Leveraging National Health Reform to Reduce Recidivism & Build Recovery

Presented to SAMHSA’s ATCC Grantees

January 23, 2013
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 for the Webinar

• Brief overview of the current challenges providing substance abuse and mental health services in specialty courts and other criminal justice settings

• Discuss how the Patient Protection and Affordable Care Act (ACA) can allow courts and probation officers to apply evidence-based practices, expand services and reduce future arrests

• Discuss how ACA creates an unprecedented sustainability path for ATCC grantees

• Discussion / Q&A

• Additional resources
Adults Involved in CJS in the U.S.

Sources: Bureau of Justice Statistics, Correctional Surveys, as reported by the Pew Trust, “One in 31” (2009).
Incarceration & Community Supervision

• 1 in 100 adults behind bars (2006)
  – Jails = 748,728 (2010)
  – Prisons = 1,617,478 (2009)

• 1 in 45 adults on probation or parole (2007)
  – Probation = 4,203,967 (2009)
  – Parole = 819,308 (2009)

• **Revolving door** of justice involvement
  – 730,000 people admitted and released from prisons each year (2009)
  – Two-thirds (68%) of prisoners rearrested within 3 years of release (1997)
  – Half (52%) of prisoners returned to prison for new crime or violation (1997)

Sources: The Pew Center on the States, 2008; Minton, 2011; West, 2010; The Pew Center on the States, 2009; Glaze & Bonczar, 2010; Langan & Levin, 2002; Beck, 2006 vin, 2002; Beck, 2006
Substance Use Disorders are Nearly Universal in the 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

Sources: CASA, "Behind Bars II", February 2010; DOJ ADAM Report, Adams, Olson & Adams, 2002
Other Chronic Conditions More Widespread Than in General Population

• Much higher rates of serious mental illness
  – 15% of men compared to 3.4% in the general population
  – 30% of women compared to 6.5% in the general population

• Higher rates of chronic medical conditions
  – Diabetes, Heart Disease, Asthma, Cancer, HIV

• About 10% have health insurance
  – In the 40+ states that have not already expanded Medicaid to cover low income adults
  – Medicaid/disability, All Kids, Family Care, Private Insurance, Veterans’ benefits
Proven models for effective treatment of offenders have been proven over the past 40 years

- Recognized by national experts:
  - NIDA, SAMHSA/CSAT & CMHS, BJA, NIC
- Treatment participation reduces subsequent criminal activity by 33%-70%, depending on the model (Mancuso & Felver, 2009, Olson 2008)
- Reach only a small proportion of people with untreated addiction and psychiatric disorders today
- Specialty courts reach approximately 1% of people under justice supervision
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
  - OJP – Drug Court Guidelines
  - NIC – EBPs to reduce recidivism; NIC – Guidelines for implementing EBPs in policy and practice in community corrections
What Keeps Us From Using These Interventions Universally Today?
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
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
How will National Health Reform Change Things?
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

• Survived Supreme Court Review (June 2012)
What is the Affordable Care Act?

• We’re focusing on one aspect:
  • Expansion of Medicaid for low-income adults regardless of disability (up to 133% FPL)
  • Access to subsidized insurance through Health Insurance Exchanges

• Creates broad access to insurance/care
  • Mental health and substance abuse services required
  • Opportunity to shift from programs to system-level interventions and create comprehensive linkages between criminal justice and community behavioral health
How does the ACA create a sustainability path for ATCCs?

- ACA creates a new funding stream for substance abuse, mental health and medical services for low-income people
  - Federally reimbursed at 100% in first years, drops to 90% by 2019 and remains there
  - Will support treatment as well as assessment and case management by Medicaid-certified providers
- Business processes in CJS and health systems can be aligned for big wins
  - Examples: Brooklyn Drug Court, Tucson
## State Implementation

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<tr>
<th>Status</th>
<th>Examples</th>
<th>What happens in 2014?</th>
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| States with comprehensive coverage for low-income adults | New York, Massachusetts, Hawaii, Arizona, Vermont, Maine, DC | • Match increases to ACA FMAP  
• (100% through 2016, slides to 90% by 2019 and stays there)  
• Stronger provisions for MH/SA services |
| States with recent early expansion (ACA)           | Illinois, California                          | • All eligible adults covered, beyond those enrolled early  
• Match increased to ACA FMAP  
• Stronger provisions for MH/SA services |
| States with some coverage for low-income adults    | Pennsylvania, Michigan, Indiana               | • If the state adopts the Medicaid expansion, all eligible adults will be covered  
• Stronger provisions for MH/SA services |
| States with no coverage for low-income adults      | Ohio, Texas                                   | • If the state adopts the Medicaid expansion, all eligible adults will be covered  
• Stronger provisions for MH/SA services |
CJS Population Will Be A Large Part of the “Newly Eligible” in 2014+

New Medicaid Enrollees in Illinois beginning in 2014

- Justice Involvement: 300,000 (approx.)
- No Justice Involvement: 350,000 (approx.)

Illinois is expecting 500,000 – 800,000 new Medicaid enrollees beginning in 2014

Note: Chart reflects the median range of 650,000 total new enrollees

Justice involvement includes:
- People on bond, pretrial supervision and pretrial detention
- On Felony Probation
- Released From Prison

Sources: Illinois Criminal Justice Information Authority (2008); Illinois Supreme Court (2009); Illinois Department of Corrections (2009)
The Promise of Health Care Reform

Won’t solve all challenges, but...

➢ Unique opportunity for significant change on a broad scale

➢ Near universal coverage for low income adults

➢ Address gaps in services

➢ Eliminate long waiting lists
  ➢ Developing unified systems with single point of access to care – improve outcomes, increase competitive position

➢ Ending piecemeal approach to public funding
Increased coverage reduces crime

Washington State moved funds from its corrections system to its substance abuse treatment system 10 years ago

What happened?

- They experienced 17-33% reduction in arrests among those who went to treatment
- This all happened with limited resources and attention from the criminal justice system
Through the Lens of Specialty Courts/ATCCs

- Experienced in addressing behavioral health issues
- Established care networks
- Reduce rearrest
- Reach about 1% of people under supervision nationally
- Labor intensive model
1. Specific Opportunity: Courts/Probation

• Reduce probation violations and new arrests due to untreated substance use and psychiatric disorders

• Gain these results across all probationers, not just in smaller “demonstration” programs

• For specialty courts:
  • Better access to timely treatment
  • Opportunity to focus on high risk/high need probationers
  • Important leadership role for specialty courts in system planning
What will be needed to gain these results?

- Timely enrollment in Medicaid/Insurance
- Universal screening early in the CJS process
- Matching to appropriate services
  - Substance Abuse: Outpatient, Intensive Outpatient, Residential & Medication-Assisted Treatment
  - Mental Health Services
  - Expanded capacity will be needed
- Infrastructure for referrals will be needed
- Universal reporting and sanctions process
  - Must avoid net widening
2. Specific Opportunity: Jails

- 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
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
Coming Challenges

• Negotiating CJS-specific enrollment processes
• Expansion of SA/MH treatment capacity
• Significant expansion of Medicaid managed care in many states
• New criteria for treatment placement
  – “Medical Necessity”
Coming Challenges

“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
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
Challenges Coming in the Community-Based Treatment Systems

• State Medicaid authority – primary funder/rules
  – Medicaid managed care & CJS
• Essential services
  – Need sufficient duration & intensity
• Workforce
  – Teams: Licensed counselor + CADC + recovery support specialist (FAVOR)
• Medicaid certification & billing
• Greater individualization of care plans
Collaborative Planning Underway

Objectives

– Develop workable strategies for Medicaid enrollment in jails, prisons and in probation (2014+)
– Develop recommendations for policies and practices in HCR implementation (health insurance exchanges, managed care purchasing, etc.) that will encourage people under CJS supervision to participate
– Develop model projects to test these strategies
Roles for Stakeholders

• **Community Providers:** Expand treatment capacity

• **County Budget Officials:** Maximize diversion and re-entry initiatives

• **State Medicaid Directors:** Expedite enrollment from jails & prisons; develop favorable managed care policies

• **State Insurance Directors:** Reduce barriers to enrollment/coverage through exchanges; assure that arrest-related health care costs are reimbursable
Judges & Probation Chiefs:

- Convene planning processes
- 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
  - Sufficient duration & intensity to create durable recovery
Justice & Health Initiative

• Presiding Judge Paul P. Biebel, Jr. convened this planning process

• CJS stakeholders
  – Court, Probation, Jail, SAO, PD

• Health System stakeholders
  – CCHHS, Substance Abuse, Mental Health & Medical providers, Foundations

• Funded by Chicago Community Trust
Goals

• Identify wins for CJS and health system

• Identify opportunities
  – Create “on ramps” to medical coverage & care
  – Build “off ramps” from CJS via diversion to treatment in the community
  – Examples:
    • Low level offenders diversion at bond court
    • People with addiction and SMI linkage to services
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

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