SAMHSA Report on Model Program That Provides Medicaid Coverage on Release From State Prison

Federal and state officials have grown increasingly concerned about the large number of individuals with serious mental illness who leave state prisons without health insurance and therefore without access to treatments and services to help them live successfully in the community and avoid recidivism and use of emergency care. Their disability and low income would qualify many for Medicaid, but complex eligibility rules and application procedures have created barriers.

A demonstration project in three Oklahoma correctional facilities significantly improved access to Medicaid for discharged inmates with mental illness, according to a report from the Substance Abuse and Mental Health Services Administration (SAMHSA), which funded the project. On the day of release, about 25% of eligible inmates were enrolled in Medicaid, compared with 8% of eligible inmates at the same facilities in the three years before the program and 3% of eligible inmates discharged from similar facilities during the program period.

Although the program was implemented in June 2007 and evaluated over the next year, Mathematica Policy Research (MPR), which provided technical assistance and conducted the evaluation, began work in January 2005 with an interagency steering committee of staff from a wide range of state agencies to design the model program. Three facilities were chosen that represent 23% of all inmates in Oklahoma's correctional facilities and about 36% of inmates with serious mental illness in the state: a 1,400-bed, medium-security facility for men with designated units for inmates with mental illness; a 200-bed, maximum-security facility for women with units for inmates with mental illness; and a 2,000-bed, maximum-security prison with a mental health unit.

The model program aimed to achieve Medicaid enrollment on the day of release for all inmates with mental illness in a three-step process: about six to nine months before their release, identify inmates with severe mental illness who are likely eligible for Medicaid; four months before release help them apply for federal disability benefits; and two months before release assist them with subsequent Medicaid applications. Critical to the success of the program, according to MPR's evaluation, were new appropriations from the state legislature that enabled the Oklahoma Department of Mental Health and Substance Abuse Services to hire three discharge managers to improve discharge planning for the target group. The evaluation also indicated that staff training, interagency agreements that simplified application procedures, and sustained interagency collaborations were critical to successful implementation.

The 78-page report, *Establishing and Maintaining Medicaid Eligibility Upon Release From Public Institutions,* provides a description of program implementation, analyses of outcomes (both quantitative and qualitative), and a summary of key lessons learned. An important chapter details the complex federal Medicaid rules governing establishment and maintenance of eligibility—as well as lapses and suspension for inmates in state facilities—and Social Security Administration rules and procedures for establishing disability and becoming eligible for cash assistance. Barriers created by federal and state policies are identified and solutions proposed.

"The study underscores the importance of interagency collaboration to help people with serious mental illness and substance abuse disorders obtain access to needed services to sustain their life in the community," said SAMHSA Administrator Pamela S. Hyde, J.D., when the report was released. "As a result, barriers to health and behavioral health care are reduced and recovery is supported so that people do not find their way back into higher cost systems."

The report is available on the SAMHSA Web site at www.samhsa.gov/shin.

NEWS BRIEFS

Most justice-involved youths affected by traumatic childhood experiences: The Justice Policy Institute released a 15-page brief that compiles research findings on the relationship between childhood trauma and justice system involvement for youths. According to *Healing Invisible Wounds: Why Investing in Trauma-Informed Care for Children Makes Sense,* of the more than 93,000 children who are currently incarcerated in the United States, between 75% and 93% have had at least one traumatic experience, including sexual abuse, war, community violence, neglect, and maltreatment. The research brief notes that although it is important to hold youths accountable if they engage in delinquent behavior, it is critical that trauma exposure be considered in placement decisions, because youths who receive treatment in the community have better outcomes. Researchers have found that youths who suffer trauma are more likely to develop life-long psychiatric conditions, including personality disorders, conduct disorder, attention-deficit hyperactivity disorder, depression, anxiety, substance use disorders, and posttraumatic stress disorder. Traumatized youths can experience developmental delays, decreased cognitive abilities, and learning disabilities, with school dropout and expulsion rates nearly three times as high as peers. As detailed in the research brief, currently the justice system does not meet the needs of traumatized youths and may increase trauma through its use of incarceration. Thousands of youths are incarcerated each year, and few are screened for trauma-related symptoms or provided trauma-informed care. Experts advocating for system reforms that address the unique needs of trauma-affected children say that long-term strategies to treat rather than incarcerate are needed to curb the cycle of justice system involvement. The research brief concludes with recommendations for improvements in six areas. A copy of the brief is available at www.justicepolicy.org.

Guide to help employers promote delivery of behavioral services to youths: The effects of child and adolescent mental health disorders can be far reaching, affecting not only those with the disorder but also their caregivers. These caregivers are more likely to report increased work absences, reduced productivity, and job termination. *An Employer's Guide to Child and Adolescent Mental Health: A Blueprint for Action* is a new guide to help employers improve the delivery of child and adolescent behavioral services and provide services for family caregivers. The guide contains employer-based strategies for health plans, employee assistance programs, and workplace policies that can help improve the delivery of behavioral health care services in both the general medical and mental health sectors, improve employee health and productivity, improve the health state of the future workforce, reduce unnecessary health care expenditures, and reduce the use of family medical leave. Part I of the guide provides an overview of the most prevalent behavioral health disorders experienced by children and adolescents, the impact on the workplace, and the treatment and cost trends of these disorders. Part II contains a review of the current state of treatment and challenges facing providers, and it provides specific recommendations for health plans, employer oversight, and the workplace. It is intended to guide employers as they review the structure, purpose, coordination, and integration of their behavioral health benefits. The 44-page guide was developed by the Advisory Council on Child and Adolescent Behavioral Health, which was created in 2008 by the National Business Group on Health through a contract with the Substance Abuse and Mental Health Services Administration. It is available at www.businessgrouphealth.org.

Kaiser brief on uninsured, low-income adults: In 2014 Medicaid will extend to uninsured adults with the lowest incomes—at or below 133% of the federal poverty level ($14,404 for an individual in 2009). Lacking coverage, many of these individuals will have had very little interaction with the health care system. Finding and enrolling them will present challenges because they are unlikely to hear about their eligibility through a health care provider. To better understand this group, the Kaiser Commission on Medicaid and the Uninsured has compiled an issue brief that provides a profile of the 38% of uninsured adults in this income range who received no health care for two years (2006 and 2007). By comparison, just 7% of Medicaid-enrolled adults in this income group received no care over this period. Uninsured adults who receive no care are more likely to be young; 60% are aged 19 to 24. Most are male—71%, compared with 33% of those covered by Medicaid and 47% of uninsured adults who receive care. Only 28% have dependent children, compared with 59% of Medicaid enrollees and 38% of uninsured adults who receive care. They are significantly more likely than Medicaid enrollees to be in working families (66% compared with 42%), which means that employers represent an important outreach route. Forty-one percent do not speak English at home (35% speak Spanish at home), and about 25% are non–U.S. citizens who have been legal residents for five or more years. Five percent report fair or poor mental health, and 6% report fair or poor general health. Because this diverse group differs from the current Medicaid population, the authors note, multiple and new outreach strategies will be required. Also, once enrolled, many will not have a usual source of care or be accustomed to receiving preventive care, which will require additional educational and linkage efforts. The issue brief is available on the Kaiser Web site at www.kff.org/uninsured/8083.cfm.

AHRQ guides on hospital evacuation, assessment, and recovery: Two new guides are available from the Agency for Healthcare Research and Quality (AHRQ) to help hospital administrators make decisions about how to protect patients and workers and assess damage when a disaster threatens the soundness of a facility. The 55-page *Hospital Evacuation Decision Guide* is designed to supplement hospital emergency plans, which frequently lack specific guidance on how to make the evacuation decision. It is based on an extensive literature review, discussions at an expert panel meeting, telephone interviews with individuals who have conducted evacuations in different types of disasters, and meetings with disaster planners, medical staff, and facilities experts. The 58-page *Hospital Assessment and Recovery Guide* is designed to help organize the initial assessment of a hospital upon return after an evacuation or closure. The guide is divided into 11 sections; each section describes a separate team and assignment to assess damage to the hospital and provide information needed to create a comprehensive recovery plan. Both guides are available on the AHRQ Web site at www.ahrq.gov.

IOM report on disorders in sub-Saharan Africa: Mental, neurological, and substance use disorders are especially disruptive in sub-Saharan Africa, where most of the world's poorest countries are found. Millions of Africans in 47 countries have one of these disorders. Few psychiatrists or other mental health professionals work in sub-Saharan Africa, and those who do usually have private practices in urban centers. Few health centers exist in rural areas, where the majority of the population lives, and many of these disorders go undiagnosed and untreated. In August 2009 the Uganda National Academy of Sciences' Forum on Health and Nutrition and the Institute of Medicine's (IOM's) Forum on Neuroscience and Neurological Disorders hosted a workshop in Uganda to discuss the state of care for mental, neurological, and substance use disorders in sub-Saharan Africa. More than 150 researchers, providers, patient advocates, and policy specialists attended. Speakers explored strategies to improve the quality and consistency of care, taking into account countries' limited resources, infrastructure, and other realities. The 140-page report, *Mental, Neurological, and Substance Use Disorders in Sub-Saharan Africa: Reducing the Treatment Gap, Improving Quality of Care,* summarizes the workshop and is available at www.iom.edu.