NATIONAL COUNCIL *for* Mental Wellbeing

HEALTHY MINDS
STRONG COMMUNITIES

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS
AND THE JUSTICE SYSTEMS

From police departments to courts of law, the CCBHC model provides a mechanism to coordinate, deliver – and often pay for – mental health and substance use services for justice-involved persons.

A report by the National Council for Mental Wellbeing for the National Center for State Courts' National Judicial Task Force to Examine State Courts' Response to Mental Illness

SEPTEMBER 2021

Overview

In 2017, eight states launched a demonstration program to create a new model for mental health (MH) and substance use (SU) treatment service delivery called Certified Community Behavioral Health Clinics (CCBHCs). The CCBHC model, which today extends to over 430 clinics across 42 states, raises the bar for the delivery of services by providing clinics with a financial foundation to expand access to care and improve coordination with community partners such as law enforcement, courts and the civil and criminal legal systems (justice settings). This model for care delivery allows staff to provide services outside the four walls of the clinic, including through 24/7/365 crisis response. To date, the model has resulted in reduced emergency department visits, hospitalization, incarceration and homelessness among clients served by the program, among other positive outcomes.[1, 2]

Among the innovative features of the CCBHC model are its requirements related to CCBHCs' partnerships with criminal justice agencies, along with flexibility for CCBHCs to deliver services in various non-clinical settings such as courts, police offices and peoples' homes. By embedding health care staff in certain justice settings, the CCBHC model holds the potential to absorb certain costs (city-, county- and state-level) that the justice systems may incur for those services and potentially prevent incarceration or recidivism by enabling greater access to treatment and support for justice-involved individuals. The enhanced services and quality reporting requirements of the CCBHC model work to not only meet the needs of the individual but can also provide a picture of how complex those individual and family needs are as police, county prosecutors or judges make decisions.

CCBHCs' activities in collaboration with and in justice settings have produced the following statistics:

- **76% of CCBHCs participate in specialty courts** (e.g., mental health, drug and veterans' courts).
- **72% of CCBHCs train law enforcement and corrections officers** in Mental Health First Aid (MHFA), Crisis Intervention Team (CIT) or other MH/SU awareness trainings.
- **70% of CCBHCs provide pre-release supports** such as screening, referrals or other activities to ensure continuity of care upon re-entry from a jail or prison.
- **63% of CCBHCs have enhanced outreach and service delivery programs** to expand access to care among individuals who have or are at risk of justice system involvement.
- **34% of CCBHCs share data with justice entities** in their community to support collaboration.
- **20% of CCBHCs provide technology to justice partners** (e.g., iPads, tablets) to support telehealth co-response or other education or intervention supports.[3]

At the request of the **National Center for State Courts (NCSC) National Judicial Task Force to Examine State Courts' Response to Mental Illness (Task Force)**, the National Council for Mental Wellbeing (National Council) outlines examples in this report of how states and localities utilize the CCBHC model to partner with various divisions of the justice systems, with recommendations for states as more policymakers begin to implement the model through legislative and executive actions. The Task Force seeks to identify a new model that creates a team to "triage" a case once it is filed into the court, much like a client within an emergency department. The CCBHC model holds the potential to play a significant role in triaging cases to screen, diagnose and treat clients to better support them and the courts in every state.

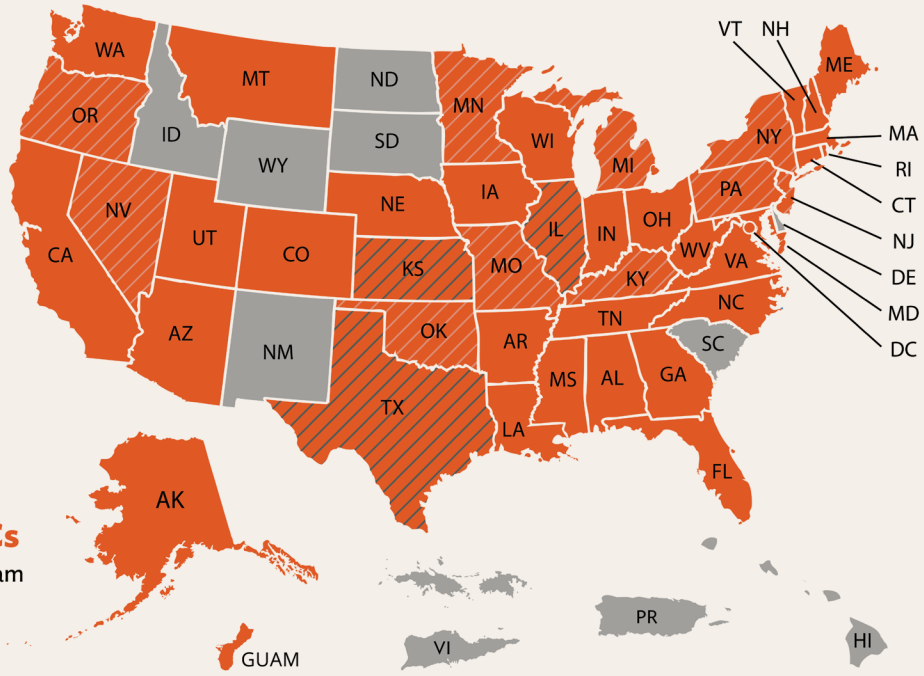
Status of Participation in the CCBHC Model

States where clinics have received expansion grants

States selected for the CCBHC demonstration

Independent statewide implementation

No CCBHCs



There are over **430 CCBHCs** in the U.S., across 42 states, Guam and Washington, D.C.

CCBHCs may be established via multiple pathways:

- The **CCBHC Demonstration** today includes 10 states where state-certified CCBHCs receive a special Medicaid payment rate designed to cover their costs of expanding services to fully meet communities' needs, with 66 clinics participating in the CCBHC demonstration as of September 2021 and up to 18 more expected to join by January 2022.
- **CCBHC Expansion Grantees** receive up to $4 million directly from the Substance Abuse and Mental Health Services Administration (SAMHSA) to carry out the activities of a CCBHC but are not part of a statewide CCBHC initiative and do not receive an enhanced Medicaid payment rate.
- States have the option to **independently implement CCBHCs statewide** in Medicaid. Four demonstration states have used this option to expand CCBHC participation beyond the demonstration, and three additional states are actively working to adopt the model.

The Justice and Public Health Systems Challenge that CCBHCs Work to Solve

Having a MH or SU condition is not illegal, nor are individuals with these conditions inherently dangerous to the public. Yet far too often, lack of access to timely, high-quality treatment can lead to situations where the individual may require crisis care, engage in behavior that results in law enforcement involvement or result in death by suicide, overdose or other means. While working to ensure public safety and justice, professionals within law enforcement, corrections and courts rarely have the resources to connect people to MH/SU treatment. CCBHCs provide supports that work to ensure evidence-based care is available to prevent incarceration and recidivism.

A Disproportionate Burden on Jails and Prisons: While 20.6% of American adults have a MH and 7.7% have a SU challenge,[4] data from 2017 show that half of individuals in state prisons (48%) had an diagnosed mental illness, 26% had a substance use disorder (SUD) and 24% had co-occurring MH/SU treatment needs.[5] A report by Arnold Ventures and the National Association of Counties identified similar data for county jail populations, with 44% of those sentenced to jail having been diagnosed with a serious mental illness (SMI) such as schizophrenia or bipolar disorder, 63% with an SUD and 45% with both conditions.[6] These numbers do not include those persons who are incarcerated in a jail prior to being sentenced (i.e., held pretrial). A 2019 national survey identified[7] that 3.8% of American adults have both an SMI and an SUD, meaning the population of people in jails with both conditions is more than 11.8 times that of the public.

Jails and Prisons Rarely Provide SMI and SUD Medications: Not only are a disproportionate number of people with MH/SU challenges in jails and prisons, but those facilities often do not have access to medications for individuals with these conditions. The "gold standard" treatment for opioid use disorder (OUD) is medication-assisted treatment (MAT),[8] which pairs counseling with medications such as methadone, buprenorphine or naltrexone. In a 2017 study, less than 1% of jails and prisons (30 out of 5,100 sites) offered methadone or buprenorphine.[9] Moreover, a Johns Hopkins University study identified that only 5% of all clients referred from a justice setting received these medications.[10] The vast majority of CCBHCs (70%) offer at least two of the three medications for OUD.[11]

Medications for SMI such as long-acting injectables, which are extremely effective,[12] are also rare in correctional settings. The lack of access to comprehensive SMI treatment in jails and prisons often causes individuals' health conditions to worsen while incarcerated[13] and can result in challenges upon re-entry if individuals are not connected to a community-based source of care, often leading to re-offense, reincarceration, overdoses or death.[14] Seventy percent of CCBHCs provide pre-release screening, referrals or other

> "The CCBHC demonstration changed everything. Once Burrell [Behavioral Health Clinic] became a CCBHC, they had more resources for staffing to support the round-the-clock crisis response line on our tablets and Burrell had enough funds to upgrade to a more secure telehealth platform on the tablets. They were able to invest more time in community outreach and partnership building, as well as increasing access to their services and reducing wait times for people who needed outpatient care. The work they do with individuals who otherwise would have ended up in jail could be continued and expanded."
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> **– Paul Williams, Chief of Police, Springfield Police Department, State of Missouri,** ***Congressional Briefing on "Law Enforcement & Certified Community Behavioral Health Clinics: Increasing Access to Treatment, Decreasing Recidivism" December 4, 2018***

activities to ensure continuity of care upon reentry and 63% have increased outreach and engagement efforts to individuals who have justice involvement or are at risk of being involved with the justice systems.[15]

An alarming 84.2% of people with MH or SU concerns have co-occurring physical health conditions, such as hypertension and diabetes.[16] These conditions often go unaddressed,[17] leading to significantly higher rates of mortality among this population compared to the public.[18] These complex care needs are also high cost to jails[19] and prisons[20] and may not be a part of the contract with their correctional health care vendor with variability by locality and by state. CCBHCs provide physical health services and have shown to decrease cholesterol and hemoglobin A1C rates, reducing risks related to hypertension and diabetes respectively, while also treating SMIs and SUDs with evidence-based care.

High Costs to Local Law Enforcement: Prior to a person arriving in jail or prison, law enforcement and 911 operators must use significant resources in responding to crises for those with MH/SU issues. A report from the Treatment Advocacy Center found that law enforcement agencies, specifically police and sheriff offices, spend 10% of their total budget on transporting persons with MH needs, amounting to around $918 million nationwide in one year's time.[21] These data do not show the costs of incarceration, costs for the courts or the costs of community supervision. CCBHCs are required to deliver a defined scope of crisis services, including 24/7 crisis response, mobile crisis services and crisis stabilization. Most CCBHCs (91%) are going beyond these core requirements with additional services and activities, including crisis call lines, co-responder models in collaboration with law enforcement and more.[22] More than half of CCBHCs reported adding these services because of CCBHC certification,[23] an indicator of the expanded scope of crisis response resources[24] now available in CCBHCs' communities.

Too Few Interventions With the Courts: The availability of clinical staff who can screen, assess and diagnose a person's MH/SU conditions correlates to the time someone waits in a jail pretrial for appointment of specialized defense counsel and for an evaluation for a problem-solving court (i.e., specialty court) or specialized behavioral health docket. These long wait times not only negatively affect the health of the individual by delaying care, but they also backlog the court system and add costs. CCBHCs can embed staff into the courts to coordinate care with 50% of CCBHCs offering same-day services and 84% offering services within a week.[25]

Published in 2014, a six-year study on mental health courts (MHC)[26] found that while MHCs are very effective and created a return on investment for the justice systems, individuals involved in these programs personally incurred an average of $4,000 annually with the highest costs for persons with co-occurring MH/SU conditions. Beyond specialty courts, research completed by the Task Force[27] with partners such as the Council of State Governments[28] shows the complex steps that a person takes through the courts in a criminal case and provided recommendations to improve caseflow management within the Judicial system, including access to technology and data sharing.

CCBHCs provided person-centered, integrated care for their clients regardless of their ability to pay while absorbing costs in the justice systems for services such as screening and assessments as well as the court liaisons who are coordinating access to care. CCBHCs can also provide technology to members of the judicial system (e.g., iPad, tablets)[29] to immediately connect someone with staff who can conduct a screen and provide appropriate information to decision-makers to help inform them and provide more availability of justice and health care options. The scope of services that CCBHCs are required to provide can be coordinated with the courts or delivered directly within those justice settings.

> "To complement and support the work of the CCBHCs, New York has over 30 Mental Health Courts. These courts cannot succeed without the mental health professionals within our communities who are willing to provide treatment, targeted case management, peer support and other services. Moving forward, we need to foster new collaborations among our criminal justice, family justice and health care systems. CCBHCs have a critical part in achieving these goals by linking participants with community service and treatment providers."
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> **– Lawrence Marks, Chief Administrative Judge of the Courts, State of New York**
> ***NATCON21 "CCBHCs: An Ideal Model for Effective Diversion Strategies" Tuesday, May 4, 2021***

Justice Partnerships are a Requirement of the CCBHC Model

CCBHCs' advances in coordinating care with community partners have been widely hailed[30] as one of the most important benefits of the model. Care coordination may be defined as deliberately organizing a client's care activities and sharing information among all the participants concerned with a client's care to achieve safer and more effective care outcomes.[31]

The CCBHC statutory requirements outline specifically which partnerships,[32] through formal contracts or otherwise, are required,[33] including but not limited to "schools, child welfare agencies and **juvenile and criminal justice agencies and facilities**." SAMHSA defines juvenile and criminal justice agencies to include drug, mental health, veterans and other specialty courts. CCBHCs have also worked closely with the larger court systems, as the courtroom is the penultimate opportunity to refer individuals to treatment prior to sentencing. CCBHCs are also required to develop protocols with local law enforcement in responding to MH/SU-related emergencies.[34]

PROPORTION OF CCBHCS WITH JUSTICE SYSTEM PARTNERSHIPS, AS OF 2019[35]

Care Coordination Partner	Proportion of CCBHCs with a Formal Relationship	Proportion of CCBHCs with an Informal Relationship
Juvenile justice agencies	52%	44%
Adult criminal justice agencies/courts	68%	29%
Mental health/drug courts	76%	24%
Law enforcement	53%	47%

The federal CCBHC guidance creates a foundation on which states can build, tailor and enhance the CCBHC model to meet their own communities' needs. States may require additional specific partnerships to meet their populations and systems' needs. For example, the judicial system, as the third branch of government in each state, may join the planning process with the legislative and executive branches when states are taking action to establish the CCBHC model statewide and can support a pre-implementation needs assessment highlighting gaps and opportunities for justice-involved individuals in the state. The courts may also work to inform and train judges on the CCBHC model.

CCBHCs must establish care coordination partnerships with law enforcement and with juvenile and criminal justice agencies and facilities (including drug, mental health, veterans and other specialty courts).[36] In practice, CCBHCs are engaging in additional collaborative activities such as providing telehealth support for law enforcement officers responding to MH/SU-related calls, providing pre-release screening and referrals to ensure continuity of care upon release from jail and more.[37]

CCBHCs and the Sequential Intercept Model

The Sequential Intercept Model (SIM) was developed by Policy Research Associates (PRA)[38] as a conceptual means to inform community-based responses to the involvement of individuals with MH/SU needs within justice systems.[39] NCSC has broadened this model[40] to reflect needs within the civil legal system as well as social needs of people with MH/SU conditions such as housing and healthy meals.

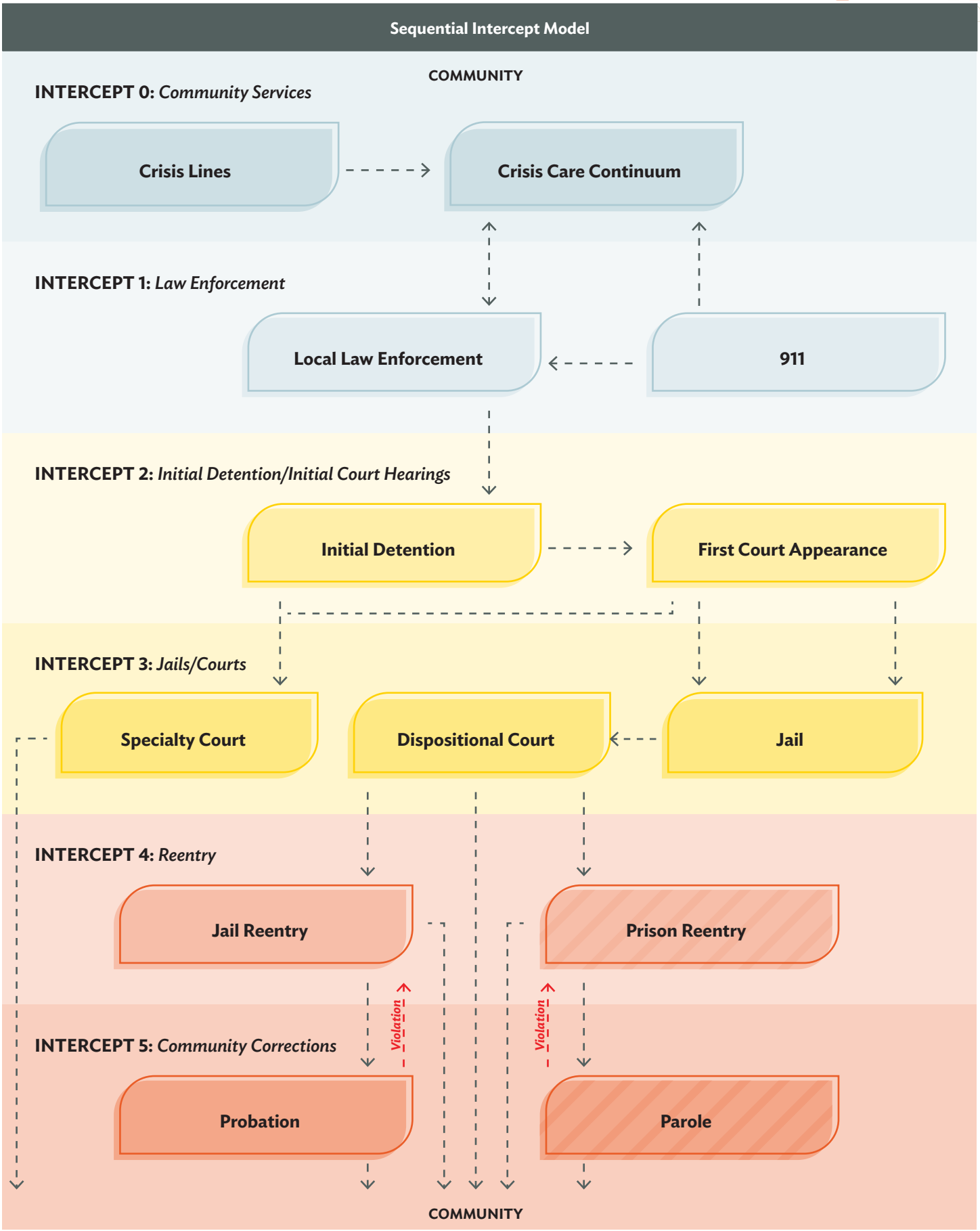
Due to their unique financing model and comprehensive scope of services, CCBHCs are well-positioned to provide support to law enforcement, jails, courts and other justice system partners at each stage of the SIM. The CCBHC criteria offer both standardized requirements (such as required care coordination partnerships with criminal justice entities) and flexibility to tailor individual clinics' activities to the unique needs of their communities. CCBHCs support justice system partners at each stage of the SIM.

The federal CCBHC guidelines establish criteria clinics must meet across six domains: staffing; availability and accessibility of services; care coordination; scope of services; quality and other reporting; and organizational authority, governance and accreditation.[41] These requirements are the floor upon which states may build the model to meet the state's unique MH, SU and overall public health needs, including with justice-involved individuals.

CCBHCs are required to deliver a comprehensive scope of services to meet clients' full MH/SU needs while integrating services with primary care. CCBHCs may partner with other community providers known as Designated Collaborating Organizations (DCO) to deliver some of these services, enabling the CCBHC to establish a strong network of community providers that work together to meet community members' needs.

CCBHC REQUIRED SCOPE OF SERVICES
Must be delivered directly by a CCBHC
• Screening, Assessment, Diagnosis
• Patient-centered Treatment Planning
• Outpatient Mental Health/Substance use Disorder (MH/SUD)
• Crisis Services: 24-Hour Mobile Crisis; Crisis Stabilization
Delivered by a CCBHC or a Designated Collaborating Organization (DCO)
• Peer Support
• Psychiatric Rehab
• Targeted Case Management
• Primary Health Screening & Monitoring
• Armed Forces & Veteran's Services

For crisis response services for which law enforcement and emergency medical services are often involved, CCBHCs must have an established protocol specifying the role of law enforcement during the provision of crisis services. The state defines and ensures inclusion of these crisis services: 24-hour mobile crisis teams; emergency crisis intervention services; crisis stabilization services, suicide crisis response; and services capable of addressing crises related to substance abuse and intoxication, including ambulatory and medical detoxification. SAMHSA provided areas of state discretion[42] within the CCBHC model where justice partnerships can be strengthened and elevated.


Sequential Intercept Model
COMMUNITY
INTERCEPT 0: Community Services
Crisis Lines
Crisis Care Continuum
INTERCEPT 1: Law Enforcement
Local Law Enforcement
911
INTERCEPT 2: Initial Detention/Initial Court Hearings
Initial Detention
First Court Appearance
INTERCEPT 3: Jails/Courts
Specialty Court
Dispositional Court
Jail
INTERCEPT 4: Reentry
Jail Reentry
Prison Reentry
Violation
Violation
INTERCEPT 5: Community Corrections
Probation
Parole
COMMUNITY

Components of the SIM as outlined by PRA		The CCBHC Care Delivery Model
0	**Mobile crisis outreach teams and co-responders**	CCBHCs are required to provide crisis response services, including 24-hour mobile crisis response and crisis stabilization services. EDs and local justice agencies are required care coordination partners for CCBHCs. The CCBHC model has supported clinics in engaging in co-responder initiatives (38%), dispatching MH/SU response teams in lieu of law enforcement (19%), establishing crisis drop-off facilities to allow officers to transition an individual more quickly to clinical treatment rather than hospitalization or jail (33%) and working with EDs to divert individuals in crisis to outpatient services where clinically appropriate (79%).[43]
	Emergency department (ED) diversion	
	Police-friendly crisis services, including deflection services	
1	**Dispatcher training**	The CCBHC funding model supports clinics in working with 911 and law enforcement when MH/SU-related calls are made with 72% of CCBHCs provide training to law enforcement or corrections officers in MHFA, CIT or related trainings that support officers in responding to individuals with MH/SU needs. Many CCBHCs (20%) provide officers with tablets to deliver telehealth support when interacting with an individual with a MH/SU need, and 13% partner with 911 to have relevant calls rerouted to a behavioral health response team. CCBHCs are required to develop a crisis plan with each consumer and to have an established protocol specifying their role with law enforcement in the provision of crisis services.
	Specialized police responses	
	Intervening with high-need persons and providing follow-up post-crisis	
2	**Screening, assessments and diagnoses for MH/SU conditions**	Screening, assessment and diagnosis are required core services for CCBHCs. Two-thirds (63%) of CCBHCs increased their efforts to engage with individuals who have justice system involvement or are at risk of being involved with the justice systems,[44] and 83% have targeted outreach to consumers who were previously incarcerated in order to bring them into treatment.[45] Many CCBHCs (34%) have initiated data-sharing activities with law enforcement and/or local jails to support improved collaboration.[46]
	Data initiatives between the justice systems and MH/SU providers	
	Pretrial diversion to reduce episodes of incarceration with local treatment	
3	**Court diversion programs for persons with MH/SU needs, including but not limited to specialty courts**	CCBHCs are required to establish care coordination partnerships with juvenile and criminal justice agencies and facilities (including drug, mental health, veterans and other specialty courts). While 33% of CCBHCs deliver direct services in courts, police offices and other justice-related facilities,[47] 98% of CCBHCs accept referrals from courts,[48] with 76% actively participating in specialty courts.[49] And although Medicaid funding cannot be used to deliver direct services in jails, many CCBHCs are providing jail-based services through grants or other sources of funding. CCBHCs are also required to partner with local Veterans' Affairs facilities to support military members as their care is a component of CCBHCs' required scope of service.
	Jail-based programming and health care services	
	Collaboration with specialist from the Veterans Health Administration	
4	**Transition planning by the jail or in-reach providers**	More than two-thirds (70%) of CCBHCs coordinate with local jails to provide pre-release screening, referrals or other activities to ensure continuity of care upon individuals' reentry to the community from jail. Through their partnerships with jails and prisons, CCBHCs support warm hand-off supports from correctional settings to community-based settings to reduce risks of harms, including overdose, suicide or other adverse events. CCBHCs have staff that can also work to enroll or re-enroll individuals into benefits like Medicaid to ensure their services are covered.
	Medication and prescription access upon release from jail or prison	
	Warm hand-offs from corrections to providers increases engagement	
5	**Specialized community supervision caseloads of people with MH needs**	The extent of CCBHCs' relationships with community supervision has not been fully documented, but at least 5% of CCBHCs include corrections staff such as external probation and parole offers on treatment teams to create a plan to support successful outcomes for individuals with MH/SU needs.[50] CCBHCs must ensure MAT and MH medications are part of individuals' treatment plans where necessary. The majority (89%) of CCBHCs offer direct access to MAT (with the remainder partnering with other organizations to deliver this service), compared with only 56% of SU treatment facilities nationwide.[51] CCBHCs create community partnerships with organizations that provide job training, housing and other needed supports within their communities.
	MAT for people with SUDs	
	Access to recovery supports, benefits, housing and competitive employment	

How the CCBHC Model Funds Care in Justice Settings

CCBHCs' activities are supported through two funding streams: 1) an enhanced Medicaid payment rate known as the prospective payment system (PPS) that covers the costs associated with CCBHCs' enhanced requirements and activities and 2) grant funding that provides a fixed sum to enable clinics to carry out the activities of a CCBHC during the two-year term of the grant. Some CCBHCs receive only the PPS, others receive only the grant and some may receive both.

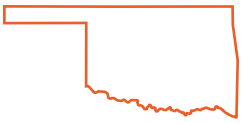
Medicaid CCBHC PPS: Medicaid, as a form of health insurance for indigent populations, splits states' health care costs with the federal government at a minimum of 50% of the costs for those enrolled. This division in costs varies state by state and can extend as high as 100% of costs being covered federally for some populations or services.[52] CCBHCs that are eligible for Medicaid PPS – either because they are a state-certified demonstration site or because their state has independently implemented CCBHC PPS in Medicaid – receive a daily or monthly payment rate expressly structured to reflect CCBHCs' anticipated costs of expanding access and services, including costs that are not billable under traditional payment sources such as outreach, partnership building or technology.

Some states have leveraged this opportunity to maximize federal financial support for previously state-funded activities by building these activities – when considered Medicaid-allowable – into the CCBHCs' scope of services. Within justice and judicial divisions of government, many of the programs that connect people with MH or SU conditions to treatment services are currently paid for either through time-limited grants or by a line-item within city, county or state budgets. The CCBHC model thus holds potential to draw down additional federal funds to support these activities while freeing up state, county or city funds and establishing a pathway for sustainability for time-limited, grant-supported activities. For example, Missouri's state-funded Community Mental Health Liaison program, an initiative that leverages clinic staff working closely with the justice systems (including courts and police) to help direct consumers into care, was added to the state's CCBHC program, allowing the state to expand the program while drawing down a federal match for these services.

SAMHSA CCBHC Expansion grants: These grants are awarded directly to individual clinics receiving a fixed sum of up to $4 million for two years to carry out the activities of a CCBHC. While federal grant funding is time-limited and therefore not sustainable over the long term, it can provide a springboard for states to initiate CCBHC implementation with a PPS through a State Plan Amendment or Medicaid waiver. Grant funding may also be used to pay for activities not otherwise allowable in Medicaid, such as delivery of services within jails and prisons.

Case Studies: CCBHC Alignment With the SIM

Identifying CCBHCs' effects in different justice settings can be difficult as public health and public safety budgets are managed separately with separate data tracking systems and indicators for success. Two CCBHCs have data on their impacts to the justice systems and how those within justice settings have also supported increased access to care for people with MH/SU challenges. The CCBHCs profiled, Grand Lake Mental Health Center in Nowata, Okla., and Integral Care in Austin, Texas, are two examples of how the CCBHC model supports all sectors of the justice systems. While these are local-level efforts, they were supported by state-level actions: Oklahoma joined the CCBHC demonstration and received the PPS rate structure and Texas moved forward independently of the demonstration with statewide support from the executive and legislative branches of government.



GRAND LAKE MENTAL HEALTH CENTER (OKLAHOMA)

Unparalleled innovations for rural justice partnerships

Grand Lake Mental Health Center (GLMHC), a rural CCBHC in northeast Oklahoma that serves 12 counties, is embedded in every part of the SIM within their communities. In an interview with staff at the CCBHC, the chief executive officer, Larry Smith, identified that much of their success has been built off the ability to be embedded within the justice system at no cost to those partners. GLMHC states that the success of these efforts, including the ability to share and reduce costs, has established a trust upon which the clinic and justice divisions have grown more diverse programs within its CCBHC.

Intercepts 0 to 1 – Community services and law enforcement

Law enforcement officers can reach out to the CCBHC seven days a week, 24 hours a day via tablets embedded in every patrol car that link officers to trained mental health counselors when responding to calls involving individuals with MH/SU challenges. GLMHC has also opened a 24-hour crisis drop-in facility where officers can bring individuals in distress rather than taking them to jail or driving them to a psychiatric hospital — sometimes previously requiring trips to multiple hospitals to find an open bed. Through these partnerships, the CCBHC has been able to save law enforcement officers in Northern Oklahoma 275 days of continuous driving — that is approximately 6,600 hours of staff time. In its first three years, the program produced a 99% reduction in emergency psychiatric hospitalizations, producing an estimated $14.9 million in savings.

Intercepts 2 to 3 – Courts and jails

According to GLMHC, Oklahoma's average length of time between a case being filed in the court and final disposition for a person with a MH/SU-related charge is around seven months. GLMHC, in partnership with the county commissioner and district attorney, has decreased this time to approximately 80 days in Rogers County, the site of a pilot pretrial release project. GLMHC has established a shared savings program with the Rogers County jail whereby the jail pays the clinic half of what it would cost to keep someone incarcerated in return for GLMHC taking responsibility for that individual's MH/SU care. To date, the pilot has saved money for the county, reduced or eliminated jail time for eligible persons held pretrial and provided additional financial support for justice-related work.

This program has saved participants 1,761 days in jail, which equates to more than $68,000 saved for the jail. The program provides weekly updates to the district attorney on the progress of the individuals' health with these programmatic outcomes:

- More than one-third (35%) of those in the program make it to their final disposition without any technical violations;
- Approximately half of the remaining clients may have an unintended technical violation with the remaining half reoffending; and
- While not all clients are able to reach their final disposition without issues, all judges may access to the complexity of needs of the individual to know if jail is the best solution.

Intercepts 4 to 5 – Reentry and community corrections

Although the jail and court efforts are in one county, GLMHC is on a multi-disciplinary team within justice-specific collaborations in all twelve counties where they can identify opportunities for engagement in care. This includes community corrections supports within probation and parole efforts, including connecting care for those with sex offender charges. In six of their counties, GLMHC conducts offender screenings to support these justice divisions with the information on the individuals care needs even if they do not continue into treatment through their CCBHC. GLMHC has county partnerships with one county for local probation and parole and with six counties for federal probation and parole. These relationships include conducting the urine analyses for those with SU screening requirements.

INTEGRAL CARE (TEXAS)

State actions to establish and expand the CCBHC model with local innovations

Integral Care, an Austin-based CCBHC that serves Travis County, provides robust services in every part of the SIM with outstanding outcomes. Data were acquired through National Council's 2021 Impact Survey as well as CCBHC and Court data received through the State of Texas' Department of Health and Human Services.

Intercepts 0 to 1 – Community services and law enforcement

The CCBHC has two mobile crisis teams and a walk-in psychiatric urgent care clinic. In December 2019, the City of Austin and Integral Care launched the Crisis Call Diversion program to help divert people experiencing a MH crisis from an automatic police dispatch in situations where there is no imminent risk of harm or death. The program embeds Integral Care clinicians into the Austin Police Department (APD) 911 Call Center, allowing clinicians to receive direct transfer of calls from 911 call takers when a caller is in an MH crisis. In 2020, the Crisis Call Diversion program handled 747 total calls, with 82% resulting in a complete diversion from law enforcement. As part of the MH/SU support provided to law enforcement, Crisis Center Counselors also provide telehealth services for first responders that are already on scene or enroute when they need a rapid response/consultation from a MH professional. In an eight-month review of the program, the total cost avoidance for law enforcement was $1.64 million (approximately $2,900 per diverted call).[53]

Intercepts 2 to 3 – Courts and jails

The CCBHC participates in the County Behavioral Health and Criminal Justice Advisory Committee, which is a collaborative of city and county health and criminal justice entities to ensure people get the care and treatment they need at every step of the criminal justice process. Integral Care redirects individuals from the criminal justice system to community-based treatment through the Mental Health Bond Program, the County's Pre-trial Services. In 2020, 1,417 unduplicated individuals received face to face services through the program and were provided transitional supports (e.g., housing, employment and transportation).

Integral Care's Community Competency Restoration Program supports justice-involved adults who have been found incompetent to stand trial. Services include social and life skills training, case management, MH testing, legal education and access to medicine. The CCBHC operates a Forensic Assertive Community Treatment (FACT) team, an evidence-based, intensive, multi-disciplinary, team-based intervention to reduce recidivism rates for people with SMI and to reduce over-utilizing law enforcement, jail, local emergency and hospital services. The FACT team served 193 unduplicated clients in 2020. Housing placements are a key indicator of the successful impact of the FACT program, and more than 30% of participants are permanently housed within six months of enrollment. In 2019 those enrolled in FACT experienced a 10% reduction in overall arrests and a 46% reduction in jail bed days.

Intercepts 4 to 5 – Reentry and community corrections

The CCBHC provides pre-release screening, referrals and other activities to ensure continuity of care upon reentry from jail. They also support individuals supporting their enrollment (or re-enrollment) for services such as Medicaid, Medicare or applications for disabilities as well as screenings for any other unmet social need. Integral Care has relationships with many other local organizations and businesses, including the department of transportation, to support broad care coordination efforts in the county. For community-based care, this CCBHC provides access to all medications for OUD, reducing risks of overdose and or recurrence of use.

Recommendations for States

The COVID-19 pandemic is likely to exacerbate negative trends within the justice systems by increasing the incidence and prevalence of MH/SU needs across the nation. The Centers for Disease Control and Prevention (CDC) has estimated at least a 36% increase[54] in the demand for treatment of MH conditions (anxiety and depression), resulting in SU and other harms. Tragically, suicidal ideation doubled from 2018 to 2020 (10.7% in 2020 from 4.3% in 2018).[55] At the same time, treatment organizations report[56] they are struggling to meet increased demand for services due to COVID-19.

CCBHCs must be able to provide immediate access for emergency or crisis needs as well as access within 10 days for routine needs.[57] In fact, most CCBHCs report exceeding these standards, making them ideal referral partners for law enforcement, courts and other entities in the justice systems. Also, CCBHCs must serve all individuals who seek care, without regard to their place of residence, insurance coverage status or ability to pay.[58] Most CCBHCs (83%) report they have launched activities specifically aimed at individuals who were previously incarcerated,[59] with the intent of facilitating their access to care and preventing re-engagement with the justice systems.

The CCBHC model – by ensuring all community members' access to comprehensive MH/SU care and strengthening clinics' relationships with criminal justice partners – represents a promising key to success in states' efforts to save lives and alleviate burdens on the justice systems. As many states establish task forces, working groups and committees to solve the growing needs for MH/SU care delivery as well as similar groups for justice-focused solutions, the CCBHC model should be at the top of the list for consideration as a state creates a strategic plan to prevent the growing rates of suicide, overdose and incarceration. The National Council recommends that state leaders:

1. **Establish the CCBHC model statewide:** Adopt the CCBHC model as part of their state Medicaid programs, with PPS available to state-certified CCBHCs.
2. **Include justice officials in CCBHC planning:** Engage with court officials, law enforcement officials and other leaders within the justice systems when identifying system gaps and establishing CCBHC criteria to address unmet needs within the state.
3. **Create innovative CCBHC partnerships:** Consider how to support and incentivize public health-justice system partnerships beyond the minimum federal criteria through collaborative efforts with the judicial system, law enforcement, crisis responders and others engaged in working with individuals at each point in the SIM.

For more information and to obtain support with further exploring or initiating the CCBHC model, please visit the National Council's CCBHC Success Center.

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