Comparative Overview of
Three Recent Reviews of the District's Criminal Justice, Mental Health and Substance Abuse Continua of Care

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Prepared for:
The
District of Columbia Department of Mental Health
and
Criminal Justice Coordinating Council
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U.S. Department of Justice Bureau of Justice Assistance
Justice and Mental Health Collaboration Program

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Executive Summary

In 2006, the Department of Mental Health and the Criminal Justice Coordinating Council (CJCC) were the collaborative recipients of a Bureau of Justice Assistance Justice and Mental Health Collaboration Program Grant award to develop a strategic plan addressing the needs in the District. The Strategic Plan for the District of Columbia builds upon the work of three recent reviews of the District's criminal justice, mental health and substance abuse continua of care: 1) the Criminal Justice Coordinating Council's (CJCC) Substance Abuse Treatment and Mental Health Services Integration Taskforce's Completed Roundtable Discussion Worksheet, 2) the Gap Analysis completed by the Department of Psychiatry at Georgetown University Hospital, and 3) the Urban Institute's report, Addressing Co-occurring Mental Health and Substance Abuse Disorders in the Criminal Justice System: Guiding Principles and District of Columbia Practices. This report presents a comparative overview of the recommendations from these three reviews and is intended to serve as a tool for decision makers in developing the priorities for the strategic plan.

The three documents are:

- **CJCC's Substance Abuse Treatment and Mental Health Services Integration (SATMHSI) Taskforce** --- Currently* co-chaired by Peter Nickles, General Counsel to the Mayor, and Pretrial Services Agency Director Susan Shaffer, SATMHSI undertook an initiative in 2006 to better connect mental health services, substance abuse treatment, and other support services for persons with co-occurring disorders involved in the criminal justice system. The Completed Roundtable Discussion Worksheet presents a review of the current challenges agencies face, gaps that exist, and suggestions that might lead to solutions or improvements for substance abuse and mental health treatment, and treatment services for the dually diagnosed in the criminal justice system. These reflect input gathered from interviews of agency principals, their key staff, as well as others who are active and knowledgeable in this arena – about 50 people in total representing 15 local entities.

- **Gap Analysis ---** Commissioned by the CJCC and completed by the Department of Psychiatry at Georgetown University Hospital in January 2007, the Gap Analysis describes areas of concern, offers background related to best practices in other jurisdictions, and provides a series of recommendations targeted toward system reform.

- **Urban Institute's report, <u>Addressing Co-occurring Mental Health and Substance Abuse Disorders in the Criminal Justice System: Guiding Principles and District of Columbia Practices</u>** --- Prepared by the Criminal Justice Coordinating Council's Substance Abuse and Mental Health Workgroup, this 2004 report identifies promising practices in the treatment of people in the criminal justice system with co-occurring

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* Brenda Donald-Walker, former Deputy Mayor for Children, Youth, Families and Elders, was the former Co-Chair with Ms. Shaffer.

mental health and substance use disorders and details the current practices and services available to this population.

The following summarizes the major recommendations of each document.

CJCC SATMHSI TASKFORCE

Key Recommendations

Phase I—Arrest/Pre-Booking

- Explore models and best practices and develop comprehensive approach to police responses.
- Implement police training
- Build up outreach teams from critical agencies to assist police with urgent, community-based crisis services, including crisis stabilization beds and connection or re-connection to core service agencies.
- Equip CPEP and CMH crisis beds with ability to handle persons whose behaviors do not require proceeding with arrest and booking.
- Move appropriate low level, quality of life incidents directly to CPEP and link to core service agencies after stabilization. Develop guidelines with assistance from OAG so that MPD is supported in exercising discretion.

Phase II—Community Supervision and Treatment

- Expedite criminal justice system referrals to DMH and APRA. Consider redesign of processing procedures. Consider protocol designed to address the criminal justice population differently and more intensively. Simplify referral processes.
- Implement MOU between CSOSA, PSA and DMH ---assessment and treatment within 24 hours.
- Complete MOU between CSOSA, PSA, and APRA for collaboration on assessments, referrals, and receipt of compliance information.
- Develop MOU for expeditious referrals from Court and/or OAG to DMH and APRA for persons charged with DC Misdemeanors and Traffic offenses. Consider placing DMH and APRA resources at the courthouse for "one stop" shopping.
- Provide specialized training and support to designated core service agencies and ACT teams on the needs of the criminal justice population and requirements of criminal justice for compliance information.
- Implement and publicize the process for accessing fully-dedicated ACT teams for the non-compliant criminal justice population.
- Provide co-occurring treatment services with programs certified by APRA and DMH.
- Explore stopgap measures for DC Alliance (non-Medicaid) clients—for coverage for mental health and substance abuse treatment. Explore ways to better connect criminal justice and social service agencies with DOH's Medicaid Office to maximize applications for coverage.

Phase III—DC Jail

- Develop comprehensive system to assess and treat mental illness/substance abuse at the DC Jail and move them as appropriate to community-based services. Clarify the roles of DMH, APRA, Unity and DOC.
- Develop electronic interfaces between information systems at the Jail, DMH and APRA for sharing information.
- Develop a method for processing jail inmates for Medicaid benefits prior to release.
- Explore ways to access medications for persons (with or without Medicaid) released from jail.

Phase IV—After Care—and/or After Release from Criminal Justice Supervision

- Develop appropriate mechanism to maintain services started in earlier phases of criminal justice supervision—prevent recidivism.
- Ensure smooth transfer of primary responsibility from criminal justice to DMH, APRA and appropriate support services without forcing individual to "start over" with new assessments, referrals, and treatment regimens.
- Explore out of the box ideas in meeting service needs, homelessness concerns.
- Develop options for housing.

GAP ANALYSIS

Recommendations Impacting All Phases

- Develop a coordinated and comprehensive data system
- Integrate approaches for addictive disorders and other mental illnesses

Phase I—Pre-Event, Arrest and Pre-Booking, Up to Booking

- Assure clinically appropriate assessment in the field
- Optimize District-wide capacity for emergency psych assessment and disposition
- Determine and provide appropriate clinical care and booking disposition

Phase II – Pre-Trial

- Ensure consistency of mental health assessment and interventions for each of the DC Superior Court Tracks
- Maximize the use of diversionary strategies

Phase III – Sentence/Supervision/Custody: Jail, Prison, Supervised Release, Probation or Parole (Including pre-trial jail detention of defendants)

- Develop standards for pre-sentence screening/assessment and effective interagency communications
- Provide adequate care during incarceration or supervision
- Ensure appropriate and consistent re-entry planning for individuals with mental illnesses

Phase IV – Post-Release/Aftercare: “Ex-Offenders” and “Ex-Defendants”

- Promote referral and planning for clinical care and psychosocial referrals of forensic cases after release
- Provide a system in aftercare to increase treatment adherence

URBAN INSTITUTE REPORT

Overarching Guiding Principle: Developing and implementing comprehensive and appropriate community-based services will help local public behavioral health systems treat problems, improve individual functioning, and prevent criminal justice system involvement for people with co-occurring mental health and substance abuse disorders. These services should be designed to be easily accessible to potential clients.

Overarching Guiding Principle: Collaboration between criminal justice agencies, mental health treatment providers, substance abuse treatment providers, and funding and advocacy groups will help communities serve individuals with co-occurring mental heath and substance abuse disorders and provide appropriate justice system responses. It is important to develop planning processes that include top-level representatives from the criminal justice, mental health treatment, and substance abuse treatment fields.

Recommendations Applying Guiding Principles from Four Points in the Criminal Justice System

(1) Crime/Incident

Guiding Principle: Training dispatchers to consider the nature of a call and whether or not mental health issues are a factor in the call will increase the likelihood that the most appropriate first responder will be sent to the scene.

Guiding Principle: Training and requiring law enforcement officers to identify mental health and/or substance abuse issues will help them determine how best to address an incident for the individual person based on the type of offense that was committed, the safety issues involved, and the types of programs and resources available in the community. Written policies and protocols should be developed to ensure that officers know how to proceed in particular situations and document the course of action taken.

Recommendation: Provide training opportunities for dispatchers and law enforcement officers about substance abuse and mental health disorders and appropriate ways to address people with such needs.

- Include MPD personnel along with reps from DMH and APRA in the same training sessions.

Recommendation: Ensure that the treatment provider network is ready to work with police when they are interested in transporting someone to a program for assistance. Consider the range of program possibilities to assist police when they identify someone with mental health or

substance abuse issues, or the co-occurrence of these issues. Perhaps eligibility rules could be revised or, if appropriate, entirely new programs to assist people may be created.

(2) Pretrial

Guiding Principle: Screen for substance abuse and mental health disorders as early as possible using a simple and effective screening instrument. Screening results should inform assessments, the use of diversionary programs, and treatment. Screening and assessment information should be shared across agencies and specific mechanisms to easily share such information should be created.

Recommendation: Continue to pursue the implementation of the Universal Screener.

Recommendation: Continue to pursue ways to share information from screenings or assessments conducted by one agency with other agencies, so such information can follow an offender through the system. Results: greater staff efficiency and greater likelihood that a person's needs are met immediately upon entering a new agency.

Recommendation: CJCC JUSTIS information system — provide access for behavioral health system to such a system to document clientele in the criminal justice system.

(2) Pretrial

Guiding Principle: When possible and appropriate, criminal justice agencies should use pretrial diversion for cases involving people with co-occurring mental health and substance abuse disorders. If diversion opportunities are not available and the case is appropriate, offenders with co-occurring mental health and substance disorders should be released with the least restrictive conditions and pretrial agency staff should assist defendants in complying with conditions of pretrial release. Defendants should not be detained before trial based on a lack of information or referral resources.

Recommendation: Consider more diversion program options for offenders with co-occurring mental health and substance abuse disorders.
Seek peer-to-peer technical assistance from grantees funded through SAMHSA's Jail Diversion Knowledge Development and Application Program.

(3 & 4) Incarceration, Community Supervision and Reentry

Guiding Principle: Jail and prison procedures should include screening and identification of mental health and substance abuse issues upon arrival at jail or prison.
Results from internal screening, assessments, and treatment plans should feed into transfer and/or release planning efforts. Correctional facility staff and staff from community supervision agencies should be familiar with and able to refer to community-based mental health and substance abuse treatment providers and this information should directly lead into release decisions, determination of release conditions, and release plans.

Facility staff, community supervision staff, and staff from mental health and substance abuse treatment providers should collaborate to help an inmate transition successfully from the facility to the community.

Recommendation: Create better mechanisms for coordinated treatment from inside facilities to outside in the community.

Recommendation: Expand Safety Net Program. Develop similar program that would place SA offenders into other types of treatment options besides residential care.
Build CSOSA's efforts to "reach in" before offenders are released.
Workgroup to facilitate relationships between criminal justice agencies with DMH and APRA at the departmental level and at the individual provider level.
Develop programs for co-occurring disorders.
Address funding shortfalls.
Identify ways to best support the services offenders most need.

Recommendation: Collaborate, collaborate, collaborate.
Specifically for co-occurring.
Bring in outside facilitator.

Recommendation: Gather more information on a regular basis. Perhaps one member of the Workgroup could be responsible for culling the literature, filtering list-serve information, and visiting web sites to identify new innovations or initiatives. Sources: Co-Occurring Dialogues Electronic Discussion List, ATTC website, Center for Substance Abuse Treatment—Treatment Improvement Protocols Series

Recommendation: Use current funding creatively and apply for new funding; SAMHSA Block Grant (SAPT), CMHS Block Grant, PATH, and COSIG as examples.

Recommendation: Pursue technical assistance opportunities (particularly when they are free of charge);
Co-occurring Center for Excellence – SAMHSA, SAMHSA Policy Academies, GAINS, Addiction Technology Transfer Centers (ATTC), and Technical Assistance from Community Representatives (nationally) as examples.

Comparative Overview

<table>
<tr><th>CJCC SATMHSI TASKFORCE
(AUGUST 2006)</th><th>GAP ANALYSIS
(JANUARY 2007)</th><th>URBAN INSTITUTE
(JANUARY 2004)</th></tr>
<tr><td colspan="3">IMPACTING ALL PHASES</td></tr>
<tr><td>▪ Develop a system that enables assessors to know the individual's criminal history and whether the individual has been the subject of past repeated diversion services, before new diversion decisions are made.
▪ Develop standards for interagency information sharing (e.g., criminal history).</td><td>Develop a coordinated and comprehensive data system
▪ Identify a suitable agency within the District of Columbia government to develop and monitor policies for data collection
▪ Assure that issues regarding mentally ill persons involved in the CJS are incorporated in ALL data plans
▪ Universal definitions and outcome measures should be agreed upon
▪ Specific recommendations for data collection by agency by each phase
▪ Data collection should conform to standards of HIPAA and the DC Mental Health and Information Act
▪ All stakeholders should have access to available information and be able to utilize a common computer platform to add data to the shared community</td><td></td></tr>
<tr><td>▪ Discuss ways in which APRA and DMH Directors can disseminate the MOU to each SA provider/CSA under their auspices in an annual training forum.

▪ Integrate treatment approaches for the dually diagnosed with programs certified by DMH and APRA.</td><td>Integrate approaches for addictive disorders and other mental illnesses.
▪ In the absence of a full institutional merger, DMH and APRA should continue the COSIG grant activities as initial steps towards integration of addictions and mental illnesses.
▪ Establishment of the capacity for clinicians from the agencies to freely share clinical information with each other
▪ "Cross training" of each agencies' practitioners in the other's area of knowledge and expertise
▪ Coordination of research and analysis
▪ Presence of APRA alongside DMH representatives in CJS settings, including DCSC and DC Jail</td><td></td></tr>
<tr><td></td><td></td><td><u>Overarching Guiding Principle</u>: Developing and implementing comprehensive and appropriate community-based services will help local public behavioral health systems treat problems,</td></tr>
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		improve individual functioning, and prevent criminal justice system involvement for people with co-occurring mental health and substance abuse disorders. These services should be designed to be easily accessible to potential clients.
		Overarching Guiding Principle: Collaboration between criminal justice agencies, mental health treatment providers, substance abuse treatment providers, and funding and advocacy groups will help communities serve individuals with co-occurring mental heath and substance abuse disorders and provide appropriate justice system responses. Recommendation: Collaborate, collaborate, collaborate. ▪ Specifically for co-occurring. ▪ Bring in outside facilitator.
		It is important to develop planning processes that include top-level representatives from the criminal justice, mental health treatment, and substance abuse treatment fields.
		Recommendation: Gather more information on a regular basis. ▪ Perhaps one member of the Workgroup could be responsible for culling the literature, filtering list-serve information, and visiting web sites to identify new innovations or initiatives. Sources: Co-Occurring Dialogues Electronic Discussion List, ATTC website, and Center for Substance Abuse Treatment—Treatment Improvement Protocols Series
Develop better funding mechanisms for ongoing substance abuse and mental health care. ▪ Explore ways for DMH and APRA to recruit and/or train additional grant researchers and writers. ▪ Discuss ways to better utilize individual agencies and the CJCC in exploring grant and other funding streams		Address funding shortfalls
		Recommendation: Use current funding creatively and apply for new funding, such as SAMHSA Block Grant (SAPT), CMHS Block Grant, PATH, and COSIG.
		Recommendation: Pursue technical assistance opportunities

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		(particularly when they are free of charge) ▪ Co-occurring Center for Excellence – SAMHSA ▪ SAMHSA Policy Academies ▪ GAINS ▪ Addiction Technology Transfer Centers (ATTC) Technical Assistance from Community Representatives (nationally)
		Seek peer-to-peer technical assistance from grantees funded through SAMHSA's Jail Diversion Knowledge Development and Application Program
PHASE ONE – ARREST/PRE-BOOKING		
	Phase I --- Pre-Event, Arrest and Pre-Booking (Up to Booking)	**(1) Crime/Incident**
Explore various models and best practices and develop comprehensive approach to police responses to individuals with mental illness	Convene a group of mental health, law enforcement, and judicial stakeholders to implement a crisis intervention model for the District of Columbia that incorporates both mental health and police professionals and services	
Implement police training for dealing effectively with the mentally ill ▪ Discuss the concern for placing police in the position of conducting mental observations on the street as opposed to merely assessing whether or not a crime has been committed. ▪ Discuss the "holistic" role of police as first responders. ▪ Discuss if/how mental health issues are included in basic training at the Academy and how MPD's "Roll Call Training" can assist in continuing the education and clarification of mental health (MH) policies/procedures. What training is MPD already receiving? ▪ Re-establish the 8 hours of mental health training provided by DMH at MPD's Academy. ▪ Consider training dispatchers to better determine mental health versus police emergencies. ▪ Explore various models and best practices for approaches to police response to the handling of the mentally ill. ▪ Develop a comprehensive approach to police responses to individuals with a MH illness. The planning and development of the initiative should at a minimum involve DMH, MPD, APRA and	Improve effectiveness of mental health training for police officers.	Guiding Principle: Training dispatchers to consider the nature of a call and whether or not mental health issues are a factor in the call will increase the likelihood that the most appropriate first responder will be sent to the scene. Guiding Principle: Training and requiring law enforcement officers to identify mental health and/or substance abuse issues will help them determine how best to address an incident for the individual person based on the type of offense that was committed, the safety issues involved, and the types of programs and resources available in the community. Written policies and protocols should be developed to ensure that officers know how to proceed in particular situations and document the course of action taken. Recommendation: Provide training opportunities for dispatchers and law enforcement officers about substance abuse and mental health disorders and appropriate ways to address people with such needs.

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community groups such as the Alliance on Mental Illness (NAMI)-DC chapter. ▪ Police should be trained on their own Gen Order 308.4 "Processing of Persons Who May Suffer from Mental Illness" and the video jointly developed by DMH and MPD. ▪ Minimize MPD incentives to paper cases in lieu of MH assistance (e.g., minimize waiting time for police officers).		▪ Include MPD personnel along with reps from DMH and APRA in the same training sessions.
Build up outreach teams from various critical agencies to assist the police with urgent, community based crisis services, including beds for those needing stabilization and connection or reconnection to core service agencies	Assure clinically appropriate assessment in the field ▪ Ensure that an effective mobile crisis team is available at all times to police, supervising justice professionals, clinicians, or citizens	Recommendation: Ensure that the treatment provider network is ready to work with police when they are interested in transporting someone to a program for assistance. ▪ Consider the range of program possibilities to assist police when they identify someone with mental health or substance abuse issues, or the co-occurrence of these issues. Perhaps eligibility rules could be revised or, if appropriate, entirely new programs to assist people may be created.
Equip CPEP and DMH crisis beds with ability to handle persons whose behavior does not require proceeding with the criminal justice process of arrest and booking.	DMH and MPD should create a procedure by which CPEP is available as an evaluation service for pre-arraignment arrestees in MPD custody without the need for an FD-12.	
	Determine and provide appropriate clinical care and booking disposition	
Move appropriate low level, quality of life incidents directly to CPEP instead of the criminal justice system, from there linking them directly to core service agencies after stabilization. Develop guidelines with assistance from the Office of the Attorney General so that MPD is supported in this exercise of discretion. Train CPEP, and DMH and community CSAs on civil commitment procedures and petitioning for outpatient civil commitments. Discuss how best to serve MH suspects taken to CPEP displaying signs of a physical injury (i.e., the emergency room visit). For instance, is it essential that CPEP be located on the grounds of a hospital?	CPEP and MPD should review their policies on the perceived need for MPD to complete an FD-12 for MPD transport to CPEP of non-arrestees they believe need emergency hospitalization to CPEP ▪ Dissemination of current policy that includes retained MPD custody whether admitted to CPEP or even inpatient units such as St. Elizabeth's ▪ Utilize existing CJC workgroups (including DMH, MPD, DOH, others) to develop interagency procedures for response and to address: ○ Availability of crisis services (e.g., CPEP) ○ Inpatient voluntary and involuntary beds ○ Detoxification services ▪ Expand CPEP capacity for ○ emergency psychiatric services/assessment	

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The goal of DMH is to enhance the range of services which are under the auspices or have a formal relationship with CPEP, which is a site-based emergency room. These include but are not limited to mobile crisis services, urgent care services, community based crisis services, 72-hour holding beds and a close working relationship with MPD.	○ involuntary beds ○ detoxification ○ social work attention for successful linking with follow up care ▪ CPEP should have centralized location with immediate access to emergency medical assessment (including labs, imaging, non-psychiatric physicians) ▪ Consideration should be given to adding a second CPEP in order to address geographic/capacity concerns (each may work at a different pace ▪ CPEP should have capacity to restrain aggressive patients, and not rely upon MPD officers (even if the patient was brought to CPEP by police) ▪ Conduct an analysis of required number of inpatient beds ○ Based on that analysis, work with local hospitals on arrangements to open more beds ▪ Educate all District professionals who have the power to emergently detain using the FD-12 (and hospital administrators as well) about the parameters of the Ervin Act and subsequent case law	
	PHASE TWO – COMMUNITY SUPERVISION AND TREATMENT	
	Phase II --- Pre-Trial	**(2) Pretrial**
Work to expedite criminal justice system referrals to DMH and APRA due to the public safety concerns presented by these residents and/or the expenditure of needless resources as they repeatedly recycle through the criminal justice system. ▪ Consider redesign of processing procedures such as DMH's Access Helpline for court-involved population. ▪ Consider a protocol designed to address the criminal justice population differently, more intensively, as these residents are often at "the end of the line" and in need of immediate services when they end up in the criminal justice system. ▪ Simplify referral processes, such as for emergency crisis beds, so that unnecessary encumbrances to access are removed.	DMH should continue to implement quality control measures for the Access Help Line that include: ▪ Dissemination of Access Help Line Rules for approval of services ▪ Reduction of Wait Time ▪ Internal Reviews of "gate-keeping" decisions to crisis services and St Elizabeth's Hospital	
Implement MOU between CSOSA, PSA and DMH so that persons under		

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criminal justice supervision in need of MH services are seen and receive appropriate medications within 24 hours.		
Complete the MOU being developed between CSOSA, PSA and APRA to collaborate in order to expedite criminal justice assessments, referrals, and receipt of compliance information.		
Commit to developing an MOU for expeditious referrals from the Court and/or the Office of the Attorney General to DMH and APRA for persons charged with DC Misdemeanors (quality of life crimes) and Traffic offenses. Consider placing DMH and APRA resources at the courthouse for "one stop" shopping with immediate assessments and services for mentally ill and substance abusing clients charged with low level offense		
Provide specialized training and support to designated core service agencies and ACT teams on the needs of the criminal justice population and the requirements of the criminal justice system for appropriate compliance information.		
Implement and publicize the process for accessing fully-dedicated ACT teams for the non-compliant criminal justice population.		
Provide co-occurring treatment services with programs certified by APRA and DMH.		Guiding Principle: Screen for substance abuse and mental health disorders as early as possible, using a simple and effective screening instrument. Screening results should inform assessments, the use of diversionary programs, and treatment. Screening and assessment information should be shared across agencies and specific mechanisms to easily share such information should be created.
Explore stopgap measures for DC Alliance (non-Medicaid) clients since DC Alliance does not provide coverage for mental health and substance abuse treatment and waits can be substantial for DMH and/or APRA service delivery. ▪ Explore ways to better connect criminal justice and social services agencies with the Department of Health's Medicaid Office so as to maximize appropriate applications for coverage.		

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	Ensure consistency of mental health assessment and interventions for each of the DC Superior Court "Tracks"	Recommendation: Continue to pursue the implementation of the Universal Screener.
Develop an MOU between DCSC, OAG, DMH for mental health referrals for persons charged with DC misdemeanors and Traffic offenses. OAG defendants are not generally receiving such referrals because the DC Misdemeanor/Traffic community court does not presently include the resources from PSA and the core service agencies to conduct assessments and make referrals. OAG understands that DMH may conduct assessments when current DMH clients are found on the lockup list or when the community court social worker has identified a mental health or substance abuse issue for a quality of life defendant in lockup; however, only detained defendants are screened and defendants facing traffic charges are not screened. Thus, the screening does not include the majority of cases. Provide one-stop shopping (sort of diversion alternatives) at the courthouse for quality of life type crimes (e.g., mandatory session on nature of mental illness and treatments, screenings and voluntary appointments for follow-up at CSAs). Implement a process to expedite criminal justice referrals, including DC misdemeanor and traffic cases, to APRA. Complete the MOU that is being developed between APRA, CSOSA and PSA for expediting criminal justice referrals. Identify providers approved by DMH who will work with the justice-involved population and understand the immediacy of this request for those with mental illness.	▪ OAG should expand its pre-trial capabilities to incorporate the capacity to screen, supervise and monitor compliance to serve all OAG charges	
	▪ Complete the development of a "universal screener" which can be utilized in all tracks during the pre-trial phase; key components should include: ○ Documentation of current medication and other treatments ○ Potential for withdrawal from substances	

CJCC SATMHSI TASKFORCE (AUGUST 2006)	GAP ANALYSIS (JANUARY 2007)	URBAN INSTITUTE (JANUARY 2004)
	○ Disposition summary	
	Develop system of ongoing monitoring and reporting compliance with care ▪ Adopt the National Association of Pretrial Services agencies standards for screening and monitoring of compliance if not already done	
Develop a collaborative referral and case management system between criminal justice and treatment agencies that recognizes the urgency of treating those in the criminal justice system Develop an MOU between DCSC, OAG, DMH for mental health referrals for persons charged with DC misdemeanors and Traffic offenses. OAG defendants are not generally receiving such referrals because the DC Misdemeanor/Traffic community court does not presently include the resources from PSA and the core service agencies to conduct assessments and make referrals. OAG understands that DMH may conduct assessments when current DMH clients are found on the lockup list or when the community court social worker has identified a mental health or substance abuse issue for a quality of life defendant in lockup; however, only detained defendants are screened and defendants facing traffic charges are not screened. Thus, the screening does not include the majority of cases. Provide one-stop shopping (sort of diversion alternatives) at the courthouse for quality of life type crimes (e.g., mandatory session on nature of mental illness and treatments, screenings and voluntary appointments for follow-up at CSAs). Implement a process to expedite criminal justice referrals, including DC misdemeanor and traffic cases, to APRA. Complete the MOU that is being developed between APRA, CSOSA and PSA for expediting criminal justice referrals. Develop estimates from OAG as to how many screenings would be needed each day.	Representatives of both DMH and APRA should be present in the DCSC and address both mental illness and substance use disorders concurrently, embodying the spirit of the DMH-APRA COSIG grant	Recommendation: Continue to pursue ways to share information from screenings or assessments conducted by one agency with other agencies, so such information can follow an offender through the system. ▪ Results: greater staff efficiency and greater likelihood that a person's needs are met immediately upon entering a new agency. ▪ CJCC JUSTIS information system—provide access for behavioral health system to such a system to document clientele in the criminal justice system.

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Look to the Family Court Liaison's Office Model, where representatives from various social services agencies are located. Look at space requirements to determine if the courthouse can accommodate additional staff. Determine how to obtain urine samples at lock-up from DC misdemeanor and Traffic Court defendants to detect (early) substance abuse (SA) problems. Implement a process to expedite APRA and DMH services. Consider locating APRA staff at the Court to conduct assessments and referrals, as DMH does presently. Consider location DHS/IMA staff at the court to begin process for Medicaid eligibility and linkage to DC Alliance. Improve coordination among the Courts, OAG, DMH and APRA regarding outcome and tracking of treatment services. In order for the OAG to divert a significant number of low level offenders in favor of treatment rather than prosecution, case management is needed so that the prosecutor and the Court receive accurate information about compliance with treatment conditions. Since PSA is not funded to provide these supervision services for DC misdemeanor and Traffic cases, it is essential that DMH and APRA treatment providers give current compliance information directly to the Court and/or prosecutor. For any changes in assessment procedures at the Court, factor in impact on the arraignment process.		

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<tr><td>OAG receives a significant number of low level case referrals for quality of life offenses (disorderly conduct, aggressive panhandling, etc.) involving individuals who appear to have substance abuse and/or mental health issues that cannot be adequately addressed in the criminal justice system. Many also appear to be homeless. Many OAG criminal traffic cases also involve mental health or substance abuse issues. Often these cases could best be dealt with outside of the criminal justice system, or through a treatment-oriented diversion program, to address the underlying issues that are resulting in the problematic conduct. Fines and intermittent jail time (days at most) are not an adequate solution since they will not address the underlying mental health and addiction issues that result in this behavior.

Develop eligibility criteria for linkage to CPEP instead of the criminal justice system. These criteria should be agreed to by the prosecuting offices – OAG and the USAO – so that MPD is not operating in a vacuum.

Ensure that appropriate assessments for both mental health and substance abuse are conducted at CPEP so that appropriate referrals to DMH and APRA can be made.</td><td>Maximize the use of diversionary strategies
Mental Health Court pilot tailored to DC Superior Court and DMH capacities, possibly using the Connecticut model, including education for Court, clinical service providers
Criteria for acceptance in the Mental Health Court should be non-violent, non-serious crime, likely as a result of mental disorder as determined by uniform screening and assessment program (criteria currently used in the Options Program would also be acceptable)
A Mental Health Court would involve rewards and sanctions along with the following:
Educated courts (including all court staff and parties)
Ongoing returns for status
Regular meetings with a team
Overall court coordinator
Active partnership with DMH, APRA, and other social service agencies</td><td><u>Guiding Principle:</u> When possible and appropriate, criminal justice agencies should use pretrial diversion for cases involving people with co-occurring mental health and substance abuse disorders.
If diversion opportunities are not available and the case is appropriate, offenders with co-occurring mental health and substance disorders should be released with the least restrictive conditions and pretrial agency staff should assist defendants in complying with conditions of pretrial release.
Defendants should not be detained before trial based on a lack of information or referral resources.
Recommendation: Consider more diversion program options for offenders with co-occurring mental health and substance abuse disorders.</td></tr>
<tr><td colspan="3">PHASE THREE – DC JAIL</td></tr>
<tr><td></td><td>Phase III --- Sentence/Supervision/ Custody: Jail, Prison, Supervised Release, Probation, or Parole (including pre-trial jail detention of defendants</td><td></td></tr>
<tr><td>Develop comprehensive system to assess and treat the mentally ill and substance abusing population at the DC Jail and move them as appropriate to community-based services.
Clarify the various roles of DMH, APRA, Unity and DOC.</td><td>Provide adequate care during incarceration or supervision
Monitor quality of care provided by the Dept. of Corrections and Unity Healthcare</td><td><u>Guiding Principles</u>: Jail and prison procedures should include screening and identification of mental health and substance abuse issues upon arrival at jail or prison.</td></tr>
<tr><td>Better coordination has to be developed for services after release from jail. Unity Healthcare's involvement with DMH and APRA will be essential.
Explore ways in which persons released from jail can get their medications filled quickly. (Note: Three concerns are that not everyone can go to Phoenix, and Phoenix does not employ a full-</td><td>Ensure appropriate and consistent re-entry planning for individuals with mental illnesses</td><td>Facility staff, community supervision staff, and staff from mental health and substance abuse treatment providers should collaborate to help an inmate transition successfully from the facility to the community.</td></tr>
</table>

CJCC SATMHSI TASKFORCE (AUGUST 2006)	GAP ANALYSIS (JANUARY 2007)	URBAN INSTITUTE (JANUARY 2004)
time physician to conduct evaluations and prescribe medications, and medication prescriptions are effective for only 7 days). ▪ Investigate whether the physician's evaluation and any follow-up medications can be prescribed prior to release from jail. What is the limit on quantities for psychotropic medication that can be prescribed from the jail? ▪ Discuss ways to enable D.C. Alliance to cover the costs of medications, despite its inability to cover MH services. ▪ Explore ways to better collaborate with DMH and pool (rather than duplicate) resources in addressing the overwhelming needs of jail releasees. ▪ DMH plans to develop a MOU with Unity regarding the coordination of mental health services and linkage in the community. ▪ Consider attaching an APRA Substance Use Disorders intake staff to the Unity site for immediate assessment and referral. Strengthen the process of jail mental health evaluations and the speed with which inmates are connected to services on release. ▪ Unity is hiring more clinicians and social workers to enhance patient care and connection to community services upon release (particularly the homeless who, according to reports, represent a significant portion of the Jail's MH Unit). ▪ Identify a smaller number of CSAs who are trained to focus on the service needs of this population. ▪ Explore ways to strengthen DMH's ability to connect clients to services (especially medication administration services) immediately upon release. (Note: According to reports, clients' inability to access and refill psychotropic medication quickly upon release leads to their failing repeatedly in residential substance abuse treatment programs.) ▪ It will be important to explore with DOC ways in which access to clients in the jail can be expedited regarding logistical issues (e.g., changes of release dates, release from courts, etc.) Undertake comprehensive planning for how to best effectuate linkages to and from the planned therapeutic communities in the D.C. Jail.		

CJCC SATMHSI TASKFORCE (AUGUST 2006)	GAP ANALYSIS (JANUARY 2007)	URBAN INSTITUTE (JANUARY 2004)
▪ Clarify APRA's and/or DOC's support of or involvement in providing therapeutic community treatment services. ▪ Explore whether APRA can conduct the SA (GAIN-I or GAIN-Q) assessments in the Jail that will follow clients into the community. ▪ Clarify the roles and responsibilities of APRA and Jail personnel. ▪ Discuss linkages to APRA-funded SA services from the Jail, and explore ways to best effectuate those linkages. ▪ Explore the universal use of the GAIN-I or the GAIN-Q city-wide, eliminating the need to duplicate SA assessments at APRA's Assessment and Referral Center. ▪ Consider training Jail staff to conduct substance abuse assessment and work with APRA to facilitate linkages.		
Develop automatic, electronic interfaces between the Jail's computer network and DMH and APRA computer networks. ▪ In preparation to take over the Jail's healthcare on October 1, 2006, Unity hopes to develop a software program that will establish an interface between the Jail and DMH computer systems. ▪ Automated transfer of information will require working out disclosure authorizations either from client or the court.	▪ Comprehensive, data-based needs assessment to determine available post-release resources	Results from internal screening, assessments, and treatment plans should feed into transfer and/or release planning efforts.
	▪ CJCC should convene relevant agencies and stakeholders to develop a set of clinically relevant post-release standards	Workgroup to facilitate relationships between criminal justice agencies with DMH and APRA at the departmental level and at the individual provider level
	▪ BOP and CSOSA should collaborate fully to address issues related to release, including: ○ Transportation between BOP site and CSOSA intake ○ Compliance with post-release plan ○ Housing ○ Clinical care	Identify ways to best support the services offenders most need.
		Expand Safety Net Program (this was a grant-funded substance abuse treatment program in the DC Jail that no longer exists)
		Develop similar program that would place SA offenders into other types of treatment options besides residential care
		Build CSOSA's efforts to "reach in" before offenders are released

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Establish a collaborative team of "safety net" providers who divide the clinical and fiscal responsibility among both agencies and coordinate the delivery of co-occurring treatment. ▪ Discuss and review literature on the unique demands of the dually diagnosed (e.g., addiction in the low cognitively functioning population requires a different approach than either traditional addiction models or ones appropriate for combination of addiction and mental illness). ▪ Explore drafting/re-drafting an MOU between APRA and DMH, making it clear exactly which roles each will play and the specific duties each will perform in delivering co-occurring treatment interventions. This would include delivery of services to dually-diagnosed hospital patients. ▪ Consider establishing a treatment coordinating council to monitor and quality control the policies and procedures established in the MOU to ensure treatment providers/CSAs are given the direction and support necessary. ▪ Explore conducting a "top-to-bottom" review of access points to DMH and APRA services (e.g., process to access APRA vouchers). ▪ Note that the COSIG grant is designed to address this issue from a systemic perspective. It is finishing the first of a 4-year effort and is already working on a sustainability plan. Mandate co-occurring treatment service delivery (Axis I and II) of certified programs. ▪ Discuss ways in which APRA can quickly acquire and/or train programs/providers who are certified to provide co-occurring services. (Note: Per reports, the COSIG grant process may resolve this issue in the future.) ▪ Discuss ways in which DMH can quickly acquire and/or train programs/providers who are certified to provide co-occurring services. ▪ If expanded areas of service delivery are required, consider the need for more training on co-occurring disorders.	▪ DMH/APRA to collaborate with CSOSA, BOP, USPC, DCJ, and PSA to ensure that appropriate integrated services are available for individuals with co-occurring disorders. Note: The report did not include DOC in this recommendation, which appears to be an oversight.	Develop programs for co-occurring disorders.
Develop electronic interfaces between the Jail's computer network and DMH and APRA computer networks so that information can be shared		Recommendation: Create better mechanisms for coordinated treatment from inside facilities to outside in the community.

CJCC SATMHSI TASKFORCE (AUGUST 2006)	GAP ANALYSIS (JANUARY 2007)	URBAN INSTITUTE (JANUARY 2004)
quickly. ▪ In preparation to take over the Jail's healthcare on October 1, 2006, Unity hopes to develop a software program that will establish an interface between the Jail and DMH computer systems. ▪ Automated transfer of information will require working out disclosure authorizations either from client or the court.		
▪ Develop a method for processing Jail inmates for Medicaid benefits so that there is not a major gap in services when residents who are eligible for Medicaid are released to community services.		
▪ Explore ways in which persons released from jail (with or without Medicaid) can access mental health medication immediately.		
	Develop standards for pre-sentence screening/assessment and effective inter-agency communications ▪ Adoption of a standard for assessment and reporting of mental disorders by Bureau of Prisons and CSOSA and, if possible, US Parole Commission and US Probation Officer ▪ Convene relevant agencies to review current PSI procedures to improve provider to provider communication which can facilitate full communication of clinical information across agencies and settings	
PHASE FOUR – AFTERCARE AND/OR AFTER RELEASE FROM CRIMINAL JUSTICE SYSTEM		
	Phase IV --- Post-Release/Aftercare: "Ex-Offenders" and "Ex-Defendants"	

CJCC SATMHSI TASKFORCE (AUGUST 2006)	GAP ANALYSIS (JANUARY 2007)	URBAN INSTITUTE (JANUARY 2004)
Develop appropriate mechanism to maintain services started in earlier phases of criminal justice supervision—how to ensure continued service delivery of needed resources to assist the individual in not again coming into the criminal justice system on a new charge.	Provide a system in aftercare to increase treatment adherence ▪ DMH should assume a role in monitoring, and supporting outpatient treatment ordered under Commitment ▪ DMH should also have a role in identifying individuals who would meet the standard of commitment by evidence of previous episodes of violence or other interactions with law enforcement that resulted from noncompliance with treatment ▪ DMH should communicate treatment plan non-compliance immediately to the Mental Health Commission ▪ Increase citywide capacity to case managers and ACT teams to make appropriate treatment referrals in general and under above proposed system of mandated treatment	
Ensure smooth transfer of primary responsibility from criminal justice system to DMH, APRA, and appropriate support services without forcing individual to "start over" with new assessments, referrals, and treatment regimens.	Promote referral and planning for clinical care and psychosocial referrals of forensic cases after release	
	▪ DMH Linkage Plus and its providers create a plan improving referrals to community providers through: ○ System to ensure immediate acceptance of patients ○ Attend to individual needs of referees ○ DMH Linkage Plus to provide as much information to referees as possible ○ DMH Linkage Plus, Unity, and DMH LP Providers, ACT teams, and assigned CSA to improve coordination of clinical information ○ DMH Linkage Plus, Unity (medical and psychiatric providers) and DOC Inmate Health Program Administrator to meet regularly (no less than weekly) to review potential referrals ○ Intensive education for all CSAs and ACTs regarding how to provide optimal care for ex-offenders	
	Work group established to identify mechanisms and resources needed to make appropriate referral and linkage for non-residents	
Explore out of the box ideas in meeting service needs, homelessness		

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concerns. ▪ Adopt "out of the box" thinking to address the pervasive problem of homelessness (e.g., turn closed/closing D.C. schools into tiered/staged shelters [i.e., emergency shelters, stabilization shelters, family shelters, and transition shelters]). ▪ Explore with the D.C. Council other (mutually beneficial) ways to look to existing (unutilized, underutilized, or simply overlooked) City resources to meet the overwhelming and chronic housing needs of its residents.		
Develop options for housing (housing is in actuality critical in all phases of the system).		