Findings and Recommendations from *Everything is Scattered…* The Intersection of Substance Use Disorders and Incarcerations in the District

August 2020

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.

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.

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.

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:

    1. Have any history in DOC's own medical records of a SUD diagnosis or treatment from a prior period of custody; or

    2. 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.

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.

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:

    1. 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; and,

    2. 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.

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.

Related Recommendations:

1. DBH should increase access to its services by:

    1. Adopting the proposed revision to D.C.M.R Chapter 22-A to allow any SUD provider to conduct assessments and referrals;

    2. Amending D.C.M.R Chapter 22-A to remove the requirement that initial SUD assessments be conducted in person; and,

    3. 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:

    1. Significantly expanding Screening, Brief Intervention, and Referral to Treatment (SBIRT) referrals into broader community settings; and,

    2. Developing programs integrating behavioral health and primary care to foster close collaboration between care teams in a co-located setting.

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.

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.

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.

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.

Finding 7: DBH has not established adequate communication channels with critical substance use disorder stakeholders, including providers and members of the public.

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.