HEALTHIER LIVES, STRONGER FAMILIES, SAFER COMMUNITIES

HOW INCREASING FUNDING FOR ALTERNATIVES TO PRISON WILL SAVE LIVES AND MONEY IN WISCONSIN

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HEALTHIER LIVES, STRONGER FAMILIES, SAFER COMMUNITIES

Increased investment by Wisconsin in problem-solving courts and other programs to keep low-risk, non-violent offenders out of prison would likely reduce crime, strengthen families and communities, improve public health and begin to correct racial inequities in the state criminal justice system, according to a wide-ranging study of the impacts of alternatives to incarceration. More funding for prison alternatives is also likely to reap significant savings on public safety, health care and social services.

Human Impact Partners, in collaboration with WISDOM, conducted a year-long Health Impact Assessment from October 2011 – October 2012 of the predicted results of increasing funding for state Treatment Alternative Diversion (TAD) programs. These programs include drug and alcohol treatment courts, day reporting centers, mental health treatment courts and other initiatives, all based on the principle that public health issues, such as substance abuse and mental health problems, are at the root of many crimes.

TAD pilot programs were established in seven Wisconsin counties in 2007, but currently get less than $1 million a year in state funding. The pilot programs have been highly effective at reducing prison recidivism as well as treating substance abuse and mental health issues, but they barely scratch the surface of statewide need. As Wisconsin Circuit Court Judge Lisa Stark notes, in Eau Claire County, "For every one person that we treat now through these (alternative diversion) methods, there are 10 more who could be eligible but instead get sent to prison due to lack of resources."

But the human impacts – prison terms avoided, families kept intact, lives given a second chance – are only part of the story. *Alternatives to prison will make Wisconsin safer and also save Wisconsin money.*

PRISON IS FOUR TIMES MORE COSTLY THAN TREATMENT

According to the Wisconsin Department of Corrections, the average cost of putting someone behind bars for one year is about $32,000. But a state report[3] evaluating TAD's first four years found that even in the most expensive alternative programs, the average annual cost per participant is $7,551. The Wisconsin Office of Justice Assistance estimates that every dollar spent on treatment alternative programs saves almost $2 in criminal justice costs. By that yardstick alone, increased investment of $75 million in alternatives to prison would yield an annual savings of almost $150 million.

Human Impact Partners' research team included advisors from the state Public Defender's Office, University of Wisconsin Population Health Sciences, and Community Advocates Public Policy Institute. The team conducted an exhaustive survey of peer-reviewed studies and existing data, including on-the-ground results from the seven Wisconsin counties with TAD pilot programs and the more than 2,500 alternative courts nationwide. HIP also conducted focus groups with former prisoners, non-violent offenders enrolled in TAD programs, judges and others in the criminal justice, social services and public health systems.

> *For every one person in our county we treat now through these methods, there are 10 more who could be eligible but instead get sent to prison due to lack of resources.*
> *– Treatment court judge*

1. **Human Impact Partners (HIP)** is a non-profit, non-partisan organization in Oakland, Calif., that conducts Health Impact Assessments, a research tool that uses data, original investigation and stakeholder input to determine a policy or project's impact on the health of a population.
2. **WISDOM** is a Wisconsin grassroots network of about 145 religious congregations of 19 different faith traditions who work together to speak as a common voice on issues of social justice.
3. **Treatment Alternatives and Diversion (TAD) Program: Advancing Effective Diversion in Wisconsin**. Wisconsin Office of Justice Assistance, Wisconsin Department of Corrections and Wisconsin Department of Health Services, December 2011.

$75 Million for Wisconsin TAD Programs		
Impact	**TAD Program Effect**	**Projected Outcome**
Reduce Cost	Decrease prison admissions	3,100 (nearly 40%) of the 8,000 prison admissions each year will be eligible for TAD programs
	Decrease jail admissions	21,000 (nearly 10%) of the 227,000 jail admissions each year will be eligible for TAD programs
	Decrease re-incarceration	Recidivism would be 12% - 16% lower for non-violent offenders in TAD programs
Reduce Crime	Decrease recidivism	20% fewer crimes would be committed by participants in TAD programs (1,100 fewer crimes over 5 years)
Increase Recovery	Improve access to treatment	All eligible offenders would have access to drug court treatment programs
	Improve efficacy of treatment	Drug court participants would have double the rate of recovery than those in minimal treatment
Strengthen families	Increase number of families that remain intact	Between 1,150 – 1,619 parents could stay out of prison and receive treatment
Improve Economic Opportunity	Increase likelihood of employment	13% more non-violent offenders with substance abuse issues would be employed

We found strong evidence of an array of likely benefits from increased funding. We are confident in predicting that by raising funding for prison alternatives to $75 million a year, Wisconsin is likely to:

- **Reduce the prison and jail population.** In September 2012, 21,713 people were in Wisconsin state prisons – 4,600 more than the facilities' permitted capacity. Of the approximately 8,000 people sent to prison in the state each year, at least 3,115 would be eligible for alternative diversion programs. Of the approximately 227,000 jail admissions per year, about 21,000 would be eligible.
- **Reduce crime.** Graduates of alternative programs commit fewer crimes than ex-prisoners. We project that 20 percent fewer crimes would be committed by the low-risk, non-violent offenders who qualify for expanded TAD programs. Over five years, this would mean about 1,100 fewer crimes committed in Wisconsin.
- **Make Wisconsin safer.** TAD programs are not designed for those who pose a danger or serious threat to others in the community, and graduates of TAD programs are less likely to commit another crime. Expanded TAD programs will not mean fewer violent criminals behind bars. On the contrary, it will let the law enforcement system focus on preventing violent crime.
- **Improve recovery from substance abuse.** Drug offenders and drunk drivers accounted for 80 percent of the growth in Wisconsin prisons since 1996. Drug courts are six times more likely than prison programs to keep offenders in treatment long enough for them to get better.
- **Improve mental health.** Mental health courts, which focus on diagnosing and treating disorders that can lead to crime, have been found to reduce the future likelihood of psychiatric hospitalization and jail time for graduates of their programs.
- **Keep ex-offenders from returning to prison.** After just two years, only half of those released from Wisconsin prisons successfully reintegrate into society, but more than 80 percent of graduates from TAD programs do not return to jail or prison.
- **Strengthen families.** Increased TAD funding would mean that between 1,150 and 1,619 Wisconsin parents would not be imprisoned each year, meaning fewer single-parent families, fewer children placed in foster care and brighter futures for the children of offenders.

"DRUG COURT SAVED MY LIFE"

In focus groups held in Milwaukee and Madison, we asked offenders enrolled in TAD programs, judges and social service providers what they want those who set state policy to know. Resoundingly, they all wanted decision-makers to get the fact that alternatives are cheaper than prison and better at protecting public safety. They said that alternatives to prison are better for offenders, their families, and their communities. Said one judge:

> *Alternatives to incarceration save money and save lives . . . It's much cheaper to treat people than to lock them up, and you have better outcomes. There is less recidivism, fewer victims, and less use of the justice system. You end up with contributors to society and all of the benefits of that.*

One ex-offender said simply: "Drug court saved my life."

The impact of prison on families is also heart-wrenching.

In our focus groups, parents who had been prisoners reported feeling like failures, and missing large portions of their children's lives. Most also reported that their children had cut off all contact for a portion of time, or forever. In some cases, parents lost custody of children due to the substance abuse and mental health issues that led to their crimes. One judge said: "Keeping kids with parents, even if they're not the best parents, as long as they are safe – the outcomes are always better to remain with parents."

Tragically, parents who go to prison also endanger their children's life prospects: Studies have found that children with parents in prison are significantly more likely to fail at school or drop out, and nearly half of boys who before age 10 had a parent imprisoned were convicted of a crime as adults.

RECOMMENDATIONS

Based on the overwhelming evidence, the Health Impact Assessment research team and Advisory Committee make these recommendations.

- Beginning in FY 2013, expand state funding of TAD programs to $75 million a year.
- Allocate an additional $20 million per year to TAD programs statewide to improve mental health, jobs, substance abuse, and family services.
- Redefine eligibility criteria for TAD programs to include those who have their parole revoked, those with serious substance abuse or mental health issues, and create a sliding risk assessment of addiction and ensuring that all racial groups are given proportional access to their involvement in the criminal justice system.
- Give parents priority access to TAD program slots.
- Continue to conduct annual standardized statewide evaluations of all problem solving courts and diversion programs with more detailed outcome measures.[4]

To read the full Health Impact Assessment, go to www.prayforjusticeinwi.org

To learn more about Treatment Instead of Prison in Wisconsin, contact David Liners at davidl_wisdom@sbcglobal.net
To learn more about this Health Impact Assessment, contact Kim Gilhuly at kim@humanimpact.org

[4] **For a complete list of recommendations and further explanation, see Chapter 6.**

INTRODUCTION

Wisconsin's prison population, like America's, has soared. Wisconsin imprisons just under 22,000 people each year - 4,600 more than the state's facilities were designed to hold.[1] Wisconsin's prison population more than tripled between 1983 and 1999, and the rate of imprisonment in Wisconsin exceeds the average for Midwestern states and for the nation. [2] [3] In 2010, approximately 7.1 million Americans were behind bars, and the proportion of people in prison had almost doubled from 1980 to 2010.[4]

According to the Federal Bureau of Justice Statistics, over half of the U.S. prison population has mental health issues[8] and an estimated 85% have substance abuse issues.[9] The vast majority of those incarcerated are low-income, and in Wisconsin nearly half are African-American - in a state where the overall African-American population is about 6%.[10] There is a highly disproportionate impact of incarceration among racial and ethnic minority groups, with African-Americans being five times more likely to be incarcerated over their lifetime than whites. (Table 1).

Table 1. Lifetime Likelihood of Imprisonment

	Men 1 in 9 Overall	Women 1 in 56 Overall
African-American	1 in 3	1 in 18
Hispanic	1 in 6	1 in 45
White	1 in 17	1 in 111

Source: Bonczar T. 2003. Prevalence of Imprisonment in the US Population, 1974-2001. Washington DC: Bureau of Justice Statistics.

Considering the substantial numbers of people affected by the criminal justice system, a shift by Wisconsin funding priorities to problem solving courts instead of incarceration could benefit thousands of people statewide and help address the massive social inequities inherent in Wisconsin's prison system.

Problem solving courts funded through the state's existing Treatment Alternatives Diversion pilot program include drug courts for offenders with drug addiction and dependency and Operating While Intoxicated (OWI) or drunk driving courts. Wisconsin also has mental health courts, family courts and veterans' courts; each builds off the proven drug court model to treat the specific issues that brought these populations into the criminal justice system. In this report we examine drug courts, mental health courts, and OWI courts. Because they are not funded through TAD, this report does not look at the other alternative courts in depth. In addition, the state has a variety of diversion programs that allow non-violent offenders to participate in substance abuse treatment in lieu of facing criminal charges.

The ripple effects of incarceration are far-reaching, resulting in serious harm to the health of prisoners, their families and the communities we all live in. These impacts are both direct and indirect. Documented direct impacts include increased rates of suicide, infectious disease, injury and lack of access to proper physical and mental health care. Documented indirect impacts include isolation from opportunity, decreased family and social support, difficulty obtaining housing and employment and reduced access to educational opportunities. Another level of impact is the toll parental imprisonment takes on children. At the community level, municipalities have fewer employable citizens and therefore a smaller tax base, and communities may swell with single-parent families, unemployable and homeless parolees, and ongoing crime.

In contrast to a system of mass incarceration, problem solving courts and diversion programs present alternatives that do less harm to individuals, their families and our communities. Problem solving courts reflect a range of specialized courts incorporating treatment for criminal offenders based on the principle that public health issues (e.g., drug or alcohol abuse, mental health disorders) are at the root of many crimes. Diversion programs divert offenders from the court system, help them get treatment, follow criminal justice principles, and have also been more effective than incarceration at addressing offenders' health problems while protecting public safety.

These alternative approaches allow low-risk, non-violent offenders to remain in the community while complying with mandated treatment. If offenders drop out of a court-mandated program they can be sent to prison. In 2011, the Wisconsin Office of Justice Assistance estimated that every dollar spent on treatment alternative programs saves almost $2 in criminal justice costs.[11] The average cost of incarcerating an individual for one year in Wisconsin is approximately $32,000. [12] [13] [14] In contrast, the average annual cost of the more expensive treatment alternatives is $7,551. Increasing funding for treatment alternatives rather than prisons could contribute meaningfully toward closing the state's budget gap.

This Health Impact Assessment highlights how increasing annual funding for problem solving courts and other treatment alternatives in Wisconsin from the current level of less than $1 million to $75 million would impact the health of individuals who are incarcerated, their families and the communities we all live in.

WHAT IS A HEALTH IMPACT ASSESSMENT?

HIA is a public engagement and decision-support tool that can be used to assess policy and planning proposals and make recommendations to improve health outcomes associated with those proposals. The fundamental goal of HIA is to ensure that health and health inequities are considered in decision-making processes using an objective and scientific approach, and engaging stakeholders in the process.

HIA is a flexible research process that typically involves six steps:

- *Screening* involves determining whether or not a HIA is warranted and would be useful in the decision-making process.
- *Scoping* collaboratively determines which health impacts to evaluate, the methods for analysis, and the workplan for completing the assessment.
- *Assessment* includes gathering existing conditions data and predicting future health impacts using qualitative and quantitative research methods.
- *Developing recommendations* engages partners by prioritizing evidence-based proposals to mitigate negative and elevate positive health outcomes of the proposal.
- *Reporting* communicates findings.
- *Monitoring* evaluates the effects of a HIA on the decision and its implementation as well as on health determinants and health status.

For more information about how this health impact assessment was screened, scoped, and the stakeholder engagment process, please see Appendix 1.

BACKGROUND

TREATMENT INSTEAD OF PRISON

In response to the soaring number of prisoners with substance abuse and mental health problems, Wisconsin has established a pilot program of alternative treatment courts, known as problem solving courts, and prison/jail diversion programs. In 2006 the Wisconsin legislature dedicated just over $1 million per year to pilot several treatment alternatives to incarceration, also called Treatment Alternatives and Diversion (TAD). For 2012, TAD funding was $968,400.

After setting up Criminal Justice Coordinating Councils, seven counties won grants to begin drug and alcohol treatment courts, day reporting centers, mental health treatment courts and similar programs, implementing them in 2007. While the pilot programs have been nearly universally successful at decreasing recidivism as well as treating substance abuse and mental health needs, they only scratch the surface of statewide need.[17] As Wisconsin Circuit Court Judge Lisa Stark notes, in Eau Claire County, "For every one person that we treat now through these (alternative diversion) methods, there are 10 more who could be eligible but instead get sent to prison due to lack of resources." The positive results of the pilot programs in Wisconsin mirror results from national evaluations of the more than 2,500 drug courts and many other alternative treatment courts across the country. [18] [19]

The goal of this HIA is to predict the future health impacts of a Wisconsin state proposal to provide $75 million per year for the budget beginning July 1, 2013 for Treatment Alternative Diversion programs – funds for counties to initiate or expand programs that provide treatment alternatives to incarceration.[5] Both major parties appear committed to continued funding for the pilot programs, but no consensus has emerged on the level of future funding. We seek to change the focus of the incarceration debate in Wisconsin – away from punishment of low-risk non-violent offenders to improvement of health and community safety. We assess how this policy shift would affect these determinants of health:

- Recovery from substance abuse and ability to manage mental health issues.
- Crime and public safety.
- Families and children.
- Community impacts such as employment, housing, and social cohesion.

INCARCERATION

According to a September 2012 report by the Wisconsin Department of Corrections, there are 21,713 people in state prisons – 4,600 more than these facilities are collectively permitted to hold.[20]

Marked racial disparities in incarceration exist, both in Wisconsin and nationally. While just under 6% of Wisconsin's population is African American, 45% of the prison population is African American.[21] Western and Pettit (2010) provide a stark analysis of this risk nationwide: Based on the likelihood having a brush with the criminal justice system, about 5 percent of white men aged 32 to 35 were at risk of imprisonment, compared to 12% of Latino men and 27% of black men. For black men without a high school diploma, the risk of being sent to prison jumps to 68%.[22]

In Wisconsin state prisons 94% of prisoners are male and 6% female. About 11,800 prisoners in are parents.[23] [24] Approximately 2.3%, or 30,000, of Wisconsin's children have a parent in prison. Fewer than one percent of white children have a parent in prison, compared to 2.4% of Latino children and 6.7% of black children. [25]

[5] The research in this HIA primarily focuses on problem solving courts, as opposed to diversion programs first because there is more research for problem solving courts than for the wide variety of existing diversion programs, which range from universal screening programs to day reporting to bail monitoring and beyond. Second, we were interested in outcomes beyond recidivism such as for recovery from substance abuse, ability to manage mental health issues, employment, and other health-related outcomes. Recidivism is the primary outcome measured in diversion program evaluations, and problem solving court evaluations had at least some level of measurement on some of these outcomes.

The Wisconsin Department of Corrections offers a variety of health, substance abuse treatment, educational, employment and life skills programs to incarcerated offenders. However, merely offering programs does not guarantee that prisoners can get in. In our focus groups, former prisoners mentioned long waiting lists and restrictive criteria that kept them out of the programs they wanted to enroll in. Said one former prisoner: "The waiting list is so long – hundreds and hundreds of people – so many people don't get in."

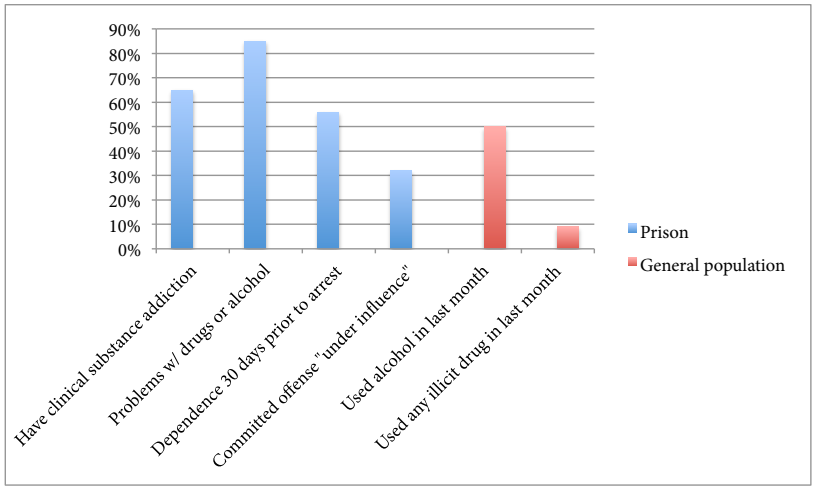
SUBSTANCE ABUSE AND INCARCERATION

Though specific rates vary somewhat by source, a variety of credible sources cite high levels of drug and alcohol use by those incarcerated, often in the course of the crime that landed them in prison. The National Center on Addiction and Substance Abuse at Columbia University estimates that while 65% of U.S. prison inmates meet the American Psychiatric Association's medical criteria for alcohol or other drug abuse and addiction, fully 85% have problems with drugs or alcohol – a history of regular drug or alcohol use, meet the medical criteria for substance abuse disorder, were under the influence when they committed their crime, were incarcerated for a drug or alcohol law violation or committed their offense to get money to buy drugs.[26] The Bureau of Justice Statistics found that 56% of U.S. prisoners had substance use dependence or abuse in the month prior to entering prison, and 32% of state prisoners committed their offense under the influence of drugs.[27] A 2006 study concluded that adults were 12 times more likely to be involved in the criminal justice system if they had substance abuse issues than if they did not.[28]

> *For 20 years I had an addiction. Heroin, crack. It was known by the courts that this was the driving force behind my crimes. Not once . . . in 12 years . . . did I ever get treatment inside the prison walls.*
> *– Formerly incarcerated focus group participant*

Alcohol, alone or in combination with another substance, is involved in the incarceration of 57% of all prisoners in the U.S.[29] Centers for Disease Control and Prevention data from 2009 show that 9% of the adult and adolescent populations had used any illicit drug in the past month and just over half had used alcohol. Of those using illegal drugs, the highest use was in those aged 18 to 25 (21%) and of those using alcohol, the highest use was among those aged 26-34 (64%).[31] (Figure 1.)

Figure 1. Prevalence of Drug or Alcohol Abuse in Prison and General Population



Sources: CASA. 2010. Behind Bars II: Substance Abuse and America's Prison Population. National Center on Addiction and Substance Abuse at Columbia University; Bureau of Justice Statistics. 2006. Drug Use and Dependence, State and Federal Prisoners, 2004. Bureau of Justice Statistics Special Report. Revised 1/19/07; Centers for Disease Control and Prevention. 2011. Table 64. Use of selected substances in the past month among persons 12 years of age and over, by age, sex, race, and Hispanic origin: United States, selected years 2002 – 2009. Centers for Disease Control and Prevention FastStats: Illegal Drug Use.

Drug offenders accounted for more than 20% of the growth in the prison population from 1996 to 2006 in Wisconsin. From 2001 to 2006, drunk driving offenders were responsible for more than 60% of the growth in the prison population.[32] All told, drug and alcohol use has accounted for about 80% of the growth in the prison population in Wisconsin since 1996.

MENTAL HEALTH AND INCARCERATION

According to a 2004 Bureau of Justice Statistics report based on thousands of interviews with prisoners, 56% of state prisoners nationwide have a mental health disorder.[33] In Wisconsin in 2007, 10% of people admitted to prison were assessed as having a serious mental health disorder and an additional 21% were assessed as having some mental health need.[34] One study found that adults were 20% more likely to be involved in the criminal justice system if they had mental health issues than those who do not have mental health issues.[35] Notably, three out of four state prisoners who had a mental health problem met the criteria for substance dependence or abuse as well.[36] Across the board, the prevalence of mental health issues among those in prison is significantly higher than among the general public.

PHYSICAL HEALTH AND INCARCERATION

The Bureau of Justice Statistics reports that 44% of state prison inmates in the U.S. report a current medical problem other than a cold or virus [39] and 43% of state inmates report having a chronic condition such as diabetes, hypertension, prior heart attack, kidney problems, asthma, cirrhosis or HIV/AIDs.[40] A RAND study compared rates of disease and illness in the prison population to those in the general population and found that the prevalence of health conditions among inmates was far higher among those incarcerated when compared to the general population. Most notably, the prevalence of HIV and hepatitis infection is 8 to 10 times greater, and prevalence of active tuberculosis is four times greater.[42]

PROBLEM SOLVING COURTS

Drug courts and other problem solving courts emerged during the late 1980s and early 1990s in response to the dramatic increase in drug offender arrests and prosecutions, which resulted in overburdened prison systems across the country. The latest national tally includes 3,648 problem solving courts, of which 2,459 are drug courts.[43]

The general criteria for admission to Wisconsin problem solving courts are that the participant must live in the county of the court at the time of the referral, be 18 or older, non-violent with no prior felony convictions, have a diagnosed substance abuse or mental health problem, have been charged with a felony related to their diagnosis, and be willing to address the issue in treatment. Each problem solving court may have its own criteria, but those above reflect nationally-accepted guidelines.[44]

A typical problem solving court process begins when a person is arrested for a non-violent drug-related crime, drunk driving or an offense related to a mental health disorder. If convicted, at arraignment the court determines the offender's eligibility for problem solving court. Defendants who choose the problem solving court plead guilty and are then placed under the court's supervision. The clients must follow the court program of drug and alcohol testing, court supervision, and substance abuse and mental health treatment. Offenders must attend self-help meetings and work with rehabilitation counselors who provide therapy, educational sessions and job training. If clients fail to comply with the court program, there are sanctions that may include jail time. Usually problem solving courts do not dismiss anyone unless they fail to remain sober or commit another personal or property crime. In the early phases of a problem solving court program, participants have weekly or daily court appearances, therapy sessions and drug tests, becoming less frequent as they move through the program. Even after graduation they return regularly to court and therapy and take a drug test twice a month.

Table 2: Composite Example of Problem Solving Court Program

Phase	Minimum Length	Court Dates	Individual Therapy	Recovery Group	Education Class	NA/AA	Drug Test
I	2 months	Weekly	Weekly	Weekly	Weekly	5/wk	Several times a week
II	4 months	Every other week	Every other week	Weekly	Weekly	5/wk	Weekly
III	6 months	Monthly	Every other week	Weekly	Monthly	3-4/wk	Weekly
Graduation: diploma given at ceremony							
Aftercare	6 months	Every 3rd month		2/mo		2/wk	2/mo

Note: NA-Narcotics Anonymous, AA- Alcoholics Anonymous
Source: Adopted from Lessenger, J. E., & Roper, G.F. (2002) Drug court: A primer for the family physician. The Journal of the American Board of Family Practice, 15(4): 298-303.

On average nationwide, 62% of the participants in drug courts are white, 21% are African American and 10% are Hispanic.[46] This breakdown is much different than the racial makeup of the prison population, showing how white offenders are much more likely to be offered drug court instead of prison. Nationally, about half of drug court participants complete the program.

The average Treatment Alternative and Diversion (TAD) cost for drug courts is $7,551 and for diversion programs is $1,664.[47] Due to variability of costs across the country, the Washington State Institute for Public Policy has calculated a nationwide average cost of $4,095 per drug treatment court slot. [48]

As of December 2011, Wisconsin had 44 problem solving courts with six more on the way.[52] [53] [54] Seven TAD sites, including drug courts and diversion programs, were funded by the legislature in 2006. These sites serve an annual capacity of between 426 and 545 participants, and from 2007 until 2011 admitted 2,061 participants. [li] The number of available slots varies with the length of the programs, ranging from 9 to 22 months. Treatment for at least one year is considered best practice for effective treatment in a drug court. [56]

Nationally, an estimated five million adults in the criminal justice system need substance abuse treatment services, yet on a given day fewer than 7% can participate. In 2010, only one percent of non-violent offenders in Wisconsin counties with TAD programs participated in TAD.[58]

FINDINGS: RECOVERY

KEY FINDINGS

- Adults are 12 times more likely to be involved in the criminal justice system if they have substance abuse issues than if they do not.
- As many as 85% of prisoners are substance involved, and alcohol is implicated in the incarceration of over half (57%) of all inmates in America - alone or in combination with another substance.
- The Bureau of Justice Statistics reports that 56% of prisoners have had a mental health disorder.
- Problem solving courts adhere to principles of substance abuse and mental health treatment at a higher rate than prisons. As a result, drug courts are six times more likely to keep offenders in treatment long enough for them to get better.
- Up to 85% of prisoners who could benefit from substance abuse treatment in prisons do not receive it.
- Most prisons and jails fail to conform to nationally accepted guidelines of mental health screening and treatment.
- Problem solving courts are superior in terms of helping people recover. Drug court participants are significantly less likely to relapse than comparison groups.
- Problem solving courts have better results in reducing overdoses, suicides and motor vehicle fatalities.

The prison population has significantly higher rates of substance and alcohol abuse and mental health issues than the general population (Table 3). Adults with substance abuse issues are 12 times more likely to be involved in the criminal justice system than those without substance abuse issues.[59] The Bureau of Justice Statistics (BJS) reports that 32% of prisoners committed their crime while under the influence. [60]

Table 3. Rates of Substance Abuse, Alcohol Abuse, and Mental Health Issues Among the Incarcerated and General Populations

	Among incarcerated	Among general U.S. population
Substance abuse	56% reported substance abuse dependence in the month prior to incarceration (1) 85% meet the clinical definition of substance dependence or other recognized criteria (2)	9% reported using any illicit drug in the past month (3)
Alcohol abuse	Implicated in incarceration of 57% of inmates either alone or in combination with another substance (2)	24% reported binge drinking and 7% reported heavy use in the past month (3)
Mental health	56% have had a mental health disorder in the last 12 months (1) 50% of inmates have mental health disorders (4)	6% suffer from a serious mental illness (5) 9% meet the criteria for current depression (6) 15% have ever had anxiety disorder (7)

Sources: 1) Bureau of Justice Statistics. 2006. Drug Use and Dependence, State and Federal Prisoners, 2004. Bureau of Justice Statistics Special Report. Revised 1/19/07; 2) CASA. 2010. Behind Bars II: Substance Abuse and America's Prison Population. National Center on Addiction and Substance Abuse at Columbia University; 3) Centers for Disease Control and Prevention. 2011. FastStats: Illegal Drug Use. Table 64. Use of selected substances in the past month among persons 12 years of age and over, by age, sex, race, and Hispanic origin: United States, selected years 2002 – 2009; 4) Substance Abuse and Mental Health Services Administration. 2012. Behavioral Health and Criminal Justice: Challenges and Opportunities. Presentation by Administrator Hyde, American Correctional Association, July 21, 2012; 5) National Institute of Mental Health. The Numbers Count: Mental Disorders in America; 6) Centers for Disease Control and Prevention. 2010. Current Depression Among Adults – United States, 2006 and 2008. Morbidity and Mortality Weekly Report 59(38):1229-35. Revised estimates for depression MMWR erratum Feb 2011; 7) CDC. 2011. Burden of Mental Health. Centers for Disease Control and Prevention. Mental Health Basics.

THE WISCONSIN CONTEXT: SUBSTANCE ABUSE AND MENTAL HEALTH ISSUES IN AND OUT OF PRISON

The Wisconsin Department of Corrections estimates that 70% of state prisoners have a substance abuse addiction. In comparison, the Wisconsin Department of Health Services estimates the rate of dependence or abuse of illicit drugs in the general population as 3%.[72]

Wisconsin's rates of alcohol misuse are among the highest in the nation, with some of the highest rates of alcohol consumption, binge drinking, and heavy drinking among all states, and rates of underage drinking exceeding national levels.[73] From 2002 to 2008, between 9% to 11% of those 12 and older in Wisconsin reported alcohol dependence compared to 8% nationally,[74] and 24% of Wisconsinites engage in excessive drinking[75] (a measure of binge plus heavy drinking). The state of Wisconsin does not separate alcohol abuse from general substance abuse prevalence.

The Wisconsin Board for People with Developmental Disabilities estimates that about 4% of Wisconsinites suffer from a serious mental illness,[76] and over one in four (26%) suffer from a diagnosable mental disorder in a given year. [77] [78] Among the Wisconsin prison population, over one in three inmates have a mental health condition requiring monitoring and treatment and 9% have a serious mental illness. [79]

We'll examine how prisons and problem solving courts measure up to standards for substance abuse treatment and mental health services, then extend that analysis to practices in Wisconsin.

SUBSTANCE ABUSE TREATMENT

Simply receiving substance abuse treatment, whether inside or outside of a corrections setting, is beneficial to recovery. In a meta-analysis of 87 studies comparing substance abuse treatment to either no treatment or minimal treatment, researchers found that those who received substance abuse treatment had better outcomes on decreasing drug use and crime than comparison groups. Specifically, participating in drug treatment increased a participant's chances of success at dealing with his or her addiction by 36%.[80]

The National Institute on Drug Abuse has established evidence-based standards for substance abuse treatment in the general population and within a correctional facility. The National Drug Court Institute has also defined 10 Key Components for Drug Courts (See Appendix 4). In sum, key factors of substance abuse treatment success are:

- Access to treatment
- Amount of time in treatment
- Having a range of services to meet the differing needs of individuals
- Balance of rewards and sanctions
- Monitoring of drug use
- Coordination of services among various professionals
- Continual updating of treatment plan

In terms of access to treatment, most prisons do not provide the recommended services. According to an article in the Journal of the American Medical Association, 80% to 85% of prisoners who could benefit from substance abuse treatment in prisons do not receive it.[81] Despite the preponderance of evidence showing that treatment reduces drug use and drug-related crime, the U.S. Office of Justice Assistance notes that only 15% of state prisoners receive treatment while incarcerated.[82]

> *Substance abuse is an illness. How do you address an illness with incarceration? It's nonsensical.*
> *– Formerly incarcerated focus group participant*

Only 61% of state prisons even provide substance abuse treatment, according to the US Substance Abuse and Mental Health Services Administration.[83] In focus groups with those who had been incarcerated in Wisconsin, many participants noted long wait lists for drug treatment. One man said: "You get sent back say for 18 months – the wait list for treatment is so long you don't receive treatments. By the time you get in through the wait list, your sentence is up so you don't get the treatment."

Problem solving courts, however, do provide access to services. One of the primary goals of drug treatment or OWI court is to provide all participants access to substance abuse treatment services. Mental health courts also provide substance abuse services, given their origin in the drug court treatment model and the high preponderance of co-occurring substance and mental disorders.

The main issue in treatment courts with access to treatment is that there are not enough open slots for all who could benefit. As one formerly incarcerated focus group participant put it, "Treatment courts are not the only alternative, but it's damn close because they don't have money in prison system to provide drug and alcohol treatment for individuals who need it. There's a three year waiting list to get into treatment in the prison system."

In terms of providing a range of services, drug education – not drug treatment – is the most common service provided to prisoners with substance abuse problems.[85] [86] One review found that substance abuse education and awareness is the most prevalent form of substance abuse service in prisons, offered in 74% of state prisons. Group counseling was offered at 55% of prisons. About one in three offenders participated in self-help, peer counseling, or education/ awareness programs.

With the prison treatment program I learned how to deal with the behavior when I want to get high, but I never got to the serious issues of why I want to get high. If you don't deal with that you will never stop wanting to get high.
– Formerly incarcerated focus group participant

These substance abuse education and low-intensity group counseling treatment services are offered to a relatively small number of the 8 million adults involved in the correctional system.[88] Even the federal agency overseeing standards and practice in substance abuse points out that this will not address the needs of offenders, who are four times more likely to have a dependence problem then the general population. [89]

Problem solving courts, on the other hand, do provide a range of services. These services include group and individual counseling; peer support groups (NA, AA, etc); drug/alcohol counseling; treatment through a series of phases; education and employment services; referrals to health care practitioners; and medication for drug or alcohol aversion or withdrawal.

While access to treatment and a range of treatments in prison is limited, prisons have made significant progress in terms of time in treatment with nearly two-thirds of prisons reporting their drug treatment services lasting for 90 days or longer. Length of treatment is a well-documented and important factor in recovery success.[91]

Drug courts, in contrast, are six times more likely to keep offenders in treatment long enough for them to get better.[92] One drug court evaluation found that the amount of treatment received and participation in more services were related to lower recidivism.[93] A length of stay of at least one year in a treatment court has been related to lower correctional costs through reduced recidivism, and greater lengths of stay in drug courts have been associated with better outcomes.[94] [95]

THE WISCONSIN CONTEXT: SUBSTANCE ABUSE TREATMENT

The state's 2011 TAD Program Evaluation[96] examined a range of programs being considered as models for increased funding.

Range of services. All of the TAD sites utilized five of the most commonly recognized evidence-based practices for substance abuse treatment: cognitive behavioral treatment; motivational interviewing; relapse prevention; social skills training; and use of a valid criminal risk assessment instrument. TAD projects also provide mental health services for those with co-occurring substance abuse and mental health issues, including: mental health assessment; psychological testing; outpatient and inpatient services; medication management, and linkages to aftercare.[97] Some drug treatment courts also offer access to medication treatment for substance abuse, such as Vivitrol or Antabuse.

Time in treatment. TAD program participants had an average length of stay of just over 6 months. For drug courts, the average length of stay was almost 10 months. For those who actually completed the drug court program, the average stay was a little over one year. These tenures are significantly longer than prisons, who reported their drug treatment services lasting for 90 days or longer.

MENTAL HEALTH TREATMENT

The National Alliance for the Mentally Ill lists pillars of quality mental health systems, the Substance Abuse and Mental Health Services Administration details fundamental components of recovery, and the National Center on Correctional Health Care has identified the necessary components of mental health care inside correctional settings. The standards can be summarized as having enough appropriately trained staff; providing screening; providing timely delivery of services; a full range of treatment options that incorporates the mind, body, family, community, and support systems; safe and respectful treatment environments; and creating individualized treatment plans in which the individual is empowered to take part in decision-making (For details, see Appendix 4).

Most prisons and jails fail to conform to nationally accepted guidelines of mental health screening and treatment. Specifically, 17% of prisons do not provide recommended intake screening for mental illness; the same percentage do not provide recommended mental health evaluations.[100] Mental health interventions in the criminal justice system are at times unavailable, and of more concern, of inadequate quality.[101]

While almost all prisons reported that they offer mental health assessments and 96% offer mental health counseling, only 87% and 59% of the prison population state that they have access to these services, respectively.[102] The quality of services is often also far below national standards and non-medical staff are unprepared to respond adequately to psychiatric crises. Discharge planning is one of the most critical but least frequently provided mental health services in criminal justice settings, and there are inadequate aftercare services and poor connections to existing treatment for mentally ill offenders released from prison. [103]

Relative to the number of prisoners needing help, Human Rights Watch has determined that often there are often an insufficient number of qualified staff, too few specialized facilities and few programs. Prisons acknowledge this: 22 of 40 state correctional systems reported in a survey that they did not have an adequate mental health staff.[104]

Even the most healthy people would be depressed in jail.
– Treatment court judge

Human Rights Watch conducted extensive research into mental health treatment in prisons across the country and determined that no prison system provides all of the components of the National Commission on Correctional Health Care guidelines. Human Rights Watch said: "Many have developed protocols and policies but implementation often lags far behind and appropriate services are not available for all the prisoners who need them." The national commission itself has only accredited 231 of the country's 1,400 prisons.[105]

Problem solving courts provide a range of therapeutic services including individual counseling, group counseling, peer support groups, case management, and linkages to medical and psychiatric treatment. The Department of Justice Office of Justice Programs conducted a survey of treatment services in adult drug courts and found that while mental health treatment was listed as a "support service" as opposed to a primary service, 91% of drug courts provided mental health treatment and 96% had the capacity to refer to mental health treatment. [106]

THE WISCONSIN CONTEXT: MENTAL HEALTH TREATMENT

In the TAD programs, 17% of those participating in drug court or diversion programs received mental health outpatient treatment. Drug courts provided more services; 31% of those participating in drug courts received outpatient treatment where only 14% of those in diversion programs did.

Several treatment court judges in Wisconsin noted a gap in services in drug courts for those suffering from mental health issues. As one said, "We need to do more in terms of mental health – there's not enough available to help people in our treatment court." Another noted, "We had some people with co issues (mental health and addiction). We in the problem solving courts aren't doing a good job at helping those folks."

In focus groups with drug court treatment providers, they definitely felt that at times their ability to be counselors was subsumed by the need for case management. While support and services are offered in drug courts by trained professionals they are not as specialized or even in the quantity needed.

RELAPSE, SUBSTANCE ABUSE RECOVERY AND ABILITY TO MANAGE MENTAL HEALTH

Drug treatment works. A meta-analysis of 78 studies of general drug treatment provision showed a 36% higher chance of decreased drug use for those in drug treatment as compared to no treatment or minimal treatment. Authors calculated that drug treatment programs had a 57% success rate vs. the no treatment/minimal treatment comparison groups with a 42% success rate. [107]

Studies of recovery from substance abuse were scarce for both incarceration and problem solving courts. Most researchers and funders are interested in whether programs have any impact on future crime and do not measure the intermediate outcome of being able to live without drugs or alcohol.

> *At first I thought (drug court) it was a piece of crap. But now I stand here in front of my peers, and see people who care about my recovery, really care, and they really saved my life. If I didn't go to the drug treatment court, I would have ended up dead somewhere when I got out of prison.*
> *– Drug court graduate*

A meta-analysis of 66 evaluations of incarceration-based drug treatment programs found only therapeutic community intervention was effective in reducing post-release drug use – not residential treatment, group counseling, narcotic maintenance in prison or boot camps. [108] In measures of post-release drug use, people were 28% more likely to abstain from drug use post-release if they participated in the prison-based programs vs. no treatment during prison, however the finding was not statistically significant.[109] More recent studies of prison-based substance abuse interventions such as motivational interviewing[110], opioid substitution[111], and therapeutic communities[112] show support for their success, but as noted earlier most prisons have only fair to inadequate implementation of such programming. In another study considering drug use after prison without prison treatment, 57% reported using marijuana post release, 69% reported heavy alcohol consumption, 31% reported using other drugs, and 3% injected drugs[113]. Wisconsin was one of three states participating in this study.

Another indicator of substance abuse after prison is death from overdose. Many studies have documented increased risk of fatal overdose upon release from prison.[114] Specifically, there is a three- to eight-fold increased risk of drug-related death in the first two weeks after release from prison compared with the subsequent 10 weeks.[115]

The few evaluations of problem solving courts that measure substance use show better results for drug court participants than for those who have been arrested for similar crimes and gone through more typical criminal justice processes. The national Multi-Site Drug Court Evaluation found that drug court participants were significantly less likely to relapse than comparison groups, which included those on standard parole, in court-mandated treatment, and overall programs for offenders that were not drug courts.

- 56% of drug court participants vs. 76% of controls self-reported use of all drugs 18 months after their baseline assessment.
- 41% vs. 58% self-reported use of "serious drugs" (not marijuana or light alcohol use)
- 29% of drug court participants vs. 46% of controls tested positive for drugs on oral fluids test
- Drug court participants who report using drugs use report using them less frequently.[116]

This evaluation looked not just at if participants used drugs, but how often. Researchers found that 18 months after participation, the average number of days of use for drug court participants was lower, at 2.1 days per month vs. the comparison group's 4.8. The evaluation also found the drug court participants used less per month, used for fewer months, and used less serious drugs.[117]

One study in New York City shed light on a number of relapse-related measures, highlighting that Brooklyn Treatment Court participants outperform comparison group participants on the number of days experiencing substance abuse problems and the amount of money spent on drugs (Table 5). And a randomized controlled trial in Baltimore showed that drug court cases used fewer different types of drugs than did controls, scored lower on the alcohol addiction severity scale, and had fewer days of cocaine use. [118]

Table 4. Self-reported Problems From Substance Abuse in 30 days prior to Follow up (Group Means)

	BTC (n=110)	Comparison (n=26)
Number of days experiencing alcohol problems	0.29	1.61
Money spent on alcohol	$1.80	$5.55
Troubled by alcohol problems	5%	23%
Number of days experiencing drug problems	2.33	2.19
Money spent on drug	$41.10	$52.90
Troubled by drug problems	23%	39%

Source: Harrell A, Roman J, Sack E. 2001. Drug court services for female offenders, 1996-1999: Evaluation of the Brooklyn Treatment Court. Urban Institute Justice Policy Center.

Few studies measure alcohol abuse relapse in OWI courts. The limited available findings show that alcohol courts are effective at reducing recidivism, which can be used as a proxy for relapse.[120] [121] One of the most cited evaluations found greater declines in measures of alcohol use among participants in alcohol courts, however, there were increases in binge drinking.[122]

MENTAL HEALTH OUTCOMES AFTER PRISON

Many studies highlight that former prisoners with mental health issues continue to struggle upon release. One study considered short-term outcomes of offenders with mental illness three months after their release from jail or prison. Of the offenders who were followed, 63% engaged remained out of prison and out of the hospital, 20% were hospitalized, and 17% returned to prison.[123]

Former prisoners who participated in our focus groups said the experience of being in prison creates negative mental health impacts that continue upon release. One participant stated, "The stress and depression of being in prison can get very emotional." Another talked about bringing that pain with him when he left: "The stress, mental and emotional parts, can be very damaging, and we bring those issues to our communities and families when we exit, in ways they aren't able to address. For those of us who are low income and can't get medical treatment, those things explode." As one treatment court judge said, "Even the most healthy people would be depressed in jail. You're with scary people, under surveillance all the time, with very, very restrictive rules."

Many participants also described the overuse and inadequate supervision of medication for psychological issues.

- "They put me on a medication that you're supposed to be on for 90 days max; I was on it for two years. They were mentally subduing people."
- "They put you on medication for security and control. If they put you on medication and you don't take it, you have to go to seg [segregation]."
- "I told the doctor I was depressed and he gave me a dose. . . . he would double the dose and whoa, I'm a recovering addict, I don't want to get dosed. I just need balance. They don't give you the reason they give you prescription drugs, they just give them to you."

MENTAL HEALTH OUTCOMES AFTER PROBLEM SOLVING COURTS

In assessing mental health outcomes, we considered mental health courts as well as drug treatment courts. Mental health courts are slightly different than drug courts in that they focus on a primary diagnosis of the mental illness that caused crime. Mental health courts measure mental health outcomes according to a variety of indicators.

- Significantly fewer psychiatric hospitalization days in the year after graduation than the year before enrollment. One evaluation showed that 50% had been hospitalized in the year before enrollment vs. 19% in the year after enrollment.[124] [125]

- Significantly fewer inpatient treatment days in the year after mental health court (37)n than the year before (145), and more outpatient service days in the year after mental health court (48) vs. before (24).[127]
- Length of stay in the hospital declined by an average of 2.5 days vs. the comparison group, where length of stay increased by 3.4 days. [128]
- Increase in the use of mental health services with a dramatic decrease in jail time, resulting in cost savings.[129]

Drug courts and alcohol courts also include mental health services, but with less intention and regularity. Studies of drug courts report a range of 20% to 57% of participants needing mental health services upon admission. Implementation of mental health services in drug courts has been slow and sporadic, with only 58% of participants having specialized mental health treatment services available.[130] Notably, drug court participants with mental health problems are less likely to successfully complete the drug court program. [131]

THE WISCONSIN CONTEXT: RELAPSE, RECOVERY, AND ABILITY TO MANAGE MENTAL HEALTH

During the course of the TAD programs between 2007 and 2010, 86% of those in treatment courts had negative urinalysis tests and 95% had negative breath analysis tests. If looking at both treatment courts and diversion programs together, 96% of urine and 98% of breath tests were negative for substance use.[132]

Staff at TAD programs also rated the emotional stability of participants upon discharge and found that 72% were stable or somewhat stable upon release, and 27% were somewhat unstable or unstable.

Eau Claire Mental Health Court evaluated several outcomes and determined that mental health court participants "enjoyed marked improvement" in symptom control and substance use/abuse.[133] The LaCrosse County OWI court found that only 9% of alcohol tests were positive over the course of three and a half years of data collection.[134]
Similarly, in the Bureau of Justice Assistance-funded evaluation of the Waukesha County Alcohol Treatment Court, only 9% of participants tested positive at least one time for alcohol use during the program.

Keeping in mind that the TAD programs that were evaluated by the Office of Justice Assistance did not include mental health courts, but only drug courts and diversion programs dealing with substance abuse, the TAD evaluation found that 18% of participants were diagnosed with mental health disorders. The most common were depression and ADHD, although there were more severe diagnoses as well. Nearly one-third of treatment court participants and 14% of diversion program participants received mental health outpatient treatment as part of TAD project services.

PHYSICAL HEALTH OUTCOMES

There are many additional health risks faced by those with substance abuse and mental health issues.

Fatal overdose. Substance abusers, understandably, have a higher incidence of drug overdose than the general population. In samples of drug users, studies have found the lifetime prevalence of overdose among drug users ranges from 13% to 69%.[135] Some studies looking at overdose in the general population suggest that a period of abstinence from drugs may increase the risk of fatal overdose.[136] Researchers posit that forced abstinence from drugs during prison decreases the body's tolerance, leaving users highly susceptible to overdose upon release. In fact, a meta-analysis of studies on overdose in ex-prisoners showed that there is a three- to eight-fold increased risk of death from drug overdose for individuals released from prison in the first two weeks of release compared to later on (measured up to 12 weeks).[137] Failure to receive treatment on release increases risk of relapse and also risk of death due to overdose.[138]

With regard to fatal overdose and drug treatment courts, the randomized controlled evaluation of the Baltimore drug court found that 6.5% of participants in the drug court vs. 7.3% of those in the control group (felons going through the traditional criminal justice system) had died three years after release. The major cause of death by medical examiner report was overdose. [139]

Suicide. Suicide attempts are relatively common among those with recent arrests (2.3%) compared to the general US population (0.4%), with the highest prevalence among males aged 25-34 with multiple recent arrests (5.7%).[140] Alcohol use disorders are associated with anywhere from 4.8 to 6.5 times greater odds for a lifetime suicide attempt and those with drug use disorders have 5.8 times greater odds of a lifetime suicide attempt.[141] This same meta-analysis reported studies showing that between 32% and 47% of drug users had attempted suicide in the past. Also, recently released prisoners are at higher risk for suicide than individuals in the general population.[142] With regard to those dealing with mental health issues, those who are mentally ill and incarcerated are at increased risk for suicide and victimization.[143]

Fatal auto accidents. Consumption of too much alcohol is a risk factor for a number of adverse health outcomes – for example, approximately 80,000 deaths annually are attributed to excessive drinking. It is the third leading lifestyle-related cause of death for people in the United States each year.[144] There is a strong association between alcohol consumption and alcohol-impaired driving, with alcohol-related motor vehicle crashes making up a significant portion of alcohol-related deaths. [145] Alcohol-impaired driving was linked to 40% of all traffic fatalities in the United States in 2003,[146] and in 2008, almost 12,000 people across the country were killed in alcohol-related crashes, which accounted for one-third of all highway deaths for that year.[146]

Wisconsin has particular reason for concern with regard to driving under the influence. Wisconsin ranks first among states for the highest rates of driving under the influence of alcohol. Also, more than 1 out of 4 adults in Wisconsin have driven under the influence of alcohol, compared to 15% nationally, and Wisconsin is in the top one-third of states for having the highest proportion of alcohol-related fatal crashes.[147]

Infectious disease. People entering prison have high rates of certain infectious diseases. In particular, drug-using offenders are at high risk for HIV and hepatitis C.[148] Studies show higher rates of hepatitis B than in the general population, hepatitis C rates that are nine to ten times higher, HIV rates that are four times higher, and that the proportion of those with sexually transmitted infections in prisons or jails is as high as 35%.[149] Unfortunately, there are no studies that consider the risk of contracting these illnesses while in prison. Heightened rates of these diseases are conflated with the pre-prison behaviors that led to them: injection drug and other drug abuse, alcohol abuse, and risky sexual behavior.

Drug use, and in particular injection drug use, is a major risk factor for hepatitis C, HIV, and tuberculosis transmission.[150] [151] [152] [153] In a study of hepatitis C rates in homeless adults, one of the major predictors of having hepatitis C was if they had had a prison stay, independent of if they had injected drugs.[154]

FINDINGS: CRIME AND SAFETY

KEY FINDINGS

- Crime rates in Wisconsin and nationwide have been decreasing and some of the decline has been attributed to an increase in the use of problem solving courts.
- 47% of those in prison committed non-violent offenses. Of those in prison, 72% of those with substance abuse issues and 39% of those with mental health issues commit non-violent crimes.
- Higher incarceration rates may lead to lower crime rates up to a certain point, after which higher incarceration leads to higher recidivism.
- In Wisconsin, 46% of offenders return to prison within 3 years. Of TAD participants, 19% of those who completed the program returned to prison in under two years.
- OWI courts are effective in lowering recidivism rates of driving and drinking.

CRIME RATES

Crimes are categorized as violent or property crimes. Violent crime, according to the Uniform Crime Reporting program from the FBI, is composed of murder, forcible rape, robbery, and aggravated assault. Nationwide, in 2009 approximately 53% of state prisoners were sentenced for violent offenses.[155] 2010 marked the fifth consecutive year of decline of violent crime across the country, with a violent crime rate of 404 per 100,000.[156]

Property crime is composed of theft, motor vehicle theft, arson and burglary where the object is taking money or property without threat of force. In 2009, about 19% of state prisoners were sentenced for property offenses.[157] In 2010 the property crime rate was 2,942 per 100,000, the ninth consecutive year of decline.[158]

The Wisconsin TAD programs, like drug courts and other problem solving courts across the country, only offer admission to those who did not commit a dangerous or harmful offense. An important part of alternatives to incarceration in Wisconsin and elsewhere is thorough screening for those who are not a danger to the health and well-being of society. Judges do not admit offenders to TAD programs if they have committed a violent crime that has resulted in harm to someone. According to the Bureau of Justice Statistics, 47% of those in state prison commit non-violent offenses; the number is higher for those in county jails.[159]

While the FBI does not report drug-related crimes, they do report arrests due to drug abuse violations. In 2009, about 18% of U.S. prisoners were sentenced for drug-related offenses,[160] and in 2010, 13% of total arrests were directly due to drug abuse violations.[161] In Wisconsin, an increase in drug offenders accounted for more than 20% of the growth in incarceration from 1996 to 2006, and OWI offenders were responsible for more than 60% of the growth from 2001 to 2006.[162]

Many people who commit non-violent crimes have substance abuse and mental health issues. By report of the Substance Abuse and Mental Health Services Commission we know that 60% and 50% of inmates have a substance abuse or mental health issue, respectively,[164] and that 33% of all inmates have co-occurring disorders.[165] Meanwhile, 72% of those with substance abuse issues[166] and 39% of those with mental health issues [167] commit non-violent crimes.

Incarceration can reduce crime by taking criminals out of society. Many studies have looked at the impact of incarceration on crime rates. A meta-analysis showed that for every 10% increase in the rate of incarceration, different studies have associated between a 0.5% drop in crime and a 9% decrease in crime. This wide range of estimates is due in part to methodological and logical limitations of the studies, but more recent studies with complete

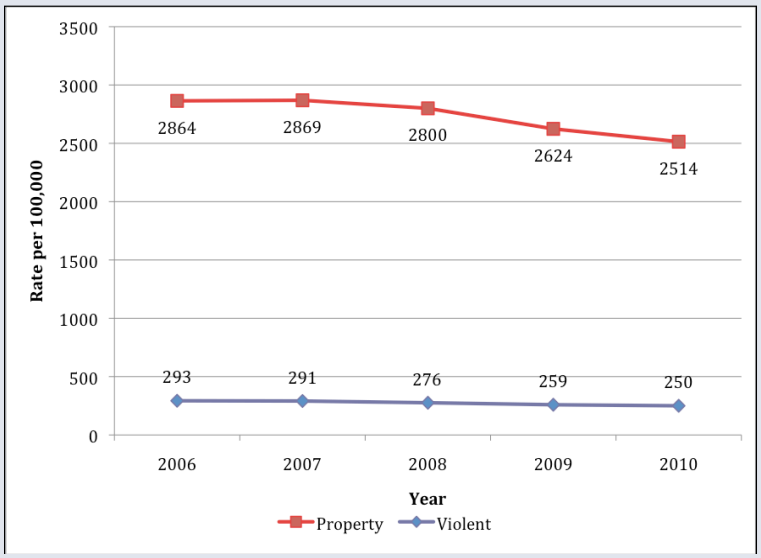
data sets and more reliable methods tend to show smaller effects. In addition, there is a general belief that the impact of higher rates of imprisonment on crime rates is becoming smaller and smaller – that is, that building more prisons at this point will have a negligible effect on crime. [169]

High rates of incarceration in a neighborhood can actually worsen crime. Several studies show that while removing people from a neighborhood to go to prison has a small effect on crime at low levels of removal, as the number of residents removed gets higher, crime actually *rises* in the following year. This has been empirically tested in eight epidemiological studies, even when controlling for various factors such as neighborhood-level poverty, reentry rates, and violent crime the prior year. One explanation for this is that willingness of residents to engage in informal social control, or community self-policing, declines. Also, offenders build relationships with highly criminally active peer groups, and many offenders return to the same neighborhoods. This may permanently alter their future in terms of criminal trajectory, making it more likely that they will recidivate.[172]

THE WISCONSIN CONTEXT: CRIME

Wisconsin's violent and property crime rates have been decreasing for a number of years. Figure 2 shows the trend of these crime rates from 2005 to 2010.

Figure 2. Property and Violent Crime Rates in Wisconsin, 2005-2010



Source: Crime in Wisconsin 2010. Wisconsin Office of Justice Assistance Statistical Analysis Center. 2011. oja.wi.gov/docview.asp?docid=21985&locid=97.

In 2010, Wisconsin as a whole had lower violent and property crime rates compared to the nation, but Milwaukee County had a violent crime rate that was 79% higher that of the nation, and a property crime rate that was 59% higher than the US. A disproportionate share of the state's violent crime takes place in Milwaukee: in 2007, although 16% of the state population lived in Milwaukee, the city reported over half (55%) of the state's violent crime.[174]

In Wisconsin, the rate of violent crime decreased by 3.5% from 2009 to 2010, a decline from 259 to 250 violent crimes per 100,000 residents. In 2010, there were 14,120 violent crimes throughout the state.[175] The rate of property crime decreased during the same time by 4.2%, from a rate of 2,624 down to 2,514 property crimes per 100,000 residents. In 2010, there were 142,187 property crimes throughout the state. [176]

Table 5. Crime Rates in the United States, Wisconsin and Milwaukee 2010

Place	Violent Crime Rate per 100,000	Property Crime Rate per 100,000
United States	404	2,942
Wisconsin	249	2,508
Milwaukee County	724	4,675

Crime in Milwaukee has also decreased by 23% since 2007, the year TAD programs went into effect. Specifically, homicide and rape have decreased between 4% and 6%, aggravated assaults by 27%, and theft and auto theft between 17% and 27%. There was an 8% increase in robbery in 2011 from 2010, although it gradually declined in 2012.[178]

Most notably, Milwaukee experienced a significant 14% decline in inmate population at the county jail and County Correctional Facility-South between 2008 and 2010.[179] Although no one is certain about the cause of the decline, many have attributed it to lower crime rates, better policing, a standardized inmate screening program and better diversion programs, such as TAD.

In addition, focus group respondents supported the effectiveness of alternatives to incarceration. Respondents generally asserted that incarceration does not work to reduce crime, and many said that prison makes offenders come out worse than when they entered. One participant said: "Everyone wants a safe community but the person going to prison doesn't change – a person going to prison changes, but not for the better."

RECIDIVISM

A 2011 report released by the Pew Center on the States revealed that 46% of those released in 2004 across the country returned to prison within three years.[180] Continuous cycles of incarceration, release, and return to prison take a toll on the physical, mental, and emotional health of offenders and the communities from which they are removed. In the criminal justice system, recidivism can mean re-arrest, re-conviction, or re-incarceration.

RECIDIVISM AFTER PRISON

The most recent Department of Justice's Bureau of Justice Statistics report on recidivism, published in 2002, found that 52% of offenders were back in prison by the end of the 3-year study period [181] [182] (Table 7). A more comprehensive study released in 2011 revealed that 46% of those released in 2004 returned to prison within three years.[183] Both reports' figures include those who either committed a new crime or violated the terms of their original release.[184] Each state has very different rates for incarcerating people for technical violations of their parole or supervision. (See The Wisconsin Context: Recidivism, below). Recidivism rates are generally higher among inmates who committed a nonviolent crime.

We come out the (prison) door with no job, no opportunities, and nothing to look forward to. So (ex-prisoners) go back to the only thing they know how to do.
– Formerly Incarcerated Participant in Focus Group

Table 6. National Recidivism Rates for Prisoners Who Were Released in 1994, By Most Serious Offense for Which They Were Released

Most serious offense for which released	Percent of all released prisoners	Percent of released prisoners who returned to prison with or without a new prison sentence within 3 years
All released prisoners	100%	52%
Violent Offenses	23%	49%
Property Offenses	34%	56%
Drug offenses	33%	50%
Possession	8%	43%
Trafficking	20%	46%
Other/unspecified	5%	72%
Public-order offenses	10%	48%
Weapons	3%	56%
Driving under the influence	3%	44%
Other public-order	3%	44%
Other offenses	2%	67%

Source: Langan PA, Levin DJ. Recidivism of Prisoners Released in 1994. United States Department of Justice Office of Justice Programs Bureau of Justice Statistics. 2002. http://bjs.ojp.usdoj.gov/content/pub/pdf/rpr94.pdf

According to the Bureau of Justice Statistics report, rates of return to prison with or without a new prison sentence was higher among men compared to women (53% versus 39%), among blacks compared to whites (54% versus 50%), and among non-Hispanics compared to Hispanics (57% versus 52%). [186]

Simple recidivism rates among racial and ethnic groups do not tell the whole story, though. A more detailed study showed that while Hispanic recidivism rates fell between those of whites (lowest recidivism) and blacks (highest recidivism), Hispanic rearrest and reconviction rates were closer to those of whites, but they were reincarcerated at rates that were closer to blacks. Therefore, Hispanics received harsher punishments than similarly arrested whites and blacks. [187]

Incarceration has been found to actually increase recidivism when compared to recidivism-reduction programs such as drug courts and state sentencing and corrections policy reform.[188] This was supported in a focus group of judges in Wisconsin, where participants said things like, "Going in and coming out of prisons, they are going to be better trained criminals," and "Incarceration is ineffective except in controlling people. It increases risk rather than reducing risk by putting people together who negatively infect one another. Bad people infect good people more than good people infect bad people."

In addition, incarceration impairs people's ability to obtain jobs, join the military, and as one judge said in a focus group, "It doesn't change criminogenic elements of people's lives," including factors like substance abuse and untreated mental illness. In a study of prison-based substance abuse treatment in California, psychological impairment was the strongest predictor of recidivism for both men and women.[189] Once released, if the ex-offenders cannot get support or treatment services, they are much more likely to return to their old behaviors—the same ones that got them into prison in the first place.

RECIDIVISM AFTER PROBLEM SOLVING COURTS AND DIVERSION PROGRAMS

The expanse of data from drug court evaluations clearly show drug courts have a better success rate at preventing recidivism than incarceration. In 2011 the General Accounting Office did a review of drug court evaluations and found that, across the board, drug courts show reduced recidivism for program completers versus comparison groups drawn from the criminal court system. Drug court program completers were re-arrested in a range of 12 to 58 percentage points below the rate of their comparison groups, with an average of 16% lower re-arrest rates three years out. Keep in mind that these drug court evaluations measured re-arrest; rates of conviction would be lower. In an 18-month post-drug court interview of participants, 40% reported that they committed crimes compared to 53% of the comparison group.[191] Finally, another rigorous systematic statistical meta-analysis of effect sizes also averaged multiple drug court evaluations and found a 12% average difference between recidivism rates of drug court participants and matched non-participants.[192]

Studies on mental health courts have shown them to be effective at reducing the rates of recidivism among those that have mental illness. For example, in an evaluation of mental health courts in Clark County, Washington, in the year prior to participation in the mental health court, 26% were frequent offenders; in the year after mental health court, 54% remained arrest-free with only 3% counting as frequent offenders.[193] Given the chronic nature of severe mental illness, continued support, in the form of treatment and service following the completion of the mental health court program, is necessary to maintain reduced recidivism.[194]

From studies on OWI courts, participants recidivated at lower rates than their comparison groups. In a 2006 DUI court evaluation in Oregon, those who went through DUI court had nearly half the recidivism rate compared to those that did not (10% compared to 18%).[195] A 2009 study looked at recidivism rates for offenders in Idaho over a 4.5-year period, and found that those incarcerated but not participating in OWI courts were 60% more likely to recidivate compared to those that did go through OWI courts.[196] (For details see Appendix 5).

Problem solving courts were also favored by participants in our focus groups. One former prisoner said, "Treatment works if it's done well, if it's more personalized." A judge said, "Right off the bat with our problem solving courts we were able to show that if we kept someone out of jail, it was very beneficial and more cost effective. People get jobs, they end up sober, taking care of families, they end up being mentors for others going through the system." Problem solving courts can be an effective way to reduce recidivism rates by giving ex-offenders resources and support to succeed outside of prison.

In addition to drug, mental health and OWI courts, there are other variations on the drug court model such as Veteran's Courts and Family Courts. There are developments in pre-adjudication diversion programs, where low-to medium-risk offenders, who are non-violent, are diverted into case management and treatment services instead of undergoing a trial and sentencing. If the offenders are successful at completing the treatment services, no charges are filed. A survey conducted by the National Association of Pretrial Services Agencies[197] of 69 diversion programs in 26 states found that the median recidivism rates were 5% for new felonies, 12% for new misdemeanors, and 1% for new serious traffic offenses. The periods that respondents tracked new convictions following program completion varied greatly, from one to five years.[198] Difficulties tracking the success of diversion programs include the lack of data collection, lack of comparable data between programs, and vast differences in types of diversion programs as well as implementation across sites.

THE WISCONSIN CONTEXT: RECIDIVISM FROM PRISON AND PROBLEM SOLVING COURTS

According to the most recent study, looking at offenders who were released in 1999 and 2004 in states across the nation, around 46% of those released in both cohorts in Wisconsin returned to prison within three years of initial release. Compared to the other states in the sample, Wisconsin's recidivism rate was on the higher end of the spectrum.

Between the 1999 and 2004 cohorts, the state's recidivism only decreased by 0.2%. For Wisconsin, 25% of those that recidivated did so due to new crimes committed, while 21% recidivated due to technical violations of supervision.[199] A separate report using data from the state Department of Corrections stated that about 38% of those released from prison are convicted for a new offense within 3 years.[200]

Recidivism in Wisconsin for participants of problem solving courts has been studied in several evaluations, most comprehensively and recently in the state-funded TAD evaluation from December of 2011. That study found that out of all TAD participants, 76% were not convicted of a new crime, and 88% did not return to state prison after program participation. TAD completion played a large role; only 19% of TAD graduates had been convicted of a new crime within 3 years of discharge. TAD graduates were also nine times less likely to be admitted to state prisons compared to those that terminated the program.

A drug court evaluation in Dane County found that 30% of the drug court participants in the sample committed a new crime compared to 46% of the comparison group, who were eligible for drug court participation but underwent typical adjudication.[201]

Two counties in Wisconsin completed evaluations on OWI courts. In La Crosse County, only 4% of OWI court graduates were rearrested. Also, since the OWI court started operation, the county saw a 47% reduction in the number of third-time OWI offenses, and a 24% decrease in OWI convictions. Meanwhile, a 2009 Waukesha County Alcohol Treatment Court evaluation found that 29% of the group recidivated in 2 years after the program compared to 45% of the controls.[202]

Nineteen percent of offenders graduating from diversion programs were reconvicted of a new offense after graduating, whereas between 14% to 25% of participants at the same risk levels were reconvicted of new crimes after graduating from treatment courts. [203]

INJURIES AND FATALITIES FROM CRIME

Only people who have committed a non-violent offense are eligible for problem solving courts, which by definition means there have been no injuries or fatalities. However, for those who recidivate, the second and third crimes can escalate in severity. Of the nonviolent prisoners released from 15 states in 1994, about 1 in 5 were rearrested for a violent crime within 3 years of discharge.[204] Also, nonviolent offenders who are exposed to more violent offenders in higher-security federal prisons tend to recidivate at higher rates compared to nonviolent offenders in lower-security prisons.[205]

Mortality and injury rates can be difficult to obtain for rape, robbery, and aggravated assault because victim outcomes are not typically reported by national criminal incident databases. However, in 2010, there were 18.7 million violent and property crime victims among US residents; 3.8 million were victims of violent crimes.[206] Because "victims" includes all people who have had a crime perpetrated upon them, whether or not they were physically harmed, the number of victimizations is not necessarily equal to the number of people who are injured every year. However, the Bureau of Justice Statistics conducts a National Crime Victimization Survey, and they found that in an average year, about 20% of the victims of violent crime in the United States were injured. Using this estimate would lead to a figure of about 760,000 injuries from violent crime in 2010. The young, those with lower household incomes, blacks, Native Americans and Hispanics were more likely to be victimized and were more likely to be injured than others. Meanwhile, injury rates were lower among the elderly, persons with higher incomes and better-educated persons.

When the crime involves a violent act, such as homicide, the rates do not take into account the possibility of multiple persons killed or injured, which means these rates are underestimates of actual mortality and morbidity rates. Also, many types of crimes are dramatically underreported to law enforcement agencies, such as rape and domestic violence, which further inhibits the ability to obtain an accurate injury, and to a lesser extent, death count.

Drug offenders are responsible for 1 in 25 homicides, but these offenders would not be eligible for inclusion in problem solving courts. Even so, homicide is consistently among the top 5 causes of death for persons younger than 35, and the homicide rate in the United States was 4.8 per 100,000 in 2010. Homicide victims represent the smallest proportion of violent crime victims. Nationally, for every 1,000 violent crimes, 2 are homicides.

Data is limited on the actual number of fatalities due to homicide. In the United States in 2008, the overall number of deaths from firearms was 10 per 100,000. When broken out by racial/ethnic groups, whites suffered 9 deaths per 100,000 due to firearms, blacks suffered 18 per 100,000, and other racial groups suffered 4 per 100,000.

THE WISCONSIN CONTEXT: INJURIES AND FATALITIES FROM CRIME

In Wisconsin in 2008, there were 160 violent deaths homicide, a violent death rate of 2.8 per 100,000.[212] There were 105 deaths from homicides by firearms in 2010 in Wisconsin, with a rate of 1.9 deaths per 100,000. There were 54 deaths by homicide from other unspecified means, for a rate of .94 per 100,000.[213] (Table 8).

Table 7. Homicide death rates per 100,000 in the United States, Wisconsin and Milwaukee, 2004 – 2008

Place	2004	2005	2006	2007	2008	All 5 years
United States[1]	5.9	6.1	6.2	6.1	5.9	6.0
Wisconsin[2]	2.87	4.16	3.42	3.44	2.82	3.34
Milwaukee County[2]	10.16	15.22	12.92	12.63	9.07	12.00

[1] *Source:* Centers for Disease Control and Prevention, National Center for Health Statistics. Mortality File 1999-2008 Archive. CDC WONDER Online Database, compiled from Compressed Mortality File 1999-2008 Series 20 No. 2N, 2011. Accessed on Sep 28, 2012. http://wonder.cdc.gov/cmf-icd10-archive2008.html.
[2] *Source:* Wisconsin Interactive Statistics of Health. Last updated on: December 13, 2010. Accessed on August 19, 2012. http://www.dhs.wisconsin.gov/wish/measures/violentdeath/rates-form.htm

In 2010, Wisconsin's assault-related injury hospitalization rate was 21.9 per 100,000, and its assault-related injury emergency room department rate was 269.4 per 100,000.[214]

None of the drug court evaluations researched for this HIA measured actual reduced injury and fatality due to reduced recidivism. However, national evaluations of mental health courts have been found to reduce recidivism rates and offense severity. [215] [216] [217] [218] With regard to Wisconsin, no state-level evaluation measured this outcome. However, in 2012 a University of Wisconsin-Madison La Follette School of Public Policy economics class conducted a cost-benefit analysis forecasting reduced "victimization" from three TAD scenarios: [219] an increase in the number of drug court slots, an increase in the number of diversion slots, or an increased combination of the two types of TAD programs (drug courts and diversion programs) – all at three different funding levels. All of the scenarios of increased TAD funding resulted in reduced victimization, defined as both real financial losses that victims of crime incur from property damage and loss, medical and mental health care expenses due to injury or stress, and intangible impacts from pain, suffering and loss of quality of life. A scale-up of TAD programs at the $20 million level resulted in:

- 987 fewer victimizations if only drug court slots were funded;
- 8,682 fewer victimizations if only diversion program slots were funded;
- 6,751 fewer victimizations if 75% of the slots were diversion and 25% of the slots were drug courts.

This class used a validated methodology developed by the Washington State Institute of Public Policy and upon which criminal justice policy nationwide is based.[202]

HOW ARE STRESS AND CRIME RELATED AT THE COMMUNITY LEVEL?

The atmosphere of fear that comes along with the presence and/or perception of crime can cause elevated stress, anxiety, and other mental health outcomes. One study found that the relationship of fear of crime is significantly correlated to intrusive thoughts, feelings or nightmares; avoidance of experiences associated with the event; and feelings of hypervigilance, irritability, anger, jumpiness, and other arousal when reminded of the event. These responses took place whether or not participants had actually been exposed to crime.[221] Also, people with a strong fear of crime are almost twice as likely to show symptoms of depression as those without a strong fear of crime. Those with a strong fear of crime exercised less, saw friends less often, and participated in fewer social activities compared with less fearful participants.[222]

FINDINGS: FAMILIES AND CHILDREN

KEY FINDINGS

- About 30,000 Wisconsin children, and over 1 million nationwide have a parent in prison.
- Children whose parents are incarcerated are 4-5 times more likely to become foster children.
- Problem solving courts enable parents to work and contribute to a family's economic well-being. Incarceration damages an individual's ability to find a job and be economically self-sufficient.
- In comparison to prisons, problem solving courts provide improved opportunities for parental bonding and attachment with children which supports their emotional and behavioral development and educational success.
- Among boys whose parents were imprisoned before the children were 10, nearly half were convicted of a crime as adults, compared to a quarter of matched boys separated from parents for other reasons.

In 2007, an estimated 800,000 prisoners in the United States were parents of children under the age of 18. These parents reported having over 1.7 million children, or roughly 2.3% of the U.S. population under age 18.[224] This number has been climbing steadily – the growth in the number of parents in prison has outpaced the growth of the overall prison population. In 2008, the U.S. Bureau of Justice Statistics released a report describing key trends related to parents in prison and their minor children, including differences based on race/ethnicity and gender. Key findings include:[225]

- Fifty-three percent of the 1.5 million people held in U.S. prisons are the parents of one or more minor children. In other words, every other person in prison has left children behind.
- One in 15 black children and 1 in 42 Latino children has a parent in prison, compared to 1 in 111 white children.
- Two-thirds of the incarcerated parent population is non-white.

The Wisconsin Context: Parents in Prison and the Children They Leave Behind

In Wisconsin, as in the U.S. nationwide, every other prisoner has children that someone else is caring for. Using Bureau of Justice Statistics figures, we calculated that there are approximately 11,800 prisoners in Wisconsin state prisons who are parents. Of those, 93% are men and about 800 are women.[226]

About 30,000 children in Wisconsin – approximately 2.3% of the total – have a parent in prison. Racial inequities in the incarceration system extend to children as well: 2.4% of Hispanic children and 6.7% of Black children have a parent in prison, as compared to 0.9% of White children.[227]

FAMILY STRUCTURE AND LIVING ARRANGEMENTS

Perhaps the most visible, short-term impact when a parent goes to prison is that children must live in single-parent households, with other relatives or in foster care. Results from the longitudinal Fragile Families studies highlight that children whose parents are incarcerated are approximately 34% less likely to live with married parents and 4-5 times more likely to enter the foster care system.[231] As 92% of state prisoner parents are male,[232] women are disproportionately left to care for children on their own. One study found that the rate of imprisonment and release increased the rate of female-headed households and that going to prison in and of itself substantially reduced the

likelihood of being married.[233] Last, for all races/ethnicities, but in particular for black males, incarceration substantially reduces the likelihood of being married. For black males over age 23, the likelihood of getting married drops by 50% following prison.

Perhaps most significantly, children may permanently lose their parents. One study found that 4.1% of children had a parent in prison were placed in foster care, compared to 1.6% of those who did not have a parent in prison. As noted in the Urban Institute Broken Bonds report, "The 1997 Adoption and Safe Families Act proscribes that the process for termination of parental rights begin when a child has been in foster care for 15 out of the most recent 22 months. Given that . . . the average sentence for an incarcerated parent ranges from 80 to 103 months, many inmates risk losing custody of their children prior to their release, regardless of desire or willingness to parent (Travis, McBride and Solomon 2003)."

If you remove (kids) from their home, risk increases for kids in many ways. Keeping kids with parents, even if they're not the best parents, as long as they are safe – the outcomes are always better to remain with parents.
– Judge participant in focus group

In contrast to being incarcerated, problem solving courts (specifically, family drug courts) provide an alternative approach to maintaining family structure and reducing the risk of children entering the foster care system and the loss of parental rights. Through our focus groups, participants of drug courts and judges detailed how problem solving courts helped participants keep custody of their children through support and advice of peers, as well as through close monitoring by case managers, parole agents, and other treatment team members. One recently released study found that drug court participants report significantly less family conflict than comparison groups.[237] Multiple evaluations of family drug courts and their impacts on children's welfare have also been conducted, and they have found that overall, parents who complete substance abuse treatment are significantly less likely to lose their parental rights and are more likely to be reunified with their children.[238] Their children also spend significantly fewer days in out-of-home foster care.[239]

Participants in our focus groups confirmed the benefits of problem solving courts on family structure. For those who had been in prison, the impact of separation on future relationships with children and trust between family members was pronounced. Parents reported feeling like failures and missing large portions of their children's lives. Most also reported that their children had either cut off all contact for a time, or forever. The relationship between parents and children was strained, with a ready accusation: "Where were you when I needed you?" In contrast, for those in treatment court, separation from families was minimized and relationships were less strained. As one participant stated, "If you're in treatment court, you're seeing your family every day . . . But in prison, it's like me being in Wisconsin and you in Ohio. You're there, I'm here. We don't see each other, and it's hard to make it happen."

I have a 24-year-old daughter who doesn't know who I am. I contacted her when I started getting my life together, and her response to me was 'I don't know you. Where were you for all the birthdays and Christmases?' I don't have a relationship with my child because of incarceration.
– Formerly incarcerated participant in focus group

Judges agreed that problem solving courts promote family unity. One stated: "The structure and accountability [of treatment court] has enhanced the parents' ability to have visitation with kids. When you're clean you can keep your visits with social worker, more stable residence for the kids, you don't have undesirable people there, you have a clean house. All of this helps you get your kids back, and keep them closer." Another said, "For kids, if you remove from then from their home, risk increases for kids in many ways. Keeping kids with parents, even if they're not the best parents, as long as they are safe - the outcomes are always better to remain with parents."

THE WISCONSIN CONTEXT: FAMILY STRUCTURE AND LIVING ARRANGEMENTS

Using Bureau of Justice Statistics data, we estimated that for 84% of parents in Wisconsin state prisons, a non-incarcerated parent is the current caregiver for their children. However, there is a significant disparity in male and female prisoners: Only 37% of female prisoners have a non-incarcerated parent as the current caregiver for their children,

compared to 88 percent of incarcerated men. It is more common for female prisoners to have their children stay with a grandparent (45%) than male prisoners (13%). The disparity is also evident in children in the foster care system: 11% of female prisoners have a child in foster care, but only 2% of male prisoners.

The Wisconsin Department of Children and Families reports that in 2010, 517 children were removed from parental custody to foster homes, group homes, treatment foster homes, or shelter or residential care centers due to the parents' imprisonment. Sixty-two percent of those children were white, 26% were black, and 9% were Native American. Thirty-seven percent of the children removed were age 3 or under, 29% were ages 4–8, and 34% were ages 9-19. The median length of the child's stay in the foster care system was 31 days. [241]

For many mothers, incarceration leaves their children in immediate need of a caretaker. For 77% of female parent prisoners (n=975) in Wisconsin, they provided most of the daily care for their children. [242]

MATERIAL HARDSHIP FOR FAMILIES

Bureau of Justice Statistics data show that more than half of parents in state prison (54% of fathers and 52% of mothers) provided the primary financial support to their children before imprisonment.[243] The Fragile Families studies found that children are 25% more likely to experience material hardship when their father is incarcerated and they are between 11-19% more likely to receive public assistance. [244] One study found that the proportion of children growing up poor increases by 8.5 percentage points and that family income declines by $8,726 in the years that a father is incarcerated when compared to the year prior to incarceration. [246]

Children who experience parental imprisonment also face poor economic futures for themselves. One study looking at outcomes for boys whose parents were imprisoned as they grew up showed that by age 32, over half of these now men had poor life success in comparison to 20% of men who had not experienced parental imprisonment during childhood. "Poor life success" was measured by housing stability, success with children, employment history, fights, substance abuse, anxiety and depression, and criminal convictions. [247]

For those who participate in problem solving courts, research shows that families may experience fewer material hardships. Those who participate in a problem solving court are more likely to be employed and make more money than those who are incarcerated. Participants in our focus groups confirmed these findings. Almost all drug court participants stated that they were either working or in school leading to a vocation, and that the court helped them figure out what they could do or connect them to work. Judges also said that problem solving courts helped participants maintain employment, which then affected mental health, financial stability and standard of living. Finally, TAD evaluation findings found that those completing treatment courts were significantly more likely (36%) than those who dropped out (15%) to have found a job while in TAD.[248]

> *Going to prison did not help me get a job. Prison was a deterrent for trying to get a job. it didn't motivate me. Prison did not give me a productive feeling – it gave me animosity that triggered relapse.*
> *– Formerly incarcerated participant in focus group*

In contrast, former prisoners reported that it was far more difficult for someone with a record to get a job and that the job training programs in prison were ineffective – "not worth the paper the certificate was printed on." Another participant said: "Prison was a deterrent for trying to get a job – it didn't motivate me. Prison did not give me a productive feeling, it gave me animosity that triggered relapse." Judges concurred with this sentiment. One said: "People can't get into military, they can't get into school, and the barriers with housing or employment are huge."

EMOTIONAL AND BEHAVIORAL WELL-BEING OF CHILDREN

Bureau of Justice Statistics data highlight that nationwide more than half of prisoners with children live more than 100 miles from where they lived before prison.[250] Over half of incarcerated parents do not receive any visits from their children during their sentence, and 40% of mothers and 60% of fathers report no weekly contact of any kind. [251] Sixty-three percent of children with mothers in prison did not have secure attachments to their current caregivers.[252]

Research also shows that the younger the separation, the more difficult for the child.[253] As one woman put it, "When my mother was sentenced, I felt that I was sentenced. . . . She was sentenced to prison – to be away from her kids and her family. I was sentenced, as a child, to be without my mother."[254] These insecure attachments have been linked to poorer peer relationships and diminished cognitive abilities [255], and one study found that 70% of young children with incarcerated mothers experienced emotional or psychological problems.[256] Bonding is important not only for the child but also for the parent. Studies of prison visitation by children and family members show that these visits are important to help the offender maintain their identity as a family member and not a criminal.[257]

Research literature also suggests that parental incarceration can generate feelings of shame, grief, guilt, abandonment, and anger, as well as an impaired ability to cope with future stress and trauma among children [258] Studies cited the Broken Bonds report collectively illustrate that "children who have an incarcerated parent also experience a two-fold increase in risk for mental health problems, and higher rates of major depression and attention disorders, than the general population of youth."[260] Another Fragile Families study found that children with incarcerated parents were 44% more likely to display aggressive behavior.[261]

Children of incarcerated parents may also abuse drugs and alcohol at higher rates. Data show that youth with a parent in prison exhibit a compromised sense of self-worth, susceptibility to peer pressure and risky behaviors.[262] Both boys and girls whose fathers served time in prison were more likely to start using illegal drugs earlier, use more drugs, and use them for a longer period of time than youth whose father never went to prison.[263]

In contrast, it appears that there are no studies examining the impacts of parent participation in problem solving courts on their children's emotional, behavioral or substance abuse outcomes. Participants in our focus groups discussed issues related to parental bonding and attachment that are associated with emotional and behavioral well-being among children. For example, multiple participants stated that they felt they missed key moments in their children's lives and felt disconnected from their children upon release. One participant said, "Having been in prison puts distance between me and my kids. Physically I wasn't there and tried to be there through mail, but that's not like being there. Kids don't see you they think that you don't love them. All things go through their minds . . . It's hard to figure out how to mend the bridge and reach them. I want to be there, but what could I do?" Another participant said, "All the things I wanted to do with my kids, teach them to drive, play ball, I missed it, I failed." In contrast, one participant in a drug court stated, "I have been in my daughter's life a lot more than when I was using (drugs) and if I would have gone to prison. Since I have been clean I have been able to be with her, and actually be someone to her."

Judges in the focus groups agreed. One said, "Obviously if you are in jail or prison, at best you'll have your kids come visit every week or two, and in many cases they can't visit in person due to distance or rules. Prison is a horrible place to visit." And another judge stated, "When you see problem solving courts done well, they really bring families together instead of tearing them apart, as incarceration does."

EDUCATIONAL OUTCOMES FOR CHILDREN

Qualitative research shows that youth with a parent incarcerated have a "compromised educational experience" – for example, acting out in school or being stigmatized by other kids.[264] Children of the incarcerated demonstrate below-average academic performance. [265] Children with parents in prison are also significantly more likely to fail in school (45%) than their friends (20%), and are more likely to have dropped out of school (36% compared to 7%).[266] Youth whose fathers are in prison are more likely than other children to be expelled or suspended from school (23% vs. 4%).[267]

CHILDREN'S INVOLVEMENT WITH CRIMINAL JUSTICE SYSTEM

Not surprisingly, material hardship, emotional and behavioral problems and poorer academic performance – all associated with a parent being incarcerated – increase the likelihood of a child's involvement in the criminal justice system. As described in Broken Bonds, "One longitudinal study of English boys found that . . . among boys who experienced parental incarceration before the age of ten, nearly half were convicted of a crime as adults, compared to a quarter of demographically-matched boys who were separated from their parents for other reasons. The difference between the two groups remained significant after controlling for parent criminality and other childhood risk factors. (Table 9).[268 269] Overall, the data illustrate that boys whose fathers are imprisoned during childhood are significantly

more likely to be convicted of a crime and imprisoned when compared to boys who have no separation from their fathers.

Table 8. Parental Incarceration and Association with Son's Outcomes

Son's outcome (age)	No parental imprisonment or separation	Parental imprisonment during childhood	Odds of having problem
Anti-social personality (32)	19%	71%	10.6
Convicted juvenile (10 – 16)	16%	48%	4.9
Convicted (17 – 25)	22%	65%	6.7
Imprisoned by age 40	8%	30%	4.9
Self-reported delinquency (32)	19%	52%	4.8
Self-reported violence (18)	18%	43%	3.4

Source: Adapted from Murray J and Farrington DP. 2005. Parental imprisonment: Effects on boys' antisocial behaviour and delinquency through the life-course. J Child Psychol Psychiatry 46(12):1269-78.

Focus group participants highlighted the role that problem solving courts could play in reducing a child's potential contact with the criminal justice system. One judge stated, "When you put people through a treatment court and they are not incarcerated, you're increasing the chance of them continuing to remain with families and then their families have less chance of being brought into another part of the system, for example Child Protective Services and delinquency. When you incarcerate parents and those children get involved in the system, there is that ripple effect."

FINDINGS: COMMUNITY

KEY FINDINGS

- Former prisoners have lower employment rates than those going through problem solving courts. Having a job is a key factor that contributes to an ex-offender's ability to adjust to society and care for themselves.
- In Wisconsin, those who completed TAD treatment programs were more likely than those who dropped out to have gotten a job while in TAD (36% and 15%, respectively).
- Incarceration depresses wages for ex-offenders. Serving time reduces hourly wages for men by approximately 11% and annual earnings by 40%.
- Over 50% of the homeless and marginally housed have a history of incarceration.
- In contrast to incarceration, which isolates ex-offenders within communities, problem solving courts create positive peer relationships and provide opportunities to give back to the community by getting a job and being part of society. Nationwide, one in eight of adult male residents of the poorest minority neighborhoods of cities are sent to prison each year, and one in four is behind bars on any given day.

During 2009, 730,000 individuals nationwide were released from state and federal prisons [270] and another 9 million cycled through local jails.[271] According to the Urban Institute, between 90-95% of people leaving prison return to the same community as before they were incarcerated.[272] The majority of these individuals are unprepared for reentry and experience difficulty with finding a job, housing, and reconnecting with families. In addition, the communities in which they are likely to be reintegrating are also heavily impacted by social and economic disadvantages, making reintegration even more difficult.

THE WISCONSIN CONTEXT: INCARCERATION AND PROBLEM SOLVING COURTS IN MILWAUKEE COUNTY

Throughout this chapter we refer to Milwaukee County as a "case study" of the type of community that has been highly impacted by imprisonment. Although the region is not representative of all counties across Wisconsin, the data, findings and discussion are relevant in understanding the effectiveness of problem solving courts for communities highly impacted by incarceration.

Milwaukee County operates a 960-bed facility in downtown Milwaukee that mostly holds individuals accused of felonies and misdemeanors on a pretrial basis, and a 2,000-bed detention facility that houses individuals sentenced to prison terms of less than one year.[273] The state operates the Milwaukee Secure Detention Facility with a capacity of 1,040 and a 2011 population of 972.[274] In Milwaukee, the state also operates Felmers Chaney Correctional Center, Marshall Sherrer Correctional Center, and the Milwaukee Women's Correctional Center. In 2008, there were almost 11,000 Milwaukee adults incarcerated in Department of Corrections facilities across the state.

Of the 7,500-8,000 individuals admitted into Wisconsin correctional facilities from Milwaukee County neighborhoods each year since 2002, 67% are African American, 16% are White, and 1% are Hispanic. [275]

From 1993 to 2008, about 31,000 adults from the Wisconsin DOC system have been released in Milwaukee County. Since 2002, each year 7,500-8,000 individuals have been released into Milwaukee County neighborhoods.[276]

Between 2007 and 2010, there were 2,061 TAD admissions in Wisconsin, and 1,153 of these were a part of Milwaukee-based programs. [277] The Milwaukee completion rate of TAD programs was 66% compared to the 64% completion rate of programs statewide.[278] Milwaukee programs include one drug treatment court and one family court. The annual capacity of Milwaukee's TAD programs is 200 to 300, with the drug treatment court capacity of about 75 slots.

Note: In Milwaukee County, TAD is a pre-trial diversion project that diverts non-violent offenders with substance abuse and mental health problems through either diversion before charges are filed or deferred prosecution. [279] If an individual successfully participates in case management and treatment services no charges are filed. As such it is called a diversion program, although in every other way it resembles the problem solving court model.

EMPLOYMENT

High rates of incarceration in a community can lead to high rates of unemployment. In an Urban Institute study of 740 people returning home from prison, 65% of respondents had been employed at some point, but only 45% were currently employed 8 months after release. Only 41% had legal employment for their income, 47% had informal work, 24% relied on government programs and 6% were engaged in illegal activities for income.[280] Another study found that serving time reduces annual employment by 9 weeks.[281]

The prison population is typically excluded from unemployment statistics, skewing differences between white and black communities. Among men age 20 to 34 who are not in prison, whites are 16% more likely to have a job than blacks, but the gap increases to 23% if prisoners are counted. Western and Pettit (2000, 2005) and Raphael (2006) argue that much of the increase in black male joblessness after 1980 can be attributed to increased incarceration in jails and prisons. Incarceration since 1980 has reduced the participation of young black male in the workforce by 3 to 5%.[282] Businesses may choose not to locate in neighborhoods with a high percentage of former prisoners, further decreasing local job opportunities.[283]

Unemployment can also worsen the cycle of incarceration and re-incarceration. Former offenders able to secure a job within two months of release are more likely to avoid recidivism 8 to 12 months after release.[284] Ex-offenders who worked in the 6 months prior to prison were nearly half as likely to be reincarcerated 12 months after release when compared to those who had not worked.[285]

People in our focus groups described their experiences seeking out employment, and the differences between former prisoners and drug court participants two groups was striking. Almost all drug court participants said they were either working or in school leading to a vocation, and that the court helped them figure out what they could do or connect them to work. In contrast, former prisoners reported that it was far more difficult to get a job and that the job training programs in prison were ineffective.

> *If anything, jail is like a criminal school, but drug courts – they give us opportunities to actually give back to the community by giving us the means to get a job and be a part of society.*
> *– Drug court participant*

Research is beginning to show that problem solving courts may have a positive impact on employment outcomes. Evaluation of a drug treatment alternative to prison program in New York City found that while only 26% of the participants were working full or part time before their arrest, 92% were working after the drug court program.[286] Drug court participants were less likely to report needing employment, educational, and financial services, suggesting that drug court participation addressed those needs. However, there were only modest non-significant differences in actual employment rates and income.[287]

This finding is repeated in a more recent study that specifically set out to look at employment as one of the psychosocial indicators impacted by drug courts. Green and Rempel (2012) show that significantly fewer drug court participants need help finding a job (27%) than the comparison group (42%), again suggesting that those needs had been better met in drug courts programs. In this case, the comparison group included sites that ranged from strict probation with no programming to some that had some mandated treatment but no drug courts.[288] This same study included findings that 61% of the drug court participants were employed 18 months after the program, vs. only 55% of the comparison, and 52% of drug court participants were employed at 6 months after vs. 48% of the comparison group.

The U.S. Bureau of Labor Statistics reports that in August 2012, Wisconsin's official unemployment rate was 7.5%, and the rate in Milwaukee County was 8.2%. Among ex-offenders specifically, rates are significantly higher; 2005 data

illustrate that two months and eight months after release, male ex-offenders had unemployment rates of 48% and 29%, respectively. As these figures are pre-recession levels, it is likely that rates of unemployment among ex-offenders are even higher.[289] [290]

THE WISCONSIN AND MILWAUKEE COUNTY CONTEXTS: EMPLOYMENT

According to the 2011 TAD Evaluation Report of the Wisconsin Treatment Alternatives and Diversion,[291] the majority of participants entered the programs unemployed but looking for work (45%). Adding those unemployed but not looking for work, disabled, or unavailable to work, a total of 54% of TAD participants were unemployed at admission. Table 9 highlights the barriers to employment across type of court throughout the state of Wisconsin. Lack of training, education, transportation were cited as some of the top concerns for ex-offenders seeking employment.

Table 9. Percent of TAD Program Participants Reporting Barriers to Employment

Barriers	Treatment Court	Diversion Courts	Overall
Lack of education/training	26%	1%	12%
Lack of experience	22%	1%	11%
Physical disability	5%	<1%	2%
Child care	5%	<1%	3%
Transportation	23%	2%	11%
Other (criminal record, felony charges, lack of ID, pending charges, mental disorder, drug use)	16%	<1%	8%

Source: University of Wisconsin Population Health Institute. 2011. Treatment Alternatives and Diversion (TAD) Program: Advancing Effective Diversion in Wisconsin. 2007-2010 Evaluation Report. December 2011. Office of Justice Assistance.

TAD programs assisted participants in gaining employment; overall 24% of those completing TAD programs became employed while in the program. Overall, graduates of TAD programs were much more successful than people who dropped out to obtain employment while in TAD. Treatment court participants were more successful at gaining employment than diversion programs, owing in part to treatment courts receiving more employment services.[292]

Table 10. TAD Program Participant Employment Gains

Program Graduates	Percent
Employed at admission & discharge	35%
Gained employment while in TAD program	24%
Unemployed at admission and discharge	28%
Became unemployed while in TAD program	13%

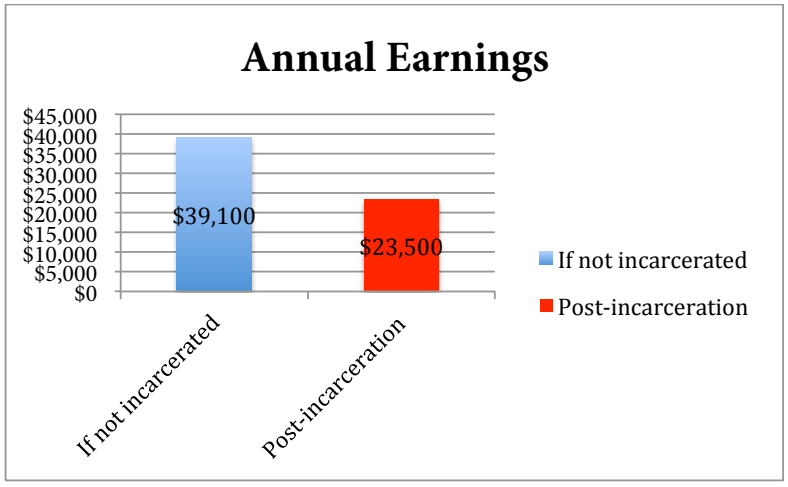
Source: University of Wisconsin Population Health Institute. 2011. Treatment Alternatives and Diversion (TAD) Program: Advancing Effective Diversion in Wisconsin. 2007-2010 Evaluation Report. December 2011. Office of Justice Assistance

Even with these encouraging findings, providers of treatment services in TAD programs who participated in our focus groups stated overwhelmingly that there is a deep need for more opportunities for job training, or programming to connect clients with employment. Treatment providers felt this gap in services would make a difference with regard to finding employment and decreasing recidivism even more.

Studies show a significant decrease in earnings among men who were formerly incarcerated. One study shows that family income declines by an average of $8,726 during incarceration. Incarceration means that those who are already at the bottom of the economic ladder are more likely to stay there. Two-thirds (67%) of men who were in the bottom fifth of the earnings range in 1986 remained there if they had been incarcerated. In comparison, only one-third remained stuck at the bottom if they had not been incarcerated.[293] In one study of potential earnings, recidivism was associated with a decrease in wages of 5.3%.[294] Examining the opposite effect, the ability to earn higher wages within two months after release lowers the likelihood of recidivism. Those who made more than $10 an hour were half as likely to return to prison as those making less than $7 an hour.[295]

In an Urban Institute study of 740 people returning home from 8 months in prison, for those who were working, their median hourly wage was $8.95, and most respondents relied on family and friends for income 8 months after release. [296] Serving time has been shown to reduce hourly wages for men by approximately 11% and annual earnings by 40%.[297] [298] By age 48, the typical former inmate will have earned $179,000 less than if he had never been incarcerated. Incarceration depresses the total earnings of white males by 2%, Hispanic males by 6%, and black males by 9%.

Figure 3. Estimated Effect of Incarceration on Annual Earnings



Source: Western & Pettit. 2010. Collateral Costs: Incarceration's Effect on Economic Mobility. Pew Charitable Trusts.

While several problem solving court evaluations attempt to look at employment outcomes, barely any measured income levels before and after problem solving court participation. A recent 2012 evaluation found that only 28% of those going through drug courts needed financial assistance 18 months after program completion as compared to 44% of the comparison group, who were those arrested and either on probation or in some treatment programming but not a drug court. The authors also found that only 31% of drug court program participants were on public financial assistance while 42% of comparison group participants were on public financial assistance. One last point of comparison was that the drug court participants earned $12,746 vs. their comparison group's average of $10,532.[299]

THE WISCONSIN AND MILWAUKEE CONTEXT: INCOME, INCOME INEQUALITY, AND POVERTY

The median household income for Milwaukee in 2010 was $15,677 less than the average for the state of Wisconsin. The formerly incarcerated fare even worse: In one analysis of 740 ex-offenders returning home from prison in four states (including Wisconsin), the median hourly wage was $8.95,[300] which translates into $18,616 annually – far lower than the median household income in Milwaukee City, County and in Wisconsin overall. The earning potential of ex-offenders can be estimated to be about $5,000 short of the city median if comparing to Milwaukee to ex-offenders in the Urban Institute's 2008 study of individuals in Illinois, Ohio and Texas.

Table 11. Median Household Income

	Milwaukee City	Milwaukee County	WI Overall
2006-2010	$35,921	$43,215	$51,598
2005	$32,666	$37,808	$47,105

Source: State & County QuickFacts. US Census Bureau.

In 2010, the poverty rate in Wisconsin was 13%, and in Milwaukee, 22% of the population lives in poverty.[301] According to the 2009 American Community Survey, Milwaukee ranks as the fourth poorest city in the country. [302]

HOUSING INSTABILITY

Housing instability is closely linked with incarceration. One study of returning prisoners with a drug abuse history found that 18% were homeless for a month or more in the year after they were released.[303] In a study of 1426 people who are homeless and marginally housed, almost one-fourth of them (23%) had a history of imprisonment, and 93% of those reported drug use during their lifetime, compared with 82% of those in the group who had not been in prison. Those who were homeless or marginally housed and had a history of being in prison were more likely than those who had not been to prison to have used illicit drugs in the prior year, to have HIV infection, to have been hospitalized in a psychiatric facility, and to have fair or poor health. [304]

Potentially contributing to homelessness or other marginal housing situations, federal laws in 1996 and 1998 permit public housing agencies to deny housing to anyone who has ever engaged in any drug-related activity. As a result, the number of applicants denied public housing because of criminal background doubled from 9,835 to 19,405. [306]

Some providers of homeless shelters have reported that as many as 70% of their residents were formerly in prison, and in 1996 a national survey found that 54% of those using homeless shelters have some experience of incarceration.[307] A California study found that in 1997, 10% of parolees were homeless, and in areas such as San Francisco and Los Angeles an estimated 30 to 50% of all parolees were homeless.[308] One study found no significant differences in the rate of homelessness between those in drug court and those in comparison groups (about 4% eighteen months after the program), but the comparison groups excluded former prisoners. The study did find that only 27% of the drug court participants needed help finding or keeping a place to live, compared to 35% of the comparison group.

Nonetheless, numerous participants in our drug court focus group discussed how their housing needs were met the by program for example, "They helped me pay rent, security and even get furniture." One participant said: "I have been in a few treatment programs, and all of them use their resources, but when you are able to get those other things [housing and employment] those are what really help turn things around." Several judges echoed that access to these other resources via drug court programs was instrumental in meeting participant needs, and that doing so improved participant well-being, program success, and ultimate success in their communities.

THE WISCONSIN AND MILWAUKEE CONTEXT: HOUSING INSTABILITY

Homelessness in Milwaukee has been monitored through various surveys. [310] [311] In a survey conducted on January 26, 2011, there were 1,466 homeless adults and children. In 2011, the Milwaukee shelter system provided services to 5,253 people, an increase of 11.0% over the 2010 total of 4,732.[312] Of the total, 3,455 were single individuals (65.8%) and 1,798 persons in households/families (34.2%). This 2011 survey of homelessness reports a significant decrease from 2005 surveys, where on any given night, as many as 1,000 individuals were without shelter in Milwaukee. On January 26, 2005, 2,579 homeless individuals were estimated; about three times as many as available beds in shelters.
Table 12 notes the living situation of the discharged 2007-2010 TAD participants at admission. Only 10% of individuals lived independently and 3% were homeless. Rates of independent living were much lower in Milwaukee was compared to all TAD sites overall.

Table 12. Selected Demographic Description of TAD Discharges Included in 2007-2010 Outcomes Analyses

Living Situation at Admission	Milwaukee	Overall
Independent living	10%	23%
With parents/other relatives	86%	66%
Incarcerated in jail	0%	6%
Residential treatment	1%	1%
Halfway house	0%	<1%
Transitional living	0%	<1%
Homeless	3%	2%
Other	0%	1%

Source: TAD 2007-2010 Evaluation Report.

SOCIAL COHESION

One theory behind social cohesion is that strong social ties create bridges to other networks, expand horizons, and offer access to assistance from other networks.[314] Incarceration limits these strong ties and limits access to these types of resources.

Imprisonment and reentry of offenders is often concentrated in the poorest urban minority neighborhoods. Nationwide, one in eight adult male residents of these neighborhoods are sent to prison each year, and one in four is behind bars on any given day. This transiency can cause great disruption in social networks in these communities.[315] Bursik and Grasmik argue that regular turnover of a portion of the population for the purpose of imprisonment weakens community willingness to "call on" each other's poor behavior, or what they call "informal social control. [316]

A large proportion of jobs are found through personal connections that provide information about job opportunities. [317] This social capital is weakened by incarceration and many ex-offenders have limited access to apprenticeships and future careers in the public sector that might otherwise emerge through networking.[318] Incarceration can also lead to disruptive family networks as studies have shown a low likelihood of marriage or cohabitation among ex-offenders.

[In prison] you become institutionalized. You come out and you don't know how to function on a normal level. When you are in drug court you are learning how to live . . . on the outside.
– Drug court participant

Another outcome of incarceration within communities is stigma. Even in communities where many are incarcerated, former prisoners say "offender" becomes their primary status, and neighbors are often suspicious and may even avoid them. This stigma often extends to the ex-offender's family.[320] Social ties among offenders are often strengthened through this dynamic, promoting opportunities for further criminal activity. [321] [322] One ethnographic study reports that incarceration can lead to increased attachments to gangs. [323]

Social support helps people cope with daily problems.[234] [235] Incarceration weakens ties of social support, and thus weakens family functioning. Incarceration can also lead to weakened ties from residents withdrawing from community life to cope with financial problems or the stigma of having a family member in prison.[326]

There is seemingly no research on the quantifiable impacts of problem solving courts on social cohesion. However, our focus groups provided strong evidence that participating in problem solving courts provided peer support that was instrumental to a participant's recovery, and also to improved social relationships. There were hopeful comments about showing the friends they used to associate with that another way of life is possible. One alumni of a drug treatment court said the first year he was in the community he kept getting approached by drug dealers, but after a while others in the community started cheering for him.

All spoke of the constant temptation of readily available drugs, the stress of living with high crime, and the lack of role models following a non-criminal way of life. However, in the focus groups with formerly incarcerated participants, many spoke of a commitment to working with their communities to keep others out of prison, to help them get jobs and stay off drugs.

CONNECTIONS TO HEALTH

Throughout this HIA we reference how crime, recidivism, housing instability, employment, income level, family structure, and substance use are highly connected with mental and physical health outcomes. This section provides the evidence of those links.

CRIME, RECIDIVISM AND HEALTH

Incarceration is associated with an increased prevalence of infectious and chronic diseases, such as HIV, tuberculosis, and hepatitis C.[327] In addition, those incarcerated have a higher prevalence of mental illnesses such as schizophrenia, depression, bipolar disorder and posttraumatic stress disorder. Some main contributing factors include close quarters of prisons, boredom and idleness of daily life, and problems due to overcrowding.[328] A 2009 study found that among inmates in federal prisons, state prisons and local jails, around 40 percent suffered a chronic medical condition. At the same time 14.8% of federal inmates, 25.5% of state inmates, and 25.0% of local jail inmates had at least 1 previously diagnosed mental illness.[329] Those who have been incarcerated can be considered a vulnerable population as they already exhibit a higher incidence of disease. Additionally, elevated rates of suicide and suicidal behavior among prisoners and jail inmates have been observed worldwide.[330]

STRESS AND HEALTH

If stress levels are elevated over an extended period and are not allowed to return to a lower baseline, the person's health can deteriorate. The body responds to stress by releasing stress hormones which can make blood pressure, heart rate, and blood sugar levels go up. Long-term stress can cause a variety of health problems, including depression and anxiety, obesity, heart disease, high blood pressure, and abnormal heart beats.[331] Long-term and repeated exposure to crime and the resulting stress that it causes has been associated with multiple chronic diseases, such as coronary heart disease, hypertension, stroke, sleeping problems, headache and stomachaches in children.[332] In addition to increasing risk for developing chronic diseases, stress from crime can cause poor mental health, or exacerbate existing mental illness.[333] [334]

DRUG AND ALCOHOL ABUSE AND HEALTH

Drug abuse has been linked to a range of acute and long-term health outcomes, including mental health problems, overdose and death, lung disease, violent behavior, unwanted pregnancies, and transmission of HIV and other communicable diseases.[335] Alcohol abuse has some similar and unique health outcomes, including unintentional injuries and fatality from falls, drownings, domestic abuse, and motor vehicle collisions; risky sexual behaviors leading to unintended pregnancy and STIs; miscarriage and stillbirth in women; alcohol poisoning; liver, cardiovascular disease, and certain cancers; and a host of social and family problems.[336]

FAMILY STRUCTURE AND HEALTH

With over one-fourth of all children in the United States living with only one parent, single-parent families can no longer be viewed as nontraditional. However, research illustrates that living in a single-parent family can be associated with poorer health. For example, one study found that for several physical and mental health indicators (e.g., overall health status, injury, asthma, depression, learning disabilities, behavioral issues), children in single-mother families had poorer outcomes than children living with two biological parents, even when taking levels of income and education into account. For most health indicators, children in grandparent-only families had even poorer health than children living with two biological parents or with a single parent.[337] Finally, compared with children from the same socioeconomic background, children living in foster care have much higher rates of serious emotional and behavioral problems, chronic physical disabilities, birth defects, developmental delays, and poor school achievement.[338]

EMOTIONAL AND BEHAVIORAL HEALTH AND WELL-BEING

Parental bonding and attachment are considered essential to the healthy development of a child, and disrupted bonding is linked with insecure attachment, diminished cognitive abilities, and weak relationships with peers[339] as well as the development of mental disorders later in life.[340]

EDUCATION AND HEALTH

Understanding how incarceration impacts educational outcomes is essential to understanding incarceration's impacts on health as education is a key determinant of health. The more education people have, the better their health knowledge, behaviors and outcomes.[341] Highly educated people have lower likelihoods of engaging in risky, health-detrimental behavior and are less likely to be overweight or obese.[342] Overall, well-educated adults have better mortality outcomes than their less educated peers: educational attainment directly impacts people's earnings potential. One year of education, for example, leads to roughly an 8% increase in earnings.[343] [344] [345] Education improves people's access to social networks of support, reducing social stressors, improving community cohesion and increasing social capital.[346] Attendance and grade point average are the two best predictors of whether incoming ninth-grade students will graduate.[347]

EMPLOYMENT AND HEALTH

Persistent perceived job insecurity and unemployment are significant predictors of poor physical and mental health. Unemployment and underemployment carry significant health risks. Multiple studies have noted significant associations between neighborhood-level unemployment and mental health, self-rated health, coronary heart disease, and mortality.[348] [349] One study even showed that the unemployment level of an entire neighborhood is associated with individuals' levels of depression, regardless of whether an individual is employed. The longer and more persistent the neighborhood-wide unemployment level, the higher the levels of depression.[350] We also see that unemployment at younger ages has an impact on later sickness. A study showed that those unemployed in 1992 had elevated risks for extended sickness absence, disability, and death.[351] Finally, with the recent financial crisis in the U.S, there is evidence of drastic health impacts; an increase of 10% in unemployment (say from 8% to 8.8%) is associated with a 1.47% increase in the suicide rate for males in the population. Unemployed men face a 25% higher risk of dying of cancer, and higher risks for heart disease and psychiatric problems.[352] Employment status can be a strong predictor of recovery from limiting illness – in a British study, economically inactive men were 2.7 times and economically inactive women were 1.4 more likely to remain ill as those of the same sex who were employed.[353]

Underemployment is another health risk. Looking at those who were marginally employed – those with temporary vs. permanent work – a study found temporary workers were 42% more likely to report poor health.[354] Another study found that men who involuntarily have temporary work have a 2.6 times higher risk of mortality than men permanent employees.[355] Men who experience job insecurity during a year between a baseline reading and follow up reading have higher blood pressure, report poorer health, and have higher levels of stress relative to men who do not experience job insecurity. Women who experience job insecurity show higher depressive symptoms, report more hostility, loneliness and stress than women who do not experience job insecurity.[356]

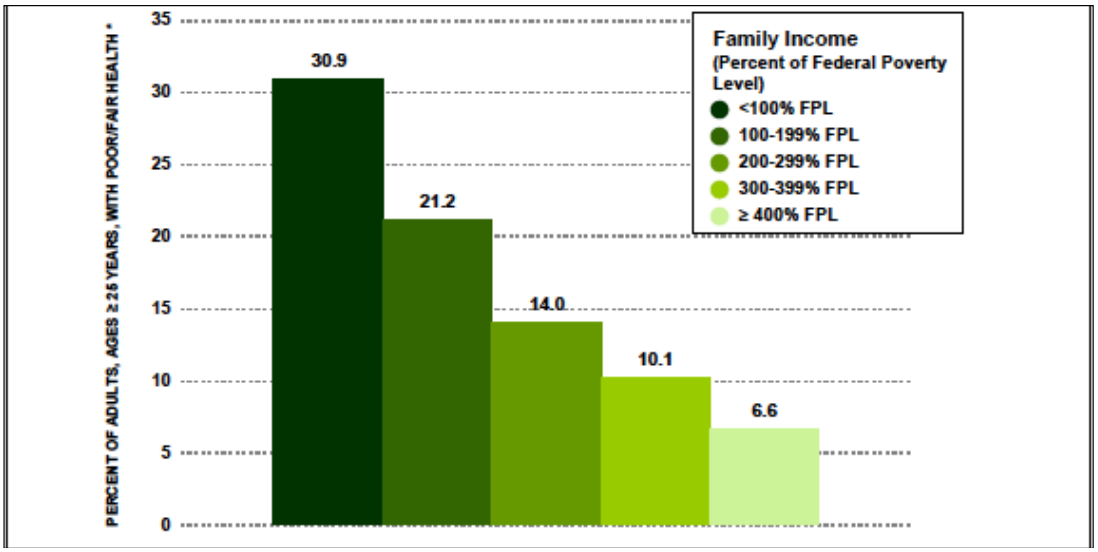
MATERIAL HARDSHIP AND HEALTH

Income is one of the strongest and most consistent predictors of health in the public health literature, and understanding how incarceration impacts an individual's earnings potential is important for understanding how incarceration can impact a range of health outcomes. Nationally, individuals with the lowest average family incomes ($15,000-$20,000) are three times more likely to die prematurely than those with higher family incomes (greater than $70,000).357 It has also been shown that every additional $12,500 in household income buys one year of life expectancy (up to an income of $150,000). Poorer adults are also three times as likely to have a chronic disease that limits their activity, twice as likely to have diabetes, and are nearly 50% more likely to die of heart disease.[358] Additionally, being low-income is a risk factor for low birth weight, injuries and violence and most cancers. Children in low-income families are seven times as likely to be in poor or fair health as compared to high-income families.

INCOME, INCOME INEQUALITY, POVERTY AND HEALTH

Evidence is clear that there is a correlation between income inequality and poor health outcomes. There is a gradient of health outcomes depending on one's socio-economic position, correlating higher incomes with a better range of outcomes.[360] For example, one study in the U.S. showed that loss of life from income inequality is equal to the combined loss of life due to lung cancer, diabetes, motor-vehicle collisions, HIV-related causes, suicide, and homicide.[361] Those who are poorer are more likely to report fair or poor health, and even those who have middle-class incomes are less healthy than those with higher incomes.362 (Figure 6).

Figure 4. Income Levels and Self-reported Health



Source: Robert Wood Johnson Foundation Commission to Build a Healthier America.

COMMUNITY-LEVEL POVERTY AND HEALTH

The effect of neighborhood poverty on health is mediated by social and physical neighborhood characteristics, such as social cohesion, social and physical disorder, fear of crime, and racism.[363] [364] Neighborhood socioeconomic status is resoundingly seen as a "fundamental cause of disease."[365] Researchers distinguish between the effects of individual poverty and neighborhood poverty on health and found that neighborhood level poverty affects the cumulative physiological response to chronic stress, independent of race and health behaviors such as smoking and exercise.[366] Neighborhood disadvantage can manifest its effect via lower neighborhood cohesion, which is associated with maternal depression and family dysfunction. These processes are, in turn, related to less consistent, less stimulating, and more punitive parenting behaviors, and ultimately, poorer child outcomes.[367]

HOUSING INSTABILITY AND HEALTH

Homeless individuals have many of the same health problems as people with homes, but at rates three to six times greater.[368] Studies have shown homelessness can impact health in many ways. Many homeless people are in desperate need of health care services, but because they are often uninsured and lack access to preventative health care, they go without care until minor problems become urgent medical emergencies.[369o] Homelessness is linked to higher rates of mortality and increased morbidity due to respiratory infections and poor nutrition.[370o]

Those in marginal housing, or those who are transient or "couch-surfing," have their own set of health risks. One study found that those experiencing housing instability also had higher risk of not having a usual source of health care, had postponed getting medical care and buying medications, and had increased emergency room use and hospitalizations.[371] Housing instability has mental health outcomes as well. Another study showed that those who had moved for cost reasons, were behind on their rent or mortgage, or experienced foreclosure in the past three years were more likely than those who hadn't to report a recent anxiety attack, experience major or minor depression, and report fair or poor self-rated health.[372]

SOCIAL COHESION AND HEALTH

Shifts in the socio-economic conditions and emotional and social relationships of community members in and out of prison affect their social, mental, and physical health. Social cohesion in a neighborhood can be a source of material and emotional support for health. Social support from neighbors and family can buffer stressful situations, prevent isolation and contribute to self-esteem.[373] [374] Social connections to others can shape the flow of resources and information, which determines access to opportunities and constraints on behavior.[375] For example, many public health interventions to shape behavior rely on the dissemination of information by social networks, and we know that people's resources, for example to job leads and help with services, are embedded in their networks.[376] Finally, the norms, networks, trust, reciprocity, and civic engagement that can exist in a community facilitate coordination and cooperation for mutual benefit, on occasion to advocate for resources for a neighborhood.[377]

PREDICTED IMPACTS

Table 13 summarizes our predictions on how increasing the state funding level of TAD programming to $75 million would impact the state's capacity to serve the target population and how increased capacity would impact recovery from substance abuse and ability to manage mental health issues, crime and safety, family and children, and community outcomes. Our predictions are based on a comparison of this increased funding for TAD programs vs. funding the status quo approach of incarceration.

The majority of our predictions use evidence gathered from the research literature and focus group findings. We were able, however, to quantify several predictions as data or estimates were available to apply to a number of outcomes. Specifically, we examine how an increase in $75 million would impact the following measures:

- Number of new slots created
- Number of state prisoners who could qualify to participate in programs
- Number of jail admissions who could qualify to participate in the programs
- Number of deaths due to overdose
- Number of new crimes
- Number of parents in prison
- Number employed

To make predictions regarding those who would qualify for TAD slots as well as our other outcomes of interest, we used the most conservative estimates of prevalence of substance abuse and mental health disorders among those in prison. Our findings likely reflect an underestimate of impacts. (See detailed explanations of calculations below). Also note that our predictions primarily relate to impacts on the prison system, not the jail system. While TAD programs have a great impact on county jails, we did not include in these predictions because our proposal targets an increase in state-funded TAD programs.

Table 13. Summary of Wisconsin HIA Impact Predictions

Health Determinant	**Impact**	**Magnitude** (i.e., how many?)	**Severity** (i.e., how bad?)	**Strength of Evidence**	**Equity Impact**
I. Capacity to Serve Target Population					
Slots created	+	18,000 new problem solving court slots OR 49,000 new diversion slots OR Combination of 42,000 slots if 75% diversion and 25% problem solving court slots	N/A	♦♦♦	+
State prisoner participation in program	+	3,100 new admissions to state prison would qualify for one of these problem solving court or diversion slots	N/A	♦♦♦	+
County jail prisoner participation in program	+	21,300 new county jail admissions would qualify for TAD programming	N/A	♦♦♦	+

Compliance with treatment standards	+	Major	Moderate	♦♦♦	+
Substance abuse recovery and ability to manage mental health	+	Double the number of offenders do not relapse after drug court participation compared to offenders receiving minimal drug treatment	High	♦♦	+
Overdose	+	8 fewer people would die due to drug overdose	High	♦♦	+
Suicide and motor vehicle fatality	+	Moderate	High	♦♦	+
III. Crime & Safety					
Crime	+	There will be approximately 20% fewer crimes among non-violent offenders who have substance abuse issues	High	♦♦♦	+
Recidivism	+	Major	Moderate	♦♦♦	+
Injury, fatality, and stress associated with crime	+	Minor/Moderate	Moderate	♦♦	+
IV. Families					
Number of parents incarcerated	+	Between 1,150 – 1,619 incarcerated parents could stay out of prison and use TAD program slots	Moderate	♦♦♦	+
Families staying together	+	Major	Moderate	♦♦	+
Material hardship	+	Major	Moderate	♦♦	+
V. Communities					
Employment	+	13% more non-violent offenders with substance abuse issues would be employed	High	♦♦	+
Income	+	Major	Moderate	♦♦	+
Housing Instability	+	Minor	Moderate	♦	Insufficient evidence
Social cohesion	+	Moderate	Low	♦	Insufficient evidence

Explanations:

- *Impact:* will the proposal will improve health (+), harm health (-), or whether results are mixed (~).
- *Magnitude:* quantitative or qualitative judgment of the size of the anticipated change in effect (increase in the number of cases of disease, injury, adverse events): Negligible, Minor, Moderate, Major.
- *Severity:* nature of the effect on function and life-expectancy and its permanence: High = intense/severe; Mod = Moderate; Low = not intense or severe.
- *Strength of Evidence:* strength of the research and evidence showing causal relationship between mobility and the health outcome: ♦ = plausible but insufficient evidence; ♦♦ = likely but more *evidence needed;* ♦♦♦ = causal relationship certain. A causal effect means that the effect is likely to occur, irrespective of the magnitude and severity.

Equity impact refers to whether the proposal will further worsen (-), improve (+), or have no effect on the distribution of currently unequal impacts within sub-population (e.g., by race/ethnicity, gender, income).

EXPLANATIONS

CAPACITY TO SERVE TARGET POPULATION

The anticipated funding increase could create more than 41,000 new slots in problem solving courts and diversion programs. There are currently approximately 450 TAD slots.[378] Our estimate is calculated based on formulas provided by the University of Wisconsin – Madison La Follette School of Public Affairs Working Paper on the costs and benefits of increasing TAD funding (methodology described in La Follette paper).[379] Specifically, we estimate that if funding increased to $75 million, the following number of slots would be created:

- If funding was used only for problem solving court slots: 18,315 slots
- If funding was only used for diversion slots: 49,702 slots
- If funding was based on a 75% diversion and 25% problem solving court mix: 41,855 slots

At least 3,115 of the approximate 8,000 annual prison admissions in Wisconsin would be eligible to participate in TAD-like programs. In general, inmates who commit non-violent crimes and have either substance abuse or mental health disorders would be eligible to participate in drug treatment, OWI, mental health courts, or potentially other diversion programs).

Between 21,315 to 31,555 of the approximately 227,000 annual jail admissions would be eligible to participate in TAD-like programs. We used the same eligibility criteria of people charged with non-violent crimes and who have either a substance abuse or mental health problem or both, however rates were slightly different for the jail population. Also, given the various reasons for which jail inmates are admitted, our best estimate was that those who were admitted to jail for felonies and had not gone to trial were the most likely population to qualify for TAD programs. The estimated range used percentages of those who were admitted for those reasons from Dane and Milwaukee County reports (for more detail on the calculation, see Appendix 6).

Equity impacts. We predict that increasing the number of problem solving and diversion slots would help to improve the currently inequitable distribution of impacts of incarceration on racial and ethnic minority groups in Wisconsin. However, we note that the gap between the proportion of whites and blacks in TAD programs and those in prison indicates that whites currently have more access to treatment alternatives African Americans. For example, in Milwaukee in 2010, 67% of those booked in jails were black and 32% were white;[380] in the Milwaukee TAD program from 2007-2010, blacks comprised 53% of the participants and whites comprised 36%.[381] In our focus groups, about half of the Milwaukee drug treatment court focus group participants were white, whereas in the Milwaukee group with formerly incarcerated, there were no white participants. One participant who was formerly incarcerated noted that even in prison, when there are privileged programs such as earned release, they are populated with more whites, and the same may be true of problem solving courts. Also, one judge noted that treatment court graduation rates were lower for minorities and hypothesized that there were cultural effects at play that could be better considered. Thus, while increasing the number of TAD program slots would help to address inequities, there could be improvements that would better equalize positive impacts.

RECOVERY

Problem solving courts are far superior in their adherence to substance abuse and mental health treatment standards than prisons. There are nationally accepted standards, based on evidence-based studies and reviewed by peers in academic journals and national committees, for treatment of substance abuse and mental health disorders. With regard to access to treatment services, having a range of treatment options, time in treatment, balance of incentives and sanctions, and monitoring of substance use, problem solving courts far exceed prisons.

Recovery rates are almost twice as good for offenders going through drug treatment courts than for comparable offenders who go through non-prison based substance abuse treatment programs. In one of the few larger drug court evaluations that measured substance abuse outcomes, evaluators found that 44% of drug court participants reported no

use of any drug 18 months after their baseline measurement while only 24% of the comparison group reported no use after 18 months. While the comparison group was not comprised of prisoners, they were offenders arrested on drug-related charges who were either on probation or had some form of mandated treatment.[382]

Only 61% of state prisons even provide substance abuse treatment[383] and 80%-85% of prisoners who could benefit from substance abuse treatment in prisons do not receive it.[384] [385] Mental health courts similarly have consistent measures of decreased psychiatric hospitalizations, fewer inpatient days and shorter stays than mentally ill offenders going through the criminal justice system. Mental health courts show a higher use of outpatient mental health services as well as decreased jail use.

Overdose, suicide and motor vehicle deaths and injuries would decline. Rates of drug overdose are particularly elevated for offenders released from prison in the first two weeks, and have been measured as elevated as long as 12 weeks. A randomized controlled evaluation of a drug court found that 6.5% of participants in the drug court vs. 7.3% of those in the control group (felons going through the traditional criminal justice system) had died three years after release from overdose.[386] We adjusted for the differences in the reported drug of choice in the study cited (Baltimore) and in TAD programs in Wisconsin, where about there was about one-third the rate of opiate and cocaine use. For our purposes, we used these percentages and applied them to the number of people who would qualify for a drug treatment court in Wisconsin prison admissions in a typical year versus offenders participating in the typical criminal justice system. Using this approach, we found that there could be 71 deaths due to drug overdose in the 3 years after release from prison compared to 63 deaths due to overdose for those participating in a drug court, or a difference of 8 fewer deaths if Wisconsin had increased drug court slots.

Similarly, suicide attempts would decline among these populations. People at all stages of the criminal justice system are at increased risk for suicide, as are alcohol and drug abusers, and those freshly released from prison. Finally, motor vehicle fatality and injury would decline if there were more TAD slots. Wisconsin has one of the highest rates of binge, heavy drinking, and drinking while driving in the country. Participants in OWI courts in other states have 50% to 60% less recidivism, pointing toward fewer episodes of driving while drinking. [387] [388]

CRIME AND SAFETY

Recidivism for problem solving court participants would be approximately 12% - 16% lower than that of non-violent offenders who go to prison. The vast amount of studies on drug treatment courts confirm that they are effective at decreasing recidivism. About 46% of those released from prison in Wisconsin return in three years. In contrast, the 2011 TAD evaluation showed a recidivism rate of 19% for those who graduated from TAD programs for the three years after baseline, a difference of 27%. Evidence from the TAD evaluation in Wisconsin shows that recidivism would potentially decline more than our projection, however national meta-analyses averaging multiple drug court evaluations give a lower range of recidivism rate decline. The TAD summary recidivism number of 19% convicted for new crimes post-TAD graduation, also, is based in part on diversion programs in addition to drug treatment courts. Extrapolating on these findings, if TAD funding were increased and more people went through problem solving courts and diversion programs, recidivism rates would decline and Wisconsin would see a gradual decline in numbers of people returning to the prison population.

There will be an approximately 20% reduction in new crimes committed by those eligible for problem solving courts. If funding for TAD increased to $75 million, and all those eligible for participated in the programs, we estimate that there would be a 20% reduction in new crimes committed.

While 46% of those that are released from prison in Wisconsin recidivate, only 25% actually commit a new crime. The remaining are re-incarcerated on a technical violation of their supervision agreement. In contrast to those released from prison, only 19% of those participating in TAD programs actually committed new crimes. If we compare these rates against the number of those qualifying for TAD programs we find that there is a significant decrease in the number of new crimes being committed. Projecting this 20% decrease in crime out for the next five years, we would see almost 1,000 fewer crimes committed by the population using TAD programs.

We anticipate a decrease in injury and death from crime. Since people eligible for TAD programming are those who have committed non-violent offenses, we predicted only a negligible change in the number of injuries and fatalities.

However, since some recidivists may go on to commit more serious crimes we do expect that the ability of increased TAD funding to decrease recidivism would also prevent these new, potentially violent, crimes. Of the nonviolent releasees from 15 states in 1994, about 1 in 5 were rearrested for a violent crime within 3 years of discharge.[389] Given our expectation that new crimes committed by the TAD-eligible population will decline by 2o%, we also predict there would be a qualitative decrease in stress due to living in a high-crime area.

FAMILIES

Between 1,150 – 1,619 Wisconsin parents would qualify for problem solving court slots or other diversion programs and would be able to remain with their families. We calculated this using Bureau of Justice Statistics data on the number of non-violent parents in prison (52%), and the number with any history of substance abuse (67%) and recent history of mental health problems (23%) who committed non-violent crimes, and used national estimates on co-occurring disorders in the prison population.[390] [391] We applied these estimates to the number of parent offenders who are admitted annually to prison in Wisconsin in order to calculate the number of parents who would be eligible for problem solving courts, and thus have the potential to remain in the community and with their families and children. There will be fewer single parent families, less involvement with Child Protective Services, and more children remaining with their parents. Children whose parents are incarcerated are approximately 34% less likely to live with married parents and children are 4-5 times more likely to face foster system contact.[392] In contrast, evaluations of family drug courts show that parents who complete substance abuse treatment are less likely to have a termination of parental rights, are more likely to reunified with their children, and children spend significantly fewer days in out-of-home foster care.[393]

Families will experience a decrease in material hardship as more parents participate in problem solving courts. There are two main reasons why parents participating in newly created TAD slots would lead to a decrease in material hardship among their families. First, evaluations of drug courts show better employment outcomes. Studies show that household income for a family with a parent in prison decreases by $8,726 compared to the year before the parent was in prison,[394] and that more than half of parents in state prison provided the primary financial support to their children before imprisonment. [395] Evaluations of drug courts show that those participating in drug courts are more likely to be able to find employment after their program than those released from prison. For example, while 52% of those in a national evaluation of drug courts were employed 6 months after drug court,[396] only 45% of those released from prison were employed 8 months after release.[397] In the TAD evaluation, 59% of those graduating were employed at discharge.[398] Second, those that participate in problem solving courts are able to look for and maintain a job during the course of the program. These improved employment outcomes allow for a parent to contribute to a family's economic well-being in a way that those who are incarcerated are unable to do so, and therefore we estimate that materials hardship among families would decrease with TAD funding increasing to $75 million.

We are unable to forecast an impact on emotional and behavioral well-being among youth due to a lack of information on problem solving courts. There is a vast literature about the emotional and behavioral outcomes for children when a parent is imprisoned. For example, 70% of young children with incarcerated mothers experienced emotional or psychological problems,[399] children with incarcerated parents were 44% more likely to display borderline to clinically aggressive behavior,[400] and youth with a parent in prison show a higher susceptibility to peer pressure and risky behaviors, including drug use.[401] However, none of the studies of problem solving courts considered impacts on these outcomes, so it is not possible to make a comparison between problem solving courts and prison.

We are unable to forecast an impact on educational outcomes among youth due to a lack of information on problem solving courts. Similar to emotional well-being in children, there is evidence that when a parent is imprisoned, educational attainment for their children declines. Children of the incarcerated demonstrate below-average academic performance, even when compared to children of mothers on probation (70% compared to 17%).[402] Children with parents in prison are also significantly more likely to fail in school (45%) than their friends (20%), and are more likely to have dropped out of school (36% compared to 7%).[403] However, no evaluations of problem solving courts assessed a parent's participation on educational attainment among their children, and thus we are unable to forecast a change in this indicator.

We are unable to forecast an impact on youth involvement in the criminal justice system due to a lack of information on problem solving courts. Again, because studies of problem solving courts do not assess this outcome, we are unable to compare the impact of incarceration versus problem solving courts if the number of TAD slots increased. However, we do know that youth with a parent in prison are five times more likely to be convicted as a juvenile, almost seven times more likely to be convicted as a young adult, and five times more likely to be imprisoned by age 40 than youth who do not have a parent in prison.[404]

COMMUNITIES

We predict 13% more people will be being employed after release. Evaluations of drug courts show that participants are more likely to be able to find employment after their program than those released from prison. In an important national evaluation of drug courts, 52% of those participating in drug courts were employed at 6 months after the program vs. 45% of those released from prison. We applied these estimates to the number who would be eligible for newly created drug courts slots and compared that to number of non-violent offenders entering prison who would be employed after.The difference between these two numbers indicates that 13% more of those that would qualify for TAD slots (i.e., non-violent substance abusers) would be employed after participating in a drug treatment program. For those employed, average incomes will be higher. Serving time was shown to reduce hourly wages for men by approximately 11% and annual earnings by 40%, and incarceration's effects on wages are disproportionate, depressing total earnings of Hispanic males three times more than white males and of black males by 4.5 times more than white males.[405] [406] Because those who graduate from problem solving courts have the opportunity to have their offense erased from their record, they may not face the same difficulties and discrimination as that faced by ex-offenders in finding a job. Also, drug court evaluations show that only 28% of those going through drug courts needed financial assistance 18 months after program completion as compared to 44% of the comparison group, and only 31% of drug court program participants were on public financial assistance while 42% of comparison group.[407]

Homelessness and the need for transitional housing will decrease. There is a relationship between incarceration and difficulty finding housing. A study of those that were homeless or living in transitional housing found that 23% had a history of incarceration.[408] While problem solving court evaluations do not measure housing status post-program participation, a national drug court evaluation did show that only 27% of the drug court participants needed help finding or keeping a place to live, compared to 35% of the comparison group.[409] Numerous participants in our drug court focus group discussed how their housing needs were met the by program, and one treatment court judge noted, "In treatment alternatives we enable them to access so many other resources, such as getting housing, transition housing. This, with all other resources, improves one's mental and physical well being, and increases the likelihood they will be successful in the community."

Social cohesion in communities will improve. Having served time in prison can have a devastating impact on the social cohesion of a community, and the stigma individuals experience can leave them excluded from their communities. In the poorest minority neighborhoods of cities, exit and reentry of offenders is concentrated. Nationwide, one in eight of adult male residents of these neighborhoods are sent to prison each year, and one in four is behind bars on any given day. Understandably, this transiency can cause great disruption in social networks in these communities.[410] With regard to the stigma, interviews with ex-offenders state that "offender" becomes their primary status, and non-criminal neighbors are often suspicious and may even refrain from interaction with them. While no research quantifies the impact of problem solving courts on social cohesion or social ties, our focus groups provided strong evidence that participating in problem solving courts improved peer support that is instrumental to recovery, and improved social and family relationships.

RECOMMENDATIONS

The research, data and other findings cited in this Health Impact Assessment show clearly that alternatives to prison promote healthier lives, stronger families and safer communities. Increasing Wisconsin's investment in problem-solving courts and other programs to keep low-risk, non-violent offenders out of prison would likely reduce crime, improve public health and begin to correct racial inequities in the state criminal justice system. More funding for prison alternatives is also likely to reap significant savings on public safety, health care and social services.

Our recommendations are detailed below.

PRIORITY RECOMMENDATIONS

	Recommendation	Target agency
1.	Beginning in FY 2013, expand state funding for Treatment Alternative and Diversion (TAD) programs to the level of $75 million per year.	State Legislature
	Our recommendation is based on the following calculations: 3,115 annual prison admissions qualify for TAD programs and 21,315 jail admissions qualify = need for approximately 24,000 slots. Using the University of Wisconsin La Follette School recommendation of a 75/25 split (75% diversion courts and 25% problem solving courts) and the TAD evaluation average costs for a slot in drug courts ($7,551) and diversion programs ($1,664), we found that $75 million would cover the current need for TAD programming in Wisconsin.	
2.	Allocate an additional $20 million per year for complementary services that will enhance the success of TAD programs.	State Legislature
	Priority programming identified in the HIA are those that provide greater access to mental health and case management services, incorporate the Transitional Jobs program, provide for involvement of the Wisconsin Department of Children and Families, and allow for increased use of medication therapy for substance abuse.	
3.	Expand eligibility for TAD programs as broadly as possible while maintaining best practices from around the country.	Office of Justice Assistance (OJA)
	Specifically: • *Consider replacing "non-violent" with "low risk" as a filter* • *Ensure that people with chronic or hard-to-treat conditions are included appropriately* • *Use a sliding scale of mental health and AODA assessment to ensure that participants have appropriate access to treatment* • *Include those under Parole or Supervision, especially those who could have their status revoked because of "technical violations"* • *Give special consideration to ensuring all racial groups are treated proportionally to the rates in other parts of the criminal justice system.*	
4.	Give priority to parents for TAD program slots.	Problem solving court and diversion program judges in counties
5.	Continue to conduct an annual, standardized and statewide evaluation of TAD programs and other alternatives to incarceration.	OJA in coordination with the Office of State Courts
	The evaluation should include all problem solving courts and diversion programs including mental health courts, family courts, veteran's courts, OWI courts, and the various diversion programs. Include both TAD programs and programs funded through other sources, and disaggregate all data and findings by race and ethnicity. Require measurement of outcomes other than recidivism, for example, mental health outcomes, substance abuse relapse, job placement, housing placement, physical health outcomes, and children's outcomes.	

FURTHER RECOMMENDATIONS: CAPACITY TO SERVE TARGET POPULATION

Policy Recommendations	Target agency
6. Require that the county-level Criminal Justice Coordinating Committee (CJCC) that guides county TAD implementation include members of the community, treatment providers and other stakeholders outside of the criminal justice system, in addition to judges, elected officials, district attorneys and public defenders.	County treatment court coordinators, as overseen by the Director of State Courts
7. Incorporate promotion of TAD programming as part of the mission of the Wisconsin statewide Criminal Justice Coordination Council, and include problem solving court judge and a "consumer" on the CJCC.	Chief of Staff, Governor's office
8. Increase cultural proficiency of treatment court providers and staff.	County treatment court coordinators
9. Create a full-time, state-level position dedicated to coordinating TAD efforts and providing technical assistance to problem-solving courts in Wisconsin.	Director of State Courts office
Research Recommendations	**Target agency**
10. In addition to an annual evaluation as recommended above, the Assistance should fund Wisconsin-based comparison studies of substance abuse and mental health outcomes in prison and TAD programs.	Office of Justice Assistance Department of Corrections
11. Create a "Guideline to Diversion Programs" with different types of diversion programs, best practices, and summaries of any process and outcomes evaluations.	Office of Justice Assistance
12. Track the number of jobs in the criminal justice system and in alternative treatment programs that are created and lost through the increase of funding for TAD programs.	Department of Workforce Development, Department of Corrections, Office of Justice Assistance

Policy Recommendations	Target agency
13. Explore more options for keeping people with substance abuse and mental health issues out of the criminal justice system before they are arrested. There are models for these types of programs in Dane County, WI and King County, WA where police are trained to divert people into treatment before arrested.	Office of Justice Assistance
See City of Madison. Madison Policy Department Mental Health Liaison Program. Available at http://www.cityofmadison.com/police/specialunits/health.cfm; See also Seattle Police Department. Crisis Intervention Team. Available at http://www.seattle.gov/police/work/cit.htm	
14. Incorporate family members into problem solving court mandatory meetings.	County Treatment Court Coordinators
15. Include parenting classes as part of problem solving court and diversion program meetings. To do this, partner with WI Department of Children and Families, local agencies, and/or nonprofit equivalents who can provide this.	County Treatment Court Coordinators
16. Support policies that ensure that arrests and convictions are not inappropriately considered in hiring decisions (for example, "Ban the Box)").	State Legislature
17. Create apprenticeships and internships as part of requirements for TAD programs.	County Treatment Court Coordinators
Research Recommendations	**Target agency**
18. Create a compendium of what works in Wisconsin problem-solving courts in reducing relapse, what services are most useful, what helps people find and retain employment, access job training and placement services, and find and retain housing.	University of Wisconsin Population Health Institute, or other potential academic partners
See Washington State Institute for Public Policy: Return on Investment: Evidence-Based Options to Improve Statewide Outcomes – July 2011 Update. Available at http://www.wsipp.wa.gov/pub.asp?docid=11-07-1201	
19. Investigate family court best practices to be incorporated into drug courts and mental health courts to enable better family and child outcomes.	University of Wisconsin Population Health Institute, or other potential academic partners

LIMITATIONS

DATA AND RESEARCH

While an astounding amount of reports, studies, and evaluations are written about incarceration and about drug treatment courts, there were still data limitations that we experienced.

- First, very few evaluations of drug treatment courts actually looked at the outcome of recovery from drug and alcohol abuse. Other outcomes that are important to substance abuse recovery and ability to manage mental illness are rarely measured in these evaluations: ability to gain and keep a job, ability to advance one's education, ability to remain with one's family, outcomes for children of those in these programs.
- Second, there were far fewer evaluations of mental health courts and alcohol treatment courts, and no systematic reviews.
- Finally, in some evaluations the comparison groups were not the comparison group that pertained to our policy target, i.e., prisoners. In many cases the comparison groups were prisoners, but in some of the larger evaluations the comparison groups were a combination of people on probation or supervision, or who had court-mandated drug treatment that was not a drug court yet it was not a true comparison who was undergoing prison. Again, the quantity of evaluations that were of high enough quality made our predictions possible.

Enough data exists for us to make predictions, unless otherwise indicated. However, in some cases having more data, or more robust data, would have made us judge the strength of our evidence more highly.

LIMITS OF THE POLICY TARGET

The policy target of this HIA focused on the state providing funding, and thus what impacts the state would have if TAD funding were increased. Thus, we focused on the impact to state prisons. However, TAD programs impact not only state but also county jails - in fact, TAD programs averted more jail days than prison days and thus impacts county jails to a higher degree. While we included one prediction in recognition of the impact on county budgets in addition to that of state budgets, incorporating numbers for the impacts to counties as well as the state is a topic for future research.

CAUSATION

One important caveat to consider is the difficulty of disentangling the impact that prison or problem solving courts may have on the target population from some of the risks they are exposed to in their lives (e.g., substance abuse, poverty, education). For example, children may also be living with non-parental caregivers prior to their parent's incarceration, perhaps due to parental abuse or neglect, and that may impact youth outcomes as much as parent imprisonment. In another example, does having high rates of incarceration in a community cause low rates of unemployment, or does a lack of employment have a causal effect on high rates of incarceration? Some studies attempt to tease out these complex issues, but it remains a limitation.

While these issues may call into question the strength of the research on various outcomes, we believe the research suggests that incarceration will undoubtedly compound any issues that may pre-exist in home or community settings, and therefore should contribute to our overall understanding of how incarceration impacts families and communities.

METHODOLOGICAL LIMITATIONS

We relied mainly upon secondary data, literature review, and qualitative focus group findings to make well-informed and reasoned predictions of how the policy of the state of Wisconsin providing $75 million in funding would impact social determinants of health and health outcomes for individuals, families, and communities in the state. Our quantitative predictions did not employ statistical analyses or modeling, but instead were logical extensions of descriptive data or predictive methodology used by other researchers.

In some cases, we had to use epidemiological findings from different studies in order to make a comparison between prison outcomes and drug court outcomes. We chose methodologically sound studies, but acknowledge that this is not the ideal way to be able to compare outcomes due to differences in data collection methods, analyses, populations and geographies, and the like. Given that gaps in literature that existed in terms of rigorous, randomized controlled trials on the outcomes of interest for this HIA, however, we felt this was a valid method of comparison. In places where there were concerns, we attempt to be transparent and adjust for those concerns. Additionally, when given a range of effects, we chose to use the most conservative estimates in every case.

In many cases extrapolated prevalence estimates based on nationally accepted measures that we then attributed to the Wisconsin prison or jail populations.

MONITORING

The purpose of a Health Impact Assessment is to use research and recommendations to have an impact on decisions under review and on health and health determinants. Too often, research is conducted in such a way that it is unclear whether there are any resulting impacts. To that end, HIA includes a step – monitoring – to track the impact of the HIA on the decision in question; the implementation of the decision; and any determinants of health that may change as a result of decision implementation.

In this Treatment Instead of Prison HIA, we propose that the main monitoring that takes place is an annual, standardized and statewide evaluation of TAD programs and other alternatives to incarceration. As stated in Priority Recommendation # 5, we suggest that the Office of Justice Assistance build on the excellent work they have done to date in partnership with the Population Health Institute at the University of Wisconsin, Madison tracking outcomes of the first five years of the TAD programming. We suggest that the evaluation track the following additional elements and indicators:

- Include all problem solving courts and diversion programs including mental health courts, family courts, veteran's courts, OWI courts, and the various diversion programs.
- Include both TAD programs and programs funded through other sources.
- Disaggregate all data and findings by race and ethnicity.
- Require measurement of tracking of the following additional outcomes:
    - o mental health
    - o substance abuse
    - o job placement
    - o housing placement
    - o physical health
    - o child and youth outcomes
- Include funding levels of TAD programs as well as funding levels for supplemental programming (transitional jobs, mental health services, substance abuse services, family services).
- Include changes in eligibility and how they impacted the demographics of those participating in TAD and similar programs
- Include documentation of the process of administrative oversight of TAD and alternative treatment programs offered within the Wisconsin criminal justice system.
- Include the impact of alternative treatment programs on the number of prison and jail admissions.

GLOSSARY

Alternative to Revocation: An ATR is a formal response to an offender's violation of the rules or conditions or supervision. It is intended to correct and enable the offender to demonstrate that they are suitable for return to community supervision. If the ATR is not successfully completed the community supervision can be revoked and the original sentence can be imposed resulting in incarceration.

Community-based treatment programs: Programs and interventions that are based in the community that address needs and reduce an offender's risk to the community.

Co-occurring mental health disorder: Co-occurring disorder refers to individuals diagnosed with both a mental health disorder and a substance abuse disorder. These individuals can also be categorized as "dually diagnosed."

Criminogenic risk factors: Those factors that predispose an offender to re-offend.

Diversion programs: Diversion projects allow front-end diversion from court processing and subsequent jail incarceration for non-violent offenders with substance abuse treatment needs. These models offer offenders the opportunity to participate in substance abuse treatment in lieu of criminal charging, diverting them from the criminal justice system. Diversion models can include bail monitoring, deferred prosecution agreements, diversion from prosecution, and alternative to revocation (ATR) of probation/parole.

Drug offenders: An individual convicted for violating drug laws, including use, possession, or sale of illegal substances. Violent offenders or property crime offenders who happen to be under the influence of drugs while committing the crime are generally not included in this definition.

Graduate/completer: A graduate/completer refers to an offender who has successfully met all of the participation requirements set forth by each individual TAD project.

Health Impact Assessment: A public engagement and decision-support tool that can be used to assess policy and planning proposals, and make recommendations to improve health outcomes associated with those proposals. The fundamental goal of HIA is to ensure that health and health inequities are considered in decision-making processes using an objective and scientific approach, and engaging stakeholders in the process.

Operating While Intoxicated/Driving While Intoxicated (OWI/DWI): These criminal infractions refer to the operation of vehicles while under the influence of alcohol.

Problem solving courts: Problem solving courts began in the 1990s to "hold offenders accountable" and to provide them with services and treatment to address specific needs and problems that were not or could not be adequately addressed in traditional courts. Problem solving courts seek to promote outcomes that will benefit not only the offender, but the victim and society as well. Problem solving courts were developed as an innovative response to deal with offenders' problems including drug abuse, mental illness, and domestic violence. Although most problem solving court models are relatively new, early results from studies show that these types of courts are having a positive impact on the lives of offenders and victims and in some instances are saving jail and prison costs. Common types of problem solving courts are drug treatment courts, mental health courts, family courts, veteran's courts, and juvenile treatment courts.

Recidivism: Recidivism can refer to either being arrested, charged, and/or convicted for a new offense after previous discharge and/or admission to prison or jail for any reason.

Revocation: Revocation is the act of recall or annulment, and in the criminal justice setting is used to describe when someone on supervision either commits a new crime or has a technical violation of supervision or parole (such as a dirty urine or missing an appointment) and is sent back to prison, therein "revoking" their supervision agreement.

Social determinants of health: The conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels and in turn, these circumstances shape health behaviors and health outcomes. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries. Policies governing imprisonment is an example of a social determinant of health, as is racism.

Treatment courts/drug treatment courts: Adult treatment courts are another term for "problem solving courts" (see above). They offer a way for people who are convicted of crimes to rehabilitate outside of prison or jail while simultaneously working to recover from their substance addiction. Treatment courts are based on the ten key components developed by the National Drug Court Institute. Non-violent offenders with substance abuse treatment needs typically enter treatment courts pre-plea, post-plea, post- conviction, or as an alternative to revocation of community supervision. Treatment courts are typically 12-18 months in length and offer comprehensive case management, monitoring, and treatment services. This model offers offenders the opportunity to participate in substance abuse treatment in lieu of further criminal justice system processing.

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[2] WISDOM is a Wisconsin grassroots network of about 145 religious congregations of 19 different faith traditions who work together to speak as a common voice on issues of social justice.
[3] Treatment Alternatives and Diversion (TAD) Program: Advancing Effective Diversion in Wisconsin. Wisconsin Office of Justice Assistance, Wisconsin Department of Corrections and Wisconsin Department of Health Services, December 2011.
[4] For a complete list of recommendations and further explanation, see Chapter 6.
[5] The research in this HIA primarily focuses on problem solving courts, as opposed to diversion programs first because there is more research for problem solving courts than for the wide variety of existing diversion programs, which range from universal screening programs to day reporting to bail monitoring and beyond. Second, we were interested in outcomes beyond recidivism such as for recovery from substance abuse, ability to manage mental health issues, employment, and other health-related outcomes. Recidivism is the primary outcome measured in diversion program evaluations, and problem solving court evaluations had at least some level of measurement on some of these outcomes.
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APPENDIX 1. SCREENING, SCOPING AND ASSESSMENT METHODS

WHAT IS A HEALTH IMPACT ASSESSMENT?

Health Impact Assessment (HIA) is a public engagement and decision-support tool that can be used to assess policy and planning proposals, and make recommendations to improve health outcomes associated with those proposals. The fundamental goal of HIA is to ensure that health and health inequities are considered in decision-making processes using an objective and scientific approach, and engaging stakeholders in the process.

HIA is a flexible research process that typically involves six steps:

1. *Screening* involves determining whether or not a HIA is warranted and would be useful in the decision-making process;
2. *Scoping* collaboratively determines which health impacts to evaluate, the methods for analysis, and the work plan for completing the assessment;
3. *Assessment* includes gathering existing conditions data and predicting future health impacts using qualitative and quantitative research methods;
4. *Developing* recommendations engages partners by prioritizing evidence-based proposals to mitigate negative and elevate positive health outcomes of the proposal;
5. *Reporting* communicates findings; and
6. *Monitoring* evaluates the effects of a HIA on the decision and its implementation as well as on health determinants and health status.

SCREENING: WHY DO AN HIA ON THIS TOPIC?

In deciding if an HIA would add value to the substantial amount of research and advocacy that is taking place in Wisconsin and across the country on incarceration, we considered two things:
1) the extent to which decision-makers currently consider incarceration and its alternatives as interventions to the public health epidemics of substance abuse and mental health that result from incarceration, and the impacts these alternatives have on public safety; and
2) how incarceration and its subsequent outcomes impact the most vulnerable populations in our communities – racial and ethnic minorities in Wisconsin, children, and lower-income residents.

The answer to this first question was that by and large, decision-makers primarily considered the economic impacts of the criminal justice system and applied a knee-jerk, fear-based "tough on crime" lens without the evidence-base to support continued growth of the prison system. A perspective that would improve public health, correct the inequities in incarceration, and apply the more measured "smart on crime" approach seemed absent. For this reason, the team of organizations and agencies to consider problem-solving courts as an alternative to incarceration decided to move forward with an HIA.

While the primary partners for this HIA ultimately were considering the expansion of treatment alternatives to prison as the general policy, a specific policy proposal had not been identified or offered in the legislature. As such, WISDOM and Human Impact Partners convened an HIA Advisory Committee (described below) to craft a policy proposal as the subject of this assessment. The HIA Advisory Committee determined that a policy of the state contributing $75 million to fund treatment alternatives parallel to those that are currently funded at the level of ~$1 million (the current seven Treatment Alternatives and Diversion [TAD] programs) was a policy worthy of proposing and assessing.

In addition, resources were available as partial funding was obtained from the Robert Wood Johnson Foundation Roadmaps to Health project; WISDOM, the lead organization, had a robust multi-year campaign to consider the expansion of treatment alternatives to prison, and a myriad of partners were willing to participate (see partners in Scoping, below).

PARTNERS AND STAKEHOLDER ENGAGEMENT

Human Impact Partners and WISDOM were the lead organizations for this HIA.

Human Impact Partners' (HIP) mission is to transform the policies and places people need to live healthy lives. HIP accomplishes this by increasing the consideration of health in decision-making arenas through the use of health impact assessment. HIP both conducts HIAs and works to build the capacity of others to do so, with a focus on communities facing health inequities. HIP has conducted HIAs on the local, state and federal levels – with experience in communities across the country, from California to Maine. Working in direct partnership with communities, public health and other agencies, and academic experts, HIP helps pinpoint tailored strategies to bring diverse stakeholders to the table, navigate the practical steps of conducting HIAs and determine how to understand and use their results so that the health needs of the community are met. Through training and mentorship we also build the capacity of impacted communities and their advocates, workers, public agencies, and elected officials to conduct HIA and use results to take action. www.humanimpact.org

WISDOM was incorporated as a statewide entity in 2000, growing from the work of three local faith-based community organizations starting in 1988. WISDOM currently employs six full-time and two part-time organizers. WISDOM and its nine local member organizations throughout the state include active participation from approximately 145 congregations representing 19 different religious traditions and including more than 150,000 Wisconsin residents as congregation members. Though WISDOM is a multi-issue organization (recent campaigns include predatory lending and access to public transit), its work for alternatives to incarceration has been a constant. In recent years, WISDOM incarceration campaigns have had remarkable successes, including winning funding for the pilot alternative programs.

HIA ADVISORY COMMITTEE

At the outset of this project, as Advisory Committee was established to perform a variety of functions, including helping to screen the policy for the HIA, prioritize the scope of research, participate in data collection and assessment, review the draft products of the HIA, and disseminate the findings of the HIA. The HIA Advisory Committee consisted of the following organizations.

- **Community Advocates Public Policy Institute**. The Community Advocates Public Policy Institute goals are to explain why so many Milwaukeeans are poor, and to develop and implement a practical strategy to reduce poverty throughout Wisconsin. Community Advocates is a well-respected, Milwaukee-based research, advocacy, and service delivery organization currently working on developing a Community Corrections bill that would complement budget shifts.
- **University of Wisconsin, Madison** – Department of Sociology. Pam Oliver studies racial inequity in the criminal justice system and is an academic expert on this topic as well as a source for policy experts on a variety of topics.
- **University of Wisconsin, Madison** – Population Health Service Fellows – The fellowship is a two-year service and training program with a commitment to public service. The primary goal of the Fellowship Program is to develop the next generation of public health leaders skilled in planning, implementation, and evaluation of public health programs. Several committee members were Population Health Service fellows with a background and expertise in conducting HIA and building capacity across the state.
- **Wisconsin Center for Health Equity** - WCHE works at the intersection of social justice and public health. We recognize that Wisconsin is a state rich with strong organizations rooted deep in community development working toward health equity. Through our unique expertise, experience and approach, we work statewide as a catalyst and support system strengthening community and governmental efforts to attain health equity.
- **Wisconsin State Public Defender's Office** – in addition to providing legal services to those who cannot afford them in trial and appellate courts, the Wisconsin SPD advocates for effective defender services and a fair rational justice system.
- **MICAH** – Milwaukee Inner City Congregations Allied for Hope (MICAH) is the Milwaukee chapter of WISDOM. Reverend Joe Ellwanger is the statewide lead organizer for the 11 X 15 campaign and the lead community organizer with MICAH.

- **JONAH (Join Our Neighbors, Advancing Hope)** – John Stedman is the lead community organizer with JONAH, a chapter of WISDOM, and is also working statewide on the 11 X 15 campaign.

STAKEHOLDER ENGAGEMENT

Stakeholder engagement is a vital part of any HIA. The Wisconsin Treatment Instead of Prison HIA had the active participation of Advisory Committee members in all phases of the HIA. Advisory Committee members decided on the policy that was the topic of the HIA, prioritized research questions, vetted interim and final drafts of the HIA results, helped organize focus groups, reviewed literature, collected data, and disseminated the HIA findings and recommendations.

In addition to the Advisory Committee, there were other stakeholders and community members who participated. We heard from formerly incarcerated individuals, drug court participants, problem solving court judges, and drug court treatment providers in focus groups and interviews. WISDOM members from congregations across the state participated in Treatment Instead of Prison outreach, contributed to the HIA, and disseminated findings. State agency staff from the Wisconsin Department of Children and Families, the Wisconsin Division of Public Health, and the Wisconsin Department of Corrections provided data that was used in the HIA assessment.

SCOPING: WHAT WE DID AND WHY

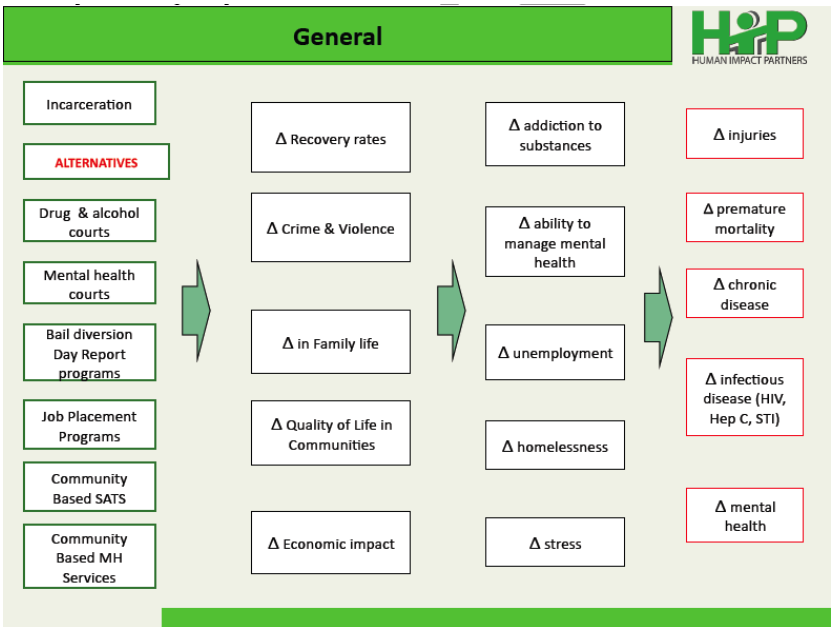
In the scoping stage of HIA, relevant stakeholders develop goals for the HIA and prioritize research questions and methods to guide the assessment. Partners identified the following goals:

- To influence the discussion around incarceration to include a public health frame.
- To reduce the prison population of Wisconsin by half, from the current 22,000 people, by 2015. WISDOM has entitled this goal as "11 X 15."

To that end, the main objective of this HIA was to predict the future health impacts on the Wisconsin prison population and their larger communities if problem solving courts and alternative treatment programs were expanded at a funding level of $75 million per year. This resource shift would mark a significant policy change that will impact many social determinants of health.

To aid our research, Human Impact Partners developed causal pathway diagrams that hypothesized the connections between the proposal and potential health outcomes. After sharing pathway diagrams and potential research topics with the HIA Advisory Committee, the direction of research was summarized in the following causal pathway diagram.

Pathways from a policy to fund treatment alternatives to health outcomes



PATHWAYS FROM A POLICY TO FUND TREATMENT ALTERNATIVES TO HEALTH OUTCOMES

Based on these hypotheses and the most plausible potential impacts identified, the following elements were identified as core components of this HIA: how would incarceration vs. problem-solving courts impact:
1) recovery from substance abuse and ability to manage mental health;
2) crime and public safety;
3) families and children; and
4) community outcomes such as employment, housing, and social cohesion.

A subset of the Advisory Committee (Research Committee) helped HIP develop research questions assessing these impacts and identify indicators to measure impacts. These questions and indicators were then prioritized by the entire HIA Advisory Committee. Research questions specific to each element are detailed in each section of the HIA.

Some decisions were made to narrow the scope due to resource constraints. For example:

- The HIA originally proposed to assess not only incarceration and problem solving courts as alternatives, but also community-based treatment outside of the criminal justice system. Ultimately a decision was made that including community-based treatment outside of the problem-solving courts was beyond the scope of the main research question of providing $75 million to fund alternative treatment courts such as those funded in the original TAD program.
- Also, since diversion programs such as day report centers and bail diversion are part of TAD, they were originally in the scope, but since the programming is similar to problem solving courts, a resource decision was made to include only problem solving courts in the literature review and data collection portion of the analysis. Diversion programs were considered in predictions portion of the assessment.
- An early decision to narrow the scope was to research the impacts of prisons and make predictions about the prison population, and not include jails. The primary reason for this was that the policy focused on the state allocating funding for TAD, so we focused on impacts to the state. Ultimately we included a prediction about the number of jail admissions who could participate in TAD programs due to the reality that TAD programs had averted more jail days than prison days. However, we did not revise the report to include literature about how the jail population might differ from the prison population due to time constraints.
- Finally, economic impacts were originally included in the scope, but the large breadth of current research on the economic impacts of problem-solving courts was considered adequate to inform the policy discussion such that its inclusion in this HIA was deemed unnecessary. However, findings from other economic research, most notably the University of Wisconsin La Follette School of Public Affairs.

ASSESSMENT METHODS

This HIA employed mixed research methods to assess the prioritized research questions. Specific methods included:

- **Literature review.** Scientific evidence on the relationships between incarceration, alternative treatments, and the health determinants we prioritized were gathered from the following databases: PubMed, Google Scholar, JSTOR, Sociological Abstracts, and criminal justice databases. In addition, evaluations of problem-solving courts were used extensively and citations were extracted from grey literature from organizations such as The Sentencing Project, Pew Center on the States, the Center for Court Innovation, Wisconsin's Office of Justice Assistance, the Wisconsin Public Defender's Office, and the Racial Disparities Task Force also supplied assistance in finding literature and studies.
- **Focus groups, key informant interviews, and observations**. In order to gather evidence to answer research questions for which there were no publicly available studies or when local evidence was prioritized, five focus groups were held. Two focus groups were with formerly incarcerated individuals, one with participants in a drug treatment court, one with drug treatment court judges, and one with treatment court service providers. Key informant interviews were also conducted with other problem-solving court judges, and one drug treatment court observation was conducted. All qualitative data collection took place in August 2012. Qualitative data was coded for themes and a summary of the results is included in Appendix 4.
- **Quantitative data.** The United States Bureau of Justice Statistics, the Federal Investigation Bureau's Uniform Crime Reporting Statistics, the Wisconsin Department of Corrections, Office of Justice Assistance, Department of Children and Families, and Department of Health Services were some of the major sources of data used throughout the report.

APPENDIX 2: HEALTH IMPACT ASSESSMENT TIP FOCUS GROUP GUIDES

INTRODUCTION

- **Thank you** for agreeing to participate in this focus group.
- **Who are we?** WISDOM is a congregation-based statewide organization that works on a variety of social justice issues. One of the biggest issues we are working on is the 11 X 15 campaign – to reduce by more than half the number of people incarcerated in Wisconsin from 23,000 to 11,000 by 2015. Human Impact Partners is a research organization that looks at the health impacts of policies, and we are doing a health impact assessment on this policy of increasing funding for alternatives to prison substantially.
- **Purpose.** We want to talk about your experiences of having been in prison, in drug court, as a judge or a drug court treatment provider in order to compare experiences that people have in prison or jail with experiences of alternatives to incarceration, such as drug treatment courts, mental health courts, and alcohol courts. We'd like to hear your opinion about the impact of spending time in prison or at a drug treatment court has on health, families, and communities. This focus group is part of the Health Impact Assessment, which is a study to try to predict how the following policy change will ultimately impact health if it is implemented.
- **Policy.** The policy change we are looking at is: What would happen if alternatives to prison were funded at $75 million instead of the current $1.2 million? As you may know, there is ongoing debate at the State House about how best to decrease the prison population, provide treatment for those who become involved with the criminal justice system due to drug or alcohol issues or mental health concerns, and how to keep communities safe and strong. Treatment courts are one solution that is receiving a lot of attention, and we would like to get your perspective.
- **Description of treatment courts.** If you are not familiar with treatment courts, they are offered to those convicted of certain types of crimes as an alternative to going to jail. At this point there are very few slots available, but if people are offered a slot, they agree to do a bunch of things: have urine tests several times a week, go to AA or NA meetings every night, have individual psychotherapy, have a case manager, and the like.
- **Timing.** We expect the HIA to be done around late November. At that time, WISDOM will use the results to have discussions with legislators and other decision-makers about the state budget.
- **Why you?** You have invited because you have been through the prison system in Wisconsin.
- **Our goal.** We want to create a narrative from alternative treatment providers, judges, those who have been through alternative treatments and through prison about how the alternatives impacted or might have impacted health. Your opinions and feedback will be used in a report that will feed into existing advocacy campaigns about how those with drug, alcohol, and mental health issues are treated in the criminal justice system.

LOGISTICS

Confidentiality

- Participation is completely voluntary – people can leave at any time
- Discussion is totally confidential - will not report/describe comments by name - will keep no records of participants' names/addresses
- Do not need to state full name
- The final HIA report will have data from many sources – not just these focus groups that we are doing with different people.

Discussion

- There are no right or wrong answers so please feel free to be totally honest. We appreciate your input, and want to hear from all of you about experiences at work and how those experiences might relate to your health
- Hope the information can help identify ways to save permanently affordable public housing.

Process

- We have scheduled 2 hours total for this focus group.
- We will ask fairly broad questions, but really looking for you to elaborate on your experiences

- My role is to guide the discussion – focus on some questions and let people tell their stories
- Sometimes might have to move everyone onto another question so we can get through it – or to give everyone a chance to speak - Please don't take it personally!
- Not everyone has had the same experience, which is why this is so valuable to us, but also why we want to remind everyone to respect others' experiences
- We will be talking together for about two hours
- Permission to audiotape? Want an accurate description of what was said; will also take notes, if that's ok with folks.
- If folks agree to audiotape, we will start recording after introductions
- Hand out information sheet with my contact information
- Please let us know if you want to receive the report when it is done, which should be some time in late November. If so provide us with a way to get it to you separate from this focus group (perhaps there is a sign-in?)

QUESTIONS FOR FOCUS GROUPS WITH THOSE FORMERLY INCARCERATED

1. If you had had the opportunity to volunteer to go to an alternative treatment program, like a drug treatment court or mental health court, instead of prison, would you have? Why or why not?

The following questions have to do with how being in prison impacted your health.

2. How did being in prison impact your health? After you were released, has having been in prison impacted your health? In what ways?
    - *Probes: Physical assault, sexual assault, depression, stress, addiction recovery, mental health treatment, etc.*
3. Did you experience any interruptions in medical care as a result of going into prison, or leaving prison? If so, can you tell us a little bit about them?
    - *Probes: could not get medications for a span upon entering prison, was unable to get Medicaid or other health insurance after prison, etc*

The following questions have to do with being able to get help with problems with drugs, alcohol, and mental health issues.

4. If you have had issues with drugs or alcohol, did your experience in prison help in any way? Was it detrimental? Or neutral, with regard to drugs and alcohol? How so?
    - *Probes: substance abuse treatment services in prison, ability to access those types of services after release, supportive environment for recovery, etc*
5. If you have had mental health problems, such as stress, depression, anxiety, or other types of mental health issues, did your experience in prison help in any way? Was it detrimental? Or neutral, with regard to being able to deal with any mental health issues? How so?
    - *Probes: mental health treatment in prison, ability to access those types of services after release, supportive environment for mental health, etc*
6. What impact do you think your race or ethnicity has had on your experience with the criminal justice system?
7. Are you a parent? What impact did going to and being in prison have on your children and family?
    - *Probes: could not communicate with family, tension with partners, disappointed family, loss of in come, stigma, lack of a role model*
8. Do you live in a community where a lot of people have been incarcerated? If so, what kind of impact do you think that has had on your community?
    - Probes: Seems normal to go to jail, lack of role models, a lot of people who can't get jobs, a lot of stress and/or sadness, many single mothers, many people who are homeless because they can't get housing, participation in the "underground economy" has gone up/down etc.
9. How has having been incarcerated impacted your ability to access other resources? How has your ability to be able to access these resources impacted you and your family?
    - *Probes: Get a job, get housing, further your education, have a good income, etc*

Questions for focus groups with participants of drug treatment courts

1. What type of treatment court program or alternative to prison did you participate in?
    - *Probes: drug court, alcohol court, mental health court*
2. How did participating in drug, OWI, or mental health court impact your health?
    - *Probes: Dealing with addiction, seeing health care providers, treatment for illnesses, stress, ability to get prescriptions, etc.*
3. People elected to public office make decisions about how government money is spent. If you had the chance to talk with them about alternatives to incarceration, what would you tell them? What is the most important thing they should know?
4. Elected officials say public safety is among their highest priorities. Do alternatives to incarceration affect public safety? Are there aspects of alternatives to incarceration that make communities less safe? Safer?
5. Did you graduate from the program? For those who completed the program, what helped you to do that? For those who did not, what was your obstacle and what do you think would have helped you?
    - *Probes: Support from family, outpatient setting, addiction support, what else??*
6. How has participation in this program impacted your life? How do you think it might have been different if you had gone to prison?
    - *Probes: Avoided prison, avoid future arrest, stayed with family, dealt with addictions, got connected to resources*
7. Describe the different services you were able to access in your alternative treatment court. How were these services helpful? Why or why not? Have you needed to access those types of services post-treatment court? If so, have you been able to access them?
    - *Probes: Mental health providers, job placement resources, health care, etc.*
8. What impact do you think your race or ethnicity has had on your experience with the criminal justice system?
9. Are you a parent? What impact did participating in the treatment court have on your children and family?
    - *Probes: Was able to see children, didn't disappoint family by going to prison, could provide financial resources by continuing to work, etc.*
10. Do you live in a community where a lot of people have been incarcerated? If so, what kind of impact do you think that has had on your community?
    - *Probes: there are a lot of single mothers, people have stress and anger, there are people who are homeless because they can't get housing, participation in the "underground economy" has gone up/down, etc.*
11. How has having gone through a treatment court impacted your ability to access other resources?
    - *Probes: Get a job, get housing, further your education*

Questions for treatment court judges

1. How do you think incarceration versus treatment alternatives have impacted health outcomes for those sentenced to each?
    - *Probes: ability to deal with addictions, access to services, access to treatment, mental health, physical/sexual assault*
2. What do you think works about treatment alternatives? What could be improved?
    - *Probes: getting underlying issues addressed, future employability, deterring future crime, etc.*
3. People elected to public office make decisions about how government money is spent. If you had the chance to talk with them about alternatives to incarceration, what would you tell them? What is the most important thing they should know?
4. Elected officials say public safety is among their highest priorities. Do alternatives to incarceration affect public safety?
    - *Probes: Are there aspects of alternatives to incarceration that make communities less safe? Safer?*

5. Do you feel like treatment courts offer offenders who use drugs and alcohol the best road to recovery? Why or why not?
6. What has your experience been with regard to treatment courts vs. incarceration to keep parents with their children?
7. How do treatment courts affect the racial inequities evident in the criminal justice system?
    - *Probes: in terms of who is in prison, who is arrested, who can access resources, who can stay with family, etc.*
8. It seems that treatment courts require an extra commitment and more time from judges. Is this accurate? In your opinion, is that time and commitment worth it? Why or why not?
9. If TAD programs were scaled up from their current $1.2 million to $75 million state-wide, what type of impact would that have on communities (specifically communities where a lot of people have been imprisoned)?
    - *Probes: less people in prison, less recidivism, families staying together more, better employment outcomes, etc.*

Questions for treatment court service providers

1. What type of treatment court do you work for? What type of provider are you?
2. What types of health issues do you see treatment court participants dealing with?
    - *Probes: addiction, recovery, mental health, stress, etc.*
3. How do you think treatment courts are able to have any impact on these issues (even if in a tangential way)?
4. Do participants experience any interruptions in medical care as a result of their arrest and subsequent participation in your program? What impact do those interruptions in service or coverage have on their health?
5. What services offered through your program do your participants take advantage of the most? The least?
6. Who typically chooses/is offered the choice to participate in the programs? Why do you think that is?
7. Has the treatment court had any impact on the provision of services to the community that it is in?
    - *Probes: more providers, more different types of services, cut the cost of services to community members outside of the court programs because the costs are supported through the treatment court*
8. Are there disparities with regard to who is offered the option of treatment courts? How so, and why?
9. How do you think your program impacts access to resources for those who have been enrolled (whether or not they graduate)? How is this different from someone who is incarcerated?
    a. *Probes: finding housing, finding employment, completing/continuing their education?*
10. How do you think your program impact parents and families? How is this different for those who might be incarcerated?
11. In terms of community-wide impacts, what do you think the difference is of having residents of the community treated locally in treatment courts available vs. having those residents of the community incarcerated?
    a. *Probes: fewer single mothers, less interruption in employment (i.e., more people employed), less homelessness, etc*
12. People elected to public office make decisions about how government money is spent. If you had the chance to talk with them about alternatives to incarceration, what would you tell them? What is the most important thing they should know?
13. Elected officials say public safety is among their highest priorities. Do alternatives to incarceration affect public safety? Are there aspects of alternatives to incarceration that make communities less safe? Safer?

APPENDIX 3: WISCONSIN TREATMENT INSTEAD OF PRISON FOCUS GROUPS METHODS AND FINDINGS

INTRODUCTION

This narrative summarizes the findings of five focus groups and two interviews with treatment court judges regarding a proposal to increase funding for treatment alternatives to incarceration in Wisconsin, or Treatment Instead of Prison (TIP). The focus groups were conducted by Human Impact Partners and WI TIP HIA Research Committee members ("HIP") as part of a larger health impact assessment (HIA) of this funding proposal. The purpose of these focus groups was to gather qualitative information on the experiences of former prisoners, drug court participants, problem-solving court providers, and problem-solving court judges. Questions were about the effects of being incarcerated or going through a problem-solving court on mental and physical health, as well as family and community health.

HIP conducted the focus groups in August 2012 with members of Voices Beyond Bars in Madison, Table of Saints in Milwaukee, Milwaukee Drug Treatment Court participants and graduates, Milwaukee drug treatment court judges, and providers of alternatives treatment court services.[1] HIP also conducted interviews with Eau Claire treatment court judges and observed a drug treatment court in Milwaukee.

Given the limited availability of data of how problem-solving courts affect some of the outcomes identified as most important and influencing health, findings from these focus groups help to fill some of these data gaps. And while these findings may not be representative of all of the groups represented, the results provide powerful perspectives often overlooked in a discourse dominated by economic cost-benefit analysis.

METHODS

Upon initial contact from HIP researchers through WISDOM 11 X 15 connections and an explanation of the HIA purpose, organizers of each type of participant group agreed to have researchers hold focus groups during regularly scheduled meetings of their members and participants. The two interviews were with judges who were unable to travel to the judges focus group, and the drug court observations was invited via one of the drug court judges.

The Voices Beyond Bars and Table of Saints focus groups convened as leaders of these groups invited HIP to a regular meeting of their membership. Thirteen participants were present for each focus group. At Voices Beyond Bars in Madison, WI there were 12 men and 1 woman who had been in prison or jail, and of those thirteen, eleven were African American and two were white. At Table of Saints all participants were men, twelve were African American and one was white. The Public Policy Institute of Community Advocates[2] helped to arrange both the Milwaukee Drug

Treatment Court participant and the alternative treatment provider focus groups. At the Milwaukee Drug Treatment Court focus groups, 14 people participated, of whom ten were men and four were women. The racial mix in this group included 6 African-Americans, 7 white, and 1 Mexican-American. The focus group and interviews with judges included a total of five judges, three from Milwaukee and two from Eau Claire counties. The focus group with alternative treatment providers was held in Milwaukee and included clinicians, counselors, administrators, and therapists with organizations that are contracted to provide treatment services for drug courts. All focus groups and interviews were conducted in English.

If I didn't go to treatment court, I would have ended up dead somewhere when I got out of jail.
-Treatment court participant

[1] Voices Beyond Bars and Table of Saints are support and advocacy groups for formerly incarcerated individuals.
[2] The Community Advocates Public Policy Institute develops and implements practical strategies to reduce poverty throughout Wisconsin. They are a Milwaukee-based research, advocacy, and service delivery organization currently working on developing a Community Corrections bill that would complement budget shifts. See http://communityadvocates.net/ppi/

Participation in all groups and interviews was completely voluntary, and participants were told that their names and identifying information would be kept confidential. Each participant in the formerly incarcerated focus groups received a $20 Pick-n-Save gift card as compensation. Focus group moderators asked for permission to take notes at the outset of the meeting in an effort to obtain an accurate description of the discussion.

FINDINGS

In 2006, the state of Wisconsin appropriated approximately $1 million in the state budget to fund six pilot treatment alternatives and diversion programs in the state of Wisconsin.[3] Ultimately, seven programs were funded by the state and were intensively evaluated. [4] At the time of press, there are 44 problem-solving courts in Wisconsin, mostly funded through federal grants and other means; the state funding in the 2012 budget is under $1 million. Knowledge of problem-solving courts in participants in the focus groups ranged from intimate knowledge by judges and those going through the drug court; moderate knowledge of the entire treatment court program by treatment providers, to little to no knowledge from some of those who were formerly incarcerated.

Prison and Problem-Solving Court Impacts on Health

There were some details about physical health impacts of prison, but far more comments about mental health impacts. Physical health impacts ranged from effects of infectious diseases passed through poorly sanitized cells to infections caused by neglectful hygienic conditions. Other physical health effects described mostly had resulted from misdiagnoses, ignoring a problem despite repeated entreaties, lack of proper treatment or neglect, poor diet, lack of ability of prisoners to pay for the health care required, and poor condition of health care infrastructure. Mental health impacts of prison were many, with the most commonly mentioned being automatic prescribing of medication for anxiety and depression when there was no history, prescribing the wrong medication due to expense, and side effects from such medications. There was a generally held opinion that "they put you on medication for security and control." Additionally, stress and depression were common, and were the effects from being cut off from families, being "broken down" when arriving, living with no control, and coming in with a limited set of social tools to advocate for oneself. Two positive health impacts of prison were first, a religious and spiritual connection to God, which helped many prisoners through tough times, and second, working out with weights, if an individual took advantage of it.

Participants noted that treatment courts literally saved lives. Judges demonstrated that treatment courts took people when they had a blood alcohol level of 5.3, or they were seizing so badly in jail from withdrawal that they were harming their shoulders. Judges pointed out that to monitor people's driving they have taken away keys or disabled vehicles. On a very basic level, participants talked about problem-solving courts connecting them to health care services right away, providing long-needed glasses or dental work, although treatment court providers noted that participants' access to services was not extensive enough to meet the need.

However, again the positive mental health effects of treatment courts were most profound. Instead of being looked at as a "monster" from being in prison, others in their communities cheered them on. "An individual that's given opportunities to do something for himself looks at himself differently." As a focus group participant who went through a drug treatment court stated, "Prison doesn't give you the tools and socialization to live in society", and treatment court "gave me the tools I needed to be good in every aspect of my life. They gave me a chance."

Prison and Problem-Solving Court Impacts on Recovery from Substance Abuse and Ability to Manage Mental Health

A resounding finding from the focus groups was that those in prison wanted to the chance to embark upon treatment programs but there is a lack of programming so the waiting list is very long. Prisoners wanted to start Alcohol and Other Drug Abuse (AODA) programs early on in their incarceration but are not eligible for them until 30 months prior to their mandatory release date, by law. At times they are not eligible for years or even decades, so they cannot

[3]See the Wisconsin Office of Justice Assistance description: http://oja.state.wi.us/programs/criminal-justice/treatment-courts-and-diversion-programs
[4]See the University of Wisconsin – Population Health Institute for a copy of the evaluation: http://uwphi.pophealth.wisc.edu/about/staff/van-stelle-kit.htm

access substance abuse treatment. By the time they are eligible, many are bitter with the system that does not reward their motivation. Many questioned a system that would treat illnesses, such as chronic mental health issues and substance abuse, with incarceration.

For 20 years I had an addiction, heroin, crack – it was known by the courts that this was the driving force behind my crimes. Not once in 3 incarcerations – a total of 12 years - did I ever get treatment inside the prison walls.
- Formerly incarcerated focus group participant

For those who were able to access treatment programs while incarcerated, they often spoke of the inadequacy of those treatments, either because providers did not care about them as individuals, or the treatments were behavioral and did not get to the psychological root of their substance abuse issue. More than one participant felt that prison programs existed to keep the providers employed, not to help prisoners with their issues. Many noted that what offenders need is opportunities – mostly in the form of jobs – and access to helpful programming and assessments to deal with their addictions and mental health issues. As one treatment court provider of services stated, "Treatment while incarcerated does not give the person the tools to survive once they are out – this is what we've seen."

Problem-solving courts combine treatment with accountability in a way that helps people make a change.
- Treatment Court Judge

Nearly every former prisoner felt that they would have jumped at the chance to go to problem-solving courts if they had only been offered. In one of the focus groups with former offenders, about 95% of those attending had had substance abuse issues that resulted in their imprisonment. In one focus group with former prisoners there was less familiarity with the concept of drug courts and distrust that they would be successful until one of the participants who had read evaluation results told them of a 75% success rate with the local drug treatment court. Bolstering multiple evaluation results in Wisconsin and across the country, drug treatment court participants and judges said over and over again that treatment courts work to help people overcome their addictions and get help for their psychological issues. Every judge we asked agreed that while problem-solving courts take a lot of the judge's and participant's time, every judge also stated that it is absolutely worth it. One summed it up this way, "My treatment court is the most meaningful thing I have had the opportunity to do. To know that you can help them, their family, and see the impact in such a positive way is absolutely worth it."

My mental health wasn't good when I got there, and being in prison made me more paranoid and introverted. I shut down and cut everything off.
- Formerly incarcerated focus group participant

The services and supports offered through problem-solving courts help participants start and stay in recovery. Resources such as housing, job training and placement, peer support with AA and NA, counseling, Vivitrol shots to decrease addiction to heroin, random urine tests, and help from those in their cohort are some of the many services available. The combination of these resources with intensive monitoring that make up the best practices of treatment courts support participants in their recovery. The humanity of treatment courts also leads to success; participants felt like they were being given a chance and opportunities for success, and that people really cared what happens to them.

There's a parable from the Bible where they are going to cut down a tree because it is not growing, and another guy says, 'Give me a year to bring it back to life. I will fertilize it and take care of it.' That other guy was drug court for me. I was the tree. Drug court gave me that care for that year, they gave me another chance.
-Treatment court participant

Prison and Problem-Solving Court Impacts on Crime and Safety

Focus group participants agreed with the preponderance of evidence that prison leads not to less, but more crime. As one former prisoner said, "I don't believe that the Department of Corrections really wants to reduce recidivism. If you don't take the scarlet letter away, there's no change at redemption." Varying reasons for prison's negative impact on public safety were offered: learning from and being connected to other criminals; a negative impact of the atmosphere, the lack of programs and services that address the underlying psychological and socioeconomic roots of crime; and

extreme lack of opportunity post-incarceration. Participants from all focus groups acknowledged that there are some people for whom there must be an imprisonment option, but everyone also agreed that the majority of people do not need that level of controlled structure.

> *We're actually more at risk and less safe because people come out of prisons worse than they went in.*
> *- Treatment Court Judge*

The impact of treatment courts on recidivism and thus crime and public safety is well documented in a myriad of evaluations. Our participants echo those results in saying that by dealing with the reasons people have to commit crimes, whether that be addiction to illegal substances or unaddressed mental health issues, will reduce crime. Reasons that treatment courts work to reduce recidivism that participants gave mostly had to do with following the best practices of problem-solving courts – a combination of treatment and support with close monitoring and accountability; having a "stick" if participants in problem-solving courts are noncompliant; targeting the highest-risk offenders that need the structure of the treatment court and will reduce crime the most. As one judge said, "You get more effective changes in an individual by these programs rather than the routine 'I'm going to lock you up and let you have some in-prison programs'. If you really want to be successful, you have to focus on their issues."

> *I don't steal when I'm 'normal'. But before I needed my drugs, and I needed to do what I had to do to get them – I would steal whatever I could. Now that I've been through drug treatment court, I am not going to be doing those things again.*
> *-Treatment court participant*

Prison and Problem-Solving Court Impacts on Families

The impact of prison on families is heart-wrenching. Parents who had been prisoners reported feeling like failures, and missing large portions of their children's lives. Most also reported that their children had either cut off all contact for a portion of time, or forever. Minimally the relationship between parents and children was strained, with a ready accusation: "Where were you when I needed you?" In some cases, parents lost custody of children due to the substance abuse and mental health issues that led to their crimes. Prison does not support family relationships; often prisons are hundreds of miles from the family and difficult to visit so contact is mainly through letters. One judge pointed out, "Prison is a horrible place for a child to visit."

> *When you see problem-solving courts done well, they really bring families together instead of tearing them apart, as incarceration does.*
> *- Treatment Court Judge*

On main benefit to problem-solving courts is that the participant remains in the community – and with their family unless there is a treatment reason for them not to be there. One drug court participant said, "At first I hated drug court, then I started to like it because it started helping me. I saw results, I started to have a better relationship with my family, and I started being a better person." Participants noted that their parents and siblings became their "No. 1 supporters", and involving families as part of a support system was an important part of the recovery process. A treatment court provider witnessed, "Parents get to practice parenting skills and find out the best way to be a parent." Finally, participants of drug courts and judges detailed how problem-solving courts help participants keep custody of their children through support and advice of peers but importantly through the close monitoring of case managers, parole agents, and other treatment team members, which leads to a clean house, appointments kept, clean urine screens, and the ability to financially support their children by maintaining their job.

Prison and Problem-Solving Court Impacts on Communities

The impact of living in communities where many men and women go to prison was not very different for those who had been in prison as for those who went through treatment courts. All spoke of the constant temptation of readily available drugs, the stress of living with high crime, and the lack of role models following a non-criminal way of life. However, in the focus groups with formerly incarcerated participants, many spoke of a commitment to working with their communities to keep others out of prison, to help them get jobs and stay off drugs.

Drug courts . . . give us the opportunity to actually give back to the community by giving us the means to get a job and be part of society.
-Treatment court participant

For those in drug treatment courts, there were hopeful comments about showing the friends they used to associate with that another way of life is possible. One alumni of a drug treatment court said that the first year he was in the community he kept getting approached by drug dealers, but after a while the community members started cheering for him. One of the biggest impacts to community well-being that problem-solving court participants and judges note was the opportunity for those participating in problem-solving courts to remain in the community and work in a job, or prepare to work. Almost all of drug court participants mentioned that they were either working or in school leading to a vocation, and that the court helped them figure out what they could do, get enrolled, or get them hooked into work. It is important to note that treatment providers for drug courts were very critical of the current lack of enough services available to help people participate in the community, particularly to gain employment, within treatment courts. Treatment court participants felt well-supported by proffered resources, but providers felt it was not nearly enough.

I have a 24 year old daughter who doesn't know who I am. I contacted her when I started getting my life together, and her response to me was 'I don't know you, where were you for all the birthdays and Christmases?' I don't have a relationship with my child because of incarceration.
- Formerly incarcerated focus group participant

There is vast literature base to bolster observations by former prisoners that it is more difficult for someone with a record to get a job. One formerly incarcerated man stated that the job training programs in prison are "not worth the paper the certificate was printed on", and those that mentioned being able to get work were highly self-motivated. "Prison was a deterrent for trying to get a job – it didn't motivate me. Prison did not give me a productive feeling, it gave me animosity that triggered relapse."

What Works with Problem Solving Courts

Drug court participants and problem-solving court judges are committed to this alternative method to reduce crime in society with a zeal that comes from taking part in something that works. As one judge stated when asked what they got out of being a treatment court judge, "It's the best thing I ever did, no question about it. You feel like you're actually doing something. To be part of a team, to say we want to do what's best rather than what's easiest – that's harder than just sending people to prison, and more satisfying."

My treatment court is the most meaningful thing I have had the opportunity to do. To know that you can help them, their family, and see the impact in such a positive way is absolutely worth the time required.
- Treatment Court Judge

So, what makes drug courts work? Following evidence-based decision-making, and following the 10 components of treatment courts. More specifically, judges note taking high-need offenders who need the structure and monitoring that problem-solving courts offer, providing treatment with oversight and accountability, having an array of services ranging from case management, counseling, peer support from AA and NA, housing support, job training and placement, random urine tests, the chance to have one's record nullified, the risk of going to jail if noncompliant, and good communication and collaboration between all members of the drug court treatment team.

A vital element of what makes problem-solving courts work, however, is the dedication, temperament, and supervision of the judge. Problem-solving court judges readily note that "not every judge should be a treatment court judge," but it was clear from the drug court participant focus group as well as from observation of the drug court that while participants mentioned the toughness of their judge, they also felt fond of him, respected him for calling them on noncompliant behavior, and felt that they mattered to him as well as to the treatment team. In drug court observation, the team communicated about what was working or not for participants in great detail, and the judge's pride in their successes and honest communication when they were straying was inspirational.

What Does Not Work with Prisons and Problem-Solving Courts

While treatment court participants felt that they were able to access many services, it was clear from talking with clinicians who provide services that there is a need for much more, especially regarding employment services, mental health treatment, and ensuring that offenders who participate have access to health insurance, health care, and uninterrupted medication. Providers were also critical of the emphasis on monitoring compliance and infractions with treatment court rules versus helping clients comply with treatment for their addiction. Finally, due to insufficient funding, providers felt that the lack of case managers turned counselors into case managers and stretched the limits of their knowledge of referrals as well as time to provide counseling.

Focus group participants also addressed the issue of race. Former offenders, treatment court participants and judges all mentioned that at each stage of the criminal justice system there is racism, however, the front end of arrest and being stopped by the police was singled out as most inequitable. African American and Mexican participants are stopped often and for no reason in their communities. The stage of sentencing and charging was not free of racism, though, and similar stories of receiving a harsher sentence than white individuals who had committed similar crimes abounded. Even prison selection for privileged programs are rife with racial inequities. One former prisoner stated, "I was in this unit called the earned release program. In my mind I felt that there were more white guys in prison than black, but then I was in another unit and saw. The Earned Release Unit was a 6 month unit where you got to go home after it, in other words, it was a privilege to be in that unit and it was selective who got to go. So, there were a lot more white guys in that selective unit than in the regular prison."

All of this leads to what many mentioned – that there is an inordinate disproportion of African Americans, who make up about 6% of Wisconsin's population, being incarcerated. In some places, like Milwaukee, the proportion of African Americans in prison is approximately 50%, according to several focus group members. In other places, while the proportion of people of color is much lower, they are still represented more highly in the criminal justice system – in one area of rural Wisconsin there are not many African Americans, but there is a disproportionate number of Native Americans and Latinos in prison.

While treatment court judges try to apply eligibility criteria fairly and note that those who want to participate in treatment courts all have the same chances of getting in, they are still judging those who have first been arrested, charged, and made it to trial. Drug court participants felt that there were no racial impacts of treatment courts, yet the numbers in our focus groups were telling, if not randomly selected and representative; less than half of the Milwaukee drug court participant focus group was African American, and in both the Milwaukee and Madison focus groups with formerly incarcerated individuals, about 93% of those attending were African American. Racism is a larger problem than in problem-solving courts and starts in society at large and in all parts of the criminal justice system, however, problem-solving courts must do a better job at targeting those selected to more fairly represent who is already in the system.

Beyond dealing with racism, there were other recommendations to improve the criminal justice system, and some applying to problem-solving courts specifically. For example: require evidence-based decision-making (EBDM), such as that which is currently applied in problem-solving courts, throughout the entire criminal justice system, and support that with training in EBDM; reverse the trend of criminalizing every activity; develop a database to evaluate outcomes and effectiveness of problem-solving courts, and including a range of outcomes beyond recidivism; more state assistance for employment, one of the biggest barriers to success for anyone in the criminal justice system; not require that judges put in extra time in order to administer a treatment court; i.e., to make the significant time required for treatment courts a legitimate part of their calendar; and the biggest suggestion was to expand problem-solving courts exponentially so that more people could be helped.

What Participants Want Elected Officials to Know

We asked all focus group participants if they could tell elected officials one important thing about problem-solving courts, what would that be? Resoundingly, they all wanted decision-makers to know that problem-solving courts cost less and are more effective at protecting public safety then incarceration. Given the cost `of incarceration (~$32,000/year per prisoner) and problem-solving courts (~$8,000/year per participant), why, they ask, are we spending more money on a system that is inferior to reaching it's stated goal of protecting public safety? As one judge said, "Alterna-

tives to incarceration saves money and saves lives – in a variety of ways. It's much cheaper to treat people than to lock them up, and you have better outcomes. There is less recidivism, fewer victims, and less use of the justice system. You end up with contributors to society and all of the benefits of that."

> *Why would a system ask people to change then not make room and support for the change?*
> *- Formerly incarcerated participant*

The second major thing that participants wanted elected officials to know is that problem-solving courts saves lives, and that the health benefits of treatment courts are obvious and important. Drug court participants wished for more drug court slots so that more people could benefit in the way they had. One person stated, "Drug court saved my life." If you turn the health benefits into dollars saved, you see the financial benefits of health savings as well as the savings strictly within the criminal justice system. In Eau Claire, they quantified some of the benefits they have seen from problem-solving courts: "Families stay together so there are no foster care costs, we have more drug-free babies which saves money, and people get jobs – they pay taxes, child support, rent – it's amazing how much money is saved for every dollar spent."

CONCLUSION

Collectively, the stories and experiences of participants illustrated that whether one is sent to prison or participates in a drug court can have very different effects on their health via a number of different pathways. From former offenders, judges, and treatment court providers, prison is seen as harmful to mental health, how people see themselves, their relationship with their families, and their ability to operate in society once they are out – and prison does not reduce crime. Participants in the focus groups and interviews feel that treatment courts work for their stated purpose – getting people treatment to combat their addictions. Treatment courts also save lives, keep people connected to the community, put them back to work, and keep families together. All of these benefits cost the taxpayer and the state much less than incarceration. Treatment courts need tweaking; they are not perfect. However, much suggested changes have to do with needing more resources and ensuring racial equity.

APPENDIX 4. SUBSTANCE ABUSE AND MENTAL HEALTH TREATMENT PRINCIPLES

Principles of Substance Abuse Treatment for the General Population, Corrections, and Drug Courts

	National Institute on Drug Abuse (NIDA) Principles of Effective Drug Treatment[1]	NIDA Principles of Effective Drug Treatment for Criminal Justice Populations[2]	National Drug Court Institute Guidelines[3]
1	Addiction is a complex but treatable disease that affects brain function and behavior.	Drug addiction is a chronic brain disease that affects behavior.	
2	No treatment is appropriate for all individuals.	Tailoring services to fit the needs of the individual is an important part of effective drug abuse treatment for criminal justice populations.	Ongoing participation with each drug-court participant is essential.
3	Treatment needs to be readily available.	Treatment needs to be readily available.	Eligible participants are identified early and promptly placed in the drug court program.
4	Effective treatment attends to multiple needs of the individual, not just his or her drug use.	- Treatment should target factors associated with criminal behavior. - See also Row 2.	A coordinated strategy governs drug-court responses to participants' compliance.
5	Remaining in treatment for an adequate period of time is critical for treatment effectiveness.	- Duration of treatment should be sufficiently long to produce stable behavioral changes. - Recovery from drug addiction requires effective treatment, followed by continued care. - Continuity of care is essential for drug abuser reentering the community.	
6	Counseling - individual and/or group - and other behavioral therapies are critical components of effective treatment for addiction.		Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.
7	Medications are an important element of treatment for many patients, especially when combined with counseling and behavioral therapies.		Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.
8	An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs.	- Assessment is the first step in treatment - Criminal Justice supervision should incorporate treatment planning for drug-abusing offenders, and treatment providers should be aware of correctional supervision requirements.	Ongoing participation with each drug-court participant is essential.

	National Institute on Drug Abuse (NIDA) Principles of Effective Drug Treatment[1]	NIDA Principles of Effective Drug Treatment for Criminal Justice Populations[2]	National Drug Court Institute Guidelines[3\]
9	Many drug-addicted individuals also have other mental disorders, and they should have both disorders treated in an integrated way.	Offenders with co-occurring drug abuse and mental health problems often require an integrated treatment approach.	--Forging partnerships among drug courts, public agencies, and community-based organizations enhances drug court effectiveness and generates local support.
10	Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.	Medications are an important part of treatment for many drug-abusing offenders.	--Effective drug court operations require continuing interdisciplinary education.
11	Treatment does not need to be voluntary to be effective.	A balance of rewards and sanctions encourages pro-social behavior and treatment participation.	--Drug courts integrate alcohol and other drug treatment services with justice system processing. --Drug courts use a non-adversarial approach, with prosecution and defense counsel promoting public safety while protecting participants' due process rights.
12	Drug use during treatment must be monitored continuously, as lapses during treatment do occur.	Drug use during treatment should be carefully monitored.	--Abstinence and use of alcohol and other drugs are monitored through frequent drug testing. --Monitoring and evaluation measures the achievement of program goals and gauges effectiveness.
13	Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves or others at risk of infection.	Treatment planning for drug-abusing offenders living in or reentering the community should include strategies to prevent and treat serious, chronic medical conditions such as HIV/AIDS, hepatitis B and C, and tuberculosis.	

APPENDIX 5: PROBLEM-SOLVING COURT EVALUATION SUMMARIES

Drug Court Evaluation Outcomes

Title of Evaluation	Year	Study design	Comparison group	Recidivism rate
Multi-site Drug Court Evaluation [7]	2011	23 Drug Courts and 6 comparison sites = 1,781 participants; self-report surveys at baseline, 6 mo and 18 mo after baseline	Comparison sites were in same geographic areas as drug courts; included array of activities to assist drug-involved offenders rather than strict "no treatment"	In 18-mo interview 40% of drug court participants self-reported committing crimes vs. 53% of comparison group. Probability of re-arrest over 24 months 52% for drug court participants vs. 62% for comparison group, but this was not statistically significant
GAO Drug Court Evaluation[8]	2011	Reviewed evaluations of 32 drug court programs	Evaluations included a comparison group	Re-arrest percentages were lower for drug court completers than for comparison groups by 12% – 58%. If looking at all drug court participants, re-arrest rates were lower by 6% - 26%.
Wisconsin Treatment Alternative and Diversion (TAD) Evaluation [9]	2011	Evaluation of 7 TAD sites from 2006 – 2010, looking at drug court graduates vs. terminators	Comparison was drug court terminators, not those who were incarcerated	11% of TAD graduates were convicted of new offense within 1 year vs. 23% of those who were terminated. As a comparison, WI DOC data has that 38.2% of a new crime within 3 years.
Dane County Drug Treatment Court Evaluation[10]	2011	137 people charged with drug related crimes from 2004 – 2006 in Dane County, WI. Matched case-cohort study.	Comparison group were those eligible for drug courts but underwent typical adjudication	30% of Dane County Drug court participants committed a new crime vs. 46% of comparison group
New York City Drug Treatment Alternative to Prison (DTAP) Program [11]	2003	280 DTAP participants and 130 comparison.	Comparison group is matched; went through regular criminal justice process.	39% of DTAP completers are rearrested after 2 years vs. 58% of controls; 26% of DTAP graduates are reconvicted after 2 years vs. 47% of controls
Sentencing Project [12]		Review of 76 drug court evaluations	Individual evaluations had comparison groups	10% reduction in rearrest; 13% decline in reconvictions. Also sites GAO report and MADCE evaluations.

Mental Health Court Evaluation Outcomes

Title of Evaluation	Year	Study design	Comparison group	Recidivism rate
Clark County, WA MH Court Evaluation[13]	2005	Outcomes for 368 offenders with mental illness 12 months before and after MH court	No comparison group	In 12 months pre-MHC, all offenders had 718 arrests and 26% were frequent offenders; in 12 months post-MHC, 199 remained arrest-free and the remaining 169 were arrested 178 times; only 2.8% were frequent offenders.
Eau Claire County MHC Evaluation[14]	2011	Outcomes from 17 offenders admitted since 2008	No comparison group	In 3 years prior to MHC, these 17 people had 98 arrests and 4,277 incarceration days; since 2008 they accounted for 12 arrests and 843 incarceration days.
Southeastern US MHC Evaluation[15]	2006	82 participants with mental health issues in MHC in 2001 – 2002	183 similar offenders in traditional criminal court (TTC) the year prior to establishment of MHC	Rearrest for MHC participants was ½ of that of TTC; for those completing MHC rearrest was ¼ that of TTC.
San Francisco MHC Evaluation [16]	2007	170 participants in San Francisco MHC from Jan 2003 – Nov 2004	8,153 incarcerated individuals diagnosed as having a mental disorder	At 18 months, the likelihood of MHC participants being charged with a new crime was 26% lower than comparison; likelihood of being charged with new violent crime was 55% lower

OWI Court Evaluation Outcomes

Title of Evaluation	Year	Study design	Comparison group	Recidivism rate
Multnomah County OR DUI Court Program [17]	2006	Quasi-experimental study over a 3-year DUI court program period.	Comparison group: subjects living in the Portland area (exposed to similar police activity and judicial conditions). Frequency-matched based on age category at sentencing (18–29 years, 30+ years), gender, year of conviction, and number of DUI offenses between 1993 and the conviction date (from 1 to 4+ convictions). 460 DISP participants and 497 matched comparison offenders.	The various analyses completed on the outcome data showed that recidivism of the DISP participants was significantly lower than for the comparison group. DISP participants had a 9.8 percent recidivism rate, while the comparison group had an 18.3 percent recidivism rate. DISP participation is associated with a 48 percent reduction in rearrests for impaired driving.
La Crosse County OWI Court Evaluation [18]	2006 - 2009	515 participants over 3 years of OWI court programming	Compares the number of OWI convictions for the three years prior to the start of the OWI Treatment Court to the three years of program operation, and the pre and post individual histories of each OWI offender in the program.	In 3-year follow-up, only 3.6% of graduates have been rearrested; 7% of those who dropped out, and 14% of those who were expelled. The county overall showed a 47% reduction in number of OWI third offenses in the years since the OWI court has been in operation, and a 24% decrease in OWI convictions.
Idaho DUI Court Evaluation [19]	2009	DUI court participants from multiple sites in Idaho, looking at recidivism over a 4.5-year time frame.	Similar offenders who were incarcerated and did not undergo DUI program	23% of DUI court participants were rearrested vs. 37% of comparison. Those not in DUI group were 1.6 times more likely to recidivate.
RAND Los Angeles Rio Hondo DUI Court Evaluation [20]	2007	284 participants assessed at baseline and 24 month follow-up. 139 assigned to treatment	145 controls randomly assigned to traditional criminal court with mandatory minimums	DUI court participants did not differ significantly on self-reported or official records of drinking and driving. Third-time DUI offenders served significantly fewer number of days in jail and more likely to complete treatment, but there were no differences in arrests between treatment and control groups.
Waukesha Alcohol Treatment Court Evaluation [21]			81 individuals on waiting list for WATC but could not participate due to capacity.	29% of WATC group recidivated in 2 years after the program, vs. 45% of those in comparison.

APPENDIX 6. BACKGROUND ON QUANTITATIVE PREDICTIONS

PREDICTION I.2. CAPACITY TO SERVE TARGET POPULATION: NUMBER OF PRISON ADMISSIONS THAT WOULD BE ELIGIBLE.

3,115 of the approximate 8,000 annual prison admissions in Wisconsin would be eligible to participate in TAD programs.

We used a number of assumptions to calculate the percentages eligible for TAD participation, including the number of new annual admissions to prison, the rate of non-violent offenses, and the rate of substance abuse and mental health disorders among prison inmates:

- There are approximately 8,000 new admissions to state prisons [22] [23] [24]
- Using date from the Substance Abuse Mental Health Services Administration,[25] we estimated that:
  - 50% of inmates have mental health problems
  - 60% of inmates have substance abuse disorders
  - 33% of inmates have co-occurring disorders
- Using Bureau of Justice Statistics data, we estimated that:
  - 47% of inmates commit non-violent offenses [26]
  - 39% of inmates with mental health problems commit non-violent offenses[27]
  - 72% of inmates with substance abuse issues commit non-violent offenses [28]

Based on these figures, we determined that:

- 1,555 non-violent inmates with substance abuse issues only would qualify for drug courts
- 530 non-violent inmates with mental health issues only would qualify for mental health courts
- 1,030 non-violent inmates with co-occurring disorders (having both a substance abuse and a mental health disorder) would qualify for some kind of problem solving court
- Thus we arrived at a determination that a minimum of 3,115 would qualify.
- Each individual was, on average, booked seven times

PREDICTION I.3. CAPACITY TO SERVE TARGET POPULATION: NUMBER OF JAIL ADMISSIONS THAT WOULD BE ELIGIBLE.

Between 21,315 – 30,551 of the approximate 227,000 annual jail admissions in Wisconsin would be eligible to participate in TAD programs.

- In 2011, there were approximately 226,985 new admissions to county jails. [29]
- Of those, between 15% (Dane County) and 21.5% (Milwaukee County) were pre-trial felony admissions. Only those booked for felonies, not misdemeanors, are eligible for TAD. Also those who are in jail for violations of their supervision are not eligible, thus leading us to conclude that only those inmates who are pre-trial would be eligible. [30] [31]
- 68% of jail inmates meet substance abuse criteria.[32]
- 64% of jail inmates had mental health problems.[33]
- 76% of jail inmates with mental health have co-occurring substance abuse disorders.[34]
- 33% of prison inmates have co-occurring disorders.[35] There were no studies that specifically considered those with substance abuse as their primary diagnosis who also had mental health disorders, so we used the prison estimate of co-occurring disorders to calculate the number of jail inmates with substance abuse disorders who also had mental health issues.
- 75% of jail admissions are for nonviolent offenses.[36]

Using the percentage of jail inmates who were pre-trial felony admissions in Dane County (15%) and extrapolating it to statewide jail admissions:

- 34,000 of 227,000 are pre-trial felony admissions.

- 25,500 of those are non-violent.
- 21,315 of those have either substance abuse or mental health disorders, or both.
- Using the percentage of jail inmates who were pre-trial felony admissions in Milwaukee County (21.5%) and extrapolating it to the entire state's jail admissions:
- 48,800 of 227,000 are pre-trial felony admissions.
- 36,600 of those are non-violent.
- 30,551 of those have either substance abuse or mental health disorders, or both.

There are several assumptions we made in order to calculate the estimated number of jail admissions per year who would be eligible:

- It was unclear what the average number of jail admissions was *per person per year*. Given the lack of data on this, we made our calculation assuming that even if there were individuals who were arrested more than once per year, the vast majority of the 227,000 jail admissions were booked only once in a year.
- While there are national estimates on the number of jail inmates with mental health disorders who have substance abuse problems (76%), there were no studies reporting the opposite: the number of jail inmates with substance abuse disorders who also have mental health disorders. As a result, we used the estimate that we had from the national Substance Abuse and Mental Health Services Agency for the number of people with co-occurring disorders among prison inmates for this estimate.
- We used the smaller number (based on Dane County's percentage of pre-trial felony admissions) for our over all estimate. While the highest number of jail admissions in the state are in Milwaukee County, we recognize that most counties are far lower. Thus we felt that using the Dane County proportion for those who would qualify was a more accurate middle ground.

PREDICTION II.3. RECOVERY: NUMBER OF DEATHS DUE TO DRUG OVERDOSE.

There will be 8 fewer deaths if Wisconsin increases drug court slots.

A randomized controlled evaluation of a drug court in Baltimore found that 6.5% of participants in the drug court vs. 7.3% of those in the control group (felons going through the traditional criminal justice system) had died three years after release from overdose.[37] Using the same prevalence data as in Prediction I.2 above, we found that under "business as usual" operations, there would be 3,115 non-violent prison admissions with substance abuse issues that could be eligible for drug treatment court if the slots were available.

However, there is a difference in the drug of choice between the Baltimore population under study and TAD participants in Wisconsin. Ninety-six percent of the Baltimore drug court participants reported that heroin or cocaine were their primary drug of choice, whereas only 30% of TAD participants statewide reported opiates or cocaine as their primary drug of choice. That percentage rises to 35% if considering Milwaukee TAD participants only. Thus, 31% of the TAD population used the type of drug likely to cause an overdose.

If the drug court slots were not available, 71 people would die from drug overdose (3,115 X .31 X .073 = 71). If those slots were available, 63 people would die from drug overdose (3,115 X .31 X .065 = 63). The difference between the two scenarios is 8 fewer deaths if Wisconsin had increased drug court slots.

PREDICTION III.2. REDUCTION IN CRIME

There will be a 20% reduction in new crimes committed by those eligible for problem-solving courts.

To assess the reduction in crime among those who participate in problem solving courts, we made a number of assumptions in our estimates. First, we identified the rates of new crime being committed among people participating in a TAD program (19%) versus among people released from prison (25%) and we then applied those estimates to the number of people admitted to prison per year for non-violent crimes (n=3,760), the number of non-violent inmates with mental health problems (n=1,560) and substance abuse issues (n=3,115) who would qualify for TAD. Based on our analysis, we found that:

- 940 new crimes would be committed by non-violent ex-offenders under the funding status quo, with no new problem solving court slots
- 592 new crimes would be committed if everyone who was eligible for TAD for substance abuse problems went through TAD

- 3,760 admissions for non violent crimes – 3,115 eligible for TAD = 645 admissions not going through a TAD program. 645 X 25% convicted for new crimes = 161 new crimes
- 592 new crimes committed by TAD program participants + 161 new crimes committed by those release from prison = 753
    - Based on these numbers, the number of fewer new crimes committed was 187.
- We then calculated the overall reduction of new crime committed by dividing the number of fewer new crimes committed (n=187) by the number of new crimes that would be committed by non-violent ex-offenders under the funding status quo (n=940), which resulted in a 20% reduction in new crimes committed by the population of interest.

PREDICTION IV.1. FAMILIES:

Between 1,150 – 1,619 parents would qualify for problem Solving court slots or other diversion programs and would be able to remain with their families.

Using the same estimate of new admissions (8,000), we used the following prevalence data[38] to make our prediction:

- Percent of state prison inmates who are parents 52%
- Among parent inmates, percent non-violent 52%
- Parent inmates with a recent history of mental health problems 23%
- Parent inmates with any history of substance abuse problems 67%
- Percent of state inmates with co-occurring disorders 33%

Using these numbers we calculated a range of parents who would be eligible for TAD programs if funding were increased. The range includes a difference in the numbers of those with primarily mental health issues who also have substance abuse issues, and those who primarily have substance abuse issues but also have mental health issues. Based on our calculations, the lower bound of those who would be eligible would be 1,150 and the upper bound would be 1,619.

PREDICTION V.1. COMMUNITIES:

Approximately 13% more people will be being employed after release.

Using the following epidemiologic findings, we were able to estimate how many of our target population (nonviolent offenders qualifying for TAD slots due to substance abuse or mental health issues) would be employed 8 months after completion of the program versus prison. We know that:

- 52% of those participating in drug courts were employed at 6 months after the program[40]
- 45% of those released from prison were employed at 8 months after release[41]

Thus, 218 more people, or 13% more, would be employed.

- 1,692 non-violent offenders entering prison who would be employed after release (3,760 non-violent new admissions to Wisconsin prison per year X 45%)
- 1,910 non-violent offenders participating in TAD programs would be employed after release ([3,115 people eligible and participating in newly created problem solving court slots X 52%] + [(3,760 -3,115)X 45%])

Note that both studies had a confidence interval, or error band, around their numbers which in the end could potentially make the difference between the prison group and the drug court group quite small, such that our hypothesis could be null. What this translates to is that first a very similar amount could end up employed after drug court than prison.

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