Leveraging National Health Reform to Reduce Recidivism & Build Recovery: National Health Care 101 for Criminal Justice

GLATTC Webinar

September 7, 2011
The TASC Perspective

• Nearly 35 years of research, public policy involvement and direct service provision

• TASC serves more than 20,000 justice-involved individuals annually with substance use, mental illness, or both

• Designed and managed numerous programs connecting criminal justice with community-based care:
  – Statutory authority / state licensure around clinical case management for drug-involved probation and parole populations
  – Court advocacy and case coordination for specialty courts
  – Design and implementation of Cook County Jail treatment and re-entry program

• TASC participates extensively in national and state planning on health care reform and for people under criminal justice supervision
Goals of the Webinar

• Overview of the current challenges providing sa/mh services for justice populations
• Discuss how the Patient Protection and Affordable Care Act (ACA) can apply evidence-based practices and expand services for justice populations
• Recommendations for planning that should be happening NOW
• Examines the financial and practical implications of health care reform for the criminal justice system
• Discussion / Q&A
• Additional resources
What is the Affordable Care Act?

Law enacted in March 2010 to:

– Expand access to under-served populations
– Improve outcomes
– Maximize efficiency of public health expenditures
What is the Affordable Care Act?

• We’re focusing on one aspect:
  • Expansion of access to care for low-income populations regardless of disability
  • Expansion shifts planning from program-level to system-level, linking criminal justice and community behavioral health
What is the Affordable Care Act?

- Status of Implementation
  - Federal and state govts currently in planning process, implementing early phases (e.g. pre-existing condition provisions)
  - Building health insurance exchanges, enrollment procedures
  - Federal “essential benefit” plan expected within the next year
  - Medicaid expansion takes effect January 1, 2014
Substance Use Disorders Are Nearly Universal in CJS

- Criminal justice populations include people who are addicted to drugs and/or alcohol as well as people who abuse and misuse these substances.
  - More than 70% of jail inmates test positive for drugs
  - 47.9% of state prison inmates and 43.7% of local jail inmates met criteria for substance dependence
    - This is over 7 times greater than in the general population.
  ❖ Most of the remaining group demonstrate significant substance abuse that have serious consequences, including legal consequences
- Result of untreated substance use disorders
- Incredibly expensive especially to states and counties

Other Chronic Conditions More Widespread Than In General Population

• Much higher rates of serious mental illness
  – Over 10%
• Higher rates of chronic medical conditions
  – Diabetes, Heart Disease, Asthma, Cancer, HIV

• About 10% have insurance
  – Medicaid/disability, All Kids, Family Care
  – Private insurance
Scope of the Challenge - Snapshot: Jails in Illinois

- Jail bookings (2008): 366,923
- Two-thirds report using drugs regularly (~241,000)
- 14.5% (~53,000) have psychiatric disorders
- Of those, 72% (~38,000) have co-occurring disorder
- Highly variable lengths of stay
- Difficult to coordinate care around case processing
- Little-to-no post-release care
- High likelihood of return if clinical needs aren’t addressed
Scope of the Challenge: Probation

- Indiana (2009): 130,178
- Michigan (2009): 175,421
- Ohio (2009): 260,577

- Special probation supervision, specialty courts, individual officer referrals
Scope of the Challenge: Parole

- Illinois (2009): 33,683
- Indiana (2009): 10,653
- Ohio (2009): 19,119

  - Special parole supervision initiatives, individual officer referrals
  - Recent Ohio initiative; Illinois Sheridan CC
Current Challenges in Providing and Funding Health Care Services for Justice Populations
Continuum of risk / need

<table>
<thead>
<tr>
<th>High Risk</th>
<th>Low Risk</th>
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<td>Accountability, Treatment &amp; Habilitation</td>
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<td>Accountability &amp; Habilitation</td>
<td>Prevention</td>
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Douglas B. Marlowe, J.D., Ph.D.
What is treatment?

• Evidence-based
• Behavioral therapies:
  – Counseling
  – Cognitive therapies
  – Psychotherapy
• Physician-prescribed medications
• Combination of one or more therapies
• Step-up / Step-down based on progress
Under current justice and health care structures...

• Multiple and interconnected barriers to providing coordinated and effective health care
• Especially pronounced with substance use and psychiatric disorders
• Specific challenges include:
  – Divergent system goals
  – Insufficient or fragmented funding
  – Lack of health insurance coverage
  – Insufficient or inadequate care
  – Lack of coordination
Divergent goals...

• Justice: Public safety and reduce recidivism
• Health Care: Protect or improve individual and community health
• Mutual objective of cost containment
• Justice systems not designed as providers of healthcare, but often obliged to assume that role
• Case precedents and constitutional safeguards compel a level of care within institutions
Insufficient/inadequate treatment...

- Demand for community-based treatment in most states exceeds availability
- Justice-based treatment programs rarely reach all individuals who are legal eligible (or legally entitled)
- Lack of resources to expand successful models
Fragmented funding streams...

- Public sa/mh supported largely by federal block grants & categorical Medicaid eligibility (MH)
- Federal Justice and Human Services funding streams / initiatives
- State and County-level funding
- Pursuit of non-block grant funding requires long RFA processes for only incremental increases
- Uncoordinated funding creates isolated pockets of service, not seamless continuums of care
Inadequate and truncated care...

• SA/MH are chronic – require ongoing, long-term treatment and management
  – At least 3 months in treatment to stop or curtail use
  – Durable recovery requires multiple episodes of care over many years

• Acute care treatment in justice settings can’t address chronic conditions
Lack of insurance...

• Most people in justice systems don’t have health insurance
  – Only 10% of jail inmates
• State Medicaid rules may exclude most childless adults
• Those with Medicaid may get unnecessarily dropped while incarcerated
• Once released, little assistance reinstating benefits
Lack of capacity / recovery focus...

- Resistance to community-based services
- Lack of systems linkage between treatment, vocational, housing, educational services
- Lack of coordination between criminal justice and mental health systems
- Lack of capacity to engage families and other recovery allies
Lack of resources in rural areas...

• Rural jails/corrections have become default setting for health and social services that are absent in the community

• Health care in rural settings limited to screenings, medications management and crisis response

• Fewer pre-trial or post-release treatment programs
  • In 2004, 91% of substance abuse treatment facilities were in or near a metro county
Lack of resources in rural areas...

• As a result, behavioral health care falls largely on primary care providers
  – Few offer mental health services, and if they do, it’s usually for less serious conditions (depression, anxiety, hyperactivity, etc.)

• Clients have to travel significant distances for services
The promise of health care reform

• Won’t solve all challenges, but...

• Unique opportunity for significant change on a broad scale
  – Near universal coverage
  – Eliminate long waiting lists
  – Address gaps in services
  – Ending piecemeal approach to application of public funding
Preparing for 2014 Health Care Reforms: Applying What Works
Evidence-Based Practices (EBPs)

Federal agencies articulate EBPs for service delivery to justice populations with SA/MH conditions:

- **NIDA** – “Principles of Drug Abuse Treatment for Criminal Justice Populations”
- **SAMHSA** – “Treatment Improvement Protocol 44: Substance Abuse Treatment for Adults in the Criminal Justice System (TIP 44)”
- **SAMHSA** – National Registry of Evidence-based Programs and Practices (NREPP)
- **SAMHSA / GAINS Center** – Six EBPs for mental health treatment in justice settings
- **NIC** – EBPs to reduce recidivism
- **NIC** – Guidelines for implementing EBPs in policy and practice in community corrections
EBPs Evolve

• New evidence, new conditions, new priorities:
  • E.g. Trauma-informed care
    • Childhood trauma common in justice population
    • Half of women in jail report past physical or sexual abuse
    • Trauma associated with high rates of psychiatric and substance use disorders
    • Un-addressed trauma can impede treatment and recovery
  • Trauma-informed care now one of SAMHSA’s cross-cutting policy and program principles
Applying EBPs

• Align EBP with target population:
  • Phase of justice involvement
  • Behavioral need
  • Criminogenic risk

• Align EBP with goals
  • Reduction of costs
  • Corrections supervision
  • Improved clinical diagnosis
  • Stable, durable recovery

• Align EBP with system capacity and design
  • Don’t assume what works in one setting will work in another
The ACA and Cost Reduction

- Broad expansion of funding / eligibility in 2014
- More opportunities for diversion and intervention at each point in justice process
- Jurisdictions work with community providers to expand access to SA/MH services
- Bring to scale programs that are already in place
- Incorporate proven models (EBPs)
The ACA and Cost Reduction

- Expanded capacity as happened in 12 states that have already expanded Medicaid coverage
  - WA State results: 33% reduction in arrests after treatment WITHOUT CJS LEVERAGE
1. Specific Opportunities for Sheriffs/Jail Administrators:

• Reduce “frequent fliers” due to untreated substance use and psychiatric disorders

• Reduce jail health care expenditures related to chronic conditions

• Potential opportunity: Reduce incarceration through increased diversion to treatment with pre-trial/probation supervision
Potential Impact of Broad Reentry Programs

• Hypothetical county jail
  – 500 beds – 13,000 detainees/yr (ALOS 2 weeks)
  – Two-thirds (8,580) report using drugs regularly
  – Current capacity to only treat several hundred per year
  – 14.5% (1,885) have psychiatric disorders, will benefit from treatment in jail or community

• Even moderate reduction in detainees could result in significant cost savings.
  – A 10% reduction in jail days would yield over $1M in savings annually
What is needed to gain these results?

- Enrollment in Medicaid/Insurance during incarceration
- Universal screening
  - Substance use & psychiatric disorders, chronic medical conditions
- Matching to appropriate services
  - Substance abuse treatment
  - Mental health treatment
  - Community medical care for chronic conditions
2. Specific Opportunity for Probation:

• Reduce probation violations due to untreated substance use and psychiatric disorders
• Gain these results across all probationers, not just in smaller “demonstration” programs and specialty courts
• For specialty courts:
  • Better access to timely treatment
  • Opportunity to focus on high risk/high need probationers
What is needed to gain these results?

- Timely enrollment in Medicaid/Insurance
- Universal screening early in the CJS process
- Matching to appropriate services
  - Drug Education
  - Outpatient, Intensive Outpatient, Residential Treatment
  - Expanded capacity will be needed
- Universal reporting and sanctions process
  - Must avoid net widening
3. Specific Opportunity for Parole:

- Develop reentry services for parolees who have had treatment inside correctional centers
  - Research shows that pre- and post-release treatment together have the greatest impact
- Reduce parole violations due to untreated substance use and psychiatric disorders
  - Increased access to community based treatment as an alternative to re-incarceration
- Gain these results across all parolees, not just in smaller “demonstration” programs
  - Universal access to sa/mh services on release
What is needed to gain these results?

• Timely enrollment in Medicaid/Insurance
• Universal screening early in the CJS process
• Matching to appropriate services
  • Drug Education
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What Will Change: Benefits and Impact of Health Care Reform for Justice Populations
Change #1: Funding & Billing Mechanisms

- Medicaid funding rules will govern how SA/MH is structured, reviewed and approved.
- State Medicaid authority – primary funder and overseer.
- Providers must implement Medicaid-compatible, fee-for-service billing structures.
- Medicaid certification requirements.
- Electronic health records.
Change #1: Funding & Billing Mechanisms

- Providers receiving block grant may be required to shift funding sources
- State may use block grant for “non-medical” services (e.g. recovery homes, recovery support, trauma-informed care) or may be substantially reduced
Change #2: Reimbursement Based on Necessity

- Medicaid billing requires authorization based on medical necessity
- Each state Medicaid authority puts in place processes for “medical necessity” determination
  - Medicaid managed care
- SA/MH providers will need to understand Medicaid provisions
  - Ensure categorization of SA/MH as necessary
Change #2: Reimbursement Based on Necessity

• “Medically necessary” in justice context:
  • Incarceration suppresses use
  • Substance dependence is chronic – symptoms may disappear temporarily – likely to reappear
  • Disconnect with how medical necessity is traditionally determined
  • Clinical treatment still necessary to manage illness and build recovery
Change #3: Increased Demand

• Potentially dramatic increase in number of patients requiring SA/MH services.

• NASADAD review of utilization expansion:
  • +20% in Massachusetts (had low uninsured population prior to their coverage expansion)
  • +32% in Maine
  • +100% in Vermont

• Need to build community treatment capacity
Change #4: Supply of services will shift

• Supply of services dictated by what will be covered by Medicaid

• Depth of care may be reduced
  • Residential treatment less available
  • Reorganize away from acute care and toward long-term recovery support
    • Recovery Oriented Systems of Care

• Less expensive services may expand:
  • E.g. Brief interventions; outpatient; day treatment; medication-assisted treatment
Change #5: Integration of SA/MH with Primary Care

• Integration of specialized care with primary care is a priority under ACA
  • Improve access
  • More coordinated care
  • Fewer acute care episodes
• Collaboration and partnership will be expected
  • Federally-qualified health centers
  • Community health teams
  • Home health care providers
  • New referral networks
Change #5: Integration of SA/MH with Primary Care

- Planning efforts focus on practical systems changes that facilitate access to a continuity of care
  - Transfer of prescriptions b/w corrections and community
  - Integrating electronic health records
  - Increasing public health education
  - Centralized care facilities offering SA/MH alongside primary care
• Workforce issues in ACA oriented around primary care access and medical homes, not specialty care
• Providers required to employ staff who meet Medicaid-defined professional standards.
• Shortages of credentialed clinicians must be addressed
• Staff trained how to operate in Medicaid environment:
  • Language / terminology
  • Billing
  • Use of technology (e.g. telemedicine)
Increased Opportunities for Justice
Interventions that Combine Supervision with Clinical Care
Opportunity #1: Earlier interventions / sustained services

- Broad-based screening will identify larger pool of individuals in need of services
- Screen all individuals coming into justice system provides opportunity to intervene before condition becomes chronic
- Overall expansion of resources for SA/MH services should expand access and promote adoption of EBPs
Opportunity #2: Implement protocols for screening

- Justice system will need to employ screening tools to determine eligibility for covered services
- Can / should be done at intake to assess clinical need and criminogenic risk
- Tools may already exist:
  - SAMHSA TIP 44
  - Texas Christian University Drug Screen
  - National GAINS Center
  - SBIRT Model
- Early screening also informs participation in treatment alternatives
Opportunity #3: Justice system as Medicaid enrollment partner

- Identify and respond to barriers to enrollment
  - Lack of identification and documentation
  - Substance use and psychiatric disorders may interfere with ability to make healthful choices
  - Unfamiliarity with procedures and processes
- State Medicaid directors play a critical role in establishing procedures
Opportunity #3: Justice system as Medicaid enrollment partner

- Kaiser Family Foundation Survey
  - Lack of awareness among newly eligible
  - Difficulty communicating through conventional strategies
  - Failure to complete forms
  - Periodic incarceration / cessation of eligibility
- Justice system can be an active partner in enrollment
- Development of electronic enrollment records must be explored
  - Identify potentially eligible detainees
  - Automatically enroll / leave jail/prison with valid Medicaid card
Opportunity #4: Balance clinical intervention and public safety

• At each point in the CJS (jail, probation, parole):
  – Develop legal eligibility criteria
  – Develop community supervision requirements
  – Both of above inform scale and scope and likely population
  – Employ validated risk assessment tools
  – NIC EBPs for community corrections
Opportunity #5: Patient choice in justice settings

- Patient choice of providers is a condition of Medicaid
- Justice system can have processes in place to recommend levels of care, but...
- Client will have access to a network of approved providers
- Similar process used in Access to Recovery initiative
- Justice practitioners and community providers need to collaborate to develop the network
Need to avoid net-widening

• “Net-widening” – expansion of intervention program actually leads to increased numbers in the justice system:
  • More technical violations
  • Lower risk offenders placed into more intensive supervision to ensure access to care
  • Medicaid may recommend less-intensive levels of care, judges may be reluctant and impose harsher sentences
• Criminal justice partners need to be involved in planning for ACA expansion
Leveraging ACA and Justice Mandates to Increase Recovery
Take a Systems Approach

• Incorporate essential elements of recovery
• Balance sanctions and rewards of justice system
• Promote client recovery from SA/MH conditions
• Involve the community where offenders come from / will be returning to
Components of Care Continuity for Justice Populations

- Screening for SA/MH and medical needs
- Comprehensive clinical assessment leading to course of care
- Placement in community SA/MH services and with medical care provider
- Ongoing care management to support engagement and retention in services
- Ongoing care management to facilitate access to recovery support services
- Regular reporting on compliance and progress (including drug testing)
Infrastructure for coordinated care

- Recovery-focused continuity of care
- Follow individuals from institution to community
- Shift framework from acute episodic treatment to sustainable chronic disease management
- Support long-term, durable recovery, not just cessation of use
Community recovery capacity

• Recovery happens in context of community, where people live, work and engage in relationships

• Communities must have capacity to support ability to live in healthful ways

• Based on systems partnerships involving justice practitioners, community providers, recovery support services, and peer support
Realizing the Potential of ACA Reforms: 
A Call to Action for Stakeholders
Behavioral Health and Medical Care Providers:

- Expand treatment capacity
- Integrate primary care and specialty care
- Integrate community services with justice-based services
- Expand capacity to enroll clients in Medicaid/insurance
- Improve treatment through use of EBPs
- Cultivate new partnerships with other stakeholders
County Government Officials:

- Maximize 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 reallocation of funding from county corrections to community health services
State Medicaid Directors:

• Collaborate with criminal justice, medical & behavioral health care providers to reduce barriers to coverage for Medicaid-eligible population
  – Expedite enrollment from jails & prisons

• Facilitate strategic planning of capacity expansion
  – Special attention to rural / underserved communities
State Insurance Directors:

- Collaborate with health care providers to reduce barriers to coverage for insurance-eligible population through exchanges
- Address integration of this population in managed care
Jail / Corrections / Probation / Parole Officials:

• Partner in systems integration efforts that provide continuity of care between community and justice settings and support practices to reduce recidivism

• Maximize Medicaid/insurance enrollment among justice population

• Partner in diversion initiatives / community treatment alternatives
Judges:

• Partner with correctional and community / 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 criminal justice perspective

• Advocate for treatment resources needed to reduce recidivism
resources

COCHS Conference Papers
http://www.cochs.org/health_reform_conference_dc/papers

SAMHSA Presentation on HCR from the treatment provider/system perspective

Council for State Governments FAQ on HCR
Contact Information

Maureen McDonnell
TASC Institute for Consulting & Training
mmcdonnell@tasc-il.org
312-573-8222

www.tasc-il.org
www.centerforhealthandjustice.org