

INSTALLMENT 5

By the Numbers 4

Developing a Common Understanding
for the Future of Behavioral Health Care

Responses,
Models, and
Approaches

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



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Mental Health & Addiction
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Contents

<u>About The Center for Community Solutions and the MHAC</u>	3
<u>Quick Response Teams</u>	4
<u>Models</u>	4
<u>Related State Funding</u>	5
<u>Project SOAR</u>	5
<u>The Crisis Intervention Team Model</u>	6
<u>The Ohio CIT Strategic Plan</u>	7
<u>Prevention Programming</u>	9
<u>Medication-Assisted Treatment</u>	10
<u>Addiction Treatment Pilot Program</u>	11
<u>ODRC’s Medication-Assisted Addiction Treatment Pilot Program</u>	12
<u>Specialized Dockets</u>	12
<u>Civil Commitment</u>	13
<u>Inpatient Treatment</u>	13
<u>Assisted Outpatient Treatment</u>	13
<u>Involuntary Commitment for SUDs</u>	14
<u>Diversion</u>	15
<u>Intervention in Lieu of Conviction</u>	15
<u>Targeted Community Alternatives to Prison</u>	15
<u>National Examples of Diversion Centers</u>	16
<u>Work of Managed Care</u>	18
<u>Community Transition Program</u>	18
<u>Medicaid Pre-Release Enrollment Program</u>	19
<u>Recommendations</u>	22
<u>End Notes</u>	24

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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.

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Quick Response Teams

Administering the life-saving antidote naloxone¹ to opioid overdose victims throughout Ohio has become a regular part of the job for first responders. Many police departments and other first responders are equipped with naloxone that was purchased by funds from state grants. The state provided \$1 million in funding over the biennium of state fiscal years (SFY) 2016 and 2017 for local entities to purchase naloxone.² The naloxone grant program resulted in the purchase of more than 7,800 naloxone kits, or units, across the state. Data collected from the Ohio Department of Mental Health and Addiction Services (ODMHAS) revealed that there were at least 2,363 overdose reversals in SFY 2016.³ *The Columbus Dispatch* reported that, emergency responders administered more than 43,000 doses of naloxone throughout the state in 2017, up from 31,800 in all of 2016, due to the increase of fentanyl⁴ in the opioid supply.⁵ The latest state operating budget for SFY 2018 and 2019 included an increase in funding for naloxone, with up to \$500,000 in SFY 2018 and \$750,000 in SFY 2019 to continue providing access to the reversal drug across the state.⁶ County health departments will continue to disperse the funding as a grant program to local law enforcement, emergency personnel, and other first responders.

Recognizing a need to help survivors of opioid overdoses access treatment services and reduce the strain on first responders, three police departments have collaborated with treatment providers in different corners of the state to develop Quick Response Team (QRT) models in their communities. This model pairs first responders such as police officers with behavioral health counselors to form a team. The team follows up with overdose survivors immediately or within days to discuss treatment options. Pioneering these programs led to others adopting the model around the state.

Models

Lucas County began using a team approach to battle the opioid crisis when it launched the Drug Abuse Response Team (DART) Unit in July 2014.⁷ The Lucas County Sheriff's Department established the program to link overdose survivors to treatment. With community partners, DART brings law enforcement and forensic counselors to area hospitals treating patients who have overdosed. DART members also meet with survivors in their homes. DART compassionately offers support and encouragement to gain community trust. Building relationships is a key factor in guiding survivors toward treatment.

In Hamilton County, Colerain Township began the state's first QRT in July 2015.⁸ The model follows the same format as the DART initiative but uses a different name. QRT has now become the recognized name around the state. The community of 60,000 residents experienced an increase of more than 100 overdoses each year since 2012. Generally, the QRT model uses a team that consists of a police officer, paramedic, and counselor who visit survivors just days following an overdose. During the visit, the survivor is offered counseling, resources, and referrals to facilities for assessment, detoxification, drug treatment, and wraparound services. The Colerain QRT has experienced an 80 percent success rate in linking people who have overdosed to treatment services.

In Summit County, the city of Cuyahoga Falls adopted the QRT model from Colerain Township and began making house calls in January 2017.⁹ The team dedicates one day per week to follow up with each survivor. Until they are able to contact the survivor or their family, the QRT leaves notes to inform them they want to offer a helping hand and that they will return. After the initial contact, the counselor continues to engage with the survivor until they are connected to treatment.

Combining law enforcement and treatment providers, these three communities led the state in implementing these models to reduce overdoses. These models benefit communities in many ways, including reducing incarceration, raising awareness, reducing stigma around substance use disorders (SUD), lowering property crime, and increasing investigations of drug dealers. Most importantly, these models save lives by getting more people into treatment because each program meets survivors wherever they are in the recovery process.

The model's innovative approach to connecting with survivors at three touch points using peer support specialists does not utilize law enforcement as part of the team. This may increase the number of people willing to access treatment because they may feel open to discussing their SUDs without fear of arrest. However, as this model does not include police departments, it was not eligible for the aforementioned state funding. Lakewood was successful in receiving funding from the Cuyahoga County Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board. The program launched in December 2017.

Related State Funding

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. The Ohio Attorney General announced the grant application process immediately following the passage of the state budget in July 2017. By September, 40 police departments were awarded funding. To ensure police departments serving different size populations are guaranteed adequate funding to develop the model, the grants were divided into three tiers, capping the amount of funding by the total population.

Project SOAR

In response to the increasing opioid-related death and overdose tolls, which had more than tripled in the city of Lakewood from 2015 to 2016, the city developed a model similar to QRTs. This program, called Project SOAR (Supporting Opiate Addiction Recovery), blends a community support program with rapid response emergency services through a peer support specialist model.¹⁰ Peer support specialists are certified by the state and can offer support and understanding because of their own lived experience. Project SOAR has shown early success similar to the models in Lucas, Hamilton, and Summit Counties. Project SOAR has three touch points: the Cleveland Clinic Lakewood Emergency Department, the Safe Station Lakewood (Fire House 1), and the Lakewood Municipal Court Probation Office. Safe stations are being replicated around the country and provide a doorway to treatment where individuals ready for opioid treatment can walk in 24 hours a day, seven days a week, and be connected to treatment.

2

The Crisis Intervention Team Model

An estimated 10 percent of calls to police involve individuals with mental illness.¹¹ As a response to this issue, 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. CIT programs are community partnerships between law enforcement agencies, behavioral health professionals, individuals with mental illnesses and/or SUDs, their families, and other community advocates.¹² These partnerships aim to direct those with behavioral health needs towards treatment instead of incarceration when they exhibit disruptive illness-related behaviors.

CIT educates officers on practical techniques for de-escalation and integrates their traditional police training with ways to approach individuals they believe to have a mental illness.¹³ When teaching each of these techniques, the CIT model utilizes role playing to simulate reality and promotes the safety of both officers and individuals in crisis.^{14 15} CIT revolves around a set of “core elements,” outlined in Figure 1.¹⁶ Not all officers are trained to participate in CIT. CIT International recommends that participants have adequate on-the-job experience prior to becoming CIT trained, and that they demonstrate a history of mature behavior.¹⁷ Despite this recommendation, the small size of some police departments can make it necessary to train all officers on the CIT model so that there will always be at least one CIT officer on duty.

FIGURE 1: CIT Core Elements¹⁸



The CIT Model was first developed in Memphis in 1988 and has since spread throughout the United States and the world. It is often referred to as the “Memphis Model.”¹⁹ Ohio’s first CIT training program began in Summit County in 2000, with 18 police officers and four fire lieutenants completing the pilot course.^{20 21} Figure 2 outlines the number of CIT trainings and participants that have taken place in Ohio through the end of 2017. As of December 2017, a total of 12,065 participants had completed CIT training in Ohio.^{22 23} Figure 3 identifies the number of CIT-trained officers in each Ohio County as of January 2018.²⁴

The Ohio CIT Strategic Plan

In May 2001, the Criminal Justice Coordinating Center of Excellence (CJCCoE) was established to promote jail diversion for those with behavioral health disorders.²⁵ Since its inception, the CJCCoE has provided organizational support for the expansion of CIT throughout Ohio. This has included partnering with ODMHAS, the National Alliance on Mental Illness of Ohio (NAMI Ohio), the Office of Criminal Justice Services (OCJS), and the Ohio Attorney General’s Office to create Ohio’s CIT Strategic Plan as a roadmap for continued development of CIT programs across the state.²⁶

Ohio’s CIT Strategic Plan outlines 10 major goals the partners (CJCCoE, ODMHAS, NAMI Ohio, OCJS, and the Ohio Attorney General’s Office) should work toward to successfully expand CIT programs across the state, as well as additional action steps to contribute to each goal.²⁷ The overarching goals include the following:²⁸

- Build strong partnerships between law enforcement, advocacy groups, and mental health providers, in order to best identify the core needs in each community;
- Ensure community ownership by including stakeholders in planning, implementing, and networking of all CIT programs;
- Standardize procedures across the state for responding to a mental health crisis;
- Identify local leadership for communities implementing CIT to act as stewards for each program;
- Develop a core curriculum with standardized components, as well as expert presenters and teachers;
- Identify community partners in the areas of mental health and emergency services, who operate under shared principles and procedures;
- Conduct ongoing program and training evaluation efforts for the purpose of continuous quality improvement;
- Provide continuing education, both refresher and advanced, for CIT officers and companion training for community partners;
- Recognize and honor officers who complete CIT training and effectively implement CIT principles and techniques in a crisis situation; and
- Promote the CIT principles and techniques in neighboring towns, counties, and around the state.

According to the strategic plan, the ultimate goal for CIT in Ohio is to have a fully developed CIT program in every county, with every law enforcement agency within the county participating.²⁹

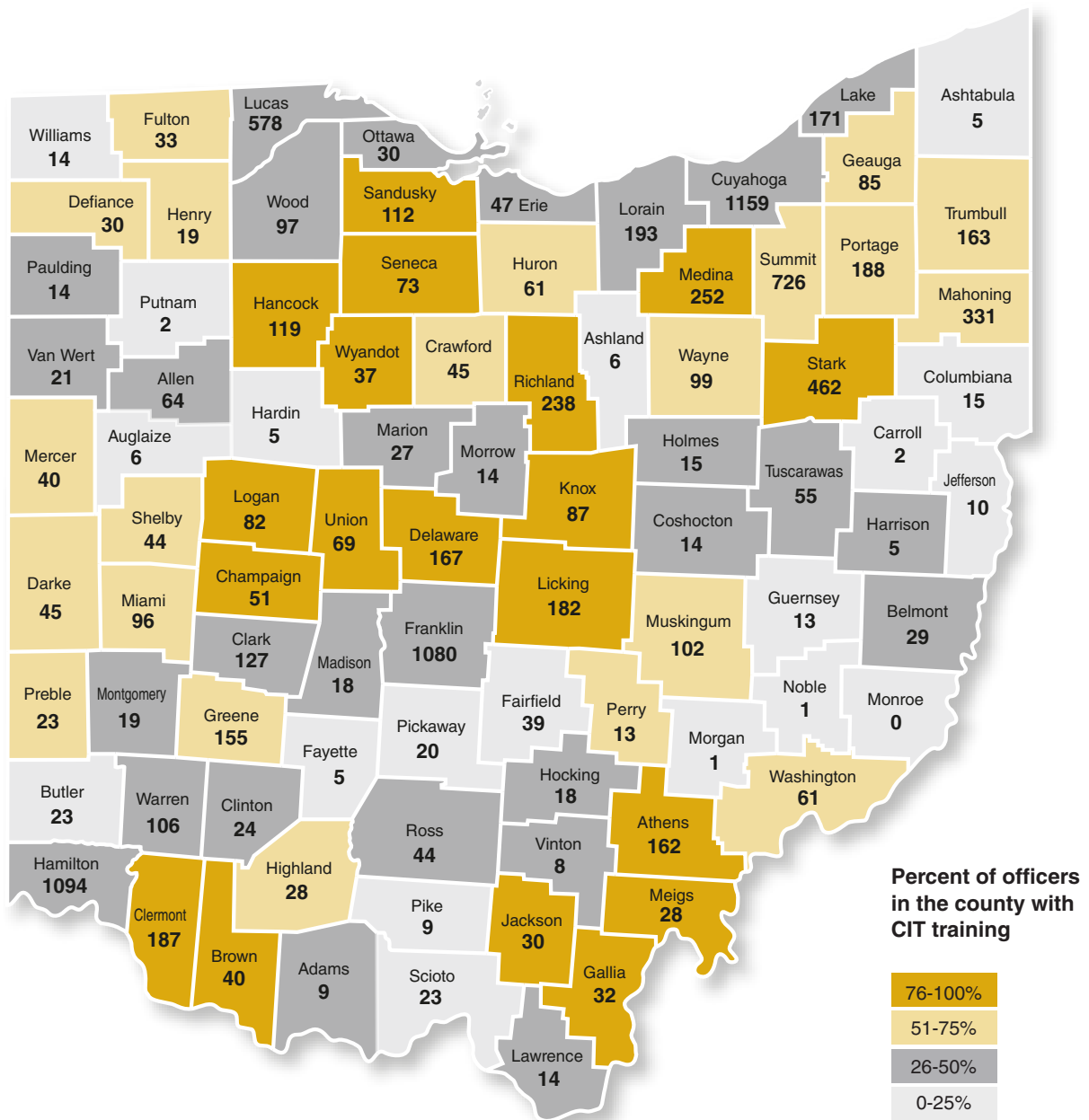
FIGURE 2: CIT Trainings in Ohio 2000-2017³⁰

Year	Individuals Trained	Counties Providing CIT Training
2000	49	1
2001	84	2
2002	165	3
2003	179	5
2004	618	12
2005	445	13
2006	429	16
2007	615	22
2008	572	22

Year	Individuals Trained	Counties Providing CIT Training
2009	647	23
2010	791	25
2011	709	25
2012	809	30
2013	687	34
2014	951	47**
2015	1234	55**
2016	1367	67**
2017	1714	59**

** Locations counted, not counties

FIGURE 3: Full-Time Sworn Law Enforcement Officers with CIT Training³¹



* Hamilton County calls their specially trained officers Mental Health Response Team (MHRT/CIT)

** This map reflects the total numbers of officers trained regardless of the location in which they received their training

3

Prevention Programming

Directing efforts upstream to prevent mental health and SUDs plays a major role in quelling current and future behavioral health issues that may plague our communities and criminal justice system. The Substance Abuse and Mental Health Services Administration (SAMHSA), under the U.S. Department of Health and Human Services, is the federal agency responsible for advancing the behavioral health of the country. SAMHSA provides a framework for a continuum of care for substance use and mental health, which includes promotion and prevention.

Prevention of mental illness generally boils down to reducing risks and strengthening protective factors among entire communities, or through efforts that target high-risk individuals. Protective factors that reduce the risk of mental illness include strong physical health, a sense of safety and security, adequate financial and material resources, and healthy relationships. Significant threats to any of these protective factors are risks that may make an individual more susceptible to mental illness. For example, adverse childhood experiences (ACEs) are strong predictors of physical and behavioral health problems later in life. ACEs can include physical, verbal, and sexual abuse, as well as neglect and emotional turbulence at home. Since half of all chronic mental health disorders appear by age 14, prevention efforts that aim to mitigate risk factors like ACEs are most effective when they begin in early childhood and continue into adulthood.³²

It is important to emphasize the relationship between mental illness and SUDs. A 2014 report from the National Survey on Drug Use and Health showed that of adults with any mental illness, 18.2 percent had a SUD, but for adults with no mental illness, only 6.3 percent had a SUD. Among criminal offenders rates of substance abuse and dependence are more than four times the rate of individuals in the general population.³³ Within the broad

concept of prevention, there are different categories of prevention strategies. Each category is vital to providing services within the continuum of care for both behavioral health and criminal justice. The most commonly known prevention strategies fall within the category of universal prevention. This refers to interventions and strategies that target the general population. Effective prevention strategies build skills that promote healthy decision-making and life choices that protect against many negative outcomes, such as substance use and other harmful behaviors. More targeted prevention efforts are also increasingly important in the midst of the opioid crisis. The other categories of prevention take into account the risk levels a target population may have for developing a mental health or SUD.

In the current environment, as SUDs affect more people and families, risk factors for developing behavioral health disorders are also increasing. Selective prevention involves strategies that target individuals, or subgroups, whose risk level for developing a SUD is higher than average. The next level of targeted prevention strategies is indicated prevention, which applies to individuals who are beginning to show signs or symptoms of SUD. Knowing what prevention strategies work best for an individual or community, and then utilizing those strategies, can have lasting effects on an individual's disease development and potential involvement with the criminal justice system.

4

Medication-Assisted Treatment

Medication-Assisted Treatment (MAT) is the use of pharmaceuticals, in combination with counseling and behavioral therapies, to treat SUDs.³⁴ Typically, MAT is used for the treatment of addiction to opioids, such as heroin and prescription pain medications. Research shows that the appropriate use of MAT as a therapeutic tool can significantly reduce the need for inpatient detoxification services, decrease mortality, improve health outcomes, reduce infectious disease, and decrease illicit opioid use and criminal activity among those with SUDs.³⁵ As Ohio has one of the highest overdose death rates in the United States, policymakers have pursued a number of strategies to combat the crisis, including MAT.

Common medications associated with MAT include methadone, buprenorphine, and naltrexone. All medications can be safely taken for either short or long periods of time and are reimbursed by Ohio's Medicaid program.³⁶ Currently, half of all buprenorphine spending in Ohio is financed by Medicaid.

- **Methadone** is a full agonist³⁷ therapy that has been proven to be effective in treating opioid use disorders; however, it is highly regulated by the state and federal governments. It activates the same receptors in the brain as heroin and other opioids while suppressing cravings.
- **Buprenorphine**, commonly known as Suboxone, is an opioid partial agonist prescription medication with combined active ingredients buprenorphine and naloxone used to reduce cravings for an abused drug. However, there is potential for buprenorphine abuse without strong controls to prevent diversion.³⁸ Evidence demonstrates these drugs can be effective when combined with physician oversight and therapy during the course of treatment.³⁹ Buprenorphine is also tightly regulated by the government.

- **Naltrexone** is an antagonist⁴⁰ therapy, which blocks opioid receptors in the brain while decreasing cravings. If an individual is planning to utilize this medication they must first undergo detoxification for seven to 10 days.⁴¹ Naltrexone is commonly used in criminal justice settings because it does not allow the body to feel any sense of euphoria as with the other MAT therapies. It can be administered in a pill form or as an extended-release injectable, known as Vivitrol.

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.⁴² The need for more access to MAT because of the exploding opioid crisis has pushed the federal government to loosen regulations on prescribing rules. To prescribe buprenorphine, prescribers must have a Drug Addiction Treatment Act (DATA) 2000 waiver, which permits them to treat opioid dependence with this form of MAT.⁴³ Previously, to begin prescribing buprenorphine, physicians were limited to treat 30 patients at a time and had to apply for the waiver to treat up to 100 patients after one year. Under new regulations in 2016, physicians can apply to increase that number to 275, after serving 100 patients for at least one year.⁴⁴ Another recent change allows nurse practitioners and physician assistants to become DATA certified practitioners, allowing them to prescribe buprenorphine. The Comprehensive Addiction and Recovery Act (CARA) expanded this prescribing privilege to these practitioners through October 1, 2021.⁴⁵

In the spring of 2017, to increase the number of providers certified to treat opioid use disorders with buprenorphine, the state of Ohio used funds from the 21st Century Cures Act. The funds from SAMHSA awarded a \$2.2 million grant to the American Society of Addiction Medicine to offer the DATA 2000 certification to interested physicians and practitioners around the state.⁴⁶

Opioid Treatment Programs (OTPs), certified by SAMHSA, treat patients with opioid dependency using methadone. OTPs must follow strict guidelines, and patients are highly supervised. OTPs can dispense all three drugs associated with MAT. Buprenorphine MAT programs can prescribe or dispense at an Office-Based Opioid Treatment site (OBOT); however, they cannot dispense methadone. Naltrexone can be prescribed in any health care setting by any licensed prescriber, making it more accessible than the other two. As of January 2017, there were only 26 OTPs in Ohio, and, with more access to treatment needed, ODMHAS eased requirements in the 2016 Opioid Mid-Biennium Review.⁴⁷ The less-restrictive state law waives a statutory requirement that a treatment provider had to be established and certified in Ohio for two years before becoming a methadone clinic. The new law also lifts the ban on for-profit methadone clinics. As of January 2018, Ohio had 32 OTPs and 77 OBOTs with others in the licensing process with the State Board of Pharmacy. ODMHAS expects nearly double the number of OTPs to begin providing MAT during the next two years.

Addiction Treatment Pilot Program

In the SFY 2014-2015 state operating budget, through an initiative called 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.⁴⁸ The pilot program was initiated to treat adult offenders utilizing MAT. The ATP used either buprenorphine or naltrexone when providing MAT. The ATP did not include methadone for treatment purposes because it was not available in the chosen counties.

Ohio's ATP began in Crawford, Franklin, Hardin, and Scioto Counties. However, according to the Begun Center for Violence Prevention Research and Education at Case Western Reserve University, in its evaluation of the program, Scioto County withdrew and was replaced by Morrow County. Hocking and Mercer Counties were added as part of the pilot.⁴⁹ An appropriation of \$5 million was made to carry out the pilot. A community SUD services provider certified by ODMHAS provided treatment services. Provider responsibilities include conducting assessments, recommending treatment services, developing individualized goals and objectives, providing access to medications, providing other therapies as necessary, and monitoring compliance.⁵⁰

The SFY 2016-2017 state operating budget expanded the ATP for drug courts to an additional 12 counties and provided \$5.5 million per year for this purpose. The status of the initiative was changed from a pilot to an official

program and renamed MAT Drug Courts. The additional counties include: Allen, Clinton, Cuyahoga, Fairfield, Gallia, Hamilton, Hocking, Jackson, Marion, Montgomery, Summit, and Warren.⁵¹

As these MAT drug courts expanded, there was a growing need to provide additional recovery supports along with medication and counseling. Recovery supports help people stay in treatment by providing additional resources like child care, transportation, and employment training. In Senate Bill 319 (131st General Assembly), the Opioid Mid-Biennium Review that became law in April 2017, a provision was added clarifying that the funding could be used to support these wraparound services.

In the SFY 2018-2019 state operating budget, House Bill 49 (132nd General Assembly), 18 additional counties received funding from the state to start a MAT drug court. More clarifying language was added requiring community behavioral health centers to provide treatment, time-limited recovery supports, and program compliance monitoring. Methadone was also added as one of the accepted forms of medication to be used in MAT drug court programs. The language specified that no step therapies or prior authorizations are allowed by insurance companies. Step therapy is a protocol used by health plans requiring individuals to try other medications first and failing before covering the prescribed medication. Prior authorizations used by health plans require providers to obtain permission to prescribe medications or treatment services before the plan will cover them. To ensure the MAT drug courts can access medications quickly and without any barriers, a provision was added to prohibit health plans from enforcing these internal mechanisms on the courts' programs.

The General Assembly provided \$8 million in each fiscal year to continue the initiative as well as expand it throughout additional parts of the state. A total of 33 counties were named in the budget bill.⁵² Findings will be reported by December 31, 2019 by a research institution to evaluate the MAT drug courts. It is known that MAT services have a higher rate of recovery success.⁵³ The program is a pathway to treatment and reduces recidivism. The legislature realized that the ATP, over its course of three years, was showing positive results and supported making it a permanent part of the court system's framework and expanding it.

ODRC's Medication-Assisted Addiction Treatment Pilot Program

In a pilot lead by the Ohio Department of Rehabilitation and Correction (ODRC), the Office of Correctional Health Care sought to increase access to MAT to opioid-addicted individuals prior to release. The protocol applies to all ODRC incarcerated individuals in Cuyahoga, Mahoning, Franklin, Hamilton, Lucas, and Summit Counties, as well as the Ohio Reformatory for Women, the Pickaway Correctional Institution, and the Richland Correctional Institution.

Eligible patients, who are identified by an internal "recovery services coordinator" must select a managed care plan 120 to 90 days before release. Sixty days before release, the patient will be screened to ensure he or she is in treatment, has a clinical diagnosis, and that he or she applies for Medicaid. The coordinator will notify internal and external coordinators of the patient's interest in the program, log relevant data into the electronic medical record, and schedule an appointment 30 days prior to release. During this 30-day window, the patient will go through a medical assessment, and eligibility for the program will be determined. If eligible, the patient will be connected with a managed care plan, necessary medical appointments will be made, and the Community Linkage Worker, who helps during the transition upon release, will be notified.

Fifteen days prior to release, a medical provider will conduct a drug screen and provide a Vivitrol injection, logging information into the electronic record. Seven days before release, another screen and injection will be provided, monitored, and documented. Upon release of the patient, the information will be logged and included in the discharge summary to be used by the managed care plan and other relevant case managers.

It should be noted that a similar proposal was outlined in legislation via Ohio House Bill 117 of the 132nd General Assembly.⁵⁴ Currently, the bill remains in the House Criminal Justice Committee. Based on the fiscal note of the legislation, Vivitrol costs \$1,250 per injection with a yearly cost of about \$15,000.⁵⁵ Per the note, the reimbursement for this medication can come from ADAMHS Boards, though it is reimbursable by Medicaid. Most of the individuals who matriculate through this program are likely Medicaid eligible through the expansion of the program to non-disabled adults. Ninety-four percent of the cost is currently borne by the federal government.

Specialized Dockets

Specialized dockets provide a different judicial approach than traditional means by recognizing an individual's specific mental illness, SUD and other trauma related conditions and providing coordinated care to treat the root cause of an individual's behavior with the goal of working towards lasting rehabilitation. Only 3.5 percent of the 2,575 adults who are discharged from all specialized dockets offered throughout the state are released to ODRC facilities.

Since their inception, drug courts have demonstrated a high rate of success for individuals struggling with both SUDs and the criminal justice system, who committed low-level, non-violent crimes.⁵⁶ There are 66 drug-specific courts of the 138 specialized dockets receiving funding from ODMHAS.⁵⁷ Drug courts can include adjudications for juveniles, opioid users, families, and individuals receiving MAT such as Vivitrol. Forty of Ohio's counties are currently operating drug courts, which exist under the current Ohio court structure.⁵⁸ In total, the Ohio Supreme Court cites 56 counties with drug, mental health, or Substance Abusing Mentally Ill (SAMI) courts.⁵⁹

Led in part by Ohio judges, specialized docket courts, like drug courts, were created in an effort to reduce the steady stream of repeat offenders judges saw in their courts. Drug courts assist individuals to break the cycle of crime by creating a strict and holistic treatment program that is tailored to an individual's needs. By creating a seamless partnership between treatment providers, probation, law enforcement, and courts, services are made available to assist the specific needs of individuals who are most at risk for recidivism.

ODMHAS funds 22 mental health courts in 16 different counties in Ohio.⁶⁰ The Ohio Supreme Court identifies 26 counties with mental health or SAMI courts. Like drug courts, mental health courts assist in providing individuals with targeted programming and individualized assistance as they move through the criminal justice system.

Continual monitoring allows all parties involved to remain informed of an individual's progress. This grants individuals the ability to have a program that is tailored to their specific needs, while also creating an environment of accountability and compassionate treatment. On average, individuals are in drug court program for about 18 months.⁶¹

5

Civil Commitment

Based on certain criteria, courts have the authority to commit an individual with a mental illness or SUD to inpatient or outpatient treatment. This court-ordered treatment serves people who may otherwise continue to cycle in and out of the criminal justice system, homelessness, or the emergency room. Court ordered treatment helps stabilize an individual and increases medication adherence and access to therapies and recovery supports to maintain wellness.

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 involuntarily hospitalized. These standards are:

1. Be a danger to self,
2. Be a danger to others,
3. Be in substantial and immediate risk of serious physical impairment or injury to self as manifested by inability to provide for basic physical needs and provision for needs is unavailable in the community, or
4. Be in need and would benefit from treatment in a hospital as evidenced by behavior creating grave and imminent risk to substantial rights of others/self.⁶²

Assisted Outpatient Treatment

For those who do not require inpatient hospitalization, Assisted Outpatient Treatment (AOT), also known as “involuntary outpatient treatment” or outpatient commitment, is another option. On September 17, 2014, a fifth standard was added to the above list outlining criteria for judges to commit someone to court ordered outpatient treatment:

5. Would benefit from treatment as manifested by evidence of behavior that indicates all of the following:
 - The person is unlikely to survive safely in the community without supervision, based on a clinical determination.
 - The person has a history of lack of compliance with treatment for mental illness and one of the following applies:
 - At least twice within the 36 months prior to the filing of an affidavit seeking court-ordered treatment of the person, the lack of compliance has been a significant factor in necessitating hospitalization or receipt of services in a forensic or other mental health unit of a correctional facility, provided that the 36-month period must be extended by the length of any hospitalization or incarceration of the person that occurred within the 36-month period.
 - Within the 48 months prior to the filing of an affidavit seeking court-ordered treatment of the person, the lack of compliance resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others, provided that the 48-month period must be extended by the length of any hospitalization or incarceration of the person that occurred within the 48-month period.
 - The person, as a result of mental illness, is unlikely to voluntarily participate in necessary treatment.
 - In view of the person’s treatment history and current behavior, the person is in need of treatment in order to prevent a relapse or deterioration that would be likely to result in substantial risk of serious harm to the person or others.⁶³

Individuals who meet only the fifth criteria cannot be ordered to the hospital, but can be ordered to AOT.

There are two ways to order a person into one of these court ordered treatment options based on the need of the individual. First, when a person requires emergency inpatient hospitalization because of a crisis situation and meets the criteria above representing a substantial risk of physical harm to self or others, that person can be hospitalized and examined. This is also known as “pink slipping.” The application for emergency admission can be initiated by certain professionals including: a psychiatrist, a licensed clinical psychologist, a licensed physician, a health officer, a parole officer, a police officer, or a sheriff.

The second way allows anyone to file an affidavit in probate court to begin the process. Most courts require an accompanying document signed by a physician who has examined the person.⁶⁴ A court hearing with a judge takes place to determine if the person has a mental illness and meets criteria 1,2,3,4 or 5 of the definition of “mentally ill person subject to court order” and a review of other determinants such as past hospitalizations and history of arrests. The court must find clear and convincing evidence that the individual needs court ordered treatment. The involuntary treatment order expires after 90 days unless there is a hearing to continue the order. Placement must be in the least restrictive setting which could include outpatient treatment.⁶⁵

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.⁶⁶ Similar to the process for those with serious mental illness (SMI), the petitioner must have a certificate from a physician who examined the person within two days prior to the petition’s filing. Also, the court must find evidence that the person presents an imminent threat of danger to themselves, their family, or others resulting from their addiction, or the likelihood of such a threat of danger in the near future. However, unlike the process for SMI, the petitioner must also show that they have arranged for treatment from a behavioral health provider with an estimated cost for treatment services. The petitioner must also place a security deposit for 50 percent of the total cost of treatment, and sign a guarantee for the rest of the payment for services before the court will order treatment.⁶⁷



Diversion

Diversion and other forms of alternative sentencing began in the United States in the late 1940s and have become a widely used model for communities seeking a way to rehabilitate offenders.⁶⁸ Diversion programs are a valuable resource for individuals who may find themselves in a behavioral health crisis. By assisting individuals to maintain jobs and connect them with the treatment and care they need, diversion programs help individuals avoid trauma that may come with unnecessary incarceration. Proper screening to determine if an individual is a candidate for diversion programming is crucial to determining the services that can be provided for an individual and supporting an individual's success in any specific program. Care is approached in a holistic way that is tailored to an individual's needs.

Pre-arrest diversion programs can swiftly assist an individual in crisis by properly aligning him or her with resources they need, after criminal justice involvement but prior to booking. Post-arrest diversion programs take place in the court system and often involve negotiations with prosecutors. This, too, can consist of behavioral health interventions and may be used in lieu of serving jail time. Finally, post-plea diversion programs are present after an offender has often plead guilty to a crime.

Intervention in Lieu of Conviction

Courts are using intervention in lieu of conviction as a way to help more offenders receive needed treatment services. The SFY 2016-2017 state budget included a provision making this intervention available to courts and offenders for certain criminal cases.⁶⁹ With this in place, courts may accept an offender's request for the intervention if he or she does so prior to trial. The court must determine if the offender has a mental illness or SUD based on information

from a certified behavioral health provider. Either the crime must be a misdemeanor or felony of the fourth or fifth degree and the prosecuting attorney must recommend that the offender be found eligible for participation. There is a narrow subset of offenders who are eligible for treatment in lieu of conviction because of the strict criteria. Offenders must not have any of the following:

- Any prior violent felony convictions;
- Previously participated in the program;
- Certain Felony drug offenses;
- Crimes subject to mandatory prison or jail time under Ohio law; or
- Crimes against the elderly, permanently and totally disabled, youth under age 13, or peace officers in the course of their employment.⁷⁰

Once the eligible offender pleads guilty to the charge of a crime, 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.⁷¹

Targeted Community Alternatives to Prison

The Targeted Community Alternatives to Prison (T-CAP) initiative, ushered into law by ODRC, 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

individuals as of March 2018. At its highest, Ohio's prison population was 51,273 on November 10, 2008.⁷² T-CAP passed in the SFY 2018-2019 state budget and included \$58 million in funding over the biennium for counties to administer the program. 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.⁷³

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. In a state prison setting, rather than rehabilitation, the offender becomes less likely to successfully re-enter society, find employment, and avoid recidivism. From July 1, 2017 through June 30, 2018, county participation was voluntary, but starting July 1, 2018, the bill mandates participation in T-CAP for the 10 most populous counties: Franklin, Cuyahoga, Hamilton, Summit, Montgomery, Lucas, Butler, Stark, Lorain, and Mahoning, while still allowing the other 78 counties to participate in T-CAP voluntarily.⁷⁴

The funding will be provided to interested counties through a grant application process. Some counties chose not to participate because of the cost to local government. When offenders carry out their sentences in a jail setting the county is responsible for the commitment. However, if the offender serves time at a CBCF, and is also participating in treatment and recovery services, this is recognized by many as an opportunity to divert these offenders into more effective treatment programs, while simultaneously reducing the state's overcrowded prison population. As Ohio continues to look for more ways to fight the opioid crisis, this initiative can lead more people to treatment and on a path to recovery, instead of a road that cycles in and out of the criminal justice system.

National Examples of Diversion Centers

Miami-Dade County Diversion

Florida's Miami-Dade County has taken a transformative approach to how the criminal justice system interacts with individuals with SMI. Through this effort, led by Judge Steven Leifman, the county has provided CIT training to 6,000 police officers across 36 police departments, making it the largest force of CIT-trained officers in the country.⁷⁵ In 2017, the county's two largest agencies handled 83,427

mental health calls and made 149 arrests. The county's daily audit of incarcerated individuals went from 7,300 to 4,000.⁷⁶ Officer involved shootings have almost stopped entirely.

The jail diversion program in Miami-Dade County assists in moving individuals from a jail setting to a crisis stabilization unit where 80 percent of individuals agree to treatment.⁷⁷ Individuals are then taken directly into treatment where they are supervised by *The Advocate Program* or *Court Options* and provided with everything from medication to clothing in an effort to deliver streamlined treatment. The results for the misdemeanor mental health population include a significant drop in the recidivism rate from (2000) 72 percent to 20 percent. The initial success of the program has allowed it to be expanded to non-violent felony offenders. The recidivism rate of non-violent felonies amongst people with a mental illness is 35 percent, and over the last 6 years, it has saved the county 68 years of jail bed days.

The county has found that by working collaboratively, they are able to give people hope, opportunity, and recovery that they could not have done without buy-in from a myriad of community partnerships. Together, the county has created a model that each community can use to determine how to collaborate and develop systems of care to keep people out of the criminal justice system.

Utah

Driven by its Governor, Utah recently conducted a comprehensive review of the state's rising prison population. From 2004 to 2014, the state prison population grew by 18 percent and continually increased at a rate more than six times the national average.⁷⁸

The state has since set goals to accelerate change throughout the state. Among those goals were a focus on space for serious and violent offenders, improving and expanding the reentry and treatment services that were already in place, and providing additional resources for a holistic, wraparound approach to addressing the specific needs of each individual. With these goals in mind, Utah began fundamental changes to sentencing, treatment standards, drug courts, and funding available to counties.

In an early phase of the evaluation, both criminal justice and behavioral health officials came to the table with ways they could share accountability through various forms of treatment. Together, the two entities assessed their need to

allow for acceptance and reduce the stigma that surrounds their clients in the behavioral health and criminal justice systems. Highlighting treatment as an important element in curbing recidivism and providing the tools and resources for incarcerated individuals to make substantive changes were key aspects of the Utah model.

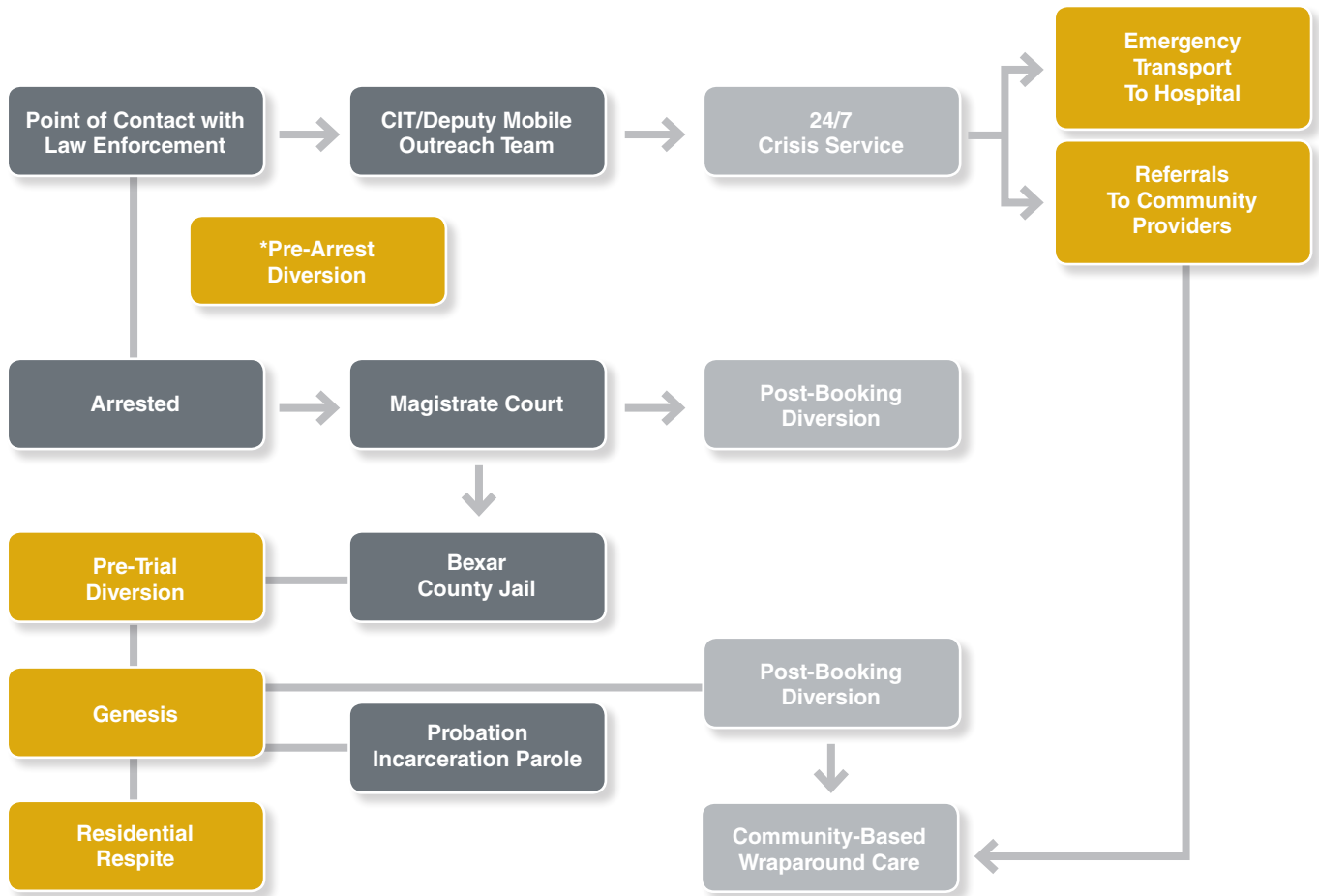
Bexar County, Texas

Utilizing Crisis Care Centers, the Bexar County, Texas criminal justice community has diverted thousands of individuals from jail. In the first year of operation, the

program diverted 1,000 people from the costly, often traumatic jail settings. The program’s Crisis Care Centers saved the county more than \$5 million in 2006 alone.⁷⁹

In addition to the monetary savings, the diversion program saw an improvement in the quality of life of individuals served, and more space was available in the jail and prison for violent offenders. By working with stakeholders, judges, mayors, sheriffs, pre-trial services, health care service centers, attorneys, police, local hospitals, and child and adult protective services, caseworkers have come together to provide comprehensive wraparound services for the individuals they serve.

FIGURE 4: *The Diversion Process*⁸⁰



* Federal Grant Award



Work of Managed Care

Medicaid Managed Care is a health care delivery system designed to manage cost, utilization, and quality of care for those enrolled in Medicaid.⁸¹ Contracts between state Medicaid departments and Managed Care Organizations (MCOs) designate a fixed per-member per-month payment, which pays for the cost of Medicaid health benefits and additional services for each member.⁸² Five MCOs cover Medicaid behavioral health services in Ohio, following the July 1, 2018 carve-in of managed care. These are the Buckeye Community Health Plan, CareSource, Molina Healthcare of Ohio, Paramount Advantage and UnitedHealthcare Community Plan.⁸³ These entities play a role in addressing the behavioral health service needs of those involved in the criminal justice system. Two programs, the Community Transition Program and the Medicaid Pre-Release Enrollment Program, provide examples of the Ohio Department of Medicaid's (ODM) and MCOs' efforts to support this population.

Community Transition Program

Among those incarcerated in Ohio's prisons, an estimated 70 percent have a history of substance abuse.⁸⁴ Beginning July 1, 2016, ODRC and ODMHAS began contracting with CareSource to provide the Community Transition Program (CTP).⁸⁵ ⁸⁶ This program leverages the knowledge and expertise of its partners to ensure continuity of treatment and recovery support services for individuals with SUDs who are re-entering the community throughout Ohio.⁸⁷ Participants in this voluntary program have accessed continued treatment, including MAT, in order to reduce the risk of relapse. In addition, the program provides other recovery supports related to each individual's specific needs, including housing assistance, vocational supports, life skills, transportation, and other supportive services.⁸⁸

To deliver CTP, CareSource contracts with a network of ODMHAS Certified Alcohol and Other Drug (AOD) Treatment Providers to provide the following new services:

- Pre-release referral to an AOD Provider in an individual's returning community;
- Improved continuity of care and information sharing between institutions and community providers;
- Community-based care management services by Certified AOD providers;
- An initial intake in the community within seven days of release;
- Prison in-reach⁸⁹ services, including care planning and assessment;
- Pre-release housing assessments; and
- Access to safe and supportive housing for those at risk of homelessness upon release.⁹⁰

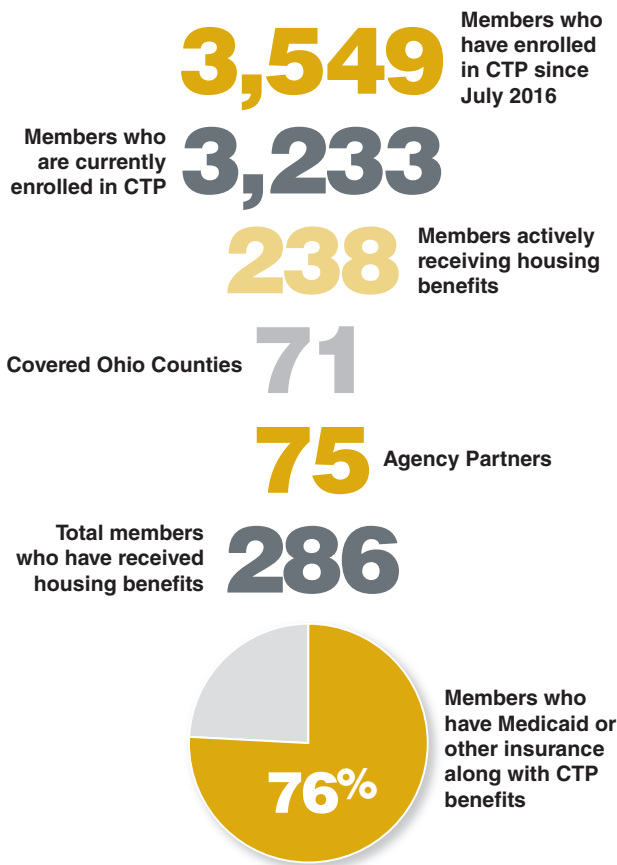
CTP is funded under Ohio's biennial budget, with funding secured through June 2019. Within its first 18 months, the program enrolled more than 3,000 participants and expects to serve more than 3,000 each year moving forward. In addition to connecting incarcerated individuals to community based treatment after release, the program has provided:

- In-reach services to more than 434 participants prior to their release to improve engagement and transitional care planning
- Coordination of CTP services to members enrolled with the five Ohio MCOs
- Permanent supportive housing to more than 122 participants
- Rapid Rehousing (four-month subsidy and housing supportive services) to 91 participants

- Access to a network of recovery housing and supports through collaboration with Ohio Recovery Housing
- A contracted network of 76 ODMHAS Certified AOD Providers⁹¹

Figure 5 provides a snapshot of additional CTP enrollment statistics as of December 2017.

FIGURE 5: Community Transition Program Metrics - December 2017⁹²



Medicaid Pre-Release Enrollment Program

Following Ohio’s adoption of Medicaid expansion in 2014, ODM and ODRC began to develop plans for Ohio’s Medicaid Pre-Release Enrollment Program (MPRE), with the goal of connecting incarcerated individuals with Medicaid managed care coverage upon release.⁹³ Successful enrollment and health care planning for these individuals could result in improved continuity of care from incarceration through the return to the community. Throughout the planning process, additional partners joined this effort, including the Ohio Department of Health, ODMHAS, and MCOs.

ODRC piloted the MPRE program in the Ohio Reformatory for Women in Marysville in October 2014, with the first participants enrolling in November 2014.⁹⁴ Over the next two years, MPRE rolled out in all 28 ODRC facilities throughout the state, becoming fully operational in all facilities in March 2017. From 2014 through the end of 2017, 20,000 individuals had enrolled in the program, with an average of 1,000 enrollees per month. From March 2017 through March 2018, 10,466 eligible individuals were enrolled, which represents 64 percent of the overall ODRC release population (see Figure 6). The multi-agency team conducting enrollment at ODRC facilities includes peer-to-peer Medicaid guides, who help explain the process. MPRE is only conducted in ODRC facilities, but ODM encourages private facilities to develop their own processes to help individuals with Medicaid determinations.

FIGURE 6: Medicaid Cumulative Information: March 2017 - March 2018⁹⁵

Totals	Number	% of Releasing Population	% of Applied Population
Releases	16,385	-	-
Applied	13,780	84%	-
Eligible Approved	10,466	-	76%
- Eligible Not Approved	792	-	6%
- Pending Eligibility	5,127	-	37%
Opt-outs	1,752	11%	-
CRIs	3,581	22%	-
CRIs with R3 Indicator	2,828	17%	-
No Shows	683	4%	-
Not Scheduled	170	1%	-

Definitions of each of the above categories:

Applied: Submitted Medicaid forms

Eligible: Medicaid reviewed forms and applied eligibility

Eligible: Approved

Eligible No Approved: Not approved for various reasons: Have Medicare; too much Income; SSN discrepancy; Name discrepancy; etc.

No Eligibility Indicator (Pending): Medicare still researching eligibility. DRC never receives a determination of eligible status prior to release

Opt-outs: Inmate chooses to not apply for Medicaid

CRI: Inmate has been determined to have a medical Critical Risk Indicator (CRI)

CRI with R3: Inmates who have a Mental Health diagnosis

No Shows: Inmates who have been asked to attend Medicaid meeting or to sign up but do not attend or take the passes provided

Not Scheduled: Health Info Techs are not always scheduling the inmates to apply for or attend Medicaid meetings. Michele Addison is watching this closely and keeping in close communication with the institutions

In order to enroll individuals in MPRE, each ODRC facility begins in-reach 120 days prior to each individual’s release.⁹⁶ Figure 7 outlines the steps involved with the MPRE enrollment process. After potential participants have been notified about the program, each facility holds a peer-led pre-enrollment class, which includes a video presentation with information from all five MCOs in Ohio, as well as the completion of a consent form to allow ODRC to assist with transition planning.^{97 98} Participation in this pre-enrollment class helps incarcerated individuals decide whether they would like to enroll in Medicaid, and if so, how to choose an MCO. Those interested in proceeding with enrollment attend a subsequent enrollment class, during which they complete eligibility and enrollment forms and select an MCO.⁹⁹ During enrollment, 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.^{100 101} 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 post-release.¹⁰²

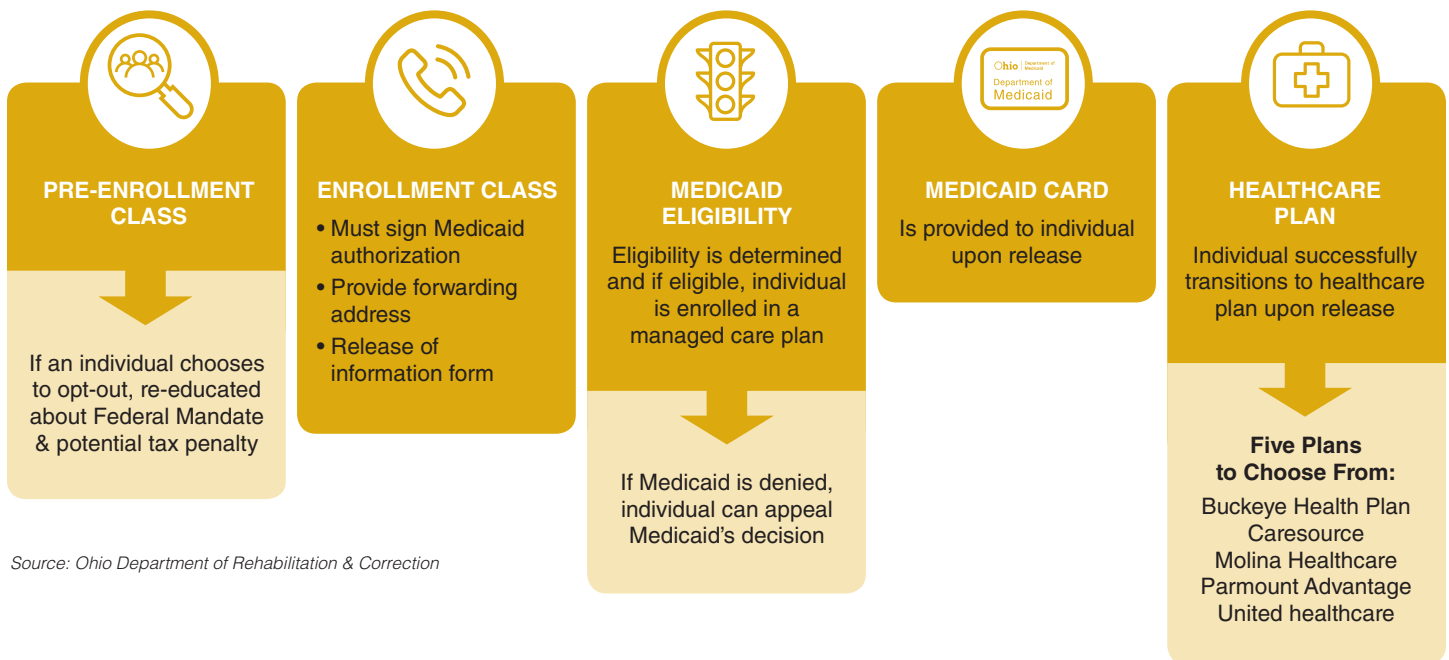
Given the relatively recent development of the MPRE program, long-term data points are limited. However, ODRC is tracking the process, including enrollment, through a series of measures. Figure 6 provides a cumulative overview of enrollment statistics for MPRE between March

2017 and March 2018. Additionally, in fall 2017, ODM’s Office of Health Innovation and Quality conducted an initial evaluation of the MPRE. This evaluation sought to assess the effectiveness of the program in maintaining, and improving, pre-release individual health status and preventing recidivism, specifically for target participants with severe and persistent mental illness, hepatitis C, HIV, and/or SUDs. It utilized data from ODRC’s patient health records, as well as data from ODM claims.¹⁰³

Of the 9,259 unique MPRE program participants included in the analysis, 60 percent had a mental health condition and 23 percent had a SUD, based on primary diagnoses on claims submitted.¹⁰⁴ When compared with the service usages among other Medicaid program enrollees, MPRE participants showed higher utilization rates for mental health and/or SUD services than those enrolled in Medicaid through other programs (Figure 8). Of the participants, 1,738 were flagged as having an ODRC Critical Risk Indicator (CRI) and submitted a Medicaid claim in the 2015-2017 measurement period, outlined in Figure 9. CRI eligibility depended on a diagnosis of either:

- | | |
|---|--|
| <p>Two or more of the following:</p> <ul style="list-style-type: none"> • Mental illness, • Substance abuse, or • Chronic condition | <p>One of the following:</p> <ul style="list-style-type: none"> • HIV+ • Hepatitis C, or • Pregnancy |
|---|--|

FIGURE 7: Medicaid Enrollment Process Overview ¹⁰⁵



Source: Ohio Department of Rehabilitation & Correction

Other key findings of the evaluation included the following:

- MPRE retention rate (the percentage of individuals maintaining Medicaid coverage after initial enrollment) is comparable to other Medicaid populations.
- MPRE included a higher percentage of incarcerated individuals with mental health and SUD diagnoses as compared to Group VIII (Medicaid expansion) population.

- MPRE enrollees accounted for a higher percentage of SUD- and mental health-related inpatient admitting diagnoses as compared to other Medicaid populations.
- Incarcerated individuals flagged as CRI demonstrated an inpatient psychiatric services utilization rate four times higher and other service utilization rate twice as high in comparison with non-CRI consumers.

FIGURE 8: Comparison of Service Category Utilization Among Offenders Population with Ohio Medicaid Programs: 2015 - 2017 ¹⁰⁶

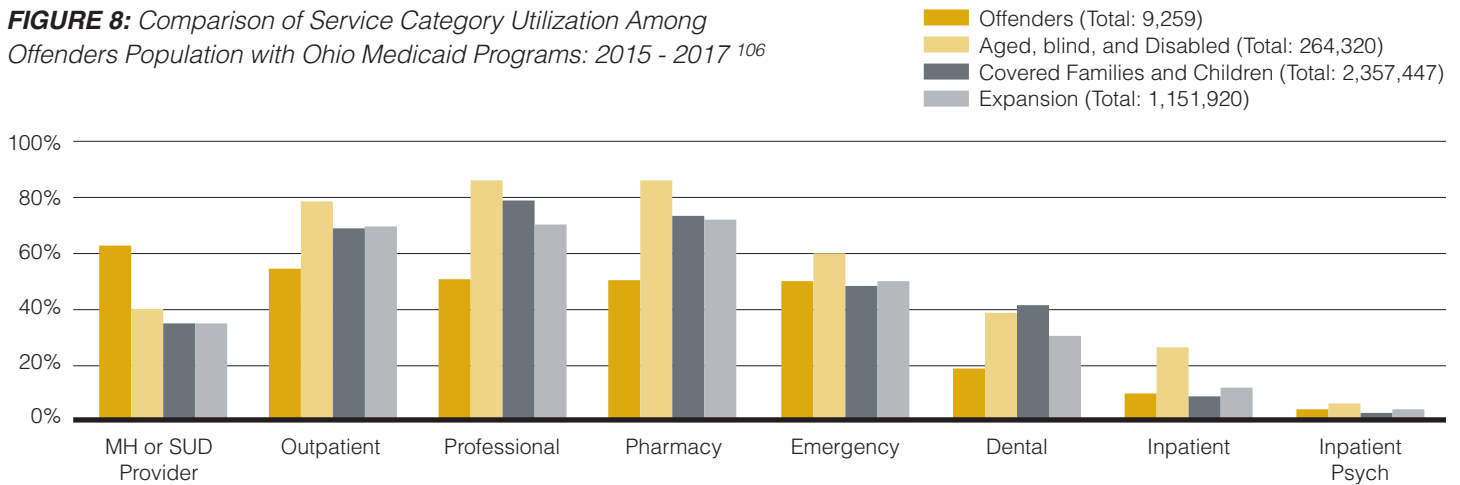


FIGURE 9: CRI Data Breakdown ¹⁰⁷

	# of Inmates
Total CRIs (March 2017 - Feb 2018)	3,834
R3	3,040
MH1	846
R3 & MH1	619
Chronic Care Condition	3,516
Automatic Qualifier HIV+	83
Automatic Qualifier Hep C	2,386
Automatic Qualifier Pregnancy	28

Keep in mind the various combinations that exist for CRI determination. Due to the numerous combinations, data is individually accurate but could be duplicated throughout CRI qualifiers.

Example: CRI individual could be MH1, R3, HIV Positive, and Hep C.

* CRI stands for Critical Risk Indicator



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.

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

- 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.
- A provision in Senate Bill 319, the 2016 Mid-Biennium Review, waived the requirement to be an established provider for two years before becoming a methadone clinic and allows for-profits to provide this service. Ensure for-profit clinics are providing MAT services (e.g., counseling and therapy as well as recovery supports).
- 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

- 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.

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.

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.

End Notes

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