

Informing a Program Model to Reduce Recidivism

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Abstract

This study investigates healthcare disparities among individuals recently released from incarceration, focusing on Peterborough County. The purpose and rationale of this research is to identify systemic health disparities upon release from incarceration and identify necessary improvements in healthcare services for people recently released from incarceration. Through the combination of literature assessments and six semi-structured interviews, barriers to healthcare access were explored, including transportation challenges, limited mental health and substance abuse treatment options, and difficulties in obtaining medications post-release. Findings revealed a critical need to address these barriers to ensure equitable healthcare access for individuals recently released from incarceration. Recommendations include implementing drop-in appointment options, expanding supportive transitional housing with on-site medical services, and streamlining processes for medication access. Overall, the study underscores the necessity of comprehensive interventions to address healthcare disparities for recently incarcerated individuals, with the ultimate goal of informing healthcare policies and practices to improve outcomes for this vulnerable population.

Introduction and Background

This research investigates health disparities faced by individuals who have recently been released from incarceration. By thoroughly examining the barriers contributing to these disparities, the primary objective is to gain a comprehensive understanding of the unique challenges encountered by this demographic in accessing healthcare.

The ultimate goal of this research is to inform healthcare practices and policies. By identifying the gaps in healthcare access for people recently released from incarceration, areas for improvement can be pinpointed. This research contributed to the development of targeted interventions and policies aimed at enhancing healthcare services for this vulnerable population. As a result, it has paved the way for more equitable healthcare outcomes for all individuals, irrespective of their prior involvement with the criminal justice system.

Healthcare disparities in Peterborough Counties for previously incarcerated individuals stem from systemic issues that encompass challenges in physical access to healthcare and financial constraints within the healthcare system, despite being studied in Canada, where healthcare is considered free. In Canada, essential healthcare needs such as dental care, vision care, and prescription medication are among the primary healthcare necessities not covered by the healthcare system (Health Canada, 2019). This is particularly significant for individuals who have been incarcerated, as access to dental and vision care can significantly improve their chances of securing employment, successfully integrating into their communities, and achieving success in reintegration efforts such as gaining employment (Russell et al., 2022a). Continuity of care presents further hurdles, as the transition from incarceration disrupts any previously provided care, necessitating the search for new providers and consistent access to appointments outside the confines of incarceration (Matheson et al., 2010). In the incarceration system, care is less voluntary, with appointments made for inmates, thus shifting the responsibility for one's health upon release, which may entail changes in how healthcare situations are managed.

Additionally, there exists a stigma surrounding formerly incarcerated individuals, which may lead to reluctance to seek support for their health needs or even avoidance of medical attention altogether upon reentry into society (Matheson et al., 2010). Despite efforts to improve healthcare access, recently incarcerated individuals continue to encounter significant challenges in obtaining necessary medical care. By identifying these disparities, researchers can begin to understand the intersectional components that contribute to barriers in accessing healthcare services for recently incarcerated individuals, thus paving the way for these issues to be effectively addressed.

Understanding the intersectionality of factors such as socioeconomic status, race, gender, and mental health status is crucial for comprehending the multifaceted nature of the challenges faced by recently incarcerated individuals in accessing healthcare resources. Intersectionality, a concept introduced to analyze how various social identities intersect and interact, is highly relevant to understanding the dynamics of social systems. Socioeconomic status, race, gender, and mental health status are key intersecting factors that significantly shape individuals'

experiences and opportunities. These factors intertwine in complex ways, influencing one another and creating unique experiences and consequent healthcare challenges for each individual.

During re-entry into society after incarceration, individuals face a myriad of challenges compounded by these intersecting factors. Discrimination, lack of resources, and stigma often hinder their successful integration into communities (Kouyoumdjian et al., 2015). Moreover, the compounding effects of intersecting factors exacerbate these challenges, making it even more difficult for individuals to access essential services like healthcare.

Another challenge in post-incarceration reintegration and accessing healthcare arises when individuals encounter significant hurdles transitioning to community-based healthcare services. As they shift to community-based healthcare, continuity of care becomes a hurdle as appointments are no longer arranged for them, especially not with the same healthcare providers they are used to. Recently incarcerated individuals must navigate logistical challenges such as finding a healthcare provider suited to their needs and arranging transportation in a timely manner. This may even involve obtaining a health card to access the parts of Canadian healthcare that are considered free. Particularly for those with substance abuse disorders, locating specialized healthcare providers can be especially difficult due to stigma, and restrictions imposed on individuals leaving incarceration while enrolled in parole programs.

Furthermore, vulnerable populations who have had negative experiences with one healthcare provider are more likely to generalize these traits to all providers, potentially deterring them from seeking healthcare services altogether. Research conducted by Mitchell and colleagues (2012) underscores how housing instability and social stigma compound these healthcare barriers for individuals leaving incarceration, resulting in a lack of continuity of care and support systems for this demographic.

Research conducted by Kouyoumdjian and colleagues (2015) underscores that individuals with a history of incarceration encounter poorer health outcomes compared to the general population. While Kouyoumdjian and colleagues' (2015) research delves into the barriers faced by

previously incarcerated individuals in accessing healthcare, a gap remains in understanding whether these health disparities primarily stem from obstacles encountered in healthcare access for those with a history of incarceration. Nonetheless, the study explores several contributing factors, such as lower social determinants of health, mental health issues, and the potential impact of substance use, thereby shedding light on reasons why people with a history of incarceration tend to experience worse health outcomes (Kouyoumdjian et al., 2015). The current research study examines the obstacles encountered in accessing healthcare while integrating the potential impacts of factors identified as contributors to decreased health outcomes for individuals with a history of incarceration. Additional disparities in healthcare access are attributed to factors like limited healthcare availability and social determinants of health like housing instability, food insecurity, and the stigma associated with incarceration, thereby contributing to the observed lower health outcomes among individuals with a history of incarceration (Howell et al., 2021). Overall, there exists a complex interplay between a history of incarceration and health outcomes.

Furthermore, Ward and colleagues (2019) posit that the healthcare situation for those who have been incarcerated is more complex, suggesting a nuanced relationship between health and recidivism rates. They argue that health issues can present challenges to obtaining and sustaining employment, which poses a risk for recidivism (Ward et al., 2019). This assertion underscores the significance of the current research, as it highlights the potential for health impacts to influence recidivism rates. Identifying healthcare challenges faced by individuals who have been incarcerated could yield benefits for this population.

Ward and colleagues (2019) ascertain those additional stressors, compounded by health issues, contribute to a heightened likelihood of reoffending. Moreover, they propose a positive correlation between physical health problems and criminal behaviour, suggesting that health-related challenges may compel individuals toward risky coping mechanisms. Understanding this relationship highlights the importance of providing adequate healthcare support for those with a history of incarceration to facilitate their successful reintegration into society. Furthermore, if there is a direct correlation between recidivism and access to adequate healthcare, interventions

aimed at improving healthcare access or programming could potentially lead to lower recidivism rates (Ward et al., 2019).

Methodology

The methodology employed in this research involved a combination of literature reviews and consultations and considered grey literature, deeming the available resources not applicable to this research. These consultations comprised semi-structured interviews ($n = 6$) with healthcare, social work, and correctional professionals. Healthcare personnel included a nurse practitioner and safer supply worker, of which the goal of consulting these individuals was to assess the current struggles and stigma encountered by recently incarcerated individuals accessing healthcare resources. Consultations in the realm of social work involved conducting semi-structured interviews with justice service workers and mental health support workers who had experience supporting individuals' post-incarceration, both in provincial and federal corrections. The purpose of these consultations was to understand the differences in healthcare access inside and outside incarceration institutions, discuss barriers to access healthcare post-incarceration among local incarceration facilities, and address challenges in accessing mental health resources post-incarceration.

The consultations conducted were primarily geared towards thoroughly exploring the multifaceted challenges associated with accessing healthcare resources after incarceration. The overarching objective was to delve into the barriers surrounding the availability and accessibility of resources to meet diverse health needs among individuals transitioning from incarceration to society. Central to this endeavour was the identification and examination of perceived barriers encountered by those who have been previously incarcerated, shedding light on the complexities of post-release healthcare access.

A significant aspect of this comprehensive inquiry was the scrutiny of substance use and its impact on individuals post incarceration. Specifically, the consultations meticulously examined the availability and efficacy of drug rehabilitation centers tailored to meet the needs of recently incarcerated individuals. Furthermore, the investigation delved into the nuanced dynamics surrounding the provision of substance use resources, including the complexities surrounding the

exclusion of safer supply options due to liability concerns from post-incarceration support systems.

Moreover, the research explored various pathways for rehabilitation post-incarceration, meticulously assessing associated concerns and practicalities. Within the realm of substance use, the feasibility and effectiveness of resources such as methadone programs and opioid agonist treatment (OAT) modalities for recently incarcerated individuals were carefully evaluated. Additionally, attention was directed towards the utilization of mental health services post-incarceration, uncovering the various challenges inherent in this domain.

A notable dimension of this inquiry pertained to the health outcomes of incarcerated populations, particularly concerning autoimmune disorders. As highlighted by Larsen and colleagues (2021), there is a tendency for individuals who have recently been incarcerated to experience worse physical health outcomes, particularly concerning autoimmune disorders. This observation has garnered increased interest among a variety of researchers, prompting a focused examination of the healthcare challenges faced by this population. Consequently, a sizable portion of this research was dedicated to scrutinizing concerns related to autoimmune disorders, with a specific emphasis on assessing the adequacy of diabetes treatment for type 1 diabetics and HIV-positive individuals, post-incarceration (Larsen et al., 2021). By delving into these specific health issues, the study aimed to provide valuable insights into the effectiveness of current healthcare interventions for managing autoimmune conditions among individuals re-entering society after incarceration.

All aspects and the scope of this research were examined from the perspective of identifying barriers for recently incarcerated individuals in accessing or being satisfied with the available resources to address their concerns. Additionally, early on in the research, transportation and housing concerns emerged as significant factors, leading them to become integral parts of this investigation.

Potential biases in these consultations stemmed from the respondent's profession, career stages, and the nature of their interactions with incarcerated individuals. To address these biases, efforts

were made to include individuals from diverse career backgrounds and stages. Nonetheless, a limitation persists in the absence of consultations involving professionals with similar roles, where one works with federally incarcerated individuals while the other serves in the same capacity but within a provincial prison context. Incorporating perspectives from professionals engaged with recently incarcerated individuals in federal and provincial prisons could have illuminated potential healthcare disparities arising from operational differences between these incarceration systems and varying durations of confinement.

The literature review consisted of primary literature and meta-analyses, as much of the grey literature proved unsuitable for this project due to its focus on comparing healthcare provisions inside and outside of prison. Since the grey literature's emphasis did not distinctly examine concerns outside of incarceration and instead compared data from inside to outside of prison, its utilization was restricted for the research at hand.

Among the available grey literature, the majority originated from other countries, primarily the United States. The fact that the grey literature is not Canadian based presents an additional barrier. While there may be some similarities between Canadian and American prison systems, the significant differences between the two correctional systems precluded reliable comparisons within a Canadian context. Additionally, the lack of literature addressing local systems, such as the absence of official comparisons between federal and correctional prisons in Canada, further complicates matters, let alone comparing each state's incarceration system to federal prisons in the United States. In addition, Canadian and American healthcare systems are so vastly different that this could not be an aspect compared through grey literature.

Consequently, the literature reviewed for this research primarily comprised meta-analyses and primary studies sourced from the Omni database, consisting of peer-reviewed articles spanning from 2010 to 2023. The aim was to ensure the research remained updated and relevant. The selected studies aimed to shed light on the unreliability of healthcare access for individuals recently released from incarceration. Inclusion criteria stipulated that each article must be peer-reviewed, offer recent findings, provide clear operational definitions pertinent to the topic, conduct exploratory analyses, and for meta-analyses, utilize databases from the 2000s onwards,

with a preference for those from the 2010s or later. While some meta-analyses incorporated data from before 2010 due to the nature of longitudinal comparisons or different temporal frames in location-based data, at least one dataset within each meta-analysis was from 2010 or beyond. These studies underscored the complex needs of individuals in this demographic, a subject this research aimed to delve deeper into. Much of the literature scrutinized the challenges encountered by individuals' post-incarceration, notably concerning substance use disorders and obstacles to healthcare access.

Data collection involved an iterative process, beginning with a comprehensive literature review to identify areas requiring further investigation. Grey literature was examined, and most of it was found unsuitable for a Canadian context. Subsequently, semi-structured interviews were conducted, preceded by thorough research into the interviewee's career and role, leading to the formulation and posing of open-ended questions. The ensuing analysis was founded upon these consultations, utilizing Dr. Cahn's adapted coding method to extract themes from the transcripts. These themes were then compared with those identified in the literature to enrich the synthesis and comprehension of the data.

Results

The aim of this research was to explore the healthcare challenges faced by recently incarcerated individuals in accessing healthcare resources. The term "recently incarcerated" lacks a precise timeline definition, as these challenges persist until an individual is effectively reintegrated into society, a process highly variable and contingent on the individual's motivations and circumstances. Importantly, by this definition, some individuals may never fully re-integrate into society.

This research delves into the myriad obstacles hindering recently incarcerated individuals from accessing healthcare. It identifies several crucial barriers, including transportation limitations, housing instability, challenges in scheduling appointments, mental health issues, substance use concerns, difficulties in obtaining medications, and perceived risks associated with seeking assistance. Additionally, it examines existing efforts aimed at mitigating these risks to facilitate healthcare access for this vulnerable population.

Specifically, from consultations and literature transportation emerged as a significant impediment (Lyeo et al., 2023). Main healthcare facilities tend to purposely be situated in centralized areas, which may not align with the residential locations with the housing of individuals post-incarceration. In addition, consultations discussed there are often logistical issues such as the timing of appointments which presents accessibility challenges for a recently released demographic. Notably, the scheduling of appointments, particularly for individuals grappling with substance use disorders post-incarceration, presents an obstacle. Long healthcare waits times prevalent in Canada further exacerbate the issue, with little empathy or prioritization for time-sensitivity with individuals transitioning from incarceration (Vandergrift & Christopher, 2021).

Through consultations, it was voiced that voluntary programs aimed at facilitating re-integration into society encounter logistical hurdles, especially concerning appointment scheduling. Consultations revealed uncertainty surrounding release dates, particularly for individuals in remand, which complicates healthcare appointments and waitlists. In consultations, drop-in appointment options were identified as more effective, catering to the time blindness commonly observed among recently incarcerated populations (Vandergrift & Christopher, 2021). Additionally, a consultation revealed the imposition of stringent appointment schedules, as discussed in consultations is perceived as indicative of the service provider's lack of concern, and may deter individuals from seeking further assistance.

Furthermore, the limited duration of program funding poses a significant barrier. As mentioned through consultations with justice workers, any support programs, particularly those of a voluntary nature, operate within constrained timelines, despite potentially being the primary form of support for individual's post-release. As discussed in consultations and mentioned in the literature, this limitation is particularly pronounced in mental health and substance use support services, which are often only available during working hours and consequently impede sustained access to crucial healthcare resources (Erickson et al., 2023).

Logistical challenges extend to accessing mental health services, posing significant barriers for recently incarcerated individuals. Transportation barriers hinder access to mental health specialists like psychiatrists, essential for diagnoses and treatment (Butsang et al., 2023; Link et al., 2019). The prison environment places a heavy reliance on social workers post-incarceration for mental health support after incarceration. However, as mentioned by a consultation with a justice worker these programs are typically voluntary, leading to higher rates of discontinuation of services once parole requirements are fulfilled according to a consultation with a parole officer. Moreover, consultations and literature indicated that limited access to mental health resources within prisons may lead individuals to perceive external resources as futile once released from prison (Link et al., 2019). Consultations revealed mental health services in Peterborough County, for instance, are primarily led by social workers or healthcare professionals in hospitals, with extensive wait times and high caseloads, posing challenges for sustained support, especially without continuity of care from familiar faces.

Recurring substance use, known as substance, use disorder (SUD), exacerbates healthcare challenges for recently incarcerated individuals, as reported in consultations and literature (Howell et al., 2021). Community discussions have highlighted that SUD treatment may be mandated during parole, necessitating access to public resources due to the restrictions placed on parole officers' ability to monitor clients in privately funded rehabilitation facilities. This, coupled with financial constraints, presents significant obstacles. Even if the family members of a formerly incarcerated person are willing to support immediate drug rehabilitation post-release through a private facility, parole restrictions hinder these efforts. Approval for public drug rehabilitation by the parole board may encourage participants to aim for sobriety while incarcerated, but failure to achieve abstinence within mandated timelines can lead to reincarceration, raising concerns about relapse in environments with high drug availability, such as correctional facilities.

Alternative forms of support for those struggling with substance use include methadone or OAT (Opioid Agonist Treatment). OAT therapy is a medical approach utilizing medications to manage opioid addiction by reducing cravings and withdrawal symptoms (Russell et al., 2022a). Methadone is the most widely known medication used in OAT therapy (Russell et al., 2022a).

However, methadone treatment is not available during incarceration and later on, parole restrictions regarding drug-based interventions can create similar barriers for treatment. For instance, if methadone treatment is part of parole requirements, missing an appointment for any reason would violate parole and potentially lead to re-incarceration for a parole violation (Farrell-MacDonald et al., 2014; Mitchell et al., 2012).

Additionally, as highlighted in consultations with parole officers and justice workers, substance abuse programs within prisons often lack specificity and consist of nonspecific, disjointed self-led modules. These programs aim to equip individuals with tools for sobriety but lack a structured pathway to long-term recovery, thus complicating the transition to community-based rehabilitation programs upon release.

Access to stable housing emerges as another critical aspect affecting the healthcare landscape for recently released individuals. In Peterborough County, the absence of transitional housing facilities providing services for individuals with mobility or complex health needs exacerbates challenges to finding adequate housing as stated in consultations. This could be in terms of finding housing that can be accessed with the person's current or lack thereof mobility aid, or in the case of having complex medical needs there being a requirement that the housing is situated in a specific area of town to access certain healthcare resources if such would impact the individual's quality of life. Moreover, existing transitional housing facilities often lack sufficient funding for full-time medical care, with a shortage of registered nurses noted across Ontario. The conducted consultations underscore the pressing need for expanded supportive transitional housing, integrating on-site medical services, including physician availability, to cater to the healthcare needs of a previously incarcerated demographic.

Barriers to accessing medications post-incarceration present additional challenges. As informed in a consultation, while individuals are typically provided with a 14-day supply of medication upon release, they can request medications within a 90-day period of leaving incarceration and beyond the initial 90-day period the responsibility of getting medications falls upon recently incarcerated individuals. For individuals dependent on narcotic prescriptions, accessing medications can be especially challenging, as cited by a parole officer in consultation. Literature

and this consultation mentioned clinics typically lack authorization to prescribe such medications, prompting individuals to turn to hospital doctors (Matheson et al., 2011). However, going to the hospital for a prescription entails long waits, and doctors may reject this request or be hesitant to fulfill medication requests due to the stigma associated with being previously incarcerated (Erickson et al., 2023; Matheson et al., 2011). If doctors do decide to renew prescriptions, they often provide them for a very short duration with no refills, instructing individuals to find a family doctor for the possibility of a prescription refill, as stated in a parole officer consultation. However, this is not a feasible option given the difficulty of obtaining a doctor in most parts of Canada.

Risk mitigation strategies further complicate healthcare accessibility for this population. Contacting resources for problematic substance use healthcare often requires collaboration with parole officers, involving strict appointment scheduling and adherence to avoid violating parole, which could result in being sent back to prison, as advised during consultations with a parole officer. When it comes to mitigating risk with higher-risk individuals' post-incarceration, particularly those with higher acuity needs, they may encounter increased barriers to accessing community-based healthcare. This is because risk mitigation measures prioritize community safety, inadvertently hindering medical accessibility to health-related risk mitigation strategies that others would have access to, due to liability concerns within the correctional system.

An example discussed during consultations was the provision of safer supply for individuals who dealt with substance use while incarcerated. A consultation with a nurse practitioner highlighted how this approach empowers individuals and fosters self-motivation, potentially leading to a desire to wean themselves off drugs while still ensuring a safe environment for consumption. In contrast, consultation with a parole officer explained that, since they are responsible for individuals on parole, obtaining drugs in this manner shifts the responsibility to the correctional facility or the parole officer, making such actions impermissible.

Perceived fears and stigma surrounding healthcare engender apprehension among individuals transitioning from incarceration. Consultations reveal concerns from those leaving incarceration about the potential loss of assets, heightened stigma about their criminal record, and existing

biases within healthcare settings that deter recently incarcerated individuals from seeking necessary medical care. Additionally, logistical hurdles such as obtaining healthcare documents, including provincial health cards, can pose significant challenges. In Canada, if someone loses their health card, it impedes their ability to access essential healthcare support that would normally be free within Canada. As mentioned in consultations, if a considerable amount of time has passed since the expiration or loss of a health card, additional challenges may arise, particularly in obtaining required identification, compounded by factors like transitional housing. This underscores the necessity for streamlined processes and supports to facilitate access to healthcare resources, even preceding the actual utilization of healthcare services.

After discussing factors relevant to the difficulties faced by recently incarcerated individuals in accessing health resources, Table 1 will present a breakdown of the most commonly encountered healthcare-related challenges identified through conducted consultations for individuals' post-incarceration in the Peterborough Counties. This breakdown is crucial as it demonstrates the perspectives of professionals working in healthcare-related fields and those engaging with incarcerated individuals, revealing the barriers to healthcare faced by this demographic, either firsthand or through their clients. The table outlines the frequency with which each variable was mentioned during consultations. While the sample size is small and the percentages may not fully capture the breadth of available information, they provide insight into which variables were identified as the most significant challenges for individuals transitioning from incarceration to accessing healthcare.

Table 1 - Healthcare related concerns and barriers post incarceration.

Number of respondents indicated (Respondent indicated), Percentage of respondents (Percentage), and total number of respondents (n).

<i>Condition</i>	<i>Respondent indicated</i>	<i>Percentage</i>	<i>n = 6</i>
Transportation	5	83.3%	
Housing situation	5	83.3%	
Substance Use Concerns	5	83.3%	
Mental Health	4	66.6%	
Timing of Appointments	4	66.6%	
Stigma	3	50%	
Medications	3	50%	
Risk Mitigation	2	33.3%	
Concern about assets	1	16.6%	

Note. Housing situation refers to living situation after leaving incarceration. Timing of appointments refers to accommodations that could be a benefit to this demographic. Risk mitigation refers to inter-agency procedures to mitigate risk and liability in the community that may be inadvertently doing a disservice to this population. Concern about assets refers to concerns of individuals post-incarceration that accessing certain health-related resources may inadvertently impact any assets they may have or loss of a need for them.

Discussion

Transportation stands out as a critical determinant of healthcare accessibility for individuals who were previously incarcerated. The need for improved transportation outlines the necessity for accessing essential healthcare resources. For instance, treatments such as those for cancer often necessitate frequent transportation, spanning multiple times a week. However, in an area like Peterborough and Kawartha Lakes these treatment facilities or specialists are typically situated in major cities, which are beyond where recently incarcerated people are residing. As a result, appointments with specialists often necessitate transportation to larger hospitals. In addition, safety regulations often dictate that in order to provide transportation for medical appointments to those who have been recently incarcerated multiple volunteers are required to accompany the person to medical appointments. This requires the commitment of additional volunteers and personnel to be committed to removing a transportation barrier on a regular basis.

The geographical dispersion of healthcare facilities necessitates transportation while also posing a significant obstacle, particularly when specialized medical care across counties is necessary. This often requires individuals to travel considerable distances, requiring reliability with transportation arrangements to secure timely appointments. Public transportation systems, if available, may not extend between counties, consuming an entire day, a proposition often infeasible for recently released individuals due to various constraints.

Moreover, routes into the city center are not publicly funded, and although most cities allocate funds to provide bus passes to a limited number of vulnerable residents, the allocation remains discretionary. To compound these challenges, there is often a preference for assisting low-income individuals who may be perceived as being law-abiding citizens who have endured adverse life circumstances, as opposed to the stigma associated with recently incarcerated individuals.

Furthermore, financial constraints post-incarceration frequently renders car ownership unattainable. Relying on borrowing someone else's vehicle for medical appointments may prove unreliable, particularly considering the uncertainty regarding the recently incarcerated individual's possession of a valid driver's license. Additionally, there may be concerns regarding

changes in their vision, hearing, and other faculties related to driving since their time in incarceration, or potential logistical hurdles in re-obtaining a driver's license if they were previously licensed.

Additionally, socioeconomic disparities intersect with transportation barriers, further impeding healthcare access. Research indicates that individuals with incomes below \$69,000 already encounter substantial transportation barriers in scheduling primary care appointments, with a quarter experiencing difficulties (Lyeo et al., 2023). These challenges are compounded by the socioeconomic status and the stigma associated with reintegration into society following incarceration (Lyeo et al., 2023). Therefore, addressing transportation barriers is imperative to ensure equitable healthcare access for recently incarcerated individuals, necessitating comprehensive interventions that consider both financial and logistical constraints.

The logistical aspect of accessing mental health services presents a daunting challenge for individuals recently released from incarceration. Research demonstrates elevated rates of major depression, psychosis, post-traumatic stress disorder (PTSD), substance use disorders, and developmental disorders among individuals within the prison population, compared to rates of these mental health conditions within the general public (Butsang et al., 2023; Fovet et al., 2023). Some may not perceive it as mental health treatment but rather as an opportunity to discuss their prison experiences or the circumstances in their lives that led to or motivated their initial involvement in crime (Butsang et al., 2023).

Based on a consultation with a mental health worker, it is common for individuals, upon reintegrating into society, to seek diagnoses or support for mental health conditions upon recognizing these patterns in their lives. This desire may arise from an effort to avoid committing crimes again but is often not the primary focus immediately post-incarceration. Frequently, people access these mental health resources due to recognizing the pivotal link between mental health and successful reintegration. Untreated mental health conditions can significantly impede an individual's ability to navigate daily life, maintain stable housing, and secure gainful employment (Kouyoumdjian et al., 2015).

Substance use disorder (SUD) poses a significant barrier to healthcare access for individuals recently released from incarceration, necessitating comprehensive and interprofessional support systems. Recognizing the importance of addressing SUD in this population, global health bodies such as the World Health Organization (WHO) and the United Nations (UN) have emphasized the need for interprofessional development to support individuals with SUD after their release from incarceration (Larsen et al., 2021). This imperative arises from the substantial proportion of individuals within the incarcerated population affected by SUD, with international meta-analyses suggesting that a quarter of offender's experience SUD following release from prison. Consequently, there has been a call for the collaboration of professionals and welfare services, particularly within the corrections systems in Canada, to address this pressing issue (Larsen et al., 2021).

One promising avenue for addressing Substance Use Disorder (SUD) post-incarceration is the availability of opioid agonist treatment (OAT), a medication-based approach specifically targeted at individuals with Opioid Use Disorder (OUD), a subtype of SUD (Edwards et al., 2022; Russell et al., 2022a). Research into the effectiveness of OAT as a treatment is ongoing, with preliminary studies indicating its success. However, despite its potential benefits, as of 2022, OAT was not yet widely accessible to individuals' post-incarceration, highlighting a gap in healthcare provision for this population (Russell et al., 2022a). According to the CSC website, OAT is available and will be paid for by CSC upon release from incarceration, but it is unclear whether changes have been made in the past two years since Russell and colleagues (2022a) identified this programming post-incarceration as subpar in terms of availability. It remains uncertain whether OAT has become readily available or functionally accessible, as concerns persist that missed appointments may result in expulsion from the program and potential return to prison for parole violation. During a consultation with a parole officer, it was mentioned that OAT programming is frowned upon during parole due to this exact reason, and participants are subject to frequent random drug testing as part of their parole requirements (random drug testing may occur regardless of OAT participation, but those enrolled in OAT programs are subject to frequent testing). Furthermore, there is a zero-tolerance policy; if any of these drugs are detected in a person's bloodstream, they will be deemed to have violated parole and be returned to prison.

While research into effective interventions for Substance Use Disorder (SUD) post-incarceration is crucial, it is equally essential to recognize the need for collaboration between healthcare systems and other relevant agencies. Research conducted by Larsen and colleagues (2021) has pointed to positive outcomes resulting from interprofessional collaboration, significantly influencing the quality of health services post-incarceration.

In 2017, Shavit and colleagues conducted a study on a pilot project known as the Transitions Clinic Network (TCN) aimed at establishing a network of health resources for individuals recently released from incarceration in San Francisco, USA. While this program has expanded to various parts of the United States and may vary from city to city, it effectively prepares recently incarcerated individuals for success in the healthcare system. This is achieved by improving healthcare coordination through proactive measures such as arranging healthcare appointments in advance while the person is still incarcerated, ensuring proper documentation, and directing individuals to clinics offering a wide range of services to meet various healthcare needs. For those grappling with substance use, this program provides access to diverse resources and allows practitioners to obtain more contextual information about the patient, facilitating the collaborative creation of a care plan (Larsen et al., 2021).

Discussions in the current research highlight how certain aspects of this collaborative effort could benefit Peterborough Counties. However, there are additional barriers to implementing such programs, including geographic and transportation challenges. Healthcare providers, particularly specialists, are often located in urban centers rather than in centralized medical facilities, making transportation a crucial consideration. Even if transportation issues were addressed, there remains the challenge of timely access to healthcare resources, as revealed in consultations conducted for this research.

A related project conducted by Yamatani and Spjeldnes (2011) examined the outcomes of a collaborative resource access initiative, including addressing healthcare needs, for incarcerated and post-release individuals. The study concluded that participating prisoners exhibited a 50% lower recidivism rate compared to the control group (Larsen et al., 2021).

Efforts to address substance use disorder (SUD) within the corrections system must be complemented by comprehensive healthcare support upon release. However, systemic barriers, such as geographical disparities in accessing resources, pose challenges to the seamless provision of healthcare services post-incarceration. For instance, the geographical spread of healthcare resources may necessitate transportation support, which may not always be readily available, funded, or supported solely by volunteers, thereby lacking reliability, as mentioned in a consultation.

Moreover, while healthcare resources can be recommended, mandating treatment for individuals with SUD is complicated by ethical considerations, especially when there is no immediate harm to self or others (Larsen et al., 2021). Ethical concerns arise regarding the disregard for autonomy and consent in mandating programming, particularly within vulnerable populations like incarcerated individuals. Thus, determining the duration of vulnerability post-incarceration remains a grey area. It can be argued that previously incarcerated individuals might perceive certain recommendations as impacting their parole or sentencing, raising ethical concerns.

Mandating a treatment like opioid agonist therapy (OAT) for those with opioid-related SUD would be unethical, as people have different medical needs and responses to treatment. Forcing a treatment on someone may not meet their unique needs, and mandating a drug could perpetuate stigma about people with SUD and foster distrust with healthcare providers. When immediate harm to self or others is present, there may be some leeway for someone else to make decisions on behalf of the person, but otherwise, this would be an unethical practice (Howell et al., 2021; Russell et al., 2022a).

Housing instability poses a significant barrier to healthcare access for individuals recently released from incarceration, with increased concerns about homelessness and exposure to risky environments. Studies evaluating the impact of housing instability on healthcare-seeking behaviours among individuals with opioid use disorder (OUD) post-incarceration have highlighted the critical link between housing status and access to care (Russell et al., 2022b). Having a stable address can facilitate continuity of care, while those lacking healthcare support may prioritize other pressing needs over their health (Mitchell et al., 2012). The unpredictable

nature of post-release housing arrangements often impedes an individual's ability to prioritize their health needs, particularly when grappling with concerns such as substance use disorders (Larsen et al., 2021).

For individuals residing in halfway houses after incarceration, financial constraints can exacerbate the challenges of accessing healthcare. Despite receiving a modest stipend to cover basic necessities such as food and transportation, individuals lacking stable employment encounter significant obstacles in accessing medical services (Russell et al., 2022b).

Furthermore, the stipend provided to those transitioning from federal prisons in Ontario, amounting to \$28.70 as of December 2022, fails to adequately address the financial burdens associated with accessing transportation for specialized medical care, thus perpetuating disparities in healthcare access (Russell et al., 2022b). Importantly, this stipend is designated solely for essentials like food and transportation, leaving individuals to prioritize which necessity is most pressing (Russell et al., 2022b). Moreover, the stipend is unavailable to individuals employed, regardless of its stability, highlighting the limited financial assistance available to individuals navigating housing instability post-incarceration (Russell et al., 2022b).

In addressing the intersectionality of housing instability and healthcare access, there arises a compelling need for comprehensive interventions. Such interventions should not only cater to the immediate housing requirements but also address the underlying health concerns of individuals recently released from incarceration. Efforts undertaken by community support and social workers to mitigate the barriers posed by housing instability must incorporate the provision of stable housing options alongside accessible healthcare services.

Policy interventions aimed at augmenting financial support for individuals residing in halfway houses warrant exploration to alleviate the financial burdens associated with accessing medical care. By establishing a budget to cover additional needs beyond the provided stipend, there could be supplementary funding to support transportation to and from essential resources, as well as adequate funding for necessities like food. This would eliminate the need for individuals residing in such housing to prioritize basic needs, thus alleviating stress, and removing barriers for those

seeking resources, including healthcare. However, current investigations have not revealed any programs offering this within Peterborough Counties.

Ultimately, addressing housing instability as a barrier to healthcare access for recently incarcerated individuals demands a multifaceted approach. Such an approach must acknowledge the complex interplay between housing status, financial resources, and healthcare-seeking behaviours. Notably, a comprehensive program addressing these aspects does not currently exist. Achieving this requires inter-agency collaboration, as those facilitating access to housing post-incarceration may not be the same individuals capable of identifying and supporting financial resources or referring individuals to healthcare services, as indicated by a consultation.

Access to medications poses a significant barrier to healthcare for individuals recently released from incarceration, impacting their ability to maintain stability and avoid recommitting offences (Link et al., 2019). Testimonies from consultations underscore the vital role of medications in enabling individuals to effectively reintegrate into society post-release. From a provincial correctional perspective in Canada, and notably for federal prisons under Correctional Services Canada (CSC), individuals often face limitations in coverage for essential medical expenses beyond medications within the first 90 days post-release. These limitations extend to items like glasses, hearing aids, and other medical necessities crucial for successful societal integration. Successful integration entails individuals addressing the underlying issues related to their involvement in crime and adapting to societal norms. A lack of comprehensive coverage could further complicate access to necessary healthcare resources, particularly in the context of seeking employment and meeting societal expectations.

While the initial 90-day period typically covers healthcare services, it falls short in addressing the long-term medical needs and recommended aids essential for individuals transitioning out of incarceration. A consultation in collaboration of investigating standards outlined on the Correctional Service Canada website show the limitations of coverage during the 90-day critical transition period, emphasizing the gap in support for individuals navigating healthcare access post-release (Correctional Service Canada, 2022). The discrepancy is in CSC willingness to pay for doctor's appointments for an individual to be evaluated for healthcare and healthcare aids but

not in covering the cost for any healthcare aids that may be required after an evaluation is conducted.

Despite these challenges, certain healthcare services are available to individuals upon release from incarceration through CSC. Notably, the coverage includes Opioid Agonist Treatment (OAT) for those who may suffer from Opioid Use Disorder (OUD), as well as screening and prevention services for common communicable diseases prevalent in carceral environments (Farrell-MacDonald et al., 2022; Russell et al., 2022a). The availability of these services illustrates CSC's commitment to addressing specific health concerns prevalent among incarcerated populations and mitigating the risk of communicable disease spread, as well as potentially facilitating opioid use disorder treatment upon release (Russell et al., 2022b). However, the provision of OAT and preventive services alone is insufficient in addressing the broader spectrum of healthcare needs post-release. Additionally, OAT services may not fully meet all the healthcare needs of a person leaving incarceration with OUD, as each individual's needs may be different and it is unclear whether CSC would fund similar treatments or supports for OUD post-incarceration (Mitchell et al., 2012; Russell et al., 2022a).

The transition from incarceration to community living presents individuals with a multitude of perceived fears associated with healthcare access, which are further compounded by systemic barriers and stigma. One concern that emerged from community consultations is the fear among recently released individuals of losing their possessions, including property, upon transitioning to transitional housing or long-term care facilities. This apprehension, whether justified or not, reflects potential hesitations in seeking healthcare resources that individuals should access post-incarceration. Moreover, the extensive waitlists for long-term care facilities in Canada exacerbate these fears, as individuals may fret over the availability of suitable accommodations and the potential loss of possessions during such an uncertain period.

Perceived stigma within healthcare settings exacerbates the challenges faced by individuals recently released from incarceration. Negative encounters with healthcare providers post-release may foster reluctance to re-engage with healthcare services, perpetuating a cycle of avoidance and unmet healthcare needs (Matheson et al., 2010). For instance, mental health workers in

consultations have recounted instances where individuals released from incarceration expressed reservations about accessing certain resources mandated by parole due to past negative experiences and the fear of being stigmatized. The stigma surrounding mental health and substance use is particularly impactful in this scenario, as individuals may experience shame or stigma when seeking support for these issues, further amplifying their sense of alienation within society (Erickson et al., 2023; Vandergrift & Christopher, 2021). This internalized stigma poses a significant obstacle to accessing essential healthcare services, especially in environments where trust in healthcare providers is already lacking.

Additionally, the scarcity of healthcare providers, especially those willing to collaborate with individuals with complex needs or unpredictable behaviours as the perception of incarcerated individuals would be seen as, intensifies perceptions of stigma and discrimination in healthcare settings (Erickson et al., 2023). Based on consultations with social workers, it has become apparent that the unpredictability linked to individuals recently released from incarceration may serve as a deterrent for healthcare providers in accepting them as patients, thereby exacerbating the limitations on their access to essential care. Research by Vandergrift and Christopher (2021) underscores the pervasive nature of healthcare stigma among incarcerated and recently incarcerated populations, with participants reporting direct experiences of discrimination within the healthcare system attributed to their criminal record or status as formerly incarcerated individuals. These findings highlight the systemic inequities and policy constraints that contribute to disparities in medical care for individuals transitioning out of incarceration, accentuating the urgent need for comprehensive interventions to address healthcare stigma and improve access to equitable care for this vulnerable population.

One aspect of this research was to examine whether healthcare professionals should receive specialized training to treat patients who were transitioning from incarceration. Upon investigation, it was found that the needs of recently incarcerated individuals do not significantly differ from those of other marginalized groups, suggesting that specialized healthcare training may not be necessary for this demographic (Howell et al., 2021; Link et al., 2019; Vandergrift & Christopher, 2021). However, it remains imperative for healthcare providers to educate themselves and be sensitive to the unique challenges faced by individuals' post-incarceration

(Vandergrift & Christopher, 2021). According to a community consultation, while many healthcare workers endeavour to educate themselves to better support patients struggling after release, there are currently no standardized guidelines or best practices in Peterborough County for this purpose. Consequently, it would be beneficial to develop educational modules to assist healthcare professionals in understanding and addressing the needs of recently incarcerated individuals at their place of work (Howell et al., 2021).

Addressing stigma surrounding individuals recently released from incarceration is a priority, as stigma in healthcare settings may vary across demographics, and individual healthcare providers may have differing levels of comfort in evaluating the needs of this population. By addressing stigma and promoting awareness among healthcare providers, it is possible to create a more inclusive and supportive healthcare environment for individuals transitioning out of incarceration. While specialized healthcare training may not be deemed necessary, efforts to educate healthcare professionals and combat stigma should remain a priority to ensure equitable access to healthcare for all individuals, regardless of their past involvement with the criminal justice system. This prioritization entails developing educational modules for healthcare professionals to comprehend the experiences of incarcerated individuals and how these experiences may influence healthcare workers' interactions. It also involves destigmatizing incarcerated individuals through this training. Fostering collaboration between correctional facilities and healthcare clinics would also be beneficial in facilitating incarcerated individuals' access to healthcare follow-ups upon release. This collaboration could include enabling incarcerated individuals to sign up for healthcare waitlists while in prison and facilitating the transfer of ongoing appointment data from incarceration facilities to outside healthcare providers. Such measures would alleviate concerns about recently released individuals facing long waitlists for healthcare and promote continuity of care from incarcerated doctors to outside healthcare providers.

Implications

The findings of this study underscore the need for tailored program development aimed at supporting individuals recently released from incarceration. Specifically, initiatives should address the multifaceted healthcare barriers faced by this population, including challenges related

to transportation services and the duration of healthcare coverage beyond the initial 90-day post-release period. Interprofessional collaboration emerges as a critical component in ensuring continuity of care, necessitating cooperation among healthcare professionals, social workers, parole officers, and correctional services.

Additionally, the study highlights the intricate intersectionality between various barriers to accessing healthcare systems post-incarceration. Recognizing and addressing these intersecting factors are essential for developing effective interventions and support systems.

Limitations

It is important to acknowledge the limitations of this research. The first limitation is the study being confined to Peterborough County, limiting its generalizability to other regions.

Additionally, the use of a small sample size and specific professional experiences may introduce biases and restrict the broader applicability of the findings. However, the geographical specificity of the research may have skewed the prominence of certain barriers, potentially overlooking issues that are more prevalent in other locations.

Future Research Directions

Future research should aim to enhance the generalizability of findings by exploring whether the identified healthcare challenges in Peterborough are applicable in other geographical regions. Comparative studies across multiple regions can identify common trends and variations in healthcare access for individuals transitioning from incarceration. Incorporating diverse perspectives and experiences from a wider range of participants will ensure a comprehensive understanding of the topic.

There is also potential for future research to examine differences, if any, between federal and provincial healthcare funding post-incarceration. While this research mentions the healthcare funding provided by CSC after release from federal prison, a comprehensive comparison to healthcare funding after provincial prison is lacking.

A more multi-level approach could also be taken to understanding healthcare access barriers by considering barriers that exist in the healthcare system for individuals who have been released from prison. This approach involves examining all factors influencing healthcare access in the community and assessing the application of programs designed to mitigate these barriers. Statistical analyses, such as employing stepwise regressions, can help understand the most significant factors hindering healthcare access for the recently incarcerated demographic. Further research could delve into specific areas of healthcare that treat recently incarcerated individuals and assess differences in attitudes and stigma among healthcare providers in different sectors towards the recently incarcerated. This exploration could support the development of programming to educate healthcare providers on supporting recently incarcerated individuals as patients. Additionally, assessing the availability and adequacy of trauma-informed care could be an important aspect of this training, considering the type of security level from which a person was released. This could shed light on potential biases or stigma towards recently incarcerated individuals.

Future research should also explore how intersectional factors such as race, gender, sexual orientation, disability, and age intersect with perceptions among recently incarcerated individuals regarding healthcare access. Understanding what type of resources, they are more likely to access and identifying different barriers or stigmas associated with certain groups could inform the development of more culturally competent and inclusive healthcare services.

Additionally, future research should investigate best practices for working with recently incarcerated individuals within healthcare settings, considering the intersectionality of identity and exploring additional determinants of health post-incarceration beyond healthcare accessibility and substance use challenges. Proactive steps should be taken to engage pertinent stakeholders, such as the Elizabeth Fry Society, John Howard Society, and OneCity, at the inception of research endeavours in Peterborough.

The involvement of the Elizabeth Fry Society would be beneficial given their support framework for individuals within the criminal justice system. Their array of services, including advocacy, housing assistance, and reintegration initiatives, are instrumental in facilitating successful

transitions into the community following incarceration. Similarly, the John Howard Society's diverse range of programs aimed at curbing recidivism rates, providing rehabilitation aid, and advocating for systemic reforms make them invaluable collaborators. Consulting with both organizations would illuminate perceived barriers confronting recently incarcerated individuals and shed light on how these barriers impact their access to healthcare resources.

OneCity Peterborough, an organization dedicated to supporting marginalized communities, including those with incarceration histories, could be another crucial ally for future research. Their provision of programming and aid in housing, education, and employment offers vital assistance in the process of re-integration. Recognizing the pivotal role of such support in mitigating reintegration challenges that impede healthcare access, engaging with OneCity promises invaluable insights into the specific hurdles faced by this demographic in accessing healthcare services.

Recommendations

Based on the findings, recommendations include developing a manual to assist recently incarcerated individuals in navigating healthcare settings. Healthcare professionals could benefit from optional training modules focusing on the challenges of post-incarceration and best practices for supporting this population. Advocacy for expanded healthcare support, including options for transportation assistance and improved information sharing between social services, healthcare, and parole, is essential. Additionally, encouraging after-hours walk-in clinic hours can mitigate timing and transportation concerns for individuals' post-incarceration.

Efforts to address these challenges must be comprehensive and collaborative. Policy interventions, such as expanding healthcare coverage beyond the initial 90-day post-release period and exploring financial support options, could be essential in accessing necessary healthcare resources. Additionally, healthcare providers must be equipped with the knowledge and sensitivity to understand unique needs and experiences of this population.

Conclusion

In conclusion, this research has shed light on the multifaceted challenges and barriers that hinder recently incarcerated individuals from accessing healthcare resources upon reintegrating into society. Systemic issues such as transportation concerns, housing instability, substance use disorders, mental health challenges, and access to medication all significantly impact an individual's ability and motivation to seek healthcare.

Interprofessional collaboration and tailored program development emerge as crucial steps towards ensuring continuity of care and support for individuals recently released from incarceration. By directly addressing these barriers and fostering a more inclusive healthcare environment, greater equity in healthcare access for all individuals, regardless of their involvement in the criminal justice system, can be achieved.

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