

**COMMUNITY-BASED CARE AND SERVICES FOR JUSTICE INVOLVED
INDIVIDUALS WITH MENTAL ILLNESS: THE ROLE OF FEDERAL BENEFITS**

by

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The number of individuals with mental illness in the criminal justice system is increasing. These individuals are the most vulnerable and disadvantaged in the public mental health system, yet little national data are available regarding their characteristics and experiences. Upon release from jail or prison, they face barriers to successful transition into the community. Mentally ill offenders can access mental health and addiction services and income support to pay for housing, food, and other necessities through federal entitlement programs. Many jail and prison inmates with mental illness either lose or are never connected with federal entitlements. It follows that without benefits, these individuals face the same challenges that are likely to have contributed to their original arrest. Connecting these individuals with services and support in the community can enhance their health and safety, and the health and safety of the public; hence this issue is of particular public health importance.

This paper reviews the literature to explore the following questions: (1) Are individuals with mental illness who receive federal benefits upon release from jail more likely to seek and continue care than those who do not? And (2) what are the consequences of not continuing care for individuals with mental illness upon release from jail? Many policy organizations have released publications in recent years, highlighting the importance of having federal benefits and maintaining these during incarceration to enhance the likelihood of receiving care once released.

A review of the academic literature reveals that there are major gaps in our knowledge and that there is little to substantiate the hypothesis that having federal benefits increases the likelihood of receiving services in the community. There is a need for data-based empirical studies, yet conducting these may be difficult. This issue is complex and it is likely that federal benefit enrollment is only one component of the problem and that facilitating enrollment will not necessarily enhance care. Programs that use an integrated approach to connect these individuals with community-based services are recommended.

TABLE OF CONTENTS

1.0 INTRODUCTION.....	1
1.1 BACKGROUND.....	3
1.2 OBJECTIVE	4
1.3 METHODS.....	5
2.0 CRIMINALIZATION OF INDIVIDUALS WITH MENTAL ILLNESS.....	6
3.0 IMPACT OF CRIMINAL RECORD AND MENTAL ILLNESS ON QUALITY OF LIFE	12
3.1 EMPLOYMENT.....	13
3.1.1 Criminal Record and Employment	13
3.1.2 Employment for Mentally Ill Offenders	14
3.2 HOUSING	15
3.2.1 Criminal Record and Housing	15
3.2.2 Homelessness	17
3.3 EDUCATION.....	19
4.0 IMPACT OF CRIMINAL RECORD AND MENTAL ILLNESS ON RECIDIVISM	20
5.0 FEDERAL ENTITLEMENT PROGRAMS	24
5.1 SUPPLEMENTAL SECURITY INCOME (SSI) PROGRAM AND SOCIAL SECURITY DISABILITY INSURANCE (SSDI) PROGRAM	25
5.2 MEDICAID	26
5.3 TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) PROGRAM	28

6.0	FEDERAL BENEFITS AND USE OF SERVICES.....	31
7.0	TERMINATION OF BENEFITS.....	38
7.1	SSI/SSDI & MEDICAID.....	38
8.0	RESTORING BENEFITS.....	43
8.1	SSI/SSDI.....	43
8.2	MEDICAID.....	44
9.0	CONCLUSION	45
	APPENDIX. TIME IN JAIL AND SSI ELIGIBILITY	51
	BIBLIOGRAPHY	52

LIST OF TABLES

Table 1: Estimates of the Number of Incarcerated Individuals with Mental Illness	7
Table 2: How Time in Jail Affects Eligibility for SSI.....	51

1.0 INTRODUCTION

As the number of inmates housed in correctional facilities continues to rise, so does the number of those with mental illness. A great number are arrested for reasons related to their disorders and enter jails and prisons with a disproportionate burden of illness. Many receive limited or inadequate care while incarcerated, and then return to the communities without appropriate care and support. The purpose of this paper is two-fold: (1) to determine if enrollment in federal benefit programs increases access to and use of services for these individuals, and (2) to determine the consequences of not seeking or receiving care after release from jail or prison.

The first chapter provides the background to this paper, sets out its objectives, and describes the methods used to identify the included articles. In the second chapter, the criminalization of individuals with mental illness is addressed by discussing the prevalence mental illness in prison and jail populations, and potential underlying causal factors that lead to criminalization. This chapter also addresses how the investment of public funds in the health of inmates is compromised in the absence of continuity of care. The third chapter discusses the barriers that individuals with a criminal record and mental illness face in accessing employment, housing, and education in the community (indicators of “quality of life”). The independent and combined effects of having a criminal record and mental illness are discussed. Policies and legal guidelines that may affect access are included for each indicator. The fourth chapter discusses the impact of a criminal record and mental illness on recidivism, specifically in terms of the

effect of mental health service use (pre-arrest and post-release) on recidivism. The fifth chapter provides an overview of the primary programs that pay for care and support of individuals with mental disorders (Medicaid, Supplemental Security Income, Supplemental Security Disability Insurance, and the Temporary Assistance to Needy Families program). A description of the eligibility criteria and the program's relevance to individuals with mental illness and inmates with mental illness are given for each respective program. In the sixth chapter, the relationship between federal benefit enrollment and use of services is evaluated. Next, the role of insurance (in general and by type) and mental health service use is addressed. Chapter seven discusses the disenrollment of incarcerated individuals with mental illness from federal benefit programs, a practice condemned by mental health policy organizations. Policy organizations stress the importance of restoring eligibility for inmates whose benefits are terminated or who were not previously enrolled. This issue is described in more detail in chapter eight. Chapter nine presents the conclusions of the paper.

Policy organizations, such as the Bazelon Center for Mental Health Law, advocate for connecting individuals with mental illness with federal benefits after release and maintaining eligibility for individuals enrolled upon incarceration to enable successful re-entry into the community. However, there is little in the academic literature to support the hypothesis that having federal benefits increases the likelihood of receiving mental health services in the community. There is a need for data-based empirical studies, yet conducting these may be challenging particularly as comprehensive data on jail and prison detainees with mental illness are lacking.

The issues are exceedingly complex and it is likely that federal benefit enrollment is only one contributing factor. A review of the literature does not indicate a direct causative relationship

between having federal benefits and use of services. Programs that use an integrated approach to connect individuals with mental illness leaving jail with community-based services are recommended, yet there is a need for more evidence-based models to support this recommendation.

1.1 BACKGROUND

There are more than 2.2 million people incarcerated in federal and state prisons and in local jails in the United States (Bureau of Justice Statistics, 2007). The U.S. Department of Justice estimated that in 2005 more than half of all inmates in prisons and jails had a mental problem and that in 2002 more than two thirds of inmates in jail were dependent on or abusing alcohol or drugs (James & Glaze, 2006; Karberg & James, 2005). Based on these figures, it follows that many of the inmates released each year will have mental illness and/or are addicted. Incarcerated individuals with mental illness have higher rates of homelessness, unemployment, past physical and sexual abuse, and substance abuse and dependency than those without mental problems (The Bazelon Center for Mental Health Law, 2001). There is also a correlation between mental illness and violent criminal records (James & Glaze, 2006).

Inmates returning to their communities face numerous barriers to successful transition, including poor job prospects, a limited amount of subsidized housing, and fewer educational opportunities (Pager, 2003). Many individuals with criminal records do not have access to employer-based health insurance and are forced to rely on public funding for medical care (ibid.). Given these issues, an increasing number of legislatures, advocates, community-based

health providers, and corrections officials are focusing on the barriers that threaten successful “re-entry.”

1.2 OBJECTIVE

As the number of incarcerated persons in the United States continues to increase, the number of those who have mental health and/or substance use disorders also increases. The Bazelon Center for Mental Health Law, a research and advocacy organization for people with mental illness, in 2001 noted that in many cases, the reason such individuals are arrested is associated with “their lack of income and their unmet need for services, such as mental health and addiction treatment, and supports, such as housing and employment that are essential if they are to maintain themselves in the community” (p.1). These individuals are the most vulnerable and disadvantaged in the public mental health system, yet little national data are available regarding their characteristics and experiences.

Offenders with mental illness can access mental health and addiction services and income support to pay for housing, food, and other necessities through federal entitlement programs. Many jail and prison inmates with mental illness either lose or are never connected with federal entitlements. It follows that without benefits, individuals released from jail or prison face the same personal challenges that led to their original arrest. This paper reviews the literature to explore the following questions:

1. Are individuals with mental illness who receive federal benefits upon release from jail more likely to seek and continue care than those who do not?

2. What are the consequences of not seeking or continuing care for individuals with mental illness upon release from jail?

1.3 METHODS

Four strategies were employed to conduct this review of the literature. First, studies cited in the few existing reviews on mental health services for incarcerated individuals with mental illness were examined. Second, searches using electronic databases (e.g., Ovid MEDLINE, Pub Med, Policy File, and Scopus) were performed using combinations of terms including—but not limited to—mental illness, severe mental illness, mood disorders, community mental health services, mental health services prisons, mental health service use, mental health service access, and continuity of care prisoners, jails, inmates, incarceration, recidivism, quality of life, education, employment, housing, and homelessness. Due to the interdisciplinary nature of the subject matter, the use of multiple databases (listed above) was necessary. Third, searches were conducted for publications from relevant policy organizations, identified through personal communications with several mental health policy professionals. Fourth, searches for pertinent published materials in the University of Pittsburgh Library system were performed. The combination of these methods yielded approximately 98 sources, 74 of which were included in the review. The 74 sources include 36 journal articles, 12 policy papers/publications, 6 book sections, 18 government reports/documents/publications, and 2 sections of legislation. The remaining 24 sources were not included as they were either not relevant to the topic of this paper or were not empirically based.

2.0 CRIMINALIZATION OF INDIVIDUALS WITH MENTAL ILLNESS

The exact number of incarcerated individuals with mental illness is unknown, but scholars estimate that it more than doubled between 1980 and 1992 (Schaefer & Stefancic, 2003). In 1999, the American Association of Community Psychiatrists estimated that 7 to 20 percent of all inmates in prison and jail suffer from a serious mental illness and that it is most likely an underestimate. Estimates of mental illness among incarcerated individuals vary depending on the methodology of the study, the definition used of mental illness, and the population sampled (see Table 1 below). The prevalence of mental illness among inmates varies by gender, with women reporting a higher rate of mental illness than men (24 percent of female State prisoners and jail inmates, compared to 16% of male State prisoners) (Ditton, 1999).

In 1972, Abramson noted that individuals with mental illness who engaged in minor crimes (e.g., misdemeanors) were increasingly susceptible to being arrested and prosecuted in a county jail system (Abramson, 1972). He coined the phenomenon the “criminalization of the mentally ill.” Subsequently, the concept of criminalization has been applied to individuals with mental illness who were also arrested for serious crimes also (e.g., felonies).

Table 1: Estimates of the Number of Incarcerated Individuals with Mental Illness

Study/Report	Survey Used/Data Source	Sample	Diagnostic Criteria	Rate
Steadman, H.J., et al., 1987	Survey instrument adapted from NY state's level-of-care surveys of psychiatric population	n=3,332 inmates (or 9.4% of New York state's general prison population at the time) and 352 of the 360 inmates in the prisons' MH units	None given	-8% had severe psychiatric functional disabilities (warranting MH intervention) -16% had significant mental disabilities (requiring periodic services); specific diagnoses not given
Telpin, L.A., 1990	-National Institute of Mental Health Diagnostic Interview Schedule (NIMH-DIS) administered -Baseline data from Epidemiologic Catchment Area Study	Cook County, IL jail admissions (men); n= 728	NIMH-DIS uses diagnostic categories; differentiates between lifetime disorders and current disorders; diagnoses scored using interview data by computer program	-6.4% (total includes rates of major depression, mania, schizophrenia, and "any severe disorder", or any of the three)
Telpin, L.A., et al., 1996	-NIMH-DIS administered -Baseline data from Epidemiologic Catchment Area Study	Cook County, IL pre-trial jail detainees (women); n=1272	Same as above	-15% had severe psychiatric disorders within previous 6 months (1.8% had schizophrenia; 2.2% had mania; 13.7% had major depression)
Ditton, P.M., 1999	Surveys completed by Bureau of Justice Statistics (the 1997 survey of Inmates in State or Federal Correctional Facilities, the 1996 Survey of Inmates in Local Jails, and the 1995 Survey of Adults on Probation)	State prison inmates, Federal prison inmates, local jail inmates. Estimates calculated by multiplying number of total number of these inmates by ratios identified by BJS surveys	If meet 1 of 2 criteria: -Reported current emotion or mental condition -Reported overnight stay in a mental hospital or treatment program	-16% of state prison inmates -7% of Federal prison inmates -16% of local jail inmates
James & Glaze, 2006	Data from personal interviews with State and Federal prisoners in 2004 and local jail inmates in 2002	State prison inmates (n=14,499), Federal prison inmates (n=3,686), local jail inmates (n=6,982)	"Mental problem" defined by 2 measures: -A recent history of a mental health problem (included clinical diagnosis or treatment by MH professional) -Recent symptoms of a mental health problem (based on criteria from DSM-IV)	-56% of State prison inmates -45% of Federal prison inmates -64% of jail inmates

In 1939, British psychologist Lionel Penrose noted the decrease in the mental hospital population and the subsequent increase in the number of incarcerated individuals, an occurrence that has been termed the Penrose Effect (Pallone & Hennessy, 1992; Penrose, 1939). Penrose theorized that if one form of confinement is reduced, use of the other will increase (Lamb & Weinberger, 1998). Thus, where incarcerated populations are large, mental hospital populations will be small, and vice versa. If there is room in prisons and a shortage of hospital beds, the majority of individuals with mental illness who encounter law enforcement are likely to be channeled through the criminal justice system.

Over the last three decades, researchers have become increasingly concerned about the number of individuals in jails and prisons with mental illness, an issue that has not been raised since the 19th century (Lamb & Grant, 1982). In the 19th century, the public began to express outrage about the use of jails to hold mentally ill individuals and a movement led by reformers Dorothea Dix and Louis Dwight began to build psychiatric hospitals to provide appropriate treatment. More recently, however, jails are serving as surrogate mental hospitals, attributable in part to the deinstitutionalization (e.g., closure of public psychiatric hospitals, shifting patients to community-based mental health services) during the 1960s and 1970s (Schaefer & Stefancic, 2003). The high cost of treatment resulted in the release of 85 percent of patients, most of whom returned to the community without treatment plans, medications, or housing (ibid.). Without appropriate support, many of these individuals became homeless or turned to criminal activity, ending up in jails or prisons.

Although deinstitutionalization is implicated in the rise of individuals with mental illness in the criminal justice system, it is likely not the only explanation. In their review of the literature on the topic, Lamb and Weinberger (1998) pointed out that since there is a lack of good studies

of individuals with mental illness in jails and prisons before deinstitutionalization, we cannot conclude irrefutably that the number has increased since. Even so, it does appear that a greater proportion of individuals with mental illness are arrested compared to the general population. Other commonly cited causative factors are the unavailability of long-term hospitalization in state hospitals for those with chronic and severe mental illness (SMI); more rigid criteria for civil commitment; the difficulty that offenders with mental illness released from the criminal justice system have in accessing treatment in the community; and the lack of adequate support systems in the community for individuals with mental illness (Jamelka, Trupin, & Chiles, 1989; Laberge & Morin, 1995). Lamb and Weinberger (1998) contend that deinstitutionalization may have provided the preconditions for increasing numbers of individuals with mental illness to enter the criminal justice system and that the causative factors identified above have arisen from its implementation.

Another possible explanation for the rise in involvement of individuals with mental illness in the criminal justice system is the change in sentencing for drug-related crimes. The application of mandatory minimum sentencing guidelines for such crimes has increased, due in part to the “war on drugs” of the 1990s, resulting in an increasing proportion of incarcerated drug offenders. Nearly 33 percent of state prisoners released in 1999 were drug offenders (up from 26 percent in 1990 and 11 percent in 1985) (Hughes, Wilson, & Beck, 2001). Data from the Epidemiologic Catchment Area Study and the National Comorbidity Study show high prevalence of co-occurring substance abuse among individuals with serious mental illness (Kessler, Chiu, Demler, & Walters, 2005; Regier et al., 1990). Given the high prevalence of co-occurrence, it is likely that the harsher sentencing resulting from the war on drugs increased the number of individuals with mental illness incarcerated for drug-related crimes.

Although causal explanations for the phenomenon may vary, the number of sentenced individuals with mental illness and/or addiction is increasing. Many researchers are critical of the trend, citing certain jails—Riker’s Island in New York City and the LA County Jail— as the largest mental hospitals in the country (Torrey, 2008). The large number of offenders with mental illness in jails and prisons has caused problems for correctional staff. Corrections personnel have identified inmates with mental illness as a critical concern, second only to overcrowding (Gibbs, 1983).

The criminalization of individuals with mental illness is perpetuated by the lack of adequate support systems in the community. An estimated 16 percent of those returning to the community have serious mental illness (Ditton, 1999). These individuals are often released without any type of aftercare or pre-release planning, increasing the likelihood that they decompensate, or that previously maintained symptoms or behaviors associated with their mental illness return, affecting functioning (Lamb & Weinberger, 1998; Schaefer & Stefancic, 2003). In reviewing literature on facilitators and barriers to continuing healthcare after jail, Lincoln et al. (2006) outline four reasons why connecting those incarcerated with medical care both in jail and after release is necessary: (1) to reduce the progression and spread of disease; (2) to improve public safety; (3) to shift the use from more expensive and reactive healthcare services (e.g. emergency departments and hospitals) into preventative, self-care, and primary care services; and (4) to facilitate successful reentry to society for the benefit of the individual, family, and community. Although these recommendations do not address mental health care specifically, they are applicable to individuals with mental illness returning to the community.

From an economic perspective, investment of public funds in the health of inmates while incarcerated is compromised without continuity of care. In 1999, the Bureau of Justice Statistics

estimated that prisons use an average of 12 percent of total operating expenditures on health care (Stephan, 1999). Additionally, 17 cents of each correctional health care dollar goes to mental health services for incarcerated individuals (Metzner, 2002). According to the U.S. Department of Justice, all federal prisons and most state prisons and jails provide mental health services to inmates, including “screening inmates at intake for mental health problems, providing therapy or counseling by trained mental health professionals, and distributing psychotropic medication” (James & Glaze, 2006, p. 9). In spite of this, many do not receive treatment and treatment has been criticized as inadequate (Steadman & Veysey, 1997). Also, offenders with mental illness typically receive longer sentences than offenders without mental illness (Ditton, 1999). Offenders with mental illness also spend more time in jails than offenders without mental illness (Goldkamp & Irons-Guynn, 2000), which is more costly.

3.0 IMPACT OF CRIMINAL RECORD AND MENTAL ILLNESS ON QUALITY OF LIFE

Individuals with mental illness who have no criminal history face multiple barriers to accessing supports in the community, impacting their quality of life and survival. Successful use of community services may be further impeded by the presence of a criminal record, which can impact employment, housing, and education. Individuals with mental illness who come into contact with the criminal justice system are an especially vulnerable group. They must live with the “double stigma” of mental illness and a criminal justice history. The burden of their arrest or charges can exacerbate the distrust and isolation associated with mental illness.

The degree to which individuals are connected with services in the community upon release from jail or prison varies by state and jurisdiction. With regard to parole, many agencies do assist in connecting individuals with services to make the transition from prison to the community (e.g., helping to find employment and a place to live). However, parole supervision has increasingly shifted to becoming more for surveillance purposes (e.g., drug testing and monitoring curfews) than for rehabilitation purposes (Petersilia, 2003). Furthermore, there is a lack of special programs for parolees with mental illness (ibid.).

3.1 EMPLOYMENT

3.1.1 Criminal Record and Employment

Incarceration is associated with limited future employment opportunities and reduced earning potential (Pager, 2003; Western & Pettit, 2005). These factors in turn serve as strong predictors of recidivism (Pager, 2003). In his seminal article on the relationship between incarceration and employment, Pager (2003) posits that a criminal record has a “negative credential” associated with it, and stratifying the individual and predisposing him or her to discrimination or social exclusion (p. 942). The research demonstrates that having a criminal record markedly reduces employment opportunities, especially in young black men. Mechanisms that may contribute to the relationship between incarceration and employment include the effect on social networks (Hagan, 1993); legal barriers; interference with social and family relations; and the stigma of criminal justice association (Pager, 2003).

State laws largely create the policies and legal guidelines governing the employment of individuals with criminal records. Most states have legal prohibitions against employing people with a criminal history in certain jobs. According to a report published in 2000 by the National Institute of Justice, some states place employment restrictions on parolees, barring them from certain professions. For example, California bars them from the law, medicine, nursing, real estate business, physical therapy, and education (The National Institute of Justice, 2000). States spend millions of dollars to rehabilitate offenders, stressing the importance of finding employment, but hinder the process by barring them from many kinds of work.

Even when legal barriers are not in place, “employers can easily obtain an applicant’s criminal history and often refuse to hire people who have been convicted or—in jurisdictions that

make arrest records public—have been arrested but not found guilty of any crime” (The Bazelon Center for Mental Health Law, 2002, p. 3). Thirty-seven states have laws permitting employers to find out about and consider arrests that did not result in conviction in making employment decisions (Legal Action Center, 2004). Ten states do not have these laws and three have laws prohibiting some employers from considering arrests if they did not lead to conviction (ibid.).

3.1.2 Employment for Mentally Ill Offenders

The employment situation may be exacerbated for individuals with mental illness returning from jail or prison to the community to find work. Employment is critical to individuals with mental illness as it provides income and connections to society. In addition, access to employment for offenders with mental illness leaving the criminal justice system increases the likelihood that one has access to employer-based health insurance. According to Frank and Glied (2006), the evidence on the effect of mental illness on the ability to find employment has remained rather stable, yet consistently poor. Analyses of data from the National Comorbidity Survey indicate that a diagnosable mental disorder reduced employment among men by between 8 to 12 percent (Ettner, Frank, & Kessler, 1997). Moreover, studies suggest that earnings for those with mental illness have remained lower than their peers. Frank and Gertler (1991) estimated that they earn 25 percent less.

Stigma associated with mental illness presents a significant employment barrier and influences decisions to hire or to keep an individual with mental illness in the workplace. Scheid (1998) found that 16 percent of employers indicated that they would be uncomfortable hiring someone with a physical impairment, but 44 percent indicated that they would be uncomfortable hiring someone in treatment for depression. Research also suggests that employers are more

reluctant to make accommodations for individuals with mental illness in the workplace than to make accommodations for individuals with physical disabilities, such as mobility impairments (Micheals, Nappo, Barrett, Risucci, & Harles, 1993). The stigma associated with mental illness may discourage individuals with mental illness from disclosing their condition (Mechanic, 1998), yet disclosure is necessary for employers to make accommodations. All of these factors can make it challenging for individuals with mental illness to secure employment upon returning to the community.

3.2 HOUSING

3.2.1 Criminal Record and Housing

Due to a combination of both federal and local policies, many individuals with a criminal history are excluded from federal subsidized housing. Federal laws give local housing agencies some flexibility in deciding whether to deny individuals with criminal records access to public housing. They do not require that the agencies consider the individual circumstances or history of the applicants or take into account arrests that did not lead to conviction. The two major exceptions are for those convicted of producing methamphetamine on public housing property and those registered under a state's lifetime sex offender registry program (Legal Action Center, 2004). Federal policy permits substantial local discretion and increasingly local housing authorities are left to their own interpretations. For example, federal policy requires public

housing authorities “to deny access to anyone with a conviction for a crime, including a misdemeanor, that could affect the health, safety, and welfare of other tenants” (The Bazelon Center for Mental Health Law, 2002, p. 3). Some housing authorities have interpreted this to include conviction for disorderly conduct, harassment, and misdemeanor drug possession (The Bazelon Center for Mental Health Law, 2002) and apply a policy of blanket refusals to former inmates.

Access to subsidized housing has become more challenging as federal support for public housing, housing assistance, and homeless programs has decreased. The principal form of housing assistance is the Housing Choice Voucher Program, otherwise known as Section 8. Enacted in 1974, this program, operated by the U.S. Department of Housing and Urban Development (HUD), provides subsidized public housing to those with disabilities or low to moderate incomes. Although largely funded by the federal government, a network of state, regional, and local housing agencies also gives out vouchers that can be used to pay rent (National Coalition for the Homeless, June 2008). However, the program faces dwindling funding, be it federal or otherwise. In fact, the program lost 150,000 vouchers between 2004 and 2007, the largest reduction in its history (Rice & Sard, 2007). Although the program provides valuable assistance, relatively few people have access to it. Of the 15.8 million people eligible for tenant-based subsidies such as Section 8, only one in nine actually receives these subsidies (ibid.). In addition, private landlords renting to individuals with Section 8 housing vouchers can evict or refuse to admit tenants based on their criminal history, including misdemeanor drug-related and other crimes (The Bazelon Center for Mental Health Law, 2002).

3.2.2 Homelessness

In its first annual Homeless Assessment Report to Congress of 2007, the U.S. Department of Housing and Urban Development (HUD) reported that on a single night in January 2007—the measure used to calculate the number of homeless individuals on the streets and in shelters—the number of homeless people was 666,295, less than the 754,147 counted in 2005. The report also stated that 1.6 million people had spent time in homeless shelters between October 1, 2006, and September 30, 2007 (U.S. Department of Housing and Urban Development, 2007).

Research indicates that the provision of housing to individuals with mental illness who have been involved in the criminal justice system can enhance post-release success in the community. Overall, housing is believed to be an important component of good mental health care (Mechanic, 2003). By providing housing, individuals with mental illness can live in the community, enabling them to use community-based treatment services (Frank & Glied, 2006). Programs that contain housing components have shown promising results.

California's Community Mental Health Treatment (AB2034) program is one such example. Designed to address the needs of individuals with mental illness who are homeless or at risk of becoming homeless or incarcerated, it offers integrated services that include outreach programs and mental health services, substance abuse programs, vocational training, and housing assistance. The program uses a range of strategies to find housing for these individuals, including securing Section 8 vouchers. A report found that persons provided with housing were much more likely to remain in the program, particularly among those with serious challenges (e.g. serious mental illness) (Davis, Johnson, & Mayberg, 2000). This suggests that housing leads to residential stability and may be a key factor in achieving the positive outcomes that have been

observed in AB2034 participants, including decreased incarceration and hospitalization (Davis et al., 2000).

Research indicates a connection between homelessness and reincarceration among released individuals, impacting their reintegration into the community. A large study examining persons released from New York state prisons found high rates of shelter use (11.4%) and reincarceration (32.8%) (Metraux & Culhane, 2004). The authors also found that a history of shelter use increases the risk for reincarceration and shelter use post-release. Individuals with links to the mental health system had notably higher proportions of shelter stays and reincarcerations than individuals without links to the mental health system, yet the difference was not significant (ibid.). The elevated proportion of shelter use supports the assertion that the relationship between mental illness and homelessness is mediated by other socioeconomic factors (Draine, Salzer, Culhane, & Hadley, 2002). The elevated proportion of reincarcerations suggests that mental illness may contribute to the risk of being reincarcerated, but the authors warn that this result should be interpreted with caution.

California's AB2034 program has reduced recidivism rates, in terms of both hospitalization and incarceration: the total days of incarceration for those served fell 84.6 percent (from 600,438 days in the previous year to 11,609 days since enrollment) and the total days of hospitalization fell 77.7 percent (from 10,906 days in the previous year to 2,435 days since enrollment) (The National GAINS Center for People with Co-Occurring Disorders in the Justice System, 2004). The program also produced sizeable reductions in other costs: an investment in 2000 of \$14.1 million produced an estimated savings/cost avoidance of \$7.3 million, \$3.07 million of which was due to reduced incarceration costs (\$60 per day for 51,151 fewer days) (Davis et al., 2000). By providing comprehensive services and connecting returning individuals

with vital supports, such as housing, integrated programs like these can foster successful reintegration into the community.

3.3 EDUCATION

While illiteracy and low levels of educational attainment are not necessarily direct causes of criminal involvement, individuals who have inadequate education are disproportionately found in jails and prisons. Rubenstein (2001) found that among adult state prisoners, 19 percent were completely illiterate and 40 percent were functionally illiterate, compared to 4 percent and 21 percent, respectively, of the nonincarcerated public. Research shows an inverse relationship between education and recidivism: the higher the level of education, the less likely the individual is to be rearrested or reincarcerated (Gottfredson, Wilson, & Najaka, 2002; Petersilia, 2003).

Education has been cited as a contributing factor to recovery and rehabilitation in the community (Petersilia, 2003; The Bazelon Center for Mental Health Law, 2001, 2002). However, paying for education is increasingly challenging for individuals with a criminal record. Access is limited by federal restrictions barring persons with a previous conviction for possession or sale of controlled substances from receiving subsidized student loans or Pell grants (The Bazelon Center for Mental Health Law, 2001). Thus, many individuals leaving prison or jail are cut off from federal educational assistance and few can afford to pay for education by themselves.

4.0 IMPACT OF CRIMINAL RECORD AND MENTAL ILLNESS ON RECIDIVISM

Not surprisingly, many individuals released from jail or prison are rearrested and reincarcerated. In 2002, the Bureau of Justice Statistics released the results of one of the most comprehensive studies to date of prisoner recidivism (Langan & Levin, 2002). The study found that 30 percent of released prisoners were rearrested within the first six months, 44 percent within the first year, and 67.5 percent within three years of release from prison (ibid.). However, the study did not discuss the role of mental illness directly. In a 2006 report on the mental illness of prison and jail inmates, the Bureau of Justice Statistics found that inmates who had a “mental problem” were more likely to have served prior sentences than inmates without a mental problem. Of state prisoners who had a mental problem, 47 percent had served three or more prior sentences, compared to 39 percent of those without a mental problem (James & Glaze, 2006). Of jail inmates who had a mental problem, 42 percent had served three or more prior sentences, compared to 33 percent of jail inmates without a mental problem. Although the authors found that the proportion of inmates with a mental problem who served prior sentences is higher, tests of significance were not conducted. In addition, the two measures used to define “mental problem” were not very clear (“a recent history *or* symptoms of a mental health problem”) and the data were collected using interviews only. Unfortunately, there is a general lack of studies on the relationship between mental illness and recidivism.

The literature on mental health service use and recidivism, which is also limited, indicates that timely delivery of mental health treatment may mitigate or even prevent criminal justice involvement. As part of the Vermont Mental Health Performance Indicator Project, a study using data from 14 states found a strong correlation between incarceration rates and use of public mental health services. The states with the highest rates of utilization had the lowest incarceration rates and the states with the lowest rates of utilization had higher incarceration rates (Vermont Mental Health Performance Indicator Project, 2002). However, the report does not discuss possible explanations for this association. Another study looked at the population of mentally ill offenders in Washington state and examined the post-release services they received, new offenses committed, and factors associated with recidivism (Lovell, Gagliardi, & Peterson, 2002). The authors found that most offenders with mental illness received post-release social or mental health services (73 percent), yet the services received were not “clinically meaningful” (ibid., p.1290). Of the 337 mentally ill offenders studied, 52 percent received cash assistance in the first year; yet only 25 percent received consistent cash assistance (nine or more months of the first twelve months after release); 50 percent received community mental health services in the first year; and only 16 percent received consistent community mental health services. In addition, only 5 percent received consistent drug and alcohol services during the same time period. The intensity of treatment, measured by hours of mental health service, was also low for most subjects during the first twelve months after release. Typically, subjects only received two to five hours of service per month, which the authors posit may not be enough for individuals who face challenges related to mental illness, substance abuse, and recent incarceration. Seventy percent were convicted of new offenses or supervision violations and 10 percent were convicted of felony crimes within a follow-up period averaging 39 months (ranged from 27 to 55 months,

depending on when subjects were released). The authors suggest that factors that mitigate the quality and quantity of community mental health services a person with mental illness receives after release from prison and how these relate to recidivism both merit further study, as “subjects who committed new felonies tended to receive community mental health services later and in smaller amounts than those who did not commit new felonies, but any causal relationships between these variables cannot be determined” (Lovell et al., 2002, p. 1295). Although the differences were considerable, they were not significant. Furthermore, even if a significant relationship were observed, confounding variables would preclude making any causal inferences between service use and recidivism. Confounding variables not measured by the study include, but are not limited to, the subject’s attitude towards treatment, level of functioning, and social support. In sum, although the study does not examine federal benefits directly and further analysis is necessary, the results imply that higher levels of service in the first months after release may affect recidivism.

The literature on receiving pre-arrest community services incarceration for offenders with mental illness is inadequate. Data are lacking on whether persons with mental illness who were arrested had been treated, or if treated, the duration of the interval between treatment and arrest (Veysey, Steadman, Morrissey, & Johnsen, 1997). A major obstacle is that researchers may not have access to comprehensive mental health treatment data and comprehensive criminal justice data. Merging these data sources is rarely attempted due to technical challenges and confidentiality issues.

A study by Cuellar, Snowden, and Ewing (2007) addressed the pre-arrest treatment characteristics of arrested individuals. The authors examined retrospectively the criminal records of persons receiving Medicaid-financed mental health treatment and their treatment patterns

before and after arrest. Over a ten-year period, one quarter of the 6,624 individuals sampled had at least one arrest and received the same number of mental health services, on average, as those who were not arrested. Of those arrested, 57.3 percent were arrested more than once. The authors found that the type of crime varied by mental health diagnosis: individuals diagnosed with schizophrenia or psychosis were disproportionately arrested for violent crimes, whereas individuals diagnosed with other disorders were disproportionately arrested for drug crimes. Although the drug crimes finding most likely reflects the high rate of co-occurring addiction among individuals with mental illness, it does not imply that some persons with schizophrenia do not also suffer from addiction. The authors propose that persons with schizophrenia may be more likely to act aggressively or violently than persons with other mental disorders. Another explanation is that persons with symptoms of schizophrenia (e.g., hallucinations, delusions) may be more likely to be arrested than those without, but are not necessarily more likely to be more aggressive or violent. The authors did not find that arrested individuals were more likely to receive treatment services after arrest than before. Only 27 percent of arrested individuals with a diagnosis of mental illness had received any kind of treatment within thirty days after the arrest, thus “arrest was not associated with meaningful increases in service use, pointing to potential missed opportunities to reconnect those individuals to treatment” (Cuellar, Snowden, & Ewing, 2007, p. 119).

5.0 FEDERAL ENTITLEMENT PROGRAMS

The advent of the Medicaid, Medicare, and—later—the Supplemental Security Income programs significantly expanded resources available to individuals with mental illness. These programs also made the federal government a major financer and regulator of mental health care in general, thereby reducing the mental health sector’s influence in mental health policy (Frank & Glied, 2006). Today, the primary federal programs that pay for care and support of individuals with mental disorders are Medicare, Medicaid, Supplemental Security Income (SSI)/ Supplemental Security Disability Insurance (SSDI), Temporary Assistance to Needy Families (TANF), and other social service programs run by the U.S. Department of Housing and Urban Development (e.g., Section 8) and the U.S. Department of Agriculture (e.g., food stamps). These programs provide more disposable income to recipients, some of which can be used to pay for medical and mental health care. They may also connect clients to other programs and services. Although these public insurance and assistance programs were not originally intended to provide for individuals with mental illness specifically, they allow them to make choices concerning their own lives and health that were not possible before.

5.1 SUPPLEMENTAL SECURITY INCOME (SSI) PROGRAM AND SOCIAL SECURITY DISABILITY INSURANCE (SSDI) PROGRAM

While access to treatment in correctional settings varies by state and facility, many inmates with mental illness receive assessment and treatment while incarcerated. When released, this population has access to mental health treatment largely through federal entitlement programs, principally Medicaid. Many individuals are also entitled to income supports through the Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) programs, which are often linked with Medicaid. A substantial proportion of individuals enrolled in the SSI and SSDI programs have mental illness. In 2007, individuals with mental disorders other than “retardation” accounted for almost 40 percent of all SSI beneficiaries under the age of 65 (Social Security Administration, 2008b). Individuals with mental illness represented nearly 30 percent of all SSDI beneficiaries and 39 of those under the age of 50 (Social Security Administration, 2008a).

Welfare agencies administer SSI as per federal rules whereas the federal Social Security Administration oversees SSDI. SSI provides support for low-income people with limited resources who are aged 65 years or older, blind, or disabled (Social Security Administration, 2007). To be eligible for SSI due to disability, individuals must have a diagnosed disorder, such as mental illness. In most states, those who receive SSI automatically receive Medicaid coverage. In others, filling out a separate application will permit most to obtain Medicaid coverage. SSDI recipients are eligible for Medicare after a 24-month waiting period. SSDI provides income support for individuals with disability who have worked long enough to have paid social security taxes (Social Security Administration, 2008d). Essentially, SSI payments supplement SSDI payments for disabled low-income individuals (Frank & Glied, 2006). Most individuals

with serious and persistent mental illness have a limited work history because of that illness and the age at which they became disabled, so they typically receive SSI benefits (either alone or in conjunction with a small SSDI benefit payment) (The Bazelon Center for Mental Health Law, 2001).

Federal SSI/SSDI benefit eligibility for inmates is determined by the amount of time an individual is incarcerated, thus affecting Medicaid eligibility since they are often connected. Practically all prison inmates lose their SSI benefits (and often Medicaid benefits) due to lengthy stays, yet this is not the case for jail inmates (see Appendix for more information). SSDI benefits, on the other hand, are suspended after a thirty-day incarceration period, but are never terminated. It is important to underline the difference between prisons and jails since the average duration of confinement varies by type of correctional facility. Jails are short-stay facilities, designed to hold persons convicted of a crime sentenced to a year or less on misdemeanor offenses and persons awaiting trial (Morrissey, Dalton et al., 2006, p. 804). Prisons are generally long-stay facilities for those who have been convicted of a felony.

5.2 MEDICAID

Medicaid provides access to health and mental health treatment by providing medical benefits to groups of low-income people, some of whom have no health insurance or have inadequate health insurance (Center for Medicaid and State Operations, 2005, p. 2). When the program was enacted in 1965, it provided public health insurance for some groups of poor and disabled people who had previously not had access to health insurance. It established a voucher-like system through which beneficiaries could receive mental health services from providers who would

accept Medicaid payment, allowing non-hospitalized people with serious mental illness to access services in the community. Since the program's inception, it has become increasingly valuable to individuals with mental illness, as reflected by the rising proportion of the population covered. Frank and Glied (2006) estimate that in 1972, 24 percent of persons with serious mental illness were covered and by 1998, 60 percent were covered by Medicaid and Medicare (many disabled individuals eligible for Medicare also qualify for Medicaid because their incomes are low enough). Indeed, Medicaid is the main insurance program and payer of services for persons with mental illness (Frank, Goldman, & Hogan, 2002). It pays for more than half of the public health services provided by the states, and this is expected to continue (Buck, 2001, 2003). It is increasingly difficult for those without Medicaid coverage to have access to care through the public mental health system (The Bazelon Center for Mental Health Law, 2002).

While the federal government establishes general guidelines for the program, states administer benefits according to their own rules. In this way, whether an individual qualifies for Medicaid depends on the requirements in his or her own state. States are required to cover certain groups of individuals (e.g., individuals who qualify for SSI) and have the option to include others (e.g., persons aged 65 or older) (Center for Medicaid and State Operations, 2005). Under Medicaid law, states must provide certain services to the groups of individuals they are required to cover, yet other services are optional (ibid.). Mental health services are no different: certain services are mandatory (e.g., hospital inpatient care; physician services; emergency room services), while others are optional (e.g., case management; rehabilitation services) (Taube, Goldman, & Salkever, 1990). Many mental health services are not mandatory, thus states are afforded the flexibility to define Medicaid service coverage for optional services. In this way,

they can impose more limitations on mental health services than general medical services (Grob & Goldman, 2006).

For inmates who are eligible for Medicaid through SSI, Medicaid eligibility will be lost if SSI eligibility is terminated. Moreover, many states automatically terminate Medicaid benefits upon incarceration, even if SSI has not been terminated. For inmates whose Medicaid eligibility is not connected to SSI, the state has the option under federal law to suspend Medicaid eligibility during incarceration rather than terminate it. However, in practice, Medicaid eligibility is often terminated despite the option for suspending benefits, even when the inmate is incarcerated for only a short period of time.

5.3 TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) PROGRAM

In 1996, President Clinton signed the Personal Responsibility and Work Opportunity Reconciliation Act, replacing individual entitlement to welfare with block grants to states called Temporary Assistance for Needy Families (TANF) (formerly known as “welfare”). This law imposed a five-year lifetime limit on benefits, required welfare recipients to work in order to receive benefits, and intensified child support enforcement requirements for parents without custody (Petersilia, 2003, p. 124). Essentially, TANF is a federal assistance program for families in need with dependent children (Petersilia, 2003). The TANF Bureau under the Administration for Children and Families administers block grants to states to develop their own welfare programs for families. Although the federal TANF Bureau oversees the allocation of the block grants, the states administer these. The federal government does not provide direct assistance under TANF and individuals must apply through the agency administering the grant in their

community (Administration for Children and Families, 2008). As delineated in the Social Security Act, the purposes of the program are to:

- 1) Provide assistance to needy families so that children may be cared for in their own homes or the homes of relatives;
 - 2) End the dependence of needy parents on government benefits by promoting job preparation, work, and marriage;
 - 3) Prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and
 - 4) Encourage the formation and maintenance of two-parent families
- (Social Security Act § 401).

According to the Administration for Children and Families, the overarching goal of the program is to promote self-sufficiency and the programs must be designed and created to fulfill this objective. As the TANF programs are run by the states, they are given the flexibility to determine the design of the program, the type and the amount of the assistance provided, what other services are provided, and eligibility rules.

Some researchers argue that the Personal Responsibility and Work Opportunity Reconciliation Act not only dismantled the American welfare system, but also disenfranchised offenders (Petersilia, 2003). The law stipulates that states must *permanently* prohibit individuals with drug-related felony convictions from receiving federally funded public assistance and food stamps. Petersilia (2003) points out that this lifetime ban applies only to individuals with drug-related convictions, so “[...] offenders released from prison after serving a sentence for murder, for example, are eligible for welfare benefits and food stamps, but not those who have a conviction for possessing or selling a small quantity of drugs” (p. 124). Although the law permits states to opt out of or to modify this provision, specific legislation must be passed by the state to do so. According to the Legal Action Center, seventeen states have adopted the ban as is; twenty-one states have modified it to include those with drug-related felony convictions if they satisfy certain requirements (e.g., participating in drug or alcohol rehabilitation); and twelve states have

removed the ban completely (Legal Action Center, 2004). The law also requires that individuals in violation of their parole or probation conditions be provisionally ineligible for TANF assistance, SSI payments, housing assistance, or food stamps. The duration of ineligibility varies by program. Denying access to public assistance and food stamps can be detrimental to an individual returning to the community with a criminal record, especially if the individual has a mental illness.

6.0 FEDERAL BENEFITS AND USE OF SERVICES

Public health insurance programs (e.g., Medicaid and Medicare) and public income support programs (e.g., SSI/SSDI, TANF) have transformed the mental health system in the United States. A major change is that these programs moved money and resources from a centralized mental health system to a more decentralized network, a phenomenon referred to by Frank and Glied (2006) as “mainstream[ing] the care and support of people with mental illnesses” (p.141). Mainstreaming has afforded individuals with mental illness greater choice and flexibility (Frank & Glied, 2006). Through this decentralized network, individuals with mental illness are most likely to receive benefits from programs that serve individuals with other disabilities. Furthermore, programs that pay for medical care also finance mental health care and afford access to mental health care in the community for individuals with mental illness. Programs such as SSI/SSDI and TANF provide vital income support and assistance so that individuals with mental illness can pay for housing, food, clothes, and other goods and services to live in the community.

Resources available through federal entitlement programs for individuals living outside institutions have improved continuously. According to calculations performed by Frank and Glied (2006), both the proportion of individuals with serious mental illness receiving resources and the amount these individuals receive annually have increased. For example, the percentage of individuals with SMI receiving Medicaid benefits increased from 39 percent in 1990 to 60

percent in 1998 and the amount received increased from \$8,700 to \$9,600 respectively (Frank & Glied, 2006). During the same time period, the percentage receiving SSI benefits increased from 30 percent to 41 percent and the percentage receiving SSDI benefits rose from 22 percent to 30 percent (ibid.). These figures raise the question: as resources have increased and more individuals with mental illness receive them, has service use also increased for this population?

The literature shows a positive relationship between mental health services use and receipt of insurance in general. Insurance increases access to mental health services such that those who are insured (public or private) are more likely to receive services (Landerman, Burns, Swartz, Wagner, & George, 1994; Rabinowitz et al., 1998). The type of insurance (i.e. public or private) is important. McAlpine and Mechanic (2000) found that among individuals identified with serious mental illness (SMI), those with public insurance (Medicare or Medicaid) are almost six times more likely to have access to specialty mental health care, while those with private insurance were roughly 2.5 times more likely. The authors contend that these results demonstrate the crucial importance of public insurance (McAlpine & Mechanic, 2000, p. 288).

Although these studies indicate that having insurance can improve the likelihood that an individual uses mental health services, there is still a sizeable gap between the need for mental health care and insurance coverage. McAlpine and Mechanic (2000) found that individuals with severe mental illness disorders are more likely to be uninsured than the general population. The proportion of people surveyed that had no insurance was 20 percent of those with a SMI diagnosis, 18.2 percent of those with a non-SMI diagnosis, and 11.4 percent of those without a diagnosed disorder. Nonetheless, public insurance programs assume the major share of the burden of paying for mental health care: in 1996, public programs accounted for almost 36

percent of the estimated \$24.4 billion spent to finance treatment for noninstitutionalized individuals (Zuvekas, 2001).

Most of the research on how public insurance (particularly Medicaid) affects health service use has focused on certain at-risk populations, including children and homeless adults. Using data from the 1997 National Survey of America's Families (NSAF), Dubay and Kenney (2001) found that low-income children with Medicaid were no more likely to receive mental health services than either privately insured or uninsured low-income children. A second study found similar results: after controlling for selection into insurance status, poor children with Medicaid use more mental health services than uninsured poor children, yet both groups are just as likely as children with private insurance to use mental health services (Glied, Hoven, Moore, Garrett, & Regier, 1997). Research focusing on the effects of health insurance on service use for homeless adults is mixed: some studies indicate that receipt of insurance leads to positive outcomes (Glied, Hoven, Moore, & Garrett, 1998; Kushel, Vittinghoff, & Haas, 2001; Padgett, Struening, & Andrews, 1990). In examining Medicaid insurance specifically, Glied and colleagues (1998) found inconsistent results from two cohorts: data from a 1985 cohort suggested that having Medicaid increases mental health service use, whereas data from a 1987 cohort did not (Glied et al., 1998). A large report on Medicaid and access to care for the homeless found that in a national cohort of single homeless adults, those receiving Medicaid were less likely to receive any kind of mental health treatment than those without Medicaid (Burt & Sharkey, 2002). In sum, these studies suggest that Medicaid does not provide any advantage in obtaining mental health services for these vulnerable groups.

Much less is known about the role of public insurance and mental health service use among justice-involved individuals with mental illness, another vulnerable population. This issue

is gaining considerable momentum in the policy area as agencies and advocates stress the importance of connecting such individuals with public insurance and supports so that they can access services in the community (The Bazelon Center for Mental Health Law, 2001, 2002). Advocacy groups propose that by connecting these individuals with public entitlement programs, they will be more likely to access mental health services and pay for housing, food, and other necessities. Although this is a logical conjecture, there is little academic research to support it.

The few studies that exist focus on Medicaid coverage specifically and individuals with serious mental illness (SMI) released from jail. Spearheaded by Joseph Morrissey and colleagues, this research suggests that coverage upon release increases the likelihood of persons with mental illness receiving continuity of care. Using data from two cohorts (one from Pinellas County, Florida and one from King County, Washington), Morrissey and colleagues (2006) found that individuals with SMI enrolled in Medicaid upon release from jail are (1) more likely to receive services more quickly, (2) to access community services, and (3) to obtain more days of service than those without Medicaid in the 90 days following their release from jail. The authors contend that a major policy implication of these findings is ensuring that Medicaid coverage is not disrupted for individuals with SMI who are detained in jail since having it is an advantage for these individuals in receiving timely services when released from jail (Morrissey, Steadman et al., 2006, p. 814). However, the Medicaid advantage was not consistent in each county as both Medicaid and non-Medicaid groups in King County were more likely to receive services, received them faster, and received more days of service than their counterparts in Pinellas County (ibid.). Differences in data sources and the presence of an enhanced “social safety-net” in King County could account for this discrepancy. The authors identified several limitations of their research. As the study was observational, direct causality cannot be made to

attribute greater service use to enrollment exclusively in Medicaid. Additionally, certain characteristics of individuals enrolled in Medicaid could account for observed differences in service use. For example, individuals enrolled in the Medicaid program could be more ill or disabled, or more persistently so, than those not enrolled.

In a second study, Morrissey, Cuddeback, Cuellar, and Steadman (2007) found that inmates with mental illness who are enrolled in Medicaid at the time of release have fewer detentions (16 percent) in the following year than those released without enrollment in Medicaid, yet the difference was small. Medicaid enrollment is implicated in reducing recidivism rates for these individuals. However, the authors acknowledge that research on the relationship between mental illness and criminal involvement has identified other factors, such as level of education, severity of symptoms, level of social functioning, and degree of social cohesion, which could be associated with Medicaid enrollment (Morrissey, Cuddeback, Cuellar, & Steadman, 2007).

The research conducted by Morrissey and colleagues suggests that having Medicaid can improve service access and use for individuals with SMI leaving jail. Although the results obtained are encouraging, sizeable gaps remain in the literature. Research uses data on individuals incarcerated in jail, not prison. Since prisons are longer-stay institutions than jails, practically all inmates lose Medicaid and SSI/SSDI benefits during their confinement (Morrissey, Steadman et al., 2006). There are no studies using data on individuals incarcerated in prison, thus the role of Medicaid for individuals with SMI released from prison is unknown. Additionally, the research does not examine the types of community services received and whether the services were appropriate based on the needs of the individual. Another factor that has not been studied is how receiving social security benefits in conjunction with Medicaid could enhance access to and use of services after release for an offender with mental illness. Morrissey

and colleagues concede that SSI often accompanies Medicaid, thus it could have an effect on the findings. They argue, however, that access to and use of mental health services are determined by insurance status more than income, especially for the population they studied (Morrissey et al., 2007, p. 800).

In recent years, programs at local and state levels have tried to improve the linkages between the criminal justice system and the mental health system by helping offenders obtain access to care upon release from prison or jail. These programs stem from the hypothesis that released inmates who obtain benefits are more likely to seek and continue care than those who do not, even if, as discussed previously, the research is limited. The National Institute of Justice and the Centers for Disease Control and Prevention funded a study to investigate and report the experiences of three jurisdictions (State of Texas, Philadelphia County, and the State of New York) that help inmates prepare and file prerelease applications to initiate or restart federal entitlement benefits. The report released on this study claims that the experiences of the three sites show that helping inmates to qualify for federal entitlements does facilitate access to community-based care and also can reduce the financial burden on state and local governments that fund health care for populations in need, yet doing so is a challenging process (The National Institute of Justice, 2007). The program in the state of Texas is the only one to address inmates with mental illness directly. Benefits eligibility specialists assist individuals with special needs (“including those with mental illness, mental retardation, or terminal illness”) with applications for federal entitlements up to 120 days before release (ibid., p. 7). The specialists check records from the Mental Health and Mental Retardation (MHMR) agency and Department of Human Services (DHS) to determine whether these agencies treated the applicant prior to incarceration. Following release, the individual’s file is transferred to the MHMR or DHS office that is closest

to where the individual will live, at which time a caseworker at that location monitors the status of the application(s). The report claims that this pilot program succeeded in helping inmates obtain benefits, yet the results indicate otherwise. Of 1,686 individuals referred to benefit eligibility specialists in the first nine months of the program, 64 percent did not submit applications. Most refused to apply, reporting that they believed themselves to be capable of working, others said that they did not feel ill enough to warrant receiving benefits, and some did not want the stigma associated with being recipients of public assistance. Additionally, the results indicate that more applications were denied for offenders with mental illness than applications for offenders with medical claims (47 percent and 38 percent respectively). Program staff reported that it was easier to have applications approved when the applicant had a history of mental health treatment in the community, yet no data are provided to substantiate this claim.

7.0 TERMINATION OF BENEFITS

In 2001, the Bazelon Center for Mental Health Law released a call to action, claiming that disenrollment of individuals with mental illness from federal benefit programs (principally SSI/SSDI and Medicaid) is increasing. Other advocacy organizations have followed suit, pointing out that substantial amounts of money are spent to provide mental health services and medications to incarcerated persons, yet due to a lack of coordination, many prisoners are released without access to aftercare services in the community, compromising their recovery (National Alliance on Mental Illness, 2004; Re-entry Policy Council, 2004). Many individuals are released without access to benefits due to the fact that they enter jail or prison without benefit eligibility or their eligibility is terminated upon incarceration. A central issue is that governments at the federal, state, and local levels are all involved in the administration of benefits. Conflicting guidelines at different levels of government and agencies render the system complex and difficult to navigate.

7.1 SSI/SSDI & MEDICAID

Federal law prohibits state Medicaid agencies from using federal funds to pay for services “[...] for any individual who is an inmate of a public institution (except as a patient in a medical institution)” (Social Security Act 1905 (a) (28) (A)). Federal policy does not delineate, however,

how states should execute this requirement. In fact, termination of Medicaid eligibility is not required and states have the option of suspending eligibility while individuals are incarcerated. Suspending eligibility implies that the inmate stays on the Medicaid rolls, but that the jail or prison does not receive reimbursements. Federal policy does not prohibit states from using their own funds to provide services to eligible persons who are held in public institutions, such as jails, prisons, juvenile detention, and correctional facilities. The Department of Health and Human Services has issued directives in recent years urging states to suspend rather than terminate Medicaid eligibility for incarcerated individuals. A memo sent to all state Medicaid directors in 2004 by the Acting Director of the Centers for Medicare and Medicaid Services (CMS) acknowledged the inconsistency. It encouraged the suspension of Medicaid benefits while a person is housed in a public institution, citing the importance of “establishing a continuum of care and ongoing support that may reduce the demand for costly and inappropriate services later” (Stanton, May 24 2004, p. 2). The memo goes on to say that when the inmate’s release is imminent, “[...] the state should take whatever steps are necessary to ensure that an eligible individual is placed in payment status so that he or she can begin receiving Medicaid-covered services immediately upon leaving the facility” (ibid., p. 2).

Despite such recommendations, inconsistency between federal and state policy frequently results in unnecessary loss of benefits for several possible reasons:

- Many states do not have information management systems that allow for the suspension of benefits (The Bazelon Center for Mental Health Law, 2001).
- States may terminate Medicaid to ensure that claims are not inadvertently filed by inmates (The Bazelon Center for Mental Health Law, 2001).
- The number of states and localities that have implemented procedures to help inmates with mental illness and/or substance use disorders claim or retain their benefits upon release is low (The Bazelon Center for Mental Health Law, 2001). This includes

providing assistance from jail staff or community mental health providers to file an application (ibid.).

- The Social Security Administration (SSA) provides financial incentives (up to \$400 per case) for reporting incarcerated persons in receipt of federal benefit payments so that SSI/SSDI benefits can be suspended or terminated (Morrissey et al., 2007). However, no incentive is provided to notify SSA when such persons are released so that benefit eligibility can be reinstated (The Bazelon Center for Mental Health Law, 2001). This program can be detrimental to inmates with mental illness since Medicaid benefits are tied to these federal income programs (Morrissey et al., 2007).

For newly-released inmates seeking medical coverage, applications for Medicaid enrollment can take three to five months for approval (Social Security Administration, May 2007). As a result, the released person is likely to enter the community without access to mental health and addiction services for ninety days or more, increasing the risk of relapse, re-hospitalization, and recidivism.

Although policy organizations (e.g., the Bazelon Center for Mental Health Law) strongly recommend that Medicaid eligibility be suspended, some states have introduced such legislation, while others have not. Some have introduced *requiring* that Medicaid benefits be suspended during incarceration (Colorado, New York, passed and adopted; Illinois, in progress; Florida, failed) while other states, such as Iowa, have introduced legislation *recommending* suspension, yet passage was not successful. It is likely that this legislation will not be readily adopted by all states as policy makers face considerable tradeoffs: the benefits highlighted by policy organizations must be weighed against the costs. A major issue is that the suspension of benefits for inmates requires ongoing inter-agency coordination and policy changes for the state agencies involved (e.g., social service agencies, benefit management staff, corrections administrators). This high level of coordination presents a significant technical limitation, as many states do not have the necessary integrated technical systems. In order to process suspension of benefits, states would need new administrative resources, or redirect existing administrative resources. Given

recent state revenue and budget shortfalls, states are facing increasing tight budgets that prevent them from adding or redistributing staff and other resources. A recent report released by the Kaiser Family Foundation surveyed State Medicaid directors across the country and found that Medicaid officials are already concerned about the impact of covering behavioral services on Medicaid budgets for fiscal years 2008 and 2009 (Smith et al., September 2008).

New York serves as an example of a state that recently passed legislation to suspend Medicaid benefits for inmates, yet faces barriers in implementing it. In April 2008, New York state law was changed to require that Medicaid eligibility for inmates be suspended. The administrative directive (ADM) reads:

[...] A State Department of Correctional Services or local correctional facility inmate in receipt of Medicaid immediately prior to incarceration on or after April 1, 2008, shall have eligibility maintained during incarceration
(New York State Administrative Directive (08ADM-03), April 21, 2008).

This legislation is beneficial for those who have Medicaid eligibility upon admission to prison/jail (which is an estimated 20-30% of their booked inmates) and requires that the effort be a shared responsibility between state and local departments of social services (New York State Bill A10864, 2008, May). However, although the law clearly requires the suspension of eligibility, the reinstatement process is less explicit and there are several barriers that must be clarified. In order for individuals to have their benefits reinstated upon release, the state must be able to check whose Medicaid eligibility was suspended against who is released from jail. Although state law requires coordination between the Department of Corrections (DOC) and the Office of Temporary and Disability Assistance to identify those who need Medicaid suspended upon entering correctional facilities, many states, including New York, do not require that correctional facilities report information about an inmate's release to the State, thus rendering information about incarcerated individuals incomplete and hindering reinstatement of Medicaid

coverage. Many State agencies issue a “Memorandum of Understanding” (MOU) that specifies requirements and responsibilities for information exchange between the two entities. However, this approach is largely relationship-based and can be problematic. Although suspension legislation could increase the number of inmates enrolled in federal benefit programs upon release, its implementation requires a level of interagency coordination and an amount of resources that many states do not have available.

8.0 RESTORING BENEFITS

For inmates whose benefits are terminated or who were not previously enrolled, a desirable option is to ensure that an application for Medicaid, SSI, and other benefits is submitted well in advance of release (at least one to three months) so that assistance is available upon release. A variety of federal, state, and local funds and grants provides benefit enrollment as part of the transition planning process. Pre-release planning varies by length of incarceration, size of the correctional facility, and resources available. Planning programs can include ensuring that the individual has identification cards (e.g. for Medicaid), a supply of medications, and community resource supports (e.g. food stamps, cash assistance, and housing) upon release. Co-locating relevant specialized staff (e.g. trained social workers) or local Social Security Administration staff at the institution to facilitate the process is advisable. A case study from Texas indicates that having a single agency with responsibility for discharge planning (especially assisting with benefit enrollment) is most effective (Re-entry Policy Council, 2004).

8.1 SSI/SSDI

To help inmates submit applications while incarcerated, the Social Security Administration (SSA) recommends establishing a prerelease agreement (either verbal or written) between a correctional institution and the local Social Security office. The agreement outlines

responsibilities for each party to “streamline the process for starting/restarting benefits promptly after an inmate is released,” but only “if the inmate is likely to be eligible for benefits within 30 days of his or her scheduled release date” (Social Security Administration, May 2007, p. 4). Under the agreement, the SSA agrees to provide a contact in the Social Security office and to instruct the social service and institutional staff in the federal benefit application process (Social Security Administration, 2008c). The Social Security office is also responsible for timely processing of the application and prompt notification when a decision has been made (ibid.). The responsibilities of the correctional institution include collecting the relevant information to complete the claim, providing the Social Security office with the anticipated release date, and notifying the office when an inmate is released (ibid.).

8.2 MEDICAID

As suggested previously, federal rules do not require that Medicaid eligibility be terminated upon incarceration and state Medicaid policy could allow incarcerated individuals to maintain eligibility—where permitted by Federal law—to improve continuity of care. Released individuals would then be able to go directly to a Medicaid provider, demonstrate eligibility, and receive services, without interrupting access to medications and other treatment. Suspension of eligibility does not require that a new application be filed and benefits can be restored with minimal delay.

9.0 CONCLUSION

Despite disparaging public attitudes towards individuals with mental illness, two noted mental health policy analysts, Frank and Glied, write that the civic and legal rights of such individuals have improved, allowing for “broader rights, expanded resources, and more accessible treatments” to collectively improve their lives (2006, p. 138). They continue, crediting public policy for much of the improvement in the well-being of publicly insured mentally ill individuals:

The introduction of mainstream health insurance and social insurance programs has benefited the most disadvantaged groups in society, particularly those with mental illness. By tying money to individuals rather than to providers or programs, these mainstream programs provide financial autonomy that buttresses the civil rights of people with mental illness (p. 138).

Certainly, the literature indicates that access to federal programs can enhance quality of life, particularly regarding employment, housing, and education. Although the well being of offenders with mental illness may have improved due in part to these programs, less is known about the role of public benefits and mental health service access and use.

The lack of continuity of care for individuals with mental illness leaving jail or prison, particularly with regard to benefit eligibility during incarceration, is becoming increasingly in vogue in mental health policy advocate circles. Many policy organizations have released publications in recent years claiming that the issue is symptomatic of policy failure and that individuals are falling through the gaping cracks in the system (e.g., the Bazelon Center for

Mental Health Law, NAMI, the National GAINS Center for People with Co-occurring Disorders in the Justice System, and the Consensus Project and the Re-entry Policy Council Project, both of the Council of State Governments, to name the major players). These organizations and agencies have released publications highlighting the importance of having federal benefits and maintaining these during incarceration (or staying on the rolls without receiving payments) to enhance the likelihood of receiving care once released (National Alliance on Mental Illness, 2004; Re-entry Policy Council, 2004; The Bazelon Center for Mental Health Law, 2001; The Consensus Project, June 2002; The National GAINS Center for People with Co-occurring Disorders in the Justice System, 2002).

A review of the academic literature reveals that there are major gaps in our knowledge. While an attempt was made to identify as much of the relevant literature as possible, it spans multiple disciplines and reconciling all of the sources in a systematic manner was challenging. As a result, this review may not be complete.

Based on the articles that were reviewed for this paper, there is little to substantiate the hypothesis that having federal benefits increases the likelihood of receiving mental health services in the community. This suggests a need for data-based empirical studies, yet conducting these may be difficult. Comprehensive data on jail and prison detainees with mental illness are lacking, perhaps due to lack of interagency coordination, confidentiality issues, and underreporting. Studies published by Morrissey and colleagues address this issue directly, but as discussed previously, they suffer from several limitations. First, the studies only look at those enrolled in Medicaid. This is problematic since there could be factors that account for differences in the Medicaid group that are not attributable to being enrolled in Medicaid. For example, individuals could be more likely already to have contact with providers or could be more likely

to be ill, or more chronically ill. Second, studies use the administrative data sets from two different counties, acknowledging that the advantage of having Medicaid was not consistent in both. There could be major differences between counties that affect the results. Third, the data used are several years old (for King County, the data are from 1996 to 1998; for Pinellas County, they are from 1998 to 2000), thus they do not reveal how the population has been affected by recent cuts in federal funding to public programs and global economic malaise. Last, there are issues that threaten our ability to generalize on the basis of these studies. The authors concede that the demographic profiles of the two counties do not mirror the characteristics of the national population and that the findings should not be generalized to individuals released from prison (Morrissey, Steadman et al., 2006).

It is possible that the limitations of these studies introduce bias in the results. First, the integrity of the administrative data may have suffered from underreporting in the information systems (the county Medicaid system, correctional system, and mental health system). This could be problematic as the data for the studies were obtained by matching person-specific data across all three systems. The authors do not specify how much of the data were unusable and they do not provide more detail on the data linkage procedures used. Second, the authors did not use an independent measure of mental health status. For Pinellas county, they relied on Medicaid claims to identify individuals with severe mental illness as “anyone who had at least one Medicaid claim associated with one of the following DSM-IV diagnostic categories: schizophrenia, affective disorders, unspecified psychotic disorder, and delusional disorder” (Morrissey, Dalton et al., 2006, p. 805). For King County, Medicaid claims were unavailable, so individuals were identified as having severe mental illness if they received any community mental health service associated with any of the diagnostic codes. In this way, individuals with

severe mental illness who entered jail without service contact information in these systems were not included. Nor were those with service contacts from private physicians, local community hospitals, or state hospitals. Third, the analyses are based on jail detentions rather than individuals, thus each detention is treated as a separate occurrence. This does not account for individuals with multiple detentions and could contribute to a possible overestimation of the hypothesized Medicaid advantage. The authors do note that standard errors were adjusted in the statistical models to reduce the risk of dependency among events. Last, these studies were based on a sample of only two jails, so they may not be generalizable to jails in other communities. Although the studies do suggest a possible association between Medicaid enrollment and mental health service access and utilization, further study to address these limitations is warranted.

This issue is extremely complex and it is likely that federal benefit enrollment is only one component of the problem. Providing federal benefits alone will not necessarily enhance care for offenders with mental illness and although having insurance may improve health care access and use, other factors may play a part. Individuals with mental illness may be resistant to treatment, irrespective of whether they have public insurance. Research suggests that individuals with mental illness tend to be resistant to treatment and may refuse referrals, medications, appointments, and housing placements (Lamb & Weinberger, 1998). It is likely that addressing the needs of offenders with mental illness is best achieved by using an integrated approach to connect them with community-based services. Integrated service programs consist of both structural elements (e.g., multidisciplinary teams) and treatment elements (e.g., medication), both of which depend on the population and the desired outcomes (Mueser, Noordsy, Drake, & Fox, 2003). It is not simply the use of both of these elements, but the degree of coordination and appropriateness of the services within a program that determine the degree of integration (ibid.).

In integrated programs, individuals are connected with the services (such as treatment) and resources they need upon reentering the community (such as housing placement and employment assistance), in conjunction with connecting them with appropriate entitlements. One example of a program that achieves these aims is the APIC Model, a best-practice integrated services model for individuals with co-occurring disorders leaving jail. The goal of the model is to facilitate the transition from jail to community using case managers to coordinate a “transition plan” (Osher, Steadman, & Barr, 2002). A vital feature of the transition plan is that the inmate is engaged in every stage of the transition planning to determine his or her own needs and also to build trust between the staff member and the inmate. The model identifies connecting individuals with entitlement programs (including Medicaid, SSI, SSDI) as a means to access and pay for treatment and services in the community. Pre-release planning is incorporated into the model by assessing benefit status and eligibility as early as possible.

Incarcerated individuals with mental illness are among the most vulnerable in the public health system. Many suffer from physical ailments and psychiatric disorders at rates that far exceed those found in the general population. Individuals with serious mental illness die 25 years younger than the general population, due largely to treatable medical conditions (e.g., cardiovascular disease, diabetes, respiratory disease, and certain infectious diseases) caused in part by modifiable risk factors (e.g., smoking, obesity, substance abuse, and inadequate access to medical care) (Parks, Svendsen, Singer, & Foti, 2006). These individuals are placed more at risk by other factors, including higher rates of homelessness, incarceration, and poverty (ibid.). Connecting these individuals with services and support in the community can enhance their health and safety, and the health and safety of the public. While there are major gaps in the literature, some studies suggest that individuals who have insurance following release from

prison have higher rates of mental health services use and lower rates of reincarceration. The role of public insurance and support is less known. The major players in the policy area contend that federal benefit enrollment is critical and can increase access to and the use of mental health services for offender with mental illness leaving jail or prison. This is a logical conjecture, yet further study is warranted. In sum, individuals should not leave jail or prison without immediate access to vital care and support in the community, whether this is achieved through federal benefit enrollment or by other means.

APPENDIX

TIME IN JAIL AND SSI ELIGIBILITY

Table 2: How Time in Jail Affects Eligibility for SSI

<p>In jail less than one calendar month: Inmate remains eligible for SSI and should receive the full cash benefit. ◆ For example, someone who enters jail on February 10 and is released before midnight March 31 should lose no cash payments.</p> <p>In jail throughout a calendar month: Inmate will have SSI payments suspended but not terminated. This means that an inmate who is in jail on the first of the month and stays the whole month is not eligible for a cash payment for that month. ◆ For example, someone who enters jail on February 10 and is not released until April 1 will not lose February's payment (not being in jail for the whole month) but will lose the March payment.</p> <p>In jail at least one month and then released after the first of another month: Inmate can receive an SSI cash payment for part of the month in which he or she is released. ◆ For example, someone who enters jail on February 10 and is released May 15 the same year will not lose the February payment, but will lose March and April benefits. In May, the person will be eligible for half of the monthly benefit. While this will be paid eventually, it could be delayed if the Social Security Administration (SSA) is not informed promptly that the individual has been released.</p>	<p>In jail for 12 consecutive calendar months: Inmate's eligibility is terminated. Technically, termination occurs after 12 continuous months of suspension. Only full months count. ◆ For example, someone who enters jail on February 1st of one year and is released on February 10th the following year will have SSI eligibility terminated because benefits were suspended for 12 continuous months. This person will have to file a new application and resubmit evidence of disability. ◆ But someone who enters jail on February 10th of one year and is released on February 10 a year later has benefits suspended for March through January and prorated for February of the second year. This person's eligibility will not be terminated because benefits were not suspended for 12 continuous months.</p> <p>© Copyright 2001 Washington DC Judge David L. Bazelon Center for Mental Health Law. Reproduced with permission from Finding the Key to Successful Transition from Jail to Community.</p>
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BIBLIOGRAPHY

- Abramson, M. F. (1972). The criminalization of mentally disordered behavior: possible side-effect of a new mental health law. *Hospital and Community Psychiatry*, 23, 101-105.
- Administration for Children and Families. (2008). Temporary Assistance for Needy Families (TANF). Retrieved November 17, 2008, from <http://www.acf.hhs.gov/programs/ofa/tanf/about.html>
- Buck, J. (2001). Spending for State Mental Health Care. *Psychiatric Services*, 52(10), 1294.
- Buck, J. (2003). Medicaid, health care financing trends, and the future of state-based public mental health services. *Psychiatric Services*, 54, 969-975.
- Bureau of Justice Statistics. (2007). Prison Statistics. Retrieved June 20, 2008
- Burt, M. R., & Sharkey, P. (2002). The role of Medicaid in improving access to care for homeless people. Washington, D.C.: Urban Institute.
- Center for Medicaid and State Operations. (2005). Medicaid At-a-Glance 2005. In Centers for Medicare and Medicaid Services (Ed.). Baltimore, MD: Department of Health and Human Services.
- Cuellar, A., Snowden, L. M., & Ewing, T. (2007). Criminal records of persons served in the public mental health system. *Psychiatric Services*, 58(1), 114-120.
- Davis, G., Johnson, G., & Mayberg, S. (2000). Effectiveness of Integrated Services for Homeless Adults with Serious Mental Illness: A report to the Legislature as Required by Assembly Bill (AB) 2034.
- Ditton, P. M. (1999). Mental health and treatment of inmates and probationers: special report. In Bureau of Justice Statistics (Ed.). Washington, D.C.: U.S. Department of Justice.
- Draine, J., Salzer, M. S., Culhane, D. P., & Hadley, T. R. (2002). Putting social problems among persons with mental illness in perspective: Crime, unemployment, and homelessness. *Psychiatric Services*, 53, 565-573.
- Ettner, S. L., Frank, R. G., & Kessler, R. C. (1997). The impact of psychiatric disorder on labor market outcomes. *Industrial and Labor Relations Review*, 51(1), 64-81.

- Frank, R. G., & Glied, S. A. (2006). *Better but not well: mental health policy in the United States since 1950*. Baltimore: The Johns Hopkins University Press.
- Frank, R. G., Goldman, H. H., & Hogan, M. (2002). Medicaid and mental health: be careful what you ask for. *Health Affairs*, 22(1), 101-113.
- Gibbs, J. J. (1983). Problems and priorities: perceptions of jail custodians and social service providers. *Journal of criminal justice*, 11, 327-349.
- Glied, S. A., Hoven, C. W., Moore, R. E., & Garrett, A. B. (1998). Medicaid and service use among homeless adults. *Inquiry*, 35(4), 380-388.
- Glied, S. A., Hoven, C. W., Moore, R. E., Garrett, A. B., & Regier, D. A. (1997). Children's access to mental health care: Does insurance matter? *Health Affairs*, 16(1), 167-174.
- Goldkamp, J. S., & Irons-Guynn, C. (2000). Emerging judicial strategies for the mentally ill in the criminal caseload: Mental health courts in Fort Lauderdale, Seattle, San Barnadino, and Anchorage. Washington, D.C.: Crime and Justice Research Institute.
- Gottfredson, S., Wilson, D. B., & Najaka, S. (2002). The Schools. In J. Q. Wilson & J. Petersilia (Eds.), *Crime: Public Policies for Crime Control*. San Francisco, CA: ICS Press.
- Grob, G. N., & Goldman, H. H. (2006). *The Dilemma of Federal Mental Health Policy*. New Brunswick, NJ: Rutgers University Press.
- Hagan, J. (1993). The social embeddedness of crime and unemployment. *Criminology*, 31(4), 465-491.
- Hughes, T., Wilson, D. J., & Beck, A. J. (2001). Trends in State Parole, 1990-2000. Washington, D.C.: Bureau of Justice Statistics.
- Jamelka, R. P., Trupin, E. W., & Chiles, J. A. (1989). The mentally ill in prisons: A review. *Hospital and Community Psychiatry*, 40(481-491).
- James, D. L., & Glaze, L. E. (2006). Mental Health Problems of Prison and Jail Inmates. In U.S. Department of Justice (Ed.). Washington, D.C.: Bureau of Justice Statistics.
- Karberg, J. C., & James, D. J. (2005). Substance Dependence, Abuse, and Treatment of Jail Inmates. In U.S. Department of Justice (Ed.). Washington, D.C.: Bureau of Justice Statistics.
- Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), 617-627.
- Kushel, M. B., Vittinghoff, E., & Haas, J. S. (2001). Factors associated with the health care utilization of homeless persons. *Journal of the American Medical Association*, 285(2), 200-206.

- Laberge, D., & Morin, D. (1995). The overuse of criminal justice dispositions: failure of diversionary policies in the management of mental health problems. *International Journal of Law and Psychiatry*, *18*, 389-414.
- Lamb, H. R., & Grant, R. W. (1982). The mentally ill in an urban county jail. *Archives of General Psychiatry*, *39*, 17-22.
- Lamb, H. R., & Weinberger, L. E. (1998). Persons with severe mental illness in jails and prisons: a review. *Psychiatric Services*, *49*, 483-492.
- Landerman, L. R., Burns, B. J., Swartz, H. R., Wagner, H. R., & George, L. K. (1994). The relationship between insurance coverage and psychiatric disorder in predicting use of mental health services. *American Journal of Psychiatry*, *151*(12), 1785-1790.
- Langan, P. A., & Levin, D. J. (2002). Recidivism of prisoners released in 1994. In Bureau of Justice Statistics (Ed.). Washington, D.C.: U.S. Department of Justice.
- Legal Action Center. (2004). After Prison: Roadblocks to Reentry (a report on state legal barriers facing people with criminal records). Washington, DC, New York, NY.
- Lovell, D., Gagliardi, G. J., & Peterson, P. D. (2002). Recidivism and use of services among persons with mental illness after release from prison. *Psychiatric Services*, *53*(10), 1290-1296.
- McAlpine, D. D., & Mechanic, D. (2000). Utilization of specialty mental health care among persons with severe mental illness: The roles of demographics, need, insurance, and risk. *Health Services Research*, *35*(1), 277-292.
- Mechanic, D. (1998). Cultural and organizational aspects of application of The Americans with Disabilities Act to persons with psychiatric disabilities. *Milbank Quarterly*, *76*(1), 5-23.
- Mechanic, D. (2003). Policy challenges in improving mental health services: Some lessons from the past. *Psychiatric Services*, *54*, 1227-1232.
- Metraux, S., & Culhane, D. P. (2004). Homeless shelter use and reincarceration following prison release. *Criminology and Public Policy*, *3*(2), 139-160.
- Metzner, J. L. (2002). Class action litigation in correctional psychiatry. *Journal of the American Academy of Psychiatry and Law*, *30*, 19-29.
- Micheals, C., Nappo, P., Barrett, K., Risucci, D., & Harles, C. W. (1993). Provisions of reasonable accommodation: What do employers think? In P. Wehman (Ed.), *The ADA mandate for social change* (pp. 89-115). Baltimore: Paul H. Brookes.
- Morrissey, J. P., Cuddeback, G. S., Cuellar, A. E., & Steadman, H. J. (2007). The Role of Medicaid Enrollment and Outpatient Service Use in Jail Recidivism Among Persons with Severe Mental Illness. *Psychiatric Services*, *58*(6), 794-801.

- Morrissey, J. P., Dalton, K. M., Steadman, H. J., Cuddeback, G. S., Haynes, D., & Cuellar, A. (2006). Assessing Gaps Between Policy and Practice in Medicaid Disenrollment of Jail Detainees With Severe Mental Illness. *Psychiatric Services, 57*(6), 809-815.
- Morrissey, J. P., Steadman, H. J., Dalton, K. M., Cuellar, A., Stiles, P., & Cuddeback, G. S. (2006). Medicaid Enrollment and Mental Service Use Following Release of Jail Detainees With Severe Mental Illness. *Psychiatric Services, 57*(6), 809-815.
- Mueser, K. T., Noordsy, D. L., Drake, R. E., & Fox, L. (2003). *Integrated Treatment for Dual Disorders: A Guide to Effective Practice*. New York: Guildford Press.
- National Alliance on Mental Illness. (2004). Decriminalizing Mental Illness. Retrieved November 20, 2008, from http://www.nami.org/Template.cfm?Section=criminal_justice&template=/ContentManagement/ContentDisplay.cfm&ContentID=13150
- National Coalition for the Homeless. (June 2008). *Federal Housing Assistance Programs*. Washington, D.C.
- New York State Administrative Directive (08ADM-03). (April 21, 2008). Retrieved June 16, 2008, from http://www.health.state.ny.us/health_care/medicaid/publications/docs/adm/08adm-3.pdf
- New York State Bill A10864(2008, May).
- Osher, F., Steadman, H. J., & Barr, H. (2002). A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model: The National GAINS Center.
- Padgett, D., Struening, E. L., & Andrews, H. (1990). Factors affecting the use of medical, mental health, alcohol, and drug treatment services by homeless adults. *Medical Care 28*(9), 805-821.
- Pager, D. (2003). The mark of a criminal record. *American Journal of Sociology, 108*(5), 937-975.
- Pallone, N. J., & Hennessy, J. J. (1992). *Criminal Behavior: A Process Analysis*. New Brunswick, NJ: Transaction Publishers.
- Parks, J., Svendsen, D., Singer, P., & Foti, M. E. (2006). Morbidity and Mortality in People with Serious Mental Illness. In B. Mauer (Ed.) (pp. 1-87). Alexandria, VA: National Association of State Mental Health Program Directors.
- Penrose, L. (1939). Mental disease and crime: Outline of a comparative study of European Statistics. *British Journal of Medical Psychology, 18*, 1-15.
- Petersilia, J. (2003). *When prisoners come home: Parole and prisoner reentry*. New York: Oxford University Press.

- Rabinowitz, J., Bromet, E. J., Lavelle, J., Severence, K. J., Zariello, S. L., & Rosen, B. (1998). Relationship between type of insurance and care during the early course of psychosis. *American Journal of Psychiatry*, 155(10), 1392-1397.
- Re-entry Policy Council. (2004). Report of the Re-Entry Policy Council: Charting the Safe and Successful Return of Prisoners to the Community. Washington, D.C.: The Council of State Governments.
- Regier, D. A., Farmer, M. E., Rae, D. S., Locke, B. Z., Keith, S. J., Judd, L. L., et al. (1990). Comorbidity of mental disorders with alcohol and other drug abuse. Results from the Epidemiologic Catchment Area (ECA) Study. *The Journal of the American Medical Association*, 264(19), 2511-2518.
- Rice, D., & Sard, B. (2007). The Effects of the Federal Budget Squeeze on Low Income Housing Assistance. In Center on Budget and Policy Priorities (Ed.). Washington, D.C.
- Rubenstein, G. (2001). *Getting to work: How TANF can support ex-offender parents in the transition to self-sufficiency*. Washington, D.C.: Legal Action Center. Document Number)
- Schaefer, N. J., & Stefancic, A. (2003). "Alternative to Prison" Programs for the Mentally Ill Offender. *Journal of Offender Rehabilitation* 38(2), 41-55.
- Scheid, T. L. (1998). The americans with disabilities act, mental disability, and employment practices. *The Journal of Behavioral Health Services and Research*, 25(3), 312-324.
- Smith, V., Gifford, K., Ellis, E., Rudowitz, R., O'Malley, M., & Marks, C. (September 2008). Headed for a Crunch: An Update on Medicaid Spending, Coverage, and Policy Heading into an Economic Downturn. In K. F. Foundation (Ed.), *Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2008 and 2009*: The Henry J. Kaiser Family Foundation.
- Social Security Act 1905 (a) (28) (A).
- Social Security Act § 401.
- Social Security Administration. (2007). Supplemental Security Income (SSI). Baltimore, MD.
- Social Security Administration. (2008a). Annual Statistical Report on the Social Security Disability Insurance Program, 2007. In Office of Policy Data (Ed.). Washington, D.C.
- Social Security Administration. (2008b). SSI Annual Statistical Report, 2007. In Office of Retirement and Disability Policy (Ed.). Washington, D.C.
- Social Security Administration. (2008c). Understanding Supplemental Security Income: SSI Spotlight on Prerelease Procedure 2008 Edition. *Supplemental Security Income (SSI)* Retrieved July 24, 2008, from <http://www.ssa.gov/ssi/spotlights/spot-prerelease.htm>

- Social Security Administration. (2008d). What you need to know to get social security disability benefits. Baltimore, MD.
- Social Security Administration. (May 2007). Entering the Community After Incarceration- How We Can Help, *ICN 382004* (Vol. 05-10504). Washington, D.C.
- Stanton, G. (May 24 2004). Ending Chronic Homelessness. Baltimore, MD: Centers for Medicare and Medicaid Services.
- Steadman, H. J., Fabisiak, M. A., Dvoskin, J., & Holohean, E. J. (1987). A survey of mental disability among state prison inmates. *Hospital and Community Psychiatry*, 38.
- Steadman, H. J., & Veysey, B. M. (1997). *Providing services for jail inmates with mental disorders*. Washington, D.C.: National Institute of Justice.
- Stephan, J. J. (1999). State Prison Expenditures. In Bureau of Justice Statistics (Ed.): U.S. Department of Justice.
- Taube, C. A., Goldman, H. H., & Salkever, D. (1990). Medicaid coverage for mental illness: balancing access and costs. *Health Affairs*, 9(1), 5-18.
- Teplin, L. A. (1990). The prevalence of severe mental disorder among male urban jail detainees: comparison with the Epidemiologic Catchment Area Program. *American Journal of Public Health*, 80(6), 663-669.
- Teplin, L. A., Abram, K. M., & McClelland, G. M. (1996). Prevalence of psychiatric disorders among incarcerated women. *Archives of General Psychiatry*, 53(6), 505-512.
- The Bazelon Center for Mental Health Law. (2001). For people with serious mental illnesses: Finding the key to successful transition from jail to community. Washington, D.C.
- The Bazelon Center for Mental Health Law. (2002). A Better Life--A Safer Community: Helping Inmates Access Federal Benefits. Washington, D.C.
- The Consensus Project. (June 2002). Criminal Justice/ Mental Health Consensus Project Report. In Council of State Governments (Ed.). New York: Council of State Governments.
- The National GAINS Center for People with Co-occurring Disorders in the Justice System. (2002). Maintaining Medicaid Benefits for Jail Detainees with Co-Occurring Mental Health and Substance Use Disorders. In S. A. a. M. H. S. Administration (Ed.). Delmar, NY: The National GAINS Center.
- The National GAINS Center for People with Co-Occurring Disorders in the Justice System. (2004). Integrated Services Reduce Recidivism Among Homeless Adults with Serious Mental Illness in California. In Substance Abuse and Mental Health Services Administration (Ed.). Delamar, NY: Policy Research Associates,.

- The National Institute of Justice. (2000). When Prisoners Return to the Community: Political, Economic and Social Consequences. In U.S. Department of Justice (Ed.), *Sentencing & Corrections: Issues for the 21st Century*. Washington, D.C.: Office of Justice Programs.
- The National Institute of Justice. (2007). Helping Inmates Obtain Federal Disability Benefits. Washington, D.C.
- Torrey, E. F. (2008). The Consequences of Unconstrained Civil Liberties: Homeless, Incarcerated, and Victimized. In *The Insanity Defense: How America's Failure to Treat the Seriously Mentally Ill Endangers its Citizens* (pp. 265): W.W. Norton & Company.
- U.S. Department of Housing and Urban Development. (2007). The Annual Homeless Assessment Report to Congress. In Office of Community Planning and Development (Ed.). Washington, D.C.
- Vermont Mental Health Performance Indicator Project. (2002). Incarceration Rates and Community Mental Health Utilization Rates. Waterbury, VT,.
- Veysey, B. M., Steadman, H. J., Morrissey, J. P., & Johnsen, M. (1997). In search of missing linkages: continuity of care in U.S. jails. *Behavioral Health Sciences and the Law*, 15, 383-397.
- Western, B., & Pettit, B. (2005). Black-white wage inequality, employment rates, and incarceration. *American Journal of Sociology*, 111(2), 553-578.
- Zuvekas, S. H. (2001). Use and expenditures for treatment of mental health problems. *Health Affairs*, 20(2), 214-224.