

Know the Difference Between Jail and Prison? Both Are Associated With Risk of Death

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 See also Hill et al., p. 913.

Incarceration harms health. Individuals released from carceral facilities have high rates of suicide, overdose, psychiatric hospitalization, and death.¹ Yet, some of the most often cited literature on postrelease mortality precedes the COVID-19 pandemic and the introduction of fentanyl in the illicit drug supply, both adding significant risk to the well-being of incarcerated individuals.

Incarceration takes many different forms. Jails, typically operated by local municipalities, are short-term facilities with rapid turnover and short stays. In contrast, prisons are usually state-run, housing individuals with multiyear sentences. The variability of jails and prisons makes comparing health outcomes challenging; a state-run prison in Washington is very different than a jail in New York City. Even within one state, aggregated data are often unavailable as county- and state-run facilities do not share or make available their data.

NEW FINDINGS IN THE POST-COVID-19, FENTANYL ERA

Yet, in this issue of *AJPH*, Hill et al. (p. 913) become the first to fill a major

research gap, simultaneously analyzing statewide jail and prison mortality rates in a post-COVID-19, postfentanyl era. Using linked data sets in Minnesota, the authors compared postrelease standardized mortality rates and overdose fatalities for individuals exposed to jail versus prison.

While the rate of mortality in the general population has gone up over time, the results still confirm that individuals returning to the community from carceral facilities face a disturbingly high mortality rate compared with the general population. Using conservative estimates, the findings are stark: people released from jail or prison were 15.5 times and 28.3 times more likely, respectively, to die from an overdose compared with an age- and gender-matched general Minnesota population. Moreover, these Minnesota cohort data update an absolute mortality rate even higher than the seminal work of Binswanger et al.,² though lower than previously calculated standardized mortality rates in very different populations at different times (Table 1).

These findings have significant implications. With more than 10 million individuals cycling through jails in the United States each year, the elevated mortality rate highlights the substantial public health impact of incarceration. Whether they stay one day or 365 days, these data suggest they face a 15-times-higher risk of dying upon release compared with those not incarcerated. The data also reveal that prison stays are associated with an even higher risk of death compared with jails.

UNANSWERED RESEARCH QUESTIONS

However, core research questions remain. One, is the mortality rate for prison higher because of longer length of incarceration or because of something unique to prison exposure? Previous literature—in a prison setting—has found a linear dose-response relationship of time served on mortality: each additional year in prison produced a 15.6% increase in the odds of death for parolees, translating to a two-year decline in life expectancy for each year served in prison.⁶ Currently, no data identify if jails have a similar dose-response relationship: a two-day jail incarceration may be very different than a 14-day incarceration.

Second, how does the broader criminal legal system affect these health outcomes? Incarceration is just one aspect of the sequential intercept model of the criminal legal system.⁷ A natural follow-up study would compare standardized mortality rates not across just jail and prison but also diversion programs, probation, parole, or other community supervision programs. Other factors, such as recidivism and desistance, may also significantly influence health outcomes.

TABLE 1— Comparison of Previous Literature on Mortality Rate and Overdose Fatalities in US Jails and Prisons

Article	Location	Time Period	Jail or Prison	Sample Size	All-Cause Mortality ^a per 100 000 PY (95% CI)	Overdose Fatalities ^a per 100 000 PY (95% CI)	All-Cause Standardized Mortality Rate, OR (95% CI)	Overdose Standardized Mortality Rate, OR (95% CI)
Hill et al., 2024 (p. 913)	Minnesota	2020–2021	Jail	99065	1505.3	283.3	1.42 (1.33, 1.51)	15.51 (14.93, 17.11)
			Prison		2169.2	517.6	2.05 (1.69, 2.41)	28.34 (19.71, 37.09)
Lim et al., 2023 ³	New York	2011–2017	Jail	15797	MOUD: 1160 (940, 1420)	MOUD: 490 (350, 660)
					No MOUD: 1430 (1170, 1680)	No MOUD: 830 (640, 1040)
Ranapurwala et al., 2022 ⁴	North Carolina	2000–2018	Prison	229274	...	2 wk postrelease: 960 (646, 1274)	...	2 wk postrelease: 46.6 (31.4, 61.8)
					...	Overall follow-up: 302 (268, 335)	...	Overall follow-up: 14.6 (13.0, 16.6)
Binswanger et al., 2013 ⁵	Washington	1999–2009	Prison	76208	737 (708, 766)	167 (153, 181)	3.61 (3.48, 3.73)	10.33 (9.61, 11.10)
Binswanger et al., 2007 ²	Washington	1999–2003	Prison	30237	...	2 wk postrelease: 1840 (1213, 2677)	...	2 wk postrelease: 129 (98, 168)
					777 (707, 852)	Overall follow-up: 137 (109, 171)	3.5 (3.2, 3.8)	Overall follow-up: 12.2 (10.2, 14.9)

Note. CI = confidence interval; MOUD = medications for opioid use disorder; OR = odds ratio; PY = person-years.

^aData from Hill et al., Ranapurwala et al., and Binswanger et al. are standardized to surrounding general population; Lim et al. data are crude rates at 1-y follow-up.

Finally, how should policymakers interpret these poor health outcomes? These data provide an association without causality. The pathway between carceral setting and death is likely multifactorial. Health care service delivery in carceral settings often lacks evidence-based treatment options (including medications for opioid use disorder [MOUD]), and, without mandatory accreditation bodies or oversight infrastructure, there is substantial heterogeneity among facilities.⁸ Moreover, incarceration creates collateral consequences that directly impact social determinants of health. When one has a criminal record, housing, food stamps, employment, and other social services can become more difficult to attain. Limited re-entry service coordination resources and insufficient community supports often exacerbate harms of incarceration.

THE INTERSECTION OF INCARCERATION AND DRUG OVERDOSE

One question has a clear answer: what drives these high mortality rates? The number-one cause of death among people leaving jail (35.9%) and prison (33.1%) is drug overdose.

Upon re-entry from prison, people who use drugs often have reduced tolerance, misjudge dosing, face new adulterants in the illicit drug supply (e.g., xylazine, fentanyl), or lack access to effective treatment therapies without established health care access. The authors confirm these issues (and others) apply to individuals leaving shorter-term facilities (i.e., jails), not just prisons.

Individuals released from carceral facilities—whether jail or prison—face high overdose risk. Indeed, one

simulation study in Maryland suggested that nearly 50% of fatal opioid overdoses were with individuals exposed to the criminal legal system.⁹ To seriously address the overdose crisis, targeted interventions must not overlook this population.

POLICY IMPLICATIONS

A policy agenda emerges from these findings, focusing on access to both medical and social service relevant care, harm-reduction approaches, and decarceration.

The high rates of opioid overdose demonstrate a clear need for initiation of MOUD in all carceral facilities: jails and prisons alike. Initiation of in-jail treatment has been associated with an 80% decrease in mortality.³ Despite the robust evidence to support this lifesaving, essential medicine (found to be constitutionally mandated in court cases), uptake of MOUD in carceral facilities remains incredibly low.¹⁰

In addition, re-entry services are needed to help improve the social and structural determinants of health. This includes housing, food access, employment support (including fair-chance hiring practices), legal services, and social connectedness. Medical programs such as the Transitions Clinic Network work to provide these practices to a patient group most in need.

Harm reduction, now a key pillar of the Substance Abuse and Mental Health Services Administration's Overdose Prevention Strategy, offers an opportunity to save lives and "meet people where they are." Needle exchange programs, safe smoking supplies, low-barrier treatment options, naloxone distribution, drug-checking programs, and safer settings to

consume drugs can all help mitigate overdose risk, particularly for this patient population. Harm reduction can also provide a framework to address public health harms of incarceration. How can care be more effectively provided in carceral settings to reduce harms of incarceration? In addition to the need for expansion of MOUD in jails and prisons, facilities can offer programs in HIV, hepatitis C, mental health, cancer screening, and other core improvements in the quality of care. In addition, broader policies that extend beyond harm reduction and eliminate the harmful exposure of carceral settings are needed.

DECARCERATION AS PUBLIC HEALTH INTERVENTION

In 2021, the American Public Health Association published a policy statement that explicitly stated their recommendation of "moving toward the abolition of carceral systems and building in their stead just and equitable structures that advance the public's health."¹¹ Ruth Wilson Gilmore is often quoted as stating, "Abolition is about presence, not absence. It's about building life-affirming institutions."¹² To assuage the health impact of jails and prisons, public health leaders must work toward the creation of resources to support individuals with addiction, mental health diagnoses, unstable housing, poverty, and other social and structural determinants of health rather than relying on carceral facilities to be safety net providers.

Ultimately, Hill et al. provide a starting point for change. While a Washington State prison differs from a New York City jail, this Minnesota analysis has

implications for any state. There is a spectrum of harm between jail and prison that warrants further clarification, but the public health message remains clear: incarceration harms health. **AJPH**

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CONFLICTS OF INTEREST

The authors report no conflicts of interest.

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AJPH invites the submission of manuscripts on the topic of the global oppression and legal persecution of LGBTQ+ people and communities, and its implications for public health. On a global level, a resurgence of anti-LGBTQ+ legislation is under way in a number of countries. These efforts have perhaps been most notable in African countries, where US-based anti-LGBTQ+ crusaders have found fertile ground for promoting anti-LGBTQ+ hate. We invite the submission of manuscripts in a number of critical areas related to global LGBTQ+ persecution, public health, and health equity; including, but not limited to topics addressing:

- History of anti-LGBTQ+ fundamentalism abroad,
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- Anti-LGBTQ+ legislation abroad and in the US,
- Impact of anti-LGBTQ+ legislation on community and population health,
- Role of anti-LGBTQ+ legislation on effective HIV prevention and treatment,
- Impact of anti-LGBTQ+ legislation on the delivery of LGBTQ+ specific health services,
- Role of public health funder advocacy and organizing in challenging harmful laws, and
- Importance of building diverse, multi-sector coalitions.

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