How and Why Medicaid Matters for People with Serious Mental Illness Released From Jail

Research Implications

Hundreds of thousands of people with mental illness are released from jail each year.

In US jails, the prevalence of mental illness is two to four times higher than in the general population.[1] Correctional institutions, which are among the few places in the country where a person has a constitutional right to mental health care, have become our nation's largest mental hospitals.[2] Between 8 and 16 percent of people who are incarcerated have a mental illness, and of those, 72 percent also have substance abuse disorders.[3]

Without continuity of care, they are likely to be reincarcerated.

Corrections directors spend enormous amounts of money to provide mental health services and medications in settings full of stressors that typically cause a person's mental health to deteriorate. When a person is released, that investment may be wasted if the releasee lacks access to the services needed to stay in recovery. He or she may stop taking medication, resume abusing drugs or alcohol, and violate conditions of release or commit new crimes. Seventy-three percent of jail inmates in 2002 reported at least one prior sentence to incarceration or probation; 39 percent reported at least three prior sentences.[4] Many people are released with debt and a criminal record, which creates numerous obstacles to employment, housing, and reintegration generally into the community. Those with mental illness are particularly likely to cycle in and out of jail and prison, with the vast majority jailed for minor, non-violent misdemeanors.[5] According to a study conducted in Lucas County (OH), nearly three out of four people with mental illness released from jail are re-arrested within 36 months.[6]

Services provided in jail or prison and continued upon re-entry can facilitate recovery and reduce recidivism.

Various programs have demonstrated that connecting this population to intensive, targeted services makes a real difference in recidivism rates. Participants in the Nathaniel Project, an alternative to incarceration program in New York City for people with serious mental illness (SMI) who have committed felony offenses, demonstrated very high rates of engagement with treatment (80 percent over two years) and a dramatic decrease in arrests (among 53 participants, seven total arrests in the year following intake to the program compared to 101 arrests in the year prior).[7] Similarly, people released from jail who participated in the Allegheny County (PA) Forensic Support Program had a rate of recidivism (new arrests) of only 10 percent.[8] Of this 10 percent, none were sent to prison, only to county jail.[9] These programs, unlike most mental health services available to releasees, are specifically tailored to the needs of people with SMI who have criminal records.

Enrollment in Medicaid increases access to treatment for people with mental illness released from jail, who typically lack other means to pay for those services.

A recent study linked Medicaid enrollment to better access to services for people with SMI released from jail.[10] In King County (WA), where a wide range of mental health services supported those released at the time of the study, people who had Medicaid at the time of release had a clear advantage with regard to service use: they received significantly more total days of outpatient services (46 v. 28) and used mental health services at twice the rate (10 percent v. 5 percent) of those who did not have Medicaid upon release. In Pinellas County (FL), where all releasees had fewer service days overall, there was no significant difference in services obtained by people who

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had Medicaid upon release compared to those who did not. In both counties, however, the researchers found that the more days a person was enrolled in Medicaid after release from jail, the better his or her access to services. In addition, a separate study of the same population, found that those with Medicaid at the time of release gained access to services significantly faster than those who did not.[11]

People enrolled in Medicaid upon release experience fewer detentions and are more likely to remain in the community after one year.

People with SMI who had Medicaid upon release had significantly (16 percent) fewer detentions during the following year than those released without Medicaid. In addition, in King County, people who had Medicaid upon release stayed in the community longer than those who did not have Medicaid upon release. In Pinellas County, there was no significant difference between people with and without Medicaid upon release in terms of the number of days they stayed in the community, though a slightly higher percentage of people who had Medicaid upon release remained in the community after one full year.

People need access to appropriate services that can be funded by Medicaid.

Medicaid is only the first step—the doorway to receiving community-based mental health services after release from jail. But simply connecting people with SMI to generic mental health services with Medicaid does not have the striking effect on recidivism and other outcomes demonstrated by specialized programs, such as the Pennsylvania Forensic Support Program and the Nathaniel Project. If high-quality mental health treatment and other supportive services to address the needs of people released from prison or jail are not available in a community, Medicaid access is unlikely to significantly improve their ability to reintegrate into the community.

Additional research is needed about Medicaid and re-entry, from prison as well as jail.

Very little research exists on the overall number of people leaving incarceration who might be eligible to receive Medicaid; increasing knowledge of the scope and characteristics of this population should be a high priority. Differences in Medicaid enrollment and its effects on the distinct population released from prisons, rather than jails, must also be researched. Detainees in the King/Pinellas County study spent an average of 16 to 32 days in jail; since Medicaid enrollment is typically suspended, not terminated, when a person is incarcerated for fewer than 30 days, virtually everyone in the study who had Medicaid at jail entry also had it upon release. Unlike jails, which typically detain people for days or weeks pending adjudication or hold sentenced offenders serving less than a year, prisons are state or federally-operated facilities that confine convicted felons for months or years. Because people stay longer in prison than jail, people sentenced to prison are much more likely to have Medicaid enrollment terminated while they are incarcerated. Research is needed to determine whether having Medicaid upon release helps prisoners obtain needed services in the community, as it did for jail detainees in the King/Pinellas County study.

Programs to boost treatment engagement and reduce recidivism also need more research.

Research is also needed to see whether parole or probation supervision of engagement in services or targeted, evidence-based treatment programs reduce recidivism in people with SMI. Additionally, researchers should explore whether programs that help inmates apply for benefits actually increase their enrollment in Medicaid or other benefits programs. Policymakers and practitioners should seek to fill these knowledge gaps to best target limited resources intended to halt the cycle of incarceration and recidivism.

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1. Paula M. Ditton, *Mental Health and Treatment of Inmates and Probationers*, US Department of Justice, Bureau of Justice Statistics (Washington, DC: 1999), NCJ 174463.
2. Mental health care is constitutionally guaranteed to people in custody of the government, as in prisons, jails, or other places where a person may be involuntarily committed (*see* Youngberg v. Romeo, 457 U.S. 307 (1982)) .
3. Ditton, *Mental Health and Treatment of Inmates and Probationers*.
4. Doris J. James, Profile of Jail Inmates, 2002, US Department of Justice, Bureau of Justice Statistics (Washington, DC: 2004), NCJ 201932.
5. Joseph P. Morrissey, *Medicaid Benefits and Recidivism of Mentally Ill Persons Released from Jail*, revised draft, December 8, 2004.
6. Lois A. Ventura, Charlene A. Cassel, Joseph E. Jacoby, and Bu Huang, "Case Management and Recidivism of Mentally Ill Persons Released from Jail," *Psychiatric Services* 49:10, October 1998.
7. GAINS Center for People with Co-Occurring Disorders in the Justice System, *The Nathaniel Project: An Alternative to Incarceration Program for People with Serious Mental Illness Who Have Committed Felony Offenses* (Delmar, NY: GAINS Center for People with Co-Occurring Disorders in the Justice System, Fall 2002).
8. Amy Kroll, presentation at Access to Benefits Summit, Pennsylvania DOC Training Academy (Elizabethtown, PA: December 3, 2004).
9. Ibid.
10. Joseph P. Morrissey, *Medicaid Benefits and Recidivism of Mentally Ill Persons Released from Jail*, revised draft, December 8, 2004. Commissioned by the National Institute of Justice at the direction of Congress, the study looked at people with SMI released from two jails. No special interventions to promote Medicaid enrollment or access to services were used, in order to present outcomes under ordinary circumstances within two large urban public mental health systems. The study also only tracked people who were enrolled in Medicaid at some point over three years, in order to control for Medicaid eligibility. The study used existing records for people detained between September 1998 to August 2000 (Pinellas County, FL) and between January 1996 and December 1998 (King County, WA).
11. Joseph P. Morrissey, Henry J. Steadman, Kathleen Dalton, Alison Cuellar, Paul Stiles, and Gary Cuddeback, *Medicaid Enrollment and Mental Health Service Use By Mentally Ill Persons Following Jail Release*, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, draft, June 4, 2004.