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Council for Court Excellence
Improving Justice for the Community

Statement of the Council for Court Excellence
Before the Committee on Health
of the Council of the District of Columbia

Performance Oversight Hearing for the
Department of Behavioral Health

February 12, 2019

Good morning, Chairman Gray and members of the Committee. My name is Adam Bernbaum, and I serve as a policy analyst for the Council for Court Excellence (CCE). For the past 37 years, CCE, a nonpartisan, nonprofit, civic organization has identified and proposed justice system solutions by collaborating with diverse stakeholders to conduct research, advance policy, educate the public, and increase civic engagement. As is our practice, no judicial members of the CCE Board of Directors participated in the formulation of this testimony.

Our testimony today addresses four issues related to the Department of Behavioral Health (DBH). First, we discuss DBH's efforts towards implementation of recommendations that the Auditor and CCE made in our 2018 report. Second, we'll tell you about new research underway and the importance of DBH improving how it collects, analyzes and shares behavioral health information. Third, we address some concerns about DC's pre-arrest diversion pilot program. And finally, we talk about the hiring of a new permanent Director for the agency.

Implementation of 2018 Recommendations

As you likely recall, beginning in 2016, CCE contracted with the Office of the D.C. Auditor (ODCA) to review the effectiveness of the Department of Behavioral Health's (DBH) interactions with the criminal justice system and the services it provides to justice-involved people. *Improving Mental Health Services*

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and Outcomes for All: The D.C. Department of Behavioral Health and the Justice System, a report of our findings and recommendations, was published in February 2018 and has been presented to this Committee. CCE has met with and sought to work with staff at DBH over the last year to support their efforts to implement the recommendations.

In April 2018, CCE met with representatives from DBH and the Office of the Deputy Mayor for Health and Human Services (DMHHS) to discuss the District's progress toward implementing 44 of the 77 recommendations from our report with which DBH agreed or agreed in part. At that time, we were pleased to report that DBH and DMHHS had developed a plan for implementation for each of the 44 recommendations, a handful of which were in progress. Last summer, we were gratified to receive informal feedback from several judges that they perceived an improvement in some of the issues surrounding competency evaluations at the court following publication of the report, which should be credited to DBH's efforts.

Finally, during the fall CCE was invited to a strategic planning session hosted by DBH and met with a newly hired FUSE fellow working within the Division of Forensic Services. We saw these as promising steps the agency was undertaking. Unfortunately, DBH provided the last update on the status of these efforts in October 2018. Of course, we recognize that DBH has lacked a permanent director since November 30, 2018, but implementation of these recommendations is too important to lose momentum and fall by the wayside. We look forward to sitting down soon with DBH leadership to receive a progress update and discuss any hurdles to implementation.

New Review of Substance Use Disorder Service Provision

Since we last appeared before this Committee, CCE has once again partnered with ODCA to undertake a new evaluation of the District's provision of substance use disorder services for justice-involved consumers. A 2012 study by the Vera Institute of Justice concluded that around

one-third (1/3) of individuals arrested in D.C. have some mental health care need.[1] We seek to get more up-to-date information about the mental health and substance use disorder treatment needs of justice-involved people in the District, and a better understanding of how that particularly vulnerable population is being served in our city. Effective substance use treatment before, during, and after criminal justice system involvement can help our city reduce crisis health care costs and fatalities, costs for future criminal proceedings, costs for incarceration, and result in safer, healthier communities.

This new review of substance use disorder (or "SUD") services is ongoing, having kicked off in October 2018, and involves interviews with community stakeholders, SUD providers, consumers, and DBH and other DC agency administrators, along with legal review, a jurisdictional comparison, and quantitative analysis of relevant data. We look forward to sharing the results of this review with this Committee and the public once it is completed. We hope that this substance use project will lay the groundwork for a renewed emphasis on the behavioral health of D.C.'s justice-involved residents. Such an emphasis requires developing a durable and innovative behavioral health infrastructure which can anticipate and preempt crises like the opioid epidemic that the District is currently experiencing. This infrastructure must also be flexible enough to incorporate new innovations in behavioral health practices as they emerge, and compassionate enough to win the trust of the District's residents.

Data-sharing Concerns

DBH's behavioral health information systems and practices are a specific example of one domain in which D.C. could become more responsive and innovative. These systems are currently fragmented and data is not consistently compared and analyzed across agencies, posing unique challenges for providers of behavioral health services. Just last year, after a methodological review working with District agencies, the Vera Institute of Justice concluded that, "behavioral health

[1] Parsons, Jim, and Talia Sandwick, "Closing the Gap: Using Criminal Justice and Public Health Data to Improve the Identification of Mental Illness," Vera Institute of Justice, July 2012.

information was widely held throughout the D.C. justice and health systems" and yet, that information "was relatively siloed."[2] This failure to integrate sources of information is an important problem worth correcting, because data-sharing is not just a complement to adequate provision of behavioral health services, it is a core-component of them. This is especially true of organizations that serve justice-involved consumers, many of whom have co-occuring behavioral health and non-behavioral health morbidities, problems with housing, and other chronic challenges. When these problems are addressed in isolation, agencies can miss critical insights about their clients.

To give an example: there is no reference in the "Live. Long. DC" opioid crisis strategic plan released by the District in December to the association between justice-involvement and opioid overdoses in the District, nor about the association between alcohol use and arrests in the District, despite the known links in other jurisdictions between overdoses and alcohol consumption, on the one hand, and incarceration and arrest on the other.[3] To our knowledge, DBH has published no report or strategic document in the past 10 years on this topic, despite the fact that the relative risk of drug overdose death for recently released inmates compared to the general population is 129:1 based on national data. On average, that means that a person is 12,900% more likely to have a drug overdose if that person is within the first 2-4 weeks of release than if the person is a member of the general public. This finding is not new; it received mainstream coverage and a special note in the New England Journal of Medicine in 2007.[4] Yet we can find no evidence that DBH has sought to study this association in its own consumers. Similarly, alcohol has been implicated in 56% of incarcerations nationwide,[5] but we are not aware of any DBH publications or initiatives that

[2] Sinkewicz, Marilyn, Yu-Fen Chiu, and Leah Pope, "Sharing Behavioral Health Information Across Justice and ,Health Systems: Opportunities in the District of Columbia," Vera Institute of Justice, December 2018.
[3] *See* https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/LIVE.%20LONG.%20DC-%20Washington%20DC%27s%20Opioid%20Strategic%20Plan.pdf.
[4] Binswanger, Ingrid, Marc Stern, Richard Deyo, Patrick Heagerty, Allen Cheadle, Joann Elmore, and Thomas Koepsell, "Release from Prison- A High Risk of Death for Former Inmates," *New England Journal of Medicine* 365, no. 2 (2007).
[5] The National Center on Addiction and Substance Abuse at Columbia University, "Behind Bars II: Substance Abuse and America's Prison Population," 2010.

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examine or address the role of alcohol use disorders as a driver of justice-involvement in the District.

To gain a better understanding of these issues in D.C. and the intersections between substance use disorders and justice-involvement, DBH cannot simply rely on its own data or national data. This is why data-sharing between agencies is critical to paint the full – or at least fuller – picture. We encourage the District to continue supporting agency efforts to collaborate, as well as their efforts to improve inter-agency data matching and data analysis with the Criminal Justice Coordinating Council, the Auditor's office, and outside organizations, like CCE. Through these efforts, we hope that DBH will be able to learn more about the complex needs of the residents it serves, and adopt programs that are even more effectively tailored to meet those needs.

DBH and MPD's Pre-Arrest Diversion Program

Since April 2018, DBH and MPD staff have piloted a pre-arrest diversion (PAD) program that was designed to have two entry points for participants.[6] First, instead of being arrested on the scene of an incident, people who have mental health conditions or substance use disorders could be diverted to needed services upon becoming a suspect in certain minor crimes. This diversion would be in lieu of an arrest, with no arrest, booking, or charges being filed at that point. Second, participants could be connected through a "social referral" where DBH or MPD identifies their potential need for support outside of the context of an arrest.

We are happy to hear that 69 officers have received PAD training so far and MPD and DBH leadership supports the program. CCE understands that 71 people have been enrolled in the program to date and we are eager to see reports on PAD's outcomes. While CCE fully supports MPD and DBH's efforts to develop the social referral program, we want to emphasize that this effort should complement, not substitute for, what we would consider a true pre-arrest diversion program.

[6] *See,* https://dhs.dc.gov/page/dc-pre-arrest-diversion-pilot-program.

After nearly a year of operation, it is our understanding that fewer than 10 people have been actually diverted for treatment in lieu of arrest, as opposed to being referred to the program through a social contact. We understand the pilot is a work in progress, and that the pre-arrest diversion component will continue to be developed with time. We hope this is true. Diversion in lieu of arrest should be the program's center, and we are troubled that it seems to have been forced to the periphery and underemphasized as the primary purpose.

We are also concerned that data critical to a robust evaluation of the program is not being collected. To give an example: it is unclear why the number of diversions is so low. Two critical pieces of data could provide a window into what is happening: first, the number of individuals arrested by PAD trained officers who were eligible for diversion but did not receive it, and second, the number of individuals who have been offered diversion, whether they accept it or not. These are both important evaluation questions to ask, especially during a pilot period, and, as best we can tell, neither PAD's outside evaluator, (the Lab), MPD nor DBH are collecting these data points..

CCE encourages DBH and MPD to facilitate open lines of communication with community stakeholders and get support in helping hone and improve the PAD pilot. While the program's managers have made strides in this direction, critical decisions related to pre-arrest diversion are still being made with no input from the network of social workers, medical professionals, advocates, and justice-involved people who encounter these issues every day. For example, we learned last month that the program no longer plans to move forward with active outreach to people identified by data systems as being at high risk of future arrest. This decision was made with no community input or comment. Programming designed to foster community trust and engagement requires input from the individuals it seeks to serve. CCE is hopeful that this engagement will continue to grow, and that we will see the success of the PAD program grow with it.

Qualifications of the New DBH Director

As the Mayor considers candidates to serve as the permanent DBH Director, and Council prepares to consider the eventual nominee, CCE encourages the prioritization of certain traits, values, and skills in selecting the next director. These recommendations are based on information obtained in the course of our research for *Improving Mental Health Services and Outcomes for All: The D.C. Department of Behavioral Health and the Justice System*, as well as feedback from the D.C. Reentry Action Network, a coalition of community based reentry service providers.[7]

Specifically, CCE encourages the District to hire a DBH Director that will prioritize community-based services and minimize institutionalization, whenever possible. Policy changes and greater oversight by the leadership of DBH (and partner agencies, including the courts and the Dept. of Corrections) is needed to avoid prolonged and sometimes repeated institutionalizations and incarcerations of D.C. residents who have psychiatric disabilities, including those who are in limbo in the justice system, either awaiting competency determinations, restoration of competency care, or other determinations of their abilities to be in the community while getting care.[8]

CCE also hopes that the person selected will bring energy, focus, and evidence-based strategies to address the significant and growing problem of drug overdoses in the District.[9] CCE and its reentry partner organizations have been monitoring innovative practices from across the country and would welcome DBH leadership's employment of new strategies that have proven successful

[7] Office of the District of Columbia Auditor and the Council for Court Excellence, *Improving Mental Health Services and Outcomes for All: The D.C. Department of Behavioral Health and the Justice System*, 2018, http://dcauditor.org/wp-content/uploads/2018/09/DBH.Report.2.26.18.pdf.
[8] *Id.*
[9] *See, e.g.*, Clarence Williams, *Dozens in D.C. taken to hospitals in new spike of suspected synthetic marijuana overdoses*, Washington Post (Sept. 13, 2018), https://www.washingtonpost.com/local/public-safety/dozens-in-dc-taken-to-hospitals-in-new-spike-of-suspected-synthetic-marijuana-overdoses/2018/09/13/907e1cfc-b79a-11e8-94eb-3bd52dfe917b_story.html?noredirect=on&utm_term=.0219100c4bec; Peter Jamison, *An opioid epidemic nobody talks about*, Washington Post (Dec. 18, 2018), https://www.washingtonpost.com/graphics/2018/local/opioid-epidemic-and-its-effect-on-african-americans/?utm_term=.d8b3c5e6710e.

elsewhere, including, for example, offering anti-addiction medication and treatment in emergency rooms[10] and pairing needle exchanges with treatment.[11]

The new DBH Director should also bring significant skills in leveraging and navigating the complex federal and local funding streams to improve service provision and incentivize evidence-based mental health providers to remain operational in our city. Our research found that there have been onerous restrictions placed on the use of local dollars for providers to assist people with mental illness in preparing to leave St. Elizabeth's Hospital and the D.C. Jail who were not yet eligible for Medicaid.[12] Some providers have experienced delays in receiving reimbursements for services rendered, placing some in such precarious financial situations they turned away people requesting services. Finally, a new Director needs to be able to recruit highly-qualified medical professionals, particularly those with forensic training, social workers, and other professional staff and improve agency morale.

Conclusion

Without a doubt, DBH has had a challenging last year, but it has also taken many positive steps, and CCE looks forward to continuing to work with DBH, its new leadership, and the Council with respect to all of these important issues. Thank you for your attention today; we are happy to address any questions that you may have.

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[10] Christine Vestal, *Facing an overdose epidemic, some ERs now offer addiction treatment*, Washington Post (Oct. 28, 2018), https://www.washingtonpost.com/national/health-science/facing-an-overdose-epidemic-some-ers-now-offer-addiction-treatment/2018/10/26/1829df84-c73f-11e8-9b1c-a90f1daae309_story.html?utm_term=.6f86398eb31e.

[11] German Lopez, *A Vermont needle exchange isn't just giving out syringes. It's offering treatment on the spot*, Vox (Nov. 20, 2018), https://www.vox.com/science-and-health/2018/11/20/18096123/opioid-epidemic-vermont-needle-exchange-buprenorphine.

[12] *See*, *Improving Mental Health Services and Outcomes for All.*