Rehabilitation, Healthcare and the Economics

Second in the series on health care reform and county criminal justice systems in California

COURSE MATERIALS
June 12, 2013
Rehabilitation, Healthcare and Economics

An introduction to health care reform and the opportunities and challenges for county criminal justice systems in California

June 12, 2013

*Rehabilitation, Healthcare and Economics* – the second in a series on the intersection of healthcare reform and Realignment – examines cost-effective opportunities for interrupting the cycle of offending at the local level through treatment. Speakers will discuss the mutual benefits of public health and public safety as well as the fiscal implications of providing a system of care inside and outside of the secure facilities. There will be a review of lessons learned from the evidence, innovative strategies for targeting treatment needs, and the impact of managed care plans. Concrete strategies for collaboration among managed care and the criminal justice system will be provided.

**Agenda**

Times are approximate

10:00 Welcome and Introductions
- Participant Questions: What are the key areas of Interest?
  - Bill Chiat, Dean, California State Association of Counties Institute for Excellence in County Government

10:25 Meeting the Need for Treatment in California Counties: A Systemic Perspective
- This session will envision systemic strategies for safely and effectively managing a local criminal justice population that aligns with the principles of effective intervention and capitalizes on blended funding opportunities.
  - Scott McDonald, Chief Probation Officer, Santa Cruz County

11:20 Understanding the Impact of Healthcare Reform on Behavioral Health Treatment
- This session will discuss the behavioral health needs of defendants and offenders in local criminal justice systems and benefit eligibility opportunities for addressing behavioral health needs under healthcare reform.
  - Steve Rosenberg, President, Community-Oriented Correctional Health Services (COCHS)

12:20 Lunch, provided

1:10 The Nexus between Healthcare Reform and the Principles of Risk, Need and Responsivity: A review of what works and what is to come
- This session will delve deeper into the treatment needs of the criminal justice population, research on what works to reduce recidivism, and how cost-effective services can be delivered within eligibility guidelines.
  - Faye Taxman, Ph.D., University Professor, Criminology, Law & Society, Director, Center for Advancing Correctional Excellence (ACE!)

2:10 Panel Discussion: Lessons learned and other questions from the audience
- A brief presentation of lessons learned and/or anticipated by the experts as well as their tips for next steps will be provided.
  - Faye Taxman, Ph.D., ACE! and Steve Rosenberg, President, COCHS

3:50 Summary and Closing; Evaluation

4:00 Adjourn
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COURSE FACULTY

William Chiat

Bill Chiat (pronounced ‘shy-at’) is Dean of the California State Association of Counties Institute for Excellence in County Government. His expertise spans 33 years in local government with executive positions in state, county and city governments, including County Executive Officer of Napa County. Bill also served as Executive Director of the Arizona Governor’s Office for Excellence in Government. From 2004 until October 2012 Bill was Executive Director of the California Association of Local Agency Formation Commissions. He provides organizational development, continuing education and facilitation services to local governments throughout the West through his consultancy practice, Alta Mesa Group LLC.

Dean Chiat has a B.S. from the University of Minnesota and a M.S. from the University of Michigan. He is a graduate of the Senior Executives in State and Local Government Program from Harvard’s Kennedy School of Government. He has research and taught numerous courses in public agency leadership, structure, governance and operations.

Scott MacDonald

Scott MacDonald is the Probation Chief of the Santa Cruz County Probation Department and is responsible for the juvenile hall and probation services. He has been a Probation Officer with the department since 1984, working equally in the juvenile and adult probation systems. Scott Holds an M.S. in Administration of Justice from San Jose State University and a B.S. in Psychology from the University of California Santa Cruz.

Chief MacDonald has been an instrumental and guiding force in reforming the juvenile justice system in Santa Cruz, which is now a recognized national model in reducing unnecessary detention, racial disparities and building effective community based partnerships to address public safety and reduce recidivism and improve youth outcomes. Scott took the lead in replicating many of these strategies in the adult criminal justice system with similar results. This work resulted in the concept and development of “systemic interventions,” created in partnership with the Crime Justice Institute, which focuses on system changes that foster probation success. He has co-authored two publications with the Center for Juvenile and Criminal Justice on the successful systemic interventions to address the unnecessary and expensive use of jail for low risk populations.

Chief MacDonald has lectured nationally in the areas of restorative justice, and juvenile and criminal justice reform. Scott has also taught criminal justice courses at San Jose State University and at Cabrillo College.

Chief MacDonald is one of twelve justice practitioners invited to participate in the Juvenile Justice Leadership Network at Georgetown University to advance reform and improve juvenile justice systems. His research on effective probation practice in the courtroom is published in Federal Probation and he contributed to three chapters of a book on Juvenile Reentry, which was published in January 2004 by the Federal Office of Juvenile Justice Delinquency Prevention.

Steve Rosenberg

President, Community-Oriented Correctional Health Services (COCHS)

Steve Rosenberg has more than 30 years of experience providing technical assistance and directing projects that increase access to health care for the most vulnerable populations in our nation. He founded Community Oriented Correctional Health Services (COCHS) in 2006 to develop a public health approach to serving the population of people who cycle through jails, and to connect them to community-based health care. Mr. Rosenberg is a specialist in health care policy and finance with expertise in Medicaid and correctional health.

Community Oriented Correctional Health Services (COCHS) is a non-profit organization that works to build partnerships between jails and community health care providers. Its goal is to establish medical homes for offenders in their communities. The organization’s objectives include supporting changes in public policy and practice that promote access to health preventive and treatment services both in jail and in partner community institutions; insuring that local health care systems are in place to treat jail-involved populations; improving the ability of jails to connect offenders with health care; and, developing health care delivery systems that are financially viable and sustainable.

Faye S. Taxman, Ph.D.

Faye S. Taxman, Ph.D. is a University Professor in the Criminology, Law and Society Department and Director of the Advancing Correctional Excellence Center at George Mason University. Dr. Taxman is recognized for her work in the development of the seamless systems of care models that link the criminal justice with other service delivery systems as well as reengineering probation and parole supervision services. She has active “laboratories” with her nearly 20 year agreement with the Maryland Department of Public Safety and Correctional Services as well as received funding National Institute of Drug Abuse, National Institute of Justice, Bureau of Justice Assistance, National Institute of Corrections, and other agencies. She is the co-author (with Steven Belenko) of Implementation of Evidence Based Practices in Community Corrections and Addiction Treatment (Springer, 2011) and senior author of Tools of the Trade: A guide to incorporating science into supervision. She has received numerous awards including a Fellow of the Academy of Experimental Criminology and the Distinguished Scholar from the American Society of Criminology’s Division on Sentencing and Corrections.
The Primacy of Drug Intervention in Public Safety Realignment Success

CSAC Healthcare Conference June 12, 2013

Figure 3.4: California’s Crime Rate Versus Imprisonment Rate (indexed to 1973)

Using Data to determine local impact of AB109

Methodology -
• Case File Review of felony probationers sent to Prison in 2010
• Focus on Non-Non’s
• Prison Commitment by Offense Type /Technical Violation
• Technical Violations by type
• Substance Abuse Residential Treatment involvement – referral & outcome

Limitations –
• Probation file data –
• Time to analyze the data / information

2010 Prison Commitments Data Set

- 2010 District Attorney Data
  - 162 Individuals sent to Prison in 2010

- 2010 Felony Probationers to Prison
  - 70 Individuals on Felony Probation

- 2010 Felony Probationers to Prison
  - 41 Identified as Non-Non-Non (If sentenced today)

- 2010 Felony Probationers to Prison
  - 46% (19) Violation of Probation Only
  - 53% (22) New Conviction Only
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Primacy of Drug Intervention

| A Look at Felony N3 Probationers sent to Prison prior to realignment in Santa Cruz County |
|----------------------------------|-------------------|
| 46% (19) Violation of Probation Only | 53% (22) New Conviction Only |

Demographics:
- 83% Males
- 66% Anglo
- 54% North County Residents

Probation Grants:
- Average 1.3 active grants of Probation
- Average of 2.5 convictions per grant
- Average LOS on Probation = 4.2 years

New Convictions to Prison

- Drug - Sales: n=5, 22%
- Property: n=7, 31%
- DUI: n=3, 13%
- Evading: n=1, 4%
- Non Serious Violence: n=1, 4%
- Technical Violation w/ other Conviction: n=5, 26%
- Drug - Sales w/ other Conviction: n=5, 22%
- DUI w/ other Conviction: n=3, 13%
- Evading w/ other Conviction: n=1, 4%
- Non Serious Violence w/ other Conviction: n=1, 4%
- Property w/ other Conviction: n=7, 31%
- Other: n=19, 46%
Chronicity Factor: Six Property Offenders accounted for 56 prior crimes, 66% Drug related.
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Probation Technical Violations to Prison

- **Technical Violation (type):**
  - Drug / Alcohol Terms: 1, 5%
  - Gang Terms: 1, 5%
  - Tx Program Failure: 7, 37%

- **Dismissed New Offense Handled as Technical Violation (type):**
  - Drug Sales: 1, 11%
  - Misc. Offenses: 1, 11%
  - Drug/Alcohol (Poss or Influence): 5, 56%

- Probationer arrested on new charges, but charges dismissed in the interest of justice (typically as part of a plea agreement).

Felony Probationers Referred to Residential Treatment

- **Total Number Treatment Referrals:**
  - Unsuccessful: 41, 85%

- **Successful Treatment Completions by Program:**
  - The Camp: 1, 15%
  - Si Se Puede: 1, 14%
  - Santa Cruz Residential: 4, 57%
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• Less than half of the individuals sent to prison were on formal probation at the time.
• Nearly two-thirds of probationers sent to prison in 2010 qualify as non-non-nons and will not go to prison under realignment.
• By far, Drugs are the main referral source to prison, and property offenses follow.
• All but one property offender had a substance abuse issue.

KEY FINDINGS Based on 2010 Study

The growing dominance of drugs as a driver in jail populations (pre-realignment)

Source: Justice Policy Institute; Jailing Communities 2008
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The Primacy of Drugs

• The Prison Explosion can not be explained by crime rates; it is better explained by the increased use of prison as the preferred response to crime.

• Drug crimes and property crimes driven by drug use explains most N3 / AB109 populations.

• Prior to AB109, many N3’s were sent to prison for treatment failure from probation.

• If we are to become successful in public safety realignment without replicating a local jail version of the state prison problem, we need to envision and implement new approaches to substance use and abuse.

• New opportunities exist through AB109 funding and ACA.

Opportunities to Enhance Substance Abuse Services through ACA

• Currently 9 out of ten people in jail do not have health insurance or financial resources to pay for medical care, yet they are far more likely to have mental health and substance abuse issues than the general population.

• Individuals in jail are not eligible for ACA; however, pretrial detainees, individuals on electronic monitoring, and individuals on probation or under Sheriff custody but not on probation are eligible.

• Services may include: Assessment and planning; group and individual counseling; case management, medication support; intensive day treatment and rehabilitation; crisis intervention and stabilization; residential treatment; psychiatric and psychological services and more.
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Primacy of Drug Intervention

A Vision for the Future

- To Borrow from Reclaiming Futures, we need
  - More Treatment – Tap into new opportunities to expand resources
  
  - Better Treatment- Use the rapidly advancing knowledge to improve treatment approaches, fidelity monitoring and evaluation, and merge the criminal justice research with the substance abuse literature
  
  - More than Treatment – Not everyone needs treatment (Kleinman and Hawkens); not every offender should have the same sanction or punishment; we need to remember that criminogenic needs are different than treatment needs and attitudes, beliefs, antisocial characteristics and associates should be targeted as separate but concurrent issues; also, lets not forget jobs and transitional support for stability....

Food for Thought:

- How big should the criminal justice system reach be for non violent drug offenders and/ or offenders who do not harm others through property crimes? Might a public health response be more fitting for some offenders.

- For those that are determined to need criminal justice intervention because they harm others, will swift and certain responses suffice in some cases without significant treatment resources, thus allowing resources to be reallocated to others who need it.

- Could we envision and deliver a system where treatment involvement is only met with rewards and incentives and punishment is only used to address the problem behaviors – new crimes or positive drug tests?
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Primacy of Drug Intervention

Recommendations

• Given the timing of two major system initiatives– ACA and Public Safety Realignment– there exists a “perfect storm” for innovation and expansion of substance abuse intervention.

• Counties should be having collaborative planning processes between justice partners, health and social services, to thoughtfully plan for better services to address substance abuse.

• We need to teach each other about our respective subjects and lexicons as well as the EBP that exists in criminal justice and health systems to understand how to merge these practices for maximum impact in criminal justice populations.

• We should do a lot of piloting and evaluation to continue to learn and evolve our interventions.

• We should maintain a “systemic lens” as well as an “offender lens” so that we improve both system efficacy and client outcomes.
The COCHS Approach: Jails and Community Health

- Public safety and public health systems are intertwined.
- The health of the jail population is similarly intertwined with the health of the community outside of jail.
- Connecting health care in jails to health care in the community preserves the investment counties make in their vulnerable criminal justice-involved populations.
Rehabilitation, Healthcare and Economics
Understanding the Impact of Health Care Reform on Behavioral Health Treatment

Presentation Overview

1. Who’s in Jail?

2. The Economics of Treating the Justice-Involved Population

1. Health Reform

1. What Works: Behavioral Health Treatment

Health Status of Jail Inmates

- Jail inmates are disproportionately young, male, persons of color, and poor.

- They have high rates of health problems (chronic and infectious disease, injuries), psychiatric disorders, and substance use disorders (SUD).

- 80% of detainees with chronic medical conditions have not received treatment in the community prior to arrest.
Release from Prison –
A High Risk of Death for Former Inmates

- A 2007 study reported overall increased mortality rates for former inmates in Washington State: 3.5x greater than the general population.

- Mortality was the highest during the first two weeks after release: 12.5x greater than the general population.

- The study found a high incidence of death due to: overdose, HIV, homicide, motor vehicle accidents, cancer, liver disease.


Characteristics of the Jail-Involved Population
Comparing the incidence of disease among the general population with the criminal justice population:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Gen'l : CJ Pop</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Use Disorder</td>
<td>1:2</td>
</tr>
<tr>
<td>Mental Health Disorder</td>
<td>1:2</td>
</tr>
<tr>
<td>Co-Occurring MH/SU Disorder</td>
<td>1:2</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>1:5</td>
</tr>
<tr>
<td>Sexually Transmitted Infections</td>
<td>1:2</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>1:4</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>1:48</td>
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Understanding the Impact of Health Care Reform on Behavioral Health Treatment

Jails as Behavioral Health Care Providers

• Jails have become de facto behavioral health providers in many communities, a role for which they are not adequately equipped to meet the need.
  – A 2009 study estimated current prevalence rates of serious mental illness among adult jail inmates to be 15% for males and 31% for females.
  – Among jail detainees with a diagnosed mental illness, 75% of women and 72% of men have a co-occurring substance use disorder.

Jails as Behavioral Health Care Providers
The ADAM II 2011 Report

• Over 60% of arrestees in all sites tested positive for at least one drug in their system, and fewer reported having received outpatient drug or alcohol treatment in the prior year—less than 10% in 8 of the 10 sites.

• 13 - 38% of arrestees tested positive for multiple substances.

• 13 - 30% of arrestees said they had been arrested two or more times in the prior year.
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Uninsured

• Few people in jail or prison today are enrolled in Medicaid because they have not been eligible as single, childless adults.

• Currently, 90% of detainees have no health insurance upon release from jail.

Massachusetts Uninsured

• According to a recent NASADAD study, less than 3% of Massachusetts residents are uninsured, but the uninsured residents “are likely to have elevated rates of chronic SUDs.”

• In fact, approximately 22% of the admissions for publicly funded SAT in MA in 2009 were uninsured. The uninsured population was disproportionately low-income and young adult, Black, and Hispanic, characteristics that mirror the demographics of the jail-involved population.
Jails ➔ Community NOT Prison

• Nationally, only about 4% of jail admissions result in sentences to prison.

OR, in other terms...

• 96% of jail detainees and inmates return directly to the community from jail, along with their often untreated health conditions.

• COCHS’ Mantra:
  – The health of the jail population is intertwined with the health of the community outside of jail.
  – Connecting health care in jails to health care in the community preserves the investment counties make in their vulnerable criminal justice-involved populations.

The Economics of Treating the Justice-Involved Population
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Reduced Crime / Improved Health & Safety

- When chemical dependency treatment was offered to very low income adults—a population very similar to the jail population—research found:
  - improved physical and mental health and significant cost savings in health care.
  - reduced crime and recidivism, and correlated savings to crime victims and criminal justice systems.

Reduced Crime / Improved Health & Safety

- The next two slides illustrate the savings reported by Dr. David Mancuso, Senior Research Supervisor, Department of Social and Health Services.
  - Mancuso, D, Felver, B. Bending the Health Care Cost Curve by Expanding Alcohol/Drug Treatment, Washington State DSHS Research and Data Analysis Division, RDA Report 4.81 (Sept 2010).
  - Mancuso, D, Felver, B. Providing chemical dependency treatment to low-income adults results in significant public safety benefits, Washington State DSHS Research and Data Analysis Division, Report 11.130 (Feb 2009).
Arrests decline significantly after alcohol/drug treatment

Decline in the number of arrests in the year following treatment
Relative to untreated comparison group

<table>
<thead>
<tr>
<th>Disability Lifeline</th>
<th>ADATSA</th>
<th>Low Income Adults</th>
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<tr>
<td>33% DECLINE</td>
<td>18% DECLINE</td>
<td>17% DECLINE</td>
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Alcohol/drug treatment impacts: Medical Costs

Annual percent change in medical expenditures before and after alcohol/drug treatment expansion
Clients with alcohol/drug treatment (AOD Tx) need relative to balance of medical coverage group
The Economics of Treating the Justice-Involved Population

- Without access to care, many jail-involved individuals will be repeat users of emergency room services and inpatient psychiatric services in the community, and jail health services as “frequent flyers.”

- From a fiscal perspective, it will be in the interest of the state and counties to offer effective behavioral health treatment to Medi-Cal and Covered California beneficiaries.

Federal Health Reform

The Patient Protection and Affordable Care Act (“Health Reform”):

- expands eligibility for publically subsidized coverage to qualified adults, many of whom may be jail-involved.

- creates new opportunities for local jurisdictions that are responsible for the public health and safety of their residents.

- requires parity between somatic and behavioral health coverage.
Health Reform Creates New Access to Health Care for Justice-Involved Individuals

1. Allows “qualified individuals” to enroll in a federally subsidized, qualified health plan offered through a health insurance exchange.

2. Expands eligibility for Medicaid (Medi-Cal) to many of society’s most vulnerable populations for the first time.

1. Exchange Plan Eligibility and Coverage

- The ACA requires each state to create or participate in a health insurance exchange where qualified individuals can buy subsidized health insurance.

- Californians with income from 138% - 400% FPL will be able to purchase plans with federal premium support through Covered California, the state’s health insurance exchange.
Exchange Plan Eligibility and Coverage

- Regarding health insurance exchanges, the ACA specifies that: “[a]n individual shall not be treated as a qualified individual if, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges.”

- This means that, subject to the requirements of health plans, jail health care providers may be reimbursed for covered services they deliver to Covered California beneficiaries who are incarcerated while pending disposition of charges.

2. The Expansion of Medi-Cal Eligibility

- Medi-Cal will be available to a new category of individuals: non-elderly adults with income up to 138% FPL, regardless of health status, gender, or parental status.

- Medi-Cal eligibility is not precluded if an individual is incarcerated, but Medi-Cal coverage is not currently available for individuals in jail.

- COCHS estimates that about 2/3 of the jail-involved population will be eligible for Medi-Cal under the expansion, creating access to health care for many individuals for the first time.
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Projected 2014 Statewide Medi-Cal Eligibility for Jailed Individuals:
Males, Ages 18-24

- In 2012, COCHS developed a model to project the size of the jail-involved population in California likely to be Medi-Cal eligible in 2014.

- Approximately 69% of jail-involved male individuals between the ages of 18 and 24 in the state of California may be eligible for Medi-Cal in 2014.

Need for Treatment

- High rates of SUD among justice-involved population tend to go untreated.

- Historically, access to treatment for SUD does not meet the need.

- Medi-Cal is proposing to enhance its current benefit in 2014.

- Under Health Reform, coverage for mental health and substance abuse services is supposed to be provided “at parity”— to the same degree that physical healthcare services are delivered.
Medi-Cal in 2014

- Governor Brown’s recently released May budget revise proposes to continue a state-based approach for Medi-Cal expansion:

  Newly eligible individuals will receive the comprehensive benefits currently provided by Medi-Cal, including county-administered comprehensive specialty mental health services and county-supported substance use disorder services.

Drug Medi-Cal (DMC) Now

The state-administered DMC Treatment Program provides medically necessary substance use disorder treatment services for Medi-Cal eligible beneficiaries:

- Perinatal Drug Medi-Cal funds may be used to finance Medi-Cal substance abuse services provided to women who are pregnant or 60 days post-partum (and their infants) who have family incomes that are not in excess of 185% of the federal poverty level and meet medical necessity criteria.

- General Drug Medi-Cal funds may be used to finance Medi-Cal substance abuse services provided to all Medi-Cal beneficiaries who meet medical necessity criteria.

http://www.cimh.org/downloads/Jan-Feb01.pdf
Perinatal Drug Medi-Cal

1. Day Care Habilitative
2. Perinatal Residential Rehabilitation

General Drug Medi-Cal

1. Naltrexone
2. Narcotic Treatment Programs – benefit does not include detoxification, but includes Methadone.
3. Outpatient Drug-Free Treatment

Drug Medi-Cal in 2014

- Counties will use their existing resources to continue providing Drug Medi-Cal services to the currently eligible Medi-Cal population.

- Counties will continue to operate with the current benefit and delivery system for the expansion population.

- However, there’s a new wrinkle: “... At a county option, beneficiaries, both existing enrollees and new eligibles, may receive an enhanced benefit package for substance use disorders.”

  Governor’s 2013-2014 Budget May Revise Summary
Proposed Enhanced Medi-Cal SUD Benefit for 2014

The Department of Health Care Services has indicated that it is considering the following enhanced benefits that counties may opt to offer to all Medi-Cal beneficiaries:

1. Intensive outpatient treatment
2. Residential substance use disorder services
3. Recovery supports
4. Opioid detoxification
5. Alcohol detoxification

Benefits of the Medi-Cal SUD Benefit

- Given their intimate knowledge of local populations, counties are uniquely qualified to develop new systems of substance use disorder services.

- The enhanced SUD benefit option is an opportunity for counties to develop capacity to deliver crucial services to some of their most vulnerable populations.

- Providing justice-involved populations in particular with robust SUD treatment can help counties by reducing health care costs, reducing criminal justice system costs, and improving public safety.
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Current Medi-Cal Mental Health Benefit

- Counties provide non-specialty Medi-Cal mental health services through managed care and fee-for-services systems.

- Under a federal waiver, counties provide or arrange for provision of specialty mental health services for individuals who meet medical necessity criteria:
  - Day rehabilitation
  - Targeted case management
  - Crisis stabilization
  - Crisis residential services
  - Psychiatric hospital inpatient services

2014 Medi-Cal Mental Health Benefit

- Counties will continue to operate with the current benefit and delivery system for all beneficiaries, including the expansion population.

- Counties may realize some savings as individuals who received services delivered to them through county indigent health programs may qualify for Medi-Cal under expansion. Services delivered to the expansion population will receive 100% federal funding (leveling off at 90% in 2020).
Evidence-based Risk Reduction

What the criminal justice literature teaches us:

- Various forms of cognitive behavioral therapy are crucial
- Time is of the essence

There are services that are proven to reduce morbidity, mortality, and—for individuals with histories of justice-involvement—recidivism.

What Works

- Harm Reduction
- Medication
- Behavioral Health Treatment
- Other Services Needed For Success

Komaromy M, "What Works in Addiction Treatment," PowerPoint presentation, April 12, 2013
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Harm Reduction

- Infection prevention
  - Syringe exchange

- Overdose death prevention
  - Naloxone reduces opioid overdose deaths

Komaromy M, "What Works in Addiction Treatment," PowerPoint presentation, April 12, 2013

Medication

- Alcohol addiction medication
  - Naltrexone
  - Acamprosate
  - Topiramate
  - Disulfiram

- Opioid addiction medication
  - Injectable naltrexone
  - Opioid agonists (methadone, buprenorphine)

Komaromy M, "What Works in Addiction Treatment," PowerPoint presentation, April 12, 2013
Opioid Agonist Medications

• Methadone

• Buprenorphine
  – As effective as moderate-dose methadone
  – Reduces overdose death
  – Administered by any trained physician
  – Office-based, by prescription
  – Safe, almost impossible to overdose
  – Likely very long term treatment

Komaromy M, "What Works in Addiction Treatment," PowerPoint presentation, April 12, 2013

Behavioral Health Interventions

• Essential for more complex patients— injection drug users, individuals with co-occurring disorders, and individuals with justice-system involvement.

• Key Modalities:
  – Motivational interviewing, cognitive behavioral therapies (MRT, REBT, etc.), therapeutic communities, contingency management, Community Reinforcement Approach.

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Other Services Needed for Success

• Individuals involved with the criminal justice system with behavioral health disorders could benefit from additional services, such as:
  – Pre-vocational training, supported employment, career planning, problem solving skills, self-help, social skills, adaptive skills, anger management, etc.
  – Analogous supportive services are often provided to individuals with developmental disabilities through habilitative services benefits.


Questions?

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The Nexus between Healthcare Reform & the Principles of RNR (Risk, Need and Responsivity): A review of “what works” and what is to come

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RNR Simulation Tool (www.gmuace.org/tools)

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Ken Robertson
The World’s Incarceration Leader

The U.S. has **5%** of the world’s population…

…and **23%** of the world’s prisoners

The United States has the highest prison population rate in the world, **756 per 100,000**, followed by:

- Russia (629)
- Rwanda (604)
- St Kitts & Nevis (588)
- Cuba (531)
- U.S. Virgin Is. (512)
- British Virgin Is. (488)
- Palau (478)
- Belarus (468)
- Belize (455)
- Bahamas (422)
- Georgia (415)
- American Samoa (410)
- Grenada (408)
- Anguilla (401)

Nearly 3/5 of countries (59%) have rates below 150 per 100,000.

**Sources:**
- Pew Charitable Trusts, 2010: Collateral Costs: Incarceration’s Effect on Economic Mobility
Rehabilitation, Healthcare and Economics

The Nexus between Healthcare Reform & the Principles of RNR (Risk, Need and Responsivity)

The Growing Use Of CJ Control:
293 % growth in ~30 years

3.5:100 11-17 Year Olds are in the Juvenile Justice System

Sources:
The Nexus between Healthcare Reform & the Principles of RNR (Risk, Need and Responsivity)

~4:100 18-65 Year Olds are on Probation/Parole

1:100 Adults are Incarcerated

1:5 American Adults with a Criminal Record
Rehabilitation, Healthcare and Economics
The Nexus between Healthcare Reform & the Principles of RNR (Risk, Need and Responsivity)

Criminal Justice System Reach is Deep in the US and abroad

<table>
<thead>
<tr>
<th>Ratio</th>
<th>Description</th>
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<tbody>
<tr>
<td>4:100</td>
<td>Adults under Correctional Control</td>
</tr>
<tr>
<td>1:100</td>
<td>Adults Incarcerated</td>
</tr>
<tr>
<td>3.5:100</td>
<td>Youth Involved in JJ System</td>
</tr>
<tr>
<td>1:5</td>
<td>Adults with a Criminal Record</td>
</tr>
<tr>
<td>3.5:100</td>
<td>Adults will serve “time” in their lifetime</td>
</tr>
<tr>
<td>1:28</td>
<td>Children with a parent behind bars</td>
</tr>
</tbody>
</table>


$6.4 \text{ B} = \begin{align*} & \text{A country} + \text{300 new schools} + \text{Cleveland Browns} \end{align*}$
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The Nexus between Healthcare Reform & the Principles of RNR (Risk, Need and Responsivity)

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**Health Issues Among Adults in the Correctional System**

- **Substance Use Disorder**: 1:2
- **Co-Occurring Disorders**: 1:2
- **Mental Health Disorder**: 1:2
- **Sexually Transmitted Infection**: 1:2
- **Hepatitis C**: 1:4
- **Tuberculosis**: 1:5
- **HIV/AIDS**: 1:48

*Sexually transmitted infections include: HIV, AIDS, Hepatitis C, Chlamydia, gonorrhea, and syphilis.


Gender health status numbers came from Cropsey, et al 2013

---

**Rate of Substance Use or Dependence by Racial Group and CJ Status**

<table>
<thead>
<tr>
<th>Racial Group</th>
<th>Parolees</th>
<th>Probationers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>4.5</td>
<td>37.2</td>
</tr>
<tr>
<td>African American</td>
<td>8.5</td>
<td>9.4</td>
</tr>
<tr>
<td>Caucasian</td>
<td>9.3</td>
<td>9.3</td>
</tr>
<tr>
<td>Hispanic</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td></td>
<td>21</td>
</tr>
<tr>
<td>American Indian</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

% reported abuse last year

National Household Survey on Drug Use and Health, 2010

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37
Health Issues Among Juveniles in the Justice System

Substance Use Disorder 1:2
Mental Health Disorder 1:2
Co-Occurring Disorders 1:2
Sexually Transmitted Infection 1:6
Hepatitis C 1:50
HIV 1:200

*Sexually transmitted infections include: HIV, Hepatitis C, Chlamydia, gonorrhea, and syphilis.
*Juvenile correctional population numbers came from: Taxman et al. (2007).

Release from Prison — A High Risk of Death for Former Inmates


- Washington state
- Overall increased mortality 3.5 times greater than general population
- Mortality highest (12.5 times) in the first two weeks post-release
- Increased mortality for overdose, HIV, homicide, MVA, cancer, liver disease
The Role of Science in Dealing with Fragile Policy Issues

- Health Disparities
  - Differences between groups of people that affect the disease prevalence, how many people get sick, or how often the disease causes death
  - Differences between who gets access to care, type of care received, and outcomes

- Effective Interventions:
  - Meta-analyses to identify the type of programs and services that reduce negative outcomes
  - Cross-disciplinary since the emphasis is on individual level outcomes in the areas of recidivism, drug use, mental health symptoms

- Focus on underfunded areas within the realm of health disparities:
  - Substance use disorders
  - Cognitive impairments for antisocial disorders/ADHD
  - Mental Health Services
  - Vocational Rehabilitation Skills

What Has Been Tried: CJ Interventions to Change Offending Behaviors?

- Intensive Supervision
- Boot Camp
- Case Management
- Prison/Incarceration
- Case management & services provided
- Diversion to residential treatment
- Specified treatment programs (e.g. Break the Cycle, Seamless System, etc.)
- Medication Assisted Therapies with Behavioral Therapies
- Drug Treatment Courts
- RNR Supervision
- In-Prison Therapeutic Programs (TC) with Aftercare

Red: ineffective  Blue: Promising  Green: Effective
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What Has Been Tried: Clinical?

- Psycho-Social Educational
- Non-Directive Counseling
- Directive Counseling

- Motivational Interviewing
- Moral Reasoning
- Emotional Skill Development
- 12 Step Based Programming
- Medications for SUD & MH

- Cognitive Behavioral (Social Skills, Behavioral Management, etc.)
- Family Interventions (MST, FFT)
- Therapeutic Communities (with aftercare)
- Contingency Management/Token Economies

But, Programs Work Better When….

◆ Integrated (CJ, Public Health, etc.) & incarceration to community

◆ SUFFICIENT duration to affect change
  - <90 days for low risk
  - >90 days for moderate risk
  - >180+ days for higher risk

◆ Focus on “working alliance” & the culture supports change (recognizing relapse is part of that process)

◆ Integrate medication for SUD, MH, ADHD, etc. into behavioral interventions, case management, habilitation services

◆ Use incentives to motivate people & staff

◆ Integrate peer navigators or support
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Better Outcomes via Tx Matching

<table>
<thead>
<tr>
<th>Program</th>
<th>% Reconvicted with High LSI-R Need</th>
<th>% Reconvicted with No Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic Community</td>
<td>26%</td>
<td>55%</td>
</tr>
<tr>
<td>(26.6% High Need)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse Tx</td>
<td>31%</td>
<td>49%</td>
</tr>
<tr>
<td>(25.8% High Need)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>31%</td>
<td>53%</td>
</tr>
<tr>
<td>(63.5% High Need)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Program Quality Matters

- Across the tools used, most programs score < 50 or are unsatisfactory

- Program quality (Implementation, Risk-Need Assessment, Orientation) related to Recidivism

<table>
<thead>
<tr>
<th>Score Level</th>
<th>% Difference in Recidivism</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Score (N=1)</td>
<td>22%</td>
</tr>
<tr>
<td>Moderate Score (N=13)</td>
<td>8%</td>
</tr>
<tr>
<td>Low Score (N=24)</td>
<td>2%</td>
</tr>
</tbody>
</table>

Lowenkamp, Latessa, & Smith, 2006; see also Nisovic, 2003.
Factors to Consider in Assessing Programs

- Target Population
- Program Goals
- Program Theory
- Client Level Factors
  - Spectrum of Needs/Severity of Program Needs
  - Developmental Factors (e.g., age, gender, cognitive, physical)
- Program Structure
- Program Dosage (a lot unknown, clinical literature)
- Implementation Issues
  - Staffing
  - Fidelity Monitoring, Training
  - Quality Assurance

“Quality in a product or service is not what the supplier puts in. It is what the customer gets out and is willing to pay for. Customers pay only for what is of use to them and gives them value. Nothing else constitutes quality.”

Peter Drucker (1985)
Innovation and Entrepreneurship
Factors Associated with EBP Use

Statistically Significant with Use
- Community based programs
- Administrators:
  - Background in human service
  - Knowledge about EBP
  - Belief in rehabilitation
- Performance driven culture
- Emphasis on training
- Emphasis on internal support
- Network connections

Factors Not Found to be Related to Use
- Size of Population
- Physical Plant
- Staffing
- Leadership Style

Friedmann, Taxman, & Henderson, 2007; Grella et al, 2007; Henderson et al., 2007
System Integration to Improve Networkness? Integration of SA & CJ Agencies

- Most Typical Activities:
  - Share Information with agencies
  - Develop Client Eligibility Across Agencies
  - Written Program Programs
  - Joint Staffing of Program
  - Modified Program to Meet Correctional and SA Agencies
  - Written MOU between agency

- Average Number of Activities Integrated:
  - Drug Court = 6.1
  - Probation/Parole = 4.5
  - Prison = 3.2
  - Jails = 3.7

  - At state level, shared activities between substance abuse treatment and probation and parole related to more EBP use (p = .003)
  - Also at state level, more involvement between criminal justice agencies related to more EBP use (p = .006)

Why Criminal Justice Population & System?

- CJS is not a service provider, yet over 14 million adults in any given year interact with the system
- Over 8 million adults and over 650,000 youth under correctional control
- No longer an anomaly—1:23 adults
- Offenders are high need for SA, MH, and somatic care
- “Life in CJS” involves churning through the system
- Tend to be “treated” in critical situations—ER, booking stations/arrests, jail/prison
- Access to large concentration of the population covered under health disparities (males, minorities, younger adults)
Criminal Justice Risk

Use Actuarial Risk Measure to Prioritize for Care
Use to Triage for Cognitive Impairment

What is Risk?

- Risk is the likelihood that an offender will engage in future criminal behavior (recidivate)
  - Can be discussed as static or dynamic or both
- Risk does NOT refer to dangerousness or likelihood of violence
  - Static risk factors have a direct correlation with criminal behavior
    - Historical – based on criminal history
    - Cannot be decreased by intervention
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CJ Risk Assessment

• EBP: Risk level should drive receipt of care—moderate to high risk offenders benefit more from care
• Actuarial based Models
• Main Factors
  • Age of first arrest
  • Number of arrests and/or convictions
  • Number of failed attempts on probation (or parole)
  • Number of incarcerations
  • Number of escapes
• Substance Abuse

Common Static Risk Factors

<table>
<thead>
<tr>
<th>Item</th>
<th>LSI-R¹</th>
<th>Wisconsin²</th>
<th>COMPAS³</th>
<th>ORAS⁴</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Adult Convictions (Arrests)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Age of First Conviction (Arrest)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Prior Incarceration</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>History of Escape from Correctional Facility</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>History of Institutional Misconduct</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Number of Prior Periods of Probation/Parole Supervision</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Probation/Parole Revocations</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Official Record of Assault or Violence</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Juvenile Conviction for Burglary, Theft, Auto Theft, Robbery, Worthless Checks, or Forgery</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

³2009 Northpointe Institute for Public Management, Inc.
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CJ Risk Matters…..(3 year, all offenses)

Risk Level

- High
- Moderate
- Low

% Rearrested

- Probation
- Jail
- Prison

Ainsworth, Crites, Caudy, & Taxman, 2011

Risk Principle in Action – High Risk

8% Recidivism Reduction

Lowenkamp & Latessa, 2005
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Risk Principle in Action – Low Risk

Change in Recidivism Rates

-36 -32 -29 -29 -21 -21 -21 -21 -16 -15 -11 -11 -11 -7 -7 -6 -5 -4 -4 -4 -2 -2 -2 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1

4% Recidivism Increase

Lowenkamp & Latessa, 2005

Risk & Criminal Behavior

Piquero and colleagues (2007) found that chronic offenders tend to suffer from more health problems than desisters.

Using the Baltimore stratification of the National Collaborative Perinatal Project (n = 1,758 subjects), they examined the trajectories of individuals 27 to 33 years old

- 8+ arrests in their lifetime were classified as “life-course persistent”
- life-course persistent offenders had higher rates of alcohol and other drug use and cigarette smoking than desisters.
- significant relationship between adverse health outcomes and being a life-course persistent offender.
**HCV Study**

- 685 subjects recruited in 2 (experimental) studies
  - 509 (76.4%) tested negative for HCV
  - 157 (23.6%) tested positive for HCV
- Dependent variable, HCV seropositivity, was determined from a serum ELISA antibody assay performed on all enrolled subjects
- Self-report data from intake interview completed prior to the testing and intervention


### Demographic Characteristics by HCV Status

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>~HCV</th>
<th>HCV+</th>
<th>p-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Subjects</td>
<td>509 (76.4%)</td>
<td>157 (23.6%)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>81.7%</td>
<td>74.3%</td>
<td>.058</td>
</tr>
<tr>
<td>African-American</td>
<td>65.6%</td>
<td>43.4%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Average Age</td>
<td>32.9 years</td>
<td>41.8 years</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>High School Graduate</td>
<td>42.4%</td>
<td>30.9%</td>
<td>.016</td>
</tr>
<tr>
<td># Hospitalizations (lifetime)</td>
<td>1.7</td>
<td>3.1</td>
<td>.017</td>
</tr>
<tr>
<td>Rated Heath as Poor or Fair</td>
<td>10.8%</td>
<td>28.7%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Reported Serious Pain (lifetime)</td>
<td>30.8%</td>
<td>41.9%</td>
<td>.016</td>
</tr>
<tr>
<td>Reported Serious Depression (&gt;2 weeks)</td>
<td>25.7%</td>
<td>36.3%</td>
<td>.018</td>
</tr>
<tr>
<td>Bothered by Emotional or Psychological Problems</td>
<td>12.3%</td>
<td>22.1%</td>
<td>.005</td>
</tr>
<tr>
<td>Attempted Suicide</td>
<td>8.9%</td>
<td>14.7%</td>
<td>.052</td>
</tr>
</tbody>
</table>
## Criminal Justice Involvement Characteristics

<table>
<thead>
<tr>
<th></th>
<th>~HCV</th>
<th>HCV+</th>
<th>p-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td># Lifetime Arrests</td>
<td>16.3</td>
<td>23.9</td>
<td>.017</td>
</tr>
<tr>
<td>Percent of Arrests Drug-Related</td>
<td>50.5%</td>
<td>70.3%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td># Times Locked Up (lifetime)</td>
<td>12.2</td>
<td>19.5</td>
<td>.015</td>
</tr>
<tr>
<td>Time in Confinement (months)</td>
<td>60.8</td>
<td>104.8</td>
<td>&lt;.001</td>
</tr>
<tr>
<td># Drug-Related Crimes (lifetime)</td>
<td>2310.73</td>
<td>2677.42</td>
<td>.033</td>
</tr>
<tr>
<td># Violent Crimes (lifetime)</td>
<td>52.20</td>
<td>97.34</td>
<td>.051</td>
</tr>
<tr>
<td>Income = Selling Drugs</td>
<td>38.2%</td>
<td>21.3%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Selling Sex</td>
<td>2.2%</td>
<td>6.6%</td>
<td>.012</td>
</tr>
<tr>
<td>Current Confinement – Local Jail</td>
<td>8.5%</td>
<td>12.5%</td>
<td>.160</td>
</tr>
<tr>
<td>Current Confinement – Prison</td>
<td>25.7%</td>
<td>37.5%</td>
<td>.007</td>
</tr>
<tr>
<td>Confinement – Halfway House</td>
<td>65.8%</td>
<td>50%</td>
<td>.001</td>
</tr>
<tr>
<td>Criminal Risk Scale</td>
<td>5.2</td>
<td>5.7</td>
<td>.001</td>
</tr>
<tr>
<td>Lifetime Arrests – 8 or More</td>
<td>56.5%</td>
<td>72.8%</td>
<td>.001</td>
</tr>
</tbody>
</table>

## Risk Behaviors & SUD by HCV Status

<table>
<thead>
<tr>
<th></th>
<th>~HCV</th>
<th>HCV+</th>
<th>p-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td># Inject Drugs (30 days)</td>
<td>2.8</td>
<td>28.5</td>
<td>&lt;.001</td>
</tr>
<tr>
<td># Inject Drugs w/Other People (30 days)</td>
<td>2.3</td>
<td>15.5</td>
<td>&lt;.001</td>
</tr>
<tr>
<td># Loaned Needles w/o Cleaning (30 days)</td>
<td>0.03</td>
<td>3.3</td>
<td>.001</td>
</tr>
<tr>
<td># Unprotected Sex while Trading Sex (30 days)</td>
<td>2.1</td>
<td>4.5</td>
<td>.060</td>
</tr>
<tr>
<td># Unprotected Sex who Shot Drugs</td>
<td>0.6</td>
<td>3.1</td>
<td>.002</td>
</tr>
<tr>
<td># Unprotected Sex &amp; Smokes Crack or Meth</td>
<td>3.6</td>
<td>6.4</td>
<td>.043</td>
</tr>
<tr>
<td>HIV Positive</td>
<td>0.7%</td>
<td>5.1%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Self-Report of being HCV+ Prior to Testing</td>
<td>0.4%</td>
<td>45.9%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Reported Having TB</td>
<td>4.3%</td>
<td>8.1%</td>
<td>.080</td>
</tr>
<tr>
<td>Reported Having Hepatitis B</td>
<td>0.9%</td>
<td>10.4%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Life Stressful Because of Drug Use</td>
<td>34.9%</td>
<td>56.6%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Times in Substance Abuse Treatment</td>
<td>1.9</td>
<td>3.2</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Ever Gone to Self-Help Meetings</td>
<td>65.2%</td>
<td>80.9%</td>
<td>.001</td>
</tr>
<tr>
<td>Currently in Drug Treatment</td>
<td>55.1%</td>
<td>45.9%</td>
<td>.060</td>
</tr>
<tr>
<td>Heroin as Most Serious Drug Problem</td>
<td>9.6%</td>
<td>27.2%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Cocaine as Most Serious Drug Problem</td>
<td>25.7%</td>
<td>36.0%</td>
<td>.019</td>
</tr>
<tr>
<td>Age First Used Illicit Substances</td>
<td>14.4</td>
<td>14.9</td>
<td>.244</td>
</tr>
<tr>
<td># Drug Overdoses</td>
<td>21</td>
<td>1.55</td>
<td>.001</td>
</tr>
</tbody>
</table>
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**Adjusted Logistic Model Results:**
Predictors of HCV Positive

<table>
<thead>
<tr>
<th>Variable</th>
<th>Overall Odds Ratio (95% CI)</th>
<th>Male OR (95% CI)</th>
<th>Female OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>1.11 (1.08, 1.14)**</td>
<td>1.11 (1.08, 1.54)**</td>
<td>1.19 (1.05, 1.19)**</td>
</tr>
<tr>
<td>Criminal Risk</td>
<td>1.25 (1.07, 1.46)**</td>
<td>1.28 (1.07, 1.54)**</td>
<td>1.09 (0.78, 1.51)</td>
</tr>
<tr>
<td># Sex Partners</td>
<td>0.84 (0.41, 1.74)</td>
<td>0.43 (0.15, 1.25)</td>
<td>2.11 (0.66, 6.75)</td>
</tr>
<tr>
<td>Gender</td>
<td>0.59 (0.34, 1.03)</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Jail or Prison Site</td>
<td>0.73 (0.43, 1.24)</td>
<td>0.71 (0.39, 1.31)</td>
<td>0.65 (0.20, 2.09)</td>
</tr>
</tbody>
</table>

---

**Importance of Criminal Justice Risk**

- Criminal Justice risk is an important measure of offending, substance abuse, mental health, etc.—important to effective services
- An easy factor to screen—merely 5 questions
- Should be integrated into regularly screening factors regarding other lifestyle factors
- High risk offenders are more likely to benefit from substance abuse treatment than low risk offenders
- Higher risk offenders are at higher risk for a multitude of other disorders
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## SUD & Criminal Risk

- Offenders have 4 times the SUD disorders
- Criminal risk does not “cause” substance abuse dependency but substance abuse dependency increases the risk factors
- Substance abuse is considered a risk factor
- We have not found that higher risk offenders tend to have more severe substance dependency disorders

## Mental Health Conditions & Criminal Risk

- In the CJS, offenders have higher rates of MH symptoms than regular population—primarily situational factors
  - Uncertainty of events
  - Loss of liberties
  - Impact on family and self
  - Concerns of personal safety
- Weak statistical association between mental illnesses and violence
- Weak statistical association between mental illness and CJ risk factors
- Stronger relationship to overall functioning and ability to make changes
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Dynamic Risk (Needs)

The area where ACA opens a potential world of services

The area where CJ and Public Health organizations can address the unmet habituation and socio-psychological needs

This is about managing risky behaviors and addressing health inequities

CJ RISK
Criminogenic Needs
Substance Tolerance for “Hard Drugs”
3+ Criminal Lifestyle—attitudes, family, peers, personality, substance abuse

Stabilizers
- Supportive Family
- Stable Employment
- Education > HS Diploma
- Stable Housing
- Location in non-Hot Spots

Destabilizers
- Alcohol Abuse
- Drug Abuse
- Family Dysfunction
- Poor Mental Health Status
- Employment-Related Issues
- Literacy Related Problems
- Housing Instability
- Location in Hot Spots

Gender & Age
DSM 5…a new world

- “DSM-5 has now arrived. It is critical to recognize that addictive disease itself has not changed with this new publication. The disease is what it was. We may use different terminology, as “abuse” is now gone, and “dependence” has returned to its pharmacologic roots where it will again refer to the development of tolerance and withdrawal. We applaud DSM-5 for using the term “addictive disorders” within its overall framework. DSM-5 does not, however, speak to addiction but rather to some of the markers seen with addictive illnesses” Stuart Gitlow (2013). (http://www.drugfree.org/join-together/addiction/commentary-dsm-5-new-addiction-terminology-same-disease)

- The new SUD disorder is **dimensional**, meaning that the larger the number of criteria met, the more severe is the disorder and the associated dysfunction. For all DSM-5 disorders there is a range denoting severity: mild (two criteria), moderate (four criteria), and severe (six or more criteria).

---

Drug of Choice Matters

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>Weighted Mean Effect Size (odds ratio – random effects)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana</td>
<td>1.46</td>
</tr>
<tr>
<td>Cocaine</td>
<td>2.56</td>
</tr>
<tr>
<td>Crack</td>
<td>6.09</td>
</tr>
<tr>
<td>Heroin</td>
<td>3.08</td>
</tr>
</tbody>
</table>

*Bennett, Holloway, & Farrington, 2008*
Criminogenic Needs & Tx

- Substance Dependence
  - A pattern of harmful use of any substance for mood-altering purposes.
  - Includes 3 or more of the following:
    - Increased tolerance, withdrawal
    - Increased time spent using, difficulty quitting or cutting back, or continued use despite negative consequences
  - Not the same as substance abuse
  - Drug of choice matters

- Criminal Thinking (Cognitive Impairments, Poor Decision Making Skills)
  - A pattern of thinking that rationalizes and supports criminal behavior.
  - Should be assessed using a validated instrument

ACA Benefits Structure: Risky Behaviors

- Define a benefit area that is focused on a spectrum of diagnosable disorders
- Address the unmet habituation and socio-psychological needs
- Convergence of risky behaviors including offending
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Age & Rearrests

![Graph showing recidivism rates by age group.]

Gender Matters

![Bar chart showing rearrest rates by risk level and gender.]

Ainsworth, et al. 2011
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CJ RISK
Criminogenic Needs
Substance Tolerance for “Hard Drugs”
3+ Criminal Lifestyle—attitudes, family, peers, personality, substance abuse

Stabilizers
Supportive Family
Stable Employment
Education > HS Diploma
Stable Housing
Location in non-Hot Spots

Destabilizers
Alcohol Abuse
Drug Abuse
Family Dysfunction
Poor Mental Health Status
Employment-Related Issues
Literacy Related Problems
Housing Instability
Location in Hot Spots

Gender & Age

Infrastructure to Support ACA

- Social work qualified (MSW) for assessment & diagnoses
- Peer Navigators to enroll in Benefits, Manage Benefits, Enhance Access to Care
- Incentives to Engage in Care
- Electronic Health Records (link with treatment providers, etc.)
Ethical Challenges

- To what degree should criminal behavior be considered personality disorders?
- To what degree, due to financing potentials, should be create benefit structures to encompass criminogenic needs within the framework of behavioral health disorders?
- To what degree should we use the justice system as a means to deal with health and social inequities (as a priority population?)
- How can we reduce the stigma attached to behavioral health and infectious diseases for justice involved individuals? Is “stigma” better than “disenfranchisement”?

Individualized Case Plans
(Practice Guidelines)

<table>
<thead>
<tr>
<th>Typology</th>
<th>Supervision Plan Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disassociated</td>
<td>Developing a social network</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>Addressing violent tendencies, power and control issues, and substance abuse issues</td>
</tr>
<tr>
<td>Drug-Involved</td>
<td>Addressing addiction issues</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Finding treatment and care for mental health issues</td>
</tr>
<tr>
<td>Sex Offender</td>
<td>Including controls and treatment to address sexual deviancy</td>
</tr>
<tr>
<td>Violent Offender</td>
<td>Addressing internal and external controls for violent behaviors</td>
</tr>
</tbody>
</table>
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### Severe SUD

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Benefit Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Severe Disorder with increased tolerance &amp; withdrawal</td>
<td>• MAT for OPIOID, ALCOHOL (lifetime; 6-12m)</td>
</tr>
<tr>
<td>• Focus on drug of choice</td>
<td>• CBT for 12 months &amp; vocational (habituation)/Residential for relapsing</td>
</tr>
<tr>
<td>• CJ Risk (all levels)</td>
<td>• COD treatment, if needed</td>
</tr>
<tr>
<td>• Co-occurring disorders (50%)</td>
<td>• Family Interventions as part of CBT</td>
</tr>
<tr>
<td>• Gender differences</td>
<td>• Cognitive Impairment for developmentally disabled</td>
</tr>
</tbody>
</table>

### Drug Trafficker (Retail) & SUD

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Benefit Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Low to Moderate Disorder</td>
<td>• CBT for 12 months with vocational training (habituation)</td>
</tr>
<tr>
<td>• Focus on marijuana and alcohol use</td>
<td>• COD treatment, if needed</td>
</tr>
<tr>
<td>• CJ Risk (Moderate to High)</td>
<td>• Family Interventions as part of CBT</td>
</tr>
<tr>
<td>• Co-occurring disorders (25-50%)</td>
<td>• Cognitive Impairment for developmentally disabled</td>
</tr>
<tr>
<td>• Gender differences</td>
<td>• Drug Testing/Area curfews</td>
</tr>
<tr>
<td></td>
<td>• Medications for MH disorders</td>
</tr>
<tr>
<td></td>
<td>• RNR Supervision</td>
</tr>
</tbody>
</table>
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DUI/DWI (Chronic)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Benefit Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Severe Disorder with increased tolerance &amp; withdrawal</td>
<td>• MAT for OPIOID, ALCOHOL (lifetime; 6-12m)</td>
</tr>
<tr>
<td>• Focus on drug of choice</td>
<td>• CBT for 12 months &amp; vocational (habituation)/Residential for relapsing</td>
</tr>
<tr>
<td>• CJ Risk (all levels)</td>
<td>• COD treatment, if needed</td>
</tr>
<tr>
<td>• Co-occurring disorders (50%)</td>
<td>• Family Interventions as part of CBT</td>
</tr>
<tr>
<td>• Gender differences</td>
<td>• Cognitive Impairment for developmentally disabled</td>
</tr>
<tr>
<td></td>
<td>• Housing assistance for homeless</td>
</tr>
<tr>
<td></td>
<td>• Drug Testing</td>
</tr>
<tr>
<td></td>
<td>• RNR Supervision (Case Management)</td>
</tr>
<tr>
<td></td>
<td>• Incentives</td>
</tr>
</tbody>
</table>

Criminal Lifestyles (Cognitive Impairments)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Benefit Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Low to moderate SUD disorder, primarily marijuana and alcohol</td>
<td>• CBT for 12 months with vocational training (habituation)</td>
</tr>
<tr>
<td>• CJ Risk (all levels) if have a diagnosable cognitive impairment, dissociation disorder</td>
<td>• COD treatment, if needed</td>
</tr>
<tr>
<td>• Focus on lifestyle related antisocial personality and cognitions</td>
<td>• Family Interventions as part of CBT</td>
</tr>
<tr>
<td>• Legal cynicism</td>
<td>• Cognitive Impairment for developmentally disabled</td>
</tr>
<tr>
<td>• Separate out developmental disabled from cognitive impairments</td>
<td>• Peer Navigator</td>
</tr>
<tr>
<td>• Co-occurring disorders (25-50%)</td>
<td>• Social support system (prosocial, family)</td>
</tr>
</tbody>
</table>
Antisocial Social Personality Disorders

- 3 or more of the following:
  - failure to conform to lawful behaviors
  - deceitfulness, impulsivity
  - irritability and aggressiveness
  - reckless disregard for safety of self or others
  - repeated failure to sustain consistent work behavior or honor financial obligations
  - lack of remorse

Partner Violence (Victim or Perpetrator)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Benefit Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check for SUD and severity of disorder with increased tolerance &amp; withdrawal</td>
<td>MAT, if needed</td>
</tr>
<tr>
<td>CJ Risk (all levels)</td>
<td>CBT for 12 months &amp; vocational (habitation)/Residential for relapsing</td>
</tr>
<tr>
<td>Aggressive behavioral disorders</td>
<td>Family Interventions as part of CBT</td>
</tr>
<tr>
<td>Legal cynicism</td>
<td>Cognitive Impairment for developmentally disabled</td>
</tr>
<tr>
<td>Family disorders</td>
<td>Housing assistance for homeless</td>
</tr>
<tr>
<td>Conduct disorders and defiant oppositional (youth)</td>
<td>RNR Supervision (Case Management) or drug treatment court</td>
</tr>
<tr>
<td>Personality Disorders (adults)</td>
<td>Incentives</td>
</tr>
</tbody>
</table>

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Responsivity: the Core to Success

- Match: Offender to Appropriate Services (treatment & controls)
  ACA: Diagnosable conditions, proper benefit structure
- Services: Treatment
  ACA: benefits
- Services: Community Engagement & Reparation
  ACA: reinforcements, habituation
- Services: Controls of Behaviors
  ACA: Drug testing, monitors, health
- Natural Support System: Linkage to the Community (Sponsors)
  ACA: Peer navigators
RNR Program Level Targets

- Target = Primary intervention focus
- Placement based on primary and secondary needs
  - Step-down model

| LEVEL A | • Dependence on Criminogenic Drugs |
| LEVEL B | • Criminal Thinking/Cognitive Restructuring |
| LEVEL C | • Self-Improvement |
| LEVEL D | • Social/Interpersonal Skills |
| LEVEL E | • Life Skills (Employment, Education, etc.) |
| LEVEL F | • Punishment Only |
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More Principles = More Effective

Scoring The Program Tool

- Essential features and targets drive program level classification

- 6 scoring areas
  - Risk principle (15pts)
  - Need principle (15pts)
  - Responsivity principle (15pts)
  - Implementation (25pts)
  - Dosage (20pts)
  - Additional features (10pts)
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RNR Program Tool

- Here’s the link: www.gmuace.org/tools
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Portal Features:

- Adjusts calculations based on jurisdiction’s own recidivism rate
- Assesses programming capacity against programming need
- Identifies gaps in service delivery
- Provides recommendations for “minding the gap”
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**Gap Analysis**

[Graph showing gap analysis between recommended and current program participation across different levels.]
Components of the Model

- **Static Risk**
  - Use of validated risk assessment tool required
  - High and moderate risk prioritized

- **Demographics**
  - Age and gender weighted heavily

- **Criminogenic Needs**
  - Drug dependence (hard drugs)
  - 3 or more criminogenic needs

- **Stabilizers and Destabilizers**
  - Clinically-relevant factors
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Offender Profile:
- Gender: Male
- Age Group: < 28
- Risk Level: High
- Criminogenic needs:
  - Drug Dependence: Yes
  - 3+ Other Needs: No
- Stabilizers:
  - High School Diploma
- Destabilizers:
  - Alcohol Abuse
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Lots of Opportunities

- Most offenders do not have medical insurance
- Benefits need to target
  - Substance abuse disorders
  - Cognitive Impairments
  - Crisis management

Ethical Challenges

- To what degree should criminal behavior be considered personality disorders?
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