

Effective Substance Abuse Treatment for the Criminal Justice Population

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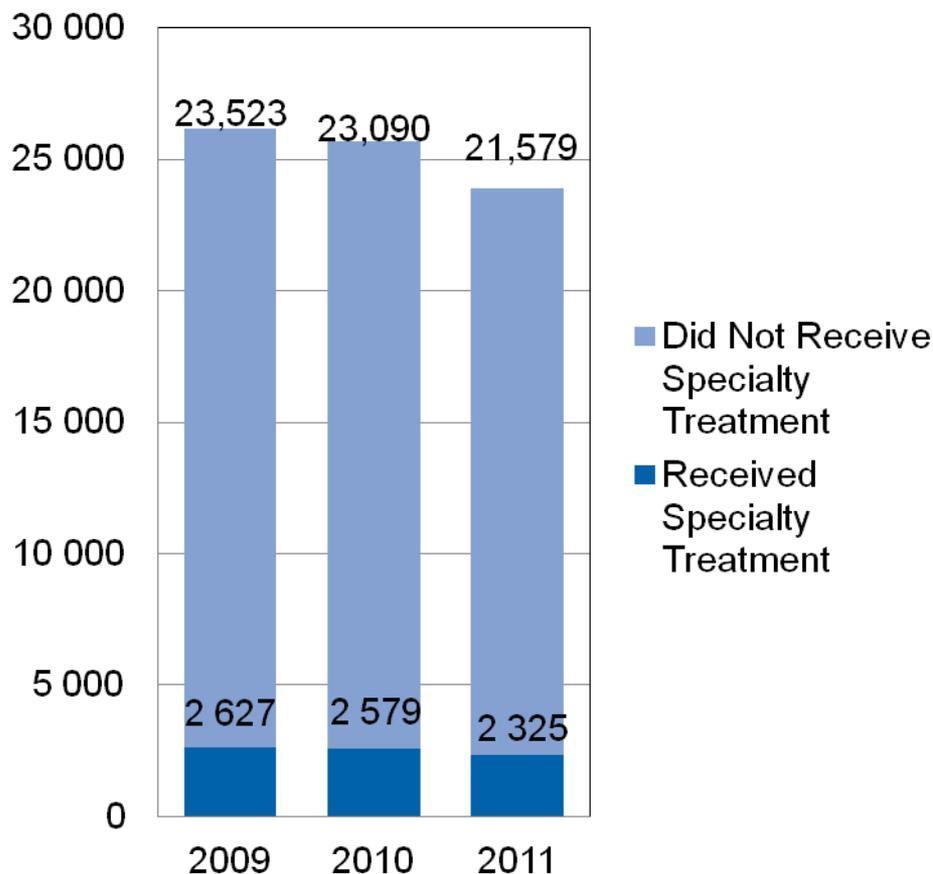
Overview

- Research on effective outcomes across the country
- Review of assessment and treatment issues
- Components of effective treatment
- Recommendations/Discussion

Substance Use Disorders: Snapshot

Treatment Gap

Numbers in Thousands Needing Treatment for Illicit
Drugs or Alcohol, 2011



- According to the NSDUH report, nationally we offer enough drug and alcohol treatment to address the needs of 10.8% of individuals who need it.
 - In Pennsylvania we do a little better; about 13 percent of those needing services get them
- According to data from the Survey of Inmates in Local Jails, in 2002 more than two-thirds of jail inmates were found to be dependent on or to abuse alcohol or drugs
- Substance abuse expenditures represented 1.3 percent of all healthcare expenditures in 2003 (\$21 billion for substance abuse vs. \$1.6 trillion for all health expenditures).
- The 2010 U.S. Drug Control Strategy cites that untreated addiction costs society over \$400 billion annually with \$120 billion of that in wasted or inappropriate health care procedures.

Treatment Goals

Sick/Symptoms

Absence of
Symptoms/Health

Wellness

Addiction

Abstinence

Recovery

Treatment Goals

Addiction

Abstinence

Recovery

| | | |
|-------------------------------------|--|--|
| Chemical addiction | Withdrawal | “Addiction” to recovery behaviors |
| Dysfunctional relationships | Tension/ distrust/ judgment in relationships | Trust, partnership, respect in relationships |
| Negative self image | Lack of confidence/ doubts | Self respect |
| Lack of values/spiritual connection | Questioning of values | Knowing personal values and following them |
| Motivation to use/drink | Motivation to stop drinking/avoid pain | Motivation to seek pleasure/ health |

Treatment Goals

Addiction

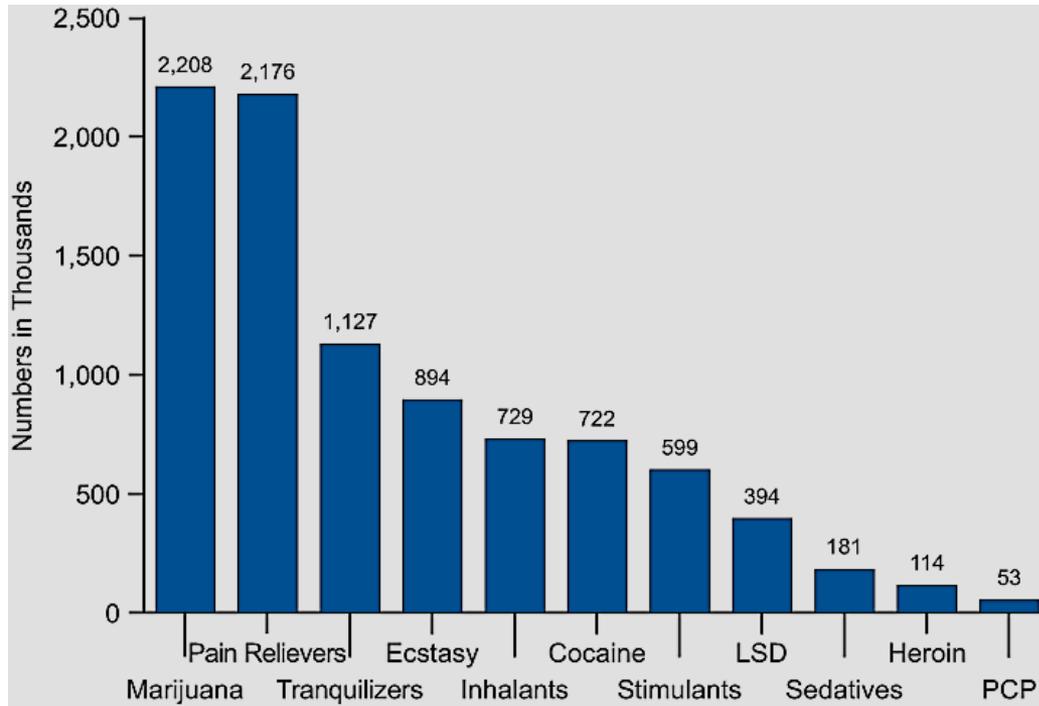
Abstinence

Recovery

| | | |
|---------------------------------|---|---|
| Mental health issues | Awareness of mental health as triggers | Management/ remission of mental health issues |
| Depression | Boredom, blunted emotion | Happiness, range of emotion |
| Avoidance /numbing of feelings | Aware of uncomfortable feelings | Able to tolerate unpleasant feelings as they arise |
| Lack of range of coping skills | Novice at identifying coping strategies | Competent at a range of coping strategies |
| Unresolved trauma/grief | Aware of losses | Able to “let go” of past |
| Personality disorder(s) | Aware of personal issues | Able to reduce negative impact of personality style |
| Unmedicated (bipolar, ADHD etc) | Finding proper medication combination | Stable on effective medication |

Overview of Substance and Drug Use

Past-Year Initiates for Specific Illicit Drugs Among Persons Age 12 or Older



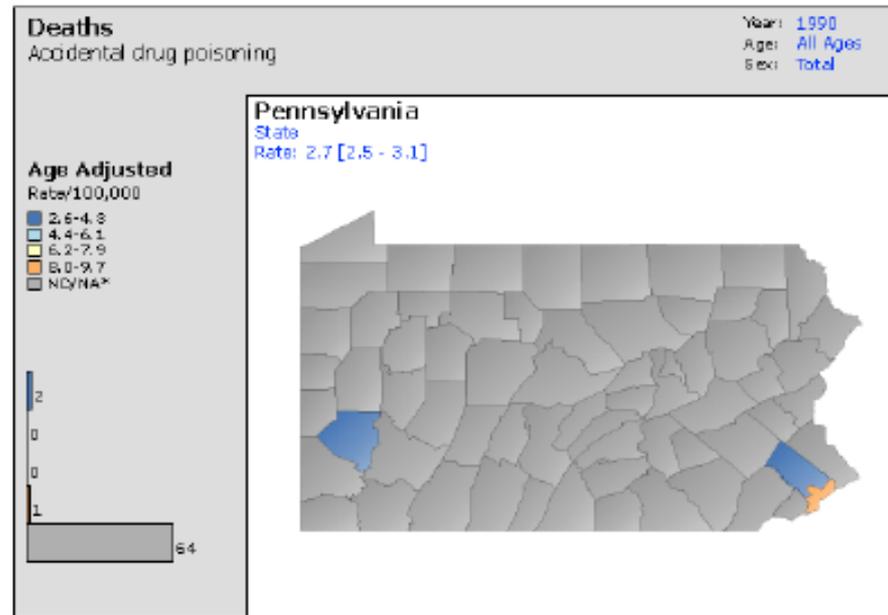
Source: Substance Abuse and Mental Health Services Administration. (2009). *Results From the 2008 National Survey on Drug Use and Health: National Findings*. Rockville, Maryland.

Overdose Deaths in Pennsylvania

| Drug Overdose Deaths in Pennsylvania | | | |
|---|------------------|-------------------|----------------|
| Year | Number of Deaths | PA Population | Rate per 1,000 |
| 2012 | 2,026 | 12,763,536 | 16.3 |
| 2011 | 1,909 | 12,742,886 | 15.4 |
| 2010 | 1,550 | 12,702,379 | 12.5 |
| 2008 | 1,522 | 12,448,279 | 12.6 |
| 2006 | 1,344 | 12,440,621 | 11.2 |
| 2004 | 1,278 | 12,406,292 | 10.6 |
| 2002 | 895 | 12,335,091 | 7.5 |
| 2000 | 896 | 12,281,054 | 7.4 |
| 1998 | 628 | 12,001,451 | 5.4 |
| 1996 | 630 | 12,056,112 | 5.4 |
| 1994 | 596 | 12,052,410 | 5.1 |
| 1992 | 449 | 11,995,405 | 3.8 |
| 1990 | 333 | 11,881,643 | 2.7 |

- Based on Pennsylvania Department of Health data, overdose deaths have been on the rise over the last two decades with an increase in the rate of death from 2.7 to 16.3 per thousand Pennsylvanians

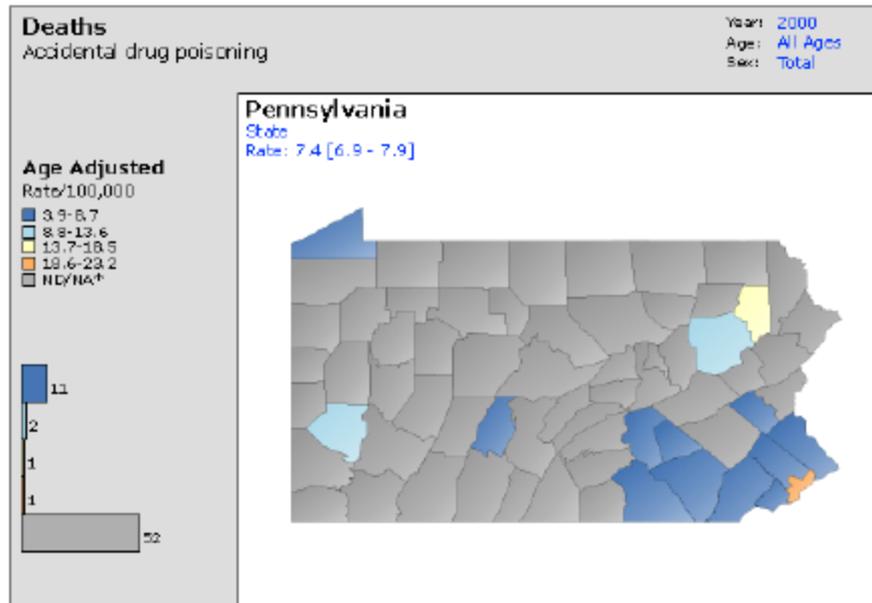
Overdose Deaths in Pennsylvania



* ND = Not displayed if count <10 (age-adjusted/specific rates and SMRs) or <3 (all other rates)
NA = Data not available to calculate statistic.

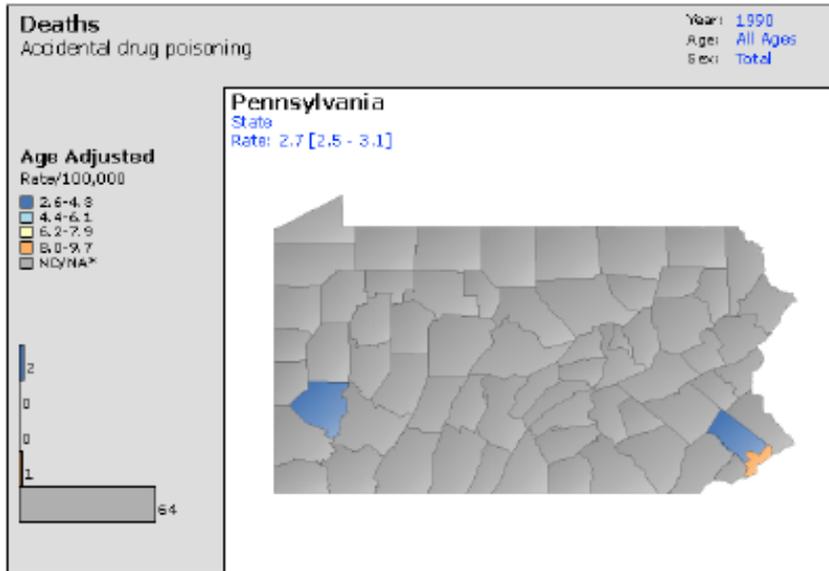
- In 1990, note for the 64 grey counties, the death rate is too low to be accurately counted, at less than 3 deaths per 1,000 citizens. The state average is 2.7 deaths per 1,000 citizens, so any colored counties are above average, while grey is below average.

Overdose Deaths in Pennsylvania

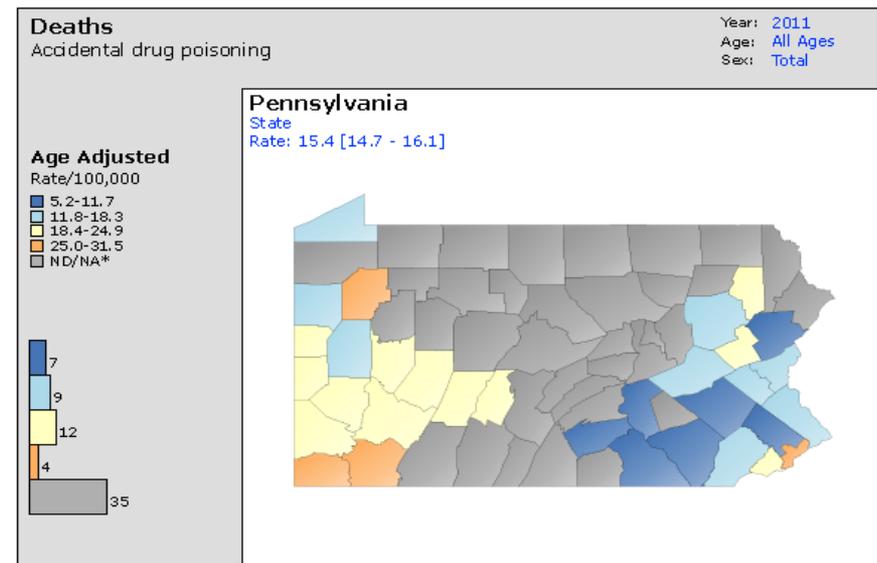


- In 2000, note for the 52 grey counties, the death rate is too low to be accurately counted, at less than 3 deaths per 1,000 citizens. The state average is 7.4 per 1,000 citizens, so the light blue, yellow and orange counties are above average, while grey and dark blue are below average.

Overdose Deaths in Pennsylvania



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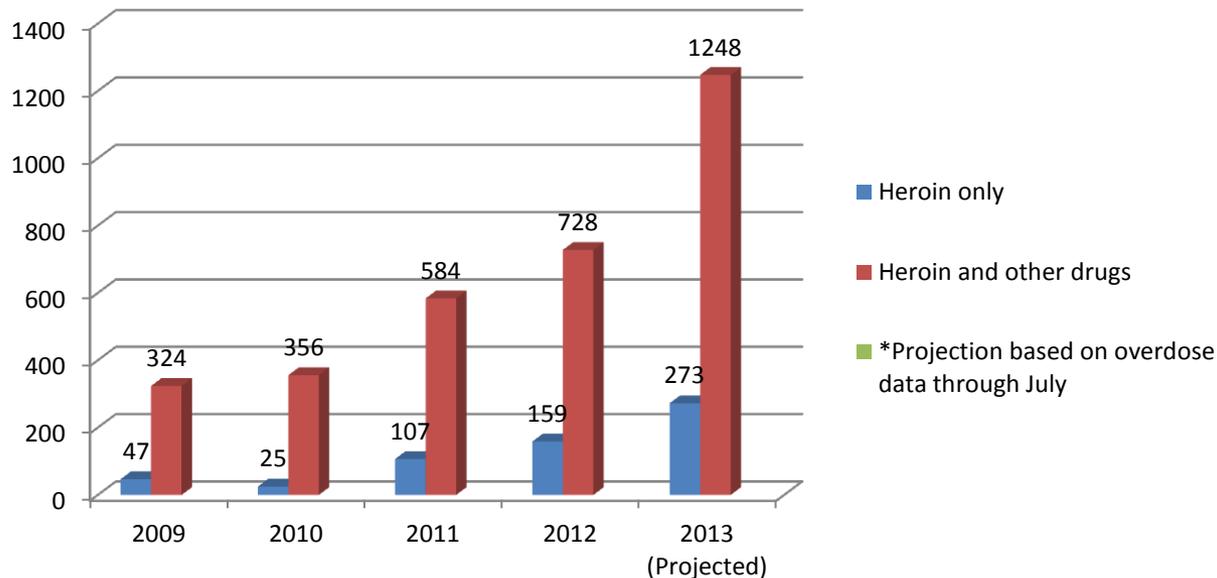


* **ND** = Not displayed if count <10 (age-adjusted/specific rates and SMRs) or <3 (all other rates)
NA = Data not available to calculate statistic.
Source: Pennsylvania Certificates of Death

- In 2011 (on right), note for only 35 grey counties, the death rate is too low to be accurately counted, at less than 3 deaths per 1,000 citizens. The state average is 15.4 per 1,000 citizens, so the yellow and orange counties are above average, while grey and dark blue are below average.

Heroin Related Overdose Deaths in Pennsylvania

Heroin Only and Multidrug Toxicity Deaths



- Based on Pennsylvania Coroners Association (PCA) reports in 43 counties, heroin and heroin related deaths have been on the rise for the past 5 years (PCA, 2013)
- Between 2009 and 2013 there 2,929 heroin related overdose deaths identified by county coroners. Of these, 490 (17%) were heroin only, while 2,439 (83%) involved multiple drugs.
- Other drugs commonly found along with heroin overdose include
 - Other opiates: Methadone, Oxycodone, Fentanyl, Morphine, Codeine, Tramadol
 - Other Illegal drugs: Marijuana, cocaine
 - Other sedating drugs: Alcohol, benzodiazapines
 - Antidepressant medications: Prozac, Celexa, Remeron, Trazadone, Zoloft

FDA Warning Labels

- In September 2013 the FDA updated the warning labels on long acting opioid products.
 - The new labeling adds: "Because of the risks of addiction, abuse and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve [Trade name] for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain."

Cost/Benefit



In 2007, the cost of illicit drug use alone (Does not include alcohol abuse) totaled more than \$193 billion. Direct and indirect costs attributable to illicit drug use are estimated in three principal areas: crime, health, and productivity.

- **Crime:** includes three components: criminal justice system costs (\$56,373,254,000), crime victim costs (\$1,455,555,000), and other crime costs (\$3,547,885,000). These subtotal \$61,376,694,000.
 - **Health:** includes five components: specialty treatment costs (\$3,723,338,000), hospital and emergency department costs for non-homicide cases (\$5,684,248,000), hospital and emergency department costs for homicide cases (\$12,938,000), insurance administration costs (\$544,000), and other health costs (\$1,995,164,000). These subtotal \$11,416,232,000.
 - **Productivity:** includes seven components: labor participation costs (\$49,237,777,000), specialty treatment costs for services provided at the state level (\$2,828,207,000), specialty treatment costs for services provided at the federal level (\$44,830,000), hospitalization costs (\$287,260), incarceration costs (\$48,121,949,000), premature mortality costs (non-homicide: \$16,005,008,000), and premature mortality costs (homicide: \$3,778,973,000). These subtotal \$120,304,004,000.
- Taken together, these **costs total \$193,096,930,000** with the majority share attributable to lost productivity. The findings are consistent with prior work that has been done in this area using a generally comparable methodology (Harwood et al., 1984, 1998; ONDCP, 2001, 2004).
- This report by ONDCP does not include alcohol related costs, which would add to these numbers
- **For Pennsylvania this cost for illicit drug use would be \$8,289,740,227**

Treatment Benefits

Table 1: Summary of Costs and Benefits Associated with Substance Abuse Treatment (Based on the Social Planner Perspective)

| | <i>All Treatment Modalities</i> (N = 2,567) | <i>Methadone Maintenance</i> (N = 115) | <i>Outpatient Treatment</i> (N = 1,585) | <i>Residential Treatment</i> (N = 867) |
|--|--|---|--|---|
| Average cost per substance abuse treatment episode (based on weighted per diem prices) | \$1,583 (\$1,506, \$1,660) | \$2,737 (\$2,469, \$3,004) | \$838 (\$806, \$871) | \$2,791 (\$2,600, \$2,984) |
| Average cost per substance abuse treatment episode (based on unweighted per diem prices) | \$3,336 (\$3,150, \$3,524) | \$2,867 (\$2,440, \$3,290) | \$1,505 (\$1,443, \$1,567) | \$6,745 (\$6,282, \$7,215) |
| Average benefits | \$11,487 (\$9,784, \$13,180) | \$5,313 (-\$2,418, \$8,265) | \$9,049 (\$6,864, \$11,225) | \$16,257 (\$13,482, \$19,078) |
| Net benefits (benefits minus cost of treatment, based on weighted per diem prices) | \$9,903 (\$8,205, \$11,592) | \$2,575 (-\$321, \$5,529) | \$8,211 (\$6,028, \$10,385) | \$13,467 (\$10,706, \$16,269) |
| Cost-benefit ratio (based on weighted per diem cost estimates) | 7:1 | No statistically significant benefits | 11: 1 | 6: 1 |

Note: The follow-up period is 9 months. Ninety-five percent confidence intervals (shown in parentheses) were bootstrapped using normal-based methods and 10,000 replicate samples.

Ettner, et al., 2006



What the Treatment Research Indicates

Length of Stay

Studies consistently find length of stay as the primary predictor of outcomes, along with intensity of treatment and continuum of care.

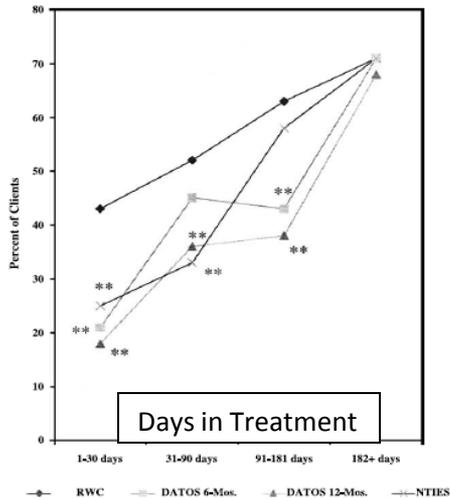
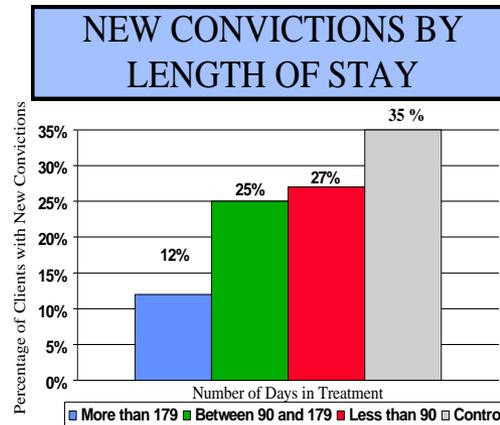
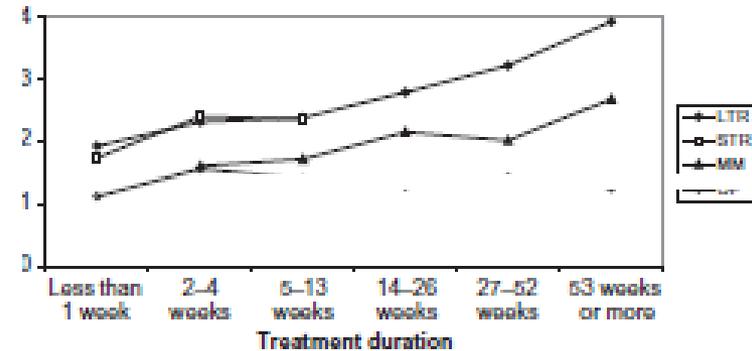


Figure 1. Percentage of abstinent post-discharge by LOS and study. Note: **Difference from RWC is statistically significant at $p < .01$.

Source: Greenfield et al, (2004).
Effectiveness of Long Term Residential Treatment for Women: Findings from 3 National Studies



Source: Pennsylvania Department of Corrections (1997) *Pennsylvania FIR Evaluation*



Source: Zhang (2002). *Does retention matter? Treatment duration and improvement in drug use. (4,005 clients)*

Length Of Stay

Studies consistently find length of stay as the primary predictor of outcomes, along with intensity of treatment and continuum of care.

- Improvements in criminal recidivism and relapse rates are correlated to length of treatment, with highest rates of improvement among those with 9 months of treatment, and reduced effectiveness for treatment of less than 90 days (NIDA, 2002)
- Highest improvements were found in long term treatment with least improvement found in methadone maintenance (Friedmann et al, 2004)
- Lengths of stay are the number one predictor of outcomes for treatment (President's Commission on Model State Drug Laws, 1993)
- Average length of stay for Medicaid clients was 90 days (Villanova Study, 1995). Best outcomes were found for longer lengths of stay and more complete continuum of care, measured as lack of criminal recidivism, abstinence, employment and higher paying jobs. No benefit was found for treatment less than 90 days. Currently, average length of stay in treatment for long term residential is 47 days (DPW, 2011)
- Length of stay has a direct linear relationship with improved outcomes (Toumbourou, 1998)

| | <u>PCPC</u> | <u>LSI-R</u> |
|------------------------|--|---|
| Assessment: | <u>Severity of substance abuse</u> | <u>Severity of criminality</u> |
| Use: | Level of placement For substance abuse <u>treatment</u> | Level of placement/ supervision due to <u>security risk</u> |
| Areas examined: | <u>Substance use intoxication/withdrawal</u> | <u>Criminal history</u> |
| | frequency of use, severity of abuse tolerance/withdrawal | frequency of arrest, severity of charges |
| | Crimes caused by substance use as severity of substance use | <u>Substance abuse</u> as risk of recidivism |
| | Impact of substance on work performance | <u>Employment history</u> |
| | <u>Biomedical Complications</u> | N/A |
| | <u>Emotional/Behavioral Complications</u> | N/A |
| | <u>Treatment Acceptance/Resistance</u> | N/A |
| | <u>Relapse Potential</u> : ability to manage urges | N/A |
| | Substance abuse in household | <u>Criminal family/household</u> |
| | <u>Recovery Environment</u> | <u>Lives in high crime neighborhood</u> |
| | Substance using acquaintances | <u>Criminal acquaintances</u> |

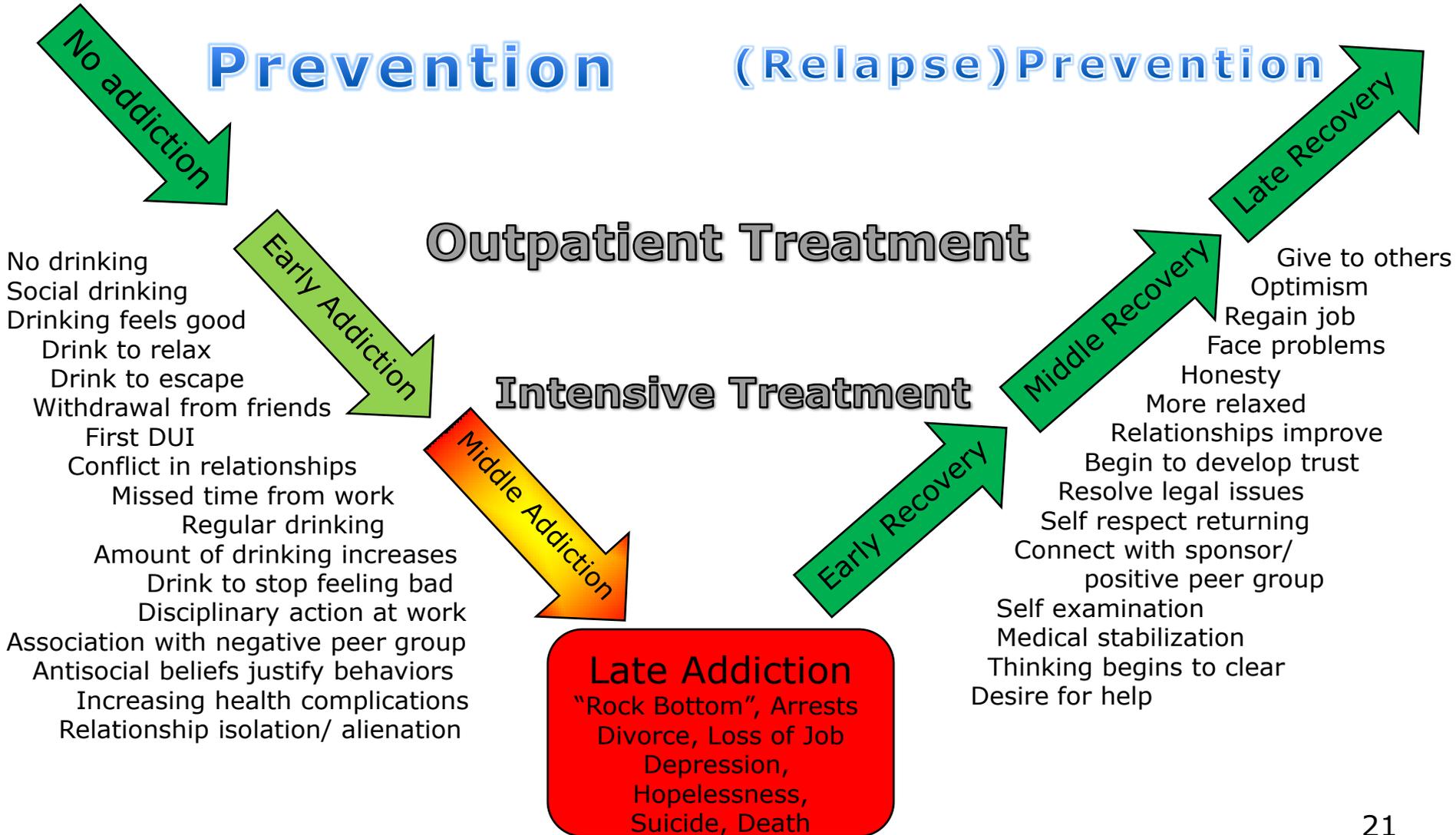
PCPC

- PCPC is a highly acclaimed system based on the criteria from the American Society of Addiction Medicine (ASAM)
- Using a detailed assessment, the criteria suggest what level of care is needed for an individual (eg. Detox, Long term residential, Intensive outpatient, or outpatient)
- Almost by definition, those in the criminal justice system are the most severe levels of addiction and in need of the highest levels of care

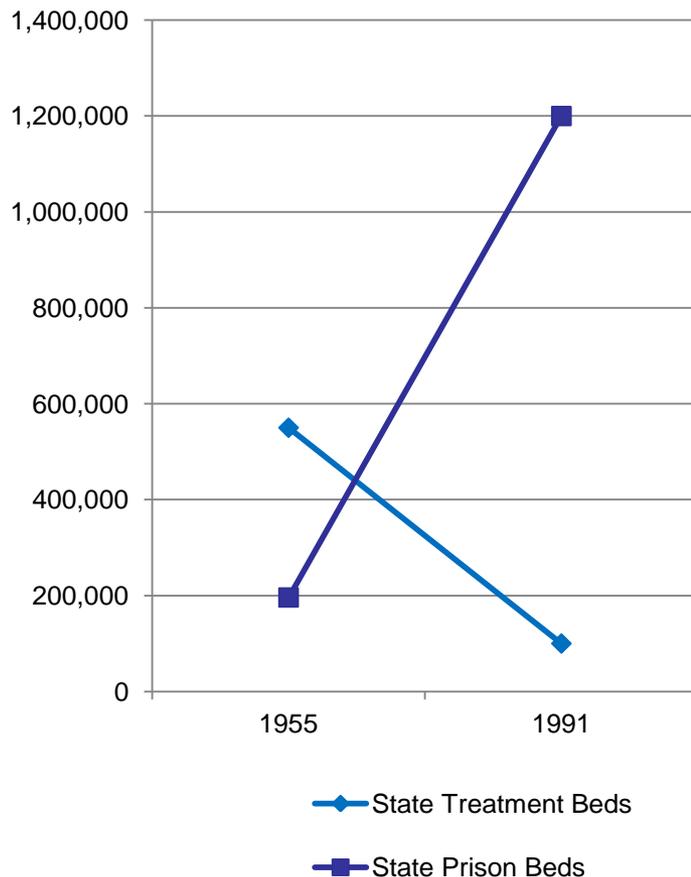
Progression of a Disease and Recovery

Prevention

(Relapse) Prevention



Who is treating?



- On the national and county levels, as we have deinstitutionalized our intensive treatment, we have cost shifted to corrections
- By increasing treatment we can reverse the trend

Current: Trend continues

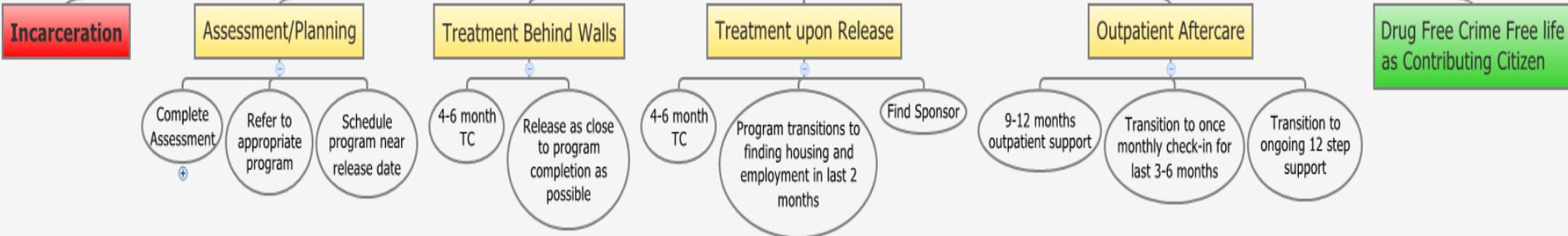
- 2009 About 50,000 psychiatric beds
- 2010 Over 2 million prison beds

Treatment Works: But what is treatment?

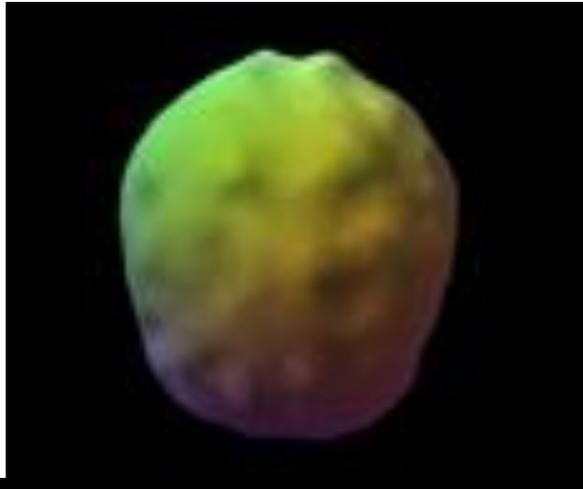
- Treat addresses a wide range of clinical issues that cause and exacerbate risks of substance abuse.
 - These include the needs for habilitation and rehabilitation, including vocational supports, addressing trauma, learning coping skills, learning relapse prevention skills, improving relationships etc.
- This is not to be confused with supporting services such as detoxification, medications, peer supports, 12-step programs, housing and other similar approaches which complement the core treatment program.

Transition Timeline

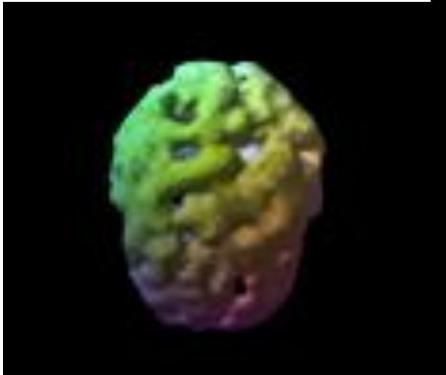
Incarceration/Reentry 2 year Treatment Timeline



Which Brain do You Want?



Normal healthy view.
Top down surface view.
Full, symmetrical activity



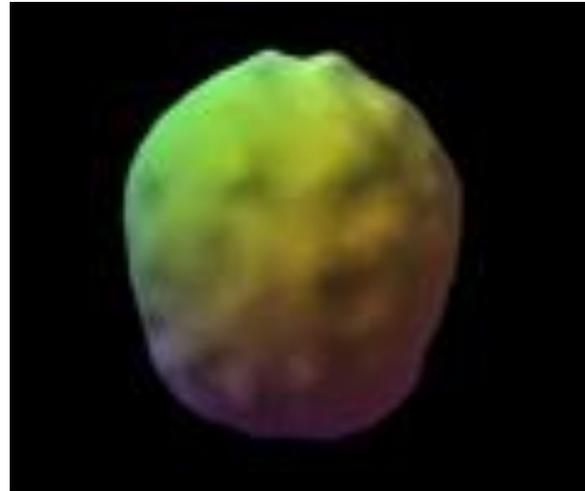
During substance abuse



One year drug and alcohol free

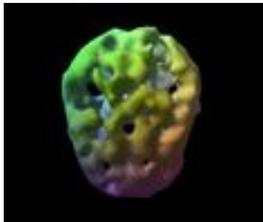
Notice the overall holes and shriveled appearance during abuse and marked improvement with abstinence.

Which Brain do You Want?

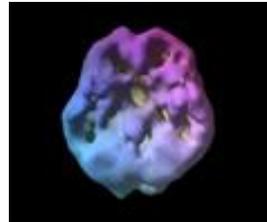


Normal healthy view.
Top down surface view.
Full, symmetrical activity

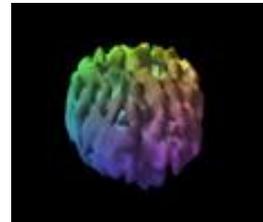
Effects of other substances:



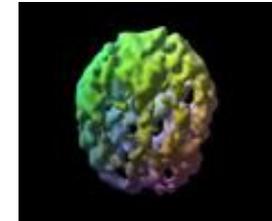
Long term alcohol
abuse



57 y/o 30 years
marijuana abuse
(underside view)



39 y/o – 25 years
frequent heroin use



40 y/o, 7 years on
methadone.
Heroin 10 years
prior.

The Solution

- Prevention
 - Healthy Pennsylvania Permanent Drop Boxes for medication disposal
 - Prescribing Practices Guidelines adopted
- Treatment
 - Medicaid expansion provides additional federal funding for more individuals to access treatment
- Innovative Thinking
 - Governor Wolf has proposed an additional \$5 million for the upcoming budget to address the overdose epidemic.

The Solution (cont.)

- Continue /Expand current initiatives
 - Restrictive Intermediate Punishment
 - Enforcement of DUI laws
 - Medicaid Jail Project
 - Prevents unnecessary spending from lack of agency coordination
 - Prescriber Practices Workgroup
 - Emergency Department Pain Treatment Guidelines
 - Opioid to Treat Non-Cancer Pain
 - Prescription Drug Monitoring Program
 - Naloxone
 - Good Samaritan

Why use the PCPC?

Required by Act 152 of 1988

- Added to services covered by Medicaid (previously only covered limited outpatient and hospital services)
 - non-hospital residential detoxification
 - non-hospital residential rehabilitation
 - halfway house
- Requires use of criteria developed and/or approved by DDAP for governing type, level of care and length of stay
 - PCPC for adults
 - ASAM for adolescents

▶ A note about Act 106 of 1989

- Requires all commercial group health plans, HMOs, and the Children's Health Insurance Program to provide comprehensive treatment for substance use disorders.
- Minimum benefits
 - 30 days residential per year
 - 30 sessions outpatient/partial hospitalization per year
 - 30 additional outpatient/partial hospitalization sessions that may be exchanged on a 2:1 basis for up to 15 additional residential treatment days
 - Family counseling and intervention services
- Only lawful prerequisite is a certification and referral from a licensed physician or licensed psychologist
- Concurrent reviews are not required during this time

Recommendations

| Why Treatment Fails | Why Treatment Works |
|---|--|
| Length of Stay (Less than 90 days) | Length of Stay (More than 90 days) |
| Undertreating (Giving OP instead of TC) | Appropriate Level of Care |
| Fragmented care (Detox only, 12-step only) | Full Continuum of Care |
| Weak Enforcement of Insurance Law | Enforcement of State and Federal Laws |
| Medicating all Pain | Appropriate Prescribing |
| Stigma (Seeing individuals as “bad”) | Humanizing (Treating those with disease) |
| Locking up Drug Users | Treating those with Substance Use Disorder |
| Thinking There is a Silver Bullet | Clinical Integrity |

What Works: Clinical Integrity

▶ What Can I Do? 10 Simple Steps

- Are my programs trained in criminal thinking and needs?
- Are my programs trained in drug and alcohol treatment?
- Are we using adequate lengths of stay or terminating based on funding?
- Are we using a continuum of care?
- Are we educating on proper prescribing practices?
- Does our county have medication take back boxes?
- Are we expanding the use of Naloxone to save overdose victims?
- Are we facilitating access to funding for needed services such as implementing the jail Medicaid project?
- Are we supporting our community efforts for prevention, to reach long term improvement.
- Are we doing SOMETHING? Pick one and keep moving forward.

Contact Information

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