

# COVID-19

## Homeless System Response: Justice Partnerships and Reentry Solutions

In response to the COVID-19 pandemic, many jails and prisons have reduced occupancy to stop the spread of disease in their facilities, which have had high rates of infection in many places. People released from institutions may be at risk of housing instability or homelessness and need housing where they can safely quarantine. This resource will help Emergency Solutions Grants (ESG) recipients and Continuum of Care (CoC) leaders proactively engage key justice system partners and define specific roles and actions needed to ensure a seamless and safe connection between reentry and rehousing.

### Essential Stakeholders in the Release Process

In partnership with local justice systems, ESG recipients can collaboratively mitigate the spread of COVID-19, prevent justice system-involved individuals from exiting into homelessness, and protect those at risk of homelessness who may also be at [risk of dangerous COVID-19 complications](#). Justice system stakeholders plan and coordinate the release of detained persons. When the homeless services system improves real-time coordination with these stakeholders, it can improve outcomes for people upon reentry, preventing delays and barriers to those individuals obtaining necessary services and protections. Key justice system stakeholders include the following:

**Jail and prison leadership, program service managers, and discharge planners**—Engaging leadership will facilitate coordination of COVID-19-related reentry services for people with early releases who are at risk of homelessness as well as people who have a positive COVID-19 test result (COVID+) or COVID-like symptoms. Leaders can connect homeless services system leaders to discharge planners who may be best positioned to identify those inmates scheduled for release who are at high risk of homelessness and health-related crises. These discharge planners can then help ensure that inmates connect to COVID-19-response and/or homeless system services and sites immediately upon release.

**Jail and prison primary care and mental health providers**—Jails and prisons provide either in-house or contracted primary and mental health care on site. In either case, on-site health care providers can help coordinate referrals to isolation and quarantine and other specialized resources for people who are COVID+, have COVID-19-like symptoms, or require protective isolation because of age or underlying health conditions. These providers can coordinate with community health centers, community behavioral health agencies, and other health care partners willing to provide follow-up care, regardless of their COVID-19-related needs. Inmates are often released with only a few days' worth of medication, often because on-site providers cannot verify that they will have ready access to follow-up health care; connecting those responsible for care "on the inside" to health care providers can ensure timely follow-up.

### Connections to Housing through Coordinated Entry

When coordinated entry (CE) managers work in partnership with jail and prison leadership and discharge planners, they help ensure appropriate referrals to CE from jail and prison staff. Close collaboration allows justice system staff to learn more about available and appropriate homeless system options and processes to inform their housing discharge plans. This collaboration can also protect this marginalized and stigmatized population from the compounding threats of COVID-19 and housing instability.

Address the following considerations in your CE policies and procedures to accommodate the needs of people reentering from the justice system:

#### **Access:**

- The incarcerated population [tends to have high rates of substance use and mental health challenges](#). Partnering with appropriate providers will enable your outreach to participants and their ability to access the system.
- It is critical to embed a [prevention and diversion](#) approach in partnership with jails and prisons. Use local prevention resources and a [housing problem-solving approach](#) to ensure most people exiting these institutions do not touch the homeless system at all.

#### **Assessment and Prioritization:**

- Assessments should consider the eligibility implications of an individual's length of time in an institution. For instance, an individual or head of household cannot be considered chronically homeless if they are exiting an institution where they resided for 90 days or longer—even if they meet all of the criteria of the definition of chronically homeless prior to entering the institution because that entire period residing in the institution is considered a break. This means the individual or head of household would not be considered chronically homeless immediately upon discharge. These households may fall under a different U.S. Department of Housing and Urban Development (HUD) category of homelessness that may not be prioritized or eligible for CoC permanent supportive housing (PSH) or rapid rehousing (RRH) programs and may be better served with ESG resources.
- If your community is making COVID-19-driven [changes to your CE prioritization process](#), consider and assess for barriers faced by people exiting carceral systems. Identify [Homeless Management Information System \(HMIS\) setup and data-sharing](#) opportunities to inform your planning and evaluation, develop and leverage key partnerships to begin assessing individuals' housing needs and vulnerabilities prior to release, and target high-acuity individuals with pre-release enrollment for resources from multiple providers including housing, healthcare, and behavioral health.

#### **Match and Referral:**

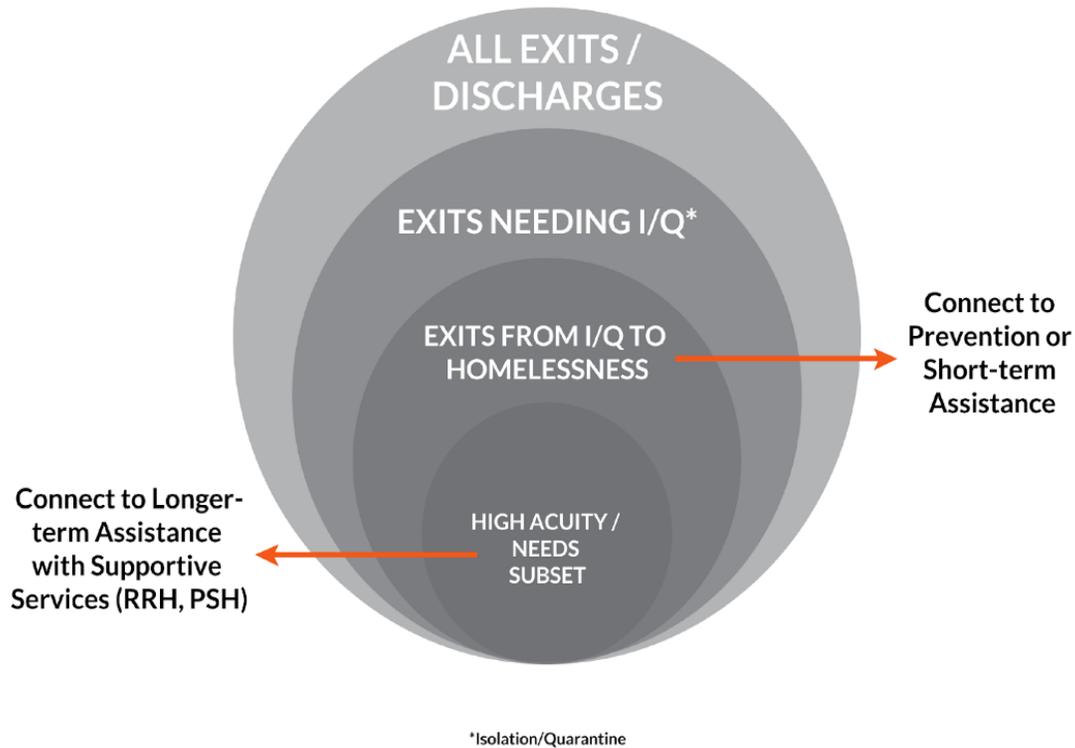
- When matching for housing placement, identify participants and offer connections with agencies experienced with carceral systems and barriers faced by this population, such as obstacles to obtaining employment and lack of income.
- Consider the individual's conditions of release or parole to determine whether they are restricted from living in specific locations. Consulting the local housing authority's administration plan restrictions around criminal histories for issuing tenant-based rent assistance will help refine a match. In some cases, project- or sponsor-based options might work better.

## **Pre-Release Assessment for Referral to Appropriate Resources**

ESG and CE leadership should help determine strategies for referrals from the justice system to specialized resources for people who are COVID+, have COVID-19-like symptoms, or require protective isolation because of age or underlying health conditions. They will require both short-term and long-term strategies for effectively connecting inmates upon release to alternative care sites (ACS) providing isolation or quarantine, protective non-congregate shelter (NCS), and other resources developed by communities as part of their homeless COVID-19 response. These strategies should address the rehousing needs of the subset of jail and prison inmates who will need longer-term supportive services such as PSH or RRH. Homeless system leaders will need to collaborate with discharge planners, probation and parole officers, and other justice system partners to develop effective ways of receiving and processing information about physical and behavioral health diagnoses and the severity of needs related to these diagnoses.

The figure below provides a framework for determining the needs for assistance for people exiting the justice system.

## Justice System Exits During COVID



Examples of strategic frameworks for addressing the needs displayed in the diagram include the following:

### **COVID+ Diagnosis or COVID-19-like Symptoms:**

Individuals without a fixed residence who are released with COVID+ diagnoses or COVID-19-like symptoms should be immediately connected to the COVID-19 isolation or quarantine (I/Q) sites in your community. You will likely need to provide a formal referral and transportation, depending on the I/Q operator's specific intake protocols. Plan to provide people in this subgroup with services that include [connections to benefits](#) (e.g., Medicaid, food stamps) and planning for both post-quarantine housing and any immediate safety needs.

### **High Acuity or Vulnerability with No COVID-19 Diagnosis or Symptoms:**

This subgroup has high rates of behavioral, mental, and physical health issues that put them at risk of dangerous complications if they contract COVID-19. If possible, [coordinate a release directly to PSH](#) to reduce the impact and trauma of homelessness on people with extensive involvement in the justice system with co-occurring mental and behavioral health disorders. Because direct connection to PSH is often not possible, this subgroup requires a clear and effective pathway to protective NCS sites established in your community. You will likely need to provide a formal referral and transportation, depending on the NCS operator's specific intake protocols. In addition to immediate and short-term assistance with accessing benefits (e.g., Medicaid, food stamps) and planning for immediate safety needs, you may also need to directly connect people in this group to the locally established rehousing process. Many in this group may need to exit NCS sites into PSH and other permanent housing, and they may require longer-term connections to supportive services to prevent further episodes of homelessness.

### **Low Acuity or Vulnerability with No COVID-19 Diagnosis or Symptoms:**

This group's needs for care and assistance tend to differ substantially from the two groups above. To mitigate the high risk of long-term homelessness and trauma associated with homelessness, connect people in this group

directly to permanent housing or a shelter that follows social distancing protocols and has appropriate support services. Such connections will both help individuals remain safe during the pandemic and reduce barriers to accessing benefits and services provided by prevention and RRH programs. It will be critical to create specific interventions that address the [disparate impact on people of color by the justice system](#).

## Managing Roles within Justice System Partnerships

Articulating clear roles and responsibilities will help distribute the work and reduce duplication of effort. Below are actions by each partner to protect people being released during the COVID-19 pandemic.

### ***Jail Leadership, Program Services Managers, and Discharge Planners:***

- Isolate inmates whose age or underlying chronic health conditions make them more vulnerable to poor COVID-19 outcomes and ensure all inmates receive individualized release planning.
- Use a [standardized checklist](#) to identify needs.
- Ensure access to birth certificates and photo IDs.
- Coordinate release with probation or parole as appropriate.
- Coordinate access to benefits as appropriate.
- Partner with homeless system partners to ensure access to homeless system resources when needed.
- Determine short- and long-term housing release plans including non-congregate isolation, quarantine or protective shelter, [reunification](#), shelter, or other options.

### ***Jail and Prison Primary Care and Mental Health Care Staff or Contractors:***

- Identify specific medical, mental health, and substance use treatment needs to make appropriate referrals.
- Provide written discharge summaries of current and ongoing medication and medical needs.
- If possible, before release or immediately after, enroll or connect patients to community health centers, community mental health agencies, and substance use treatment providers, including opioid use disorder (OUD) providers who can educate individuals on the importance and use of naloxone, provide doses on release, and connect individuals with opioid treatment providers for appointments on release.
- Once a connection has been made to a community health care agency, provide a minimum 30-day paid prescription for medications and schedule an appointment with the provider.
- Create protocols for identifying anyone who is COVID+, symptomatic, or exposed to COVID+ staff or individuals on the unit and providing them with an individualized discharge plan as well as referrals to COVID-19-specific resources such as ACS and protective NCS sites. Use the [Denver Sheriff's Office's example of protocols](#).
- Test inmates for COVID-19 or facilitate access to local testing as available prior to release.

### ***ESG Recipient Leadership:***

- Convene meetings with jail and prison leaders and leaders of the agencies that establish ACS and NCS policies and procedures (e.g., public health departments, Health Care for the Homeless agencies, shelter operators, and housing agencies) to establish protocols for referring people who, upon release, will need services and shelter at isolation or quarantine ACS and protective NCS. This could mean formal agreements across these agencies for how people will be referred. [Alameda County, CA provides an example](#).
- Collaborate with CoC leadership to minimize stigma and stereotypes about people exiting carceral systems that negatively impact entry into community-based programs (including homeless services) and could compromise entry into ACS and NCS.
- Ensure ACS and NCS facilities have sufficient [behavioral health](#), [case management](#), and [milieu management](#) capacity to meet the needs of high-acuity people, including those being released from jail and prison.

### Coordinated Entry Leadership:

- Reach out to jail and prison leadership and program services managers to connect discharge planners with the CE process and to ensure that inmates can access CE prior to release.
- Include discharge planners as key stakeholders in evaluating and making revisions to CE policies and procedures.
- Grant jail and prison release planners access to HMIS and train them to administer local assessment tools to complete a pre-release vulnerability assessment.
- Use this as an opportunity to educate partners on [housing problem-solving techniques](#).

### Additional Cross-System Partners:

In addition to the release process stakeholders listed above, reach out to others within the criminal justice system who can partner and collaborate to improve both health and housing outcomes for people reentering communities from jails and prisons. The chart below provides a list of potential partners along with key functions of each.

Partner	Key Functions
Community agencies providing diversion and jail- and prison-based services such as Veterans Justice Outreach, clergy, inmate programming, etc.	Many of these agencies may have resources that people exiting jail or prison can access. Assign each a key role in the discharge planning process. For example: <ul style="list-style-type: none"><li>• Veterans Justice Outreach can help to navigate resources both within and outside of Veterans Affairs-funded programs, including prevention—SSVF, and housing—GPD or HUD-VASH.</li><li>• Clergy may operate groups both inside and outside facilities (e.g., recovery groups) that provide a sense of continuity for released people.</li></ul>
Health centers, Health Care for the Homeless	Establish processes to ensure clients can continue to access medications and make primary care appointments soon after release.
Probation and parole	Releases will be supervised by probation and those exiting state prisons will be supervised by parole while in the community. San Francisco’s community supervision agency <a href="#">invested in housing to keep probationers safe</a> . Identify potential providers and resources within your community.
Key court leadership	Key court leadership, including specialty court judges (e.g., veterans or domestic violence court), can help advocate for individuals, particularly for those who may be arrested on a technical violation or minor offense.
Human services and public benefit agencies	People exiting correctional institutions rarely have health insurance (Medicaid, if available for low-income singles in a state, automatically switches off if a person is incarcerated). They may need to access food stamps and other benefits.  Those with significant health and behavioral health conditions should be connected to federal SSI/DI benefits. If your community has a SOAR initiative or agency, they can assist with applications.

Partner	Key Functions
Diversion and service linkage program models: <ul style="list-style-type: none"> <li>• <a href="#">Law Enforcement Assisted Diversion (LEAD)</a></li> <li>• <a href="#">Police Assisted Addiction and Recovery Initiative (PAARI)</a></li> <li>• <a href="#">Misdemeanor Diversion</a></li> </ul>	These diversion program models provide access to substance use and mental health treatment and generally reduce repeat offending.
High-utilizer initiatives	These efforts typically have cross-sector participation from specialized homeless, mental health, substance use disorder, and hospital frequent-user teams aimed at stabilizing individuals through housing and other supports.
Peer support and recovery agencies and networks	Peer support is a well-established evidence-based practice for maintaining sobriety and is particularly effective for those with justice system histories.
Managed care organizations	Managed care, particularly for those former inmates who have been connected with Medicaid, can be a resource for providing services and accessing housing and health care.