Access in Brief: Health Care Needs of Adults Involved with the Criminal Justice System

In 2018, an estimated 6.4 million individuals were under the supervision of the adult correctional system, including 4.4 million under community supervision (e.g. on parole or probation) and 2.1 million under the custody of state or federal prisons or local jails (BJS 2020a).[1] The majority of adults under community supervision have committed non-violent offenses (e.g., crimes related to property, drugs, or traffic offenses such as driving under the influence) (BJS 2020b).

While Medicaid's role is limited with respect to those who are incarcerated, it plays an important role in the treatment of mental illness and substance use disorders (SUD) for adults under community supervision. Historically, most justice-involved adults were uninsured. But, with the expansion of Medicaid to the new adult group under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), more individuals involved with the criminal justice system became eligible for Medicaid (MACPAC 2018). From 2015 – 2019, 28 percent of adults under community supervision were enrolled in Medicaid. Even so, about one quarter (26 percent) of adults under community supervision remain uninsured (MACPAC 2021).

This issue brief uses five years (2015 – 2019) of data from the National Survey on Drug Use and Health (NSDUH) to analyze the treatment needs and access to behavioral health services for adults age 18–65 who reported that they were under community supervision in the past 12 months.[2] Specifically, our analysis examines selected demographic and health characteristics, and prevalence and treatment rates for behavioral health conditions among these adults, comparing the experience of adults with Medicaid to adults with other forms of coverage. Where sample size permits, we also report estimates by race, ethnicity, sex, and sexual orientation.

The vast majority of adults under community supervision (54 percent) were either enrolled in Medicaid or lacked health insurance. Further, we found:

- Relative to their privately insured peers, Medicaid beneficiaries under community supervision were more likely to be Black or Hispanic. They were also more likely to be female.
- When compared to their peers with other forms of coverage, Medicaid beneficiaries under community supervision were more likely to have Hepatitis B or C, chronic bronchitis, or asthma.
- Medicaid beneficiaries under community supervision reported changes in housing more often than their peers with private coverage and at similar rates to those who are uninsured. Across all racial and ethnic groups, Medicaid beneficiaries reported moving at similar rates. However, female beneficiaries moved more frequently than their male peers.
- With few exceptions, Medicaid beneficiaries under community supervision reported higher rates of behavioral health conditions than their privately insured or uninsured peers. They also reported receiving mental health or SUD treatment at higher rates. However, Black beneficiaries with behavioral health conditions reported receipt of treatment at lower rates than their white peers.

Medicaid and CHIP Payment and Access Commission

1800 M Street NW
Suite 650 South
Washington, DC 20036

www.macpac.gov
202-350-2000
202-273-2452

Characteristics of Adults on Parole or Probation

Below we discuss the demographic, physical health, and housing-related characteristics of adults under community supervision.

Demographic characteristics

From 2015 – 2019, over half of adults under community supervision were either uninsured or covered by Medicaid (Table 1). Relative to their privately insured peers, Medicaid beneficiaries are more likely to be Black or Hispanic. However, a higher proportion of adults on parole or probation who lack coverage identify as Hispanic (28.8 percent) compared to their peers with Medicaid (21.2 percent). Medicaid beneficiaries were also more likely to be female, compared to their peers with private insurance or those without coverage. Finally, Medicaid beneficiaries are more than twice as likely to identify as bisexual than their privately insured peers. Among beneficiaries, a higher percentage (19.6 percent) of female beneficiaries on parole or probation identify as bisexual than males (2.7 percent) (MACPAC 2021). (Additional demographic data for adults under community supervision is discussed in Appendix A.)

TABLE 1. Characteristics of Non-Institutionalized Adults Age 18 – 64 Under Community Supervision in the Past Year, by Insurance Status, 2015 – 2019

	Percentage of adults age 18–64	Percentage of adults age 18–64 in each coverage category		
		Medicaid	Private coverage	Uninsured
Total	**100%**	**28.1%**	**34.4%***	**25.5%***
Age				
18 – 25	24.8	23.8	30.2*	22.7
26 – 34	27.9	33.3	24.9*	33.2
35 – 49	30.4	27.6	30.0	31.9
50 – 64	16.9	15.3	14.9	13.1
Sex				
Male	70.1	59.4	74.6*	75.7*
Female	29.9	40.6	25.4*	24.3*
Sexual orientation				

Heterosexual	91.4	88.6	92.7*	91.7*
Lesbian or gay	2.7	1.9	3.1	2.9
Bisexual	5.9	9.5	4.2*	5.4*
Race and ethnicity				
White, non-Hispanic	54.3	50.2	61.9*	48.6
Black, non-Hispanic	18.6	21.7	16.1*	17.8*
Hispanic	20.4	21.2	15.5*	28.8*
Asian American, non-Hispanic	1.5	1.1	2.6	0.5
American Indian, Alaskan Native, Native Hawaiian, or Pacific Islander, non-Hispanic	2.1	2.5	1.6	1.0*
Two or more races, non-Hispanic	3.2	3.3	2.2	3.3

Notes: We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid, other, or uninsured. Coverage source is defined as of the time of the most recent survey interview.

* Difference from Medicaid is statistically significant at the 0.05 level.
– Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: MACPAC analysis of the 2015 – 2019 National Survey on Drug Use and Health (NSDUH), 2021.

Chronic physical health conditions

Adults involved in the criminal justice system have higher rates of chronic diseases than the general population (MACPAC 2018).[3] For many chronic health conditions, Medicaid beneficiaries under community supervision reported higher rates of such conditions when compared to their peers with private coverage (Table 2). For example, Medicaid beneficiaries under community supervision were more than eight times as likely to report that they had Hepatitis B or C in their lifetime. They were also more likely to have chronic bronchitis or asthma (MACPAC 2021).

TABLE 2. Lifetime Rates of Chronic Conditions among Non-institutionalized Adults Under Community Supervision, Age 18–64, by Insurance Status, 2015 - 2019

Condition	Percentage of adults age 18–64	Percentage of adults age 18–64 in each coverage category		
		Medicaid	Private coverage	Uninsured
Ever had any chronic condition	34.2%	39.7%	30.2%*	29.4%*

Ever had a heart condition	5.9	6.0	5.5	4.8
Ever had diabetes	7.3	7.0	5.8	6.8
Ever had chronic bronchitis	4.8	6.5	3.5*	3.2*
Ever had hepatitis B or C	4.3	8.5	1.0*	4.4*
Ever had asthma	10.1	13.3	8.4*	8.8*
Ever had high blood pressure	9.3	9.9	7.9	6.2*

Notes: Any chronic condition includes HIV or AIDS, heart conditions, diabetes, chronic bronchitis, cirrhosis of the liver, Hepatitis B or C, kidney disease, asthma, cancer, high blood pressure, and sexually transmitted diseases**.** Respondents were asked whether they had any of the chronic conditions listed in this table over their lifetime (SAMHSA 2019a).

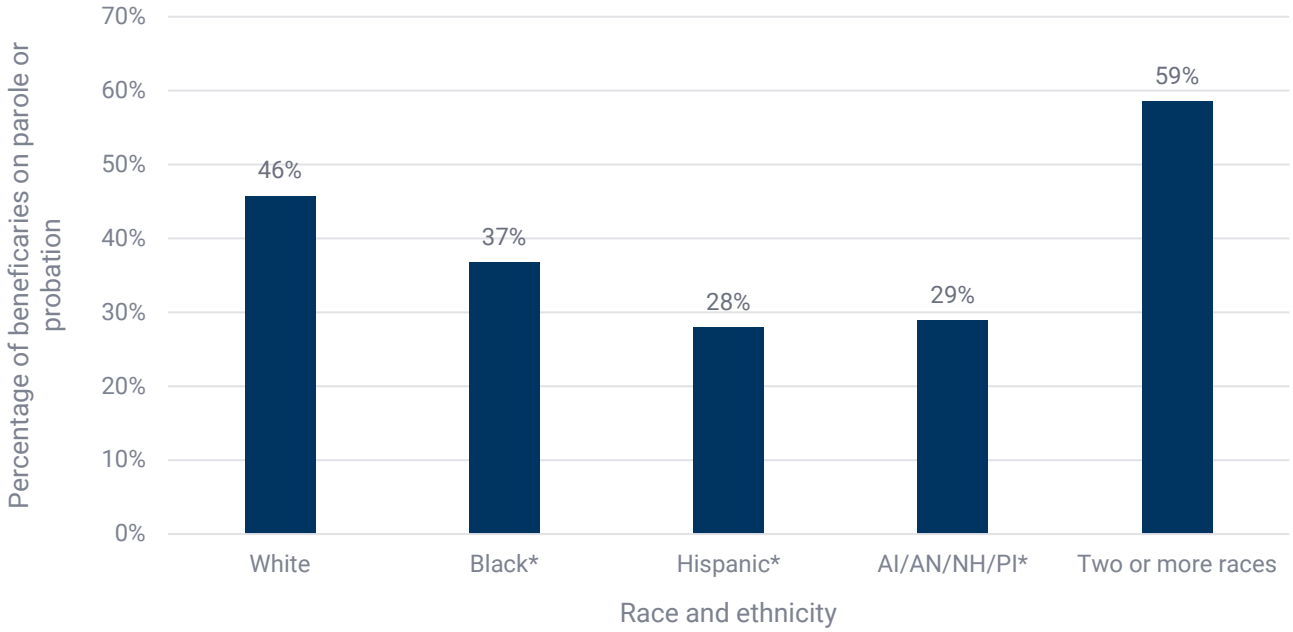
We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid, other, or uninsured. Coverage source is defined as of the time of the most recent survey interview.

* Difference from Medicaid is statistically significant at the 0.05 level.
– Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: MACPAC analysis of the 2015 – 2019 National Survey on Drug Use and Health (NSDUH), 2021.

Beneficiaries under community supervision who were white or identified as two or more races experienced chronic physical health conditions at higher rates than others (Figure 1). However, those identifying as Black, reported having a sexually transmitted infection within the past year at more than twice the rate (9.9 percent) of their white peers (4.6 percent).[4] Similarly, female beneficiaries under community supervision had higher rates of sexually transmitted infections in the past year (8.9 percent) than their male counterparts (4.7 percent).

FIGURE 1. Reported Lifetime Rates of Chronic Physical Health Conditions among Adults Covered by Medicaid Under Community Supervision, Age 18 –64, by Race and Ethnicity, 2015 – 2019



Notes: Hispanic is anyone of Hispanic, Latino, or Spanish origin. AI/AN/NH/PI combines data for respondents who identified as American Indian, Alaska Native, Native Hawaiian, or other Pacific Islander and are not of Hispanic origin. White, Black, and two or more races do not include respondents of Hispanic origin. Due to issues with sample size, we were unable to produce estimates for lifetime rates of chronic physical health conditions among Asian Americans under community supervision.

We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid, other, or uninsured. Coverage source is defined as of the time of the most recent survey interview.

*Difference from white beneficiaries is statistically significant at the 0.05 level.

Source: MACPAC analysis of the 2015 – 2019 National Survey on Drug Use and Health (NSDUH), 2021.

Changes in housing status

Individuals leaving prison or jail move more frequently than the general public and are almost 10 times more likely to be homeless (CJCC 2020). According to U.S. Department of Health and Human Services, more than 10 percent of people released from prisons and jail face homelessness upon reentry. In large urban areas, the share may be as high as 50 percent (HHS 2020).

Access to affordable housing substantially increases the likelihood that a person returning home from prison or jail will be able to find and retain employment, abstain from drug use, and refrain from committing additional crimes. Among the general population, poor housing conditions can worsen health outcomes and make it difficult for individuals to obtain health care and manage complex medical conditions. Moreover, frequent moves (moving three or more times within a one-year period), put adults at greater risk for suicidal outcomes compared to those with stable housing (Forman-Hoffman, Glasheen, and Ridenour 2017).

Medicaid beneficiaries under community supervision reported moving more often than their peers with private coverage and at similar rates to their uninsured peers (Table 3). From 2015 – 2019, beneficiaries under community supervision reported that they moved at least once in the past year at higher rates (52.2 percent) compared to their peers with private coverage (38.1 percent). Moreover, they were nearly twice as likely to report that they moved three or more times in the past year when compared to their privately insured peers. While there were no differences in rates of moving across racial and ethnic groups, a higher percentage of female beneficiaries under community supervision moved at least one time (58.4 percent) compared to their male peers (47.9 percent) (MACPAC 2021).

TABLE 3. Changes in Housing Status among Non-Institutionalized Adults Age 18–64 Under Community Supervision in the Past Year, by Insurance Status, 2015 – 2019

Change in housing status	Percentage of adults 18 – 64	Percentage of adults age 18–64 in each coverage category		
		Medicaid	Private coverage	Uninsured
No moves	54.5%	47.8%	61.9%*	50.1%
One move	25.6	26.8	24.7	27.6
Two moves	11.0	13.3	7.8*	13.2
Three or more moves	8.9	12.1	5.6*	9.1
Moved at least one time	45.5	52.2	38.1*	49.9

Notes: We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid, other, or uninsured. Coverage source is defined as of the time of the most recent survey interview.

We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid, other, or uninsured. Coverage source is defined as of the time of the most recent survey interview.

* Difference from Medicaid is statistically significant at the 0.05 level.

Source: MACPAC analysis of the 2015 – 2019 National Survey on Drug Use and Health (NSDUH), 2021.

Behavioral Health: Prevalence, Treatment Rates, and Disparities Among Adults on Probation or Parole

For adult respondents, the NSDUH captures prevalence of mental health conditions among adults age 18 to 64 that vary in terms of severity. Prevalence estimates for mental health conditions are reported in four categories:

- **Any mental illness** – This category includes those who currently have or at any time in the past year reporting having had a diagnosable mental, behavioral, or emotional disorder. Mental illness in this category can vary in severity.[5]

- **Mild to moderate mental illness** – This category includes those with any mental illness except serious mental illness who currently have or at any time in the past year reporting having had a diagnosable mental, behavioral, or emotional disorder resulting in less than substantial impairment in carrying out major life activities.[6]
- **Serious mental illness** – This category includes those who currently have or at any time in the past year reported having had a diagnosable mental, behavioral, or emotional disorder resulting in substantial impairment in carrying out major life activities.[7] Major life activities include activities of daily living, such as eating or dressing; instrumental activities of daily living, including managing money and taking prescribed medication; and functioning in social, family, and vocational or education contexts (SAMSHA 2019).
- **Major depressive episode** – This category includes adults who reported experiencing certain symptoms for two weeks or longer in the past 12 months.[8]

Below we discuss the prevalence of mental health and SUDs among adults under community supervision. We also examine the rates at which they receive treatment.

Prevalence of behavioral health conditions

With few exceptions, Medicaid beneficiaries under community supervision report higher rates of behavioral health conditions than their privately insured peers, or those without insurance (Table 4). In part, this may be because many individuals qualify for Medicaid based on a disability, including those with serious mental illness, such as schizophrenia.[9] From 2015 – 2019, nearly 40 percent of Medicaid beneficiaries under community supervision reported experiencing any mental illness. They are also more likely to experience mild to moderate mental illness, major depressive episodes, or co-occurring conditions compared to those with private coverage. Generally, beneficiaries report higher rates of drug dependence or abuse than their privately insured peers, as well as their peers without insurance. They are also more likely to report experiencing co-occurring mental health and SUD. Rates of serious mental illness are similar across types of coverage. (See Appendix B for additional information on prevalence of selected SUDs.)

TABLE 4. Prevalence of Behavioral Health Conditions Among Non-Institutionalized Adults Under Community Supervision, by Insurance Status, 2015 – 2019

Condition	Percentage of adults age 18–64	Percentage of adults age 18–64 in each coverage category		
		Medicaid	Private coverage	Uninsured
Mental health				
Any mental illness, past year	34.6%	39.2%	30.8%*	31.5%*
Mild to moderate mental illness, past year	23.3	27.2	21.1*	22.1*
Serious mental illness, past year	11.3	12.0	9.7	9.4

Major depressive episode, past year	13.2	14.9	11.5*	11.2*
Substance use disorders				
Nicotine dependence, past year	26.9	32.3	20.8*	27.9
Illicit drug or alcohol dependence, past year	23.7	28.3	20.7*	23.1*
Illicit drug dependence, past year	15.3	21.4	11.9*	14.8*
Illicit drug dependence or abuse, past year	19.5	26.3	15.6*	18.2*
Illicit drug or alcohol dependence or abuse, past year	33.8	36.3	32.7	32.8
Co-occurring mental health and substance use disorders				
Any mental illness and illicit drug or alcohol dependence or abuse, past year	17.2	20.2	16.0*	15.6*
Serious mental illness and illicit drug or alcohol dependence or abuse, past year	6.3	7.4	5.7	6.1

Notes: Estimates of any mental illness, mild to moderate mental illness, and serious mental illness are based on a statistical model of a clinical diagnosis and responses to questions in the main National Survey on Drug Use and Health (NSDUH) interview on distress, using the Kessler-6 scale; impairment, which is assessed through an abbreviated version of the World Health Organization Disability Assessment Schedule; past year major depressive episode; past year suicidal thoughts; and age. Mental illnesses in this category can vary in severity, ranging from no impairment, to mild or moderate, to severe impairment.

Estimates for dependence or abuse questions for alcohol and illicit drugs were based on criteria in the *Diagnostic and Statistical Manual of Mental Disorders, 4TH edition.* Illicit drugs include marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, and the misuse of prescription psychotherapeutic drugs (i.e., pain relievers, tranquilizers, stimulants, and sedatives). The NSDUH instrument included items asking about symptoms of dependence or abuse related to the use of a specific substance in the past 12 months.

With the 2015 – 2019 NSDUH survey, a diagnosable mental, behavioral, or emotional disorder, and dependence and abuse are defined based on the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* and excludes developmental and substance use disorders (2019).

We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid, other, or uninsured. Coverage source is defined as of the time of the most recent survey interview.

* Difference from Medicaid is statistically significant at the 0.05 level.

Source: MACPAC analysis of the 2015 – 2019 National Survey on Drug Use and Health (NSDUH), 2021.

Prevalence across racial and ethnic groups. The prevalence of behavioral health conditions in this population varied across racial and ethnic groups (Table 6). Among Medicaid beneficiaries, reported rates of any mental illness are highest for those who identify as either white or two or more races. White beneficiaries under community supervision also had significantly higher rates of nicotine dependence than their peers. Those identifying as American Indian, Alaska Native, Native Hawaiian or Pacific Islander reported significantly higher rates of illicit drug or alcohol dependence than their white peers. While Black beneficiaries report significantly lower rates of illicit drug or alcohol dependence than their white counterparts.

TABLE 6. Prevalence of Behavioral Health Conditions Among Non-Institutionalized Beneficiaries Under Community Supervision, by Race and Ethnicity, 2015 – 2019

	Percentage of Medicaid beneficiaries age 18–64 in each racial and ethnic group				
	White	Black	Hispanic	AI/AN/NA/PI	Two or more races
Mental health					
Any mental illness, past year	47.8%	25.4%*	35.7%*	23.5%*	37.0%
Mild to moderate mental illness, past year	31.6	21.2*	26.0	22.9%	16.2*
Serious mental illness, past year	16.2	4.2*	9.8*	–	–
Major depressive episode, past year	19.3	6.9*	12.2*	–	–
Substance dependence or abuse					
Nicotine dependence, past year	45.5	18.8*	16.3*	29.0*	29.8
Illicit drug or alcohol dependence, past year	30.9	23.2*	28.0	50.5*	–
Illicit drug dependence, past year	23.8	14.9*	23.1	32.6	–
Illicit drug dependence or abuse, past year	28.8	18.6*	29.2	34.5	–
Illicit drug or alcohol dependence or abuse, past year	37.5	31.6	38.3	53.4	–
Co-occurring mental health and substance use disorders					

Any mental illness and illicit drug or alcohol dependence or abuse, past year	26.0	11.1*	17.9*	–	–

Notes: Hispanic is anyone of Hispanic, Latino, or Spanish origin. AI/AN/NH/PI combines data for respondents who identified as American Indian, Alaska Native, Native Hawaiian, or other Pacific Islander and are not of Hispanic origin. White, Black, and two or more races do not include respondents of Hispanic origin. Due to issues with sample size, we were unable to produce estimates for behavioral health conditions among Asian Americans under community supervision.

Estimates of for any mental illness, mild to moderate mental illness, and serious mental illness are based on a statistical model of a clinical diagnosis and responses to questions in the main National Survey on Drug Use and Health (NSDUH) interview on distress, using the Kessler-6 scale; impairment, which is assessed through an abbreviated version of the World Health Organization Disability Assessment Schedule; past year major depressive episode; past year suicidal thoughts; and age. Mental illnesses in this category can vary in severity, ranging from no impairment, to mild or moderate, to severe impairment.

Estimates for dependence or abuse questions for alcohol and illicit drugs were based on criteria in the *Diagnostic and Statistical Manual of Mental Disorders, 4TH edition.* Illicit drugs include marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, and the misuse of prescription psychotherapeutic drugs (i.e., pain relievers, tranquilizers, stimulants, and sedatives). The NSDUH instrument included items asking about symptoms of dependence or abuse related to the use of a specific substance in the past 12 months.

With the 2015 – 2019 NSDUH survey, a diagnosable mental, behavioral, or emotional disorder, and dependence and abuse are defined based on the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* and excludes developmental and substance use disorders (2019).

We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid, other, or uninsured. Coverage source is defined as of the time of the most recent survey interview.

*Difference from Medicaid is statistically significant at the 0.05 level.
– Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: MACPAC analysis of the 2015 – 2019 National Survey on Drug Use and Health (NSDUH), 2021.

In interpreting these data, it is important to consider differences in how people of color report and experience mental health conditions. For several decades, research has demonstrated that Black Americans often have higher rates of psychological distress than white Americans. Moreover, when Black and Hispanic people experience mental illness, their episodes tend to be more severe, result in higher levels of impairment, persist for longer periods of time, and be more debilitating than for any other racial or ethnic group (Williams 2019).

Thoughts and plans of suicide. The rate of suicide among adults involved in the criminal justice system is significantly higher than the general population. From 2015 – 2019, roughly 10 percent of adults on parole or probation reported that they seriously thought about committing suicide in the past year. Among those that seriously thought about suicide, 43.0 percent made plans to commit suicide, and 24.4 percent attempted suicide. Reported rates of past year suicidal ideation and suicide attempts were generally similar across coverage groups (MACPAC 2021).

These rates varied across racial and ethnic groups. White beneficiaries reported serious thoughts of suicide at more than twice the rate (11.7 percent) of their Black peers (5.2 percent). However, Black beneficiaries who had thoughts of suicide were more likely to make plans of suicide (49.7 percent), or report attempting suicide (48.2 percent) compared to white peers.[10] Similarly, Hispanic beneficiaries reported rates of suicidal

ideation at similar rates to their white peers (10.1 percent); however, they were significantly more likely to make plans of suicide (66.9 percent), or report attempting suicide (51.7 percent) (MACPAC 2021).

Access to behavioral health treatment

Judges and parole boards often require that individuals participate in mental health or SUD treatment as a condition of probation or release (Skeem and Louden 2006). Treatment could occur as a condition of incarceration, probation, or pretrial release, or be required in-lieu of incarceration (NIDA 2018).

Generally, Medicaid beneficiaries under community supervision with behavioral health conditions received treatment at higher rates than their privately insured and uninsured peers. However, treatment rates among beneficiaries under community supervision varied significantly based on race and ethnicity (MACPAC 2021).

Mental health treatment. Medicaid beneficiaries under community supervision reported both experiencing behavioral health conditions and receiving treatment at higher rates than their peers with private insurance or those without insurance. From 2015 – 2019, 57.8 percent of beneficiaries under community supervision with any mental illness reported receiving mental health treatment, compared to 42.4 percent of their peers with private coverage, and 35.2 percent of those without insurance (Table 7). They most frequently reported taking medication for their mental health condition (49.1 percent) and receiving some form of outpatient treatment (37.3 percent). However, nearly one third (31.0 percent) of those with mental illness reported that they needed mental health treatment or counseling but did not receive it. These rates did not differ by coverage type. Female beneficiaries with a mental health condition who were under community supervision reported higher rates (41.0 percent) of unmet need than their male counterparts (21.3 percent) (MACPAC 2021).

TABLE 7. Mental Health Treatment among Non-institutionalized Adults Age 18–64 Under Community Supervision with Any Mental Illness, by Insurance Status, 2018

Treatment setting	Percentage of adults age 18 – 64	Percentage of adults age 18–64 in each coverage category		
		Medicaid	Private coverage	Uninsured
Received any mental health treatment	48.9%	57.8%	42.4%*	35.2%*
Needed mental health treatment or counseling but did not received it	27.0	31.0	24.8	24.1
Received treatment in an inpatient hospital	9.1	11.0	5.5*	9.3
Received any outpatient treatment	31.1	37.3	25.6*	21.7*
Received treatment in an outpatient mental health center or day treatment program	15.4	22.4	9.4*	11.6*
Received treatment in a private therapist's office	10.7	9.3	12.8	6.1

Took any prescription medication for a mental health condition	39.2	49.1	33.4*	22.4*

Notes: Inpatient treatment settings for mental health include a public or private psychiatric hospital, a psychiatric unit or medical unit of an acute care hospital, a residential treatment facility, or some other inpatient setting. Estimates of for any mental illness are based on a statistical model of a clinical diagnosis and responses to questions in the main National Survey on Drug Use and Health (NSDUH) interview on distress, using the Kessler-6 scale; impairment, which is assessed through an abbreviated version of the World Health Organization Disability Assessment Schedule; past year major depressive episode; past year suicidal thoughts; and age. Mental illnesses in this category can vary in severity, ranging from no impairment, to mild or moderate, to severe impairment.

With the 2015 – 2019 NSDUH survey, a diagnosable mental, behavioral, or emotional disorder, and dependence and abuse are defined based on the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* and excludes developmental and substance use disorders (2019).

We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid, other, or uninsured. Coverage source is defined as of the time of the most recent survey interview.

*Difference from Medicaid is statistically significant at the 0.05 level.

Source: MACPAC analysis of the 2015 – 2019 National Survey on Drug Use and Health (NSDUH), 2021.

As with prevalence, treatment rates varied across racial and ethnic groups (Table 8). Beneficiaries with mental illness who identify as Hispanic or as two or more races, reported receipt of mental health treatment at similar rates as their white peers. However, Black beneficiaries with mental illness under community supervision received mental health treatment at significantly lower rates than their white counterparts (MACPAC 2021).

TABLE 8. Reported Use of Mental Health Treatment among Non-Institutionalized Adult Medicaid Beneficiaries Age 18 – 64 Under Community Supervision with Past Year Mental Illness, by Racial and Ethnic Group, 2015 - 2019

Treatment characteristics	Percentage of Medicaid beneficiaries age 18–64 in each racial and ethnic group			
	White	Black	Hispanic	Two or more races
Needed but did not receive mental health treatment, past year	33.0%	24.0%	27.6%	45.1%
Received any mental health treatment, past year	62.4	41.8*	57.0	44.5
Took any prescription medication for a mental health condition, past year	53.1	32.0*	51.5	33.9

Notes: Estimates of for any mental illness are based on a statistical model of a clinical diagnosis and responses to questions in the main National Survey on Drug Use and Health (NSDUH) interview on distress, using the Kessler-6 scale; impairment, which is assessed through an abbreviated version of the World Health Organization Disability Assessment Schedule; past year major depressive episode; past year suicidal thoughts; and age. Mental illnesses in this category can vary in severity, ranging from no impairment, to mild or moderate, to severe impairment.

With the 2015 – 2019 NSDUH survey, a diagnosable mental, behavioral, or emotional disorder, and dependence and abuse are defined based on the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* and excludes developmental and substance use disorders (2019).

We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid, other, or uninsured. Coverage source is defined as of the time of the most recent survey interview.

*Difference from Medicaid is statistically significant at the 0.05 level.

Source: MACPAC analysis of the 2015 – 2019 National Survey on Drug Use and Health, 2021.

Substance use treatment. Beneficiaries under community supervision with SUD were more likely to engage in treatment compared to those with private insurance, or adults who are uninsured (Table 9). Specifically, they were nearly twice as likely as privately insured or uninsured peers to report receiving such treatment in the past year. They were also more likely to participate in support groups, such as Alcoholics Anonymous, and receive treatment in jail or prison. However, male beneficiaries with SUD who were under community supervision reported receiving SUD treatment in their lifetime at significantly higher rates (73.0 percent) than their female counterparts (62.0 percent) (MACPAC 2021).

Table 9. Substance Use Treatment among Non-institutionalized Adults Age 18–64 Under Community Supervision with Past Year Substance Use Disorder, by Insurance Status, 2015 – 2019

Condition	Percentage of adults age 18–64	Percentage of adults age 18–64 under community supervision		
		Medicaid	Private coverage	Uninsured
Currently receiving treatment or counseling	21.7%	31.1%	17.8%*	17.3%*
Received any substance use treatment, past year	38.7	49.6	33.9*	34.7*
Ever received alcohol or drug treatment	58.0	68.7	53.6*	50.5*
During previous 12 months				
Perceived the need for treatment or counseling for alcohol or drug use	71.4	61.2	75.0*	76.9*
Received treatment in a hospital overnight as an inpatient	8.0	10.7	8.0	-
Received treatment in a residential drug or alcohol rehabilitation facility	11.5	17.7	9.7*	7.6*
Received treatment in a drug or alcohol rehabilitation facility as an outpatient	21.4	29.9	17.2*	18.4*

Received treatment in a mental health center or facility as an outpatient	13.4	19.1	12.5*	9.1*
Received treatment in prison or jail	8.3	12.0	5.9*	8.7
Participated in a mutual aid group such as Alcoholics Anonymous or Narcotics Anonymous	23.1	31.0	21.1*	18.6*
Received treatment in some other place	13.5	17.3	9.8*	12.6

Notes: Estimates for dependence or abuse questions for alcohol and illicit drugs were based on criteria in the *Diagnostic and Statistical Manual of Mental Disorders, 4TH edition.* Illicit drugs include marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, and the misuse of prescription psychotherapeutic drugs (i.e., pain relievers, tranquilizers, stimulants, and sedatives). The National Survey on Drug Use and Health (NSDUH) instrument included items asking about symptoms of dependence or abuse related to the use of a specific substance in the past 12 months.

With the 2015 – 2019 NSDUH survey, a diagnosable mental, behavioral, or emotional disorder, and dependence and abuse are defined based on the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* and excludes developmental and substance use disorders (2019).

We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid, other, or uninsured. Coverage source is defined as of the time of the most recent survey interview.

*Difference from Medicaid is statistically significant at the 0.05 level.
– Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: MACPAC analysis of the 2015 – 2019 National Survey on Drug Use and Health (NSDUH), 2021.

Except for Black beneficiaries, Medicaid beneficiaries under community supervision with past year SUD received treatment at similar rates as their white peers (Table 10). White beneficiaries under community supervision with past year SUD were more than twice as likely to report that they were currently receiving SUD when compared to their Black peers. Moreover, Black beneficiaries under community supervision with SUD were less likely to receive treatment for their SUD in the past year, or at any point in their lifetime compared to their white counterparts (MACPAC 2021).

TABLE 10. Reported Use of Substance Use Treatment among Non-Institutionalized Adult Medicaid Beneficiaries Age 18 – 64 Under Community Supervision with Past Year Substance Use Disorder, by Racial and Ethnic Group, 2015 - 2019

Treatment characteristics	Percentage of Medicaid beneficiaries age 18–64 in each racial and ethnic group				
	White	Black	Hispanic	AI/AN/NH /PI	Two or more races
Perceived the need for treatment or counseling for alcohol or drug use, past year	53.6%	71.6%*	66.9%	67.8	61.9

Received any substance use disorder treatment, past year	56.0	36.3*	47.7	54.7	44.8
Ever received substance use disorder treatment	78.2	44.0*	68.3	72.2	53.2
Currently receiving substance use disorder treatment	37.4	16.5*	–	49.0	–

Notes: Hispanic is anyone of Hispanic, Latino, or Spanish origin. AI/AN/NH/PI combines data for respondents who identified as American Indian, Alaska Native, Native Hawaiian, or other Pacific Islander and are not of Hispanic origin. White, Black, and two or more races do not include respondents of Hispanic origin. Due to issues with sample size, we were unable to produce estimates for behavioral health treatment among Asian Americans under community supervision.

Estimates for dependence or abuse questions for alcohol and illicit drugs were based on criteria in the *Diagnostic and Statistical Manual of Mental Disorders, 4TH edition.* Illicit drugs include marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, and the misuse of prescription psychotherapeutic drugs (i.e., pain relievers, tranquilizers, stimulants, and sedatives). The National Survey on Drug Use and Health (NSDUH) instrument included items asking about symptoms of dependence or abuse related to the use of a specific substance in the past 12 months.

With the 2015 – 2019 NSDUH survey, a diagnosable mental, behavioral, or emotional disorder, and dependence and abuse are defined based on the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* and excludes developmental and substance use disorders (2019).

We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid, other, or uninsured. Coverage source is defined as of the time of the most recent survey interview.

*Difference from Medicaid is statistically significant at the 0.05 level.
–Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: MACPAC analysis of the 2015 – 2019 National Survey on Drug Use and Health (NSDUH), 2021.

Data and Methods

Data sources

Data for this report comes from the 2015–2019 NSDUH, an annual survey sponsored by the Substance Abuse and Mental Health Services Administration, that conducts interviews with approximately 70,000 randomly selected, civilian, non-institutionalized individuals age 12 and older in the United States. NSDUH respondents are residents of households and individuals in non-institutional group quarters, such as shelters, rooming houses, college dorms, and halfway houses. Individuals with no fixed household address, such as individuals who are homeless and not in shelters; active-duty military personnel; and residents of institutional group quarters, including congregate settings for youth in foster care, correctional facilities, nursing homes, and mental institutions, are excluded. The NSUDH is a primary source of national and state-level estimates on use of tobacco products, alcohol, illicit drugs, SUDs, mental health status, and related treatment (SAMHSA 2020b).

Insurance coverage

The following hierarchy was used to assign individuals with multiple coverage sources to a primary source: Medicare; private; Medicaid/CHIP; other type of insurance (e.g., TRICARE, military health care); or uninsured.

Coverage source is defined as primary coverage at the time of the interview. Private health insurance coverage excludes plans that paid for only one type of service, such as accidents or dental care.

Point estimates were calculated using sample weights, and corresponding variances accounted for the complex sample design of NSUDH. All estimates in this brief have a relative standard error of less than or equal to 30 percent. All differences discussed were computed using t-tests and are significant at the 0.05 level.

Endnotes

[1] Individuals on parole include people released through discretionary or mandatory supervised release from prison. In comparison, probation is a court-ordered period of correctional supervision in the community, typically viewed as an alternative to incarceration.

[2] NSDUH respondents are residents of households and non-institutionalized group quarters (e.g., shelters, rooming houses, dormitories) and civilians living on military bases age 12 and older. The survey excludes individuals experiencing homelessness who are not residing in shelters; military personnel on active duty; and residents of institutional group quarters, including jails, nursing homes, mental institutions, and long-term care hospitals.

[3] Adults involved with the criminal justice system have a higher prevalence of HIV/AIDS, tuberculosis, and sexually transmitted diseases than the general population (NCCHC 2002). They also have higher rates of chronic conditions such as asthma, diabetes, and hypertension, as well as behavioral health conditions.

[4] In part, this may reflect differences in age between Black and white beneficiaries on parole or probation. Roughly 30 percent of Black beneficiaries on parole or probation are 18 – 25 years in age, compared to 18.8 percent of white beneficiaries.

[5] Estimates for any mental illness are based on a statistical model of a clinical diagnosis and responses to questions in the main NSDUH interview on: distress, using the Kessler-6 scale; impairment, which is assessed through an abbreviated version of the World Health Disability Assessment Schedule; past year major depressive episode; past year suicidal thoughts; and age (SAMHSA 2019).

[6] Estimates for mild to moderate mental illness are based on a statistical model of a clinical diagnosis and responses to questions in the main NSDUH interview on: distress, using the Kessler-6 scale; impairment, which is assessed through an abbreviated version of the World Health Disability Assessment Schedule; past year major depressive episode; past year suicidal thoughts; and age. Less than substantial impairment is defined based on clinical interview Global Assessment of Functioning scores of 50 or less (SAMHSA 2019).

[7] Estimates for serious mental illness are based on a statistical model of clinical diagnosis and responses to questions in the main NSDUH interview on: distress, using the Kessler-6 scale; impairment, which is assessed through an abbreviated version of the World Health Organization Disability Assessment Schedule; past year major depressive episode; past year suicidal thoughts; and age. Within the 2019 NSDUH survey, a diagnosable mental, behavioral, or emotional disorder is defined based on the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* and excludes developmental and substance use disorders. Substantial impairment is defined based on clinical interview Global Assessment Functioning scores of 50 or less (SAMHSA 2019).

[8] The 2019 NSDUH defined individuals as having an MDE if they reported at least five or more of the following symptoms in the same two-week period in the past year (with at least one of the symptoms being a depressed mood or loss of interest or pleasure in daily activities): (1) depressed mood most of the day, nearly every day; (2) markedly diminished interest or pleasure in all or almost activities most of the day; (3) significant weight loss when not dieting or weight gain or decrease or increase in appetite nearly every day; (4) insomnia or hypersomnia nearly every day; (5) psychomotor agitation or retardation at a level that is observable by others nearly every day; (6) fatigue or loss of energy nearly every day; (7) feelings of worthlessness or excessive or inappropriate guilt nearly every day; (8) diminished ability to think or concentrate or indecisiveness nearly every day; and (9) recurrent thoughts of death or recurrent suicidal ideation (SAMHSA 2019).

[9] In 2019, among those qualifying for Supplemental Security Income, 6 out of 10 were diagnosed with a mental disorder (SSA 2020).

[10] Among white beneficiaries on parole or probation who had seriously thought about suicide, 38 percent made plans to commit suicide, and 19 percent attempted suicide.

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Appendix A: Education and Employment by Insurance Status

TABLE A-1. Education and Employment among Non-institutionalized Adults Age 18–64 Under Community Supervision, by Insurance Status, 2015 – 2019

	Percentage of adults age 18–64	Percentage of adults age 18–64 in each coverage category		
		Medicaid	Private coverage	Uninsured
Total	**100%**	**28.1%**	**34.4%***	**25.5%***
Education				
Less than high school	23.1	28.1	13.7*	31.7
High school graduate	37.0	38.8	34.3	38.6
Some college or associate degree	32.5	29.8	38.4*	25.5
College graduate	7.4	3.3	13.5*	4.2
Employment				
Working full time	49.2	30.7	70.0*	51.0*
Working part time	11.2	11.9	9.9	11.0
Unemployed	13.1	19.1	7.5*	15.6
Other	26.5	38.3	12.6*	22.4*

Notes: We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid, other, or uninsured. Coverage source is defined as of the time of the most recent survey interview.

* Difference from Medicaid is statistically significant at the 0.05 level.

Source: MACPAC analysis of the 2015 – 2019 National Survey on Drug Use and Health (NSDUH), 2021.

Appendix B: Substance Misuse, Abuse, and Dependence by Insurance Status

TABLE B-1. Substance Misuse, Abuse, and Dependence among Non-institutionalized Adults Age 18–64 Under Community Supervision, by Insurance Status, 2015 – 2019

Substance use	Percentage of adults 18–64	Percentage of adults age 18–64 in each coverage category		
		Medicaid	Private coverage	Uninsured
Alcohol				
Alcohol dependence or abuse, past year	21.1%	17.8%	23.4%*	21.3%
Marijuana				
Marijuana dependence or abuse, past year	7.5	8.8	8.2	5.1*
Opioids				
Used oxycontin not directed by a doctor, past year	3.6	4.7	3.2	3.6
Heroin use, past year	3.8	6.0	2.6*	3.7*
Opioid dependence or abuse, past year	7.1	12.0	3.0*	6.6*
Pain reliever dependence or abuse, past year	5.0	8.3	2.4*	4.7*
Heroin dependence or abuse, past year	3.6	7.3	1.3*	3.2*
Cocaine				
Cocaine use, past year	9.1	10.0	8.9	9.2
Cocaine dependence or abuse, past year	3.4	5.3	1.9*	3.4
Methamphetamines				
Methamphetamine use, past year	8.4	12.5	5.1*	9.1*

Methamphetamine dependence or abuse, past year	6.3	9.5	3.9*	6.7*
Psychotherapeutics				
Psychotherapeutic misuse, past year	22.0	25.0	20.4*	21.8
Psychotherapeutic dependence or abuse, past year	6.6	9.7	4.7*	5.9*

Notes: Estimates for dependence or abuse questions for alcohol and illicit drugs were based on criteria in the *Diagnostic and Statistical Manual of Mental Disorders, 4TH edition.* Illicit drugs include marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, and the misuse of prescription psychotherapeutic drugs (i.e., pain relievers, tranquilizers, stimulants, and sedatives). The National Survey on Drug Use and Health (NSDUH) instrument included items asking about symptoms of dependence or abuse related to the use of a specific substance in the past 12 months.

With the 2015 – 2019 NSDUH survey, a diagnosable mental, behavioral, or emotional disorder, and dependence and abuse are defined based on the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* and excludes developmental and substance use disorders (2019).

We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid, other, or uninsured. Coverage source is defined as of the time of the most recent survey interview.

* Difference from Medicaid is statistically significant at the 0.05 level.

Source: MACPAC analysis of the 2015 – 2019 National Survey on Drug Use and Health (NSDUH), 2021.