INSTALLMENT 3

By the Numbers 4

Developing a Common Understanding for the Future of Behavioral Health Care

Survey Data:
Jail Administrators and ADAMHS Boards

LANDSCAPE AND ANALYSIS OF THE INTERSECTION BETWEEN THE BEHAVIORAL HEALTH AND CRIMINAL JUSTICE SYSTEMS

THE CENTER FOR COMMUNITY SOLUTIONS EST.1913
RESEARCH • ANALYSIS • ACTION

mhac
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CCS and the MHAC would like to extend special thanks to all of the departments, agencies, and organizations that provided data contained in this report.

Contents

About The Center for Community Solutions and the MHAC . . . 3

Survey Data: Jail Administrators and ADAMHS Boards . . . 4
- County Jail Administrator Survey . . . 4
- Jail Standards: ORC 5120.10 and OAC 5120:1-10-09 . . . 5
- Survey of Alcohol, Drug Addiction, and Mental Health Services Boards . . . 8
- Overview of Survey Findings . . . 10
- Services for Individuals Involved with the Criminal Justice System . . . 10
- Funding Levels, Programs, and Individuals Served . . . 12
- Medicaid Enrollment and Impact of Behavioral Health Redesign . . . 14
- Post-Incarceration . . . 15
- Program Categories Funded by Boards . . . 16
- Jail-Based Programs . . . 16
- Alternative Courts and Specialized Dockets . . . 16
- Re-entry and Post-Incarceration Programs . . . 17

Recommendations . . . 20

Appendix A . . . 21

Appendix B . . . 22

Appendix C . . . 23

End Notes . . . 25

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.

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.

The Center for Community Solutions' and the Mental Health & Addiction Advocacy Coalition's work on this report has been made possible in part due to generous support from The Columbus Foundation, Interact for Health, Ohio Transformation Fund, and Peg's Foundation.

Survey Data: Jail Administrators and ADAMHS Boards

County Jail Administrator Survey

The number of individuals with mental illness and substance use disorders (SUDs) housed in Ohio jails continues to rise, and as a result, jails are experiencing increased psychotropic drug[1] costs and other challenges associated with management of these populations. To better understand the financial and administrative challenges that jails face, the Ohio Jail Advisory Board conducted a survey of jail administrators in 2016. The key findings from an analysis of the jail administrator survey are highlighted below.[2]

While jails are not mental health facilities, increasingly more individuals with serious mental illness (SMI) are occupying county jails across the state. In 2015, more than 15,500 individuals with SMI occupied jails in Ohio – an increase of 6 percent from the previous year. This is likely an undercount, because only 40 of 61 jails responded to this survey question. However, among the 40 jails reporting, in one year, eight county jails experienced at least an increase of 50 percent of incarcerated individuals with SMI. The average number of incarcerated individuals with SMI per jail was 398 in 2015. Summit and Warren County Jails had the highest number of individuals with SMI in 2015, with 3,050 and 2,466 individuals respectively. Of the individuals with SMI that received treatment in county jails, 72 percent were male and 28 percent were female.

Individuals with SMI represent a growing and costly segment of the county jail population. In 2015, the estimated average annual cost of providing SMI services was $29,250 per county jail, compared to $22,417 per jail in 2014. This represented a 30 percent increase in costs, but there was considerable variation among jails. For example, 14 jails reported expenditure increases for SMI services, while the spending for five jails remained flat and three jails reported a decrease in spending for SMI services between 2014 and 2015. The remaining county jails did not respond to this survey question.

Detoxification medicine is increasingly administered to individuals in jail, but this is not the preferred setting for recovery from mental illness or SUDs. Five percent of the total county jail population, or an estimated 24,400 individuals, received detoxification services in 2015 (40 jails reporting). On average, 610 individuals per jail received detoxification services in 2015, representing an increase of 14 percent between 2014 and 2015. The majority of individuals who receive detoxification services are male; however, females account for nearly 30 percent of individuals receiving detoxification services.

The continued incarceration of individuals with mental illness and SUDs in county jails places a burden of both risk and cost upon these facilities. Cost estimates for providing detoxification services, including medications, extra staff time, overtime, and hospitalizations, varied widely among the 22 jails that responded to this survey question. In 2015, two jails (Washington County Jail and Stark County Jail) reported spending more than $100,000 on detoxification services. The average dollar amount spent on detoxification services was $24,500 per jail in 2015. The vast majority of jails reported that this data is not tracked or was unknown. Some jails only provided the cost estimates of medications.

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. When asked to report which type of incarcerated individual is more expensive to care for, the overwhelming response from jail administrators (85 percent) was a person with SMI. Compared to those withdrawing from opioids or alcohol, individuals with SMI are also more likely to cause disruptions in jails and cause overtime for jail staff. The vast majority (89 percent) of jails would prefer to receive assistance for individuals with SMI from the state or community mental health or addiction services. Almost all (95 percent) jail administrators would prefer to transfer incarcerated individuals with SMI to a more appropriate setting.

On average, 1,505 incarcerated individuals per jail received psychotropic medications in 2015, costing $75,353 per jail. Although the average number of individuals receiving psychotropic medications declined by 8 percent between 2014 and 2015, average spending on psychotropic medications increased by 17 percent. Twenty-five jails (54 percent of jails reporting) reported an increase in the number of individuals receiving psychotropic medication from the previous year.

Most jails contract pharmacy services for psychotropic medications through local or national pharmacies. The vast majority (87 percent) of Ohio jails report contracting pharmacy services for psychotropic medications. Typically, these contracts are through either a local pharmacy (43 percent) or national pharmacy (34 percent). Just 11 percent of jails contract directly with the Ohio Department of Mental Health and Addiction Services (ODMHAS). Sixty-one percent of county jails have a formulary for psychotropic medications. When asked about jail policy regarding the administration of psychotropic medications, most county jails reported a generic substitution policy, enabling substitution of a generic psychotropic for a name-brand psychotropic. Just 15 percent of jails reported following the Medicaid formulary, while 13 percent have a generic-only policy where pharmacies can only order generic psychotropic medications.

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 administrators are concerned about the rising costs of medications and being understaffed and undertrained to handle individuals with mental illness and SUDs. They also often have difficulty obtaining hospitalization or admittance to mental health facilities for those in crisis or in need of specialized care. Additionally, a number of jail administrators acknowledged a lack of data around these issues and a need for further data collection in order to show a more complete picture of jail operations.

Jail Standards: ORC 5120.10 and OAC 5120:1-10-09

Ohio law provides all persons incarcerated in jail a right to medical and mental health care. The standards for treatment of people in jails are codified in Ohio Revised Code (ORC) Section 5120.10 and the Ohio Administrative Code (OAC) 5120:1-10-09,[3] which define what is required to meet the minimum conditions necessary to ensure the safe, efficient, and constitutional operation of a jail. For a list of "essential" and "important" standards that relate to physical health and mental health, see Table 1. These standards address a number of areas of jail operations, including specific rules for physical and mental health services. Starting in 2014, these standards were updated to put incarcerated individuals' mental health needs on par with medical needs.

The revised regulations include requirements for full-service jails (effective April 2014) and 12-day facilities (effective February 2016) with respect to prescreening, health evaluations, medications, mental health services, and suicide prevention. For example, jail officials must establish a process in which incoming individuals are questioned about suicidal thoughts and mental health concerns before acceptance into a jail. Following the prescreening, health-trained personnel must screen all individuals upon arrival at the jail, before they are placed in the general population. The purpose of the health evaluation is to determine if the person is experiencing any physical or mental disorder. All people in jail showing signs of a serious medical condition or mental illness must be sent to the jail physician, or other qualified health professional or agency, for appropriate medical, psychiatric, or psychological services or other necessary treatment.[4] Furthermore, jails are required to provide 24-hour emergency health, dental, and mental health care services, and ensure that individuals can access the medications they need. Jails also must have written policies and procedures to address suicide prevention. However, it should be noted that the jail standards do not require reporting deaths by suicide within jails.

The revised jail standards were an important step forward in mental health care, however, equally important is compliance with these standards. When a jail is noncompliant, it must develop a "plan of action." Bureau of Adult Detention (BAD) within the Ohio Department of Rehabilitation and Corrections has the statutory responsibility to create jail standards and to apply them through on-site inspections. While BAD performs inspections, it does not have administrative oversight to enforce these policies. Analysis of the 2016 jail inspection reports revealed the following key findings.[5]

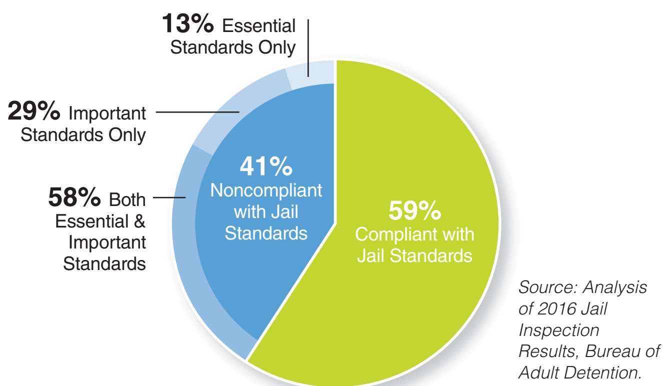
In 2016, a majority of jails (59 percent) were in compliance with jail standards pertaining to physical health and mental health (see Figure 1). Among the 41 percent of jails that were not compliant on some physical health and mental health standards, most jails (58 percent) lacked compliance on both "essential" and "important" health standards. Twenty-nine percent of jails were not in compliance with only "important" standards, and just 13 percent were only noncompliant on "essential" health standards.

TABLE 1: *Selected Examples of Medical/Mental Health Jail Standards*

Standard	Description
ESSENTIAL STANDARDS	
Health authority	Jails have a designated health authority with responsibility for arranging all levels of health care, mental health care and dental care for inmates and for assuring that these services are appropriate in scope, accessibility and timeliness. The health authority may be a physician, health administrator or agency.
Inmate prescreen	Before acceptance into a jail, inmates must be asked about mental health issues (e.g., suicidal thoughts, mental health issues or use of force during arrest).
Inmate screen	Health-trained personnel must screen all inmates upon arrival at the jail and prior to being placed in the general population. The health evaluation must include information about current and past illnesses and health/mental health problems, medications taken, behavioral observation, medical needs and assessment of suicide risk.
Scope of services	Jails are required to provide 24-hour emergency health, dental and mental health care.
Sick call	The health authority establishes policies and procedures for sick calls, where a physician or other health-care professional is available to assist people with medical needs.
Physical and mental health complaints	Jails are required to establish procedures whereby inmates have the opportunity to voice physical and mental health complaints through health-trained personnel. Medical personnel must review all medical complaints daily and appropriate treatment must be provided. The health authority must also establish an inmate grievance system. These written requests and complaints can be used to request physical and mental health and disability-related services in jail.
Physical/mental health record	Jails are required to maintain an accurate physical and mental health record in a written or electronic format. Medical records maintained at the jail must include documentation of medical problems, examinations, diagnosis and treatment. All medical records are confidential and accessible only by authorized persons. Correctional staff may be advised on inmates' physical or mental health status only to preserve the health and safety of the inmate, other inmates or jail staff.
Pharmaceuticals	Jails are required to develop a policy, with approval by the health authority, regarding incoming medications. The policies must address requirements for dispensing and administering prescribed medications and the management of medication.
Mental health services	The health authority is responsible for developing policies for the following areas: (1) screening for mental health problems, (2) referral to outpatient services, including psychiatric care, (3) crisis intervention and management of acute psychiatric episodes, (4) stabilization of inmates with mental illness and prevention of psychiatric deterioration in the jail, (5) referral and admission to inpatient facilities and (6) informed consent.
Suicide prevention program	Jails must have written policies for identifying and responding to suicidal and potentially suicidal inmates. These policies and procedures should address suicide prevention, detection, intervention, response and review of incidents.
Intoxication and detoxification	The health authority is responsible for establishing specific policies and procedures in accordance with local, state and federal laws for the treatment of inmates manifesting symptoms of intoxication or detoxification from alcohol, opioids, hypnotics or other drugs.
IMPORTANT STANDARDS	
Continuous quality-improvement program	The health authority shall develop a continuous quality-improvement system of monitoring and reviewing, at least annually, the fundamental aspects of the jail's physical/mental health care system. This includes, but is not limited to, access to care, intake process, emergency care, hospitalizations and adverse inmate occurrences, including all deaths.
Inmate death	In all inmate deaths, the health authority determines the appropriateness of clinical care. The authority ascertains whether corrective action in the system's policies, procedures or practices is warranted, and identifies trends that require further study.
Informed consent	The health authority shall develop a policy and procedure requiring that all examinations, treatments and procedures are governed by informed-consent practice applicable within in the jail's jurisdiction.
Privacy	The health authority shall develop a policy whereby health care encounters -- including medical health interviews, examinations and procedures -- are conducted in a setting that respects the inmate's privacy.

Source: Ohio Administrative Code, 5120:1-10-09

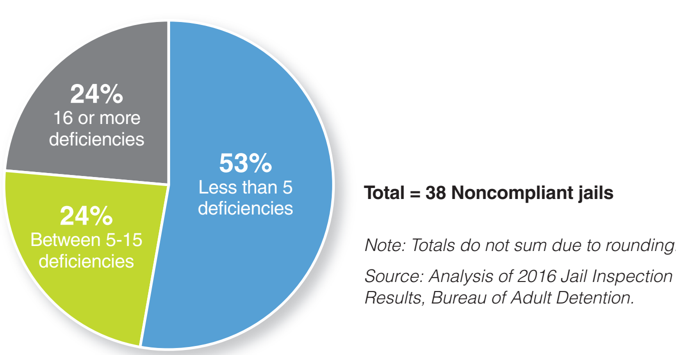
FIGURE 1: *Jail Compliance with Health and Mental Health Standards, 2016*



Source: Analysis of 2016 Jail Inspection Results, Bureau of Adult Detention.

The jails inspected in 2016 accounted for more than 300 failed standards related to medical and mental health care, with wide variation in occurrences of noncompliance. Overall, just more than half (53 percent) of noncompliant jails had fewer than five deficiencies, 24 percent had between five and 15 deficiencies, and another 24 percent of jails had 16 or more areas of noncompliance in 2016 (see Figure 2). Four jails (Brown, Clark, Gallia, and Harrison) were deficient on more than 25 medical/mental health standards. By contrast, seven jails reported just one area of noncompliance (Ashtabula, Delaware, Holmes, Jackson, Knox, Lake, and Middletown).

FIGURE 2: *Number of Deficiencies Related to Health and Mental Health Standards, Among Noncompliant Jails, 2016*



Total = 38 Noncompliant jails

Note: Totals do not sum due to rounding.

Source: Analysis of 2016 Jail Inspection Results, Bureau of Adult Detention.

The most frequently cited areas of noncompliance among "essential" standards were: health appraisals (42 percent of jails), pharmaceuticals (39 percent), inmate prescreen (37 percent), and infectious disease control (37 percent) (see Table 2). Nearly one in four noncompliant jails were deficient in the standard relating to a designated health authority – the position responsible for overseeing all policies and procedures with regard to medical and mental health standards. Slightly more than one-third of noncompliant jails were deficient in their suicide prevention program policies. The most common "important" standards cited for noncompliance included continuous quality-improvement program (71 percent) and emergency response plan (68 percent). At the time of the inspection, many jails had not yet updated their current policies and procedures to reflect these standards. Additionally, more than 25 percent of jails were noncompliant in standards related to dental care and deaths of incarcerated individuals.

TABLE 2: *Areas of Noncompliance with Selected Medical/ Mental Health Standards*

Selected Medical/ Mental Health Standards	Counts of Noncompliance	Percentage
ESSENTIAL STANDARDS		
Health appraisal	16	42%
Pharmaceuticals	15	39%
Inmate pre-screen	14	37%
Infectious disease control	14	37%
Suicide prevention	13	34%
Receiving screen	13	34%
Restraints	12	32%
Mental health services	11	29%
Medical/mental health record	11	29%
Continuing education for health-trained personnel	11	29%
Intoxication and detoxification	11	29%
Confidentiality	10	26%
IMPORTANT STANDARDS		
Continuous quality improvement program	27	71%
Emergency response plan	26	68%
Inmate death	11	29%
Dental care	11	29%
Privacy	10	26%

Source: Analysis of 2016 Jail Inspection Results, Bureau of Adult Detention

Survey of Alcohol, Drug Addiction, and Mental Health Services Boards

Our research included a survey of Alcohol, Drug Addiction, and Mental Health Services (ADAMHS) boards. Across Ohio, 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. Together, the geographic jurisdiction of these boards covers all 88 Ohio counties. They are governed by Ohio law and each has an independent Board of Directors. Boards generally contract with behavioral health[6] providers to deliver services. We gathered primary data about the types of services funded and funding levels as well as connections between ADAMHS boards and the criminal justice system. The survey was distributed to boards with the help of the Ohio Association of County Behavioral Health Authorities.

Thirty-two boards completed at least some portion of the survey between October and December 2017. Responses were collected online via the SurveyMonkey tool. A printable version of the survey was available so boards could prepare their responses before submitting them online. In total, the boards that responded to the survey have service areas which cover 48 of Ohio's 88 counties and approximately 75 percent of Ohio's population. Both urban and rural counties are represented within the sample, as well as counties spread throughout the state.

Results are reported by geographic region rather than individual board, to preserve confidentiality. During data analysis, boards were grouped into five regions: Southwest, Southeast, Northwest, Central, and Northeast. The specific groupings were based on the regions identified by ODMHAS via the Trauma Informed Care Regional Collaboratives.

TABLE 3: *Survey Respondents*

Region	Responded	Did Not Respond
Central	• Mental Health, Drug & Alcohol Services Board of Logan & Champaign Counties • Delaware-Morrow Counties Mental Health & Recovery Services (MHRS) Board • The Alcohol, Drug & Mental Health (ADAMH) Board of Franklin County	• Crawford-Marion Board of ADAMHS • Paint Valley ADAMH Board • Mental Health & Recovery Board for Licking & Knox Counties • Mental Health & Recovery Board of Union County
Northeast	• Ashtabula County ADAMH Board • Columbiana County Mental Health & Recovery Services Board • County of Summit ADM Board • ADAMHS Board of Cuyahoga County • Geauga County Board of Mental Health & Recovery Services • Lake County Board of ADAMHS • ADAS Board of Lorain County • Medina County ADAMH Board • Mental Health & Recovery Board of Ashland County • Mental Health & Recovery Board of Wayne & Holmes Counties • Stark County Mental Health & Addiction Recovery • Mental Health & Recovery Services Board of Richland County • Trumbull County Mental Health & Recovery Board	• ADAMHS Board of Tuscarawas & Carroll Counties • Mahoning County Mental Health & Recovery Board • MH & Recovery Board of Portage County • Lorain County Mental Health Board
Northwest	• MHRS Board of Allen, Auglaize, Hardin Counties • Hancock County Board of ADAMHS • Huron County Board of Mental Health & Addiction Services • Mental Health & Recovery Services Board of Lucas County • ADAMHS Board of Mercer, Van Wert & Paulding Counties • Tri-County Board of Recovery & Mental Health Services	• Four County Board of ADAMHS • MH & Recovery Board of Erie & Ottawa • Mental Health & ADA Recovery Board of Putnam County • Mental Health & Recovery Services Board of Seneca, Sandusky and Wyandot Counties • Wood County ADAMHS Board
Southeast	• MH & Recovery Board Serving Belmont, Harrison & Monroe Counties • Jefferson County Prevention & Recovery Board • Washington County Behavioral Health Board	• Athens, Hocking & Vinton Counties ADAMHS Board • Muskingum Area Mental Health & Recovery Services Board • Fairfield County ADAMH Board • Gallia - Jackson - Meigs Board of ADAMHS
Southwest	• The ADAMHS Board of Adams, Lawrence & Scioto Counties • Brown County Board of Mental Health & Addiction Services • Clermont County Mental Health & Recovery Board • Hamilton County Mental Health & Recovery Services Board • Mental Health & Recovery Board of Clark, Greene, and Madison Counties • Mental Health & Recovery Services Board of Warren & Clinton Counties • ADAMHS Board for Montgomery County	• Butler County Mental Health & Addiction Recovery Services Board • Preble County Mental Health & Recovery Board

Overview of Survey Findings

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. Unlike the other regions, most of the boards in the Southwest Ohio region reported funding services for individuals in most of the components of the criminal justice system including jails, prisons, day programs, preventive programs, Community Based Correctional Facilities (CBCFs), and specialized dockets.

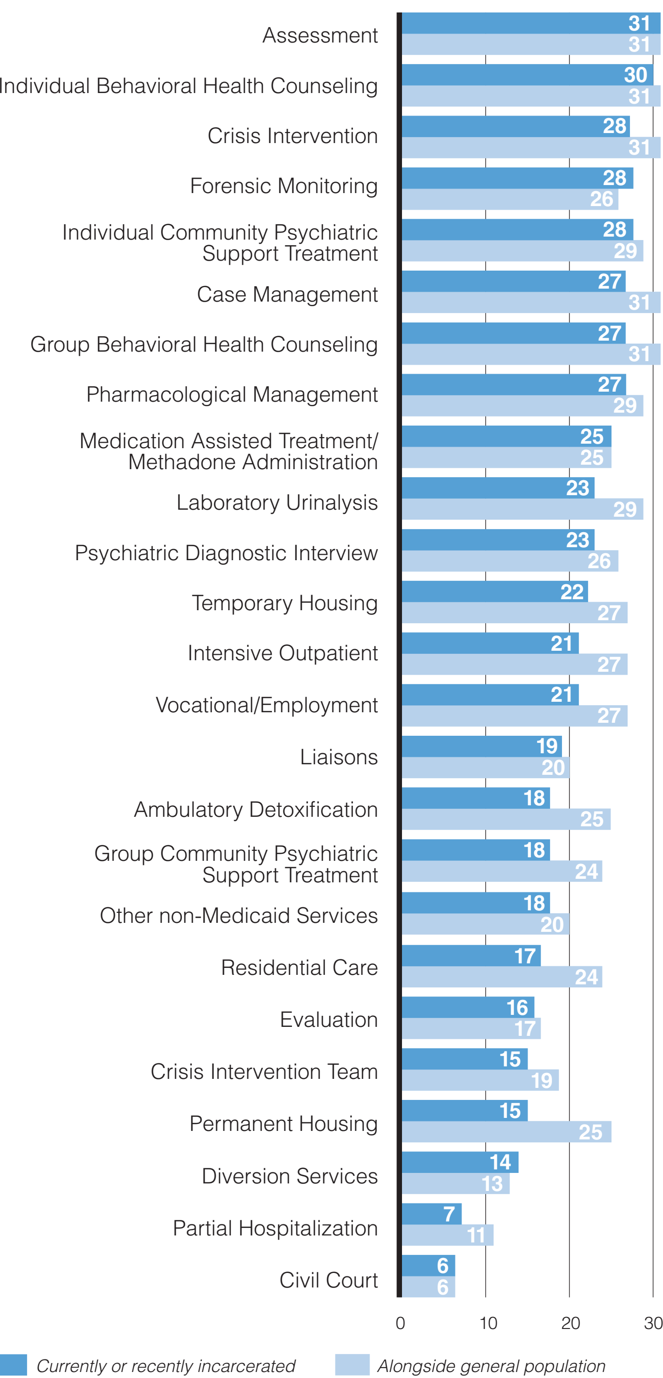
The number of individuals served, share of budget, and amount of funding for services for those who are currently, or recently,[7] incarcerated varies widely across the state. However, the most likely scenario is that a board spends less than five percent of its total budget on between one and five programs, which serve fewer than 200 justice-involved people. Although responses came from a good mix of urban and rural boards and covered all corners of the state, it became clear through the data collected and the additional board comments that many boards do not track individuals involved in the criminal justice system separately from the general population. Therefore, differences between regions should be interpreted with caution. As one board pointed out, "The system in our county is designed to serve all who need care and does not differentiate based on criminal status. We served roughly 9,000 individuals in SFY 2016. Many of those may have been individuals who were incarcerated in the past five years."

Crisis Intervention Team[8] (CIT) training and work related to criminogenic thinking[9] are relatively well-supported initiatives, but fewer than half of the boards reported that jails in their areas are enrolling people in Medicaid. Some boards identified services which they expect to fund at higher levels as a result of Behavioral Health Redesign. At least one board's responses indicated that it expects the mix of services funded to change significantly.

Services for Individuals Involved with the Criminal Justice System

Boards were asked to identify services[10] they fund for currently or recently incarcerated individuals. They were also asked to identify services they fund for the general population, which may include previously incarcerated individuals. All of the boards that answered these questions indicated they fund assessment services for both groups. All of the responding boards also noted they fund Individual Behavioral Health Counseling, Crisis Intervention, Case Management, and Group Behavioral Health Counseling for the general population, which may include recently incarcerated individuals. Civil court, partial hospitalization, and diversion services were least likely to be funded for either group.

Figure 3: *Board Funded Services for Individuals Involved in the Criminal Justice System*



Boards in the Central and Southwest regions were most likely to be funding services specifically for individuals currently or recently involved with the criminal justice

system, while those in the Southeast region were least likely. There were 11 categories all boards in the Central region funded.[11] Those were assessment, forensic monitoring, psychiatric diagnostic interview, individual behavioral health counseling, individual community psychiatric support treatment, medication-assisted treatment/methadone administration, laboratory urinalysis, liaisons, group behavioral health counseling, intensive outpatient, and group community psychiatric support treatment. There were six categories funded by all boards in the Southwest region, which included assessment, case management, crisis intervention, pharmacological management, forensic monitoring, and psychiatric diagnostic interviews. Conversely, eight service categories for people currently or recently involved with the criminal justice system weren't funded by any boards in the Southeast region. These categories were ambulatory detoxification, crisis intervention team, liaisons, other non-Medicaid services, residential care, diversion services, partial hospitalization, and civil court. Several of the services were available for recently incarcerated people along with the general population in the Southeast region.

TABLE 4: *Most and least common services funded, by region*

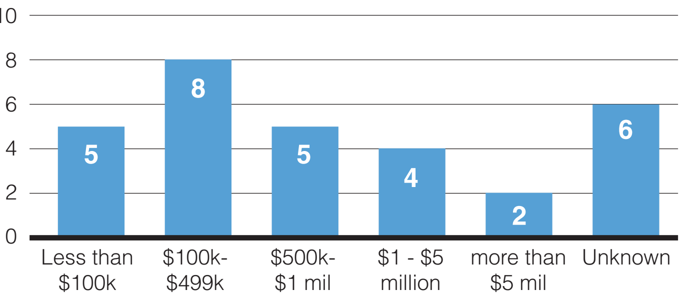
Region	Most Common Services Funded	Least Common Services Funded
Central	• Assessment • Case Management • Forensic Monitoring • Group Behavioral Health Counseling • Group Community Psychiatric Support Treatment • Individual Behavioral Health Counseling • Individual Community Psychiatric Support Treatment • Intensive Outpatient • Laboratory Urinalysis • Liaisons • Medication Assisted Treatment/Methadone Admin. • Psychiatric Diagnostic Interview	• Civil Court • Crisis Intervention Team • Other non-Medicaid Services • Partial Hospitalization • Residential Care
Northeast	• Assessment • Crisis Intervention • Forensic Monitoring • Group Behavioral Health Counseling • Individual Behavioral Health Counseling • Individual Community Psychiatric Support Treatment	• Civil Court • Crisis Intervention Team • Evaluation • Partial Hospitalization • Permanent Housing
Northwest	• Assessment • Case Management • Crisis Intervention • Group Behavioral Health Counseling • Individual Behavioral Health Counseling • Medication Assisted Treatment/Methadone Admin. • Pharmacological Management • Temporary Housing	• Civil Court • Diversion Services • Partial Hospitalization • Residential Care
Southeast	• Assessment • Case Management • Crisis Intervention • Individual Behavioral Health Counseling • Individual Community Psychiatric Support Treatment • Medication Assisted Treatment/Methadone Admin. • Pharmacological Management	• Ambulatory Detoxification • Civil Court • Crisis Intervention Team • Diversion Services • Liaisons • Other non-Medicaid Services • Partial Hospitalization • Residential Care
Southwest	• Assessment • Case Management • Crisis Intervention • Forensic Monitoring • Individual Community Psychiatric Support Treatment • Pharmacological Management • Psychiatric Diagnostic Interview	• Civil Court • Diversion Services • Evaluation • Group Community Psychiatric Support Treatment • Partial Hospitalization • Permanent Housing

Larger, urban boards were much more likely than the overall sample to fund services specifically for individuals who are currently or recently incarcerated. Eight of the nine boards that serve a county with a population greater than 300,000 completed the survey. These include all of Ohio's largest, urban counties (Cuyahoga, Franklin, Hamilton, Summit, Montgomery, Lucas, Stark, and Lorain[12]). The larger, urban boards also funded a more robust mix of services for those involved with the criminal justice system to receive services as part of the general population than the sample boards overall. The exceptions are civil court and evaluation.

Funding Levels, Programs, and Individuals Served

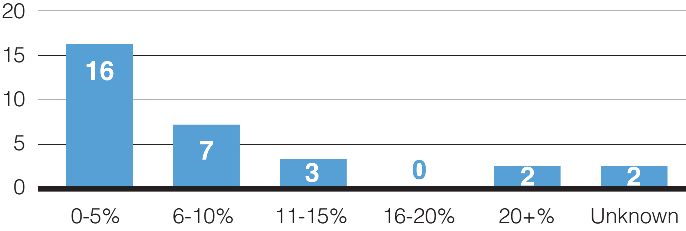
Specific spending on services for currently or recently incarcerated individuals varied widely. Of the 24 boards that indicated they spent at least some money on these services, the amounts ranged from $10,000 to nearly $6.5 million in FY 2016. The most common answers were in the $100,000 to $500,000 range. An additional two boards indicated that they spend no money for this specific population, while four said that they did not know.

FIGURE 4: *Board spending on programs specifically for individuals involved in the criminal justice system*



Similarly, most boards reported spending only a small portion of their total budget specifically on services for the population involved with the criminal justice system. Seventeen of the 28 boards that provided an estimate reported spending less than 5 percent.

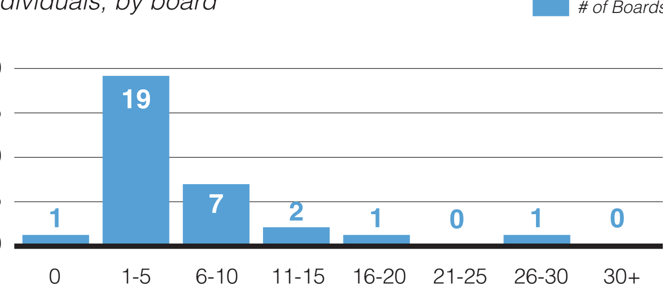
FIGURE 5: *Percentage of board's budget allocated toward BH services for individuals involved with the criminal justice system*



The two boards that reported spending more than 20 percent of their total budget on services for the population involved with the criminal justice system provide services in jails and via specialized dockets. They are located in the Northeast region and Southwest region. One funds liaisons for re-entry and post-incarceration programs, and crisis intervention, under family programming.

Most boards that are funding programs that specifically serve currently or recently incarcerated individuals are funding only a handful of projects. Nearly two-thirds of these boards reported funding five or fewer programs. The board that funds zero programs is located in the Southwest region, while the board that funds more than 25 programs is in the Central region. Otherwise, there were no discernable patterns by region in the number of programs funded by boards.

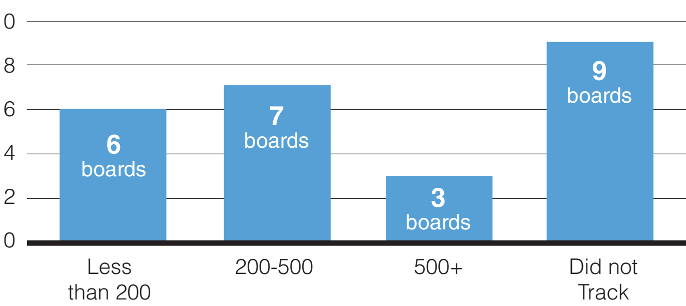
FIGURE 6: *Number of programs funded that serve currently or recently incarcerated individuals, by board*



The number of individuals served through board funding while incarcerated varied widely, ranging from six boards serving fewer than 200 individuals, to three boards serving 500 or more individuals. The greatest number of boards (7) reported serving between 200-500 individuals. Nine of the boards that responded stated that they did not know, or did not track, how many people they were serving. Two

boards reported that they did not serve any individuals. One board was an outlier, reporting that 4,042 individuals received board-funded behavioral health services while incarcerated.

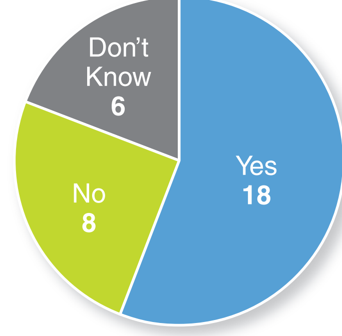
FIGURE 7: *Number of individuals served through board funding while incarcerated*



The three boards with funds serving the most individuals are spread throughout the state. Two are larger urban boards, and all three have a prison in their service area. Each of these boards report providing services in jails, in Community Based Correctional Facilities, and via specialized dockets. As with the overall sample, most of the individuals are served during an individual's incarceration in a jail.

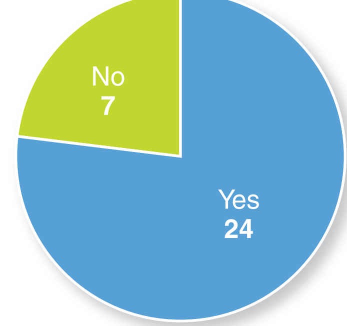
Most boards (56 percent) report that their dollars are combined with other sources of funding that support services for individuals involved in the criminal justice system. Boards in the Central region were most likely to report that the agencies they fund receive other competitive funding for services for individuals involved in the criminal justice system, with all three boards responding "yes" to this question. The majority of boards in the Northeast and Southwest region also indicated that the agencies they fund receive other competitive financial support. On the other hand, boards in the Northwest region were least likely to report that the agencies they fund receive other competitive financial support, with only one responding "yes," two responding "no," and the remaining three were unsure.

FIGURE 8: *Do the agencies you fund have any other competitive funding sources that support services for individuals involved in the criminal justice system?*



More than two-thirds of boards reported that jails in their board areas use CIT officers (explained in further detail in Installment 5 of this report). This includes every board in the Central region and all but one in the Northwest and Southwest regions. The Northeast region has the greatest number of boards that reported jails are not using CIT officers, at four, but because this is the region with the most boards, it still represents only 30 percent of the boards in that region overall. One board noted that corrections officers are one of the classifications invited to participate in CIT, and the county this board serves has trained more than 450 first responders. Of the twelve boards that provided additional comments in this section, eleven indicated CIT training has had some level of successful integration into the jails within their service area. One board commented that they had attempted CIT training but had little interest from officers.

FIGURE 9: *Are jails in your Board area using CIT officers?*



Most boards (59 percent) reported that they support work related to criminogenic thinking. This includes all boards that have a prison in their service area. However, there are clear differences across regions. None of the boards that responded in the Southeast region support this work, while nearly all boards in the Central and Northwest regions do.

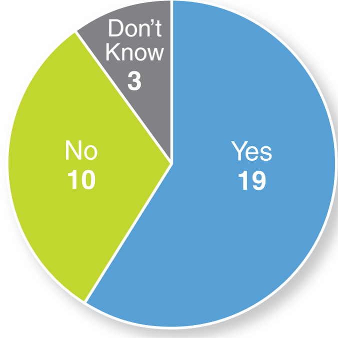
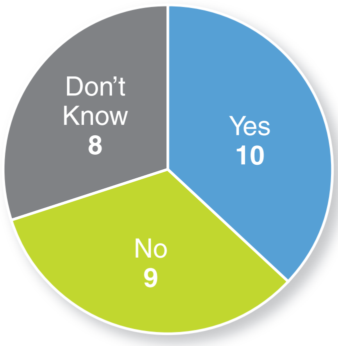


FIGURE 10: *Are boards supporting work around criminogenic thinking?*

Of the 18 boards that provided additional comments, nine indicated they support the criminogenic-based *Thinking for a Change*[13] program, often in collaboration with other behavioral health services. In addition to *Thinking for a Change*, other programs mentioned were *Ohio Risk Assessment System*[14] screenings and *Greene Leaf*[15]. Three of the boards indicated they were starting to talk about, and plan to introduce, criminogenic thinking into the work they support.

When asked if jail planners in their respective service areas consider mental health and SUDs as part of the new facility, the number of responses were almost evenly split between yes, no, and do not know. Eight boards indicated no new jails are being planned at this point. For those boards in service areas with new jails, or jails undergoing remodeling, experiences with the incorporation of mental health and SUDs appear to be unique within each service area. For example, one comment explained, "The new jail being built will include a mental health 'pod' which will allow those diagnosed with a mental illness to be monitored in an area away from general population. This pod will also have space to allow case managers and clinicians to work more effectively with individuals who are incarcerated." However, a less supportive position was described in the following comment: "Our county is expanding the capacity of the current jail. I am on the criminal justice task force that has studied the options for this project. I have proposed offering services in the jail numerous times and for the most part have been told it's not the responsibility of the county general fund to provide treatment services. Some headway has been made recently and they are at least considering offering some services in the jail once the new section opens but it is under consideration and dependent upon cost."

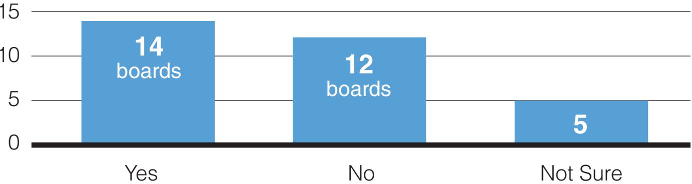
FIGURE 11: *If a new jail is being built in your board area, are mental health and substance use disorders being considered in the planning and arrangements?*



Medicaid Enrollment and Impact of Behavioral Health Redesign

Just under half of the boards reported that jails in their area are enrolling people in Medicaid. Boards in the Northeast and Southwest regions were most likely to report that jails were enrolling people in Medicaid, as opposed to the Northwest and Southeast region where no boards answered "yes" to this question. The Northwest region had the greatest number of boards reporting jails are not enrolling people in Medicaid. The "not sure" answers were evenly spread amongst regions.

FIGURE 12: *Are the jails in your board area enrolling people in Medicaid?*



Many of the mental health and SUD services funded for individuals who have been involved in the criminal justice system receive Medicaid reimbursements. The Medicaid Behavioral Health Redesign will impact agencies providing these services across the state. Boards responding to this survey were asked if the Redesign would change the funding of services by the board for currently or recently incarcerated individuals. The majority of boards reported that they did not anticipate a change in most services provided as a result of the Redesign. However, six boards indicated they would provide more funding for crisis intervention, and five anticipated more funding would go to assessment services. Few boards anticipated providing less service, with each specific service being selected by no more than one board. Some boards anticipate funding new

services as a result of the Redesign. The services boards selected as those they do not currently fund, but anticipate funding, include liaisons (3), crisis intervention team (2), civil court (2), diversion services (2), medication-assisted treatment/methadone administration (1), permanent housing (1), vocational/employment (1), and evaluation (1). Only one board chose one service that they funded in the past, but anticipate they will no longer fund due to Redesign, which was diversion services.

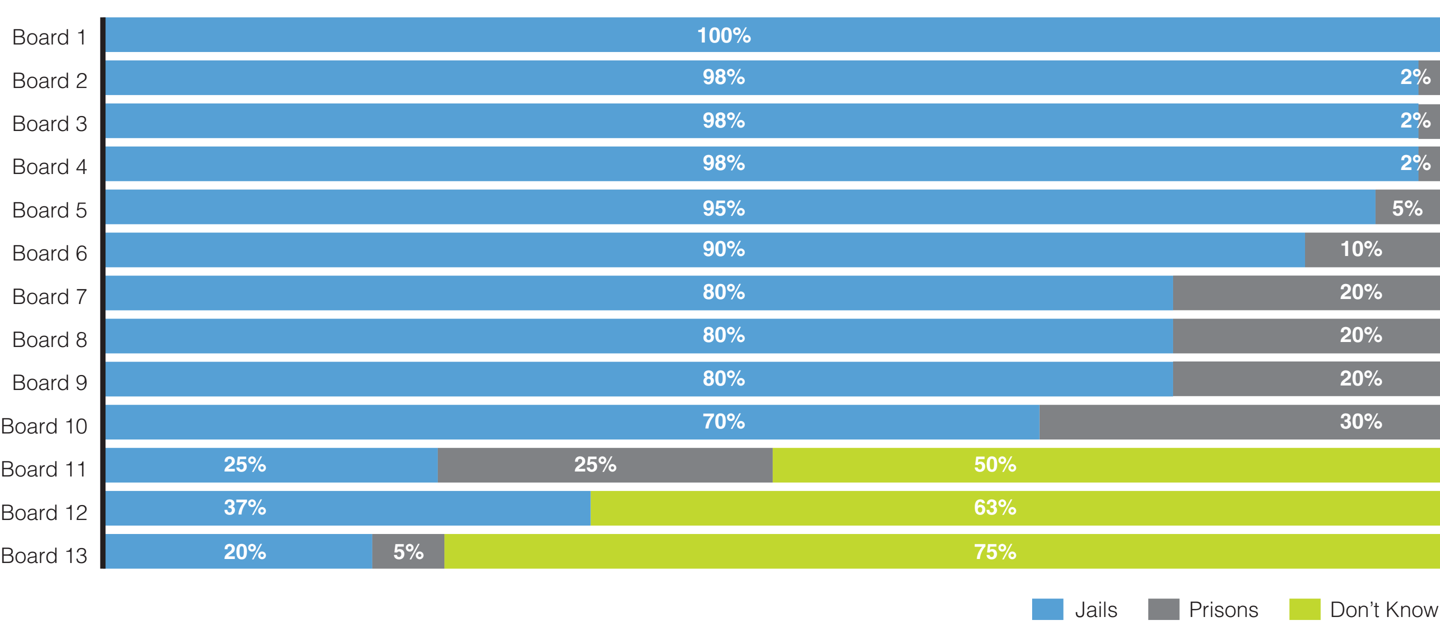
Boards in the Southwest and Southeast regions were most likely to report that they anticipated providing new funding for certain categories of services as a result of the Redesign. In addition, there were nine service categories in which boards in the Central region expected to provide more funding, ten in the Northeast Region and 15 in the Southeast region. On the other hand, at least one board in the Southwest region indicated that they anticipate less funding will be available for a variety of categories, all of which would likely be covered by Medicaid. This could indicate that the mix of funded services will change as a result of the Redesign.

Post-Incarceration

Boards reported mostly serving individuals who are returning to their communities from jails, rather than from prisons. This holds true even for boards that have a state prison in their service area.

Ten of the 13 boards that provided an estimate in response to this question, reported that at least 70 percent of individuals receiving post-incarceration services from agencies their boards fund are from jails. It should be noted that three boards indicated that they did not know or did not track this information.

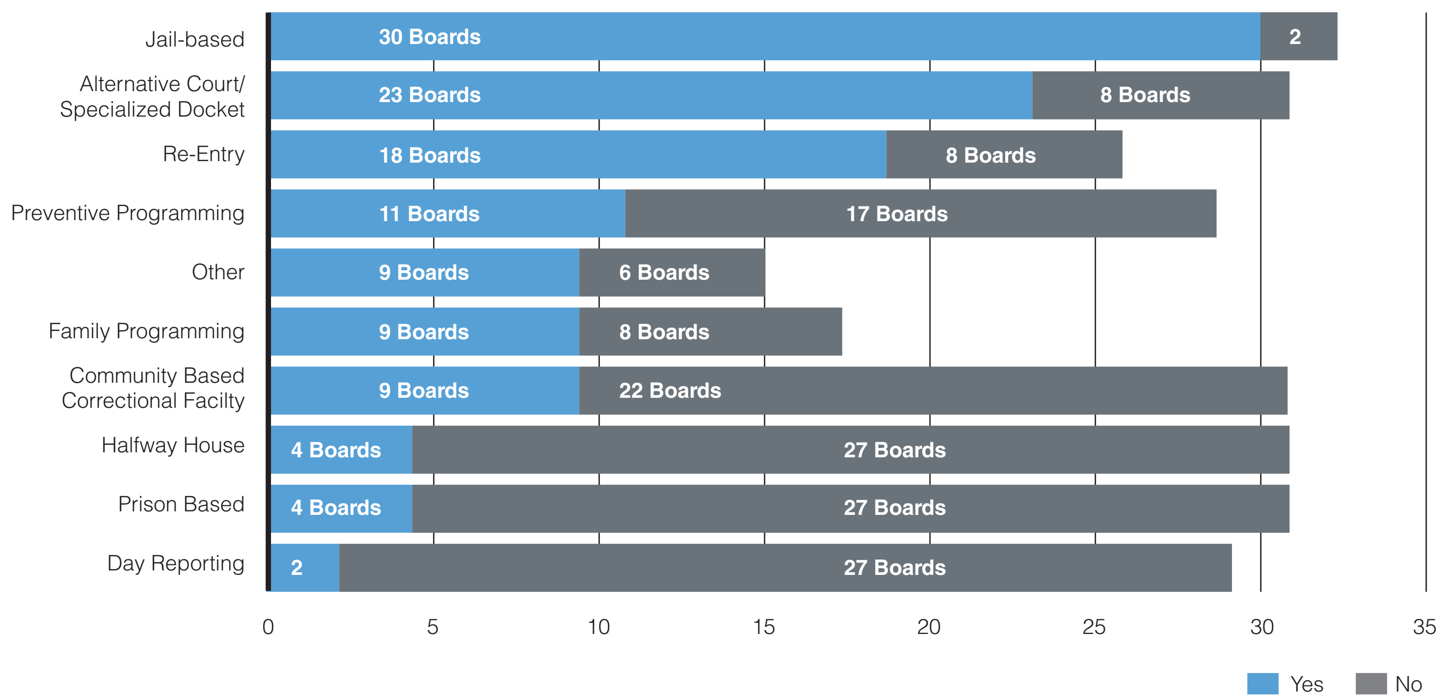
FIGURE 13*[17]*: What percentage of individuals receiving post-incarceration services from agencies your board funds are from each of the following?



Program Categories Funded by Boards

Boards were asked about the funding they provide for a variety of programs. These programs may cover the full spectrum of the criminal justice system, from prison services to preventive programming. If a board indicated it provided funding for a specific type of program, additional questions were asked about the number of individuals served, percentage of budget allocated to funding the program, and what specific behavioral health services were being provided. Jail-based, alternative court/specialized dockets (dockets), re-entry, and preventive programming are the types of programs that are most likely to receive funding from boards across the state. Halfway houses/transitional control programs, prisons, and day reporting programs are the least likely to receive funding from boards.

FIGURE 14: *Funding for behavioral health services related to the criminal justice system by boards*



Jail-Based Programs

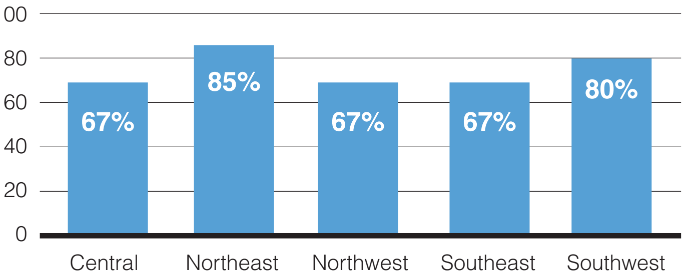
Thirty boards indicated they provide funding for behavioral health services while individuals are incarcerated in jails. The two boards who indicated that they did not fund services for individuals in jails were in the Southwest region. The most commonly funded services for individuals in jails are assessment, case management, individual behavioral health counseling, crisis intervention, and individual community psychiatric support treatment. Eleven of the 30 boards that fund jail-based behavioral health services provide funding to just one jail each, while five provide funding to two or three jails. Four of the boards clarified that while they do not provide funding directly to jails, they do provide funding to agencies that offer the behavioral health services in jails. The remaining boards did not indicate the number of jails to which they provide funding. The percent of funding allocated to jail-based behavioral health services ranged from less than 1 percent to 7 percent, with most boards allocating less than 5 percent of funding to this type of service provision. The number of individuals receiving behavioral health services in jails through programs funded by boards ranged from 20 to 4,145, with many boards reporting that they do not know how many individuals were served.

Alternative Courts and Specialized Dockets

Twenty-three boards indicated they provide funding for behavioral health services through programs administered by dockets. At least one board provides funding for each of the categories in the survey through dockets. The most common services funded that serve these individuals are assessment, individual behavioral health counseling, case management, crisis intervention, medication-assisted

treatment/methadone administration, and laboratory urinalysis. Other funded services listed by boards include peer supporters, recovery housing, recovery coaches, treatment plan compliance, peer specialists, seeking safety, and transportation. The funding of services via specialized dockets was evenly spread throughout the regions.

FIGURE 15: *Share of boards funding services for individuals via alternative court systems/specialized docket (by region)*



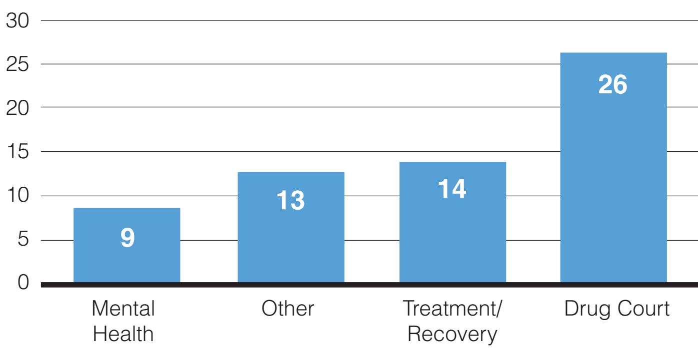
The number of dockets funded by boards varies between one and nine dockets. One of the boards clarified that while they do not provide funding directly to dockets, they do provide funding to the agencies that provide the behavioral health services through dockets. The percent of funding allocated to alternative court-based behavioral services ranged from less than 1 percent to 20 percent, with most boards allocating less than 5 percent of funding to this type of service provision. The number of individuals receiving behavioral health services through programs funded by boards ranged from five to 400, with five boards reporting they do not know, or have access to, how many were served.

TABLE 5: *Specialized Dockets*

Number of Specialized Dockets	Number of boards funding service
1 Docket	3
2 Dockets	5
3 Dockets	6
4 Dockets	1
5 Dockets	2
6 Dockets	0
7 Dockets	1
8 Dockets	1
9 Dockets	1

The dockets vary by type and name throughout the state. The type of court most often listed was drug court (26), including men's, women's, juvenile, and veterans' drug courts. The second most common type of docket boards listed was treatment and recovery court (14). Mental health courts were also listed nine times by boards. Thirteen other courts were listed, including human trafficking, intervention, and re-entry courts.

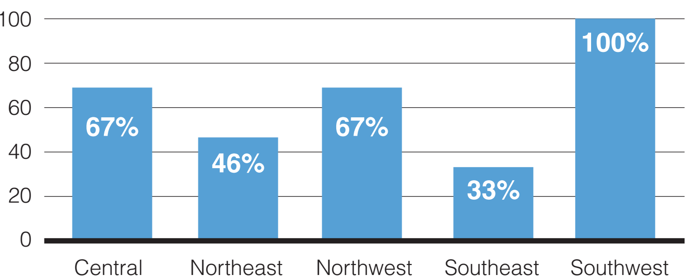
FIGURE 16: *Type of alternative court/specialized dockets receiving funds from boards*



Re-entry and Post-Incarceration Programs

Eighteen boards indicated they provide funding for behavioral health services through re-entry or post-incarceration programs. The most common service types were individual behavioral health counseling, assessment, case management, medication-assisted/methadone administration and individual community psychiatric support treatment. Boards fund between one and nine re-entry, or post-incarceration, programs, with seven boards funding a single program. The percent of funding allocated to re-entry and post-incarceration programs was small, with all but one board indicating that they spend less than two percent of their budgets on these services. The final board indicated the figure is less than five percent. All of the boards in the Southwest region indicated that they provide funding for behavioral health services through re-entry or post-incarceration programs, as do two-thirds of boards in the Central and Northwest regions. On the other hand, only one board in the Southeast region indicated that it funds this specific type of program.

FIGURE 17: *Share of boards funding services for individuals via re-entry or post-incarceration programs, by region*



Eleven boards indicated they provide funding for behavioral health services as a means to prevent individuals from entering, or re-entering, the criminal justice system. As in other service locations, the most common services provided in preventive programs are assessment, individual behavioral health counseling, and case management. The majority of the boards funding preventive behavioral health services provide funding to one preventive program, while two boards provide funding to three programs. Three separate boards each funded multiple programs, with funding allocated to two, seven and 74 programs through their respective board area. The percent of funding allocated to preventive behavioral services ranged from less than 1 percent to 3 percent. Boards in the Northeast, Northwest, and Southeast regions were less likely than the overall sample to fund preventive programs. This is in contrast to the Southwest region, where all boards reported funding these programs.

Nine boards indicated they provide funding for behavioral health services while individuals are connected to CBCFs. The most commonly funded services provided in CBCFs are assessment, individual behavioral health counseling, and case management. The majority (6) of the boards funding CBCF-based behavioral health services provide funding to one CBCF, while one board provides funding to five CBCFs. The percent of funding allocated to CBCF-based behavioral services ranged from less than one percent to three percent. Only one board provided the number of individuals receiving behavioral health services through a board-funded CBCF program (76), with the remaining boards not knowing how many were served. No boards in the Northwest and Southeast regions reported funding services for individuals connected to CBCF, while boards in the Central and Southwest regions were most likely to fund these services.

Nine boards indicated they provide funding for behavioral health services through family programming. The most common services provided in family programming are group behavioral counseling, individual behavioral health counseling, and other non-Medicaid services. Six boards listed other services provided through family programming including family therapy, family education, intervention, grief support, family support, peer support, "Stable Cradle," Multi-Systemic Therapy (MST) and High Fidelity Wrap Around, parenting classes, and "families of promises."

Boards that provide funding for behavioral health services, through family programming, fund between one and five programs each. For each of the responding boards, less than 2 percent of funding was allocated to family programming behavioral services. Two boards provided information about the number of individuals who received behavioral health services through board funded family programming, 15 and 74, with the remaining boards not knowing or having access to the number of individuals served.

TABLE 6: *Family Programming*

Number of Family Programming Programs	Number of Boards funding service
1 Program	2
2 Programs	2
3 Programs	3
4 Programs	1
5 Programs	1

The 28 state correctional facilities (prisons) fall into 20 different board areas. Thirteen of the 20 boards (65 percent) that have a prison in their service area responded to the survey. Of those 13, only four boards reported that they fund prison-based services. Three of these four boards provide assessment services in prisons. The fourth board that reported providing prison-based services does not have a prison in its service area, but there are several in adjoining counties. Four boards indicated they provide funding for behavioral health services while individuals are incarcerated in prisons. Three of these four boards provide assessment services in prisons. At least one board funds individual behavioral health counseling, case management, and a community linkage program as prison-based services. The share of funding allocated to provide services in prisons is low.

Boards that have a prison in their service area were more likely than the overall sample to fund services specifically for currently or recently incarcerated individuals. This was especially true for partial hospitalization, medication-assisted treatment/methadone administration, civil court,

ambulatory detoxification, vocational/employment, liaisons, residential care, and temporary housing.

Four boards indicated they provide funding for behavioral health services while individuals are housed in halfway houses and/or transitional control programs. These include two boards in the Northeast region and one each in the Central and Southwest regions. Many behavioral health services are funded by at least one board. One board also indicated it funds peer support for individuals living in halfway houses and/or transitional control programs. Two boards indicated they provide funding to two programs and one board provides funding to five programs. The percent of funding allocated to halfway houses and/or transitional control program behavioral services was provided by two boards; one board allocates less than 1 percent and the other allocates 1.5 percent.

Only two boards, both in the Southwest region, indicated they provide funding for behavioral health services while individuals are participating in day reporting programs. Specific services funded by these boards include assessment, crisis intervention, vocational/employment, and other non-Medicaid services. One board providing funding to day reporting programs funds one program, while the other board funds two programs. Neither board knew how many individuals were served through these programs or what percentage of their budgets were allocated to the programs.

Boards were also given an opportunity to list additional types of programs they fund. These included community alternative sentencing center, stepping up community, criminogenic risk and behavioral needs framework, *Thinking for a Change*, rapid re-entry initiative, forensic peer support, mentoring programs, and others.

Recommendations

Our research brings together information to examine the intersection of the criminal justice and behavioral health systems. While information exists across Ohio, there remains a need for data that fully captures key information at different points along a cycle that people with a behavioral health disorder have experienced as it relates to the criminal justice system.

Beyond questions about data, our research has resulted in a series of policy recommendations for moving forward.

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 percent of jails contract directly with the ODMHAS. Sixty-one percent 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 disruptiion in care.

Jail Standards

- The revised jail standards were an important step forward in mental health care, but equally important is compliance with these standards. Invest in efforts to impove, 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.

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.

Appendix A: List of Services Funded

Service Funded	Community Based Correctional Facilities (9 Boards)	Family Programming (9 Boards)	Prisons (4 Boards)	Halfway Houses (4 Boards)	Day Reporting (2 Boards)
Ambulatory Detoxification	1	1	0	1	0
Assessment	7	3	3	1	1
Case Management	4	1	1	1	0
Civil Court	0	0	0	0	0
Crisis Intervention	2	3	0	1	1
Crisis Intervention Team	1	1	0	1	0
Diversion Services	1	2	0	1	0
Evaluation	1	2	0	2	0
Forensic Monitoring	1	1	0	1	0
Group Behavioral Health Counseling	3	5	0	1	0
Group Community Psychiatric Support Treatment	1	2	0	1	0
Individual Behavioral Health Counseling	5	4	1	1	0
Individual Community Psychiatric Support Treatment	2	3	0	1	0
Intensive Outpatient	2	1	0	1	0
Laboratory Urinalysis	1	2	0	1	0
Liaisons	2	2	0	2	0
Medication Assisted Treatment/Methadone Administration	3	2	0	1	0
Other	1	6	1	1	1
Other non-Medicaid Services	1	4	0	0	1
Partial Hospitalization	1	1	0	1	0
Permanent Housing	1	1	0	0	0
Pharmacological Management	3	1	0	1	0
Psychiatric Diagnostic Interview	1	1	0	1	0
Residential Care	1	0	1	0	0
Temporary Housing	1	1	0	1	0
Vocational/Employment	1	1	0	1	1

Appendix B: Services Funded: Currently or Recently Incarcerated

	All Boards Responding (31 Boards)	**Large Urban Boards** (8 Boards)	**Boards w/Prisons** (13 Boards)
Ambulatory Detoxification	18	7	9
Assessment	31	8	13
Case Management	27	7	12
Civil Court	6	4	4
Crisis Intervention	28	7	11
Crisis Intervention Team	15	7	7
Diversion Services	14	6	6
Evaluation	16	4	7
Forensic Monitoring	28	7	11
Group Behavioral Health Counseling	27	7	11
Group Community Psychiatric Support Treatment	18	5	8
Individual Behavioral Health Counseling	30	7	11
Individual Community Psychiatric Support Treatment	28	7	11
Intensive Outpatient	21	7	9
Laboratory Urinalysis	23	7	9
Liaisons	19	8	9
Medication Assisted Treatment/Methadone Administration	25	7	12
Other non-Medicaid Services	18	5	7
Partial Hospitalization	7	5	5
Permanent Housing	16	4	6
Pharmacological Management	27	6	10
Psychiatric Diagnostic Interview	23	7	9
Residential Care	17	5	8
Temporary Housing	22	7	10
Vocational/Employment	21	7	10

Appendix C: Related Data Sources

In addition to the survey data provided by this report, the following publicly available data resources provide further insights into the intersection of the criminal justice and behavioral health systems at the national and state level.

National Data Resources

The Bureau of Justice Statistics (BJS) within the U.S. Department of Justice collects, analyzes, and publishes data on a wide range of topics relating to criminal justice, including the mental health needs of justice involved populations throughout the country. Recent BJS reports on this subject include: The National Survey of Prison Health Care: Selected Findings (2016),[17] Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates (2017),[18] and Census of Problem-Solving Courts, 2012 (2016).[19]

The Bureau of Justice Assistance (BJA) administers federal Second Chance Act grants, which since 2009 have awarded $475 million to state, local, and tribal government agencies and community organizations for programs that reduce recidivism by helping people returning from jail and prison to reintegrate into their communities. These programs include substance abuse and mental health treatment, mentoring, career training, housing, education, and more. Biannual Grantee Feedback Reports are publicly available through BJA and provide aggregate data on outcomes for each of the Second Chance Act program areas.[20]

The Substance Abuse and Mental Health Services Administration (SAMHSA) annually conducts the National Survey on Drug Use and Health, which provides a comprehensive picture of substance use trends in the United States, including data on drug use among parole and probation populations.[21] Additionally, a library of SAMHSA publications on criminal and juvenile justice can be found on SAMHSA's website, along with a database of mental health courts in every state.[22]

The Council of State Governments Justice Center maintains the What Works in Reentry Clearinghouse, which is described as a "one-stop shop" for research on the effectiveness of a wide variety of reentry programs, including cognitive behavioral treatment, case management, education, employment, housing mental health, substance abuse treatment, youth, and other programs.[23] For each study in this extensive library, the Justice Center establishes ratings for the level of rigor and strength of evidence provided by the research.

The Stepping Up Initiative is a national movement launched by the National Association of Counties, the American Psychiatric Association Foundation, and the Council of State Governments Justice Center in 2015 to provide counties with tools to develop cross-systems, data-driven strategies to reduce the number of people with mental illnesses and co-occurring disorders in jails. Stepping Up continuously updates an online toolkit that provides the latest information on relevant research and best practices for counties. Other resources include monthly webinars and networking calls, educational workshops and conferences, and guidance on measuring the number of people with mental illness in jails.

Ohio Data Resources

The Office of Criminal Justice Services (OCJS) within the Ohio Department of Public Safety publishes annual data on violent and property crimes committed in Ohio counties and major cities. OCJS' drug crime data, though not as readily available as the violent and property crime reports, is useful for informing the growing need for substance use treatment within Ohio jails and prisons. A 2016 report detailed the rates of drug crime in Ohio and by county, along with drug possession and trafficking rates by county, incident counts by drug type, and demographics of drug crime arrestees.[24] OCJS has also published data on drug use among all arrestees, as well as the percentages of inmates in various types of correctional facilities who were arrested for drug crime.[25]

The Ohio Department of Rehabilitation and Correction annually publishes extensive statistics on the state's prison population that can inform further research into the intersection of behavioral health and criminal justice. The Institution Census along with monthly fact sheets provide prison population data, including demographic breakdowns, custody level, costs per inmate, parole population, crime type, inmates by county, and more.[26] *Time-Served Reports* contain data on amount of time served by crime and gender for prison releases each calendar year.[27] Key Recidivism Information Reports provide one-, two-, and three-year recidivism rates by gender, return type, release type, age at release, offense category, and county of commitment.[28]

The Bureau of Behavioral Health Services within ODRC publishes Annual Reports that provide data on ODRC inmates receiving alcohol and other drug (AOD) treatment.[29] These reports identify what AOD programs are offered at each ODRC institution, as well as the length and capacity of each program. Annual data is presented on total clients, new admissions, early terminations, and successful completions by program type.

The Correctional Institution Inspection Committee (CIIC) is a state legislative committee that provides oversight to the state's prisons and youth services facilities. The committee issues Biennial Reports to the General Assembly on inspection findings in the areas of prison safety and security, health and wellbeing of inmates, fair treatment, rehabilitation and reentry, and fiscal accountability.[30] The report assigns ratings of "exceptional," "good," "acceptable," and "needs improvement" to each DRC institution for specific measures within each category. Particularly relevant here are CIIC's ratings for mental health and recovery services provided by each institution.

The Ohio Department of Mental Health and Addiction Services houses research and informational materials on initiatives the department sponsors designed to divert individuals with mental illness or substance use disorders from incarceration, assist with reentry, and reduce recidivism.[31] These include the Addiction Treatment Program for Court-Involved Individuals, the Stepping Up Initiative, the Criminal Justice and Behavioral Health Linkage Grant Program, the Community Transition Program, the Specialized Dockets Program, and others.

ODMHAS also administers the Ohio Behavioral Health System (OHBH), a web-based reporting system that collects admission and discharge data from providers certified by ODMHAS to deliver drug and alcohol treatment. OHBH tracks the number of clients referred to treatment by a criminal justice entity at the county, board service area, and regional levels. The system also records the number of clients who are arrested within 30 days of admission to or discharge from treatment. This data provides a picture of what counties and areas within the state have seen high volumes of justice-involved clients receiving treatment.[32] However, ODMHAS has seen a decline in reporting in recent years, meaning the data may not be generalizable to the entire state.

End Notes

1. Psychotropic drugs affect mental activity, behavior, or perception, as a mood-altering drug.
2. Analysis of the County Jail Administrator Psychotropic(s) & Mental Illness/Addiction Questionnaire, Ohio Jail Advisory Board, 2016.
3. Ohio Revised Code. Accessed April 2018. http://codes.ohio.gov/NLLXML/ohiocodesGetcode.aspx?userid=PRODSG&interface=OHCODES&statecd=OH&codesec=5120.10&sessionyr=2017&datatype=S&noheader=0&nojumpmsg=0 and Ohio Administrative Code. Accessed April 2018. http://codes.ohio.gov/oac/5120:1-10-09v1.
4. Disability Rights Ohio. "Access to Services in Jail: Medical, Mental Health, and Disability-Related Services for People in Ohio's County and Regional Jails." Accessed April 2018. https://www.disabilityrightsohio.org/assets/documents/dro_services_for_people_in_jail.pdf?pdf=Access_to_Services_in_Jail.
5. Analysis of 2016 Annual Jail Inspections Results, Ohio Department of Rehabilitation and Corrections, Bureau of Adult Detention, http://www.drc.ohio.gov/bad.
6. The term "behavioral health" is used throughout the text to encompass both mental illness and/or substance use disorders.
7. Individuals are considered to be recently incarcerated if they have been incarcerated within the past five years.
8. According to NAMI, "A Crisis Intervention Team (CIT) program is a model for community policing that brings together law enforcement, mental health providers, hospital emergency departments and individuals with mental illness and their families to improve responses to people in crisis."
9. Criminogenic thinking is a primary risk factor for criminal recidivism.
10. A full list of services, including definitions, is included in Appendix A.
11. Boards could skip questions when filling out the survey. Therefore, the number of responses to each question may vary.
12. Lorain County ADAS Board responded to the survey. Lorain County MH Board did not.
13. United States Department of Justice, National Institute of Corrections. "Thinking for a Change." https://nicic.gov/thinking-for-a-change
14. Ohio Department of Rehabilitation and Correction, "Ohio Risk Assessment System." http://www.drc.ohio.gov/oras
15. Greene County, https://www.co.greene.oh.us/102/Greene-Leaf
16. Where responses did not total 100 percent, we assumed that the boards did not know whether the remaining individuals had been in a jail or a prison.
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June 2018