

## Realizing the Potential of National Health Care Reform to Reduce Criminal Justice Expenditures and Recidivism Among Jail Populations

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### Perspective

This paper is written from the perspective and experience of a statewide service organization, Treatment Alternatives for Safe Communities (TASC, Inc.), which bridges the criminal justice system with community-based substance use treatment and recovery services across Illinois, ensuring client participation in treatment and compliance with justice mandates. The lens of authorship is informed by TASC's nearly 35 years of research, public policy involvement and direct service provision to more than 20,000 justice-involved individuals annually who have substance use or psychiatric disorders, or both. Since 1976, TASC has designed and managed numerous programs that connect courts, jails and prisons with supervised substance use and mental health care services in the community. As an example of its work in pre-trial jail diversion, TASC provides court advocacy and case coordination for the Cook County State's Attorney's Drug Abuse Program (SADAP), which annually redirects approximately 4,000 individuals charged with low-level drug offenses into drug education sessions as an alternative to further prosecution or jail. The program saves the county more than \$2 million per year in court costs alone. More than 90 percent of participants complete the program, and 83 percent of graduates have no further arrests for drug crimes in the three years following completion.<sup>1</sup> As an example of post-jail re-entry, TASC was instrumental in the design and implementation of the Cook County jail's substance abuse treatment and community re-entry program, Project IMPACT. Re-arrest rates for participants who completed 90 to 150 program days in the jail were

reduced by more than a quarter; re-arrest rates decreased an additional 50 percent for those who also received case management in the community.<sup>2</sup> This approach of combining justice mandates with behavioral health goals is used in jurisdictions throughout the country and consistently improves client outcomes and saves public dollars. (See section entitled *Preparing for 2014 Health Care Reforms: Applying What Works.*)

This paper discusses how lessons learned from both direct experience and research can influence the implementation of broad health care coverage for jail populations. It provides an overview of the current structural challenges in providing substance use and mental health care services for jail populations; puts forth best practices in treating criminal justice populations; discusses how the implementation of the Patient Protection and Affordable Care Act (ACA) can apply evidence-based practices and expand services for jail populations; examines the financial and practical implications of health care reform for the criminal justice system, particularly within the jail population; and calls on state and local leaders to plan for and act on the opportunities that the ACA presents.

### Introduction

As the front door to the criminal justice system, jails represent one of the largest catchment areas for people with substance use and mental health conditions, infectious diseases and other chronic health problems. Approximately 9 million adults churn through local jails each year.<sup>3</sup> Compared to the general population, they have disproportionately high rates of chronic medical conditions,<sup>4</sup> substance use disorders,<sup>5</sup> serious mental illness<sup>6</sup> and co-occurring substance use and mental health disorders.<sup>7</sup> These conditions, which contribute to recurring criminal behavior and affect millions of arrestees, usually are untreated or inadequately treated.



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The delivery of health care services in the criminal justice system in the United States is often disjointed and sporadic, consisting of an uncoordinated series of interventions mostly in response to episodes of acute illness. The vast majority of jail detainees — 90 percent in one study<sup>8</sup> — have no private or public health insurance, especially in states that exclude childless adults from Medicaid eligibility. Under The Patient Protection and Affordable Care Act (ACA) and the Health Care and Education Reconciliation Act of 2010, most of these men and women will become newly eligible for health care coverage in 2014. Should continuous, integrated health care services — particularly treatments for substance use and psychiatric disorders contributing to criminal behavior and arrests — become widely available for jail populations, a reduction in criminal behavior and repeated incarcerations associated with these chronic health conditions can be expected. The ACA has the potential to produce tremendous financial savings for local jurisdictions by reducing incarceration costs and redirecting eligible people from jail into supervised, community-based health care.

The ACA alone will not solve the health care problems of jail populations, but it serves as a launching pad for broad-scale system improvements. The new legislation

offers unprecedented opportunities to provide appropriate and timely interventions to millions of jail detainees and ensure continuity of care in the community, thus minimizing county expenditures for jails, lowering recidivism, facilitating recovery and improving public safety by reducing drug-related crime. Also, given the vast overrepresentation of African Americans in the jail population<sup>9</sup> and disproportionately low access to health care for people of color,<sup>10</sup> the ACA could also reduce health and justice disparities among different racial/ethnic populations. For substantial progress and cost savings to be realized, it is critical for criminal justice and treatment systems to use proven strategies that maximize community safety and rehabilitation to bring these efforts to scale. (See Table 1 below.)

One pillar of the ACA is to expand coverage for the uninsured; the exact provisions of how that will occur will be decided before full implementation in 2014. With regard to jail populations, what is yet undetermined is whether and how eligibility distinctions will be made between individuals who are pre-trial and those who are post-sentence, and between those who are acquitted and those who are found guilty. The ACA may also affect people differently depending on whether they are detained in jails or released in the community (i.e., out on

**Table 1. Percentage of U.S. Jail Population and U.S. General Population, by Race/Ethnicity**

Bureau of Justice Statistics Categories*	Percentage of Jail Population (2009)	U.S. Census Categories*	Percentage in General Population (2009)
White	43%	White	80%
Black/African American	39%	Black or African American	13%
Hispanic/Latino	16%	Hispanic/Latino of Any Race	16%

\* Bureau of Justice Statistics methodology excludes all individuals identified as “Hispanic/Latino” from being counted in other categories. The U.S. Census Bureau counts individuals identified as “Hispanic/Latino” in that category as well as in race categories, including “White” and “Black.” Figures in the “White” and “Black” categories include people reporting only one race.

Source: Minton T. *Jail Inmates at Midyear 2009 — Statistical Tables*. Washington: Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice, 2010.

bond pre-disposition, or released on probation post-disposition). This paper raises issues and opportunities regarding substance use and mental health care services for all jail populations, understanding that some eligibility restrictions may be enacted for some subsets.

Leveraging the opportunities of the ACA will require intention, leadership, strategic planning and deliberate coordination among several systems, including county government officials, state Medicaid and insurance directors, criminal justice administrators and medical care and community treatment providers. Counties in particular must prepare to take advantage of opportunities, as they have jurisdiction over local jails in almost all states. They must be equipped to redirect arrestees into community supervision and treatment programs that hold participants accountable, and strengthen linkages to community re-entry programs that can facilitate recovery and reductions in recidivism.

### Current Challenges in Providing and Funding Health Care Services for Jail Populations

Under current criminal justice and health care structures, there are multiple and interconnected barriers to providing coordinated and effective health care for jail populations. These challenges are especially pronounced when it comes to dealing with substance use and psychiatric disorders. Challenges include divergent goals of criminal justice and health care systems, insufficient funding and fragmented funding mechanisms, lack of health insurance coverage among those who need health services, insufficient and inadequate clinical care and a lack of coordination among systems.

**Divergent goals.** To begin, criminal justice systems and health care services are premised on different goals. The primary goals of the criminal justice system are to protect public safety and reduce recidivism. The primary goals of health care systems are to protect or improve individual and community health. These two premises intersect in the provision of rehabilitative programming and health services for justice populations, and in their mutual objective of cost containment. Although criminal justice systems are not designed to be providers of health

care, they have often been obliged to assume that responsibility, sometimes under threat of litigation: Case precedents and constitutional safeguards have established the right of people in criminal justice custody to receive medical care that matches the prevailing quality of care in each medical specialty.<sup>11</sup>

**Insufficient treatment for justice populations.** A 2008 survey of arrestees found that between 49 percent and 87 percent tested positive for illicit drugs.<sup>12</sup> In 2002, 68 percent of jail detainees reported symptoms that met the clinical criteria for substance dependence or abuse.<sup>13</sup> Approximately 14.5 percent of men and 31 percent of women entering jail have a serious mental illness,<sup>14</sup> and among those, 72 percent of both men and women have a co-occurring substance use disorder.<sup>15</sup> In spite of the prevalence of substance use and mental health disorders among people in the criminal justice system, few who need treatment actually receive it.<sup>16</sup> The demand for community-based treatment in most states exceeds availability,<sup>17</sup> resulting in long waiting lists and thwarting the justice system's efforts to mandate participation in treatment. Programs that combine criminal justice sanctions with treatment rarely reach all individuals who are legally eligible to participate,<sup>18</sup> and the lack of resources to expand successful intervention models has limited the potential of the criminal justice system to reduce recidivism.<sup>19</sup>

Evidence-based, clinical treatments for substance use or mental health disorders include behavioral therapy (such as counseling, cognitive therapy or psychotherapy delivered by credentialed professionals), physician-prescribed medications or a combination of both.<sup>20</sup> More common in jails are mutual-help programs, participant-led groups in which members support one another's efforts toward recovery. Of jail detainees in 1998 who had used drugs at the time of the offense, only 19 percent had participated in any type of substance abuse programs since their admission, with mutual-help programs being the most common activity.<sup>21</sup> Although 64 percent of local jails made mutual-help programs available to at least some detainees, only 43 percent of jails had any clinical treatment programs, and three-fourths of treatment capacity was concentrated in

jails holding 500 or more people.<sup>22</sup> In the past decade, treatment in the community for those under jail supervision has declined while the jail population has grown. While the number of people under jail supervision in the United States (including both those detained in facilities and those released to receive treatment, perform community service or participate in work release programs) increased 22 percent from mid-2000 to mid-2009 (687,033 to 837,833), the number of people under jail supervision released to receive drug, alcohol, mental health and other medical treatment declined by 64 percent (5,714 to 2,082).<sup>23</sup>

**Funding geared toward problems rather than solutions.**

State spending on corrections has grown continually and precipitously, more than quadrupling between 1988 and 2008.<sup>24</sup> Dollars spent dealing with substance use in the United States are skewed toward responding to the consequences of substance use conditions rather than implementing solutions. Currently, only 4 cents of every dollar spent on substance use disorders are allocated for prevention and treatment; the other 96 cents are spent on the consequences of untreated or inadequately treated disorders, including expenses related to health care; criminal, juvenile and family court justice systems; incarceration; child welfare; domestic violence and child abuse; homelessness; mental illness; and developmental disabilities.<sup>25</sup> Likewise, the burden of untreated mental illness is often borne by the criminal justice system; people with serious mental illness are three times more likely to be in jails or prisons than in psychiatric hospitals.<sup>26</sup>

**Fragmented funding streams.** Health services funding for criminal justice populations is usually piecemeal and fragmented. The public substance use and mental health treatment systems are currently supported largely by federal block grants (i.e., large fiscal grants to states to fund programs, with relatively few restrictions as to how the funds are spent) and local resources. Other monies may come from different federal departments (e.g., Justice or Health and Human Services), assorted county agencies or various divisions within state government (e.g., those that fund corrections, substance use treatment or mental health services). Criminal justice officials and service providers contend with lengthy

grant-writing processes to secure funding for small increments of treatment. Disjointed and uncoordinated funding streams create isolated pockets of service rather than the seamless continuums of care needed for the treatment and management of chronic illnesses. Also, when treatment for substance use disorders, mental health conditions and other medical issues are all treated in separate systems, the likelihood of access to all required services is diminished, and individuals are less likely to participate in a sustained course of treatment that effectively addresses each of their health conditions.

**Inadequate and truncated care.** Analogous to other chronic health conditions, substance use and mental health disorders require ongoing, long-term treatment and management. Most people with these disorders need at least three months in treatment to stop or significantly curtail their use,<sup>27</sup> and current research shows that attaining durable recovery typically involves multiple episodes of care over many years.<sup>28</sup> Meanwhile, 80 percent of jail detainees are incarcerated for less than one month.<sup>29</sup> The acute care treatment currently offered in jail and justice settings is insufficient to address chronic conditions. For those who receive it, treatment in jail can begin the process of recovery, but continued services in the community are necessary for recovery to be sustained.<sup>30</sup>

When care for substance use and psychiatric disorders is absent, inefficient or interrupted, these conditions persist, resulting in continued alcohol and drug use and criminal activity,<sup>31</sup> as well as costly emergency department visits,<sup>32</sup> intimate partner violence, child abuse and neglect cases and DUI injuries and mortalities.<sup>33</sup> Service delays and interruptions allow health problems to become even more difficult and expensive to treat.

**Lack of insurance.** Few adults who go through jail have either private or public health insurance. As noted, one study found 90 percent of jail inmates lacked it.<sup>34</sup> Current Medicaid rules exclude most childless adults from program eligibility except in select states that have sought waivers. Among those who do qualify for Medicaid, many are unnecessarily dropped from coverage while incarcerated, usually because federal

rules and state implementation processes are not well understood. Once released, very few receive assistance in reinstating their federal benefits, and without coverage for care, their substance use or mental health conditions (or both) persist and contribute to repeated criminal justice involvement.<sup>35</sup>

**Lack of community capacity and recovery orientation.**

The delivery of coordinated, community-based health care services and supports for people involved in one or more public systems is rare in most places, and especially in justice settings. Some barriers include resistance to providing services in the community; a lack of systems linkage between treatment and vocational, housing and educational services; a lack of coordination between criminal justice and mental health systems; and ongoing challenges in engaging families and allies in the treatment and recovery process.<sup>36</sup> Without continuity of care and access to services in the community, individuals are likely to return to previous behaviors and be reincarcerated.<sup>37</sup>

As noted, treatment capacity itself is a challenge; broad-scale conditional release and jail re-entry programs are unavailable in most jurisdictions, and most community health and specialized mental and substance use treatment systems do not have the capacity to fully serve the jail population. Beyond treatment, essential elements of recovery for justice populations include housing, employment and peer support.<sup>38</sup> However, people with criminal records face substantial barriers to housing and employment,<sup>39</sup> and they encounter difficulties in establishing positive peer relationships and dealing with stigma.<sup>40</sup>

Finally, community capacity challenges involve workforce issues. Challenges in the addictions treatment workforce include low salaries, an aging workforce and a shortage of credentialed clinicians.<sup>41</sup> Additionally, there is resistance among some community-based health care providers to serve individuals with mental health conditions who have been incarcerated.<sup>42</sup>

One approach to system transformation, known as a recovery-oriented system of care (ROSC), has evolved

over the past decade. This approach aims to achieve coordination and continuity of care by integrating proven strategies in community treatment and recovery support service provision, and by providing care and support over the long term. This approach has evolved as a standard of best practice, whereby coordinated, community-based networks of services and supports are built around strength-based, person-centered abstinence, health, wellness and quality of life for individuals, families and communities.<sup>43</sup> California, North Carolina and Vermont are examples of states that have begun to develop local ROSCs.<sup>44</sup>

**Lack of resources in rural areas.** The barriers described above are exacerbated in small jails, located mostly in rural areas. Rural jails have become the default setting for health and social services absent in the community, yet they too lack the capacity to provide needed health services.<sup>45</sup> Health care in rural jails is often limited to screening assessments, medication management and crisis response.<sup>46</sup> Outside the jail, there are very few opportunities for pre-trial or post-release treatment due to the dearth of clinical services available. Of the total 13,267 substance abuse treatment facilities in the United States in 2004, 91 percent were located in or next to a metro county,<sup>47</sup> leaving very few providers to serve very large expanses of rural states.<sup>48</sup> Additionally, the proportion of residential and inpatient treatment beds for substance use disorders is lower in rural areas (27.9 per 100,000 population) than in metro areas (42.8 per 100,000 population).<sup>49</sup> The shortage of mental health care in rural areas is equally pronounced. The responsibility to provide mental health care in rural communities has fallen largely on primary care providers. However, while the 3,800 rural health clinics in the United States are important providers of primary care, very few offer mental health services, and the most commonly treated disorders are less-serious disorders and conditions (i.e., depression, attention deficit hyperactivity/attention deficit disorders and anxiety).<sup>50</sup> People must travel great distances to access care, if indeed their release terms do not prohibit them from driving.<sup>51</sup>

**The promise of health care reform.** Health care reforms enacted through the ACA will not solve all the challenges outlined, but they provide a unique opportunity to affect significant change on a broad scale. By facilitating near-universal health insurance coverage, the ACA will greatly expand access to care, thus eliminating long waiting lists for treatment, addressing gaps in services and ending the piecemeal use of grant dollars to purchase mental health and substance use treatment services for criminal justice populations. Appropriately managed and leveraged, this will help break the cycle of repeated criminal justice involvement and reduce the country's jail population while maintaining public safety. The reinvestment of saved correctional dollars on health care, education, job training, housing and care management services could revitalize impoverished communities.

To successfully achieve these outcomes, and to maximize the ACA's potential to facilitate recovery, reduce recidivism and save money, counties and states must implement best practices in providing clinical services for jail populations.

### Preparing for 2014 Health Care Reforms: Applying What Works

State and county entities that have contact with justice-involved populations will be significantly affected by, and would do well to prepare for, implementation of the ACA. With leadership, planning and coordination, jurisdictions can leverage the legislation's health care reforms to implement or expand jail interventions and clinical practices that have already proven effective in reducing crime, recidivism and public expenditures. The convergence of proven practices from a variety of authoritative sources presents invaluable guidance for those directing such implementation and expansion activities.

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 that should inform service

delivery for justice populations with substance use and mental health conditions. NIDA, the federal agency charged with bringing forth the latest science in preventing and treating problematic drug use, produced in 2006 a research-based publication detailing 13 evidence-based principles of drug treatment specifically for criminal justice populations. (See Table 2 on page 7.) In 2005, SAMHSA, the federal agency responsible for reducing the impact of substance use and mental illness on communities, released its *Treatment Improvement Protocol 44: Substance Abuse Treatment for Adults in the Criminal Justice System*. This publication offers information on clinical services for people involved in various criminal justice settings, and is intended for use by treatment providers who supervise justice-involved clients or the justice system workforce that comes in contact with people who have substance use conditions. SAMHSA has also compiled its *National Registry of Evidence-based Programs and Practices* (NREPP), which includes more than 160 proven interventions in the treatment and prevention of psychiatric and substance use disorders, and their co-occurrence. In 2007, NIC published evidence-based practices to reduce recidivism, a guide intended for state judiciaries,<sup>52</sup> and in 2009, released guidelines for implementing evidence-based policy and practice in community corrections.<sup>53</sup> Also, SAMHSA's National GAINS Center, in coordination with the Center for Mental Health Services (CMHS), has identified six evidence-based practices for mental health treatments with potential for application in criminal justice settings.<sup>54</sup>

It is important to note that evidence-based practices evolve over time. As such, programs should be regularly evaluated and appropriately adapted based on new research. For example, new evidence has emerged in recent years regarding the impact of trauma on behavior. Experiences of childhood trauma are common among adults in the criminal justice system,<sup>55</sup> and more than half of women in jail report having been physically or sexually abused in the past.<sup>56</sup> Trauma history is associated with high rates of psychiatric and substance use disorders,<sup>57</sup> and the process of attaining sobriety often exposes underlying trauma that can impede the achievement of durable recovery.<sup>58</sup> SAMHSA has made trauma-informed

**Table 2. 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.

care one of its cross-cutting principles in policy and programs, and as programs evolve and are evaluated, new evidence-based practices will emerge and can be applied as indicated for justice-involved populations.

To illustrate how counties and jurisdictions can begin planning for implementation of health care reform, the NIDA principles provide a framework for addressing the nexus between substance use disorders and criminal justice involvement. These principles can be directly applied as policies and programs are established or expanded under the ACA's provisions. For example, given that addiction is a disease that requires treatment and care management over time (principles 1-3, 9), the health care responses should be similar to those for other chronic conditions covered by Medicaid.

While substance use treatment providers are not traditionally concerned with criminal justice sanctions, patient accountability becomes an essential component of the recovery process for people receiving care in a criminal justice context. Therefore, treatment and justice system care management need to be integrated (principles 7-8). The same applies to the use of medication-assisted treatment. Whereas medication in a traditional medical setting may involve periodic drug testing, medication in a criminal justice setting should be paired with frequent and random drug testing to ensure compliance with criminal justice mandates (principle 12). Thus, as jurisdictions prepare for the expansion of Medicaid coverage for jail populations, both the treatment aspects and the criminal justice aspects of evidence-based recovery should be considered in design and funding.

Applying the evidence-based practices published by NIDA, SAMHSA, NIC, the National GAINS Center and other researchers, jail-based interventions can take many forms. Interventions usually target individuals charged with low-level drug and property crimes, and they integrate participation in substance use and mental health care as a condition of participation or release. (See Table 3 below.) Various forms include redirection into health services at the time of arrest, whereby police take people with mental health issues to hospitals rather than jails; conditional release from jail, whereby detainees are stabilized at the jail and released to community mental health providers; and pre-trial intervention for low-level drug offenders, whereby the chief prosecutor sets standards allowing certain defendants to be redirected to drug education

courses. Under health care reform, creation and expansion of jail-based interventions can yield meaningful change for individuals, their families and communities, and can result in significantly reduced public expenditures and recidivism.

**Evidence to practice: how the ACA can help reduce jail expenditures.** As noted, inadequate funding and fragmented funding streams have long been barriers to medical and specialized health treatments for jail populations. Once health insurance is broadly expanded in 2014, current funding barriers will be largely displaced and there will be more opportunities for diversion and intervention at each point in the criminal justice process. Jurisdictions will be able to work with community providers to greatly increase access to substance use and

**Table 3. Criminal Justice 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"> <li>■ Reduces jail costs in current budget year</li> <li>■ Linkage with treatment reduces future days spent in jail</li> </ul>
<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"> <li>■ Reduces jail costs in current budget year</li> <li>■ Linkage with treatment reduces future days spent in jail</li> </ul>
<i>Screening/Brief Intervention.</i>	All jail detainees	<ul style="list-style-type: none"> <li>■ Determines which detainees need which type of linkage services</li> <li>■ Brief intervention alone reduces future substance use</li> </ul>
<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"> <li>■ Reduces jail costs in current budget year</li> <li>■ Linkage with programming reduces future days spent in jail</li> </ul>
<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"> <li>■ Linkage with treatment reduces future arrests</li> </ul>

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 BEM. *Providing Chemical Dependence Treatment to Low-income Adults Results in Significant Public Safety Benefits*. Olympia, WA: 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.



mental health treatment programs, bring to full scale the intervention programs that are already in place and successful and adopt other proven models as well. Based on the volume of research proving the success of such interventions,<sup>59</sup> the result will likely be a reduction in repeat incarcerations and their associated costs.

Following is an illustration of how the ACA can help reduce jail expenditures. Consider a medium-sized county jail with a 500-bed capacity that houses at least 13,000 people each year.<sup>60</sup> A majority of jail populations are substance-involved; two-thirds of detainees report using drugs regularly.<sup>61</sup> In a jail that admits 13,000 people in a year, potentially 8,580 detainees with substance use conditions would be identified as needing some level of clinical intervention.<sup>62</sup> Those who also fall within the eligibility boundaries of a criminal justice risk assessment (i.e., those charged with nonviolent offenses) could participate in conditional release with community treatment. Similarly, research suggests that on average 14.5 percent, or 1,885 detainees in this illustration, have psychiatric disorders that require treatment.<sup>63</sup> Identified detainees would benefit from treatment in jail, in the community or both. A mid-size county may already have in place several types of intervention programs, such as a 50-bed substance use treatment program that serves up to 600 detainees each year,<sup>64</sup> and an expedited release program for people with psychiatric disorders that serves 500 people each year. With new resources under the ACA, far more people can receive treatment.

Should this mid-size jail direct more arrestees to supervised release with the condition of community treatment, the county's annual costs for incarceration would be reduced. A reduction in the number of detainees in jail by only 10 percent through such programs could save this mid-size county more than \$1 million in incarceration costs in one year.<sup>65</sup>

### **What Will Change: Potential Benefits and Impact of Health Care Reform for Jail Populations**

Under the ACA, broadened eligibility for health insurance has the potential to launch a series of related changes that will reverberate through the

publicly funded primary care and specialty substance use and mental health care systems. What follows is a description of the anticipated changes in substance use and mental health treatment for jail populations, along with implications for local governments, service providers and criminal justice systems.

#### ***Changes Affecting Treatment for Jail Populations***

**Funding and billing mechanisms will change.** After ACA implementation, Medicaid funding rules will govern how substance use and mental health care is structured, reviewed and approved. Each state's Medicaid authority will be a primary funder and oversight manager for services. Providers will be required to implement Medicaid-compatible, fee-for-service billing structures and maintain electronic health records for utilization and documentation review. Those not already Medicaid-certified will need to become so.

For service providers that currently receive block grant dollars to provide treatment, they may need to apply for and shift to different sources of funding. In cases where counties currently fund treatment, the ACA may open up opportunities for Medicaid reimbursement. However, it is not necessarily so that the block grant dollars will disappear. It is possible that once Medicaid more broadly funds treatment, block grant dollars could be used for recovery support services not covered by Medicaid, such as housing costs in recovery homes, or trauma recovery services not widely available for low-income people. The National Association of State Alcohol and Drug Abuse Directors (NASADAD) reviewed state-level health care reforms and concluded that federal block grant funds are an important component of health care reform; such dollars cover the "non-medical" (i.e., non-Medicaid reimbursable) services that are nonetheless critical to rehabilitation, such as the housing portion of residential treatment or certain psychosocial support services.<sup>66</sup>

#### **Criteria for reimbursement will be based on medical necessity as determined by state Medicaid authorities.**

Medicaid billing and verification requirements require that authorization for substance use and mental health treatment services be based on medical necessity.

Each state's Medicaid program develops its own definition of what is medically necessary.<sup>67</sup> Substance use and mental health care providers will need to understand the Medicaid provisions in their state and determine how the vital elements of treatment, recovery support services and continuity of care services are structured and funded within these provisions. Providers must work to ensure that evidence-based treatments for chronic substance use and mental health disorders are indeed categorized as medically necessary under Medicaid.

A key question to be answered is whether treatment will be deemed medically necessary for jail detainees whose substance use disorders have been interrupted during their incarceration. The nature of chronic substance use disorders is that while symptoms may disappear temporarily during a period of non-use, the illness is still present and will likely manifest itself again once the individual is released from confinement. Justice-involved individuals who have long histories of drug or alcohol use disorders could test negative for drug use at the time of their jail release, and as such, they might not meet the medical criteria to enter treatment (i.e., they have no active substance use or need for detoxification). However, in such cases, the substance use disorder has only been interrupted during incarceration, and clinical treatment is still needed to manage the illness and build durable recovery.

**With expanded insurance coverage, demand for substance use and mental health care services for previously uninsured people, including many jail populations, will likely increase.** Although it is yet unknown the extent to which substance use and psychiatric services will be required and reimbursed through state insurance plans after ACA implementation, community treatment systems must prepare for a dramatic increase in the number of new patients with insurance, including those coming out of jail. The NASADAD review found that expansion resulted in substantially more treatment utilization in each state, ranging from a 20 percent increase in Massachusetts (2006 – 2008), to a 32 percent increase in Maine (1999 – 2008) to a 100 percent increase in Vermont (1998 – 2007).<sup>68</sup>

**The ACA will propel capacity expansion.** With broad expansion of coverage to previously uninsured populations, and increased demand for services, stakeholders should encourage state Medicaid directors and insurance directors to convene and facilitate strategic planning of capacity expansion, with attention to making services available in underserved communities and rural areas. For treatment providers, capacity expansion planning and implementation efforts must begin now, along with plans to integrate primary and specialty care in the community with jail-based health care services. Providers will need to decide how much to expand capacity and when to do so, even as they deal with current state funding reductions. Larger providers may have greater reserves, allowing them to sustain expanded capacity until client numbers increase. Smaller providers are less likely to be able to exercise this option, and as a result, may look to partner with primary care and larger specialized health service providers in order to maintain or expand service delivery.

States' reform implementation processes in Massachusetts, Maine and Vermont allowed them to expand treatment capacity and medication-assisted treatment, especially for opiate dependence. Expansion also provided an opportunity to reorganize their systems away from an acute-care orientation toward a long-term recovery orientation.<sup>69</sup>

**New outcome measures will emerge.** Under Medicaid, service providers must be prepared to define and measure health outcomes and the functional status of care recipients. From now through 2014, decisions are being made regarding which service quality and health outcomes will be measured under the ACA, how evidence-based practices should be incorporated, how care will be managed and integrated and how health information technology will be used.<sup>70</sup> Providers must be actively engaged in these discussions so that decisions are informed by research and direct experience, particularly with regard to the variables involved in serving jail populations.

**Substance use and mental health treatment can become more integrated with primary care.** Integration of community-based specialized care with primary care was enhanced through reform implementation in Massachusetts, Maine and Vermont<sup>71</sup> and is a priority under the ACA.<sup>72</sup> The intent of this integration is improved access to services, more coordinated care, fewer discrete acute-care episodes over the life span and better overall patient outcomes. As described earlier, many individuals involved in the criminal justice system have numerous and complicated health problems. The successful integration of care can foster access to services and enhance the clinical integration of all care, leading to better medical outcomes. Because of the ACA's focus on integration and expansion of services, substance use and mental health treatment providers will be expected to collaborate with a number of new partners who serve the same patients. Depending on how services are designed in each locality, new partners in patient care may include federally qualified health centers (FQHCs), community health teams, home health care providers and new referral networks.

Better integration will benefit patients regardless of justice system involvement; however, the potential benefits to health and reductions in expenditures are even greater if implemented within jail populations, which are characterized by high rates of infectious and chronic diseases, including psychiatric and substance use disorders. Expanded funding for services through broad eligibility for insurance coverage could be used to integrate primary and specialty community health care in new ways. Planning efforts should focus on practical systems changes that facilitate access to continuity of care, including the transfer of prescriptions from jails to community health systems; integrating electronic health records between jails and public clinics; increasing public health education and outreach within jails; and creating jail re-entry centers that offer primary medical, substance use and mental health care, as well as care management services that facilitate utilization of available services and access to housing and employment.

**With cost containment, supply of substance use and mental health care services will shift.** The manner in which treatment is structured and delivered will change under

the ACA. The supply of publicly funded services will be largely dictated by what will be covered by Medicaid, and given state budgetary shortages and pressures, there may be an increased focus on cost containment. Historically, when managed care models were implemented as cost containment measures in the 1990s, there were cutbacks in residential care in the private treatment system.<sup>73</sup> If the managed care pattern is followed, treatment stays could become shorter and residential treatment will be less available under the ACA. Similar challenges in providing care arose in the first years of Massachusetts' recent coverage expansion.<sup>74</sup> Such service challenges arise when the pool of eligible care recipients is significantly widened. When there is a need to control costs while at the same time serving a broader pool of recipients, the depth of services (e.g., length and intensity of care) is necessarily reduced.

One challenge of health care is to provide the most effective level of clinical care at the least expensive cost. In treatment of substance use and psychiatric disorders, brief interventions, outpatient care and day treatments in hospitals or other medical or clinical settings are less expensive than residential care, and will likely be expanded under the ACA. Continuing education of judges and other criminal justice administrators will be necessary to demonstrate that these clinical interventions, combined with supervision, are effective and less likely to result in recidivism than incarceration.

**New workforce issues will emerge.** As services and reimbursement eligibility expand under health care reform, providers of substance use and mental health care can expect to face new workforce challenges and opportunities. Many of the workforce issues addressed in the ACA focus on improving access to primary care and creating more medical homes, with less attention to improving access to specialty care.<sup>75</sup> Under the ACA, providers will be required to employ staff who meet Medicaid-defined professional standards. Shortages of credentialed specialized health care clinicians must be addressed. Also, providers who are new to Medicaid procedures will need to be trained in the responsibilities of operating in a Medicaid environment, including learning new health care language and terminology and new sets of billing and reimbursement requirements.

They may also need to develop more advanced skills in the field of information technology. For example, in an effort to expand services to remote and underserved areas, providers may expand their use of telemedicine, the delivery of health care via video technology and interactive communication networks. Opportunities for improved care will likely become available through the expansion of resident training programs in both primary and specialized health care programs in underserved communities.

### **Increased Opportunities for Criminal Justice Interventions that Combine Structured Supervision with Effective Clinical Care**

**With expanded coverage, there will be greater opportunity for both earlier interventions and sustained services.** Under the current system, people with chronic health conditions cycle frequently in and out of the criminal justice system without their treatment needs being identified or addressed. Under the ACA, broad-based screening would mean that many people not previously identified as needing services will now have evident treatment needs for a variety of clinical conditions. By screening all individuals coming into the justice system, there will be opportunities to intervene earlier, before the health problem becomes chronic and more expensive and difficult to treat. Expansion of resources for substance use, mental health and primary care treatment should allow the treatment system to serve more people and create better evidence-based models of care in the community.

### **There will be increased incentives to redirect people into community health care with structured supervision.**

Most people entering jail today have no way to pay for health care. As a result, they tend to receive acute care in emergency rooms and jails, and their chronic conditions tend to go underdiagnosed and undertreated. Once Medicaid expansion is in place, it is likely that many more people will obtain some level of health care in the community. Such individuals will come into jail with treatment plans and medication plans already in place, and jails may be required

to sustain their care. Without plans for redirecting eligible arrestees back into community care, jail health care costs may increase substantially. One approach for counties to consider is pre-trial release with supervision for detainees who pose a low safety risk and have established health care options in the community. This approach would allow detainees to continue their health care in the community uninterrupted and would allow counties to avoid the additional expense of expanded clinical services for detainees who already have intact care in the community.

### **Jails will need to implement protocols for screening.**

Currently, jail intake procedures focus on stabilizing acute medical and specialized health needs, such as injuries, detoxification and psychotic symptoms. Under the ACA, jails will need to implement brief screening processes to determine who is eligible for which services and levels of supervision. Screening takes place at jail intake to identify both clinical needs and criminogenic risks (i.e., characteristics making them less likely to succeed in rehabilitation and more likely to return to substance use or crime). Several research-driven, validated tools exist for rapid screening in incarcerated settings, such as those published by SAMHSA (e.g., *Treatment Improvement Protocol 44: Screening and Assessment*)<sup>76</sup> and the Texas Christian University (TCU) Institute of Behavioral Research (e.g., *TCU Drug Screen II*) and those described by the National GAINS Center (e.g., *Screening and Assessment of Co-Occurring Disorders in the Justice System*).<sup>77</sup> Jails can also apply the elements of the Screening, Brief Intervention and Referral to Treatment model (SBIRT), including universal screening, brief substance use and mental health interventions and linkage to treatment for those identified as needing services. (See Table 3 on page 8, “Screening/Brief Intervention.”) Based on the level of need for clinical intervention and public safety risk, detainees can be set on a track for conditional release with the requirement to participate in community services or comprehensive re-entry services at release from the jail. To screen all entering detainees, jails will need to add intake staff or contract with community agencies to provide screening services.

**Intervention programs must protect public safety.**

To ensure supervision in the community that protects public safety, county criminal justice officials, including sheriffs, judges, prosecutors, defense attorneys and jail administrators, will need to develop legal eligibility criteria and community supervision requirements for intervention programs (where no or insufficient criteria and requirements exist). Such criteria and requirements will determine the scale and scope of interventions and the likely population of jail detainees that will be redirected to the community treatment services. Local criminal justice agencies increasingly use validated risk assessment tools,<sup>78</sup> which aid in evaluating the suitability of individual detainees for release programs. NIC's evidence-based practices for community corrections provide further guidance to local jurisdictions regarding maintenance of public safety.

**Jails will need to implement Medicaid enrollment procedures.**

In order to achieve the cost savings that come from redirecting detainees into community-based clinical care, jails will need to identify and respond to patient barriers to enrollment. For jail populations, a significant barrier to enrollment is that, at the time of arrest, people do not necessarily have with them the identification and documentation necessary for Medicaid enrollment. Additionally, Medicaid enrollment will need to be simplified and expedited, as many detainees have substance use and psychiatric disorders that interfere with their ability to make healthful choices toward recovery and rehabilitation. For detainees, unfamiliar insurance enrollment and eligibility maintenance procedures will present significant and unexpected barriers to accessing and engaging in health care services. State Medicaid directors and insurance directors will have a major voice in determining enrollment procedures and processes and must play a critical role in reducing barriers to coverage for all eligible people.

Additional barriers to Medicaid enrollment were identified by a Kaiser Family Foundation survey<sup>79</sup> of Medicaid directors in states with program expansions that include childless adults. Barriers included the lack of awareness among the newly eligible population and difficulty communicating with them through conventional public

messaging strategies. The directors surveyed described effective outreach strategies that addressed these problems, including the utilization of primary and specialty community health providers as enrollment sites. Additionally, the NASADAD evaluation identified subgroups of eligible people who did not enroll in publicly funded plans or were only episodically insured. The lack of enrollment was caused by a failure to complete enrollment forms, a problem that escalated as the number of people with substance use disorders increased. Periodic incarceration also exacerbated the situation, as Medicaid eligibility ceased during confinement and a cumbersome re-enrollment process was required following release.<sup>80</sup>

The criminal justice system can and should be an active partner in enrollment. As a mechanism for enrolling new Medicaid patients, jail personnel may be assigned to enrollment, or the jail may contract with a community provider to handle enrollment. 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 their detention. Individuals receive Medicaid cards with their personal property at release,<sup>81</sup> enabling access to and continuity in community-based care.

The development of electronic enrollment records must be explored in depth and well in advance of ACA implementation. A high-tech option for enrollment technology would be for the jail's data system and the state Medicaid and insurance enrollment data systems to connect. This would help (1) identify detainees who are not currently enrolled in Medicaid or insurance and (2) automatically enroll them while in jail, so they would leave with a valid Medicaid card. Pursuit of this option should be explored with state Medicaid authorities, and should include their recommendations on how to streamline procedures and ensure their simplicity.

**Justice leaders and clinical care providers must plan for alignment of the ACA's patient choice requirement and justice system's practice of mandating treatment participation.** When the criminal justice system requires people to participate in treatment, the level, provider and

location of care are often prescribed. This specificity could be attributable to the criminal justice practitioner's familiarity and comfort with particular programs, because previous participants have been successful in a certain program or because specific grant funding or contract arrangements facilitate admission to specific treatment programs. A condition of Medicaid is that patients have a choice of providers, and this condition applies to justice-involved populations. Although choice might appear antithetical to the notion of a criminal justice mandate, as long as the criminal justice system has processes in place to recommend appropriate clinical levels of care for each treatment episode, clients and staff will be able to choose treatment programs from a network of approved providers that offer the prescribed level of care. States have had the opportunity to use this process under the federal Access to Recovery (ATR) initiative.<sup>82</sup> Collaboration between criminal justice practitioners and local providers to develop such a network will increase the chances that both systems will be able to meet their mutual goals.

**Caution: There is a risk of net widening.** While the ACA may pave the way for expanded criminal justice interventions, “net widening” could become an unintended consequence of the reform. Net widening refers to the effect of intervention programs actually increasing the number of people returned to jail or prison. When more people are being served and supervised, there is the potential to identify more violations of release terms. Net widening can also occur when people at low risk of reoffending are put in more intensive levels of criminal justice supervision, including incarceration, in order to ensure their access to needed services. Additionally, state Medicaid plans will likely contain provisions that emphasize less-intensive yet clinically appropriate treatment modalities, such as outpatient instead of residential treatment. If judges are reluctant to mandate individuals to outpatient treatment in the community, this change could result in increased sentences to prisons and jails. Criminal justice leadership participation in planning is also imperative lest unintended barriers be created that actually reduce utilization of needed treatment, further impede continuity of care and result in more, not fewer, sentences to jail and

prison. These and other unintended consequences for justice-involved populations under a Medicaid-dominated public treatment system should be addressed during system planning and must be resolved before 2014 when the applicable Medicaid expansions will take effect.

### ***Leveraging the ACA and Criminal Justice Mandates to Increase Recovery***

The successful leveraging of the ACA's opportunities goes beyond the programmatic issues previously described; a systems approach is necessary. A recovery-oriented system for criminal justice populations must incorporate the essential elements of recovery while balancing the sanctions and rewards of the justice system, promoting clients' recovery from substance use and mental health conditions, as well as reductions in offending behaviors.<sup>83</sup> Additionally, for full reintegration upon release from the jail, such a system must involve the communities in which arrestees ultimately will be able to live without returning to criminal behavior.

**Stakeholders must develop the infrastructure for coordinated, community-based care management and supervision.** As noted, there is a need for a recovery-focused continuity of care that follows individuals from the institution into the community. The ACA will allow for a shift from a framework of acute treatment episodes to one of chronic disease management and durable recovery supported in the community. Each acute episode of treatment can support this trajectory but is not in itself sufficient to “cure” patients of their substance use disorders. The concepts of recovery management and recovery-oriented systems of care have been advanced to support long-term, durable recovery, not just cessation of use, and to include extensive recovery supports, both formal and informal. The criminal justice system is critical in that it can initiate and reinforce participation in care.

The ACA calls for new investments in community health teams to manage chronic disease.<sup>84</sup> All partners will need to collaborate to develop a care management infrastructure that can relate to a new public system. (See Table 4 on page 15.) When community treatment is required as a condition of release, several other

**Table 4. 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

challenges will emerge, such as the need for a standardized, streamlined process for conducting assessments, making referrals to treatment, developing treatment plans and meeting medical standards. Timely participant compliance and progress reports must be delivered in order to ensure client accountability and adherence to justice mandates. A shared, uniform understanding of both clinical needs and justice oversight requirements and processes is also necessary. Intervention strategies must be based on rehabilitation needs as well as public safety implications. Sharing the common goals of rehabilitation, reductions in recidivism and cost savings can help keep such approaches on track and well-coordinated.

**Communities must strengthen capacity to support re-entry and recovery.** A core concept of recovery-oriented systems of care is that recovery is not confined to traditional services, but happens in the context of community, where people live, work and engage in social relationships.<sup>85</sup> To facilitate durable recovery for jail populations, there must be community capacity to support people's ability to live in healthful ways without returning to the justice system. Jail intervention programs must be designed as systems partnerships, involving collaborations among providers of treatment, housing and employment,<sup>86</sup> as well as the availability of positive peer support and community engagement.<sup>87</sup>

#### Call to Action: Preparing for ACA Implementation

Health care reform can yield substantial county correctional savings by redirecting eligible individuals from jail and into community-based care. Additionally, leveraging health care reform to better coordinate jail- and community-based services has the potential to improve the health and justice status of millions of individuals passing through the country's jails every year. By providing access to coordinated, evidence-based clinical care with justice supervision for arrestees who have substance use and psychiatric disorders, current and future incarcerations can be reduced and public safety improved.

How reforms unfold in any locality will depend considerably on leadership within state and county governments, state and local justice professionals, community health care providers and other partners. (See Table 5 on page 16-17.) In addition to pursuing the opportunities discussed in the previous section, stakeholders must lay the groundwork now for reforms that will be implemented in 2014. State and local government officials will play an important role through regional and state planning for location and utilization of primary health and specialty substance use treatment and psychiatric services. As a major referral source for publicly funded treatment, criminal justice

**Table 5. Realizing the Potential of ACA Reforms: A Call to Action for Stakeholder Leaders**

<i>Stakeholder Leaders</i>	<i>Call to Action</i>
Community Behavioral Health and Medical Care Providers	<ul style="list-style-type: none"> <li>■ Expand treatment capacity</li> <li>■ Integrate primary care and specialty care</li> <li>■ Integrate community services with jail-based services</li> <li>■ Expand capacity to enroll clients in Medicaid/insurance</li> <li>■ Improve treatment through use of evidence-based practices</li> <li>■ Cultivate new partnerships with other stakeholder leaders to maximize diversion and successful re-entry</li> </ul>
County Government Officials	<ul style="list-style-type: none"> <li>■ Maximize jail diversion and re-entry initiatives</li> <li>■ Minimize costs and risk of litigation</li> <li>■ Assess potential benefits and risks</li> <li>■ Convene planning processes to develop local action plans</li> <li>■ Investigate the reallocation of funding from corrections to community health services</li> </ul>
State Medicaid Directors	<ul style="list-style-type: none"> <li>■ 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</li> <li>■ Facilitate strategic planning of capacity expansion, with attention to making services available in underserved communities and rural areas</li> </ul>
State Insurance Directors	<ul style="list-style-type: none"> <li>■ 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</li> </ul>
Single State Agency Directors	<ul style="list-style-type: none"> <li>■ 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 and rural areas</li> <li>■ Plan integration of Medicaid-funded and Block-grant funded services</li> <li>■ Advocate public policies that ensure health insurance coverage and enrollment for all jail detainees who are legally eligible</li> </ul>
Jail Officials	<ul style="list-style-type: none"> <li>■ Partner in systems integration efforts that provide continuity of care between community and detention settings and support successful re-entry to reduce recidivism</li> <li>■ Maximize Medicaid/insurance enrollment among detainees</li> <li>■ Partner in jail diversion initiatives</li> </ul>
Judges	<ul style="list-style-type: none"> <li>■ Partner with correctional and community health and behavioral health care providers and funders to bring diversion and re-entry initiatives to scale</li> <li>■ Represent the concerns of public safety and behavioral health intervention from the criminal justice perspective</li> <li>■ Advocate for treatment resources needed to significantly reduce recidivism by changing the behavior of jail detainees</li> </ul>



**Table 5. Realizing the Potential of ACA Reforms: A Call to Action for Stakeholder Leaders (cont.)**

Stakeholder Leaders	Call to Action
Probation	<ul style="list-style-type: none"> <li>■ Develop and expand pre-trial supervision systems to manage justice compliance among arrestees who are participating in the community-based treatment</li> <li>■ Partner with judges and community providers to integrate substance use treatment as an intervention for people who would otherwise return to jail on a technical violation of community supervision requirements</li> </ul>
Parole	<ul style="list-style-type: none"> <li>■ Partner with judges and community providers to integrate substance use treatment as an intervention for people who would otherwise return to jail on a technical violation of community supervision requirements</li> </ul>

system leaders will have important contributions to this planning process. Jails will need to implement health screening and Medicaid enrollment procedures. Providers of substance use and mental health treatment must stay informed as implementation unfolds and engage in planning efforts that will respond quickly to changes. Community-based recovery supports will need to be strengthened so that detainees will have access to employment, housing and peer support to help them sustain recovery. All stakeholders will need to communicate and collaborate with one another throughout the planning process.

**County Governments Play a Leading Role**

County governments are uniquely positioned to address the challenges and needs of both the correctional and community health care provider systems, and they have much at stake in the new health care environment. They could benefit substantially through reduced incarceration costs, but they could also bear the brunt of increases in jail medical care costs. Further, they face the primary risk of litigation stemming from inadequate provision of health care services. As county boards control funding for the local criminal justice system as well as safety net hospitals (i.e., those that offer access to services regardless of ability to pay and have patient mixes substantially composed of uninsured, Medicaid and other vulnerable patients<sup>88</sup>) and public clinics, they play a pivotal

role in influencing the direction and priorities of the planning process.

To promote public safety and public health, and to reduce criminal justice expenditures, it is important that officials assure that county correctional systems maximize: (1) redirection of arrestees into accountable community supervision and treatment programs, and (2) linkage to re-entry programs that can facilitate reductions in recidivism. The high-stakes challenge is to design and implement a new system that ensures improved, coordinated health care in the least restrictive setting that is protective of public safety.

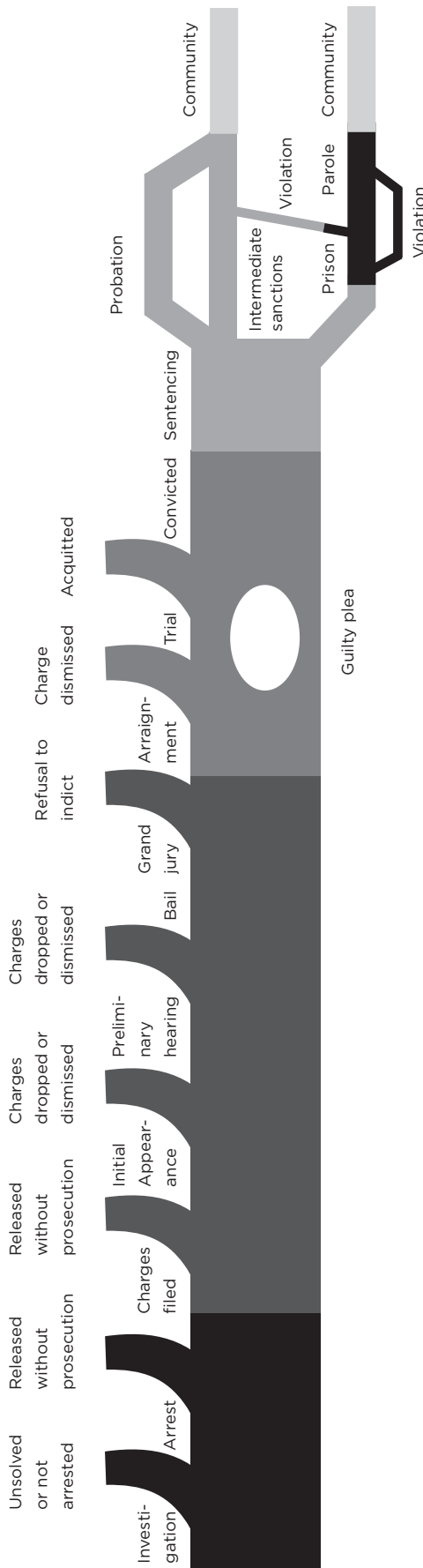
**Criminal Justice Officials Are Key Drivers**

Criminal justice officials’ unique capacity to catalyze change will be instrumental in local health care reform planning efforts. In many jurisdictions, sheriffs, judges and other criminal justice leaders have convened stakeholder groups to build substance use and mental health interventions to reduce recidivism and public expenditures.<sup>89</sup> Over the past 30 years, these coalitions have conceived, initiated and sustained diversion and intervention programs throughout the criminal justice continuum. (See Figure 1 on page 18.) Such partnerships provide important expertise in designing and managing collaborative projects that reduce recidivism without increasing risks to public safety.<sup>90</sup> Because judges and jail officials are responsible for making decisions that

Figure 1. Continuum of Justice Interventions

**Sentencing/Community-based Supervision**

- Peer Support
- Re-entry Management
- Drug/Specialized Probation
- TASC Programs
- Graduated Incentives/Sanctions
- Day/Evening Reporting



**Law Enforcement**

- Crisis Intervention Teams

**Prosecution/Pre-trial**

- Drug Education/Drug Schools/Deferred Prosecution
- Jail-based Services (Day Reporting)
- Electronic Monitoring
- Pre-trial Supervision
- Day/Evening Reporting

**Adjudication**

- Problem-solving Courts
- Veteran's Court
- Domestic Violence Court
- Drug Courts
- Family Court
- Mental Health Court
- TASC Programs

**Incarceration/Parole**

- Jail-based Treatment
- Re-entry Case Management

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

have broad public safety and clinical implications, they have the potential to drive engagement and retention in continuous, integrated care in community settings.

### Summary

Health care reform has the potential to catalyze large-scale, positive change in communities across the country. To achieve improved recovery outcomes and recidivism reduction for jail populations, all stakeholders must work together to plan for ACA implementation. The reality of chronic health conditions must be acknowledged, and the standards of care for such conditions must be woven into the new systems. The goal of treatment intervention services should be durable recovery, using evidence-based practices and including the provision of longer-term care and management. With cost savings as a key driver for local communities, health care services should be protective of the public's safety and delivered in the most cost-effective, community-based treatment environment.

They must be coordinated between county correctional systems and community service providers, and integrated with primary care. There are numerous proven models and lessons learned from many states; with expanded health care coverage under the ACA, these models can be adapted and brought to scale in communities and jurisdictions across the country.

States, counties, other jurisdictions and providers need to communicate and collaborate with one another to influence and plan for how the ACA will be implemented in their states. Those involved in the implementation of health care reform at state and local levels must work together to advocate and implement reforms that address the long-term health care needs of individuals with chronic health conditions. Success in implementing health care reform has the potential to result in reduced crime, recidivism and criminal justice expenditures as well as healthier and safer communities across the country.

## References

- <sup>1</sup> Mark Kammerer, telephone conversation, 13 July 2009.
- <sup>2</sup> Mahoney M, Fitzgerald JT and Heaps MM. *Cook County Substance Abuse Intervention Project: State of the System and a Blueprint for Action*. Chicago: TASC, Inc., 1995.
- <sup>3</sup> Beck AJ. "The Importance of Successful Reentry to Jail Population Growth." (Presented to the Urban Institute Jail Reentry Roundtable, Washington, DC, June 27, 2006.)
- <sup>4</sup> Binswanger IA, Krueger 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.
- <sup>5</sup> 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.
- <sup>6</sup> Steadman HJ, Osher FC, Robbins PC, et al. "Prevalence of Serious Mental Illness Among Jail Inmates." *Psychiatric Services*, 60(6): 761-765, 2009.
- <sup>7</sup> Center for Mental Health Services' National GAINS Center. *The Prevalence of Co-Occurring Mental Illness and Substance Use Disorders in Jails*. Delmar, NY: Center for Mental Health Services' National GAINS Center, 2002 (revised 2004).
- <sup>8</sup> Wang EA, White MC, Jamison R, Goldenson J, Estes M and Tulskey 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.
- <sup>9</sup> Minton T. *Jail Inmates at Midyear 2009—Statistical Tables*. Washington: Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice, 2010; *2006-2008 American Community Survey 3-Year Estimates*. Washington: U.S. Census Bureau, n.d. (No authors given.)
- <sup>10</sup> Institute of Medicine. *Health Care Reform and Future Workforce Needs: Addressing the Needs of Racial and Ethnic Minority Patients and Other Underserved Populations*. Washington: Institute of Medicine of the National Academies, 2010.
- <sup>11</sup> Coyne RM and Green R. "Standards of Care: Advancing Inmate Health Care Through Performance-Based Outcomes." *Corrections Today*, (70)3: 50-72, 2008.
- <sup>12</sup> Office of National Drug Control Policy. *ADAM II: 2008 Annual Report*. Washington: Office of National Drug Control Policy, Executive Office of the President, 2009.
- <sup>13</sup> Karberg, JC and James DJ. *Substance Dependence, Abuse, and Treatment of Jail Inmates, 2002*. Washington: Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice, 2005.
- <sup>14</sup> Steadman et al.
- <sup>15</sup> Center for Mental Health Services' National GAINS Center, *The Prevalence of Co-Occurring Mental Illness and Substance Use Disorders in Jails*.
- <sup>16</sup> 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.
- <sup>17</sup> Substance Abuse and Mental Health Services Administration. *Results from the 2009 National Survey on Drug Use and Health: Volume I. Summary of National Findings*. Rockville, MD: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, 2010.
- <sup>18</sup> Bhati AS, Roman JK and Chalfin A. *To Treat or Not To Treat: Evidence on the Prospects of Expanding Treatment to Drug-Involved Offenders*. Washington: Urban Institute Justice Policy Center, 2008.
- <sup>19</sup> *ibid.*
- <sup>20</sup> National Institute on Drug Abuse. *Principles of Addiction Treatment: A Research-Based Guide*. Washington: National Institute on Drug Abuse, National Institutes of Health, U.S. Department of Health and Human Services, 1999 (reprinted 2009).
- <sup>21</sup> Wilson DJ. *Drug Use, Testing, and Treatment in Jails*. Washington: Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice, 2000.
- <sup>22</sup> *ibid.*
- <sup>23</sup> Minton.
- <sup>24</sup> Pew Center on the States. *One in 31: The Long Reach of American Corrections*. Washington: The Pew Charitable Trusts, 2009. (No authors given.)
- <sup>25</sup> 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.
- <sup>26</sup> 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.
- <sup>27</sup> National Institute on Drug Abuse. *Principles of Addiction Treatment: A Research-Based Guide*.
- <sup>28</sup> Dennis ML and Scott CK. "Intervening in the Recovery Process." (Presented at the NIDA Meeting on Treatment and Recovery Process, Bethesda, MD, January 15-16, 2004.)
- <sup>29</sup> Beck.
- <sup>30</sup> National Institute on Drug Abuse. *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide*.
- <sup>31</sup> Hser Y, Huang D, Teruya C, et al. "Diversity of Drug Abuse Treatment Utilization Patterns and Outcomes." *Evaluation and Program Planning*, 27(3): 309-319, 2004.
- <sup>32</sup> 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.
- <sup>33</sup> The National Center on Addiction and Substance Abuse at

Columbia University.

<sup>34</sup> Wang et al.

<sup>35</sup> 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.

<sup>36</sup> Halvorson A, Skinner J and Whitter M. *Provider Approaches to Recovery-Oriented Systems of Care: Four Case Studies*. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2009.

<sup>37</sup> 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.

<sup>38</sup> Kaplan L. *The Role of Recovery Support Services in Recovery-Oriented Systems of Care*. Rockville, MD: Center for Substance Abuse Services, Substance Abuse and Mental Health Services Administration, 2008.

<sup>39</sup> Samuels P and Mukamal D. *After Prison: Roadblocks to Re-entry. A Report on State Legal Barriers Facing People With Criminal Records*. New York: Legal Action Center, 2004.

<sup>40</sup> Taxman FS, Young D and Byrne J. *Offender's Views of Re-entry: Implications for Processes, Programs, and Services*. College Park, MD: University of Maryland, Bureau of Governmental Research, 2002.

<sup>41</sup> Whitter M. *Strengthening Professional Identity: Challenges of the Addictions Treatment Workforce*. Bethesda: Abt Associates Inc., 2006.

<sup>42</sup> Race M, Yousefian A, Lambert L, et al. *Mental Health Services in Rural Jails*. Portland, ME: Maine Rural Health Research Center, Muskie School of Public Service, 2009.

<sup>43</sup> Whitter M and Hillman DJ. *Recovery-Oriented Systems of Care (ROSC) Resource Guide*. Bethesda: Abt Associates Inc., 2010.

<sup>44</sup> *ibid.*

<sup>45</sup> 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.

<sup>46</sup> Race et al.

<sup>47</sup> 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.

<sup>48</sup> Kerlikowske G. "Testimony of R. Gil Kerlikowske, Director, Office of National Drug Control Policy." (Testimony presented at the Senate Committee on the Judiciary Field Hearing "Effective Community Efforts to Counter Drug-Related Crime in Rural America," Barre, VT, March 22, 2010.)

<sup>49</sup> Lenardson J et al.

<sup>50</sup> 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.

<sup>51</sup> Race et al.

<sup>52</sup> 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.

<sup>53</sup> 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.

<sup>54</sup> The Center for Mental Health Services' National GAINS Center. "EBPS," 2010, [www.gainscenter.samhsa.gov/html/ebps/default.asp](http://www.gainscenter.samhsa.gov/html/ebps/default.asp) (accessed September 2010).

<sup>55</sup> Adams EJ. *Healing Invisible Wounds: Why Investing in Trauma-Informed Care for Children Makes Sense*. Washington: Justice Policy Institute, 2010.

<sup>56</sup> James DJ. *Profile of Jail Inmates, 2002*. Washington: Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice, 2004.

<sup>57</sup> 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.

<sup>58</sup> Simons KL. "Women, Trauma and Substance Abuse." *Counselor*, 7(6): 12-17, 2006.

<sup>59</sup> Center for Mental Health Services' National GAINS Center. *Practical Advice on Jail Diversion: Ten Years of Learnings on Jail Diversion From the CMHS National GAINS Center*. Delmar, NY: Center for Mental Health Services' National GAINS Center, 2007.

<sup>60</sup> Assuming that the average length of stay is 14 days: 500 jail beds x 26 time periods/year = 13,000.

<sup>61</sup> James DJ.

<sup>62</sup> 13,000 x 66 percent = 8,580.

<sup>63</sup> Steadman et al.

<sup>64</sup> Assuming that the average treatment stay is 30 days: 50 treatment beds x 12 time periods/year = 600.

<sup>65</sup> Ten percent of the population needing intervention: (8,580 + 1,885) x 10 percent = 1,046 x 14 days x \$75/day in jail = \$1,098,300.

<sup>66</sup> 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.

<sup>67</sup> Sindelar T. *The "Medical Necessity Requirement" in Medicaid*. Boston: Disability Law Center, 2002.

<sup>68</sup> National Association of State Alcohol and Drug Abuse Directors.

<sup>69</sup> *ibid.*

<sup>70</sup> Mueller KJ. *The Patient Protection and Affordable Care Act: A Summary of Provisions Important to Rural Health Care Delivery*. Iowa City, IA: RUPRI Center for Rural Health Policy Analysis, College of Public Health, University of Iowa, 2010.

<sup>71</sup> National Association of State Alcohol and Drug Abuse Directors.

- <sup>72</sup> *Affordable Care Act: Laying the Foundation for Prevention*. Washington: Department of Health & Human Services, [www.healthcare.gov/news/factsheets/aca\\_laying\\_the\\_foundation\\_for\\_prevention.html](http://www.healthcare.gov/news/factsheets/aca_laying_the_foundation_for_prevention.html) (accessed September 2010).
- <sup>73</sup> Galanter M, Keller DS, Dermatis H, et al. "The Impact of Managed Care on Substance Abuse Treatment: A Report of the American Society of Addiction Medicine." *Journal of Addictive Diseases*, 19(3): 13-34, 2000.
- <sup>74</sup> National Association of State Alcohol and Drug Abuse Directors.
- <sup>75</sup> Institute of Medicine.
- <sup>76</sup> Center for Substance Abuse Treatment. *Substance Abuse Treatment for Adults in the Criminal Justice System. Treatment Improvement Protocol (TIP) Series 44*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.
- <sup>77</sup> Peters RH and Bartoi MG. *Screening and Assessment of Co-Occurring Disorders in the Justice System*. Delmar, NY: Center for Mental Health Services' National GAINS Center, 1997.
- <sup>78</sup> Taxman FS, Cropsey KL, Young DW, et al. "Screening, Assessment, and Referral Practices in Adult Correctional Settings: A National Perspective." *Criminal Justice Behavior*, 34(9): 1216-1234, 2007.
- <sup>79</sup> 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.
- <sup>80</sup> National Association of State Alcohol and Drug Abuse Directors.
- <sup>81</sup> Steve Rosenberg, telephone conversation, 14 July 2010.
- <sup>82</sup> Gaumond P and Whitter M. *Access to Recovery (ATR) Approaches to Recovery-Oriented Systems of Care: Three Case Studies*. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2009.
- <sup>83</sup> 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.
- <sup>84</sup> *Health Disparities and the Affordable Care Act*. Washington: U.S. Department of Health & Human Services, [www.healthcare.gov/law/infocus/disparities/index.html](http://www.healthcare.gov/law/infocus/disparities/index.html) (accessed September 2010).
- <sup>85</sup> Center for Substance Abuse Treatment. "Working Definition of Recovery." (Presented at the National Summit on Recovery Conference, Washington, DC, Sept 28-29, 2005.)
- <sup>86</sup> Solomon et al.
- <sup>87</sup> Center for Substance Abuse Treatment. "Working Definition of Recovery."
- <sup>88</sup> Institute of Medicine. *Research Brief: America's Health Care Safety Net - Intact but Endangered*. Washington: Institute of Medicine, 2000.
- <sup>89</sup> Berman G and Feinblatt J. "Problem-Solving Courts: A Brief Primer," *Law & Policy*, (23)2: 125-140, 2001.
- <sup>90</sup> Steadman HJ and Naples M. "Assessing the Effectiveness of Jail Diversion Programs for Persons with Serious Mental Illness and Co-occurring Substance Use Disorders." *Behavioral Sciences and the Law*, 23(2) 163-170, 2005.