We Must Do Better: Addressing High Mortality After Release from Incarceration

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People who are incarcerated have high rates of mental illness, substance use disorder, suicide attempts, and chronic medical conditions. Mortality rates are also significantly elevated following release. Additional work needs to be done to understand the risk factors for increased morbidity and mortality of people impacted by incarceration to better inform future interventions and system changes.

Introduction

People who are incarcerated have a heavy burden of health problems and following release have rates of mortality exceeding those of the general population. We briefly examine these disparities, describe our ongoing work to address them, and consider challenges that remain. In doing so, we start by considering health care in jails and prisons.

Although media often use the terms "jail" and "prison" synonymously, they serve predominantly different, although sometimes overlapping, functions. Jails are typically operated at the county level and are under the management of the local sheriff. They are where people are incarcerated after being arrested for allegedly committing a crime. If ineligible for bail or unable to meet conditions set for bail, they may remain incarcerated for extended periods of time while awaiting completion of judicial proceedings. Jails are also used to incarcerate people serving short sentences, typically of less than one year. In contrast to locally operated jails, every state and the federal government operates its own prison system. Prisons are where people are incarcerated to serve out felony sentences, typically of one year or longer. As part of the federal or state systems, prisons have some operational advantages in creating economies of scale, but like jails they often struggle with not having sufficient staffing or resources [1-3].

In a 1976 decision, the US Supreme Court ruled that people who are incarcerated have a constitutionally based right to health services [4]. However, standards of care for health services in jails and prisons have not been codified into law. Without enforceable standards for care—i.e., without the standards required in other settings such as hospitals, clinics, and nursing homes—jails and prisons provide care with little oversight. There are organizations that provide accreditation of health services in jails and prisons, but that process is optional.

With the vastly different budgets and resources, and lack of meaningful oversight, there is wide variation in the availability and quality of health services among and between jails and prisons. Further complicating the issue is that about half of prison systems and more than half of jails contract with private companies to provide health care [2, 3, 5]. Although these companies can provide jails and prisons with resources and staffing not otherwise available, they are fundamentally driven by profit, and are thus incentivized to minimize the care provided [1]. In this context, jails and prisons—and the companies that provide care on their behalf—rarely make available information about the prevalence of health problems among their populations or the delivery of health care, further stifling oversight.

Nevertheless, it is well documented that, compared to the general population, people impacted by the criminal legal system have high rates of mental illness, substance use disorders, suicide attempts, and chronic medical conditions [6]. In North Carolina prisons, one in three people incarcerated (and released) in 2015–2016 had at least one chronic medical condition, with a large proportion suffering from multiple conditions [7]. Multiple comorbidities were particularly prevalent among those with mental health problems: 56% of people with a psychiatric diagnosis also had a chronic medical condition [7].

Beyond management of chronic health problems, acute issues (including crises precipitated from chronic conditions) are also sources of morbidity and mortality. For example, in a national report of jail deaths, rates of suicide deaths exceeded those of the general population, and greater than half of all jail deaths (51%) were due to causes that could be readily preventable, including suicide, drug overdose, homicides, and injuries [8]. Compounding the challenges in providing care and preventing injuries, many jails and prisons

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have low staffing rates of medical providers, nurses, and officers [3, 9]. When medical staff are not on site, officers must decide if incarcerated individuals need medical attention.

In addition to lack of health care resources, the stressful environments of jails and prisons can induce or exacerbate health problems, particularly mental health issues such as depression and post-traumatic stress disorder (PTSD). Solitary confinement, which is commonly used in these environments, can have profoundly negative consequences, such as self-harm and PTSD [10, 11]. The repercussions of these experiences may follow people back to the community, as solitary confinement is associated with greatly elevated levels of post-release mortality [12]. Although a minority of people find greater access to care in prison and jails than in the community [13]—a sad commentary on the state of community resources—the difficult living conditions and lack of health care in prisons and jails likely contribute to poor outcomes and higher post-release mortality.

High rates of post-release mortality have been documented in numerous studies. For example, in Washington State, the risk of death in the first two weeks following prison release was 12 times that of the general population [14]. In North Carolina the mortality rate among men released from prison was more than two times that of those in the general population [15, 16], and in recent years the opioid epidemic has had an added devastating impact. Among people released from North Carolina prisons from 2016 to 2018, the rate of fatal overdose in the first two weeks in the community was 47 times that of the general population [17].

In returning to the community, people face enormous challenges to successful reentry, where social determinants of health can further impact overall morbidity and mortality. People often return to communities that suffer high rates of incarceration, poverty, lack of living-wage jobs, and inadequate public services. They have high rates of housing and food insecurity and unemployment or underemployment. Additionally, people with a criminal record are burdened with widespread discrimination in housing, employment, eligibility for safety net programs, and many types of public assistance [18]. If on a registry for a sex offense, restrictions on where one can live create tremendous additional barriers to housing stability. The impact of these multiple social determinants of health likely contributes significantly to poor health outcomes.

Racial health disparities are exacerbated by the disproportionate impact of the criminal legal system on communities of color. In the United States, one-third of Black men will experience incarceration in their lifetime [19]. The effects of incarceration reach beyond the individual and also impact the family and the community; 44% of Black women have a family member who has experienced incarceration, compared to just 12% of White women [20]. This disparity in incarceration has worsened racial health inequities observed across the United States.

Following release, robust connections to comprehensive reentry support and health services could improve morbidity and mortality. However, effective reentry programs are insufficient for the need, as they are underfunded and poorly distributed. The majority of people with chronic medical conditions, mental illness, and/or substance use disorder are not meaningfully connected to health services upon release from jail or prison [6]. There are exceptions where programs have targeted certain medically vulnerable populations, but they are small in scale and not widely implemented.

Lack of medical insurance is another barrier to post-release health care. The federal Medicaid inmate exclusion policy results in states terminating or suspending Medicaid for people while incarcerated in prison. Delays in reinstating those benefits upon release cause gaps in Medicaid coverage even in states that expanded Medicaid under the Affordable Care Act (ACA). In the 12 states, including North Carolina, that have not expanded Medicaid coverage under the ACA, large portions of people are ineligible for Medicaid altogether, and many are too poor to qualify for subsidies under the ACA.

NC FIT

The North Carolina Formerly Incarcerated Transition (NC FIT) Program was created to help address these issues. NC FIT is based on a model created by the Transitions Clinic Network (TCN) and is part of the national TCN. This evidence-based program has demonstrated 50% reductions in emergency room utilization, decreased primary-care-sensitive hospitalizations, a 45% reduction in days reincarcerated in the first year of participation, and reduced parole and probation violations [21]. The program's community health workers (CHWs), who have a history of incarceration themselves, work with incarcerated and recently released clients to create comprehensive community reentry plans to connect them to community health providers and other essential social services.

The NC FIT Program has also partnered with the North Carolina Department of Public Safety (DPS), which runs the state prison system. DPS has invested in reentry support through a number of novel mechanisms. The department has supported the creation of local reentry councils (LRCs) across the state to coordinate local reentry services and referrals. The LRCs bring together local stakeholders, transitional housing providers, job program representatives, mental health treatment providers, parole and probation officers, and others to coordinate efforts. DPS also created a network of prisons that focus on reentry. These prisons bring people closer to their county of residence up to 18 months prior to release. They facilitate reentry planning and allow people to directly connect with their support systems and local reentry providers prior to release. The NC FIT Program leverages this statewide investment by locating FIT programs in areas supported by these efforts. NC FIT Program CHWs can do "in-reach" into these prisons and local jails to help establish rapport and start planning prior to release.

NC FIT began in Durham in 2017, and now has programs in six counties: Wake, Guilford, Durham, Orange, Mecklenburg, and New Hanover. A contract with DPS supports funding for six CHWs and program administration. NC FIT Program CHWs also work with their local jails and other reentry partners to get referrals and identify clients who could most benefit from their assistance. To be eligible for the NC FIT program, participants must have been recently released from prison or jail and have a chronic medical condition, mental illness, and/or substance use disorder.

All NC FIT Program CHWs are embedded in a primary care medical home to ensure connections to essential health services. The medical homes are almost exclusively federally qualified health centers (FQHCs) that provide low-cost comprehensive primary care services and have integrated behavioral health and care management services. In efforts to reduce cost barriers, NC FIT covers the sliding-scale fee at the clinics and up to $100 per month in medication costs for each client. We work to help clients apply for Medicaid, Medicare, ACA insurance, or financial assistance programs. Other forms of coverage are essential for specialty care and other medical expenses.

To address the high rates of post-release mortality from drug overdose, NC FIT is engaged in several efforts to improve access to care for people with opioid use disorder. As in much of the country, most jails and prisons in North Carolina do not offer continuation of medications for opioid use disorder (MOUD) upon incarceration. MOUD, such as buprenorphine and methadone, are withheld even if a person was in treatment with a medical provider. As a result, periods of incarceration can precipitate withdrawal, and upon release there is an elevated risk for relapse and overdose. Identifying people in prison and jail with OUD and starting them on MOUD prior to release has been shown to reduce overdose deaths by up to 85% [22].

In response, the NC FIT Program has worked with the jails in Durham and Orange counties to establish medication-assisted treatment (MAT) services that continue people on MOUD, and Durham is offering initiation of treatment prior to release for people not already on MOUD. NC FIT, along with the Mountain Area Health Education Center (MAHEC), is assisting the state prison system in a pilot at two sites to initiate MOUD before release and connect people to care in the community. Furthermore, NC FIT is part of a technical assistance team supporting 24 communities around the state that are working to improve connections to SUD treatment upon release from jail, enhancing harm reduction and creating programs to divert people from arrest for low-level drug crime and get them into treatment. This work is funded through a grant from the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

Preliminary data from the NC FIT Program have confirmed that we are enrolling people with significant burdens of chronic disease, mental illness, and/or SUD; typically, clients have four different chronic health problems. We have been successful in linking our clients to comprehensive primary care medical services and supporting adherence to medical treatment, and over time our clients have higher rates of housing security and employment and lower rates of recidivism [23].

Conclusion

Increased mortality after release from incarceration is multifactorial and poses many unanswered questions. Prior studies have identified suicide, drug overdose, and violence as large contributors. However, we know little about access and quality of health care during incarceration, and how these may impact the post-release period.

In conclusion, more data is needed to better understand risk factors that can predict increased mortality and inform interventions designed to lower risk. We also recommend that jails and prisons adopt comprehensive, verifiable standards of medical care that address pregnancy, women's health, gender-affirming care, chronic and acute illness, mental illness, and substance use disorder. Additionally, a required reporting system for jails and prisons to document timely details of unanticipated health outcomes, suicide, homicide, and mortality is needed, as is adequate staffing of licensed nurses and clinicians. NCMJ

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