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).
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:

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

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.

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.

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

633 reported murders (2016)

251 arrests for murder (2016)

- 128 (51%) no prior felony arrests
- 87 (35%) prior felony arrests

36 (14%) released from prison within last 2 years

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

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

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.

<table>
<thead>
<tr>
<th>1. IDENTIFY</th>
<th>2. TARGET</th>
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<td>Identify high-impact Medicaid recipients for whom current approaches aren’t working.</td>
<td>Require MCOs to target these people with comprehensive, proactive supports and services using a collaborative, multi-agency approach.</td>
<td>Incentivize MCOs to improve health care and criminal justice outcomes for these people.</td>
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B. Reducing impacts and improving outcomes for people in Ohio’s criminal justice systems who have serious behavioral health conditions involves **three key strategies**.

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</tbody>
</table>
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:

- 15,063 people were arrested 3 or more times in 2015–2016.
- 50% were arrested at least once for a drug or property offense.
- MOST COMMON OFFENSES: drug possession, misdemeanor theft.

Total arrests generated: 54,792.

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.

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.

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.

Comparison for Medical and Prescription Payments in 2017
N = 9,919

- Total Paid Medical & RX
- Total Paid RX Amount

1 BOOKING 2 BOOKINGS 3+ BOOKINGS

29% -27%

40% -33%

66% -26%

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:

- 0.1 inpatient hospitalization visits for all members
- 11.5 outpatient visits for all members
- 4.05 care management visits for all members

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.

Comparison for Condition Codes in 2017
N = 9,919

- Diabetes
- Congestive Heart Failure
- Hepatitis C
- Chronic Liver Disease

1 BOOKING
- Diabetes: -49%
- Congestive Heart Failure: -32%
- Hepatitis C: 313%
- Chronic Liver Disease: 260%

2 BOOKINGS
- Diabetes: -66%
- Congestive Heart Failure: -43%
- Hepatitis C: 481%
- Chronic Liver Disease: 329%

3+ BOOKINGS
- Diabetes: -58%
- Congestive Heart Failure: -52%
- Hepatitis C: 654%
- Chronic Liver Disease: 501%

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

Comparison for Behavioral Health Condition Codes in 2017
N = 9,919

Anxiety, neuroses  | Substance Use  | Major Depression  | Bipolar Disorder  | Schizophrenia
--- | --- | --- | --- | ---
1 BOOKING | 18% | 29% | 100% | 96% | 17%
2 BOOKINGS | 243% | 340% | 18% | 130% | 162%
3+ BOOKINGS | 435% | 288% | 25% | 52% | 179%

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.

- 10,523 Bookings
  - 969 People flagged as having SMI
  - +1,346 People likely to have SMI but not flagged

- 609 Received treatment in community
- 360 Did NOT receive treatment in community

- 1,706 Total that did NOT receive treatment in the community

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

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

<table>
<thead>
<tr>
<th>Medicaid expansion</th>
<th>Medicaid Managed Care</th>
<th>Behavioral Health Redesign</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health “Carve In”</td>
<td>Performance Payments</td>
<td>Workforce investments</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured</td>
<td>32.4</td>
<td>12.8</td>
</tr>
</tbody>
</table>

**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.

Proportion of Adults with Behavioral Health Conditions Who Received Treatment, 2015

- Mental Health:
  - Uninsured: 23%
  - Medicaid: 47%

- Substance Addiction:
  - Uninsured: 10%
  - Medicaid: 20%

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.

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.

**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

![Diagram of ODM and OMHAS/COUNTY roles in BH Redesign]

**ODM**
- Medicaid Services
  - MCO’s
  - Primary Care
  - Behavioral Health

**OMHAS/COUNTY**
- ADAMH
- Non-Medicaid

---

*Council of State Governments*
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:
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.

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.

TOTAL FY15 ~$21 BILLION STATE & FEDERAL EXPENDITURE

- **$14.4B** LEVERAGED FEDERAL Traditional Medicaid Share
- **$6.2B** STATE Mandatory Medicaid share
- **$73.1M** MEDICAID EXPANSION

$6.4B STATE SHARE

<table>
<thead>
<tr>
<th>TRADITIONAL MEDICAID</th>
<th>MEDICAID EXPANSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1 spent by the state</td>
<td>$1 spent by the state</td>
</tr>
<tr>
<td>$1.71 federal dollars matched</td>
<td>$9.00 federal dollars matched</td>
</tr>
</tbody>
</table>

- ~37% costs covered by the state
- smaller eligible population
- 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.
### B. Reducing impacts and improving outcomes for people in Ohio’s criminal justice systems who have serious behavioral health conditions involves three key strategies.

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</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Recidivism Risk Factors</th>
<th>SDOH &amp; Recovery Factors</th>
<th>Driver of System Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jail Bookings + ED Visits</td>
<td>X</td>
<td>X</td>
<td>$$</td>
</tr>
<tr>
<td>Housing Stability</td>
<td>*</td>
<td>X</td>
<td>$$$</td>
</tr>
<tr>
<td>Employment Stability</td>
<td>X</td>
<td>X</td>
<td>$$</td>
</tr>
<tr>
<td>Recovery Management</td>
<td>X</td>
<td>X</td>
<td>$$</td>
</tr>
</tbody>
</table>

* Some evidence of correlation with recidivism
B. Achieving improvements in outcomes measures will be rewarded with incentives to further drive performance.
B. Ohio must invest in workforce development to achieve its goals.

<table>
<thead>
<tr>
<th>BIG CHALLENGES</th>
<th>Rank</th>
<th>Stats</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2nd</td>
<td>Drug overdose deaths</td>
</tr>
<tr>
<td></td>
<td>5th</td>
<td>Percentage of adults with serious thoughts of suicide</td>
</tr>
<tr>
<td></td>
<td>15th</td>
<td>In prevalence of mental illness</td>
</tr>
<tr>
<td></td>
<td>21st</td>
<td>In prevalence of addictions</td>
</tr>
<tr>
<td></td>
<td>8.7%</td>
<td>AGE 12 OR OLDER with alcohol addiction received treatment in the past year</td>
</tr>
<tr>
<td></td>
<td>13.9%</td>
<td>AGE 12 OR OLDER with drug addiction received treatment in the past year</td>
</tr>
</tbody>
</table>

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.

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

Pilot Program(s)

CY19

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

<table>
<thead>
<tr>
<th>Key Goals</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Establish workgroups</td>
<td>• Legislation</td>
</tr>
<tr>
<td>• Develop multi-year implementation plans</td>
<td>• Form oversight workgroup</td>
</tr>
<tr>
<td>• Develop model</td>
<td>• Establish subcommittees:</td>
</tr>
<tr>
<td>• Secure initial funding</td>
<td>• Services model and financing</td>
</tr>
<tr>
<td>• Develop sustainable funding source(s)</td>
<td>• Workforce</td>
</tr>
<tr>
<td>• Select pilot sites</td>
<td>• Needs assessment</td>
</tr>
<tr>
<td>• Begin services</td>
<td>• Metrics and data reporting</td>
</tr>
<tr>
<td>• Deliver workforce assessment and recommendations report</td>
<td>• Select MCO(s) and initial sites</td>
</tr>
<tr>
<td></td>
<td>• Establish data-sharing agreements</td>
</tr>
<tr>
<td></td>
<td>• Develop target population selection</td>
</tr>
<tr>
<td></td>
<td>• Establish pricing and incentive levels</td>
</tr>
<tr>
<td></td>
<td>• Develop short- and long-term data reporting processes</td>
</tr>
</tbody>
</table>
### B. Possible Agency/Entity Roles and Responsibilities

<table>
<thead>
<tr>
<th></th>
<th>ODM</th>
<th>OMHAS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lead Agency</strong></td>
<td>MCO contracts</td>
<td>Statewide service needs assessment</td>
</tr>
<tr>
<td></td>
<td>Service pricing</td>
<td>Workforce strategic planning</td>
</tr>
<tr>
<td></td>
<td>Incentive development and implementation</td>
<td>Enhanced service model</td>
</tr>
<tr>
<td></td>
<td>Selection criteria</td>
<td>Workforce training</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Telehealth</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outcomes development and reporting</td>
</tr>
</tbody>
</table>
| **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

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tasks</strong></td>
<td>Q1</td>
<td>Q1</td>
<td>Q1</td>
</tr>
<tr>
<td><strong>Workgroups</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data systems</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Develop contracts</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Needs assessments</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Evaluation-adjustments</strong></td>
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</tr>
<tr>
<td><strong>Workforce report</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Service expansion</strong></td>
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<td><strong>Statewide services</strong></td>
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</table>
B. The focus and amounts of spending would evolve during implementation.

Sample Project Budgeting Progression

<table>
<thead>
<tr>
<th></th>
<th>FY19</th>
<th>FY20</th>
<th>FY21</th>
<th>FY22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workforce</td>
<td>$0.5M</td>
<td>$0.5M</td>
<td>$1.0M</td>
<td>$1.0M</td>
</tr>
<tr>
<td>Tech, TA, Start-up</td>
<td>$1.0M</td>
<td>$0.5M</td>
<td>$0.5M</td>
<td>$0</td>
</tr>
<tr>
<td>Enhanced services and incentives</td>
<td>$1.5M</td>
<td>$3.0M</td>
<td>$5.0M</td>
<td>$7.0M</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$3.0M</strong></td>
<td><strong>4.0M</strong></td>
<td><strong>$6.5M</strong></td>
<td><strong>$8.0M</strong></td>
</tr>
</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>“Recovery Sentencing”</th>
<th>Sentencing</th>
<th>Judicial Release</th>
<th>Civil Commitment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using community control to propel more property and drug cases to treatment</td>
<td>Sanctions for violations &amp; place of confinement for low-level felonies</td>
<td>Settling on one effective and fair mechanism for the state’s reliance on judicial release</td>
<td>Removing barriers to people entering treatment through probate courts</td>
</tr>
</tbody>
</table>

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.

Convicted of a property or drug felony with 5+ prior arrests

Probation ~$1,500

1-Year Rearrest Rate

32%

Prison ~$29,000

43%

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.

Commitments to ODRC for Drug Offenses, 2011–2017

- **Drug possession**
  - 2,213 in 2011
  - 2,738 in 2017
  - +24%

- **Drug trafficking**
  - 2,290 in 2011
  - 1,687 in 2017
  - -26%

- **Illegal manufacture**
  - 388 in 2011
  - 434 in 2017
  - +12%

- **Other drug offenses**
  - 236 in 2011
  - 172 in 2017
  - -27%

- **Total commitments to ODRC for any drug offense in 2017**: 5,031
- **Total commitments to ODRC for a property offense in 2017**: 3,686

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.

Prior Arrests for ODRC Commitments in 2016

- **F1**: 42% No Prior Arrests, 24% 2–4 Prior Arrests, 7% F1
- **F2**: 33% No Prior Arrests, 22% 2–4 Prior Arrests, 12% F2
- **F3**: 33% No Prior Arrests, 26% 2–4 Prior Arrests, 15% F3
- **F4**: 40% No Prior Arrests, 21% 2–4 Prior Arrests, 18% F4
- **F5**: 41% No Prior Arrests, 20% 2–4 Prior Arrests, 17% F5

- **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.”

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

![Bar chart showing the estimated number of F4 and F5 commitments to ODRC with SMI or substance addiction from 2013 to 2017.]

*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.

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

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.

<table>
<thead>
<tr>
<th>TOPIC</th>
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<td>50,403</td>
<td>50,839</td>
<td>50,211</td>
</tr>
<tr>
<td>F3 Judicial Release Eligible Commitments</td>
<td>4,555</td>
<td>4,396</td>
<td>4,456</td>
<td>4,511</td>
<td>4,429</td>
</tr>
<tr>
<td>F5 Judicial Release Eligible Commitments</td>
<td>4,985</td>
<td>4,879</td>
<td>4,729</td>
<td>4,937</td>
<td>4,603</td>
</tr>
<tr>
<td>Total Judicial Release Eligible Commitments</td>
<td>15,010</td>
<td>14,631</td>
<td>14,240</td>
<td>14,622</td>
<td>13,975</td>
</tr>
<tr>
<td>Total Judicial Releases</td>
<td>2,414</td>
<td>2,491</td>
<td>2,538</td>
<td>2,475</td>
<td>2,450</td>
</tr>
<tr>
<td>Average LOS for Judicial Releases (in months)</td>
<td>15.8</td>
<td>16.0</td>
<td>16.0</td>
<td>16.8</td>
<td>17.6</td>
</tr>
</tbody>
</table>

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.

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.
   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.

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?

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

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

<table>
<thead>
<tr>
<th>Sentence (Years)</th>
<th>Current Minimum “Eligibility” (Petition Filing)</th>
<th>Proposed Minimum Eligibility (Judicial Discretion to Grant)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Upon arrival (0%)</td>
<td>180 days (50%)</td>
</tr>
<tr>
<td>2</td>
<td>Upon arrival (0%)</td>
<td>180 days (25%)</td>
</tr>
<tr>
<td>3</td>
<td>180 days (16.6%)</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>180 days (12.5%)</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>4 (80%)</td>
<td>2.5 (50%)</td>
</tr>
<tr>
<td>6</td>
<td>5 (83%)</td>
<td>3 (50%)</td>
</tr>
<tr>
<td>7</td>
<td>5 (71%)</td>
<td>3.5 (50%)</td>
</tr>
<tr>
<td>8</td>
<td>5 (62.5%)</td>
<td>4 (50%)</td>
</tr>
<tr>
<td>9</td>
<td>5 (55.5%)</td>
<td>4.5 (50%)</td>
</tr>
<tr>
<td>10</td>
<td>5 (50%)</td>
<td></td>
</tr>
<tr>
<td>&gt; 10</td>
<td></td>
<td>50%</td>
</tr>
</tbody>
</table>
**HB 365 and Justice Reinvestment**

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

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>HB 365 (REAGAN TOKES)</th>
<th>JR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public Safety</strong></td>
<td>Focuses on public safety at the point of prison release and strengthens post-release supervision</td>
<td>Emphasizes strengthening community control to reduce recidivism and preventing crime through effective policing</td>
</tr>
<tr>
<td><strong>Prison Capacity &amp; and Cost</strong></td>
<td>Adds maximum sentences that will likely increase the prison population and cost</td>
<td>Promotes simplified sentencing and increased diversion of drug and property offenses to recovery sentencing</td>
</tr>
<tr>
<td><strong>Judicial Release</strong></td>
<td>Continues reliance on existing, overlapping processes</td>
<td>Requires a single, meaningful process for granting judicial release</td>
</tr>
<tr>
<td><strong>Using Data</strong></td>
<td>Creates new law enforcement data system for GPS monitoring, operated by prison system</td>
<td>Broadly emphasizes improving data collection, sharing, and mapping data landscape</td>
</tr>
</tbody>
</table>
This project was supported by Grant No. 2015-ZB-BX-K001 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Department of Justice’s Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, and the SMART Office. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.