



Criminal Justice Coordinating Council

*Research Report*

Mental Health Information Sharing in the  
District of Columbia Criminal Justice  
System

An Identification of Information Sharing Opportunities  
for Member Agencies

***July 31, 2015***

## Table of Contents

<b>SECTION 1: EXECUTIVE SUMMARY</b>	1
1.1 Background	1
1.2 Scope	2
1.3 Methodology	3
1.4 Summary of Recommendations	4
<b>SECTION 2: TECHNICAL APPROACH</b>	8
2.1 Background	8
2.2 Key Stakeholders	8
2.3 Scope	9
2.4 General Methodology	12
2.5 Technical Approach	13
2.5.1 Review of Prior Work Product	13
2.5.2 Categorization of Agencies by Function	15
2.5.3 Examination of Relevant Legal Standards	15
2.5.3.1 <i>The Privacy Act</i>	16
2.5.3.2 <i>The Health Insurance Portability and Accountability Act</i>	18_Toc426136991
2.5.3.3 <i>Substance and Alcohol Abuse Treatment</i>	20
2.5.3.4 <i>The Mental Health Information Act</i>	21
<b>SECTION 3: FINDINGS</b>	23
3.1 Paths Through the Criminal Justice System	23
3.2 MHI Needs By Partner Category	25
3.3 Agency Operational Processes and MHI Needs	26
<b>SECTION 4: RECOMMENDATIONS</b>	39
4.1 Comprehensively Automate MPD MHI Collection and Sharing	39
4.2 Share the CCB Intake Lists Electronically and in Real-Time	41
4.3 Provide the DOC and the PSA with Access to Partner Agency Records	41
4.4 Create a HIPAA-Compliant Process at the MPD and USMS for MHI Access	43
4.5 Share USMS Records with other Custodial Agencies Electronically	43
4.6 Share MHI Automatically and Electronically with Custodial Agencies	44
4.7 Designate a Centralized Database to Maintain and Share MHI	44
4.8 Conclusion	46
Appendix I: Glossary of Key Terms	47
Appendix II: Interviews Conducted	49
Appendix III: Points of Contact by Agency	50
Appendix IV: Agency Legal Status and MHI Access Rights	51

# SECTION 1: EXECUTIVE SUMMARY

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*This section summarizes the approach, findings, and recommendations of the research report.*

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## 1.1 Background

It is often the case that the criminal justice system is the first to identify individuals in critical need of mental health services. A 2012 study by the Vera Institute of Justice (the “Vera Study”) concluded that nearly a third of those arrested in the District of Columbia (the “District”) have some mental health need. While the criminal justice system uniquely comes into contact with such individuals, courts, law enforcement, and corrections facilities have limited resources and trained professionals available to efficiently identify and treat individuals with mental illness. This concern is compounded by the fact that recidivism rates of individuals with mental illness, who pass through the criminal justice system, are extremely high. To address the needs of this vulnerable group, extensive efforts have been undertaken by numerous government agencies in the District, including those in the criminal justice system, to provide greater access to mental health services. A significant opportunity for improvement that was identified by the Vera Study concerns the sharing of mental health information between and among the criminal justice agencies.<sup>1</sup>

As an independent agency, the Criminal Justice Coordinating Council (“CJCC”) is dedicated to continually improving the administration of criminal justice in the city by serving as the forum for identifying issues and their solutions, proposing actions, and facilitating cooperation that will improve public safety and the related criminal and juvenile justice services for District of Columbia residents, visitors, victims and offenders. The CJCC draws upon local and federal agencies and individuals to develop recommendations and strategies for accomplishing this mission. The Substance Abuse Treatment and Mental Health Services Integration Taskforce (“SATMHSIT”) was formed by the CJCC in 2006 to address the long-recognized need for preventive and diversion services for individuals with serious and persistent mental illness or co-occurring mental health and substance use disorders. SATMHSIT is dedicated to interagency collaboration to improve the treatment options for criminal justice-involved individuals with mental health issues, substance abuse problems, or co-occurring disorders.

The CJCC developed and administers the Justice Information System (“JUSTIS”), a web-based application that allows registered law enforcement and criminal justice users to view criminal justice related information from multiple sources at the same time. The system relies entirely on the voluntary sharing of information from contributing public safety agencies. JUSTIS facilitates interagency information sharing by providing member agencies with the ability to access and view information that is maintained in their respective databases, providing a secure conduit for member agencies to transfer data to each other's systems, and hosting certain information about individuals arrested in DC.

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<sup>1</sup> Jim Parsons, Talia Sandwick. *Closing the Gap: Using Criminal Justice and Public Health Data to Improve the Identification of Mental Illness*. New York: Vera Institute of Justice, 2012.

A significant JUSTIS accomplishment was the Case Initiation Project (CIP), which automated the exchange of adult criminal case information (both data and documents), from arrest through prosecutorial action, to the filing of the criminal action.

To help address the need for better mental health information sharing among its members, the CJCC sought and obtained a grant from the Bureau of Justice Statistics (the “BJS”) to conduct research and provide analysis regarding the mental health information currently being collected and shared among the District’s criminal justice agencies. BDA Global was retained by the CJCC to perform the work funded by this grant.

## *1.2 Scope*

Pursuant to the BJS grant, BDA Global set out to examine the current sharing of Mental Health Information (“MHI”) among the members of the CJCC and to identify opportunities for enhancement. BDA Global’s review involved eleven of the member agencies of the CJCC (the “Partner Agencies”) who serve the public in the District through the criminal justice system.<sup>2</sup> The Department of Behavioral Health (the “DBH”) was also consulted as it collaborates closely with the Partner Agencies to deliver mental health services to individuals in the system.

Specifically, BDA Global’s work involved the following:

1. Identifying legal and other restrictions to sharing MHI collected by the Partner Agencies, conducting research as to the scope of those restrictions as applied to the MHI currently being collected by the member agencies, and providing analysis as to whether further sharing of that MHI is permitted.
2. Considering the privacy and security requirements for MHI sharing relevant to the form in which the data is stored or transmitted.
3. Understanding the MHI needs of the Partner Agencies in light of their varying roles and functions within the District’s criminal justice system.
4. Understanding the current MHI sharing practices of the Partner Agencies, in part, to identify instances of duplication of effort by service providers and the existence of any information silos that could compromise efforts by the Partner Agencies to serve the mentally ill.
5. Preparing a report presenting findings and observations concerning current practices and offering recommendations for improvements.

Our review of the purposes for which the respective Partner Agencies need MHI identified five key datapoints that may be considered the minimum MHI that, for safety reasons, should follow an individual through the criminal justice system. The Partner Agencies also need and share other forms of MHI, for the purposes of determining the disposition of criminal charges against an individual and to monitor compliance with any terms or conditions of release.

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<sup>2</sup> The members of the CJCC who are not the subject of this study are those that are not directly involved with individuals in the criminal justice system.

It is important to distinguish information concerning individuals in substance abuse treatment programs that are governed by the federal regulations published at 42 CFR Part 2. Although those regulations impose greater restrictions on information disclosure than the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) or the DC Code, they should not be relevant, or significant obstacles, to the sharing of the five key datapoints by the Partner Agencies.

This report does not address the needs of the juvenile justice system. Similar challenges exist there, and some of our observations may be relevant, but the juvenile system is sufficiently distinct to require separate examination. Nor does the report examine MHI sharing when DC inmates committed to the custody of the Bureau of Prisons (the “BOP”) are transferred between various federal facilities. Finally, it does not address potentially similar issues that might arise for the Partner Agencies in the context of non-criminal matters.

In summary, the focus of this report is limited to the review of the MHI sharing needs and practices of the Partner Agencies to try to identify vulnerabilities in the current system and opportunities for enhancement. Generally, that information is not inherently different from other types of personal information that is protected by HIPAA, the Federal Privacy Act, or the DC Code.

### *1.3 Methodology*

The project focused both on legal and non-legal information sharing barriers and opportunities, and involved four key data gathering and analytic steps, as follows:

- **Project Initiation and Planning:** Developing a sponsor letter and document request list, engaging Partner Agencies, identifying interview targets and research sources, and developing a detailed work plan
- **Data Gathering and Initial Analysis:** Reviewing a range of historical documents including:
  - 2014-2015 CJCC Mental Health Information Sharing Survey
  - 2006 Substance Abuse Treatment and Mental Health Services Integration Taskforce (“SATMHSIT”) Report on Data Sharing for individuals with substance abuse issues
  - 2012 Study by the Vera Institute of Justice
  - PowerPoint presentations to Interagency Research Advisory Committee (“IRAC”) on Mental Health Information Collection
  - Minutes from recent IRAC meetings
  - Review of information published on Partner Agency websites.
- **Data Collection and Analysis:** Conducting multiple interviews, aggregating data, and performing analysis to develop findings and recommendations

- **Developing this report of findings and recommendations**

Research efforts identified five key MHI datapoints and examined how the agencies use and share them. The analytic approach also considered other information currently available that might be of value if shared. Input was solicited from each Partner Agency and reflected in the report and its recommendations.

The factual basis of this report is drawn from the data provided by the Partner Agencies in response to the CJCC's 2014 online survey, meetings with various representatives of the Partner Agencies, documentation provided on the collection and use of mental health data, and from publicly available information.

## *1.4 Summary of Recommendations*

### *1.4.1 Comprehensively Automate MPD MHI Collection and Sharing*

As a community police force, the Metropolitan Police Department ("MPD") has frequent interactions with the general public and its officers interact daily with individuals who have mental health needs. Although the MPD keeps records of its interactions with the public, only a fraction of that information is routinely shared with the community supervision agencies including: the Court Services and Offender Supervision Agency (the "CSOSA") and the Pretrial Services Agency for the District of Columbia (the "PSA"), or with the DBH. It should be noted that the CSOSA deals with individuals who are post-adjudication, while PSA deals with pretrial defendants who have not yet been adjudicated.

The CSOSA, the PSA and the DBH routinely receive information about individuals who have been arrested by the MPD and who are brought to the Central Cell Block (the "CCB"). This information is used by the CSOSA and the PSA to evaluate whether the individual has violated a condition of release. It is used by the DBH to help ensure continuity of service and provide support between the community providers and the DBH personnel embedded at the DC Superior Court (the "DCSC") as well as at the Department of Corrections (the "DOC").

The MPD generally does not share information with the Partner Agencies concerning its encounters with individuals under community supervision unless that interaction results in an arrest. After they are released from the structured living and treatment environment of incarceration to community supervision and treatment by community-based providers, often individuals with mental health needs experience some deterioration in their mental health over time. This decline is often manifested in behavior that results in encounters with the MPD. Those encounters are red flags for the DBH's community-based mental health providers, but they currently learn of them only if the client self-reports. Sharing this information with the DBH, the CSOSA and the PSA, would provide the opportunity for more timely intervention to try to prevent this decline.

Currently, only a portion of the information gathered by the MPD that would assist the DBH is entered into an information system that could facilitate timely sharing with the Partner Agencies and the DBH. The development of the MPD's new Records Management

System (RMS) presents the opportunity both to electronically record more of the information that the MPD is already gathering and to enhance the electronic sharing of that information.

#### ***1.4.2 Share the CCB Intake List Electronically and in Real-Time***

The arrest and subsequent detention of individuals with mental health needs is a critical event for the individual's wellbeing that should be communicated to the relevant Partner Agencies as soon as possible. The DBH, the CSOSA, the PSA, and the US Marshals Service (the "USMS") all depend on timely receipt of the CCB intake list to properly respond to the arrest of individuals with mental health needs.<sup>3</sup>

For example, when the DBH or the CSOSA know that an individual who has been arrested presents a suicide risk, prompt sharing of this information with the DOC and the other Partner Agencies who will have custody is essential. Likewise, timely notification to the community caseworker and medical providers that an individual has been arrested can allow for continuity of care between the community and institutional providers.

The CCB intake list is currently transmitted from the DOC to the USMS by email in the form of a PDF attachment, which then must be entered manually into the USMS case management system. Although the USMS usually receives the list in advance of the arrival of a prisoner, there have been occasions when it has not. Entering the CCB intake list into a database could enable prompter and more reliable transmission of the information.

#### ***1.4.3 Provide the DOC and the PSA with Better Access to Partner Agency Records***

The DOC and the PSA report that they do not have prompt and comprehensive access to Partner Agency records concerning individuals who are brought to the CCB following an arrest. Although both agencies have thorough intake processes that involve medical and other screenings of individuals, they are largely dependent on self-reporting of mental health needs by individuals. The Partner Agencies, however, will likely possess a substantial quantity of MHI concerning individuals arriving in the CCB who have a history in the criminal justice system. That information is not readily available to the PSA and the DOC, and inevitably results in duplicative screening efforts and raises the possibility that important risks will not be timely identified.

Sharing of more information among the agencies raises issues concerning the governmental functions of the respective agencies and the purposes for which they are permitted to gather MHI. For example, the PSA is an independent entity within CSOSA with its own separate budget and records system. Some of the functions and purposes of the PSA and the CSOSA are the same, such as the oversight of individuals released into the community, arranging for community-based health services, and monitoring compliance with the

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<sup>3</sup> There are multiple agencies that receive the information in the CCB intake list in various forms and at various times. Not all of them are relevant to the scope of this report. Rather, this report specifically addresses the transmission of the intake list from the DOC to the USMS because of the importance of transmitting this information to the Custodial Agencies in a timely manner.

conditions of release. Thus, although the PSA's role is limited to pre-disposition activities, its involvement with diversion programs, such as the Mental Health Community Court (the "MHCC"), gives it similar community supervision responsibilities as the CSOSA, which principally supervises individuals post-conviction.

The high rate of recidivism means that many of the individuals with mental health needs who arrive in the CCB and become the responsibility of the DOC and the PSA are already under the supervision of the CSOSA. The CSOSA possesses extensive MHI records concerning the individual, including records provided from the BOP, but these are not available to the PSA when the PSA sets out to recommend a diversion program or treatment for a recidivist with mental health needs. Nor are they routinely shared electronically with the DOC while the DOC has the recidivist in custody.

Providing the PSA and the DOC access to the CSOSA's more extensive MHI records for recidivists may raise some broader policy considerations regarding the respective agencies' roles. Under the Privacy Act, the PSA and the CSOSA may need to amend the scope of the Routine Uses of information that they publish in the Federal Register. It is also possible that advocates for individuals with mental health needs would object to those agencies having automatic access to an individual's MHI because it might result in cognitive bias that would impact how the individual is treated by the DOC, or the nature of the PSA's recommendations for diversion and disposition.

#### ***1.4.4 Ensure a HIPAA-Compliant Process at the MPD and the USMS for Access to MHI (For Individuals in Custody, Not Employees)***

Under both HIPAA and the DC Code, the MPD and the USMS have similarly broad rights to access MHI for individuals in their custody as correctional institutions like the DOC and the BOP. The MPD and the USMS do not need the individuals' entire medical record and history, but they do need timely access to key MHI datapoints such as suicide risk, necessary medical treatment or medication requirements. Sharing of necessary MHI with the MPD and the USMS would be permissible under HIPAA's Privacy Rule, but the electronic transmission and maintenance of such information must comply with HIPAA's Security Rule. To receive MHI electronically, the MPD and the USMS need a process that complies with HIPAA's standards for protection of the information.

#### ***1.4.5 Share USMS Records with Other Custodial Agencies Electronically***

The USMS has custody of individuals while they are at the courthouse to appear before a judge. It has a screening process at intake that is designed to help prevent prisoners from harming themselves or others, and its officers have the opportunity to observe individuals in its custody. Behavioral risks identified by the USMS are documented on a form, USM 130 Prisoner Custody Alert Notice, and that data is entered into the USMS' internal database. That information is, however, not currently shared electronically with other Partner Agencies when the individual is returned to their custody.



#### ***1.4.6 Share the Safety-Related MHI Datapoints with Custodial Agencies Automatically and Electronically***

A common concern voiced by all of the Partner Agencies who have physical custody of individuals with mental health needs, (i.e., the DOC, the BOP, the USMS, and the MPD), is the timeliness of the flow of safety-related MHI to them. The current manual methods of information sharing present the risk that the delivery will fail or that the MHI will not be assimilated in a timely manner. The current methods are also vulnerable to the extent that they are inquiry-based and require human intervention to inquire about relevant records in other agencies' possession.

Automated transmission between electronic record systems could help ensure more timely and reliable sharing of the key MHI datapoints. Automated transfers of data can also allow for the transfer of warning flags that require acknowledgement directly into the receiving system.

The MPD, the DOC, the USMS, and the BOP, are all expressly authorized by both HIPAA and the DC Code to receive MHI concerning an individual in their custody without the individual's consent. There is, therefore, no apparent Privacy Rule reason why necessary MHI cannot be transferred electronically before or at the time of the physical transfer of custody.

#### ***1.4.7 Designate a Centralized Database to Maintain and Share MHI***

Several of this report's recommendations suggest the use of electronic information systems to automate and expedite the sharing of MHI between the Partner Agencies. The Partner Agencies and the DBH should consider developing a central MHI database that maintains at least the key MHI datapoints. The system should be capable of automated transfers, real-time or same-day updates, and storage of electronic medical records. Determination of where a MHI database should be hosted and maintained will require a more in-depth examination of the IT capabilities of the various agencies. There are several existing information systems that may be suitable.

## SECTION 2: TECHNICAL APPROACH

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*This section outlines BDA Global's technical approach to collecting and analyzing information on Mental Health Information Sharing.*

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### 2.1 Background

The CJCC is an independent DC agency dedicated to continually improving the administration of criminal justice in the District. Established in 2001 by the City Council, the CJCC's mission is to serve as the forum for identifying issues and their solutions, proposing actions, and facilitating cooperation that will improve public safety and the related criminal and juvenile justice services for DC residents, visitors, victims and offenders.

The CJCC draws upon local and federal agencies and individuals to develop recommendations and strategies. Specifically, the CJCC is committed to: promoting continuous improvements within criminal justice agencies in the District; facilitating systemic changes in the criminal justice system through shared commitment and collaboration; providing a forum for stakeholders to address the District's longstanding and emerging public safety issues; and increasing communication among criminal justice agencies to foster efficiency and maximize available resources.

### 2.2 Key Stakeholders

#### *2.2.1 Substance Abuse Treatment and Mental Health Services Integration Taskforce*

In 2006, the CJCC created the Substance Abuse Treatment and Mental Health Services Integration Taskforce ("SATMHSIT") to better serve District residents who are involved with substance abuse treatment, mental health services and the criminal justice system. The Taskforce's primary focus is to improve treatment options available to offenders, ex-offenders and defendants with mental illness and/or co-occurring substance abuse disorders. The goals of the SATMHSIT are to: increase opportunities and improve capacity for diversion of mentally ill defendants from the criminal justice system; link citizens returning from incarceration to mental health services and substance abuse treatment; decrease recidivism by individuals who have completed treatment programs and; improve aftercare opportunities for residents of the District who have mental health or co-occurring mental health and substance abuse disorders.

#### *2.2.2 Interagency Research Advisory Committee*

The Interagency Research Advisory Committee ("IRAC") serves as an advisory board to the CJCC's Statistical Analysis Center ("SAC") and supports the SAC's efforts to conduct rigorous research to inform decision-making in the District's criminal and juvenile justice systems. Established in 2001, the SAC's mission is to identify activities and operations that can improve the administration of justice in the District by applying the highest level of scientific rigor and objectivity to the study of juvenile and criminal justice policies, programs and practices. The SAC aims to produce empirical research, evaluation and analysis that informs stakeholders and enhances decision-making in the District. Accordingly, the IRAC is the authority that empowers the SAC to collect and analyze Partner Agency's

administrative data, to the extent allowed by law, regulation, court order and agency policy. The mission of the IRAC is to monitor the implementation of appropriate recommendations from commissioned research studies. In line with this mission, in February 2014, IRAC established data-sharing and inter-agency collaboration as a priority research topic.

## *2.3 Scope*

The review addresses the needs of eleven member agencies of the CJCC, referred to in this report as the “Partner Agencies.”<sup>4</sup> These agencies serve the public in the District through various aspects of the criminal justice system and they routinely and frequently encounter individuals with mental health needs. The Partner Agencies are:

1. District of Columbia Department of Corrections (DOC);
2. Superior Court of the District of Columbia (DCSC);
3. Office of the Attorney General for the District of Columbia (OAG);
4. District of Columbia Metropolitan Police Department (MPD);
5. Pretrial Services Agency for the District of Columbia (PSA);
6. United States Marshals Service (USMS);
7. Court Services and Offender Supervision Agency for the District of Columbia (CSOSA);
8. Office of the United States Attorney for the District of Columbia (USAO);
9. Public Defender Service for the District of Columbia (PDS);
10. United States Parole Commission (USPC); and,
11. United States Bureau of Prisons (BOP)

The Partner Agencies’ needs for MHI concerning individuals in the criminal justice system vary in accordance with the differing roles the agencies play. This report attempts to identify the information that the Partner Agencies need, and other available information that may be helpful to them, in performing their respective functions.

### *2.3.1 Mental Health Information*

Throughout this report, we refer to the sharing of mental health information (“MHI”). Our review of the purposes for which each Partner Agency requires MHI has identified the following five key points of safety-related information:

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<sup>4</sup>There are three other members of the CJCC who are not the subject of this report as they do not interact directly with individuals in the adult criminal justice system. These are the Office of the Mayor, the City Council, and the Department of Youth Rehabilitation Services.

1. the risk that the individual will attempt suicide or otherwise cause self-harm;
2. the risk that the individual will attempt to cause harm to others;
3. a diagnosis of serious mental illness;
4. essential medical treatment; and
5. essential medications.

These five datapoints may be considered the minimum MHI that should be available to the Partner Agencies, especially those who take physical custody, as they encounter an individual in their respective phase of the criminal justice system. The review also sought to identify other relevant MHI that is currently gathered and maintained by the Partner Agencies that could be of value if shared with other partners.

In addition to working with the Partner Agencies, we worked with the DBH to understand how it interacts with those agencies to serve individuals with mental health needs who find themselves in the criminal justice system. The discussion with the DBH has been limited to its work with adult clients who are in the criminal justice system following arrest.<sup>5</sup> Of course, the DBH serves a much broader population in DC than this specific group, and its public service role is not limited to the criminal justice system. The DBH also serves individuals who have never encountered the criminal justice system or who are involved in the system long before or after they were DBH clients. Indeed, the membership of these different client groups is dynamic, and individuals are constantly moving between the various groups. Although the DBH may have interactions with an individual both while the individual is in the criminal justice system and also in other contexts, the means by which the DBH serves individuals within the criminal justice system is sufficiently distinct that it is possible to consider the DBH's activities solely within that context.

### *2.3.2 Substance Abuse Treatment Information*

When considering information sharing, it is important to distinguish between MHI and information concerning individuals in substance abuse treatment ("SAT") programs. Individuals in SAT programs constitute a substantial percentage of the individuals with mental health needs who are involved in the criminal justice system. As discussed more fully below, federal regulations published at 42 CFR Part impose strict limitations on the disclosure of information concerning an individual's participation in a treatment program that receives federal assistance. These restrictions are greater than those imposed by HIPAA and the DC Code. The review of the information needs of the various agencies indicates that the heightened privacy standards for SAT information need not be a significant obstacle to

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<sup>5</sup> All of the individuals with mental health needs with whom this report is concerned are in the criminal justice system because they were arrested. The review acknowledges that certain individuals who are arrested are subsequently released when charges are dismissed or if no charges are brought. Some of those may have mental health needs. Once the charges are dismissed, the individual is no longer involved in the criminal justice system. Accordingly, notwithstanding their brief interactions with the criminal justice system, those individuals are not addressed in this report. Likewise, this report does not address the individuals who are transported to a mental health institution by the MPD in lieu of an arrest.

the flow of necessary information among the relevant Partner Agencies. Accordingly, information concerning an individual's participation in a SAT program is not essential safety-related MHI for the Partner Agencies. The five key MHI datapoints are safety-related and do not encompass the fact an individual may be participating in a covered treatment program.

### ***2.3.3 Juvenile Justice System***

The scope of the review of the criminal justice system's needs for mental health information was limited to adults in the system and did not include the juvenile justice system. While many of the Partner Agencies provide similar functions with regard to juveniles, the juvenile system is sufficiently distinct in terms of its legal framework and its operational needs that it requires separate examination and consideration.

### ***2.3.4 DC Inmates of BOP Facilities***

The BOP has custody of individuals convicted of crimes in the District who have been sentenced to serve time in a correctional institution. The analysis for this report included an examination of the sharing of MHI with and by the BOP when those individuals are committed to the custody of the BOP and when they return to the District to be released to community supervision. For a variety of reasons, during the period of their incarceration in the federal prison system, inmates from the District may be transferred to and from multiple federal facilities located in various jurisdictions. The analysis performed did not include the sharing of MHI concerning these individuals as they move among the federal facilities.

### ***2.3.5 Civil Matters***

The CSOSA also uniquely monitors individuals who have Civil Protection Orders ("CPOs") in collaboration with the Attorney General's Office for the District of Columbia ("OAG"). To perform those responsibilities, the CSOSA may encounter many of the same information sharing needs and obstacles as those that are the subject of this report. This report, however, is focused only on individuals with mental health concerns who are in the criminal justice system and not those involved in civil proceedings.

### ***2.3.6 Other Health Information***

Finally, while the focus of the report is on mental health needs and the information the Partner Agencies require to meet them, much of this information is not inherently different from other types of health or personal information that the District's agencies maintain regarding individuals under their jurisdiction. It is subject to the same privacy and security regulations under HIPAA and the Federal Privacy Act as MHI. Thus, many observations or suggestions in this report may be applicable to the use and sharing of other types of health information. It is potentially as important for the DOC or the BOP to promptly receive information concerning an individual's need for treatment or medication for diabetes, epilepsy or heart disease as it is for them to receive MHI.

## *2.4 General Methodology*

The objective of this study was to conduct a comprehensive review of the MHI sharing needs and practices of the Partner Agencies to try to identify vulnerabilities in the current system and opportunities for enhancement. For each of the Partner Agencies, the report seeks to identify the key MHI datapoints that the agency needs to perform its respective functions, the source of that information, the recordkeeping system that maintains it, and the process by which it is shared with other agencies. To identify further opportunities for information sharing, BDA Global reviewed the various types of information gathered by the agencies to try to identify information that one agency may have that would be of value to another. BDA Global also explored opportunities for the Partner Agencies to share such information in a way that is both timely and compliant with information privacy and security laws.

BDA Global sought input from each of the Partner Agencies and the report seeks to acknowledge their concerns and as much as possible reflect their differing perspectives. It is important to note that while specific opportunities for enhancement are identified in this report, further review and consideration will be necessary to determine the most effective means of implementation.

The factual basis of this report is drawn from several sources, including:

- a) the data provided by the Partner Agencies in response to the online survey conducted by the CJCC in 2014;
- b) the information provided in the course of meeting with various representatives of the Partner Agencies;
- c) documents provided by those agencies and by the CJCC; and,
- d) information that is publicly-available on the Partner Agency websites and elsewhere.

This report is not an audit of the Partner Agencies' operations, but instead focuses on the gathering of primary data to develop findings and recommendations tailored to improve the sharing of MHI between Partner Agencies. The report seeks to (a) summarize the agencies' current use of and need for MHI and (b) identify potential opportunities for enhancement through the modification of business practices or better use of technological resources. Whether recommendations or suggestions should be pursued, and how they might be used, is a matter for further consideration by the CJCC and its members.

## *2.5 Technical Approach*

### *2.5.1 Review of Prior Work Product*

#### *2.5.1.1 2012 Vera Study*

The 2012 Vera Study (“Vera Study”) contains findings from the Vera Institute of Justice’s (“Vera”) District of Columbia Forensic Health Project that are directly relevant to this project. Specifically, the Vera Study examined the mental health needs of individuals arrested in the District with the aim of providing criminal justice and health agencies with information to improve the delivery of mental health services to them. To achieve this, the Vera Study analyzed administrative data, for the years 2006 through 2011, that was supplied by five of the Partner Agencies.<sup>6</sup>

The Vera Study posed two critical inquiries: (1) among the population arrested in the District which people have mental health needs, and (2) when this population comes in contact with relevant federal and local criminal justice agencies, are the agencies recognizing their mental health needs when they have the opportunity to do so? A key finding of the report was that criminal justice agencies often failed to identify the mental health needs of the people they encountered. For example, of the people with mental health needs that came in contact with probation or pretrial services nearly half (46 percent) were not identified as having a mental health need by those agencies.

The Vera Study identified several gaps in information sharing that are relevant here:

- Roughly 33% of individuals arrested in the District have some indication of a mental health need.
- Among those with a mental health need, 83 percent were known to have such a need by at least one criminal justice agency, however the DMH was aware of only 59 percent.<sup>7</sup>
- There is enormous potential to improve speed and efficiency of referral between agencies, particularly a potential for data-sharing to increase identification of mental health needs, and improved communication between mental health and criminal justice agencies to coordinate provision of treatment.
- For over 66 percent of participants identified with a mental health need, either the DMH or the DOC was the first agency to identify those needs, while the PSA was the first agency to identify such needs in only 12 percent of cases. Given that (after the MPD) the PSA is likely to be the first criminal justice

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<sup>6</sup> These were: the CSOSA, the DOC, the Department of Mental Health (the “DMH”), the MPD, and the PSA. The study marked the first time that records from these agencies were combined into an aggregate dataset.

<sup>7</sup> DMH has since merged with the Addiction Prevention and Recovery Administration to become the Department of Behavior Health (DBH).

agency that individuals come in contact with, this low rate of first identification highlighted an untapped early opportunity for detection of mental health needs.

- Participating agencies identified the mental health needs for fewer than half of their respective index clients who may benefit from services, including many with serious conditions.

The Vera Study produced two critical recommendations: (1) it urged relevant agencies to capitalize on opportunities to identify among participants in the District's criminal justice system which individuals would benefit from mental health services, and (2) it called on agencies to facilitate continuity of treatment for those with mental health needs as they move among the various agencies.

Particularly relevant to this report, the Vera Study identified a need to: improve and leverage agencies' internal data systems; increase interagency communication; and initiate targeted information-sharing initiatives between criminal justice agencies and the DMH. Lastly, the Vera Study emphasized the importance of connecting participants in the District's criminal justice system with community mental health services as they transition out of contact with criminal justice agencies.

#### *2.5.1.2 CJCC Online Survey Responses*

In preparation for the relevant agency interviews, BDA Global reviewed the various agencies responses to the online survey conducted by the CJCC in November 2014 ("CJCC Survey"). The Partner Agencies that responded to the survey were: the CSOSA, the DBH, the DCSC, the DOC, the MPD, the Office of the Attorney General (the "OAG"), the PSA, the USMS, and the United States Parole Commission (the "USPC"). The DBH and Unity Healthcare ("Unity"), the principal provider of services to the DOC, also provided responses.

The survey asked responding agencies to provide numerous categories of information. Survey inquiries included:

- the number of individual records stored in the respective agency's database;
- the nature of agency's database management system;
- whether there are data collection or reporting processes established and documented in the agency;
- what (if any) relevant information is captured by the agency data system;
- whether the agency is a source agency and/or holding agency of the listed information;
- what information is shared by other agencies;
- which other agencies information is shared with;



- the reasons why any information is not shared;
- the means by which data is exchanged with other agencies.

Survey responses varied significantly and illustrated the diverse policies, goals and operational processes of each of the polled Partner Agencies as well as DBH and Unity.

### 2.5.2 *Categorization of Agencies by Function*

This report examines the purposes for which each Partner Agency needs MHI. Accordingly, the agencies can be grouped into three different categories depending on their function within the criminal justice system: 1) Custodial, 2) Dispositive, and 3) Supervisory.

**Custodial:** The agencies that take physical custody of individuals and are responsible for providing for their safety and medical needs, including the MPD, the DOC, the USMS, and the BOP.

**Dispositive:** Partner Agencies that are responsible for the disposition of the criminal charges against the individual, and which require MHI for the purpose of determining the appropriate action, including DCSC, the OAG, the US Attorney’s Office for the District of Columbia (the “USAO”), the USPC, and the Public Defender Service for the District of Columbia (the “PDS”).

**Supervisory:** Partner Agencies responsible for supervising individuals who have been released into the community on bail, on parole, or pursuant to the terms of a diversion agreement that provides for the individual to seek mental health treatment, including the CSOSA and the PSA.

These three categorical labels are used throughout the rest of this report.

### 2.5.3 *Examination of Relevant Legal Standards*

An essential aspect of any consideration of the Partner Agencies’ MHI-sharing practices is an examination of the regulatory framework in which each agency operates. The District’s criminal justice system is a hybrid of federal and local agencies that work together in the District under distinct regulatory regimes. The federal Partner Agencies (the USAO, the BOP, the CSOSA, the PSA, the USMS and the USPC) are not governed by the DC Code. The non-federal Partner Agencies (the MPD, the DOC, the OAG, and the DCSC) are not governed by the federal Privacy Act. The PDS is an independent agency that is not subject to either the Privacy Act or the DC Code. All of the Partner Agencies, however, are potentially subject to HIPAA.

### 2.5.3.1 *The Privacy Act*

The Privacy Act of 1974 (“Privacy Act”), regulates the collection, maintenance, use, and dissemination of personal information by federal executive branch agencies.<sup>8</sup> It is applicable only to the federal Partner Agencies and it governs how they collect and share MHI regarding individuals in the DC criminal justice system.

The statute seeks to balance the government’s need to maintain personal information against the individual’s right to privacy. To achieve this, it gives individuals the right to inspect the information concerning them that is contained in government records and the right to correct inaccurate information in those records. It also restricts how and when an agency may use and disclose personally identifiable information in its possession.

The Privacy Act protects citizens and lawful permanent residents<sup>9</sup> and applies to government records that personally identify an individual.<sup>10</sup> The term “Agency” is defined in the statute. It includes any department or other establishment of the executive branch and any independent regulatory agency.<sup>11</sup> The federal Agency Partners governed by the Privacy Act are the USMS, the BOP, the USAO, and the CSOSA.<sup>12</sup>

The collection of information concerning an individual by a federal agency is restricted and the agency may “maintain in its records only such information about an individual as is relevant and necessary to accomplish a purpose of the agency required to be accomplished by statute or by executive order of the President.”<sup>13</sup> Thus, a Partner Agency may collect only the MHI that is necessary to fulfill that agency’s specific purpose. The purpose of the USMS, for example, is significantly different to that of the BOP and, therefore, the BOP is authorized to collect different categories of information concerning an individual than is the USMS.

The Privacy Act also governs the process of collecting information. When a federal agency gathers information it must:

“inform each individual whom it asks to supply information, on the form which it uses to collect the information or on a separate form that can be retained by the individual – (A) the authority (whether granted by statute, or by executive order of the President) which authorizes the solicitation of the information and whether disclosure of such information is mandatory or voluntary; (B) the principal purpose or purposes for which the information is intended to be used; (C) the routine uses which may be made of the information as published pursuant to paragraph (4)(D) of

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<sup>8</sup> 5 U.S.C. § 552a

<sup>9</sup> 5 U.S.C. § 552a(a)(2)

<sup>10</sup> 5 U.S.C. § 552a(a)(4)

<sup>11</sup> 5 U.S.C. § 552a(1)

<sup>12</sup> There are four law enforcement agencies in the District with the power to arrest: the MPD, the Secret Service, the Capitol Police and the Metro Police. Among these, only the Secret Service is an executive branch federal agency subject to the Privacy Act. For the purposes of this review, however, the MPD is the only police force relevant to the exchange of MHI with other Partner Agencies in DC.

<sup>13</sup> 5 U.S.C. § 552a(e)(1)

this subsection; and (D) the effects on him, if any, of not providing all or any part of the requested information.<sup>14</sup>”

The use of the information collected is generally limited to the stated purposes for which it is collected. This has important implications for the sharing of information with other agencies that have purposes which are different from the agency that originally collected the information.

In addition to restricting the collection of information, the Privacy Act restricts its disclosure. Subject to specific enumerated exceptions, federal agencies may not disclose personal information from their records without the consent of the individual.<sup>15</sup> There are twelve exceptions to the requirement of consent for disclosure. Of those, the following are relevant to sharing MHI:

#### *For A Published Routine Use*

An Agency may disclose information regarding an individual without that person’s consent “for a routine use as defined in subsection (a)(7) of this section and described under subsection (e)(4)(D).”<sup>16</sup> Subsection (a)(7) defines the term “Routine Use” to mean “with respect to the disclosure of a record, the use of such record for a purpose which is compatible with the purpose for which it was collected.” Subsection (e)(4)(D) requires Federal Register publication of “each routine use of the records contained in the system, including the categories of users and the purpose of such use.” The Routine Uses published by the federal Partner Agencies prescribe the scope of any disclosures of MHI to any of the other Partner Agencies. Relevant provisions will be discussed in the sections of this Report addressing the Partner Agencies individually.

#### *In Response to a Law Enforcement Request*

An Agency may disclose information about an individual without consent “to another agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States for a civil or criminal law enforcement activity if the activity is authorized by law, and if the head of the agency or instrumentality has made a written request to the agency which maintains the record specifying the particular portion desired and the law enforcement activity for which the record is sought.”<sup>17</sup>

#### *To Protect the Health or Safety of an Individual*

An Agency may disclose information “to a person pursuant to a showing of compelling circumstances affecting the health or safety of an individual if upon

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<sup>14</sup> 5 U.S.C. § 552a(e)(3)

<sup>15</sup> 5 U.S.C. § 552a(b)

<sup>16</sup> 5 U.S.C. § 552a(b)(3)

<sup>17</sup> 5 U.S.C. § 552a(b)(7)

such disclosure notification is transmitted to the last known address of such individual.”<sup>18</sup>

### *In Response to a Court Order*

An Agency may disclose information “pursuant to the order of a court of competent jurisdiction.”<sup>19</sup>

Finally, the Privacy Act requires an Agency to keep a record of “the date, nature, and purpose of each disclosure . . . and the name and address of the person or agency to whom the disclosure is made.”<sup>20</sup> The Agency must also “establish rules of conduct for persons involved in the design, development, operation, or maintenance of any system of records, or in maintaining any record, and instruct each such person with respect to such rules and the requirements of this section[.]”<sup>21</sup>

### *2.5.3.2 The Health Insurance Portability and Accountability Act*

HIPAA regulates the use and disclosure of protected health information (“PHI”). It is important to note that not all information concerning an individual is PHI. Health information created, obtained or maintained by a covered entity is protected. HIPAA governs the circumstances in which a “covered entity” can disclose PHI, regardless of whether the entity is a federal or non-federal agency, or whether it is a governmental or private entity. To determine whether PHI can be shared, a threshold question is whether the Partner Agency is a covered entity that is subject to HIPAA’s standards.

### *What is Protected*

Health information is expressly defined in the statute and does not encompass all information concerning a person’s health. Health information protected by HIPAA is “any information . . . that-- (A) *is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.*” Thus, for example, information concerning an individual’s health that is observed by, or self-reported to, a police officer, a lawyer, or any other person who is not a healthcare provider, is not protected by HIPAA.

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<sup>18</sup> 5 U.S.C. § 552a(b)(8)

<sup>19</sup> 5 U.S.C. § 552a(b)(11)

<sup>20</sup> 5 U.S.C. § 552a(c)(1)

<sup>21</sup> 5 U.S.C. § 552a(e)(9)

### *Who is Restricted*

A “covered entity” is defined in HIPAA as “(1) a health plan; (2) a health clearinghouse; or (3) a health-care provider who transmits any health information in electronic form in connection with a transaction.”<sup>22</sup> Although the Partner Agencies may not be covered entities for all purposes, to the extent that they provide health services to individuals in the criminal justice system, or contract with vendors to do so, they can be covered entities governed by HIPAA.

### *When Can Information Be Shared Without Consent*

Whether, and how, a Partner Agency can share PHI depends on whether the agency is a covered entity, whether the recipient is also a covered entity, the purpose for which the information is shared, and the scope of any permission granted to allow the disclosure.

The general rule is that an “authorization” is required to obtain PHI from a covered entity. Any written consent obtained from an individual to authorize the potential future disclosure of PHI must specify the purposes for which such disclosure may be made and the persons to whom the information may be disclosed. In most circumstances, the individual retains the right to revoke the consent at any time. There are, however, significant exceptions to the consent requirement that are directly relevant to the question of collaboration among the Partner Agencies.

HIPAA does not require an authorization for a provider to share PHI with another provider when the purpose is to deliver treatment to the individual, or to perform other healthcare operations related to that treatment. Other circumstances when authorization is not required include emergencies where a provider has first made reasonable efforts to obtain consent.<sup>23</sup> HIPAA also does not require consent to disclose PHI for specified purposes where sharing information has been deemed to be in the public interest. These include disclosures for judicial proceedings, for specified law enforcement purposes, and to comply with reporting obligations mandated by other statutes.<sup>24</sup>

Significantly, HIPAA expressly permits the sharing of PHI with a correctional institution that has custody of the individual without consent. Moreover, a correctional institution is broadly defined to include:

[A]ny penal or correctional facility, jail, reformatory, detention center, work farm, halfway house, or residential community program center operated . . . for the confinement or rehabilitation of persons charged with or convicted of a criminal offense or other persons held in lawful custody [such as] persons committed

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<sup>22</sup> 42 CFR, subpart E

<sup>23</sup> 45 CFR §164.512(f)(2)

<sup>24</sup> 45 CFR §164.512(j)

to mental institutions through the criminal justice system, witnesses, or others awaiting charges or trial.<sup>25</sup>

The USMS and the MPD are covered by this definition of correctional institution and they do not need the consent of an individual in their lawful custody to obtain health information they need to ensure that individual's safety and welfare.

#### *Minimum Disclosure*

HIPAA generally requires that a Covered Entity disclose only the "minimum information necessary for the allowed purpose," and not all of the information they have concerning the individual. There are important exceptions relevant to this report. Minimum disclosure is not required when providers are sharing information to facilitate treatment, or when information is being disclosed for a reason required by law, or when it is being provided to the individual or the individual's representative.

#### *Information Security*

HIPAA establishes a "Privacy Rule" and a "Security Rule." The Privacy Rule sets the standards by which PHI can be disclosed. The Security Rule establishes the security requirements for information systems that store or transmit PHI.<sup>26</sup> As discussed further in this report, it appears that the principle HIPAA-related obstacle to the sharing of MHI among the Partner Agencies stems not from the provisions of the Privacy Rule discussed above, but from the requirements of the Security Rule which mandates security standards for the storage and transmission of PHI.

HIPAA's Security Rule requires Covered Entities to implement policies and procedures to prevent, detect, contain, and correct security violations. Access to records contained in information systems must be restricted to designated employees who are specifically trained in HIPAA's requirements. Technical security measures must be implemented to guard against unauthorized access to electronic PHI that is transmitted over an electronic communications network.<sup>27</sup>

#### **2.5.3.3      *Substance and Alcohol Abuse Treatment***

An additional set of federal regulations applies to PHI related to substance and alcohol abuse treatment. The regulations set forth at 42 CFR Part 2 apply to:

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<sup>25</sup> 45 CFR §164.501

<sup>26</sup> 45 CFR 164.308

<sup>27</sup> 45 CFR 164.312(e)(1)

*Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any drug abuse prevention function conducted, regulated, or directly or indirectly assisted by any department or agency of the United States[.]*<sup>28</sup>

The restrictions on disclosure apply to any information that would identify a patient as an alcohol or drug abuser and is drug or alcohol abuse information obtained by a federally-assisted program for the purpose of treating alcohol or drug abuse, making a diagnosis for that treatment, or making a referral for that treatment.

Patient consent is required for almost all disclosures.<sup>29</sup> The exceptions relevant to this report are (1) the disclosure of records to medical personnel in case of a medical emergency or (2) to comply with a court order issued upon a showing of good cause and containing “appropriate safeguards against unauthorized disclosure.”

#### **2.5.3.4      *The Mental Health Information Act***

District of Columbia law protects MHI through two statutes. The Mental Health Information Act of 1978 (the “MHIA”) governs the disclosure of MHI by mental health professionals or facilities in the District. The Data-Sharing and Information Coordination Amendment Act of 2010 (the “DICAA”) governs the use and disclosure of health and human services information, including information relating to the mental health of an individual, by a DC “Agency” or its service providers. It is not applicable to the federal Partner Agencies.

Under the DICAA, an Agency is defined as “an agency, department, unit, or instrumentality of the District of Columbia government.”<sup>30</sup> Thus, the Partner Agencies subject to the requirements of the DICAA are the MPD, the DOC, the DCSC, and the OAG. The DBH is also subject to the DICAA. The DICAA does not apply to the disclosure of MHI by federal agencies to DC’s agencies.

The provisions of the MHIA and the DICAA are generally consistent with HIPAA and permit much of the same information sharing among the Partner Agencies as is allowed by HIPAA.<sup>31</sup> Indeed, the DICAA expressly requires that the use and disclosure of health information comply with HIPAA standards.<sup>32</sup> Disclosure is generally “limited to the minimum amount of information necessary to accomplish the purpose of the disclosure.”<sup>33</sup> The MHIA expressly authorizes the disclosure of MHI, without the consent or knowledge of the individual, to Partner Agencies in several circumstances.

#### *To Custodial Agencies*

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<sup>28</sup> 42 CFR 2.1(a)

<sup>29</sup> 42 CFR 2.1(b)(2)

<sup>30</sup> DC Code § 7-242

<sup>31</sup> Generally, HIPAA and 42 CFR Part 2 set a minimum standard for protecting and securing PHI that is often exceeded by state law requirements. DC’s MHIA, however, was amended for the specific purpose of facilitating information sharing by DC’s criminal justice agencies and is largely consistent with the approach taken by HIPAA.

<sup>32</sup> DC Code § 7-242(c)

<sup>33</sup> DC Code § 7-242(d); DC Code § 7-1204.03(b)(2); DC Code § 7-1203.02; DC Code § 7-1203.03(a-1)

The MHIA authorizes mental health professionals to disclose to “a correctional institution or a law enforcement official having lawful custody of an individual mental health information about the individual to facilitate the delivery of mental health services and mental health supports to the individual.”<sup>34</sup> Thus, the Custodial Agencies are unambiguously authorized to receive the information they need to ensure the individual receives necessary mental health services while in custody.

MHI may also be disclosed to “[a]n officer authorized to make arrests in the District of Columbia” if “necessary to initiate or seek emergency hospitalization . . . or to otherwise protect the client or another individual from a substantial risk of imminent and serious physical injury.”<sup>35</sup>

#### *To Dispositive Agencies*

MHI may be disclosed in court proceedings where the individual’s mental health or competence is at issue.<sup>36</sup> It also authorizes a court to order the disclosure of MHI to the extent necessary to “monitor the defendant or offender’s compliance with a condition of pretrial release, probation, parole, supervised release, or diversion agreement[.]”<sup>37</sup>

In addition, MHI may be disclosed to a court with jurisdiction over the individual in a pending criminal proceeding, if “necessary to initiate or seek emergency hospitalization . . . or to otherwise protect the client or another individual from a substantial risk of imminent and serious physical injury.”<sup>38</sup>

#### *To Supervisory Agencies*

In addition to the information provided as a result of court orders, such as conditions of probation or release, MHI may be disclosed to the CSOSA or the PSA if “necessary to initiate or seek emergency hospitalization . . . or to otherwise protect the client or another individual from a substantial risk of imminent and serious physical injury.”<sup>39</sup>

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<sup>34</sup> D.C. Code § 7-1203.05a

<sup>35</sup> DC Code § 7-1203.03(a)(9)

<sup>36</sup> DC Code § 7-1204.01 (Court Ordered Examinations); § 7-1204.03(a)(Court actions)

<sup>37</sup> DC Code § 7-1204.03(b)(1)

<sup>38</sup> DC Code § 7-1203.03(a)(7)

<sup>39</sup> DC Code § 7-1203.03(a)(5) and (6)



## SECTION 3: FINDINGS

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*This section outlines BDA Global's Findings concerning current MHI Needs and Sharing*

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### *3.1 Paths Through the Criminal Justice System*

#### *3.1.1 MHI is Needed at Various Decision Points in the System*

Individuals who enter the criminal justice system encounter the Partner Agencies at various points. When considering these various points it is worth noting how the Sequential Intercept Model has been integrated into DC's criminal justice system. The model provides a conceptual framework to guide the interface between criminal justice and mental health systems involving individuals with mental health needs who come in contact with the criminal justice system.<sup>40</sup> Specifically, the model identifies several key points of interception at which intervention can prevent individuals from either entering or penetrating further into the criminal justice system. The model allows a community to provide diversion of individuals with mental health needs from the criminal justice system to community treatment.<sup>41</sup> The CJCC SATMHSIT's strategic plan was largely based on the sequential intercept model by providing recommendations to improve ways that individuals with mental illness are identified and serviced at every point in the criminal justice system. Specifically, since the plan was released DC agencies have implemented new initiatives including the MDP's Crisis Intervention Officers, the DC Jail Mental Health Unit PSA's Specialized Supervision Unit for individuals with pretrial supervision who have mental health needs, DBH Jail Liaison and CSOSA's Mental Health Supervision Team.

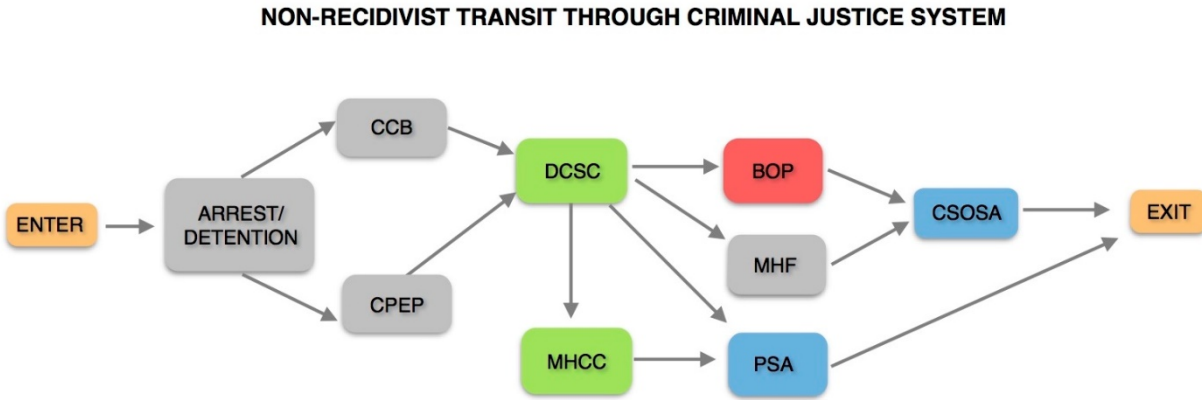
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<sup>40</sup> Jim Parsons, Talia Sandwick. *Closing the Gap: Using Criminal Justice and Public Health Data to Improve the Identification of Mental Illness*. New York: Vera Institute of Justice, 2012.

<sup>41</sup> Mark R. Munetz and Patricia A. Griffin, "Use of the Sequential Intercept Model as an Approach to Decriminalization of People With Serious Mental Illness," *Psychiatric Services* 57, no. 4 (2006): 544-549).

### 3.1.2 Non-Recidivist Progression Through the Criminal Justice System

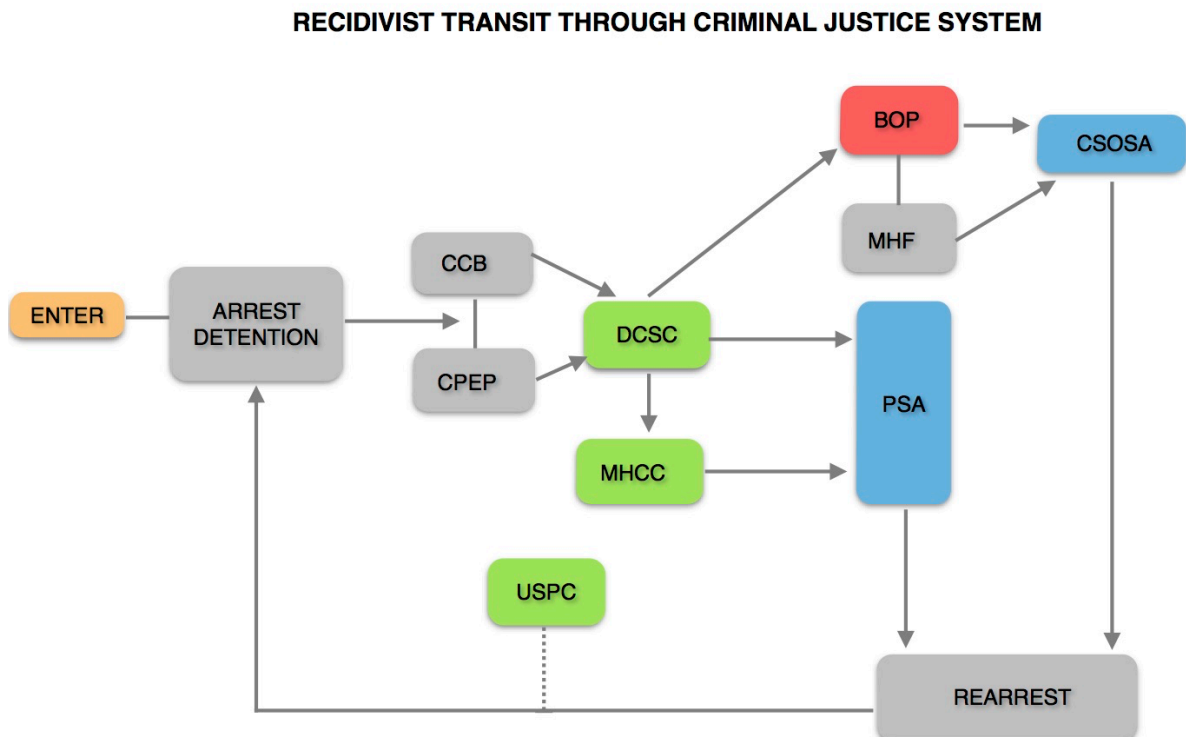
**Figure 1** below illustrates the individual's potential alternative paths through the criminal justice system in the District.



### 3.1.3 Recidivist Cycle In the Criminal Justice System

Many of the individuals who enter the criminal justice system with mental health needs do not permanently leave the system. Instead, they often revert to a cycle of recidivism and keep re-entering the system.

**Figure 2** below illustrates the potential paths of the recidivist.



## *3.2 MHI Needs By Partner Category*

### *3.2.1 The Partner Agencies form Three Sub-Groups*

#### *3.2.1.1 Custodial Agencies:*

The Custodial Agencies (the MPD, the DOC, the USMS, and the BOP) have physical custody of an individual and are responsible for the safety and well-being of that individual, other individuals in their custody, government employees, and members of the public who could be at risk from that individual's behavior. They need to receive safety-related MHI promptly and on a real-time basis. To meet their responsibilities the Custodial Agencies must consider observational information concerning an individual's mental health and behavioral risks provided by police and correctional officers, and by others, even though the observer may not be a mental health professional. Moreover, because Custodial Agencies need to be aware of any potential risks while they have custody, they cannot wait for the delivery of a mental health evaluation or examination report

#### *3.2.1.2 Dispositive Agencies*

The Dispositive Agencies (the DCSC, the OAG, the USAO, the PDS, and the USPC) do not have physical custody of an individual and are not directly responsible for ensuring the safety and wellbeing of the individual or others. Accordingly, and unlike the Custodial Agencies, their MHI needs are not time sensitive. The Dispositive Agencies' MHI needs are also qualitatively different to those of the Custodial Agencies.

The Dispositive Agencies require MHI that is produced by mental health professionals and is subject to examination and validation in the adversarial process. The decision on whether to bring criminal charges, the disposition of those charges, the determination of whether the individual will be incarcerated, referred to a special court, or committed to a mental health facility, and the terms and conditions governing whether and when the individual will be released to the community are all made on the basis of professional evaluations ("Evaluative MHI"). Evaluative MHI is distinguished from Safety-Related MHI in that it does not include the non- professional observations of behavioral risk by police and correctional officers that the Custodial Agencies cannot afford to ignore.

#### *3.2.1.3 Supervisory Agencies*

The Supervisory Agencies (the PSA and the CSOSA) are responsible for supervising individuals who are released into the community subject to conditions imposed by the criminal justice system. They are charged with recommending and monitoring compliance with those conditions. The

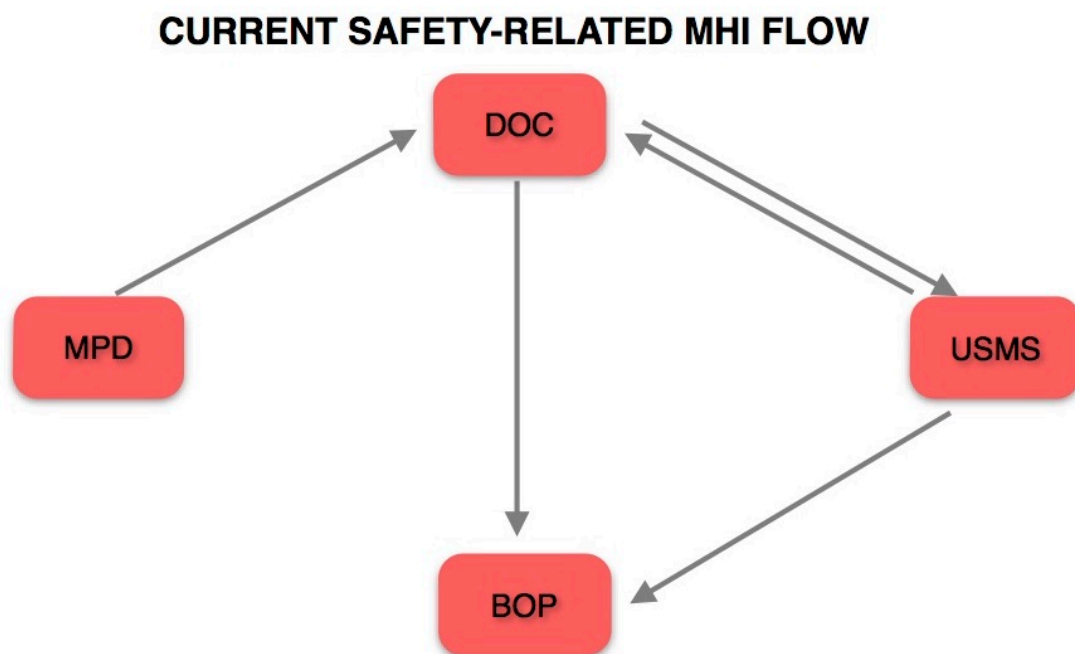
Supervisory Agencies need both safety-related MHI and Evaluative MHI in order to make the most appropriate recommendations and to ensure the necessary mental health services are provided during the period of incarceration, probation or community supervision.

### 3.3 *Agency Operational Processes and MHI Needs*

#### 3.3.1 *Custodial Agencies*

The Custodial Agencies have expressed concerns with vulnerabilities in the current system for sharing information. There are frequent delays in receiving safety-related MHI concerning individuals who are committed to Custodial Agencies. These agencies have unanimously expressed the desire for improvements in MHI sharing.

**Figure 3** below illustrates the flow of safety-related MHI that is currently shared among the Custodial Agencies on a piecemeal basis.



##### 3.3.1.1 *The Metropolitan Police Department*

#### **Operational Process**

The MPD is the District's primary law enforcement agency. It is generally the first agency to come in contact with individuals entering the criminal justice system. The MPD is also often the initial responder to individuals in crisis or with acute mental health needs. The MPD has established detailed procedures governing

how it will respond to an incident involving a person with apparent mental health needs.<sup>42</sup>

Since 2009, the MPD has been working with the DBH and its predecessor the DMH to provide special training to officers to help them identify mentally ill individuals. The MPD, with the assistance of the DBH, has also provided substantial training to a selected group of Crisis Intervention Officers (“CIOs”). When an officer identifies an individual in crisis as having mental health needs, the officer can request that the Office of Unified Command dispatch a CIO to the scene. The MPD can respond to an incident involving an apparently mentally ill individual in several different ways. The MPD can arrest the individual, it can transport the individual to a mental health facility if the individual agrees to seek help, or it can involuntarily transport the individual for a Comprehensive Psychiatric Emergency Program (“CPEP”) evaluation at a mental health facility.

Regardless of the outcome of the MPD’s interactions with an individual with mental health needs, the circumstances of that interaction are documented on a variety of forms that are maintained in the MPD’s records and information systems. An incident that does not result in an arrest is reported on a Form 251. An incident involving an individual experiencing an apparent mental health crisis is reported on a form 251C.<sup>43</sup> A Form FD-12 is used to document the reasons for submitting an individual to a CPEP evaluation.

The PD 163 Form, referred to as the arrest report, includes information relating to the reasons an individual is arrested and contains a text field where an officer can enter a “name alert” such as a risk for suicide. When the MPD delivers an individual to the CCB, a paper copy of PD 163 is given to the DOC intake officer.

Certain information in the PD 163 is input into iLeads, the MPD’s current database, and is then provided to JUSTIS as part of the arrest feed. The complete form, which contains the critically important Name Alerts, is shared with the Partner Agencies only in the form of a PDF file that is distributed through JUSTIS. Sharing Form 163 only in paper form or by PDF requires human intervention to review, analyze the information on the form and input it into the recipients’ systems.

### **MHI Sharing and Needs**

Although it might be helpful for the MPD to know that an individual it encounters is a mental health consumer, the MPD generally responds to incidents based on the circumstances observed by the officer on that occasion. When the MPD takes an individual into custody, however, the MPD needs safety-related MHI, to the extent that it exists, and is in the possession of the other Partner Agencies. For example, if an individual arrested by the MPD was previously identified as presenting a risk of suicide or harm to others while in the custody of the DOC, the BOP or

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<sup>42</sup> See MPD GO-308-04 eff. February 9, 2015

<sup>43</sup> It should be noted that Crisis Intervention Officers (CIOs), who receive specific training from the DBH, share copies of the Form 251C reports with the DBH.

another agency, the MPD can address those concerns appropriately only if it has prompt access to that information.

The timeframe in which the MPD would keep an at-risk individual in its custody is typically limited. Generally, individuals who are arrested are promptly transported to the CCB and turned over to the custody of the DOC. Individuals can, however, be detained by the MPD in Station Cell Blocks, where even a short period in custody without appropriate safety measures can present a risk to the detainee and to MPD officers.

The MPD might also benefit from access to MHI concerning persons under community supervision so that its CIOs can respond in the most appropriate manner when the individual is in crisis. It is likely that advocates for the mentally ill, including those under community supervision, would object to making this information available to the MPD for individuals who are not in MPD's custody because of the possibility of cognitive bias.

### **Technological Resources**

Currently, the MPD uses iLeads as its information management system. MPD also provides certain information into JUSTIS to make it available to specified Partner Agencies. The MPD's iLeads system stores name records of individuals where it is possible to place flags such as: mental health needs, suicidal ideation, or attempted suicide. The current data configurations in iLeads limit the types of information that the MPD can share electronically, but its newly developed Records Management System (RMS) will provide more flexibility. The implementation of a new RMS provides a significant opportunity for broader and timelier information sharing with the Partner Agencies.

#### *3.3.1.2 The United States Marshals Service*

### **Operational Process**

The USMS has physical custody of individuals while at the courthouse, usually while they are waiting to be processed. The USMS holds individuals for a limited amount of time and does not keep them overnight. Individuals are either released by the court or returned to the custody of the DOC.

If an individual is combative or disruptive while in the custody of the USMS, a Marshal may complete a USM 130 Prisoner Custody Alert Notice. The information contained in the USM 130 is manually entered into the USMS's information database, but it is not electronically shared with Partner Agencies. A paper copy of USM 130 is provided to the DOC or other officer taking custody of the individual from the USMS.

## **MHI Sharing and Needs**

Since the USMS has custody of individuals for a limited amount of time, it does not receive MHI on a routine basis or as part of its operational process. While the USMS has an intake process, it does not perform a psychiatric assessment or health assessment. Often, the USMS becomes aware of an individual's mental health needs and risks only when the individual exhibits non-compliant behavior and in response the Marshals' inquire of the individual. On rare occasions, the DOC will deliver an individual who has been in a psychiatric unit or at St. Elizabeth's Hospital and in those circumstances the DOC will inform the USMS that there is a mental health risk. Since the USMS does not have custody overnight, Marshals are not required to provide medical or mental health services or medications to individuals other than in case of an emergency.

The USMS receives information concerning individuals who will be delivered to its custody from the DOC. It rarely generates additional information that could be shared with other agencies.

Currently, the USMS receives two MHI datapoints from the DOC or the PSA, the risk of suicide and essential medications. That information is provided by email or on a paper form delivered with the prisoner. The USMS currently does not have an automated alert system to flag mental health concerns such as a suicide risk and believes that such a system would be beneficial.

## **Technological Resources**

The Justice Detainee Information System ("JDIS") is the USMS information system and is generally intended for internal use. However, some of the information it contains is shared with the BOP. The functions of JDIS are primarily focused on recordkeeping and information used for statistical analysis.

### *3.3.1.3 The Department of Corrections*

## **Operational Process**

The DOC is the agency that operates the adult correctional institutions in the District. It runs the Central Detention Facility ("CDF"), which houses pre-trial prisoners, convicted misdemeanants, and convicted felons who are awaiting transfer to the BOP and the Correctional Treatment Facility ("CTF") which houses female offenders and juveniles being adjudicated as adults.

As part of the DOC's intake process, each individual arriving at the CCB receives a mental health screening by a doctor or nurse practitioner. If an individual does not present with an immediate medical or mental health concern upon arrival at the CCB, a comprehensive medical and mental health assessment is performed within fourteen days. Approximately one third of the individuals who find themselves in the DOC's custody have been diagnosed with serious mental health disorders, such as major depressive disorder, bipolar disorder and schizophrenia. If the intake screening by a doctor or nurse practitioner indicates further

immediate evaluation is necessary the individual is seen within four hours by a mental health clinician and, if psychiatric care is needed, a psychiatrist sees the individual within twenty-four hours.

Individuals arriving at the CCB from a mental health facility are seen by a nurse practitioner and typically will be delivered with a copy of the PD Form 251-C. The information from the PD Form 251-C is manually input into the DOC's electronic medical records system.

The DOC recently initiated a new protocol intended for suicide prevention by which the Shift Lieutenant administers a "Booking Questionnaire" to each inmate. The Shift Lieutenant also reviews the "alert screen" in the agency's Jail and Community Corrections System (JACCS), to determine if the inmate has been flagged as a potential risk for suicide based on current or prior behavior known to the DOC.

Acutely psychotic or suicidal individuals are sent to a special supervision unit or are placed on suicide watch. If an individual in the CCB exhibits signs of a mental health crisis, the DOC may send him to a CPEP facility if treatment at the cellblock is not possible. The majority of individuals are in the DOC's custody for less than three months. Accordingly, mental health services at the DOC focus on stabilization and coordination of follow-up care outside of the DOC.

### **MHI Sharing and Needs**

The DOC receives all five of the safety-related MHI datapoints: risk of self-harm, risk of harm to others, serious mental illness diagnosis, essential medical treatment and essential medications. Of these, the DOC shares mental illness diagnosis, essential medical treatment and essential medications with the BOP, and mental illness diagnosis with the DBH.

The DOC receives MHI primarily through a query process. This means that its staff must contact providers, or access other agencies' databases, to determine whether MHI is available and to request copies. It receives limited information from the DCSC and the MPD when an individual is committed to its custody.

At times, the DOC experiences delays in receiving information because of the time required by the other entity to confirm that the release of information to the DOC is permitted and to prepare paper copies of the files for transfer to the DOC. Likewise, most of the information that the DOC shares is transmitted on paper or via email as scanned attachments. When individuals are referred to St. Elizabeth's hospital after their intake evaluation, the physical files are delivered with the individual to the hospital. Similarly, when a person is transported from CCB to the USMS, critical MHI alerts such as a suicide risk are communicated on paper, a "van sheet," that is delivered with the inmates to the USMS. The DOC is currently unable to share these records in a more efficient and reliable manner because the process is not automated.



## **Technological Resources**

In addition to the JACCS database, the DOC operates an electronic medical record (EMR) system based on GE Centricity. The two systems are housed separately, have different access permission levels, and have different capabilities. JACCS stores information about inmates and has the ability to contain flags such as a suicide alert. Information (such a suicide risk) is synched with an inmate's EMR so there is a continuity of care.

The DOC provides access to information from JACCS to other Partner Agencies through JUSTIS. It does not import data from JUSTIS into JACCS and it uses JUSTIS only on an inquiry and view basis. The DBH, and its contract provider for the CDF, Unity Health Care, have limited access to the Centricity EMR system.

### *3.3.1.4 The Federal Bureau of Prisons*

## **Operational Process**

The BOP is responsible for the administration of the prison system for the District. The BOP holds prisoners convicted of felonies under the District's law. While the BOP receives the Pretrial Service Report (PSR) from the PSA and Presentence Investigation (PSI) report from CSOSA, and potentially more recent observations made by the USMS, this data is examined solely from a historical perspective. As part of its intake process, the BOP uses a "Medical Calculator" which considers the inmate's health conditions, including mental health needs, to determine the most appropriate institution to which to assign the inmate. Upon arrival at an institution, new inmates receive a screening by staff from the Health Services Department and the Psychology Services Department. The intake process and the Medical Calculator are designed to ensure that the BOP identifies acute mental illness at an early stage through a mental health screening process.

## **MHI Needs and Sharing**

Notwithstanding the fact that the BOP conducts its own medical screenings, it would be useful for BOP to receive a detailed medical history record for all individuals committed to its custody. That would include datapoints such as whether the individual was recently hospitalized.

An offender released from the BOP subject to conditions is either: (1) released to the custody of CSOSA for community supervision; (2) placed on parole and supervised by CSOSA; or (3) committed to a halfway house within the care of the BOP through a contracted facility. Accordingly, prior to and as a condition of such release, the BOP obtains a signed consent from inmates to share relevant information with CSOSA and the community supervision treatment contractors. The BOP's release process requires advanced coordination with CSOSA and its providers and generally provides for the transfer of relevant information and records prior to the inmate's release.

## **Technological Resources**

The two databases used by the BOP relevant to MHI are SENTRY and the Bureau's Electronic Medical Record system (BEMR).

SENTRY is the BOP's primary mission support database. This real-time information system contains a wide variety of data on inmates including demographic data and disciplinary data.

The BEMR system is used to collect, store and maintain electronic medical records. The system stores data such as an inmate's medical and psychological history and ongoing data and related informational records.<sup>44</sup> There is a master file for each individual and it includes: records of diagnoses, individual or group therapy, evaluations, suicide risk assessments and treatment program participation. Significant notes are kept, and may include details on suicide risk assessments, mental health needs, medication and diagnosis. The BEMR system is available to clinicians within the BOP but not to outside parties. Certain CSOSA staff have access to some of the information stored in SENTRY.

### ***3.3.2 Supervisory Agencies***

The Supervisory Agencies report that they would benefit from more timely flow of and comprehensive sharing of various forms of information. The PSA would be better situated to make recommendations as to diversion programs and mental health services for recidivists if it had better access to the MHI maintained on those individuals by the DOC, the BOP, and the CSOSA. Both CSOSA and the PSA could provide more effective community-based services if they received timely information from the MPD concerning non-arrest incidents involving individuals under their supervision.

#### ***3.3.2.1 The Pre-Trial Services Agency***

### **Operational Process**

The PSA is an independent entity within the CSOSA. The PSA interacts with individuals in the criminal justice system for the period from arrest through arraignment and through trial and sentencing. In the time between arrest and arraignment, the PSA's diagnostic unit screens individuals to assess criminal risk and to determine whether the individual needs mental health services. If the PSA determines that there may be a need a mental health services, it refers the individual to the DBH mental health liaison assigned to the CCB for a mental health assessment.

## **MHI Sharing and Needs**

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<sup>44</sup> The Psychology Data System, formerly a separate system, is being integrated into BEMR.

The PSA prepares a Pretrial Service Report (PSR) that addresses any mental health issues or suicide risks. In general, the PSA places participants in treatment primarily following a court order. Currently, the PSA shares two of the key MHI datapoints with other Partner Agencies. Risk of harm to others is shared with the DBH, the DOC, the MPD and the DCSC. Essential medical treatment is shared with the DBH and the DCSC.

It would be useful for the PSA to have information about individuals who arrive at the CCB who are already in the care of the DBH. If the DBH could process the list of individuals brought to the CCB and flag those who are DBH clients that would be helpful to taking appropriate safety measures, particularly when the DBH is aware that the individual is a suicide risk.

#### *3.3.2.2 The Court Services and Offender Supervision Agency*

### **Operational Process**

The Court Services and Offender Supervision Agency (“CSOSA”) is a federal, executive branch agency, which performs the offender supervision function for DC in coordination with the DCSC. When an individual is first committed to the CSOSA, the agency may be informed through a Presentence Investigation (“PSI”) report or a Transitional Intervention for Parole Supervision (“TIPS”) report, completed by CSOSA’s Diagnostic and Investigations staff, or direct communication with BOP staff, that the individual being released may require supervision by the mental health unit, in which case the person would be sent to the DBH for an evaluation. CSOSA also receives information from the BOP concerning mental health treatment received by the individual while incarcerated. The CSOSA and the BOP closely coordinate on the transfer of individuals from the BOP to CSOSA, and the two agencies’ social workers communicate regularly. The CSOSA’s database has a direct feed from the BOP, and MHI is shared routinely and automatically.

### **MHI Sharing and Needs**

The CSOSA receives information from mental health providers depending on the severity of an individual’s mental health condition. Information shared by CSOSA with other agencies is limited to what is absolutely necessary and balanced against the need to continue an individual’s treatment, as well as what is required for supervision or additional assessment. The CSOSA agrees that it would be helpful to be informed of encounters between the MPD and individuals under its supervision even if they do not result in an arrest.

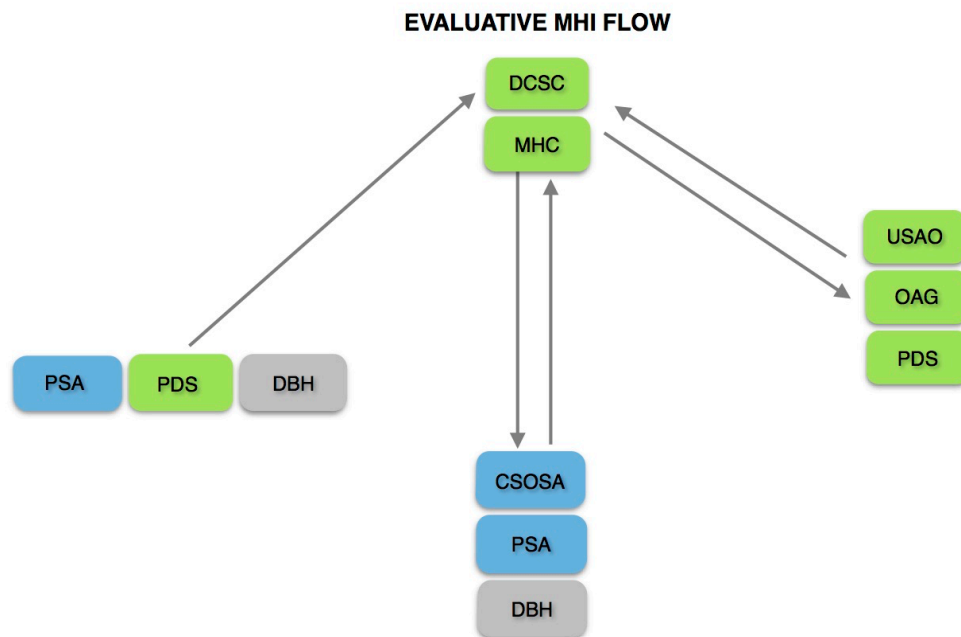
### **Technological Resources**

The CSOSA currently uses the SMART case management system and maintains a separate data warehouse for reporting purposes. It currently receives data electronically from the BOP and the PSA. Data provided by other Partner Agencies to JUSTIS can be accessed by CSOSA staff.

### 3.3.3 Dispositive Agencies

The Dispositive Agencies report that they are generally satisfied with the current flow of information concerning individuals in the system with mental health needs. The Dispositive Agencies need Evaluative MHI consisting of professional opinions rendered for the judicial proceeding that can form the basis for disposition of criminal charges. Less reliable MHI is generally relevant only to the initial determination of whether to divert a defendant to the MHCC or to order a competency examination. The PSA, CSOSA, or PDS identify and provide the MHI that form the basis of those determinations.

**Figure 4** below illustrates the flow of Evaluative MHI among the Dispositive Agencies.



#### 3.3.3.1 The Superior Court of the District of Columbia

##### Operational Process

The Superior Court of the District of Columbia (the DCSC) is the District's trial court. Its Criminal Division is responsible for all local criminal matters including felony, misdemeanor, and District of Columbia code violations. The DCSC requires access to MHI to determine whether an individual is competent to stand trial and when an individual's mental health is at issue in a proceeding.

The Criminal Division also operates the Mental Health Community Court (the MHCC), which was established to help integrate community resources to meet the

needs of individuals in the criminal justice system that have mental health needs. Diversion to the MHCC is voluntary and the individual's consent to the disclosure of relevant MHI as part of that process is a condition of participation. The USAO screens the charges against an individual to determine legal eligibility and the PSA is responsible for screening for clinical eligibility. The DCSC has DBH professional staff onsite at the courthouse who provide assessment of individuals in the system and who coordinate with the appropriate Community Service Agency if the individual is already under the DBH's care.

### **MHI Sharing and Needs**

The OAG and the USAO receive arrest information from the MPD and, if they decide to press charges, they enter relevant information into the DCSC's Courtview database. The DCSC typically receives MHI in the PSA report, from competency evaluations or as evidence in a hearing, or if a Medical Alert is requested. Data is transmitted electronically to JUSTIS and then sent electronically to the Court.

#### *3.3.3.2 The Public Defender Service*

### **Operational Process**

The PDS is a federally funded, independent legal organization governed by an eleven-member Board of Trustees appointed by the Chief Judges of the Federal and DC Courts and the Mayor. It provides legal services to defendants in the DC criminal justice system.

The PDS typically meets with its client within twenty-four hours of an arrest. By that time the individual has already been interviewed by PSA. The PDS receives a copy of the PSR, which can refer to mental health needs, and with express client consent the PDS can obtain MHI from any of the client's medical providers.

Although the Custodial Agencies need to know if individuals in their custody pose a risk of harm to themselves or to others, or if they have essential medical needs that must be provided for, clients of the PDS do not always believe that it is in their own best interest to disclose this information.

For example, a client may decide that it is better to decline to disclose mental health needs to a Custodial Agency if doing so makes it more likely that the individual will be placed in solitary confinement, or transferred to a mental health facility. In such circumstances, even if the PDS attorney is aware of the client's mental health condition, the PDS attorney is not at liberty to disclose that information without the client's consent.

### **MHI Sharing and Needs**

At the direction of the client, after consultation, the PDS can request a competency screening if that is relevant to the disposition of the charges against the client. The PDS can also request that the Court issue a Medical Alert if there is a suicide risk.

The relationship with the individual is strictly that of lawyer and client and the PDS acts only in the interest and at the direction of its client. Accordingly, the PDS' approach to sharing MHI with other Partner Agencies is entirely dictated by the rules of professional conduct and relevant case law that govern the Attorney-client relationship.

#### *3.3.3.3 The Office of the Attorney General and the US Attorney's Office*

##### **Operational Process**

Both prosecutorial agencies report that they have limited need for or access to MHI. The relevance of MHI to the OAG and the USAO depends on the posture of the case: whether the defendant is eligible for diversion to the MHCC, or whether the defendant has raised the issue of competence for trial.

The pre-trial report prepared by the PSA typically will include MHI that the PSA believes is relevant to the disposition of the case. Where competency for trial is raised, or when mental health is an issue at trial, the parties or the court can commission a professional mental health evaluation. The CSOSA also provides PSI reports to the court to be used by the judges when sentencing offenders.

#### *3.3.3.4 The United States Parole Commission*

##### **Operational Process**

The USPC has sole authority to grant parole, and to establish the conditions of release, for all DC Code prisoners who are serving sentences for felony offenses, and who are eligible for parole by statute, including offenders who have been returned to prison upon the revocation of parole or mandatory release. It retains authority over all felony offenders who have been released to parole or mandatory release supervision, including the authority to revoke parole and return them to prison.

The CSOSA provides supervision for the DC Code parolees and mandatory releasees who are released to the District. US Probation officers provide supervision for US Code parolees and mandatory releasees.

The USPC has well-established procedures for granting parole or releasing individuals with mental health needs. A parole hearing examiner can order a competency evaluation for a parole applicant or for a parolee in revocation proceedings. If the hearing examiner believes that the parolee is not mentally competent, the examiner is nonetheless authorized to conduct the hearing and make a recommendation as to parole, revocation, or re-parole with conditions, taking into account the parolee's mental health condition.

The USPC may then condition parole on: the individual's enrollment in a mental health program prior to release, community; community supervision requiring appropriate mental health treatment, including medication; or even voluntary self-commitment to a mental health institution until the parolee has sufficiently recovered to be allowed to return to community supervision.

Even if the USPC finds that an individual in a revocation hearing did not violate parole, it may impose additional conditions requiring treatment if it determines that the individual cannot meet normal parole obligations because of mental health issues.

### **MHI Sharing and Needs**

The USPC receives extensive information, including MHI, from the BOP for parole hearings and it has access to the BOP's SENTRY database and CSOSA's SMART database. It also maintains records concerning current and former inmates of the Bureau of Prisons including physical and mental health data. Former inmates include those presently under supervision as parolees, mandatory releases or supervised releases. The USPC also receives information from CSOSA regarding an offender's mental health status for USPC revocation or status hearings.

As with the other Dispositive Agencies, the USPC requires Evaluative MHI to adjudicate an individual's competence and to determine any special terms and conditions of release. This Evaluative MHI is developed through the hearing process and the individual has the right to representation and to provide evidence, including mental health evaluations.

### ***3.3.4 Non-CJCC Agencies***

Although the DBH is not a criminal justice agency, and is not a member of the CJCC, it provides essential expertise and professional services to the Partner Agencies as they seek to serve the many individuals in the system with acute and/or chronic mental illness.

#### ***3.3.4.1 The Department of Behavioral Health***

### **Operational Process**

The DBH provides prevention, intervention and treatment services and support for individuals in the criminal justice system, including emergency psychiatric care and community-based outpatient and residential services. The DBH operates St. Elizabeth's Hospital, the District's psychiatric facility. It provides professional staff for the CCB and for a mental health clinic at the DCSC. The DBH provides training and other support to the MPD to enable the MPD to better respond to individuals experiencing a mental health crisis. It also collaborates closely with the PSA, the CSOSA, and the DOC, to delivery necessary mental health services and to try to ensure continuity of services as individuals move through the criminal justice system.

## **MHI Sharing and Needs**

The DBH receives most of the MHI it needs, but the process is uncoordinated and differs from agency to agency and there is no central source or repository for the information. There is also no centralized record of the screenings and evaluations conducted by the various Partner Agencies and DBH staff have often been asked to perform evaluations or examinations that are duplicative of those conducted by the DOC's medical provider, Unity Health Care, or by the PSA or the CSOSA.

Similarly, treatment information for services provided by the Partner Agencies does not routinely follow as the individual moves through the criminal justice system. The process of sharing treatment information is ad hoc and is not reliable.

The DBH receives information from the MPD and the DOC regarding individuals who are arrested and brought to the CCB, but it does not currently receive other information regarding the numerous encounters the MPD has every day with DBH clients in community supervision, unless the individual self-reports those encounters to the caseworker. As a result, the DBH often learns that a client's mental health is deteriorating only after the client has engaged in behavior that is sufficiently serious to result in an arrest or transportation to CPEP.

## **Technological Resources**

The DBH is in the process of implementing a new case management system known as ICAMS. ICAMS will be a comprehensive system for tracking clients and their care and it will include information as to the individual's status in the criminal justice system. The system will have the capability of creating and sharing warning flags for specific individuals and also is designed to provide the various provider services with comprehensive access to the patient treatment records. ICAMS will be capable of exporting or importing data securely from Partner Agency systems and Partner Agencies could be granted access to ICAMS to obtain relevant MHI.



## SECTION 4: RECOMMENDATIONS

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*This section outlines BDA Global's Recommendations to Improve Mental Health Information Sharing Between Partner Agencies.*

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### *4.1 Comprehensively Automate MPD MHI Collection and Sharing*

As the community police force, the MPD has more frequent interactions with members of the public than any of the other Partner Agencies. In the ordinary course of business, MPD officers interact often with individuals in the community who have mental health needs. Many of those individuals have had previous, and often numerous, encounters with the criminal justice system. Indeed, a significant number of the individuals with mental health needs who are encountered by the MPD are under the continuing jurisdiction of the criminal justice system on pre-trial release, parole, probation, or in diversion programs. Compliance with ongoing treatment and assistance programs offered by the DBH is typically a condition of their release.

Although the MPD keeps records of its interactions with the public, only a fraction of that information is routinely communicated to the Supervisory Agencies or to the DBH, even if it relates to individuals under their supervision. The Supervisory Agencies and the DBH do routinely receive information as to individuals who have been arrested in the District or who appear on the list of individuals brought to the CCB. This information is used by the Supervisory Agencies to evaluate whether the individual has violated a condition of release. It is also used by the DBH to help ensure continuity of service and support between the community-based providers and the providers at the CCB.

As has been explored in various studies, individuals with mental health needs often maintain better health while they are incarcerated, either in a corrections institution or in a mental health facility. This is not remarkable given the facts that while incarcerated the individual has a place to sleep, a structured routine, and access to medical care and proper nutrition. An individual who receives mental health services as a result of entering the criminal justice system usually attains a much-improved level of mental health by the time they are released and, often, the release is a result of that improvement. When released into the community they receive ongoing human services support from the DBH and others.

Even with the most optimum level of support it is often difficult for individuals to maintain the same level of mental health after their release and most of them experience deterioration in their mental health, to at least some degree, over time. This deterioration frequently will be exhibited in behavioral issues that will result in encounters with the MPD. Indeed, individuals with deteriorating mental health typically encounter the MPD on numerous occasions before their behavior escalates to the level that results in an arrest.

The MPD currently does not share information with other agencies concerning its encounters with members of the public that do not involve an arrest or the transportation of an individual to a psychiatric facilities. The MPD records non-arrest incident information on PD Form 251, but it is not currently shared with other Partner Agencies. Thus, the Supervisory Agencies are not aware of encounters between the MPD and the individuals they are supervising unless the incident is serious enough to require an arrest or commitment.

That information could be of enormous value to the DBH, and to other Partner Agencies. Those incidents constitute important red flags for DBH's community-based providers. Currently, DBH providers work with individuals under community supervision to help them maintain their mental health and their compliance with other conditions of their release.

Typically, DBH learns of a client's encounters with the police only if the client self-reports. A routine sharing of incident information by the MPD with the DBH and the Supervisory Agencies would create opportunities for earlier, and likely more effective, intervention before the individual destabilizes to the extent that something sufficiently serious to result in arrest occurs.

In addition to PD Form 251, the MPD uses PD Form 251-C (Crisis Intervention Officer Tracking Form) to capture information observed by an officer when encountering an individual that appears to have mental health needs. It contains a description of the nature of the incident and any injuries, the behaviors exhibited, whether the officer had prior contacts with the individual, and identification information consisting of the individual's name and date of birth. Currently, paper versions of these forms are provided to the DBH on an *ad hoc* basis under the auspices of the CIO training program.

The current development of the MPD's new RMS, presents the opportunity to electronically record more of the information that the MPD is already gathering and also to enhance the sharing of that information. The MPD's current information system, iLeads, principally contains information about persons who have been arrested. Even for incidents as serious as arrests, however, not all information recorded by officers is entered into iLeads.<sup>45</sup> For example, PD Form FD-12 records the factual grounds for the decision to bring an individual to a mental health facility for evaluation before making an arrest. The information entered on the Form FD-12 describes the specific behaviors or statements of the individual that led the officer to believe that the individual was in imminent danger of harming himself or herself or others. A paper copy of Form FD-12 is provided to the mental health facility that receives the individual, but its contents are not available electronically to the MPD or anyone else.

Examples of options available in the MPD's new system that present opportunities for enhanced information sharing include:

- 1) providing the DBH case workers access to the new RMS to allow them to set up and receive automated alerts if their clients encounter the police or are arrested;
- 2) automating the export of data from the MPD's system to the DBH's system so that the DBH could match the incident and arrest reports against its client lists;
- 3) automating the export of data from the MPD's system to the individual systems operated by certain Partner Agencies, such as the CSOSA or the PSA,<sup>46</sup> so that they could match the incident and arrest reports against their client lists; or

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<sup>45</sup> The following are some examples of the forms used by the MPD to document information concerning arrested individuals: PD Form 150 (Tour of Duty Supervisor's Report); PD Form 163 (Prosecution Report); PD Form 313 (Arrestee's Injury or Illness Report and Request for Examination and Treatment); PD Form 256 (Quick Booking Form).

<sup>46</sup> This recommendation principally concerns adding the category of incident data to the data (arrest) that is already shared. In addition, for both categories of data there needs to be sufficient content to permit the agencies to match the report to their client lists. That will require an identification not only of the MPD data that is available but also the data fields in the Partner

- 4) automating the export of all of the relevant data from the MPD's system to JUSTIS so that all of the Partner Agencies can access both incident and arrest report information concerning individuals under community supervision.

## *4.2 Share the CCB Intake Lists Electronically and in Real-Time*

The arrest and subsequent detention of individuals with mental health needs is a critical event for the individual's wellbeing that should be communicated to the relevant Partner Agencies as soon as possible. The DBH, the CSOSA, the PSA, the USMS all depend on timely receipt of the list of individuals arriving in the CCB to properly respond to the arrest of individuals who have mental health needs.

For the DBH, the arrest of an individual to whom it is providing mental health service while under community supervision is a red flag that the individual has suffered a relapse or significant deterioration in mental health. Particularly when the individual is known to the DBH to have a suicide risk, prompt notification of those special needs to the DOC and other Custodial Agencies is essential. Further, timely notification to the individual's caseworker and medical providers can allow them to provide earlier and more effective intervention.

The list of prisoners that will be transferred to the USMS is currently transmitted from the DOC by email in the form of a PDF attachment, which then must be entered manually into J-DIS (the USMS' internal database system). Although the USMS usually receives the list sufficiently before the arrival of a prisoner, there have been occasions when it has not. There have also been occasions when information concerning suicide risk or medical needs is received several hours after the prisoner has been delivered to the USMS.

## *4.3 Provide the DOC and the PSA with Access to Partner Agency Records*

The DOC and the PSA report that they do not have prompt and comprehensive access to information concerning individuals who are brought to the CCB following an arrest. Both agencies have extensive intake processes. These include inquiry into and evaluation of the arrestee's health by onsite medical professionals. Nonetheless, they report that they are largely dependent on self-reporting of mental health needs when an individual arrives at the CCB. Many of the individuals arriving at the CCB have a history with, or are currently under the supervision of, the judicial system. There is, therefore, already a substantial quantity of MHI concerning that individual in the possession of Partner Agencies, but it is not readily available to the PSA and the DOC.<sup>47</sup>

For example, comprehensive MHI is provided by the BOP to the CSOSA and the DBH when an inmate is released to community supervision. Likewise, the CSOSA and the DBH have MHI concerning individuals in diversion programs. Both the DOC and the PSA expressed the view that they could perform their respective responsibilities more effectively if they had access to the

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Agencies that the MPD data will be matched with. This will be an easier process for the arrest data, but the incident data will be more variable in both quantity and quality.

<sup>47</sup> Specifically, the CSOSA, the MPD, the BOP, and the USMS all are likely to have relevant records concerning individuals who have been through the judicial system previously. Likewise, the DBH will also have records of them as clients.

CSOSA's records and were not entirely dependent on self-reported MHI gathered during intake at the CCB.<sup>48</sup>

Although an entity of the CSOSA, the PSA operates independently and maintains separate record systems. The PSA's records contain . . .

but are not limited to D.C. Superior Court information, offender information, details of the casework performed by the CSOSA staff and a completed copy of the pre-sentence report (investigation).

In contrast, the CSOSA's records contain . . .

but are not limited to presentence information, sentencing information, institutional adjustment (parole only), treatment records, compliance orders, field notes, PD-163 (police report), electronic monitoring information (for example, Global Positioning System (GPS) data), judgment and commitment orders, program reports, psychiatric reports, assessments, Parole Board and United States Parole Commission and judicial decisions and post-release information to include risk assessment, substance abuse testing, referrals, offender reporting forms, progress and behavior reports and correspondence.

Currently, the CSOSA's Routine Uses include: "Disclosure to Federal, local and state court or community correction officials to the extent necessary to permit them to accomplish their assigned duties in any criminal matter unless prohibited by law or statute." This Routine Use appears to authorize disclosure from the CSOSA's information systems to the DOC but not to the PSA.

The question of whether the PSA should have access to the CSOSA's more extensive records is a matter that will likely involve significant policy debate. The functions and purposes of the PSA and the CSOSA overlap to some degree but there are significant differences. The PSA is charged with assisting the court by conducting a pre-trial investigation and preparing a report to the court. However, it is also responsible for referring individuals to mental health services and to other diversion options prior to disposition.

The CSOSA's role is somewhat broader. Community supervision places individuals under the jurisdiction of the criminal justice system in the community subject to numerous conditions. The CSOSA's role is to ensure that the individual complies with those conditions, including obtaining mental health care, and also to enable the individual to do so by working with the DBH and other agencies to provide the individuals with the necessary services.

Advocates for individuals with mental health needs may object to the PSA having automatic access to an individual's MHI because that could result in cognitive bias in the PSA's recommendations. The CSOSA's and other Partner Agencies' records certainly would contain such information.

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<sup>48</sup> It should be noted that in order to best serve its clients' interests, PDS at times may have a disincentive to share MHI with the MPD or the PSA. The possession of such information by a police officer could make it more likely that a client will be arrested or brought for psychiatric evaluation. Likewise, the PSA's possession of MHI might make it less likely that the PSA will make a pretrial-release recommendation.

#### *4.4 Create a HIPAA-Compliant Process at the MPD and USMS for MHI Access (For Individuals in Custody, Not Employees)*

Under both HIPAA and the MHIA, the MPD and the USMS have similar rights to access MHI that they need for individuals in their custody as do correctional institutions. Thus, the MPD is authorized to receive or access MHI concerning individuals it is holding in a Station Cell Block, or concerning individuals it is transporting to the Central Cell Block or to a medical facility. The USMS is authorized to receive MHI concerning individuals in its custody at the courthouse. These agencies do not need the individuals' entire medical record and history, but they do need at least the key MHI datapoints such as suicide risk, necessary medical treatment or medication requirements.<sup>49</sup>

Although the Privacy Rule is not an obstacle to the sharing of MHI with the MPD and the USMS in these circumstances, the transmission of that information must comply with the Security Rule. For example, privacy and civil liberty advocates would object if MPD officers had unrestricted access to MHI, even if it was limited to individuals under community supervision, because of the dangers of stigmatization and cognitive bias. To obviate such concerns, and to comply with HIPAA, the MPD and the USMS should establish a process that is compliant with the Security Rule for the treatment of MHI and for the designation and training of officers authorized to access and use it.<sup>50</sup>

#### *4.5 Share USMS Records with other Custodial Agencies Electronically*

The USMS has custody of individuals at the courthouse to appear before a judge. It operates a cellblock in the courthouse and is responsible for the security and wellbeing of individuals in its custody. The USMS does not keep prisoners overnight. It needs MHI primarily concerning suicide risk and urgent medical needs and it has a screening process at intake that is designed to help prevent prisoners from harming themselves or others.

Information concerning an individual's behavioral risks that is observed by the USMS, or that is brought to its attention, is documented on a form USM 130 Prisoner Custody Alert Notice.<sup>51</sup> This information can include personal observations by a Marshall that an individual is combative, acting erratically, or is expressing suicidal ideations. It can also reflect concerns raised by the individual's counsel or medical alerts issued by the Court. The information captured on a form USM 130 is entered into the J-DIS database, but is not shared electronically with other agencies. It is communicated only to the extent that a paper copy is given to the officers transporting the individual to be provided to the next agency that takes custody. Similarly, when the Court issues a medical alert, a copy is provided to the USMS and it is sent by fax to the DOC's Medical Office. It is not otherwise disseminated.

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<sup>49</sup> Providing just the key MHI datapoints would be consistent with the minimum disclosure approach required by HIPAA and the MHIA.

<sup>50</sup> The MPD already has similar processes in place to comply with HIPAA because it is a provider of medical services to its employees.

<sup>51</sup> Similar useful information is also recorded by the USMS on forms USM 129 and USM 312.

#### *4.6 Share MHI Automatically and Electronically with Custodial Agencies*

A common concern voiced by all of the Custodial Agencies (DOC, BOP, USMS and MPD), is the timeliness of the flow of MHI to them concerning individuals in their custody. Information that these agencies need concerning critical matters, such as suicide risk, necessary treatment and required medication, is in many circumstances delivered manually, either by transmission of an email with an attached PDF document or by the manual delivery of a paper form by the officer transporting a prisoner. This manual method contains the risk that the delivery will fail entirely, for a variety of reasons including human error, or that the information will not be received, or properly assimilated by the recipient, in a timely manner.<sup>52</sup>

The current system of MHI sharing is also vulnerable to failures to the extent that it requires the Custodial Agency to inquire as to the existence of relevant records in other agencies' databases. A database that maintained the MHI datapoints in real-time could push that information to the relevant agencies whenever it is updated so that the need for inquiries and updates is eliminated.

Automated transmission between electronic record systems could also help ensure more timely and reliable sharing of key MHI datapoints. Emails can be misdirected or delayed by spam filters and operational obligations may delay the review of email. Moreover, when information is transferred in an email or in an attachment, it often needs to be reformatted or manually entered into a recipient's database. These steps consume time and resources. Automated transfers of data can also allow for the transfer of warning flags directly into the receiving system, without the need for human intervention. Moreover, most systems can accommodate the use of warning flags that require acknowledgement or action.

Likewise, less urgently needed MHI contained in medical records is typically transferred only if the receiving agency makes an affirmative inquiry and request. The receiving agency must contact the prior agency and the individual's medical providers to determine whether additional MHI exists and to request copies of it. Delivery of those records is often delayed by the need to obtain internal approvals of a request and to prepare copies of paper files to be sent in response. The Custodial Agencies are expressly authorized by both HIPAA and the DC Code to receive MHI concerning an individual in their custody without the individual's consent. There is, therefore, no apparent privacy law reason why the electronic transfer of medical records cannot be performed automatically at the time of the physical transfer of the individual.<sup>53</sup>

#### *4.7 Designate a Centralized Database to Maintain and Share MHI*

Several of our recommendations suggest the use of electronic information systems to automate and expedite the sharing of MHI between the Partner Agencies. The Partner Agencies and the DBH

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<sup>52</sup> It should be noted that when the process of communicating by email and with PDF attachments was introduced it constituted a significant improvement at the time over mail or hand delivery of relevant documents. The fact that such methods are no longer the most rapid and reliable means of transmission is a result of the continuing development of information systems technology and the adoption of state-of-the-art database technologies by several of the Partner Agencies.

<sup>53</sup> The absence of a privacy rule obstacle to the sharing of information with Custodial Agencies does not change the Security Rule requirements that record systems be securely designed and operated.

should consider developing a central MHI database that maintains at least the key MHI datapoints identified above. The database should have the following technical capabilities:

- 1) automated transfer (“pushing”) of data out to the relevant Partner Agencies’ databases to eliminate the need for Partner Agency staff to submit *ad hoc* inquiries to other databases or to input data received;
- 2) real-time or same-day assimilation of updates on the MHI datapoints from the Partner Agencies or the DBH so that the most current information is continually available to all agencies; and,
- 3) hosting of PDF documents or other electronic files containing medical records.

Determination of where a MHI database should be hosted and maintained will require a more in-depth examination of the IT capabilities of the various agencies. Several of the Partner Agencies have implemented or are developing state-of-the-art information systems that are capable of fulfilling these functions. Indeed, there are several agency databases that may be suitable candidates to host the MHI information.

The JUSTIS system already functions as a central repository and exchange for information concerning persons arrested in the District and all of the Partner Agencies have the capability to distribute or view data through JUSTIS. Accordingly, it already contains a record for each individual in the District criminal justice system and it is capable of adding information fields for the MHI datapoints to those name records. Importantly, JUSTIS is not designed or intended to be a case management system and would require upgrades to enable field level filtering of data if it were to be used as a central MHI database.

The DBH also has a new and robust system that tracks all of the DBH’s clients and communicates with the DBH’s case managers and provider network. It is specifically designed to function as a case management system. DBH’s dataset is more focused than JUSTIS. Whereas JUSTIS maintains a name record for everyone arrested in the District, the DBH’s system contains a record for everyone receiving mental health services in the District through the criminal justice system.

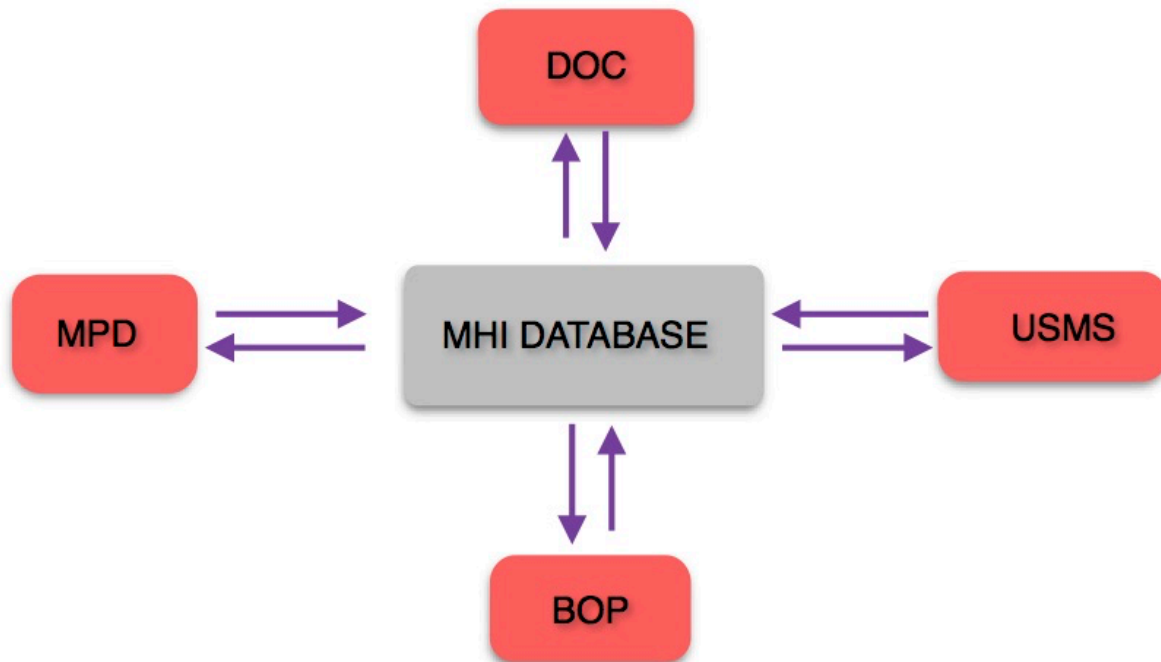
If DBH were to host a centralized MHI database for the criminal justice system it could permit the Custodial Agencies to have the same level of access as is provided to DBH’s service providers, who are permitted to view the client’s entire medical treatment history. Just as for the medical providers, access could be restricted to the records of only those individuals currently in the agency’s custody. Electronic transfer of relevant information from the Custodial Agencies to ICAMS would also ensure that the records are simultaneously available to the other Custodial Agencies.

It appears that either of these two systems is capable of hosting some form of centralized MHI database, but both would likely require some level of upgrade or development.

The new RMS under development at the MPD and the systems maintained by the other Partner Agencies are also likely technically capable of hosting the MHI database. The question of which agency, and which system, should host the database will likely depend on the database’s security features and capability for compliance with HIPAA’s Security Rule.

**Figure 5** below illustrates the data flow that would result from the use of a centralized database

**RECOMMENDED CENTRALIZED DATABASE  
FLOW FOR SAFETY-RELATED MHI**



#### *4.8 Conclusion*

This report identifies 5 key types of mental health information that should be shared timely between Partner agencies, and provides a framework to achieving efficient and effective information sharing, as well as an approach to improving the potential for effective interventions. It is, hence, key that agencies work collaboratively to implement the 7 recommendations and to streamline the processes by which mental health information is shared about individuals in the criminal justice system.



## Appendix I: Glossary of Key Terms

Acronym	Name
BEMR	Bureau's Electronic Medical Record
BJS	Bureau of Justice Statistics
BOP	United States Bureau of Prisons
CCB	Central Cell Block
CDF	Central Detention Facility
CIO	Critical Incident Officer
CJCC	Criminal Justice Coordinating Council
CPEP	Comprehensive Psychiatric Emergency Program
CSOSA	Court Services and Offender Supervision Agency for the District of Columbia
DBH	Department of Behavioral Health
DCSC	Superior Court of the District of Columbia
DICAA	Data-Sharing and Information Coordination Amendment Act 2010
DMH	Department of Mental Health
DOC	District of Columbia Department of Corrections
DYRS	Department of Youth Rehabilitation Services
HIPAA	Health Insurance Portability and Accounting Act
IIHI	Individually Identifiable Health Information
JACCS	Jail and Community Corrections System
JDIS	Justice Detainee Information System
IRAC	Interagency Research Advisory Committee
JUSTIS	Justice Information System

MHCC	Mental Health Community Court
MHF	Mental Health Facility
MHI	Mental Health Information
MHIA	Mental Health Information Act of 1979
MPD	District of Columbia Metropolitan Police Department
OAG	Office of the Attorney General for the District of Columbia
PDS	Public Defender Service for the District of Columbia
PHI	Protected Health Information
PSA	Pretrial Services Agency for the District of Columbia
PSR	Presentence Report
RMS	Records Management System
SAC	Statistical Analysis Center
SAT	Substance Abuse Treatment
SATMHSIT	Substance Abuse Treatment and Mental Health Services Integration Taskforce
UHC	Unity Health Care
USAO	Office of the United States Attorney for the District of Columbia
USMS	United States Marshals Service
USPC	United States Parole Commission

## Appendix II: Interviews Conducted

Agency/Organization	Date Conducted
Bureau of Prisons (BOP)	April 8, 2015
Court Services and Offender Supervision Agency (CSOSA)	March 26, 2015
Department of Behavioral Health (DBH)	April 3, 2015 April 21, 2015
DC Superior Court (DCSC)	March 26, 2015 May 18, 2015 May 22, 2015
DC Department of Corrections (DOC)	April 21, 2015
Metropolitan Police Department (MPD)	March 25, 2015 May 18, 2015 May 22, 2015
Office of Attorney General (OAG)	April 9, 2015
Public Defender Service for DC (PDS)	March 24, 2015
Pretrial Services Agency (PSA)	March 24, 2015
Unity Health Care (UHC)	March 23, 2015 April 16, 2015
US Attorney's Office for DC (USAO)	April 13, 2015
US Marshals Service (USMS)	April 15, 2015
US Parole Commission (USPC)	April 2, 2015
CJCC IT Staff	April 22, 2015

## Appendix III: Points of Contact by Agency

POC	Agency	Email
Patricia Butterfield	Bureau of Prisons	pbutterfield@bop.gov
Tom DiPaola	Bureau of Prisons	tdipaola@bop.gov
Reena Chakraborty	DC Department of Corrections	reena.chakraborty@dc.gov
Lisa VanDeVeer	DC Superior Court	Lisa.VanDeVeer@dcsc.gov
Kim Beverly	DC Superior Court	Kim.Beverly@dcsc.gov
Michele May	Department of Behavioral Health	michele.may@dc.gov
Matt Bromeland	Metropolitan Police Department	matthew.bromeland@dc.gov
Brittany Keil	Office of the Attorney General	brittany.keil@dc.gov
Cliff Keenan	Pretrial Services Agency	Cliff.Keenan@psa.gov
Spurgeon Kennedy	Pretrial Services Agency	Spurgeon.Kennedy@psa.gov
Julia Leighton	Pretrial Services Agency	Jleighton@pdsdc.org
Sharon E. Winget	Unity Health Care	SWinget@UnityHealthCare.org
Michelle Jackson	US Attorney's Office	michelle.d.jackson@usdoj.gov
Eric Clark	US Marshal	eric.clark@usdoj.gov
Kenneth Holland	US Parole Commission	kenneth.holland@usdoj.gov

## Appendix IV: Agency Legal Status and MHI Access Rights

PARTNER AGENCY	HIPAA	PRIVACY ACT	DC MHIA	DC DICAA
District of Columbia Department of Corrections	Covered Entity  Unrestricted Access to MHI for persons in custody*	Not Applicable	Unrestricted Access to MHI for persons in custody*	Unrestricted Access to MHI for persons in custody*
Superior Court of the District of Columbia	By Consent or Court Order**	Not Applicable	By Consent or Court Order**	By Consent or Court Order**
Office of the Attorney General	By Consent or Court Order**	Not Applicable	By Consent or Court Order**	By Consent or Court Order**
Metropolitan Police Department	Not a Covered Entity  Unrestricted Access to MHI for persons in custody*	Not Applicable	Unrestricted Access to MHI for persons in custody*	Unrestricted Access to MHI for persons in custody*
Pretrial Services Agency	By Consent	Applicable	By Consent or Court Order**	Not Applicable
United States Marshals Service	Not a Covered Entity  Unrestricted Access to MHI for persons in custody*	Applicable	Unrestricted Access to MHI for persons in custody*	Unrestricted Access to MHI for persons in custody*
Court Services and Offender Supervision Agency	By Consent	Applicable	By Consent or Court Order**	Not Applicable
Office of the United States Attorney	By Consent or Court Order**	Applicable	By Consent or Court Order**	By Consent or Court Order**
Public Defender Service	By Consent	Not Applicable	By Consent or Court Order**	Not Applicable
United States Parole Commission	By Consent	Applicable	By Consent or Court Order**	Not Applicable
United States Bureau of Prisons	Covered Entity  Unrestricted Access to MHI for persons in custody*	Applicable	Not Applicable	Not Applicable

\*45 CFR §164.501; DC Code § 7-1203.05a

\*\*DC Code § 7-1204.01