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Identifying and Addressing the Unmet Health Care Needs of Drug Court Clients

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Abstract

Drug courts address issues such as employment and housing, but largely miss the opportunity to address important healthcare issues. The current study examined the prevalence and correlates of chronic medical conditions among a sample of drug court clients who were participating in a clinical trial of an intervention to reduce HIV risk. A total of 256 clients completed a health survey at entry into the drug court program and 9-months post-entry. The baseline health survey included a comprehensive list of chronic medical conditions, and participants were asked to indicate which, if any, they had ever been diagnosed as having. They were also asked to indicate whether or not they were currently receiving treatment for each chronic condition that they endorsed. The follow-up survey was identical to the baseline survey with the exception that it contained items reflecting (1) whether or not any member of the drug court team engaged in discussion with the client about each of the chronic conditions reported and (2) whether the client received a referral to medical care for endorsed conditions while in the drug court program. Results indicated that over 50% of clients reported at least one chronic condition and 21% reported more than one condition. Among those with chronic conditions, 71% reported having chronic conditions for which they were not currently receiving treatment. Unfortunately, drug court clients reported that the drug court team did little to address these unmet health needs. Findings from this study suggest clients could benefit if drug court programs began to widen their focus to include addressing health-related issues.

Keywords

substance use disorder; drug abuse; drug court; chronic medical condition; criminal justice; health care

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1. Introduction

Over 600,000 individuals are court-mandated to enter substance abuse treatment each year (Substance Abuse and Mental Health Services Administration, 2013). Drug courts, diversion programs that offer individuals who are charged with drug-related offenses the opportunity to participate in a voluntary course of judicially supervised substance abuse treatment in lieu of incarceration, have been shown to be highly effective in reducing criminal recidivism and substance use (e.g., Belenko, 2001; Gifford, Eldred, McCutchan, & Sloan, 2014; Mitchell, Wilson, Eggers, & MacKenzie, 2012; Peters & Murrin, 2000; Shaffer, 2011). Although these specialized programs engage offenders in substance abuse treatment and often provide referrals for services to address unmet needs such as vocation or educational services and housing assistance, most do not formally address the co-morbid chronic and acute medical problems that are characteristic of this population and, most often, go untreated.

1.1 Substance use and health

Chronic substance use is associated with an increased susceptibility to physical ailments in virtually every system of the body that range from common infections to fatal illnesses (see Stein, 1999 for a comprehensive review). Cardiovascular problems including hypertension, cardiomyopathy, and heart failure have been linked with substance abuse (Frishman, Del Vecchio, Sanal, & Ismail, 2003a, 2003b; Stankowski, Kloner, & Rezkalla, 2015; Stein, 1999; Thomas, Kloner, & Rezkalla, 2014). Similarly, serious gastrointestinal and renal problems including pancreatitis, cirrhosis, chronic liver disease, kidney failure, hepatitis B and hepatitis C (Bini et al., 2011; Brown et al., 2006; Chen & Lin, 2009; Crowe, Howse, Bell, & Henry, 2000; Stein, 1999) are associated with chronic substance abuse. Within the central nervous system, it has been linked to dementia, memory and attention impairments, intraparenchymal hemorrhage, cerebral vasculitis, ischemic events, and strokes as well as an increase in and poor recovery from traumatic brain injury (Büttner, 2011; Cadet & Bisagno, 2016; Foneseca & Ferro, 2013; Frishman et al., 2003b; Stein, 1999; Strickland et al., 1993; Taylor, Kreutzer, Demm, & Meade, 2003). Pulmonary problems linked to substance abuse include bronchospasm, pulmonary edema, pneumonia, hypersensitivity pneumonitis, barotrauma, undifferentiated hemoptysis, and one-third of all tuberculosis cases in the United States (Mégarbane & Chevillard, 2013; Murphy, 1993; Oeltmann, Kammerer, Pevzner, & Moonan, 2009; Polen, Sidney, Tekawa, Sadler, & Friedman, 1993; Stein, 1999). Substance abuse has also been linked to anemia, bone marrow hypofunction, pregnancy and birth complications, endocarditis, and HIV transmission (Bini et al., 2011; Brown et al., 2006; Chen & Lin, 2009; Goforth, Murtaugh, & Fernandez, 2010; Stein, 1999). In sum, practically every bodily system is more vulnerable when exposed to chronic substance use.

This increased risk can be attributed to both the toxic effects of the drugs themselves along with a number of unhealthy lifestyle factors that are often associated with chronic substance use. For example, it is estimated that at least 65% of adults receiving substance abuse treatment smoke cigarettes, which is almost four times the number in the general population (Guydish et al., 2011; Jamal et al., 2015; Kalman et al., 2001; SAMHSA, 2011; Teater & Hammond, 2010; Williams & Ziedonis, 2004). In fact, more clients in substance abuse treatment die from the effects of smoking cigarettes than from the effects of the drugs for

which they are receiving treatment (SAMHSA, 2011). Many substance abusers have inadequate housing and poor nutrition which can increase exposure to diseases and reduce ability to fight off infections (Leshner, 2000). Over 90% of substance abusers are underweight as a result of caloric and protein malnutrition (Santolaria et al., 2000), and almost one-third show clinical signs of nutritional deficiency with extremely low hemoglobin and serum protein levels (Nazrul Islam, Jahangir Hossain, & Ahsan, 2001). Substance abusers may also visit locations like shooting galleries, crack houses, and other environments that are breeding grounds for infectious diseases like tuberculosis (Kaushik, Kapila, & Praharaj, 2011; Leonhardt, Gentile, Gilbert, & Aiken, 1994; Singer, 2014; Story, Bothamley, & Hayward, 2008). Substance use also often leads to poor decision making with respect to sexual partners and safe sex practices, increasing the individual's risk of contracting HIV and other sexually transmitted infections (Brewer, Zhao, Metsch, Coltes, & Zenilman, 2007; Celentano, Latimore, & Mehta, 2008; Cheng et al., 2010; Kwiatkowski & Booth, 2000; Royce, Sena, Cates, & Cohen, 1997; Thamotharan, Grabowski, Stefano, & Fields, 2015). These are just a few examples of the lifestyle factors that increase substance abusers' susceptibility to a host of medical conditions.

While chronic substance users are at higher risk of poor health outcomes, they also have elevated rates of poverty, unemployment, and lack of medical insurance (Compton, Gfroerer, Conway, & Finger, 2014; Wells, Sherbourne, Strum, Young, & Burnam, 2002) that may limit access to medical care. This combination of high need for medical care and limited access to it makes them a medically vulnerable population (Gelberg, Anderson, & Leake, 2000). Chronic substance users tend to underutilize primary and preventive medical care and over utilize emergency care (Doupe et al., 2012). This approach often results in patients receiving treatment after conditions have substantially worsened and are more difficult and expensive to address. Although primary and preventive medical care is important for all populations, its benefits are perhaps the greatest among those with the most unmet health needs such as chronic substance users (Blumenthal, Mort, & Edwards, 1995; Druss & von Esenwein, 2006; Starfield, Shi, & Macinko, 2005).

1.2 Access to care

Research has documented chronic substance users' lack of access to primary medical and preventive care. One study reported that 50% of outpatient substance abuse treatment clients do not have a regular source of medical care and that few obtain preventive screenings (Benjamin-Johnson, Moore, Gilmore, & Watkins, 2009). Similar findings have been noted among injection drug users in needle exchange programs (Heinzerling et al., 2006) where most clients did not receive any recommended medical services beyond HIV testing. This population also has elevated rates of emergency department utilization and hospital admissions (Doran, Raven, & Rosenheck, 2013; French, Roebuck, McGeary, Chitwood, & McCoy, 2001; Rockett, Putnam, Jia, Chang, & Smith, 2005). Additionally, the intergenerational nexus of poverty, low education, and substance abuse is likely to contribute to a culture of underutilization of medical services, even if they are available. Although cost, limited access, and other factors related to accessibility are typically cited as the principal barriers to obtaining care for this population (Chitwood, Sanchez, Comerford, & McCoy et al., 2001), other factors include fear of discrimination or stigmatization (McCoy, Metsch,

Chitwood, & Miles, 2001) as well as inaccurate beliefs about the need for regular medical care that can diminish motivation and lead to an inability to navigate the healthcare system (Larson, Saitz, Horton, Lloyd-Travaglini, & Samet, 2006).

Similar patterns related to unmet health needs have been identified among substance users who are involved in the criminal justice system (e.g., Joosen et al., 2005; Webster et al., 2005). Research has demonstrated that these individuals have high rates of chronic medical conditions (e.g., Binswanger, Krueger, & Steiner, 2009; Wilper et al., 2009), poor access to health services in the community (e.g., McCorkel, Butzin, Martin, & Inciardi, 1998), and an overutilization of emergency department services (e.g., Frank et al., 2013; Frank, Linder, Becker, Fiellin, & Wang, 2014). This is particularly disconcerting given the overrepresentation of individuals with substance use disorders in the criminal justice system (e.g., Mumola & Karberg, 2006) as engagement in criminal behavior is four times greater among drug users than non-drug users (Bennett, Holloway, & Farrington, 2008).

1.3 Drug courts and health services

When an individual voluntarily enters drug court and is mandated to participate in treatment for their addiction, it may be one of the few times that they come into contact with a healthcare provider in a non-emergency setting. Entry into drug court and substance abuse treatment may provide a critical opportunity or “teachable moment” to link these clients to primary medical care. According to the Adult Drug Court Best Practice Standards (National Association of Drug Court Professionals, 2015), drug courts should provide participants with referrals for medical treatment for conditions that are life threatening, cause serious pain or discomfort, or may lead to long-term disability. These guidelines also state that treatment referrals for non-acute conditions that are exacerbated by substance abuse *may* be provided in later phases of the program or included in the aftercare plan. In fact, one review identified that providing healthcare to drug court clients was associated with reduced recidivism and increased cost savings (Carey, Mackin, & Finigan, 2012). Unfortunately, the extent to which drug courts offer referrals for acute and non-acute services is unknown. Borrowing from what we know about outpatient substance abuse treatment more generally, it is likely that this number is rather low. The majority of individuals who participate in outpatient substance abuse treatment [which represents 90% of all substance abuse treatment in the U.S. (see McLellan, Carise, & Kleber, 2003)] leave treatment without ever being examined by a medical provider (D'Aunno & Vaughn, 1995; Edwards, Knight, & Flynn, 2010). Although participation in drug court may improve substance use and criminal justice outcomes, many clients still face serious health risks resulting from undetected, often life-threatening, medical conditions following graduation.

This study examined the prevalence of chronic medical conditions in a cohort of drug court clients who were participating in an ongoing research trial. In addition, it examined whether clients are currently engaged in medical treatment for these conditions and the extent to which the drug court team attempted to address clients' medical needs. Findings from this study will provide insight about the prevalence of chronic conditions in this population and the need for drug courts to connect their clients to medical care to address unmet health needs.

2. Method

2.1 Participants

A total of 256 clients from a felony drug court in Philadelphia comprised the sample. They were participating in a research trial that evaluated the efficacy of a computer-based educational intervention to increase HIV testing rates and reduce engagement in high risk behaviors (Festinger, Dugosh, Kurth, & Metzger, 2016). To be eligible for the drug court program, participants are required to: (1) be at least 18 years of age; (2) be charged with a nonviolent felony offense; (3) have no more than two prior nonviolent convictions, juvenile adjudications, or diversionary opportunities; (4) be in need of treatment for drug abuse or dependence as assessed by a clinical case manager employed by the court; and (5) be willing to participate in the drug court program for at least twelve months. Of the 430 drug court clients who were approached for participation, 300 enrolled in the study (70% recruitment rate) and 14 later withdrew from the research. The 256 individuals who completed both the baseline and 9-month follow-up assessment described below (90% follow-up rate) comprised the sample for the secondary analyses presented in this paper.

The study participants in the sample were primarily male ($n = 203$, 79%) and never married ($n = 236$, 92%). Most participants self-identified as African American ($n = 168$, 66%) or Caucasian ($n = 24$, 9%). The majority of participants were unemployed ($n = 166$, 65%). Their average age was 25 years old ($SD = 9$). A substantial proportion of participants reported marijuana as their primary drug problem ($n = 193$, 76%), followed by opioids ($n = 27$, 11%), alcohol ($n = 15$, 6%), cocaine ($n = 10$, 4%), sedatives ($n = 4$, 2%), and hallucinogens ($n = 4$, 2%). Seventy percent of the sample ($N = 180$) reported a secondary drug problem with alcohol ($n = 73$, 40%), marijuana ($n = 32$, 18%), opioids ($n = 30$, 17%), and sedatives ($n = 22$, 12%) being the most frequently reported secondary problems. A total of 64% ($n = 165$) reported that they had medical insurance at baseline with 81% ($n = 133$) of those insured having public insurance.

2.2 Procedures

The study was overseen by the institutional review boards of the Treatment Research Institute and the City of Philadelphia. All participants provided informed consent to participate in the larger HIV risk reduction study (see Festinger et al., 2016 for a detailed description of the study). To recruit participants for the study, research assistants (RAs) attended all drug court status hearings and provided all defendants with a flyer that provided a comprehensive overview of the research study. Following their admission into the drug court program, all interested individuals met with an RA in a private office in the courthouse to complete the consent process. In the event that the consent could not take place at that time due to space limitations, courtroom availability, or client commitments, the RAs rescheduled the appointment for a future time. Eligibility criteria for entry into the study were that the individual was (1) fluent in the English language and (2) deemed competent to provide informed consent. Importantly, during the consent procedure, participants were informed that all research data collected in the study would be kept strictly confidential and would not affect their criminal case or substance abuse treatment. They were also informed

that we had obtained an NIH Confidentiality Certificate that generally shielded the research data from a subpoena or court order.

As a part of the larger study, participants completed baseline and 9-month follow-up assessments in a private room at the rear of the court. The battery included a brief health survey that was modeled after the ASI 6 medical section (Cacciola, Alterman, Habing, & McLellan, 2011). The baseline health survey included a comprehensive list of chronic medical conditions from the ASI 6 [i.e., high blood pressure, diabetes, heart disease, stroke, epilepsy or seizures, cancer, HIV/AIDS, tuberculosis or a positive test for TB, hepatitis, cirrhosis or other chronic liver disease, chronic kidney disease, chronic respiratory or breathing problem (e.g. asthma, emphysema, COPD), other chronic physical or medical conditions (e.g. arthritis, chronic back pain, digestive problems)], and participants were asked to indicate which, if any, they had ever been diagnosed as having. They were also asked to indicate whether or not they were currently receiving treatment for each chronic condition that they endorsed. The follow-up survey was identical to the baseline survey with the exception that it contained items reflecting (1) whether or not any member of the drug court team engaged in discussion with the client about each of the chronic conditions reported and (2) whether the client received a referral to medical care for endorsed conditions while in the drug court program.

2.3 Data analyses

Response frequencies were calculated from the baseline interview to determine (1) the prevalence of each chronic condition in the sample and (2) whether or not participants were currently receiving treatment for the endorsed chronic conditions. For individuals who reported at least one chronic condition, response frequencies were calculated from the follow-up data set to determine (1) whether a member of the drug court team discussed the chronic condition(s) with them and (2), among those with untreated conditions, whether they received a referral to medical care for untreated conditions. Finally, bivariate (i.e., correlation) and multivariate (logistic regression) analyses were performed to examine the relationship between client-level variables (i.e., age, race, gender, drug use [marijuana vs. other], and health insurance status) and (1) whether a person reported having been diagnosed with a chronic condition and (2) whether a person reported having an untreated chronic condition.

3. Results

3.1 Prevalence of chronic conditions

Approximately 51% ($n = 130$) of the 256 drug court clients in the sample had at least one chronic medical condition, and 21% ($n = 53$) had more than one chronic condition. As seen in Table 1, the most prevalent conditions were chronic respiratory problems ($n = 66$, 26%), high blood pressure ($n = 43$, 17%), diabetes ($n = 14$, 5%), and epilepsy ($n = 12$, 5%). Among the 130 drug court clients with chronic conditions, 71% ($n = 92$) reported having chronic conditions for which they were not currently receiving treatment.

3.2 Addressing chronic conditions while in drug court

Among 130 clients who reported at least one chronic condition, only 13% ($n = 17$) reported that someone from the drug court team spoke to them about their condition, and only 5% ($n = 5$) of the 92 individuals with untreated conditions received a referral to medical treatment.

3.3 Predictors of reporting a chronic condition

As seen in Table 2, results of the bivariate analyses indicated that reporting marijuana as the primary substance of abuse was significantly negatively correlated with reporting a chronic condition ($r = -0.14$, $p = 0.02$). Although they did not reach statistical significance, positive correlations were observed for age ($r = .11$, $p = 0.09$) and race ($r = 0.11$, $p = 0.08$). No other bivariate correlations approached significance. Results from the multivariate logistic regression analysis indicated significant effects for race ($X^2(1) = 5.84$, $p = 0.02$) and primary drug type ($X^2(1) = 4.04$, $p = 0.04$). Specifically, African Americans were more likely to report a chronic condition (OR = 2.02, 95% CI = 1.14-3.58) and those who indicated that marijuana was their primary substance of abuse were less likely to report a chronic condition than those who reported other primary substances (OR = 0.50, 95% CI = 0.25-0.98). No other predictors reached statistical significance in the model. Importantly, multicollinearity was not observed for the predictor variables as correlations among the predictors were modest (r 's = 0.03-0.36) and variance inflation factors ranged from 0.08-1.30.

3.4 Predictors of unmet health needs

Also seen in Table 2, results of the bivariate analyses indicated that race ($r = 0.16$, $p = 0.01$) and primary drug problem ($r = -0.13$, $p = 0.04$) were significant predictors of having an unmet health need. No other bivariate correlations approached significance. Results from the multivariate logistic regression analysis indicated significant effects for race ($X^2(1) = 11.71$, $p = 0.0006$) and primary drug type ($X^2(1) = 5.33$, $p = 0.02$). African Americans were more likely to report having an unmet health need compared to participants of other races (OR = 3.12, 95% CI = 1.63-5.99). In addition, participants who indicated that marijuana was their primary substance of abuse were less likely to report having an unmet health need than those who reported other primary substances (OR = 0.43, 95% CI = 0.21-0.88). No other predictors reached statistical significance in the model.

4. Discussion

This paper examined the prevalence of chronic medical conditions in a sample of urban felony drug court participants. Results indicated that at entry into the drug court program, over half of the sample had a previously diagnosed chronic condition with over one fifth reporting more than one existing chronic condition. Furthermore, the large majority of individuals with at least one chronic condition were not engaged in care. Unfortunately, results indicated that at 9 months into the drug court program, only a small proportion of individuals with untreated chronic conditions reported that someone from the drug court team spoke to them about their condition(s), and referrals to medical treatment were made in less than a handful of cases.

In addition, results indicated that after controlling for other factors including age, gender, and insurance status, African American clients were more likely to report having a diagnosed chronic condition than individuals from other races. They were also more likely to report having untreated chronic conditions. These findings are consistent with those from other studies that demonstrate the racial disparities in chronic disease burden (e.g., Bauer, Briss, Goodman, & Bowman, 2014; Bravemen et al., 2011; Khabbaz, Moseley, Steiner, Levitt, & Bell, 2014). Furthermore, individuals who reported substances other than marijuana as their primary drug problem were more likely to report a chronic illness as well as unmet health needs. This may be due, in part, to the lower toxicity levels associated with marijuana relative to other drugs such as cocaine and heroin (Drug Enforcement Administration, 2001; Gable, 2004)

These figures highlight the opportunity for drug court programs to focus on clients' unmet healthcare needs. Drug courts were developed to address specific issues related to drug use and crime. Over the past 27 years since they were first conceived, drug courts have been demonstrated to significantly reduce rates of drug use and criminal recidivism (Belenko, 2001; Gifford et al., 2014; Mitchell et al., 2012; Peters & Murrin, 2000; Shaffer, 2011). Similar to many other medical and specialty services, drug courts could maintain their current mission and ignore the opportunity they have to address the many other chronic issues plaguing their patients. However, not responding to these health issues would not only represent a lost opportunity to improve client health and reduce the spread of infectious disease, but also a lost opportunity to further enhance their ability to reduce clients' drug use and criminal involvement as engaging in medical care has been shown to improve these outcomes as well (Carey et al., 2012; Saitz, Horton, Larson, Winter, & Samet, 2005).

Drug courts as they are currently structured may not have the resources or capacity to assess and refer clients with chronic health conditions to the appropriate services. Nevertheless, there may be a number of possible ways to restructure the programs to address these issues. The growing use of computer-facilitated screening and intervention tools may provide a practical and efficient approach to this problem. For example, an alternative and promising strategy that may be effective, affordable, and easily transportable is the use of brief, computer-facilitated motivational interventions. These types of interventions have been shown to address a wide range of health-related behaviors including smoking cessation, improved nutrition, breast cancer screening, and HIV prevention (see Krebs, Prochaska, & Rossi, 2010 for a review). In a recent drug court study, Festinger, Dugosh, Kurth, and Metzger (2016) demonstrated the efficacy of a brief, 3-module, self-administered computer intervention for improving rates of HIV screening among clients in an urban felony drug court.

In addition to screening and referral for health problems, it may also be possible to use the therapeutic alliance with the drug court team and the influence and behavioral leverage wielded by the judge to increase follow-through with medical care and adherence to medical treatment. Both tangible and intangible rewards for successive achievements have been demonstrated to play an integral role in helping clients maintain abstinence and avoid recidivist behaviors. Future research might examine strategies for adding these health behaviors to those currently reinforced by judges and other drug court stakeholders.

Developing effective strategies to connect drug court clients with a regular source of medical care has the potential to not only improve individual lives, but to also improve public health by preventing the spread of diseases and to reduce healthcare costs by eliminating over-reliance on emergency healthcare services. Such an approach is consistent with the U.S. Department of Health and Human Services Healthy People 2020 initiative (Office of Disease Prevention and Health Promotion, 2013) that seeks to improve access to comprehensive, quality health care including primary and secondary prevention services.

4.1 Limitations

This study had a number of limitations that must be noted. First, all of the data collected for this study relied on client self-report. Although the study questionnaires were confidential and the information covered was not anticipated to make clients misrepresent themselves, the possibility for biased responses exists. For example, clients may have underreported their health problems due to embarrassment of self-presentation bias. Similarly, clients may have chosen to underreport whether their health concerns were addressed or whether they received a referral for care by drug court staff. Finally, given the underutilization of primary and preventive care that is characteristic of this population, it is likely that some participants had existing medical conditions of which they were not aware and, consequently, could not report. Future research should examine these issues using more objective data on the presence of chronic health conditions including medical record verification and the degree to which they are identified and addressed by court staff.

Second, the study was conducted with clients from a single drug court, with a single group of drug court participants. Although there are substantial efforts by NADCP to develop practice standards and standardize drug court procedures, it is likely that the procedures used by the drug court in this study and subsequently the resulting outcomes regarding these procedures may not generalize to other drug courts. It is therefore necessary to attempt to replicate these findings in other drug courts.

5. Conclusion

In conclusion, chronic exposure to the toxic effects of drugs, regular involvement in the drug using lifestyle, and diminished access to and utilization of medical care conspire to severely increase substance abusers' susceptibility to everything from the common cold to deadly diseases. Given this heightened vulnerability, entry into drug court may be the perfect opportunity to link substance abusers with therapeutic medical care. For many of these individuals, this may be one of the few, if not the only, opportunities to have a meaningful interaction with a healthcare provider.

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Highlights for submission of “Identifying and Addressing the Unmet Health Care Needs of Drug Court Clients.”

- Examined prevalence of chronic medical conditions among drug court clients Half of sample reported having at least one chronic medical condition
- Almost 75% of those with chronic conditions were not engaged in their treatment
- Many reported that the drug court team did little to address unmet health needs
- Drug courts should consider broadening their focus to address health-related issues

Table 1
Prevalence of chronic medical conditions among 256 felony drug court participants

Chronic Medical Condition	<i>n</i>	%
High Blood Pressure	43	17
Diabetes	14	5
Heart Disease	7	3
Stroke	1	1
Epilepsy or Seizures	12	5
Cancer	2	1
HIV/AIDS	3	1
Tuberculosis or a positive test for TB	4	2
Hepatitis	1	1
Cirrhosis or other chronic liver disease	0	0
Chronic kidney disease	3	1
Chronic respiratory or breathing problem	66	26
Other chronic medical condition	16	22

Table 2
Bivariate and multivariate predictors of health-related outcomes

	Bivariate		Multivariate			
	R	p	OR	95% CI	Wald χ^2	p
Having a chronic illness						
Age	0.11	0.09	1.01	0.98-1.05	0.49	0.49
Race (African American vs. other)	0.11	0.08	2.02	1.14-3.58	5.84	0.02
Gender (male vs. female)	-0.10	0.12	0.74	0.38-1.44	0.78	0.38
Primary drug (cannabis vs. other)	-0.14	0.02	0.50	0.25-0.98	4.04	0.04
Medical insurance status (yes vs. no)	.06	0.31	1.23	0.72-2.10	0.56	0.45
Having an untreated chronic illness						
Age	0.08	0.20	1.0	0.96-1.03	0.03	0.87
Race (African American vs. other)	0.16	0.01	0.31	1.63-5.99	11.71	0.0006
Gender (male vs. female)	-1.0	0.11	0.63	0.32-1.25	1.74	0.19
Primary drug (cannabis vs. other)	-0.13	0.04	0.43	0.21-0.88	5.33	0.02
Medical insurance status (yes vs. no)	-0.06	0.33	0.67	0.38-1.12	1.93	0.16