SERVICES FOR RE-ENTRY POPULATIONS: POLICY EVIDENCE AND RECOMMENDATIONS

CHIPTS
Center for HIV Identification, Prevention and Treatment Services

POLICY BRIEF

BACKGROUND

America is facing multiple, often intertwining epidemics – including mental illness, substance use disorder, mass incarceration, and fragmented health care systems that are often inaccessible. For those caught in the intersections of these epidemics, the impacts of the current COVID-19 pandemic are even more destructive and deadly.

Incarcerated people experience these epidemics with greater frequency than the general population. The majority of individuals in prisons and jails have a substance use disorder [1], and more than one quarter report experiencing psychological distress in the prior 30 days [2]. Hepatitis C and sexually transmitted infections, which can in turn potentiate the risk of acquiring HIV and complicate treating it, are also major issues [3].

As of February 26, 2021, 4329 COVID cases and 13 deaths had been reported in Los Angeles County jails [4]. To mitigate the risk of coronavirus transmission, the jail population was reduced by approximately 5,000 individuals by the end of April 2020, from approximately 17,000 to 12,000 [5].

The reduction of the jail population represents both a risk and an opportunity. Re-entry has been associated with increased, illness, mortality, and risky health behaviors [6-8]. However, the process of community re-entry also presents a crucial opportunity to link individuals with needed health and social services. This brief looks to HIV, a pandemic predating COVID-19, in order to draw broader lessons for addressing the needs of incarcerated populations in the United States during re-entry.

EVIDENCE

People living with HIV and people at risk of incarceration.
Both populations experience **stigma and discrimination** that impact **health care access**, are disproportionately **Black and Latino**, **lower income**, and have a high prevalence of **substance use disorder**, **mental illness,** and **other chronic conditions** [2, 9, 10]. In 2006, it was estimated that one-in-seven people living with HIV experience incarceration in a given year [11].

A system of care tailored to a specialized population can be effective.
In 1990, a specialized system of care with comprehensive wraparound services was developed to meet the needs of people living with HIV. The Ryan White Care Act provided such services to those who otherwise lacked coverage and ability to pay. Bundled together and offered in the same setting as HIV clinical care was support for mental health, substance use disorder, transportation, and nutrition. A more intensified application -- the Los Angeles Medical Care Coordination Program was initiated in 2013, integrating a social worker, caseworker, and registered nurse into the clinical teams of Ryan White patients [12].

EVIDENCE (CONT'D)

Results: Levels of HIV care engagement for uninsured Ryan White patients are similar to those of privately insured patients without Ryan White, and patients with both Ryan White and private insurance do better still [13]. CHIPTS investigators followed 6,400 patients enrolled in the Los Angeles Medical Care Coordination Program. They found that six months after enrolling, participants' viral suppression increased to 77%, compared to 35% in the year prior to enrollment. The program's impact was durable, with suppression levels remaining high over 3 years of follow-up [14].

Conclusion: Ryan White and Medical Care Coordination successfully meets the needs of populations that have much in common with re-entry populations and could be expanded to re-entering individuals with chronic health conditions.

Treatment can and should start in custody.

Comprehensive programs for treatment of substance use disorders that **begin in custody and that provide facilitated links to treatment in the community have a strong evidence base**, with examples of how integrated re-entry programs might be shaped [15]. These approaches can also lower the risks for HIV transmission that accompany the sustained interruptions of HIV care that often occur following re-entry [16, 17]. The Substance Abuse and Mental Health Services Administration has issued guidelines for in-custody screening for both substance use and mental health needs as part of re-entry planning [18].

The range of **evidence-based treatment modes** for different disorders include **medication-assisted treatment for opioid and alcohol use disorder** and behavioral therapies for other types of substance use disorder [17], along with medication-based and behavioral therapies for mental health disorders. Initiating appropriate treatment in custody can reduce relapse, overdose, and death following release -- a particularly urgent need given that overdoses continue to skyrocket in California as fentanyl replaces heroin (Mexican black tar and powder) as the common street opioid [19].

RECOMMENDATIONS

Based on current available evidence, **a coordinated care model that integrates social, mental health, and substance use services is recommended**. The approach proposed here draws from the HIV Medical Care Coordination described above [12]. It has three key goals:

1. Reduce harms during the four-week window after release from jail or prison
2. Centralize provision of all types of services
3. To link and re-engage those who might otherwise not engage in care

To help achieve these goals, we have five recommendations.

A. Initiate re-entry before release.
B. Offer peer navigation to address stigma and facilitate access.
C. Engage a Certified, Coordinated, Integrated Continuum of Care (CCICC) model.
D. Ensure flexibility in eligibility criteria.
E. Avoid potential conflicts between service access and community supervision.

The next page will detail those recommendations.

RECOMMENDATIONS (CONT'D)

A. Initiate re-entry before release

Because of the disruption that frequently follows release, the time to address the risks facing individuals re-entering the community begins *prior to* release and should consider the following:

- **Up-to-date, evidence-based treatment for mental health and substance use disorders**, including medication-based treatments. Deliberate indifference to the serious medical needs of the incarcerated is prohibited under the 8th amendment of the United States Constitution.
- **A four-week supply (or prescriptions)** of needed medications.
- **Assistance to ensure that insurance coverage is active the moment they are released**. For example, Covered California allows for a 60-day enrollment period for anyone leaving incarceration. Those previously enrolled in Medi-Cal who were incarcerated less than one year should have coverage automatically restored without having to re-apply [20].
- **Release during hours when services are available**. While not always avoidable, not infrequent middle-of-the-night releases from LA County jails could be reduced substantially by a comprehensive review of current practices and policies.
- For all individuals, make available at release from incarceration: **naloxone** (Narcan) for opioid overdose and **transportation from release to a service provider. Include reimbursement** to family members or community-based organizations that assist with arranging the transportation.

B. Offer peer navigation to address stigma and facilitates access

Peer models of patient navigation have been successfully used in substance use treatment, mental health, HIV, and re-entry programs. **They should be implemented for all re-entry populations because of the evidence that they may reduce recidivism** [21] **and increase engagement and retention in care** [15]. In collaboration with the larger re-entry team (next section), **peer navigators help address issues of mistrust, stigma, and communication** that can interfere with reentering persons' ability to successfully navigate the complex service landscape [22-26]

C. Engage a Certified, Coordinated, Integrated Continuum of Care (CCICC) model

Also known as Integrated Service Facilities [27], the CCICC model bundles social and medical services together in a manner that reduces the complexity of navigating social and healthcare systems. An individual re-entering society should ideally be working with one team that coordinates and provides all services that are vital to successful re-entry. These include housing, substance use and mental health treatment, medical care, and legal, food, and transportation assistance, etc.

D. Ensure flexibility in eligibility criteria

When establishing eligibility to receive re-entry services, criteria should be **broad enough to capture everyone in need**. Criteria should include both biomedical and social determinant factors, with the ability to accommodate individuals with needs in either category. Those with marginal housing situations or food instability, for example, should be considered even if their medical conditions are under active management by medical professionals.

E. Avoid potential conflicts between service access and community supervision

For individuals under supervised release (parole, probation, etc.), **their conditions of release should not limit access to services**, including harm-reduction, prevention, and treatment services.

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Suggested Citation: *Re-Entry Services for Incarcerated Individuals.* Los Angeles, CA; UCLA Center for HIV Identification, Prevention and Treatment Services, March 2021. www.chipts.ucla.edu