Justice Center
THE COUNCIL OF STATE GOVERNMENTS

JUSTICE REINVESTMENT 2.0 IN OHIO

Presentation to the Justice Reinvestment Ad Hoc Committee
of the Ohio Criminal Sentencing Commission
November 8, 2018

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The objective of Ohio JR 2.0 is to "Develop a statewide public safety strategy to reduce crime, improve behavioral health treatment, and adopt more cost effective sentencing, corrections, and supervision policies."

Reduce violent crime through effective law enforcement interventions.

Move people with substance addictions and mental health needs into **treatment that works** and reduce criminal justice involvement.

Reduce recidivism and costs to taxpayers from an overcrowded prison system.

In June 2017, state leaders in all three branches of government requested the CSG Justice Center's assistance with a second Justice Reinvestment project (JR 2.0).


OHIO
CRIMINAL SENTENCING COMMISSION


OHIO
CRIMINAL SENTENCING COMMISSION

A. Reduce Violent Crime through effective law enforcement interventions.

Research demonstrates that certain data-driven policing strategies can reduce violent crime effectively but must be sustained. Such efforts are more cost-effective than trying to reduce violent crime by prolonging incapacitation.

Strategies and Areas of Focus:

Hot-spot policing	Focused deterrence	Place-based problem solving	Alternatives to arrest	Crime analysis
burglaries	gang member-involved violence, homicides, shootings	robberies, shootings, property crime, drug markets	minor misdemeanors; people who have mental illnesses	patterns and repeat victims, crimes, locations, times

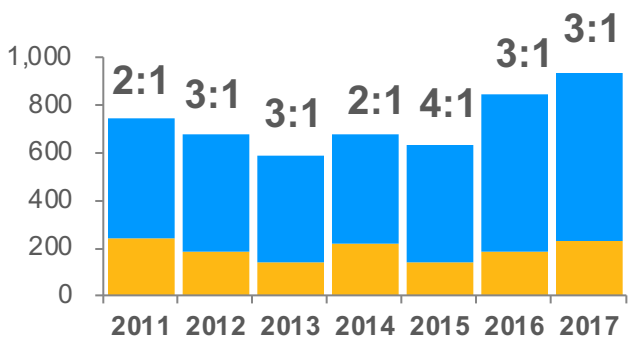
Ohio Data Shows:

- *Violent crime is rising slightly from historic lows.*
- *A small number of violent crimes result in an arrest. In 2016, Ohio had the largest gap among states between the number of violent crimes reported and arrests for those crimes.*
- *People recently released from prison account for a small percentage of people arrested for murder.*

A. In recent years, there have been upticks in violent crime but a low rate of arrests for those crimes.

Murder

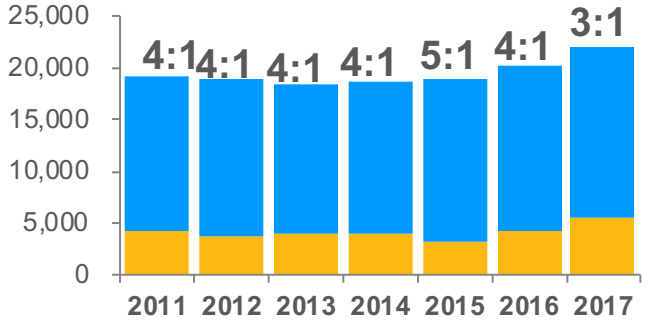
Reports and Arrests, 2011–2017



	Percent Change 2011–2017	Percent Change 2014–2017
Reported Murders	↑ 38%	↑ 53%
Murder Arrests	↓ 20%	↑ 6%

Aggravated Assault

Reports and Arrests, 2011–2017



	Percent Change 2011–2017	Percent Change 2014–2017
Reported Agg Assaults	↑ 10%	↑ 12%
Agg Assault Arrests	↑ 32%	↑ 40%

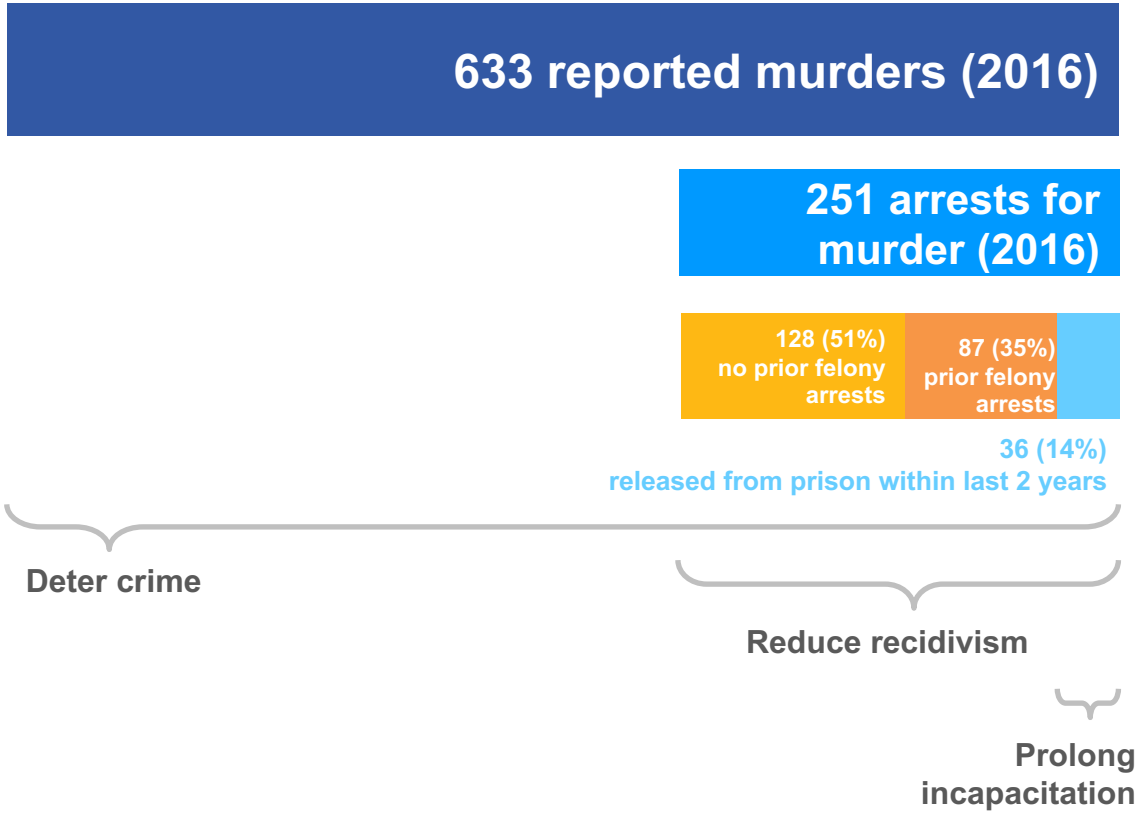
Every year there are many more reported homicides and aggravated assaults than there are arrests for those offenses.

In 2016, Ohio had the largest gap among states between the number of violent crimes reported and arrests made for those crimes. Ohio's violent crime rate was four times higher than the state's violent crime arrest rate.

Low-level crimes drive arrest activity and limit law enforcement's capacity to respond to violent crime. Arrests for violent crime accounted for just 4 percent of all arrests in 2017.

Source: FBI Uniform Crime Report, 2011-2017.

A. Preventing violent crime from occurring is more cost-effective than prolonging incapacitation.



In Ohio, half of the people arrested for committing murder had no prior arrests in the previous eight years.

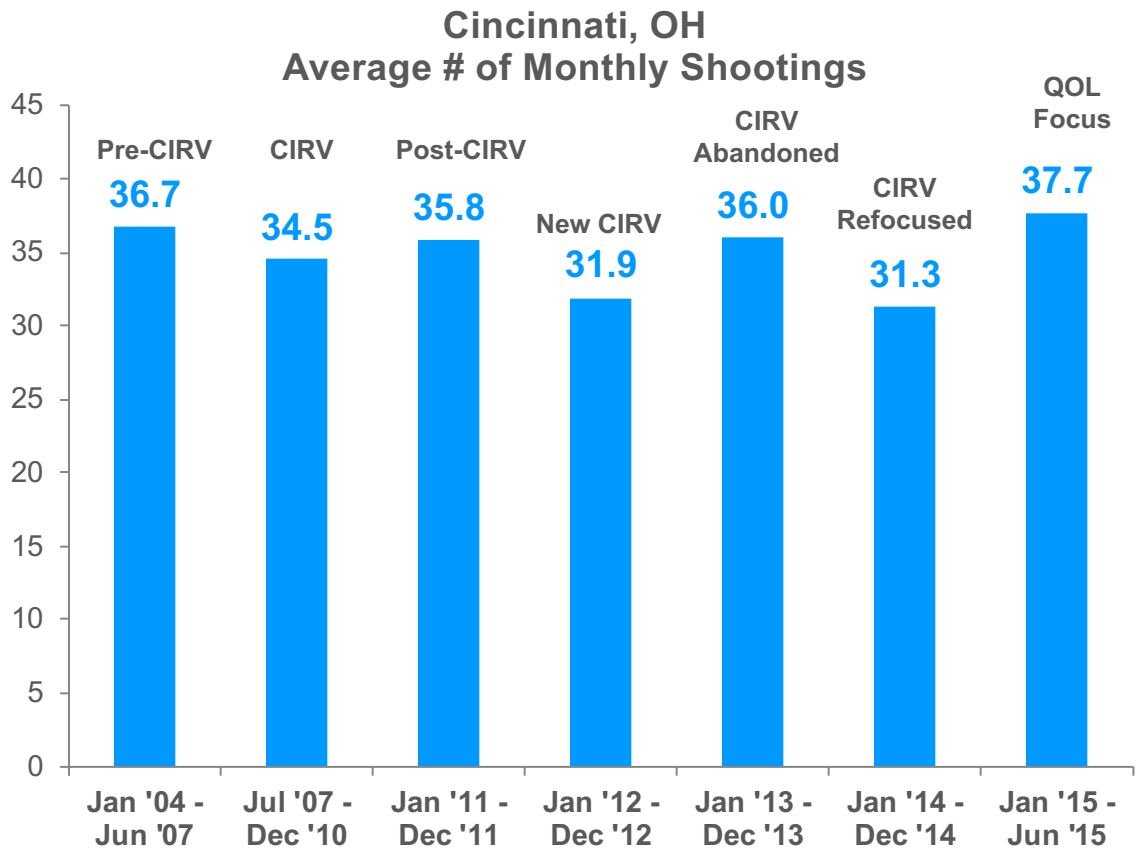
Only 14 percent of people arrested for murder in 2016 were released from prison within the previous two years.

Prolonging incapacitation for this 14 percent is less cost-effective than focusing on reducing recidivism and deterring violent crime.

Deterrence efforts have the greatest benefit-cost ratio.

Source: OCJS Crime Report, CSG analysis of BCI arrest data, and CSG analysis of ODRC release data.

A. Ohio's own experience shows that effective policing strategies can reduce violence but must be sustained.



The Cincinnati Initiative to Reduce Violence (CIRV) was initiated in 2007, but support ebbed and flowed over time.

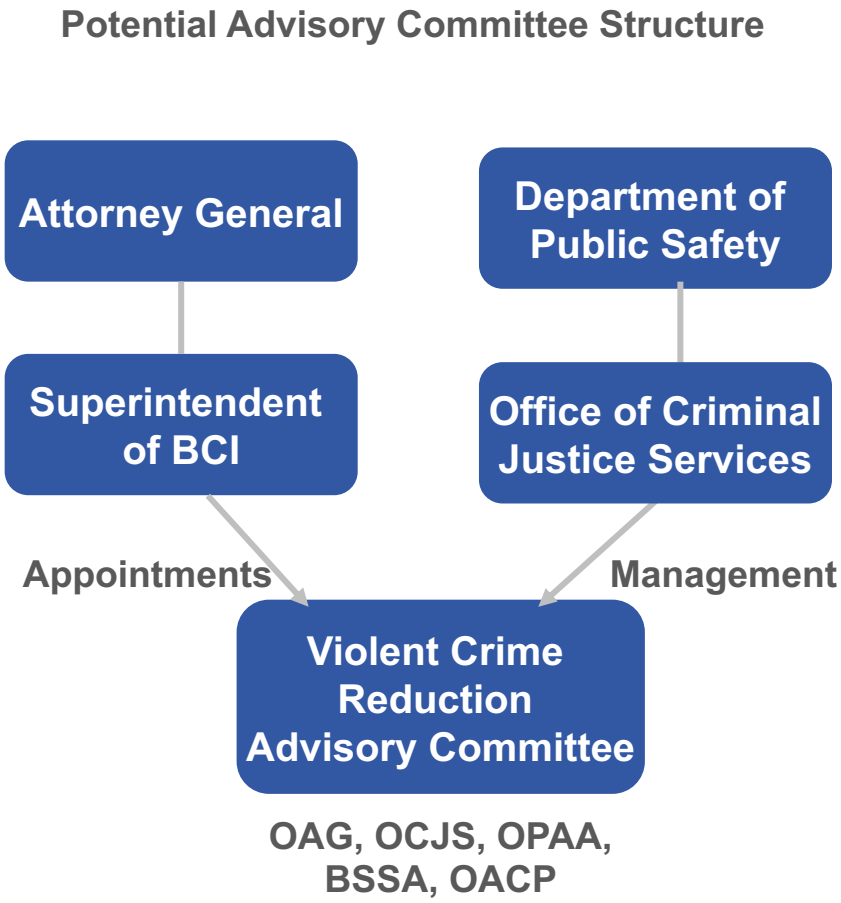
CIRV resulted in a 42-percent reduction in gang member involved homicides and a 22-percent reduction in shootings over a 42-month evaluation period.

The success led to replications across Ohio, with training and technical assistance funded by Ohio Office of Criminal Justice Services (OCJS) for Dayton, Mansfield, Toledo, Youngstown, and Cleveland.

A. Ohio law enforcement partners collaborated on the development of a violent crime reduction strategy.

Since August JR Committee update, CSG Justice Center staff have:

- Consulted JR Committee members and primary partners (OAG, DPS-OCJS, OPAA, BSSA, OACP) to develop details including a funding estimate
- Consulted internal CSG law enforcement experts
- Reviewed Oklahoma JRI state grant program
- Mapped potential Advisory Committee structure for consideration
  - AG to appoint members
  - OCJS to manage grant with direction from Advisory Committee tasked with strategic planning, ensuring use of EBP, & facilitating collaboration.
  - Potential budget of $330,000 (two $90,000 and three $50,000 grants)



POLICY

A. Reduce violent crime through effective law enforcement interventions.

A1: Designate a single statewide entity and advisory committee for violence reduction:

a. Engage in strategic planning, including coordination of state and federal funding sources.

b. Ensure dissemination and use of data analyses, research, training opportunities, and evidence-based policing strategies.

c. Facilitate connection to technical assistance providers and peers for collaboration.

A2: Create violent crime reduction grant program:

a. Award grants to local law enforcement department to support crime-reduction efforts.

B. Move people with substance addictions and mental health needs into treatment that works and reduce criminal justice involvement.

People involved in Ohio criminal justice systems with substance addictions and mental illnesses generate significant and persistent social and economic impacts.

- Incarceration pressures remain high.
- Increasing number of calls for service that involve substance addiction or mental illness.
- Opioid overdose and death rates remain dangerously high.
- Rising health care costs.

Ohio is positioned for innovative national leadership in improving criminal justice and health outcomes for these populations through smart, fiscally responsive strategies.

- Using merged arrest and health systems data to identify people who are driving the greatest system impacts and better understand their complex service needs;
- Incentivizing Medicaid managed care entities to focus on these populations with increased access to essential services, more effective utilization of those resources, and greater accountability through clear, meaningful outcomes reporting; and
- Leveraging significant federal financial participation.

People with behavioral health conditions in Ohio's criminal justice systems have complex needs and are contributing to Ohio's persistent corrections and health care systems challenges.

Ohio won't be able to solve these challenges without developing stronger, more effective, behavioral health systems.

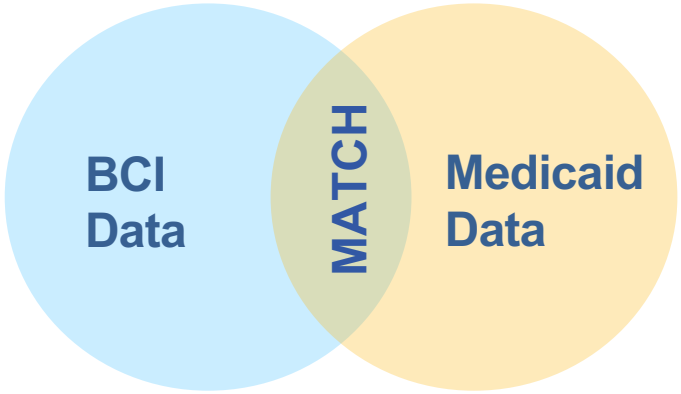
B. The proposed Ohio policy leverages health care "high utilizer" strategies with people who have poor outcomes and drive costs and other impacts across systems.

- ***Study**: 14,372 Vancouver residents with Provincial Court involvement*
- *Reviewed frequency and costs associated across corrections, health, and social welfare services*

	All N=14,372	Frequent Supervision N=216	Frequent Custody N=107
Rate of co-occurring disorders	30%	82%	94%
Average jail sentences (5 yr)	2.2	4.6	12.7
Average days in custody (5 yr)	93.2	158.4	590.9
Average health care costs (5 yr)	$15,160	$81,918	$85,344
Total average corrections and health care costs (5 yr)	$53,003	$168,389	$246,899

SOURCE: Somers, Julian M., et al. "High-Frequency Use of Corrections, Health, and Social Services, and Association with Mental Illness and Substance Use." Emerging Themes in Epidemiology, vol. 12, no. 1, 2015, doi:10.1186/s12982-015-0040-9.

B. The results from the ongoing BCI-Medicaid data match will be helpful in refining Ohio's target population, determining the needed service enhancements, costs, and incentive levels.



- How many people are **arrested frequently** and consistently require law enforcement, court, and confinement resources due to rearrest? To what extent do these people also interact with the behavioral health system?
- How many people **require medical care often** and consistently utilize emergency rooms, treatment services from community behavioral health providers, or pharmacy resources? How many of these people also come in contact with the criminal justice system?
- What will it take to better coordinate an already expensive system, maximize existing resources, and **improve outcomes**?

B. Reducing impacts and improving outcomes for people in Ohio's criminal justice systems who have serious behavioral health conditions involves three key strategies.

1. IDENTIFY	2. TARGET	3. INCENTIVIZE
Identify high-impact Medicaid recipients for whom current approaches aren't working.	Require MCOs to target these people with comprehensive, proactive supports and services using a collaborative, multi-agency approach.	Incentivize MCOs to improve health care and criminal justice outcomes for these people.

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B. Ohio arrest data shows that people who are frequently arrested by law enforcement are likely to be arrested for drug or property offenses, suggesting a need for addiction or mental health services.

IN OHIO:

Source: CSG Analysis of BCI data.

B. CareSource examined the health profiles and utilization patterns for their members who were booked into Ohio jails and created comparisons using the Johns Hopkins ACG System.

CareSource analyzed the behavioral health and primary care needs and services access of its members:

- **Utilization** of health care services
- **Conditions of high prevalence** (e.g., depression, diabetes, bipolar disorder)
- Certain **diagnostic clusters** of interest (e.g., behavioral health conditions, Hepatitis C, substance use)

Johns Hopkins ACG®

The ACG system uses markers to highlight specific conditions that are commonly selected for disease management or that warrant ongoing medication therapy.

Source: CareSource Presentation: Combined Jail Data and Analysis: 2014 and 2017.

B. CareSource data provides helpful health care insights into people booked into Ohio jails.

In three Ohio counties, CareSource examined:

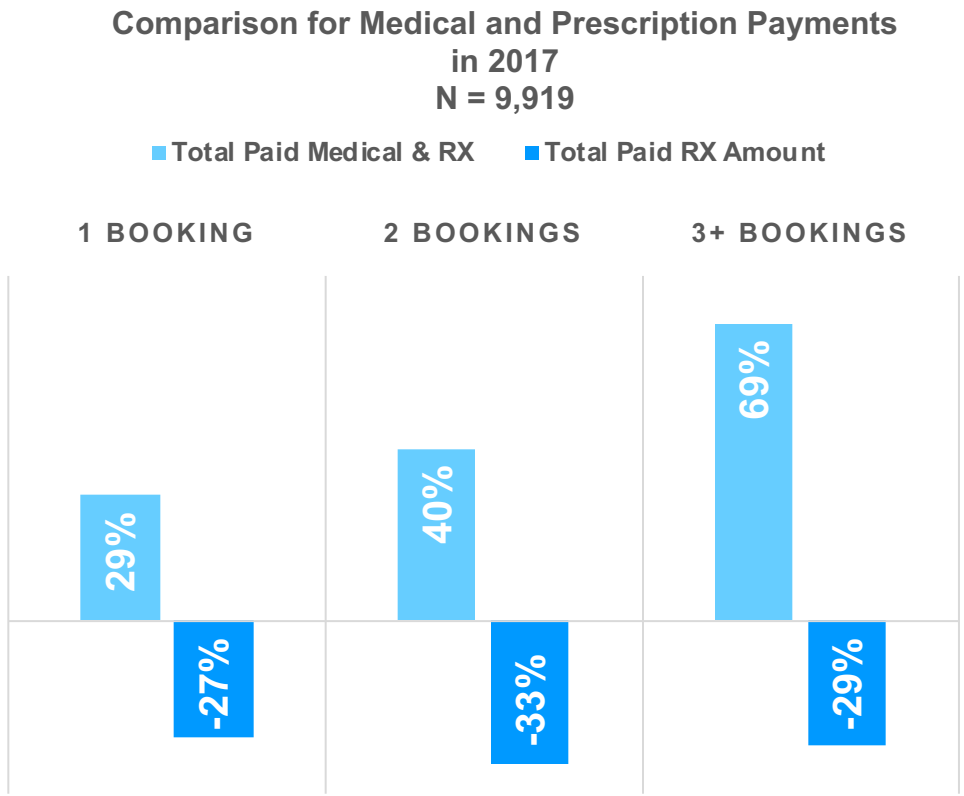
43,000+
people booked in Franklin, Montgomery, and Clermont counties.

23,000+
were historical CareSource members.

9,919
were CareSource members in the year of their jail booking.

Sources: CareSource Presentation: Combined Jail Data and Analysis: 2014 and 2017.

B. People booked into jail had higher overall medical costs than all members, but these costs were partly offset with lower prescription costs.



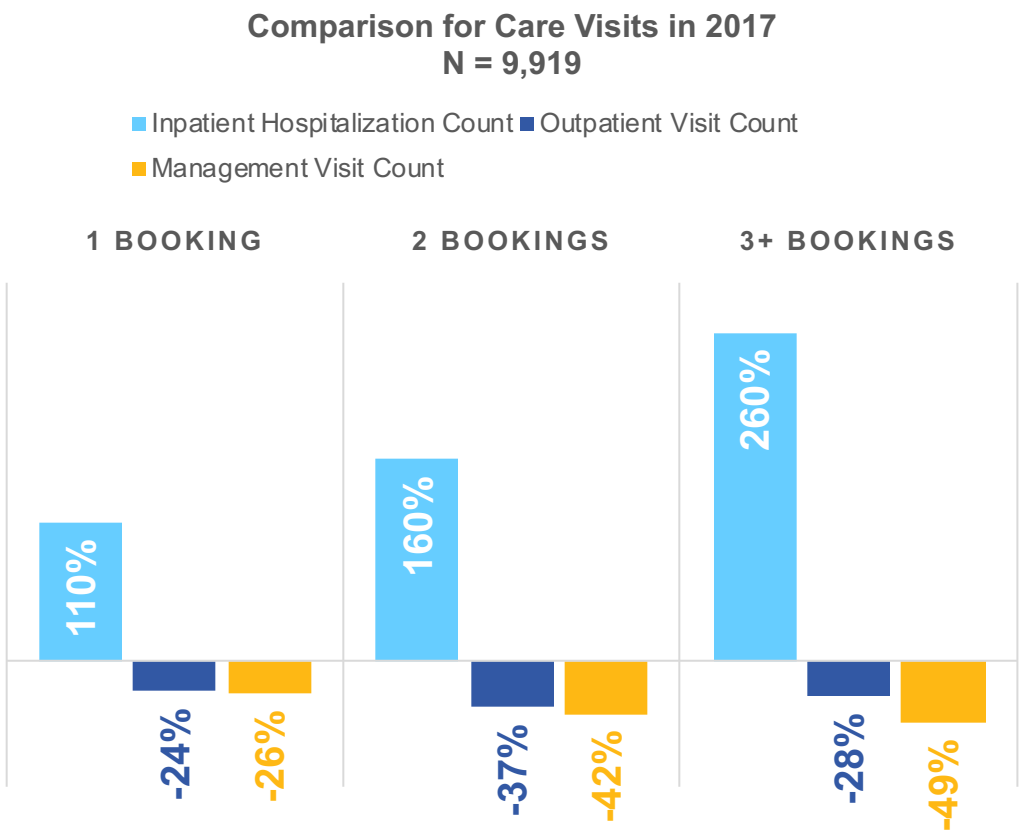
CareSource examined the average costs of care for adults and compared them to people booked:

3x

The total paid for **medical and prescription costs** for all members is three times the total paid for **prescription costs**.

Sources: CareSource Presentation: Combined Jail Data and Analysis: 2014 and 2017.

B. People booked into jail utilized expensive hospital care more often and less expensive routine care less often than other MCO members.



CareSource examined the average costs of care and compared them to people booked:

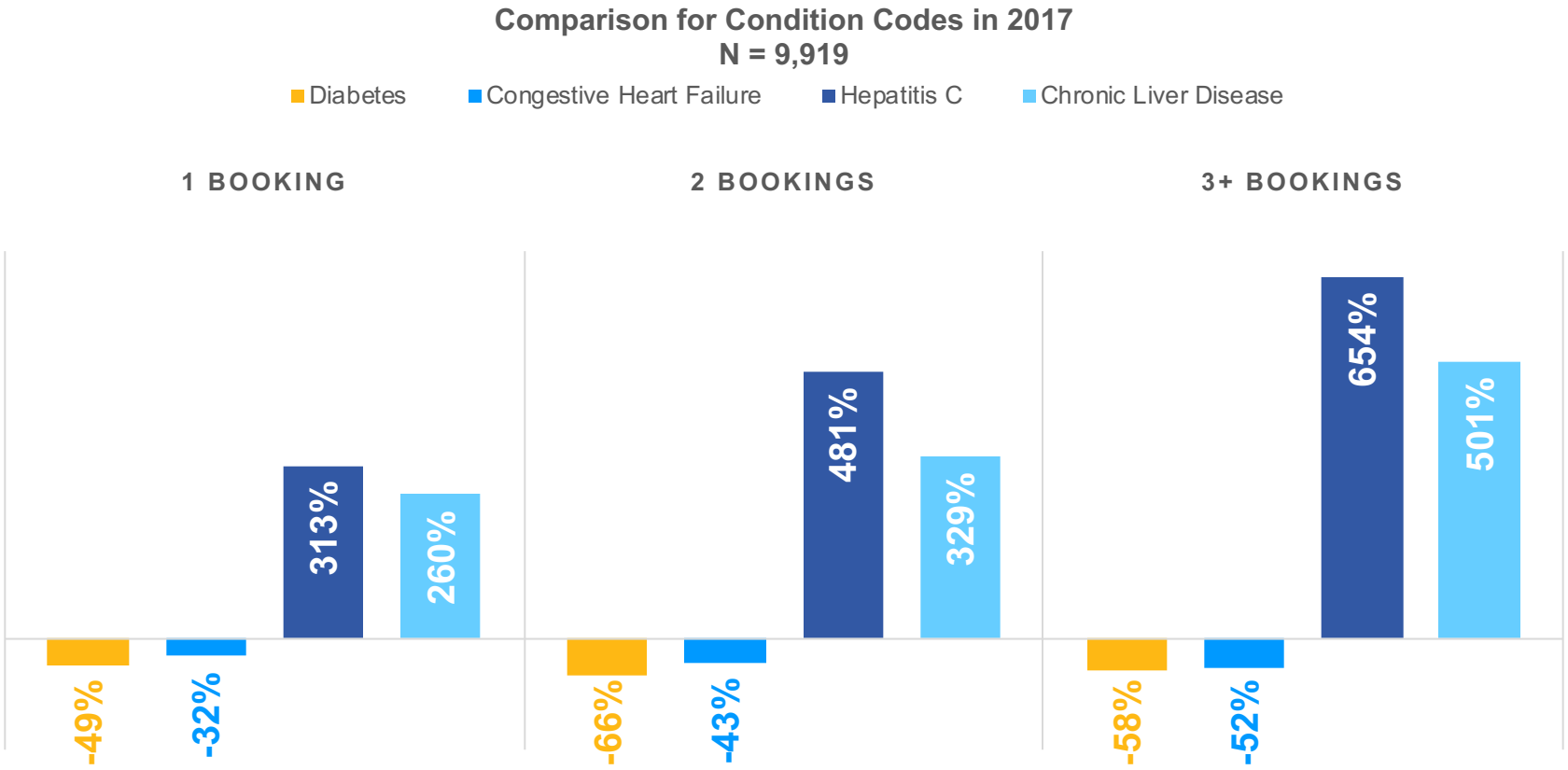
.1
inpatient hospitalization visits for all members

11.5
outpatient visits for all members

4.05
care management visits for all members

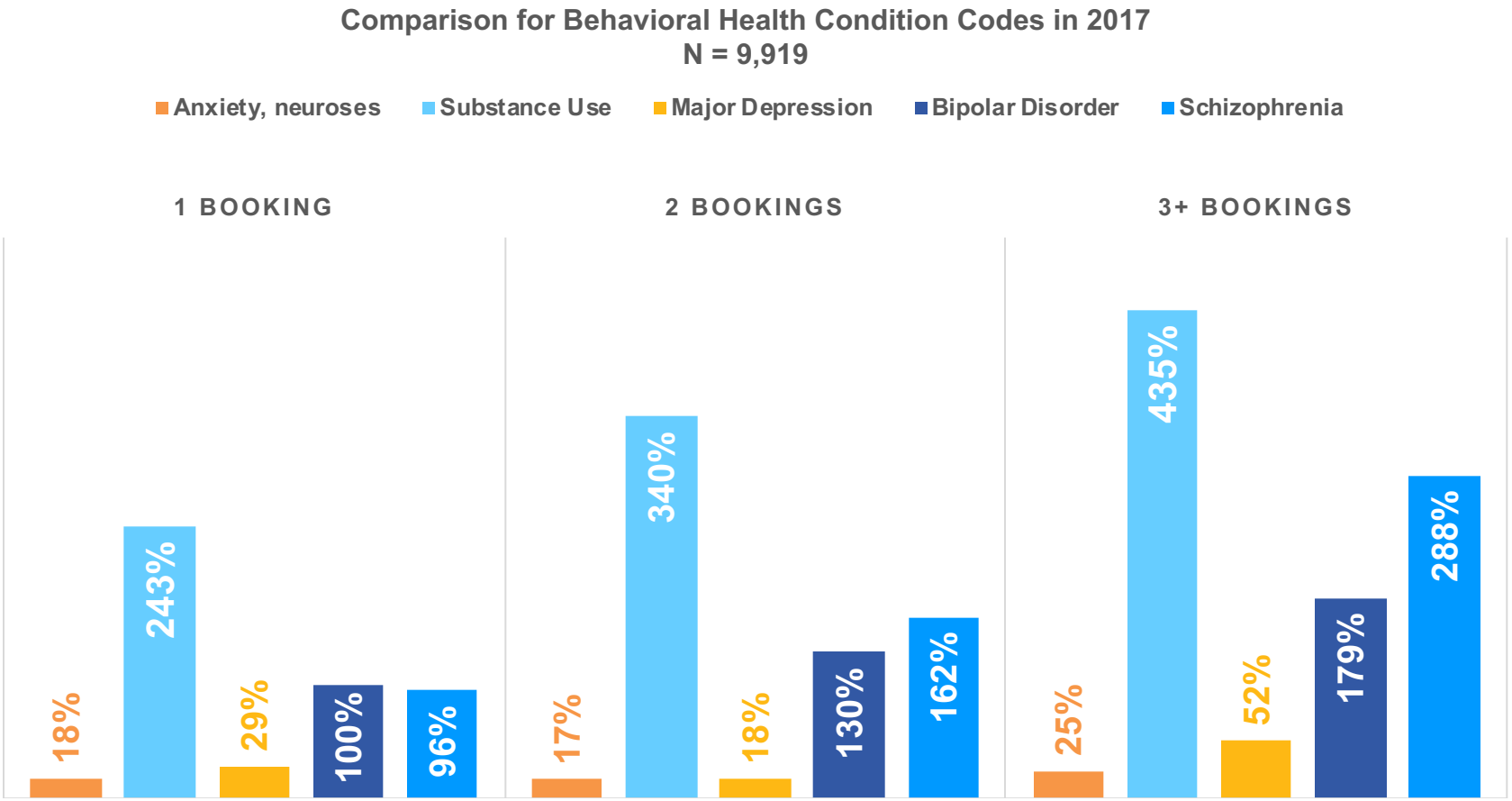
Sources: CareSource Presentation: Combined Jail Data and Analysis: 2014 and 2017.

B. People booked into jail three or more times in the period over-index for serious health conditions such as hepatitis C and chronic liver disease when compared to other MCO members.



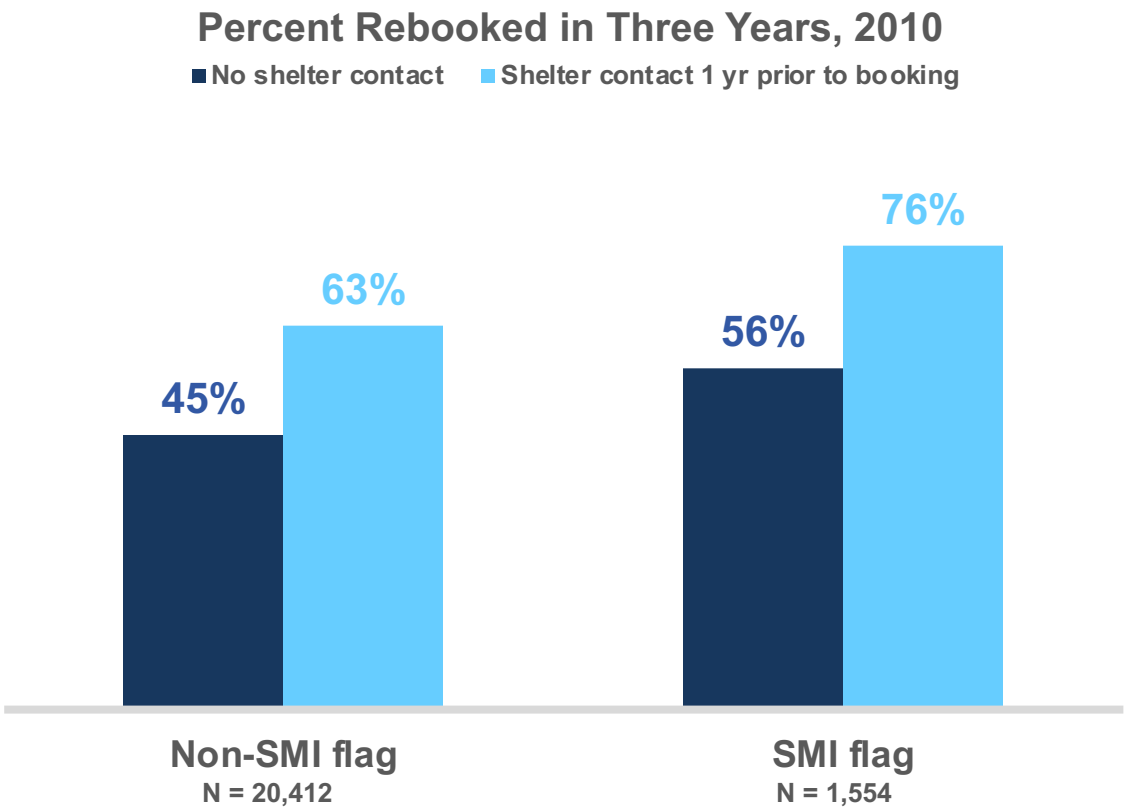
Sources: CareSource Presentation: Combined Jail Data and Analysis: 2014 and 2017.

B. People booked into jail over-index for serious behavioral health conditions when compared to the rest of the managed care population.



Sources: CareSource Presentation: Combined Jail Data and Analysis: 2014 and 2017.

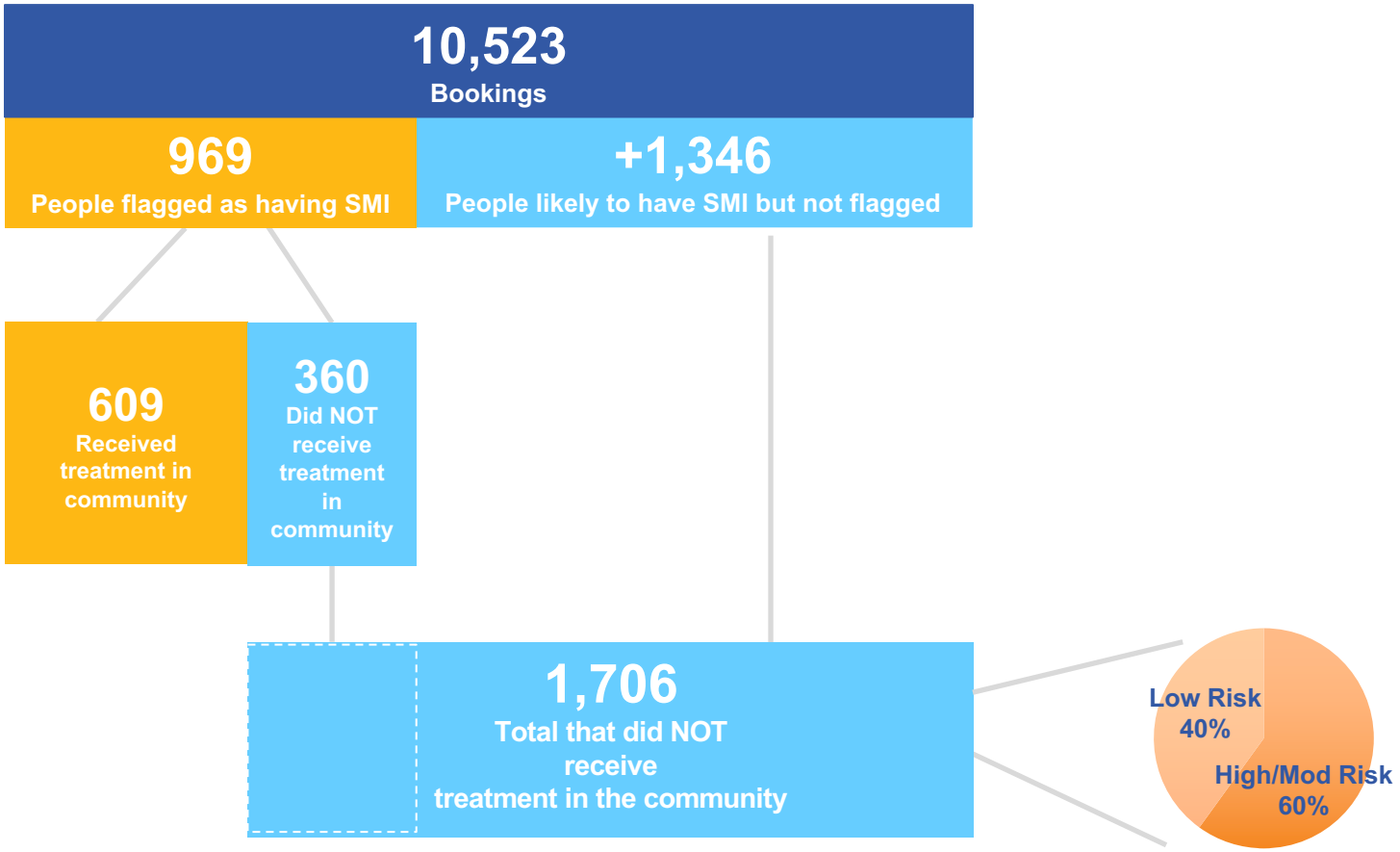
B. People with serious mental illnesses who experienced homelessness prior to jail booking have higher recidivism rates.



Source: CSG analysis of first Franklin County jail bookings in 2010; SMI identified using match to behavioral health service utilization data;

*** Shelter flag defined as accessing shelter one year prior to jail booking*

B. Data from a Franklin County study found that people with serious mental illnesses were often not identified, contributing to the number of people who did not receive community treatment services.



Source: CSG analysis of first Franklin County jail bookings in 2010; SMI identified using match to behavioral health service utilization data;

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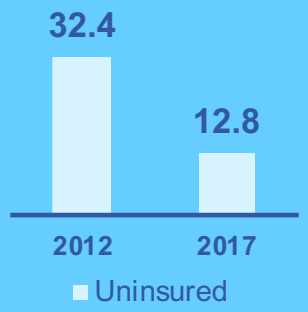
B. Ohio has been engaged in significant health care system reform, making the state well positioned to take next steps to address its challenges.

Medicaid expansion	Medicaid Managed Care	Behavioral Health Redesign
Behavioral Health "Carve In"	Performance Payments	Workforce investments

B. In 2014, Ohio expanded Medicaid to include low-income people, greatly broadening access to health care services for many people in the criminal justice system.

Population Served



Traditional Medicaid

Expansion

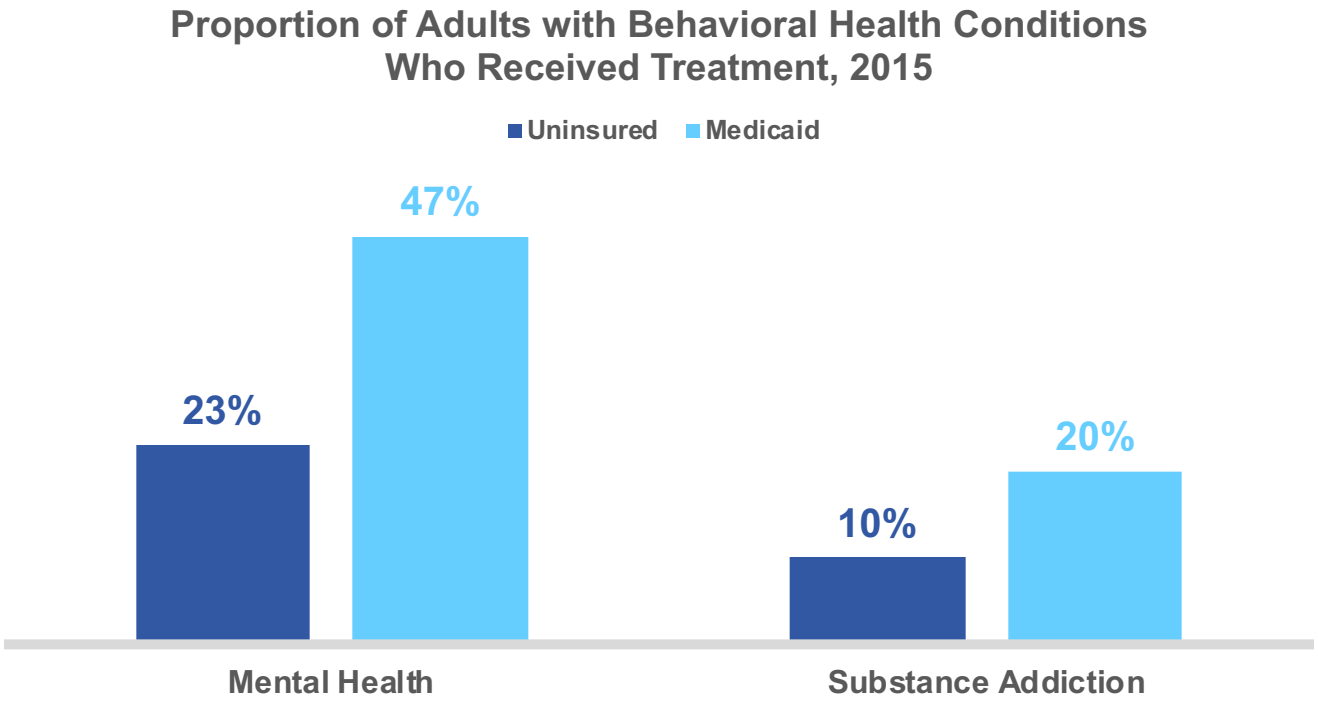
Ohio adopted Medicaid expansion in 2014, facilitating a dramatic reduction in the number of people without health care coverage.

Nationwide, up to 90 percent of people leaving jails and 70 percent leaving prisons were uninsured prior to Medicaid expansion.

Ohio now provides insurance cards to approximately 95 percent of people being released from prison.

Source: Ohio Mental Health and Addiction Services presentation at National Governor Association's "Behavioral Health Integration Learning Lab Convening" held on September 12 and 13 2018 (Washington D.C.)

B. Having health insurance is strongly linked to increased treatment utilization for individuals with mental illnesses and substance addictions.



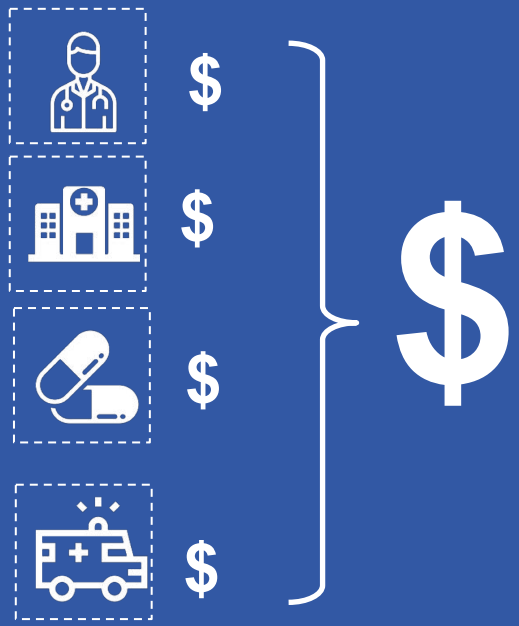
Note: Totals include people with mental illnesses or substance addictions who have Medicaid or are uninsured. Source: Kaiser Family Foundation analysis of 2015 National Survey on Drug Use and Health.

Source: Kaiser Family Foundation: https://www.kff.org/report-section/medicaids-role-in-financing-behavioral-health-services-for-low-income-individuals-issue-brief/

B. Ohio has been an early adopter of a managed care approach to health care delivery, going back to the 1970s.

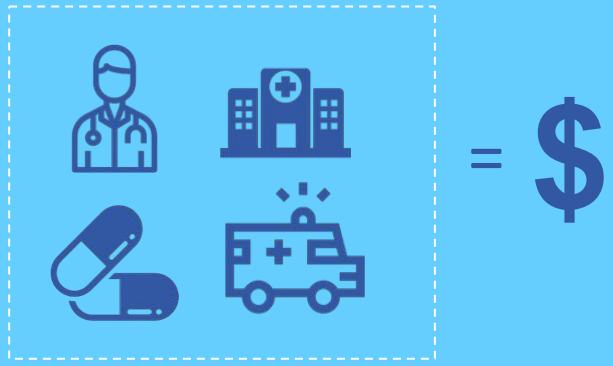
Fee for Service

- State pays participating providers for each individual service.
- Can contribute to uncoordinated care, duplication of service, and fragmentation.



Managed Care

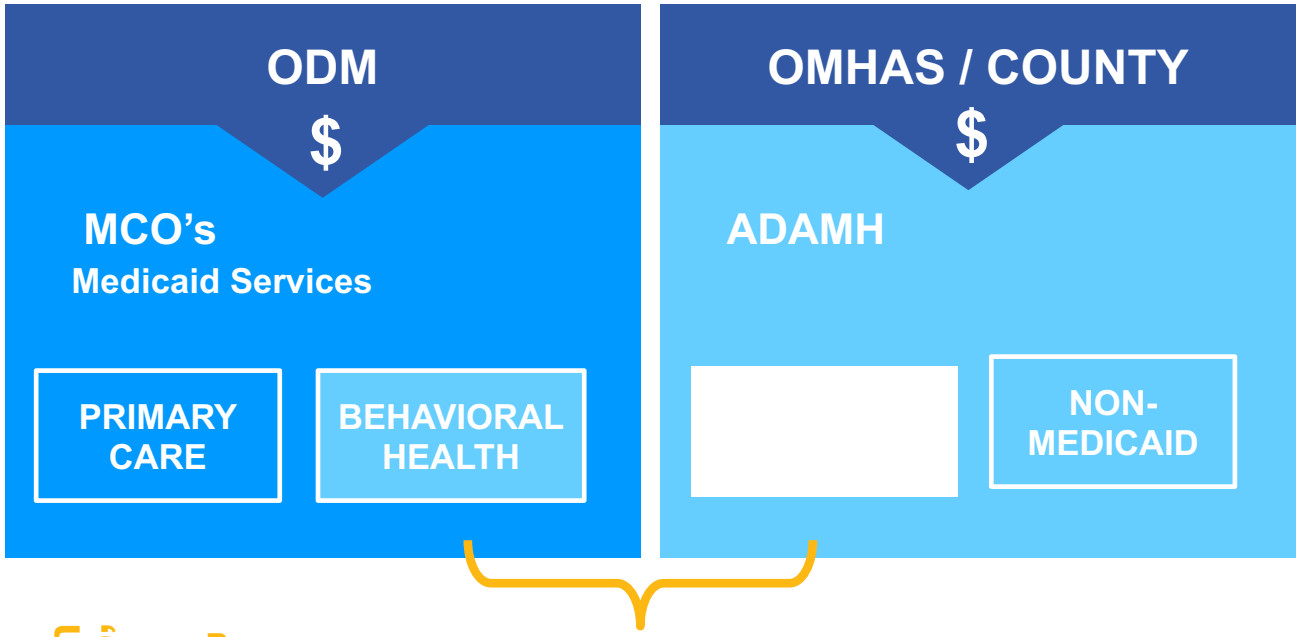
- State signs contracts with MCOs (own network of providers and hospitals).
- State pays MCOs fixed fee for each enrollee (per member/per month).
- MCOs are incentivized to keep members as healthy as possible (reduce unnecessary or costly services to recover savings).



Ohio Progression

- *1970s:* Experimental voluntary programs
- *1990s:* Mandatory managed care
- *2005:* Statewide, risk-based, comprehensive Medicaid Managed Care Program begins phase-in
- *2013:* Managed care extends to all plans, all regions, all eligible populations
- *2018:* Behavioral health "carve in"

B. Ohio launched its BH Redesign behavioral health "carve-in" in July 2018 to more fully integrate primary and behavioral health care services.



Behavioral Health "Carve-In"

Purpose

- Integrate behavioral health and primary care services
- Manage behavioral health costs
- Improve coordination and access to comprehensive services

Policy

- Absorb behavioral health services into existing managed care contracts
- MCOs accountable for behavioral health and primary care outcomes

B. Ohio's system of Alcohol, Drug Addiction, and Mental Health Boards (ADAMH) provide additional supports and services in most counties.

Statutorily empowered to plan, develop, fund, manage, and evaluate community-based mental health and addiction services.
Utilize federal, state and local funds

49 ADAMH Boards

1 Community Mental Health Board

1 Alcohol and Drug Addictions Services Board

Services

Provide for supports and services for children and adults. Areas of focus:

Peer Services

Jail-Based Services

Addiction Treatment Services

Supportive Housing Services

B. Given the complex needs of the people in the target population, it is essential to ensure provision of a broad array of supports and services, leveraging Medicaid and other existing funding streams where feasible.

B. The MCOs would be the primary agency funding and directing the provision of services with the potential to leverage ADAMH Boards for non-Medicaid services.

BUNDLED RATE

ODM $

MCOs

Medicaid Services

Coordination

OMHAS/ COUNTY $

ADAMH

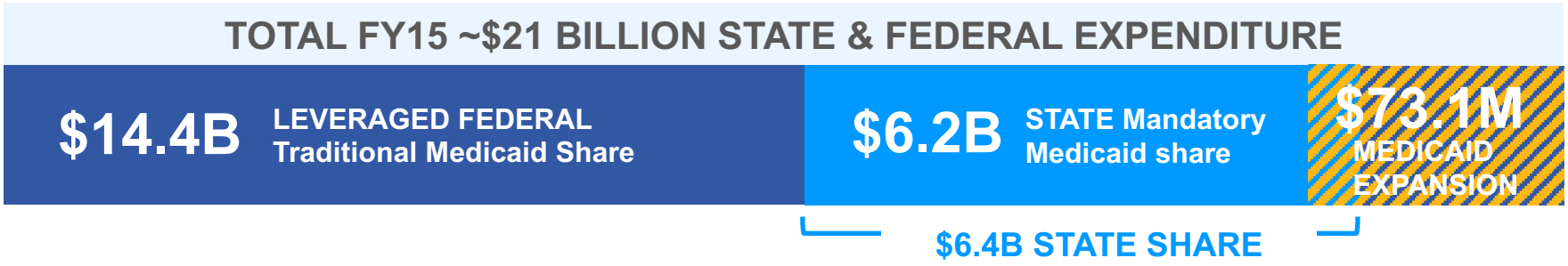
Non-Medicaid Services

GRANTS

Agencies and Providers

If both entities are engaged in service delivery, creation of formal agreements is needed to ensure coordination.

B. Most people in the target population are Medicaid eligible, enabling Ohio to leverage significant federal participation in addressing its statewide challenges.



TRADITIONAL MEDICAID

$1 spent by the state → **$1.71** federal dollars matched

~37% costs covered by the state

smaller eligible population

MEDICAID EXPANSION

$1 spent by the state → **$9.00** federal dollars matched

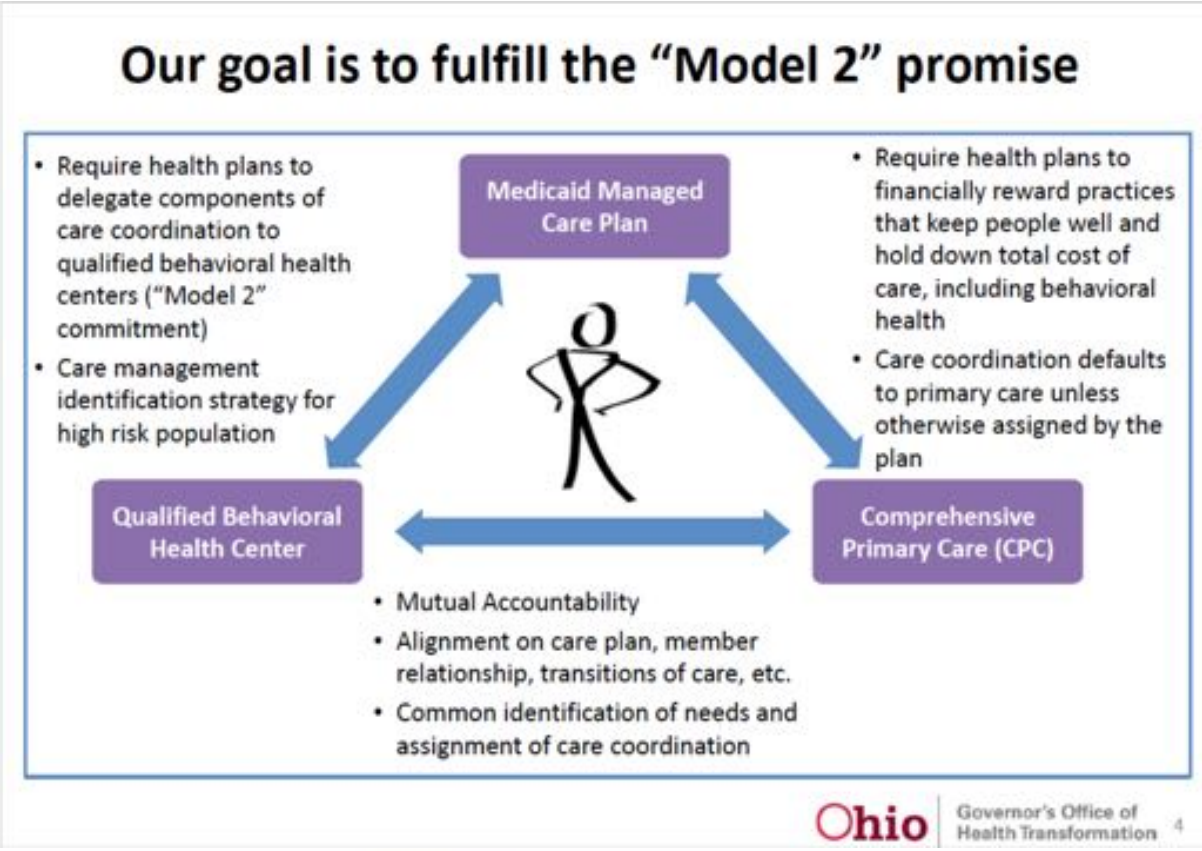
10% costs covered by the state

larger eligible population

Source: Kaiser Family Foundation, Medicaid Expansion Spending.

B. This program could also take advantage of Ohio's Behavioral Health Care Coordination initiative, which is in development and is designed to improve communication, coordination, and collaboration.

Most people in the target population are expected to meet program criteria.



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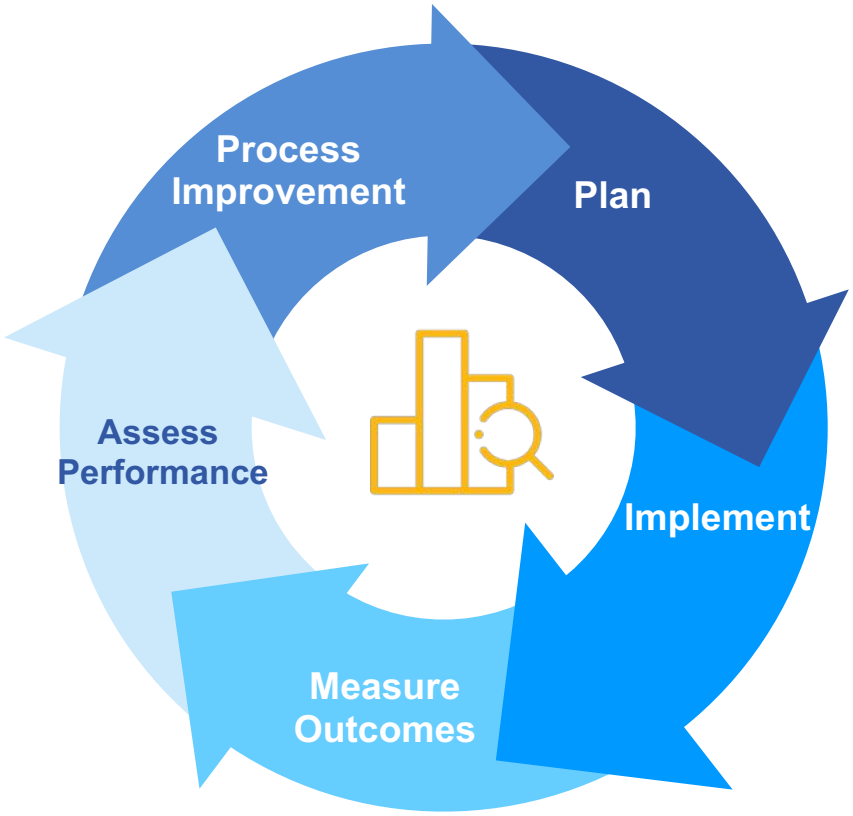
B. It is important to not only assess performance but to use that information to make adjustments at both the case and system levels.



The right measures can improve system focus and contribute to both improved public safety and health outcomes.

Other success metrics:

- ✓ Reductions in jail bookings
- ✓ Maintaining employment
- ✓ Adherence to treatment
- ✓ Stability in housing
- ✓ Passing drug/alcohol screens
- ✓ Reductions in overdoses
- ✓ Reductions in emergency department visits

B. Performance of the enhanced service delivery will be measured by outcomes linked to indicators of improved access and recovery and reductions in criminal justice involvement and system costs.

Sample Outcome Metrics

Outcome Measure	Recidivism Risk Factors	SDOH & Recovery Factors	Driver of System Costs
Jail Bookings + ED Visits	X	X	$$
		X	$$$$
Housing Stability	*	X	$$
Employment Stability	X	X	$$
Recovery Management	X	X	$$

* Some evidence of correlation with recidivism

B. Achieving improvements in outcomes measures will be rewarded with incentives to further drive performance.

$

MCOs

Medicaid Services

+

POTENTIAL KEY PARTNERS

Providers, ADAMH Boards, etc

OUTCOMES

- REDUCTIONS JAIL & ED
- HOUSING STABILITY
- EMPLOYMENT STABILITY
- RECOVERY MANAGEMENT

INCENTIVE FUND

B. Ohio must invest in workforce development to achieve its goals.

BIG CHALLENGES

Rank	**2nd** HIGHEST Drug overdose deaths	**5th** HIGHEST Percentage of adults with serious thoughts of suicide	**15th** HIGHEST In prevalence of mental illness	**21st** HIGHEST In prevalence of addictions
Stats	**8.7%** AGE 12 OR OLDER with alcohol addiction received treatment in the past year	**13.9%** AGE 12 OR OLDER with drug addiction received treatment in the past year		

SMALL WORKFORCE

37th in available behavioral health workforce

Source: http://www.mentalhealthamerica.net/sites/default/files/2016%20MH%20in%20America%20FINAL%20SPOTLIGHT.pdf

B. Workforce Policy Recommendations

1. Enhance workforce stimulus funds for
   - Tuition reimbursement
   - Scholarships
   - Relocation
   - Clinical supervision

2. Establish behavioral health workforce task force to provide additional recommendations for funding and policy strategy for 2020 session.

3. Fund technology to increase use of telemedicine.

4. Provide technical assistance and funding to develop statewide “hub and spoke” models for “hard to find” professional specialties, including addiction medicine and psychiatry.

5. Strengthen utilization of peer specialist positions.

B. Implementation is designed to expand in scale over multiple years.

CY19

- Initial investments
- Implementation planning/needs assessment
- Infrastructure development
- Deliver services

- Pilot Program(s)

CY20

- Evaluate; adjust
- Expand service delivery

- Increase number of people served

CY21

- Sustainable funding
- Evaluate; adjust
- Expand service delivery

- Statewide implementation

B. Year 1: CY2019 Proposed Implementation Goals and Activities

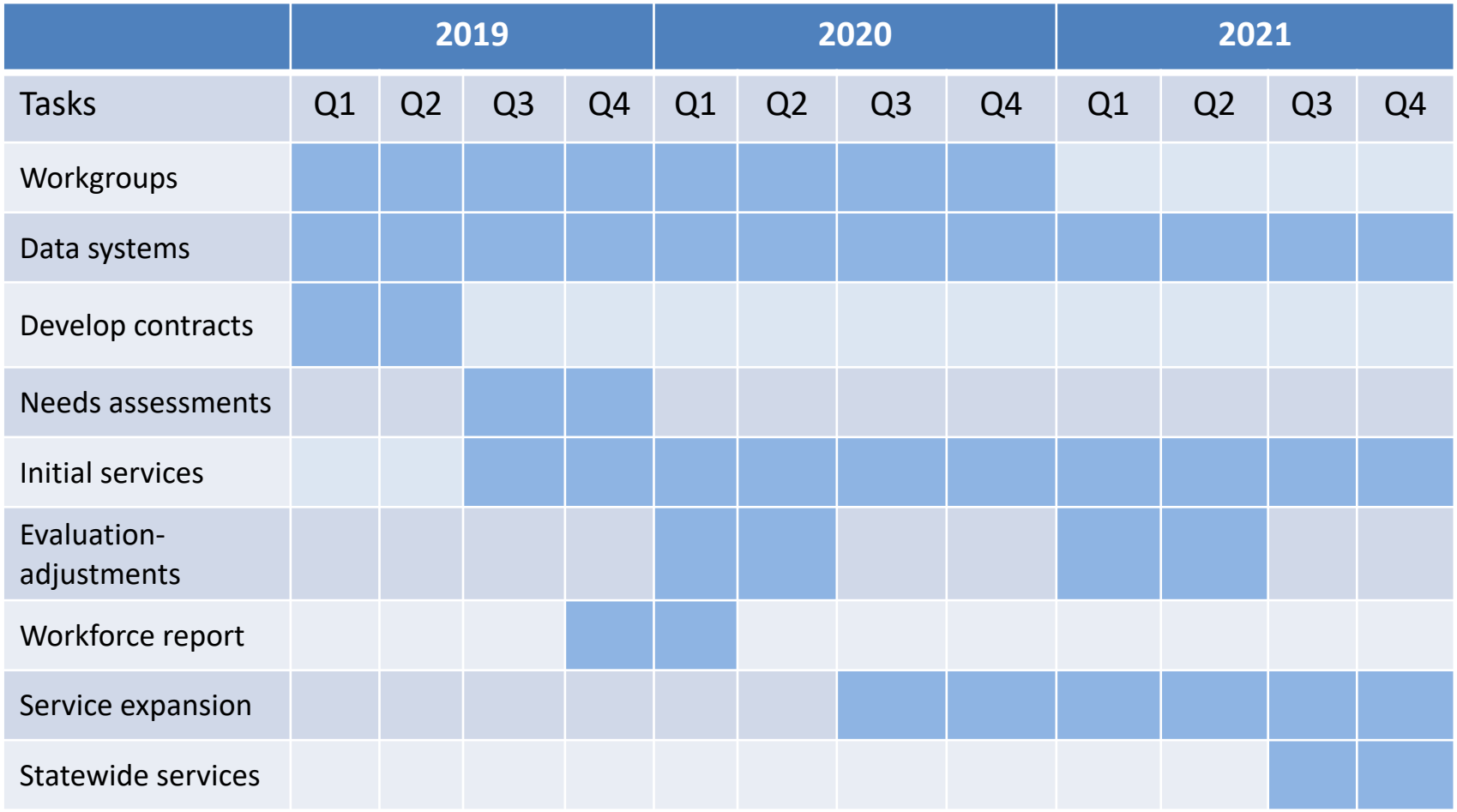
Key Goals	Activities

• Establish workgroups
• Develop multi-year implementation plans
• Develop model
• Secure initial funding
• Develop sustainable funding source(s)
• Select pilot sites
• Begin services
• Deliver workforce assessment and recommendations report
	• Legislation
	• Form oversight workgroup
	• Establish subcommittees:
	  • Services model and financing
	  • Workforce
	  • Needs assessment
	  • Metrics and data reporting
	• Select MCO(s) and initial sites
	• Establish data-sharing agreements
	• Develop target population selection
	• Establish pricing and incentive levels
	• Develop short- and long-term data reporting processes

B. Possible Agency/Entity Roles and Responsibilities

	ODM	OMHAS	
Lead Agency	MCO contracts Service pricing Incentive development and implementation Selection criteria	Statewide service needs assessment Workforce strategic planning Enhanced service model Workforce training Telehealth Outcomes development and reporting	
Partners	During the development and implementation period, it will be valuable to include agencies and individuals with subject matter expertise to help guide and inform the process.	• ODRC • ODH • MCOs • OACBHA • Treatment and recovery support providers	• Housing providers • Universities • Community and post-release control agencies • Courts • Law enforcement

B. Sample Implementation Timeline



B. The focus and amounts of spending would evolve during implementation.

Sample Project Budgeting Progression

	FY19	FY20	FY21	FY22
Workforce	$0.5M	$0.5M	$1.0M	$1.0M
Tech, TA, Start-up	$1.0M	$.5M	$.5M	$0
Enhanced services and incentives	$1.5M	$3.0M	$5.0M	$7.0M
Total	**$3.0M**	**4.0M**	**$6.5M**	**$8.0M**

POLICY

B. Provide treatment that works for people who have substance addictions and mental health needs.

B1: Identify high-impact Medicaid recipients for whom current approaches aren't working.

B2: Require Managed Care Organizations to target these people with comprehensive, proactive supports and services using a collaborative, multi-agency approach.

B3: Incentivize Managed Care Organizations to improve health care and criminal justice outcomes for these people.

C. Reduce recidivism and costs to taxpayers from an overcrowded prison system.

Ohio continues to be challenged by who should or shall be sent to prison versus community control, and how the state's unique reliance on judicial release can be optimized.

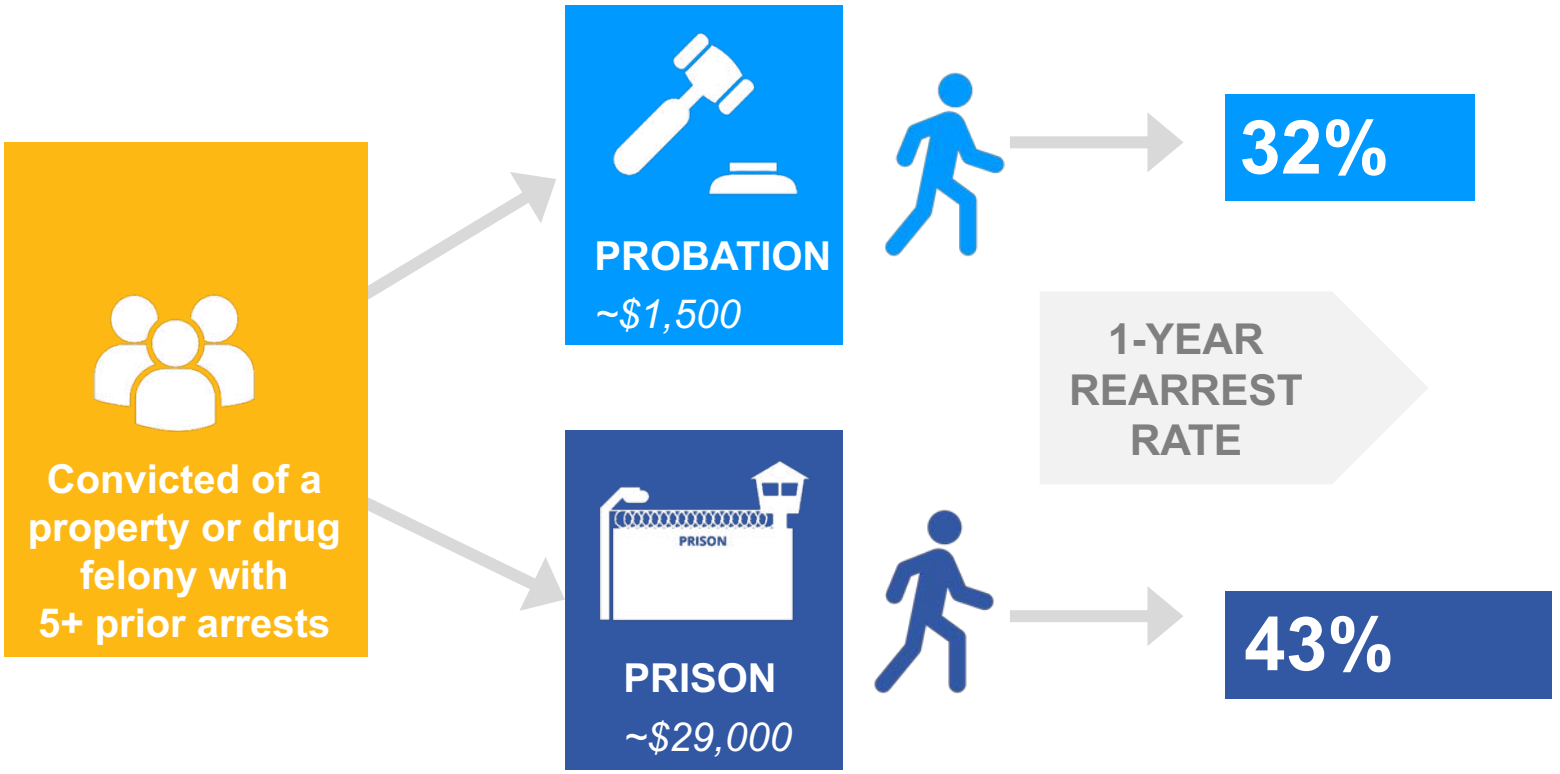
Strategies and Areas of Focus:

"Recovery Sentencing"	Sentencing	Judicial Release	Civil Commitment
Using community control to propel more property and drug cases to treatment	Sanctions for violations & place of confinement for low-level felonies	Settling on one effective and fair mechanism for the state's reliance on judicial release	Removing barriers to people entering treatment through probate courts

Ohio Data Shows:

- *Sentencing people convicted of property and drug offenses to probation rather than prison results in much lower costs and slightly lower rearrest rates; this is true even for those with multiple prior arrests.*
- *In 2017, 5,031 people were sentenced to prison for drug offenses, and 3,686 people were sentenced to prison for property offenses.*
- *An estimated 1,000 people annually are sentenced to prison for F4 and F5 offenses even though they have a substance addiction or serious mental illness.*
- *In 2017, 11 percent of releases from prison were through judicial release, while thousands more were eligible.*

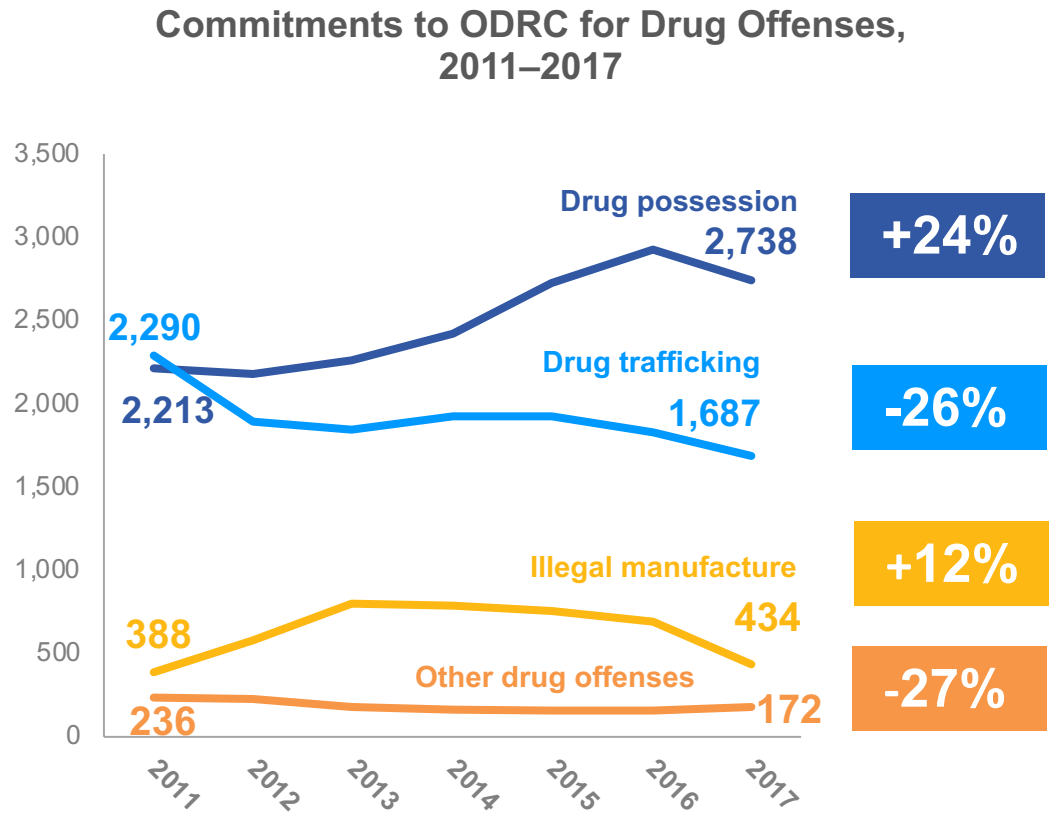
C. In Ohio, sentencing people to probation instead of prison for property and drug offenses is much cheaper and results in slightly lower recidivism.



Results varied by arrest history.
No prior arrests: probation (11%), prison (11%).
One prior arrest: probation (16%), prison (15%).
Two to four prior arrests: probation (21%), prison (25%).

Source: CSG analysis of BCI Arrest Data and ODRC Release Data.

C. Yet, thousands of people convicted of property and drug offenses continue to be sentenced to state prison each year.



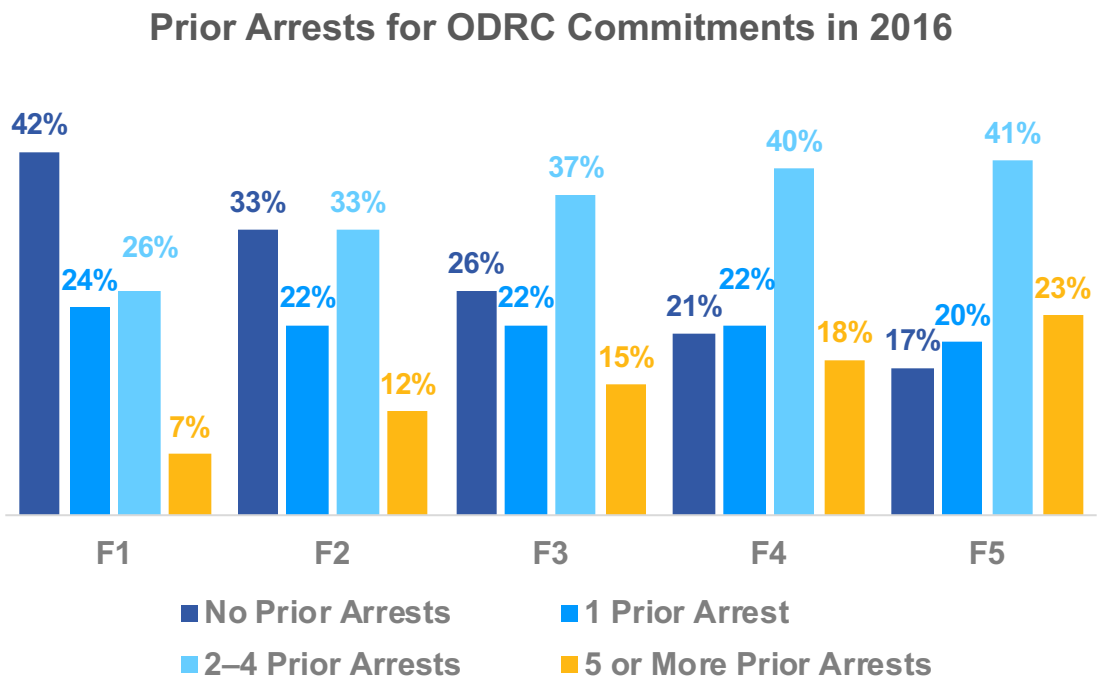
+24%
drug possession commitments between 2011 and 2017

5,031
commitments to ODRC for any **drug offense** in 2017

3,686
commitments to ODRC for a **property offense** in 2017

Source: ODRC Commitment Sheets.

C. Thirty-seven percent of people committed to DRC for an F5 offense had only one or no prior arrests; 64 percent had two or more.



Source: CSG analysis of ODRC Data and BCI Arrest Data.
Note: Justice Center staff examined the first commitment in a 2016.

43%

of people committed to ODRC for an F4 offense had only one or no prior arrests before commitment to ODRC.

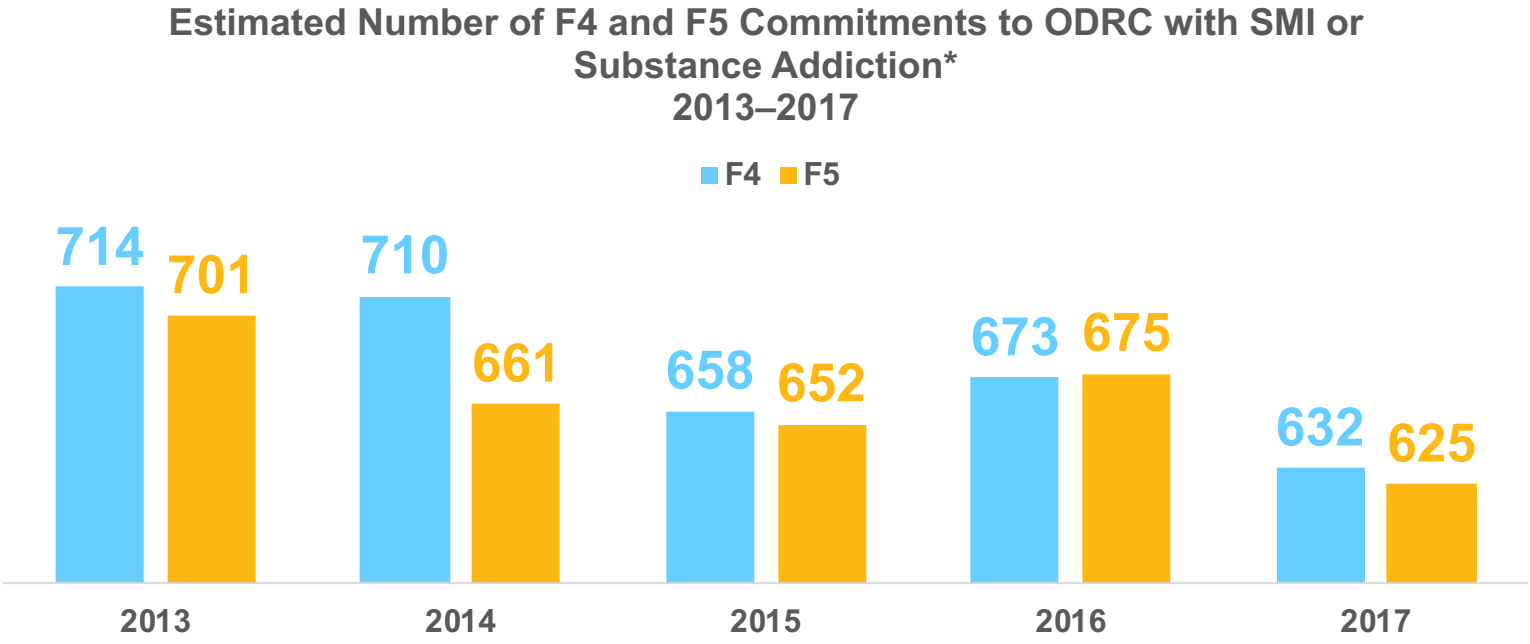
2–4 prior arrests

The largest proportion of people committed to ODRC for an F4 or F5 had two to four prior arrests.

1/4

of community control violator admissions appear to have no prior arrests. The data does not show whether these are "technical violators."

C. Using national estimates for serious mental illness and substance addiction, more than 1,000 commitments to prison for F4 and F5 offenses could be diverted to recovery sentencing.



**Note: CSG Justice Center staff examined F4 and F5 commitments that did not have a community control, post-release control, or parole violation flag and estimated that two-thirds would be moderate to high risk. Staff then estimated that 36 percent had a substance addiction and 16 percent had a serious mental illness.*

Sources: CSG analysis of ODRC data.

C. Qualified F5 commitments to ODRC between 2013 and 2017 are split about 50/50 between mandatory and non-mandatory TCAP counties.

	2013	2014	2015	2016	2017
Prison Population	50,328	50,510	50,403	50,839	50,211
F5* Commitments	1,817	1,714	1,696	1,799	1,692
F5* Commitments from Mandatory Counties	999	812	769	805	778
Average LOS for F5* Releases (in months)	5.95	6.15	6.47	6.36	6.61

Note: CSG Justice Center staff examined F5 commitments who were not recommitted from PRC or parole, who were not a community control violator, and did not have a violent or sex offense as the most serious offense of conviction.

Sources: CSG analysis of ODRC data, ODRC Master Population Count Reports, ODRC Memo Analysis of Impact of Statewide Issue 1.

C. Changing judicial release to a more efficient and fair process has the potential to substantially affect prison crowding.

For each year between 2013 and 2017, over 10,000 people are estimated to be eligible for judicial release. Only a small percentage are granted under current law, and in 2017, just 11 percent of releases from prison were through judicial release.

TOPIC	2013	2014	2015	2016	2017
Prison Population	50,328	50,510	50,403	50,839	50,211
F3 Judicial Release Eligible Commitments	4,555	4,396	4,456	4,511	4,429
F4 Judicial Release Eligible Commitments	3,447	3,472	3,215	3,336	3,176
F5 Judicial Release Eligible Commitments	4,985	4,879	4,729	4,937	4,603
Total Judicial Release Eligible Commitments	**15,010**	**14,631**	**14,240**	**14,622**	**13,975**
Total Judicial Releases	2,414	2,491	2,538	2,475	2,450
Average LOS for Judicial Releases (in months)	15.8	16.0	16.0	16.8	17.6

Note: The CSG Justice Center included commitments that did not have a violent or sex offense as the most serious offense of conviction, that did not have a firearm specification, and cases that had less mandatory time than the total term as judicial eligible.

Sources: CSG analysis of ODRC data, ODRC Master Population Count Reports. Impact of House Bill 86 & Sentencing Related Legislation on the Incarcerated Population in Ohio.

POLICY

C. Reduce recidivism and costs to taxpayers from an overcrowded prison system.

C1: Use recovery sentencing to direct appropriate people to treatment.

a. Apply a presumption of treatment under community control for people with mental illnesses or substance addictions.
b. Use current definitions for mental illness and substance addiction.
c. Connect this approach to the Medicaid Managed Care program envisioned in Part B.

C2: Modernize and streamline sentencing laws.

a. Require violation sanctions to be based on the violation and define technical violations.
b. Remove requirement for judges to announce the possible sentence in advance.
c. Apply “place of confinement” law uniformly statewide.
d. Refine probation maximum terms and set probation conditions according to risk and needs.
e. Rescale drug offenses along the lines recommended by recodification.

C3: Utilize judicial release to effectively choose when prison terms can end.

a. Explore simplifying timing and requiring at least one hearing.
b. Examine developing enhanced opportunities for legal representation for people in prison.
c. Repeal 80-percent release and risk-reduction sentencing.
d. Consider repealing judicial veto of transitional control on short sentences.

C4: Lower barriers to civil commitment for treatment.

D. Begin resolving Ohio's data deficits to understand how the system can be improved.

Ohio struggles to collect and share aggregate case disposition and supervision data to inform criminal justice policy development, enactment, implementation, and evaluation.

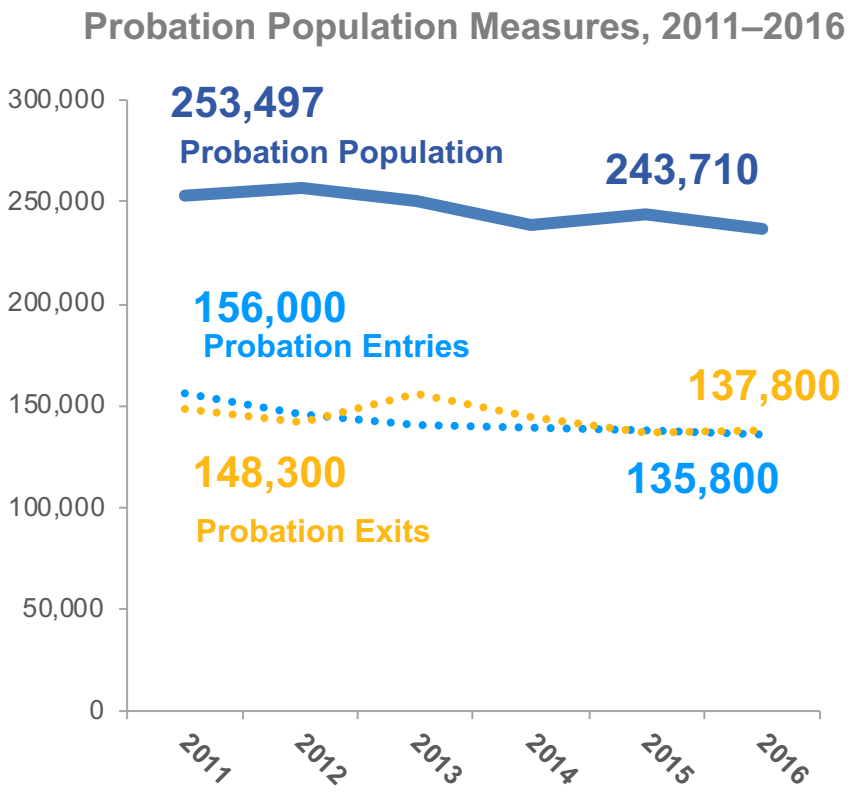
Multiple data systems are in place but most were not useful for providing policy-relevant information.

- For example, the Ohio Courts Network (OCN) was not developed for aggregate data reporting, has incomplete state coverage, relies on every local jurisdiction to agree, and has a small number of data fields that are mandatory so limited data is collected.

Ohio needs a systematic effort to plan next steps in the quest for useful data.

- Ohio should document the flow of cases through the criminal justice system, starting with law enforcement, to identify sources of data and types of data that may be shared.
- Next, develop a detailed plan for leveraging electronic data, automating paper processes, identifying processes that could be improved, and identifying data hand-offs that reduce redundancy and improve accuracy.

D. Ohio's locally-run probation departments supervise a quarter of a million people, and the state still lacks meaningful data needed to analyze and inform efforts to reduce probation revocations and recidivism.



Source: Bureau of Justice Assistance Probation and Parole in the United States.

People who violate probation conditions make up 21–24 percent of prison commitments.

Revocation pressure on the prison population can be alleviated using state improvement and incentive funding.

Ohio lacks basic information:

- How many people are on felony versus misdemeanor probation?
- How do dispositions to probation vary by county, offense, criminal history, etc.?
- What are demographics and risk levels of people on probation?
- How many people in total are on probation?

POLICY

D. Improve data collection.

D1: Require sentencing commission to establish a process to document the flow of criminal justice cases and identify the sources and types of data for the purpose of developing a statewide plan to improve data collection, sharing, and coordination.

D2: Require sentencing commission to maintain a centralized database of sentencing and probation data and be responsible for collecting this data, and require probation departments to submit data to the sentencing commission.

D3: Encourage the Supreme Court to adopt a uniform format for sentencing journal entries.

D4: Encourage the state to generate summary reports of any required local data as a quality check and to track trends.

D5: Adopt data definitions to standardize information and allow aggregation and research.

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Thank You

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Changing the eligibility for judicial release will provide greater judicial discretion.

Sentence (Years)	Current Minimum "Eligibility" (Petition Filing)	Proposed Minimum Eligibility (Judicial Discretion to Grant)
1	Upon arrival (0%)	180 days (50%)
2	Upon arrival (0%)	180 days (25%)
3	180 days (16.6%)	
4	180 days (12.5%)	
5	4 (80%)	2.5 (50%)
6	5 (83%)	3 (50%)
7	5 (71%)	3.5 (50%)
8	5 (62.5%)	4 (50%)
9	5 (55.5%)	4.5 (50%)
10	5 (50%)	
> 10	50%	

HB 365 and Justice Reinvestment

Justice Reinvestment policies would improve upon the significant changes embodied in HB 365.

TOPIC	HB 365 (REAGAN TOKES)	JR
Public Safety	Focuses on public safety at the point of prison release and strengthens post-release supervision	Emphasizes strengthening community control to reduce recidivism and preventing crime through effective policing
Prison Capacity & and Cost	Adds maximum sentences that will likely increase the prison population and cost	Promotes simplified sentencing and increased diversion of drug and property offenses to recovery sentencing
Judicial Release	Continues reliance on existing, overlapping processes	Requires a single, meaningful process for granting judicial release
Using Data	Creates new law enforcement data system for GPS monitoring, operated by prison system	Broadly emphasizes improving data collection, sharing, and mapping data landscape

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