

The Intersection of Public Health and Public Safety in U.S. Jails: Implications and Opportunities of Federal Health Care Reform

Bonita M. Veysey, School of Criminal Justice, Rutgers-The State University of New Jersey

Perspective

This paper was written from the perspective and experience of the Corrections and Re-entry Policy Research Center at Rutgers-Newark¹ at the Rutgers School of Criminal Justice. The Center focuses on community and institutional corrections policies and practices and on the difficult transitions between arrest and eventual release. The Center investigates questions related to legislative and policy initiatives, operations and procedural impacts, organizational change and community and individual outcomes. As an organization embedded in Rutgers-Newark, the Center has a strong commitment to urban issues, particularly those that affect Newark and northern New Jersey. In this regard, the health of New Jersey's jail detainees and inmates has particular salience to general public health. New Jersey has the highest incarceration rate of any state of persons on drug-related charges.² Consequently, rates of other health problems, such as tuberculosis, sexually transmitted diseases, hepatitis C and HIV/AIDS are very high.³ Poverty is highly concentrated in New Jersey's urban centers. Health care reform, particularly as applied to the jail population, is of deep interest to New Jersey's state and county governments.

This paper discusses the implications and opportunities of health care reform for jails from a public health perspective, beginning with an overview of U.S. jails and the characteristics of the jail detainee and inmate population. Prevalence estimates of acute, infectious and chronic diseases, mental and substance use disorders and experiences of interpersonal violence follow. In view of the nature of U.S. jails and the high rates of medical and

mental and substance use disorders among detainees and inmates, the paper discusses common strategies for the organization and delivery of health care within jails together with current financing strategies. The paper concludes with a discussion of the possible impacts of health care reform on jail services.

Introduction

The United States has achieved an historic milestone. A 2009 report by the Pew Center on the States⁴ estimates that 1 in 99 Americans are incarcerated in our nation's jails and prisons – more than 2.3 million adults behind bars on any given day. On a yearly basis, the numbers are staggering. Local jails, for example, process nearly 13 million admissions a year.⁵

Jail detainees and inmates are not representative of the U.S. population. They are disproportionately young, male, persons of color and poor.^{6,7} They also have high rates of health problems (such as injuries, chronic conditions and infectious diseases), acute and chronic psychiatric disorders and alcohol and other drug addictions.^{8,9} Upon booking, in fact, arrestees are often at their sickest.

Jails are required to provide treatment for acute medical and psychiatric problems¹⁰ and often focus their resources on urgent care and crisis stabilization.¹¹ For this reason, jails are an attractive treatment option for police and judges. With few affordable treatment services in the community, it is not unknown for police officers to arrest and judges to remand people to jail with the clear knowledge that they will receive treatment that they may not receive (or may refuse) if left in the community.¹²

The intersection of poverty, poor health and justice involvement is not accidental. The three factors go hand in hand. Poor people are more likely than their more affluent counterparts to be arrested; they are less likely to have health insurance of any kind, including Medicaid, and to have received regular health care; and they have



COCHS
COMMUNITY
ORIENTED
CORRECTIONAL
HEALTH
SERVICES

high rates of mental health and substance use disorders and consequently other medical concerns.

In many ways, poverty is at the center of the need for correctional facility-based health care. First, a large proportion of individuals arrive at the jail in acute psychiatric crisis and/or with active addictions. These same individuals often have not received treatment in the community. In some cases, this is because the person refuses or does not pursue treatment, but in many other cases community treatment resources are simply non-existent and the person lacks insurance coverage to pay for the few services that may be available. Some argue, in fact, that lack of access to medical, mental health and substance abuse treatment contributes to arrest and recidivism.¹³ Second, persons without financial resources often cannot make bail and therefore remain in jail awaiting trial and sentencing. In many cases, these individuals present no greater risk to the community than those who are released either through bail or on their own recognizance. Jails are responsible for providing health care – including treatment of acute and chronic medical and psychiatric disorders and detox from drugs and/or alcohol – for detainees for as long as they are in jail.

The Patient Protection and Affordable Care Act (ACA) promises to expand health coverage to all U.S. citizens.¹⁴ This legislation may reduce the number of arrests by providing treatment for people in the community who have mental health and substance use disorders and improve the health of those held in jail (assuming that future arrestees will have had preventive care and regular treatment for medical needs prior to arrest). Further, the ACA may allow for unsentenced jail detainees to maintain their health insurance benefits, including Medicaid.¹⁵ This may reduce pressure on jail health care staff to provide minimal services and to use cheaper, less effective alternatives in order to contain costs, thus encouraging local correctional professionals to provide high-quality treatment at a community standard of care. Additionally, greater use of electronic medical record systems could increase information transfer across a range of providers and expand access to pharmaceuticals to reduce symptoms and increase health. Thus, increased coverage, information transfer and

access to medication could have a substantial effect on continuity of care from pre-arrest to detention to re-entry while reducing recidivism and increasing overall public safety.

Because of the local nature of jails and the characteristics of those held in their custody, jails are in a unique position to serve as public health outposts by embracing a public health model. Five principles derived from the Hampden County (Mass.) Correctional Center community-oriented model can guide this work, including “(1) early assessment, (2) prompt and effective treatment at a community standard of care, (3) comprehensive health education, (4) prevention measures and (5) continuity of care in the community upon release.”¹⁶ Sound clinical practice based upon principles of public health has been found to increase both public health and public safety. Providing effective treatment at a high standard of care together with improving the health literacy and good health behaviors of detainee and inmate patients has been demonstrated to increase self-efficacy and reduce risk behaviors, leading to a reduction in recidivism.¹⁷ Ultimately, these factors can reduce crimes (particularly those that are drug-related), infection rates in the community, use of urgent and emergency care and community costs. Increased continuity of care is related to improved person-level outcomes, including improved health and well-being and longer periods of time in the community.¹⁸

Overview of U.S. Jails

Jails are short-term facilities that hold people who are awaiting trial and those serving short sentences, generally of one year or less.¹⁹ Many people booked into jail are released pending trial and their time in jail is very brief, ranging from several hours to a few days. Sixty-four percent of the population turns over every week.²⁰ The average stay in jail for a *sentenced* inmate is about three months (92 days).²¹ As such, jails are best characterized as people-processing institutions. At mid-2009, 767,992 individuals were confined in the nation’s nearly 3,000 jails.²² However, this number does not capture the vast number of persons processed through these facilities. Local jails admitted an estimated 12.8 million people

during the 12-month period from July 1, 2008, and June 30, 2009.²³ Because some individuals are booked into jail more than once a year, these nearly 13 million admissions represent approximately 9 million unique individuals.²⁴

The country's jail population has grown substantially over the past decade. This trend is driven in large part by an increase in detainees held pre-trial and in individuals returned to jail because of a probation or parole violation. Specifically, half the jail population on any given day is confined for a probation or parole violation or for bond forfeiture,²⁵ while 62 percent of jail detainees have not been sentenced.²⁶ Further, the proportion of unconvicted jail detainees has grown 56 percent since 2000.²⁷ Importantly, only approximately 4 percent of jail admissions result in prison time.²⁸ This suggests that the vast majority of jail detainees and inmates will return to the community — and in a relatively short time.

Despite the growth in the jail population, arrests, particularly for violent crimes, have decreased.²⁹ Currently, approximately 22 percent of detainees and inmates are held on violent charges, while 27 percent are held on property crimes, 30 percent on drug-related charges and 20 percent on public disorder or other crimes.³⁰ These numbers are based on the total jail population on a given day and do not represent the arrest charges of those booked into jail over the course of a year. Those who are remanded and/or sentenced tend to have more serious charges than those who are released. Based upon admissions, the vast majority are charged with misdemeanor offenses and only a small number are charged with felonies.^{31, 32}

Jails are commonly operated by county or municipal governments. In some states (such as Alaska, Connecticut, Delaware, District of Columbia, Hawaii, Rhode Island and Vermont), jails and prisons are integrated into a single system. Jails vary in size from a few cells to a rated capacity of over 22,000 (Los Angeles County, Calif.). The nation's 171 jails with a rated capacity of 1,000 or more account for 42 percent of the jail population,³³ but about 40 percent of jails hold 50 or fewer people.³⁴

Regardless of size, all jails, as 24-hour secure facilities, are under constitutional mandate to provide adequate care so that those held in custody do not suffer beyond what is allowable by law. In addition to providing adequate housing, clothing and food, custodial facilities have both the duty to protect individuals from harm and the duty to treat serious medical and psychiatric conditions.^{35, 36} Case law, such as *Estelle vs. Gamble*³⁷ and *Bowring vs. Godwin*,³⁸ established the right to receive medical and mental health treatment.³⁹ Provision of medical and psychiatric services to persons in need is not optional. However, resources for meeting this mandate vary widely among jails and in direct relation to their size.

Jail Demographics

Jail detainees and inmates are largely young, poor, male and people of color. Currently, 88 percent of the jail population is male. Although the largest proportion of detainees and inmates are white, 43 percent of other races and ethnicities are overrepresented in comparison to the general population. Specifically, 39 percent are black/African-American, 16 percent are Hispanic/Latino and 2 percent are Native American, Alaska Native, Asian, Pacific Islander and mixed-race/ethnicity.⁴⁰ In 2002, 30 percent of the jail population was 24 or younger.⁴¹ However, according to the Federal Bureau of Investigation's Uniform Crime Reports, 44 percent of all arrestees in 2008 were 24 or younger.⁴²

People in jail are often poor and have few resources — such as education, previous work experience, vocational training and social networks — that could help them secure a permanent living wage. Compared to the general population, persons in jail have low educational attainment. Specifically, 47 percent have some high school education or less, 14 percent have a general education diploma, 26 percent have a high school diploma and only 14 percent have any post-secondary education. In the general population, 33 percent have a high school diploma and 48 percent have at least some post-secondary education.⁴³ Further, nearly 40 percent of jails do not offer any education programs.⁴⁴ Sixty percent of people in jail have never been married.⁴⁵

Although 71 percent of respondents stated they had been employed in the month prior to their arrest, including full-time, part-time and occasional work, 59 percent earned less than \$1,000 per month, including 19 percent who reported no income at all.⁴⁶ Six percent reported receiving income from welfare benefits and 9 percent received support from Social Security, Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI), worker's compensation, unemployment insurance or other compensation sources.^{47, 48} Only 10 percent have health insurance.⁴⁹

Health Status of Jail Detainees and Inmates

People generally are booked into jails directly from the community. When they arrive, they are often at their worst. Some arrive with injuries, others are drunk or high and will detox during their stay in jail and others suffer from acute mental illness. In addition, many jail admissions suffer from chronic health conditions and poor oral health.⁵⁰ One study reported that 80 percent of jail detainees and inmates with chronic health problems, such as diabetes, heart conditions, hypertension and asthma, did not receive any regular medical care prior to entering jail.⁵¹ Ninety percent have no health insurance⁵² and over half used their local emergency room to receive needed care.⁵³

Racial and Sex Disparities

It is well documented that jail detainees and inmates are not representative of the U.S. population. While approximately equal in society at large, men far exceed women in jails, and the numbers of African Americans and Latinos in jail are disproportionate to their representation in the general population.⁵⁴ Poor people are also more likely to be found in jail than their more affluent counterparts.⁵⁵

Not only are there racial and sex disparities between the jail and the general populations, there are racial and sex disparities in health status,⁵⁶ health literacy^{57, 58} and services receipt⁵⁹ within the general public. These disparities are compounded by the disproportionate representation of specific population groups in jails, creating health care delivery challenges for jails similar to those of providing

indigent care in the community, including serious and acute medical crises and comorbidity of multiple health and behavioral health problems.⁶⁰ For example, women are a small minority of jail populations. However, women in jail are more likely than their male counterparts to have histories of physical and/or sexual abuse, mental illnesses, drug addictions, and a wide range of medical problems (see specifics presented below). While representing only a small proportion of the jail population, women use a disproportionate amount of correctional health services.⁶¹

General health studies of the U.S. population have found that rates of illnesses differ by gender and race.⁶² The intersection of health status, criminal behavior, sex, race and ethnicity and poverty is unknown. Although some jail-based health-related studies report findings broken down by sex, few do so by any of these other characteristics. The information on health, mental health and substance use disorders discussed below will describe sex differences in cases where information exists.

Health disparities by race and ethnicity are assumed to be equal or greater in jail populations than the disparities found in the general population. Summarizing the literature, Conklin and colleagues⁶³ state that African-Americans have higher death rates for heart disease, stroke, lung cancer, breast cancer, motor vehicle accidents and homicide than white, non-Latino citizens. African Americans and Latinos also have higher rates of tuberculosis, syphilis and AIDS.

Injuries and Acute and Chronic Health Conditions

Serious injuries and acute health problems can decimate a jail's health care budget, especially if the jail is a small one. A single inpatient surgical procedure can cost hundreds of thousands of dollars, severely limiting a jail's capacity to provide care to other inmates.

Very little information is available on injuries sustained prior to, or during, arrest and booking. In many cases, jails maintain the right to refuse admission if the individual has serious injuries, requiring the police to transport the arrestee to an emergency room. However, 13 percent of jail detainees/inmates report being injured at some point after their admission to the jail.⁶⁴

In 2002, 53 percent of women and 35 percent of men in jails reported having a current medical problem.⁶⁵ The most commonly reported medical problems of individuals in jails were arthritis (12.9 percent overall; 12.0 percent male versus 19.4 percent female), hypertension (11.2 percent overall; 10.8 percent male versus 14.1 percent female), asthma (9.9 percent overall; 8.7 percent male versus 19.4 percent female) and heart disease (5.9 percent overall; 5.5 percent male versus 9.2 percent female). Four percent noted kidney problems (3.0 percent male versus 8.9 percent female) and 3 percent reported having diabetes (2.5 percent male versus 4.1 percent female).⁶⁶ All of these chronic conditions except arthritis require ongoing routine care, are very costly if left untreated and may be improved by increasing patient education and health behaviors.

Approximately 5 percent of women were pregnant at time of arrest.^{67, 68}

Infectious Diseases

Infectious diseases pose particular problems for jails, and screening for and treatment of these communicable diseases have a large potential to improve public health.⁶⁹ Left untreated in jail, other inmates, corrections officers and staff may be infected, spreading disease to families and friends in the general community even while the infected inmate remains behind bars. Given the rapid turnover of jail populations, inmates themselves may simply carry the contagion back to their home communities. Without screening and testing, these inmates may do so unknowingly.⁷⁰

Self-reported rates of infectious diseases among jail detainees and inmates are: 2.6 percent for hepatitis, 4 percent for tuberculosis (lifetime), 1.3 percent for HIV and 0.9 percent for sexually transmitted diseases (STDs).⁷¹ These relatively low estimates based on self-report may be due to lack of awareness of the disease and low access to health care in the community. Other studies using lab screens estimate the prevalence of various diseases at higher levels. For example, in Maryland jails, 6.6 percent of detainees and inmates tested positive for HIV infection while prevalence of hepatitis C was 29.7 percent and hepatitis B was 25.2

percent. Less than 1 percent (0.6%) tested positive for syphilis.⁷² In San Francisco, 27 percent of inmates tested positive for latent tuberculosis infection.⁷³ Of women tested in three large urban jails, rates of Chlamydia ranged from 15 percent to 22 percent, depending on jurisdiction, and rates of gonorrhea ranged from 8 percent to 9 percent.⁷⁴

More importantly, the proportion of the correctional (combined jail and prison) population to the total U.S. infected population for various diseases is dramatic. Persons released from correctional settings represent 17 percent of the total AIDS population, 13 percent to 19 percent of those with HIV, 12 percent to 16 percent of those with hepatitis B, 29 percent to 32 percent of those with hepatitis C and 35 percent of those with tuberculosis.⁷⁵

According to the National Commission on Correctional Health Care,⁷⁶ 12 percent to 35 percent of the general population with communicable diseases spent time in jail or prison in 1996.

Mental Disorders

Mental health problems are exceedingly common in jail settings. In fact, jails have become the *de facto* mental health providers for many communities.⁷⁷ Many of the nation's largest jails, such as those in Los Angeles and New York, operate the nation's largest psychiatric inpatient hospitals.⁷⁸ A recent report noted that 63 percent of men and 75 percent of women in jail exhibit symptoms of mental disorder.⁷⁹ In the most carefully designed study of prevalence of mental illnesses among jail detainees, researchers found that 6.1 percent of males and 15.0 percent of females admitted to the Cook County (Chicago, Ill.) jail had symptoms of acute and serious mental illnesses, including schizophrenia, bipolar disorder and major (unipolar) depression.^{80, 81} For lifetime prevalence, these estimates increase to 8.9 percent for men and 18.5 percent for women. In addition, more than 50 percent of jail detainees have other mental health diagnoses, including dysthymia (8.3 percent), anxiety disorders (10.8 percent) and antisocial personality disorders (44.9 percent). Women and men had comparable rates of acute schizophrenia and bipolar disorder (1.8 percent females vs. 3.0 percent males met

criteria for schizophrenia; 2.2 percent females vs. 1.2 percent males for bipolar disorder). However, 13.7 percent of women met the criteria for depression compared to only 3.4 percent of men. In addition, a notable 22.3 percent of women in jail met the criteria for post-traumatic stress disorder (PTSD).⁸² Clearly, women in jail are more likely than their male counterparts to exhibit symptoms of mental illnesses, particularly depression and post-traumatic stress disorder. Some have argued that the rate differential in psychiatric diagnosis by sex may be explained largely by differences in rates of exposure to interpersonal violence across the lifespan (see discussion below).⁸³ This same argument applies to sex differences in drug abuse and dependence.

Co-occurring Substance Use and Abuse

Approximately 85 percent of the nation's jail detainees were substance-involved in 2006 (up from 73 percent in 1996). Alcohol plays a role in more than half and illicit drugs in more than three-quarters of incarcerations.⁸⁴ In the 2003 Arrestee Drug Abuse Monitoring (ADAM) Program report, 67 percent to 68 percent of arrested men and women tested positive for one or more drugs.⁸⁵ The most common drugs for both men and women were cocaine and marijuana. According to the ADAM data and based on a standardized screen of past-year behavior, approximately one-quarter of arrestees are at risk for alcohol dependence⁸⁶ (28.6 percent men vs. 23.8 percent women) and 40.5 percent for dependence on other drugs (same rate for men and women).⁸⁷

Teplin and colleagues also found that a large percentage of admissions to jail had a diagnosable substance use disorder, including 70.2 percent of women (32.3 percent alcohol abuse/dependence and 63.5 percent other drug abuse/dependence) and 61.3 percent of men (51.1 percent alcohol abuse/dependence and 32.4 percent other drug abuse/dependence). These rates are even higher for persons with a diagnosed mental illness. Among jail detainees with serious mental illnesses, 74.9 percent of women and 72.0 percent of men have a co-occurring substance use disorder.⁸⁸

Interpersonal Violence, Community Disorder and its Consequences

Many chronic and infectious diseases are directly or indirectly correlated with substance use, and appear to reflect common early negative childhood experiences. In 2002, 12 percent of jail detainees and inmates had lived in a foster home or other institution at some time while they were growing up, 46 percent had a family member who had been incarcerated and a substantial proportion had a parent or guardian who abused alcohol or other drugs (20 percent alcohol, 2 percent drugs and 9 percent both alcohol and drugs).⁸⁹ In addition, persons in jail are more likely than the general population to have experienced early childhood physical and/or sexual abuse. Fifteen percent had been physically abused (11 percent of men vs. 45 percent of women) and 8 percent had been sexually abused before age 18 (4 percent of men and 36 percent of women).⁹⁰ In nearly every case, the victim knew the abuser (92 percent).⁹¹

A decade-long, community-based investigation of over 17,000 respondents, the Adverse Childhood Events (ACE) Study (see results discussed below), is arguably the most important study investigating the relationship of negative childhood events to adult health. This study found that childhood traumatic events, particularly abuse and neglect, are associated with many adolescent and adult emotional, health and behavioral health problems. The health consequences include obesity, STDs, liver disease, ischemic heart disease and chronic obstructive pulmonary disease. Adverse childhood events are related to poor mental health in general,⁹² hallucinations,⁹³ depression⁹⁴ and suicide attempts.⁹⁵ They are also related to alcohol use in general as well as age of first use,⁹⁶ illicit drug use,⁹⁷ adolescent pregnancy and fetal death⁹⁸ and sexual risk behaviors.⁹⁹

The ACE study findings suggest that early childhood trauma leads to impaired neurodevelopment, adoption of risk behaviors in adolescence (such as smoking and other substance use and unprotected sex), development of chronic health problems in adulthood and early death. As the number of adverse childhood events increase, the odds of displaying specific problems in a number of

domains, including mental health, addiction, sexuality, risk behaviors and health, also increase.¹⁰⁰ Compared to persons without negative childhood events, the odds of any given problem typically increase by a factor of two to 10 times when four or more adverse childhood events are present.¹⁰¹

As a conceptual organizing paradigm, the common experience of adverse childhood events helps to explain the complex and interrelated health, psychiatric and substance abuse problems that jail detainees and inmates exhibit.

Organization of Jail Health Care Services

Jails provide health and psychiatric services to detainees and inmates in several ways. Breadth of services, organization and staffing vary widely among U.S. jails and differ systematically by jail size. Large jails (over 1,000 rated capacity) operate much more like prisons. They often have a comprehensive array of services, including medical/surgical units and an inpatient capacity. They may have specialized housing units for persons with mental health problems as well as therapeutic communities. Because these very large jails also tend to employ their own health care staff and directly administer health care services, linkages to community providers are weak and non-violent indigent detainees are likely to be held pre-trial. The smallest jails rely almost exclusively on the communities in which they are imbedded for medical and psychiatric care. Providers of care to jail detainees and inmates are likely to be the same providers to these same individuals after release. While small jails typically do not provide discharge planning, community ties to health providers are strong, creating an opportunity for continuous care. Because of the nature of small communities and the relatively limited jail resources (across the board from budget to security to treatment), non-violent individuals are likely to be released pre-trial. When detainees are released pre-trial, the burden of payment for treatment falls to the individual and not the county. If a detainee remains behind bars and needs critical care, small jails will transport the individual to a local emergency room or hospital. In this case, the cost of care remains with the jail. In many cases, these

hospitalizations are very expensive.^{102, 103} For example, according to one small jail administrator, a bypass surgery may cost \$75,000 to \$100,000. This one fee “could take up about 15 percent of the jail’s total budget.”¹⁰⁴ Although small jails may unintentionally defer costs through pre-trial release, the intentional release of a detainee to avoid the cost of medical care is not legally defensible. State and federal courts have ruled against counties in these circumstances.¹⁰⁵ Further, public safety should not be sacrificed to economics when determining who should be released pre-trial.¹⁰⁶ However, carefully planned pre-trial release for the purpose of maintaining non-violent individuals in their home communities, increasing treatment engagement and improving continuity of care, can have direct effects on patient health and well-being and reduce municipal and county correctional expenditures. In fact, this is the foundation upon which specialty courts are built. Mental health and drug courts divert arrestees from jail into community-based treatment services, maintaining individuals in their home communities and often paying for treatment through Medicaid.

Medical and psychiatric services may be provided directly by the jail, employing treatment staff and purchasing lab services, pharmaceuticals and other medical supplies. Increasingly, however, moderate-size to large jails contract with for-profit correctional health care providers for all essential services.¹⁰⁷ This is essentially a capitated cost system. The contractor agrees to provide specified services, often including staff, lab services, medical and psychiatric (and sometimes dental and optometry) treatment and pharmacy services. As more service units are provided or more resources are spent on expensive treatment alternatives, the contractor’s profit margin is reduced. Contracted services by their very nature build in disincentives for the health care organization to provide comprehensive, state-of-the-art treatment.¹⁰⁸ For example, South Carolina found that health care (medical and psychiatric) delivered by a privatized, for-profit provider was of poor quality and involved cost overruns and expenditures on services that were never provided.¹⁰⁹

Finally, a model of community-oriented correctional health care is emerging that partners jails with community

providers and can be implemented by even large jails. Based upon principles of public health, the Hampden County Correctional Center (population approximately 1,800) contracts with local community health centers “that provide care and case management both on-site at the jail and after release.”¹¹⁰ Approximately 80 percent of the population comes from a single urban center that is also served by these facilities. Dually locating health care staff creates relationships between the patient and provider that increase the likelihood that the patients will pursue their treatment plans after release. This arrangement also avoids common information exchange barriers, increases the breadth and quality of services and provides financial incentives to provide quality care.^{111, 112}

Financing of Jail Health Care Services

Historical changes in law and policy have led to the decrease of affordable treatment in the community and an increased reliance on jails and prisons to manage an increasingly ill population. The deinstitutionalization of persons with mental illnesses in the 1970s and 1980s, new drug laws and the concomitant reductions in federal support for substance abuse treatment, increased eligibility restrictions on Medicaid and Medicare receipt and even the expansion of health management organizations and mental health/substance abuse carve-outs have contributed to the reduction in community-based health care resources.¹¹³

Many of these policy changes had the effect of shifting costs. For example, some argue that the deinstitutionalization of individuals with mental illnesses from long-term inpatient psychiatric hospitals led to many being arrested and sent to jails and prisons because of the lack of comprehensive psychiatric services and supported housing in their communities.¹¹⁴ This shifted the costs from state mental health budgets, where services were often reimbursable through federal dollars, to state and local correctional budgets.

Cost-shifting in the health care literature often refers to “raising private reimbursement rates in response to lower public reimbursement rates.”¹¹⁵ In the current context,

cost-shifting means the shifting of costs from one organization or governmental entity to another for the same service or treatment. For example, increased restrictions on Medicaid eligibility would shift costs from federal and state dollars onto those providers that treat indigent individuals (such as federally qualified health centers) that bear most of the costs themselves. Domino and colleagues suggest that community providers or managed care organizations shift costs to local jails *indirectly*. By failing to provide adequate care, these organizations place persons with mental health conditions (and arguably those with addictive disorders) at increased risk of arrest and jail confinement. In fact, given the comorbidity of chronic and infectious disease with mental and substance use disorders, failure in one area increases general health care costs as well as public health risks.

Obviously, cost-shifting requires moving patients from one setting to another. These are policy and organizational decisions that have a profound and long-term effect on patients’ lives. In this case, shifting treatment of indigent people from one type of government funding support to another is a failure. There is no evidence to suggest that people receive better care in jail. At the same time, confinement in jail disrupts lives and families.

To a large degree, counties and municipalities bear the costs of jail health care. In many municipalities and counties, correctional services are the fastest-growing budget item,¹¹⁶ and health care accounts for about 15 percent of jails’ budgets (excluding costs of mental health services and hospitalizations).¹¹⁷ In real terms, for example, this amounts to \$24 million a year in the Miami-Dade area¹¹⁸ (Broward County books approximately 77,000 individuals a year.¹¹⁹) These costs are incurred partially because of suspension of health insurance payments, particularly federal benefits such as Medicaid and Medicare, upon confinement, and partially due to lack of any insurance coverage for a large proportion of the arrestee population. While there is no federal requirement to terminate federal benefits,^{120, 121} most jurisdictions and local Social Security offices have standing policies to do so.¹²²

Three facts are worth mentioning in regard to the practice of Medicaid termination. First, access to community health care for Medicaid recipients is similar to that for the privately insured population and much greater than that for the uninsured.¹²³ Second, not only can maintenance of Medicaid benefits result in greater access to care, but “it can also (1) reduce the financial burden on state and local governments that fund indigent health care systems and (2) increase the number of disabled offenders who receive treatment.”¹²⁴ Third, in one study of two large jails, 97 percent of offenders who were receiving Medicaid benefits at booking were not incarcerated long enough to have their benefits terminated.¹²⁵ Taken together, these facts suggest that patient engagement and continuity of care may be enhanced while reducing county costs simply by not terminating benefits immediately. Further, if the ACA exception for detainees is supported, termination of benefits may no longer be allowed.

Some states have implemented or are considering legislation that would require individuals who have private insurance to pay for any medical care they receive while in jail (see, for example, Florida and Utah). This strategy has met with strong resistance by the insurance industry, but with support from legislators and the general public.¹²⁶ Other jurisdictions are investigating the option of covering jail inmate populations through competitive health insurance plans similar to those used by small businesses.¹²⁷ Both options, however, make it difficult for insurers to assess the patient risk profile.

Several states are considering legislation limiting the reimbursement rates that outside providers can charge jails for services. For example, Colorado passed a bill (SB 03-141) that requires that any health care provider receiving state funding charge the county the same reimbursement rate as it charges Medicaid. This reduces the reimbursement rate from 75 percent or more to about 35 percent of cost¹²⁸ and shifts costs from the county budget to the hospital or community provider. In some cases, providers are walking away and refusing jail patients and the attendant lower reimbursement rate.¹²⁹

Many small and very large jails have found ways to meet their health care challenges through creative use of

internal resources. The many U.S. jails that fall in the mid-range population are neither large enough to financially support full-time medical and psychiatric staff and lab and pharmacy services nor small enough to make maximum use of community resources. For these mid-size jails, the most common solution to skyrocketing health costs and high-risk patient populations is to contract with privatized for-profit correctional health care providers. Clearly, the advantage of this strategy is that the county can anticipate the contract costs. However, there are also substantial potential downsides to these contracts, including poor quality of care, lack of capacity for information exchange and little incentive for release planning or follow-up.

Potential Leveraging of Health Care Reform

The implications of the ACA for jail-based health care may be profound.¹³⁰ The legislation will have at a minimum an indirect impact on all detainees and inmates, unsentenced and sentenced. It may also have a direct impact for those awaiting trial or sentencing if the ACA allows third-party reimbursement. Most importantly, Medicaid expansion and the creation of insurance exchange coverage will vastly increase the number of people covered by health insurance who, at present, either do not receive any treatment at all or use emergency rooms as their provider of choice. Although health behaviors are not expected to change immediately, over time the poorest of the American public are predicted to act like their more privileged counterparts in their medical decisions, including preventive care and regular treatment for chronic health problems.

The ACA is also likely to affect many aspects of the health care delivery system, including parity for mental and substance use disorders, the broad use of electronic medical records and increased access to pharmaceuticals. In addition, the law emphasizes the importance of developing community-based “medical homes.” All these ancillary aspects of health care reform — expanded coverage, integrated behavioral health and primary health care, comprehensive information transfer and medication accessibility — could have a large effect on continuity of care from pre-arrest through jail and re-entry, while

reducing recidivism and increasing overall public safety.

The single largest and predictable outcome that the ACA may have on corrections is in addiction treatment. Early intervention, together with an array of treatment resources, including inpatient, residential, outpatient and medication-assisted support, means more people in the community in recovery with longer periods of abstinence. This in turn may translate to fewer drug-related crimes or crimes committed for the purpose of purchasing drugs and fewer negative health consequences, particularly infectious diseases such as HIV, hepatitis and STDs and chronic conditions such as heart disease and chronic pulmonary obstructive disorder.

In general, improving the health of all Americans will lead to improved health of jail detainees and inmates. With the potential shift in focus for poor Americans from emergency care to prevention and early intervention, theoretically those who are arrested will arrive at jail in better health. Further, if health insurance under the ACA allows for federal reimbursement of health care services for detainees, community health care providers will have financial incentives to continue to treat this group. In this case, jails may be more likely to contract with community providers rather than large, national for-profit correctional health care organizations.

Even in the absence of reimbursement for detainee health care, jails may be interested in exploring ways of shifting costs from county budgets onto state and federal governments through the development and implementation of community-based release programs (including formal diversion programs, other structured alternatives to incarceration and release on recognizance) for indigent individuals with non-violent and/or substance-related charges. As noted, persons without financial resources often cannot make bail and therefore remain in jail while awaiting trial and sentencing. In many

cases, these individuals present no greater risk to the community than those who are released either through bail or on their own recognizance.

However, in order for these programs to succeed and for judges to release individuals to the community, a sufficient array of services is needed, and Medicaid agencies must be encouraged to establish policies that will increase service availability and expand the breadth of services that are reimbursable. This is particularly true for persons with alcohol and other drug addictions. Since individuals cycling through jails are community patients as well, keeping these individuals in their communities carries enormous health benefits while not increasing, and potentially decreasing, community (i.e., taxpayer) health care costs.

Finally, if indeed detainee health care coverage is allowable, there are important consequences for jail health care staffing and standards of care. In the future, jails and/or contract providers will be required to hire physicians and other health care staff who meet the highest standards of community treatment to be compliant with Medicaid requirements. Further, Medicaid requires specific outcome measures. This means that the facility must actually meet these standards and have an information system that can track these outcomes.

Jails face incredible challenges and incredible opportunities as the nation prepares for full implementation of the ACA. They now have incentives to become critical public health outposts for identifying and treating people with serious health needs. They can become truly integrated community-based agencies working with other health care agencies to ensure continuous, uninterrupted care. This public health vision of correctional health care shows promise for improving the public's health and safety while incurring less cost to local governments and to taxpayers.

References

- ¹ The Corrections and Re-entry Policy Research Center grew out of the former Center for Justice and Mental Health Research. The former Center was founded in 1998 to investigate issues related to behavioral health populations and services in U.S. correctional settings. The goal of the Center was to partner research and practice across multiple disciplines to identify critical needs and points of intervention, and to test treatment effectiveness of services.
- ² Kleycamp M, Rosenfeld J and Scotti R. *Wasting Money, Wasting Lives*. Trenton, NJ: Drug Policy Alliance, 2008.
- ³ *Reentry: A Strategy for Safe Streets and Neighborhoods*. Trenton, NJ: The State of New Jersey, 2007.
- ⁴ *One in 100: Behind Bars in America 2008*. Washington, DC: The Pew Charitable Trusts, 2008.
- ⁵ Minton TD. "Jail Inmates at Midyear 2009-Statistical Tables." *Bureau of Justice Statistics Statistical Tables* (NCJ 230122). Washington: U.S. Department of Justice, 2010.
- ⁶ *ibid.*
- ⁷ James DJ. "Profile of Jail Inmates, 2002." *Bureau of Justice Statistics Special Report* (NCJ 201932). Washington: U.S. Department of Justice, 2004.
- ⁸ Conklin TJ, Lincoln T and Wilson R. *A Public Health Manual for Correctional Health Care*. Ludlow, MA: Hampden County Sheriff's Department, 2002.
- ⁹ *The Health Status of Soon-to-be-Released Inmates. A Report to Congress. Volume 1*. Chicago: National Commission on Correctional Healthcare, 2002.
- ¹⁰ Cohen F and Dvoskin J. "Inmates with Mental Disorders: A Guide to Law and Practice." *Mental and Physical Disability Law Reporter*, 16: 339-346, 462-470, 1992.
- ¹¹ Morris SM, Steadman HJ and Veysey BM. "Mental Health Services in United States Jails." *Criminal Justice and Behavior*, 24(1): 3-19, 1997.
- ¹² Torrey EF, Stieber J, Ezekiel J, et al. *Criminalizing the Seriously Mentally Ill: The Abuse of Jails as Mental Hospitals*. Washington: Public Citizen's Health Research Group and the National Alliance for the Mentally Ill, 1992.
- ¹³ Domino ME, Norton EC, Morrissey JP and Thakur N. "Cost Shifting to Jails after a Change to Managed Mental Health Care." *Health Services Research*, 39(5):1379-1401, 2004, p. 1380.
- ¹⁴ Several specific groups will remain ineligible for coverage under the ACA, including convicted jail and prison inmates and military personnel (and undocumented persons who are not, by definition, U.S. citizens).
- ¹⁵ Blair P, Greifinger T and Stone TH. "Eligibility of Pre-trial Detainees under the Patient Protection and Affordable Care Act." Unpublished paper, 2010.
- ¹⁶ Conklin, Lincoln and Wilson, p. ix.
- ¹⁷ *ibid.*
- ¹⁸ *ibid.*
- ¹⁹ Sabol WJ and Minton TD. "Jail Inmates at Midyear 2007." *Bureau of Justice Statistics Bulletin* (NCJ 221945). Washington: U.S. Department of Justice, 2008.
- ²⁰ Minton.
- ²¹ Camp CG and Camp GM. *The 2000 Corrections Yearbook: Jails*. Middletown, CT: Criminal Justice Institute, 2000.
- ²² *ibid.*
- ²³ *ibid.*
- ²⁴ Beck AJ. "The Importance of Successful Reentry to Jail Population Growth." (Presentation to The Urban Institute Jail Reentry Roundtable, Washington, DC, June 27, 2006.)
- ²⁵ *ibid.*
- ²⁶ Minton.
- ²⁷ *ibid.*
- ²⁸ This estimate is based upon the 478,100 admissions to state and federal prisons for a new court commitment (i.e., not a parole violation) in 2008, as reported in Sabol WJ, West HC and Cooper M. "Prisoners in 2008." *Bureau of Justice Statistics Bulletin* (NCJ 228417). Washington: US Department of Justice, 2009. This estimate is divided by 12.8 million jail admissions in the same year (Beck, 2006) resulting in 3.7 percent.
- ²⁹ U.S. Department of Justice, Federal Bureau of Investigation. *Crime in the United States, 2009, Preliminary Annual Uniform Crime Report*, www.fbi.gov/ucr/prelimsem2009/index.html (accessed September 2010).
- ³⁰ James.
- ³¹ Solomon AL, Osborne JWL, LoBuglio SF, et al. *Life After Lockup: Improving Reentry from Jail to the Community*. Washington, DC: Urban Institute Justice Policy Center, 2008.
- ³² Thanks to Pamela Rodriguez, Arthur Lurigio, Melody Heaps, Maureen McDonnell, Laura Brookes and Seth Eisenberg at the Center for Health & Justice at TASC for information contained in this paragraph.
- ³³ Minton.
- ³⁴ Sabol and Minton.
- ³⁵ Cohen and Dvoskin.
- ³⁶ Moore J. "Public Health Behind Bars." *Popular Government*, Fall: 16-23, 2005.
- ³⁷ *Estelle versus Gamble*, 429 U.S. 97, 1976.
- ³⁸ *Bowring versus Godwin*, 551 F.2d. 44, 47 (4th Cir.), 1977.
- ³⁹ *N.B.*, substance abuse treatment is not generally considered to fall under this mandate except for medical detox.
- ⁴⁰ Minton.
- ⁴¹ James.
- ⁴² U.S. Department of Justice, Federal Bureau of Investigation. *Crime in the United States, 2008*, Table 41, www.fbi.gov/ucr/cius2008/data/table_41.html (accessed August 2010).
- ⁴³ Harlow CW. "Education and Correctional Populations." *Bureau of Justice Statistics Special Report* (NCJ 195670). Washington: U.S. Department of Justice, 2003.
- ⁴⁴ *ibid.*
- ⁴⁵ James.
- ⁴⁶ *N.B.*, these are 2002 estimates and do not reflect the current economic situation.
- ⁴⁷ James.

- ⁴⁸ Individuals report all sources of income. Therefore, these estimates reflect duplicated counts.
- ⁴⁹ Wang EA, White MC, Jamison R, Goldenson J, Estes M and Tulsy JP. "Discharge Planning and Continuity of Health Care: Findings From the San Francisco County Jail." *American Journal of Public Health*, 98 (12): 2182-84, 2008.
- ⁵⁰ Conklin, Lincoln and Wilson.
- ⁵¹ *ibid.*
- ⁵² Wang, White, Jamison et al.
- ⁵³ Conklin TJ, Lincoln T and Tuthill RW. "Self-Reported Health and Prior Health Behaviors of Newly Admitted Correctional Inmates." *American Journal of Public Health*, 90:1939-1941, 2000.
- ⁵⁴ Minton.
- ⁵⁵ James.
- ⁵⁶ Conklin, Lincoln and Wilson.
- ⁵⁷ See, for example, Artinian MP, Templin TN, Stallwood LG and Hermann CE. "Functional Health Literacy in an Urban Primary Care Clinic." *The Internet Journal of Advanced Nursing Practice*, 5(2), 2003.
- ⁵⁸ Gazmararian JA, Baker DW, Williams MV, et al. "Health Literacy Among Medicare Enrollees in a Managed Care Organization." *Journal of the American Medical Association*, 281(6):545-551, 1999.
- ⁵⁹ Ashton CM, Haidet P, Paterniti DA, et al. "Racial and Ethnic Disparities in the Use of Health Services: Bias, Preference, or Poor Communication." *Journal of General Internal Medicine*, 18(2): 146-152, 2003.
- ⁶⁰ *Poverty in America: Economic Research Shows Adverse Impacts on Health Status and Other Social Conditions as well as the Economic Growth Factor*. Washington: U.S. Government Accountability Office, 2007.
- ⁶¹ Lindquist CH and Lindquist CA. "Health Behind Bars: Utilization and Evaluation of Medical Care Among Jail Inmates." *Journal of Community Health*, 24(4): 285-303, 1999.
- ⁶² Keppel KG, Percy JN and Wagener DK. *Trends in Racial and Ethnic-specific Rates for Health Indicators: United States, 1990-1998*. Centers for Disease Control, National Center for Health Statistics. Atlanta: U.S. Department of Health and Human Services, 2002.
- ⁶³ Conklin, Lincoln and Wilson.
- ⁶⁴ Maruschak LM. "Medical Problems of Jail Inmates." *Bureau of Justice Statistics Special Report* (NCJ 210696). Washington: U.S. Department of Justice, 2006.
- ⁶⁵ *ibid.*
- ⁶⁶ *ibid.*
- ⁶⁷ Bell JF, Zimmerman FJ, Cawthorn ML, Huebner CE, et al. "Jail Incarceration and Birth Outcomes." *Journal of Urban Health*, 81:630-644, 2004.
- ⁶⁸ Maruschak, 2006.
- ⁶⁹ Lincoln T, Miles JR and Scheibel S. "Community Health and Public Health Collaborations." In *Public Health Behind Bars: From Prisons to Communities*, Greifinger R (ed.). New York: Springer, 2007.
- ⁷⁰ Williams NH. "Prison Health and the Health of the Public: Ties That Bind." *Journal of Correctional Health Care*, 13(2):80-92, 2007.
- ⁷¹ *ibid.*
- ⁷² Solomon L, Flynn C, Muck K and Vertefeuille J. "Prevalence of HIV, Syphilis, Hepatitis B, and Hepatitis C Among Entrants to Maryland Correctional Facilities." *Journal of Urban Health*, 81(1):25-37, 2004.
- ⁷³ White MC, Tulsy JP, Goldenson J, et al. "Randomized Controlled Trial of Interventions to Improve Follow-up for Latent Tuberculosis Infection After Release From Jail." *Archives of Internal Medicine*, 162:1044-1050, 2002.
- ⁷⁴ Mertz KJ, Schwebke JR, Gaydos CA, et al. "Screening Women in Jails for Chlamydial and Gonococcal Infection Using Urine Tests: Feasibility, Acceptability, Prevalence, and Treatment Rates." *Sexually Transmitted Diseases*, 271-276, 2002.
- ⁷⁵ Conklin, Lincoln and Wilson.
- ⁷⁶ *The Health Status of Soon-to-be-Released Inmates*.
- ⁷⁷ Torrey EF. "Jails and Prisons: America's New Mental Hospitals." *American Journal of Public Health*, 85(1):1611-13, 1995.
- ⁷⁸ Freudenberg N. "Jails, Prisons, and the Health of Urban Populations: A Review of the Impact of the Correctional System on Community Health." *Journal of Urban Health*, 78(2): 214-235, 2001.
- ⁷⁹ James DJ and Glaze LE. "Mental Health Problems of Prison and Jail Inmates." *Bureau of Justice Statistics Special Report* (NCJ 213600). Washington: US Department of Justice, 2006.
- ⁸⁰ Teplin LA. "Psychiatric and Substance Abuse Disorders Among Male Urban Jail Detainees." *American Journal of Public Health*, 84(2): 290-293, 1994.
- ⁸¹ Teplin LA, Abram KM and McClelland GM. "Prevalence of Psychiatric Disorders among Incarcerated Women." *Archives of General Psychiatry*, 53:505-512, 1996.
- ⁸² *ibid.*
- ⁸³ See, for example, Veysey BM. "Mental Health Issues of Incarcerated Women," in Levin BL and Becker MA (eds.). *A Public Health Perspective of Women's Mental Health*. New York: Springer, 2010.
- ⁸⁴ *Behind Bars II: Substance Abuse and America's Prison Population*. New York: The National Center on Addiction and Substance Abuse at Columbia University, 2010. (No authors given.)
- ⁸⁵ Zhang Z. *Drug and Alcohol Use and Related Matters Among Arrestees 2003*. Washington: U.S. Department of Justice, 2004.
- ⁸⁶ "Risk of dependence to alcohol" in the ADAM assessment is defined as "an indication of need for treatment, ... measured by a clinically based dependency screen regarding alcohol use experiences during the prior year." Zhang.
- ⁸⁷ Zhang.
- ⁸⁸ Teplin, Abram and McClelland.
- ⁸⁹ James.
- ⁹⁰ Other studies using different methodologies report much

higher abuse rates, particularly for females. For greater detail, see Veysey, 2010.

⁹¹ James.

⁹² Edwards VJ, Holden GW, Anda RF and Felitti VJ. "Relationship between Multiple Forms of Childhood Maltreatment and Adult Mental Health: Results from the Adverse Childhood Experiences Study." *American Journal of Psychiatry*, 160:1453-1460, 2003.

⁹³ Whitfield CL, Dube SR, Felitti VJ and Anda RF. "Adverse Childhood Experiences and Hallucinations." *Child Abuse and Neglect*, 29:797-810, 2005.

⁹⁴ Chapman DP, Whitfield CL, Felitti VJ, et al. "Adverse Childhood Experiences and the Risk of Depressive Disorders in Adulthood." *Journal of Affective Disorders*, 82:217-225, 2004.

⁹⁵ Dube SR, Anda RF, Felitti VJ, et al. "Childhood Abuse, Household Dysfunction and the Risk of Attempted Suicide Throughout the Lifespan: Findings from Adverse Childhood Experiences Study." *Journal of the American Medical Association*, 286:3089-3096, 2001.

⁹⁶ Dube SR, Miller JW, Brown DW, et al. "Adverse Childhood Experiences and the Association with Ever Using Alcohol and Initiating Alcohol Use during Adolescence." *Journal of Adolescent Health*, 38:444.e1-444.e10, 2006.

⁹⁷ Dube SR, Felitti VJ, Dong M, Chapman DP, Giles WH and Anda RF. "Childhood Abuse, Neglect and Household Dysfunction and the Risk of Illicit Drug Use: The Adverse Childhood Experience Study." *Pediatrics*, 111:564-572, 2003.

⁹⁸ Hillis SD, Anda RF, Dube SR, et al. "The Association Between Adolescent Pregnancy, Long-Term Psychosocial Outcomes, and Fetal Death." *Pediatrics*, 113:320-327, 2004.

⁹⁹ Hillis SD, Anda RF, Felitti VJ and Marchbanks PA. "Adverse Childhood Experiences and Sexual Risk Behaviors in Women: A Retrospective Cohort Study." *Family Planning Perspectives*, 33:206-211, 2001.

¹⁰⁰ Anda RF, Felitti VJ, Bremner JD, et al. "The Enduring Effects of Abuse and Related Adverse Experiences in Childhood: A Convergence of Evidence from Neurobiology and Epidemiology." *European Archives of Psychiatry and Clinical Neuroscience*, 256:174-186, 2006.

¹⁰¹ *ibid.*

¹⁰² Lundby T. "Medical Expenses Remedied: Boone County Jail Has a New Protocol for Medical Treatments." *The Missourian*, August 14, 2005, www.columbiamissourian.com/stories/2005/08/14/medical-expenses-remedied/ (accessed September 2010).

¹⁰³ Shimkus J. "Community Provider Fees Too Steep? There Oughta Be a Law!" *CorrectCare*, Fall, 2003.

¹⁰⁴ Bennett L. "Jail Inmates Get Health Insurance." *WCTV.tv*, February 4, 2010. www.wctv.tv/home/headlines/83594802.html (accessed September 2010).

¹⁰⁵ Moore.

¹⁰⁶ *ibid.*

¹⁰⁷ Pollack H, Khoshnood, K and Altice F. "Health Care Delivery

Strategies for Criminal Offenders." *Journal of Health Care Finance*, 26(1):63-77, 1999.

¹⁰⁸ *ibid.*

¹⁰⁹ Rosenthal MG. "Prescription for Disaster: Commercializing Prison Health Care in South Carolina." Special Report. Charlotte, NC: Grassroots Leadership South Carolina Fair Share, 2004.

¹¹⁰ Conklin, Lincoln and Wilson, p.30.

¹¹¹ While Medicaid reimbursement for services is suspended during the jail stay, the individual is not disenrolled. Further, preventive care and improved health behaviors reduce the use of urgent and emergency care. Finally, this arrangement reduces the use of indigent care after release. See Conklin, Lincoln and Wilson.

¹¹² Conklin, Lincoln and Wilson.

¹¹³ Pollack, Khoshnood and Altice.

¹¹⁴ See, for example, Veysey BM and Steadman HJ. *Double Jeopardy: Persons with Mental Illnesses in the Criminal Justice System*. Report to Congress. Washington, DC: Center for Mental Health Services, 1995.

¹¹⁵ Domino, Norton, Morrisey and Thacker, p. 1380.

¹¹⁶ Freudenberg.

¹¹⁷ Based upon a 1999 NCCHC/NIC study of 17 of the 30 largest U.S. jails as cited in Lincoln et al., 2007.

¹¹⁸ Dorschner J. "Prisoners' Health Bills in Spotlight for Jackson Health System." *The Miami Herald*. September 20, 2010.

¹¹⁹ *Broward Sheriff's Office*. www.sheriff.org/about_bso/dodcc/ (accessed September, 2010).

¹²⁰ Griffin PA, Naples M, Sherman RK, et al. *Maintaining Medicaid Benefits for Jail Detainees with Co-Occurring Mental Health and Substance Use Disorders*. Delmar, NY: The National GAINS Center for People with Co-Occurring Disorders in the Justice System, 2002.

¹²¹ Perez LM, Ro MJ and Treadwell HM. "Vulnerable Populations, Prison, and Federal and State Medicaid Policies: Avoiding the Loss of a Right to Care." *Journal of Correctional Health Care*, 15(2):142-149, 2009.

¹²² Lipton L. "Medicaid Eligibility Termination Plagues Former Inmates." *Psychiatric News*, 36(17): 8, 2001.

¹²³ Morrissey JP, Steadman HJ, Dalton KM, et al. "Medicaid Enrollment and Mental Health Service Use Following Release of Jail Detainees With Severe Mental Illness." *Psychiatric Services*, 57(6):809-815, 2006.

¹²⁴ Moses M and Potter RH. "Obtaining Federal Benefits for Disabled Offenders. Part 1 - Social Security Benefits." *Corrections Today*, April: 112-114, 2007, p.112.

¹²⁵ Moses M and Potter RH. "Obtaining Federal Benefits for Disabled Offenders. Part 2 - Medicaid Benefits." *Corrections Today*, June: 76,78, 2007.

¹²⁶ Shimkus.

¹²⁷ Bennett.

¹²⁸ Shimkus.

¹²⁹ *ibid.*

¹³⁰ Blair, Greifinger and Stone.