By the Numbers 4
Developing a Common Understanding for the Future of Behavioral Health Care
Why we did this research

• Criminal Justice system is the largest provider of behavioral health services

• Cycle that individuals with behavioral health disorders can find themselves in with criminal justice system
What we will cover

• Overview and History
• Access to Services
• Survey Data
• Current Availability of Services
• Responses, Models, and Approaches
Who we are

The Center for Community Solutions is a nonprofit, nonpartisan think tank focused on solutions to health, social and economic issues. Through applied demographic research, policy analysis and advocacy, Community Solutions provides data and analysis that is critical to inform the work, effectiveness and decision-making of direct services organizations, funders and policy makers.
Who we are

Mental Health & Addiction Advocacy Coalition

The Mental Health & Addiction Advocacy Coalition is comprised of over 120 member organizations statewide, including health and human service agencies, the faith based community, government and advocacy organizations, courts, major medical institutions, the corporate arena, and behavioral health agencies serving children and adults. The MHAC’s mission is to foster education and awareness of mental health and addiction issues while advocating for public policies and strategies that support effective, well-funded services, systems, and supports for those in need, resulting in stronger Ohio communities. MHAC supporters include: Eva L. & Joseph M. Bruening Foundation, The Cleveland Foundation, Community West Foundation, The Greater Cincinnati Foundation, The George Gund Foundation, Interact for Health, The McGregor Foundation, The Sally and John Morley Family Fund, Mt. Sinai Health Care Foundation, The Nord Family Foundation, Peg’s Foundation, The Daniel and Susan Pfau Foundation, Saint Luke’s Foundation, and Woodruff Foundation.
Presenters

The Center for Community Solutions
- Tara Britton, Director of Public Policy and Advocacy
- Loren Anthes, Public Policy Fellow, Medicaid Policy Center
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Mental Health & Addiction Advocacy Coalition
- Karen Kearney, Northeast Ohio Hub Director
- Kelly Smith, State Program and Policy Director
Jails are defined by the U.S. Department of Justice (DOJ) as correctional facilities that confine persons before or after adjudication and are usually operated by local law enforcement authorities. Jail sentences are usually for 1 year or less.

In Ohio, jails fall into 5 categories.

**Full Service Jails**
County and large city jail operations

**Minimum Security Jails**
Function like a full service jail, except prisoners must meet certain requirements including being minimum risk offenders

**12-Day Jails**
Intended for local city, village and township jurisdictions, they are used for booking and processing fresh arrests, and allow local ordinance offenders to serve their jail sentences locally

**12-Hour Jails**
Intended for local city, village and township jurisdictions to have a jail facility for booking and processing fresh arrests

**Temporary Holding Facilities**
Can hold prisoners for a maximum detention time of 6 hours. These facilities do not fall under Ohio’s minimum jail standards, and instead are operated by “guidelines” established by the Bureau of Adult Detention.

Source: Ohio Department of Rehabilitation and Correction
ORDC has 28 institutions
  • 3 are privately operated

Availability of services for mental health and SUDs for incarcerated individuals varies depending on the type of correctional facility and existence of financial resources.

Prisons fall under the jurisdiction of state and federal governments. According to DOJ, “State and federal prisoner populations differ from the jail inmate population in terms of conviction status, offense distribution and average length of stay. The federal prisoner population is also unique from the state prisoner population, most notably in offense distribution. Similarly, prison facilities differ from local jail facilities in average size, treatment and programming resources and crowding, among other characteristics.”
Deinstitutionalization & Criminalization

Average Daily Resident Population for Public Inpatient Mental Health Care in Ohio

In 1962, there were nearly 24,000 Ohioans receiving public inpatient mental health care on any given day.

By 2017, that number had dropped to just 1,084.

Average Daily Jail and Prison Population in Ohio

In 1978, there were just over 18,000 Ohioans in state prison or county jail on any given day.

By 2017, that number had risen to over 69,500.
Deinstitutionalization & Criminalization

The rate of recidivism among people with co-occurring mental illness and substance abuse.\(^7\)

Recidivism: The repetition of criminal or delinquent behavior, most often measured as a new arrest, conviction, or return to prison and/or jail for the commission of a new crime or as the result of a violation of terms of supervision.\(^8\)
Drug Use Policy
• History

Impact of Reform
• Just say No & War on Drugs

State Efforts
• Justice Reinvestment Act
# Financing

## Medicaid Covered Services
- Alcohol and Drug Addiction
- Alcohol/Drug Screening Analysis/Lab
- Urinalysis
- Ambulatory Detoxification
- Assessment
- Case Management
- Crisis Intervention
- Individual or Group Counseling*
- Induction of Buprenorphine
- Injection of Naltrexone**
- Intensive Outpatient**
- Medical Somatic
- Methadone Administration
- Mental Health
- Community Psychiatric Supportive Treatment
- Health Home Comprehensive Care Coordination
- Individual or Group Counseling*
- Individual or Group Counseling***
- Injections
- Mental Health Assessment
- Partial Hospitalization
- Pharmacological Management
- Psychiatric Diagnostic Interview
- Psychological Testing

* Ohio Department of Mental Health and Addiction Services (ODMHAS) Certified Providers.
** To Treat Addiction.
*** Non-ODMHAS Certified Providers.
**** Additional services have been added under Specialized Recovery Services and the Behavioral Health Redesign

## Non-Medicaid Services
- Treatment and Other Health Services
- Hospitalization at state operated psychiatric hospitals
- Residential Treatment
- Treatment in Jails

## Non-Health Services
- Housing
- Transportation
- Education
- Consultation
- Crisis Stabilization
- Employment
- Peer Support
- Prevention
- Protective Services
- Court Services
- Hotlines
- Referral Services
Recommendations

Increased Support for Community Behavioral Health

• The role that deinstitutionalization played in increasing the number of individuals with behavioral health disorders in the criminal justice system can be significantly impacted by providing additional behavioral health resources to communities.

• Additional services and broader access to behavioral health services for communities can assist with providing the proper tools to treat an individual’s behavioral health needs before a crisis may occur and provide ongoing care and treatment.

• Tools such as early screening and diversion programs can address behavioral health issues at an early stage and remediate concerns before the criminal justice system becomes involved.
Recommendations

Sentencing Reform

• By supporting key pieces of legislation that promote effective rehabilitation, in addition to the recommendations from the Criminal Justice Recodification Committee that aim to remove provisions like mandatory sentencing, the state can move away from incarcerating high numbers of individuals with behavioral health disorders.

• These reforms can also reduce disparities that exist in the criminal justice system specific to race and socio-economic circumstances by allowing courts to properly examine and identify appropriate sentencing for individuals.

• Removing bail bond requirements that make it easier for wealthier individuals to be released over individuals of lower socio-economic status, rather than based on the severity of an offense, should be reexamined.
Sentencing Reform

- Medicaid eligibility should be active the moment individuals enter a halfway house.
- If Medicaid payment cannot be made for services that help divert individuals post-release from any type of involvement with the criminal justice system, ADAMHS boards or state general revenue funds should finance services, regardless of county.
- Work requirements in the Medicaid program should exempt anyone returning from a correctional facility for at least one year.
- The landscape of the behavioral health treatment system may undergo significant changes. It will be important to closely monitor any mergers, affiliations, closures, and layoffs. Data should be tracked to ensure access to care remains across the state. The Joint Medicaid Oversight Committee should continue to monitor the implementation of the Redesign and move to managed care over the next several years.
Behavioral Health Services in Ohio

Levels of the Behavioral Health Treatment System

- ODMHAS
- ADAMHS Boards
- Local Service Providers
Continuum of Care

1. Prevention and wellness promotion services
2. Engagement services
3. Health homes/physical health
4. Outpatient and Medicaid services
5. Intensive support services
6. Community supports and recovery services
7. Other supports
8. Out-of-home residential services, and
9. Acute intensive services.

Evidence-based Interventions

1. Individual and group counseling, medication treatments, and supportive services are evidence-based behavioral health interventions.

2. For many people with behavioral health disorders, the most effective treatment approach often involves a combination of counseling and medication.
Mental Health Services within Ohio’s Prison System

ODRC has responsibility for \textit{providing services} within the prison system, and ODMHAS has responsibility for \textit{oversight} by establishing standards of care and surveying services provided.

Substance Use Disorder Treatment Services within Ohio’s Prison System

The Bureau of Correctional Recovery Services, a partnership between ODRC and ODMHAS, treats incarcerated individuals in need of SUD recovery treatment.

Behavioral Health Services within Ohio’s Jails

Because jails are administered on a local basis, they represent a wide range of different infrastructures, resources, and needs. Currently, \textit{no centralized data storage system exists} to uniformly capture and delineate the behavioral health services available in every Ohio jail.
Service Availability

• Reentry Supports
• Criminal Justice and Behavioral Health Linkage Grants
• Community Linkage Program
• Reentry Coalitions

Collateral Sanctions

Voting, bearing arms, holding public office, jury service, witnessing documents, and ability to access behavioral healthcare.
Access to Health and Social Services

- Medicaid services should be broadened and additional funding invested in the community mental health and SUD system to ensure access to these services across Ohio.

Services within Jails and Prisons

- Jails should be mandated to collect and report standardized data on mental illness and/or SUDs among incarcerated individuals, as well as the availability of behavioral health services in these jails.

Post-Release

- ODMHAS should encourage counties to support individuals in the criminal justice system with behavioral health needs by applying for Criminal Justice and Behavioral Health Linkages grants. Policy makers should encourage limitations on collateral sanctions, specifically those targeting reductions in public healthcare benefits and limitations on employment eligibility.
Jail Administrators Survey Data

• While jails are not mental health facilities, increasingly more individuals with serious mental illness (SMI) are occupying county jails across the state.

• Individuals with SMI represent a growing and costly segment of the county jail population.

• Detoxification medicine is increasingly administered to individuals in jail, but this is not the preferred setting for recovery from mental illness or SUDs.

• The continued incarceration of individuals with mental illness and SUDs in county jails places a burden of both risk and cost upon these facilities.
Jail Administrators Survey Data

• Compared to incarcerated individuals withdrawing from opioids or alcohol, caring for those with SMI is more costly, is disruptive and requires more overtime for jail staff, according to jail administrators.

• On average, 1,505 incarcerated individuals per jail received psychotropic medications in 2015, costing $75,353 per jail

• Most jails contract pharmacy services for psychotropic medications through local or national pharmacies.

• Despite variations in jail size and population mix, jail administrators report common challenges in providing psychotropic medications and services to incarcerated individuals with mental illness and SUDs
Jail Standards

Jail Compliance with Health and Mental Health Standards, 2016

- 59% Compliant with Jail Standards
- 41% Noncompliant with Jail Standards
- 13% Essential Standards Only
- 29% Important Standards Only
- 58% Both Essential & Important Standards

Number of Deficiencies Related to Health and Mental Health Standards, Among Noncompliant Jails, 2016

- 53% Less than 5 deficiencies
- 24% Between 5-15 deficiencies
- 24% 16 or more deficiencies

Total = 38 Noncompliant Jails

Note: Totals do not sum due to rounding.
Source: Analysis of 2016 Jail Inspection Results, Bureau of Adult Detention.
ADAMHS Boards Survey Data

- ADAMHS boards are responsible for planning, funding, and monitoring of public mental health and addiction recovery services. Ohio has 49 ADAMHS boards, one Community Mental Health (CMH) board, and one Alcohol and Drug Addiction Services (ADAS) board.

- 32 boards completed at least some portion of the survey between October and December 2017.

- In total, the boards that responded to the survey have service areas which cover 48 of Ohio’s 88 counties and approximately 75% of Ohio’s population.

- Both urban and rural counties are represented within the sample, as well as counties spread throughout the state.
ADAMHS Boards Survey Data

• Regardless of the way an individual is connected to the criminal justice system, boards most often provide funding for Assessment, Individual Behavioral Health Counseling, and Crisis Intervention.

• Boards are far more likely to fund services for individuals in jails than in any other segment of the criminal justice system.
Percentage of board’s budget allocated toward BH services for individuals involved with the criminal justice system

- 16%: 0-5%
- 7%: 6-10%
- 3%: 11-15%
- 0%: 16-20%
- 2%: 20+
- 2%: Unknown
Board spending on programs specifically for individuals involved in the criminal justice system

- Less than $100k: 5
- $100k-$499k: 8
- $500k-$1 mil: 5
- $1 - $5 million: 4
- More than $5 mil: 2
- Unknown: 6

# of Boards
Number of programs funded that serve currently or recently incarcerated individuals, by board

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<td>30+</td>
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Number of individuals served through board funding while incarcerated

- Less than 200: 6 boards
- 200-500: 7 boards
- 500+: 3 boards
- Did not Track: 9 boards

Do the agencies you fund have any other competitive funding sources that support services for individuals involved in the criminal justice system?

- Yes: 18
- No: 8
- Don't Know: 6

Are jails in your Board area using CIT officers?

- Yes: 24
- No: 7
## Funding for behavioral health services related to the criminal justice system by boards

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<tr>
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</table>
Recommendations: Jail Administrators

• To better understand the challenges faced by jails and the growing number of incarcerated individuals with mental illness and SUDs, emphasis should be given to collecting, sharing, and using data. Jail administrators were unable to provide a consistent reporting of data. Information should be available by jail regarding the number of inmates with SMI and SUDs and costs associated with serving these populations, including psychotropic medications and detoxification services.

• Jail administrators are concerned about the rising costs of medications and being understaffed and undertrained to handle inmates with mental illness and SUDs. Jail staff should undergo training in working with individuals with mental illness and SUDs.

• Most jails contract pharmacy services for psychotropic medications through local or national pharmacies. Just 11% of jails contract directly with the ODMHAS. 61% of county jails have a formulary for psychotropic medications. Jails should ensure that incarcerated individuals have access to all needed medications, including those prescribed when arrested to ensure there is little to no disruption in care.
Recommendations: Jail Standards

• The revised jail standards were an important step forward in mental healthcare, but equally important is compliance with these standards. Invest in efforts to improve, track, and enforce jail compliance with physical and mental health standards.

• Jail standards should be updated to include the reporting of deaths by suicide within jails, a category that is not currently tracked.
Recommendations: Services in the Community

• There needs to be better data collection as it relates to services provided to people in or recently involved with the criminal justice system. Not all boards see the reentry population as separate from the general population, and so don’t provide services that way.

• The survey results show that not all jails are doing everything they can do to enroll eligible individuals into Medicaid upon release. This is an opportune time to connect a vulnerable population with access to health services and every effort should be made to enroll eligible individuals into Medicaid and other safety net programs.
Current Availability of Services

Sequential Intercept Model

• The Criminal Justice Coordinating Center of Excellence (CJCCoE) in Ohio partnered with the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop a conceptual framework.

• The CJCCoE has applied this model in 19 counties around Ohio through a process called Sequential Intercept Mapping.

• Of the 19 participating counties, two adapted the model to focus on the opiate epidemic. Four additional counties are currently in progress.
The Stepping Up Initiative

Ohio Stepping Up: Participating Counties

- Aims to reduce the number of adults with behavioral health disorders in jails.
- More than 420 counties across 43 states have passed a resolution or proclamation to join the initiative, including 41 counties in Ohio.
A 2016 “Readiness Assessment” survey, funded by Peg’s Foundation in partnership with ODMHAS, was conducted to understand the size, scope, and organizational structure of county activities aimed at reducing the number of adults with behavioral health disorders in jails.

The survey covers 26 counties representing 4.8 million people, or 41 percent of Ohio’s total population, and include both rural and urban settings.

A large percentage (85 percent) of counties ensure offenders have access to needed medication upon release. In stark contrast, only 31 percent of counties reported assisting incarcerated individuals with Medicaid enrollment.

While 77% of counties have a system to track individuals who have a mental illness, only 27% can track the total number of people cycling through county jails which can help identify rates of recidivism.
Quick Response Teams

- Lucas County Drug Abuse Response Team (DART) Unit in July 2014
- Hamilton County, Colerain Township began the state’s first QRT in July 2015
- Summit County, the city of Cuyahoga Falls adopted the QRT model from Colerain Township and began making house calls in January 2017
- The SFY 2018-2019 state operating budget included $3 million for a grant program to either replicate or expand successful law enforcement programs that address the opioid crisis through models resembling those described above. Last September, 40 police departments were awarded funding.
- Project SOAR (Supporting Opiate Addiction Recovery), blends a community support program with rapid response emergency services through a peer support specialist model.
- Funded by the Cuyahoga County Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board. The program launched in December 2017.
Medication Assisted Treatment

• Medication-assisted treatment (MAT) is the use of pharmaceuticals in combination with counseling and behavioral therapies to treat substance use disorders (SUDs).

• Can significantly reduce the need to inpatient detoxification services, decrease mortality, improve health outcomes, reduce infectious disease and decrease illicit opiate use and criminal activity amongst those with SUDs.

• Half of all buprenorphine spending in Ohio is financed by Medicaid.

• According to ODMHAS, the relapse rate for those with opiate-related substance use disorders is as high as 90 percent without the use of MAT.
Medication Assisted Treatment and Courts

• In the SFY 2014-2015 state operating created the Addiction Treatment Pilot Program (ATP), the legislature established a two-year pilot program to arm drug courts in certain counties with MAT as an additional tool.
  • An appropriation of $5 million was made to carry out the pilot.
  • A community SUD provider agency provided treatment services.

• The SFY 2016-2017 state operating budget expanded the ATP for drug courts to an additional 12 counties and changed the status of the initiative from a pilot to an official program and renamed MAT Drug Courts.
  • $5.5 million per year for this purpose.
  • Senate Bill 319, the Opioid Mid-Biennium Review included a provision clarifying that the funding could be used for recovery support services.

• In the SFY 2018-2019 state operating budget-18 additional counties received funding from the state to start a MAT drug court.
  • Methadone was also added as one of the accepted forms of medication to be used in MAT drug court programs.
Civil Commitment
Inpatient Treatment

- A person with mental illness, per Ohio Revised Code (ORC) 5122.01, must meet one of the first four of the definition of “mentally ill subject to court order” to be involuntarily hospitalized.

Assisted Outpatient Treatment

- September 17, 2014, a fifth standard was added outlining criteria for judges to commit someone to court ordered outpatient treatment.

Involuntary Commitment for SUDs

- Beginning in 2012, Ohio law allows individuals to file an affidavit with a probate court to commit friends and family members to SUD treatment.
Recommendations

Sequential Intercept Model

• All 88 counties in Ohio should participate in Sequential Intercept Mapping workshops through CJCCoE in order to identify opportunities to strengthen behavioral health supports throughout individuals’ interactions with the criminal justice system.

Stepping Up Initiative

• County jails should assist incarcerated individuals with Medicaid enrollment to ensure access to services upon release.
• Ohio should engage stakeholders in the criminal justice system at the local and state level to develop an improved statewide record of tracking individuals going through the county jails.
Quick Response Teams

- Counties should consider adding peer support specialists as part of their teams. Peers have lived experience and can relate to what the individual is going through. Peers provide a different perspective than first responders and behavioral health counselors. Peers may be able to help more individuals accept treatment services that are being offered during the visit.

- QRTs should continue to be funded in the budget. However, the funding should not be through the Attorney General’s office but instead through ODMHAS. The funding could have more flexibility for communities that want to approach the QRT model without using law enforcement agencies.
Medication Assisted Treatment and Courts

• Recently, CARA expanded prescribing privileges to nurse practitioners and physician assistants. Ohio should ensure more mid-level practitioners are trained and can prescribe MAT using buprenorphine as soon as possible. These privileges are in effect until 2021. This provision should be revisited and consideration given to extending the time.

• Justice-involved individuals should have all MAT services available in their recovery. The MAT drug courts, through a provision in the recent state budget, allows methadone to be used by individuals in the program. However, this is not always the case and individuals are forced to use a preferred drug in MAT drug courts.
Crisis Intervention Team
Crisis Intervention Team (CIT) programs have developed in order to aid first responders with making appropriate treatment referrals for individuals experiencing a mental health crisis, ultimately aiming to divert these individuals from entering the criminal justice system.

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**Locations counted, not counties**
Prevention

Directing efforts upstream to prevent mental health and SUDs plays a major role in quelling current and future behavioral health issues.

- Reducing Risks
- Strengthening protective factors among entire communities
- Targeting high-risk individuals
Intervention in Lieu of Conviction

Courts are using intervention in lieu of conviction as a way to help more offenders receive needed treatment services.

After determining if the offender has a mental illness or SUD from a certified behavioral health provider, a court can order treatment.

To successfully complete the program, one must abstain from using alcohol and other substances for 12 consecutive months, participate in treatment and recovery services, submit to random drug and alcohol testing, and any other requirements imposed by the court. If the offender completes the program successfully, the case is dismissed. However, if the participant fails the program, they will be found guilty by the court and sentenced accordingly.
Targeted Community Alternatives to Prison (T-CAP) initiative is another approach to help low-level, non-violent offenders stay out of the prison system.

ODRC has been trying to find ways to reduce the prison population, which stands at 49,337 as of March 2018. At its highest, Ohio’s prison population was 51,273 on November 10, 2008.

The T-CAP program is for non-violent, non-sexual, and non-mandatory Felony 5 convictions. ODRC estimates that, of the approximate 20,000 offenders committed annually to serve less than one year in the state’s prison system, about 3,400 would meet these criteria.

These offenders will benefit by serving time in a local setting such as a jail or Community Based Correctional Facility (CBCF), instead of a state prison. CBCF offers treatment and recovery services and is an opportunity to provide a path to recovery.
Diversion

National Examples:
- Miami-Dade County
- Utah
- Bexar County, Texas
Work of Managed Care

Community Transition Program

80 percent of offenders in Ohio’s prison have documented histories of SUD

July 1, 2016, the Ohio Department of Rehabilitation and Correction (ODRC) and the Ohio Department of Mental Health and Addiction Services (OhioMHAS) began contracting with CareSource

• Connects returning individuals with substance use disorders (SUDs) to treatment and recovery support services
  – Medication Assisted Treatment (MAT)
  – Housing assistance
  – Vocational supports
  – Life skills
  – Transportation

Funded through the biennial budget, CTP financing is secured through June 2019.

Within its first 18 months, the program enrolled over 3,000 returning citizens, and expects to serve over 3,000 participants each year moving forward.
Work of Managed Care

Medicaid Pre-Release Enrollment Program

Goal of connecting incarcerated individuals with Medicaid managed care coverage upon release
Piloted at Ohio Reformatory for Women in Marysville in October 2014, with the first participants enrolling in November 2014.
Now in all 27 ODRC facilities throughout the state by March 2017
Each ODRC facility begins in-reach 120 days prior to an inmate’s release.

• ODRC conducts a screening for care management, during which some program participants are identified as “critical risk,” or having a serious need for ongoing health care services to manage chronic conditions.
• Critical risk participants engage in an ODM-mandated videoconference with their MCOs prior to release, and MCOs report to ODM monthly and quarterly regarding their follow up with these individuals.

In the Fall of 2017, ODM’s Office of Health Innovation and Quality conducted an initial evaluation of the MPRE:

• Retention rate is comparable to other Medicaid populations
• Higher percentage of consumers with mental health and SUD diagnoses as compared to Group VIII (Medicaid expansion) population
• Higher percentage of SUD- and mental health-related inpatient admitting diagnoses as compared to other Medicaid populations
• Consumers flagged as CRI demonstrated an inpatient psych utilization rate four times higher and other service utilization rate twice as high in comparison with non-CRI consumers
Prevention

- Ohio should examine prevention programming around the state to better understand what evidence-based programs are being utilized by communities and school districts. Prevention programming in the state should utilize evidence-based models that communities determine meet their specific needs. Federal, state, and local governments should provide the funding and tools that individuals, families, and communities need to support prevention programming.

Crisis Intervention Team

- CIT International should update the existing Ohio CIT Strategic Plan to include a timeline for implementing CIT programming in all 88 Ohio Counties.
- CIT International should publicize accomplishments of CIT in Ohio as a national leader in the CIT movement, having improved the criminal justice response to community behavioral health needs.

Diversion

- Diversion programs should be expanded throughout the state as a resource to help individuals avoid trauma that may come with unnecessary jail time. Giving communities the resources to properly screen individuals who enter the criminal justice system can assist in higher utilization of diversion programs in Ohio. Those tools can aide individuals in crisis by properly aligning them with the resources they need to remain out of jail and be provided with the opportunity to seek behavioral health interventions.
Work of Medicaid Managed Care

- Jail administrators should adopt the MPRE for their incarcerated individuals. This would entail screening individuals at intake for Medicaid eligibility and enrolling eligible participants as soon as possible in order to maximize enrollment prior to release from jail. A point of contact in jails to assist with Medicaid enrollment would improve access to services for individuals coming in and out of local jail systems.

- CareSource, ODRC, and ODMHAS should conduct an evaluation of CTP that examines the rate of utilization to linkage, in order to determine why this rate is only 30%.

- CareSource, ODRC, and ODMHAS should build out additional linkage opportunities for participants, including recovery supports such as peer support and employment.

- CareSource, ODRC, and ODMHAS should create a direct phone line for CTP services.
Time for questions and answers
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