# Capitalizing on Community Behavioral Health for Criminal Justice Reform in Ohio

## Leveraging State and Local Resources to Achieve Impact and Efficiency

**A White Paper of the**

**Ohio Criminal Justice Diversion, Reentry and Behavioral Health Workgroup**

**Prepared by the Great Lakes Addiction Technology Transfer Center--Center on Criminal Justice at TASC of Illinois**

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# Ohio Criminal Justice Diversion, Reentry and Behavioral Health Workgroup

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# Capitalizing on Community Behavioral Health for Criminal Justice Reform in Ohio
## - Leveraging State and Local Resources to Achieve Impact and Efficiency

## EXECUTIVE SUMMARY

The State of Ohio in recent years has engaged in vigorous criminal justice reforms that encompass research, public policy, and programmatic efforts. Most recently, the 2011 passage of major sentencing reform in HB 86 created an overarching framework for integrating efforts at both the state and county levels. The aim of these efforts is to reduce state and local corrections costs, attack the opiate epidemic, and reduce recidivism by engaging community-based programs in treating substance use and mental health problems correlated with repeated criminal justice involvement.

Many of Ohio's investments are yielding promising results that can be expanded and leveraged. Most programs, however, are created and administered independently of one another, thus duplicating efforts, impeding the transfer of knowledge, and severely limiting their cost-saving and public safety benefits. Without a systemic plan that leverages both local and state initiatives, including sufficient collaboration and allocation of resources, criminal justice reforms are likely to have limited impact or may even fail.

To maximize the impact of these changes, indeed to even be able to realize these changes, Ohio must make an equivalent investment at the very outset in quickly and substantively ramping up community-based behavioral health services, including mental health and substance use treatment. Without sufficient resources and coordination for behavioral health services and reentry in the community, the promise of rehabilitation will not be realized and consequently anticipated reductions in incarceration and their attendant costs will not be realized. Now is the time to substantially develop the community-based behavioral health treatment network that is almost an assumption of HB 86. The momentum generated by the justice reinvestment effort, and indeed the success of that effort, is contingent upon a viable network of providers able and willing to address the criminogenic needs of offenders.

The purpose of this document is to lay the foundation for the joint participation and investment of key partners in the development of a community service system with the capacity and expertise to effectively support the statewide justice reinvestment effort and help achieve those promises of rehabilitation, community safety, and relief of state economic burden.

## A Foundation for Action

The following core activities lay the groundwork from which specific policies and practices may emerge.

### 1. Invest and Reinvest in Community Behavioral Health Services for Adults and Youth

- Invest in evidence-based treatment and services in the community that can provide the basis for diversion from incarceration, successful community supervision and effective reentry systems. Jurisdictions that make sufficient investments in these services are likely to experience lower crime rates and lower incarceration rates.
- Provide for sufficient mental health and substance use disorder treatment to meet the existing needs in Ohio's communities as well as the additional demand generated by HB 86.

- Because the youth currently served by the Ohio Department of Youth Services (ODYS) demonstrate high levels of illness severity, specific attention should be paid to increasing the depth of resources available for these youth upon release to the community.

**2. Build on the Foundation of HB 86**

- Divert people with mental illness and substance abuse needs to the public health system and community-based treatment.

- Use the Ohio General Inventory of Services by County along with the associated community plan as the framework for reinvestment of resources.

- Evaluate the efficacy of targeted interventions, holding all parties accountable for implementation and outcomes to ensure that the promise of HB 86 will be realized.

- Identify and evaluate opportunities for achieving statewide economies of scale.

**3. Develop Effective and Coordinated State and Community Partnerships for Diversion and Reentry**

- In full collaboration, the state and community build the framework for community partnerships to reduce county-by-county variations by establishing standardized methods and systems of care that can be applied within unique local contexts, but while maintaining fidelity to the Community Corrections Act model.

- Develop effective and coordinated community partnerships between the criminal justice system and the behavioral health service system, enhancing collaboration among both systems. ODRC, ODYS, ODADAS and ODMH must engage with these partnerships in an ongoing system development effort to achieve the diversionary goals of HB 86 while meeting the behavioral health needs of offenders.

- The County Courts, Probation Departments, Correctional Planning Boards, ADAMHS Boards, and behavioral health service providers, along with local Reentry Councils, serves as one of several possible forums for state/local partnerships that balance criminal justice and behavioral health strategies, establish priority populations for the local service system to guide funding and inform reinvestment strategies and targets.

- Probation, jail reentry, and other community corrections systems/processes can leverage these standards and work collaboratively with designated treatment providers that are utilizing identified evidence-based practices applicable to a criminal justice population.

- Develop community-level partnerships between state and local agencies and organizations to provide meaningful reentry services and recovery-oriented systems of care (ROSC) that include access to a broad array of necessary services and supports.

- Bridge gaps in knowledge, experience and expertise by ensuring that treatment partners and justice partners are involved in cross-training activities, development of information exchange and integration of technology and communication practices designed to make the coordination more effective and efficient.

### 4. Executive, Legislative and Judicial Leadership is Key to Support Necessary Collaboration

- Ohio's interagency collaborative initiatives have demonstrated remarkable success in addressing the issues of mental health and substance use disorders and criminality. Continued support of these working groups and their integration into Ohio's overall strategy is needed.

- Focus on opportunities to pool and leverage existing resources, grant funds and nontraditional funding opportunities to expand interventions.

- Individual agencies and working groups should continue their focus on utilizing evidence-based practices in mental health treatment, substance use disorder treatment, screening/assessment within criminal justice systems, and community supervision strategies. Evidence-based practices that have been identified as essential program elements should be codified and institutionalized.

## Sound Justice Policy = Substantial Cost Savings

There is a persuasive body of evidence that demonstrates that with an effective criminal justice policy, public safety can be improved, crime rates lowered, and incarceration reduced. Research has consistently shown that criminal justice sanctions, combined with substance abuse and mental health treatment, can reduce drug use and related crime. In Ohio, the potential cost-savings associated with investing in community-based treatment are significant.

- The average cost of addiction treatment in the community in Ohio is $1,600, and the average cost of mental health treatment includung two medications is $7,500. This is compared to $25,269 for a year of incarceration in an adult prison. The cost of incarcerating an offender in prison for one day is $69.23 while the cost of parole for one day is only $11.54. By diverting appropriate offenders from prison to treatment, Ohio could drastically decrease the costs associated with incarceration.

- If half as many low-level nonviolent (F4 and F5) offenders were sent to adult prison as are currently committed, the savings would be equivalent to 5,000 fewer inmates per year, resulting in a savings of $126.34 million (based on the $69.23 per day prison cost). If just 40 percent of those savings were reinvested in community-based treatment, net savings would be $75.8 million per year.

- For Ohio's youthful offender population, the FY 2011 institutional per diem was $442.46 per day; the average length of stay for FY 2011 was 7.1 months with an average cost per youth for FY 2011 of $94,243.

HB 86, and the commitment to justice reinvestment it reflected, builds on a series of proactive steps that leadership in Ohio has taken to improve the way it addresses issues of substance use, mental illness and justice. The past several years have seen the creation of many working groups, including the Ex-Offender Reentry Coalition, the Justice Reinvestment Workgroup, the Ohio Interagency Task Force on Mental Health and Juvenile Justice, and the Criminal Justice Diversion and Behavioral Health Workgroup. Each of these groups brings together committed stakeholders and constituencies to collaborate and develop coordinated strategies for better outcomes for justice populations and Ohio communities.

If Ohio is to parallel its justice reinvestment efforts with investment in community behavioral health programming for adults and youth, those efforts will be built on leadership and partnership. The justice reinvestment effort succeeded as a powerful bi-partisan initiative from which sound, strategic policies and legislation emerged, in large part because executive, legislative and judicial leadership were invested in common outcomes of public and community safety. Likewise, it succeeded because public and private partners were engaged in both the analysis and the response, including identifying opportunities to partner at a community level and leverage resources and expertise. Similar dynamics will need to be brought to bear in developing a behavioral health component that supports justice reinvestment in Ohio.

## Capitalizing on Community Behavioral Health for Criminal Justice Reform in Ohio
### - Leveraging State and Local Resources to Achieve Impact and Efficiency

The State of Ohio in recent years has engaged in vigorous criminal justice reforms that encompass research, public policy, and programmatic efforts. The aim of these efforts is to reduce state and local corrections costs, attack the opiate epidemic, and reduce recidivism by engaging community-based programs in treating substance use and mental health problems correlated with repeated criminal justice involvement.

Many of Ohio's investments are yielding promising results that can be expanded and leveraged. Most programs, however, are created and administered independently of one another, thus duplicating efforts, impeding the transfer of knowledge, and severely limiting their cost-saving and public safety benefits. Without a systemic plan that leverages both local and state initiatives, including sufficient collaboration and allocation of resources, criminal justice reforms are likely to have limited impact or may even fail.

The 2011 passage of major sentencing reform in HB 86 creates the overarching framework for integrating efforts at both the state and county levels. To achieve the intended cost savings, efficiencies and impact, existing efforts at state and local levels must be coordinated and aligned to mutually beneficial outcomes.

The purpose of this document is to lay the foundation for the joint participation and investment of key partners in the development of a community service system with the capacity and expertise to effectively support the statewide justice reinvestment effort and help achieve those promises of rehabilitation, community safety, and relief of state economic burden. The document includes an overview of the current justice crisis from the perspective of behavioral health treatment, both in clinical effectiveness and cost effectiveness. It then describes the assets Ohio currently possesses: the building blocks of programs and practices that can be expanded and leveraged. Finally, it presents action areas for consideration by executive and legislative leaders in Ohio.

## The Groundwork for Reform in Ohio

In 2008, executive and legislative leadership in Ohio requested technical assistance from the Council of State Governments (CSG) Justice Center to use a data-driven justice reinvestment approach to develop a statewide policy framework designed to reduce spending on corrections and reinvest in strategies to increase public safety. This initiative was prompted by many converging dynamics, including: a) an overall increase in the number of offenders supervised by state and local justice systems, b) Ohio prisons operating significantly above capacity, c) an outbreak of opiate-related cases, d) the financial burden of maintaining and supervising these populations in ever-increasing numbers, particularly given, e) national and state fiscal crises.

The work of the CSG Justice Center involved a bipartisan, inter-system working group and the collection and analysis of state criminal justice, mental health and substance abuse data, drawing on information systems maintained by the Ohio Department of Rehabilitation and Correction (ODRC), the Ohio Department of Mental Health (ODMH), the Ohio Department of Alcohol and Drug Addiction Services (ODADAS), the Ohio Supreme Court, and county probation departments—as well as FBI Uniform Crime Reports.

The outcome of this activity was the February 2011 publication of a policy framework by CSG including 13 specific policy and legislative recommendations. As a direct result, the Ohio legislature passed, and Governor Kasich signed into law, a sweeping prison reform bill (HB 86) in June 2011. The central policy construct of this bill was the diversion of non-violent, low-level offenders out of the prison system and into community supervision.

## The Role of Behavioral Health in the New Policy Framework

One of the key findings of the CSG analysis was as follows:

“Property and drug offenders in Ohio cycle through a costly ‘revolving door’: they are sentenced to state prison for a short time and are subsequently released to the community with no supervision.” [1]

In support of this finding, CSG presented the following statistics:

- In 2008, more than 10,000 fourth and fifth degree (F4 and F5) felony property and drug offenders were sentenced to state prison. There, they served an average of nine months at a cost of $189 million.
- After serving their sentences in state prison, where few received treatment for their addictions or services to assist with behavior change, 72 percent of these property and drug offenders returned to the community with no post-release community supervision.
- Short periods of incarceration without treatment or supervision upon release back to the community provides little to no public safety benefit while producing sizeable costs to taxpayers. [2]

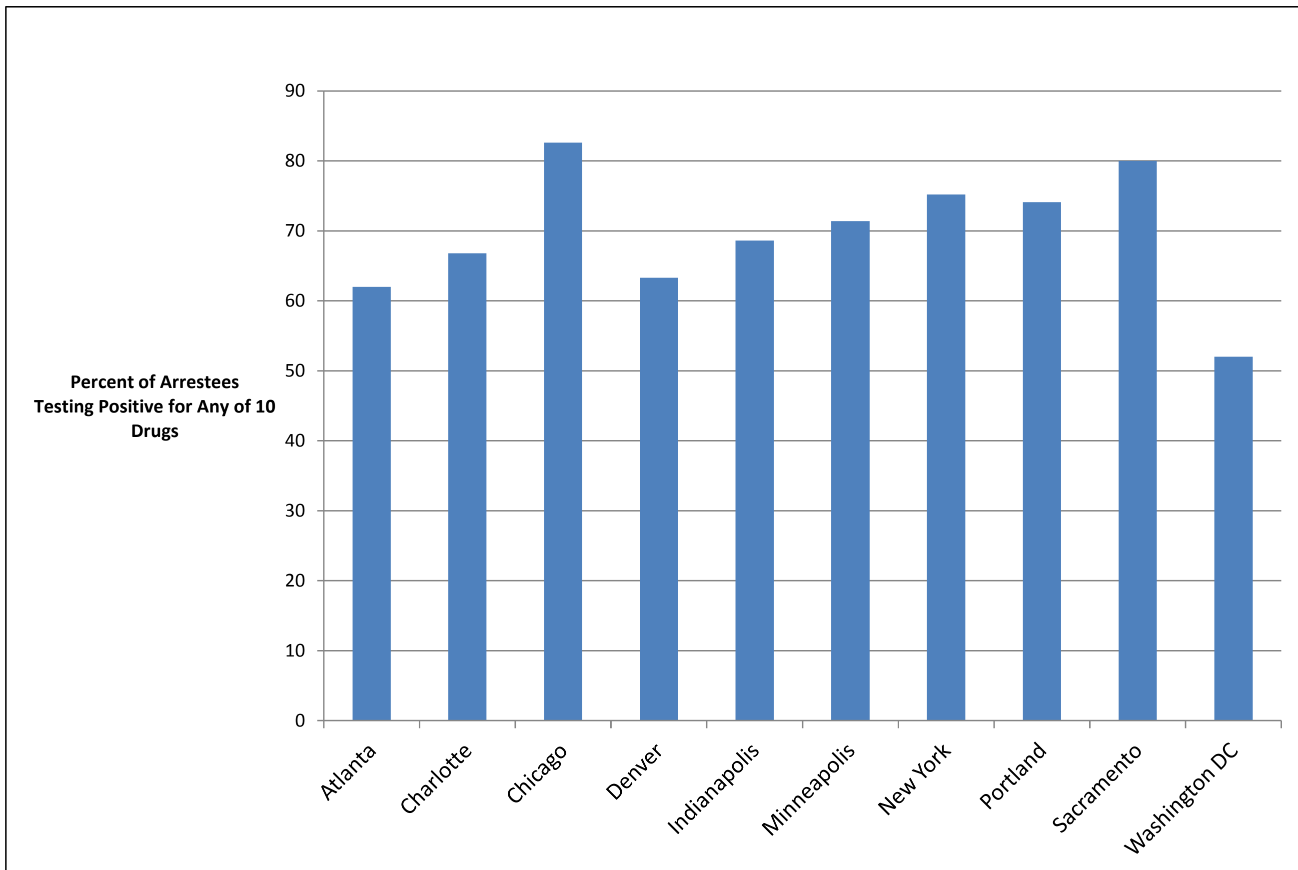
Clearly these findings were under consideration in the development and passage of HB 86. However, a key factor missing from both the CSG recommendations and HB86 is an investment in the full development to scale of a community-based behavioral health service delivery system capable of effectively serving and managing what will be a sizable, newly-divertible supervised population in addition to post-release and other community corrections populations.

The intention of the policy and systems changes described in the CSG report and promoted in HB 86 is to improve public safety, enhance community supervision of offenders and reduce public expenditures for incarceration. To maximize the impact of these changes, indeed to even be able to realize these changes, Ohio must make an equivalent investment at the very outset to quickly and substantively ramp up community services. Some of these reinvestment efforts are already underway. F4 and F5 admissions to ODRC are dropping, and the state’s budget strategy reflects some level of anticipated reductions in the ODRC budget and reciprocal increases in community services. However, without sufficient system-level resources and coordination for services and reentry in the community, the full promise of rehabilitation will not be realized.

## Criminal Justice Costs and Consequences of Behavioral Health Problems

Criminal behavior is often intertwined with substance use disorders. Those who use illicit drugs may be prosecuted for possessing, using, or distributing drugs and drug paraphernalia (including syringes). Some people commit crimes to obtain drugs or money to buy drugs, and many are under the influence of drugs when they commit crimes. In addition, in the past decade, the prevalence of mental illness among justice populations has come alongside substance use disorders as a major contributing factor in the growth of justice populations. The concept of co-occurring disorders, or co-morbidity, has been a driving factor in shaping certain funding and public policy initiatives.

## Percent of Arrestees Testing Positive for Any of 10 Drugs




Currently in Ohio, one out of every 25 adults is under correctional supervision, costing Ohio taxpayers $1.79 billion a year. The incarcerated population currently (as of October 2011) stands at 50,572 adults, far exceeding the statewide prison capacity of 38,196. According to a recent analysis (using data from 2005-2007), the statewide prison population experienced a 14% overall increase in these three years alone. If these admission and release patterns continue, projections place the statewide prison population at 58,000 by 2018, or 52% over capacity. [3]

In Ohio, it costs approximately $25,000 to incarcerate an adult for a year, and approximately $86,000 to confine a juvenile. Between FY 2000 and FY 2008, the Ohio Department of Rehabilitation and Correction (ODRC) budget climbed 18%, an increase of approximately $239 million. [4] Overall, Ohio spends 7.3% of its budget on corrections, slightly higher than the national average of 6.7%. [5] These figures do not account for other criminal justice-related costs, such as enforcement, prosecution, court or jail costs, or the costs to the victims or communities as a result of crime. [6]

Ohio's prison growth has been accelerated by lower level, non-violent drug offenders and probation violators.[7] This trend has been fueled by a significant increase in opiate dependence over the past decade. And while drug crimes represent the most common type of commitment offense, they do not represent the extent of the problem. Substance use disorders are widespread among criminal justice populations, for drug offenses and non-drug offenses alike. A profile of almost 3,300 inmates entering the Ohio prison system in 2004 found that 86.6% of males and 85.7% of females had a history of drug abuse. Furthermore, 63.2% of males and 52.3% of females had a history of alcohol abuse. 8 In 2011, ODADAS reported that 70 to 80 percent of all ODRC offenders had a history of substance abuse, with 60 percent of that number having a moderate to high risk screening score.

The rate of substance abuse or dependence among adult offenders on probation or parole supervision is more than four times that of the general population (38.5% vs. 9%). [9]

**8 in 10 People in Ohio Prisons Have a History of Substance Abuse**

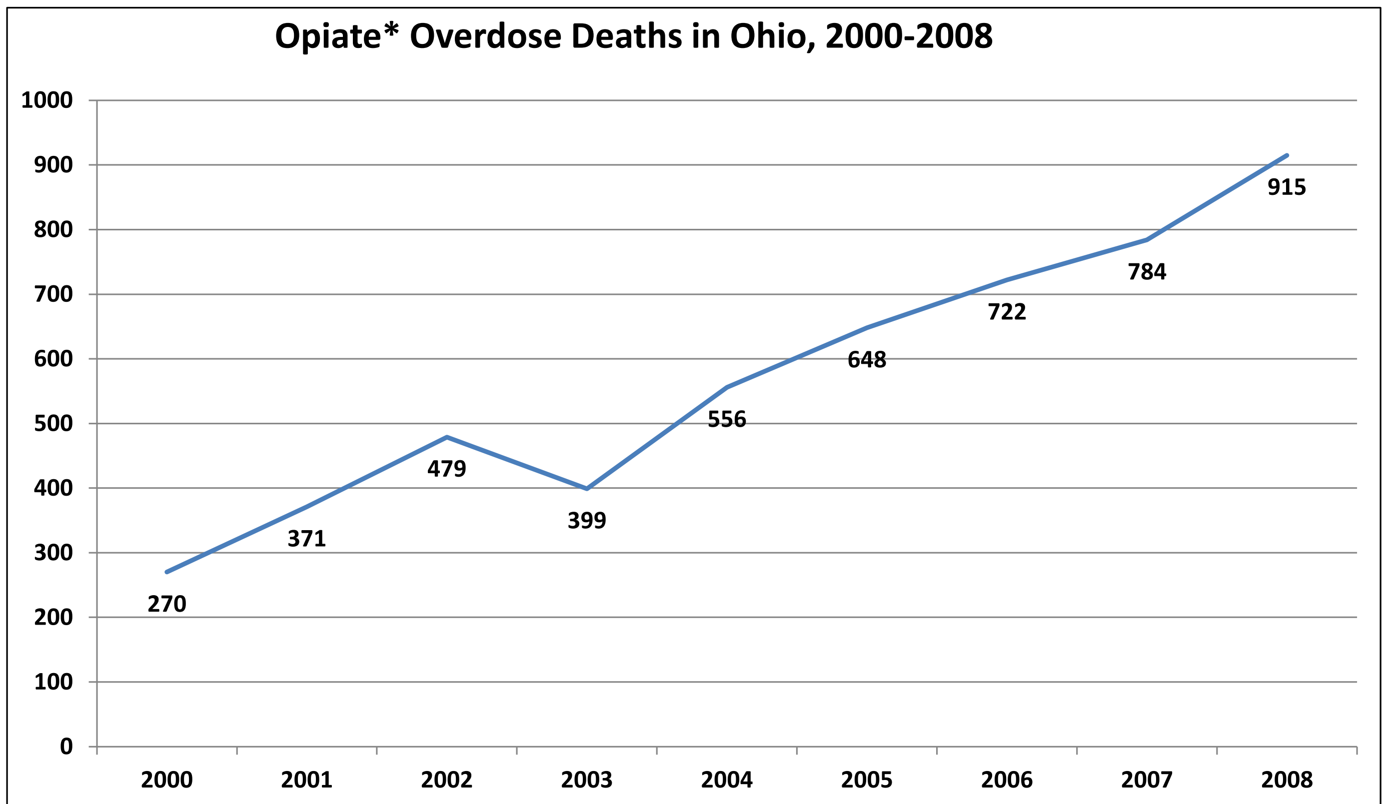
Likewise, while the general population of Ohio's state prisons increased 43% between 1990 and 1996, the population of state prisoners with mental illness went up by an astounding 225% during that same period. As of October 2005, Ohio was treating 8,371 mentally ill prisoners at a cost of about $67 million a year. [10] In 2011 the percentage of offenders with a Severe and Persistent Mental Illness is approximately 9 percent of the prison population, and 18 percent of offenders are receiving mental health services for a diagnosable mental health condition according to the Ohio Department of Mental Health (ODMH).

## Progress and Challenges in Ohio's Youth System

Over the past decade, the Ohio Department of Youth Services (ODYS) undertook major systems redesign consistent with, although unrelated to, the justice reinvestment principles supported in HB 86. ODYS reduced its average daily census by nearly 60 percent over the past 10 years, from 2,100 in 2000 to 685 in 2011. This major reduction in daily population was accomplished through extensive use of structured screening, assessment and diversion from incarceration programs. [11] The success of these initiatives provides clear evidence of effective systems transformation.

At the same time, the smaller numbers of youth who are held in custody are generally those with more serious underlying mental health, substance abuse and behavioral challenges. Today, 76 percent of these youth are diagnosed with substance use disorders, and 53 percent present with a mental illness diagnosis. Like ODRC, ODYS sees significant gaps in transitional and community programs for its supervised population.[12]

The current body of research supports the effectiveness of keeping youth in their communities and out of congregate facilities as part of their case plans. Consistent with this research, ODYS is implementing, in collaboration with its numerous community partners, a comprehensive community-based service delivery system that is designed to provide appropriate services and supports for youth by matching risk level with the least restrictive program setting. This is being achieved by expanding community program capacity to provide services for youth and engage families through increased support for assessment and program delivery.




***Opiates group includes heroin, other opioids, methadone, other synthetic narcotics, other narcotics and psychodysleptics**
**Source: Ohio Department of Health: Center for Public Health Statistics and Informatics**

## Opiates in Ohio

Ohio is facing a surge in opiate-related public health and public safety concerns:

- From 2000-2008, there was more than a 300% increase in overdose deaths where opiates were listed on death certificates. [13]
- Prescription painkillers accounted for nearly 37% of unintentional overdose deaths in 2008. [14]
- Opiate abuse has significantly increased criminal justice system costs. In just one county in Ohio, annual jail days nearly doubled between 2003-2008, with most of the increase coming from arrests related to opiate abuse. [15]

In 2011, a Leadership Summit, as part of a statewide Opiate Summit, was sponsored to bring together key stakeholders in the state to address how to handle the issue of opiate addiction in Ohio. Based upon the discussions during that summit, the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) synthesized the data and other findings into "A Plan for Attacking Ohio's Opiate Epidemic." This action plan takes a comprehensive view of how best to tackle the opiate epidemic, and includes nine major action areas and strategies for implementation including both public safety and public health strategies such as collaboration with the judiciary and providing needed treatment. (See Appendix A). Integration of these efforts within the overall strategy of HB 86 implementation will enhance the impact of both initiatives.

## Building on Research: Using Public Policy to Shape Criminal Justice Reform

There is a persuasive body of evidence that demonstrates that with an effective criminal justice policy, public safety can be improved, crime rates lowered, and incarceration reduced.[16] Research has consistently shown that criminal justice sanctions, combined with substance abuse and mental health treatment, can reduce drug use and related crime.[17]

Over-incarceration has a devastating effect on American communities, with its impact concentrated in poor and usually minority communities. The mere circumstance of justice involvement enhances and perpetuates many of the conditions that prompted criminal behavior in the first place, even in cases where community supervision is selected as the sentence over incarceration. In many states, felony convictions – even at the lowest level, and even if they result in less than a year of incarceration or supervision – act ostensibly as additional punishment, often serving as a bar to employment in certain professions, or preventing an individual from seeking a loan or pursuing a degree. Whether returning offenders become taxpayers or tax burdens is largely dependent on their ability to find productive employment, stable housing, and links to vital community services.[18] Indeed, our justice processes, which seek rehabilitation and community stability, often have the unintended opposite effect of making rehabilitation and community stability nearly impossible.

A recent Department of Justice study confirms these assertions. Researchers found that if first-time arrestees remained "arrest-free" for three to eight years, they were no more likely to be arrested in the future than individuals who had never been arrested. Statistically speaking, they had been "rehabilitated."[19] Conversely, research also shows that spending more on prisons does not result in greater public safety outcomes. [20]

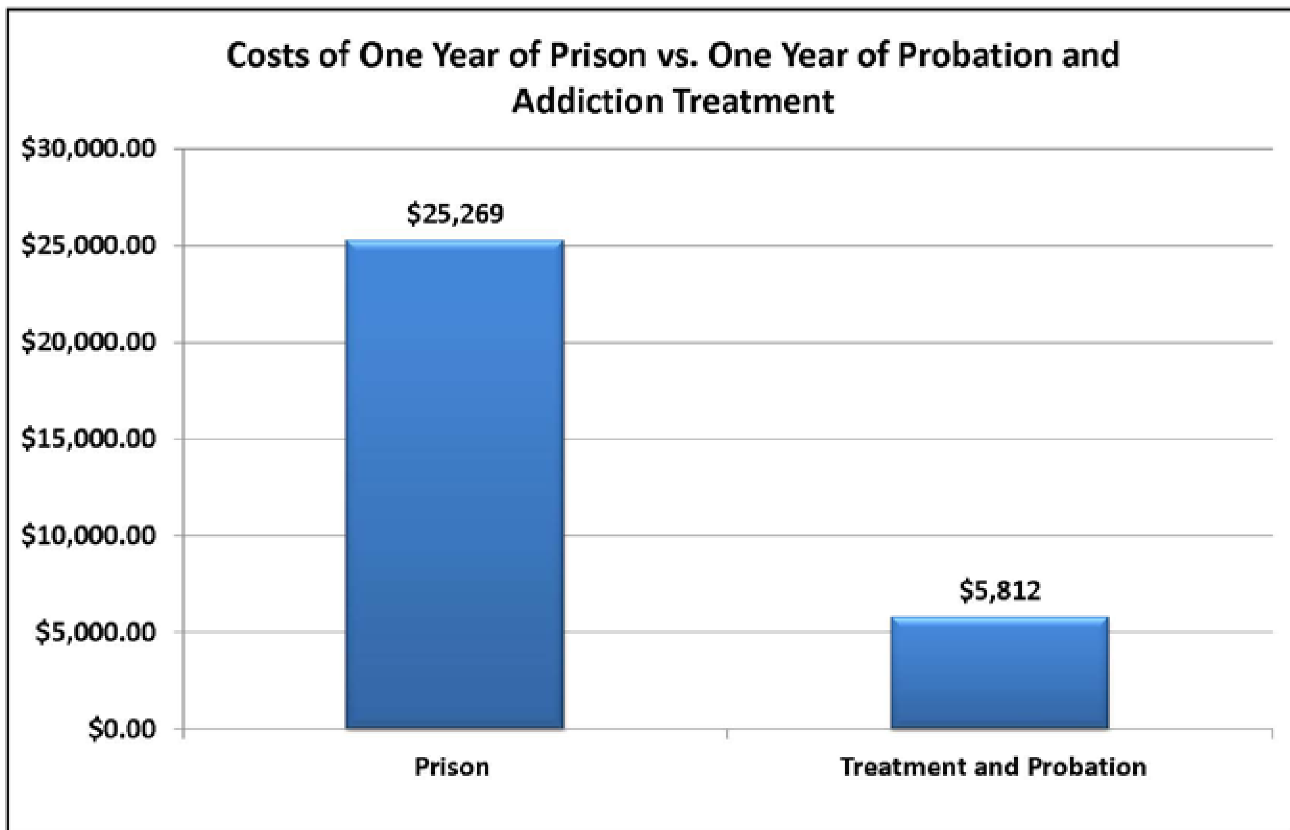
As justice populations (and, by extension, county and state justice budgets) have exploded, and as the science of treatment and recovery have advanced, policymakers are increasingly viewing substance use and mental health problems as public health issues with significant public safety and cost implications.

## Treatment Alternatives as a Public Policy Tool

Research consistently finds that criminal justice offenders (both adults and youth) who receive appropriate community-based treatment are less likely to have multiple incarcerations, to turn over their children to foster care, or to have continual medical/mental health crises. The "hidden costs" associated with crime-related substance abuse and mental health issues include: avoidable emergency room visits, increased police and court prosecution activity, expanded demand for foster care when parents are incarcerated or unable to care for their children, loss of economic productivity and increased insurance premiums. In fact, the existing quantitative studies detailing the economic impact of corrections-based substance abuse treatment suggest that the economic benefits of treatment derived from reduced criminal activity, reduced medical costs, reduced prison management costs, and increased employment earnings offset the cost of treatment. [21]

Some Ohio-specific statistics are illustrative in demonstrating the potential cost-savings associated with investing in community-based treatment.

- The average cost of addiction treatment in the community in Ohio is $1,600, and the average cost of mental health treatment includung two medications is $7,500. This is compared to $25,269 for a year of incarceration in prison. The cost of incarcerating an offender in prison for one day is $69.23 while the cost of parole for one day is only $11.54. By diverting appropriate offenders from prison to treatment, Ohio could drastically decrease the costs associated with incarceration.




- If half as many low-level non-violent (F4 and F5) offenders were sent to prison as are currently committed, the resulting savings would be equivalent to 5,000 fewer inmates per year, resulting in a savings of $126.34 million (based on the $69.23 per day prison cost). If just 40 percent of those savings were reinvested in community-based treatment, net savings would be $75.8 million per year.[24]

- A 2007 Kent State University study found that the Ohio mental health courts examined were effective in reducing re-incarceration among participants as compared with a control group of similar mentally ill offenders who did not go through a mental health court. [25]

Of course, the math of state budgeting and the circumstances and nuances of the target population of offenders are rarely so straightforward. The reality with corrections costs and corrections savings is that systems-level savings only occur in corrections if an entire facility, or part of a facility, is closed. While it remains open, even if one category of offenders is diverted into the community, the beds are likely to remain filled with other categories of offenders. On a year-to-year basis, the state may only realize marginal cost savings by diverting certain individuals. However, on a long-term basis, when issues such as intervention effectiveness, recidivism, rehabilitation, public safety and ongoing public burden are factored into the discussion, the savings per offender are clear.

## Current Initiatives and Remaining Gaps

HB 86, and the commitment to justice reinvestment it reflected, builds on a series of proactive steps that leadership in Ohio has taken to improve the way it addresses issues of substance use, mental illness and justice. The past several years have seen the creation of many working groups, including the Ex-Offender Reentry

Coalition, the Justice Reinvestment Workgroup, the Ohio Interagency Task Force on Mental Health and Juvenile Justice, the Attorney General's Task Force on Criminal Justice and Mental Illness, and the Criminal Justice Diversion and Behavioral Health Workgroup. Each of these groups brings together committed stakeholders and constituencies to collaborate and develop coordinated strategies for better outcomes for justice populations.

Each of these efforts, and the stakeholders that participate in them, are important and necessary building blocks. However, a truly systemic response requires that policymakers in Ohio leverage the collective resources, learnings, efforts and activities of these groups and the systems and stakeholders they represent. Too often even the best-designed programs operate in isolation, or with such a narrow focus as to not fully realize the potential for broad-scale positive change. Effective leveraging of savings and reinvestment from sound public safety and public health policy requires the cooperation of multiple governmental bodies and community organizations. When stakeholder systems work independently without a collective knowledge base or unifying strategy that seeks the best possible outcome for the individual and the community, the likely outcomes are disconnected activities with duplication of some efforts and gaps in important areas of action.

This is a common challenge presented by state and county criminal justice "systems" where the independent agencies operate under different statutes, mandates, priorities, authorities and funding streams. This challenge is further complicated in states like Ohio, where the benefits of local control of justice processes via the Community Correction Act may be offset by lost economies of scale that can be achieved through statewide standards, common practices, centralized information management or oversight of certain activities. Layer the clinical nature of treatment for substance use or mental illness on top of an already disconnected process, and the result is often duplication of effort, gaps in services resulting in clinical setbacks, absence of long-term planning, lack of efficiency, and ultimately reduced prospects for long-term stability.

In order to build upon the good work already underway, now is the time to substantially develop the community-based behavioral health treatment network that is almost an a priori assumption of HB 86. The momentum generated by the justice reinvestment effort is contingent upon a viable network of providers able and willing to address the criminogenic needs of offenders.

## Key State Agencies, Initiatives, and Partners

Below is a summary of each of the stakeholder systems, as well as some key programs, practices and inter-agency initiatives that should serve as building blocks to a statewide effort.

### *State Agencies*

**Ohio Department of Rehabilitation and Correction (ODRC).** With an FY11 budget of $1.76 billion, the ODRC operates 30 institutions statewide, with a current incarcerated population of 50,334, and supervised parole population of 27,613. Seventy to eighty percent of ODRC's population has a history of substance abuse; sixty percent have a moderate to high risk screening score. ODRC provided substance use disorder treatment to 3,975 inmates in FY 2011, and ancillary support programs such as alcohol and other drug education and support groups to 11,250 inmates. Approximately 18 percent of inmates receive mental health treatment within ODRC, with 9 percent meeting criteria for serious mental illness.[26] ODRC also faces a shortage of community treatment resources for releasees with substance use and psychiatric disorders.

**Ohio Department of Youth Services (ODYS).** With an FY12 allocated budget of $252.6 million, ODYS operates five facilities statewide, in addition to 12 community correctional facilities. The current population includes

685 incarcerated youth and 726 youth on community supervision. This represents a substantial reduction from an average daily population of 2,100 in 2000. This major reduction in daily population was accomplished through extensive use of structured screening, assessment and diversion from incarceration programs. [27]

The youth who are held in custody today are generally those with more serious underlying mental health, substance abuse and behavioral challenges. Today, 76 percent of these youth demonstrate substance use disorders (61 percent severe), and 53 percent with a mental illness diagnosis. ODYS experiences similar gaps to ODRC in transitional and community programs for its supervised population. [28]

**Ohio Department of Alcohol and Drug Addiction Services (ODADAS).** With an SFY 2011 operating budget of $217.1 million, ODADAS oversees and funds an array of services and initiatives for prevention, treatment and recovery support services. ODADAS-certified providers served 100,490 clients in 2011, 25 percent of whom were referred from the corrections system. ODADAS is experiencing a significant gap in meeting demand, particularly for treatment of drug-involved offenders, where the demand outstrips available services for non-Medicaid clients.[29] Over the past several years, there have been reductions in the ODADAS budget for prevention and treatment services. The Department is working to maximize efficiencies for effective treatment to ensure that resources reach as many youth and adults who need care as possible.

With regard to Ohioans with opiate addiction, ODADAS has issued a "Low Dose Protocol for Buprenorphine and Suboxone" to begin to standardize care for opiate addiction with the use of behavioral therapy combined with medication-assisted treatments (MAT). Over the next year, the Department will issue additional guidelines for MAT with other FDA-approved medications.

**Ohio Department of Mental Health (ODMH).** ODMH operates six regional psychiatric hospitals that have a total capacity of 1,100 inpatient beds. Additionally, the Department funds and monitors community mental health programs, in part, through 50 county-level boards. These boards, which in most cases oversee both mental health and addiction services, contract with more than 400 local agencies to provide services to approximately 350,000 clients (adults and children) with mental health needs each year. ODMH is also responsible for regulatory oversight of community mental health agencies, private psychiatric hospital inpatient units and various residential options for people with disabilities. Funding for community mental health services comes from federal, state and local sources. [30]

Investments in treatment for mental illness and supports for recovery are cost effective and result in positive outcomes equal to those achieved in physical health. Economic realities require ODMH to stretch those investments as far as possible to meet a growing demand for services in all sectors of our population. It is anticipated that the need for all levels of care will increase with more offenders (both adult and youth) exiting ODRC/ODYS or being diverted from prison into community programming. The Department recently awarded "mini-grants" to 14 counties for reentry support services for people with serious mental illness. In total, these grants are expected to serve 350 releasees. [31]

**Ohio Department of Public Safety.** The Ohio Department of Public Safety serves and protects the safety and security of Ohioans through several divisions: Ohio State Highway Patrol, Ohio Bureau of Motor Vehicles, Ohio Emergency Management Agency, Emergency Medical Services, Ohio Office of Criminal Justice Services, Ohio Homeland Security, Ohio Investigative Unit and Administration.

**Supreme Court of Ohio.** The Supreme Court of Ohio, acting through the Chief Justice and the Justices of the Court, possesses constitutional and statutory authority to exercise general powers of superintendence over the courts of the state. This includes responsibility for providing leadership for the judicial branch of Ohio

government. The administrative staff of the Supreme Court supports these efforts by performing numerous administrative functions.

**Ohio Rehabilitation Services Commission.** Independence for Ohioans with physical or mental disabilities is the mission that unites all aspects of the Ohio Rehabilitation Services Commission (RSC). RSC works with partners in business, education and non-profits to facilitate customized employment plans for Ohioans with disabilities. RSC also works with Ohio's behavioral health system of care to provide funding for mental health and addiction care and for vocational rehabilitation services to help Ohioans become employed. This project is called Recovery to Work.

### *Interagency Initiatives*

**Justice Reinvestment Project.** The Justice Reinvestment Project involved the development of a statewide policy framework to reduce spending on corrections and reinvest in strategies to increase public safety. Policymakers, experts, and stakeholders worked together through three phases of activity: 1) Analyze data and develop policy options; 2) Adopt new policies and put reinvestment strategies into place; and 3) Measure performance.

In December 2008, the Ohio General Assembly passed a historic piece of reentry legislation, House Bill 130. HB130 offers a framework for a long-term investment in the state's economy by addressing legal and other barriers to employment for people released from prison. A key component of the bill is the removal of non-relevant prohibitions or collateral sanctions to employment. The legislation calls for the formation of an Ex-Offender Reentry Coalition.

**Ex-Offender Reentry Coalition.** The Ex-Offender Reentry Coalition is serving as a guiding hub for expanding and improving reentry efforts across state and local agencies and communities. The Coalition's overriding goals are to: reintegrate offenders into society, reduce recidivism, and maintain public safety. The membership of the Reentry Coalition is comprised of both statutory and at-large members.

Additionally, representatives from community-based organizations, service providers, local governments, and individuals interested or involved in the reentry of offenders are invited to participate in Coalition meetings and are consulted by the Reentry Coalition during the course of its work. The Director of the Ohio Department of Rehabilitation and Correction or the Director's designee serves as the Chairperson of the Ohio Ex-Offender Reentry Coalition.

**Opiate Action Team.** The Governor's Cabinet Opiate Action Team is a cabinet director-led workgroup assembled for this mission: To attack the opiate epidemic on behalf of Ohioans to end opiate abuse by reforming prescribing practices for appropriate pain management, punishing those involved in illegal activity, and treating those who are addicted to enable them to return to productive lives. The committees acting under the Opiate Action Team are Professional Education, Treatment, Enforcement, Public Education and Recovery Supports. In addition, the state is moving forward on expanding treatment options for Ohioans with opiate addiction through medication-assisted treatment.

On the prevention and education side, ODADAS and stakeholder partner the Ohio Association of County Behavioral Health Authorities, have created ten new Community Opiate Task Forces covering 23 counties. The two organizations also partnered to develop and launch a new public education campaign called Don't Get Me Started that features personal testimonial videos, a Facebook page, and a number of messaging activities directed at a 14-29 year-old audience. The campaign's website is at www.dontgetmestartedohio.org.

To build a network of grief support and family engagement groups, ODADAS has enlisted the Drug-Free Action Alliance and Jo Anna Krohn, founder of SOLACE, which stands for Surviving Our Loss and Continuing Everyday. SOLACE was started after Ms. Krohn's son Wes died from an accidental gunshot while high on opiate painkillers. The SOLACE movement is offering a supportive community for people who have lost loved ones and for those who have addiction issues among their families and friends. Through SOLACE, vital prevention and education information is being shared with local families so that parents and caregivers can recognize the signs of addiction and relapse and know how to get help for their loved ones.

**Ohio Interagency Task Force on Mental Health and Juvenile Justice.** House Bill 86 also focused on improving the juvenile justice system in Ohio. One provision creates an Interagency Task Force on Mental Health and Juvenile Justice to address the challenges of delinquent youth who "suffer from serious mental illness or emotional and behavioral disorders." The six month Task Force has representation from the state Supreme Court, the Governor's office, the House, the Senate, ODYS, ODMH, juvenile judges, public defenders, prosecutors, academic institutions and numerous other experts, such as the National Alliance on Mental Illness (NAMI). It must submit a report with findings and recommendations to the legislature by March 31, 2012.

**Attorney General's Task Force on Criminal Justice and Mental Illness.** This Task Force evolved from the former Advisory Committee on Mental Illness and the Courts (ACMIC), originally founded in 2001 to develop solutions for the revolving door issue of persons with mental illness trapped in the criminal justice system. The group helped establish 37 mental health courts, promoted the training of 4,580 Crisis Intervention Team (CIT) law enforcement officers in 76 of 88 counties, recommended changes to Medicaid, and advocated for a new Juvenile Competency statute.

**Criminal Justice Diversion and Behavioral Health Workgroup.** This workgroup was established as a result of the justice reinvestment efforts and inter-agency collaborations that developed as a part of HB 86. The mission of this workgroup is to substantially reduce relapse from addiction and mental illness and reduce incarceration and recidivism throughout Ohio with creation of a cross-departmental and local evidence-based systems of care/services. Agencies participating include: the Department of Rehabilitation and Correction, the Department of Mental Health, the Department of Youth Services, the Department of Alcohol and Drug Addiction Services, the State Supreme Court, various service and advocacy agencies.

Additionally, the Ohio Department of Mental Health (ODMH) collaborates with its constituencies to develop policies, propose programs, assist with legislation and provide consultation, education and training in the following areas:

Reentry Services – ODMH works collaboratively with the Ohio Department of Rehabilitation and Correction, Office of Criminal Justice Services, Supreme Court of Ohio and other agencies to support reentry services in the areas of housing, benefits, treatment, forensic peer specialists, employment, trauma-informed care and medication provision for people leaving jails, prisons and regional psychiatric hospitals in a forensic status.

Diversion Alternatives – ODMH provides technical assistance to local collaborative efforts focused on diverting people with mental illness from the criminal justice system and decreasing jail days. ODMH funds the Criminal Justice Coordinating Center of Excellence which promotes the Memphis model Crisis Intervention Team approach to diversion as well as the development of mental health courts.

**Health Home Model.** Under the Affordable Care Act, a health home provision has been authorized that provides the opportunity for states to build a person-centered care system that results in improved outcomes for beneficiaries and better services and value for State Medicaid and other programs, including mental health and substance abuse agencies. A health home is a provider or a team of health care professionals that provide inte-

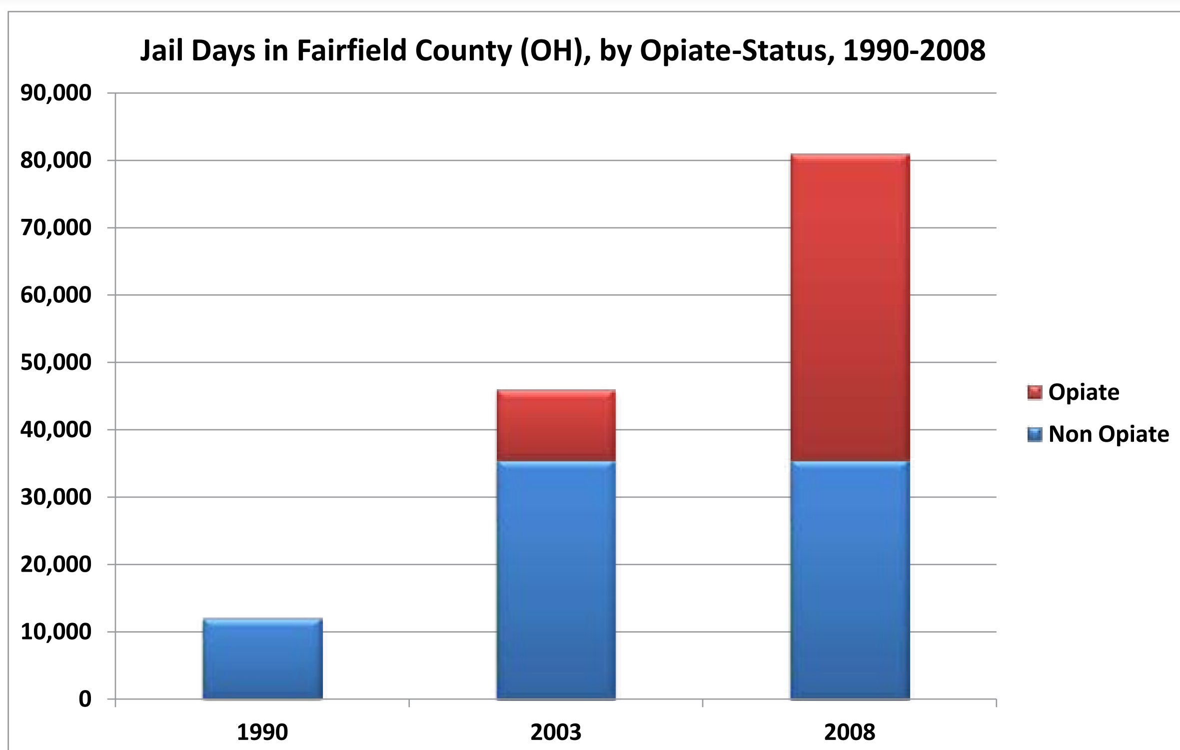
grated health care, from a primary care doctor to behavioral health. The whole team shares the same information and coordinates treatment based on that information. Health homes operate under a "whole-person" philosophy, providing linkages to long-term community care services and supports, social services and family services. The integration of primary care and behavioral health services is critical to achievement of enhanced outcomes. The health home model is consistent with the Recovery Oriented System of Care (ROSC) model, common in many reentry and justice reintegration programs for youth and adults.

**Criminal Justice Best Practices Website.** Ohio is developing a website directory modeled on the Office of Justice Program's *crimesolutions.gov* site for identifying and understanding appropriate evidence-based practices for given populations and goals. The site is currently under construction.

**SNAPSHOT:**

**Fairfield County, Ohio.** In Fairfield County, 85 percent of theft-related crime is fueled by opiate dependence, and opiate use has become epidemic. Faced with this multidimensional challenge, the Fairfield County Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board partnered with law enforcement, criminal justice, and community treatment agencies to look for viable solutions. In January, 2007, the ADAMHS Board allocated funds for a one-year pilot program to administer Suboxone to 20 people with opiate addiction. The program proved to be so successful that it was expanded the next year. In addition, the county received grants from the U.S. Department of Justice to start adult and family drug court programs. Most of the people admitted to the Suboxone program were referred from those drug courts.

In its first three years alone, the drug court (Fresh Start) saved the county more than $1 million in suspended jail time. Those diverted to the program have also saved the county thousands of dollars in public defender fees, jail medical expenses, and theft-related crime. Of the drug court participants who took Suboxone, 77 percent maintained their sobriety for six months or more, compared with 23 percent who tried abstinence-based treatment alone.



*County and Community Partners*

**County Courts and Probation.** Each of Ohio's 88 counties maintains a court system, including the General Division of the Court of Common Pleas, which hears criminal cases. Sentencing can include a term of probation or in the state correctional system. In some counties, probation supervision is provided through the county; in others it is provided in full or in part by the Adult Parole Authority.

**Specialized Court Dockets.** The development of specialized court dockets has been an evolving process over the past 20 years. In the summer of 1992, Chief Justice Thomas Moyer began working with the Director of the Ohio Department of Alcohol and Drug Addiction Services to integrate alcohol and drug addiction treatment services into the criminal justice system. Formal evaluations have been conducted by University of Cincinnati, Wright State University, and Youngstown State University on the efficacy of specialty drug courts in Ohio. The overwhelming success of these programs in reducing recidivism in Ohio has been validated. Common Pleas Courts showed a 19 percent reduction in re-arrest rates two years from graduation.

In Ohio, there are currently 40 adult drug court programs, 28 juvenile drug courts, 19 family drug courts, and 33 mental health courts. Other specialty courts include: Family Court, Domestic Violence Court, Reentry Court, Veterans Court, Juvenile Court, Sex Offender Court, Child Support Enforcement Court, and OVI/DUI Court.[32]

**ADAMHS Boards.** The Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards are county-based Boards responsible for the planning, funding and monitoring of public mental health and alcohol and other drug addiction services delivered to the residents of specific Ohio counties. ADAMHS Boards do not provide services directly to consumers and clients, but contract with provider agencies to deliver services that assist consumers and clients on the road to recovery. They are financed through a combination of federal, state, and county grants and general revenue funds. The Boards are served by their member organization, the Ohio Association of County Behavioral Health Authorities.

**TASC.** Treatment Alternatives to Street Crime (TASC) serves as a bridge between criminal justice system and the treatment community for eligible defendants. A program model developed by the White House in 1972, TASC provides juveniles and adults with an opportunity to receive community-based treatment as an alternative or supplement to more costly legal sanctions and procedures. Drug abstinence, employment and social personal functioning are monitored closely to hold the offender accountable and support positive reintegration into the community. TASC programs work in partnership with the courts and probation.

There are 17 TASC programs in 13 Ohio counties providing a variety of services to both adult and youthful offenders both at the county and state level. Ohio's TASC program serves the following counties: Athens, Butler, Clermont, Cuyahoga, Gallia, Hamilton, Lucas, Mahoning, Montgomery, Preble, Sandusky, Stark, and Warren.

**Ohio Addiction Prevention, Treatment and Mental Health Service Providers.** Ohio's publicly-funded behavioral health services system reaches approximately 350,000 Ohioans each year through a network of about 600 community-based agencies. The provider agencies are supported by two member organizations: the Ohio Council of Behavioral Health & Family Services Providers and the Ohio Alliance of Recovery Providers.

**Community-Based Correctional Facilities.** CBCFs in Ohio refers to a system of specific facilities that provide residential and non-residential services to a convicted offender. These facilities receive state funds and are based in and operated by local communities. These programs provide an intermediate sanction at the front end of the system between probation and prison, called diversion, and re-integration services at the tail end of the system between prison and parole, called transition. The three types of agencies/services include: Community

Correction Act (CCA) programs, Community Based Correctional Facilities (CBCFs), and Community Residential Services.

In SFY 2009, 7,108 offenders were admitted to state-contract half-way house programs, 2,332 of which were Transitional Control participants.

- 33% of offenders were under Transitional Control supervision
- 31% of offenders were under Parole/Post-Release Control supervision
- 36% of offenders were under Court of Common Pleas supervision

In SFY 2009, there were 23 Halfway Houses serving 7,108 offenders for an average length of stay of 92 days and at a cost per day of $60.96. There were 18 Community-Based Correctional Facilities serving 5,749 offenders at an average length of stay of 124 days and a cost per day of $80.10.

**Community Reentry Coalitions.** In Ohio, there are a number of county specific reentry coalitions whose main focus is the successful reentry of offenders to the community. Often, these coalitions are a group of nonprofits, social services, businesses, citizens, and faith-based partners who are committed to reducing recidivism among former offenders by sharing ideas, expertise and resources.

## A Framework for Action

If Ohio is to parallel its justice reinvestment efforts with investment in community behavioral health programming for adults and youth, those efforts will be built on leadership and partnership. The justice reinvestment effort succeeded as a powerful bi-partisan initiative from which sound, strategic policies and legislation emerged, in large part because executive, legislative and judicial leadership were invested in common outcomes of public and community safety. Likewise, it succeeded because public and private partners were engaged in both the analysis and the response, including identifying opportunities to partner at a community level and leverage resources and expertise. Similar dynamics will need to be brought to bear in developing a behavioral health component that supports justice reinvestment in Ohio.

*Guiding Principles*

A statewide strategy must be guided by core principles that focus activities and ensure their alignment with the goal of improving public safety while improving the individual prospects for offenders with behavioral health concerns. Those core principles are as follows:

**The criminal justice system presents multiple opportunities for intervention.** Each phase of justice involvement - arrest, jail, arraignment, sentencing, probation, incarceration and release – represents an opportunity for engaging the behavioral health needs of offenders and strategizing clinical responses. These responses must be reflective of the needs of the individual while also positioning the individual for successfully meeting their justice mandates. These responses must also anticipate changes in justice supervision and plan for continuity through the justice system and into the community.

**Capacity for recovery in the community is central to long-term success.** If offenders have not received treatment for their drug and/or alcohol problems in prison, haven't received adequate discharge planning, and do not have community-based support services lined up, their long-term prospects for stability and a crime-free lifestyle dwindle.[33] Recovery, when considered in a systems approach such as is represented by Recovery Oriented Systems of Care (ROSC), represents more than just behavioral health care, and may encompass

**Realizing the Potential of HB 86: Necessary Next Steps for Stakeholder Leaders**

| Stakeholder Leaders | Next Steps |
|---|---|
| **State Agency Directors: Mental Health, Substance Abuse, Corrections, Youth Services, State Supreme Court** | • Secure legislative support for sustained investment in community mental health and substance abuse disorder treatment to meet the demands of HB 86.<br>• Sustain collaborative initiatives that leverage expertise and resources between agencies<br>• Sustain focus on increasing use of evidence-based practices throughout criminal justice and community treatment systems<br>• Quantify funding request and justice reinvestment proposal |
| **Community Mental Health and Substance Use Disorder Treatment Providers** | • Integrate community services with diversion, community supervision and reentry programs<br>• Improve criminal justice and participant functional outcomes through use of evidence-based practices<br>• Identify current performance and set targets for improvement |
| **County ADAMHS Board Leaders** | • Convene forums to build partnerships between the courts, probation, parole, community mental health agencies, substance use disorder treatment providers and reentry service organization with the purpose of maximizing diversion and reentry initiatives<br>• Promote the development of integrated community plans to maximize diversion, successful community supervision and reentry<br>• Establish processes to track the gap between demand and supply of community services |
| **County Judicial and Probation Leadership** | • Partner with correctional and community health and behavioral health care providers and funders to plan and implement collaborative diversion, community supervision and reentry initiatives pursuant to HB 86<br>• Develop and expand pre-trial supervision systems to manage justice compliance among defendants who are participating in community-based treatment<br>• Partner with judges and community providers to integrate substance use treatment as an intervention for initial diversion and appropriate management of technical violations related to substance use and psychiatric disorders.<br>• Advocate for treatment resources needed to significantly reduce recidivism by changing the behavior of offenders |

services such as employment training and assistance, faith-based supports, housing, education, and primary health care. In keeping with the principles of justice reinvestment, Ohio should consider allocation of resources for these services to those communities to which offenders are returning.

**Community-based treatment must be responsive to the needs/challenges facing justice populations.** This document is not simply a call for more treatment, but a call for effective, evidence-based treatment designed around and targeted toward the behavioral health needs of justice-involved individuals. In recent years, an array of evidence-based programs and practices have emerged reflecting a wide range of substance use and behavioral health needs, phases of justice involvement, rewards and sanctions, case management and justice supervision and recovery-oriented planning. These practices and programs must be evaluated for their applicability to Ohio justice populations and implemented as part of the investment in community treatment capacity.

**Ongoing research and iterative design is critical.** Broader economic evaluations that include other outcomes such as health services utilization, criminal activity, and employment are important for understanding the net benefits associated with corrections-based community treatment. Long term outcome-based evaluations need to be administered to determine the most effective interventions and to identify what works and is the most cost effective for Ohio, and programs need to be designed around what the data suggests is most effective at achieving the goals.

**Strategies must anticipate, plan for, and guide future reforms.** Expansion of access to insurance, such as may come through national health reform, has the potential to significantly expand resources available to states to provide substance abuse and mental health treatment for offenders in communities. Expanded Medicaid eligibility for low-income adults contemplated in the federal Patient Protection and Affordable Care Act (PPACA) is slated to begin in 2014. How that eligibility plays out among justice populations, how people are enrolled, what agencies manage and provide care, and what the essential benefits will be has yet to be fully determined, but state and federal public aid authorities are working now to design these systems. These stakeholders should be engaged in discussions about broad-scale public investment in behavioral health for justice populations, both to inform that process as well as inform and guide the Medicaid expansion process.

## *Core Activities*

The following core activities spring from the core principles described above and lay the groundwork from which specific policies and practices may emerge.

### 1. Invest and Reinvest in Community Behavioral Health Services for Adults and Youth

- Invest in evidence-based treatment and services in the community that can provide the basis for diversion from incarceration, successful community supervision and effective reentry systems. Jurisdictions that make sufficient investments in these services are likely to experience lower crime rates and lower incarceration rates. Research shows that education, employment, drug treatment, health care, and the availability of affordable housing coincide with better outcomes for all people, whether involved in the criminal justice system or not. Jurisdictions that make sufficient investments in these services are likely to experience lower crime rates and lower incarceration rates. An increase in spending on education, employment and other services not only would improve public safety, but also would enhance and enrich communities and individual life outcomes.
- Provide for sufficient mental health and substance use disorder treatment to meet the existing needs in Ohio's communities as well as the additional demand generated by HB 86. Attention must be given to increased funding throughout the state for mental health and substance use disorder treatment to ensure

that there is a full continuum of care available for the criminal justice offenders and youth diverted from the prisons and for those released to the community.

- Because the youth currently served by the Ohio Department of Youth Services demonstrate high levels of illness severity, specific attention should be paid to increasing the depth of resources available for these youth upon release to the community.

**2. Build on the Foundation of HB 86**

- Divert people with mental illness and drug treatment needs to the public health system and community-based treatment. Research shows that people who have mental health or substance abuse problems are better served by receiving treatment in their community and conversely that incarceration can exacerbate these problems. Treatment is more cost-effective than incarceration and promotes a positive public safety agenda. Even when treatment is available inside of a correctional facility, similar treatment in the community is more effective at reducing recidivism and also costs less.

- Use the Ohio General Inventory of Services by County as the framework for reinvestment of resources. Dollars saved in a community should be redirected to those services within that community that will perpetuate reduced expenditures and increased effectiveness in health and public safety. Community plans developed from the General Inventory could be keyed to spending invested and reinvested funds.

- Evaluate the efficacy of targeted interventions, holding all parties accountable for implementation and outcomes to ensure that the promise of HB 86 will be realized. Employ long-term evaluations to assess systemic impacts on incarceration, community treatment capacity and overall cost benefit.

- Identify and evaluate opportunities for achieving statewide economies of scale. With several decades of Community Corrections Act experience informing how HB 86 will be implemented on a local level, the broad-scale policy changes also present an opportunity to evaluate whether additional economic benefits may be realized by centralizing or standardizing functions common to all CCA programs.

**3. Develop Effective and Coordinated State and Community Partnerships for Diversion and Reentry**

- In full collaboration, the state and community build the framework for community partnerships to reduce county-by-county variations by establishing standardized methods and systems of care that can be applied within unique local contexts, but while maintaining fidelity to the Community Corrections Act model. Implicit in this model are guidelines, whether through legislation or administrative rule, for ensuring accountability in reinvestment – tying reinvestment of funding to priority populations based on risk, need and responsiveness, and standardized tools like the Ohio Risk Assessment System (ORAS).

- Develop effective and coordinated community partnerships between the criminal justice system and the behavioral health service system, enhancing collaboration among both systems. ODRC, ODYS, ODADAS and ODMH must engage with these partnerships in an ongoing system development effort to achieve the diversionary goals of HB 86 while meeting the behavioral health needs of offenders.

- The County Courts, Probation Departments, Correctional Planning Boards, ADAMHS Boards, and behavioral health service providers, along with local Reentry Councils, serves as one of several possible forums for state/local partnerships that balance criminal justice and behavioral health strategies, establish priority populations for the local service system to guide funding and inform reinvestment strategies and targets.

- Probation, jail reentry, and other community corrections systems/processes can leverage these standards and work collaboratively with designated treatment providers that are utilizing identified evidence-based practices applicable to a criminal justice population.
- Develop community-level partnerships between state and local agencies and organizations to provide meaningful reentry services and recovery-oriented systems of care that include access to a broad array of necessary services and supports. These should include substance abuse and mental health treatment, medical care, recovery support services, faith-based services, support in obtaining safe and sober housing and support in obtaining employment. A holistic, collaborative approach to reentry can yield a positive and lasting impact on individuals, families and communities.
- Create collaborative diversion and reentry measures in which all program partners are responsible for mutual success in terms of reduced drug use, stable mental health, reduced recidivism, and increased employment among former offenders who receive services.
- Bridge gaps in knowledge, experience and expertise by ensuring that treatment partners and justice partners are involved in cross-training activities, development of information exchange and integration of technology and communication practices designed to make service coordination more effective and efficient.

**4. Executive, Legislative and Judicial Leadership is Key to Support Needed Collaboration**

- Ohio’s interagency collaborative initiatives have demonstrated remarkable success in addressing the issues of mental health and substance use disorders and criminality. Continued support of these working groups, and their integration into Ohio’s overall strategy is needed.
- These working groups should focus on opportunities to pool and leverage existing resources, grant funds and nontraditional funding opportunities to expand interventions that stop the revolving door of criminality and drugs.
- Individual agencies and working groups should continue their focus on utilizing evidence-based practices in mental health treatment, substance use disorder treatment, screening/assessment within criminal justice systems, and community supervision strategies. Evidence-based practices that have been identified as essential program elements should be codified and institutionalized.

## Lessons from Justice Reinvestment and Drug Policy Changes in Other States

Across the country, agencies, organizations, and providers are establishing and maintaining innovative programs for substance abusers who are involved with criminal justice. Recognizing the significant costs associated with such high incarceration rates, a number of these states have recently implemented innovative strategies for reducing their prison and jail populations and ensuring better outcomes for people who come into contact with the criminal justice system.

**Texas.** The Texas Reinvestment in Justice State Report lists a number of cost savings with increased diversions from facilities to community-based programs.[34] Texas reallocated funding through the Justice Reinvestment Initiative, by investing in community-based treatment and diversion programs for people charged with non-violent offenses. As a result, parole and probation made significant changes, including a restructuring of violation sanctions by diverting people to treatment rather than revoking their parole or probation, thus reducing caseloads and the number of people being sent back to prison. Texas Christian University and Dr. Kevin Knight have developed a series of instruments and manualized treatment interventions specifically for criminal justice offenders with mental health and substance use disorder issues. The TCUDS- Texas Christian University Drug Screening tool is an evidence-based instrument recognized nationally and recommended by NIDA (National Institute of Drug Abuse).

**Washington.** The Washington State Policy Institute conducted research that found that the benefits of treatment far outweigh the costs. Treatment can save money by diminishing the huge financial consequences imposed on employers and taxpayers.[35] This analysis estimated the total potential impact that an evidence-based strategy could have for the state and the total net benefits to Washington would be about $1.5 billion.[36] Washington State's research shows that evidenced-based treatment of these disorders (substance abuse and mental health issues for criminal justice offenders) can achieve about $3.77 in benefits per dollar of treatment cost. This is equivalent to a 56 percent rate-of-return on investment. The cost savings potential is significant. Washington State estimated that a reasonably aggressive implementation policy could generate $1.5 billion in net benefits for people in Washington ($416 million are net taxpayer benefits). The risk of losing money with an evidence-based treatment policy is small.

## APPENDIX A:

## A Plan for Attacking Ohio's Opiate Epidemic

1. Focus actions strategically on Scioto County and other high risk areas: limit unnecessary prescription of opiate medications, work with local law enforcement, seek judicial collaboration, provide access to treatment (including medication-assisted treatment), provide comprehensive community education, and work with enhanced existing community task force.

2. Prosecute prescriber abuse, drug dealers, pill mill operators and those who commit drug-related crimes: make necessary changes in policy and enforcement at the Ohio Board of Pharmacy, the Ohio Medical Board, and the Ohio Dental Board, pursue state law and regulatory changes to limit the practice of physicians directly dispensing controlled substances; enhance the Ohio Automated Rx Reporting System (OARRS) to detect abuse, and enhance law enforcement interdiction, investigation and prosecution efforts at all levels.

3. Promote judicial best practices: collaborate with the judiciary regarding the opiate problem and provide continuing education to judicial staff on addiction and recovery.

4. Treat and support opiate addicts and their families in recovery: provide more effective treatment services and supports to opiate addicts and their families, provide adult mentoring and family wrap-around services to support family stability, and allow for medication-assisted treatment.

5. Change state law and regulations to better address opiate issues: develop and support key legislative initiatives focused on limiting physicians and dentists directly dispensing controlled substances, closing unscrupulous pain management facilities, enhancing authority/funding for OARRS, permitting medication-assisted treatment beyond methadone, and removing unreasonable legal impediments to appropriate and timely administrative actions by the Ohio Medical Board, Ohio Dental Board, and Ohio Board of Pharmacy.

6. Mobilize state and local task forces against opiates: mobilize the people, organizations, and resources necessary to execute anti-opiate plans at the state and local levels.

7. Marshal Ohioans: rally civic and community leaders, statewide associations and local Task Force members to focus on opiate abuse and diversion, educate and marshal Ohioans to prevent and stop opiate abuse, and expand drug take-back programs.

8. Fund the work: establish public-private partnerships and maximize local, state and federal resources.

9. Track the results: use research and evaluation to inform Task Force actions by determining the fiscal impact of opiate addiction and conducting clinical trials to establish the effectiveness of medication-assisted treatment and other clinical interventions.

Under the leadership of Governor John R. Kasich, the Cabinet Opiate Action Team has been formed to take the lead on attacking Ohio's opiate epidemic. The group's mission is:

*To attack the opiate epidemic on behalf of Ohioans to end opiate abuse by reforming prescribing practices for appropriate pain management, punishing those involved in illegal activity, and treating those who are addicted to enable them to return to productive lives.*

## APPENDIX B:

## National Institute on Drug Abuse (NIDA) 13 Principles for Drug Abuse Treatment for Criminal Justice Offenders

1. **Drug addiction is a brain disease that affects behavior.**
   Drug addiction has well-recognized cognitive, behavioral, and physiological characteristics that contribute to continued use of drugs, despite the harmful consequences. Scientists have also found that chronic drug abuse alters the brain's anatomy and chemistry and that these changes can last for months or years after the individual has stopped using drugs. This transformation may help explain why addicts are at a high risk of relapse to drug abuse even after long periods of abstinence and why they persist in seeking drugs despite deleterious consequences.

2. **Recovery from drug addiction requires effective treatment, followed by management of the problem over time.**
   Drug addiction is a serious problem that can be treated and managed throughout its course. Effective drug abuse treatment engages participants in a therapeutic process, retains them in treatment for an appropriate length of time, and helps them learn to maintain abstinence over time. Multiple episodes of treatment may be required. Outcomes for drug-abusing offenders in the community can be improved by monitoring drug use and by encouraging continued participation in treatment.

3. **Treatment must last long enough to produce stable behavioral changes.**
   In treatment, the drug abuser is taught to break old patterns of thinking and behaving and to learn new skills for avoiding drug use and criminal behavior. Individuals with severe drug problems and co-occurring disorders typically need longer treatment (e.g., a minimum of 3 months) and more comprehensive services. Early in treatment, the drug abuser begins a therapeutic process of change. In later stages, he or she addresses other problems related to drug abuse and learns how to manage the problems.

4. **Assessment is the first step in treatment.**
   A history of drug or alcohol use may suggest the need to conduct a comprehensive assessment to determine the nature and extent of an individual's drug problems, establish whether problems exist in other areas that may affect recovery, and enable the formulation of an appropriate treatment plan. Personality disorders and other mental health problems are prevalent in offender populations; therefore, comprehensive assessments should include mental health evaluations with treatment planning for these problems.

5. **Tailoring services to fit the needs of the individual is an important part of effective drug abuse treatment for criminal justice populations.**
   Individuals differ in terms of age, gender, ethnicity and culture, problem severity, recovery stage, and level of supervision needed. Individuals also respond differently to different treatment approaches and treatment providers. In general, drug treatment should address issues of motivation, problem solving, and skill-building for resisting drug use and criminal behavior. Lessons aimed at supplanting drug use and criminal activities with constructive activities and at understanding the consequences of one's behavior are also important to include. Treatment interventions can facilitate the development of healthy interpersonal relationships and improve the participant's ability to interact with family, peers, and others in the community.

6. **Drug use during treatment should be carefully monitored. Individuals trying to recover from drug addiction may experience a relapse, or return, to drug use.**
   Triggers for drug relapse are varied; common ones include mental stress and associations with peers and social situations linked to drug use. An undetected relapse can progress to serious drug abuse, but detected use can present opportunities for therapeutic intervention. Monitoring drug use through urinalysis or other objective methods, as part of treatment or criminal justice supervision, provides a basis for assessing and providing feedback on the participant's treatment progress. It also provides opportunities to intervene to change unconstructive behavior—determining rewards and sanctions to facilitate change, and modifying treatment plans according to progress.

7. **Treatment should target factors that are associated with criminal behavior.**
   "Criminal thinking" is a combination of attitudes and beliefs that support a criminal lifestyle and criminal behavior. These can include feeling entitled to have things one's own way, feeling that one's criminal behavior is justified, failing to be responsible for one's actions, and consistently failing to anticipate or appreciate the consequences of one's behavior. This pattern of thinking often contributes to drug use and criminal behavior. Treatment that provides specific cognitive skills training to help individuals recognize errors in judgment that lead to drug abuse and criminal behavior may improve outcomes.

8. **Criminal justice supervision should incorporate treatment planning for drug abusing offenders and treatment providers should be aware of correctional supervision requirements.**
   The coordination of drug abuse treatment with correctional planning can encourage participation in drug abuse treatment and can help treatment providers incorporate correctional requirements as treatment goals. Treatment providers should collaborate with criminal justice staff to evaluate each individual's treatment plan and ensure that it meets correctional supervision requirements, as well as that person's changing needs, which may include housing and childcare; medical, psychiatric, and social support services; and vocational and employment assistance. For offenders with drug abuse problems, planning should incorporate the transition to community-based treatment and links to appropriate post-release services to improve the success of drug treatment and re-entry. Abstinence requirements may necessitate a rapid clinical response, such as more counseling, targeted intervention, or increased medication, to prevent relapse. Ongoing coordination between treatment providers and courts or parole and probation officers is important in addressing the complex needs of these re-entering individuals.

9. **Continuity of care is essential for drug abusers re-entering the community.**
   Those who complete prison-based treatment and continue with treatment in the community have the best outcomes. Continuing drug abuse treatment helps the recently released offender deal with problems that become relevant only at re-entry, such as learning to handle situations that could lead to relapse, learning how to live drug-free in the community, and developing a drug-free peer support network. Treatment in prison or jail can begin a process of therapeutic change, resulting in reduced drug use and criminal behavior post incarceration. Continuing drug treatment in the community is essential to sustaining these gains.

10. **A balance of rewards and sanctions encourages prosocial behavior and treatment participation.**
    When providing correctional supervision of individuals participating in drug abuse treatment, it is important to reinforce positive behavior. Nonmonetary "social reinforcers" such as recognition for progress or sincere effort can be effective, as can graduated sanctions that are consistent, predictable, and clear responses to noncompliant behavior. Generally, less punitive responses are used for early and less serious noncompliance, with increasingly severe sanctions issuing from continued problem behavior. Rewards and sanctions are most likely to have the desired effect when they are perceived as fair and when they swiftly follow the targeted behavior.

11. **Offenders with co-occurring drug abuse and mental health problems often require an integrated treatment approach.**
    High rates of mental health problems are found both in offender populations and in those with substance abuse problems. Drug abuse treatment can sometimes address depression, anxiety, and other mental health problems. Personality, cognitive, and other serious mental disorders can be difficult to treat and may disrupt drug treatment. The presence of co-occurring disorders may require an integrated approach that combines drug abuse treatment with psychiatric treatment, including the use of medication. Individuals with either a substance abuse or mental health problem should be assessed for the presence of the other.

12. **Medications are an important part of treatment for many drug abusing offenders.**
    Medicines such as methadone and Buprenorphine for heroin addiction have been shown to help normalize brain function and should be made available to individuals who could benefit from them. Effective use of medications can also be instrumental in enabling people with co-occurring mental health problems to function successfully in society. Behavioral strategies can increase adherence to medication regimens.

13. **Treatment planning for drug-abusing offenders who are living in or reentering the community should include strategies to prevent and treat serious, chronic medical conditions, such as HIV/AIDS, hepatitis B and C, and tuberculosis.**
    The rates of infectious diseases, such as hepatitis, tuberculosis, and HIV/AIDS, are higher in drug abusers, incarcerated offenders, and offenders under community supervision than in the general population. Infectious diseases affect not just the offender, but also the criminal justice system and the wider community. Consistent with Federal and State laws, drug-involved offenders should be offered testing for infectious diseases and receive counseling on their health status and on ways to modify risk behaviors. Probation and parole officers who monitor offenders with serious medical conditions should link them with appropriate healthcare services, encourage compliance with medical treatment, and re-establish their eligibility for public health services (e.g., Medicaid, county health departments) before release from prison or jail.

## END NOTES

1. Council of State Government's Justice Reinvestment in Ohio. (2010). Summary report of analyses. Retrieved from http://www.justicereinvestment.org/states/ohio

2. Council of State Government's Justice Reinvestment in Ohio. (2010). Summary report of analyses. Retrieved from http://www.justicereinvestment.org/states/ohio

3. Pew Center on the States. (2009). One in 31: the long reach of American corrections, Ohio Fact Sheet. Retrieved from http://www.pewcenteronthestates.org/news_room_detail_aspx?id=49398

4. Center of State Government's Justice Reinvestment in Ohio. (2010). Implementing the strategy. Retrieved from http://www.justicereinvestment.org/states/ohio/how-oh/

5. Levin, M. (2010). Smart on crime. Buckeye Institute for Public Policy Solutions.

6. Levin, M. (2010). Smart on crime. Buckeye Institute for Public Policy Solutions.

7. Ohio Department of Rehabilitation and Correction Fiscal Year 2011 Annual Report.

8. Ohio Department of Rehabilitation and Correction Fiscal Year 2005 Annual Report.

9. Ohio Department of Rehabilitation and Correction Fiscal Year 2011 Annual Report.

10. Mental Illness Policy Organization. (2011). Criminalization of individuals with severe psychiatric disorders.

11. Kretschmar, J., Flannery, D. (2008). An evaluation of the behavioral health/juvenile justice initiative: 2005-2007. Kent State University.

12. Ohio Department of Youth Services Fiscal Year 2011 Annual Report.

13. Ohio Association of County Behavioral Health Authorities. (April 2011). Ohio's opiate epidemic: a summit on policy, prevention, and treatment.

14. Ohio Association of County Behavioral Health Authorities. (April 2011). Ohio's opiate epidemic: a summit on policy, prevention, and treatment.

15. Day, M. (2010, May 10). Jail overdosing on inmates: drug addiction at heart of facilities' overcrowding. Lancaster Eagle Gazette.Retrieved from 111.lancastereaglegazette.com/print/article20100510/NEWS01/5090315/Jail-overd

16. National Institute of Drug Abuse. (2011). Treating offenders with drug problems: integrating public health and public safety. Retrieved from http://www.nida.nih.gov/tib/drugs_crime.html

17. National Institute of Drug Abuse. NIDA infofacts: treatment for drug abusers in the criminal justice system. Retrieved from http://www.nida.nih.gov/Inforfacts/cjtreatment.html

18. Justice Policy Institute. (2008). Substance abuse treatment and public safety. Retrieved from http://www.justicepolicy.org.

19. McCollister, K. (2009). Cost effectiveness of substance abuse treatment in criminal justice settings. Substance Abuse Policy Research Program. Retrieved from http://saprp,org/knowledgeassests/knowledge_detail.cfm?KAID=10

20. National Institute of Drug Abuse. (2006). NIDA announces recommendation to treat drug abusers, save money, and reduce crime. Retrieved from http:www.drugabuse.gov.newsroom/06/NR7-24.html

21. Office of National Drug Control Policy. (2004). The economic costs of drug abuse in the United States, 1992-2002. Washington, DC: Executive Office of the President (Publication No. 207303).

22. Ohio Department of Alcohol and Drug Addiction Services State Fiscal Year 2011 Annual Report.

23. Ohio Department of Rehabilitation and Correction State Fiscal Year 2011 Annual Report.

24. Levin, M. (2010). Smart on crime. Buckeye Institute for Public Policy Solutions.

25. Hussey, D.L., Drinkard, A.M., & Flannery, D.J. 2007. Comorbid substance use and mental disorders among offending youth. Journal of Social Work Practice in the Addictions 7(1): 117-138.

26. Ohio Department of Rehabilitation and Correction. (2011). Verbal communication from Rod Woods of DRC.

27. Ohio Department of Youth Services State Fiscal Year 2011 Annual Report.

28. Ohio Department of Youth Services. (2011). Verbal communication from Kim Kehl of DYS.

29. Ohio Department of Alcohol and Drug Addiction Services State Fiscal Year 2011 Annual Report.

30. Ohio Department of Mental Health. Retrieved from http://mentalhealth.ohio.gov/assets/who-we-are/odmh-description.pdf

31. Ohio Department of Mental Health. (2011). Office of Forensic Services-Forensic focus. Retrieved from http://www.mh.state.oh.us/assets/forensic-services/newsletter-201112.pdf

32. Supreme Court of Ohio and the Ohio Judicial System. Retrieved from http://www.scon.state.ohio.us/JCS/specDockets/

33. Ohio Ex-Offender Re-entry Coalition State Fiscal Year 2010 Report.

34. Justice Policy Institute. (2011). Due south: looking to the south for criminal justice innovations. Retrieved from http://www.justicepolicy.org/research/2472

35. Washington State Institute for Public Policy. (2009). Evidence-based public policy options to reduce crime and criminal justice costs: implications in Washington state. Retrieved from http://www.wsipp.wa.gov/rptfiles/09-00-1201.pdf.

36. Washington State Institute for Public Policy. (2011). Return on investment-evidence-based options to improve state outcomes. Retrieved from http//:www.wispp.wa.gov/rptfiles/11-07-1201.pdf.

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