



“Meeting the Health Needs of Youth Involved in the Juvenile Justice System”

FACT SHEET

Based on the report by: **Karen Clark & Shelly Gehshan**
Dellums Commission

BACKGROUND

This fact sheet summarizes a paper that examines emerging strategies and models for effective treatment and support for young people in the juvenile justice system. It clarifies Medicaid regulations that affect states’ ability to deliver vital health services in a timely manner as young people enter and leave the juvenile justice system. And it offers guidance to state legislators, mental health and juvenile justice professionals, as well as others who are working to provide the wide range of health services needed by young people in the juvenile justice system. Along with its contribution to the Dellums Commission’s work, the paper is part of a collaboration between the Joint Center Health Policy Institute (HPI) and the National Academy for State Health Policy to help policymakers and leaders determine how best to use Medicaid funding for juveniles involved with the justice system. This collaboration and the recommendations in this paper contribute to a framework for improving physical and mental health—and, by extension, life options—of young persons, particularly young men of color, who are disproportionately represented in the juvenile justice system.

National Commission on Correctional Health Care, Health Care Funding for Incarcerated Youth

In a position statement regarding health care and incarcerated youth, the National Commission on Correctional Health Care states the following: “America’s future depends on the health of all of our children. Incarcerated youth represent an especially vulnerable population whose lives are at high risk for illness and disability. Early diagnosis and treatment is essential. The National Commission urges equality in access and funding for health care and, therefore, recommends that all youth in public and private confinement and detention facilities remain eligible for all public and private health care coverage consistent with the state and local eligibility requirements. (<http://www.ncchc.org/resources/statements/funding.html>)

HEALTH AND JUVENILE JUSTICE

Nearly 100,000 of young people are in juvenile justice facilities of some sort on any given day, with more than 2 million arrested in a year. Of those in residential settings, 62 percent are minorities, 85 percent are boys, and many, if not most, lack adequate health insurance coverage. Youth in juvenile justice facilities—including detention centers, shelters, diagnostic centers, group homes, wilderness programs, residential treatment facilities and training schools (where most juveniles are committed)—suffer disproportionately from a host of mental and physical health problems. The presence and severity of health problems may help explain the behaviors that led to their involvement in the criminal justice system and make it critical that they receive the appropriate medical services both in the system and upon their release.

Oral Health

The oral health of the juvenile population is a serious problem that has received little by researchers and program administrators. Tooth decay is the most common chronic disease among children in America. Children from families who earn less than 200 percent of the federal poverty level—who are overrepresented in the juvenile justice population—are three times as likely to have unmet dental care needs than those from higher-income families. A survey in Washington state found that dental problems were reported in 65.9 percent of youth in its juvenile justice system. Because untreated oral health problems affect the ability to eat, learn, sleep, develop healthy self-esteem and interact with peers and adults, they can substantially affect young people’s behavior and need to be addressed.

Substance Use Disorders

According to the National Center for Addiction and Substance Abuse (CASA) at Columbia University, addiction and substance use disorders affect a majority of the juvenile justice population: “Four of every five children and teens (78.4 percent) in juvenile justice systems—1.9 million of 2.4 million arrests of 10- to 17-year

olds— are under the influence of alcohol or drugs while committing their crime, test positive for drugs, are arrested for committing an alcohol or drug offense, admit having substance abuse and addiction problems, or share some combination of these characteristics.”

Only about 3.6 percent of juveniles in the justice system receive treatment services (in any form). Research shows that juveniles with substance use disorders who received treatment were less likely to commit a drug-related crime in the year following admission to treatment. Incarceration presents an opportunity to engage with juveniles who typically have little contact with or access to treatment services. Incarceration presents and opportunity to engage with juveniles

Mental Health

Almost as common, and often co-occurring with substance use disorders, are mental illnesses. Evidence suggests that more than 70 percent of juveniles involved in the system have a mental health and/or substance use disorder. These identified problems include, but are not limited to, attention-deficit/hyperactivity disorder, conduct disorder, post-traumatic stress disorder, oppositional-defiant disorder, and depression. This makes mental health services a necessary component for those high-risk juveniles involved in the system, both in and out of public institutions. Researchers have documented that juveniles who do not receive appropriate, effective treatment after release are more likely to return to jail. Unfortunately, the juvenile justice system is not well-equipped to handle mental health disorders. To close this gap, the issue needs to be addressed among *all* state agencies that work with this population, not by the juvenile justice system alone.

Recidivism

Simply put, recidivism is the repetition of criminal behavior. Some analyses count a re-arrest when determining recidivism, while others only count re-incarceration. It is very difficult to estimate the actual recidivism rate due to great differences among tracking methods used by juvenile justice systems in each state. However, the Bureau of Justice Statistics states that 80 percent of youth under the age of 18 who were released from juvenile justice institutions in 1994 were re-arrested. A study by the Vermont State Department of Developmental and Mental Health Services found a strong correlation between juvenile incarceration rates and the utilization of public mental health services. Ensuring that quality treatment services for mental and physical health are offered in correctional institutions could have a positive impact on juveniles as they leave the facilities and return to their communities. These guidelines focus on “total disease management” and provide some guidance on barriers to treatment within the correctional institutions. While there is a great need for services for youth involved in the juvenile justice system, there is an equally great need for these youth to be re-connected to services when they leave. Discharge planning and the process used to establish care in the community are a critical, but often neglected, part of the system.

MEDICAID

Health needs of juveniles are among the most important factors to consider upon re-entry. The lack of immediate re-connection to Medicaid upon release from a public institution (in some states) makes it more difficult for juveniles to access the services they need. Juveniles re-entering the community from a public institution face many barriers at the outset: stigma associated with incarceration, delays and missed material in education, and a stressed family environment, among many others. Accessing services becomes even more difficult when involvement in the criminal justice system and lack of prior connection to services are factors in determining availability of treatment. In an issue brief on access to federal benefits by inmates, the Bazelon Center noted “With long waiting lists, most community programs select people they believe can benefit quickly from services and those who will not pose particularly challenging problems for the program or engage in behaviors that disturb other clients. Lack of Medicaid coverage (despite possible eligibility) is an easy justification for denying access to such services.” Mental health, dental, and substance abuse services are often not available due to Medicaid state plan specifications regarding medical necessity and utilization review.

Statute and Regulation

Federal Medicaid law prohibits Federal Financial Participation (FFP) “with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution).” Therefore, states can receive Medicaid funding to pay for medical services for eligible youth in settings other than public institutions (such as privately run group homes). States are also free to use state funding for these services, but not bill the federal government.”

Suspension vs. Termination

Although federal Medicaid regulations do not require termination of the juvenile's Medicaid case and/or benefits, many states choose termination. States report that termination frequently occurs for one of the following reasons:

- Computer systems do not allow suspension; either the individual is deemed "Eligible" or "Not Eligible."
- The state has determined that the family the young person had when entering the juvenile justice system is different from the family he or she will join upon release, therefore creating eligibility problems upon re-entry.
- The state has determined that maintaining eligibility for those juveniles takes up too much staff time when the eligibility does not allow access to benefits until the juvenile is released.
- The state has determined that when a case is terminated in the system, re-application is easily completed when needed.

Presumptive Eligibility

One mechanism that has promise for ensuring that this vulnerable population receives services immediately, so no interruption in care occurs, is presumptive eligibility which allows states to give health care providers and community organizations (referred to as "qualified providers") the authority to enroll individuals who appear eligible in the Medicaid program "presumptively" and to receive payment for services rendered. This type of eligibility helps fill in the gaps in services during the time it takes for a Medicaid application to be processed.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

EPSDT is a service that states are required to include in their Medicaid packages for children under the age of 21. Under federal law, a state must provide any service that is needed to "correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services" even if the state has chosen not to cover those services in its state plan. In other words, a state can provide those services needed to resolve or improve any condition identified in the screening process, despite its state plan limits on the scope of services for a particular condition.

Access to Health Services

A delay in access to community treatment services can potentially undo any progress an individual makes while incarcerated. Ensuring that juveniles are enrolled in Medicaid, and have a medical home or assigned physician who can address prevention issues and treat other maladies as they arise, makes it more likely that adequate, cost-effective, and preventative care are provided to the at-risked juvenile justice population. Uninterrupted care is important because youth diagnosed with severe physical and mental health disorders (including schizophrenia, bipolar disorder, chemical dependence, and severe depression) need to be able to take their prescribed and medically necessary medications in order to remain stable and function well in the community.

FINDINGS

Given the lessons learned in state programs and current research on serving the juvenile justice population, there are a number of options available to states to increase access to health care services.

1. Screen young people for Medicaid eligibility at intake.

The process should be required and standardized in order to ensure that all juveniles are screened appropriately so that none are able to "slip through the cracks."

2. Make the connection to Medicaid prior to re-entry into the community.

Best Practices

A number of state and local initiatives that demonstrate creative ways to work within current federal guidelines and streamline systems to effectively connect the juvenile population to Medicaid and other services.

- Albany, New York, created an Options Committee to focus on services issues for person with co-occurring mental health and substance abuse disorders
- Lake County, Oregon has an agreement between the criminal justice system and the local social services office for the following 1) Application for Medicaid benefits can be done prior to release, 2) The Medicaid office "fast tracks" the applications by two-day processing and 3) Issuing temporary Medicaid cards to inmates, such that they have immediate access to benefits upon release.

Training juvenile justice staff on Medicaid eligibility helps to speed up the process of determination and enrollment. Designating specific workers to process juvenile justice applications (because of the quick turnaround needed and special circumstances presented) also appears to help with making the connection. At the very least, assisting families with applications for Medicaid is necessary.

3. Consider implementing presumptive eligibility for this population.

The use of presumptive eligibility for enrollment in Medicaid would provide coverage during the 45 to 90 days it takes for application processing upon re-entry into the community. Presumptive eligibility would promote access to the services that juveniles need in order to have uninterrupted medical services. The juvenile justice system could refer children that appear Medicaid-eligible to qualified providers in the community, where their eligibility could be assessed and presumptive eligibility granted if appropriate.

4. Ensure use of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services when appropriate for Medicaid-eligible children.

The use of EPSDT for cases in which a child does not qualify for continued services relating to a medically diagnosed condition could help overcome barriers associated with limits in a state Medicaid plan. For example, if a state plan limits the number of counseling sessions that a child can receive, but more are medically necessary, EPSDT services could fill in the gap and allow for more services.

5. Ensure that agencies work together and focus on providing care and treatment to juveniles.

Spending time attempting to figure out which agency should have primary responsibility for each child wastes resources and time. Cooperation among agencies is integral to successful treatment for juveniles, such as in the Alaska model.

6. Expand sentencing options from basic incarceration to treatment-centered services.

Providing services such as day treatment has lower costs and has shown a higher rate of success than incarceration (as noted in Texas' SNBP). In addition, Medicaid funding can be accessed when a juvenile is not placed in a public institution, which helps increase the pool of funds available to provide services to Medicaid-enrolled juveniles.

7. Involve parents and families in services being rendered.

As the New York program demonstrates, the involvement of parents in treatment can be beneficial. Some states even provide mental health counseling to parents if needed. Although parent services are not Medicaid-reimbursable, they help improve the support, general health, and well-being of the child. When a child has a firm family foundation, dealing with problems is much easier.

8. Provide mental health services, substance abuse services, and dental care during incarceration.

States such as New York that have placed mental health clinicians in their public institutions have shown great progress. States such as Alaska that provide substance abuse treatment in conjunction with juvenile justice have reduced recidivism and improved public safety. Although some of these services cannot be Medicaid-funded, juveniles who receive them experience better integration into community mental health services than those who do not.

CONCLUSION

The juvenile justice population consists of many different types of young people who require a range of services well beyond what juvenile justice programs were initially created to address. According to the Coalition for Juvenile Justice, "Emerging strategies and models to treat this population include collaboration across mental health, social services and juvenile justice systems (strategic planning, cross-training and providing services), diversion of youth from the juvenile justice system, [both physical and mental health] screening of all youth who come into contact with the juvenile justice system, use of community-based alternatives and appropriate treatment of juveniles placed in correctional facilities." States are revamping their health and juvenile justice systems to more effectively meet the changing needs of this population. Funding restrictions and administrative procedures have played a large role in the type and quality of services provided. Therefore, states have begun to examine how to best use Medicaid funding and screen youth entering and leaving the juvenile justice system for Medicaid eligibility. Because a large number of services are not eligible for Medicaid funding, because Medicaid cannot be used during incarceration, and because some children do not meet Medicaid eligibility criteria, states use local and state-only funding when needed. According to the National GAINS Center, "in some systems the loss of medical assistance benefits does not prevent the person from accessing public treatment services, but instead shifts the full cost of mental health, substance abuse, and medical treatment to the local city, county, or state agencies that bear those costs without the federal assistance to which they are entitled." In order to avoid unnecessary cost shifting, and to plan services for the wide range of problems that this population presents, agencies need to work together so that the youth involved can move on to a more satisfying and productive life.