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**Idaho Department
of Health and Welfare
Division of Behavioral Health**

***Gap Analysis:
Behavioral Health Needs
of Probationers and Parolees***

January 2016



Western Interstate Commission
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Executive Summary

The Study

In May 2015 the Idaho Department of Health and Welfare (IDHW) retained WICHE to conduct an evaluation of behavioral health services provided to Idaho's adult probationers and parolees. Both IDHW and Idaho Department of Correction (IDOC) staff provided data and input to WICHE. IDHW asked WICHE to

- estimate the mental health and substance use disorder treatment needs of this offender population;
- identify current funding available to provide treatment services to the offender population; and
- estimate any gap in funding to meet the treatment needs of all moderate- and high-risk probationers and parolees.

Background

Idaho is one of several states involved in a Justice Reinvestment Initiative.¹ The Council of State Governments Justice Center (CSG) defines justice reinvestment as “a data-driven approach to improve public safety, reduce corrections and related criminal justice spending, and reinvest savings in strategies that can decrease crime and reduce recidivism.” CSG provides technical assistance to states to implement justice reinvestment approaches that aim to decrease spending on incarceration and reinvest savings in strategies that reduce recidivism. From 2013 to 2014, CSG worked with IDHW and IDOC to create justice reinvestment options. This collaboration culminated in the passage of legislation in 2014 to develop data-driven policy options designed to increase public safety and reduce spending on corrections.

The legislation is projected to help the state avoid up to \$157 million in prison construction and operating costs that would otherwise be needed to accommodate forecasted prison population growth as of fiscal year (FY) 18-19. To achieve these outcomes, the state reinvested nearly \$4 million in FY 14-15 for training probation and parole officers to provide community-based treatment services to offenders who are at risk of reoffending and to implement quality assurance measures. According to CSG, Idaho policymakers aim to reduce recidivism by up to 15% through improved community supervision. This study is intended to add to the state's efforts to reduce prison populations by providing the state legislature, executive branch, and state policy makers with estimates of the need for behavioral health treatment in the population of probationers and parolees, particularly those offenders with a moderate- to high-risk to reoffend.

¹ Information in this section is from: January 16, 2014. *Justice Reinvestment in Idaho: Analyses and Policy Framework*, from: <https://csgjusticecenter.org/jr/idaho/publications/justice-reinvestment-in-idaho-analyses-and-policy-framework/>

Idaho's Process to Assess Offender Treatment Needs

IDOC staff administer the Level of Service Inventory-Revised (LSI-R) and the Global Appraisal of Individual Needs Initial (GAIN-I) to all offenders prior to sentencing and within 90 days of being placed on parole.² Results from the GAIN-I and LSI-R are reviewed by IDOC staff to assess substance use disorder (SUD) needs and to prepare a recommendation about SUD treatment needs for the court. IDHW staff review the GAIN-I results, along with other appropriate collateral information, to prepare a recommendation for the court regarding mental health treatment needs. The court uses these reports to determine whether or not to order offenders to obtain SUD treatment, mental health treatment, or both, as a condition of release on bail or probation.

Findings

The evaluation results in this report reflect a large number of data points and sources, including criminogenic risk assessment data measured by the LSI-R; mental health and substance use treatment history data collected through the GAIN-I; treatment need indicators obtained from the GAIN-I; as well as service-related cost data that is tracked through the Web Infrastructure for Treatment Services (WITS). It is important to note that IDHW and IDOC's dedication to collecting and obtaining such a considerable range of data relevant to understanding probationers' and parolees' experiences and needs reflects a commitment to evaluation and the use of data to ensure the needs of this population are met.

Both IDHW and IDOC are serving probationers and parolees with behavioral health needs. IDHW service data indicates 71 offenders received services between June 1, 2014 and May 31, 2015. IDOC data indicate 4,492 offenders received SUD treatment services in FY 14-15. The results of this evaluation suggest that an estimated 9,252 moderate- and high-risk to reoffend offenders may need mental health or SUD treatment. *Thus, a significant gap in the number of offenders needing treatment appears to exist.* It is important to note that the evaluation did not include data for offenders who may have received treatment services through the state Medicaid program, Medicare, private insurance, Veterans Health Administration, or indigent care services provided by non-state providers (e.g. hospital emergency departments).

Criminogenic risk. IDOC provided WICHE with LSI-R data for 18,417 active supervised adult probationers and parolees who were 17 years of age or older between June 1, 2014 and May 31, 2015. The LSI-R is a nationally normed and validated risk assessment tool used to predict the likelihood of recidivism.³ *Of the 18,417 active supervised adult probationers and parolees within in the evaluation timeframe, 50.2% (or 9,252) scored at moderate- or high-risk to reoffend. The percentage of offenders with moderate- or high-risk levels ranges from 45.7% in District 4 to 58.5% in District 5.*⁴

²When IDOC does not have the staffing resources to complete the GAIN-I, they may pay private providers to complete the GAIN-I.

³ Andrews, D. A., & Bonta, J. (2003). *Level of service inventory-revised: U.S. norms manual supplement*. Toronto, Canada: Multi-Health Systems.

⁴Probation and parole specific tables for LSI-R risk level by IDOC district are presented in Appendix D and Appendix E.

Mental health treatment needs. For offenders screened with the GAIN-I during the evaluation timeframe, almost half (46.8%) screened at the moderate- or high-level for mental health distress within the past year. Approximately 1 in 3 adults with moderate and 1 in 2 adults with high mental health distress reported that they were in current regular treatment for mental, emotional, behavioral, or psychological problems. *These results suggest that approximately 65% of offenders with moderate and 50% of offenders with high mental health distress may need treatment but are not receiving it. Further, nearly half of offenders (48.3%) may have met Idaho criteria for a serious mental illness.*

Substance use treatment needs. For offenders screened with the GAIN-I during the evaluation timeframe, almost half (43.3%) may suffer from a co-occurring need (i.e., they may have a substance abuse or dependence diagnosis and a mental health or psychiatric diagnosis). More than one-third (36.2%) experienced moderate-level substance use problems within the past year and more than one-third (39.5%) experienced high-level problems within the past year. Further, approximately 1 in 12 adults who were experiencing moderate-level problems and fewer than 1 in 7 adults who were experiencing high-level substance use problems indicated that they were in current regular treatment for alcohol or other drug problems. *These results suggest that approximately 91% of offenders with moderate-level substance use problems and approximately 87% of offenders with high-level substance use problems may have needed treatment at the time of the assessment.*

Summary of behavioral health needs model. The National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) developed a model used to assess behavioral health need based on offender criminogenic risk. The model uses four categories to classify individuals based on the severity of mental health and substance use treatment needs. Category I includes offenders that have low mental distress and low substance use. Category II includes offenders that have moderate or high mental distress and low-level substance use. Category III includes offenders that have low mental distress and moderate- or high-level substance use. Category IV includes offenders that have moderate or high mental distress and moderate or high substance use. This study applies a modified version of this model to a sample of Idaho's offender population.

Results suggest that the majority of offenders are categorized in Categories II, III, or IV across both moderate and high criminogenic risk levels (61.9% and 65.2%, respectively). This finding indicates that substance use treatment, specifically treatment for substance abuse or dependence with a co-occurring mental health focus when appropriate, is needed by a significant portion of probationers and parolees. Further, 27.6% of moderate-risk offenders across Categories II to IV and 38.3% of high-risk offenders across Categories II to IV reported currently receiving behavioral health treatment. *Taken as a whole, these results suggest there is a significant number of moderate-risk and high-risk offenders who may need mental health and/or substance use treatment but are not receiving it.*

Current Funding and Estimated Funding to Address Behavioral Health Needs

Based on available data, it is estimated that the state spent approximately \$8.7 million in state FY 14-15 for behavioral health services for offenders. Expenditures included \$28,745 for mental health services by IDHW and approximately \$7.1 million for substance use disorder services by IDOC via the state's contract SUD private provider network. To service the SUD needs of reentering offenders and conduct court ordered GAIN-I assessments, IDOC also expended approximately \$1.6 million for 25 Full Time Equivalent (FTE) Drug and Alcohol Rehabilitation Specialist (DARS) and other clinical staff. As the Idaho legislature does not appropriate funding categorically to IDHW to provide mental health services to offenders, IDHW was not able to provide the amount of funding currently available to address the mental health needs of the offender population. Adult offenders are served by state staff as part of the IDHW Division of Behavioral Health (DBH) Adult Mental Health program. Staffing and other costs for services provided to adult offenders are not captured separately from costs provided to other adults.

To estimate funding needs, WICHE used the average mental health treatment expenditure (\$2,927) for moderate- and high-acuity needs, generated from a 2011 IDHW analysis of annual cost per client, times the estimated number of moderate- and high-risk offenders with moderate- or high-risk mental health treatment needs. Similarly, WICHE used the average FY 14-15 SUD treatment services cost per offender (\$1,574) times the estimated number of offenders with moderate- or high-risk SUD treatment needs. *Based on this methodology, approximately \$19.7 million is needed annually to meet the co-occurring needs of an estimated 9,252 moderate- and high-risk offenders on probation and parole.* It is not possible to estimate the gap in funding between the amounts currently spent and the estimated \$19.7 million needed because data are not available about how much is spent on offenders with moderate or high criminogenic risk and moderate to high behavioral health treatment needs.

It is important to keep in mind that this estimate does not account for Medicaid expenditures for mental health or substance use services provided to the offender population. Data were also not available to determine the amount of funding provided by private insurers, the Veterans Administration, or any other treatment providers, including emergency departments. Thus, if an offender presented at a location and received emergent care for mental health or substance use, those data are not included in this evaluation. IDOC is increasing use of evidence based programs and services for offenders and the cost to provide these services may be more expensive than the FY 14-15 actual cost per offender used in this report.

Limitations

While the use of multiple data points and sources may allow for more comprehensive examination of probationers' and parolees' outcomes, it also introduces more limitations and challenges. Most importantly, the ability to successfully match individual-level data and retain a representative sample decreases, while the resources and time required to address these issues increases. Large-scale programs that track and enter data for their participants commonly encounter issues of missing, incorrect, and/or duplicative identifying information due to the sheer volume of data being tracked and the increasing number of staff and sites involved in maintaining records. Further,

to the extent that not all offenders will have identifiable data across all the sources included in a study, rates of missing data increase and the representativeness of the final sample is less certain. Nearly half of the offenders screened with the GAIN-I ($n = 2,426$, 43.4%), were eliminated despite extensive data cleaning procedures, both automated and manual, to resolve as many cases of inconsistent or missing data as possible. The data limitations WICHE encountered support the need for IDHW and IDOC to streamline their data collection processes, including an investigation of how to connect each entity's data management systems. Alignment of data collection and data management systems will help ensure that results from future evaluations are more reliable and valid.

Introduction

In May 2015 the Idaho Department of Health and Welfare (IDHW) retained WICHE to conduct an evaluation of behavioral health services provided to Idaho’s adult probationers and parolees. Both IDHW and Idaho Department of Correction (IDOC) staff provided data and input to WICHE. IDHW asked WICHE to

- estimate the mental health and substance use disorder treatment needs of this offender population;
- identify current funding available to provide treatment services to the offender population; and
- estimate any gap in funding to meet the treatment needs of all moderate- and high-risk probationers and parolees.

This report begins with a description of Idaho’s current Justice Reinvestment Initiative (JRI) efforts and is followed by an overview of the methodology used for this evaluation, including data limitations. A description of the Idaho probation and parole population, including assessment of criminogenic risk and the population’s mental health and substance use treatment needs is provided. Next, risk data and treatment-related data are combined to estimate behavioral health treatment need based on a co-occurring model developed by the National Association of State Mental Health Program Directors (NASMHPD) and National Association of State Alcohol and Drug Abuse Directors (NASADAD)⁵. A description of the service delivery system and current funding for probationers and parolees who have substance use and mental health treatment needs is then provided. The report concludes with a discussion of funding estimates to meet the treatment needs of adult probationers and parolees.

Justice Reinvestment Initiative

The Council of State Governments Justice Center (CSG) defines justice reinvestment as “a data-driven approach to improve public safety, reduce corrections and related criminal justice spending, and reinvest savings in strategies that can decrease crime and reduce recidivism.”⁶ CSG provides technical assistance to states to implement justice reinvestment approaches that aim to decrease spending on incarceration and reinvest savings in strategies that reduce recidivism. From 2013 to 2014, CSG worked with IDHW and IDOC to create justice reinvestment options. This collaboration culminated in the passage of legislation in 2014 to develop data-driven policy options designed to increase public safety and reduce spending on corrections. This legislation is projected to help the state avoid up to \$157 million in prison construction and operating costs that would otherwise be needed to accommodate forecasted prison population growth as of FY 18-19. To achieve these outcomes, the state reinvested nearly \$4 million in FY 14-15 for training probation and parole officers to provide community-based treatment services to offenders who

⁵ National Association of State Mental Health Program Directors & National Association of Alcohol and Drug Abuse Directors. (1998). National dialogue on co-occurring mental health and substance abuse disorders. Washington, DC.

⁶ Retrieved from <https://csgjusticecenter.org/jr/>

are at risk of reoffending and to implement quality assurance measures. According to CSG, Idaho policymakers aim to reduce recidivism by up to 15% through improved community supervision.⁷

Assessment of Offender Behavioral Health Needs

IDOC staff administer the GAIN-I to all offenders prior to sentencing and within 90 days of placement on parole.⁸ Results from the LSI-R and GAIN-I are reviewed by IDOC staff to assess substance use disorder (SUD) needs and to prepare a recommendation about SUD treatment for the court. Following, GAIN-I results are sent to IDHW. If the GAIN-I, in combination with other collateral information, indicates that additional information is needed then IDHW may recommend a full mental health assessment per the pre-sentence investigation report. A full mental health assessment is completed by a psychiatrist, licensed physician, or licensed psychologist.

If the pre-sentence investigation report or the full mental health assessment indicates that an offender suffers from a serious mental illness (SMI) or a post-traumatic stress disorder, the court may order the offender to obtain mental health treatment as a condition of release on bail or probation. Idaho law defines a SMI as “any of the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, (DSM-5):

- Schizophrenia spectrum and other psychotic disorders;
- Bipolar disorders (mixed, manic and depressive);
- Major depressive disorders (single episode or recurrent);
- Obsessive-compulsive disorders.”⁹

⁷ January 16, 2014. Justice Reinvestment in Idaho: Analyses and Policy Framework. Retrieved from: <https://csgjusticecenter.org/jr/idaho/publications/justice-reinvestment-in-idaho-analyses-and-policy-framework/>

⁸ When IDOC does not have the staffing resources to complete the GAIN-I, they may pay private providers to complete the GAIN-I.

⁹ Idaho Administrative Code 16.07.33.011 (10)

Methodology

This section of the report discusses the methodology used to generate the report findings. Findings are generated from three data sources: 1) the Level of Service Inventory-Revised (LSI-R); 2) the Global Appraisal of Individual Needs Initial (GAIN-I); and 3) the Web Infrastructure for Treatment Services (WITS). Each of these data sources is described below.

Data Sources

Offender and LSI-R data. IDOC provided WICHE with LSI-R data for active supervised adult probationers and parolees who were 17 years of age or older between June 1, 2014 and May 31, 2015. The LSI-R is a nationally normed and validated risk assessment tool used to predict the likelihood of recidivism.¹⁰ The LSI-R is comprised of 54 items grouped according to the following ten domains: criminal history, education/employment, finances, family/marital, accommodations, leisure time, criminal friends/acquaintances, drug and/or alcohol use, emotional/personal and anti-social attitudes.¹¹ The LSI-R is administered by IDOC staff during initial pre-sentence investigations in response to significant events during community supervision, as annual reassessments while on community supervision, during Receiving and Diagnostic Unit (RDU) intakes, and within approximately 90 days post-release on to parole.

Global Appraisal of Individual Needs Initial (GAIN-I) data. IDHW, IDOC, Idaho Supreme Court, and Idaho Department of Juvenile Corrections have adopted and fully integrated the GAIN-I as the primary assessment tool to determine substance use and mental health needs of adult and juvenile offenders. Chestnut Health Systems provided IDHW with GAIN-I data for persons 17 years of age and older within the evaluation timeframe. The GAIN-I includes scales and subscales, the reliability and validity of which has been observed across studies with a variety of populations and levels of care. The eight content areas of the GAIN-I are background, substance use, physical health, risk behaviors and disease prevention, mental and emotional health, environment and living situation, and legal and vocational skills. Within each content area, questions inquire about problem areas, recency of problems, provided services, attitudes and beliefs, and desire for help and to change.¹²

Substance use and mental health services (WITS) data. Idaho uses the WITS system to record services provided to individuals. IDHW provided WICHE with substance use and mental health services data for offenders who completed a GAIN-I assessment within the evaluation timeframe. Three datasets were provided: 1) offenders with substance use service claims recorded in WITS, b) offenders who received non-billable mental health services through IDHW, and c) offenders who received billable mental health services through IDHW.

¹⁰ Andrews, D. A., & Bonta, J. (2003). *Level of service inventory-revised: U.S. norms manual supplement*. Toronto, Canada: Multi-Health Systems.

¹¹ Andrews, D. A., & Bonta, J. L. (2000). *The level of service inventory-revised: User's manual*. Toronto, Canada: Mental Health Systems.

¹² Chestnut Health Systems. (2015). Products & services: GAIN-I. Retrieved from: <http://www.gaincc.org/products-services/instruments-reports/gaini/>

Data Cleaning and Merging

Data cleaning procedures began with cleaning the individual data sources. Offender and LSI-R data provided by IDOC were reviewed to ensure that only active supervised adult probationers and parolees who were 17 years of age and older were included. This dataset was also reviewed for duplicates. Duplicates can include an exact replica of data across two or more rows, and duplicates can include repeat identification numbers (i.e., IDOC number) with different data across two or more rows (e.g., the data has the same identification number but contrasting gender and contrasting race/ethnicity). If an exact replica of data was found, one of the records would be deleted. If a duplicate was found that had the same identification number but different data, both records would be deleted as there is no way to infer which offender was correctly assigned to the identification number. No duplicates were found in this dataset.

Second, substance use and mental health services data were reviewed. Given that the data were provided by service-level and not offender-level¹³, in addition to the distinct nature for which the data were provided (i.e., three separate datasets for which an offender could be present in all), the majority of evaluation resources were spent cleaning these datasets. For analysis, each row in a dataset should be assigned to a single subject, or participant, and no subject should appear on different rows. Data cleaning methods that restructured data within each dataset by the unique identifier assigned via the WITS system were implemented so that each offender was assigned to a single row that included all services received.

Third, these datasets were merged by the same unique identifier to match offenders across datasets who may have received substance use and mental health treatment services. This merge resulted in one dataset that included one row of data for each offender that was included in one, two, or three of the substance use and mental health services datasets. Next, this dataset was merged with the offender and LSI-R dataset provided by IDOC. The final step of data cleaning was to merge the combined substance use and mental health service and LSI-R dataset with the GAIN-I dataset which resulted in a matched sample of Idaho probationers and parolees.

Limitations

A significant challenge across datasets regarded offender identifiers, which are used to uniquely identify participants or cases. There was limited ability to detect unique identifiers across the distinct datasets provided for this evaluation.

The substance use and mental health treatment data included a unique identifier that was generated by WITS using a domain-specific structure. This identifier was a valid identifier and was used to clean and restructure these datasets. However, this identifier was not available in LSI-R and GAIN-I datasets and could not be used when merging with these datasets. Mental health and substance use service data could be merged with LSI-R data only by IDOC numbers. IDOC numbers are not a required data entry field in WITS and are manually entered. Thus, missing IDOC numbers

¹³ These raw datasets included rows for services received thus an offender could have between one and many rows of data according to the number of services he or she received.

or incorrectly entered IDOC numbers may have resulted in loss of data. Further, mental health and substance use service data could only be merged with GAIN-I data by client ID. This identifier may or may not be unique across offenders as one offender could have different client IDs for different providers; therefore, this merge may have resulted in loss of data. There was no unique identifier present across LSI-R and GAIN-I data that allowed for these datasets to be merged directly.

The challenges encountered with matching probationers and parolees across the data sources limit the findings of the study. The findings presented in this report are for a subset of offenders who could be connected across data sources with confidence. It is important to be mindful of this limitation when processing findings presented in this report. Another significant challenge to be noted is that IDHW does not report mental health service expenditures by population served (e.g., probationers and parolees). As a result, assessment of available funding to address probationer and parolee mental health treatment needs has limitations and estimates generated should be interpreted with caution.

Description of Probationers and Parolees

This evaluation focused on active probationers and parolees who were 17 years of age or older and screened with the GAIN-I between June 1, 2014 and May 31, 2015. The demographic characteristics of these probationers and parolees include offender gender, race/ethnicity, and age. Other information reported includes the types of crimes committed and the dispersion of offenders across IDOC districts.

During the time period of focus for this evaluation there were 18,710 probationers and parolees under supervision by IDOC. Of these offenders, 14,125 (75.5%) were on probation and 4,585 (24.5%) were on parole. Table 1 provides the number of offenders by IDOC judicial district.

Table 1. Offender Dispersion across Idaho

District	Counties	Number	Percent of Total
0	NA*	276	1.5%
1	Boundary; Bonner; Benewah; Kootenai; Shoshone	2,704	14.5%
2	Clearwater; Idaho; Latah; Lewis; Nez Perce	870	4.7%
3	Adams; Canyon; Gem; Owyhee; Payette; Washington	3,469	18.6%
4	Ada; Boise; Elmore; Valley	5,707	30.5%
5	Blaine; Camas; Cassia; Gooding; Jerome; Minidoka; Twin Falls	2,422	13.0%
6	Bannock; Bear Lake; Caribou; Franklin; Oneida; Power	1,178	6.3%
7	Bingham; Bonneville; Butte; Clark; Custer; Fremont; Jefferson; Lemhi; Madison; Teton	<u>2,065</u>	<u>11.0%</u>
Total		18,691	100.1%

*District 0" is the limited supervision unit (LSU). This unit was created in 2013 for low-risk offenders across Idaho who require minimal supervision. Currently, IDOC has one senior probation and parole officer who monitors the LSU. These offenders report to this probation and parole officer through an online system.

These offenders were between 17 and 87 years of age with a mean of 36.2 years. There were more males (14,121 or 75.5%) than females (4,588 or 24.5%).¹⁴ Offender race/ethnicity is reported in Table 2 and shows that the predominant racial/ethnic group was White (13,556 or 72.5%). Offender race/ethnicity by gender is reported in Appendix A.

¹⁴ One offender reported being transgender (i.e., a male who identified as a female).

Table 2. Offender Race/Ethnicity

Race/Ethnicity	Number	Percent of Total
White	13,556	72.5%
Unknown	2,173	11.6%
Hispanic	1,961	10.5%
Indian	468	2.5%
Black	316	1.7%
Other	122	0.7%
Asian	<u>114</u>	<u>0.6%</u>
Total	18,710	100.0%

The crime of conviction, or most severe crime, for most offenders was a drug-related crime ($n = 6,371$, 34.1%). The rates for the types of crimes committed by offenders are reported in Table 3. Offender crime types and dispersion by gender are reported in Appendix B.

Table 3. Offender Crime Types

Crime Type	Number	Percent of Total
Drug	6,370	34.1%
Property	4,805	25.7%
Assault	3,094	16.5%
Alcohol	2,961	15.8%
Sex	1,333	7.1%
Murder & Manslaughter	<u>139</u>	<u>0.7%</u>
Total	18,710	100.0%

Risk to Reoffend

Agencies responsible for assessing recidivism use assessment tools to attempt to predict an individual's risk for reoffending. Most currently used assessment tools screen for both static and dynamic risk factors. Static risk factors are unchanging or historical (i.e., happened before the offender was deemed at risk) whereas dynamic risk factors are more malleable and often tend to be the focus of intervention and treatment (e.g., leisure/recreational activities and social supports).¹⁵ As Latessa and Lowenkamp note explain, "These dynamic risk factors are also called criminogenic needs: crime producing risk factors that are strongly correlated with risk"(p. 15).¹⁶

The LSI-R is a nationally normed and validated actuarial risk assessment prediction tool rooted in evidence-based practice that aims to predict one's likelihood of reoffending.^{17,18,19} IDOC administers the LSI-R during an individual's pre-sentence investigation, in response to significant events, annually during supervision (including parole and probation), during Receiving and Diagnostic Unit (RDU) intakes, and approximately 90 days after release from parole. A useful aspect of actuarial assessments, including the LSI-R, is that they categorize an offender's risk of recidivism as low, moderate, or high.

The LSI-R is comprised of 54 items which are grouped according to ten subscales of criminogenic factors related to recidivism. The ten subscales are criminal history, education/employment, financial, family/marital, accommodations, leisure/recreation, companions, drug/drug problem, emotional/personal and attitudes/orientation.²⁰ Questions are in a yes-no format or a 0-3 rating format. Each question answered with a "yes" receives a point, and all points are added together to determine an offender's LSI-R total score with higher scores indicating higher likelihood of reoffending. Scores range from 0 to 54 with 0 to 23 considered low-risk (11.7 to 31.1% chance of reoffending), 24 to 33 considered moderate-risk (48.1 to 57.3% chance of reoffending), and 34 to 54 considered high-risk (76.0% chance or higher of reoffending).²¹

¹⁵ Hanson, R. K. (2000). Risk assessment. *Beaverton, OR: Association for the Treatment of Sexual Abusers.*

¹⁶ Latessa, E. J., & Lowenkamp, C. (2005). What are criminogenic needs and why are they important. *For the Record, 4*, 15-16.

¹⁷ John Howard Society of Alberta. (2000). Offender risk assessment. Retrieved from www.johnhoward.ab.ca/pub/c21.htm

¹⁸ Motiuk, L. L. (1995). Refocusing the role of psychology in risk management: Assessment, communication, and intervention. In Leis, T. A., Motiuk, L. L., & Olgoff, J. R. (Eds.). *Forensic psychology: Policy and practice in corrections.* Ottawa, ON.

¹⁹ Sveinivasam, S., Kirkish, P., Gamick, T., Weinberger, L. E., & Phenix, Al. (2000). Actuarial risk assessment models: A review of critical issues related to violence and sex-offender recidivism assessments. *The Journal of American Academy of Psychiatry and the Law, 28*, 439-448.

²⁰ Descriptive statistics for LSI-R subscales are reported in Appendix C.

²¹ Andrews, D. A., & Bonta, J. L. (2000). *The level of service inventory-revised: User's manual.* Toronto, Canada: Mental Health Systems.

IDOC provided WICHE with LSI-R data for 18,417 active supervised adult probationers and parolees within in the evaluation timeframe. The average LSI-R score of these probationers and parolees was 23.95 with a standard deviation of 9.59 and range of 0 to 50.²² Idaho’s adjusted ranges and categories for LSI-R risk levels by district are reported in Table 4.²³ As the table indicates, 50.2% scored at moderate- or high-risk to reoffend. The percentage of offenders with moderate- or high-risk levels ranged from 45.7% in District 4 to 58.5% in District 5.²⁴

Table 4. Offender LSI-R Risk Levels by IDOC District

		District								
		0	1	2	3	4	5	6	7	State
Risk Level										
Low Risk (≤ 13)	Number	190	420	109	482	989	176	99	279	2,744
	% of Total	68.8%	16.0%	13.0%	14.0%	17.6%	7.3%	8.5%	13.6%	14.9%
Low-moderate Risk (14 – 23)	Number	79	947	272	1197	2059	824	387	656	6,421
	% of Total	28.6%	36.0%	32.5%	34.8%	36.7%	34.2%	33.2%	32.0%	34.9%
Moderate Risk (24 – 33)	Number	6	842	264	1146	1563	825	418	703	5,767
	% of Total	2.2%	32.0%	31.5%	33.3%	27.9%	34.3%	35.9%	34.2%	31.3%
Moderate-high Risk (34 – 40)	Number	1	325	156	509	758	447	206	316	2,718
	% of Total	0.4%	12.4%	18.6%	14.8%	13.5%	18.6%	17.7%	15.4%	14.8%
High Risk (41 – 54)	Number	0	94	36	107	242	134	55	99	767
	% of Total	0.0%	3.6%	4.3%	3.1%	4.3%	5.6%	4.7%	4.8%	4.2%
TOTAL		276	2,628	837	3,441	5,611	2,406	1,165	2,053	18,417
Moderate- to High-Risk (24 – 54)	Number	7	1,261	456	1,762	2,563	1,406	679	1,118	9,252
	% of Total	2.6%	48.0%	54.4%	51.2%	45.7%	58.5%	58.3%	54.4%	50.3%

²² Descriptive statistics for LSI-R subscales are reported in Appendix C.

²³ Two hundred and seventy-five offenders were missing LSI-R total scale scores and are not included in Table 4.

²⁴ Probation and parole specific tables for LSI-R risk level by IDOC district are presented in Appendix D and Appendix E.

Behavioral Health Needs

Between June 1, 2014 and May 31, 2015, there were 5,613 adult probationers or parolees screened using the GAIN-I.²⁵ Of these offenders, 4,476 (80.2%) were on probation and 1,102 (21.7%) were on parole. Thirty five offenders (0.6%) were on probation and parole. Of the offenders screened, 3,491 offenders (62.2%) indicated being required or mandated to go to treatment.

Offender Diagnoses

More than half of the offenders (3,267 or 58.2%) reported that a doctor, nurse, or counselor has told them they have a mental, emotional, or psychological problem. Of these offenders, 795 (14.2%) mentioned a substance use diagnosis. Co-occurring diagnoses (i.e., any substance use diagnosis combined with any mental health diagnosis) were observed for 2,432 offenders (43.3%). Rates of diagnoses indicated by offenders are reported in Figure 1.²⁶ Based on GAIN-I categories of diagnoses, 2,311 offenders (41.2%) may have met Idaho criteria for a SMI.²⁷ Idaho defines a SMI as schizophrenia spectrum and other psychotic disorders; bipolar disorders (mixed, manic, and depressive); major depressive disorders (single episode or recurrent); or obsessive-compulsive disorders.²⁸ As individuals with an SMI represent the adult priority population IDHW is charged to serve, more information is provided in Appendix F.

Per the National Survey on Drug Use and Health (NSDUH; 2015)^{29,30}, the 2013-14 annual average of Idahoans 18 years of age or older with any mental illness in the past year was between 20.3 and 22.7%. The average of serious mental illness among Idahoans was between 4.9 and 5.5%. It may be inferred that Idaho's offender population has a heightened behavioral health need; however, it is important to note that these rates were not measured or calculated in the same manner as the GAIN-I.

²⁵ The GAIN-I data provided, which included 11,396 unduplicated records, was restricted to those who indicated currently being on probation or parole (5,613).

²⁶ Diagnosis categories, including titles, generated according to available GAIN-I variables.

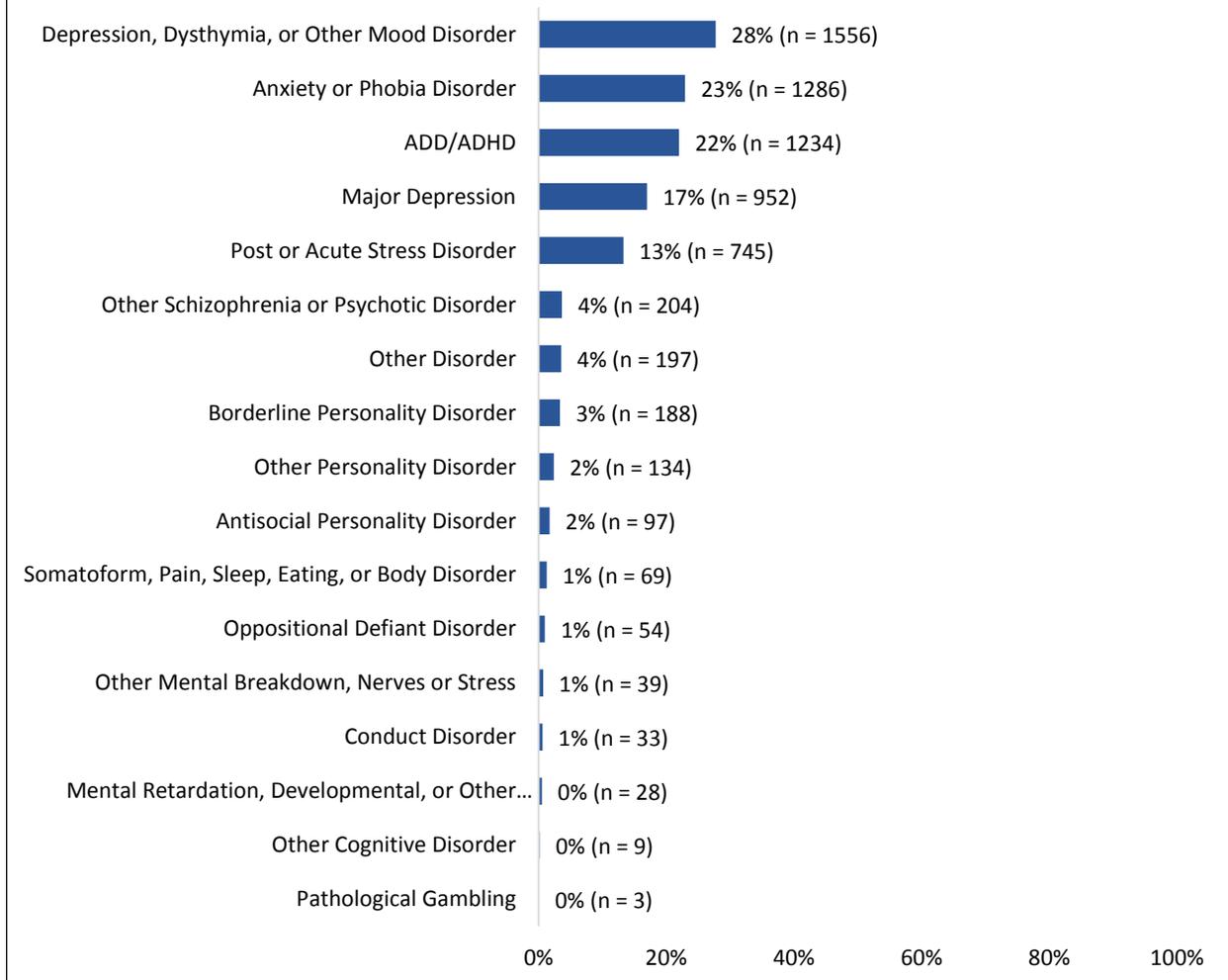
²⁷ This calculation included the following categories from Figure X: "Depression, Dysthymia, or Other Mood Disorder", "Major Depression", and "Other Schizophrenia or Psychotic Disorder".

²⁸ Idaho Administrative Code 16.07.33.010.

²⁹ Center for Behavioral Health Statistics and Quality. (2015). *Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health* (HHS Publication No. SMA 15-4927, NSDUH Series H-50). Retrieved from <http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf>.

³⁰ Center for Behavioral Health Statistics and Quality. (2015). *Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health* (HHS Publication No. SMA 15-4927, NSDUH Series H-50). Retrieved from <http://www.samhsa.gov/data/sites/default/files/NSDUHsaeMaps2014/NSDUHsaeMaps2014.pdf>

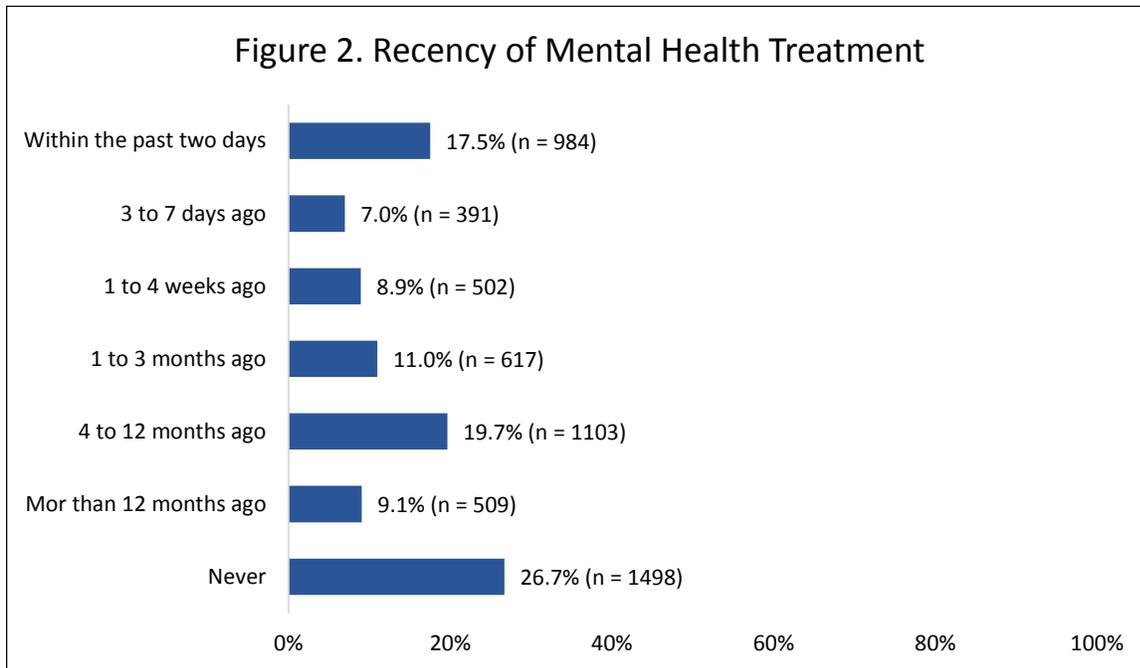
Figure 1. Rates of Offender Diagnoses



Mental Health Treatment History

Assessment of probationer and parolee treatment history is important because it may provide information about an experience with or willingness to participate in Idaho’s mental health systems. Persons suffering acute psychiatric emergencies or needing psychiatric or mental health services that are inaccessible or unavailable elsewhere may rely on emergency room services. Of the probationers and parolees screened with the GAIN-I, 1,078 (19.2%) reported visiting an emergency room for mental, emotional, behavioral, or psychological problems in their lifetime. The mean number of lifetime emergency room visits was 3.70 times ($SD = 8.57$) with a range between 1 and 150 visits. Lifetime hospital admissions for at least one night for mental, emotional, behavioral, or psychological problems were reported by 1,088 offenders (19.4%) with a mean of 3.09 nights ($SD = 5.70$) and a range between 1 and 80 nights. Taken together, it may be inferred that nearly one-quarter of offenders have used emergency room and/or hospital services for mental, emotional, behavioral, or psychological problems.

Another important aspect of treatment experiences is assessment of participation in current treatment. Current regular treatment for mental, emotional, behavioral, or psychological problems was reported by 1,447 offenders (25.8%). Figure 2 reports the last time offenders indicated receiving treatment for a mental, emotional, behavioral, or psychological problem by a mental health specialist; in an emergency room, hospital, or outpatient mental health facility; or with prescribed medication. Sixty-four percent of offenders indicated receiving mental health treatment within the past year; however, it is important to note that this treatment may have been received in prison or jail.



Mental Health Treatment Need

One estimate of behavioral health need is prevalence of behavioral health conditions (e.g., serious mental illness, psychological distress, and substance use disorders (see “Offender Diagnoses” section)).³¹ Assessment of recent behavioral health symptoms is another way to gauge behavioral health need. Of probation and parole offenders screened, almost half ($n = 2,438$, 43.4%) reported being bothered by any nerve, mental, or psychological problems at least one day within the past 90 days with a mean of 49.71 ($SD = 34.02$). Thus, offenders experiencing mental health problems reported, on average, feeling this way for 50 of the past 90 days. Further, nearly one-quarter of offenders ($n = 1,175$, 20.9%) reported that these problems make them feel like they could not continue living or kept them from meeting responsibilities at work, school, or home with a mean of 36.98 days ($SD = 32.03$) and range between 1 and 90 days. Thus, offenders experiencing mental health problems reported that, on average, feeling this way significantly impacted their ability to function for almost 40 of the past 90 days. Taken together, it may be inferred that almost half of

³¹ Substance Abuse and Mental Health Services Administration. Behavioral Health Treatment Needs Assessment Toolkit for States. HHS Publication No. SMA13-4757. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

offenders experienced recent mental health problems and that these experiences significantly impacted their ability to function for nearly one-quarter of offenders.

In addition to offender self-report of recent behavioral health symptoms and the impacts, the mental and emotional health section of the GAIN-I has questions about common nerve, mental, or psychological problems. The Internal Mental Distress Scale (IMDS), the Behavior Complexity Scale (BCS), and the Traumatic Stress Scale (TSS) are generated from this section of the GAIN-I, and scores from these scales are considered by IDHW when assessing mental health treatment needs. The IMDS is used in this report to evaluate the mental health treatment needs of adult probationers and parolees.

The IMDS is a count of past-year symptoms related to internalizing disorders including somatic, anxiety, depression, traumatic stress, and suicidal or homicidal thoughts. Subscales are the Somatic Symptom Index (SSI), the Depressive Symptom Scale (DSS), the Homicidal Suicidal Thought Scale (HSTS), the Anxiety/Fear Symptom Scale (AFSS), and the Traumatic Stress Scale (TSS). Higher values indicate greater levels of internal mental distress. Total scale scores ranged from 0 to 43 with a mean of 10.79 ($SD = 10.81$). Scale scores were categorized as low ($SPS \geq 0$ and ≤ 8), moderate ($SPS \geq 9$ and ≤ 23), or high ($SPS \geq 24$). Figure 3 reports on the past-year rates of these categories for probationers and parolees screened. Nearly half of offenders scored at the moderate- or high-level for mental health distress within the past year.

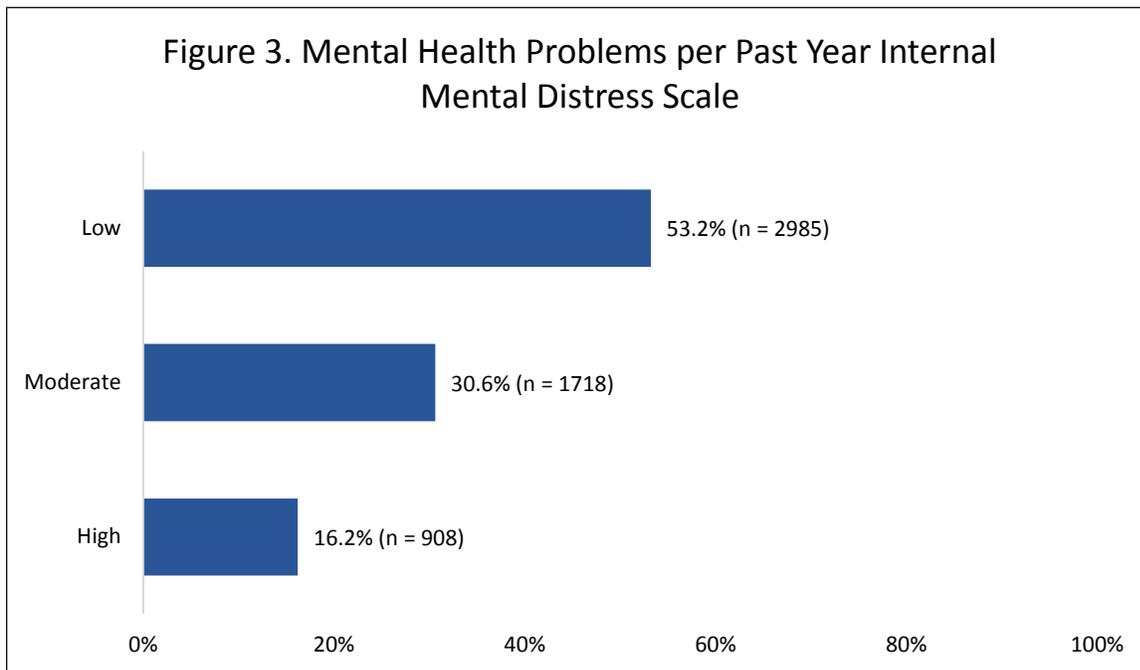
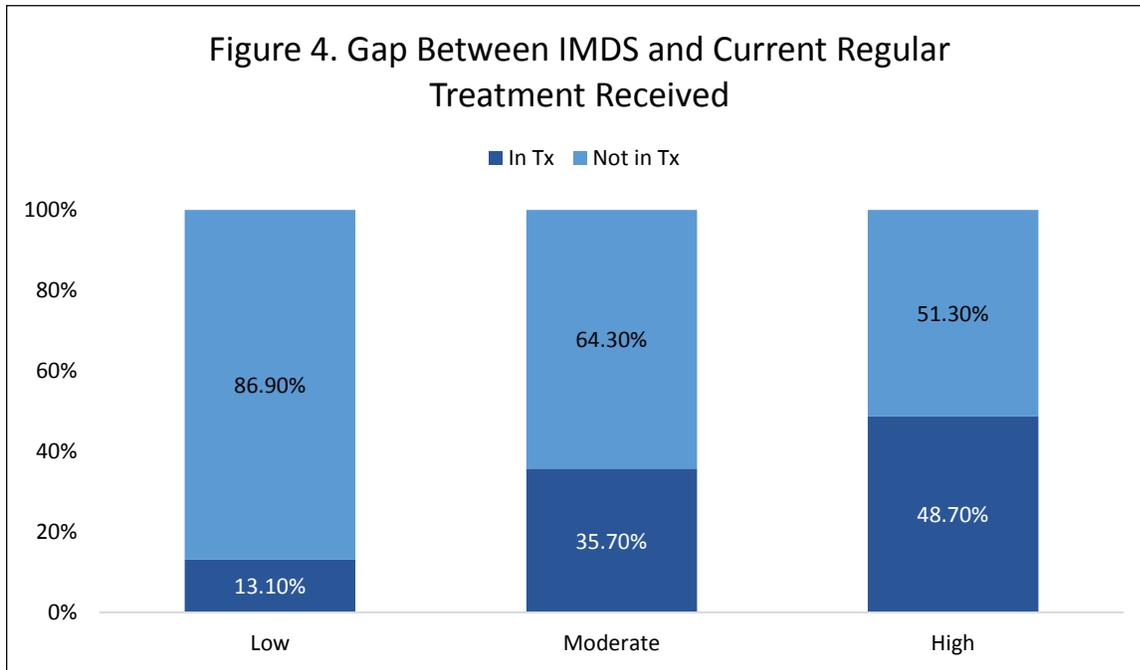


Figure 4 shows the disparity between probationers and parolees in current regular treatment for mental, emotional, behavioral, or psychological problems and those not in current regular treatment across IMDS categories. Approximately 1 in 7 adults with low, 1 in 3 with moderate, and 1 in 2 with high mental health distress received treatment (14.3%, 33.3%, and 50.0%, respectively).



Summary of Mental Health Treatment Needs

Assessment of mental health treatment need includes review of the prevalence of behavioral health conditions and symptoms across a population. For offenders screened with the GAIN-I during the evaluation timeframe, almost half (46.8%) screened at the moderate- or high-level for mental health distress within the past year. Approximately 1 in 3 adults with moderate and 1 in 2 adults with high mental health distress reported that they were in current regular treatment for mental, emotional, behavioral, or psychological problems. These results suggest that approximately 65% of offenders with moderate and 50% of offenders with high mental health distress may need treatment but are not receiving it. Further, nearly half of offenders (48.3%) may have met Idaho criteria for a serious mental illness.

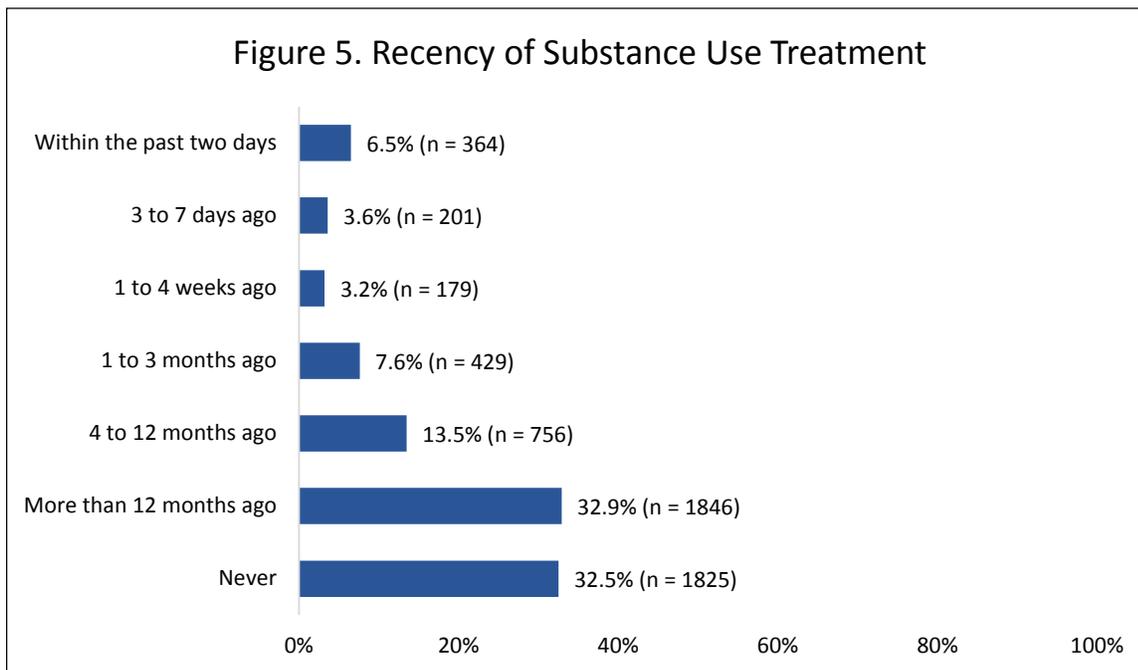
Substance Use

As noted, offenders who have been found guilty of or have pleaded guilty to a felony must be screened and/or assessed to determine if they have SUD or mental health needs. IDOC screens these offenders using the GAIN-I. The substance use section of the GAIN-I has questions about lifetime, past 90 days, and past month substance use. In addition to the GAIN-I, IDOC assesses criminogenic risk with LSI-I observations. The alcohol and drug subscale of the LSI-I is also used to assess possible SUD needs. The sections that follow present findings from the GAIN-I regarding substance use treatment history and need, as well as from the alcohol and drug subscale of the LSI-R.

Substance Use Treatment History

Of probation and parole offenders screened, 1,091 offenders (19.4%) reported at least one visit to an emergency room in their lifetime for their alcohol or other drug use problems with a mean of 3.04 visits ($SD = 6.35$) and range between 1 and 99 visits. Further, 737 (13.1%) reported being admitted to a detoxification program for alcohol or other drug use in their lifetime with a mean of 2.23 admissions ($SD = 2.88$) and a range between 1 and 40 admissions. Lifetime admissions to treatment or counseling for use of alcohol or any other drugs were reported by 3,789 offenders (67.5%) with a mean of 2.71 episodes and range between 1 and 61 episodes.

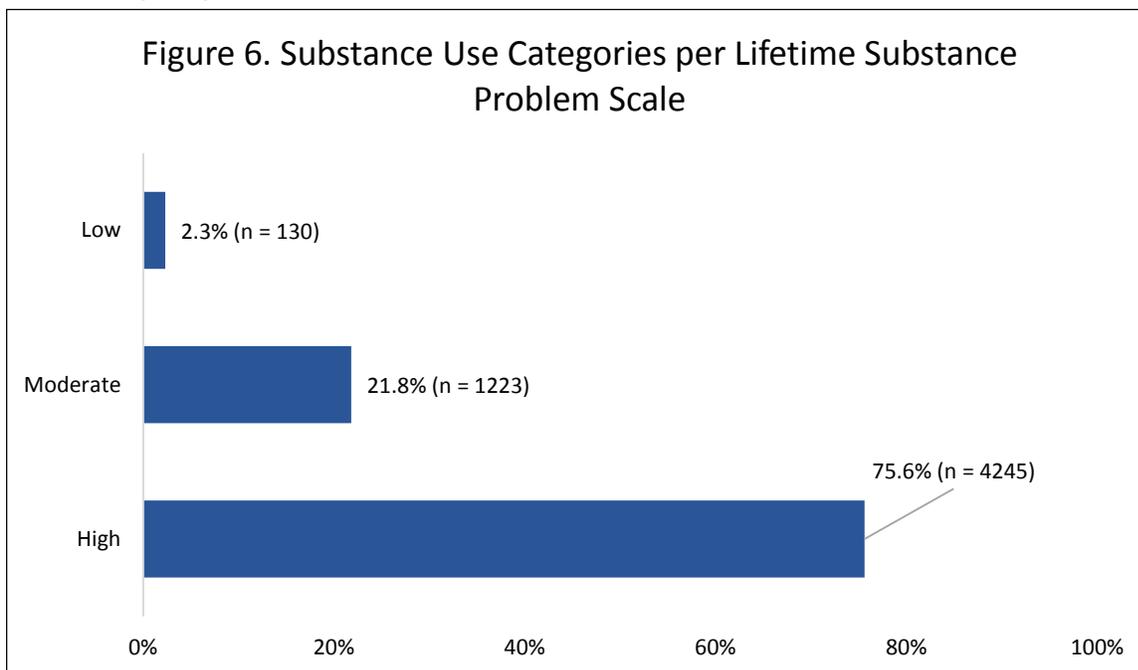
Current regular treatment for alcohol or other drug problems was reported by 644 offenders (11.5%). Figure 5 reports on the last time offenders indicated receiving treatment, counseling, medication, case management, or aftercare for use of alcohol or any other drug. Thirty-four percent of offenders indicated receiving substance use treatment within the past year; however, it is important to note that this treatment may have been received in prison or jail.



Substance Use Treatment Needs

The Substance Problem Scale (SPS) is comprised of 16 recency-related items (e.g., “When was the last time you...?”) and is a count of lifetime symptoms of substance abuse, dependence, and substance-induced health and psychological disorders. Seven items of the scale are based on DSM-IV criteria for substance dependence, four items are based on DSM-IV criteria for substance abuse in addition to other questions regarding symptom severity.³² This scale can be further divided into three subscales: Substance Issues Index (SII), Substance Abuse Index (SAI), and Substance Dependence Scale (SDS).

Higher scores on this scale represent greater severity of alcohol and drug problems. The scale includes physiological, psychological, and social criteria, as well as an item on comorbid use with alcohol or drugs that is likely to exacerbate the other problems. A general score of 0 suggests no or low-level alcohol or drug problems, 1 or more generally suggests moderate-level problems, and 4 or more generally suggests high-level problems.³³ Total lifetime scale scores ranged from 0 to 16 with a mean of 12.08 and total past-year scale scores ranged from 0 to 16 with a mean of 7.11. Scale scores as suggestive of “Low” (SPS = 0), “Moderate” (SPS ≥ 1 and ≤ 9), and “High” (SPS ≥ 10 and ≤ 16). Figures 6 and 7 report on the lifetime and past-year rates of these categories for probationers and parolees screened. As shown in Figure 6, the majority of offenders (75.6%) have had high-level substance use problems in their lifetime. In comparison, as shown in Figure 7, the majority of offenders (75.5%) may have had moderate- and/or high-level substance use problems within the past year.



³² Riley, B. B., Conrad, K. J., Bezruczko, N., & Dennis, M. L. (2007). Relative precision, efficiency and construct validity of different starting and stopping rules for a computerized adaptive test: The GAIN substance problem scale. *Journal of Applied Measurement, 8*(1), 48.

³³ The scale is not the sole determinant of a diagnosis per se as such requires meeting other criteria not measured by this scale.

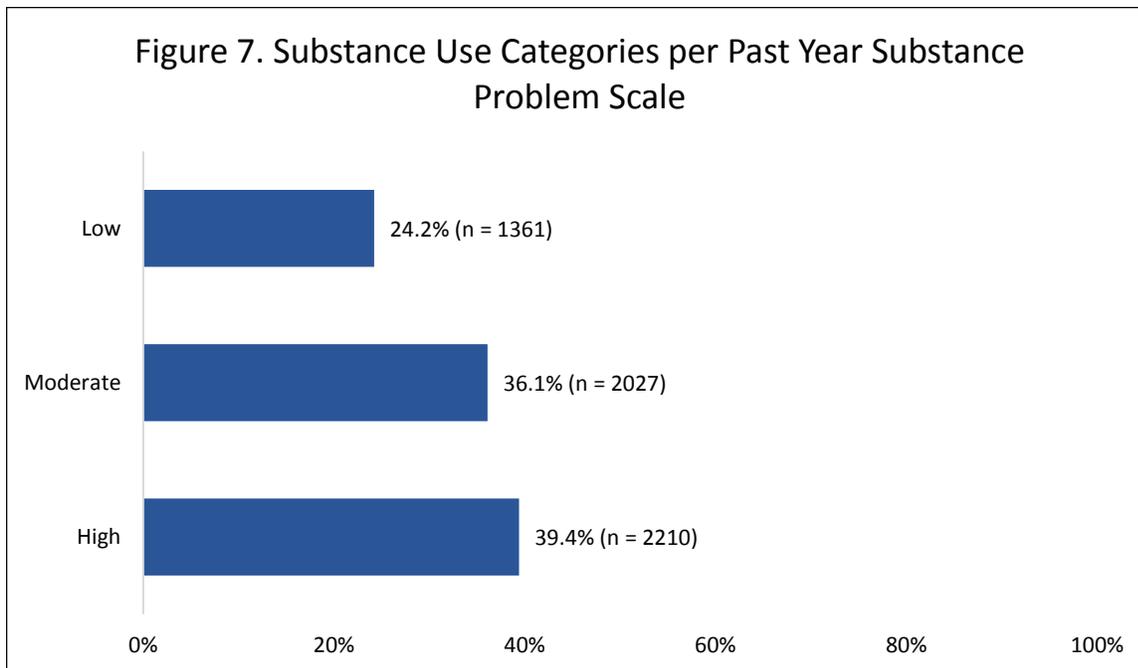
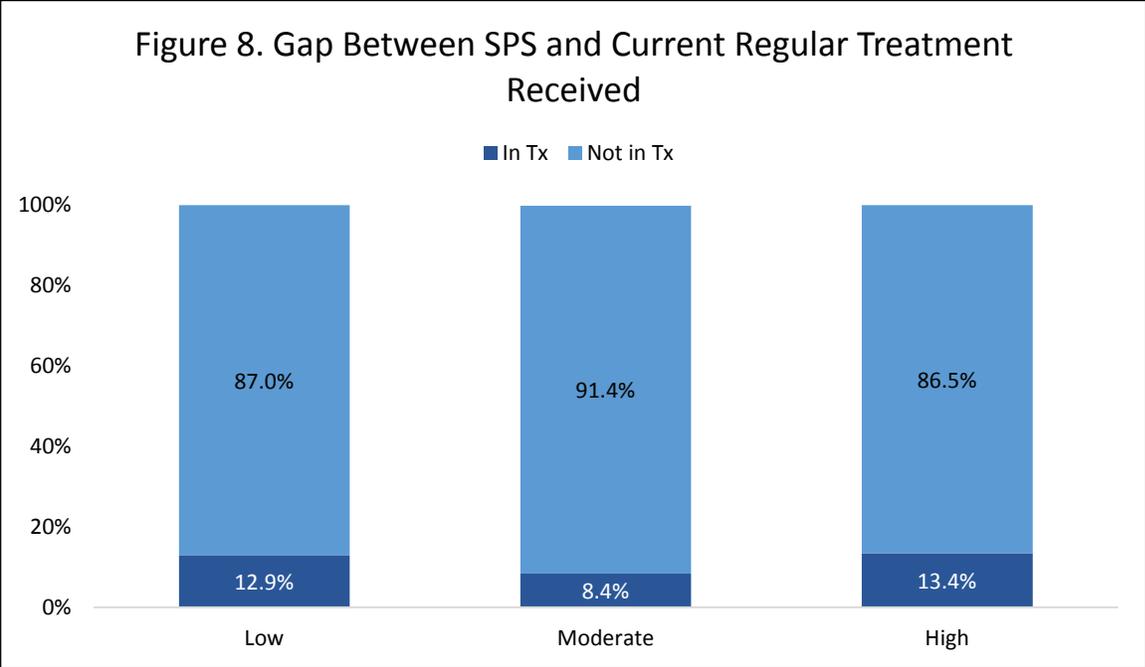


Figure 8 shows the disparity between probationers and parolees whose SPS scores were observed in the moderate and high categories and the percent of those who reported current regular treatment for alcohol or other drug problems. Approximately 1 in 12 adults who were experiencing moderate-level substance use needs and fewer than 1 in 7 adults who were experiencing high-level needs indicated they were in treatment at the time of assessment (8.3% and 14.3%, respectively). Nationally, 1.5% of individuals 12 and older reported receiving treatment for a substance use diagnosis in the past year.³⁴ Findings for individuals 18 years and older were not available at the time this report was generated. Further, it is important to note that this rate was not measured or calculated in the same manner as the GAIN-I.

³⁴ Substance Abuse and Mental Health Services Administration, *Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014. Retrieved from: <http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf>



LSI-R Alcohol and Drug Subscale

IDOC uses the alcohol and drug subscale of the LSI-R, in combination with GAIN-I results, to assess substance use treatment need. IDOC implements a weighting process. Per this weighting process, subscale scores range from 0 to 1. IDOC considers .44 and higher as indicating a potential need for substance use treatment. Of all active probationers and parolees within the evaluation time frame,³⁵ 9,197 offenders (48.2%) had a weighted subscale score of .44 or higher and may have been referred for substance use treatment.

Summary of Substance Use Treatment Needs

For offenders screened with the GAIN-I during the evaluation timeframe, almost half (43.3%) may suffer from co-occurring concerns (i.e., any substance abuse or dependence diagnosis and any mental health or psychiatric diagnosis). This is supported by the number of offenders for whom the GAIN-I screened as moderate- and high-level substance use needs. More than one-third (36.2%) experienced moderate-level substance use problems within the past year and more than one-third (39.5%) experienced high-level problems within the past year. Further, approximately 1 in 12 adults who were experiencing moderate-level problems and fewer than 1 in 7 adults who were experiencing high-level substance use problems indicated that they were in current regular treatment for alcohol or other drug problems. These results suggest that approximately 91% of offenders with moderate-level substance use problems and approximately 87% of offenders with high-level substance use problems may have needed treatment at the time of the assessment.

³⁵ Data presented in this section is representative of all active probationers and parolees (*N* = 18,710), whereas the rest of this section is representative of probationers and parolees that were screened with the GAIN-I (*n* = 5,613). Due to data source limitations, these datasets could not be merged directly.

Risk to Reoffend and Behavioral Health Needs Model

This section of the report combines the findings of the risk assessment (LSI-R) data with the GAIN-I data to assess risk to reoffend in combination with behavioral health needs for probationers and parolees. “The Model” discussed below was developed by the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD).³⁶ This work served as a foundation for the Council of State Governments’ (CSG) “shared framework for reducing recidivism and behavioral health problems” (p. viii) among individuals on probation or parole.³⁷ This model has been coined a “planning tool” and is reported to be utilized across the United States. It has established a “common language to categorize the needs of individuals with co-occurring disorders, and it has established shared priorities between mental health and substance abuse treatment systems” (p. 31).

The sample used for this analysis represents those offenders whose LSI-R and GAIN-I data match. As discussed, data limitations make the size of this sample much smaller than the active population of probationers and parolees within the study timeframe. Specifically, the matched sample includes 3,177 offenders, comprised of 2,314 probationers (72.8%) and 863 parolees (27.2%). Descriptive information of the matched sample is included in Appendix G.

³⁶ National Association of State Mental Health Program Directors & National Association of Alcohol and Drug Abuse Directors. (1998). National dialogue on co-occurring mental health and substance abuse disorders. Washington, DC.

³⁷ Osher, F., D’Amora, D. A., Plotkin, M., Jarrett, N., & Eggleston, A. (2012). Adults with behavioral health needs under correctional supervision: A shared framework for reducing recidivism and promoting recovery. New York: Council of State Governments Justice Center.

The Model

Model description. The purpose of the model is to document a continuum of care for individuals with co-occurring mental health and substance use concerns, with the underlying assumption that these concerns vary in severity. Categorical designation is not based solely on diagnosis; it is based on “symptom multiplicity and severity” (p. 10).³⁸ Further, levels of severity associate with specific service delivery systems. There are four major categories based on severity of mental health and substance use treatment needs and their associated locus of care:

- Category I: Less severe mental disorder/less severe substance disorder
 - Locus of care: Primary health care setting
- Category II: More severe mental disorder/less severe substance disorder
 - Locus of care: Mental health system
- Category III: Less severe mental disorder/more severe substance disorder
 - Locus of care: Alcohol and other drug system
- Category IV: More severe mental disorder/ more severe substance disorder
 - Locus of care: Joint alcohol and other drug system and mental health system

According to NASMHPD and NASADAD,³⁹ individuals in Category IV are those with the most severe behavioral health symptoms who are more likely to be found in “inappropriate settings” (e.g., jail or homeless; p. 12). It is important to focus resources on these individuals as attention to them may reduce overall treatment costs. Although this model classifies individuals in categories, it is important to note that individuals may move across categories during the course of their behavioral health condition.

For this evaluation, mental illness severity was measured by the Internal Mental Distress Scale (IMDS) which was collected via GAIN-I screenings. The categories generated per this scale’s scores were low, moderate, and high mental health distress. Alcohol and other drug use was measured by the Substance Problem Scale (SPS) which was also collected via GAIN-I screenings. The categories generated per this scale’s scores were low-, moderate-, and high-level substance use concerns. The four major categories per the measures used in this evaluation are

- Category I: Low mental distress/low substance use;
- Category II: Moderate or high mental distress/low substance use;
- Category III: Low mental distress/moderate or high substance use; and
- Category IV: Moderate or high mental distress/moderate or high substance use.

³⁸ National Association of State Mental Health Program Directors & National Association of Alcohol and Drug Abuse Directors. (1998). National dialogue on co-occurring mental health and substance abuse disorders. Washington, DC.

³⁹ National Association of State Mental Health Program Directors & National Association of Alcohol and Drug Abuse Directors. (1998). National dialogue on co-occurring mental health and substance abuse disorders. Washington, DC.

Moderate and high criminogenic risk offenders in the sample. The matched sample includes 3,177 offenders, including 2,314 probationers (72.8%) and 863 parolees (27.2%). Figures 9 and 10 present the model for moderate and high criminogenic risk offenders, respectively, using the sample.

Figure 9. Co-occurring Concerns by Severity for Moderate Criminogenic Risk

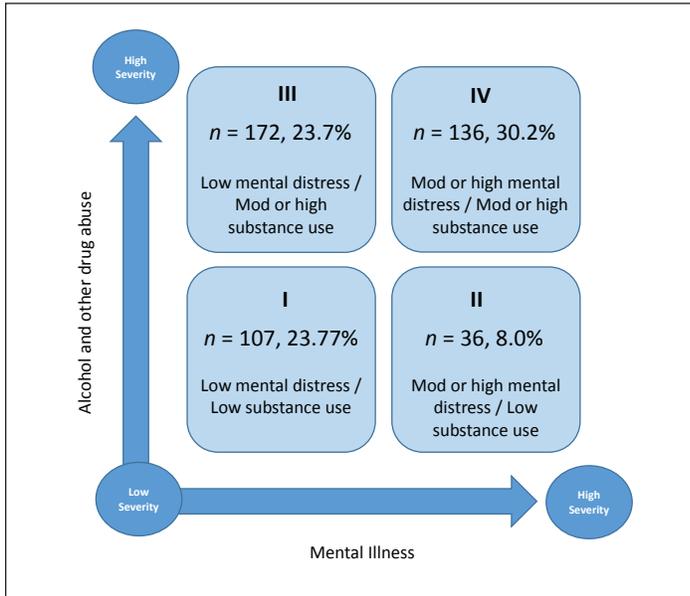
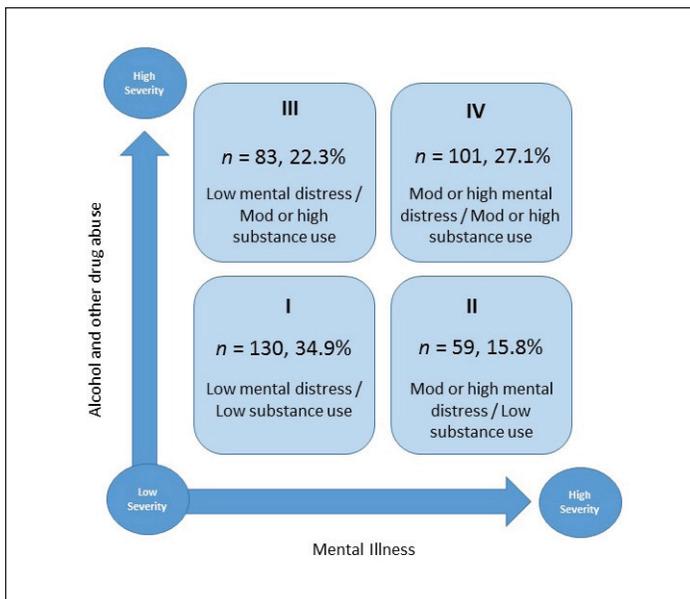


Figure 10. Co-occurring Concerns by Severity for High Criminogenic Risk



Approximately 24% of moderate-risk and 35% of high-risk offenders were observed in Category I. Offenders in this category have the lowest severity of symptoms. As they are at moderate- or high-risk for reoffending, these individuals may be likely to reoffend no matter the level of treatment received. Given less symptom severity plus a higher likelihood to reoffend, fewer resources should be allocated to this group of offenders.

Across both risk levels, the majority of offenders were identified in Categories II, III, or IV (i.e., 61.9% of moderate criminogenic risk and 65.2% of high criminogenic risk). This finding indicates that substance use, specifically coupled with some level of mental distress, may be present for the majority of offenders observed at moderate-risk or high-risk for recidivism. Further, offenders in Categories III and IV have the highest level of symptom severity in mental distress and/or substance use concerns; thus, allocation of resources to offenders in these categories is important. Although at moderate- or high-risk of reoffending, these offenders' potential risk may decrease if they receive the treatment they need. Appendix H presents the number of offenders that reported being in substance use treatment, mental health treatment, or both for each of the co-occurring categories just discussed.

Moderate and high criminogenic risk offenders in the state. Given similar demographic trends between the matched sample and the larger probation and parole population during the evaluation timeframe (see Appendix G), statewide estimates can be generated with some confidence but should be interpreted with caution. Per LSI-R data, the larger probation and parole sample included 5,767 offenders at moderate-risk for recidivism and 3,485 offenders at high-risk⁴⁰ for recidivism. The statewide estimates generated below were calculated by multiplying the rates of each category in Figures 9 and 10 above by the number of offenders in each risk level (i.e., 5,767 or 3,485). Figures 11 and 12 below present a statewide estimate of offenders with co-occurring concerns for moderate and high criminogenic risk categories, respectively.

⁴⁰ This amount is the sum of offenders who scored at the moderate-high and high risk level.

Figure 11. Statewide Estimate of Co-occurring Need by Severity for Moderate Criminogenic Risk

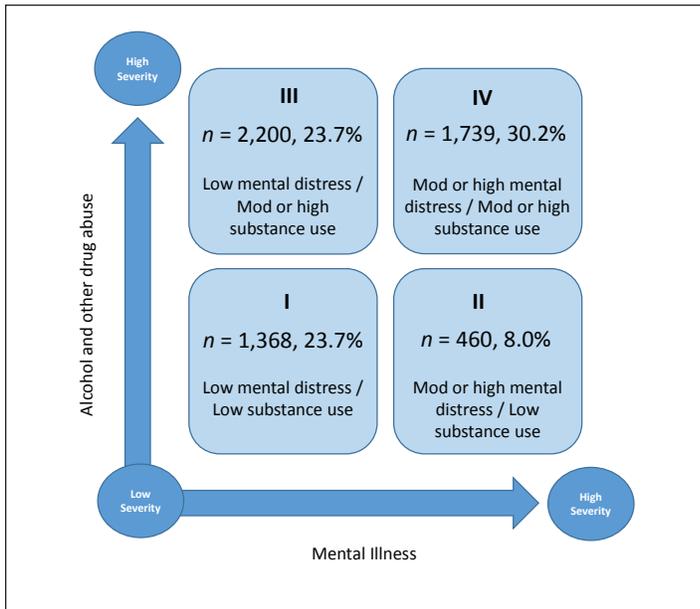
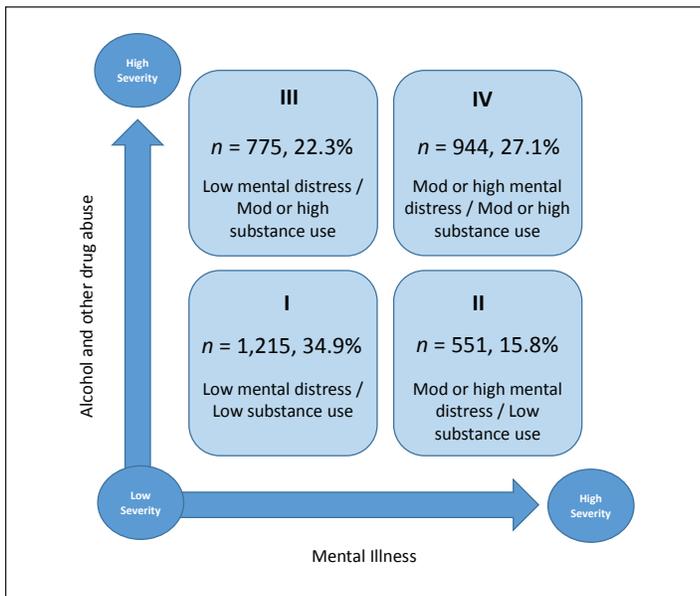


Figure 12. Statewide Estimate of Co-occurring Concerns by Severity for High Criminogenic Risk



Summary of Criminogenic Needs and Behavioral Health Needs Model

Results suggest that the majority of offenders are categorized in Categories II, III or IV across both moderate and high criminogenic risk levels (61.9% and 65.2%, respectively). Category II is offenders that have moderate or high mental distress and low-level substance use. Category III is offenders that have low mental distress and moderate- or high-level substance use and Category IV is offenders that have moderate or high mental distress and moderate- or high-level substance use. This finding indicates that substance use treatment, specifically treatment for substance abuse or dependence with a co-occurring focus when appropriate, is a significant portion of the criminogenic needs of probationers and parolees. Further, 27.6% of moderate-risk offenders across Categories II to IV and 38.3% of high-risk offenders across Categories II to IV reported currently receiving behavioral health treatment. Taken as a whole, these results suggest that there is a significant number of moderate-risk and high-risk offenders who may need mental health and/or substance use treatment but are not receiving it.

Idaho Service Delivery System

Mental health and substance use treatment services ordered by the court for probationers and parolees are provided by IDHW and IDOC, respectively. This section provides an overview of each agency's structure and how each agency delivers these services.

Mental Health Services⁴¹

IDHW provides mental health services to non-Medicaid eligible individuals who meet income and clinical requirements. Medicaid eligible individuals are served through a managed care delivery service administered by United Healthcare (or Optum Idaho). The IDHW Division of Behavioral Health includes five program areas: the Adult Mental Health services program (AMH), the Children's Mental Health services program (CMH), the Substance Use Disorders treatment program (SUD), and two state hospitals. IDHW provides services through seven Regional Mental Health Centers (RMHC) located throughout the state. Each RMHC provides mental health services through a system of care that is both community based and consumer guided. Each region has separate teams for adult services and children services. Figure 13 shows Idaho's seven regions.

⁴¹ DBH information for this section comes from the following: September 30, 2015. Uniform Application FY 2016/2017 - State Behavioral Health Assessment and Plan. Substance Use Prevention and Treatment and Community Mental Health Services Block Grant.

Figure 13. IDHW Service Regions



Adult mental health services. The AMH program serves as Idaho's primary safety net by providing crisis evaluation and intervention to adults experiencing a psychiatric emergency. This includes court ordered designated examinations to determine if individuals are at eminent risk of life-threatening harm to themselves or others or are gravely disabled due to mental illness. The AMH program manages the admissions and discharge processes for the two state psychiatric hospitals. Additionally, the AMH program provides assessments and treatment for adult felony offenders on probation and parole and treatment and service coordination for the Mental Health Courts in Idaho. IDHW is statutorily mandated to serve the following priority adult populations:

- Individuals requiring emergency psychiatric services including crisis intervention, designated exams, and police holds
- Individuals committed to state custody
- Court ordered clients providing outpatient services for offenders on supervised probation
- Mental Health Court participants needing forensic community treatment
- Voluntary clients without benefits

The AMH program provides care and treatment for these populations through services including assessment and evaluation, psychiatric services, medication management, case management, individual and group counseling, crisis services, and Assertive Community Treatment (ACT). For purposes of establishing capacity given limited funding, patients are categorized in two groups: moderate needs and high needs. Moderate needs patients are often provided one or more of the less intensive services, including medication management and case management. Patients in the high needs category, or individuals involved in the Mental Health Court, typically get ACT level of care. Adult mental health services provided by the RMHC's include:

- Crisis Screening and Intervention
- Mental Health Screening
- Psychiatric Clinical Services
- Case Management
- Individual Therapy
- Group Therapy
- Community-Based Rehabilitation Services (CBRS)
- Assertive Community Treatment (ACT)
- Patient Assistance Program (PAP)
- Benefit Assistance
- Co-occurring Disorders Treatment
- Pharmacological Education
- Short-term Mental Health Intervention

Substance Use Disorder Services^{42,43}

IDOC is responsible for providing SUD services to adult offenders in the community. IDOC guarantees that offenders convicted of a felony receive services; however, other priority populations are not guaranteed services due to budgetary constraints. IDOC prioritizes funding for offender populations in order of priority as follows:

1. Court mandated offenders convicted of a felony (referred to as 19-2524 offenders)
2. Reentry offenders (Rider graduates in rural areas, parolees with SUD disorder. A “Rider” is a sentence where court retains jurisdiction for up to 365 days.)
3. Offenders deemed by IDOC as having a risk to revoke (offenders with active substance use)

IDOC SUD staff. IDOC clinical teams in each of the state’s seven judicial districts are responsible for determining an individual’s eligibility for SUD services and making treatment referrals. These clinical teams include a licensed clinician who supervises at least one Drug and Alcohol Rehabilitation Specialist (DARS). This person is responsible for meeting court and legislative mandates, as well as implementing best clinical and correctional treatment practices. There are between two to six clinical staff in each of the seven district clinical teams. The primary roles of the clinical teams are to

- administer court mandated 19-2524 pre-sentence GAIN-I assessments;
- submit service authorizations and referrals to the provider network via WITS
- deliver treatment services (primarily for aftercare for Rider and Therapeutic Community graduates);
- assign or ensure appropriate assignment to the IDOC Treatment Pathway; and
- serve as a stakeholder resource.

In addition, the IDOC clinical teams manage pre-sentence GAIN-I administration, conduct offender intakes, determine programmatic pathway assignment, deliver correctional programs, serve as a clinical resource to probation and parole officers, and act as a district liaison to the provider network.

SUD treatment network. IDOC contracts with Business Psychology Associates (BPA) to manage a network of treatment and recovery support service providers to deliver community-based SUD treatment to clients funded by state agencies and the judiciary. The network consists of 75 treatment providers offering services at 144 sites and 30 stand-alone recovery support service providers at 63 sites across 37 counties in Idaho. The network is authorized by IDOC to deliver drug and alcohol treatment services (e.g., assessment, pre-treatment, parolee aftercare, outpatient care, and intensive outpatient care) and recovery support services (e.g., case management, drug testing, safe/sober housing, life skills, and transportation).

SUD services are delivered by private community-based providers that meet clinical and contractual criteria. Based on clinical necessity and funding availability, eligible offenders receive

⁴² October 10, 2014. Idaho Department of Correction Substance Use Disorder (SUD) Program Criminal Justice Overview

⁴³ “Community-based Substance Use Disorder (SUD) Services: Provider Network” document provided by IDOC.

up to 240 days of treatment services in a full treatment episode. A drug and alcohol treatment episode for probationers includes up to 60 days of initial pre-treatment, followed by a 90 day Stage I treatment service, and a 90 day Stage II treatment service. For parolees, a drug and alcohol treatment episode begins with 90 days of parolee aftercare and can be extended based on clinical need. Corresponding recovery support services are also available in each treatment stage, with the exception of safe and sober housing, which has a maximum benefit of 90 days.

Probation and parole officer role in treatment. Probation and parole officers are an essential part of the treatment team that helps guide an offender through a successful period of treatment and supervision in the community. These officers gather information, conduct interviews with the offenders, and conduct risk and needs assessments. They also work closely with the offenders to create program and supervision goals based on behavioral health assessments that are completed while in the community or in custody. Officers meet frequently with treatment providers to check on attendance and program progress. During a period of supervision, an officer will meet with offenders regularly to discuss the individual's program goals and progress, needed changes in behaviors, unaddressed needs, and any other behavior or need that could lead to success or failure. The officer may also administer substance use tests.

Evidence based services. According to a November 2015 IDOC report to the legislature about state-funded recidivism reduction programs, IDOC has made significant progress towards monitoring and improving evidence based practices within prisons and community programs. During FY 14-15, IDOC's SUD contractor, BPA, conducted an evidence based practices and programs audit as part of its clinical audit of each provider site's annual clinical audit. According to an IDOC document, BPA reviewed the results internally to identify those programs that are on the NREPP site (National Registry of 349 Evidence-based Programs and Practices) or have some other evidence-based foundation. In total, 116 provider sites active in the network during the fiscal year reported using 80 programs and practices. Over 80% report using four or more programs or practices to treat their clients.⁴⁴

In September 2015, the Council of State Governments completed a comprehensive assessment of the correctional programs in Idaho's prisons, probation and parole offices, and community-based agencies. Among other findings, the CSG assessment notes that IDOC has trained more than 35 staff to monitor the quality of existing program delivery using a validated program evaluation tool called the Correctional Program Checklist (CPC). Initial CPC results demonstrate that IDOC's programs are not being implemented with fidelity to effective models.⁴⁵

⁴⁴ November 15, 2015. *Program Evaluation Report. Report to the Legislature on State Funded Recidivism Reduction Programs.* Idaho Department of Corrections.

⁴⁵ <https://csgjusticecenter.org/jr/idaho/posts/idaho-set-to-overhaul-correctional-programs-after-in-depth-assessment/>

Current Behavioral Health Services Funding

This section of the report provides data about current funding for mental health and SUD treatment services for offenders and an estimate of the cost to fund mental health and SUD services for moderate- and high-risk offenders. Limitations on the availability of financial data are significant and are discussed below.

Limitations

As the Idaho legislature does not appropriate funding categorically to IDHW to provide mental health services to offenders, IDHW was not able to provide the amount of funding currently available to address the mental health needs of the offender population. Adult offenders are served by state staff as part of the Adult Mental Health program. Staffing and other costs for services provided to adult offenders are not captured separately from costs provided to other adults. The only actual funding data available is from the WITS database. These amounts are reported in the next section.

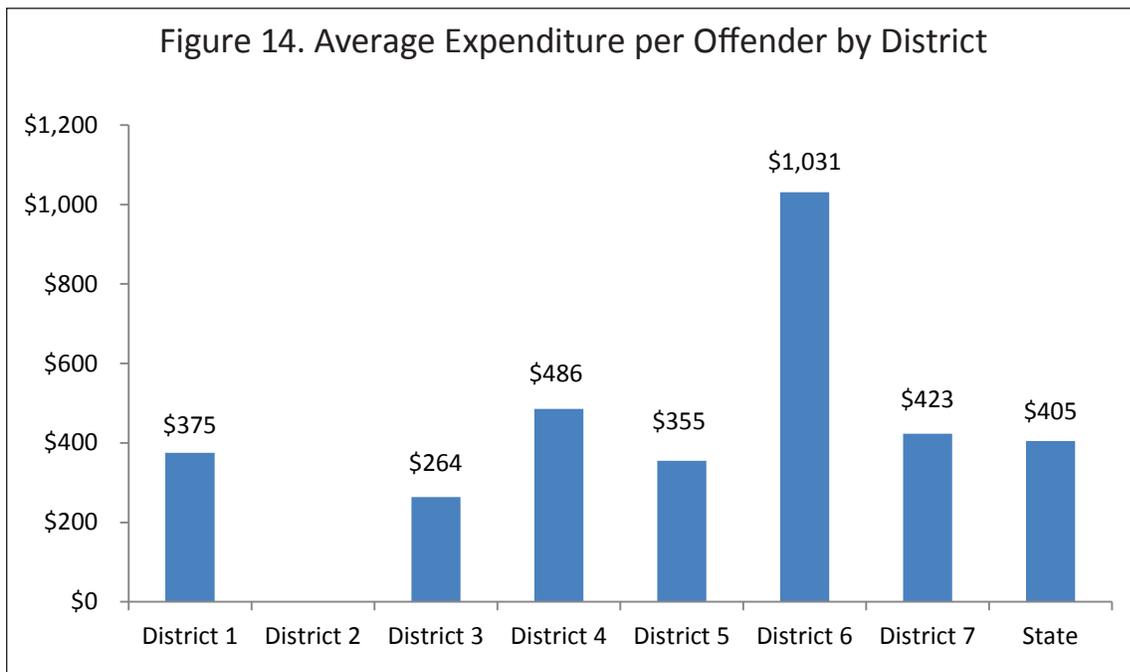
Further, IDHW funds services for non-Medicaid indigent individuals. Medicaid data were not available to identify which, if any, Medicaid expenditures for mental health or substance use services were provided to the offender population. Thus, if an offender became Medicaid eligible and obtained behavioral health services through Optum, those expenditure amounts are not provided in this evaluation. Data were also not available to determine the amount of funding provided by private insurers, the Veterans Administration, or any other treatment providers, including emergency departments. Thus, if an offender presented at a location and received emergent care for substance use or mental illness, those data are not included in this evaluation.

Mental Health Services Funding

IDHW provided WICHE with cost data from WITS, the electronic health system used by IDHW, IDOC, and other Idaho state agencies. Data provided represented anyone over the age of 17 with a GAIN-I who received mental health services entered into WITS between June 1, 2014 and May 31, 2015. Table 5 presents the WITS cost data. As the table indicates, IDHW spent \$28,745 for services to 71 unique offenders. The average cost per offender ranges from \$0 in District 2 to \$1,031 in District 6. Figure 14 provides the average cost per offender. It is important to note that the current funding amounts do not include IDHW costs for state staff and resources providing direct treatment services to probationers and parolees as these data are not available.

Table 5. Mental Health Services Expenditures

District	WITS Mental Health Expenditures	Unique Offenders Served	Average Cost Per Offender
1	\$2,249	6	\$375
2	\$0	0	\$0
3	\$3,693	14	\$264
4	\$5,345	11	\$486
5	\$9,951	28	\$355
6	\$4,122	4	\$1,031
7	\$3,383	8	\$423
State	\$28,745	71	\$405

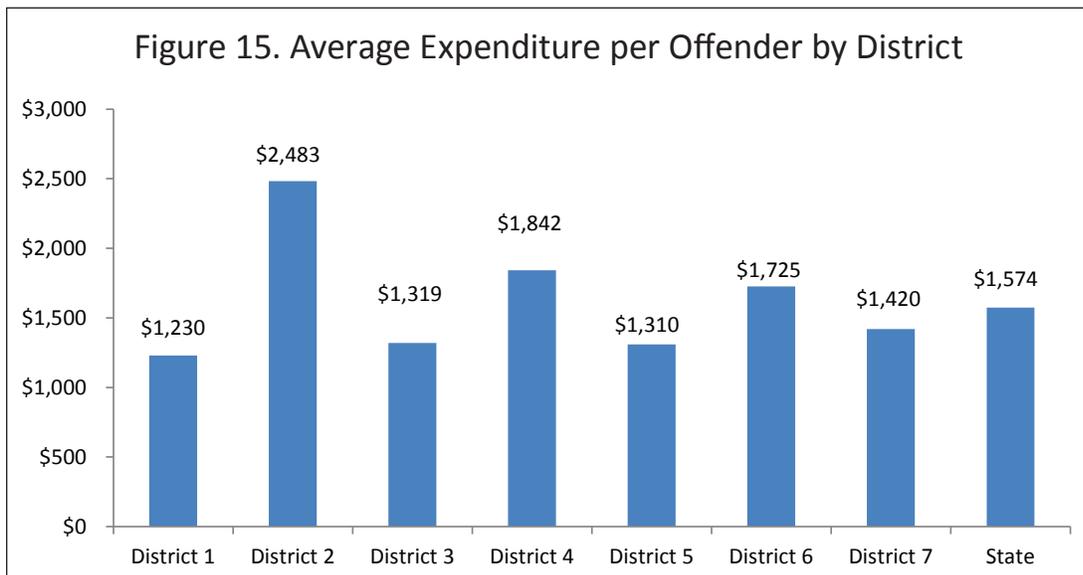


SUD Treatment and Recovery Services Funding

Table 6 provides FY 14-15 SUD treatment services expenditures by district. The “Unique Offenders Served” column represents the number of unique offenders with a billable event during the evaluation time period. Treatment services include alcohol and drug assessments, outpatient and intensive outpatient services, parolee aftercare, pre-treatment services, and staff travel. Recovery services include safe and sober housing, case management, drug and alcohol testing, transportation, and child care. As the table indicates, cost per offender ranged from \$1,230 in District 1 to \$2,483 in District 2.

Table 6. FY 14-15 SUD Treatment and Recovery Services Expenditures by District

District	Total SUD Treatment Funding	Unique Offenders Served	Average Expenditure Per Offender
1	\$761,442	619	\$1,230
2	\$660,459	266	\$2,483
3	\$1,235,941	937	\$1,319
4	\$2,602,843	1,413	\$1,842
5	\$774,412	591	\$1,310
6	\$517,636	300	\$1,725
7	\$519,714	366	\$1,420
State	\$7,072,447	4,492	\$1,574



Services Provided by IDOC staff. IDOC provides at least one Full Time Equivalent (FTE) clinician and one FTE Drug and Alcohol Rehabilitation Specialist in each IDOC district. As Table 7 indicates, some IDOC districts include more than one DARS. According to IDOC, in FY 14-15 IDOC clinical staff administered 3478 GAIN-I assessments and delivered reentry programming to approximately 2580 offenders.

Table 7. IDOC FY 2015 Funding for Clinician and DARS FTE

District	FTE	Funding
1	3.0	\$192,480
2	2.0	\$131,749
3	4.0	\$251,718
4	6.0	\$361,630
5	4.0	\$245,223
6	2.0	\$138,655
7	<u>4.0</u>	<u>\$253,677</u>
Total	25.0	\$1,575,132

Table 8 details funding for both mental health and SUD services for the offender population. This funding includes \$28,745 for mental health services and \$7,072,146 for SUD services expended by IDOC in FY 2015, along with the IDOC costs for DARS and clinical staff which total \$1,575,132. It is important to note that Table 8 reflects funding for all offenders served during these time periods, and not just funding for moderate- and high-risk offenders.

Table 8. Estimated Current Mental Health and SUD Funding

Type of Funding	Number of Offenders Served	Average Cost MH	Average Cost SUD	Total Average Cost	Estimated Cost
Mental Health	71	\$405		\$405	\$28,745
SUD - Contract Services	4,492		\$1,574	\$1,574	\$7,072,446
IDOC DARS and Clinical Staff					<u>\$1,575,132</u>
TOTAL	4,563	\$405	\$1,574	\$1,979	\$8,676,323

It is important to keep in mind that this estimate does not account for Medicaid expenditures for mental health or substance use services provided to the offender population. Data were also not available to determine the amount of funding provided by private insurers, the Veterans Administration, or any other treatment providers, including emergency departments. Thus, if an offender presented at a location and received emergent care for substance use or mental health, those data were not available and are not included in Table 8.

Estimated Funding Needed to Address Behavioral Health Needs

Moderate and high risk offender funding estimate. Table 9 provides an estimate of the funding needed to address the statewide co-occurring needs of moderate- and high-risk offenders. To estimate funding needs, WICHE used the average mental health treatment expenditure (\$2,927) for moderate- and high-acuity individuals (generated from a 2011 IDHW analysis of annual cost per client) times the estimated number of offenders with moderate- or high-risk mental health treatment needs. Similarly, WICHE used the average FY 14-15 SUD treatment services cost per offender (\$1,574) times the estimated number of offenders with moderate- or high-risk SUD treatment needs. *Based on this methodology, approximately \$19.7 million is needed annually to meet the co-occurring needs of an estimated 9,252 moderate- and high-risk offenders on probation and parole.*

Current funding for behavioral health needs. Table 9 also summarizes the current funding amounts provided earlier in the report. It is important to note that the current funding amounts do not include IDHW or IDOC costs for state staff and resources providing direct treatment services to probationers and parolees as these data are not available. IDOC spent \$1.6 million in FY 14-15 for SUD clinical staff; however, data about what proportion of staff time was spent on delivering SUD treatment services is not available. Also, IDHW does not capture the costs to serve adult offenders. These costs are significant as IDHW staff provide treatment services to offenders, along with other individuals needing behavioral health services.

Funding gap. It is not possible to estimate the gap in funding to meet the behavioral health needs of moderate and high risk offenders. The estimated funding need of \$19.7 million represents the cost to provide services to moderate and high risk offenders. However, data are not available about how much of the current funding for behavioral health services provided by IDHW and IDOC is being spent on only offenders with moderate or high risk and moderate to high behavioral health treatment needs.

Table 9. Estimated Funding to Address Co-occurring Needs of Moderate- and High-risk Offenders

	Estimated # of Offenders	Avg. Cost MH	Avg. Cost SUD	Estimated Cost
Moderate-risk, Co-occurring Need				
Category I - Low MI and Low SUD	1,368			
Category II - Moderate/High MI and SUD	460	\$2,927		\$1,346,409
Category III - Low MI and Mod/High SUD	2,200		\$1,574	\$3,463,799
Category IV - Mod/High MI and Mod/High SUD	<u>1,739</u>	\$2,927	\$1,574	<u>\$7,827,985</u>
	5,767			\$12,638,192
High-risk, Co-occurring Need				
Category I - Low MI and Low SUD	1,215			
Category II - Moderate/High MI and SUD	551	\$2,927		\$1,612,763
Category III - Low MI and Mod/High SUD	775		\$1,574	\$1,220,202
Category IV - Mod/High MI and Mod/High SUD	<u>944</u>	\$2,927	\$1,574	<u>\$4,249,349</u>
	3,485			\$7,082,314
Moderate- and High-risk, Co-occurring Need				
Category I - Low MI and Low SUD	2,583			
Category II - Moderate/High MI and SUD	1,011	\$2,927		\$2,959,172
Category III - Low MI and Mod/High SUD	2,975		\$1,574	\$4,684,000
Category IV - Mod/High MI and Mod/High SUD	<u>2,683</u>	\$2,927	\$1,574	<u>\$12,077,334</u>
Total	9,252			\$19,720,506
Current Funding				
IDHW - Mental Health (From WITS Data)	71	\$405		\$28,745
IDOC - SUD (FY 14-15 Actual IDOC Expenditure)	<u>4,492</u>		\$1,574	<u>\$7,072,446</u>
TOTAL	4,563			\$7,101,191
Note: "Current Funding" does not include IDHW or IDOC costs for state staff and resources providing direct treatment services to probationers and parolees as these data are not available.				

Appendices

Appendix A: Table 10. Offender Race/Ethnicity by Gender

Race/Ethnicity		Male	Female	Total
White*	Frequency	10,237	3,318	13,555
	% within Gender	72.5%	72.3%	72.4%
Unknown	Frequency	1,491	682	2,173
	% within Gender	10.6%	14.9%	11.6%
Hispanic	Frequency	1,614	347	1,961
	% within Gender	11.4%	7.6%	10.5%
Indian	Frequency	311	157	468
	% within Gender	2.2%	3.4%	2.5%
Black	Frequency	277	39	316
	% within Gender	2.0%	0.9%	1.7%
Other	Frequency	98	24	122
	% within Gender	0.7%	0.5%	0.7%
Asian	Frequency	93	21	114
	% within Gender	0.7%	0.5%	0.6%

*The offender who reported being transgender indicated her race as White but is excluded from this table due insufficient sample size of those indicated transgender.

Appendix B: Table 11. Offender Crime Types by Gender

Crime Type		Male	Female	Total
Drug	Frequency	4,279	2,091	6,370
	% within Gender	30.3%	45.6%	34.1%
Property	Frequency	3,309	1,496	4,805
	% within Gender	23.4%	32.6%	25.7%
Assault	Frequency	2,724	369	3,093
	% within Gender	19.3%	8.0%	16.5%
Alcohol	Frequency	2,395	566	2,961
	% within Gender	17.0%	12.3%	15.8%
Sex	Frequency	1,285	48	1,333
	% within Gender	9.1%	1.0%	7.1%
Murder & Manslaughter	Frequency	122	17	139
	% within Gender	0.9%	0.4%	0.7%

*The offender who reported being transgender is excluded from this table to protect confidentiality.

Appendix C: Table 12. Descriptive Statistics for the LSI-R Subscales

	Number	Minimum	Maximum	Mean	Std. Deviation
Total LSI Scale Score	18,435	0	50	23.95	9.59
Subscale					
Criminal History	18,435	0	10	5.10	2.12
Education/Employment	18,435	0	10	4.37	2.81
Financial	18,435	0	2	1.10	0.76
Family/Marital	18,435	0	4	1.87	1.27
Accommodations	18,435	0	3	0.65	0.90
Leisure/Recreation	18,435	0	2	1.22	0.87
Companion	18,435	0	5	2.45	1.30
Alcohol/Drug	18,435	0	10	3.62	2.40
Emotional/Personality	18,435	0	5	1.73	1.37
Attitudes/Orientations	18,435	0	4	1.85	1.46

Appendix D: Table 13. Probationer LSI-R Risk Levels by IDOC District

		District								
		0	1	2	3	4	5	6	7	State
Risk Level										
Low Risk (≤ 13)	Frequency	144	377	86	393	816	149	89	238	2,292
	% of Total	71.3%	16.4%	12.4%	14.8%	22.5%	8.0%	9.4%	15.0%	16.5%
Low-moderate Risk (14 – 23)	Frequency	56	826	227	948	1,399	650	317	530	4,953
	% of Total	27.7%	36.0%	32.6%	35.6%	38.6%	35.0%	33.7%	33.5%	35.7%
Moderate Risk (24 – 33)	Frequency	2	748	221	892	940	649	351	541	4,344
	% of Total	1.0%	32.6%	31.8%	33.5%	25.9%	34.9%	37.3%	34.2%	31.3%
Moderate-high Risk (34 – 40)	Frequency	0	270	132	364	384	325	152	222	1,849
	% of Total	0.0%	11.8%	19.0%	13.7%	10.6%	17.5%	16.1%	14.0%	13.3%
High Risk (41 – 54)	Frequency	0	74	30	67	84	85	33	52	425
	% of Total	0.0%	3.2%	4.3%	2.5%	2.3%	4.6%	3.5%	3.3%	3.1%
TOTAL		202	2,295	696	2,664	3,623	1,858	942	1,583	13,863
Moderate-to High-Risk (24 – 54)	Frequency	2	822	383	1,323	1,408	1,059	536	815	6,618
	% of Total	1.0%	35.8%	55.0%	49.7%	38.9%	57.0%	56.9%	51.5%	47.7%

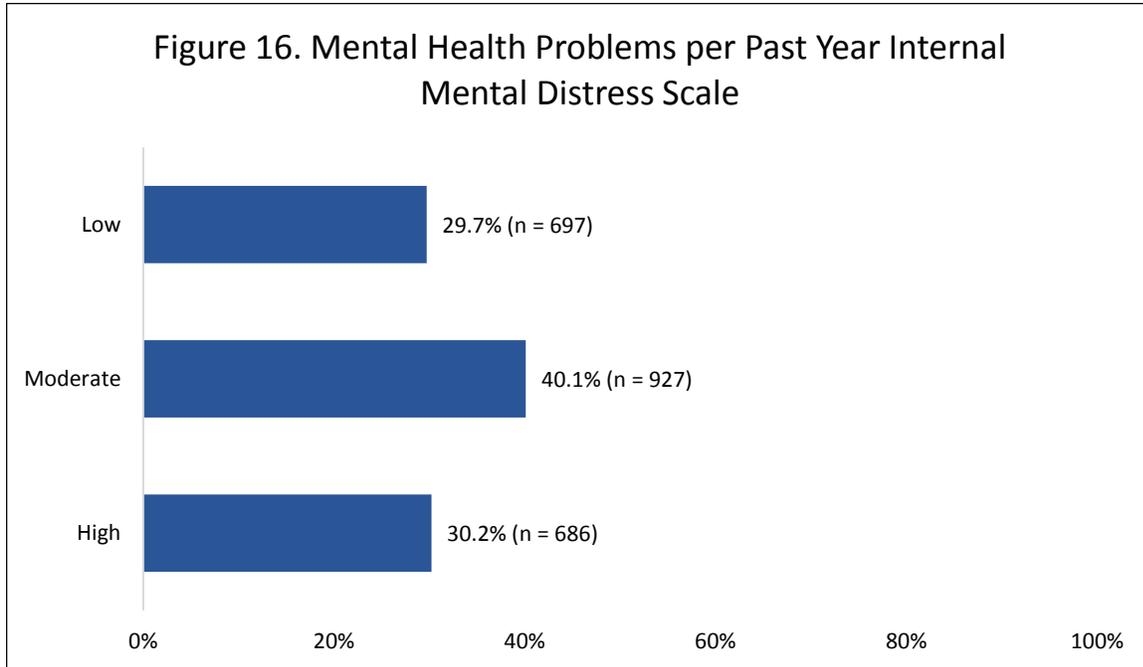
Appendix E: Table 14. Parolee LSI-R Risk Levels by IDOC District

		District								
		0	1	2	3	4	5	6	7	State
Risk Level										
Low Risk (≤ 13)	Frequency	46	43	23	89	173	27	10	41	452
	% of Total	62.2%	12.9%	16.3%	11.5%	8.7%	4.9%	4.5%	8.7%	9.9%
Low-moderate Risk (14–23)	Frequency	23	121	45	249	660	174	70	126	1,468
	% of Total	31.1%	36.3%	31.9%	32.0%	33.2%	31.8%	31.4%	26.8%	32.2%
Moderate Risk (24 – 33)	Frequency	4	94	43	254	623	176	67	162	1,423
	% of Total	5.4%	28.2%	30.5%	32.7%	31.3%	32.1%	30.0%	34.5%	31.2%
Moderate-high Risk (34 – 40)	Frequency	1	55	24	145	374	122	54	94	869
	% of Total	1.4%	16.5%	17.0%	18.7%	18.8%	22.3%	24.2%	20.0%	19.1%
High Risk (41 – 54)	Frequency	0	20	6	40	158	49	22	47	342
	% of Total	0.0%	6.0%	4.3%	5.1%	7.9%	8.9%	9.9%	10.0%	7.5%
TOTAL		74	333	141	777	1,988	548	223	470	4,554
Moderate-to High-Risk (24 – 54)	Frequency	52	169	73	439	1,155	347	143	303	2,634
	% of Total	70.3%	50.8%	51.8%	56.5%	58.1%	63.3%	55.2%	64.5%	57.8%

Appendix F. Description of Seriously Mentally Ill Offenders

Based on GAIN-I categories of diagnoses, 2,311 unique offenders (41.2%) may have met Idaho criteria for a SMI.⁴⁶ Of these offenders, 1,790 (77.91%) were on probation and 507 (22.1%) were on parole. Fourteen offenders (2.7%) were on probation and parole. Further, 1,497 offenders with a SMI (64.8%) indicated being required or mandated to go to treatment.

The figures that follow present mental health and substance use treatment need figures for offenders who may have met Idaho criteria for a SMI.



⁴⁶ This calculation included the following categories from Figure X: “Depression, Dysthymia, or Other Mood Disorder”, “Major Depression”, and “Other Schizophrenia or Psychotic Disorder”.

Figure 17. Gap Between IMDS and Current Regular Treatment Received

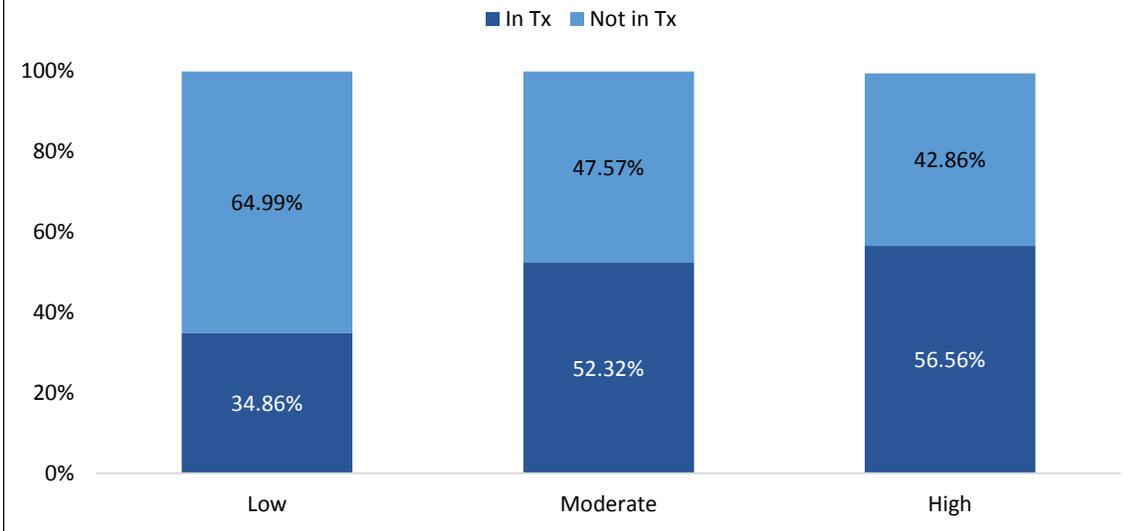


Figure 18. Substance Use Categories per Lifetime Substance Problem Scale

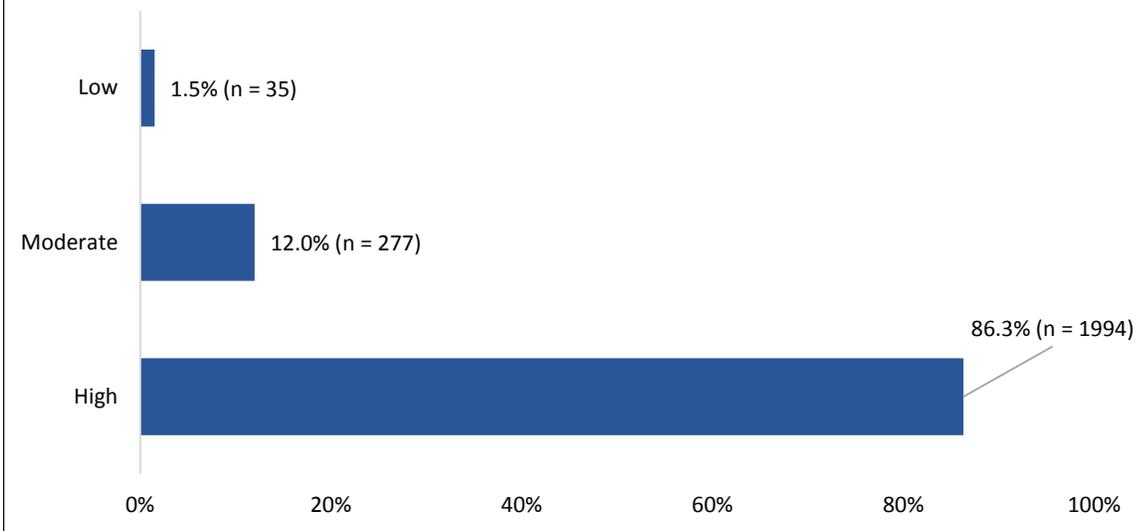


Figure 19. Substance Use Categories per Past Year Substance Problem Scale

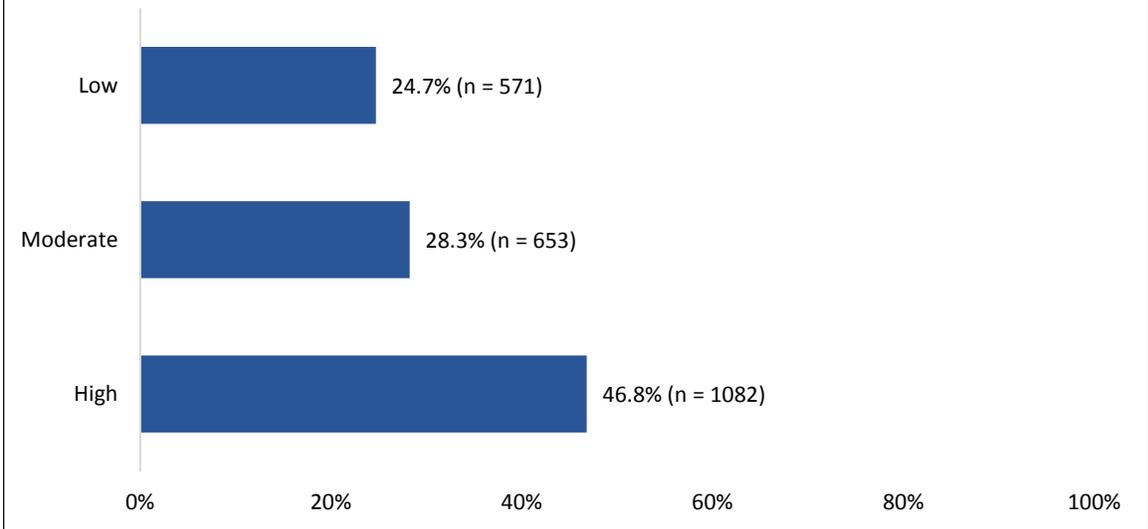
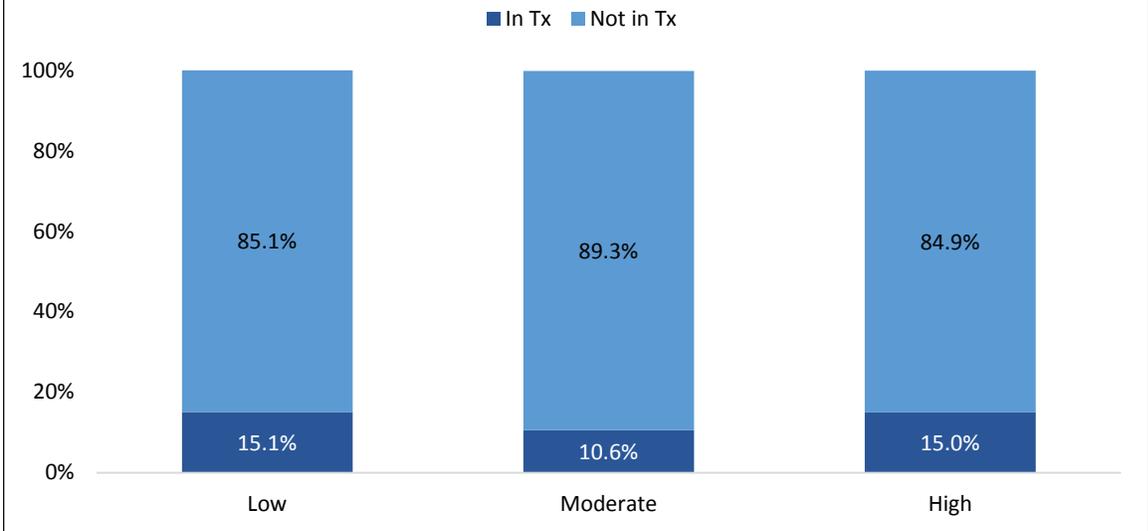


Figure 20. Gap Between SPS and Current Regular Tx Received



The figures that follow present “The Model” for moderate and high criminogenic risk offenders with a SMI, respectively, using the matched sample. Based on GAIN-I categories of diagnoses, 448 offenders (14.1%) of the matched-sample may have met Idaho criteria for a SMI.

Figure 21. Co-occurring Concerns by Severity for Moderate Criminogenic Risk

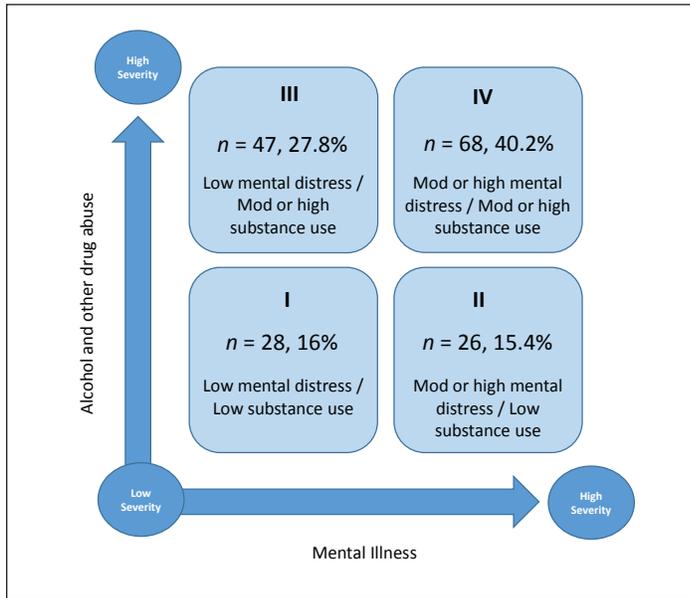


Figure 22. Co-occurring Concerns by Severity for High Criminogenic Risk

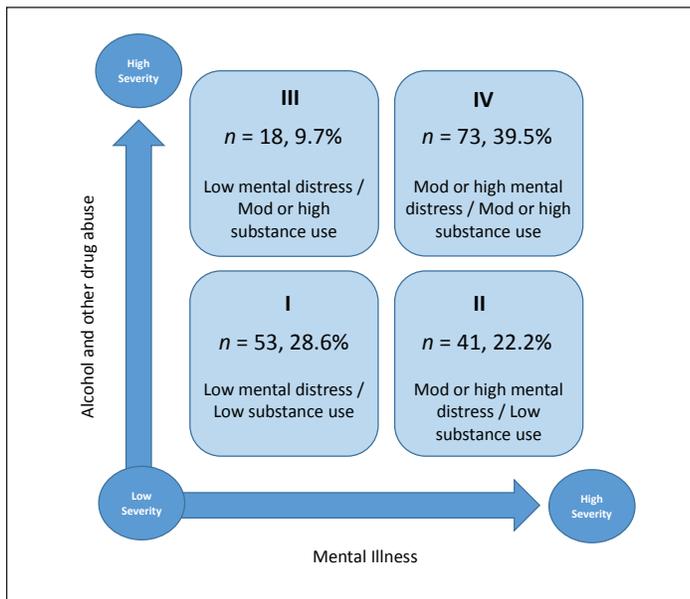
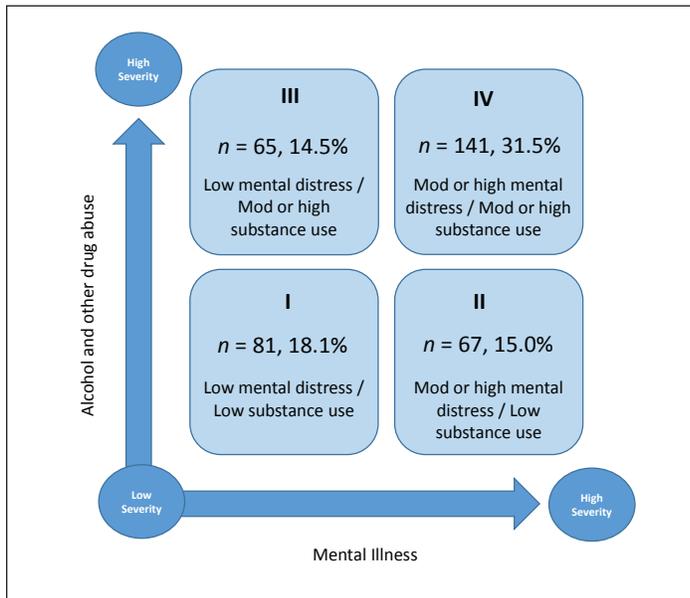
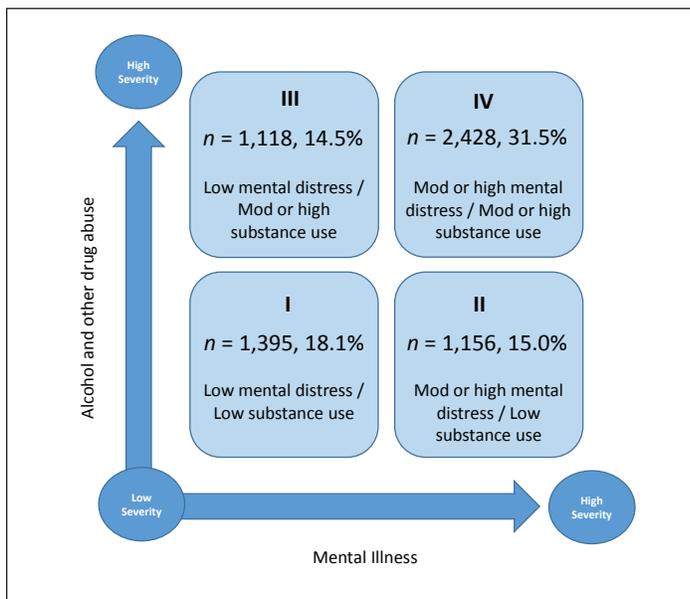


Figure 23. Co-occurring Concerns by Severity for Moderate and High Criminogenic Risk⁴⁷



The statewide estimates generated below were calculated by multiplying the rates of each category in Figure 23 by the number of offenders who may have met Idaho criteria for a SMI (i.e., $n = 7,709$ or 41.2% of 18,710 offenders). Figure 24 presents a statewide estimate of SMI offenders with co-occurring concerns across moderate and high criminogenic risk categories.

Figure 24. Statewide Estimate of Co-occurring Need for Moderate *and* High Criminogenic Risk Offenders with a Serious Mental Illness⁴⁸



⁴⁷ These rates will not total 100% as the remaining are assumed to be at low criminogenic risk.

⁴⁸ Per footnote 44, these counts will not total 7,709 offenders (i.e., the estimated number of offenders with SMI) as the remaining are assumed to be at low criminogenic risk.

Table 15 provides an estimate of the funding needed to address the statewide co-occurring needs of moderate- and high-risk offenders who may have an SMI. As the table indicates, approximately \$16.1 million is needed to meet the co-occurring needs of an estimated 6,097 offenders on probation and parole.

Table 15. Estimated Funding to Address Co-occurring Needs of Moderate- and High-risk SMI Offenders

	Estimated # of Offenders	Avg. Cost MH	Avg. Cost SUD	Estimated Cost
Moderate and High Risk: Co-Occurring Need				
Category I - Low MI and Low SUD	1,395			
Category II - Moderate/High MI and SUD	1,156	\$2,927		\$3,383,612
Category III - Low MI and Mod/High SUD	1,118		\$1,574	\$1,759,732
Category IV - Mod/High MI and Mod/High SUD	<u>2,428</u>	\$2,927	\$1,574	<u>\$10,928,428</u>
Total	6,097			\$16,071,772
Current Funding				
IDHW - Mental Health (From WITS Data)	71	\$405		\$28,745
IDOC - SUD (FY 14-15 Actual IDOC Expenditure)	<u>4,492</u>		\$1,574	<u>\$7,072,446</u>
TOTAL	4,563			\$7,101,191
Note: "Current Funding" does not include IDHW or IDOC costs for state staff and resources providing direct treatment services to probationers and parolees as these data are not available.				

Appendix G. Description of Matched-sample

The matched-sample included 3,177 probationers ($n = 2,314$, 72.8%) and parolees ($n = 863$, 27.2%) under supervision by IDOC. These offenders were between 17 and 75 years of age with a mean of 34.71 years ($SD = 11.11$). There were more males ($n = 2,375$, 74.8%) than females ($n = 802$, 25.2%) probationers and parolees in the matched-sample and the predominant racial/ethnic group was White ($n = 2,047$, 64.4%). Offender race/ethnicity is reported in Table 16.

Table 16. Offender Race/Ethnicity of Matched-sample

Race/Ethnicity	<i>n</i> (%)
White	2,047 (64.4%)
Unknown	712 (22.4%)
Hispanic	274 (8.6%)
Indian	67 (2.1%)
Black	52 (1.6%)
Other	16 (0.5%)
Asian	9 (0.3%)

The crime of conviction, or most severe crime, for most offenders in the matched sample was a drug-related crime ($n = 1,269$, 39.9%) with the majority of offenders in Southwest Idaho across District 4 ($n = 1,057$, 33.3%) and District 3 ($n = 525$, 16.5%).⁴⁹ Offender crime types and dispersion are reported Tables 17 and 18.

Table 17. Offender Crime Types of Matched-sample

Crime Type	<i>n</i> (%)
Drug	1,269 (40.0%)
Property	852 (26.8%)
Assault	484 (15.2%)
Alcohol	464 (14.6%)
Sex	93 (2.9%)
Murder & Manslaughter	14 (0.4%)

⁴⁹ Six offenders were assigned to "District 0" which is the limited supervision unit (LSU).

Table 18. Offender Dispersion Across Idaho of Matched Sample

District	Counties	n (%)
0	NA*	6 (0.2%)
1	Boundary; Bonner; Benewah; Kootenai; Shoshone	518 (16.3%)
2	Clearwater; Idaho; Latah; Lewis; Nez Perce	142 (4.5%)
3	Adams; Canyon; Gem; Owyhee; Payette; Washington	525 (16.5%)
4	Ada; Boise; Elmore; Valley	1,057 (33.3%)
5	Blaine; Camas; Cassia; Gooding; Jerome; Minidoka; Twin Falls	438 (13.8%)
6	Bannock; Bear Lake; Caribou; Franklin; Oneida; Power	199 (6.3%)
7	Bingham; Bonneville; Butte; Clark; Custer; Fremont; Jefferson; Lemhi; Madison; Teton	291 (9.2%)

*District 0" is the limited supervision unit (LSU). This unit was created in 2013 for low-risk offenders across Idaho who require minimal supervision. Currently, IDOC has one senior probation and parole officer who monitors the LSU. These offenders report to this probation and parole officer through an online system.

Appendix H: Table 19. Services Rendered for Co-occurring Concerns by Severity

Risk Level	Current Substance Use Tx	Current Mental Health Tx
<i>Co-occurring Category</i>	<i>n (%)</i>	
Moderate Criminogenic Risk		
<i>I (n = 107)</i>	15 (14.0%)	11 (5.1%)
<i>II (n = 36)</i>	4 (11.1%)	14 (29.4%)
<i>III (n = 172)</i>	12 (7.0%)	21 (12.2%)
<i>IV (n = 136)</i>	17 (12.5%)	43 (31.6%)
High Criminogenic Risk		
<i>I (n = 130)</i>	19 (14.6%)	12 (9.2%)
<i>II (n = 59)</i>	3 (5.1%)	19 (32.2%)
<i>III (n = 83)</i>	13 (3.6%)	12 (14.5%)
<i>IV (n = 101)</i>	16 (15.8%)	37 (36.6%)