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Delinquent Youth in Corrections: Medicaid and Reentry Into the Community

ABBREVIATION. SCHIP, State Children's Health Insurance Program.

In general, states and public agencies acting as custodians for youth in the corrections branch of the juvenile justice system are responsible for ensuring that such youth receive access to timely and appropriate physical and mental health care. However, to date, health care for youth in the juvenile justice system has generally been considered inadequate. Note that in this article "health care" refers to the treatment of both physical and mental health problems. The American Academy of Pediatrics and others have issued policy statements in the past 2 decades that stress the need for better health care for juvenile offenders in correctional facilities.¹⁻⁴ In response, correctional facilities have put in place enhanced acute care services for children and adolescents in juvenile justice.

Although such services are almost certainly needed, these efforts are likely to be deficient on at least 2 counts. First, many of these youth suffer not only from acute medical and psychiatric problems but also chronic ones including substance abuse and other psychiatric disorders. Second, with an estimated 88 000 youth being released from juvenile commitment facilities each year,⁵ the need for ongoing medical treatment after parole and reentry into the community is high. However, care often stops when the juveniles leave the system, with little or no reintroduction to community services.⁶ Pediatricians and other primary care clinicians have a central role to play in establishing a medical home for these youth and expediting access to critical medical and behavioral services.

This review will provide an overview of the juvenile justice system, present the extant literature on the chronic health problems found in incarcerated youth, and discuss how the absence of care after release from the juvenile justice system impacts public health and society. We argue that Medicaid financing could be used as an immediate measure to ameliorate part of this problem and outline recommendations for future interventions.

JUVENILE JUSTICE SYSTEM

It is estimated that 2.4 million juveniles were arrested in 2000, accounting for 17% of all arrests in the

United States.⁷ Approximately 2 million cases are handled by US juvenile courts each year. In 1999, there were 80 400 committed youth in juvenile facilities, of which 88% were male. Because no current data exist, it is estimated that 88 000 youth are released from juvenile facilities each year.⁵ Among these, the number afflicted with chronic illnesses is small but represents an important subgroup, because they are a high-risk, high-cost group, prone to recidivate. Although the rate of juvenile crime steadily fell between 1994 and 2001, arrests of juvenile females, although only comprising 28% of all juvenile arrests in 2001, are increasing more than those of males in most offense categories including aggravated assault, drug-abuse violations, and simple assault.⁷ Minorities and youth of low socioeconomic status are also overrepresented in the juvenile justice population.^{5,8}

An arrested youth may be brought home without charges or detained in a detention facility. Postadjudication, the youth may be sentenced to a correctional facility, assigned to a community program, or admitted to a mental health treatment facility or program. The focus of this article is youth in correctional facilities. Specifically, we are interested in the outcomes of youth with chronic health problems postrelease.^{9,10} Youth are released from correctional facilities by either being placed on parole or completing their sentence. Parole is the supervised release of a prisoner from imprisonment with certain conditions. A violation of parole, such as not maintaining regular contact with parole or probation officers, truancy, substance use, or failure to attend treatment, can result in reimprisonment.⁹

HEALTH STATUS

Research to date has focused on the health of youth in detention facilities. Few studies have investigated these issues in incarcerated youth. In addition, we are not aware of any studies that have addressed the health of youth postrelease.

Detained youth present with higher rates of substance abuse, acute illnesses, sexually transmitted diseases, unplanned pregnancies, and psychiatric disorders. In 1 study, 46% of detained youth had medical problems including drug use, chronic liver infections, and gonorrhea.¹¹ Another study of adolescents being admitted to a detention center reported that 16.5% had a history of hospitalization for a medical or surgical reason; the same percentage received previous treatment for mental illness by a psychiatrist or therapist, and 11% were found to have a condition that needed close medical supervision after release.¹² These conditions can be attributed to their high-risk behaviors, challenging social environments, and lack of previous health care.⁴ Although many detained youth have chronic physical health problems, there is also a high prevalence of psychiatric disorders among this population. Teplin et al¹³ report that even after excluding conduct disorder, almost three fifths of male juvenile detainees and more than two thirds of females met the criteria for ≥ 1 psychiatric disorders. It is reported that as

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many as 60% of youth in detention meet the criteria for conduct disorder, 20% for a major depressive disorder, and 18% for attention-deficit/hyperactivity disorder.¹⁴ This compares with 37% of youth in the community reported to have at least 1 psychiatric disorder.^{15,16} One specific category of mental disorders that affects this population are trauma disorders. These youth are not only perpetrators but victims of trauma. As Cauffman¹⁷ reports, 43% of females and 40% of males present with traumatic experiences.

A large proportion of youth already incarcerated are afflicted with chronic illnesses that require ongoing medical attention. A survey of Washington State correctional facilities found that youth in long-term correctional facilities tend to have more chronic medical conditions than youth in short-term facilities. Dental problems were reported in 65.9% of youth, 44.1% had dermatological problems, 35.6% had respiratory problems, and 33.7% had substance-use problems.¹⁸ According to the 2001 National Household Survey on Drug Abuse, 10.8% of youth 12 to 17 years old were current illegal-drug users.¹⁹ In long-term facilities, 68% of males have a mental health disorder. Anywhere from 21% to 45% have a disruptive-disorder diagnosis, 20% to 50% have a substance-abuse diagnosis, and 7% to 36% have an anxiety diagnosis.²⁰⁻²⁵ Although specific information on the physical health status of female offenders could not be found, the rate of mental health disorders is higher for females in the juvenile justice system than for males.^{5,26}

Although physical and mental health problems are common both before and during incarceration, no studies have examined aftercare services or medical/behavioral services provided after reentry into the community for these extremely high-risk youth. There is reason to be concerned. First, any abrupt discontinuity in the care received while incarcerated puts the youth at significant risk for relapse.²⁷ Second, many questions remain about challenges to enrollment, eligibility for benefits, and identification of treatment facilities for youth released from juvenile justice facilities. Third, not only should the percentage of youth in the juvenile justice system with chronic illnesses be alarming, but the lack of services being received by this population should be of concern.

THE COSTS OF INACTION

In addition to the ethical argument that all children with chronic illness are deserving of care, any delay in receiving treatment after release may not only lead to increased morbidity and mortality but also may contribute to public health and legal problems such as increased spread of infection, continuation of antisocial behavior, higher health care use, and commitment of repeat offenses (criminal recidivism). Moreover, ignoring this problem may have dire consequences for the next generation of children.

Youth involved in the juvenile justice system are more likely to engage in high-risk behaviors such as

substance abuse and sexual activities. Detained juveniles report high rates of behaviors that could be detrimental to their health. Ninety-three percent of these youth claim to have had sexual intercourse, and the prevalence of sexually transmitted diseases was nearly double that of a comparison group of high-school youth.²⁸ Nearly all youth have engaged in alcohol drinking by age 15, and 40% have used marijuana >40 times.²⁸ After release, it is likely that these youth continue to engage in high-risk behaviors, thereby communicating diseases through many avenues including sexual contact and drug use. In this instance, this "revolving-door" effect of spreading disease both inside the prison and inside the community after release can occur.²⁹

Although research has been performed on recidivism and its prediction, not much has been conducted on recidivism among persons who have received psychiatric services in jail³⁰ or in children and adolescents. Although untreated physical illnesses are not likely to contribute to the rate of recidivism, in the absence of adequate treatment, mental illnesses (attention-deficit/hyperactivity disorder, conduct disorder) have been shown to be predictors of recidivism.^{31,32} Thus, it is likely that by maintaining a continuum of high levels of care for youth leaving a correctional facility, a drop in the rate of recidivism may be achieved.

In a study of incarcerated female juvenile offenders, 47% had used mental health services in the past, and 63% were repeat offenders.²⁶ The Bureau of Justice Statistics states that 80% of youth under the age of 18 years that were released in 1994 were rearrested.³³ As Draine et al³⁰ conclude, those who do not get appropriate, effective treatment after release are more likely to return to jail. From this we can determine that mental illness plays a role in the higher arrest (and rearrest) rates of those with mental illnesses,³⁴ showing that mental health care must be provided to this population. In addition, Hammett et al⁶ present the idea that many individuals deliberately return to incarceration because they receive better care in correctional facilities than after release. No studies, however, could be found on the effect of postrelease mental health services on recidivism rates.

Lack of follow-up care also places an inordinately high burden on the health care system. Because of a lack of insurance and access to health care, juveniles are forced to use emergency departments as their usual source of care. Wilson and Klein³⁵ report that 1.5 million adolescents in the United States reported using the emergency department as their usual source of health care. This places an enormous burden on the health system, because emergency departments are required to treat patients without the ability to pay. This cost, however, is absorbed by the system and is translated to higher costs of medical care for everyone, including those using Medicaid. Although the emergency department may be an immediate solution to an immediate problem, it does not provide adolescents with preventive screening or counseling, nor does it provide routine check-ups. Therefore, the emergency department is not consid-

ered an appropriate source of primary care.³⁵ Although no research could be found in this area, it is hypothesized that youth involved in the juvenile justice system use the emergency department as a primary source of care at a higher percentage than youth not involved with the juvenile justice system. This usage of emergency departments as primary care facilities is preventable by providing access to proper care.

The financial costs of crimes committed by a typical juvenile delinquent is estimated to be \$80 000 to \$335 000 between the ages of 14 and 17 years alone. An adult career criminal can add an extra \$1.4 million. It can be estimated that by preventing a high-risk youth from embarking on a criminal life path, a savings of \$1.7 to \$2.3 million can be generated.³⁶ Costs to the victim, including direct financial losses and pain and suffering, compose a majority of these costs. For crimes committed by juveniles, the annual victim costs (based on 1–4 crimes per year) is estimated to be \$15 000 to \$62 000.³⁶ Many of these youth might be prevented from traveling such a path if provided proper health care, especially mental health treatment. There are studies that show that mental health treatment reduces crime^{37–42}; therefore, based on existing research we can infer that mental health treatment also reduces associated costs.

As previously stated, there are many youth released from the juvenile justice population that do not have health insurance but are Medicaid eligible. It is estimated that it costs Medicaid approximately \$1600 per year, on average, to provide health services to each Medicaid-eligible child.⁴³ Comparing this figure to the financial costs of crimes committed by a juvenile, the potential for savings seems great.

POLICY ISSUES AND BARRIERS TO CARE

However clear it is that health and mental health care should be provided to youth released from correctional facilities (and detention centers) with chronic health problems, numerous hurdles to adequate aftercare services remain, including complex societal issues such as generally inadequate support for mental health services, stigma, and discrimination. However, specific financing issues seem particularly relevant and remediable. Although Medicaid is the most likely source of insurance for health coverage after release, enrollment in Medicaid is often terminated after the youth is placed in a detention center, prison, or jail. Thus, youth leaving correctional facilities on parole are often uninsured and not eligible for immediate benefits. One of the main barriers to receiving medical care is not having medical insurance, because the uninsured are more likely to not have a usual source of care than insured individuals.⁴⁴ As Aday and Andersen⁴⁴ show, the percentage of individuals with Medicaid coverage who had seen a physician in the last year was very close to the number who had some form of private insurance. Kasper et al⁴⁵ also report on the outcomes of individuals who gained insurance coverage after not having any initially. Their research shows that those

who gained insurance coverage had an increase in access to medical care “across all indicators of access.” Over the course of the study, the percentage of subjects who reported having no usual source of care dropped from 33% to 20% after gaining insurance.

In addition to funding, other barriers are related to enrollment difficulties, such as the lengthy eligibility-determination process. In the following section, various financing issues and barriers are discussed and solutions are presented.

Funding

There are 2 major sources of funding available to delinquent youth: private and public funds. Private insurance plans generally pay for most medical expenses but frequently have upper limits on the amount of money that they will pay for most services. Although an individual may have medical insurance, many times the copayments or deductibles for visits or medications can prove to be prohibitive. Parents and their youth then must either pay for the remaining expenses out-of-pocket or attempt to obtain help through the public sector.⁴⁶ However, as a result of their socioeconomic status, most youth released from correctional facilities do not have private health insurance and cannot afford to pay for the repeated physician visits required by chronic illnesses such as mental disorders. Even when their parents have adequate private insurance, their juvenile justice record and activities may have severed ties with their family, making them functionally uninsured. This leads them to seek public assistance to pay for medical care.

Public funds are primarily available in the form of Medicaid and the State Children’s Health Insurance Program (SCHIP). In 2002, Medicaid became the largest health insurance program in the United States, with expenditures totaling \$259 billion.⁴⁷ In federal fiscal year 2000, this federal-state program covered 44 million Americans, 24 million of which were children.⁴³ To receive Medicaid benefits, a youth must apply and be found to be eligible for benefits, that is, she or he must meet certain requirements set by the state using federal guidelines. Once eligibility is determined, benefits cannot be paid until a youth has been enrolled successfully.

Although no studies could be found that report the insurance status or Medicaid eligibility of youth released from correctional facilities, it is suspected that a large portion of this population may be eligible for Medicaid or SCHIP programs. Many of these youth may have participated previously in these programs but may no longer be enrolled, because most states terminate program benefits for the youth after incarceration.

Although we cannot be sure why states are choosing this course of action, anecdotal reports provide several possible reasons. First, many states may not be aware of other options available to them such as the suspension, rather than termination, of benefits. In addition, stiff penalties are given to states that bill Medicaid inappropriately. To avoid any possibility of billing Medicaid for an incarcerated youth, states may find it easier to terminate the youth’s benefits. If

a state is found to have billed Medicaid for an incarcerated youth, a possible fraud investigation may ensue, which again can be avoided by terminating enrollment. As a result, many states may find it is easier to terminate rather than suspend a youth's Medicaid benefits after incarceration.

States justify this termination of benefits by citing CFR §416.211,⁴⁸ which states that Medicaid benefits cannot be paid for any month throughout which an individual is a resident of a public institution. In addition, §1905(a)(A) of the Social Security Act⁴⁹ also excludes federal financial participation for medical care to inmates of a federal institution. Applied equally to juveniles and adults, these laws exclude federal financial participation in "care or services for any individual who is an inmate of a public institution" unless the inmate is in a medical institution. Although federal law does not require termination of eligibility,⁵⁰ most states automatically terminate participation because of this misunderstanding of current policies.²⁷

In a letter to all state Medicaid directors, the Centers for Medicare and Medicaid Services encouraged all states to "'suspend' and not 'terminate' Medicaid benefits while a person is in a public institution."⁵¹ The letter goes on to clarify that the eligibility of an individual for Medicaid is not affected by their status as a resident of a public institution. In addition, states are urged to place an eligible inmate in a "suspended status" so that the individual may begin receiving Medicaid benefits immediately after release.⁵¹ However, many youth that are eligible for Medicaid benefits after release are no longer enrolled and thus cannot receive any benefits. Although it is not a complete solution, Medicaid could be used to pay for health benefits for a large portion of these youth after release.

Although there is no clear-cut solution for solving the funding issue, Congress did provide 1 option when it passed the Balanced Budget Act of 1997. Presumptive eligibility allows states to give health care providers and community-based organizations the authority to "presumptively" enroll children in Medicaid or SCHIP programs who seem eligible based on age and family income.⁵² This enrollment greatly decreases the waiting time of getting health insurance and allows youth to receive needed care immediately rather than waiting for eligibility to be completely determined. To keep coverage, however, families must be found eligible for Medicaid or SCHIP through the regular eligibility-determination process by the end of the month after the initial application.⁵³

Although presumptive eligibility would immediately make health insurance (and subsequently health care) available to many more youth, as of August 2002 only 10 states had adopted presumptive eligibility in Medicaid and 5 had adopted presumptive eligibility as part of the SCHIP program. A contributing factor to why many states may not have adopted presumptive eligibility is the additional costs (administrative and programmatic) associated with covering and enrolling more people into state-

funded health insurance programs. One major concern is that the state may end up paying health care costs for individuals who are found later to be ineligible for health coverage.⁵³

Medicaid provides retroactive payments to individuals who received services before enrollment and pays providers for services rendered only if the individual is determined to have been eligible during that time.⁵³ The problem with this, especially when dealing with the juvenile population, is that many youth and families of youth cannot afford to take the risk of being found ineligible, causing them to be responsible for payments to service providers. With the inability to pay medical expenses, care is not sought by youth. Therefore, it is necessary to provide coverage during the period in which eligibility is being determined. Presumptive eligibility allows a child to receive services while guaranteeing that the provider will be paid for those services, even if he or she is found to be ineligible for Medicaid or SCHIP. The law also allows the state to designate any entity to determine presumptive eligibility,⁵³ which means that the ability to determine eligibility can be given to state juvenile correctional facilities, and delinquent youth can be deemed eligible on the day of their release.

Another option to providing Medicaid coverage immediately after release is that states can suspend a youth's enrollment after incarceration. To suspend Medicaid coverage would result in the youth remaining eligible for Medicaid after discharge, but no benefits would be paid during incarceration.⁵⁴ Although many states may not have a system in place for suspending eligibility,⁵⁰ the development of such a system would certainly be beneficial in the long run. Aside from providing immediate funding for health care, benefits include no waiting time for the resumption of coverage and the elimination of a potentially lengthy reenrollment process.

Enrollment

According to a policy report from the Urban Institute,⁵⁵ knowledge gaps such as not being aware of public-assistance programs is a primary barrier to enrolling 32% of all low-income uninsured children. The authors also state administrative hassles as a primary barrier to enrolling another 10% of all low-income uninsured children. It can be assumed that these numbers apply equally, if not to a greater extent, to youth released from the juvenile justice system, because low socioeconomic status is a risk factor for involvement in the juvenile justice system.⁸ Once an application has been submitted successfully, it is not unusual for there to be a processing time of ≥ 60 days before a youth becomes eligible for benefits.⁵⁶ This delay of access to community treatment services can potentially undo any stabilization the individual gained while incarcerated.²⁷ The gap between submission of the application and access to benefits can result in a large gap of time, during which the youth has no available medical care. Many states do not allow the application process to begin until after release.⁶

States could reduce the time required to enroll delinquent youth in Medicaid in 3 ways: improving enrollment efficiency, providing release planning, and allowing the application to start before a youth is released. Enrollment efficiency can be attained in several ways. For example, enrollment times can be reduced by eliminating the face-to-face interview, permitting mail-in applications, and allowing the self-verification of income.⁵⁵ Federal law (42 CFR 435.916) also allows states to use simplified procedures to determine a youth's eligibility after release from correctional facilities.⁵⁷

Release planning is becoming more important in helping to make the transition between jail and the community easier. Services provided through a release-planning program should include plans for social services (housing, food, vocational rehabilitation) as well as mental and physical health services.⁵⁸ Wolff et al⁵⁹ report that 71% of New Jersey jails believe release planning is "very" or "extremely" important, yet almost all the jails reported providing "no real release planning." Providing contact to post-release medical services and insurance coverage, especially mental health services, is important in maintaining continuity of care while youth make the difficult transition. Because many inmates are unaware of their Medicaid eligibility and lack knowledge about the application process, they are delayed further in receiving program enrollment. Release planning can provide invaluable assistance in ensuring the timely restoration of medical insurance benefits by educating youth about Medicaid and assisting inmates in completing applications and getting their paperwork in order.

In addition to simplifying the application process and providing release planning, states can enroll delinquent youth in Medicaid more rapidly by allowing the application process to begin while the youth is still committed. Generally, the determination process begins after a youth is released.⁵⁰ If states would allow the processing of applications to start before release, for example, after parole has been approved or 2 months before the release date, youth could be approved for and enrolled in Medicaid on the day they are released.

Combining simplified enrollment procedures, release planning, and an earlier application process can greatly reduce the amount of time and hassle it takes to enroll a youth in Medicaid, which would lead to a higher percentage of youth on parole having health insurance that, one would hope, would lead to better treatment of their chronic illnesses.

RECOMMENDATIONS

Improving the aftercare for youth released from corrections with chronic physical and mental illnesses is a daunting task because of financial and nonfinancial barriers that exist. However, clinicians, researchers, and lawmakers can reduce these barriers to care. Here we outline some possible improvements in the current system.

Clinicians should:

1. Have a higher index of suspicion of psychiatric disorders during evaluation of these youth. Because of the prevalence of chronic illnesses in this population, clinicians must be more vigilant in identifying these conditions during evaluations regardless of whether the youth are seen in emergency departments, primary care clinics, or urgent care settings.
2. Assess barriers to community reentry and health services. When receiving medical care, it is not enough for these youth to be provided a referral or prescribed medication without first ensuring that they have the resources available to receive the recommended care. If the resources are not available, appointments with community health organizations should be made or assistance provided to help the youth apply for Medicaid or other forms of health insurance.
3. Act as a "medical home" for managing and coordinating all of a youth's care and preventative services for all medical needs.
4. Use their powerful community voice to act as advocates to encourage change, increase access to services, and decrease stigmas.

Researchers should:

1. Describe the aftercare or medical/behavioral services received by youth on reentry into the community after release from long-term correctional facilities. The focus of this work should be on those youth with chronic (physical and mental) health problems, because these youth have the greatest need for health care.
2. Investigate the factors associated with recidivism and desistance and apply those data to the creation of new transition programs for aftercare services.
3. Determine the usual source of care (if any) for uninsured youth.
4. Collect data on how many youth are eligible for public insurance (Medicaid, SCHIP, Social Security Insurance) after release from correctional facilities and identify the barriers they face to obtaining coverage.
5. Investigate the relationship between mental health treatment and a decrease in crime and associated costs.

Policy makers should:

1. Adopt presumptive eligibility as an immediate solution to providing health benefits to eligible youth released from corrections until a permanent solution can be developed.
2. Develop a structured, streamlined system by which youth can apply for public insurance while they are still incarcerated so that they can have insurance benefits immediately available to them after release from correctional facilities.
3. Reduce the time taken to determine eligibility and enroll youth into public insurance programs by

eliminating the face-to-face interview, permitting mail-in applications, and allowing the self-verification of income.

4. Implement a system to suspend Medicaid benefits as an alternative to terminating them after a youth's incarceration.
5. Collect data on the insurance status or Medicaid eligibility of youth released from correctional facilities.
6. Provide better release planning to youth in correctional facilities, which is important in helping to make the transition between jail and the community easier. These services should include social services, as well as mental and physical health services.

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Structure Versus Function: Time Will Always Tell

ABBREVIATIONS. ELBW, extremely low birth weight; HUS, head ultrasound; CP, cerebral palsy; IVH, intraventricular hemorrhage; PVL, periventricular leukomalacia.

The article by Laptook et al¹ in the March issue of *Pediatrics* examined clinical follow-up assessments at 18 to 22 months' corrected age of an extremely low birth weight (ELBW) infant cohort cared for in the Neonatal Research Network Centers within the years 1995–1999. From the study cohort of 1749 infants, 84% (1473 infants) returned for follow-up assessments. The authors found that nearly 30% of those infants with a normal, early, and late head ultrasound (HUS) (performed at a mean age of 6 and 47 days, respectively) were found later to have either cerebral palsy (CP) (9.4%) and/or a low (<70) Mental Developmental Index (25.3%) on Bailey Scales of Infant Development II. All infants included in the study had a birth weight of 729 ± 134 g and a gestational age of 26 ± 2 weeks.

Multivariate analyses revealed that factors associated with subsequent CP were male gender, multiple birth, decreasing birth weight, pneumothorax, and days of mechanical ventilation.¹ The same factors, with the exception of pneumothorax, were associated with a Mental Developmental Index of <70 in addition to less maternal education and having Medicaid or lack of coverage for maternal insurance. Equally important, however, is the fact that from the initial cohort of 6905 infants with a birth weight of <1000 g, one third (2378 [34.4%]) died before discharge. Of the survivors, 2006 were excluded because of intrauterine infection, major malformation syndrome, or at least 1 abnormal ultrasound. Other exclusions and lack of follow-up resulted in the final 1473 infants who met inclusion criteria comprising the report. It is clear that the vast majority (~75%) of ELBW infants will die or have readily identifiable problems early.

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Delinquent Youth in Corrections: Medicaid and Reentry Into the Community
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