Effective Substance Abuse Treatment for the Criminal Justice Population

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Pennsylvania Department of Drug and Alcohol Programs
Overview

- Research on effective outcomes across the country
- Review of assessment and treatment issues
- Components of effective treatment
- Recommendations/Discussion
• There are approximately 51,000 inmates in the PA Correctional Prison System.
• In national studies approximately 70-80% of offenders have a substance abuse problem.
• In national studies approximately 50% of offenders reach central booking under the influence of drugs and alcohol.
• Pennsylvania research finds comparable findings
• Every dollar spent in AOD treatment saves 7$
• If medical expenses are included that rises to 11$
• Effective treatment works.
• Clinically appropriate levels of care work.
Why care about drug and alcohol treatment?
- 1 in 4 people has substance abuse in their families
- 1 in 4 people with addiction will die as a result
- Most addicted individuals never commit crimes
- One addicted offender may commit 2-3 crimes per day, 3-4 days per week.
  - This calculates to 455 offenses per year
  - Multiply this by the number of offenders reaches tens of thousands of families affected by crime due to untreated addictions
• Recidivism versus relapse
  – Recidivism is a return to committing crimes
  – Relapse is a return to substance use

  – Often relapse happens first
    • Once the addiction process is restarted, then crimes resume to fund the addiction.
• **Addiction versus criminality**
  – Recidivism is a return to committing crimes
  – Relapse is a return to substance use
  – Most addicted individuals don’t become criminals
  – Many criminals don’t become addicted
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.
The Department’s primary purpose is to develop a drug and alcohol system that is responsive to the needs of the public client. The public client is identified as an individual who is uninsured or underinsured.

Sub-populations are prioritized for services as identified by the Federal Substance Abuse Prevention and Treatment Block Grant, and the Pennsylvania Drug and Alcohol Abuse Control Act, Act 1972-63.

Pennsylvania’s Bureau of Drug and Alcohol Programs reported 50,852 admissions to treatment for FY11 through its 650 licensed treatment providers and provided prevention services to 168,261 individuals.

- For adults, the Pennsylvania Client Placement Criteria (PCPC) is the medial necessity criteria utilized. For adolescents, criteria from the American Society of Addiction Medicine (ASAM) is used for placement.

- Of individuals served, the number of clients without an arrest increased from 60 percent at admissions to 97.5 percent at discharge.
Treatment Goals

Sick/Symptoms → Absence of Symptoms/Health → Wellness

Addiction → Abstinence → Recovery
### Treatment Goals

<table>
<thead>
<tr>
<th>Addiction</th>
<th>Abstinence</th>
<th>Recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemical addiction</td>
<td>Withdrawal</td>
<td>“Addiction” to recovery behaviors</td>
</tr>
<tr>
<td>Dysfunctional relationships</td>
<td>Tension/ distrust/ judgment in relationships</td>
<td>Trust, partnership, respect in relationships</td>
</tr>
<tr>
<td>Negative self image</td>
<td>Lack of confidence/ doubts</td>
<td>Self respect</td>
</tr>
<tr>
<td>Lack of values/spiritual connection</td>
<td>Questioning of values</td>
<td>Knowing personal values and following them</td>
</tr>
<tr>
<td>Motivation to use/drink</td>
<td>Motivation to stop drinking/avoid pain</td>
<td>Motivation to seek pleasure/ health</td>
</tr>
</tbody>
</table>
# Treatment Goals

<table>
<thead>
<tr>
<th>Mental health issues</th>
<th>Awareness of mental health as triggers</th>
<th>Management/ remission of mental health issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>Boredom, blunted emotion</td>
<td>Happiness, range of emotion</td>
</tr>
<tr>
<td>Avoidance /numbing of feelings</td>
<td>Aware of uncomfortable feelings</td>
<td>Able to tolerate unpleasant feelings as they arise</td>
</tr>
<tr>
<td>Lack of range of coping skills</td>
<td>Novice at identifying coping strategies</td>
<td>Competent at a range of coping strategies</td>
</tr>
<tr>
<td>Unresolved trauma/grief</td>
<td>Aware of losses</td>
<td>Able to “let go” of past</td>
</tr>
<tr>
<td>Personality disorder(s)</td>
<td>Aware of personal issues</td>
<td>Able to reduce negative impact of personality style</td>
</tr>
<tr>
<td>Unmedicated (bipolar, ADHD etc)</td>
<td>Finding proper medication combination</td>
<td>Stable on effective medication</td>
</tr>
</tbody>
</table>
Past-Year Initiates for Specific Illicit Drugs Among Persons Age 12 or Older

Overdose Deaths in Pennsylvania

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 15.4 per thousand Pennsylvanians.
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.
• 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.
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.
Based on Pennsylvania Corners 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
Source of Nonmedical Use of Prescription Drugs

**Source Where User Obtained**
- More than One Doctor (1.8%)
- Free from Friend/Relative (54.0%)
- One Doctor (19.7%)
- Other\(^1\) (5.1%)
- Bought on Internet (0.2%)
- Drug Dealer/Stranger (4.3%)
- Bought/Took from Friend/Relative (14.9%)

**Source Where Friend/Relative Obtained**
- One Doctor (82.2%)
- More than One Doctor (3.6%)
- Free from Friend/Relative (5.4%)
- Bought/Took from Friend/Relative (5.4%)
- Drug Dealer/Stranger (1.4%)
- Bought on Internet (0.2%)
- Other\(^1\) (1.8%)
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."
Other Drug Issues of Concern

- Synthetics (e.g. K-2, Spice, synthetic marijuana)
  - Particularly in the CJ population as there is limited drug testing for it

- Fentanyl
  - High risk of mortality
  - Recent increase in PA, with 50 confirmed deaths in the past few months

- Poly substance use
  - Medications are often drug specific (i.e. methadone for opiates vs. antabuse for alcohol)
  - Drug using individuals can often use multiple types of substances

- Although medications exist for opiates and alcohol, they do not exist for a range of other abused substances
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**
Table 1: Summary of Costs and Benefits Associated with Substance Abuse Treatment (Based on the Social Planner Perspective)

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

*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
Delaware Correctional System participants in prison TC (Key) and work release TC (Crest)
Drug-free and arrest-free 1 year after work release

Percent of patients

<table>
<thead>
<tr>
<th></th>
<th>Drug-free</th>
<th>Arrest-free</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Tmt</td>
<td>16%</td>
<td>22%</td>
</tr>
<tr>
<td>Key</td>
<td>46%</td>
<td>43%</td>
</tr>
<tr>
<td>Crest</td>
<td>31%</td>
<td>57%</td>
</tr>
<tr>
<td>Key-Crest</td>
<td>47%</td>
<td>77%</td>
</tr>
</tbody>
</table>

*p<.05 from no treatment.

Percentages show any use of drugs (either self-reported or detected by urinalysis) and any arrests in the year after work release. Note that prisoners were allowed to access treatment on their own, and some of those in the no treatment condition did receive services that were not part of the Key or Crest programs. Total number of patients was 448.

### What would this mean to PA?

#### Delaware Correctional System participants in prison TC (Key) and work release TC (Crest)
Drug-free and arrest-free 1 year after work release

#### Percent of patients

<table>
<thead>
<tr>
<th></th>
<th>No Tmt</th>
<th>Community TC</th>
<th>Prison and Community TC</th>
<th>Difference/ Annual Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Arrest Free</strong></td>
<td>46%</td>
<td>57%</td>
<td>77%</td>
<td>31%</td>
</tr>
<tr>
<td><strong>Arrested</strong></td>
<td>54%</td>
<td>43%</td>
<td>23%</td>
<td>31%</td>
</tr>
<tr>
<td>Number of inmates returned to prison</td>
<td>5,208</td>
<td>4,147</td>
<td>2,218</td>
<td>2,990 crime free lives</td>
</tr>
<tr>
<td><strong>Annual Cost</strong></td>
<td>$166,965,965</td>
<td>$132,954,380</td>
<td>$71,115,133</td>
<td><strong>$95,850,832</strong></td>
</tr>
</tbody>
</table>

Cost per inmate per year in PA: $32,059

Number of new releases per year in PA: 13,778

Number of releases with addiction (based on 70% rate): 9,645
Across States: Outcome Evaluation

• Similar treatment effects with criminal justice populations have been replicated across 5 states.

• Treatment is best when begun behind the walls and continues into the community.

• Treatment outcomes are lost if clients return to general population with non-recovery focused peer group.
Comparison Group consists of 360 programs nationally.
Pennsylvania Success Story

• Restrictive Intermediate Punishment Program (RIP)
  • Current Alternative Sentencing Option for Level 3 & 4 Offenders Places Offenders in Treatment Based on Need
    • 79% Overall Successful Program Completion Rate
      • 93% Successful Outcomes for DUI Offenders
      • 66% Successful Outcomes for Drug Offenders

• 13.7% Recidivism Rate for Successful Completions at 1 year
  • DOC 1 Year Recidivism = 25.9%
  • At 18 months Program Recidivism has flattened; DOC continues to trend up
Pennsylvania Success Story

• RIP may not save DOC money immediately for some counties unless they shut a prison wing

• RIP saves/generates money in 3 ways:
  • If prison is overcrowded and you are paying for extra prison beds elsewhere
  • If you have empty prison beds and you are paid to house other county state or federal inmates
  • Returning offenders to the community allows ex-offenders to gain employment, generating tax revenues
Pretrial Opportunities

Judges Benefit
• Provides effective alternative to lack of prison beds
• Reduces recidivism

District Attorneys Benefit
• After an offender is successfully attending treatment for a period of time, DAs can feel more confident in supporting completion of treatment rather than state prison time

Offender Benefit
• At the time of arraignment, the offender is in crisis and more willing to accept needed treatment
• There is more incentive to do well in treatment to reduce sentence
• Low risk offenders being placed with high risk offenders leads to poor outcomes. Diversion avoids this risk.
Pennsylvania’s Client Placement Criteria (PCPC)
- Treatment targets Risks/Needs
- Continuum of care
- Access to treatment
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.
• Importance of Level of Care
  – Under treating can lead to treatment resistance or increased progression of the disease
    • What happens if you take a half dose of antibiotic?
    • What happens if you take a half dose of insulin?
    • What happens if you take a half dose of treatment?
  – Answer:
    • It doesn’t work
    • Individuals get sicker
    • Individuals and providers “give up” believing that there is no hope
What about overtreating?

- For years TC’s did not have a length of stay requirement
- Treatment lengths have shortened due to financial constraints
- Increased lengths of care are associated directly related to better outcomes (i.e. abstinence, recidivism, continued employment)
- When a client receives a higher level of care (eg. TC) when they are recommended a lower level of care, they have better outcomes (DeLeon, 2001)

  - For appropriate treatment there is no risk of overtreatment
  - Overtreatment is an issue with medication (causing illness) or with maintenance without treatment (e.g. hospitalization or incarceration becoming “institutionalized”)

For appropriate treatment there is no risk of overtreatment
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 higher rates of improvement among those with 9 months of treatment, and reduced effectiveness for treatment 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


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

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- 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)
Elements of Effective AOD Treatment

• 1. Program Leadership and Development
  – Eg: Experienced program director, valued by the criminal justice community, adequately funded

• 2. Staff Characteristics
  – Eg: Education specific to CJ population, clinical supervision

• 3. Offender Assessment
  – Eg: Risk/Needs assessed, target high risk issues

• 4. Treatment Characteristics
  – Eg: Program length minimum of 6 months, appropriate rewards/punishers

• 5. Quality Assurance
  – Eg: Quality improvement process, evaluations
  -Latessa, Correctional Program Checklist
<table>
<thead>
<tr>
<th>Assessment:</th>
<th>PCPC</th>
<th>LSI-R</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Severity of substance abuse</td>
<td>Severity of criminality</td>
</tr>
<tr>
<td>Use:</td>
<td>Level of placement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For substance abuse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>treatment</td>
<td>Level of placement/ supervision due to security risk</td>
</tr>
<tr>
<td>Areas examined:</td>
<td>Substance use intoxication/withdrawal</td>
<td>Criminal history</td>
</tr>
<tr>
<td></td>
<td>frequency of use,</td>
<td></td>
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<tr>
<td></td>
<td>severity of abuse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>tolerance/withdrawal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Crimes caused by substance use as severity of substance use</td>
<td>Substance abuse as risk of recidivism</td>
</tr>
<tr>
<td></td>
<td>Impact of substance on work performance</td>
<td>Employment history</td>
</tr>
<tr>
<td></td>
<td>Biomedical Complications</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Emotional/Behavioral Complications</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Treatment Acceptance/Resistance</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Relapse Potential: ability to manage urges</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Substance abuse in household</td>
<td>Criminal family/household</td>
</tr>
<tr>
<td></td>
<td>Recovery Environment</td>
<td>Lives in high crime neighborhood</td>
</tr>
<tr>
<td></td>
<td>Substance using acquaintances</td>
<td>Criminal acquaintances</td>
</tr>
</tbody>
</table>
Progression of a Disease and Recovery

Prevention

No addiction
No drinking
Social drinking
Drinking feels good
Drink to relax
Drink to escape
Withdrawal from friends
First DUI
Conflict in relationships
Missed time from work
Regular drinking
Amount of drinking increases
Drink to stop feeling bad
Disciplinary action at work
Association with negative peer group
Antisocial beliefs justify behaviors

Intensive Treatment

Outpatient Treatment

Early Addiction
"Rock Bottom", Arrests
Divorce, Loss of Job
Depression,
Hopelessness,
Suicide, Death

Middle Addiction
Give to others
Optimism
Regain job
Face problems
Honesty
More relaxed
Relationships improve
Begin to develop trust
Resolve legal issues
Self respect returning
Connect with sponsor/
positive peer group
Self examination
Medical stabilization
Thinking begins to clear
Desire for help

Late Recovery

Late Addiction
No drinking
Social drinking
Drinking feels good
Drink to relax
Drink to escape
Withdrawal from friends
Winuffs
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
• In terms of assessment, offenders in prison are considered to be for example:

“303.90 Alcohol Dependent, in a controlled environment”

• In terms of addiction treatment, the level of care needs to be based on the substance use just prior to incarceration, even if that was several years past.
Biology
Example of 2 Brain pathways

Urge to Use

Decision to Use
- Get Money (may be illegally)
  - Go to dealer
    - Use, Use, Use
      - Drug wears off, crash

Decision not to Drink
- Engage in Abstinence Behavior, eg call sponsor
  - Recovery Behavior, eg go to work, be honest, manage family etc
    - Late Stage Recovery Behavior
Urge to Use
Decision to use
Get Money
Go to dealer
Use
Drug wears off, crash

Decision not to use
Engage in Abstinence Behavior, eg. call sponsor
Recovery Behavior eg. go to work, be honest, manage family etc
Late Stage Recovery Behavior

Prison
Anticipation
Excitement
Hope
Rush Chemical
Oh Shoot
Depressed
Hate Self

Enjoyment
Passion
Hope
Variety/New experiences
Like Self
A COMPREHENSIVE CONTINUUM OF CARE
What is a Therapeutic Community?
What were they doing that worked?
What it is not:

- “Hug a thug”
- “He had such a difficult life. We should let him off easy”
- “Tell me about your mother”
- “If I get you a job you will be cured”
- “If I teach you that drugs are bad, you will stop”
What it is:

- High accountability
- Behavioral practice and feedback
- Correction of criminogenic beliefs and thinking patterns
- Tools in practicing effective management of negative emotions

Although the TC has many elements, a defining principle is the use of Community as Method.
The Goal of the TC is not only to stop addiction.

The Goal of the TC is Right Living

– This is a higher standard that requires both:
  • Abstinence from substances
    AND
  • Develop a crime free lifestyle
    AND
  • Contributing members of society
## TC as cultural change

<table>
<thead>
<tr>
<th></th>
<th>Prison Culture</th>
<th>TC Culture</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rules</strong></td>
<td>“No snitching”</td>
<td>Open communication</td>
</tr>
<tr>
<td><strong>Expectations</strong></td>
<td>Trust no one</td>
<td>Trust</td>
</tr>
<tr>
<td><strong>Goal Focus</strong></td>
<td>Short term gains</td>
<td>Long term gains</td>
</tr>
<tr>
<td><strong>Gratification</strong></td>
<td>Instant gratification</td>
<td>Delay of gratification</td>
</tr>
<tr>
<td><strong>Peer group</strong></td>
<td>Negative peer group</td>
<td>Positive peer group</td>
</tr>
<tr>
<td><strong>Ethics</strong></td>
<td>My best interest</td>
<td>The interest of the community</td>
</tr>
<tr>
<td><strong>Goals</strong></td>
<td>Money, power, pleasure</td>
<td>Right living</td>
</tr>
<tr>
<td><strong>Responsibility</strong></td>
<td>Blame/victim</td>
<td>Personal Responsibility</td>
</tr>
</tbody>
</table>
Good Treatment = Cost Savings
Cost Savings from Substance Abuse Services

Criminal Justice System Impact

Health System Savings

Figure 2: Criminal Recidivism One Year After Treatment Initiated but Not Completed or Treatment Completed

The Average Cost Of An ER Visit Declines By 29 Percent

Untreated

- $1,456

Average Per ER Visit

29% Reduction

Treated

$1,039

Reduced Cost Per ER Visit

n = 8,881

n = 7,153
• Children born of mothers abusing drugs/alcohol are at high risk of medical complications and costs such as Neonatal Abstinence Syndrome and an average of 24 days spent in Neonatal Intensive Care Units at birth.

• A CSAT grant in 2008-2011 providing treatment to pregnant women resulted in 34 healthy babies being born at an estimated cost savings of $2,380,000 due to reduced need for NICU stays.

• This grant project found cost savings are estimated to save $140,000 for every child born free of addiction because their mother got treatment.

Long-term benefit: Priceless
– Substance Abuse Treatment
  • Treatment based on appropriate level of care, eg. Long term residential
– Recovery Support
  • Connection to a support group
  – Support group: 12 step, etc.
  – Sponsor
– Psychiatric Follow up
  • PTSD and other Trauma
  • Bipolar Disorder
  • Depression/Anxiety
– Medical
  • HIV/AIDS
  • Other complications from chronic substance abuse
– Employment/Vocational training
  • Resources to connect with available jobs
– Housing
– Identification and Driver’s License
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.
• Continue /Expand current initiatives
  – Restrictive Intermediate Punishment
  – Enforcement of DUI laws
  – Medicaid Pilot 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
• 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/90 days lifetime
  – 30 sessions outpatient/partial hospitalization per year/120 days lifetime
  – 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

• Continue to focus on allocation of funding and better utilization of funding

• Effective treatment practices (long enough, strong enough, with continuum of care) to support those in need, and return them to their role as productive citizens

• Investing in these practices today saves money, reduces unnecessary government costs of untreated addiction, and saves lives.
• Treatment works
  – If it is long enough and strong enough
  – If it is at the appropriate level of care
  – If it has appropriate step down in intensity continuum
  – If it bridges from institution to community
• Treatment saves money
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