

final minutes

Criminal Justice Policy Commission Meeting

9:00 a.m. • Wednesday, April 6, 2016

Senate Appropriations Room • 3rd Floor State Capitol Building

100 N. Capitol Avenue • Lansing, MI

Members Present:

Senator Bruce Caswell, Chair
Senator Patrick Colbeck
Representative Vanessa Guerra (via teleconference)
D. J. Hilson
Kyle Kaminski
Sheryl Kubiak
Barbara Levine
Sarah Lightner
Sheriff Lawrence Stelma
Jennifer Strange
Judge Paul Stutesman (via teleconference)
Andrew Verheek
Judge Raymond Voet
Representative Michael Webber (via teleconference)

Members Excused:

Stacia Buchanan
Senator Bert Johnson
Laura Moody

I. Call to Order and Roll Call

The Chair called the meeting to order at 9:01 a.m. and asked the clerk to take the roll. A quorum was present and absent members were excused.

II. Approval of the March 2, 2016 CJPC Meeting Minutes

The Chair asked for a motion to approve the March 2, 2016 Criminal Justice Policy Commission meeting minutes.

Commissioner Lightner moved, supported by Commissioner Hilson, that the minutes of the March 2, 2016 Criminal Justice Policy Commission meeting as proposed be approved. There was no objection. The motion was approved by unanimous consent.

III. Mental Health Subcommittee Update

a. Update by Subcommittee Chair

The Chair called on Commissioner Lightner who noted that, as requested by the Chair, several individuals are present at today's meeting to provide information on mental health issues within the criminal justice system.

b. Presentations on Mental Health

Commissioner Kubiak introduced the first set of speakers.

1) Steven Mays, Department of Health and Human Services

Mr. Mays provided an overview of the Mental Health Diversion Council.

2) George Strander, Member of the Mental Health Diversion Council

Mr. Strander talked briefly about assisted outpatient treatment and efforts to revamp legislation known as Kevin's Law.

3) Honorable Curtis Bell, Member of the Mental Health Diversion Council

Judge Bell spoke about roadblocks the Council ran into with regard to the release of information and the standardized probation release form that was developed to address this issue.

4) Lynda Zeller, Department of Health and Human Services

Ms. Zeller shared information on the major initiatives that are underway within the department including the Stepping Up initiative.

5) Professor Sheryl Kubiak

Commissioner Kubiak spoke a few words regarding her activities as part of the team evaluating the Governor's Diversion Council pilot programs.

Commissioner Lightner then introduced the next presenter.

6) Judge Michael Klaeren

Judge Klaeren provided information about the Jackson County Mental Health Court. For more details, see his testimony attached to these minutes.

Commissioner Strange introduced the last presenter.

7) David Dawdy, Director of Mental Health Services, MDOC

Mr. Dawdy provided information on mental health services available for individuals after they are released. See his presentation attachments for more details.

IV. Presentation by Dr. Douglas Marlowe, Evidence-Based Practices for Measuring Criminal Justice Performance Indicators, Recidivism, and Outcomes

The Chair called on Judge Voet to introduce the next presenter, Dr. Douglas Marlowe. After the introduction, Dr. Marlowe began his presentation on data collection and program evaluation in the criminal justice system. For more details, please see his slide presentation which is attached to these minutes. A period of question and answer followed.

V. CJPC Budget and Boilerplate Language Discussion and Update

The Chair directed members' attention to the proposed boilerplate language from Senator Colbeck.(see attachment) and noted that the timeframe in the second line has been changed from "quarterly" to "semi-annual". Commissioner Kubiak offered that it might be nice to use the information provided by Dr. Marlowe to create more succinct indicators. The Chair tasked the subcommittee to work with Senator Colbeck on this change and distribute the revised language to Commission members as soon as possible.

VI. Robina Institute Criminal History Enhancements Sourcebook and Worksheet

The Chair noted that he will be sending out a list of the remaining categories in order of importance from the Criminal History Enhancements Sourcebook worksheet.

VII. Commissioner Comments

The Chair asked if members had any additional comments. Commissioner Kaminski raised a general concern that the proposed boilerplate language obligates the Commission to be the data collector for the legislature and may create a redundancy in the data already being collected by others. A discussion followed.

VIII. Public Comments

Mr. Jim Casha, of Ontario, Canada, testified and submitted written testimony which is attached to these minutes. There were no other public comments.

IX. Next CJPC Meeting Date

The next CJPC meeting is scheduled for **Wednesday, May 4, 2016, at 9:00 a.m. in the Senate Appropriations Room, 3rd Floor of the State Capitol Building.**

X. Adjournment

There was no further business. The Chair adjourned the meeting at 12:34 p.m.

Jackson County Mental Health Court

Introduction

Planning for the Mental Health Court began in April of 2007 with the formation of the Community Stakeholder's Steering Committee which drew from a wide swath of the community. Members included representatives from the legislature, judiciary, Lifeways (CMH), law enforcement, county commission, mental health providers, substance abuse providers and NAMI. The Court began operation in the summer of 2008 (without outside funding) and continues to operate through the present. Jackson County's court is the second oldest in Michigan.

What is a Mental Health Court?

Mental Health Court (MHC) is a special court docket consisting of participants who have committed a crime and have a mental illness or mental illness/substance use disorder. This is a voluntary court and no defendant is forced to participate.

A single judge presides over this docket and leads the MHC Treatment Team. This team tailors a treatment plan which is incorporated into court ordered probation. It is much more structured than traditional probation and monitoring is very extensive thereby limiting the defendant's ability to get too far off track without being discovered. The goal of the court is to teach individuals how to deal with their illness thereby eliminating future criminal activity. An ancillary benefit is an improved quality of life for the participants enhancing their productiveness within the community.

Make-up of Mental Health Court Treatment Team

- Judge – 12th District Court
- Prosecutor
- Defense Attorney
- District Court Probation Officer
- Circuit Court Probation Officer
- MHC Coordinator
- LifeWays (Community Mental Health)
- Mental Health Evaluator
- Case Manager
- Substance Abuse/Inpatient Community Hospital Provider- Allegiance Health

General Eligibility Criteria

The team utilizes the following general eligibility criteria to accept/reject individuals:

- Individual is 18 years or older and resident of Jackson county.

- Individual has the capacity to understand the requirements of the Mental Health Court Program and voluntarily agrees to participate in the Mental Health Court Program.
- Individual has a diagnosis of schizophrenia, schizoid affective disorder, bipolar disorder, or major depressive disorders.
- Mental illness contributed to crime
- Individual is not on parole
- Individual has committed any misdemeanor; any possession of drugs; felony offenses with maximum penalty of up to 5 years (without habitual) based on conviction , not charge; CSC 4th and Child Abuse -3rd degree are not eligible charges

Overview of Jackson County Mental Health Court Process

Selection of Participants

The process begins with the completion of a one page application by the defendant. The Mental Health Coordinator screens applicants to determine whether non-medical criterion are met. Thereafter, a licensed professional counselor through Integro conducts an assessment and generates a report. The treatment team meets bi-weekly (with the report(s) reviewed beforehand) and vote on admittance/rejection. Approximately 50% are accepted. Primary reasons for rejection are:

1. Individual does not have cognitive ability to follow instructions
2. Participant suffers from organic brain dysfunction which is not amenable to treatment
3. Substance abuse is the overriding problem with mental illness either playing a small role in defendant's situation and/or in the alternative is sequela of the substance abuse.

If the defendant is accepted, a plea must occur. There is a no guarantee that the conviction will be set aside/deferred upon successful completion of probation. The "carrot" is the avoidance of jail time. Generally, individuals who are accepted into the Mental Health Court will not receive up-front jail. If up front jail is required, the individual is allowed to opt out of the program and is returned to the originating court for sentencing.

Probation

Misdemeanants are normally placed on fifteen months probation and felons receive two –three year terms. In addition to standard requirements, most terms of probation include medication compliance, substance abuse counseling and adherence to treatment team instructions. Medication compliance may be monitored as all participants are required to obtain medications from a designated pharmacy. This allows the court to track frequency of prescription refills. We also occasionally use a med-drop

program with medication delivered on a daily basis to ensure administration of the same. Failure to take medication can potentially result in jail time via a probation violation.

Substance abuse treatment is an integral part of the program. Self-medication with illicit drugs occurs regularly with our population. As an adjunct to counseling, random drug testing is frequently utilized with some individuals testing as often as three times per week. An outside vendor (ADAM) conducts the testing and the expenses are paid through our grant funding. Inpatient treatment is also implemented as needed (currently three individuals are hospitalized).

Regular probation contact is required along with routine case manager contact. These interactions are in addition to regular court reviews (two times per month for those in the early part of their probation). The treatment team participates in these sessions.

Although court reviews are on the record, they are more relaxed when compared with traditional proceedings. Extensive interaction between the participants and the judge occurs. Encouragement is given, accomplishments recognized and requests for probation changes discussed. These interactions convey to the participants that the treatment team is interested in their welfare/success.

Probation violation arraignments may occur at review. Sanctions can include admonishments, community service, and jail. Defendants need to see these proceedings as non-performance has consequences. The mind-set that mental illness devolves the individual of all personal responsibility needs to be eliminated.

For those that successfully complete the program, a graduation ceremony is held. A framed certificate along with a Meijer gift card is presented. The participant is allowed to make a valedictory address. The pride with which many of the graduates approach the ceremony is heartening and gratifying. For this population, success in anything has been in frequent.

Statistical Data

The cap for the Jackson Court is forty members. Currently, we have participating/ awaiting sentencing 37 individuals. Three of those are in bench warrant status.

For the fiscal year 2015, 19 individuals were discharged from the program, eleven successfully for a pass rate of 58%. Thirty seven percent of these individuals were felons with the remainder misdemeanants. Mental health courts have limited participants for several reasons. First, the programs are voluntary and many ill people either do not want or perceive the need for treatment. Second, for those courts that accept misdemeanants there is little incentive to participate in a mental health court program (because it is a lot of work) since opting out probably will result in a sentence of fines and costs only. Third, these programs are labor intensive with funding/ personnel potentially in short supply. Finally, not all entities/individuals associated with the criminal justice system believe in the need or efficacy for specialty courts.

Given the relatively small participant numbers, it is difficult to develop meaningful data without the passage of extensive time. The Michigan Supreme Court/State Court Administrative Office has issued a performance report entitled Michigan Problem Solving Courts covering the period 10/1/12 through 9/30/14. In addition to finding reduced recidivism for successful mental health court participants, the following was disclosed:

- a) Average age of all participants is 34
- b) Forty eight percent of all participants lack a GED or high school diploma
- c) Forty eight percent graduate successfully
- d) Male/female breakdown is 59% /41%
- e) Sixty percent of all participants have a co-occurring substance abuse disorder
- f) Thirty one percent of all participants suffer from some form of bi-polar disorder and another 21% suffer from some form of depression as their primary diagnosis
- g) Caucasian/African American breakdown is 69%/ 26%
- h) Ninety five percent of graduates have improved quality of life and 82% are medication compliant

The above referenced report can be reviewed at the Michigan Problem-Solving Courts section of the SCAO website at courts.mi.gov/SCAO see page 18-27.

Final Note

Additional information to be provided during oral presentation

Honorable Michael J. Klaeren

Re-Entry Transition and Aftercare Planning Responsibilities For Mental Health Services (MHS) Treatment Teams

QUICK REFERENCE GUIDE

PCS (Professional Consulting Services): Contract agency to MDOC to provide aftercare planning and coordination for Special Needs prisoners, including those with deferred paroles (D47, D48) and Maxout prisoners.

D47 PRISONERS – Prisoners receive a deferred parole with expectation that an aftercare plan will be developed by PCS. Designated prisoners are generally transferred to the Adrian Facility (ARF) unless they are in inpatient care or reside in one of the ASRP programs, or cannot transfer due to medical/program issues or SPON. Mental Health Services Re-Entry staff complete a Needs Assessment for each prisoner. Video conferencing may be utilized for prisoners who cannot transfer to ARF.

Treatment Team Responsibilities:

- Ensure QMHP/CPE assessments and treatment plan (CTP) are in NextGen prior to prisoner transfer (1-3 weeks from date of notification to the team).
- Complete P&C Review prior to prisoner transfer to ARF (or 1-3 weeks from date of notification).
- Approve or recommend changes to the Needs Assessment when forwarded by the MHS Re-Entry team.
- Approve or recommend changes to the Aftercare Plan when forwarded by Lynda Bragg of the Re-Entry office.
- Discuss both Needs Assessment and Aftercare Plan with prisoner.
- Arrange for 30 days of medications to accompany prisoner at release.
- Adhere to other discharge planning requirements indicated in the operating procedure referenced immediately below.

D47 PRISONERS NOT ACTIVE WITH MHS – The Parole Board issues deferred paroles to certain prisoners not currently active with MHS.

Treatment Team Responsibilities:

- Complete QMHP assessment and notify Lynda Bragg. Refer case to OPT psychiatrist for possible admission to OPT if QMHP assessment indicates mental health issues.

MHS Re-Entry Team Responsibilities Include:

- Forward QMHP assessment to Parole Board staff and to PCS;
- Re-Entry Team completes Needs Assessment, PCS completes Aftercare Plan.

D48 PAROLES (MEDICALLY FRAGILE) – Health Care has responsibility for the case unless the prisoner is also active with MHS. MHS Re-Entry team collaborates with Health Care to ensure that mental health needs, if any, are documented.

P SERIES PAROLES (P70, P61, P76) – Prisoners receive a positive parole action. Prisoners with P70 are given a parole date which is usually 60 days from the action date and are transferred to an In-Reach facility based on prisoner's county of return. The P61 Code is a positive parole action but the prisoner is not designated for Re-Entry In-Reach involvement. The P76 Code is similar to the P61 code but prisoners are given a parole action without a hearing.

Treatment Team Responsibilities:

- Consult Ad Hoc Insyte Report weekly to identify prisoners on the caseload.
- Within the first 1-2 weeks following identification (and before transfer), update QMHP, CPE, and Treatment Plan.
- Within first 1-2 weeks, submit electronic version of P&C Review to Lynda Bragg at ARF.

- For P70 prisoners, OPT team at In-Reach Facility completes Needs Assessment within 2-4 weeks of transfer in and provide Needs Assessment to Re-Entry Facility Staff (Institutional Parole Agent or IPA) – IPA will document needs in the COMPAS and TAP.
- Work with In-Reach Facility Re-Entry staff to complete the Aftercare Plan by contacting community mental health service programs (CMHSPs) or other community providers to arrange an appointment for psychotropic medication renewal and assessment for mental health service need.
- Document mental health appointments on the NA/AP Form and provide completed form to IPA with request that it be included in COMPAS/TAP and forwarded to Field Agent responsible for parolee.
- For other P Series prisoners, complete needs assessment and work directly with community providers to develop arrangements for medication renewal and assessment for need for mental health services.
- Arrange for 30 days of medications to accompany prisoner at time of release.

DISCHARGING / MAXOUT PRISONERS – Prisoners who serve their entire sentence. PCS will provide pre-release aftercare planning for maxouts from Inpatient, RTP and Outpatient levels of care regardless of their county of return. For all max out prisoners it is the responsibility of the treatment team to complete the Needs Assessment which becomes the basis of the referral to PCS.

Treatment Team Responsibilities include:

- Consult Ad Hoc Insyte Report weekly to identify maxout prisoners on the caseload who are discharging and/or maxing out in the next six (6) months.
- Within the first few weeks following identification of the prisoner, update all key assessments and plans, including QMHP, CPE, and Treatment Plan.
- At approximately 60 days prior to discharge, submit completed electronic version of P&C Review to Lynda Bragg at ARF.
- Within 60 days of discharge date, complete the Needs Assessment portion of the Needs Assessment and Aftercare Plan form and forward to Lynda Bragg at ARF who will forward to PCS for completion of the Aftercare Plan portion of the document.
- Within 60 days of discharge date, for a prisoner on OPT caseload who refuses to consent to PCS involvement, OPT team completes Needs Assessment and contacts Community Mental Health Services Program (CMHSP) or other community providers in prisoner's county of residence/return to arrange appointment for mental health services.
- Document mental health appointments on the NA/AP Form and forward completed form to CMHSP or other community provider.
- Arrange for 30 days of medications to accompany prisoner at time of release.

HYTA CASES – Youthful trainees committed to the MDOC under the Holmes Youthful Training Act (HYTA) will be served by PCS only if they qualify for service as Mentally Ill, Medically Fragile or Developmentally Disabled. Qualifying HYTA cases will receive pre-release services only (see Discharging/Maxout guidelines above) unless they are discharging to a term of state supervision.

Updated 05/05/2014

Key Points:

1. CPEs must be updated within 12 months of parole action for active prisoners;
2. Insyte Release Date Report should be run weekly by each of the teams;
3. Teams can request through Re-Entry Program that prisoners have access to PCS services – this includes P70 prisoners or non-qualifying maxouts with high risk factors for recidivism (please provide rationale).
4. Prisoners in RTP or Inpatient should always be designated for deferred parole – contact Re-Entry Program if any of these prisoners have a P70, P61, or P76.
5. Max out prisoners from Inpatient and RTP levels of care who refuse PCS involvement are likely to have a positive P&C review.

Bureau of Health Care Services
Mental Health Services Continuum of Care
 September 2015

Level of Care	Location(s)	September FY 2015	Percent of Prisoners in Treatment
Inpatient: <ul style="list-style-type: none"> ▪ CSP ▪ Acute ▪ RTS 	<ul style="list-style-type: none"> ▪ WCC (Woodland) ▪ WHV (Women’s Huron Valley) 	243	2.59%
Residential Treatment Program: <ul style="list-style-type: none"> ▪ RTP (includes SS RTP) ▪ ASRP 	<ul style="list-style-type: none"> ▪ MRF ▪ WHV ▪ ARF ▪ MTU ▪ SLF/MTU 	979	10.44%
Outpatient Mental Health Services (OPMHT) (includes SS OPT)	24 teams cover all prisons	7,826	83.43%
CSI	Counseling Services Intervention cases managed by OPT teams	332	3.54%
Total		9,380*	100%
CFA Total		43,045**	

Based on September FY 2015 data, 22% of MDOC prisoners receive MH services.

*Mental health data was collected on 9/15/2015.

**CFA total obtained from OMS Report CB-971, week of 9/18/2015 – 9/25/2015.

Bureau of Health Care Services

Mental Health Services Continuum of Care

September 2015

The continuum of mental health services includes the following:

Inpatient Services

Inpatient Services include the Crisis Stabilization Program (CSP), Acute Care (AC) and Rehabilitative Treatment Services (RTS). The Crisis Stabilization Program is intended for prisoners whose symptoms indicate a potential mental health emergency and a need for immediate intervention and treatment. Acute Care provides intensive assessment and treatment for prisoners with acute mental illness, severe emotional disorders and possible co-existing disorders. Rehabilitation Treatment Services provides inpatient treatment services to prisoners who exhibit significant impairments in activities of daily living and other social skills. Prisoners receiving Inpatient services typically exhibit symptoms of their mental illness that have proved to be resistant to treatment, requiring intensive monitoring and clinical supports to prepare them for a return to a less restrictive level of care in the general population.

Residential Treatment Programs

The Residential Treatment Program (RTP) is the recommended level of care for seriously mentally disabled prisoners. It offers treatment to those individuals who cannot function adequately in the general population without significant supports and modified behavioral expectations and helps them independently function within the general prison population or in the community following parole release or discharge. This includes a Secure Status Residential Treatment Program (SSRTP) which provides a secure and safe alternative treatment option to prisoners with a serious mental disability who would otherwise be in Administrative Segregation because of assaultive, disruptive or unmanageable behavior. The Adaptive Skills Residential Program (ASRP) is a specialized housing option for prisoners who have significant limitations in adaptive functioning due to a developmental disability, traumatic brain injuries or chronic brain disorder.

Outpatient Mental Health Program

The Outpatient Mental Health Program (OPMHT) provides mental health treatment to prisoners with a mental disability and/or behavioral disorder that reside in general population. This includes services through a Secure Status Outpatient Treatment Program (SSOTP) which provides a safe and secure alternative treatment option to prisoners with a serious mental disability who, because of behavioral issues which present a risk to the custody and security of the facility, would otherwise be in Administrative Segregation.

Counseling Services and Intervention

Individual and group psychotherapy are available to offenders who have been determined by a qualified mental health professional (QMHP) to have significant psychological disturbances that affect overall psychosocial functioning. It includes, but is not limited to, supportive counseling, brief therapy, cognitive-behavioral therapy, and dialectical behavior therapy. Prisoners are admitted to and discharged from the counseling program by a QMHP.

**Profiles of D47 Candidates for Discussion
 October 2015**

Profile Type	Indicators	Challenges	Comments
High Need	<ul style="list-style-type: none"> • Serious & persistent mental illness • Hx of psychiatric hospitalization • Hx of treatment noncompliance • Multiple failed paroles or past D47 • Co-occurring SA issues • Hx of RTP or Inpatient Tx • Requires post-release involuntary treatment order • Requires structured placement to support med compliance and basic needs 	<ul style="list-style-type: none"> • Disentangling criminal behavior from symptoms of mental illness • Securing placement, particularly inpatient psychiatric • Ensuring prompt mental health engagement after release • Timely application for traditional Medicaid and SSI • Unlikely to secure employment • Requires support to attend to basic needs 	<ul style="list-style-type: none"> • More likely to meet CMH agency eligibility criteria for services and placement • More likely to qualify for traditional Medicaid and social security benefits
Moderate Need	<ul style="list-style-type: none"> • Hx of mental health treatment • Has not required treatment at RTP or Inpatient units • Few indications for risk of harm as a result of mental illness • Does not meet post release involuntary treatment criteria • Few family or social supports in community 	<ul style="list-style-type: none"> • Supervision needs may be quite high - more likely to have criminal history and multiple criminogenic needs • Not as likely to meet CMH agency criteria for admission (under ACA, this is changing but benefits are limited) • Not as likely to qualify for traditional Medicaid and social security support • No or limited financial support for housing 	<ul style="list-style-type: none"> • Needed referrals may include programs focused on: employment skills training, substance abuse programming, anger management and coping skills, criminal thinking, cognitive behavior therapy
Low Need	<ul style="list-style-type: none"> • Non-serious mental illness or symptoms are in remission • Inactive with Mental Health • Stable housing options • No Hx of parole failure • Positive employment Hx • Strong family and social supports in community 	<ul style="list-style-type: none"> • Unlikely to qualify for traditional Medicaid and social security support • Unlikely to meet CMH agency criteria for admission 	<ul style="list-style-type: none"> • Extenuating circumstances may still warrant D47 designation with these cases

MONITORING & EVALUATION IN THE CRIMINAL JUSTICE SYSTEM

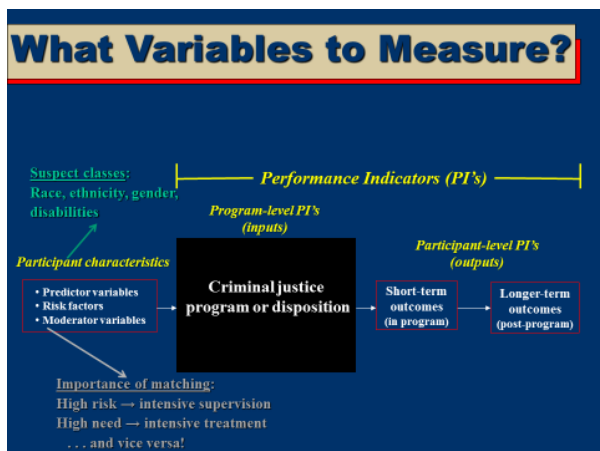
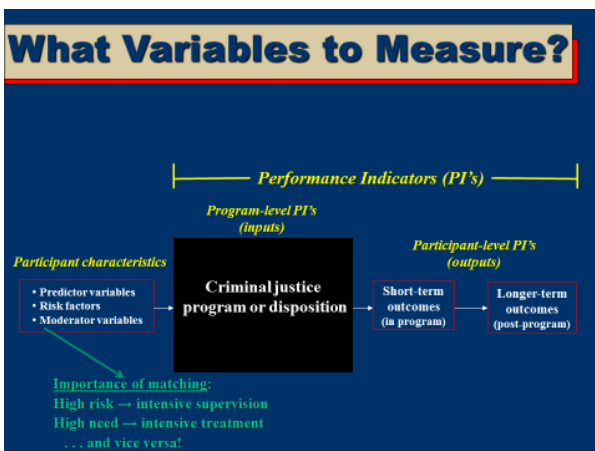
Douglas B. Marlowe, J.D., Ph.D.
 Chief of Science, Law & Policy
 National Association of Drug Court Professionals

- ## Evaluation Landscape
- Data collection, analysis & reporting is largely voluntary and selective (self-interested opacity)
 - Data systems (e.g., DOC, AOC, probation, treatment) don't, can't, or won't talk to each other
 - Questionable reliability, timeliness, and completeness of data
 - Time lag for analysis and reporting (stale information)
 - Ambiguity and disagreement concerning key variable definitions (e.g., "recidivism" or "risk")
 - Failure to prioritize critical vs. desirable information (justified cost and burden of data collection)
 - No information on model adherence
 - Insufficient clarity concerning permissible uses of information leads to insurmountable roadblocks

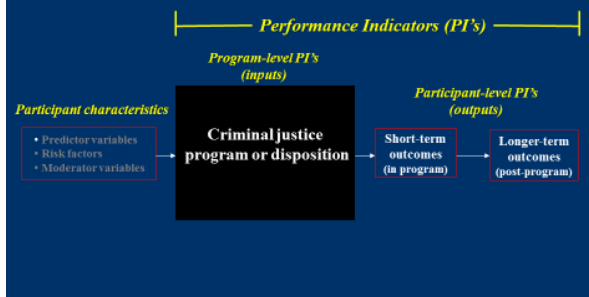
Uses of Information

Use of Information	Interest	Safeguards
Impose detention	5th Amendment self-incrimination (non-public record)	voluntary & informed (non-public record)
Augment a sentence or charge	Due Process liberty interest	accurate / reliable valid use
Eligibility for a community disposition (where detention is authorized)	Due Process rational basis	accurate / reliable valid use (?)
Match to community programs or services	Public access / accountability	accurate / reliable
Program or policy evaluation	Equal Protection disparate impact	accurate / reliable valid use if contributes to disparities
Assess disparate impacts for protected classes		

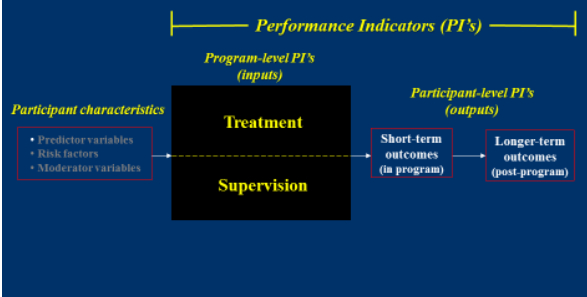
- ## Minimum Safeguards
- Central data-repository; secure & confidential unique identifiers
 - Timely and reliable data entry and reporting is a condition of program funding and staff employment
 - Require de-identification and public access to data for program and policy evaluation, and analysis of disparate impacts
 - Access limitations if not de-identified (none, read-only, entry)
 - Use immunity (if could potentially impact disposition)
 - Use limitations & privacy and disclosure notices or waivers (if not de-identified)
 - Memoranda of understanding or business associate contracts; including limitations on re-disclosure



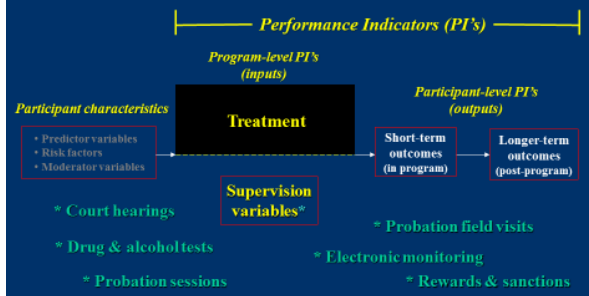
What Variables to Measure?



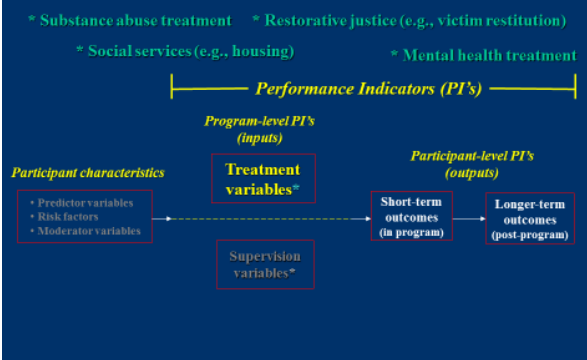
What Variables to Measure?



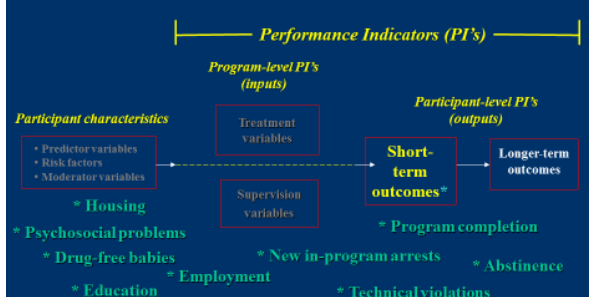
What Variables to Measure?



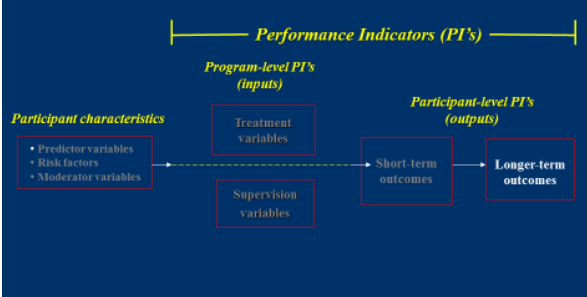
What Variables to Measure?



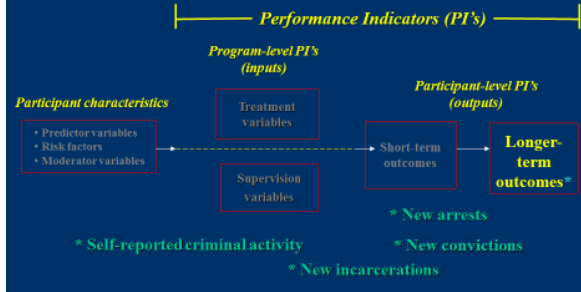
What Variables to Measure?



What Variables to Measure?



What Variables to Measure?



Core Indicators

- Relatively easy and inexpensive to collect
- Predict outcomes or differentiate effective from ineffective programs
- Of primary interest to stakeholders (e.g., taxpayers, policymakers)

“Recidivism”

- **New arrests**
 - Occur relatively quickly
 - Not influenced by plea-bargains
 - BUT: May in fact be innocent
- **New convictions**
 - Offense more likely to have occurred
 - Incur court and sentencing costs
 - Collateral consequences of a criminal record
 - BUT: Takes time to process and influenced by plea agreements
- **New incarcerations**
 - Accounts for most criminal justice costs
 - BUT: Takes time to process and influenced by sentencing discretion
- **Self-reported crime**
 - Not dependent on detection by law enforcement
 - BUT: difficult and expensive to assess, and MUST be assessed anonymously

Recidivism Follow-up

- **1 to 2 years**
 - Recidivism rates highly unstable
- **3 years**
 - Between-group differences likely to remain statistically significant
 - BUT: recidivism rates still unstable
- **5 years**
 - Recidivism rates largely (but not entirely) stabilized
- **OK to report earlier recidivism rates, but should acknowledge potential for instability clearly**

Recidivism Indicators

New arrest rate = $\frac{\# \text{ arrested (for crime before disposition)}}{\# \text{ entered program} - \# \text{ neutral discharges}}$ Low-frequency data is best analyzed by percentages

New conviction rate = $\frac{\# \text{ convicted (for crime before disposition)}}{\# \text{ entered program} - \# \text{ neutral discharges}}$ Categorize by type of offense (property, drug, violent, etc.)

New incarceration rate = $\frac{\# \text{ incarcerated (for crime before disposition)}}{\# \text{ entered program} - \# \text{ neutral discharges}}$ Analyze with and without technical violations

Days of incarceration = date of release from custody - date of entry into custody + 1 Jail vs. prison may have cost implications

Retention Indicators

Completion rate = $\frac{\# \text{ completed successfully} - \# \text{ still enrolled}}{\# \text{ entered program} - \# \text{ neutral discharges}}$ Benchmarks
- probation: 35%
- drug court: 59%

Length of stay = date of discharge or last in-person contact with staff - date of entry + 1

Violation Indicators

Technical violations = # in-program technical violations

Days of detention for violations = date of release from detention – date of entry +1
 (for each in-program episode)

“Risk”

1. **Risk of violence or dangerousness**
 - e.g., Violence Risk Appraisal Guide (VRAG); Sex Offender Risk Appraisal Guide (SORAG)
2. **Criminogenic risk (general recidivism)**
 - e.g., Level of Service Inventory-Revised (LSI-R); Ohio Risk Assessment System (ORAS)
3. **Prognostic risk (treatment/supervision failure)**
 - e.g., Risk and Needs Triage (RANT)

- **The higher the risk level, the more intensive the supervision should be, and vice versa**
- **Mixing risk levels is contraindicated!**

Criminogenic / Prognostic Risks

- Current age < 25 years
- Delinquency onset < 16 years
- Substance abuse onset < 14 years
- Prior felony or serious misdemeanor arrests or convictions (~ 5 yrs.)
- Prior rehabilitation failures (~ 5 yrs.)
- **History of violence***
- Antisocial personality disorder / **psychopathy***
- Familial history of crime or addiction
- Criminal or substance abuse associations

*violence risk

Risk Proxy (Public Record)

- Exclusively public record data
- Short, easy and inexpensive to administer
- Screen out low-risk offenders
- (1) Current age; (2) age of first arrest; (3) number of prior arrests as an adult
- Individuals not screened-out may be offered further voluntary assessment to reduce criminal justice burden or obligations, or access desired services
- Also: Arnold Foundation pretrial risk tool

Bogue et al., 2006

Suspect Classes

- Race, ethnicity (strict scrutiny)
- Gender (intermediate scrutiny)
- Race and ethnicity are not risk factors (though they are often correlated with risk factors)
- Male gender is a risk factor
- Duty to assess and avoid disparate impacts

Core Dataset

1. New arrest rate
2. New conviction rate
3. New incarceration rate
4. Days of incarceration
5. No. of in-program technical violations
6. Days of in-program detention for violations
7. Successful completion rate
8. Length of stay in program
9. Broken down by validly measured risk level
10. Broken down by race, ethnicity, and gender

} By offense category
 } Jail or prison
 } By program type (e.g., probation, Drug Court)

Whom to Measure?

- Intent-to-Treat Analyses
- Exclude neutral discharges only
 - Unrelated to outcomes!

Compared to What?

- National outcomes (e.g., BJS probation completion rates; BJS jail or prison re-offense or readmission rates)
- Average program effects (e.g., WSIPP meta-analyses; Drug Court meta-analyses)
- Quasi-experimental or matched comparison samples
- NOT drop-outs or terminated cases!

Program Fidelity

- Model adherence is associated with 50% to 100% greater effects
- Published Best Practice Standards (e.g., NADCP Standards; Core Correctional Practices for probation)
- Require validated program assessment tool
 - e.g., Correctional Program Checklist (CPC), Correctional Program Assessment Inventory (CPAI)

Cost Evaluations

- Cost Analysis (routine and mandatory)
 - investment costs
- Cost-Effectiveness Analysis
 - improvement in outcome per unit of investment
- Cost/Benefit Analysis
 - cost savings per unit of investment
- Published national outcome costs or savings per arrest, conviction, jail day, etc.

“Need”

1. **Criminogenic needs (dynamic risks; cause crime)**
 2. **Responsivity needs (interfere with rehabilitation)**
 3. **Maintenance needs (reduce rehabilitation gains)**
 4. **Clinical needs (syndromes or diagnoses)**
 - Addiction is criminogenic, and mental illness interferes with rehabilitation
- **The higher the need level, the more intensive the treatment should be, and vice versa**
 - **Mixing need levels is contraindicated!**

Recommended Indicators

- Found in prior studies to predict outcomes or differentiate effective from ineffective programs
BUT . . .
- Difficult or costly to measure
- Partially redundant with other indicators

Discretionary Indicators

- Theoretically relevant to criminal justice outcomes
- Recommended by leading research or practitioner organizations
- BUT . . .
- Have not been well studied
- Are difficult or costly to measure reliably

Court Supervision

- Core performance indicator

Dose of hearings = # of hearings attended

- Discretionary performance indicators

Court appearance rate = $\frac{\text{\# of hearings attended}}{\text{\# of hearings scheduled} - \text{\# of hearings cancelled or rescheduled}}$

Density of hearings = $\frac{\text{\# of hearings scheduled per phase}}{\text{\# of hearings scheduled} - \text{\# of hearings cancelled or rescheduled}}$
U.S. and Australian Benchmarks:
 Every 2 weeks for first phase

Also consider:

Length of time (in seconds) Judge interacts with each participant in court

Likert-scale ratings of judicial demeanor, knowledge, fairness, and neutrality

Drug & Alcohol Testing

- Core performance indicators

Testing dose = # of urine, breath or saliva tests administered

U.S. Benchmark:
Two per week

Testing dose – # days on continuous surveillance

U.S. Benchmark:
90 consecutive days

- Discretionary performance indicators

Testing compliance rate = $\frac{\text{\# of tests provided} - \text{\# of tests invalid or adulterated}}{\text{\# of tests scheduled} - \text{\# of tests excused}}$

Density of testing = $\frac{\text{\# of tests scheduled per phase}}{\text{\# of tests scheduled} - \text{\# of tests excused}}$

U.S. Benchmark:
Maintain testing until last phase

Probation Supervision

- Discretionary performance indicators

Probation dose = # of probation sessions attended + # field visits

Probation attendance rate = $\frac{\text{\# of probation sessions attended}}{\text{\# of sessions scheduled} - \text{\# of sessions cancelled or rescheduled}}$

- Also consider:

Ratings of adherence to Core Correctional Practices (CCPs)

Rewards & Sanctions

- Discretionary performance indicators

Certainty of rewards = $\frac{\text{\# of rewards administered}}{\text{\# of achievements}}$

Certainty of sanctions = $\frac{\text{\# of sanctions imposed}}{\text{\# of infractions committed}}$

Balance of reinforcement = $\frac{\text{\# of rewards administered}}{\text{\# of sanctions imposed}}$
U.S. Benchmark:
4:1 ratio

Electronic Monitoring

- Discretionary performance indicators

Electronic monitoring dose = # days on continuous monitoring (e.g., ankle monitor, GPS monitor, vehicle interlock device)

Electronic monitoring density = # days on continuous monitoring per phase

Substance Abuse Treatment

- Core performance indicator

Dose of treatment = # of treatment sessions attended

U.S. and Canadian Benchmarks:
 100-200 hours

- Recommended performance indicator

Treatment attendance rate = # of treatment sessions attended

$$\frac{\# \text{ of sessions scheduled} - \# \text{ of sessions cancelled or rescheduled}}{\# \text{ of sessions scheduled}}$$

Also consider:

Likert-scale ratings of satisfaction with treatment services and therapeutic alliance with clinician

***Complementary treatment and social services (e.g., mental health, vocational services):**
 Limit analyses to participants with an assessed need for those services.

Restorative Justice

- Discretionary performance indicators Very little data

Community service dose = # of hours of "useful" community service performed
 (do not include punitive community service)

Victim restitution = degree to which fulfilled (e.g., no payment, partial payment, full payment)

Fines and fees = degree to which satisfied (e.g., no payment, partial payment, full payment)

** Financial amount appears to be curvilinear and based on ability to pay.*

Timeliness of Services

- Recommended performance indicator

Intake efficiency = date of entry into DTC - date of arrest or probation violation + 1

U.S. Benchmark: 30 - 50 days

- Discretionary performance indicator

Treatment intake efficiency = date of first treatment session - date of entry into DTC + 1

Abstinence

- Core performance indicators

Abstinence = # drug tests negative for all unapproved substances - # of tests invalid or adulterated

$$\frac{\# \text{ of drug tests scheduled} - \# \text{ of tests excused}}{\# \text{ of drug tests scheduled}}$$

Abstinence = # of days with no positive reading on continuous monitoring device

Employment

- Recommended performance indicator

Employment improvement rate = # employed at discharge - # employed at entry

$$\frac{\# \text{ entered program} - \# \text{ neutral discharges}}{\# \text{ entered program}}$$

Example:

- 105 entered the program
- 5 neutral discharges
- 25 were already employed at entry
- 50 were employed at discharge

Employment improvement rate = 50 - 25 / 105 - 5 = 25%

Education

- Recommended performance indicator

Educational improvement rate = (# with diploma or equivalent at discharge + # enrolled in educational program at discharge) - (# with diploma or equivalent at entry + # enrolled in educational program at entry)

$$\frac{\# \text{ entered program} - \# \text{ neutral discharges}}{\# \text{ entered program}}$$

Example:

- 105 entered the program
- 5 neutral discharges
- 10 already had a diploma at entry
- 15 were already enrolled in school at entry
- 12 had a diploma at discharge
- 35 were enrolled in school at discharge

Educational improvement rate = (12 + 35) - (10 + 15) / 105 - 5 = 22%

Housing

- Recommended performance indicator

Housing improvement rate = $\frac{\# \text{ in stable housing at discharge} - \# \text{ in stable housing at entry}}{\# \text{ entered program} - \# \text{ neutral discharges}}$

Psychosocial Problems

- Recommended performance indicators

Emotional improvement rate = $\frac{\# \text{ with emotional problems at entry} - \# \text{ with emotional problems at discharge}}{\# \text{ entered program} - \# \text{ neutral discharges}}$

*Same analyses for medical, dental, family and interpersonal problems

Drug-Free Babies

- Discretionary performance indicator

Drug-free babies = # of drug- and alcohol-free babies delivered or fathered by DTC participants

Joanne DeHetre

From: Patrick Colbeck
Sent: Wednesday, April 6, 2016 7:43 AM
To: Joanne DeHetre
Subject: Fwd: CJDCM Boilerplate

Sent from my Verizon Wireless 4G LTE smartphone

----- Original message -----

From: Nick Plescia <NPlescia@senate.michigan.gov>
Date: 04/05/2016 3:55 PM (GMT-05:00)
To: Patrick Colbeck <PColbeck@senate.michigan.gov>
Subject: CJDCM Boilerplate

- semi-annual*
- (1) From the amount specified in Part 1 for the CJ Data Collection and Management Program, the commission shall provide ~~quarterly~~ reports to the legislature starting December 31, 2016 featuring following criminal justice data: prison capacity and population, parole populations, parole officers, probation populations, probation officers, the percentage of state prisoners that return to prison within 3 years and 5 years, the re-arrest rate of state prisoners within 3 years and 5 years of release, the reconviction rate of state prisoners within 3 years and 5 years of release, county jail populations and capacities, district court probation populations, district court probation officers, the percentage of jail prisoners that return to jail or prison within 3 years and 5 years, the re-arrest rate of jail prisoners within 3 years and 5 years of release, the reconviction rate of jail prisoners within 3 years and 5 years of release and sentencing information for all offenders.
- (2) Funds appropriated under this part shall be used to address criminal justice data deficiencies identified under subsection (1). If there are initial data deficiencies in the reports required under subsection(1), the commission shall include recommendations for the closure of any data gaps in each of these reports and the status of any activities related to these recommendations. The commission shall issue a report to the Legislature by March 1, 2017 accounting for all funds spent under this section that will include recommendations for the funding requirements for subsequent year project(s) that would facilitate the collection of the data in subsection (1) on a statewide basis.

Public Comment - Criminal Justice Policy Commission - April 6th, 2016

Chair: Bruce Caswell

Jim Casha
Norwich, ON, Canada
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540-717-9240

Commission Members:

Why is the State of Michigan ignoring the number one way to reduce the prison population ...and save babies at the same time?

Will this Criminal Justice Commission save them?

This Commission reads a lot of reports and studies. Has anyone on this Commission read the MDHHS report:

Preventing Prenatal Alcohol Exposure and Supporting Individuals Affected by Fetal Alcohol Spectrum Disorders - Michigan Five Year Plan 2015-2020?

The report is dated November 7, 2014 and lists the Population Health and Community Services Administration, Senior Deputy Director Susan Moran and Behavioral Health and Developmental Disabilities Administration, Deputy Director Lynda Zeller, on the cover. It is my understanding that Lynda Zeller had previous experience with Michigan's Department of Corrections.

The complete report and more information and audio recordings of interviews regarding FASD Frequently Asked Questions feature Bureau of Family, Maternal and Child Health Director, Rashmi Travis, are also available online: www.michigan.gov/fasd

Here is an excerpt on the financial impacts of Prenatal Alcohol Exposure (PAE):

Financial Impact

The costs for individuals who are affected comprise expenditures related to an inability to grow and develop appropriately. Individuals who are affected require additional support in education as they tend to perform poorly in school and have a number of behavioral problems due to poor neurologic development. In addition, those who are affected are often involved in the juvenile and criminal justice systems as they age into adulthood. Recent studies confirm children affected with FASD have significantly more co-occurring psychiatric disorders and this fact is under recognized. This makes becoming a contributing member of society difficult.

The cost estimate to support a person affected by the most devastating of the conditions within the spectrum, FAS, is \$2 million. This cost is so great because the needs stretch across multiple service systems: health, education, social service, and juvenile and criminal justice. The cost savings of preventing FAS is substantial and does not take into account the benefit to the individual who does not have to live with a lifetime of disabilities. The costs associated with treating FASD include time in the high level care hospital unit, Neonatal Intensive Care Unit, at birth; therapeutic interventions throughout life; special education services; extenuating health care and behavioral healthcare services; and residential placement for individuals over age 21.

These costs do not include a caregiver's lost wages [like mine, estimated at well over \$600,000] or the costs of incarceration when that is often a result.

At the March 10th DHHS Senate Subcommittee meeting, DHHS Deputy Director, Lynda Zeller gave a presentation which contained a spoken part about FAS ...but nothing in her written report. Senior Deputy Director, Susan Moran said ...nothing about prenatal alcohol exposure in her report or presentation. Here is what she had to say:

"5. FASD. Regarding prevention, whole health and wellness I also want to mention activities related to Fetal Alcohol Syndrome prevention.

I mentioned last year that we produced a five year plan (2015-2020) to address FASD: "Preventing Prenatal Alcohol Exposure and Supporting Individuals Affected by Fetal Alcohol Spectrum Disorders."

We have continued to require FASD prevention education in all of MDHHS Women's Specialty Services programs (SUD)

We offered training (FY 15) related to treatment of adults with FASD and how to screen adults for FASD to better inform treatment practices. The training was full at 100 clinicians.

We completed an online education course for providers to improve skills in alcohol and substance use disorder screening and assessment in pregnant women.

And, we expanded from five to six FASD Diagnostic Centers of Excellence. The newest center is located in Flint, MI at Mott Children's Hospital. These centers can provide a definitive diagnosis of FASD or not.

Finally, we continued to support eight community-based prevention and intervention projects.

While I am mentioning these in my presentation, these are initiatives that cross administrations between Sue Moran's area of Population health and the BHDDA."

After reading this report ...I would have thought Lynda Zeller would have had A LOT more to say than that, especially as to the devastation caused by prenatal alcohol exposure to the brains of our unborn children and how it sets them up for a life behind bars.

The neglect and abuse of these innocent child victims must stop ...now.

Governor Snyder and DHHS Director Nick Lyon have the money (\$614 million in the Rainy Day Fund) to immediately fund programs to prevent Prenatal Alcohol exposure and support individuals affected by FASD.

Why did DHHS Director Nick Lyon, tell me prenatal alcohol exposure is not a problem and he is not going to fund it?

Why won't they do it?

Why do they, just like Flint, ignore the information they have, and continue to let these individuals suffer?

Will this Commission do something ...other than talk about a definition of recidivism?

Pressing on, with unwavering faith,

Jim Casha