How the Criminal Justice System Can Contribute to Eliminating Inequities in Healthcare at Two Pivotal Times: While Incarcerated, and During Reentry into the Community

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Abstract
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How the Criminal Justice System Can Contribute to Eliminating Inequities in Healthcare at Two Pivotal Times: While Incarcerated, and During Reentry into the Community

By

Karen Ann Buck

Submitted in partial fulfillment of the requirements for the degree
Doctorate of Education in Executive Leadership

Supervised by
C. Michael Robinson Ed.D.
Committee Member
Christine Braunberger Ph.D.

Ralph C. Wilson, Jr. School of Education
St. John Fisher College

December 2018
Dedication

I dedicate this dissertation to three extraordinary men in my life who feed my spirit and nourish my soul. My “boys” Erich and Matthew, and my husband Thomas, who remind me that “life is not about waiting for the storm to pass, it’s about learning how to dance in the rain.” (Vivian Greene, 2006). I’d also like to acknowledge the support and friendship of my loving sisters, Jo-Ann and Jennifer. Words cannot express how grateful I am to have all of you in my life.

I also dedicate this to my parents, grandmother, and brother. Although death has separated us physically, faith and love have bound us eternally. I miss them all very much and am blessed to have had them in my life.

I would also like to thank my Dissertation Chairperson, Dr. Michael Robinson, my Committee Member, Dr. Christine Braunberger, my Editor, Dr. Cynthia Smith, and my advisor, Dr. Linda Evans.
Biographical Sketch

Karen Ann Buck is the Director of Nursing at Syracuse Community Health Center, a federally funded health center located in Syracuse New York. Prior to joining Syracuse Community Health Center, Ms. Buck was the Contract Compliance Administrator for Onondaga County Health Department.

Ms. Buck received her BSN from Syracuse University and her Master of Science from New School of Social Research. In addition, she obtained an MBA from Columbia College in Syracuse New York. She entered the St. John Fisher College’s Ed.D. Program in Executive Leadership where she pursued research in how the criminal justice system can contribute to eliminating inequities in healthcare under the guidance of Dr. Michael Robinson, and Dr. Christine Braunberger, successfully defending her dissertation August 28, 2018.
Abstract

The purpose of this qualitative study was to explore and understand, from the perspective of the jail administrator, the elements required for a comprehensive healthcare program for those incarcerated and during reentry into the community. Research confirms that a comprehensive, replicable healthcare model for services while incarcerated, and a reentry program that recognizes both the medical and social needs of the incarcerated are beneficial for the individual, and the community. In this qualitative descriptive study, the intention was to add to the body of knowledge; the elements required to provide comprehensive medical and social services while incarcerated and when transitioning back into the community, including the broad collective challenges that exist with implementation and sustaining these efforts. The topic was explored through open-ended inquiry utilizing a theoretical framework of life course theory. Three themes emerged from the data derived from the semi-structured interviews with six jail administrators of short-term correctional facilities in New York State: (a) bare minimalism, (b) societal truths, and (c) resource realities. These three themes propel this study’s implications and suggestions for practice. The bare minimalist approach to providing healthcare services while incarcerated and during reentry into the community is further exacerbated by societal truths of righteousness justified through resource realities. This research yielded recommendations for further research to ensure social welfare is maximized and policy revisions are informed by social justice, and lastly, improved practice be informed by a synthesis of available evidence.
# Table of Contents

Dedication ........................................................................................................................................ iii

Biographical Sketch .................................................................................................................. iv

Abstract ...................................................................................................................................... v

Table of Contents ................................................................................................................... vi

List of Tables ........................................................................................................................... ix

Chapter 1: Introduction .......................................................................................................... 1

  Problem Statement .............................................................................................................. 3
  Theoretical Rationale ......................................................................................................... 6
  Statement of Purpose and Potential Significance of the Study .............................................. 8
  Research Questions ........................................................................................................... 9
  Chapter Summary ............................................................................................................ 10

Chapter 2: Review of the Literature ...................................................................................... 12

  Introduction and Purpose ................................................................................................. 12
  Review of Literature ......................................................................................................... 12
  Conclusion ......................................................................................................................... 39

Chapter 3: Research Design Methodology .......................................................................... 41

  Introduction ....................................................................................................................... 41
  Research Questions .......................................................................................................... 42
  Research Context .............................................................................................................. 43
  Research Participants ....................................................................................................... 44
Instruments Used in Data Collection ................................................................. 46
Procedures for Data Collection and Analysis ..................................................... 47
Summary .............................................................................................................. 49

Chapter 4: Results ............................................................................................. 50
Research Questions ............................................................................................ 50
Data Analysis and Findings ............................................................................... 50
Research Question 1 ......................................................................................... 53
Research Question 2 ......................................................................................... 57
Research Question 3 ......................................................................................... 61
Summary of Results ......................................................................................... 65

Chapter 5: Discussion ....................................................................................... 67
Introduction ....................................................................................................... 67
Implications of Findings .................................................................................... 68
Recommendations ............................................................................................. 71
Limitations ....................................................................................................... 77
Conclusion ....................................................................................................... 78
References ....................................................................................................... 84
Appendix A ....................................................................................................... 91
Appendix B ....................................................................................................... 92
Appendix C ....................................................................................................... 93
Appendix D ....................................................................................................... 95
Appendix E ....................................................................................................... 96
Appendix F ....................................................................................................... 98
## List of Tables

<table>
<thead>
<tr>
<th>Item</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 4.1</td>
<td>Summary of Changes and Themes</td>
<td>53</td>
</tr>
</tbody>
</table>
Chapter 1: Introduction

The United States represents 5% of the world’s population and 25% of the world’s prisoners, or an estimated 2.2 million individuals (Collier, 2014). State and federal prisons house inmates sentenced to more than 1 year (Dumont, Brockmann, Dickman, Alexander, & Rich, 2012). Jails and prisons detain individuals charged with and/or convicted of a crime. Jails fall under the jurisdiction of a county or municipality. Additionally, jails house a larger population of those not yet convicted and those sentenced to less than 1 year (Dumont et al., 2012). While incarcerated, individuals rely on the correctional facility to provide healthcare (Wilper et al., 2009).

Correctional healthcare was not a major concern for policy makers, courts, or the corrections departments until the mid-20th century (Kinsella, 2004). In the 1970s, ethical, health, and legal issues were the identified precursors that forced correctional healthcare into the spotlight (Kinsella, 2004). In 1976, the United States Supreme Court decision in Estelle v. Gamble found that deliberate indifference to the medical needs of those incarcerated constitutes a violation of the Eighth Amendment to the United States Constitution (Smith & Braithwaite, 2016). This case defined the guidelines for the correctional healthcare systems (Kinsella, 2004).

Violation of the Eighth Amendment occurs if an inmate is denied or experiences unreasonable delayed access to a physician for a diagnosis or treatment, failure to administer treatment prescribed by a physician, and/or denial of professional medical judgement (Anno, 2009). Under Estelle v. Gamble, jails must provide medical care that
meets the standards of healthcare that others in the community would experience (Marks & Turner, 2014). Despite this ruling, 2.2 million incarcerated Americans who depend on the jail for healthcare continue to face limited access to medical care (Wilper et al., 2009).

Most correctional healthcare services provided in the United States are predicated on an infectious disease control model adopted from the public health sanitation movement (Golembeski & Fullilove, 2005). The public health benefits of incorporating the 10 essential public health functions as a framework to improve correctional healthcare services is supported by research (Winterbauer & Diduk, 2012). A disconnect exists between correctional healthcare and public health departments in diagnosis and in planning delivery of care for inmates and those released into the community with an infectious disease (Wilper et al., 2009).

The legal stipulation for providing healthcare to those incarcerated was established in 1972, however, some of the most compelling reasons to improve correctional healthcare is based on ethics (Anno, 2009). After the passage of Medicare and Medicaid legislation on national health insurance during the 1960s and 1970s citizens supported access to quality healthcare as a right, not a privilege (Anno, 2009). A poignant statement from the U.S. Bureau of Prisons’ on jails states:

No jail is too small to provide adequate medical care. Whether the jail holds one inmate or a thousand, the administrator has a responsibility to protect the health of his prisoners and to safeguard the health of the community. He cannot meet this responsibility if he does not provide medical care for prisoners. Certainly, no jail administrator has the right to impose a death sentence, and failure to provide for
the medical needs of those in custody is equivalent to pronouncing a death sentence … (Papas, 1972, p. 140).

The literature on this topic presents a discussion of several barriers and challenges faced by jail administrators with the provisions for medical care of those incarcerated. Few studies in the literature were found that have examined the challenges jail administrators are currently facing with providing comprehensive healthcare for those who are incarcerated and during reentry into the community. A majority of the studies have addressed standalone issues such as: (a) rate of chronic illness and access to care, (b) re-entry into the community, (c) fiscal impact of incarceration, and (e) leadership.

Many of the studies evaluated quantitative data with a primary focus on evaluation of one segment of service as opposed to examining services collectively. Additionally, most of the research provides suggestions on how to structure that segment of service with little or no follow-up to determine whether these proposed strategies were successful in similar environments. Lastly, few researchers have queried the jail administrator to identify what is needed to provide comprehensive medical services to those incarcerated and during reentry into the community.

**Problem Statement**

The United States Supreme Court upholds that inmates are the only class of people in the United States constitutionally given the right to healthcare (Kinsella, 2004). Secondary to the substantial racial, ethnic, and health disparities consistent with those incarcerated in the United States, it is important to address the relationship between healthcare and health disparities (Wilper et al., 2009). The health and social vulnerabilities of the inmate population distinguish these inmates from the general
population (Freudenberg & Heller, 2016). Forty years after the Estelle v. Gamble ruling, the practical application of this decision is still debated as correctional healthcare often fails to meet the needs of those incarcerated (Wilper et al., 2009).

Comprehensive medical and support services provided to individuals when incarcerated, and when those ex-offenders return to the community, the healthcare services they receive lack consistency, recognition, and replication on a national level. The standard of care for individuals incarcerated with an illness is not equal to the services available in the community (Cloud et al., 2014).

Greater than 40% of jail inmates with a chronic condition were not taking previously prescribed medication because a medical practitioner visit did not occur during incarceration. As such prescriptions were not reevaluated or renewed (Bureau of Justice, 2012). Research is proposed to improve access to services in communities with high rates of incarceration (Kulkarni et al., 2010). However, there is limited data available nationally on the accessibility of healthcare provided to prisoners (Wilper et al., 2009).

Research efforts have primarily focused on the evaluation of infectious disease (Dumont, Gjelsvik, Redmond, & Rich, 2012). Significant variations in care exists in both prison and jail settings. Additionally, evaluation of those services is challenged as treatment varies from state to state (Dumont et al., 2012). Mears and Cochran (2012) indicate that the extent of the healthcare and services gap among the incarcerated and ex-offender is unknown. These researchers argue that without an evidence-based needs assessment, both the correctional facility and the community cannot effectively allocate
scarce resources. Additionally, Mears and Cochran (2012) stress the need for a cross-
nation sample to accurately assess empirical claims of service gaps.

Serious adverse outcomes are directly related to inadequate healthcare in the
correctional setting (Dumont et al., 2012). Massoglia (2008) posits that incarceration
exerts negative effects on health. A disproportionate number of prisoners are minorities
from low-income communities with inadequate healthcare resources (Macmadu & Rich,
2015). Socioeconomic disparities plague the incarcerated individual, their families and
their communities. Underserved communities remain the primary recipient of the ex-
offender and their health afflictions (Kulkarni et al., 2010). An estimated 95% of those
incarcerated will return to their communities with the consequences of their health
problems (Macmadu & Rich, 2015).

In New York State, the Commission of Correction (SCOC), is responsible for
oversight of the 63 county jails (Ochs, 2015). The annual budget of $2.9 million covers
inspections of the jail facilities; however, evaluation of medical care is limited to deaths
and grievances filed by inmates alleging inadequate care (Ochs, 2015). Inmates in New
York State have infection rates 8 to 10 times higher than those in the community
(Sanchez, 2005). In addition, New York State jails and prisons fail to provide education
to inmates on the benefits of testing for chronic and infectious diseases, treatment of
disease and access to specialists (Ochs, 2015). The overarching theme present in New
York State prisons and jails is a lack of uniformity and treatment and overall substandard
delivery of care (Sanchez, 2005).

Furthermore, New York State has the seventh-largest state jail population in the
United States and reports 54,235 individuals under custody in 2013 (Shalev, Chiasson,
Dobkin, & Lee, 2011). Excluding New York City, there are 63 county jails representing 57 counties in the State. Data from 2007 indicates 182,779 inmates where admitted into New York county jails (Shalev et al., 2011). On average 590,000 inmates are released annually nationwide, with approximately 25,000 discharged in New York State (Bureau of Justice Statistics, 2015). Research supports the concept of the best reentry programs begin during incarceration. These programs provide support and services throughout the release and the reintegration into the community (Woods, Lanza, Dyson, & Gordon, 2013).

In sum, the wide variation in the quantity and quality of correctional healthcare that occurs within the jail system presents challenges with evaluation of services. In addition, no research has explored from the perspective of the administrator, the elements required for a comprehensive healthcare program during incarceration and when transitioning back into the community. To address these lacks and add to the body of knowledge on this topic, this study seeks to gain a deeper understanding of the challenges and barriers with the implementation of identified elements that will be derived from this study from the perspective of the jail administrator.

**Theoretical Rationale**

The life course perspective commonly referred to as life course theory is a multidisciplinary approach to understanding the mental, physical, and social health of individuals. Additionally, the life course theory incorporates both life span and life stage concepts that determine the health trajectory (Mitchell, 2003). Sociologists, social historians, psychologists, and anthropologists have applied this theory over the past 45 years (Hutchinson, 2005). While relatively new, this theory has gained popularity. Life
course theory is often used to understand criminology as a perspective of longitudinal study of health behaviors and outcomes (Hutchinson, 2005). The timing and sequence of life course transitions can have long-term consequences for health and development (Elder, 1994). Kim (2015) investigated whether age at first incarceration disrupted the transition to adulthood, and in turn, affected the health and well-being in midlife. Kim (2015) concluded that despite research limitations, the results supported the life course perspective in examining the association between incarceration and health and attempts to differentiate the consequences of incarceration by its timing.

A turning point is a life event or transition denoting when a major change occurs in the life course trajectory and creates a lasting change (Hutchinson, 2005). Citing longitudinal research studies, Elder, Johnson, and Crosnoe (2003) assert specific life events provide an opportunity for a “turning point” which may permanently modify an individual’s environment and events; altering the individual’s beliefs, expectations, and self-concept. Brinkley-Rubinstein (2013) presented a hypothetical heuristic framework to illustrate the ways in which incarceration affects individual, family, and community level health. This theoretical framework includes implications for policy intervention programs and future research to address diminished health among incarcerated populations.

Application of the life course theory is relevant to exploring the longitudinal and continual impact of the incarceration experience (Hutchinson, 2005). The existing research has repeatedly demonstrated the compounding impact of incarceration on the physical health of prisoners, both while serving their sentences and following their release. The life course theory also suggests a multilevel approach to transformation be implemented (Brinkley-Rubinstein, 2013). Life course theory recognizes the importance
of health equity regarding populations and emphasizes that inequity in health reflects more than genetics and personal choice (Hutchinson, 2005). The life course perspective strongly emphasizes the concept of social position which is pivotal in the social determinants of health inequities (Hutchinson, 2005). Instead of concentrating on one health disease or condition at a time, the life course theory focuses on the social, economic, and environmental factors as underlying causes of persistent inequalities in health. Furthermore, this theory suggests that each life stage influences the next. Together the social, economic, and physical environments in which one lives has a profound influence on one’s personal health and the collective health of the individual’s community (Hutchinson, 2005).

Hutchinson (2005) further purports that the prominent theoretical perspective of this theory proposes that framing health as a social phenomenon emphasizes health as a topic of social justice and health equity which has the propensity to become an operational framework, a guiding criterion or a principle. Providing an operational framework of the life course theory for utilization by the jail administrator may prove valuable whereby eliminating isolated efforts and encouraging broader thinking about the factors impacting the health of those incarcerated.

Statement of Purpose and Potential Significance of the Study

The purpose of this qualitative study is to explore and to understand the critical elements required for a comprehensive healthcare program for those who are incarcerated and those who reenter into the community, from the perspective of the jail administrators. In addition, these administrators will be queried to identify the implementation challenges of the identified elements. These identified elements from the perspective of the jail
administrators may provide an understanding of the comprehensive healthcare needs of those incarcerated and those ex-offenders when transitioning back into the community.

Additionally, the purpose of this study is to aid in addressing the following problems: (a) developing a deeper understanding of the collective challenges that short-term correctional facilities face with implementing a comprehensive healthcare program for those who are incarcerated, (b) understanding the challenges short-term correctional facilities face with implementing comprehensive reentry services, and (c) utilizing the theoretical perspective of life course theory as a frame for understanding health as a social phenomenon.

The potential significance of this qualitative descriptive study is to contribute to the limited research on the critical elements required to create a uniform comprehensive healthcare program for the incarcerated. By adding to the body of knowledge of this problem, the State, local communities, jail administration, and the Commission of Correction may have an increased awareness of the challenges that short-term correctional facilities face. Best practices may be identified which may further translate into the implementation of a comprehensive healthcare program throughout the incarceration period as well as during reentry into the community.

**Research Questions**

Three broad research questions will guide the qualitative descriptive study, particularly the semi-structured interviews that are designed to obtain practical information from jail administrators of short-term incarceration facilities in New York State.
1. From the perspective of the administrators of short-term incarceration facilities, what are the elements required for a comprehensive healthcare program for those who are incarcerated?

2. From the perspective of the administrator of the short-term incarceration facilities, what are the elements required for a comprehensive healthcare program during reentry into the community after incarceration?

3. From the perspective of the administrator of short-term incarceration facilities, what are the challenges and barriers to implementation of the identified elements in research questions 1 and 2?

**Chapter Summary**

Much remains unknown about the health and healthcare of the incarcerated (Kulkarni et al., 2010). However, what is known is that the incarcerated population over represents socially marginalized and disadvantaged individuals with a high burden of disease (Wilper et al., 2009). In addition, opportunities to improve the health not only of the incarcerated but also of the communities to which those released will return exist (Macmadu & Rich, 2015).

The purpose and the potential significance of this study is its contribution to development of uniform, replicable, comprehensive healthcare for those incarcerated and during reentry into the community in New York State. Guided by three broad research questions, semi-structured interviews will be conducted with administrators of short-term correctional facilities to identify, from their perspective, the elements required for a comprehensive healthcare program for those who are incarcerated and for those poised for reentry into the community.
The theoretical rationale for this study is life course theory. This theory proposes that framing health as a social phenomenon emphasizes health as a topic of social justice and health equity becomes a guiding criterion or principle (Hutchinson, 2005). The data from the study could provide criterion to eliminate health inequities of those currently incarcerated in New York State jails and those former inmates who are reentering their communities after incarceration.

Chapter 2 provides a literature review of empirical research on the current state of medical care for those in short-term incarceration and when transitioning into the community. Chapter 3 details the methodology for the proposed study. The findings of the study are presented in Chapter 4. Chapter 5 provides a general overview of the findings, possible implications, and suggestions for future research.
Chapter 2: Review of the Literature

Introduction and Purpose

Jails today are facing significant challenges associated with access to care, staffing, funding, and reentry services (Kulkarni et al., 2009). Therefore, jail administrators are struggling to provide adequate medical care to individuals while incarcerated and when reentering the community (Wilper et al., 2009). Exacerbating the problem is that those who are incarcerated are not free to access healthcare services. The incarcerated must rely on the jail to provide comprehensive services (Anno, 2009). Additionally, 90% of all jail inmates will return to their communities. The return of these individuals to their communities provides a social reason as to why comprehensive healthcare services should be provided (Wilper et al., 2009). The treatment of chronic illness while incarcerated can preserve physical function and decrease the burden to society (Massoglia, 2008). Overall, inmates represent a segment of society with the largest percentage of health problems associated with risk taking (Wilper et al., 2009). Containment and possible eradication of their disease state is a strong argument in support of establishing a consistent, comprehensive, replicable program for health service delivery for persons in short-term incarceration and during transition back into the community.

Review of Literature

This chapter will discuss research studies, editorials, and commentaries that have examined barriers and challenges with providing comprehensive healthcare to those
incarcerated, including: (a) demographics of the jail population, (b) chronic illness and access to care, (c) re-entry into the community, (d) fiscal impact of incarceration, (e) jail structure and leadership responsibilities. The focus of this literature review is on the many challenges jails face today and how administrators can manage these challenges, thereby, validating present gaps in the literature and the need for this study.

Demographics of the jail population. The public’s marginalization of the incarcerated population disproportionately represented by minorities from low-income medically underserved communities contributes to overall public health concerns (Dumont et al., 2012). Adult males of color make up most of the incarcerated population (Wilper et al., 2009). As of 2013, 99% of jail inmates were adults, and 86% were male (Wilper et al., 2009). Just over half of the jail population (53%) was people of color, including more than a third who were Black (36%) and 15% who were Hispanic (Wilper et al., 2009).

Among prisoners, more than nine in 10 are male (93%) and two-thirds (66%) are people of color (Wilper et al., 2009). These patterns reflect higher incarceration rates among people of color compared to Whites. Incarceration rates for Black men are over six times higher than the rate for White men and nearly two and half times higher than the rate for Hispanic men (Wilper et al., 2009). American Indians also have higher rates of incarceration compared to Whites (Wilper et al., 2009).

To understand the complex healthcare needs of the growing elderly incarcerated population; Nowotny, Cepeda, James-Hawkins, and Boardman (2015) examined patterns of multi-morbidity among elderly male inmates across four domains of health that included; chronic medical conditions, drug and alcohol related diseases, impairments, and
mental health. Data from the Bureau of Justice Statistics 2004 survey of inmates was stratified in a two-stage selection process to examine 22 health problems among 1,025 men aged 50 and older (Nowotny et al., 2016). Medical conditions were assessed based on the inmates’ self-reports obtained through a computer-assisted personal interview (Nowotny et al., 2016). The four groups have unique sociodemographic backgrounds, significant healthcare needs, and incarceration history characteristics (Nowotny et al., 2016). The study concludes that the epidemiological data reported by the Bureau of Justice in 2004 is accurate and demonstrates the complexity of health needs of the elderly inmate (Nowotny et al., 2016).

In an effort to better understand the demographic and social factors related to healthcare utilization while incarcerated, Nowotny (2016) conducted a secondary analysis of the 2004 Survey of Inmates in State Correctional Facilities. This study examined the differential utilization of healthcare while incarcerated among a nationally representative sample of inmates. The primary research question she sought to answer; does the utilization of healthcare by inmates vary by demographic and other social factors (Nowotny, 2016). The secondary analysis of demographic data evaluated by Nowotny (2016) included: (a) age, (b) sex, (c) race and ethnicity, (d) marital status, (e) socioeconomic status, (f) veteran status, (g) childhood trauma, and (h) the total number of past incarcerations.

A thorough analysis included multivariate application with three main logistic regression models. The findings support that the strong predictors of the healthcare utilization in the community, identified as education and employment, are not associated with healthcare utilization while incarcerated (Nowotny, 2016). In addition, Black men
are more likely to utilize healthcare while incarcerated than are White and Latino men, and those who have experienced childhood trauma have lower healthcare usage while incarcerated (Nowotny, 2016). The researcher’s suggestions to jail administrators for future consideration include trauma informed care to adult male inmates and providing quality healthcare while incarcerated, as well as during transition back into the community. The adaption of these recommendations can potentially contribute to reducing racial disparities in healthcare. In conclusion, the demographics of the inmate population often contribute to chronic illnesses and access to care.

**Chronic illness and access to care.** Until 1970 very few studies on the healthcare provided jail inmates existed (Anno, 2009). A significant number of the early reports regarding healthcare provided in a jail setting was theoretical rather than empirical, relying on anecdotes rather than experimental data (Anno, 2009). Research indicates that chronic illness is prevalent among the incarcerated population, access to care is limited, and inconsistencies in care exist across facilities (Anno, 2009). Correctional facilities are required to provide health services to incarcerated individuals, but many inmates remain without needed medical care (Wilper et al., 2009).

The provision of healthcare varies significantly across states, and types of correctional facilities (Kulkarni, 2008). In jails, healthcare is primarily provided through contracts with local healthcare providers, such as public hospitals or other safety-net providers who come to the jail to provide services (Wilper et al., 2009). As with large prisons, some large jails have on-site primary care, pharmacy, and mental health and substance abuse centers (Anno, 2009). Even though these services are available, data
shows that many inmates do not access these healthcare services during incarceration (Wilper et al., 2009).

Research conducted by the United States Department of Justice, Bureau of Justice (2002, 2004) supports the fact that chronic illness is pervasive among the incarcerated population, access to care is limited, and inconsistencies in care exist across facilities. The 2002 Survey of Inmates in Local Jails and the 2004 Survey of Inmates in State and Federal Correctional Facilities, conducted by the Bureau of Justice is the most reliable epidemiological data available to assess the health of the incarcerated populations (Nowotny, 2016; Wilper et al., 2009). The government survey found that among inmates with a persistent medical problem, approximately 68% of local jail inmates did not receive a medical examination while incarcerated (Bureau of Justice, 2002). The study findings support prevalence of chronic illness (37%) and limited access to care when incarcerated as evidenced by only 42% of inmates with chronic illness reporting services rendered them by a medical provider (Bureau of Justice, 2002).

The prevalence of chronic illnesses, including mental illness, and access to health care among inmates in the United States was assessed by Wilper et al. (2009) using the 2002 Survey of Inmates in Local Jails and the 2004 Survey of Inmates in State and Federal Correctional facilities to analyze disease prevalence and clinical measures of access to healthcare services. Wilper et al. (2009) conducted a secondary analysis of the qualitative data and accepted the self-reported responses of the inmate. In addition, the researchers developed five clinically based access to care measures indicating that most standard access to care measures are meaningless in an incarceration setting (Wilper et al., 2009).
Based on the analysis by Wilper et al, local jails in the United States held 631,241 inmates, primarily male, younger than 35 years old and disproportionately minorities (2009). Chronic medical conditions were common among jail inmates, with 38.7% or 244,336, reporting at least one chronic medical condition (Wilper et al., 2009). Among the jail inmates with a chronic medical condition, 68.4% reported they had not received a medical examination since incarceration (Wilper et al., 2009). More than one in five inmates were taking a prescription medication for an active medical problem routinely requiring medication at the time of admission; however, 41.8% did not receive the required medication during incarceration (Wilper et al., 2009).

Furthermore, greater than half (64%), of the jailed population in the United States has a diagnosis of a mental health condition (Scheyett, Vaughn, & Taylor, 2009). These disorders include mania, major depression, and psychotic disorders (Scheyett et al., 2009). Jail inmates who have a mental health disorder are more likely than those without a disorder to have been homeless in the year prior to their incarceration, less likely to have been employed prior to their arrest, and more likely to report a history of physical or sexual abuse (Wilper et al., 2009). Moreover, the majority of inmates with a mental health disorder also have a substance or alcohol use disorder (Maruschak, 2006).

Scheyett, Vaughn, and Taylor (2009) examined jails in North Carolina to determine how incarcerated individuals with a serious mental illness are identified, treated and compared their findings against research based recommendations. Telephone interviews were conducted with sheriffs and jail administrators for each county in the state. The interview questions focused on four domains that included: (a) screening for mental illness while incarcerated, (b) access to mental health services while incarcerated,
(c) access to psychotropic medication while incarcerated, and (d) communication with community providers (Scheyett et al., 2009). Of the 93 active jails invited to participate, 80 agreed to the 30 question telephone interview (Scheyett et al., 2009). One researcher was responsible to conduct all telephone interviews, and another researcher was assigned to review all transcripts (Scheyett et al., 2009).

The majority of respondents were jail administrators (73%) who were responsible for facilities with an average daily census of under 200 inmates (Scheyett et al., 2009). Almost all participants (96%) reported that they screen all inmates for mental illness at booking (Scheyett et al., 2009). However, the researchers cautioned that none of the jails used an evidenced-based screening tool, and most of the screenings had been conducted by a jail official (63 jails or 79%), who did not have education and experience in mental health (Scheyett et al., 2009).

Access to mental health treatment services was primarily provided (33 jails, 42%) by a community provider (Scheyett et al., 2009). A limited number (12 jails, 15%) of jails interviewed reported having mental health staff on-site (Scheyett et al., 2009). Many jails (32%) reported a greater than a five day wait time for a face-to-face encounter with a mental health provider (Scheyett et al., 2009). Study participants (69, 86%) indicated that they encourage inmates to have family members bring their psychotropic medications to the jail (Scheyett et al., 2009). A small, yet significant finding is the number of the participants (9, 11%) that had no data on the number of days it takes for an inmate to receive psychotropic medications (Scheyett et al., 2009). The risk for decompensation from psychotropic medication is less than one week, however, 19% (15 facilities),
reported that it takes five days or longer to receive and administer psychotropic medications (Scheyett et al., 2009).

When assessing communication with community providers of mental health, more than half (49, 61%) of the facilities interviewed reported that they always contact the mental health provider of incoming inmates, in contrast, only (15, 19%) a small number of jails reported notifying the provider when the inmate is released (Scheyett et al., 2009).

Despite the availability of guidance on best practices for individuals with a serious mental illness in jails settings, the researchers report that in many cases jails followed none (0%) of the recommendations (Scheyett et al., 2009). The researchers recommend education and training for jail staff, mental health providers, and policy makers on the existence of, and implementation of evidenced based guidelines to ensure adequate mental healthcare both during and after incarceration (Scheyett et al., 2009).

In addition to homelessness, low employment rates, and history of abuse, inmates with a serious mental health illness were more likely to suffer from a substance abuse disorder (MacDonald et al., 2015). The 2013 study focused on those most frequently admitted into the New York City jail system since 2008 and compared them to a randomly selected control group of 800 others admitted in 2013. Findings reported support both Wilper (2009), and Scheyett et al. (2009) assertion of homelessness (51.5% vs. 14.7%) in the frequently incarcerated with a serious mental health illness. Mental illness (19% vs. 8.5%) among the frequently incarcerated was almost double that of the control group (MacDonald et al., 2015). Those frequently incarcerated averaged 21 incarcerations, representing 18,713 admissions and $129 million in custody and healthcare costs versus $38 million for the control group (MacDonald et al., 2015).
The majority (96%) of the frequently incarcerated had evidence of significant drug or alcohol use as compared with (55%) the control group (MacDonald et al., 2015). The study results conclude that those frequently incarcerated have chronic mental health and substance use problems, in addition, these prisoners’ criminal charges were generally minor offenses, but costly (MacDonald et al., 20015). Opportunities exist to better understand the life circumstances and trajectories through qualitative interviews (MacDonald et al., 2015).

**Reentry into the community.** Both incarceration and release have lasting effects on the community. Seven million former inmates are released annually from jails in the United States (Dumont et al., 2012). Incarceration is not evenly distributed, but concentrated in some communities, impacting the health of the community and the individual (Dumont et al., 2012). Individuals transitioning into and out of the criminal justice system include many low-income adults with significant physical and mental health needs who face a variety of economic and social challenges (Massoglia, 2008). Poverty, unemployment, lower education levels, housing instability, and homelessness are all more prevalent issues among those incarcerated than the general population (Massoglia, 2008). This population also generally has higher rates of learning disabilities, and lower rates of literacy (Massoglia, 2008).

Overall, data on the income and insurance status of individuals revolving in, and out of jails is limited, however, survey data from 2002 show that nearly six in 10 jail inmates reported monthly income of less than $1,000 prior to their arrest (Chodos et al., 2014). Data also suggest that the jail population is largely uninsured (Chodos et al., 2014). For example, a survey of San Francisco county jails found that about 90% of
people who enter county jails have no health insurance (Chodos et al., 2014). Another survey of inmates returning to the community from Illinois jails found that more than eight in 10 were uninsured after returning to the community at 16 months post-release (Chodos et al., 2014). The high burden of disease among jail inmates presents challenges and opportunities to develop a consistent, comprehensive, replicable program for health service delivery while incarcerated and during transition back into the community (Wilper et al., 2009).

Chodos et al. (2014) research studied pre-detainment acute care use of the emergency department or hospitalization in the three months before incarceration, and the inmates’ plans for acute care use after release. The researchers performed a cross-sectional study of 247 jail inmates aged 55 or greater assessing sociodemographic characteristics, health, and geriatric conditions associated with pre-detainment along with anticipated post release acute care use. The researchers reported that 53% utilized the emergency room or had been hospitalized three months prior to incarceration, and 47% indicated they planned on using the emergency department after release (Chodos et al., 2014). High acute care use may be due to a poor understanding of the benefits of primary care secondary to low literacy rates which is common in the incarcerated population (Chodos et al., 2014).

Most of the study participants reported an annual income that would qualify them for Medicaid under the Affordable Care Act (Chodos et al., 2014). In addition, study participants who anticipated using the emergency room after release from jail reported problem alcohol use (66%), a diagnosis of a (70%) chronic illness, and were less likely (79%) to have a primary care provider (Chodos et al., 20014). Greater than half of the
study participants reported homelessness (55%), medication (50%), and food (70%) insecurity (Chodos et al., 2014). Finally, having a primary care provider is associated with a 31% decrease risk of anticipated acute care use (Chodos et al., 2014). These findings support the necessity for a structured coordinated care plan for re-entry transition from incarceration into the community that addresses the health, chronic illness, and social factors prevalent in older adults leaving jail (Chodos et al., 2014).

The continuity and quality of healthcare in either the community or jail will impact, and burden resources needed in both systems (Schmittker, Uggen, Shannon, & McElrath, 2015). Evaluation of the effect ex-inmates have on the health of the community these former inmates return to, also known as the spillover effect, has been studied by Schmittker et al. (2015). The researchers applied a multilevel approach, first exploring cross-sectional individual level data on healthcare behavior, and merged to aggregate state-level data regarding incarceration (Schmittker et al., 2015).

Findings indicate that for each percentage-point increase in the ex-inmate population in the community, emergency room visits increased 28 visits for every 1,000 residents (Schnittker et al., 2015). In addition, individuals residing in states with a larger number of former inmates experience diminished access to care, less access to specialists, and less satisfaction in the care received (Schnittker et al., 2015). Finally, the spillover effect impacts those least likely to be personally affected by incarceration, including: (a) the insured, (b) individuals over 50, (c) women, (d) non-Hispanic whites, and (e) individuals with incomes far exceeding the federal poverty threshold (Schnittker et al., 2015). The researchers indicate that efforts to improve the health of inmates will be
limited if the criminal justice system fails to provide support and resources after release (Schnittker et al., 2015).

Woods, Lanza, Dyson, and Gordon (2013) propose the use of a prevention science framework strategy for successful reentry from incarceration back into the community. Prevention science framework is focused on the skills and supports an individual needs to produce practical and meaningful change (Woods et al., 2013). The researchers indicate that understanding how health risks and disparities affect the transition from incarceration back into the community will improve reentry efforts (Woods et al., 2013). Woods et al. (2013) evaluated a community-based inmate reentry initiative through a quasi-experimental evaluation to determine the effectiveness of the initiative. Program strengths and client engagement was assessed. The findings support the importance of employment, substance abuse treatment, and information supports for successful reintegration into the community, including a necessity to understand the clients’ perception of their recidivism risks (Woods et al., 2013).

Additionally, the prevention science framework needs to include, integrate universal, selective, and indicated strategies to facilitate successful reentry (Woods et al., 2013). The researchers’ findings challenge all involved in reentry initiatives to abandon the traditional program model and adopt the prevention model that considers multilevel risks (Woods et al., 2013).

One in seven living with human immunodeficiency virus (HIV), in the United States will serve time in jail and almost all will return to the community where these former inmates will require services to manage this disease and other competing needs (Hammett et al., 2015). Wang et al. (2008) assessed if discharge planning for HIV
positive inmates improved access to care when released. The researchers studied a cross section of individuals incarcerated in a San Francisco County jail from March 2005 to January 2006. Trained personnel conducted 347 interviews and asked participants about sociodemographic variables including: (a) history of homelessness, (b) substance abuse, (c) incarceration, (d) health status, and (e) history of chronic illness. The researchers hypothesized that HIV inmates who receive discharge planning services will experience better access to medical and social services when released (Wang et al., 2008).

Survey participants were broken down into one of three categories: (a) HIV positive, (b) HIV negative and another chronic illness, and (c) HIV negative and no other chronic illness (Wang et al., 2008). The researchers applied analyses to characteristics associated with having a regular source of care and compared age, gender, ethnicity, and insurance specific proportions of inmates reporting regular sources of care for each of three categories, and applied findings to the civilian population survey entitled California Health Interview Survey and weighted based on 2001 HIV prevalence in San Francisco County jail (Wang et al., 2008).

Results support the importance of discharge healthcare planning. Inmates who were HIV positive and received discharge healthcare planning were found to be six times more likely to have a regular source of care in the community as compared with inmates with other chronic medical conditions (Wang et al., 2008). In addition, the association continued after adjustment for factors associated with having regular care, age, marital status, insurance, and health status (Wang et al., 2008). Finally, when compared to the general public, formerly incarcerated persons with HIV, who received discharge planning, experienced no significant differences with access to medical care (Wang et al.,
The results indicated that the lack of a comprehensive, replicable healthcare reentry services program contributes to a community’s challenge to provide necessary medical and social services (Wang et al., 2008).

The effectiveness of transition care planning services for HIV infected individuals upon release from a New York City jail was studied by Teixeira, Jordon, Zaller, Shah, and Venters (2015). At the 6-month interval, released jail inmates with a HIV diagnosis who accepted a transitional care plan during incarceration were assessed to evaluate program effectiveness. Baseline surveys were completed by 434 HIV positive inmates, and a total of 243 were evaluated at the 6-month interval, all inmates lost in the follow-up process were assessed using HIV surveillance data (Teixeria et al., 2015).

Study results support a significant increase in the number of individuals taking antiretroviral medications (92.6% vs. 55.6%), had improved medication compliance (93.2% vs. 80.7%), and a notable reduction in emergency room visits (20 vs. 60 visits), including unstable housing (4.15% vs. 22.4%), and food insecurity (1.67% vs. 20.7%) compared to baseline (Teixeria et al., 2015). The study concludes that comprehensive reentry services facilitate continuity of care and improved health outcomes for individuals infected with HIV.

A similar study was conducted by Hammett et al. (2015) to assess HIV infected inmates’ transition into community-based care. The quantitative component of their research connected data from the National Corrections Reporting Program and the Ryan White Services Reports to assess transitional services for releases with HIV (Hammett et al., 2015). Qualitative findings obtained through 65 semi-structured, in-depth individual and group interviews was conducted with correctional staff (27), community HIV
providers (13), and other community providers and state agencies (25), identified opportunities to improve coordination of care including access to benefits and entitlements (Hammett et al., 2015). Recommendations for improved reentry services include the involvement of jail leadership, expansion of services, and activities, including the development of transitional policies and procedures (Hammett et al., 2015). In conclusion, future studies should involve in-depth examination of program and providers who have achieved success with transition from incarceration to community based HIV care (Hammett et al., 2015).

Reentry program impact on recidivism rates was explored by Miller and Miller (2015) who hypothesized that inmates who participate in a jail reentry program would experience more successful outcomes than those inmates who did not, as evidenced by a lower recidivism rate. The researchers evaluated the jail reentry program by applying a quasi-experimental design. The mean age of participants was 29.9 years old ($n=77$), descriptive statistics revealed a recidivism rate of 29% for the experimental group versus 73% for the comparison group (Miller & Miller, 2015). This study provides further evidence of the benefits of a reentry program.

Freudenberg, Daniels, Perkins, and Richie (2005) evaluated the health consequences of 967 ($n=491$ males, $n=476$ women) a year after release from jail. Two sources of data were applied; one from a random trial, and the other from a two-year study of public policies related to reintegration (Freudenberg et al., 2005). The study concluded that that men with health insurance had a lower risk of rearrest, and women who reported unmet health needs had increased odds of rearrest (Freudenberg et al., 2005). These findings support similar studies that demonstrated the importance of
meeting the health and social needs of ex-inmates. Accessing services in the community is essential for both the health of the individual and the community (Freudenberg et al., 2005).

Evident in the research reviewed on reentry services into the community, is the prevalence of high rates of physical and behavioral health issues, including infectious diseases and substance abuse disorders. In addition to their health challenges, the incarcerated population suffers from high rates of poverty, unemployment, unstable housing, and homelessness, including varying degrees of personal and family problems.

Secondary to the disruptive impact of incarceration, research has referenced how major life events such as divorce, incarceration, loss of a job, or loss of a loved one adversely impacts health (Massoglia, 2008). The key theoretical notion is that these events are moments in the life course that require major behavioral adjustments in a relatively short period of time, providing an opportunity to apply interventions in a manner consistent with the life events framework (Massoglia, 2008). Literature supports that there are tremendous complexities in understanding the medical and social service needs of those incarcerated and when reentering the community (Massoglia, 2008).

**Fiscal impact of incarceration.** High rates of incarceration experienced in the United States (700 out of every 100,000 people) is financially burdensome on society, with lasting negative effects to the incarcerated individual, their families, and communities (McLaughlin, Pettus-Davis, Brown, Veeh, & Renn, 2016). Per capita expenditure on corrections has more than tripled over the past thirty years (McLaughlin et al., 2016). Today's high rate of incarceration is costly to American taxpayers, with state and local governments bearing the bulk of the fiscal burden (Henrichson, Rinaldi, &
Delaney, 2015). In addition to the budgetary costs, current incarceration policy generates economic and social costs for those incarcerated and their families (McLaughlin et al., 2016). Typically, spending recorded by correctional facilities does not factor in the costs endured by incarcerated persons, families of the incarcerated, the children of the incarcerated, and the communities the formerly incarcerated return to. These costs are known as the social costs of incarceration (McLaughlin et al., 2016).

**Social costs of incarceration.** Substantial literature is available that measures the cost of crime; however, only one study has included the social costs as a component of the total expenditures (McLaughlin et al., 2016). McLaughlin et al. (2016) evaluated the economic burden of incarceration in the United States by assigning monetary value to 22 different costs that reduce social welfare (McLaughlin et al., 2016). Each cost represented in the study was approached as a cost-benefit analysis representing either the opportunity cost of resources deployed or an individual’s willingness to pay to avoid an undesirable outcome. The cost analysis applied is consistent with the definition of social costs (McLaughlin et al., 2016). The concept of willingness to pay acknowledges that social policies have winners and losers, and the amount the losers will pay to avoid an undesirable outcome is the social cost (McLaughlin et al., 2016). In addition, opportunity costs assume that the monies spent on incarceration are not available to benefit society and are treated as social costs (McLaughlin et al., 2016).

The study by McLaughlin et al. relied on findings from prior research that identified a monetary value of an individual’s life and time, applying those findings to calculate opportunity costs, and people’s willingness to pay to avoid incarceration related harms (McLaughlin et al., 2016). Monetary values had been assigned to 22 different
costs grouped into the following categories: (a) costs of corrections, (b) costs borne by incarcerated persons, (c) costs borne by families, children, and (d) communities (McLaughlin et al., 2016). The results reported estimated the cost of incarceration to be one trillion dollars (McLaughlin et al., 2016).

Cost of corrections. The study results are significant and require further exploration and understanding of how the trillion-dollar figure was calculated, as many of the costs will not be reported on a balance sheet. McLaughlin et al. (2016) calculated the cost of corrections by applying the steady state methodology that assumes little or no fluctuation from one year to the next. Application of one year to serve as a proxy for the lifetime cost for persons incarcerated that year, McLaughlin et al. (2016) reported federal and state governments spend $80 billion annually to operate prisons and jails. However, 13.9% of correctional costs do not appear in government budgets (Henrichson, Rinaldi, & Delaney, 2015). Those costs include pension contributions, correctional staff healthcare benefits, and the healthcare provided to inmates (McLaughlin et al., 2016). In total, the costs related to corrections are estimated to be $91.1 billion (McLaughlin et al., 2016).

Current methods applied by Henrichson, Rinaldi, and Delaney (2015) to measure the price of jails included development of a survey instrument to capture all the costs incurred to run a jail, as well as identifying if those costs were included in the jail’s budget or were paid by another department. Thirty-five jail jurisdictions returned the survey, including four from New York. The respondents represented five small jails (< 200), 12 medium jails (200-999), and 18 large (>1,000) jails (Henrichson et al., 2015). Thirty-two of the jails that responded to the survey reported that their counties general fund paid for greater than 85% of jail costs (Henrichson et al., 2015).
The largest cost category reported by all jail jurisdictions is personnel related costs (Henrichson et al., 2015). All jurisdictions indicated that at least some of their expenses were covered by other government agencies, however; only five respondents could provide data on the costs outside of their jail budget (Henrichson et al., 2015). Of the four jurisdictions that responded from New York, the percentage of costs outside of the jail budget ranged from a low of 2.7% to a high of 53.6% (Henrichson et al., 2015). It is important to note that the cost categories that are outside of the jail budget include: (a) employee benefits, (b) inmate healthcare costs, (c) capital costs, (d) administrative costs, (e) legal judgments and claims, and (f) inmate programming and other costs (Henrichson et al., 2015).

Employee benefits (20%) and inmate healthcare (10%) represents the largest costs represented outside of the jail budget (Henrichson et al., 2015). The breakdown of annual cost for healthcare services for those incarcerated in jails ranged from $1.4 million to $5 million, with 18 of the 35 respondents indicating that another county agency paid at least a portion of inmate medical costs (Henrichson et al., 2015). Healthcare services include the cost for doctors, nurses, medications, and hospital care provided by the county health department or through a contracted provider (Henrichson et al., 2015). In addition, most of the jails indicated being administratively reliant, receiving a significant amount of resources from other county agencies to provide human resources, legal services, and information technology support (Henrichson et al., 2015).

Both surveys demonstrate that there is a significant difference between the price of corrections and the price of incarceration. The $80 billion spent annually on corrections has been cited as the cost of incarceration (McLaughlin et al., 2016). As
concluded by McLaughlin et al. (2016), the true cost of incarceration far exceeds the amount spent on corrections. Knowing the cost of incarceration is crucial for policymakers who are responsible to determine the costs and benefits of incarceration. Underestimating the true cost incarceration has on an individual and society could result in a level of incarceration beyond that which is socially optimal (McLaughlin et al., 2016).

**Costs borne by incarcerated persons.** Due to the loss of employment, the two cost centers of reduction in lifetime earnings and lost wages while incarcerated of those detained persons is profound. The reduced lifetime earnings of formerly incarcerated individuals are estimated to be $230 billion dollars (McLaughlin et al., 2016). These reduced wages of formerly incarcerated individuals constitute lost productivity and are treated as a social cost (McLaughlin et al., 2016). The higher mortality rate of formerly incarcerated persons is another cost center tenant which is reported at 3.5 times greater than that of those who have never been incarcerated accounts for $62.6 billion (McLaughlin et al., 2016). Lastly, application costs for the nonfatal injuries to incarcerated persons, and fatal injuries to incarcerated persons while incarcerated account for $28 billion and $1.7 billion, respectively (McLaughlin et al., 2016). These staggering costs cause a reduction in the gross domestic product of the United States, and therefore constitutes lost productivity as a nation including an estimated $17 billion from divorce and $9 billion in cost resulting from the reduction rate in marriage (McLaughlin et al., 2016).

The challenge of the ex-offender who is stigmatized by law abiding members of society is a collateral consequence of incarceration, further impacting community
reintegration (Shicker, 2014). Rade, Desmarais, and Mitchell (2016) conducted a meta-analysis to synthesize existing research to assess the public attitudes toward ex-offenders. The researchers assert that identification of correlates associated with negative attitudes toward ex-offenders may assist to reduce stigma, and facilitate successful reentry (Rade et al., 2016). A majority of the studies had been conducted in the United States ($n=15$, 83.3%) the majority were produced after 2009 ($n=12$, 66.7%) and analyzed attitudes toward sex offenders ($n=15$, 83.3%). Effect sizes were negligible except for the public characteristic correlates of political affiliation and interpersonal contact and the ex-offender characteristic of sexual offense history (Rade et al., 2016).

Individuals who participated in the survey and self-identified as politically conservative reported an increased negative attitude, versus a liberal view of an ex-offender (Rade et al., 2016). Individuals who had no previous contact with an ex-offender reported a more negative attitude toward an ex-offender as compared to those with a personal experience (Rade et al., 2016). These findings conclude that the stigma of incarceration is prevalent in public perception and contributes to the costs borne by those once incarcerated.

The costs borne by the families and children of those incarcerated. Costs borne by incarcerated persons and communities include evaluation of 16 different social costs deserving of review to fully appreciate the economic burden of incarceration. Family costs associated with incarceration include:

- $0.8 billion estimated visitation costs,
- $0.5 billion estimated moving costs,
- $0.2 million estimated eviction costs,
- $5.0 billion estimated on criminal justice debt,
- $10.2 billion estimated adverse health effects.

Empirical studies and statically significant findings support the cost centers evaluated that are estimated to contribute $16.7 billion annually to the costs associated with incarceration (McLaughlin et al., 2016).

The costs endured by the children of those incarcerated include:
- $130 billion - increased criminality of the children of incarcerated parents,
- $30 billion - children’s education level and subsequent wages as an adult,
- $5.3 billion - child welfare costs,
- $1.2 billion - increased infant mortality rate,
- $0.9 billion - children rendered homeless by parental incarceration.

In sum, these costs represent $168 billion in social costs to the children of the incarcerated (McLaughlin et al., 2016).

**Costs borne by the community.** The United States Department of Justice (2011) estimated that local communities spent $22.2 billion on jails in 2011. Jails are one of a community’s largest investments and jail funding is provided from the same source that supports social services, schools, roads, and other essential functions of a local government (Henrichson et al., 2015). The $22.2 billion price tag is not an accurate representation of costs, due to the exclusion of other government agencies’ contributions and negates the social costs of incarceration (Henrichson et al., 2015). As indicated by McLaughlin et al. (2016), the costs reported are too often incomplete leaving policy makers and the public unaware of the full financial commitment to the operations of a local jail.
• $285 billion - criminogenic nature of prison,
• $11 billion - decreased property values,
• $2.9 billion - reentry programs,
• $2.2 billion - homelessness of formerly incarcerated persons.

The aggregate burden of incarceration in the United States is estimated by McLaughlin et al. (2016) at $997 million, which is nearly 6% of the country’s gross national product and 11 times corrections spending (McLaughlin et al., 2016). Failure to acknowledge the $513 million in social, and opportunity costs to the families, children, and communities could impact policy makers to overestimate the net benefit of incarceration (McLaughlin et al., 2016).

Analysis of all costs associated with incarceration is critical because social welfare is maximized when incarceration is supplied at the level where marginal social benefit equals the marginal social cost (McLaughlin et al., 2016). The economic and social costs of incarceration compel efforts to promote successful reintegration into the community. A critical component identified is the insufficient resources, opportunities, and supports. Finally, when individuals are not adequately supported during transition from incarceration back into the community, the impact is significant for these former detainees, their families, their community, and the jail system.

**Leadership roles in New York State jails.** A jail is a secure facility that houses three main types of inmates, (a) people who have been arrested and are being held pending a plea agreement, trial, or sentencing; (b) people who have been convicted of a misdemeanor criminal offense and are serving a sentence of one year or less, and; (c) people who have been sentenced to prison and are about to be transferred to another
facility (State Commission of Correction, 2017). Each county in New York has a jail which ranges in inmate capacity from 50 to greater than 2,000; and is operated by the county or city government (New York State Sheriffs Association, 2017).

**New York State Commission of Correction.** Unlike most states, New York has an agency vested with power to regulate incarceration. The New York State Commission of Correction (SCOC) is the oversight body for prisons, jails, and local lockups (SCOC, 2017). The SCOC is authorized to visit and inspect correctional facilities, and establish rules and regulations outlining the minimum standards for the care, custody, correction, treatment, supervision, discipline and other correctional programs for all persons confined in correctional facilities (SCOC, 2017). In addition, the SCOC has subpoena power and can appoint monitors for failing jails and can even order the closure of any correctional facility deemed, unsafe, unsanitary or inadequate (SCOC, 2017). Under title 9, subtitle AA, Chapter 1, Section 7010 of New York State Correctional Law, the SCOC delegates the provision of adequate medical care for incarcerated persons to the chief administrative officer of each local correctional facility. The administrative officer, under the supervision of the county sheriff is responsible for the development and implementation of policies and procedures to ensure compliance with Part 7010, entitled, Health Services (SCOC, 2017).

**New York State Sheriffs Association.** New York State Sheriffs Association (NYSSA, 2017) reports the county level county commissioners establish county budgets and staffing for all county departments, including the jails. The Commissioner is responsible for the structure and overall function of all county departments and balances the work between the departments. The authority of the Commissioner does not extend to
elected officials, including the sheriff. The sheriffs in New York State are elected and rely on the county Commissioner to establish a working budget for their department (NYSSA, 2017). The sheriff is responsible for public safety and assures compliance with the New York State Commission of Correction (SCOC) requirements at the local level (SCOC, 2017). In addition, the sheriff is responsible for the jail, including all policy decisions; they are the ultimate authority for health services in the jail facility (SCOC, 2017). The jail administrator or chief administrator is responsible for the daily operations of the jail and oversees the provision of cost effective medical care for inmates as required by state and federal law (SCOC, 2017). The jail administrator or chief administrator is the budgetary authority over operations of the jail and function under the direct authority of the sheriff (SCOC, 2017).

**Jail administrator, chief operating officer.** The jail administrator is responsible to facilitate communication, collaboration, and coordination across agencies to synchronize policies and services by bringing governmental and community stakeholders together (Shicker, 2014). In addition, the jail administrator is responsible to ensure that medical care provided those incarcerated is adequate and minimally provides the following as prescribed by the New York State Commission of Correction;

- appointment of a properly registered physician for the local correctional facility,
- examination by a physician licensed to practice in the State of New York or by medical personnel legally authorized to perform such examination at the time of admission or as soon thereafter as possible, but no later than 14 days after admission,
• physically incapacitated inmates due to drug or alcohol intoxication shall be examined immediately by a physician, and shall be subject to increased supervision as determined pursuant to section 7003.3(h) of this title,
• no medication or medical treatment shall be dispensed to an inmate except as authorized or prescribed by the facility physician,
• facility personnel shall receive training and maintain certification in first aid and emergency life saving techniques including the use of emergency equipment,
• definite arrangements shall be made to insure the prompt transportation of an inmate to a hospital or other appropriate medical facility in an emergency situation,
• provision for the necessary security and supervision during the period of hospitalization and in the course of transportation to and from a medical facility (SCOC, 2017).

The SCOC (2017) also tasks the chief administrative officer, or jail administrator to make maximum use of community medical and mental health facilities, services, and personnel. In addition, the law has strict provisions for the management of medications, including storage, and return of unused medications (SCOC, 2017).

**Custody staff.** The State Commission of Correction (2017) requires prompt screening of all inmates upon admission. Application of evidence-based practice was assessed at four correctional institutions to determine the use of a validated assessment instrument to assess risk and service needs. The study conducted by Blasko, Souza, Via, and Taxman (2016) evaluated custody staff use of a medical assessment tool during the
admission process. The results indicate that only two of the four analyzed sites were found to consistently use the assessment tool. Additionally, one of the sites evaluated had not conducted medical assessments on more than 50% of their population (Blasko et al., 2016).

In addition to the legal requirement to provide healthcare to inmates, there are three additional reasons to address the medical needs of the incarcerated, they are ethics, reentry, and public health (Shicker, 2014). Principles of health and equality are recommended core subjects for custody staff (McDonnel, Brookes, & Lurigio, 2014).

The value custody staff has on the health and equity of services provided to those incarcerated was evaluated by Camp and Daggett (2016). The stratified random sample survey data (n=7,730), was analyzed using descriptive statistics for the variables (Camp & Daggett, 2016). The survey respondents (34%) were identified as front-line custody staff with average tenure of 14 years (Camp & Daggett, 2016). Treatment staff rated coordination of reentry into the community, four points higher than correctional officers. The correctional supervisors evaluated coordination of reentry into the community, 1.5 points higher than custody staff (Camp & Daggett, 2016). Additional education is required for custody staff to appreciate the importance of coordination of reentry services for those incarcerated (Camp & Daggett, 2016).

A similar study was conducted by Young, Antonio, and Winegeard (2009) to evaluate a new corrections employee training program aimed at reinforcing medical treatment concepts to benefit those incarcerated. Using a five-point scale, the survey analyzed the results of 1,250 custody staff attitude and support of inmate medical treatment and rehabilitation. Unfortunately, custody staff scored lowest in each of the five
questions, designed to assess attitude in support of rehabilitation programs (Young et al., 2009). Support staff \( (n=630) \) more strongly agreed (4.58) with the statement “staff support of inmate rehabilitation can make a difference on treatment outcomes” than did custody staff (4.43) (Young et al., 2009).

Written policies and procedures consistent with the State Commission of Correction, Subtitle AA, Part 7010, entitled Health Services, delegate’s authority of policy and procedure development, including implementation to ensure compliance with providing adequate medical services to the chief administrator. Analysis of the studies conducted concludes that correctional leadership can have a direct effect on the health of the incarcerated individual, their families, the children of the incarcerated, and the community.

**Conclusion**

The overview of the empirical studies discussed in Chapter 2 suggests that there is limited data available in the United States on the accessibility of healthcare provided to those incarcerated in the jail system (Wilper et al., 2009). Research has broadly examined the staggering social implications and fiduciary impact associated with the incarcerated.

Throughout the literature review common themes have emerged and are examined through previously conducted research studies and include: (a) limited data available nationally on the accessibility of healthcare provided for those incarcerated in short-term correctional facilities, (b) significant variations in the healthcare provided in jail settings and evaluation of those services, and (c) unknown service gaps among those incarcerated in short-term correctional facilities. In sum, current research supports that no consistent, comprehensive, replicable program for health service delivery for persons in short-term
incarceration and during transition back into the community exists in New York State or nationwide.

The proposed study aim is to gain a better understanding of the elements required from the perspective of the administrator to achieve comprehensive medical services for those incarcerated in short-term correctional facilities and during re-entry into the community. Chapter 3 proposes and defends the methodology chosen to conduct the qualitative study of inquiry.
Chapter 3: Research Design Methodology

Introduction

In 2012, the United States incarcerated over 1.3 million people, of whom a disproportionate share was minorities (Smith & Braithwaite, 2016). Those incarcerated have higher rates of physical and behavioral health issues, including infectious diseases and substance abuse disorders, than does the general population (Smith & Braithwaite, 2016). Surveys of jails by the Bureau of Justice Statistics have reported rates of substance use that exceeds 80% (Patel, Boutwell, Brockmann & Rich, 2014). In addition, greater than half of all jail inmates meet diagnostic criteria for co-occurring mental illness and substance abuse disorders (Patel et al., 2014).

The frequently incarcerated have high rates of poverty and unemployment, unstable housing, and differing degrees of personal and family problems (Patel et al., 2014). Generally, individuals involved with the justice system have higher rates of learning disabilities and lower literacy rates than the general population (Patel et al., 2014). Cloud et al. (2014) posits that these factors contribute to the risk of re-incarceration.

Competing priorities negatively impact the recently incarcerated when returning to the community such as reestablishing employment, finding suitable housing, and rebuilding family and other relationships (Patel et al., 2014). Empirical research provides evidence that treating medical and behavioral health conditions while incarcerated and
during transition into the community improves the probability of successful reintegration (Cloud et al., 2014). The American judiciary has outlined a series of basic rights for all incarcerated individuals seeking healthcare that includes but is not limited to, the right of access to care and assurance of healthy living conditions as a matter of social justice (Cloud et al., 2014). The problem of health inequity while incarcerated and when transitioning back into the community is an issue of social justice due to the disparity of access to care.

The purpose of this study was to identify from the perspective of the jail administrator, the elements required for a comprehensive healthcare program for those who are incarcerated and during reentry into the community after incarceration. A qualitative descriptive study design was used to answer the “what” question and provide the researcher with rich descriptive content. The Institutional Review Board of St. John Fisher College approved the study, participation was voluntary, and informed consent was obtained. Data were collected during interviews with the six study participants who were representative of jail administrators in New York State. Measures were taken to protect the participants’ identities and the confidentiality of the data. Names and identifying demographic details were not used. Ethical research conduct was important as the issues could have been complex.

**Research Questions**

The researcher used semi-structured open-ended questions that addressed the guiding research questions:
1. From the perspective of the administrators of short-term incarceration facilities, what are the elements required for a comprehensive healthcare program for those who are incarcerated?

2. From the perspective of the administrator of the short-term incarceration facilities, what are the elements required for a comprehensive healthcare program during reentry into the community after incarceration?

3. From the perspective of the administrator of short-term incarceration facilities, what are the challenges and barriers to implementation of the identified elements in questions 1 and 2?

The research design for the study identified the elements, challenges, barriers, and opportunities through the lens of the jail administrator was a qualitative method with a descriptive inquiry. According to Sandelowski (2010) qualitative descriptive studies are primarily concerned with answering the “what” question and provide the researcher with rich descriptive content. Creswell (2014) defines qualitative research as a means for exploring and understanding the meaning individuals or groups ascribe to a social or human problem. Qualitative inquiry provides richer opportunities for gathering and assessing what the research participant values, believes, and thinks about social life (Saldana, 2015).

**Research Context**

New York State has the seventh-largest state jail population in the United States and reports 54,235 individuals under custody (Shalev et al., 2011). Excluding New York City, there are 63 county jails representing 57 counties in the State (Shalev et al., 2011). Data from 2007 indicates 182,779 inmates were admitted into New York county jails
(Shalev et al., 2011). On average 590,000 inmates are released annually nationwide, with approximately 25,000 in New York State (Bureau of Justice, 2015; SCOC, 2010).

In New York State, the provision for a safe, stable, and humane correctional system is the responsibility of the Commission of Correction. The Commission is an oversight agency tasked with evaluating all state correctional facilities, county jails, local police lock-ups and secure centers operated by the state. The Commission delegates the authority to provide adequate medical care for incarcerated persons to the chief administrative officer of each local correctional facility (SCOS, 2017).

This study solicited jail administrators in New York State, excluding the five boroughs of New York City. Omission of New York City was intentional as access to the complex system is limited and medical management was transferred to the public health system of the city in 2015. The average daily census for non-New York City jails was 15,446 in 2016 (Bureau of Justice, 2017).

**Research Participants**

Prior to soliciting participants and collecting data from the New York State jail system, the researcher completed the Collaborative Institutional Training Initiative (CITI) training and secured a certification (Appendix A) validating that ethically sound research strategies would be employed throughout the research process. The qualitative semi-structured interview is non-experimental and focused on obtaining information from jail administrators through semi-structured open-ended questions (Appendix B). The authority to ensure the provision of adequate medical care to those incarcerated is under the jurisdiction of the jail administrator. An interview script was developed to ensure
consistency with gathering demographic information and sequence of research questions (Appendix C).

The proposed study identified active jail administrators in New York State, excluding the five boroughs of New York City to participate in this study. The purposive sampling strategy aimed to recruit six to eight jail administrators in urban and rural areas in different parts of New York State to capture maximum variation in size as defined by their average daily jail population (Appendix D). The selection of a sample in qualitative research has a significant effect on the quality of the research. Creswell (2013) stated that there is no true answer to how many participants are enough, although the author suggests three participants as the minimum number. The criteria for the proposed qualitative study required that the participant is an active jail administrator in one of the 57 counties of New York State with greater than one-year experience in that position.

To obtain this sample, an invitation letter was sent to New York State jail administrators (Appendix E) listed on the New York State Commission of Correction website. The letter outlined the purpose of the study, and detailed informed consent information, including the right to withdraw from the study at any time. The intended safeguards to ensure confidentiality during and after the study was outlined and included the removal of any unique identifier information such as names, location, and specific incidents or dates. In addition, all interview tapes will be maintained by the researcher under lock and key, at the researcher’s home, with no unique identifiers, and a planned destroy date of three years after the interview. A written, informed consent document approved by St. John Fisher’s Institutional Review Board (Appendix F) was signed by the participant before the interview was scheduled. Approval from the St. John Fisher
College Institutional Review Board was secured after acceptance of the dissertation proposal (Appendix G).

The overarching theme present in New York jails is a lack of uniformity with delivery of medical services contributing to substandard medical care (Sanchez, 2005). The jail administrators are rich informants and can describe in their own words, what elements are needed to develop a comprehensive healthcare program during incarceration and during reentry into the community.

**Instruments Used in Data Collection**

After establishing consent, the qualitative data was generated through individual, semi-structured interviews, utilizing a qualitative descriptive approach to collect, interpret, and synthesize the rich data. Creswell (2013) suggests that qualitative research is preferred in four realms of research, one of which is when health science researchers seek to understand the context or setting of issues. The rationale for administering a qualitative descriptive study with jail leadership was to obtain an in-depth understanding from these information rich informants. The research questions were designed to explore and understand the “what” inquiry and align with the problem and research questions. To answer the research questions posed, face-to-face, semi-structured interviews were conducted to obtain the perspective of the participant related to the “what” research questions. Semi-structured interviews are a qualitative method of inquiry conducted with a set of questions to prompt discussion and provide opportunity for the researcher to explore emerging themes (Colorafi & Evans, 2016). In addition, face-to-face, semi-structured interviews allow the researcher to capture verbal cues, emotions, and
behaviors, as well as keeping the interview on focus and probing for adequate answers (Fowler, 2014).

Lincoln and Guba (1985) posit that trustworthiness of a research study is important to evaluating the worth of the research study. Trustworthiness involves establishing credibility, generalizable, dependability, and conformability. Believability or credibility will be established through member-checking. Thick, rich descriptions were obtained and adequate to make the study generalizable to other jail facilities. Dependability was accomplished using low inference descriptors to ensure an accurate account of what the participants say. Interviews were audiotaped by the researcher and transcribed by a professional transcription company that guarantees accuracy of all transcripts produced. To ensure conformability, and reduce researcher bias, adequate indexed field notes were maintained to record what the researcher felt, did, saw, heard, and thought. In addition, participants’ emotions, flexion of voice, and body language was noted.

The research questions were pretested with two veteran jail administrators to identify any ambiguities with the interview questions and the protocol script (Appendix B & Appendix C). The pretest also allowed for interviewing practice and feedback. Validity and reliability were tested during the pretest and demonstrated that the completed instrument measured what the study proposed to measure.

Procedures for Data Collection and Analysis

Qualitative research analytic strategy consisted of first and second cycle coding in conjunction with analytic memo writing. A code is defined as a qualitative inquiry and is most often a short phrase or word that symbolically assigns a summative, salient, essence
capturing, and/or evocative attribute for a portion of language-based or visual data (Saldana, 2016).

Saldana (2016) posits first cycle coding methods for ontological inquiry of the “what is” can reveal the participants perspectives and actions. The first cycle, or initial coding of data can be divided into seven subcategories identified by Saldana (2016) as: (a) grammatical, (b) elemental, (c) affective, (e) literary, (f) language, (g) explorational, and (h) theming the data. Following this prescription of sub-categorical produces reliable themes.

A strong analysis of the transcription requires knowledge of the data collected, achieved through immersion of the details (Creswell, 2014). The preliminary review included reading through the transcribed interviews and marking up the hard copy with highlighting and notation of any impressions. Each transcript was evaluated, line by line and reoccurring words and phrases grouped into codes. A master list of codes emerged during phase one of the data analysis. The researcher read through the data several times, creating tentative labels for chunks of data that summarize what was observed through the participants’ words in response to each question. Pattern coding was the third cycle coding methodology applied to assist the researcher with building a framework for analysis of major themes identified from the data (Miles et al., 2014). Analytic memos served as a reference for the researcher to determine and track coding choices, possible categories, and themes. The memos provided the researcher an opportunity to reflect on and write about how participants related on a personal level with the participant and support code choices, including unique operational definitions (Saldana, 2016).
Summary

This study explored the elements identified by the jail administrators as Chapter 3 described the rationale for selecting a qualitative research method design. Research instrumentation, participant selection, and data analysis methods for this study were discussed.

The findings of the study are presented in Chapter 4. Chapter 5 provides a general overview of the findings, possible implications, and suggestions for future research. In summary, the goal of this qualitative descriptive study was to explore and understand from the perspective of the jail administrator, the elements required for a comprehensive healthcare program for those incarcerated and during reentry into the community after incarceration. In addition, the study addressed the challenges jail administrators may face and what is needed to establish a comprehensive healthcare program for those incarcerated and for the ex-offender during reentry into the community.

Information obtained from the semi-structured interviews with jail administrators from New York State were compared to the evidence obtained through the review of literature on comprehensive healthcare provided those incarcerated and reentry programs for the ex-offender. Proper protocols and actions were used to ensure trustworthiness and credibility. This chapter identified the purpose and problem of the study, its theoretical rationale and choice of methodology, the study sample, context, instruments, participant data, and procedures for data collection and analysis. Also discussed was the role of the researcher within the field of correctional healthcare services and procedures used to help negate bias.
Chapter 4: Results

Research Questions

The purpose of this qualitative descriptive study was to identify, from the perspective of the jail administrator, how the criminal justice system can contribute to eliminating inequities in healthcare at two pivotal times: during incarceration and later during reentry into the community. Three broad research questions guided this qualitative descriptive study:

1. From the perspective of the administrators of short-term incarceration facilities, what are the elements required for a comprehensive healthcare program for those who are incarcerated?

2. From the perspective of the administrator of short-term incarceration facilities, what are the elements required for a comprehensive healthcare program during reentry into the community after incarceration?

3. From the perspective of the administrator of short-term incarceration facilities, what are the challenges and barriers to implementation of the identified elements in research questions 1 and 2?

Data Analysis and Findings

To provide insight into each of the three research questions, an open-ended, semi-structured, face-to-face interview was conducted with six jail administrators from various counties in New York State, representing large, medium, and small jails. In addition, exploration of the challenges and barriers with the implementation of the
elements identified in research questions 1 and 2. The topic was specifically examined through each practitioner’s lens of open-ended inquiry and applied to the life course theory.

Participants were acquired for this study through purposive sampling by identifying active jail administrators in New York State, excluding the five boroughs of New York City. To be eligible for this study, participants were required to meet specific criteria. This criterion consists of being employed as an active jail administrator in one of the 57 counties of New York State with greater than one-year experience in this role.

A purposive sampling strategy was employed to achieve variation of jail population, ranging from small to large. Data were collected from the jail administrators at six different jails across New York State. Six jail administrators, comprised of four male administrators and two female administrators, consented to be interviewed for this study. Each administrator had an average tenure of greater than 20 years as a corrections officer in a jail and three years as a jail administrator. Semi-structured interviews using open-ended questions which were aligned with the research questions were the sole instrument for the data collection. Each participant engaged in an individual interview with the researcher. Each participant reported the elements required for a comprehensive healthcare program for those incarcerated, and during reentry into the community. In addition, these administrators were probed to discuss the barriers and challenges with implementing the identified research question elements.

The researcher audio recorded each interview. All audio recordings were transcribed verbatim by an external consultant. To ensure reliability, credibility, and validity, the researcher conducted review of the audio recording versus the transcribed
interview to ensure there were no discrepancies or typographical errors. Additional data was captured from the researcher’s field notes. These descriptive and reflective notations were added to transcripts. Additionally, interviewees were offered the opportunity to review their individual interview transcript, however all declined.

**Data analysis.** Data analysis consisted of three distinct coding cycles; initial descriptive, and pattern coding. In addition, multiple reviews of the researcher’s field notes and analytical memos served as a reference to support and track coding choices, themes, and sub-themes.

The first cycle, or initial coding of the data, was further analyzed with application of descriptive coding to identify the participants’ perspectives and actions, comparing the data for similarities and differences. Pattern coding was applied during the third cycle, allowing the researcher to build a framework for analysis of major themes identified from the data.

**Findings.** Through this extensive coding process, three major themes emerged from the research data. The first major theme is entitled, *bare minimalism*, the second major identified theme is *societal truths*, and the final major theme is *resource reality*.

Table 4.1 illustrates a summary of the major themes as each aligns with the research questions posed, as well as providing a description or the essence of the themes.
Table 4.1

Summary of Themes

<table>
<thead>
<tr>
<th>Major Themes</th>
<th>Subtheme</th>
<th>Essence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bare Minimalism</td>
<td>Mandate</td>
<td>Letter of the Law</td>
</tr>
<tr>
<td>Societal Truths</td>
<td>Public Health Crisis</td>
<td>Inequality</td>
</tr>
<tr>
<td>Resource Reality</td>
<td>Political</td>
<td>Unpopular Platform</td>
</tr>
</tbody>
</table>

Research Question 1

From the perspective of the administrators of short-term incarceration facilities, what are the elements required for a comprehensive healthcare program for those who are incarcerated? The analysis of the data yielded one major theme which emerged as ‘bare minimalism’ and one subtheme identified as ‘mandate’. To better understand the participants’ experience, the essence of the theme and subtheme was defined as ‘letter of the law’.

Theme 1: bare minimalism. The combination of terms coined for this theme is intentional and underscores two distinct concepts that are relevant to this study. The term ‘minimalism’ is defined as the decision to be mindful in that an individual implements practical and sensible moderation in application of services. Thrifty minimalists embrace a financial mindset of achieving the end goal of spending less rather than using less (www.theminimalists.com). The use of the adjective “bare” is necessary to provide context to the theme of minimalism, as the behavior to provide nominal services, which is not always the individual administrator’s choice, rather this behavior is a compulsion to comply to the letter of the law.
Wilper et al. (2009) noted that jails are required to provide health services to those incarcerated, however many inmates remain with substandard medical care. All of this study’s participants identified that their individual facility provided the mandated minimum healthcare services required. Participant 1 responded stated, we [administrators] only need to include the mandates that resulted from “Estelle v. Gamble”; also, New York State Commission of Correction constitutes the minimum standards of healthcare.

In addition, Participant 2 referenced risk aversion as a catalyst for ensuring implementation of mandated minimum standards of healthcare for those incarcerated:

You realize inmates are a litigious group. We have lost a significant amount of money from frivolous lawsuits. Our best option is to ensure that the New York State Commission of Correction minimum standards of care are implemented. Those standards are simplistic yet challenging. For example, everyone needs to have a physical within 14 days of admission; and if, for any reason, they [the inmate] appear under the influence, they need to be seen immediately by a doctor. Or, if custody staff suspects the individual is intoxicated or high on drugs, they [custody staff] must increase supervision. The bottom line is, examine everyone at booking and document well and most important, and make sure they [the inmate] don’t die while in custody.

Jails are not required to participate with agencies that confirm that they provide an efficient and well-managed healthcare delivery system for those incarcerated. The National Commission of Correctional Health Care (NCCHC), is one of three private nationally recognized non-governmental agencies that uses external peer reviews to
determine whether correctional institutions meet national standards in their provision of health services. Participant 3 indicates:

Our facility chose to voluntarily participate in the accreditation process as a means to ensure we [our jail] meet the New York State Commission of Correction requirements and to minimize our risk exposure. We struggle to meet the accreditation standards that are slightly higher than the minimum standards. In response to your question, I advocate for the minimum standards to address that many jail inmates have a short stay, at our facility it is an average of 21 days. The initial exam timeframe of 14 days is too long. All incarcerated should be subjected to a full exam within 24 hours by a mid-level provider or physician. In addition, medication for an existing illness or newly diagnosed disease identified during the exam should be within 24 hours of the exam. Many of our incarcerated have mental health issues. It would be great to have a psychiatrist on-board to provide an evaluation and necessary medication.

Participant 4 indicated that the necessary healthcare elements outlined by the New York State Commission of Correction are easy to implement. This participant cautions that what becomes tricky is determining sufficient healthcare access, including 24/7 access to a physician if the inmate presents with various healthcare needs.

We [jail staff] are not healthcare experts and many times we send an individual out to the hospital as we do not have 24/7 physician coverage. Our contractual physician coverage is 5 days a week, 9-5. During booking, after 5, and on weekends, if Custody suspects an individual needs medical attention, then we must bring them to the local hospital. This requires two guards, a deputy car and
an unknown amount of time away from the jail. I would like to see NYS mandate a staff physician be available full-time and on-call.

Participants 5 and 6 provided confirmation that the New York State Commission of Correction minimum requirements are straightforward. Participant 5 indicated it would be ideal to decrease the service timeframe for assessment from 14 days to immediate full assessment stating:

Elements should include immediate assessment at booking, medication within 24 hours of exam for existing illness, as well as a new diagnosis. Access to a specialist while incarcerated is paramount as well as mental health medications and therapy. Mandatory drug counseling and medication should be available.

Participant 6 proposed that the necessary elements cover the requirements outlined in the Supreme Court Case (Estelle v. Gamble), that ensures timely access to care, timely access to specialists, medication for drug addiction and mental health services provided by a psychiatrist:

Let me give that some thought, you know, nobody has ever asked me about our medical services. I am not aware of any government agency that ensures we [our jail] provide the services outlined by the New York State Commission of Correction. We are only told to provide evidence of services in the case of a sentinel event. I would propose that the elements closely cover the requirements outlined by the Supreme Court Case (Estelle v. Gamble); to ensure timely access to care, specialists available in a reasonable timeframe, medication therapy, mental health services, physical therapy, and drug addiction services.
In aggregate, all the study participants supported the New York State Commission of Correction minimum standards of healthcare for those incarcerated and many are in agreement that the standards should be expanded to include mental health services, medication, and immediate access to care.

Research Question 2

From the perspective of the administrator of short-term incarceration facilities, what are the elements required for a comprehensive healthcare program during reentry into the community after incarceration?

The results of the data analysis yielded one major theme identified as ‘societal truths’ and one sub-theme ‘public health crisis’. The essence was identified to best understand the participants’ experience described as ‘inequality’.

Theme 2: societal truth. The cultural identity of the United State is defined by personal behaviors deemed either acceptable or unacceptable, and by the racial composition of our population. Societal truth is an agreed on set of behaviors that we as a society believe is right, correct and in the best interest of the group (www.truthmasters.com, 2018). At a social level, the public’s stigmatizing attitudes and discrimination toward inmates, largely represented by people of color, is a societal truth that many non-offenders are unaccepting of behaviors that are deemed unacceptable. This societal truth that wrongdoers should not receive free healthcare services provided by law abiding citizens’ tax dollars permeates the current public policy. Frustration towards society was expressed by all participants due to the lack of resources available to provide the identified services as required for a comprehensive healthcare program during reentry into the community after incarceration. Participant 3 stated:
We [the jail] struggle in our community to provide reentry services for those leaving jail. It is imperative that we view the inmates as an individual, this is not a one-size fits all approach. Reentry services should be provided by a government agency from a place of support that is non-punitive or judgmental. This would eliminate having probation or custody involved as many do not or will not open up to us regarding their struggles. I advocate for individual support and therapy which would include a range of educational and vocational opportunities based on their [the inmate’s] personality, temperament, and interests. Substance abuse treatment and conducting a risk needs responsivity assessment should be used to best determine a path for that individual.

Participant 4 emphasized the power in collaboration, and readily expressed frustration at the lack of coordination of services amongst the community providers:

Unfortunately, our community has a very high recidivism rate, close to 40% return to jail within one year of their release. Many return as an indirect result of no home, job, or access to needed safety net services. We [the jails] have opportunities and the obligation to build partnerships and collaborate with community agencies to provide services that would include problem solving skills, mental health and substance abuse counseling, community integration, job skills, housing, and medical services. The services should be coordinated through a government agency, either the public health department or social services.

The challenge of the ex-offender who is stigmatized by law abiding members of society is a collateral consequence of incarceration, further impacting community reintegration (Shicker, 2014). Participant 5 stated:
Justice-involved people are highly stigmatized and marginalized in relation to community structures, including the healthcare system. However, effective collaborations across justice and community-based health settings and among social, medical, and behavioral healthcare providers can improve the outcomes and reduce costs for our entire community. Health insurance alone will not be sufficient to effectively link people released from jail to appropriate community-based care. Don’t get me wrong, healthcare coverage is important for everyone, but by itself it does not ensure the availability of a provider, or the individual’s ability to successfully navigate our complex healthcare system. Many complain that there are no providers who will accept Medicaid, or the wait list is greater than three months. As a community, we will need to create linkages to, or settings capable of providing comprehensive social, behavioral health, and physical care for everyone reentering their community.

Incarceration and release have lasting effects on the individual and the community. The distribution of those incarcerated is typically concentrated in inter-city neighborhoods plagued by poverty, unemployment, lower education levels, and limited housing options (Massogolia, 2008). Participant 1 echoes the struggle in their community and stated:

It would make sense to have our local health department [public health] transition inmates from jail back into our community. As the jail administrator, I have been successful with securing grants to help defray the cost of continuing care for mental health issues when someone is released. Sadly, in New York State, we, the jail, are only required to conduct discharge planning for individuals with a mental
health diagnosis. My staff is unable to secure housing, food stamps, employment opportunities, training, and any other identified needs. We have been successful in identifying treatment options and providing 30 days of medication. My frustration is that the individual, and our community deserve better than what we alone can do. Again, I advocate every year during our budget presentation, that the affiliated local health department be the primary discharge planner for everyone incarcerated. This approach will ensure connection with needed services. The program design I would advocate for includes insurance for primary care services, housing support services, job training, mental health counseling, and addiction services.

All participants advocate for a structured, coordinated care plan for re-entry that addresses the health, chronic illness, and social factors that are prevalent among ex-offenders. Participant 2 recognized that the time incarcerated provides an opportunity to intervene, and states:

My thoughts are the key elements of a successful reentry program needs to start when at booking, period. At my facility the average days in is 32. Assessment of needs immediately is important, we [the jail] don’t have a long time to impact their [the inmates] lives. I am a big proponent of our municipality, whether it be our public health department, or social services, assess the individual within 24 hours and identify what their [the inmate’s] needs will be at release. Minimally, these departments should act as an extension of the jail system to identify the individual’s need for job training, housing, medical, mental health, and any other community resources required.
Participant 6 agreed and vocalized support towards a structured reentry model. This model, however, does provide a bleak reality of the fiscal burden to the community, stating:

Our jail recognizes the importance of reentry initiatives. The unfortunate reality is we [the jail] have very little funding to provide services, other than what is required while the individual is under this roof. At this time, I rely heavily on our public health department that works with probation, social services, and other external agencies. The challenge is we [the jail] do not have one agency responsible for oversight of the whole process. Many of the individuals released lack a primary doctor, mental healthcare access, no formal job training, and undesirable living arrangements. We are fortunate that our population is small and manageable for assessment of needs, but our county is small, poor, and lacks good employment opportunities. My primary goal is individuals leave with medical coverage and referrals for services. To answer the question, services need to include assessment of needs, ensure medical coverage and a doctor, job training, housing assistance and drug addiction help if needed.

**Research Question 3**

From the perspective of the administrator of short-term incarceration facilities, what are the challenges and barriers to implementation of the identified elements in research questions 1 and 2?

The results of the data analysis yielded one major theme identified as ‘resource reality’ and one sub-theme ‘political’. The essence was identified to best understand the participants’ experience described as ‘political platform’.
Resonant throughout every interview was a collective awareness of the lack of resources available and then later allocated to the needs of those incarcerated as well as the ex-offender reentering their community. Resource availability and deployment is not limited to just a financial commitment. These leaders described a reoccurring reality of limited human resources including support from taxpayers, legislatures, and the community to allocate those resources to this vulnerable population.

Participant 1 was very vocal and shared a common challenge that has become a resource reality struggle.

There is a new political force every four years [the election of a sheriff] that significantly impacts my ability to provide the services that are necessary…not just for those incarcerated, including the ex-offender, but also for their families, the community and everyone’s well-being. Currently, we [the jail] contract with a private medical/mental health services provider for all those incarcerated in our county. We once had a very strong health program for those incarcerated provided by our local health department. In addition, we had transition services provided by probation that included referrals and follow-up for housing and job training which had direct access to and reported to our court system. Six years ago, that all changed with the election of a conservative county executive that advocated for the outsourcing of vital services to save money. Gone is our transition planning and any follow-up to the court system. What is most concerning is that the strength of the services provided, medical and mental health, are all negotiated and outlined in a contract with a for-profit out of state vendor. Whenever we [the jail] identify anything we feel is needed and was not agreed on at the time of
signing [vendor contract], we [the jail] must petition for an amendment to the existing contract, and typically there is an increase for the added or enhanced service. My last experience with requesting an amendment to ensure all inmates being released received a 30-day supply of vital medications took over a year to become a reality. In addition, the vendor charges ex-offenders for copies of their medical records. This practice places an undue burden on them [the ex-offenders]. Participant 2 provided a very global account of various challenges with implementation of comprehensive services and stated:

Providing services to those incarcerated is not a popular political platform in our community. We have multiple jails, pre-sentencing, sentenced, and a prison. Many [correction and support staff] rely on the system to support their families, these jobs send their kids to college, buy their houses, cars, and boats. Resources for reform [benefitting inmates and ex-offenders] and providing anything above the minimum standards outlined under New York State Commission of Correction is frowned on. Every year during our budget allocation meetings me and the Sheriff advocate for additional funding to ramp-up services, however, we have not been approved.

Participant 6 represented a small rural community and the impact of poverty and how that poverty cycle continues.

Our biggest challenge is effectively engaging people who understand just how complex and interrelated health, legal, social, and economic needs are for those incarcerated and when reentering into our community. Our community is small and has socioeconomic challenges for many of us [citizens]. We [citizens] have
limited medical and mental health providers in our community. Their [the providers’] first allegiance is to the law-abiding citizen. Many of our ex-offender’s report having to wait weeks, if not months for services.

Participants 3 and 4 were eager to share the social injustice they witness daily and offer an expert overview of the challenges that plague their jail system. Participant 3 was well versed on the significance of the Affordable Care Act, stating:

Individuals that frequent our system, you know, those who move in and out of jail, also known as frequent flyers. These individuals, and most of their families have a low income and substantial medical and mental health needs. Many do not have health insurance, and experience limited access to needed services, both medical and social. The Affordable Care Act should have helped us increase coverage. We are fortunate in New York State that we have expanded Medicaid. What we can’t figure out is why our incarcerated population continues to either not seek medical coverage or is unaware of options. Overall, we have multiple challenges with adopting services that would improve access to care for the ex-offender and provide stability in their lives. Those challenges include recent reduction in human resources in our social services division, expanding services provided in the jail, as well as coordination of services during reentry.

Participant 4 was passionate when reiterating various solutions:

We must connect people during reentry with survival needs. Again, cross-agency collaboration is essential for success. When I reference survival needs, I am including medical, mental health, housing, and jobs. Overall, money is needed to
support efforts to organize and implement a referral agency to work with these individuals and help them access services.

The political environment in a community is viewed as a considerable challenge. Participant 5 expressed concerns with the stigma attached with having been incarcerated:

I see it every day in my community. Those who are incarcerated are typically shunned by their family, and worse when they [the ex-offenders] are released, both their family and their community reject them. It may be that in addition to being embarrassed, they [the ex-offender] now faces added financial burden. We [the jail] lack an organized structure to evaluate and coordinate what is needed while incarcerated and when released. Money is always tight in our budget; however, I feel there is enough to have a consultant evaluate our current approach and provide a cost-effective approach that will ensure availability of comprehensive services when in jail and when released.

Summary of Results

In conclusion, each of the six jail administrator participants expressed a keen awareness of the comprehensive medical services that should be provided to those while incarcerated and during reentry back into the community. In addition, each of these administrators openly acknowledged the challenges and barriers encountered with the allocation of resources and implementation of desired services. Despite these leaders’ daily challenges, each administrator demonstrated through actions, the professional acceptance of responsibility to advocate for continued awareness of comprehensive services necessary for those incarcerated as well as those for the ex-offender.
Additionally, these leaders readily talked about their dissatisfaction with the “bare minimalist” approach to providing the services mandated by law. Collectively, each leader described their actions which helped to ensure a higher standard of medical services be provided to those incarcerated and during reentry into the community. These responses reflected well thought out solutions to improve a very complex issue.

Jails are structured so that the decision-making authority is clear to both those that work in that environment and those that are incarcerated. Each leader expressed frustration with the inequities related to the medical, social, and economic circumstances of those reentering their communities. These leaders provided details of actions taken that resulted in a positive impact on the cumulative disadvantages the incarcerated have endured.

The lack of funding, including opposition from forces in the community, has not swayed these leaders in their conviction to providing comprehensive services. In many instances, these jail administrators were relentless in advocating for consistent comprehensive services. The external environment continues to challenge these leaders who are committed to gathering allies to get the message across and to attract funding to support needed services.

Chapter 4 described both the interview process and the results of the qualitative methodology garnered through extensive coding outcomes. In addition, this section discussed the results of the interviews and the subsequent data analysis, including identified themes that emerged from the coding.

Chapter 5 will address and discuss the implications and recommendations resulting from this research study.
Chapter 5: Discussion

Introduction

The purpose of this study was to explore and to understand from the perspective of the jail administrator of short-term correctional facilities in New York State, the elements required for a comprehensive healthcare program for those who are incarcerated and those ex-offenders reentering into the community after incarceration. Utilizing qualitative research methodology, semi-structured, face-to-face interviews with six New York State jail administrators were conducted, transcribed and coded to address the following research questions and to identify themes towards the solution of this complex problem:

1. From the perspective of the administrator of short-term incarceration facilities, what are the elements required for a comprehensive healthcare program for those who are incarcerated?

2. From the perspective of the administrator of short-term incarceration facilities, what are the elements required for a comprehensive healthcare program during reentry into the community after incarceration?

3. From the perspective of the administrator of short-term incarceration facilities, what are the challenges and barriers to implementation of the identified elements in questions 1 and 2?
Implications of Findings

The findings of this study indicated wide variations exist with the provision of minimum healthcare services provided to the incarcerated in short-term facilities. The application of minimum healthcare services as required by the New York State Commission of Correction is in response to the 1976 Supreme Court, *Estelle v. Gamble* ruling that defined the guidelines for the provision of healthcare in correctional settings. Consistent with previous studies (Anno, 2009; Kulkarni, 2008; Wilper et al. 2009,) the existence of anecdotal data versus experimental data is the basis of establishing provisions for healthcare to a vulnerable population. As such, services to incarcerated individuals remains inconsistent across facilities.

Three themes emerged from the data derived from the semi-structured interviews with six jail administrators of short-term correctional facilities in New York State: (a) *bare minimalism*, (b) *societal truths*, and (c) *resource realities*. These three themes propel this study’s implications and suggestions for practice.

**Bare minimalism.** Throughout the data collection process, reference to bare minimum was a consistent theme described by all participants. In conjunction with the literature review and the data reported by the participants of this study, both demographic and social factors contribute significantly to the complex healthcare needs of the incarcerated population (Bureau of Justice, 2004; Wilper et al., 2009). The *Estelle v. Gamble* ruling that the bare minimalism concept is exacerbated by the overall community concern for return on investment of those incarcerated and those released back into the community. These concerns include the disenfranchisement of law-abiding, tax paying
community members, healthcare provider concerns for recompense of services rendered, and political posturing.

**Societal truths.** The future of every community is dependent on a commitment to understand and to respond to the health risks and disparities impacting the incarcerated. As indicated by Smith and Braithwaite (2016), acknowledgement is not enough regarding a system that disproportionality lessens the life opportunities of disadvantaged ethnic minority groups. Likewise, the respondents acknowledged the criminal justice system is overwhelmed with imperfections that negatively impact health equity. All agreed, social justice and criminal justice go hand in hand.

Respondents concurred with Massoglia’s (2008) study regarding the impact of incarceration identified as a new stage in the life course of young low-skilled men of color. The participants of this study were not familiar with the theoretical perspective of the life course theory. Nevertheless, these leaders’ actions demonstrated a commitment to the social, economic, and environmental factors as underlying persistent inequalities. As such, these leaders’ actions have indirectly framed health as a social phenomenon, resulting in the topics of health and healthcare for the offender and as well as the ex-offender to become social justice and health equity issues for this population. This indirect operational framework has served the participants to better understand the life circumstances and trajectories of those incarcerated. Incarceration is a significant event in the life course of any individual, yet incarceration is also an opportunity for the criminal justice system to mitigate inequities in healthcare during the incarceration period and again during reentry into the community.
Community disenfranchisement. The vulnerability of the incarcerated is noted by the participants and acknowledged in the literature as a population that is marginalized and disproportionately represented by minorities from low-income medically underserved communities (Dumont et al., 2012). Consistent with the findings from Wilper et al. (2009), adult males of color make up most of the incarcerated population. Consequently, participants reported difficulty in obtaining internal and external support to provide services identified as necessary to preserve physical function and decrease the burden to society.

Physician disenfranchisement. Congruent with the Scheyett, Vaughn, and Taylor (2009) study participants also stated that the majority of the inmate population suffers from both mental health and substance abuse disorders. All the participants of this study spoke to the need for mental health and substance abuse services, however, only one participant referenced use of a diagnostic mental health tool that was administered by an individual who did not have education and/or experience in mental health. Additionally, all participants stated that opportunities exist to better understand the life circumstances of those incarcerated. Consistent with Dumont et al. (2012), all participants acknowledge that incarceration and release have lasting effects on the community.

Resource realities. Participants concurred with Schmittker, Uggen, Shannon, and McElrath (2015), study of the spillover effect of incarceration as the current reality their communities are experiencing. Without jail leadership securing the necessary support required for those incarcerated and after release, law abiding citizens who thought they were unlikely to be impacted by incarceration will continue to experience the spillover effects identified as diminished access to care, less access to specialists, and decreased
satisfaction in healthcare received. Therefore, the consequences of incarceration will continue to impact the quality of life for the entire community. Congruent with the Schmittker et al. (2015) study, participants agreed that continuity and quality of healthcare provided to those incarcerated, and the ex-offender, whether in jail or in the community will both impact and burden resources needed in both the jail and community systems. Likewise, all participants of this study struggled to effectively communicate the social costs of incarceration that linger long after inmate release impacting the entire life course of each ex-offender’s life trajectory.

Recommendations

To make practical use of the findings in this study, several tenets will be explored including recommendations for further research, recommendations for policy revisions informed by social justice, and lastly, recommendations for improved practice by identifying collaborative partners.

**Recommendations for further research.** Continued research is needed to evaluate the various mechanisms of incarceration on health issues. Massoglia (2008) reports that the disruptive impact of incarceration, combined with major life events such as divorce, loss of employment, loss of loved ones, adversely impacts health.

In addition, Nowotny (2017) concluded that the varying patterns of healthcare service use may be influenced by the availability and access to services in response to their medical needs while incarcerated. Conducting a cross-national empirical research study to identify medical and support service gaps while incarcerated is needed to determine varying patterns of healthcare use while incarcerated.
Furthermore, longitudinal and in-depth research can expound the ways in which incarceration affects the individual, their family and the community in the long-term.

**Recommendations for policy development.** The study participants and scholarly researchers (Macmadu & Rich, 2015; Massogolia 2008; Wilper et al. 2009), concur that jails have become the primary care provider for some of the sickest individuals. Likewise, there is acknowledgment that the quality and quantity of healthcare provided and required while incarcerated and during reentry remain unclear. Meeting the minimum standards is critical in protecting against Eighth Amendment violations however, improving the health of individuals while incarcerated and during reentry will require higher standards to be developed and to be supported through the lens of social justice. The ultimate outcome is formulating a consistent, replicable program for health service delivery for all persons in short-term incarceration and during transition back into the community.

Anno (2009) reported that the most compelling reasons to improve correction healthcare should be based on ethics. In this research study, participants suggested the need for an integrated approach to correctional healthcare. The recommended design is one that is consistent with the best interest of those incarcerated, including the ex-offender, and developed from sound public policy incorporating the tenets of social justice.

The first step toward realizing this vision is to identify stakeholders that will serve as advocates in the development of policy. The second step requires engagement of the community stakeholders to work together to develop and implement systems to support the initiatives. Both of these steps will require application of the life course perspective to
identify how the criminal justice system can contribute to eliminating inequities in healthcare at two pivotal times: during incarceration and later during reentry into the community.

Researchers and study participants agree that the health-related services provided those while incarcerated and during reentry into the community either provide or fail to provide the intended service. The criminal justice system is one component of a complex web of systems that contribute to the social determinants of health. Winterbauer and Diduk (2012) indicate that the social determinants of health are the conditions in the places where people live, learn, work, and play. Application of these determinants can improve individual and population health and advance health equity (Winterbauer & Diduk, 2012). Creation of multifaceted advocacy groups will include organizing a jail administrator consortium that includes representation across New York State to identify and create standard best practices.

Efforts to amend the existing policy will require the offender, the ex-offender and the family to form a consortium of sorts, to ensure a voice in the process and to provide public and political awareness of the social costs of incarceration. These individuals should be part of the multi-faceted advocacy group contributing to policy. Spending recorded by correctional facilities does not factor in the costs endured by incarcerated persons, families of the incarcerated, the children of the incarcerated, and the communities the formerly incarcerated return to. These costs are known as the social costs of incarceration (McLaughlin et al., 2016). It is imperative that all costs associated with incarceration are known to ensure maximization of social welfare that is achieved
when incarceration is supplied at the level where marginal social benefit equals the marginal social cost (McLaughlin et al., 2016),

In addition, medical professionals have an unpresented opportunity to advocate for inmates and the health of their communities by working with other stakeholders to develop evidence-based treatment guidelines to include the medical, mental, dental, and social needs of those while incarcerated and services during re-entry into the community. Replication of service guides already developed by medical professionals in various communities for the long term medical needs of the geriatric population could be developed for those incarcerated, the ex-offender, and the community at large. These guides serve as identifiers of Medicaid-friendly medical providers and serve as points of contact for ex-offenders who seek medical care upon release.

Furthermore, marketing and education of the public as to cost of recidivism, and the public health impact of incarceration are required. The term “spillover effect” was coined by Schnittker et al. (2015) and implies the impact of incarceration on the public includes but is not limited to diminishing their access to medical care and decreasing their access to medical specialists. These unintended consequences of incarceration experienced by the public can be reduced though effective transition planning of offenders from jail to the community as well as exploring ways of improving healthcare practices focusing on this population (Schnittker et al, 2015).

**Recommendations for improved practice.** Varying standards have been identified as a confounding factor with the provision of healthcare services provided (Wilper et al., 2009). The participants of this study confirmed that the minimum standards of care, although sometimes difficult to meet, need to be evaluated and
timelines modified, to ensure evaluation of inmate needs begins the during intake process. The respondents indicated that the medical evaluation timeline should be amended to an immediate timeframe, indicating of within 24 hours of booking. In addition, all participants responded that immediate access to needed medication and specialty services is a best practice. Expanding services to include mental health and substance counseling is also critical. Application of this framework can assist with identification of medical and social needs during incarceration and referral to services when reentering the community.

Incorporating public health systems science to address complexities is a necessity. These identified complexities have become concepts that focus attention on improving understanding of the interactions within and across various systems to identify opportunities to change the structures that produce health. Application of this cross-sectional approach may help to understand and to change the provision of healthcare services, including the identified health consequences of those while incarcerated and during reentry into the community. The recommended framework has the potential to provide a comprehensive, consistent, recognized medical and support services mandate for individuals incarcerated and when transitioning back into the community that can be replicated throughout short-term incarceration facilities on a national level.

Goals to construct a comprehensive medical and support services program in short-term incarceration facilities for those incarcerated and during transition back into the community can be informed by a synthesis of available evidence and recommendations for future research.
Application of health information technology to achieve a system integration both within and between jails and the community service provides will provide an immediate improvement in continuity of care across the systems. Integration of systems can be accomplished by broadening the jail's scope of services beyond the immediate medical needs. Implementation of an expanded receiving screening tool would be beneficial for immediate identification of both medical and social needs while incarcerated and when transitioning back into the community. The expanded screening tool will consider all inmates’ needs and map interventions at various stages of individual interaction within the jail from arrest, through arraignment, and to reentry back into the community.

A disconnect between correctional healthcare and local health departments exists (Winterbauer & Diduk, 2012). Interconnectivity of public health and corrections should be a priority. The need to evoke Public Health Department’s involvement is paramount. Historically, Public Health departments were founded to advance human well-being by improving health and to do so by focusing on the needs of the most disadvantaged (Winterbauer & Diduk, 2012). Although many of the community level impacts of incarceration are overwhelmingly negative, such as exacerbating social, economic, and political inequalities for vulnerable populations, correctional healthcare offers a unique public health opportunity. The participants in this study referenced their local health department as the desired healthcare provider for those incarcerated and when transitioning back into the community.

Chronic illness and infectious disease are prevalent among the incarcerated population, however, while incarcerated approximately 68% of jail inmates do not receive the medical services required for their chronic illness or infectious disease
(Bureau of Justice, 2002). The spread of disease within jails is a small factor compared to the effects of releasing inmates into the community with these diseases being transmitted into the community due to ex-offenders’ lack of access to treatment (Wilper et al., 2009).

Exacerbating the ex-offenders existing cumulative disadvantages is the post-release effects of incarceration includes substantial social costs. Reentry initiatives require understanding how health risks and disparities affect the transition from incarceration back into the community. Evaluation of existing models of success include the Prevention Science Framework that focuses on the skills and supports individual needs to produce practical and meaningful change.

**Limitations**

The complexity of this study over the duration of an abbreviated doctoral programmatic timeframe of 28 months provided several limitations. These limitations were related to sample size and the potential for researcher bias.

Although the researcher was able to focus on these six interviews which incorporated only four of the 52 New York State counties, rich data was obtained. However, this small sample size limits the generalizability of this study. In the context of short-term incarceration facilities in New York, it may be valuable to interview a wider cross-section of jail administrators. The commonality in opinions, experience, challenges and barriers was remarkably consistent given the small sample size.

In addition, a limitation of the study that could be considered was that the researcher worked in the justice system. Measures were taken by the researcher to ensure that bias was mitigated in the study by adherence to ethical guidelines, descriptive and reflective field notes, as well as following the interview with minimal deviation.
Conclusion

This study examined the elements necessary for the provision of comprehensive healthcare to those incarcerated and during reentry into the community from the lens of the jail administrator. In addition, the jail administrators detailed the challenges and barriers encountered with implementation of the identified elements, including possible solutions. These jails administrators agreed that as healthcare becomes more equitable, less spillover of disease into the community from ex-offenders with adequate medications and treatment options can benefit all.

The limited social response from the public, lawmakers, and municipalities has worked to further disenfranchise an already vulnerable population. To successfully improve the conditions of the offender, both during incarceration and following release, the focus of interventions and programs must shift to ensure successful reintegration.

Problem statement. Violation of the Eighth Amendment of the United States Constitution occurs if an inmate is denied or experiences unreasonable delayed access to a physician for diagnosis or treatment. In addition, failure to administer treatment prescribed by a physician, and or denial of professional medical judgement constitutes a violation of the eighth amendment.

Jails are constitutionally mandated to provide medical care that meets the standards of healthcare that others in the community experience. Despite this ruling, 2.2 million incarcerated Americans who depend on the jail for healthcare continue to face limited access to medical care (Wilper et al., 2009).

Those incarcerated present with substantial racial, ethnic, and health disparities that distinguish them from the general population. Forty years after the Estelle v. Gamble
ruling, the practical application of this decision is still debated as correctional healthcare often fail to meet the needs of those incarcerated (Wilper et al., 2009). Comprehensive medical and support services provided individuals when incarcerated and the ex-offender returning to the community, lack consistency, recognition, and replication on a national level.

Development and implementation of a comprehensive healthcare program could have a profound effect on how the criminal justice system can contribute to eliminating inequities in healthcare at two pivotal times: during incarceration and later during reentry into the community.

**Purpose of the research.** The purpose of the qualitative study was to explore and understand, from the perspective of the jail administrator, the elements required for a comprehensive healthcare program for those incarcerated and during reentry into the community. Additionally, the purpose of the study was to aid in addressing the collective challenges that short-term correctional facilities face with implementing a comprehensive healthcare program for those who are incarcerated and during reentry into the community.

Application of a theoretical framework that emphasizes the cumulative effect of disparity and focuses on structural approaches for change is suggested to develop a multi-level approach with establishing comprehensive medical and social services programing for those incarcerated and when returning to the community. Utilizing the theoretical perspective of life course theory as a framework for understanding health as a social phenomenon will aid in identifying the interventions this vulnerable population requires.
**Theoretical rationale.** Life course theory serves as a framework for better understanding the needs of the incarcerated and ex-offender through identification and understanding of their experienced cumulative disadvantages (Hutchinson, 2005). This theory proposes that when health is framed as a social phenomenon, then health is emphasized as a topic of social justice and health equity becomes the guiding criterion (Hutchinson, 2005).

Life course theory recognizes the importance of health equity in populations and emphasizes that inequity in health reflects more than genetics and personal choice. The literature on this topic has broadly examined the staggering implications and fiduciary impact associated with the incarcerated.

**Review of the literature.** The literature on this topic addressed standalone issues such as: (a) incarcerated individuals rate of chronic illness as compared to non-incarcerated; (b) access to medical care while incarcerated; (c) transition of the ex-offender into the community; (d) fiscal impact of incarceration on those incarcerated, the ex-offender, and the community; (e) social costs of incarceration for those incarcerated, the ex-offender, and the public; and; (f) leadership influence and opportunities on current policy impacting those incarcerated and the ex-offender.

Quantitative data was the primary methodology and focused on evaluation of one segment of service and outcome as opposed to collectively examining services and outcomes collectively.

**Research Methodology.** The study used a qualitative method with a descriptive inquiry. Specifically, the research sought to answer the “what” question and provide rich descriptive content. This qualitative study explored from the perspective of the jail
administrator of short-term correctional facilities in New York State, the elements required for a comprehensive healthcare program for those who are incarcerated and when the ex-offender is transitioning back into the community. The topic was specifically examined through the practitioner’s lens of open-ended inquiry with consideration of the life course theory concept of cumulative disadvantage and health.

The Institutional Review Board of St. John Fisher College approved this study. Participation in the study was voluntary and informed consent was obtained from each participant. Data were collected during face-to-face interviews with six study participants representing five of 57 counties in New York State with a short-term incarceration facility.

Measures were taken to protect the identity of the participants and the confidentiality of the data. In addition, no demographic information was collected or reported as anonymity and ethical research conduct was essential as the issues could have been sensitive.

Descriptive and reflective field notes were compiled during the interview and incorporated into the notes section of the transcription. Participants were offered an opportunity to review their interview transcript, however, all declined. From this extensive research process, the researcher endeavored to discover the findings and implications of the data.

**Findings and implications.** Interview recordings of the face-to-face, semi-structured interviews were transcribed verbatim into transcripts. All transcripts were reviewed and compared to the digital recordings. Once in written form, three distinct coding cycles were applied. The first cycle, or initial coding of the data, was further
analyzed with application of descriptive coding to identify the participants’ perspectives and actions, comparing the data for similarities and differences. Pattern coding was applied during the third cycle, allowing the researcher to build a framework for analysis of major themes identified from the data.

The three-step coding process led to the identification of the following three themes:

1. Bare minimalism was coined as the theme that references the behavior to provide the bare minimum, not as a choice, but a justification.
2. Societal truths are an agreed-on set of behaviors, that we, as a society believe is right, correct and in the best interest of the group.
3. Resource realities are inclusive of financial and human resources, including support from taxpayers, legislatures, and the community.

Given what is known regarding the needs of the offender while incarcerated and when transitioning back into the community, without change, jail administrators will continue to struggle to meet the minimum standards of care. Without radical policy change, the offender and the community will continue to experience the collateral consequences of incarceration.

**Discussion.** The jail administrators have been presented with a dilemma in that the high rate of incarceration offers an opportunity to identify and treat the most vulnerable people who might otherwise not have access to healthcare, but at the same time jail administrators are challenged to provide the minimum mandated healthcare. This problem is already aggravated by an already stressed public health system and an already stressed system of providers who are tasked to provide quality services to the
masses who stigmatize the inmate and the ex-offender who are in need of similar services. Therefore, the majority of inmates represent the most disadvantaged segments of society. The poor health status of the jail inmate population is an indicator of their cumulative disadvantages and reinforces the importance of healthcare provisions while incarcerated and when reentering the community as an extension of public health.

The results of the study suggest the immediate needs for a comprehensive plan be developed in collaboration with identified stakeholders to ensure adequate healthcare is provided individuals incarcerated and during reentry into the community. In addition, the comprehensive plan must recognize that the bare minimalist approach to providing healthcare services while incarcerated and during reentry into the community is further exacerbated by societal truths of righteousness justified through resource realities. Analysis of all costs associated with incarceration is critical to ensure social welfare maximization that will be achieved when incarceration is supplied at the level where the marginal social benefit equals the marginal social cost.
References


Appendix A

Collaborative Institutional Training Initiative (CITI)
Appendix B

Research Questions

1. From the perspective of the administrators of short-term incarceration facilities, what are the elements required for a comprehensive healthcare program for those who are incarcerated?

2. From the perspective of the administrator of the short-term incarceration facilities, what are the elements required for a comprehensive healthcare program during reentry into the community after incarceration?

3. From the perspective of the administrator of short-term incarceration facilities, what are the challenges and barriers to implementation of the identified elements in questions 1 and 2?
Appendix C

Interview Protocol Script

Facility: _____________________________________ADP_________________

Interviewee (Title and Name): ______________________________________

Date_______________Time_________________________Setting____________

Jurisdiction ______________________Funding Source____________________

Appointed or Elected

Semi-Structured Interview Script

Introductory Protocol

*To facilitate my note-taking, I would like to audio tape our conversations today. Please sign the release form. For your information, only researchers on the project will be privy to the tapes which will be eventually destroyed after they are transcribed. Essentially, this document states that: (1) all information will be held confidential, (2) your participation is voluntary, and you may stop at any time if you feel uncomfortable, and (3) we do not intend to inflict any harm. Thank you for your agreeing to participate.*

*I have planned this interview to last no longer than one hour. During this time, I have three questions that I would like to cover.*

Introduction & Ground Rules

You have been selected to speak with me today because you have been identified as someone who has a great deal to share about the healthcare and service needs of inmates, while incarcerated and when transitioning back into the community. The research project as a whole focuses on identification of the critical elements required for a comprehensive healthcare program while incarcerated and when reentry into the community, as well as the challenges and barriers with implementation of the identified elements. The study does not aim to evaluate your current programs or services, rather I am trying to gain in-depth knowledge about your experience and perception related to cultivate comprehensive medical and support services while incarcerated and during transition into the community.

A. Interviewee Background

How long have you been …

_______ in your present position?
_____ at this facility?

General- What led you to law enforcement?

Did you study criminal justice in school? ____________________________

What was your field of study? ________________________________

Are you a member of the Chiefs Association?__________

**Grand Tour:** Briefly describe the current healthcare services program at your facility

Probe: If outside source—how long______________

Probe: How are you involved in oversight of those services?

Probe: How are you kept informed of issues/concerns?

Is your facilities medical services NCCHC certified? ________ if yes, how long; if no- are you planning on participating in accreditation?

**Elements required for a comprehensive healthcare program while incarcerated**

1. What do you feel are the critical elements required for a comprehensive healthcare program while incarcerated?

Probes: What critical elements can be provided by the community in this facility?

**Elements required when returning to the Community?**

1. What elements do you feel are critical for individuals when transitioning back into the community?

Probes: How are you kept informed of the services provided those during reentry?

**Challenges/Barriers**

1. What are some of the major challenges your facility faces when attempting to implement the critical elements required for a comprehensive healthcare program for individuals while incarcerated?

Probes: How can those challenges be overcome?

How can opportunities be maximized?

2. What are the major barriers experienced with implementation of the critical elements of the healthcare program for individuals while incarcerated?

Probes: How can those barriers be overcome?

How can opportunities be maximized?
Appendix D

New York State Jails – List

New York State County Jail Administrator's Addresses, Telephone, and Facsimile Numbers

Addresses

- County Jail Addresses
- New York State Sheriffs
- New York State County Jail Administrators
Appendix E

Invitation Letter

March 2018

Dear (Insert name of potential participant)

This letter is an invitation to consider participating in a study I am conducting as part of my doctoral degree in the Department of Education at St. John Fisher College under the supervision of Dr. Michael Robinson. I would like to provide you with more information about this project and what your involvement would entail if you decide to take part.

We know that the incarcerated population over-represents socially marginalized and disadvantaged individuals with a high burden of disease. Opportunities exist to improve the health not only of those incarcerated, but also of the communities to which those released will return. The purpose and the potential significance of this study is its contribution to development of uniform, replicable, comprehensive health services for those incarcerated and during their reentry into the community. This study will focus on healthcare during short-term incarceration and during their return to the community, including the critical elements and challenges.

In sum, the wide-variation in the quantity and quality of correctional healthcare that occurs within the jail system presents challenges with evaluation of services. In addition, no research has explored from the perspective of the jail administrator, the elements required for a comprehensive healthcare program during incarceration and when transitioning back into the community. This study seeks to gain a deeper understanding of the challenges and barriers with the implementation of identified elements that will be derived from your perspective.

Participation in this study is voluntary. It will involve an interview of approximately one hour in length to take place in a mutually agreed upon location. You may decline to answer any of the three interview questions if you so wish. Further, you may decide to withdraw from this study at any time without any negative consequences by advising the researcher. With your permission, the interview will be tape-recorded to facilitate collection of information, and later transcribed for analysis. Shortly after the interview has been completed, I will send you a copy of the transcript to give you an opportunity to confirm the accuracy of our conversation and to add or clarify any points that you wish. All information you provide is considered completely confidential. Your name will not appear in any thesis or report resulting from this study. Data collected during this study will be retained in a locked cabinet in my home office and destroyed no later than 2021.
If you have any questions regarding this study or would like additional information to assist you in reaching a decision about participation, please contact me at (315) 558-9795, or by e-mail at kab00640@sjfc.edu. You can contact my supervisor, Dr. Michael Robinson at (315) 498-7237, or e-mail aticrobinson@sjfc.edu.

I would like to assure you that this study has been reviewed and received ethics clearance through the Institutional Review Board at St. John Fisher College. However, the final decision about participant is yours. I hope that the results of my study will benefit jails through the identification of elements required for comprehensive medical services to those incarcerated and during reentry back into the community.

I will call you in one week to discuss your participation in this study and/or if you would like to discuss the details of this project. Please forward this invitation to other who might be interested.

Thank you for your consideration.

Sincerely,

Karen Ann Buck (kab00640@sjfc.edu)
Ed.D. candidate, Department of Education, St. John Fisher College
Appendix F

Informed Consent

St. John Fisher College
INFORMED CONSENT FORM

Title of study: Healthcare During Short-Term Incarceration and Return to Community: Critical Elements and Challenges

Name(s) of researcher(s): Karen A. Buck MS, MSA, BSN

Faculty Supervisor: Dr. Michael Robinson  Phone for further information: (585) 758 3637

Purpose of study: The purpose of this qualitative study is to explore and to understand the critical elements required for a comprehensive healthcare program for those who are incarcerated and those who reenter into the community, from the perspective of the jail administrators. In addition, those administrators will be queried to identify the implementation challenges of the identified elements.

Place of study: New York State Jails, excluding New York City; Includes; 63 county jails representing 57 counties in the State. Length of participation: 1 hour

Method(s) of data collection: Face-to-face, semi-structured interview, tape recorded.

Risks and benefits: The expected risks and benefits of participation in this study are explained below:

The potential significance of this qualitative descriptive study is to contribute to the limited research on the critical elements required to create a uniform comprehensive health care program for the incarcerated. By adding to the body of knowledge of this problem, the State, local communities, jail administration, and the Commission of Correction has an increased awareness of the challenges that short-term correctional facilities experience. Best practices may be identified which may further translate into the implementation of a comprehensive healthcare program throughout the incarceration period as well as during reentry into the community.

Method for protecting confidentiality/privacy of subjects: All digital audio recordings and transcripts of interviews will be maintained using a private, locked, and password-protected file and password-protected computer stored securely in the private home of the principal researcher. Electronic files will include assigned identity codes and pseudonyms; they will not include actual names or any information that could personally identify or connect participants to this study. Other materials, including notes or paper files related to data collection and analysis, will be stored securely in sealed boxes, locked inside a cabinet in the private home of the principal researcher. Only the researcher will have access to electronic or paper records. The digitally recorded audio data will be kept by the researcher for a period of five years following publication of the dissertation. Signed informed consent documents will be kept for five years after publication. All paper records will be cross-cut shredded and professionally delivered for incineration. Electronic records will be cleaned, purged, and destroyed from the hard drive and all devices such that restoring data is not possible.

Your rights: As a research participant, you have the right to:

1. Have the purpose of the study, and the expected risks and benefits fully explained to you before you choose to participate.
2. Withdraw from participation at any time without penalty.
3. Refuse to answer a particular question without penalty.
4. Be informed of the results of the study.

I have read the above, received a copy of this form, and I agree to participate in the above-named study.

Print name (Participant)  Signature  Date

Print name (Investigator)  Signature  Date
St. John Fisher College
INFORMED CONSENT FORM

Title of study: Healthcare During Short-Term Incarceration and Return to Community: Critical Elements and Challenges

Name(s) of researcher(s): Karen A. Back MS, MBA, BSN

Faculty Supervisor: Dr. Michael Robinson  Phone for further information: (585) 738 3567

Purpose of study: The purpose of this qualitative study is to explore and understand the critical elements required for a comprehensive healthcare program for those who are incarcerated and those who reenter into the community, from the perspective of the jail administrators. In addition, three administrators will be queried to identify the implementation challenges of the identified elements.

Place of study: New York State Jails, excluding New York City; Includes; 83 county jails representing 57 counties in the State. Length of participation: 1 hour

Method(s) of data collection: Face-to-face, semi-structured interview, tape recorded.

Risks and benefits: The expected risks and benefits of participation in this study are explained below:

The potential significance of this qualitative descriptive study is to contribute to the limited research on the critical elements required to create a uniform comprehensive health care program for the incarcerated. By adding to the body of knowledge on this problem, the State, local communities, jail administrators, and the Commission on Correction has an increased awareness of the challenges that short-term corrections facilities experience. Their practices may be identified which may further translate into the implementation of a comprehensive healthcare program throughout the incarceration period as well as during reentry into the community.

Method for protecting confidentiality/privacy of subjects: All digital audio recordings and transcriptions of interviews will be maintained using a private, locked, and password-protected file and password-protected computer stored securely in the private home of the principal researcher. Electronic files will include assigned identity codes and pseudonyms; they will not include actual names or any information that could personally identify or connect participants to this study. Other materials, including notes or paper files related to data collection and analysis, will be stored securely in unmarked homes, locked inside a cabinet in the private home of the principal researcher. Only the researcher will have access to electronic or paper records. The digitally recorded audio data will be kept by this researcher for a period of five years following publication of the dissertation. Signed informed consent documents will be kept for five years after publication. All paper records will be cross-out shreded and professionally delivered for incineration. Electronic records will be cleared, purged, and destroyed from the hard drive and all devices such that restoring data is not possible.

Your rights: As a research participant, you have the right to:

1. Have the purpose of the study, and the expected risks and benefits fully explained to you before you choose to participate.
2. Withdraw from participation at any time without penalty.
3. Refuse to answer a particular question without penalty.
4. Be informed of the results of the study.

I have read the above, received a copy of this form, and I agree to participate in the above-named study.

Print name (Participant)  Signature  Date

Print name (Investigator)  Signature  Date
March 27, 2018

File No: 3864-041918-02

Karen A. Buck
St. John Fisher College

Dear Ms. Buck:

Thank you for submitting your research proposal to the Institutional Review Board.

I am pleased to inform you that the Board has approved your Expedited Review project, "Healthcare During Short-Term Incarceration and Return to Community: Critical Elements and Challenges."

Following federal guidelines, research related records should be maintained in a secure area for three years following the completion of the project at which time they may be destroyed.

Should you have any questions about this process or your responsibilities, please contact me at irb@sjfc.edu.

Sincerely,

Eileen Lynd-Balta

Eileen Lynd-Balta, Ph.D.
Chair, Institutional Review Board

ELB: jdr