

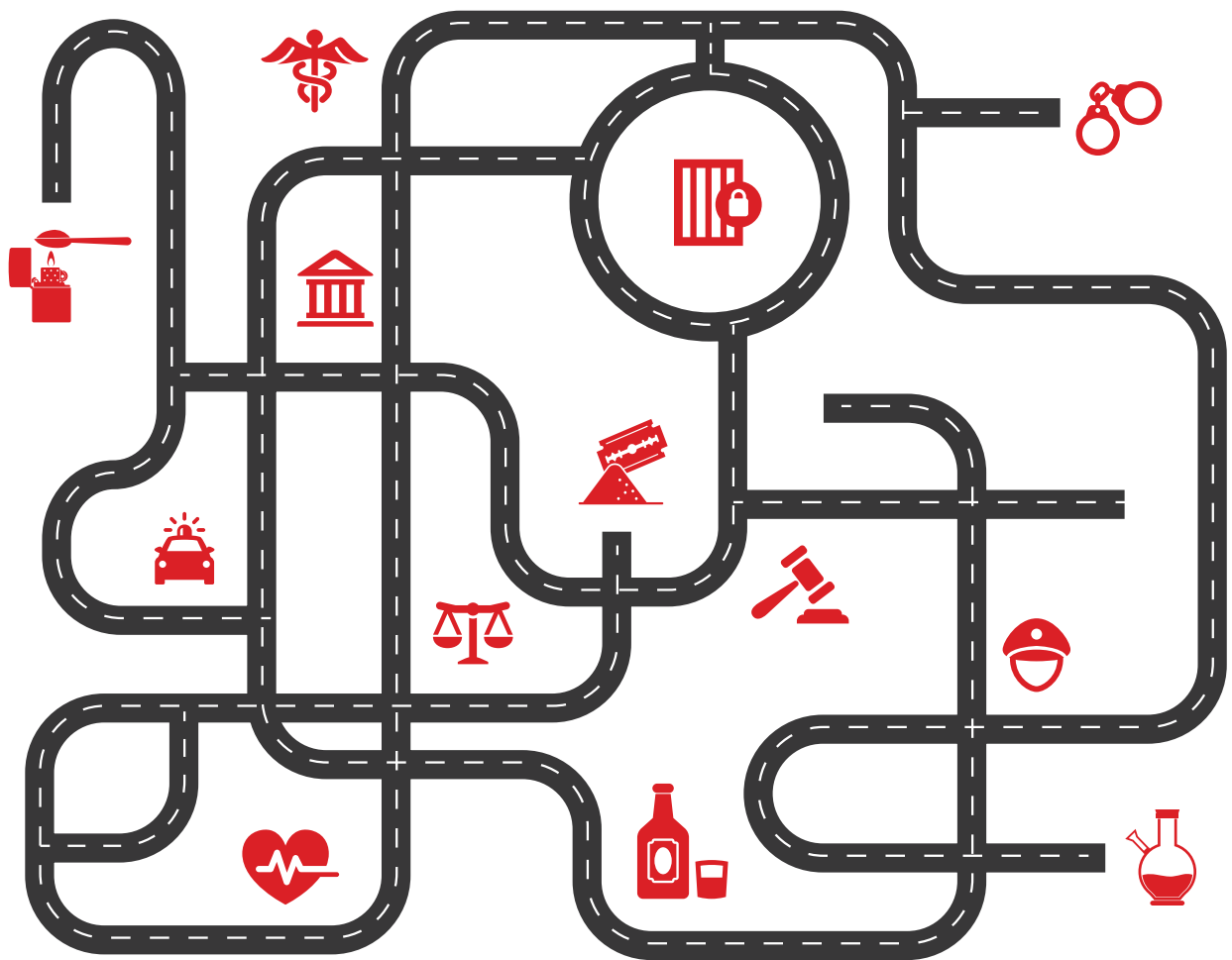
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# *Everything is Scattered...*

## The Intersection of Substance Use Disorders and Incarcerations in the District

August 25, 2020

A report for ODCA from the Council for Court Excellence



# Everything is Scattered... The Intersection of Substance Use Disorders and Incarcerations in the District

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This report, written for ODCA by the Council for Court Excellence, is a first-ever analysis of substance use disorder (SUD) services and incarceration data from D.C. agencies. It highlights the District's successes and challenges in addressing the treatment needs of people who are involved in the criminal justice system. The report includes recommendations for policy and practice change, with the goal of better health and reduced incarceration for D.C. residents.

## ODCA recommends that the District:

- 1** Make D.C.'s pre-arrest diversion pathways more robust to keep people with SUDs out of jail.
- 2** Develop jail entry procedures to identify more people with SUDs.
- 3** Expand SUD treatment in the D.C. Jail.
- 4** Ensure more people get quickly connected to community-based treatment when leaving the jail.
- 5** Legally share information about SUD clients between agencies.
- 6** Set public benchmarks for improved outcomes for this client population and hold the relevant agencies accountable.
- 7** Continue to improve communications with clients, providers, and the public.

**11%**



Residents of D.C. who have a SUD.

**25**



Individuals in 3.5 years who had SUD care before, during, and after their incarceration.

**95%**



Incarceration episodes we analyzed that involved a Black person, compared to the 46% of District residents who are Black.

**40%**



Percentage of the records we evaluated that indicated that an incarcerated individual had a SUD.





August 24, 2020

The Hon. Muriel E. Bowser  
Mayor of the District of Columbia  
The John A. Wilson Building  
1350 Pennsylvania Avenue N.W.  
Washington, DC 20004

The Hon. Phil Mendelson, Chairman  
Council of the District of Columbia  
The John A. Wilson Building  
1350 Pennsylvania Avenue N.W.  
Washington DC 20004

Dear Mayor Bowser and Chairman Mendelson:

I am pleased to present this report, ***Everything is Scattered: The Intersection of Substance Use and Justice-Involvement in the District***, prepared by the Council for Court Excellence (CCE) for the Office of the D.C. Auditor (ODCA), providing a comprehensive review of the District's provision of substance use disorder services (SUDS) to persons involved in the criminal justice system in our community. It represents a first-ever analysis of what the data collected and maintained by District agencies on SUD services can tell us, and highlights both the successes and the long-term challenges in addressing the persistent needs. We include a series of recommendations for policy and practice change, all with the goal of better health and reduced incarceration.

We are pleased to include here a comprehensive and detailed response to the draft report. The Bowser Administration concurs with a majority of our recommendations and provides further description of reforms underway including actions taken after the time period covered in the report such as expansion of the pre-arrest diversion program and adding new leadership expertise at DBH. We particularly appreciate the ongoing commitment to improving cross-agency collaboration and the reminder that building systems to securely share data can be a costly endeavor. The cover letter signed by Deputy Mayors Wayne Turnage and Kevin Donahue notes that the report "affirms that work remains to connect individuals through the system in the community, interactions with the justice system, and by assessments and engagements by our service providers."

This report is the third 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 nearly four decades. 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.

This report builds on our last engagement with CCE published in 2018, **Improving Mental Health Services and Outcomes for All: D.C.'s Department of Behavioral Health and the Justice System**.

That initiative put a spotlight on the critical need for diversion programs in place of incarceration for those with behavioral health disorders and the similarly critical need to connect individuals being released from incarceration to needed community behavioral health services.

We are publishing a companion report, **Lessons From the Life and Death of Alice Carter**, that provides a case study of Alice Carter, a transgender District woman who received SUD services and experienced time incarcerated. Her story is told by Street Sense Media and is largely based on District government documents and social agency staff interviews, providing a very human picture of the policies and practices in place and the challenges in carefully serving those who suffer from substance abuse.

I am pleased that the CCE work helps highlight significant achievements by both DBH and the District's Department of Corrections while also focusing on the long road ahead to improving cross-agency collaborations including the need to better identify a larger proportion of those who would could greatly benefit from treatment while in custody. We look forward to next steps in sharing the findings and recommendations with members of the D.C. Council and the public.

Finally, I want to extend ODCA's appreciation to senior members of the Bowser Administration, and in particular DBH Director Barbara Bazron, DOC Director Quincy Booth, Deputy Mayor for Health and Human Services Wayne Turnage, General Counsel Betsy Cavendish and Deputy General Counsel Karuna Seshasai, as well as members of the Administration's information technology team who worked to provide access to health and public safety data including Mario Field, Data Curation Program Manager, Office of the Chief Technology Officer. My thanks as well to our CCE partners for another productive partnership and for this comprehensive report.

Sincerely yours,



Kathleen Patterson  
Auditor of the District of Columbia

AUGUST 25, 2020

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# *Everything is Scattered...* The Intersection of Substance Use Disorders and Incarcerations in the District

A report by the Council for Court Excellence  
for the Office of the District of Columbia Auditor

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# Note from the Chair

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The Council for Court Excellence (CCE) is pleased to share this audit examining the District's challenges and successes in providing substance use disorder (SUD) services to low-income adults who are eligible for publicly funded health care and are justice-involved in the District. While an important undertaking, a review of these issues is inherently difficult and limited given both the complex mix of local and federal actors included within D.C.'s criminal justice system, and the many different agencies and health care providers involved in the identification of individuals needing SUD services and the referral to, provision, and tracking of SUD services. Despite (or perhaps because of) this large and varied group of stakeholders, no single entity in the District has yet succeeded in ensuring the inter-agency collaboration necessary to assess the full scope of justice-involved individuals needing SUD services or to facilitate system-wide data-sharing and program evaluation. Nevertheless, an examination of the services and programs provided by Department of Behavioral Health (DBH) and the Department of Corrections (DOC) can help us understand what the District does well—in some cases serving as a national leader—and what the District could do better to serve this uniquely vulnerable population.

Our report is based on a tremendous amount of research and data analysis conducted over the past year and a half that explored the ways in which DBH and DOC interacted with SUD consumers and the effectiveness of these interactions. The research included more than 100 interviews with DBH and DOC administrators, SUD clients, community behavioral health providers, community stakeholders and advocates, attorneys and judges, academic experts, and current and former senior officials from other behavioral health agencies around the country. In addition, the research included a SUD practitioner survey, a review of SUD and other behavioral health practices in other jurisdictions, analysis of D.C. statutes and regulations, and a thorough review of DBH and DOC internal documents and data. Finally, this audit is unique because it analyzed an inter-agency, person-level dataset of behavioral health medical claims, arrest records, incarceration records, and overdose deaths. This is the first time that such a dataset has been assembled and used in the District of Columbia to analyze the interrelationship of SUD services, justice-system involvements, and deaths. The audit expands the universe of what is now knowable about SUD clients and their involvement with the justice system, and we hope that the dataset will live on and be used by the District to improve SUD treatment outcomes and reduce justice involvement.

We found that, during a period of significant change, DBH and DOC accomplished much to enhance and expand their provision of SUD services, progress for which they can be justly proud. For instance, DBH is moving from a centralized model for SUD assessments and referrals to care to a “no-wrong-door” model that is considered best practice nationwide. DOC offers state-of-the-art Medication-Assisted Treatment (MAT) to opioid users in its custody. At the same time, however, many areas need improvement.



In particular, DBH and DOC are not yet ensuring continuity of care with respect to the delivery of services to SUD clients before and after incarcerations. In addition, both agencies, as well as other District actors, need to improve inter-agency cooperation, communication, planning, and information sharing to identify the clients who need care or are at risk of being arrested. We recommend that DOC improve the way that it gathers information about its clients' SUD status and that DOC deliver SUD services to all individuals in its custody with SUDs, not just those who need detoxification services or receive MAT for opioid dependencies. DBH should improve the way that it sets, and measures its achievement of goals, and it should continue to build on recent successes in its communication with stakeholders. We also recommend that DBH work with other relevant agencies to expand and improve its pre-arrest diversion services to fulfill the Neighborhood Engagement Achieves Results (NEAR) Act's goal of using public health approaches to prevent violence and reduce incarceration. We hope that this report will provide impetus toward such further improvement.

As chair of the Audit Steering Committee, I wish to express our sincere appreciation to Deputy Mayor for Health and Human Services Wayne Turnage, DOC Director Quincy Booth, DBH Director Barbara Bazron, and their staff members who participated in this process. Finally, I thank the Audit's Steering Committee members 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 D. Hays  
Audit Steering Committee Chair  
CCE Board Director

# Executive Summary

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Throughout the nation, substance use disorders (SUD) have profoundly destructive and far-reaching effects on individuals, families, and communities. The physical, emotional, and economic costs of addiction and dependency, and the associated burdens on the public health and criminal justice systems, are enormous. The District of Columbia is a participant in the pain. According to federal government estimates, more than one in 10 D.C. adults have a SUD. In 2017 alone, the number of lethal overdoses approached 300. Compounding the problem, individuals struggling with addiction and dependency frequently have encounters with and become entangled in the criminal justice system. Many become caught up in the debilitating cycle of repeated trips through the revolving door of arrest, judicial proceedings, incarceration, release, and re-arrest.

Breaking free from that cycle is difficult. Nevertheless, it can be done with appropriate treatment services. In the District of Columbia, three agencies play critical roles in providing and supporting such care: the Department of Behavioral Health (DBH), which is responsible for SUD services in the community; the Department of Corrections (DOC), which has that responsibility in the jails; and the Department of Health Care Finance (DHCF), which is the District's state Medicaid agency and the source of much of the funding for SUD services in the community. In light of the importance of those roles, the Office of the District of Columbia Auditor (ODCA) engaged the Council for Court Excellence (CCE) to review, and make recommendations for improving, the agencies' policies, systems, and procedures for providing SUD services for the District's justice-involved population.

To carry out the ODCA contract, the CCE audit team conducted numerous interviews of current and former DBH and DOC administrators, community and government stakeholders, D.C. Superior Court judges, and practitioners. CCE also interviewed individuals currently receiving community-based SUD services in the District, and it used on-line surveys to get additional information about providers' experiences when serving clients with SUDs or interacting with behavioral-health and criminal-justice agencies. The audit team educated itself about best practices by conducting an extensive literature review and interviewing behavioral-health and substance-use administrators and practitioners and other experts in the field. The CCE audit team reviewed the statutory, regulatory, and caselaw bases for the provision of SUD services in the District and analyzed DBH's and DOC's organizational histories and legal structures to gain an understanding of their relevant policies, practices, and objectives. In response to questions and document requests from CCE, DBH and DOC produced numerous internal and inter-agency documents and other useful information.

In addition to combing through publicly available data about SUD services for justice-involved people in the District, the CCE audit team compiled and analyzed a first-of-its-kind dataset consisting of information supplied by DBH, DOC, DHCF, the Metropolitan Police Department (MPD), and the Office of the Chief Medical Examiner (OCME). This unique dataset reveals a number of patterns and relationships among arrests, SUD services in the community and in the jail, and overdose deaths during the Audit Period (Jan. 1, 2015 through Sept. 30, 2018).

CCE found that, during the Audit Period, DBH and DOC accomplished some significant achievements and launched some promising initiatives to enhance and expand the provision of SUD services. These include DOC's implementation of leading-edge Medication-Assisted Treatment in the jails and DBH's improved communications with community providers and members of the public and its recent shift away from a single point of intake to a "no-wrong-door approach" to accessing SUD services. We commend the agencies for those actions.

At the same time, CCE's review revealed several areas where improvements are needed, and CCE makes several corresponding recommendations. Some recommendations call for specific actions by either DBH or DOC. Other recommendations require coordinated actions by multiple governmental agencies. And some necessitate greater communication and cooperation between DBH and community providers. None of the recommendations, however, are likely to succeed unless government and community leaders make a sustained commitment to achieving steady progress over the long term and to cultivating a healthy culture of collaboration, cooperation, and communication by and among relevant public and private agencies and organizations.

The following summarizes the data-matching analysis conducted as part of this audit and CCE's key findings and recommendations. These topics are discussed in greater detail in the body of this report.

## INTER-AGENCY DATA ANALYSIS

The CCE audit team matched various anonymized datasets for the Audit Period—arrests (MPD), claims for SUD services (DHCF and DBH), incarceration and SUD identification (DOC), and overdose fatalities (OCME)—to follow the contacts of justice-involved adults through the stages of assessment and treatment in the community, arrest, incarceration, and release back into the community. This exercise suggests some interesting, and in some cases startling, observations. For example, during the Audit Period:

- Only a tiny fraction (just over 1%) of the incarcerations associated with a SUD in the 4,602 cases analyzed by CCE received SUD services before, during, and after incarceration, suggesting that virtually no one receives the benefit of complete continuity of care, which is important to effective treatment and reduced recidivism.
- It took an average of 33 days after release from DOC to connect an individual to SUD services.
- DBH had no contact with approximately 77% of the cases in which an individual died of an overdose.

As explained in the report, these observations are made using limited data and should be scrutinized further before drawing any definitive conclusions. Nevertheless, the analysis does show the promising potential of assembling and analyzing data collected by the relevant agencies to develop a complete picture of the patterns of interaction that people with SUDs have with behavioral health, correctional, and related agencies in the District. This type of analysis should help identify the system intercepts having the greatest need for attention and improvement.

## SUMMARY OF FINDINGS AND RECOMMENDATIONS

### Pre-Arrest Diversion

*“Sooner begun is sooner done.”* –Patrick Rothfuss, *Writer of Epic Fiction*

Many jurisdictions around the country, including the District, use drug courts and other post-book-ing programs to divert people with mental illness and/or SUDs away from the criminal justice system and into treatment and related services. Another effective point of diversion occurs even earlier—before arrest and entanglement in the criminal justice system. SUDs are progressive—the earlier treatment starts, the better the chances of long-term recovery. In addition, avoiding a criminal record enhances the prospects of ultimately finding housing and employment, and treatment in the community costs taxpayers less than judicial proceedings and incarceration.

In April 2018, MPD, DBH, and the Department of Human Services announced a pilot pre-arrest diversion program. The program was restricted to two police service areas and was operational only during limited hours and days of the week. A relatively small number of police officers completed training, and even fewer actively participated in the pilot program. Approximately 80 individuals with mental illness or co-occurring mental illness and SUDs were enrolled in the program, most of whom received individualized service plans within 72 hours and some of whom received housing assistance. In October 2019, the pilot was merged into DBH’s new mobile, multi-disciplinary, 24-hour crisis response team. CCE did not review that new arrangement because it started after the conclusion of the Audit Period.

Pre-arrest diversion is a best practice and has yielded positive outcomes in other jurisdictions. CCE recommends that it be continued, strengthened, and expanded in the District. In the body of this report, CCE makes recommendations for improving the District’s pre-arrest diversion efforts, including proposals for increasing community-based organizations’ and providers’ involvement and trust in the program. In addition, a key to successful pre-arrest diversion is having sufficient numbers of properly trained police officers. MPD buy-in is thus vital, and CCE makes recommendations for improvements in that regard.

### More Accurate SUD Detection Within DOC

*“Fast is fine, but accuracy is everything.”* –Wyatt Earp, *Frontiersman, Deputy U.S. Marshal*

CCE’s data-matching analysis suggests that, during the Audit Period, DOC failed to identify a substantial number of people in its custody who had SUDs. Of the 4,602 “incarceration episodes” analyzed by CCE, only about 333 (or slightly more than 7%) were identified by DOC as having a SUD. On its face, that percentage is suspect—it is lower than the 11.55% SUD rate in the District’s general adult population, according to the federal government’s 2018 National Survey on Drug Use and Health. CCE’s analysis suggests that DOC should have detected many more SUD cases. For example, of 772 DOC residents who had received SUD care in the 90 days before their incarceration, DOC identified only 63 as having a SUD. It seems likely that many of the other 709 had a SUD that went undetected by DOC. As a result of this undercounting, many people who would have benefited from SUD services did not receive them, and opportunities were missed to connect people in need with SUD services and to support continuity of care between correctional and community settings.

In the body of this report, CCE recommends that DOC adopt protocols and policies requiring the use of a best-practices screening tool and other instruments and techniques to improve the accuracy rate of SUD identification.

## Expand SUD Services and Improve Reentry Planning at DOC

*“We know what we are but know not what we may be.”* –Ophelia in Hamlet, William Shakespeare, Playwright

To its credit, DOC is among the nation’s leading correctional facilities in providing Medication-Assisted Treatment (MAT) in the jail, but it needs to do a better job with respect to expanding the availability of other types of SUD services and planning for released residents’ reentry into the community. In the body of this report, CCE makes recommendations for additional therapeutic programming, “brief interventions” suited to short stays at the jail, and ways to strengthen reentry planning and post-release connections to SUD services.

## Improving Access to SUD Care

*“Be an opener of doors.”* –Ralph Waldo Emerson, Essayist, Transcendentalist

During the Audit Period, DBH’s single point of intake for SUD services assessment, combined with the substantial delay between assessment and connection to care, created serious barriers to accessing and receiving treatment and contributed to higher rates of arrest and incarceration. Recently, however, DBH has been taking steps to lower those barriers. It is moving toward a “no-wrong-door” decentralized model that increases the number of points of entry into SUD services. In 2019, after the conclusion of the Audit Period, DBH certified six additional intake centers and is now considering additional expansions of the number of intake points. In the body of this report, CCE makes recommendations for further improvements, including a proposal that the D.C. Council fund a pilot program requiring at least one SUD service provider to be open 24/7 for assessment and care. CCE also makes recommendations for shortening the lag time between assessment and treatment.

## Priorities, Benchmarks, and Strategic Planning

*“If you don’t know where you are going, you’ll end up someplace else.”* –Yogi Berra, Baseball Legend

It is a fundamental principle of effective management that an organization should engage, on an ongoing basis, in disciplined and thoughtful long-term strategic planning, including the setting of priorities and benchmarks. Engaging in such planning helps to get everyone within the organization to work together toward common goals, provides a guide for day-to-day decisions and a rational framework for allocating resources, and enables management to assess progress toward the organization’s goals and evaluate whether a course correction is needed in response to changing circumstances.

For DBH, strategic planning has been a struggle. Although it has prepared single-year performance reports and started an unfinished strategic planning effort nearly four years ago, DBH has not adopted a multi-year, agency-wide strategic plan to guide its medium to long-term decision-making. The absence of a clear set of agreed-upon goals, priorities, and benchmarks has hampered DBH's ability to assess the effectiveness of its programs and policy changes and may have delayed its responses to developments in the opioid crisis. Moreover, several administrators expressed concern about the agency's overall lack of strategic vision, describing management as functioning solely in a reactive mode.

CCE recommends that, considering DBH's planning struggles, the D.C. Council enact legislation requiring the agency to develop and complete, on a timely basis, a multi-year, agency-wide strategic plan. In the body of this report, CCE also makes several related recommendations, including that DBH supplement its "Live. Long. DC. Washington, DC's Strategic Plan to Reduce Opioid Use, Misuse, and Related Deaths" to cover services and care for all SUDs, not just opioids.

## Sharing of SUD Information Among Relevant District and Federal Agencies

*"Information is like compost; it does no good unless you spread it around."* –Eliot Coleman, Organic Farmer, Researcher, Writer

Notwithstanding its limitations, CCE's data-matching exercise shows the potential ways in which interagency sharing of data can reveal important information about the functioning of the behavioral health and criminal justice systems with respect to justice-involved people with SUDs. In the body of this report, we elaborate on the various ways in which such information sharing, including the real-time sharing of authorized SUD information by the agencies and community-based providers, could improve outcomes—for example, by de-escalating law enforcement encounters, promoting interventions to prevent harm to at-risk individuals, or facilitating prompt connections to care.

In the District, information sharing among behavioral health and criminal justice agencies about justice-involved people with SUDs is extremely circumscribed. This situation leaves each agency with only limited and fragmented information, thereby depriving it of a full picture of the individuals it is trying to serve. The lack of common information across agency lines also inhibits interagency collaboration, a prerequisite to developing coherent, integrated solutions to the complex issues presented by the population at issue. In addition, the current inability to match data from multiple agencies to individuals impairs the ability of the agencies, governmental officials, researchers, and others to assess the effectiveness of the SUD services and programs being offered to those in need. For example, the District cannot evaluate how its Opioid Strategic Plan is functioning without cross-agency information sharing and the ability to discern causal relationships among the different datasets. Moreover, the federal government's involvement in the prosecution, adjudication, and incarceration of D.C. Code offenders adds a layer of complexity to effective information sharing.

In the body of this report, CCE makes various recommendations for facilitating information sharing among behavioral health and criminal justice agencies, including the outlines of an interagency agreement and potential protocols and consents for addressing privacy and ethical concerns. CCE

also suggests that the Criminal Justice Coordinating Council may be able to play a constructive role in facilitating the sharing of information among the relevant District and federal agencies.

## **Communications with SUD Providers and the Public**

*“The biggest problem with communication is the illusion that it has taken place.”*

–George Bernard Shaw, Playwright

Based on interviews and online surveys, CCE found that, during much of the Audit Period, individuals with SUDs, professionals in the field, and community-based SUD providers had many complaints about the quality of DBH’s communications. In many cases, these perceived communication deficiencies led to misunderstandings, negative feelings, and distrust. A number of providers also complained about the lack of adequate advance notice of DBH policy changes. This situation was exacerbated by high turnover at DBH, which resulted in communications disruptions and mixed messages. The good news is that, during the late stages of the Audit Period, those that had dealings with DBH reported a marked improvement. DBH has made significant progress in upgrading its communications with providers and the public and has developed some high-quality models for enhancing its future communications.

In the body of this report, CCE makes recommendations for ways in which DBH can build on its recent communications improvements. The recommendations include regular meetings with providers at which they, not DBH, set most of the agenda; informational sessions with the public; and improvements in the ways in which DBH dispenses information to the public. In addition, CCE proposes improvements in the procedures by which members of the public can complain about provider misconduct.

# Introduction

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## OBJECTIVE AND SCOPE

The objectives of this audit were to examine and evaluate the ways in which three District agencies—the Department of Behavioral Health (DBH), the Department of Corrections (DOC), and the Department of Healthcare Finance (DHCF)—directly provided or supported the provision of substance use disorder services to justice-involved people in the District of Columbia.

To produce a series of findings and recommendations in the areas related to criminal justice and behavioral health outcomes, including possible legislative, regulatory, policy, and practice changes, we sought to answer several fundamental questions.

- How are SUD services provided in the District, particularly to individuals eligible for publicly funded health care and those who are arrested and incarcerated in D.C.?
- What are the barriers or challenges faced by individuals seeking care for a SUD and are those barriers different for individuals who have been incarcerated?
- Is relevant information shared among the local and federal agencies that interact with these vulnerable individuals, and if so, how?
- What are promising or best practices for providing SUD services to justice-involved clients?

The Council for Court Excellence (CCE) conducted this audit between November 2018 and February 2020. The period of review, called the “Audit Period” throughout this report, covered January 1, 2015, through September 30, 2018. The scope of CCE’s review was limited to evaluating how effectively DBH, DOC, and, to a limited extent, DHCF (hereinafter referred to collectively as the “engaged agencies”) interact to provide SUD services to D.C.’s justice-involved population. Much of the audit pertains to the intersections of these agencies where justice-involved SUD clients are served. We also reviewed facets of the agencies that serve a broader population but have a distinct impact on justice-involved SUD clients. We focused on District agencies, so federal agencies involved in D.C.’s behavioral or criminal justice systems were not engaged in the audit.

In addition to analyzing publicly available datasets related to the District’s behavioral health and criminal justice systems, the CCE audit team developed a first-of-its-kind person-level dataset that it used to observe how individuals interacted with D.C.’s SUD and justice systems. To offer a meaningful evaluation of the intersection of these systems, it was critical to understand who was assessed for SUD care, who received SUD care, who was arrested and incarcerated, whether an individual received SUD care while incarcerated, whether those who died of overdoses received SUD care or had been incarcerated, and how those groups intersected. CCE compiled the dataset based on information supplied by the three agencies the Auditor formally engaged as well as the MPD and the Office of the Chief Medical Examiner (OCME).



Throughout this report, CCE uses the term “justice-involved” to refer to individuals who were arrested or held in connection with the alleged commission of a crime or who either are currently or were previously incarcerated. In keeping with DBH’s conventions, CCE refers to individuals who are receiving SUD services as “clients” and refers to individuals who are receiving mental health services as “consumers.” Consistent with DOC’s conventions, CCE refers to individuals who are incarcerated as “residents” of a jail facility except when discussing their treatment, in which case they are referred to as “patients” or “clients.” For a glossary of terms used in this report, see Appendix D.

The first chapter of the report, this **Introduction**, gives a high-level overview of the audit and the District’s behavioral health and criminal justice systems and populations. The second chapter, **Inter-Agency Data Analysis**, explains the dataset given to CCE, describes how that dataset was analyzed, and presents findings from that data analysis. The third chapter, **Findings and Recommendations**, details the seven main findings and recommendations of the audit. The first four findings are organized roughly by system intercept, beginning at the point of arrest, moving to the identification of individuals in DOC custody who have SUDs, then DOC’s available SUD treatments and its reentry planning in conjunction with DBH, and then DBH’s assessments, referrals, and connections to care for justice-involved people. The last three findings are related to higher-level agency operations: data sharing, use, and analysis, strategic planning, and communications. Finally, we provide a brief conclusion with potential next steps for the District.

## METHODOLOGY

This audit’s focus was on justice-involved adults who were eligible for publicly funded SUD services in D.C. To assess how publicly-funded SUD services in D.C. are provided to adults in the community and in DOC, CCE’s research and analysis combined information from myriad sources about the behavioral health and criminal justice systems in the District of Columbia and gauged the opinions and perceptions of SUD clients, SUD providers, governmental staff, other stakeholders, and experts in and outside of the District.

CCE formed a five-member Steering Committee that was supported by several behavioral health expert advisors, CCE staff, and two research fellows. The Steering Committee helped to guide and conduct legal, quantitative, and qualitative research; ensure an independent evaluation of the facts identified in the data-collection phase; and create reasonable and implementable recommendations based on D.C.’s unique traits, the information collected, and best practices. Steering Committee members led methodology-based working groups that had responsibility for different types of information-collection. The four methodologies were:

**Qualitative Data Collection.** The qualitative working group was chiefly responsible for overseeing more than 80 interviews with current and former DBH and DOC administrators, community and government stakeholders, D.C. Superior Court judges, and practitioners. CCE also interviewed 26 individuals who were receiving community-based SUD services in D.C. They provided explicit, informed consent before being interviewed and received \$25 gift cards after completing their interviews. All participation in the interviews, including by government staff, was voluntary and anonymous. Information from those interviews is included as supporting evidence throughout this

report.<sup>1</sup> At several points in 2019, CCE sought to interview individuals with SUDs who were in DOC custody, but ultimately did not obtain access to the interviews.

In addition to interviews, CCE distributed an online survey to members of the D.C. Behavioral Health Association to solicit anonymous responses to questions related to the experience of serving clients with SUDs and interacting with justice and behavioral health agencies in D.C. In total, 21 providers responded to the survey. Throughout this report the survey results are used to improve the quality and detail of the audit team's findings, but they are not used as statistical data or for causal inference. Survey results bolster findings that were identified first through interviews or research, describe subjective experiences of providers, and highlight areas for further analysis.

**Best Practice Information Collection.** The best practice working group was chiefly responsible for identifying and learning about best practices in other jurisdictions based on extensive literature reviews and interviews of behavioral-health and substance-use system administrators and health care services practitioners. The other functional working groups relied on information and background data developed through this exercise to inform their analysis.

**Legal Framework Analysis.** The legal working group was responsible for evaluating the statutory and regulatory bases for the provision of SUD services in the District of Columbia, as well as relevant case law. CCE analyzed the organizational histories and legal structures of DBH and DOC to understand their policies, practices, and objectives as they related to serving individuals who have SUDs. DBH and DOC provided responses to dozens of questions and document requests to further inform CCE's review; these included descriptive organizational documents, relevant contracts and inter-agency agreements, and qualitative data on program performance outcomes.

**Quantitative Data Collection.** This effort had two components. First, CCE staff and research fellows evaluated publicly available data related to the provision of SUD services to justice-involved clients in the District and the quantitative data included in the agencies' responses to information requests. Second, ODCA and CCE worked with the Executive Office of the Mayor, representatives from the engaged agencies, MPD, OCME, and the Office of the Chief Technology Officer (OCTO), to create a novel dataset that matched behavioral health and justice information for individuals during the Audit Period. This dataset—the first of its kind in D.C.—gave CCE and ODCA a unique view of justice-involved SUD clients in the District. Details of how CCE analyzed this dataset can be found in Appendix C: Quantitative Methodology.

## SUBSTANCE USE DISORDERS AND JUSTICE INVOLVEMENT

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), which provides the standard classifications of *mental disorders* used by *mental* health professionals in the United States, the term substance use disorder (SUD) describes “a problematic pattern of using alcohol or another substance that results in impairment in daily life or noticeable distress.” More specifically, a SUD is “a cluster of cognitive, behavioral, and physiological symptoms indicating that the

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<sup>1</sup> All notes taken during interviews conducted for the audit were redacted to preserve anonymity and are on file with CCE.

individual continues using the substance despite significant substance-related problems.”<sup>2</sup> The DSM-V describes 10 separate classes of drugs relevant to SUDs: alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics, stimulants, and tobacco.

The 2018 National Survey on Drug Use and Health indicates that 7.6% of Americans age 18 and older met the DSM-IV diagnostic criteria for a SUD.<sup>3</sup> The same survey estimated that 11.55% of D.C. residents aged 18 or older had a SUD in 2018.<sup>4</sup> The Substance Abuse and Mental Health Services Administration (SAMHSA) claims that, “[b]y 2020, mental and substance use disorders will surpass all physical diseases as a major cause of disability worldwide.<sup>5</sup> In the U.S., drug overdoses are already a leading cause of death among individuals under the age of 50.<sup>6</sup> Among individuals aged 24-35, opioids were involved in one in five deaths nationally.<sup>7</sup> In D.C., there was a 178% increase in fatal overdoses due to opioid use from 2014 to 2016; the peak occurred in 2017, with 279 overdoses.<sup>8</sup> Nationally, illicit drugs, prescription opioids, and alcohol abuse are associated with economic and health costs that are estimated to be around \$572 billion dollars annually.<sup>9</sup> This constitutes a major public health crisis.

While SUDs are a significant issue for all Americans, they have a particularly strong connection to our criminal justice system. Substance use contributes to rates of incarceration, taxpayer and other “hidden” costs, disease, and death among people who are justice-involved. In the most comprehensive study of drug use among arrestees in the U.S., 68% of arrestees nationally tested positive for at least one illicit substance at the time of arrest.<sup>10</sup> Following arrests, among the people who are subsequently jailed or imprisoned, illicit drugs are implicated in 75.9% of incarcerations, and

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- 2 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (5th ed. 2013). The DSM-V updated the definitions of a SUD from the manual’s prior edition, also commonly referred to by its acronym, the DSM-IV.
  - 3 Substance Abuse and Mental Health Services Administration (“SAMHSA”), *Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health* (2019), <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf>.
  - 4 SAMHSA, NSDUH State Estimates, accessed Mar. 5, 2020, <https://pdas.samhsa.gov/saes/state/>; see also SAMHSA, *Section 5 PE Tables—Results from the 2018 National Survey on Drug Use and Health: Detailed Tables, Sections 1 - 3*, SAMHSA, CBHSQ, accessed Mar. 11, 2020, <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2018R2/NSDUHDetTabsSect5pe2018.htm>.
  - 5 SAMHSA, SAMHSA: *Prevention of Substance Abuse and Mental Illness* (last updated Feb. 3, 2020), <https://www.samhsa.gov/prevention>.
  - 6 Karin Mack et al., Center for Disease Control and Prevention, *Illicit Drug Use, Illicit Drug Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas - United States* (2017), [https://www.cdc.gov/mmwr/volumes/66/ss/ss6619a1.htm?s\\_cid=ss6619a1\\_w](https://www.cdc.gov/mmwr/volumes/66/ss/ss6619a1.htm?s_cid=ss6619a1_w).
  - 7 Tara Gomes et al., *The Burden of Opioid-Related Mortality in the United States*, 1 JAMA Network 2 (2018).
  - 8 D.C. Department of Behavioral Health, *Washington, DC’s Strategic Plan to Reduce Opioid Use, Misuse, and Related Deaths* (Mar. 2019), <https://livelong.dc.gov/sites/default/files/u23/LIVE.%20LONG.%20DC-%20Washington%20DC%27s%20Opioid%20Strategic%20Plan-%20March%20Revision.pdf>.
  - 9 National Institute on Drug Abuse, *Trends & Statistics* (2017), <https://www.drugabuse.gov/related-topics/trends-statistics>.
  - 10 Dana Hunt et al., Office of National Drug Control Policy, *ADAM II 2013 Annual Report* (2013), [https://www.abtassociates.com/sites/default/files/migrated\\_files/91485e0a-8774-442e-8ca1-5ec85ff5fb9a.pdf](https://www.abtassociates.com/sites/default/files/migrated_files/91485e0a-8774-442e-8ca1-5ec85ff5fb9a.pdf).

alcohol alone is implicated in 56.6% of incarcerations nationally.<sup>11</sup> A 2017 U.S. Bureau of Justice Statistics (BJS) report found that 58% of people incarcerated in state prisons and 63% of people detained in jails met the criteria for a SUD diagnosis.<sup>12</sup>

Put together, the data tell us that the majority of people who are charged with or convicted of a crime in America have a diagnosed SUD or have recently consumed an illicit or impairing substance at the time of their arrest. This compounds the impacts of this public health crisis, further burdening public resources, degrading community safety, and leading to collateral consequences that can make recovery even more difficult. At the same time, an encounter or involvement with the criminal justice system can present the opportunity to connect with and help an individual who may be struggling to get SUD treatment and other needed supports. Many in the District of Columbia are working hard to provide this care and connection to services, but more collaboration, commitment, information, and resources are needed to address the complex crisis of addiction and criminal justice involvement.

## D.C.'S BEHAVIORAL HEALTH SYSTEM AND POPULATION OVERVIEW

There are two local agencies central to the provision of community-based behavioral health care in D.C.: DBH, which oversees the city's public mental health and SUD services, and DHCF, which is D.C.'s state Medicaid agency.

DHCF, formerly the Medical Assistance Administration under the D.C. Department of Health (DOH), administers D.C.'s Medicaid program and the D.C. Healthcare Alliance, which serves low-income residents not eligible for federally-supported programs. Medicaid serves as a significant source of funding for DBH and community-service providers in the District. Federal Medicaid regulations give states the flexibility to determine the scope of services that can be offered and the populations eligible to receive them. DHCF determines what behavioral health care services are covered by Medicaid and Alliance and sets reimbursement rates for the services provided.

DBH was established in 2013 when the District merged the Department of Mental Health (DMH), an independent District agency, with the Addiction Prevention & Recovery Administration (APRA), which had been operating within DOH. DBH provides prevention, intervention, and treatment services for people with mental health and/or SUDs in D.C. DBH also provides emergency psychiatric care and community-based long- and short-term outpatient and residential services, and it operates Saint Elizabeths Hospital, D.C.'s inpatient psychiatric hospital. The number of adult SUD clients served by DBH decreased every year during the Audit Period from a high of 6,908 SUD clients in FY2015.<sup>13</sup> In FY2018, DBH reported serving 4,977 adult SUD services clients and 19,855 adult mental health services consumers.

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11 The National Center on Addiction and Substance Abuse at Columbia University, *Behind Bars II: Substance Abuse and America's Prison Population* (2010).

12 Jennifer Bronson et al., Bureau of Justice Statistics, *Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009* (2017), <https://www.bjs.gov/content/pub/pdf/dudaspi0709.pdf>.

13 D.C. Department of Behavioral Health, *Reports: Mental Health and Substance Use Report on Expenditures and Services (MHEASURES)*, accessed March 12, 2020, <https://dbh.dc.gov/page/reports-01> (years 2015 through 2018).

In 2017 the District's Health Systems Plan described D.C.'s behavioral health system as an "expansive and fragmented private system of care made up of hundreds of individual and small group practices."<sup>14</sup> These include mental health service providers, SUD service providers, and general healthcare providers that offer behavioral health services.

At the end of the Audit Period, DBH had 30 SUD providers certified to operate in the District, down from 40 certified SUD providers at the beginning of the Audit Period. Some SUD providers operate out of a single facility, while others have several. According to the National Survey of Substance Abuse Treatment Services, the number of SUD treatment facilities in the District also declined, from 34 to 24, between 2016 and 2018.<sup>15</sup>

DBH contracts with some, but not all, of the SUD providers it certifies. In FY2018, DBH had 23 contracts for SUD services with 20 certified SUD providers.<sup>16</sup> The contracted providers offer, on DBH's behalf, a continuum of SUD services, including prevention, treatment, and recovery support. Preventive services include educational and outreach efforts to children and youth in the District. Treatment services include outpatient, intensive outpatient, residential, detoxification and stabilization, and Medication Assisted Treatment (MAT). Recovery Support Services (RSS) are wrap-around services such as care coordination, peer mentoring, and a range of other social supports that aim to improve the recovery process. Not every provider offers all of these services, and some providers offer only specialized or targeted SUD care.<sup>17</sup>

Even though the number of certified SUD providers has declined, evidence suggests that the number of individuals with SUDs in the District increased over the course of the Audit Period. Specifically, the National Survey on Drug Use and Health estimated that 10.59% of adult D.C. residents between 2015 and 2016 had a SUD, while between 2017 and 2018, 13.01% of adult D.C. residents had a SUD.<sup>18</sup> This means that between 2015 and 2016, there were 58,000 adult D.C. residents who had a SUD, while between 2017 and 2018, there were 73,000 adult D.C. residents who had a SUD.<sup>19</sup>

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14 D.C. Department of Health, District of Columbia: Health Systems Plan 2017, p. 80 (2017), [https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/DC%20Health%20Systems%20Plan%202017\\_0.pdf](https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/DC%20Health%20Systems%20Plan%202017_0.pdf).

15 SAMHSA, *2016 State Profile - District of Columbia - N-SSATS*, p. 46 (2016), [https://www.dasis.samhsa.gov/dasis2/nssats/n2016\\_st\\_profiles.pdf](https://www.dasis.samhsa.gov/dasis2/nssats/n2016_st_profiles.pdf); SAMHSA, *2018 State Profile - District of Columbia - N-SSATS*, p. 37 (2018).

16 DBH Correspondence on Feb. 13, 2020.

17 In addition to dedicated SUD providers, SUD services in D.C. are also provided in Acute Care Hospitals and in the two psychiatric hospitals, St. Elizabeths and the Psychiatric Institute of Washington (PIW). Of D.C.'s hospitals, only Providence, which closed April 30, 2019, and PIW offered detoxification. Acute Care Hospitals, Federally Qualified Health Centers, and primary care physicians can all provide SUD services part of their routine care, but are not under DBH's authority.

18 SAMHSA, *NSDUH State Estimates*, accessed Mar. 5, 2020, <https://pdas.samhsa.gov/saes/state>; see also SAMHSA, *2017-2018 State Level Estimates*, accessed Mar. 13, 2020, <http://www.samhsa.gov/data/sites/default/files/reports/rpt23235/2k18SAEExcelTabs/NSDUHsaPercents2018.pdf>.

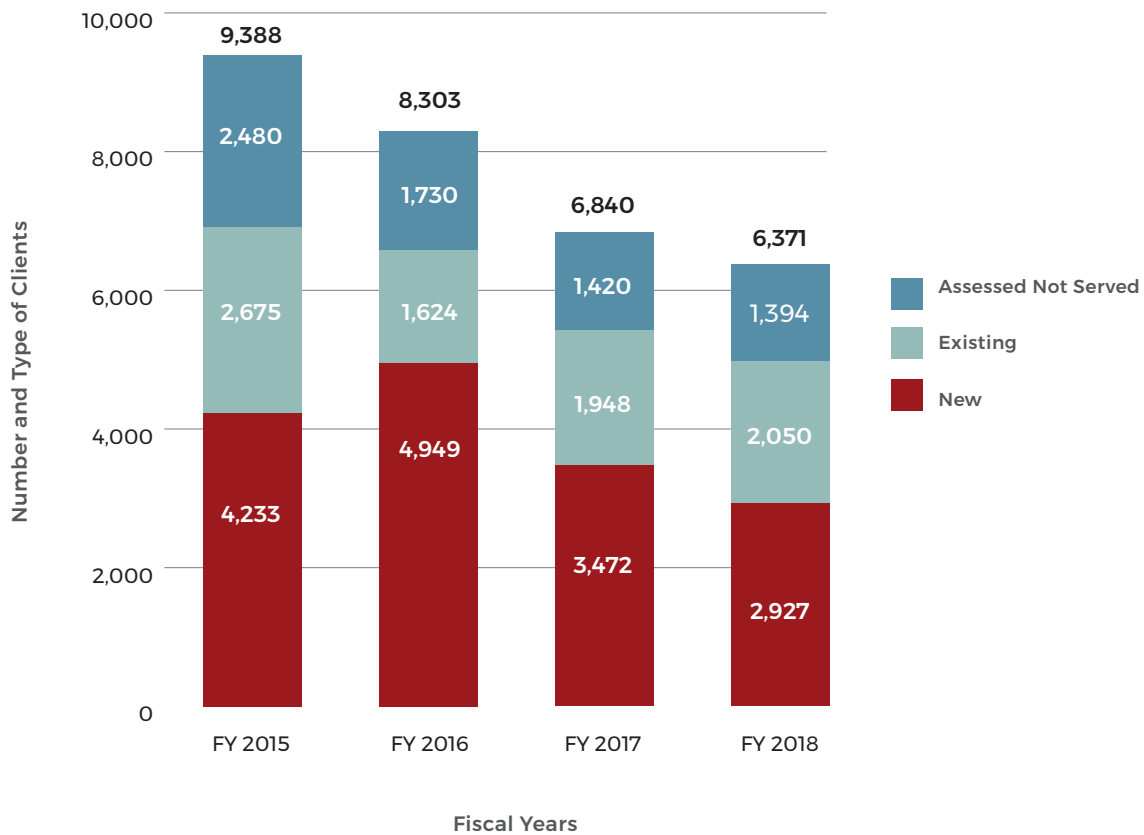
19 SAMHSA, *2017-2018 National Surveys on Drug Use and Health: Model-Based Estimated Totals (in Thousands) (50 States and the District of Columbia) (2019)*, <https://www.samhsa.gov/data/sites/default/files/reports/rpt23259/NSDUHsaTotals2018/NSDUHsaTotals2018.pdf>.

The number of adults in the District who needed but did not receive SUD care also increased during the Audit Period. In D.C., between 2015 and 2018, there were between 55,000 and 64,000 adults who needed but did not receive treatment at a specialty facility for a SUD.<sup>20</sup> From 2015 to 2018 there were between 16,000 and 24,000 adults in D.C. who needed but did not receive treatment for illicit drug use.<sup>21</sup> For context, there were 27,000 adults in D.C. from 2017 to 2018 who had an illicit drug use disorder in the past year.<sup>22</sup> In short, during the Audit Period, and at the same time as the opioid crisis peaked, the number of adults in D.C. with a SUD increased, and the number of individuals needing but not receiving treatment also increased.

Simultaneously, the number of people receiving care from DBH decreased. As seen in Figure 1 below, between 2015 and 2018, the number of SUD clients served, the “Existing” and “New” client categories in the chart below, decreased by 28%. While it is beyond this audit’s scope to determine why SUD services in D.C. decreased, it is notable that DBH served fewer SUD clients, fewer providers offered SUD services, and fewer facilities delivered SUD services.

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- 20 See *id*; see also SAMHSA, 2015-2016 National Surveys on Drug Use and Health: Model-Based Estimated Totals (in Thousands) (50 States and the District of Columbia) (2017), <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsaeTotal2016/NSDUHsaeTotals2016.pdf>.
- 21 *Id.*; SAMHSA, 2017-2018 National Surveys on Drug Use and Health: Model-Based Estimated Totals (in Thousands) (50 States and the District of Columbia) (2019), <https://www.samhsa.gov/data/sites/default/files/reports/rpt23259/NSDUHsaeTotals2018/NSDUHsaeTotals2018.pdf>.
- 22 SAMHSA, 2016-2017 NSDUH State Estimates of Substance Use And Mental Disorders (2018), <http://www.samhsa.gov/data/report/2016-2017-nsduh-state-estimates-substance-use-and-mental-disorders>.

**Figure 1: DBH Adult SUD Clients Assessed and Served**



*Source: D.C. Department of Behavioral Health, 2018 Mental Health and Substance Use Report on Expenditures and Services (2019), p.23*

## D.C.'S CRIMINAL JUSTICE SYSTEM AND POPULATION OVERVIEW

Like most places in the U.S., there are two separate criminal justice systems at work in D.C. The first is federal, where the U.S. Attorney's Office for the District of Columbia (USAO-DC) prosecutes people charged with violating federal laws in U.S. District Court. If convicted, these people could be 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 or convicted of violating federal law.

In most cases, however, individuals in the District who are charged with a crime will face prosecution under D.C.'s local laws. People convicted under D.C. law are commonly referred to as "D.C. Code offenders." 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 complex chain of custody and supervision that bounces back and forth between local and federal agencies.



MPD, a locally funded agency, is the primary law enforcement agency in the District. During the Audit Period, MPD made 225,180 arrests, 213,517 of which were of adults.<sup>23</sup> In addition to MPD, however, nearly 30 independent law enforcement agencies operate in the District, the most active of which include the D.C. Housing Authority's Office of Public Safety, Metro Transit Police Department, U.S. Secret Service, U.S. Park Police, and the U.S. Capitol Police.

The USAO-DC, a federal office within the U.S. Department of Justice (DOJ) which has both federal and local jurisdiction, prosecutes most D.C. Code charges. The D.C. Office of the Attorney General (OAG), a local agency, prosecutes juveniles and some misdemeanor crimes. In 2019, there were 4,949 convictions for D.C. Code offenses in the D.C. Superior Court, excluding an additional 1,723 convictions for traffic offenses.<sup>24</sup>

Generally, after being arrested for an alleged violation of D.C. law and arraigned in D.C. Superior Court, a federally funded and controlled court with local jurisdiction, an individual is either conditionally released under the supervision of the Pretrial Services Agency for the District of Columbia (PSA), is a federal agency with local jurisdiction, or detained by the DOC, a local agency, at either the Central Detention Facility (CDF or D.C. Jail) or the Correctional Treatment Facility (CTF). CTF houses all women and some men deemed to be special populations, including people with acute health needs, people participating in a Residential Substance Abuse Treatment (RSAT) unit, and the new Young Men Emerging unit. People can also be confined at a halfway house facility while awaiting trial, particularly if they are participating in a work-release program, although pre-trial halfway house confinement is infrequent.

During the Audit Period, 22,373 individuals were incarcerated at DOC facilities a total of 40,112 times.<sup>25</sup> From 2015 to 2018, DOC incarcerated between 1,500 and 2,000 people daily.<sup>26</sup> Approximately 60% of individuals released from DOC are released back into the community. Many incarcerations in DOC are short: 34.7% of stays are for one week or less.

If an individual is sentenced to probation or time served with community supervision for a D.C. Code offense, they are supervised by 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 or supervised release. An individual convicted of a misdemeanor and sentenced to less than a year of incarceration will remain either in the CDF or CTF. Finally, someone convicted of a D.C. Code felony and sentenced to a period of incarceration of a year or longer will be sent to one of more than 100 BOP facilities scattered around the country.

Upon release from custody, an individual will serve any remaining parole or supervised-release sentence under the supervision of CSOSA staff. An individual under CSOSA supervision accused

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23 CCE Analysis of Inter-Agency Data.

24 D.C. Superior Court, *District of Columbia Courts 2019 Statistical Summary* (2019), [https://www.dccourts.gov/sites/default/files/2019\\_Statistical\\_Summary.pdf](https://www.dccourts.gov/sites/default/files/2019_Statistical_Summary.pdf).

25 *Id.*

26 D.C. Department of Corrections, *DOC Population Statistics* (December 31, 2019), [https://doc.dc.gov/sites/default/files/dc/sites/doc/publication/attachments/DOC%20Population%20Statistics\\_Dec31\\_2019\\_01\\_24\\_2020.pdf](https://doc.dc.gov/sites/default/files/dc/sites/doc/publication/attachments/DOC%20Population%20Statistics_Dec31_2019_01_24_2020.pdf).



of violating the terms of parole or supervision will face a revocation hearing before the U.S. Parole Commission (USPC), which is a federal agency. Those awaiting a hearing before the USPC are frequently held in the custody of the DOC. When the USPC decides to revoke parole or supervised release, the individual will typically be returned to the custody of the BOP.

The total reach of the District's criminal justice system is vast. On any given day in 2017, one in every 22 adults in D.C. was actively involved in the local criminal justice system.<sup>27</sup> Over the past ten years, one in seven adults in D.C. had a publicly available criminal record, and one in 14 had a criminal conviction.<sup>28</sup>

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27 Council for Court Excellence, *Beyond Second Chances, Returning Citizens' Re-Entry Struggles and Successes in the District of Columbia*, p.1 (2016), <http://www.courtexcellence.org/uploads/File/BSC-FINAL-web.pdf>.

28 Marina Duane et al., Urban Institute, *Criminal Background Checks and Access to Jobs, A Case Study of Washington, D.C.* (2017), [https://www.urban.org/sites/default/files/publication/91456/2001377-criminal-background-checks-and-access-to-jobs\\_2.pdf](https://www.urban.org/sites/default/files/publication/91456/2001377-criminal-background-checks-and-access-to-jobs_2.pdf).

# Inter-Agency Data Analysis

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As part of this audit, CCE matched and analyzed four years' worth of behavioral health, criminal justice, and fatality data from five different D.C. agencies. The following provides a snapshot of the relationship between SUD services in the community, MPD arrests, incarcerations at DOC, and overdose deaths between January 1, 2015, and September 30, 2018 ("the Audit Period").<sup>29</sup>

Specifically, the de-identified, person-level data used to perform this evaluation included:

- SUD claims data generated by DHCF for Medicaid funded services and DBH for local-dollar funded services.
- DOC incarceration and SUD identification data.
- MPD arrest data.
- OCME overdose fatality data.

In compliance with all health and personal information privacy protections required by law and the July 19, 2019, Data Sharing Agreement<sup>30</sup> entered into by these agencies, ODCA, CCE, the Office of the Chief Technology Officer (OCTO), and the Deputy Mayor for Health and Human Services (DMHHS), we matched these person-level datasets together using the unique identifiers included in each. We then used the matched datasets to identify and evaluate relationships between D.C. justice involvement, as measured by record of encounters with MPD and DOC, and SUD services, as measured by record of service claims generated by DHCF and DBH in the delivered datasets, as well as any overdose deaths that occurred in the District during the Audit Period.

This preliminary analysis offers an illuminating and troubling first look into the intersection between SUD care and criminal justice involvement in the District. However, it is simply that—a first impression based on an imperfect and incomplete data set. While this audit identifies important new facts about the provision of SUD services to justice-involved individuals in the District, it makes an even more valuable contribution by suggesting the examinations and conclusions that might be possible with a more comprehensive inter-agency data sharing agreement and protocols. In short, our analyses point to the imperative need for the District to: 1) establish and implement ongoing behavioral health and criminal justice data sharing between local and federal partners; and 2) identify a single entity that will be responsible for managing this dataset, addressing data problems and solutions, conducting rigorous analyses, and regularly publishing information gleaned from the data.

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29 For a more detailed explanation of the datasets used in this analysis, see Appendix C: Quantitative Methods.

30 See Appendix B: Data Sharing Agreement.

## LIMITATIONS OF THE DATASET

Before describing the most interesting findings from the inter-agency matched data analysis, it is important to note several distinct limitations of the information presented below:

- First, this data does not include any federal agencies or any jurisdictions other than D.C. that may have had relevant contact with District residents during the Audit Period. It therefore does not represent the full universe of justice involvement or received SUD services for District residents during the Audit Period. We do not know whether the universe of data we analyze is representative of the broader data about justice involvement and SUD services, and we do not attempt to extrapolate that information. While we were able to remove individuals who were released to a non-DOC custodial setting by only considering cases in which an individual was “released to community,”<sup>31</sup> not all individuals who were in the DOC and MPD datasets are D.C. residents, and we cannot know where an individual who is released to the community will reside after they leave DOC.
- Second, there is no universal identifier for individuals in different D.C. or federal datasets. Therefore, matching the data between agencies required the creation of unique identifiers for each individual in the data provided by the agencies, and then merging the different datasets using these unique identifiers to be able to track one person’s information between different agencies. For reasons described in greater detail in the Quantitative Methods appendix, this necessary process further narrowed the data considered in the audit team’s analysis.
- Third, the audit team performed this analysis with considerable time constraints. From the time of first request on December 19, 2018, it took more than eleven months for CCE to receive a final version of the agencies’ data that was usable for evaluation. The final version of the data was not delivered until November 21, 2019, leaving only three months to clean, test, and analyze the data provided for publication.
- Finally, the analysis presented in this audit was limited in scope of time, including data for the Audit Period only. Thus, January 1, 2015, and September 30, 2018, served as artificial start and stop points, or “censors.” With a few exceptions, one cannot know from the datasets received what happened before or after the censor dates.<sup>32</sup> A person may have received SUD care or had justice involvement just outside of those censors, but since we could not confirm that, we could not fairly make assumptions about those people in our analysis. To address this issue, we analyzed the data through “Incarceration Episodes,” and added additional buffers of time around the edges of the censors. This further limited the data that we analyzed and any findings described in this report.

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31 See Appendix C: Quantitative Methods.

32 DOC data contained some records for incarcerations that started before the Audit Period began but were in progress during the Audit Period. DOC also delivered a “SUD Ever” variable that measured whether an individual ever had a SUD while in DOC custody.

## TERMS USED

**Incarceration Episode.** For the purposes of this report, an Incarceration Episode is the period of time beginning with an MPD arrest that most closely preceded a person's DOC incarceration, and ending with the release date for that particular incarceration. Our data analysis did not track individual people and group together their different arrests or incarcerations, but instead looks at the distinct times any person came in and out of DOC custody during the Audit Period.

**Look Forward.** The Look Forward period is the 90 days following an Incarceration Episode, helping us to understand what happened to a person in the days immediately after their release from DOC custody in terms of SUD assessment, care, or death.

**Look Back.** The Look Back period is the 90 days prior to an Incarceration Episode, helping us to understand what happened to a person in the days immediately preceding their arrest or DOC incarceration in terms of SUD assessment or care.

**Look Around.** The Look Around period encompasses both the Look Forward and the Look Back periods, counting the 90 days on each side of an Incarceration Episode.

**Active SUD.** The Active SUD flag is the term used in the DOC data to indicate whether an individual had a current SUD diagnosis while incarcerated and is also the only proxy for whether that individual was receiving any SUD treatment during a particular incarceration based on the data held by DOC during the incarceration.

**SUD Ever.** The SUD Ever flag is the term used in the DOC data to indicate whether an individual has ever had a SUD diagnosis while in DOC custody, either during the current incarceration or any prior incarcerations.

**Justice Involvement.** Justice Involvement (or JI) following an Incarceration Episode is limited to either a new MPD arrest or a new DOC incarceration.

**Care.** A person is determined to have received care in the community if they have a SUD service claim record generated by DHCF or DBH or a record of a DBH assessment for care during the relevant period. In almost all analyses, care is not differentiated by the types of actual treatment provided.

**Continuous Care.** Continuous Care is the term used when an Incarceration Episode shows Care in the Look Back, an Active SUD flag, and Care in the Look Forward. Here, the Active SUD flag during an incarceration is used as a proxy for an individual receiving SUD treatment in DOC during that Incarceration Episode.

**Assessment.** A person is determined to have received an assessment for SUD Care if there is a claim generated by DBH for an initial assessment for SUD services during the relevant period.

## DATA FINDINGS: RACIAL DEMOGRAPHICS

Most of the analyses run in this report rely on a narrowed dataset of 4,602 Incarceration Episodes, as described in greater detail in Appendix C: Quantitative Methods. Of those 4,602 Incarceration Episodes, 4,406 involved someone identified by the DOC as Black, 82 involved someone identified as Hispanic, and 100 involved someone identified as white. In other words, over 95% of the Incarceration Episodes that we analyzed involved a Black person. Similarly, nearly all of the 26 justice-involved SUD clients interviewed for this report were Black. At the same time, only 46% of District residents are Black, according to the most recent U.S. Census data.

Therefore, we make two observations about race and this report. First, because nearly all of the individuals we considered in this report were of the same race, and the small sub-group size of the non-Black individuals, we could not analyze racial differences between Incarceration Episodes. Second, because nearly all of the individuals we consider in this dataset are Black, the findings of the report speak directly to the Black experience at the intersection of the District's public behavioral health and criminal justice systems.

## DATA FINDINGS: CONTINUITY OF SUD CARE BEFORE, DURING, AND AFTER INCARCERATION EPISODES

A significant portion of our analysis is related to the continuity of care. Relevant literature identifies behavioral health care continuity as important for protecting individuals' health and public health care investments.<sup>33</sup> First, the period immediately following an individual's release from custody is especially dangerous, with increased risk of death from overdose, suicide, and cardiovascular disease. Second, the recidivism-reduction and public health effects of correctional health programs can be undermined if treatment is not continued in the community, leading to re-incarceration and higher justice system costs. Third, poorly managed chronic conditions, including SUDs, can result in avoidable and costly emergency room visits and hospitalizations. Treatment for a SUD received while incarcerated has delivered better and more durable results when followed up by treatment in the community.

After restricting the merged dataset based on the rules described above and removing clear data errors, we were left with 4,602 distinct Incarceration Episodes during the Audit Period. To be clear, not all Incarceration Episodes necessarily involved a person with a SUD—the Incarceration Episode is counted irrespective of whether that individual had an Active SUD or SUD Ever flag in DOC or was identified in the DHCF or DBH datasets.

The first questions asked were related to care continuity; in short, did people who received care before an Incarceration Episode continue to receive care after the Incarceration Episode? We observed a pattern of discontinuous care in the community before and after Incarceration Episodes,

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33 See, e.g., The Pew Charitable Trusts, *Prison Health Care: Costs and Quality* (2017), [https://www.pewtrusts.org/-/media/assets/2017/10/sfh\\_prison\\_health\\_care\\_costs\\_and\\_quality\\_final.pdf](https://www.pewtrusts.org/-/media/assets/2017/10/sfh_prison_health_care_costs_and_quality_final.pdf).

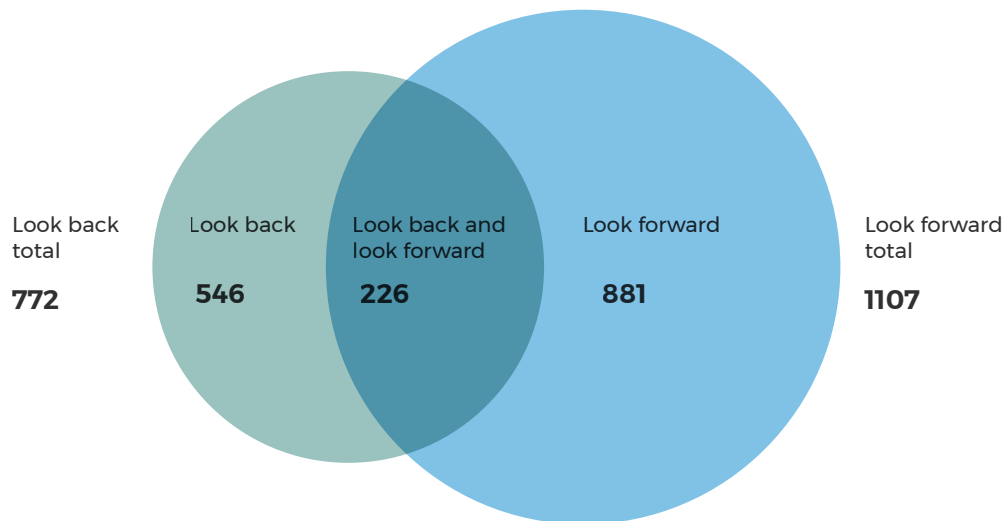
the under-identification of individuals with SUDs in DOC, and limited post-release care among those known to DOC to have SUDs. Of the 4,602 Incarceration Episodes, only 7.24% had an Active SUD flag while incarcerated. In 1,653 (35.92%) of the 4,602 Incarceration Episodes, the person who was incarcerated received care at some point in the Look Back period, the Look Forward period, or both periods. Figure 2 and Figure 3 provide breakdowns of the number of Incarcerations Episodes that were followed or preceded by care.

**Figure 2: Care Received Before and After Incarceration Episode**

Care Received	n <sup>34</sup>
No Care in Look Around	2949
Care in Look Forward Only	881
Care in Look Back Only	546
Care in Both Look Forward and Back	226

**Source: Matched District Data**

**Figure 3: Care Before and After Incarceration Episode**



**Source: Matched District Data**

This data shows that Incarceration Episodes (i) may affect both SUD care discontinuity (or the disruption of care being received in the community in the Look Back) and the initiation of care (or

<sup>34</sup> Throughout the charts in this report, “n” refers to the count or “number” of the unit of analysis being described. In this chart it refers to the count of “Incarceration Episodes.”

the starting of care in the Look Forward), but (ii) rarely presents a continuous stream of care that preceded and followed an incarceration in the District. Of the 1,107 Incarceration Episodes that were associated with care in the Look Forward, only 226 (20.42%) had also received care in the Look Back. Similarly, of the 772 Incarceration Episodes for which care was received at some point in the Look Back only 226 (29.27%) also received care in the look forward.

Very few people had continuous care before, during, and after an Incarceration Episode. Of the 1,653 total Incarceration Episodes in which care was received at some point in the Look Around, only 13.67% had continuous care both before and after the incarceration. It is impossible to determine, based on this data, whether individuals did not receive continuous care because they did not need such care during all of those intervals (perhaps because the care they did receive was sufficient to address their active symptoms, or the need did not arise until post-incarceration, or they moved into or out of D.C.), or if they did need continuous care but were not effectively connected. In any case, the District should further explore this finding, as it is not plausible that in 70.73% of incarcerations in which the incarcerated individuals needed SUD care before incarceration (in the Look Back), they did not also need care after release (in the Look Forward). Similarly, it is unlikely that for the 79.58% of incarcerations in which the incarcerated individual needed community-based SUD care in D.C. in the Look Forward that those individuals did not need some care in the Look Back.

Additional data sharing and further research could also help reveal whether individuals were receiving related services from other agencies (such as the Fire and Emergency Medical Services Department or the Department of Human Services), which would help the District better understand whether an individual is in need of care but not receiving it, or is simply not in need of care.

We also analyzed the relevance of a DOC Active SUD flag on whether there was continuity of care in the community. The DOC Active SUD flag serves as a proxy for whether DOC knew an individual needed care and may have delivered SUD services to those individuals. The Active SUD flag allows us some insight into how care delivery to individuals changed when DOC knew that those individuals had SUDs. As can be calculated from the information in Figure 4, of the 1,653 cases in which care was received in the Look Back, Look Forward, or both periods, only 142 Incarceration Episodes, or 8.59%, had an Active SUD flag during the incarceration.

**Figure 4: Care Received before and after Incarceration Episode by SUD Flag**

<i>Care Received</i>	<i>SUD Flag</i>	<i>n</i>
No Care in Look Around	No Active SUD Flag	2758
	Active SUD Flag	191
Care in Look Forward Only	No Active SUD Flag	802
	Active SUD Flag	79
Care in Look Back Only	No Active SUD Flag	508
	Active SUD Flag	38
Care in Both Look Forward and Back	No Active SUD Flag	201
	Active SUD Flag	25

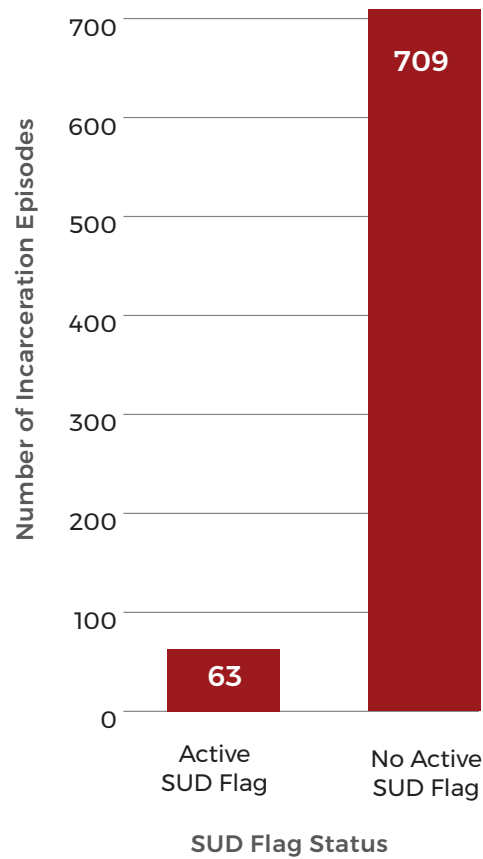
**Source: Matched District Data**

Of course, not all cases of care receipt before or after an Incarceration Episode are automatically indicative of a SUD during incarceration, but it is not plausible that 91.4% of those cases either abated before the incarceration began or started after the incarceration ended, especially since the Look Back and Look Forward periods were specifically-designed to be short in duration surrounding an incarceration. Even using a conservative interpretation of SUD prevalence in DOC, where one assumes that only those incarcerations with care in both the Look Back and Look Forward reflect an individual that had an Active SUD during their Incarceration Episode, we find that DOC correctly detected only 11.1% of those cases. However, even that 11.1% may be an overestimation of DOC's actual SUD detection rate, as DBH and DHCF data is not comprehensive, either; there are many other sources of data that could identify individuals who received SUD services, but are not included in our definition of "care."

Next, we consider only the 772 cases in which an individual received care in the Look Back period, before the Incarceration Episode began. This group reflects the cases where DBH, DHCF, or specific SUD providers could have potentially shared information with DOC about whether or not an incarcerated individual had received SUD services in the 90 days prior to the incarceration. As is shown in Figure 5, only 8.16% of those Incarceration Episodes had an Active SUD flag.



**Figure 5: Incarceration Episodes with Care in the Look Back by Active SUD Flag**



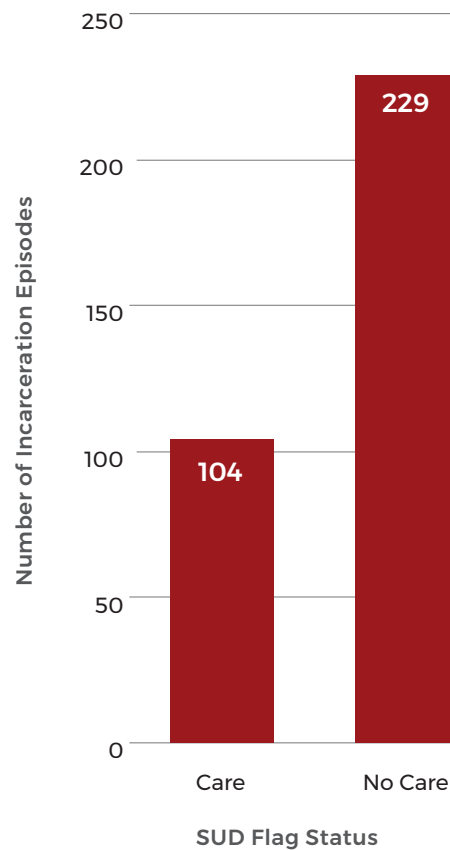
**Source: Matched District Data**

Conversely, DOC's Active SUD flag also did not have a strong relationship to receipt of care in the Look Forward period, suggesting that DOC identification of (and potential treatment for) a SUD during an Incarceration Episode did not necessarily facilitate care continuation after release. As is shown in Figure 6, of the 333 cases in which an Incarceration Episode had an Active SUD flag, only 31.23% received care in the Look Forward period. Looking at the data from another angle, of the 1,107 cases in which an individual did receive care in the Look Forward period, only 9.39% had an Active SUD flag while they were incarcerated at DOC. In this sense, DOC's Active SUD flags were poor predictors of future SUD care connectivity.

On a positive note, there is some indication that the presence of an Active SUD flag did support better connection to care post-incarceration than did the absence of an Active SUD flag. Of the 333 cases in which an incarceration had an Active SUD flag, 31.23% received care in the Look Forward period, while of the 4,269 cases where there was no Active SUD flag only 19.37% of those cases received care in the Look Forward. Stated another way, the odds of an incarceration with an Active SUD flag being followed by care were 1.8 times higher than the odds of an incarceration without

an Active SUD flag being followed by care.<sup>35</sup> While more examination is needed, this suggests that increasing SUD detections in DOC could help to increase the rate of SUD care connectivity upon release.

**Figure 6: Active SUD Flags by Care in Look Forward**



**Source: Matched District Data**

When attempting to synthesize all of these variables together and understand how often people had indications (limited as they may be) of consistency of care before, during, and after an Incarceration Episode, the results are stark.

In summary, of the 1,844 Incarceration Episodes in which an individual received care in the Look Back or Look Forward periods or had an Active SUD flag (the universe of all individuals likely to have a SUD in this dataset), only 25 total Incarceration Episodes, or 1.3% of cases received SUD care in all three stages: before, during, and after incarceration. As noted above, not all of these

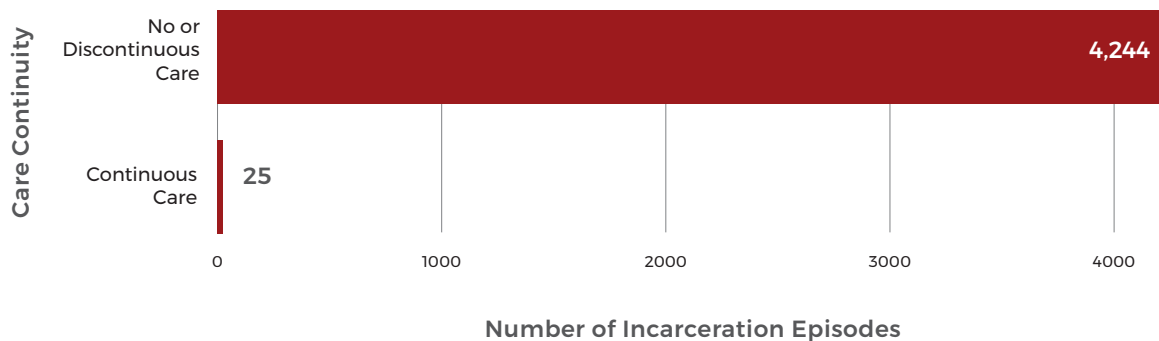
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35 Considering only those cases in which an Incarceration Episode had care before or after an incarceration (excluding the 2,797 cases in which there was no delivery of care in the Look Back or Look Forward), the odds ratio was 1.68.

1,844 Incarceration Episodes definitively reflect an individual who needed care at all three stages. However, in light of the short length of the established censors—only 90 days in either direction—and the short length of average stays in DOC custody, it is significant that so few cases reflect seamless receipt of SUD care.

As discussed in the Introduction, the most recent national data shows that the majority of adults in D.C. who had SUDs during the Audit Period needed, but did not receive, treatment. Given that there is significant unmet treatment need here, and an individual with an unmet treatment need would not show anywhere in our dataset as having a SUD, the dearth of individuals receiving continuous care before, during and after incarceration is even more stark. When considering all 4,602 Incarceration Episodes, only 0.5% of all incarcerations—or one in 200—were preceded by care, followed by care, and had an Active SUD flag during the incarceration, as shown in Figure 7.

**Figure 7: Continuous and Discontinuous Care**



*Source: Matched District Care*

## DATA FINDINGS: TIME UNTIL CARE CONNECTION FOLLOWING RELEASE FROM CUSTODY

We also utilized the Incarceration Episodes data to look at the length of time between release from DOC custody and the onset of care in the Look Forward period. This information told us whether individuals who received care before and during incarcerations got care faster after release relative to those who only received care after incarceration. We considered whether Incarceration Episodes that had care in the Look Back period got care faster in the Look Forward period, and found that they did. Figure 8 shows that Incarcerations Episodes that received care in both periods received care in the Look Forward 11.5 days faster, on average, than individuals who received care only in the Look Forward. This suggests that SUD care prior to incarcerations may help to facilitate timelier care-initiation after release.

**Figure 8: Release to Care Duration by Look Forward and Look Back**

Care Received	Median	n
Look Forward only	28	881
Look Forward and Back	16.5	226

**Source: Matched District Data**

We also evaluated whether the presence of an Active SUD flag in DOC facilitated faster care-connectivity in the Look Forward period than those who did not have an Active SUD flag. As Figure 9 shows, those with an Active SUD flag were not connected to care faster than those without an Active SUD flag; in fact, they were connected half a day slower on average over the entire Audit Period. This is a troubling “null” observation because it may suggest that DOC’s reentry processes for individuals known to have a SUD do not improve the speed with which care connectivity occurs after release.

**Figure 9: Release to Care Duration by Active SUD Flag**

Care Received	Median	n
Active SUD Flag	26.5	4269
No Active SUD Flag	26	333

**Source: Matched District Data**

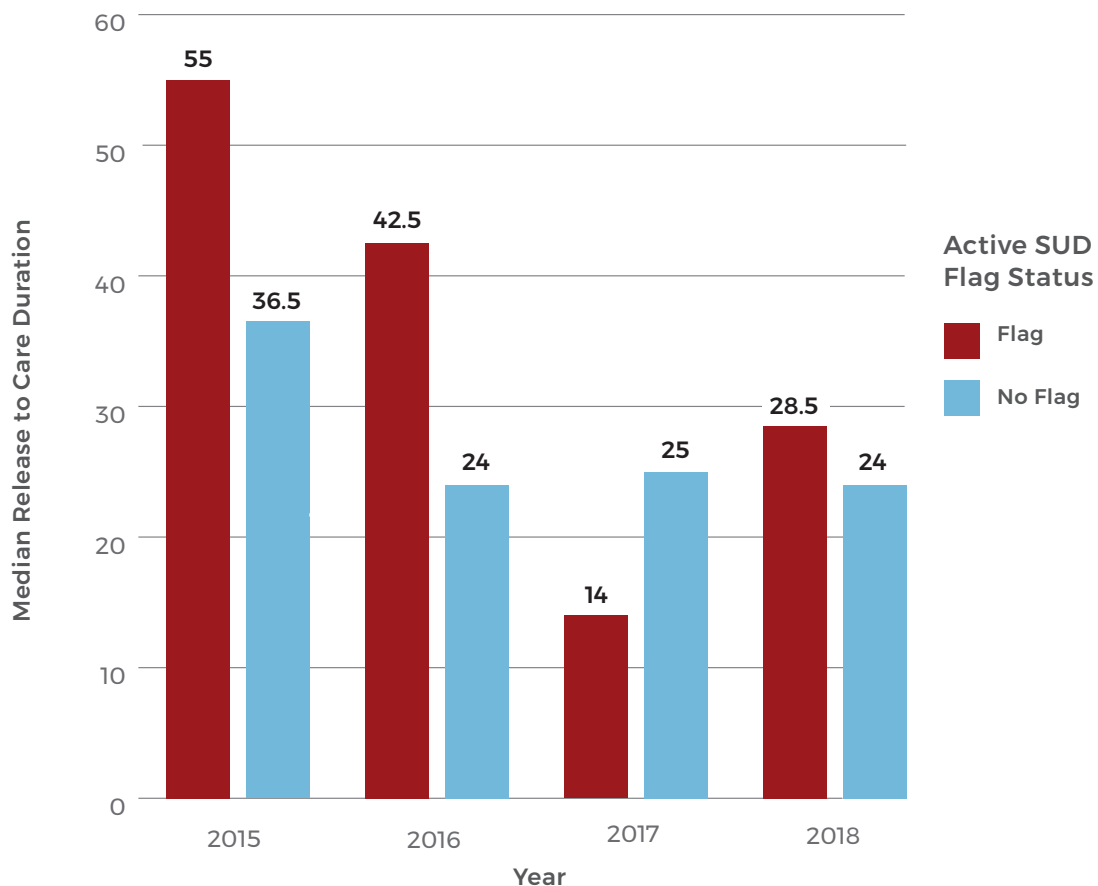
We then calculated the mean and median intervals of time from release from DOC custody to the first receipt of care for each year during the Audit Period (referred to as the “release-to-care interval”). As Figure 10 shows, while the release-to-care interval shrank from 2015 to 2016, it did not meaningfully change from 2016 to 2018. This data also shows that, on average, individuals took 33 days from the end of an Incarceration Episode, their release from DOC, to get connected to care. Unfortunately, we are not able to evaluate the reasons for the changes over time using the data available, but do note later in the report that DOC added several different Medication Assisted Treatment options during the Audit Period and had unique protocols for reentry planning related to those treatments that may have affected the release to care intervals for the individuals receiving those specific services.

We also sought to evaluate whether the presence of an Active SUD flag in an Incarceration Episode facilitated faster care-connectivity in the Look Forward period compared to Incarceration Episodes that did not have Active SUD flags. Interestingly, we found that Incarceration Episodes with Active SUD flags had far more *variable* release-to-care intervals over time than Incarceration Episodes without an Active SUD flag, but where the individual nevertheless sought treatment in the Look Forward period. See Figure 10 below.

For those with an Active SUD flag, the median release-to-care interval was 55 days in 2015. That interval dropped to 42.5 in 2016 and 14 in 2017, and then rebounded to 28.5 in 2018. In contrast,

those without Active SUD flags had relatively consistent release-to-care intervals from 2016 to 2018 of around 24 days. This is clearly an area that is ripe for further analysis and consideration by the District to understand the nuances of why these intervals varied so significantly, what, if any programmatic changes may have contributed to lengthy intervals, and how to potentially shrink the intervals in the future.

**Figure 10: Average Release to Care Duration by Year and Active SUD Flag Status**



*Source: Matched District Data*

## DATA FINDINGS: RELATIONSHIPS BETWEEN CARE DURING AN INCARCERATION EPISODE AND ADDITIONAL JUSTICE INVOLVEMENT

Bringing together the previous analysis with an evaluation of Active SUD flags, we also consider the interactions between care, the presence of Active SUD flags during the Incarceration Episode, and new “justice involvement” (either an MPD arrest or DOC incarceration) in the 90 days after the Incarceration Episode. We considered these factors to learn more about the way that care continuity may affect the experiences of individuals in the Look Forward.

Individuals who received care in the Look Forward were associated with less additional justice involvement during that same period, compared to individuals for whom care was not received in the Look Forward. The odds of new justice involvement after an Incarceration Episode for those who received care in the Look Forward was 36.3% lower than were the odds of those who did not receive care in the Look Forward.<sup>36</sup> Figure 11 shows the relationship between receipt of SUD Care in the Look Forward, Active SUD Flags, and justice involvement for all cases in which an individual received care in the Look Back. It shows that, independent of whether an individual had an Active SUD flag, if an individual received care in the Look Forward after an Incarceration Episode, that Look Forward was associated with less new justice involvement compared to Incarceration Episodes in which a person did not receive care in the Look Forward.

**Figure 11: Arrests and Care in Incarceration Episode Look Forward**

Active SUD Flag	SUD Care	Justice Involvement	n
No Active SUD Flag	No SUD Care	No JI	286
		JI	222
	SUD Care	No JI	127
		JI	74
Active SUD Flag	No SUD Care	No JI	17
		JI	21
	SUD Care	No JI	17
		JI	8

**Note:** This table shows those who received care and justice involvement in the Look Forward, only among those who also received care in the Look Back.

**Source:** Matched District Data

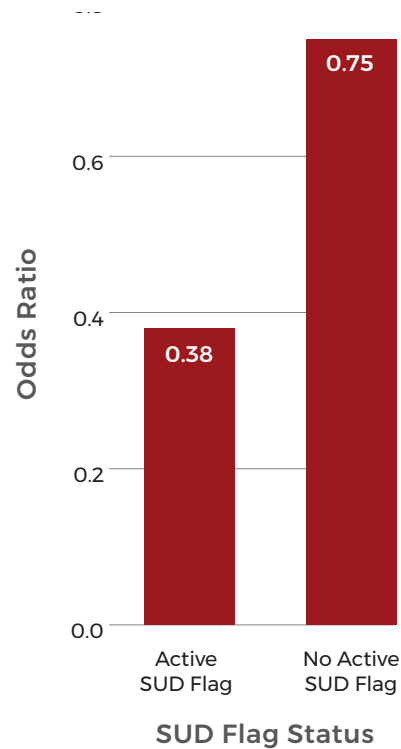
We then considered those who had Continuous Care, or in other words, those who had care in the Look Back and Look Forward and who additionally had an Active SUD flag. In general, Incarceration Episodes associated with Continuous Care were also associated with less justice involvement in the Look Forward than Incarceration Episodes that were not associated with Continuous Care. We determined this by examining how breaks in care continuity impacted the protective effect of care in the Look Forward on new justice involvement.

While the odds ratio of justice involvement among those who had care in the Look Forward was 0.75:1 (relative to those who did not have care in the Look Forward), the odds ratio of those who had

36 Care in the Look Back alone had an odds ratio of 1.07. Active SUD flag alone had an odds ratio of 1.09, where “care in the Look Back” and “Active SUD flag” are considered the “treatment” and “justice involvement” is considered the outcome. Given the small sizes of the effects, we did not explore these relationships further.

Continuous Care was 0.38:1 (relative to those who did not have care in the Look Forward).<sup>37</sup> This is illustrated in Figure 12.

**Figure 12: Odds of Justice Involvement for Incarceration Episodes with Care in Look Forward**



**Source: Matched District Data**

This suggests both that receiving care in the Look Forward has a protective effect on justice involvement, *and* that the protective effect of receiving care in the Look Forward is moderated by the presence of an Active SUD flag and the presence of care in the Look Back. Those who had Continuous Care had 62% lower odds of justice involvement in the Look Forward than those who did not receive care in the Look Forward. Whether or not the individual had an Active SUD flag in DOC moderated the effect of care in the Look Forward on the odds of new justice involvement: the odds of new justice involvement in the Look Forward were 25% lower among Incarceration Episodes with care in the Look Forward but no Active SUD flag compared to Incarceration Episodes

<sup>37</sup> We also calculated the effect of care in the Look Forward on justice involvement for cases that did not have care in the Look Back. When there was *neither* an Active SUD flag *nor* care in the Look Back, the odds ratio for care in the Look Forward was .61, whereas when there was an Active SUD flag (but still no care in the Look Back), the odds ratio for care in the Look Forward was .58. In other words, we only observe Active SUD flags to moderate the effect of care in the Look Forward when the incarceration was also associated with care in the Look Back.

without care in the Look Forward. This stands in contrast to Incarceration Episodes that received care in the Look Forward and had Active SUD flags, for which the odds were 62% lower.

## **DATA FINDINGS: DEATHS, JUSTICE INVOLVEMENT, AND CARE**

As noted above, our dataset included information about drug-related fatalities in the District. Of individuals who suffered a lethal overdose during the Audit Period, 15.07% had a DOC incarceration, and 22.65% received SUD care at some point during the Audit Period. Figure 13 shows that DBH and DOC had contact during the Audit Period with 31.41% of the individuals who died in the District due to overdoses. With further data analysis and case studies of the identified individuals, DBH and DOC could potentially offer better-targeted overdose prevention strategies to individuals who are at risk and who are already in the populations they serve. While these two agencies alone cannot carry the responsibility of predicting and preventing opioid overdoses, these known relationships represent a significant opportunity for the District to improve the way that it connects SUD and other support services to at-risk individuals.

Looked at another way, however, this data also suggests that DBH is not identifying and connecting to care individuals in the District who use drugs and might benefit from additional outreach and support. Specifically, based on our analysis of the District's data, DBH did not have any contact during the audit period with 77.35% of cases in which an individual died of an overdose.

Considering only the subset of deaths that were identifiable in the DBH or DHCF data, 97 people (or 8.75%) were incarcerated at some point during the Audit Period but did not receive any SUD services in the Audit Period. There were 251 people (22.64%) who received some kind of SUD services in the Audit Period but still died. In particular, the 97 individuals who were incarcerated, received no care, and died is a group worth significant examination and case study by the District, as they may represent the most urgent opportunity for targeted outreach and additional supports to improve care connectivity to its known, justice-involved residents with SUDs who may be at risk for overdose.



**Figure 13: Deaths by Incarceration and Care in Audit Period**

<b>Incarceration</b>	<b>Care</b>	<b>n</b>	<b>%</b>
No Incarceration	No Care	760	68.59%
	Care	181	16.34%
Incarceration	No Care	97	8.75%
	Care	70	6.32%

**Source: Matched District Data**

In Figure 14, we show the number of individuals who received care in the months preceding a fatal overdose. As reflected therein, 92.32% of individuals who died of an overdose during the Audit Period received no SUD care in the three (3) months preceding their deaths. This further supports the observation that the District may be able to prevent lethal SUD overdoses by improving the way that it connects clients to care.

**Figure 14: Care in Fatality Look Back**

<b>Care</b>	<b>n</b>	<b>%</b>
No Care	1023	92.32
Care	85	7.67

**Source: Matched District Data**

## **DATA FINDINGS: DEATHS, JUSTICE INVOLVEMENT, AND ASSESSMENTS**

We also considered the universe of DBH assessments in the Audit Period and the relationship between assessments, SUD care, new justice involvement, and lethal overdoses. Assessments are evaluated using 90-day Look Forwards. When we say an assessment was “followed” by an event we mean that event occurred in the 90-day period after the assessment occurred, or during the “Assess Look Forward.” These are defined using Department of Behavioral Health “Assess” data. The Assess data contains information about Assessments that DBH conducted at the Assessment and Referral Center (ARC) during the Audit Period. This data is comprised of 12,259 assessments and 8,234 individuals. After removing duplicated Assessments, Assessments that violated our censors, and or were clearly erroneous, we were left with a dataset consisting of 8,601 assessments and their associated Look Forwards. Unlike in other parts of this report, “care” in an Assessment Look Forward does not include additional Assessments that were performed within that 90-day period.

As discussed in detail in Finding 4, during the Audit Period, individuals seeking SUD care were required to receive an assessment prior to beginning therapy or treatment. We treat Assessment Episodes as the beginning of a discrete period of time in which an individual may have received

SUD services (as reflected as a billed claim for SUD service in DBH or DHCF data). Assessment Episodes allow us to look at periods of SUD care from some fixed start point, and therefore allows us to consider the relationship between receipt of SUD care after an assessment, Justice Involvement, and deaths.

Of the 8,601 total assessments evaluated in the Audit Period: 4,906 (57.04%) were followed by the receipt of a SUD service; 713 (8.29%) were followed by new justice involvement; and 123 (1.45%) were followed by a lethal overdose. Figure 15 below shows a breakdown of how these different factors—care, justice involvement, or death—overlap. Of those 123 assessments in which there was a lethal overdose in the Look Forward, 59 had received no SUD care in the associated Look Forward, and 64 had received SUD care in the Look Forward. Of the cases in which an individual received SUD care after an assessment, 1.3% had an overdose. In contrast, of the 3,695 individuals who did not receive SUD services in the 90 days after an assessment, 1.5% had an overdose. Although seemingly small differences, the human impact is clearly high; and when looked at in terms of odds, we found that the odds of death after assessments that did not lead to SUD care in the Look Forward were 18.55% higher than the odds of death after an assessment when the assessment was followed by Care.

**Figure 15: SUD Care, Deaths, and Justice Involvement in Assessment Look Forward**

<b>SUD Care</b>	<b>Deaths</b>	<b>Justice Involvement</b>	<b>n</b>
No Care	No Deaths	No JI	3291
		JI	345
	Deaths	No JI	55
		JI	4
Care	No Deaths	No JI	4487
		JI	355
	Deaths	No JI	55
		JI	9

**Note:** Values are measures of whether an event occurred in an Assessment Look Forward.

**Source:** Matched District Data

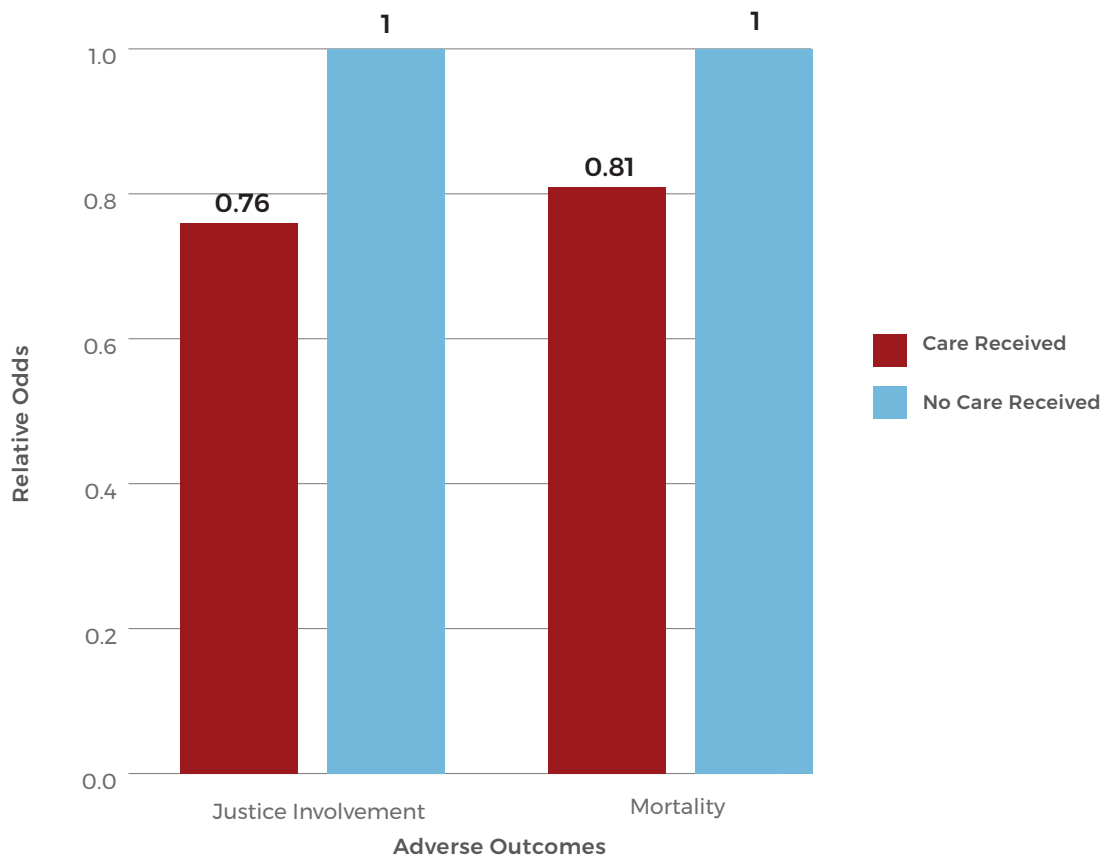
We also considered the relationship between assessments that did and did not result in care, and new justice involvement. Of the 3,695 assessments that did not result in care, 349 (9.45%) resulted in justice involvement. In contrast, of the 4,907 assessments for which the assessment resulted in a connection to care only 364 assessments (7.4%) were also associated with new justice involvement during the Look Forward period. An assessment that was associated with SUD care was 0.76 times less likely to have a new justice involvement than an assessment that did not result in SUD care.

We recognized the possibility that the new justice involvements prevented some individuals who

were assessed and given a referral for SUD services from receiving those services in the community during the Assessment Look Forward. To address this, we also looked at the subset of cases in which there was an arrest but no incarceration. We found that 7.36% of assessments that did not result in care in the Assessment Look Forward were followed by an arrest but no incarceration, while only 6.16% of assessments that did result in care were followed by an arrest. Using these more conservative assumptions, absence of care in the assessment Look Forward is still associated with 16.4% more new justice involvements in D.C.

There were only 13 cases in which an assessment was followed by both new justice involvement and a lethal overdose. Figure 16 shows the odds ratios for justice involvements and deaths in assessment Look Forwards based on whether or not the assessed individual received care. Relative to the odds of someone who did not receive care in the assessment Look Forward, individuals who did receive care were both less likely to have justice involvements and less likely to have died.

**Figure 16: Likelihood of Adverse Outcomes by Care Received After Assessment**



**Source: Matched District Data**

Finally, we considered features of assessments that occurred in Incarceration Episode Look Forward and Look Back periods. Of the 1107 individuals who received care in the Look Forward, 295 of those individuals received an assessment during the Incarceration Episode Look Forward. Figure 17 shows

a troubling null association between assessments and arrest: there was no relationship between whether or not an assessment was followed by care and whether there was an arrest within the Incarceration Episode Look Forward. Roughly 25% of those who did and did not receive care after an assessment were arrested at some point during the Incarceration Episode Look Forward.

**Figure 17: Arrests and Care in Look Forward**

<b>SUD Care in Look Forward</b>	<b>Arrest in Look Forward</b>	<b>n</b>
SUD Care	No Arrest	151
	Arrest	49
Care	No Arrest	71
	Arrest	24

**Note:** This table only shows the 295 assessments that occurred after an incarceration episode.

**Source:** Matched District Data

We explored this relationship further based on the referred level of care. We found that for those referred to Outpatient Care, Intensive Outpatient Care, and Withdrawal Management, the above relationship only marginally changed. However, those who were referred to and received Residential Care were more likely to have arrests than those who were referred to but did not receive Residential Care. Roughly 40% of those who were referred to and received Residential Care were arrested, whereas roughly 30% of those referred to Residential Care who did not receive care were arrested. Figure 18 shows this relationship.

**Figure 18: Arrests and Care in Look Forward among Referrals to Residential Treatment**

<b>SUD Care in Look Forward</b>	<b>Arrest in Look Forward</b>	<b>n</b>
SUD Care	No Arrest	32
	Arrest	14
Care	No Arrest	20
	Arrest	13

**Source:** Matched District Data

The null relationship between care connectivity among individuals with assessments and arrests indicates that DBH can do a better job providing additional support to those receiving Residential Care after incarcerations. The *increase* in arrests among those who receive Residential Care in contrast to those who were referred to but did not receive residential care is particularly notable and deserves further exploration by DBH.

## **FINDING 1:**

**An enhanced Pre-Arrest Diversion program in the District would provide opportunities for substantial improvement in outcomes for people with substance use disorders who are at risk of justice involvement.**

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## **RELATED RECOMMENDATIONS:**

1. The District should continue to offer pre-arrest diversion (PAD), building on the successes of the PAD pilot.
2. DBH and other PAD administrators should ensure that external stakeholders directly advise the program, consistent with best practices. The program should be transparent, creating a process for providing and responding to external feedback.
3. DBH, MPD, and other PAD administrators should work to increase police officer participation in and support of PAD by providing ongoing opportunities for feedback; updating policies based on officer feedback; and implementing pre-arrest referrals so that officers can divert someone from arrest without handcuffing them or bringing them to a police station.
4. PAD administrators should collaborate with community stakeholders to establish and publish a clear set of programmatic goals for PAD. Those goals should include measures of success for both improved health outcomes and reduced justice involvement.
5. PAD administrators should implement procedures to correct the PAD pilot's data collection and reporting shortcomings, including publishing information to help evaluate program efficacy and implementing data sharing procedures, consistent with best practices.

## **COMMENTARY:**

### **Overview of the District's Pre-Arrest Diversion Pilot**

In 2016, the District enacted the Neighborhood Engagement Achieves Results Amendment Act of 2016 (NEAR Act). That Act required, among other things, that MPD establish a "Community Crime Prevention Team Program," to be operated jointly by MPD, DBH, and the Department of Human Services (DHS).<sup>38</sup> Under the statute, the program's goal is to "immediately identify individuals in need of assistance and connect those who may be impacted by homelessness, mental illness, or substance abuse, with available services."<sup>39</sup>

As a first step toward fulfilling this mandate, the District launched a pre-arrest diversion (PAD) pilot

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38 D.C. Code § 5-132.31(a)-(b).

39 *Id.*

in April 2018.<sup>40</sup> PAD is a type of diversion program that occurs before an individual's arrest and is designed to break the cycle of justice involvement that may be caused by underlying behavioral health problems.<sup>41</sup> PAD programs can take different forms, but usually involve offering individuals connection to treatment programs in lieu of arrest or other criminal sanction. They may also involve active outreach to individuals who are either at high risk of contact with law enforcement or who have had high levels of past justice involvement.<sup>42</sup> While PAD programs take different forms, they are generally recognized as resulting in positive outcomes for participants, including a greater degree of treatment initiation and fewer future justice interactions.<sup>43</sup>

Increasingly, PAD programs are viewed as a best practice.<sup>44</sup> Several jurisdictions, including Maryland, Massachusetts, and King County, Wash. have implemented various PAD programs with significant positive effects.<sup>45</sup> King County's Law Enforcement Assisted Diversion (LEAD) program was one of the first PAD programs and was designed to include a robust program evaluation. It proved to be cost-effective, saving more in justice system costs driven by typical recidivism rates than were incurred in case management and social service costs, and has become a model program.<sup>46</sup> An evaluation of the LEAD program indicated that participants recidivated 60% less than counterparts

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40 Executive Office of the Mayor, District of Columbia. *Pre-Arrest Diversion: Connecting Police Community Contacts with District Services - Overview of the 2018 Pilot Period* (Apr. 23, 2019), <http://lms.dccouncil.us/Download/42362/RC23-0058-Introduction.pdf>.

41 Kathleen Hartford et al., *Pre-Arrest Diversion of People with Mental Illness: Literature Review and International Survey*, 24(6) *Behav. Sci. & L.*, 845 (2006), <https://doi.org/10.1002/bsl.738>.

42 Barry Goetz & Roger E. Mitchell, *Pre-Arrest/Booking Drug Control Strategies: Diversion to Treatment, Harm Reduction and Police Involvement*, 33(3) *Contemporary Drug Problems* 473 (2018), <https://doi.org/10.1177/009145090603300307>.

43 Greg Frost, Safety and Justice Challenge, *Pre-arrest Diversion—An Effective Model Ready For Widespread Adoption* (2016), <http://www.safetyandjusticechallenge.org/2016/07/pre-arrest-diversion-effective-model-ready-widespread-adoption>.

44 This section considers only “pre-arrest” diversion programs, although there are also diversion programs that occur “pre-booking” and “pre-trial.” The former of which do not currently exist in the District of Columbia but have been implemented in jurisdictions such as New York City and Bexar County. The latter of which does exist in the District of Columbia through its specialty courts, including the District of Columbia Superior Court Drug Court and the District of Columbia Superior Court Mental Health Community Court.

45 Davida Schiff et al., *A Police-Led Addiction Treatment Referral Program in Massachusetts*, 375 *New Eng. J. Med.* 25 (2016), <https://www.fels.upenn.edu/sites/default/files/NE%20Journal%20of%20Medicine-Gloucester%20Police%20Angel%20Program.pdf>; Arlington Massachusetts Police Department, *Arlington Police Department Implements New Addiction Protocols* (2015), <https://www.arlingtonma.gov/Home/Components/News/News/3078/494?arch=1>; Johns Hopkins Bloomberg School of Public Health, *Criminal Justice Diversion Programs: Policy Recommendations for Maryland* (2015), [https://www.jhsph.edu/research/centers-and-institutes/institute-for-health-and-social-policy/award-programs/lipitz-award/past-awardees/\\_documents/Criminal-Justice-Diversion.pdf](https://www.jhsph.edu/research/centers-and-institutes/institute-for-health-and-social-policy/award-programs/lipitz-award/past-awardees/_documents/Criminal-Justice-Diversion.pdf); Center for Health and Justice, *STEER Deflection Model: Pre-Booking Diversion Option for Law Enforcement* (2016), <http://www2.centerforhealthandjustice.org/content/project/steer-deflection-model-pre-booking-diversion-option-law-enforcement>.

46 Susan E. Collins et al., *Seattle's Law Enforcement Assisted Diversion (LEAD): Program Effects on Recidivism Outcomes*, 64 *Evaluation and Program Planning* 49 (2017), <https://doi.org/10.1016/j.evalprogplan.2017.05.008>.

in a control group, who were arrested during a randomized no-LEAD shift.<sup>47</sup> In the 18 months after LEAD participation, clients were 46% more likely to be in training, employed, or retired; 89% more likely to be permanently housed, and 33% more likely to have a legitimate income source.<sup>48</sup>

Recognizing that many MPD arrests each year involved individuals who were diagnosed with a mental illness, diagnosed with a SUD, or tested positive for illicit substances, the District's PAD pilot focused on connecting individuals struggling with mental illness and/or SUDs to treatment and social services.<sup>49</sup> The PAD pilot utilized community outreach and peer support to connect individuals to services prior to arrest, with the goal of diverting low-level, would-be offenders away from arrest and incarceration and into appropriate treatment and social supports.<sup>50</sup> The pilot was limited to two target Police Service Areas, and PAD services were only available during limited hours and days of the week.<sup>51</sup>

For an individual to be eligible for D.C.'s PAD pilot, they must have exhibited indications of a mental health condition or a SUD, been 18 years of age or older, and been subject to arrest for one or more of the approved non-violent misdemeanor charges (i.e., disorderly conduct, liquor law violations, narcotics, prostitution, theft, trafficking/receiving stolen property, and unlawful entry).<sup>52</sup> An individual who was not capable of conducting a coherent interview, could not be identified, attempted to flee, attempted to cause harm to another person or property, or who had outstanding warrants, was not eligible for the PAD pilot.<sup>53</sup> Finally, the individual was required to voluntarily choose to participate in PAD.

There were two entry points to D.C.'s PAD pilot. The first was through a pre-arrest referral.<sup>54</sup> When a PAD-trained MPD officer encountered an individual who was engaged in behavior that could be charged as one of the qualifying crimes and appeared to meet the PAD's enrollment eligibility criteria, the officer was required to first confirm that the potential enrollee did not have any disqualifying warrants. The officer then was required to describe to the potential enrollee the services available through the voluntary program and to explain that arrest could be avoided by agreeing to enroll. If the potential enrollee expressed an interest in participating, the officer called PAD social workers from DBH, and the officer would handcuff and transport the enrollee to an intake location, either the First District or Fifth District precincts. There, a PAD social worker would complete the enrollment, at which point the potential enrollee would become a program participant.<sup>55</sup>

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47 Susan E. Collins et al., *LEAD Program Evaluation: Criminal Justice and Legal System Utilization and Associated Costs* (2015), [https://docs.wixstatic.com/ugd/6f124f\\_2f66ef4935c04d37a11b04d1998f61e2.pdf](https://docs.wixstatic.com/ugd/6f124f_2f66ef4935c04d37a11b04d1998f61e2.pdf).

48 *Supra*, n. 46.

49 *Supra*, n. 40.

50 *Id.*

51 D.C. Metropolitan Police Department, *Pre-Arrest Diversion Pilot Program*, G.O. 502.04 (IV)(C) (effective Apr. 24, 2018), [https://go.mpdonline.com/GO/GO\\_502\\_04.pdf](https://go.mpdonline.com/GO/GO_502_04.pdf).

52 *Id.* at Attachment A.

53 *Id.*

54 *Id.* at IV(A).

55 *Id.*

The second PAD pilot entry point was through a social contact referral, or social referral.<sup>56</sup> Social referrals were made when there was no active behavior justifying a criminal charge, but the person was known to MPD because of a history of arrests or previous interactions with an officer in the community. The person still would have to meet the other eligibility requirements of the program, but could enter the program without being handcuffed and taken to one of the intake sites. Instead, an MPD officer would make a referral to the PAD social workers or a PAD social worker would make direct contact with the individual to facilitate enrollment.<sup>57</sup>

Once an enrollee was accepted into the program, staff would provide “services based on a plan tailored to the participant’s individual needs.”<sup>58</sup> Such services could include ongoing assessments of the participant’s “vulnerability and service needs,” outreach and referrals to relevant community providers, and other supports. Successful participants would graduate from the PAD pilot program after 180 days.

Between April and December 2018, the PAD pilot program was staffed by both existing MPD officers and DHS staff and new primary programmatic staff DBH hired through a \$970,000 allocation in the FY2018 budget. These specialized programmatic staff included a program director, four licensed clinical social workers, and four certified peer specialists.<sup>59</sup> The PAD pilot trained 69 MPD officers who offered pre-arrest and social referrals near Gallery Place and Starburst Plaza, the two locations the pilot targeted.<sup>60</sup>

When the pilot period concluded in September 2018, there were 50 PAD participants, and all had individualized service plans developed within 72 hours of enrollment.<sup>61</sup> Through the end of 2018, the program had 82 enrolled participants. Some 95% of the clients served had been diagnosed with a Severe Mental Illness (SMI), and 46% had a co-occurring SUD and SMI.<sup>62</sup> Some 95% had unstable housing at the time of enrollment, and 26 of the participants (about one-third of those with unstable housing) had received, or were approved to receive, some form of housing assistance.<sup>63</sup> The pilot showed promising initial outcomes, and DC should continue a PAD program.

Beginning in October 2019, the PAD program merged into DBH’s new mobile, multi-disciplinary, 24-hour response team. This team is designed to “provide crisis services to District residents that are

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56 *Id.* at IV(B).

57 *Id.*

58 D.C. Department of Human Services, *District of Columbia Pre-Arrest Diversion Pilot Program: Pilot Program Update* (2018), [https://dhs.dc.gov/sites/default/files/dc/sites/dhs/page\\_content/attachments/DC%20Pre-Arrest%20Divers%20Pilot%20Program\\_Updated%20v3.pdf](https://dhs.dc.gov/sites/default/files/dc/sites/dhs/page_content/attachments/DC%20Pre-Arrest%20Divers%20Pilot%20Program_Updated%20v3.pdf).

59 *Supra*, n. 40.

60 *Id.*

61 Office of the Deputy Chief Administrator & Deputy Mayor for Public Safety and Justice, *Deputy Mayor for Public Safety and Justice Performance Oversight Responses* (2019) (see response to 40(f); the other 35 participants were in FY19).

62 *Supra*, n. 40.

63 *Id.*



experiencing a wide range of behavioral health distresses.”<sup>64</sup> CCE did not examine the crisis team because it was created after the conclusion of the Audit Period. MPD’s General Order authorizing the PAD pilot and laying out procedures for officers is still in place.<sup>65</sup>

### **Limited Engagement of Community-Based Organizations and SUD Providers in PAD Pilot**

During the initial PAD pilot development in 2018, external organizations and community stakeholders were invited to listening sessions hosted by the government regarding the program and invited to give feedback. However, as the PAD pilot was implemented, no non-governmental community partners were involved as collaborators in the planning, functioning, or evaluation of the program. In jurisdictions with successful PAD programs, external stakeholders are involved in advising and/or managing the program. For instance, administrators of the LEAD program in King County, Wash., on which D.C.’s PAD pilot is based, noted that, “part of the secret sauce is that LEAD is run by a civil society group, and chose not to become city employees to ensure the viability of the program... there is an intentional power-sharing structure, because it contains police and prosecutorial discretion, those [non-governmental community leaders] are needed to maintain credibility” among community members.<sup>66</sup> Indeed, the LEAD National Support Bureau notes explains:

LEAD is a voluntary agreement among independent decision-makers to collaborate, and therefore must work for all stakeholders. LEAD cannot work without the dedicated efforts of independent agencies and, sometimes, multiple jurisdictions. The program can only proceed as far as the key participants can achieve agreement at any given time. In addition to law enforcement, service providers, community groups, prosecutors, elected officials and others, persons with relevant lived experience (e.g. drug use, sex work, homelessness, poverty) are essential stakeholders who should be meaningfully involved partners.<sup>67</sup>

Experts who conduct national trainings for PAD programs note that, “nationally, the jurisdictions that have struggled the most are the ones where the government is sitting in the project management position.”<sup>68</sup> External management and oversight allows PAD programs to effectively learn about community needs, build trust between law enforcement and members of the community who are historically distrustful of law enforcement, and build relationships between diverse stakeholders, including healthcare providers, prosecutors, and the judiciary.<sup>69</sup>

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64 Government of the District of Columbia, *FY 2020 Approved Budget and Financial Plan: Volume 4, Agency Budget Chapters - Part III* (submitted July 25, 2019), [https://cfo.dc.gov/sites/default/files/dc/sites/ocfo/publication/attachments/DC\\_2020\\_OCFO\\_Budget\\_Vol\\_4.pdf](https://cfo.dc.gov/sites/default/files/dc/sites/ocfo/publication/attachments/DC_2020_OCFO_Budget_Vol_4.pdf).

65 *Supra*, n. 51, at IV.

66 CCE Interview with LEAD Program Staff.

67 LEAD National Support Bureau, *Essential Principles for Successful LEAD Implementation* (updated Jan. 2017), [https://56ec6537-6189-4c37-a275-02c6ee23efe0.filesusr.com/ugd/6f124f\\_552d331f637f436189a38d-14f9b823ad.pdf](https://56ec6537-6189-4c37-a275-02c6ee23efe0.filesusr.com/ugd/6f124f_552d331f637f436189a38d-14f9b823ad.pdf)

68 *Supra*, n. 66.

69 *Id.*

These problems have arisen in the District, where governmental management of D.C.'s PAD pilot and a perceived lack of transparency undermined the trust of community-based organizations, SUD providers, and their clients. For instance, the D.C. Deputy Mayor for Public Safety and Justice reported that:

PAD's focus is to connect and utilize existing service delivery networks as resources. The PAD team has met with providers and stakeholders on an ongoing basis to develop workflows that support consumer choice while promoting effective service utilization. Providers and stakeholders have also been invited to participate in planning sessions, observe and comment on officer trainings, and meet with the PAD planning group to offer feedback.<sup>70</sup>

However, community members involved in advocacy concerning people with SUDs and the PAD pilot noted that they did not believe that their feedback had been adequately considered or adopted, and that they had no impact on shaping the PAD pilot's design or efficacy. One community member explained: "I'd like to see meaningful community engagement and an iterative process to best meet the needs of the target population. I haven't seen the PAD team engage with many community providers."<sup>71</sup>

Moreover, providers' lack of knowledge about the PAD pilot's processes and outcomes led to an unwillingness among some SUD providers to engage with the program. For example, one provider who serves clients who are frequently justice-involved said that they would not refer their clients to PAD because they did not know enough about what would happen to their clients if they participated. Several providers attributed their lack of comfort with the program to the absence of clear information on the implications of participation from governmental leaders.<sup>72</sup> Another common concern was that enrollees were being handcuffed and transported to police stations after agreeing to participate in the PAD pilot, scaring them by making the process feel like an arrest. The community organizations and advocates who raised these concerns did not believe that the agencies were interested in revising the PAD pilot protocols to address barriers to participation.

To address these issues, the MPD General Order and DBH policy should be amended to make D.C.'s program more closely resemble LEAD's best practice model. D.C.'s program should require that, in addition to MPD, DBH, and DHS, one or more community-based partners be engaged as part of the program administration and evaluation.

Additionally, to move the program beyond the pilot phase, the D.C. Council must ensure sufficient funding for all PAD partners to train and engage sufficient staff to participate in the program. While the precise need for PAD in D.C. is not currently known, continued inter-agency data-sharing and analysis, as discussed in Finding 5, could facilitate a reasonably accurate estimate of individuals who may be eligible for PAD and who might benefit from enhanced connections to behavioral health services.

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<sup>70</sup> *Supra*, n. 61.

<sup>71</sup> Email Correspondence with Community Organizer.

<sup>72</sup> CCE Provider Interview.

PAD partner agencies should work with interested community-based organizations, SUD providers, and directly impacted individuals to: debrief on lessons-learned from the PAD pilot, consider changes to enhance participation of both potential enrollees and law enforcement officers, and establish agreed-upon benchmark goals, as well as a set of data points to collect, for use in quarterly evaluations of the program's performance. This data and any evaluations should be made public on a quarterly basis. Additionally, the partner agencies should establish periodic standing meetings to discuss progress toward achievement of the program's goals, resource needs, and any challenges faced as well as to receive and respond to stakeholder and public feedback.

### **Low MPD “Buy-In” of PAD**

The PAD pilot also suffered from insufficient buy-in from MPD officers. Of the more than 3,800 sworn MPD officers in February 2018, 69 received PAD training and only 25 MPD officers, less than 1% of the force, actively referred one or more potential arrestees to the program or acted as “hub” officers during the PAD pilot.<sup>73</sup> One DBH administrator estimated that for PAD to function efficiently across the city, approximately 10%-20% of MPD officers would need to participate.<sup>74</sup>

Generally, low MPD officer buy-in was attributed to a lack of interest in participating in trainings, the perception that SUD treatment was not effective, and the perception that diversion was not a good use of officer time.<sup>75</sup> Unless agency leaders and program staff devote additional resources to educating more officers about the benefits of PAD and addressing any concerns about administrative burdens, this limited participation will be a barrier to the program's growth and, ultimately, its ability to serve as a vital tool to divert individuals with SUDs away from the criminal justice system and into treatment, reducing recidivism and the costs associated with unnecessary incarceration.<sup>76</sup>

Building buy-in from rank-and-file officers is a challenge in every jurisdiction. In interviews with LEAD trainers in King County, they explained that the problem could be addressed through targeted efforts by department leadership, particularly ongoing dialogue and training. The LEAD program established carefully managed focus groups with officers to convey information about the diversion program as it developed and to elicit feedback.<sup>77</sup> Based on our evaluation and interviews, we understand that targeted focus groups with officers—including those who have been trained and those who express disinterest in being trained—have not been conducted by the PAD pilot program agencies in the District.

The District should collect feedback from officers regarding their perceptions of and experiences with PAD in order to address their concerns in future iterations of the program. The District should also work with trainers and experts from other jurisdictions who have implemented full-scale and functional PAD or LEAD programs to help D.C. develop engagement strategies and design revised training resources for agency leadership, staff, and officers.

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<sup>73</sup> *Supra*, n. 40.

<sup>74</sup> CCE Interview with DBH Administrator.

<sup>75</sup> *Id.*

<sup>76</sup> *Id.*

<sup>77</sup> *Supra*, n. 66.

## Goal Setting, Data Collection, and Information Sharing for PAD

Lessons learned from the D.C. PAD pilot offer the opportunity for the District to join a handful of other jurisdictions in implementing a best-in-class diversion program. Together, the partner agencies must develop a clear and transparent set of program goals and measurements to ensure PAD's future efficacy in D.C.

First, although DBH and DHS published summary data regarding the number of clients who received PAD services, and the types of services received, the PAD pilot did not collect or report sufficient information necessary to evaluate the program's efficacy and functions. In no publicly available document regarding the pilot did the District specify goals of the PAD pilot or describe how any goals should be measured. Measurements of individual PAD participants' success were reported, but the impact of the pilot as a whole was not. At the end of the PAD pilot evaluation period, the District could not answer the following questions posed by the PAD working group:

- The number of individuals arrested for PAD eligible offenses during the pilot period.
- The number of individuals offered PAD during the pilot period, and, of those, how many declined to participate and how many were determined to be ineligible.
- The number of MPD officers who made PAD referrals.
- The number of social referrals that occurred in lieu of arrest.
- The estimated cost-savings of diversions compared to processing through the standard criminal justice system.<sup>78</sup>

Second, the D.C. PAD pilot suffered from low information sharing that was anomalous relative to other jurisdictions. In King County, community information sharing is written into the LEAD protocol.<sup>79</sup> For example, that protocol stipulates: "At least monthly, LEAD project management staff conduct a staffing meeting that includes community advisory representatives, [and city and state law enforcement agencies]. LEAD partners will use the staffing meetings to share information about... referral criteria, program capacity and compliance with the protocol; and to focus the attention of LEAD program staff and [the Seattle Police Department] in particular areas viewed with concern by community representatives."<sup>80</sup> Information on program alternatives, non-participating but eligible encounters, and client outcomes are each measured, allowing for robust program evaluation and monitoring.<sup>81</sup>

In Albany, N.Y. , which implemented a LEAD program in 2016, information sharing underpins the program's success. Albany LEAD started as a memorandum of understanding between city agencies, business improvement districts, law enforcement, and justice-system oversight groups;

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78 DC LEAD Working Group Meeting Notes.

79 LEAD King County, *Law Enforcement Assisted Diversion (LEAD) Referral and Diversion Protocol* (Nov. 2018).

80 Catherine Lester, City of Seattle, *Statement of Legislative Intent (SLI) 87-1-A-2 Response: Adjustment to 2016 Contracts with The Law Enforcement Assisted Diversion (LEAD) and Multi-Disciplinary Team (MDT) Programs* (June 24, 2016), [http://clerk.seattle.gov/~CFS/CF\\_319829.pdf](http://clerk.seattle.gov/~CFS/CF_319829.pdf).

81 *Id.*

a series of health care providers signed on later. A justice-system oversight group hosts regular public meetings to share information about program operations and to listen to public concerns with other signatories present.<sup>82</sup> A “Data and Evaluation Committee” that included community and governmental stakeholders determined what diversion data to collect and how to measure the data required for ongoing outcome evaluations.<sup>83</sup> After collecting the data with evaluators, the committee returns its findings to all signatories to provide recent information about program outcomes. These findings are also presented to the public and to business and government stakeholders. Early successes evidenced in Albany were attributed chiefly to LEAD signatories’ “inter-agency communication and planning to ensure that checks and balances are in place to assist the client.”<sup>84</sup>

Third, procedures for D.C.’s PAD pilot prompted misreporting that appears to underrepresent the number of “pre-arrest referral” diversions offered through the program. CCE learned, through interviews, that pre-arrest referrals are likely underreported because the city tracked the number of individuals referred to PAD in lieu of arrest through a count of Form 1004s—the Pre-Arrest Diversion Pilot Program Referral Form that MPD officers were required to complete when an individual was offered and accepted diversion through a pre-arrest referral.<sup>85</sup> However, the number of Form 1004s generated likely does not reflect the true number of individuals diverted.

MPD policy requires that officers offering diversion in lieu of arrest handcuff and transport the individual to a booking station, where they are enrolled in PAD by a social worker.<sup>86</sup> At that point, the officer must fill out the Form 1004, which some officers were disinclined to do. Some officers participating in the pilot would instead contact PAD programmatic staffers directly, then report the diversions as “social referrals,” both to avoid taking custody of the person and to avoid the paperwork.<sup>87</sup> Other officers funneled diversions through “hub” officers, who were more comfortable with the PAD process, after initial contact with a potential diversion participant.<sup>88</sup> Administrators reported that there were 25 active PAD officers, although only a handful actually signed Form 1004s.<sup>89</sup> MPD also chose not to track any offers of PAD participation declined by arrestees.<sup>90</sup> These practices combined to undercount both the number of “pre-arrest referrals” made and the number of officers who were making them.

Whether a diversion is attributed to a pre-arrest referral or a social referral is an important distinction. Community members interpreted the absence of “true” diversions—those attributed to

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82 Katal Center for Health Equity and Justice, *Albany LEAD First-Year Report* (Apr. 5, 2017), [https://d3n8a8pro7vhmx.cloudfront.net/katal/pages/1743/attachments/original/1517565036/2017\\_Albaney\\_LEAD\\_First\\_Year\\_Report.pdf?1517565036](https://d3n8a8pro7vhmx.cloudfront.net/katal/pages/1743/attachments/original/1517565036/2017_Albaney_LEAD_First_Year_Report.pdf?1517565036).

83 *Id.* at 6.

84 *Id.* at 7.

85 *Supra*, n. 51; CCE Interview with DBH administrator.

86 *Supra*, n. 56.

87 CCE Interview with DBH administrator.

88 *Id.*

89 *Id.*

90 Office of the Deputy Chief Administrator & Deputy Mayor for Public Safety and Justice, *Deputy Mayor for Public Safety and Justice Performance Oversight Responses* (Feb. 7, 2019).

pre-arrest referrals made in lieu of arrest—as an indication that the PAD pilot functioned as only a social-service referral program, another version of homeless outreach, but not as an actual diversion from a path leading to further justice involvement. The low number of officers completing the Form 1004s compounded these concerns.<sup>91</sup> Overall, the inaccuracy of the measures used to reflect the PAD pilot, combined with the low-level of external engagement, created a perception among District stakeholders that the program was not a good-faith effort to implement “true” PAD in D.C.

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91 *Supra*, n. 78.

## **FINDING 2:**

**DOC is failing to identify all individuals with substance use disorders who may benefit from treatment while in custody or connection to care during reentry.**

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## **RELATED RECOMMENDATIONS:**

1. DOC should use a best practice screening protocol for SUDs at intake, and revise its internal policy (PS 6000.1H) to require such screening.
2. In addition to self-reporting by residents, DOC should use collateral information to supplement SUD screenings to identify individuals with Active SUDs in its custody. Specifically, DOC should refer a resident for a full SUD assessment, regardless of the outcome of their intake screening, if they:
  - a. Have any history in DOC's own medical records of a SUD diagnosis or treatment from a prior period of custody; or
  - b. Have a positive drug test or are found guilty of a substance-related disciplinary violation while in DOC custody, which requires revision of DOC Program Statements 6050.2G and 5300.1H.
3. DOC should establish a protocol to request informed consent from all residents at intake to allow their community-based SUD providers and DBH to share SUD information with DOC, and to allow DOC to share information and communicate with DBH and their community-based SUD providers.
4. DBH and DHCF should provide DOC's medical provider limited access to SUD records and claims databases, through an MOU, for the purposes of accessing the SUD histories of patients in DOC custody who provide informed consent.

## **COMMENTARY:**

The D.C. Code provides that “[t]he Mayor shall contract for delivery of health care for inmates in the custody of the Department of Corrections...including primary care, specialty care, emergency care, and hospital care, and for connecting inmates with a health center in the community for continued care after the inmates are released from the custody of the Department of Corrections.”<sup>92</sup> DOC contracted with Unity Healthcare (“Unity”) to serve as its Health Care Vendor during the Audit Period and continues to have an active contract with Unity through April 14, 2020, with an option to

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92 D.C. Code § 24-140.

extend the base contract through 2024.<sup>93</sup> Unity is responsible for the day-to-day delivery of health care, including SUD services like MAT and detoxification, for DOC's entire resident population.<sup>94</sup> Despite many areas of effective provision of care, the data CCE analyzed and stakeholder experiences make clear that DOC has been unable to comprehensively or consistently identify all residents in its custody who have a SUD. This reflects an important missed opportunity to connect residents who could benefit from SUD treatment to care, and to support the continuity of care between correctional and community settings.

## Overview of Intake Screenings at DOC

Any individual entering DOC custody is screened by a "qualified health care professional or health/mental-health trained personnel," regardless of the reason for their detention or their expected length of stay.<sup>95</sup> During the Audit Period, the intake screener at DOC's Inmate Reception Center (IRC) was either a physician, nurse practitioner, or physician assistant employed by Unity.<sup>96</sup> The intake screening includes questions about: the "use of alcohol and other drugs (legal and illegal), including type(s) of drugs used, mode of use, amounts used, frequency used, date or time of last use, and history of any problems that may have occurred after ceasing use; drug withdrawal symptoms; and history of treatment."<sup>97</sup> If indicated by the screening, the patient is referred for a more comprehensive assessment by a Unity mental health clinician. This assessment asks for details about the patient's "substance use history and assesses [their] acute symptomatology," including risk of self-harm and withdrawal.<sup>98</sup>

Unity's evaluation of whether a patient has a SUD is based almost exclusively on the patient's participation in the evaluation and willingness to self-report; Unity does not generally review a patient's DOC records, DBH's SUD treatment database (DataWITS), or other agency-provided information during the intake process to determine whether the patient has a SUD history or an "Active SUD."<sup>99</sup> The limited exception is if the assessor looks for records in Centricity, Unity's Electronic Medical Record (EMR), and finds a medical history of SUD diagnosis or treatment at Unity during a prior DOC incarceration or at one of its community-based clinics.<sup>100</sup>

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93 See §§ 13 and 14 of Contract No. CW37196, Comprehensive Medical, Mental Health, Pharmacy and Dental Services for Department of Corrections (Oct. 1, 2015), and Contract No. CW37196 (Oct. 1, 2017); see also Contract Extension, Contract No. CW68868 (Apr. 15, 2019), [http://app.ocp.dc.gov/Award\\_attachments/CW68868-Base%20Period-Contract%20Award-CW68868%20Award%20File%20Redacted.pdf](http://app.ocp.dc.gov/Award_attachments/CW68868-Base%20Period-Contract%20Award-CW68868%20Award%20File%20Redacted.pdf) (the "Unity Contracts").

94 D.C. Department of Corrections, Program Manual No. 6000.1I at p. 2, ¶¶ 3(a)-(d) (effective June 20, 2017), <https://doc.dc.gov/sites/default/files/dc/sites/doc/publication/attachments/PM%206000.1I%20Medical%20Management%2006-20-2017.pdf>.

95 *Id.*

96 DOC Correspondence on Nov. 1, 2019.

97 D.C. Department of Corrections, Program Manual No. 6000.1H, at ¶¶ 1(c), 6-8 (effective Aug. 26, 2013), <https://doc.dc.gov/sites/default/files/dc/sites/doc/publication/attachments/PM%206000.1H%20Medical%20Managment.pdf>.

98 *Supra*, n. 96.

99 CCE Administrator Interviews; *supra*, n. 5.

100 *Supra*, n. 96; see also CCE DOC Administrator Interviews; CCE SUD Provider Interviews.



If the intake screening does not identify a SUD, DOC reports that a resident in its custody can still be connected to SUD care, “through the vigilance of staff and medical providers,” who identify residents suffering the effects of withdrawal, or if medically indicated during the course of care for other health concerns. DOC reports that residents in its custody can also request medical care for substance use concerns at any time.<sup>101</sup>

## Reported SUD Prevalence in DOC

DOC collects SUD data exclusively through patient records in Centricity. Patient records in Centricity include a code of the SUD diagnosis plus the diagnosis’ onset and end dates. When DOC extracts data for analysis, the information is flagged with two indicators based on the presence and timing of the diagnosis: (i) if a patient has ever had a SUD diagnosis in their record, they receive a “SUD Ever” indicator; and (ii) if a SUD diagnosis onset date is during a patient’s current period of incarceration, they receive an “Active SUD” indicator.<sup>102</sup>

DOC’s reported rates of identified SUDs among people in its custody during the Audit Period are summarized in Figure 19 below. In 2015, 58.8% of individuals in custody that year had some historical SUD diagnoses recorded in Centricity, while 8.4% had Active SUD flags because SUD diagnoses were made during their current period of incarceration. By 2018, 50.1% of individuals in custody that year had a SUD diagnosis history recorded in Centricity, while only 6% received Active SUD flags. From 2015 to 2018, DOC’s data shows a 27% decrease in the number of individuals incarcerated who “ever” had a SUD, and a 39% decrease in the number of individuals with an Active SUD diagnosis. The majority of the decrease in individuals who had ever had a SUD diagnosis occurred between 2017 and 2018, while the declines in the number of individuals who had an Active SUD diagnosis took place over a longer period between 2016 and 2018.

**Figure 19: Persons with SUD Information in DOC**

Year	Total Distinct Persons	No SUD Diagnoses Ever	SUD Diagnoses Ever	Active SUD Diagnoses	Opioid Diagnoses Ever
2015	8920	3671	5249	453	515
2016	9412	4058	5354	746	523
2017	9831	4583	5248	631	576
2018	7688	3840	3848	462	464

**Source: DOC Correspondence with CCE, Response 2**

<sup>101</sup> *Supra*, n. 96, at Response 6.

<sup>102</sup> *Supra*, n. 96, at Responses 1 and 2(e).

DOC's own interpretation of its data during the Audit Period indicated "only 2-9% of EMR records indicated substance use disorder diagnoses in the EMR."<sup>103</sup> This is consistent with the results of a 2017 custodial population study commissioned for the Criminal Justice Coordinating Council in which the authors reported a 5% rate of Active SUD diagnosis among residents in DOC custody in FY2015.<sup>104</sup>

However, DOC administrators and medical providers acknowledged that the current screening protocols likely capture only a small percentage of the total number of individuals in DOC with SUDs.<sup>105</sup> DOC has even gathered supplementary information indicating that SUD levels among its residents are much higher than identified. In correspondence with CCE, DOC reported that in a recent survey of the individuals released from custody who received reentry services through DOC's Resources to Empower and Develop You (READY) Center, "approximately 40% of respondents anticipated that substance use would be a barrier to [their] reentry."<sup>106</sup>

### Alternative Data About Substance Use Prevalence

There are several sources of data that suggest that DOC has undercounted individuals in its custody with a SUD, including the first-impression data analysis that CCE conducted using inter-agency matched data. As noted above, the DOC screenings to identify a SUD largely involve patient self-reporting. Aside from limited Unity medical record access, the information about which clients have SUDs is collected based on the disclosures of the person entering custody. DOC recognized that its method of collecting SUD information likely resulted in a significant undercount,<sup>107</sup> but it did not modify its intake screening process to improve the quality of its data during the Audit Period.

First, in the general U.S. population, approximately 7.6% of Americans age 18 and older met the DSM-IV diagnostic criteria for a SUD in 2018.<sup>108</sup> The same survey estimated that 11.55% of D.C. residents aged 18 or older had a SUD.<sup>109</sup>

Second, narrowing to those with justice involvement, people who are arrested are more likely to test positive for one or more substances and to have SUDs than non-arrestees. In the most comprehensive national study of drug use among arrestees, the Arrestee Drug Abuse Monitoring Program

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<sup>103</sup> *Supra*, n. 96.

<sup>104</sup> Moss Group, *District of Columbia Custodial Population Study: Seeking Alignment between Evidence Based Practices and Jail Based Reentry Services*, p. 2 (2017), [https://cjcc.dc.gov/sites/default/files/dc/sites/cjcc/page\\_content/attachments/DC%20Custodial%20Population%20Study%2009.2017.pdf](https://cjcc.dc.gov/sites/default/files/dc/sites/cjcc/page_content/attachments/DC%20Custodial%20Population%20Study%2009.2017.pdf).

<sup>105</sup> CCE Provider Interviews; CCE Administrator Interviews.

<sup>106</sup> *Supra*, n. 96.

<sup>107</sup> *Supra*, n. 96.

<sup>108</sup> SAMHSA, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health*. Rockville, MD: August 2019. <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf>.

<sup>109</sup> SAMHSA, *NSDUH State Estimates*, accessed Mar. 5, 2020, <https://pdas.samhsa.gov/saes/state>; see also SAMHSA, *Section 5 PE Tables—Results from the 2018 National Survey on Drug Use and Health: Detailed Tables, Sections 1 - 3*, SAMHSA, CBHSQ, accessed Mar. 11, 2020, <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2018R2/NSDUHDetTabsSect5pe2018.htm>.

(ADAM) II, 68% of arrestees nationally tested positive for at least one illicit substance at the time of arrest.<sup>110</sup> The majority of ADAM II positive tests were for marijuana.<sup>111</sup> Another study estimated that 45.5% of arrestees nationwide had alcohol dependence or abuse in the past year.<sup>112</sup> Locally, the Pretrial Services Agency for the District of Columbia (PSA) found in 2018 that between 25%-30% of individuals arrested in a given month tested positive for an active metabolite of either amphetamines, cocaine, opiates (non-heroin), PCP, heroin, or synthetic cannabinoids. PSA did not test for alcohol or marijuana.<sup>113</sup>

Third, in a recent systemic review of the literature on the relationship between alcohol use disorders, drug use disorders, and corrections internationally, 18%-30% of men and 10%-24% of women in prison had an alcohol use disorder, and 10%-48% of men and 30%-60% of women had a drug use disorder.<sup>114</sup> In the U.S., the Bureau of Justice Statistics estimates that more than half of people incarcerated in state prisons and two-thirds of people serving sentences in jails met the criteria for substance dependence or abuse.<sup>115</sup>

It is important to note that an incident of substance use near the time of an arrest does not necessarily mean that a person has a SUD, nor does the absence of a positive drug test mean the person does not have a SUD. Prison and jail SUD rates are also not directly comparable because of differences between pre-trial and sentenced populations. Nevertheless, the fact that rates of positive drug tests of arrestees in D.C. and national rates of substance use corresponding to arrests and incarceration significantly exceed the identified rates of SUDs in DOC supports DOC's and this audit's conclusion that it significantly under-identifies individuals with SUDs in its custody.

Fourth, CCE's interagency data analysis also found significant evidence to suggest that DOC under-identifies residents with Active SUDs, visualized in Figures 20 and 21 below. Of the 4,602 Incarceration Episodes analyzed during the Audit Period, 1,653 had community-based SUD care in D.C. either before, after, or both before and after the incarceration. Of those 1,653 cases, only 142, or 8.5%, had an Active SUD at DOC during their incarceration, meaning that more than 90% of the people in DOC custody who had community-based SUD treatment in D.C. within 90 days of their incarceration were not identified by DOC as having an Active SUD.

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110 *Supra*, n. 10.

111 *Id.*

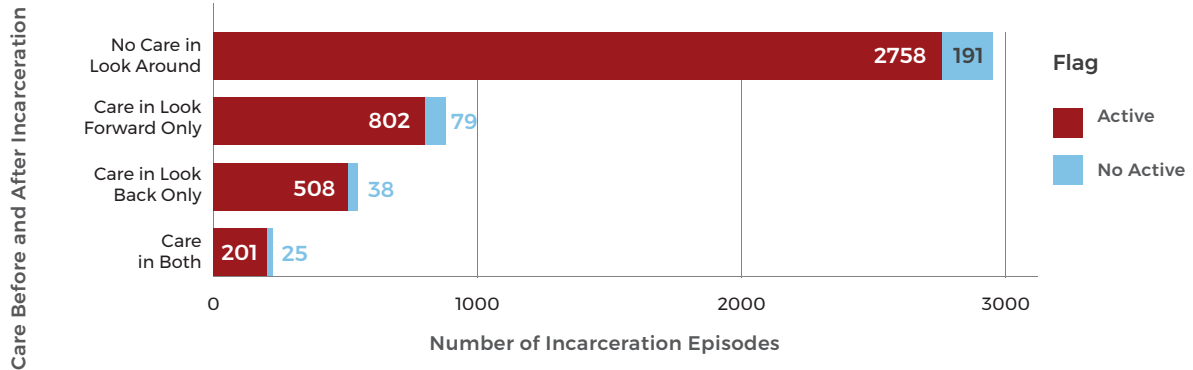
112 Pamela K. Lattimore et al., CBHSQ Data Review, *Arrestee Substance Use: Comparison of Estimates from the National Survey on Drug Use and Health and the Arrestee Drug Abuse Monitoring Program* (2014), <https://www.ncbi.nlm.nih.gov/books/NBK390289>.

113 Leslie Cooper, Pretrial Services Agency for the District of Columbia, *December 2018 Drug Test Statistics* (2019), <https://www.psa.gov/sites/default/files/PSA%20Drug%20Stats%20Report%20December%202018.pdf> (data for D.C. only).

114 Jack Tsai & G. Xian, *Utilization of Addiction Treatment among U.S. Adults with History of Incarceration and Substance Use Disorders*, 14. *Addiction Science & Clinical Practice* 1, 9 (2019), <https://doi.org/10.1186/s13722-019-0138-4>; see also The National Center on Addiction and Substance Abuse at Columbia University, *Behind Bars II: Substance Abuse and America's Prison Population*, p. 14 (2010).

115 *Supra*, n. 12.

**Figure 20: Incarceration Episodes by Active SUD Flag and Care in Community**



**Source: Matched District Data**

Taking a more conservative approach and assuming that only those people who received SUD care *both* before and after an incarceration reflect those actively in need of SUD care, DOC correctly detected 11.1% of cases. However, this is likely an overestimation of DOC's true overall SUD detection rate, as the matched dataset we had did not include several relevant data sources that may have identified additional individuals that were unknown to DBH and DHCF, but nevertheless had SUDs and were ultimately incarcerated in DOC. In other words, there likely are more individuals, even beyond those known to DBH but not DOC, who had SUDs while they were in custody and could have benefitted from treatment.

**Figure 21: Care received before and after Incarceration Episode by SUD Flag**

Care Received	SUD Flag	n
No Care in Look Around	No Active SUD Flag	2758
	Active SUD Flag	191
Care in Look Forward Only	No Active SUD Flag	802
	Active SUD Flag	79
Care in Look Back Only	No Active SUD Flag	508
	Active SUD Flag	38
Care in Both Look Forward and Back	No Active SUD Flag	201
	Active SUD Flag	25

**Source: Matched District Data**

Put together, this data suggests that DOC systematically and significantly undercounted the number of individuals in its custody with SUDs during the Audit Period, and, therefore, also was under-delivering SUD services to individuals who might have benefited from them.

## Screening Protocols to Improve SUD Identification in DOC

As CCE's analysis shows, DOC did not detect the vast majority of individuals who consumed SUD services in the District in the months before and after their incarceration. In light of this data, DOC and Unity should re-examine their clinical methods of screening and assessing for SUDs and explore and test alternative diagnostic instruments and processes that might increase accurate identification of SUDs.

Relying on self-reporting at intake as the primary source of information is problematic because patients entering DOC's custody have often recently undergone the often long and stressful process of arrest, booking, and arraignment, and may not believe that disclosing a SUD is necessary or will benefit them. Medical providers in DOC explained that, "intake screening is a poor place to capture this information. Individuals at intake are stressed, they may have slept little over the past several days, and may just not want to talk to you."<sup>116</sup> As a consequence, "we have piss-poor data about SUDs... we are not capturing anywhere close to the amount of SUDs in DOC."<sup>117</sup>

SUD clients also reported skepticism about the efficacy of the DOC screening protocols. Several reported that they did not go into detail about the nature of their SUDs during intake screenings because they believed that DOC already knew about their issues since they had been in and out of jail for years. Others felt that nothing happened when they did disclose their SUD to DOC, and so they were less likely, when re-incarcerated, to raise it again or to seek any kind of treatment when they were re-incarcerated.<sup>118</sup> To counter some of these limitations of self-reporting, DOC could both improve and supplement the information it receives during intake screenings.

DOC's current screening protocols include asking a series of questions about an individual's past substance use and draws on a list of mandatory questions enumerated under the American Correctional Association (ACA) Standards' Performance-Based Detention Standards for "Health Screens."<sup>119</sup> The ACA standard sets the floor for SUD screenings for accreditation purposes, but does not represent best practice. SUD screening instruments are questionnaires developed by researchers for clinical use and are designed to ascertain the risk, presence, and severity of SUDs. Differences in approach are considered rigorously in SAMHSA's *Screening and Assessment of Co-Occurring Disorders in the Justice System* monograph.<sup>120</sup> Some jurisdictions are even successfully exploring the use of computer-administered SUD screenings to combat conditions that inhibit accurate

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<sup>116</sup> CCE Administrator Interview.

<sup>117</sup> *Id.*

<sup>118</sup> CCE Client Interviews.

<sup>119</sup> U.S. Department of Justice, *Federal Performance-Based Detention Standards* (revised Feb. 2011), <https://www.justice.gov/archive/ofdt/fpbds02232011.pdf>.

<sup>120</sup> SAMHSA, *Screening and Assessment of Co-Occurring Disorders in the Justice System* (revised Jun. 2019), <https://store.samhsa.gov/product/Screening-and-Assessment-of-Co-Occurring-Disorders-in-the-Justice-System/PEP19-SCREEN-CODJS>.

self-reporting.<sup>121</sup> Currently, DOC policy does not call for the explicit use of a best practice screening tool. DOC should work with Unity to test alternative SUD screening tools and identify instruments or protocols that could enhance DOC's identification rate. Following that clinical evaluation, DOC should amend its internal policy 6000.1H to require the delivery and implementation of a best practice SUD screening tool.

### Using Collateral Information to Improve SUD Identification in DOC

Given patients' potential reluctance to answer questions about their history of substance use during a correctional intake, DOC should also use collateral information to help decide whether to refer a patient for a full SUD assessment. One source of such information is patients' Unity health records. Patients with a SUD diagnosis anywhere in their Unity health records should be referred for a full assessment, regardless of what they self-report during the intake screening.

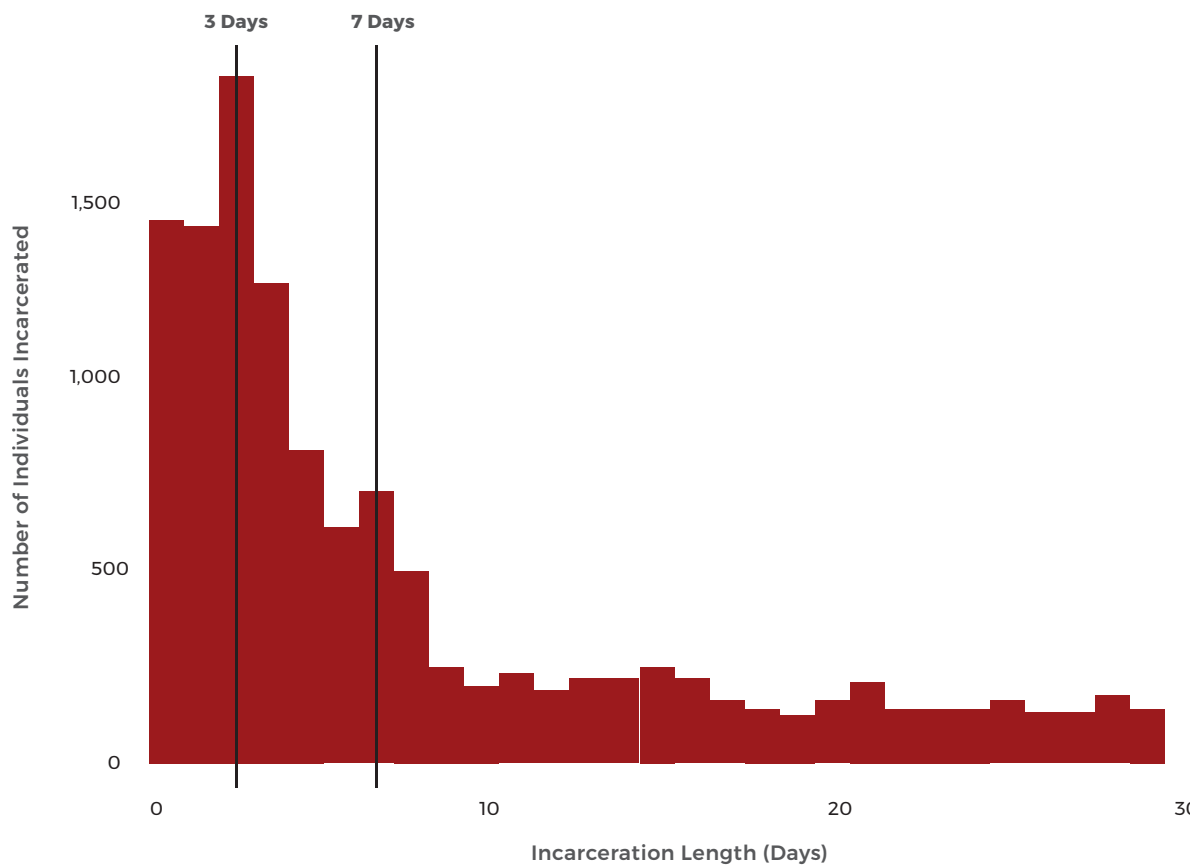
In the case of those who are quickly released from custody, however, it is impractical to expect them to undergo full assessments. Figure 22 below shows that, during the Audit Period, 20.3% of people were released from DOC custody in three or fewer days, and 35.2% in seven or fewer days. DOC should automatically review medical histories in Centricity for the 64.8% of residents who are in custody longer than a week and refer any resident with a recorded SUD diagnosis for a full SUD assessment. For those likely to be in custody for a short period of time or for an unknown duration, DOC should use the best practice "Screening, Brief Intervention, and Referral to Treatment" (SBIRT) model, discussed at greater length in Finding 3, to quickly rank individuals at intake who are at risk of having or may have a SUD and give them a brief intervention or a referral to later treatment—either in DOC custody or in the community.<sup>122</sup>

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121 Nancy Wolff & J. Shi, *Screening for Substance Use Disorder among Incarcerated Men with the Alcohol, Smoking, Substance Involvement Screening Test (ASSIST): A Comparative Analysis of Computer-administered and Interviewer-administered Modalities*, 53 J. Subst. Abuse Treat. 22 (2015), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4414742/>.

122 See, e.g., SAMHSA, *Screening, Brief Intervention, And Referral To Treatment (SBIRT) In Behavioral Health-care* (2011), [https://www.samhsa.gov/sites/default/files/sbirtwhitepaper\\_0.pdf](https://www.samhsa.gov/sites/default/files/sbirtwhitepaper_0.pdf).

**Figure 22: Length of Incarceration at DOC Throughout Audit Period**

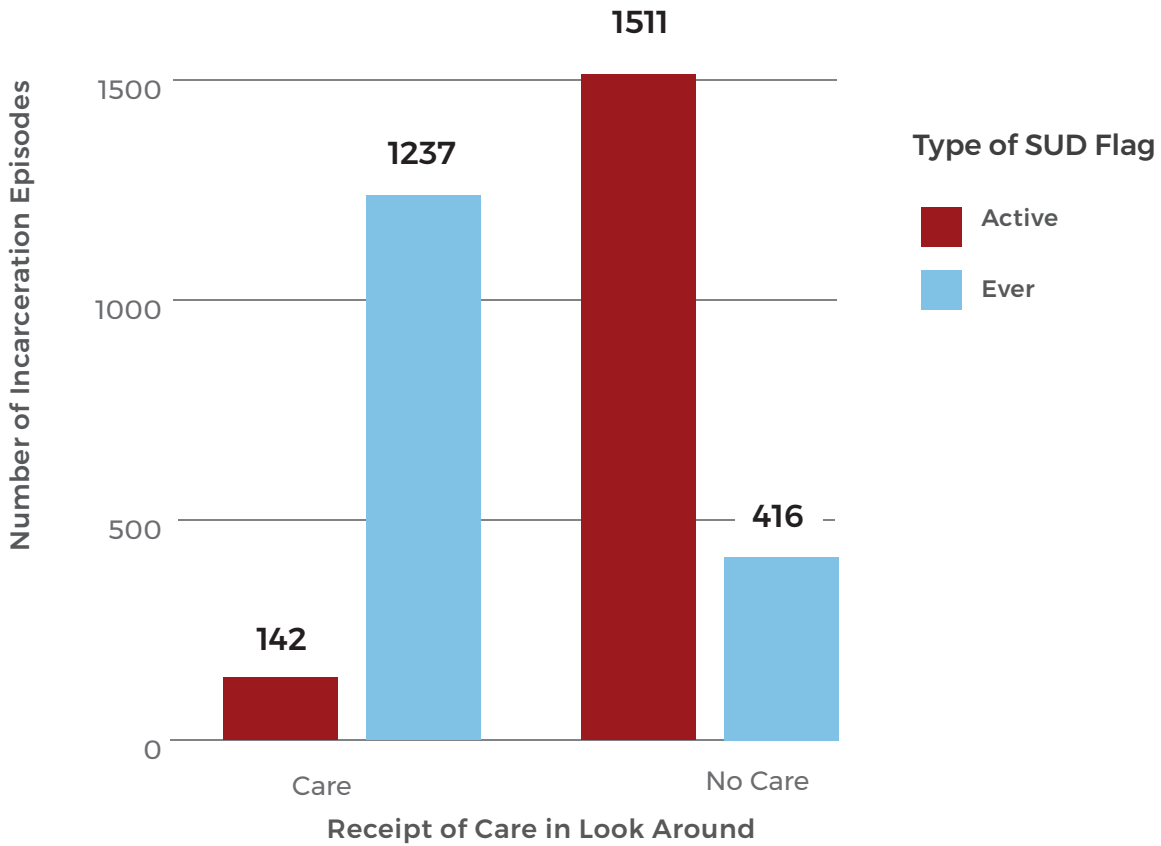


**Source: Matched District Data**

These procedures should significantly raise the rate of identification of patients with SUDs at DOC. As shown below in Figures 23 and 24, CCE found that DOC’s SUD Ever flag, created from patients’ SUD diagnosis histories, did a significantly better job capturing the universe of people who had received SUD services during the 90-day period before or after an Incarceration Episode than the screening and assessment procedure DOC currently uses. Of the 1,653 individuals who received care in the community at some point before or after an Incarceration Episode, 1,237 individuals (74.8%) had a SUD Ever flag at DOC; in contrast, only 142 (or 8.59%) of those 1,653 individuals had an Active SUD flag.<sup>123</sup>

<sup>123</sup> Please note the SUD Ever Flag does a poor job discriminating between individuals who do or do not receive care in the Look Around. 71.93% of all Incarceration Episodes analyzed in this Audit Period had an SUD Ever Flag, but 62.63% of SUD Ever Flags were held by individuals who did not receive SUD services in the Look Around.

**Figure 23: Incarceration Episodes that Received  
Care in Look Around by Type of SUD Flag**



Source: Matched District Data

**Figure 24: Care Received Before and After Incarceration Episode by SUD Flag**

Care Received	SUD Flag	n
No Care in Look Around	No Active SUD Flag	2758
	Active SUD Flag	191
Care in Look Forward Only	No Active SUD Flag	802
	Active SUD Flag	79
Care in Look Back Only	No Active SUD Flag	508
	Active SUD Flag	38
Care in Both Look Forward and Back	No Active SUD Flag	201
	Active SUD Flag	25

Source: Matched District Data

A second source of collateral information is the record of the resident's disciplinary incidents. Residents housed at the Central Detention Facility (CDF) for more than 30 days are subject to



randomized drug testing.<sup>124</sup> A resident who tests positive for an illicit substance, is supposed to receive “appropriate disciplinary action” and “may be offered the opportunity to participate in a substance abuse counseling, education or treatment program.”<sup>125</sup> However, DOC explained that, in practice, individuals who tested positive during the Audit Period only received a disciplinary report (DR) “and were not sent to Unity for SUD assessment.”<sup>126</sup> In addition to testing positive, if a resident were found to possess, control, use, make, or be under the influence of an “illegal drug, marijuana, a controlled substance, or a narcotic [not prescribed by a physician],” that behavior would also be written up in a DR, and the resident could face an investigation, hearing, and sanction.<sup>127</sup> Similarly, “individuals found to possess illicit substance contraband were given a DR and were not assessed for [a] SUD.”<sup>128</sup>

These drug tests and possession of contraband infractions are both missed opportunities for DOC to identify additional residents who may have a SUD that was not identified at the intake screening, or who would benefit from an increase in care. DOC should amend its internal Policy Statements 6050.2G and 5300.1H to require that residents who either test positive for an illicit substance or are found guilty of a disciplinary violation related to an illicit substance are referred to Unity for SUD assessments.<sup>129</sup>

### Increasing SUD Identification and Care Coordination Through Information Sharing

The inability of medical staff to rely on existing, contemporaneous health records when making screening decisions impedes efforts to accurately track patients’ diagnoses and deliver high-quality SUD services in correctional settings.<sup>130</sup> As noted above, people who are undergoing the stressful process of arrest and incarceration are a poor place to report accurate information about their SUD status or to seek treatment. The District can mitigate that problem by facilitating DOC’s consistent and immediate access to client-level SUD information generated by medical records or claims.

If Unity, acting as DOC’s medical provider, had access to specific patient information in DBH, DHCF, and PSA databases, it could use recent drug test results, SUD diagnoses, level of care assignments, and recent care history to better identify DOC residents in need of SUD care and ensure that appropriate care is delivered. As our data analysis shows, this information sharing could immediately result in the more accurate identification, during intake, of individuals with SUDs in DOC custody.

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124 D.C. Department of Corrections, Policy and Procedure No. 6050.2(f), 2(a) (Jan. 17, 2017), <https://doc.dc.gov/sites/default/files/dc/sites/doc/publication/attachments/PP%206050.2G%20Drug%20Testing%20of%20Inmates%2001-17-2017.pdf>

125 *Id.* at 16(a).

126 *Supra*, n. 96, at Question 7.

127 D.C. Department of Corrections, Program Manual No. 5300.1H (Apr. 21, 2017), <https://doc.dc.gov/sites/default/files/dc/sites/doc/publication/attachments/PM%205300.1H%20Inmate%20Disciplinary%20and%20Administrative%20Housing%20Hearing%20Procedures%2006-28-17.pdf>.

128 *Supra*, n. 96, at Question 8.

129 This is not currently occurring. See *supra*, n. 96, at Response 7.

130 See Justice and Health Connect, *Background*, accessed Mar. 13, 2020, <http://www.jhconnect.org/background>.

To facilitate this client-level SUD information sharing, it is critical that individuals in DOC custody provide specific and informed consent to share their SUD records with DOC. While other agencies and SUD providers may also be involved in efforts to educate SUD clients about the benefits of sharing certain limited SUD information with other behavioral health and criminal justice entities, DOC should ensure that it has a procedure that will maximize its ability to obtain informed consent from individuals in its custody.

Specifically, DOC should establish a protocol to request and record informed consent from all residents at intake to allow their community-based SUD providers, DBH, DHCF, and PSA to share SUD records with DOC, and to allow DOC to share SUD information and communicate with DBH and the residents' community-based SUD providers. The forms used to record consent must be compliant with federal and local law and should be consistent with the forms used by other providers and agencies to ensure appropriate use.

With such consent protocols in place, DBH and DHCF should then work with DOC to establish a Memorandum of Use that will grant DOC's medical provider limited, but ongoing access to their SUD records and claims databases for the purposes of accessing the SUD histories of patients in DOC custody who have active consent on record.

There are additional benefits to DOC's having better information about individuals with SUDs in its custody. By more accurately identifying residents with SUDs, not only will DOC be better poised to provide appropriate treatment and reentry planning, as will be discussed in Finding 3, but DOC also will have information to better scale its SUD treatment programs, make more targeted requests for grants or District funds, and tailor its future medical provider contracts to reflect patient needs. Furthermore, the District must transform the way it shares population-level information about SUD clients between community-based providers and local and federal agencies if it wants to increase the successful provision of care in the jail and the community more generally. A range of recommendations to improve inter-agency information sharing and program evaluation practices surrounding SUD records and justice-involved individuals, inside the boundaries of federal and local law, are made as part of Finding 5 of this report.

### FINDING 3

**DOC is a leader in the delivery of medication-assisted treatment in a correctional setting, but needs to improve the availability of other types of substance use disorder services, reentry planning, and Medicaid reconnection support for people leaving custody.**

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#### RELATED RECOMMENDATIONS:

1. DOC should offer group and individual therapeutic programming, in addition to existing chemical dependency care, that will address the interest in and need for SUD treatment for DOC residents that Residential Substance Abuse Treatment (RSAT) cannot fulfill in light of its capacity limitations, eligibility criteria, and abstinence requirement.
2. DOC should make “brief interventions,” practices that clinicians can undertake in short periods of time and that are designed to motivate residents at risk of substance abuse to change their behavior, available to all individuals with SUDs in DOC custody, regardless of the length of their stay.
3. DOC should determine the minimum length of incarceration needed for it to provide effective treatment—beyond medication-assisted treatment (MAT) and detoxification—at the appropriate level of care to individuals in its custody who have an Active SUD.
4. DOC and DBH should prioritize reentry planning and data collection for people with Active SUD flags. This should include the facilitation of connections between SUD providers in DOC to community-based SUD providers, and tracking systems that will allow DOC and DBH to evaluate connection to care rates.
5. DOC should use the Uniform Consent Form with residents with Active SUD flags so that:
  - a. If a resident has a community-based SUD provider, DOC can inform that provider when its client has been taken into custody and when the client is scheduled for release.
  - b. The provider can share information with DOC about the SUD client’s level and type of care.
6. DOC and DHCF should establish annual goals and relevant procedures to ensure that all eligible individuals leaving DOC have Medicaid coverage initiated or reinstated within 48 hours of their release from custody.

## COMMENTARY:

### Overview of SUD Services in DOC

The D.C. Code provides that “[t]he Mayor shall contract for delivery of health care for inmates in the custody of the Department of Corrections at the D.C. Jail and Correctional Treatment Facility... including primary care, specialty care, emergency care, and hospital care, and for connecting inmates with a health center in the community for continued care after the inmates are released from the custody of the Department of Corrections.”<sup>131</sup> As noted above, DOC contracted with Unity to serve as its Health Care Vendor, with an option to extend its contract through 2024.<sup>132</sup> Unity is responsible for the day-to-day delivery of health care, including SUD services, to the DOC correctional population.<sup>133</sup>

As noted in the previous finding, data suggests that DOC is failing to identify all of the individuals in its custody with active SUDs. That problem is compounded by the barriers to care posed by a limited range of SUD services available to DOC residents. During the Audit Period, DOC offered the following SUD-specific services: medication-assisted treatment (MAT) or detoxification services for clients with chemical dependencies, through Unity; the Residential Substance Abuse Treatment (RSAT) program for a select group of eligible participants; and the opportunity to “partake in NA [Narcotics Anonymous] or AA [Alcoholics Anonymous] programming, even though that has a re-entry/abstinence-based perspective.”<sup>134</sup> DOC reported that, during the Audit Period, “there was no SUD curriculum used with residents, which is typical for most jails,” but that people in DOC custody “may have also had exposure to Ministry of Hope SUD-focused psycho-educational materials.”<sup>135</sup>

**Detoxification and MAT.** Under its contract with DOC, Unity has the responsibility to develop the “medical detoxification policy for drug and alcohol addicted inmates.”<sup>136</sup> Patients undergoing acute withdrawal receive appropriate assessments and treatment to address withdrawal symptoms.<sup>137</sup> Detoxification may occur “at a DOC facility, a D.C. Detoxification Center or an off-site inpatient service facility.”<sup>138</sup> Detoxification “is a set of interventions aimed at managing acute intoxication and

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131 D.C. Code § 24-1401 (2010) (Chapter 14, Delivery of Health Care to Inmates).

132 See §§ 13 and 14 of Contract No. CW37196, Comprehensive Medical, Mental Health, Pharmacy and Dental Services for Department of Corrections (Oct. 1, 2015), and Contract No. CW37196 (Oct. 1, 2017); see also Contract Extension, Contract No. CW68868 (Apr. 15, 2019), [http://app.ocp.dc.gov/Award\\_attachments/CW68868-Base%20Period-Contract%20Award-CW68868%20Award%20File%20Redacted.pdf](http://app.ocp.dc.gov/Award_attachments/CW68868-Base%20Period-Contract%20Award-CW68868%20Award%20File%20Redacted.pdf). Also, see *supra*, n. 93.

133 *Supra*, n. 94, at p. 2, ¶¶ 3(a)-(d).

134 DOC Correspondence on Nov. 1, 2019.

135 *Id.* DOC also stated that in 2020 a new curriculum was expected be used for SUD reentry planning services, but CCE has not confirmed its roll out.

136 There are slight differences in the language of H.13.12 the 2015 Unity Contract, as compared to the corresponding sections of the 2017 Unity Contract. See 2017 Unity Contract at C.5.13.1 (“Contractor shall develop and provide medical detoxification policy for drug and alcohol addicted inmates. Contractor shall include description of medical detoxification policy in its Operations Manual.”) and C.5.13.2 (“Contractor shall coordinate its services with the DOC residential Substance Abuse Treatment (RSAT) program...”).

137 *Supra*, n. 134.

138 *Supra*, n. 97, at pp. 28-29, ¶ 13(a).

withdrawal. It denotes a clearing of toxins from the body of the patient who is acutely intoxicated and/or dependent on substances of abuse.”<sup>139</sup> During the Audit Period, Unity’s detoxification policy included the use of MAT. MAT is the use of medications, in combination with counseling and behavioral therapies, for the treatment of SUDs.<sup>140</sup> MAT is consistently heralded as a key best practice in the treatment of individuals with SUDs, particularly opioid use disorder. MAT has been found to reduce criminal activity, arrests, probation revocations, and re-incarcerations.<sup>141</sup> MAT is associated with reduced patient odds of relapse and reduced medical costs.<sup>142</sup>

The use of MAT services puts DOC in good company.<sup>143</sup> Despite the growing attention to the opioid crisis, “few prisons and jails provide evidence-based substance use disorder treatments.”<sup>144</sup> The National Commission on Correctional Health Care’s “Jail-Based MAT: Promising Practices, Guidelines and Resources” notes that best practices among MAT providers include many of the features that are present in DOC’s MAT program, including a wide variety of choice in treatment options, appropriate detoxification protocols, and reentry supports.<sup>145</sup>

Within DOC, MAT includes the continuation of methadone and Suboxone prescriptions that individuals were receiving in the community and the initiation of Suboxone.<sup>146</sup> These services meet the National Commission on Correctional Health Care (NCCHC) standards for opioid treatment programs in correctional facilities,<sup>147</sup> for which DOC has received an NCCHC accreditation.<sup>148</sup> Additionally, DOC’s use of the triple-MAT model (initiating methadone and Suboxone, as well as delivering Narcan upon release) is comparable to the program in Rhode Island, which is broadly considered to have the best correctional MAT protocols in the country.<sup>149</sup> A study comparing the

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139 SAMHSA, *Detoxification and Substance Abuse Treatment: A Treatment Improvement Protocol*, <https://store.samhsa.gov/system/files/sma15-4131.pdf>.

140 SAMHSA, *MAT Overview*, accessed Mar. 11, 2020, <https://www.integration.samhsa.gov/clinical-practice/mat/mat-overview>.

141 SAMHSA, *Medication-Assisted Treatment (MAT) in the Criminal Justice System: Brief Guidance to the States* (Mar. 2019), [https://store.samhsa.gov/system/files/pep19-matbriefcjs\\_0.pdf](https://store.samhsa.gov/system/files/pep19-matbriefcjs_0.pdf); see also *supra*, n. 1.

142 Naoko A. Ronquest et al., *Relationship Between Buprenorphine Adherence and Relapse, Healthcare Utilization and Costs in Privately and Publicly Insured Patients with Opioid Use Disorder*, 9 *Substance Abuse and Rehabilitation* (2018), <https://doi.org/10.2147/SAR.S150253>, p. 59.

143 *Supra*, n. 139.

144 Warren J. Ferguson et al., *Advancing the Implementation and Sustainment of Medication Assisted Treatment for Opioid Use Disorders in Prisons and Jails*, 7 *Health & Justice* 1, 19 (2019), <https://doi.org/10.1186/s40352-019-0100-2> (citing Amy Nunn et al., *Methadone and Buprenorphine Prescribing and Referral Practices in US Prison Systems: Results from a Nationwide Survey*, 105 *Drug and Alcohol Dependence* 1, 83 (2009)).

145 National Commission on Correctional Healthcare, *Jail-Based MAT: Promising Practices, Guidelines and Resources* (2018), <https://www.ncchc.org/jail-based-mat>.

146 DOC Correspondence on Feb. 15, 2019, Attachment entitled *DOC MAT Trends and Plans 2016-2019* (FINAL).pptx.

147 D.C. Department of Mental Health, Notice of Final Rulemaking, 62 D.C. Reg. 12056 (Sep. 4, 2015) (Pub. L. No. 37, 62).

148 *Supra*, n. 146, Attachment entitled *OTP re-certifications (2019\_2016\_2013)\_DBH OTP certification (2014-2017) and 2019 DBH approval to initiate Methadone.pdf*.

149 *Supra*, n. 140.

six-month period before implementation of the Rhode Island MAT program to the same period a year later found a 61% decrease in post-incarceration deaths. That decrease contributed to an overall 12% reduction in overdose deaths in the state’s general population in the post-implementation period.<sup>150</sup>

Additionally, over the course of the Audit Period, DOC’s provision of best-practice MAT services increased significantly, consistent with its plans to increase the delivery of MAT services.<sup>151</sup> The expansion of DOC’s MAT services has continued after the end of the Audit Period to include the initiation of methadone and the delivery of Vivitrol injections to patients discharged from the facility.<sup>152</sup>

**Figure 25: Trends in DOC MAT Treatment 2015–2018**

Year	Methadone prescription	Suboxone Prescription
2015	64	43
2016	72	42
2017	78	58
2018	51	73

**Source:** DOC Correspondence on Nov. 1, 2019.

As is shown in Figure 25, during the Audit Period, DOC increased the number of individuals who received Suboxone from 43 in 2015 to 73 in 2018, while the number of individuals provided methadone decreased somewhat from 64 in 2015 to 51 in 2018.<sup>153</sup> DOC has expanded its MAT services by initiating Suboxone in DOC facilities in 2018, initiating methadone in 2019, and beginning the delivery of Narcan kits to patients upon discharge.<sup>154</sup>

**Residential Substance Abuse Treatment.** DOC also provides SUD services through the RSAT program, a therapeutic program within the Central Treatment Facility (CTF) that provides “treatment, education and/or counseling to individual inmates, needs assessments, activities, treatment plans, planning and linkages” to a select group of participants.<sup>155</sup> The RSAT program mission is “to provide comprehensive diversified treatment interventions and support service linkages, upon release, to

150 Traci Green et al., *Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System*, 75 JAMA Psychiatry 4, 405 (2018); see also *At Rikers Island, a Legacy of Medication-Assisted Opioid Treatment* (2016), <http://pew.org/27lSkFh>.

151 DOC Correspondence on Nov. 1, 2019.

152 *Id.*

153 *Supra*, n. 151, at Question 14.

154 *Supra*, n. 146.

155 *Supra*, n. 94, at p. 30, ¶ 14(c).

participants with substance use disorders, for the purpose of developing and enhancing the effective coping skills necessary to the recovery process and becoming productive members of their communities.”<sup>156</sup>

The RSAT units can house a total of 75 men and 15 women at any one time, and DOC reports that the average stay in the program is 90 days.<sup>157</sup> During each Fiscal Year covered by the Audit Period, RSAT served between 104 and 115 residents, except for FY2018 when RSAT served only 65 residents at DOC.<sup>158</sup> Eight people were put on a waitlist for the program during FY2015, and none were wait-listed throughout the rest of the Audit Period.<sup>159</sup> Individuals in DOC custody are eligible for RSAT if there is a SUD diagnosis, evidence of substance use within the last 12 months, custody clearance by DOC, and the ability to participate in the RSAT program for a minimum of 30 days (in other words, release or transfer to different custody is not expected before participation in RSAT is completed).<sup>160</sup> Anyone who had already participated in the program in the last 12 months is disqualified from re-applying to RSAT.<sup>161</sup> Additionally, RSAT is an abstinence-only program, and any participant who has a positive drug screening is expelled from the program.<sup>162</sup>

In addition to the services described above that were available during the Audit Period, DOC has several new or expanded SUD programs planned. DOC reported:

In FY2020 DOC will also develop a state-of-the-art SUD therapeutic housing unit for men and comprehensive mental health/SUD therapeutic housing unit for women, offering comprehensive mental health care as well as Medication Assisted Treatment (MAT) with Methadone, Suboxone, and Vivitrol. Residents on these units will also fortify medical treatment with comprehensive SUD curricula and Trauma Informed Curricula, which will be co-lead [sic] by officers and mental health clinicians. All DOC officers and Unity clinicians involved will have been trained by Trauma Informed Care (TIC) Subject Matter Experts.<sup>163</sup>

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<sup>156</sup> *Supra*, n. 151.

<sup>157</sup> Government of the District of Columbia, Substance Abuse Treatment at DOC, accessed Mar. 2, 2020, <https://doc.dc.gov/page/substance-abuse-treatment-doc>.

<sup>158</sup> DOC Correspondence on Feb. 26, 2020 (Note that “Between February-May 2019 there were no RSAT referrals from USPC pending their review of the program’s outcomes for its clientele. Thereafter, RSAT started receiving referrals again from USPC between June-September 2019 for the RSAT program. During the review period, 53 USPC referred clients were instead moved to alternative community programs.”).

<sup>159</sup> DOC Correspondence on Feb. 14, 2020, Response 6a.

<sup>160</sup> D.C. Department of Corrections, *Policy and Procedure*, 6050.3C (Mar. 31, 2017).

<sup>161</sup> *Id.*

<sup>162</sup> *Id.* at 6050.3C.13.b and 17.b.

<sup>163</sup> *Supra*, n. 158.

DOC also plans to partner with community-based organizations to “provide clinical care on the TIC curricula, a 30-module unit combining psycho-education and mindfulness from a TIC perspective, so that residents can continue their stabilization with community-based partners well versed in TIC and DOC’s evidence-based groundbreaking SUD work.”<sup>164</sup>

**Reentry Planning.** DOC’s policy is to provide continuity of care “from admission to transfer or discharge from the DOC facilities, including discharge planning and referral to community-based providers, when indicated” for all individuals in its custody.<sup>165</sup> In addition to its contractual duties to provide “medical detoxification,” Unity is responsible for providing patients, before release from DOC custody, “referrals to substance abuse treatment and counseling programs, as appropriate.”<sup>166</sup> All inmates must receive a “discharge treatment plan, and, if applicable, an initial appointment to an assigned health care center of their choice in the inmate’s neighborhood, ideally with the same health care team that provided services while the inmate was in custody.”<sup>167</sup>

For individuals in DOC custody with diagnosed mental health disorders, “the Mental Health Liaison from the D.C. Department of Behavioral Health (DBH) assigned to the DOC evaluates patients with mental health problems who are due to be released into the community.”<sup>168</sup> The liaison then facilitates a connection between those patients and community-based care.<sup>169</sup> However, for clients with only SUDs (and who do not also have a co-occurring mental health diagnosis), DOC explained that reentry planning was provided only through their health care vendor contract, via Unity’s “comprehensive discharge planning services.”<sup>170</sup>

### Insufficient Services Available for Non-Chemical Dependency SUDs

As noted, DOC implements a well-regarded MAT program, offers detoxification, and serves up to 115 people annually in the RSAT program. It does not provide, however, any other SUD care to people in its custody. This effectively leaves anyone who has a SUD but who does not require detoxification (such as for opioid or alcohol withdrawal) or MAT, or who cannot qualify for RSAT, without any SUD treatment, even though a wide range of SUDs exist within the incarcerated population. If left untreated, these SUDs can have significant health and social impacts. This concern is borne out in DOC’s SUD flag indicators. DOC reported that, during the Audit Period, only between 9.81% and 12.06% of individuals in DOC custody who had SUD Ever flags also had Opioid Ever flags,

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<sup>164</sup> *Id.*

<sup>165</sup> *Supra*, n. 94, at p. 40, ¶ 40(d). It is noteworthy that this policy further states that “Discharge planning occurs of inmates in need of community follow up; those with acute or chronic medical/mental health/dental concerns,” completely omitting substance use needs as a basis for discharge planning. While there are other sub-provisions that provide for some SUD discharge planning, it is clearly not prioritized as the same level as these areas of care.

<sup>166</sup> See Contract No. CW37196, Comprehensive Medical, Mental Health, Pharmacy and Dental Services for Department of Corrections (Oct. 1, 2015), at p. 45, C.5.12.10.

<sup>167</sup> *Supra*, n. 94, at p. 40, ¶ 40(c).

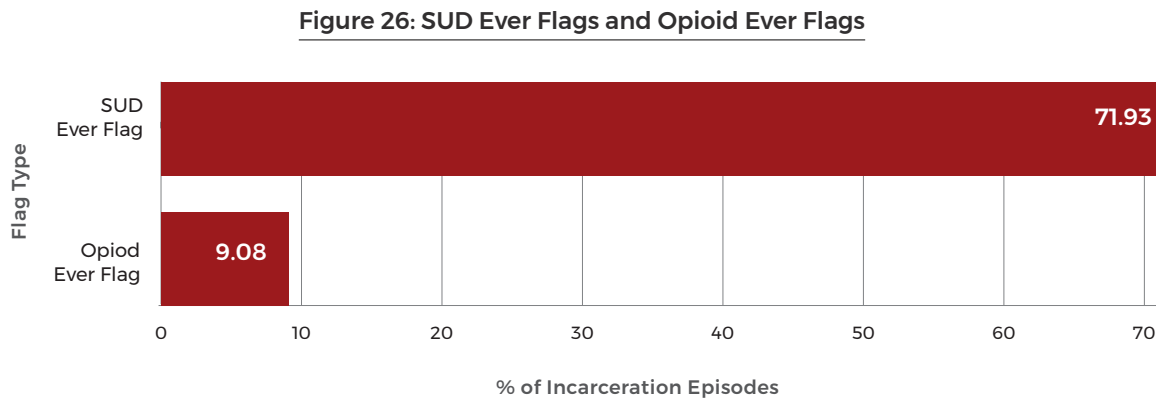
<sup>168</sup> *Id.* at p. 40, ¶ 40(d).

<sup>169</sup> *Id.*

<sup>170</sup> *Supra*, n. 134.



suggesting that MAT would have benefited a minority of DOC residents with SUDs.<sup>171</sup> At the same time, as Figure 26 shows, CCE found in its analysis of agency data that most individuals in DOC had some prior record of having a SUD. In Incarceration Episode's analyzed by DOC, 71.93% of individuals in DOC had a SUD Ever flag while only 9.08% had an Opioid Ever flag.<sup>172</sup>



**Note:** This graph shows the percentage of incarceration episodes with SUD Ever flags vs. Opioid Ever flags.

**Source:** Matched District Data

While D.C. law requires DOC to provide for the care of “all persons committed” to the jail,<sup>173</sup> DOC’s own policies make clear that SUD services are primarily intended for chemical dependency. First, Chapter 4 of the DOC’s Medical Management Policies details the “Procedures for Provision of a Continuum of Health Care Services” of the Health Care Vendor within DOC facilities. This section includes expectations for its full range of services and includes both a “mental health program” and “management of chemical dependency.”<sup>174</sup> There is no reference to substance use services within the mental health sub-section and “Management of Chemical Dependency” contemplates only two options: detoxification (and related MAT care) and the RSAT program. While the sub-heading that describes the RSAT program uses the more general “Substance Abuse Programs,” it does not in fact reference more than one potential additional program that might be available to individuals in DOC custody with SUDs that are not chemical dependencies.<sup>175</sup> The only other reference in Chapter 4 to substance use services is under “Health Education” where it requires that the offered health education program topics include “substance abuse.”

<sup>171</sup> Opioid Ever flags are indicators of whether an individual in DOC has ever had an opioid addiction. DOC Correspondence on Nov. 1, 2019.

<sup>172</sup> CCE Analysis of Agency data.

<sup>173</sup> D.C. Code § 24-211.02a (2012) (Processing and Release of Inmates from the Central Detention Facility), <https://code.dccouncil.us/dc/council/code/sections/24-211.02a.html>.

<sup>174</sup> *Supra*, n. 94.

<sup>175</sup> *Id.*

In its contracts with DOC during the Audit Period, Unity's obligations for providing SUD services were exclusively to "develop and provide medical detoxification policy for drug and alcohol addicted inmates."<sup>176</sup> Unlike its detailed expectations for the provision of mental health services,<sup>177</sup> DOC did not specifically require Unity to develop individual treatment plans, support visitation from SUD providers, or prescribe any other forms of care such as group or individual counseling for individuals with SUDs who were not otherwise in MAT or detoxification programs.

While the 2019 contract between DOC and Unity includes significant changes to expand the requirements and resources for behavioral health services, the contracts that were active during the Audit Period did not contemplate services for all individuals who had SUDs in DOC custody. Administrators emphasized that residents in DOC custody who did not need detoxification or MAT and who could not access RSAT received no SUD counseling during the Audit Period, regardless the level of care they had previously been receiving in the community. One member of the medical team reported that "generally, if you screen positive for SUD, you are not going to receive counseling through Unity, however the behavioral health unit also does individual and group counseling services."<sup>178</sup> DOC medical staff in charge of the behavioral health unit also confirmed there was no systematic delivery of SUD-specific counseling services in DOC, outside of the RSAT program.

One provider working inside DOC explained that group and individual counseling focused on substance use was, in fact, provided only to people who were actively receiving MAT care.<sup>179</sup> "[During the Audit period] the group was only for people who were on Methadone."<sup>180</sup> Providers and DOC noted that NA/AA meetings are also offered to individuals in DOC, but those are not offered specifically by [Unity].<sup>181</sup>

For example, one DOC-based provider explained that, for a person entering DOC with a chronic marijuana or PCP addiction, "I don't think they would receive any specific follow-up for that, I think it would go in their chart, and any provider that saw them for something else would note it, and those providers might provide motivational interviewing, but would not provide other care."<sup>182</sup> Another explained that, with regard to SUD counseling, "we didn't have any SUD counseling [or] treatment in our contract other than [Opioid Treatment Program] weaning. There wasn't a big push for SUD treatment in our contract."<sup>183</sup> For patients who come in with an alcohol or marijuana problem, "there is not an addiction counselor."<sup>184</sup>

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<sup>176</sup> *Supra*, n. 94, at C.5.13.

<sup>177</sup> See *supra*, n. 94, at C.5.10.1.2.8, C.5.10.1.3.5, C.5.10.3.5.5, C.5.10.3.5.6, C.5.10.3.5.7, C.5.10.3.5.8.

<sup>178</sup> CCE SUD Provider Interview.

<sup>179</sup> *Id.*

<sup>180</sup> *Id.*

<sup>181</sup> DOC Correspondence on Nov. 1, 2019.

<sup>182</sup> CCE SUD Provider Interview.

<sup>183</sup> *Id.*

<sup>184</sup> *Id.*

While DOC program statements require that individuals undergoing chemical dependency management receive “on-going substance abuse counseling and linkage to services internally and upon release,”<sup>185</sup> no comparable services are required for patients who have other types of SUDs. Most of the justice-involved SUD clients interviewed about their experience receiving SUD care in jail reported that they did not receive any SUD services while incarcerated at DOC.<sup>186</sup> A client with a marijuana addiction explained that he received no rehabilitation while he was in DOC, but was later connected to care by his supervision officer after he failed a urine screening.<sup>187</sup>

The diversity and volume of SUD care in DOC would benefit from offering regular group and individual counseling for individuals with SUDs, regardless of whether they have chemical dependencies. As a best practice, SAMHSA calls for criminal-justice agencies to provide “therapeutic programming (such as relapse prevention counseling, cognitive-behavioral therapy, etc.) in addition to MAT medications, either through in-house services or by partnering with community-based agencies.”<sup>188</sup>

As a practical matter, DOC is unable to provide comprehensive and tailored SUD treatment to every individual who enters its custody because a significant majority are held for only a short period of time, often only a few days. As the graph below shows, 25% of incarcerations last for four or fewer days. Over the course of the full Audit Period, the median amount of time that individuals spent in DOC custody was 20 days, and 56.4% of incarcerations had a duration of stay under 30 days.<sup>189</sup> It is unrealistic to expect DOC to implement a comprehensive SUD treatment plan for each person who is in custody for such a brief period of time.

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185 *Supra*, n. 94, at p. 30, ¶ 14(a) and p. 26, ¶ 5(a).

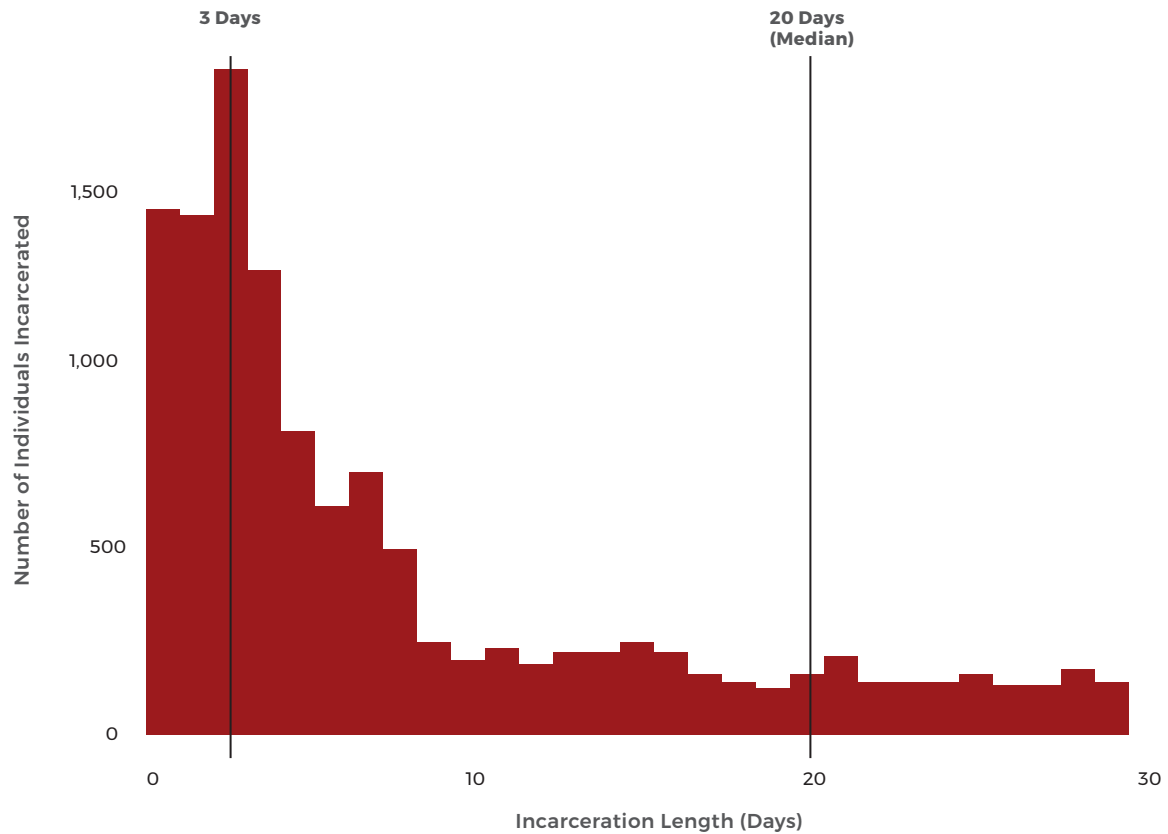
186 CCE Client Interviews.

187 *Id.*

188 *Supra*, n. 141 at, pp. 4, 7.

189 CCE Analysis of Inter-Agency Data.

**Figure 27: DOC Stays by Length of Custody**



**Source: District Matched Data**

Jails present many barriers to connecting SUD clients to care, both in the correctional setting and in the community. DOC should explore options for alternative offerings for residents who may leave the facility too quickly to engage in treatment or reentry planning but could still benefit from a brief intervention. One solution is to implement a Screening, Brief Intervention, and Referral to Treatment (SBIRT) screening to all people entering DOC custody. The SBIRT model is a “comprehensive, integrated, public health approach to the delivery of early intervention for individuals with risky alcohol and drug use, and the timely referral to more intensive substance abuse treatment for those who have substance abuse disorders.”<sup>190</sup> The short timeframe of SBIRT is well-suited for jails, and its structure allows referral to further treatment at subsequent justice intercepts or in the community. For individuals whose score meets a particular threshold of need based on SBIRT or other intake assessment tools, and who are expected to be in custody for 72 hours or more, the jail can administer a more robust clinical screening to identify what level of care that individual should be receiving while incarcerated and connect the individual to appropriate treatment. For those with shorter stays, but who still show signs of a SUD, or who have some record of SUD diagnosis or treatment in their medical history, DOC can deliver brief interventions or other motivational

<sup>190</sup> *Supra*, n. 122.

interviewing techniques appropriately tailored for correctional contexts.<sup>191</sup>

This is similar to a practice highlighted by SAMHSA in Hancock County, Ohio. In that program, individuals who score positively on a SUD assessment and who are anticipated to have a jail stay of less than 72 hours are quickly re-screened using SBIRT and, in the case of those with high scores, referred to more intensive, SUD-focused discharge planning, in addition to general programming.<sup>192</sup> In at least one study, the authors found that SBIRT screenings in a correctional context resulted in a “significant decrease in average number of arrests in the 12-month period after receiving the intervention compared to the 12-month prior period.”<sup>193</sup>

While DOC and Unity should decide the exact extent of screenings and services based on their clinical and custodial population analyses, it is clear that DOC should change its policy and practice regarding SUD care to ensure that (i) brief interventions are offered to all individuals who have a non-chemical dependency SUD, even if they will be in DOC custody only for a very short period; and (ii) there is available and relevant SUD care, including counseling and other therapeutic programs, for all individuals with an Active SUD diagnosis who are expected to be in DOC custody for more than a few days. DOC should engage in an evaluation to determine the length of incarceration during which they can ensure the DOC’s ability to provide relevant services to all individuals in DOC who are determined to have an Active SUD and evaluate whether their planned SUD services and capacity are adequate to address the needs of this population.

### Insufficiency of RSAT as Lone Residential Treatment Option

It is the policy of DOC “to provide substance use treatment programs for participants with substance use disorders, to include monitoring and testing.” The RSAT program was contemplated as the sole “therapeutic community substance use treatment program for...DOC participants housed at...CTF.”<sup>194</sup> The RSAT program, however, is too limited with respect to its bed space, general availability, and strict requirements for participation to serve all of the individuals in DOC who might benefit from SUD care. These factors, and others, make RSAT inadequate to serve as the sole option for SUD patients in DOC custody in need of services beyond MAT and detoxification.

First, the RSAT program is very limited in its availability. At any given time, RSAT can house only 75

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191 For considerations in selecting an appropriate evidenced based SUD intervention, see John W. Finney & H. Hagedorn, *Introduction to a Special Section on Implementing Evidence-Based Interventions for Substance Use Disorders*, 25 *Psych. of Addictive Behav.* 2, 191-93 (2011), <https://doi.org/10.1037/a0023949>. This article also supports brief motivational interviewing in a correctional context for SUD treatment initiation. *Id.* For a feasibility study of SBIRT in jails see Mandy D. Owens & B. McCrady, *A Pilot Study of a Brief Motivational Intervention for Incarcerated Drinkers*, 68 *Substance Abuse: Research and Treatment* 1 (2016), <https://doi.org/10.1016/j.jsat.2016.05.005>.

192 *Supra*, n. 141 at, p. 13.

193 Jeffrey A. Cigrang et al., “Brief Motivational Interview-Based Intervention for Women in Jail with History of Drug Addiction and Sex-Trading,” *Professional Psychology: Research and Practice* 51, no. 1 (2020): 25-33, <https://doi.org/10.1037/pro0000273>.

194 D.C. Department of Corrections, *Policy and Procedure*, 6050.3B (Nov. 17, 2015), <https://doc.dc.gov/sites/default/files/dc/sites/doc/publication/attachments/PP%206050.3B%20%20Residential%20Substance%20Abuse%20Treatment%20Program%2011-17-15.pdf>.

men and 25 women total, inherently limiting the availability of the program, regardless of the prevalence of SUD diagnoses in the DOC population. Additionally, up to 14 of those beds may be taken up by “mentors” or “tutors” who have graduated from the program and who can stay in the RSAT unit for up to 90 days.<sup>195</sup> DOC reported that residents entering the program are either self-referred, referred by the United States Parole Commission (USPC), or referred by the court. For each of the years covered by the Audit Period, individuals referred by the USPC constituted between 64.6 and 75.9% of total of RSAT program participants; for the Audit Period as a whole, they averaged 71.9% of all RSAT program participants.<sup>196</sup> Between 2015 and 2018, only between 11 and 34 individuals participated in the RSAT program from self-requests.<sup>197</sup>

To participate, individuals must be able to stay in the RSAT unit for a minimum of 30 days.<sup>198</sup> However, as noted above, 56.4% of incarcerations had a duration of under 30 days, rendering more than half of the people in DOC custody ineligible to receive care through RSAT, regardless of whether they had a SUD.<sup>199</sup> Additionally, individuals may not know how long they are going to remain in custody, and the 30-day minimum requirement may deter some people from applying to participate in the program. Of the 803 individuals referred to RSAT from all sources (self-request to DOC staff, USPC, or court) during the Audit Period, only 398, or 49.56%, were considered eligible to participate. In 2015 and 2017, more than half of the residents who asked to participate in RSAT were rejected, and in 2018, 47.62% were rejected.<sup>200</sup> While the data provided by DOC does not break down the reasons for rejection by referral category, it is clear that interest in participating in a SUD treatment was greater than the program could accommodate or accept.

Even participants in RSAT have recommended changes to the program to allow them to get more care and additional programs. As part of one recent evaluation, RSAT participants reported getting “approximately five to ten hours of programming” each week, “resulting in a lot of idle time and a desire for much more intensive programming and treatment time.”<sup>201</sup> Additionally, RSAT participants expressed frustration that they were “unable to link to or participate in other programs [like employment, housing, etc.] while housed within RSAT units.”<sup>202</sup>

Finally, RSAT is an abstinence-only program and any participant who has a positive drug screening is expelled.<sup>203</sup> Evidence has shown that abstinence-only requirements can be a barrier to care

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195 *Id.* at 11.A .

196 DOC Correspondence on Mar. 3, 2020.

197 *Id.*

198 *Supra*, n. 190, at 19.a.2.

199 CCE Analysis of DOC Audit Data.

200 *Supra*, n. 192.

201 See Moss Group, District of Columbia Custodial Population Study: Seeking Alignment between Evidence Based Practices and Jail Based Reentry Services, p. 103 (2017), [https://cjcc.dc.gov/sites/default/files/dc/sites/cjcc/page\\_content/attachments/DC%20Custodial%20Population%20Study%2009.2017.pdf](https://cjcc.dc.gov/sites/default/files/dc/sites/cjcc/page_content/attachments/DC%20Custodial%20Population%20Study%2009.2017.pdf).

202 *Id.*

203 *Supra*, n. 160 (DOC Policy and Procedure), at 6050.3C.

for patients attempting to begin SUD recovery.<sup>204</sup> In St. Paul, Minn., a nationally renowned abstinence-based SUD program reduced its drop-out rate from 25% to 5% by including MAT services in its programming.<sup>205</sup> Of the individuals who participated in DOC's RSAT during the Audit Period, 145 individuals failed to complete the full 120-day RSAT program, 129 of whom were dismissed from the program with the remaining 16 withdrawing voluntarily.<sup>206</sup> The data does not specify whether dismissals were abstinence-related or for other reasons; whatever the explanation, the result was that another group of individuals with SUDs did not have a therapeutic alternative inside DOC.

In light of RSAT's shortcoming as the sole source of residential and therapeutic programming, DOC should establish adequate alternative SUD care options for individuals who do not need chemical dependency care and for whom abstinence-based programming, or programming requiring long stays in DOC, are inappropriate or infeasible. As noted above, DOC has described plans to start new therapeutic SUD units for both men and women that incorporate comprehensive SUD and trauma-informed curricula. These programs, assuming they have flexible, low-barrier eligibility criteria, would be a welcome addition to the chemical dependency and RSAT options. Once piloted and confirmed to offer needed additional services, the full range of SUD programs should be funded and offered so that individuals receiving SUD care in the community can continue to receive the same level of care within DOC.

### **Inadequate Reentry Planning and Connection to Care upon Release**

One significant finding from our analysis of the District's interagency matched data is the extent to which DOC's knowledge of individuals' SUD status through Active SUD flags failed to correspond to meaningful connections to SUD care following release from DOC custody. In only 31.23% of Incarceration Episodes in which an individual had an Active SUD flag at DOC was the Incarceration Episode followed by the receipt of SUD care in the 90 days after the incarceration. Conversely, as the figure below shows, in the broader group of Incarceration Episodes where the individual received SUD care in the community in the 90 days after the incarceration, only 9.39% had an Active SUD flag during the incarceration itself.<sup>207</sup> These facts suggest that DOC's Active SUD flags are weakly associated with connection to care after incarceration. DOC needs to work with DBH to evaluate how to increase SUD detection and to facilitate better reentry planning for individuals in DOC who are identified as having a SUD.

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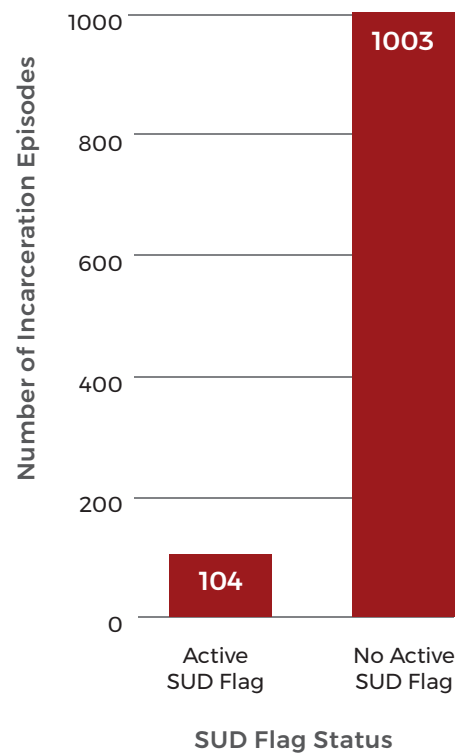
204 William R. Miller & A. Page, Warm Turkey: Other Routes to Abstinence, 8 *Journal of Substance Abuse Treatment* 8, 227 (1991), [https://doi.org/10.1016/0740-5472\(91\)90043-A](https://doi.org/10.1016/0740-5472(91)90043-A).

205 Christine Vestal, The Pew Charitable Trusts, At Fabled Addiction Treatment Center, a New Approach (2016), <http://pew.org/2aX80Av>.

206 *Supra*, n. 159, at Response 5.

207 For more on the relationship between Active SUD Flags and care continuity, see Inter-Agency Data Analysis.

**Figure 28: Incarceration Episodes with Care by Active SUD Flag**



**Source: Matched District Data**

This data also suggests that during the Audit Period, DOC reentry protocols usually failed to maintain continuity of care, even though in some instances individuals who had not been receiving care before their arrest were connected to care following incarceration. While DOC is not solely responsible for the low level of care secured after release among the individuals with Active SUD flags in its custody, DOC does need to collaborate with other organizations, including DBH, DHCF, and community partners, to remedy this situation and institute new reentry protocols for individuals with SUDs.

The reentry planning protocols for individuals receiving MAT during the Audit Period were significantly more robust than for those with other SUDs, but still did not necessarily result in successful care connections provision after release. Specifically, Unity providers reported that patients receiving MAT care “would follow up with their medical or mental health providers in the jail.”<sup>208</sup> They might also be referred to Methadone or Suboxone clinics, or to clinics that provide Vivitrol.<sup>209</sup> Those actively receiving MAT care from DOC when they were slated to be released from custody could schedule a follow-up appointment for services, including MAT at a community-based Unity site,

<sup>208</sup> CCE SUD Provider Interviews.

<sup>209</sup> DOC Correspondence on Feb. 15, 2019, Response 23.



without a new referral from a DBH Assessment and Referral site. Unity also could schedule MAT appointments at a community-based SUD provider of the patient's choice while the patient was still incarcerated. Patients who wish to continue receiving services from Unity in the community were referred to Unity's community-based MAT social workers.<sup>210</sup>

Unity staff explained that during the Audit Period, "there [was] no systematized process for doing release planning of clients."<sup>211</sup> At least one provider who participated in care delivery at the jail said that it was "under the impression that for non-MAT [SUD clients]...there [was] no current reentry planning... [and] that SUD was [n]ever something that was envisioned in the contract as the goal of discharge planning. It's not to say it never happens, but the focus was on the medical/physical health piece."<sup>212</sup>

Community-based behavioral healthcare providers also indicated that they perceived little reentry planning occurring in DOC. They also expressed frustration that they did not receive information from DOC or Unity personnel about the release dates of clients they had been treating before the period of incarceration. One provider described a client with severe disabilities being released in the middle of the night without notice to the provider, who had prepared transitional housing for the client.<sup>213</sup> Another put it bluntly, "there is no continuity of care, we don't know when [clients] are released." Other providers explained that they had some success learning from Unity about clients with opioid dependencies specifically. The overwhelming consensus was that there is a substantial need for greater coordination between behavioral health and correctional agencies as clients leave custody. As one provider put it, "better alignment between Unity, DOC, and DBH needs to happen to assure continuity of care and to save lives."<sup>214</sup>

Clients reported similar experiences. "[A] lot of people have nothing when they get back, and they get discouraged," one man explained. He had been unemployed and in and out the justice system, including DOC, and had used illicit substances since he was 15.<sup>215</sup> "There needs to be a core somewhere, where you can get help," he said, "everything is so scattered...go here for an ID, go here for mental health, the services are there but they aren't together." Multiple clients reported benefiting from mental health and psychiatric care in federal prison facilities, where staff encouraged them to seek help for their SUDs. This approach resulted in them being connected to care after returning to the District, and they noted that they did not receive similar connections during their stays at DOC.<sup>216</sup> Clients who received SUD services in the DOC reported receiving a packet of information from Unity with a list of health care resources, but little other information.<sup>217</sup>

One researcher summarizes what numerous studies have found: "continuity of behavioral health

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210 *Id.* at Response 20.

211 *Supra*, n. 205.

212 CCE Administrator Interview.

213 CCE Survey Responses.

214 CCE Survey Responses.

215 CCE Client Interview.

216 CCE Client Interview.

217 CCE SUD Provider Interviews.

and addiction services during the transition between incarceration and community reentry is a crucial factor in determining reentry success."<sup>218</sup> Nevertheless, transition planning remains a generally under-developed area of service for people with behavioral health needs. The most common barriers to care include eligibility problems, loss of insurance during incarceration, and inability to meet service costs, while patients also have difficulties with transition planning, transportation issues, and getting appointments quickly enough after release.<sup>219</sup>

Noting that the hours, days and weeks following release are critical, SAMHSA's *Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison* describes promising practices for improving the reentry planning and transition process, including advance planning to identify appropriate community-based interventions and prioritizing continuity of care by promoting direct linkages for post-release treatment and supervision agencies.<sup>220</sup>

The Hampden County Sheriff's Department, in Massachusetts, established a program called After Incarceration Support System (AISS). AISS uses individuals who were incarcerated previously and/or are in recovery from a SUD as peer mentors who meet with individuals pre-release and provide them with information about the range of services and treatment options available in the region.<sup>221</sup> The peer mentors then follow discharged individuals into the community, transporting them to appointments and encouraging compliance with treatment plans.<sup>222</sup>

In New York, there are "care managers" who work with the individuals with behavioral health needs slated for release to develop a community treatment plan. There, the care manager "meets the individual at the jail and transports him or her to...activate Medicaid coverage and...to treatment and services providers to minimize disruption in services."<sup>223</sup> Across the country, some jails and prison systems "establish affiliations directly with community-based agencies or Federally Qualified Health Centers (FQHCs) to create a pathway for continued [SUD] care."<sup>224</sup>

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218 Audrey L. Begun et al., *Mental Health and Substance Abuse Service Engagement by Men and Women During Community Reentry Following Incarceration*, 43 *Adm Policy Ment Health* 2, 207-18 (2016), <https://doi.org/10.1007/s10488-015-0632-2>. For the studies that this article addresses in this claim, see Jacques Baillargeon et al., *Addressing the Challenge of Community Reentry Among Released Inmates with Serious Mental Illness* (2010), 46 *Am. J. of Comm. Psych.* 46 (2010), <https://doi.org/10.1007/s10464-010-9345-6> pp. 3-4; see also Steven Belenko, *Assessing Released Inmates for Substance-Abuse-Related Service Needs*, 52 *Crime & Delinquency* 1, 94 (2016), <https://doi.org/10.1177/001128705281755>; Brenda J. Bond & J. Gittell, *Cross-Agency Coordination of Offender Reentry: Testing Collaboration Outcomes*, 38 *Journal of Criminal Justice* 2, 118 (2010), <https://doi.org/10.1016/j.jcrimjus.2010.02.003>; Fred Osher et al., *A Best Practice Approach to Community Reentry From Jails for Inmates With Co-Occurring Disorders: The Apic Model*, 49 *Crime & Delinquency* 1, 79 (2003), <https://doi.org/10.1177/001128702239237>.

219 Audrey L. Begun et al. *Mental Health and Substance Abuse Service Engagement by Men and Women During Community Reentry Following Incarceration*, 43 *Adm. Policy Ment. Health.* 2, 207 (2016).

220 SAMHSA, *Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide* (2017), p. 7, <https://store.samhsa.gov/system/files/sma16-4998.pdf>.

221 Hampden County Sheriff's Department, *AISS HCSD Website Content*, accessed Mar. 12, 2020, <http://hcsd-ma.org/wp-content/uploads/2015/09/Website-Content-for-AISS.pdf>.

222 SAMHSA, *Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide* (2017), p. 7, <https://store.samhsa.gov/system/files/sma16-4998.pdf>.

223 *Id.* at 16.

224 *Supra*, n. 141 at 4.

To address such issues, DOC and DBH should work together to link all DOC residents who have an Active SUD flag with community-based SUD providers before release through “in-reach” services, or services delivered by community-based SUD providers within a correctional setting. DOC should facilitate the SUD providers’ ability to establish relationships, conduct assessments, and schedule appointments for individuals while they are still in custody.<sup>225</sup>

For those who were receiving care before incarceration and were happy with that care, DOC should establish a protocol to enable those individuals to reconnect with their community-based SUD providers and give the providers advance notice of when such individuals are expected to be released. One step to help facilitate this recommendation would be to work with the Criminal Justice Coordinating Council to complete the new “Uniform Consent Form for the Release of Protected Health Information” that has been in development since at least 2017 and ensure that it also encompasses substance use information, in addition to mental health information.<sup>226</sup>

DOC should explore the capacity of its new READY Center and/or develop pilot programs in partnership with other agencies to provide “warm hand-offs,” or connections to care that are conducted in person by members of a care team—perhaps through peer mentors or care managers—who help individuals with SUDs in a more active way than simply providing a referral or information about available services upon release. DOC and DBH could collect data and evaluate the impacts on successful connection to care by providing transportation or other supports for individuals who need to get to the ARC or another DBH assessment location.

## Support for Medicaid Reinstatement upon Release

The federal Center for Medicare and Medicaid Services (CMS) currently does not allow reimbursement for services provided to individuals who are incarcerated, except when those services are provided in a community-based hospital setting.<sup>227</sup> D.C. complies with this process by automatically suspending Medicaid coverage for all individuals incarcerated in DOC.<sup>228</sup> DOC also adopted a protocol for reconnecting people to Medicaid. Since 2017, when individuals are released from

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225 For a discussion of the need for appropriate PHI releases as best practices, see *supra*, n. 10 at p. 7 (*MAT Treatment in the Criminal Justice System: Brief Guidance to the States*). For unified consent form progress in D.C., see Pretrial Services Agency for the District of Columbia, *Congressional Budget Justification and Performance Budget Request Year 2019* (Feb. 12, 2018) at p. 38, <https://www.csosa.gov/wp-content/uploads/bsk-pdf-manager/2018/07/FY2019-PSA-CBJ-Performance-Budget-02122018-1.pdf> and D.C. Criminal Justice Coordinating Council, *An Evolving City, An Ever-Present to Public Safety and Justice* (2017), [https://cjcc.dc.gov/sites/default/files/dc/sites/cjcc/page\\_content/attachments/2017%20Criminal%20Justice%20Coordinating%20Council%20Annual%20Report.pdf](https://cjcc.dc.gov/sites/default/files/dc/sites/cjcc/page_content/attachments/2017%20Criminal%20Justice%20Coordinating%20Council%20Annual%20Report.pdf).

226 D.C. Criminal Justice Coordinating Council, *Public Safety, Justice and Community—The Fabric of a Safer DC: Annual Report 2018* (2018) at p. 21, [https://cjcc.dc.gov/sites/default/files/dc/sites/cjcc/page\\_content/attachments/CJCC\\_Annual\\_Report\\_2018.pdf](https://cjcc.dc.gov/sites/default/files/dc/sites/cjcc/page_content/attachments/CJCC_Annual_Report_2018.pdf). See Finding 7 for more treatment of this issue.

227 Jane Wishner & Kamala Mallik-Kane, Urban Institute, *Information Sharing between Medicaid and Corrections Systems to Enroll the Justice-Involved: Arizona and Washington* (Jan. 2017), [http://www.urban.org/sites/default/files/publication/88046/info\\_sharing\\_2.pdf](http://www.urban.org/sites/default/files/publication/88046/info_sharing_2.pdf).

228 The Henry J. Kaiser Family Foundation, *States Reporting Corrections-Related Medicaid Enrollment Policies In Place for Prisons or Jails* (Oct. 2019), <https://www.kff.org/medicaid/state-indicator/states-reporting-corrections-related-medicare-enrollment-policies-in-place-for-prisons-or-jails>.

DOC, Unity is supposed to ensure that all individuals who are Medicaid eligible have filled out the paperwork, which DOC subsequently delivers to a partner-agency that facilitates the enrollment. DHCF is supposed to check two weeks after discharge to ensure that Medicaid re-enrollment was completed.<sup>229</sup> However, in multiple interviews, SUD providers insisted that they had many clients leaving the DOC who had not been re-enrolled in Medicaid. One SUD provider estimated that, during the three months before the interview (December 2018 through February 2019), it knew of five patients who arrived at its office without being re-enrolled in Medicaid, and only two of them returned to the provider after being instructed to go first to the Medicaid re-enrollment office and then to ARC.<sup>230</sup>

DOC and DHCF should collaborate to study Medicaid re-enrollment times for individuals leaving DOC custody. Further, they should set a joint Key Performance Indicator (KPI) to ensure that all DOC clients who were enrolled in Medicaid before their incarceration have their Medicaid eligibility fully re-instated within 48 hours of release.

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229 CCE Administrator Interview.

230 CCE SUD Provider Interview.

#### **FINDING 4:**

**DBH requires people seeking substance use disorder services to be assessed in-person at an intake location with limited availability; there are delays between referrals and care; and DBH does not follow up to ensure people connect to treatment.**

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#### **RELATED RECOMMENDATIONS:**

- 1.** DBH should increase access to its services by:
  - a.** Adopting the proposed revision to D.C.M.R Chapter 22-A to allow any SUD provider to conduct assessments and referrals;
  - b.** Amending D.C.M.R Chapter 22-A to remove the requirement that initial SUD assessments be conducted in person; and,
  - c.** Expanding days and hours of access for the initial assessments, ensuring that at least one SUD provider is open, 24 hours a day, 7 days a week to assess and accept clients into each level of care and to serve individuals in acute withdrawal.
- 2.** DBH should track the time between referrals and care initiation in the new “no wrong door” system, and set goals to decrease any wait times, particularly for people with SUDs suffering withdrawal.
- 3.** DBH should minimize the time between identification of a treatment need and initiation of care by:
  - a.** Significantly expanding Screening, Brief Intervention, and Referral to Treatment (SBIRT) referrals into broader community settings; and,
  - b.** Developing programs integrating behavioral health and primary care to foster close collaboration between care teams in a co-located setting.

#### **COMMENTARY:**

##### **Overview of DBH Assessments and Referrals**

Research shows that referrals to behavioral health services have low treatment initiation rates. People who seek care for their SUD do not always start treatment right away.<sup>231</sup> While there are many reasons for the disconnect between the initial desire to get help and actually receiving care, clients and providers in D.C. reported two distinct challenges to accessing SUD care in the

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231 Clayton Brown et al., Predictors of Initiation and Engagement in Substance Abuse Treatment among Individuals with Co-Occurring Serious Mental Illness and Substance Use Disorders, 36 Addictive Behaviors 5 (2011); see also CCE Client Interviews and CCE Provider Interviews.

community: (i) the limited options for getting assessed for care; and, (ii) the lag time between seeking and starting treatment.<sup>232</sup> Data from the National Survey on Drug Use and Health indicated that 10.67% of the District's population from 2016 to 2017 needed but did not receive specialty treatment for a SUD.<sup>233</sup> If a person is readily able to initiate treatment in the community they may avoid becoming justice-involved, thereby avoiding court-ordered treatment either in the community or in a correctional setting.

In CCE's analysis of District data, we found that when a person was assessed and needed but did not receive SUD care within 90 days, they were 24% more likely to be arrested or incarcerated within that 90-day period compared to assessments that did lead to care. Similarly, a person who was assessed and did not receive SUD care within 90 days was 18.55% more likely to die of an overdose within that same 90-day period as compared to assessments that did lead to care.<sup>234</sup> To minimize justice-involvement and deaths, D.C. must make the initiation of SUD care in the community as easy as possible.

For almost all individuals in D.C. who are insured by Medicaid, the path to access SUD services, either for the first time or after a meaningful lapse in their care, begins at a DBH-certified intake center.<sup>235</sup> There, a person undergoes an "initial assessment," designed to evaluate whether a person is in need of SUD treatment and, if so, to determine the appropriate Level of Care ("LOC"). After the assessment, the person will initiate a course of treatment with a referral to an appropriate SUD provider.<sup>236</sup> While we could not find a calculation of the exact proportion of D.C.'s justice-involved residents eligible for Medicaid, prior analyses indicate that nearly all people incarcerated at DOC

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232 SUD Client Interviews.

233 SAMHSA, *2016-2017 NSDUH State-Specific Tables* (2019), <https://www.samhsa.gov/data/report/2016-2017-nsduh-state-specific-tables>.

234 For a more in depth analysis, please see the Inter-Agency Data Analysis.

235 There are some exceptions to this rule. If the payer for the services is not DBH (through local dollars) or the Department of Health Care Finance (through Medicaid), then a client is not required to undergo an initial assessment. However, even when another party (like PSA or D.C. Superior Court) is paying for care, they still frequently send their clients to a DBH-certified assessment center to receive level of care assignment and referral to treatment, even though the initial assessment is not strictly required. Additionally, some justice-involved individuals may be able to avoid the initial assessment process if they receive MAT services in DOC custody and then continue that treatment with a community-based DBH certified SUD provider after incarceration. Finally, individuals with private insurance or who pay for care out of pocket do not require an initial assessment or referral to begin receiving services. See DBH Administrator Interviews.

236 D.C. Mun. Regs. 22-A § 6336.7.

are likely eligible upon their release from custody.<sup>237</sup> Thus, the community-based points of entry to SUD services for most people who have a history (or are at risk) of justice-involvement are likely a DBH-certified intake center or a court order.

DBH regulations in place during the Audit Period require that clients “be referred for SUD services at the level of care determined by a Level 1-AR provider or other intake center authorized by the Department, unless the clients are only receiving Recovery Support Services.”<sup>238</sup> During the Audit Period, DBH had only one certified intake center, the Assessment and Referral Center (ARC), a facility at 64 New York Avenue NE, in Ward 5, run directly by the agency. Until 2019, the ARC was the only community access-point into the public SUD service system in the District. All potential clients had to complete an initial assessment at the ARC by appointment or as a walk-in on weekdays from 6 AM to 7 PM.

An individual who completes the initial assessment at the ARC is then referred for an intake appointment by a DBH-certified SUD provider to ensure the appropriate level of care.<sup>239</sup> The referral itself involved DBH representatives communicating with the future care provider to schedule an intake appointment for the client, and sending a packet of information to the future care provider containing information confirming the assessed level of care.<sup>240</sup> If the referral was for either residential treatment or withdrawal management (detoxification), and the SUD provider was open and has available bed space, DBH provides transportation directly to the care-site and the patient leaves for care immediately.<sup>241</sup>

At the SUD provider intake appointment, the SUD provider is also required to perform a “comprehensive assessment” designed to determine an individual’s treatment and recovery needs.<sup>242</sup> At this stage, a client is officially diagnosed, their level of care is confirmed, and a treatment plan

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237 While the exact number of individuals who were Medicaid eligible and justice-involved in D.C. has not been calculated in any study CCE could identify, there are good reasons to believe that nearly all previously incarcerated D.C. residents who are not disqualified because of matters related to citizenship and a lack of social security numbers, are eligible. A Legislative Analyst Office report, “*The 2013-2014 Budget: Obtaining Federal Funds for Inmate Medicaid Care—A Status Report*,” found that in other jurisdictions 80% of incarcerated individuals were eligible for Medicaid (see Washington State and Colorado). They note that the remainder “were only ineligible because they are not lawfully residing in the United States or lack a valid social security number.” These jurisdictions also had more restrictive Medicaid eligibility requirements (see [www.healthinsurance.org](http://www.healthinsurance.org) for a comparison) and are therefore more likely to exclude an incarcerated individual on the basis of income. See also Moss Group, *District of Columbia Custodial Population Study: Seeking Alignment between Evidence Based Practices and Jail Based Reentry Services*, p. 66 (2017), [https://cjcc.dc.gov/sites/default/files/dc/sites/cjcc/page\\_content/attachments/DC%20Custodial%20Population%20Study%2009.2017.pdf](https://cjcc.dc.gov/sites/default/files/dc/sites/cjcc/page_content/attachments/DC%20Custodial%20Population%20Study%2009.2017.pdf) (noting that in 2017, while 47% of DOC male residents reported no income at all, “the other 53% reported that their primary source of income was generally from 3 sources—wages (31%); TANF or Public Assistance (29%) and Disability (29%)”).

238 D.C. Mun. Regs. 22-A § 6301.4(b) (2015).

239 D.C. Mun. Regs. 22-A § 6336.7(a) (2015).

240 CCE Administrator and Provider Interviews.

241 D.C. Dept. of Behavioral Health, SUD Assessment and Referral Sites FAQ, accessed Mar. 11, 2020, [https://dbh.dc.gov/sites/default/files/dc/sites/dmh/page\\_content/attachments/SUD%20ASSESSMENT%20AND%20REFERRAL%20SITES%20FAQ%208-1.pdf](https://dbh.dc.gov/sites/default/files/dc/sites/dmh/page_content/attachments/SUD%20ASSESSMENT%20AND%20REFERRAL%20SITES%20FAQ%208-1.pdf).

242 D.C. Mun. Regs. 22-A § 6336.8(a) (2015).

is developed and adopted by licensed professionals and the client.<sup>243</sup> This comprehensive assessment must be completed within seven calendar days of admission to a SUD provider.<sup>244</sup> “Ongoing assessments” are then performed regularly throughout an individual’s course of treatment by the SUD provider to ensure that the diagnosis continues to be appropriate or is revised if warranted.<sup>245</sup>

### Accessing Assessments: “No Wrong Door”

The system of assessment and referral in place during the Audit Period was a “centralized” intake model with one single entry-point, the ARC, through which most individuals were required to pass to get access to care. For the last several years, stakeholders, including both DBH administrators and SUD service providers, have called explicitly for the “no wrong door” model to be embraced in D.C.<sup>246</sup> DBH is actively working to address this issue, but it remained a significant one during the Audit Period.

The single “right door” at the ARC created a geographic barrier to care for justice-involved individuals. Some 76% of people in DOC custody in 2018 resided in Wards 5, 7, and 8,<sup>247</sup> and many reported that transportation issues were barriers to effective reentry.<sup>248</sup> Providers also noted that long commutes made it hard for their clients to access SUD care.<sup>249</sup> For clients who are poor and justice-involved, transportation can be a particularly acute barrier to care initiation.<sup>250</sup>

Hitting a “wrong door” is a known barrier to securing SUD services. For example, if a Medicaid insured person was self-motivated to seek care and walked into a SUD provider in D.C., perhaps one recommended by a friend, or one located nearby in the neighborhood, the person was told that they must first go to the ARC for an initial assessment and referral, and that they then could return to the provider for care.<sup>251</sup> SUD clients interviewed by CCE regarded the ARC as an onerous bureaucratic hoop through which they had to jump before getting services.<sup>252</sup> All individuals receiving SUD services must also ultimately undergo an intake appointment with their chosen provider, which includes a comprehensive assessment at the point of service initiation.<sup>253</sup> This often

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243 D.C. Mun. Regs. 22-A § 6336.8(c) (2015).

244 D.C. Mun. Regs. 22-A § 6336.8(d) (2015).

245 D.C. Mun. Regs. 22-A § 6336.9 (2015).

246 *Supra*, n. 241.

247 *District Task Force on Jails and Justice, Jails & Justice: A Framework for Change*, p. 16 (Oct. 2019), <http://www.courtexcellence.org/uploads/publications/FrameworkForChange.pdf>.

248 *Supra*, n. 232.

249 SUD Provider Interviews.

250 James B. Luther et al., *An Exploration of Community Reentry Needs and Services for Prisoners: A Focus on Care to Limit Return to High-Risk Behavior*, 25 *AIDS Patient Care and STDs* 8, 475 (2011), <https://doi.org/10.1089/apc.2010.0372>; see also Miriam Bohmert, *The Role of Transportation Disadvantage for Women on Community Supervision*, 43 *Crim. Justice and Behav.* 11, 1522 (2016), <https://journals.sagepub.com/doi/abs/10.1177/0093854816654267>.

251 *Supra*, n. 249; see also D.C. Mun. Regs. 22-A § 6336.7.

252 *Supra*, n. 232.

253 D.C. Mun. Regs. 22-A § 6336.8(a) (2015).



feels repetitive and wasteful to clients.<sup>254</sup> Providers interviewed during the Audit Period stated that the initial assessment could take place during the provider intake appointment.<sup>255</sup>

There is broad consensus among experts that initial assessments should be decentralized, and a “no wrong door” model embraced. “No wrong door” is the “principle... that the healthcare delivery system, and each provider within it, has a responsibility to address the range of client needs wherever and whenever a client presents for care.”<sup>256</sup> SAMHSA has encouraged this approach for the last two decades as part of a series of patient-centered recommendations designed to improve the quality of care for SUD clients.<sup>257</sup> In fact, national best practices increasingly recognize that care coordination and integration can be improved by increasing the points of entry into the system and ensuring that service connectivity and delivery for a given domain of care (such as SUDs) are not siloed among one group of care providers. Research also suggests that referral points into the care delivery system should be widely distributed across care providers in the community, including primary care, acute care, and outpatient care.<sup>258</sup>

A 2015 study of women with behavioral health needs returning to the community from prison found that behavioral health clients viewed “jumping through hoops” as a barrier to care connectivity.<sup>259</sup> The participants indicated that, although they often intended to seek care, they sometimes did not follow through because of the number of steps required to access care. Similarly, providers interviewed by CCE for this audit emphasized that clients seeking services are often doing so during periods of high stress, and that delays in connection to services lead to the abandonment of service initiation.<sup>260</sup>

To begin addressing these limitations, DBH modified its regulations last year and certified six additional community-based SUD providers to conduct initial assessments of adults as of November 2019.<sup>261</sup> This exceeded the initial goal in the District’s Opioid Strategic Plan to “expand DBH’s Assessment and Referral (AR) sites to establish multiple points of entry and expedited access into

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254 *Supra*, n. 232.

255 CCE Provider Interviews.

256 SAMHSA, *Substance Abuse Treatment For Persons With Co-Occurring Disorders A Treatment Improvement Protocol*, pp. 11-12 (2013), <https://store.samhsa.gov/system/files/sma13-3992.pdf>.

257 National Treatment Plan Initiative, *Changing the Conversation* (2000), <https://atforum.com/documents/Natxplan%201.pdf>.

258 Martha Gerrity, Millbank Memorial Fund: The Reforming States Group, *Evolving Models of Behavioral Health Integration: Evidence Update 2010-2015* (2016); Marcela Horvitz-Lennon et al., From Silos To Bridges: Meeting The General Health Care Needs Of Adults With Severe Mental Illnesses, 3 *Health Affairs* 25, 659-69 (2006), <https://doi.org/10.1377/hlthaff.25.3.659>; W. J. Doherty et al., *Five Levels of Primary Care/Behavioral Healthcare Collaboration*, 5 *Behav. Healthcare Tomorrow* 5, 25-27 (1996); A. Blount, *Integrated Primary Care: Organizing the Evidence*, 21 *Families, Systems, & Health* 2, 121-33 (2003).

259 Jennifer Johnson et al., *Provider Experiences with Prison Care and Aftercare for Women with Co-Occurring Mental Health and Substance Use Disorders: Treatment, Resource, and Systems Integration Challenges*, 42 *J. Behav. Health Services and Research* 4 (2015).

260 Provider Interviews.

261 LiveLong.DC, Government of the District of Columbia, *The District’s Approach to Saving Lives from the Opioid Epidemic* (2019), [https://livelong.dc.gov/sites/default/files/dc/sites/opioid/page\\_content/attachments/LLDC%20Accomplishments\\_website\\_November%202019.pdf](https://livelong.dc.gov/sites/default/files/dc/sites/opioid/page_content/attachments/LLDC%20Accomplishments_website_November%202019.pdf).

the system of care for substance use disorder treatment services” by certifying “at least four substance use disorder treatment providers as AR sites.”<sup>262</sup> CCE did not collect information on the functioning of these new assessment sites because they were not certified during the Audit Period.

On February 28, 2020, DBH issued a rulemaking notice proposing that the “certification requirement for intake and assessment as a level of care” be eliminated and that “all treatment providers provide intake and assessment services.”<sup>263</sup> Decentralizing assessment and referral services, and increasing the availability of entry points into the SUD system for individuals who access care through Medicaid is an important step forward to improve SUD care in the District. This would also make it easier for people who are justice-involved—or at risk of justice involvement—to get connected to care quickly.

DBH’s efforts to decentralize SUD intakes reflect a significant movement toward the “no wrong door” model, but some barriers persist. In particular, it remains notable that the procedures in place to initiate SUD care in D.C. pose more “wrong doors” than those to initiate mental health care. Although SUD initial assessments must be done in-person at limited locations, Medicaid-insured individuals seeking mental health treatment can call DBH’s Access HelpLine, available 24 hours a day.<sup>264</sup> Staff at the Access HelpLine refer people directly to a community-based mental health services provider, called a Core Service Agency (CSA), for an intake assessment and care.<sup>265</sup> A centralized intake, like that at the ARC, is not required; the relevant regulation only requires that a qualified practitioner determine that a person is in need of mental health services to initiate care.<sup>266</sup> Multiple DBH administrators and community stakeholders expressed a desire for DBH to have a common set of standards for admitting SUD clients and mental health consumers into D.C.’s behavioral health system.<sup>267</sup>

DBH should not only adopt the proposed revision to D.C.M.R Chapter 22-A to allow assessments and referrals to be conducted by any SUD provider, but should go further and make its regulations for SUD assessments correspond with the assessment and referral requirements for mental health services. This change would increase the parity of SUD and mental health services by allowing referrals to come from any qualified practitioner, for instance at a community-based SUD provider, by phone from the DOC, or via Access HelpLine, instead of requiring an in-person visit to a designated assessor.

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<sup>262</sup> *Id.*

<sup>263</sup> *Notice of Fourth Emergency and Proposed Rulemaking, Certification Standards for Substance Use Disorder Treatment and Recovery Providers*, 67 D.C. Reg. 2252 (Feb. 28, 2020), <https://www.dcregs.dc.gov/Common/DCMR/SectionList.aspx?SectionNumber=22-A6328>.

<sup>264</sup> D.C. Dept. of Behavioral Health, *Access HelpLine*, accessed Mar. 11, 2020, <https://dbh.dc.gov/service/access-helpline>.

<sup>265</sup> *Id.*

<sup>266</sup> D.C. Mun. Regs. § 22A 3403.1.

<sup>267</sup> CCE Interviews with Administrators and Stakeholders.

## ARC Operational Barriers

In addition to being the sole site for assessments and referrals during the Audit Period, operational limitations at the ARC also increased the barriers to care for some clients. As noted above, there are many steps that an individual with a SUD must navigate in order to get care. If any of those steps prove too difficult or too slow, it could result in the person abandoning their efforts to receive treatment in D.C. Specifically, once a person identified the need to go to the ARC, they must either get an appointment or try to be seen during walk-in hours. The process entails getting to the ARC during its limited hours of operation, often waiting for hours to be seen, getting assessed, and receiving a referral to a SUD provider. If those hurdles are cleared successfully, a client must still travel to the first appointment with the SUD provider and undergo another comprehensive assessment—all before receiving any treatment whatsoever.<sup>268</sup>

**Limited Dates and Hours of Operation.** The ARC's first operational limitation is its dates and hours of operation, which impair the accessibility of its services. The ARC is closed on Saturdays and Sundays.<sup>269</sup> On weekdays, the ARC opens at 7 a.m. and closes at 6 p.m., but stops accepting walk-ins for initial intake assessments at 3:30 p.m. each day. Clients reported that, when the lobby was too full, ARC security sometimes turned them away before 3:30 p.m.<sup>270</sup>

These limited hours have had a significant impact on some individuals with untreated SUDs. For example, clients who arrive at the ARC on a Friday afternoon only to be told to return Monday morning are left to fend for themselves over the weekend as they struggle with their disorder. The three new intake assessment sites, which began operation in 2019, have slightly varied hours, but each also operates only on weekdays during the day and evenings and requires in-person meetings to complete the initial assessment process.<sup>271</sup>

To complicate matters further, the ARC's hours of operation have not been clearly communicated to the public or important justice system actors who direct individuals to treatment. SUD clients interviewed by CCE reported being told by case workers as well as PSA and CSOSA supervision officers to arrive at the ARC after walk-in hours are over, only to be turned away and told to come back the next day, wasting precious time and travel funds.<sup>272</sup> One client described being told by her supervision officer that she could go to the ARC as late as 5:30 p.m. to accommodate her work schedule, only to show up and be told walk-ins were no longer being accepted. When she came back later that week around 11 a.m., she waited for a few hours to be seen but then had to leave and thus had to make another appointment. Finally, several days after she first attempted to receive care, she was able to carve out enough time in her schedule to go to the ARC and receive an assessment and referral.<sup>273</sup>

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268 See SUD Client Interviews, SUD Provider Interviews, and DOC Correspondence with CCE.

269 D.C. Dept. of Behavioral Health, *Substance Use Disorder Services*, accessed Mar. 11, 2020, <https://dbh.dc.gov/page/aprat>.

270 *Supra*, n. 232.

271 *Supra*, n. 269.

272 *Supra*, n. 232.

273 *Id.*

Even for clients who have accurate information, the limited hours of operation at assessment and referral sites can act as a barrier to clients who may have many stressors and complicated lives. For these individuals, maintaining an easily accessible point of entry into a system that has the flexibility they need is important. This is especially true for individuals leaving the criminal justice system who are more likely to experience high-stress lifestyles characterized by little structure.<sup>274</sup> Traditional daytime operating hours may not serve these individuals well. One qualitative study of people returning from incarceration found that juggling irregular work hours was one of the most common causes of job loss among returning citizens.<sup>275</sup> The authors noted that returning citizens often work jobs with shifting hours and little predictability, and that juggling competing obligations led to job loss among the individuals interviewed.

**Extended Wait Times.** The second operational limitation at the ARC is wait times once a person arrives. The ARC system required significant patience—and an open schedule—for people seeking SUD services, as it often consumed half a day to be seen and to complete an assessment. Between January and August 2019, the only time period for which CCE received DBH data, people (including both walk-ins and appointments) waited an average of 2.5 hours to be seen for their initial assessment after arriving at the ARC. Initial assessments took an average of 57 minutes to perform, totaling approximately three and a half hours of total time at the ARC per client.<sup>276</sup>

Clients' self-reported wait times at the ARC were consistent with the DBH data—an estimated average of four hours from arriving at the ARC to completing the initial assessment and receiving a referral for services.<sup>277</sup> CCE learned through interviews that these wait times present barriers both to potential clients' connection to care and to fulfilling their other obligations, especially for those who must find time to wait at the ARC around work shifts, medical appointments, or required appointments with their supervision officer.<sup>278</sup>

To address these barriers, DBH should ensure that at least one SUD provider is open, 24 hours a day, 7 days a week to assess and accept clients into each level of care. The D.C. Council should fund a pilot for such a program, and DBH should work with SUD providers to evaluate the utilization and efficacy of the services in order to determine how to make such a model financially and logistically feasible.

## Delays Between ARC Referral and Care Initiation

We also found evidence of meaningful gaps between individual assessments and referrals and the actual initiation of SUD care during the Audit Period. Significant wait times between a client's

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<sup>274</sup> Ingrid A. Binswanger et al., *Return to Drug Use and Overdose after Release from Prison: A Qualitative Study of Risk and Protective Factors*, 7 *Addiction Science & Clinical Practice* 1 (2012), <https://doi.org/10.1186/1940-0640-7-3>.

<sup>275</sup> David J. Harding et al., *On the Outside: Prisoner Reentry and Reintegration*, Univ. of Chicago Press (2019).

<sup>276</sup> See DBH Response to CCE Document Request (August 23, 2019).

<sup>277</sup> CCE Client Interviews.

<sup>278</sup> *Id.*

referral from the ARC and initial service from a SUD provider are yet another barrier to connecting vulnerable people to treatment.<sup>279</sup> Delays can contribute to attrition among people seeking services. While delays between referral and initial service for different levels of care were identified during this audit, CCE did not have access to the information required to determine the sources of delays, nor did DBH report on this topic in any of the strategic planning or evaluation materials that it produced. Therefore, CCE cannot point to the specific causes of long wait times, and encourages further study of this topic.

During the Audit Period, DBH reported that the average SUD clients in D.C. spent just over a week between receiving a referral to care from the ARC and getting their first instance of care, as is shown in Figure 29.<sup>280</sup> However, as is shown in the table below, there were considerable differences between the mean and median periods of time it took clients to be connected to care; the means were shorter than the medians and increased from 2015 to 2018. This skew may reflect differences in the amount of time it took clients to be connected to service for different levels of care, as detailed below.

The aggregate data about referral-to-service wait times reflects worsening conditions in D.C. over the Audit Period that may be a consequence of the increasing number of untreated SUDs and the decreasing number of SUD treatment facilities in the District, as was discussed in the Introduction. In FY2018, DBH clients waited longer to receive care than they did in 2017, 2016, and 2015.

**Figure 29: Annual ARC Intake Assessment Data**

Measure of Central Tendency	FY 2015	FY2016	FY 2017	FY2018
Mean Days	2.99	5.77	5.3	7.91
Median Days	4	6	6	14

**Source: Matched District Data**

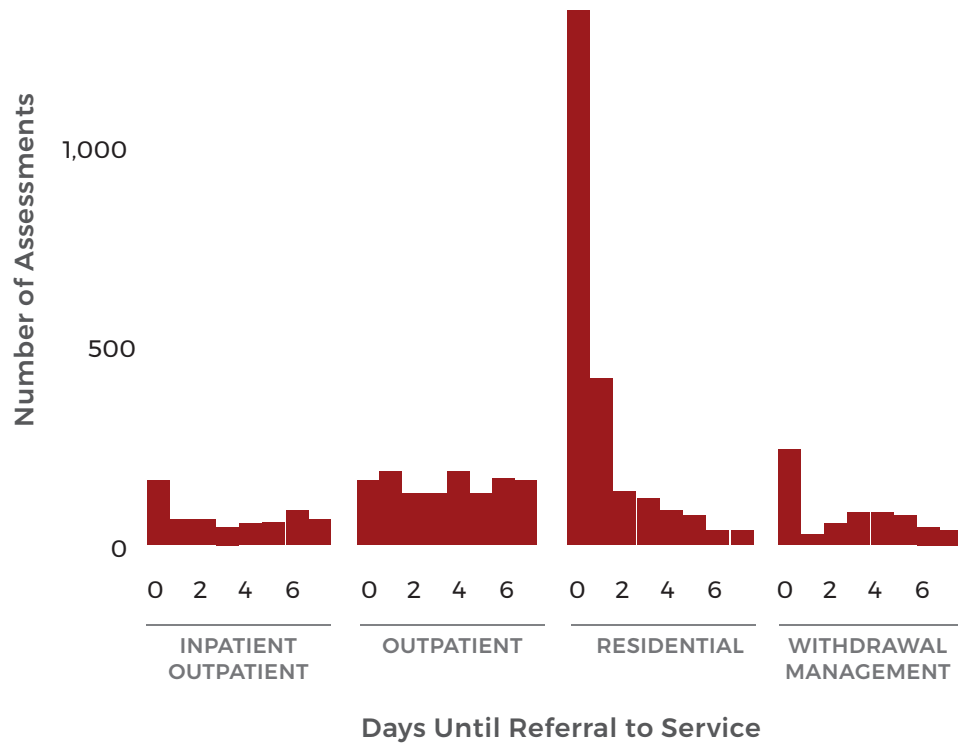
In our analysis of the District's assessment and claims data, CCE observed meaningful differences in the lengths of time that individuals waited to be connected to different levels of SUD services. For example, as seen in Figures 30 and 31, median wait times were significantly longer for outpatient care and withdrawal management than for residential care. This is particularly troubling for withdrawal management, as client and SUD provider interviews both indicated that longer wait times for the receipt of withdrawal management services were associated with a return to substance use.<sup>281</sup>

279 CCE Correspondence with DOC Nov. 2, 2019.

280 CCE Analysis of DBH Response to CCE Document Request (Aug. 23, 2019).

281 SUD Client Interviews and SUD Provider Interviews.

Figure 30: ARC Referral-to-Care Interval by Level of Care Throughout Audit Period <sup>282</sup>



Source: Matched District Data

Figure 31: Between ARC Referral and First SUD Service

Measure of Central Tendency	Outpatient	Intensive Outpatient	Residential	Withdrawal Management
Mean Days	90.81	102.99	94.75	135
Median Days	12	13	1	7

Source: Matched District Data

Withdrawal management is an important example of why delays between referral and care can be harmful for patients. Withdrawal management or Medically Monitored Intensive Inpatient Withdrawal Management is sometimes referred to as detoxification and “refers to the medical and psychological care of patients who are experiencing withdrawal symptoms as a result of ceasing

<sup>282</sup> CCE analysis of Inter-Agency Data. Note that because of the data censorship constraints noted in *Appendix C: Quantitative Methods*, we believe that these estimates are *not valid* estimates of the true mean and median values but are instead only useful for making comparisons between types of services.

or reducing their use of drugs.”<sup>283</sup> In D.C., these services are for, “clients with sufficiently severe signs and symptoms of withdrawal from psychoactive substances such that medical monitoring and nursing care are necessary but hospitalization is not indicated.”<sup>284</sup>

For opioids, “withdrawal syndrome usually begins...6 to 12 hours for short-acting opioids such as heroin and morphine, and 36 to 48 hours for long-acting opioids such as methadone...symptoms [can] reach peak intensity within two to four days, with most of the obvious physical withdrawal signs no longer observable after 7 to 14 days.”<sup>285</sup> While withdrawal itself, “is rarely life-threatening...the combination of uncomfortable symptoms and intense craving makes completion of withdrawal treatment difficult for most people.”<sup>286</sup> Initiation of withdrawal management services, therefore, are critically time-dependent, as they are intended to reduce symptoms that occur within the first 6-48 hours, and that peak within two to four days. D.C. clients who wait more than four days are not benefiting from the effects of withdrawal treatment, and are at increased risk of returning to substance use.<sup>287</sup>

As shown below in Figures 32 and 33, while the number of individuals in D.C. receiving withdrawal management care within 24 hours of referral increased in 2017 and 2018, until 2018 most DBH clients did not receive withdrawal management care within 72 hours of referral, a critical window for care. However, that changed in 2018, when 156 individuals received withdrawal management services within one day of referral, and 102 received withdrawal management services at least one day after referral.

**Figure 32: Number of Referrals to Withdrawal Management by Duration from Referral to First SUD Service**

Year	One Day or Fewer	More than one day
2015	6	412
2016	29	235
2017	78	224
2018	156	102

**Source: Matched District Data**

283 World Health Organization, *Clinical Guidelines for Withdrawal Management and Treatment of Drug Dependence in Closed Settings* (2009), <http://www.ncbi.nlm.nih.gov/books/NBK310654> (WHO Guidelines Approved by the Guidelines Review Committee); D.C. Mun. Regs. 22-A § 6300.16(h) (described as “Medically Monitored Intensive Inpatient Withdrawal Management”).

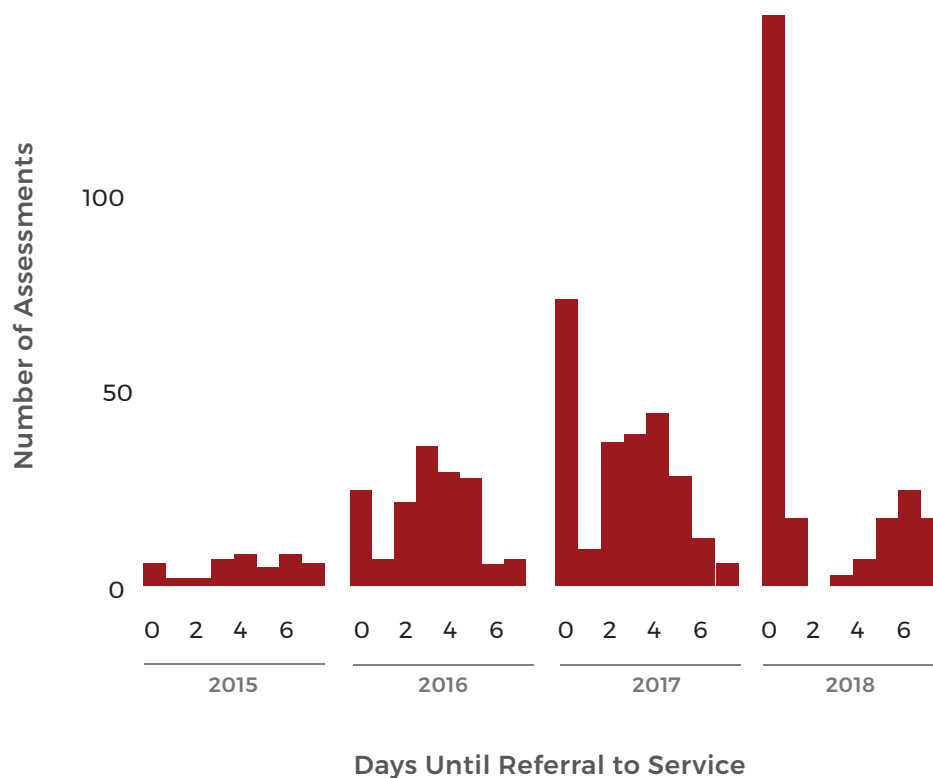
284 D.C. Mun. Regs. 22-A § 6334.1.

285 Linda Gowing et al., *Buprenorphine for Managing Opioid Withdrawal*, 2 Cochrane Database of Systematic Reviews (2017), <https://doi.org/10.1002/14651858.CD002025.pub5>.

286 *Id.*

287 See *id.* (noting that individuals are at increased risk of returning to substance use during periods of withdrawal).

**Figure 33: Days from Referral to Care to Receipt of Withdrawal Treatment by Calendar Year**



**Source: Matched District Data**

This means the majority of DBH clients referred to withdrawal management services during the Audit Period did not receive access to those services prior to the average peak of withdrawal intensity, exposing clients to unnecessary suffering and increasing the risk that they return to substance use.<sup>288</sup> In 2015, only six of 418 clients referred to Withdrawal Management services received a SUD service within 24 hours. As the research shows, and as SUD providers explained, the periods of time in which clients are interested in receiving services can be short and fleeting.<sup>289</sup> Clients may be disposed to entering treatment for only very small window of time. This was corroborated by SUD clients who described the difficulties they had engaging services. Many described not feeling ready to receive treatment for many years, or having only fleeting desires to enter treatment during long periods of sustained substance use.<sup>290</sup>

This reality makes it even more important to minimize the “wrong doors,” delays, and other barriers

288 The duration of withdrawal varies by substance use. For a treatment of alcohol withdrawal and duration. See Maurizio A. Leone et al., *Gamma- hydroxybutyrate (GHB) for Treatment of Alcohol Withdrawal and Prevention of Relapses*, 2 Cochrane Database of Systematic Reviews (2010), <https://doi.org/10.1002/14651858.CD006266.pub2> (“[Alcohol withdrawal syndrome] is a life-threatening condition.”); see also A. Lautieri, American Addiction Centers, *Alcohol Withdrawal: Symptoms, Timeline & Detox Process*, <https://americanaddictioncenters.org/withdrawal-timelines-treatments/alcohol>.

289 SUD Client, Provider, and Agency Interviews.

290 SUD Client Interviews.



that people face when seeking SUD services in the District. While DBH's movement towards a "no wrong door" model will likely have significant positive impacts on the problem of delays between assessment and care initiation, it may not be able to solve all delays. For example, some individuals may seek assessments from SUD providers that are unable to offer the appropriate level of care, and will need to make referrals to another provider.

To address these issues, DBH should expand its use of SBIRT referrals in broader community settings to facilitate an increase in care initiation among the 10.67% of District residents who have SUD needs and who are not being connected to care by the District's current assessment and referral system.<sup>291</sup> Facilitating assessments and referrals for these individuals, and improving the flow of care generally, requires the wide adoption of a model appropriate for the diffuse contacts that individuals with SUDs have with health care and justice systems.

SBIRT is considered a best practice for connecting individuals who use alcohol and other drugs at risky levels, and who may not already have a SUD diagnosis or treatment plan.<sup>292</sup> SBIRT programs have been shown to facilitate connectivity to treatment. Further, SBIRT has been associated with significant cost-savings across the healthcare system by preventing the use of other public services, in particular the public safety and justice systems, as substitutes for behavioral health care. Estimates have shown that each dollar spent on SBIRT programs delivers four dollars in savings in local budgets.<sup>293</sup>

Since the conclusion of the Audit Period, DBH and DOH began a peer-based Rapid Peer Responder (RPR) program pursuant to the objectives of the Opioid Strategic Plan. This program enables peers to deliver SBIRT to in-need clients, offer harm-reduction services, and make connections to MAT.<sup>294</sup>

However, as SAMHSA notes, SBIRT programs are often rendered less effective by inadequate referral to treatment, which SAMHSA describes as a, "critical yet often overlooked component of the SBIRT process."<sup>295</sup> Effective and complete referral to treatment involves:

"...establishing a clear method of follow-up with patients that have been identified as having a possible dependency on a substance or in need of specialized treatment. The referral to treatment process consists of assisting a patient with accessing specialized treatment, selecting treatment facilities, and helping navigate any barriers such as treatment cost or lack of transportation that could hinder treatment in

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291 SAMHSA, 2016-2017 National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia (2018), <http://www.samhsa.gov/data/report/2016-2017-nsduh-state-estimates-substance-use-and-mental-disorders>.

292 SAMHSA, Why SBIRT?, accessed Mar. 11, 2020, [https://www.integration.samhsa.gov/clinical-practice/sbirt/SBIRT\\_Colorado\\_WhySBIRT.pdf](https://www.integration.samhsa.gov/clinical-practice/sbirt/SBIRT_Colorado_WhySBIRT.pdf).

293 *Id.*, see also CASA Nat'l Advisory Commission on the Costs of Substance Abuse to Government, Nat'l Center on Addiction and Substance Use at Columbia Univ., *Shoveling up II: The Impact of Substance Abuse on Federal, State and Local Budgets* (2009), <https://www.centeronaddiction.org/addiction-research/reports/shoveling-ii-impact-substance-abuse-federal-state-and-local-budgets>.

294 *Supra*, n. 261.

295 SAMHSA, Referral to Treatment (2010), <https://www.integration.samhsa.gov/clinical-practice/sbirt/referral-to-treatment>.

a specialty setting. The manner in which a referral to further treatment is provided can have tremendous impact on whether the client will actually receive services with the referred provider.”<sup>296</sup>

Models that have been successful in addressing poor client connectivity in behavioral health settings emphasize integrating behavioral health care in primary care settings, as recommended above.<sup>297</sup> Co-located and integrated care models show significant improvements in client care initiation after referral as compared to non-integrated programs.<sup>298</sup> In these models, behavioral health and primary care providers work together to design and implement patient care plans and deliver those care plans at a single-site with a closely coordinated team.<sup>299</sup> The models encourage the availability of same-day appointments for routine and urgent care, providing routine and urgent care outside regular business hours, providing alternative types of clinical encounters, tracking appointment availability, and monitoring no-show rates.<sup>300</sup> This can prevent care initiation drop-offs caused by delays from assessment to treatment, the need to identify additional transportation, or miscommunication between a fragmented care-team.<sup>301</sup>

This also aligns with recommendations made in the “DC Health Systems 2017 Plan,” which found that “behavioral health integration in primary care and other settings” could help decrease fragmentation in the District health care system.<sup>302</sup> DBH should continue to study and consider these models as a means of reducing barriers to client care.

DBH should also coordinate with DOH to develop a plan to encourage the widespread adoption of SBIRT as part of the SUD assessment and referral process, as well as in primary care settings across the District. Finally coordination should be done to evaluate the RPR and other implementations of SBIRT in the District and beyond.

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296 *Id.*

297 A. Auxier et al., Behavioral Health Referrals and Treatment Initiation Rates in Integrated Primary Care: A Collaborative Care Research Network Study, 2 Translational Behav. Med. 3, 337 (2012).

298 Mindy Klowden, SAMHSA, Best Practices for Sustaining Behavioral Health Integration Models in Health Centers Using Health Information Technology (2018), [https://integration.samhsa.gov/about-us/Best\\_Practices\\_for\\_Sustaining\\_BH\\_Integration\\_Models\\_in\\_Health\\_Centers\\_using\\_HIT\\_slides\\_final.pdf](https://integration.samhsa.gov/about-us/Best_Practices_for_Sustaining_BH_Integration_Models_in_Health_Centers_using_HIT_slides_final.pdf).

299 *Id.*

300 *Id.*

301 *Id.*

302 Department of Health, District of Columbia, DC Health Systems Plan 2017, accessed Mar. 11, 2020, [https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/DC%20Health%20Systems%20Plan%202017\\_0.pdf](https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/DC%20Health%20Systems%20Plan%202017_0.pdf).

## **FINDING 5:**

**The District and federal governments do not adequately share, utilize, or analyze information about D.C.’s justice-involved substance use disorder client population across agencies.**

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## **RELATED RECOMMENDATIONS:**

1. DBH, DOC, and DHCF, in collaboration with the Criminal Justice Coordinating Council (CJCC), should finalize a “Uniform Consent Form for the Release of Protected Health Information” that includes specific, informed consent for release of SUD records.
2. DBH should establish a protocol for certified SUD providers to seek informed consent from SUD clients that would specifically allow for the lawful and appropriately-limited sharing of behavioral health information (BHI), including SUD information, between providers, DBH, DHCF, and DOC, in the case of a client’s incarceration.
3. DOC, DBH, and DHCF should establish a protocol for the real-time sharing of clients’ authorized SUD information—both electronically and through other forms of communication—between community-based SUD providers and the agencies as is appropriate and necessary to ensure care-continuity for people entering and leaving DOC custody.
4. D.C. should establish an inter-agency agreement to facilitate data sharing between all agencies that regularly come into contact with justice-involved SUD consumers. The agreement should create a process for agencies, on an ongoing and permanent basis, to combine their person-level data into a single, anonymized dataset that includes all variables relevant to a person’s behavioral health needs and service consumption and justice involvement in the District of Columbia.
5. The Deputy Mayor for Health and Human Services (DMHHS) and the Deputy Mayor for Public Safety and Justice (DMPSJ) should collaborate to identify the appropriate entity, with adequate staffing and expertise, to manage this data sharing on an ongoing basis, to ensure compliance from all participating D.C. agencies, and to analyze the dataset.
6. The District should publish an annual report summarizing the inter-agency dataset analyzed about SUDs and justice system involvement, including any indicators of emerging barriers to care or significant population trends.

## COMMENTARY:

### Overview of D.C. Agency SUD Data Collection, Sharing, and Publication

Interagency behavioral health information (BHI) and criminal justice data sharing in D.C. is extremely limited. Currently, no single agency or office in the District has the responsibility or authority to collect, track, synthesize, and evaluate information about the intersections between substance use and our criminal justice system. Indeed, no D.C. agency could do those tasks alone; they require significant collaboration and a sustained focus. Because of our unique jurisdictional status, many of the relevant criminal justice agencies are federal and are not under the authority of the Mayor or D.C. Council, adding a layer of complexity to the partnerships required.

To date, no entity has successfully established a comprehensive, continuous interagency data sharing and evaluation scheme for behavioral health and criminal justice information. Unfortunately, this leaves D.C. policymakers, agency staff, SUD providers, and the public with fractional and fragmented SUD and justice involvement data. Such data, if appropriately collected, shared, and analyzed, could significantly deepen the District's understanding of this complex issue and improve its ability to serve this vulnerable population.

**Sharing Data with Other Agencies.** During the Audit Period, DBH did not “receive any information about behavioral health outcomes, including SUD treatment, from any other District or federal agency,” did not “provide any information about SUD treatment outcomes” to any local or federal criminal justice agency, and did not participate in regional health information exchanges for data sharing.<sup>303</sup> In 2017, DBH signed a limited agreement with the Office of the Deputy Mayor for Public Safety and Justice (DPMSJ) that facilitated the annual matching of DBH data to MPD and D.C. Superior Court data to identify “whether individuals who have been arrested and individuals who have been victims of a crime have had prior contact with DBH.”<sup>304</sup> Taking the court and police data provided by DPMSJ, DBH is supposed to “determine whether an individual identified...received services from DBH at any point in time.” In December 2017, DPMSJ used DBH's analysis to complete statutorily required reporting on crime trends, and reported the number of individuals arrested on a felony charge who had received substance abuse treatment in either CY2015 or 2016.<sup>305</sup> This data-matching agreement does not include all relevant agencies that have behavioral health data, nor all relevant criminal justice data sources. Nor does the agreement require any specific breakdowns for SUDs or other types of behavioral health services.

DOC did not cite any interagency data-sharing agreements during the Audit Period, but did point to a FY2019 agreement between DOC and DBH regarding the provision of Vivitrol and Nalaxone,

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303 DBH Correspondence on Aug. 23, 2019, Requests 14, 15, 18.

304 D.C. Department of Behavioral Health & Office of the Deputy Mayor for Public Safety and Justice, *Data Use Agreement* (Nov. 8, 2017).

305 Office of the Deputy Mayor for Public Safety and Justice, District of Columbia, *A Report on Felony Crime in the District of Columbia for 2016* (Dec. 2017), <https://github.com/thelabdc/NEAR-Act-Public>. For NEAR Act requirements, see D.C. Law 21-356, 63 D.C. Reg. 4659 (Neighborhood Engagement Achieves Results Amendment Act of 2016) (Apr. 1, 2016).

which included a requirement that DOC will “provide DBH with client-level data and participate in an evaluation of each initiative.”<sup>306</sup>

DBH does report behavioral health data to SAMHSA. DBH explained that it “sends SAMHSA automated Treatment Episode Data Set (TEDS) and National Outcome Measure reports from DATA WITS.”<sup>307</sup> The anonymized data SAMSHA collects from participating agencies like DBH allows for the evaluation of national trends in admission and discharge patterns by jurisdiction, service type, and time, but does not track individual clients through treatment. While the data can be used for retrospective studies of the efficacy of SUD services, they are inadequate for use in evaluating SUD services at a local level in a timely way. No administrators at DBH, DOC, or any of the SUD providers interviewed, report using TEDS and NOM data for SUD outcomes evaluation.

Thus, DBH relies primarily on its own agency and provider data to maintain clients’ individual records, track service utilization trends and outcomes, and perform evaluations of SUD service provision. DBH uses two electronic health records (EHR) systems for its billing and claims processing, DATA WITS and iCAMS.<sup>308</sup> DATA Wits tracks service claims related to SUDs and iCAMS tracks claims related to mental health disorders.<sup>309</sup> These EHRs contain information about individuals and their claims generated by DBH, as well as by the community-based SUD and mental health care providers with which DBH contracts. In addition to billing and claims, these EHRs are used for clinical communication, as medical records for individual clients, and as “a source of data for clinical, health services, and outcomes for mental health and substance use services.”<sup>310</sup>

DBH administrators consistently reported that the DATA WITS claims and billings data collected during the Audit Period was also used to track “service utilization” or the number of individuals receiving different types of SUD services over time.<sup>311</sup> DOC relies primarily on Centricity—the internal EHR system maintained by Unity, its healthcare contractor—to collect and analyze its SUD related data.

**Publishing Information about SUDs.** DBH, DOC, and other D.C. entities have published a variety of reports about the populations of people in the District who have SUDs or those who are involved with our justice system, but there have been virtually no studies analyzing data about both of those groups together. For example, DBH publishes its Mental Health and Substance Use Report on Expenditures and Services (MHEASURES) on an annual or biannual basis. This “is a comprehensive overview of the usage of community based mental health and substance use disorder

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306 D.C. Department of Corrections, *FY-19 Memorandum of Understanding between District of Columbia Department of Behavioral Health and DOC* (Jan. 29, 2019).

307 DBH Correspondence on Aug. 23, 2019, Request 14; see also *id.* at Request 15.

308 DBH Correspondence on Aug. 23, 2019, Request 19 (regarding the number of systems). For services that DBH provides itself, it may not need to generate payment claims (it would not need to reimburse itself for services it provides). In these cases, services directly provided by DBH would not be captured in the same iCAMS and Wits data systems that are used to track and store other health records.

309 CCE DBH Administrator Interviews.

310 D.C. Department of Behavioral Health, Policy 115.6, at § 6 (Responsibilities and Procedures) (2016); see also CCE DBH Administrator Interviews.

311 CCE DBH Administrator Interview.

services.”<sup>312</sup> Additionally, in FY2018, DBH released a Community Service Review of Adult Substance Use Treatment Services Summary Report.<sup>313</sup> This was a “case-based review” of 31 adult clients who received care from 16 different DBH-certified providers to gauge the quality of the SUD services delivered by particular providers.<sup>314</sup> In 2017, DBH also released the results of its annual Behavioral Health Satisfaction Survey that, for the first time, included specific questions about client satisfaction with SUD services.<sup>315</sup>

During the Audit Period, DOC published information regarding its SUD services through its “Program Effectiveness Rates for Reentry and RSAT programs” Key Performance Indicator (KPI). Starting in 2016, DOC began reporting the number of RSAT participants as a KPI.<sup>316</sup> Starting in 2017, DOC began reporting the “effectiveness” of RSAT, which was retained in its 2018 KPI and defined as the “reduction in 12-month reincarceration rate compared to that for DOC inmates.”<sup>317</sup> DOC also publishes quarterly population statistics, but these reports do not include information about SUD prevalence in DOC.<sup>318</sup> The most detailed information about people in DOC custody known to have a SUD and the services offered was reported in the custodial population study published by the Moss Group in 2017 for the Criminal Justice Coordinating Council (CJCC).<sup>319</sup> The study included an estimate of the rate of SUDs in the population of people incarcerated in D.C., as well as a survey of individuals in DOC who had at some point received a DBH assessment.<sup>320</sup>

The CJCC is an independent agency designed to identify issues and their solutions, propose actions, and facilitate cooperation to improve public safety and criminal justice services in D.C.<sup>321</sup> It published three reports during the Audit Period related to behavioral health information sharing in the District. Two of the reports were part of CJCC’s, “Research in Brief” series published in 2016. One provided a high-level overview of “super-utilizers” of health care and the justice system in the District, who are people with complex and unaddressed behavioral health, physical health, and

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312 Reports, D.C. Department of Behavioral Health, <https://dbh.dc.gov/page/reports-01>.

313 DBH Correspondence on Jan. 16, 2019, Response 1.

314 D.C. Department of Behavioral Health, *FY18 Community Services Review of Adult Substance Use Treatment Services Summary Report* (2018).

315 D.C. Department of Behavioral Health, *Behavioral Health Satisfaction Survey* (2017), [https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/BHSS\\_Annual%20Report\\_FY17\\_20180221\\_REQ1011%20%28002%29%20-%20FINAL.pdf](https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/BHSS_Annual%20Report_FY17_20180221_REQ1011%20%28002%29%20-%20FINAL.pdf).

316 D.C. Department of Behavioral Health, *FY 2016 Performance Accountability Report* (2016), [https://oca.dc.gov/sites/default/files/dc/sites/oca/publication/attachments/DBH\\_FY16PAR.pdf](https://oca.dc.gov/sites/default/files/dc/sites/oca/publication/attachments/DBH_FY16PAR.pdf).

317 Office of the City Administrator, District of Columbia, *DC Department of Corrections FY2017* (2017) (“[E]ffectiveness” is not defined in the KPI for 2017, but in the 2018 KPI is defined as the “percent reduction in 12-month reincarceration rate compared to that for DOC inmates”).

318 See, e.g., D.C. Department of Corrections, DOC Population Statistics (Dec. 31, 2019), [https://doc.dc.gov/sites/default/files/dc/sites/doc/publication/attachments/DOC%20Population%20Statistics\\_Dec31\\_2019\\_01\\_24\\_2020.pdf](https://doc.dc.gov/sites/default/files/dc/sites/doc/publication/attachments/DOC%20Population%20Statistics_Dec31_2019_01_24_2020.pdf).

319 F. Shawn & M. Flower, The Moss Group, *District of Columbia Custodial Population Study: Seeking Alignment between Evidence Based Practices and Jail Based Reentry Services* (2017), <https://www.jrsa.org/pubs/reports/jrsa-dc-custodial-pop-study-9-2017.pdf>.

320 *Id.*

321 Criminal Justice Coordinating Council, *About CJCC*, accessed Mar. 12, 2020, <https://cjcc.dc.gov/page/about-cjcc>.

social needs.<sup>322</sup> The other was a high-level overview of synthetic cannabinoids and their known use in the District.<sup>323</sup>

CJCC also published the comprehensive “Mental Health Information Sharing in the District of Columbia Criminal Justice System” report in 2015.<sup>324</sup> The report details a wide variety of opportunities for improved mental health information sharing between mental health providers and the correctional system.<sup>325</sup> The report concludes that because of Health Insurance Portability and Accountability Act (HIPAA) exceptions for information provided to a custodial agency for treatment purposes, DOC could automatically receive vital BHI from DBH through a secure, shared database. However, CJCC reported that the federal requirements of 42 CFR Part 2 establish a higher level of protection for SUD information, and would require releases to be signed by clients for any sharing of their SUD diagnosis or treatment information. Similar releases would also have to be signed for DOC to share SUD information with justice partners or DBH and its certified SUD providers.

### Fragmentation of D.C. Behavioral Health Data

A 2018 study of D.C. and federal agency data by the Vera Institute of Justice (Vera) found that BHI is distributed across several health and justice agencies in the District and is highly fragmented.<sup>326</sup> Vera’s study looked at administrative data from MPD, PSA, DOC, CSOSA, DBH, and DHCF. In addition to successfully demonstrating that these diverse agencies’ data could be shared, anonymized, and matched, Vera’s analysis found that 57% of people arrested by MPD in October 2012 had mental health or substance use data on record with at least one of these health or justice agencies at the time of their arrest. Further, 47% of that data was held by either health or justice agencies, but not by both types of agencies, reflecting significant data fragmentation.

For the period examined—between 2006 and 2014—Vera found that DBH held BHI for just 28% of individuals who were arrested in October 2012, while DHCF held BHI for only 13% of individuals at the time of arrest. Only 2.26% of the cohort had information shared by both DBH and DHCF at arrest. Just over half of the cohort’s BHI was held by non-health agencies. Despite not being a local or health agency, federal CSOSA, not DBH or DHCF, held a plurality of behavioral health data for justice-involved behavioral health clients in the District. Specifically, Vera found that CSOSA held BHI for 85% of the people in the October 2012 arrest cohort with whom it had contact.<sup>327</sup>

In conducting this audit and analyzing agency data, CCE’s findings are consistent with Vera’s

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322 District of Columbia Statistical Analysis Center, *Brief: Super-Utilizers in the District of Columbia* (2016).

323 District of Columbia Statistical Analysis Center, *Brief: New Psychoactive Substances* (2016).

324 Criminal Justice Coordinating Council, *Mental Health Information Sharing in the District of Columbia Criminal Justice System* (2015), <https://cjcc.dc.gov/sites/default/files/dc/sites/cjcc/publication/attachments/CJCC%20Mental%20Health%20Final%20Report%20081315.pdf>.

325 *Id.*

326 Marilyn Sinkewicz et al., Vera Institute of Justice, *Sharing Behavioral Health Information Across Justice and Health Systems* (2018), <https://www.vera.org/downloads/publications/Sharing-Behavioral-Health-Information-across-Justice-and-Health-Systems-Full-Report.pdf>.

327 *Id.*



conclusion about siloed data, albeit based on different information and analytical designs. While we did not have access to CSOSA or PSA data as part of this audit's matched dataset, we found that the majority of information that DBH and DOC held about the SUD care and status of individuals in period of transition into and out of correctional settings was not held by the other agency. Of the 11,534 individuals for whom DOC had any SUD data in its record system at *any* time before that individual's incarceration (the "SUD Ever" flag), only 28.71% of those individuals also generated a SUD record in either the DBH or DHCF data received by CCE during the Audit Period. Because there were not agreements or protocols for the relevant D.C. and federal agencies to share behavioral health information about clients with each other during the Audit Period, the majority of the information these agencies had about overlapping clients or people in custody remained siloed and unshared.

### Sharing Justice-Involved Individuals' SUD Information in Real Time

For people with SUDs who are justice-involved, interventions at different intercepts—at the time of arrest when diversion is being considered, at the time of incarceration when DOC is evaluating a person's SUD needs, or at the time of reentering the community when DBH tries to reconnect a person to community-based care, among others—could be better targeted if these agencies had better data about the individual people and their behavioral health and justice-involvement histories. The combination of behavioral health and justice information, when appropriately shared, can create opportunities to better identify individuals at higher risk of negative outcomes like arrests, relapse, or service disruption, and can help ensure those people are targeted for outreach by relevant stakeholders.

To reach clients before a behavioral health crisis, D.C. needs to engage in real-time (or as close to real-time as is practicable) data sharing between agencies to identify opportunities for just-in-time adaptive interventions (JITAs).<sup>328</sup> JITAs are an "intervention design aiming to provide just-in-time support, by adapting to the dynamics of an individual's internal state and context."<sup>329</sup> Studies have shown that JITAs have been successful at mitigating alcohol use<sup>330</sup> and increasing symptom management for people with mental illness,<sup>331</sup> even when the implementing agencies had access only to scarce behavioral health data. These types of policies can leverage individualized information about behavioral health clients to deliver tailored interventions to clients at critical times and reduce the likelihood of the deterioration of a person's behavioral health.

D.C. does have one example of inter-agency, real-time behavioral and health data sharing that

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328 Inbal Nahum-Shani et al., *Just-in-Time Adaptive Interventions (JITAs) in Mobile Health: Key Components and Design Principles for Ongoing Health Behavior Support*, 52 *Annals of Behavioral Medicine*, A Publication of the Society of Behavioral Medicine 6, 446 (2018), <https://doi.org/10.1007/s12160-016-9830-8>.

329 *Id.*

330 David H. Gustafson et al., *A Smartphone Application to Support Recovery from Alcoholism: A Randomized Clinical Trial*, 71 *JAMA Psychiatry* 5, 566 (2014), <https://doi.org/10.1001/jamapsychiatry.2013.4642>.

331 Dror Ben-Zeev et al., *Development and Usability Testing of FOCUS: A Smartphone System for Self-Management of Schizophrenia*, 36 *Psychiatric Rehabilitation Journal* 4, 289 (2013), <https://doi.org/10.1037/prj0000019>.



appears to improve connections to SUD services, although the details about how any SUD client information was shared are sparse. In 2015, D.C. launched a Screening, Brief Intervention, and Referral to Treatment (SBIRT) pilot that was implemented through a collaboration between DBH and D.C. Fire & Emergency Medical Services (FEMS).<sup>332</sup> As described in earlier Finding 3, SBIRT is a SUD-specific, targeted method of delivering interventions to connect clients to care when they are most in need of, and may be most willing to seek help.<sup>333</sup> As part of this pilot, DBH was able to identify opioid “super-users” using FEMS data on the administration of Naloxone during a 911 EMS response. These individuals were then targeted for SBIRT in the immediate aftermath of their overdose. Some 54% of those contacted for SBIRT agreed to treatment planning, and 21% agreed to be transported immediately to treatment intake.<sup>334</sup> While there is not a comparison to a control group of individuals who did not receive SBIRT following an overdose, that pilot supports the potential of cross-agency data-matching between DBH and other health and justice partners.

Based on the data collected and matched as part of this audit, CCE’s limited analysis suggests that incarceration-related disruptions to SUD care delivery are associated with adverse health and justice outcomes. As discussed in Finding 2, in only 9.39% of Incarceration Episodes in which the person received SUD care in the Look Forward, did that individual have an Active SUD flag during their most recent incarceration.

Then, when looking at the cases in which community-based care was received either in the Look Forward or the Look Back period, only 8.59% had an Active SUD flag during those incarcerations. In other words, as is shown in Figure 34, between 90.61% and 91.41% of incarcerations that could have—and perhaps should have—been flagged as “Active SUD” cases because of the proximity to care received in the community, were not identified by DOC.

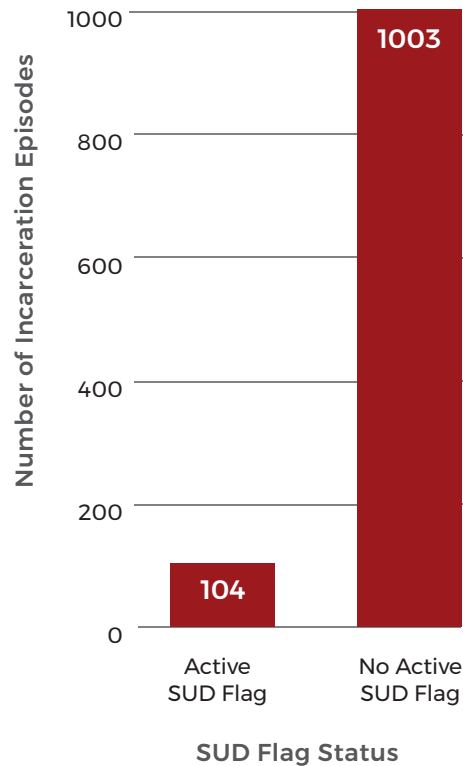
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332 Rafael Sa’adah & Jessica Bress, *Final Analysis of SBIRT Pilot Program*.

333 CCE Stakeholder Interview.

334 Rafael Sa’adah, MWCOG Regional Opioid and Substance Abuse Summit, *Holistic Response to the Opioid Epidemic: The District of Columbia Experience* (May 9, 2017).

**Figure 34: Incarceration Episodes with Care in Look Forward by Active SUD Flag**



**Source: Matched District Data**

Additionally, this suggests that individuals DOC identifies as having active SUD service needs are not receiving care from DBH providers upon release. These findings demonstrate significant information fragmentation and gaps in both agencies' data sets regarding SUD diagnoses, leaving each agency respectively hindered in its ability to provide timely and relevant care to the full universe of individuals who might benefit from treatment or other supports.

To improve the District's capacity to identify and serve individuals who need SUD care and other interventions, D.C. should establish targeted agency protocols for obtaining client consent and, when provided, sharing of BHI among agencies that can facilitate just-in-time interventions, or at the very least help better identify people with SUDs and their histories of care. This protocol should, at minimum, include DOC and DBH, but may also ultimately include other federal or local partners that have BHI and that support justice-involved individuals with SUDs, like FEMS or PSA.

In addition to the recommendation made in Finding 2 for DOC to obtain consent from individuals in its custody, DBH should establish a practice among its certified SUD providers to seek consent from SUD clients that would specifically allow for the sharing of BHI between providers, DBH, and DOC, in the case of an incarceration. Furthermore, these agencies should allow for the sharing of SUD health information and the real-time communication between community-based SUD

providers, DBH, and DOC care providers, as is appropriate to ensure more robust care-continuity for people entering and leaving DOC custody.

This recommendation is not made without recognition that there are significant ethical considerations, as well as legal protections and restrictions, related to disclosing or sharing individuals' BHI generally, and substance use information specifically. In D.C., the Data-Sharing and Information Coordination Amendment Act of 2010 controls the use and disclosure of information relating to the health of or provision of health care to an individual, by a D.C. government agency or its service providers.<sup>335</sup> This law explicitly allows interagency sharing of a person's health information in order to coordinate their treatment, services, or support, among other purposes. At the federal level, HIPAA and 42 CFR Part 2 place limits on the disclosure of a person's health information, including when consent is required to share information, who is allowed to access the information, and how it is stored and transmitted. Part 2 specifically protects peoples' "identity, diagnosis, prognosis, or treatment" records related to substance use, and is more restrictive than HIPAA, requiring patient consent for almost all disclosures, including between different SUD providers and agencies.<sup>336</sup> The purposes of these regulations are to protect confidentiality, promote access to treatment, support the doctor-patient relationship, and reduce stigma.<sup>337</sup>

However, these laws are not categorical bars to interagency SUD data sharing. In developing this protocol, the District can ensure compliance with all federal and local laws and appropriately tailor the information shared, by creating a process to obtain written, informed consent from individuals with SUDs who receive care at a community-based SUD provider or from DBH, or who receive care inside DOC. Across the country, "agencies have developed single or multi-party consent forms to enable communication between stakeholders coordinating care and services, while respecting the autonomy and privacy of the patient."<sup>338</sup> It is allowable under Part 2 for patients to specifically designate entities that can make disclosures or to provide a "general designation" like "my treating providers" or "all programs in which the patient has been enrolled as an alcohol or drug abuse patient" in their consent, offering the flexibility of one consent form facilitating communications between DOC, DBH, and individual care providers in the community.<sup>339</sup> However, the forms will still need to be explicit in the amount and kind of SUD treatment information that may be disclosed and the duration of the consent.

DBH and DOC should work closely with SUD providers, advocates, and individuals with SUDs to: develop the consent form and the information provided to individuals whose consent is

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335 D.C. Code § 7-241, et. seq.

336 42 C.F.R. § 2.1(a).

337 See Justice and Health Connect, *Module 3: Legal and Ethical Regulations*, accessed Mar. 12, 2020, <http://www.jhconnect.org/toolkit#module-3-map-legal-and-ethical-regulations>.

338 See Justice and Health Connect, *The Legal Landscape of Justice and Health Information Sharing*, accessed Mar. 12, 2020, <http://www.jhconnect.org/wp-content/uploads/2013/06/Legal-Issue-Paper-Final.pdf>.

339 See, e.g., SAMHSA, *Substance Abuse Confidentiality Regulations*, accessed Mar. 12, 2020, <https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs>.

requested;<sup>340</sup> determine the appropriate, and least-coercive, circumstances under which individuals are asked to give consent; and decide how to implement patient decisions to revoke any consent. The agencies and SUD providers should establish different opportunities, outside moments of crisis, acute stress, or incapacitation, for clients to provide informed consent for information about their SUD diagnosis and treatment history to be shared with DOC or DBH. Additionally, they should explore including the option for people to “opt out” of sharing their health records with particular agencies, as a way to protect privacy rights and promote autonomy.<sup>341</sup>

Most importantly, DBH, DOC, and these stakeholders must develop a protocol for how they will actually share authorized information, both electronically and interpersonally, on an ongoing basis. While participation in the D.C. Health Information Exchange by all SUD providers, as contemplated by DBH-proposed regulations in 2020, could meaningfully improve real-time information sharing that is possible between the DOC-contracted SUD provider and other providers who serve justice-involved individuals before and after periods of incarceration, there are more decisions to be made about what triggers a contact, who holds primary responsibility at each entity to communicate, and when those communications must be made.

With this type of ongoing information sharing, DOC and DBH could work together to deliver more timely interventions, ensure the delivery of continuous SUD care before, during, and after incarcerations, and ultimately help disrupt the harmful cycle of substance use and justice-involvement for many vulnerable people.

### Inter-Agency SUD and Justice Data Matching and Analysis

The District's current inability to match data collected across agencies to individual clients makes it difficult for each agency to track the efficacy of its own SUD programs or for the DMHHS, the D.C. Council, the CJCC, researchers, or the public to evaluate these systems more broadly. The District needs to understand whether the delivery of a specific type of service to a specific group of clients generates improvements for those clients according to one or more established, pre-existing measures. Lack of capacity to do these analyses ultimately puts the District's programmatic investments at risk.

D.C. justice and health agencies must rely on each other—as well as other federal and community partners—if they want to have a more robust understanding of the impacts of their services on the people who interact with them simultaneously and sequentially. For example, a DOC administrator explained that, “Unity [the medical contractor in DOC] can make recommendations that people follow-up for their chronic problems [in the community]... but [Unity] doesn't know why people

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340 It may be most efficient for these agencies and community stakeholders to work with the Criminal Justice Coordinating Council (CJCC) to finalize the “Uniform Consent Form for the Release of Protected Health Information” that remains in development and ensure that the form is explicitly compliant with Part 2 requirements. See Criminal Justice Coordinating Council for the District of Columbia, *Public Safety, Justice and Community—The Fabric of a Safer DC: Annual Report 2018* (2018), at 21, [https://cjcc.dc.gov/sites/default/files/dc/sites/cjcc/page\\_content/attachments/CJCC\\_Annual\\_Report\\_2018.pdf](https://cjcc.dc.gov/sites/default/files/dc/sites/cjcc/page_content/attachments/CJCC_Annual_Report_2018.pdf).

341 See Justice and Health Connect, *Background*, accessed Mar. 12, 2020, <http://www.jhconnect.org/background>.

don't show up if DBH doesn't track if there are follow-ups or connectivity. We need for there to be a way for the liaisons to transmit that information back to DOC."<sup>342</sup>

Interagency BHI sharing is an emerging best practice, and many jurisdictions have proven that statutory and ethical privacy barriers can be overcome using well-designed and implemented data-sharing protocols.<sup>343</sup> Studies using interagency matched data have shown a relationship between the receipt of behavioral health outpatient services and arrests,<sup>344</sup> and a relationship between mental health service provision and a variety of justice outcomes such as arrest and lengths of incarceration.<sup>345</sup> D.C. is currently not able to conduct ongoing analyses like this on any behavioral health and justice system interactions.

Further, DOC cannot currently evaluate the medium- or long-term efficacy of its SUD services and reentry planning provided in the jail if it does not know whether clients are successfully connected to treatment or have adverse SUD-related health events after release from its custody. These are outcomes that can currently be tracked only by DBH, DHCF, and OCME, as DOC does not have access to the information necessary to observe whether a referral made from DOC is followed through on in the community.<sup>346</sup> Similarly, DBH cannot evaluate the impacts of its SUD services on different judicial outcomes such as police contacts, arrests, convictions, or incarcerations, as that data is not shared with DBH.

Additionally, the District cannot effectively identify or understand relationships between the rate of lethal drug overdoses by District residents and the provision or lack of SUD services or justice-involvement. Finally, the District cannot evaluate the efficacy of many of the important and innovative strategies outlined in the Opioid Strategic Plan without cross-agency information sharing and the ability to decipher correlations, causations, and other relationships between different data points. Without robust and ongoing inter-agency data-matching, these analyses are not possible.

Using the novel inter-agency data set analyzed as part of this audit, CCE was able, for the first time, to identify significant disruptions in the continuity of publicly funded SUD care before and after incarceration in D.C. This analysis shows that while DOC incarcerations appear to have a positive effect on initiating SUD care delivery for some individuals, they also contribute to the disruption of community-based care for almost as many other individuals.<sup>347</sup> These findings, and others noted in the Inter-Agency Data Analysis, would not have been possible without the data match done as

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<sup>342</sup> DOC Administrator Interview.

<sup>343</sup> John Petrila & H. Fader-Towe, The Council of State Governments, *Information Sharing in Criminal Justice - Mental Health Collaborations: Working with HIPAA and Other Privacy Laws* (2010), [https://bja.ojp.gov/sites/g/files/xyckuh186/files/Publications/CSG\\_CJMH\\_Info\\_Sharing.pdf](https://bja.ojp.gov/sites/g/files/xyckuh186/files/Publications/CSG_CJMH_Info_Sharing.pdf).

<sup>344</sup> A. R. Gilbert et al., *Reductions in arrest under assisted outpatient treatment in New York*, 61 *Psychiatric Services* 10, 996 (2010); see also R. A. Van Dorn et al., *Effects of outpatient treatment on risk of arrest of adults with serious mental illness and associated costs*, 64 *Psychiatric Services* 9, 856 (2013).

<sup>345</sup> Robert Constantine et al., *Characteristics and Experiences of Adults with a Serious Mental Illness Who Were Involved in the Criminal Justice System*, 61 *Psychiatric Services* 5, 451 (2013), <https://doi.org/10.1176/ps.2010.61.5.451>.

<sup>346</sup> CCE DOC Administrator Interview; see also DBH Correspondence.

<sup>347</sup> See CCE Analysis of Inter-Agency Data.

part of this audit. While the audit team's analysis was of time-limited data from a small set of local agencies and does not point to definitive conclusions, it does demonstrate that a concerted and ongoing evaluation of these care disruptions will be necessary to identify relevant predictors and, ultimately, to repair breaking points in the cycle of community-based SUD treatment in D.C.

D.C. should develop and execute an inter-agency agreement designed to facilitate data sharing among all agencies that regularly come into contact with justice-involved SUD consumers in the District. Ideally, this agreement should include both local and federal agencies, including: MPD, DOC, DBH, DHCF, FEMS, BOP, PSA and CSOSA.<sup>348</sup> The agreement should create a process for the agencies, on an ongoing and permanent basis, to combine their person-level data into a single, anonymized dataset that includes all variables relevant to a person's SUD status, health service consumption, and justice involvement in the District of Columbia. The data should be analyzed to detect emerging trends that are associated with continuity of care provision, justice outcomes such as arrests and incarcerations, and negative health outcomes such as unintended hospitalizations, use of FEMS services, overdoses, and deaths.

As noted above, this recommendation is made in recognition of the relevant legal restrictions related to disclosing or sharing individuals' BHI. While federal regulations significantly restrict disclosure of private information as it pertains to SUD patient records,<sup>349</sup> 42 CFR Part 2 permits non-consent disclosure to an entity performing an audit or evaluation on behalf of a federal, state, or local agency that is authorized by law to regulate the activities of the Part 2 program or another lawful holder.<sup>350</sup> The evaluating entity must provide written assurance that it will remove and destroy records with BHI after its evaluation is complete in a manner consistent with the law.<sup>351</sup>

Likewise, 45 CFR Part 46 generally prohibits the disclosure of any records containing personally identifiable information or any other indicators that could potentially link data to a particular individual. However, this regulation provides an exception for information that is used to "study, evaluate, improve, or otherwise examine public benefit or service programs" and is subject to the approval of department heads (a requirement that would be taken care of by establishing an agreement to which those departments are a party).<sup>352</sup> Additionally, Vera's research in 2018 and this audit's data matching exercise demonstrate that such information sharing protocols are possible in the District.

Finally, there needs to be clear leadership to ensure implementation of the data sharing agreement by each agency; identify the appropriate entity or entities to conduct the related analyses; solicit independent review of the analytical methods used; and publish relevant findings to the

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348 The list could, of course, be even broader and should likely include the D.C. and federal courts, and agencies like the D.C. Department of Human Services, and could even include agencies serving youth, if it were to truly capture various social determinants of health.

349 42 C.F.R. Part 2.

350 42 C.F.R. § 2.53.

351 *Id.*; 42 C.F.R. § 2.16.

352 See 45 C.F.R. § 46-104(d)(5). For more on the topic of data-sharing, see Appendix: Federal Data-Sharing Memo.

public. The DMHHS and the DPMSJ should collaborate to identify the specific entity that has adequate staffing and expertise to manage this data-sharing on an ongoing basis, ensure initial compliance from all relevant D.C. agencies that needs to participate, and analyze the resulting dataset.

In the District of Columbia, the “Substance Abuse Treatment and Mental Health Services Integration Task Force” (SATMHSIT) established by the CJCC conceivably could perform some of the necessary functions to support this project. SATMHSIT was formed in 2006 to support “interagency collaboration to improve the treatment options for criminal justice-involved individuals with mental health issues, substance abuse problems, or co-occurring disorders.”<sup>353</sup> To date, SATMHSIT has not been called upon by the District to support ongoing data sharing agreements or conduct evaluations of interagency SUD data. However, all of the relevant federal agencies are members of CJCC, including the Directors of PSA, BOP, CSOSA, and other potential data partners.<sup>354</sup> CJCC does have statisticians, data analysts, and policy analysts on its staff that could likely conduct the necessary analyses. Another option for the District would be to use OCTO and “The Lab,” a team of data scientists within the Office of the City Administrator, to collect and analyze the data.

The entity identified to perform this task, following the initial matching process, should then be empowered to perform ongoing analyses of the emerging trends and existing gaps in the District’s system of care delivery at least annually, if not more frequently. This body could make recommendations, as warranted, for improving the existing data sharing protocol, identifying justice-system intercepts ripe for diversion, improving care-continuity, and more. This body should also be responsible for publishing an annual report that would contain information pertaining to the interaction between SUDs and the justice system, including any indicators of emerging barriers to care or significant population trends. This report should not be limited only to opioids but should contain information for all SUDs.

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353 *Supra*, n. 22, at 1.

354 Criminal Justice Coordinating Council, CJCC Members, accessed Mar. 12, 2020, <https://cjcc.dc.gov/page/cjcc-members>.

## **FINDING 6:**

**DBH does not have clear strategic priorities, goals, and benchmarks that guide its delivery of substance use disorder services in the District generally, or for justice-involved individuals in particular, and it has not consistently used the same benchmarks annually to evaluate performance.**

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## **RELATED RECOMMENDATIONS:**

1. DBH should produce a multi-year, agency-wide strategic plan addressing the findings identified in this audit and other reports. DBH's Strategic Management and Policy Division should develop these plans and oversee 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.
2. DBH should supplement the goals articulated in the Opioid Strategic Plan to establish a relevant plan for all SUD service delivery and care outcomes.
3. The Office of the City Administrator should work with DBH to develop and incorporate into DBH's annual Performance Accountability Report (PAR) performance metrics that effectively capture and measure DBH's provision of SUD services and its work with justice-involved consumers. The City Administrator should require DBH to evaluate Key Performance Indicators (KPI) over at least three years consistently. If a new KPI goal or measurement is required by a shift in strategy or funding, the reasoning behind the change should also be fully explained by DBH.
4. DBH should revise D.C. Mun. Regs. 22-A § 2204.1(a) to make SUD-only clients who do not receive care at a Core Services Agency (CSA) eligible for DBH's Home First subsidy.
5. DBH should revise D.C. Mun. Regs. 22-A § 2207.1 to add individuals returning from incarceration as a priority population for supported housing subsidies.
6. DBH should also update Policies 511.1 and 511.2 to reflect the agency merger and explicitly make SUD-only clients eligible for housing services.
7. In its annual PAR to the Office of the City Administrator, DBH should fully explain the reasons for any significant shortfalls in the achievement of its goals.



## COMMENTARY:

### Overview of DBH's Planning Processes

DBH has not had an active, agency-wide, multi-year strategic plan since its creation via the merger of the Department of Mental Health (DMH) and the Addiction Prevention & Recovery Administration (APRA) in 2013, despite the general best practice for governmental agencies to have such plans,<sup>355</sup> and the statutory expectations that DBH produce annual plans.<sup>356</sup> DBH does work with the Office of the City Administrator (OCA) to produce its required annual Fiscal Year Performance Plan (FY Plan) with Key Performance Indicators (KPIs) at the beginning of each Fiscal Year.<sup>357</sup> Then, at the end of the Fiscal Year, it submits a Performance Accountability Report (PAR) to OCA.<sup>358</sup> The PAR contains information about the agency's success in implementing its KPIs and other elements of its FY Plan, and an account of other organizational highlights from the previous year.<sup>359</sup> The KPIs include information about DBH's performance related to certain key metrics, and if the agency failed to meet those metrics, explanations for why that occurred.

Aside from these required single-year annual documents, DBH was not functioning under an agency-wide strategic plan during the Audit Period. Instead, DBH identified two alternative sources of multi-year agency planning it was developing during the Audit Period.

First, the agency pointed to D.C.'s inter-agency opioid-related strategic plan called "Live. Long. DC. Washington, DC's Strategic Plan to Reduce Opioid Use, Misuse, and Related Deaths," (Opioid Strategic Plan), published in December 2018.<sup>360</sup> Development of the Opioid Strategic Plan began in October 2017 when an Opioid Stakeholder Summit was convened to discuss the emerging crisis.<sup>361</sup> The Opioid Strategic Plan was revised in March 2019 and includes goals, strategies, completion dates, action steps, lead actors, measures of success, and funding targets for proposed goals.<sup>362</sup> Monthly progress updates on the plan were published through the District's Live.Long.DC. website through December 2019.<sup>363</sup>

Second, DBH began what was slated to be an 18-month strategic planning process in 2016 that

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355 See Frances Berry, *Innovation in Public Management: The Adoption of State Strategic Planning*, 54 Public Admin. Review 4, 322 (1995); see also Theodore Poister & G. Streib, *Strategic Management in the Public Sector: Concepts, Models, and Processes*, 22 Strategic Management in the Public Sector 3, 308 (1999).

356 CCE Administrator Interviews; see also D.C. Code § 7-1141.06(2).

357 D.C. Code § 7-1141.06(2).

358 For a description of performance plans and reports, see Office of the City Administrator, District of Columbia, *Performance Plans and Reports: Health and Human Services*, accessed Mar. 5, 2020, <https://oca.dc.gov/node/160702>.

359 *Id.* (specifically, the sections on *Performance Plans and Performance Accountability Reports*).

360 *Supra*, n. 8.

361 *Id.*

362 *Id.*

363 Live.Long. DC, D.C. Department of Behavioral Health, <https://livelong.dc.gov> (button labeled *Read the Strategic Plan*).

was intended to produce a three-year agency-wide strategic plan.<sup>364</sup> DBH selected “Results-Based Accountability” (RBA) as the model for its strategic planning process. RBA is a proprietary process developed by a private consultant for public institutions and agencies to identify problems, develop strategic plans, and track outcomes.<sup>365</sup> For DBH, the goal of RBA was to develop a series of outcomes associated with each of the agency’s different functional units and for the network of care providers.<sup>366</sup> The RBA process began in 2016 as DBH worked to integrate former DMH and APRA units. As one DBH administrator explained, the agency tried to build a common culture and resolve frustrations expressed by SUD and Mental Health Rehabilitative Services (MHRS) providers.<sup>367</sup> DBH conducted extensive interviews with “consumers, clients and their families, advocates, behavioral health practitioners, community-based service providers, government leaders, and other community members.”<sup>368</sup> As of February 2020, DBH had not yet completed its RBA process and did not have an active agency-wide strategic plan to guide its medium- and long-term priorities.

### Impacts of Not Having a Multi-Year Strategic Plan

In over 20 interviews, no DBH administrator could point to a single document or set of documents that served as guidance to the staff about the agency’s long-term goals or performance measures during the Audit Period. Further, many expressed concern that there was a lack of strategic vision at DBH.<sup>369</sup> Despite the RBA process being underway, some administrators considered DBH leaders to be generally reactive, rather than embracing any strategic vision during the Audit Period. One administrator explained that DBH “functioned around a lot of requests—from the Auditor, from the Mayor, from Council.”<sup>370</sup> Several DBH administrators reported that the result of the RBA will reflect the agency’s strategic plan, but DBH administrators indicated that the plan was still a work in progress and was not ready for external review, citing fears that circulation of an incomplete document would compromise its later successful rollout to the provider network.<sup>371</sup>

DBH should prioritize completing and publishing its RBA and creating a sustainable process to update its agency-wide strategic plan every three years. Strategic planning is a critical part of agency function because it helps to coordinate all of an agency’s resources in an “omnidirectional alignment.”<sup>372</sup> Surveys of state agencies indicate that strategic plans are widely used across state

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364 DBH Correspondence with CCE Aug. 23, 2019, Request 10.

365 Mark Friedman, FSI Publishing, *Trying Hard Is Not Good Enough* (2005).

366 CCE DBH Administrator Interview.

367 CCE DBH Administrator Interview.

368 DBH Correspondence with CCE Aug. 23, 2019, Request 11.

369 CCE DBH Administrator Interview.

370 CCE DBH Administrator Interview.

371 CCE DBH Administrator Interview.

372 Theodore Poister, *The Future of Strategic Planning: Linking Strategic Management and Performance*, 70 *Public Administration Review* 1, 246 (2010).

agencies and local governments.<sup>373</sup> Strategic planning should be ongoing rather than episodic, and allows organizations to set goals, measure critical external trends, and develop plans to react to those trends.<sup>374</sup> Two particular problems have resulted from DBH's lack of multi-year goals or metrics during the Audit Period.

First, DBH does not have a framework in place for evaluating the ways in which the implementation of new practices, policies, and regulations affect patient outcomes. One administrator explained: "When we change a policy, we don't collect information about the impact."<sup>375</sup> The absence of consistent measures makes it impossible to evaluate whether DBH policy changes have been effective.

Second, DBH may have missed significant problems or trends relevant to the provision of and demand for SUD services in D.C., and consequently failed to respond to the problems in a timely manner. For example, as part of a SAMHSA grant, DBH issued its Opioid State Targeted Response (STR) Needs Assessment in July 2017.<sup>376</sup> That report identified a range of unanswered questions regarding DBH's provision of SUD services during the height of the opioid crisis, and highlighted several areas ripe for future analysis. For the STR, DBH analyzed a 2015 study of 2012 data and learned that D.C.'s Opioid Treatment Program (OTP) facilities, clinics that provide MAT services, had likely been operating at maximum capacity since 2012, before the onset of the opioid crisis. DBH wrote that "the District may lack the capacity to serve additional clients at the current OTPs," and that it would "seek to better assess the ability of...OTPs...to provide comprehensive, coordinated care—which DBH believes is an area of concern."<sup>377</sup> Despite the recognition of this issue in the 2017 STR Needs Assessment, DBH did not include evaluating or increasing OTP capacity as a KPI or strategic initiative in its FY2018 or FY2019 Plan.

The District's Opioid Strategic Plan did include a generalized goal to "Conduct a comprehensive assessment of the availability of treatment services slots/beds...in Washington, DC for adequacy, and develop a plan for building capacity as may be required."<sup>378</sup> DBH was listed as the lead agency for this goal, with a target completion date of September 30, 2019, but as of February 2020, no capacity evaluations have been published. OTP capacity is also not included in DBH's annual MHEASURES. Those reports, provide a summary of key agency measures related to service cost, utilization, and access to the public behavioral health system, but do not publish target goals or provide any other context for the data.<sup>379</sup>

These facts offer a troubling example of an important issue that was identified as the opioid crisis

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373 Theodore Poister & G. Streib, *Elements of Strategic Planning and Management in Municipal Government: Status after Two Decades*, 65 *Public Administration Review* 1, 45 (2005), <https://doi.org/10.1111/j.1540-6210.2005.00429.x>.

374 *Supra*, n. 372.

375 CCE Administrator Interview.

376 D.C. Department of Behavioral Health, *District of Columbia Opioid STR Needs Assessment* (July 31, 2017).

377 *Id.*

378 See *supra*, n. 8, at p. 16 (Goal 5.1).

379 D.C. Department of Behavioral Health, *Reports: Mental Health and Substance Use Report on Expenditures and Services*, accessed Mar. 12, 2020, <https://dbh.dc.gov/page/reports-01>.

was growing, deserved further study and, possibly, a policy response. But the issue did not become a specific target or goal in any DBH plan produced by DBH during the Audit Period. By failing to incorporate the issue of OTP capacity into DBH's internal goals and metrics for program evaluation, it likely hindered the District's ability to answer vital questions in 2016 and 2017, when overdoses were increasing in D.C.

To address these issues, the D.C. Council should require DBH to produce multi-year, agency-wide strategic plans addressing findings identified in this and other reports. In addition, on a more granular level, it should ensure that DBH produces and publishes annual plans, as D.C. Code § 7-1141.06(2) mandates, including information detailing progress in carrying out those plans. Further, the Executive Office of the Mayor should work with DBH to develop short- and long-term goals for improving the Department's operations as they relate to SUD services, establish plans for achieving these goals, and devote sufficient resources to ensuring that those goals are met. DBH's Strategic Management and Policy Division should 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 can measure progress. These goals should include a plan to ensure that network capacity is sufficient for service demand. The goal setting and strategic planning process should include a structure through which DBH can incorporate new information that it receives about the behavioral health needs and challenges of District residents into the existing plan on a regular basis. As is more fully addressed below, DBH should supplement the goals articulated in the Opioid Strategic Plan to establish a relevant plan for all SUD service delivery and care outcomes.

### **Looking Beyond Opioids at All SUD Service Needs**

The Opioid Strategic Plan is an example of a clear, detailed strategic plan that, if implemented fully, could make a meaningful difference in the District's opioid crisis. It identifies key stakeholders, targets, completion dates, lead agencies, and funding sources. Several of the goals are specifically related to the intersection of the justice and behavioral health system, many of which are consistent with the findings and recommendations in this audit.<sup>380</sup> However, there are two important omissions in the Opioid Strategic Plan that DBH should seek to address in its own individual agency strategic planning before seeking to use it as the basis for an agency-wide, multi-year strategic planning initiative.

First, while the opioid epidemic is an exigent public health crisis, SUDs are a broader universe deserving of strategic attention. In fact, the overwhelming majority of District residents who have a SUD do not have an opioid use disorder (OUD). In 2016 and 2017, 11.5% of adult residents in D.C. had a SUD, but only .39% of adult residents reported having used heroin in the past year. Of the 10.67% of D.C. adult residents who reported needing but not receiving treatment for substance use, 8.5% reported needing but not receiving treatment for alcohol use.<sup>381</sup>

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<sup>380</sup> *Supra*, n. 360, at 19-20.

<sup>381</sup> SAMHSA, 2016-2017 NSDUH *State-Specific Tables* (2019), <https://www.samhsa.gov/data/report/2016-2017-nsduh-state-specific-tables>.

Second, the Opioid Strategic Plan does not contain any specific measures to evaluate progress toward achieving its listed health and justice outcomes. DBH should supplement the Opioid Strategic Plan by setting clear, measurable outcomes related to client health. For example, DBH could set goals such as:

- Correctly identifying 90% of individuals who were actively receiving SUD services in community settings in the 30 days prior to their incarceration as having an Active SUD.
- Reducing the arrest rate of individuals with SUDs by 10% from the previous year.
- Reducing the rate of lethal overdoses that occur within 90 days of leaving jail by 15% from the previous year.

The goals that DBH adopts should reflect the full spectrum of SUDs, not just OUD, and should measure client level improvements of both health and justice involvement outcomes. The goals should be developed in conjunction with stakeholders to ensure they are aligned with the client populations needs and that there is buy-in among SUD providers and other District agencies to achieve them.

### **SUD Client Access to DBH's Specialized Housing Programs**

The overwhelming consensus of the SUD consumers that CCE interviewed during this audit emphasized the challenges that homelessness, poor family relationships, low-education, and adverse childhood experiences had on their pathways to treatment initiation and recovery. In recognition of these important social factors that affect behavioral health, DBH has several specialized housing programs for the consumers and clients it serves.

In FY2018, DBH provided housing or housing support to 2,282 people. This included 892 individuals served through Home First vouchers, which are housing vouchers provided to DBH consumers that cover the difference between 30% of a client's income and the cost of rent in the home of their choice.<sup>382</sup> Unfortunately, however, this significant part of DBH's housing is only accessible to its mental health consumers.

DBH regulations require that a person who wishes to apply for a Home First subsidy must be a consumer receiving care from "a CSA or other DMH-certified provider."<sup>383</sup> As previously noted, a Core Services Agency (CSA) is a specific designation for mental health providers that serve as clinical homes to their consumers.<sup>384</sup> Clients who are only associated with SUD providers and who do not receive services at a CSA are rendered ineligible under current DBH regulations from accessing DBH Home First support. Additionally, DBH prioritizes consumers who are transitioning from Saint Elizabeths to the community, chronically homeless, or are moving to a less-restrictive environment for supportive housing. In contract, DBH does not prioritize consumers or clients who are returning

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382 Council of the District of Columbia Committee on Health, *Department of Behavioral Health FY 18-19 Performance Oversight Questions* (2019), <https://dccouncil.us/wp-content/uploads/2019/04/dbh.pdf>.

383 D.C. Mun. Regs. 22-A § 2204.1(a) (2013).

384 See D.C. Mun. Regs. 22-A § 3411 (2011).

to D.C. from incarceration or otherwise justice-involved.<sup>385</sup> Finally, both DBH's policy on Access to Housing and its policy on Providing Housing and Services to Homeless Consumers were issued in 2005, before the DMH-APRA merger. They, contemplate housing services only for consumers diagnosed with Serious Mental Illness or Serious Emotional Disturbance, not clients exclusively diagnosed with a SUD.<sup>386</sup>

One of the most common narratives SUD clients shared during interviews was that incarceration, homelessness, and substance use formed a vicious cycle that consumed many years of their lives. For these people, homelessness led to more substance use, which resulted in petty crime, which in turn led to arrests and incarceration. Incarcerations further destabilized SUD clients. Many used PCP or cocaine instead of opioids, and therefore received no services of any kind for their SUDs in jail, nor were they connected to services upon release.<sup>387</sup> Indeed, the need for housing support is particularly acute for individuals who have SUDs and are justice involved. In 2015, 90 days into their reentry, more than a quarter of people returning from incarceration under CSOSA's supervision in D.C. lacked stable housing.<sup>388</sup> In the 2019 Point in Time (PIT) District-wide survey of people experiencing homelessness, 25% of individuals reported having "a problem with drugs." The majority of people experiencing homelessness in D.C. (57%) said they had previously been incarcerated, and of those, 55% said that incarceration had caused their current episode of homelessness. A smaller proportion, 31%, said they had been treated at a residential rehabilitation facility, and of those, 61% said they entered homelessness after leaving the residential program.<sup>389</sup>

Access to housing is strongly associated with positive outcomes among individuals with SUDs and improves the efficacy of treatment.<sup>390</sup> One study demonstrated that supportive housing like that offered by DBH can reduce reported SUD symptoms by 50% relative to intensive case management alone.<sup>391</sup> Additionally, Housing First programs have proven successful for maintaining cli-

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385 See D.C. Mun. Regs. 22-A § 2207.1 (2013).

386 D.C. Department of Mental Health, DMH Policy 511.1 (June 10, 2005), <https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/TL73.pdf>; DMH Policy 511.2 (June 10, 2005), <https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/TL74.pdf>.

387 CCE Client Interviews (multiple); see also Finding 3.

388 Council for Court Excellence, *Beyond Second Chances, Returning Citizens' Re-Entry Struggles and Successes in the District of Columbia* (Dec. 2016), <http://www.courtexcellence.org/uploads/File/BSC-FINAL-web.pdf>.

389 Interagency Council on Homelessness, *2019 Point in Time Plus Survey, Part One Initial Findings* (May 2019), <http://www.community-partnership.org/LiteratureRetrieve.aspx?ID=141162>.

390 For example, for the effect of residential treatment, see John M. Majer et al., *Abstinence Self-Efficacy and Substance Use at 2 Years: The Moderating Effects of Residential Treatment Conditions*, 34 *Alcoholism Treatment Quarterly* 4, 386 (2016), <https://doi.org/10.1080/07347324.2016.1217708>; for the effect of housing on treatment initiation see Deborah Padgett et al., *Housing First Services for People Who Are Homeless With Co-Occurring Serious Mental Illness and Substance Abuse*, 16 *Research on Social Work Practice* 1, 74 (2006); for the effect of housing first models on homelessness and hospitalization among a cohort with mental illness and SUD needs, see Gulcur et al., *Housing, Hospitalization, and Cost Outcomes for Homeless Individuals with Psychiatric Disabilities Participating in Continuum of Care and Housing First Programmes*, 13 *Journal of Community & Applied Social Psychology* 2, 171 (2003).

391 G. Hall et al., Taylor & Francis Online, *Housing Versus Treatment First for Supportive Housing Participants with Substance Use Disorders: A Comparison of Housing and Public Service Use Outcomes* (2018), <https://www.tandfonline.com/action/showCitFormats?doi=10.1080%2F08897077.2018.1449049>.

ents in housing, regardless of whether SUD clients are abstinent or acutely using substances.<sup>392</sup> Unfortunately, with the D.C. Housing Authority waiting list remaining closed to new applicants for subsidized housing support for more than seven years, low-income or homeless individuals with SUDs are without any generalized or targeted resources to support their housing needs.

In interviews with CCE, DBH administrators characterized the agency's regulations that prevent SUD clients from qualifying for supportive housing vouchers as something that they intended to fix eventually but had not been prioritized.<sup>393</sup> Moreover, in 2018, DBH introduced a KPI to measure the "number of housing subsidies to individuals who are mentally ill and homeless," but did not introduce a goal to change its relevant regulations or to increase the number of SUD clients who had access to housing programs within DBH.<sup>394</sup>

To address this disparity and align with its stated goals of enhancing parity between mental health and SUD clients, DBH should evaluate how individuals who receive SUD services can be included in its specialized housing programs that are currently available to mental health and co-occurring disorder consumers. DBH should modify its regulations to add people returning from incarceration as a priority population and to make clients with SUD-only diagnoses and who receive care from non-CSA providers eligible for Home First vouchers and other relevant housing supports. This modification would also allow for funding from the District or other sources to be targeted to SUD clients' housing needs in the future. DBH should also update Policies 511.1 and 511.2 to reflect the agency merger and include SUD-only clients.

### **Inconsistent KPIs Related to SUDs**

Of all the potential sources for DBH agency-wide goal-setting and evaluation metrics related to SUDs, only KPIs existed throughout the entire four-year Audit Period. Unfortunately, however, the relevant KPIs that DBH established during the Audit Period to evaluate SUD service provision were limited in number, and, more important, changed meaningfully from year to year in ways that prevent consistent evaluation. Indeed, as detailed below, DBH's constant changes to the KPIs frustrates oversight.

CCE analyzed every KPI related to SUD services and found that, between 2015 and 2018, DBH failed to have even a single SUD-related KPI that did not qualitatively change at least once. As one example, in FY2015, DBH set the KPI goal of having 60% of adults that receive SUD services complete their course of treatment. The agency did not reach that goal, as only 46.97% of adults completed treatment.<sup>395</sup> Then, in FY2016, this KPI was revised as the "percent of adults that successfully complete DBH substance use disorder treatment," and only 35.7% of the 60% target was

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392 K. Urbanoski et al., *Effects of Comorbid Substance Use Disorders on Outcomes in a Housing First Intervention for Homeless People With Mental Illness*, 113 *Addiction* 1, 137 (2017), <https://doi.org/10.1111/add.13928>.

393 CCE DBH Administrator Interview.

394 See D.C. Department of Behavioral Health, *FY 2018 Performance Accountability Report* (2018), [https://oca.dc.gov/sites/default/files/dc/sites/oca/publication/attachments/DBH\\_FY18PAR.pdf](https://oca.dc.gov/sites/default/files/dc/sites/oca/publication/attachments/DBH_FY18PAR.pdf).

395 D.C. Department of Behavioral Health, *FY 2015 Performance Accountability Report* (2015), [https://oca.dc.gov/sites/default/files/dc/sites/oca/publication/attachments/DBH\\_FY15PAR.pdf](https://oca.dc.gov/sites/default/files/dc/sites/oca/publication/attachments/DBH_FY15PAR.pdf).



met.<sup>396</sup> The effect of this linguistic change is unknown. However, DBH noted in its FY2016 PAR that the decreased discharge and completion rates of a particular program may skew results and be a barrier to achieving this goal, noting that the agency might “rethink the programs associated with this KPI.”<sup>397</sup>

Then, in FY2017, DBH eliminated the KPI regarding the total number of adults successfully completing treatment. Instead, it broke out two different KPIs: successful completion of “residential level of substance use disorder treatment” and “intensive outpatient substance use disorder treatment.” Under these new KPIs, DBH met its 60% target for residential treatment, with a 62.3% completion rate.<sup>398</sup> However, for intensive outpatient treatment, DBH changed the target to 41.2% and reached only 28.8% completion for that metric.<sup>399</sup> Combined back together, these figures show that 46% of adults in residential and outpatient completed their course of treatment in FY2017, comparable to the combined rate in FY2015. In FY2018 without any stated rationale, all KPIs related to successful adult completion of SUD treatment were removed.<sup>400</sup>

There was a similar inconsistency with DBH’s Planned Prevention Services KPIs during the Audit Period. In FY2015 and FY2016 DBH had two Planned Prevention Services KPIs with separate outreach goals for youth and adults. The targets in FY2016 were to reach 10,047 adults and 11,350 youth. It met the target for adults (12,977 adults reached), but badly missed the target for youth (6,803 youth reached).<sup>401</sup> In FY2017, DBH based its Planned Prevention Services KPI targets on the prior year’s actual results, with a goal to reach 5% more in each category, but then missed both goals by wide margins: only 4,069 adults and 5,167 youth were reached.<sup>402</sup>

Then, in FY2018, DBH removed the two distinct Planned Prevention Services KPIs and replaced them with a combined target to “achieve a five percent increase in the number of individuals (adults and youth) reached through planned prevention strategies over [the] FY2017 number.” That year, DBH set a target of 19,289 total individuals—both adults and youth—reached through Planned Prevention Services outreach, which was a 6% increase over the combined targets set in FY2017, and a 109% increase over the number of individuals actually reached in FY2017.<sup>403</sup> In its FY2018 PAR, DBH reported meeting this new goal, reaching 20,639 people; however it offered no data to

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396 D.C. Department of Behavioral Health, *FY 2016 Performance Accountability Report* (2016), [https://oca.dc.gov/sites/default/files/dc/sites/oca/publication/attachments/DBH\\_FY16PAR.pdf](https://oca.dc.gov/sites/default/files/dc/sites/oca/publication/attachments/DBH_FY16PAR.pdf).

397 *Id.* at 12.

398 Technically the goal was related to the percent of adults who successfully completed residential SUD treatment on a quarterly basis, and only 56.1% of individuals completed residential treatment in Q3. D.C. Department of Behavioral Health, *FY 2017 Performance Accountability Report* (2017), [https://oca.dc.gov/sites/default/files/dc/sites/oca/publication/attachments/DBH\\_FY17PAR.pdf](https://oca.dc.gov/sites/default/files/dc/sites/oca/publication/attachments/DBH_FY17PAR.pdf).

399 *Id.*

400 D.C. Department of Behavioral Health, *FY 2018 Performance Accountability Report* (2018), [https://oca.dc.gov/sites/default/files/dc/sites/oca/publication/attachments/DBH\\_FY18PAR.pdf](https://oca.dc.gov/sites/default/files/dc/sites/oca/publication/attachments/DBH_FY18PAR.pdf).

401 *Supra*, n. 397.

402 *Supra*, n. 399.

403 *Id.*



suggest whether the success was continuing to primarily reach adults, or if the gains were also with youth.<sup>404</sup>

Because DBH's KPIs and targets related to SUDs were not consistent throughout the Audit Period, DBH cannot be effectively evaluated on whether it is consistently succeeding or failing at any of its performance metrics over periods of time longer than one or two years. Even small positional shifts in short periods of time can make it difficult for the OCA, D.C. Council, and the public to track agency priorities and related progress, and difficult for agency staff to know what goals they are working to achieve.

DBH's lack of consistency in setting its KPIs and its PAR reporting reflect the agency's insufficient focus on developing detailed goals and metrics for success. These metrics must be detailed, consistent, and clearly explained over time to provide a clear picture of where the agency is excelling and where improvements should be targeted. DBH should identify short-term and long-term goals and metrics for improving care in a way that is public and transparent. Clear long-term goals can help build trust with the community, and will help external stakeholders hold DBH accountable and DBH to hold itself accountable.

To address these concerns, the D.C. Office of Performance Management (OPM) should develop and incorporate into DBH's annual PAR performance metrics that effectively capture and measure DBH's provision of SUD services and its work with justice-involved consumers. When DBH adopts a measure as part of its KPIs or other strategic planning, it should continue to evaluate outcomes on that specific measure for at least three years (the period of a strategic plan), and preferably five years, regardless of whether it identifies an updated or more appropriate measure, as long as outcome reporting for that measure is still possible. DBH should adopt this internal policy to prevent changing measures that inhibit its ability to track its progress on a given outcome from year-to-year.

## Errors and Inaccuracies in KPI Reporting

In addition to inconsistent KPIs and targets, when DBH reports on its progress on SUD-related goals, it has in the past failed to adequately and accurately address why the results were so dramatically different from the goal. The following incidents provide examples of this problem.

First, in its FY2017 PAR, DBH inaccurately asserts that it reached 97% of its target for "adults reached through planned prevention services," when the data cited reflects that only 33% of the target had been reached.<sup>405</sup> While such errors (typographical or not) are troublesome, it is more noteworthy that DBH goes on to suggest in its explanation that the agency has no control over its success on this metric because the number of prevention services it provides are simply a function of the number of requests the agency receives for materials and the people who attend its events.<sup>406</sup> If

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<sup>404</sup> *Id.*

<sup>405</sup> The stated target goal was 13,626 "number of adults reached through planned prevention services" annually and the number reached annually was 4,069.

<sup>406</sup> *Supra*, n. 399.

KPIs are to serve as a source of DBH strategic planning, the agency should also be setting goals that measure its actions (such as its various outreach activities), the outcomes they produce, and the ultimate impact on clients.

Second, DBH also offered an incomplete and inconsistent explanation for the 97.2% decrease in Recovery Support Services (RSS) from FY2016 - FY2017, one of its most significant KPI and service delivery changes during the Audit Period.<sup>407</sup> RSS include recovery coaching and mentoring, life-skill support, education support services, transportation, supported employment and housing, and other services that contribute to keeping people engaged in maintaining sobriety after completing treatment.<sup>408</sup>

In FY2016, DBH reported delivery of RSS to 5,115 clients, far exceeding the target of 2,500, but still a 17.4% decrease from the 6,192 individuals who received those services the previous year. In the FY2016 PAR, DBH cited as one of its agency accomplishments that it had revised its regulations so all SUD providers could be certified to bill Medicaid for SUD services, which would “allow a diversion of local funds to increase non-Medicaid-eligible services such as the Recovery Support Services, previously funded by a now-expired grant.”<sup>409</sup> Then, in FY2017, DBH set an increased goal to deliver RSS to 3,000 people, but ultimately delivered RSS to only 167 people, a 97.2% decrease from FY2016.<sup>410</sup>

This significant reduction in SUD RSS occurred at the peak of the opioid crisis, the same year during which the number of fatal overdoses in D.C. spiked to 279, more than three times the number of people who died from an opioid overdose in the first year of the crisis.<sup>411</sup> DBH’s explanation in the FY2017 PAR for this severe drop was that, “DBH received an Access to Recovery (ATR) Grant from SAMHSA that ended during FY17. Estimates were set based on ATR requirements and once grant funding ended previous targets were not sustainable which explains the reduction in RSS clients receiving treatments.”<sup>412</sup> Nowhere in its explanation does it reference the plan, articulated only a year before, to divert local funds to “increase” services like RSS. The dramatic FY2017 drop in RSS—services that were in high demand in the District—show that DBH did not successfully plan for or effectuate the diversion of local funds to ensure continuity of RSS availability after the grant expired.

DBH should fully explain any significant goal shortfalls in its annual PARs. Also, as noted above, KPIs should remain consistent over time; however, when a new goal or measurement is required by a shift in strategy or funding, the reason for the change should also be fully explained in any new KPI.

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407 *Id.*; see also *supra*, n. 397.

408 D.C. Department of Behavioral Health, Recovery Support Services, accessed Mar. 12, 2020, <https://dbh.dc.gov/service/recovery-support-services>.

409 See *supra*, n. 396 (FY 16 Performance Accountability Report).

410 See *supra*, n. 399 (FY 17 Performance Accountability Report).

411 *Supra*, n. 360.

412 *Supra*, n. 399 (FY 17 Performance Accountability Report).

## **FINDING 7:**

**DBH has not established adequate communication channels with critical substance use disorder stakeholders, including providers and members of the public.**

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## **RELATED RECOMMENDATIONS:**

1. DBH should use its Results Based Accountability (RBA) process as a model for designing ongoing engagement with SUD stakeholders, including community-based organizations, justice system actors, and SUD clients and their loved ones.
2. DBH should host a regular Provider Meeting at which SUD providers set the agenda.
3. DBH should establish a protocol, based on their robust process prior to revising the agency's Chapter 63 regulations in 2019, for soliciting and addressing SUD provider feedback on future changes to agency regulations, policies, and practices that will significantly impact SUD providers or their clients.
4. DBH should issue a policy establishing clear procedures for organizations, or people who are not themselves SUD clients, to alert DBH of alleged violations of client rights at DBH certified SUD providers.
5. DBH should amend its regulations, D.C. Mun. Regs. 22-A §3 and § 6319, to align with DBH Policy 515.3, Consumer Rights (August 15, 2017), formally merging the grievance procedures for mental health consumers and SUD clients.
6. DBH should maintain its public list of SUD providers and update it as SUD providers are certified and decertified.
7. DBH should improve its website to increase usability for SUD clients, SUD providers, individuals involved in the justice system, and the public.
8. DBH should train all outward facing staff on connecting the public to its resources.

## **COMMENTARY:**

### **Contextualizing DBH's Communications Practices**

During the Audit Period—which coincided with the peak of the opioid crisis—members of the public, including individuals with SUDs and professionals working in the field, struggled to find information about the SUD services available in D.C. Additionally, over the Audit Period, DBH's communication challenges extended to its working relationships with the network of community-based SUD providers. In fact, SUD providers expressed general dissatisfaction with the way DBH

communicated with them during large parts of the Audit Period. SUD providers struggled to work effectively with DBH through emerging opioid and synthetic drug crises to improve the services targeted to affected populations.

The information gathered during the audit suggested that these difficulties stemmed from low trust between SUD providers and DBH, and a culture at DBH that did not prioritize external communication and collaboration. DBH has only one policy statement, originally issued in 2003 by the Department of Mental Health (DMH), governing “procedures for the release of information to the public, publications by staff members, and employees’ testimony before legislative committees.”<sup>413</sup> During the Audit Period, no other policies were in place setting the standards for communication with SUD providers or other D.C. agencies.

Two features of the observations discussed in this finding are notable. First, they rely heavily on the perceptions and attitudes of the SUD providers and agency administrators whom CCE interviewed and surveyed during the Audit Period, and include feedback received from interviews with SUD clients. Almost all SUD providers that responded to the Provider Survey or whom the audit team interviewed responded that they were not satisfied with the way that DBH communicated with its SUD provider network. For the most part, instead of attempting to evaluate the “quality” of outgoing communications from DBH, the focus here is on the way that the recipients perceived these communications and the effect those perceptions had on SUD providers, agencies, and the clients they served.

Second, a consistent theme was that while the perceptions of DBH communications were very negative at times, they improved in the latter part of the Audit Period. The RBA process for some, and the end of Dr. Royster’s tenure as DBH Director for others, marked turning points for the better in SUD providers’ relationship with DBH. The following findings and recommendations should be viewed within this context.

## Challenges with DBH Provider Meetings

DBH hosts Provider Meetings several times a month that are designed to be the main forum for in-person communication between DBH and its SUD provider network. DBH administrators of varying levels of responsibility convene these meetings, depending on the topic.<sup>414</sup> DBH reported that, during the Audit Period, there were four classes of SUD Provider Meetings: (1) combined mental health and SUD provider Chief Executive Officer meetings, planned and facilitated by the Director of DBH and DBH’s Director of Network Development; (2) SUD and MAT Provider meetings, planned and facilitated by DBH’s Network Development Supervisor; (3) SUD iCAMS and DATA Wits user trainings, planned and facilitated by DBH’s Information Technology Department; and (4) Recovery

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413 Department of Mental Health, *Transmittal Letter re: DMH Policy 640.1* (Dec. 13, 2003), <https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/TL37.pdf>.

414 See DBH, *August 2018 Provider Meeting Calendar* (Aug. 2018), <https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/Provider%20Calendar%20for%20DBH%20WEBSITE%20August%202018.pdf>.

Support Services and ACRA/ASTEP meetings, planned and facilitated by DBH's SUD program staff.<sup>415</sup> However, in 2017, "due to changes in leadership, 'Recovery Support Services' [meetings] were terminated and then reinstated." DBH explained that "[t]opics listed on the agendas were identified as areas required [sic] discussion by the provider network, DBH staff, and/or the DBH Director two to three weeks prior to the scheduled meeting."<sup>416</sup>

Several SUD providers singled out these meetings as a source of dysfunction, explaining that the issues they considered most pressing, like the decentralization of the ARC and changes in the certifications, were rarely included on Provider Meeting agendas during the Audit Period.<sup>417</sup> When SUD providers asked about those issues during meetings, DBH representatives seemed unprepared to give answers.<sup>418</sup> According to one provider, many questions went unasked because, "for folks that are new to the network ... they don't feel comfortable speaking up." This SUD provider explained that this fear was tied to the idea that speaking out against DBH policies or practices could have consequences.<sup>419</sup> CCE did not find evidence that there was retaliation against SUD providers for speaking out during Provider Meetings. However, this anecdote reflects issues commonly reported to CCE: that SUD providers struggled to identify the appropriate individuals to reach out to with critical issues, or felt that they were not comfortable elevating the issues that they had with DBH.<sup>420</sup>

DBH administrators interviewed acknowledged this perception and noted the existence of "animus and distrust toward providers" at the beginning of the Audit Period, under the Royster administration.<sup>421</sup> One DBH administrator explained that they believed that while DBH does "a good job of the big stuff, the news campaigns and press support, we need to work on communicating with the middle, the churches and support groups and actual agencies that provide community supports to [clients]."<sup>422</sup>

These feelings were also acute among community-based organizations that provided job training, harm reduction, housing, and reentry services; although these organizations were not DBH certified or contracted SUD providers, they frequently shared clients with those SUD providers. In interviews, these organizations frequently reported not knowing the appropriate channels through which to voice their concerns and felt that DBH ignored or was uninterested in their feedback.<sup>423</sup>

To address SUD providers' concerns, DBH should host regular Provider Meetings at which all or most of the agenda would be set by SUD providers. DBH should solicit topics from SUD providers in advance of the meeting, synthesize those topics into common thematic areas, and facilitate the

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<sup>415</sup> DBH correspondence with CCE Feb. 13, 2020, response 10a.

<sup>416</sup> DBH correspondence with CCE Feb. 13, 2020, response 10b.

<sup>417</sup> CCE SUD Provider Interviews.

<sup>418</sup> CCE SUD Provider Interview.

<sup>419</sup> CCE SUD Provider Interview.

<sup>420</sup> CCE SUD Provider Interview; CCE Survey Responses.

<sup>421</sup> CCE DBH Administrator Interviews.

<sup>422</sup> CCE SUD Provider Interview.

<sup>423</sup> CCE Stakeholder Interviews.

discussion of those topics during the meeting. Empowering SUD providers to take a collaborative role in leading discussions with DBH support may reduce SUD providers' feelings of isolation or disengagement.

Additionally, to facilitate better communication with stakeholders that are not DBH certified or contracted SUD providers, including community based organizations, justice system actors, and SUD clients and their loved ones, DBH should also host regular listening and informational sessions specially designed for these additional, but important stakeholders. These should be modeled after DBH's successful RBA community engagement sessions, covered in Section 4, below.

### Improved Procedures for Provider Grievance Reporting

While Provider Meetings discouraged SUD providers from effectively communicating their questions and concerns to DBH, breeding distrust, the SUD grievance reporting policies and practices inhibited client and provider reporting of SUD provider misconduct. This stood in contrast to the grievance reporting policies and practices in place to report provider misconduct and wrongdoing among MHRS providers in several ways.

First, the culture of mistrust between SUD providers and DBH discouraged the *ad hoc* reporting of grievances. Multiple small SUD providers expressed the suspicion that the ARC might not send clients their way if they upset DBH by bringing attention to an issue that would result in additional scrutiny being applied to DBH's practices.<sup>424</sup> Although CCE found no evidence that any client referrals were made on the basis of anything other than client need and preferences, the perception of preferential treatment influenced SUD provider behavior. One SUD provider described the consequences of this mistrust through an anecdote about their willingness to turn to DBH with reports of wrongdoing:

"If [a client] lodge[s] an official complaint [they] could be retaliated against, you don't want [providers] to come back and attack their clients... I can think of lots of times contractors misbehaved or took actions that seemed wrong and I felt that I couldn't reach out to DBH or lodge a complaint... There's a sense that you don't want to rock the boat or make a fuss.

We had a couple of clients who came to us saying that their Suboxone was stolen or taken from them by staff at a DBH funded program, the program wouldn't answer their calls and eventually we went there in person. We sent a physician to the provider who said, "I prescribed this, they should have this medication," and the boss there said, "Well I'm in charge here, so what I say goes," and we felt that we couldn't tell DBH that, we didn't feel we had recourse to do anything about it, and were worried about whether there would be consequences for causing trouble."<sup>425</sup>

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424 CCE SUD Provider Interviews.

425 CCE SUD Provider Interview.

There is no formal system for people who are not themselves SUD clients to file a grievance against a SUD provider with DBH. Outside of the mandatory reporting of abuse or neglect of children, elders, and vulnerable adults,<sup>426</sup> SUD providers are not required to report violations of client rights by the hands of organizations other than their own. Some stakeholders explained to CCE that, instead, they would informally report *ad hoc* issues observed among SUD providers to DBH senior leadership.<sup>427</sup> Others indicated that they were unwilling to report issues informally because of a culture of suspicion surrounding DBH.<sup>428</sup> DBH should establish formal procedures for SUD providers, other community-based organizations, as well as for friends and family of SUD clients to report violations of client rights witnessed at DBH-certified SUD providers.

Second, the absence of formal grievance policies for SUD clients during part of the Audit Period prevented people from navigating the grievance reporting process directly. While DBH had a formal agency process for mental health clients to file grievances with DBH against MHRS providers, and be protected from retaliation,<sup>429</sup> similar regulations do not exist for SUD clients. Instead, the regulations governing SUD providers only require them to establish an internal grievance process, report the allegation of an incident and the outcome of any investigation to DBH, and cooperate with any “inquiries related to client rights” instigated by DBH staff.<sup>430</sup> These regulations also prohibit retaliation.

In August 2017, DBH issued a new policy on consumer rights, applicable to all DBH licensed, certified, and/or contracted SUD and mental health community-based providers.<sup>431</sup> This new policy brings SUD client grievance procedures in line with those for MHRS consumers by requiring all providers to broadly distribute information on clients rights, requiring all providers to establish formal and informal internal grievance processes, and allowing all consumers, including SUD clients, to file their grievance directly with DBH. DBH should modify its regulations to align with this new policy, merging the old DMH and APRA grievance regulations into a single, equitable system.

## Communications About Agency Policy and Operational Changes

When asked, “What are the specific changes that you would like to see regarding DBH’s communication with the provider network?” SUD providers most frequently responded that they wanted

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426 D.C. Department of Behavioral Health, *Transmittal Letter re: DMH Policy 630.3* (June 24, 2014), <https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/630.3%20TL-256.PDF>; D.C. Department of Behavioral Health, *Transmittal Letter re: DMH Policy 630.2* (Mar. 28, 2014), <https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/630.2%20TL-245.PDF>.

427 CCE Stakeholder Interview.

428 CCE Stakeholder Interview.

429 D.C. Department of Behavioral Health, *Notice of Final Rulemaking*, 50 D.C. Reg. 8480 (Oct. 10, 2003); D.C. Mun. Regs. 22A § 305. <https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/DCR8480.pdf>.

430 D.C. Mun. Regs. 22A § 6319.

431 D.C. Department of Behavioral Health, *Transmittal Letter re: Policy 515.3* (Aug. 15, 2017), [https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/515.3%20%20TL-310\\_0.PDF](https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/515.3%20%20TL-310_0.PDF).

DBH to make clear communications “well in advance of any policy or operational changes.”<sup>432</sup> This was a top concern during the search for a new DBH Director in 2018. The D.C. Behavioral Health Association, a membership association representing many of the District’s SUD providers, wrote a letter to Mayor Bowser recommending that the new Director should focus on “collaborative, iterative, and transparent decision-making.”<sup>433</sup> SUD providers sought quicker and clearer communications about major issues that DBH identified or changes DBH intended to implement that would affect their functioning or their clients’ health outcomes.

For instance, one SUD provider explained that in 2016, DBH “notified providers that there were problems with local dollars due to billing issues and that there would be no incremental extensions as local funds ran out.” This information was conveyed after many SUD providers had already performed services that should have been reimbursable, so some had to cover the costs from their own operating budgets. Several SUD providers reported the belief that this fiscal strain led to some SUD providers being “forced to close their doors.”<sup>434</sup> While DBH has not fully investigated the potential causal link between the local dollar issues and SUD provider closures (nor has there been an independent financial audit), a handful of SUD providers that closed in 2016 and 2017 testified before the D.C. Council that payment issues caused them to discontinue services or even to go out of business.<sup>435</sup>

In another example, DBH’s failure to adequately respond to SUD provider questions regarding policy clarification had near-lethal consequences:

“The Narcan thing is another place where DBH is just being fuzzy...there are some caveats about the use of Narcan. A citizen is protected by the Good Samaritan laws in the District, but a professional is not. That raises a question for us as a provider about whether we should use Narcan in some contexts. For us to administer Narcan, DBH needs to tell us explicitly, ‘we’ve got your back.’ ...I had written [a DBH contact] and said ‘DHS is telling us to do this, where are you guys at with this?’, but they won’t write us back...Recently, we had a guy who overdosed in the office. Fortunately, the EMT came and gave him three doses of Narcan and he revived. That was a close call. We did not deliver Narcan earlier because we are hesitant to have Narcan around when there are questions that we have asked DBH about the specific support of the use of Narcan in a population that has traumatic brain injuries or an undiagnosed seizure disorder and who may be receiving medical medications that are contraindicated with Narcan. Because we haven’t resolved that risk, we are hesitant to move forward until DBH helps us resolve this risk analysis.”<sup>436</sup>

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432 CCE Survey Responses.

433 DC Behavioral Health Association, *Department of Behavioral Health Director Search* (2018), <https://www.dcbehavioralhealth.org/public-policy>.

434 CCE Survey Responses.

435 Office of the District of Columbia Auditor, *Improving Mental Health Services and Outcomes for All: The D.C. Department of Behavioral Health and the Justice System* (Feb. 26, 2018), [http://www.courtexcellence.org/uploads/publications/ODCA\\_Report\\_Audit\\_of\\_DBH\\_2.pdf](http://www.courtexcellence.org/uploads/publications/ODCA_Report_Audit_of_DBH_2.pdf).

436 CCE SUD Provider Interview.



The quoted SUD provider indicated that it had still not received a communication indicating an official agency position on this issue more than five months after making the request. Some SUD providers suspected there was disagreement between DBH's programmatic administrators, who supported the practice of delivering Narcan, and DBH's accountability administrators, who are responsible for regulating the SUD provider's delivery of health care services as a DBH certified entity. But, without clarifying communication from DBH or a discussion at Provider Meetings, there was no way to obtain needed guidance on this important and nuanced SUD service issue.

Similarly, from 2016 to 2017, SUD providers described receiving unclear information about how and when they could seek certification for different types of SUD services. In some cases, this delayed SUD providers from receiving certifications for over a year, ultimately constraining the availability of SUD services in the District.<sup>437</sup> In 2016, DBH issued a request for proposals (RFP) for SUD providers to prescribe methadone. Some SUD providers described not knowing how or whether to apply for this RFP because, as they explained, methadone is traditionally dispensed, not prescribed. DBH recalled the RFP, and then re-issued it several months later, correctly characterizing methadone as being dispensed and not prescribed.<sup>438</sup> This resulted in DBH-certified SUD providers being unable to expand their provision of methadone services to clients during the time that the RFP was recalled. The delay came at an inopportune time, as there were 233 deaths from opioid overdoses in D.C. in 2016, with another 281 following in 2017.<sup>439</sup>

Beyond improving communications about policy and practice decisions at DBH, SUD providers also want to be involved earlier in DBH's policy-making process, rather than being informed of changes after they had already been decided. Even when SUD providers were invited to provide feedback on proposed changes, they did not always receive indications from DBH that their feedback was seriously considered.<sup>440</sup> "DBH has offered more opportunities for feedback, but the providers do not know how their feedback is being interpreted and who is involved in reviewing it, are their [sic] any misconceptions or follow-up information needed concerning the feedback, is it going somewhere or not."<sup>441</sup> At least one SUD provider cited examples of offering feedback on proposed changes to D.C.'s Medicaid State Plan Amendment and never receiving an indication from DBH about whether and how the feedback was used.

During the Audit Period, DBH had two Interim Directors and three Directors.<sup>442</sup> A common complaint among SUD providers was that staff turnover exacerbated DBH's difficulties communicating with the provider network. They explained that "it leaves us with [DBH staff contacts] who do not understand previous commitments and challenges....We are left with unresolved issues when we

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<sup>437</sup> CCE SUD Provider Interview.

<sup>438</sup> CCE SUD Provider Interview.

<sup>439</sup> Leak, Chirkarlo, "Opioid-Related Fatal Overdoses: January 1, 2014 to October 28, 2019." D.C. Office of the Chief Medical Examiner, Jan. 22, 2018.

<sup>440</sup> *Id.*

<sup>441</sup> CCE Survey Responses.

<sup>442</sup> DBH Correspondence with CCE Feb. 13, 2020, request 10e.

had almost reached a conclusion.”<sup>443</sup> Frequent staff turnover disrupted the flow of communication between agency personnel and community members. It is hard to gauge the exact consequence of this disruption; however, many SUD providers expressed frustration and disillusionment with DBH as a change-maker, and partially attributed those feelings to their inability to bring complaints, questions, and concerns to DBH representatives who were appropriately knowledgeable to address their issues.<sup>444</sup>

## Positive Communication Approaches as Models for Future Engagement

In CCE’s Provider Survey, several indicated that DBH’s communications did change for the better over the course of the Audit Period. SUD providers reported positive participation in a variety of fora with DBH in 2017, including RBA sessions and meetings, as part of a strategic planning process that is covered more in depth in Finding 6.<sup>445</sup> In describing how external entities were involved in the RBA, DBH explained that it had:

“[L]ed an 18-month comprehensive, collaborative community engagement and planning process to develop a three-year strategic plan. DBH brought together consumers, clients and their families, advocates, behavioral health practitioners, community-based service providers, government leaders, and other community members. Throughout the process, hundreds of stakeholders and partners were invited to participate in 15 community engagement sessions and several online follow-up surveys.”<sup>446</sup>

Multiple SUD providers described this RBA process as an example of productive communication from DBH.<sup>447</sup> They felt that it was structured in a way that enabled DBH to listen to SUD provider complaints and concerns.<sup>448</sup> Most SUD providers said that they noticed an improvement in their relationships with DBH during the RBA process, but indicated the day-to-day relationships between the providers and DBH are still developing.<sup>449</sup> Because of the success of this approach, CCE recommends that DBH use the RBA process as a model for continued engagement with SUD stakeholders.

DBH also received praise for the transparency and clarity with which it designed and initially approached its process for revising the agency’s Chapter 63 regulations, “Certification Standards for Substance Use Disorder Treatment and Recovery Providers.”<sup>450</sup> In 2018, DBH put out a request for SUD providers to comment on and propose revisions to the existing regulations. DBH then

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<sup>443</sup> CCE Survey Responses.

<sup>444</sup> CCE SUD Provider Interviews; CCE Survey Responses.

<sup>445</sup> CCE Provider Survey.

<sup>446</sup> DBH Correspondence with CCE Aug. 23, 2019, response 11.

<sup>447</sup> CCE Survey Responses.

<sup>448</sup> CCE SUD Provider Interviews; CCE Survey Responses.

<sup>449</sup> CCE SUD Provider Interview.

<sup>450</sup> D.C. Mun. Regs. 22-A § 63.

published a table that listed each suggestion it had received, stated whether DBH accepted the SUD provider proposed change, described whether that change would be enacted through regulation, policy, or process, and, explained the agency's reasoning for its decision.<sup>451</sup>

DBH also proposed some of its own regulatory changes on which it solicited feedback from SUD providers. In September 2018, DBH held a "Stakeholder Question and Answer Session" to update SUD providers on the process and explained that the proposed revisions would be run through DBH's Office of General Counsel, the Mayor's Office of Policy and Legislative Affairs, the Office of the Deputy Mayor for Health and Human Services, and the Office of the Attorney General. Then, the proposed regulations would be published in the D.C. Register, and a formal 30-day public comment period would commence.<sup>452</sup> Through these efforts, DBH provided a straightforward and transparent process for SUD providers to be heard and their view considered.

However, this process was pushed off-track when compliance with a Section 1115 Behavioral Health Transformation Demonstration Program through the federal Centers for Medicare and Medicaid Services, designed largely "as a response to the crisis unfolding in the District relating to opioid use and abuse," required DBH to update its regulations immediately. Between April 2019 and February 2020, DBH issued a series of four emergency rulemakings.<sup>453</sup> SUD providers told CCE they did not feel that DBH clearly informed them of this change in plans, and expressed confusion about why they never received formal notice of the proposed rulemaking.<sup>454</sup> After a period of very clear communication, some SUD providers felt the agency was returning to a pattern of routinely excluding them from the process of formulating rules and policies.

The evidence collected during this audit suggests that DBH generally made significant progress in improving its communication with SUD providers, and it now has high-quality models on which to base future efforts. DBH should continue what has proven effective: RBA-style engagement sessions, clear, transparent processes for providing early feedback on proposed regulatory changes, and, a formal notice and comment period prior to regulation changes as required by the Administrative Procedure Act. This protocol should also be extended to changes in policy and practice that will have a significant impact on SUD providers and their clients. This protocol is particularly important for clarifying decisions where interpretations have varied between DBH's own administrative units. For SUD provider informational requests that are urgent—either because of significant cost or risk of harm to patients or because of a potential emerging public health crisis—DBH should establish a protocol to provide rapid responses regarding such policies to SUD providers.

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451 DBH, *Chapter 63 Proposals from Providers and DBH Responses*.

452 DBH, *Update on Revisions to Chapter 63: Stakeholder Question and Answer Session* (Sept. 18, 2018).

453 Notice of Fourth Emergency and Proposed Rulemaking, *Certification Standards for Substance Use Disorder Treatment and Recovery Providers*, 67 D.C. Reg. 2252 (Feb. 28, 2020), <https://www.dcregs.dc.gov/Common/DCMR/SectionList.aspx?SectionNumber=22-A6328>.

454 CCE SUD Provider Interview; CCE Survey Responses.

## Agency Communications With and Information For the Public

DBH's provision of information for the general public, including people who may have been seeking SUD services, was also inadequate during the Audit Period. According to many clients, when they decided to seek care it was difficult for them to learn about available SUD services in the District. A common frustration articulated by clients, SUD providers, and administrators at other D.C. and federal agencies who interact with individuals with SUDs, was the absence of a public, accurate, and complete list of SUD providers in the District. In fact, a complete list of DBH-certified or contracted SUD providers was never available to the public during the Audit Period. The only SUD providers that DBH listed online were those who also provided mental health services, and they were listed only in that capacity, as a CSA.

To confirm there was no comprehensive online list of SUD providers, CCE analyzed web captures on WayBack Machine, a public archive of historical and inactive webpages. In the months leading up to and immediately after the APRA/DMH merger in October 2013, both agencies' public listings of providers were available.<sup>455</sup> A list of SUD providers was maintained on the APRA website and a list of mental health providers was listed on the DMH website. As of September 5, 2015, the first "capture" on WayBack during the Audit Period showed that both lists were still online.<sup>456</sup> By that point, however, DMH's list of MHRS providers had become the list of providers posted by DBH on its new website. While some of the mental health providers, often known as CSAs, also provide SUD services, this was not indicated anywhere on the page, and SUD providers were not specifically identified anywhere on DBH's site.<sup>457</sup> Unfortunately, the APRA list of SUD providers was still technically a live page, but it was only accessible by directly typing in the exact URL to the old APRA webpage or, theoretically, if someone happened to know to go to the former agency's website. There was no way to navigate to the list of SUD providers from the DBH website.

The absence of an accurate list of SUD providers created two problems during the Audit Period. First, some clients and providers attempted to access a complete list of SUD providers but were unable to do so. Second, other clients and providers looked at the DBH website and interpreted the list of providers available there, labeled "Community Service Providers," as a list of all providers of behavioral health services in the community, thus creating confusion for those clients and providers about whether additional SUD providers existed in the District.

To confirm the challenges that providers and clients faced when attempting to access a list of SUD services, CCE called and emailed DBH using publicly-available contact information between February and May of 2019, in a series of attempts to access a complete list of DBH-certified or contracted SUD providers like any member of the public might. Audit team members called the ARC,

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455 For the SUD Provider List, see <https://web.archive.org/web/20140823072546/http://dbh.dc.gov/node/236132>. For the Mental Health provider list, see <https://web.archive.org/web/20140822182607/http://dbh.dc.gov/page/list-community-based-service-providers>.

456 *List of Community-Based Service Providers*, accessed Mar. 11, 2020, <https://dbh.dc.gov/page/list-community-based-service-providers>; *List of Adult Substance Abuse Treatment Services* (Sept. 5, 2015), <https://web.archive.org/web/20150905201848/http://dbh.dc.gov/node/197082>.

457 This was the case for the list during the instances of time it was visible on WayBack Machine.

using the phone number provided on DBH's website, requesting a comprehensive list of services and identifying themselves as D.C. residents who wanted to learn more about the SUD services that were available in the District.<sup>458</sup> While several ARC staff members tried to be responsive, a full list was never provided. In some communications, a DBH staff member provided the names of a few SUD providers but never a complete list. After follow-up requests, DBH staff eventually either stopped responding to communications or explained that they had already provided all of the SUD provider information that they had.<sup>459</sup>

Multiple SUD providers and other D.C. agencies described the absence of a comprehensive list of SUD providers as a barrier to care for their clients. One MAT provider noted that even though it was DBH-certified, it was not listed anywhere online as a SUD provider. Another observed that during the Audit Period, the Psychiatric Institute of Washington, the only free-standing psychiatric care facility in D.C. open throughout the duration of the Audit Period, was not listed on DBH's list of community-based providers.<sup>460</sup> Others noted that the absence of an accurate and complete list meant that they did not know all of the providers in the community, thus making it difficult to refer clients to additional resources.<sup>461</sup>

Several clients whom CCE interviewed reported relying on word-of-mouth referrals from other clients for information on how to get SUD care.<sup>462</sup> In many cases, such referrals were sufficient to get clients connected to treatment, but in others it was not.<sup>463</sup> One privately insured SUD client described going to the ARC to get help after receiving an order from PSA to get treatment, but was turned away because they had private health insurance. DBH staff did not offer any other resources to them. Not sure what to do, this client tried to research programs online, but was unsuccessful. It took several weeks for them to finally enroll in a service.<sup>464</sup>

Many clients described struggling with substance use for years without learning about or being connected to SUD services. The first time they made such a connection occurred when they came into contact with the justice system. Many of the individuals interviewed by CCE had no awareness of the services available in the community until a court mandated their participation in a program.<sup>465</sup>

SUD providers explained that the periods of time in which clients are interested in receiving services

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<sup>458</sup> *Memoranda of SUD Provider Request.*

<sup>459</sup> *Id.*

<sup>460</sup> *About The Psychiatric Institute of Washington*, accessed Mar. 10, 2020, <https://psychinstitute.com/about-us/>.

<sup>461</sup> CCE SUD Provider Interviews; CCE Administrator Interviews.

<sup>462</sup> CCE Client Interviews.

<sup>463</sup> CCE interviewed clients who were currently receiving SUD services and who had some justice involvement. This inclusion criterion necessarily excludes individuals who are not receiving SUD services. Those individuals may have been more likely to not know about available services than individuals who had been successfully connected to care.

<sup>464</sup> CCE Client Interviews.

<sup>465</sup> CCE Client Interviews.

can be fleeting.<sup>466</sup> Because clients may be disposed to enter treatment for only a very small window of time, it is crucial that they have the information they need to access services in that moment. SUD clients corroborated this view and described the difficulties they had engaging services. Many described not feeling ready to receive treatment for many years or having only occasional desires to enter treatment during long periods of sustained substance use.<sup>467</sup>

In August 2019, after the conclusion of the Audit Period, DBH posted a list of SUD providers on its website, including a description of the services provided and contact information.<sup>468</sup> While this reflects progress, the list of SUD providers remains a difficult page to find on DBH's website and is not given co-equal visibility with the list of mental health service providers. Currently, mental health providers are easily found from DBH's homepage under the "Services" or "Adults" menus as "Community Based Service Providers." Furthermore, the "Community Based Service Providers" designation may foster confusion because it does not immediately suggest that it excludes SUD-only providers. A list of SUD providers cannot be accessed from any part of the site's main navigation. Instead, one must navigate from the "services" drop-down menus to "Substance Use Disorder Services," and then to a text-based link called "Substance Use Disorder Provider Listings."

To address these issues, DBH should ensure that its comprehensive lists of mental health and SUD providers are available in one easily accessible place and that they clearly describe the services offered at each SUD provider. DBH should also update these lists regularly to ensure accuracy. More generally, DBH should improve its website to be more consumer-focused and user-friendly, helping to guide a person with a SUD, and/or their loved ones, through the steps required to connect to care, determine their eligibility for DBH services, and find SUD providers available in the District. Additionally, DBH should create specific content on its site dedicated to providing information for individuals involved in the justice system, explaining in particular how that justice involvement might uniquely affect their connection to behavioral health services. Overall, improvements in the clarity, simplicity, and organization of information about SUDs and SUD services on DBH's website could help support and supplement the educational goals and strategies described in the Opioid Strategic Plan to "[i]ncrease the targeted advertisement of treatment and recovery programs throughout Washington, DC."<sup>469</sup>

Finally, DBH should provide regular training for all of its staff members who are public facing to ensure that they can identify all important DBH materials and information and are well-equipped to point people to relevant resources.

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466 CCE SUD Provider Interview.

467 CCE SUD Provider Interview.

468 D.C. Department of Behavioral Health, *List of Substance Use Disorder Providers* (Aug. 1, 2019), <https://dbh.dc.gov/node/1417206>.

469 *Supra*, n. 8 (Washington, DC's Strategic Plan to Reduce Opioid Use, Misuse, and Related Deaths).

# Conclusion

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The findings and recommendations in this report offer a path forward to further improve the delivery of SUD services to justice-involved residents of the District of Columbia. However, they should not be viewed as completing the needed analysis, but rather as part of an ongoing effort to improve the services that many in this underserved community desperately need to move beyond the cycle of drug use and incarceration that is so damaging to them and our community.

In particular, as noted in the report, the data analysis conducted is a starting point that, if developed further, could offer valuable insights into further improvements in the District's delivery of services. The District should preserve and expand this dataset to conduct further analysis, and ideally construct a system that could be updated in real time. The potential benefits of data sharing across the various government agencies are real and significant. While data sharing presents some unique challenges, data-sharing and analysis can be accomplished without running afoul of HIPPA or 42 CFR Part 2. We are making our data-sharing agreement public to offer a template for such further efforts.

Two data analysis projects recommend themselves as offering particularly valuable information. First, with further data analysis and case studies of the identified individuals, DBH and DOC could potentially offer better targeted overdose prevention strategies to individuals who are at risk and who are already in the populations they serve. Second, the ninety-seven individuals who were incarcerated, received no care, and died, is a group worth significant examination and case study by the District, as they may represent the most urgent opportunity for targeted outreach and additional supports to improve care connectivity to its known, justice-involved residents with SUDs who may be at risk for overdose.

Our audit was necessarily limited in certain ways that, if further examined, offer additional opportunities for improvement. We were unable to evaluate the quality of care due to data and other constraints. Quality of care is a very important topic that needs to be evaluated in future studies. Further, this audit examined only those aspects of the criminal justice system that are under local control. However, D.C.'s criminal legal system also includes federal agencies, including PSA, the USAO-DC, local and federal trial courts, BOP, and CSOSA. These entities also have an important role to play in improving the delivery of SUD treatment to justice-involved residents. The current data collected and reports prepared are insufficient. There needs to be serious work with these entities to share data, measure and track outcomes, and provide policies that improve accountability and transparency.

While the above future steps are important, this report also offered some concrete and immediate operational changes that can readily be accomplished and that offer a road to further improvements in the delivery of services. The D.C. Government should pursue more opportunities for diversion from the justice system, provide better diagnosis and treatment for those with SUDs, and

provide continuity of treatment across justice intercepts. To accomplish these goals, there must be a close partnership between the D.C. government and its federal partner agencies.

Finally, our review of those jurisdictions where improvements in SUD treatment have been particularly noteworthy indicates that meaningful progress requires a focus on developing comprehensive, integrated systems, not just individual programs. Achieving this goal requires not only a shared vision within the community, but also an entity or agency responsible and accountable for coordination and collaboration among, and joint planning by, the relevant behavioral health and criminal justice agencies and service providers.



# Appendix A

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# Appendix B

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## DATA SHARING AGREEMENT

## **DATA USE AGREEMENT**

**AMONG THE OFFICE OF THE DEPUTY MAYOR FOR HEALTH AND HUMAN SERVICES, DEPARTMENT OF BEHAVIORAL HEALTH, THE DEPARTMENT OF CORRECTIONS, DEPARTMENT OF HEALTH CARE FINANCE, THE METROPOLITAN POLICE DEPARTMENT, THE OFFICE OF THE CHIEF MEDICAL EXAMINER, OFFICE OF THE CHIEF TECHNOLOGY OFFICER, AND THE OFFICE OF THE DISTRICT OF COLUMBIA AUDITOR AND THE COUNCIL FOR COURT EXCELLENCE**

This DATA USE AGREEMENT ("Agreement") is entered into between the following agencies in the District of Columbia ("District"): the Office of the Deputy Mayor for Health and Human Services ("DMHHS"), Department of Behavioral Health ("DBH"), the Department of Corrections ("DOC"), the Department of Health Care Finance ("DHCF"), the Metropolitan Police Department ("MPD"), the Office of the Chief Medical Examiner ("OCME"), and the Office of the Chief Technology Officer ("OCTO") (collectively referred to as "the Agencies"), the Office of the District of Columbia Auditor ("ODCA"), and the Council for Court Excellence ("CCE"). Each of DMHHS, DBH, DHCF, DOC, MPD, OCME, OCTO, ODCA, and CCE are referred to herein together as the "Parties" and individually as a "Party." This Agreement will be effective upon execution by the date of the last signatory ("Effective Date").

### **I. THE PARTIES**

- A. DMHHS supports the District Mayor in coordinating a comprehensive system of benefits, goods and services across multiple agencies to ensure that children, youth and adults, with and without disabilities, can lead healthy, meaningful and productive lives.
- B. DBH provides prevention, intervention, and treatments services and supports for children, youth, and adults with mental and/or substance use disorders including emergency psychiatric care and community-based outpatient and residential services. DBH serves eligible adults, children, youth, and their families through a network of community-based providers and unique government delivered services and operates Saint Elizabeth's Hospital, the District's public inpatient psychiatric facility.
- C. DOC's mission is to ensure public safety for citizens of the District by providing an orderly, safe, secure and humane environment for the confinement of pretrial detainees and sentenced inmates, while providing meaningful opportunities for community reintegration.
- D. The DHCF, formerly the Medical Assistance Administration under the Department of Health, is the District of Columbia's state Medicaid agency. DHCF works to improve health outcomes by providing access to comprehensive, cost-effective and quality healthcare services for residents of the District of Columbia.
- E. MPD is the primary law enforcement agency for the District. Founded in 1861, the MPD of today is on the forefront of technological crime fighting advances, from highly

developed advances in evidence analysis to state-of-the-art-information technology. These modern techniques are combined with a contemporary community policing philosophy, referred to as Customized Community Policing. Community policing bonds the police and residents in a working partnership designed to organize and mobilize residents, merchants and professionals to improve the quality of life for all who live, work, and visit the nation's capital.

- F. OCME investigates all deaths in the District that occur as the result of violence or injury, as well as those that occur unexpectedly, without medical attention, in custody or pose a threat to public health. OCME provides forensic services to government agencies, health-care providers and citizens in the District to ensure that justice is served and to improve the health and safety of the public.
- G. OCTO is the District's central technology organization. It develops, implements, and maintains the District's technology infrastructure, including but not limited to developing and implementing major enterprise applications, establishing and overseeing technology policies and standards, providing technology services and support to District agencies, and developing technology solutions for improving services to businesses, residents, and visitors to the District. OCTO provides the information technology (IT) infrastructure support to agencies throughout District government.
- H. ODCA's mission is to support the Council of the District by making sound recommendations that improve the effectiveness, efficiency, and accountability of the District government. ODCA conducts performance audits, non-audit reviews, and revenue certifications.
- I. CCE is a not-for-profit, nonpartisan civic organization. Its mission is to enhance the justice system in the District of Columbia to serve the public equitably. CCE identifies and proposes solutions by collaborating with diverse stakeholders to conduct research, advance policy, educate the public, and increase civic engagement. CCE is a contractor engaged by ODCA in order to assist it in meeting the purposes set out in this Agreement.

## **II. PURPOSE OF THE AGREEMENT**

**WHEREAS**, ODCA is conducting a programmatic audit of the District's system of Substance Use Disorder ("SUD") services to Justice-Involved Individuals pursuant to D.C. Official Code § 1-204.55 and § 1-301.44 (c) ("SUD Audit"). The SUD Audit will be used to determine how justice-involved individuals access SUD services in District before, during, and after points of contact with the justice system; how providers of SUD services interact with District government agencies to coordinate the provision of care to justice-involved individuals with SUDs; what are the most salient barriers to access to SUD services among justice-involved individuals, and how can they be lowered; what are social,

economic, and health characteristics of District's justice-involved population with SUDs; and whether District has sufficient capacity to meet their health needs;

**WHEREAS**, ODCA has contracted with CCE as its third-party contractor to assist ODCA in collecting, reviewing and analyzing Data for purposes of the SUD Audit;

**WHEREAS**, ODCA has requested the assistance of the Agencies in producing datasets to allow for ODCA to perform the SUD Audit;

**WHEREAS**, the Agencies have agreed to assist ODCA as requested to fulfill the purposes of the SUD Audit. Only DBH, DHCF, and DOC have been formally engaged by ODCA for the SUD Audit;

**WHEREAS**, in order for ODCA to complete the SUD Audit, the Agencies agree to share Data with each other and with ODCA and CCE, pursuant to the terms and conditions of this Agreement;

**WHEREAS**, the purpose of this Agreement is to govern the sharing of Data between the Parties, protect the privacy and provide for the security of the Data disclosed to each Receiving Party, and to establish standards for its use in connection with the SUD Audit;

**NOW, THEREFORE**, in consideration of and reliance upon the covenants and agreements contained herein, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Parties agree as follows:

### **III. DEFINITIONS**

As used in this Agreement, the following terms have the following meanings:

- A. "Data" means all information that is collected and disclosed by a Party or its Representatives to another Party in connection with the SUD Audit, whether disclosed or accessed in written, electronic or other form or media, including without limitation the datasets described in Appendix A to this Agreement.
- B. "Data Custodian" means the individual responsible for compiling Data on behalf of a Disclosing Party as described in Section X.
- C. "Disclosing Party" means the Party disclosing Data hereunder to a Receiving Party.
- D. "De-Identify" or "De-Identified" means information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.
- E. "Final Data" means the De-Identified Data that Agencies disclose to ODCA and CCE for purposes of the SUD Audit.

- F. "Justice-Involved Individual" means individual(s) who are either currently or previously incarcerated, or who are arrested or held in connection to the alleged commission of a crime.
- G. "Personally Identifiable Information" or "PII" information that can be used to identify a specific individual (such as a name, address, social security number, driver's license number, taxpayer identification number, email address, telephone number, financial records, educational records, health records, criminal records, or biometric information and indirect identifiers, such as an individual's date of birth, place of birth, or mother's maiden name) or information for which there is a reasonable basis to believe that the information can be used to identify an individual in combination with other reasonably available information.
- H. "Protected Health Information" or "PHI" shall have the same meaning as defined in the Health Insurance Portability and Accountability Act of 1996, approved August 21, 1996 (Pub. L. No. 104-191; 42 U.S.C. §§ 1320d, *et seq.*), and its corresponding regulations located at 45 C.F.R. 160, 162, and 164 (collectively referred to as "HIPAA").
- I. "Representatives" means any Data Custodian, employee, officer, director, manager (including any consultants, accountants, and counsel) or any third-party provider of a Disclosing Party or Receiving Party.

#### **IV. ELECTRONIC DATA TO BE SHARED**

- A. In order for ODCA to perform the SUD Audit, it is necessary for the Agencies to disclose to ODCA and CCE the Final Data. The Final Data shall be prepared as set forth in this Section IV.
- B. Within one month, or otherwise agreed upon by the Agencies and CCE, after the Effective Date of this Agreement, the District Parties will concurrently compile Data containing the information identified in Appendix A and provide that Final Data electronically to CCE.
- C. Final Data will be compiled by each District Party, specifically MPD, DBH, DOC, DHCF, and OCME, utilizing the services of employees from OCTO to De-Identify each Disclosing Party's Data. OCTO will use a unique identifier where PII is contained in the Data received from the Disclosing Parties so as to De-Identify the Data compiled from District Parties in a manner where a unique identifier may be matched across Final Data sets from each District Party to represent the same individual's name. De-Identification will remove PII and/or any Data or combination of Data listed in Appendix A for which there is a reasonable basis to believe that the information could be used to identify an individual (such variables may include an individual's name, date of birth, court case title, social security number, and police department identification number).

- D. An employee from OCTO will provide CCE with an explanation of the methodology of its De-Identification process and an explanation of any potential rate of error or information relevant to matching across unique identifiers.
- E. ODCA and CCE are not responsible for De-Identifying the Data. In the event ODCA or CCE becomes aware that the Final Data is not De-Identified, ODCA and CCE shall promptly notify DMHHS.
- F. The Original Data, and all Data to be shared under this Section IV, shall be compiled in .xlsx, .csv, or .dat, or similar format as agreed by the Parties. Further, the Disclosing Parties shall ensure that the transfer of Data as described in this Section IV is in accordance with the security requirements set forth in Appendix B.

## **V. REPRESENTATIONS**

- A. Each Disclosing Party represents and warrants that it has all the authorizations, rights, and permissions necessary to provide Data to the Receiving Parties, and to use and permit the Receiving Parties to use the Data for the purposes contemplated herein.
- B. Each Disclosing Party further represents and warrants that any Data it discloses in accordance with Section IV above and for purposes of the SUD Audit are complete and accurate to the best of its knowledge.
- C. ODCA and CCE represent and warrant that the requested Data is the minimum necessary to achieve the purposes of the SUD Audit.

## **VI. AUTHORIZED USES OF DATA**

- A. During the Term, the Disclosing Party hereby grants to the Receiving Party a right to use the Data solely in connection with the SUD Audit and as set forth herein. All Data of the Disclosing Party is and shall remain the property of the Disclosing Party.
- B. Any portion of the Data or its content merged into or used in conjunction with other material will continue to be the property of the Disclosing Party and subject to the terms and conditions of this Agreement.
- C. Each Receiving Party shall use the Data or Final Data, as the case may be, solely for the purposes permitted by Agreement or required by applicable law.
- D. Each Receiving Party shall not copy or alter, or modify Data received from a Disclosing Party, and shall not remove, overprint, deface, or change any notice of confidentiality, legends or other notices of ownership from any originals or copies of Data it receives from a Disclosing Party.
- E. ODCA and CCE will not identify, attempt to re-identify Final Data. ODCA and CCE will not aid any other Party in re-identification efforts. Likewise, ODCA and CCE will not alter or modify Final Data so it can access PII.



## **VII. PROTECTION OF DATA**

- A. The Receiving Party shall take all reasonable measures to protect the Data from any accidental, unauthorized, or unlawful destruction, loss, alteration, or disclosure of, or access to Data ("Security Incident") or the possession of persons other than those authorized hereunder to have any such Data, which measures shall include (i) employing industry-standard security and encryption protocols to securely transfer and store the Data, as described in Appendix B and (ii) taking the same degree of care that Receiving Party utilizes to protect its own information of a similar nature, but in no event less than a commercially reasonable degree of care.
- B. In the event a Party becomes aware of a Security Incident, the discovering Party shall notify the other Parties in writing within two (2) business days. The discovering Party agrees to cooperate fully in the investigation of each Security Incident. Such notification shall include the following information (to the extent known):
  - 1. The nature of the unauthorized use, access, or disclosure;
  - 2. The Data used, accessed, or disclosed; and
  - 3. The actions taken by the discovering Party to mitigate any impact of the Security Incident.
- C. To the extent that a Security Incident is determined to be the result of a Party's breach of this Agreement, the breaching Party agrees to cooperate fully in the investigation of each Security Incident, is responsible for making reasonable efforts to eliminate or mitigate the impact of any Security Incident, and taking corrective action to prevent future similar Security Incidents from occurring. The owner of the Data that is the subject of the Security Breach shall be responsible for any notifications to affected individuals or other persons or authorities as required under applicable law.

## **VIII. AUTHORIZED DISCLOSURES OF DATA**

- A. The Data of each Disclosing Party is confidential and sensitive in nature and shall be used by Receiving Party solely in connection with the Agreement. The Receiving Party shall hold Disclosing Party's Data in confidence at all times, and, except as set forth in this Agreement, shall not use or disclose Disclosing Party's Data without the prior written consent of Disclosing Party, which consent may be withheld in Disclosing Party's sole and absolute discretion.
- B. The Parties shall disclose or provide Data or Final Data, as the case may be, only to Authorized Users as described below and as is necessary for the Authorized Users to carry out his or her work in the purposes of this Agreement.
- C. Authorized Users of the Agencies include their Representatives and the Representatives of the District whose services the Agencies determine are necessary to fulfill the purposes of this Agreement.

- D. Authorized Users of ODCA include its Representatives whose services ODCA determines are necessary to fulfill the purposes of this Agreement and CCE. If ODCA or CCE determine that any additional subcontractors, agents, or other partners are necessary to fulfill the purposes of this Agreement, ODCA shall itself or shall authorize CCE to provide notice to the Agencies within two (2) business days of that determination. The Agencies must consent to the disclosure of Data to an additional subcontractor, agent or other party before ODCA or CCE may disclose any Data such third party.
- E. The Parties agree that within the Party's organization, access to Data covered by the Agreement shall be limited to the minimum amount of Data and minimum number of Authorized Users necessary to achieve the purpose. Any Authorized User of a Receiving Party given access to any Data of a Disclosing Party must have a legitimate "need to know" basis for access.
- F. Before a Party's Authorized User may receive or be provided access to Data, the Authorized User must execute and provide to the Data Custodian of the relevant Party a Data Confidentiality Agreement (in the form provided in Appendix C).
- G. Nothing in this Agreement shall prohibit the Parties from disclosing any Data if the Parties are legally required to do so by law or by a judicial or governmental order or in a judicial or governmental proceeding. In the event of such disclosure, the Disclosing Party shall, where permissible:
  - 1. Notify the other Parties of the requirement to make the disclosure within two (2) business days after it becomes aware of such requirement; and
  - 2. Cooperate with the other Party or Parties if that Party elects or Parties elect to contest the requirement to make the disclosure or to seek a protective order, or any other course designated by the Party or Parties.

## **IX. PUBLICATION OF RESULTS OF DATA ANALYSIS**

- A. Notwithstanding Section VIII of this Agreement, ODCA or CCE on behalf of ODCA may publish and present the results and conclusions of its analyses based on the Final Data ("Final Report") under this Agreement to individuals and entities outside of ODCA provided however, that the publication or presentation of the Final Report shall not include:
  - 1. PII or information that would lead to the identification of a Justice-Involved Individual; or
  - 2. Data a Disclosing Party has determined is protected from disclosure by law, including state and federal Freedom of Information Act ("FOIA"), regulation, or contract and that is either highly sensitive or is restricted by law, by regulation, or by contract from disclosure to other public bodies.

- B. ODCA or CCE on behalf of ODCA shall provide a draft of the Final Report to the Agencies for the Agencies to review at least ten (10) business days before publishing the results or conclusions of ODCA's analyses that include Final Data under this Agreement. The purpose of the Agencies review pursuant to this Section is only to ensure conformity with paragraph A of this Section.
- C. ODCA, or CCE on behalf of ODCA shall provide a draft of the Final Report to the Agencies for review of its content. ODCA will provide the Agencies at least thirty (30) days to meet and confer about the content of draft Final Report and respond, in writing, no fewer than ten (10) days after any such meeting. ODCA or CCE shall have the right to publish or present the Final Report if the Agencies do not respond within forty (40) days of providing the Agencies the draft Final Report.

#### **X. DATA CUSTODIANS**

- A. The Data Custodians are responsible for compiling the Data identified in Appendix A and working with OCTO to transfer Final Data to CCE.
- B. Once Data is compiled by a Data Custodian pursuant to Section IV of this Agreement, he or she is responsible for:
  - 1. Providing the Data to Authorized Users and ensuring that such Authorized Users receive access to the Data only in conformity with this Agreement (including by ensuring that a signed Data Confidentiality Agreement is signed before the Data Custodian provides access to the Data to an authorized user);
  - 2. Maintaining a record of all Data requested and received; and
  - 3. Ensuring that the Data is disposed in accordance with Section XI of this Agreement.
- C. Before any Data is shared by the Parties, each Data Custodian shall execute and deliver to the contacts for DMHHS a signed copy of his or her Data Confidentiality Agreement in the form set forth in Appendix C.
- D. As of the Effective Date of this Agreement, the following individuals have been designated as the Data Custodians:
  - 1. DBH designates Laura Heaven, LICSW, Chief, Data and Performance Management, DC Department of Behavioral Health, [laura.heaven@dc.gov](mailto:laura.heaven@dc.gov).
  - 2. DOC designates Reena Chakraborty, PhD, Chief of Strategic Planning and Analysis D.C. Department of Corrections, [reena.chakraborty@dc.gov](mailto:reena.chakraborty@dc.gov).
  - 3. DHCF designates Dr. LaRah Payne, Information & Privacy Officer, D.C. Department of Health Care Finance, [larah.payne@dc.gov](mailto:larah.payne@dc.gov).

4. MPD designates Marty Afhami, Enterprise Data Officer, Information Technology Bureau, MPD, marty.afhami@dc.gov.
5. OCME designates Dr. Chikarlo Leak, Forensic Epidemiologist, Office of the Chief Medical Examiner, chikarlo.leak@dc.gov.

## **XI. DISPOSITION OF DATA**

- A. Each Party shall return or delete, unless otherwise and independently authorized to retain Data or Final Data (or any copies thereof), as the case may be, from all places where it is stored and in any medium, without retaining a copy thereof (including expunging copies from any computer or other device). Each Party shall provide verification, in writing, to the other Parties of the manner and date of deletion within thirty (30) days after the later of the following occurrences:
  1. ODCA, or CCE on its behalf, issues a Final Report based on the Final Data;
  2. Upon termination of this Agreement pursuant to Section XII.C; or
  3. As otherwise required by state or federal law.
- B. By mutual agreement, the Parties may, for good cause shown, extend the Agreement for ninety (90) days beyond the Term (as defined below). Such extension must be in writing, executed by the Parties' signatories listed in Section XIV of this Agreement.
- C. ODCA and CCE may not maintain data sets developed from the Final Data beyond the Term and must dispose of any additional datasets as set forth in Section XI.A above.
- D. Notwithstanding the other requirements of Section VII and this Section XI, OCME may disclose Data to the Opioid Fatality Review Committee, established by Mayor's Order 2019-024, dated May 2, 2019.

## **XII. TERM & TERMINATION; REMEDY; NON-WAIVER**

- A. The Term of this Agreement will commence on the Effective Date and will continue until the publication of the Final Report (the "Term").
- B. Any failure by any Party, or its Representatives to comply with the terms or conditions of this Agreement may constitute a default under this Agreement.
- C. In the event of a default, a Party shall provide written notice to the other Party's Data Custodian promptly, and in any case within forty-eight (48) hours, of becoming aware of a default and a courtesy copy of the written notice to all other Parties in the Agreement. The written notice shall include a description of the alleged default along with a demand to cure by a reasonable date. If the defaulting Party does not cure or remedy the default within thirty (30) calendar days of the receiving the notice, that

failure to cure shall be considered a breach of the Agreement, under which a Party may terminate its participation in this Agreement and request immediate destruction of its Data by all Parties. If the breach is cured in the specified period, the defaulting Party shall notify all other Parties by written notice.

- D. No delay or omission of a Party to exercise any right, power, or remedy accruing upon the happening of a default shall impair any such right, power, or remedy, or shall be construed to be a waiver of, or acquiescence to, any such default.

### **XIII. COMPLIANCE WITH THE LAW**

- A. The Parties will perform under this Agreement in compliance with all requirements of all applicable laws, rules and regulations, which are, in part, included below, as well as all professional standards applicable to such data-sharing and disclosure. The Parties shall cooperate with each other to facilitate compliance with these laws, regulations and standards.
- B. To the extent applicable, CCE and its Representatives shall comply with:
1. The District of Columbia Personnel Manual as if its personnel were employees of the District and bound by the District's ethics laws. This includes the provisions of the District Personnel Manual, Part I, Section 1800.3.
  2. The Data-Sharing and Information Coordination Amendment Act of 2010, effective December 4, 2010 (D.C. Law 18-273; D.C. Official Code § 7-242) ("Data Sharing Act") and its accompanying regulations at 29 DCMR §§ 3000–3099.
  3. The Freedom of Information Act of 1976, effective March 25, 1977 (D.C. Law 1-96; D.C. Official Code § 2-531 et seq.)
  4. The Federal Policy for the Protection of Human Subjects and the District of Columbia Department of Corrections Policy and Procedure Number 1311.11, issued September 10, 2018 on Research Activity.
  5. The Substance Abuse Confidentiality Regulations, specifically 42 CFR § 2, which applies to all records relating to "the identity, diagnosis, prognosis, or treatment of any patient in a substance abuse program that is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States."
  6. All applicable data protection and privacy laws.
- C. To the extent the Parties use or disclose PHI in connection with this Agreement, the Parties agree not to use or disclose such PHI other than as permitted or required by

HIPAA; provided however the Parties agree and understand the disclosure of PHI is permitted pursuant to 45 C.F.R. § 164.512(e).

#### **XIV. PARTIES' SIGNATORIES**

- A. The following individuals are the Parties' signatories and legal representatives under this Agreement:

##### **DMHHS**

[For Notices Only]

Amelia Whitman

Policy Director

Office of the Deputy Mayor for Health and Human Services

1350 Pennsylvania Avenue NW, Suite 223

Washington, DC 20004

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202-807-0348

Michael Grier

Policy Advisor

Office of the Deputy Mayor for Health and Human Services

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Washington, DC 20004

Michael.grier@dc.gov

202-727-2320

[As a signatory]

Wayne Turnage

Deputy Mayor

Office of the Deputy Mayor for Health and Human Services

1350 Pennsylvania Avenue NW, Suite 223

Washington, DC 20004

##### **DBH**

Barbara J. Bazron, Ph.D.

Acting Director

DC Department of Behavioral Health

64 New York Avenue, N.E.

Washington, D.C. 20002

##### **DHCF**

Wayne Turnage

Director

D.C. Department of Health Care Finance

441 4th Street NW, 900S

Washington, DC 20001

**DOC**

Quincy L. Booth  
Director  
D.C. Department of Corrections  
2000 14th Street NW  
Washington, DC 20009

**OCME**

Dr. R Mitchell Jr. MD  
Chief Medical Examiner  
Office of the Chief Medical Examiner  
401 E Street SW, Suite 6080  
Washington, DC 20024

**MPD**

Chief Peter Newsham  
Chief of Police  
Metropolitan Police Department  
300 Indiana Avenue NW  
Washington, DC 20001

**OCTO**

Lindsey V. Parker  
Chief Technology Officer  
Office of the Chief Technology Officer  
200 I Street SE  
Washington, DC 20003

**CCE**

Misty Thomas  
Executive Director  
Council for Court Excellence  
1111 14th Street NW, Suite 500  
Washington, DC 20005

**ODCA**

Kathleen Patterson  
D.C. Auditor  
Office of the D.C. Auditor  
717 14th Street NW, 9th Floor  
Washington, DC 20005

All writings and notices delivered under this Agreement shall be provided to the Parties' aforementioned signatories by electronic mail and also may be copied and provided by mail or by hand.

#### **XV. SURVIVAL**

Sections IV, VI, VII, VIII, IX, XIX and XXI shall survive beyond the Term.

#### **XVI. MODIFICATIONS**

The terms and conditions of this Agreement may be modified only upon the agreement of the Parties. A modification must be in writing and signed by the duly authorized signatories of each Party.

#### **XVII. COUNTERPARTS**

This Agreement may be executed in counterparts, each of which shall be deemed an original and all of which shall be taken together and deemed to be one instrument.

#### **XVIII. NO JOINT VENTURE OR THIRD-PARTY BENEFICIARIES**

Nothing contained in this Agreement shall be deemed or construed by the Parties or by any third party to create the relationship of partnership, joint venture or any association between the Parties.

#### **XIX. LIABILITY**

Each Party shall be responsible for any liability arising from its own conduct and retain immunity and all defenses available to it pursuant to law.

#### **XX. NOTICE OF CLAIMS**

Each Party shall promptly inform the other Party of any information related to the provision of services under this Agreement which could reasonably lead to a claim, demand or liability of or against the other Party or the District by any third party.

#### **XXI. SEVERABILITY**

This Agreement shall be deemed severable and any provision of this Agreement that violates any law, statute, rule, or regulation of the District of Columbia or the United States, or is otherwise invalid or unenforceable, shall be deemed to be severed and shall not affect the enforceability of any other provision thereof.

#### **XXII. HEADINGS/COUNTERPARTS**



The headings in this Agreement are for purposes of reference only and shall not limit or define the meaning of any provision hereof. This Agreement may be executed in any number of counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one and the same document.

### **XXIII. JOINTLY DRAFTED AND ENTIRE AGREEMENT**

This Agreement shall be deemed to have been drafted by all Parties and, in the event of a dispute, shall not be construed against any Party on that basis. This Agreement contains the entire understanding of the Parties with respect to the matters contained herein, and supersedes any and all other agreements between the parties relating to the matters contained herein. No oral or written statements not specifically incorporated or referenced herein shall be of any force or effect.

The Parties, by the signatures of the authorized representatives below, hereby acknowledge and agree to the terms and conditions of this Agreement.

[signatures on the following page]

IN WITNESS WHEREOF, this Agreement has been executed by the Parties as of the dates set forth below.

By: Wayne Turnage  
Title: Deputy Mayor for Health and Human Services, Office of the Deputy Mayor for Health and Human Services  
Date:


By: Dr. R. Mitchell, Jr. MD  
Title: Chief Medical Examiner, Office of the Chief Medical Examiner  
Date:


By: Barbara J. Bazron, PhD.  
Title: Acting Director, Department of Behavioral Health  
Date:

By: Chief Peter Newsham  
Title: Chief of Police, Metropolitan Police Department  
Date:

By: Wayne Tumage  
Title: Director, D.C. Department of Health Care Finance  
Date:

By: Lindsey V. Parker  
Title: Chief Technology Officer, Office of the Chief Technology Officer  
Date:

  
By: Quincy L. Booth  
Title: Director, D.C. Department of Corrections  
Date: 7/19/19

  
By: Misty Thomas  
Title: Executive Director, Council for Court Excellence  
Date: 6/17/19

  
By: Kathleen Patterson  
Title: D.C. Auditor, Office of the D.C. Auditor  
Date: 6/17/19

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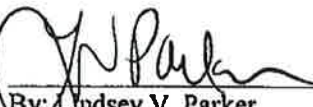
By: Wayne Turnage  
Title: Deputy Mayor for Health and Human Services, Office of the Deputy Mayor for Health and Human Services  
Date:

By: Dr. R. Mitchell, Jr. MD  
Title: Chief Medical Examiner, Office of the Chief Medical Examiner  
Date:


By: Barbara J. Bazron, PhD.  
Title: Acting Director, Department of Behavioral Health  
Date:

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Date:

By: Wayne Turnage  
Title: Director, D.C. Department of Health Care Finance  
Date:

  
By: Lindsey V. Parker  
Title: Chief Technology Officer, Office of the Chief Technology Officer  
Date: 6/18/2019


By: Quincy L. Booth  
Title: Director, D.C. Department of Corrections  
Date:

  
By: Misty Thomas  
Title: Executive Director, Council for Court Excellence  
Date: 6/17/19

  
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Date: 6/20/2019

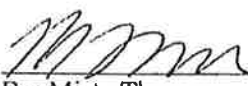
By: Barbara J. Bazron, PhD.  
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Date:


By: Chief Peter Newsham  
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By: Wayne Turnage  
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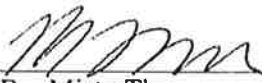
\_\_\_\_\_  
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Department  
Date: 6/21/2019

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By: Wayne Turnage  
Title: Director, D.C. Department of Health  
Care Finance  
Date:

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By: Lindsey V. Parker  
Title: Chief Technology Officer, Office of  
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Date:

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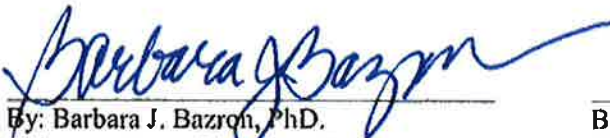
  
\_\_\_\_\_  
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Title: Executive Director, Council for Court  
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Date: 6/17/19

  
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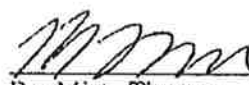
  
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Date:

By: Kathleen Patterson  
Title: D.C. Auditor, Office of the D.C. Auditor  
Date:

## **APPENDIX A**

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### **1. Dataset name: MPD Full Data**

#### **Data description**

MPD will provide a person-level dataset containing data about arrests made between January 2015-September 2018. The dataset shall contain the following for each Justice-Involved Individual:

- a) if an arrest occurred
- b) the date of each arrest
- c) Police Service Area of arrest
- d) the offense for which individuals were arrested

The following demographic information will be provided about each individual in the dataset, if available:

- a) Year of birth
- b) Race
- c) Ethnicity

### **2. Dataset name: DOC Full Data**

#### **Data description**

DOC will provide a person-level dataset containing data about all individuals incarcerated between January 2015-September 2018 for all Justice-Involved Individuals in the "Original Data". The dataset that DOC will provide will contain the following data for each individual:

- a) The date(s) at which an incarceration began
- b) The date(s) at which the individual was released
- c) Whether the individual received a SUD-diagnosis during intake
- d) Whether the individual received treatment for a SUD while incarcerated and the date(s) during which each of the following services were provided, if applicable;
- e) What services were provided to the individual including;
- f) Enrollment in the Residential Substance Abuse Treatment (RSAT) program;
- g) Clinical Care Coordination;
  - a. Case Management;
  - b. Crisis Intervention;
  - c. Substance Use Disorder Counseling, including the following;
- h) Individual Counseling;
- i) Group Counseling;
- j) Group Counseling - Psycho-education; and
- k) Family Counseling; and
  - a. Medication Management;
  - b. Medication Assisted Treatment; and



c. Recovery Support Service

The following demographic information will be provided about each individual in the dataset:

- a) Zip code of home address
- b) Native language, if not English
- c) Education level
- d) Income level

**3. Dataset name: DBH Full Data**

**Data description**

DBH will provide a person-level dataset containing data about the SUD-related service(s) provided by DBH itself and community providers with its clients. These records will be at the individual level and will include demographic information about each Justice-Involved Individual, as well as data on the nature of the SUD-related service(s) they received during the Audit Period, which is January 2015 through September 2018. SUD-related Services refers to the following:

- a) Assessment/Diagnostic and Treatment Planning Services; including an indication of whether a referral was made, and the level of service for which the referral was made
- b) Clinical Care Coordination;
- c) Case Management;
- d) Crisis Intervention;
- e) Substance Use Disorder Counseling, including the following;
  - i. Individual Counseling;
  - ii. Group Counseling;
  - iii. Group Counseling - Psycho-education; and
  - iv. Family Counseling;
- f) Drug Screening, as follows;
  - i. Toxicology Sample Collection; and
  - ii. Breathalyzer Testing;
- g) Medication Management;
- h) Medication Assisted Treatment; and
- i) Recovery Support Services.

**4. Dataset name: OCME Full Data**

OCME will provide the following information for each individual, when available, in the dataset from January 2015 –September 2018:

- a) Cause of Death; and
- b) Manner of Death.

**5. Dataset name: DHCF Full Data**

**Data description**

DHCF will provide a person-level dataset containing data about the SUD-related service(s) provided to all Justice-involved Individuals. The dataset that DHCF will provide will contain data about the following SUD related services for each individual:

- a) Assessment/Diagnostic and Treatment Planning Services; including an indication of whether a referral was made, and the level of service for which the referral was made
- b) Clinical Care Coordination;
- c) Case Management;
- d) Crisis Intervention;
- e) Substance Use Disorder Counseling, including the following;
  - i. Individual Counseling;
  - ii. Group Counseling;
  - iii. Group Counseling - Psycho-education; and
  - iv. Family Counseling;
- f) Drug Screening, as follows;
  - i. Toxicology Sample Collection; and
  - ii. Breathalyzer Testing;
- g) Medication Management;
- h) Medication Assisted Treatment; and
- i) Recovery Support Services

## **Appendix B**

### **Security Requirements**

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#### **Security Controls for the Transfer of Data**

- Disclosing Parties must transmit Data employing industry-standard security and encryption protocols to securely transfer Data, and in all cases no less than the same protocols as it employs to protect and transfer its own data. Disclosing Parties shall not provide Data to Receiving Parties in an unencrypted format or through an insecure means.
- The Disclosing Party may provide Data via an encrypted flash drive or an approved secure, encrypted upload facility. When provided via a secure encrypted upload facility, the Receiving Party shall download any Data or Final Data, when available, only to a secure computer or server with strong password protection. In the case that the Data or Final Data is available for download using a secure website with an assigned user name and password, the login information shall not be shared with anyone not authorized by the Receiving Party to receive the Data or Final Data.
- If Data is transferred via flash drive, the Data will be deleted immediately from the flash drive after the transfer is complete and the deletion will be confirmed by ensuring that the Data does not appear in the trash or recycle bin of the flash drive.
- The Receiving Party shall ensure that any computers hosting, transmitting or storing the Data or Final have the latest security patches and are running virus protection software, in accordance with industry standards.
- The Receiving Party shall avoid storing any Data or Final on a laptop or other portable devices. If the Data or Final Data is stored on portable devices, the Receiving Party shall ensure that the Data or Final Data and device are encrypted, in accordance with industry standards. If Data or Final Data is stored on an immobile computer, the Receiving Party shall ensure that the computer is locked when the computer is unattended, and is password protected and the password is not visible, accessible, or shared with any unauthorized individuals.

#### **General Security Controls for the Agencies**

- All Data collection and analysis by the Agencies must be conducted on District-issued devices.
- All District-issued computers on which Data analysis is conducted must:
  - Run Windows 10 to facilitate encryption;

- Use full disk encryption (using Check Point endpoint security);
- Be password-protected issuing appropriate password protection and controls; and
- Have the computer screen set to automatically lock and require a password to re-open after 5 minutes or less of inactivity
- When using a Wi-Fi connection (other than the secure Wi-Fi connection operated by the District government), all Authorized Users shall comply with the following guidelines:
  - The Authorized Users shall not use an unsecured public Wi-Fi connection unless such use is absolutely necessary (for example, a hotel only provides unsecured Wi-Fi connection and it is necessary for the user to perform work while at the hotel);
  - The Authorized Users shall immediately connect to the DC VPN (regardless of whether the Wi-Fi connection is secure or unsecure);
  - The Authorized Users shall avoid accessing or analyzing Data when connected to a public Wi-Fi connection, even if the Authorized Users is connected to the DC VPN and even if the Wi-Fi connection is secured; and
  - The user shall ensure that the user's home network uses WPA2 authentication

#### **General Security Controls for CCE**

If analysis is conducted by Council for Court Excellence ("CCE") staff, CCE shall also comply with all relevant elements of the General Security Controls above for any of its computers that access or analyze the Data. Upon request, CCE should be prepared to demonstrate to District staff its relevant security protocols, as applicable to its own network.

## Appendix C

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### Data Confidentiality Agreement

Pursuant to the Data Use Agreement between the District and the Office of the District of Columbia Auditor ("ODCA") and the Council for Court Excellence ("CCE") ("Agreement") regarding the sharing of records, I understand that I will be given access to data that may include confidential or sensitive information such as personally identifiable information and medical information ("Data"). As an authorized user of such data, I make the following affirmations.

I understand that it is my responsibility to know the security protections in place and necessary to protect the Data. I have carefully read and completely understand the data security guidelines outlines in Appendix B. I understand that I must, and affirm that I will, comply with all data security requirements specified in Appendix B. I have carefully read, understand, and will comply with the terms and conditions of the Agreement, including the restrictions on the use and disclosure of the Data provided to ODCA and CCE pursuant to the Agreement.

I will not disclose, and will take all necessary and reasonable precautions to prevent others from disclosing, any Data provided pursuant to the Agreement, and the security protections in place and necessary to protect the Data.

I will not use, and will take all necessary and reasonable precautions to prevent others from using, the Data provided pursuant to the Agreement for any purpose not authorized by the Agreement. I will not use, and will take all necessary and reasonable precautions to prevent others from using, the Data provided pursuant to the Agreement to contact any person in the data for any purpose unless such contact is authorized by the Agreement.

I understand that my disclosure of Data in violation of the Agreement, or my failure to abide by this Agreement or Appendix C, may subject me to disciplinary action, up to and including termination of employment.

I agree to report the violation or potential violation of any term of this Agreement or the Agreement to the Data Custodian without unreasonable delay.

I acknowledge and affirm that I am personally responsible for compliance with the terms of this Data Confidentiality Agreement.

Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

Date \_\_\_\_\_

# Appendix C

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## QUANTITATIVE METHODS

To perform this audit, the Office of the D.C. Auditor (ODCA) requested that the Department of Behavioral Health (DBH), Department of Corrections (DOC), Department of Healthcare Finance (DHCF), and the Department of Health (DOH) produce datasets that the Council for Court Excellence (CCE) could match together to evaluate the relationship between substance use disorder (SUD) services and justice involvement, among individuals in the District of Columbia, between January 1, 2015 and September 30, 2018 (the “Audit Period”). After discussions with representatives from the Executive Office of the Mayor and the Deputy Mayor for Health and Human Services, it was determined that DOH would not provide data and, instead, the Metropolitan Police Department (MPD) and Office of the Chief Medical Examiner (OCME) would contribute data to the dataset, even though they were not initially agencies engaged in this audit. DHCF was never intended to be subject to programmatic evaluation, but instead was party to this audit only for the purposes of data sharing. The following describes the methodology CCE used to analyze the data provided by these agencies.

### DESCRIPTION OF THE DATA

On November 21, 2019, CCE received final person-level datasets from the above agencies that provided information about the individuals who had been in various forms of contact with each agency during the Audit Period. As part of each different dataset, each agency produced a number of individual “identifiers” as well as substantive data that could be used for analysis. To protect the individual peoples’ identities, the identifiers were reported to CCE as a 32-character “hash.” Each hash was deterministically created from the original identifying content held only by the agency, such that each name, date of birth, and any other agency identifier was represented by one distinct hash. The creation of those hashes was performed identically for data from each agency. Agency identifiers were pre-processed by the Office of the Chief Technology Officer (OCTO) to account for differences in spacing and capitalization conventions.

Once delivered to CCE, the audit team created a unique identifier (UID) for each distinct person in the dataset, using a combination of hashes of first names, last names, and dates of birth. Social Security Numbers (SSNs) were not used for identifying matches because there was missing data and a hashing error in the data as it was delivered to CCE which prevented the use of SSNs as a common identifier between DHCF and other agencies. For reasons discussed in greater detail below, Metropolitan Police Department’s unique personal Identification Numbers (PDIDs), were used to match MPD data to DOC data, and UIDs were not used to match MPD data to other datasets. Therefore, this limited the ability to match MPD data to the behavioral health data sources in this dataset, leaving only arrests that were associated with DOC incarcerations to be considered in our analysis. Figures 35 and 36 outline the data delivered to CCE from each agency.

**Figure 35: Identifiers and Data by Agency**

Agency	Identifiers	Data
MPD	Names, birthdate, PDID, SSN	Demographics, arrest date
DOC	Names, birthdate, PDID, DCDC, SSN, USM	Incarceration start and end date, SUD flags
DBH	Names, birthdate	Assess and referral data, care episode data
DHCF	Names, birthdate, Medicaid ID	Care episode data
OCME	Names, birthdate	Mortality data and dates

*Source: Matched District Data*

**Figure 36: Agency Data by Observation and Identified Individual<sup>470</sup>**

Agencies	Observations	ID'd individuals
MPD	225,180	68,026
DOC	40,122	23,283
DBH (Assess)	12,259	8,234
DBH (Claims)	567,248	12,901
DHCF	941,499	25,414
OCME	1,140	1,140

*Source: Matched District Data*

## DATA-MATCHING AND QUALITY CHECKS

As noted above, the data that CCE received contained a number of identifiers, however, those identifiers were encrypted in such a way that only a direct match of hashes between a first name, last name, or date of birth could be used to correctly identify a particular person and/or their specific justice involvement or SUD care. As discussed below, we found that a combination of first name, last name, and date of birth resulted in a dataset that closely resembled unique internal identifiers used by the agency to track individuals. Figure 37, below, shows counts of individuals between CCE's UID and our best available agency identifier.

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<sup>470</sup> The count of *Identified Individuals* for each agency is the total of UIDs developed from that agency's data, except for MPD. MPD's count of *Identified Individuals* is the total number of unique PDIDs.

**Figure 37: “Our” Identifier and Alternative Identifier**

<b>Agencies</b>	<b>Our Identifier</b>	<b>Best Alternative Identifier</b>
MPD	91,800	68,026 (PDID)
DOC	22,283	23,373
DBH (Assess)	12,259	NA
DBH (Claims)	12,901	NA
DHCF	25,414	25,455 (Medicaid ID)
OCME	1,140	NA

**Source: Matched District Data**

CCE was able to identify roughly 100 more individuals in DOC with our UID than we could with DOC’s own internal identifier (DCDC), representing a known error rate of approximately .04% in the DOC data. Using a similar comparison, we identified an error rate of .02% in the DHCF data. However our identifier has a roughly 25.9% error rate in the MPD data. We had no metric for analyzing the error rates in the OCME, DBHA, or DBH data, as they did not contain internal agency identifiers against which we could make our comparisons.

The MPD data posed a challenge because there were a significant number of missing PDIDs (their agency internal identifier), and CCE found that our UID was less reliable when matching to DOC data than the PDID was, even when accounting for the missing PDIDs. As a consequence, we chose to use PDIDs instead of UIDs to match MPD to DOC data, and then used the associated UIDs in the DOC dataset as a means of bridging the MPD observations to other datasets.

## **ASSUMPTIONS AND CREATION OF “EPISODES”**

In light of the limitations on tracking individual people consistently through the different agency data, CCE chose to evaluate relationships by “episode,” rather than by individual persons identified in the datasets, for all of our analyses. In particular, we established “Incarceration Episodes,” “Assessment Episodes,” and “Fatality Episodes.” Developing these “Episodes” allowed us to anchor and conduct our analyses around distinct events that occurred wholly within the Audit Period, rather than around an individual person who may or may not have been incarcerated multiple times before, during, and after the Audit Period, or who may or may not have received care multiple times before, during and after the Audit Period. This allowed us to increase the precision of the claims that we made about our analyses. As we performed these analyses, we also chose to limit the data we evaluated to control for events that happened outside of the Audit Period, or that were not reflected in our dataset, as best we could.

For the purposes of this report, an Incarceration Episode is the period of time beginning with the MPD arrest that most closely preceded an incarceration through the release date for that incarceration. An Assessment Episode is an assessment for SUD services at the Assessment and Referral Center (ARC), and a Fatality Episode is an accidental drug overdose in which the individual died, as measured by OCME.



For some Incarceration Episodes, we could not identify a MPD arrest in the dataset that we reasonably believed correlated with a specific DOC incarceration; this could be because there was an arrest initiated by a law enforcement agency other than MPD, or because the arrest occurred more than 365 days prior to the incarceration, the bound we set in defining what was the likely arrest link to a particular incarceration. When this occurred, we dropped the arrest, and defined the Incarceration Episode as the period from the beginning of the DOC incarceration to the end of that incarceration. Additionally, as noted above, if the incarceration had an intake date or release date after that did not fall between January 1, 2015, and September 30, 2018, that Incarceration Episode was removed from our analysis.

Once we identified the Episodes we then created “Look Forward” and “Look Back” periods to facilitate our analysis of what happened to individuals immediately preceding and following an Episode. These bounds were set to attempt to approximate activity that could be reasonably considered “close in time” to major life incidents, like an arrest, an incarceration, or a decision to get assessed and seek SUD care. For Assessments we only created Look Forward periods, and for deaths we only created Look Back periods.

We defined the “Look Forward” period as the 90 days after an Episode and the “Look Back” period as the 90 days before an Episode. We used these windows to evaluate whether an individual had received SUD care paid for by either DBH or DHCF in a finite period before or after their release from incarceration, whether that individual was assessed by DBH, whether that individual was arrested by MPD during that period of time, and whether that individual died during that period of time. The “Look Around” period encompasses both the Look Forward and the Look Back period, 90 days on each side of an event. Any Incarceration Episode for which any part of the Look Around period was outside of January 1, 2015, or September 30, 2018, was dropped completely from our data analyses, as we determined that we could not get a consistent picture of what happened during these Episodes or fairly compare them to the Episodes that occurred completely within the Audit Period.

“Care” was defined in this analysis as any SUD service claim record generated by DHCF or DBH or a record of a DBH assessment for care, as was provided in the datasets delivered by the agencies to CCE. The universe of care that we consider is constrained to the data delivered to the audit team by the agencies. If an individual received privately funded care, or care from a non-D.C. public health agency, CCE received no data on that care and it is not reflected in our analysis. Moreover, with few exceptions, we do not distinguish between types of SUD care in the analyses reported and instead focus on whether care occurred or did not. While a more detailed analysis of how patterns of incarceration varied by type of care received at various intercepts before or after justice-involvement would have been revealing, it was not feasible given our time constraints.

## IMPOSED CENSORS BASED ON TIME INTERVALS

As noted above, we completely excluded any Incarceration, Assessment, or Fatality Episodes that violated the “left” censor (January 1, 2015) or “right” censor (September 30, 2018) in the dataset. For example, if an incarceration occurred such that the individual first entered DOC custody within 90 days of January 1, 2015, or September 30, 2018, we excluded those Incarceration Episodes from our

analysis. Similarly, any deaths that occurred within 90 days of January 1, 2015 and any Assessments that occurred within 90 days of September 30, 2018, were excluded. This decision, while limiting of the amount of data that we could analyze, ensured our ability to create more consistent observational units overall. Failing to exclude cases that violated the censors would have risked identifying cases around incarceration as “no care” cases, when in fact they were “care” cases, but the care was delivered before or after the time censor.

The downside of the decision to create data censors was some information loss from within the Audit Period dataset. For the 30 day Look Around, only 4% of the relevant data was excluded. However, imposing the 90 day Look Around resulted in 12.3% of the relevant data being excluded. For 365 day Look Around, 730 days were excluded, or 50% of the Audit Period. For nearly all evaluations reported in this report, we set our Look Around periods at 90 days. To test the appropriateness and stringency of our chosen censors, we repeated our analysis of the relationship between care in the Look Forward and care in the Look Back with both 30 and 365 day Look Arouns, and found that these changes did not meaningfully impact the data results or our interpretation of events. The broader academic literature used various lengths of time post-incarceration to evaluate behavioral health outcomes. 90 days is a commonly used window for these types of outcomes.<sup>471</sup>

## IMPOSED CENSORS BASED ON DOC RELEASE TYPE

Individuals in DOC were not always released to the community, many were released to the custody of other jurisdictions (like Maryland and Virginia) or other authorities (like the federal Bureau of Prisons, the U.S. Marshal’s Service or the MPD Fugitive Unit). Because we have no data on SUD services provided by other jurisdictions’ correctional institutions, these cases were also categorically removed from our data analysis of Episodes. We subset our Episodes down to only those who were identified in DOC’s records as being “released to community.” This shrunk the number of incarcerations we considered from 40,112 to 21,194. Unfortunately, the data we were provided did not indicate an address or place of residency of an individual “released to community.” We were, however, comfortable assuming D.C. residency of those who received SUD care funded through D.C. Medicaid or DBH’s local dollars, and who were part of the DBH and DCHF data. We have no way of knowing, with the data available to us, whether a person received SUD care in another jurisdiction.

We considered retaining two limit cases that we thought might have relevance to our analysis: there were 2,709 incarcerations that were identified as released to “treatment program” and 689 incarcerations identified as release to “St. Elizabeths Hospital.” To test the effect of excluding these cases on our results, we re-ran our analyses related to Incarceration Episodes and care in the Look Around, as well as Active SUD flags while including the release to treatment program and release to St. Elizabeths Hospital cases. We found that excluding these cases slightly *decreased* the percentage of individuals receiving care before and after incarcerations. We believe that this may be

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471 Kinlock, Timothy W., Michael S. Gordon, Robert P. Schwartz, and Kevin E. O’Grady. “A Study of Methadone Maintenance For Male Prisoners: 3-Month Postrelease Outcomes.” *Criminal Justice and Behavior* 35, no. 1 (2008): 34–47. <https://doi.org/10.1177/0093854807309111>.

the case because these individuals are being released to court-funded SUD services that are not captured within our dataset. Without any further information with which to consider these cases, and with a suspicion that they may be receiving SUD services that are not captured in our dataset, we chose to exclude all non-“release to community” cases, narrowing the universe that we consider to only those who are released to community.

## POPULATION VS. SAMPLE DATA

Philosophically, we treated the data presented in this report not as a sample of a broader universe of data, but as *the* universe of data itself. We made this choice for two reasons. First, our goal in this audit is to evaluate the provision of SUD services to justice-involved clients by certain D.C. agencies during a particular period of time. We are neither trying to generalize our results to years outside the Audit Period, nor to jurisdictions other than D.C., nor as data reflecting trends. Albeit imperfect, the inter-agency matched dataset is population data, not a sample data set for research. Tests of statistical significance are not considered appropriate with population data, because they are uninterpretable.<sup>472</sup> Our data findings, therefore, should be considered a look at the relationship between the District’s SUD service system and justice system *at a particular point in time*, and not as a general exploration of the District’s SUD service system and justice system today.

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472 Allen Rubin, “Significance Testing with Population Data,” *Social Service Review* 59, no. 3 (Sept. 1, 1985): 518–20. A test of statistical significance is a test of the likelihood that a relationship observed between two variables in a sample exists between the population parameters the sampled variables represent. When looking at the parameters themselves, this is a meaningless test.

# Appendix D

## GLOSSARY OF TERMS

Acronym	Name
<b>AA</b>	Alcoholics Anonymous
<b>APRA</b>	The Addiction Prevention & Recovery Administration
<b>AR</b>	Assessment and Referral
<b>ARC</b>	Assessment and Referral Center
<b>ATR</b>	Access to Recovery
<b>AUD</b>	Alcohol-Use Disorder
<b>BHI</b>	Behavioral Health Information
<b>BOP</b>	U.S. Bureau of Prisons
<b>CCE</b>	Council for Court Excellence
<b>CDF</b>	Central Detention Facility or “DC Jail”
<b>CJCC</b>	Criminal Justice Coordinating Council
<b>CMS</b>	Center for Medicare and Medicaid Services
<b>CSA</b>	Core Services Agency
<b>CSOSA</b>	Court Services and Offender Supervision Agency
<b>CTF</b>	Correction Treatment Facility
<b>DCMR</b>	D.C. Municipal Regulations
<b>DBH</b>	D.C. Department of Behavioral Health
<b>DBHA</b>	Department of Behavioral Health Assessment (data)
<b>DHCF</b>	D.C. Department of Health Care Finance
<b>DHS</b>	D.C. Department of Human Services
<b>DMH</b>	D.C. Department of Mental Health
<b>DMHHS</b>	D.C. Deputy Mayor for Health and Human Services
<b>DMPSJ</b>	D.C. Deputy Mayor for Public Safety and Justice
<b>DOC</b>	D.C. Department of Corrections

## GLOSSARY, CONTINUED:

<b>DOH</b>	D.C. Department of Health
<b>DOJ</b>	U.S. Department of Justice
<b>DR</b>	Disciplinary Report
<b>DUD</b>	Drug-Use Disorder
<b>EHR</b>	Electronic Health Record
<b>EMR</b>	Electronic Medical Record
<b>EOM</b>	Executive Office of the Mayor
<b>FEMS</b>	Fire & Emergency Medical Services
<b>FQHC</b>	Federally Qualified Health Centers
<b>FY</b>	Fiscal Year
<b>HIPAA</b>	Health Insurance Portability and Accountability Act
<b>IRC</b>	Inmate Reception Center
<b>JITAI</b>	just-in-time adaptive interventions
<b>KPI</b>	Key performance Indicator
<b>LEAD</b>	Law Enforcement Assisted Diversion
<b>LOC</b>	Level of Care
<b>MAT</b>	Medication-Assisted Treatment
<b>MH</b>	Mental Health
<b>MHRS</b>	Mental Health Rehabilitation Services
<b>MOU</b>	Memorandum of Understanding
<b>MPD</b>	Metropolitan Police Department
<b>MUD</b>	marijuana use disorders
<b>NA</b>	Narcotics Anonymous
<b>NCCHC</b>	National Commission on Correctional Health Care
<b>NEAR Act</b>	Neighborhood Engagement Achieves Results Act
<b>OAG</b>	D.C. Office of the Attorney General
<b>OCA</b>	D.C. Office of the City Administrator
<b>OCME</b>	D.C. Office of the Chief Medical Examiner

## GLOSSARY, CONTINUED:

<b>OCTO</b>	D.C. Office of the Chief Technology Officer
<b>ODCA</b>	Office of the District of Columbia Auditor
<b>OTP</b>	Opioid Treatment Program
<b>ODU</b>	Opioid Use Disorder
<b>PAD</b>	Pre-Arrest Diversion
<b>PAR</b>	Performance Accountability Report
<b>PCP</b>	Phencyclidine
<b>PDID</b>	Police Department Identification Numbers
<b>PIT</b>	Point-in-Time Count
<b>PSA</b>	Pretrial Services Agency for the District of Columbia
<b>RBA</b>	Results-Based Accountability
<b>READY Center</b>	Resources to Empower and Develop You Center
<b>RFP</b>	Request for Proposal
<b>RPR</b>	Rapid Peer Responder
<b>RSAT</b>	Residential Substance Abuse Treatment Program
<b>RSS</b>	Recovery Support Services
<b>SAMHSA</b>	Substance Abuse and Mental Health Services Administration
<b>SATMHSIT</b>	Substance Abuse Treatment and Mental Health Services Integration Task Force
<b>SBIRT</b>	Screening, Brief Intervention, And Referral to Treatment
<b>SMI</b>	Severe Mental Illness
<b>SSN</b>	Social Security Numbers
<b>STR</b>	State Targeted Response
<b>SUD</b>	Substance Use Disorder
<b>TED</b>	Treatment-Episode Data
<b>TIC</b>	Trauma Informed Care
<b>UID</b>	Unique identification number created using a combination of first name, last name, and date of birth

GLOSSARY, CONTINUED:

<b>USAO</b>	U.S. Attorney’s Office for the District of Columbia
<b>USPC</b>	U.S. Parole Commission

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