



***Improving Mental Health Services and
Outcomes for All: The D.C. Department of
Behavioral Health and the Justice System***

February 26, 2018

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A Report by the Office of the District of Columbia Auditor

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About the Office of the District of Columbia Auditor

The Office of the District of Columbia Auditor's (ODCA) mission is to support the Council of the District of Columbia by making sound recommendations that improve the economy, efficiency, and accountability of the District government.

To fulfill that mission, ODCA conducts performance audits, non-audit reviews, and revenue certifications. The residents of the District of Columbia are one of our primary customers, and ODCA strives to keep the residents of the District of Columbia informed on how their government is operating and how their tax money is being spent.



About the Council for Court Excellence

Founded in 1982, the Council for Court Excellence (CCE) is a nonprofit, nonpartisan civic organization that envisions a justice system in the District of Columbia that equitably serves its people and continues to be a model for creating strong and more prosperous communities. CCE identifies and proposes solutions by collaborating with diverse stakeholders to conduct research, advance policy, educate the public, and increase civic engagement.

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CCE's Project Advisory Committee includes membership from CCE's Board of Directors and a diverse group of stakeholders and subject matter experts, including representation from local government agencies, community-based behavioral health providers, consumer advocacy groups, and research organizations. A full list of the Project Advisory Committee members is in Appendix VI of this report.

Acknowledgements

This report was written by **Benjamin Moser, M.P.A.**, with contributions from CCE project staff and Steering Committee members. Several CCE interns have also contributed to this project:

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February 26, 2018

The Hon. Vincent Gray, Chairman
Committee on Health
The Hon. Charles Allen, Chairman
Committee on the Judiciary & Public Safety
The Council of the District of Columbia
1350 Pennsylvania Avenue N.W.
Washington DC 20004

Dear Councilmembers Gray and Allen:

I am pleased to present this report, ***Improving Mental Health Services and Outcomes for All: DC's Department of Behavioral Health and the Justice System***, prepared by the Council for Court Excellence (CCE) for the Office of the D.C. Auditor, providing a comprehensive review of the Department of Behavioral Health (DBH) and its work with justice-involved individuals and with the criminal justice system as a whole.

This marks the second public-private partnership between the D.C. Auditor and CCE, a non-profit, non-partisan civic organization that has focused on justice in the Washington metropolitan area for the last 36 years. I am particularly pleased to partner with CCE because their methodology brings together a wide range of representatives in the legal, business, and social services community of Washington, D.C., who give of their own time on a pro-bono basis to produce research and recommendations that assist policymakers in serving the District's residents.

The report that resulted from our first partnership, the [***Administrative Justice in the District of Columbia: Recommendations to Improve D.C.'s Office of Administrative Hearings***](#), contained policy proposals that remain under review by the Office of Administrative Hearings itself, and the Council.

CCE's current work puts a spotlight on a broad range of difficult challenges from the critical need for diversion programs in place of incarceration for those with behavioral health disorders to the similarly critical need to connect individuals being released from incarceration to needed community behavioral health services. The report addresses the need for statutory change in several areas, and recommends elevating the status of the Division on Forensic Services within DBH, as well as significant increases in funding to help stabilize the workforce within the agency and within the community organizations with which DBH contracts for services.

In the final steps of completing this report, representatives of the Bowser Administration met on numerous occasions with CCE and ODCA representatives to discuss the report's findings and recommendations and work through areas of disagreement. As a result, this report is more accurate and

has a stronger presentation of facts and challenges than would otherwise be the case. We also include written comments from the Administration in the report itself where exception is taken with some of the findings and recommendations, and where areas of agreement are also noted. For their willingness to engage in recent weeks in what has been a very constructive process, I extend my thanks to DBH Director Tanya Royster; DBH Chief of Staff Vu Dang; Executive Office of the Mayor Deputy General Counsel Karuna Seshasai; and Office of the Deputy Mayor for Health and Human Services Policy Advisor Amelia Whitman and Chief of Staff Jay Melder.

We look forward to continuing the conversation about how to improve services for those District residents who come into the justice system and also face behavioral health challenges. My thanks to the team at the Council for Court Excellence for this comprehensive review.

Sincerely yours,



Kathleen Patterson

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February 26, 2018

The Council for Court Excellence (CCE) is pleased to provide this report that addresses the District of Columbia's Department of Behavioral Health (DBH) and its interactions with the criminal justice system.

Our report is based on a tremendous amount of research conducted over the past year and a half that analyzed how DBH interacts with justice-involved consumers and the effectiveness of these interactions. That research included almost 60 interviews, totaling over 150 hours, with DBH staff, stakeholders, community behavioral health providers, leading academic experts, and current and former senior officials of forensic departments of other mental health agencies from around the country; focus groups with consumers, their advocates, and providers; surveys of the aforementioned groups; a review of forensic behavioral health practices in other jurisdictions; analysis of D.C. law and municipal regulations; and a thorough review of DBH internal documents and data.

As explained in detail in this report, we found that DBH has many areas for improvement, not only in its direct interactions with justice-involved consumers, but also department-wide. DBH's shortcomings have several bases – structural deficiencies related to the agency's organizational hierarchy; leadership issues that hinder progress and do not foster healthy work environments; inconsistent and inadequate funding support for community providers; inadequate and ineffective data tracking and management; and poor strategic vision. While we found that much of its staff are passionate about their work and are dedicated to improving the agency's operations, we also found that DBH has much room for improvement. We hope that this report will provide impetus toward such further improvement.

As co-chairs, we wish to express our sincere appreciation to DBH Director Dr. Tanya Royster and her staff at DBH and staff from the Executive Office of the Mayor who worked with CCE and the staff from the Office of the D.C. Auditor (ODCA) to facilitate this review and provide comments on its findings and recommendations.

Finally, we thank this project's Advisory Committee members (identified in Appendix V) and the CCE staff. Their extensive combined efforts in conducting interviews and research, analyzing the data obtained, and their thoughtful drafting and editing of the material have assured the quality of this report.

Sincerely,



Michael Hays
Of Counsel, Cooley, LLP



Barry Coburn
Partner, Coburn & Greenbaum, PLLC

Objectives and Scope

Objectives

The objectives of this review were to:

1. Review and assess the Department of Behavioral Health's interactions with the D.C. criminal justice system and justice-involved people.
2. Produce a report with a series of findings and recommendations in the areas related to criminal justice and behavioral health, including possible legislative, policy, and/or regulatory changes.

Scope

The Council for Court Excellence (CCE) conducted its review from October 2016 to February 2018. The scope of CCE's review was limited to reviewing and assessing the interactions of the Department of Behavioral Health (DBH) with the D.C. criminal justice system, the services DBH provides to justice-involved and/or forensic consumers, and the systems it has in place to support those interactions and services.

In the District of Columbia, where one in eight adults has a criminal record and one in 22 is under some form of correctional control,¹ justice-involved people are inextricably intertwined with the larger community and can be affected by policy decisions seemingly unrelated to their involvement in the criminal justice system. CCE has found that policy changes that adversely affect individuals with no history of justice-involvement are likely to have even more serious consequences for those who do. Therefore, certain aspects of the Department's work not traditionally considered forensic or otherwise related to the criminal justice system fell necessarily within the scope of CCE's review. For instance, DBH's general billing practices and medical necessity criteria repeatedly surfaced during CCE's assessment of the services provided to justice-involved consumers and were thus included in the review.

Throughout this report, CCE uses the terms *forensic consumer* and *justice-involved consumer*. These two terms are not mutually exclusive. While all forensic consumers are justice-involved consumers, not all justice-involved consumers are forensic. In defining the scope of this report, CCE applied DBH's definition a *forensic consumer*:

An individual with active criminal justice and/or court involvement where DBH has some obligation to provide a service, whether one time, intermittent, or long term. The involvement can range from a simple competency screening through inpatient hospitalization at Saint Elizabeths [Hospital], to community oversight and supervision [by DBH]. By statute, in the District of Columbia, both forensic[ally] and civil[ly] commitment[ed individuals] are committed to DBH for direct care, monitoring, and/or oversight. Both sets of consumers receive their direct services, monitoring, and/or oversight of community services by [DBH's] Clinical Services Administration.²

For the purposes of this report, CCE broadly defines *justice-involved consumer* as an individual with active involvement in the criminal justice system, including, but not limited to, individuals who are incarcerated or criminally institutionalized (e.g., at Saint Elizabeths Hospital), under the care of law enforcement (e.g., under arrest), or on community supervision, such as parole or probation.

i June Kress, Benjamin Moser, Emily Tatro & Tracy Velázquez, *Beyond Second Chances: Returning Citizens' Re-entry Struggles and Successes in the District of Columbia*, Council for Court Excellence, 1, 1 (December 2016), available at <http://www.courtexcellence.org/uploads/File/BSC-FINAL-web.pdf> [hereinafter, Kress *et al.*, "BSC"].

ii CCE e-mail correspondence with DBH executive staff, (February 5, 2018).

Executive Summary

The Department of Behavioral Health's (DBH) mission is "to develop, manage and oversee a public behavioral health system for adults, children and youth and their families that is consumer driven, community-based, culturally competent and supports prevention, resiliency and recovery and the overall wellbeing of the District of Columbia."¹ Among the populations that DBH serves are adults with behavioral health disorders who commit, or are accused of committing, a criminal offense. In October 2016, the Office of the District of Columbia Auditor (ODCA) engaged the Council for Court Excellence (CCE) to conduct a review of, and make recommendations for improving, the effectiveness of DBH's interactions with the criminal justice system and the services it provides to justice-involved behavioral health consumers.

To carry out the ODCA contract, CCE staff worked with over two dozen project advisory committee members (a complete list of whom can be found in Appendix VI). To educate itself on the issues, the project team interviewed senior management and staff at DBH and its Division of Forensic Services (DFS) and relevant individuals at Saint Elizabeths Hospital (SEH), D.C.'s public psychiatric facility; other governmental agencies; the D.C Superior Court; and community mental health providers in the District. The project team also conducted focus groups of DBH consumers and others; obtained input through online surveys; toured Saint Elizabeths Hospital and other key sites; spent thousands of hours reviewing documents and data (both internal and external to DBH); reviewed academic publications and other literature in the field; and interviewed experts, including leading academics and former and current senior officials at mental health forensic departments in other jurisdictions.²

Based on its review, CCE has identified several areas where DBH should make improvements. Many of CCE's recommendations are systemic and institutional in nature and, if implemented, would improve outcomes for not only justice-involved consumers but DBH's other consumers as well. The areas for improvement span the continuums of the behavioral health (prevention, treatment, and recovery for both mental health and substance use disorders) and criminal justice systems (before, during, and after incarceration). In several of these areas, DBH recently has made or is in the process of making improvements. The effectiveness of these efforts, however, is inherently limited so long as the behavioral health system for justice-involved consumers in the District (a) has structural deficiencies; (b) lacks a clear vision and coordinated strategies for delivering forensic and other related services; (c) lacks adequate infrastructure to support effective forensic service delivery; (d) is not fully staffed with forensically trained specialists; and (e) lacks effective community-based alternatives to incarceration, high utilization of the psychiatric emergency system, and psychiatric hospitalization.

A broad cross-section of stakeholders, including some that traditionally have held sharply diverging viewpoints, supports the findings and recommendations in this report. Some of the recommendations are sweeping, and implementing them will require cooperation among, and substantial efforts and investments by, DBH, the Executive Office of the Mayor (EOM), the D.C. Council, and other government agencies, both local and federal. Moreover, in implementing CCE's recommendations, these entities would benefit from significant input from the courts, community stakeholders and service providers, and, most important, justice-involved behavioral health consumers themselves.

The human and economic costs of failing to make needed improvements are substantial. Among the many problems persons with behavioral disorders face is a revolving door of incarceration, treatment, relapse or decompensation, and re-incarceration, often for minor, non-dangerous offenses. This revolving door not only imposes enormous and unnecessary burdens and costs on the District government, its court system, and ultimately its taxpayers but also tragically results in preventable human misery.

The following sub-sections summarize CCE's findings and recommendations on key topics that are discussed

iii DBH, *About DBH: Our Vision* [webpage], available at <https://dbh.dc.gov/page/about-dbh-01>.

iv The methodology for this review can be found in Appendix V.

in greater detail in the body of the report.

Improving Outcomes by Improving the Division of Forensic Services

DBH has lodged responsibility for providing and managing the full range of behavioral health and other services for justice-involved persons, from pre-arrest to post-incarceration, in the Division of Forensic Services (DFS), an administrative unit within DBH's Clinical Services Administration. To carry out its many broad and important responsibilities, DFS must be appropriately positioned and empowered within DBH's organizational structure, supported by adequate and properly trained staff, and led by a person with the proper mix of substantive and managerial skills and the right temperament. Based on its review, CCE believes that improvements are needed in each of those areas.

DFS's Organizational Position and Authority

DFS has many responsibilities and functions. It operates as: (1) a direct mental health service and treatment provider, providing psychiatric treatment to forensic consumers at one of DBH's clinics; (2) a forensic evaluation service, administering and overseeing all court-ordered psychiatric evaluations of defendants; (3) a forensic program delivery service, administering and overseeing competency restoration programs for defendants who have been determined incompetent to stand trial; (4) a community supervisory agency, monitoring the compliance of criminal defendants living in the community who have either been acquitted by reason of insanity or been civilly committed to DBH; and (5) a forensic/justice-involved policy and program coordinating body, liaising with criminal justice agencies and advising on justice-related behavioral health policies. Given this wide range of diverse duties, DFS functions as both an operational command center and coordinating body.

In DBH's recent organizational realignment, the Director of DBH placed DFS within the Department's Clinical Services Administration apparently because, like the other divisions housed within that Administration, DFS provides direct clinical services. However, given the breadth and nature of its responsibilities, DFS is inherently different from those other divisions. Moreover, placing it within the Clinical Services Administration does not appear to give DFS the cross-administration coordinating authority and stature it needs to carry out the full range of its responsibilities, including responsively interacting with the local courts.

In other state-level public mental health agencies around the country, similarly purposed forensic services divisions tend to be located much higher in the public mental health agency organizational structure. The national forensic behavioral health experts and experienced administrators to whom CCE spoke unanimously agreed that a forensic services division should be placed at a high level within an agency's organizational hierarchy to ensure that the special needs and legal requirements of the forensic population are part of the overall policy and resource deployment discussion. Thus, CCE recommends that DFS be elevated to the level of an administration within DBH and that the head of the forensics administration report directly to the DBH Director. Furthermore, if this recommended restructuring is implemented, CCE suggests that, given its importance and sensitivities, the position of forensics administration director be a mayoral-level appointment.

Another theme that emerged in CCE's discussions with experts and current and former administrators is the importance of centralizing operational and fiscal authority over all forensic services, both inpatient and outpatient, to promote sound managerial control, consistent standards, and effective resource coordination. In the case of inpatient forensic services in the District, however, the scope of DFS's authority and its role are unclear to almost everyone with whom CCE spoke, including DBH staff. In fact, the Director of DFS lacks direct managerial and budgetary authority over inpatient forensic services.

SEH is officially located outside of the DFS organizational and management structures. Thus, with one exception, the Director of DFS does not have supervisory authority over those who do much of DBH's forensic work, including conducting over 700 evaluations annually and managing the bed space for pre- and

post-trial individuals. Although the Director of DFS signs all of the SEH evaluations, the evaluators actually report to their respective managers within the hospital's management hierarchy, not DFS. Moreover, the persons who conduct forensic evaluations at SEH do so on a volunteer basis. That work is not within their job descriptions, and they are free to decline it whenever they wish. As a practical matter, relying on a volunteer workforce for inpatient forensic evaluations means that the Director of DFS cannot effectively establish and enforce qualification, training, and job performance standards. Nor does the Director of DFS have authority over the SEH staff that administer the inpatient competency restoration programs. In addition, the DFS Director's lack of authority over a unified budget for forensic services precludes centralized fiscal planning and control.

Accordingly, CCE recommends that the Director of DFS have operational and budgetary authority over all of DBH's forensic programs, whether administered on an inpatient or outpatient basis. In addition, CCE recommends that DFS develop and directly manage an independent team of forensic evaluators and competency restoration staff, employed by DBH, to perform the Department's forensic work wherever it may occur.

Adequate Staffing Levels and Properly Trained Forensic Staff

During the past year, DFS has had significant staff turnover and long-standing position vacancies. Indeed, there was a several-week period during this review when approximately one-fourth of the Division's full-time positions were vacant. However, even if fully staffed, DFS would not be able to fulfill its responsibilities without overburdening staff. For example, DFS has only three forensic psychologist positions embedded at the D.C. Superior Court to perform more than a thousand competency screenings and evaluations annually. DBH staff reported that the number of evaluator positions is not enough. They also reported that DFS is short-staffed in other programs too, such as its Forensic Outpatient Department, which serves individuals who have been either civilly committed or acquitted by reason of insanity and who have been discharged from SEH to live in the community.

Moreover, of the current staff at DFS, the levels of experience, training, and education vary widely across the spectrum of employees who interact with forensic consumers. CCE found that several DFS and SEH forensic staff did not have formal forensic training at all. Forensic staff play key roles in decisions that may affect individuals' mental health, legal cases, and, thus, their personal liberties. Therefore, it is paramount that DFS and SEH staff be well trained, highly skilled, and experienced in their field.

Unlike many other states, D.C. does not have a formal forensic evaluator training and certification program. Nor does D.C. law require that psychologists or psychiatrists be forensically trained to conduct a forensic evaluation, a standard that is considered a best practice. Similarly, DBH does not provide formal forensic training to or certification of other non-clinical staff who interact with forensic consumers, such as staff who assist in the competency restoration programs. Accordingly, CCE recommends that the D.C. Code be amended to require that psychologists and psychiatrists performing forensic screenings and evaluations be (a) board-certified and (b) forensically trained, either through formal education or through comparable professional training programs. Moreover, the D.C. Council should require that evaluators be recertified as appropriate. Furthermore, CCE recommends that DBH develop comprehensive forensic training and certification programs for evaluators and others who interact with forensic patients in the various evaluation and competency restoration processes.

DFS Management and Work Environment Concerns

During CCE's review, D.C. Superior Court judges ordered DBH to appear in court multiple times to explain why DFS had failed to comply with court orders. During the different hearings, the judges contended that DFS had failed to: (1) admit defendants promptly to Saint Elizabeths Hospital (SEH) for competency evaluations and restoration treatment as required by D.C. Code § 24-531.04; (2) conduct preliminary competency screening examinations of defendants as required by D.C. Code § 24-531.03(c)(2); (3) ensure

timely completion of competency evaluations within required statutory timeframes as required by D.C. Code § 24-531.04(a)(1); and (4) provide necessary ancillary services to fulfill competency restoration services as required by D.C. Code § 2-1931 *et seq.*

The problems discussed above — short-staffing, inadequate training, poor resource allocation — can be blamed in part for DFS’s failures to comply with various court orders and statutory requirements. In interviews with CCE, however, many DBH staff and stakeholders remarked that, in their opinions, the current Director of DFS does not seem to understand the importance of DBH’s statutory obligations to both the court and justice-involved consumers and, thus, does not respect them as one should. Furthermore, DBH staff and stakeholders suggested that the Director of DFS does not show a great deal of respect to DFS staff, which has led to low morale and problems with turnover and recruitment. In several interviews, DBH staff and stakeholders remarked that, despite its many current structural and staffing shortcomings, DFS would function much more effectively if someone new were in the position of DFS Director.

Enhanced Community-Based Outpatient Forensic Services

Admissions Waitlists and Alternatives to Inpatient Treatment

For decades, DBH and its predecessor agencies have struggled to keep pace with demands placed on them by the courts, especially conducting timely evaluations of defendants whose competency to participate in their legal proceedings is in question. When it is perceived that a mental health disorder may be preventing a defendant from exercising the constitutional right to assist in his or her own defense, the court will order DBH to conduct an evaluation and issue a competency opinion. If the court, after reviewing the opinion, finds the defendant to be incompetent, it will order DBH to try to restore the defendant’s competency to stand trial. Further evaluations and attempts to restore the defendant’s competence may ensue until ultimately the court makes a final competency determination. Throughout this entire process, the defendant’s case is on hold. Evaluations and restoration can occur at SEH (inpatient), at a facility in the community (outpatient), or sometimes in the D.C. Jail.

For the past few years, bed space limitations have prevented SEH from promptly admitting all of the defendants ordered to the hospital for competency evaluations and restoration services. During the course of CCE’s review, these limitations, which are especially problematic during the high-arrest winter and summer months, resulted in an “admissions waitlist,” causing defendants to remain incarcerated without receiving evaluation and restoration services. Over time, the waitlist grew, delaying many defendants’ evaluations beyond the statutorily permissible timeframe. When the problem persisted, D.C. Superior Court judges threatened the Department with contempt citations.

In August 2017, DBH responded to those threats by effectively clearing the waitlist and admitting 28 defendants to SEH within 16 days, and a total of 47 defendants for the month, an all-time high for the hospital. To accommodate the record-level of admissions, SEH internally transferred 47 patients, temporarily closed its pre-trial treatment mall (centralized psychosocial rehabilitation services), merged patients with different legal statuses into the same wards, and repurposed wards entirely. During the following month, DBH again admitted high numbers of defendants and shuffled numerous patients within the hospital. SEH staff reported that, in their opinions, such rapid and huge shifts in hospital operations were clinically inappropriate and had an unsettling effect on patients. In August and September 2017, SEH reported higher rates of psychiatric emergencies, emergency medication events and orders, physical assaults, high- and medium-severity unusual incidents, and patients restrained and secluded.

The increased number of forensic admissions to SEH also reduced its capacity to serve other types of patients. Throughout 2017, there was an admissions waitlist at SEH for people who have been civilly committed (individuals who have been found by the court to be in danger to self or others). That, in turn, strained local hospitals and providers, which must sustain civilly committed patients until SEH can admit them. Near the end of the project review period, CCE received troubling reports from stakeholders and community

providers that local hospitals and providers were forgoing the initiation of civil commitment procedures in part because of the financial and practical burdens associated with sustaining commitments.

According to many at DBH, the continuing strains put on the system by increased forensic patient admissions to SEH are unnecessary. A number of the defendants being ordered to SEH, in the view of DBH interviewees, do not meet the clinical or legal thresholds requiring hospitalization and could effectively receive forensic services in a less restrictive and much less costly outpatient setting in the community. The apparent stumbling block, however, is the general lack of confidence in the current outpatient alternative. CCE heard from many corners, including DBH staff and D.C. Superior Court judges, the perception expressed that DBH's Outpatient Competency Restoration Program (OCRP) cannot be trusted to provide effective forensic services to additional patients, particularly compared to the quality of service traditionally provided at SEH. As a result, staff suggested that DBH evaluators may be reluctant to recommend sending a defendant to outpatient services.

CCE recommends that DBH devote time and resources to enhancing the quality, capabilities, and accessibility of the OCRP and take steps to improve the current perceptions of the program held by the courts and others. CCE also recommends that DBH become more proactive in developing forward-looking strategies, in collaboration with other relevant parties, for providing more responsive and efficient forensic services.

Prevention and Re-Entry: Diversion from the Criminal Justice System and Reducing Recidivism

Diversion

People with mental illness are disproportionately more likely to be arrested, incarcerated, and recidivate than the general population.³ Consequently, thousands of people with behavioral health disorders in D.C. regularly revolve through the criminal justice system, typically for petty crimes such as minor shoplifting, taking food when hungry, or trespassing to find a place to sleep. In interviews with CCE, several D.C. Superior Court judges noted that they daily see dozens of defendants with behavioral health disorders who should have been diverted from the criminal justice system to support services instead of being arrested. Dealing with this population through the criminal justice system not only entails enormous social and economic costs but also fails to provide the type of help needed to avoid a repetition of the behavior that initially brought them into the system.

Research has shown that incarceration, especially when chronic, greatly limits a person's social and economic mobility, disrupts families and social support networks, destroys the continuity of care and treatment a person may be receiving, and disrupts other factors (housing, employment, participation in educational or social service programs) that are vital to the ability to live successfully in the community. Incarceration is also much more expensive for the District than behavioral health and social support services. CCE reviewed one case in which it cost the District almost half a million dollars in just less than two years to detain, evaluate, treat, and, eventually, release multiple times a mentally ill defendant charged with only petty misdemeanors. Research also has shown that incarceration seldom provides the supports and treatment needed to curb unlawful behavior by individuals with behavioral health disorders.

As discussed in the body of this report, various jurisdictions around the country have achieved some success using different types of pre-arrest diversion programs in lieu of arrest for dealing with minor offenses by persons with behavioral health disorders — for example, by locating housing for someone found trespassing while looking for a place to sleep overnight. While none of these diversion programs offer an easy recipe for success, the approach they embody likely holds great potential for constructively responding to conduct by persons with behavioral health disorders that intersect with the criminal justice system.

^v See, generally, KiDeuk Kim, et al., *The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System: A Scan of Practice and Background Analysis* [Research Report], Urban Institute (March 2015), available at <https://www.urban.org/sites/default/files/publication/48981/2000173-The-Processing-and-Treatment-of-Mentally-Ill-Persons-in-the-Criminal-Justice-System.pdf>.

In FY 2018, after receiving almost a million dollars from the Mayor, the Metropolitan Police Department and DBH began a collaboration to develop and implement a pre-arrest diversion pilot program. Although that is a positive step, much work will need to be done, and pitfalls avoided, for this collaborative effort to succeed. Indeed, as a threshold matter, DBH does not know whether its provider network has the capacity to handle such a diversion program, and it has not yet engaged community stakeholders or program experts in the development of the pilot program. CCE recommends that DBH actively pursue input from community stakeholders and diversion program experts, and that it be required to develop program performance targets and annually report on outcomes in relation to those targets. As one stakeholder put it, “Diversion programs should be working to improve outcomes, not just become another revolving door in a system of revolving doors.”

CCE also recommends that DBH conduct a study of super-utilizers of the criminal justice and behavioral health systems. Specifically, CCE recommends that, in addition to looking at the super-utilizer population writ large, DBH assess a specific sub-population: people who are frequently arrested and subsequently found incompetent to stand trial. The process from arrest to a determination of incompetence can last several weeks or extend over several months and for just one individual can cost taxpayers tens of thousands of dollars (and potentially more). Such a study could focus on the gaps in resources for the general super-utilizer population and the specific sub-population of those who repeatedly are found incompetent to stand trial in an effort to identify ways of disengaging them from the criminal justice system.

Re-Entry from Prison or Jail

The D.C. Department of Corrections (DOC) reports that a high number of individuals at the D.C. Jail have some type of severe mental illnesses (SMI) and that the numbers are trending upward. When such persons are released, behavioral health supports are crucial to their ability to successfully re-integrate into society. DBH, however, does not have a strong behavioral health support system to meet the specific needs of returning citizens.

In particular, DBH has not been effective at linking individuals in jail or prison to behavioral health providers. DBH staff at the jail, whose primary responsibility is to link individuals to community providers, reach a relatively low percentage of individuals with an SMI – only 55 percent in FY 2015 and 35 percent in FY 2016. Between FYs 2015-17, DBH reported that only 47 of the 1,097 women served by its staff at the jail were newly linked to services. Of those women, only nine – or 19 percent – attended their scheduled appointments. DBH does not have data on the number of men served by its staff until FY 2017, even though they comprise over 90 percent of the jail’s population. These low success rates may be attributed to a poor referral system. There is no formal system, outside of DBH’s Access HelpLine, to refer a consumer to a provider. DBH consumers and provider staff reported that consumers often find themselves scheduled for an appointment with a provider that they may not prefer (e.g., the location is inconvenient or burdensome), that may not offer all of the services the consumer wants or needs, or that may not be able to meet promptly with the consumer after release. DBH also has placed reimbursement limitations on many of the discharge-planning and other post-release services that community providers have traditionally furnished to consumers transitioning from the prison or jail to the community.

CCE recommends that DBH establish a formal system for linking incarcerated persons to community providers and that it re-examine the limitations apparently imposed on various discharge-related services. Those limitations may be penny-wise but pound-foolish. The services may be well worth their cost if they reduce recidivism risk.

Prevention: Maintaining a Network of Financially Stable, High-Quality Community Providers

DBH relies on a network of Core Service Agencies (CSAs) — small to mid-sized, mostly non-profit community mental health clinics — to provide the vast majority of public behavioral health services in

the District. The CSAs are vital to accomplishing the Department's mission of providing comprehensive community-based services in support of District residents with behavioral health disorders, including those involved in the criminal justice system. Over the past five years, however, several CSAs reportedly have experienced serious financial problems, and some have cut back on services, particularly services affecting justice-involved consumers, or have closed, or announced plans to close, their doors entirely.

A number of providers have attributed their financial stress and service cut-backs at least in part to disruptions in their receipt of funding for local-dollar services (that is, services not covered by Medicaid) as a result of one or more of the following problems: (a) DBH's assertedly inadequate rate structure for local-dollar services; (b) past lengthy delays in reimbursement payments stemming from the failure in FY 2016 of DBH's medical billing software, iCAMS; (c) limited or no increases by DBH to the providers' local-dollar funding allocations to meet the demand for services; and (d) DBH's newly implemented reimbursement restrictions on local-dollar services for incarcerated or institutionalized consumers. According to the providers, the financial pressures they are experiencing have limited their ability to hire and retain quality staff and to provide forensics-related services. Moreover, poor quality staff and high staff turnover at CSAs were major concerns of nearly every person to whom CCE spoke for this review, including consumers, CSA management, and DBH management.

DBH disagrees with the providers' reimbursement claims, noting that it is responsible for ensuring that D.C. taxpayers receive value for local-dollar payments, not guaranteeing the financial well being of community providers. CCE is not in a position to evaluate who is right or wrong regarding the provider claims. Nor does CCE believe that DBH is responsible for ensuring the financial health of individual private providers. DBH, however, is responsible for ensuring that high-quality, community-based services are available to behavioral health consumers throughout the District. To fulfill that responsibility, it is essential that DBH monitor the financial health and performance of CSAs and regularly assess whether governmental policies or other trends are adversely affecting the network's overall financial stability and thereby threatening its ability to meet the needs of residents throughout the District.

The recent demise of Green Door, a local nonprofit that served approximately 1200 consumers, is an example of a long-standing and significant CSA whose financial condition that DBH apparently did not fully understand. DBH had consistently rated Green Door highly, and in interviews with CCE DBH staff expressed surprise about Green Door's closing.

Accordingly, CCE recommends that DBH take various steps to stay apprised of the financial health and performance of CSAs, to assess on an ongoing basis the CSA network's overall health and its ability to provide consistent high-quality service to District residents throughout the community, and to analyze whether DBH's policies, rules, and practices may be adversely affecting the CSA network's ability to provide such service.

Overview of the District's Public Behavioral Health System

To grasp this project's scope, findings, and recommendations, it is useful to understand D.C.'s public behavioral health system and how it relates to the District's criminal justice system. This introductory section briefly describes those systems and their relationship. Because this project focused solely on forensic programs and services for adults, this section does not discuss the relationship of the District's public mental health and juvenile justice systems. An overview of DBH's programs related to this project's scope is included in Appendix IX.

In the District of Columbia, two agencies are central to the behavioral health system: the Department of Behavioral Health (DBH or "the Department"), which oversees the city's public mental health and substance use services, and the Department of Health Care Finance (DHCF), which is D.C.'s state Medicaid agency.

A number of lawsuits, their consequent legal decisions, and oversight by the federal court and the U.S. Department of Justice (DOJ) have largely shaped D.C.'s behavioral health system framework. The District's public mental health agency has spent more years under federal oversight than not, with the most recent case concluding in 2014. This review is the first of its kind to assess the Department's performance, albeit within a limited scope, since it has functioned independently.

Federal engagement with and control over the system posed a number of burdens and challenges to the system that have had a number of lasting, positive impacts, including the creation of a community-based mental health framework and the development of a series of systems and procedures enhancing DBH's ability to administer and oversee behavioral health services to District residents.

Saint Elizabeths Hospital

Founded in 1855, the Government Hospital for the Insane, renamed Saint Elizabeths Hospital (SEH) in 1916, was the nation's first federally operated psychiatric hospital. Located on a large tract of land east of the Anacostia River in the Congress Heights area of D.C., the hospital formerly housed almost 7,000 patients and employed more than 4,000 workers. Over the decades, the old campus featured centers for people with substance use disorders, barbershops, libraries, a theater, and a credit union. It functioned much like a self-contained small town.¹

While under the federal government's control, SEH was the subject of a landmark court case, *Dixon et al. v. Weinberger, et al.*, known simply as *Dixon*. That case began in 1974 when a class of civilly committed mentally ill individuals confined at SEH filed suit in U.S. district court against the federal and District of Columbia governments challenging their historical failure to re-locate Saint Elizabeths inpatients to alternative community-based facilities where they could benefit from treatment in less restrictive environments. The court ruled in the plaintiffs' favor, holding that the unnecessary hospitalization of mentally ill patients who could be safely treated in less restrictive settings violated the Hospitalization of the Mentally Ill Act,² typically referred to as the "Ervin Act."

To implement the findings of the 1975 decision, the federal and District governments in 1980 entered into a consent order, which required the development of a community-based model for the delivery of mental health services. Years of court proceedings, additional consent orders, and court-appointed receiverships followed to enforce the defendants' obligations under the court's rulings. Along the way, Congress in 1987

1 Joe Holley, *Tussle Over Saint Elizabeths*, The Washington Post (June 17, 2007), available at <http://www.washingtonpost.com/wp-dyn/content/article/2007/06/16/AR2007061601192.html>.

2 See *Dixon v. Weinberger*, 405 F. Supp. 974, 977-79 (D.D.C. 1975).

transferred control over SEH to the District. In 2002, the court appointed a monitor to report on the District's compliance with the terms of various court-approved orders and plans. Eventually, the parties agreed that, if the District substantially satisfied 19 "exit criteria," the litigation would be dismissed.³ Several of the 19 criteria (for example, the responsibility to leverage and maximize Medicaid funds) became foundational pieces of the legislation creating the current Department of Behavioral Health. In 2011, the parties entered into an agreement recognizing the District's demonstrated compliance or substantial compliance with 15 of the 19 exit criteria and providing for further monitoring until 2013 and subsequent dismissal of the litigation. In 2012, the court approved the agreement, and in 2014, it ordered the case closed.⁴

In addition to the *Dixon* litigation, in 2005 the DOJ investigated SEH under the Civil Rights of Institutionalized Persons Act, finding that the hospital had violated "the constitutional or federal statutory rights of persons with mental illness." DOJ uncovered numerous problems related to the environment of care, integrated treatment planning, the provision of treatment services, discharge planning, and community integration, use of restraint and seclusion, medication prescribing practices, and quality improvement, among others.⁵ In 2007, the District of Columbia and the DOJ entered into an agreement obligating the Department of Mental Health (DMH) (DBH's predecessor agency) to work toward satisfying approximately 224 requirements identified during the investigation, under monitoring of the DOJ.⁶ In 2014, the DOJ terminated its oversight after finding DMH to be in compliance.

Over the years, the number of patients at Saint Elizabeths has decreased steadily, consistent with the goals of the *Dixon* litigation and the nationwide trend of de-institutionalizing mental health patients and expanding community-based mental health care. Today, SEH remains the District's only public inpatient psychiatric facility and continues in its mission to serve people with serious and persistent mental illnesses in need of inpatient care and treatment, as well as defendants ordered to undergo evaluation and treatment by the courts. SEH has 291 inpatient beds, of which 285 are available to serve the individuals in its care.⁷ The individuals in care are categorized under three different statuses: pre-trial, post-trial, and civil, which includes individuals with voluntary, emergency, or civilly committed statuses. At any given time, it is common for the pre- and post-trial individuals to comprise a little over two-thirds of the total census population.

Department of Behavioral Health

For decades, state and local governments throughout the nation addressed substance use disorders and mental illnesses separately, often through different administrative agencies. For many years, this was the case in the District: The Department of Mental Health (DMH) operated as a standalone agency from the beginning, and the Addiction Prevention & Recovery Administration (APRA) operated within the D.C. Department of Health. In 2013, however, the District merged DMH and APRA to form DBH based on research showing a strong link between addiction and mental illness.⁸

Although mental illnesses and substance use disorders can have significant differences, they are now commonly referred to together under the umbrella term "behavioral health." For example, the federal government's Substance Abuse and Mental Health Services Administration defines behavioral health as "problems [that] include substance use disorders; alcohol and drug addiction; and serious psychological

3 Justin Benson and Jessica Kindcaid, *Case Profile: Dixon v. Weinberger* [webpage], University of Michigan Law School's Civil Rights Clearing House (2016), at paragraph four, available at <https://www.clearinghouse.net/detail.php?id=5495>.

4 *Id.*

5 Letter from Assistant United States Attorney Wan J. Kim to then-D.C. Mayor Anthony A. Williams, *CRIPA Investigation of Saint Elizabeths Hospital*, Washington, D.C. (May 23, 2006), 1, available at https://www.justice.gov/sites/default/files/crt/legacy/2010/12/15/St_Es_findlet_5-23-06.pdf [hereinafter "CRIPA Investigation Letter"].

6 *See, generally*, Joint Motion for Final Dismissal, *United States v. the District of Columbia et al.* Civil Action No. 1:74-cv-00285 (TFH).

7 In interviews with CCE, DBH staff explained that, although the hospital has 291 licensed beds, that total includes restraint beds, which are excluded from the total capacity calculation because they cannot be permanently filled.

8 *See* Written Testimony of Stephen T. Baron, then-Director of DMH before the Committee on Health, Council of the District of Columbia, 1, 3 (April 18, 2013), available at <https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/FY%2014%20Budget%20Request%20Testimony.pdf>.

distress, suicide, and mental disorders.⁹

The five-year-old DBH provides prevention, intervention, and treatment services for people with mental health and/or substance use disorders. DBH also provides emergency psychiatric care and community-based long- and short-term outpatient and residential services, and it operates SEH.¹⁰

DBH's budget, which for fiscal year (FY) 2018 is just over \$255 million,¹¹ funds the work of the Department's six administrations and SEH.¹² The Department employs more than 1,300 full-time employees.¹³ In FY 2016, DBH reported serving almost 25,000 mental health services consumers and nearly 7,000 substance use disorder (SUD) services consumers.¹⁴ Of the FY 2016 mental health consumers, 86 percent were reported to be seriously and persistently mentally ill, which is generally defined as having a psychiatric diagnosis of disability such that a person is eligible for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI); results in extended impairment in functioning; and/or relies on psychiatric treatment, rehabilitation, or support services.¹⁵

Department of Health Care Finance

The D.C. Department of Health Care Finance (DHCF), formerly the Medical Assistance Administration under the D.C. Department of Health, is D.C.'s state Medicaid agency and administers D.C.'s Medicaid and Alliance programs. Federal Medicaid regulations give states the flexibility to determine the scope of services offered and the populations eligible to receive them. Thus, DHCF "determines what behavioral health care services are covered by [Medicaid and Alliance] programs and sets reimbursement rates for services provided to individuals enrolled in [each]."¹⁶ Medicaid serves as a significant source of funding for DBH and community services providers in D.C. For example, people enrolled in Medicaid who are disabled because of their mental illness are eligible for DBH's Mental Health Rehabilitation Services (MHRS) program, which DBH and its Core Service Agencies (CSAs) administer. Medicaid-eligible services provided through MHRS are routed from CSAs through DBH to DHCF for reimbursement. DHCF oversees the District's Medicaid managed care and Medicaid fee-for-service programs, through which some DBH CSAs also provide services in addition to MHRS. DHCF provides oversight for D.C.'s freestanding mental health clinics, which serve people who are not enrolled in MHRS; however, as of the drafting of this report, the D.C. government is actively working to transfer oversight of these clinics to DBH. Services, both Medicaid-eligible and not, are billed directly from these clinics to DHCF for reimbursement.

9 SAMHSA, *National Behavioral Health Quality Framework – Overview* [webpage], available at <https://www.samhsa.gov/data/national-behavioral-health-quality-framework>

10 See, generally, DBH, *About DBH* [webpage] (2017), available at <https://dbh.dc.gov/page/about-dbh>.

11 D.C. Office of the Chief Financial Officer, *Operating Budgets by Agency* [webpage] (2017), available at <http://cfoinfo.dc.gov/>.

12 In March of 2017, DBH announced it would be undergoing a department-wide reorganization ("realignment"). Effective October 1, 2017, the Department consists of six administrations and SEH. Each of the administrations is divided into divisions, with some further divided into branches. The six administrations are: Accountability, Administrative Operations, Clinical Services, Community Services, Consumer and Family Affairs, and Systems Transformation. Descriptions of these administrations are included in Appendix VII.

13 See, DBH, *FY 2018 Proposed Position Listing*, 1, 32 (2017), available at http://dccouncil.us/files/user_uploads/budget_responses/RM0_FY18_Position_Listing_-_DBH.pdf.

14 DBH, *Mental Health and Substance Use Report on Expenditures and Services (MHEASURES)* (January 15, 2017), available at https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/MHEASURES%20January%202017_0.pdf, [hereinafter "MHEASURES 2017"].

15 National Registry of Evidence-Based Programs and Practices, *Behind the Term: Serious Mental Illness*, SAMHSA (2016), available at https://nrepp.samhsa.gov/Docs/Literatures/Behind_the_Term_Serious%20%20Mental%20Illness.pdf.

16 Carole Roan Gresenz, et al., *Behavioral Health in the District of Columbia: Assessing Need and Evaluating the Public System of Care*, RAND, i, 5 (2010) [hereinafter "RAND Report"].

Overview of the District's Criminal Justice System

Around the country, government agencies and courts enforce and uphold laws specific to their jurisdiction. Most are funded by their state or locally at the county or city level. Much like those states and localities, the District of Columbia has its own local laws, outlined in the D.C. Code. The District's criminal justice system, however, is unique in that it is subject to the control of both federal and local agencies. For example, the federal government has responsibility for the District's prison, courts, its probation and parole functions, and most of its prosecutorial functions. This section outlines that complex system as a compliment to this report

Like most places in the U.S., there are two separate criminal justice systems at work in D.C. The first is federal. People involved in that system are charged with violating federal laws, prosecuted by the U.S. Attorney for the District of Columbia in the U.S. District Court for the District of Columbia and sentenced to serve time in the Federal Bureau of Prisons (BOP). If released to the community, they are supervised by U.S. Probation and Pretrial Services. This is the same system that anyone in the country is subject to if charged with violating federal law.

Most people in the District, however, are charged with violating D.C. law, also known as the D.C. Code. This second system is D.C.'s equivalent of a state system, but because of D.C.'s unique position as a federal district, D.C. Code offenders follow a chain of custody and supervision that bounces back and forth between local and federal agencies.

Generally, after being arrested for a violation of D.C. law and arraigned at D.C. Superior Court, a federally funded and controlled court with local jurisdiction, a person is either conditionally released under the supervision of the Pretrial Services Agency for the District of Columbia (PSA),¹⁷ which is a federal agency with local jurisdiction, or is confined by the D.C. Department of Corrections (DOC), a local agency, either at the Central Detention Facility (CDF or "the D.C. Jail") or the Correctional Treatment Facility (CTF). It is also possible, on occasion, that a person will be confined at a halfway house facility while awaiting trial, particularly if that person is participating in a work-release program.

D.C. Code offenders are prosecuted by the U.S. Attorney's Office for the District of Columbia (USAO D.C.), a federal office within the U.S. Department of Justice (DOJ) with local jurisdiction. The D.C. Office of the Attorney General (OAG), a local agency, prosecutes juveniles and some misdemeanor crimes. D.C. Code offenses are tried in the D.C. Superior Court. If a defendant is convicted of a misdemeanor and sentenced to less than a year of incarceration—or is still awaiting trial and has not been awarded conditional release—he or she will remain either in the CDF or CTF.¹⁸

If a defendant is sentenced to probation or time served with community supervision, they will come under the supervision of the Court Services and Offender Supervision Agency (CSOSA). CSOSA is another federal agency with local jurisdiction over D.C. Code offenders who are on probation, parole and supervised release.¹⁹

If a defendant is convicted of a felony and sentenced to a period of incarceration of a year or longer, they will be sent to a Federal Bureau of Prisons (BOP) facility. BOP prisons are scattered around the country, and some D.C. Code offenders are housed as far away as Washington State and California, although many are in West Virginia, Pennsylvania and North Carolina.

¹⁷ Pretrial Services Agency for the District of Columbia, *About* [webpage], available at <https://www.psa.gov/?q=about>.

¹⁸ Corrections Information Council, *CIC Pop-Up Think Tank: Reimagining CTF* (2016).

¹⁹ CSOSA, *History* [webpage] (2016) available at <http://www.csosa.gov/about/history.aspx>.

Parole decision-making functions for people with felony convictions are handled by the United States Parole Commission and not CSOSA.

When approaching the end of one's sentence, a person will often be transferred from a BOP prison to a privately run residential re-entry center (RRC or halfway house) that contracts with the BOP. Upon release from custody, a person serves the term of their parole or community supervision under CSOSA, and CSOSA's Transitional Intervention for Parole Supervision (TIPS) team works with returning citizens to develop a re-entry plan. If someone is returning directly to the community, this plan is developed while that individual is incarcerated; if the person is transitioning to an RRC or halfway house, the plan is not developed until the individual gets there.

If a person is accused of violating the terms of his or her parole or supervision, that person will face the U.S. Parole Commission, which is federal. If the person serving parole or supervised release is found in violation, they will be returned to the custody of the BOP;²⁰ however, they are most likely to be held in the custody of the DOC while awaiting their hearing.²¹

²⁰ Avis E. Buchanan, *Improve D.C.'s Parole Practices*, The Washington Post (August 14, 2015), available at https://www.washingtonpost.com/opinions/improve-dcs-parole-practices/2015/08/14/56b9f03c-3475-11e5-8e66-07b4603ec92a_story.html.

²¹ CCE e-mail correspondence with R. Chakraborty, D.C. DOC (November 2, 2016). According to the D.C. DOC, "on an average daily basis, more than 450 inmates [in their custody] are parole violators," most having violated technical aspects of the conditions of their release, or are not being held at D.C. DOC for charges other than parole violation. For individuals awaiting a final USPC decision, "the average length of stay prior [to the decision] exceeds 100 days. These inmates comprise more than 15 percent of the incarcerated population [at D.C. DOC]."

DBH Organization and Management Structure

Finding One

The Division of Forensic Services (DFS) does not have a clear mandate, and its current position and responsibilities within DBH may impede its ability to carry out its larger mission.

Recommendations

1. That DFS be located within the Office of the Director of DBH with the mandates to (a) act as both an inter- and intradepartmental coordinating body, and (b) develop and implement policies for justice-involved consumers.
2. That the position of the Director of DFS be a mayoral-level appointment, given the responsibilities of the Director of DFS to (a) coordinate with multiple federal and local government agencies, and (b) fulfill significant statutory obligations on DBH's behalf that implicate other D.C. agencies (e.g., jail-based competency restoration).
3. That the Director of DFS be given the authority to develop and manage a unified budget.
4. That the DFS budget be increased to fund current and new programs and related expenses.

Implementation

These recommendations may be implemented by (a) DBH's relocating DFS within the Office of the Director; (b) the D.C. Council's elevating the position of the Director of DFS to that of a mayoral-level appointment; (c) DBH's issuance of a directive giving the Director of DFS the authority to develop and manage a unified budget; and (d) the D.C. Council increasing DFS funding.

Comment

Proper Positioning Within Organizational Hierarchy

The consolidation of all of DBH's forensic services into one division began in 2015 with the creation of the Office of Forensic Services. It was later renamed the Division of Forensic Services (DFS) on October 1, 2017, after DBH's department-wide reorganization. In testimony before the D.C. Council, the Director of DBH explained that DBH's intention in establishing DFS was to "oversee the continuum of services for justice-involved individuals," and monitoring "programs and services from pre-arrest to post-incarceration."²² The Division, the Director explained, consolidates into one agency unit the administration and responsibilities of DBH's widespread forensic work, including providing direct mental health treatment for some consumers. As one division, DFS would develop, implement, manage, and coordinate programs and policies for justice-involved individuals throughout DBH.²³

While the intent of the consolidation appears logical – centralizing services and expertise related to the intersections with the criminal justice system – in practice, the result is a division with an unclear mandate. As currently structured, DFS operates as a direct mental health service and treatment provider, a supervisory agency for court-mandated community psychiatric treatment, and a policy and program coordinator.²⁴

²² Testimony of DBH Director, Tanya A. Royster, before the Committee on Health and Human Services, Council of the District of Columbia, 1, 4 (April 6, 2016).

²³ *Id.*

²⁴ See Position Description for Director, Office of Forensic Services, 1, 3 (2016), [hereinafter "Position Description"] (stating that DFS is

After the department-wide realignment, DFS was placed within DBH's Clinical Services Administration (which oversees all of DBH direct services programs, except Saint Elizabeths Hospital), a location that does not seem to give it the cross-administration coordinating authority required by a division of its kind. While some cities, such as Philadelphia, have similar structures with the head of the forensic division reporting to someone akin to a director of an administration in DBH, other similarly purposed divisions at the state-wide level – which more closely depicts DBH's role as a “state” agency – are not commonly located within other administrations, but are equal to them in the organizational hierarchy of the department. For example, the Director of the Washington State Office of Forensic Mental Health Services operates at the level of Deputy Assistant Secretary (akin to a director of an administration at DBH) and reports directly to the Assistant Secretary for Behavioral Health (akin to the Director of DBH, as Washington State does not have a separate behavioral health department).²⁵

Moreover, if forensic services are housed within another administration, that administration is usually one with similar functions. For example, in New York State, the Division of Forensic Services is located in a separate, non-clinical branch of the organizational hierarchy, one that is comprised of all of the Department of Mental Health's interdepartmental coordinating bodies (e.g., financial management, human resources, and integrated community services).²⁶ Dr. Ira Packer, a former Assistant Commissioner of the Massachusetts Department of Mental Health, attributed the success of that state's forensic services unit (which many experts with whom we spoke considered to be among the best in the nation) to its high-level placement within the Department of Mental Health, saying: “It is essential that whoever oversees the forensic services be at a high level within [the Department].”²⁷ Similarly, when interviewed by CCE, Michael Schaefer, Ph.D., Assistant Commissioner for Forensic Services of the Virginia Department of Behavioral Health and Developmental Services, emphasized the importance of locating the head of forensic services in a high-level position in the Department's central office to ensure that the special needs and legal requirements of the forensic population are part of the broader policy discussion.

Forensic behavioral health experts contend that positioning a division of forensic services toward the top of the hierarchy of a mental health administration is crucial to engendering coordination, communication, “collaboration and synergy among the various services, rather than isolation.”²⁸ Implicit in such a structure is a division's authority to influence and enforce interdepartmental coordination. Given its place within the Clinical Services Administration at DBH, DFS appears to lack the high-level collaborative influence and authority its mandate suggests it should have.

Accordingly, CCE recommends that DFS be elevated to the level of an administration within DBH to provide it with the necessary stature to carry out its duties. Furthermore, given the responsibilities of the Director of DFS to (a) coordinate with other D.C. federal and local government agencies, (b) coordinate services and programs for consumers that fall under the purview of two Deputy Mayors (Health and Human Services and Public Safety and Justice), and (c) fulfill significant statutory obligations for DBH that implicate other D.C. agencies (e.g., pre-arrest diversion must be developed in concert with the Metropolitan Police Department), we also recommend that the position of the Director of DFS be a mayoral-level appointment. Deputy level mayoral appointments are not without precedent in D.C. For example, the Mayor appoints Deputy Fire Chiefs

responsible for managing the inpatient forensic care at SEH; services delivered through the Jail and Prison Re-Entry Linkage programs; residential services for criminally involved individuals; competency restoration and evaluations, the monitoring and treatment of NGRI acquittees in the community; pre- and post-trial evaluations; provides mental health services directly and through contracts services (e.g., with CSAs); and coordinates the services for justice-involved people with co-occurring disorders).

25 Washington State Department of Social and Health Services, *Department of Social and Health Services: Behavioral Health Administration Organizational Chart* [web page], available at https://www.dshs.wa.gov/sites/default/files/SESA/office%20of%20the%20secretary/Org%20Charts/BHA_Org.pdf.

26 New York State Office of Mental Health, *New York State Office of Mental Health Organization Chart* [webpage], available at <https://www.omh.ny.gov/omhweb/orgchart/orgchart.htm>.

27 CCE phone interview with Ira Packer, Ph.D., Clinical Professor of Psychiatry at the University of Massachusetts Medical School (November 15, 2017).

28 W. Neil Gowensmith, et al., *Forensic Mental Health Consultant Review Final Report*, 1, 12 (June 30, 2014), available at <https://www.dshs.wa.gov/sites/default/files/BHSLA/WSH/GroundswellReport6.30.14.pdf> [hereinafter “Consultant Review”].

of the Fire and Emergency Management Services Department.²⁹ However, this recommendation relates solely to organizational structure. It is not a recommendation regarding the person whom the Mayor should appoint as Director of DFS. Indeed, as noted in Finding 9, many DBH staff, stakeholders, and community providers expressed serious concerns about the performance of DFS’s current Director. Accordingly, in CCE’s view, the questions of who should be appointed to serve as Director of DFS should be thoroughly discussed and considered by the Executive Office of the Mayor and DBH.

Budgetary Authority

Forensic services divisions in other states have been successful when the division director has “operational and fiscal oversight” of the entire forensic system.³⁰ As of October 2, 2017, the Director of DFS manages a budget for outpatient forensic services but does not have budgetary authority for inpatient forensic services provided at Saint Elizabeths Hospital (SEH). For example, in FY 2018, DFS had a budget of about \$3.89 million, chiefly spent on the salaries of less than two dozen people dispersed widely throughout the Department, but as shown below, did not include funding for inpatient forensic services. DBH staff reported that, at least since the Division’s creation, DBH had not consulted the Director of DFS the Division’s budget, despite DFS’s growing responsibilities. The Director of DFS could be more effective if they had greater input and autonomy over a unified budget for all forensic services.

Figure 1. DBH Budget for Forensic Services, FYs 2015-18

Year	FY 2015	FY 2016	FY 2017	FY 2018*
Adult	\$1,511,218	\$1,063,714	\$879,239	--
Outpatient	\$0	\$0	\$1,747,812	--
Inpatient	\$0	\$0	\$0	--
Total:	\$1,511,218	\$1,063,714	\$2,627,051	\$3,890,041

Source: CCE E-mail Correspondence with DBH Executive Staff, (2017-2018)

*The budget information DBH provided to CCE for FY 2018 was not categorized in the same way as the information it provided from the previous years.

Insufficient Programmatic Funding

During CCE’s review period, DFS and its predecessor, the Office of Forensic Services, did not receive any funding from DBH allocated specifically for developing programs and related materials, such as educational materials for the Outpatient Competency Restoration Program (OCRP) or the Forensic Outpatient Department (FOPD) housed within DFS.³¹ Because DFS’s budget is largely dedicated to personnel, the Director is limited in their ability to develop programs, to the extent that those programs would require resources beyond staff costs (e.g., educational materials, community outings). Furthermore, as shown in Figure 1 above, the Director does not have funding allocated to inpatient services, which essentially gives the Director no financial control over the programs under DFS’s purview at SEH.

To fund some of its initiatives, DFS has opted to apply for federal grants.³² In implementing one such grant, DFS had to postpone hiring staff due to an unexplained funding delay. As a result, the program experienced a delay in implementation. Staff was hired within four weeks of funding becoming available, although DBH

29 See D.C. Code § 5-402.

30 Gowensmith, *Consultant Review*, supra note 28, at 13.

In other states, forensic services divisions are tasked with coordinating a state’s forensic services across municipalities and counties, which may be far flung and vary tremendously in size. Unlike these divisions, DFS would not have such responsibility. Nevertheless, it is important that DFS have the operational and fiscal authority necessary to coordinate services in D.C., albeit on a smaller scale.

31 CCE e-mail correspondence with DBH executive staff (2017-2018).

32 DBH, *FY 2018 Budget Responses*, 1, 97 (2017), available at http://dccouncil.us/files/user_uploads/budget_responses/dobh.pdf (showing that in FY 2017, DBH received funding from the Office of Victim Services and Justice Grants to develop a re-entry program initiative targeting incarcerated women with co-occurring disorders.); See also DBH, *FY 2018 Budget Responses, Attachment III – Federal Grants* (2017), available at http://dccouncil.us/files/user_uploads/budget_responses/RM0_FY18_Attachment_III.PDF (showing that in the same fiscal year, DBH received a grant from the Department of Justice to “support cross-system collaboration” for people with co-occurring disorders who are justice-involved).

reported that it and the D.C. Criminal Justice Coordinating Council worked on the grant internally before hiring staff. DFS received another grant from the U.S. Department of Justice as part of its Justice and Mental Health Collaboration Program. Due to another unexplained delay in funding availability, the work plan for achieving deliverables is under discussion. The Office of Forensic Services received the grant in October 2016 and hired one person for the grant-funded role nine months into the two-year grant period. DFS expects to develop a tool to help identify and divert “super-utilizers,” people who have frequent contact with both the behavioral health and criminal justice systems, from the criminal justice system.³³

CCE has concluded that DFS could be more effective if its Director were given greater authority and control over a unified budget for the forensic system, to include inpatient forensic services. DFS would also benefit by having a budget line item specifically to fund its various programs and related expenses, such as funding to purchase materials for the OCRP classes.

³³ In 2016, CCE assisted DBH and the Metropolitan Police Department in applying for the Justice and Mental Health Collaboration Program award by helping to collect letters of support from various justice system stakeholders. CCE did not receive any funding from the grant or compensation from either department for its efforts.

Finding Two

The Division of Forensic Services (DFS) does not have effective management and staffing structures.

Recommendations

1. That the Director of DFS should have budgetary and operational authority over and manage all of the Department's forensic programs, whether administered on an inpatient or outpatient basis.
2. That DBH establish an independent team of forensic evaluators and competency restoration program staff to perform the Department's forensic work at facilities throughout the city – at the courthouse, the jail, the 35 K Street clinic, and Saint Elizabeths Hospital. The forensic teams would report to DFS management and would not be assigned to any one location, allowing DFS to meet the need for evaluations whenever and wherever it arises.
3. That DBH clarify that the Director of DFS's responsibilities do not include a role over consumers' non-forensic direct medical services.
4. That DBH establish two Deputy Director positions: a Deputy Director for Forensic Outpatient Treatment and Services; and a Deputy Director for Forensic Policies and Program Development.
5. That the D.C. Council allocate additional clinical and direct services to DFS.

Implementation

These recommendations may be implemented by (a) DBH's amending of its internal policies and (b) the D.C. Council's increasing of DFS's budget.

Comment

Responsibility of the DFS Director over Inpatient Forensic Services

The Division's mission statement and program descriptions indicate that DFS is responsible for the management of forensic programs at Saint Elizabeths Hospital (SEH). Indeed, the Director of DFS's position description explicitly states that they are responsible for "providing management and oversight of all of the forensic psychiatric services provided to forensic consumers... at [SEH]..."³⁴ However, while DFS's responsibility for and authority over the outpatient forensic programs is clear, its role with regard to forensic inpatient services at SEH was unclear to almost everyone with whom we spoke, including DBH staff. As contemplated by the consolidation of forensic services into DFS, there are now two different structures through which staff conducting forensic work at SEH must report, which creates an organizational quagmire.

First, DFS is officially located outside of the SEH organizational and management structures (see DBH organizational chart, Appendix VIII). Thus, with one exception, the Director of DFS does not have direct supervisory authority over the staff who conduct much of DBH's forensic work,³⁵ including over 700 evaluations annually and managing the bed space for pre- and post-trial individuals.³⁶ While the Director of DFS signs all of the evaluations conducted by SEH evaluators, technically, SEH psychologists and psychiatrists

³⁴ See Position Description, *supra* note 24.

³⁵ There are three DFS staff members who are co-located at SEH: the Assistant Director for Inpatient Services and two administrative support staff. The current Assistant Director is a licensed psychologist and is currently the only DFS staff who performs forensic evaluations at SEH.

³⁶ As outlined in D.C. Code § 24-531.03 *et seq.*, DBH evaluators may conduct two different types of competency examinations. *First*, outpatient evaluators at the D.C. Superior Court will conduct a "preliminary screening examination." These examinations may indicate a defendant's competence or whether they need further evaluation. *Second*, if further evaluation is needed, DBH will be ordered to complete a full competency examination, either inpatient or outpatient.

respectively report to the hospital's directors of the psychology and psychiatry divisions.

Second, to the extent that the SEH psychiatrists and psychologists conduct forensic evaluations, they do so on a volunteer basis; none of their job descriptions includes that work. While their willingness to volunteer for such work is admirable, they are free to decline evaluation work whenever they please. Relying on a volunteer forensic evaluation service impedes the ability of the Director of DFS to establish qualifications for, select, train, manage, and evaluate personnel at SEH who are performing forensic services. It also creates high risks of evaluator shortages and workload backlogs.

Third, the Director also does not have authority over the SEH staff that administer the inpatient competency restoration programs, which includes staff from yet more areas of SEH's organizational structure, including psychologists, psychiatrists, social workers, and, occasionally, behavioral health technicians. Thus, the limitations on the Director's authority over staff who perform evaluations are amplified with regard to the restoration programs.

Based on CCE's discussions with forensic behavioral health experts and its review of forensic systems in other jurisdictions, the general trend in other jurisdictions is to centralize responsibility for and authority over all mental health forensic services in the director or head of the forensic services agency or division. Accordingly, under that approach the director would have responsibility for and direct operational and budgetary authority over the forensic staff at state-run psychiatric hospitals to the extent that the staff performed forensic services – specifically, conducting forensic evaluations (competency to stand trial, criminal responsibility, risk assessment), performing competency restorations, and evaluating and working with people who have been acquitted by reason of insanity. Experts note that a director's fiscal and operational control over forensic services should “allow for consistent standards, uniform training, ability to track data, and ability to make recommendations about system needs based on accurate information.”³⁷ Thus, some state forensic systems have dedicated independent teams of forensic evaluators and competency restoration program staff that work at multiple locations throughout their states and report directly to the forensic division. In other states where the forensic staff is permanently located at that state's hospitals, the director of forensics has the authority to reallocate resources as needed, standardize procedures across hospitals, and liaise with non-forensic staff as needed to meet the demand for forensic services. The experts with whom we spoke made clear, however, that the authority of directors of forensic services should not extend to the non-forensic psychiatric treatment (i.e., medical services) provided to forensic consumers.

Thus, CCE believes that the Director of DFS should have budgetary and operational authority over and manage all of the Department's forensic programs, whether administered on an inpatient or outpatient basis. This includes authority over and management of all professionals to the extent that they perform forensic services. To make that approach work, the Department's current staffing structures for forensic work, particularly the forensic evaluation function, must change. CCE thus recommends that DBH establish an independent team of forensic evaluators and competency restoration program staff to perform the Department's forensic work at facilities throughout the city – at the courthouse, the jail, DBH's 35 K Street clinic, and SEH. The forensic teams would report to DFS management and would not be assigned to any one location, allowing DFS to meet the need for evaluations whenever and wherever it arises. These independent teams could consist of either DBH staff, a network of contractors, or a combination of both, depending on what the Department concludes will work best under the circumstances. Of course, moving to this system will not happen overnight. CCE recommends that, during the transition period, DBH centralize as much managerial authority as possible over forensic services and programs in the Director of DFS, consistent with the other recommendations in this report.

One final note on this topic: During interviews DBH, staff suggested that the wording of the DFS Director's position description could be interpreted broadly to give the Director managerial authority over all aspects of the psychiatric treatment provided to forensic patients, including non-forensic medical services (e.g., the prescribing or administration of medications for non-forensic purposes). CCE does not believe that the

³⁷ Gowensmith, *et al.*, *Consultant Review*, *supra* note 28, at 12.

drafters of the position description intended to lodge such broad authority in the DFS Director. Moreover, CCE believes the position description has the potential for creating an ethical, and perhaps legal, quandary for the Director. To avoid any ambiguity or confusion, CCE recommends that the position description language be modified to clarify the scope of the Director's responsibilities and authority.

DFS Organizational Structure

CCE has determined that the management structure of DFS is currently untenable, and that its organizational structure does not seem to provide sufficient support for the execution of the Division's day-to-day responsibilities.

Currently, the Director of DFS does not have a deputy director for outpatient work; occasionally performs competency evaluations (including drafting and submitting reports to the court and testifying); oversees outpatient programs, including competency restoration services and community monitoring programs in collaboration with other agencies, such as the Metropolitan Police Department, Pre-Trial Services for D.C., Court Services and Offender Supervision Agency for D.C., and the court; oversees all functions related to human resources (such as hiring and performance reviews); is responsible for program and policy development, grant writing, and management; and serves as a part-time psychiatrist for consumers in the Forensic Outpatient Department – to mention just some of the Director's responsibilities.

DBH staff reported and CCE observed that providing direct services to patients often occupies much of the DFS Director's time, which impairs their ability to function effectively in the managerial role required of a division head. Staff reported that the Director simply does not have enough time to address all of the work that is required of the position.

On several occasions, CCE observed the Director of DFS testifying in court for several hours about competency evaluations the Director had conducted (not to mention the time she spent waiting in court before the case was called). The provision of direct services and participation in the often-necessary follow-up activities are not effective uses of a division director's time.

Given the lack of staffing support for the Director, the Division's workload is unsustainable. Nevertheless, DBH staff reported that the Division's responsibilities continue to grow. This year and next, DBH plans on DFS: (a) supervising staff at the DOC "Portal of Entry"; (b) managing the District's newly funded pre-arrest diversion program; and (c) supervising one or two "forensic-specific" Core Service Agencies that will provide services to justice-involved consumers at all levels of interaction with the criminal justice system.

The responsibilities of DFS, and thus of its Director, can be separated into two units: (a) (access to) treatment and services; and (b) policy-making and coordinating. To provide full support for the Director to fulfill these responsibilities, CCE recommends that DBH establish two new deputy director positions to divide responsibility for those units: a Deputy Director for Forensic Outpatient Treatment and Services and a Deputy Director for Forensic Policies and Program Development.

CCE further recommends that all DFS outpatient staff report through these Deputy Directors (inpatient staff should continue to report to the Assistant Director for Inpatient Services). Staff currently responsible for providing consumers with or connecting consumers to outpatient treatment or services would report to the Deputy Director for Forensic Outpatient Treatment and Services. These programs include DFS's Forensic Outpatient Department, Outpatient Competency Restoration Program, and the re-entry from incarceration linkage programs. The Deputy Director for Forensic Policies and Program Development would oversee the development and implementation of programs and policies related to justice-involved consumers throughout DBH. One or two policy or program analyst positions should be created under this deputy director, as appropriate. Additionally, this unit should house a small data and performance improvement team staffed with experienced professionals who have worked in criminal justice systems to help DFS leverage available data from other agencies.

Staffing Levels

DFS has had significant staff turnover and long-standing position vacancies during the past year. At one point during this review, for several weeks, there were up to five full-time-position vacancies within DFS, or approximately one-fourth of its FY 2017 workforce. In some cases, the Director of DFS assumed the responsibilities of these roles, often because they were one of the few people in the Division qualified or licensed to do so (e.g., the director is a licensed psychiatrist, which is a requirement of one of the vacancies); however, the vacancies span professional disciplines for which specific licenses are required.

Even if fully staffed, DFS would not be able to fulfill its responsibilities without overburdening staff. For example, DFS has only three forensic psychologist positions co-located at the D.C. Superior Court to perform more than a thousand competency screenings and evaluations annually.³⁸ DBH staff reported to CCE in interviews that the number of evaluators was not sufficient to meet the demand. The staff went on to note that this short-staffing limited the flexibility for courthouse evaluators to take leave or pursue professional development. To complicate matters further, two of these positions are currently vacant – one vacancy has been open for several months and the other recently opened after one evaluator was permanently reassigned.³⁹ DBH staff and senior management further reported that, because of the high demand for completing evaluations, DFS significantly truncated evaluator onboarding training for its new-hires because, as one senior staff member said to CCE, “someone needed to get the work done.”

Without being fully staffed at the courthouse, DBH has had to spend a significant amount of money on short-term contract evaluators to meet the court’s demand. In a court hearing, DBH counsel reported that, in November 2017, they paid one contractor ten thousand dollars for ten outpatient evaluations, and expected that contract to last them until DBH was able to contract one or more new short-term evaluators, who would hold the Department over until a full-time staff evaluator was hired.⁴⁰ Instead, DBH exhausted the first contract by the end of the month before any other contractors had been secured, which resulted in DBH’s entering into another short-term contract with the previous contractor until new contractors could be secured in January 2018.⁴¹

In another example of being stretched thin, DBH reported that DFS’s Forensic Outpatient Department has approximately 80 consumers on conditional release from SEH, all of whom DFS monitors in the community and often require some treatment by a bare-bones staff of one nurse, one social worker, a part-time psychiatrist, and a program coordinator. While this might seem like an insignificant caseload of average consumers, DBH staff reported that these consumers have the most complex mental health disorders, many of which are comorbid (i.e., at least two disorders or illnesses in the same person, often interacting such that each condition complicates or worsens the other), and often have complex legal issues (i.e., complicated conditions of release), and, thus, require special, focused attention. For comparison, staff at SEH reported that they generally have less than 30 patients at a time on their caseloads. While many of the individuals at SEH may be more acutely ill than those in the community, consumers in the FOPD have come from SEH and, for many, life in the community gives rise to many often-unforeseen challenges that staff must be ready to navigate.

One DBH staff member said of the FOPD, “[staff] twist themselves like pretzels to keep people in [the FOPD in] the community.” Another staff member reported that such efforts would not be necessary if there were sufficient staff and resources to mitigate problems before they became crises, such as a person decompensating (i.e., losing the ability to maintain normal or appropriate psychological defenses) in the community and having to be returned to SEH.

38 Written response to CCE from DBH General Counsel, Matthew Caspari, at “Response 5”, (April 7, 2017) [hereinafter “DBH response 4/7/17”].

39 In December 2017, CCE sent a Management Alert Memo to the D.C. Auditor expressing concerns about the evaluator’s qualifications. In response to the memo, the Director of DBH wrote that she had reassigned the evaluator to other duties. A copy of the memo and DBH’s written response are included in Appendix III.

40 CCE observation of Mental Observation Hearing, *United States v. [REDACTED TEXT]* 2017 DVM 001300 (D.C. Sup. Ct. November 7, 2017).

41 CCE e-mail and phone correspondence with DBH staff, (2017).

First, DBH should determine whether three evaluators at the courthouse are sufficient to meet the demand for evaluations. If DBH determines that more are needed, funding for additional evaluators, whether full-time employees or contract workers, should be allocated promptly to DFS for their hiring. *Second*, DBH would benefit from creating and implementing an employee-training program, especially for employees in DFS, to ensure clinically appropriate service delivery across the Division. DBH should apply this program to both full-time and contractual staff to ensure the Department's approach to such evaluations is standardized.

Finally, CCE recommends that the Department hire additional staff for the FOPD as a priority to ensure that consumers are receiving needed services and their and the public's safety are protected. In addition, such additional clinical and other direct services staff would lessen the pressure on the Director to provide direct services to forensic consumers.

Internal Controls, Performance Measures, & Data

Finding Three

The Division of Forensic Services' (DFS) internal policies and procedures need strengthening.

Recommendation

That DBH's internal compliance officials work with DFS to ensure that it has adequate internal policies and procedures to meet its statutory and regulatory obligations, such as written employment manuals specific to the Division.

Implementation

This recommendation may be implemented by DFS's amending its internal policies and procedures.

Comment

The Division of Forensic Services lacks adequate internal policies and procedures. Much of the work conducted by DFS's internal staff and others outside of the Division but under its purview (e.g., competency evaluations at SEH) is done in silos, without guidance from written policies and procedures, which results in poor intradivisional communication and, in some instances, inadequate performance. CCE observed several of these communication failures during its review:

First, in a June 2017 D.C. Superior Court hearing, defense attorneys questioned the Director of DFS about the Division's failure to locate, and produce for the hearing, notes from a defendant's competency evaluation, written by a former DFS evaluator. The Director responded that DFS has no formal systems or procedures to archive notes made by DFS employees who have left DBH. Rather, the Director testified, DFS psychologists and psychiatrists maintain their own notes and are free to take them when they leave the agency. Consequently, the Director testified that they were unable to locate, and provide to defense counsel, the notes in question. Defense counsel often request the evaluator notes because they may include more detail than the report submitted to the court. Although subsequent evaluators do not use the handwritten notes of former evaluators to conduct competency examinations, such notes should be available when subpoenaed. DBH staff explained that DFS's lack of note-retention policies and procedures stands in sharp contrast to the practice of SEH, which maintains electronic copies of all the evaluators' notes, including scanned handwritten notes.

Second, in the fall of 2017, DFS did not have enough evaluators at the D.C. Superior Court to meet the court's demand for evaluations. DBH staff and D.C. Superior Court judges reported that, rather than allocating resources to the courthouse, DFS would turn away, and not reschedule, defendants whose examinations had been double-booked by the court. When that happened, judges reported to CCE that DFS would send the court a letter stating that the Division could not complete the examination and request that the court reschedule the appointment. CCE observed that, generally, the court would not become aware of the missed examination, and thus not order the rescheduling until the defendant's next hearing date, thus further postponing the case's progress. On one occasion, when a D.C. Superior Court judge ordered DBH to appear to explain why DFS had turned away a defendant, the Director of DFS admitted to instructing the evaluator to turn away a defendant whose scheduled examination time conflicted with another defendant's appointment, despite DBH reporting to the court that the double-booked defendant was willing to wait. This decision directly violated the court's order, which required DBH to conduct the examination within a specific

statutory time frame (within three days of the court's order if detained, within five days if not). In a written declaration, the Director of DFS later apologized to the court, assuring that no defendant would be turned away again.⁴² In interviews with CCE, DBH staff reported that DFS had no internal policy or procedure for handling overscheduling situations, aside from notifying the Director of such on the day of the evaluation.

Although DBH reports that DFS has not turned away any other defendants for a courthouse evaluation, DFS continues to experience resource allocation challenges when trying to staff the courthouse office. For example, on December 12, 2017, the evaluator's office opened at 10:45 AM despite having a 9:30 AM appointment, reportedly due to an emergency with the evaluator. While emergencies do happen, the lack of written policies and procedures outlining what staff should do when such situations arise impedes the Division's ability to handle scheduling and similar problems nimbly. Moreover, a set of written policies and procedures for handling forensic evaluations at the courthouse would benefit DFS and the people it serves by limiting the need to rely on off-the-cuff discretion and ad hoc decisions for court-ordered work.

Third, DFS did not have adequate policies in place to request and secure interpreters for consumers at its 35 K Street clinic. In a November 2017 hearing that CCE observed, the court ordered DBH to appear after finding that a defendant did not receive interpretation services at the Outpatient Competency Restoration Program for any of his 11 sessions. The court demanded that DBH explain why DFS failed to fulfill its obligations to (a) provide interpretation services for the consumer who needed them and (b) provide court-ordered competency restoration services for the defendant. Counsel for DBH explained to the court that staff had reached out to the language access coordinator, but that the coordinator was on extended leave. There were no follow-up procedures in place if the language access coordinator was unavailable. Counsel for DBH told the court that DFS staff was aware that someone should have arranged for the interpreter in the coordinator's absence, but that no one did.⁴³ Failure to provide interpretation services is a violation of D.C.'s Language Access Act, which requires D.C. government agencies to provide the services for people with no or limited English proficiency.⁴⁴

In these three examples and several others noted by CCE in this report, DFS did not have basic internal policies and procedures in place to ensure that it could fulfill its statutory obligations. Moreover, in at least two cases, DFS developed internal policies only after judges ordered representatives from DBH to appear in court to explain why the failures had occurred. During the hearings, the court offered numerous examples of policies and procedures that might improve DFS's performance, such as reallocating resources to the understaffed units. In making those observations, however, the court emphasized that it is not its place to tell a D.C. executive branch agency how to manage itself. That responsibility, the court noted, resides with the agency. The court urged the Department to be proactive in developing clear and consistent policies and procedures to promote more efficient and responsive operations by DFS.

DFS did not appear to have any employment manuals with information, policies, and procedures specific to its employees' roles, the Division's workplaces, and so forth. Developing such manuals may be helpful for staff to know if internal policies exist and how to handle problems when they arise.

⁴² See *United States v. [REDACTED TEXT]*, *supra* note 40.

⁴³ CCE observation of Mental Observation Hearing, *United States v. [REDACTED TEXT]* 2017 CF1 004105, (D.C. Sup. Ct. November 7, 2017).

⁴⁴ See D.C. Code § 2-1931 *et seq.*

Finding Four

In many instances, DBH was unable to provide requested documentation or data to CCE in a timely manner or at all, suggesting significant department-wide internal control deficiencies.

Recommendations

1. That the Office of the D.C. Auditor (ODCA) or the D.C. Office of the Inspector General (OIG) conduct an audit of DBH's internal controls and control framework.
2. That the Executive Office of the Mayor ensure that DBH has the necessary technical assistance and guidance to improve or where needed, properly design and implement effective internal controls using an internal control framework. The framework should be instructive on how to improve and/or design and implement both operational and financial controls, in addition to controls that will ensure DBH's compliance with laws and regulations at both the local and federal levels. A review of DBH's internal controls would further assist in defining how DBH's internal control framework could be improved.

Implementation

These recommendations may be implemented by (a) ODCA's or OIG's conducting an audit and (b) amending DBH's internal policies and procedures.

Comment

The Government Accountability Office's *Standards for Internal Control in the Federal Government* (the "Green Book") sets forth an overall framework for establishing and maintaining an effective internal control system. The Green Book repeatedly emphasizes that a key attribute of an effective internal control system is an organization's ability to make data, reports, and other relevant information readily available for internal and external examination.⁴⁵

DBH had difficulty providing much of the documentation requested by CCE and ODCA to conduct this review in a timely fashion. While DBH provided timely responses to many requests, on average it took the Department 45 days to provide CCE with the requested information. In some cases, the time between CCE's request and the receipt of responsive information was so long that CCE could not always test and accurately assess the information, DBH's policies, or processes. For example, on August 10, 2017, CCE requested information about the volume of consumers and wait time for services at a specific intercept point within the criminal justice system. CCE received a complete response on November 7, 2017, approximately 89 days (61 business days) after the original request. In another example from the August 10 request, CCE requested information from DBH about staff turnover and vacancy rates at Saint Elizabeths Hospital (SEH) and the Division of Forensic Services (DFS). CCE did not receive a complete response until November 27, 2017, approximately 109 days (73 business days) after the original request.

In some instances, DBH was unable to provide CCE with the information requested at all. DBH responded to several requests that it did not "have responsive data"; "[information] could not be located"; "DBH does not have data for ... available"; and "DBH does not collect data on..." For example, CCE requested the number of consumers served by DBH's Comprehensive Psychiatric Emergency Program (CPEP) Division over three fiscal years, to which DBH responded, "DBH does not have responsive data." However, in previous years, at the request of the D.C. Council during the agency's performance oversight hearing, DBH

⁴⁵ See, generally, U.S. Government Accountability Office, *Standards for Internal Control in the Federal Government* (September 2014), available at <https://www.gao.gov/assets/670/665712.pdf>.

reported not only the number of consumers, but also additional data on those consumers broken down into categories. Ultimately, in February 2018, DBH was able to provide CCE with much of the documentation it had requested throughout 2017, but only after a draft of this report was reviewed executive leadership from DBH and the Executive Office of the Mayor.

Several of the documents received from DBH appeared to have been generated for the first time in response to CCE's request, despite CCE's belief that such documents would be crucial to tracking and planning DBH services. This, coupled with DBH's delays in responding to CCE's requests cast doubt on the reliability of some of the information provided to us. In several cases, CCE and ODCA had to take additional steps to verify the accuracy of information provided by DBH.

The length of time that it took for DBH to respond to CCE's requests for information, and the uncertain reliability of some of the information provided, made it difficult at times – and in some cases impossible – to draw reliable conclusions about certain aspects of DBH consumer volume, policies, and processes; doing so would have raised the risk of error associated with CCE's conclusions as to those matters to an unacceptably high level.

All of the information requested by CCE and ODCA was necessary to facilitate this review – to understand DBH's policies and procedures and the volume of consumers throughout the behavioral health and criminal justice systems, and to assess whether the Department's processes and staff were operating effectively and efficiently. Given the scope of its project, CCE requested data from several areas throughout the agency. CCE did not receive consistently reliable data from any one branch, division, or administration within DBH. The delays in responses and the questionable reliability of certain information received suggest that DBH has significant department-wide internal control deficiencies, which should be urgently addressed.

Given the breadth of these potential internal control deficiencies and DBH's history of problems with internal controls,⁴⁶ CCE believes that this problem requires not only an in-depth review by ODCA, but also technical assistance and guidance from the Executive Office of the Mayor (EOM) to help DBH properly to develop and implement effective *department-wide* internal controls.

⁴⁶ See, e.g., D.C. Office of the Inspector General, *Audit of the District of Columbia Department of Mental Health's Program Management and Administration of Provider Reimbursements* (2007), available at <http://app.oig.dc.gov/news/view2.asp?url=release07%2FReport121107%2Epdf&mode=audit&archived=0&month=00000&agency=74>, [hereinafter "DMH Audit"] (finding that DMH had weak and inadequate internal controls).

Finding Five

DBH does not clearly define, support, or report on performance measures related to services for justice-involved consumers. While DBH has taken steps to understand better the connections between the criminal justice and behavioral health systems and their various programs, and to identify resources, gaps, and priorities, there is still much work to be done.

Recommendations

1. That the D.C. Office of Performance Management (OPM) develop and incorporate into DBH's annual Performance Accountability Report performance metrics that effectively capture and measure DBH's work with justice-involved consumers.
2. That DBH develop an official definition for "forensic" and "justice-involved" consumer.
3. That the appropriate divisions within the Office of the City Administrator work with DBH to develop, implement, and report on internal performance metrics, both department-wide and division-specific, that measure DBH's outcomes vis-à-vis justice-involved consumers.
4. That, in its public reports (e.g., PRISM), DBH report its performance targets alongside their respective actual performance.
5. That DBH publish quarterly reports containing data, trends, and analyses on the justice-involved population.

Implementation

These recommendations may be implemented by (a) DBH's amendment of its internal policies and performance metrics and (b) D.C. OPM's addition of enhanced performance metrics to DBH's *Performance Plan* specific to justice-involved consumers.

Comment

Insufficient Performance Measures

As previously described, DFS oversees the continuum of DBH services for justice-involved people; however, DBH reported to CCE that, until recently, neither it nor DFS formally defined a "forensic consumer" (outside of the definition of "forensic consumer" outlined in the D.C. Code,⁴⁷ which DBH staff reported being rather limited). DBH reported that in 2017, they adopted a more detailed definition of "forensic consumer" than what is outlined in the D.C. Code. Moreover, DBH and DFS reported in early 2018 that they only have a "work-in-progress" definition of "justice-involved consumer." While forensic consumers, given their legal status, are a population that is more easily defined and identified, the lack of a formal definition for justice-involved consumers inhibits DFS from clearly identifying, engaging, and serving a target population. Consequently, DFS cannot effectively develop division-wide performance measures, and DBH cannot assess how the work of its other divisions affects justice-involved consumers.

Without clearly defining the population, DBH cannot distinguish justice-involved consumers as a priority population whose specific needs could be analyzed in the aggregate and addressed appropriately. For example, DBH staff are supposed to link consumers released from jail or prison to Core Service Agencies (CSAs)

⁴⁷ D.C. Code § 7-1321.03 (defining forensic consumers as "persons committed to the care of [DBH] by order of the court in a criminal proceeding.") Justice-involved behavioral health consumers are not a population specifically defined in the D.C. Code. Per D.C. Code 7-1321.03, the definition of a forensic consumer only includes individuals who have been court-ordered to the care of DBH during a criminal proceeding, e.g., ordered to SEH for competency restoration. Thus, "forensic consumer" does not include the average person with a mental illness who is actively involved with the criminal justice system (e.g., is on probation, has one or more cases pending).

(community mental health providers that provide many services to justice-involved consumers). However, DBH does not track those linkages to determine whether those consumers continue to receive services from CSAs after their initial appointments. Once in the community, DBH has no long-term follow-up plan tailored to justice-involved consumers' unique needs, nor an assessable outcomes or quality of care analysis specific to the population. Such follow-up or analysis could prove useful, for instance, in understanding recidivism rate trends among justice-involved behavioral health consumers, from which a strategic plan for systematic improvement could be developed. Instead, once a person is re-enrolled in Medicaid upon release from jail or prison, that person becomes one more consumer among thousands. Thereafter, extrapolating useful data on this important sub-population becomes much more challenging.

Within DFS, there is a dearth of official performance measures. In interviews, DBH staff reported having only three true performance measures, although they are internal: (1) timely completion of forensic evaluations, (2) outpatient competency restoration rates, and (3) the timely completion of monitoring reports on civilly and forensically committed outpatients. While D.C.'s outpatient competency restoration rates from 2009-2014 were published in the *World of Journal Psychiatry* in 2015, the other measures are not readily accessible to the public. Rather, DFS's performance measures appear to be assessed only because there is a statute that requires DBH to generate reports for another government agency. DBH does not publicly report many of the performance outcomes of DFS's other activities not required by statute, such as linking returning citizens with CSAs upon their release from prison or jail ("non-required programs"), the percentage of forensic outpatients in compliance with their court-ordered release, or the number of individuals served by the forensic outpatient program annually. Thus, it did not appear that DFS measures non-required program's outcomes to assess employee or program performance, and, through CCE's many interviews with DBH staff and stakeholders, the outcomes did not appear to be among DFS's top priorities.

Perhaps as a result, previously unpublished outcomes data given to CCE by DBH on DFS's non-required programs demonstrate significant underperformance. For example, DBH reported to CCE that, from FYs 2014-17, only 47 of the 1,142 women (or around only four percent) screened by DBH staff co-located at the Department of Corrections' (DOC) facilities ("DBH liaisons") were newly connected to services upon release from jail. Of those, only nine women, or 19 percent, attended their first appointment with a provider, which is as far as the DBH liaisons reportedly track.⁴⁸ When asked why the majority of women consumers did not attend their first appointments, DBH staff speculated that the women just did not want the help. From FY 2014-16, DBH was unable to report data on the numbers of men served because, it reported, the staff member responsible for tracking such data retired without relinquishing it.⁴⁹ If the performance of these programs is not measured and publicly reported, appropriate attention cannot be paid to their promise or failures.

Outside of DFS, DBH does produce reports on certain aspects of its performance. One report, the department-wide *Mental Health and Substance Use Report on Expenditures and Services* (MHEASURES) is biannual, and the other report, SEH's *Performance Related Information for Staff and Managers* (PRISM) is monthly. MHEASURES contains summaries of "key agency measures related to service cost, utilization and access to the public behavioral health system,"⁵⁰ such as gender and race distribution of consumers, service penetration rates, and so forth. PRISM contains a series of monthly data analyzing various trends related to such things as admissions and the proportions of individuals in various legal statuses. Neither of these reports has published outcome targets from which a lay reader could reasonably assess the success of DBH's performance. For example, MHEASURES reports the total numbers of *all* DBH consumers enrolled in services and the numbers of consumers receiving services; it does not, however, publish target goals or generally any other context for the data. This makes it difficult for the public to assess DBH's performance. In other jurisdictions, such as Washington State, mental health departments will publish their data alongside

48 Written response from DBH General Counsel, Matthew Caspari, at "Request 65," (September 15, 2017) [hereinafter "DBH response 9/15/17 response"] (reporting that beginning in FY 2017, DBH began recording data for men linked to services from the jail).

49 See, Kress, *et al.*, BSC, *supra* note i.

50 DBH, MHEASURES, *supra* note 14, at 2.

that department's specified targets with explanations for any shortcomings.⁵¹ Similarly, in its PRISM and MHEASURES reports, DBH should report its performance targets alongside their respective data and provide analyses for shortcomings.

For every D.C. executive branch agency, the Office of Performance Management (OPM) within the Office of the City Administrator (OCA) annually sets forth a series of strategic objectives, key performance indicators (KPIs), and workload measures, which are measured against specific annual performance objectives in the agencies performance plans. The performance outcomes for each agency are published in an annual individualized report called the *Performance Accountability Report (PAR)*. In FY 2016, DBH had 31 KPIs and 14 initiatives measured in its PAR, none of which focused on the agency's interaction with the criminal justice system or services for justice-involved consumers, including forensic consumers at SEH.⁵² For FY 2017, two items were added to DBH's performance plan – the document that outlines what will be measured annually – that were tangentially related to justice-involved consumers: a strategic objective to maximize housing options for people with severe behavioral health challenges who are homeless or returning from institutions (both forensic and civil consumers), and a “workload measure” of the average daily census of forensic consumers reported each quarter.⁵³

To measure success toward achieving DBH's first additional strategic objective, D.C. OPM uses two new KPIs: (1) the number of housing subsidies awarded to persons who are mentally ill and homeless, and (2) the average length of time a homeless person waits on a DBH waitlist until housed.⁵⁴ Neither of these KPIs nor the workload measure fully captures DBH's success or lack thereof in serving the needs of justice-involved consumers with respect to matters other than housing. DBH must more carefully consider performance and workload measurements that accurately the dynamic nature of the Department: fluctuations in volumes, variance in needs of consumers, statutory and regulatory obligations, and quality and effectiveness of services for both the aggregate population and special subpopulations. More broadly speaking, the lack of performance and workload measurements related to forensic consumers for a department that is statutorily required to provide those consumers with services is striking.

CCE recommends that the appropriate divisions within the Office of the City Administrator (OCA) should work with DBH to develop internal performance metrics, both department-wide and division-specific, when appropriate, that measure DBH's outcomes for services for justice-involved consumers. Specifically, performance metrics should be developed, implemented, and reported for DFS. Below is an example of a performance measures DFS could use to assess the outcomes of its Jail Linkage program:

- Percent of consumers linked to a CSA while incarcerated actively receiving services 30 days after their release.
- ... 60 days after release.
- ... 90 days after release.
- ... 120 days after release.

51 See, e.g., Washington State Department of Social & Health Services, *Strategic Plan 2015-2017* (2016), available at <https://www.dshs.wa.gov/sites/default/files/SESA/spmrw/documents/current/Strategic%20Plans/BHA.pdf>.

52 D.C. Office of Performance Management, *DBH FY 2016 Performance Accountability Report (PAR)*, 1, 2 (2017) https://oca.dc.gov/sites/default/files/dc/sites/oca/publication/attachments/DBH_FY16PAR.pdf.

The PAR does indicate that of the 31 key performance indicators for FY 2016, 39 percent were met, 13 were nearly met, and 45 percent were unmet. Of the 14 initiatives, 21 percent were completed, 21 percent were nearly completed, and 57 percent not completed.

53 See, D.C. Office of Performance Management, *DBH FY 2017 Plan* (2017) available at <https://oca.dc.gov/sites/default/files/dc/sites/oca/publication/attachments/DBH17.pdf>.

The same workload measures for average daily census of forensic consumers carried over into the FY 2018 *Performance Plan*. The reported actuals for this measurement in FY 2017, however, appear to be incorrect, as they did not match up with DBH's own PRISM reports.

54 *Id.*, at 2.

The data from these performance measures might also help DFS in assessing the role of the community provider network in providing services to consumers returning to the community from prison or jail. Other examples of performance measures include:

- wait times for outpatient versus inpatient services,
- denial rates for services and the top reasons for those denials (e.g., no pre-authorization, improperly filed claim),
- percentage of justice-involved consumers receiving ACT and other specialized services.

Gaps and Resources Assessment

Notwithstanding the lack of performance measures, DFS has taken some steps to identify and develop priorities for filling gaps in resources for justice-involved consumers. In 2016, DBH contracted with a research firm to conduct a resource and gaps analysis focusing on the existing connections between programs in the behavioral health and criminal justice systems. After a two-day workshop attended by dozens of stakeholders and DBH staff, the research firm compiled a report for DBH outlining priorities, recommendations, and next steps.

While identifying gaps in resources is important, understanding how best to allocate resources requires reliable data, and a further in-depth study to determine whom programs are reaching, how programs are working, and what impact they are having – or could have – on consumers.

Data Specific to Justice-Involved Consumers

During its review, CCE found that DBH had not made a sufficient concerted effort to collect meaningful data on justice-involved consumers receiving services throughout the Department⁵⁵ and its existing data collection efforts were disjointed. Consequently, the detail and quality of the data DBH staff collected on justice-involved consumers throughout the system varied tremendously. DBH's lack of an applied formal definition for justice-involved consumers may have been a fundamental cause of this problem because it left ambiguous the data that might be relevant.

DBH relies on its staff located at various points throughout the criminal justice system to enter different quantities and qualities of data through different data management systems. The reports generated by these systems reflect their limitations in capturing multiple variables, be them staff- or systems-based. For example, SEH uses a comprehensive electronic health record system that can capture and analyze thousands of variables (e.g., the percentage of times judges agreed with forensic evaluators' recommendations over the course of several fiscal quarters). Conversely, DBH staff co-located at the D.C. Jail use iCAMS, but have limited access to the Department of Corrections' (DOC) data management system. Despite having access to iCAMS, a comprehensive data system, the data recorded by this staff provided very limited information, which consisted of only limited demographic information and the number of people in the jail linked to services by DBH upon their release. For example, for people seen in the D.C. Jail, DBH was able to provide CCE with information only on the number of women served over two fiscal years and not men, reportedly due to limitations in funding,⁵⁶ even though men have comprised over 90 percent of the jail's population for many years.⁵⁷ It was unclear to CCE why the liaisons would be unable to report data on all of the consumers they served if they had access to iCAMS. The liaisons' abilities to collect and report on additional information is inherently limited given the barriers to the resources they have at their disposal.

55 Written response to CCE from DBH General Counsel, Matthew Caspari, at "Response 27", (May 9, 2017) [hereinafter "DBH response 5/9/17"] (writing "DBH does not have any written policies dealing with entering [forensic] consumer data.")

56 *DBH response 9/15/17, supra* note 48 (stating that DBH received a grant a "Second Chances" grant to provide linkage services and supports to women in the D.C. Jail. The grant, which began in July 2014, required data tracking for women served during the award period. The grant ended in 2016, but the data tracking has continued. Data tracking for men at release (but not intake) began after the end of the grant, although it is not clear why. DBH reported that in FY 2017, the Director of DFS requested and was given additional funding to collect data on men at the jail).

57 D.C. Department of Corrections, *Facts and Figures* [webpage], (April 2016), available at <https://doc.dc.gov/sites/default/files/dc/sites/doc/publication/attachments/DC%20Department%20of%20Corrections%20Facts%20and%20Figures%20April%202016.pdf>.

Without a formal definition of justice-involved consumers, it is difficult to obtain accurate data – and in some cases, any data at all – on the population. This makes it particularly challenging for DBH and its stakeholders to know the number of justice-involved consumers DBH serves, the nature of the services, and the timeliness and quality of the services provided. For example, DBH reported to CCE that they “do not collect data on unique individuals evaluated [at the courthouse by evaluators], only [the number of] actual evaluations performed [within a fiscal year].”⁵⁸ However, DFS now asserts that in 2017 it began collecting data on unique individuals evaluated at the courthouse in addition to the number of evaluations performed.

DBH is also apparently incapable of answering the questions other forensic mental health systems ask themselves, including:

- “Do incompetency or insanity findings differ appreciably across evaluators?”
- “What types of community forensic programs exist? How many forensic consumers are served by them? What outcomes exist?”
- “What are the approximate costs of the services described above? Where are the areas with the greatest expense and greatest opportunity for savings?”⁵⁹

⁵⁸ DBH response 9/15/17, *supra* note 48.

⁵⁹ Gowensmith, *et al.*, *Consultant Review*, *supra* note 28, at 15.

Finding Six

DBH's data infrastructure is insufficient to support effective operations and proper resource allocation, especially with regard to the justice-involved consumer population. While DBH has made efforts to improve this infrastructure, DBH cannot realize the necessary improvements without adequate investments in upgrades and enhancements to DBH's systems.

Recommendation

1. That DBH's Systems Transformation Administration produce a comprehensive report for the D.C. Council outlining the capabilities of the current software, a cost-benefit analysis of enhancements and upgrades, and a needs assessment for a system-wide overhaul of the current systems.
2. That, for the time being, DBH develop a comprehensive, interoperable data infrastructure by upgrading and enhancing the software of its *current* systems. Such an infrastructure must be able to capture and warehouse reliable data, adequately track services throughout the continuum of the system, monitor quality of care, and analyze and report on trends and health outcomes.

Implementation

These recommendations may be implemented by (a) the D.C. Council's augmenting DBH's IT infrastructure budget, (b) DBH's leveraging the potential of its current systems, and (c) DBH's amending its internal policies and procedures.

Comment

DBH's Current Data Infrastructure

Since its inception as DMH, DBH's data infrastructure has been critiqued as insufficient. For example, several of the "exit criteria" in the *Dixon* agreement required that DMH collect and report on certain types of data.⁶⁰ In a 2010 report, the RAND Corporation recommended that the District "fundamentally upgrade the data infrastructure of [its] public behavioral health system to allow for improved monitoring of service utilization, quality of care, and patient outcomes."⁶¹ Indeed, DBH has made improvements to its data infrastructure over the years, such as substantially complying with the "exit criteria" and a steady, general improvement of its systems to improve their abilities to compile and analyze data. Nevertheless, DBH's data infrastructure remains inadequate, especially as it pertains to its present abilities to assess the needs of justice-involved consumers. Without knowing how many justice-involved consumers are receiving certain services annually, DBH cannot accurately understand trends, reliably identify high-utilizers of services, or know whether it has allocated enough resources to meet the needs of justice-involved consumers.

CCE observed that DBH uses different systems across its various programs to capture, process, store, and analyze data. For example, the Department uses iCAMS and WITS as its electronic health record systems for mental health services and substance use services, respectively; Incedo (formerly called eCura) as its medical billing software (from which some patient data can be extracted, such as diagnoses); Avatar as the electronic health records system for Saint Elizabeths Hospital (SEH); and dozens of QuickBase applications specifically built for the individual needs of a division or program with limited department-wide access. However, to

⁶⁰ See, generally, DBH, *Dixon Exit Criteria* [webpage], available at <https://dbh.dc.gov/page/dixon-exit-criteria>.

As part of the District's agreement to end federal judicial oversight of DBH during the *Dixon* litigation, the parties agreed to a 19 "exit criteria" with which the Department was required to substantially comply. The exit criteria (a list of them is included in the link above) were broad and included such reforms as "demonstrated implementation and use of function consumer satisfaction methods," and "demonstrated provision of newer generation anti-psychotic medications to adults with schizophrenia."

⁶¹ Gresenz, *et al.*, *RAND Report*, *supra* note 16, at xi.

its credit, DBH has made strides to ensure that responsibility for systems oversight, implementation, and development; data extraction, analysis, and reporting; and development of performance measures and outcome reporting are under the same division. The realignment brought these activities into a single division, Information Systems Innovation and Data Analysis under the Systems Transformation Administration, which is a promising development.⁶² Nonetheless, its present abilities to assess the needs of justice-involved consumers is inadequate.

Many CSAs use an electronic health records system different from that of DBH. DBH can access detailed consumer data from CSAs that use iCAMS, but only limited data – if any at all – from CSAs that use different electronic health records systems. Therefore, DBH does not have an in-depth understanding of the all of the consumers served by its CSAs.⁶³

Senior DBH management reported to CCE that DBH recognizes the gaps and complexities of its existing IT systems and data infrastructure and, therefore, will contract with a consultant to analyze the current systems' utilization, the systems' capabilities, and DBH's system and data needs. The goal of this effort is to develop an enterprise modernization plan, including an implementation timetable, to ensure that DBH has an achievable roadmap for consolidating and replacing existing systems with modern, flexible, scalable, and interoperable IT systems.

Some staff explained that DBH has made numerous attempts to change its systems over the past few years, such as its more recent transition to iCAMS, which staff described as “frustrating” and “chaotic.” Moreover, DBH failed to assess the billing and claiming capabilities of iCAMS before its rollout, which resulted in a costly system failure and the need to recommission the previous system (for more on the system failure, *see* Finding 25). Some DBH and CSA staff invested much time of their time learning one system only to have to revert to using the previous system, eCura (now called Incedo).

DBH staff explained that significant changes from one data system to another inhibit the purpose of the systems: to show the agency how it is performing and how it could improve. DBH staff explained that with several system changes, instead of improving the current systems – such as understanding where there are gaps in information collection and how to fill them, or streamlining workflows and data input processes – IT staff are bogged down in migrating information from one system to another (and occasionally back again). Consequently, meaningful data risk being lost or not adequately or accurately captured. As a result, DBH staff reported that their data has not often been reliable and has been, in some cases, barely sufficient to satisfy minimum data reporting requirements (for an example, *see* Finding 4).

As described by DBH staff and stakeholders to CCE, DBH's newer iCAMS software and older Incedo and SEH's Avatar softwares have the capabilities at present to collect and analyze data, but they can do more if upgraded to their newest versions. However, DBH does not use these software in the same way throughout the Department – if some divisions use them at all – and the training, purpose, and use of data vary significantly. Rather than immediately commence an acquisition of a new system entailing all the risk of system implementation and migration, DBH should leverage its current software capabilities so it can better use data to its advantage. This would require policy development, department-wide training, and changes in attitudes toward data collection. These efforts would not be in vain, however, because they would improve the Department's ability to understand the impacts of its efforts.

⁶² Full descriptions of DBH's Administration are included in Appendix VII of this report.

⁶³ DBH staff reported that limited clinical data can be derived from medical billing claims, but not as much as is provided through an electronic health record.

Management Performance

Finding Seven

DBH leadership needs to be proactive in developing strategies to address systemic and institutional problems as they pertain to justice-involved consumers.

Recommendations

1. That the Executive Office of the Mayor review this report and work with DBH to develop short- and long-term goals for improving the Department's operations as they relate to justice-involved consumers, and devote sufficient resources to ensuring that those goals are met.
2. That the D.C. Council require DBH to produce strategic plans addressing the systemic and institutional failures mentioned in this and other reports, and that the D.C. Council require DBH to produce annual reports detailing progress in carrying out those plans.
3. That DBH's Strategic Management and Policy Division be tasked with developing these plans and overseeing their implementation and progress. This should be done in coordination with DBH's Data and Performance Management Branch, which should develop performance goals against which DBH and the D.C. Council could measure progress.
4. That DBH comply with its statutory mandate that it prepare and publish annual plans (*See* D.C. Code § 7-1141.06(2)).
5. That DBH's establishment act be amended to highlight specifically DBH's roles and responsibilities for justice-involved consumers.

Implementation

These recommendations may be implementing by (a) DBH's amending its internal policies and procedures and (b) the D.C. Council's amending D.C. Code §7-1141 *et seq.*

Comment

In preparing this report, CCE spoke with many current and former DBH staff who have or had worked at the Department and its predecessor agencies for decades. All of them explained how DBH overall has improved tremendously since the time of the *Dixon* litigation and the U.S. Department of Justice (DOJ) oversight, particularly regarding the conditions and care at Saint Elizabeths Hospital (SEH). However, those interview participants, and many others with whom we spoke, described significant systemic and institutional failures pertaining to justice-involved consumers that have persisted for years, including DBH's inability to stem the flow of forensic inpatient admissions to SEH for competency evaluations and restoration, to improve forensic outpatient programs, and to provide for the timely discharge of patients within the most integrated, least-restrictive appropriate setting.

As described in more detail in the introduction of this report, many federal and local lawsuits, their consequent legal decisions, and extended periods of judicial and DOJ oversight have largely shaped the framework of the behavioral health system in D.C. Throughout these various legal proceedings, DBH has largely functioned reactively, responding to standards established by others (e.g., *Dixon* exit criteria, DOJ Civil Rights of Institutionalized Persons Act, or "CRIPA," compliance). With respect to justice-involved

consumers, CCE has similarly found DBH to be largely reactive, developing solutions, policies, and programs to address significant and/or widespread problems in response to forceful demands from the judiciary or the D.C. Council. Stakeholders of all types, Core Service Agency (CSA) staff, and current and former DBH staff reported to CCE that DBH was improving in developing a forward-looking approach to addressing systemic issues, which staff explained were the reasons DBH was successful in exiting DOJ and federal judicial oversight. The same sources, however, also asserted that, more recently, the Department's efforts have largely stalled and, in some cases, been reversed or undone by new senior leadership throughout the agency who lack proactive strategies. Examples of a lack of proactive strategies are discussed below.

First, judges at the D.C. Superior Court ordered DBH, on several occasions throughout the latter half of 2017, to appear to explain why defendants were being waitlisted at the D.C. Jail for admission to SEH. The waitlist and the defendants' subsequent detention at the Jail, the judges explained, violated court orders for admission to SEH and resulted in the unlawful detention of the people with mental illness. They went on to explain how the waitlist subsequently delayed a person's ability to be evaluated within the 30-day statutory requirement. It was not until the judges threatened to hold DBH in contempt that the agency made changes to reduce admission wait time drastically (for pre-trial defendants) and implement a short-term jail-based competency restoration program. (The subject of the admissions waitlist is explored further in Finding 16).

During one hearing, Judge Milton Lee criticized DBH for its delays and failure to follow through on developing solutions to remedy the waitlist, stating:

I got a letter [in] November 2015 sent to the presiding and deputy presiding judges from Dr. Johnson talking about what was going to happen back then to try and resolve the problem... For example, one of the things identified in the document that just baffles me why it hasn't happened is exploring with the Department of Corrections the feasibility of a competency restoration program at the jail... It existed back in November 2015. Best I can tell, in August 2017, it's no further along than the paper [the document is] written on.⁶⁴

He went on to state that DBH's proposed solutions have "zero credibility," saying, "I've given [DBH] enough opportunity to say this is what [DBH is] going to do."

The following week, the court ordered DBH to appear again, this time in front of Judge Lynn Leibovitz. In the hearing, the judge outlined in great detail the history of the court's attempts to work with DBH to find a solution to the SEH waitlist problem, which she referred to as a situation in which DBH's "systematic and institutional... failures being effected upon mentally ill persons who are unable to speak for and represent themselves[.]"⁶⁵ She described how, over the course of two years, DBH leadership repeatedly assured the court that measures were being pursued to alleviate the problem, but that the problem only worsened each summer, becoming the most serious in 2017. She explained how DBH's effort to deflect attention away from the problem allowed it to persist, stating:

On a number of occasions, judges, frustrated at having their orders systematically violated, have ordered the hospital to explain failures to follow their orders and transfer people from the jail [to SEH]... To make the problem go away in those cases, where DBH had been ordered to appear when a defendant had not yet been transferred to SEH, the persons on those judges' particular calendars were then transferred [from the Jail to SEH] immediately so that the problem would go away in that case, and DBH would continue its disregard of others sitting in the jail whose judges had not issued similar orders...⁶⁶

Judge Leibovitz went on to state, "I do believe that the business of transferring individuals in individual cases when the individual judges make a fuss is, unfortunately, a way that has caused the

⁶⁴ Transcript of mental observation hearing, *United States v. [REDACTED TEXT]*, 2017 CF2 11477, 1, 11 (August 4, 2017).

⁶⁵ Transcript of mental observation hearing, *United States v. [REDACTED TEXT]*, 2017 CF2 11477, 1, 17 (August 11, 2017).

⁶⁶ *Id.* at 14.

problem to persist...”⁶⁷

As she observed, instead of proactively addressing the waitlist issues at a systemic-level, DBH focused on transferring individuals case-by-case to render judges’ concerns moot. Judge Leibovitz said the waitlist issue was “capable of repetition, yet evading review,”⁶⁸ thus allowing the court to continue to order DBH to appear on the matter until “a systemic and ... institutional resolution” had been achieved.⁶⁹ In August 2017, the SEH admissions waitlist was dramatically reduced.⁷⁰ However, the reduction was in direct response to forceful demands from the court and not the foresight of DBH.

Second, DBH has not been effective in allocating sufficient resources and sufficient qualified staff to meet the demand for forensic services. Throughout the course of this review, DBH staff reported that the forensic staffing levels throughout the Department were low and that the staff was overburdened. For example, at the D.C. Superior Court, three full-time forensic evaluator positions are responsible for conducting over a thousand competency screenings and examinations annually, which staff said does not allow for much flexibility for staff vacation and sick leave or professional development. Of those three positions, one was vacant for much of the period of this review, while the other was staffed with an individual who did not have any forensic training prior to working for DBH and had their D.C. psychology license rescinded.

On December 8, 2017, CCE wrote a memo to DBH senior management to alert them about (a) information it had received regarding the licensure of a DBH forensic psychologist (“the doctor”) at the D.C. Superior Court, and (b) reports that the doctor was continuing to conduct forensic evaluations (the memo and DBH’s response are included in Appendix III). In early December, CCE learned that the doctor’s psychology license had been rescinded and the doctor was given a psychology associate’s license on December 1, 2017. CCE believed, based on D.C. municipal regulations and ethical guidelines for psychologists, that the doctor’s new license would prohibit them from further conducting forensic evaluations unless directly supervised (i.e., in-person supervision). The doctor continued on staff as a forensic evaluator until December 11, when DBH permanently reassigned the doctor to another role within DBH’s forensic outpatient work, which resulted in one less staff member available to conduct the evaluations at the courthouse.

CCE further explained in its memo that many, if not all, of the evaluations conducted by the doctor at DBH may have put the criminal cases associated with those evaluations at risk for review by the courts. In their response to our memo, DBH disagreed with CCE’s concerns (DBH’s response is included verbatim in Appendix III). Nevertheless, the courts and stakeholders remained concerned about DBH’s abilities to foresee and mitigate this and other similar problems. In a court hearing on another matter in which DBH was ordered to appear, D.C. Superior Court Judge Milton C. Lee told DBH with regard to the topic of CCE’s memo, “This is a nightmare waiting to happen. [The case of the doctor] is a new fire in putting out fire after fire. I want to see something internally to address these issues rather than someone outside of DBH bringing it to your attention.”⁷¹

In another example, there is only one full-time forensic evaluator at SEH, who reportedly recently changed roles at the hospital. The remaining evaluators are SEH psychologists and psychiatrists who volunteer their time to conduct evaluations but are not required to do so. SEH staff reported that if even a handful of volunteer evaluators were to no longer volunteer, the inpatient forensic evaluation system may very well

⁶⁷ *Id.* at 24.

In November of 2015, DBH stakeholders reported that D.C. Councilmember Mary Cheh sent a letter to DBH also inquiring about the Department’s plans to address the growing admissions waitlists at the jail. According to the reports, DBH did not formally respond to the letter until approximately three months later.

⁶⁸ *Id.*

⁶⁹ *Id.*

⁷⁰ Arguably, DBH rebranded the waitlist as a short-term jail-based competency program, which is not something expressly permitted by D.C. law. This topic is discussed further in Finding 16.

⁷¹ Keith L. Alexander, *Advocacy Group Raises Concerns About Psychological Evaluations on Hundreds of Defendants*, The Washington Post (December 14, 2017), available at https://www.washingtonpost.com/local/public-safety/advocacy-group-raises-concerns-about-psychological-evaluations-on-hundreds-of-defendants/2017/12/14/9d926822-dff9-11e7-8679-a9728984779c_story.html?utm_term=.895fe0c0e1dc.

unravel. At the drafting of this report (February 2018), two SEH psychologists who were volunteer forensic evaluators had reportedly resigned from DBH, thus decreasing the total number of available evaluators.

The volunteer network of SEH evaluators is neither dependable or sustainable long-term. DBH should urgently reconfigure the forensic evaluation system at SEH in an effort to mitigate the problems that could arise from a dwindling volunteer evaluation service.

Third, DBH failed to test the billing capabilities of its new comprehensive medical records software, iCAMS before it was rolled out (see Finding 25). A few months after rolling out the software in early 2016, DBH discovered that the software was not properly differentiating Medicaid and local-dollar reimbursement claims from DBH's Core Service Agencies (CSAs). Instead, iCAMS was identifying Medicaid-eligible claims as local-dollar claims – or non-Medicaid eligible services paid for by local D.C. funds – thus drawing down on providers' finite local-dollar allocations. To correct the issue, DBH decommissioned iCAMS and recommissioned its previous billing software through which is reprocessed all of the claims. During this reprocessing of claims, from April to August 2016, DBH suspended local-dollar payments to CSAs on claims they had submitted after April 15, 2017. Providers reported to CCE that they were uncertain about the availability of local dollar funds – both their contracted amounts and requests for increases, which providers reported are commonly requested mid-fiscal year. Accordingly, providers reported ceasing to provide local-dollar services for consumers, many of whom, they said, were consumers in the most need of care. Indeed, providers reported to CCE and testified to the D.C. Council that DBH delayed payments by months for many large reimbursement claims, which financially restricted providers' abilities to serve consumers and reportedly contributed to the closures of some providers with pre-existing financial troubles. At the end of FY 2016, providers and DBH remained in dispute about many local-dollar claims that providers had submitted to DBH during that fiscal year.

In interviews and discussions with CCE and ODCA, DBH senior management conceded that the Department should have tested the capabilities of the billing aspects of iCAMS before the software went live. While DBH was successful in recommissioning its old software to reprocess all of the claims, which ultimately allowed the providers to be paid, DBH's failure to test the software had tremendous fiscal impacts on the Department, local providers, and on D.C.'s most vulnerable residents.

These examples are a handful of many described in CCE's findings throughout this report that show DBH's continued need to develop and implement strategies to proactively address long-term concerns. The examples in this finding also serve as evidence for other findings throughout this report, which demonstrates the ripple effects the lack of applied strategies can have.

Finally, DBH reported to CCE that it did not have any annual plans.⁷² DBH would benefit from a regular strategic planning process, as is done by departments of mental health in 8 other states. These processes help the agencies articulate their priorities for a period of years and outline the strategies they plan to implement to achieve their goals. For instance, the New York Department of Mental Health produces a statewide, comprehensive plan every four years. The plan informs the public about the department's mission, core values, and vast portfolio, and about programs in place and those in development. In producing the plan, the Department surveys communities to understand their mental health service priorities, the findings of which are reported and then used to develop statewide priorities. The plan also includes a chapter on forensic-specific initiatives.⁷³ DBH's establishment act, and that of its predecessor agency to which DBH is also required to adhere, mandate that services be funded for the priority populations identified in DBH's "annual plan."⁷⁴

In exercising its oversight of DBH, the D.C. Council should direct the Department to produce such annual

⁷² CCE e-mail correspondence with DBH General Counsel, Matt Caspari (March 9, 2017).

⁷³ See, generally, New York State Office of Mental Health, 2016-2020 OMH Statewide Comprehensive Plan (2016), available at <https://www.omh.ny.gov/omhweb/planning/docs/507-Plan.pdf>.

⁷⁴ See D.C. Code § 7-1131.01(1); and D.C. Code § 7-1141.06(2).

plans. Furthermore, the D.C. Council should amend DBH's establishment act to highlight specifically its roles and responsibilities for justice-involved consumers.

Finding Eight

DBH leadership has reportedly implemented ill-advised changes, including new policies that may have increased the Department's risk of violating patient's rights and reversed progress it had been making.

Recommendation

That the Executive Office of the Mayor (EOM) conduct a thorough review of the performance of the current Director of DBH, with respect to the Department's forensic work, including risk assessments of any policy or rule that may impact justice-involved consumers, and take appropriate action.

Implementation

The EOM can implement this recommendation in the course of its review of the performance of DBH leadership.

Comment

Note: This finding contains allegations related to personnel matters reported to CCE and ODCA throughout the course of their review by current and former DBH staff. None of this information was received through official personnel files or human resources personnel. CCE notes that DBH is restricted from commenting on personnel matters, including in interviews with CCE or in its written responses to this report.

Over the past three decades, staff and management at DBH's predecessor agencies, a few of whom still work for DBH, helped implement drastic changes that significantly improved the District's behavioral health system. Interviewees with whom CCE spoke, who had decades of involvement with the Department, explained that, during those years, the Department had acquired a very negative national reputation. Through hard work and dedication, staff and management turned things around and the Department ultimately became well regarded and could attract talent from across the country. The interviewees went on to assert, however, that DBH's reputation has suffered since the appointment of its new Director in 2015 and that individual's subsequent implementation of a series of changes. In opinion of many interviewees, many of these changes have stalled or reversed the progress DBH had been making. Multiple DBH staff and stakeholders stated that, in their opinions, DBH's current performance is the worst it has been in many years. The interviewees pointed to several examples to illustrate their concerns:

First, as reported to CCE by several interviewees, one of the most notable actions by the current Director was their termination of and request for the resignations of several members of DBH and SEH upper management who had helped see the Department through significant improvements, including exiting federal oversight. For example, in early 2016, the Mayor and the Director of DBH replaced the interim CEO of Saint Elizabeths Hospital (SEH), a forensic psychologist with 20 years of experience at the hospital who had helped see the hospital through the U.S. Department of Justice (DOJ) oversight, with a candidate who seriously misrepresented his credentials and was not qualified for the position. In fact, D.C. regulators had previously found the candidate unqualified to work at the University of the District of Columbia as the "[Registered Nurse] director of nursing for non-credit programs,"⁷⁵ a position to which the Executive Office of the Mayor also appointed him. While these two positions may not require the same qualifications, it seems logical that the individual's removal from one mayoral-appointment for lack of qualifications would have warranted a more thorough vetting process for a more consequential position. Nonetheless, the Director of DBH defended his qualifications and told *The Washington Post*, "The staff are united behind him; the staff

⁷⁵ Fenit Nirappil, *Bowser's Pick for St. Elizabeths CEO Resigns Amid Questions About Qualifications*, The Washington Post (April 4, 2016), available at https://www.washingtonpost.com/local/dc-politics/bowsers-pick-for-st-elizabeths-ceo-resigns-amid-questions-about-qualifications/2016/04/04/dcd2762e-faa6-11e5-80e4-c381214de1a3_story.html?utm_term=.e3d929088c7b

are engaged.”⁷⁶ That was not the case, according to a number of current and former DBH staff who spoke to CCE. Ultimately, that CEO resigned in less than a month, after which the current Director of DBH assumed the role of interim CEO until the current CEO was appointed several months later.

Second, current and former DBH staff asserted to CCE that the current Director of DBH terminated or requested the resignation of several key figures throughout the Department. Current and former staff further asserted that several staff also resigned because they believed the changes being implemented or proposed by the new leadership were not in the interest of the individuals served by the Department and would not lead to improvements in care or processes. One former senior DBH staff member said, “I don’t know why you would drive out the people who got the department in the best shape it had ever been.” DBH staff asserted that the current Director then filled management positions often without competition, and that in some cases, the new managers were not among the candidates most qualified for their roles. In discussions with CCE and ODCA, DBH executives said that the Director of DBH has made all personnel decisions in compliance with D.C. rules.

Third, during the course of this review, staff throughout DBH reported to CCE that they suffered from low levels of morale under the leadership of the current Director of DBH. In interviews with CCE, staff alleged that the new leadership (the Director and the much of the management the Director hired) are not receptive to constructive feedback, are hostile and aggressive to employees and patients, and are flippant with respect to the Department’s relationship with and obligations to the court. Many staff said that they or their colleagues would likely leave DBH if presented with work opportunities elsewhere.

Fourth, a number of current and former staff stated that the current management made several potentially significant decisions without consultation that they believe have increased DBH’s risks in a number of areas. For example, they state that DBH has limited the amount of money Core Service Agencies (CSAs) can bill for providing discharge planning services to consumers while they are incarcerated or institutionalized (*see* Finding 20). These DBH and CSA staff reported that the recent changes have shifted much of the burden of discharge planning at SEH from the CSAs to the hospital’s social workers, which has overwhelmed their workload, as they also have clinical and other responsibilities. Consequently, DBH staff asserted that patients are held at SEH for protracted lengths of stay beyond clinical necessity. During federal oversight of SEH, DOJ found that similar over-hospitalizations were violations of patients’ rights and required the Department to take steps to remedy the problem. DBH’s recent change in policy reportedly failed to consider DOJ’s previous recommendations during federal oversight to improve discharge planning.⁷⁷ As such, the change may have been ill advised because it greatly increases the potential for delayed discharge, which in turn increases the risk that DBH will again be found to have violated the Civil Rights of Institutionalized Persons Act (CRIPA).

A number of current and former staff stated that this and other policy changes by current leadership fail to improve consumer outcomes because they are stringent and do not consider the importance of flexibility in policies for individuals with varying needs. In her testimony at DBH’s oversight hearing in front of the D.C. Council, the Director of DBH explained that discharge planning outside of the timelines outlined in the new policies was not clinically or medically necessary or appropriate.⁷⁸ Current and former staff interviewees all agreed that reforms to discharge services timing were necessary to mitigate the potential for inappropriate overbilling for services, but they expressed frustration that the Director of DBH made the policy changes without the input of staff or stakeholders, resulting in a significant unintended system-wide impact. Current and former senior DBH staff familiar with the various compliance requirements asserted that delays in patient discharge, especially when the patients no longer require hospitalization, may jeopardize the hospital’s CMS funding.⁷⁹

⁷⁶ *Id.*

⁷⁷ *See, e.g., CRIPA Investigation Letter, supra* note 5, (reporting as part of the DOJ’s CRIPA investigation that SEH did not have adequate discharge planning procedures, which resulted in prolonged hospitalization of inpatients. The letter also outlined six recommendations for SEH to become compliant with CRIPA.)

⁷⁸ Testimony of DBH Director Tanya A. Royster before the Committee on Health, Agency Performance Oversight Hearing (February 23, 2017).

⁷⁹ “CMS” stands for Centers for Medicare and Medicaid Services. The “CMS maintains oversight for compliance with Medicare health and safety

Finally, current and former DBH staff, community providers, stakeholders, and consumers all expressed to CCE that for the past four years, DBH has been in a significant state of flux. While interviewees noted that many of the changes were positive, most of the changes happened in such quick succession that DBH staff, providers, and consumers felt they were not given enough time to adjust to and assess the impact of the changes. Below are some of the significant changes that have happened at DBH within the past four years:

- The Department of Mental Health and Addiction Prevention and Recovery Administration merge to form DBH (2014)
- DBH contracting authority shifts from internal control to under the purview of the Office of Contracting and Procurement (2015)
- DBH adopts Health Homes model (2015)
- DBH procures and rolls out iCAMS, a new electronic health records and medical billing system, which ultimately failed to adjudicate claims (2015-2016)
- DBH switches to Medicaid billing for substance use providers (2017)
- New, more stringent medical necessity criteria are imposed on some local-dollar services (2017)
- DBH reorganizes majority of its organizational structure, which included the reclassification of some employees (2017)

DBH does not appear to have managed all of these changes successfully. Moreover, DBH has reported that more significant changes can be expected in the coming years. At the drafting of this report, DBH is in the process of procuring new software that would determine a consumer's eligibility for services based on medical necessity criteria. Additionally, the Department of Health Care Finance (DHCF) and DBH have been working to transfer the certification and oversight authority of the District's freestanding mental health clinics from DHCF to DBH. Many interviewees believe that these changes could have a positive impact on the community if rolled out carefully but questioned whether current DBH leadership was capable of so doing.

standards for acute and continuing care providers," such as hospitals. See, generally, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/index.html>.

Finding Nine

The Division of Forensic Services' management has failed to (a) meet the Division's statutory obligations and (b) foster a healthy work environment in which staff can flourish.

Recommendations

1. That the Executive Office of the Mayor (a) review the performance of DFS management and assess DFS management's ability to carry out effectively the Division's obligations, and (b) to take appropriate action.
2. That the Executive Office of the Mayor consider management for DFS that can succeed under CCE's recommended new divisional structure (*See* Finding 2, Recommendation 1, recommending that the Director of DFS be a mayoral-level appointment).

Implementation

The EOM can implement these recommendations in the course of its review of the performance of DFS management.

Comment

Note: *This finding contains allegations related to personnel matters reported to CCE and ODCA throughout the course of their review by current and former DBH staff. None of this information was received through official personnel files or human resources personnel. CCE notes that DBH is restricted from commenting on personnel matters, including in interviews with CCE or in its written responses to this report.*

DFS Leadership

The position description for the Director of DFS states that the incumbent's responsibility is to "ensure that DBH maintains compliance with all court mandates and the provision of oversight of all forensic programs within the DBH."⁸⁰ During CCE's review, D.C. Superior Court judges ordered DBH to appear in court numerous times to explain why DFS had failed to comply with a number of court orders. Throughout the different hearings, the judges contended that DFS failed to:

1. Admit people promptly to Saint Elizabeths Hospital (SEH) for competency evaluations and restoration treatment as required by D.C. Code § 24-531.04 (discussed in Finding 16);
2. Conduct preliminary competency screening examinations of defendants as required by D.C. Code § 24-531.03(c)(2) (discussed in Finding 3);
3. Ensure timely completion of competency evaluations within required statutory timeframes as required by D.C. Code § 24-531.04(a)(1) (discussed in Finding 16);
4. Provide necessary ancillary services to fulfill competency restoration services as required by D.C. Code § 2-1931 *et seq.* (discussed in Finding 3).

Many of the DBH staff and stakeholders with whom CCE spoke remarked that, in their opinions, the current Director of DFS does not seem to understand the importance of the Department's statutory obligations to both the court and consumers.

During the course of this review, several interview participants explained that DBH staff working with justice-involved consumers suffer from low morale. According to many interviewees, the low morale is mainly attributable to the new DFS and DBH leadership. Current and former DBH staff asserted that the consequences of the low morale include staff departures, high staff turnover rates, recruiting difficulties, and attrition, all of which have resulted in increased workloads.

⁸⁰ See Position Description, *supra* note 24.

Many DBH staff reported that, if they were presented with another employment opportunity, they would leave, albeit many regretfully because of their deep love of their work and their passion for their clients. Indeed, in a CCE survey of DBH forensic staff, 100 percent of the respondents reported both that they enjoy the work they do (with 58.33 percent strongly agreeing) and that the work they do is important (with 84.62 percent strongly agreeing). Conversely, only about 42 percent of staff reported having confidence in and a high level of respect for DBH senior leadership. One respondent wrote that the DBH senior leadership was the “worst [I] have ever seen.”

Almost everyone with whom CCE spoke raised concerns about the management style and behavior of the Director of DFS. Current and former DBH staff, stakeholders, CSA staff, and consumer advocates described the management style and behavior as “vindictive,” “punitive,” “volatile,” and “adversarial.” Many expressed concerns about the number of staff and patient complaints filed against the Director. Many DFS staff agreed to speak with CCE only on the condition of anonymity, asserting a fear of retribution from the DFS Director. Moreover, many DBH staff stated that former colleagues have left because of frustrations in working with the Director of DFS and that many are considering leaving.

Indeed, court records show a long list of complaints filed against the Director of DFS while they were in their role as a forensic psychiatrist at SEH. Moreover, after investigating six complaints filed against the Director in 2008 ranging from lack of professional deportment to verbal abuse of staff and patients, DBH’s Office of Accountability issued a 10-page report that reached the following conclusion:

... the overall findings of this review support the position that [the current Director of DFS] behaved in a manner towards patients and staff members that could reasonably be considered to be argumentative, loud, offensive, abusive, and unprofessional. [The current Director of DFS]’s behavior could be characterized as inappropriate for a professional work environment in an inpatient forensic psychiatric setting.⁸¹

Despite the findings of that report, the Director of DFS was promoted to their current position. Court records further show that, in FY 2017, the Director of DFS was the target of two Equal Employment Opportunity (EEO) complaints,⁸² which DBH asserted were both unsubstantiated. DBH staff and stakeholders asserted that DFS has difficulty recruiting because of the DFS Director’s reputation within the close-knit forensic behavioral health community. One staff member said, “No one wants to work for [the Director of DFS], because they’ve heard how horrible it is [to do so].” Staff noted that, in the past, they encouraged friends and former colleagues to apply for forensic positions at DBH but that they no longer do so because of the hostile and negative work environment reportedly fostered by the Director of DFS.

In interviews with CCE, DBH leadership cited low pay rates as the primary reason for the Department’s recruiting difficulties. However, several current and former DBH staff members, national experts, and stakeholders reported that DBH pays more than most places, especially in the region, with the noted exception of psychiatrists. For example, one staff member said they made more money in their current job at DBH than they would in a similarly situated position in a different state within the D.C. region. Indeed, throughout this review, full-time forensic psychologist positions listed by the state of Maryland showed a salary range in which the maximum salary possible was still lower than the salary of the lowest paid psychologist on DBH’s payroll in September 2017.⁸³

81 Transcript of mental observation hearing, *U.S. v. [REDACTED TEXT]*, 2017[REDACTED], 1, 85 (June 9, 2017).

82 See, generally, *id.*

83 In November 2017, the State of Maryland listed a “forensic psychologist” position on their state jobs website with a salary range of \$53,193 to \$85,401 (position recruitment #17-000612-00007). In September 2017, the lowest psychologist salary on DBH payroll (excluding psychologist interns) was almost \$88,000. See, generally, DCHR, *Public Body Employee Information as of September 30, 2017*, (September 2017), 1, 902, available at https://dchr.dc.gov/sites/default/files/dc/sites/dchr/publication/attachments/public_body_employee_information_09302017.pdf.

DBH reported that in a recent union negotiation with Doctor’s Council Union, the Doctor’s Council Union presented information to show that salaries of the psychiatrists at Saint Elizabeths Hospital were significantly lower in comparison to other public psychiatric salaries in the area. The final report findings concluded with a recommendation to increase salaries of the doctors at DBH. Data and research highlight that the District pays psychiatrists less than other neighboring jurisdictions. Thus, D.C.’s recruitment problem for psychiatrists is not surprising; an average psychiatrist will make an annual salary of \$186,000 in Maryland or \$193,920 in Virginia, contrasted with only \$134,070 in the District. In 2013, for instance, there were in 340 psychiatrists licensed in the District. In 2016, there were 240.

In several interviews, DBH staff and stakeholders remarked that, despite its many current structural flaws, DFS would function much more effectively if a different were to person assume the position of Director of DFS. Stakeholders stated that DFS staff are passionate about their work and deeply care for consumers, for which they should be appreciated, but that the Division's *esprit de corps* needs urgent improvements to avoid an exodus of staff.

Forensic Processes

Finding Ten

For years, DBH has not had a standardized approach to its competency evaluation and restoration procedures, such as department-wide policies, guidelines, or training manuals. Recently, staff at Saint Elizabeths Hospital developed a competency restoration-training manual for use throughout DBH.

Recommendation

That DBH consult with national experts who specialize in forensic training programs to develop a formal, rigorous forensic training program for current and future staff

Implementation

DBH can implement this recommendation by consulting with national experts to develop and/or amend its internal policies and procedures.

Comment

DBH staff reported that, for many years, DBH lacked a set of policies and procedures that outlined the competency evaluation and restoration process. In lieu of such procedures, staff reported that they leaned on their educational and professional experiences to perform evaluations, write reports, and fulfill other duties. More experienced staff informally compiled some of these policies and procedures into a manual for new hires to develop consistency in written reports. These manuals were not official DBH documents and reportedly changed frequently.

In October 2017, Saint Elizabeths Hospital (SEH) staff developed a comprehensive manual with resources and guidelines for providing competency restoration services. The manual, called the “CompKit,” is based on a guide used in Florida’s state hospital, with minor adaptations for D.C. law and procedures.⁸⁴ SEH staff should be commended for taking the initiative to pursue a standardized approach to competency restoration and provide resources and information for staff who have less familiarity with the process.

The CompKit, however comprehensive, is no substitute a formalized training program for forensic evaluators or staff administering restoration services. Instead, the CompKit should be used as a tool to provide *forensically trained* staff with additional resources. Indeed, in Florida, where the CompKit was originally developed, the kit is used as a resource, as evaluators are required to complete an approved forensic training program.⁸⁵ The Florida Department of Children and Families contracts with the University of South Florida to provide forensic training to its evaluators.⁸⁶ While their training program is not as rigorous as others described elsewhere in this report, it offers its evaluators more than is currently offered in D.C.

DBH could use the CompKit as a basic tool in developing a formal, rigorous training program. The kit could be used throughout the program, but not in lieu of a comprehensive training program for evaluators and staff. Given the heavy workloads of the current forensic staff at DBH, CCE does not recommend that they devote time to develop and implement a comprehensive forensic training program for DBH. Therefore, DBH should contract with experts from other jurisdictions who have developed training programs elsewhere.

⁸⁴ At the writing of this report, while in use at DBH, the CompKit was still an unfinished product, *i.e.*, was still being adapted by DBH staff to best fit the needs of staff performing evaluations at SEH.

⁸⁵ See Fla. Stat. Ann. § 916.115(1)(a).

⁸⁶ See Florida Department of Children and Families, *Forensic Evaluator Training and the Importance of Appointing Approved Forensic Evaluators as Experts* [webpage], available at <http://www.myflfamilies.com/service-programs/mental-health/forensic-evaluator-training-and-importance-appointing-approved-forensic-evaluators-experts>.

DBH should develop the program in concert with DBH staff, local forensic behavioral health experts, and attorneys who specialize in the District's mental health laws. The program should culminate in a certification exam administered either by the Department or by an entity providing the training under contract with DBH.

Finding Eleven

DBH forensic evaluators and other staff working with forensic consumers vary tremendously in their professional abilities, experience, and training, including some who have no formal training, education, or experience in forensic behavioral health whatsoever. The lack of proper training or credentials presents an ethical dilemma for some employees.

Recommendations

1. That the D.C. Council amend the D.C. Code to require that psychologists and psychiatrists performing forensic screenings and evaluations are (a) board-certified and (b) forensically trained and certified, either through formal education or through comparable professional training programs. The D.C. Council should also require that forensic evaluators be recertified as appropriate. (Suggested language is included in Appendix XI)
2. That DBH require that its forensic evaluators comply with the standards in CCE's recommended legislative amendment in this finding's first recommendation.

Implementation

These recommendations may be implemented by (a) the D.C. Council's amendment of D.C. Code § 24-231 *et seq.*, and (b) DBH's establishment of a certification program for its forensic evaluators, and (c) DBH's requirement that its forensic evaluators be certified in compliance with the standards set forth in the referenced amendment

Comment

Forensic evaluators are a crucial component of DBH's forensic work. DBH's evaluators – who, by law, must be psychologists or psychiatrists⁸⁷ – are located throughout DBH (Saint Elizabeths Hospital, outpatient at DBH's 35 K Street, N.E., clinic, the D.C. Superior Court, and the D.C. Jail). They provide a variety of forensic evaluations for the court, although the most common being an assessment of a defendant's competency to stand trial. Despite the high demand from the court for evaluations, DBH allocates only three full-time evaluators at the courthouse to administer preliminary competency screening examinations and full competency evaluations.⁸⁸ Approximately eight Psychologists and two psychiatrists at Saint Elizabeths Hospital (SEH) conduct forensic evaluations on a mostly volunteer basis, doing so in addition to their full-time responsibilities as treatment providers in the hospital's units. Two part-time psychiatrist positions, one of which is vacant and whose responsibilities are frequently assumed by the Director of DFS, function as both outpatient evaluators at 35 K Street, N.E., and as the psychiatrists for the Forensic Outpatient Department (FOPD).

In addition to the forensic evaluators, hospital and outpatient program staff also must interact with and provide various services to forensic consumers. SEH unit staff – psychologists, psychiatrists, clinical administrators, behavioral health technicians, and others – provide competency restoration and other services to pre-trial defendants. Mental health coordinators and licensed clinicians at DFS provide competency restoration and other services for outpatient forensic consumers. The levels of experience, training, and education vary widely across this spectrum of employees who interact with forensic consumers. Many do not have any forensic training or experience at all. Additionally, DBH reported in correspondence with CCE that “staff who have previously not done forensic pre-trial work are now being forced to do so without proper training.”⁸⁹ Evaluators and other staff with exposure to forensic consumers are discussed in turn.

⁸⁷ See, e.g., D.C. Code § 24-531.03(d)(1).

⁸⁸ At the drafting of this reporting, one of the psychologist positions was vacant and the other filled by an individual who has been temporarily reassigned to other duties. For more on the reassignment, see Appendix III.

⁸⁹ DBH response 4/7/17, *supra* note 38, at “Response 10,” (information from document provided in the response titled, *Saint Elizabeths Hospital: Forensic Services – Pre-trial*).

Requirements for Forensic Evaluators

The American Psychological Association (APA) code of ethics states explicitly that psychologists should practice “with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, study, or professional expertise.”⁹⁰

The APA code of ethics allows psychologists to practice outside of their scopes of competence and conduct assessments “for training purposes with appropriate supervision.”⁹¹ Despite this and as noted, DBH does not have a forensic training program, and SEH and DFS handle forensic training on a case-by-case basis without formally developed training materials. While there is not a national standard for the training and certification of forensic evaluators, the National Judicial College cites forensic training as a national best practice: “Regardless of the clinical skills of the mental health professional, it is a best practice for the mental health professional who performs the competency evaluation to be forensically trained in performing [such evaluations.]”⁹² Accordingly, several states have adopted statewide training and certification standards that are reflective of their laws and practices. However, Matthew Huss, a forensic clinical psychologist at Creighton University, explains that forensic training alone is generally not sufficient, saying, “Someone might be trained as a forensic psychologist but that does not give her the requisite experience to practice all aspects of forensic psychology.”⁹³

In Massachusetts, forensic evaluators must gain and keep state certification. The certification program includes both the initial certification and an ongoing periodic review period for those enrolled. The certification program has four parts: a week of classroom training on legal standards relevant to the field, a period of practice supervised by an assigned experienced evaluator, a written exam, and a satisfactory report from an outside committee that reviews a sample of the candidate’s written evaluation reports.⁹⁴ Dr. Ira Packer, who directs the Forensic Evaluation Service at the University of Massachusetts Medical School for the state’s Department of Mental Health, says that a contract with the state funds the certification program. The medical school also manages the evaluation program for the forensic evaluators at the state’s courthouses and in forensic hospitals. Dr. Packer explained that the certification process could take two to three years if an evaluator is working at a courthouse, which has a limited volume of work, but the process can take a shorter time if the person works at a state hospital, where there is greater and more frequent exposure to the material. Generally, the preference in the field, he said, is to hire evaluators who have participated in a post-doctoral forensic fellowship program. However, he explained, there are not enough graduates completing those fellowships to meet the demand from the court, which is one of several reasons DBH has had difficulties recruiting qualified professionals in the forensic division.

Relevant stakeholders in the District of Columbia echo these conclusions that evaluators be properly trained and credentialed. Judges have said, both to CCE and in hearings, that they generally agree with the recommendations of DBH’s forensic evaluators vis-à-vis hospitalization for treatment, competency restoration, and further evaluation, especially those from courthouse evaluators conducting the initial competency screenings and first full competency evaluations.⁹⁵ Courthouse evaluators play a key role in helping judges determine whether to order a person to SEH or outpatient programs. Therefore, it is paramount that they be highly skilled and experienced in their field; they are essentially DBH’s first line of defense in mitigating unnecessary or improper hospitalizations at SEH, which take up much-needed bed space.

90 American Psychological Association (APA), *Ethical Principles of Psychologists and Code of Conduct*, 1, 4 (effective June 1, 2003, as amended 2010), available at <https://www.apa.org/ethics/code/principles.pdf> [hereinafter “Ethical Principles”]

91 *Id.*, at 13.

92 National Judicial College, *Model Competency: Best Practices Model*, 1, 8 (2012) [hereinafter “Model Competency”].

93 Matthew T. Huss, *Forensic Psychology: Research, Clinical Practice, and Applications* 65 (1st ed. 2009).

94 CCE phone interview with Ira Packer, Ph.D., *supra* note 27.

Dr. Packer also reported that the state has report-writing manuals for both competency to stand trial and criminal responsibility evaluations.

95 For an on-the-record example, see, e.g., Mental health observation hearing, *United States v. [REDACTED TEXT]*, 2017 CF1 5232 (August 11, 2017), (stating, “... and when the Department of Behavioral Health recommends that [a defendant] be hospital for treatment, that is what I generally order.”)

DBH staff, judges, and attorneys reported to CCE that, in general, the quality of the reports of non-forensically trained evaluators is unsatisfactory. Judges and attorneys reported that some of the evaluators' reports reflect incorrect understandings of the legal system. One judge asked rhetorically, "How can you evaluate someone's understanding of the legal system if you yourself do not know how it functions?" One such example reported to CCE was that an untrained forensic evaluator was unaware that in D.C. people charged with certain misdemeanors have a right to a jury trial.

DBH staff explained the importance of evaluators having a keen understanding of mental illness and substance use disorders and the effects they might have on a person's competency. For example, a person may present with symptoms of psychosis, but further observation and evaluation may indicate that the person has dementia or has a long history of drug use, or is perhaps even inebriated at the time of the evaluation. An improper assessment by an untrained evaluator could unnecessarily land a person in SEH for days or weeks at the expense of D.C. taxpayers.

DBH's Compliance with Appropriate Training and Certification Standards

CCE's review of DBH's training and compliance with various requirements suggests that a number of DBH's practices can be improved, with respect to both forensic evaluators and other staff.

Forensic Evaluators

First, during this review, CCE found that at one time, two of three forensic psychologists – both recent hires at the D.C. Superior Court – were not forensically trained, with no formal education or professional experience in forensics, and at least one had no experience in identifying or working with individuals with severe mental illness. One of the two newly hired psychologists reportedly resigned after two weeks, and DBH reassigned the other evaluator to other duties after the D.C. Board of Psychology rescinded the evaluator's psychology license, which precluded the person from conducting unsupervised evaluations.⁹⁶

Second, DBH reported to CCE that both of those newly hired forensic psychologists were sent to SEH to shadow staff to learn how to conduct forensic evaluations and learn about severe mental illness. DBH sent two evaluators to a weeklong forensic evaluator-training program at the University of Virginia (UVA), a training program DBH has used in the past to enhance and refresh staff's knowledge. When CCE interviewed that program's director, Daniel Murrie, Ph.D., he advised that, although the UVA program is most likely the longest of its kind in the country, a week's worth of training and workshops is not alone sufficient to qualify someone as a forensic evaluator. He went on to explain that there is a general belief in the forensic psychology field that forensic post-doctoral experience is necessary to qualify a person. Dr. Murrie stated, "The field is trending in such a way that places are requiring fellowship-trained psychologists. Concurrent with that is an emphasis on forensic board certification."⁹⁷

Third, D.C. does not have a formal evaluator certification program. As the state public mental health agency, DBH is responsible for developing such a program. Many of the forensic experts with whom we spoke insisted that formal certifications and required recertifications are national best practices that ensure public mental health departments have high-quality evaluators, which is a critical component for instilling confidence in the forensic system.

To address these problems, we recommend that the D.C. Council amend the D.C. Code to ensure that psychologists and psychiatrists performing forensic screenings and evaluations are (a) board-certified, though not necessarily forensically board-certified, and (b) forensically trained and certified, through either formal education or comparable professional training programs. The Council should also require that forensic evaluators be recertified as appropriate.

⁹⁶ See note 39 and Appendix III for additional comment on this topic.

⁹⁷ CCE phone interview with Daniel Murrie, Ph.D. (October 17, 2017).

Other Staff

Many of DBH's non-evaluator staff working with forensic consumers are not forensically trained and do not possess even a basic understanding of the principles of forensics. DBH staff explained that DBH hired several hospital employees to staff SEH's civil units with no expectation that they would be exposed to forensic consumers. When the hospital downsized, all the different types of units – civil, pre-trial, and post-trial, which were previously located in different buildings –merged into a single building. As the volume of pre-trial admissions increased, the populations of single units were blended to create more pre-trial space. As a result, civilly committed individuals were held with post-trial and, in some cases, pre-trial consumers. This also required adjustments by staff, including assuming unexpected responsibilities for forensic consumers. DBH staff reported that the Department did not provide forensic training to those who had none and were moved into these new roles.

DBH staff explained that, because of their legal cases, working with forensic consumers is different from working with civil consumers. For example, DBH staff explained that maintaining progress notes in a forensic consumer's medical record is particularly tricky; medical records are permanent and can be subpoenaed and used against a person in a legal proceeding. Therefore, staff should be sensitive to the potential legal implications of the words they use when writing notes — for example, remembering to use the word “alleged” and avoid, as much as possible, including potentially incriminating information. DBH staff cited one instance in which a staff member recorded that a patient had prayed for forgiveness for committing the crime for which the patient had been charged. This patient, DBH staff explained, was acutely mentally ill and may have believed they had committed the crime simply because the prosecution had said so. It took a significant amount of work by DBH legal counsel and hospital staff to remedy the situation.

DBH staff also reported that the non-forensically trained employees at SEH are sometimes the ones who conduct certain aspects of the competency restoration programs. Prosecutors and defense attorneys expressed to CCE that these staff do not know the subject matter or material well enough to be leading competency restoration groups or monitoring an individual's progress within such a program. For instance, untrained staff may focus too much on the legal education piece of the program and not enough on a person's ability to retain information or interact well with defense counsel or in a group setting. Attorneys also reported that staff often do not have an accurate understanding of the legal system and teach incorrect information, which may impede a defendant from being opined competent. For example, the attorneys mentioned that DBH staff often inaccurately define a “suspended sentence” for consumers. At times, the attorneys said, this miseducation has resulted in people staying longer at the hospital because the evaluator does not believe they are effectively retaining information about the legal system, when, in fact, the consumer may have been correct.

DBH staff explained that some of the staff running the competency restoration programs, both inpatient and outpatient, do so because “they have done it for so long now,” despite not having any training or formal education in the principles and theories applied in forensic behavioral health. Experience administering a program has not, in this case, equated with effectiveness.

Finding Twelve

DBH's Outpatient Competency Restoration Program (OCRCP) needs improvement because it does not have strong outcomes.

Recommendations

1. That DBH develop a robust Outpatient Competency Restoration Program model that meets the needs of participants, including expanding program availability options and accessibility, such as location and operation times, and increasing program capacity.
2. That DBH provide forensic training for its current OCRCP staff and require that OCRCP staff be trained or possess sufficient professional experience regarding forensic behavioral health.
3. That DBH provide training for D.C. Superior Court judges on the benefits of the OCRCP model.
4. That DBH develop comprehensive housing and employment options for OCRCP participants in order to help reduce recidivism.
5. That DBH track and monitor the readmission rate to both of its competency restoration programs, and that it track data on individuals who have been in both programs, and on individuals who have been transferred from one program to another.
6. That DBH be required to analyze and report on data from its OCRCP and Saint Elizabeths Hospital restoration programs to the D.C. Office of Performance Management or the D.C. Council annually.

Implementation

DBH can implement these recommendations by amending its internal policies and procedures and offering trainings to D.C. Superior Court judges.

Comment

Outpatient competency restoration programs, in lieu of costly inpatient programs, have become an emerging best practice nationwide, with the first starting in Ohio in 1997. DBH started its Outpatient Competency Restoration Program (OCRCP) in 2005 – one of the first in the nation – to provide options that more closely complied with the statutory requirement to provide treatment for non-dangerous defendants in the least restrictive setting.⁹⁸ OCRPs are a relatively new development; thus, their outcomes have not yet been exhaustively researched. Nonetheless, researchers have generally found positive results, with one study's results indicating that OCRPs result in “financial savings, increased inpatient bed capacity, maintenance of public safety, and high rates of restoration.”⁹⁹ D.C.'s OCRP, however, reports low referral-to-program rates, low participation rates, and low rates of competence restored when compared to the inpatient restoration program at Saint Elizabeths Hospital (SEH). Many of the DBH and CSA staff, D.C. judges, and attorneys with whom CCE spoke for this review reported that they did not trust the program to be effective. Judges questioned the effectiveness of the OCRP, with some reporting a preference for inpatient competency restoration over the program. As one judge said, “The outpatient restoration program has never lived up to our hopes. People are not impressed with it. There is no comparison between it and what defendants get at the [SEH].” Nevertheless, judges said that, per statute, they have to order the person to outpatient restoration unless, as one said, “The person is psychotic and acting out in court or has a history of being noncompliant

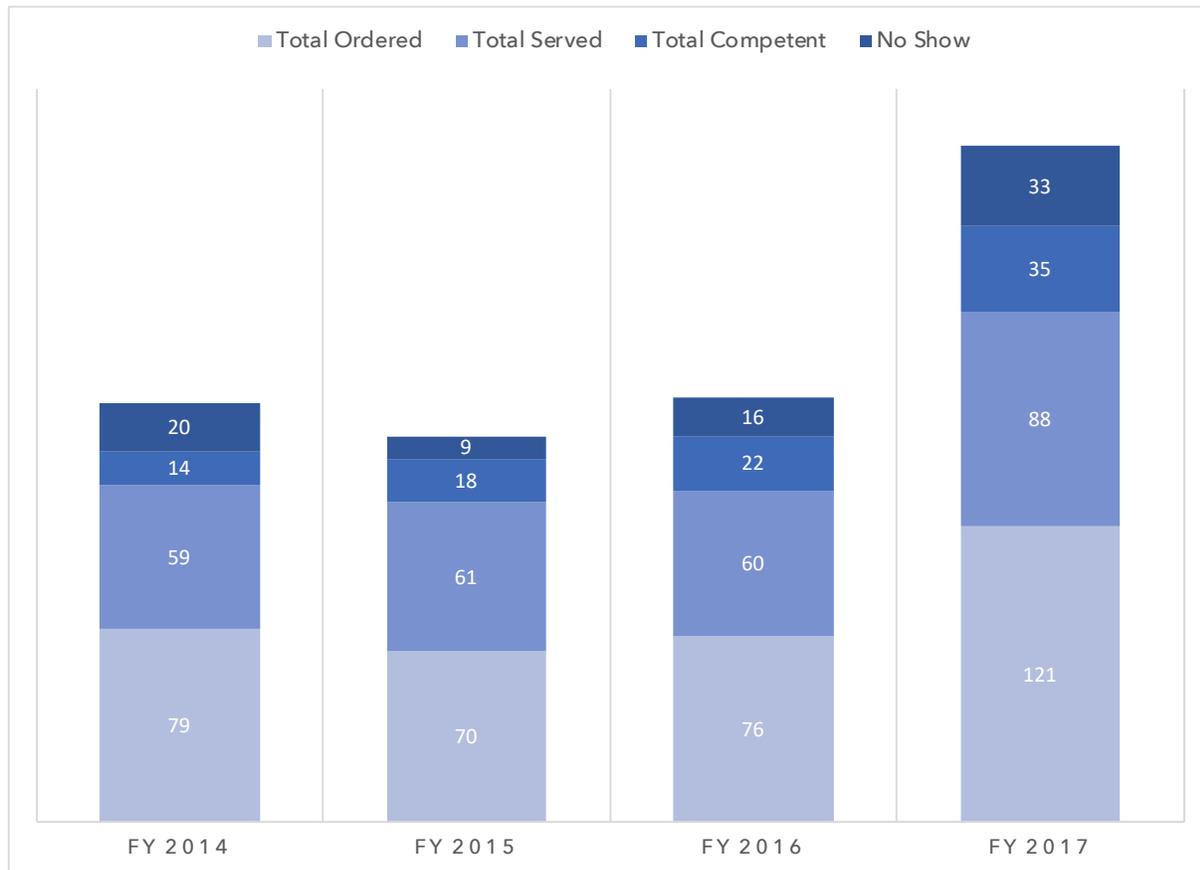
⁹⁸ See, generally, Nicole R. Johnson and Philip J. Candilis, *Outpatient Competence Restoration: A Model and Outcomes*, 5 *World Journal of Psychiatry*, 228-233 (2015).

⁹⁹ W. Neil Gowensmith, et al., *Lookin' for Beds in All the Wrong Places: Outpatient Competency Restoration as a Promising Approach to Modern Challenges*, 22 *Psych. Pub. Pol. & L.* 293 (August 2016), 1, 17 [hereinafter “Lookin' for Beds”].

[with showing up for outpatient services.]” The data, however, paint a different picture about court referrals to the outpatient program.

In FY 2015, DBH reported that there were 70 referrals to the program, a rate of roughly almost six referrals a month; of those, 61 people participated in the program. In contrast, in FY 2015, SEH had 246 pre-trial admissions with an average of more than 20 admissions a month, the vast majority of whom were admitted for competency evaluation and restoration, a difference of 303 percent.¹⁰⁰

Figure 2. OCRP Outcomes, FYs 2015-2017



Source: CCE e-mail correspondence with DBH executive staff (February 2018).

The restoration rates for the OCRP are reportedly lower than that of the inpatient program, which is common among jurisdictions as described below, although they have risen in recent years. Between 2009 and 2013, OCRP restored 55 of 170 participants to competence, an average restoration rate of approximately 29.4 percent, with an average referral rate of 35 people per year. In FY 2015, there were 70 defendants ordered to the program and 61 participants,¹⁰¹ of whom 18 were opined competent (29.5 percent).¹⁰² In FY 2016, DBH reported 76 orders to the program, 60 participants served, and 22 participants opined competent (36.7 percent).¹⁰³ Finally, in FY 2017, there were 121 defendants ordered to the program and 88 participants, of whom 35 were opined competent (39.8 percent).¹⁰⁴ Results show a steady upward growth in restoration rates,

¹⁰⁰ DBH, *Performance Related Information for Staff and Managers (PRISM): September 2016* (2016), at Appendix 1, available at <https://dbh.dc.gov/page/saint-elizabeths-prism-reports>.

¹⁰¹ While defendants are court-ordered to participate in outpatient competency restoration, DBH cannot compel them to attend the sessions. Thus, in presenting this data, DBH calculates the number of program participants as the total number of people ordered to the program minus the number of people who did not show for any sessions at all, which accounts for the variance in totals.

¹⁰² E-mail correspondence with DBH executive staff (February 5, 2018).

¹⁰³ *Id.*

¹⁰⁴ *Id.*

yet they remain notably low. DBH was unable to provide CCE with reliable data on inpatient restoration rates to compare with the OCRP's rates. However, DBH asserted that the inpatient restoration rates are much higher than those of the outpatient program.

Researchers suggest that there are many reasons why an OCRP might have lower levels of restoration than a hospital's inpatient program. *First*, courts may choose to use OCRPs as a post-arrest, pre-trial diversion model, eventually dismissing the charges before the person is restored to competence. They suggest judges may "view OCRPs as a chance for participants to establish a track record of stability in the community, albeit with enhanced structures and services, before releasing them from criminal commitment."¹⁰⁵ *Second*, OCRPs reported higher rates of unrestorability as compared to inpatient programs, perhaps "based on programmatic criteria – clinical stability, manageable dangerousness, ability to withstand program demands – and not necessarily [the participants'] likelihood to regain competence." They went on to say, "Program representatives reported that their primary responsibility in identifying appropriate OCRP candidates was to find competent patients who no longer need hospital-level care."¹⁰⁶ *Third*, "OCRPs ... reported higher proportions of participants with head injuries and developmental disabilities as compared to corresponding inpatient units."¹⁰⁷

Nevertheless, a national survey of OCRPs found indicates that the District's OCRP restoration rates, which over the past decade have ranged from a low of 29.5 percent to a high of 39.8 percent, are lower than the national average of 70 percent. Similarly, D.C.'s rates from the past decade are lower than those for many other long-established programs around the country. For example, in 2014, Hawai'i's OCRP reported a restoration rate of 95 percent,¹⁰⁸ and in 2013, Wisconsin's program reported a restoration rate of 75 percent.

DBH staff reported that one of the most challenging aspects of the program is that the defendants do not show up and that neither DBH nor the court can compel them to do so. DBH reported that from FY 2014-17, 23 percent of defendants did not show up to the program at all. This percentage does not indicate the number of defendants who only showed up a handful of times, but did not see the program through to completion. CCE found that the District's OCRP is not responsive to the needs of its participants, which may affect its attendance rates and, thus, its outcomes.

First, there is only one location for the program – at 35 K Street, N.E. – which, while located close to Union Station, is not easily accessible for many defendants. For example, defendants who live in Wards 3, 4, 7, or 8 would likely spend over 45 minutes traveling on public transportation each way. DBH does not arrange for transportation to and from the group sessions. Core Service Agencies (CSAs) are not allowed to bill for transportation, so their time taking defendants from one place to another is costly, preventing them from doing so regularly. Further, round-trip daily commutes on D.C. public transportation to the program cost a minimum of \$4.00, an expense beyond the reach of many defendants who are likely to be without income or relying solely on government assistance.

Second, the program is four days a week for one hour– in either the morning or the afternoon – but does not offer course options with weekend or night hours, which may prevent a defendant from obtaining and maintaining employment. When asked about this, one DBH staff member said, "Only a handful of OCRP clients in many years have actually had jobs." CCE did not speak with participants in the OCRP about whether the program impeded their ability to get a job; however, it seems logical that the program model would be restrictive for job hunters.

Third, DBH staff anecdotally reported that many of the program participants are experiencing homelessness. DBH does not provide supportive housing for people in the OCRP beyond that which is available for any other consumer. Staff reported that housing would not be helpful to OCRP participants because, as one said,

¹⁰⁵ Gowensmith, *et al.*, *Lookin' for Beds*, at 17, *supra* note 99.

¹⁰⁶ *Id.*, at 18.

¹⁰⁷ *Id.*

¹⁰⁸ *Id.* at 12.

“They are used to being homeless.” However, national experts in competency restoration with whom CCE spoke disagreed. W. Neil Gowensmith, Ph.D., Director of the Denver Forensic Institute for Research, Science, and Training, told CCE that forensics divisions should work to meet the full breadth of a patient’s needs, including housing, employment, and substance use treatment.¹⁰⁹ Formerly the Chief of Forensic Services for the Hawai’i Department of Health, he explained that Hawai’i had a housing program folded into the OCRP’s budget. The program functioned as a group home, he explained, which worked well to give participants a place to stay if they need one, and helped program administrators know where people were and how they were doing. He said, “There is a need for housing and employment, and those things should be considered because they may very well be the reasons that brought them back to court [in the first place].”¹¹⁰ The National Judicial College reported that effective outpatient competency restoration “requires that the defendant have a stable, supportive living arrangement.”¹¹¹

Fourth, forensically trained professionals, other than the Director of DFS, do not staff D.C.’s OCRP. A review of the job descriptions for the OCRP positions showed that forensic training or experience is not required or even preferred. The importance of forensic training for non-clinical staff is discussed in Finding 11.

Because of the program’s flaws and its poor outcomes, DBH and CSA staff, stakeholders, and judges reported a tremendous lack of confidence in the program. Some DBH staff members asserted that they have never heard anything positive about the OCRP from judges and attorneys and, perhaps because of that, judges often choose SEH. Indeed, many DBH staff complained that judges send defendants too frequently to SEH and keep them there for too long.

One interviewee said that DBH’s forensic evaluators have long distrusted the program and, coupled with the presumption that judges prefer SEH over OCRP, draft their reports to give judges options when considering where to send a defendant. Below is an example of one such recommendation provided to CCE:

[The defendant] clearly requires competency restoration and psychiatric oversight and therefore it is recommended that [the defendant] be transferred to [SEH]. If the court agrees that [the defendant] can benefit from outplacement in the community, then he can be ordered to the Outpatient Competency Restoration Program and [a CSA] for psychiatric oversight.¹¹²

Since the beginning of our review, however, data from DBH indicates that the rate of defendants ordered to the program has increased by 53 percent since FY 2014 to FY 2017 (from 79 orders to 121),¹¹³ which is higher than the increase in the rate of pre-trial admissions to SEH during the same period (42 percent, from 229 to 325).¹¹⁴ In light of the significant criticisms about the OCRP, CCE could not determine if the sharp increase in defendants ordered to the program was attributable to judges’ increased confidence in it. Considering both the surge in demand for competency restoration services from the court and the limited bed space at SEH, it is likely that the increase in defendants ordered to the OCRP is simply reflective of a supply and demand relationship. The demand for competency restoration at SEH has by no means decreased: the hospital had 325 pre-trial admissions in FY 2017, almost surpassing the total number of orders to the OCRP over the past four years (346 from FYs 2014-17).¹¹⁵

Determining where a defendant will participate in competency restoration should involve a multi-factor

109 CCE phone interview with W. Neil Gowensmith, Ph.D. (September 11, 2017).

110 *Id.*

111 National Judicial College, *Model Competency*, *supra* note 92, at 28.

112 Document including language from a recommendation in a competency evaluation. Document on file with CCE. Names and identifying information have been redacted from the text.

113 CCE e-mail correspondence with DBH executive staff (February 5, 2018).

114 Compare DBH, PRISM: September 2014 (October 17, 2014) available at <https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/webpage%20%20PRISM%20%20September%202014.pdf>, at Appendix I and DBH, PRISM: September 2017 (November 11, 2017) available at <https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/PRISM.%20September%202017.pdf>, at Appendix I.

115 CCE e-mail correspondence with DBH executive staff (February 5, 2018).

analysis that takes into account all relevant statutory factors, (e.g., the defendant's charge, history of compliance with outpatient treatment, the likelihood of successful restoration in the least restrictive environment). Nevertheless, DBH staff reported to CCE that many of the defendants evaluated for competency at SEH often do not require hospitalization and are often charged only with misdemeanor or traffic violations, charges that would otherwise not require they be detained.

If judges and DBH's own evaluators do not trust the program, then it has no credibility and no chance to succeed. So long as the only outpatient program available has no credibility, then the flow of numerous very costly pre-trial admissions to SEH will continue.

Finding Thirteen

Use of inpatient competency restoration over outpatient when not clinically necessary is not cost effective.

Recommendation

That DBH continue work to improve the outcomes of the Outpatient Competency Restoration Program (OCRP).

Implementation

These recommendations may be implemented by (a) amending DBH's internal policies and procedures and (b) the D.C. Council and Mayor augmenting DBH's budget for the OCRP.

Comment

Inpatient competency evaluation and restoration programs are costly for public mental health departments and consume a significant portion of available bed space in psychiatric hospitals nationwide. Increasingly, public state mental health hospitals, including Saint Elizabeths Hospital (SEH), have seen a rising number of court orders for competency evaluation and inpatient restoration.¹¹⁶ To complicate matters further, states are also looking at ways to reduce justice-involved consumers' lengths of stay when ordered to a hospital for competency restoration.¹¹⁷ Nationally, research has shown that it takes an average of 90-120 days for most persons to be restored to competency.¹¹⁸ The data on the median length of stay for pre-trial individuals, the vast majority of whom are receiving competency restoration services, suggest that SEH restores individuals to competency much more quickly than the national average: In December 2017, the median length of stay for pre-trial defendants at SEH was 74 days.¹¹⁹

While this number is low when compared to national data, DBH staff reported that many defendants sent to SEH should not have been hospitalized in the first place because, in the staff members' opinions, they often do not meet the clinical and legal thresholds required for inpatient hospitalization. Many non-dangerous defendants, staff reported to CCE, are sent to the hospital for competency restoration in cases involving petty misdemeanors or minor traffic violations.

D.C. law provides for competency restoration in the least restrictive setting unless the court finds that (1) an inpatient treatment setting is necessary to provide appropriate treatment, or (2) the defendant is unlikely to comply with an order for outpatient treatment.¹²⁰ Judges and attorneys told CCE that evidence to support the former is generally the recommendation from the DBH evaluator, and evidence to support the latter is a history of (non)compliance with previous outpatient treatment or community supervision. However, DBH executive staff reported to CCE that recommendations to the court vary by evaluator based on the population with which they work. For example, it reported that the evaluator who handles the detained calendar – defendants whom the judge determines require detention at the D.C. Jail – “will generally recommend that [competency restoration] occur at SEH due to the individual's detained status and the unlikelihood that they will be eligible to participate in the outpatient program.”¹²¹ Conversely, DBH reported, the evaluator

¹¹⁶ See, generally, Gowensmith, *Lookin' for Beds*, *supra* note 99.

¹¹⁷ See, e.g., Justice Policy Institute, *When Treatment is Punishment: The Effects of Maryland's Incompetency to Stand Trial Policies and Practices*, (October 2011), available at http://www.justicepolicy.org/uploads/justicepolicy/documents/when_treatment_is_punishment-full_report.pdf.

¹¹⁸ Gowensmith, *Lookin' for Beds*, *supra* note 99, at 294.

¹¹⁹ The average length of stay for pre-trial defendants is significantly higher at 155 days. However, this number considers defendants who remain at the hospital while their competency determination is contested and litigated. This number also includes individuals who are competent but detained at the hospital for a criminal responsibility evaluation, which is used in an insanity defense, and for the course of their trial. These evaluations are incredibly time consuming, which results in defendants spending significantly longer periods at the hospital.

¹²⁰ See D.C. Code § 34-531.05.

¹²¹ CCE e-mail correspondence with DBH staff, (January 2018).

working with defendants that have been released into the community recommends outpatient competency restoration a majority of the time.

CCE found these reports from DBH about evaluator recommendations to be troubling. Evaluators who examine defendants in the holding cells should not have the general practice of referring defendants to SEH, as the conditions of their release are based on legal criteria that a judge must evaluate. A recommendation that a defendant being held at SEH based in large part on where the defendant is being examined is prejudicial and biases the recommendation provided to the judge. The evaluator's recommendation is a medical opinion about whether or not *hospitalization* is warranted and should be independent of a defendant's conditions of release. Defendants held in the courts' holding cells are often released to the community, so the status of a defendant's detention should be presumptively irrelevant to an evaluator because that detention may expire soon after the evaluation. For example, if a person violates the conditions of their release, they may be detained until their next hearing, after which they may be released to the community, pursuant to the D.C. Bail Reform Act.¹²² Thus, an evaluator's recommendation that a defendant be transferred to SEH based solely on their current conditions of confinement may unwittingly result in a defendant's detention at SEH.

Those involved in designing the law passed in 2004 report that the goal was to increase use of outpatient restoration. Enhanced civil liberties and cost reduction could work together. DBH's Outpatient Competency Restoration Program (OCRCP) provides services to incompetent defendants released to the community on their own recognizance. The estimated cost per person per day in the program is \$286.57, a daily cost savings of more than \$600 when compared to the \$954 dollar a day hospitalization at SEH.¹²³ DBH staff reported that the capacity of this program is significantly less than that of its inpatient counterpart – the program can serve only 24 defendants at a time, although it is not often full. Nevertheless, the cost for 24 defendants at SEH is \$16,018 more per day than in the OCRCP (\$22,896 a day at SEH over \$6,877.68 at the OCRP). DBH staff suggested that an additional staff member allocated to the OCRP could allow for at least 12 more defendants, which could potentially save DBH another \$8,009 per day over SEH.

Participation in OCRP has steadily increased since the program's inception in 2005, including 121 new referrals in 2017.¹²⁴ Despite the significant cost reduction, there have only been just over 350 participants in the program since 2005. Moreover, the aggregate program outcomes have been underwhelming – only 33 percent of defendants since FY 2014 (89 people) have been restored to competency.¹²⁵ However, the annual program outcomes have increased in the last two years: 29.5 percent of defendants were restored to competence in FY 2015 (18 of 61 participants), 36.7 percent in FY 2016 (22 of 60 participants), and 39.8 percent in FY 2017 (35 of 88 participants). Furthermore, the treatment time in which restoration is achieved decreased, for example, from 21 sessions in 2015 to 19 in 2016.¹²⁶

Nevertheless, the improving outcomes have not resulted in a substantial increase in referrals to the program. In FY 2016, only 76 people were referred to the program, or approximately six people a month compared to the dozens of individuals admitted to SEH every month. Several Judges, DBH, and Core Service Agency (CSA) staff, and stakeholders explained that the community does not have faith in the OCRP. As one judge said to us, "I need to know that the [outpatient] program will work, and I do not have faith that it will."

In many cases, DBH clinicians felt that inpatient consumers' hospitalization was not clinically necessary and that the outpatient program could have provided their competency restoration services. Some DBH staff members estimated that about one-third of the pre-trial population was hospitalized for restoration erroneously (30 of the 90 pre-trial defendants at the time). DBH estimates the average daily cost per bed at SEH to be \$954, which means that a defendant's median length of stay of 74 days costs D.C. taxpayers

122 See, generally, D.C. Code § 23-1322.

123 Gowensmith, *Lookin' for Beds*, *supra* note 99, at 231.

124 CCE notes that referrals to the program do not equate the number of program participants, as participants are not required by the court under the conditions of their release to participate in the services.

125 E-mail correspondence with DBH executive staff, (February 5, 2018).

126 Nicole Johnson, *OCRCP in DC* [PowerPoint presentation], (2017).

\$70,596. Even a one-week stay at SEH costs the D.C. taxpayers almost \$7,000 per person, quickly adding up the longer a person stays.

To address issues related to hospital capacity, the statute allows DBH to contract for competency restoration with qualified local area hospitals,¹²⁷ which the court has advised DBH to consider.¹²⁸ This does not resolve the ballooning costs of restoration treatment, however, and may exacerbate the problem, if private hospital treatment costs are greater than those at SEH. DBH and the courts must consider how to manage the tradeoffs – assuming effective results while lowering a pre-trial defendant’s average length of stay and place defendants in programs that are clinically appropriate.

127 D.C. Code § 24-531.05.

128 See Mental Health Observation Hearing, *U.S. v. [REDACTED TEXT]*, *supra* note 65.

Alternative Methods of Delivery

Finding Fourteen

DBH lacks the components necessary to implement a strong pre-arrest diversion program that diverts people from the criminal justice system to behavioral health services, improves their mental health outcomes, and reduces their risk of recidivism.

Recommendations

1. That DBH develop a long-term pre-arrest diversion program beyond its initial FY 2018 pilot program.
2. That, in developing its diversion program(s), DBH actively pursue input from community stakeholders and diversion program experts. The input should be formal, such as through town hall-style meetings.
3. That DBH develop performance targets for the program and publicly report on its outcomes annually.
4. That DBH assess the ability of its provider network to provide services for people through a pre-arrest diversion program.

Implementation

These recommendations may be implemented by (a) DBH amending its internal policies and procedures and (b) the D.C. Council and Mayor augmenting DBH's budget to provide for long-term pre-arrest diversion programs.

Comment

The Need for Diversion

People with mental illness are disproportionately more likely to be arrested and incarcerated, and to recidivate than the general population.¹²⁹ Researchers estimate that people with major psychiatric disorders and people with bipolar disorder are 2.4 and 3.3 times respectively more likely to recidivate than returning citizens without severe mental illnesses.¹³⁰ Incarceration, especially when persistent or repeated, has long-term consequences. These consequences include greatly limiting a person's social and economic mobility, disrupting families and an individual's network of social supports, and greatly undermining a person's continuity of care for treatment they may be receiving in the community. For people with severe mental illness, such consequences can result in decompensation or the worsening of a person's illness.¹³¹ Incarcerating people with mental illness is also very costly for local governments.¹³²

In FY 2017, the District government spent an average of \$218.28 per person per day for confinement at the

¹²⁹ See, generally, KiDeuk Kim, et al., *The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System: A Scan of Practice and Background Analysis* [Research Report], Urban Institute (March 2015), available at <https://www.urban.org/sites/default/files/publication/48981/2000173-The-Processing-and-Treatment-of-Mentally-Ill-Persons-in-the-Criminal-Justice-System.pdf> [hereinafter, "Processing and Treatment"].

¹³⁰ See Jacques Baillargeon, et al., *Psychiatric Disorders and Repeat Incarcerations: The Revolving Prison Door*, 166 *American Journal of Psychiatry*, 103-109 (2009).

¹³¹ See, generally, Kress, et al., BSC, *supra* note i.

¹³² Kim, et al., *Processing and Treatment*, *supra* note 129.

jail¹³³ and \$954 per person per day at Saint Elizabeths Hospital (SEH).¹³⁴ In FY 2015, the DOC diagnosed 1,441 individuals with severe mental illness, and 1,515 in FY 2016.¹³⁵ By contrast, SEH served 628 individuals in FY 2017.¹³⁶ Indeed, based on its contract to provide mental health care for the Department of Corrections (DOC) alone, Unity Healthcare is one of the largest public mental health providers in the city. SEH and DOC staff reported to CCE that many of the justice-involved individuals with behavioral health disorders who come through their doors should not be involved with the criminal justice system. Many, they said, are arrested for petty crimes or “crimes of survival,” e.g., stealing food or engaging in sex work to make money. Staff explained that, if DBH and other D.C. agencies had a stronger integrated system of community supports, people with mental illness would be better able to meet their needs without resorting to petty crime. As one DOC staff member explained to CCE, “You have people with mental illness [in the jail or SEH] who have been arrested because they stole some food from a convenience store or because they were urinating in public. They don’t need to be warehoused in the jail; they need help.”

The District’s Program

The District does not yet have robust programs and policies in place for police officers to identify individuals with mental illness and divert them from the criminal justice system to behavioral health services in lieu of arrest, although a pilot is currently being developed and is reportedly scheduled to launch in spring 2018. As one judge explained to CCE, “D.C. is far, far behind on the [pre-arrest diversion] in place in other jurisdictions.” The judge, and other stakeholders with whom CCE spoke, explained that D.C. agencies have discussed a pre-arrest diversion program for years, but that progress to implement such a program has been excruciatingly slow. The District does have a Crisis Intervention Officer (CIO) program, a collaborative effort between DBH and the Metropolitan Police Department (MPD) that began in 2009, which may function, to some degree, as a diversion program. The program provides 40 hours of training to police officers covering a wide range of topics, including identifying symptoms of mental illness and de-escalation techniques.¹³⁷ MPD and DBH report that, in FY 2016, there were 735 MPD and 117 other officers actively trained as CIOs.¹³⁸ The program has been effective in connecting people with emergency psychiatric treatment, but the program’s scope limits its ability to provide lasting help beyond the point of crisis.

From FY 2011-16, police transported 73 percent of people who interacted with CIOs during a call to DBH’s Comprehensive Psychiatric Emergency Program (CPEP) or a local hospital for psychiatric evaluation, either voluntarily or not. The trend for involuntary transport has increased, from 43 percent in FY 2011 to 58 percent in FY 2016, with the highest being in FY 2014, when 79 percent of incidents resulted in involuntary transport. Only five percent of incidents resulted in arrest during the same period. However, during the same period, officers only referred people to case management (through DBH) four percent of the time.¹³⁹ While CPEP and local hospitals are equipped to handle involuntary transports, DBH staff reported that they are not the most adept at linking someone to ongoing services at a Core Service Agency (CSA) or another provider. Without linkage to proper community treatment, DBH staff reported that individuals would likely be sent to the psychiatric emergency system more frequently than should be necessary. This indicates that a CIO program alone is not adequate.

The Pilot Program

After receiving almost \$1 million from the Mayor in FY 2018, MPD and DBH began a collaboration to

133 E-mail correspondence with R. Chakraborty, Chief of Strategic Planning and Analysis, D.C. DOC (November 20, 2017).

134 Written response to CCE from DBH General Counsel, Matthew Caspari, (October 6, 2017) [hereinafter “DBH response 10/6/17”].

135 E-mail correspondence with M. Pflaum, Operations Research Analyst, D.C. DOC (November 14, 2017).

136 DBH, *Performance Related Information for Staff and Managers (PRISM): September 2017*, (November 2017) available at <https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/PRISM.%20September%202017.pdf>.

137 DBH, *Reports* [webpage], available at <https://dbh.dc.gov/page/reports-01>.

138 DBH and MPD, *Crisis Intervention Officer (CIO) Program Annual Trend Report: Reporting Period: FY11 through FY16 (2016)*, available at https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/CIO_FY11-FY16_Trend%20Report_12-19-16Final.pdf.

139 *Id.*, at 6.

develop and implement a pre-arrest diversion program that the D.C. Council hoped would be similar to Law Enforcement Assisted Diversion (LEAD) programs that have been successful throughout the country.¹⁴⁰ The pilot program, which is reportedly scheduled to launch in spring 2018, intends to satisfy the requirements of Section 105 of the Neighborhood Engagement Achieves Results Act of 2015 (“NEAR Act”), albeit through a different program structure.¹⁴¹ The NEAR Act established a pilot program pairing DBH and Department of Human Services (DHS) specialists with MPD officers in the field to identify people with severe unmet needs and divert them from the criminal justice system to services.

The pilot program that the NEAR Act initially conceptualized is not a LEAD program, per se. Instead, the NEAR Act envisioned a program reflective of a successful model implemented by the Los Angeles Police Department, called System-wide Mental Assessment Response Team (SMART), which pairs mental health clinicians with police to de-escalate crises, better identify mental health needs, share information between agencies in real time, and connect individuals to appropriate treatment and rehabilitation services, among other types of services.¹⁴² While expensive at the outset, the program has ultimately saved Los Angeles, and other jurisdictions who have implemented similar models, millions of dollars.¹⁴³

D.C.’s diversion program could be successful in combining models, such as the SMART program and LEAD. From discussions with MPD, DBH staff, and stakeholders, the boundaries of the program are not yet clearly defined, but the development of the program has already begun, and a newly hired program director is coordinating DBH’s efforts. Thus far, however, DBH reported that the development of the pilot program has not included input from the community. As the pilot proceeds, DBH should include input from community stakeholders and experts in diversion who can help D.C. to implement a model that considers and is responsive to the unique needs of our city.

Several pre-arrest diversion programs are reliant on a network of community-based mental health providers that have the capacity and resources to handle the influx of consumers diverted from the system through linkages to services.¹⁴⁴ CSA staff and stakeholders explained that D.C. CSAs and community providers do not currently have the capacity to handle what might be many referrals for services. Indeed, some providers have had long waiting lists for consumers for years, and many CSAs have had and will have to assume the clients from the several CSAs that have closed in this year.

In discussions with DBH staff and stakeholders, they did not believe it clear whether DBH had a strategy to improve the outcomes for individuals in the community who have been diverted from the justice system. Stakeholders reported that discussions about the program have largely centered on developing a process of triaging the mental health needs of people who might not meet the criteria for involuntary detention but who have committed low-level offenses, and then releasing them back into the community. Advocates for LEAD programs explained to us that consumers should not be required to pursue services, but that a strong network of community providers that can provide readily available services to consumers is key to the success of the program. As one stakeholder said to CCE, “Diversion programs should be working to improve outcomes, not just become another revolving door in a system of revolving doors.”

Development of a Robust Diversion Program

To correct these shortcomings, DBH should first assess the ability of its provider network to provide case management and other necessary services for people who will be diverted through the diversion program. If the provider network is unable to provide the services needed to meet the demand, DBH should hire a case

140 Committee on the Judiciary and Public Safety, Council of the District of Columbia, *Report and Recommendations of the Committee on the Judiciary and Public Safety on the Fiscal Year 2018 Budget for Agencies under Its Purview*, 1, 138 (May 18, 2017), available at http://dccouncil.us/files/user_uploads/budget/judiciary_final.pdf [hereinafter “CJPS Committee Report and Recommendations”].

141 *Id.*, at 139.

142 For more information on the SMART program, see, generally, Stephanie O’Neill, *Police and the Mentally Ill: LAPD Unit Praised as Model for Nation*, KPCC (March 09, 2015), available at <http://www.scpr.org/news/2015/03/09/50245/police-and-the-mentally-ill-lapd-unit-praised-as-m/>.

143 *Id.*

144 See, e.g., *About LEAD* [webpage], available at <http://leadkingcounty.org/about/>.

management team specifically designed to work with consumers diverted through the program to ensure that consumers do not fall through the cracks.

After an assessment of the provider network is complete and the results of the pilot program are analyzed, DBH should develop a long-term pre-arrest diversion program beyond the initial FY 2018 pilot program. In developing this program, DBH should actively pursue input from community stakeholders and diversion program experts. The input should be formal and transparent, such as through town hall-style meetings. Finally, DBH should be required to develop performance targets for the program and publicly report on those outcomes annually.

Finding Fifteen

DBH does not ensure that people who have been found incompetent to stand trial receive the behavioral health treatment they need to keep them from recidivating or being civilly committed. The criminal justice system in D.C. does not have enough options to disengage this population from criminal involvement, which costs the city millions of tax dollars each year.

Recommendations

1. That the District conduct a study of super-utilizers of the criminal justice and behavioral health systems, focused especially on people who have been *Jacksoned* by the court.
2. That DBH develop policies and programs that proactively address the unique needs of *Jacksoned* individuals in the community to prevent them from recidivating.

Implementation

These recommendations may be implemented by (a) the D.C. Council's and Mayor's providing funding for a super-utilizer study; (b) DBH's amending its internal policies and procedures accordingly.

Comment

DBH staff reported that many of the District's super-utilizers of the behavioral health and criminal justice systems are people who find themselves in a grey area between the systems: they are arrested and charged with a crime, their mental illness is such that they are determined incompetent to stand trial, yet, they are not considered dangerous to self or others and are, therefore, not eligible for civil commitment. Forensic mental health professionals refer to these individuals as *Jacksons*.¹⁴⁵

In the District, *Jacksoned* individuals rotate in and out of the criminal justice system and the mental health system. After arrest, they are charged and sent to either SEH or OCRP for competency evaluation and restoration. Once determined to be incompetent and unlikely to regain competence in the foreseeable future, they are *Jacksoned*, their charges are often dropped, and the D.C. Office of the Attorney General (OAG) decides whether to pursue civil commitment. If so, the individual is either evaluated at SEH, in the community at OCRP, or in the community at their respective CSA to determine whether, due to their mental illness, they pose a danger to self or others. If the court decides the individual does not pose a danger, the individual is not committed and is released from SEH. Upon their release, the court cannot force these persons to receive psychiatric or other behavioral health treatment or to report to a Core Service Agency (CSA) for any other services. While DBH tries to connect *Jacksoned* individuals to services, it is often unsuccessful. DBH staff explained, without medicine, these individuals frequently decompensate in the community and commit further crimes, thus repeating the cycle.

In late 2017, CCE observed a court hearing in which the court *Jacksoned* a defendant charged with several misdemeanors was *Jacksoned* by the court after SEH opined that the defendant was incompetent. A subsequent review of the defendant's court records showed that the defendant had been *Jacksoned* more than once that year, and been ordered to DBH's inpatient and outpatient competency restoration programs (having been ordered to the former more than twice). Using DBH's estimates of the average daily cost per bed at SEH, CCE estimated that, based on the number of days spent at SEH according to court records, the defendant's time at SEH alone cost District taxpayers almost \$500,000 in just under two years.¹⁴⁶ This estimate did not

¹⁴⁵ "Jackson" is a colloquial term used by behavioral health professionals to refer to the 1972 Supreme Court decision, *Jackson v. Indiana* (406 U.S. 715), holding that the state cannot constitutionally commit someone indefinitely because they are incompetent to stand trial on the charges. "Such a defendant cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain competency in the foreseeable future. If it is determined that he will not, the State must either institute civil proceedings applicable to the commitment of those not charged with a crime, or release the defendant."

¹⁴⁶ In materials provided to CCE by DBH, the Department estimates the average daily cost per bed during FY 2016 and FY 2017 was \$942 and \$954 respectively.

include the numerous other costs associated with the defendant's interactions with DBH's outpatient and other programs or with the police, the Department of Corrections, the prosecutors, the D.C. Superior Court, and other agencies.

This defendant's case is not atypical. DBH does not track data on and, thus, does not know the number of defendants in a given year who have been *Jacksoned* after involvement with the criminal justice system. This is despite having evaluated all *Jacksoned* individuals from their initial competency screenings through their civil commitment evaluations, often confining them at SEH during that time. Anecdotal evidence from DBH staff, however, suggests that there are several people *Jacksoned* each year; at one point during this review, it was reported that there were approximately 12 people confined at SEH while awaiting civil commitment hearings after having been *Jacksoned*. Notwithstanding the lack of data on this population, CCE observed how costly they are for the District government.

Without a study of this population, as part of the a super-utilizer population study, DBH is left trying to handle each consumer on a case-by-case basis. If a super-utilizer study were to include a special focus on the *Jacksoned* population in the aggregate, DBH could better understand the trends among the population, which could result in efforts to target their needs more thoughtfully and precisely.

Saint Elizabeths Hospital's Delivery of Forensic Services

Finding Sixteen

Persistent and worsening capacity problems at Saint Elizabeths Hospital (SEH) have had significant negative impacts on the District's residents with mental illness, and particularly justice-involved consumers. These impacts include long admissions waitlists for pre-trial and civil admissions, the unlawful detention of pre-trial defendants at the D.C. Jail, and mass internal transfers of patients within the hospital, which staff described as clinically inappropriate.

Recommendations

1. That DBH develop long-term solutions for its bed space capacity problem at SEH.
2. That DBH and the D.C. Superior Court review the reasons for the spike in pre-trial admissions and the difference of viewpoints between the courts and DBH on appropriate placement for defendants whose competency is in question.
3. That DBH develop appropriate inpatient alternatives for waitlisted civil admissions.
4. That the D.C. Office of the Inspector General or ODCA conduct a thorough review of the civil commitment process in the District and assess the impacts of DBH's civil commitment waitlist.

Implementation

These recommendations may be implemented by (a) DBH's amending its current policies and procedures and (b) review of the civil commitment process by the D.C. Office of the Inspector General or ODCA.

Comment

For many years, Saint Elizabeths Hospital (SEH) has not been able to admit promptly all of the defendants ordered to the hospital for competency evaluations and restoration services because of limitations on its bed space capacity. These constraints, which are especially pronounced during the high-arrest rate periods of the summer and winter, have resulted in an "admissions waitlist" causing defendants to remain incarcerated at the D.C. Jail while awaiting transfer to SEH. The court's increasing demand over the years for inpatient hospitalization and DBH's lack of applied strategies for (a) creating additional capacity at SEH and (b) addressing the underlying issues to develop solutions to the increased demand (e.g., pre-arrest diversion) ultimately came to a head. In the summer of 2017, judges at the D.C. Superior Court forcefully directed DBH to develop and implement remedial strategies for the admissions waitlist.

The Problems with an Admissions Waitlist

Over the past decade, the demand for court-ordered inpatient competency evaluation and restoration services has increased throughout the country, as well as in the District.¹⁴⁷ For example, in FY 2014, SEH had 229 pre-trial admissions for competency evaluation and restoration, or 53 percent of SEH's admissions for the year.¹⁴⁸ In FY 2017, there were 325 pre-trial admissions, 74 percent of all admissions for that year, and a 42

¹⁴⁷ See, e.g., State of California Health & Human Services Agency, *The Department of State Hospitals Incompetent to Stand Trial* [memo] (July 2016), available at <http://www.chhs.ca.gov/IST%20Workgroup/IST%20Memo%20July%202016%20FINAL.PDF> (reporting on a series of legal challenges related to waitlists for inpatient admissions for defendants found incompetent to stand trial); and Washington State Department of Social & Health Services, *Report to the Legislature: Forensic Admission and Evaluations – Performance Targets 2014, First Quarter* (September 26, 2014), available at https://app.leg.wa.gov/ReportsToTheLegislature/Home/GetPDF?fileName=Forensic%20Admissions%20and%20Evaluation%20SB%206492%20Q1_8672fb91-9850-4eac-a31b-a2d5f92c7ce7.pdf (reporting, "Both [Eastern State Hospital] and [Western State Hospital] continue to have long waitlists, and are significantly deviating from performance targets," at 5).

¹⁴⁸ DBH, *FY14 Trend Analysis: Hospital Statistics* (April 30, 2015).

percent increase over FY 2014.¹⁴⁹ Despite the increase, the District has not increased the dedicated resources as necessary to meet the demand.

Over the years, DBH's response to this increased demand and lack of resources had been the admissions waitlist. The concept of an admissions waitlist in D.C. is problematic for several reasons. *First*, the court has found the defendants on the waitlist to be in need of hospitalization because they meet certain statutory requirements.¹⁵⁰ As one judge explained to CCE, "A court order for inpatient hospitalization is a legal finding and not a clinical one." Therefore, defendants at the D.C. Jail awaiting transfer to SEH are held in violation of court orders and, thus, judges explained, are detained unlawfully in the custody of the D.C. Department of Corrections (DOC).

Second, delayed transfers to SEH may prevent hospital staff from conducting a defendant's competency evaluation within the statutory period (30 days), resulting in requests to the court for extensions. One judge observed that, despite the waitlist, SEH was for several years often capable of completing the evaluations on time; however, as the waitlist times increased, the judge said, defendants were eventually not transferred to SEH with enough time to complete the evaluations within the statutory period. Thus, the judge said, DBH would make requests for significant extensions to complete the evaluations that exceeded permissible limits under the statute. Nevertheless, as long as the waitlist has been around, the judge said, so has the reality that defendants' cases have been procedurally delayed while they wait for evaluation and treatment at SEH.

Third, not only does the waitlist delay defendants' cases, but prolonged detention at the D.C. Jail also prevents the defendants from receiving the type of treatment and services they would otherwise receive in a hospital setting. For example, as DOC and DBH staff explained, the D.C. Jail has a mental health unit with a wide range of mental health services, but it does not offer the variety of services or the freedom of movement (e.g., programs off-unit) that are available at a hospital like SEH.

Fourth, the waitlist has financial implications for DOC and other ancillary government agencies involved in the competency restoration process. While held at the jail, DOC subsidizes the cost of caring for defendants ordered in the custody of SEH and must provide not only for the safe detention of the individual but also for specialized costs of care, such as expensive psychotropic medication. Additionally, the United States Attorney's Office and Public Defenders Service may have to appear in court repeatedly to address, for instance, a motion for a continuance because an evaluation has not yet been conducted.

DBH staff and D.C. Superior Court judges noted that the SEH admissions waitlist had been a problem for many decades. However, they explained, the problem worsened over the years as SEH moved into a single newer, smaller building with far more limited bed capacity than its previous building complex where one entire building was dedicated entirely to forensic patients. Over the past few years, the average number of days per month spent on the waitlist has risen and fallen sharply from month to month, but the average number of days per month spent on the waitlist increased steadily from almost eight days in 2015 to 11 by the end of September 2017. Similarly, the monthly average number of orders for defendants to SEH has increased over the two-year period, from an average of 11 orders a month in 2015 to 19 in 2017.

The SEH Waitlist and the Court

Commonly referred to as the "new building," SEH's current facility, opened in 2010, has a 285-bed capacity to serve all of its patients: pre- and post-trial individuals and people who are civilly or voluntarily committed.¹⁵¹ The capacity of this facility is several hundred beds and almost a dozen units fewer than the previous facilities, although the conditions in the facilities are much improved. In FY 2017, SEH had a daily average capacity

¹⁴⁹ DBH, *PRISM: September 2017* (November 1, 2017) available at <https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/PRISM.%20September%202017.pdf>.

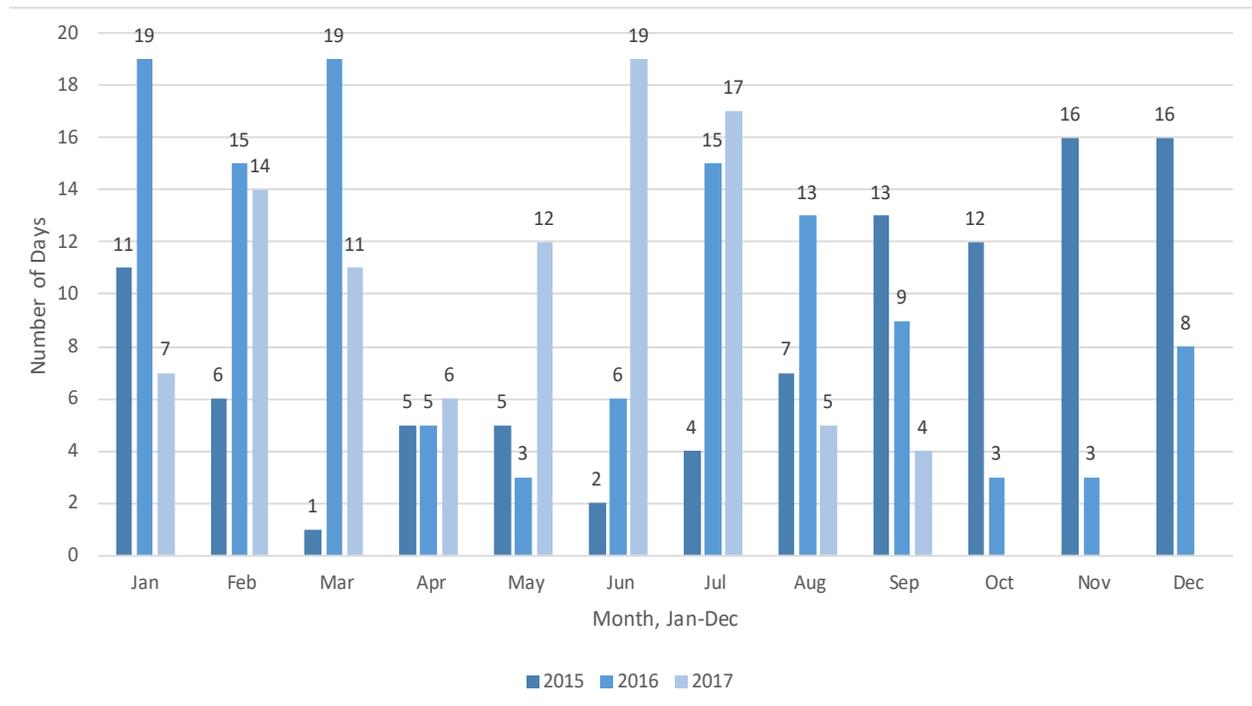
¹⁵⁰ See D.C. Code § 24-531.03(e).

¹⁵¹ During CCE's interviews of staff, they explained that the hospital has 291 licensed beds but that total includes restraint beds, which must be licensed but are not included in the calculation of total capacity because they cannot be permanently filled.

utilization of 93 percent.¹⁵² Capacity limits at the hospital are under particular pressure during the summer and winter months, when arrests are higher.

Over the last few years, the number of pre-trial inpatient admissions has gradually grown; between 2015 and 2017, however, that number sharply increased, which resulted in growing wait times on the SEH pre-trial admissions waitlist (*see* Figure 3 below).¹⁵³ In June 2015, there were 61 pre-trial defendants at SEH, just less than one-quarter of the hospital's census at the time.¹⁵⁴ By early August 2017, that number had increased by 87 percent to 114 defendants, or 40 percent of the hospital's census.¹⁵⁵

Figure 3. Average Number of Days on the SEH Admissions Waitlist while at the D.C. Jail, CYs 2015-17



Source: CCE e-mail correspondence with DBH executive staff (September 2017).

Note: In early August 2017, DBH admitted all of the patients on the waitlist in response to the court's inquires, resulting in the precipitous drop in wait times.

In August 2017, the capacity constraints and the gradually growing admissions waitlist at the D.C. Jail reached a flashpoint, when the court ordered DBH to appear on the first of several occasions to explain why it had failed to comply with court orders to conduct an evaluation within the statutory period. In July 2017, a defendant had been held at the D.C. Jail for 24 days before being transferred to SEH. Unable to conduct the evaluation in time, the hospital requested a 30- to 45-day extension, which the court described as “patently unlawful”¹⁵⁶ because it greatly exceeded the 15-day extension period allowed by statute.

In response to this case and to the growing size and wait times of the admissions waitlist, the presiding and deputy-presiding judges of D.C. Superior Court's Criminal Division separately ordered DBH to appear in court to explain why it had failed to comply with the court's orders to admit promptly several defendants who had been on the SEH waitlist throughout the summer.¹⁵⁷ Citing their administrative responsibilities for

¹⁵² DBH, *PRISM: September 2017*, *supra* note 149, at Appendix 1.

¹⁵³ Data for chart provided to CCE by DBH. Additional numbers provided through correspondence with DBH staff (August 11, 2015).

¹⁵⁴ DBH, *PRISM: July 2015* (2015), at Appendix 1.

¹⁵⁵ DBH, *PRISM: September 2017*, *supra* note 149, at Appendix 1.

¹⁵⁶ Status Hearing, *United States v. [REDACTED TEXT]*, 2017 CF1 005232, 1, 9 (D.C. Super. Ct. August 11, 2017).

¹⁵⁷ *See* Order to Appear, *United States v. [REDACTED TEXT]*, 2017 CF1 5232 (D.C. Super. Ct. August 9, 2017) (ordering, in addition to DBH, that DOC appear to explain why it had failed to comply with related orders to release the defendants from the custody of the jail and transfer them to SEH).

the criminal division, the judges forcefully criticized DBH for its failure to manage the bed space problems successfully over the past two years and insisted that the Department develop a solution. Judge Lynn Leibovitz described the situation of the bed space capacity limits as a series of systematic and institutional “failures being effected on mentally ill persons who are unable to speak for themselves...”¹⁵⁸ On August 7, 2017, there were 18 male defendants at the jail on the SEH admissions waitlist.¹⁵⁹ At the time, the average wait time was about nine days, with the longest wait being 21 days.¹⁶⁰ Most of these defendants, Judge Leibovitz explained, were court-ordered to the hospital at the recommendation of a DBH evaluator.¹⁶¹ Between January 2015 and September 2017, the court had ordered 602 defendants to SEH (with 479 being men and 123 being women). During that period, the monthly average number of days male defendants spent on the list ranged from one day (in March 2015) to 19 days (in January and March 2016 and June 2017), and for women range from zero days to (for several months through both years) to 15 days (in June 2017).¹⁶²

Within 16 days of the August 11 hearing, SEH admitted 28 pre-trial defendants. Throughout August 2017, SEH admitted an all-time high of 61 people, 47 of whom were pre-trial admissions.¹⁶³ SEH staff reported that to accommodate that many admissions, they had to transfer internally 47 people,¹⁶⁴ close SEH’s pre-trial treatment mall (centralized psychosocial rehabilitation services) because of strained staffing levels from August to October, merge individuals with different legal statuses into the same ward, and re-purpose entire wards. In September, SEH effected 25 more transfers to facilitate the month’s 38 admissions.¹⁶⁵ While SEH’s efforts successfully reduced the waiting list, DBH clinicians told CCE that such a significant shift in hospital functions in a short period of time was, in their opinion, clinically inappropriate. Clinicians explained to CCE that they prefer to transfer patients gradually, to mitigate the potential for destabilization and violent incidents, among other concerns. According to DBH staff, the transfer caused some patients to decompensate. For instance, one long-term resident of SEH, who had no history of violence, was abruptly transferred from one unit to another. Following the move, he reportedly assaulted a member of the nursing staff because of, in one clinician’s opinion, the stress the move caused.

Temporarily halting services, such as the closing of the treatment mall, and disrupting long-standing living arrangements can undermine an individual’s continuity of care. Unit staff from throughout the hospital facilitate programs on the pre-trial treatment mall (e.g., competency restoration and group therapy). The treatment mall is often the only time medically stable pre-trial defendants can leave their units. When the treatment mall closed, individuals who were successfully participating in those programs suddenly had to receive all their services on-unit from that unit’s staff. Staff reported that this change meant some individuals either did not receive their typical services or received them from someone with whom they were unfamiliar.

Furthermore, patients often have complex clinical and legal issues with which unit staff are intimately familiar. SEH staff explained that, generally, if a long-term patient is slated to be transferred from one unit to another, the treatment teams meet to learn about the patient’s clinical and legal progress. This time is also used to develop rapport and trust between the patient and the new treatment team. The gradual transfer period is used to introduce the individual to the other people who live in the new ward. More rapid transfers, especially in high volume, limit the clinicians’ ability to understand and respond to the complexities of their patients’ cases, which can result in higher rates of assaults, restraint and seclusion, patient falls, and psychiatric emergencies.

158 See *U.S. v. [REDACTED TEXT]*, *supra* note 65, at 17, line 3-6.

159 E-mail correspondence with DBH staff (August 11, 2017).

160 *Id.*

161 See *U.S. v. [REDACTED TEXT]*, *supra* note 65.

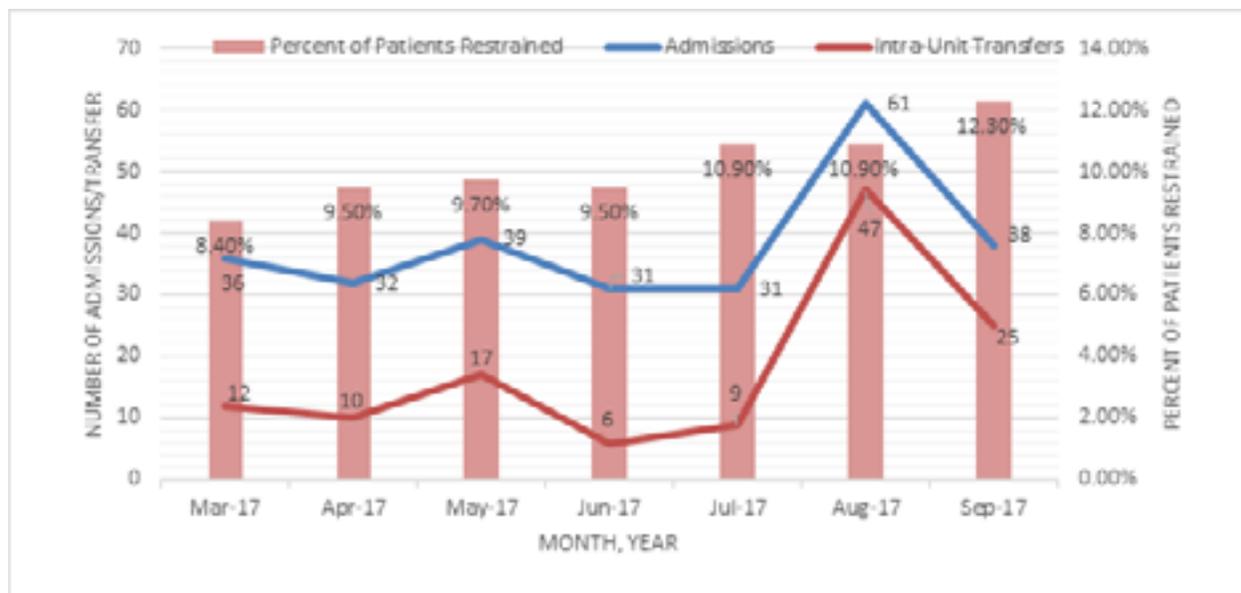
162 Data provided to CCE through correspondence with DBH Staff (November 2, 2017). DBH reported that they did not have responsive data for women court-ordered to SEH during the same period.

163 DBH, *PRISM: September 2017*, *supra* note 149, at 1.

164 Correspondence with DBH staff, *supra* note 159.

165 DBH, *PRISM: September 2017*, *supra* note 149, at Appendix 2.

Figure 4. Percent of Patients Restrained, Number of Admissions, & Intra-Unit Transfers at SEH, March 2017-September 2017



Source: DBH, PRISM: September 2017 (October 2017).

While staff reported to CCE that there was not a drastic spike in unusual incidents or physical assaults following the 72 transfers in August and September 2017, the number of psychiatric emergencies, the number of physical assaults, high- and medium-severity unusual incidents, and percent of patients restrained all increased (see Figure 4 above). Additionally, there were higher rates of emergency medication orders and events and higher numbers of individuals having both more than one and more than three emergency medication events in one month. Emergency medication events, known as “STAT” events, may include multiple orders for different medications within the same event. In June 2017, there were 64 STAT orders and 29 STAT events, with 18 patients having more than one event and two having more than three in that month. In August 2017, there were 142 orders (an increase of 122 percent), 68 events (an increase of 134 percent), 33 patients who had more than one event (an increase of 83 percent), and eight patients who had more than three events (an increase of 300 percent).¹⁶⁶

Diverging Viewpoints

In many of our interviews, DBH staff and senior management expressed the view that the admissions waitlist is the result of D.C. judges’ sending growing numbers of defendants to the SEH, contrary to DBH’s treatment recommendations. Staff asserted that judges doubt the effectiveness of DBH’s Outpatient Competency Restoration Program (OCRP) and believe that SEH, to its credit, is a stellar institution capable of consistent, successful results. Indeed, the number defendants sent to SEH increased sharply over two years: In 2015, the D.C. courts ordered 154 defendants to SEH for competency evaluation and restoration, and in 2016, that number rose to 228, a 48 percent increase.¹⁶⁷ The number of orders to SEH had reached 220 by the end of September 2017, almost surpassing the total previous year. However, DBH’s data shows that judges do not disagree as often as staff and senior management had asserted. For example, from January to July 2017, judges disagreed with evaluator’s recommendations only an average of six percent of the time.¹⁶⁸ Moreover, from FY 2015 to the first two quarters of FY 2017, the court disagreed with DBH an average of 13.3 percent of the time, with the number of average number of disagreements showing a steep downward trend, although this data captured only the recommendations of SEH’s evaluators after a defendant had already been hospitalized and *not* the recommendations of the DBH courthouse evaluators who make the initial recommendations

¹⁶⁶ *Id.*

¹⁶⁷ CCE e-mail correspondence with DBH staff (November 2017).

¹⁶⁸ Data provided by DBH to CCE.

regarding the location for restoration.¹⁶⁹

Judges' reports to CCE that they usually follow DBH evaluators' recommendations for hospitalization were consistent with DBH's data. Judges explained that they receive training from the Superior Court on D.C.'s competency laws at least once a year and that there is a good professional support system amongst judges to ask their colleagues for advice when interpreting cases that are complex or involve unfamiliar material. The judges suggested a couple of reasons for why there has been an increase in orders for competency evaluation and restoration. *First*, the public in general, including judges, have a greater awareness of mental health and substance use issues and the need for treatment and services. *Second*, D.C. does not have an adequate pre-arrest diversion program to help divert people with mental illness from the criminal justice system to services. Judges remarked that they see too many defendants with mental illness "who should not be [in court]." One judge observed that between five and ten defendants with notably severe mental illness or substance use disorders pass through the judge's courtroom every day.

CCE found that DBH and the court have diverging viewpoints on many issues related to pre-trial admissions to SEH. CCE observed that in many of the dialogues, DBH and the court talked past each other, which prevented the development of solutions. DBH and the court should work more closely together to understand their perceptions of the reasons for the problems and to develop innovative, sustainable solutions to the problem.

DBH's Recent Efforts to Remedy the Bed Space Waitlist

As noted above, DBH moved swiftly to admit the remaining defendants on the admissions waitlist. However, the additional admissions only further strained the hospital's capacity and did not represent a long-term solution to the clash between SEH's capacity constraints and escalating demand for forensic beds. At all the hearings at which the court ordered DBH to appear, judges were greatly troubled that defendants they had ordered to SEH remained in jail receiving no restoration services. These defendants likely could have benefited from restoration treatment in their first weeks at SEH before undergoing the required 30-day full evaluation. Indeed, by the time of that evaluation they might have been found, with the benefit of timely restoration sessions, competent and transferred either back to the jail or released to the community while they awaited trial.

In a hearing, Judge Leibovitz expressed the view that a "good competency restoration unit [at the jail]... would address a lot of the bed space problems. Some people have to be in the hospital. Some people do not."¹⁷⁰ In early October 2017, DBH staff reported that it had started a short-term jail-based competency restoration program for defendants who had been awaiting transfer to SEH for more than three calendar days. DBH jail liaison staff would provide on-site restoration services for less than two hours a day. In a November court hearing, DBH counsel assured that anyone waiting at the jail for more than three days (i.e., still on the waitlist) would receive services and that five men had already begun the restoration program. The court seemed satisfied with this temporary solution.¹⁷¹ DBH counsel also explained that, by remodeling one of the existing units, DBH planned to expand capacity at SEH, later reported to CCE as an increase of seven beds. According to DBH counsel, DBH would complete the expansion within several months "in anticipation of the influx of summer admissions."¹⁷²

In discussions with one judge, CCE raised the question whether jail-based competency restoration would comply with the statute and, thus, the court's orders. The judge agreed that was an issue because the "program at the jail is not actually a transfer to [SEH]." In fact, the judge noted, the jail-based approach, as currently structured, could be viewed as merely a different form of, and have the same problems as, delayed transfer to SEH.

169 CCE e-mail correspondence with DBH staff (August 2017).

170 *U.S. v. [REDACTED TEXT]*, *supra* note 65, at 22.

171 CCE observation of Preliminary Hearing, *United States v. [REDACTED TEXT]* 2017 CF2 011477 (D.C. Sup. Ct. November 7, 2017).

172 *Id.*

Currently, the D.C. Code does not contemplate a jail-based competency restoration program when a court has ordered *inpatient* competency evaluation and restoration. As currently written, an inpatient facility is defined as:

(A) Saint Elizabeths Hospital; (B) [a]ny other physically secure *hospital* (emphasis added) for the examination or treatment of persons with mental illness; or (C) [a]ny physically secure or staff-secure facility for the examination, treatment, or habilitation of persons with intellectual disabilities.¹⁷³

While the jail can provide mental health services in a secure facility, it is limited in its abilities to provide inpatient services. If the District were to move forward with a more permanent jail-based competency restoration program, CCE believes that such a program would require a statutory revision.

Jail-based restoration programs are an emerging development in the competency restoration field. The experts with whom CCE spoke about the subject suggested that not enough research has been conducted on the outcomes of the programs. The National Judicial College cites jail-based competency restoration as a best practice, but only under certain circumstances. The benefits and competing considerations are outlined in the table below:

Figure 5. Considerations to Using Jail-Based Competency Restoration.

Advantages	Competing Considerations
<ol style="list-style-type: none"> 1. Defendant does not need to wait for transfer to SEH; 2. Defendant does not need to be transported from one setting to another across agencies; 3. Greater likelihood the defendant will maintain continuity of care – “using the same treating professional and formulary from the onset of treatment through disposition of legal proceedings”; 4. Jail-based restoration is much less costly than SEH. 	<ol style="list-style-type: none"> 1. “There is strong support – even within the mental health system – that jails should not be treatment facilities”; 2. The cost of treatment shifts from DBH to DOC, “and the jail may be reticent to incur liability”; 3. Incompetent defendants take up space that could otherwise be used to detain other people; 4. There may be statutory or contractual issues that prevent the jail from providing the services.

Source: National Judicial College, Mental Competency: Best Practices Model, 1, 26 (2012).

The jail should be used only when hospitalization is not required and outpatient restoration is not an option either because it is not available or because the court has ordered the defendant to remain detained. Every effort should be made to improve and expand the use of D.C.’s Outpatient Competency Restoration Program.

Impacts on Space Limitations on People Civilly Committed

The growing demand for forensic bed space has decreased the availability of beds for civilly committed individuals resulting in a separate waitlist for their admissions. DBH staff explained that this is a particular concern because the civilly committed are often more acutely ill than pre-trial defendants and, thus, in greater need of hospitalization. Staff noted that civil admissions wait times are often much longer than those at the

¹⁷³ See D.C. Code § 24-531.01(6). “Intellectual disabilities” or “persons with intellectual disabilities,” as defined by D.C. Code, means “a substantial limitation in capacity that manifests before 18 years of age and is characterized by significantly below-average intellectual function, existing concurrently with 2 or more significant limitations in adaptive functioning.” D.C. Code § 7-1301.03(17A). Mental illnesses, as defined by D.C. Code, exclude intellectual disabilities and other development disorders, “unless [they] co-occur with another diagnosable mental illness.” D.C. Code § 7-1301.03(17A). Finally, D.C. Code does not define the term “facility” as “a jail, prison, other place of confinement for persons who are awaiting trial or who have been found guilty of a criminal offense, or a hospital for people with mental illness within the meaning of § 24-501.” D.C. Code § 7-1301.03(13).

jail, with civil patients waiting weeks or longer to be admitted to SEH. In these cases, DBH staff reported, civilly committed individuals are held at local hospitals while they wait for transfer. To help resolve these issues, DBH should develop appropriate inpatient alternatives for waitlisted civil admissions.

CCE received reports that local hospitals may discharge patients who have waited long periods for transfer to SEH because of the high cost of treating them, especially if the patient lacks Medicaid or insurance coverage. In some instances, DBH staff, stakeholders, and providers reported, local hospitals do not begin the civil commitment process due to (a) a reluctance to complete the necessary paperwork and prepare physicians for courtroom testimony, which may take a physician away from work for a number of hours, and (b) the financial burden involved with sustaining an individual's commitment while they await admission to SEH, which could take several weeks. In these instances, interviewees asserted that local hospitals "sufficiently stabilize" an individual and then discharge them to the street. In some cases, consumer advocates and stakeholders reported that their clients were then either arrested or transported to DBH's Comprehensive Psychiatric Emergency Program. Many of these reports came to CCE during the drafting of this report. As such, CCE could not verify these reports but believes that they merit further investigation by the D.C. Office of the Inspector General or the Office of the D.C. Auditor, which should conduct a thorough review of the involuntary detention and civil commitment processes in the District and to further assess the impacts of DBH's civil commitment waitlist. Attorneys, consumer advocates, and DBH staff noted that mentally ill persons rarely commit violent crimes. However, they also noted that civil commitment is reserved for those individuals who present a danger to themselves or others.¹⁷⁴ Thus, DBH, local hospitals, and providers should prioritize the care of these individuals and better communicate with each other to ensure they receive the services they need, regardless of the administrative burdens necessary to begin commitment proceedings or the financial burdens associated with sustaining an individual's commitment.

¹⁷⁴ See D.C. Code § 21-541 *et seq.*

Finding Seventeen

Procedural delays cause defendants to be held at Saint Elizabeths Hospital at the expense of the D.C. taxpayer even after they have been found competent.

Recommendations

1. That the D.C. Council amend the D.C. Code to require a competency hearing within three days of a completed inpatient competency evaluation.
2. That DBH develop a comprehensive “maintenance” program that differs from the restoration program and focuses on an individual’s rehabilitation.
3. That the D.C. Council amend the D.C. Code to recognize orders of competency “maintenance” and authorize a judge to make findings similar to those already in the statute to permit the defendant to continue as an inpatient undergoing competency “maintenance.” (Sample language is included in Appendix X)
4. That the D.C. Superior Court consider the development of a “competency court” or “competency docket,” which is considered a best practice

Implementation

These recommendations may be implemented by (a) DBH’s amending its current policies and procedures, and (b) the D.C. Council’s amending D.C. Code § 24-531.06 to provide for competence maintenance.

Comment

Procedural Delays

DBH staff reported that many defendants are held at Saint Elizabeths Hospital (SEH) even after they have been found competent because of procedural delays related to the court system. An individual may be found competent within one week but be required to remain at SEH until their court date, in the hope that the prosecutors, defense counsel, and judge agree with DBH’s recommendation. If one party does not agree, the defendant will remain at SEH while the case is litigated. During litigation, either party is allowed to request and contract with an expert evaluator to provide a different opinion on the defendant’s competence. The finding of that evaluation can also be contested and litigated. Ultimately, a judge makes the final determination of competence, and the case either moves forward or not. DBH staff reported that one individual went through this process for over two years before ultimately being found competent.

SEH staff expressed frustration when competent defendants are held at the hospital waiting on the pace of the justice system. In many cases, they said, the person could remain stable after transfer back to the D.C. Jail, which they said has greatly improved its mental health treatment in recent years.

In the current court system, scheduling delays are inevitable. Judges are statutorily required to schedule a hearing within a 30-day window after their first order for competency.¹⁷⁵ However, the requirement that a defendant be evaluated within 30 days does not apply to subsequent hearings with further evaluations are considered.¹⁷⁶ DBH staff explained, and CCE observed in hearings, that judges would schedule such later hearings for when they were next available, generally, a period of one to two months. The statute permits DBH to report to the court before the hearing date if the defendant has been deemed competent before then.¹⁷⁷ However, DBH staff reported that because of short-staffing, they see court dates as deadlines by which an evaluation must be completed, and they are not always able to conduct evaluations in advance. Even if DBH staff is successful in completing an evaluation earlier, the court may not hear the matter until

¹⁷⁵ See D.C. Code § 24-531.03.

¹⁷⁶ See D.C. Code § 24-531.06.

¹⁷⁷ *Id.*

the subsequent hearing date, leaving defendants at SEH while they wait for that date.

On several occasions throughout the course of CCE's review, DBH staff consistently reported no less than ten individuals who had been opined competent and were waiting at SEH until their court hearing. These defendants, staff said, did not require hospitalization and could have been transferred back to the jail, which would have freed up space at SEH for others who require hospitalization, such as civilly committed persons. Thus, CCE recommends that the D.C. Council amend the D.C. Code to require a competency hearing within three days of a completed inpatient competency evaluation.

Understanding the restrictive scheduling implications this may create for D.C. judges' calendars, CCE further recommends that the D.C. Superior Court implement a "competency court" or "competency docket," a specialty court/docket dedicated to handling all competency matters within the court, which is an emerging best practice that has been implemented in other jurisdictions.¹⁷⁸ The National Judicial College recommends the court/docket be established within the court's existing mental health court or presided over by the mental health court judges, use prosecutors and defense attorneys who have been educated and trained in mental health and competency law, be staffed by mental health professionals and case managers, and have special rules and procedures for transferring a case back to the criminal court judge upon resolution of the competency matters.¹⁷⁹ As the National Judicial College notes:

Such collaboration is likely to result in the best outcome for the criminal justice system – meaning, the outcome most likely to protect the public safety, decrease system costs, and increase the quality of life for the mentally ill defendant to prevent the individual from recidivating. From a defense [counsel] perspective, collaboration enhances the ability of counsel to focus on the client's long-term interests, e.g., stabilizing the individual so that he or she does not recidivate. From a prosecution perspective, if an individual is stabilized, he or she is less likely to commit illegal acts or to jeopardize public safety. From an overall perspective, the fewer the number of individuals who recidivate, the better it is for the community.¹⁸⁰

Competence Maintenance

Additionally, staff and attorneys reported that some people are held at SEH for "competency maintenance." In other words, they are kept at SEH because their release to the community or transfer to the jail would likely result in their decompensation and becoming incompetent once again, thus repeating the competency process from the beginning. In these cases, staff and attorneys agree that the defendants' continued hospitalization would be medically necessary to maintain their competence throughout the course of their legal proceedings.

While CCE does not take a position on the medical necessity of competency maintenance, CCE does recognize that the statute is ambiguous on this matter. Currently, the D.C. Code does not explicitly permit the court to hold an individual at SEH for competency maintenance. Therefore, CCE recommends that the D.C. Code be amended to provide for orders of competency maintenance.

Finally, staff and attorneys noted that there is no program specifically designed for defendants held for competency maintenance, which often means that those defendants end up participating in the restoration programs that may no longer be necessary. CCE recommends that DBH develop competency maintenance programs for defendants who no longer need the restoration program but would benefit from other rehabilitative services. Moreover, DBH should consider using OCRP procedures for maintenance for individuals whom the hospital believes have demonstrated that they could be clinically maintained in an outpatient setting and for whom the court believes maintenance is necessary.

¹⁷⁸ National Judicial College, *Model Competency*, *supra* note 92, at 39.

¹⁷⁹ *Id.*

¹⁸⁰ *Id.*, at 40.

Operational Issues

Finding Eighteen

Evidence suggests that DBH does not have adequate performance measures or provide adequate oversight of the Core Service Agencies (CSAs) with which it contracts for the provision of mental health services to many justice-involved consumers.

Recommendations

1. That DBH develop more robust performance measures for CSAs and strengthen its oversight of them to ensure that they meet the performance measures and are financially stable.
2. That the D.C. Council provide more direct oversight of DBH's management of CSAs and other DBH-certified providers by, for example, scrutinizing the methodologies DBH uses to assesses their performance, reviewing DBH's overall capability for supervising the performance and financial stability of its providers, and holding DBH accountable for its failure to identify and effectively respond to poor performance by CSAs and low consumer satisfaction.

Implementation

These recommendations may be implemented by (a) DBH's amending its internal policies and procedures and (b) the D.C. Council's exercising stronger legislative and regulatory oversight of DBH's supervision of CSAs.

Comment

As discussed below, DBH contracts with and oversees the Core Services Agencies (CSAs) that provide mental health services to many justice-involved consumers. Although DBH has worked to strengthen its oversight of the CSAs, it should take additional steps to improve the quality of health care received by justice-involved consumers throughout the District.

Financial Stability of the DBH Network

Over the past five years, several CSAs reported experiencing significant financial problems. In interviews with CCE and testimony to the D.C. Council, many providers attributed much of their recent financial stress to one or more of the following problems resulting from disruptions in their receipt of local-dollar funding from DBH during FY 2016: (a) months-long delays in reimbursement payments related to the failure of DBH's medical billing software, iCAMS; (b) an insufficient rate structure for local-dollar services; and (c) limited or no increases to the providers' local-dollar funding allocations to meet the demand for services (more about limitations to local-dollar funding is discussed in Finding 25). Some CSAs reported to both CCE and the D.C. Council that, to offset their local-dollar shortages, they had to make significant changes to their business models, including discontinuing certain types of local-dollar services, and, in some cases, closing business altogether.

The demise of Green Door, a local nonprofit that served approximately 1200 consumers, is an example of a long-standing and significant CSA whose financial condition was not fully understood by DBH. In recent years, it had experienced a series of difficulties that had weakened its financial condition, which it asserted ultimately became untenable when subjected to the additional stress of FY 2016's local-dollar complications.¹⁸¹ Many stakeholders and DBH staff with whom we spoke were surprised to learn about Green Door's financial

¹⁸¹ Scott Rodd, *Advocates Say Some Mental Health Patients Aren't Being Adequately Served Amid Policy Changes*, DCist (February 23, 2017), available at http://dcist.com/2017/02/advocates_say_some_mental_health_pa.php (reporting that in early 2017, Green Door, which had operated in the District for more than 40 years, closed.)

difficulties. Since 2011, DBH had consistently ranked Green Door as one of its top five providers, in terms of both its financial and quality-of-service scores.¹⁸² DBH has explained that the CSAs’ financial scores in DBH’s annual “Provider Scorecard” are measured by:

the providers’ ability to submit accurate claims to DBH/Medicaid, compliance with performing required checks to insure [sic] that Medicaid is payor [sic] of last resort, the provider’s commitment to pursuing compliance activities as required by regulation, and whether or the not the provider sent DBH required documentation.¹⁸³

Apparently, these measures did not accurately and fully apprise DBH of Green Door’s true financial condition. Youth Villages is another example of a CSA that had financial troubles notwithstanding its high rating by DBH. In June 2017, Joe Goldsmith, then-District Manager for Youth Villages, testified before the D.C. Council’s Committee on Health that Youth Villages would close its doors at the end of the month because of the organization’s long-standing problems with DBH’s rate structure. According to Mr. Goldsmith, that structure had caused the organization to operate at a loss.¹⁸⁴ In FY 2015, Green Door and Youth Villages received financial scores of 86 and 87 respectively from DBH and ranked in the top seven of 28 total providers (see Figure 6 below).

Figure 6. Top Seven of 28 providers from DBH’s FY 2015 Provider Scorecard

Mental Health Rehabilitation Services Provider Scorecard - FY 2015 Results

NO	Provider	Quality Score	Financial Score	Accreditation Bonus	Total Percent	FY15 Number of Stars
1	McClendon Center	99	87	5	98	★★★★★
2	Anchor Mental Health	99	82	5	95	★★★★★
3	Youth Villages	87	87	5	92	★★★★
4	Green Door	97	86	0	91	★★★★
5	MBI	94	80	0	87	★★★★
6	Outreach Solutions	86	86	0	86	★★★
7	Community Connections	88	82	0	85	★★★

Source: DBH, FY 2015 Provider Scorecard (2016).

In 2017, Neighbors Consejo, a CSA and ASARS provider, testified to the D.C. Council that it had to file for bankruptcy in part due to lack of payments from DBH. Andromeda Transcultural Health, another provider with a 40-year presence in the District, announced it would no longer be able to provide substance use services in the District also reportedly because of financial problems. Since FY 2012, seven CSAs and even more substance use providers have reportedly closed.

In interviews with CCE and testimony before and correspondence with the D.C. Council, DBH contested the accuracy of the providers’ claims of untimely or non-payments, stating that poor business practices had caused the weakened financial performances and closures of some CSAs. For example, in a June 2017 hearing of the Committee on Health, the Director of DBH testified that Neighbors Consejo had failed to submit any billing claims at all for FY 2015 within that year, but rather had submitted them the following year, which the Director stated was beyond the timely filing waiver limitations.¹⁸⁵ The Director testified that DBH had provided Neighbors Consejo with technical assistance to help its staff improve its billing practices and that the organization was working with the Mayor’s Office of Latino Affairs to apply for an infrastructure-building grant. During that same June 2017 hearing, the Chair and other members of the Committee on Health expressed alarm that they had heard so much and for so long (over a year at that point) from the

¹⁸² See, generally, DBH, *Provider Scorecard* [webpage], available at <https://dbh.dc.gov/node/237752>.

¹⁸³ Written correspondence with DBH (January 2018).

¹⁸⁴ Testimony of Joe Goldsmith before the D.C. Council Committee on Health (June 5, 2017).

¹⁸⁵ Testimony of Tanya A. Royster, Director of DBH, before the D.C. Council Committee on Health (June 5, 2017).

providers directly about their financial problems.

In interviews with CCE, community providers, and stakeholders remarked that stronger financial oversight by DBH of community providers, such as reporting requirements about an organization's liquidity, might improve DBH's understanding of the providers that need more supervision and support. Moreover, the interviewees said, an agency such as DBH, that both provides oversight and provide for the public welfare, should both oversee the CSAs, but also provide access to a comprehensive support system to which providers could turn if necessary, such as DBH providing infrastructure building or interim financial assistance.

DBH's Assessment of CSAs' Performance

DBH publicly describes the Provider Scorecard as a ranking system that "makes valuable information available to residents seeking or receiving mental health services to help them choose a provider they believe can best meet their needs." The DBH website further states, "The Provider Scorecard illuminates the strengths of an individual provider and the public mental health system and helps to identify areas that require provider and system improvement."¹⁸⁶ Over the past five years, the scorecards have indicated an average overall score of 80 percent. In FY 2016, the average overall score was 77.5 percent, or the equivalent to "two stars" as ranked by DBH, with only two providers receiving "five-star" rankings, almost 60 percent of providers receiving "two-star" rankings or below, and nearly a quarter of providers receiving one or no stars.¹⁸⁷

During CCE's interviews, however, DBH staff stated that the Scorecard is not a good tool for measuring a CSA's financial strength. DBH staff explained that, while the Scorecard is helpful in identifying providers whose performances are clearly below par, it cannot be relied on to accurately portray the financial condition of an organization or provide a nuanced look at its quality of care. For this reason, DBH staff said, they have chosen to discontinue the Provider Scorecard and are developing a new tool to assess provider performance.

Beyond the scorecards, DBH employs several different mechanisms to assess provider performance. For example, DBH requires an organization to go through a lengthy and detailed certification process to become a qualified provider and at least annually revisits each provider to assess its quality and compliance. The agency also uses a process called the Community Services Review, an interview-driven assessment of the quality of care provided to a consumer and whether that care met their needs. Further, DBH performs Medicaid claims audits to determine whether providers have adequate treatment plans in place to guide services and whether those services are of appropriate quality. In addition to these more formal processes and tools, each provider receives oversight and technical assistance from its assigned Network Development representative.

In interviews and surveys, CSAs and DBH consumer advocates reported to CCE that, in its oversight role, DBH overemphasizes regulatory and administrative functions and does not focus enough on ensuring that there is support for robust clinical services. As such, interviewees reported that some CSAs concentrate heavily on meeting minimum administrative requirements and not on providing the highest quality of services. In both a focus group of consumer advocates and written survey responses, advocates complained that the quality of services, staff, and facilities vary tremendously from one CSA to the next, and that DBH does not do enough to ensure that the providers with which it contracts meet minimum adequate standards. This was echoed by DBH staff who, in interviews and responses to CCE's online survey, staff also indicated that the quality of CSA services varies tremendously.

In a CCE survey of DBH consumer advocates (e.g., social workers, attorneys, and others who work with DBH consumers), nearly 55 percent of respondents disagreed with the proposition that DBH has strong oversight of its CSAs, with only roughly six percent agreeing. Furthermore, 58 percent of advocate respondents disagreed with the proposition that DBH demonstrates a strong financial commitment to ensuring CSAs provide high-quality services. Similarly, in a survey of DBH forensic staff, 46 percent responded that they

¹⁸⁶ See, generally, DBH, *Provider Scorecard* [webpage], available at <https://dbh.dc.gov/node/237752>.

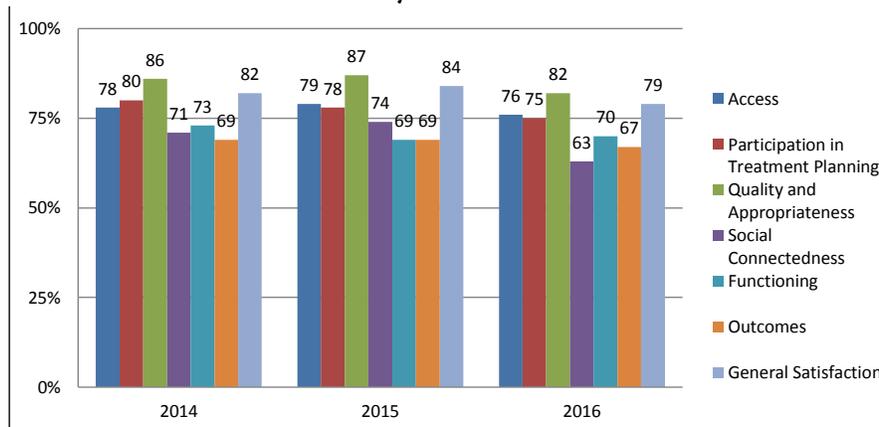
¹⁸⁷ *Id.*

were dissatisfied with the quality of services provided to justice-involved consumers by CSAs.

To its credit, DBH does provide corrective action reports to CSAs that score poorly on performance audits. DBH reported that in 2017 they revoked the certification of two providers that were unable to improve their performance to meet minimum standards. Nevertheless, the information received by CCE during this audit indicates that the quality of service provided by CSAs and their financial stability vary tremendously, which can lead to a serious inequitable distribution of access to high-quality mental health services.

Consumer Satisfaction

Figure 7. DBH Adult Consumer Satisfaction by Year.



Source: DBH, *Mental Health Statistics Improvement Program and Youth Services Survey for Families Narrative Report: Perceptions of Public Mental Health Services in the District of Columbia among Adults and Caregivers of Children and Youth (2016)*.

The results of DBH’s consumer satisfaction survey appears to bear out the perceived variance in quality of service. From 2014 to 2016, adult consumer satisfaction scores decreased across all domain scores.¹⁸⁸ Most notably, scores were persistently low with respect to consumers’ perceptions of overall improvement in their mental health and social well-being and their perceptions of the benefits received from treatment.¹⁸⁹

The community mental health provider network is the foundation of D.C.’s public behavioral health service delivery system, and DBH is statutorily responsible for ensuring that the system provides quality services to all its consumers. When a CSA fails, that failure immediately affects the city’s mentally ill. The poor overall performance of the CSAs and the closure of seven, some of which were highly ranked, in five years suggest that DBH has not exercised strong enough oversight or responded with the corrective policies and actions needed to support a successful network of community providers.

Freestanding Mental Health Clinics

In responses to the D.C. Council, DBH reported that it had created a working group with the Department of Health Care Finance to “review the role, responsibilities, [and] capacity of the [freestanding mental health clinics] with a goal of transferring the regulatory authority over these clinics from [Department of Health Care Finance] to DBH.”¹⁹⁰ In principle, CCE agrees that it makes sense for DBH (the equivalent of a state mental health agency) to oversee the city’s freestanding mental health clinics. CCE also believes, however, that at this time DBH is not well equipped to take on oversight of these clinics. Thus, the D.C. Council and the Executive Office of the Mayor should carefully monitor the results of any such transfer of oversight authority to DBH to ensure that the freestanding mental health clinics do not experience the same instability suffered over the past two years by the District’s mental health and substance use providers.

¹⁸⁸ See DBH, *Behavioral Health Satisfaction Survey: Mental Health Statistics Improvement Program and Youth Services Survey for Families Narrative Report*, 1, 7 (2016), available at <https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/2016%20MHSIP%20Report.pdf>.

¹⁸⁹ *Id.*

¹⁹⁰ DBH, *FY 2018 Budget Responses*, *supra* note 32, at 172.

Finding Nineteen

DBH does not have a formalized, automated system for connecting justice-involved consumers to appropriate care during their transition from D.C. Department of Corrections or Federal Bureau of Prisons custody to the community.

Recommendations

1. That DBH consult with IT experts to develop and implement a formal and appropriately automated referral program that addresses the specific needs of justice-involved consumers.
2. That DBH develop performance measures for evaluating the success of DBH liaisons in linking justice-involved consumers to the appropriate care and collect information necessary to judge their success in meeting their goals.
3. That DBH review the roles and responsibilities of the DBH liaisons to determine whether they have the resources and abilities to perform their roles successfully, and make changes as necessary.

Implementation

DBH may implement these recommendations by amending its internal policies and procedures.

Comment

DBH does not have a formalized or automated system of referral that effectively captures all of the individuals with identified severe mental illnesses who pass through the D.C. Jail or return to D.C. from incarceration in the Federal Bureau of Prisons (BOP) and refers them to services in the community. Furthermore, although DBH has not established target performance objectives for the referral system, the available outcomes data are clearly poor.

Current DBH Procedures

DBH forensic mental health coordinators (“DBH liaisons”) are embedded at the Department of Corrections (DOC) and the Court Services and Offender Supervision Agency (CSOSA) to assist incarcerated consumers with re-entry planning. At the DOC, the liaisons are responsible for identifying people with mental illness who could benefit from DBH services in the community and linking them to those services upon their release. They also administer any necessary screenings and assessments and provide counseling when and if appropriate.¹⁹¹ If a DBH Core Service Agency (CSA) has been serving a consumer before that person’s arrival at the jail, the liaison must notify the CSA of their incarceration. Before DBH imposed additional restrictions on local-dollar funding for re-entry planning services that CSAs provide to incarcerated and institutionalized consumers (*see* Finding 20), DOC, Unity Healthcare, and DBH staff reported that, upon receiving these notifications, case managers from the CSAs would enter the jail to serve their consumers, staying in communication with them, increasing continuity of care to the extent possible, and helping plan for re-entry. With the recently imposed restrictions on funding for re-entry planning, the same staff reported that CSAs now rarely come to the jail to serve consumers because the process is cost prohibitive.

There is one CSA, MBI Health Services, Inc. (MBI), that contracts with DBH to provide re-entry planning services at the D.C. Jail, which are not tied to DBH’s recently imposed funding restrictions.¹⁹² Because MBI is the only CSA with a presence within the jail, DBH liaisons reported that they refer many clients to them.

For a consumer who is incarcerated with no pre-existing relationship with a CSA, the DBH liaison at the DOC is responsible, as part of the re-entry planning process, for reviewing a consumer’s institutional and mental health records and connecting them with a CSA or other behavioral health services in the community, as

¹⁹¹ See, Position Description for Forensic Mental Health Coordinator, Division of Forensic Services (2016).

¹⁹² This contract was held previously by Green Door, but was assumed by MBI Health Services, Inc. when Green Door closed.

appropriate. Thus, the DBH liaison will schedule the consumer's initial post-release appointment with a CSA, and will later follow up with that CSA to find out whether the consumer went to the initial appointment. The DBH liaison will record the attendance information but will not provide any additional follow-up.

Each month, the DBH liaison at CSOSA, DBH staff explained, receives a list of consumers incarcerated in BOP facilities throughout the country who are scheduled for release during the next 120 days. The liaison is responsible for coordinating with BOP and CSOSA social workers, reviewing a returning consumer's institutional and DBH mental health records, and connecting them with a CSA or other appropriate behavioral health services. DBH staff estimated that the monthly BOP lists contain on average between 35 and 50 names, of which the DBH liaison typically prioritizes 20 for assistance.

DOC and DBH staff reported that, DBH liaisons have limited access to the mental health intake evaluations in the DOC and Unity Healthcare (DOC's contracted health care provider) systems, and there is no clear or formal process through which a person is referred to the DBH liaison. Instead, the DBH liaisons at the DOC will intermittently ask Unity and DOC staff whether any consumers seem to need their attention. DBH and DOC staff also reported that the liaisons will reach out to consumers who submit "sick call requests" to be seen for mental health services. The liaisons will also serve persons they happened to meet during their walks through the cell blocks.

DOC and DBH staff explained that the liaisons' system for referrals to community-based services is largely word-of-mouth and usually involves making referrals to CSAs with which the liaisons are familiar, rather than an analysis of which CSA might be the best fit for the consumer's individual needs. Staff further explained that, because of the recent restrictions on providers, CSAs no longer come in to visit consumers have an appointment scheduled with them for after their release. Instead, DBH and DOC staff explained that consumers are essentially told, "You have an appointment with [CSA] on [date]; here's their information." Thus, consumers in the jail do not establish rapport with their providers before they are released. Some consumers reported to CCE that they were referred to a provider from which they did not want to receive services or that was too far from their home, so they chose to go elsewhere. Other consumers reported to CCE that the referral process from the jail to a CSA was not seamless and that they were waitlisted for services at the CSA. Consumers and consumer advocates (e.g., attorneys representing consumers, social workers at advocacy organizations) further reported that they had to fill the gaps in these situations, calling DBH's Access HelpLine to obtain referrals to more appropriate or available services. As one consumer said, "If it were not for the help of my social worker at [the Public Defender Service], I would not have gotten into the services I needed and would probably be back in jail."

Indeed, there is much overlap between the transition plan duties of correctional institutions, supervision agencies, DBH, and CSAs. It is unclear which agency or organization is in the best position to take on discrete yet urgently important tasks, such as applying for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI), Medicaid, Assertive Community Treatment (ACT) services,¹⁹³ or housing, because each of those entities often undertake those tasks, but in different cases for different reasons.

DBH staff reported that DBH's only roles in transition planning are to provide other government agencies with appropriate access to the consumer's DBH records, and appropriately connect consumers pending release to DBH services. Other agencies could assume these responsibilities if given proper access to DBH's system, iCAMS.

DBH should review the responsibilities of its DBH liaisons to determine if they have the abilities to perform their roles successfully, such as access to all of the consumers with identified mental health needs or improved process for identifying and engaging with consumers who are incarcerated.

Inadequate Linkage and Data Collection

Based on data provided to CCE by DBH, DOC, and CSOSA, it was apparent that the DBH liaisons were not

¹⁹³ Assertive Community Treatment, or ACT, is an intensive, community-based service provided by an interdisciplinary team for adult consumers with severe and persistent mental illnesses enrolled in DBH's MHRS program.

able to interact with everyone that was reported as having a mental illness. For example, in FY 2015:

- 1,441 people in DOC's custody had a severe mental illness diagnosis¹⁹⁴(1,120 men and 321 women); of those, DBH liaisons at DOC served only 793 consumers (541 men, 252 women).¹⁹⁵
- 1,419 people entered CSOSA supervision, 649 (49 percent) of whom had a mental health diagnosis.¹⁹⁶ The CSOSA liaison served 190 consumers.¹⁹⁷ Of those, DBH reported that it referred 95 consumers (50 percent) to DBH services; however, it was not made clear if those individuals were newly connected to services or if a DBH CSA had previously served them before their incarceration.

Similar statistics exist for FY 2016:

- 1,515 (1,221 men and 294 women) in DOC's custody had a severe mental illness diagnosis;¹⁹⁸ of those, DBH liaisons at the DOC served only 526 consumers (302 men, 224 women).¹⁹⁹
- DBH's CSOSA liaison served 263 consumers,²⁰⁰ of whom 112 (42 percent) were linked to DBH services (the same limitations on data apply here).²⁰¹

As suggested by this data, the sheer volume of people at the DOC and entering CSOSA supervision with mental health diagnoses might be more than the DBH liaisons are able to handle. DBH should assess whether its DBH liaisons have sufficient resources to meet the demand, and if not, hire more staff.

It is further apparent that the success rates of the linkage program staffed by the liaisons are dismally low. Between FY 2015-17, the DBH reported that 47 of the 1,097 women served by DBH liaisons at DOC were newly linked to services. Of those women, only nine, or 19 percent, attended their first appointments. Despite CCE's request for information, DBH failed to report how many individuals returning from the BOP attended their first appointment.²⁰² DBH should also assess the extent to which the structure of the linkage program is hindering outcomes that are more favorable.

CCE believes that a formalized, automated program for referrals to DBH services that addresses the specific needs of justice-involved consumers would address many of the shortcomings of the current system. Such as a system could incorporate into one system data from the consumer's mental health records, interviews with the DBH liaisons and DOC medical staff, types of services needed or requested, and other consumer preferences (e.g., location). Using these data, the system could then refer the consumer to the CSA that best meets their needs and preferences. A referral system of this type could better facilitate consumer choice, increase attendance for first appointments, and increase continuity of care.

194 CCE email correspondence with M. Pflaum, D.C. DOC Operations Research Analyst (November 14, 2017).

195 DBH response 4/7/17, *supra* note 38.

196 Kress, *et al.*, *BSC*, at 70, *supra* note i.

197 DBH response 4/7/17, *supra* note 38.

198 CCE email correspondence with M. Pflaum, D.C. DOC Operations Research Analyst (November 14, 2017). Fifteen of those women and 543 of the men were on the DOC census for both fiscal years.

199 DBH response 4/7/17, *supra* note 38.

200 *Id.*

201 DBH response 9/15/17, *supra* note 48.

202 *Id.*

Finding Twenty

DBH's restrictions on the amount of discharge services (transition planning) Core Service Agencies (CSAs) disadvantage justice-involved consumers.

Recommendations

1. That DBH immediately increase the amount of time for which CSAs may bill for discharge planning from inpatient care or incarceration. These increases should reflect the realities involved with discharge planning in the District.
2. That, even when increased, discharge billing restrictions be considered for extension on a case-by-case basis to ensure that individuals with more complicated situations are eligible for the same quality of discharge planning as other consumers.
3. That DBH produce a comprehensive study on discharge planning services to better understand the process and its associated costs so that the Department can develop a plan to improve the efficiency of discharge planning.

Implementation

DBH can implement these recommendations by amending its internal policies and procedures.

Comment

DBH uses its local-dollar funding to cover the cost of specific services that Medicaid does not cover or expressly prohibits. Several Medicaid restrictions are particularly significant for justice-involved consumers. For instance, a person is ineligible for Medicaid while incarcerated (at a jail, prison, or halfway house) or institutionalized (psychiatric hospitalization). In D.C., an individual's Medicaid eligibility is suspended during incarceration and can be reinstated immediately upon release. Thus, DBH and the D.C. Department of Corrections (DOC) pay for behavioral health services rendered at their institutional own facilities from their respective local-dollar allocations. The BOP pays directly for behavioral health services at Federal Bureau of Prisons (BOP) prisons and halfway houses (also known as "residential re-entry centers" or "RRCs").

DBH also uses local-dollar funds to pay for discharge planning services for justice-involved consumers anticipating release from any institution – BOP custody, DOC custody, or SEH. DBH requires that Core Service Agencies (CSAs), including Assertive Community Treatment (ACT) providers, develop a discharge plan for each of their consumers "to meet the psychosocial needs upon release to the community that will address housing, benefits, and other follow-up requirements, and as necessary, complete applications for benefits and housing."²⁰³

If an individual is confined at SEH, DBH further requires that CSA and/or ACT providers meet with their consumers face-to-face at least once a month throughout the consumer's hospital stay, attend all treatment meetings, develop a detailed discharge plan, and attend all court hearings.²⁰⁴ Recently, however, DBH has greatly restricted the availability of local-dollar funds for CSAs to provide this re-entry planning, which greatly limits funding for providers' required activities.

In early 2017, DBH established new medical necessity criteria that restrict CSAs from billing more than a total of eight hours for re-entry planning services within a total of 30 days for consumers at SEH and 60 days at the jail or in the BOP without prior authorization.²⁰⁵ DBH reportedly intended for the new restrictions to limit

²⁰³ DBH Policy 200.2, *Continuity of Care for Adult Consumers*, 1, 10 (August 2012), available at <https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/TL178.pdf>.

²⁰⁴ *Id.* at 11-12.

²⁰⁵ See DBH, *Medical Necessity Criteria for Treatment Planning Services Provided to Department Of Behavioral Health Consumers In Institutional Settings*, Bulletin ID No. 111 (effective February 22, 2017). [hereinafter "Bulletin ID No. 111"].

Providers bill for "units" measured in increments of 15 minutes, and are eligible for up to 32 units, or 480 minutes.

discharge-planning services to a fixed period and mitigate over-billing.²⁰⁶ However, providers reported that these restrictions significantly limit their ability to assist consumers in preparing for re-entry. For instance, the best practice for assisting people at risk of homelessness to apply and receive approval for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefits is to begin the application process 90 days pre-release from an institution.²⁰⁷ As such, CSOSA allows for up to 120 days of re-entry planning for clients diagnosed with a mental illness, at risk of homelessness, or otherwise at high-risk.²⁰⁸

CSAs reported that eight hours over the span of a month or two is not enough to support a consumer effectively in securing employment, housing, Medicaid, SSI/SSDI or other crucial benefits. Moreover, it can be difficult for providers to predict when a person will be released from the jail or SEH. DBH policy requires that providers treat the court date as the discharge date.²⁰⁹ However, a court date does not guarantee, or even imply, that a person will be released. Procedural delays in court hearings have often resulted in a case being scheduled and re-scheduled months out. CCE observed several hearings at which the court was considering a person's release, but the hearings were not completed that day and were granted continuances. To avoid confusion regarding court dates, DBH should amend the policy to clarify that the discharge date is the date of the judge's final ruling.

DOC and SEH staff reported that CSAs are no longer intimately involved in the discharge-planning process and that many providers do not visit their consumers or participate in team meetings in person, despite their mandate from DBH to do so.²¹⁰ DBH reported to CCE that CSAs should not have trouble requesting and being approved for additional re-entry services, however, CSAs reported that DBH requesting additional authorizations is administratively burdensome and serves as a disincentive for providing services. CSAs reported that if a consumer has reached eight hours of discharge services, the consumer must wait until they are released until they can receive any further services from the CSA. CSAs report that they cannot afford to cover expenses for transition services, even when they believe that such services are in the best interest of the consumer. CCE requested data from DBH on the approval rates for discharge planning reauthorizations but had not received such data at the drafting of this report.

As the CSA and/or Assertive Community Treatment (ACT) providers are responsible for developing and implementing the discharge plan, their lack of involvement has resulted in the release of people from jail, prison, or SEH without necessary supports in place (housing, health insurance, source of income, treatment plan, or medications). When these supports are prerequisites to release, consumers experience delays in discharge from SEH. Thus, other entities, including DBH, justice-system stakeholders, and advocates, often assume CSA/ACT providers' responsibilities and workloads. For example, the 14 full-time SEH social workers now almost exclusively conduct discharge-planning work. DBH staff reported that the social workers are no longer involved in providing clinical interventions to consumers at SEH because they had to take on the CSAs' transition planning workload. The social workers have very limited time to assist consumers in preparing for the discharge process, especially because the amount of time needed for each person varies significantly from case to case. For example, DBH staff explained that many individuals who have been institutionalized for more than five years are uncomfortable with the idea of living in the community and need to be reintroduced to life outside the hospital gradually before they feel safe enough to engage in discharge planning. This can be done through day programs at CSAs, familiarization trips to the city, and various other activities to help integrate a person into the community.

Finally, as of the drafting of this report, DBH did not have sufficient data to support its restricting of

206 *Id.* at 1 (citing as an example of over-billing: a provider billing local dollars for monthly visits for a consumer with a five-year term of incarceration who was not within a discharge window).

207 See Jaqueline F. Kauff, *et al.*, *An Evaluation of SOAR: Implementation and Outcomes of an Effort to Improve Access to SSI and SSDI*, Mathematica Policy Research (October 2016), available at <http://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201500247>.

208 CSOSA, *Community Supervision Services Operations Manual, Chapter IV: Offender Investigations, Diagnostics and Evaluations*, available at <https://www.csosa.gov/about/policies/css/manual/4ChapIV-OffendInvestDiagEval-030108.pdf>.

209 DBH Policy 200.2, *supra* note 203.

210 *Id.*

discharge planning services. Therefore, DBH should produce a comprehensive study on discharge planning services to understand the process and its associated costs better so that the Department can develop a plan to improve the efficiency of discharge planning. Such a study should assess the fiscal impacts of various proposed restrictions to discharge planning, as well as the practical impacts the restrictions have on DBH staff and consumers who would be affected by any proposed changes. The study should also assess any effects the recent restrictions have had on DBH and its consumers, such as increased wait times for discharge from SEH (if any) and hospital readmission rates.

Finding Twenty-One

DBH's restrictions on the type of community support services Core Service Agencies (CSAs) can result in disadvantages for justice-involved consumers.

Recommendations

1. That DBH allow CSAs to bill for and adequately fund the additional services provided to justice-involved consumers, which are often court-ordered.
2. That DBH ensure CSAs have appropriate resources to facilitate transition-planning work.

Implementation

DBH can implement these recommendations by amending its internal policies and procedures.

Comment

There are several components of services for justice-involved consumers that fall within the scope of service delivery but are not themselves considered direct services for the purposes of billing. While many activities related to service provision in the medical field are considered the cost of doing business (e.g., writing case notes, administrative follow-up), DBH's policy of not allowing Core Service Agencies (CSAs) to bill for additional required activities related to providing services for justice-involved consumers is financially restrictive, and discourages CSAs from actively reaching out to justice-involved consumers.

DBH permits CSAs to bill only for clinical care and a limited set of other types of direct care – this generally includes all face-to-face treatment and support services time. CSAs reported that DBH does not allow them to bill for the time in which a consumer is not actively receiving treatment. Moreover, while this may be tenable for serving the average consumer, just getting a CSA staff member in the physical or virtual (i.e., telephone or video) presence of a justice-involved consumer can be so time-consuming and costly that, financially, services for these consumers often result in a net loss. CSAs reported that DBH would not compensate them for much of the time they invest in working with justice-involved consumers to achieve stability and fulfill the court's requirements.

For example, DBH does not permit CSAs to bill for the time spent writing court-ordered reports, such as reports for individuals who have been committed to the outpatient care of DBH either criminally or civilly. In drafting these reports, the back and forth correspondence with the government (court, prosecutors, and supervision agencies) and defense attorneys is often expected, but not a billable service. Furthermore, travel time to and from the court and the time waiting for the case to be heard (which, in some cases can be hours) are also not billable expenses. Required testimony, often in response to subpoena from the government or defense counsel, and the time it takes to prepare are also not covered. Travel times to and wait times in the jail (which can also be hours) are also not covered. The list goes on.

CSAs explained that local-dollar funding previously covered some of these services, such as those for incarcerated consumers, but that DBH's recent restrictions have significantly limited their ability to continue providing services, either at the same pace or at all. They explained that, while they understood the need for increased restrictions to limit frivolous billing, DBH's newly imposed restrictions are so stringent that they all but eliminate the services. Indeed, D.C. Superior Court judges, supervision officers, prosecutors, and defense attorneys with whom CCE spoke for this review said that the presence of CSA staff in the jail, Saint Elizabeths Hospital, and the court has almost entirely disappeared.

CSA staff and consumer advocates reported that they had voiced their concerns about how the new limitations were restrictive to certain type of services to the Director of DBH, to which they assert the Director replied, "You need to make smart business decisions." CSA staff also asserted to CCE that their limiting the provision

of services to justice-involved consumers in response to the new billing restrictions might be a fiscally smart decision for their organization, but that it is, by no means, a smart decision for the community.

Housing Issues

Finding Twenty-Two

DBH is not effective in meeting the housing needs of justice-involved consumers.

Recommendations

1. That DBH make an explicit effort to collect information about consumers' justice-involvement as part of the housing process.
2. That DBH conduct a needs assessment to determine the extent of the need for housing among justice-involved consumers and make changes in housing program capacity as necessary to accommodate that need.
3. That DBH provide more housing options dedicated to justice-involved consumers, as they face numerous additional barriers to obtaining stable housing.

Implementation

DBH can implement these recommendations by amending its internal policies and procedures.

Comment

Housing is an especially crucial piece of the treatment plans for people with mental illness. DBH staff reported that people are more likely to stray from their treatment plans if they do not have stable housing. As such, DBH and other government agencies should increase its focus on meeting the housing needs of justice-involved consumers.

Housing Data for Justice-Involved Consumers

DBH noted that it could only report the number of justice-involved consumers housed for its Home First Program (DBH's housing voucher program) because that application contains a section that asks about prior living arrangements.²¹¹ Thus, DBH is only able to identify a consumer as justice-involved if that consumer chooses to self-report that their previous living arrangement was incarceration.²¹² Regardless, DBH does not directly track through reliable processes housing data for justice-involved consumers. In FY 2016, DBH had the capacity to house 2,668 people through eight housing programs and increased its capacity by 42 beds to 2,711 beds in FY 2017.²¹³

As of December 31, 2016, 5,754 DBH consumers were on its housing waiting list, more than double the Department's capacity.²¹⁴ DBH reported to CCE that, during FYs 2015 and 2016, only one self-reported justice-involved consumer was housed from prison or jail each year in DBH's Home First Program. No justice-involved consumers were reported to be housed during FYs 2014 and 2017.²¹⁵ Community Residential Facilities, DBH's supervised housing programs, have average wait times for all consumers of four weeks from application to placement. The Home First Subsidy Program, which provides consumers with vouchers, has

211 Correspondence with DBH executive staff (February 5, 2018).

212 DBH response 9/15/17, *supra* note 48, at "Request 74" and "Request 76"

213 See DBH, *DBH FY 2017 Budget Responses*, at Q17, available at http://dccouncil.us/files/user_uploads/budget_responses/dobh.pdf.

214 *Id.*

215 DBH response 9/15/17, *supra* note 48, at "Request 74" and "Request 76" (providing that in FY 2014, there were 805 people enrolled in DBH's Home First Program, 884 in FY 2015, 882 in FY 2016, and 892 in FY 2017; the data provided for FY 2017 are as of September 15, 2017, and therefore do not reflect the full fiscal year).

an average wait time of over 21 months for consumers who were provided with housing vouchers.²¹⁶ DBH does not have data on the average wait time for housing for justice-involved consumers. However, multiple consumer advocates (e.g., attorneys and social workers) told CCE that they have never had a justice-involved consumer enrolled in housing from jail or prison within four weeks through a DBH-funded housing program and often have to rely on securing housing for their clients through other providers, such as local religious groups or other government agencies.

A shortage of housing capacity is the *first* barrier to securing housing for DBH consumers returning from prison or jail. The *second* barrier is that Core Service Agencies (CSAs) have a limited window in which to help consumers plan for their re-entry before they are released. As outlined in Finding 20, CSAs can bill up to eight hours (32 units) of re-entry planning services within a 60-day period before a person is released from jail and a 30-day period before release from Saint Elizabeths Hospital (SEH) without prior authorization. Housing is particularly challenging to secure in this period, given D.C.'s limited market for affordable housing and property-by-property restrictions (e.g., housing available only for certain sub-populations, such as people living with HIV/AIDS, custodial parents, or restrictions on people with certain types of convictions, such as arson or sex crimes).

Third, DBH does not consider to be a special population justice-involved consumers who have a behavioral health disorder but are not diagnosed with severe and persistent mental illnesses (e.g., schizophrenia, bipolar disorder). Such consumers, therefore, are not given special consideration for housing, despite remaining at high risk for homelessness and recidivism.²¹⁷ DBH encourages CSAs to ensure that their consumers that respond to the VI-SPDAT survey. This survey measures the vulnerability in homelessness, including justice-involvement, and places the consumer's information the Housing Management Information System, a District-wide housing database, to increase the consumer's access to available housing resources through other agencies' and organizations' housing waiting lists. CSAs and consumer advocates reported to CCE that they must find creative ways to house justice-involved consumers, who already compete at a disadvantage as compared to the average housing applicant.

Consumers voiced to CCE their need for housing. In a CCE survey of DBH consumers, one-third of respondents indicated a need for housing services of some kind from their CSAs. Moreover, in a CCE focus group with justice-involved consumers, almost every participant desperately voiced their need for permanent, supportive housing assistance. One participant said that they were released from jail in March of 2017 but did not receive any housing support until July of that year, and was sleeping in a homeless shelter. The participant said that trying to secure housing was "the most important thing in my life right now."

Fourth, this past year, DBH eliminated many positions within the Department responsible for providing housing assistance for consumers, for the stated reason that the eliminations would reduce duplication of efforts since CSAs already had housing liaisons assisting consumers.²¹⁸ DBH has also removed housing assistance from a "request for proposal" to provide re-entry services through its Linkage Plus Program.²¹⁹ Instead of reducing duplication, however, DBH effectively shifted the burden to house justice-involved consumers on consumer advocates (e.g., the Public Defender Service and University Legal Services), since CSAs are greatly restricted in providing re-entry services and have faced significant financial burdens. CCE spoke with several consumer advocates who said that they have had to find creative ways to house their

216 *Id.*

217 DBH reported that it does prioritize consumers discharged from Saint Elizabeths Hospital for its housing resources. DBH provides temporary funding (payable to the CRF operator) for consumers at Saint Elizabeths Hospital who are transitioning to a CRF to cover room and board expense, plus a personal needs stipend, while their Social Security benefits are being processed. DBH provides housing vouchers to consumers whose level of care is independent living (apartment). The DBH voucher will cover the consumer's rental payment until the consumer's benefits are in place. Voucher awards are provided within three (3) days of request from Saint Elizabeths Hospital social work staff. The consumer's housing search and the pre-lease process (unit inspection done by DCHA) play a large role in the amount of time the consumer remains at Saint Elizabeths Hospital prior to lease-up.

218 *See, generally*, Committee on Health, *Council of the District of Columbia, DBH Performance Oversight Hearing* [video] (February 23, 2017), available at <http://dccouncil.us/granicus/archive/> [hereinafter "DBH Performance Oversight Hearing"].

219 *Id.*

clients because DBH would not. For instance, consumers often rely on housing owned and provided by non-profits and religious organizations. One consumer told CCE that they would most likely still be in jail if their attorney and non-CSA/DBH social worker were not able to work together to find them housing.

Fifth, many of DBH’s housing programs do not pre-emptively address the housing concerns faced by justice-involved consumers. The vast majority of DBH’s programs that explicitly mention justice-involved consumers with severe and persistent mental illness as a priority population are designed for people in crisis, such as the Urgent Care Clinic or Homeless Outreach Program. In its “2012-2017 Supportive Housing Strategic Plan,” DBH did not estimate the needs for affordable housing for justice-involved consumers, whom they stated are “difficult to place.”²²⁰ Accordingly, we recommend that DBH conduct another housing needs assessment that estimates the housing need for justice-involved consumers throughout the continuum of the criminal justice system. DBH can also make adjustments to its Housing Eligibility and Assessment List (HEAL) housing application to expand data collection for justice-involved consumers to include current and historical information. Without these data, DBH is limited in its abilities to assess the housing needs for the population.

²²⁰ DMH, *Government of the District of Columbia Department of Mental Health Supportive Housing Strategic Plan 2012-2017*, 1, 46 (September 2012).

Finding Twenty-Three

Long waiting lists for housing placements have resulted in consumers remaining detained at Saint Elizabeths Hospital (SEH) for long periods after a court has conditionally ordered release. Protracted inpatient lengths of stay beyond clinical necessity are a violation of patient rights and impose unnecessary costs.

Recommendations

1. That DBH's needs assessment (*see* Finding 22, Recommendation 1) specifically analyze the long-term community housing needs for post-trial individuals at SEH.
2. That DBH clarify which DBH affiliated entity is responsible for securing housing for consumers with different kinds of justice system involvement and ensure that the entity has access to the resources necessary to do so.
3. That DBH invest in housing stock specifically for justice involved consumers.
4. That DBH contract for more beds at assisted living facilities or construct such a facility of its own, if and when appropriate.
5. That DBH create incentives to address housing providers' reluctance to house consumers, such as flat monthly incentive rates per individual.

Implementation

DBH can implement these recommendations by amending its internal policies and procedures.

Comment

People found not guilty by reason of insanity (NGRI) are confined at Saint Elizabeths Hospital (SEH), and can be released with or without conditions if they have been determined (1) to have recovered their sanity; (2) no longer to be a threat to themselves or others; and (3) to be ready for life in the community.²²¹ At least annually, SEH's Forensic Review Board (FRB) meets to consider the progress of NGRI acquittees and make recommendations related to their treatment and/or release.²²² The FRB's recommendations are then submitted to the court, which makes the final determination regarding the individual's release.

The FRB's recommendations to the court often include conditions to which the person must adhere upon release, and the FRB develops them in consideration of a person's treatment plan. Housing is an evidence-based practice and is fundamental to successful mental health treatment plans. When the court grants conditional release (as opposed to unconditional release), DBH staff reported that SEH-approved housing is always a condition of that release.²²³ A person who does not have approved housing will remain at SEH until such housing is secured. Likewise, if a person released to the community loses their housing or their housing situation destabilizes such that SEH withdraws approval, they must secure new approved housing or be returned to the hospital. CCE heard reports of individuals being sent back to SEH after years of successful placement in the community simply because their housing situation changed, such as the property owner selling the house, and DBH was unable to secure new housing for the consumers in time.

In of August 2017, DBH staff reported that seven NGRI acquittees were still at SEH despite conditional release orders because DBH had not yet secured them housing. In some cases, individuals have been confined at SEH for over a year after receiving conditional release orders, costing D.C. taxpayers an estimated \$348,210

²²¹ See D.C. Code § 24-501(e).

²²² DBH, *Forensic Review Board Policy*, Policy Number 110-14 (revised July 9, 2014).

²²³ DBH staff reported that SEH approves housing based on the unique needs of each individual, and may include family homes, group homes, individual apartments, or health homes.

per person annually.²²⁴ This cost per person is hundreds of thousands of dollars higher than the average costs associated with housing a person in the community at fair market value for one year.²²⁵ One Core Service Agency (CSA), Pathways to Housing, estimated that its Housing First program saves the D.C. government an average of \$296,275 per consumer annually over psychiatric hospitalization (based on FY 2015 estimates).²²⁶

DBH policy dictates that the burden of finding and securing housing falls on CSAs – typically through a housing liaison or community support worker. However, DBH’s recent funding restrictions on re-entry planning services for institutionalized individuals permit CSAs to bill for only eight hours of re-entry planning only if conducted within the 30 days of a person’s discharge from the hospital.²²⁷ DBH staff reported that hospital social workers have assumed the responsibilities of discharge planning in place of community support workers and other CSA staff. Staff explained that social workers perform their clinical responsibilities, such as facilitating therapy groups, much less frequently than before, which, has reportedly decreased the social workers’ morale because, for many of them, those responsibilities were what attracted them to the positions.

Finding housing for NGRI acquittees is particularly challenging for many reasons. *First*, they often have unique needs and require additional services to ensure successful integration into the community. For example, DBH staff explained that a person at SEH may also have an autism spectrum disorder, or another comorbid disorder, that requires more gradual transition back to the community, such as initially participating in a CSA-administered day program outside of the hospital. DBH may not reimburse a CSA for the services associated with coordinating the logistics of the day program for that person (e.g., coordinating treatment with the program and treatment team) because the services would have to begin more than 30 days before the anticipated discharge (*see* Finding 24).

Second, the NGRI population at SEH is aging, which adds physical health considerations to housing requirements, such as ensuring that apartments are wheelchair accessible. Moreover, DBH staff explained that nursing homes are generally reluctant to administer psychotropic medication to their residents for many reasons (e.g., patients pay flat rates, which often includes but does not fully cover the expensive medication, and facilities do not always have appropriate psychiatry staff), which many people coming from SEH often require.²²⁸

Third, acquittees often still have the arrest and charge listed on their criminal records, and some offenses, such as a sex offense or arson charge, greatly limit their housing options. To help lessen these barriers, many staff and stakeholders remarked that DBH should build or contract for housing that is less restrictive than SEH for its aging population. Some suggested that the hospital could contract out an entire unit of a community nursing home, while others suggested that DBH could construct a residential facility for geriatric patients in need of nursing home-level care on the campus of SEH. However, consumers who need a nursing facility level of care still have the right to live in the community and can live in their home or a community residential facility under waivers for home and community-based services. Thus, DBH should try to access community-based housing options for consumers who would prefer such over a nursing home or other facility.

Moreover, it should be noted that DBH does not have the authority to construct new housing but, instead, must partner with the D.C. Department of Housing and Community Development to develop capital projects, such as affordable housing units. Nonetheless, construction of a residential facility could provide

²²⁴ DBH response 10/6/17, *supra* note 134, at “Request 34” (estimating the daily cost of operation at the hospital is \$954 a day per person in FY 2017. This estimate considers the daily operational costs for individual over the course of one year [365 days]).

²²⁵ See Zumper, *February 2015 Rent Report*, 1, 2 (February 2015), available at <https://www.zumper.com/blog/wp-content/uploads/2015/03/Zumper-February-2015-National-Rent-Report.pdf> (reporting that in 2015, the median rent for D.C. was \$2000 a month – or \$24,000 a year – one of the highest medians in the country).

²²⁶ Pathways to Housing D.C., *Annual Highlights FY 2015* [graphic] (2015), available at https://www.pathwaystohousingdc.org/sites/pathwaystohousingdc.org/files/Pathways%20to%20Housing%20DC%20Annual%20Highlights%202015_3.pdf.

²²⁷ DBH Bulletin No. 111, *supra* note 205.

²²⁸ In recent years, DBH staff reported that it has housed some acquittees in nursing homes – namely in Maryland – but the Department does not have guaranteed beds in nursing homes, as it does with other types of communal housing properties.

DBH with a viable long-term solution for its current and future aging populations, some of whom might prefer such a facility.

A simple, more immediate solution could be to expand the discharge planning billing restrictions DBH has placed on CSAs. It is unlikely that SEH's 14 social workers can perform the work previously done by dozens of CSA staff in addition to their current workloads at the hospital. DBH staff reported that SEH social workers now often stay late to finish their work because of these increased responsibilities. DBH staff said, from their experience, the more someone overworks, the more likely that person is to make a mistake. They went on to say that mistakes related to discharge planning work might ultimately result in delayed discharge and restricts an individual's personal liberties by keeping the individual confined at SEH for too long.

In 2007, SEH was under oversight by the U.S. Department of Justice (DOJ). One of the many areas for which the DOJ required improvement was discharge planning. The DOJ found that SEH was in violation of the Civil Rights of Institutionalized Persons Act by not actively pursuing "the appropriate discharge of patients and ensur[ing] that they [were] provided services in the most integrated, appropriate setting... consistent with patients' needs."²²⁹ While SEH has vastly improved its discharging procedures in the years before and during DOJ oversight, DBH staff reported there exist myriad problems that prevent them from promptly discharging patients once clinically appropriate, which, they believed, is a reversal of the progress made since leaving oversight.

²²⁹ CRIPA Investigation Letter, *supra* note 5, at 64.

Funding Issues

Finding Twenty-Four

DBH's reimbursement rates for community service providers have not kept pace with their funding needs, thereby adversely affecting their ability to recruit and retain quality clinical and non-clinical staff.

Recommendations

1. That the D.C. Council require DBH to conduct a rate study every two to three years.
2. That the D.C. Council adjust DBH's budget to allow for appropriate reimbursement rate changes consistent with the rate study findings.
3. That DBH, in concert with its provider network, develop and implement transparent rate-setting processes.

Implementation

These recommendations may be implemented by (a) the D.C. Council's requiring DBH to conduct rate studies every two or three years, (b) the D.C. Council's adjusting DBH's budget to reflect the rate study findings, and (c) DBH's amending its internal policies and procedures.

Comment

Mental Health Rehabilitation Services (MHRS) and Adult Substance Abuse Rehabilitative Services (ASARS)-certified community service providers-reported to CCE that inadequate local-dollar reimbursement rates have limited their ability to hire and retain quality staff. Poor quality staff and high staff turnover at Core Service Agencies (CSAs) were major concerns of nearly every person to whom CCE spoke for this review, including consumers, CSA management, and DBH management. Providers reported to CCE that the increasing costs of and demand for health care, coupled with the rising demand for sophisticated delivery of those systems, greatly limits the funding available for competitive compensation of staff. As a result, providers reported that their staff are paid well below the average for their field despite their increasing workloads.

In the FY 2018 budget, the D.C. Council increased DBH's budget to allow for MHRS reimbursement rates for local-dollar services for the first time since 2013.²³⁰ The Council reported that "a number of MHRS/ASARS [providers had] recently gone out of business because of the insufficient rate structure and months-long delays at DBH in disbursing payments to providers."²³¹

In late 2017, DBH conducted a rate study for services provided through local dollars. The study analyzed the costs associated with providing behavioral health care in the District and, based on that analysis, calculated adjustments to DBH's standardized rates for services. By in large, the study recommended rate increases for a majority of local-dollar services. Some increases to the original rates were minimal and did not meet or exceed the 5.8 cumulative rate of inflation since 2013 when the rates were last calculated (e.g., one rate increased by 1.28 percent). On the other hand, some rates increased significantly, such as a 38.73 percent increase to the residential treatment rate and a 45.39 percent increase to one of the rates for community-based intervention services.²³²

230 Committee of the Whole, Council of the District of Columbia, *Report on Bill 22-242, the "Fiscal Year 2018 Local Budget Act of 2017"*, 1, 14 (May 30, 2017), available at <http://lims.dccouncil.us/Download/37845/B22-0242-CommitteeReport1.pdf> [hereinafter "COW Committee Report"].

231 *Id.*

232 DBH, *PCG's Proposed Community Behavioral Health Rates* [table] (January 2018).

Some rates for services decreased; most decreases were marginal, others were substantial. For example, the rate for day treatment services decreased by almost 60 percent, more than a 50 dollar-per-unit deduction.²³³ The rate study recommended that DBH implement this rate differently from the others, considering that day treatment services might be the largest (or only) service provided by some providers.²³⁴

CSAs explained that there is a growing sophistication in the provision of health care, which limits the ability of smaller, community-based providers (especially nonprofits) to compete economically. Thus, the successful implementation of DBH's new rates would greatly benefit community-based providers. However, given the rising costs associated with providing behavioral health care services coupled with the rising demand for such services, it is likely that these rates will soon become insufficient. Thus, CCE recommends that the D.C. Council require that DBH conduct cost studies every two to three years. Furthermore, DBH, in concert with its provider network, should develop rate-setting processes that are transparent.

²³³ *Id.*

²³⁴ *Id.*

Finding Twenty-Five

Due to failures of DBH's medical billing system, in FY 2016 DBH was unable to (a) pay providers promptly for local-dollar services, and (b) accurately assess the availability of and (re)allocate local-dollar funding as necessary.

Recommendations

1. That the Executive Office of the Mayor (EOM) conduct an extensive review of the iCAMS software failure and its impact(s) on consumers, community service providers, and the District government.
2. That DBH and the EOM analyze the financial stability of DBH's provider network and develop a comprehensive plan that appropriately addresses the findings of that analysis.
3. That the D.C. Council provide more direct oversight of DBH's supervision and support of the financial stability of its provider network.

Implementation

These recommendations may be implemented by (a) EOM's conducting of a review of the iCAMS software failures and its impacts, (b) DBH and EOM's working together to analyze the financial stability of DBH's provider network and develop a comprehensive plan in response to such analysis, and (c) the D.C. Council's exercising stronger legislative and regulatory oversight of DBH's supervision and support of its provider network.

Comment

Core Service Agencies (CSAs) submit reimbursement requests to DBH for mental health rehabilitative services (MHRS) funded both by Medicaid and "local dollars" (used to pay for services that are non-Medicaid reimbursable, such as those for people who are incarcerated or institutionalized). The medical billing functions of DBH's electronic health records software review both Medicaid and local-dollars reimbursement requests to ensure that CSAs have properly submitted them. DBH forwards properly submitted Medicaid requests to the D.C. Department of Health Care Finance for payment. DBH processes and remits local-dollar reimbursements. The same billing software processes local-dollar reimbursement requests, and DBH reviews the requests to determine whether a consumer meets DBH's eligibility and authorization requirements for the service, as well to ensure proper billing coding. DBH pays approved local-dollar claims directly to the CSAs.

In FY 2016, CSAs reported to the D.C. Council that they had outstanding local-dollar claims from FY 2015. DBH was aware of these claims and reported that it had made efforts to process them.²³⁵ However, in early 2016, the medical billing function of DBH's newly installed electronic health records software,²³⁶ iCAMS failed properly to adjudicate Medicaid reimbursement requests, resulting in their being paid from local-dollar funds. The subsequent reduction in available local-dollar funding led DBH to believe that it did not have enough local-dollar funding to provide for services, when in fact it did.²³⁷

In early 2016, DBH noticed that the software was not properly adjudicating claims and began working on a plan to fix the problem. Before the problem was able to be resolved, CSAs reported to CCE that in March

²³⁵ *DBH Performance Oversight Hearing, supra* note 218.

²³⁶ Many electronic health records (EHR) software now have an integrated medical billing component that processes authorizations for services and medications and runs claims through the appropriate channels for reimbursement. Integrated Care Applications Management System (iCAMS) is a proprietary EHR software developed for DBH by Credible Wireless, Inc. after they were awarded a contract in 2013.

²³⁷ *DBH Performance Oversight Hearing, supra* note 218. (DBH Director testified that DBH had sufficient local-dollar funding for MHRS services for FY 2016, however, the improper adjudication of Medicaid claims resulted in DBH paying the claims from its DBH's local-dollar allocation. According to the Director, this resulted in the perception from providers that the Department did not budget enough money for the year.)

2016, DBH issued “stop-work orders” directing them to temporarily stop providing local-dollar services because the CSAs had gone over their FY 2016 local-dollar funding allocations (colloquially referred to as a CSA’s “purchase order”).

In an effort to process and adjudicate claims, DBH worked with the iCAMS vendor that had developed the software but ultimately determined that a vendor fix to the software was not possible. DBH then decommissioned iCAMS and recommissioned its previous medical billing software, eCura, to reprocess all of the claims submitted thus far in FY 2016 (including FY 2015 claims that were not submitted in that fiscal year).

As DBH was reprocessing all claims through eCura, it became more aware of providers’ purchase order balances and rescinded the stop-work orders for CSAs that it determined had not yet exceeded their annual funding allocations, thus allowing those CSAs to continue providing locally funded services. In some cases, DBH increased the purchase orders of some providers that indeed had exceeded their annual local funding allocation.

In June 2016, DBH suspended payments for all local-dollar claims made after April 15, 2016. For the claims made before that date, DBH told the CSAs that it would pay approved claims only if they did not exceed the CSA’s purchase order amount. DBH reported to CCE that it paid \$1.4 million in advances to some providers, which were later recouped from the claims providers had submitted, while other providers reported to CCE that they did not receive any advances. Moreover, those providers reported that, for five months, they did not receive any local-dollar reimbursements, which, they reported, negatively affected their cash flow. To stay solvent, one provider reported to CCE that it had to reduce its local-dollar services by 50 percent, which ultimately reduced their local-dollar funding allocation for the next fiscal year.²³⁸

In August and September 2016, after reprocessing all of the claims submitted in FY 2016, DBH began adjusting CSAs’ purchase orders to account for the services they had provided during the claims reprocessing. Some providers reported that their purchase orders for FY 2016 were not increased. In some of those cases, providers had billed over their purchase order amount, expecting that it would be increased. Many providers felt that they were owed this money from DBH and, thus, some reported to CCE in 2017 that they had not been paid for all of the services they performed. However, D.C. regulations prevent DBH from paying for services in excess of a CSA’s purchase order amount. Thus, DBH disputed many of the providers’ overage claims. In some cases, DBH negotiated with the providers and made payments, albeit lower than the total requested claims over the purchase order amounts. During the course of its review, CCE found no evidence to indicate that DBH has failed to pay providers for properly claimed amounts.

In early FY 2017, similar system failures resulted in DBH’s delaying payments to Adult Substance Abuse Rehabilitative Services (ASARS) providers as well, although DBH reported that those technical problems were resolved and that providers were paid eventually, albeit some of them delayed.²³⁹

The iCAMS failure was costly for both the District government and community service providers: DBH paid \$4.465 million for the system, and its failure had significant ripple effects.²⁴⁰ During DBH’s performance oversight hearing, Councilmember Brianne Nadeau stated that community service providers had essentially “subsidized services for [the D.C. government] for eight months,” until DBH could process payments again.²⁴¹ She went on to say, “I’m not sure that is in compliance with the Prompt Pay Act,” and that “[the D.C. government has] to find a way to pay people even when our technology is failing.”²⁴² The Committee of the Whole of the D.C. Council reported, “Two of the District’s MHRS/ASARS providers – Green Door and

²³⁸ Local-dollar funding allocations for a fiscal year are determined by the previous fiscal year’s “burn rate,” or the rate at which a provider draws down their total balance.

²³⁹ *DBH Performance Oversight Hearing*, *supra* note 218.

²⁴⁰ *Id.* (This is the total cost for the system reported by the Director of DBH in her testimony to the D.C. Council, and not the total fiscal impact of the iCAMS failure on the Department.).

²⁴¹ *Id.*

²⁴² *Id.*

Youth Villages – have recently gone out of business because of the insufficient rate structure and months-long delays at DBH in disbursing payments, and a number of other providers testified to the Council about facing financial instability.²⁴³ As noted in Finding 18, several of the CSAs had long-standing financial problems before the iCAMs failure. However, many of the CSAs testified that the additional financial burdens imposed by the local-dollar funding shortages caused them extreme financial difficulty.

DBH's inability to make payments to providers promptly has serious negative implications for its justice-involved consumers. *First*, as Councilmember Vincent Gray explained in a hearing, if providers must borrow against themselves, i.e., from their cash reserves, they cannot collect interest earnings on their accounts that could be used to support their services. *Second*, providers who had to increase lines of credit because of DBH's non-payment could have their credit ratings lowered and their cost of borrowing increased because of higher debt-to-income ratios, which in turn could restrict their future ability to deliver services. They also incur interest fees on this additional debt. As the D.C. Behavioral Health Association noted in a document it provided to CCE, interest rates for short-term financing loans, such as lines of credit, ranged from between 3.75 percent to 4.25 percent in March 2017.²⁴⁴ Such rates are two to three percentage points higher than the late-payment interest rate a provider can currently receive under D.C. law.²⁴⁵

Third, DBH local dollars fund community-based mental health services for incarcerated and institutionalized individuals (e.g., pre-release re-entry planning). CSAs provide intensive, multi-disciplinary locally funded services for justice-involved consumers, such as those provided by Assertive Community Treatment (ACT) teams. Those services often involve court accompaniment and acting as a liaison to various criminal justice agencies. Because of the local-dollar funding issues, several CSAs restricted such services to individuals who were Medicaid-eligible; in some cases, the CSAs stopped serving justice-involved consumers altogether while they were incarcerated or institutionalized.²⁴⁶

In a 2016 letter to then-Deputy Mayor for Health and Human Services Brenda Donald and Councilmember Yvette Alexander, Disability Rights D.C. at University Legal Services (DRDC) gave several examples of how DBH's funding problems have adversely affected their clients at Saint Elizabeths Hospital (SEH) and the jail. DRDC wrote that delays in discharge "can put an individual at risk for decompensation, violates individual rights to the most integrated setting, and wastes District funds."²⁴⁷ The letter went on to argue that, "restrictions on medically necessary locally funded mental health services run afoul of the Department's Establishment Act, and corresponding District regulations."²⁴⁸ Furthermore, DBH staff reported to CCE that DBH's Comprehensive Psychiatric Emergency Program sees a spike in emergency admissions when CSAs close their doors.

Providers lamented in interviews with CCE that the iCAMS failure was not the first of its kind. In 2006, DMH experienced an almost identical problem. From January to mid-March 2006, DMH shut down eCura because of software issues that resulted in failures in Medicaid claims adjudications.²⁴⁹ A key difference during this period was that providers were advanced approximately \$5.5 million (nearly \$6.7 million in 2017 dollars) "to continue operations while the system was shut down."²⁵⁰ This approach, however, "required an

243 *Cow Committee Report*, *supra* note 230, at 14.

244 DCBHA, *Aging of DBH Receivables –Aggregate Report for Nine Providers* [table] (March 2017).

245 See D.C. Code § 31-3132(c) (stating, "the interest payable [on late payments] shall be at a monthly rate of: (1) one and one-half percent from the 31st day through the 60th day; (2) two percent from the 61st day through the 120th day; and (3) two and one-half percent after the 120th day.")

246 Testimony of Dan Menzer before the D.C. Council Committee on Health (June 5, 2017).

247 Letter from Disability Rights D.C. at University Legal Services to Deputy Mayor Brenda Donald and Councilmember Yvette Alexander (August 1, 2016), [hereinafter "DRDC Letter"].

248 *Id.* (citing D.C. Code § 7-1131.03 "In... meeting the service needs of consumers of mental health services, the Department shall not discriminate against consumers based upon their eligibility or non-eligibility for Medicaid, Medicare, or private insurance coverage..." Institutionalized and incarcerated individuals are not eligible for Medicaid.)

249 D.C. Office of the Inspector General, *Audit of the District of Columbia Department of Mental Health's Program Management and Administration of Provider Reimbursements*, Report No. *OIG-06-2-13RM*, 1, 24 (December 11, 2007), available at <http://app.igdc.gov/news/view2.asp?url=release07%2FReport121107%2Epdf&mode=audit&archived=0&month=0000&agency=74>.

250 *Id.*

extensive reconciliation of advanced payments to providers versus the actual claims filed.”²⁵¹

The central piece of the District’s delivery system for behavioral health services is the community-based provider network. If DBH cannot and does not pay providers such that the network operates as intended, individual consumers will likely suffer most of the impact. When discussing the payments problem, several DBH staff and stakeholders explained that there is a tendency in the criminal justice and behavioral health systems for people immediately to fault an individual for noncompliance with treatment (whether court-ordered or not). Rather, they said, one should first consider DBH’s systemic problems that may have forced those individuals into noncompliance, such as the inability to receive services because DBH is not promptly paying providers. As DRDC wrote in its letter, “While providers can be made whole for services provided, consumers cannot be made whole retroactively for the loss in services that were not provided... [emphasis removed].”²⁵²

251 *Id.*

252 DRDC Letter, *supra* note 247, at 3.

Agency Comments

ODCA and CCE sent a draft of this report to DBH and the EOM on December 22, 2017, and held an exit conference with DBH and the EOM on January 17, 2018. ODCA and CCE subsequently met with DBH and the EOM two more times to discuss the report findings. ODCA and CCE appreciate the written comments we received on the draft report from DBH on February 10, 2018. The written responses from DBH are appended in full to this final report.



Office of the Director

February 10, 2018

Ms. Kathy Patterson
District of Columbia Auditor
717 14th Street NW, Suite 900
Washington, DC 20005

RE: Office of the District of Columbia Auditor’s Draft Report Entitled “The D.C. Department of Behavioral Health and the D.C. Justice System”

Dear Auditor Patterson,

Thank you very much for taking the time to meet with the Department of Behavioral Health (DBH) and our executive branch partners to discuss the District of Columbia Audit Report (Report), and for the subsequent meetings between your staff, the Council on Court Excellence (CCE) who drafted the report, and our team to continue the discussion and work towards a greater understanding among all parties of this very important and complex issue. As indicated, DBH welcomed the audit as we endeavor at our young agency to transform the District’s mental and behavioral health system—including our services to forensic and justice involved residents—into a coordinated system of care that is transparent, accountable, and focused on the needs of residents.

Our mission at DBH is to develop, manage, and oversee a public behavioral health system for adults, children, and youth and their families that is consumer driven, community based, culturally competent, and supports prevention, resiliency and recovery, and the overall well-being of the District of Columbia. And specifically, for our newly formed Division on Forensic Services, we strive to provide and oversee a continuum of behavioral health and others services for justice-involved individuals from pre-arrest to post-incarceration to ensure their successful return to the community. Our mission is big, ambitious, and necessary—and we take our work and responsibility seriously.

Still, we know that DBH alone cannot achieve and maintain these goals; it requires strong partnerships and shared visions across agencies and sectors. This is especially true when it comes to serving justice-involved consumers. The justice system in the District of Columbia is complex. As CCE noted in its introduction, the District is unique in that its criminal justice system is subject to both federal and local control and often an individual can bounce between

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both local and federal agencies while receiving services. DBH is one agency that cooperates with its local, federal, and community partners. This complexity does not serve as an excuse, but as a mandate to all partners to commit to transparency, collaboration, and communication in order to strengthen access to care and better serve those who need mental health treatment.

For example, DBH serves approximately 29,000 consumers, without distinction for those who are justice-involved. In order to obtain an exact universe of those individuals, DBH would need to rely on its federal partners and correctional facilities to identify those consumers, which is not the case currently. And while recognizing the importance of serving those who are justice involved, DBH must commit to providing programmatic and educational support for all of its consumers.

Complexity as a mandate to better partnership is important, because throughout its report CCE calls on DBH to develop or expand programs that it cannot do alone. For example, DBH-funded housing programs serve approximately 2,000 consumers, spread primarily across DBH's Home First voucher program, Community Residential Facilities, and a small number of units matched with DCHA LRSP vouchers. Through this existing housing process, DBH housing resources are available to consumers who are justice-involved. Expansion of housing capacity dedicated to justice-involved consumers solely would need to be accomplished within fiscal and regulatory constraints associated with the development of affordable housing.

We appreciate that CCE acknowledges in its report that DBH does not have the authority to construct new housing, but must work with the Department of Housing and Community Development to develop capitol projects. To develop a comprehensive housing and employment option program for Outpatient Competency Restoration Program (OCRP) participants, as discussed in Finding 12, or only those who are justice-involved, DBH must work and collaborate with other government agencies. The construction of a dedicated residential facility would involve considerable time and resources. The Bowser administration has made unprecedented investments in affordable housing for District residents in all eight wards. Mayor Bowser has committed \$100 million annually to the Housing Production Trust Fund, controlled by DHCD and since taking office in January 2015, the administration has created or preserved over 12,000 affordable units in various stages of construction.¹

The challenge of affordable housing options is not unique to DBH consumers. Last year, the Mayor announced the creation of the Landlord Partnership Fund to provide mitigating financial support to landlords who assume the risks of renting to vulnerable persons, such as those experiencing homelessness. Mayor Bowser and the Downtown BID have been actively fundraising and anticipate a launch this spring.

Also in the spring, the District is set to launch a pilot, pre-arrest diversion program relying on the collaboration of law enforcement and human services. The success of this pilot program will rely

¹ Press Release, Mayor Bowser Makes a Historic Investment of \$138 Million in Affordable Housing, October 2, 2017, available here: <https://mayor.dc.gov/release/mayor-bowser-makes-historic-investment-138-million-affordable-housing>

on how well participants opt-in to the services offered and capitalize on the access of care available to them.

As expanded upon in our responses to each recommendation below, DBH emphasizes that it is one part of a complex system that supports an individual involved in the criminal justice system who may need mental health services. A large component of taking advantage of those services is that participation is voluntary. DBH cannot mandate that an individual seek or engage in treatment or continue to receive services once initially engaged. That is where we share responsibilities with our partners to ensure that the community knows where services exist. The courts and DBH's partner organizations are vital to communicating with individuals their ability to access care. DBH will continue to work with judges on education and training and evaluating instances where an individual may need a competency evaluation or access to services.

In its report, CCE also makes several recommendations regarding the Department of Behavioral Health's oversight of its community service providers—again an acknowledgement of the strong partnerships needed to achieve our shared goals. Community Service Providers and non-profit partners are extremely important to the work we do—as these are the organizations often on the front line of our services and supports. DBH takes its responsibility to monitor and support those who provide services to our justice-involved consumers, as well as every District resident, very seriously. Its primary focus is always to ensure that consumers throughout the District have access to high-quality behavioral health services that meet their needs.

Simultaneously, the Department has a fiduciary responsibility to the District taxpayers to ensure that their money is used efficiently and effectively. As such, in recent years, DBH has made changes to its business systems and processes to make our services stronger, providers more accountable, and our system of care more sustainable.

Previously, providers could spend taxpayer money without adequate oversight from the Department to determine if the funds were being used appropriately. For example, if providers spent money over their contract with the District, they expected that they would be automatically reimbursed for such overages and a purchase order could be adjusted. That is no longer the case. DBH is actively engaged with providers to ensure that if additional money is needed, providers have made responsible use of the funds already provided and that any additional funds are appropriate for the treatment of the consumers with which they are engaged.

DBH is proud of the changes that it has implemented and recognizes that providers must adapt to these changes as well. An adjustment to a new model may affect temporary stress to the system while people make modifications to the way they conduct business. However, DBH has also worked to ensure that there are training and technical assistance opportunities in place for providers as they adapt to these changes. DBH's Training Institute incorporates courses that allow providers to develop their clinical skills, as well as their business skills. For example, in January 2018, DBH offered trainings on motivational interviewing, which helps providers develop their skills in this person-centered approach to treatment, and claims review, which helps providers understand the claims audit process. As DBH continues to strengthen the behavioral health system in the District, it remains engaged with providers to ensure that their

business models enable them to prosper and that District residents continue to have access to behavioral health services they need.

Finally, the Report makes several recommendations and assertions about the leadership and management needed to achieve the goals of the Forensic Services Division. While DBH cannot directly address former or current employees and their personnel matters in this document, unquestioned is the notion that it takes uncommon vision, and clinical and management skill to enact the types of reforms we are undertaking. As a young Department and as a younger still Division we strive to ensure the right teams and the right leaders are in the right places as we move forward. I have every confidence in our Department's ability to lead, grow and respond to the demands of our charge.

As more fully discussed below, DBH has made significant progress in our efforts to improve and reform services to justice-involved residents, including better organization and resources to the division level to focus specifically on forensic services, data and performance management, stronger and more reliable oversight and supports to community service providers, and expanded forensic capacity at Saint Elizabeths Hospital.

After careful review of the Report, DBH and our executive agency partners would like to respond to each finding and recommendations. Our response follows my letter.

Sincerely,



Tanya Royster, MD
Director, Department of Behavioral Health

Finding 1: The Division of Forensic Services does not have a clear mandate, and its current position and responsibilities within DBH may impede its ability to carry out its larger mission.

Recommendation 1.1. That DFS be located within the Office of the Director of DBH with the mandates to (a) act as both inter- and intradepartmental coordinating body, and (b) develop and implement policies for justice-involved consumers.

DBH disagrees with this recommendation. DFS's position now within DBH does not restrict DFS from acting within and outside the agency to coordinate forensic services within its authority, nor does it restrict DFS from developing and implementing policies for its consumer population. DFS was only formally created on October 1, 2017 through the Department's realignment. Still in its early stages of developing as its own department, DBH is actively engaged in the creation of a solidified mandate, as well as standard operating procedures for both the forensics division as well as the entire department.

Recommendation 1.2. That the position of the Director of DFS be a mayoral-level appointment, given the responsibilities of the Director of DFS to (a) coordinate with multiple federal and local government agencies, and (b) fulfill significant statutory obligations on DBH's behalf that implicate other D.C. agencies (e.g., jail-based competency restoration).

DBH disagrees with this recommendation. By nature of their work, many divisions within DBH have responsibilities to coordinate with federal and local agencies on a regular basis, including the fulfillment of statutory obligations implicating other District agencies. For example, DBH participates in coordination with the District's Interagency Heroin Task Force, alongside the Department of Health, Fire and Emergency Medical Services Department, Office of the Attorney General, Office of the Chief Medical Examiner, and other agencies. DBH also works closely with the U.S. Substance Abuse and Mental Health Services Administration to fulfill its federal statutory obligations.

Recommendation 1.3 That the director of DFS be given the authority to develop and manage a unified budget.

DBH agrees with this recommendation. As of FY18, there is a unified budget that the director has authority to develop and manage. The budget includes three (3) Saint Elizabeths hospital staff, whose function is to manage and support forensic services at the hospital. One of the three staff at the hospital is the assistant director of DFS. Throughout every fiscal year, every division director monitors current needs and pressures versus his or her established budget and is able to request and draw on any available funds within his or her respective Administration's budget as well as the Department's budget. For example, DFS is considering requesting the establishment of additional positions and the re-allocation of available funds within the Department to these positions, which may include another Deputy Director position as well as positions stationed at Saint Elizabeths hospital that are devoted solely to forensic evaluation.

Recommendation 1.4 That the DFS budget be increased to fund current and new programs and related expenses.

Directors have autonomy to manage their budgets in order to meet current needs during the fiscal year. DBH, like other agencies, assesses current fiscal year budgets and makes appropriate projections and plans for future fiscal years during the annual budget formulation process, after which the Mayor submits her proposed budget to the Council. DBH will begin its internal process to develop its FY20 budget this summer and fall. The Mayor and the administration will consider CCE's recommendation as they finalize their FY19 budget submission to the Council, which ultimately must enact the budget for the District, representing its determination as to competing priorities.

Finding 2: The Division of Forensic Service does not have effective management and staffing structures.**Recommendation 2.1 That the Director of DFS should have budgetary and operational authority over and manage all of the Department's forensic programs, whether administered on an inpatient or outpatient basis.**

DBH agrees with this recommendation. As of FY18, the Director of DFS has budgetary and operational authority over and manages the Department's inpatient and outpatient forensic programs. The establishment of DFS, and the consolidation of its appropriate authority and management oversight to its current extent, represent significant progress and change from prior years. Work still needs to continue to further consolidate DFS authority, which does include addressing historic operating practices (e.g., evaluations conducted on a voluntary basis) and structures (e.g., formal position descriptions) at the hospital that do not adhere and are not conducive to achieving the intent of a strong, centralized DFS. Addressing practices and structures of this kind, which will involve HR-related and union-related issues, can be complex.

Recommendation 2.2 That DBH establish an independent team of forensic evaluators and competency restoration program staff to perform the Department's forensic work at facilities throughout the city – at the courthouse, the jail, the 35 K Street clinic, and SEH. The forensic team would report to DFS management and would not be assigned to any one location, allowing the DFS to meet the need for evaluations whenever and wherever it arises.

DBH agrees with this recommendation in part. DBH is considering the establishment of additional positions for DFS, and the re-allocation of available funds within DBH to these positions. These positions would include a team of forensic evaluators, physically stationed at the hospital, who would conduct forensic evaluations at the hospital and also be called to conduct evaluations at other locations when needed. This could be an effective way to handle the need for evaluations; generally, the need for evaluations increases in the fall for the courthouse, whereas it increases starting in the spring and through the summer months at the hospital.

Recommendation 2.3 That DBH clarify that the Director of DFS's responsibilities do not include a role over consumers' non-forensic direct medical services.

DBH disagrees with this recommendation because there is not a need to clarify responsibilities. The Director of DFS's responsibilities do not include a role over consumers' non-forensic direct medical services and the Director has never assumed such a role. Non-forensic direct medical services are provided by the appropriate clinicians for the needed service.

Recommendation 2.4 That DBH establish two Deputy Director positions: a Deputy Director for Forensic Outpatient Treatment and Services; and a Deputy Director for Forensic Policies and Program Development.

DBH agrees with this recommendation in part. The position description for a Deputy Director has been drafted; hiring for this role will require a psychologist with specialized training. DFS is considering options to fund additional positions in the current fiscal year, as well as for FY19.

Recommendation 2.5 That the D.C. Council allocate additional clinical and direct services to DFS.

This finding is directed at the DC Council and accordingly DBH does not submit a response.

Finding 3: The Division of Forensic Services internal policies and procedures need strengthening.

Recommendation 3.1 That DBH's internal compliance officials work with DFS to develop robust internal policies and procedures that will help it fulfill its statutory and regulatory obligations.

DBH agrees with this recommendation. DFS has begun consultation and work with appropriate DBH staff to develop policies and procedures for the division and the services it provides and oversees. This work is ongoing. Those policies and procedures will be formulated, reviewed, and published following the Department's established process.

Finding 4: In many instances, DBH was unable to provide requested documentation or data to CCE in a timely manner or at all, suggesting significant department-wide internal control deficiencies.

Recommendation 4.1 That the Office of the D.C. Auditor or the D.C. Office of the Inspector General conduct an audit of DBH's internal controls and control framework.

DBH disagrees with this recommendation. This report presents scant evidence—other than that data was not provided as quickly as desired—that would reasonably lead to such a conclusory finding, and one that would warrant an Inspector General audit of all of DBH's internal controls and framework. The role of the Inspector General is to investigate and eliminate waste, fraud, and abuse – none of which are present here. Further, the resources necessary to devote to an audit or investigation would impede and delay DBH's implementation of its goal to provide services to its consumers and to provide timely responses to judicial inquiries.

In this audit, documentation or answers that were not provided oftentimes sought data that rested with or was controlled by independent, external agencies. A whole series of questions from CCE sought answers that encompassed consumers from across several agencies in the larger criminal justice system, which would have required a long period of concerted effort from all of the agencies, local and federal, to address and overcome any legal and other hurdles to sharing data on its consumers.

Further, not all of the data requested was collected in the first place, and data that is collected may not be collected in a manner that can respond directly to the way a question was asked. Consequently, it required time for DBH and its counsel to conscientiously search, pull, rework, analyze, and present the data CCE sought on behalf of the Auditor.

Finally, DBH recognized prior to this audit that data and the management of that data too often was insufficient and existed in silos. As part of its larger effort to integrate the agency fully and realign its organizational structure to reduce silos and increase accountability, during FY17, DBH began the process of centralizing important data as well as data management. As a result, in FY18, DBH established a single IT/Data division, the Information Systems Innovation & Data Analytics Division, to plan, oversee, and guide data collection, analytics, and reporting functions across the agency.

It is also worth noting that the provision of complex behavioral health care and ancillary services, particularly in a criminal justice context, will inevitably require significant flexibility for highly qualified clinicians to address unique consumers and circumstances, and to respond quickly to various agencies and other decision-makers.

4.2 That the Executive Office of the Mayor ensure that DBH has the necessary technical assistance and That the Executive Office of the Mayor ensure that DBH has the necessary Recommendation technical assistance or guidance to improve or where needed, properly design and implement effective internal controls using an internal control framework. The framework should be instructive on how to improve and/or design and implement both operational and financial controls, in addition to controls that will ensure DBH's compliance with laws and regulations at both the local and federal levels. A review of DBH's internal controls would further assist in defining how DBH's internal control framework could be improved.

DBH agrees with this recommendation. EOM and other executive agencies are working with DBH, through various means and agencies, to ensure the highest level of performance at the Department, on behalf of its customers. For example, the Mayor's Office of Legal Counsel works with counsel from DBH through individual consults and trainings, as with any agency, to ensure legal compliance at the local and federal levels. The Deputy Mayor for Health and Human Services (DMHHS) meets regularly with the Director on goals and progress towards goals; and other divisions within the Office of the City Administrator (OCA) provide guidance, assistance, and oversight on operations, budgeting, personnel and human resources, technology, and performance. Numerous other agencies interface with DBH to advance missions of providing care, reducing crime, and ensuring smooth delivery of services, in conformance with legal and medical norms.

Finding 5: DBH does not clearly define, support, or report on performance measures related to services for justice-involved consumers. While DBH has taken steps to understand better the connection between the criminal justice and behavioral health systems and their various programs, and to identify resources, gaps, and priorities, there is still much work to be done.

Recommendation 5.1 That the D.C. Office of Performance Management (D.C. O.P.M.) develop and incorporate into DBH’s annual Performance Accountability Report performance metrics that effectively capture and measure DBH’s work with justice-involved consumers.

DBH agrees with this recommendation, as DBH works with OPM (and now consolidated with the budget office under Director Jennifer Reed) every year to develop and monitor DBH’s PAR. DBH is in the process of identifying priority performance measures for the Division of Forensic Services and, equally important, planning for systems to be in place so that data collection, retrieval, analytics, and reporting on those measures will be efficient. DBH will incorporate DFS measures into its PAR.

Recommendation 5.2 That DBH develop an official definition for “forensic” and “justice-involved” consumer.

DBH agrees with this recommendation and includes its definitions below. DBH also notes that the use of these terms varies in meaning across the District, given the multiple agencies and stakeholders in the criminal justice system.

Forensic consumer: An individual with active criminal justice and/or court involvement where DBH has some obligation to provide a service, whether one time, intermittent, or long-term. The involvement can range from a simple competency screening through inpatient hospitalization at Saint Elizabeths, to community oversight and supervision. By statute, in the District of Columbia, both forensic and civil commitments are committed to DBH for direct care, monitoring, and/or oversight. Both sets of consumers receive their direct services, monitoring, and/or oversight of community services by the Clinical Services Administration.

Justice-involved individual: An individual who is an inmate in a public institution, under the care of law enforcement, or under community correctional supervision. (Note that this definition is a work in progress that is based on an initiative formerly led at the federal level.)

Recommendation 5.3 That the appropriate divisions within the Office of the City Administrator work with DBH to develop, implement, and report on internal performance metrics, both department-wide and division-specific, that measure DBH’s outcomes vis-a-vis justice-involved consumers.

DBH agrees with this recommendation, and is in the process of developing and establishing a Results-Based Accountability framework for the agency, which consists of priority performance measures for each of the agency’s units and respective action plans to move the measures in the

right direction. OCA is aware of this, and DBH welcomes working with OCA on any aspect of DBH's effort to establish an RBA system for the agency.

Recommendation 5.4 That in its public reports (e.g. PRISM), DBH report its performance targets alongside their respective actual performances.

DBH agrees in part with this recommendation and will include targets alongside respective actual performances, where appropriate.

Recommendation 5.5 That DBH publish quarterly reports containing data, trends, and analyses on the justice-involved population.

DBH agrees with this recommendation and notes that PRISM reports already include data on justice-involved individuals. For example, some metrics in these reports quantify "justice-involved admissions," "number of justice-involved competency evaluations," and "length of stay for justice-involved consumers." PRISM reports are available on DBH's website; the most recent report was published in November 2017². DBH welcomes feedback on ways to improve performance measures and supports the development of different formats for analyzing data on justice-involved populations, where necessary.

Finding 6: DBH's data infrastructure is insufficient to support effective operations and proper resource allocation, especially with regard to the justice-involved consumer population. While DBH has made efforts to improve this infrastructure, DBH cannot realize the necessary improvements without adequate investments in upgrades and enhancements to DBH's systems.

Recommendation 6.1 That DBH's Systems Transformation Administration produce a comprehensive report for the D.C. Council outlining the capabilities of the current software, a cost-benefit analysis of enhancements and upgrades, and a needs assessment for a system-wide overhaul of the current systems.

DBH agrees in part with this recommendation. DBH is already working with the Office of Contracting and Procurement (OCP) to release a solicitation in February 2018 to procure independent, expert consultants to complete an assessment of the current electronic health records (EHR) and provide a roadmap for creating the infrastructure that will best support the District's behavioral health programs. The scope will include determining whether to increase investment in the current systems and increase their capabilities and inter-operabilities, to replace the systems with a single system, or to procure a hybrid solution.

Recommendation 6.2 That, for the time being, DBH develop a comprehensive, interoperable data infrastructure by upgrading and enhancing the software of its current systems. Such an infrastructure must be able to capture and warehouse reliable data,

² The report is available here:

<https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/PRISM.%20November%202017.pdf>

adequately track services throughout the continuum of the system, monitor quality of care, and analyze and report on trends and health outcomes.

DBH agrees in part with this recommendation. DBH began the development of a data warehouse infrastructure more than two years ago. During the past year, DBH has hired a data warehouse architect to enhance the infrastructure to include data from our mental health clinical EHR (iCAMS), our inpatient psychiatric facility EHR (Avatar), and our substance use clinical system (WITS). We have begun using a data visualization tool (Microstrategy) that will allow us to display data from the warehouse. Microstrategy will allow DBH to create and disseminate data management reports and dashboards with information regularly needed by leadership. Once all of the information from the relevant systems is configured in the warehouse, DBH will be able to report on forensic consumers across community and inpatient treatment. However, such reports will require data sharing agreements and participation by agencies that refer forensic consumers to DBH, such as the District's Department of Corrections and the Federal Bureau of Prisons.

Finding 7: DBH leadership needs to be proactive in developing strategies to address systemic and institutional problems as they pertain to justice-involved consumers.

Recommendation 7.1 That the Executive Office of the Mayor review this report and work with DBH to develop short- and long-term goals for improving the Department's operations as they relate to justice-involved consumers, and devote sufficient resources to ensuring that those goals are met.

DBH agrees with this recommendation. Numerous executive agencies have been involved in the review of this report and actions to be taken pursuant to it.

Recommendation 7.2 That the D.C. Council require DBH to produce strategic plans addressing the systemic and institutional failures mentioned in this and other reports, and that the D.C. Council require DBH to produce annual reports detailing progress in carrying out those plans.

This recommendation is directed at the DC Council. However, DBH notes that it is already producing a strategic plan for the agency this calendar year. It is in the process of identifying priority performance measures for forensic services and every other unit within the agency, as well as developing action plans that each unit and the agency as a whole will be implementing in order to move the needle on those measures. The plan is grounded in the recognized Results-Based Accountability framework that other jurisdictions and states use as a planning, management, and accountability tool for a variety of services. Part of this framework, and DBH's vision, is to report out on an annual basis its challenges, successes, and overall progress towards moving the needle on the measures. The Council conducts oversight with annual budget and performance hearings.

Recommendation 7.3 That DBH's Strategic Management and Policy Division be tasked with developing these plans and overseeing their implementation and progress. This should be done in coordination with DBH's Data and Performance Management Branch, which

should develop performance goals against which DBH and the D.C. Council could measure progress.

DBH agrees in part with this recommendation. DBH's Strategic Management and Policy (SMP) Division and Data and Performance Management (DPM) Branch are involved in the development of the strategic plan. Because the development of the plan is a bottom-up process, the task of developing the plan cannot and does not rest with the SMP Division alone. The plan's development starts necessarily with staff in each unit, and involves engaging them in tackling the tough questions of what do they do, what is most important, how do we measure it, where we are on the measures, what explains where we are, and what can we do and with which partners to move the measures. When priority measures are identified, the DPM Branch is consulted on the feasibility of the measures in order to ensure the agency has, or will have, the system and process in place to collect, retrieve, analyze, and report on those measures in an efficient manner.

Recommendation 7.4. That DBH comply with its statutory mandate that it prepare and publish annual plans (See D.C. Code § 7-1141.06(2)).

DBH agrees with this recommendation. In conjunction with OPM, DBH prepares and publishes an annual Performance Accountability Report that includes the Department's mission, summary of services and programs in place, top accomplishments, strategic objectives, key performance indicators and other measures, and strategic initiatives it plans to undertake as well as status of progress in implementing those initiatives. DBH also prepares and publishes an annual report called MHEASURES that is a snapshot of that year, along with trends from past years of the kinds, quantities, and costs of behavioral health services accessed by consumers broken down by sex, age, and other demographic traits. DBH also plans to release its strategic plan during this calendar year, which will be comprehensive and more forward-looking.

Recommendation 7.5 That DBH's establishment act be amended to highlight specifically DBH's roles and responsibilities for justice-involved consumers.

DBH disagrees with this recommendation as DBH provides a variety of services accessed by approximately 29,000 consumers every year that include, among others: individuals experiencing homelessness or at risk for homelessness, transitional-aged youth, individuals with or at risk of HIV and TB infections, people who inject drugs, adults and teens with substance use disorders (SUDs), women with dependent children with SUDs, children and youth with severe emotional disturbance (SED) removed or at risk of removal from their homes, youth committed and involved in the juvenile justice system, court-ordered domestic violence families, youth in psychiatric residential treatment facilities, children age 0-6 with SED or at risk of SED diagnosis, undocumented individuals, justice-involved individuals, and more.

While justice-involved individuals are unique and have unique needs, every other sub-population DBH serves is likewise unique and important. DBH does not believe it necessary to raise one above the other to such an extent as amending its establishment act, which is meant to cover the full diversity of everyone with a severe mental illness, SED, SUD, or in recovery.

Finding 8: DBH leadership has reportedly implemented ill-advised changes, including new policies, that may have increased the Department’s risk of violating patient’s rights and reversed progress it had been making.

DBH disagrees with the hearsay and innuendo that is the basis of this section and finding. As the report acknowledges, the behavioral health system in the District was under federal and court supervision for over a decade. The District recently came out of supervision and gained control of its own system and services. There is no evidence that any changes DBH led and was responsible for have increased risk or reversed progress.

Recommendation 8.1 That the Executive Office of the Mayor (EOM) conduct a thorough review of the performance of the current Director of DBH, with respect to the Department’s forensic work, including risk assessments of any policy or rule that may impact justice-involved consumers, and take appropriate action.

As CCE indicates in its note under its recommendation, DBH is restricted from commenting on personnel matters and accordingly, is restricted in responding to the allegations asserted in the report. However, DBH is appreciative of CCE’s perspective here and will take into account this report and the interviews it conducted in accordance with its own review of an individual’s or division’s performance.

Finding 9: The Division of Forensic Services’ management has not provided the leadership needed to (a) achieve the Division’s statutory objections or (b) foster a healthy work environment within the Division in which staff can flourish.

As noted above, while DBH cannot directly address former or current employees and their personnel matters in this document, DBH affirms that the Department takes its statutory responsibilities seriously and strives to have a healthy, productive work environment. In the ramp up and initial four months (since DFS creation in October 2017) of operation, much attention was paid to developing practice and standards to support the work of the division. Creating and leading a new division whose goal is to unify previously independent and disparate units is a challenging task. The unified Division of Forensic Services has:

- implemented a new competency program at the DC Jail;
- implemented a juvenile competency remediation program;
- standardized monitoring of civilly committed consumers in the community; and
- standardized the inpatient and outpatient forensic review boards.

DBH and EOM remain committed to effective leadership and management of this newly created Division in order to support the effective and efficient delivery of the statutorily mandated services.

Recommendation 9.1. That the Executive Office of the Mayor (a) review the performance of DFS management and assess its ability to provide the leadership needed to achieve the Division’s objectives and to promote a healthy work environment, and (b) take appropriate action in light of the outcome of that review.

As CCE indicates in its note, DBH and EOM are restricted from commenting on personnel matters and accordingly, are restricted in directly responding to allegations asserted in this report and this recommendation.

Recommendation 9.2. That the Executive Office of the Mayor analyze the Division's management needs under CCE's recommended new divisional structure (See Finding 2, Recommendation 1, recommending that the Director of DFS be a mayoral-level appointment).

DBH and EOM disagree with this recommendation. As indicated in its response to Finding 2, Recommendation 1, DFS is a new division, and there is already ongoing review of the functions of the new division and the appropriate staffing and management structure needed to support those functions. DBH disagrees with the recommendation that the Director of DFS must be a mayoral-appointed position in order to accomplish the goals of the division.

Finding 10: For years, DBH has not had a standardized approach to its competency evaluation and restoration procedures, such as department-wide policies, guidelines, or training manuals. Recently, staff at Saint Elizabeths Hospital developed a competency restoration-training manual for use throughout DBH.

The division was established in October 2017 to centralize and standardize the forensic services across the department. DFS is currently implementing a standardized restoration manual in a streamlined and consistent fashion across three sites: DC jail, 35 K Street clinic, and at Saint Elizabeths Hospital. DFS's Outpatient Competency Restoration Coordinator will oversee this effort and collaborate with the Chief Clinical Officer at the hospital. This Coordinator will be the point person tasked with ensuring this standardization with full implementation by December 2018. Establishing consistent documentation requirements will ensure standardization across the different sites and services the division delivers.

Recommendation 10.1. That DBH consult with national experts who specialize in forensic training programs to develop a formal, rigorous forensic training program for current and future staff.

DBH agrees with this recommendation. DBH plans to create a formal training program for forensic evaluators in partnership with regional and national experts.

Finding 11: DBH forensic evaluators and other staff working with forensic consumers vary tremendously in their professional abilities, experience, and training, including some who have no formal training, education, or experience in forensic behavioral health whatsoever. The lack of proper training or credentials presents an ethical dilemma for some employees.

Initial staffing of the division is comprised of the staff who have been at the agency and doing the agency's forensic work. Some staff have formal forensic training and others have clinical experience obtained over years of working for District government. As a result of starting a division with staff from legacy agencies, there is variation in the experience and skills of the current staff. All staff do possess active licenses, which are consistent with the scope of work for

their positions. DBH is standardizing expectations of our staff across the department and offering training to support the staff's ability to deliver consistent care.

Recommendation 11.1. That the D.C. Council amend the D.C. Code to require that psychologists and psychiatrists performing forensic screenings and evaluations are (a) board-certified and (b) forensically trained and certified, either through formal education or through comparable professional training programs. The D.C. Council should also require that forensic evaluators be recertified as appropriate. (Suggested language is included in Appendix VII).

This recommendation is directed at the DC Council, but DBH notes that it does not agree. As the experts that CCE quoted also expressed, there are not enough forensic programs to generate enough forensically-trained professionals to meet the demand locally, regionally, or nationally. If the DC Code were to include language as recommended by CCE, it would severely limit DBH's ability to fill necessary positions from the very limited, highly competitive, sought-after pool of individuals. DBH must maintain the flexibility to hire individuals with relevant experience and provide them with additional training and/or support to meet the growing needs of our statutorily mandated work.

Recommendation 11.2. That DBH require that its forensic evaluators comply with the standards in CCE's recommended legislative amendment in this finding's first recommendation.

As noted above, DBH disagrees with the premise of the first recommendation. As discussed in response to Finding 10, DBH aims to develop a formal training program for forensic evaluators in partnership with regional and national experts. The creation of this formalized training program was incorporated into DBH's 2018 strategic planning process and addresses the quality assurance goal of this recommendation without the recommended statutory changes.

Finding 12: DBH's Outpatient Competency Restoration Program needs improvement to achieve a stronger record of successful outcomes and to instill greater public confidence in its effectiveness.

DBH continually works to improve all of its programs, including the Outpatient Competency Restoration Program (OCRCP). As stated in CCE's report, the OCRCP has been steadily improving its outcomes and percentage of persons restored through the program (from 29.4% prior to 2014 to 39.8% in FY17). As CCE states, OCRPs are a new development and have not been researched to determine a national standard or measurement of what constitutes a successful program. DBH and DFS will continue their continuous quality improvement activities with ORCP.

Recommendation 12.1. That DBH develop a robust Outpatient Competency Restoration Program (OCRCP) model that meets the needs of participants, including expanding program availability options and accessibility, such as location and operation times, and increasing program capacity.

DBH agrees with this recommendation, as it has already been strengthening the OCRP. DFS is currently expanding and making the program more robust by offering additional sessions in the morning and evening in order to increase program capacity, options, and accessibility for consumers.

Recommendation 12.2. That DBH provide forensic training for its current OCRP staff and require that OCRP staff be trained or possess sufficient professional experience regarding forensic behavioral health.

DBH agrees with this recommendation and is already in the process of training OCRP staff in forensic behavioral health, as discussed in response to Finding 10.

Recommendation 12.3. That DBH provide training for D.C. Superior Court judges on the benefits of the OCRP model.

DBH agrees with this recommendation. DBH met with Judge McKenna on Wednesday, January 17, 2018 to discuss providing a comprehensive overview of the OCRP model and its benefits to DC Superior Court judges. The presentation to the judges is currently scheduled for February 28, 2018.

Recommendation 12.4. That DBH develop comprehensive housing and employment options for OCRP participants in order to help reduce recidivism.

DBH disagrees with this recommendation. DBH is not the District government agency responsible for developing housing. While DBH and our core service agencies work to connect our consumers with resources within the appropriate government agency, provide supports and funding for housing vouchers to a portion of DBH clients, and with other partners support residents toward housing stability, the development of affordable housing is managed by the DC Department of Housing and Community Development (DHCD), which incorporates mayoral priorities and the goals of the Interagency Council on Homelessness (ICH). The Department of Human Services (DHS) also operates programs to support District residents in need of housing resources and services.

DBH also supports our network of providers' ability to offer evidenced-based Supported Employment services. All justice-involved consumers who express an interest may participate in that program to support their employment goals. Additionally, the Mayor has created the Aspire program to support entrepreneurship among our returning citizens. DBH supports its consumers' ability to participate in the myriad of services the District offers to improve integration of our justice-involved residents back into the community. DBH disagrees that it should develop a parallel system, but rather it will prioritize educating consumers to ensure they are aware of, and take advantage of, all the programs supporting housing and employment that the District currently offers.

Recommendation 12.5. That DBH track and monitor the readmission rate to both of its competency restoration programs, and that it track data on individuals who have been in

both programs, and on individuals who have been transferred from one program to another.

DBH agrees with this recommendation. This is one of the data elements that DBH intends to track and monitor. DBH supports all initiatives to track and monitor persons as part of evaluation of performance measures. The Department is working to implement an internal system to capture forensic data. As part of this effort, DBH has been meeting regularly with its IT division. Representatives from both the inpatient and outpatient restoration programs attend these meetings.

Recommendation 12.6. That DBH be required to analyze and report on data from its OCRP and Saint Elizabeths Hospital restoration programs to the D.C. Office of Performance Management or the D.C. Council annually.

DBH agrees with this recommendation. DBH currently analyzes and reports on data to DC Council pursuant to oversight and performance measurement.

Finding 13: Use of inpatient competency restoration over outpatient when not clinically necessary is not cost effective.

DBH notes that it must comply with court orders that determine whether inpatient or outpatient restoration occurs.

Recommendation 13.1. That DBH continue work to improve the outcomes of the Outpatient Competency Restoration Program (OCRP).

DBH agrees with this recommendation and is currently working to expand the capacity of its outpatient program as described in response to Finding 12.1. DBH anticipates that the OCRP program will be successful in accommodating a greater number of individuals with improved restoration outcomes.

Finding 14: DBH lacks the components necessary to implement a strong pre-arrest diversion program that diverts people from the criminal justice system to behavioral health services, improves their mental health outcomes, and reduces their risk of recidivism.

DBH disagrees with this finding. DBH has the resources to develop and operate a strong pre-arrest diversion program. In the FY18 budget, Mayor Bowser allocated funds for the development of a pilot pre-arrest diversion program. The Pre-Arrest Diversion program is scheduled to launch in Spring 2018. A director of the program has been hired and the programmatic elements are nearly complete. The success of the program is built upon collaboration with appropriate partners, including law enforcement and human services. Those connections continue to be developed in support of the pilot launch. The pilot program in FY18 will help determine the expansion needs and allocation of resources for the program in FY19.

Recommendation 14.1. That DBH develop a long-term pre-arrest diversion program beyond the initial FY 2018 pilot program.

DBH agrees with this recommendation and is already undertaking the necessary steps to develop a long-term pre-arrest diversion program that incorporates lessons learned from programs across the nation. DBH meets weekly with MPD, DHS, and EOM on this initiative. Other activities to support this program include regular stakeholder meetings, developing a budget, and creation of a staffing plan. DBH hired a director to oversee the pilot program, who began work in January 2018. The director of the program will guide implementation of the pilot. DBH has budget appropriations to hire eight (8) additional staff to support the pre-arrest diversion program.

Recommendation 14.2. That, in developing these programs, DBH actively pursue input from community stakeholders and diversion program experts. The input should be formal, such as through a town hall-style meeting.

DBH agrees with this recommendation and supports stakeholder input and expert engagement, and regularly engages stakeholders through both formal and informal channels. Information is collected by DBH, and stakeholders may share sensitive information privately as well, especially regarding individual cases. DBH has received input from the successful ACE (Alternatives to Court Experience) Diversion program in the District. The Department has also incorporated best practices from the LEAD (Law Enforcement Assisted Diversion) program and other successful models from around the nation, including traveling to Baltimore to learn from its diversion program.

Recommendation 14.3. That DBH develop performance targets for the program and publicly report on its outcomes annually.

DBH agrees with this recommendation and has already incorporated performance targets as a component of the pilot program. The multi-agency pre-arrest diversion planning team is working with the Lab @ DC, a specialized data analysis team, to measure implementation and develop outcomes measures for evaluation of the program. The multi-agency planning team is working with the Lab to conduct an evaluation to both measure success and gain an understanding of improvements that will be needed as the program grows.

Recommendation 14.4. That DBH assess the ability of its provider network to provide services for people through a pre-arrest diversion program.

DBH agrees with this recommendation and is currently engaged in discussions to develop metrics to determine the ability of stakeholders to provide services through a pre-arrest diversion program.

Finding 15: DBH does not ensure that people who have been found incompetent to stand trial receive the behavioral health treatment they need to keep them from recidivating or being civilly committed. The criminal justice system in D.C. does not have enough options to disengage this population from criminal involvement, which costs the city millions of tax dollars each year.

Reducing recidivism is a key goal of Mayor Bowser’s Safer, Stronger initiatives. DBH is one part of a complex system that supports an individual who is involved in the criminal justice system and needs mental health treatment. Unless court ordered, mental health treatment is voluntary. Civil commitment and mental health courts are examples of the tools that the court may use to mandate an individual engage in mental health treatment, but DBH cannot force people into mental health treatment. The courts and the resultant court orders are valuable tools for some individuals and DBH works with all the appropriate criminal justice partners to support an individual’s access to care. Individuals found incompetent to stand trial receive behavioral health treatment by CSAs. Their care is monitored and tracked by DBH.

Recommendation 15.1. That the District conduct a study of super-utilizers of the criminal justice and behavioral health systems, focused especially on people who are released into the community because they have been determined to be non-dangerous and incompetent to stand trial.

DBH agrees in part with this recommendation. DBH is engaged with our criminal justice partners to determine strategies on who the District’s super-utilizers are and what services these individuals need. However, DBH disagrees with focusing exclusively on people who are released into the community because they have been determined to be non-dangerous and incompetent to stand trial. DBH needs to understand our entire population of super-utilizers and is engaged in understanding these individuals.

In Spring 2017, DBH applied for and was awarded the Justice and Mental Health Collaboration Program Grant from the US Department of Justice.³ That grant has supported the work of DBH and its criminal justice partners in defining the District’s super-utilizer population. This grant involves interagency participation with MPD, DHS, ICH, and DHCF. Final report findings will be published in Spring 2019. These results will help inform service delivery for super-utilizers.

Recommendation 15.2. That DBH develop policies and programs that proactively address the unique needs of these individuals when they are released into the community to prevent them from recidivating.

DBH does not agree with this recommendation. The scope of DBH policies and programs relevant to this population extend beyond this limited subset of criminally-involved individuals. The needs assessment arising as an outcome from the grant described in DBH’s response to 15.1 will inform programmatic decisions, to include policies and programs as appropriate. DBH utilizes a client-centered approach, recommending that services and supports are tailored to meet an individual’s needs rather than be based on the individual’s legal or criminal status.

More broadly, Mayor Bowser’s “Safer, Stronger” and “Pathways to the Middle Class” agendas include numerous programs and tactics to prevent and reduce crime and recidivism. In February of 2018, the Mayor released “A Fair Shot: A Toolkit for African-American Prosperity,” compiling numerous programs spanning multiple agencies designed to ensure pathways to the middle class. That inclusive vision and programming are helping to drive down crime and

³ For more information on this grant, please visit: https://www.bja.gov/ProgramDetails.aspx?Program_ID=66.
64 New York Avenue NE Washington DC 20002

unemployment. One key example of a program for returning citizens is project Aspire, to promote entrepreneurship. The Mayor introduced, and Council enacted, legislation to repeal the hitherto mandatory revocation of drivers' licenses for those convicted of drug offenses. Restoration of drivers' licenses is of course a precursor to obtaining many types of jobs, in many locations, and the ability to drive may enable this population to restore and maintain family and community ties. A pilot for returning citizens whose Department of Motor Vehicles (DMV) debt precluded them from renewing or obtaining a license is now underway in partnership among the DMV, the Central Collections Unit of the Office of the Chief Financial Officer, with the Lab @ DC, with support from the Mayor's Office of Returning Citizen Affairs. Meanwhile, the Office of Human Rights is enforcing DC's "Ban the Box" law prohibiting questions regarding convictions until after a preliminary offer of employment has been made, and only then allowing it to be used to revoke such an offer following tight consideration of relevance to the job and various other factors. This brief sample of the policies and programs benefitting justice-involved populations (and in turn reducing recidivism) demonstrates that such efforts are undertaken by a range of agencies, sometimes working independently and sometimes in conjunction with DBH.

Finding 16: Persistent and worsening capacity problems at Saint Elizabeths Hospital have had significant negative impacts on the District's residents with mental illness, and particularly justice-involved consumers. These impacts include long admissions, the unlawful detention of pre-trial defendants at the D.C. Jail, and mass internal transfers of patients within the hospital, which staff described as clinically inappropriate.

Increasing demand for forensic psychiatric inpatient services is an issue that jurisdictions across the nation are facing and working to address. Saint Elizabeths works diligently to meet this increasing demand. Staff at Saint Elizabeths work to ensure that all treatment decisions are clinically appropriate, tailored to meet the needs of individuals, and consistent with legal requirements. We adhere to any legal conclusions regarding unlawful detention. CCE is not an adjudicatory body and such a conclusion is damaging and unwarranted.

Recommendation 16.1. That DBH develop long-term solutions for its bed space capacity problem at Saint Elizabeths Hospital.

DBH agrees with this recommendation and is working with EOM to implement long-term solutions to meet the court's demands for inpatient forensic psychiatric services. For example, DBH is currently working with the Department of General Services on the build-out of an unoccupied transitional unit at the hospital in order to increase bed capacity. Construction is beginning this month, February 2018, with an anticipated opening date of May 2018. This unit would add seven (7) beds. Additionally, the development of OCRP will continue to decrease the pressure on inpatient bed necessity.⁴ DBH has worked with DOC to begin competency restoration education in the DC Jail if needed.

⁴ Gowensmith, W. N., Frost, L. E., Speelman, D. W., & Therson, D. E. (2016). *Lookin' for beds in all the wrong places: Outpatient competency restoration as a promising approach to modern challenges*. *Psychology, Public Policy, and Law*, 22(3), 293.

Recommendation 16.2. That DBH and the D.C. Superior Court review the reasons for the spike in pre-trial admissions and the difference of viewpoints between the courts and DBH on appropriate placement for defendants whose competency is in question.

DBH agrees with this recommendation and will work with the DC Superior Court presiding judge to review reasons for the spike in pre-trial admissions.

Recommendation 16.3. That DBH develop appropriate inpatient alternatives for waitlisted civil admissions.

DBH agrees in part with this recommendation and is working with EOM to ensure all District residents receive the inpatient psychiatric treatment they need. This fiscal year, DBH invited stakeholders to participate in a review of our system of care and to propose recommendations for addressing identified gaps.

Recommendation 16.4. That the D.C. Office of the Inspector General or ODCA conduct a thorough review of the civil commitment process in the District and assess the impacts of DBH's civil commitment waitlist.

DBH does not agree with this recommendation. The District's civil commitment process is a legal process based on statutory requirements. This is not an internal process at DBH that would lend itself to an ODCA review. Additionally, there is no demonstrated waste, fraud, or abuse here that would warrant a review by the Office of the Inspector General.

Finding 17: Procedural delays cause defendants to be held at Saint Elizabeths Hospital at the expense of the D.C. taxpayer even after they have been found competent.

The current DC Code gives a judge the sole authority in determining when a defendant enters and exits Saint Elizabeths Hospital. Procedural delays are a part of the legal due process and exist outside of DBH control. The decision to move defendants from SEH relies solely on the judges presiding over the defendant's case. DBH makes recommendations to the court regarding needed level of care, but it is at the discretion of the judge to decide whether the defendant is to remain at the hospital or be discharged to another location.

Recommendation 17.1. That the D.C. Council amend the D.C. Code to require a competency hearing within three days of a completed inpatient competency evaluation.

While this recommendation is directed at the DC Council, DBH agrees with this recommendation. There are times when competency evaluations are completed and the court will wait until the next scheduled hearing date to hear the case rather than move the hearing date up after the evaluation has been completed. This recommendation would require the court to opine in a defendant's case in a more expeditious manner. This recommendation would not prevent a judge from ordering a defendant to stay at Saint Elizabeths after a clinical recommendation concludes that treatment is complete.

Recommendation 17.2. That DBH develop a comprehensive “maintenance” program that differs from the restoration program and focuses on an individual’s rehabilitation.

DBH does not agree with this recommendation. DBH has contacted experts in the field of forensic behavioral health and found that there are no identified comprehensive “maintenance” programs. DBH proffers that this is not a best practice, nor an established practice. Maintenance does not operate differently than standard restoration. Competency is the mental capacity to participate in legal proceedings and to be responsible for one’s decisions and actions. DBH strives to get persons the mental health care they need.

Recommendation 17.3. That the D.C. Council amend the D.C. Code to recognize orders of competency “maintenance” and authorize a judge to make findings similar to those already in the statute to permit the defendant to continue as an inpatient undergoing competency “maintenance.” (Sample language is included in Appendix VII).

While this recommendation is directed at the DC Council, DBH does not agree with this recommendation. See DBH’s above response in 17.2 for additional context. Maintenance does not operate differently than standard restoration. The premise is exposing and educating individuals to legal concepts and material and determining whether they have a factual and rational understanding of the material. The standard for competence does not change nor does how the individual is educated.

Recommendation 17.4. That the D.C. Superior Court consider the development of a “competency court” or “competency docket,” which is considered a best practice.

This recommendation is directed at DC Superior Court. DBH will support the DC Superior Court’s determination.

Finding 18. Evidence suggests that DBH does not have adequate performance measures or provide adequate oversight of the Core Service Agencies (CSAs) with which it contracts for the provision of mental health services to many justice-involved consumers.

DBH does not agree with this finding. The report demonstrates that DBH has a robust and well-developed set of tools for evaluating CSAs and other providers, detailing at least five tools. In describing these mechanisms, the report shows that DBH does exercise robust and detailed oversight of its providers. The mechanisms and methods used by DBH for oversight contribute to a well-rounded picture of the provider for oversight purposes, and no evidence is presented that this level of oversight is inadequate.

DBH recognizes that some network providers have closed recently, but DBH does not agree that these closures are the result of DBH action or lack of action, or the result of poor oversight by DBH. The number of provider closures over a given time period is not, in itself, an indicator of poor oversight. In the case of at least two providers, the closures were actually a result of DBH *exercising oversight* and implementing the closure due to chronic poor performance by the providers. Further, neither the “Financial” section nor the “Quality” section of the Provider Scorecard measures provider financial viability. Referencing the high Scorecard scores of

providers who closed reportedly due to financial issues does not indicate that DBH has not exercised appropriate oversight.

Also, while the report is correct that DBH has decided to reassess the Scorecard, that reassessment does not indicate that DBH does not have confidence in the tool. In September 2017, DBH Director Dr. Royster signed a memo detailing the goals of the Scorecard redesign: “to be 1) more responsive to Provider concerns, 2) more representative of what DBH would like to measure (e.g., develop a way to include outcomes on the Scorecard), and 3) more reliant on automated data collection.” Further, DBH has not “discontinued” the Scorecard, but has undertaken a redesign.

Finally, the report details concerns relayed by DBH consumer advocates, but such advocates may have misunderstandings regarding DBH’s role and its limitations. For example, DBH routinely receives complaints from advocates that CSAs are not performing tasks that the CSA is either prohibited from performing or that the CSA may choose whether they want to perform. In cases like these, the complaint may identify service needs without that need being associated with a failing on the part of the provider or the oversight provided by DBH. Without carefully reacting to individual complaints, it is impossible to know whether the complaints in question are pertinent to DBH’s appropriate exercise of its oversight.

Recommendation 18.1. That DBH develop more robust performance measures for CSAs and strengthen its oversight of them to ensure that they meet these performance measures and are financially stable.

DBH agrees in part with this recommendation. As detailed in the report, DBH has at least five different and complementary tools for assessing and providing oversight to network providers. For this reason, DBH does not agree that it needs to develop or implement increased oversight methodologies. DBH can explore the possibility of whether it should examine the financial viability of the independent businesses in our network.

Recommendation 18.2. That the D.C. Council provide more direct oversight of DBH’s management of CSAs and other DBH-certified providers by, for example, scrutinizing the methodologies DBH uses to assesses their performance, reviewing DBH’s overall capability for supervising the performance and financial stability of its providers, and holding DBH accountable for its failure to identify and effectively respond to poor performance by CSAs and low consumer satisfaction.

This recommendation is directed at the DC Council, but DBH does not agree that greater oversight by the Council is needed or warranted, or that it failed to effectively respond to poor performance by CSAs. DBH implemented the Provider Scorecard at the direction of the Council, and is responsive to Council oversight inquiries. Further, management of contracts with vendors is an executive branch function.

DBH also disagrees that there has been a “failure” on its part to effectively respond to what the report cites as poor performance and low consumer satisfaction scores. For example, it’s important to note that the report, in citing decreases in consumer satisfaction scores from 2014 to

2016, fails to acknowledge that scores went up on many domains in FY15, that decreases were slight in many cases, and most important contextually, that the overall trend is relatively stable, with outcomes consistent with national data. Of course, a low baseline across the country is not an excuse for DBH not to take action. Rather, DBH strives to outperform other jurisdictions. To do this, DBH recently consolidated functions related to consumer and family affairs into one DBH Administration to ensure a strategic and coordinated effort to address consumer issues and concerns.

Finding 19: DBH does not have a formalized, automated system for connecting justice-involved consumers to appropriate care during their transition from D.C. Department of Corrections or Federal Bureau of Prisons custody to the community.

Recommendation 19.1. That DBH consult with IT experts to develop and implement a formal and appropriately automated referral program that addresses the specific needs of justice-involved consumers.

DBH disagrees with this recommendation, as this responsibility does not rest solely with DBH. While an automated referral program would facilitate connecting justice-involved consumers to appropriate care, DBH disagrees that developing and implementing such a system is solely its responsibility. A District-wide automated referral system would be a significant undertaking that would require participation of several District agencies and the Federal Bureau of Prisons, all of which may have various and necessary legal and other restrictions on sharing data on its consumers with other agencies. Such restrictions would need to be negotiated. Further, an undertaking of this kind would likely require a scope of work for a contract that spans multiple independent agencies. In addition, it would necessitate coordination across disparate technology platforms. The functionality would need to be created in each agency's IT system, which would send referrals to another agency and those systems would need to be modified to receive the referral. Alternatively, a standalone referral system could be created, but referral information would still need to be received by the agencies' systems. Interagency ownership and governance of the system (i.e., who is responsible for maintaining the separate system and how changes are approved and prioritized) and cost allocation for developing the solution would need to be resolved as well.

Recommendation 19.2 That DBH develop performance measures for evaluating the success of DBH liaisons in linking justice-involved consumers to the appropriate care and collect information necessary to judge their success in meeting their goals.

DBH agrees with this recommendation. DBH will develop performance measures for forensic services, which include the work of liaisons. DBH will collect information that is available to DBH, noting that the information can reside across multiple public and private agencies.

Recommendation 19.3 That DBH review the roles and responsibilities of the DBH liaisons to determine whether they have the resources and abilities to perform their roles successfully, and make changes as necessary.

DBH agrees with this recommendation. DBH currently reviews roles and responsibilities of DBH liaisons and other DBH staff. DFS meets with the Pretrial Services Agency (PSA), the Department of Corrections (DOC), and the Court Services and Offender Supervision Agency (CSOSA) on a regular basis to coordinate services and supervise staff located at these agencies. DFS is also currently working with PSA to evaluate the role of liaisons housed there.

Finding 20: DBH’s restrictions on the amount of discharge services (transition planning) Core Service Agencies (CSAs) disadvantages justice-involved consumers.

DBH has instituted a minimum control that requests providers ask for authorization beyond a certain number of units. DBH disagrees that requesting a vendor to ask for and provide justification for a service, *before* the vendor renders the service, is a “restriction.” Providers can provide up to 32 units, or eight hours, of the service without receiving authorization. It is only when they exceed the 32 units that DBH requests information regarding the service that will continue to be rendered, so that it can authorize additional units. DBH has not restricted the availability of local dollar funds and local dollars remain available for all local-dollar funded services.

Also, the finding is based on a misunderstanding of where the locus of responsibility lies for discharge planning services at Saint Elizabeths hospital. It is not the CSA/ACT provider who develops the discharge plan of care, but rather it is the hospital’s social workers. One of the primary responsibilities of hospital’s social work staff is to ensure consumers have a discharge plan, to work with both internal and external partners to ensure consumers are making progress towards discharge, and to ensure that consumers are discharged when ready. CSA/ACT providers can certainly assist and be active in discharge planning, but they are not and cannot be the leads. DBH’s goal is for consumers to step down out of the hospital as soon as clinically appropriate. If social workers are now spending a large part of their time working to achieve this goal, that is a good thing.

Finally, DBH disagrees with the report’s broad assertion that lack of CSA involvement “has resulted in release of people from jail, prison, or Saint Elizabeths without necessary supports (housing, health insurance, source of income, treatment plan, or medications) in place.” The jail, prison, and Saint Elizabeths are incredibly different institutions and the nature of discharge treatment planning varies accordingly at each institution. At Saint Elizabeths, for example, a consumer’s lack of income is not a barrier to discharge for consumers transitioning into community residential facilities (CRFs) or their own apartment. DBH provides temporary funding (payable to the CRF operator) for consumers at Saint Elizabeths Hospital who are transitioning a CRF to cover room and board expense, plus a personal needs stipend, while their Social Security benefits are being processed. DBH provides housing vouchers to consumers whose level of care is independent living (apartment). The DBH voucher will cover the consumer’s rental payment until the consumer’s benefits are in place.

Recommendation 20.1. That DBH immediately increase the amount of time for which CSAs may bill for discharge planning from inpatient care or incarceration. These increases should reflect the realities involved with discharge planning in the District.

DBH disagrees with this recommendation. DBH allows up to 32 units for discharge planning within 60 days of discharge from DC Jail without prior authorization. After these 32 units have expired, providers can request and receive additional units upon providing justification. This is a basic, minimum control consistent with other behavioral health services. DBH also considers extensions. The reasonable limits DBH has imposed are consistent both with sound medical and social practice, as well as sound financial stewardship and oversight.

Recommendation 20.2 That, even when increased, discharge planning restrictions be considered for extension on a case-by-case basis to ensure that individuals with more complicated situations are eligible for the same quality of discharge planning as other consumers.

DBH agrees with this recommendation, and in fact it has been implemented already. Extensions for discharge planning services are already considered on a case-by-case basis to ensure that individuals with more complicated situations are eligible for the same quality of discharge planning services as other consumers. DBH has received only a few requests for extensions and has authorized all of them.

Recommendation 20.3 That DBH produce a comprehensive study on discharge planning services to better understand the process and its associated costs so that the Department can develop a plan to improve the efficiency of discharge planning.

DBH agrees with this recommendation in part. DBH works to ensure that discharge planning services appropriately address each consumer's particular needs and circumstances, depending on the institution in which they are housed. This report states that those interviewed all agreed that there was a need to address frivolous or fraudulent billing; we agree. On that understanding and to address that problem, DBH is open to re-assessing discharge planning services to develop, at a minimum, a consensus understanding of what the current challenges are in the provision of these services among the involved institutions and CSAs.

Finding 21: DBH's restrictions on the type of community support services Core Services Agencies (CSAs) can provide may result in disadvantages for justice-involved consumers.

DBH disagrees with this finding. DBH, like the Department of Healthcare Finance and the federal government, which oversee Medicaid payments, does not allow reimbursement for certain activities like travel and wait time. These limitations are unrelated to the prior authorization DBH requires for discharge planning services.

Recommendation 21.1 That DBH allow CSAs to bill for and adequately fund the additional services provided to justice-involved consumers, which are often court-ordered.

DBH disagrees with this recommendation. Activities such as travel time, wait times, making phone calls, writing reports, and similar actions should not be a part of the regular menu of fee-for-service reimbursable activities. Medicaid does not reimburse for such activities and neither does DBH as documentation for those services is difficult to obtain and verify.

Recommendation 21.2 That DBH ensure CSAs have appropriate resources to facilitate transition-planning work.

DBH agrees in part with this recommendation. DBH is taking steps to implement an alternative payment strategy whereby it provides a monthly fixed-fee incentive to two contracted providers to provide services to forensic consumers that would include activities that are currently non-billable. DBH is working with OCP to release an RFQ for this service.

Finding 22: DBH is not effective in meeting the housing needs of justice-involved consumers.

DBH disagrees with this recommendation. DBH is not the District's agency responsible for housing. The District has a robust set of coordinated services that DBH consumers, including justice-involved consumers, can access through multiple channels. We agree that there can and should be increased coordination among agencies working to meet the housing needs of District residents, including DCHD, the District of Columbia Housing Authority, DHS, ICH; agencies with housing vouchers and programs; private partners; and other stakeholders, as these consumers have additional barriers that make their ability to obtain stable housing more challenging.

Recommendation 22.1 That DBH make an explicit effort to collect information about consumers' justice-involvement as part of the housing process.

DBH agrees in part with this recommendation. DBH serves all consumers and does not affirmatively ask for prior incarceration history. For its Home First Program (voucher program), its program application has a section asking for the applicant's prior living arrangements. The applicant can choose to *self-report* his or her former incarceration in this section. For Community Residential Facilities (group homes), which house roughly half of the consumers who are served by a DBH-funded housing program, DBH focuses on assessing and determining the consumer's level of care needed based on his or her clinical diagnosis and status. For example, a higher-functioning consumer with a lower level of care need is prioritized for the kind of CRF that meets that consumer's need, such as a Supportive Residence. The documentation submitted by the referral source (e.g., Saint Elizabeths social worker, CSA staff, etc.) is a clinical tool focused on this psycho-social assessment and does not require any information regarding prior incarceration status.

Still, DBH agrees that it can make an explicit effort to collect information about consumers' by adjusting its voucher program application materials so that it asks explicitly whether a consumer has been incarcerated and for how long. Further, DBH can explore feasible ways for this information to be captured in documentation required to access CRFs. It should be noted, however, that the consumer or relevant staff member filling out these materials ultimately chooses to report or not report the facts as he or she sees fit.

Additionally, in order to gain the most accurate information regarding which consumers served by which DBH-funded housing program have been justice-involved, DBH would need to receive from federal and local correctional institutions lists of every individual released from their

institutions. With this information, DBH could match identifying information of those individuals against that of consumers served by DBH-funded housing programs, and could do so on a regular basis as lists are updated. In order for this analysis to take place, however, a concerted effort on the part of all agencies involved would need to happen to address legal and other issues that have thus far prevented this kind of information from being shared across agencies within the criminal justice system.

Recommendation 22.2 That DBH conduct a needs assessment to determine the extent of the need for housing among justice-involved consumers and the changes in housing program capacity as necessary to accommodate that need.

DBH disagrees with this recommendation, as this responsibility does not rest solely with DBH. DBH serves approximately 29,000 consumers. In order for DBH to identify which of these 29,000 are or were justice-involved, DBH would need access to lists of individuals released in the District from federal and local correctional facilities. Having identified which consumers are justice-involved, a needs assessment could begin to determine the particular needs of this diverse sub-population and could include assessment of changes in housing capacity. Such an assessment would be an effort involving the resources of multiple local and federal government and private agencies that touch justice-involved consumers.

Recommendation 22.3 That DBH provide more housing options dedicated to justice-involved consumers, as they face numerous additional barriers to obtaining stable housing.

DBH disagrees with this recommendation, as this responsibility does not rest solely with DBH. DBH-funded housing programs serve approximately 2,000 consumers, spread primarily across DBH's Home First voucher program, Community Residential Facilities, and a small number of units matched with DCHA LRSP vouchers. Through this existing housing process, DBH housing resources are available to consumers who are justice-involved. Expansion of housing capacity solely dedicated to justice-involved consumers would need to be accomplished within fiscal and regulatory constraints associated with the development of affordable housing, in which other agencies have a role.

Finding 23: Long wait lists for housing placements have resulted in consumers remaining detained at Saint Elizabeths Hospital for long periods after a court has conditionally ordered release. Protracted inpatient lengths of stay beyond clinical necessity are a violation of patient rights and impose unnecessary costs.

DBH disagrees that consumers remain at Saint Elizabeths Hospital for long periods after court-ordered release due to long waiting lists for housing placements and does not concede any violation of patient rights. DBH prioritizes consumers discharged from Saint Elizabeths Hospital when allocating DBH housing resources. DBH provides temporary funding (payable to the CRF operator) for consumers at Saint Elizabeths Hospital who are transitioning to a CRF, to cover room and board expense plus a personal needs stipend, while the consumer's Social Security benefits are being processed. The availability of vacant CRF beds and consumer choice play a role in determining the resources for consumers.

DBH also provides housing vouchers through its Home First program to consumers whose level of care is independent living (apartment). The DBH voucher covers the consumer's full unit rent until the consumer's benefits are in place, at which time the consumer will pay a portion of his or her income to the landlord and the DBH subsidy payment will cover the remainder of the rent. Voucher awards are provided within three (3) days of request from Saint Elizabeths Hospital social work staff. The consumer's housing search and the pre-lease process (required unit inspection by DCHD) play a large role in the amount of time the consumer remains at Saint Elizabeths Hospital prior to lease-up.

Recommendation 23.1 That DBH's needs assessment (see Finding 22, Recommendation 1) specifically analyze the long-term community housing needs for post-trial individuals at Saint Elizabeths Hospital.

DBH disagrees with this recommendation. Post-trial individuals at Saint Elizabeths hospital refer to those found not-guilty-by-reason-of-insanity (NGRI). The current census of NGRI individuals is 65. Due to the nature of NGRI, the average length-of-stay for these individuals is roughly two decades. The NGRI Review Board, along with all relevant psychiatric, social work, and other hospital staff, engages in a highly structured and deliberative process to review the status of each individual a minimum of once a year, which is required. The Board can meet more than once a year if there is a potential for a change in status (e.g., the individual's treatment team believes the individual is ready for certain privileges, such as supervised visits in the community). If and when individuals are well enough to reach the stage where consideration can begin regarding their release from the hospital, the same process takes place and necessarily addresses the needs of the individual, including arrangements for housing with family, guardians, or other available supports.

Recommendation 23.2 That DBH clarify which entity is responsible for securing housing for consumers with different kinds of justice system involvement and ensure that the entity has access to the resources necessary to do so.

DBH disagrees with this recommendation, as this responsibility does not rest solely with DBH. The route by which individuals with different kinds of justice system involvement secure housing, and who is responsible for it, depends on the institution the individual is touched by, and the processes that institution have established. Institutions include the Bureau of Prisons, DOC, Pre-Trial Services, CSOSA, and law enforcement agencies. Further, DBH cannot ensure every entity responsible for securing housing has access to necessary resources. As it relates to consumers stepping down from Saint Elizabeths hospital into a Community Residential Facility (CRF), the hospital social worker is responsible for submitting the proper materials for entry into a CRF, which DBH housing services staff review and approve. DBH housing services staff ensure CSA staff have the vacancy list of every CRF serving the consumer's approved level of care. CSA staff then follow-up with the contracted, independent CRFs to set up interviews for consumers so that consumer choice is respected and a good match is obtained. As it relates to consumers stepping down from Saint Elizabeths hospital into independent living (i.e., her or his own apartment, subsidized by a voucher) the hospital social worker notifies DBH housing services staff, who then sends notice of a voucher award to the CSA. The CSA staff completes the necessary documentation required by DBH housing services staff to coordinate with

landlords, DCHD, and others involved in the process of a consumer moving into an apartment. The CSA staff can then work with the consumer to identify an apartment the consumer chooses.

Recommendation 23.3 That DBH invest in housing stock specifically for justice involved consumers.

DBH disagrees with this recommendation. DBH does not have authority to decide on its own to invest in housing stock specifically set aside for justice-involved consumers. DBH investment in the development of affordable housing is through DHCD, which incorporates mayoral priorities and the goals of ICH in establishing criteria for proposals submitted by developers in response to Notices of Funding Availability (NOFA) issued by DHCD. Other innovative programs, like the Landlord Partnership Fund, are being launched to encourage more landlords to rent to persons – like formerly homeless people – who have faced challenges in finding affordable and appropriate housing, as discussed below at 23.5.

Recommendation 23.4 That DBH contract for more beds at assisted living facilities or construct such a facility of its own.

DBH disagrees with this recommendation, as this responsibility does not rest solely with DBH. The DBH contracting process for assisted living beds would be driven by funding availability, an assessment of the clinical level of care needs among potential consumers, and the number of prospective vendors of relevant types of CRF facilities that have the willingness, capacity for such operations, and ability to become certified, as well as compete for this new contract. These are all factors over which DBH has varying levels of influence or control. As for construction of a facility, as noted above, DBH does not have authority to construct new housing on its own. Various factors drive the development of criteria for DHCD's selection of development proposals, including mayoral priorities and recommendations from ICH and the DC Housing Preservation Strike Force.

Recommendation 23.5 That DBH create incentives to address housing providers' reluctance to house consumers, such as flat monthly incentive rates per individual.

DBH disagrees with this recommendation, in that the DBH Home First program already works with 350 landlords and property managers across the entire District who lease to nearly 1,000 DBH consumers. DBH leverages its relationship with landlords to identify available units; negotiate rents for consumers seeking housing; and actively troubleshoot and facilitate communication and CSA outreach to the consumer when the landlord has concerns about tenant behavior. The supports DBH provides to tenants to facilitate successfully maintaining their housing and the responsiveness of DBH to landlord concerns sustains the program. The value added through the addition of financial incentives has yet to be proven.

Further, in 2017, the Mayor announced the creation of the Landlord Partnership Fund to provide mitigating financial support to landlords who assume the risks of renting to vulnerable persons, such as those experiencing homelessness. Mayor Bowser and the Downtown Business Improvement District have been actively fundraising and anticipate a launch this spring. Participating landlords will be able to tap into the fund for losses from unpaid rents or damage

exceeding security deposits. Wraparound services and longer subsidies will boost the success of this program. Further, District law prohibits housing discrimination based on matters including disability, and forbids landlords from asking about prior convictions before making a conditional housing offer.

Finding 24: DBH’s reimbursement rates for community service providers have not kept pace with their funding needs, thereby adversely affecting their ability to recruit and retain quality clinical and non-clinical staff.

DBH believes that this finding represents an unqualified opinion. DBH contracts with independent experts to conduct objective rate studies; the results of those rates studies determine how rates are set. Further, total Medicaid and local payments to mental health providers increased by nearly 100% from FY12 to FY16 (\$63 million to \$124 million), while the total number of mental health consumers accessing services has remained relatively steady at approximately 24,000.

Recommendation 24.1 That the D.C. Council require DBH to conduct a rate study every two to three years.

This recommendation is directed at the DC Council, but DBH notes that it disagrees. No objective evidence or standard presented supports the recommendation for a rate study every two to three years. DBH completed a rate study in 2013 and recently completed another rate comparison study with comparable jurisdictions in 2017. Some rates increased and some rates decreased. When rates are changed, either up or down, both DBH and DHCF have to work together on implementing rulemaking and administrative and operational changes in order for the rates to go into effect, which may take up to six months.

Recommendation 24.2 That the D.C. Council adjust DBH’s budget to allow for appropriate reimbursement rate changes consistent with the rate study findings.

This recommendation is directed at the DC Council and accordingly, DBH does not submit a response.

Recommendation 24.3 That DBH, in concert with its provider network, develop and implement transparent rate-setting processes.

DBH agrees with this recommendation and has already developed a transparent, inclusive, rate setting process with providers, who have been involved in all aspects of the process. Some providers served as the sample group for the study. DBH contracted with PGC, a reputable independent contractor, to conduct the study and presented the results, its methodology, and calculations to providers in December 2017. Now that the study is complete, DBH staff are working very closely with providers to plan and develop phase-in options for implementing a rate cut to Rehab Day services of 46 percent, which is the steepest of the cuts. DBH has also actively engaged providers both individually and collectively to identify how to sustain some part of their services. It is doing this by working with the providers to identify all of the different kinds of services and activities they provide to different populations under the umbrella of

“Rehab Day,” so that individual component services that are most needed can be redefined into new services. DBH will work with DHCF and the provider network to cost out these potential new services and amend the District plan to more accurately reflect the service needs of consumers.

Finding 25: Due to failures of DBH’s medical billing system, in FY 2016 DBH was unable to (a) pay providers promptly for local-dollar services, and (b) accurately assess the availability of and (re)allocate local-dollar funding as necessary.

The iCAMS system that was procured, developed, and rolled out between 2013 and 2015 did not adjudicate as was needed and required. DBH began taking corrective action in early 2016 and by March had set in place and implemented a plan to fix the problem and pay providers. DBH increased providers’ purchase orders by \$2.1 million beginning in August and through September to accommodate increased payments. Adjudicated payments to providers for FY16 were \$122.6 million. In addition, payments to providers that exceeded their legal purchase orders must follow an OCP-OCFO review and approval process and totaled \$1.8 million. The grand total in FY16 was \$124.4 million, representing a more than 15% increase from FY15. In FY17 and currently in FY18, DBH continues to adjust providers’ purchase orders to accommodate payments.

Recommendation 25.1 That the Executive Office of the Mayor (EOM) conduct an extensive review of the iCAMS software failure and its impact(s) on consumers, community service providers, and the District government.

DBH agrees with this recommendation and notes that it is already underway. DBH has worked closely with DMHHS and OCA to review the history of iCAMS, document the course of events surrounding its adjudication failure, implement solutions that fixed the problem and enabled DBH to pay providers, and maintain the stability that has been achieved since then.

Recommendation 25.2 That DBH and the EOM analyze the financial stability of DBH’s provider network and develop a comprehensive plan that appropriately addresses the findings of that analysis.

DBH disagrees with this recommendation. Financial stability is important; however, provider agencies are independent, private vendors with which DBH contracts for services. DBH is not and cannot be responsible for the financial health of all—or even some—of its vendors. It is not appropriate for the District to play a role in the internal business and financial planning of a private vendor, beyond ensuring those vendors fulfill contractual obligations with the District. As the behavioral health authority, DBH is responsible for ensuring the fundamentals—that operations for every aspect over which DBH has authority are safe, that services are rendered clinically appropriately, that practices are not fraudulent, and consumers are receiving care and services.

The reality is that vendors do close, for a variety of reasons, every year. Some vendors are decertified by DBH due to longstanding violations of the fundamentals that DBH is responsible for, some may close due to factors that stem from changes in their own organizational leadership,

some become subsidiaries to other providers, some cannot adjust a business model, and so on. The fact that some vendors do better and some vendors do worse (regardless of size and services provided) within the same overall operating environment in the District highlights the importance of a vendor’s internal business practices and decisions. At the same time, DBH also recognizes that provider network vitality is crucial to achieve our shared missions, and DBH provides technical assistance and other supports to providers.

Accordingly, “analyzing financial stability” and creating a “comprehensive plan” to address it is neither the role of DBH, the expertise of DBH, nor the sole responsibility of DBH. Other relevant District agencies and federal and private partners would need to be involved in any effort to ascertain and ensure the financial health of vendors that contract with DBH. What DBH can do, and is already doing, is to plan for and propose to DHCF and CMS changes to the state plan, which is essentially the framework for behavioral health services in the District. DBH helps to shape what services, who provides them, how they provide them, at what rates, covering which people, and so forth. Changes to the state plan affect the operating environment for behavioral health, which influences the landscape of vendors and services. DBH goal is to ensure a “healthy” behavioral health system, but such a system is not dependent on the same vendors continuing to provide the same services to the same consumers, at all times. A healthy system is a dynamic one, where providers do leave, where new providers enter, and where existing providers who do well can grow.

Finally, it is important to note that while vendors do close every year, the number of residents accessing behavioral health services remains relatively steady and payments to vendors have continued to increase (doubling from FY12 to more than \$120 million in FY16).

Recommendation 25.3 That the D.C. Council provide more direct oversight of DBH’s supervision and support of the financial stability of its provider network.

This recommendation is directed at the DC Council, but DBH does not agree that greater oversight by the Council is needed or warranted. DBH is responsive to Council oversight inquiries.

CCE Response to Agency Comments

CCE and ODCA greatly appreciate DBH's response to our findings and recommendations. We are pleased that DBH disagreed with less than a quarter of our 25 findings and that it agreed or agreed in part to 40 of the recommendations (more than half). CCE and ODCA are also pleased that DBH is starting to implement some of our recommendations.

In CCE's view, DBH's comments do not require any change in the text of the final report. CCE would like to respond, however, to some of DBH's comments. CCE notes that the reader should not construe the absence of a response to a particular comment as an indication of agreement with it.

FINDING ONE

Recommendation 1.1, p. 97.

CCE does not believe that the Division of Forensic Services's (DFS) position within DBH necessarily restricts it from taking particular actions. However, CCE continues to believe that, given the nature of DFS's unique responsibilities, it would be better positioned to fulfill them if it were located higher in the organization's hierarchy.

Recommendation 1.2, p. 97.

DFS is unique among DBH's administrations and divisions because of its (a) ongoing interactions and relationship with the courts and (b) need to coordinate programs and policies between two deputy mayors (for Health and Human Services and for Justice and Public Safety) and the executive branch agencies that fall within their respective jurisdictions. Moreover, the Division's responsibilities involve decisions that directly affect public safety and the mental health and personal liberties of justice-involved consumers. In light of these considerations, CCE believes that having a director who is a mayoral-level appointee would enhance the Division's ability to carry out these unique and challenging responsibilities.

Recommendation 1.3, p. 97.

Although DBH states that it agrees with CCE's recommendation, its comments suggest that it misunderstands the point. DFS's budget, under the authority of its Director, should encompass *all forensic activities*, including inpatient forensic services at Saint Elizabeths Hospital (SEH), which is not currently the case.

FINDING TWO

Recommendation 2.1, p. 98.

DBH's statement that "[a]s of FY 2018, the Director of DFS has budgetary and operational authority over and manages the Department's inpatient and outpatient forensic programs" is not true. The Director of DFS currently does not have full budgetary and operational authority over inpatient forensic programs at SEH, as the balance of DBH's comments seem to concede.

FINDING FOUR

Recommendation 4.1, p. 99.

CCE stands by the text as written. The unavailability and unreliability of some of the data and information

that CCE requested from DBH suggest that the agency's internal control framework is deficient. Furthermore, in addition to investigating and eliminating waste, fraud, and abuse, the role of the Inspector General is to "conduct independent fiscal and management audits of District government operations" (*see* D.C. Code § 1-301.115a.(a)(3)(A)).

FINDING SEVEN

Recommendation 7.5, p. 104.

The special civil liberty and public safety concerns associated with the services provided to justice-involved consumers make that sub-population fundamentally different from the other sub-populations mentioned in DBH's comment and deserving of special attention.

FINDING ELEVEN

Recommendation 11.1, p. 107.

CCE disagrees with DBH's assertion that this recommendation would be limiting. The proposed statutory language would be broad enough to include currently practicing forensic clinicians, graduates from forensic post-doctoral programs, and others who would be trained by DBH if DBH develops a comprehensive forensic training and certification program pursuant to CCE's recommendation (*see* Finding 10, Recommendation 1), with which DBH agrees. Further, DBH's description here does not explain why such qualifying language would be a limitation, as the last sentence of the comment supports CCE's recommendation that DBH develop its own comprehensive training program.

FINDING TWELVE

Recommendation 12.4, p. 108.

CCE agrees that DBH is not responsible for *developing housing* for consumers in the most technical sense, such as the construction of units; however, CCE continues to recommend that, in collaboration with other relevant agencies, DBH play a leadership role in developing housing *options* for justice-involved consumers. The implication in DBH's response to this recommendation, and many of its other responses related to housing, is that, because DBH is not solely responsible for housing, its only responsibility is to link its consumers with whatever existing housing options may be presented to it by other agencies. But that passive approach is neither consistent with the Department's responsibilities under the Department of Mental Health establishment act (*see* D.C. Code § 7-1131.03(d)(1)) nor compatible with the needs of justice-involved consumers. Indeed, developing housing options for this population is vital to breaking the tragic and costly arrest-incarceration-treatment-recidivism cycle discussed in CCE's report.

FINDING FOURTEEN, p. 109

CCE notes that, while DBH disagrees with the finding, it agreed with all of the finding's associated recommendations. As such, CCE believes that DBH can and should develop a robust pre-arrest diversion program.

FINDING FIFTEEN

Recommendation 15.1, p. 111.

CCE did not recommend that a super-utilizer study focus *specifically* on the population of people who have been *Jacksoned*, but that the population have a special focus. Based on CCE's research and its interviews with DBH staff, stakeholders, and other experts in the field, this population is both (a) the most likely to suffer from the human misery of persistent involvement in both the criminal justice and public psychiatric systems, and (b) because of that recurring involvement, are the most likely to impose the greatest cost on the District.

FINDING SIXTEEN, p. 112.

In developing its finding, CCE relied on judicial statements and determinations from transcripts of hearings at the D.C. Superior Court about the unlawful detentions of people awaiting transfer from the Department of Corrections to SEH, *see* pages 28 and 59.

CCE further notes that, although DBH disagrees with the finding, it agrees with all but one of CCE's associated recommendations.

Recommendation 16.4, p. 113.

CCE's finding does not suggest that civil commitment is a process internal to DBH. A review of the process would have to include entities outside of DBH, such as local hospitals, Core Service Agencies (CSAs), the D.C. Office of the Attorney General, and others. Moreover, the troubling reports that CCE received – local providers forgoing the initiation of civil commitment procedures in part because of the financial and practical burdens associated with the process in spite of statutory requirements – are precisely the type of reports that merit investigation. Furthermore, the reports received by CCE involve potential abuses of the civil commitment process, which would be an appropriate subject for review by OIG.

FINDING SEVENTEEN**Recommendation 17.2, p. 114.**

CCE stands by its recommendation that maintenance is different from competency restoration. From our discussions with national experts and extensive reviews of relevant material (academic, legal, and others), CCE understands that the concept of competency maintenance is a common sense point – adhering to a treatment plan and regimen so as to *remain competent*, which is different from adhering to a treatment plan and regimen so as to *restore competence*. Even if the current restoration program has some of the same elements for the purposes of restoring and maintaining competence, the concept is still different because it is implemented at a different treatment stage and has a different purpose. CCE heard reports of defendants who were found competent and were ordered to remain in their restoration program for competency maintenance. The reports said that the defendants had to sit through the instruction of and group discussions of material they had already learned and were able to retain. In those cases, DBH should work to develop a program that maintains their competency and is a more effective use of their time.

Furthermore, the National Judicial College's *Mental Competency: Best Practices Model* states that it is a best practice for defendants to continue to adhere to their treatment plan (*see* National Judicial College, *Mental Competency: Best Practices Model*, 1, 31 (2012).) It does not say, however, that it is a best practice for defendants to continue to adhere to their restoration program regimen (i.e., courses, group therapy).

Recommendation 17.3, p. 114.

The D.C. Code currently does not provide DBH with the express legal authority to hold defendants for competency maintenance. Thus, it is possible that a defendant or group of defendants could file a lawsuit against the Department for wrongful and/or prolonged detention. Therefore, CCE recommends that the statute be changed so as to provide DBH with the clear and express authority to hold individuals for competency maintenance at the order of a judge.

FINDING EIGHTEEN, p. 114.

DBH'S response suggests a complete insensitivity to the population that DBH serves. DBH does have an obligation – legal, ethical, and moral – to make sure that consumers do not suffer. Although DBH does not agree with the finding, it does not dispute that seven CSAs have left the network within the last five years. Of those, three CSAs, which collectively served more than five thousand consumers in FY 2016,¹ closed within

¹ *See* DBH, DBH Oversight Responses FY 2017 (2017), at "Attachment 4 of 6," available at http://dccouncil.us/files/user_uploads/budget

one year: Green Door, Contemporary Family Services, and Youth Villages. The consumer network must now absorb the shock of those CSAs closures by taking on their consumers, despite not always receiving increases to their annual DBH contracts for doing so.

While it might not be DBH's responsibility to protect its providers from closing, it is DBH's job to protect its consumers. So much churn within the provider network is hugely disruptive to consumers.

Recommendation 18.2, p. 115.

While the management of contracts is an executive branch function, the services rendered to consumers on behalf of DBH by way of its contracts are well within the purview of the Council's oversight of the agency. As outlined in CCE's response to DBH's general comment on this finding, consumers have experienced tremendous disruption with the closing of several CSAs and ASARS providers. For the last two years, providers have increasingly sought the help and intervention of the D.C. Council on matters related to their contractual relationship with DBH.

FINDING NINETEEN

Recommendation 19.1, p. 116.

DBH's comment to this recommendation provides another example of the agency manifestly not exercising its assigned leadership role. DBH agrees that it is responsible for connecting individuals to DBH services upon their release from prison or jail. However, DBH's response implies that, because it is not solely responsible for developing such a referral system to connect consumers to such services, that it cannot take the lead on advocating for one. This response does not address the question about DBH's overall responsibility for connecting consumers to providers, nor does it provide a solution for its inadequate performance in the area.

Nevertheless, while the technical aspects of this recommendation are indeed a challenge, they are not insurmountable. In lieu of an immediate technical option, DBH should develop comprehensive alternatives to its current referral system that would better link consumers to services without IT upgrades.

FINDING TWENTY, p. 117

Thirty-two units are equivalent to only eight hours, which CSAs do not believe are sufficient for the work expected of them within that timeframe. As the report cites, the evidence that CCE has accumulated supporting this finding indicates that the present limit is unjustifiable and that the process for requesting additional authorizations is administratively burdensome for CSAs, which, together, act as a disincentive for providing the services altogether.

Recommendation 20.1, p. 118.

See response above.

FINDING TWENTY-ONE, 118.

DBH has the authority to change reimbursement rates for particular services and can add billable services if not explicitly prevented from doing so by D.C. law or municipal regulations. Thus, DBH can implement locally funded reimbursements for a number different activities that providers must conduct on behalf of consumers, especially justice-involved consumers. Disallowing such reimbursement for often required activities is unreasonable and restrictive.

Recommendation 21.1, p. 118.

See comment above. For justice-involved consumers, disallowing reimbursement for these services is

[responses/dobh.pdf](#)

unreasonable. If Medicaid does not provide for these services, DBH should be responsible for making up the difference in the best interest of the consumer.

FINDING TWENTY-TWO

Recommendation 22.1, p. 119.

Nothing prevents DBH from collecting these data, and it is apparent that these data would be useful.

Recommendation 22.2, p. 120.

DBH must fulfill its leadership obligations in providing housing for its consumers. *See* CCE's response to Recommendation 12.4.

FINDING TWENTY-THREE, 120.

Data from DBH and CCE's interviews show that consumers are staying at SEH longer than necessary. Despite DBH's assertion that it prioritizes consumers from SEH, with which CCE agrees in part, CCE nevertheless received data from the agency showing that individuals at SEH were waiting for years to be placed in community housing.

Further, DBH's comment about the availability of temporary funding, while admirable, is moot if consumers remain at SEH for years because they have not been placed in housing.

Recommendation 23.1, p. 121.

A board that addresses an individual consumer once a year is not a satisfactory substitute for a housing needs assessment. The Board looks at individuals on a case-by-case basis and does not consider the needs of the groups in the aggregate.

A housing needs assessment could outline for DBH the consumers' needs as a group so that the hospital could mobilize to address similar needs at once. The annual cost for D.C. taxpayers to house 65 individuals at SEH is \$22.6 million a year.

Recommendations 23.2 - 23.5, pp. 121-2.

DBH must fulfill its leadership obligations in providing housing for its consumers. *See* CCE's response to Recommendation 12.4.

FINDING TWENTY-FOUR, p. 123.

CCE assessed DBH's rate study and found that it did not include in its calculations, for example, the cost of inflation or the increases to the minimum wage, both of which affect providers. In the materials about the rate study provided to CCE, DBH included the calculations used by the independent expert consultations, their definitions of the terms used in the calculations, and their justifications for why variables were included in the calculations. Thus, CCE does not believe that all of the rates in the study accurately reflect the costs associated with doing business in D.C.

Moreover, there has not been a substantial increase to local dollar funding for mental health services in recent years. While Medicaid payments have increased, local dollar payments have decreased. DBH should be careful not to conflate the two, as local dollar funding provides for services explicitly denied by Medicaid and, thus, may serve an entirely different population altogether.

Recommendation 24.1, p. 123.

There has not been a local dollar rate increase since 2013, which indicates that there is not a clearly defined

timetable for conducting reassessments. Given that there have been five years without a rate increase and that there is no periodic timetable for conducting another rate study, this recommendation proposes such a timetable.

FINDING TWENTY-FIVE

Recommendation 25.2, p. 124.

See Response to Finding 18.

Throughout CCE's review, it was apparent that there were problems with DBH's interactions with CSAs. Nevertheless, this is the community-based model that the District and DBH have developed, so they must take responsibility for it. DBH and the District can ill-afford to experience any further tumult within the provider network.

ODCA Management Alert Memo & DBH Response

December 8, 2017

The Honorable Kathleen Patterson
District of Columbia Auditor
717 14th Street, N.W., Suite 500
Washington, D.C. 20005

Dear Ms. Patterson:

During the course of our review of the Department of Behavioral Health (DBH), an issue has come to our attention that we feel deserves to be brought to the immediate attention of the appropriate parties prior to the completion of our review.

In the conduct of our review, we have interviewed several DBH staff members and DBH stakeholders at the D.C. Superior Court. Yesterday, CCE received concerning reports regarding the license of **Reston Bell, PhD**, one of DBH's forensic psychologists at the D.C. Superior Court. According to our reports, the D.C. Board of Psychology had downgraded her license from that of a psychologist to that of a psychology associate, reportedly for not having sufficient educational experience required of a psychology license. We have confirmed the change in licensure and have attached to this memo a screenshot of Dr. Bell's current license information from the Department of Health's license verification system. The reports further indicate that Dr. Bell has continued to work for DBH, fulfilling the responsibilities of a forensic psychologist at the court, which appears to be in violation of D.C. Code and D.C. Municipal Regulations. Furthermore, in fulfilling those duties, her direct supervisor, DBH Director of Forensic Services, **Nicole Johnson, MD, FAPA**, also appears to have violated D.C. Municipal Regulations. Also, the reports further implicate DBH Associate Chief Medical Officer, **Christopher Raczynski, MD, FAPA**, as he may have also reportedly served as a supervisor to Dr. Bell on one occasion.

Background

DBH's forensic psychologists at the D.C. Superior Court conduct outpatient competence screening examinations and full outpatient competence evaluations pursuant to Section 24-531.03 of the D.C. Code. The statute also requires that the evaluator be a licensed psychologist or psychiatrist affiliated with DBH. Dr. Bell was hired by DBH as a forensic psychologist in September, 2016.

Dr. Bell's qualifications had previously been brought to our attention out of concern that, based on her educational and professional experiences, she was not qualified to conduct forensic evaluations because they were outside of the scope of her professional competencies. CCE confirmed that Dr. Bell did not have any formal education or training in forensic behavioral health. Moreover, CCE was concerned that Dr. Bell did not have sufficient experience in working with individuals who presented with severe and persistent mental illness.¹ Dr. Johnson told CCE that Dr. Bell was hired for the position because of a lack of qualified applicants. DBH staff reported to CCE that the hiring of Dr. Bell was in spite of concerns from the Chief

¹ For all licensed professionals not currently registered with the Board of Professional Fire, George Mason University, the Counseling and Human Services Center, and the Department of Psychology are available by email at info@dcps.org. For all licensed professionals not currently registered with the Board of Professional Fire, George Mason University, the Counseling and Human Services Center, and the Department of Psychology are available by email at info@dcps.org.

Clinical Officer of Saint Elizabeths Hospital and other DBH psychologists that her lack of forensic experience might violate the American Psychology Association's (APA) ethical guidelines.²

On December 1, 2017, the D.C. Board of Psychology downgraded Dr. Bell's license from that of a psychologist to that of a psychology associate because of lack of sufficient educational experience required of a psychology license.

In response to the downgrade, CCE was told that Dr. Johnson and Dr. Raczynski, and Dr. Michele Godwin, of Saint Elizabeths, would complete evaluations at the courthouse in place of Dr. Bell. However, we have since received reports that Dr. Bell has conducted forensic screening examinations without direct supervision, which have been signed off by Drs. Johnson and Raczynski after the fact, neither of whom were reportedly present for the examinations.³ Furthermore, we have received reports that Dr. Bell is anticipated to return to her position full-time to continue her duties as a forensic evaluator in the coming week.

Requirements for Competence Evaluators in D.C.

In the District, a licensed psychologist or psychiatrist must conduct competence screening examinations and full competence evaluations.⁴ A non-licensed practitioner (e.g., student, graduate or person seeking re-licensure) only under the supervision of a licensed psychologist or psychiatrist may conduct a competence evaluation;⁵ however, there are a series of conditions that would preclude Dr. Bell from conducting competence evaluations as psychology associate.

First, and foremost, the supervisor must ensure that the associate is practicing within the scope of the associate's competencies as demonstrated by their documented training and experience.⁶ As previously mentioned, Dr. Bell does not have any experience in forensic psychology, aside from her largely unsupervised experience at DBH over the past year.

Second, while D.C. Municipal Regulations require that the supervisor be directly present for a minimum of ten (10) percent of the time,⁷ the work product of the psychology associate is considered that of the supervising psychologist or psychiatrist and is therefore attached to supervisor's license.⁸ Given this, it would be the supervisor who would be called to testify as an expert in court if the evaluation were to be contested by counsel. If the supervisor were not present, as our reports have indicated has been the case, they may not be able to identify the defendant in court, let alone speak to their competence at the time

² American Psychological Association, "Ethical Principles of Psychologists and Code of Ethics," <http://www.apa.org/ethics/principles.asp>. Stating that "psychologists provide services to individuals and communities and in so doing, they must be guided by the highest ethical standards of conduct and professional performance."

³ CCE has received reports that Dr. Bell's work has not yet been submitted to the DC Superior Court by Dr. Bell's supervisor. The DC Superior Court may require any such evaluations to be submitted to the DC Superior Court.

⁴ DC Code § 24-2101

⁵ DC Code § 24-2101

⁶ DC Code § 24-2101

⁷ DC Code § 24-2101

⁸ DC Code § 24-2101

of the examination or evaluation. Moreover, there are serious concerns that, in the case of a contested competence evaluation, Dr. Bell herself might not qualify as an expert witness, as she does not meet the statutory requirements to conduct such an examination or evaluation.

Finally, D.C. Municipal Regulations explicitly state that the psychology associate's supervisor is "required to fully inform a client or a patient that the supervisee will be providing services and obtain the client's or patient's consent thereto prior to the provision of the services by the supervisee."⁹ In the case of competence examinations, the D.C. Superior Court is the client and not the defendant. According to our reports, the courts may not have been notified of Dr. Bell's license change and her continued conducting of examinations. If this is the case, her examinations may be at further risk for invalidation.

Additional Concerns

Given the change in Dr. Bell's license, CCE has additional concerns that many, if not all, of the evaluations she conducted throughout her tenure at DBH have put the criminal cases associated with those evaluations at risk for review by the courts. Judges have told CCE that they generally follow the recommendations of DBH's courthouse evaluators when deciding to admit defendants to inpatient or outpatient competency restoration programs. Based on the qualifications of Dr. Bell, it is possible that, based on her recommendations to the court, defendants may have been inappropriately sent to Saint Elizabeths, released to the community for outpatient restoration, or released without any recommendation for treatment at all. As you know, during the competency restoration process, defendants' cases are placed on hold until the court makes a determination as to their competence. This process can add significant delays to a defendant's case, sometimes up to several months long.

Recommendation

We recommend that Dr. Bell immediately cease conducting competency screening examinations and full competency evaluations, even under direct supervision, as forensic psychology is not within her scope of professional competencies. Furthermore, we recommend that DBH investigate the claims that Drs. Johnson and Raczynski signed competency examination reports for which they were not physically present. If it is found that they did do so, we recommend that appropriate disciplinary actions be taken. Finally, we recommend that this memo be shared with the Court (Judges Lee and Leibovitz) and the D.C. Board of Psychology so that they may conduct any appropriate inquiries they might find relevant to their interests in this matter.

Thank you for your consideration of this information and recommendation. I am happy to answer any questions you or your associates have about this information.

Sincerely,

Benjamin Moser, MPA | Research & Policy Analyst
Council for Court Excellence

Benjamin Moser



December 13, 2017

The Honorable Kathleen Patterson
District of Columbia Auditor
717 14th Street NW., Suite 500
Washington, D.C. 20005-5628

Dear Ms. Patterson:

This letter is in response to concerns raised by the Council for Court Excellence, ("CCE") during the course of its review of the Department of Behavioral Health about the professional licensure of Reston Bell, PhD, a DBH forensic psychologist at the D.C. Superior Court.

We acknowledge CCE's concerns and take the allegations raised in the letter very seriously. With that said, we have reviewed this matter and disagree with the CCE suggestion that the Department of Behavioral Health or its employees, including Dr. Bell, violated any licensing or supervision regulations or that her prior competency reports did not comply with D.C. law.

Dr. Bell applied for a psychology license with the District of Columbia's Department of Health ("DOH") in 2015 and furnished all requisite documents concerning her education and professional qualifications which included a doctorate in Education with a focus on counseling and clinical psychology. DOH reviewed her application and deemed her qualified at that time. Accordingly, DOH licensed her on October 28, 2015.

DBH hired Dr. Bell as a forensic psychologist on August 22, 2016. Since that time, she received intense on the job training, ongoing professional education, and practical experience from hundreds of screenings and evaluations. At the direction and recommendation of DBH's Director of Forensic Services, Dr. Nicole Johnson, MD, FAPA, Dr. Bell attended 40 hours of forensic training, from October 24 - 28, 2016, at UVA's Institute of Law, Psychiatry and Public Policy. Additionally, from August 3 - 6, 2017, Dr. Bell attended another conference, Criminal Law and Mental Illness, the Rising Significance of Neuro Science and the Courts. And over the past year, she attended several forensic-related seminars at Saint Elizabeths Hospital. In addition to her training and experience, Dr. Johnson (or her designee) reviewed and signed off on all completed competency evaluations prepared by Dr. Bell. In short, Dr. Bell was licensed as a psychologist by DOH when she conducted competency evaluations.

On November 15, 2017, Dr. Bell received a telephone call from Mr. Derek Brooks, supervisory investigator at DOH, seeking information pertaining to her District of Columbia psychology license. This was the first time that Dr. Bell was put on notice from DOH that she was being investigated regarding her District of Columbia Psychologist license. Dr. Bell fully cooperated with DOH and furnished all requested materials in her possession. At the close of the investigation,

Letter to D.C. Auditor
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December 12, 2017

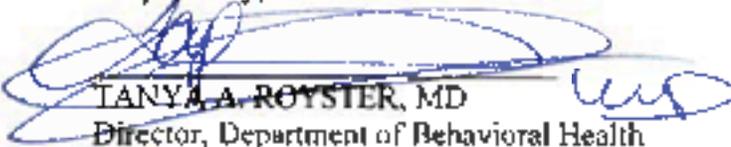
Dr. Bell received a letter from DOH, on Friday, November 24, 2017, informing her that an error had been made when her license was granted, and that she did not meet the District of Columbia's qualifications for a Psychologist license. Dr. Bell voluntarily surrendered her license on December 1, 2017. Notably, from November 22, 2017 – December 10, 2017, Dr. Bell did not conduct evaluations on behalf of DBH; therefore, we do not believe there is any evidence of inappropriate supervision by Dr. Johnson or Dr. Chris Raczynski.

At the suggestion of DOH, Dr. Bell immediately applied for and received a Psychology Associate license, which was issued by DOH on December 1, 2017. Since receiving her Psychology Associate license, Dr. Bell performed two evaluations at D.C. Superior Court, which occurred on Monday, December 11, 2017, between the hours of 11:00am-1:00pm. Her supervisor, Dr. Johnson was at the courthouse and available by telephone consistent with the direct supervision requirements in the D.C. regulations.

In closing, we take your concerns seriously but after reviewing the matter we do not agree that Dr. Bell did anything wrong or that her reports were not well-qualified and supported expert opinions when rendered. Furthermore, we believe Dr. Bell is currently qualified by her Psychology Associate license, education and professional experience to render competency opinions under the direct supervision of Dr. Johnson. With that said, the direct supervision requirements are administratively difficult to sustain because it requires Dr. Johnson's constant presence at the courthouse during Dr. Bell's evaluation sessions. While to date Dr. Johnson has been able to comply with these supervision requirements, her duties do not allow her to maintain a presence at the courthouse indefinitely. Therefore, and as a result of this requirement, DBH has decided to remove Dr. Bell from competency evaluation duties. For the immediate future, until DBH can hire a full time replacement, DBH has made a programmatic decision to use Dr. Johnson, Dr. Grant and contracted psychologists to conduct all competency screenings and evaluations going forward.

If you have any questions about this matter, please contact me at Tanya.Royster@dc.gov or (202) 671-3180.

Respectfully,



TANYA A. ROYSTER, MD
Director, Department of Behavioral Health

cc:
Benjamin Moss, MPA
Research & Policy Analyst
Counsel for Court Excellence

The Honorable Judge Lynn Leibowitz
Presiding Judge, Criminal Division

The Honorable Judge Milton C. Lee
Deputy Presiding Judge, Criminal Division

Findings & Recommendations

Finding 1:

The Division of Forensic Services does not have a clear mandate, and its current position and responsibilities within DBH may impede its ability to carry out its larger mission.

Recommendations:

1. That DFS be located within the Office of the Director of DBH with the mandates to (a) act as both an inter- and intradepartmental coordinating body, and (b) develop and implement policies for justice-involved consumers.
2. That the position of the Director of DFS be a mayoral-level appointment, given the responsibilities of the Director of DFS to (a) coordinate with multiple federal and local government agencies, and (b) fulfill significant statutory obligations on DBH's behalf that implicate other D.C. agencies (e.g., jail-based competency restoration).
3. That the Director of DFS be given the authority to develop and manage a unified budget.
4. That the DFS budget be increased to fund current and new programs and related expenses.

Finding 2:

The Division of Forensic Services does not have effective management and staffing structures.

Recommendations:

1. That the Director of DFS should have budgetary and operational authority over and manage all of the Department's forensic programs, whether administered on an inpatient or outpatient basis.
2. That DBH establish an independent team of forensic evaluators and competency restoration program staff to perform the Department's forensic work at facilities throughout the city – at the courthouse, the jail, the 35 K Street clinic, and SEH. The forensic teams would report to DFS management and would not be assigned to any one location, allowing DFS to meet the need for evaluations whenever and wherever it arises.
3. That DBH clarify that the Director of DFS's responsibilities do not include a role over consumers' non-forensic direct medical services.
4. That DBH establish two Deputy Director positions: a Deputy Director for Forensic Outpatient Treatment and Services; and a Deputy Director for Forensic Policies and Program Development.
5. That the D.C. Council allocate additional clinical and direct services to DFS.

Finding 3:

The Division of Forensic Services internal policies and procedures need strengthening.

Recommendation:

That DBH's internal compliance officials work with DFS to develop robust internal policies and procedures that will help it fulfill its statutory and regulatory obligations.

Finding 4:

In many instances, DBH was unable to provide requested documentation or data to CCE in a timely manner or at all, suggesting significant department-wide internal control deficiencies.

Recommendations:

1. That the Office of the D.C. Auditor or the D.C. Office of the Inspector General conduct an audit of DBH's internal controls and control framework.
2. That the Executive Office of the Mayor ensure that DBH has the necessary technical assistance and guidance to improve or where needed, properly design and implement effective internal controls using an internal control framework. The framework should be instructive on how to improve and/or design and implement both operational and financial controls, in addition to controls that will ensure DBH's compliance with laws and regulations at both the local and federal levels. A review of DBH's internal controls would further assist in defining how DBH's internal control framework could be improved.

Finding 5:

DBH does not clearly define, support, or report on performance measures related to services for justice-involved consumers. While DBH has taken steps to understand better the connections between the criminal justice and behavioral health systems and their various programs, and to identify resources, gaps, and priorities, there is still much work to be done.

Recommendations:

1. That the D.C. Office of Performance Management (D.C. OPM) develop and incorporate into DBH's annual Performance Accountability Report performance metrics that effectively capture and measure DBH's work with justice-involved consumers.
2. That DBH develop an official definition for "forensic" and "justice-involved" consumer.
3. That the appropriate divisions within the Office of the City Administrator work with DBH to develop, implement, and report on internal performance metrics, both department-wide and division-specific, that measure DBH's outcomes vis-à-vis justice-involved consumers.
4. That, in its public reports (e.g., PRISM), DBH report its performance targets alongside their respective actual performance.
5. That DBH publish quarterly reports containing data, trends, and analyses on the justice-involved population.

Finding 6:

DBH's data infrastructure is insufficient to support effective operations and proper resource allocation, especially with regard to the justice-involved consumer population. While DBH has made efforts to improve this infrastructure, DBH cannot realize the necessary improvements without adequate investments in upgrades and enhancements to DBH's systems.

Recommendations:

1. That DBH's Systems Transformation Administration produce a comprehensive report for the D.C. Council outlining the capabilities of the current software, a cost-benefit analysis of enhancements and upgrades, and a needs assessment for a system-wide overhaul of the current systems.
2. That, for the time being, DBH develop a comprehensive, interoperable data infrastructure by upgrading and enhancing the software of its current systems. Such an infrastructure must be able to capture and warehouse reliable data, adequately track services throughout the continuum of the system, monitor quality of care, and analyze and report on trends and health outcomes.

Finding 7:

DBH leadership needs to be proactive in developing strategies to address systemic and institutional problems as they pertain to justice-involved consumers.

Recommendations:

1. That the Executive Office of the Mayor review this report and work with DBH to develop short- and long-term goals for improving the Department's operations as they relate to justice-involved consumers, and devote sufficient resources to ensuring that those goals are met.
2. That the D.C. Council require DBH to produce strategic plans addressing the systemic and institutional failures mentioned in this and other reports, and that the D.C. Council require DBH to produce annual reports detailing progress in carrying out those plans.
3. That DBH's Strategic Management and Policy Division be tasked with developing these plans and overseeing their implementation and progress. This should be done in coordination with DBH's Data and Performance Management Branch, which should develop performance goals against which DBH and the D.C. Council could measure progress.
4. That DBH comply with its statutory mandate that it prepare and publish annual plans (*See* D.C. Code § 7-1141.06(2)).
5. That DBH's establishment act be amended to highlight specifically DBH's roles and responsibilities for justice-involved consumers.

Finding 8:

DBH leadership has reportedly implemented ill-advised changes, including new policies that may have increased the Department's risk of violating patient's rights and reversed progress it has been making.

Recommendation:

That the Executive Office of the Mayor (EOM) conduct a thorough review of the performance of the current Director of DBH, with respect to the Department's forensic work, including risk assessments of any policy or rule that may impact justice-involved consumers, and take appropriate action.

Finding 9:

The Division of Forensic Services' management has not provided the leadership needed to (a) achieve the Division's statutory objections or (b) foster a healthy work environment within the Division in which staff can flourish.

Recommendations:

1. That the Executive Office of the Mayor (a) review the performance of DFS management and assess its ability to provide the leadership needed to achieve the Division's objectives and to promote a healthy work environment and (b) take appropriate action in light of the outcome of that review.
2. That the Executive Office of the Mayor analyze the Division's management needs under CCE's recommended new divisional structure (*See* Finding 2, Recommendation 1, recommending that the Director of DFS be a mayoral-level appointment).

Finding 10:

For years, DBH has not had a standardized approach to its competency evaluation and restoration procedures, such as department-wide policies, guidelines, or training manuals. Recently, staff at Saint Elizabeths Hospital developed a competency restoration-training manual for use throughout DBH.

Recommendation:

That DBH consult with national experts who specialize in forensic training programs to develop a formal, rigorous forensic training program for current and future staff.

Finding 11:

DBH forensic evaluators and other staff working with forensic consumers vary tremendously in their professional abilities, experience, and training, including some who have no formal training, education, or experience in forensic behavioral health whatsoever. The lack of proper training or credentials presents an ethical dilemma for some employees.

Recommendations:

1. That the D.C. Council amend the D.C. Code to require that psychologists and psychiatrists performing forensic screenings and evaluations are (a) board-certified and (b) forensically trained and certified, either through formal education or through comparable professional training programs. The D.C. Council should also require that forensic evaluators be recertified as appropriate. (Suggested language is included in Appendix X)
2. That DBH require that its forensic evaluators comply with the standards in CCE's recommended legislative amendment in this finding's first recommendation.

Finding 12:

DBH's Outpatient Competency Restoration Program needs improvement to achieve a stronger record of successful outcomes and to instill greater public confidence in its effectiveness.

Recommendations:

1. That DBH develop a robust Outpatient Competency Restoration Program (OCRCP) model that meets the needs of participants, including expanding program availability options and accessibility, such as location and operation times, and increasing program capacity.
2. That DBH provide forensic training for its current OCRCP staff and require that OCRCP staff be trained or possess sufficient professional experience regarding forensic behavioral health.
3. That DBH provide training for D.C. Superior Court judges on the benefits of the OCRCP model.
4. That DBH develop comprehensive housing and employment options for OCRCP participants in order to help reduce recidivism.
5. That DBH track and monitor the readmission rate to both of its competency restoration programs, and that it track data on individuals who have been in both programs, and on individuals who have been transferred from one program to another.
6. That DBH be required to analyze and report on data from its OCRCP and Saint Elizabeths Hospital restoration programs to the D.C. Office of Performance Management or the D.C. Council annually.

Finding 13:

Use of inpatient competency restoration over outpatient when not clinically necessary is not cost effective.

Recommendation:

That DBH continue work to improve the outcomes of the Outpatient Competency Restoration Program (OCRCP).

Finding 14:

DBH lacks the components necessary to implement a strong pre-arrest diversion program that diverts people from the criminal justice system to behavioral health services, improves their mental health outcomes, and reduces their risk of recidivism.

Recommendations:

1. That DBH develop a long-term pre-arrest diversion program beyond the initial FY 2018 pilot program.
2. That, in developing this program, DBH actively pursue input from community stakeholders and diversion program experts. The input should be formal, such as through town hall-style meetings.
3. That DBH develop performance targets for the program and publicly report on its outcomes annually.
4. That DBH assess the ability of its provider network to provide services for people through a pre-arrest diversion program.

Finding 15:

DBH does not ensure that people who have been found incompetent to stand trial receive the behavioral health treatment they need to keep them from recidivating or being civilly committed. The criminal justice system in D.C. does not have enough options to disengage this population from criminal involvement, which costs the city millions of tax dollars each year.

Recommendations:

1. That the District conduct a study of super-utilizers of the criminal justice and behavioral health systems, focused especially on people who are released into the community because they have been determined to be non-dangerous and incompetent to stand trial.
2. That DBH develop policies and programs that proactively address the unique needs of these individuals when they are released into the community to prevent them from recidivating.

Finding 16:

Persistent and worsening capacity problems at Saint Elizabeths Hospital (SEH) have had significant negative impacts on the District's residents with mental illness, and particularly justice-involved consumers. These impacts include long admissions waitlists for pre-trial and civil admissions, the unlawful detention of pre-trial defendants at the D.C. Jail, and mass internal transfers of patients within the hospital, which staff described as clinically inappropriate.

Recommendations:

1. That DBH develop long-term solutions for its bed space capacity problem at SEH.
2. That DBH and the D.C. Superior Court review the reasons for the spike in pre-trial admissions and the difference of viewpoints between the courts and DBH on appropriate placement for defendants whose competency is in question.

3. That DBH develop appropriate inpatient alternatives for waitlisted civil admissions.
4. That the D.C. Office of the Inspector General or Office of the D.C. Auditor conduct a thorough review of the civil commitment process in the District and assess the impacts of DBH's civil commitment waitlist.

Finding 17:

Procedural delays cause defendants to be held at Saint Elizabeths Hospital at the expense of the D.C. taxpayer even after they have been found competent.

Recommendations:

1. That the D.C. Council amend the D.C. Code to require a competency hearing within three days of a completed inpatient competency evaluation.
2. That DBH develop a comprehensive "maintenance" program that differs from the restoration program and focuses on an individual's rehabilitation.
3. That the D.C. Council amend the D.C. Code to recognize orders of competency "maintenance" and authorize a judge to make findings similar to those already in the statute to permit the defendant to continue as an inpatient undergoing competency "maintenance" (sample language is included in Appendix X).
4. That the D.C. Superior Court consider the development of a "competency court" or "competency docket," which is considered a best practice.

Finding 18:

Evidence suggests that DBH does not have adequate performance measures or provide adequate oversight of the Core Service Agencies (CSAs) with which it contracts for the provision of mental health services to many justice-involved consumers.

Recommendations:

1. That DBH develop more robust performance measures for CSAs and strengthen its oversight of them to ensure that they meet the performance measures and are financially stable.
2. That the D.C. Council provide more direct oversight of DBH's management of CSAs and other DBH-certified providers by, for example, scrutinizing the methodologies DBH uses to assess their performance, reviewing DBH's overall capability for supervising the performance and financial stability of its providers, and holding DBH accountable for its failure to identify and effectively respond to poor performance by CSAs and low consumer satisfaction.

Finding 19:

DBH does not have a formalized, automated system for connecting justice-involved consumers to appropriate care during their transition from D.C. Department of Corrections or Federal Bureau of Prisons custody to the community.

Recommendations:

1. That DBH consult with IT experts to develop and implement a formal and appropriately automated referral program that addresses the specific needs of justice-involved consumers.
2. That DBH develop performance measures for evaluating the success of DBH liaisons in linking justice-involved consumers to the appropriate care and collect information necessary to judge their success in meeting their goals.
3. That DBH review the roles and responsibilities of the DBH liaisons to determine whether they have the resources and abilities to perform their roles successfully, and make changes as necessary.

Finding 20:

DBH's restrictions on the amount of discharge services (re-entry planning) Core Service Agencies (CSAs) can provide disadvantage justice-involved consumers.

Recommendations:

1. That DBH immediately increase the amount of time for which CSAs may bill for discharge planning from inpatient care or incarceration. These increases should reflect the realities involved with discharge planning in the District.
2. That, even when increased, discharge billing restrictions be considered for extension on a case-by-case basis to ensure that individuals with more complicated situations are eligible for the same quality of discharge planning as other consumers.
3. That DBH produce a comprehensive study on discharge planning services to better understand the process and its associated costs so that the Department can develop a plan to improve the efficiency of discharge planning.

Finding 21:

DBH's restrictions on the type of community support services Core Service Agencies (CSAs) can result in disadvantages for justice-involved consumers.

Recommendations:

1. That DBH allow CSAs to bill for and adequately fund the additional services provided to justice-involved consumers, which are often court-ordered.
2. That DBH ensure CSAs have appropriate resources to facilitate transition-planning work.

Finding 22:

DBH is not effective in meeting the housing needs of justice-involved consumers.

Recommendations:

1. That DBH make an explicit effort to collect information about consumers' justice-involvement as part of the housing process.
2. That DBH conduct a needs assessment to determine the extent of the need for housing among justice-involved consumers and make changes in housing program capacity as necessary to accommodate that need.
3. That DBH provide more housing options dedicated to justice-involved consumers, as they face numerous additional barriers to obtaining stable housing.

Finding 23:

Long waiting lists for housing placements have resulted in consumers remaining detained at Saint Elizabeths Hospital (SEH) for long periods after a court has conditionally ordered release. Protracted inpatient lengths of stay beyond clinical necessity are a violation of patient rights and impose unnecessary costs.

Recommendations:

1. That DBH's needs assessment (*see* Finding 22, Recommendation 1) specifically analyze the long-term community housing needs for post-trial individuals at SEH.
2. That DBH clarify which DBH-affiliated entity is responsible for securing housing for consumers with different kinds of justice system involvement and ensure that the entity has access to the resources necessary to do so.
3. That DBH invest in housing stock specifically for justice involved consumers.

4. That DBH contract for more beds at assisted living facilities or construct such a facility of its own, if and when appropriate.
5. That DBH create incentives to address housing providers' reluctance to house consumers, such as flat monthly incentive rates per individual.

Finding 24:

DBH's reimbursement rates for community service providers have not kept pace with their funding needs, thereby adversely affecting their ability to recruit and retain quality clinical and non-clinical staff.

Recommendations:

1. That the D.C. Council require DBH to conduct a rate study every two to three years.
2. That the D.C. Council adjust DBH's budget to allow for appropriate reimbursement rate changes consistent with the rate study findings.
3. That DBH, in concert with its provider network, develop and implement transparent rate-setting processes.

Finding 25:

Due to failures of DBH's medical billing system, in FY 2016 DBH was unable to (a) pay providers promptly for local-dollar services, and (b) accurately assess the availability of and (re)allocate local-dollar funding as necessary.

Recommendations:

1. That the Executive Office of the Mayor (EOM) conduct an extensive review of the iCAMS software failure and its impact(s) on consumers, community service providers, and the District government.
2. That DBH and the EOM analyze the financial stability of DBH's provider network and develop a comprehensive plan that appropriately addresses the findings of that analysis.
3. That the D.C. Council provide more direct oversight of DBH's supervision and support of the financial stability of its provider network.

Methodology

This review is based on research, data collection, and analysis. To assess how DBH interacts with justice-involved behavioral health consumers, the research and analysis combines information from many sources about the behavioral health and criminal justice systems in the District of Columbia and gauges the opinions and perceptions of behavioral health consumers, stakeholders, and experts in the District.

Upon receipt of the contract with ODCA, CCE established a Project Committee to conduct this review and allocated staff resources to support the Committee. Committee members were drawn from experienced researchers and attorneys on CCE's Board of Directors, and community stakeholders, such as behavioral health experts and community service providers. The committee was organized into five working groups, each focusing in-depth on a different area of research. The five working groups are (i) organizational review, (ii) legislative review, (iii) jurisdictional comparison, (iv) pre-adjudication, and (v) post-adjudication. The pre-adjudication working group worked across intercepts one, two, and three as determined by the Sequential Intercept Map (*see* Appendix IX). The post-adjudication working group worked across intercepts four and five. Finally, legislative review, jurisdictional comparison, and organizational review working groups worked across all five intercepts.

The working groups, in concert with CCE staff, conducted literature review on the theories, principles, and best practices of forensic behavioral health, model forensic behavioral health systems, and the intersection of D.C.'s criminal justice and behavioral health systems. CCE reviewed the legislative, legal, and organizational histories and structures of DBH to understand its intent, scope of work, procedures, and objectives related to its interactions with the criminal justice system and with justice-involved people. Additionally, CCE requested DBH to provide, and subsequently received, hundreds of documents to inform our review. These included descriptive organizational documents (e.g., division and position descriptions), fiscal year budgets and actuals, and qualitative data on program performance outcomes.

CCE staff and project working group members also participated in qualitative and quantitative data collection efforts, examples of which are outlined below:

- Developed and disseminated four surveys to target populations: (i) DBH consumers; (ii) DBH forensic staff within the Division of Forensic Services and at Saint Elizabeths Hospital, (iii) staff at DBH-certified core service agencies (CSAs), and (iv) people who professionally advocate on behalf of justice-involved DBH consumers (e.g., defense attorneys, social workers, policy advocates).
- All surveys were created in SurveyMonkey, an online surveying tool, and were developed in collaboration with behavioral health experts (forensic social workers, psychologists, mental health researchers, and others). The surveys were designed to measure respondents' perceptions on various topics related to our project's scope. Responses were recorded anonymously. Each survey contained a description of our project, the purpose of the survey, and an informed consent form.

The following explains the methodology for the dissemination of the surveys and the collection of their responses:

- **Consumer survey.** CSAs and consumer advocates were given a link to the

survey and asked to distribute it among their consumers widely. Additionally, CSAs and advocates were provided with a PDF copy of the survey in the event they wanted to print and distribute hard copies. CSA staff and consumer advocates (e.g., social workers and attorneys) were asked to offer the survey to all of their consumers, not just those whom they knew to be justice-involved. Questions within the survey asked about justice-involvement. CCE staff also trained CSA staff on how to obtain informed consent from their consumers to participate in the survey and how to administer the survey properly: providing consumers with the link to or paper copy of the survey to complete the survey online themselves, or reading the survey out loud to participants and filling in their responses online or paper copy on their behalf. CCE staff also administered several surveys to justice-involved consumers at several CSAs.

- **CSA staff survey.** CCE sent a link to the survey to the management staff at all of DBH's CSAs. The recipients were asked to forward the survey to their staff as they saw appropriate (it is likely that not all staff employed by a CSA have adequate subject matter knowledge, e.g., maintenance).
- **DBH staff survey.** A link to this survey was sent to CCE's DBH liaison for this project. DBH distributed the survey to staff at Saint Elizabeths Hospital and in the Division of Forensic Services who work most frequently with justice-involved consumers.
- **Consumer advocate survey.** The Project Committee sent surveys to people it identified as being actively involved in providing services in connection with or in support of a person's DBH-funded mental health services, including direct legal representation (e.g., for defendants going through the competency evaluation and restoration process, consumers filing grievances against DBH), social workers not employed by CSAs (such as those working for the Public Defender Service or a legal aid organization), policy advocates from behavioral health associations, and others.
- Conducted more than 50 hours-long interviews with current and former DBH staff and executives, community and government stakeholders, D.C. Superior Court judges, and forensic behavioral health experts and practitioners from around the country. Participation in the interviews by DBH and other local government staff was voluntary and confidential. Information from those interviews is included as supporting evidence throughout this report. Members of CCE's Project and Steering Committees and/or a member of CCE staff attended all interviews.
- CCE staff and Project Committee members also conducted two focus groups for DBH consumers (6 participants), one focus group for consumer advocates (with more than 15 participants), and one focus group for community service provider staff (more than 15 participants).
- Observed seven "stakeholder meetings" organized by advocacy organizations self-identified as DBH consumer advocates. Meeting agendas focused on the stakeholders' various topics of concern, such as proposed changes to DBH policies and regulations.
- Participated in two four-hour ride-alongs with police officers from the D.C. Metro-

politan Police Department during which police discussed their experiences with and impressions of interfacing with the District's behavioral health system, particularly DBH.

- Conducted multiple site tours of DBH and D.C. Department of Corrections facilities.

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DBH Administrations

This appendix provides descriptions of DBH's six administrations and Saint Elizabeths Hospital. The text was pulled directly from DBH's Employee Realignment Orientation Guide, which DBH sent to its staff in March 2017.

New Organizational Structure

Our newly realigned DBH consists of the Behavioral Health Authority, six administrations, and Saint Elizabeths Hospital. Each administration is divided into divisions which may break down into smaller units called branches. The six administrations are (1) Accountability Administration (2) Administrative Operations (3) Clinical Services Administration (4) Community Services Administration (5) Consumer and Family Affairs Administration and (6) Systems Transformation Administration. The DBH leadership team includes the leaders of the administrations, divisions and branches.

BEHAVIORAL HEALTH AUTHORITY

The Behavioral Health Authority plans and develops mental health and substance use disorders services; ensures timely access; monitors the service system; supports service providers by operating DBH's Fee for Service (FFS) system; provides grant or contract funding for services not covered through the FFS system; regulates the providers within the District's public behavioral health system; and identifies the appropriate mix of programs, services, and supports necessary to meet the behavioral health needs of District residents. The Authority is made up of:

- **Office of the Director** – leads management and oversight of the public behavioral health system; directs the design, development, communication, and delivery of behavioral health services and supports; and identifies approaches to enhance access to services that support recovery and resilience. The Office of the Director includes the Chief of Staff who oversees risk management and compliance with Language Access requirements and the Americans with Disability Act.
- **Office of the Ombudsman** - identifies and helps consumers and clients resolve problems, complaints and grievances through existing processes; educates on available services and helps to maximize outreach; refers individuals when appropriate to other District agencies for assistance; and comments on behalf of residents on District behavioral health policy, regulations and legislation.
- **Legal Services**—provides legal advice to the Director on all aspects of DBH's operations and activities; drafts, researches and/or reviews legislation, regulations, and policies affecting DBH's mission and programs; formulates strategic advice on DBH Program development and compliance and oversight activities.
- **Legislative & Public Affairs**—develops, leads and coordinates the agency's public education, internal and external communications, and public engagement and outreach initiatives; manages legislative initiatives and acts as the liaison to the Executive Office of the Mayor and the DC Council; facilitates responses to constituent complaints and service requests, and provides information and support for special projects.

ACCOUNTABILITY ADMINISTRATION

The Accountability Administration oversees provider certification, mental health community residence facility licensure, program integrity, quality improvement, incident management, major investigations, claims audits, and compliance monitoring. It issues the annual Provider Scorecard. The Accountability Administration includes a new division called Program Integrity that strengthens provider oversight and overall system performance review. This Administration contains the following:

- **Office of Accountability**—leads the Accountability Administration by providing oversight and management of DBH certification, licensure, incident management, and program integrity activities.
- **Investigations Division**—conducts major investigations of complaints and certain unusual incidents and develops the final investigative report submitted to the agency Director, General Counsel, and other appropriate parties that includes recommendations for remedial action.
- **Licensure Division**—reviews and processes applications for licensure for Mental Health Community Residence Facilities (MHCRF) for approval, monitors MHCRF compliance with agency regulations and policies and generates and enforces statements of deficiencies and corrective action plans when necessary.
- **Certification Division**—reviews and processes applications for certification and recertification for behavioral health providers for approval, monitors provider compliance with certification regulations and policies, and generates and enforces statements of deficiencies and corrective action plans when necessary.
- **Program Integrity Division**—provides oversight of certified providers through audits and reviews to ensure they meet service delivery and documentation standards for mental health and substance use disorder services.



ADMINISTRATIVE OPERATIONS ADMINISTRATION

Led by the Chief Operating Officer, the Administrative Operations provides highly functioning administrative activities to support the vision and mission of DBH. The Administration is responsible for the business functions including budget and financial management, human resource management, property and space management, records management, and general administrative support.

- **Office of the Chief Operating Officer** –provides leadership, management, and vision necessary to ensure proper operational controls, administrative and reporting procedures, and people systems are in place to effectively manage day-to-day operations and to guarantee financial strength and operating efficiency of DBH.
- **Claims and Billing Division** – manages the services revenue cycle for Saint Elizabeths, CPEP, and DBH operated adult and child/youth outpatient clinics; processes claims for the certified community based behavioral health providers, and responsible for billing and claim adjudications including local payments, claim accounts receivable, customer service for provider claims, claim reporting, and eligibility file management.
- **Fiscal Services Division** – coordinates, in conjunction with the Director and senior management, financial plans to fulfill ongoing program requirements; leads operational and capital budget preparation, execution, and administration; coordinates budget loading and tracking activities; provides guidance on strategic financial planning and fiscal soundness of spending plans; develops options to achieve budget objectives; conduct fiscal monitoring for compliance, audits, risk assessments, fiscal orientations, site visits and closeout reports for all sub grants, and monitors spending for Human Care Agreements and Contracts.
- **Records Management Division** –manages the medical records program and maintains official medical records for DBH consumers and clients; oversees the development, implementation, maintenance of, and adherence to DBH policies and procedures covering the privacy of, and access to, patient health information in compliance with federal and state laws and the provider’s information privacy practices.
- **Human Resources Division**—develops and administers human resource services including management advisory services, human resources policy development, position classification/ position management, staffing and recruitment, employee and labor relations, performance management, benefits administration, records management, human resources information systems, and human rights, and equal employment.
- **Revenue Management Division** – plans, implements and manages finance and revenue generating sources for DBH-directly-provided services and Saint Elizabeths.

CLINICAL SERVICES ADMINISTRATION

Led by the Chief Clinical Officer, the Clinical Services Administration supervises the operation of all clinical programs and sets standards for the provision of clinical care throughout the public behavioral health system. It includes all DBH-directly-provided assessment, referral, and clinical services; forensic services, the comprehensive emergency psychiatric program, and the disaster behavioral health program. The Administration oversees involuntary commitment at community hospitals, and coordinates services that assist individuals transitioning from psychiatric hospitals and nursing homes to community based behavioral health services. This administration includes the following:

- **Office of the Chief Clinical Officer**—supervises and sets standards for the provision of clinical care throughout the agency and public behavioral health system for children, youth, and adults; oversees community hospitals that treat consumers on an involuntary basis; and serves as the petitioner in guardianship cases, and oversees the agency’s disaster response for the city.
- **Behavioral Health Services Division**—directs and manages mental health services at two agency-operated locations, currently 35 K St NE and 821 Howard Rd SE.
 - **Adult Services Branch**— provides clinical assessment and treatment of persons who are 18 years of age and older who present with urgent same-day mental health concerns, and evaluations for persons in crisis that do not arise to the level of needing an emergency room visit are also provided.
 - **Children Services Branch** —provides urgent same-day service and clinical assessment and treatment for children up to 7 years old who present with challenging social, emotional and disruptive behaviors that cause impairment in functioning at home, school/daycare and the community.
 - **Pharmacy Branch**—provides psychiatric medications for residents enrolled in the public behavioral health system who are uninsured and unable to pay for medications.
- **Comprehensive Psychiatric Emergency Program Division (CPEP)**—provides emergency mental health services to adults 18 years of age and older, including immediate and extended observation care to individuals who present in crisis, as well as services in the community; participates in the District’s cold weather alert response.
 - **Psychiatric Emergency Services Branch**—provides immediate access to multi-disciplinary emergency psychiatric services 24/7; assesses and stabilizes psychiatric crises of patients who present voluntarily or involuntarily who live or visit the District, and formulates appropriate next level of care in the community or at other treatment facilities.
 - **Mobile Crisis/Homeless Outreach Branch** —Mobile Crisis provides crisis

intervention and stabilization services to residents and visitors who are experiencing psychiatric crises in the community or at home; services include linkage to DBH, psychoeducation, treatment compliance support, and grief and loss services to individuals after a traumatic event. Homeless Outreach connects homeless individuals and families with behavioral health services and assists in the District's encampment protocol.

- **Access Helpline Division**—enrolls consumers into services, authorizes appropriate units and duration of services based on clinical review of medical necessity criteria and capacity limits; ensures District residents receive crisis services, as well as provides telephonic suicide prevention and other counseling as appropriate.
- **Forensics Division**—provides and oversees continuum of behavioral health and others services for justice-involved individuals from pre-arrest to post-incarceration to ensure their successful return to the community.
- **Assessment & Referral Center Division**—assesses and refers adults seeking treatment for substance use disorders to appropriate services, including detoxification, inpatient, medication assisted treatment or outpatient substance use disorder treatment programs or recovery support services. The Mobile Assessment and Referral Center, a mobile outreach vehicle, visits communities throughout the District to conduct assessment, referral, and HEP-C and HIV testing.



COMMUNITY SERVICES ADMINISTRATION

The Community Services Administration develops, implements and monitors a comprehensive array of prevention, early intervention and community-based behavioral health services and supports for adults, children, youth, and their families that are culturally and linguistically competent and supports resiliency and recovery. This administration includes services and supports in the former Adult Services, Children/Youth Services, and Substance Use Disorder Prevention Services, and Treatment and Recovery Services. It contains the following:

- **Office of Community Services**—leads oversight and management of the agency's integrated community-based, prevention, early intervention and specialty behavioral health programs.

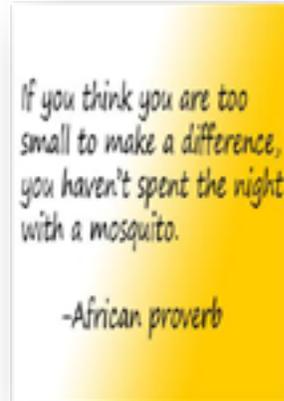
- **Prevention & Early Intervention Division**—develops and delivers prevention and early intervention services, education, support, and outreach activities to help inform and identify children, youth and their families who may be at risk or affected by some level of mental health and/or substance use disorder. This division applies a public health and community-based approach to delivering evidence-based substance abuse prevention and mental health promotion programs. It includes the Early Childhood Branch, School Mental Health Branch, and a Substance Use Disorder Prevention Branch.
 - **Early Childhood Branch**— provides school-based and center-based early childhood mental health supports and child and family-centered consultation to staff and families to build their capacity to promote social and emotional development, respond to mental health issues and prevent escalation of challenging behaviors, and increase referrals for additional services.
 - **School Mental Health Branch**—provides school-based, primary prevention services to students and school staff and consultation to schools, principals, teachers and classrooms on early intervention and treatment to students and parents.
 - **Substance Use Disorder Prevention Branch**—ensures comprehensive prevention systems by developing policies, programs, and services to prevent the onset of illegal drug use, prescription drug misuse and abuse, alcohol misuse and abuse, underage alcohol and tobacco use.

- **Specialty Care Division**—develops, implements and ensures sustainability of specialized and evidence-based behavioral health programs for adults, adolescents, transition-aged youth, children and their families, and new grant funded initiatives that impact the well-being of individuals and communities. This division includes the Community-Based Services Branch and a New Initiatives Branch.
 - **Community-Based Services Branch**— oversees development, implementation and monitoring of community-based mental health and substance use disorders services including evidenced-based and promising practices, to address the needs of adults, children, youth and their families.
 - **New Initiatives Branch**—provides overall technical direction and administration of a broad range of grant-funded projects and other new initiatives, tracks and monitors their progress and outcomes, and makes recommendations on their integration into the agency and full-scale implementation.

- **Linkage & Assessment Division**—provides community-based mental health and substance use disorder screening, assessments, and referrals for adults, children, youth and families, ensuring they have easy access to a full continuum of quality behavioral health services and supports. It includes the Assessment Center Branch, the Co-Located Program Branch, and the Psychiatric Residential Treatment Facility Branch.
 - **Assessment Center Branch** — provides the Superior Court of the District of Columbia with court-ordered, high-quality, comprehensive, culturally competent mental health consultation, and psychological and psychiatric evaluations for children and related adults with involvement in child welfare, juvenile justice and family court.
 - **Co-Located Programs Branch**—oversees the co-location of DBH clinicians at various District government agency and community-based sites who conduct behavioral health screenings, assessments and consultations, and make referrals to the behavioral health provider network.
 - **Psychiatric Residential Treatment Facility Branch**—provides centralized coordination and monitoring of placement, continued stay, and post-discharge of children and youth in psychiatric residential treatment facilities (PRTF), and oversees the coordination of the PRTF medical necessity review process.

- **Housing Development Division**—develops housing options and administers associated policies and procedures governing eligibility, access to housing, and issuance of vouchers for eligible individuals enrolled with DBH; monitors providers' compliance with contracts and provides technical assistance to providers on the development of corrective action plans; develops and monitors any Memorandum of Understanding or grant agreements related to housing development and funding of housing vouchers.

- **Residential Support Services & Care Continuity Division**—manages the housing program to support consumers based on housing needs and required level of support; provides referrals to landlords; assures properties are inspected and approved; monitors service provision according to individualized clinical treatment



plans; assures coordination and resolves problems among landlords, tenants, and providers, and conducts regular reviews to transition ready individuals to more independent housing of their choice.

CONSUMER AND FAMILY AFFAIRS ADMINISTRATION

The Consumer and Family Administration promotes and protects the rights of individuals with behavioral health disorders; encourages and facilitates consumer and client and family leadership of treatment and recovery plans, and ensures consumer and client voice in the development of the behavioral health system. The Administration also promotes consumer and client leadership, manages the peer certification training, and provides expertise on the consumer and client perspective. This Administration is made up of the following teams: Peer Support, Consumer Engagement, Consumer Rights, Quality Improvement and Saint Elizabeths.

SYSTEMS TRANSFORMATION ADMINISTRATION

*When you're
finished
changing,
you're finished.*
Ben Franklin

The Systems Transformation Administration conducts research, analysis, planning and evaluation leading to defined individual, service and system outcomes; works to improve efficiency and collaboration among internal and external partners; develops and implements learning opportunities to advance system change, and greater effectiveness of the service delivery system.

The Systems Transformation Administration uses information systems and data to develop a transformational strategic plan as well as programmatic regulations, policies, and procedures to support the DBH mission. The Administration includes functions of the former Provider Relations, Information Technology and Applied Research and Evaluation, and the Office of Strategic Planning, Policy and Evaluation. The Administration is made up of the following:

- **Office of System Transformation**—leads the development and implementation of programmatic, organizational, and system change management process, and manages the grant process.
- **Information Systems Innovation & Data Analytics Division (ISIDA)**—provides and maintains high-quality hardware and software applications that support the provision and monitoring of consumer and client services. It also produces and analyzes data for decision-making. This division is made up of the Data and Performance Management Branch, Information Systems Support Branch, and Technology Infrastructure Branch.

- **Data & Performance Management Branch** —meets the agency’s data reporting and analysis needs by working with staff to identify what information is needed, creating reports and dashboards that presents and makes the information accessible, and helping staff understand what the information means and how it can be used to improve performance.
 - **Information Systems Support Branch**—ensures continuity of operations and continual improvement of existing practice management, billing software applications, electronic health record applications and other systems, and provides business analysis support for new systems.
 - **Technology Infrastructure Branch** —manages the agency’s technical support systems, including server maintenance; maintains asset inventory, and provides multi-functional device support and management.
- **Strategic Management and Policy Division**—develops programmatic regulations, policies and procedures to support the agency’s mission and manages the Performance Plan and Performance Accountability Report.
 - **Network Development Division**—monitors and provides technical assistance to individual providers and the provider network on emerging clinical, care coordination, administrative and organizational issues to ensure and enhance the provision of services. Supports the development of new providers interested in certification.
 - **Training Institute Division** —enhances the knowledge and competencies of the DBH provider network and internal and external customers through performance-based and data-driven learning environments.

SAINT ELIZABETHS HOSPITAL

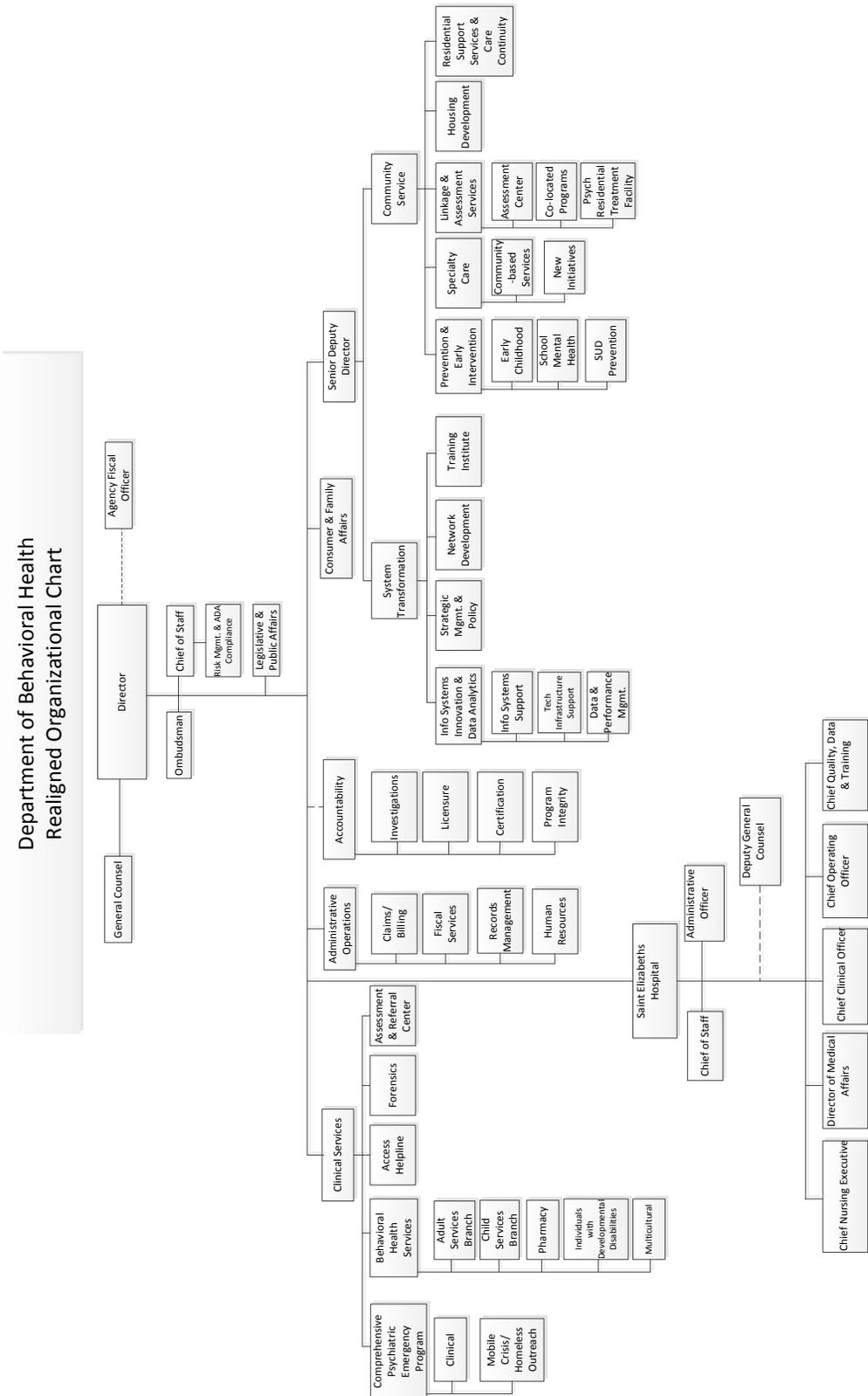
Saint Elizabeths Hospital provides inpatient psychiatric, medical, and psycho-social person-centered treatment to adults to support their recovery and return to the community. The Hospital’s goal is to maintain an active treatment program that fosters individual recovery and independence as much as possible. The Hospital is licensed by the District’s Department of Health and meets all the conditions of participation promulgated by the federal Centers for Medicare and Medicaid Services. Saint Elizabeths is made up of the following:

- **Office of the Chief Executive** – provides overall executive management and leadership for all services and departments of Saint Elizabeth.
- **Office of the Director of Medical Affairs**—provides the clinical, operational, strategic, and cultural leadership necessary to deliver care that is high- value (in terms of cost, quality and patient experience) to support their recovery and reintegration into the community.

- **Chief Clinical Officer** – provides clinical leadership and interdisciplinary treatment teams; ensures the provision of social work services, treatment programs, rehabilitation services, utilization review, and volunteer services
- **Nursing Services** – provides active treatment and comprehensive, high-quality 24 hour nursing care through a recovery-based therapeutic program; establishes the training curriculum for all levels of hospital staff and ensures compliance with training programs for clinical and clinical support staff to maintain the health and safety of patients and staff
- **Office of the Chief of Staff**- primarily responsible for the organization, ongoing management and oversight of key Hospital administrative functions; regularly interacts and coordinates with medical staff and executive leadership, and serves as liaison with external partners including the Department of Corrections, DC Superior Court, and the District of Columbia Hospital Association.
- **Quality and Data Management** – provides quality improvement utilizing performance improvement techniques; uses data and research to guide clinical practices, provides oversight of reporting functions; and manages the reporting functions from the electronic medical record.
- **Office of the Chief Operating Officer** - provides the operational, strategic, and cultural leadership necessary to plan, direct and manage major administrative functions. This ensures the provision of high quality services while also meeting the needs of individuals in care and external stakeholders. The Chief Operating Officer regularly interacts and coordinates with finance, information systems, human resources, performance improvement, and risk management.
- **Engineering and Maintenance** provides maintenance and repairs to ensure a functional, safe, and secure facility to maximize the benefits of the therapeutic environment.
- **Fiscal and Support Services** -- provides for the formulation, execution, and management of the Hospital's budget, billing and revenue operations; approves and finances all requests for procurements; and oversees the overall financial integrity of the Hospital to ensure the appropriate collection, allocation, utilization and control of resources.
- **Housekeeping** – maintains a clean and sanitized environment to enhance the therapeutic environment and level of clinical performance.
- **Materials Management** – receives and delivers materials, supplies, and postal and laundry services; maintains an inventory of goods, replenishes stock, and performs electronic receiving for all goods and services.
- **Nutritional Services** – provides optimum nutrition and food services, medical nutrition therapy and nutrition education services in a safe and sanitary environment.

- **Security and Safety** – provides a safe and secure facility for patients, visitors, and staff to support a therapeutic environment.
- **Transportation and Grounds** – manages the resources, administrative functions, contracts, and personnel; provides transportation and maintenance services including solid and medical waste disposal, and snow and ice removal.

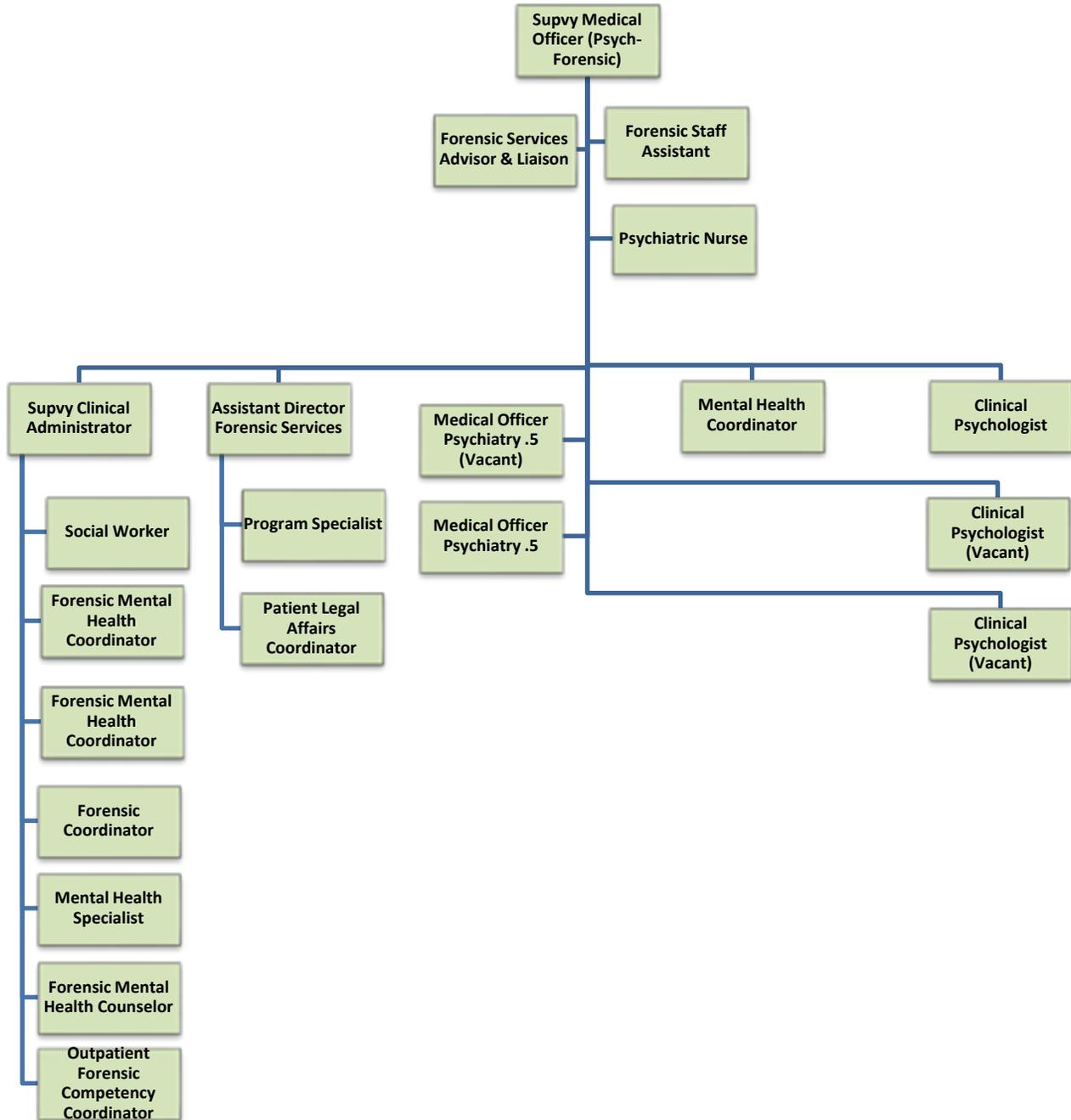
DBH Organizational Chart



Department of Behavioral Health
March 2017

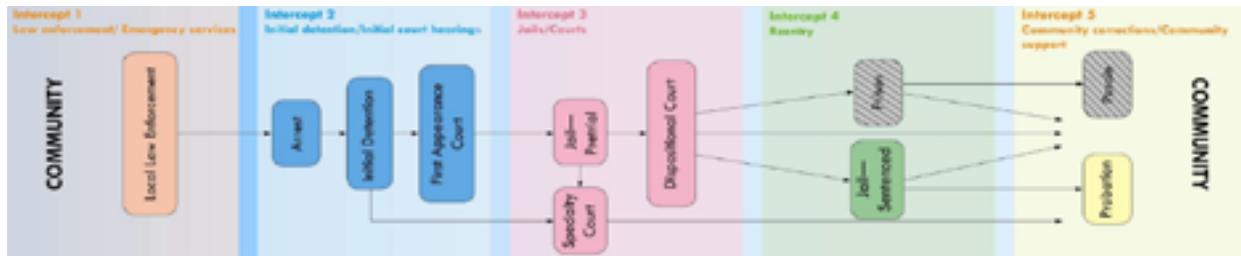
DFS Organizational Chart

Forensics Division Organizational Chart (Current)



DBH Justice-Involved Work at a Glance

Sequential Intercept Model



The Sequential Intercept Model divides the criminal justice system into five “intercepts,” or points for intervention.

The Sequential Intercept Model (SIM) is a tool used to assess community resources, determine gaps in services, and develop plans for coverage, and has been frequently used to map other systems’ interactions with criminal justice systems. In 2016, the DBH commissioned Policy Research Associates, Inc. to assess the resources and gaps in services vis-à-vis the Department’s interactions with the criminal justice system.

A traditional SIM map (pictured above) divides the criminal justice system into five “intercepts”: (1) law enforcement and emergency services; (2) initial detention and initial court hearings; (3) jail/courts; (4) re-entry; and (5) community corrections/community support.

DBH Forensic Work across Intercepts

Division of Forensic Services (DFS).¹ DFS “provides and oversees the continuum of behavioral health and other services for justice-involved individuals from pre-arrest to post-incarceration to ensure their successful return to the community.” The DFS oversees or is intimately involved with many of the programs outlined below. DFS provides direct services through its Forensic Outpatient Department and the Outpatient Competency Restoration Program, both of which are explained below.

Core Service Agencies (CSA). DBH does not directly provide most community-based services. CSAs are DBH-certified mental health agencies that provide the four “core services” of DBH’s Mental Health Rehabilitative Services (MHRS) Program. The four core services are: (1) medication and somatic treatment, (2) counseling and psychotherapy, (3) community support, and (4) diagnostic and assessment services.² CSAs also provide a variety of other community-based services but are not required by DBH to do so. For example, many CSAs provide services for people with substance use disorders (SUD), but DBH does not require them to do so. CSAs provide services to justice-involved individuals throughout the criminal justice system, including while incarcerated. CSAs may house intensive mental health services, such as DBH-certified Assertive Community Treatment (ACT) teams, to which DBH liaison staff (described below) often refer high-need forensic consumers.³

ASARS. DBH also certifies community-based providers to administer services for people with substance use disorders (SUDs) through the Adult Substance Abuse Rehabilitative Services (ASARS) Program. ASARS-certified agencies might provide such services as medication-assisted treatment, case management, and

¹ Program descriptions hereinafter are pulled from Department of Behavioral Health, *Employee Realignment Implementation Guide* (2017).

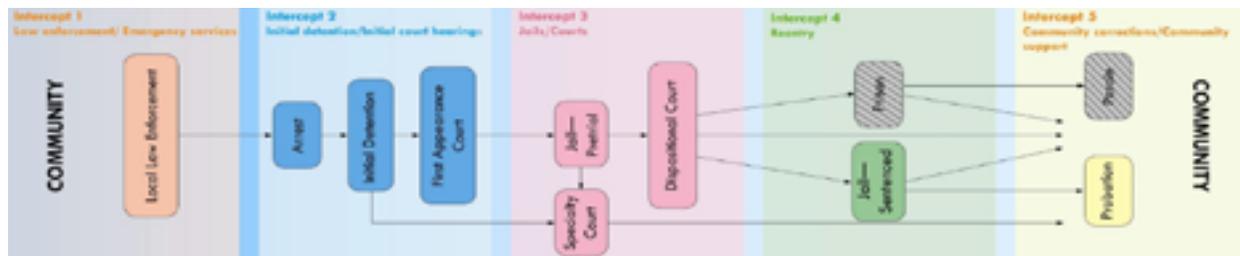
² DBH, *MHRS Services* (n.d.), available at <https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/MHRSServices.pdf>.

³ ACT Teams provide “intensive, rehabilitative, treatment and community-based service[s]... to adults with serious and persistent mental illness. ... Service coverage by the ACT team is required to have specific program hours but to be available for crisis services 24 hours per day, seven days per week. At least [60 percent] of services are required to be provided to the consumer in non-office settings in the community.” DBH, *Provision of Assertive Community Treatment to MHRS Adult Consumers*, DBH Policy 340.6 (May 8, 2014), available at https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/340.6%20TL-248_0.PDF. ACT consumers are frequently high-need forensic consumers, such as people who have been released from SEH. The average annual cost per consumer for ACT services in FY 16 was \$10,091, with 2,246 adults enrolled in the same FY, see, https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/MHEASURES%20January%202017_0.pdf.

prevention education, among many more. ASARS providers are not required to provide mental health services, but community-based service providers will often offer both mental health and SUD treatments at the same location. ASARS providers, like CSAs, serve people throughout the continuum of the criminal justice system.

DBH at Intercept 1:

Law Enforcement, Emergency and Referral Services



Comprehensive Psychiatric Emergency Program (CPEP) Division

CPEP provides emergency mental health services to adults, including immediate and extended observation care to people in crisis. CPEP also provides limited community services and assists in the District’s annual cold weather alert response plan.

- **Psychiatric Emergency Services Branch.** Multi-disciplinary emergency psychiatric services are provided to people who present voluntarily or involuntarily (i.e., through the involuntary commitment process) at CPEP’s 19-bed facility on the campus of the old D.C. General Hospital.

People can be held at CPEP for up to 72 hours, and are then released to the community or transferred to a DBH-contracted hospital for further observation. DBH staff reported that seventy percent of people are brought to CPEP involuntarily, with the number of admissions spiking during the winter when the police and others are more aggressively checking for people who are sleeping outside in freezing temperatures.

- **Mobile Crisis/Homeless Outreach Branch.** The Mobile Crisis team provides crisis intervention and stabilization services for people in the community who are unwilling or unable to be transported to the CPEP facility. The Mobile Crisis team will connect people to DBH services, and provide psychoeducation, treatment compliance support, and grief and loss services to people who may have experienced a traumatic event. The Homeless Outreach team works to connect individuals and families with DBH services in the community, and assists in D.C.’s encampment protocol.

Both teams have staff that are authorized to detain people involuntarily pursuant to D.C. Code § 21-501 *et seq.*

Access HelpLine Division. Staffed by licensed clinicians (nurses and social workers), the Access HelpLine provides 24-hour telephonic crisis services, such as suicide prevention and other counseling services as appropriate. The Helpline also enrolls people in DBH-funded services and authorizes units and durations of certain services based on clinical review of DBH’s medical necessity criteria and DBH/CSA capacity limits.

Assessment and Referral Center (ARC) Division. The ARC assesses and refers people seeking treatment for SUD to appropriate services, including detoxification, inpatient rehabilitation, medication assisted treatment (e.g., methadone treatment), or outpatient SUD treatment or rehabilitation programs. The ARC has a mobile unit that also provides assessment and referrals in the community, as well as HEP-C and HIV testing.

Crisis Intervention Officer (CIO) training. DBH provides a comprehensive 40-hour training to MPD officers on a volunteer basis with the purpose of ensuring the “safety of officers and consumers and diver[ting]

nonviolent mentally ill offenders away from the criminal justice system.”⁴ The training includes modules on an array of topics, such as co-occurring disorders, legal issues and mental health law, de-escalation through active listening, and homelessness and mental illness.

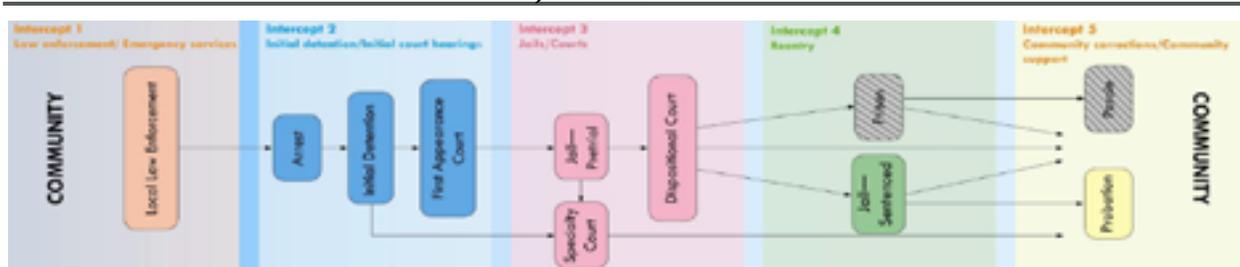
DFS and CPEP staff specifically provide training on the FD-12 process in the CIO program. Additionally, DFS liaises with CPEP to administer the biannually required FD-12 officers/agent training to MPD staff and physicians. DBH staff reported to CCE that there are about 120 officers/agents certified to initiate the FD-12 process. DBH also provides a less intensive training on mental health and substance use – called “CIT light” by some – to all new MPD recruits while they are enrolled in the Police Academy.

Pre-arrest diversion. In FY 2018, DBH and MPD began collaboration on a mental health pre-arrest diversion program. The program was funded for nearly \$1 million and will “support individuals in crisis due to problems associated with substance abuse, mental health, and homelessness.”⁵ The program intends to satisfy the requirements of Section 105 of the Neighborhood Engagement Achieves Results (NEAR) Act – the Community Crime Prevention Team Program. However, the program will be structured differently from what is outlined in the NEAR Act, with what DBH staff and stakeholders reported they hope will look more like the Law Enforcement Assisted Diversion (LEAD) model, which has been successfully implemented in cities such as Seattle and Santa Fe.⁶

Jail diversion. DBH contracts with two community service providers to operate jail diversion programming for people with serious and persistent mental illnesses who are likely to be involved with the criminal justice system. N Street Village has contracted with DBH to administer this programming for several years. MBI assumed the jail diversion contract previously held by Green Door. The D.C. Council approved funding for an additional program vendor for FY 2018. However, while titled “jail diversion,” DBH staff and stakeholders explained to CCE that the program is more geared towards people returning from prison or jail. Indeed, program contracts reviewed by CCE include re-entry services as a primary focus in the consumer eligibility criteria.

DBH at Intercepts 2 and 3:

Jail and Courts



DBH at Department of Corrections (DOC) facilities. DBH clinicians are co-located at the Central Detention Facility (CDF or “the D.C. Jail”) and the Central Treatment Facility (CTF) to identify people enrolled in services with a DBH-funded mental health provider. DBH will notify the provider of the person’s incarceration and will try to coordinate visits with the provider at the jail. If a person receives services at the jail but is not currently linked to a community provider, DBH will enroll the person in services before release and follow up to see if the appointment was kept.

Urgent Care Clinic at the D.C. Superior Court. DBH contract staff co-located at the court provide evaluation and referral services for pre-trial individuals who exhibit behavioral health needs while in the courthouse. Staff may also provide urgent treatment when necessary. D.C. is one of the few jurisdictions in the country with on-site behavioral health services in the courthouse.

⁴ DBH & MPD, Crisis Intervention Officer Program, *Introduction to the Crisis Intervention Officer (CIO) Program* (n.d.).

⁵ Committee on the Judiciary and Public Safety, *Report and Recommendations of the Committee on the Judiciary and Public Safety on the Fiscal Year 2018 Budget for Agencies under Its Purview*, 138 (2017), available at http://dccouncil.us/files/user_uploads/budget/judiciary_final.pdf.

⁶ For more information on LEAD programs, see generally, <https://www.leadbureau.org>.

Mental Health Community Court (MHCC). A post-arrest and probation specialty court that “focuses on criminal defendants [with misdemeanors or low-level felony offenses] diagnosed with a serious and persistent mental illness, or with mental illness and co-occurring substance use disorders.”⁷ The U.S. Attorney’s Office for D.C. determines a defendant’s eligibility to participate in the program. Once in the program, DBH and CSA staff liaise with community supervision officers from the Pre-Trial Services Agency (PSA) and Court Services and Offender Supervision Agency (CSOSA). Defendants who complete the program outlined for them are eligible for deferred prosecution and/or deferred sentencing, which may result in reduced or dismissed charges. At this time, DBH does not have a similar presence in the Superior Court’s Drug Intervention Program (“Drug Court”).

Competency Evaluation, Restoration and Maintenance, and “Jacksons”

Competency evaluations. The court will order defendants whose competency to stand trial is in question to undergo one or more competency evaluations. These may be conducted on an inpatient or outpatient basis. Saint Elizabeths Hospital (SEH) administers inpatient evaluations, while DFS evaluators can do outpatient evaluations at the D.C. Jail, at the D.C. Superior Court, or while the patient is enrolled in the Outpatient Competency Restoration Program at DBH’s outpatient clinic.

Competency restoration. If a defendant is determined to be incompetent to stand trial, the court will order the defendant to participate in one of DBH’s competency restoration programs. These programs are also offered both inpatient and outpatient, with the inpatient program at SEH and the outpatient program at DBH’s outpatient clinic. Limited, short-term competency restoration is offered at the D.C. Jail for defendants waiting three or more days for transfer to SEH. For defendants with misdemeanors and certain low-level felony charges, the competency restoration process may not exceed 180 days.⁸ The court may order defendants charged with a crime of violence to undergo longer periods of competency restoration treatment as the court finds necessary.⁹

SEH competency waitlist at DOC. Due to bed space issues for pre-trial statuses at SEH, defendants who have been ordered to receive inpatient competency evaluations and restoration have been waitlisted for admission and held at the D.C. Jail. Waitlisted defendants are kept in the jail’s mental health units where they receive appropriate medication and treatment. In mid-October 2017, defendants waitlisted for more than three days began receiving competency restoration services on-site administered by the DBH Jail liaisons while they continue to await transfer to SEH.

Competency maintenance. Occasionally, the court may order the defendant to participate in DBH’s competency restoration programming to maintain competence throughout the defendant’s legal proceedings. The court is more likely to order defendants who have a history of cycling in and out of competence to a competency program for maintenance. Like other programs, maintenance can be done both inpatient and outpatient.

Jacksons¹⁰. These are defendants who have been opined incompetent to stand trial and not likely to regain competency in the foreseeable future. Depending on the charge and the person’s risk to self or others, the government may release the defendant and dismiss the charges, or petition for civil commitment. In the event of the former, the government cannot force the *Jacksoned* person to receive mental health treatment. In the event of the latter, the court may order the defendant to receive inpatient or outpatient treatment until the completion of civil commitment proceedings.¹¹

⁷ District of Columbia Superior Court Mental Health Community Court (MHCC) Case Management Plan, 1-2, available at <http://www.dccourts.gov/internet/documents/MentalHealthCommunityCourtCaseManagementPlan.pdf>.

⁸ See D.C. Code § 24–531.05

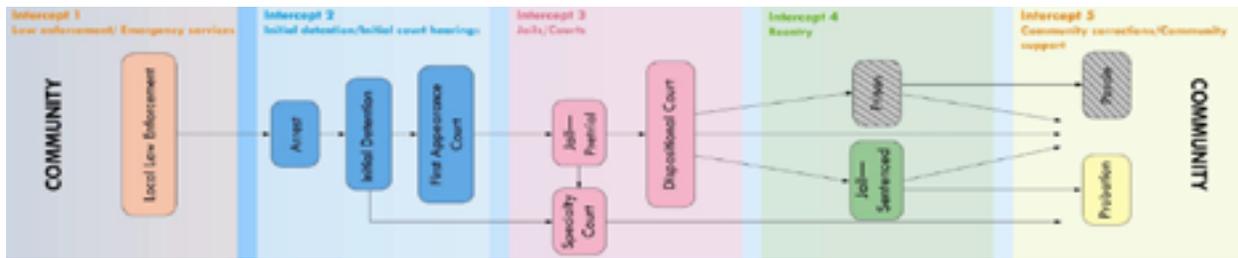
⁹ *Id.* at (c).

¹⁰ “Jackson” is a colloquial term used by behavioral health professionals to refer to the 1972 Supreme Court decision, *Jackson v. Indiana* (406 U.S. 715), holding that the state cannot constitutionally commit someone indefinitely because they are incompetent to stand trial on the charges. “Such a defendant cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain competency in the foreseeable future. If it is determined that he will not, the State must either institute civil proceedings applicable to the commitment of those not charged with a crime, or release the defendant.”

¹¹ See D.C. Code § 34–231.06.

DBH at Intercepts 4 and 5:

Commitment, Incarceration, Re-entry and Community Supports



DBH staff at DOC and CSOSA. DBH staff co-located at the D.C. Jail and CTF are responsible for connecting consumers with community-based mental health services upon release. DBH’s Prison Re-entry Liaison Coordinator, co-located at CSOSA, is responsible for enrolling in community behavioral health and other services D.C. Code offenders who are to be released from Federal Bureau of Prisons (BOP) facilities throughout the country. The coordinator will teleconference with people incarcerated in BOP facilities to identify the services they might need. The coordinator, in concert with CSOSA, will also visit BOP facilities throughout the country to “facilitate integrated care for returning citizens” and is responsible for following up with people with severe and persistent mental illnesses. The coordinator also participates in hearings with the U.S. Parole Commission when needed.

Civil commitment reviews. In the case of people who have been civilly committed – either inpatient at SEH or outpatient to DBH in the community – some of the responsibilities for their care fall within the purview of the DFS. Staff at SEH and DFS staff at the outpatient clinic oversee the process of producing quarterly and annual reports on a civilly committed individual’s progress vis-à-vis compliance with mental health treatment and overall mental health status, referred to as “Streicher Monitoring.” There are many routes a person might take towards civil commitment; frequently, *Jacksoned* individuals and people treated at CPEP are civilly committed.

Post-trial forensic consumers at SEH¹². There are three “post-trial” statuses at SEH:

- Not guilty by reason of insanity (NGRI) – legal status designation of a person found by the court to be not responsible for a crime due to mental illness
- Dual commitment – people with a criminal conviction and NGRI status
- Sexual Psychopath (Miller Act) – a person adjudicated by the court as someone who is not insane but whose repeated sexual misconduct has resulted in a lack of power or control of his or her sexual impulses, and, as a result, whose danger to others requires indefinite commitment to a psychiatric hospital.

Forensic Outpatient Department (FOPD). Located at DBH’s outpatient clinic, the FOPD provides services for all NGRI acquittees who have been conditionally released from SEH after “adequate recovery from their mental illness,”¹³ which includes monitoring compliance with those conditions, providing direct care to some consumers, and liaising with CSAs as needed.

¹² See Michele Godwin, *Principles of Forensics* [PowerPoint training for new staff] (n.d.). (provided to CCE in a document request from DBH.)

¹³ Division of Forensic Services, *Services for residents with Mental Illnesses in the Criminal Justice System* (programmatic information provided to CCE from DFS), 2.

Proposed Legislative Amendments

This appendix provides proposed language for some of the legislative amendments recommended throughout this report. The proposed language is provided in redline.

D.C. Code § 24-531.01. Definitions.

For the purposes of this chapter, the term:

- (1) “Competence” means that a defendant has sufficient present ability to consult with his or her lawyer with a reasonable degree of rational understanding and has a rational, as well as a factual, understanding of the proceedings against him or her.
- (2) “Court” or “Superior Court” means the Superior Court of the District of Columbia.
- (2A) “DDS” means the Department on Disability Services.
- (3) “Defendant” means a defendant in a criminal case or a respondent in a transfer proceeding.
- (4) “DMH” means the Department of Mental Health.
- (5) “Incompetent” means that, as a result of a mental disease or defect, a defendant does not have sufficient present ability to consult with his or her lawyer with a reasonable degree of rational understanding or does not have a rational, as well as a factual, understanding of the proceedings against him or her.
- (6) “Inpatient treatment facility” means:
 - (A) Saint Elizabeths Hospital;
 - (B) Any other physically secure hospital for the examination or treatment of persons with mental illness; or
 - (C) Any physically secure or staff-secure facility for the examination, treatment, or habilitation of persons with intellectual disabilities.
- (7) Repealed.
- (8) “Qualified psychiatrist” means a person who is licensed to practice medicine under the laws of the District of Columbia, who has completed a residency in psychiatry, and who has forensic training and experience.
- (9) “Qualified psychologist” means a person who is licensed to practice psychology under the laws of the District of Columbia, and has (1) year of formal forensic training within a hospital setting; or (2) two years of supervised forensic experience in an organized health care setting, one of which must be post-doctoral.
- (8) (10) “Transfer proceeding” means a proceeding pursuant to § 16-2307 to transfer a respondent who is alleged to be a delinquent in a juvenile case from the Family Court to the Criminal Division of the Superior Court of the District of Columbia to face adult criminal charges.
- (9) (11) “Treatment” means the services or supports provided to persons with mental illness or intellectual disabilities, including services or supports that are offered or ordered to restore a person to competence, to assist a person in becoming competent, or to ensure that

a person will be competent.

~~(10)~~ (12) “Treatment provider” means:

- (A) The Department of Mental Health;
- (B) The DDS;
- (C) An inpatient treatment facility as defined in paragraph (6) of this section; or
- (D) Any other entity or individual designated by the DMH or DDS to provide evaluation, examination, treatment, or habilitation pursuant to this chapter that:
 - (i) Is duly licensed or certified under the laws of the District of Columbia to provide services or supports to persons with mental illness or intellectual disabilities, or both; and
 - (ii) Has entered into an agreement with the District to provide mental health services or mental health supports or to provide services or supports to persons with intellectual disabilities.

D.C. Code § 24-531.03. Competence examinations.

(a) At any time after the prosecutor moves for a transfer from the Family Court to the Criminal Division of the Superior Court or charges a criminal offense by complaint, information, or indictment, either party may request, or the court on its own may order, that the defendant be examined to determine the defendant’s competence.

(b) When the issue of a defendant’s competence has been raised, the court shall order a preliminary screening examination before ordering a full competence examination pursuant to subsection (d) of this section.

(c)(1) A preliminary screening examination shall be performed either in the courthouse or on an outpatient basis by a qualified psychiatrist or qualified psychologist affiliated with the Department of Mental Health.

(2) The court shall schedule a return date or time for the defendant as early as possible following the order for the preliminary screening examination issued pursuant to subsection (b) of this section. In no case shall the return date be more than 3 business days after the order if the defendant is not released and no more than 5 business days after the order if the defendant is released.

(3) The examination shall be completed and a report submitted to the court in advance of the return date or time. The report shall indicate whether the defendant is competent, incompetent, or whether further evaluation is needed.

(4) The court shall consider the report of the preliminary screening examination, any arguments made by the parties, and any other information available to the court, and shall either:

(A) Find the defendant competent and resume the criminal case or transfer proceeding; or

(B) Order the defendant to submit to a full competence examination.

(d)(1) An order for a full competence examination pursuant to subsection (c)(4)(B) of this section shall direct the Department of Mental Health to examine the defendant. The full competence examination shall be performed by a **qualified** psychiatrist or **qualified** psychologist affiliated with the Department of Mental Health.

(2) The Department of Mental Health shall submit a written report to the court as to the

defendant's competence.

(3) Any psychiatrist or psychologist who participated in the examination shall be available to testify at any hearing involving the defendant's competence.

(e) A full competence examination may be conducted on an inpatient or outpatient basis. The court may order the defendant committed to Saint Elizabeths Hospital or to the Department of Mental Health for an inpatient examination only after a finding by the court that:

(1) Placement in an inpatient treatment facility is necessary in order to conduct an adequate examination; or

(2) The defendant is unlikely to comply with an order for an outpatient examination.

(f)(1) If the court orders the defendant committed as an inpatient for a full competence examination under subsection (e) of this section, the commitment for examination shall not exceed 30 days, except that the commitment may be extended for a 15-day period for good cause shown.

(2)(A) The Department of Mental Health shall submit a written report to the court:

(i) As soon as it reaches a conclusion that the defendant is competent or is incompetent; or

(ii) Any time it determines that the criteria for an inpatient examination set forth in subsection (e) of this section are no longer met.

(B) If the defendant is reported incompetent, the report shall include an opinion regarding the likelihood of the defendant's attaining competence in the foreseeable future or should state that no opinion has been formed on the likelihood of the defendant attaining competence.

(C) If a report indicates that the criteria for an inpatient examination set forth in subsection (e) of this section are no longer met, the court shall make new findings under subsection (e) of this section and, if it determines that the examination can be conducted on an outpatient basis, shall determine the defendant's eligibility for pretrial release pursuant to subchapter I of Chapter 23 of Title 16 or subchapter II of Chapter 13 of Title 23, if it has not previously done so. If necessary, the court may enter a new order for a full competence examination to be completed on an outpatient basis.

(D) If the court receives either report required under subparagraph (A) of this paragraph more than one court day prior to the scheduled return date, the court shall have the defendant brought before the appropriate judge on the next court day following receipt of the report for appropriate proceedings under § [24-531.04](#).

(g)(1) If the court orders a full competence examination to be conducted on an outpatient basis, it shall be completed and a report submitted to the court in advance of the defendant's return date as determined under § [24-531.04](#)(a).

(2) The Department of Mental Health shall submit a written report to the court at any time it determines that the criteria for an inpatient examination set forth in subsection (e) of this section are met. If the court receives such a report, it shall schedule the matter for a hearing as soon as practicable, to determine the appropriate disposition under subsection (e) of this section.

D.C. Code § 24-531.06. Court hearings during and after treatment.

(a) The Court shall hold a prompt hearing, with reasonable notice of such hearing given to the prosecuting attorney, the defendant, and the defendant's attorney of record, and make a new finding as to the defendant's competence when:

- (1) Any period of treatment ordered under § 24-531.05(b), (c), or (e) is completed; or
- (2) The treatment provider reports to the court that reasonable grounds exist to believe that:
 - (A) An incompetent defendant has attained competence;
 - (B) There is no longer a substantial probability that a defendant will attain competence during the allowable treatment period;
 - (C) If the defendant is committed to an inpatient treatment facility, such commitment is no longer the least restrictive setting considering the factors in § 24-531.05(a); or
 - (D) If the defendant has been ordered to undergo competence treatment on an outpatient basis, such a setting is no longer appropriate considering the factors in § 24-531.05(a).

(b) In advance of any hearing held pursuant to subsection (a) of this section, the treatment provider shall submit a written report to the court addressing:

- (1) The defendant's competence, including any progress or lack thereof made toward attaining competence;
- (2) Whether there is a substantial probability that the defendant will attain competence during the foreseeable future, or make substantial progress toward that goal;
- (3) If the defendant is committed to an inpatient facility, whether such commitment remains the least restrictive setting considering the factors in § 24-531.05(a); and
- (4) If the defendant has been ordered to undergo treatment on an outpatient basis, whether such a setting is no longer appropriate considering the factors in § 24-531.05(a).

(c)(1) At the conclusion of a hearing held pursuant to subsection (a) of this section, the court shall:

- (A) Find that the defendant is competent; or
- (B) Find that the defendant is incompetent and:
 - (i) There is a substantial probability that the defendant will attain competence or make substantial progress toward that goal with an additional period of time; or
 - (ii) There is no substantial probability that he or she will attain competence or make substantial progress toward that goal in the foreseeable future.

(2) If the court finds the defendant is competent, it shall order the criminal case or transfer proceeding to be resumed.

(3) If the court finds the defendant competent, it may order additional treatment in the least restrictive setting consistent with the goal of maintaining competence during the course of the defendant's criminal case.

(4) The court may order inpatient treatment if it finds that:

(A) Placement in an inpatient treatment facility setting is necessary in order to provide appropriate treatment for the maintenance of competency; or

(B) The defendant is unlikely to comply with his or her treatment regimen as to remain competent.

~~(4)~~ (5) If the court finds the defendant is incompetent pursuant to paragraph (1)(B)(i) of this subsection, the court shall order treatment for an additional period of time in accordance with § 24-531.05(b), (c), or (e), after making a finding as to the least restrictive placement for treatment pursuant to § 24-531.05(a).

~~(5)~~ (6) If the court finds the defendant is incompetent pursuant to paragraph (1)(B)(ii) of this subsection, the court shall either order the release of the defendant or, where appropriate, enter an order for treatment pursuant to § 24-531.05(a) for up to 30 days pending the filing of a petition for civil commitment pursuant to subchapter IV of Chapter 5 of Title 21 or subchapter IV of Chapter 13 of Title 7. The court also may order treatment pursuant to § 24-531.07(a)(2) for such period as is necessary for the completion of the civil commitment proceedings.

Glossary of Acronyms

ACT	Assertive Community Treatment
APA	American Psychological Association
APRA	Addiction Prevention & Recovery Administration
ASARS	Adult Substance Abuse and Rehabilitation Service
BOP	Federal Bureau of Prisons
CCB	Central Cell Block
CCE	Council for Court Excellence
CDF	Central Detention Facility
CIC	Corrections Information Council
CIO	Crisis Intervention Officer
CIT	Crisis Intervention Team or Crisis Intervention Training
CJCC	D.C. Criminal Justice Coordinating Council
CPEP	Comprehensive Psychiatric Emergency Program
CRIPA	Civil Rights of Institutionalized Persons Act
CSA	Core Service Agency
CSH	Corporation for Supportive Housing
CSO	Community Supervision Officer
CSOSA	Court Services and Offender Supervision Agency
CSW	Community Support Workers
CTF	Central Treatment Facility
DBH	Department of Behavioral Health
DCBHA	D.C. Behavioral Health Association
DDS	D.C. Department of Disability Services
DFS	Division of Forensic Services
DHCF	D.C. Department of Health Care Finance
DHS	D.C. Department of Human Services
DMH	D.C. Department of Mental Health
DOC	D.C. Department of Corrections
DOJ	U.S. Department of Justice
DRDC	Disability Rights D.C.
EEO	Equal Employment Opportunity
EHR	Electronic Health Record
EOM	Executive Office of the Mayor
FACT	Forensic Assertive Community Treatment
FCS	Forensic Consultation Service
FEMS	Fire and Emergency Medical Services
FFS	Fee-for-Service
FOPD	Forensic Outpatient Department
FRB	Forensic Review Board
FTE	Full-time Employee
FY	Fiscal Year
IOP	Intensive Outpatient Program
JMHCP	Justice and Mental Health Collaboration Program
KPI	Key Performance Indicators

LEAD	Law Enforcement Assisted Diversion
MHCC	Mental Health Community Court
MHEASURES	Mental Health and Substance Use Report on Expenditures and Services
MHRS	Mental Health Rehabilitation Services
MORCA	Mayor's Office of Returning Citizens Affairs
MPD	Metropolitan Police Department
NEAR Act	Neighborhood Engagement Achieves Results Act
NGRI	Not Guilty by Reason of Insanity
OAG	D.C. Office of the Attorney General
OCA	D.C. Office of the City Administrator
OCRCP	Outpatient Competency Restoration Program
OIG	D.C. Office of the Inspector General
OPM	D.C. Office of Performance Management
OVSJG	D.C. Office of Victims Services and Justice Grants
PAR	Performance Accountability Report
PDS	Public Defender Service
PRISM	Performance Related Information for Staff and Managers
PSA	Pre-trial Services Agency for the District of Columbia
RFP	Request for Proposal
RRC	Residential Re-entry Center
SAMHSA	Substance Abuse and Mental Health Services Administration
SEH	Saint Elizabeths Hospital
SIM	Sequential Intercept Model
SMART	System-wide Mental Assessment Response Team
SOAR	SSI/SSDI Outreach, Access and Recovery Program
SOME	So Others Might Eat
SRTC	Secured Residential Treatment Program
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SUD	Substance Use Disorder
TIPS	Transitional Intervention for Parole Supervision
UCC	Urgent Care Clinic
USAO D.C.	U.S. Attorney's Office for the District of Columbia
USPC	U.S. Parole Commission
UVA	University of Virginia