recovery from addiction. Men and women talked about the continuing struggle or ‘fight’ (n= 5), to ‘stay clean’ and ‘keep clean’. Others described themselves in a program (n = 5), e.g. methadone clinic or narcotics anonymous. Men and women described their current successes (n = 7) and their past failures (n = 4) in staying away from heroin or cocaine. For many men and women, they were overcoming challenges, knowing this was necessary for positive health.

A 46-year-old woman, released 9 months ago was reflective of her past life.

“When you have the mental aspect and the physical aspect, and opportunity meet together, it is pretty difficult. They are more physical cravings than anything else, and it is really irritating, it is irritating and I don’t like the way it feels; but it is not that bad because the physical craving and the mental craving has been disconnected. …, it took a very long time. As I said, some days are better than others” (P06)

A 46-year-old man having had reoccurring incarcerations describes the difficulties

“I hardly use drugs anymore. I was using pretty bad like a year ago. Heroin ...crack, I am trying to refrain from using drugs at all. I have slipped up a few times in the past year, but I am trying not to. It seems like my brain tells me to do it though. There isn’t a day that goes by, that I don’t think about using drugs though. I just try not to.”  (P29)

Others describe their history of drug addiction to be one of ‘a struggle every day’ (P10).

“I am currently in recovery from my drugs, from being addicted to crack cocaine. I recognize that and as soon as I got out, I addressed the relapse issues that I did, but it is still a struggle every day. [has history of addiction]” (P10)

A 55-year-old woman, a former heroin user of 30 years, described her family history. A sister was killed at the age of 8 months from a stabbing, and two sisters died one year apart from each other whom she was close to - one the result of HIV and AIDS. The other sister expired from liver complications from drinking. She herself was ‘using all alone during all that time’ and turned herself in with her most recent incarceration. She describes:
“I believe that each one that left, left me something to hold on to as far as strength wise, but I was not there to get it......Now with me being clean and sober, I have not maintained my drug dependency ; I started talking about a lot of issues that went on in my childhood. That was something that I never did before. So this time, I feel I am making a difference in my life... I go to a psychologist, and I do therapy, and I am also on medication for that.”(P32)

A 43-year-old never married man who had been incarcerated more than six times in his lifetime describes,

“...Being drug addicted for so many years and being homeless for so many years, I never took care of my health, unless I was in a program. Like right now, I have been in two different programs and I am coming up a year clean. I am just now getting my insurance services turned back on, and actually caring about my health... 28 years of drug abuse, on and off. I had a six or seven year period where I was clean but, for the most part, I have never had more than a year of sobriety.” (P34)

**Ineffective situational response (n = 9).** Men and women, in describing their mental health status, included accounts of how they reacted to situations and/or other people. Several men and women communicated having difficulty with employment and or other everyday life circumstances and/or people. Some expressed ‘getting mad or angry’ (P010) ‘a lot now’ (P011) or having a history of an ‘explosive temper’ (P013). Others described themselves as “a lot more settled down, less flare-ups, now that I am out and I have a way to communicate with people,” (P 8) or that they have ‘learned to control that, walk away from people’ (P015). Others continue to be affected by mental health issues that impact their ability to work and interact with others.

“I also have bipolar too, so which has caused me not to be able to keep a lot of jobs because I just snap, or I just quit a job, or I won’t show up, you know.”  (P 14)

“I only can do certain things at one time, if you tell me to go over there and get that box, then it is like, I am focusing on getting that box, and if you tell me to do something else, I get agitated, it messes me up, to where I get angry with myself. That is where it kicks off, explosive disorder. Like I said, even working around a lot of people, agitates me, I get into fights and stuff like that. So I can’t keep a job, because of my mental” (P20)

“I had a really good job there and lost it. I guess because of my bipolar, I was not able to control my anger and my actions. I lost my job over it” (P34)
“Sometimes I can’t deal with people and I snap. That is just because............. I can’t be around a lot of people.”  (P35)

**Self-efficacy (n = 7).** Men and women were asked the question, ‘are there things / is there anything that stands in your way from being healthy?’ Seven men and women stated ‘no’, or ‘no, if I want to be healthy, and I want to do these things, I am going to do it’ (P16). A 45-year-old man who is homeless and unable to work because of chronic back problem stated,

*[Is there anything that stands in your way of being healthy?] “No, if I want to be healthy, and I want to do these things, I am going to do it, I believe, you know”.  (P016)*

And also, another person when asked states,

*[Are there things stands in your way, of being healthy? That is not helping you?]  “I feel if plan A don’t work, I always have a plan B. Nothing is going to stand in my way, now. I am the only thing that can be in my way.”  (P32)*

**Social factors**

To continue to answer the question, ‘what factors influence health promotion, i.e. primary, secondary and tertiary prevention as described by men and women recently released from an adult county detention facility?’, additional probes included ‘does your family or friends help you or not help you to stay healthy’, questioning related to the availability and geographic closeness of family members. Responses were subcategorized according to the following: 1) presence of family support or connections, 2) aloneness or changes in family connections and 3) limited connections with family members. Most participants described the lack of family member involvement in health promotion.

**Family and friends (n = 11).** A question asked during the interview included ‘What influence do others have to help you stay healthy?’ Additional probes included ‘family or your
friends, are they helpful in helping you stay healthy?” Eleven participants described the influence of family and/or friends in helping to stay healthy, either mentally or physically.

“My mom is a big support, she [mom] is juicing now, she is not overweight but she is juicing now, because she wants to keep her health up, we team up, she calls me, ‘did you have your juice this morning’. I had mine, what did you juice?’ We are making fun of it.” (P004)

“I was over [sic] my step son’s house, and he cooks because he got a family, and he cooks for them. I go over there every day. (P 011)

“Me [sic] and my wife are [sic] together, basically, we look after each other. I got divorced, and not it is getting ready to go to court about kids and stuff. I basically don’t see them right now, until we are done with the courts.” (P 016)

“Yeah, my mom is in the area. She is a school bus driver, she lives with her boyfriend and she has to pay rent there. He won’t let any of her kids stay there. Like I said, she is paying rent there, so she spends most of her money, but she tries to help me when she can. Like on her breaks, she will pick me up, like she just dropped me off here, and she took me to her house yesterday, gave me some food and stuff. On her breaks, she will bring me down food and snacks and stuff. (P025)

Another man stated,

“My friends, a young lady, I deal with. She is very happy about it. She cooks with olive oil and stuff. I can’t eat shellfish. She showed me different things I can cook, that it tastes just as good .... [also.] Having the right people around you, that motivate you. I have a nice family backing, nice church family and friends. Always positive reinforcements (P 004)

For one 29 year old released within last 2 weeks who had been incarcerated for over one year, and had a history of medical and mental health diagnoses, and is now homeless, stated,

“I stay in touch with people that I talk with on a regular basis.... My friends Kris and Brennan, Kayla – I just got in touch with him today – he will give me transportation or money for food, or ride to an appointment., or something like that........ (P08)

For someone with a strong family influence towards health, family provided many supports,

“My ex-girlfriend is fitness, she is what you call, a fitness instructor. Her brother is also like a holistic... My walk in that path, was before I met her, it happened to be a nice coincidence that
her family is also into health that way. It is kind of confluence of shared values I guess you might say, and certainly I guess, I don’t know everything, she complements my knowledge and habits for that matter, and encourages. ….. It helps to have people around you that share your value. “ (P24)

The simplest relationships on an everyday basis, showing the kindness of others included

“Yeah, the lady at Burger King, her name is Rochelle. She is a manager there and ... As a matter of fact, we got into it a couple mornings ago. I just wanted a cup of coffee. ‘No, no, no, you have got to eat, you have got to eat. You are looking a little piqued’, she used that word ‘piqued’. I said ‘yeah, I am a little tired, you know.’ She said, ‘you have got to eat, here, she gave me (you know it is fast food, but what are you going to do) a little egg sandwich with sausage, some little tater tots, a cup of coffee, so”. (P30)

Also, for one gentleman with a 30-year history of addiction, support came in many forms,

“Absolutely, I have so many people encouraging me right now that are helping me. There is not a day that goes by, that there isn’t somebody checking to see if I am getting to all my appointments, encouraging me to make more, ‘hey, let’s call this place,... let’s call this one”, ‘let’s see what this can do’, ‘let’s see what they can do for you.’” (P34)

Family support or connections. In addition to helping out, family are a social support for men and women (n = 8). For instance, a 36 year old gentleman who was going to college to have a career in computer software, lost 10 pounds as he was on a juicing program with his mother. They called each other up periodically and asked how all was going. As described,

“Everybody is within an hour or two hours, my mother lives in Southern Maryland, everybody else is inside of her radius.” (P 018)

“Me and my sister, we are real real close, because we kind of raised each other. My parents passed away when we were young.” (P019)

“I am thinking about moving down to Georgia, because I have family down there. I will probably take my wife and we are going to move down to Georgia, probably a better situation, and my brother said he can get me a job down there, go down there and do that”. (P021)

“They talk sense into me. If I need help, they give me a ride somewhere, or they will take me in. If I do the right thing, they will do anything in the world for me. When I am not doing the right thing, they won’t do a whole lot for me.” (P 028S)
“And my daughter, she is with me. She [daughter] is my strength, I am hers, she’s mine. We are making it together, you know; together we make up a whole person [laugh]. So as far as decisions and thinking and all that.” (P 030)

“If I can’t go and get my medication, he will get it for me. Just anything, he will take care of me in a general way. [husband] ” (P 017)

For others, family members have not been available, and were not described as an influence to personal health promotion.

“Oh yeah, I come from a drinking family. I used to work at the Black Label Colt 45 plant right there in Lansdowne. My dad retired from there. He got me the job in there. We can drink all eight hours on our shift... Ok.” [laugh, voice change, lightened up] “I got three brothers and two sisters; I come from a large family, a pretty wealthy family, too. If I quit the drinking, I probably wouldn’t be in the woods.” (P023)

Men and women (n = 5) described their families, and instability for themselves and/or for their children,

“After just being released, family issues, Family members with mental health issues of their own, which is really stressful. Usually my mother’s. And she cannot add me to her lease, so that makes it an issue with me being able to stay there with her, and then her current physical and mental health issues she has, which are worse than mine.” (P 008)

“I started to stay with my brother; well you know my brother is a drug addict. I got my one daughter going to G... B... High School, which I keep hearing, that he is kicking her out. He is not her father. He is my ex-husband but he has raised her since she has been six months old. That’s the first thing I want to do when I get my place, is go get her. “(P031)

“It is funny when you say family. My mother has a four-bedroom house. My mother, her mother, two sisters, their boyfriends, each one of them has four kids, brother, his wife two kids. The only one working was my mother, doing private house cleaning. I went and said, get off your lazy butt and get a job and help mom with the bills. My mother told me get out and never come back. I ain’t [sic] seen her since the 80’s. “ (P015)

“They are both 11, twins. My mother, she has my children. I have not being able to live at home with my mom and my children... That is something I have to deal with, because it is never going to happen [living with her children]. If I get approved for my disability and get a house, and get my children back, and that won’t be a stressor anymore. So I am praying on that.” (P017)
“I look back on it now and my father was not in my life, basically after the age of seven, except once every couple months I would see him and I kind of see history repeating itself within the family.” (P 022)

Men and women described their motivation to stay healthy influenced by looking to the future and continuing family relationships (n = 3),

“My health is very important…… I have a 2-year-old daughter so I want to be around to watch her…. Lord willing, I just want to be around to at least see her graduate high school. If I could do that, than I will be fine. Even if I can go further than that, if I can get another 40 years, I will be blessed.”  (P033sr)

“Right now, my kids are a very very, very, huge driving force. I thought my kids were in good hands … they weren’t.”  (P013)

“Mostly I think about my kids right now, that is the main thing that is keeping me from using drugs right now, my children. Yeah, I need to get into stable housing, so I can have my children. My daughter actually is actually staying where I am staying right now and my son is with his mother.”   (P029)

Limited connectedness or aloneness. Five participants did not describe a relationship with their families (n = 5). A 41-year-old male, non-employed, with an elementary school education, who had been incarcerated more than six times in his life, stated “I spoke to my dad twice while I was in jail” (P013).

Friendship or social support. Participants described friendships and/or other social relationships both positively and negatively. Positive relationships were those where the participant designated someone as helpful in helping them stay healthy; negative relationships were described as associations with others that were unhealthy.

Positive influence of social interactions (n = 12). Approximately 35 % of participants described someone who they believed positively influenced their health. Positive influence was oftentimes described as someone providing assistance in housing (n = 5).
“Sometimes I go to the girl’s house who I have the keys to her place, and she let me come over there. I haven’t heard from her for a while, I hope she is ok. She has an apartment, that’s where I go”  (P 03)

“Like one of my friend’s brothers right now is letting me use his mailing address – all my mail right now goes there.”(P08)

“Right now, I am staying at a friend’s… every now and then. He has a trailer in his back yard, and I stay in that. He lets me stay in that a couple days a week.”(P28)

“I stay up here in [G city], with a friend of mine. He is helping out right now. Even before I was there, my daughter was there, because my daughter is best friends with his daughter. So she has been staying there. He is a really a good guy. He is the one who’s got me going to church and all now.” (P29)

Several men described how their significant others helped them with maintaining a healthy diet,

“My friend, a young lady, she cooks with olive oil and stuff. I can’t eat shellfish. She showed me different things I can cook, that it tastes just as good …” (P04)

“Got a girlfriend, she helps me, she tells me when I am using too much salt and things, or whatever, she don’t [sic] like to see me use a lot of salt.”  (P)

Others described examples of how friends and family helped in general (n = 4),

[Do other people help you stay healthy?] “They help me, if I don’t have the money and stuff, they help me, probably go to the store and get the cough medicine, you know”. My girlfriend and her mom, they help me get stuff, like if I have a cold or something”.  (P 20)

Negative influence of social interactions (n = 5). Individual health promotion was also influenced negatively by social relationships. Five participants described friends or social interaction with others that was not helpful toward maintaining health. Each description centered on a negative influence that someone had on that person’s mental or physical health.

“Yeah, I was staying with a friend, quote unquote, for a couple of days, that driving me crazy, so …. Yeah, they were judgmental… I rather be in a tent. [They] stress me out. (P17)
“One of my ex’s hinders me mentally health wise, constantly calling me because she constantly wants money or she wants to give her some of my medications. One of my medications, particularly Klonopin, what they call Benzodiazepine, which is also, like Xanax, which is something she is addicted to.” (P022)

“I went over to other people's camps, I didn’t know who they were, I had my master card in my wallet, I had my pin number in there, they robbed me for 800 dollars. I had a hard time for that money; then I went to an apartment, I went to another friends, moved in there, gave them three hundred dollars, move in there to sleep up in the attic, and they threw me out after two days; they still owe me two hundred forty dollars” (P23)

“Not yet, not really, because most of my friends did drugs and stuff, so I cut ties with all of them, got rid of my cell phone... just got a new cell phone. I am just trying to meet new people right now, and I moved away from the area I was in.” (P25)

Social support in health promotion efforts was not available for everyone. Three participants clearly stated they had no other persons influencing their health. As one man stated, “I had no contact with anybody, and now that I am out, I don’t really have any contact. I have no support group” (P 13).

Community factors

Participants were asked, “What helps you take care of your health?” Additional probes included inquiry as to community resources and other personal or social resources utilized. Answers varied regarding the use of community resources and were not limited to community agencies. As one person stated,

“Well, resources, you know, resources can mean people around you, friend, family or coworkers, whatever.” (P024).

Seventy-four percent or more than two – thirds of the men and women interviewed were homeless (n = 26). Community resources were described that included the overnight shelter, daily food resources, financial assistance programs, and other resources available through church
and county programs. Similarly, for those who were not homeless, community resources were important.

**Food banks.** The most frequently mentioned resource described by men and women (n = 15) were food banks, that were primarily church programs where food was available on a daily basis. Men and women in each of the two states described resources for food as generally available. As one person described, “I just got out of jail. I have limited resources. I go from, you call them, shelter to shelter, churches, charities, that is [sic] how I am eating now.” (P024)

Men and women who were homeless described a ‘winter relief’ program where they would spend their nights before coming to the day center. Varied church programs are part of the winter relief program and provide usually breakfast and dinner.

“We eat a good hot breakfast which is eggs, bacon and toast and then we have our bag lunch, which consists of sandwich, potato chips, cookies, and a juice or can soda and a bottle of water [winter relief program]. Then we have a regular hot meal...” (P12)

“there are a couple of food banks in the area, churches that I go to when I run out of food...places that you can go to that you can be around people living a healthier lifestyle.” (P06)

A 54-year-old white male, with less than a high school education, who had been out of work for over a year and divorced four times, recounted

“I used to steal every day,............every day I would walk into a grocery store and fill up a book bag with food, and that would last me all day long, but I stopped that, and now I planned today, to have breakfast at Father Ed’s. (P014)

“It’s just a place [Father Ed's]; they have coffee and breakfast sandwiches and stuff in the morning time. Then, today for lunch, I planned on going to, I don’t know which one it is, but every day in Glen B, they have a church that feeds you, so I was going to ride to that church, whatever church it was” (P14)

Although food choices are limited at food programs, several participants described making healthy food choices, and in one case, a man was able to maintain a gluten free diet with support.
“How do you get your breakfast? “Go to Father Ed’s...... That is where I get the coffee and the croissants. They also have a box of apples. I love apples. Even if I don’t really like a food, I know it is good for me, I am more likely to eat it. Just because I know it is responsible. I try. It is not my favorite tasting choice.” (P18)

[Do you go to a food program?] “Yeah, churches, churches. Yeah, there is a church every day, Monday through Friday, every day you can go to get something, but sometimes I can’t really eat what they have, but I can eat the salads or something like that. A lot of the churches know I am gluten [sic] and they help me out, which is a blessing on that.” (P023sr)

Food intake is planned ahead of time by some as an opportunity to meet up with family and others, and participate in other programs, is provided.

[“How about dinner, how does that work?] “I try to... there are several churches in the area that provide lunches, I try to load up on the lunch, there is a snack or whatever. Dinner not so much, probably I eat the most in the middle of the day.” (P018)

“I go to Father Ed’s; I get up early in the morning, meet my wife, and go to Father Ed’s. I eat usually the sausage patty, the egg, and a piece of cheese on it, put it in the microwave, I will eat that. Then he has a lot of canned vegetables, different kinds of canned goods and stuff, I will take it back to my camp, and I will eat that, what I can eat. “(P023SR)

“They [AC] serve lunch; on Tuesdays they have AA meetings for people who need AA meetings. It is a place for the homeless, a resource center; I go there every day... Just being there is supportive, because you talk to people who work there. Like I was talking about the priest earlier, Father Ed, and he is there, so” (P 017)

For some, the use of food programs were combined with eating at fast food places, as dependent on available personal funds,

“I try to get some money together and try to work... cut some grass make some money, then try to do it that way. You can go to different places around here, and you can eat sometimes too, if you don’t have any money.” (P021)

Going to a food bank, although appreciated by many, oftentimes was viewed as yet another challenge.

“Sometimes it is good; sometimes it is not a lot [daily food intake]. It is hard, not living somewhere, being homeless, get out of jail, being stable, being able to eat a set meal every day. I
do go to church. I try to get down there for breakfast and lunch every day, they don’t serve dinner, so. “ (P 028)

**Shelter resources.** For those who are homeless, there may be additional resources at the homeless shelter available. For instance, the medical clinic at the homeless day shelter was a primary resource for health care for many, as previously described. However, other resources may be limited,

“Unfortunately in my situation, I mean, I really haven’t gotten much help, at least the help I want. I guess there is only so much they can do. I am thankful for what I get. They help me with some stuff, but I mean, like I said, the main thing that I really want, they haven’t been able to help me with. ... The smallest thing I would want is somewhere I can sleep. The main thing I would want is help finding a job.” (P0 27)

As men and women participate in a homeless shelter day program, one advantage may be that they can make arrangements for mail to be sent to an address. One individual had difficulty receiving disability checks,

“‘Can’t send letters to the bank, so we stopped your check.’ Ok, I will get a P.O. Box, no you have to have a home address. ..... Now I am back at the House of Hope, I can use their address. They send all my bills there.” (P15)

Others may choose to live in a particular county shelter program, because the amount of help available is more than what other counties may provide.

“And that is how I made a plan coming to this place, and getting signed up with them again and stuff like that, because I want to try to get back in this area, because in this area, I will be able to improve my health. The services through this organization, and Social Services being in the area, the library not being too far, being in a more metropolitan area where I can get around and eat, and see a doctor, and things of that nature, that will help me out..” (P013).

“Yeah, down there [another county] everything is so far, and there is nobody out there to help me. Down here, at least my mom can help me. Everything is closer down here and there is a lot more resources down here to help people like me.” (P25)
In addition to shelter day programs, overnight shelter was needed particularly in winter, and could be limited.

[Questioned regarding diet]” We are coming out of winter relief right now, it’s a church shelter. We have it six months out of the year, to bring the homeless in off the street. We are trying to get a shelter started, but we have to move into something permanent. So right now, we are going from one church to another (P12)

Use of community medical clinics. The medical clinic located at the homeless shelter day program site was a source of healthcare in the community. Among participants who utilized health clinics within the last year, (n = 8), several stated that use of a clinic either at a local hospital or homeless shelter was primary care.

“The only resource that I got is general relief… and the outpatient clinic. That’s all I have, I don’t have a primary doctor.” (P007)

“No I see whoever is here, at the [homeless] center” (P012)

As one person stated, when asked how he restored his health when sick,

“Just come here to House of Hope’s medical staff. I try to deal with it the best way I can.” (P015)

For others, medical clinics were a source of information regarding treatment of existing disease.

“I definitely want to get it fixed [hepatitis c]. I learned just two days ago, and I have to check into it, because I don’t believe it, that the health department helps to get it fixed, so I have to check into that.” (P014)

“… am trying to go to a program right now in [A] county that gives free screenings for colon cancer, and stuff like that, because in my family, prostate cancer is real prevalent there.” (P019)

“About 20 minutes ago, I was speaking with the nurse out front, and was asking where is a place I can get tested, for STD’s and HIV. They gave me a phone number, and I will check that, because that is something I would like to find out, if I have any STD’s or HIV or anything.” (P22)
For some, the medical clinic served as a source for medication prescribed subsequent to a hospitalization. For instance, one man having a history of seizures had been hospitalized with a toe infection for several days, utilized the clinic at the homeless shelter medical clinic to fill his prescriptions.

[The medical clinic is your only resource right now?] “Besides hospital, yes…. One of it is seizure medication, the other one is supposed to be an antibiotic, but it is not helping, here at the House of Hope.” (P015)

For others, even with insurance, a free medical clinic continued to be a source of care.

“Sometimes I go to a free clinic to get checked. I have PAC insurance, whatever the PAC insurance can cover, and they give me some type of antibiotics, or something.” (P020)

“It is difficult. Sometimes it gets to the point where you just give up, so frustrating dealing with insurance and everything. I come here [Medical clinic]; I do have insurance now ... still a lot of the services are free. “ (P034)

Other community services. In addition to shelter and food programs, men and women discussed other assistance programs attended, both through county and voluntary organizations.

“I go to Offender Aid and Restoration. This is a wonderful resource right here. I go to meetings, things of that sort” (P05)

“I go to People Encouraging People....They pay my rent and the lady who runs the house brings us our food” (P026)

Four participants described receiving mental health services, through county or other voluntary resources.

“I keep getting appointments that I have to go to. That’s the best I can say. It is through the Anne Arundel crisis center. They are really nice people, but I seen [sic] the psychiatrist one time.” (P10)

One person having a history of heroin addiction and who was going to a Methadone treatment clinic described his personal status. He was “just starting to get my mind to where I am
trying to use every avenue I can to do the right thing.” (P 028) Another participant, also with a 30-year history of addiction, described his involvement in a 2-year live-in treatment program,

“It is very intense, yes. We have several different types of case management, community residence, psychologist, the case manager, the psychiatrist is coming. I got another case manager for the house; the house case manager who is also an addictions counselor plus they make us do 7 NA meetings, plus what I am doing right now is also part of it.” (P 34)

Environmental factors. A few men and women (n = 3) provided examples of community aspects that were not a safe environment.

“I go home to my neighborhood to go home and go to sleep. I don’t interact in my neighborhood. You keep your head down and keep moving. You stay out of harm’s way” (P 04)

Several examples included descriptions of the ‘homeless’ environment that resulted in feelings of discomfort at times.

“Is there going to be a lot of trouble tonight outside? Am I going to be shot because I am sitting in the wrong place? Am I going to be able to, maybe I can bum a couple of dollars for coffee, or something?” (P12)

“A lot of people in this program are in the Meth [adone] program, plus on the medication that they have. The mixture is not a good mixture sometime. They will come here, after they have done this [methadone clinic], they will come upstairs, and wait for us to get breathalized; they leave and go to the church. They are nodding, and this and that, whatever effects it has on them... There have been instances where people have OD’d, died, they have to call the ambulance for them, because they have over medicated themselves and stuff. (P19)

Seven men and women described their homeless environment as non-contributory toward positive health. Examples included living with others who were not as not cognizant of infection control procedures to guard against respiratory conditions (n = 4); limited access to indoors during the summer was viewed as not healthy (n = 1).

[In your shelter environment that are not helpful to maintaining your health?] “Yeah, yeah, like people is [sic] coughing.... And just not as sanitizing as I think it should be” (P02)
“and the air, I have allergies, so with the air, and COPD, I can’t’ breathe. Sometimes if I
don’t have the energy to walk to the Center, I won’t be eating. It’s terrible. I would not wish this
on my worst enemy, really wouldn’t” (P17)

“I have caught pneumonia, but I know why. I was outside, when in the 20’s, and stuff like
that, trying to sleep and stuff like that. I kind of know how I got that (P19)

“You just are breathing in everyone else’s ill health, and my family and all have been in this
shelter situation a relatively short period of time, since October of last year, and I have yet to be
well ... My voice was up a few octaves, I wasn’t coughing up this awful garbage stuff, and I was
not in as much pain as I am in right now. So I think the shelter situation and its activities all
contribute to an ill health situation.”  (P30)

One man, having severe pain in his back and hip noted,

“It is hard for me to use the steps, but they have the chairs [for the disabled to go up and
down steps] there, they should be working, but somehow they are not working, the disabled
chairs. Like an escalator thing, that take you up the steps, right now it is not working. It is very
painful for me to get up the steps.”  (P20)

For another young man, homelessness was an environment that had its own ‘social
dynamic’ that included excessive alcohol intake.

“In that social dynamic, drinking is a big force, I guess. Everybody is always high. I am not.
They wake up; they stay high with alcohol and drugs for that matter.”  (P24)

**Barriers to health promotion**

To answer the fifth research question, ‘What barriers or facilitating influences to health
promotion, i.e. primary, secondary and tertiary prevention, as described by men and women
recently released from an adult county detention center?’, men and women were asked if
‘anything stood in the way of being healthy?’

**Homelessness.** Almost 75 % (n = 26) of men and women participating in the study were
homeless. Participants described homelessness as a situation that can negatively affect your
health and/or healthy behavior. As several participants described,
“Well, my buddies give me a place to live, that has to do with health too.” (P29)

“Living in the woods. Yeah, that ain’t [sic] healthy at all.” (P23)

“Being in a shelter situation, it is very difficult to maintain good health” (P30)

Men and women described the effect of homelessness on their health in various ways. For more than 50% of men and women, homelessness was a barrier to healthy eating (n = 19). Homelessness created unhealthy eating patterns because food served in homeless shelters and church food banks was filling, but sometimes not as nutritious, as eating fruits and vegetables. Thirty-five percent of participants also described the negative effect homelessness has on sleep and rest (n = 12).

**Dietary intake while homeless.** More than half of the men and women (n = 19) described their daily diets as provided by overnight shelters and churches that included two or three meals a day. When asked about a ‘typical diet’, one person indicated, “I don’t have a typical diet. I just got out of jail. I have limited resources. I go from ...you call them shelter to shelter, churches, charities... that is how I am eating now.” (P 24)

A 52-year-old woman in a winter relief program that ended the day before, changed her diet.

“My diet yesterday, since we came out of winter relief, see we eat three meals a day through winter relief. We eat a good hot breakfast which is eggs, bacon and toast and then we have our bag lunches, which consists of sandwich, potato chips, cookies, a juice or can soda and a bottle of water [winter relief program]. Then we have a regular hot meal. Yesterday and the day before, I ate Doritos and drank a bottle of water, that is all I have.” (P 12)

For several men and women (n = 3) they would do the best they could to plan ahead each day or didn’t eat at all.
“Even though I am homeless, I still got to make sure I drink a lot of water, make sure I eat not regularly, because you can’t eat every day, but you eat when you can, try to get rest, so that you can get up the next day, you can go take care of business.” (P12)

“When I am in this type of living environment and mental status, I don’t get hungry to eat. I don’t even eat when I am hungry I eat when my body calls for it.” (P13)

“I used to eat a lot. I used to overeat really bad [sic]. I think that also having to do with being homeless. I didn’t know where my next meal was coming from. I thought that while I was here, I would eat how much I can. I stopped doing that…. I eat a lot of oodles of noodles, so that does not have a lot of nutrition (P14)

For a 41 year old gentleman who once had been self-employed for 10 years and now released over a year ago, there was recognition that, while unhealthy eating occurred, eating food was ‘through the kindness of others.’ (P18)

“White bread, fats, excessive…. white bread because we get so many sandwiches [in homeless shelter program], but that would fall into excessive carbs. White bread stands out just because white flour is horrible. The only reason we are familiar with it is because it is cheap, disease resistant, and hearty, we use it because it is fiscally efficient, it is easy. The cheese isn’t cheese, cheese made with milk, like actual cheese is expensive. (P18)

In spite of having food usually high in carbohydrates, men and women (n = 5) also might make unhealthy food choices through purchase at local fast food places.

“I try to get healthy stuff, but there is nowhere to store it, because we are homeless right now, so………. but I can get free fruits, and maybe in the course of a day, eat 2 burgers at Burger King or something.” (P20)

“Actually, I will, take for instance, this morning, I love burger king French toast sticks, so I go there and instead of ordering a 5 piece, I will order 15 of them, and I will sit there and smash them in syrup, and then kind of eat, ‘til I am content (P22)

“Lot of times, I have money and I will probably go to McDonalds again and have a burger or two. That is pretty much how it has been going, being homeless. I will drink. I do drink a lot of fluids” (P27)

[How do you eat? What is your diet every day?] “I eat a lot of cakes and sweets and I drink a lot of soda.” [With sugar in it?] “Yeah.” (P26)
Homelessness prevented the ability for healthy eating among participants (n = 5); as one person shared,

“Pretty much, because I am homeless right now and I don’t have a fridge. I can’t like keep meats and stuff like that.” (P25)

“Yeah, trying to ‘get’ healthy ...It is hard to do in a homeless situation. You have very little control. Someone gives you a bag of lunch. It seems like health has an awful lot to do with what you put in your body.”(P30)

For more than 25 percent of men and women who were homeless (n = 9) or not homeless, staying with a healthy diet was difficult or one that was not individually chosen.

“It has been really difficult not to snack, potato chips, ice cream, and cookies throughout the day, but it is getting better.” (P06)

“... But I don’t do that [i.e. eat right] I don’t eat the right foods, I still like fried chicken. Yes, I like fried food all my life. Pork, things of that nature. Some food with me is hard to let go.” (P07)

“Well, here’s how it works... certain days places have specials, like Popeye’s, chicken is not a real real bad thing. They have a special on Tuesday... because that is the time of day where I get off from work, and stuff like that, I usually eat something. I might grab something fast.”(P 19)

“I will meet up with my wife in the morning, when she will come down; I will eat breakfast at McDonald’s. I probably won’t eat lunch, but if I do, I will grab something out of the store, like pastry or candy or something” (P 27)

Altered Sleep and rest (n = 12). For more than 30 % of men and women, homelessness negatively affected their ability to sleep and rest. A 35-year-old African American man living in a truck parked on a lot and going to school during the day observed,

“So by the time I get there, take off my jacket, cut the heat on in my truck, if I got some water, put it in a crock pot....it is already about 12 o’clock. So, I read a couple of chapters for about an hour or two hours... I am back up about five or six I have 50 hours, 50 hours now. I get little sleep. Roughly in a week, I am getting about 15 hours of sleep, it depends.” (P 3)
A 29-year-old male who is on several medications for both physical and psychiatric conditions described,

“It is hard to keep up with medication, when you are homeless, because you don’t have a place to rest... And I have to lug my stuff around with me, does not help.” (P 08)

For others, worry causes sleeplessness and insomnia (n = 3),

“With all the stuff going on, my mind, I can’t sleep cause all these thoughts keep racing in my head of how I can fix it and do things, it is kind of crazy, and it is kind of slows me down, get me where I can focus.” (P10)

“Something that I was on in jail, actually it [Elavil] was prescribed for me. I have high anxiety....like I can’t sleep. Up until last night, I slept six hours, the whole time I was out, I only slept six hours. I had no desire to go to sleep, don’t even want to go to sleep” (P 14)

“I have not slept in two days. I have been on the move. A big reason why I don’t sleep is my anxieties. I have different anxieties which make it real hard to classify. I have anxieties where I need to be getting something done, or I have to come up with a plan about tomorrow of getting something done. I am afraid if I sleep, I will over sleep, and miss a chance of moving forward.” (P13)

For one 43-year-old man, alcohol intake helped feel more comfortable sleeping on the streets.

“If [alcohol] puts me in a bit more eased state of mind, as well as the ability to lay down in uncomfortable situations, very uncomfortable situations. Hard to sleep, you know. I typically wait until it is time to go to bed, just enough [alcohol] to get me to sleep. There are times, if you do it on a daily basis, it’s hard to manage, sometimes you buy more than you should, more than you planned, that is just the nature of the beast, especially at that level, that level of consumption, daily” (P24)

Homelessness Affects Physical Activity (n = 2). In addition to altering personal diet and sleep, homelessness was described as affecting the ability to do exercise because of hygiene resources or a place to exercise.

“If I had a place, maybe I can work out every day in my place. I would be willing to do that, push-ups sit ups, stuff like that. Take a break every couple of days.” (P21)
“How practical is it to exercise? It is not practical at all, because I don’t have access to shower facilities you know. Maintaining your hygiene is difficult to put it mildly, in a homeless situation” (P24)

Access to healthcare. Questions on the survey included the following, “Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?” and ‘Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare or Indian Health Services? Men and women identified access to healthcare as a barrier to health, regardless if they had insurance, or did not have insurance or were in the process of applying for insurance.

Although 66 % of men and women (n = 23) had healthcare coverage, 46% of these men and women described healthcare access to a physician when needed was still limited, primarily related to additional costs (n=16). For several persons (n = 3), the additional burden of cost, i.e. co-pays, medication, even with health insurance was a barrier. Hospitalization follow-up was required but the person chose not to follow up because of cost.

“They wanted me to do a follow up three days after I left [the hospital] which would be today, but I know when I call them, they are going to want insurance, or they are going to want, what is it, a copay.” (P025)

“Yeah, I got a doctor. Matter of fact, I get my blood work done; I got to get it done tomorrow. I got Medicare. I just talked to Larry, back in here. He is going to try to help me get medical assistance too, because I am disabled. Trying to get some extra health insurance and stuff, cause’ right now my co pay is twenty dollars a month, I mean twenty dollars every visit, gotta [sic] pay.” (P23)

[stands in your way of your health?] Is there anything you can think of, that does not allow you to be healthy?] “To me, I think it is the insurance I have. Since all of this happened I am still trying to get a psychiatrist. The man up there from PG mental health services, he is trying to help me. I don’t have any money to do none of this.” (P10)
In addition to having responsibilities for co-payments, deductibles and other additional costs while being insured, those with insurance described difficulties in accessing healthcare through physicians or other healthcare providers (n=5). A 41-year-old man, having a history of cocaine addiction and depression, seeking help after release within the last 30 days stated:

“Just recently my PAC went into play. Since all of this happened I am still trying to get a psychiatrist. I cannot find a doctor around here. Don’t [sic] nobody want to take PAC, because there is so many homeless people around, because all the doctors that did, don’t anymore. They [the doctors] keep saying they don’t pay nothing [sic] for it. They don’t pay bills for the people they are seeing. They all [doctors] like got an attitude as soon as you walk through the door, you know what I mean. You ask them and they say they don’t know nothing.” (P10)

Another 43-year-old man, having a history of blood sugar elevations and a need for pain management described,

“I am diabetic, I should be on insulin, and I still haven’t gotten that yet, because I can’t find a doctor that will do the blood work. It is difficult. Sometimes it gets to the point where you just give up, so frustrating dealing with insurance and everything.... I have a pinched nerve in my back, I need pain management for that and they don’t do pain management either. So I have to find a health clinic that is going to accept my insurance and take care of everything right there.” (P34)

A 41-year-old woman with a history of alcohol addiction and bipolar disorder missed her appointment with a new psychiatrist the morning of the interview. Subsequently, she has to wait more than 30 days for another appointment and does not have any needed medication.

“My appointment is rescheduled and I can’t get in until July and I would really like to get back on medication as soon as possible. Like right now you see me I can’t sit still, I am not medicated right now, that is why I am saying [laugh]. I have been like this, without being medicated, up and down and all around. It drives my boyfriend crazy, but.... (P31)

For men and women without health insurance (n = 7), access to services was particularly difficult.

“My physical right now, until I get insurance I can’t do anything about.” (P013)
“In order to get it fixed [jaw trauma] and everything, it would take a minimum of ten thousand dollars. I have already gone and checked it out. Like I said I don’t have insurance, I don’t have any insurance for me. I just don’t have that money” (P017)

“I do need to have prostate screenings and colonoscopy, I need stuff like that. Without insurance, it is kind of tough” (P 019)

[Do you have health insurance through PAC?] “I have applied; they denied me here and there, because I make not a lot of money, but more, outside their parameters, but not enough to purchase health insurance. It is in a stalemate type of thing, you know.” (P19)

“Your hepatitis C, are you being treated? “No, because I can’t find…it is 78,000 dollars for the treatment. I don’t have any insurance to pay for it.” (P014)

“Just because I don’t have a prescription card, to get it filled even if they did write it for me.” (P014)

For some, not knowing where to find needed resources was a barrier (n = 3).

“A lot of people keep telling me everywhere I go about the hepatitis c, you know, it is a silent killer and I should be getting it checked. I am trying to, and nobody seems to be giving me the information to do that. It is kind of frustrating”. (P10)

“Do I need to stop walking, or whatever? Do I need to take a bus all of the time? Do I need to get a car? Do I need to do that? Do I need to do that? Tell me something that my ankle will not hurt anymore.”(P011)

In order to obtain health insurance coverage through state programs, the paperwork and administrative requirements were a challenge for some (n = 4).

“All the political red tape in Social services just trying to get insurance, that the President or whatever says that I have ... how I have to file paperwork through paperwork through paperwork just to get a form for my name, you know” (P 013)

“No, I am in the process right now of trying to get PAC, but I just got out but it takes 45 days”. (P14)

A 54 year old man, described that while earning less than $10,000 a year, he was unsuccessful in meeting eligibility requirements for state program support
“Well, if I didn’t make the money that I was making, I could have got the PAC [state health insurance], I applied for food stamps, stuff like that, and got denied; I just got denied last week for food stamps, it is not like I haven’t tried. It is not like I am over by a whole lot; I am over by maybe one hundred dollars. One time I applied for PAC and I was 75 dollars over the limit. But over is over.” (P 19)

**Personal finances – Poverty.** Overall, men and women described the lack of personal income to be a barrier for everyday living. Eighty-nine percent of men and women interviewed had an income less than $10,000 (n= 31); this income was primarily the result of monthly checks received while participating in varied state and federal assistance programs, that included assistance for the disabled (n = 3), food stamps (n=5) and/ or other state aid (n = 3). Several men and women were in the process of obtaining financial support through state programs, i.e. disability, food stamps (n = 6).

Men and women described the day-to-day challenges of supporting and maintaining their livelihood, while unemployed, or living on a limited income. Several younger men described the impact of limited income on their personal independence (n= 2).

“For a young man, it is bothersome, you don’t have any money coming in, and you don’t want to go and do the wrong thing, let me say that. So, you look at your options, you are not doing bad, and a door will open, so that is what keeps me positive, but I can see how that kind of situation can cause a person to be mentally ill, in a sense and adversely affect their physical health”. (P004s)

“Court fines that have to be paid that can put you back in jail…not having the funds or resources to do things on your own. Or things that they want you to do, that you can’t do first until you have money, or have income, or a place to live that is stable.” (P008)

Several other men and women described the effects of having a limited income and their inability to secure stable housing (n = 4).

Now I am out ….it is like I am starting over. I have no money, I have no insurance, no place to stay, it is just hard to get started again.” (P25)
“Yes, enough that I can pay for a one bedroom apartment and all utilities taken care of… [Your disability would allow you to have money every month, would it also help you pay for pills, your medication?] “Yes. It would. I would get my own place, and I wouldn’t sleep under a pine tree.” (P015)

“Right, well basically I filed for disability, I went to a hearing a couple weeks ago. All I get is $187/month, until I find out I will get disability. That is really not that much to survive on, you know, so.” (P16)

Several men and women (n= 6) described how their intake of healthy foods was affected because of having limited money

“I eat all fresh fruits, if I can’t eat fresh foods because it’s expensive, I eat frozen. Vegetables, I try to eat fresh foods, vegetables. Lean meats, a lot of whole grain cereals, a lot of water, I try to drink a lot of milk. I try to eliminate any processed food. Every now and then I want to snack, but I try to limit that because I want to have a perfect body.” (P10)

“Certain day’s places have specials, like Popeye’s; chicken is not a real real bad thing. They have a special on Tuesday, where you can get for a certain price some chicken, it used to be 2 pieces for 99 cents, now they raise it to a dollar twenty-nine. Chicken is not really a bad thing there; I still go with the French fries, as a greasy thing is not that good. Every now and then, on payday, something like that, I may go down and get some orange chicken and rice, something a little more healthy.” (P10)

“Well, one thing I would like to do, I would like to eat better, but the problem is I get food stamps, two hundred dollars a month. You have to eat the cheapest food you can get, because if you don’t, your money runs out in a week or two. It’s gone, and then you don’t get to eat. I wish I can afford to have a healthier diet.” (P34)

**Personal decision-making.** Men and women (n = 6) described barriers to their own health that included not only outside forces, but themselves – a barrier toward their own positive health.

[Are there things, you do that is unhealthy?] “Drinking… By me, not doing the stupid stuff I am doing. Save my money, get me a place, get me out of the woods, get back together again,” (P23)

“It’s [health] important, I mean I don’t take as serious as I should” [If you were to take it serious what would that be?] “Quit smoking, eat better.” [Are there circumstances that don’t allow you to eat better or quit smoking?] “Um, no not really.” (P26)
[What things stand in your way from being healthy?] “Smoking stands in the way” [of personal health] (P001)

“I am supposed to be on oxygen, but you know, I am just stubborn, I guess. Actually I am on an inhaler” (P 017)

“I want to exercise moderately, the motivation for me to do it, other than just thinking about it in my head, it is difficult to get off the ground” (P06)

“No, actually my ex also told me I have to do exercise. It will deter my arthritis. She told me I have to do it ...that would help me as well. “No, I haven’t done” (P09)

Facilitating Influences to Health Promotion

Knowledge of family health history. Several men and women (n = 9) described the influence that family members had or can have, in inheriting a particular disease trait that can lead to chronic disease or personal history with addiction. As they had seen other family members faced with medical or mental health concerns, several men and women discussed their concerns and the importance they viewed for themselves in controlling disease or illness. Comments included,

“I am concerned about getting diabetes. [I] have two uncles that died from alcohol and drug abuse. My grandmother died at an early age, from drug abuse and alcohol. My grandfather has diabetes and he is still here and doing well. So I don’t want to go through some of the pain and suffering that he is going through at his old age. If I can help it to reverse some of this, that may come down the pike, it is very important that I do that. The biggest fear, my mother in my family is me getting diabetes (P 004)

“... am trying to go to a program right now in [A] county that gives free screenings for colon cancer, and stuff like that, because in my family, prostate cancer is real prevalent there, out of four brothers and all her brothers died of prostate cancer; and my dad had six brothers, right, and like four of them, including him, died of prostate cancer. Prostate was the real thing in my family. My mom smoked, my dad smoked, I don’t smoke, my sister smoked, and their blood pressure usually stays pretty high all the time, but so far, knock on wood, mine is right there, you know. “(P19)

“I didn’t have a pap smear and my aunt died from cervical cancer, because she didn’t get pap smears, and by the time, she was getting real sick, by the time she went in, it was too late.
She was gone a month to the day that they told her. So I am keeping up with my pap smears now." (P31)

One 55-year-old man in particular, described what he was doing as he cared for himself having Type II diabetes, and other chronic illness. He also talked about his family history,

“When I first found out I was a diabetic, I mean I knew diabetes ran in my family, on both sides of my family. My dad’s mother died from diabetes. She lost her eyesight, she had been back and forth in the hospital and stuff, she was getting old and tired, and she died. My dad actually died from cancer in the stomach, and the diabetes was kind of like a motivator towards the end. My diabetes is not as bad as his. It is not as bad as my older brothers, because they both were taking insulin. (P33)

“I don’t get into that, maybe the week end, but not all the time. I am not an alcohol person, because my dad is an alcoholic…. Growing up smelling that stuff just makes you sick to your stomach; say no, I am not an alcoholic.” (P35)

Health goals. Questioning included asking participants to rate their health, not only presently, but in the future, at six months and at one year. For many men and women, responses included health goals they have for themselves to get to a higher level of health than presently. Twenty five percent of men and women stated their own health goals included staying away from drugs and alcohol (n=9). Other goals included weight loss (n = 2), walking and exercise (n = 5), and to stop smoking (n = 4).

“I am down to 244. It is more of wanting to get myself healthy. I do want to lose some weight…. 80 pounds overweight have to get that down.” My target weight would be, they say, 155. But I think I would look funny at 155, so I want to bring it down to 170. (P04)

“I just have to lose some weight. I’m gaining a lot of weight.” (P35)

“I try to do my walking; I have a stepper in the house. So I do that maybe twice a week when I can; I do plan on incorporating some gym time, or swimming or something…. not heavy cardio. But it could get me gradually doing more into cardio work. I am not going to do any weight training. Once a week, I will do some calisthenics in the house, but it is not where I would like to be at. I try to do 50 push-ups. Don’t do sit ups.” (P04)
“In six months, I am starting to do other things. I have some stir-ups for ergonomically correct push-ups, strength-building exercises. Hope it keeps increasing to just general over all physical fitness.” (P18)

Several men and women had plans to reduce or quit smoking,

“I probably will quit smoking, because they are starting to taste real nasty to me. That is just where I am at with that.” (P33)

“I am going to get me one of those electronic cigarettes and try to work on that.” (P5)

For others having a history of addiction, their goal was to stay free of drugs.

“I HAD a history of ... I have been clean now for 8 months....I thank the lord [knock, knock] I have been clean for 8 months; I thank the Lord I have been clean for 8 months, yeah”. (P09)

“My addictions is [sic] good, I changed my whole lifestyle as to the people I was around to make sure I don’t relapse again.” (P10)

“So you know I gotta [sic] leave the drugs alone for a while. I gotta [sic] do that for a year. After a year, I probably say, I am going to say, probably if it pans out the way, I want it to. I probably say, you know, I ain’t [sic] doing drugs no more.” (P11)

**Health Awareness.** As men and women described their health status, they were aware of aspects of individual health that required continued attention. Almost 20 % of men and women described their awareness of daily exercise (n=8) and its importance on health. Similarly, 15% described the importance of walking on health (n = 5). Other areas of health awareness included the personal need for additional treatment of current medical conditions (n = 4), and /or mental health problems (n = 2). Several were seeking additional treatment for physical health conditions

“I have had a total hip replacement, right hip…and it is not getting better, and it is getting worse” (UP)

“One foot, just this one. It stays swollen all the time. My hands, they say I am borderline high blood pressure. If I am healthy why do my feet hurt, why are my hands swollen? ..... I am going to find out what I can do to get it fixed (P17)
“I went the first of January, and my platelet level was 60 some thousand, so they told me I needed to go.” (P17)

“On and off for maybe five years. Now this is the longest it [pain] has ever stayed. To me it feels like it is getting ready to be permanent because it is not getting any better. [And the pain in your back?] “As a matter of fact, I am going to call him tomorrow, I have to schedule a shorter appointment., cause he has me coming like every three months, and it is not working”.” (P20)

Others were in need of, or recognizing that, they may need mental health services.

“Well, mentally yeah, Right now I am in the process of doing this physical, like a lot of stuff is starting to come down on me now. Maybe when I was little, it’s like the older I get, the worse my mind gets, I don’t know.” (P20)

“I don’t know. I think crazy things some time. I obviously do, because I keep making mistakes that send me back to jail, so, I need some kind of help, maybe, I don’t know.” (P29)

Men and women also realized the benefits of exercise (n = 8) and / or walking (n=5).

“I have been walking to and from destinations, so my cardio fitness and my general weight and appearance have increased for the better.... I have lost some inches around my waist, trimmed belly fat because I am walking back and forth.” (P018)

“I do a lot of walking. I walk all day. I guess physical activity is good right now. Normally, at home when I wasn’t working, I would just lay around. I would sleep a lot, pretty much how it has been recently.” (P27)

“I am smoking less and less, because I am seeing the benefit of doing that, while walking. You know I am seeing the benefit of quitting, not smoking, when I am walking. “(P30)

“I walk a lot, so my legs are stronger. At one point, I got so used to driving, I couldn’t even walk, I couldn’t even walk 100 yards, without being out of breath. Now I can walk 2 or 3 miles and I will be fine still.” (P33)

In particular, having opportunity to stay fit and exercise was appealing to both men and women.

“..Haven’t been to the gym like I am supposed to. But I want to start that back up. Waiting to get on...be on the swim team, soon when they start it up. Yes, I lift weights, universal and free. ..... So, maybe I can do a little more exercise, I try to do 2 hours for every hour I have in class.” (P03)
“I see these little places, like these little fitness clubs, you know they have like ten dollar sign on fee, or ten dollars a month or whatever. I be [sic] wanting to try that. I trying [sic] to find a place where I be at all the time, but, I be seeing them all over, all over.” (P11)

“I used to work out a lot; I am getting ready to join a gym again, actually. Yeah, I like weights, lifting weights, and actually, I am going to start running on their machines too.” (P016)

“When I am doing the right thing, I am always big on my health, big on my appearance and working out, and staying in shape, I have always been like that. Right now, I am down on myself because I haven’t been working out, lost so much weight.” (P28)

“I was looking at the penny saver, and they have over at Bali Gold Gym, I have a flyer, that says I can get a free membership for a week, and then I will see if I like it, and then maybe look into getting a membership there. (P 31)

“I think I can do more exercise, because I am starting to get a stomach. I don’t like to be too big around here. I would like to make this flat again.” (P35)

**Perceived Importance of personal health.** How a person views the importance of health can influence their ability for health promotion. Men and women were asked ‘how important is your health to you?’ All participants (N = 35) described the importance of personal health, either as “very important” (n = 23) or “important” (n = 12).

Responses that explained why health was important were varied. In some cases, men and women had the experience of seeing a family member who was unhealthy as they got older, and did not want the same for themselves (P004). One person with varied chronic illness himself stated,

“If I can help it to reverse some of this, [family history of diabetes, effects of drug use; chronic illness] that may come down the pike, it is very important that I do that.” (P004).

Others reflected on how health affects quality of life in later years,

“My health is real important, because if I don’t take care of me now ... (P012)
In addition, overall personal health was viewed to influence day-to-day activity and independence (P019)

“Oh, health is very important, I mean, without your health man, you can’t do nothing [sic]. It is rough trying to function and not being healthy, I mean, it is harder to do everything.” (P019)

Others described health as not something they can control (n = 2). Progressive aging had an effect on health.

“How important is it to me? It’s very important to me, but some things I cannot help, because I guess some things I can’t help, because the older I get, the worse it can get.” (P021)

“Right now I think it is very important, because I am approaching 40, and all I’ve seen is a vicious cycle. (P022)

Still other viewed the importance of own health to influence their capability to care for self (P025) and others (P021).

“It’s very important because a lot of people depend on you. It is not just you, to depend on yourself, especially if you have a wife and stuff, and a child on the way. It’s very important”. (P02)

“It is very important, because I am young. I don’t really have much family to help me. I am pretty much on my own right now, so I got to be able to live, you know.” (P025)

“My health is very important….. I have a 2-year-old daughter so I want to be around to watch her.... Lord willing, I just want to be around to at least see her graduate high school. If I could do that, than I will be fine. Even if I can go further than that, if I can get another 40 years, I will be blessed.” (P033)

“Right now, I would say, it is the most important thing in my life. That is really what I am working on the most, “Yeah, it is basically what I have been saying. I have to take care of my mental health in order to handle my physical health. If I don’t take care of my mental health and get depressed, I don’t’ care about the rest. I have to stay with a positive mental attitude, so I can keep getting through everything I got to do.” (P034)

“My health is very important, you know. That is all you got, until God says you are ready. You have to really take care of it” (P35)
“Health is the most important thing in the world... More important than anything, money, anything... if you don’t have health you don’t have anything, because you are not able to do anything, and mental health is very important as well.” (P005)

“It is extremely important. Without your health, you cannot do anything” (P006)

**Change in social relationships.** Men and women \(n = 14\) described social relationships with others before they were incarcerated and that helped them to gain an understanding of the negative influence others had on their behavior in relation to the use of drugs and other substances. Men and women have since made a conscious choice of who they will socialize with; as one person stated, “I don’t put myself in that type of circle with those who are not trying to do the right thing” (P02)

A gentleman going to school after having grown up in the inner city environment described what got him into trouble ‘Driving Under the Influence’ was his relationships with others,

“I used to party every weekend Frat brothers, things of that nature, we get together and we make a weekend of it. Sunday morning, sleep all day and be ready to go to work or school on Monday [past lifestyle].” (P04)

In addition, he learned that living in his neighborhood was not safe,

“I go home to my neighborhood to go home and go to sleep. I don’t interact in my neighborhood” (P04)

For a woman who is trying to plan and do what is needed to reestablish a positive health pattern admitted,

“Well, see the circumstances that put me in jail... my entire existence was poor, alcohol, unemployed, homeless, wrong people, wrong places... (P06)

For several gentleman who are trying to stay clean after repeated incarcerations, staying away from others who do drugs was a positive decision to stay healthy,
“... a little longer than, more than one year. It’s hard, but then again, it is not that hard. All you do is stay away, stay away from people that uses [sic], then you don’t have to worry about using. (P 09)

My addictions is good [sic], I changed my whole lifestyle as to the people I was around to make sure I don’t relapse again. I recognize my triggers and I try to surround myself with nothing but positive people and it is definitely worked for me, as far as spiritually, mentally, physically and everything (P10)

Everybody laughed, everybody had fun, but I took a toll. [alcohol use]” (P13)

It is hard to explain, I just avoid people in general. I don’t know why I do that. Me and him, we just stay by ourselves, so we don’t get influenced. I don’t want to be influenced by the wrong people. We just go to the Mea Center “(P 17)

“I have very few [friends], and out of those very few, all of them are still getting high right now, so I don’t associate with anyone really, I pretty much live a solitary life right now.” (P 22)

Desire for change – out of community corrections. More than 35% of men and women described their intentions for change (n = 13) from what was an unhealthy lifestyle that included illicit drug use and / or excessive alcohol intake prior to incarceration. Personal goals included staying away from drugs and or alcohol (n = 5), taking care of personal mental health and addiction (n = 3), and wanting a life free of the criminal justice system (n = 4).

Several men described how the pieces fit together in their past life. With that knowledge, they now wanted something better for themselves.

”I don’t drink. I don’t do the drug thing no more. I was out there for a minute. I think all those things in conjunction, you know help me out a little bit, you know.” (P19)

“The fact that I am not out there with the wrong people helps, and then, things we talk about, wanting a better life and stuff, family. I have two children, so I am going to do the right thing for them.” (P29)

Others described how treatment in mental health was helping them.

“Mentally I am in a better place, than where I was. I don’t have no pending charges hanging over me, or nothing like that, so that’s all good.” (P19)
“I am now addressing with certain doctors [mental health], and certain medications help me address these issues, which now is starting to turn my life around and live a healthier life...but I am not where I want to be yet. When I get to that point, I will consider myself healthy.” (P22)

“Now with me being clean and sober, I have not maintained my drug dependency, being clean and sober; I started talking about a lot of issues that went on in my childhood. That was something that I never did before. So this time, I feel I am making a difference in my life, as far as that. I am into, I go to a psychologist, and I do therapy, and I am also on medication for that.” (P32)

Others were tired of continued recidivism for themselves and wanted a better life

“For the past 4 and a half years, I have done almost 3 ½ years in jail, a little over three and a half years in jail, but that’s getting everything out of my way. This is the first time in my life since I was 13 that I am not on probation” (P13)

“I have been in and out of jail before. I have been on probation, been there done that. Now it seems like I am drug free. I am not on no probation, no parole, or anything. Right now I am doing everything, it is not my will. It is my higher power will that I am choosing today to stay clean and sober.” (P32)

“I wouldn’t be in jail; I would be very close to getting my record cleared up, my court fines paid, petition [sic] to get off the offender registration. Through mental health and good housing, (P 08)

“It gave me some time, to really think about what it is that I want. Do I want to live the rest of my life feeling like this and living like this?” I spend a lot more quiet time and meditation with myself, and I think a lot about what it is I want to do, that is positive.” (P6)

**Self – efficacy (n = 14).** Men and women were asked the question ‘what helps you take care of yourself?’ or ‘are there things that stand in your way, at all, from being healthy? Thirty percent of men and women (n= 14) responded that they themselves were the deciding factor in staying healthy. As one person describes a response when asked the question, “me”. If I stop doing what I do. I am the one that will help me with my health.” (P23). As another person stated, “the only person that can make it better is me.” (P23). Others similarly described,
“I keep my self-healthy. Anything that is wrong with me, or that I need do, to maintain my health, I do that, because this is my body, this is me. My health is important. I be doing so much, and I want to make sure I am good. I mean I would look out for my health” (P011)

“No, because as long as I am doing it, I know I can get it done, but as long as I am dependent on something, I need something else, to get what I need to get done. For the past two years, I have been by myself. I am intelligent. I know who to ask for help, and I know who not to [ask]. (P13)

Instead of depending on others, men and women described what they were doing or what they would do if they were not healthy.

[How do you take care of yourself? How do you take care of your health?] “Basically get to a doctor, to help me figure out my problem, tell me what I need to do to either cure it, or keep it stable, or something, I guess.” (P20)

“I am now addressing with certain doctors [mental health], and certain medications help me address these issues, which now is starting to turn my life around and live a healthier life. But I am not where I want to be yet.” (P22)

“I know what I can eat and what I can’t eat. I know what will make me sick, and I am not going to go there again. Usually, I do pretty good with my health. I know how to handle it. I don’t go to the hospital that much.” (P23)

Several men and women, described how they participated in their own self-care with resources (n = 5).

“I am a grown man, I am 35 years old. It depends on you and your survival instincts, really it depends on the person, so environmental factors or environmental issues really don’t play a component in that”. (P03)

“There is plenty of information out there to help you do that, of course a lot of it is specific to different problems, but on a general level, just maintain the way you feel, if that is the way you want to feel, then keep doing what you are doing. If you don’t want to feel this way, try something else, so it is knowing what your body is, and what it is doing. So it is a cognizance of yourself, is what you need to do, you have to recognize that.” (P30)

“I read a lot of self-help books to make me feel good about me. I have been working on my self-esteem. I do [attend] workshops. Like right now, I participate in the workshop “For me, myself and I”. It is a workshop that helps you build your self-esteem, your values ... your
confidence, to be able to get interview skills. It is a very good program, and to not shy away from yourself. I realize you have to work from the inside out, not from the outside in. “(P 32)

“I take the pills. I kind of control it a whole lot better. I check my sugar every morning, or every couple of mornings. I take my medicine on a regular basis, so it is not something that is a big issue to me. I don’t think of it [as an issue]. I changed my diet. I don’t eat a lot of fried foods, which was all like ‘doctors orders’, i.e. ‘I want you to do this’. (P 33)

“But as long as I have a to do list, and I take a walk and go to the library, and attempt to accomplish something positive, then I think I will be ok”(P 6)

For some, they realized that there was no one else that was going to help them (n=2).

“I am managing; I think I am managing better than most... I am by myself in managing my health. I mean not very many people who view health like I do, at least not in my circle.” (P24)

**Spirituality.** During the interview, men and women were asked, ‘what helps you to take care of your health?’ Almost 50% of men and women included reference to a higher being, or already being ‘blessed’ (n = 17). Several participants confided,

“You have to have a spiritual background to center everything, I am not going to say that people are immoral, but they are not looking at their health in a big circle.”(P04)

“Other than God... give me the guidance and strength to keep”. (P05)

The lack of spirituality was described to have an association with being unhealthy. As several participants described,

“I guess it depends on how they take care of themselves physically. Their social life, their spiritual health, how peaceful they are things like that.” [unhealthy] (P06)

“Actually all three, if you wanted to limit to the main three groups, mental physical, and spiritual health or whatever, they all kind of go hand to hand; they enhance and have a synthetic effect.” (P024)

As one man described,

[That is helping you take care of your health?]..... “Oh, well, the good Lord, because listen to me, listen to me clearly.... He wakes us up, and he watches us in our sleep, yeah the good Lord, believe it” (P09)
For several men and woman with a history of cocaine or heroin addiction and having had many incarcerations, spirituality was a support in taking care of their health,

[What helps you take care of your health?] “For me, it is putting my Lord first and family and just trying to stay focused on the tasks I have to do to try to maintain a normal stable life, instead of an insane addicting life. Without him, I have nothing and I am nothing. Mentally I am trying to get right, but I am getting there. I am very blessed. I think it was a wakeup call from the Lord [jail] for me to get back on track, because I was stepping out of boundaries going back to my old ways. (P10)

“I go to church, usually certain days of the week are worse (struggle with addiction) than others. Usually Friday nights I go to church. They have a 2-hour program on Friday night that I go to. I made it to a few NA [Narcotics Anonymous] meetings. Friday nights there are four people that are recovering from drugs, and stuff, but we don’t talk about drugs, we talk about God…. so that helps.” (P29)

“Now it seems like I am drug free. I am not on no probation, no parole, or anything. Right now, I am doing everything. It is not my will; it is my higher power will that I am choosing today to stay clean and sober.” (P32)

For some, a higher being was described to influence present health status.

“That is really all the health problems I have, so I have been blessed.” (P14)

“I do have Hepatitis B and C, I am in no pain from that, or anything, and I think I am blessed as far as my health goes.” (P27)

“God has blest me with very good health, he has blessed with good genes, genetics and everything. I am very blessed to have the health, the genes, and the genetics. I just make wrong choices” (P28)

When asked what personal health would be like in one year,

“Yeah, God willing. I think I should be fine. I feel very healthy now” (P21)

For several women, prayer was important as she continued to face mental health concerns.

“That is something I have to deal with, ‘cause it is never going to happen [living with her children]. If I get approved for my disability and get a house, and get my children back, and that won’t be a stressor anymore. So I am praying on that.” (P17)
[You are trying] “I am trying. It’s a struggle. I said, ‘God you are testing me’; He has his hands on my shoulders. He is leading me in the right direction. I do believe in God, you know, I talk to him a lot. It seems to help me get through the day”. (P 31)

A higher being also was described to influence or restore health.

[How do you restore your health?] “You wait for the Almighty and just bide your time…. Just wait it out. (P30)

“As my spiritual reality, as of now I chose to go that route, because I did everything else, and I figure, ‘why not try that now?’ You know, and I feel good. I do bible study now. I started it when I was incarcerated. "It gave me a calling. (P32)

“How I reached rock bottom was because my mom passed before I left, before I was incarcerated, I had three sisters that had expired on me, and two brothers; I am the only one left. So you know that gave me an inspiration to call on somebody, because I couldn’t call my mom no more. My father is deceased”. (P 32)

“Constantly using it, you don’t see it until you stop using it. I am just going on my blind faith, and what I have been seeing with my sight, and just with my higher power, to just let everything rest in His hands.” (P32)

“I try to lean more toward the God for my understanding, as opposed to my own thinking or my own self will, because I know my own self will get me in trouble on a regular basis. It has proven as such, so I just kind of stay away from people, places and things that are like targets to me triggers to me. ......stuff I know will make me explode, stuff I know will have me making bad decisions, and stuff like that.” (P33)

For several participants, the blessings of a higher being was an important determinant in maintain health . .

“I have a 2 year old daughter so I want to be around to watch her.... Lord willing, I just want to be around to at least see her graduate high school. If I could do that, than I will be fine. Even if I can go further than that, if I can get another 40 years, I will be blessed.” (P33)

“My health is very important, you know. That is all you got, until God says you are ready. You have to really take care of it” (P35)
Summary

The current study suggests health promotion among men and women who have recently released from county correctional facility is a difficult process due to a number of personal, social, and community factors. The thematic personalization of health promotion occurs along a continuum - first unhealthy, then incarceration, then striving toward health.

The overall theme is *Health Promotion - A Time for Change* as men and women move along a continuum of health promotion when released. Five sub-themes contribute to this continuum of change that include 1) Toward a healthy me, 2) Continuing challenges - physical and / or mental health maintenance, 3) Changing Lifestyles – we want to be healthy, 4) Dealing with life on life’s terms – resilience to adversity and 5) Survival –overcoming the obstacles
CHAPTER V: SUMMARY OF FINDINGS, DISCUSSION, IMPLICATIONS, AND RECOMMENDATIONS AND CONCLUSIONS

Introduction

The overall purpose of this study is to 1) explore health and health promotion of men and women recently released five days to eighteen months from an adult county detention center, and 2) explore the personal, social and community factors that may act as barriers and facilitators in health promotion among men and women released from an adult county detention center. Research questions included 1) How is health described by men and women recently released from an adult county detention center? 2) How do men and women experience health after recent release from an adult county detention center? 3) What personal strategies to promote, maintain or restore health are described among men and women recently released from an adult county detention center? 4) What personal, social or community factors influence health promotion, i.e. primary, secondary and tertiary prevention as described by men and women released from an adult county detention facility? 5) What barriers or facilitating influences to health promotion, i.e. primary, secondary and tertiary prevention, as described by men and women recently released from an adult county detention center?

The first section of this chapter will describe key findings, and overall theme, subthemes and categories relevant to each research question. As many men and women in this study were homeless, the second section will provide additional information regarding what is known about homeless men and women having a history of incarceration, and health promotion.

The third section will address implications and recommendations resulting from this study and will include study limitations, the relevance to nursing theory, nursing practice, and nursing
education. The final section will include implications of this study for additional nursing research and will also address significance of this study and provide a summary of conclusions.

**Discussion of Findings**

Men and women released from county correctional facilities are in the process of personal change – from former lifestyles that ended in jail time and upon release, having a renewed interest in health promotion and maintenance and a healthy lifestyle. The overall theme emerged from this study of men and a woman coming back to the community after release is that of *Health promotion and A Time of Change*. Men and women returning to communities after incarceration want change for themselves and/or for their families. Personal health promotion and maintenance were important, as many had experienced unhealthy lives of addiction and ill health prior to incarceration.

Men and women recently released from a county correctional facility were in the process of personal change and described themselves as moving along a continuum of health promotion. – thus, the overall theme is *Health Promotion and A Time of Change*. Five sub-themes emerged describing the continuum of change, these included: 1) Toward a healthy me, 2) Continuing challenges - physical and / or mental health maintenance, 3) Changing Lifestyles – we want to be healthy; 4) Dealing with life on life’s terms – resilience to adversity and 5) Survival – overcoming the obstacles.

**Theme 1: Toward a healthy me.** In answering the first research question, ‘How is health described by men and women recently released from an adult county detention center’, men and women described their understanding of ‘health’, - what it is and what it is not. This
understanding is a basic requirement as someone decides to be involved in his or her own health promotion and maintenance.

The national agenda, Healthy People 2020, supports and encourage public health of the American people ((Healthy People.gov, 2010). The responses of men and women in this study indicated their knowledge of health - what health is, what healthy means, and what unhealthy means. The aspects of health promotion that have been described by men and women – either through stories of their past or in their ‘reentering’ the community are in line with the national agenda, that indicates the importance of personal awareness in maintaining health through everyday preventive health behavior, i.e. good nutrition, exercise, and stress reduction.

*Meaning of the word ‘health’*. As men and women were asked to describe the word ‘health’ in their own words, 40 % of men and women described health to include both physical and mental health (n = 14). About 25 % of men and women viewed mental health and physical health as affecting each other; if a person’s mental health is not good, physical health will be affected and vice versa. Eight percent of men and women (n=3) described stress as an influence on physical health and as one person described, stress is one of the ‘biggest causes of disease” because of “putting disease inward”.

Health was described as dichotomous, as ‘good health’ or ‘bad health’ or can be “positive” or “negative” health. Personal health is important and health is influenced by a person’s ability for self-care. Self-care was described as “taking care of your body”, “not smoking”, “keeping yourself in shape” or “being able to do things on your own”. Seventeen percent of men and women mentioned health was maintained through a healthy diet or proper nutrition (n= 6).
**Healthy person description.** As men and women described ‘a healthy person’, 40% of men and women described positive mental health as a characteristic (n = 14). The ability to promote ‘positive thinking’, and “proper decision making was a frequent characteristic; also, a healthy person is able to ‘deal with life… handle things’ and demonstrates ‘inner happiness’. A healthy person was described as someone who maintained a healthy diet, physical fitness and exercise, had the ability to care for self, both by maintaining positive physical health and a healthy lifestyle.

**‘Unhealthy’ person description.** In contrast, an ‘unhealthy’ person was someone who may have unhealthy eating patterns, whose mental status was negatively affected and a person who might have excessive alcohol or illicit drug use. An unhealthy person was someone who had difficulty caring for self and managing one’s every day routines because of drug and or excessive alcohol use; or, unrelated to drug or excessive alcohol use, might have difficulty with day-to-day routines or have an inability for self-care. An ‘unhealthy’ person was described someone having physical symptoms and / or a negative physical appearance. A person can have a chronic illness that makes them unhealthy.

These descriptions provided by men and women suggest that each person has an ‘emic’ understanding of health, or a perspective based on self-understanding regarding what the words ‘health’, ‘healthy’ and ‘unhealthy’ mean (Morris, Lueng, Ames & Lickel, 1999). Men and women described their own personal histories during the interview that included mental health and addiction disorders and a high prevalence of varied physical illness; that experience was their reference point. Their knowledge of ‘health’, ‘healthy’ and ‘unhealthy’ is connected to their own personal experiences as adult learners, their social environment and to their lifestyles prior
to, or subsequent to, repeated incarcerations. The health of men and women in the study was affected by not eating right, or living right, as self-described prior to incarceration. From personal descriptions of their own lifestyle of drug use and or excess alcohol intake, men and women described their inability in positive self-maintenance - ‘not having bad habits’, not putting anything in your body, like cigarettes, anything like that, or someone who is ‘not using drugs, not drinking, stuff like that’.

Studies that explore an understanding of the word health, characteristics of ‘healthy’ or ‘unhealthy’ behavior among men and having a history of incarceration were not found. Understanding the ‘emic’ perspective regarding health promotion that these men and women maintain is important as it reflects their unique life experiences prior to incarceration, and /or after release.

**Theme 2: Continuing challenges - physical and / or mental health maintenance.** In answering the second research question, ‘How do men and women experience health after recent release from an adult county detention center?’ Eighty percent of men and women indicated the presence of continuing chronic health conditions. Similar to other published findings, men and women in this study described their health histories of infectious and chronic diseases, substance abuse, and mental health problems (Binswanger, Krueger & Steiner, 2009; National Commission on Correctional Health Care, 2002; Wilper, et al, 2009).

**Physical health maintenance.** In this study, 80 % of men and women described continuing medical health problems. Although this study is qualitative in nature and includes a purposive sample of 35 men and women, the percent of men and women affected is similar to that reported in larger studies (Malik-Kane & Visher, 2008). More than 50 % of men and women in this study
reported having hepatitis and cardiovascular disease. Previous studies have indicated high rates of hepatitis found among the incarcerated than in the general population, particularly among those having a history of at-risk sexual and drug-use behaviors (Gupta & Altice, 2009).

Although rates of HIV/AIDS and other sexually transmitted diseases are found to be increased among persons living in jails and prisons in the United States as compared to the general population (Bonney, Clark, Hebert, Rosengard & Stein, 2007; Golembeski & Fullilove, 2005; National Commission on Correctional Health Care, 2002), only two of the thirty-five participants reported having HIV/AIDS (n = 2).

In this study, the prevalence of Hepatitis C was described by more than 35% of participants (n = 12) and hypertension was described by almost 30% of men and women. Reports have indicated the most frequently occurring chronic diseases include diabetes, hypertension and asthma among inmates, in state, federal and county jails (Binswinger, Krueger & Steiner, 2009; National Commission on Correctional Health Care, 2002; Wilper, et al, 2009). Men and women who are homeless are also known to have more mental health and chronic medical conditions. In addition, men and women returning to communities after incarceration have additional burdens of infectious disease and mental health disorders in increased numbers when compared to the general population (Daniels et al, 2011; Durrah, 2005).

Men and women described the presence of varied muscular skeletal / orthopedic disorders that most frequently included back injury and knee related injury. Musculoskeletal conditions in particular accounted for continuing and persistent chronic pain among 30% of men and women. Almost 25% of men and women had a history of accident-related injury that had occurred mostly through car accident involvement.
In particular, musculoskeletal injuries resulted in continuing disability and/or the inability to work among men and women. Studies have not been found that explored continuing pain and disabling conditions among the correctional population, and what impact this might have in employment, continuing low socioeconomic status, and recidivism. In the study, men and women described their disability status related to continuing mental health and physical conditions; also, the use of opiates and marijuana for several men and women was associated with symptom relief of continuing pain.

Nyamathi, Sands, Pattatucci-Aragon, Berg, et al (2004) noted, “perceived health has provided an indirect measure of an individual’s sense of long-standing chronic illness, has served as a useful means of gauging physical health status and has been associated with capacity for self-care” (p. 66). Men and women in this study were asked about their general health after release; 55% men and women described their health as ‘excellent’ (6%), ‘very good’ (20%) or ‘good’ (29%); 45% of men and women described their physical health as ‘fair’ (34%) or ‘poor’ (11%). This finding was similar to other studies of men and women in corrections.

For instance, in interviews with more than 1100 men (90%) and women (10%) inmates on day 3 of incarceration at a county correctional facility, Conklin, Lincoln & Tuthill (2000) found that 50% of all men and women rated their health to be good, fair or poor. Similar to data described in this study, Conklin et al (2000) found conditions associated with bones, back, neck and mental health to be present among men and women returning to communities. As the prevalence of mental and physical illness is greater among men and women in the criminal justice system, it is interesting that 50 – 55% percent of men women yet maintain they are in excellent, very good, or good health.
Prior to incarceration, 28% of men and women described their physical health as negatively affected by alcohol or drug use. The most frequently mentioned effect was unhealthy eating (17%). Other personal stories included a lack of exercise, smoking cigarettes with alcohol use, poor hygiene and “not living right” related to efforts to obtain drugs. Personal lifestyle concerning health maintenance and self-care while using illicit drugs have not been studied among men and women having a correctional history.

Current research efforts focus on ‘reentering’ men and women but studies that explore the lives of men and women leading up to incarceration are lacking. As men and women have described their physical and mental health prior to their incarceration as induced by unhealthy lifestyles, this would seem to be a point of public health intervention to prevent recidivating back to a correctional facility.

For several men and women, life back in jail offered a healthier status when compared to life on the streets, seeking out drugs, not eating, etc. The study of factors related to the influences of either or both mental and physical health on personal decision making for criminal offense would be interesting. As studies have explored addiction-related behavior, there is an understanding of a relationship between personality and psychopathy (Nicholls, Ogloff, Brink & Spidel, 2005); only one study was found that explored physical health status among this population as an influence to decision-making resulting in criminal activity.

Barrett, Young, Moore, Borum, et al. (2009) collected data from 96 homeless individuals in residential treatment for co-occurring mental health disorders and having similar demographics to men and women participating in this study, i.e. age, level of education and employment status. In the study, demographic data were compared to two years of arrest data
after intake into the program. Thirty three percent of the men and women were rearrested during
the two-year period – mostly for drug offenses. A perceived need for medical services was
increasingly found among men and women with a history of arrest when compared to those
without arrest (OR = 1.74 vs. 1.23 (95% CI = 1.05–2.26). Men and women, in describing their
physical health on release, noted episodes of acute illness (n = 11; 31%) occurring after release
that required an emergency room visit or hospitalization. Within this group, more than 20 %
were treated for an acquired infection. Acquired-infection included bronchitis or pneumonia,
inner ear infection, and/or injury to an extremity resulting in an infected condition. Physical
illness that includes infectious disease, related to risk behavior, (i.e. sharing of contaminated
needles), unsafe sex, mental disorders and use of healthcare services is noted among the
homeless population (Zlotnick, Zerger, & Wolfe, 2013). Studies exploring the frequency and
type of hospitalizations or emergency room visits by released men and women has not been
found. Additional study among of the types of acute infectious disease and use of services may
be helpful in understanding the public health needs of this population.

Mental health maintenance is a challenge. A history of current or past mental health
disorders was described by 80 % of the men and women in this study (n = 28). Men and women
described histories, or current treatment for, depression (52%) and/or anxiety (26%), bipolar
disorder (11%), post-traumatic stress disorder (PTSD) (11%), insomnia (n = 2; 6 %), explosive
personality (6 %); more than 60 % of men and women (n = 22) described histories of substance/
alcohol/drug use. In this study, co morbidities among men and women included both illicit drug/
excessive alcohol use (n = 22) and a mental health disorder (n = 28). Previous studies have
described the prevalence of mental health and addiction disorders among the correctional
population, with many individuals having more than one mental health condition (National Commission for Correctional Health, 2002; Steadman, Osher, Robbins, Case, & Samuels, 2009)).

Over 50% of men and women in jails have substance dependence or abuse problems without other mental health disorders and, in cases where men and women have other mental health disorders, substance dependence or abuse may be as high as 72% (James and Glaze, 2006). It is estimated that 40% to 60% of men and women have used drugs 30 days prior to incarceration (James and Glaze, 2006). Inmates with co-occurring disorders, i.e. substance abuse with depression, bipolar disorder, and schizophrenia, in particular, are at higher risk for repeated incarcerations, when compared to inmates with either a psychiatric disorder alone or a substance use disorder alone (Baillargeon, 2010). Scott, Lewis & McDermott (2006) noted the prevalence of “co-morbid substance use disorder[s] in offenders with mental illness is the rule, not the exception” (p.35).

Overall, the data regarding the prevalence of mental health conditions found among men and women in this study appear to be greater than the numbers noted in the 2002 Health Status report (National Commission on Correctional Health Care, 2002). A greater number of men and women in the study reported histories of depression and anxiety when compared to the national health status report. Homelessness can be a factor in this increase; more than 75% of men and women who participated were homeless, where increasing numbers are seen in mental illness. According to a report published by the National Coalition for the Homeless (2009), 20 to 25% of the homeless population in the United States suffers from some form of severe mental illness, a number multiplied four to six times when compared to the general population.
Prevalence estimates of major depression are reported between eight and fifteen percent (National Commission on Correctional Health Care, 2002). Visher, LeVigne & Travis, (2004) published findings of a pilot study conducted in Maryland, which looked at the healthcare needs of 324 released prisoners. At post release of 30 to 90 days, depression or anxiety was reported by 25% of both men and women. Thirty eight percent of women as compared to 20.5% of men reported depression symptoms at 30 to 90 days. Little change in findings was noted at four to six months after release.

Fifty-three percent of men and women described changes in their mental health status before and after their most recent incarceration (n = 18). Of these, more than 75% of the men and women described a positive mental health change occurring (n = 14). Personal stories involving positive change after incarceration were related to prior life histories involving addiction to illicit drugs or excessive alcohol intake (n = 7), as each described their successes, challenges and/or their failures associated with use. Although most men and women in the study reported histories of mental health disorders, men and women also viewed themselves as having no mental health problems (n = 7; 20%). For the most part, those that described their history of drug use prior to incarceration described the toll that drug use took on them physically and mentally. After incarceration, these men and women were experiencing improved health.

Studies have supported offender mental health is one of continuing morbidity and comorbidity, i.e. substance use, bipolar disease, impulsivity, addictive disorders, and is associated with continued criminal behavior (del Castillo et al., 2008; Greenberg and Rosenheck, 2008b; Zaller, Holmes, Mitty, Beckwith, Flanigan, et. al. 2008). Several qualitative studies support the
presence of ongoing depression as a clinically significant variable affecting the lives of individual women post-release (Arditti and Few, 2008; Arditti and Few, 2006).

Men and women in this study reported a negative change in their mental health before and after (n = 18) that included descriptions of mental health decline indicated by descriptions of symptoms and familiarity with their own diagnoses, i.e. obsessive-compulsive behavior, increased anger after release. Men and women described stressors in their life post-release (n = 14).

Stress was associated with the challenges of reentry. The most frequent sources of stress were homelessness or the lack of stable housing (20 %) and the lack of personal income (15 %). Similar findings were reported by Freudenberg, Daniels, Crum, Perkins, & Richie (2008) when interviewing women and adolescent males within 1 year of release from a New York City jail. At intake, women identified housing (71%), substance abuse (69 %), inadequate income (65%), education (27%), and having family problems with their children as major issues.

Other sources of stress included living in an unsafe environment, family concerns and interactions with others. Similar to other reported studies, housing and employment are of concern to men and women interviewed (van Olphen, Freudenberg, Fortin, & Galea, 2006). This study included men and women who were both homeless and not homeless, and only two men reported employment; few had income and/or were waiting on state entitlement decisions for financial aid. As men and women leave correctional settings, challenges of reentry include stress seems to be part of that transition.

Men and women appeared to respond to stress in one of three ways: a) feeling good with no mental health concerns (n = 8), b) having the ability to cope with present stress or mental health
needs \((n = 8)\), and \(c\) lacking in coping skills \((n = 11)\) as they faced continuing challenges in their daily life after incarceration. Several men and women lacking in coping skills described the presence of continuing mental health concerns and symptoms, in addition to their continuing struggle and challenge to stay away from drugs.

As men and women are unemployed, have stigma from a criminal history, are not able to find housing, and lack family support, stress and the capacity to cope can be overwhelming. Phillips and Lindsay (2009) stated that only a limited amount of research has been conducted regarding coping strategies of men and women during reentry or among those who recidivate in the criminal justice system. One hypothesis involves “coping–criminality”, formulated by Zamble and Porporino in 1988 (as cited in Phillips and Lindsay, 2009, p. 139), which proposes that men and women in the criminal justice system have reduced coping ability, which in turn, is a factor in committing crimes.

In this study, more than 50% of men and women came from lifestyles of drug use, in some cases for more than twenty years. The use of drugs prior to incarceration by men and women included use of marijuana, cocaine, alcohol, heroin and opiates, singly or in combination. For several participants, the use of marijuana was associated with stress reduction. This study supports the attention needed regarding the public health concern of illicit substance use among men and women living in communities nationwide. Nationwide men and women with ongoing substance abuse are not being treated in the community that can be associated with their own unstable living situations (Macalino et al., 2004; McGovern, 2008).

**Theme 3: Changing Lifestyles – we want to be healthy.** In answering the third research question, ‘What personal strategies to promote, maintain or restore health are described among...
men and women recently released from an adult county detention center?” men and women described their health behavior associated with primary, secondary or tertiary prevention. Studies that explored health, either describing health-related behavior that emphasizes a healthy lifestyle or behavior that indicates personal understanding of the importance of early detection, treatment, or efforts to reduce the effects of chronic disease, is limited in correctional health literature.

**Primary Prevention.** Primary prevention involves health behavior to avoid illness and try to stay healthy. In this study, as more than 75 % of men and women were homeless, physical activity included either or both walking (98 %) and other forms of exercise (30 %). When the question was asked, ‘what physical activity are you involved in’, men and women most immediately thought of walking, as many were homeless and did not have other means of transportation. Exercise was less mentioned, as it requires physical space and /or equipment. In the homeless day program where the study was conducted, rooms were occupied by men and women with little space available for exercise and / or use of any equipment.

More than 50 % of men and women mentioned eating healthy as a desired health behavior. Although homeless, men and women described choosing healthy foods, i.e. fruits and vegetables, if available on a day-to-day basis. Other health – related behavior included eating healthy (n = 19; 54%), having daily structured activities (n = 13; 38 %) or interest in personal health and health maintenance (n = 9; 26%). Men and women described their own weight loss efforts to promote health (n = 5; 14%), their efforts to abstain from illicit drug use or excessive alcohol intake (n = 3) or smoking (n = 3; 8 %). Other health related behavior mentioned included good hygiene (n = 2; 6 %) and positive social interaction (n = 2; 6 %).
Health behavior pertinent to this population has predominately been described in relation to risk behavior or behavior that may cause self or others health harm. Risk-behavior includes having unprotected sex thus increasing HIV risk (Clements-Nolle & Gauthors, 2008; Daniels, Crum, Ramaswamy, & Freudenberg, 2011; Martin, O'Connell, Inciardi, Surratt, & Maiden, 2009), tattooing with reused needles increasing risk for hepatitis C (Pena-Orellana, Hernandez-Viver, Caraballo-Correa, & Albizu-Garcia, 2011), and the influence of alcohol use and risky sexual behavior (Clarke, Anderson & Stein, 2011).

**Protected Sex.** In exploring strategies in primary prevention among men and women, probe questioning included a focus on prevention of sexually transmitted disease. Questioning included a focus on protected sex if sexually active. An equal number of men and women used a condom (36%) and did not use a condom (36%) when sexually active. Among those that did not use a condom, two – thirds of the men and women were in a monogamous relationship. Studies that examine risk behaviors in prophylaxis of sexually transmitted disease of men or women, before or after incarceration are limited. Only one study was found that explored risk behaviors of young men released from prison and living in the community (Morrow & Project Start Study Group, 2009). Studies that explore risk prophylaxis among men released from county corrections, behaviors of men across age groups, or at specific intervals of time post release were not found.

**Influenza vaccine.** National health priorities include increasing the number of adults who are vaccinated annually against seasonal influenza to promote the reduction of new cases related to influenza infectious disease; only 25 % of men and women aged 18 to 64 years received influenza vaccine in 2008 (Healthy People.gov, 2014). Less than 50 % of men and women had
received an annual influenza vaccine. Receipt of an annual influenza vaccine is not a widely accepted health behavior among men and women (n = 16). Existing studies of intervention response to health promotion efforts involving men and women released from a county correctional facility have not been found.

Vlahov, Coady, Ompad, & Galea, (2007) discussed influenza immunization barriers found among hard to reach populations such as minorities, the homeless and substance users. Studies have documented reasons as to why men and women do not get the immunization and include the individual not believing he or she will get the flu and individual fear of getting sick from the vaccine. In addition, provider attitudes, the lack of trust in medicine can affect health decision-making concerning the influenza immunization among various population groups. Among the men and women interviewed in this study, data suggest some of the same already known reasons indicated in the review article. Almost 50% of men and women interviewed did not want the influenza vaccine. Most gave reasons as to why they did not believe the vaccine to be important or safe. As most men and women were homeless, and were among hard to reach population groups, additional education appears to be needed regarding the benefits and safety of the vaccine.

**Cigarette smoking and alcohol intake.** Every day nationwide, men and women are convicted of Driving under the Influence (DUI) or Driving While Intoxicated (DWI) (Wells-Parker, 1991; Wells-Parker, et al, 1988). The prevalence of alcohol abuse among women with a history of incarceration in particular is estimated to be at least five times higher than among women without a history of incarceration and living in the community (Clarke, et al., 2011). Data describing health among the correctional population has indicated excessive alcohol intake
to be associated with risky sexual behavior, among both men and women (Staton-Tindall et al., 2007; Stein et al., 2009; Stuewig, Tangney, Mashek, Forkner, & Dearing, 2009), heroin and other drug use (Phillips, Nixon, & Pfefferbaum, 2002; Seal et al., 2001), violent crime (Weizmann-Henelius, Putkonen, Naukkarinen, & Eronen, 2009) and domestic violence (Parker, 2004) – all conditions found in this population.

In this study, over 80% of men and women reported non-use of alcohol in past 30 days to the time interviewed. About one-third of participants (37%) stated they did not drink at all or were an ‘occasional’ drinker (34%). Only two men described drinking ‘everyday’ (6%) and several men and women described themselves to be ‘ex-drinkers’ (n = 8). Even though most men and women did not drink after release, more than thirty percent of the participants described the negative effect that addiction alcohol and/or drug use had on their physical health prior to incarceration.

More than 90% of men and women participating in this study revealed that they were current cigarette smokers. Almost 70% of men and women smoked every day. Twenty-three percent of men and women smoked ¼ to ½ pack a day (n = 8), or three to five cigarettes a day (n = 3). Fifteen percent of men and women described smoking a “pack a day” and two reported “smoking a pack every few days” or “10 cigarettes a day”. Among those who smoked, more than 60% of men and women tried quitting sometime in their lifetime. Quitting to smoke was described by men and women as an important health promoting behavior (n = 4); for some, smoking was associated with drinking alcohol.

These findings are similar to other studies; seventy to eighty percent of men and women in jail or prison smoke tobacco – a percentage four times the national average of non-
institutionalized men and women (Thibodeau, Jorenby, Seal, Su-Young, & Sosman, 2010; Voglewede Jr. & Noel, 2004). Voglewede & Noel (2004) explored independent variables associated with smoking behavior among 150 male inmates in one county jail located in the southeast United States. Most were lifetime smokers (94%), and the average education level among those who participated was less than high school completion. Results of the study showed the men had smoked an average of 11.5 years and an average of 23 cigarettes daily. About one-third of the inmates tried to quit 2.5 times (mean) which lasted 43.4 days (mean).

Secondary prevention - How healthy am I. Sixty percent of men and women in this study indicated having had a physical exam within the last 12 months. Dental checkups were less frequent, with 60% of men and women having had a dental check-up sometime within last 5 years. In addition, only about 35% of men and women had a dental check-up within in last 12 months, and the same number described having a dental check-up over five or more years prior to the study.

Physical exams and health screening. More than 50 percent of men and women who described having had a physical exam described situational circumstances that did not involve a primary care physician. Instead other resources were used, i.e. county correctional facility (n = 6), when starting a methadone program (n = 3), or a new job (n = 3). Several men and women described not having ‘had an exam for ‘about 30 years” (P12), or that it has been ‘a few years ago’ (P 17), or ‘no, not really’ (P 23), or ‘not yet’ (P02). One person stated, “I never have [a physical exam] (P7). Primary care was lacking as men and women described their circumstances. Studies were not found that explored the influence of primary care in health promotion specifically among men and women released.
In addition to physical exams, the extent of health screening that occurs among the correctional population is also unclear. In this study, men and women were asked as to whether they had had recent health screening, such as having had laboratory blood work or other work-ups to detect presence of disease, fifteen men and women stated that they did (45%) have varied health screening. Several men and women (n = 5) described having had HIV and other testing as routine screening process when becoming incarcerated. Empirical evidence indicates that if services were offered in jails, inmates would participate in health screening procedures (Beckwith, et al., 2007).

As more men and women in prison and jails have a variety of health problems, efforts to provide health screening vary state to state. For instance, Seal (2005) reviewed 43 articles related to HIV/AIDS and the correctional population, published from January 2004 through March 2005, and found only two studies that addressed HIV prevention interventions. McIntyre, Studzinski, Beidinger & Rabins (2009) in a study of 81 adult county jails in Illinois found the availability of health screening services for sexually transmitted disease (STD), HIV, AIDS and hepatitis among inmates varied across the state; only 49% of the county jails in Illinois provided on-site testing for these conditions, and only if symptoms were present. Routine screening for infectious disease was reported by four jails only.

**Healthcare services.** More than 75 % of men and women participating in the study needed healthcare within the last year, and two out of three participants (66 %) did not think of anyone as their personal doctor or health care provider; with further clarification, one in two men and women (51 %) did not have a physician or other healthcare provider. Within a year prior to
the study, 46% of men and women used the Emergency Room and 43% visited a physician’s office.

Cunningham et al (2007) looked at factors associated with health care utilization among underserved HIV-infected individuals concerning the use of ambulatory care, emergency room and hospital. The sample included 40% of men and women with less than a high school education, only 10% were employed, 85% had less than $10,000 annual income, 61% had been incarcerated at least one time and 53% were homeless in past six months. Differences in healthcare utilization were seen among men and women in the study. Emergency department visits were associated with having insurance, homelessness, poor health status, length of HIV infection, mental health care and medication usage, and heavy alcohol intake, whereas increased hospitalizations were associated with men and women having graduated high school, having insurance, homelessness, poor health status, length of HIV infection, and mental health medications. (Cunningham et al., 2007)

Women’s health. As a means of early detection and treatment, The American Cancer Society recommends that Pap tests among women between the ages of 30 and 65 should occur at least once every 5 years; also, women should have yearly mammograms starting at age 40 (American Cancer Society, 2013). Among the women who participated in the study, all were between the ages of 30 and 65, and six women were over the age of 40. Eight women during the interview, were asked if each had a recent pap smear; 62% said yes (n = 5), although four of the five were non-specific as to when or how long ago.

Only a few studies have examined cancer screening among men and women who have a history of time spent in county jails. Ramaswamy, Kelly, Loblitz, Kimminau & Engelman (2011)
conducted a cross-sectional study to explore cervical cancer screening among 204 women in a Kansas City jail who may have had a history of abuse or intimate violence. Overall, 84% of the women (84%) in the study reported having a pap smear in the last 3 years and more than one-third of the women (40.1 %) reported an abnormal Pap in their lifetime, a rate six times higher than the general population.

Health guidelines for early detection of breast cancer include periodic mammography screening of women who are over 40 years (National Cancer Institute, 2014). Six women in the study were over the age of forty. Of these women, 50% (3) said yes and 50% (3) said they had not had an annual mammogram. Binswanger, White, Perez-Stable, Goldenson & Tulsky, (2005) explored knowledge and frequency of cancer screening among 133 men and women at two large county jail facilities located in San Francisco. Overall findings indicated 90% of the women had a Papanicolaou (Pap) test within 3 years, and for women aged 40 years and older, only 41% reported having had a mammogram within 2 years.

*Use of over-the-counter medication.* Use of over the counter medication has not been studied among men and women returning to communities after incarceration. The importance would include a means of pain relief for those who have persistent pain or reduce symptoms of a cold or respiratory ailment, if occurring. Men and women were asked how they cared for themselves when they had a cold or other health condition. Results indicated that almost half of the men and women (42 %) did not use over the counter medication for pain, cold, or other symptom relief. Among those that used over the counter medication, most frequently, the reason was for pain symptoms (37%), followed by cold medicine as needed (23 %). Men and women also utilized other strategies when sick; these included rest (23 %), going to the Emergency room
(20 %), drinking fluids (11 %) sometimes with liquor (11 %), and taking vitamins (9 %). Studies were not found that explored self-care strategies when sick among the correctional population. Identification of reasons as to why men and women did not use over-the-counter medication could have been due to lack of income, and/or individual health beliefs, as almost 25 % of men and women described using other strategies when sick to restore health.

**Mental health treatment.** Although drug use is reported to be high, only 7 to 17 % of drug-using jail inmates in the United States have participated in a treatment program in jail or prison (National Institute on Drug Abuse, 2011). Men and women (n = 14) described past or current participation in individual treatment modalities for addiction and other mental health disorders after release. Treatment included participation in drug treatment and counseling programs, (n = 5) and/or treatment for mental health disorders (n = 12). Men and women with a history of cocaine, heroin or opiate use (n = 6), and/or the need for pain management (n = 4) attended a methadone treatment program.

Research indicates that treatment of men and women beginning in correctional facilities and continuing in communities nationwide is effective in decreasing recidivism and substance use over a 5-year period (National Institute on Drug Abuse, 2011). When looking at men and women over a five year period, studies have indicated that with no treatment, men and women continue the use of drugs after incarceration and are likely to reoffend; similarly, if treatment is not completed, the likelihood of continued drug use is higher, than in persons that have completed treatment or have started treatment and continue with follow-up in the community after release (National Institute on Drug Abuse, 2011).
Studies which involve men and women leaving county jails with mental health needs associated with drug use and/or other mental health disorders, suggest a willingness to participate in treatment while opportunities for mental health treatment appear to be limited. Green, Miranda, Daroowalla, & Siddique, (2005) reported study results that included 100 female inmate volunteers in a nearby county correctional facility, and found these women to have an interest in drug education/treatment (75%), alcohol treatment (45%), GED preparation (50%), stress management (88%), individual mental health counseling (80%), anger management (76%), parenting skills (79%), communication skills (83%), problem-solving skills (91%) and health education (82%). The most frequent service need identified by these women was for substance abuse treatment.

Tertiary prevention. The primary means of tertiary prevention among men and women in order not to get worse, having a particular illness, was with the use of prescribed medication. More than 80% of men and women released described use of prescribed medication for either, or both, treatment of chronic mental health and medical conditions (45% - psychotropic medication; 53% - medical condition).

Medication use. Seven men and women, who were prescribed either psychotropic or medication to treat a physical illness, described their non-adherence. Reasons included hearsay about side effects (P14), cost (P14, P15), not wanting to take pain pills (P19), forgetfulness (P02), decision-making not to take an anti-depressant (P27), and anti-cholesterol (P03), not having a doctor to prescribe psychotropic medications (P31). Medical treatment adherence among men and women returning to communities has predominately centered on those with infectious disease – hepatitis C (Butt, Wagener, Shakil & Ahmad, 2005), HIV/AIDS (Arnsten, et
Medication treatment adherence has been the subject of study among low-income men and women with chronic illness. Factors that have been identified as barriers to medication adherence include those related to medication filling/use (i.e. run out of pills, doctor-patient interaction, knowledge, cost issues, logistical ability to obtain and take medication (Turner, Hollenbeak, Weiner, Ten Have, & Roberts, 2009), functional illiteracy (Bosworth, et al, 2006), not having a high school education (Aranda & Uazquez, 2004; Samet, et. al 2003), and not having an ongoing relationship with a physician or healthcare provider or maintaining a routine place for health care (Angell, et al., 2008; Morecroft, Cantrill & Kelly, 2006; Turner, et al, 2009; Victor, et al., 2008).

In mental health, medication adherence among psychotic and schizophrenic men and women has been a focus of study (Baillargeon, Contreras, Grady, et al., 2000; Bressington, Gray, Lathlean, et al., 2008; Shelton, et. al, 2010c). The focus of the national agenda, Healthy People 2020 includes the reduction of continuing morbidity or complications associated with chronic disease, e.g. diabetes, heart disease, asthma, infectious and other diseases (U.S. Department of Health and Human Services (2010) , all medical conditions found in this population.

As men and women have both medical and mental health conditions, additional study is needed concerning medical chronic illness and prescribed treatment adherence among the correctional population.

**Theme 4: Dealing with life on life’s terms – resilience to adversity.** In answering the fourth research question, ‘What personal, social or community factors influence health
promotion, i.e. primary, secondary and tertiary prevention as described by men and women released from an adult county detention facility?’, information collected through use of the demographic survey and while interviewing men and women who were able to describe their individual circumstances influencing personal health promotion. As guided by Pender’s model, personal factors included one’s life history and experience (before incarceration and incarceration), educational level, socio-economic status and health beliefs (Pender, 1996). Personal situational awareness, problem solving ability, goal setting and emotional control can also influence health decision-making (Shelton, et. al, 2010a; Shelton, et al., 2010b). Social or interpersonal influence includes “interpersonal influences (family, peers, providers): norms, social support, role models –perceptions concerning the behaviors, beliefs, or attitudes of relevant others” that influence preventive health practices (Pender, 2011, p. 3) and as importantly, community factors, such as the availability of resources can have an influence as to whether someone is able to stay healthy or not.

**Personal factors.** More than 75% of the men and women in the study were homeless (n = 26) and had annual incomes of less than $10,000 (n = 31). Most were unemployed and of these men and women, more than 35% were not able to work because of a mental health and/or physical disability, and many were out of work for more than one year. Forty percent of men and women in the study had not graduated from high school. Demographic data regarding men and women participating in this study was similar to other studies that involved men and women released from county correctional facilities and / or those having a history of incarceration. (Bureau of Justice Statistics, 2003; Freudenberg, et al., 2005; Freudenberg, et al; 2008;

More than 85% of men and women have health problems. Twenty-nine percent of men and women participating in the study described having hypertension and 34% described having and hepatitis C. In addition, most men and women in the study have been diagnosed with at least one mental health disorder (80%). More than 60% of men and women have histories of addiction to illicit drugs and excessive alcohol, and/or intake and have described their journey in recovery from addiction (50%) to be an everyday challenge.

Studies have not been found involving men and women returning to communities after incarceration who have disability related to physical or mental health impairments (unrelated to intellectual disability). Kitei and Sales (2008) discussed the status of research concerning the epidemiology of physical disability among offenders in federal and state prisons; estimates include about 30% of state and 26.5% of federal inmates have a physical disability. County and local correctional facility data is not included in these numbers. Data regarding disabling conditions include men and women having a speech disability, a hearing disability, and a visual disability. Men and women in this study described disabling conditions resulting from mental health conditions and/or physical conditions that for the most part were associated with musculoskeletal injury resulting from a car accident experience. Studies regarding physical and/or mental impairment and its influence on quality of life, employment, housing, and/or health promotion among men and women with a correctional history were not found.

Incarceration experience. Almost 75% of the participants reported having been in jail or prison more than four times in their lifetime, and almost half of the men and women had been in
jail or prison more than 6 times in their lifetime (46 %). Men and women described both positive and negative effects of incarceration on their health. Negative effects of incarceration included the lack of mental health services / proper medication (n = 2), lack of exercise (n = 3), unhealthy diet (n = 3), victim violence (n = 2), and sleeping conditions affecting bones and joints (n = 3).

Nine men and women described their mental health status to include varying emotional reactions to situations or people that affected their ability to seek or maintain employment or other activities of daily living. Among men and women who have a history of incarceration, impulsivity and other negative emotional reactions can lead to criminal behavior. The status of offender mental health is one of continuing morbidity and co-morbidity, i.e. substance use, bipolar disease, impulsivity, addictive disorders, and is associated with continued criminal behavior (Freudenberg, Daniels, Crum, Perkins, & Richie, 2005; Greenberg and Rosenheck, 2008b; Zaller, Holmes, Dyl, Mitty, Beckwith, Flanigan, et. al., 2008).

In this study, 23% of men and women described themselves as physically feeling better before incarceration than after release. For 20% of men and women, there was no difference in health status before and after incarceration nor was there a decline in their physical health after incarceration versus before (11 %). Schnittker & John (2007) discussed the effects of incarceration on health and suggested that spending time in jail or prison may have a negative effect on individual health post-release, both short and long term. In their study, approximately 20 % of female inmates, when compared to 14 % male inmates, reported severe health limitations. Functional and physical limitations were reported twice increased among those spending more time in jail when compared to men and women who spent less time in jail.
**Self-efficacy.** Men and women were asked the question, ‘are there things / is there anything that stands in your way from being healthy?’ Seven men and women stated ‘no’, or ‘no, if I want to be healthy, and I want to do these things, I am going to do it’ (P16). Personal self-efficacy influences knowledge acquisition, the sense of control that a person has to manage or adhere to a prescribed treatment plan or to participate in positive change of behavior (Evangelista, 2008; Jones, Harris, Waller, & Coggins, 2005; Schoenthaler, Ogedegbe & Allegrante, 2009).

Personal self-efficacy has been studied among the correctional population and in community populations. Loeb, Steffensmeir, & Lawrence (2008) conducted a pilot study with a convenience sample of 51 older male inmates, age 50 or older, who were incarcerated at a state correctional facility, to survey how incarcerated older men described their health status, self-efficacy beliefs, and health-promoting behaviors. The presence of chronic conditions ranged from two to 13 among the study participants. A slightly higher percentage (62.7%) reported feeling very confident in their ability to manage their health on release from prison when compared to percent of inmates very confident in their ability to manage their health in prison (60%). Inmates who reported greater self-efficacy for managing their health on release from prison were also more likely to rate their health to be better, engage in more health-promoting behaviors, and report more improved health since incarceration.

In another study, Loeb, Steffensmeir & Myco (2007) using a convenience sample, compared self-efficacy beliefs, health-promoting behaviors, and health status of 51 older male prisoners living in a minimum security prison in Pennsylvania with 33 community-dwelling older men vs. dwelling older men recruited from three rural senior centers in Pennsylvania and Delaware.
Older men in the community sample scored only slightly higher than the older male inmates on the single item measure of self-efficacy for health management.

Studies that describe a younger population of men or women and their ability to care for their chronic health needs have not been found.

**Addiction recovery.** More than 50% of participants (n = 18) described their journey in recovery from addiction. Many men and women were overcoming challenges, knowing this was necessary for positive health. Men and women talked about the continuing struggle or ‘fight’ (n= 5), to ‘stay clean’ and ‘keep clean’. Others described themselves in a program (n = 5), e.g. methadone clinic or narcotics anonymous. Men and women described their current success since release from incarceration (20%), and their past failures (12%) in staying away from heroin or cocaine.

Most men and women (74%) had been incarcerated more than four times in their lifetime. Forty – five to sixty-five percent of offenders had a history of substance use and the chances for repeat incarceration (recidivism) is doubled in this group when compared to those without a substance use history (National Re-entry Resource Center, 2012).

**Social factors.** Known factors associated with reduced or delayed recidivism in transition from incarceration to community re-entry included factors such as the degree of social and family support, both while in prison and after release, which many times is lacking for these individuals (Bales & Mears, 2008; Codd, 2007). In addition, the importance of family and social support during re-entry had been noted in several studies (Alemago, 2001; Arditti & Few, 2006; Hoyt, 2006). In this study, about 30% of men and women described family and/or friends who were involved in helping them stay healthy, mentally or physically; family in particular was
described are a means of social support by approximately 25% of men and women. Some described family relationships can act as a motivator to stay healthy for released men and women (n = 3).

As men and women described their family relationships, there was instability of families, both among themselves and/or their children (n = 5); as well, not all men and women have a relationship with their families after release (n = 5). A few men and women described friends or social interaction with others as having a negative influence on health (n = 5), and for others, family or friends may not have any influence on personal health of men and women released (n = 3).

**Community factors.** Seventy-four percent of men and women interviewed were homeless (n = 26). The use of community resources described by men and women included the overnight shelter, daily food resources, financial assistance programs, and other resources available through church and county programs. For 45% of men and women, food banks served as a primary resource for daily food intake (n = 15) and the shelter medical clinics served as a safety net for healthcare among more than 20% of men and women participating in this study (n = 8).

**Homelessness.** Homeless men and women are known to have more mental and physical health problems. Many of the homeless have existing chronic illness, which include hypertension, asthma and diabetes, and are with communicable diseases such as HIV/AIDS and Tuberculosis (TB). In addition to their homeless status, it is estimated that one-half to three quarters of the homeless lack health insurance or have difficulties in accessing needed services. (Healthcare for the Homeless, 2010).
Studies regarding the homeless indicate the presence of an increased risk and prevalence of communicable disease, of both HIV and TB, among this population that includes men and women returning to communities after incarceration (Clements-Nolle et al., 2008; Kim and Crittenden, 2007; Towe, et al., 2010). The homeless correctional population has increased rates of communicable disease because of existing poor health and illicit drug use (Courtenay-Quirk, et. al., 2008; Kushel, Hahn, Evans, Bangsberg, & Moss, 2005).

Greenberg & Rosenheck (2008b) collected data from a national survey among more than 6000 inmates to compare this population with statistics known in the general population regarding number of homeless in the year prior to the study. He found that the number of inmates who had been homeless was equal to 15.3% of the U.S. jail population and between 7.5 to 11.3 times, the standardized estimate (1.36% to 2.03%) found in the general U.S. adult population. Homelessness is evident among formerly incarcerated men and women and is a problem that presents greater health risks when compared to the general population (Kushel, et al., 2005).

Reasons are many as to why the homeless have multiple health needs. Nickasch & Marnocha (2009) conducted a study of homeless individuals older than 18 years old, using a grounded theory approach. They found that most who are homeless lacked necessary resources to meet their physical needs (housing, water, food). Additionally, most lack financial resources to obtain healthcare, and have limited access to transportation, telephones, or mail. Findings also among those interviewed included the lack of compassion among healthcare providers in serving the homeless.

Kushel et al. (2005) interviewed more than 1400 homeless persons living in a community to examine differences in health status, drug use and sexual behavior among those with a history
of incarceration compared to a community population. Results indicated that formerly incarcerated individuals were more likely to have HIV infection when compared to those who had never been imprisoned; this group tended to be male, older, and had less than a college education.

Fontana and Beckerman (2007), in a descriptive exploratory study of 105 HIV/AIDS-affected men and women released one year from a county jail, described individual and service-related characteristics that affected the use of health care services. The average age of men and women participating in the study was 41 years old, most were unemployed (82%), male (77%), single (73%), African American (57%) and had less than a high school education (47%).

Among the 105 men and women in the study, 73% reported receipt of routine medical care as needed. Those less likely to have received medical care were white (p = .02), and had less than a high school education (p = .02). Homeless men and women were less likely to see a physician, have routine lab tests, or be taking HIV/AIDS medication. Individuals with minor children were more likely to participate in their own health.

As one example, in Baltimore, more than 2500 men and women were homeless in January, 2013. This number included more than 65% men, and 58% of men and women who had spent time in a correctional facility (City of Baltimore, 2014). Fifty-two percent of men and women reported mental health experiences and 56% reported experience in the use of illicit drugs and/or substances. An individual or family who meets criteria for homelessness is one “who lacks a fixed, regular, and adequate nighttime residence, and who may be “living in a publicly or privately operated shelter designated to provide temporary living arrangements” (OneCPD Resource Exchange, 2012).
Galea & Vlahov (2002) described social factors that act as determinants of health among drug users from different racial and ethnic groups and argued that social factors of homelessness and incarceration found among decreased socioeconomic status are associated with drug use and are not consequences, but instead, are social conditions that affect drug use patterns. Higher rates of HIV are found among African Americans when compared to other populations exhibiting the same risk behavior associated with drug use, i.e. shared use of contaminated needles.

Ten men and women participating in the study were clients of a non-profit community service agency whose mission is to assist and support men and women in the re-entry process, after incarceration. Services available included job-seeking assistance with topics such as resume writing, presentation of self at job interview, and classes in anger management, and goal setting. Individual volunteers work with men and women on a one-to-one basis providing assistance in case management, employment and housing referrals. Men and women described use of assistance programs, both through county and voluntary organizations (n = 5) that included use of mental health services (n = 4).

The need for community resources among men and women released from county corrections has been studied. Alemago (2001) interviewed 165 women who had a drug abuse history prior to incarceration in an urban county Ohio jail, and found that these women reported needs for housing, mental health counseling, education, job training, medical care, family support, and parenting assistance when released. Freudenberg, et al. (2008), in a study of adult women and adolescent males returning citizens within 1 year of release from a New York city jail, found that
women identified housing (71%), substance abuse (69%), inadequate income (65%), education (27%), and having family problems with their children as major issues.

Alemagno (2001) described the self-perceived needs among 156 women living in a female housing unit upon release from jail; among these women; the need for drug abuse services and the need for community services was reported. Results of the study indicated that these women were more likely to require housing/place to stay, medical care, education/training, mental health services, family support, and parenting assistance. Similar to other studies, men and women were homeless, with no income, fighting challenges of physical and mental health conditions after release from county corrections. The importance of community service support and continuing intervention is needed among men and women released from county correctional facilities.

**Theme 5: Survival – overcoming the obstacles.** To answer the fifth research question, ‘What barriers or facilitating influences to health promotion, i.e. primary, secondary and tertiary prevention, as described by men and women recently released from an adult county detention center, men and women were asked to identify barriers that they perceived to influence their health; and also, they were asked to describe factors if any, that helped them to promote and maintain their health.

The personal characteristics described of men and women who participated in this study indicated their susceptibility to health challenges that were associated with health disparity or “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage” and “adversely affects groups of people who have systematically experienced greater obstacles to health based on their racial, or ethnic group, socioeconomic status, mental health, geographic location, or other characteristics historically linked to
discrimination or exclusion” (Healthy People.gov, 2010). In particular, homelessness, present for more than 75% of the men and women who participated in the study, was perceived as a major barrier.

**We are homeless.** Almost 75% of men and women who participated in the study were homeless. Men and women described homelessness as a barrier to health promotion and a barrier to healthy eating (n = 5); Homelessness created unhealthy eating patterns because food served in homeless shelters and church food banks was filling, but sometimes not as nutritious, as eating fruits and vegetables. For many, eating food while homeless required men and women to plan ahead. Men and women (15%) might make unhealthy food choices through purchase at local fast food places. For men and women who were both homeless and not homeless, staying with a healthy diet was difficult or not a health-related decision (26%); i.e. eating at the Burger King, or other fast food place.

As described by men and women in this study, homelessness can affect the ability to exercise because of hygiene resources or a place to exercise (n = 2). In addition, homelessness has a negative effect on sleep and rest (30%). Personal safety in homeless shelters can be a concern of men and women (n = 3) and a homeless shelter environment can be non-contributory toward positive health (n = 7). Examples included living with others who were not cognizant of infection control procedures to guard against respiratory conditions (n = 4); limited access to indoors during the summer was viewed as not healthy (n = 1).

**Difficult healthcare access.** Cost was a barrier for released men and women as to whether they saw a physician as needed. For several persons, the additional burden of cost, i.e. co-pays, medication, even with health insurance was a barrier. Although 65% of men and women had
healthcare coverage, healthcare access was described as a barrier to health promotion.

Healthcare access to a physician when needed was still limited, primarily related to additional costs (46%).

For men and women without health insurance (n = 7), access to services was particularly difficult. For some men and women, not knowing where to find needed healthcare resources was a barrier (n = 3). In order to obtain health insurance coverage through state programs, the paperwork and administrative requirements were a challenge for released men and women (n = 4). Similar to other studies, perceived barriers to healthcare access and a desire for healthcare assistance was described by men and women in this study (Conklin, et. al. 2000; Hoyt, 2006; Marlow, White & Chesla, 2010; Sered & Norton-Hawk, 2008).

Marlow et al. (2010) noted similar findings in conducting a phenomenological study of 17 chronically ill male parolees living in a community-based residential drug and alcohol treatment program; barriers of access and utilization of healthcare services were described by most participants and included financial, administrative, and provider-related factors. Financial barriers included the lack of insurance and poverty – most were using county hospitals and clinics that affected choice and decision-making of needed services. Administrative barriers included long waiting times, and paperwork procedures, and coordination of care after incarceration.

**Poverty – lack of income.** Overall, men and women described the lack of personal income money for everyday living to be a barrier. Most men and women interviewed had less than $10,000 (89%); this income was primarily the result of monthly checks received while
participating in varied state and federal assistance programs, that included assistance for the disabled (n = 3), food stamps (n=5) and/or other state aid (n = 3).

Several men and women were in the process of obtaining financial support through state programs, i.e. disability, food stamps. Men and women described the day-to-day challenges of supporting and maintaining their livelihood, while unemployed, or living on a limited income. Several younger men noted the impact of limited income on their personal independence and the effect that a limited income had on their inability to secure stable housing. Men and women also described how their intake of healthy foods was affected because of having limited money.

In addition, men and women (n = 6) described barriers to their own health that included not only outside forces, but also themselves – a barrier toward their own positive health.

**Health is important – We will keep trying - It is all up to me.** In the study, men and women were asked to describe health influences or factors thought to influence their health. Information described by men and women was analyzed as ‘facilitating’ health. Men and women (n = 9) described the influence that family members had or can have, in inheriting a particular disease trait that can lead to chronic disease or personal history with addiction. Participants who identified illness in their families described that they wanted to avoid it for themselves (30%). For some, emphasis was placed on primary prevention, i.e. weight loss and for others, the focus was on tertiary prevention to avoid future complications. The influence of family health status as a motivator to promote or maintain health has not been studied in this population.

**Health goals.** Questioning included asking participants to rate their health, not only presently, but in the future, at six months and at one year. For many men and women, responses
included health goals they have for themselves to get to a higher level of health. Men and women talked about their awareness of health behaviors to influence health. Examples included an awareness of how walking (15%) helped to promote their health. Men and women described their intention to do exercise (23%). Men and women spoke of personal health goals that included weight loss (n = 2), walking and exercise (n = 5), stop smoking (n = 4), stay away from drugs and alcohol (26%).

Additionally, as men and women described their health status, they were aware of aspects of individual health that required continued attention. These included resolution or additional treatment of current medical conditions (n = 4), and mental health problems (n = 2). In addition, men and women described their awareness of how walking (n = 5) and exercise (n = 8) influenced health.

**Health Importance.** Each person (100%) described the importance of personal health, either as “very important” (n = 23) or “important” (n = 12). Responses that explained why health was important were varied. In some cases, men and women had the experience of seeing a family member who was unhealthy as they got older, and did not want the same for themselves (P004). Others reflected on how health affects quality of life in later years (P012). Personal health was viewed to influence day-to-day activity and independence (P019). Others described that health is not something they can control and that progressive aging had an effect on health. Still other viewed the importance of their own health in relation to their capability to care for self and others.

A scarcity of studies involving men and women with a history of incarceration have been conducted that have explored motivating factors associated with health among this population.
Focus on treatment compliance has included men and women with HIV and antiretroviral therapy (Ines, et. al., 2008) or tuberculosis (Seijoeing & Crittenden, 2007), and those participating in substance use programs (Grella & Rodriquez, 2011). For instance, women scored higher in treatment motivation to attend a substance treatment program tended to have a child and have had prior treatment (Grella and Rodriquez, 2011).

**Changing social relationships.** Lastly, men and women (40%) recognized that social relationships had an effect on their use of drugs and had a negative influence on their health behavior concerning the use of drugs and other substances.

**Spirituality.** During the interview, men and women were asked, ‘what helps you to take care of your health?’ Almost 50% of men and women described reference to a higher being, or already being ‘blessed’ in their lives. (n = 17). Several studies have explored the influence of religious beliefs or spirituality among incarcerated men and women, and only one study was found the explored the influence of spirituality in the lives of men and women living in the community having a history of incarceration (Camp, et al., 2006; Leavitt and Loper, 2009; Stringer, 2009).

Redman (2008) conducted a qualitative study using a grounded theory approach to explore former stressful life experiences prior to and during incarceration and spirituality among men and women (mean age of 40) having a history of substance use. Interviews were conducted with 68 men and women recruited at a community-based residential drug treatment center who had repeated arrests (mean = 29.61 times) and incarcerations (mean = 20.30 times) Of the men and women, 69% had histories of excessive alcohol intake, and 97% used illicit drugs during the six months prior to treatment, in many cases, having come into the program directly from
incarceration. Eight central themes were reported in the study; a spiritual framework can influence, ‘a context for adversity in order to better cope with its impact’ (31%), ‘to understand one’s own true nature’ (42%), ‘develop a relationship with a divine entity as human beings have proven untrustworthy (19%), modify the use of drugs and alcohol (more than 50%); and transform one’s character (36%).

Implications and Recommendations

Study Limitations

This study was a qualitative descriptive exploratory study that included a purposive sample of thirty-five men and women. In conducting qualitative research, the sample size was small and the results cannot be generalized to all men and women with a recent history of incarceration. The interview and completion of the survey occurred at one point in time; a second interview to validate the results of information provided did not occur.

Second, the sample included mostly men and women (76%) who were homeless. Non-homeless men and women were included, but to a lesser extent. In addition, twenty-five men and women were recruited from a homeless shelter day program and ten men and women were recruited from a community agency whose mission it was to provide re-entry assistance after incarceration. Eligibility to receive services at either agency is based on financial need; those men and women who did not meet guidelines concerning poverty level would not have been included as potential candidates in the study.

Finally, men and women who were not already associated and/or received assistance through either type of agency were not included. Study bias may be present as men and women who did not participate may have felt uncomfortable in talking about health and their own health status.
Transferability of study results is limited to men and women having reduced or limited income and who have reentered the community from county detention.

**Relevance for Nursing**

Findings of this study can be discussed relative to nursing theory, clinical practice, nursing education and nursing research.

**Nursing Theory.** Two nursing models served to underpin this qualitative study: 1) Rediscovery of Self Care Model for Nursing Care of Persons with an Incarceration Experience (Shelton, et al., 2010a) and 2) Nola Pender’s Health Promotion Model (HPM) (Pender, et al., 2011).

*Rediscovery of Self-Care: A Model for Nursing Care of Persons with an Incarceration Experience* (See Figure 1) (Shelton, et al., 2010a). This nursing model describes four time intervals and environment relevant to each person with an incarceration experience; these time intervals include: 1) Community environment – prior to incarceration, 2) Prison [jail] Environment, 3) Initial Re-Entry and 4) Re-integration. Threads consistently applied to each time interval include a focus on case management, patterns of stress and adaptation, and clinical nursing care requirements.

Men and women who participated in this study were released at least five days and no more than eighteen months from a county correctional facility. They are in an ‘initial re-entry period’ or ‘reintegration’ period after recent release.

According to concepts in the model, the ‘initial re-entry’ after the incarceration period is characterized by personal tasks and challenges such as re-establish housing, employment, and reconnection with family and friends. It is a time where self-direction is important and individual
adaptation to re-entry may be influenced by ‘personal situational awareness, goal setting, problem solving, emotional control ability and other environmental factors’. The process of nursing care is directed toward supporting and assisting in stress management, self-care, and positive adaptation in community living.

Most men and women who participated in this study were homeless, unemployed, had varying chronic mental and medical illness. Some were reconnecting with family; others were not. For many, friendships and life styles of the past influenced poor health that included use of illicit drugs and excessive use of alcohol, and limited treatment of mental health concerns As they were interviewed, they described their former lifestyles, mental health and physical health status and were able to compare their past health status with the present. For some men and women, their physical and /or mental health status improved, for others, they stayed the same, and yet for others, their physical or mental health was worse than before their most recent incarceration. Each person interviewed was cognitively competent and had the capacity to describe their understanding of their health present day and in the past.

Individual adaptation to re-entry was influenced by ‘personal situational awareness, goal setting, problem solving, emotional control ability and other environmental factors’ (Shelton, et. al., 2010a; Shelton, et al., 2010b). Regarding health promotion, men and women interviewed described goals they had for themselves to maintain health; these goals included healthy eating, exercise, weight loss, obtaining financial support through state assistance programs that would enable assistance with housing and healthcare. For many, goals also included ‘staying clean’ of drugs and / or alcohol. Some men and women were able to describe individual problem-solving needing to occur so they could live healthy lives.
“Environmental factors” continued to be a negative factor for many, as homelessness, lack of primary care and/or lack of healthcare access continued to be problematic, and negatively influenced individual adaptation.

Figure 3.

Overall Theme: Health Promotion among Men and Women Released from a County Detention Centers

Themes emerging from this study appeared to support the nursing model, *Rediscovery of Self-Care: A Model for Nursing Care of Persons with an Incarceration Experience* (Shelton, et al., 2010a).
The overall theme identified was ‘Health Promotion and a time of change’. During the period of initial re-entry, men and women have been recently released and can describe what health is, ‘Toward a healthier me’. They can also describe characteristics of both a ‘healthy’ person and an ‘unhealthy person’. Many men and women have been unhealthy, due to mental health and addiction as well as continuing chronic illness. They have some level of ‘situation’ awareness of what health is, and their own perceived health and actual or perceived ‘unhealthy’.

Secondly, released men and women continue to have ‘Continuing challenges - physical and mental health maintenance’. Only seven men and women described their continuing health status on release as excellent or very good. Many described the negative health effects resulting from personal alcohol or drug use prior to their incarceration (28%); during this time, other unhealthy habits also co-existed among 30% of the men and women interviewed, i.e. no exercise, unhealthy eating.

In this study, men and women described their mental and physical health before and after their most recent incarceration. Regarding physical health prior to incarceration, 28% of men and women experienced negative health related to alcohol or drug use. Twenty-three percent of men and women felt better physically before incarceration as compared to after release. Twenty percent of men and women described no difference in their physical health before and 11% of men and women noted a decline in physical health. Among those with mental health disorders, over half of men and women described a change in their mental health status (53%) after incarceration, and most described a positive change occurring when compared to prior to incarceration.
Continuing health problems were reported among 80% of participants. Men and women described continuing mental health concerns (n = 30) and/or presence of a medical condition (n = 28). These included continuing concerns with physical and mental health disorders such as continuing prevalence of depression, anxiety, and stress as men and women were attempting to ‘problem solve’ for themselves and their families during this time period. Some men and women described behavior that indicated coping with day-to-day problems, and others did not. Many lacked coping skills and described negative changes in their mental status post release. Among those who described changes in mental status, several described working on ‘emotion control’ to situations, i.e., controlling anger, prior lack of maturity that resulted in poor decision-making. Some described that positive daily living included setting up routines and ‘goal-setting’.

Structure and routines helped them with their health.

Third, the theme of ‘changing lifestyles – we want to be healthy’ emerged. Physical activity included both walking (n = 33) and exercise (n = 14) was most frequently mentioned as a health behavior. Even though many were homeless, men and women described eating healthy if they had choices, although few. The importance of daily structure was described; men and women did have an interest in personal health, and described their own efforts in weight loss, and abstaining from alcohol and drug use. These activities, consistent with the Rediscovery of Self-Care nursing model, demonstrated ‘increase[ing] motivation to practice self-care, problem solving and goal-oriented behavior’ (Shelton, et al., 2010a).

Acute care and hospital emergency rooms were utilized for acute illness. Several men and women (n = 5) described having had HIV and other testing as routine screening process when becoming incarcerated. If men and women used over the counter medication, most frequently,
the reason was for pain symptoms, followed by symptom relief of influenza or cold symptoms. Forty-two percent of men and women did not use over the counter medication. Men and women also utilized other strategies when sick; these included rest, going to the Emergency room, drinking fluids (11%) and taking vitamins. Several men and women who had chronic gastrointestinal conditions described the importance of dietary restrictions. More than 75% of those interviewed needed healthcare within the last year and one out of two participants did not think of anyone as their personal doctor or health care provider.

Only about 50% of men and women (n = 14) who had described addiction histories preincarceration, discussed current participation in individual treatment modalities for addiction and other mental health disorders after release. Treatment included participation in drug treatment and counseling programs, methadone clinic and/or treatment for mental health disorders (n = 12). More than 80% of released men and women described use of prescribed medication for treatment of chronic mental health and medical conditions.

The fourth and fifth theme included “Dealing with life on life’s terms – resilience to adversity” and ‘overcoming the obstacles’. As men and women were homeless, many were without health insurance, and were with limited access to healthcare. Several described themselves as the only person that can make a difference in their health, in spite of facing obstacles. Included in each time period in the ‘Rediscovery of self-care model” is a continuing role for nurses in assisting clients, who have or have had an incarceration experience, to meet self-care requirements that may result from loss, illness, injury or life events.

This study did not include an intervention focus, but did explore underlying personal self-awareness of health, barriers and facilitating circumstances associated with health promotion
during this initial stage after incarceration. This study suggests the need for relevant nursing intervention that can be provided through transition of care programs, to be discussed as an implication for nursing practice in a subsequent section of this paper. Information gained from this study is viewed as a personal microcosm of the initial re-entry period identified in the model, *Rediscovery of Self-Care: A Model for Nursing Care of Persons with an Incarceration Experience* (Shelton, et al., 2010a).

The tasks associated with the initial reentry period can be applied to health promotion, i.e. personal situational awareness, goal setting, problem solving, and emotional control ability. Men and women who participated in the study described their mental and physical health at the time of the study (situational awareness); many had goals for improved health that involved staying away from illicit drugs as well as tending to continuing physical illnesses (goal setting). In addition, even though 60% had health insurance, problems continued regarding access and primary care that impacted required problem solving, i.e. get their needed medication, chronic pain persists with additional testing needed. Some men and women described having more emotional control after incarceration, while others described having anger, the inability to sleep, presence of anxiety and stress.

**Pender's Health Promotion Model (See Figure 2).** Pender's Health Promotion Model (HPM) also served as a guide in planning this study and in the development of methodology using a focused interview format in this study. Specifically, Pender's Health Promotion Model was used as a guide to explore personal factors, barriers or facilitators, and the influence of situational or interpersonal factors that can influence health promotion. Findings of this study suggested the relevance of personal, situational and interpersonal factors found among men and
women influence health promotion, while yet additional personal factors influencing health promotion may be unique to these men and women who have a history of incarceration and/or not addressed by Pender’s model.

Personal factors influencing health promotion in this study included more than 75% of the men and women were homeless and had annual incomes of less than $10,000. Most were unemployed and many were not able to work because of a disability or were out of work for more than one year. Forty percent of the men and women had not graduated from high school (n = 11). Most men and women in the study (74%) had been incarcerated more than four times in their lifetime.

More than 85% of men and women had health problems, most having health problems of a chronic nature. Most frequently, chronic illnesses include hypertension (29%) and hepatitis C (34%). In addition to physical illness, 80% of men and women were diagnosed with at least one mental health disorder (80%) and more than 60% of men and women had histories of addiction to illicit drugs and excessive alcohol intake (n = 22). Many described their journey in recovery from addiction (n= 18) as continuing to be an everyday challenge.

Most men and women had experiences of incarceration more than four times in their lifetime (the average age of men and women was forty-two years old); descriptions provided included the perceived positive and negative effects that incarceration had on personal health. Negative effects of incarceration included the lack of mental health services / proper medication (n = 2), lack of exercise (n = 3), unhealthy diet (n = 3), victim violence (n = 2), and sleeping conditions affecting bones and joints (n = 3).
Relevant aspects of Pender’s theory to this study include the relationships between individual characteristics and experiences, behavior-specific cognitions and affect and behavioral outcomes. Behavior-Specific Cognitions represent a grouping of factors influencing individual health promotion, i.e. perceived benefits of action, perceived barriers to action, perceived self-efficacy, activity-related affect, interpersonal influences and situational influences. Interview questions included asking about the influence of family or friends on personal health promotion; in addition, circumstances (situational factor) described by men and women are homelessness, also identified as a barrier to positive physical and mental health promotion.

**Situational factors.** For some men and women, family and/or friends were involved in helping to stay healthy, either mentally or physically (n = 11) and family in particular were a means of social support for men and women released from incarceration (n = 8). Maintenance and responsibilities in family relationships was described as motivator to stay healthy among men and women released (n = 3).

For other released men and women (n = 5) there was instability of families, both among themselves and/or their children; as well, not all men and women have a relationship with their families after release (n = 5). Friends or social interaction with others also was noted to have a negative influence on health among released men and women (n = 5), and for some, family or friends did not have any influence on personal health of men and women released (n = 3).

For homeless men and women, food banks served as a primary resource for daily food intake. (n = 15). Shelter medical clinics also served as a safety net for healthcare among the homeless released men and women from county correctional facilities (n = 8). Personal safety in
homeless shelters can be a concern of men and women released (n = 3) and a homeless shelter environment can be detrimental toward maintenance of positive health (n = 7). Examples included living with others who were not cognizant of infection control procedures to guard against respiratory conditions (n = 4); limited access to indoors during the summer was viewed as not healthy (n = 1), and not allowing adequate sleep and rest (n = 12).

Other situational factors included the use of assistance programs, both through county and voluntary organizations (n = 5), and use of mental health services by men and women (n = 4). Although men and women (n = 19) described their daily diets provided by overnight shelters and churches that included two or three meals a day, homelessness also contributed to unhealthy eating (n = 5) as foods were high in calorie and carbohydrates and not as nutritious as eating fruits and vegetables. In addition, men and women (n = 5) made unhealthy food choices through purchase at local fast food places. For men and women who were both, homeless and not homeless, staying with eating a healthy diet was difficult or not a health-related decision (n = 9), i.e. choosing to eat at the Burger King or other fast food place. In addition to diet, homelessness also affected the ability to exercise because of hygiene resources and/or not offering a place to exercise (n = 2).

**Barriers to health promotion.** Additional barriers included healthcare access and cost. Cost was described as a barrier for released men and women (n = 16) as to whether they saw a physician as needed. For several persons (n = 3), the additional burden of cost, i.e. co-pays, medication, even with health insurance was a barrier. Although men and women (n = 23) may have healthcare coverage, healthcare access was difficult (n = 6); and, for men and women without health insurance (n = 7), access to services was particularly difficult. Men and women
described not knowing where to find needed healthcare resources (n = 3). Some were in the process of completing paperwork and administrative requirements to obtain health insurance coverage through state programs which was a challenge for released men and women (n = 4).

Generally, the lack of money for everyday living was described to be a barrier by men and women (n = 7) and some (n = 6) described themselves to be their worst enemy, as a barrier in promoting their own positive health. Overall, this study provided information regarding factors, i.e. personal, social, community, which can influence individual capacity for health promotion. Pender’s Health Promotion model includes ‘personal characteristics’ that can influence health promotion.

To date, one of the primary instruments used in measurement of health promotion based on Pender’s model is the Health Promoting Lifestyle Profile II (HPLP-II) that includes indicators of health responsibility, physical activity, nutrition, interpersonal relations, spiritual growth and stress management as empirical referents of health promotion (Walker, Sechrist, & Pender, 1987). With this 52 item instrument, “behavior motivated by the desire to increase well – being and actualize human health potential” is measured (Pender, Murdaugh & Parsons, 2006, p. 7). Although this instrument has established content, construct and criterion related validity and reliability, the dimensions measured are limited to constructs that may not be as relevant to this population. As indicated by data in this study, health promotion may be different, and include measures of risk behavior, i.e. illicit drug use, personal care or interest in self-maintenance of health concerns, that includes physical and mental health conditions.

In addition, factors that can influence health promotion may be different in this population than for men and women not having a history of incarceration, homelessness, or poverty.
This study suggests the need for additional development of valid and reliable instruments to measure health promotion among men and women with a correctional history.

**Clinical nursing practice.**

Clinical nursing practice can influence health promotion among men and women recently released from county correctional facility, either while incarcerated or when released back to the community. Health assessment and intervention in either setting can influence individual health behavior related to primary, secondary or tertiary prevention.

Jail inmates generally have shorter stays than those in state prisons and few substance abuse programs are provided in either jails or prisons (Linhorst, Dirks-Linhorst, Bernsen & Childrey, 2009). In this study, more than 50% of men and women had a history of incarceration four or more times. The mean number of days men and women who participated in this study spent time in jail with their most recent incarceration was 127 days or more than four months – an opportunity window for health education and case management. When in jail or prison, under the law, men and women are entitled to healthcare treatment as noted in the Estelle v Gamble case thirty years ago. The United States Supreme court has stated that federal, state and local governments have an obligation to provide care to men and women who are incarcerated and failure to provide care is a violation of an inmate’s constitutional rights (Moore, 2005). Clinical nursing staff is available on medical units housed within correctional facilities to meet healthcare needs of the inmate population. A health promotion focus includes a role for clinical nursing in correctional facilities to include primary, secondary and tertiary prevention. In addition, clinical nurses can assist and support efforts in care coordination as men and women are preparing for release back to communities.
Health education. Health education is a primary means of prevention. Men and women have cited the lack of health information concerning HIV risk reduction behavior as a barrier as they were awaiting release (Catz et al, 2012). In the study, both men and women expressed interest in learning more about safe behaviors with partners, how to communicate disclosure of HIV status, and the opportunity to acquire clean needles or condoms upon release. In another study, Zucker (2006) explored health beliefs and level of understanding among women with HIV or Hepatitis C. A knowledge gap regarding HIV or Hepatitis C was reported among women who participated in a focus group, and who wanted to know more about their illness.

Informal or formal class health education concerning primary prevention or care of existing health conditions can be a primary role for nurses working in a correctional facility or in the community. Other topics, rather than only those that introduce health risk to self or others, can be included. Topics pertinent to the correctional population can include information that can support individual efforts to stay healthy. Health awareness topics can include those pertinent to positive mental health, i.e. the effects of drug and alcohol, effective coping, anger management; as well, health awareness of physical care pertinent to body systems, i.e. colds and flu, hypertension, healthy eating, etc.

Care coordination. Discharge planning and community referral to county clinics prior to release can assist in obtaining needed preventive services. Similarly, community and public health nursing efforts have focused on care coordination of health disparate populations; however, specific research or other reports appear limited in focus concerning adult men and women with a history of incarceration. As nurses have a role in ‘discharge planning’ of men and
women leaving hospitals and/or other inpatient care settings, so too, care management can be a role for nurses working in correctional health.

Discharge planning to meet the health needs of offenders prior to community release is not well documented. Research describing the use of case management models for care, treatment and coordination of those persons with mental illness, for instance, is described with mixed results as related to decreasing recidivism, stabilization on medication, improvement in social functioning, less relapse to substance abuse, and improved quality of life (Essock et al., 2006; Kleinpeter, Deschenes, Blanks, Lepage, & Knox, 2006; Loveland & Boyle, 2007;).

Although care management has been an accepted role for nurses in various care settings and in managed care, only a handful of studies were identified which explored case management or discharge planning implementation related to treatment adherence among the correctional population (Flanagan, 2004; Wohl, et al, 2010). Development of models for linking healthcare services to this vulnerable population has begun (Miles & Cajina, 2006). Demonstration projects have demonstrated the feasibility of health screening in jails and prisons, but are still needed to be implemented on a larger scale in correctional facilities throughout the United States (Spaulding, Jacob Arriola, Hammett, Kennedy, & Tinsley, 2009).

Care management has been discussed and is a recognized strategy to assist vulnerable clients, who may be homeless, in the care of chronic physical conditions (Buchanan, Kee, Sadowski, & Garcia, 2009; Schumann, Nyamathi, & Stein, 2007; Zaller et al., 2008). Regarding the effects of a case management approach in working with men and women returning to communities in the care, coordination and treatment of chronic illness or other medical conditions, the jury still seems to be out as to the short and long term benefits (Myers, Zack &
Kramer, 2005). Only one study is noted where registered nurses have had responsibilities for care coordination of men and women leaving correctional facilities (Flanagan, 2004). Other studies either are silent or instead, if provided, are the responsibilities of other professional or non-professional staff members.

Relevant legislation has been enacted to better facilitate care and coordination of care among men and women with criminal histories. The Second Chance Act of 2007 signed by President Bush in 2008 provides a national focus of the importance of the re-entry process and offers financial support to states to develop programs that support community programs that may assist to decrease recidivism among the returning population (Spjeldnes & Goodkind, 2009). Nurse involvement in the design and implementation of programs that support and encourage health promotion, related to both medical and mental health prevention can make a difference.

In addition, the Patient Protection and Affordable Care Act (ACA) as of 2014 provides a provision for Medicaid expansion in states, allowing more men and women in need of healthcare coverage to become eligible for a state program and participation in state-based health exchanges. In various states, eligibility to participate in such a program has been limited to men and women without a felony conviction or criminal history. Beginning in 2014, Medicaid expansion programs will be available for many men and women released from correctional facilities (Phillips, 2012).

**Nursing Education.** Familiarity with professional nursing in correctional and/or community settings is influenced by the availability of clinical experiences while in school. Nursing students learn of their potential interests concerning their own career development while attending a nursing program.
Men and women who have a history of incarceration can be viewed from several dimensions. Generally, personal, social and economic factors associated with this population are similar to others where health disparity exists. In addition, the specific groups who have a history of incarceration have unique needs for nursing care, related to their specific mental and physical conditions that are seen in increasing numbers when compared to the general population. While many schools offer opportunities for clinical placement in a community health experiences, few schools offer opportunity for nursing student placement in local, county or federal correctional facilities or in the community specifically to address the health care needs of men and women with a history of incarceration.

Additional to student experience concerns, nursing faculty are prepared to focus teaching and research responsibilities while working with students in facilitating understanding of health disparate populations. However, nursing faculty are not generally familiar with correctional systems and the requirements of safety and security that are of primary importance in correctional facilities in order that staff, inmates and all other personnel remain safe and free from harm.

Implications of this study for nursing education are as follows:

1). Curricula integration related to the concept of health disparity can include men and women who have a history of incarceration. As more and more is known regarding the health of this population, and more than 10,000 men and women go through a revolving door of county corrections each day, raising awareness of students regarding the public health efforts needed in support and encouragement for healthy lifestyles, the importance of mental health and health awareness intervention among this population are important.
2) In order to encourage a learning environment for students at all levels, nursing faculty need to be supported in their clinical interest, development of curricula and research engagements that involve nursing of the correctional population, in the community or in correctional facilities. Support can be provided in training efforts and integration of varied clinical sites selected for student learning.

3) Nursing faculty with an understanding of men and women who go through a revolving door each day in local, state and federal correctional facilities continue to conduct nursing research in this area of focus. To date, there is limited research that focuses on aspects of health promotion among men and women with a history of incarceration.

**Recommendations for Nursing Research**

The results of this study highlight the specific factors, barriers and facilitators affecting health promotion among men and women recently released from county correctional facilities. Analysis of interviews conducted and additional data obtained through completion of a demographic survey indicate a personal transition period of change after incarceration. In this transition period, men and women were able to describe what health is, and what healthy and unhealthy means. As men and women having a correctional history are burdened with greater mental health disorders and physical illness when compared to the general population, they view their own health to have importance. In addition, barriers exist to health promotion, similar to other disparate men and women. Descriptive data exist through qualitative study regarding factors involved in health promotion among this population, however research is needed to begin to describe associations between these known personal, social and community factors and what each aspect has on personal health promotion.
Additional factors that may influence personal behavior and health promotion include 1) recognized personal need and motivation to receive the information, 2) the capacity for self-efficacy necessary to integrate the cognitive, affective or psycho-motor skills necessary to adopt a revised way of thinking about an aspect of health or integrate a life style behavior change and 3) freedom from barriers to access or integrate the new information. (Arras, Ogletree, & Welshimer, 2006; Becker & Stuifbergen, 2004; Kaewthummanukul & Brown, 2006; Shin, Hur, Pender, Jang, & Kim, 2006). To date, these factors relevant to the correctional population leaving county jails and living in communities has not been explored.

In particular as a number of men and women have mental health conditions related to addiction disorders, leading to repeat recidivism, it would be interesting to specifically focus on men and women with addiction disorders to identify what association, if any, can be described between addiction, barriers and personal coping ability during re-entry. As health problems continue at seemingly higher rates than in community populations, e.g. chronic illness, mental illness, risk behavior associated with communicable disease, substance / alcohol use, little is known about the effect situational or other factors have on the individual decision-making and health. Additional studies that explore health and factors involved with varying levels of disease prevention, i.e. primary, secondary, or tertiary, among the correctional community population is needed.

Recommendations for further research include:

1. Comparative research between men and women with a correctional history and the general population to explore differences associated with individual health promotion.
2. Intervention studies incorporating processes such as health education or care management, both while incarcerated and in the community, that can test as to the effect each has on individual outcomes of health promotion related behavior, i.e. smoking cessation, mental health outcomes of reduced depression and anxiety, secondary prevention aspects of diagnosis and treatment.

3. Development of valid instrumentation to reliably measure health promotion among men and women with a history of incarceration. For instance, the Health Promoting Life Style II instrument based on Pender’s model does not address aspects of health promotion important for this population, i.e. risk reduction, smoking, illicit drug use and / or excessive alcohol intake.

Nola Pender’s Health Promotion model identifies personal factors could include any biological, psychological or socio cultural factors. However, Pender (1996) states that “numerous personal factors exist [for instance], and that those factors to be included in any given study should be limited to the few that are theoretically relevant to explanation or prediction of a targeted behavior “(p.69). In addition, Pender’s research has focused on the identification of behavioral factors involved in individual efforts to stay healthy, and that same model can be useful in the study of persons who already are affected by disease or illness.

The effect of “perceived competence or self-efficacy to execute a given behavior increases the likelihood of commitment to action and actual performance of the behavior” has repeatedly been demonstrated in various research studies (Shin, Jang, & Pender, 2001; Shin et al., 2006). In Pender’s model, behavior- specific cognitions and affect represent a grouping of factors influencing individual health promotion, i.e. perceived benefits of action, perceived barriers to action, perceived self-efficacy, activity- related affect, interpersonal influences and situational
influences. Pender, Murdaugh, and Parsons (2002) describe this grouping to have “major motivational significance” and “constitute a critical core” for intervention. The study of these behaviors – specific cognitions and affect has not been studied in the correctional population. There may be a window of opportunity for brief or continuous intervention that can be affected by these factors.

4. Multivariate studies to identify predictors of successful health promotion, as represented by a specific behavior, i.e. medical treatment adherence, smoking cessation, healthy nutritional intake.

5. Additional qualitative studies that explore individual concepts of health promotion among selected men and women, those who i.e. smoke cigarettes, history of depression and or anxiety, and the effect of friendship or peer group on drinking or drug use.

6. Design of studies that look specifically at concepts represented in the Rediscovery of Self-Care or Pender’s Health Promotion in order to advance nursing theory development relative to men and women with a correctional history.

Differences may also exist in health promotion among men and women who have been incarcerated for shorter time periods (county detention) as compared to those having served longer sentences in federal and state prisons. In either case, empirical research to date is needed to understand preventive health behavior among the returning population – e.g. personal behavior directed toward early detection and screening, diagnosis and treatment, and restorative or rehabilitative in nature.
Conclusion

National studies of health and health promotion to date have included only non-institutionalized men and women, and not those in jails and prisons throughout the United States. Similarly, national studies have not included demographic information as to whether men and women living in a community after incarceration have an episode of one or more incarcerations. Only a handful of studies have been conducted that included interview directly with men and women living in the community after serving a time of incarceration in a county correctional facility, which have also been qualitative in nature. Data are limited that enables an improved understanding regarding preventive health behavior among the correctional population.

Studies are also limited that explore preventive health among the correctional population returning to communities. Studies have not examined factors - personal or otherwise - that are associated with preventive health practices, such as periodic health screening or maintenance of a healthy lifestyle, early disease detection or personal efforts to curtail the effects of chronic illness. This study, although limited to a small sample size, two counties in the northeast section of the United States, and specifically describing information regarding most men and women who are homeless after incarceration, is an initial step to identify factors involved in health promotion among this population.

To date, data regarding men and women in the criminal justice system have provided indices of chronic illness, infectious disease, and mental health disorders. Healthy People 2020 is a national agenda and serves as a blueprint for continuing support of clinical, educational and multi-disciplinary research efforts that encourage public health of all people in the United States. Also, as Healthy People 2020 specifically addresses the importance of alleviating health
disparity, or “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage”, this qualitative study has provided some information regarding factors that influence personal health and health promotion, defined as primary, secondary and tertiary health prevention among men and women who have a history of incarceration, having served time at a county detention center. In addition, this study has provided information as to how men and women directly, perceive their own health, what views they may have regarding their own ability to maintain health, or what factors are associated with individual health-related behavior.

Studies that describe personal challenges faced by returning men and women in community re-entry continue to be qualitative in nature – describing personal, social, and socioeconomic conditions reported among this population. As the prevalence of mental health, physical health and at-risk health behavior is higher in this population when compared to men and women living in the community not having a history of incarceration, this study contributes to nursing knowledge specifically applicable to the understanding of men and women with an incarceration experience that can further be considered when providing nursing care in jails and community health settings.

Knowledge gained through this study can be applied to individual one – to – one effort working with individuals, or support organizational design/ redesign of appropriate health programs for the returning population nationwide. Information gained through study can add to the sparse amount of knowledge that exists regarding health and factors that affect health among this population.
As more and more individuals are released from prison each year, various areas of health concern pertinent to this population have yet been unexamined, or are incomplete. Though this population does reflect similarity to other “vulnerable” populations, there are distinct differences and challenges that result from having the experience of incarceration and finding oneself released back into the community. These challenges are different for individuals within this population, i.e. moms, dads, Afro-American young males, women, known substance abuser, known history of mental health issues. As men and women return to communities nationwide after jail or prison, they seek living arrangements, look for employment, and again attempt to reestablish relationships with family and friends.

Within this population, both diversity and healthcare disparity does exist. Nursing has an opportunity to positively affect the lives of individuals, contribute in providing an understanding of community health challenges, and promote or encourage societal understanding of this population who have paid their dues and are on the road to productive citizenship.
Appendix A

Demographic Survey (revised 11/17/2012)

Study Number: ___________ Today’s Date: _____________ Male or Female: _______

1. What is your age?
   ___ Code age in years
   0 7 Don’t know / Not sure
   0 9 Refused

2. Which one or more of the following would you say is your race? (Check all that apply)
   1 White
   2 Black or African American
   3 Asian
   4 Native Hawaiian or Other Pacific Islander
   5 American Indian or Alaska Native
   6 Hispanic or Latino
   7 Mixed race
   7. Other [specify]________________

3. Are you…?
   1 Married
   2 Divorced
   3 Widowed
   4 Separated
   5 Never married or
   6 A member of an unmarried couple
4. **What is the highest grade or year of school you completed?**

1. Never attended school or only attended kindergarten
2. Grades 1 through 8 (Elementary)
3. Grades 9 through 11 (Some high school)
4. Grade 12 or GED (High school graduate)
5. College 1 year to 3 years (Some college or technical school)
6. College 4 years or more (College graduate)

5. **Are you currently...?**

1. Employed for wages
2. Self-employed
3. Out of work for more than 1 year
4. Out of work for less than 1 year
5. A Homemaker
6. A Student
7. Retired or
8. Unable to work

6. **Is your annual household income from all sources—**

1. Less than $10,000
2. Less than $15,000
3. Less than $20,000
4. Less than $25,000
5. $25,000 to less than $35,000
6. $35,000 to less than $50,000
7. $50,000 to less than $75,000
8. $75,000 or more

7. **What county do you live in?**

_ _ _ __________Name of County  ____________ State

7. Don’t know / Not sure
9. Refused

8. Have you spent time in jail or prison? □ Yes □ No

If yes, most recent release date from jail or prison? ______________________

Most recent type of offense/s: □ Felony □ Misdemeanor □ Combination

Length of time in jail (most recent incarceration)? ______________________

9. How many times have you been in jail or prison?
□ No time □ 1 time only □ 2-3 times □ 4 – 6 times □ more than 6 times

10. Do you have health problems? □ Yes □ No

If yes, please indicate on list below:

□ Diabetes □ Asthma □ HIV - AIDS □ Hepatitis B □ heart attack
□ Depression □ Substance / Drug Use □ Hepatitis C □ circulation problems to legs
□ Alcohol Use □ renal (kidney ) disorder /failure □ angina (heart pain)
□ heart disease □ stroke

Other ______________________

Health Status

11. Would you say that in general your health is—?

1 Excellent
2 Very good
3 Good
4 Fair
5 Poor

12. Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare or Indian Health Services?

1 Yes
2 No
13. **In the past year, have you received health care at a**
   1. physician’s office
   2. community clinic
   3. Emergency Room
   4. Other health care setting: ____________________________________________

14. **Do you have one person you think of as your personal doctor or health care provider?**
   If “No,” ask: “Is there more than one, or is there no person who you think of as your personal doctor or health care provider?”
   1 Yes, only one
   2 More than one
   3 No
   7 Don't know / Not sure
   9 Refused

15. **Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?**
   1 Yes
   2 No
   7 Don’t know / Not sure

16. **About how long has it been since you last visited a doctor for a routine checkup?** A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition.
   1 Within past year (anytime less than 12 months ago)
   2 Within past 2 years (1 year but less than 2 years ago)
   3 Within past 5 years (2 years but less than 5 years ago)
   4 5 or more years ago
17. About how long has it been since you last visited a dentist for a routine checkup? A routine checkup is a general dental exam, not an exam for a specific injury, illness, or condition.
   1 Within past year (anytime less than 12 months ago)
   2 Within past 2 years (1 year but less than 2 years ago)
   3 Within past 5 years (2 years but less than 5 years ago)
   4 5 or more years ago
   7 Don’t know / Not sure
   8 Never
   9 Refused

**Tobacco Use**

18. Have you smoked at least 100 cigarettes in your entire life? NOTE: 5 packs = 100 cigarettes
   1 Yes
   2 No [Go to Q22]
   7 Don’t know / Not sure
   9 Refused

19. Do you now smoke cigarettes every day, some days, or not at all?
   1 Every day
   2 Some days
   3 Not at all
   7 Don’t know / Not sure
   9 Refused

20. During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?
   1 Yes [Go to Q21]
21. How long has it been since you last smoked a cigarette, even one or two puffs?
0 1 Within the past month (less than 1 month ago)
0 2 Within the past 3 months (1 month but less than 3 months ago)
0 3 Within the past 6 months (3 months but less than 6 months ago)
0 4 Within the past year (6 months but less than 1 year ago)
0 5 Within the past 5 years (1 year but less than 5 years ago)
0 6 Within the past 10 years (5 years but less than 10 years ago)
0 7 10 years or more
7 7 Don’t know / Not sure
9 9 Refused

22. Do you currently use chewing tobacco, snuff, or snus every day, some days, or not at all? NOTE: Snus (Swedish for snuff) is a moist smokeless tobacco, usually sold in small pouches that are placed under the lip against the gum.
1 Every day
2 Some days
3 Not at all

Alcohol Consumption
23. During the past 30 days, how many days per week or per month did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage or liquor?
1 _ _ Days per week
2 _ _ Days in past 30 days
8 8 8 No drinks in past 30 days [Go to next section]
7 7 7 Don’t know / Not sure [Go to next section]
9 9 9 Refused [Go to next section]
24. One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor. During the past 30 days, on the days when you drank, about how many drinks did you drink on the average?

NOTE: A 40 ounce beer would count as 3 drinks, or a cocktail drink with 2 shots would count as 2 drinks.

<table>
<thead>
<tr>
<th>Number of drinks</th>
<th>7</th>
<th>7 Don’t know / Not sure</th>
<th>9</th>
<th>9 Refused</th>
</tr>
</thead>
</table>

25. Considering all types of alcoholic beverages, how many times during the past 30 days did you have \( X \) \( \{\text{CATI } X = 5 \text{ for men}, X = 4 \text{ for women}\} \) or more drinks on an occasion?

<table>
<thead>
<tr>
<th>Number of times</th>
<th>8</th>
<th>8 None</th>
<th>7</th>
<th>7 Don’t know / Not sure</th>
<th>9</th>
<th>9 Refused</th>
</tr>
</thead>
</table>

26. During the past 30 days, what is the largest number of drinks you had on any occasion?

<table>
<thead>
<tr>
<th>Number of drinks</th>
<th>7</th>
<th>7 Don’t know / Not sure</th>
<th>9</th>
<th>9 Refused</th>
</tr>
</thead>
</table>
Appendix B

Focused Interview Guide

Study Number: ___________ Today’s Date: _______________ Male or Female: _____

I. How would you define being healthy?
Probes:
A. How do you think of health?
B. Think about someone who is healthy. What makes them healthy?
C. Think about someone who is not healthy. What makes them unhealthy?

II. History of health status and present view of own health
Probes:
A. How healthy do you think you are?
B. How would you describe your own health?
C. How would you describe your physical health status before going to jail?
D. How would you describe your mental health status before going to jail?
E. How would you describe your physical health today?
F. How would you describe your mental health today?
G. How important is your health?
H. What helps you to take care of your health?

I. Description of lifestyle related? Tell me about your ............
• diet yesterday?
• usual physical activity?
• smoking habits?
• drinking habits/ alcohol
• use non-prescribed drugs?
• description of visits with healthcare providers?
• diagnostic tests for illness? Physical exam? Mammograms?
• cholesterol checks? Blood pressure checks?
• immunizations/ flu vaccine?
• protected sex/use of condoms?
• mental health? Stress? Other?
• taking prescribed medication?
• other activities that help you to take care of yourself?

Focused Interview Guide (continued)

K. How do you maintain your health?
L. If you are sick, how do you restore your health?

III. What helps you take care of your health?
A. Personal Factors (biological, psychological or socio cultural factors)
B. What things do you do to stay healthy?
C. Social factors (family, peers, providers) : What influence do others have to help you take care of your health? Or not?
D. Community influences: (geography, community services)
   How does living in your community help you take care of your health?

IV. What things stand in your way from being healthy?
Personal? What things do you do that are unhealthy?
Social? Family? Friends?
Housing?
Employment?
Other Environmental Circumstances?

V. What help do you need to get healthy? Stay healthy?
Probe questions:
A. How do you stay healthy? Are there specific activities that you do daily? Less frequently?
B. How do you think you can affect your health? If you take care of yourself now by doing certain things, what difference do you think this would make in your life?
C. What do you think you can do for yourself to stay healthy?
D. On a scale of 1 – 10, (10 being the highest), where do you rate your health now? In 6 months? In one year?

VI. How do you think others can help you stay healthy?
A. How do others help you to take care of yourself? Or not take care of yourself?
   B. How do other persons influence you in taking care of your health
Appendix C

Invitational Flyer to participate

Site 1 and Site 2

Men and women are invited to participate in a nursing research study.
This study is being conducted by Terri Kapetanovic RN MSN, doctoral candidate in nursing, at
The Catholic University of America.

The aim of this study is to learn more about you and how you take care of your own health. The
knowledge gained from this research will assist nurses, healthcare providers, and community
support personnel to have a better understanding of personal factors involved in maintaining
health and identify ways to better assist persons in maintaining a positive health status.

Men and women over the age of 18 are invited to participate if you have spent time in jail (may
be anywhere from a five days to more than one year); also, if you have been released from jail
more than 5 days ago and less than one year ago.

Participation in this study will require an interview with a registered nurse and will be scheduled
here at the OAR office. Less than 60 minutes of your time will be required.

At time of interview completion, you will receive a twenty dollar gift card of your choice to any
of the following: Target stores or DC area metro rider Pass (Smart card and $20.00).
To learn more about this study, please contact by email or phone:
Terri Kapetanovic RN MSN
PhD Candidate
Researcher
The Catholic University of America
School of Nursing
49kapetanovi@cardinalmail.cua.edu
An Invitation to
Men and women are invited to participate in a nursing research study.

The aim of this study is to learn more about you and how take care of your own health. The knowledge gained from this study will assist nurses, healthcare providers, and community support personnel to have a better understanding of individual health and factors involved in maintaining health, as described among returning men and women.

This study is being conducted by Terri Kapetanovic RN MSN, doctoral student in nursing, at The Catholic University of America.

Men and women over the age of 18 are invited to participate if you speak English and

• have been released from a county / city detention center (i.e. Baltimore city, Anne Arundel, Baltimore county, other county detention center) at least 5 days ago and in the last 18 months and

• have been in a city or county detention center one or more times, for more than 5 days and no longer than two years;

Participation in this study will require a scheduled interview with a registered nurse; less than 60 minutes of your time will be required.
When you complete the interview, you will receive either:
  • $20.00 Target gift card
  Or
  • Baltimore light rail card ($20.00 value)

To learn more about this study, please contact by email or phone:

Terri Kapetanovic RN MSN
Nurse Researcher
The Catholic University of America
School of Nursing

Call or email today!

240 – 516 - 8509
terrikcua@gmail.com
Appendix D

THE CATHOLIC UNIVERSITY OF AMERICA

620 Michigan Ave., N.E. * Washington, DC 20064

CONSENT FORM – KAPETANOVIC T. DISSERTATION STUDY (revised 11/17/2012)

Title of Study: A Descriptive Exploratory Study of Health Promotion Among Men and Women Released from a County Detention Center

Investigator: Terri Kapetanovic, MSN, RN CPHQ CMCN, PhD Candidate, School of Nursing, The Catholic University of America, Washington, DC

Supervisor: Dr. Janice Agazio PhD RN Telephone: 202-319-5719

Questions: Terri Kapetanovic RN MSN; E-mail: 49kapetanovic@cardinalmail.cua.edu

Sponsor: The Catholic University of America

Why is this Research Study being Done?
This is a study about health and how you take care of yourself to stay healthy. The purpose of the study is to learn about you and what you do to take care of yourself to stay healthy.

Terri Kapetanovic is a registered nurse asking you to volunteer to participate in this study. She is a doctoral student at The Catholic University of America (CUA). This study has been approved by the Institutional Review Board (IRB) at Catholic University. Study participation is located at the Offender Aid and Restoration offices (OAR) in Arlington, Virginia. Men and women with a history of incarceration are asked to participate in this study until 35 persons agree to be included.

Procedure:
You will be asked to participate in a tape-recorded interview-taking place with a nurse researcher in a private and confidential setting. Interview questions will tell us about you, your health and how you care for yourself to stay healthy. You will be given a study number. Your name and social security number will not be used on any of the question forms in this study.

You will be asked some questions about your race, age, school grade completed, job, marriage. You will be asked about your health. You will be asked to describe your health status and additional questions related to taking your medication, your dietary habits and if you visit your health provider or physician. You will be asked to describe how you feel about your ability to care for your health.

Answering these questions should take about 45 minutes to one hour. You will only do this one time only. If you have difficulty answering the questions or choose not to answer the questions, that is your right. The nurse researcher will be available to answer any questions regarding the study, review and collect the information.

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What risks or discomforts could I experience in this study?
There is minimal risk or chance of discomfort while participating in this study. The questions or statements that you answer are personal. You may feel uncomfortable in answering them or they may cause you to worry. Worry may be a risk to mental or emotional health. The nurse researcher does not have a relationship with your healthcare provider. If questions or worries about the questions you will answer arise, you can contact your physician or other healthcare provider to discuss.

The interview will take about 45 minutes that may be an inconvenience. If you are concerned about your health, you can talk with the research nurse or your doctor.

What about my privacy?
Anything you answer during the interview is private. We will do everything we can to protect your privacy as a participant in this research study and the confidentiality of the research information. Sometimes an outside agency may check the forms to make sure aspects of the research process are carried out as according to an approval process. The findings of the study may be talked or written about, but your personal information will always be kept private. This means that no one but the researcher will know who you are or that you took part in this study.

The research nurse will keep your privacy and the privacy of the research record. Any information that identifies you will be protected. Your name and the names of others who participate in the study and / or study numbers will be kept in a locked file.

All information collected during this study will be stored under lock and key or in a password protected computer file. These records will be kept secure for 5 years following the study, and afterwards the records will be destroyed. If the results of this study are given in nursing journals or at medical / nursing meetings, your name will not be used.

We will protect any information you share with us as you participate in this research study. We will keep the information in a locked cabinet in a secure location. Research information that is collected will not have your name on it.

In order to check that we are conducting research properly, government agencies may access information that could identify you. For example, the following groups may inspect research records:

- The Office of Human Research Protections in the US Department of Health and Human Services
- State agencies such as the Department of Public Health
- Institutional Review Board of The Catholic University of America

Will you benefit from being in this study?
You may or may not benefit from being in this study. What we learn from this research may help you and others understand your health in the future.

What options other than this study are available?
This study does not involve treatment; therefore, there are no treatment alternatives.
Will there be any costs to me?
There will be no cost to you to participate in this study. Participation in this research project will not affect any of services that you may be receiving.

Will you receive any compensation?
Yes. After completion of the interview, that require an hour or less of your time, you will receive a twenty ($20.00) dollar gift card to Target department store or a Metro Smart card with fifteen dollar ($15.00) rider amount added.

You can withdraw your permission at any time. You will not be able to take back any information that has been used or shared.

If you do not sign this voluntary consent form to participate in this study, you cannot be part of the research study.

You can revoke your voluntary consent at any time. To do this, you can contact Terri Kapetanovic RN MSN at (phone) 301 438 7531 or email at 49kapetanovi@cardinalmail.cua.edu.
If you revoke your voluntary consent to participate in the study, you cannot continue to be in the study. Terri Kapetanovic may continue to use any information that has already been collected and combined with information from other participants. However, no new information will be collected.

If you revoke your voluntary consent to participate in this study, you will continue to receive all the services that you are eligible for.

The Catholic University of America is the sponsor of this study and your information may be disclosed to The Catholic University of America or its representatives. We will not share this information unless there is agreement to keep this information confidential and to use it only for purposes related to the study. The information disclosed will not include any identifiers. The information will be unidentified.

Whom should I contact if I have study concerns?
Whom should I contact if I have study concerns? If you have any questions about the study, please contact:

Terri Kapetanovic RN MSN
301 – 438-3135 (local phone)
49kapetanovi@cardinalmail.cua.edu (email)

If you experience a complication or injury that you think may be related to this study, please contact:

Terri Kapetanovic RN MSN
301- 438 – 3135 (local phone)
49kapetanovi@cardinalmail.cua.edu (email)
If you would like to talk about your rights as a research participant, or wish to speak with someone directly not involved in the study, please contact:

Janice B. Griffin Agazio, PhD, CRNP, RN
School of Nursing, Associate Professor
The Catholic University of America
(phone) 202-319-5719 or
(email) agazio@cua.edu
Washington, DC

Statement of Voluntary Consent

I have read this form. I have been told what to expect if I take part in this study, including risks and possible benefits. I have had a chance to ask questions and have had them answered to my satisfaction. I know I can choose or refuse to be in this study. The results of this study may be published, but my name will not be revealed.

In case there are medical problems or questions, I have been told that I can call the study nurse, Terri Kapetanovic at 301 438 3135 (local phone).

I understand the explanations of my rights as a study subject and I freely consent to take part in this study. I understand the explanation of what the study is about and how and why it is conducted.

I will receive a signed copy of this consent form.

By signing below, I am giving my permission to be in this research study.

Participant’s Name: (Print) __________________________________________

Signature: __________________________________________ Date: __________________________

Study Representative Statement:
I have explained the purpose of the research, the study procedures, the possible risks and discomforts, the possible benefits, and have answered all questions to the best of my ability.

Study Representative’s Name (Print): __________________________

Signature: __________________________________________ Date: __________________________

Any complaints or comments about your participation in this research project should be directed to the Secretary, Committee for the Protection of Human Subjects, Office of Sponsored Programs and Research Services, The Catholic University of America, Washington, DC 20064; Telephone: 202-319-5218
Appendix E:

Memorandum of Understanding

Memorandum of Understanding

Name of study: A descriptive exploratory study of health promotion of men and women released from a county detention facility

Researcher: Terri Kapetanovic RN MSN CP IIQ CM CN, doctoral candidate, The Catholic University of America, Washington DC, School of Nursing

Purpose and Description of the study. The overall purpose of study is to 1) explore health and health promotion of men and women recently released 10 days to one year from an adult county detention center, and 2) explore the personal, social and community factors which may act as barriers and facilitators in health promotion among men and women released from an adult county detention facility. The main questions for this study are 1) How is health described by men and women recently released from an adult county detention center? 2) How do men and women experience health after recent release from an adult county detention center? 3) What personal strategies to promote, maintain or restore health are described among men and women recently released from an adult county detention center? 4) What personal, social or community factors influence health promotion, i.e. primary, secondary and tertiary prevention as described by men and women released from an adult county detention facility? 5) What barriers or facilitating influences to health promotion, i.e. primary, secondary and tertiary prevention, as described by men and women recently released from an adult county detention center?

This study will be carried out as a doctoral dissertation research.

Men and women who have been released from a county detention of greater than 10 days and less than one year, will be invited to participate through completion of surveys.

The location of the interview will be at OAR - Arlington office; the time required will be 45 – 60 minutes.

Participant criteria:

1. release from a county detention center greater than 10 days and up to one year
2. ability to understand and speak English - as indicated by self report
3. willingness to participate in a 45 - 60 minute interview

OAR - Arlington understands and supports the purpose and description of the study. OAR - Arlington will support this study by facilitation and/or dissemination of information among potential volunteers who meet inclusion criteria to participate (as above).

Signature

Date

Print Name

Chief Operating Officer

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Memorandum of Understanding (draft)

Name of study: A descriptive exploratory study of health promotion of men and women released from a county detention facility

Researcher: Terri Kapetanovic RN MSN CPHQ CMCN, doctoral candidate, The Catholic University of America, Washington DC, School of Nursing

Purpose and Description of the study. The overall purpose of study is to 1) explore health and health promotion of men and women recently released 5 days to one year from an adult county/city detention center, and 2) explore the personal, social and community factors which may act as barriers and facilitators in health promotion among men and women released from an adult county/city detention facility. The main questions for this study are 1) How is health described by men and women recently released from an adult county/city detention center? 2) How do men and women experience health after recent release from an adult county/city detention center? 3) What personal strategies to promote, maintain or restore health are described among men and women recently released from an adult county/city detention center? 4) What personal, social or community factors influence health promotion, i.e. primary, secondary and tertiary prevention as described by men and women released from an adult county/city detention facility? 5) What barriers or facilitating influences to health promotion, i.e. primary, secondary and tertiary prevention, as described by men and women recently released from an adult county/city detention center?

This study will be carried out as a doctoral dissertation research.

Men and women who have been released from a county/city detention of greater than 5 days and less than one year, will be invited to participate through interview completion of surveys.

The location of the interview will be at Arundel House of Hope or other confidential setting as agreed to by the volunteer participating in the study. The time required for interview will be 30 – 45 minutes.

Participant criteria:

1. release from a county/city detention center greater than 5 days and up to one year prior to the study
2. most recent incarceration was 2 years or less time
2. ability to understand and speak English, - as indicated by self report
3. willingness to participate in a 30 - 45 minute interview

Arundel House of Hope understands and supports the purpose of the study and agrees to facilitate and/or disseminate flyers among potential volunteers who meet inclusion criteria and also, support the interview process by provision of office space, if available.

Signature
Asia Ward

Date
2/15/2013

Print Name
Bibliography


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Deborah Shelton, PhD, RN, NE-BC, CCHP, FAAN
Professor, School of Nursing
Director, Center for Correctional Health Networks - CCHNet
University of Connecticut
231 Glenbrook Road
Storrs, CT 06269

Terri Kapetanovic RN MSN CPHQ
Doctoral Candidate, School of Nursing
The Catholic University of America
Washington DC

April 10, 2014

Dear Terri

You have my permission to reprint "Rediscovery of Self-Care: A Model for Nursing Care of Persons with an Incarceration Experience" in your doctoral dissertation,

A descriptive exploratory study of health promotion among men and women released from a county detention center

The citations include


Best regards,

[Signature]

Deborah Shelton, PhD, RN, NE-BC, CCHP, FAAN
Request for Permissions

Re: Request for permission

Nola Pender <npender@umich.edu> Tue, Feb 25, 2014 at 8:45 PM

To: Theresa Kapetanovic <49kapetanovi@cardinalmail.cua.edu>

Dear Theresa:

You have my permission to reprint the Health Promotion Model in your dissertation. I would suggest that you cite the most recent edition of our book to make your references as current as possible. Health promotion in nursing practice is now in its 6th edition.

Wishing you good health,

Nola Pender