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PRISON & JAIL REENTRY & HEALTH

Key points

- Mass incarceration in the United States is a public health crisis that disproportionately affects Black and Brown people and their communities. Incarceration can exacerbate health conditions and complicate health and justice outcomes for both reentering people and the communities to which they return.
- Disproportionate rates of mental health issues, suicide, substance use disorders, disabilities, and physical disorders plague the reentry population.
- The reentry population faces complex barriers to health care access and often experiences homelessness, unemployment, and a lack of social and family support.
- Justice-based interventions for the reentry population generally focus on life skills or individual deficits. Compared with approaches that focus on health and well-being, these programs are unlikely to achieve identity transformation and self-efficacy in managing health and other needs.
- Savings from reform of the criminal justice system could be reinvested to make successful reentry achievable.
- Public officials should include health care as a key component of community reentry programming by supporting access to Medicaid prerelease and seamless coordination of health care in communities postrelease.

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People reentering communities after incarceration are sicker than the general population and face barriers to accessing health care and other supports. Along with criminal justice reform, policy makers must work to improve evidence-based reentry programming that supports healthy people and communities.

The United States incarcerates more people than any other country in the world, having more than two million adults behind bars at an estimated annual cost of $182 billion. A 500 percent increase in incarceration in the US during the last forty years was not merely a result of rising crime but also a result of the increasing criminalization of behaviors, exemplified by the "War on Drugs," incarceration of people with serious mental illness, and increased sentencing for disadvantaged populations. Black and Brown people are substantially overrepresented among incarcerated people. Contemporarily, the root causes of this phenomenon point to long-standing structural oppression.

Experts have pointed to incarceration as a public health crisis. Adding to its many other negative health effects, incarceration is often associated with coerced mobility, as it forces the relocation of people away from their communities. This creates challenges related to public health, housing, education, and employment for reentering people, families, and the communities hit hard by mass incarceration.

Incarceration takes place in prisons and jails. Prisons are state or federal correctional facilities that hold people with sentences generally longer than one year. Jails are managed by local law enforcement and confine people with sentences of one year or less and those awaiting trial. Release back to the community after incarceration is the norm, as nearly all incarcerated people are released from prison and jail at some point. More than 600,000 people are released from prison and more than nine million cycle through jails annually.

This brief provides an overview of research regarding the health outcomes associated with prior incarceration, a review of strategies currently used to support

the health and well-being of the reentry population, and high-level recommendations to improve health and justice outcomes. We argue that criminal justice reform coupled with targeted upstream efforts such as investment in criminal justice–based reentry programs, support for communities and the community health systems to which people return, and enhanced research evaluation of reentry programming are necessary to mitigate the negative health impacts of mass incarceration.

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Reentry And Health

People released from incarceration have a high risk for adverse health outcomes and death due to preexisting behavioral health and chronic medical conditions and the negative effect of incarceration itself. Compounding these problems are barriers to health care and basic social determinants of health such as shelter, food, and employment.

MEDICAL AND BEHAVIORAL HEALTH ISSUES

Rates of mental health problems, substance use disorders, lifetime suicide attempts, opioid use, and pain medication dependence are dramatically elevated for justice-involved populations compared with the general population. Reentering citizens experience higher rates of overdose, suicide, disabilities and physical disorders, homelessness, and death compared with the general population.

Returning cohorts also have disproportionate rates of HIV/AIDS, hepatitis C, and sexually transmitted infections, and these infections can spill over to affect communities with high incarceration rates. The COVID-19 pandemic brings new complexities to reentry, given that the infection rate among those incarcerated in state and federal prisons is 5.5 times that of the US general population, and correctional facility outbreaks have been found to affect community rates of COVID-19. Incarcerated populations that have been infected with COVID-19 have had more serious infections than nonincarcerated populations. They are also at risk for long-term sequelae of the virus, further increasing the pandemic’s footprint in communities affected by mass incarceration.

Finally, one-half of men (49 percent) and two-thirds of women (67 percent) who have been incarcerated report a chronic physical health condition in need of treatment. Cardiovascular disease disproportionately affects formerly incarcerated people, with stroke and myocardial infarction contributing to a high risk for death postrelease.

BARRIERS TO ACCESSING HEALTH CARE

Incarcerated people have been historically excluded from Medicare and Medicaid. Federal law requires suspension or termination of Medicaid benefits on incarceration, and efficient systems to reinstate Medicaid on release are uncommon. One study found that only 28 percent of jails screen for Medicaid eligibility at release, and research has identified many other barriers to Medicaid enrollment. Furthermore, as the 2010 Affordable Care Act did not anticipate rejection of Medicaid expansion in twelve states, many low-income returning citizens in those states do not qualify for Medicaid and are ineligible for health insurance subsidies under the federal marketplaces.

Even with insurance, access to care is challenging for the reentry population. Internalized racism, post-traumatic stress disorder, and the stigma associated with incarceration, mental illness, and substance use disorders negatively affect requests for needed services. Research suggests that discrimination against those with a criminal record keeps people out of the primary care system, and such perceived discrimination in health care settings is associated with increased odds of self-reported poor or fair health status. Finally, there are no evidence-based strategies for primary care providers to screen for current or former criminal justice supervision, and most have not been trained to understand the complex issues of justice-involved populations.

SOCIAL DETERMINANTS OF HEALTH

Being released from incarceration affects a person's ability to secure basic needs such as health, housing, and employment. Compounding these barriers are issues related to returning to impoverished communities and complicated relationships with families and support systems. The intensity and complexity of these issues differ for those leaving prisons versus jails. After being incarcerated for years, persons released from prison leave without an official identity card, are more likely than people who have been in jail to be estranged from family, and frequently return to communities geographically distant from their place of incarceration. However, there is an element of predictability that can facilitate release planning and programming. In contrast, most people leaving jail have been incarcerated less than a month and will return to local communities, where they may still have social support intact. However, short-term and often chaotic jail stays are coupled with variable access to physical and behavioral health care, and prerelease coordination with community-based programs for people in jail is less likely than for people in prison settings.

Supplemental exhibit 1 summarizes literature indicating how reentry is related to challenges in accessing social determinants of health. For example,

> "The COVID-19 pandemic brings new complexities to reentry."

formerly incarcerated people are nearly ten times more likely to be homeless than the general population. Factors that contribute to the reentry population's housing insecurity include landlord discrimination, legal restrictions on public housing, and limited low-cost housing options.

People reentering the community also encounter difficulty obtaining employment, having unemployment rates that are five times greater than that of the general population. Furthermore, a criminal record impedes employment, with a record having a greater cumulative effect on Blacks than on Whites. Other barriers to employment for the reentry population include low levels of education and literacy, few job skills, sporadic work histories, poor health, and low levels of social capital.

Beyond housing and employment, the reentry population also needs social support, which may be lacking in neighborhoods that are underresourced. In addition, returning to a high-crime-activity neighborhood bodes poorly for reentry success.

Although families can provide social support, the relationship between family engagement and reentry is complex. Supporting a returning family member is frequently described as extremely stressful, exhausting, and draining. Although family support is known to ease reentry pain, research suggests that family violence on return home is common. Furthermore, some family conflict outweighs the benefits of family support.

Reentry Programs

Reentry should be a process that begins in prisons or jails in the form of prerelease programming and that continues after release into the community, with a focus on both criminal justice–related and health-related outcomes. A meta-analysis of fifty-three studies authored between 1980 and 2013 found that reentry programs that consisted of both prerelease and postrelease programming were likely to reduce recidivism by 11 percent, whereas reentry efforts that offered only postrelease programming achieved just half of that recidivism reduction.

Furthermore, studies tend to find variability in effectiveness based on the characteristics of the programs. Prison-based programs often operate under programmatic constraints relating to the length of the program, staff responsible for programming, and type of curriculum. Insufficient studies exist to assess the impact of program features on effectiveness, with the exception of program duration; researchers have found that to be effective, programs should consist of at least 200–300 hours of clinical programming.

Programs that have the greatest potential to reduce recidivism generally use therapeutic modalities such as cognitive behavioral therapy and therapeutic communities to address substance use disorders,

mental illness, and criminal cognitions and values. These modalities focus on building resilience in the person and improving decision-making to address challenges such as influence of peers, housing instabilities, and interpersonal relationships. Prisons and community-based supervision agencies tend to have few programs that involve cognitive behavioral therapy or therapeutic communities. The lack of clinical programming is generally a result of an emphasis on

> "Formerly incarcerated people are nearly ten times more likely to be homeless than the general population."

life skills programming, such as preparing for work, finding housing, and opening bank accounts. For the most part, life skills programming is easier to provide because it does not require clinical staff and can be delivered using videos and workgroups.

Traditional programming during reentry and postrelease tends to focus on a person's deficits, such as criminal cognitions, antisocial behaviors, substance abuse, and antisocial peers. This focus reinforces the person's identity as an outcast. Desistance research calls for more attention to programs devoted to helping people assume a citizenship identity or reframe their identity to be more prosocial. An example of identity transformation efforts is the 5-Key Model for Reentry developed and tested by Florida State University.

Promising Approaches

Despite the vast health risks to reentry populations, there are several promising approaches to supporting reentry health, including those focused on subpopulations.

One robust initiative is the Transitions Clinic Network, a consortium of primary care clinics that aims to increase access to health care services, improve health, and reduce recidivism among people with chronic illnesses who have been recently released from incarceration. A key feature is a community health worker with lived incarceration experience who is embedded in the health care team. In a randomized controlled trial, patients engaged with the Transitions Clinic Network had fewer emergency department visits during the first year compared with those who were referred to expedited primary care on release (25.5% vs 39.2%). Subsequent research conducted in the Transitions Clinic Network has shown a decrease in hospitalized days for ambulatory sensitive care conditions and a decrease in jail days and fewer probation and parole violations compared with those engaged in standard community primary care.

The Transitions Clinic Network now includes more than forty primary care programs in twelve states and Puerto Rico. Most of these are Medicaid expansion states. Implementation of the Transitions Clinic Network in nonexpansion states is complicated by high rates of uninsured people who cannot afford even modest sliding-scale fees and low-cost medications. To address this issue, one program in a nonexpansion state—the North Carolina Formerly Incarcerated Transition Program—was successful in raising private funds and obtaining grants. However, this funding model is neither sustainable nor scalable. Also, as noted previously, irrespective of state Medicaid expansion status, reentering people often need substantive assistance in gaining or regaining Medicaid access.

PROGRAMS FOR SUBPOPULATIONS NEEDING SPECIALIZED INTERVENTIONS

The reentry population is not homogenous. Many programs are designed to address health needs of specific subpopulations.

Serious Mental Illness:

Forensic assertive community treatment is an evidence-based strategy to address serious mental illness in the reentry population. This treatment combines intensive support from justice-informed community treatment teams based in psychiatric care with legal leverage, such as mental health courts and other community supervision. Compared with usual care, which includes intensive case management, forensic assertive community treatment was associated with significant reductions in criminal

convictions and time spent in jails and hospitals, along with significant improvements in engagement in outpatient care.

Substance Use Disorders:

For the more than half of people incarcerated in state prisons and jails who meet criteria for a substance use disorder, opioid use disorder is highly prevalent. Medications for opioid use disorder (MOUD) have been shown to be highly effective in reducing post-release opioid use and overdose death among this group, but implementation in prisons and jails has lagged behind that in the community. In the Rhode Island Department of Corrections, treatment with MOUD before release and continued community treatment on release reduced overdose death rates by more than 60 percent. Ongoing investigations are examining the efficacy of jail- and prison-based MOUD programs with coordinated linkages to continue MOUD postrelease.

HIV And Hepatitis C Infections:

Targeted interventions for HIV and hepatitis C are critical for the reentry population and require coordination between correctional and community health systems. Transitional care coordination, which is based on a form of case management that includes intake, discharge, and transitional care plans, is recognized as an evidence-informed intervention for HIV care and hepatitis C treatment for this population.

Women:

Formerly incarcerated women are more likely to have mental health disorders than justice-involved men

> "A criminal record impedes employment, with a record having a greater cumulative effect on Blacks than on Whites."

or women in the general population. These phenomena are believed to be at least in part related to justice-involved women's higher rates of childhood and intimate partner abuse. The Women's Initiative Supporting Health is a hub of the Transitions Clinic Network program, which has been successful in providing screening and vaccinations, mental health treatment, and substance use disorder treatment to recently incarcerated women. Another example is the Women on the Road to Health program, an app-based intervention that has proven efficacious in reducing sexually risky behaviors, sexually transmitted infections, injurious intimate partner violence, substance use, and symptoms of mental illness.

Other Vulnerable Subpopulations:

Because of space constraints, the above review of subpopulations is incomplete. Other groups, such as those who have experienced prolonged periods of solitary confinement and members of sexual orientation and gender minority populations, also have unique health needs and challenges. More information on these groups is provided by Craig Haney and by Valerio Baćak and colleagues.

WRAPAROUND PROGRAMS: ALL-IN-ONE SERVICE PROGRAMS

In wraparound programs, multiple services such as mental health, primary care, and nonmedical services (for example, housing, education, and employment assistance) are provided with "one-stop" programs. However, there is a paucity of research demonstrating positive outcomes in the adult population. For youth involved in the justice and social welfare systems, multiple studies provide support for wraparound service programs. For adults in a noncorrectional context, a wraparound program in the safety net system in Indianapolis, Indiana, demonstrated reduced hospitalizations and saved $1.4 million annually. Further study is needed to determine the effectiveness of this model in the adult reentry population.

GOVERNMENT-SUPPORTED CARE COORDINATION

People released from a twenty-four-hour detention facility to the community have a level of need for specialized care coordination that is arguably similar to the need seen among high-risk patients discharged from the hospital. There is a significant distinction between the ability to prepare adequate release plans for the prison population—with its set release dates—and the ability to do so for the transient and unpredictable jail population. In New York City,

sudden releases of jail populations highlighted the need for enhanced care, which resulted in required discharge planning to address significant behavioral health and pharmaceutical needs.

Several states and local governments have funded such specialized reentry care coordination programs through health or social services agencies. For example, the Mentally Ill Offender Community Transition Program in Washington State resulted in decreased emergency department visits and inpatient stays for program participants released from state prisons. The provision of support and incentives can increase adherence to community referrals and reduce recidivism, as demonstrated in a similar program sponsored by San Diego County in California.

> "With savings from criminal justice reforms... government should provide more accessible health care and human services for populations at risk for incarceration."

Under the Behavioral Health Justice Involved initiative, funded by Massachusetts Medicaid, justice-involved people in that state who have histories of mental illness or substance use disorders are referred to an assigned navigator. These navigators establish relationships with their clients before and immediately after release from jails and prisons, linking them to mental health and substance use disorder care and addressing basic needs such as government-issued identification cards, housing, clothing, food, and employment. Initial evaluation shows increased housing stability and employment, decreased legal violations, and use of fewer inpatient hospital and emergency department services and more behavioral health outpatient services than before enrollment in the Behavioral Health Justice Involved initiative.

Looking Ahead

To date, justice-based interventions for the millions of people released from prisons and jails into US communities each year have focused on life skills or individual deficits. Compared with approaches that focus on health and well-being, these programs are unlikely to improve identity transformation and self-efficacy in managing physical and behavioral health or to improve social and justice outcomes. New challenges posed by COVID-19 to the reentry population must be grappled with as well.

The overwhelming costs of mass incarceration in the US, overrepresentation of communities of color, and inconsistent access to quality health care, programming, and release planning, along with the paucity of evidence-based reentry services, requires more fundamental examination of our criminal justice policies and practices. Our recommendations for policy makers and other stakeholders seeking to improve the health of this vulnerable population are as follows:

- Reform the criminal justice system in the US—reducing arrest for nonviolent offenses, enacting bail reform, mitigating sentencing practices, and scaling up compassionate release. The Second Chance Act of 2007, which supports many such reforms, must be fully implemented.
- With savings from criminal justice reforms, all levels of government should provide more accessible health care and human services for populations at risk for incarceration, including those with substance use disorders or serious mental illness and low-income communities—especially racially segregated communities of color. Savings should also be used to invest in communities disproportionately affected by incarceration, including economic stimuli, improved early childhood education and schools, and increased after-school and summer employment for youth.
- Increase federal and state support, including through expansion of Medicaid, for programs such as the Transitions Clinic Network, cognitive behavioral programming, and wrap-

around services that provide for reentering people's needs at one location.

- States should apply for Section 1115 waivers to provide Medicaid coverage while people are incarcerated. In 2019, H.R. 1329 proposed to amend the Social Security Act to allow Medicaid coverage for incarcerated persons, but the bill never left committee. The Senate introduced bipartisan legislation to provide Medicaid coverage to pretrial detainees only in 2021.
- Invest in rigorous evaluation of reentry programming offered by states and counties providing enhanced care coordination and care management.
- Support additional research on pre- and post-reentry services and programming that focus on self-efficacy, including how to manage chronic diseases.
- Given the scope of mass incarceration, training programs for health care professionals should include curricula on competencies required to provide care to justice-involved populations.

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Written by Ebony N. Russ, postdoctoral research fellow at Harvard University, in Cambridge, Massachusetts, and part-time professor of sociology at George Washington University, in Washington, D.C.; Lisa B. Puglisi, assistant professor of medicine at Yale University and director of the Transitions Clinic in New Haven, both in New Haven, Connecticut; Gabriel B. Eber, senior associate and affiliate faculty at Johns Hopkins University, in Baltimore, Maryland; Diane S. Morse, associate professor of psychiatry and medicine at the University of Rochester School of Medicine and director of Women's Initiative Supporting Health–Transitions Clinic, both in Rochester, New York; Faye S. Taxman, a professor in the Criminology, Law, and Society Department and director of the Center for Advancing Correctional Excellence at the Schar School of Policy and Government at George Mason University, in Fairfax, Virginia; Meaghan F. Dupuis, senior director of operations at the University of Massachusetts Medical School, in Worcester; Evan Ashkin, professor of family medicine at University of North Carolina in Chapel Hill; and Warren J. Ferguson, professor and senior vice chair of the Department of Family Medicine and Community Health at the University of Massachusetts Medical School in Worcester.

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