CT Feature

Maintaining Health for Incarcerated Youth

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Incarcerated youths are generally held in juvenile facilities that may be categorized as detention centers, or state-run correctional institutions for longer-term incarceration. Typically, detention facilities are administered by local governments and hold youths awaiting court decisions (i.e., preadjudicated). States generally run long-term institutions such as training schools or youth prisons. Some states also use private group homes. Once youths enter the corrections branch of the juvenile system, the state becomes their custodian and is responsible for ensuring that they receive timely, accessible and appropriate physical and mental health care. The federal government and court rulings have set minimal standards of care. Each state regulates the local facilities, and may conduct inspections with variable oversight. Nevertheless, juveniles held in custody are given — by law — access to health care that meets their clinical needs.

Many youths entering the juvenile justice system come from low socioeconomic backgrounds; have been wards of the state long enough to no longer have insurance covered by their families; or have been removed from insurance by their families, leaving the youths to be placed on Medicaid — also referred to as the State’s Children Health Insurance Program — at some point prior to their incarceration. However, their benefits are discontinued once they enter the juvenile correctional system. State and local governments must cover the cost of health services because federal restrictions do not allow inmates in public institutions to participate in Medicaid, even though it was designed to provide health care coverage for the individuals whose health care needs were not being met. This is sometimes referred to as “the Medicaid inmate exception.”

Covering the cost of health care and actually providing services has proven to be a daunting task for correctional health care staff and administrators in government agencies, because their funding streams are inconsistent, vulnerable to budget cuts and rely primarily on tax revenue funding for juvenile corrections. Correctional health care staff usually share the same budget sources that are intended to operate the juvenile correctional department or agency as a whole. Nonetheless, state and local governments have a legal and moral obligation to provide medical and mental health services that meet the community standard. This dilemma is an injustice to juvenile justice agencies and to the youths entrusted into their care.
Juvenile Health Care and Treatment

Juvenile facilities release an estimated 88,000 youths each year. In 1999, an estimated 717,036 juveniles were incarcerated in the U.S. In 2001, Stahl estimated more than one million youths under the age of 18 in the U.S. came in contact with some aspect of the juvenile justice system. Many youths remain in detention a short time, while others convicted of serious crimes spend years incarcerated. Detained youths are disproportionately afflicted with mental and physical health problems due to parental neglect, exposure to trauma, unstable home environments, lack of access to care and engaging in risky behaviors. According to Morris, approximately 10 percent of incarcerated girls are pregnant and 40 percent have been pregnant in the past. This presents a dilemma for practitioners because of varying state laws regarding minors and abortion services, as well as the individual practitioner’s moral beliefs. Menstrual disorders, injuries, orthopedic problems, gastrointestinal disorders, cancer and dermatologic concerns also afflict these youths.

According to Forest et. al., when compared with civilian youths of the same age, incarcerated male youths had significantly worse health statuses as demonstrated by poorer health and functioning scores in perceived well-being; self-esteem; physical discomfort; acute, chronic and psychosocial disorders; family involvement; physical activity; interpersonal problem-solving; risky behaviors and academic performance. Three profile types — high-risks, high-risks/low resilience and worst health — accounted for patterns of health for 69.8 percent of incarcerated youths versus 37.3 percent of an age-matched school sample. Incarcerated male youths were significantly older; were more likely to participate in at least one of three welfare programs; were more likely to have a mother who was unemployed; and were nearly twice as likely to be from single parent families as boys in the civilian sample.

It is well-documented among researchers that adolescents entering correctional facilities may be at high-risk for pre-existing conditions such as mental health disorders, drug and sexual abuse, sexually transmitted diseases, poor dental health and other chronic health conditions that are often associated with their legal problems and/or parental neglect. These conditions have been found to occur at a greater rate in incarcerated youths compared to youths who are not incarcerated.

Gupta et. al. outlined the policy issues and barriers to care for these youths in a 2005 pediatrics commentary. They cited the Social Security Act, which excludes federal financial participation in “care or services for any individual who is an inmate of a public institution” unless the individual is in a medical institution. As a result, most states terminate a youth’s Medicaid benefits upon incarceration. As Gupta et. al. pointed out, states have an option to suspend rather than terminate these youths’ public health insurance program benefits. Many states terminate coverage for fear of potential billing duplication, because they are responsible for providing necessary services. Some states apply presumptive eligibility by enrolling these youths into programs at release. However, most states are wary of adopting this policy for fear that they will pay health care costs for individuals who are later found to be ineligible for public health insurance. This only compounds the complex problem for the state and local juvenile justice systems in meeting the health care needs of youths under their supervision.

Another factor to consider is release or discharge planning. Lack of Medicaid coverage or eligibility determination prior to a youth leaving the facility makes it difficult for correctional health care staff to link the youth to mental health services, community clinics, providers and other social services upon release. An uninsured or ineligible Medicaid status delays access to community treatment services that can potentially undo any progress an individual makes while incarcerated. Appropriate discharge planning that ensures youths are reconnected to services before they return to the community has an added benefit of lowering their chances of reincarceration.
Suggestions for Improving Juvenile Health Care Coverage

Currently, several barriers and challenges exist in maintaining health insurance for incarcerated youths. States will need to carefully examine federal legislation for guidance on the provisions to identify opportunities to maximize Medicaid benefits for incarcerated youths while striving to maintain national standards of health care. It is incumbent upon clinicians, administrators, researchers and lawmakers within and around the juvenile justice system to build a broad coalition that gives a voice to this disenfranchised, underage population by advocating for policy reforms at the state and federal level. Implementing processes with timely feedback mechanisms among departments to streamline the eligibility determination, application and reactivation activities for staff and families will increase the youth’s ability to access health care services more expeditiously.

Possible improvements to the current system may include establishing health policies that seek to first determine a youth’s Medicaid enrollment and/or eligibility status once he or she enters the juvenile system; suspend, but not terminate, the Medicaid enrollment by placing safeguards in the state’s Medicaid system; and notifying the Medicaid office of pending discharge prior to a juvenile’s release back into the community. Several states have been successful with implementing Medicaid suspension versus termination, including Louisiana and Kansas. States that have expanded Medicaid within the Patient Protection and Affordable Care Act (PPACA) should allow presumptive eligibility for all youths residing in those states. States that are not expanding Medicaid through PPACA should allow presumptive eligibility for youths under age 19 who are pregnant or have a serious disability. This will ensure they receive services immediately so that no interruption in care occurs. Health care providers and community organizations have the authority to enroll individuals who appear eligible in the Medicaid program “presumptively” and to receive payment for services rendered. Further exploration and collaboration is needed by states, stakeholders and lawmakers to address this social injustice to one of the most vulnerable segments of the population.

ENDNOTES


3 Morris, R.E. 2005.


6 Morris, R.E. 2005.


10 Ibid.

11 Ibid.


14 Ibid.

15 Ibid.


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