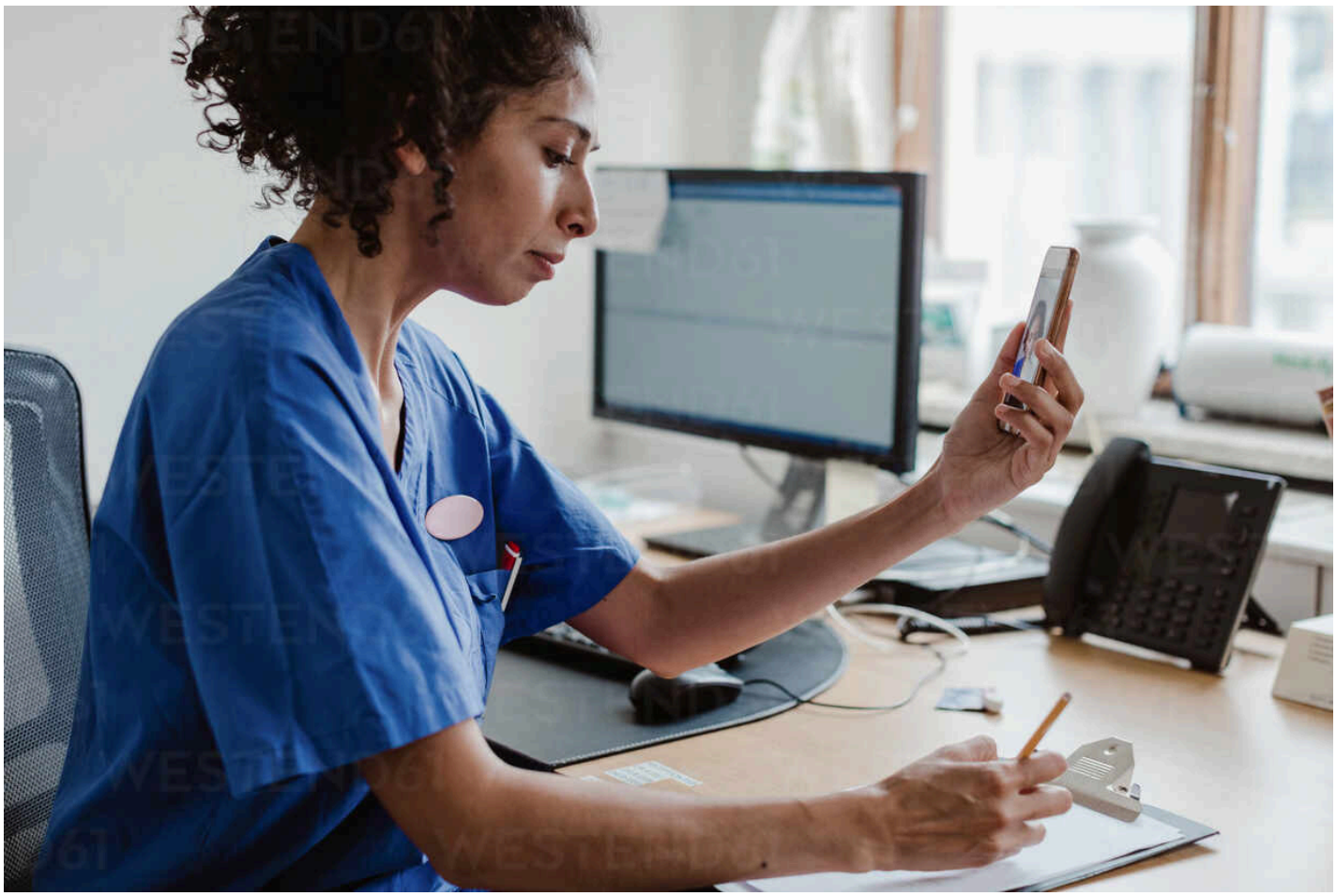
SYSTEMIC BARRIERS TO SUCCESSFUL REENTRY IN TOMPKINS COUNTY: HEALTH CARE

MARCH 2024



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EXECUTIVE SUMMARY

This qualitative research study, commissioned in 2018 by Ultimate Reentry Opportunity (URO) initiative, examines systemic barriers to effective reentry in Tompkins County. After being awarded an Engaged Research grant in the amount of $18,000 from Cornell University to pursue this study, co-principal investigators Jamila Michener, Joe Margulies and Paula Ioanide, obtained IRB approval and trained approximately 40 students at Cornell University and Ithaca College in human subject research with vulnerable populations in Fall 2019-Spring 2020. The study conducted 54 interviews with individuals living in Tompkins County who were 18 years or older and previously involved with the criminal justice system (prison and/or jail).

CHARACTERISTICS OF FORMERLY INCARCERATED PEOPLE INTERVIEWED

Of the total 54 individuals interviewed who were living in Tompkins County and were previously incarcerated in jail and/or prison, some broad characteristics emerged that are worth noting. As not all participants wished to disclose information about the characteristics outlined below, the numbers attached to the characteristics below do not always match the total sample size (n=54).

The gender breakdown of the total sample size was 17 women and 37 men (with 0 participants identifying as gender non-conforming or transgender). Of the 39 participants who self-identified their race/ethnicity, 22 identified as white, 14 as Black/African American, and 3 as Hispanic/Latinx.

CHARACTERISTICS OF FORMERLY INCARCERATED PEOPLE INTERVIEWED

The vast majority of participants (n=41) indicated that they were currently enrolled in a benefit program, such as DSS emergency housing, Medicaid, Section 8 vouchers, SSI, SSD, SNAP. Of the 15 participants who disclosed that they were homeless at the time of the interview, 8 were staying at St. John's Homeless shelter and 7 elsewhere (including the homeless encampment called "the Jungle").

Participants by Gender

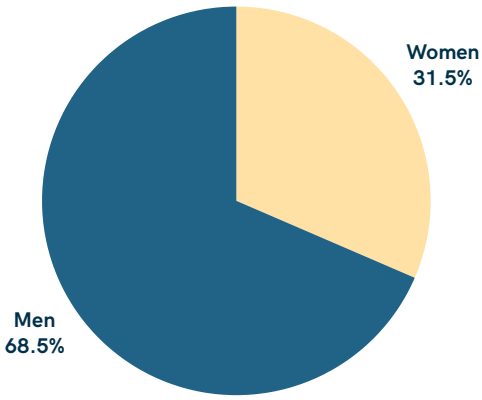

Figure 1: Of the 54 participants, 17 identified as women and 37 identified as men. There were no participants who identified as gender non-conforming or transgender.

Participants by Race

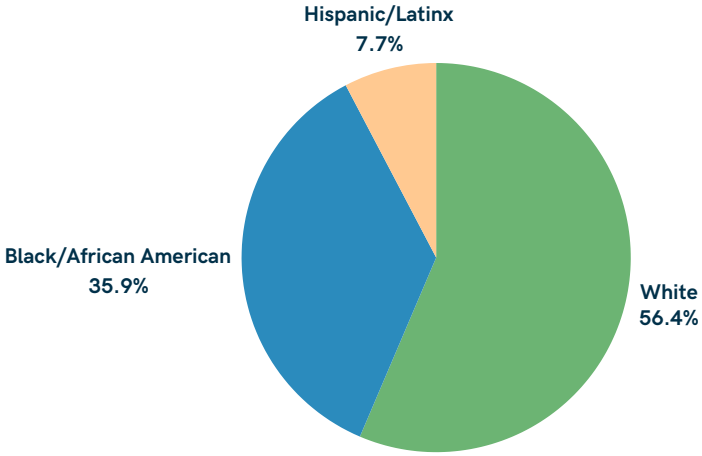

Figure 2: Of the 54 participants, 17 identified as women and 37 identified as men. There were no participants who identified as gender non-conforming or transgender.

Participants by Age

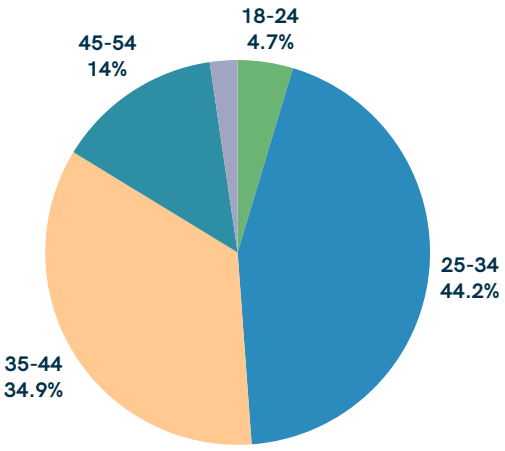

Figure 3: Of the 43 participants, the majority of students were ages 25 - 32, while no participants were ages 55 - 64.

Participants by Education Level

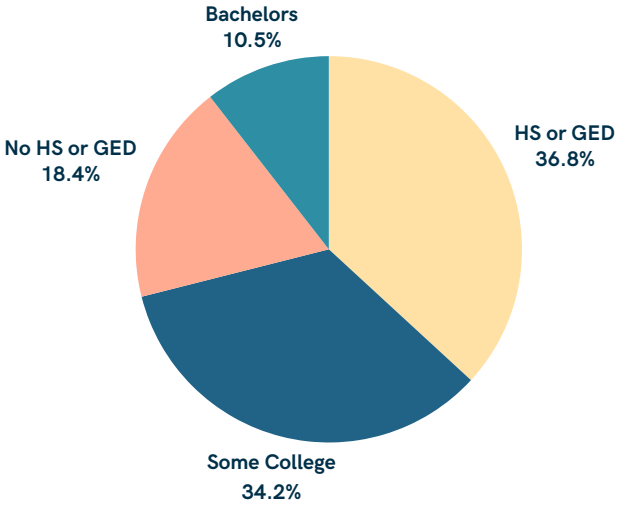

Figure 4: Of the 38 participants, the majority of participants had their high school degree or GED. It was the least common for participants to have their Bachelors degree.

INCARCERATION AS A PUBLIC HEALTH ISSUE

Extensive studies show that incarceration causes adverse health risks and outcomes for people as a result of confinement. In a review of multiple studies on incarceration and health, some of the leading adverse health effects caused by incarceration included an increase in chronic health problems, disproportionate rates of suffering from infectious diseases (e.g., hepatitis, tuberculosis) and stress related illnesses (Massoglia & Pridemore, 2015). The same review indicated that incarcerated people also suffer from radically higher mortality rates, with heart disease, cancer, liver disease, AIDS, and suicide being among the top leading causes (Massoglia & Pridemore, 2015, p. 295). Adverse health outcomes extend to the families and children of incarcerated individuals, including higher rates of obesity, behavioral health problems and increased alcohol and drug use in children of incarcerated parents (Massoglia & Pridemore, 2015, p. 293). Given that Black, Latino/a/x and other people of color are incarcerated at higher rates, these negative health outcomes produce racially and ethnically disproportionate effects in community health outcomes.

Post-release, health risks and negative health outcomes persist for people in reentry. A study of 30,237 people released from Washington State prisons between 1999-2003 found that the mortality rate for these formerly incarcerated people was 3.5 times higher than among other state residents (Binswanger et al., 2007). In the first two weeks post-release, the study found the risk of death among formerly incarcerated people to be 12.7 times higher than other state residents. Key causes included drug overdoses, cardiovascular disease, homicide and suicide. Stunningly, formerly incarcerated people in Washington State were around 129 times as likely to die of an overdose in the first two weeks after their release as other state residents (Binswanger et al., 2007, p. 1). Studies demonstrate that for each additional year in prison, there is a 2-year decline in life expectancy for parolees (Patterson, 2013; Brinkley-Rubinstein, 2013). Furthermore, it is evident that formerly incarcerated people with health conditions have a harder time adjusting to life outside of prison, specifically struggling with housing, employment, social relationships, substance use, and recidivism (Mallik-Kane & Visher, 2008). Formerly incarcerated people with physical health conditions were less likely to have housing ready for them upon release.

They were also more likely to have trouble maintaining housing and moved around more often than other formerly incarcerated persons (Mallik-Kane & Visher, 2008). Exacerbating the issue of adverse health risks and outcomes for people in reentry is the

lack of access to Medicaid coverage immediately upon release, as most cannot afford private health insurance. Medicaid will not pay for any medical care during an individual's incarceration unless they are taken to a hospital for over 24 hours, at which point that hospital visit may be paid by Medicaid if the individual was already enrolled per the Inmate Exclusion Provision of the Affordable Care Act. For those who were enrolled in Medicaid prior to their incarceration, the state of New York suspends coverage eligibility instead of terminating it. Because health insurance coverage is suspended during incarceration and is not immediately reinstated upon release, many people are unable to pay for the medications and other healthcare services that they need, which contributes to a highly increased risk of death in the first two weeks after release. The New York State Department of Health has submitted a proposal for a federal waiver to the US Center for Medicaid and Medicare Services which would enable Medicaid coverage for certain populations up to 30 days prior to their release. Eligibility for this program requires members to (1) be enrolled in Medicaid, and have one or more of the following conditions: (a) two or more qualifying chronic physical/behavioral health conditions, (b) a serious mental illness, (c) HIV/AIDS, or (d) an opioid use disorder. To date, the Medicaid Re-entry Act, which would clear the way for states to use Medicaid to provide coverage for inmates up to 30 days before the inmates' scheduled release, is currently still in political limbo in Congress.

HEALTHCARE LANDSCAPE IN TOMPKINS COUNTY

The health profile of Tompkins County indicates significant racial/ethnic disparities in risks and outcomes. The New York State Health Equity Report (2016 & 2019) for Tompkins County1 showed that Black people in Tompkins County (currently 4.4% of the total population) have significantly higher rates of premature deaths (<75 yrs), low birthweight births, asthma hospitalizations, drug-related hospitalizations, diabetes, and other health indicators compared to white people. Additionally, Tompkins County jail data2 consistently indicates that Black people are incarcerated at significantly higher rates (43% of total jail population in 2020) than whites, suggesting a strong link between incarceration and adverse health outcomes at the county level.

Tompkins County has various county, state, and non-profit organizations that attempt to mitigate the health concerns of people in reentry. Among the participants we interviewed who discussed health care (n=38), the primary health care organizations where participants sought and/or received health care services included: REACH Medical, Southern Tier AIDS Program (STAP), Mental Health Association of Tompkins County

(MHATC), Tompkins County Mental Health, Alcohol & Drug Council (ADC), Cayuga Addiction Recovery Services (CARS), Centers for Treatment Innovation (COTI), and emergency services at Cayuga Medical Center (CMC).

STUDY FINDINGS

A majority of participants in the study indicated that they were receiving some type of public assistance, with the Department of Social Services operating as the main portal for accessing various types of benefits. Common characteristics among our participants included stories of childhood trauma, substance use beginning in teenage years and/or due to prevalence of family substance use, and mental health problems (including stories of negative mental health outcomes as a result of incarceration). Of the 27 participants who disclosed struggling with substance use disorders in the past or present (50% of all participants; 11 women and 16 men), nine were past users and described themselves as sober at the time of interview, 16 were in recovery (e.g., were engaged in medically assisted treatments [MATs] like suboxone and methadone or in outpatient treatment programs), and two were actively using. The most common substances mentioned were alcohol, heroin, and opioids.

HEALTH INSURANCE ACCESS

Sixty eight percent (68%) of participants who discussed health insurance coverage (n=25) noted that they had Medicaid/Fidelis coverage while one participant had insurance coverage through Veterans Affairs. A couple participants (n=2) discussed losing their Medicaid coverage as a result of exceeding income limits and not being able to afford health insurance thereafter because they did not make enough income.

"I think that they could coordinate so that you at least have insurance when you get out of jail."

Other participants (n=3) discussed having their Medicaid suspended while in jail and the frustration of the delay to reactivate their health insurance post-release, indicating the need for the Medicaid Re-Entry Act. As Interviewee 35 noted,

"If you go to jail, they're going to shut off your Medicaid. So, you've got to get your Medicaid turned back on.... I think that they could coordinate so that you at least have insurance when you get out of jail."

Interviewee 43, who was receiving Suboxone treatment echoed similar sentiments about losing their health insurance:

"Yeah. I had a problem my first month [getting health insurance].... I called Albany and

argued with Albany for hours and with that -- I'm on the Suboxone program, too, because I was hooked on opiates. And I can't go without them, I mean, I don't want to relapse and I've been doing good for like four years. I don't want to go back down that road. But yeah. That kind of made me a little nervous when I lost my insurance."

When asked how they obtained Medicaid, several noted Catholic Charities as being helpful with the application process.

PERCEPTIONS OF BIAS: SOCIAL SERVICE AGENTS & HEALTH CARE PROVIDERS

One of the most prevalent themes that emerged among participants was the perception of stigma and bias among social service agents and health care providers toward those with criminal histories, mental health problems, and/or substance use disorders.

Interviewee 4 experienced a sense of helplessness when it came to mental health professionals:

"I don't have very much recourse as a mental health patient. I try to be argumentative towards things that go wrong in my services.... No matter if I'm saying, the earth is round and they're saying the earth is flat... And people make assumptions and stuff and it's a stigma and I'm learning it firsthand. I mean not all of it is a stigma, maybe 75, 80 percent of their services are altruistic and stuff I feel."

Interviewee 14 avoided going to health care professionals because they presumed they would experience bias:

"It's hard to get healthcare when you're using, you don't want to go to the doctor. They judge you so much. If you have a toothache and you say you're in pain and you're actually in pain, they think you just want pain pills. You get judged a lot and it's not fun or fair."

Interviewee 5 wanted to make sure that healthcare professionals did not reduce them to their criminal history.

"I go to ADC [Alcohol & Drug Council] and all these people know I smoke weed but I know how to communicate with them... I'm going to tell them how I feel and if you want to interact with that it'll be a beautiful conversation. Like I said it's that judgment that people have, you can read a rap sheet and then look at me and you're not going to see the same person from that rap sheet, you won't."

There was also a perception that social service agents were biased toward people with criminal and drug addiction pasts by imposing more mandatory requirements. As Interviewee 31 states,

"You get somebody that walk off the streets and they don't want to help them because they're in recovery or they're still using drugs and they want you to do this class, this class, and plus try to do a work program. You know you can't do all that plus try to work on recovery. So, they won't help you."

Interviewee 21 expressed similar sentiments, stating:

"R: They can tell when you've been in jail and they'll treat you different...[I]t's like they single you out...

I: How so?

R: Well, because they don't know what you go to jail for, but they always act like it's the worst thing. And, like, my kid's in jail right now. Say in -- they won't allow no kids and he don't even have no charges on the kids.

Bias from DSS agents was also perceived by Interviewee 56:

R: Like DSS and all them, if you're an addict, they look down on you.

I1: Really? In what type of way?

R: The way they talk to you, how the service is to them, and snappy to you."

Finally, Interviewee 14 expressed frustration with structural and regulatory exclusions for people with criminal backgrounds in obtaining certain kinds of benefits and the way this is entangled with stigmatization and judgment.

"R: So when you walk into somewhere -- Section 8 and you tell them you're there to file an application to get help, you have to tell them your background. They want to know what charges you've got in your past. It stinks because some of them look at you like you're a criminal. You did this, this, and this. Oh. But if you did any -- if you have a drug charge, you can't get Section 8. If you have a gun charge, you can't get Section 8. If you have a violent charge, you cannot get Section 8... So it's like they judge. A lot of them just look at you like you're a bad criminal. You suck. I think the judgment. That was the biggest one."

These excerpts indicate a broad perception of bias and/or stigmatization among study participants by social service agents and/or health care practitioners. Importantly, several participants identified specific individuals at the agencies and organizations they interacted with (DSS, ADC, CARS, REACH, STAP, TCMH) that they found helpful.

"...if you're an addict, they look down on you."

DSS SANCTIONS & MANDATED TREATMENT

In their first screening appointment, the Department of Social Services uses a state form that asks questions about the applicant's drug and alcohol past. Any person who responds to certain questions in the application about substance use, or is known or

believed to be a current substance user, is asked to meet with the Credentialed Alcohol and Substance Abuse Counselor (CASAC) that is employed with DSS. The Counselor performs their screening and determines if the applicant should be referred to treatment. The Counselor does not determine whether an applicant should be in-patient or out-patient. The applicant is then scheduled to do a full intake assessment with either Cayuga Addiction Recovery Services (CARS) or Alcohol & Drug Council (ADC) within a certain period of time. The applicant is informed that they have to follow the treatment recommendations of their provider in order to remain in compliance with DSS. Non-compliance could lead to the applicant becoming ineligible for cash assistance but they can still receive SNAP and Medicaid benefits. Applicants can also have DSS sanctions for many other reasons. For example, a person could be sanctioned at any stage in the application process, including not showing up for the assessment with the Counselor. Once a person has a certain sanction, they have to both remedy the sanction (as in follow-through with whatever treatment plan was recommended by the outside agency) AND wait out the time period, which can range between 30-90 days.

Referrals for treatment from DSS are most commonly made to ADC and CARS. Although REACH Medical, a harm-reduction organization that offers medically assisted treatments as well as general medical services, could theoretically serve as a referral agency for DSS, it does not currently receive referrals in practice. Part of the reason for this may have to do with burdensome processes in DSS's systems and onerous paperwork.

Several participants expressed perceptions of bias from DSS as a result of past addiction and/or frustration with being mandated to undergo treatment programs in order to receive certain benefits. Interviewee 9 stated, "People look at you different. Like DSS looks at you different. They make you do like -- you've got to go to like rehab and do all this other shit that I'll tell you, rehabs don't work. For me personally, no, because it's just a bunch of people glorifying drug stories. It makes you want to do it that much worse." Interviewee 32 similarly discussed frustration with mandated programs. As they were getting prepared for release with the assistance of Marie Boyer, the reentry coordinator at the Tompkins County Jail, they discovered that they had a DSS sanction, which would block their access to a lot of DSS services upon release.

"Marie Boyer, she was coming up and she was talking to me and we were getting every -- she was getting everything set to go -- everything. And then she comes up the Friday I'll go and got supposed to get out Monday, she comes in Friday. Sanction. The sanction. But she said if you get into a program or anything, they might lift the sanction. I went to CARS when I got out, I peed clean in the cup because I was incarcerated and I went back

over there. They said I don't need this, dah, dah, dah, dah.

Well, then sanction is still not lifted. You have to go do this in order to -- I don't get it. Why you trying to make me do a program that I don't have to do because of urine tests from years ago? And it's -- and that's another thing. They -- you pass. That messes up your future. If you have a bad past and your family. Like I said, Ithaca -- I got family out here, my last name's [name redacted]... Everybody looks at me like, oh, well, he's his brother's brother. Oh, he's his sister's brother or he's his mama's child. It's not right. You're judging me off my family. And you don't even know them."

"You're judging me off my family. And you don't even know them."

Interviewee 32 not only expresses frustration with the link between mandated treatment programs like CARS and DSS sanctions but the perception that they were being targeted for sanctions as a result of their family affiliations.

Relatedly, some participants stated that they lost access to certain services once they obtained sobriety, sometimes going far enough to suggest that the system punishes those who reach some level of success. As Interviewee 20 notes,

"And so now I have nothing. I have no home, no income, no food, but before, when I drank, they housed me. They gave me all these things and then it's like -- it's kind of like the repercussions all fell after the fact. They're totally ass backwards.

Like how was that? I was doing everything wrong and they're like, oh, have an apartment and have this and have that. And it was just easygoing and then now it's like, okay, I have none of those things and now everything gets set back."

Interviewee 32 perceived that there was more assistance for people with significant substance use disorders than those who did not face these problems, potentially incentivizing drug use to obtain services.

"You got all these programs for all these people to get them clean, but you don't got no programs to -- to -- to help them when they get out of jail except rehab. That's the main thing is rehab. Even if you're not a drug addict. Oh, well, you -- you pissed dirty for alcohol two years ago, go to rehab. That's the same thing for everything is incarceration or rehab. They don't have no programs to try and help people stay off the streets or better their lives.

And that's -- if they had those programs, they wouldn't be people dropping dead every other day out here overdosing if they had programs like that. Or if people get out of jail and haven't been doing drugs and want to straighten their life out and then you tell them no, you can't give them help, now they going to go do drugs and die. That's what happens to a lot of people."

ABSTINENCE VS. HARM REDUCTION PROGRAMS

Some recovery programs in Tompkins County operate on an abstinence-only model rather than a harm-reduction model. While abstinence-only programs require participants to consistently prove they are drug free or face potential penalization, harm-reduction approaches offer medically assisted detoxing as well as the expectation that relapsing may be part of recovery processes, and must not be penalized or stigmatized. Interviewees consistently expressed more positive feedback about programs focused on harm reduction such as the Southern Tier AIDS Program's (STAP) safe syringe exchange and REACH Medical than those that were abstinence-only. Among the 54 participants in the study, 11 indicated that they had used STAP and/or REACH Medical services. Interviewee 12 stated,

"REACH is very helpful. They just got a lot more...They don't look down on you because you're an addict."

"When I was younger, when I first started being -- when I first started using, the doctors that understood addiction, they're very few and far between. [inaudible] and they're a blessing. They understand better. My doctor kept trying to put me back onto opiates, my regular doctor, and when I went to REACH, they understand and they know that I'm trying to stay away."

Interviewee 56 similarly noted that they don't feel as stigmatized by REACH Medical staff.

"REACH is very helpful. They just got a lot of more -- they understand addicts more. They don't look down on you because you're an addict. They look over that and just help you [inaudible] like you're a normal citizen."

Among participants who discussed substance use (n=18), several (n=7) noted that they had used STAP's syringe exchange program and that they were receiving medically assisted treatments like Suboxone and Methadone. Others noted that they use REACH as their resource for all medical care.

Participants who had engaged mandated and abstinence-based programs like CARS and ADC tended to express negative or mixed sentiments. Interviewee 29 stated, "I don't know, it's kind of a pain in the ass, actually. But you know, it's -- at first they sent me to ADC, they were hard to work with. I came out with CARS they were much easier. Things were going good and they were helping me and things just improved a hundred percent." Interviewee 14 stated,

"So when I went to CARS, I would literally show up for groups. Most of the groups

didn't really do anything. We would sit there and either do -- she would talk a lot or play a video. It was never actually getting into details of what we need and want. There should've been more plans. I don't know. Play a game. Do a Jeopardy game or something to actually get down to some of the stuff. But they just -- they didn't care much of are you homeless? What do you need to not be homeless? They just cared about getting you off the drugs. There was no preventative work.
Interviewee 54 echoed these sentiments, stating, "I was in was CARS and I just don't get anything from that program."

HEALTH CARE IN TOMPKINS COUNTY JAIL

Some interviewees suggested that their early traumatic experiences were exacerbated by the lack of helpful mental healthcare resources during incarceration. For example, Interviewee 23 stated,
"You have to fill out a slip to even see anybody [for mental health treatment in jail]. Sometimes, it takes a while. Sometimes, it doesn't. And when you first go in, no matter if you take your medication in with you or not, you still have to see the doctor before they will allow you to take your own medication. And I think that's pretty dangerous, too, especially if you're on medication that you cannot miss... And there's a lot of people out there that's on psych meds for PTSD, everything. Like, I have everything. I have depression... I have bipolar; I have depression. I have a really bad case of anxiety. I got PTSD. I have a lot of trauma."

Interviewee 23 also expressed experiencing inadequate detoxing assistance at the local jail. Interviewee 23 stated, "I detoxed off heroin in Tompkins County Jail. They did not give me no medication to take. Nothing. They just kept bringing me in containers of Kool-Aid to drink, and that's it." Three other interviewees mentioned similar experiences with detoxing.

In addition to inadequate detoxing support inside the Tompkins County jail, interviewees highlight frustrations surrounding inappropriate requirements and unhelpful programming that occurs post-release. Rehabilitation and support group meetings are often used as leverage for housing in a way that denies individuals their autonomy in structuring their own recovery.

NEED FOR DRUG-FREE AFFORDABLE HOUSING

It is also important to discuss the links between mental health, substance abuse, and affordable housing in the greater Ithaca community. As the URO Housing Report outlines, people in reentry who are battling substance abuse disorders are often

required to remain drug free or face parole or probation violations. However, for low-income or homeless people, housing options are often limited to slumlord apartments operated by Norfe Pirro, the Jungle, or St. John's homeless shelter. Numerous participants noted that all of these places have high levels of drug trade and use. This makes staying sober an incredibly challenging task for those who do not have other affordable housing options. It also puts people on parole at very high risk of violating parole rules and ending up reincarcerated.

METHODS

The Data Development Working Group of the Ultimate Reentry Opportunity (URO) initiative commissioned a qualitative study to assess systemic barriers to successful reentry for formerly incarcerated people in Tompkins County. Co-principal investigators Paula Ioanide, Jamila Michener and Joe Margulies began the qualitative study by obtaining Institutional Review Board (IRB) approval for human subject research through Cornell University. Inviting students at Cornell and Ithaca College to participate in the qualitative study, they trained approximately 20 undergraduate students in human subject research (all students were required to obtain approval via Cornell University) and interviewing methods for vulnerable populations.

Recruitment for participant participation took place by posting flyers in locations frequented by people in reentry: OAR, Day Reporting, DSS, Homeless Shelter. The criteria for participating in the study included: 1) must be residing in Tompkins County, 2) be 18 years or older, and 3) have been previously involved with the criminal justice system (prison and/or jail). The flyer included information that participants would be given $100 Visa gift cards for their time and participation. A phone number operated by co-principal investigator Joe Margulies was listed on the flyer. Students conducted interviews in pairs, with one person asking questions and a second as notetaker. Students met participants in public places like the Tompkins County Public Library or Gimme Coffee.

Participants were given their $100 Visa gift cards prior to beginning the interview. After being read an informed consent statement, each participant was asked to verbally consent to participating in the study. Participants were also asked to verbally consent to being recorded. Interviews were audio recorded on digital voice recording devices owned by Cornell University or Ithaca College. Interview questions were open-ended but focused on asking participants to speak to their experiences post-incarceration in relation to finding a place to live, securing a job, accessing transportation, receiving health care, and negotiating judicial oversights like probation, parole, and drug court.

Once the 54 interviews were completed, the audio files were submitted to a professional service for transcription. Six undergraduate research assistants reviewed all transcribed interviews for identifying information; co-principal investigator Paula Ioanide then redacted any information that could reveal the identity of the participant from all transcribed interviews.

A group of 10 undergraduate assistants, under the supervision of Jamila Michener and Paula Ioanide, used Dedoose software to code the transcribed interviews. Codes and subcodes were developed by identifying key areas and factors that have been identified by research to be important components to successful reentry: housing, employment, transportation, health, education, judicial/court processes, stigmatization, impact of trauma prior, during and post incarceration, and availability of social resources and non-profit based services. After all interviews were coded in Dedoose, interviews and memos were reviewed for descriptor data such as gender, race/ethnicity, age group, veteran status, marital status, homelessness status, parental status, whether participants were receiving public benefits, highest education completed, employment status, self-declared substance use disorder, number of arrests and convictions, date of most recent incarceration, amount of time spent in most recent custody, and time elapsed since last custody. We imputed the descriptor data into Dedoose, allowing us to see trends across qualitative and quantitative dimensions.

Dedoose was used to determine the most frequently discussed barriers to reentry across all interviews. We cross checked the most prominent barriers mentioned with descriptors like race, gender, and age to assess whether certain groups mentioned certain issues disproportionately. By reviewing all interviews that mentioned housing, a group of six undergraduate students under the supervision of co-principal investigator Paula Ioanide were able to determine thematic patterns related to health.

EFFECTIVE HEALTH MODELS FOR PEOPLE IN REENTRY

There is an unprecedented need for better resources that address the concerns of the reentry population. Effective models that address health issues at the national level include programs that provide patient-centered care (PCC). PCC emphasizes the patient's needs, preferences, and values (McNeil et al., 2016). One specific model is the Transitions Clinic located in San Francisco. The clinic partners with doctors at the University of California San Francisco-San Francisco General Hospital and the Southeast Health Center. They provide patient-centered primary health care services and case management to aid the formerly incarcerated in finding housing and employment (Katzen, 2011). Each Transitions Clinic Program employs providers who are culturally-competent, as well as community health workers who have a history of incarceration (Transitions Clinic, n.d.). Their program is funded through the San Francisco Foundation, California Endowment, and Catholic Healthcare West (Katzen, 2011). Each site receives up to $28,000 across the project period (Transitions Clinic, n.d.) The Transitions Clinic program has been replicated successfully in other locations with over 50 clinics in 14 states and Puerto Rico, serving over 7,000 formerly incarcerated people (Transitions Clinic, n.d.).

Other effective models are programs that use a harm-reduction approach. Harm reduction programs aim to reduce substance use and drug-related harm without promoting abstinence as the only intervention (MacMaster, 2004). A popular and effective harm-reduction method is needle exchange. According to MacMaster (2004), "needle exchange attempts to remove the agent through which HIV/AIDS is spread (the shared needle)" (p. 359). Furthermore, this approach has resulted in positive changes for users who are not seeking abstinence, as well as positive changes in substance use behaviors. Studies also show that opioid-assisted treatment is beneficial (McNeil et al., 2016). This method reduces the risk of consuming drugs mixed with other unknown substances that may be especially dangerous when injecting alone or in rushed situations. Overall, harm reduction and patient-centered approaches are extremely beneficial models of care.

A contested issue with respect to substance use concerns the implementation of harm reduction programs versus abstinence-only programs. Abstinence-only models aim to eliminate any substance use. Drug courts, which are alternatives to

incarceration, often use an abstinence-only approach. According to King and Pasquarella (2009), there are two drug court models: deferred prosecution programs and post-adjudication programs. In the first model, defendants who meet certain criteria are sent into the drug court system before pleading to any charges. Failure to complete the program will result in prosecution. In the latter model, defendants are required to plead guilty to any charges but their sentences are deferred or suspended while they complete the drug court program. If they successfully complete the program, this can potentially result in a waived sentence. Regarding treatment, the research surrounding the effectiveness of drug courts yields mixed results. While drug court evaluations demonstrate that participation can reduce recidivism rates, there are many factors such as gender, age, race, socioeconomic status, criminal history, and substance abuse history that are not taken into account during these evaluations that could influence the effectiveness of the program (King & Pasquarella, 2009). Furthermore, drug courts may not be the most effective at helping those who have serious addictions or those who use the hardest drugs. Drug courts describe addiction as a "complex behavioral disorder" and state that the road to recovery will often result in many relapses as participants try to break their pattern of abuse (Fluellen & Trone, 2000; King & Pasquarella, 2009, p. 15). In response to relapses, drug courts will use a combination of treatment and punishment. However, a participant with too many relapses may be expelled from the program and subject to prosecution.

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