

**Criminal Justice and Public Health:
A Need for Cross-System Collaboration Between Jails and Medicaid
to Reduce Recidivism**

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I. Abstract

According to a report from the Council of State Governments Justice Center, 16.9% of the adults in a sample of local jails had a serious mental illness – three to six times the rate of the general population. If these rates were applied to the 13 million jail admissions reported in 2007, the study findings suggest that more than two million bookings of a person with a serious mental illness occur every year¹. Many offenders with mental illnesses don't receive treatment during incarceration. Without treatment, conditions can worsen and offenders can become a greater threat to themselves and to others when they leave jail or prison. This is not only a disservice to the offenders and their families; it is also a threat to public safety.

Mental health cases remain a challenge within the criminal justice system. A significant change in substantive law made by the Affordable Care Act (ACA) presents new opportunities for bridging the two systems (health care and criminal justice) that serve this high-needs population. This paper (1) describes challenges in providing substance use and mental health care services to incarcerated populations; and (2) identifies how these challenges shed light on what best practices can be implemented to bridge the gap between the criminal justice system and health care system, thereby improving public health, improving public safety, and reducing costs to society.

II. Executive Summary

The criminal justice and the health care systems present many challenges in providing care for incarcerated populations, especially when it comes to addressing substance use and mental health disorders. These challenges include divergent goals, inadequate funding, lack of insurance, insufficient treatment capacity, inadequate care, lack of system coordination, and lack of resources. Without continuous access to services, individuals become more likely to return to previous behaviors and become reincarcerated.

State and local jurisdictions can leverage the ACA to implement and expand interventions that have already been shown to be effective in reducing crime, recidivism, and public expenditures. Several practices have been employed in various jurisdictions in improving the link between jails and health care, including suspension (not termination) of Medicaid, implementation of Medicaid enrollment procedures, utilization of health information technology, recovery focused and continuous care, alternatives to incarceration, and stakeholder actions in maximizing ACA potential.

III. Introduction

As the front door to the criminal justice system, jails represent large catchment areas for people with substance use and mental health conditions, infectious diseases, and other chronic health problems. Approximately 9 million adults enter into local jails each year.² Compared to the general population, arrestees have disproportionately high rates of chronic medical conditions³, substance use disorders⁴, serious mental illness⁵, and co-occurring substance use and

¹ Department of Justice (2009 Dec. 1). Addressing Mental Illness in the Criminal Justice System [Web log post]. Retrieved from <http://blogs.justice.gov/main/archives/431>.

² Veysey, B. *The Intersection of Public Health and Public Safety in U.S. Jails: Implications and Opportunities of Federal Health Care Reform*. January 2011.

³ Binswanger IA, Kreuger PM and Steiner JF. "Prevalence of Chronic Medical Conditions Among Jail and Prison Inmates in the USA Compared with the General Population." *Journal of Epidemiological Community Health*, 63(11): 912-919, 2009.

mental health disorders⁶, all of which are usually left untreated and often contribute to recurring criminal behavior.

The delivery of health services in the criminal justice system is often disjointed and sporadic, consisting of an uncoordinated series of events mostly in response to episodes of acute illness. The majority of detainees (90% in one 2008 study⁷) lack private or public health insurance, especially in those states that exclude childless adults from Medicaid eligibility. However, under the ACA, many of these individuals will become eligible for coverage in states that opt into the expansion. If continuous health services — particularly treatment for substance use and mental health disorders — become available for such vulnerable populations, a reduction in criminal behavior and repeated incarcerations associated with such chronic conditions can be expected.⁸ The ACA has potential to produce financial savings for many jurisdictions by reducing incarceration costs and redirecting eligible people from jail into supervised treatment programs.

IV. Research Design and Methodology

- A. **Purpose.** The purpose of this research was to (1) determine challenges that emerge around the challenges in providing substance use and mental health care services to incarcerated populations; and (2) identify how such challenges shed light on what best practices can be implemented to bridge the gap between the criminal justice system and health care system, thereby improving public health, improving public safety, and reducing costs to society.
- B. **Method.** The research design utilized the qualitative research method in addressing the research questions. Interviewing stakeholders was instrumental to this approach. The interviewees were familiar with the processes and procedures involved in criminal justice/healthcare, making it possible to discover ideas and evaluate their feasibility. Each stakeholder was asked about his or her perceptions and observations within his or her specific role. The qualitative methodology was appropriate for this study because exploring the perceptions of individuals with experience in the criminal justice and/or health care system made it possible to obtain multiple perspectives that further our understanding of such systems, how they are related, and how they interact. A list of general topics covered during the interview can be found in Exhibit 10.
- C. **Participants.** Twelve participants were interviewed for this study — a county sheriff; a criminal psychologist; two criminal defense attorneys; a state prosecutor; a county judge; a mental health care provider; a probation officer; a Department of Social and Health Services representative; a representative of a Seattle-based health advocacy nonprofit; a representative of a California-based nonprofit that works with correctional health systems; and an ACLU affiliate located in California.

⁴ Brecht M, Anglin D and Lu T. *Estimating Drug Use Prevalence Among Arrestees Using ADAM Data: An Application of a Logistic Regression Synthetic Estimation Procedure*. Los Angeles: UCLA Integrated Substance Abuse Programs, 2003.

⁵ Steadman HJ, Osher FC, Robbins PC, et al. "Prevalence of Serious Mental Illness Among Jail Inmates." *Psychiatric Services*, 60(6); 761-765, 2009.

⁶ National GAINS Center for People with Co-Occurring Disorders in the Justice System. *The Prevalence of Co-Occurring Mental Illness and Substance Use Disorders in Jails*. Delmar, NY: The National GAINS Center, 2002 (revised 2004).

⁷ Wang EA, White MC, Jamison R, Goldenson J, Estes M and Tulsy JP. "Discharge Planning and Continuity of Health Care: Findings from the San Francisco County Jail." *American Journal of Public Health*, 98(12): 2182-84, 2008.

⁸ Wang E, Homg C, Shavit S, Sanders R, Kessell E and Kushel M, "Engaging Individuals Recently Released from Prison into Primary Care: A Randomized Trial." *American Journal of Public Health* 102, no. 9 (September 2012): 22-29.

- D. **Participant Selection.** Interviewees were selected based on purposive sampling. Each interviewee was selected based on his/her knowledge of and experiences with the health care system and/or the criminal justice system. Their background and experience was suitable in providing data to the research and meaningfully contributing to the understanding and knowledge of the intersection between the health care system and the criminal justice system.
- E. **Instrumentation.** The instrument used to collect data was an interview protocol created by the researcher. The protocol involved questions directly related to the purpose of the study and was designed to explore various perspectives on the research question(s).
- F. **Data Collection.** The data were collected in this study through the use of semi-structured interviews, which were designed to explore the views, experiences, beliefs, and motivations of the individual participants. The interviews consisted of several key questions that defined the areas to be explored, but also allowed the interviewer or interviewee to diverge in order to pursue an idea of response in more detail. This interview format was flexible enough to allow for the discovery or elaboration of information that was important to participants but may not have been pertinent by the researcher, but was also structured enough to provide participants with guidance on the scope of topics to be discussed.
- G. **Ethical Considerations.** Before each interview was conducted, participants were informed about the study details and given assurance about ethical principles, such as anonymity and confidentiality. This gave each respondent an idea of what to expect from the interview, increased the likelihood of honesty and was also a fundamental aspect of the informed consent process. This study was compliant with the U.S. Department of Health and Human Services Code of Federal Regulations, 45 CFR § 46.102. The study was qualified for exempt status in accordance with 45 CFR §46.101. The University of Washington (UW) Institutional Review Board (IRB) reviewed and approved the study as Human Subject Division (HSD) Study #47659. Care was taken to ensure that the participants fully understood the nature of the study and the fact that participation is voluntary. Confidentiality of all recovered data will be maintained at all times, and identification of participants was not made available during or after the study.

V. Jails vs. Prisons — An Important Distinction

Prisons are correctional institutions designated by federal or state law to confine offenders judicially ordered into custody for punishment following a trial or guilty plea. Jails are locally operated short-term correctional facilities that confine accused persons awaiting trial and incarcerate convicted individuals with sentences of up to one year, usually for misdemeanor offenses.⁹ Jails have a stronger connection to communities than do prisons. Due to their local nature and the characteristics of those held in their custody, they are in a unique position to serve as public health outposts.

Jails process 13 million admissions per year, or 9 million unique individuals (many with multiple admissions), compared to the 750,000 admitted annually to prison.¹⁰ They are located in local communities, whereas prisons tend to be situated far away from them. Unlike prison, where

⁹ Freudenberg N. "Jails, Prisons, and the Health of Urban Populations: A Review of the Impact of the Correctional System on Community Health." *Journal of Urban Health*, 78(2):214-235, 2001.

¹⁰ Veysey.

inmates serve sentences of at least one year, most people in jails are released after much shorter sentences (usually days or weeks) back to the communities from which they came.

Only about 4% of jail admissions result in prison sentences.¹¹ In other words, 96% of jail detainees and inmates return directly to the community from jail, along with their often untreated health condition(s). Many detainees are released on bail pending trial after a few hours or days with 64% of the jail population turning over every week.¹² The average stay in jail for a sentenced inmate is three months,¹³ although on any given day, 62% of detainees have not been sentenced.¹⁴ Half of the jail population is confined for a probation or parole violation or bond forfeiture,¹⁵ with only 22% charged with violent crimes.

VI. Health Needs of the Jail Population

Jail inmates have significantly higher rates of health needs compared to the general population. People are generally booked into jail directly from the community, and are often at their worst when they are detained, experiencing a psychiatric crisis and/or active addiction. Some arrive with injuries, some are drunk or high and detox during their stay, and others suffer from acute mental illness. They generally enter and leave jails in poor health, and suffer disproportionately from chronic and other disorders such as diabetes, hypertension, tuberculosis, AIDS, hepatitis C, traumatic brain injury, and serious mental illness.¹⁶

Mental health and substance use disorders are particularly prevalent. It has been found that 80% of detained individuals with a chronic medical condition do not receive treatment prior to arrest.¹⁷ The Department of Justice estimates that rates of serious mental illness are two to four times higher among incarcerated individuals than among members of the general population.¹⁸ While 53% of state prisoners meet any substance abuse or dependence criteria as specified by the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV)¹⁹, alcohol and drug abuse and dependence are more pronounced in jail populations with over two-thirds (68%) of inmates meeting the DSM-IV criteria for substance abuse or dependence.²⁰ Often times, mental illness and substance abuse are co-occurring conditions. It has been reported that among jail-involved men and women with a diagnosed severe mental illness, 72% have a co-occurring substance use disorder.²¹

¹¹ Sabol, WJ, West HC and Cooper M. "Prisoners in 2008." *Bureau of Justice Statistics Bulletin* (NCJ 228417). Washington: U.S. Department of Justice, 2009.

¹² Minton TD. "Jail Inmates at Midyear 2009- Statistical Tables." *Bureau of Justice Statistics Statistical Tables* (NCJ 230122). Washington: US Department of Justice, 2010.

¹³ Camp CG and Camp GM. *The 2000 Corrections Yearbook: Jails*. Middletown, CT: Criminal Justice Institute, 2000.

¹⁴ Minton.

¹⁵ Beck AJ. "The Importance of Successful Reentry to Jail Population Growth." The Urban Institute Jail Reentry Roundtable. Washington, DC, June 27, 2006.

¹⁶ National Commission on Correctional Healthcare. *The Health Status of Soon-to-be-Released Inmates, a Report to Congress*, August 2002, www.ncchc.org/pubs_stbr.html.

¹⁷ *Id.*

¹⁸ US Department of Health and Human Services. *Establishing and Maintaining Medicaid Eligibility upon Release from Public Institutions*, Jul 2010, www.mathematica-mpr.org/publications/PDFs/health/medicaid_eligibility.pdf.

¹⁹ Mumola, CJ, Karberg, JC. *Drug Use and Dependence, State and Federal Prisoners, 2004*. U.S. Department of Justice, Bureau of Justice Statistics; Washington, DC: 2006. Pub. No. NCJ 213530.

²⁰ Karberg, JC, James, DJ. *Substance Dependence, Abuse, and Treatment of Jail Inmates, 2002*. U.S. Department of Justice, Bureau of Justice Statistics; Washington, DC: 2005. Pub. No. NCJ 209588.

²¹ National GAINS Center for People with Co-Occurring Disorders in the Justice System. *The Prevalence of Co-Occurring Mental Illness and Substance Use Disorders in Jails*.

By nature of their health status, this population's health needs are likely to be greater than those of the overall expansion population. The State of Washington has been able to link data between its state funded health insurance and criminal justice programs. The data allow for the identification of the specific behavioral health needs of those with a history of jail involvement.²²

Mental health and substance use needs are substantial. Washington data suggest that 53% of jail-involved, low-income childless adults need mental health treatment, including 20% with serious mental illness, 17% with anxiety disorders, and 25% with indications of depression. Data also suggest that 79% of jail-involved, low-income childless adults need substance abuse treatment, compared to 42% of those with no history of jail involvement. Taken together, these data suggest that the jail-involved subset of the expansion population is likely to include many low-income, non-working adults with a high prevalence of mental illness and substance abuse.

VII. The Medicaid Expansion

- A. **Expansion of Eligibility.** An important provision of the ACA is the option for states to participate in the Medicaid Expansion to cover Americans under age 65 with incomes less than 138% of the federal poverty level (FPL). In 2012, 138% FPL was equivalent to an individual earning \$15,000 per year (about \$25,500 for a family of three).

Justice-involved individuals are a key population that stands to gain from this provision, as most inmates fall below this threshold, making them eligible for Medicaid in expansion states. (One profile of jail inmates found that 60% earned less than 138% FPL and 29% were unemployed at the time of arrest.²³) While the justice system has made efforts to improve connections to health services as part of re-entry planning (especially for those serving longer terms in prison), the ACA has important implications for those incarcerated in jails and detention centers. Of those potentially eligible for Medicaid under the ACA, over one-third (35%) have prior justice involvement. (See Exhibit 1.²⁴)

The ACA requires health insurance, including Medicaid, to cover the following ten essential health benefits²⁵ — (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventative and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. Thus, for the first time, many of those involved with the justice system will have access to comprehensive insurance.

Increasing the availability of health services has the potential to improve health and stabilize behavior, thereby decreasing the risks of (re)arrest and incarceration. It's possible that those entering the justice system could have improved health status, and those leaving could be better connected to care to help maintain stability after release. For example, a Washington State study found that rates of re-arrest were 21-33% lower

²² Anderson N and Gressani I. "MaineCare for Childless Adults Waiver Year 7 Annual Report, October 1, 2008 - September 30, 2009." Cutler Institute of Health & Social Policy, Muskie School of Public Service, University of Southern Maine, 2010.

²³ James DJ. July 2004. US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Special Report: Profile of Jail Inmates*, 2002. NCJ 201932. Available at: <http://bjs.usdoj.gov/content/pub/pdf/pji02.pdf>.

²⁴ Department of Justice, National Institute of Corrections, 2011. Solicitation for a Cooperative Agreement — Evaluating Early Access to Medicaid as a Reentry Strategy. Available at: <http://www.gpo.gov/fdsys/pkg/FR-2011-07-06/html/2011-16844.htm>.

²⁵ ACA, §1302(b)(1).

in groups treated for chemical dependency compared with adults who needed, but did not receive, treatment. This reduction saved the state \$5,000 to \$10,000 for each person treated.²⁶

- B. Financial Implications of Expanding Medicaid.** Recent data from California, which in 2011 spent more than \$8 billion on corrections costs, provides a sense of the savings that states could experience under expanded eligibility.²⁷ The state phased in coverage for non-pregnant adults making less than 133% FPL — a group that included nearly 75% of inmates — before the 2014 expansion. The Department of Corrections and Rehabilitation began enrolling eligible prisoners and claiming federal reimbursements for covered services, which cost the state roughly \$50 million a year. From April 2011 to December 2012, the state was reimbursed \$21 million. By expanding Medicaid eligibility in 2014, California stands to save nearly \$70 million annually due to increased federal matching rates.²⁸

Other states also project significant savings on correctional health care by expanding Medicaid eligibility. In New Hampshire, a study commissioned by the state Department of Health and Human Services estimated that the state Corrections Department would save nearly \$22 million from 2014 to 2020 as a result of expanded Medicaid coverage for inpatient care.²⁹ A study estimating the fiscal and economic effects of expanding Ohio's Medicaid eligibility found that the state correctional system would save \$273 million from fiscal year 2014 to 2022.³⁰ Michigan stands to save roughly \$250 million on inpatient hospital services delivered to prisoners during the first 10 years of implementation, according to the Center for Healthcare Research & Transformation at the University of Michigan.³¹

VIII. Barriers to Providing Health Care Services for Jail Populations

- A. Overview.** The criminal justice and the health care systems present many challenges in providing care for incarcerated populations, especially when it comes to addressing substance use and mental health disorders. These challenges include divergent goals, inadequate funding, lack of insurance, insufficient treatment capacity, inadequate care, lack of system coordination, and lack of resources. Without continuous access to

²⁶ Mancuso D and Felver B. *Providing Chemical Dependence Treatment to Low-Income Adults Results in Significant Public Safety Benefits*. Washington State Department of Social and Health Services, Research and Data Analysis Division. February 2009. Available at: <http://publications.rda.dshs.wa.gov/1372>.

²⁷ U.S. Census Bureau, State Government Finances: 2011, <http://www.census.gov/govs/state/>.

²⁸ Edwards A, Brown R and Brown B, "The 2013-14 Budget: Obtaining Federal Funds for Inmate Medical Care — A Status Report," California Legislative Analyst's Office, February 2013, http://www.lao.ca.gov/analysis/2013/crim_justice/inmate-medical-care-020513.pdf.

²⁹ Governor Maggie Hassan, "Budget Address 2013," February 2013, <http://www.governor.nh.gov/media/speeches/budget-address-2013.htm>. Megan Cole, Randy Haught, and Mengxi Shen, "An Evaluation of the Impact of Medicaid Expansion in New Hampshire: Phase II Report," The Lewin Group, January 2013,

<http://www.dhhs.state.nh.us/ombp/documents/nhmedicaidexpansion-phaseiiireport-v6-551398.pdf>.

³⁰ Amy Rohling McGee et al., "Expanding Medicaid in Ohio: Analysis of Likely Effects," Health Policy Institute of Ohio, The Ohio State University, Regional Economic Models Inc., and the Urban Institute, February 2013, <http://www.urban.org/uploadedpdf/412772-expanding-medicaid-in-ohio-report.pdf>.

³¹ Michigan Governor's Office, "Gov. Snyder signs Healthy Michigan into law, bringing health care to 470,000 Michiganders," September 16, 2013, http://www.michigan.gov/snyder/0,4668,7-277-57577_57657-312514--,00.html. Marianne Udow-Phillips et al., "The ACA's Medicaid Expansion: Michigan Impact," Center for Healthcare Research & Transformation, October 2012, <http://www.chrt.org/assets/price-of-care/CHRT-issue-brief-october-2012.pdf>.

services, individuals become more likely to return to previous behaviors and become reincarcerated.³²

- B. Divergent Goals.** Criminal justice and health care systems are premised on different goals. While the primary goals of the justice system are to protect public safety and reduce recidivism, the primary goals of the health care system are to protect and improve individual and community health. However, a California-based public health non-profit organization involved with serving jail populations draws attention to the idea that these two systems intersect in their goals of providing health services for justice populations and in their mutual objectives of cost containment.³³ Although the justice system is not designed to be a provider of health care, it is often obliged to assume that responsibility, sometimes under the threat of litigation, as case precedent and constitutional safeguards have established the right of people in custody to receive medical care that matches the prevailing quality of care in each medical specialty.
- C. Funding Focused on Consequences Rather Than Prevention.** Money spent on addressing substance use is skewed towards responding to the consequences of substance abuse rather than preventing it. State spending on corrections more than quadrupled between 1998 and 2008³⁴. Currently, only 4 cents of every dollar spent on substance use disorders are allocated to prevention and treatment, while the other 96 cents are spent on the consequences of untreated or inadequately treated disorders, including expenses related to health care; court costs; incarceration; child welfare; domestic violence and child abuse; homelessness; mental illness; and developmental disabilities.³⁵ Consequently, the burden of untreated mental illness is borne by the criminal justice system, as people with mental illnesses are three times more likely to be in jails or prisons rather than in psychiatric hospitals.³⁶
- D. Lack of Insurance.** Few adults who go through jail carry insurance. As noted, one 2008 study found that 90% of inmates lack private or public health insurance, especially in those states that exclude childless adults from Medicaid eligibility.³⁷ Among those who do qualify for Medicaid, many are unnecessarily dropped from coverage while incarcerated due to federal rules and state implementation processes that are not well understood (see Section XI, B for further discussion). Once released, few receive assistance with reinstating their benefits, and without coverage, their substance use or mental health conditions (or both) persist and often contribute to repeated justice system involvement.³⁸

³² Re-entry Policy Council. *How and Why Medicaid Matters for People With Serious Mental Illness Released from Jail: Research Implications*. New York: Justice Center, Criminal Justice and Mental Health Consensus Project, Council of State Governments, 2005.

³³ Telephone interview with California-based non-profit organization.

³⁴ Pew Center on the States. *One in 31: The Long Reach of American Corrections*. Washington: The Pew Charitable Trusts, 2009.

³⁵ The National Center on Addiction and Substance Abuse at Columbia University. *Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets*. New York: The National Center on Addiction and Substance Abuse at Columbia University, 2009.

³⁶ Torrey EF, Kennard AD, Eslinger D, et al. *More Mentally Ill Persons are in Jails and Prisons Than Hospitals: A Survey of the States*. Arlington: Treatment Advocacy Center, National Sheriffs' Association, 2010.

³⁷ Wang E et al.

³⁸ Bazelon Center for Mental Health Law. *For People With Serious Mental Illnesses: Finding the Key to Successful Transition From Jail to the Community - An Explanation of Federal Medicaid and Disability Program Rules*. Washington: Bazelon Center for Mental Health Law, 2009.

E. **Insufficient Treatment Capacity.** It has been found that between 49% and 87% of arrestees tested positive for illicit drugs³⁹ and that 68% of jail detainees meet the clinical criteria for substance abuse or dependence.⁴⁰ About 14.5% of men and 31% of women entering jail have a serious mental illness⁴¹, and among those 72% of both men and women have a co-occurring substance use disorder.⁴² Despite this prevalence of substance use and mental health disorders, few who need treatment actually receive it.⁴³ One study found that detoxification services were only offered by 5% of prisons and 34% of jails, and that medications were only offered by 6% of prisons and 32% of jails.⁴⁴ Thus, if provided to them, detoxification services and pharmacotherapy have the potential to improve offender well-being and decrease risks associated with their conditions. However, the demand for treatment often exceeds availability⁴⁵, resulting in lengthy waiting lists and thwarting the justice system's efforts to mandate participation in treatment. Programs that combine criminal sanctions with treatment rarely reach all eligible individuals, and limited resources to expand interventions has hindered the justice system's efforts to reduce recidivism.⁴⁶

In the past decade, treatment for those under jail supervision has declined while the jail population has grown. The number of people under jail supervision in the United States (including those detained and those released to receive treatment, perform community service, or participate in work release programs) increased 22% from 2000 to 2009 (687,033 to 837,833), while the number of people under jail supervision released to receive drug, alcohol, mental health, and other medical treatment declined by 64% (5,714 to 2,082).⁴⁷

F. **Inadequate Care.** Like other chronic conditions, substance use and mental health disorders require ongoing, long-term treatment. According to a criminal psychiatrist who often works with substance users, most people need at least three months of treatment in order to stop or significantly curtail use, and attaining durable recovery typically involves continuous care over many years.⁴⁸ However, 80% of jail detainees are incarcerated for less than a month⁴⁹, indicating that any care offered in justice settings is acute and insufficient to address chronic conditions. For those who do receive it, treatment in jail may initiate the recovery process, but continued services are necessary in order for that recovery to be sustained. When care for substance use and mental health disorders is absent, inadequate, or interrupted, the conditions persist and result in continued criminal

³⁹ Office of National Drug Control Policy. *ADAM II: 2008 Annual Report*. Washington: Office of National Drug Control Policy, Executive Office of the President, 2009.

⁴⁰ Karberg JC, James DJ. *Substance Dependence, Abuse, and Treatment of Jail Inmates*.

⁴¹ Steadman et al.

⁴² National GAINS Center for People with Co-Occurring Disorders in the Justice System. *The Prevalence of Co-Occurring Mental Illness and Substance Use Disorders in Jails*.

⁴³ National Institute on Drug Abuse. *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide*. Washington: National Institutes of Health Publication No. 00-4180, US Department of Health and Human Services, 2006.

⁴⁴ Oser, CB, H Knudsen, M Staton-Tindell, F Taxman, and C Leukfeld. *Drug and Alcohol Dependence*, 2009 August 1: 1104(Suppl 1): S73-S81.

⁴⁵ Telephone interview with California-based non-profit organization.

⁴⁶ *Id.*

⁴⁷ Minton.

⁴⁸ In-person interview with Boston-area criminal psychiatrist.

⁴⁹ Beck.

activity⁵⁰ and costly emergency department visits⁵¹, thereby making health problems even more difficult and expensive to treat.

G. **Lack of Coordination between Systems.** In addition to clinical treatment, essential elements of recovery include housing, employment, and peer support.⁵² People with criminal records face substantial barriers to housing and employment and encounter difficulties in establishing positive relationships and coping with stigma. There is often a resistance in providing services; lack of system linkage between treatment and vocational, housing, and educational services; and difficulties in engaging families and peers in the recovery process⁵³.

H. **Lack of Resources in Rural Areas.** Many of the challenges described above are exacerbated in small jails, many of which are located in rural areas where health care is limited to screening assessments, medication management, and crisis response⁵⁴. Beyond jail walls, there are few opportunities for pre-trial or post-release treatment due to the dearth of services available. Of the total 13,267 substance abuse treatment facilities in the United States, 91% are located in or adjacent to a metro county⁵⁵, leaving few providers to serve rural areas. Additionally, the proportion of residential and inpatient treatment beds is lower in rural areas (27.9 per 100,000 population) than in metro areas (42.8 per 100,000 population).⁵⁶

The shortage of mental health care is equally pronounced, and the responsibility to provide such care often falls on primary care providers. While the 3,800 rural health clinics in the United States are important providers of primary care, few offer mental health services, and the most commonly treated disorders are less-serious conditions (such as depression, attention deficit hyperactivity/attention deficit disorders, and anxiety).⁵⁷ People must travel great distances to access care, provided that their release terms do not prohibit them from doing so.

I. **The Potential of Health Care Reform.** While the ACA alone will not solve every challenge outlined above, it provides an opportunity to affect change on a broad scale. A Seattle-based non-profit organization that promotes access to health care notes that by facilitating near-universal health coverage, the Act expands access to care, thereby addressing gaps in services and ending the piecemeal use of grant dollars to purchase mental health and substance use treatment services for justice-involved populations.⁵⁸ With appropriate management, this will break the cycle of repeated criminal justice involvement and reduce the country's jail population. Reinvesting saved correctional dollars into health care, education, job training, and housing could revitalize this population. In order to achieve these outcomes and maximize the ACA's potential,

⁵⁰ In-person interview with Boston-area criminal psychiatrist.

⁵¹ Owens P, Mutter R and Stocks C. *Mental Health and Substance Abuse-Related Emergency Department Visits Among Adults*, 2007. Rockville, MD: Healthcare Cost and Utilization Project, Agency for Healthcare Research and Quality, 2010.

⁵² In-person interview with Boston-area criminal psychiatrist.

⁵³ *Id.*

⁵⁴ Ruddell R and Mays L. "Rural Jails: Problematic Inmates, Overcrowded Cells, and Cash-Strapped Counties." *Journal of Criminal Justice*, 35(3): 251-260, May/June 2007.

⁵⁵ Lenardson J and Gale JA. *Distribution of Substance Abuse Treatment Facilities Across the Rural - Urban Continuum*. Portland, ME: Maine Rural Health Research Center, Muskie School of Public Service, 2008.

⁵⁶ *Id.*

⁵⁷ Gale JA, Shaw B, Hartley D, et al. *The Provision of Mental Health Services by Rural Health Clinics*. Portland, ME: Maine Rural Health Research Center, Muskie School of Public Service, 2010.

⁵⁸ In-person interview with Seattle-based non-profit organization.

jurisdictions may need to begin implementing practices to provide health services for jail-involved populations.

IX. A Need for Cross-System Collaboration

A. **Overview.** Managing jail-involved members of the expansion population requires collaboration across many systems, particularly criminal justice and Medicaid. According to the non-profit in Seattle, collaboration should begin with outreach and enrollment of eligible beneficiaries. Jails should partner with state Medicaid agencies to facilitate the enrollment of eligible individuals upon release. Streamlining data between Medicaid and jails would enable timely integration of those exiting the justice system into Medicaid enrollment by simplifying communication between the two systems.

Once eligible beneficiaries are enrolled, further collaboration may be needed to (1) ensure early identification of medical, mental health, and substance use treatment needs; (2) connect individuals to appropriate services; and (3) allow monitoring and follow-up. According to a Washington State Department of Social and Health Services (DSHS) representative⁵⁹, a comprehensive approach is one that involves providing crisis intervention services; physical, mental health, and substance use assessments; referrals and treatment plans; and case coordination and status updates to justice partners. This approach is already occurring in four states — New Jersey, New York, Pennsylvania, and Washington.⁶⁰

1. All four states have created cross-system task groups aimed at fostering improved coordination of services for this population.
2. In three states, criminal justice officials work closely with local welfare and Medicaid agencies to ensure expedited (re)enrollment for eligible individuals upon release from jail.
3. One state has begun an initiative under which criminal justice officials work with the state Medicaid agency to fund a recovery-oriented substance abuse management program.
4. Two states have launched initiatives to provide services (funded by the criminal justice system) upon release from jail to individuals identified as frequent users of emergency room services.

These examples highlight factors to consider in promoting effective, cross-system collaboration, including the identification of priority populations, coordinated efforts to facilitate (and maintain) Medicaid enrollment, early identification of health needs, and cross-system accountability. As illustrated herein, agencies can look to best practices to begin building these relationships and building a foundation for system coordination.

B. **Rationale(s) in Favor of Medicaid.** As shown in Exhibit 2, the potential medical and justice system cost offsets make a compelling argument for reaching out to newly eligible jail-involved childless adults.

1. *Financial Incentives to Encourage Prevention.* Prior to health reform, states that expanded coverage to childless adults had done so through state-only funded initiatives such as General Assistance (GA) programs, under which they were financially incentivized to encourage GA beneficiaries to apply for federal disability

⁵⁹ In-person interview with a representative from the Washington State Department of Social and Health Services.

⁶⁰ *Id.*

or SSI status to allow them to transition from wholly state-funded coverage to Medicaid coverage at standard federal matching rates. Under the ACA, with childless adults eligible for enhanced federal matching rates (beginning with 100% federal match and decreasing down to 90% by 2020) states are now incentivized to prevent the escalation of chronic conditions that might otherwise lead to disability. After 2014, if expansion beneficiaries become eligible for SSI, states will lose the enhanced federal match. Exhibit 2 illustrates the incentives under health reform, suggesting a 10:1 financial advantage to states to prevent the attainment of disability status among newly covered, childless adults. Applied to large numbers of beneficiaries, the incentives to invest in prevention become powerful. Extending on the example below, preventing 1,000 childless adults from reaching disability status would result in almost \$5.5 million in annual savings to the state.

2. *Medical Cost Offsets from Treatment.* A study in Washington State found that substance abuse treatment reduced emergency room costs by 35%.⁶¹ This reduction alone, \$154 per member per month (PMPM), almost completely offset the \$162 PMPM average substance abuse treatment cost. Furthermore, emergency room visits often lead to expensive hospitalizations, suggesting additional cost savings. Consistent with these findings, a subsequent study found that receipt of substance abuse treatment among GA beneficiaries was associated with significant overall medical cost savings — about \$2,500 annually per person treated.⁶² These findings confirm that access to treatment can prevent the escalation of other health conditions, as well as prevent behaviors that can lead to expensive health service utilization (e.g., emergency room visits).

C. **Rationale(s) in Favor of the Justice System.** The financial benefits of providing low-income adults with access to treatment extends to the justice system.

1. *Reduced Rates of Re-Arrest.* Studies have shown significantly reduced risks of arrest following receipt of treatment.⁶³ Rates of arrest are 21% to 33% lower compared to adults who require, but do not receive treatment.⁶⁴ Such reductions are associated with financial savings to law enforcement, jail, court, and state corrections ranging from \$5,000 to \$10,000 per person treated.⁶⁵
2. *Reduction in Jail Expenditures.* Inadequate funding has long been a barrier to health care for jail populations. The expansion of health insurance will largely displace funding barriers and increase the number of opportunities for diversion and interventions at each point in the criminal justice process. Jurisdictions will be able to work with community providers to increase access to treatment, bring to full scale any programs already in place, and adopt other proven models. Based on the success of

⁶¹ Nordlund DJ, Mancuso D and Felver B. *Chemical Dependency Treatment Reduces Emergency Room Costs and Visits.* Washington State Department of Social and Health Services, Research and Data Analysis Division. July 2004. Available at: <http://publications.rda.dshs.wa.gov/887>.

⁶² Wickizer TM, Krupski A, Stark KD, et al. *The Effect of Substance Abuse Treatment on Medicaid Expenditures among General Assistance Welfare Clients in Washington State.* *Milbank Quarterly*, 84(3), 555-576, 2006.

⁶³ Shah MF, Mancusco D, Yakup S and Felver B. *The Persistent Benefits of Providing Chemical Dependency Treatment to Low-Income Adults.* Washington State Department of Social Health and Human Services, Research and Data Analysis Division, November 2009. <http://publications.rda.dshs.wa.gov/1397/>.

⁶⁴ Mancuso D and Felver B.

⁶⁵ *Id.*

such interventions, the result will likely be a reduction in repeat incarcerations and their associated costs.

To illustrate, consider a medium-sized county jail with a 500-bed capacity that houses at least 13,000 people annually.⁶⁶ Given that the majority of jail populations are substance-involved (two-thirds of detainees report using drugs regularly⁶⁷), in a jail that admits 13,000 people in a year, potentially 8,580 detainees with substance use conditions would need some level of treatment.⁶⁸ Those who also are eligible for a criminal justice risk assessment (i.e., those charged with nonviolent offenses) could participate in conditional release with treatment.

Similarly, research suggests that on average 14.5% (1,855 detainees in this example) have psychiatric disorders that require treatment.⁶⁹ To illustrate, consider a mid-size county already has programs in place, such as a 50-bed substance use treatment program that serves up to 600 detainees per year and an expedited release program for people with psychiatric disorders that serves 500 people per year.⁷⁰ Directing more arrestees into supervised release with the condition of treatment would reduce the county's annual costs for incarceration. A reduction in the number of detainees in jail by just 10% could save this mid-size county more than \$1 million in incarceration costs per year.⁷¹

D. Rationale(s) in Favor of Public Health.

1. *The "Cost" of Treatment.* The cost of treating substance abuse (including prevention and research) is estimated to be a fraction (\$15.8 billion annually) of that compared to the overall cost of substance abuse to society (\$180.9 billion).⁷² Data collected over a 9-month period in 2001 from thirteen counties in California established that substance abuse treatment costs \$1,583 per person on average and is associated with a monetary benefit to society of 11,487 per person on average, representing a greater than 7:1 ratio of benefits to costs. These benefits were primarily in the form of crime reduction and increased employment earnings, suggesting that even without considering the direct value to society of improved health and quality of life, that allocating tax dollars to substance abuse treatment may be a wise thing to do. The study also found an increase in income for those who completed treatment, with \$3,352 per patient on average⁷³, meaning that those who completed treatment had improved health status, which allowed to them become contributing members to society.
2. *Costs Related to Recidivism.* Improving access to health services — particularly in regards to substance use and mental health — for justice-involved individuals can improve public safety and lead to cost savings. Washington State studied the impact

⁶⁶ Assuming that the average length of stay is 14 days: 500 jail beds x 26 time periods/year = 13,000.

⁶⁷ James DJ. *Profile of Jail Inmates, 2002*. Washington: Bureau of Justice Statistics, Office of Justice Programs, US Department of Justice, 2004.

⁶⁸ 13,000 x 66 percent = 8,580.

⁶⁹ Steadman et al.

⁷⁰ Assuming that the average treatment stay is 30 days: 50 treatment beds x 12 time periods/year = 600.

⁷¹ 10% of the population needing intervention (8,580 + 1,885) x 10% = 1,046 x 14 days x \$75/day in jail = \$1,098,300.

⁷² Office of National Drug Control Policy. *The Economic Costs of Drug Abuse in the United States, 1992-2002*. US Executive Office of the President; Washington, DC: 2004. NIDA.

⁷³ Ettner SL, Huang D et al. "Benefit-cost in the California treatment outcome project: does substance abuse treatment 'pay for itself'?" *Health Services Research* 41(1):192-213.

of extending chemical dependency treatment to low-income individuals (a group more frequently justice-involved than higher income groups) and found the average medical cost savings to be \$2,500 annually per person treated⁷⁴; reductions in arrest rates ranging from 17% to 33%^{75, 76}; an additional estimated savings of \$5,000 to \$10,000 per person treated for law enforcement, jails, courts, and state corrections agencies, all from reductions in crime⁷⁷; and an increase of \$2,000 in annual income for people who received treatment⁷⁸. In addition, according to the National Institute on Drug Abuse (NIDA), every dollar spent on treatment programs is associated with an estimated \$4 to \$7 reduction in the cost of drug-related crimes. With outpatient programs, total savings can exceed costs by a ratio of 12:1.⁷⁹

X. Current Practices in Linking Jails and Health Care — A Literature Review

- A. **Overview.** Several federal agencies, including the National Institute on Drug Abuse (NIDA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Institute of Corrections (NIC), have articulated evidence-based practices in delivering services to justice involved populations with substance use and mental health conditions. These practices illustrate how jail-based intervention can take many forms, including redirection into health services at the time of arrest (whereby police take people with mental illness and/or substance use issues to hospitals rather than jail); conditional release from jail (whereby detainees are stabilized at the jail and released to mental health providers); and pre-trial intervention for low-level drug offenders (whereby the prosecutor sets standards allowing certain defendants to be redirected to drug education courses). (See Exhibit 4.) While it can be argued that such types of jail based intervention would exacerbate issues of over crowdedness in hospitals, it is also important to note that correctional facilities are also experiencing over crowdedness. However, over crowdedness will remain an area of tension until the underlying issue (i.e. treatment) is resolved. Since hospitals are better equipped and more qualified to tend to health issues, it would be more effective to leave treatment to them, since treatment is more likely to be successful in the healthcare setting, rather than the correctional setting.
- B. **SAMHSA.** The agency responsible for reducing the impact of substance use and mental illness on communities released a publication (*Treatment Improvement Protocol 44: Substance Abuse Treatment for Adults in the Criminal Justice System*) with information on clinical services for people involved in criminal justice settings. It is intended for use by treatment providers who supervise justice-involved clients and the justice system workforce that comes into contact with people with substance use conditions. SAMHSA has also compiled a *National Registry of Evidence-Based Programs and Practices*, which includes more than 160 proven interventions in the treatment and prevention of psychiatric and substance use disorders, and their co-occurrence.

⁷⁴ Wickizer TM et al.

⁷⁵ Shah MF et al.

⁷⁶ Mancuso D and Felver B.

⁷⁷ *Id.*

⁷⁸ Shah MF et al.

⁷⁹ National Institute on Drug Abuse. *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide*.

- C. **NIC.** NIC has also published evidence-based practices to reduce recidivism, a guide intended for state judiciaries⁸⁰, and has released guidelines for implementing evidence-based policy and practice in community corrections.⁸¹ Additionally, SAMHSA’s National GAINS Center, in coordination with the Center for Mental Health Services, has identified six evidence-based practices for mental health treatment with can be applied to criminal justice settings.⁸²
- D. **NIDA.** To illustrate how local jurisdictions can incorporate health reform into their agendas, the agency in charge of bringing forth the latest science in preventing and treating drug use has detailed 13 evidence-based principles of drug treatment specifically for criminal justice populations. (See Exhibit 3.) These principles provide a framework for addressing the nexus between substance use disorders and justice involvement. For example, given that addiction is a disease requiring long-term treatment (Principles 1-3, 9), the health care responses should be similar to those for other chronic conditions. Additionally, since providers are not traditionally concerned with criminal sanctions, patient accountability is an important component of recovery (Principles 7-8). The same concept can be applied to medication-assisted treatment. Whereas medication in a traditional medical setting may involve periodic drug testing, medication in a criminal justice setting may need to be paired with frequent and random drug testing to ensure compliance with justice mandates (Principle 12).

XI. Best Practices in Establishing Connectivity Between Jails and Health Care

- A. **Overview.** State and local jurisdictions can leverage the ACA to implement and expand interventions that have already been shown to be effective in reducing crime, recidivism, and public expenditures. The following practices provide guidance for policymakers and health care providers interested in improving the link between jails and health care.
- B. **Suspension (Not Termination) of Medicaid.** To obtain health services, released inmates need timely access to health coverage. While federal law prohibits the use of federal funds (i.e. Medicaid payments) for “care or services” for any inmate in a correctional facility⁸³, states are permitted to employ administrative measures including temporarily suspending an individual from payment status during the period of incarceration to ensure Medicaid claims are not filed.⁸⁴ Although states traditionally terminated Medicaid benefits upon incarceration to eliminate the possibility of incorrect billing, they are not required to do so⁸⁵, and in fact have no authority under Medicaid law to drop inmates from eligibility upon incarceration.⁸⁶

⁸⁰ Warren RK. *Evidence-Based Practice to Reduce Recidivism: Implications for State Judiciaries*. Washington: The Crime and Justice Institute and the National Institute of Corrections, 2007.

⁸¹ Crime and Justice Institute at Community Resources for Justice. *Implementing Evidence-Based Policy and Practice in Community Corrections, 2nd ed.* Washington: National Institute of Corrections, 2009.

⁸² The Center for Mental Health Services’ National GAINS Center. “EBPS,” 2010, www.gainscenter.samhsa.gov/html/ebps/default.

⁸³ The Medicaid statute precludes payment of federal matching funds to pay for services for an individual who is “an inmate of a public institution (except as a patient in a medical institution).” 42 U.S. C. § 1396d(a)(27)(A); 42 C.F.R. § 435.1008. A correctional facility is a “public institution” for purposes of this prohibition. 42 C.F.R. § 10009.

⁸⁴ Letter from Donna E. Shalala, Secretary of Health and Human Services to Honorable Charles E. Rangel, House of Representatives (April 5, 2000).

⁸⁵ *Id.* Memorandum from the Director, Disabled and Elderly Health Programs Groups, Center for Medicare and Medicaid Operations, to All Associate Regional Administrative Divisions for Medicaid and State Operations, “Clarification of Medicaid Cover-

According to the non-profit in Seattle, suspension, rather than termination, of benefits avoids inappropriate billing to the federal government and eases reentry to coverage upon release. However, implementation of such a policy requires interagency cooperation and communication. For example, some states establish memorandums of understanding or significant liaison between departments of health and corrections or other involved state agencies.

Several program evaluations have revealed the benefits of access to health care during periods of transition. One study found that enrollment in Medicaid upon release from corrections facilities contributed to reduced recidivism; inmates enrolled in Medicaid on the day of release (compared to inmates not enrolled in Medicaid on the day of release) committed fewer repeat offenses, and the time between offenses was longer.⁸⁷ This research also lends support to the practice of pre-release re-enrollment, because merely having Medicaid benefits on the day of release demonstrated improved results. A Virginia analysis emphasizes this point, suggesting no practical difference between suspension and termination because individuals are subject to eligibility review after any change in personal circumstances, which includes incarceration or release.⁸⁸

Suspending benefits also allows the state to reinstate benefits when a detainee is released, providing continuity of access to care that otherwise would not be available to most releasees. As recently as 1999, no states used this approach, and all simply terminated Medicaid benefits upon incarceration.⁸⁹ Since then, however, letters from the Centers for Medicare and Medicaid Services (CMS) have clarified federal policy and encouraged state action. In 2001, then-Secretary of the US Department of Health and Human Services Tommy Thompson stated that federal rules do not require termination of benefits, but merely preclude federal financial participation.⁹⁰ CMS has also stated that matched funding can be used to implement and operate Medicaid suspension programs⁹¹ and help inmates apply, pre-release, for benefits upon re-entry.⁹²

Some states have implemented requirements to protect short-term inmates. Oregon's Interim Incarceration Disenrollment Policy prohibits disenrollment from a

age Policy for Inmates of a Public Institution," Health Care Financing Administration, Department of Health and Human Services (December 12, 1997).

⁸⁶ Moreover, a state may not terminate anyone from Medicaid without first determining whether the individual qualifies under other Medicaid-eligibility categories. See 42 C.F.R. § 435.930(b) (states must "continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible.").

⁸⁷ Morissey J, *Medicaid Benefits and Recidivism of Mentally Ill Persons Released From Jail* (Washington, D.C.: Department of Justice, 2006). Available at: <http://ncjrs.gov/pdffiles1/nij/grants/214169.pdf>.

⁸⁸ Department of Medical Assistance Services, *Suspension vs. Termination of Medicaid for Individuals in Public Institutions* (Richmond, Va.: Department of Medical Assistance Services, 2006); <http://legis.state.va.us/jchc/BHC9.14.06Suspension.pdf>.

⁸⁹ Koyanagi C, *A Better Life — a Safer Community: Helping Inmates Access Federal Benefits* (Washington, D.C.: Bazelon Center for Mental Health Law, 2003), 9.

⁹⁰ Thompson T, Letter to the Honorable Charles Rangel. (Washington, D.C.: Department of Health and Human Services, Office of the Secretary, 2001); <http://www.lac.org/toolkits/medicaid/Tommy%20Thompson%20letter.pdf>.

⁹¹ Arden G, Letter to Nancy Atkins, Chair of the Executive Committee of the National Association of State Medicaid Directors; http://www.nasmd.org/SMD_letters/docs/inmate.pdf.

⁹² Koyanagi C, *A Better Life - a Safer Community: Helping Inmates Access Federal Benefits*, 10.

health plan for the first 14 days of incarceration.⁹³ Similarly, Texas and Washington do not disenroll individuals during the first 30 days of incarceration.⁹⁴

C. **Implementation of Medicaid Enrollment Procedures.** Despite its potential for improving access to care, suspending benefits offers no solution for individuals who are unenrolled or ineligible due to several barriers to Medicaid enrollment.

1. *Lack of Proper Identification.* At the time of arrest, many people do not have with them the necessary identification and documentation. Additionally, Medicaid enrollment will need to be simplified and expedited, as many detainees have substance use and psychiatric disorders that may interfere with their ability to make positive choices toward recovery. For detainees, unfamiliar enrollment and eligibility procedures also present challenges to engaging in health services. According to the Seattle non-profit, state Medicaid and insurance directors play a critical role in reducing such barriers to coverage, as they are the ones who determine the enrollment processes and procedures.
2. *Lack of Awareness.* A 2010 Kaiser Family Foundation survey of states with expanded Medicaid programs found that lack of awareness among the newly eligible population and difficulty communicating with them through conventional public messaging strategies presented a barrier to enrollment.⁹⁵ The survey described outreach methods to address these challenges, including the utilization of primary and specialty community health providers at enrollment sites. The evaluation also identified subgroups of eligible people who did not enroll in publicly funded plans or were only episodically insured, and found that the lack of enrollment was due to a failure to complete the enrollment forms, a problem that escalated as the number of people with substance use disorders increased. Repeated incarceration exacerbated the situation, as Medicaid eligibility ceased during confinement and a cumbersome re-enrollment process was required following release.⁹⁶ The justice system can be an active partner in enrollment. The Seattle non-profit suggests that to enroll new Medicaid patients, jail personnel may be assigned to handle enrollment, or the jail may contract with community providers to handle it. After the District of Columbia expanded health care to include childless adults, the jail system developed a protocol with the District Medicaid authority by which all detainees are automatically enrolled during detention, and receive Medicaid cards with their personal property on release⁹⁷, enabling access to continuous care.
3. *Utilization of Enrollment Technology.* The utilization of electronic enrollment technology also should be explored. One option would be to link the jail's data system with the state Medicaid and insurance enrollment data systems. This would

⁹³ See, for example, Council of State Governments, Interim Incarceration Disenrollment Policy (New York, N.Y.: CSG Justice Center, Reentry Policy Council, January 2005); <http://www.reentrypolicy.org/Report/PartII/ChapterII-A/PolicyStatement8/Recommendation8-K>.

⁹⁴ Eiken S and Galantowicz S, "Improving Medicaid access for people experiencing chronic homelessness: State examples," *MEDStat* (2004): 11-12; <http://www.cms.hhs.gov/homelessnessinitiative/downloads/improvingmedicaidaccess.pdf>.

⁹⁵ Kaiser Commission on Medicaid and the Uninsured. *Expanding Medicaid to Low Income Childless Adults Under Health Reform: Key Lessons from State Experiences*. Washington: Henry J. Kaiser Family Foundation, 2010.

⁹⁶ National Association of State Alcohol and Drug Abuse Directors. *The Effects of Health Care Reform on Access to, and Funding of, Substance Abuse Services in Maine, Massachusetts, and Vermont*. Washington: The National Association of State Alcohol and Drug Abuse Directors, 2010.

⁹⁷ Telephone interview with former Virginia criminal defense attorney.

(1) identify detainees who are not currently enrolled in Medicaid or insurance, and (2) automatically enroll them while in jail, so they leave with a valid Medicaid card. According to a former criminal defense attorney, pursuit of this option should be explored with state Medicaid authorities, and should include recommendations on how to streamline procedures in an expeditious and simplistic manner.⁹⁸

D. **Utilization of Health Information Technology.** Although part of the health care community, jails have historically not been recognized as health care providers, and have functioned as islands outside the network of health care delivery. As a result, they tend to be left out of health policy decisions, even though they serve as a critical safety net for high-need, high-cost populations. In improving re-entry processes, jurisdictions are beginning to recognize the link between successful re-entry and better jail health care that correlates with health care in the community. They have begun implementing electronic health record (EHR) systems to replace paper-based systems and are considering ways to connect with community providers through options such as health information exchanges (HIEs). The following highlight important considerations in establishing such connectivity and bridging agency divides.

1. *Data Integration.* Outside jail walls, when people receive care in an emergency room or with a provider, their medical histories are captured by EHRs and integrated into HIEs.⁹⁹ However, the care individuals receive in jail remains in a black box if it is not connected with the care they receive in the community. Integrating data across Medicaid, medical, and criminal justice agencies is important to sustaining a shared agenda. Linking databases allows for the tracking of individuals across systems, which can help policymakers evaluate the impact that each system has on others, align incentives, and appropriately marshal resources for mutual benefit.

Data integration would also help with eligibility determination and enrollment, early identification of treatment needs, and increased access to services. The jail-involved population is part of the broader community population and their health substantially impacts the health and safety of the public at large. If jails cannot share data with the community or access data from the community a critical piece of the health care continuum remains broken and efforts to improve public health fall short. The sharing of data will make that continuum whole and bridge the gap between jails and their communities and ensure that the involvement made in the health care of jail-involved populations is not lost simply due to the inaccessibility of data.

Based on discussions with a health care provider from the New York City Department of Health and Mental Health (DOHMH), there are three systems that collect and communicate health care data regarding detainees¹⁰⁰: (1) jail management systems; (2) jail health systems; and (3) community health systems. (See Exhibit 5.) Ideally, all three systems would seamlessly communicate, but this ideal is difficult to achieve, as they are complex systems with multiple sub-systems that sometimes operate independently of each other and fail to communicate. New York City has taken an innovative approach to the administration of health care provided within the jail system different from that in other jurisdictions across the country by

⁹⁸ *Id.*

⁹⁹ Telephone interview with a health care provider from the New York City Department of Health and Mental Health.

¹⁰⁰ Telephone interview with a health care provider from the New York City Department of Health and Mental Health.

implementing the Primary Care Information Project (PCIP). The Project is administered by the DOHMH, which manages all aspects of health care within the jail system, while the Department of Corrections (DOC) supervises the rest of the jail system. The Project aims to improve population health in disadvantaged communities through HIT. Specifically, the program supports the adoption and use of EHR systems among primary care providers in City's underserved communities.¹⁰¹ This means that the same government agency that oversees health care for the community at large also oversees health care for the jail-involved population. The jail population is considered part of — not separate from — the general population, and the health of both is considered linked.

2. *Privacy Considerations.* Federal law prohibits the sharing of information related to substance abuse without consent, except in the case of medical emergency.¹⁰² While invaluable for protecting individual rights to privacy, this regulation restricts the ability of individual agencies or organizations to share information for the purposes of early identification, outreach, and enrollment in treatment/care programs. Regulation that extends the ability to share information related to substance abuse treatment across the various entities imbued with health care responsibility would facilitate engagement and recovery.

- E. **Recovery-Focused, Continuous Care.** A recovery-focused system of care supports long-term, durable recovery (not just cessation of use) and includes extensive support, both formal and informal.¹⁰³ Ideally, this approach would incorporate the essential elements of recovery while balancing the sanctions and rewards of the justice system, thereby promoting recovery and striving for a reduction in offending behavior.¹⁰⁴ The system would also need to involve the communities into which arrestees ultimately will be able to thrive without returning to criminal behavior.

First, policymakers must create a system that allows for coordinated care and supervision, as a recovery-focused approach follows individuals from the institution into the community. The ACA allows for a shift in framework from one that focuses on acute treatment to one that focuses on chronic disease management, by supporting investments into community health teams to manage chronic disease.¹⁰⁵ Under this approach, community partners can collaborate to create a system that incorporates the elements of continuity of care. (See Exhibit 6.) The justice system can initiate such participation by making it a condition of release.

However, if treatment is required as a condition of release, other challenges emerge, such as the need for a standardized process for conducting assessments, making referrals to treatment, developing treatment plans, and meeting medical standards. Timely compliance and progress reports must be delivered to ensure adherence to justice mandates. A shared, uniform understanding of both clinical needs and justice oversight requirements and processes would also be necessary. Intervention strategies must be

¹⁰¹ *Id.*

¹⁰² 42 CFR Part 2, www.access.gpo.gov/nara/cfr/waisidx_02/42cfr2_02.html.

¹⁰³ In-person interview with Boston-area criminal psychiatrist.

¹⁰⁴ Heaps MM, Lurigio AJ, Rodriguez P, et al. "Recovery-Oriented Care for Drug-Abusing Offenders." *Addiction Science and Clinical Practice*, 5(1):31-36, 2009.

¹⁰⁵ *Health Disparities and the Affordable Care Act*. Washington: US Department of Health & Human Services, www.healthcare.gov/law/infocus/disparities/index.html.

based on rehabilitation needs as well as public safety implications. Sharing goals of rehabilitation, reductions in recidivism, and cost-savings can help keep such approaches on track and well-coordinated.

Second, communities must strengthen their support of re-entry and recovery. A core concept of recovery is that it happens in the context of the community, where people live, work, and engage in social relationships.¹⁰⁶ To facilitate durable recovery for jail populations, communities must have the capacity to support people's ability to live in healthful ways without returning to the justice system. This can only happen if interventions are designed as partnerships that involve collaboration among providers of treatment, housing, and employment¹⁰⁷, and if positive peer support and community engagement are made available.¹⁰⁸

- F. **Alternatives to Incarceration.** The ACA presents an opportunity to reduce reliance on incarceration for health problems and social ills and shift toward a health-centered approach to substance use and mental health. An ACLU affiliate in California, which advocates for policies to enhance public safety and reduce unnecessary incarceration, has recognized that the Medicaid expansion serves as a powerful tool in reducing the number of incarcerated individuals, especially when substance use or mental health issues are involved, by directing them to health services.¹⁰⁹ The organization works with law enforcement agencies, health care providers, and community stakeholders to establish systems of health care enrollment for justice-involved populations, increase access to care, and reduce the number of people going to jail for substance use and mental health-related offenses. They have identified opportunities at many stages in the criminal justice process where individuals can access health services in lieu of incarceration.¹¹⁰ (See Exhibit 7.)
- G. **Stakeholder Actions in Maximizing ACA Potential.** Redirecting individuals from jail into community-based care can improve the health and justice status of millions of individuals passing through the country's jails each year. The successful unfolding of any type of reform depends on the strength of leadership within state and county governments, state and local justice professionals, health care providers, and other partners. (See Exhibit 8.)
1. *State and Local Governments.* State and local governments are uniquely positioned to address the challenges of corrections systems, and have much at stake in the new health care environment. While they could substantially benefit from reduced incarceration costs, they could also bear the burden of increased jail medical costs. Furthermore, they face the primary risk of litigation stemming from inadequate provision of health services. As the primary funding mechanism for their criminal justice system, hospitals, and clinics, they play a pivotal role in influencing the planning process. Officials must assure that correctional systems maximize (1)

¹⁰⁶ Center for Substance Abuse Treatment. "Working Definition of Recovery." Presented at the National Summit on Recovery Conference, Washington, DC, Sept 28-29, 2005.

¹⁰⁷ Solomon AL, Osborne JWL, LoBuglio SF, et al. *Life After Lockup: Improving Re-entry From Jail to the Community*. Washington: Urban Institute Justice Policy Center, 2008.

¹⁰⁸ Center for Substance Abuse Treatment. "Working Definition of Recovery."

¹⁰⁹ Telephone interview with a California ACLU affiliate.

¹¹⁰ *Affordable Care Act: Building Healthy and Safe Communities, A Primer for Advocates*. San Diego: American Civil Liberties Union, San Diego & Imperial Counties, 2014. Available at: <http://cdn.aclusandiego.org/wp-content/uploads/2014/04/Toolkit-ACA+-CJ-web-final.pdf>

redirection of arrestees into community supervision and treatment programs, and (2) linkage to re-entry programs to facilitate reductions in recidivism. The challenge is to design a system that ensures improved, coordinated care in the least restrictive setting that is protective of public safety.

2. *Criminal Justice Officials*. In many jurisdictions, sheriffs, judges, and other criminal justice leaders have formed stakeholder groups to build substance use and mental health interventions to reduce recidivism and public expenditures.¹¹¹ Over the past 30 years, these coalitions have initiated and sustained diversion and intervention programs throughout the justice system. (See Exhibit 9.) Because judges and jail officials are responsible for making decisions that have broad public safety and clinical implications, they have the potential to drive engagement and retention in continuous, integrated care in community settings.

XII. Conclusion

The Medicaid expansion is a significant change that extends access to health insurance to many of those involved with the justice system. The recommendations in this paper are intended to increase awareness about the needs of a vulnerable group, maximize outreach and Medicaid enrollment, and identify opportunities where stronger connections to care are possible. While a wide range of changes prompted by the ACA focus on mainstream populations, it is important that the health needs of traditionally underserved, high needs groups are also included in planning efforts to maximize the potential for better health.

People who suffer from severe mental illness incur a significant cost and care burden on the justice system, as so many of them continually cycle in and out of the nation's jails.¹¹² Many lack basic health coverage and there is often a dearth of community alternatives. As a result, jails have become de facto mental institutions, a role they are unfairly tasked with and ill-suited to tackle.¹¹³ Many of the nation's largest jails, such as those in Los Angeles and New York, also operate the nation's largest psychiatric inpatient hospitals.¹¹⁴ The lack of collaboration between community and correctional health systems exacerbates the problem and allows these complex, high-needs individuals to drain resources on both ends.

Under the ACA, parity for mental health and substance use disorder treatments means that for the first time, many individuals will be covered for these services. The high level of jail involvement anticipated among newly eligible Medicaid populations and high rates of substance use within this subset demands collaboration between jail systems and Medicaid agencies to (1) facilitate enrollment for those who are eligible; (2) enable early identification of treatment needs; (3) connect beneficiaries to appropriate services; (4) allow for cross-system monitoring, follow-up, and accountability; and (5) provide the necessary continuity of coverage and care.

If jails continue to be used to warehouse people with mental illnesses, the judicial system is burdened, the public health system is burdened, the law enforcement offices are burdened, and taxpayers are burdened. With cost savings as a key driver, health care services should be protective of the public's safety and be delivered in the most cost-effective manner. They must be coordinated between correctional systems and health care providers. Justice system

¹¹¹ Berman G and Feinblatt J. "Problem-Solving Courts: A Brief Primer," *Law & Policy*, 23(2):125-140, 2001.

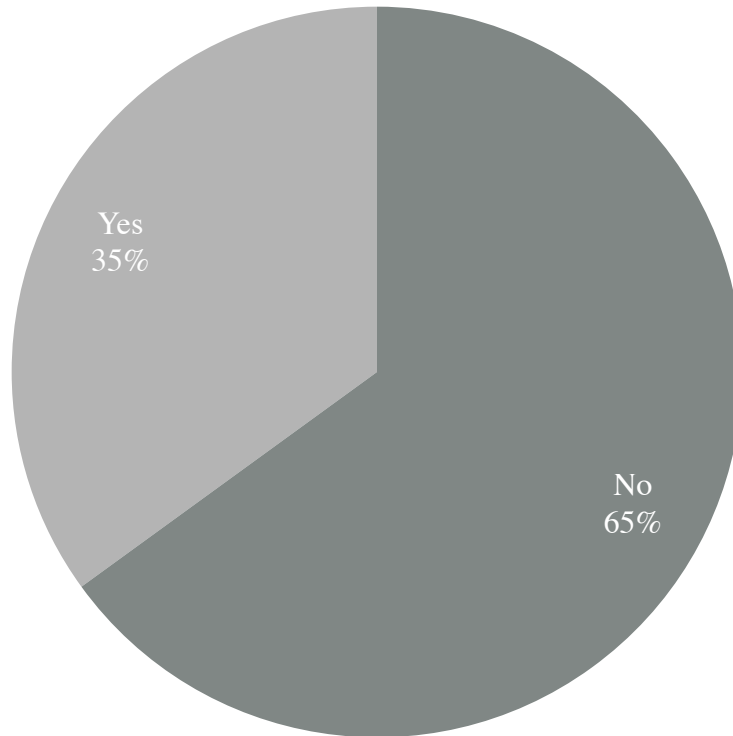
¹¹² Department of Justice: Survey of Inmates in Local Jails. Inmate Mental Illness. National Institute of Mental Health, 2002. <http://www.nimh.nih.gov/statistics/1DOJ.shtml>.

¹¹³ Torrey EF. "Jails and Prisons: America's New Mental Hospitals." *American Journal of Public Health*, 85(1): 1611-13, 1995.

¹¹⁴ Freudenberg.

administrators and health providers must collaborate to influence ACA implementation and advocate for reforms that address long-term health needs. Success in implementing health reform has the potential to result in reduced crime, recidivism, and expenditures as well as healthier and safer communities nationwide.

Exhibit 1. How many of the newly Medicaid eligible have prior justice involvement?



Source: Department of Justice, National Institute of Corrections, 2011. (Note: the total number of people newly eligible in this graph was based on earlier an earlier estimate of 16 million.)

Exhibit 2. Example of Financial Incentives to States Post Health Reform

Eligibility Group	Average Expenditure Per Member Per Month (PMPM)	Federal Matching Rate	State Share
Childless Adult	\$500	90%	\$50 PMPM
SSI	\$1000	50%	\$500 PMPM

* Note: PMPM rates for childless adults vs. SSI populations are illustrative examples based on the claims experience from numerous states.

** Federal matching rate for medical services for SSI populations will vary by state. 50% is provided as an illustrative example.

Source: Example provided through personal conversation with a representative from the Washington State Department of Social and Health Services.

Exhibit 3. Principles of Drug Abuse Treatment for Criminal Justice Populations

1. Drug addiction is a brain disease that affects behavior.
2. Recovery from drug addiction requires effective treatment, followed by management of the problem over time.
3. Treatment must last long enough to produce stable behavioral changes.
4. Assessment is the first step in treatment.
5. Tailoring services to fit the needs of the individual is an important part of effective drug abuse treatment for criminal justice populations.
6. Drug use during treatment should be carefully monitored.
7. Treatment should target factors that are associated with criminal behavior.
8. Criminal justice supervision should incorporate treatment planning for drug abusing offenders, and treatment providers should be aware of correctional supervision requirements.
9. Continuity of care is essential for drug abusers re-entering the community.
10. A balance of rewards and sanctions encourages prosocial behavior and treatment participation.
11. Offenders with co-occurring drug abuse and mental health problems often require an integrated treatment approach.
12. Medications are an important part of treatment for many drug abusing offenders.
13. Treatment planning for drug abusing offenders who are living in or re-entering the community should include strategies to prevent and treat serious, chronic medical conditions, such as HIV/AIDS, hepatitis B and C, and tuberculosis.

Source: National Institute on Drug Abuse. *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide*. Washington: National Institute on Drug Abuse, National Institutes of Health, U.S. Department of Health and Human Services, 2006.

Exhibit 4. Jail-Based Intervention Strategies to Reduce Public Expenditures and Maintain Public Safety

Strategy	Target Group	Impact
<i>Diversion at Arrest.</i> Law enforcement directs to hospital emergency room or community treatment.	People with psychiatric disorders causing disturbance in the community.	<ul style="list-style-type: none"> - Reduces jail costs in current budget year. - Linkage with treatment reduces future days spent in jail.
<i>Conditional Release.</i> Release to pre-trial supervision with required treatment participation.	People with psychiatric disorders and chronic health conditions charged with misdemeanors/low-level felonies.	<ul style="list-style-type: none"> - Reduces jail costs in current budget year. - Linkage with treatment reduces future days spent in jail.
<i>Screening/Brief Intervention.</i>	All jail detainees.	<ul style="list-style-type: none"> - Determines which detainees need which type of linkage services. - Brief intervention alone reduced future substance use.
<i>Arrest and Pre-Trial Intervention for People Charged with Drug Offenses.</i>	People charged with drug offenses who are eligible for various alternative programs.	<ul style="list-style-type: none"> - Reduces jail costs in current budget year. - Linkage with programming reduces future days spent in jail.
<i>Re-entry Services Linkage.</i> Re-entry linkage to behavioral health care services.	All detainees with psychiatric and substance use disorders exiting jail.	<ul style="list-style-type: none"> - Linkage with treatment reduces future arrests.

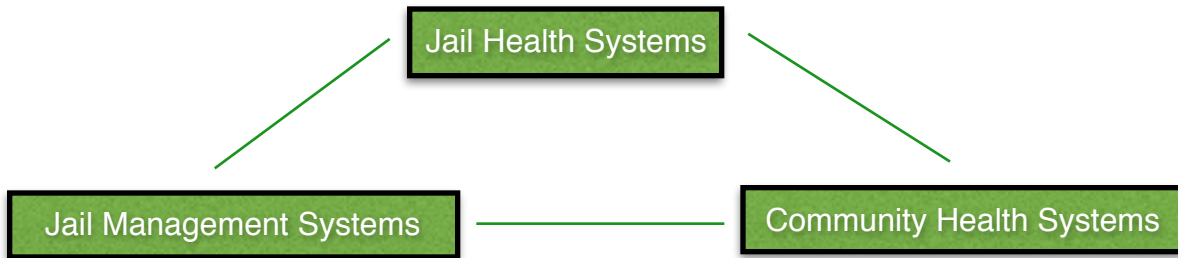
Sources: Steadman H and Naples M. "Assessing the Effectiveness of Jail Diversion Programs for Persons with Serious Mental Illness and Co-Occurring Substance Use Disorders." *Behavioral Sciences & the Law*, 23(2): 163-170, 2005.

Madras BK, Compton WM, Avula D, et al. "Screening, Brief Interventions, Referral to Treatment (SBIRT) for Illicit Drug and Alcohol Use at Multiple Healthcare Sites: Comparison at Intake and 6 Months Later." *Drug and Alcohol Dependence*, 99(1-3): 280-295, 2009.

Mancuso D and Felver B. *Providing Chemical Dependence Treatment to Low-Income Adults Results in Significant Public Safety Benefits*. Washington State Department of Social and Health Services, Research and Data Analysis Division, 2009.

Ehlers S and Ziedenberg J. *Proposition 36: Five Years Later*. Washington: Justice Policy Institute, 2006.

Exhibit 5. Ideal Connectivity Between All Systems Impacting the Health of Detainees



Source: Butler B. "Jails and Information Technology: A Framework for Creating Connectivity." *Community Oriented Correctional Health Services*, 2013.

Exhibit 6. Components of Care Continuity for Criminal Justice Populations

Screening for substance use and mental health problems, medical needs.

Comprehensive clinical assessment identifying likely course of care needed and recommended first placement.

Placement in community substance use/mental health services.

Placement with medical care provider.

Ongoing care management to support engagement and retention in substance use/mental health services and medical services.

Ongoing care management to facilitate access to critical recovery support services.

Regular report on compliance and progress to criminal justice system supervising authority, including drug testing.

Source: McDonnel M, Brookes L, Lurigio A, et al. "Realizing the Potential of National Health Care Reform to Reduce Criminal Justice Expenditures and Recidivism Among Jail Populations." Community Oriented Correctional Health Services, 2011.

Exhibit 7. ACA & Justice: Alternatives to Incarceration

Individual's Status	Advocacy Opportunities
Prior to involvement in the justice system.	<ul style="list-style-type: none"> - Establish robust health care coverage enrollment systems (particularly for Medicaid) and better access to quality services in the community in order to reduce the chance of arrest/conviction for a substance use or mental health-related offense.
At intersection with law enforcement.	<ul style="list-style-type: none"> - Leverage ACA/Medicaid to fund mental health professionals to accompany police officers or other first responders in order to provide crises intervention services and treatment referrals, and to reduce the chance of arrest.
At arrest and prosecution.	<ul style="list-style-type: none"> - Establish a program allowing police officers to connect individuals with a social worker or intervention program rather than booking an individual into jail (law enforcement assisted diversion). - Create program allowing district attorneys to offer treatment instead of prosecution.
At booking or arraignment.	<ul style="list-style-type: none"> - Adopt evidence-based risk assessments to encourage safe release of defendants awaiting trial/resolution. - Increase use of supervised or (own recognizance) release to allow defendants to access services in the community.
Pretrial Detention.	<ul style="list-style-type: none"> - Educate jail administrators, public defenders, and pretrial detainees that their private health insurance is not terminated while in pretrial status (so long as premium payments are maintained).
Plea Deals/Sentencing	<ul style="list-style-type: none"> - Increase use of risk/needs assessment of defendants. - Increase use of probation and alternative custody to allow individuals to access community care through Medicaid or private insurance. - Encourage public defenders to help clients access needed treatment that can also be helpful in a plea deal or at sentencing.
At consideration for early release.	<ul style="list-style-type: none"> - Increase use of community supervision for those who are ill (medical parole/compassionate release). - Increase good time credits for participating in mental health/drug treatment while incarcerated.
Before release from detention.	<ul style="list-style-type: none"> - Ensure individuals are enrolled in health insurance that will be effective at release. - Use booking information to pre-populate a Medicaid application. - Advocate for Medicaid suspension, rather than termination, upon incarceration, to allow for rapid return to coverage after release. - Provide education on how to access health care in the community.
While under community supervision.	<ul style="list-style-type: none"> - Implement routine use of needs assessment to identify appropriate services for individuals. - Reduce supervision revocations and increase referrals to services for relapses or minor violations. - Create effective referral systems to appropriate and quality health services for those in reentry.

Source: Telephone interview with a California ACLU affiliate.

Exhibit 8. Stakeholder Actions in Maximizing ACA Implementation

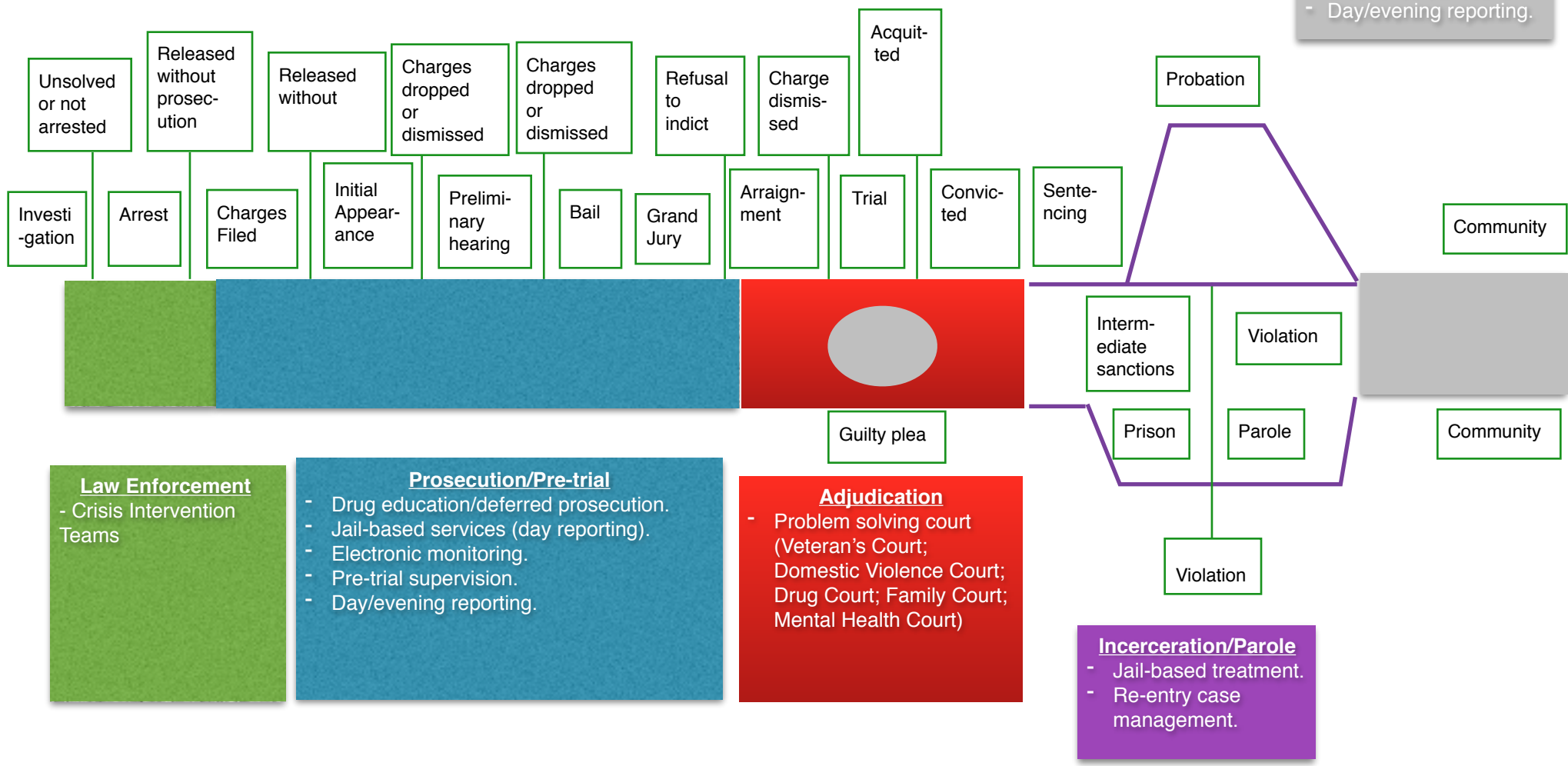
Stakeholder	Action(s)
<i>Community Behavioral Health and Medical Care Providers</i>	<ul style="list-style-type: none"> - Expand treatment capacity. - Integrate primary care and specialty care. - Integrate community services with jail-based services. - Expand capacity to enroll clients in Medicaid/insurance. - Improve treatment through use of evidence-based practices. - Cultivate new partnerships with other stakeholder leaders to maximize diversion and successful re-entry.
<i>County Governmental Officials</i>	<ul style="list-style-type: none"> - Maximize jail diversion and re-entry initiatives. - Minimize costs and risk of litigation. - Assess potential benefits and risks. - Convene planning processes to develop local action plans. - Investigate the reallocation of funding from corrections to community health services.
<i>State Medicaid Directors</i>	<ul style="list-style-type: none"> - Collaborate with health care providers of all types to reduce barriers to coverage for jail detainees/releasees who are legally eligible for the Medicaid program. - Facilitate strategic planning of capacity expansion, with attention to making services available in underserved communities and rural areas.
<i>State Insurance Directors</i>	<ul style="list-style-type: none"> - Collaborate with health care providers of all types to reduce barriers to coverage for all jail detainees who are legally eligible for health insurance through the exchanges.
<i>Single State Agency Directors</i>	<ul style="list-style-type: none"> - Facilitate strategic planning of capacity expansion among stakeholders, including courts, probation departments, sheriffs, jails, and parole agencies, with attention to making services available in underserved populations and communities, including justice-involved populations in rural areas. - Plan integration of Medicaid-funded and Block-grant funded services. - Advocate public policies that ensure health insurance coverage and enrollment for all jail detainees who are legally eligible.
<i>Jail Officials</i>	<ul style="list-style-type: none"> - Partner in systems integration efforts that provide continuity of care between community and detention settings and support successful re-entry to reduce recidivism. - Maximize Medicaid/insurance enrollment among detainees. - Partner in jail diversion initiatives.
<i>Judges</i>	<ul style="list-style-type: none"> - Partner with correctional and community health and behavioral health care providers and funders to bring diversion and re-entry initiatives to scale. - Represent the concerns of public safety and behavioral health intervention from the criminal justice perspective. - Advocate for treatment resources needed to significantly reduce recidivism by chaining the behavior of jail detainees.
<i>Probation</i>	<ul style="list-style-type: none"> - Develop and expand pre-trial supervision systems to manage justice compliance among arrestees who are participating in the community-based treatment. - Partner with judges and community providers to integrate substance use and treatment as an intervention for people who would otherwise return to jail on a technical violation of community supervision requirements.
<i>Parole</i>	<ul style="list-style-type: none"> - Partner with judges and community providers to integrate substance use and treatment as an intervention for people who would otherwise return to jail on a technical violation of community supervision requirements.

Source: McDonnell M, Brookes L, Lurigio A, et al. "Realizing the Potential of National Health Care Reform to Reduce Criminal Justice Expenditures and Recidivism Among Jail Populations." Community Oriented Correctional Health Services, 2011.

Sentencing/Community-based Supervision

- Peer support.
- Re-entry management.
- Drug/specialized probation.
- Incentives/sanctions.
- Day/evening reporting.

Exhibit 9. Continuum of Justice Interventions



Source: Adapted from the Bureau of Justice Statistics, 1997; President's Commission on Law Enforcement and Administration and Justice, 1967.

Exhibit 10

Sample Interview Protocol

*This is a general list and is not intended to be exhaustive of all topics covered in the interviews. Each interview was tailored for the specific interviewee, but these were the general topics covered.

I. Interviewee Background Information

- A. Where the interviewee is employed.
- B. How long the interviewee has been involved in their current position.
- C. How the interviewee came to be involved in their current position.
- D. Brief description of interviewee's role as it relates to the field of criminal justice and/or health care.

II. Core Questions

- A. To what extent are health care needs of incarcerated individuals evaluated at your place of employment?
- B. To what extent are health care needs valued at your place of employment?
- C. Do you think it's realistically feasible for various stakeholders (including courts, probation departments, sheriffs, jails, and health care providers) to coordinate and make health care services available to justice-involved populations?
 1. How so?
 2. What barriers need to be addressed?
 3. What opportunities need to be maximized?
- D. What actions does your field take (if any) to ensure health insurance coverage and Medicaid enrollment for all legally eligible detainees?
 1. What barriers or structural challenges have you seen to exist in this process of making health care services available to incarcerated individuals?
- E. From your perspective, does the criminal justice system employ any methods to collaborate with community health and treatment programs?
 1. What patterns have you observed to exist that contribute to the gap between the criminal justice system and community health and treatment programs?
 2. What structural barriers do you think exist that prevent the two entities from collaborating and addressing the health care needs of incarcerated individuals?
- F. What kind of partnerships do you foresee developing around such a cross-system collaborative approach in which multiple systems (including criminal justice, Medicaid, and state and local agencies) work together to provide mental health and substance abuse services?
 1. What type of resistance do you foresee occurring with such an approach?
- G. Does your organization/place of employment collaborate with other entities in addressing substance use and mental health care services of incarcerated individuals?
 1. Why or why not?
 2. What structural barriers exist that prevent the such entities from collaborating and addressing the health care needs of such individuals?
 3. What kind of partnerships do you foresee potentially developing around such a cross-system collaborative approach in which multiple systems (including criminal justice, Medicaid, and state and local agencies) work together to provide mental health and substance abuse services?
 4. What type of resistance (if any) do you foresee occurring with such an approach?
- H. What are some of the major challenges you face in attempting to address the health care needs of incarcerated individuals? What are some of the opportunities available?
 1. How can such barriers be overcome?
 2. How can such opportunities be maximized?