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Understanding the Public Health Implications of Prisoner Reentry in California

State-of-the-State Report

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Summary

Introduction

As an increasing number of prisoners are released from prisons and return to local communities, there are key questions about (1) what health care needs they have and (2) what role health plays in affecting their success at integrating back into communities. In terms of the first issue, prior research has found that the prison population is disproportionately sicker, on average, than the U.S. population in general, with substantially higher burdens of infectious diseases (such as HIV/AIDS, tuberculosis, and hepatitis B and C), serious mental illness, and comorbidities, or co-occurring disorders (National Commission on Correctional Health Care, 2002).

In terms of the second question, about the impact of ex-prisoners' health care needs on reentry, research shows that individuals with physical and mental health problems reported poorer employment outcomes than those without such problems (Mallik and Visher, 2008). Also, ex-prisoners returning to communities face a number of obstacles to accessing care, as low insurance rates among this population limit their ability to access health care services and provide case managers with few options for linking them to services. Further, many providers lack experience in treating this population.

Such concerns are especially acute in California, where the number of individuals released from California prisons has increased nearly threefold over the past 20 years. Most of the state's prisoners ultimately will return to California communities, bringing with them a host of health and social needs that must be addressed. Yet the public is largely unaware of the health needs of released prisoners, and the

challenges they present to their communities are not being addressed explicitly, despite the fact that reentry directly affects almost every California community.

Further, the current debate about California's 2011 Public Safety Realignment Plan has focused on public safety concerns in counties rather than on how counties will meet the rehabilitative and health care needs of individuals who will be housed and supervised at the local level. At the same time, implementation of the 2010 Patient Protection and Affordable Care Act (ACA) (Pub. Law 111-148) will eliminate a critical barrier to accessing care for many ex-prisoners. The ACA will expand Medicaid eligibility to include all non-Medicare-eligible citizens and legal residents¹ under age 65 with incomes up to 133 percent² of the federal poverty level, opening up the possibility for many ex-prisoners and other individuals involved with the criminal justice system to become eligible for Medicaid (or Medi-Cal in California) and to have drug treatment services, prevention services, and wellness programs—services important to the reentry population—more fully covered. Thus, California is at a critical juncture: It faces numerous challenges, but recent changes in policy also present important opportunities to improve the state's ability to meet the needs of individuals returning from state prison.

It is critical to address the public health challenges of returning ex-prisoners to assist communities in meeting the reentry needs of this population. We also need to better understand the impact of incarceration on their families and children of incarcerated parents, their risk factors, and what options exist to change the trajectories of their lives.

This state-of-the-state report examines the specific health needs of California's reentry population, the public health challenges of reentry in California, and the policy options for improving access to safety-net resources for this population.

To achieve this overall goal, the study first examined the health care needs of the reentry population by analyzing data from the Bureau

¹ That is, legal residents who have been in the country five years or longer.

² Taking into account the 5 percent waiver under the ACA, this would translate to incomes up to 138 percent of the federal poverty level.

of Justice Statistics (BJS) Survey of Inmates in State and Federal Correctional Facilities; conducted a geographic analysis to identify where parolees are concentrated in California (all 58 counties) and which counties and communities are disproportionately affected by prisoner reentry; and examined the types of health care services available in four counties—Alameda, Los Angeles, San Diego, and Kern—and developed measures to assess the capacity of the safety net in these counties to meet the health care needs of the reentry population.

The study then “bored down more deeply” in Alameda, Los Angeles, and San Diego counties, using focus groups with former prisoners and their family members and key-actor interviews with relevant service providers and community groups to understand the experiences of returning prisoners in seeking care and the role that health plays in their efforts to reintegrate back into the community and rejoin their families, what models of service provision are being used by local communities for this population, and what factors have facilitated or hindered ex-prisoners’ and providers’ efforts. In addition, we sought to understand the impact that incarceration has had on families, including what challenges they face and the need for programs and services.

Assessing Prisoner Health Care Needs and the Capacity of the Health Care Safety Net

Health Care Needs Are High, but Mental Health and Drug Treatment Needs Are Even Higher

Our analysis of self-reported data from the BJS survey of California inmates provides a rich understanding of the range of physical health, mental health, and substance abuse problems that this population brings upon their return to local communities. We found that returning prisoners self-report a high burden of chronic diseases, such as asthma, diabetes, and hypertension, as well as infectious diseases, such as hepatitis and tuberculosis—conditions that require regular access to health care for effective management.

In addition, the burden of mental illness and drug abuse or dependence is especially high in this population. About two-thirds of Cali-

California inmates reported having a drug abuse or dependence problem, but only 22 percent of those inmates reported receiving treatment since admission to prison. More than half of California inmates reported a recent mental health problem, with about half of those reporting receiving treatment in prison. These results underscore the importance of access to mental health and alcohol and drug treatment services and of continuity of care for this population. But the likelihood of ex-prisoners receiving adequate health care once they are released is poor given the high rates of uninsurance among this population and other barriers to accessing care.

Certain Counties and Communities Are Disproportionately Affected by Reentry

A number of trends complicate the successful reentry of parolees into communities. Our analysis of the geographic distribution and concentration of parolees across California and in the four focus counties showed that reentry disproportionately impacts 11 counties statewide and that, within counties, parolees tend to cluster in certain communities and neighborhoods. Such clustering has implications for linking to and providing health care services to this population and for considering how to effectively target reentry resources. As illustrated by Los Angeles County, which has a combination of both urban and more sparsely populated areas, there is a need to tailor outreach and service delivery strategies to areas where the reentry population is more concentrated versus areas where it tends to be more dispersed.

Our analyses also showed that African-American and Latino parolees, in particular, tend to return to disadvantaged neighborhoods and communities, defined by high poverty rates, high unemployment rates, and low educational attainment. This suggests that reentry will be especially challenging for these groups.

Access to Health Care Safety-Net Resources Varies Substantially

An important contribution of this study is formally defining what the health care safety net is for the reentry population and developing measures to assess the capacity of the safety net to meet this population's health care needs. Taking into account differences in capacity,

the underlying demand for safety-net services, and travel distance, our measures of accessibility (i.e., of potential versus realized access) showed that parolees' access to health care safety-net facilities varies by facility type, by geographic area, and by race/ethnicity. As policymakers consider how to improve access to health care services for the reentry population in California, they will need to take into account this variation in counties' safety nets.

In all the counties, community clinics appear to play an important role in filling gaps in primary care coverage vis-à-vis the reentry population. For mental health care and drug and alcohol treatment, separate networks provide services to the reentry population and serve as the initial safety net for them. These include, for example, the parole outpatient clinics (POCs), the Parolee Services Network (PSN), state-funded community-based alcohol and drug treatment programs, and Proposition 36 (the Substance Abuse and Crime Prevention Act), which diverts nonviolent drug offenders to treatment instead of incarceration. But these networks have limited capacity and, as discussed below, have been impacted by budget cuts, suggesting that much of the reentry population must rely instead on county mental health and alcohol and drug treatment services.

Budget Cuts Have Impacted the Health Care Safety Net the Reentry Population Relies On

Because of budget cuts, the California Department of Corrections and Rehabilitation (CDCR) has reduced funding for rehabilitative services, including alcohol and drug treatment programs, by 40 percent. The treatment capacity of in-prison substance abuse programs (SAPs) went from a capacity of 10,119 treatment slots in June 2008 to only 2,350 slots in January 2010 (CDCR, Division of Addiction and Recovery Services, *Annual Report*, 2009; CDCR, "Adult Programs Key Performance Indicators January 2010–December 2010," 2010).

Budget cuts have also impacted treatment networks out in the community. For example, the PSN, which provides community-based alcohol and drug treatment and recovery services to parolees in 17 counties statewide, has had its funding reduced. Community-based treatment programs have experienced cutbacks in state funding result-

ing in reductions in local treatment capacity. Finally, although Proposition 36 remains in effect, it is no longer being funded. Beginning in October 2011, Proposition 36 will become instead a fee-based, participant self-pay counseling program.

Given these changes, individuals leaving state prison are returning to California's communities having received less and less rehabilitative programming. This means that the reentry population will have greater unmet needs and will have to be even more self-determined than previously.

Understanding the Perspectives of Ex-Prisoners and Providers About Health Care Challenges

Ex-Prisoner Perspectives

Health Needs Were Ranked Lower Than Other Basic Needs. Focus group participants tended to view their physical health care needs as distinct from their mental health care and substance abuse treatment needs. For example, focus group participants typically ranked health needs lower than economic considerations, such as housing and employment, which were described as the most important challenges they faced. Yet participants also identified "getting sober" and finding regular care and support for mental health issues as critical.

Many discussed their struggles with substance abuse problems, and, in a number of instances, these problems were the underlying factor that resulted in their incarceration. Substance abuse problems often continued after release, resulting in violations of their parole or new crimes that led to their being returned to prison. A number of focus group participants reported having problems accessing substance abuse treatment programs in prisons, noting the limited availability of programming slots.

Other commonly mentioned health concerns included oral health problems, diabetes, hypertension, cancer, prostate problems, and infectious diseases, such as hepatitis, tuberculosis, and sexually transmitted diseases. Also, a number of participants discussed feeling depressed at times during their period of incarceration and after release.

Factors mentioned by focus group participants as limiting their access to health care while in prison included long waiting times to be seen by a physician or nurse, correctional staff serving as informal gatekeepers and influencing what type of care prisoners might receive, and a general indifference by the system.

As a result, focus group participants felt that it was up to them to do what they could to stay healthy. They expressed an interest in preventive health care and informally shared information among themselves about what one could do to stay healthy and about what type of screening exams were important. There were some misperceptions about what preventive care was needed and when, which added to the viewpoint that the correctional health care system was indifferent to their needs.

Few Received Prerelease Planning or Help in Transitioning Their Care to Community Providers. Most focus group participants had not participated in prerelease planning classes, and some felt that what little they had received was inadequate. Instead, they tended to rely on word of mouth, on a mentor in prison, or on family members, or they were self-motivated to find out where they could go to seek services. Participants who needed substance abuse treatment or help with housing or employment tended to rely on other offenders with prior experience in seeking out such care in the community.

Transitioning of care to community providers was problematic in several instances. For example, participants with diabetes or cancer reported little or no continuity of care. Many focus group participants lacked health insurance and had little prior contact with a community's health care system, making it difficult for them to understand basic steps, such as knowing where to go to get care or their medications refilled.

PACT Meetings Are One Way to Link Individuals to Health Care Services, but the Meetings Vary in the Information Available. Individuals released on parole are required within a specified period of time to attend a Parole and Community Team (PACT) meeting at which a variety of providers (e.g., housing, employment, drug treatment) are available to briefly discuss what services they offer. Focus group participants varied in their knowledge about the PACT meetings. The types

of providers present at these meetings also can vary from meeting to meeting, making it an inefficient way for parolees to learn about what services may be available to them.

The type of information focus group participants desired to know was how to apply for Medi-Cal insurance and for General Relief, where to go to get free health care, and where to seek treatment for specific problems. In addition, they were interested in information related to housing, transportation, and employment.

The focus group participants suggested that one way to improve access to information is to have community health care providers routinely participate in the PACT meetings. More importantly, they said that having this information available prior to release from prison, including packets specifically tailored to each individual county, would be particularly helpful.

Family Is Important for Motivating Individuals to Change and in Helping with the Reentry Process. A number of focus group participants honed in on the central role that family plays in providing them motivation to seek rehabilitative services while incarcerated and in assisting them with their transition back to the community. For example, individuals mentioned being motivated to participate in substance abuse treatment programs while incarcerated and continuing to do so upon release, with the goal of reuniting with their family and children. Upon release, family also helped them meet basic needs, such as food, housing, clothing, or help in finding jobs. At the same time, in some instances, family reunification also could be a significant stressor.

Ex-Prisoners' Stressed the Importance of Culturally Competent Care and Getting Information on Health Services and Health Insurance Enrollment Prerelease. Some of the focus group participants felt that having access to support services that were provided in a culturally competent manner was important. A primary concern was having someone who understood their experience of incarceration, who would treat them with respect, and who could help them access services. Also, they felt it was important to have health care providers and staff who are empathetic to their circumstances and needs. They tended to prefer interacting with staff who had been formerly incarcerated them-

selves or who had substantial experience in working with the reentry population.

Participants also felt that having information available prior to release from prison on where to seek health care services and how to apply for Medi-Cal or get their benefits reinstated was important. They also suggested that packets specifically tailored to each individual county would be the best way to get this information to them.

Provider Perspectives

The Reentry Population Has Substantial Treatment Needs.

From the providers' perspective, the reentry population has substantial mental health and substance abuse treatment needs, as well as significant health problems, including diabetes, hypertension, renal disease, and infectious diseases, such as HIV/AIDS and hepatitis C. As several providers noted, this is a population with a large amount of unmet need; illnesses such as uncontrolled diabetes, asthma, and hypertension that are typically the result of neglect or lack of access to care.

Also, this is a population with a range of other non-health-related needs, such as those related to transportation, employment, housing, and family reunification. Given this complex set of needs and the prevalence of untreated health conditions, parolees tend to be more resource-intensive to treat. Also, health care providers face the challenge of how to link these individuals with a range of other services. And when making treatment decisions for individuals who may be homeless, providers must take into account, for example, whether the individual has a place to keep his or her medications.

Inadequate Discharge Planning Raises Concerns About Continuity of Care. From the perspective of providers, a particular concern is continuity of care for those being released with serious medical conditions or mental health or substance abuse treatment needs. Lack of adequate medications upon release is problematic because it often can take time for an individual to access care in the community. As a result, individuals are at risk of self-medicating, and problems with timely access to care can negatively impact continuity of care.

Some providers had tried to coordinate with prison facilities in their region to establish bridging services for those about to be released

and who likely would need health care from their network of clinics or health centers. However, they were unsuccessful in doing so.

Lack of medical records was also seen as problematic, because providers are faced with treating individuals without any information about their past health status and care. For individuals with infectious diseases, such as HIV/AIDS or hepatitis—important public health concerns—providers felt it was critical to know what kind of care and education a patient had received while incarcerated. This was also true for those with chronic health and mental health conditions.

Financial and Communication Barriers Limit Access to Care.

The providers identified a number of factors that make it difficult for recently released prisoners to access care, including lack of health insurance or funding. These factors also hinder the ability of providers and nonprofit community organizations to link individuals to needed services. Other factors include communication barriers, lack of understanding of the complexities of accessing safety-net health care services, long waiting times for appointments, and the impact of budget cuts, which limit treatment options. Combined, these barriers make it difficult for recently released prisoners to successfully navigate the health care system. They also make it challenging for health care providers and community programs to assist individuals in placing them into treatment and in referring them to services.

For example, the lack of health insurance means that although inpatient treatment programs may be available for those with mental illness, the cost is often prohibitive. Even counseling clinics that provide services on a sliding fee scale may be too expensive for these individuals, who simply lack the ability to pay. As a result, one mental health counselor tended to rely on crisis homes, which are, at best, only as a stopgap measure. In addition, long wait times to see a psychiatrist at county mental health clinics mean that some individuals are at risk of running out of medications or of self-medicating.

Individuals Are Reluctant to Seek Help from Parole. Parole outpatient clinics are one way that individuals with mental health problems can be seen by a psychiatrist and prescribed medications. However, providers commented that there are important disincentives for an individual to seek help from these clinics or for a parolee to ask his

or her parole officer for help in accessing services. Providers said that individuals reported that they felt the parole officer may view them as troublemakers or as individuals who need to be watched closely if they report needing help accessing drug treatment or mental health services.

Communication Issues and Difficulties Navigating the Health Care System Are Key Concerns. Providers commented that adaptive behaviors that may have worked in an incarcerated setting, such as intimidating others and not trusting them, are seen as maladaptive and even threatening in a health care setting. Individuals released from prison may misinterpret delays in appointments or long waiting times as a sign of disrespect or rejection. In addition, individuals often have difficulties navigating the health care system, and the different silos in the health care and social services systems can complicate the referral process for those with a complex set of needs. Therefore, having patient navigators who are empathetic and understand the experience of incarceration was seen as essential in helping the formerly incarcerated to link to services.

Providers Are Uncertain About How to Access the Reentry Population. The providers interviewed had the sense that they are increasingly serving the reentry population but lack the data to quantify this assessment. In general, they do not know whether an individual was formerly incarcerated unless that individual self-identifies or there is another mechanism for disclosure. Nonprofit community organizations that serve the reentry population are important referral mechanisms for community health care providers.

Budget Cuts Have Impacted Providers. Providers interviewed reported on the various effects of state, county, or city budget cuts. These included having to eliminate programs, such as HIV or dental programs, or cut back on services, such as mental health programs. A provider from a community assessment center noted that it needed to reassess whether to focus only on conducting assessments or to continue to also provide other services, such as drug treatment and mental health care. State-level cuts in community-based treatment programs meant the elimination of one provider's sober living facility. Importantly, budget cuts also have impacted alcohol and drug treatment program models, including decreasing the length of stay in residential treatment programs.

Providers' Suggested Ways to Improve Access to Health Care Services. As for suggestions on how to improve access to care and better facilitate the transition of their care to community health care providers, our interviewees indicated that there is an important need for bridging services to help transition ex-prisoners' care to community providers and to address such issues as ensuring an adequate supply of medications, obtaining the medical records or developing a detailed history that can accompany the individual, and having individuals begin the process of reinstating benefits prior to release for health insurance and other services.

A related set of recommendations centered around the critical need for patient navigators who can help individuals understand the health care system, help communicate and serve as patient advocates, and help individuals access a range of services.

Prisoner Family Perspectives

As of 2000, an estimated 856,000 California children—approximately 1 in 9—have a parent involved in the adult criminal justice system (Simmons, 2000). When a parent is incarcerated, the children of that parent also are deeply affected. Not only do such children lose a parent, they must also cope with altered systems of care—such as having to live with grandparents or even having to go into foster care. Parental incarceration can have a range of negative effects on children, including feelings of shame, social stigma, loss of financial support, weakened ties to the parent, poor school performance, increased delinquency, and increased risk of abuse or neglect.

Our discussion with a small group of seven caregivers enabled us to explore these issues. Most of them were grandmothers who provided us with initial insights about the experiences of caregivers providing this type of kinship care to children with incarcerated parents. They discussed the challenges of raising young children and teenagers, of coping with behavioral problems among these children, and of trying to keep their families together (but not knowing where to turn to for help). Although our discussion was exploratory in nature and not indicative of the full range of experiences of caregivers, the themes and issues that the discussion participants raised were consistent with the research literature.

For caregivers who were middle-aged and older, the experience of being thrust into a caregiver role later in life was emotionally and physically trying. Most of the caregivers were motivated to try and keep the family together in that they did not want these children to go into the foster care system.

The support needs for children mentioned by the caregivers included assistance with school and tutoring services; mentoring opportunities; role models; and programs aimed specifically at children with incarcerated parents that enable them to feel less isolated. They emphasized the importance of having positive male role models for teenage boys, in particular. They also felt it was important to provide the children, especially teenagers, with a realistic understanding of what the juvenile justice system is like so that they understand the negative consequences of getting involved in crime.

The caregivers we spoke to said that the children they cared for had mixed feelings about seeing their parent when they returned from prison. The challenges that a newly released incarcerated parent faces in terms of meeting basic needs, such as employment and housing, also had a direct effect on their children, who experienced them firsthand. A common experience was the child going back to live with the parent, but eventually returning to the grandparent because of the unstable living situation they found themselves in.

Lastly, the support needs of caregivers included better information on what community resources and social services are available to them, assistance in obtaining help for children with learning disabilities, mentoring and family support programs, and a critical need for respite care.

Conclusions and Recommendations

We began this study to assess the health care needs of the prisoner reentry population in California in 2008, at the beginning of what has now become the most significant national recession since the Great Depression. When we finished the initial set of analyses on the capacity of the health care safety net to meet the needs of this population in 2009, we

were already witnessing the impact of the recession on the safety net. Now, California's 2011 Public Safety Realignment Plan, the continuing impact of the economic crisis in terms of even deeper cuts to the health care safety net, and prospects of health care reform provide a changing landscape in which to assess the impact of prisoner reentry in California—one that places California clearly at a crossroads.

The results of our analyses over the past four years show the following:

- The capacity of the health care safety net varies across California communities by county, type of services, and race/ethnicity and, since our first report, has become even more constrained while demand has grown.
- California's new Public Safety Realignment Plan represents an almost tectonic shift in the state's criminal justice system that will have a number of implications for thinking about how to meet the health care and rehabilitative needs of the reentry population.
- Public safety realignment presents some challenges, such as the fact that traditional mechanisms for linking ex-prisoners to health care and social services—e.g., parole officers, PACT meetings—will change dramatically for individuals placed on county-level postrelease community supervision and for low-level offenders who will serve their time in county jail.
- Realignment also presents an important opportunity to address the public health issues associated with reentry, not only to reduce the size of the state's prison population and reduce the state's high parole revocation rates, but also to focus attention on the need to improve prerelease planning, build better mechanisms to transition care from correctional health to safety-net providers, and create local partnerships among probation, law enforcement, county agencies, and community- and faith-based organizations to better address the needs of those individuals returning back to communities.
- Health care reform provides important opportunities as well as challenges to expand insurance coverage through Medicaid for the reentry/criminal justice population, to improve access to drug treatment, and to better manage their care.

Given these findings, in Table S.1 we summarize our recommendations for how California can meet the public health challenges of reentry and to put into place mechanisms to be prepared for the new opportunities realignment and health care reform represent. These recommendations are based on a combination of our review of the literature and analyses of the BJS inmate survey, parolee data, data on the health care safety net in four counties, provider interviews, and focus group discussions with formerly incarcerated individuals and family members.

The recommendations in Table S.1 can be acted on at both the state level—by departments and agencies that have a role to play in preparing California for health care reform and public safety realignment—and the county level—by county probation, law enforcement, jail systems, county and community health care safety-net providers, and community organizations and leaders. More detail on these recommendations is provided in Chapter Six.

Final Thoughts

The changes described here that California is experiencing are also occurring in other states, as they, too, grapple with how to reduce corrections costs and the size of their prison populations. Ultimately, most individuals who are incarcerated will eventually return home to local communities. We began our study with the premise that the reentry population eventually will become part of the uninsured and medically indigent populations in counties. This is even more the case today.

Importantly, our analyses were conducted prior to the October 1, 2011, implementation of California's new Public Safety Realignment Plan. Therefore, our results of the geographic distribution and concentration of parolees and the capacity of the health care safety net reflect conditions prior to the implementation of this new policy. Nevertheless, we believe that these findings will provide the state and counties with an important context for understanding and examining the impact of realignment moving forward.

Table S.1
Preparing to Meet the Health Care and Rehabilitative Needs of California's Reentry Population: Summary of Recommendations

Recommendation	Description
What Can California Do to Prepare?	
Develop informed estimates about the percentage of the Medicaid expansion population that the reentry and criminal justice population will represent.	There is a need for more informed estimates of the size of the reentry/criminal justice population that will be eligible for Medicaid and of the likely impact of different enrollment strategies. These estimates should also take into account citizenship status and what percent of the reentry/criminal justice population will be eligible for subsidies as part of California's Health Benefit Exchange.
Develop Medicaid enrollment strategies.	The participation of the reentry/criminal justice population in Medicaid will largely depend on how much states' departments of corrections and county probation and jails facilitate enrollment in Medicaid, as well as other stakeholders. California may want to consider developing strategies to enroll or reinstate Medicaid benefits for the reentry/criminal justice population.
Leverage the experience of other states that have previously expanded coverage to childless adults under Medicaid.	Research on other states that expanded Medicaid coverage provides a rich source of information on issues and analyses California may want to undertake (e.g., effectiveness of different outreach efforts and enrollment practices on participation rates) to understand the impact of insurance expansion for the reentry/criminal justice population.
Develop health homes for the reentry/criminal justice population.	The Medicaid expansion population (including the reentry/criminal justice component) is expected to include individuals with multiple comorbidities and high rates of mental illness and substance abuse, suggesting that health homes will be an important way to manage their complex care needs.
Develop care/case management systems that can account for special populations' needs, including the reentry/criminal justice population.	California may want to consider applying for planning grants to support the development of tailored care/case management programs that will include coordination with social services and community organizations that serve special populations, including the reentry/criminal justice population.

Table S.1—Continued

Recommendation	Description
Assess workforce-development strategies for alcohol, drug, and mental health treatment.	Given that existing publicly funded treatment provider networks may become overwhelmed in the face of Medicaid expansion occurs and public safety realignment, California may want to consider establishing a health task force to identify workforce-development strategies that will help build treatment provider capacity in general, and specifically to meet the expected increase in demand for services by the reentry/criminal justice population.
Consider developing electronic medical records.	Electronic medical records are one tool by which to improve the transition of care from prison to safety-net providers; as such, California may wish to consider developing a pilot study to assess the feasibility of developing such records for the reentry/criminal justice population.
Consider expanding prerelease planning efforts.	CDCR’s prerelease planning for prisoners with medical or mental health conditions is based on acuity and need; CDCR and counties may want to consider expanding prerelease planning to include those with chronic medical and mental health and substance abuse problems in general.
Undertake a comprehensive assessment of the impact of California’s new Public Safety Realignment Plan to inform future policy refinements.	California’s 2011 Public Safety Realignment Plan represents a profound change to the state’s criminal justice system. The legislature may wish to consider allocating funding to undertake a comprehensive assessment of the impact of realignment and require counties to track a standard set of metrics to enable cross-county comparisons and facilitate an assessment of the plan’s overall impact.
What Can Counties and Providers Do to Prepare?	
Develop county-level estimates to inform planning for rehabilitative services and for increased demand for mental health and alcohol and drug treatment.	Given the growing need for mental health and alcohol and drug treatment services, county departments of mental health and alcohol and drug treatment and safety-net providers will need more-informed estimates of the number of individuals that will make up the reentry/criminal justice population at the local level and of their expected demand for services.
Convene all relevant stakeholders for planning and coordination of services.	As counties refine their plans for implementing the Public Safety Realignment Plan and health care reform, they may want to consider broadening the group of stakeholders to include community- and faith-based organizations that have long been involved in serving the reentry/criminal justice population.

Table S.1—Continued

Recommendation	Description
Assess local capacity to meet new demands for health care.	Given the important role of local public health departments and agencies, counties might wish to draw on them in assessing local capacity for care, especially for those communities disproportionately affected by reentry and realignment, and in developing strategies for addressing service gaps for the reentry/criminal justice population.
Develop “welcome home” guidebooks tailored to individual counties, particularly for counties and communities with high rates of return.	Counties can use public safety realignment as a chance to improve and update these guidebooks to include problem-solving strategies—highlighting services that address immediate needs (e.g., housing, transportation, health care) and providing detailed information about local resources, especially about organizations committed to serving this population. They should be written in a culturally competent manner, take into account literacy levels, and be provided in Spanish and other languages as needed.
Train providers on cultural competence.	Counties may want to implement provider training to improve their cultural competence, especially in primary care/public health clinics and in other settings where the primary care and specialty care needs of the reentry/criminal justice population will be addressed. Also, counties could work with community-based and faith-based organizations to ensure this training includes the perspective of the formerly incarcerated.
Consider the role of patient navigators.	Being able to navigate the maze of needed services is critical. Staff who are experienced in working with this population or who have been formerly incarcerated themselves are particularly well suited to fulfill this role. Counties might want to undertake a demonstration project to explore the use of patient navigators, particularly in counties with large reentry populations.
Address the needs of families and those that care for children of incarcerated parents.	Given the importance of families to the successful reintegration of individuals returning from prison and the challenges the families face, there is a need for programs to address the needs of children of incarcerated children, the needs of caregivers (e.g., respite care), and the family reunification process. Also, to inform planning decisions, counties also need better estimates on the number of children with incarcerated parents.

In light of California's new Public Safety Realignment Plan and federal health care reform, California faces both substantial challenges and unprecedented opportunities to address the needs of this population by improving rehabilitative services at the local level and by improving access to health care for the reentry population (and other components of the criminal justice population) through Medicaid and other coverage expansions. Both will require the state and counties to establish new partnerships with the range of stakeholders that serve this population.

Lastly, private philanthropy can also play an important role in helping to address the uncertainty created by this unique confluence of public safety realignment at the state level and health care reform at the federal level. Such a role for California and national foundations includes supporting (1) local demonstration projects and collaboration among relevant stakeholders; (2) Medicaid enrollment strategies; (3) pilot projects to test innovative ideas; (4) efforts to increase the capacity of local communities and organizations to provide reentry services; and (5) ongoing evaluations and research on the impact of realignment and health care reform on the reentry population.