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How Community Health Workers Support RICMS Clients with Reentry

Los Angeles (LA) County has the largest jail system in the United States.¹ Over the past decade, the county's average daily inmate population has hovered between 15,000 and 18,700 individuals.² As an alternative to incarceration, LA County launched several reentry programs that were intended to improve the well-being of justice-involved populations and to reduce recidivism. One of these programs, the Reentry Intensive Case Management Services (RICMS) program, was established in 2018. The RICMS program coordinates the services of multiple community-based service providers throughout LA County. It links people who have been involved with the criminal legal system to community health workers, many of whom have personal experience with incarceration, substance use disorders and addiction, and other issues RICMS clients face. These community health workers provide case management services and mentorship, and help clients navigate the many services and other forms of support available to them.

MDRC evaluated the implementation of the RICMS program in LA County and found that the program offers a promising approach to improving the lives of its clients, particularly by reducing their future contact with the criminal legal system. During the first two years of RICMS clients' interaction with the program, they experienced fewer convictions, arrests, and incarcerations than a comparison group that enrolled in RICMS but did not participate in the program. They also experienced fewer days in jail, both one and two years after program enrollment.³

As part of the evaluation of the RICMS program, in 2021 and 2022 an MDRC research team conducted semistructured interviews with RICMS community health workers, program managers, and clients to learn more about how services are delivered and about the experiences of RICMS clients.⁴ This brief presents the stories and experiences shared by the 26 RICMS clients and 27 community health workers that the team interviewed.⁵ While the sample of interviewees was not intended to be representative of all RICMS clients and staff members in LA County, it represents a range of geographic service areas, referral sources, and types of services offered. Interviews with clients lasted approximately 30 minutes, and interviews with community health workers lasted approximately 1 hour. Interviews primarily took place in person at an RICMS provider's office or another location that was convenient to the interviewee.

This brief provides valuable insight into how programs such as RICMS may affect the lives of people navigating an often complicated reentry process by combining what RICMS clients said about their incarceration, reentry, and involvement with the program with information from community health workers and program managers. Strong and meaningful relationships between community health workers and clients were critical to the RICMS model.

ABOUT RICMS CLIENTS

A common phrase used by community health workers—“We have to meet them where they’re at”—captures their general approach to working with clients.⁶ This section seeks to convey where clients “are at,” or what their personal circumstances were in the context of reentry.

The RICMS clients who were interviewed came from various walks of life and had a diverse set of experiences with the criminal legal system. For example, some had experienced long-term incarceration in prison, though a majority of clients had cycled in and out of jail. Beyond their experience with the criminal legal system, clients came from diverse backgrounds and their family ties, work experiences, and personal health and well-being differed.

Some interviewees were parents. One woman had recently been reunified with her children at the time of her interview, and another was in the process of being reunified with hers. Most clients described having frayed relationships with their families, while a small number said that they didn’t have any family at all.

A few clients had owned businesses before their incarceration, while others had never had opportunities to engage in formal employment. Of those who shared details related to their economic situations, most reported that they had work histories but had also lived in poverty and had little in the way of generational wealth or capital.

Many clients contended with long-lasting mental and physical health problems that accompanied them before, during, and after their incarceration. Others spoke in depth about grappling with the intense life changes that had resulted from having a criminal record.

CHALLENGES CLIENTS FACED AS THEY NAVIGATED REENTRY

The clients who were interviewed described working hard to make meaning of their experiences and circumstances, often with the support of community health workers. The stories that clients shared with the research team shed light on the challenges and struggles associated with reentry in LA County; their stories may reflect some of the experiences of the nearly 700,000 Americans who are released from prison each year, and the 9 million who cycle through local jails annually.⁷

Difficulty Navigating Resources

In the face of the challenges that many wrestle with shortly after release, some clients noted that just being given access or referrals to additional support may not be enough. One client, Victor,⁸ said,

I mean, there’s people in place that do that [reentry support]. And what they do is they set you up with [General Relief],⁹ a housing program they recommend, and a case worker. I’m thankful for that, but it’s like giving a kid a full [tank of] gas, and a car, and the keys. He doesn’t know how to drive.

Victor understood that services exist to help people reintegrate into their communities. Yet many people face barriers that make it harder for them to take full advantage of those services, such as needing to prioritize housing and employment. The existence of resources (like keys to a car with a full tank of gas) may not be enough since people may not know how to find or use them without programs like RICMS that provide individualized, consistent guidance. Additionally, some clients said they felt overwhelmed and frustrated when they tried to navigate services on their own after being released.

Another client, Andy—who was in prison but expected to be released on parole—said,

They don't tell us anything specific because nobody knows where the board's gonna send us for parole. What city they gonna send us. What county they gonna send us. So when we get to those cities or those counties, then we find out what kind of programs are available to us within those areas.

Andy did not know where he would live after being released. Concern over housing took more of his attention than questions about where he might find other necessary but less urgent resources. Access to comprehensive services may make it easier for people to reenter society after leaving jail or prison, but clients expressed a need for help navigating the service landscape.

Social Stigmas

The RICMS clients who were interviewed described being stigmatized because of their former incarceration status, race, gender, or age. These stigmas appeared in multiple contexts, such as in the labor and housing markets. Clients who were older, for example, felt nervous and downtrodden about the prospect of seeking formal employment after not having worked in decades. One client, Zoe, explained the stigma she felt and saw affecting other Black women in situations similar to hers:

You've got women out there that are in serious crisis. . . . Black women in crisis [are] being criminalized. Like, we're not looked at as, like, damsels in distress. You don't have anywhere to go.

Frayed Social Networks

Social networks are a valuable resource, regardless of a person's circumstances. Some clients who were interviewed had strong social ties with friends and family, whom they described as helping them meet their needs following their release. For example, Michael, an RICMS client, spoke about the strengths of his social network; his family and friends supported him financially and emotionally through his long-term incarceration. After his release, he was able to draw on that network, and he bought his own car quickly and cheaply from a relative. The ability to quickly acquire a means of transportation smoothed his road to stable and gainful employment. As a result, the bulk of his reentry work with his community health worker revolved around acquiring new and updated forms of identification.

The relationships clients had with community health workers, parole officers, and others motivated them to seek supportive services. For example, one client, Leslie, who had multiple stints in rehab, said that because she had come under the supervision of a parole officer who was particularly understanding of her struggles, she was more open to her parole officer's advice to seek out RICMS services. Her love for her four-month-old child and guidance from her parole officer and from a close friend enabled Leslie to view her situation optimistically and motivated her to engage enthusiastically with the RICMS program.

However, many of the RICMS clients did not describe having positive, healthy relationships with their families or friends at the time of the interview. Another client, Isabel, talked about having a lack of support while incarcerated: "I experienced abandonment. I got abandoned when I went in there. Nobody wrote me or nothing." And some clients had never had a strong social network—one client, named Nelson, said, "I grew up by myself, and I never had nobody, you know, care for me. . . . And I never asked for help from nobody."

The Disruption of Routine

Many RICMS clients said that their life trajectories had been abruptly and intensely disrupted by their imprisonment and subsequent release. The interview sample included clients who had spent anywhere from three months in jail to 40 years in prison. Clients who had spent a significant amount of time incarcerated agreed with one interviewee's description of release as "terrifying." One client was not able to sleep the entire week before being released—this anxiety was amplified by the fact that the client did not have a place to live. Clients who are incarcerated for shorter periods also face uncertain conditions and must repair relationships and recover resources (such as employment or housing) they may have lost as a result of being incarcerated. The thought of picking up where they had left off was often daunting. Victor explained:

I got released [on] New Year's. And the feeling is very unsettling. Depending on how long you have been incarcerated, you get comfortable. It's not comforting, but . . . you get used to your circumstances. So when you're used to something and you gotta do something that's new, or out of your routine, it becomes a challenge. Even if you were a chef before, you made grilled cheese, 20,000 of them a day, but you've been making peanut butter and jelly for the past three years—or six months, or 30 days, or whatever the time was—it's a task for you to make that grilled cheese even though you used to make 20,000 of them. . . . I think that is the most unsettling part about the reentry back into society, is getting back on the horse, so to speak.

For Victor, release was unsettling because of the dramatic change in his daily routine. While he also expressed excitement about his release, Victor emphasized that he became accustomed to the day-to-day routines of being incarcerated and the sense of stability those routines created. Another client, Cynthia, said that when she got out of jail she was homeless and in desperate need of support to secure a stable place to live and address her difficulties with drugs. Clients described feeling mentally and physically exhausted about not knowing when they would be released from prison or jail—and about knowing that whenever they were released, they would need to tap into whatever (sometimes limited) resources they had to smooth their reentry.

Another example is Hector, who recalled sitting in a LA County jail for a year, awaiting his prison transfer. He expected to serve a three-year prison sentence, but an officer abruptly entered his jail cell to ask him to sign several documents that would grant his immediate release. His first thought was “You’re just releasing me?” In a moment of shock, he wondered aloud, “What is next for me?” He had already prepared himself mentally to serve a three-year prison sentence, and now he was faced with the prospect of returning to the world with few healthy relationships and a substance use disorder. Reentry was not something he was prepared for in that moment.

On a broad level, finding oneself suddenly outside the discipline and rhythms of a jail or prison meant that reentry was also about finding and adjusting to new rhythms and obligations, including the demands of employment (and commutes to and from work), check-ins with case workers and probation or parole officers, and establishing or reestablishing meaningful and lasting relationships with loved ones. The time between release from jail or prison and the moment of feeling reintegrated with life on the outside was where most of the RICMS clients “were at” when they spoke with the research team. It’s also when community health workers most often began their work with their clients. As demonstrated later in this brief, RICMS community health workers were able to detect the anxiety and uncertainty most clients felt when trying to acclimate to new routines and obligations after release.

Mental and Physical Health and Substance Use

Many clients described experiencing challenges associated with their physical and mental health. Clients who had experienced long-term prison sentences often thought about aging. Some clients had chronic health issues that they struggled to address on their own because they could not afford to pay for medical care.

Substance use disorders were also an issue for some clients. The lack of accessible and affordable housing in LA County meant some clients were at risk of seeking shelter with people who might directly facilitate a relapse, or in places where stress could lead them to relapse. The conditions of parole for some clients included mandatory classes, drug treatment, and drug screenings. These conditions necessitated ongoing surveillance by members of the criminal legal system, particularly parole officers, and clients risked penalization if they relapsed. Additionally, adherence to these conditions often imposed financial burdens. One client, James, reflected on how he had to pay out of pocket for certain classes that were a condition of his parole:

I was addicted to methamphetamine since the age of 14. I was turning 40, and I was still addicted. And I was an alcoholic, and I was smoking marijuana. And I started to shoot up, too.

Domestic violence classes were [assigned] to me by the probation officer. And I started doing them on my own, and I started paying out of my pocket. It would cost me \$25 a class, and I would start to do the 52 classes. . . . The very first time, I think I might have paid up to 22 [classes], and then I got arrested and all that went down the drain. The second time, I went up to 37 [classes], I got arrested and all that money went down the drain, and I had to start all over again.

THE COMMUNITY HEALTH WORKER AND CLIENT CONNECTION

This section examines how community health workers used their personal experiences to connect with clients, how they helped their clients access and engage with resources that they needed, and how clients perceived and understood their relationships with RICMS community health workers.

RICMS community health workers tended to live in the same communities as clients, which they claimed helped them empathize with, understand, and support their clients. The RICMS program trained them to provide unconditional, nonjudgmental, individually tailored care to clients, an approach that they took seriously and stressed the importance of during interviews. Nearly all community health workers described their underlying philosophy and approach to delivering care and developing strong relationships with clients as “meeting them where they’re at.” One community health worker discussed using a holistic approach—that is, an approach that considers all the needs, strengths, and challenges that clients may face, as opposed to focusing solely on a particular task or obligation they need to complete:

Our reentry community members are reintegrating [into] society, and they come with very minimal tools, and sometimes no tools. . . . By providing [a] holistic approach, we’re gonna meet them where they’re at and at the same time we’re gonna hold them accountable.

Community health workers’ lived experiences with incarceration, release, and struggles with substance use disorders helped them to recognize the challenges and strengths of their clients and adapted the way they delivered services to meet those clients’ needs. This approach helped them to work with clients as *peers* (or as many clients described, as something adjacent to family) instead of as authority figures; one client, Jefferson said, of his community health worker, “Honestly, he feels like a very helpful uncle. Like, almost familial, in the sense that he’s so dedicated to the care element of where you’re going and how you’re getting there.” Clients described their community health workers as people who stepped in and filled a void for them left by a lack of strong social ties to friends or family. According to one client, Christian, the community health worker “helped me all the way around, where it’s just like, damn, like, she did a lot more for me than my own family did for my child.” A different client, AJ, said, “And that’s why I told her . . . ‘You guys have done more than my family’ . . . it’s something I’m never going to forget.” Aaliyah, another client, echoed these sentiments: “For somebody like me, this is one of the only connections I have, without having family out here and things of that nature.”

This approach was praised by RICMS clients; they described a clear distinction between how they perceived their relationships with their community health workers and how they perceived past experiences with non-RICMS case workers or others they had worked with. One client, Marcus, explained:

[The community health worker] listens to you and doesn’t judge where you’re coming from either, because it’s really hard to feel like you’re valid in a state of being displaced or whatever. And still feel supported. . . . Like [the community health worker] is letting you know, “Here’s a couple of different ways to make these moves.” It’s not just like, “Where is this? Well, why

don't you have it?" Well, now you look dumb in front of an official, like, that's not how he makes you feel, you know? That's cool.

Many clients described, in experiences they had outside of the RICMS program, feeling unseen or unheard or like they were being pointed in directions that led to dead ends. Zoe, the client who discussed feeling stigmatized in a previous section of this brief, compared her participation in the RICMS program with her past experiences with other programs:

I feel that [my community health worker] went the extra mile, but without being a [burden] to me. And I have been through, like, case management, I had [non-RICMS] case managers who basically seemed to just wait me out and weren't really gonna do anything. I've written about that. I've written emails to Patients' Rights, and I'm trying to bring awareness of that because it was just so wrong.

In contrast, clients felt that their community health workers took them seriously, held them accountable, and offered persistent and unconditional support—which appeared to make clients more enthusiastic about the RICMS program and, in turn, helped them reach their goals. Generally, clients said that the strong bonds that they developed with their community health workers were very important to them and that those bonds fostered their enthusiasm for—and active participation in—the RICMS program. Community health workers facilitated access to resources such as training and employment services, housing services, or forms of public assistance. They also offered RICMS clients a subtle, yet equally important, sense of belonging and care, which clients credited as a reason for reaching some of their goals.

As described earlier, clients faced a great deal of uncertainty associated with their release. Community health workers were sensitive to the difficulties of this transition, given their own experiences with incarceration and their experiences working with previous clients who had grappled with similar challenges. One technique that helped clients make use of the resources available to them was for community health workers to accompany them, both literally and emotionally, as they navigated local service environments. One community health worker explained:

It's about helping . . . prevent [the client from] going to jail . . . going to prison. If [you] need us to go to Probation, you know, we'll go with you. If you need to go to Parole, we'll walk with you, you know, we'll get it done together. Or you need to go to the General Relief office, then we'll go to the General Relief office. . . . We're there, you know, for them.

Another community health worker noted that sometimes, taking the first step for a client could be a useful way to get that person to use a service:

In the past, I've had experiences where I give my client an organization name, and I'm like, "Look, here's the number, here's the name of the organization. Call them and this is where you can get domestic violence classes, or this is where you can get this [service]." And sometimes, they don't follow through, even though they need it. So I kind of just take the next step. "Okay, let me call. Let me get you on this list to get into these classes. Now, it's just up to you to show up."

Many of the community health workers who were interviewed described helping clients take these first steps. For example, some community health workers set up medical appointments for clients, rather than just referring them to medical providers with the expectation that they would make their own appointments. Community health workers also helped clients make appointments related to other resources or obligations, and, in some cases, physically took them to appointments.

Community health workers' initiative in taking these steps had multiple effects. It helped to strengthen their relationships with clients. A practical impact was helping clients *use* resources instead of just *referring* them to resources. Also, clients did not have to feel they were letting their community health workers down if they failed to take the first steps themselves. In interviews, community health workers noted that it helped maintain clients' engagement with the program if they could minimize the number of times clients felt that they were letting others down or felt hard on themselves.

CONSIDERATIONS

MDRC's evaluation of the RICMS program has shown it to be a promising program for its clients, especially in reducing future contact with the criminal legal system. Interviews with program managers, community health workers, and clients revealed that a major strength of the program was the nature of the relationships that were formed between community health workers and RICMS clients. These relationships were carefully cultivated by community health workers to provide clients a critical form of social support. Clients characterized these relationships as ones where they received unconditional support, genuine care, and active and holistic engagement with their individual needs. Community health workers' lived experiences also helped differentiate them from other authority figures or administrators, and made clients see them as legitimate and relatable peers.

Clients' stories also suggested that the RICMS program was especially helpful for those who, for various reasons, lacked strong social ties or networks that could help them gain access to important resources. For most of the clients who were interviewed, their community health workers filled a critical gap in their social networks that connected them to a larger service delivery network. Because of the community health workers' emphasis on "meeting them where they're at," clients described feeling less alone and overwhelmed by the many demands they had to meet and by navigating the complex patchwork of services in LA County.

NOTES AND REFERENCES

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- 3 Michelle S. Manno, Annie Bickerton, Bret Barden, Niko Leiva, and Megan Schwartz, *A Promising Approach to Coordinated Community-Based Reentry Services* (New York: MDRC, 2023).
- 4 For more details on the implementation study's data sources and methods, see Manno et al. (2023).
- 5 This brief focuses on interview findings from RICMS clients and community health workers. For the perspectives and insights of RICMS program managers, see Manno et al. (2023).
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- 8 All names have been changed to protect the identity of the clients who were interviewed.
- 9 General Relief is an LA County–funded program that provides monetary assistance to adults who do not have any income or resources, and to children (in certain circumstances) who are ineligible for federal or state programs.

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