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

Fast Facts

- **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.**

Fast Facts

- **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**

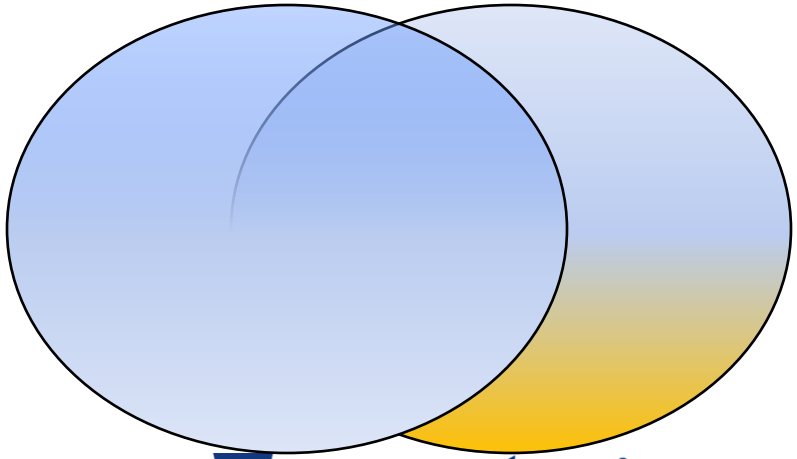
Fast Facts

- **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.**

Fast Facts

- **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**



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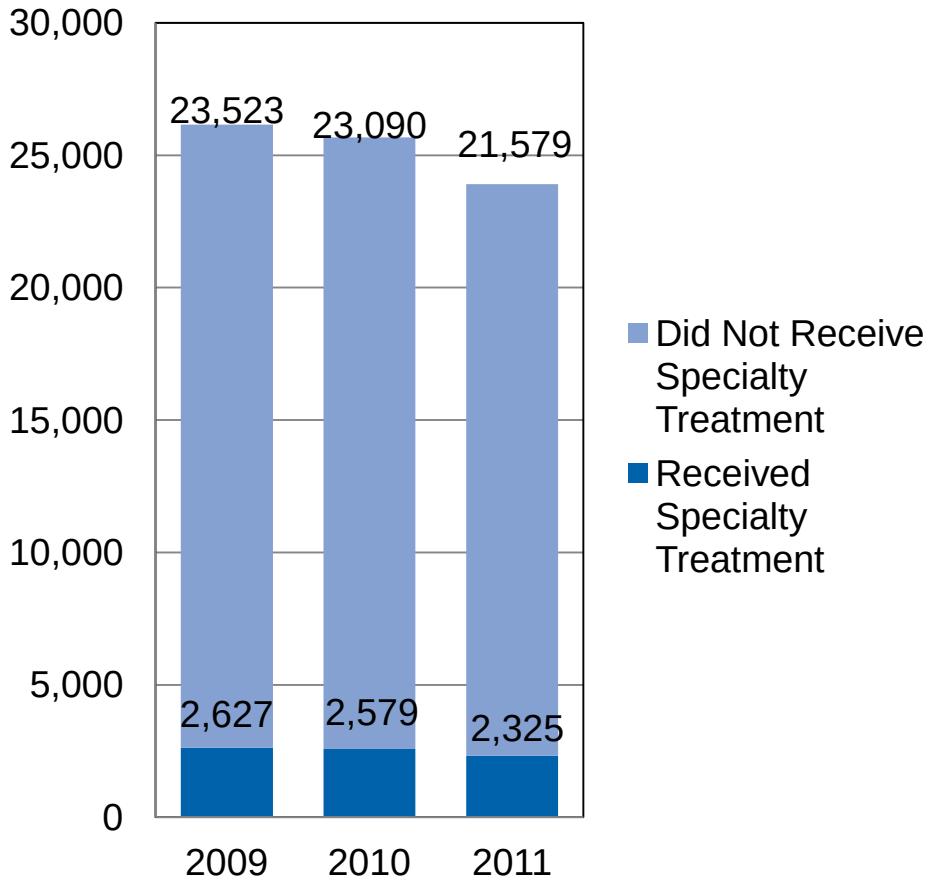
Substance Use Disorders: Snapshot

Treatment Gap

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



Source: Substance Abuse and Mental Health Services Administration (SAMHSA), *Results from the 2010 and 2011 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-44, HHS Publication No. (SMA) 12-4713, Chart 5.51A. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012.

- 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.

Role of the PA State Substance Abuse Agency

- 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.

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Treatment Goals

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Treatment Goals

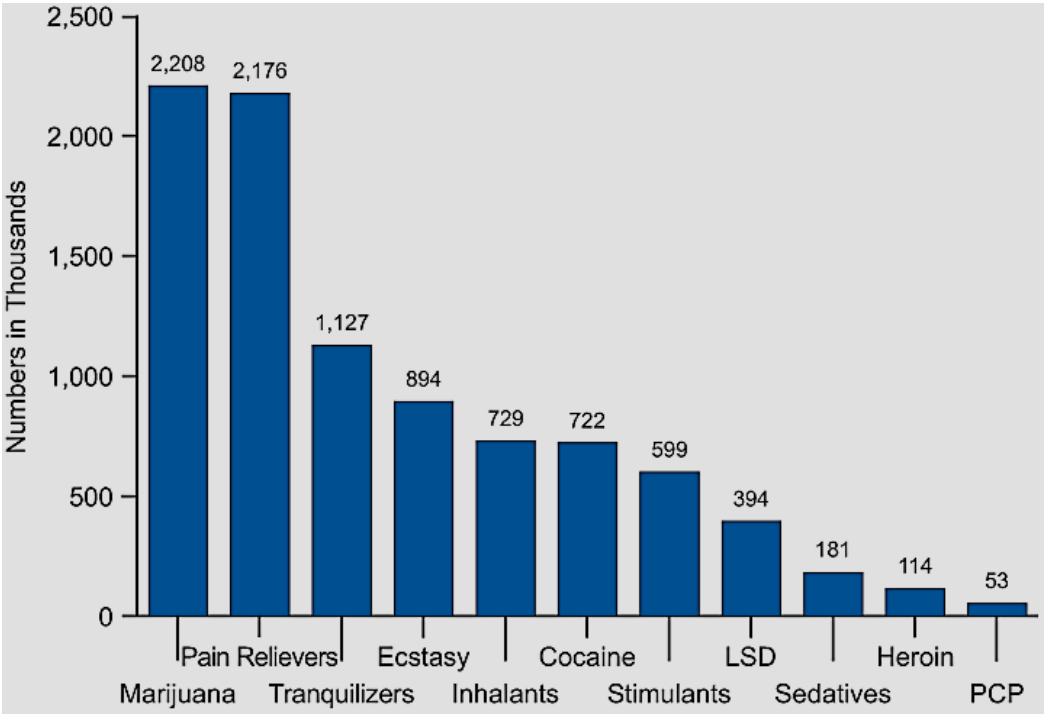
Addiction	Abstinence	Recovery
Chemical addiction	Withdrawal	“Addiction” to recovery behaviors
Dysfunctional relationships	Tension/ distrust/ judgment in relationships	Trust, partnership, respect in relationships
Negative self image	Lack of confidence/ doubts	Self respect
Lack of values/spiritual connection	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.

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Overdose Deaths in Pennsylvania

Drug Overdose Deaths in Pennsylvania			
Year	Number of Deaths	PA Population	Rate per 1,000
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 15.4 per thousand Pennsylvanians

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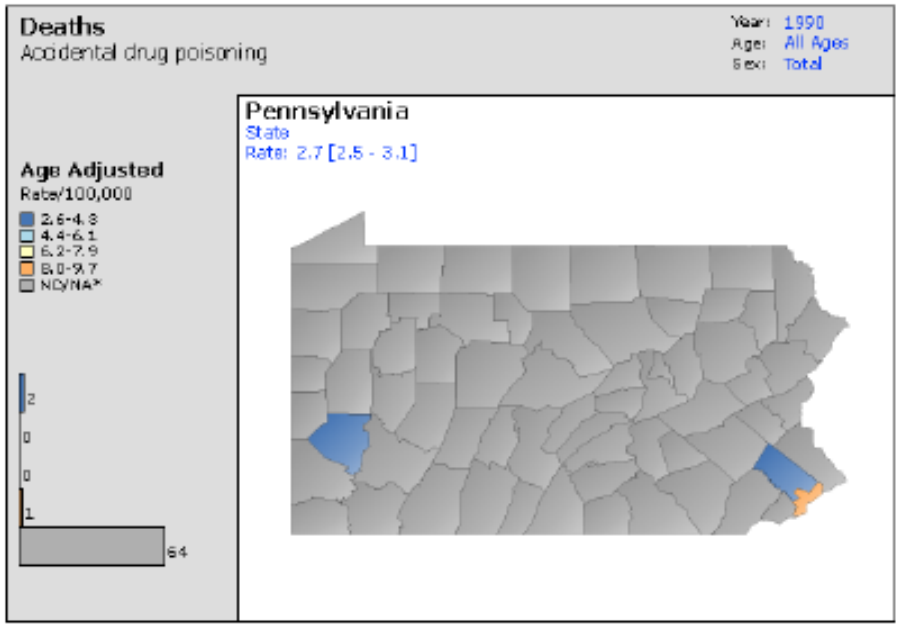
Overdose Deaths in Pennsylvania



* 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.

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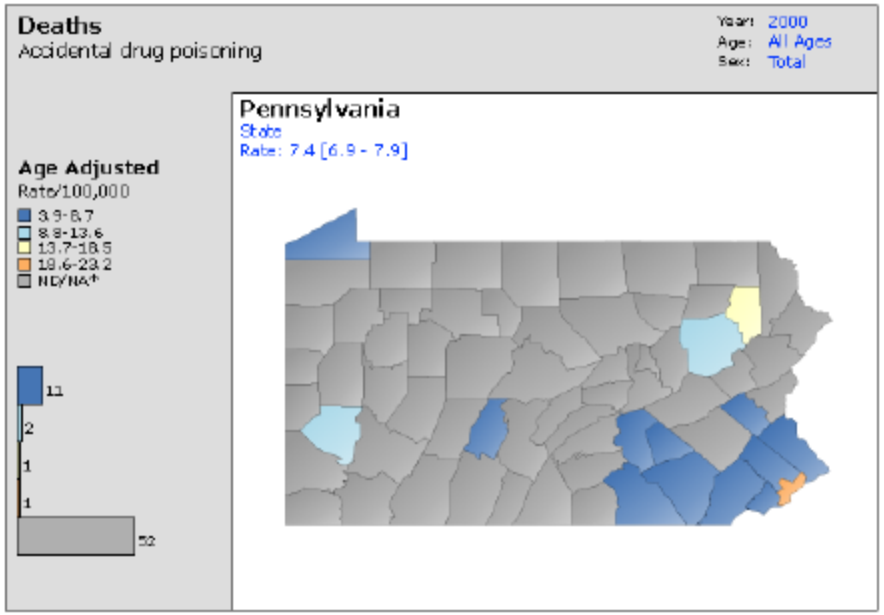
Overdose Deaths in Pennsylvania



- 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.

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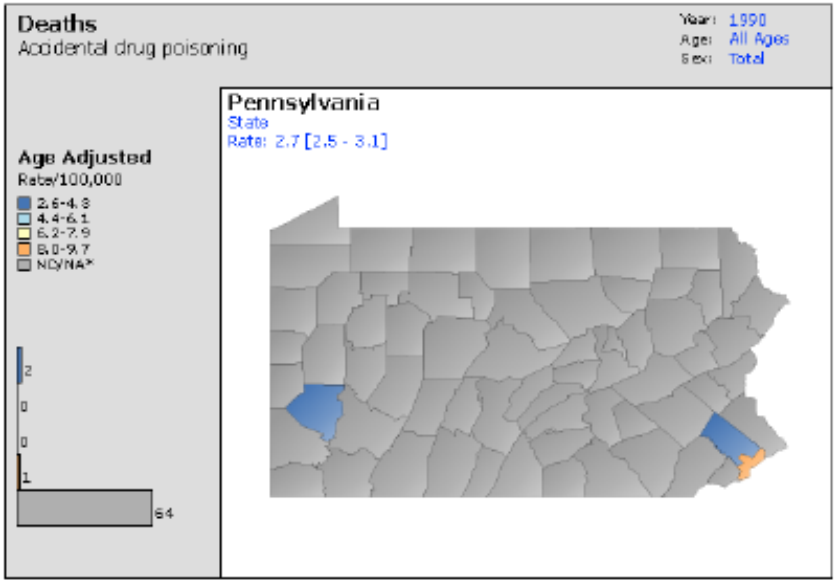
Overdose Deaths in Pennsylvania



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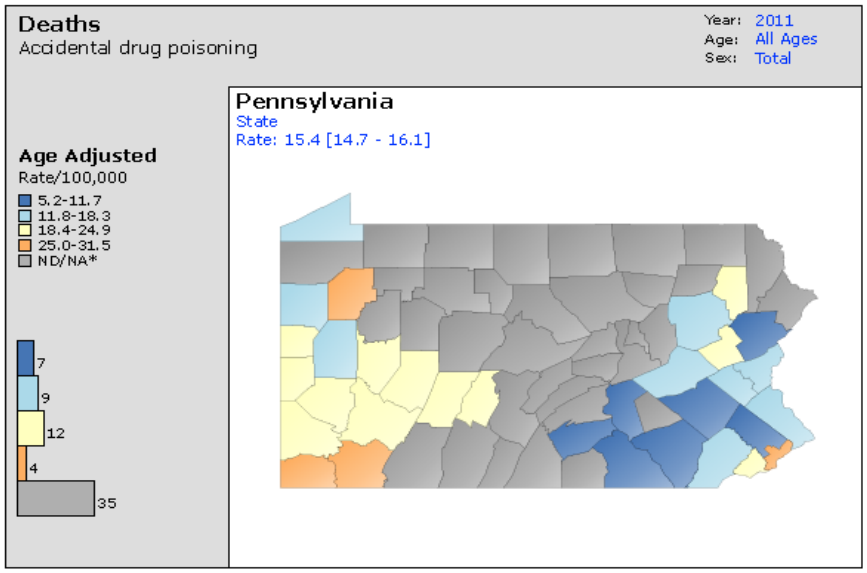

* ND = Not displayed if count <10 (age-adjusted/specific rates and SMRs) or <3 (all other rates)
NA = Data not available to calculate statistic.
Source: Pennsylvania Certificates of Death

- 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.

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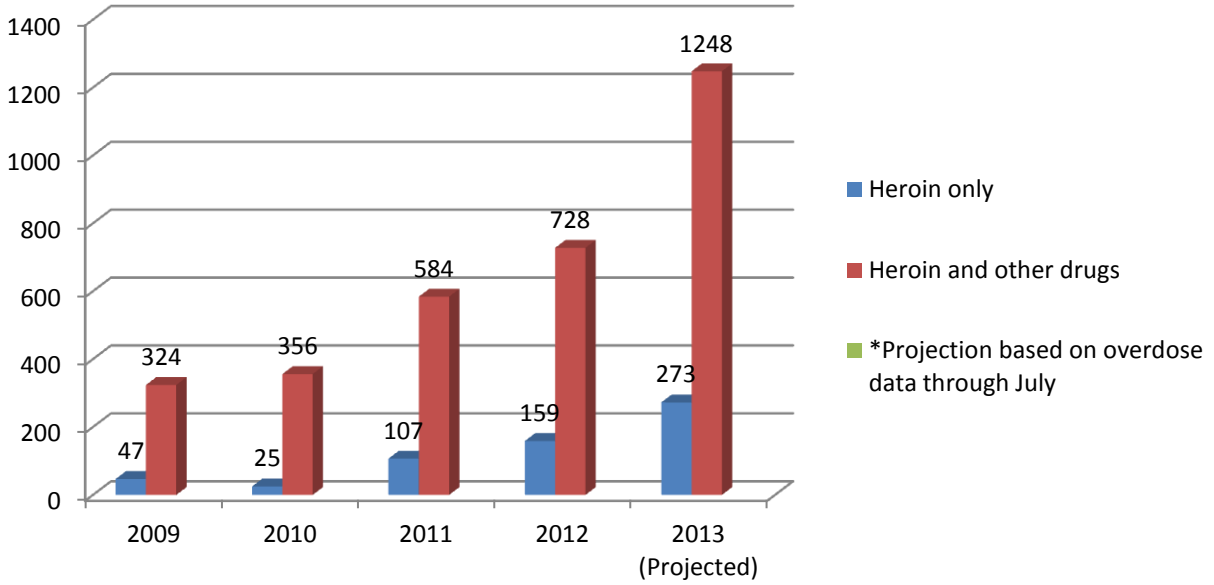
Heroin Related Overdose Deaths in Pennsylvania

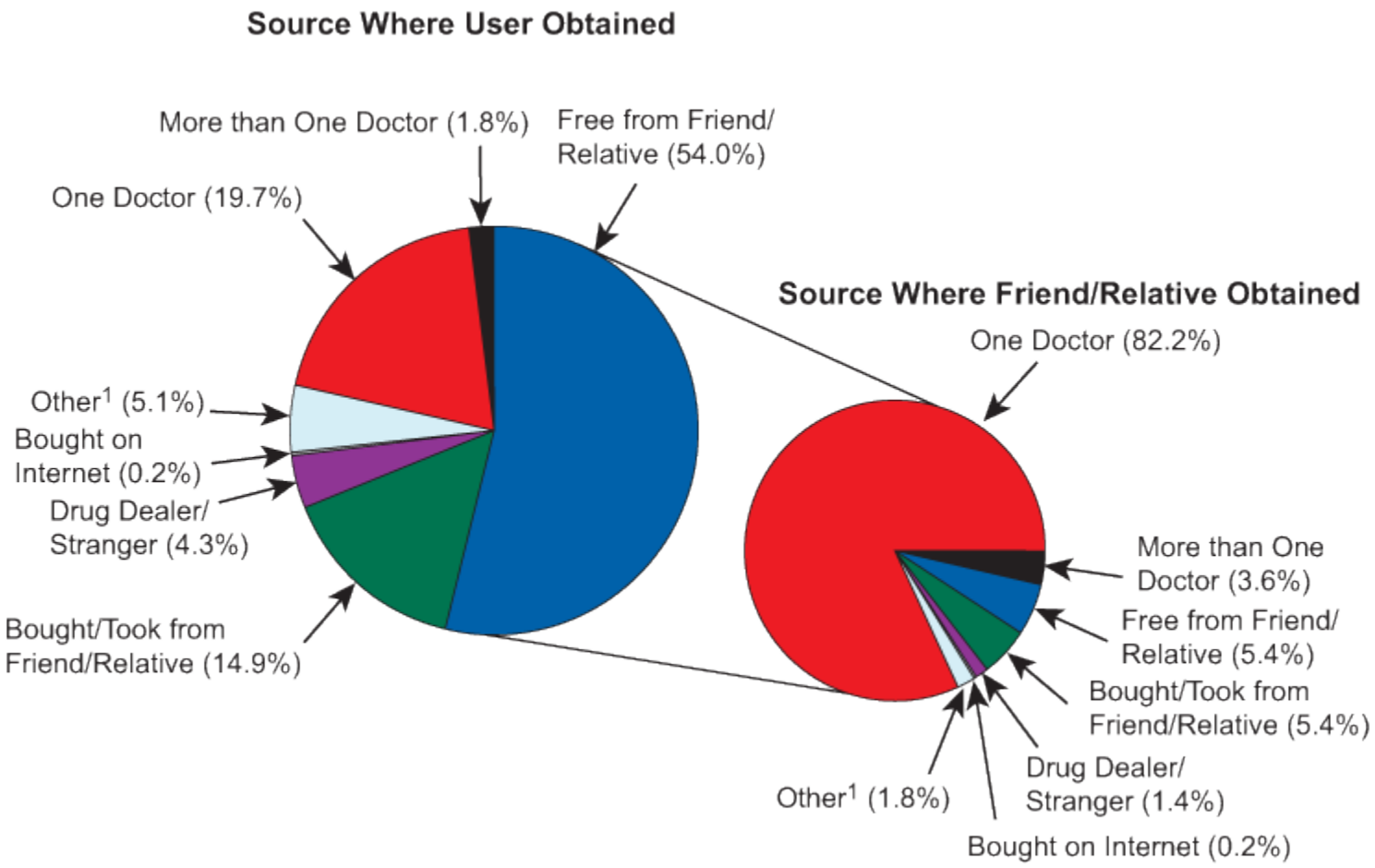
Heroin Only and Multidrug Toxicity Deaths



- 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



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 Key Drug Related Issues

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

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**

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Treatment Benefits

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

	All Treatment Modalities (N = 2,567)	*Methadone Maintenance (N = 115)*	*Outpatient Treatment (N = 1,585)*	*Residential Treatment (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

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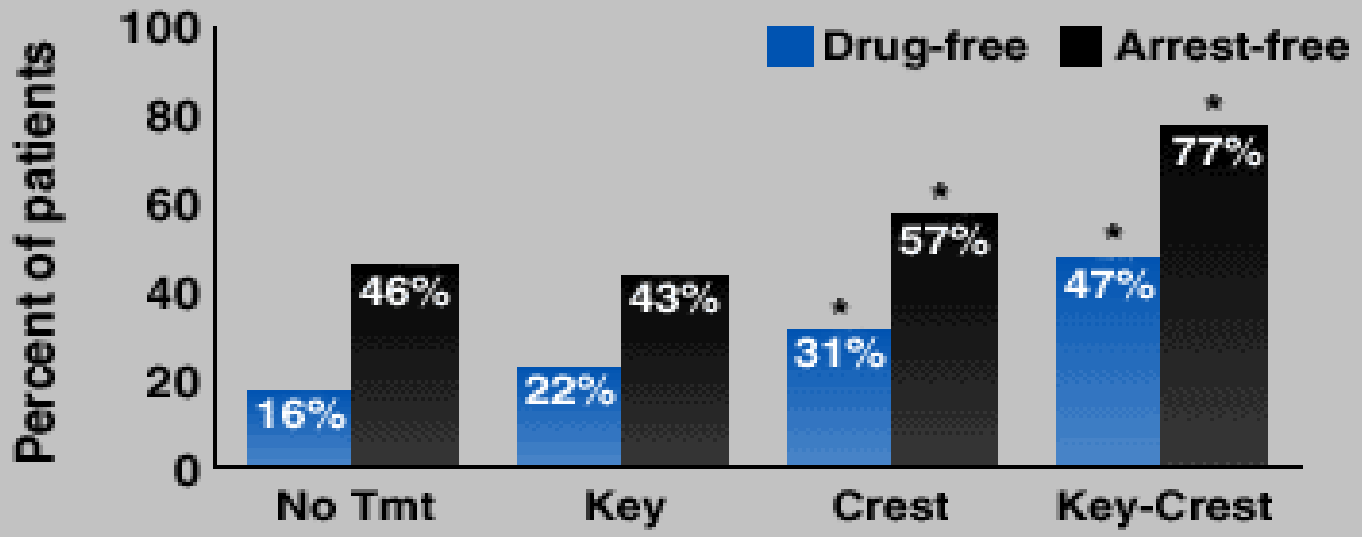
What the Treatment Research Indicates

Delaware

Delaware Correctional System participants in prison TC (Key) and work release TC (Crest)

Drug-free and arrest-free 1 year after work release



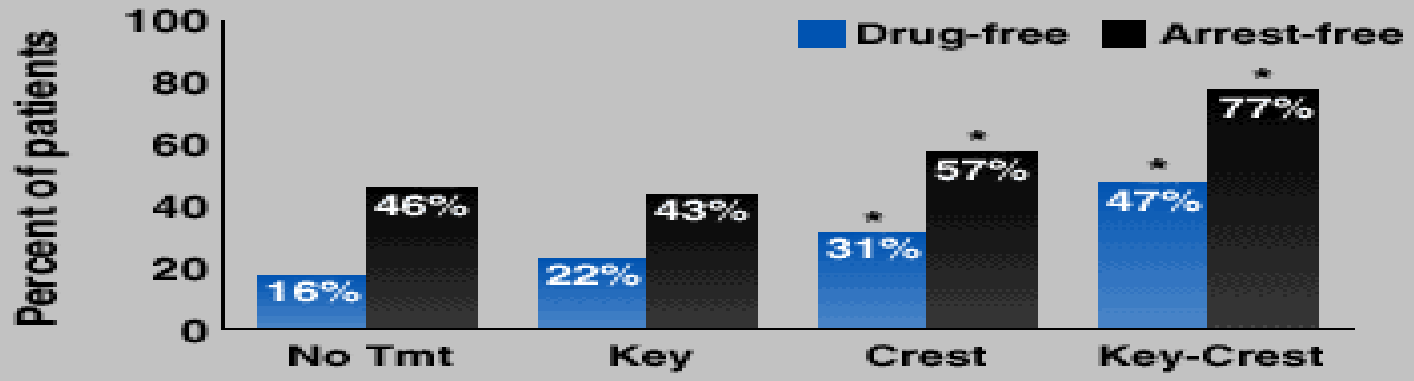
*p<.05 from no treatment.

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.

Source: Martin et al., *The Prison Journal,* 79:294-320, 1999.

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



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

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 peergroup

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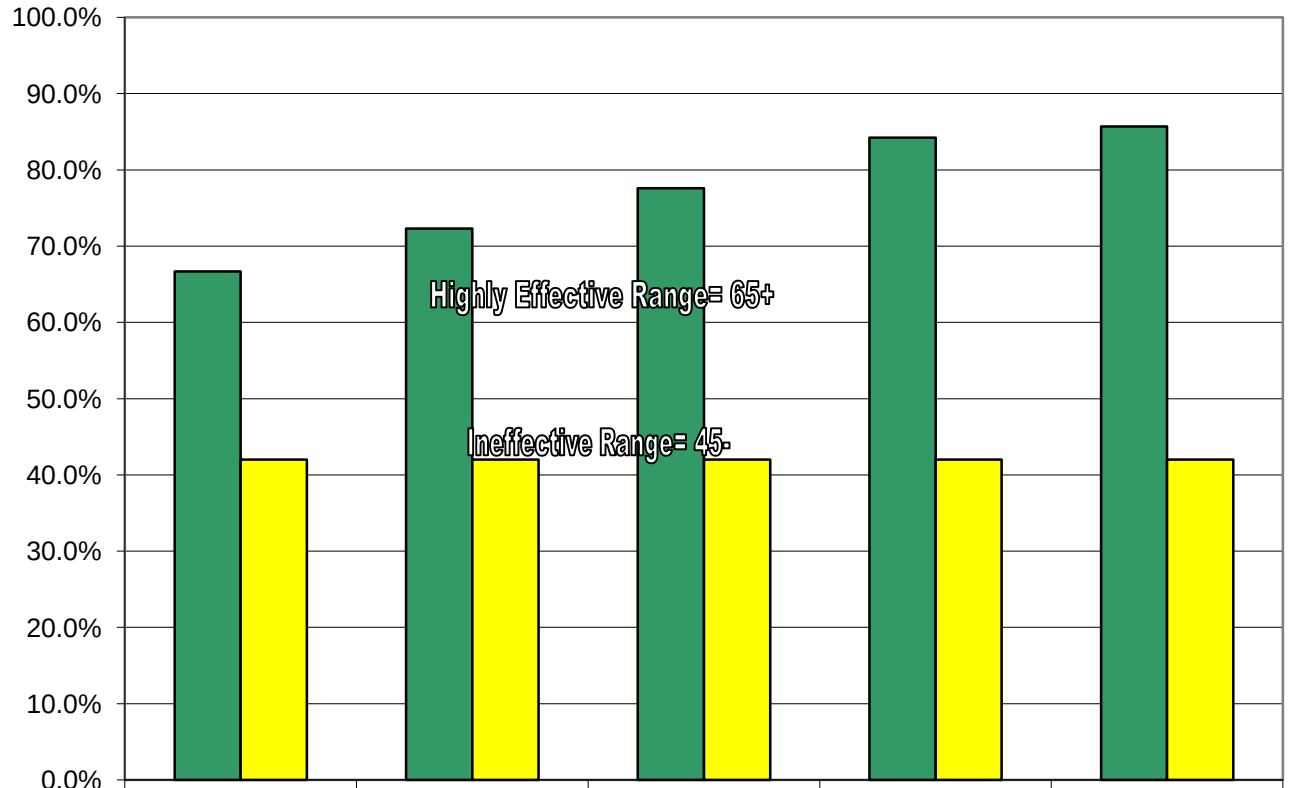
Maryland: TC's evaluated with the Correctional Programming Checklist



	MTC	CLF	MCTC	MCIW	Patuxent
TC Program Overall Score	66.7%	72.3%	77.6%	84.2%	85.7%
Comparison	42%	42%	42%	42%	42%

Comparison Group consists of 360 programs nationally.

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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

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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

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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.

Treatment Issues

- Pennsylvania's Client Placement Criteria (PCPC)
- Treatment targets Risks/Needs
- Continuum of care
- Access to treatment

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

PCPC

- 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

PCPC

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

Length of Stay

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

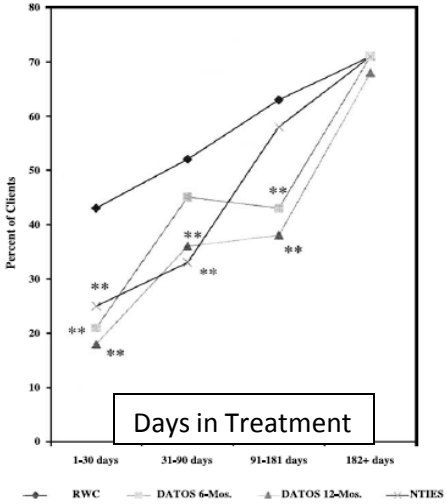
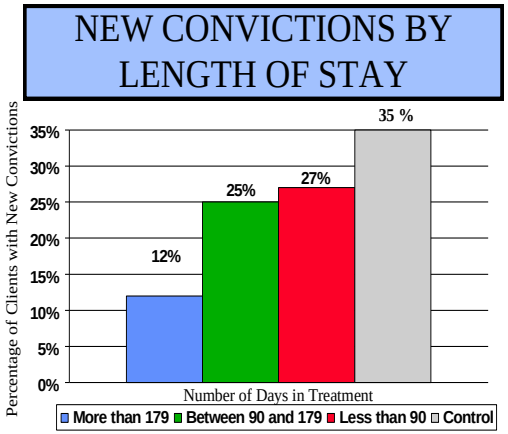
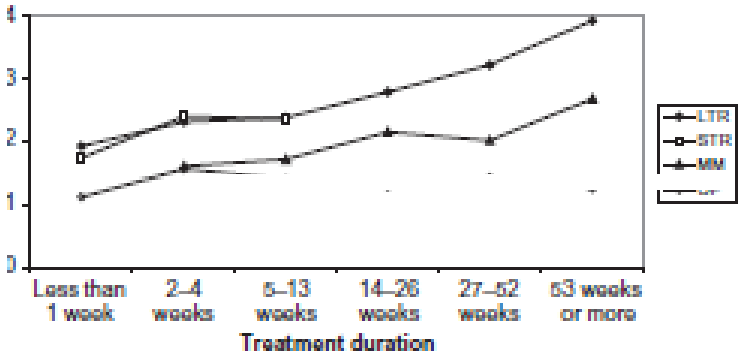


Figure 1. Percentage of abstinent post-discharge by LOS and study. Note: **Difference from RWC is statistically significant at p < .01.

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)*

•Improvements in criminal recidivism and relapse rates are correlated to length of treatment, with high rates of improvement among those with 9 months of treatment, and reduced effectiveness for treatmen less than 90 days (NIDA, 2002)

•Highest improvements were found in long term treatment with least improvement found in methadon maintenance (Friedmann et al, 2004)

•Length of stay as 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

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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)

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

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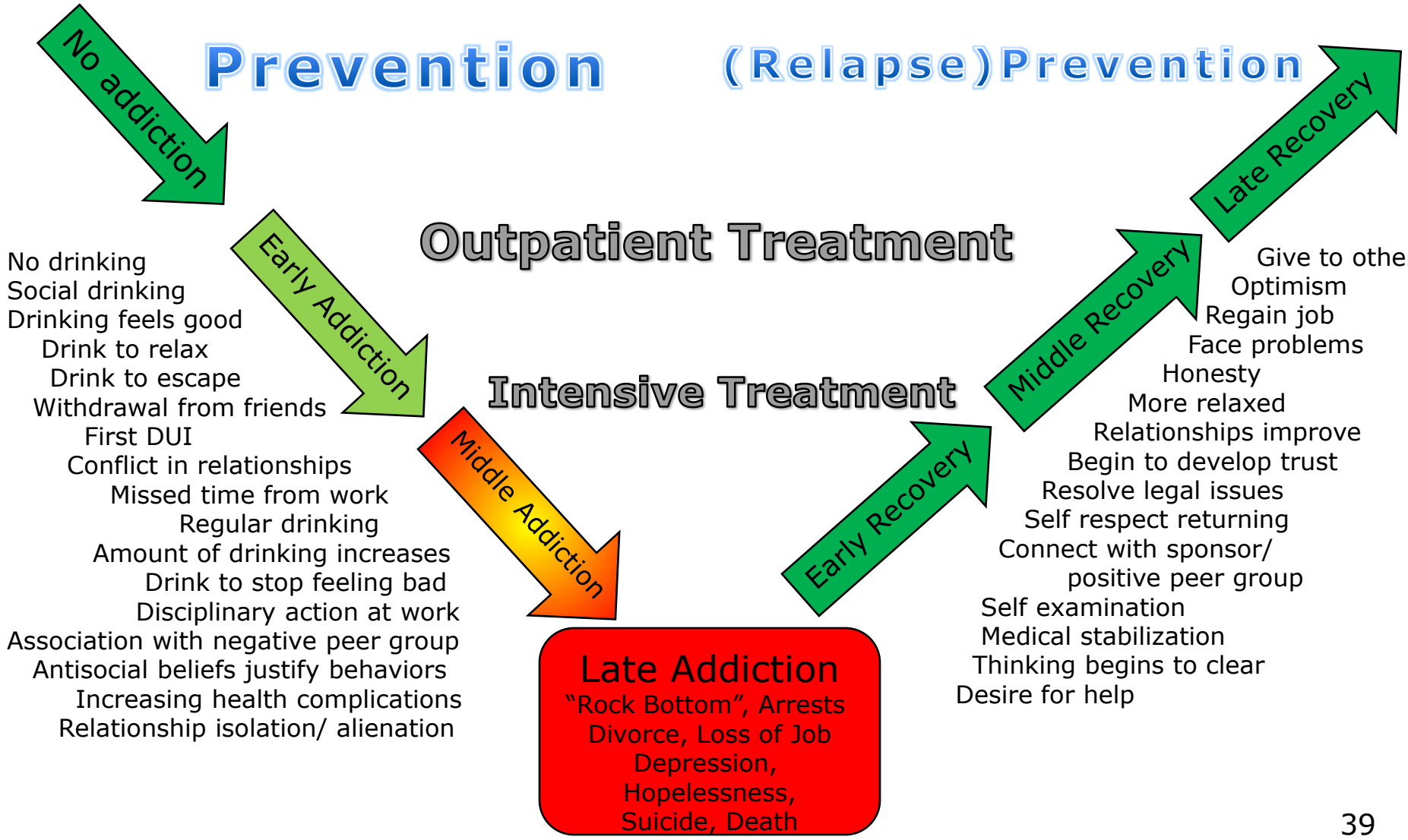
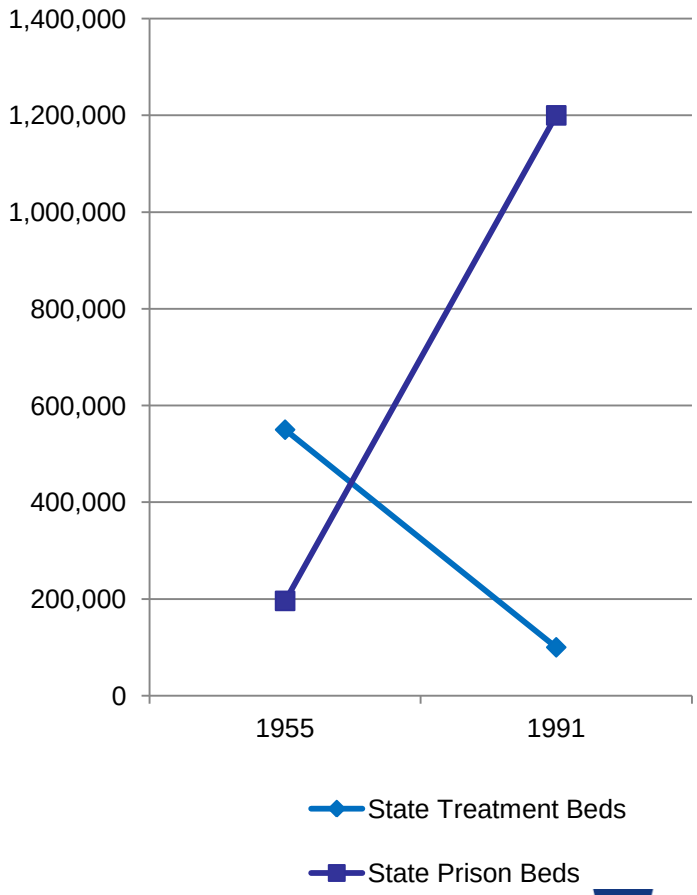
	PCPC	LSI-R
Assessment:	Severity of substance abuse	Severity of criminality
Use:	Level of placement For substance abuse **treatment**	Level of placement/ supervision due to **security risk**
Areas examined:	Substance use intoxication/withdrawal	Criminal history
	frequency of use, severity of abuse tolerance/withdrawal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

Progression of a Disease and Recovery



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

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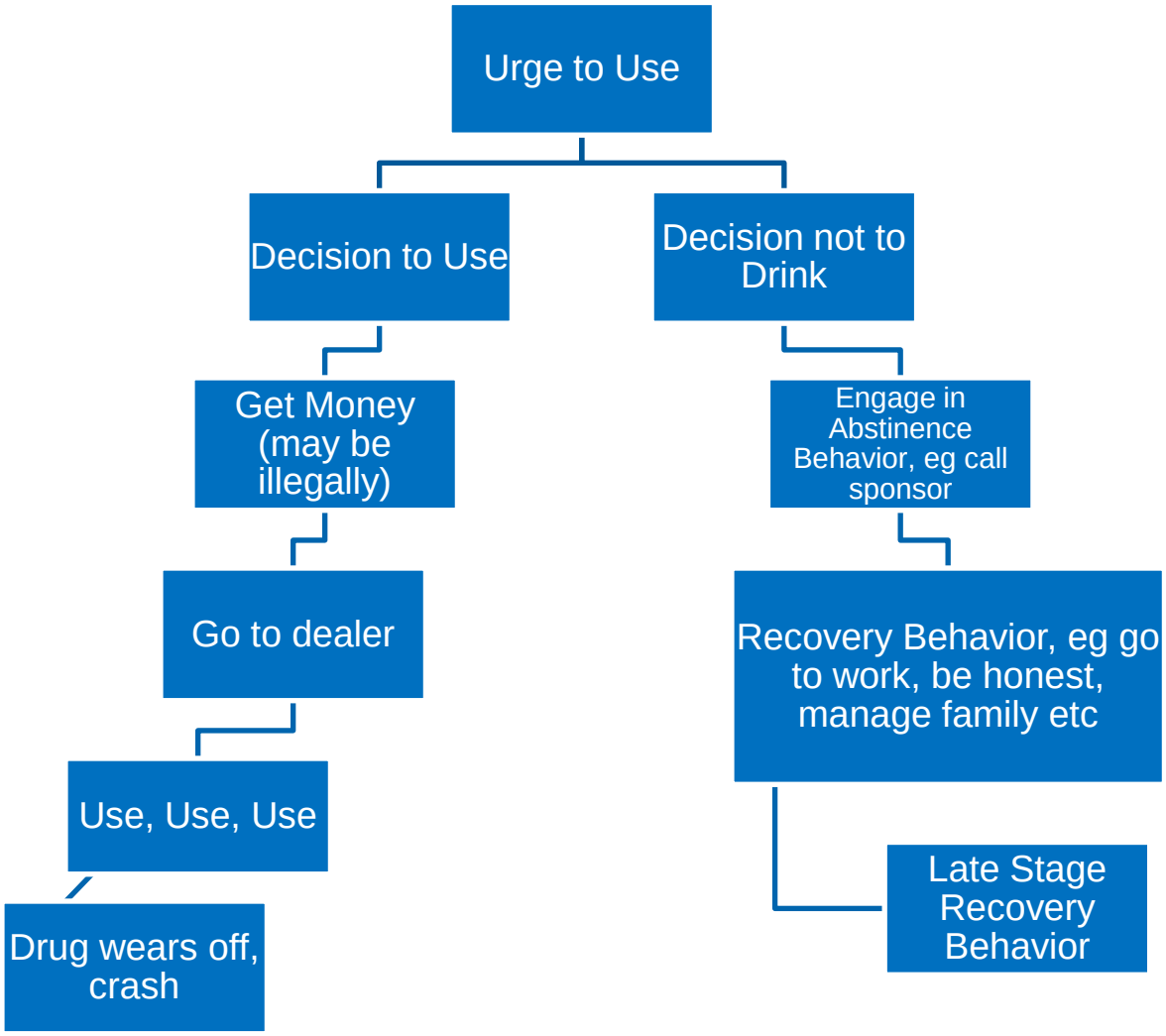
Assessment

- In terms of assessment, offenders in prison are considered to be for example:

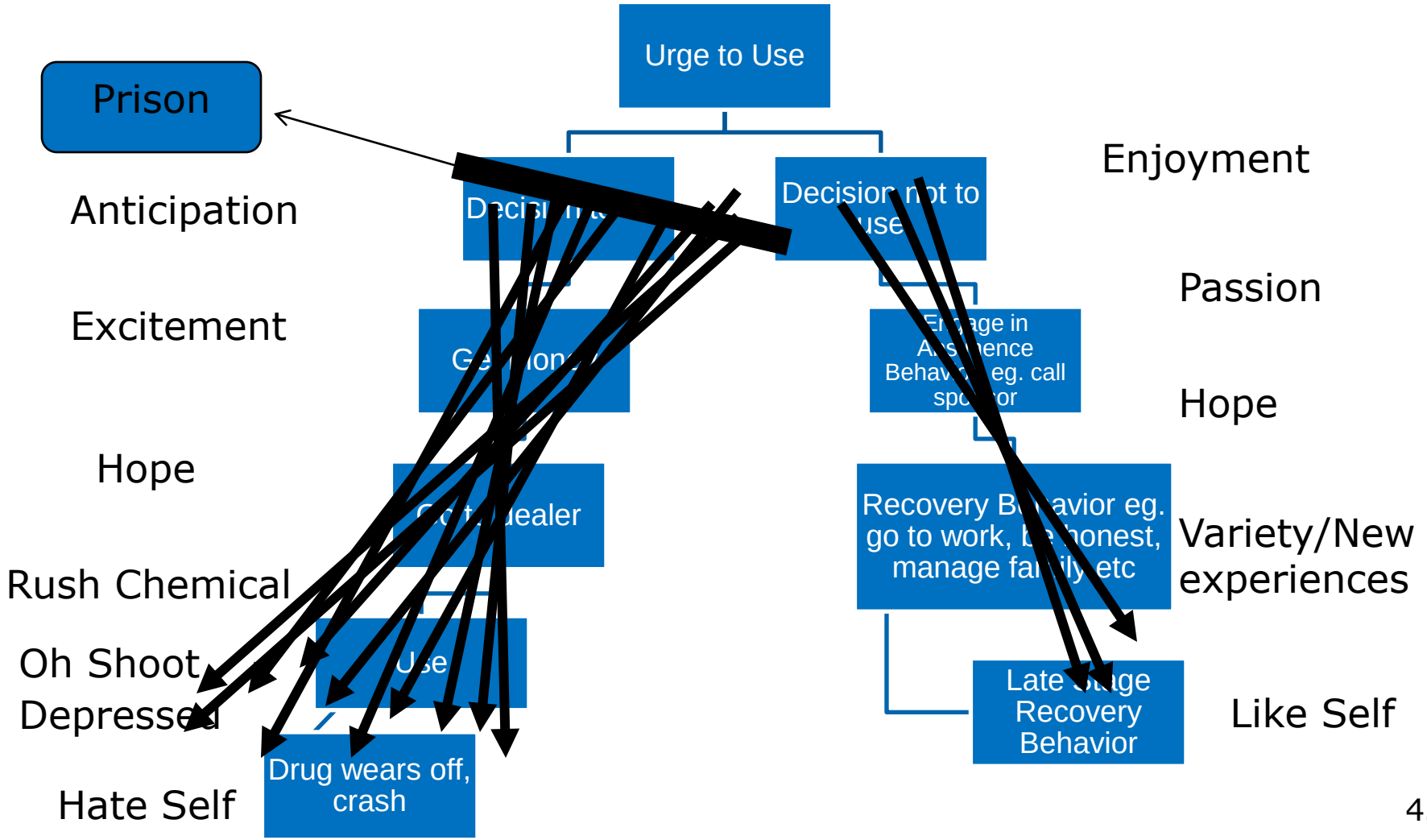
  "303.90 Alcohol Dependent, ~~In a controlled environment~~"

- 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



Biology
Example of 2 Brain pathways



Successful Offender Reentry

A COMPREHENSIVE CONTINUUM OF CARE

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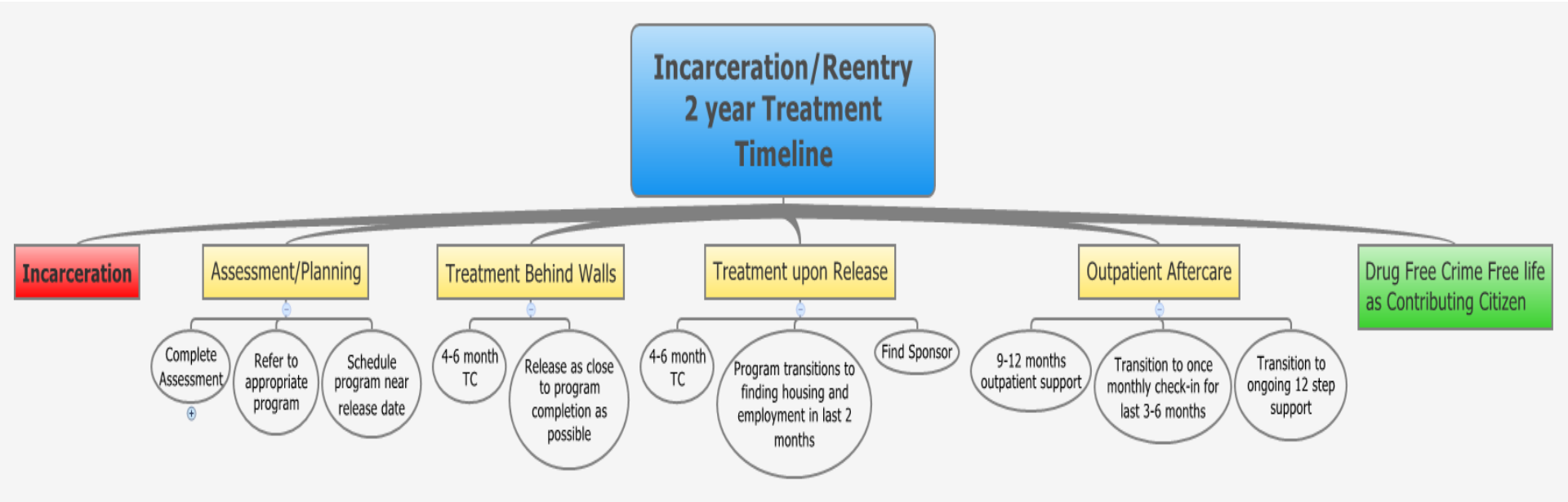
Transition Timeline



What is a Therapeutic Community?

What were they doing that worked?

What is a Therapeutic Community?

- 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 is a Therapeutic Community?

- 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

- 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

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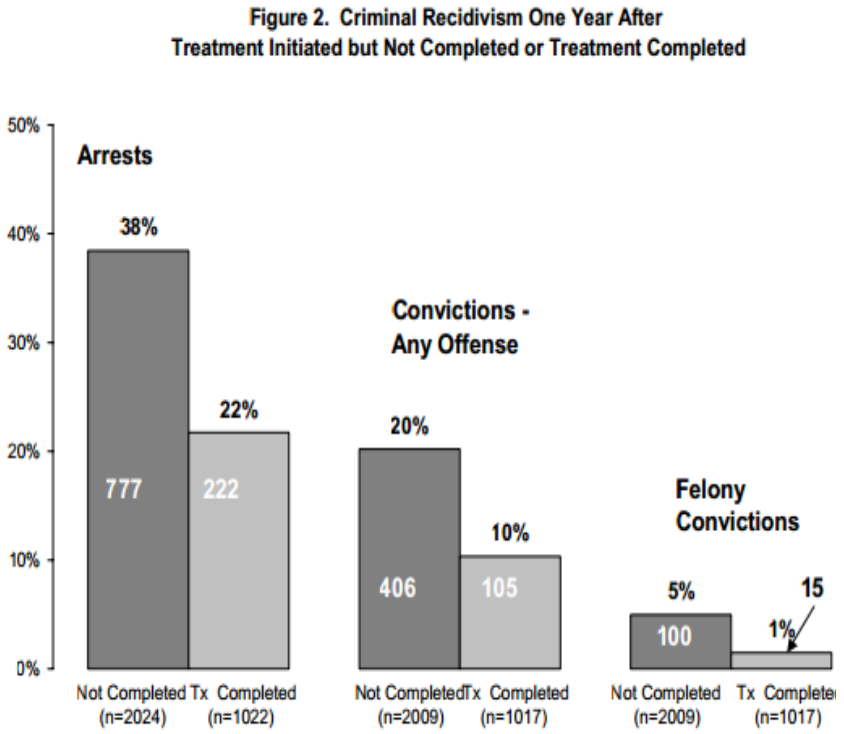
TC as cultural change

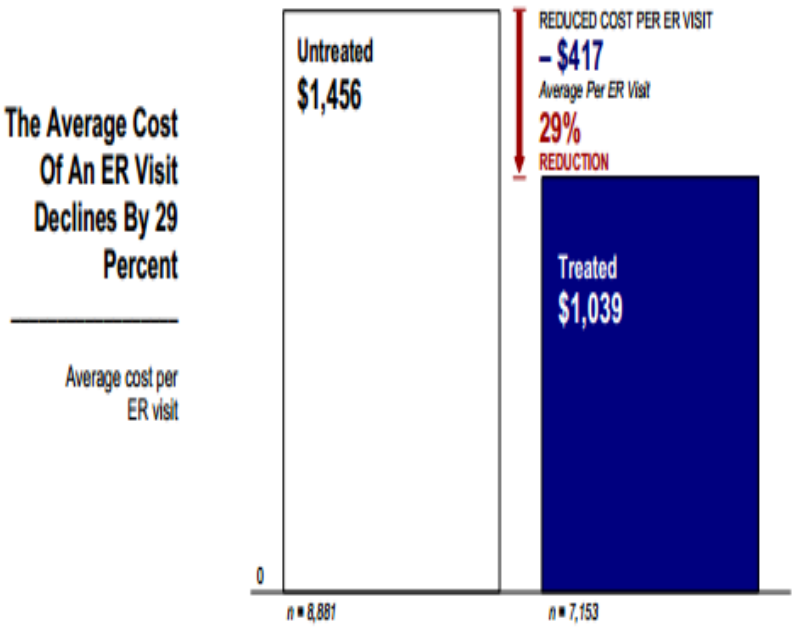
	Prison Culture	TC Culture
Rules	“No snitching”	Open communication
Expectations	Trust no one	Trust
Goal Focus	Short term gains	Long term gains
Gratification	Instant gratification	Delay of gratification
Peer group	Negative peer group	Positive peer group
Ethics	My best interest	The interest of the community
Goals	Money, power, pleasure	Right living
Responsibility	Blame/victim	Personal Responsibility

Good Treatment =Cost Savings

Cost Savings from Substance Abuse Services



Criminal Justice System Impact



Health System Savings

Children and Families

- 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

Minimal Community Based Offender Needs for Successful Transition

- **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.

The Solution (cont.)

- 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

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/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.

Remember…This is what we know…

- 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

Contact Information

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