

POLICY FORUM: INVITED COMMENTARIES & SIDEBARS

The Criminal Legal System, Serious Mental Illness, and Supported Reentry: The FIT Wellness Model

Evan A. Ashkin, MD¹, Theodore Zarzar, MD², David L. Rosen, MD, PhD, MSPH³

¹ Family Medicine, University of North Carolina at Chapel Hill, ² Psychiatry, University of North Carolina at Chapel Hill, ³ Division of Infectious Disease, University of North Carolina at Chapel Hill

Keywords: Evan A. Ashkin, Theodore Zarzar, David L. Rosen, serious mental illness, mental health, FIT Wellness, incarceration, North Carolina, community programs

<https://doi.org/10.18043/001c.160671>

North Carolina Medical Journal

Vol. 87, Issue 1, 2026

Prisons and jails have become the default safety net provider for people with serious mental illness (SMI) across the United States. The North Carolina Formerly Incarcerated Transition Program (NC FIT), including its unique program for people with SMI, FIT Wellness, connects people post-release from incarceration to essential health services.

Mental health treatment during incarceration and timely access to treatment following release remains a persistent challenge. In the past year, this challenge was starkly highlighted in North Carolina by two tragic instances in which a person living with serious mental illness (SMI), who had a long history of justice system involvement, took a life.^{1,2} The criminal legal system was not designed to serve as the social safety net for people with SMI, yet that is now the case in North Carolina and across the country. It is important to understand why people with SMI become incarcerated rather than receive needed mental health care and understand some of the emerging solutions to address this challenge.

Starting in the 1950s, psychiatric hospitals across the United States were shuttered with the good intention of better integrating people with SMI into community settings. However, without sufficient funding to support community mental health programs, the legacy of those closures left neither sufficient funding for community care nor for public psychiatric inpatient care.³⁻⁵ As a result, it is not uncommon for people with SMI to live in their communities untreated.

When a person with SMI is untreated, and especially if they are unhoused, they are at increased risk of criminal legal system involvement, often in the form of nonviolent misdemeanor crimes such as loitering, trespassing, disorderly conduct, or other low-level infractions.^{6,7} Substance use, which is highly prevalent among people with SMI, also often leads to arrest. Emerging literature suggests that community clinics striving to reduce recidivism should address not only psychiatric needs but also structural and social health determinants.⁸

If law enforcement is called about an incident with a person suffering from untreated SMI, they often have no option but to arrest the individual and bring them to the local jail where they may be booked or released with an order to appear in court at a later date. If the individual fails to appear, they will then have a warrant for their arrest and be at higher risk of serving time when re-arrested.

While in jail, people with SMI may go without medication to control symptoms or not have access to their particular medication regimen.⁹ Jails are understaffed and ill-equipped to provide the type of assessment and treatment needed, and they routinely struggle to employ mental health providers for adequate service delivery.¹⁰ Suicide remains the leading cause of death in US jails, particularly in the early period of incarceration.¹¹ Jails also struggle with having the staff and resources to create effective post-release treatment plans, with limited community mental health resources or transitional housing to support their reentry.¹²

In North Carolina, our state prison system shares many of these challenges. The North Carolina Department of Adult Correction (NC DAC) incarcerates approximately 31,000 individuals, and roughly a quarter receive mental health services. NC DAC operates a continuum of outpatient, residential, and inpatient care.¹³

Like jails, prisons struggle with the staffing necessary to create comprehensive aftercare plans. People often leave prison with a bag of belongings, a 30-day supply of medication, and a list of community resources which they are supposed to navigate themselves—with or without family support, health insurance, income, or transportation—while simultaneously working to obtain adequate shelter and food and manage the symptoms of their mental illness.

It is in this context that the North Carolina General Assembly passed Iryna's Law (House Bill 307/Session Law 2025-93) in response to the murder of Iryna Zarutka in Charlotte by a man with SMI who had repeatedly cycled through the system without either adequate treatment or a comprehensive release plan.¹⁴ Among other components, the law creates more stringent conditions of release for a broader array of charges deemed as "violent"; it also mandates psychiatric evaluations for a wider population. Although the asserted motivation for Iryna's Law is greater public safety, the legislation provided no additional funding.¹⁵ The unintended consequence may be that more people with SMI may languish in jails untreated, for longer periods of time, only to be released to communities bereft of services.

In no way diminishing the seriousness of the crimes committed, it is important to note that the vast majority of people with SMI pose no threat to public safety.¹⁶ In fact, people with SMI are at increased risk of being victimized during incarceration and post-release, and stigma and bias create

enormous barriers during reentry.^{17,18} People with SMI are discriminated against in many essential areas including housing, employment, education, and sadly, even in health care settings.

Some recent efforts in our state have promised to improve engagement in care for people with SMI in the criminal legal system. For example, mental health treatment courts seek to engage people in treatment instead of incarceration, and 911 diversion programs send mental health providers instead of law enforcement to calls that are clearly related to a mental health crisis with low potentials for harm.^{19,20} Recent investments in behavior health crisis units also have the potential to bring people to treatment instead of jails. A major investment by the state prison system is the deployment of specialty mental health parole and probation officers, who now operate in all 100 counties.²¹ They have unique training and collaborate with local mental health and substance use treatment providers to improve connections to care post-release.

In response to a tragedy several years ago, NC DAC, in collaboration with the North Carolina Department of Health and Human Services, launched the High Priority Reentry Program for people with SMI and a history of violent crime, with the goals of enhancing pre-release planning and improving care coordination and communication with community providers.²²

The NC FIT Program

NC FIT, housed within the University of North Carolina at Chapel Hill Department of Family Medicine, was established in 2017 to improve outcomes for people released from incarceration who suffer from chronic disease, mental illness, and/or substance use disorder. NC FIT is part of the Transitions Clinic Network (TCN), which adheres to an evidence-based model of hiring people with personal histories of incarceration, specially training them as community health workers (CHWs), and embedding them in primary care medical homes as peer navigators.²³⁻²⁶

NC FIT has three distinct programs: the main FIT Program, FIT Wellness, and FIT Recovery. The main program serves people leaving incarceration that suffer from chronic disease, mental illness and/or substance use disorder; it has been described in more detail in prior *NCMJ* publications.^{27,28} FIT Recovery is a collaboration with the NC DAC to link all people initiated on medication for opioid use disorder (MOUD) during incarceration to community treatment at release. FIT Wellness focuses on people being released that suffer from serious mental illness (SMI) and will be described in more detail below.

NC FIT has expanded the main program to 11 partner organizations that include 16 clinic locations across 14 counties. These locations include all the major urban areas in the state and now rural counties, including sites in

Beaufort, Rockingham, Wilson, Nash, and Edgecombe Counties. The FIT Recovery Program has built partnerships with providers in over 70 counties where we can support services for MOUD for up to 6 months post-release. In addition, we are working with virtual MOUD providers to offer access when people are not being released to one of those partner organizations or have barriers that make care at a brick-and-mortar location challenging.

As of January 1, 2026, the main FIT Program had enrolled 1688 people, FIT Recovery has received 440 referrals from NC DAC, and FIT Wellness had enrolled 213 people across four counties.

FIT Wellness

People with SMI face enormous challenges when released from incarceration. Like much of the existing literature, our own examination of clients in the main FIT Program suggests that those with SMI have higher rates of housing and food insecurity than other released persons, and nearly twice the rate of subsequent imprisonment.²⁹

With seed funding from the North Carolina Department of Mental Health, Developmental Disabilities and Substance Use Services (DMHDDDSUS), FIT Wellness was started in 2022 to address this higher level of need among re-entrants with SMI.³⁰ Although FIT Wellness employs several components from the main FIT Program, it has several unique dimensions. First, clients are linked to clinics capable of co-located community psychiatric and primary care. The FIT Wellness medical director, Theodore Zarzar, MD, practices within the state prison system and in the community. Working with NC DAC, we are able to identify people leaving state prisons with SMI and enroll them in FIT Wellness if they have a qualifying disorder (such as schizophrenia, schizoaffective disorder, bipolar I disorder, or major depression with psychotic features) and plan to return to one of the four counties in which we have services: Durham, Orange, Wake, and New Hanover.

Prior to their release, people eligible for FIT Wellness have an initial video call with one of our CHWs. This interaction offers an opportunity for CHWs to establish a face-to-face connection, build rapport with clients, and develop a warm handoff with NC DAC. Those agreeing to enroll also undergo an intake assessment which includes an assessment of clients' specific reentry challenges. Beyond the main FIT Program, FIT Wellness has financial resources to assist clients with emergency housing, food, clothing, transportation, smartphones and laptops. The goal with this funding is to address social determinants that contribute to health and risk of rearrest. Following release, a FIT Wellness CHW meets the client and begins implementing the comprehensive reentry plan to address all identified barriers to successful reentry.

Additionally, FIT Wellness collaborates with the clients' assigned specialty mental health parole and probation officer and their Medicaid Tailored Plan provider. Having access to the prison medical records, and in some cases prior direct psychiatric care with patients, FIT Wellness can provide continuity in treatment for mental illness, chronic disease, and often co-morbid substance use disorders.

Since its start, FIT Wellness has engaged more than 200 people, of which 126 were successfully linked to a community clinic. For these clients, the program has provided more than 700 psychiatric clinical visits and more than 375 primary care visits; CHWs have had more than 2000 remote or in-person interactions with clients, with each interaction lasting an average of 29 minutes (internal evaluation data, NC FIT).

The importance of this support can best be understood in the context of the patient data we collect and follow at program entry: most are single (69%), more than one-third have been living either "on the street" or in a shelter, and one-third never graduated from high school (33%). Rates of alcohol and drug use disorders are high among this group (69%), as are co-occurring, chronic non-behavioral health conditions (66%). Also, despite an average age of 37, nearly 40% had been incarcerated 10 years or longer over the course of their lifetimes (internal evaluation data, NC FIT).

Despite the population's high level of need, there are some signals suggesting that the program is having a positive impact. Receipt of community psychiatric care among FIT Wellness clients is about twice that reported for reentrants with SMI who do not have assistance matriculating into community care.^{31,32} Across their first and most recent visits, more than half of applicable FIT Wellness clients had achieved 50% reductions in clinically measured scores for depression and anxiety severity. Although we interpret these findings with caution, as the population of clients is relatively small and we are comparing their outcomes to those in other states and contexts, we also interpret them with optimism. These signals suggest that FIT Wellness is improving clients' lives and ultimately the health of their communities. As the program grows, we will continue to evaluate its performance.

Importantly, FIT Wellness is not a crisis mental health provider, nor is it capable of providing the intensive services that Assertive Community Treatment (ACT) teams are designed to deliver. DMHDDSUS and other governmental agencies have made significant investments to address those essential services. These new investments include new behavioral health crisis units, forensic ACT teams, forensic community support teams and new inpatient psychiatric facilities for children and adults.

Nevertheless, FIT Wellness is playing an increasingly important role in the mosaic of services necessary to serve the state. To date, the model has demonstrated good engagement with services and positive trends in

emergency department utilization and psychometric scales, as well as the potential for scalability across the state. The emphasis on a warm handoff between prison and community, the support of people with lived experience, and co-located primary care and psychiatric services make FIT Wellness uniquely positioned to support individuals with serious mental illness during community reentry.

Acknowledgments

We would like to acknowledge the community health workers in the FIT Wellness Program: Shawn Baker, Dwight Walker, Tasha Majette, and Shatocka Carlton, and program manager Elena DiRosa, MPH.

Declaration of interests

The authors have no conflicts to declare.

Correspondence

Address correspondence to Evan A. Ashkin, 590 Manning Dr. Chapel Hill, NC 27599 (ashkin@med.unc.edu).

Published: April 30, 2026 EDT.



This is an open-access article distributed under the terms of the Creative Commons Attribution 4.0 International License (CCBY-NC-SA-4.0). View this license's legal deed at <https://creativecommons.org/licenses/by-nc-sa/4.0> and legal code at <https://creativecommons.org/licenses/by-nc-sa/4.0/legalcode> for more information.

REFERENCES

1. WRAL staff. Raleigh murder suspect of Ravenscroft teacher had 20-year criminal history, mental health struggles. WRAL News. January 7, 2026. Accessed April 15, 2026. <https://www.wral.com/news/local/murder-ravenscroft-teacher-zoe-welsh-ryan-camacho-charged-january-2026/>
2. Richer A, Verduzco E. Man faces federal charge in Ukrainian woman’s killing on train. AP News. September 9, 2025. Accessed April 15, 2026. <https://apnews.com/article/charlotte-stabbing-ukrainian-refugee-iryna-zarutska-cc9ec826660468830b3f18a71e1a9aaf>
3. Scull A. “Community care”: Historical perspective on deinstitutionalization. *Perspect Biol Med.* 2021;64(1):70-81. doi:[10.1353/pbm.2021.0006](https://doi.org/10.1353/pbm.2021.0006)
4. Lamb HR, Weinberger LE. Deinstitutionalization and other factors in the criminalization of persons with serious mental illness and how it is being addressed. *CNS Spectr.* 2020;25(2):173-180. doi:[10.1017/S1092852919001524](https://doi.org/10.1017/S1092852919001524)
5. Fuller DA, Sinclair E, Geller J, Quanbeck C, Snook J. *Going, Going, Gone: Trends and Consequences of Eliminating State Psychiatric Beds, 2016*. Treatment Advocacy Center. Office of Research and Public Affairs; 2016. <https://www.tac.org/wp-content/uploads/2023/11/Going-Going-Gone.pdf>
6. Compton MT, Graves J, Zern A, et al. Characterizing arrests and charges among individuals with serious mental illnesses in public-sector treatment settings. *Psychiatr Serv.* 2022;73(10):1102-1108. doi:[10.1176/appi.ps.202000581](https://doi.org/10.1176/appi.ps.202000581)
7. Compton MT, Zern A, Pope LG, et al. Misdemeanor charges among individuals with serious mental illnesses: A statewide analysis of more than two million arrests. *Psychiatr Serv.* 2023;74(1):31-37. doi:[10.1176/appi.ps.202000936](https://doi.org/10.1176/appi.ps.202000936)
8. Bonfine N, Wilson AB, Munetz MR. Meeting the needs of justice-involved people with serious mental illness within community behavioral health systems. *Psychiatr Serv.* 2020;71(4):355-363. doi:[10.1176/appi.ps.201900453](https://doi.org/10.1176/appi.ps.201900453)
9. DiRosa EA, Van Deirse T, Cuddeback GS, Murray-Lichtman A, Carda-Auten J, Rosen DL. Mental healthcare practices from entry to release across Southeastern jails. *BMC Health Serv Res.* 2025;25(1):1355. doi:[10.1186/s12913-025-13507-w](https://doi.org/10.1186/s12913-025-13507-w)
10. Rosen DL, Carda-Auten J, DiRosa E, Travers D. Jail healthcare staffing in the US Southeast: A cross-sectional survey. *J Gen Intern Med.* 2024;39(4):603-610. doi:[10.1007/s11606-023-08454-3](https://doi.org/10.1007/s11606-023-08454-3)
11. Carson EA. *Mortality in Local Jails, 2000–2019 – Statistical Tables*. Bureau of Justice Statistics. U.S. Department of Justice; 2021. <https://bjs.ojp.gov/content/pub/pdf/mlj0019st.pdf>
12. Carda-Auten J, Dirosa EA, Grodensky C, et al. Jail health care in the Southeastern United States from entry to release. *Milbank Q.* 2022;100(3):722-760. doi:[10.1111/1468-0009.12569](https://doi.org/10.1111/1468-0009.12569)
13. Sheitman B, Williams JB. Behavioral health services in North Carolina’s state prison system: Challenges and opportunities. *N C Med J.* 2019;80(6):356-362. doi:[10.18043/ncm.80.6.356](https://doi.org/10.18043/ncm.80.6.356)
14. Iryna’s Law. 2025-93 Sess Laws, HB 307 (2025). <https://www.ncleg.gov/Sessions/2025/Bills/House/PDF/H307v5.pdf>
15. Crumpler R. NC lawmakers target crime with stricter pre-trial release — not mental health funding. NC Health News. September 24, 2025. Accessed April 15, 2026. <https://www.northcarolinahealthnews.org/2025/09/24/nc-lawmakers-aim-to-curb-crime-with-stricter-pretrial-release-not-mental-health-funding/>

16. Elbogen EB, Johnson SC. The intricate link between violence and mental disorder: Results from the national epidemiologic survey on alcohol and related conditions. *Arch Gen Psychiatry*. 2009;66(2):152-161. doi:[10.1001/archgenpsychiatry.2008.537](https://doi.org/10.1001/archgenpsychiatry.2008.537)
17. Desmarais SL, Van Dorn RA, Johnson KL, Grimm KJ, Douglas KS, Swartz MS. Community violence perpetration and victimization among adults with mental illnesses. *Am J Public Health*. 2014;104(12):2342-2349. doi:[10.2105/AJPH.2013.301680](https://doi.org/10.2105/AJPH.2013.301680)
18. Khalifeh H, Johnson S, Howard LM, et al. Violent and non-violent crime against adults with severe mental illness. *Br J Psychiatry*. 2015;206(4):275-282. doi:[10.1192/bjp.bp.114.147843](https://doi.org/10.1192/bjp.bp.114.147843)
19. Loong D, Bonato S, Barnsley J, Dewa CS. The effectiveness of mental health courts in reducing recidivism and police contact: A systematic review. *Community Ment Health J*. 2019;55(7):1073-1098. doi:[10.1007/s10597-019-00421-9](https://doi.org/10.1007/s10597-019-00421-9)
20. Bailey K, Lowder EM, Grommon E, Rising S, Ray BR. Evaluation of a police–mental health co-response team relative to traditional police response in Indianapolis. *Psychiatr Serv*. 2022;73(4):366-373. doi:[10.1176/appi.ps.202000864](https://doi.org/10.1176/appi.ps.202000864)
21. Van Deirse TB, Givens A, Cowell M, Ghezzi M, Murray-Lichtman A, Cuddeback GS. A randomized trial of specialty mental health probation: Measuring implementation and effectiveness outcomes. *Adm Policy Ment Health*. 2022;49(3):415-428. doi:[10.1007/s10488-021-01172-0](https://doi.org/10.1007/s10488-021-01172-0)
22. Barnes A, Grillo M, Ginn T. Coordinating Re-entry for Individuals with Behavioral Health Needs – Lessons Learned and Next Steps. In: *2025 Rehabilitation and Reentry Conference: Innovative Strategies for Success; April 2, 2025*. <http://www.dac.nc.gov/media/13291/open>
23. Wang EA, Hong CS, Samuels L, Shavit S, Sanders R, Kushel M. Transitions clinic: Creating a community-based model of health care for recently released California prisoners. *Public Health Rep*. 2010;125(2):171-177. doi:[10.1177/003335491012500205](https://doi.org/10.1177/003335491012500205)
24. Wang EA, Hong CS, Shavit S, Sanders R, Kessell E, Kushel MB. Engaging individuals recently released from prison into primary care: A randomized trial. *Am J Public Health*. 2012;102(9):e22-e29. doi:[10.2105/AJPH.2012.300894](https://doi.org/10.2105/AJPH.2012.300894)
25. Shavit S, Aminawung JA, Birnbaum N, et al. Transitions Clinic Network: Challenges and lessons in primary care for people released from prison. *Health Aff (Millwood)*. 2017;36(6):1006-1015. doi:[10.1377/hlthaff.2017.0089](https://doi.org/10.1377/hlthaff.2017.0089)
26. Aminawung JA, Harvey TD, Smart J, et al. Formerly incarcerated community health workers engaging individuals returning from incarceration into primary care: Results from the Transition Clinic Network. *Front Public Health*. 2021;9:681128. doi:[10.3389/fpubh.2021.681128](https://doi.org/10.3389/fpubh.2021.681128)
27. Clark EE, Ashkin E. Spotlight on the safety net: Connecting people released from incarceration to essential health services: The North Carolina Formerly Incarcerated Transition (FIT) Program. *N C Med J*. 2019;80(6):377-379. doi:[10.18043/ncm.80.6.377](https://doi.org/10.18043/ncm.80.6.377)
28. Baker A, Ashkin EA, Rosen DL. We must do better: Addressing high mortality after release from incarceration. *N C Med J*. 2022;83(5):342-345. doi:[10.18043/ncm.83.5.342](https://doi.org/10.18043/ncm.83.5.342)
29. Rosen DL, Zarzar TR, Baker A, Ashkin EA. Serious mental illness-associated socio-medical needs and imprisonment risk in reentry clients. *Psychiatr Res Clin Pract*. Published online 2026. doi:[10.1176/appi.prcp.20250046](https://doi.org/10.1176/appi.prcp.20250046)
30. Zarzar TR, Rosen DL, Ashkin EA. Supporting people with serious mental illness after prison release: The FIT Wellness model. *Psychiatr Serv*. 2024;75(4):395. doi:[10.1176/appi.ps.20230513](https://doi.org/10.1176/appi.ps.20230513)
31. Kouyoumdjian FG, Cheng SY, Fung K, et al. Primary care utilization in people who experience imprisonment in Ontario, Canada: A retrospective cohort study. *BMC Health Serv Res*. 2018;18(1):845. doi:[10.1186/s12913-018-3660-2](https://doi.org/10.1186/s12913-018-3660-2)

32. McNamara C, Cook S, Brown LM, et al. Prompt access to outpatient care post-incarceration among adults with a history of substance use: Predisposing, enabling, and need-based factors. *J Subst Use Addict Treat*. 2024;160:209277. doi:[10.1016/j.josat.2023.209277](https://doi.org/10.1016/j.josat.2023.209277)