SUBSTANCE ABUSE TREATMENT AND MENTAL HEALTH SERVICES INTEGRATION TASKFORCE

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COMPLETED ROUNDTABLE DISCUSSION WORKSHEET

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The CJCC Substance Abuse Treatment and Mental Health Services Integration Taskforce Completed Roundtable Discussion Worksheet

The purpose of the Roundtable Discussion is to discuss the issues and recommendations identified in the Preliminary Report of the CJCC Substance Abuse Treatment and Mental Health Services Integration Taskforce to determine how to proceed with addressing them. In order to prepare for a most productive meeting, this worksheet was developed to serve as a mechanism for gathering additional information from participating agencies that could help to clarify the issues and enable meaningful discussion.

The worksheet reflects all of the challenges, gaps and suggestions that were presented in the Taskforce Preliminary Report and are organized by where they occur in the criminal justice process – at arrest/pre-booking, community supervision and treatment, jail, or post-release/aftercare. After the release of the Preliminary Report, all of the agencies were given an opportunity to provide additional comments for each of the suggestions. A concerted effort was made to capture accurately the intent of the comments provided from all agencies. These comments are presented in this worksheet.

PHASE 1: ARREST/PRE-BOOKING	
Challenge 1 **Pre-Booking Crisis Intervention Teams - The Memphis Model***	
Gap: Persons charged with low-level crimes do not receive screenings and services for mental health and substance abuse services and continually rotate unnecessarily through the criminal justice system. There is no coordinated crisis response/assessment (outreach) team that can assist the police in diverting mentally ill persons from the criminal justice to the mental health system.	
Suggestions	**Additional Comments**
1. Train the police in handling the mentally ill.	a) 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. b) Discuss the "holistic" role of police as first responders. c) 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? d) Re-establish the 8 hours of mental health training provided by DMH at MPD's Academy. e) Train CPEP, and DMH and community CSAs on civil commitment procedures and petitioning for outpatient civil commitments. f) Consider training dispatchers to better determine mental health versus police emergencies. g) Explore various models and best practices for approaches to police response to the handling of the mentally ill. h) 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 community groups such as the Alliance on Mental Illness (NAMI)-DC chapter. i) 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. j) Minimize MPD incentives to paper cases in lieu of MH assistance (e.g., minimize waiting time for police officers).

* In 1988, the Memphis Police Department joined in partnership with the Memphis Chapter of the Alliance on Mental Illness (AMI), mental health providers, and two local universities to organize training and implement a specialized Crisis Intervention Team (CIT) Unit. The purpose of the CIT is to develop a more intelligent, understandable, immediate and safe approach to mental crisis events that supports residents' well-being, and setting a standard of excellence for police officers with respect to treatment of individuals with mental illness.

2. Build up crisis response/assessment (outreach) teams to assist the police.	a) Explore how a rapid emergency response team comprised of staff form various critical agencies could be capable of reporting to crime scenes 24 hours/day, how they could be funded, and whether they could be centralized, and/or mobile. b) Explore what models are in place in other cities and could best be considered for DC. c) Explore the development of city-wide wraparound services. d) Consider establishing resource for mental health professionals to conduct street level assessments with police officers, real time, which could minimize the incidents of incorrect assessments.
3. Equip CPEP with the staff and the resources to replicate the Memphis Model for the District of Columbia.	a) Fully explore from all agencies' perspectives the desirability and viability of replicating the Memphis Model in DC. For example, San Diego's PERT model could be explored for DC. b) Explore ways to reduce police time needed to place suspects into the care of CPEP. c) 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? d) 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.

4. 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 and/or hospitalization.	a) 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. b) Develop standards for interagency information sharing (e.g., criminal history). c) 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. d) 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. e) 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.

<table>
<tr><th colspan="2">PHASE 2: COMMUNITY SUPERVISION AND TREATMENT</th></tr>
<tr><th colspan="2">Challenge 1
Expedited Treatment Assessments and Placements for Criminal Justice Involved Residents</th></tr>
<tr><td colspan="2">Gap: Research supports that persons involved in criminal activity who (ab)use alcohol and other drugs place the public's safety at much greater risk than persons who do not. Yet, both populations receive treatment assessments and placements at the same speed.</td></tr>
<tr><th>Suggestion</th><th>Additional Comments</th></tr>
<tr><td>1. Expedite the treatment referral, assessment, and placement process for residents involved in the criminal justice system.</td><td>a) 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.
b) Discuss strategies for reviewing and enforcing the MOU between CSOSA, PSA and DMH so that persons in need of MH services are seen within 24 hours.
c) 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.
d) 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).
e) Make certain that DMH completely has solved reimbursement mechanism for CSAs with regard to waiting time at the Court.
f) Implement a process to expedite criminal justice referrals, including DC misdemeanor and traffic cases, to APRA.
g) Complete the MOU that is being developed between APRA, CSOSA and PSA for expediting criminal justice referrals.
h) 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.</td></tr>
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PHASE 2: COMMUNITY SUPERVISION AND TREATMENT	
Challenge 2 **DC Misdemeanor Offenses (Quality of Life Crimes)**	
Gap: In an effort to provide D.C. residents/arrestees the proper services as well as to reduce recidivism, mental health and substance abuse assessments of persons charged with traffic and "quality of life" crimes in the D.C. Misdemeanor Community Court should be conducted immediately so that diversion opportunities can be offered.	
Suggestion	**Additional Comments**
1. Dedicate and co-locate APRA and DMH staff at the courthouse to conduct substance abuse and mental health assessments and start the Medicaid eligibility process.	a) Develop estimates from OAG as to how many screenings would be needed each day. b) 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. c) Determine how to obtain urine samples at lock-up from DC misdemeanor and Traffic Court defendants to detect (early) substance abuse (SA) problems. d) Implement a process to expedite APRA and DMH services. e) Consider locating APRA staff at the Court to conduct assessments and referrals, as DMH does presently. f) Consider location DHS/IMA staff at the court to begin process for Medicaid eligibility and linkage to DC Alliance. g) 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. h) For any changes in assessment procedures at the Court, factor in impact on the arraignment process.

PHASE 2: COMMUNITY SUPERVISION AND TREATMENT	
Challenge 3 **Immediate Access to DMH Services**	
Gap: The MOU between PSA, CSOSA and DMH calls for client linkage to Core Service Agencies (CSA) within 24 hours, yet this often takes place anywhere from seven (7) days to six (6) weeks after referral. The gate-keeping function appears to be obstructive of patients' receiving needed services expeditiously, and wait lists are long at the public core services agencies.	
Suggestions	**Additional Comments**
1. Develop a system that better rewards public core service agency professionals for working with this tough population. Bring on more staff and significantly reduce high caseloads.	a) Review DMH recruitment constraints to reduce caseloads said to be at 100 or more. b) Revisit the DMH policy which, currently, is said to call for the development of a new treatment plan on all 3,800-4,000 DMH clients every 90 days. c) CSA staff could develop a specialized team comprised of CSA staff that is willing to work with this population and provide them with specialized training and appropriate support.
2. Ease client access to treatment services by removing those layers of bureaucracy that are unnecessarily encumbering (e.g., authorization for all mental health treatment moves through the Access Helpline, but it is often difficult for clients to get through). The gate-keeping function needs to be redesigned.	a) Discuss whether more stringent and effective quality controls around the Access Helpline and enrollment for priority populations would improve its effectiveness. b) Explore ways to improve the doctor-to-patient response time at DMH, perhaps reduce the intake process to 30 minutes (Note: The telephone/screening intake form is said to take 1.5 hours to complete and the diagnostic assessment another 1.5 hours). c) Explore options for abbreviating and/or expediting the processing time for required reports. d) Reduce the time between the Intake and the clinical manager's window to establish contact to initiate the client's treatment services (Note: According to DMH staff, the time between Intake and service delivery very well could take 4-6 weeks). e) Explore the adoption of a city-wide "urgent care" (i.e., same-day service) model. f) Explore reducing the number of Core Service Agencies (CSA) who serve the criminal justice population to a smaller number, and provide appropriate training about the criminal justice system. g) Discuss removing what are said to be inordinately stringent criteria for admissions, placement and length of stay around the use of the 16 existing emergency crisis beds at Crossing Place and the 16 beds at So Others Might Eat (SOME) (Note: Some report that half or more are empty much of the time). h) If full redesign of gate keeping function is not feasible, consider a redesign simply to target court-involved persons. This population is worthy of priority treatment because their court-involvement raises public safety issues.

PHASE 2: COMMUNITY SUPERVISION AND TREATMENT	
Challenge 4 Bifurcated Co-Occurring Treatment Services	
Gap: Clients with co-occurring problems are treated by APRA and DMH separately. There are no services for the dually diagnosed.	
Suggestions	**Additional Comments**
1. 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.	a) 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). b) 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. c) 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. d) 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. e) Explore conducting a "top-to-bottom" review of access points to DMH and APRA services (e.g., process to access APRA vouchers). f) 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.
2. Mandate co-occurring treatment service delivery (Axis I and II) of certified programs.	a) 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.) b) Discuss ways in which DMH can quickly acquire and/or train programs/providers who are certified to provide co-occurring services. c) If expanded areas of service delivery are required, consider the need for more training on co-occurring disorders.

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<tr><th colspan="2">PHASE 2: COMMUNITY SUPERVISION AND TREATMENT</th></tr>
<tr><th colspan="2">Challenge 5
ACT Teams: What Happened?</th></tr>
<tr><td colspan="2">Gap: How well are they functioning, if they're currently functioning at all?</td></tr>
<tr><th>Suggestions</th><th>Additional Comments</th></tr>
<tr><td>1. Develop wraparound services for the criminal justice population so that mentally ill persons can be treated in the mental health system.</td><td>a) Discuss Identifying and streamlining a smaller number of CSAs to focus on the overwhelming needs of the criminal justice MH population.
b) Explore ways to make housing a system-wide service goal, rather than an Options Program perk.
c) Develop new or re-design old partnerships with advocacy groups like the Red Cross and Coalition for the Homeless. (Note: There is concern that MH misdemeanants committing DC Code and Traffic crimes [especially the homeless] end up in jail).
d) Consider "out of the box" strategies to address the pervasive problem of homelessness (e.g., turning closed/closing D.C. schools into tiered/staged shelters, emergency shelters, stabilization shelters, family shelters, and transition shelters).
e) Explore ways in which APRA and DMH could utilize transportation services to help unstable individuals get to their appointments and treatment sites.
f) Ensure that individuals who have histories of non-compliance with community-based services have access to intensive community programs such as ACT Teams. Publicize the process for accessing the ACT Teams.
g) ACT Team treatment plans should specify the amount, frequency and type of contacts with the client and require documentation to verify contacts.</td></tr>
<tr><td>2. Implement fully-dedicated ACT Teams for the criminal justice population that will monitor defendant/offender compliance and report back to the court and PSA/CSOSA as appropriate.</td><td>a) Clarify ACT Team objectives and the criteria for and obstacles to accessing these services.
b) Clarify the "gatekeeper" function in providing these services.
c) Clarify the function and operation of ACT Teams (e.g., do they contain substance abuse counselors as well as mental health professionals, and what is capacity, length of stay, services provided, etc.).
d) Consider the addition of a CAC II addictions staff to each ACT team.
e) Provide training of providers and criminal justice agencies regarding how to understand the service and compliance needs of this population.</td></tr>
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<tr><th colspan="2">Challenge 6
Too Many CSAs – Can They Afford to Do the Right Thing?</th></tr>
<tr><td colspan="2">Gap: It is believed that because there are so many core service agencies under DMH, the quality control/improvement process suffers. As well, some core service agencies refuse to treat indigent clients for fear of not being reimbursed by DMH.</td></tr>
<tr><th>Suggestions</th><th>Additional Comments</th></tr>
<tr><td>1. Reduce the number of core service agencies to a number that's manageable by DMH.</td><td>a) Review how and why some CSAs are unused or underutilized and examine ways to ensure they receive the direction and support necessary to make them viable, comprehensive competitors.
b) Provide DMH CSAs with an instruction/billing mechanism which results in a contact with the police being a sentinel event requiring that the CSA employs a protocol designed to address consumers differently, more intensively, who run afoul of the law.
c) Examine why other CSAs function well but can only serve only small, discreet populations.
d) Enhance training of CSAs about the criminal justice system and the needs of the defendant/offender population.
e) DMH might consider emulating APRA's efforts in developing Centers of Excellence, one of which is the Center for Performance Improvement and Standards. APRA also has actively supported the creation of the Providers' Consortium, which is a proactive effort of community providers to organize and collaborate.</td></tr>
<tr><td>2. Improve fiscal management to guarantee no gaps in payment to private core service agencies.</td><td>a) Explore ways to increase the allocation of local dollars to provide services to this population who may not be Medicaid eligible.</td></tr>
<tr><td>3. Make certain service requirements (e.g., the acceptance of D.C. Alliance as well as Medicaid clients) mandatory across the board.</td><td>a) Explore ways to enable D.C. Alliance to cover MH and SA services for persons not eligible for Medicaid.
b) Explore stopgap measures for D.C. Alliance clients since they currently are not covered for mental health and substance abuse treatment.
c) Explore other "safety net" options for D.C. Alliance clients.
d) Consider conducting an exploratory effort to determine what targeted services are required to ensure more consistent responses for this population.</td></tr>
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<tr><th colspan="2">Challenge 7
Medicaid's "Five Finger Test"</th></tr>
<tr><td colspan="2">Gap: According to the IMA Office, if a person has not been a resident of the District of Columbia for 5+ years, he/she may not be eligible for Medicaid, despite meeting the criteria of being (1) aged; (2) blind; (3) disabled; (4) a child; or (5) a parent/caretaker.</td></tr>
<tr><th>Suggestion</th><th>Additional Comments</th></tr>
<tr><td>1. Review the current Medicaid enrollment process to make the eligibility criteria more comprehensible (e.g., ensure clients know if their disability makes them eligible for Supplemental Security Income and, if so, how to apply for it).</td><td>a) Explore ways to better connect criminal justice and social services agencies with the Department of Health's (DOH) Medicaid Office, highlighting the Medicaid Office's agency-by-agency trainings, discussing the Medicaid enrollment process.
b) Discuss the transition of D.C. Alliance clients from Alliance providers to Medicaid providers. (Note: According to reports, persons with D.C. Alliance at times have to switch providers once they become eligible for Medicaid).
c) Examine whether referring entities are encouraging their staff (in the normal course of conducting screenings/assessments) to complete and forward Medicaid applications on those residents for whom eligibility is suspected.
d) Discuss ways in which DOH in conjunction with DHS might develop "Job Aids" around the entire Medicaid eligibility process and specifically the question of disability and how to pursue enrollment for the homeless.
e) Many service agencies need to be better informed about the Medicaid enrollment process so that this can be incorporated into their service provision.</td></tr>
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<tr><th colspan="2">Challenge 8
Simplify the Referral Process</th></tr>
<tr><td colspan="2">Gap: Due to the complexity of the DMH referral/treatment process, clients most in need of services often go without them. For example, Crossing Place and So Others Might Eat (SOME) have a total of sixteen (16) crisis beds available for persons in psychiatric crisis situations, yet half are reportedly empty all the time.</td></tr>
<tr><th>Suggestion</th><th>Additional Comments</th></tr>
<tr><td>1. Remove the unnecessary layers/encumbrances in the referral process.</td><td>a) Investigate what is said to be inordinately stringent admissions criteria around the use of the 16 existing emergency crisis beds at Crossing Place and the 16 beds at So Others Might Eat (SOME) (Note: According to some reports, half or more are empty much of the time).
b) The referral process for usage of the crisis beds has been modified as of 8/11/06. However, it might be worthwhile to evaluate, explore and review utilization of the crisis beds and determine how to maximize access.
c) Many service agencies need to be better informed about the DMH referral process, including criteria and procedures for enrollment.</td></tr>
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PHASE 2: COMMUNITY SUPERVISION AND TREATMENT	
Challenge 9 **Treatment Access for the Criminal System Involved**	
Gap: Access to APRA-funded services is at times denied, delayed or otherwise limited for those D.C. residents who disclose their justice system involvement.	
Suggestion	**Additional Comments**
1. Clarification with vendors of APRA's commitment to treat D.C. residents, notwithstanding their involvement in the criminal justice system.	a) CSOSA and PSA have developed with APRA a tentative strategy for ensuring that D.C. residents involved with the justice system have access to APRA-funded services. b) It would be helpful to make available a resource that provides information about APRA's treatment providers and how to access their services. c) It would be useful to include criminal justice information in the Provider Forum Training Institute in development by APRA.

PHASE 2: COMMUNITY SUPERVISION AND TREATMENT	
Challenge 10 **A Poor Assessment and Treatment Information Sharing System**	
Gap: Due to extraneous variables, it is difficult for criminal justice partners to access APRA's intake appointment outcomes, detox status reports, assessment and voucher results, case manager assignment and compliance information.	
Suggestions	**Additional Comments**
1. Develop safe, electronic interfaces for sending and receiving useful clinical and compliance information.	a) CSOSA, PSA and APRA collaboratively are in the process of exploring the feasibility of automating referrals to APRA. b) If CSOSA and PSA automate their paper referrals to APRA, then APRA has agreed tentatively to forward to CSOSA and PSA periodic updates of defendant's intake appointment outcomes, detox status reports, assessment and voucher results, case manager assignment and compliance information. What can be done in the meantime? c) DMH and DOC should develop a system whereby the agencies use each other's information to facilitate identification and treatment. d) Automation of referrals will require working out disclosure authorizations either from client or the court. e) Consideration can be given to asking the Center for Innovation and Reform (CIR) in the Office of the City Administrator to assist with reviewing business processes where there are bottlenecks and redundancies.
2. Clarify with APRA vendors the responsibility to share compliance information with appropriate supervisory criminal justice partners and the courts.	a) If CSOSA and PSA automate their paper referrals, then APRA has agreed tentatively to ensure that its vendors share compliance information. What can be done in the meantime? b) Ensure that APRA vendors also share compliance information on the DC Misdemeanor and Traffic charges with the Court and OAG. c) Consider establishing a universal consent form that allows efficient access to client information. Establish a relationship with supervision staff to ensure that the APRA treatment system is aware of the client's criminal justice status at the time of referral.

PHASE 2: COMMUNITY SUPERVISION AND TREATMENT	
Challenge 11 Varying Assessment Instruments	
Gap: Because APRA uses the GAIN-Q and the GAIN-I as well as other evaluations to determine level of care recommendations, clients assessed by CSOSA or PSA with different assessment instruments are not automatically given clinical reciprocity. Meaning, for example, clients whose cases are dismissed while they are in treatment currently have to exit treatment to report to APRA's Assessment and Referral Center (ARC) to be assessed again by APRA before being placed back into treatment.	
Suggestions	**Additional Comments**
1. Designate and legitimize acceptable universal assessment instruments across agencies.	a) CSOSA and PSA have agreed tentatively to explore the possibility of moving from the Assessment Severity Index (ASI) assessment tool to the GAIN-Q or the GAIN-I. b) Consider establishing a universal consent form that allows efficient access to client information. Establish a relationship with supervision staff to ensure that the APRA treatment system is aware of the client's criminal justice status at the time of referral.
2. Develop a process for smoothly transferring to APRA fiscal responsibility of CSOSA/PSA clients in treatment without having them first exit treatment, be subsequently assessed at the ARC, and potentially move onto a waiting list for re-placement.	a) If CSOSA and PSA utilize the GAIN-Q, GAIN-I or another ASAM-consistent assessment instrument and automate their paper referrals, then APRA tentatively has agreed to execute placements (i.e., issue a treatment voucher and execute treatment placements) based solely on the CSOSA or PSA assessment recommendation. (Note: This would afford clients a smoother transition to APRA treatment from pretrial or probation.) b) APRA's goal is to develop CSOSA and PSA as a satellite intake sites for APRA which can refer clients directly to treatment and issue Drug Treatment Choice vouchers to certified Substance Use Disorders providers.

PHASE 2: COMMUNITY SUPERVISION AND TREATMENT	
Challenge 12 **Different Release of Information**	
Gap: Currently, APRA, CSOSA and PSA all use different releases of information, making it difficult at times to obtain client progress and compliance information.	
Suggestion	**Additional Comments**
1. Create a universal release of information form or encourage APRA to accept releases from individual criminal justice agencies.	a) A universal release of information has been drafted by APRA and should be made available for consideration soon. (Note: This must comply with HIPPA and the Mental Health Information ACT regulations for release of mental health and substance abuse information.) b) Must account for issues surrounding sharing information between DMH and DOC.

PHASE 3: JAIL	
Challenge 1 **Mental Health Assessments at the D.C. Jail**	
Gap: DMH has assigned two (2) of its staff (mental health liaisons) to facilitate continuity of care operations for the 30-33% of the Jail population receiving mental health services while incarcerated. There is no comprehensive system in place to move mentally ill persons from the jail to wraparound mental health services in the community.	
Suggestions	**Additional Comments**
1. Unity Healthcare will be hiring considerable staff to tackle this and other healthcare assessment and service provision issues in the DC Jail.	a) Because it is reported that, currently, MH Liaisons have to review the Jail's list manually and establish contact with DMH headquarters via telephone, the system-connection speed is particularly slow. b) In response to this problem and in taking over the Jail's healthcare, Unity hopes to develop a software program that will establish an interface between the Jail and DMH computer systems. c) Unity is hiring 5.5 clinicians who will conduct assessments and direct treatment and 9 discharge planners to facilitate connection to community services upon release (particularly for the homeless who, according to reports, represent a significant portion of the Jail's MH Unit). d) DMH intends to develop a MOU to determine what services will be provided by Unity and how DMH will interface with Unity's program.
2. Strengthen the process of jail mental health evaluations and the speed with which inmates are connected to services on release.	a) 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). b) Identify a smaller number of CSAs who are trained to focus on the service needs of this population. c) 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.) d) 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 the courts, etc.).

3. Develop automatic, electronic interfaces between the Jail's computer network and DMH and APRA computer networks.	a) 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. b) Automated transfer of information will require working out disclosure authorizations either from client or the court.
4. Begin helping inmates apply for Medicaid/DC Alliance as soon as they enter the Jail.	a) 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). b) Will Income Maintenance Agency staff be co-located at the jail to assist inmates to apply for Medicaid/DC Alliance? If application paper work cannot be processed until the date of release, how can the system ensure that Medicaid-eligible inmates are provided services immediately upon release? c) Who is responsible for helping DC Jail inmates apply for Medicaid/DC Alliance benefits?

PHASE 3: JAIL	
Challenge 2 **"One Stop Shop" and then what?**	
Gap: Unity Healthcare maintains a "one stop shop" at the Phoenix Program on the grounds of D.C. General Hospital where inmates being released from Jail with medical or substance abuse problems can go to receive referrals for treatment. However, waits can be long. Physician referrals are necessary for more than very limited quantities of psychotropic medication, and persons without Medicaid appear to have fewer options since DC Alliance does not cover mental health and substance abuse treatment.	
Suggestion	**Additional Comments**
1. Better coordination has to be developed for services after release from jail. Unity Healthcare's involvement with DMH and APRA will be essential.	a) 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-time physician to conduct evaluations and prescribe medications, and medication prescriptions are effective for only 7 days). b) 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? c) Discuss ways to enable D.C. Alliance to cover the costs of medications, despite its inability to cover MH services. d) Explore ways to better collaborate with DMH and pool (rather than duplicate) resources in addressing the overwhelming needs of jail releasees. e) DMH plans to develop a MOU with Unity regarding the coordination of mental health services and linkage in the community. f) Consider attaching an APRA Substance Use Disorders intake staff to the Unity site for immediate assessment and referral.

PHASE 3: JAIL	
Challenge 3 **Substance Abuse Assessments at the D.C. Jail**	
Gap: APRA does not come to the Jail to conduct substance abuse assessments.	
Suggestion	**Additional Comments**
1. Undertake comprehensive planning for how to best effectuate linkages to and from the planned therapeutic communities in the D.C. Jail.	a) Clarify APRA's and/or DOC's support of or involvement in providing therapeutic community treatment services. b) Explore whether APRA can conduct the SA (GAIN-I or GAIN-Q) assessments in the Jail that will follow clients into the community. c) Clarify the roles and responsibilities of APRA and Jail personnel. d) Discuss linkages to APRA-funded SA services from the Jail, and explore ways to best effectuate those linkages. e) 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. f) Consider training Jail staff to conduct substance abuse assessment and work with APRA to facilitate linkages.

PHASE 4: POST-RELEASE/AFTERCARE	
Challenge 1 **Insufficient Aftercare/ Transitional Housing Opportunities**	
Gap: There is a need for an array of aftercare "maintenance" opportunities for mentally ill populations and those with substance abuse histories.	
Suggestion	**Additional Comments**
1. Develop better funding mechanisms for ongoing substance abuse and mental health care.	a) Explore ways for DMH and APRA to recruit and/or train additional grant researchers and writers. b) Discuss ways to better utilize individual agencies and the CJCC in exploring grant and other funding streams.
2. Enable DC Alliance to provide such care.	a) Explore with the D.C. Council better ways to generate and allocate appropriations/resources to address the SA and MH needs of those clients not eligible for Medicaid. b) Explore "out of the box" (perhaps even private, non-profit) ideas in meeting service needs, establishing programs such as the *pro bono* legal and mental healthcare systems like other states/jurisdictions adopt when the demand is greater than the supply.
3. Develop options for housing (housing is a critical issue throughout all phases of the system).	a) 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]). b) 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.