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Healing Hands

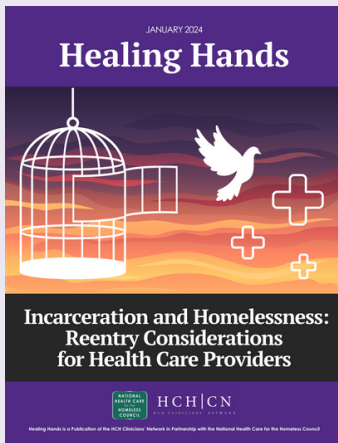


Incarceration and Homelessness: Reentry Considerations for Health Care Providers



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HCH CLINICIANS' NETWORK

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I. Introduction

According to the Transitions Clinic Network and the Network for Public Health Law, "Every year in the U.S., more than 650,000 people are released from prison and 9 million more return to their communities from jail. Upon return, they are some of the sickest and most vulnerable members of society."

Jails and prisons have key differences; the Prison Policy Initiative explains:

Prisons are facilities under state or federal control where people who have been convicted (usually of felonies) go to serve their sentences.

Jails are city- or county-run facilities where a majority of people locked up are there awaiting trial (in other words, still legally innocent), many because they can't afford to post bail. To make things a little more complicated, some people do serve their sentences in local jails, either because their sentences are short or because the jail is renting space to the state prison system.²

There are also other forms of incarceration that exist in the United States, so it is a misnomer to refer to a single "criminal justice system." The Prison Policy Initiative notes that "we have thousands of federal, state, local, and tribal systems. Together, these systems hold almost 2 million people in 1,566 state prisons, 98 federal prisons, 3,116 local jails, 1,323 juvenile correctional facilities, 181 immigration detention facilities, and 80 Indian country jails, as well as in military prisons, civil commitment centers, state psychiatric hospitals, and prisons in the U.S. territories."³

For the purposes of this report, all forms of incarceration will be grouped together, though it's important to understand the systemic differences, and also understand that significant differences exist jurisdictionally. For this reason, it's crucial for care providers to become familiar with the carceral systems and processes operating in their own communities (both state and federal), to make sure that individuals in the reentry stage can be supported in ways that are specific to the local context.



"Fire Cross Walk" by Alexa, PhotoVoice Digital Exhibit

A 2018 report by Lucius Couloute of the Prison Policy Initiative found that formerly incarcerated people are almost 10 times more likely to be homeless than the general public, finding especially high rates of homelessness among people who have been incarcerated more than once, people who have been recently released from prison, people of color, and women. Women of color were the group most likely to be found experiencing homelessness post-incarceration.⁴ These facts must be placed into the context of the statistical overrepresentation of people of color in the U.S. carceral system.⁵

There is a multi-directional relationship between homelessness and incarceration; some refer to this as a "revolving door." The precarity of homelessness may cause some people to engage in activities that are illegal—some of which are more visible when performed in public—and in many places homelessness itself is criminalized through laws that punish people for sleeping outside, asking for money or resources in public spaces, or using public spaces for other life-sustaining activities such as eating.⁶

After a person has been incarcerated, they face significant barriers to re-joining society that may lead to ongoing challenges with procuring a stable income and reliable housing. Many people are unable to find a job with a "criminal record," and many also have physical and mental health conditions that may have become exacerbated during their period of incarceration. One formerly incarcerated individual described the "vicious cycle" of incarceration and homelessness like this: "I'm still going to be punished for the next ten years via I can't find a place to live or it's going to be difficult for me to get a job, to actually start a career [even though] I have done my time; I have done my rehabilitation."⁷

Formerly incarcerated people are almost 10 times more likely to be homeless than the general public, and women of color are the group most likely to be found experiencing homelessness post-incarceration.

II. Healthcare Access and Reentry

Decades of research have established a clear connection between incarceration and worsening health. There are a variety of interactions at play, for instance:

- Populations who are at higher risk of imprisonment—e.g., people of color, people living in poverty, people experiencing homelessness, etc.—are also populations that are at a higher risk of severe chronic physical and mental health conditions, meaning that many people enter the carceral system with significant pre-existing health concerns.
- Often, these chronic health concerns are exacerbated during incarceration, as carceral systems are ill-equipped to provide consistent high-quality health care.
- The trauma of incarceration itself has been shown to have deleterious effects on health, often creating new health concerns during the period of incarceration. This is true both for physical health—with carceral facilities being risk factors for illnesses such as tuberculosis, hepatitis C, hypertension, and asthma—and for mental health, which is heavily impacted by the isolation, trauma, control, and omnipresent dangers of incarceration.
- Difficulty accessing health care and housing post-incarceration can lead to further exacerbation of physical and mental health conditions that may have already worsened during the incarceration period.
- The difficulty of the reentry period can also cause new health conditions to emerge, including new mental health conditions related to trauma, loss of community and family systems, difficulty participating in society via jobs and civic participation, the cyclical effect of compounding poverty, societal stigma, and the risk of re-incarceration.⁸

In this issue of Healing Hands, we'll begin by looking at some of the challenging dimensions of access to healthcare that face formerly incarcerated people during the reentry period, and how healthcare access intersects with homelessness, with attention to the challenges specific to young people involved in juvenile justice systems. We'll then look at key suggestions for organizational best practices during reentry, with a focus on the role of community health workers and peer support, and learn from two organizations working in this area to create access to care and a culture of welcoming.

Because formerly incarcerated people are at risk of experiencing periods of homelessness during and after the reentry period, providers who specialize in health care for the homeless are likely to encounter people in need of health support during reentry. Understanding the unique situation of each of these individuals is essential to helping them access the care they need during a difficult and stressful time.

Anne Feczko is a Nurse Practitioner at NeighborHub Health in Cincinnati, Ohio. She works at The David and Rebecca Barron Center for Men and the freestanding NeighborHub Health Primary Care Center, where she sees many clients who are in post-incarceration transitional housing programs. (She previously worked as a Nurse Practitioner at Unity Health Care in Washington DC, including at the Anacostia Health Center which has a specific [reentry clinic](#).)

II. Healthcare Access and Reentry *(cont.)*

According to Ms. Feczko, one of the most challenging aspects of helping individuals access health care during the reentry period is that “it is really different from case to case,” depending on the form of incarceration, the level of control the person is under during the reentry period, their personal resources, and so on:

Right now, in Ohio, people who come into my clinic from the halfway houses have different statuses with the county justice system, Ohio Department of Rehabilitation and Corrections (DRC), and the Federal Bureau of Prisons. Some are in a level of control that is still essentially incarceration while living in a community facility. With that status, people are ineligible for public goods like Medicaid. They are not allowed to get certain medical procedures and would actually have to be re-incarcerated to get covered for those procedures. For example, if a person needed an echocardiogram, that would not be covered and they would have to go back to prison to get treatment. People in that situation understand this, so when they come to us they are hesitant to say yes to anything. It's an unfortunate limbo; they're not incarcerated anymore, but they're definitely not out.

— Anne Feczko, Nurse Practitioner

Another complex piece of this “unwieldy system” is access to and eligibility for insurance coverage. In some jurisdictions, people are automatically un-enrolled in Medicaid when they enter incarceration, leaving them with a gap in coverage when they get out. In some situations, people may have emergency Medicaid or provisional Medicaid where they can be covered for Emergency Department services but can't get a prescription filled. “Once again,” says Ms. Feczko, “there is a limbo system where Medicaid only works in some contexts... It may take a very persistent social worker staying on the phone for hours, or a physical trip by the patient to the Medicaid office, to get it active again.” A physical trip to offices represents its own difficulty: “When folks are coming out of incarceration, they have a million things on their to-do list so losing a day to something like this is a hardship. And of course the longer they go without their meds, the more likely they are to need the Emergency Room and the hospital.”

For people coming out of federal penitentiaries, they may have coverage from NaphCare (the organization contracted by the Federal Bureau of Prisons to provide third-party administrative services and specialty provider networks for reentry centers). However, many medical care providers and hospitals don't know much about NaphCare or have integrated systems for working with it. People don't typically get an insurance card, so they may have difficulty accessing the coverage for which they are eligible.

Because of this systemic knowledge gap, there is a very real need, says Ms. Feczko, for community-based systems to understand the nuances of NaphCare and Medicaid for formerly incarcerated people—while keeping in mind “that this is all temporary. People may only have NaphCare for a few months, then be actually released and eligible for Medicaid. This may lead to people waiting until they are fully released to have procedures done,” even when there are chronic and/or worsening conditions.

II. Healthcare Access and Reentry *(cont.)*

In addition to developing systems that understand and work with eligibility and access, Ms. Feczko recommends that providers develop an understanding of the availability of medical records in locally relevant systems, since different institutions have different mechanisms in place for sharing records.

"In Ohio," says Ms. Feczko, "we have a centralized Medical Records office at the DRC. We know which form to fill out now, but it took us figuring out the process and sharing with staff. For us, it's worth it because we see lots of folks from the prison system, but it does take effort to track it all down."

She notes that often, upon obtaining the medical records, the clinic has some work to do on updating protocols: "It's pretty public information that the overall quality of care in jails and prisons is quite poor compared to community settings, so I often see people coming out of facilities on medication regimens that don't make much sense. Prisons have limited formularies based on what is lowest cost." For example, she explains that over the years health care providers have transitioned toward prescribing longer-acting insulins for people with diabetes. However, prisons often still use "short-lasting, old-fashioned insulins," and patients "need to be converted to a more modern regimen. We also see this with blood pressure medications, where patients have been using things not considered first-line because of costs."

Understanding and working with these unique challenges, then taking the time to communicate this to the consumer, says Ms. Feczko, is key to helping consumers access quality health care:

It comes down to having a champion at your clinic who will dig into local resources. In our setting, we work with two different halfway houses so we build connections, and have relationships with the halfway house....[I recommend] having someone at the clinic who can compile all of this info and make sure providers have it at their fingertips. It's a confusing system for clinicians, and even more so for patients! They don't know the terminology, levels of control, etc., and they need someone to sit down and explain their status to them.

— Anne Feczko, Nurse Practitioner

III. Special Considerations for Working with Youth

One group of people often overlooked in the conversation about the "revolving door" of homelessness and incarceration is young people experiencing the juvenile detention system. According to the Juvenile Law Center:

Tens of thousands of children are incarcerated in youth prisons every day; thousands more are also locked up in adult prisons and jails. Imagine a child locked alone in a small empty room for days, weeks, or months. Many youth prisons are called "schools," but few of these facilities provide either quality education services or mental health care or other services children need to heal.

III. Special Considerations for Working with Youth *(cont.)*

Too many incarcerated youth are subject to solitary confinement — often for 22-24 hours per day — strip searches, shackles, and chemical sprays. These abusive practices cause physical injuries, emotional trauma and psychological harm, and interrupt healthy development. Youth in prison also face physical and sexual violence, compounding the trauma imposed by their isolation and separation from their families, friends and communities.⁹

Dr. Jonathan Pletcher is the Director of Inpatient Adolescent Medicine at the Children's Hospital of Philadelphia. In this position, his focus is on developing inpatient programs for teenagers, or specialty services that cater to youth who have co-occurring mental and physical health challenges. Dr. Pletcher often works with youth who are or have been in institutions, including juvenile detention and hospitalization. Youth who experience institutionalization at a young age are at a higher risk of not making a successful transition to adult roles, and are at risk of going on to experience housing instability, relationship difficulties, and physical and mental health issues—and Dr. Pletcher is working on developing interdisciplinary programming that can turn this trajectory around.

Changes in Medicaid Policy Regarding Covered Services in Correctional Settings

By Barbara DiPietro, Senior Director of Policy at National Healthcare for the Homeless Council

Changes in federal Medicaid policy are about to directly affect the financing for some services “behind the wall” — especially for youth. Hopefully these changes will allow for greater connections to care, as well as a better continuity of services as they transition from detention to community.

Here's a brief overview of these upcoming policy changes:

For youth under age 21: Starting Jan. 1, 2025, all states are required to cover case management and some diagnostic and screening services (to include behavioral health screenings) for incarcerated youth. This policy also applies to former foster care youth up to age 26 (who remain eligible for Medicaid), meaning this policy change applies to both adult jails and prisons as well as youth justice settings.

For youth and adults: In April 2023, CMS released guidance giving states the option to cover some services during the 90 days prior to release. While states can offer more services, the minimum services under this agreement are to provide case management, medication assisted treatment (MAT), and a 30-day supply of medications upon release. To date, California (starting in April 2024) and Washington (starting in July 2025) have been approved to offer services, while 14 other state have submitted proposals to the federal government for approval (AZ, IL, KY, MA, MT, NH, NJ, NM, NY, OR, RI, UT, VT, and WV).

Given the prevalence of homelessness among people who are incarcerated, the HCH community can have a substantive role in providing greater care for this vulnerable population—especially during the transition period that can bring high risks for overdose. If your state is not listed above, advocate that your state submit a request to cover these types of services. For more information on these changes, see this [fact sheet](#).

III. Special Considerations for Working with Youth *(cont.)*

One key to developing appropriate interventions, says Dr. Pletcher, is understanding that “many kids are incarcerated because of behaviors but have never had an adequate medical workup or mental health evaluation... Having an objective assessment of the behavior or symptoms is crucial to developing a longitudinal relationship and [engaging in] risk prevention or reduction.” Dr. Pletcher notes that sometimes health care for this population can be hobbled by the assumptions of providers—“but we have to change our perspective on juvenile detention... Any kid you meet who is labeled as a juvenile delinquent is like any other kid you’d meet with or without a ‘systems’ label ... and as a health care provider you have to follow the medical evidence base like you would with anyone else who hasn’t been labeled delinquent.”

The factors driving youth incarceration exist in a milieu of interconnected challenges related to social inequalities. Systemic racism is a factor—black teenagers, especially boys but also girls, are overrepresented in the juvenile justice system. Young people with autism and learning disorders, and LGBTQ+ youth and youth with gender dysphoria, are also overrepresented. Dr. Pletcher notes that chronic nutritional deficiencies, which has been shown to drive behaviors often labeled as impulsivity and oppositional, is often a factor: “Nutrition weaves through all of this,” he says. “Homelessness, environmental toxic stress, concerns about safety, daily marijuana use (often the substance of choice for acute trauma and boredom) all affect appetite and nutrition over time, causing neurodevelopmental pathways to be altered or stall. Teenagers whose growth trajectory ‘falls off’ of childhood growth patterns are at very high risk of stunting organ growth, which over time will increase the risk of developing diabetes, heart disease, weaker bones, and other chronic health issues throughout their life course.” This vulnerability is amplified as young people with chronic mental and/or physical health issues may find themselves pushed out of their homes and/or foster homes, and experience difficulties with finding meaningful educational or vocational pathways as young adults.

“In a clinical setting,” Dr. Pletcher explains, “how can you predict which kids will be most at risk of experiencing homelessness as adults? You can start by adding up chronic health conditions, chronic mental health conditions, and time spent incarcerated, and/or in foster care.” Dr. Pletcher notes that a leading reason kids land in juvenile detention is related to inadequacies in the child protection and housing systems. (“If a youngster is ‘running away,’” he says, “our next question should be ‘What are you running away from?’”)

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“Any kid you meet who is labeled as a juvenile delinquent is like any other kid you’d meet with or without a ‘systems’ label ... and as a health care provider you have to follow the medical evidence base like you would with anyone else who hasn’t been labeled delinquent.”

— Dr. Jonathan Pletcher

III. Special Considerations for Working with Youth *(cont.)*

An overarching issue, Dr. Pletcher emphasizes, is trauma. ("Often kids diagnosed with Oppositional Defiant Disorder [ODD] have unattended trauma.") Young people in contact with the juvenile detention system are likely to have a number of Adverse Childhood Effects (ACEs) in their history, and trauma in their background. "As professionals, we're always trying to move to a trauma-sensitive or trauma informed approach," he says, "but at an institutional level we must also have clear accountability and responsibility around the ways that we reinforce and create new levels of trauma. What role can we play as an institution, and as individuals and teams of professionals, in transforming this?"

Because of these many intersecting issues, Dr. Pletcher explains that it is critical for care providers to take the time to break down personal and systemic biases against young people who have experienced incarceration. Thinking of children specifically in juvenile detention, he recommends: "Approach them like any other kid, but start by understanding that if they are in a juvenile detention center, by definition, they have recently been traumatized by having been removed from their house and community. How does that affect how you see yourself and how you see others?" Understanding the family systems at play is an important starting point for connecting with a young person's situation. Parents with resources and education can get their kids a gold star workup to understand root problems—but young people whose parents do not have these resources and access may never have had a real history taken. Spending an hour to understand the child's life and history is the starting point for developing a care plan that will take their needs into account.

As attitudes and assumptions transform, so can the services offered. Dr. Pletcher notes that in addition to physical and mental health care, young people in the reentry period need support around things like:

- Schoolwork and educational support (e.g., tutoring and study skills training)
- Drug and alcohol counseling
- Sexual health counseling and resources
- Family reunification services
- Nutrition and food security
- High-quality LGBTQIA care
- Mental health services and supports
- Support services for the family unit



These wrap-around supports are crucial, especially when teens are attempting to return to families who do not want to take them back, which dramatically increases the risk of homelessness and mental health crisis, as well as the risk of adult incarceration. Programs should consider how whole families can be supported during the reentry period and in the long term.

IV. Transitions Clinic Network

The Transitions Clinic Network (TCN) program was developed in San Francisco in 2006, and has since been implemented in 48 health systems in 14 states and Puerto Rico. The program aims to create access to healthcare for returning community members while also breaking down the societal factors that contribute to the “revolving door” of homelessness and incarceration. The Transitions Clinic Network program integrates care within current primary care system(s) and consists of three key components: 1) Integrating specially-trained community health workers (CHWs) with histories of incarceration to assist with patient navigation and care management; 2) Creating system enhancements for patient-centered services, such as access to primary care, behavioral health integration, and medication-assisted treatment for substance use disorders; 3) Identifying and creating localized system integration with criminal/legal systems and existing community-based systems working to address health re-integration and prevent re-incarceration.

The first key component of the TCN model is the inclusion of specially-trained community members who have lived experience of incarceration to work as community health workers (CHWs). Dr. Shira Shavit is the Executive Director of TCN, and she emphasizes that CHWs are crucial to this work on a variety of levels:

One of the things that is most important is understanding that cultural humility is not just training providers to understand the patients’ needs and the systems they’re in, but in this case, in working with the justice-involved population, it means meaningfully transforming systems to include people with lived experience of incarceration in the work.

Historically, because of policies of mass incarceration, people with experience of incarceration have been systematically disenfranchised from health care systems... One way health care providers can reverse those harms is to hire people who have lived experience.

We’re also valuing their personal lived experience as team members, to help design programs, care for patients, and evaluate programs. The people closest to the problem are closest to the solution, and really can build trust in ways other healthcare providers cannot. The experience of incarceration is very traumatizing and dehumanizing, so people who have experienced incarceration may not trust traditional healthcare systems. CHWs are also key in building that trust; they understand where people are coming from and can build that trust more quickly. It’s important that we include them as members of our teams and give them opportunities to lead the work and give their voice to the services that we provide.

— Dr. Shira Shavit, Executive Director of TCN

Dr. Shavit notes that people with lived experience of incarceration have a level of systems understanding and translation skills that are essential to creating policies, procedures, and programming that are sensitive to the many difficulties of the reentry period. Here are a few examples of questions that clinics might ask themselves with the contributions of CHWs who understand the process:

IV. Transitions Clinic Network *(cont.)*

- Are any clinic policies (such as late penalties) perceived as punitive or stigmatizing, and what are the impacts of that?
- Do any clinic policies or practices inadvertently discriminate against people who have been incarcerated?
- Do people who have been incarcerated know the check-in procedure at a clinic?
- Could security or police presence in clinics be triggering or uncomfortable for people?
- Are there design elements (such as glass partitions put up for COVID) that may inadvertently re-enact prison or jail environments?
- Are there other ways the clinic may be unknowingly creating an environment that feels unwelcome for certain populations?
- What is the role of social determinants of health during the reentry process? How can a clinic incorporate more holistic care for other key dimensions of wellness, such as housing, employment, food security, family reunification, and supports that help people feel a part of the community?
- How can an organization build more cross-sectoral collaboration with carceral systems, and improve the knowledge base of people who advocate for clients within these complex systems?
- How can an organization work within relevant systems without becoming an arm of the criminal justice system (or perceived as one by consumers)?
- In what other ways can systems and processes be changed out of a clearer understanding of people's needs?
- How can care and procedure become ever-more trauma-sensitive?

This last point of trauma sensitivity is crucial, says Dr. Shavit, particularly for people experiencing Post-Incarceration Syndrome (PICS),¹⁰ a form of Post-Traumatic Stress Disorder (PTSD). Some people may have a history of PTSD, and returning to the community can re-trigger it as they are reminded of things from the past. Other people may develop PTSD due to traumas experienced during the incarceration period. In either case, organizations should “work directly to address trauma,” says Dr. Shavit, while understanding that “people come out with hyper-vigilance and skills that they’ve learned to protect themselves inside that don’t serve them well in community. It may be triggering to be around large crowds or packed in small spaces.”

IV. Transitions Clinic Network *(cont.)*

These suggestions for considerations are just a starting point. “Sometimes people want a three-item checklist” for their organizations, says Dr. Shavit, “but this is real system work, and it’s a commitment to being an advocate for our patients... [TCN] is an organization that can work with providers to support them in system reform, capacity building, and collective advocacy on behalf of the communities we serve.” Involving CHWs in organizational decision-making processes is one way to integrate transformational knowledge into this system change: “It’s not a one-hour cultural humility class,” says Dr. Shavit. “We’re all always learning, and we’re humble enough to know we don’t know it all. We have to rely on our colleagues who have lived experience with us to partner in this work and help transform our organizations.... It’s easy to think we know, but we don’t. We need to ask...and be continually asking: ‘What makes sense? What do people need?’ With CHWs, you have an expert on your team right off the bat.”

It is important to note that there may be complexities involved for clinics and programs when hiring CHWs; as summarized by TCN:

Despite evidence that employment of these healthcare workers leads to better patient outcomes, individuals with histories of incarceration encounter significant barriers to becoming employed as CHWs within health systems. Barriers exist along the entire continuum, including at the entry points for education, training, certification, and hiring. While laws vary from state to state, there are commonalities in the policies blocking individuals with criminal convictions from participating in the healthcare workforce. A consequence of these policies, although often framed as protecting vulnerable patients, is that the particularly vulnerable reentry patient population is denied the optimal care that CHWs with shared lived experience of incarceration can provide.¹¹

Ways of overcoming these structural barriers are detailed in [this issue brief](#). Suggestions for funding CHW programs are detailed in [this publication](#).

For clinics that work around these barriers and find ways to hire and pay CHWs with lived experience of homelessness, the benefits are manifold. Such positions offer CHWs the opportunity to engage in meaningful employment despite their incarceration history, and use their expertise to update, reform, and transform their employers. And CHWs are uniquely situated to build trust with consumers and guide them through the reentry process with competence, clarity, cultural understanding, and sensitivity to the many challenging dimensions of reentry. Following are two examples of programs that have integrated CHWs into their work with people in the reentry period.

V. The FIT Program

Dr. Roxanne Bryant, a Family and Psychiatric Nurse Practitioner, is the Clinic Manager at Lincoln Recovery Response Center in Durham, North Carolina. Here, [the Formerly Incarcerated Transitional \(FIT\) Program](#) employs CHWs in collaboration with the Durham County Health Department. The people served by the FIT Program are navigating health challenges through their reentry process. CHWs are all formerly incarcerated people, so they understand the challenges of navigating health care, housing, and other needs after being affected by incarceration. Most consumers served by the program are living in transitional housing, although some are living with family members or are unhoused. Dr. Bryant explains the basic framework of the program:

V. The FIT Program *(cont.)*

Before people leave incarceration, they are told which county they'll be living in. We put people in touch with a CHW so that things are seamless post-discharge; someone is already working on getting them a place to stay and access to medical care. CHWs schedule the medical appointments at Lincoln [Health Center] and then come with the patient to appointments. They provide vouchers to pay for medical visits and any medications, accompany them to follow-up appointments, and help arrange a transitional living situation... [CHWs] might also help people apply for social services, Medicare, or Medicaid. They might help patients find jobs and arrange transportation. The program is designed to be a comprehensive service.

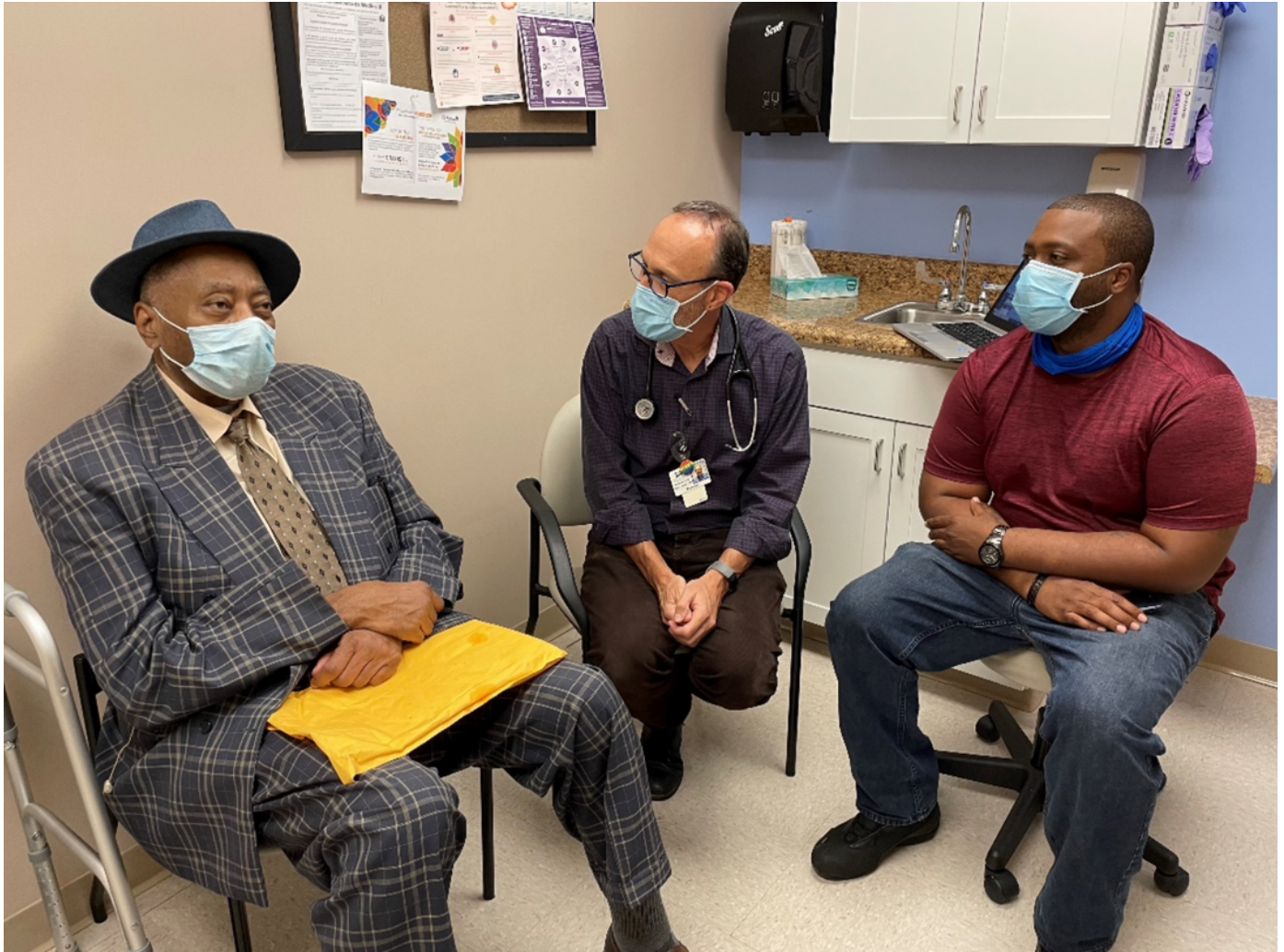
— Dr. Roxanne Bryant, Family and Psychiatric Nurse Practitioner

Through the FIT program, CHWs also facilitate access to behavioral health care and treatment for issues such as depression, anxiety, substance use disorders, and childhood experiences of trauma that may have been compounded by trauma during incarceration. "Trauma-informed care," says Dr. Bryant, "means putting on the hat of understanding that something may have happened to that person... and having an open mind to approach this person with consideration that they may have been exposed to many different types of trauma in their childhood, teenage years, and early adulthood." Through this lens, providers screen for depression and anxiety during initial medical visits and once a year thereafter, because "if you ask, people may say no, but when you start asking specific questions, people sometimes screen positive." When clients screen positive for depression, medical providers discuss and address it with them, and offer referrals to the behavioral health department, where the client can access therapy and case management services. Behavioral health is integrated into the clinic care system at Lincoln; some of the Lincoln clinics have social workers on site who can meet with the client right away, but referrals to the main site are also available.

FIT workers' ability to make transitional housing arrangements for consumers prior to release is a key part of the program, emphasizes Dr. Bryant: "In the past, people would get discharged to the shelter if they didn't have family that would take them in...[but] I haven't seen anyone come out of the FIT program and stay in the shelter... This helps tremendously, and is also a big emotional boost. They can have a clean and safe place to stay and also develop friendships" and community ties via housing.

Through the FIT program, community health workers also facilitate access to behavioral health care and treatment for issues such as depression, anxiety, substance use disorders, and childhood experiences of trauma that may have been compounded by trauma during incarceration.

V. The FIT Program *(cont.)*



Dr. Evan Ashkin and CHW Tommy Green consult with a participant in the Orange County FIT program in Durham.

Dr. Bryant says that the FIT program “has helped more people than we initially thought they would” by spreading the message about the program through other clinics and identifying people in the community who might qualify for services. Some of these people have needed additional kinds of support—for example, two elderly men who had been incarcerated for nearly 50 years and were able to learn how to use new technologies such as cell phones and the internet with the help of the FIT workers. Dr. Bryant suggests that this level of support can “help with recidivism. By being linked up with a community worker, they might feel support that helps them avoid getting re-incarcerated. We know that when people feel no support, it is a risk factor for recidivism.”

CHWs serve as the first point of contact for people navigating reentry, which is, Dr. Bryant says, “crucial for developing trust...and showing that people will not face stigma here at the clinic. Then staff and medical providers continue that, with the presence of trust and not stigmatizing people because of former incarceration.” She notes that understanding—and combatting—stigma is essential:

V. The FIT Program *(cont.)*

The biggest thing is the stigma part. Realizing that people are people, and sometimes we don't know the circumstances of why people got incarcerated: upbringing, trauma, and sometimes people have been wrongly convicted. Assuming that because somebody went to prison they were guilty is incorrect. We can't lump people together as "bad people," so we are continuing to not stigmatize people and realize that even if people did what they were accused of doing, people make mistakes and we don't know the circumstances that led to those mistakes. [This is] something for society in general to keep in mind...so we can treat people as people, and realize they might need a little more support. [Clients] may not be acclimated to all the changes in the outside world, so being patient and helping with resources can be very helpful.

— Dr. Roxanne Bryant, Family and Psychiatric Nurse Practitioner

VI. The Re-Entry Mobile Health Center

The Valley Homeless Healthcare Program (VHHP) in San Jose, California, has two specialized reentry clinics on different ends of the county of 2 million residents, which serve over 20,000 client visits per year, plus several vans that function as the Re-Entry Mobile Health Center (REC Center); supplies and staff on these vans provide mobile medical and mental health care services to people who have been recently released from California state prison or local jails. Reentry services are among the top three services requested by clients. The REC Center is comprised of a multi-disciplinary team inclusive of physicians, psychiatrists, psychologists, nurses, community health workers/outreach specialists, medical social workers, pharmacists, and therapists. The team assists formerly incarcerated persons with medical care, mental and behavioral care, nursing support, medication management, social benefits, case management, transportation, housing, among other health and social supports. The VHHP Program also offers supports via Backpack Street Medicine, Medical Respite, Gender Health, and Addiction Medicine.

At the REC Center, CHWs serve as a critical linkage for persons being released from California state and local carceral systems. The REC Center has found that attendance at the first medical appointment following jail release increased from 30 to 70 percent when patients met with a CHW with lived experience of incarceration prior to their release. To highlight a recent example, a 65-year-old male was released from state prison with history of hepatitis C cirrhosis, hepatocellular carcinoma, and metastatic colon cancer to Santa Clara County. He was referred to the REC Center via TCN with his pertinent medical information and history. He had no family nor friends in the local area and was housed temporarily as a part of his post-release plan through transitional housing. Keith Jenkins, a CHW at VHHP, made initial contact with the patient and transported him to the REC Center so he could access health and social services. Physicians worked to ensure the patient had continuity of his treatment and care that was started in prison. His Medi-Cal was active in another county where he was originally paroled, so medical social workers helped the patient transfer his Medi-Cal to Santa Clara County. Immediately afterwards, the healthcare team expedited Oncology referrals so the patient could continue his chemotherapy treatment. This patient case highlights a few of the incredible barriers and challenges faced by incarcerated individuals being released back into communities.

VI. The Re-Entry Mobile Health Center *(cont.)*

“What I attempt to do on a regular basis,” says Mr. Jenkins, “is help people come back into the community, [knowing that] a lot of them have fears, and a lot of them have uncertainty about what the world has to offer once they get back... Our main goal is to help with medical care and mental health, and then the rest of the resources come from the Re-entry Center as far as helping them get back into the workforce.” But often, says Mr. Jenkins, a crucial role of a CHW is “being an ear to them and seeing what their concerns are once they get out.” He says clients commonly have complex medical issues that need immediate attention via medication access, plus PTSD and other mental health concerns—as well as fears about the ways society has changed and how they will fit in, particularly if they were incarcerated for a long sentence. “We give them a face to see once they get out,” says Keith, “so they know they have someone to talk to once they get out. They don’t have to walk this walk alone. We’re letting them know that we’re here for them, and there’s a whole team of us.”

Dr. Annie Chang is a Physician at VHHP. She explains that the mobile clinic is staffed as a full clinic, but because it is mobile “we can provide same-day access with a physician or psychiatrist... Keith and other CHWs and community outreach specialists can help them navigate other issues, like where to get their medications.” This mobility and access enables care providers to “meet people where they’re at,” says Dr. Chang “and take part in a larger reentry program... We have the flexibility and ability to be part of a county service without requiring the patient to travel or take more buses, which saves them transport time.”

Substance Use and Mental Health Care During the Reentry Period

By Dr. Annie Chang of the REC Center

Persons with opioid use disorder are at heightened risk for relapse and overdose, especially with the rise of fentanyl. Nationally, overdose deaths have more than tripled in just over a decade, from over 21,000 in 2010 to more than 100,000 in 2021 (Kanan et al, 2022). Impacts are disproportionately worse in jails and prisons, in which substance use overdose death rates among incarcerated individuals increased by more than 600% from 2001-2019 (Carson 2021).

In January 2023, California became the first state to secure permission from the Biden administration to use Medicaid for healthcare in correctional facilities, which allows coverage for opioid treatment pre-release (Weiland 2023). Upon release, persons can continue their substance use and behavioral health treatments through the REC Center, preventing critical gaps in their care. Research has shown that 75% of formerly incarcerated persons with OUD will relapse within three months (Berg 2019). Furthermore, they are 10-40 times more likely to have a fatal overdose compared to the general

population (Berg 2019). Locally, Santa Clara County Custody Health implemented a comprehensive medication for opioid use disorder (MOUD) program in 2017, which offers all three medications for opioid use disorder (naltrexone, methadone, buprenorphine), including the novel extended-release buprenorphine, Sublocade (Will et al, 2022). Persons initiated on medication treatment in Custody Health are linked to the REC Center upon release for continuity of treatment, thus preventing risks of emergency care utilization, overdose, and recidivism. Santa Clara County has among the lowest rates of opioid-related overdose deaths in California, ranking the sixth lowest in terms of age-adjusted opioid deaths per 100,000 residents out of California’s 58 counties in 2022 (COSD 2023). Santa Clara County is also at the forefront of youth-centered substance use treatment programs offering medication treatment and behavioral health services for adolescent and juvenile youth. In 2023, 24 percent of adult reentry clients surveyed at the Santa Clara County Reentry Resource Center were previously involved in the juvenile justice system (SCC 2023).

VI. The Re-Entry Mobile Health Center (cont.)

The mobile program provides both inreach and outreach services. Inreach specialists can go into jails and prison systems to establish relationships and prepare for continuity of care post-release. Outreach specialists can go to streets and encampments to find people in need of support and can collaborate with other colleagues and organizations to find clients needing follow-up. “We can also send a backpack street medicine outreach team,” says Dr. Chang, “by looping in that part of our work and program to go look for them in the field. It makes it very agile in terms of how we can meet our patients where they are at.”

Dr. Chang shares: “The REC Center aims to end the devastating cycle of substance use and incarceration, to prevent avoidable mortality and morbidity upon release, and to empower formerly incarcerated persons with the health and social support they need to thrive in their lives and communities. The REC healthcare staff and CHWs work to dismantle the stigma in seeking treatment for substance use disorders, resolve barriers in accessing healthcare, and provide a comprehensive medical home where patients know where to seek and whom to ask for support.” Persons with substance use disorders struggle with shame, loneliness, isolation, trauma, and fear of health and social institutions that inhibit their readiness to engage with treatment and retention in care. “Having a medical home, where CHWs and healthcare staff can welcome each and every person with kindness, empathy, and trust is often the most important part of their care experience.”

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“The REC healthcare staff and CHWs work to dismantle the stigma in seeking treatment for substance use disorders, resolve barriers in accessing healthcare, and provide a comprehensive medical home where patients know where to seek and whom to ask for support.”

— Dr. Annie Chang, Valley Homeless Healthcare Program

Dr. Chang's References

1. Santa Clara County (2023). Reentry At-A-Glance: 12 month Statistics July 2022 - June 2023
2. Santa Clara Valley Medical Center. (2015). Administrative data reported by Dr. Ari Kriegsman
3. National Institute on Drug Abuse (2020). Criminal Justice DrugFacts. <https://nida.nih.gov/publications/drugfacts/criminal-justice>
4. Kanan R, Kalauokalani D, Lambert A, Allen D. (April 2022) Transforming Substance Use Disorder Treatment In California's Prison System. Impacts of the Integrated Substance Use Disorder Treatment Program. California Department of Corrections and Rehabilitation & California Correctional Health Care Services. <https://cchcs.ca.gov/wp-content/uploads/sites/60/ISUDT/Impacts-ISUDT-Program2019-22.pdf>
5. Carson, EA. (2021). Mortality in State and Federal Prisons, 2001–2019 – Statistical Tables. U.S. Department of Justice. <https://bjs.ojp.gov/content/pub/pdf/msfp0119st.pdf>
6. Weiland, N (August 2023) California Battles Fentanyl With a New Tactic: Treating Addiction in Prison. New York Times, <https://www.nytimes.com/2023/08/09/us/politics/opioid-overdoses-prison-fentanyl-california.html>
7. Berg, J. (March 2019). Breaking the Cycle: Medication Assisted Treatment (MAT) in the Criminal Justice System. Substance Abuse and Mental Health Services Administration. <https://www.samhsa.gov/blog/breaking-cycle-medication-assisted-treatment-mat-criminal-justice-system>.
8. Will J, Abare M, Olson M, Chyorny A, Wilhelm-Leen E. Emergency department utilization by individuals with opioid use disorder who were recently incarcerated. J Subst Abuse Treat. 2022 Oct;141:108838. doi: 10.1016/j.jsat.2022.108838. Epub 2022 Jul 12. PMID: 35868162.
9. California Overdose Surveillance Dashboard. Prepared by California Department of Public Health (CDPH - Substance and Addiction Prevention Branch (SAPB). Accessed on 11/21/23. <https://skylab.cdph.ca.gov/ODdash/>

VII. Conclusion: A Culture of Welcoming

Mass incarceration in the United States impacts millions of people directly, and every community by extension. Returning community members are extremely vulnerable to the impacts of stigma and other forms of social inequality, including homelessness, and are often dealing with serious physical and mental health problems. For clinics providing healthcare to people experiencing homelessness, understanding the specific challenges associated with reentry is key to offering effective and compassionate care during the reentry period. This care takes the form of understanding systems and processes in order to facilitate access to healthcare, and it also involves being willing to transform organizational structures to include people with experience of incarceration as experts in providing care to others.

Dr. Annie Chang emphasizes the crucial role of CHWs in supporting reentry transitions and establishing connections and social support, as well as the importance of community partnerships in setting up welcoming nets for people returning to society: “Partnerships help us give them the best support, skillset, and tools to make this transition successfully,” she says. “But this is also a big milestone. People are coming back into their community or back into society, and it’s exciting and scary at the same time. It’s a big moment in their lives. So to be a part of that means a lot to our team.” Keith Jenkins adds: “We’re sometimes all the family that [these clients] have, so we feel good about what we do here... I love the work.”

In other words, successful reentry programs are focused on creating a culture of welcoming.

As Anne Feczko says:

I’d encourage providers to...cultivate their own routine for welcoming someone home, especially after a long period of incarceration. If they are returning to where they used to live, I like to explicitly say ‘welcome home.’ It’s a really stressful time period, and they’re used to being a number, not a name. They’re distrustful of medical systems and authority figures...so coming into a facility like a health center, they may not assume that we have their best interests at heart or that we’re wanting to form a long-term health care relationship... I like to tell them, ‘you can keep coming back here; we would love to have you here.’

— Anne Feczko, Nurse Practitioner

References

- ¹ Transitions Clinic Network & The Network for Public Health Law. (2023). Promoting Health Equity in Communities Affected by Mass Incarceration: Addressing Legal Obstacles to Hiring Formerly Incarcerated Individuals as Community Health Workers. Retrieved from [Promoting Health Equity in Communities Affected by Mass Incarceration – Transitions Clinic](#)
- ^{2,3} Prison Policy Initiative. (2023). Mass Incarceration: The Whole Pie 2023. Retrieved from <https://www.prisonpolicy.org/reports/pie2023.html>
- ⁴ Couloute, Lucius. (2018) Nowhere to Go: Homelessness Among Formerly Incarcerated Public. Prison Policy Initiative. Retrieved from [Nowhere to Go: Homelessness among formerly incarcerated people | Prison Policy Initiative](#)
- ⁵ The Sentencing Project. (2021). The Color of Justice: Racial and Ethnic Disparity in State Prisons. Retrieved from <https://www.sentencingproject.org/app/uploads/2022/08/The-Color-of-Justice-Racial-and-Ethnic-Disparity-in-State-Prisons.pdf>
- ⁶ National Coalition for the Homeless. (n.d.). The Criminalization of Homelessness. Retrieved from <https://nationalhomeless.org/civil-rights-criminalization-of-homelessness/>
- ⁷ PBS NewsHour (2020, December 8). The Vicious Cycle of Incarceration and Homelessness [video]. Retrieved from [The vicious cycle of incarceration and homelessness | PBS NewsHour](#)
- ⁸ Brinkey-Rubenstein, Laura. (2013). Incarceration as a Catalyst for Worsening Health. Health & Justice, 1(3). Retrieved from <https://healthandjusticejournal.biomedcentral.com/articles/10.1186/2194-7899-1-3>
- ⁹ Juvenile Law Center. (n.d.). Children in Prisons. Retrieved from <https://jlc.org/children-prison>
- ¹⁰ Ferrell, Dominique. (2023, September 25). Why People Leave Prison 'More Broken' than When They Entered. GBH News. Retrieved from <https://www.wgbh.org/news/local/2023-09-25/why-people-leave-prison-more-broken-than-when-they-entered>
- ¹¹ Transitions Clinic Network & The Network for Public Health Law. (2023). Promoting Health Equity in Communities Affected by Mass Incarceration: Addressing Legal Obstacles to Hiring Formerly Incarcerated Individuals as Community Health Workers. Retrieved from [Promoting Health Equity in Communities Affected by Mass Incarceration – Transitions Clinic](#).
- ¹² Santa Clara Valley Medical Center. (2015). Administrative data reported by Dr. Ari Kriegsman.

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