FINAL REPORT

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Addressing Co-occurring Mental Health and Substance Abuse Disorders in the Criminal Justice System: Guiding Principles and District of Columbia Practices

Final Report

Submitted to the Criminal Justice Coordinating Council, Substance Abuse and Mental Health Workgroup, District of Columbia

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Acronym List

ABADABA	PSA's Automated Bail Agency Database
ACCESS	Access to Community Care and Effective Services and Support
ADS	Combined Alcohol Dependence Scale
APRA	Addiction Prevention and Recovery Administration
ASAM	American Society of Addiction Medicine
ASI	Addiction Severity Index
ATTC	Addiction Technology Transfer Centers
BSI	Brief Symptom Inventory
BOP	United States Bureau of Prisons
CALDATA	California Department of Alcohol and Drug Programs
CASA	Center on Addiction and Substance Abuse
CCF	Community Corrections Facilities
CCISC	Comprehensive Continuous Integrated System of Care
CDS	APRA's Client Data Set
CHPS	Center for Correctional Health and Policy Studies
CID	Central Intake Division at APRA
CIT	Crisis Intervention Team
CJCC	Criminal Justice Coordinating Council
CJIS	MPD's Criminal Justice Information System
CMHS	Center for Mental Health Services
COD	Lane County, Oregon's Co-Occuring Diversion Program
COSIG	State Incentive Grant for Treatment of Persons with Co-Occurring Substance Related and Mental Disorders
COTR	Contracting Technical Representative
CPEP	DMH's Comprehensive Psychiatric Emergency Program
CPS	Community Placement Specialist
CSAT	Center for Substance Abuse Treatment
CSO	Community Supervision Officer
CSOSA	Court Services and Offender Supervision Agency for D.C.
CTF	Central Treatment Facility at the D.C. Detention Center
CWFCM	San Francisco (California) Citywide Forensic Case Management Team
DATOS	Drug Abuse Treatment Outcome Studies
D.C.	District of Columbia
DCDOC	D.C. Department of Corrections
DCSC	Superior Court of D.C.
DMHAS	Connecticut's Department of Mental Health and Addiction Services
DOC	Department of Corrections
DMH	Department of Mental Health

DTMS	PSA's Drug Testing Management System
FIDD	Family Intervention for Dual Disorders Program
GAINS	Gathering information, Assessing what works, Interpreting/integrating facts, Networking, and Stimulating change
the Jail	D.C. Detention Center, more specifically the Central Detention Center
JUSTIS	Justice Information System for the District of Columbia
MCCJTP	Maryland Community Criminal Justice Treatment Program
MCMI-III	Millon Clinical Multiaxial Inventory-III
MH	Mental Health
MHA	Maryland Department of Health and Mental Hygiene Administration
MMPI-2	Minnesota Multiphasic Personality Inventory-2
MPD	D.C. Metropolitan Police Department
NDRI	National Development and Research Institute, Inc.
NIAAA	National Institute on Alcohol Abuse and Alcoholism
OCC	Office of the Corporation Counsel
PAI	Personality Assessment Inventory
PATH	Projects for Assistance in Transition from Homelessness
PDS	BOP's Psychological Data System
PDS	Public Defender Service for D.C.
PDS-ORD	Public Defender Service for D.C.-Offender Rehabilitation Division
PERT	Psychiatric Emergency Response Team
PRC	New Hampshire-Dartmouth Psychiatric Research Center
PRISM	Pretrial Real Time Information System Manager
PSA	D.C. Pretrial Services Agency
PSO	Pretrial Services Officer
RDAP	Residential Drug Abuse Program
RDS	Referral Decision Scale
SA	Substance Abuse
SAPT	Substance Abuse Prevention and Treatment Block Grant
SAMHSA	Substance Abuse and Mental Health Services Administration
SCDIP	Superior Court Drug Intervention Program
SOME	So Others May Eat
SSI	Simple Screening Instrument
SSU	PSA's Specialized Supervision Unit
TAMAR	Maryland's Trauma, Addictions, Mental Health, and Recovery Program
TC	Therapeutic Communities
TCUDD	Texas Christian University Drug Dependence Screen
TIP	Treatment Improvement Protocol
TIPS	CSOSA's Transitional Intervention for Parole Supervision

USAO	Office of the United States Attorney for D.C.
UT	University of Tennessee
WALES	MPD's Washington Area Law Enforcement System
the Workgroup	Substance Abuse and Mental Health Workgroup
YSA	Department of Human Services' Youth Services Administration

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Chapter 1. Report Summary: Findings and Recommendations

1.1. INTRODUCTION

The Criminal Justice Coordinating Council's (CJCC) Substance Abuse and Mental Health Workgroup (hereafter called the Workgroup) spearheads the District of Columbia's (D.C.'s) response to serving people in the criminal justice system with co-occurring disorders. The Workgroup commissioned the current report to identify promising practices in the treatment of people in the criminal justice system with co-occurring mental health and substance abuse disorders and to detail the current practices and services available to people with co-occurring disorders in Washington, D.C. The information provided will help guide the Workgroup's mission.

In 1997, the CJCC, then known as the Memorandum of Understanding Partners, began as an ad hoc committee of justice leaders dedicated to improving public safety and coordination among criminal justice agencies. In 2001, the D.C. Council established the CJCC as an independent agency (CJCC 2003). Today, "the mission of the CJCC is to serve as [a multi-agency] 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."[1] Participating people and agencies include the mayor of D.C., the chair of the D.C. Council, the Superior Court of D.C. (DCSC), the Office of the Attorney General, the D.C. Metropolitan Police Department (MPD), the D.C. Pretrial Services Agency (PSA), the Court Services and Offender Supervision Agency for D.C. (CSOSA), the D.C. Department of Corrections (DCDOC), the Office of the United States Attorney for D.C. (USAO), the Public Defender Service for D.C. (PDS), the United States Parole Commission, the D.C. Department of Human Services, the Youth Services Administration, the United States Bureau of Prisons (BOP), and the United States Marshals Service.

Specific CJCC goals, detailed in the latest annual report, include developing effective solutions to institutional problems, monitoring the use of personnel and resources to determine that the criminal justice system is meeting the needs of its clients and community resources are meeting the needs of the criminal justice system, working on the priority areas identified for the city, and developing the justice system's future goals and activities (CJCC 2004). The CJCC is a resource facilitating community and institutional change (CJCC 2004). Specific accomplishments of the agency include the development of JUSTIS, an information-sharing platform, and improvements in reentry services for transitioning offenders. The agency is currently funded by federal and local appropriations and a Byrne grant.

The Workgroup was devised and established in 2003 when the CJCC identified the handling and treatment of people in the criminal justice system with co-occurring disorders as an area of concern. Representatives from DCSC, PDS, PSA, CSOSA, the Department of Mental Health (DMH), USAO, the Addiction Prevention and Recovery Administration (APRA), BOP, the

[1] Description from the CJCC web site, http://cjcc.dc.gov/.

Council of Governments, and DCDOC participate in the workgroup. A recent, major accomplishment of the group was the development of a Universal Screener (CJCC 2004, more information on this can be found in chapter 3 of the current report).

This chapter synthesizes information presented in the rest of the report and presents a series of recommendations for the Workgroup to consider regarding how to address the needs of individuals with co-occurring mental health and substance abuse disorders in the D.C. criminal justice system. These recommendations are based on information presented in the remainder of the report (chapters 2, 3, and 4). First, we present a series of general recommendations related to two overarching guiding principles presented in chapter 2. Next, similar to how we present information in later chapters, we provide guiding principles and recommendations in reference to four points in the criminal justice system: (1) crime/incident – the period when first responders (such as the police) are in contact with the person which may or may not lead to an arrest or the person being in custody, (2) pretrial – the period from intake into the system through charging and case disposition (when defendants may or may not be in custody), (3) incarceration, and (4) community supervision and reentry after completing an episode of incarceration.

The rest of the report provides the foundation on which the current recommendations are built and includes the following information:

- Chapter 2 includes a series of guiding principles and promising programs in addressing the needs of individuals in the criminal justice system with co-occurring disorders. The guiding principles represent the current "best thinking" in the field, and programs and approaches from around the country are highlighted.
- Chapter 3 documents the D.C. criminal justice system's response to people with mental health and substance abuse issues and describes the current response to people with co-occurring disorders. Information for this chapter was collected during interviews with staff from stakeholder agencies[2] and through a review of various internal documents, technical assistance reports, agency web sites, and publications.
- Chapter 4 presents the results from our survey of mental health and substance abuse treatment providers in D.C. The results estimate the providers' clientele who are in the criminal justice system and have co-occurring disorders, as well as document the services available for people with mental health issues, substance abuse issues, and co-occurring disorders.

1.2. GENERAL RECOMMENDATIONS

Our first series of recommendations are general in nature and are related to two overarching principles presented in chapter 2:

<u>Overarching Guiding Principle</u>: Developing and implementing comprehensive and appropriate community-based services will help local public behavioral health systems treat problems, improve individual functioning, and prevent criminal justice system involvement for people with co-occurring mental health and substance abuse disorders. These services should be designed to be easily accessible to potential clients (Criminal

[2] Including staff members from CJCC, PSA, DCSC, MPD, DCDOC, BOP, CSOSA, PDS, APRA, and DMH.

Justice/Mental Health Consensus Project 2002; Substance Abuse and Mental Health Services Administration [SAMHSA] 2003a).

<u>Overarching Guiding Principle</u>: Collaboration between criminal justice agencies, mental health treatment providers, substance abuse treatment providers, and funding and advocacy groups will help communities serve individuals with co-occurring mental health and substance abuse disorders and provide appropriate justice system responses. It is important to develop planning processes that include top-level representatives from the criminal justice, mental health treatment, and substance abuse treatment fields (Center for Substance Abuse Treatment 1994, 1995a, 1995b; Criminal Justice/Mental Health Consensus Project 2002).

To address the needs of people with co-occurring substance abuse and mental health disorders in an area, it is critical to have a strong public behavioral health system and a strong community-wide collaboration. Building such a structure is not just the responsibility of the mental health authority or the substance abuse authority. Nor is it the sole responsibility of the criminal justice system agencies that often deal with dually diagnosed citizens. Instead, a collaboration of agencies with representation from all components of the community should come together.

D.C. currently has two collaborations that focus on individuals with co-occurring substance abuse and mental health disorders: the Comprehensive Continuous Integrated System of Care (CCISC) and the Workgroup. CCISC (presented in Chapter 3) is primarily a collaboration between DMH and APRA with support from the PSA and CSOSA. The Workgroup casts a somewhat larger net including not only the four agencies mentioned above, but also representatives from DCSC, PDS, USAO, BOP, the Council of Governments, and DCDOC. Either of these two collaborative bodies can serve as the vehicle to move D.C.'s approach to individuals with co-occurring disorders forward. However, the CCISC already has a clear set of tasks to implement. The Workgroup has a broader mandate and brings together a larger group of constituents. The Workgroup can continue to strategically plan around issues of co-occurring disorders, help create integrated treatment programs to increase providers' capacities to offer dually diagnosed capable or dually diagnosed enhanced treatment, and help create service provider networks that involve treatment providers and criminal justice system agencies alike, so that people make it into treatment, whether they are diverted from a criminal justice response or become involved in the system long term.

No matter which collaborative team D.C. agencies decide to work with, three recommendations are relevant to these teams' efforts to build a stronger service network. Because national recommendations suggest building the collaborative structure in addition to developing specific treatment practices or ideologies, the following suggestions cover the myriad needs the group may wish to address in this arena, from infrastructure to specific programs:

Recommendation: Use current funding creatively and apply for new funding.

D.C. currently receives money through a number of funding sources. These funding streams can be used creatively to address the needs of dually diagnosed clients. For instance, the following funding from the Substance Abuse and Mental Health Services Administration's (SAMHSA) block grant programs can be sources of support for collaborative efforts: the Substance Abuse Prevention and Treatment Block Grant (SAPT), the Community Mental Services Block Grant

(CMHS), and the Projects for Assistance in Transition from Homelessness (PATH) formula grant program. These grant programs allow funding to be used for services for individuals with co-occurring disorders (SAMHSA 2003a).[3] State-level agencies would need to negotiate how the monies would be used for this purpose. However, using these options for new service structures could be difficult as they already support existing projects. Changing strategic focus may not only be challenging, but also may not be the best approach for this community or the most appropriate use of monies.

SAMHSA currently is embarking on a major effort focused on people with co-occurring mental health and substance abuse disorders.[4] This effort presents another funding source to consider. As part of this national initiative, a new SAMHSA funding avenue administered by the Center for Substance Abuse Treatment and the Center for Mental Health Services may perhaps be fruitful for the Workgroup to pursue. SAMHSA started the State Incentive Grants for Treatment of Persons with Co-Occurring Substance Related and Mental Disorders – or COSIGs – in fiscal year 2003.[5] That year, SAMHSA awarded $6.5 million to seven states and anticipates awarding another $4.5 million during fiscal year 2004. Only an Office of the Governor is eligible to apply to the COSIG program, in this case the Office of the Mayor, and for this reason, the Workgroup may be the appropriate collaborative team to consider this funding option. Individual departments of mental health and substance abuse cannot apply separately – the application must be collaborative.[6]

The purpose of the COSIG funding, as stated on the SAMHSA web site, is to provide support for states "to enhance their infrastructure to increase their capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services to persons with co-occurring substance abuse and mental disorders." New funding from a source such as this one may be a way to implement the other recommendations outlined below that would require financial support, such as training and new programs focused specifically on individuals with co-occurring disorders. More information about the COSIG program and the application process can be found at http://alt.samhsa.gov/grants/2004/nofa/sm04012rfa_cosig.htm.

Recommendation: Pursue technical assistance opportunities (particularly when they are free of charge).

As the Workgroup considers its next steps, it may be helpful for the members of the group to pursue technical assistance opportunities. Again, SAMHSA offers many opportunities to receive such assistance.

- This fall, SAMHSA is launching the Co-Occurring Center for Excellence, a new technical assistance center and "help line" created to support state initiatives focused on appropriate treatment for co-occurring substance abuse and mental health disorders. The Center will

[3] Also see http://pathprogram.samhsa.gov/.
[4] Co-occurring disorders is one of four primary initiatives that SAMHSA is supporting over the next several years (SAMHSA National Advisory Committee Meeting, July 1, 2004). The other three primary initiatives related to this are: (1) Mental Health System Transformation (focused on changes in perception, access, delivery, and financing); (2) Access to Recovery (a new individualized voucher approach to treatment); and (3) a Prevention Strategic Plan.
[5] SAMHSA National Advisory Committee Meeting, July 1, 2004.
[6] http://alt.samhsa.gov/grants/2004/nofa/sm04012rfa_cosig.htm.

identify best practices in the field and assist with implementation of such practices through technical assistance, training, and other resources.

- Because addressing co-occurring disorders is one of SAMHSA's four primary initiatives, it is supporting a series of Policy Academies focused on co-occurring disorders.[7] The first Policy Academy took place in 2004 and ten states attended. Two more Policy Academies, for which states must apply to attend, are planned for 2005. Like with the COSIG funding, a collaborative team of key agency representatives must apply together to attend the Academy. The purpose of the Academy is to provide training and workshops so that the team will leave the sessions with an action plan developed for the state that is ready to be implemented.

- SAMHSA supports the National GAINS Center for People with Co-Occurring Disorders in the Justice System (www.gainsctr.com). GAINS stands for "Gathering information, Assessing what works, Interpreting/integrating facts, Networking, and Stimulating change." This center is devoted to addressing the needs of people in the criminal justice system who are dually diagnosed. It sponsors conferences, hosts a web site with publications, and provides technical assistance to communities.

- SAMHSA also currently supports the Addiction Technology Transfer Centers (ATTC; www.nattc.org), a network of regional technical assistance providers. Washington, D.C. is part of the Central East ATTC hosted at the Danya Institute in Silver Spring (phone: (240) 645-1145; www.ceattc.org). The role of these centers is to synthesize scientific research for the field and promote innovative treatment practices.

- The Workgroup could also solicit technical assistance from community representatives from those programs highlighted in chapter 2. The Workgroup could bring the identified community representatives to D.C. for this purpose or Workgroup members could conduct site visits to the programs of interest to see the programs in action and meet with the relevant stakeholders.

Recommendation: Gather more information on a regular basis.

In order for the Workgroup to have current knowledge about the state of the field, it may be useful to actively pursue information from the field on a regular basis. Perhaps one member of the Workgroup could be responsible for culling the literature, filtering list-serve information, and visiting web sites to identify new innovations or initiatives that may affect practice in D.C. A number of sources of information could be tapped:

- Co-Occurring Dialogues Electronic Discussion List Information. SAMHSA's Center for Substance Abuse Treatment has a discussion forum for information exchange and notification of new resources and publications. Those subscribed to the list can also request information or pose questions to the field. (The list can be subscribed to by sending an e-mail to dualdx@treatment.org.)

[7] SAMHSA National Advisory Committee Meeting, July 1, 2004

- The general ATTC web site offers a number of publications on co-occurring disorders: http://www.nattc.org/resPubs/pubCat/resultsTopic.asp?topic=3.

- This fall, the Center for Substance Abuse Treatment will release a new volume of their Treatment Improvement Protocols Series (TIPs) devoted to co-occurring disorders. The last time a TIP was devoted to this topic was in 1994 (TIP #9). In addition, a number of TIPs throughout the series are relevant to criminal justice populations (including TIP numbers 7, 12, 17, 21, 23, and 30) and can be found at: http://www.treatment.org/Externals/tips.html.

1.3. RECOMMENDATIONS APPLYING GUIDING PRINCIPLES FROM FOUR POINTS IN THE CRIMINAL JUSTICE SYSTEM

Chapter 2 presents guiding principles for four points in the criminal justice process representing opportune times for the system to intervene to assist someone with co-occurring disorders (crime/incident, pretrial, incarceration, and community supervision and reentry). Below are specific recommendations for the Workgroup to consider based on such guiding principles.

1.3.A. CRIME/INCIDENT

Two guiding principles presented in chapter 2 are related to the crime/incident stage of the criminal justice process:

Guiding Principle: Training dispatchers to consider the nature of a call and whether or not mental health issues are a factor in the call will increase the likelihood that the most appropriate first responder will be sent to the scene (Criminal Justice/Mental Health Consensus Project 2002).

Guiding Principle: Training and requiring law enforcement officers to identify mental health and/or substance abuse issues will help them determine how best to address an incident for the individual person based on the type of offense that was committed, the safety issues involved, and the types of programs and resources available in the community. Written policies and protocols should be developed to ensure that officers know how to proceed in particular situations and document the course of action taken (Criminal Justice/Mental Health Consensus Project 2002).

Recommendation: Provide training opportunities for dispatchers and law enforcement officers about substance abuse and mental health disorders and appropriate ways to address people with such needs.

As shown in chapter 3, MPD currently has procedures in place for officers for how to handle incidents involving people who are intoxicated (General Orders 501.03, Handling Intoxicated Person) or people who are presenting mental health issues (General Orders 308.4, Processing of Persons Who May Suffer from Mental Illness). However, officers are not specifically trained on these issues in a structured way. MPD (and other police departments) might consider training officers so that they can identify mental health and substance abuse concerns and then follow through with the procedures outlined in the Orders that focus on securing the situation, as well as addressing the physical needs (if applicable) and the mental health needs of the person.

Additionally, training dispatchers to gather information upfront that identify mental health and substance abuse issues at a scene may better prepare officers to respond.

One possible approach to training of this nature may be to include MPD personnel along with representatives from DMH and APRA in the same training sessions. Collaborative training may provide first responders with a more comprehensive set of information about mental health and substance abuse issues, as well as information on how to recognize and address co-occurring issues. Also, if such training is developed and conducted collaboratively among these agencies, the needs and concerns of officers can be taken into account, so that the training is relevant and appropriate.

With better training, officers and dispatchers may make better use of DMH's Comprehensive Psychiatric Emergency Program (CPEP), Mobile Crisis Unit. This program has civilian mental health specialists available for law enforcement to access for assistance. CPEP provides on-site services, so the team can come directly to a scene when requested. However, currently most law enforcement and CPEP interaction occurs at CPEP's program officers at the D.C. General Hospital Campus. Training also may lead to better use of the DMH first responder card that has been provided to officers.

Recommendation: Ensure that the treatment provider network is ready to work with police when they are interested in transporting someone to a program for assistance.

If dispatchers and officers become better able to handle people presenting mental health or substance abuse issues, or the co-occurrence of these issues, then the service provider network must be willing and prepared to address the needs of people the police identify as requiring assistance. Some concern has been raised that once police identify issues, they are unable to bring people to treatment providers because of eligibility rules or service capacity issues, and that the full range of mental health and/or substance abuse issues are unable to be addressed. For example, not every person the police deals with needs detoxification or emergency hospital care for psychiatric issues, but at the same time the person still may not be appropriate for legal intervention and detention.

Service providers in D.C., through APRA and DMH, could consider the range of program possibilities to assist police when they identify someone with mental health or substance abuse issues, or the co-occurrence of these issues. Perhaps eligibility rules may be revised or, if appropriate, entirely new programs to assist people may be created. For example, D.C. may benefit from reviewing the services of highlighted program models presented in chapter 2 that attempt to prevent criminal justice intervention when it is possible.

1.3.B. PRETRIAL

The first guiding principle presented in Chapter 2 for the pretrial stage is:

Guiding Principle: Screen for substance abuse and mental health disorders as early as possible, using a simple and effective screening instrument. Screening results should inform assessments, the use of diversionary programs, and treatment. Screening and assessment information should be shared across agencies and specific mechanisms to

easily share such information should be created (Mears et al. 2003; Peters and Bartoi 1997).[8]

Recommendation: Continue to pursue the implementation of the Universal Screener.

The crux of this guiding principle is to screen people early for mental health and/or substance abuse issues and to screen people often, so that defendants have multiple opportunities to present issues. Table 1.1 documents the screening and assessment tools used by D.C. agencies. Different screening and assessment tools are used throughout the system and staff members do not share the results of these tests across agencies. In response, the Workgroup embarked on an effort to create a Universal Screener with the hope that this tool will eventually be used throughout the criminal justice system. Current plans are to pilot this Universal Screener in MPD districts beginning in September 2004.

Implementation of the Universal Screener would represent an important step for D.C. Screening people while at MPD catches people very early in the criminal justice process. If other agencies adopt the same tool, offenders will have the opportunity to present such issues at various times throughout their criminal justice experience.

The Workgroup may want to continue its leadership role in implementing a Universal Screener or seek assistance from an outside technical assistance provider with expertise in creating collaborations and implementing projects across agencies. It would be beneficial to bring agencies together on this issue and overcome barriers to implementation that may exist. Recognizing that each agency has a different definition of "success" for an offender and different priorities for what they are trying to achieve with that offender may help overcome turf issues between agencies and increase understanding and trust.

Recommendation: Continue to pursue ways to share information from screenings or assessments conducted by one agency with other agencies, so such information can follow an offender through the system.

Whether or not D.C. agencies succeed at using one Universal Screener, it is important for agencies to share information about the results of screening and assessment. Currently, PSA and CSOSA are developing a way to share assessment information because PSA's assessments may be timely enough that CSOSA does not need to reassess each individual. Even if a reassessment is required, having past assessment information can inform the next steps for the agency just beginning to work with that person.

Sharing results from screenings and assessments between agencies may lead to two results. First, it may lead to greater staff efficiency in agencies, such as fewer unnecessary assessments if previous information is current. Second, it may lead to a greater likelihood that a person's needs are met immediately upon entering a new agency. For example, if past information shows a history of mental health issues then an agency can immediately assess treatment needs, rather than wait for the person's mental health issues to become acute enough to notice or until an assessment can be completed.

[8] Additional information was found in the GAINS Center Brochure, http:///www.gainsctr.com.

Table 1.1
Screening and Assessment Tools, by Agency
(as of the date of the interview conducted with each agency)

	Substance abuse		Mental health	
	Instrument	**Outcome**	**Instrument**	**Outcome**
Pretrial Services	PSA screener, Addiction Severity Index , ASAM Criteria	Inform release decision, conditions, and treatment	PSA screener	Refer to DMH for assessment, inform release decision, conditions, and treatment
APRA	Addiction Severity Index (for adults), GAIN (for juveniles)	Inform internal treatment decisions	Tool created by agency	Inform referral to Alpha Dual Diagnosis program
DMH	--	--	Tool created by agency	Inform internal treatment decisions
Public Defender Service (Offender Rehabilitation Division)	Tool created by agency	Inform case management	Tool created by agency	Inform case management, assessment not shared with providers or other agencies
DCDOC	Tool created by agency	Inform internal treatment decisions	Tool created by agency	Inform internal treatment decisions
BOP	Modified Texas Christian University Drug Screen II/ DSM-IV-R	Inform internal treatment decisions	DSM-IV-R	Inform internal treatment decisions
CSOSA	Addiction Severity Index, ASAM Criteria	Inform treatment decisions	Assessment by contract psychologists	Inform treatment decisions

Related to this, information may not only be shared within the criminal justice system but also with other relevant agencies. Criminal justice information could also be made available to public mental health and substance abuse agencies. CJCC has facilitated efforts to create the Justice Information System for the District of Columbia (JUSTIS), providing an interface for both federal and local justice agencies in D.C. to share data. In addition to justice agencies, it would be useful for the public behavioral health system to also have access to such a system to accurately document who in their clientele are also involved in the criminal justice system and to fully understand the issues and needs of the clientele they serve.

The second guiding principle presented in chapter 2 for the pretrial stage is:

Guiding Principle: When possible and appropriate, criminal justice agencies should use pretrial diversion for cases involving people with co-occurring mental health and substance abuse disorders. If diversion opportunities are not available and the case is appropriate, offenders with co-occurring mental health and substance disorders should be released with the least restrictive conditions and pretrial agency staff should assist defendants in complying with conditions of pretrial release. Defendants should not be detained before trial based on a lack of information or referral resources (Center for Substance Abuse Treatment 1995a; Criminal Justice/Mental Health Consensus Project 2002).

Recommendation: Consider more diversion program options for offenders with co-occurring mental health and substance abuse disorders.

PSA is currently working with the USAO to consider the Options program as a diversion track for defendants with mental health issues. PSA already diverts misdemeanants in the system with substance abuse issues to the Superior Court Drug Intervention Program (SCDIP). Both Options and SCDIP currently accept people with co-occurring disorders as long as the non-primary issue is under control. Other programs similar to these could be created that specifically focus on co-occurring disorders, recognizing both mental health and substance abuse issues to be primary and in need of consideration for treatment and appropriate criminal justice response.

The Workgroup may want to seek peer-to-peer technical assistance from grantees funded through SAMHSA's Jail Diversion Knowledge Development and Application Program which focuses specifically on diversion programs for people with co-occurring disorders (see chapter 2). The grantees through this program are Memphis, Tennessee; Multnomah County, Oregon; Montgomery County, Pennsylvania; Maricopa and Pima Counties, Arizona; Connecticut (six cities); Lane County, Oregon; Hawaii; New York City; and Wicomico County, Maryland. The GAINS Center is the technical assistance partner to the project.

1.3.C. INCARCERATION, COMMUNITY SUPERVISION, AND REENTRY

We combined the principles from incarceration, community supervision, and reentry, because we are making a single recommendation that applies to both facilities and services in the community. The guiding principles presented in chapter 2 for these points of the criminal justice process are:

<u>Guiding Principle</u>: Jail and prison procedures should include screening and identification of mental health and substance abuse issues upon arrival at the jail or prison. Appropriate treatment offerings should be available within the facility and release planning that includes referrals to community resources should be developed. Not all inmates will show signs of mental health and substance abuse issues at initial assessments, so processes should allow for identification and action throughout their stay (Center for Substance Abuse Treatment 1994; Criminal Justice/Mental Health Consensus Project 2002; Peters and Bartoi 1997; Peters and Hills 1997).

<u>Guiding Principle</u>: Results from internal screening, assessments, and treatment plans should feed into transfer and/or release planning efforts. In the case of transfer, such records should follow the inmate to the next facility so that staff can immediately address the identified issues. In the case of release planning, such information should assist staff in developing individualized plans that include community-based treatment along with housing and other programming options (Center for Substance Abuse Treatment 1994; Criminal Justice/Mental Health Consensus Project 2002; Hills 2000; Peters and Bartoi 1997).

<u>Guiding Principle</u>: Correctional facility staff and staff from community supervision agencies should be familiar with and able to refer to community-based mental health and substance abuse treatment providers and this information should directly lead into release decisions, determination of release conditions, and release plans. Once released, agency staff should assist offenders with co-occurring mental health and substance abuse issues to comply with conditions of pretrial release, probation, or parole (Criminal Justice/Mental Health Consensus Project 2002; Peters and Hills 1997).

<u>Guiding Principle</u>: Facility staff, community supervision staff, and staff from mental health and substance abuse treatment providers should collaborate to help an inmate transition successfully from the facility to the community (Criminal Justice/Mental Health Consensus Project 2002: 162; Peters and Hills 1997).[9]

Recommendation: Create better mechanisms for coordinated treatment from inside facilities to outside in the community.

A number of services are currently provided inside D.C. jail and in prisons. Both DCDOC and BOP seem to be attempting to match offenders with appropriate treatment options while incarcerated. We currently do not have enough information to estimate if the treatment services that are available are "enough" to serve all the inmates that require them. It may be useful to conduct a needs assessment that identifies if enough services are available in facilities.

Where the Workgroup can make a difference now, however, is in facilitating an offender's return to the community. A number of initiatives are currently in place to assist with an offender's return from jail or prison: (1) the jail has SafetyNet which coordinates substance abuse treatment services from inside the jail to a program in the community; (2) the jail has a DMH liaison who attempts to make mental health treatment placements for people returning to the community; (3)

[9] Additional information was found in the GAINS Center Brochure, http:///www.gainsctr.com.

CSOSA is piloting a project to conduct videoconferences with inmates in prison to conduct release planning in preparation for their return; and (4) CSOSA conducts assessments of people in Community Corrections Facilities (CCFs) and jail before they are released from custody to prepare for supervision conditions and treatment levels. But, even with these efforts, more work can be done.

The Workgroup could assist with facilitating efforts to increase release planning and create a true continuum of care for people. For example, SafetyNet can only serve so many clients each year (the current capacity is 101 clients). Expanding this program so that more people can directly transition from jail to residential care may be appropriate. Or, developing a similar program that would place substance-abusing offenders into other types of treatment options besides residential care may be appropriate. Similarly, finding ways to build CSOSA's efforts to "reach in" before offenders are released may further ensure people will experience continuity in their treatment, whether it is for mental health issues, substance abuse issues, or co-occurring disorders.

In addition, the DMH liaison in the jail is not always successful at placing inmates into care once they leave the facility. One reason cited was that many agencies do not want to take on clients coming directly from jail. However, our survey of service providers presented in chapter 4 showed that 87 percent of mental health and substance abuse treatment providers in D.C. are willing to unconditionally take clients who are in the criminal justice system. Current barriers to placing people may be overcome if providers and criminal justice agencies are brought together to understand each other's roles, responsibilities, and goals.

Finally, the Workgroup may be able to facilitate the relationships between criminal justice agencies with DMH and APRA both at the departmental level and at the individual provider level. Through the funding efforts and technical assistance efforts mentioned above, the collaborative group may be able to address development of programs for co-occurring disorders, funding shortfalls for services, and identification of ways to best support the services offenders most need.

1.4. CONCLUSIONS

Many of the above recommendations include elements of our final recommendation:

Recommendation: Collaborate, collaborate, collaborate.

As the guiding principles in chapter 2 show and chapters 3 and 4 clarify, no single agency can best serve individuals in the criminal justice system with co-occurring mental health and substance abuse disorders. The criminal justice system agencies need the help of the public behavioral health system, and vice versa.

A number of agencies in D.C. already work together in some capacity to address the needs of people with mental health or substance abuse issues. Criminal justice system agencies screen, assess, and refer for these issues; DMH has an assessment liaison at pretrial; PSA has created the SCDIP and the Options programs; the PDS provides case management and services to defendants; DMH has a liaison in the jail; and CSOSA does assessments in CCFs and in the jail. However, none of the current efforts focus specifically on co-occurring issues. Only one

collaborative effort does this – the Alpha Dual Diagnosis Center.[10] However, individual treatment providers conduct assessment for co-occurring disorders, provide referrals, and, in some cases, provide services. Greater collaborative efforts specifically for co-occurring issues are needed.

Yet collaboration can be very difficult, and major hurdles must be overcome to build an infrastructure that can support adequate services throughout the system. Each agency discussed here has different views of the dually diagnosed person, different philosophies about how to treat the person, different definitions of successful outcomes for that person, and different solutions to address the person's problems. Such differences exist not only between the criminal justice system and the public behavioral health system, but also among agencies within the criminal justice system and among treatment providers.

Despite these differences, common ground can be found. Washington, D.C., already has two community-level collaborative structures in place — the Workgroup and the CCISC — that could be springboards for efforts to further address the needs of individuals with co-occurring mental health and substance abuse issues in the criminal justice system. We cannot emphasize enough that these groups should use the resources out there to get technical assistance to support their collaborative efforts. As representatives from the state of Vermont recommend in chapter 2, bringing in an outside facilitator to help negotiate this change in focus is helpful. An objective resource can help to enhance the relationships between agencies, build greater trust, strengthen partnerships, and overcome barriers in order to build the local service provider network and create a truly continuous system of care for people with co-occurring mental health and substance abuse issues.

[10] The Alpha Dual Diagnosis Center is slotted to close on 11/12/04. However, DMH and APRA are negotiating two programs that will replace the Center including Assertive Community Treatment and an intensive day treatment program.

Chapter 2. Guiding Principles for Serving Defendants with Co-occurring Mental Health and Substance Abuse Disorders

2.1. INTRODUCTION

National statistics on the household population indicate that many in the United States have serious mental health and substance abuse problems and that these conditions often co-occur.

- Results from the 2001—2002 National Epidemiologic Survey on Alcohol and Related Conditions indicate that, in the United States, 19.4 million adults meet the DSM-IV criteria for a substance use disorder and 42.2 million adults meet the DSM-IV criteria for a mood or anxiety disorder (National Institute on Alcohol Abuse and Alcoholism [NIAAA] 2004).
- Results from the 2002 National Survey on Drug Use and Health indicate that four million people in the United States have a serious mental illness and a co-occurring substance use problem (Substance Abuse and Mental Health Services Administration [SAMHSA] 2003b).
- Adults with a serious mental illness are more than twice as likely to use an illicit drug compared with those adults without a serious mental illness. Approximately 23 percent of adults with severe mental illness have substance use disorders (SAMHSA 2003b).
- The 2001—2002 National Epidemiologic Survey on Alcohol and Related Conditions shows similar rates of co-morbidity, finding that 20 percent of people with a substance use disorder suffered a mood or anxiety disorder in the same time period and 20 percent of people with a mood or anxiety disorder suffered a substance use disorder in the same time period (NIAAA 2004).
- People who are not in the labor force and have a serious mental illness are three times more likely to have used illicit drugs than their counterparts who do not have a serious mental illness and are not in the labor force (21.2 percent compared with 6.9 percent) (SAMHSA 2003b).

Rates of mental health and substance abuse problems are higher among the criminal justice population than the general population (Lurigio and Schwartz 2000; Peters and Bartoi 1997). While quantifying the actual number of people in the criminal justice system with substance use disorders, mental health issues, or both has proved challenging, some relevant facts and statistics provide an estimate of the problem:[11]

[11] Several other studies have attempted to document the prevalence of mental health and substance abuse issues among people in the criminal justice. Other studies (Chulies et al. 1990; Cote and Hodgins 1990; Mirin et al. 1988) show that: 75 percent of addicted offenders have histories of depression; 25 percent of addicted offenders have histories of major depression, bipolar disorder, or atypical bipolar disorder; 9 percent of addicted offenders are schizophrenic (Federal Bureau of Prisons); and 72% of detainees with severe mental disorders have a co-occurring substance use disorder (Abram and Teplin 1991).

- In 2003, approximately 1.4 million people were in prisons in the United States and approximately 760,000 people were held in or supervised by local jails. Another 4.8 million people were on probation or parole.[12]
- Approximately 34 percent of inmates have substance abuse problems (U.S. Department of Justice, the Bureau of Justice Statistics, and the Federal Bureau of Prisons 2001).
- Approximately 16 percent of inmates in jail and state prisons have had a mental health diagnosis or went to a mental health clinic for assistance (Beck and Maruschak 2001).
- Similar problems prevail among adults on probation and parole — 20.8 percent of adults on parole or supervised release have a serious mental illness, yet only 8.2 percent of adults not on parole or supervised release have serious mental illnesses (SAMHSA 2003b).
- Offenders with co-occurring disorders have high rates of recidivism (Substance Abuse Policy Research Program 2004).

Locally, it is even more difficult to capture the number of people in the criminal justice system with substance use disorders, mental health issues, or both. Again, some statistics shed some light on the issue:

- D.C. Metropolitan Police Department (MPD) reported an official crime total of 44,456 offenses in 2002.[13]
- Approximately 60,000 D.C. residents are addicted to alcohol and other drugs. [14]
- According to the D.C. Department of Mental Health (DMH), there are between 26,000 and 42,000 individuals with a co-occurring disorder in D.C. (Mayor's Interagency Task Force on Substance Abuse Prevention, Treatment, and Control 2003).

The prevalence of co-occurring disorders and criminal justice involvement among D.C. residents coupled with the national figures suggest that many people involved in the criminal justice system face substance abuse and mental health challenges. Factors compounding the need to improve treatment opportunities and prevention programming for offenders with co-occurring disorders in D.C. include the high cost of addiction and mental illness in terms of criminal behavior and health-related issues, and the increase of low-level offenders using and reusing criminal justice facilities as treatment alternatives (Solomon and Draine 1995). In 2004, Addiction Prevention and Recovery Agency (APRA) staff estimated that drug and alcohol use in D.C. cost $1.2 billion per year due to premature deaths, criminal careers, substance use related illnesses, and incarceration (Johnson 2004).

A Court Services and Offender Supervision Agency (CSOSA) study further highlighted the need

[12] Bureau of Justice Statistics, www.ojp.usdoj.gov/bjs.
[13] http://mpdc.dc.gov/main.shtm.
[14] The rate of addiction to illegal drugs among DC residents is 40 percent higher than the national average (Johnson 2004).

for better prevention and treatment options. It found that only 14 percent of pretrial defendants, 28 percent of probationers, and 35 percent of parolees had received treatment of any kind before being involved in the criminal justice system. Of the 35 percent of parolees who had received treatment, most received treatment while incarcerated – only 28 percent had received it outside of jail or prison.[15]

Given the above information describing the extent of the problem, the Criminal Justice Coordinating Council, Substance Abuse and Mental Health Workgroup (the Workgroup) tasked the Urban Institute with identifying promising practices in the treatment of people in the criminal justice system with co-occurring disorders. The information provided will help guide the Workgroup's mission to facilitate service advancements for people with a dual diagnosis in D.C.'s criminal justice system.

To this end, national research, program information, and recommendations were gathered from a variety of sources. The Council of State Government's Consensus Project (2002) was the primary source of information on best practices on which we based our guiding principles. Next, we relied on the Center for Substance Abuse Treatment's (CSAT's) Treatment Improvement Protocols for further recommendations on service practices. Finally, we accessed other sources of information including the GAINS Center (web site and publications), the Technical Assistance and Policy Analysis Center for Jail Diversion (web site and publications), the National Development and Research Institute, Inc. (NDRI) (web site and publications), funding organizations (Robert Wood Johnson Foundation), advocacy organizations (National Alliance for the Mentally Ill), federal agency web sites (Center for Mental Health Services [CMHS], SAMHSA, National Institute of Mental Health, and National Institute on Drug Abuse [NIDA]), state Departments of Corrections (DOC) web sites, the Bureau of Prisons web site, social science/criminal justice-focused indices of publications, and personal contacts.

In this chapter, information is organized around a series of guiding principles that have been adapted from the numerous resources listed above. The guiding principles represent ideas and strategies that criminal justice system agencies can employ to identify and respond to the needs of individuals with co-occurring mental health and substance abuse disorders. The principles are intended to help guide the thinking of the Workgroup members as they are considering appropriate practices for D.C. First, an overarching guiding principle related to preventing criminal justice system contact for individuals with co-occurring disorders is presented. Second, an overarching guiding principle is presented relevant to all stages of the criminal justice system. Next, guiding principles are presented within the context of four criminal justice system access points representing opportune times for the system to intervene. The four access points of focus are: (1) crime/incident, (2) pretrial, (3) incarceration, and (4) community supervision and reentry. Where they exist, examples of communities with promising practices are presented to illustrate guiding principles.

Few rigorous research studies have been conducted about these principles or about integrated substance abuse and mental health treatment and its effect on recidivism, mental health, and substance abuse. As a result, both the guiding principles and the practices presented here should be viewed as promising strategies based on the best knowledge the field has to offer. However,

[15] Center of Juvenile and Criminal Justice, Draft Technical Assistance Report.

in a world of "best practices" and "proven programs," more research is required to argue the "proven effectiveness" of the interventions presented. What is included represents the most innovative approaches to better identify and better serve the population of interest. The information provided in the following narrative is summarized in table 2.1.

2.2. GENERAL GUIDING PRINCIPLES

Before entering the criminal justice system, people with co-occurring substance abuse and mental health disorders often rely on the public mental health or substance abuse system for services. In many parts of the country, public behavioral health system resources are being depleted and access to effective services for those with co-occurring mental health and substance abuse issues may be limited (SAMHSA, 2003a).

> *Unfortunately for people with co-occurring disorders, the decision to seek professional help can be frustrating and confusing whether they enter the mental health system or the substance abuse treatment systems. The mental health system traditionally has tended to exclude persons who also abuse substances, maintaining that the primary work of providers is with mental illness and not with substance abuse. Substance abuse programs often have excluded from treatment persons with mental illness who were taking prescribed medications by requiring individuals entering treatment to demonstrate their motivation by being 'clean of all drugs' — including prescribed medications* (SAMHSA, 2003a, 5).

The strains on the public behavioral health system may be one reason that people with co-occurring substance abuse and mental health disorders often end up in the criminal justice system.[16] The first guiding principle focuses on preventing such contact.

<u>Overarching Guiding Principle</u>: Developing and implementing comprehensive and appropriate community-based services will help local public behavioral health systems treat problems, improve individual functioning, and prevent criminal justice system involvement for people with co-occurring mental health and substance abuse disorders. These services should be designed to be easily accessible to potential clients (Criminal Justice/Mental Health Consensus Project 2002; SAMHSA 2003a).

Appropriate and accessible services may include "user-friendly" entry into both the mental health and substance abuse systems by employing a "no wrong door" method of working with clients confronted with co-occurring disorders. Instead of being left to navigate the mental health or substance abuse system on their own, clients are welcomed wherever they enter the system, given a full assessment, and linked with the appropriate services for both conditions. Research suggests that effective systems treat both disorders as primary with integrated service (Hills 2000; Peters and Hills 1997). Effective systems should also focus on the severity of

[16] GAINS Center Brochure, http://www.gainsctr.com.

Table 2.1. Programs Using Principles for Serving People with Co-Occurring Substance Abuse and Mental Health Disorders

Crime/incident	Pretrial	Incarceration	Community supervision and reentry
Improve community-based public behavioral health services and access to them. ▪ BUS and Pre-Booking Diversion Program in King County, WA ▪ The Family Intervention for Dual Disorders Program in NH ▪ Rebuilding Lives in Columbus, OH; ▪ Office of Services for the Homeless and Adults in Philadelphia, PA ▪ Metropolitan Birmingham Services for the Homeless in AL ▪ New Hampshire-Dartmouth Psychiatric Research Center in NH ▪ Community Psychiatric Clinic in Seattle, WA **Collaborate and share information between criminal justice agencies, and mental health and substance abuse treatment providers.** ▪ Office of Alcohol and Drug Abuse Programs in VT ▪ The Dual Diagnosis Task Force in Broward County, FL ▪ Maryland Department of Health and Mental Hygiene **Train dispatchers.** ▪ The Psychiatric Emergency Response Team in San Diego, CA **Train officers and establish written protocols for first responders.** ▪ Memphis Crisis Intervention Team in TN ▪ The Psychiatric Emergency Response Team and Serial Inebriates Program in San Diego, CA ▪ Dutch Shisler Sobering Support Center in Seattle, WA ▪ Harborview Medical Center Crisis Triage Unit in Seattle, WA	**Screen early and create mechanisms to share information within and between agencies.** ▪ Data Link Project in Maricopa County, AZ ▪ Akron, OH **Maximize the use of alternatives to prosecution and incarceration.** ▪ Mental Health Diversion Program in Jefferson County, KY ▪ Pima County, AZ ▪ Connecticut's Criminal Justice Diversion Program ▪ Co-Occurring Diversion Program/Drug Court in Lane County, OR ▪ Project Phoenix in MD	**Provide screening opportunities, throughout jail or prison stays and provide referrals and appropriate treatment offerings to address identified needs.** **Ensure assessment results inform treatment planning and programs, and follows inmates when transferred to other facilities and released to the community.** ▪ TAMAR Program in MD ▪ Dual Diagnosis Offender Program in IA	**Ensure criminal justice system agency staff are familiar with community-based mental health and substance abuse treatment providers and can include appropriate information in release decisions, determination of conditions of release, and release plans. Assist offenders in complying with release conditions.** ▪ Maryland Community Criminal Justice Treatment Program ▪ Co-Occurring Diversion Program in Lane County, OR ▪ District One Intensive Substance Abuse Treatment Unit in Richmond, VA **Facilitate collaboration among corrections, community corrections, and community-based mental health and substance abuse treatment providers.** ▪ San Francisco Citywide Forensic Case Management Team in CA ▪ Pennsylvania Department of Corrections ▪ Modified Therapeutic Communities in Brooklyn, NY

symptoms and individual skill deficits (Hills 2000). This includes identifying specific needs of individuals who are at risk of or have histories of criminal justice involvement.

- **The Bureau of Unified Services and Pretrial Diversion Program in King County (Seattle), Washington**, provides an example of a program focusing on providing user-friendly services. "The goal of the BUS [Bureaus of Unified Services] is to create 'no wrong door' to the existing service systems by making every doorway into treatment the 'right' door, regardless of presenting issues" (SAMHSA 1999, 12). In operation since 1997, King County's BUS aims to provide services to people who are experiencing mental illness and/or chemical addictions, especially those who are at risk for homelessness or have a chronic history of using public services and jails/prisons for acute care. BUS involves the Department of Community and Human Services, the Department of Public Health, the Department of Adult Detention, Harborview Medical Center, and community-based organizations. Of particular interest is their work developing interagency referral procedures and their development of a viable pre-booking diversion project complete with a mobile crisis triage center (based on the Memphis Crisis Intervention Team Model). For more information, contact David Wertheimer, Principal, Kelly Point Partners at (206) 914-4475 or david@kellypointpartners.com (SAMHSA 1999; Wertheimer 2000).

- The **Family Intervention for Dual Disorders Program (FIDD) in New Hampshire** exemplifies another point of this recommendation: FIDD engages family members in treatment to help clients maintain relationships with their community. Specifically, FIDD aims to meet the needs of both families and dually diagnosed clients — through incorporating the stages of dual disorder treatment into the family's therapy. FIDD also facilitates collaboration between clinicians and relatives involved with a dually diagnosed individual. The pilot study of FIDD showed that mental health clinicians were able to learn and implement FIDD and that families could be engaged and treated successfully. For more information, contact Kim Mueser at NH-Dartmouth Psychiatric Research Center at kim.t.mueser@dartmouth.edu (Mueser and Fox 2002).

- Homeless people with co-occurring disorders present an even more socially marginalized group at risk for criminal justice involvement than housed people with co-occurring disorders (Metraux and Culhane 2004; Roman 2004). In **Columbus, Ohio**, the **Rebuilding Lives** initiative focuses on providing services and shelter to homeless individuals. Programmatic components aimed at treating co-occurring substance abuse and mental health disorders include service-enriched housing, detoxification facilities, psychiatric services (available through a local hospital), and case management. The program's innovative outreach includes a mobile "triage" unit — a psychiatrist, a nurse, a chemical dependency counselor, and a case manager on-wheels. The team provides services and referrals to homeless individuals on-site. Rebuilding Lives is a collaborative effort between the Community Shelter Board, agencies involved in the Franklin County Service System, the YMCA of central Ohio, the United Way of Columbus, the City of Columbus, and other local coalitions and agencies. For more information, contact the Community Shelter Board at info@csb.org or visit http://www.csb.org (Burt et al. 2004).

- In **Philadelphia, Pennsylvania**, similar efforts to reduce street homelessness are housed under the Office of Services for the Homeless and Adults. Philadelphia takes an aggressive approach to engaging participants—conducting extensive outreach through the outreach coordination center and providing supportive housing. Once clients are engaged, administrators focus on addressing the underlying disorders that may contribute to homelessness; for people with co-occurring disorders, they offer substance abuse and mental health counseling and intensive case management. For more information, contact Robert Hess, Deputy Managing Director, Special Needs Housing, at robert.hess@phila.gov (Burt et al. 2004).

- **Birmingham, Alabama** reserves its permanent supportive housing program for those with co-occurring disorders and for people with AIDS. In addition to substance abuse and mental health treatment, the program provides employment training and placement, transitional and affordable low-income housing (for homeless and low-income people), support groups, and outreach. Additionally, program participants are required to provide community service. "In a large focus group held in Birmingham with people who had been chronically homeless, most said that being required to perform community service was the first time in their lives that anyone had treated them as if they had something to contribute, and as if they had a community that would care what they gave" (Burt et al. 2004: 28). Planning and development is coordinated under the Metropolitan Birmingham Services for the Homeless (MBSH). For more information, contact Michelle Farley, Interim Director of MBSH at (205) 254-8833 or mmfarley2003@yahoo.com.

- Some of the most notable and innovative work in co-occurring disorder treatment development has been produced by the **New Hampshire-Dartmouth Psychiatric Research Center (PRC)**. Sometimes called the New Hampshire Model or the Dartmouth Group, the center focuses on developing integrated treatment for mental health and substance abuse. Foundations of the New Hampshire Model include group treatment, phases of treatment (based on the substance abuse paradigm — engagement, persuasion, active treatment, and relapse prevention), and substitute activities and relationships. The group has implemented some programs in New Hampshire, and some of the PRC-lead programs target people involved in the criminal justice system (including FIDD, described previously). For more information about the center, its programs, and its ability to foster coordination, contact PRC at (603) 271-5747 (R.E. Drake, Director) (SAMHSA 2003a).[17]

- In addition to providing mental health services, the **Community Psychiatric Clinic in Seattle, Washington** is a licensed chemical dependency treatment provider. It operates a number of residential programs to provide housing to individuals with persistent mental illness and individuals with co-occurring mental illness and substance abuse issues. The residential programs include supportive housing with specialized case managers on site to assist clients with all their various needs. For more information about the clinic, its programs, and its ability to address dual

[17] Additional information was provided in the CT Serious and Violent Offender Reentry Initiative Workplan.

diagnosis, contact staff at the administrative offices in Seattle at (206) 461-3614 (Burt et al. 2004).

Prevention is a goal for communities to work toward now and in the future. However, communities are often unable to prevent individuals with co-occurring mental health and substance abuse disorders from coming in contact with the criminal justice system. When this happens, it is critical to have all the potential service providers working together to orchestrate the most appropriate response.

<u>Overarching Guiding Principle</u>: Collaboration between criminal justice agencies, mental health treatment providers, substance abuse treatment providers, and funding and advocacy groups will help communities serve individuals with co-occurring mental health and substance abuse disorders and provide appropriate justice system responses. It is important to develop planning processes that include top-level representatives from the criminal justice, mental health treatment, and substance abuse treatment fields (Center for Substance Abuse Treatment 1994, 1995a, 1995b; Criminal Justice/Mental Health Consensus Project 2002).

Collaboration between local agencies is a key feature of successful, long-term treatment programs. For example, a hallmark of effective treatment — treating both disorders as primary (Hills 2000; Peters and Hills 1997) — requires mental health and substance abuse providers to collaborate with criminal justice agencies. Collaboration is a long-term concerted effort between agencies; it takes time to build the partnerships and it is work to sustain them.

According to Treatment Improvement Protocol (TIP) #9 (Center for Substance Abuse Treatment 1994), administrators can help foster collaboration among service providers. Specific suggestions include:

- Ensuring "substance abuse and mental health professionals understand and respect the different historical and philosophical underpinnings of each others systems" (19),
- Addressing competing system goals — deterrence, punishment and rehabilitation — that emerge among and within substance abuse, mental health, and criminal justice agencies,
- Gathering input on program development from all the parties that could possibly be involved in treatment and funding, and
- Integrating through task forces and creating joint planning commissions.

- The **State of Vermont**'s journey from top-level planning to local-level implementation provides a model for building services for individuals in the criminal justice system with co-occurring disorders. In the mid 1990s, the (Vermont State) Office of Alcohol and Drug Abuse Programs, the Commissioner of the Department of Corrections, and the Commissioner of the Department of Mental Health and Developmental Disabilities initiated a committee to collaboratively assess and plan a coordinated approach to serving individuals in the criminal justice system with co-occurring disorders. Together, the agencies assessed the scope of the problem in each department, addressed funding issues by creating a joint fund to support a pilot project, and analyzed service duplication across agencies. In 1998, one community was selected to implement the pilot program — a regional, community-based,

integrated treatment program. A local steering committee now coordinates their efforts with the statewide planning committee and community representatives (SAMHSA 1999, 28).

- **Broward County, Florida** provides another example of a collaborative effort built because of its high rate of offenders with co-occurring disorders. The coalition includes law enforcement (Broward County Sheriff's Office), the judges from the Mental Health Court and the Drug Courts, representatives from the major mental health and substance abuse treatment agencies, and other agencies such as the United Way's Commission on Substance Abuse. The collaborative work has resulted in the Drug Court Treatment program, the Mental Health Court, the Juvenile Intervention Facility, the Dual Diagnosis Task Force, the Healthy Start Coalition, and other law enforcement/treatment initiatives (SAMHSA 1999).

Funding for Services

Identifying funding for the dually diagnosed population is difficult. Federal resources are often given to states as mental health or substance abuse block grants. When specific resources for programs treating dually-diagnosed persons do exist, finding these monies can prove difficult. TIP #9 (Center for Substance Abuse Treatment 1994, 22) adds, "Current reimbursement practices inhibit integration of services and effective treatment." The fact that people also can be involved in the criminal justice system compounds the problem.

Some suggestions for fundraisers provided by TIP #9 include:

- Facilitating the aggressive pursuit of federal funds by assigning an individual to search for federal grant programs serving people with dual disorders.
- Finding ways to use block grant funds (the Community Mental Health Services Block Grant and the Substance Abuse Prevention and Treatment Block Grant) to treat people with dual diagnosis. (SAMHSA [2003a] recently released the following statement. "Funds from the SAPT Block Grant and the CMHS Block Grant may be combined by states to support integrated treatment services [and prevention services] for individuals with co-occurring disorders."
- Encouraging agencies to seek funding available through participation in research projects.
- Designing funding to encourage providers to include services for people with dual diagnosis.
- Designing funding to promote linkages at the service delivery level.
- Educating, encouraging, and negotiating with local HMOs, managed care companies, and other reimbursing agencies (along with the public and state and federal officials). Fostering an understanding and acceptance of what a dual diagnosis is and what dually diagnosed people's treatment should entail.

The **Maryland Department of Health and Mental Hygiene Administration (MHA), Division of Special Populations** has created an innovative patchwork of funding to address the needs of special populations (including individuals who are in jail and could be served by the community and individuals with co-occurring mental health and substance abuse disorders). Annually, MHA provides $1 million worth of case management and psychiatric services to detained individuals transitioning back into the community. Local governments, detention centers, and local agencies provide some of the funding (some in-kind). However, the majority of the funding comes from federal sources, and MHA's commitment to finding different funding streams. MHA has received a Byrne Memorial Grant, a HUD Shelter Plus Care grant, PATH funds, a TAMAR Project grant, and money for participating in the SAMHSA (CSAT and CMHS) Jail Diversion Knowledge Development and Application Initiative. For more information, contact Dr. Joan Gillece, Assistant Director, MHA at gillecej@dhmh.state.md.us (Center for Substance Abuse Treatment 1994; Mears et al. 2003; SAMHSA 1999).

DEFINITIONAL ISSUES

The first step to treating substance abuse and mental health is proper identification and classification of the problem. The terms substance abuse and mental health disorders are often used as general terms, without paying specific attention to or accurately reporting the variations of the problems. This is one reason statistics about substance abuse and mental health in the criminal justice system are inconsistent.

There is a difference between substance abuse, use, addiction, and drug-involved crimes. According to DSM-IV, substance dependence is "a maladaptive pattern of substance use, leading to clinically significant impairment or distress" (American Psychological Association [APA] 1994, 181). To be considered clinically impaired or distressed, the patient must exhibit three or more of the following symptoms within a year: tolerance, withdrawal, unsuccessful efforts to limit substance use, increased use of drug (use in larger amounts or over longer period), allowing activities to revolve around the substance, and/or continued use despite the knowledge that the drug is psychologically or physically destructive. The diagnosis of substance abuse should be reserved for those who repeatedly engage in substance use despite the recurrence of significant adverse consequences (such as, legal problems and social/interpersonal problems). Substance disorders, such as substance dependence or substance abuse, should not be confused with substance intoxication. Persons who occasionally drink or use drugs do not exhibit the compulsive and maladaptive behaviors characteristic of an abuser.

Similarly, there is a difference between mild and severe mental health disorders. The type of treatment administered should match the severity of the problem. A defendant may need mental health treatment for severe mental illness (psychosis, depressive, and bipolar disorders) or less severe personality disorders or even mental retardation.

Using a quadrant system of mental health and substance abuse disorders (APA 1994), an individual could fall into one of four categories: low substance abuse/low mental health (Quadrant I); low substance abuse/high mental health (Quadrant II); high substance abuse/low mental health (Quadrant III); or high substance abuse/high mental health (Quadrant IV). In addition to treating substance abuse (severe or otherwise), mental health (severe or otherwise), a defendant may need treatment for HIV/AIDS and/or general medical care, thereby compounding the "co-occurring disorder."

2.3. CRIME/INCIDENT

The following principles apply to services for those individuals with co-occurring disorders who, despite prevention efforts, become involved with the criminal justice system. Although preventing criminal justice contact through public behavioral health offerings and community-based organizations is feasible, some people with co-occurring substance abuse and mental health issues nevertheless will become involved in the criminal justice system. The first point of contact will likely be with law enforcement. The options taken at this critical juncture — procedures, response, and possible diversion — shape the client's criminal justice path.

Guiding Principle: Training dispatchers to consider the nature of a call and whether or not mental health issues are a factor in the call will increase the likelihood that the most

appropriate first responder will be sent to the scene (Criminal Justice/Mental Health Consensus Project 2002).

This principle only focuses on mental health issues because appropriately responding when a person with mental illness is involved in an incident is critical. The involved person with mental illness may or may not have a corresponding substance abuse disorder. Regardless, it is important for first responders to be armed with information about mental illness before taking action. Dispatchers can assist first responders by implementing protocols to determine if mental illness is a factor and then assigning the call accordingly. They could use designated codes to describe behaviors on the scene rather than attempting to assess and diagnose the problems more fully.

- In **San Diego, California**, dispatchers may call the **Psychiatric Emergency Response Team (PERT)** when they suspect that a mentally ill person is involved in an incident. Calling PERT ensures both an officer and a licensed mental health professional will respond to the incident (more information about PERT is provided in the next section). For more information, contact Deputy Todd Norton at (760) 940-4551 or Todd.Norton@sdsheriff.org (The Criminal Justice/Mental Health Consensus Project 2002).[18]

<u>Guiding Principle</u>: Training and requiring law enforcement officers to identify mental health and/or substance abuse issues, will help them determine how best to address an incident for the individual person based on the type of offense that was committed, the safety issues involved, and the types of programs and resources available in the community. Written policies and protocols should be developed to ensure that officers know how to proceed in particular situations and document the course of action taken (Criminal Justice/Mental Health Consensus Project 2002).

Promising practices include training officers to identify mental health and substance abuse disorders and to collect relevant, standardized information on detainees. Officers also need knowledge of and access to local comprehensive emergency psychiatric services offering around-the-clock intake. "If you don't have appropriate access to treatment and services, the only option that most law enforcement officers have in most situations is the county jail" (The Criminal Justice/Mental Health Consensus Project 2002, 54).

- The **Memphis, Tennessee Crisis Intervention Team (CIT)** is a model pre-booking diversion program. Operated as a cooperative by a patrol division of the Memphis Police Department and the University of Tennessee (UT) Psychiatric Emergency Service at the Regional Medical Center, the CIT program provides intensive training for experienced patrol division officers who volunteer to be part of the team. The goal of the program is to provide diversion at the first interaction between the individual with mental illness and addiction disorders and the police, prior to arrest. Police officers can decide whether to refer individuals in crisis to the UT Psychiatric Service at the Regional Medical Center in lieu of filing criminal arrest charges. The program has been so successful that more than 25 cities have expressed interest in

[18] San Diego County Sheriff's Department web site, http://www.sdsheriff.net.

replicating the program. For more information, contact Major Sam Cochran, CIT Coordinator at (901) 545-5700 (Lattimore et al. 2003).

Communities may or may not have the resources to train officers in the way described above or communities may want to implement other types of approaches in addition to training officers. Other strategies for addressing incidents that involve individuals with mental health issues or individuals who are intoxicated include:(1) having civilian mental health professionals co-respond to calls with officers, (2) having civilian mental health professionals act as second responders, who are called in by law enforcement only after the scene is secured, or (3) transporting intoxicated individuals to crisis substance abuse services. In the first two cases, the civilian mental health professional networks with local service providers and places individuals into available services in the community (Criminal Justice/Mental Health Consensus Project 2002).

- Since 1993, licensed mental health professionals have been part of the first response team in **San Diego, California**. **The Psychiatric Emergency Response Team (PERT)** is comprised of an officer and a licensed mental health professional. Housed in the county sheriff's office, the PERT team may be called to an incident by dispatchers or other officers who suspect a mentally ill individual is involved in an incident. At the scene, the mental health professional provides screening and assessment. The mental health provider may also refer (and/or transport) individuals to community providers. PERT is administered and supported by PERT, Inc., which is supported by county, state and federal funds. PERT has been identified by the county as a cost-effective way to provide an immediate response to mental health emergencies. For more information contact Deputy Todd Norton at (760) 940-4551 or Todd.Norton@sdsheriff.org

IDENTIFYING THE PROBLEM

Recognizing co-occurring disorders is especially important because of the unique treatment requirements presented by defendants with co-occurring disorders (Peters and Bartoi, 1997). Identifying the problem is difficult for several reasons:

- First, the contact time with the defendant is often short; this kind of peripheral contact makes it difficult to properly screen and/or assess a population that may or may not be presenting symptoms at that moment and may want to conceal personal circumstances concerning their mental health. Identification can also be difficult because individuals in the criminal justice system may anticipate negative consequences related to disclosure of mental health or substance abuse symptoms.
- Second, there may be a lack of a standardized screening and assessment processes at each juncture point in the system. This is compounded by the fact that human error and lack of staff expertise and training may hinder the process. Even trained professionals find it difficult to diagnose co-occurring disorders because of the way the symptoms ebb and flow, synergistically affect each other, and/or precipitate effects of the disorders (Peters and Bartoi 1997).
- Finally, identifying the problem can be a duplicative process because various agencies often do not share the information; therefore, an assessment at "lock-up" will not be shared with the defendant if he moves into the jail/prison system and information collected there will not be shared with post-institutional agencies, such as probation and parole. Efficiently tracking people as they move through the system provides many benefits, such as reducing duplication of work by following up assessments (instead of repeating initial assessments) and monitoring individual improvement.

(Criminal Justice/Mental Health Consensus Project 2002).[19]

- **San Diego, California** also implements the **Serial Inebriates Program** where police officers offer homeless chronic public inebriates a choice between being taken into custody or attending an alcohol treatment program. If the treatment course is chosen, caseworkers work with individuals throughout their time in the program. For information contact San Diego Police Department, Sergeant Rich Schnell at (619) 692-4800 (Burt et al. 2004).

- **Seattle, Washington** has two emergency response options for police encountering people who are intoxicated and/or dealing with mental health issues (Burt et al 2004). The **Dutch Shisler Sobering Support Center** is a service where clients can sleep off their binge while being monitored by staff for vital signs and by nurses for other medical issues. The Emergency Service Patrol is a van service that transports people to the center. Co-located in the center is a project called REACH, which provides case management services to repeat clients of the center to connect them with longer-term substance abuse and mental health treatment, as well as other social services. The **Harborview Medical Center Crisis Triage Unit** is a diversion from law enforcement intervention and psychiatric hospitalizations for people who are intoxicated and/or violent. It provides 24-hours of crisis stabilization and medical care. The staff includes a nurse, a medical assistant, a psychiatric nurse, and a liaison social worker that helps clients link to mental health, substance abuse, and disability services.

2.4. PRETRIAL

Many people with substance abuse and/or mental health disorders move past the incident stage into the formal justice system because identification of the disorders can be difficult, there may be no pre-arrest options available in the community, or the crime may be serious enough that diversion is not available.

Guiding Principle: Screen for substance abuse and mental health disorders as early as possible, using a simple and effective screening instrument. Screening results should inform assessments, the use of diversionary programs, and treatment. Screening and assessment information should be shared across agencies and specific mechanisms to easily share such information should be created (Mears et al. 2003; Peters and Bartoi 1997).[20]

More specifically, promising practices in screening and assessment indicate that:

- Everyone should be screened for substance abuse and mental health problems at the earliest possible point after involvement in the criminal justice system (but after the person is sober),
- A standardized screening tool should be used throughout the criminal justice system,

[19] San Diego County Sheriff's Department web site, http://www.sdsheriff.net.
[20] GAINS Center Brochure, http://www.gainsctr.com.

- Multiple opportunities for screening should be provided, and
- Assessments should be comprehensive, capturing information about substance abuse history and patterns of current use, mental health history and current status, interaction between disorders, family and social relationships, medical history, current health status, criminal justice history, criminogenic factors (such as antisocial behavior and self control), and life skills.

Promising practices for sharing information include analyzing police data to identify "repeat offenders"—those people with mental illness and/or substance abuse who repeatedly enter the justice system. Police and jail personnel should be able to identify people recently treated by local providers. Information sharing presents many unique challenges — confidentiality and data security requirements, incompatible agency systems, conflicting agency goals, and limited resources curb information sharing about people in the criminal justice system with co-occurring disorders. Though these barriers exist, some criminal justice agencies have found creative ways to share pertinent information with other criminal justice agencies and community treatment providers.

SCREENING AND ASSESSMENT TOOLS

The following excerpt from Mears et al. (2003, Exec-7) describes various screening and assessment tools: "Few studies have compared the effectiveness of different substance abuse and mental health screening instruments. One study indicates that the most effective instruments in screening for substance abuse are:

- Combined Alcohol Dependence Scale (ADS) and Addiction Severity Index (ASI) instruments
- Texas Christian University Drug Dependence (TCUDD) Screen
- Simple Screening Instrument (SSI)

Several instrument combinations work best when screening for co-occurring disorders:

- either the Brief Symptom Inventory (BSI) or the Referral Decision Scale (RDS) to address mental health symptoms

and

- either the TCCUD Screen, SSI, or the combination of the ADS/ASI-Drug Use section to address substance abuse symptoms.

Several instrument combinations work best when assessing for co-occurring disorders:

- either the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), the Millon Clinical Multiaxial Inventory-III (MCMI-III), or the Personality Assessment Inventory (PAI) to examine mental health disorders

and

- the Addiction Severity Index (ASI) to examine areas related to substance abuse."

- The **Data Link Project** in **Maricopa County (Arizona)** uses an electronic platform and a computerized matching system to track whether jail detainees have received mental health services in the area. When a match is found, the person's caseworker is notified and intervenes to ensure the person receives proper medications while in jail and to assist in discharge and diversion planning. Since the implementation of Data Link, the county has doubled the number of candidates for diversion. The data link project is a product of the SAMHSA Jail Diversion Knowledge Development and Application Initiative. For more information, contact Eric Rader at (602) 914-5861 or Brian Arthur (University of Arizona) at (520) 917-0841 (GAINS Center 1999).

- In **Akron, Ohio,** information is shared via more informal channels; however, the outcome is the same. Jail personnel enjoy an efficient method for identifying arrestees with a history of mental illness. A mental health systems person sits at the jail. This employee uses a palm pilot to obtain up-to-date provider rosters. She is able to identify those offenders with a history of mental health issues. The information she provides guides processing (diverted or not) and informs sentencing. For more information, contact Mark Muntz at (330) 762-3500.

<u>Guiding Principle</u>: When possible and appropriate, criminal justice agencies should use pretrial diversion for cases involving people with co-occurring mental health and substance abuse disorders. If diversion opportunities are not available and the case is appropriate, offenders with co-occurring mental health and substance disorders should be released with the least restrictive conditions and pretrial agency staff should assist defendants in complying with conditions of pretrial release. Defendants should not be detained before trial based on a lack of information or referral resources (Center for Substance Abuse Treatment 1995a; Criminal Justice/Mental Health Consensus Project 2002).

Promising practices include incorporating questions about mental health and substance abuse in standard pretrial interview protocols and developing and maintaining appropriate links to diversion programs, treatment providers, and supervision agencies.

Diversion programs have long been recognized for their effectiveness in treating mentally ill offenders. As Lattimore et al. (2003, 32) remark, "Criminal justice diversion programs have…been recognized for their potential to produce positive outcomes for persons with serious mental illness by increasing access to community-based treatment services, reducing police contacts, reducing time spent in jail, and reducing rates of reincarceration." More recently, diversion programs have been extended to offenders with co-occurring disorders. Early evaluation evidence suggests that diversion programs are an effective means of treating offenders with co-occurring disorders (see Jail Diversion Knowledge Development and Application Program sidebar).

- The **Mental Health Diversion Program in Jefferson Country (Kentucky)** serves non-violent defendants charged with misdemeanors or felonies who suffer from chronic mental illness and have a history of treatment for mental illness. After successfully completing six months of intensive treatment, the charges are dismissed.

- In **Pima County (Arizona)**, data collected by pretrial services is used to identify misdemeanor defendants with mental health disorders who would be appropriate for

DIVERSION DEFINED

The Criminal Justice/Mental Health Consensus Project Report (2002, 83) provides the following explanation of "diversion."

"The use of the term 'diversion' [is defined in] the Diversion Standards of the National Association of Pretrial Services Agencies: 'A dispositional practice is considered diversion if (1) it offers persons charged with criminal offenses alternative to traditional criminal justice proceedings; (2) it permits participation by the accused only on a voluntary basis; (3) it occurs no sooner than the filing of formal charges and no later than a final adjudication of guilt; and (4) it results in a dismissal of charges, or its equivalent, if the divertee successfully completes the diversion process' "

diversion. Those in diversion undergo a 180-day treatment program, that includes substance abuse treatment when necessary; charges are dismissed upon successful completion (Reed 2002; Lattimore et al. 2003).

- **Connecticut's Criminal Justice Diversion Program**. Currently, Connecticut's Department of Mental Health and Addiction Services (DMHAS) has diversion programs for people with mental illness and co-occurring disorders in six mental health centers, covering nine courts (including courts in Hartford and Bridgeport). Possible diversion program participants are identified from arraignment lists (compared with DMHAS's statewide information system to identify people with known mental disorders) and by court staff. Specific clinicians (one to three in each center) screen, assess, and develop treatment plans for defendants. Treatment plans include integrated substance abuse and mental health treatment (with Bridgeport and Hartford enjoying Assertive Community Treatment teams for individuals with co-occurring disorders[21] as resources). Recommendations for clients are presented to judges, who determine if the client will be allowed to participate in the diversion program. Most of the diverted clients have minor charges, including misdemeanors and lower-level felonies. However, clients with more serious charges may receive other services from the team. The six mental health centers described here were one of the nine programs to receive money through the Jail Diversion Knowledge Development and Application Programs (see sidebar). Connecticut's programs were recommended by the program evaluator as exceptional post-booking diversion programs for defendants with co-occurring disorders. For more information, contact Linda Frisman, DMHAS at (860) 418-6788 or frisman@uconnvm.uconn.edu (Frisman, et al. 2000).

- Through **Lane County, Oregon's Co-Occuring Diversion Program (COD)**, all persons booked into the Lane County Jail are screened for mental and/or substance abuse disorders by trained corrections officers. On voluntary agreement to enter the program, and agreement from the prosecutors, appropriately diagnosed offenders are offered the opportunity to take a stipulated plea, attend treatment for a predetermined time, and, on successful completion of treatment, have their charges dismissed by the judge. Offender compliance is carefully monitored with offenders reporting at least monthly to a specialized drug court. The Lane County COD also has a component serving dually diagnosed probationers/parolees in jeporady of being sanctioned and/or revoked. For more information, contact Richard Sherman, M.S., at (541) 682-2121 or richard.sherman@co.lane.or.us (Lattimore et al. 2003; Reed 2002).

- With monies received from the SAMHSA Knowledge Development and Application Program, **Maryland** decided to augment current pre- and post-booking diversion services. Specifically, administrators wanted to augment treatment and support

[21] Assertive Community Treatment teams provide complete rehabilitation, support, and treatment to clients in over 15 states. ACT teams are based on an evidence-based model with 39 years of proven effectiveness in areas of (1) reduction in state hospitalization, (2) reduced cost over time, and (3) increase in quality of life of people served. ACT teams provide around-the-clock, on-site care and usually include a nurse, social worker, substance abuse counselor, and psychiatrist, among others.

programs available to women with co-occurring disorders and their children. Called **Project Phoenix**, the program is being evaluated by University of Maryland Center for Mental Health Research Services. For more information, contact Joan Gillece, Ph.D., Assistant Director, MHA at gillecej@dhmh.state.md.us (SAMHSA 1999).

JAIL DIVERSION KNOWLEDGE DEVELOPMENT AND APPLICATION PROGRAM

Throughout this chapter, programs associated with the **Jail Diversion Knowledge Development and Application Program** are mentioned. Though only certain programs are highlighted, all can be viewed as established diversion programs. As such, they are identified here.

In 1997, SAMHSA, a division of the U.S. Department of Health and Human Services, funded a three-year study of nine jail diversion programs serving people in the criminal justice system with co-occurring disorders. Called the Jail Diversion Knowledge Development and Application program, this comprehensive study examined nine sites with established diversion programs to assess the effectiveness of the pre-booking and post-booking jail diversion programs. SAMHSA also provided funding to the nine sites to improve and sustain existing programming. Sites included three pre-booking programs (Memphis, Tennessee; Multnomah County, Oregon; and Montgomery County, Pennsylvania) and six post-booking programs (Maricopa and Pima Counties, Arizona; Connecticut [6 cities]; Lane County, Oregon; Hawaii; New York City; and Wicomico County, Maryland).

A multi-site evaluation is underway and tests the relative effectiveness of different diversion models. Outcomes to date have been significant, particularly at sites in New York, Tennessee, Hawaii, and Arizona. For more information, contact the Research Triangle Institute (RTI), the organization evaluating the program; the GAINS Center, the technical assistance partner for the program; or, SAMHSA (CMHS and CSAT), the funder of the program (Lattimore et al.2003).

Sources: Personal correspondence with Pamela Lattimore, April 30, 2004; SAMHSA web site, http://www.samhsa.gov; and Health Foundation of Greater Cincinnati web site, http://www.healthfoundation.org.

2.5. INCARCERATION

Guiding Principle: Jail and prison procedures should include screening and identification of mental health and substance abuse issues upon arrival at the jail or prison. Appropriate treatment offerings should be available within the facility and release planning that includes referrals to community resources should be developed. Not all inmates will show signs of mental health and substance abuse issues at initial assessments, so processes should allow for identification and action throughout their stay (Center for Substance Abuse Treatment, 1994; Criminal Justice/Mental Health Consensus Project 2002; Peters and Bartoi 1997; Peters and Hills 1997).

When outside sources are not an option, promising practices include screening all detainees for mental illness and substance abuse upon arrival at the facility, including a suicide screening. Peters and Bartoi (1997) point out that some offenders will be reluctant to discuss their substance abuse and mental health issues initially. However, they say reluctance may fade after offenders see the treatment opportunities that are available in the jail or prison. They suggest that (at the

very least) facilities provide on-going screening opportunities.

In general, jails are unable to offer the full spectrum of services that longer-term, larger prison facilities might offer. Jails have been described as a less-than-ideal place for treatment because of the frequent turnover and short stays. Furthermore, until recently, incarceration facilities (including prisons) have not focused on rehabilitation, and treatment has suffered. However, some jails (and prisons), particularly larger ones, are offering more comprehensive alcohol or drug and mental health treatment services. With additional resources, it is possible to provide treatment, or at least begin part of a treatment plan that may continue through the justice system and reentry (Mears et al. 2003).

TREATMENT IN JAILS: NATIONAL STATISTICS

Substance Abuse Treatment
According to SAMHSA, 34 percent of jails provide substance abuse treatment. Of these, most jails provide individual counseling (77 percent) or group counseling (64 percent), with 28 percent of jails offering detoxification to inmates. Less than half of the jails used drug testing (42 percent) to monitor offenders. Approximately 36 percent of jails do not provide assessments for drug treatment needs.

Mental Health Treatment
Research shows that approximately one third of male detainees and one quarter of female detainees who require services for mental health issues were able to receive such treatment in jail (GAINS Center 2002).

Guiding Principle: Results from internal screening, assessments, and treatment plans should feed into transfer and/or release planning efforts. In the case of transfer, such records should follow the inmate to the next facility so that staff can immediately address the identified issues. In the case of release planning, such information should assist staff in developing individualized plans that include community-based treatment along with housing and other programming options (Center for Substance Abuse Treatment 1994; Criminal Justice/Mental Health Consensus Project 2002; Hills 2000; Peters and Bartoi 1997).

- The **TAMAR (Trauma, Addictions, Mental Health, and Recovery) Program** in **Maryland** focuses on identifying and treating inmates with co-occurring disorders and a history of violence. The program provides training and clinical services to inmates, and sometimes rental assistance upon release. The TAMAR program began in 2001. It is now implemented in eight county jails and serves approximately 350 inmates a year. The TAMAR program is built from a successful pilot project, which offered similar services to women with co-occurring disorders and their children. Pilot program participants had a recidivism rate of less than 3 percent. For more information, contact Dr. Joan Gillece, Director of Special Populations, Department of Health and Mental Hygiene, MD at gillecej@dhmh.state.md.us.[22]

[22] http://www.gainsctr.com.

- Since 1998, Iowa's First Judicial District Department of Corrections has run a residential treatment center for male offenders with co-occurring disorders called **Iowa's Dual Diagnosis Offender Program**. Convicted offenders are referred to the 16-bed treatment facility within the Waterloo, Iowa correctional facility, from state prisons, local jails, and the probation department. Offenders in the program receive a structured, individualized treatment program. Offerings include individual and group therapy, recreation groups, Alcoholics Anonymous/Narcotics Anonymous, GED courses, vocational rehabilitation services, church and leisure activities, family educational groups, and post release planning. Corrections, a local mental health agency, and a substance abuse treatment program administer the program. In 2003, female inmates with co-occurring disorders began receiving services at Waterloo. Like the dual diagnosis offender program, the women's program is residential. Other service offerings are similar, as well; however, gender-specific programming has been incorporated into treatment. Program components and philosophies are proven to be effective in the treatment of mentally ill or addicted women, including competency building and empowerment. The Dual Diagnosis Offender Program was honored with the Iowa Corrections Association's Correctional Program of the Year Award in 2003. For more information, contact Daniel Craig at (319) 36-626 ext. 239 (Craig 2004; Dolan et al. 2003).

WHY TREAT INCARCERATED OFFENDERS:
THE BENEFITS (AND COSTS) OF SUBSTANCE ABUSE TREATMENT

The following excerpt is from Mears et al. (2003, 3-8):

"A report by the Center on Addiction and Substance Abuse (CASA-1998) indicates that it costs $3,500, over and above incarceration costs, to provide residential drug treatment to inmates. The cost would be $6,500 if education, job training, and health care were included. These costs would be substantially offset by increased productivity of offenders who not only do not return to prison but obtain employment. For example, CASA (1998) estimates that there would be $68,800 in savings per inmate, assuming each inmate becomes a law-abiding citizen, avoiding incarceration and health care costs, earning a salary and paying taxes.

The 1992 CALDATA (California Department of Alcohol and Drug Programs) study is another well-known cost-benefit study (Gerstein et al. 1994). Several important findings came out of this report: each dollar spent on alcohol or drug treatment resulted in $7.14 savings to the criminal justice system, mostly due to reduction in crime; treatment reduces drug use and drug-related illnesses; the "time in program" hypothesis was supported (i.e., the more time spent in treatment, the more effective treatment is); and treatment can be effective for everyone, cutting across all demographic groups and risk levels."

2.6. COMMUNITY SUPERVISION AND REENTRY

Research highlights the value of long-term treatment planning and follow-up (continued at every step in the process) in helping persons with co-occurring disorders stay out of jail or prison once they are released (NIDA 2002). Spanning the gap from incarceration to successful reintegration is a stumbling block for program administrators and reentering offenders (especially chronic system users). The Center for Substance Abuse Treatment (1994) suggests training judges on available substance abuse and mental health treatment options so informed release decisions can be made and appropriate conditions imposed. Training of this sort might also be useful for

corrections counselors planning an inmate's release, for parole board members, and for community supervision officers.

Guiding Principle: Correctional facility staff and staff from community supervision agencies should be familiar with and able to refer to community-based mental health and substance abuse treatment providers and this information should directly lead into release decisions, determination of release conditions, and release plans. Once released, agency staff should assist offenders with co-occurring mental health and substance abuse issues to comply with conditions of pretrial release, probation, or parole (Criminal Justice/Mental Health Consensus Project 2002; Peters and Hills 1997).

- The **Maryland Community Criminal Justice Treatment Program (MCCJTP)**, through the Department of Health and Mental Hygiene, employs caseworkers to oversee each individual's treatment planning and implementation. The case manager brokers comprehensive services from a variety of agencies and follows an individual's case starting in the facility and continuing in the community (SAMHSA, 1999).

- The **Co-Occuring Diversion Program (COD) in Lane County, Oregon** offers a diversion alternative to probationers and parolees who are in jeopardy of being sanctioned or revoked (see earlier description for information on services offered to pretrial clients). If a probationer or parolee is accepted for diversion, he or she can avoid jail time and receive integrated treatment from a variety of community-based agencies and the community mental health clinic instead. Jail-based diversion staff provide case management to these clients. For more information, contact Richard Sherman, M.S., at (541) 682-2121 or richard.sherman@co.lane.or.us (Lattimore et al. 2003; Reed 2002).

- In **Richmond, Virginia**, the **District One Intensive Substance Abuse Treatment Unit** provides more immediate assistance. It uses probation and parole officers to provide on-site drug screening, assessment, and intensive treatment to offenders. A collaborative among the Medical College of Virginia, the Department of Corrections Mental Health Professionals, and three Community Service Board Substance Abuse Clinicians, the unit served 1,058 offenders (60 percent of whom were diagnosed with co-occurring disorders) in 2003. This program will be featured at the GAINS/TAPA Center's 2004 conference. For more information, contact Diana Keegan at (804) 786-0251 or keegand@vadoc.state.va.us.[23]

Guiding Principle: Facility staff, community supervision staff, and staff from mental health and substance abuse treatment providers should collaborate to help an inmate transition successfully from the facility to the community (Criminal Justice/Mental Health Consensus Project 2002; Peters and Hills 1997).[24]

- A promising practice in the treatment and supervision of reentering probationers and parolees with co-occurring disorders is the **San Francisco (California) Citywide**

[23] http://www.gainsctr.com.
[24] http://www.gainsctr.com.

Forensic Case Management Team (CWFCM). CWFCM is a collaboration between the city jail's psychiatric services and the University of California at San Francisco's Citywide Case Management Team. The Forensic Team consists of a project director, clinical supervisor, psychiatrist, licensed vocational nurse, six case managers, an occupational therapist, a money manager, two probation officers, and two parole officers. The collaboration allows the team to provide comprehensive services, including mental health and substance abuse treatment, housing assistance, Medi-Cal benefits, crisis intervention, money management training, and a range of socialization, recreation, and pre-vocational opportunities to reentering offenders. For more information, contact David Fariello, Program Director, Citywide Case Management (415) 597-8065 or fariell@itsa.ucsf.edu.[25]

- The **Pennsylvania Department of Corrections** (PA DOC) assists female prisoners with co-occurring disorders who are reentering the community. The PA DOC, in conjunction with the Pennsylvania Board of Probation and Parole and the Pennsylvania Community Providers Association, employs community placement specialists (CPS) to oversee the transition of female prison inmates with co-occurring disorders from the prison to the community.[26] The program begins 12 months prior to release, when the inmate is given a needs assessment. Following the needs assessment, the inmate is assigned her own CPS. The CPS locates community-based treatment and support services for the prisoner, such as housing, mental health and substance abuse counseling, childcare, and employment training. The CPS also ensures that the inmate is enrolled in any relevant pre-parole or reentry classes and oversees the development of an acceptable (according to all relevant parties) transition plan. Once offenders are paroled, parole agents supervise parolees' treatment and supervision and the CPS follows up with service providers to monitor the participants' progress. For more information, contact Lance Couturier at lcouturier@state.pa.us (The Criminal Justice/Mental Health Consensus Project 2004).

Therapeutic communities (TCs) are another transitional service for reentering drug abusers. Recently, TCs have been adopted to serve offenders with co-occurring disorders transitioning from incarceration to the community. TCs — or drug-free residential settings that aim to help drug abusers and addicts assimilate to social norms — have long been recognized as effective in prison and community-based drug treatment approaches for socially disconnected drug abusers (NIDA 2002). TCs typically stress the efficacy of self-help and treatment community participation. Offerings may include clinical groups, community meetings, individual counseling, recreation, job training, and sometimes outpatient aftercare. They are a popular resource for a criminal justice system needing to prepare drug-dependent offenders for reentry. The Drug Abuse Treatment Outcome Studies (DATOS) recently found that fully two-thirds of 2,345 admissions to residential TC treatment had a criminal justice status, and that one-third of admissions had been referred to the TC by the criminal justice system. TC use is well founded: people completing treatment in a TC had lower levels of drug and alcohol use, criminal behavior (including time to rearrest), unemployment, and indicators of depression than they did before

[25] http://www.gainsctr.com.
[26] This program also serves female prison inmates with mental illness and mental retardation.

treatment and when compared with people receiving treatment as usual (NIDA 2002; Hubbard, Craddock, and Anderson 2003).

In addition to the sustained, supported housing, counseling, and job/skills training provided by traditional TCs, other modifications to treat persons with co-occurring disorders incorporate programming to address this population's particular difficulties that is, psychiatric symptoms, cognitive impairments, and reduced levels of functioning. Specifically, those implementing promising practices related to TCs suggest that TCs modified to reach people with co-occurring disorders should do the following:

- Allow for the use of psychotropic medications to treat mental illness in some cases (NIDA 2002; Hills 2000);
- Place greater emphasis on psycho educational and supportive approaches instead of confrontation and compliance;
- More completely individualize movement through the program and specific tasks;
- Deliver rewards more frequently;
- Provide support and self-help groups (Hills, 2000);
- Make treatment groups and other daily activities shorter; and
- Increase the staff-to-client ratio, with more mental health staff integrated into treatment groups (Hills 2000).

▪ **The Modified Therapeutic Communities program in Brooklyn, New York,** provides an example of TCs modified to serve people with co-occurring disorders. By incorporating some of the promising practices listed above into community treatment, these modified therapeutic communities were found to decrease substance use and criminality, and increase psychological functioning and pro-social behavior in individuals residing in the therapeutic community for 12 months. When compared to dually diagnosed individuals receiving "treatment as usual," dually diagnosed individuals in modified TCs had decreased substance use and increased pro-social behavior. For more information, contact the Center for Therapeutic Community Research at (212) 845-4400 (De Leon et al. 2000).

2.7. CONCLUSIONS

Many of the practices described here have not been evaluated, instead they represent promising approaches for addressing the needs of individuals with co-occurring mental health and substance abuse disorders who are involved in the criminal justice system. The practices represent the most current knowledge available through government agencies, advocacy organizations, research institutes, resource centers, and technical assistance programs. To examine how the communities were able to implement these approaches, the Workgroup asked us to talk with representatives from two communities, the state of Vermont and King County, Washington. The guidance provided by the representatives about how to make this work happen in a community concludes this chapter.

Establishing Services for People in the Criminal Justice System with Co-Occurring Disorders: The State of Vermont's Success Story

The state of Vermont was identified as having a promising program. We talked with the Chief of Treatment at the Division of Alcohol and Drug Abuse Programs, Peter Lee, and some of his staff members who reveal some insights into realizing an effective continuum of care for offenders with co-occurring disorders.

For Vermont, the impetus to establish integrated services for offenders with co-occurring disorders came when staff at the Department of Mental Health, the Department of Health's Division of Alcohol and Drug Abuse Programs, and the Vermont Department of Corrections recognized the cost of treating (and retreating) people with co-occurring disorders.

According to these representatives, the most unique aspect of their program is the addition of trained probation officers to primary treatment teams. It allows them to provide a truly continuous treatment team model — offenders with co-occurring disorders are welcomed into an appropriate treatment system wherever they enter.

Vermont representatives believe their success was a result of the conscious efforts they made to facilitate coordination and buy-in among involved agencies. Vermont engaged stakeholders and the community from the beginning of the initiative. They recognized the initiative as a systems change, and not just as a program designed to improve treatment and services. Importantly, they hired an outside facilitator to help them establish a balanced approach and goals that met the needs of all three departments.

These representatives also advise administrators of other systems to be aware that successes do not materialize without challenges. From their own experience, Vermont suggests paying particular attention to maximizing the use of Medicaid and establishing age, gender, and culturally appropriate treatment alternatives.

Establishing Services for People in the Criminal Justice System with Co-Occurring Disorders: The King County's Success Story

Some King County programs were identified as promising programs. We talked with the founding Director of the Bureau of Unified Services, David Wertheimer, who revealed some insights into realizing an effective continuum of care for people in the criminal justice system with co-occurring disorders.

In 1993, King County became part of SAMHSA's Administration's Access to Community Care and Effective Services and Support (ACCESS) demonstration project. As the county designed and implemented its "model" system of care for seriously mentally ill homeless people, it became evident that the current treatment, health, and criminal justice systems were fragmented and that fixing select pieces of certain systems would not sufficiently provide a true continuum of care for homeless, mentally ill individuals or any other population in need of multiple services.

The initial grant spawned a lasting county initiative that ultimately resulted in the local alcohol and drug abuse and mental health authorities merging into one department. On the path to integration, Seattle faced challenges. Staff highlighted turf wars and cultural differences among the criminal justice, mental health, and substance abuse treatment agencies. Categorical government and state funding also inhibited service integration among agencies.

To foster buy-in among diverse players, program administrators focused on two "selling points": promoting early quick victories and championing customer perspective to stakeholders. Early in the initiative, program staff designed and implemented pilot programs, including the mobile crisis triage center. Favorable evaluations made a case to expand such integrated service models. Administrators also worked to address agency staffs' recommendations to make services user friendly (as opposed to allowing funding streams and administrative ease to dictate service delivery). This focus provided a common goal for which all agencies strived and a reason for agencies to participate in the initiative. Finally, to overcome funding hurdles, program administrators focused on expediting Medicaid eligibility for all clients and combining funding streams.

Chapter 3. District of Columbia Practices for Serving Defendants with Co-occurring Mental Health and Substance Abuse Disorders

3.1. INTRODUCTION

The goal of this chapter is to describe current practices related to identifying and serving individuals with co-occurring disorders in the District of Columbia (D.C.). By understanding current practices related to serving such defendants, we are able to identify points where the guiding principles presented in chapter 2 already seem to be in place in D.C. and points where guiding principles are absent. Areas for future intervention and change become obvious once current practices are compared against guiding principles.

We lay the groundwork for understanding current D.C. practices in two ways. First, we provide an overview of the public mental health and substance abuse treatment systems in D.C. This overview provides context for understanding how the criminal justice system agencies interact with the public behavioral health system. Greater detail beyond this overview, including agency-level treatment capacity and services, is presented in chapter 4.

Second, we provide an analysis of how an offender moves through the D.C. criminal justice system for cases adjudicated in D.C. Superior Court. As in the other chapters, this process is presented in four stages: (1) crime/incident, (2) pretrial, (3) incarceration, and (4) community supervision and reentry. For each stage, we describe how the agencies involved currently identify and serve offenders with substance abuse issues, mental health disorders, or both.

The information in this chapter is based on in-person and phone interviews with agency representatives that were conducted throughout the past year. We conducted interviews with staff from the Addiction Prevention and Recovery Administration (APRA), the Department of Mental Health (DMH), the Metropolitan Police Department (MPD), the Pretrial Services Agency (PSA), the Public Defender Service — Offender Rehabilitation Division (PDS-ORD), the D.C. Detention Center (DCDOC), the Bureau of Prisons (BOP), the Court Services and Offender Supervision Agency (CSOSA), and the Criminal Justice Coordinating Council (CJCC). We also reviewed internal documents, technical assistance reports, agency web sites, and publications.

3.2. OVERVIEW OF PUBLIC MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT SYSTEMS IN THE DISTRICT OF COLUMBIA

In Washington, D.C., APRA and DMH oversee the public substance abuse and mental health treatment systems, respectively. Both agencies serve as the gatekeepers of services for clients seeking help — providing intakes, services, referrals, and payment vouchers for treatment.[27] Both agencies provide services directly as well as administer contracts with non-governmental, community-based service providers to serve clients. The organizations also serve as the public substance abuse and mental health authorities, certifying D.C. providers and ensuring treatment quality.

[27] Both APRA and DMH are moving toward systems where providers will be reimbursed by Medicaid.

3.2.A. Addiction Prevention and Recovery Administration

People may access APRA services by visiting one of two intake centers: the Central Intake Division Office (CID) or the APRA intake center at D.C. General Hospital.[28] The latter facility is co-located with the Detoxification Center and is open 24 hours a day. Screening, assessment, and detoxification services are provided as soon as possible after referral. During the clinical substance abuse assessment, clients also are evaluated for mental health problems and medical conditions.[29] After assessment, clients are referred to APRA-certified providers or to in-house programs for follow-up substance abuse services.

APRA estimates that between 5,500 and 6,000 people per year are treated for substance use disorders through the D.C. public health system[30]—that is, approximately 10 percent of the estimated 60,000 residents who are addicted to alcohol and other drugs (Mayor's Interagency Task Force on Substance Abuse Prevention, Treatment, and Control 2003). Of the 6,000 people APRA serves annually, 10 percent are referred by the criminal justice system; clients entering by other routes may also be involved with the criminal justice system. APRA records criminal justice system involvement when a person is directly referred by the system. When a person comes into APRA via other routes, criminal justice involvement is self-reported.

Currently, APRA is being reorganized under the direction of Senior Deputy Director for Substance Abuse Services, Robert Johnson. The goal of the reorganization is to implement "best practice" techniques, which will lead to better matching and timing of treatment for patients. By ending the rapid cycling of patients through the system, Johnson and his team hope to reach the longer-term outcome of reducing recidivism. Some changes that have already been implemented include creating a Research and Evaluation Center to provide outcome data on successes and identify weaknesses and gaps in the system; creating a Clinical Services Center and a Clinical Director position to oversee programs; merging the Public Policy and Special Population Centers to improve services to special populations and to increase cultural appropriateness of services; and merging the Certification and Quality Improvement Centers to address staff training issues and to ensure technical improvements focusing on "best practice" treatment approaches. Future reorganization plans include changing APRA detoxification to a Medical and Social Detoxification Unit focusing on crisis stabilization and a wider array of longer-term services.

3.2.B. Department of Mental Health

D.C. residents in need of mental health treatment may access the DMH system by calling the toll-free Access Help Line (1-800-7WE-HELP), by directly seeking help from specific service providers, through referral from the criminal justice system, or, for people who are in crisis, through the Comprehensive Psychiatric Emergency Program (CPEP). DMH core service agencies include two city-operated service providers (Saint Elizabeths hospital and the Public

[28] Effective October 4, 2004, the APRA Central Intake Division will be relocated to the Detoxification Center, resulting in one intake center.

[29] At intake, APRA screens for mental health by asking seven questions. If a client is flagged for mental health disorders, he or she will be assessed at the Alpha Dual Diagnosis Center.

[30] There were 5,534 treatment admissions in the District in 2002; 5,755 in 2001; 6,025 in 2000; and 6,056 in 1999. Prior to 1999, treatment admission numbers were substantially lower (Johnson 2004). In October 2004, APRA services will begin to be reimbursed by Medicaid, at which point service numbers are expected to increase.

Core Service Agency) and a cadre of certified, non-governmental community service providers contracting with DMH. The community organizations provide services across a number of special population groups (e.g., particular cultural groups, particular family types, and gay/lesbian individuals). The public mental health system provides screening, assessment, and both in-patient and outpatient services. The Mobile Crisis Unit (within CPEP) provides on-site emergency psychiatric services throughout the city.

At the time of enrollment in the DMH system, clients receive a brief assessment and a list of appropriate treatment providers based on space availability, proximity to the client's residence, and client needs. DMH serves approximately 12,000 people annually. It does not record data on a client's criminal justice system involvement for the general population but does record it if the person was referred through D.C. Jail, the courts for competency hearings, or other routes.

Individuals involved with the criminal justice system, both under supervision and not, may be referred to the public behavioral health system by the courts pretrial or post adjudication. Only a small number of such individuals will have the means to access mental health services privately and bypass the public system. As a result, most individuals involved in the criminal justice system and in need of mental health services will need to access public services. The Veteran's Administration and other community hospitals provide additional public services.

3.2.C. APRA and DMH Services for Clients with Co-Occurring Disorders

Both DMH and APRA have a limited capacity to treat clients with co-occurring disorders. The Mayor's Interagency Task Force on Substance Abuse Prevention, Treatment, and Control (2003) criticized the agencies for their inaccessibility and the lack of treatment options for persons with co-occurring disorders. The Task Force noted that only a small number of APRA clients receive mental health treatment although approximately 60 percent report having a psychiatric disorder. Further, most D.C. residents that seek treatment for co-occurring disorders must deal with DMH and APRA organizations independently. For a client, this can mean a visit to D.C. General or CID, a call to the DMH hotline, and a visit to a DMH Core Service Agency just to be screened and assessed.

However, APRA and DMH have embarked on two collaborative efforts to address the needs of clients with co-occurring issues. APRA houses the Alpha Dual Diagnosis Center, a joint initiative with DMH, which serves APRA clients with both mental health and substance use issues.[31] The Alpha Dual Diagnosis Center is located on the first floor of the CID and is staffed by DMH employees. When a client is flagged for mental health issues at the intake assessment conducted by CID, he or she is sent directly to the Alpha Center for assessment, follow-up for outpatient treatment, referral services, and case management. The co-location of APRA and DMH staff at CID provides immediate access to co-occurring services for D.C. residents.

Another joint initiative aimed at improving programming for citizens with co-occurring mental health and substance abuse disorders is the Comprehensive Continuous Integrated System of Care (CCISC). In 2002, DMH and APRA began CCISC along with technical assistance providers, Drs. Minkoff and Cline. This five-year project aims to build the system's capability to

[31] The Alpha Dual Diagnosis Center will close on 11/12/04. However, DMH and APRA are negotiating two programs that to replace it including Assertive Community Treatment and an intensive day treatment program.

serve clients with co-occurring disorders and to provide appropriately matched services to dually diagnosed clients based on "best practices," regardless of where the client enters the system.[32]

Specific goals of the CCISC project include developing and implementing agency-specific quality improvement plans to increase each agencies' capability to serve clients with co-occurring disorders, improving identification of people with co-occurring disorders, and staff training. In April 2003, city representatives signed a charter confirming their commitment to the initiative. Individual service providers have begun to conduct self-assessments using COMPASS, a tool that measures an agency's dual-diagnosis capability and highlights areas for improvement. Staff training has commenced using a "train-the-trainers" model whereby each agency will have trained staff. Technical assistance providers have also conducted site visits to specific agencies to identify issues and improve dual-diagnosis capabilities. In addition to DMH and APRA, CSOSA and PSA have also committed to the initiative (Minkoff 2003).

Although this initiative is being implemented, an early evaluation of the CCISC Project found that DMH leadership was only partially committed to the collaboration (Minkoff 2003). Infrastructure and personnel needed to maintain the collaboration and manage the project were not provided. Leaders failed to communicate project information to key staff and garner support from the many service providers. APRA was also criticized for failing to develop a management team (Minkoff 2003). Staff reported to us that these areas of weakness are being addressed.

As part of the current project, we conducted a survey of APRA and DMH treatment providers (both in-house providers and non-governmental contracted providers) to explore service options and the extent to which dually diagnosed individuals can be served. Some providers are dually diagnosed capable (that is, providers recognize both mental health and substance abuse issues, but treat one as the primary issue and only provide limited support for the secondary issue) or dually diagnosed enhanced (that is, providers recognize both mental health and substance abuse issues as primary and are able to provide a full set of services to treat both simultaneously). Full results from the survey are presented in chapter 4.

3.3. CRIMINAL JUSTICE SYSTEM PROCESS IN THE DISTRICT OF COLUMBIA

D.C. has a complex criminal justice system involving numerous agencies and service providers. Figure 3.1 illustrates the process through which an offender would move in D.C. from arrest to reentry into the community after incarceration. The figure also identifies points at which offenders are screened and assessed for substance abuse and mental health issues. D.C.'s criminal justice system process is broken down into four stages — crime/incident, pretrial, incarceration, and community supervision and reentry — and each stage is described in detail.

3.4. CRIME/INCIDENT

3.4.A. Metropolitan Police Department

Figure 3.2 depicts how a person proceeds through initial criminal justice system processing in D.C. once s/he is involved in a detected crime or incident.

[32] The "no wrong door" treatment concept discussed in chapter 2.

Figure 3.1. D.C.'s Criminal Justice System Process for People with Substance Abuse (SA) and/or Mental Health (MH) Disorders

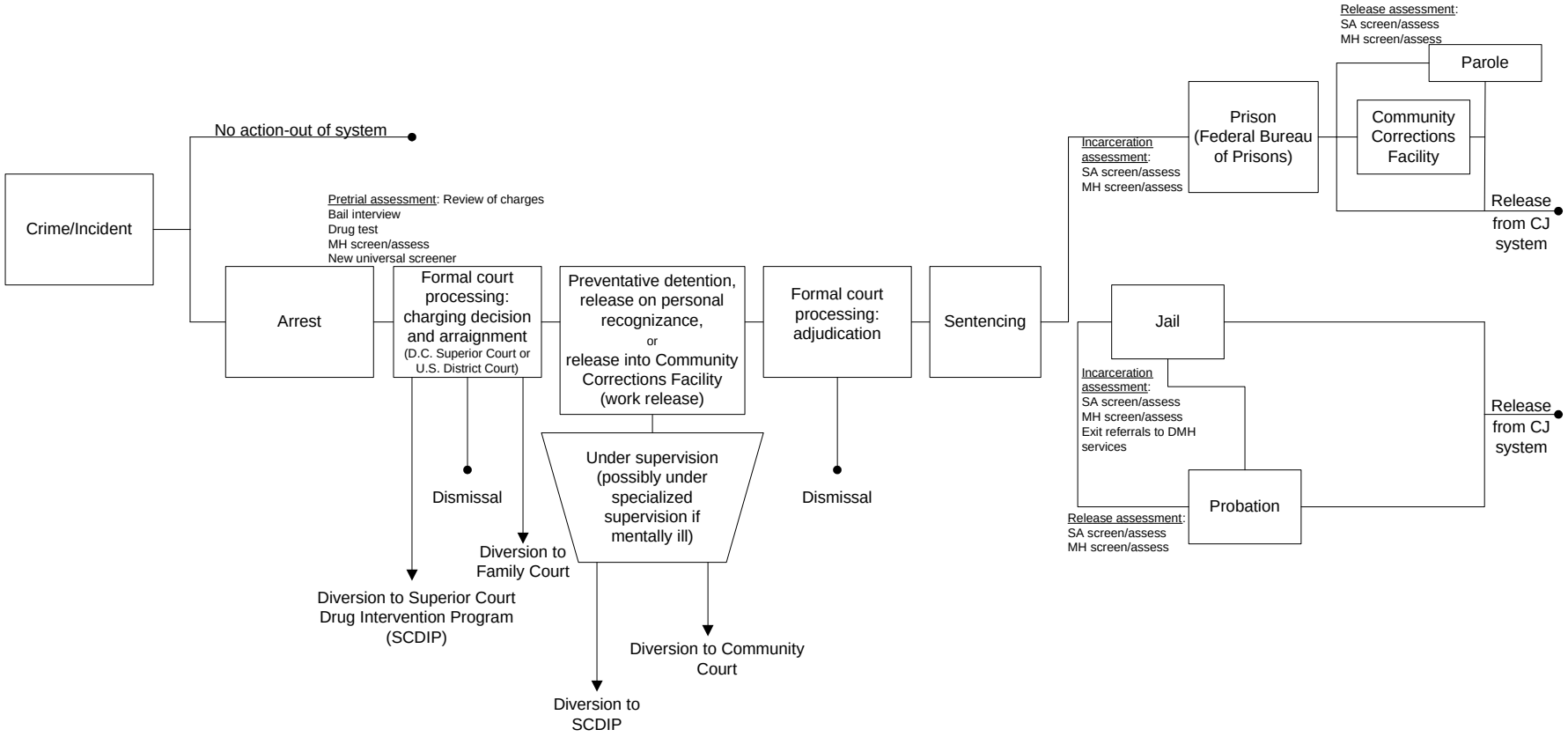
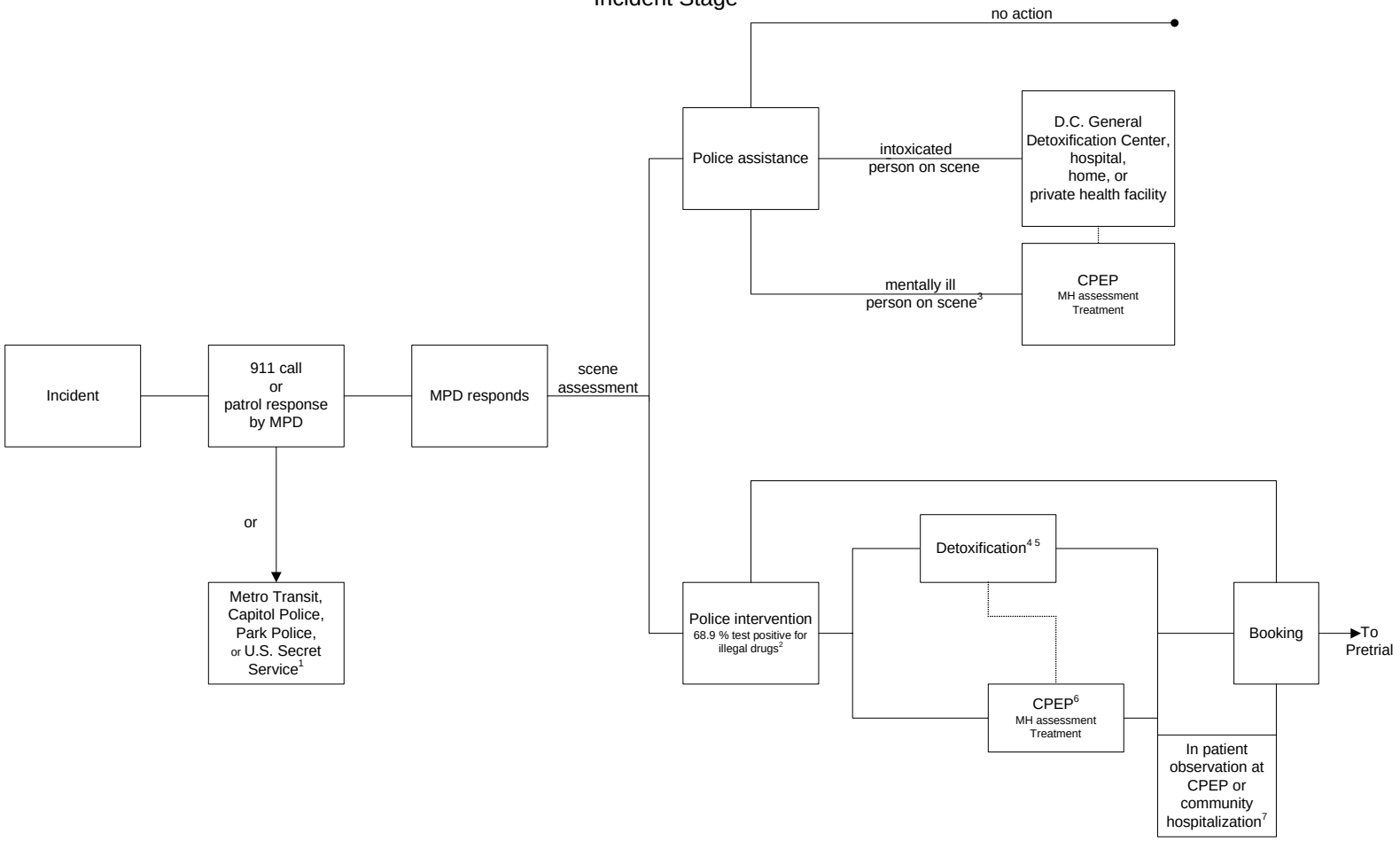


Figure 3.2. Criminal Justice Process for People with Substance Abuse (SA) and Mental Health (MH) Disorders at the Crime/ Incident Stage



1. There are four other law enforcement agencies with arrest powers in D.C.--Metro Transit Police, Capitol Police, Park Police, and the U.S. Secret Service. The D.C. official code requires agencies to follow certain processes when handling those suffering from mental illness. MPD's general order provides that MPD will transport mentally-ill people at the request of other LE agencies. However, it is the responsibility of the responding agency to recognize a problem and contact MPD.
2. From NIJ, 2003.
3. If a non arrested person requests transportation to CPEP, MPD will escort him or her ("voluntary hospitalization"). If a non arrested person is believed to be a danger to himself or others, he will be taken into custody and escorted to CPEP ("emergency hospitalization").
4. If a person is intoxicated and suicidal, once sober, the person will be processed as a mentally ill person.
5. The data is collected manually in the Detoxification Center casebook.
6. This data is collected manually on the Superior Court Form FD (12)-826.
7. CPEP notifies MPD of its intent to discharge (PD Form #311) so police can process the offender.

According to MPD personnel, no special training on handling cases involving mentally ill or substance abusing offenders is provided to police officers.[33] Further, no special task force to respond to people presenting these issues exists within the force. Instead, officers learn from experience. However, detailed written procedures exist on the treatment, processing, and disposition of mentally ill and intoxicated persons taken into custody. These general orders include mandates to transport symptom-presenting people to specific and appropriate treatment facilities, such as the D.C. General Detoxification Center, private health facilities, hospitals, and CPEP's campus at D.C. General. DMH has also recently provided MPD officers and other first responders with response cards that detail what to do and whom to call when confronted with a mentally ill person in crisis.[34]

According to General Orders 501.03 (Handling Intoxicated Persons), MPD divides intoxicated persons into three subgroups: (1) individuals who are intoxicated in public but who are not endangering their own safety or the safety of others, (2) intoxicated individuals who are an endangerment, and (3) intoxicated individuals arrested for other crimes. Police response depends on which of the three subgroups an offender falls into. Persons in the first subgroup are taken to a hospital, home, private health facility, or the Detoxification Center, depending on the circumstances. No record is made of the event. A person in the second subgroup may be placed under arrest, or, if the person is suicidal, processed according to the guidelines for handling mentally ill people (see below). If placed under arrest and in need of medical or detoxification services, the person will be taken to a hospital or the Detoxification Center, but the case will be filed with the Court Liaison Division for action. Individuals in the third subgroup are charged and processed as appropriate to the situation (if the person needs medical attention, he or she will get it). Anyone sent to the Detoxification Center will be logged into the casebook (MPD 2003).

MPD's policy on handling people with mental health issues (General Orders 308.4, Processing of Persons Who May Suffer from Mental Illness) encourages officers to treat mental illness as a disease and not a crime. Emphasis is placed on addressing the needs of the person and respecting the individual's rights. Officers may assist and transport mentally ill people (both arrested and not) to local treatment facilities. When possible, treatment choice (especially for non-arrestees) is made at the discretion of both the police officer and the individual. For example, there are many pathways to inpatient hospitalization. An individual may request voluntary hospitalization; an individual may be transferred to CPEP and later referred for psychiatric hospitalization at Saint Elizabeths or elsewhere; an officer may determine that an individual needs emergency hospitalization; or an individual may be hospitalized for examination or treatment at Saint Elizabeths through court orders at a later stage in the criminal justice process (MPD 2003). When an individual has committed a crime and will be charged with that crime, Saint Elizabeths will notify MPD when they intend to discharge that person so that the case can be processed.

MPD may contact CPEP's Mobile Crisis Outreach Unit to provide on-scene psychiatric assessment and stabilization. The mobile crisis unit is comprised of civilian mental health professionals. It may be accessed by calling DMH's Access Help Line and is used by citizens,

[33] DMH has provided training in the past, particularly related to juveniles.

[34] Beginning in September, 2004, a new Universal Screener aimed at identifying the presence of substance abuse and/or mental health issues in detainees will be piloted in all MPD jurisdictions — please see the sidebar containing more information.

case managers, parole officers, and the police. The CPEP Mobile Crisis Outreach Unit and the site-based department at the D.C. General Hospital campus are funded by DMH. Though the police rarely call the mobile crisis outreach unit to the scene, police make one-third of referrals to the site-based program (Elphick 2004).[35]

Although orders are in place for MPD officers to address mental health and substance abuse issues, lack of training on how best to deal with intoxicated or mentally ill people may present barriers for implementing orders. In addition to the lack of training, MPD identified other challenges preventing full implementation of the orders:

- Budget crises for public behavioral health programs seem to diminish the availability of treatment options;
- Eligibility rules for particular service providers may limit the treatment options available to intoxicated, less critically mentally ill persons picked up by MPD;
- Saint Elizabeths relatively new policy of no longer accepting law enforcement referrals limits MPD's ability to hospitalize people with mental health issues; and
- Inadequate MPD equipment (for example, the police do not have cell phones) impedes MPD officers from contacting other service providers in D.C. when a client is not admitted to a particular treatment agency.

This section detailed MPD's policies and procedures for handling persons with substance abuse and/or mental health disorders. However, there are four other law enforcements agencies in D.C. that also have arrest powers — the Metro Transit Police, the Capitol Police, the Park Police and the Secret Service Uniformed. There is discretion among these four law enforcement bodies as to whether or not there has been a criminal violation of the law and how to address issues related to intoxication and mental illness. A General Order provides that MPD will transport mentally ill people at the request of these other law enforcement agencies, but it is the responsibility of the responding agency to call MPD for such service. Other first responders might include Emergency Medical Services, the fire department, and MPD dispatchers.

3.5. PRETRIAL

3.5.A. Pretrial Service Agency

Figure 3.3 depicts how a person in D.C. proceeds through pretrial processes after booking. PSA supervises defendants awaiting trial in DCSC and in the U.S. District Court.

In D.C., all people with citations, misdemeanor charges, or felony charges who are being considered for release receive a general screener by PSA. The general screener is a bail interview conducted by a Pretrial Services Officer (PSO) that aims to identify any issues that may impact release and supervision conditions. The PSA screener, called the C-10 because of its use in Courtroom 10, includes a question that asks the detainee to self report any past psychological treatments that he or she received. It also includes self-report questions on prior and current substance use problems. The administering PSO also notes the detainee's condition during the interview. Information collected during this initial bail interview informs the PSO's recommendation to the judge regarding appropriate pretrial supervision and treatment levels.

[35] Information provided by DMH.

The PSO will also use the information collected by the PSA screener to request additional assessment and testing for clients.

The Universal Screener Pilot

The CJCC Substance Abuse and Mental Health Workgroup has designed a screener to assess offenders for substance abuse and/or mental health disorders. The 15-question screener aims to identify offender's current and past substance abuse and mental health issues. People who screen positive for such issues will be referred to APRA and DMH for follow-up services. The screener will be pilot tested in MPD districts for a limited number of hours per week or on a particular day starting in September 2004.

An evaluation of the tool's accuracy at identifying people with mental health and substance abuse issues, and the costs and benefits of using the screener will follow. The study will quantify the number of people in the system with co-occurring disorders. Study plans also include tracking offender outcomes, including detected recidivism and involvement with or use of the public behavioral health system. Study results will also identify areas for system improvement including opportunities to improve information sharing, referral processes, and follow-up (Universal Screening Subcommittee 2004).

The screener is composed of the following questions:

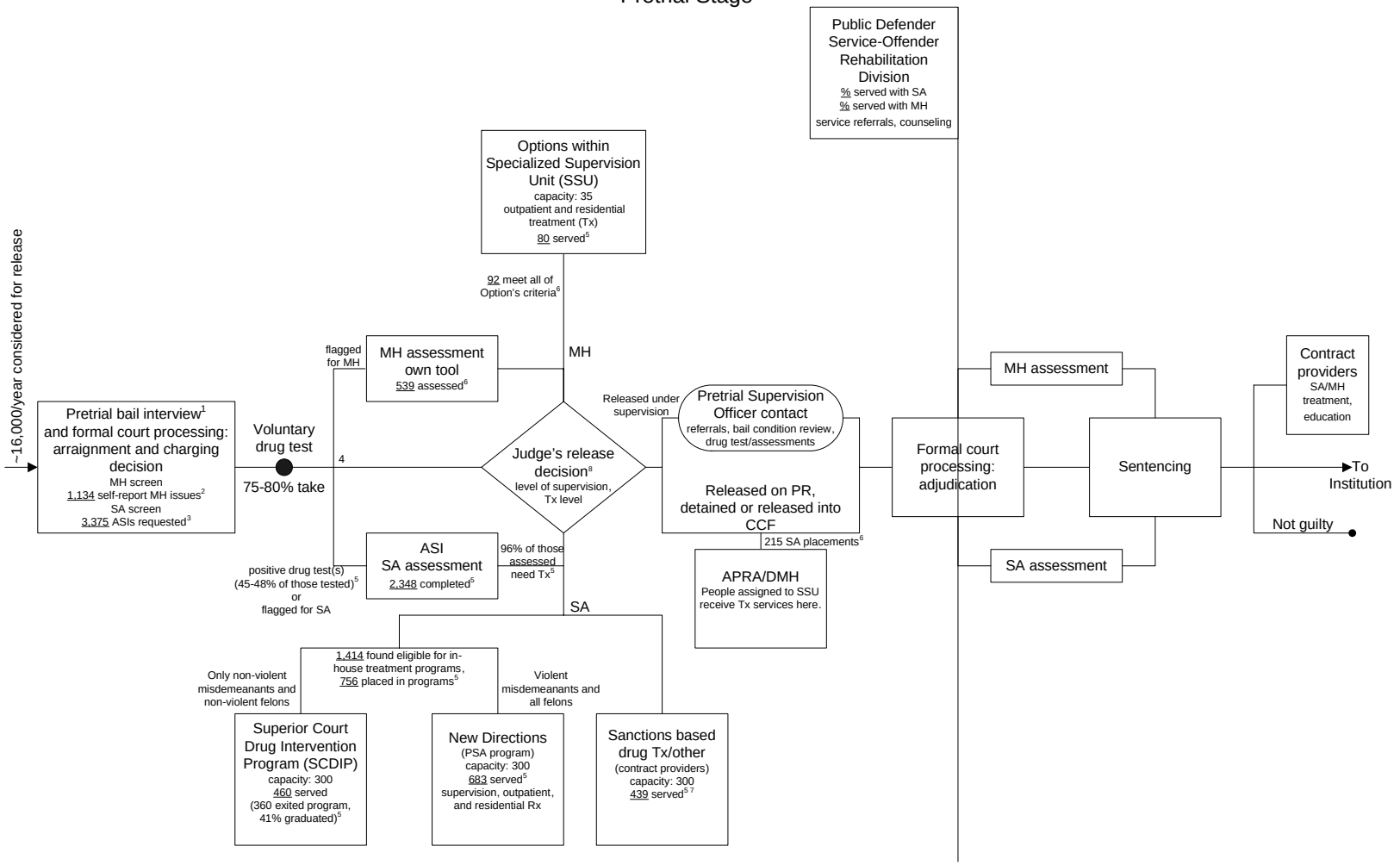
Substance Abuse Questions (8)

- Do you have any health problems that may have been caused by or made worse by your alcohol or drug use?
- Do you spend a lot of time thinking about or trying to get alcohol or drugs?
- Do you ever have a drink or use drugs first thing in the morning to get going?
- Do you feel the need to cut down or control your use?
- Does your drug or alcohol use interfere with your daily routine?
- Does drinking or drug use cause problems between you and your family or friends?
- Do you use drugs or alcohol and then can not remember what happened for a period of time?
- Have you been recommended and/or referred to or received treatment/counseling for an alcohol and/or drug problem within the last five years?

Mental Health Questions (7)

- Do you have periods of nervousness or depression that interfere with your daily routine?
- Do you have thoughts or feelings that you are afraid to talk about?
- Do you see or hear things that others do not?
- Do you think seriously about hurting yourself or killing yourself?
- Do you take medicine for your nerves or for psychiatric reasons?
- Have you received or been told you should receive mental health services?
- Have you been hospitalized for mental or emotional problems?

Figure 3.3. Criminal Justice Process for People with Substance Abuse (SA) and/or Mental Health (MH) Disorders at the Pretrial Stage



1. In the future, some people will receive the Universal Screener and may be diverted to Community Court.
2. Submitted by PSA. July 2002 to July 2003. MH issues are self-reported during PSA screener.
3. Submitted by PSA. October 2002 to September 2003. SA issues are discovered during PSA screener or during voluntary drug test.
4. Not all people flagged for SA and/or MH problems during screening will be assessed. PSA is unsure about the percentage of defendants who "slip through the cracks." Drug test outcome figures come from PSA. October 2002 to July 2003.
5. Submitted by PSA. FY 2003.
6. Submitted by PSA. First three quarters of FY 2003.
7. Seventeen defendants received intensive outpatient services from SCDIP—they were not placed in the program.
8. Defendants can move from one unit to another or one treatment program to another during supervision and may be in multiple counts.

Based on the PSA screener, the PSO may recommend that the offender be given a full assessment for substance abuse issues. The offender will complete the Addiction Severity Index[36] and have American Society of Addiction Medicine (ASAM) criteria applied in a 40-minute interview with a community treatment specialist (located within the General Supervision Unit of PSA and available immediately). Offenders also have the option to take a voluntary drug test while in lock-up. While the drug test is not mandatory, PSA reports that a majority of inmates agree to drug testing, perhaps with the belief that a positive test will give them some "perks." In an average month, 72 percent of defendants in lock-up drug test voluntarily; the remaining 20 to 25 percent either are physically unable to take the test at the time or are later required by a judge to take the test.[37] If the defendant has a positive drug test and has not already been recommended for an assessment, he or she will be given the ASI. The court can also order an assessment at any point before trial if it is deemed necessary.

Similarly, if an offender is determined to be at risk for emotional problems during the initial bail interview, he or she will likely be referred to DMH's court liaison for screening and consideration for the Options program and the Special Supervision Unit (SSU — described in further detail below). The court liaison conducts a screening using a tool created by DMH. A PSO, judge, or attorney may request a DMH screening for defendants at any point before trial. A person who self-reports emotional problems during the assessment or exhibits emotional problems during the initial bail interview may be assigned to PSA's SSU.

After screenings and assessments are completed and recommendations made to the court, the judge addresses the issue of release while the case is pending. The judge's options include preventive detention, being released into a community correctional facility (work-release) with or without conditions, and being released on personal recognizance with or without conditions. Inevitably, every defendant with a substance abuse disorder, mental health disorder, or both will not be flagged at the pretrial stage. However, if the defendant is flagged at this point, PSA offers a number of treatment programs and supervision options to appropriately serve defendants and address their needs.

3.5.A.1. PSA Services for Defendants with Substance Abuse Issues

People identified as having substance abuse problems may be diverted to the Superior Court Drug Intervention Program (SCDIP). A collaborative program of PSA, the U.S. Attorney's Office (USAO), public defenders, and the judicial branch, SCDIP provides treatment services to eligible non-violent misdemeanants and felons.[38] A defendant involved in the SCDIP

[36] The ASI is an assessment tool that addresses the severity of symptoms in six domains: medical, employment/support, drug and alcohol use, legal status, family/social relationships, and psychiatric status. According to PSA (personal communication 2003), the clinician and client rate the severity of symptoms and assess the need for treatment in each domain. The assessment results in a finding of whether or not clients need treatment but does not identify substance abuse or substance dependence disorders. However, PSA reports that clients for whom any type of treatment is requested may be at least diagnosable with "substance abuse" and clients for whom detoxification or residential treatment is recommended may be diagnosable with "substance dependence" (Information provided by PSA, 8/31/03).

[37] Information provided by PSA, 8/31/03.

[38] Charges that make offender's ineligible for the SCDIP program are: murder, voluntary manslaughter, sexual abuse or rape, child sex crimes or abuse, cruelty to children, mayhem/malicious disfigurement, assault on a police officer, assault with intent to commit any offense, assault with a dangerous weapon, aggravated assault, carjacking,

diversionary program is required to complete four phases of the drug court process. Each phase involves status hearings and treatment. Upon graduation, misdemeanants have their case dismissed and felons are sentenced. For felons, graduation from SCDIP increases the likelihood that their sentence will be limited to probation. People may be referred to SCDIP by their PSO at bail review (pending court approval) or by the judge throughout case processing. The program has a capacity to serve 300 people at any given time and served 460 defendants in fiscal year (FY) 2003. During 2003, 360 people exited the program, 41 percent of whom graduated.

Defendants who are not selected for SCDIP are released into other treatment programs, New Directions (which is an in-house program) or the Sanctions-based Treatment program, which uses contracted treatment providers or externally funded community-based service providers. New Directions provides intensive outpatient treatment and residential treatment to substance-abusing violent misdemeanants and felons of all types. Participants are referred to the program by the judge at arraignment or during their pre-trial release after repeated positive drug tests. Clients participate in therapy and focus groups, and receive referrals to employment and other social service agencies. New Directions has a capacity to serve 300 people at any given time and served 683 during FY 2003.

The Sanction-based Treatment program includes features similar to SCDIP in that defendants appear before one judge throughout their time in the program and are subject to administrative and court-imposed sanctions similar to those given to SCDIP participants; however, diversion is not offered through this program. The program offers all forms of substance abuse treatment to participants through contract providers. PSA and CSOSA have established a transition process that allows for defendants in contracted treatment who are placed on probation to remain in treatment without a lapse. Both violent and non-violent defendants are eligible to participate in this program. The Sanctions-based Treatment program served 439 defendants during FY 2003.

PSA's treatment branch manages SCDIP, New Directions, and Sanctions-based Treatment. The programs are increasing their service capability in order to become dual diagnosis capable programs. All three already accept people with co-occurring disorders as long as the mental health issue is "stabilized" (i.e., patients have their medications and are taking them) such that they can participate effectively in substance abuse treatment.

3.5.A.2. PSA Services for Defendants with Mental Health Issues

PSA launched the Specialized Supervision Unit (SSU) in June 2003 in an effort to enhance its mental health services to those defendants on pretrial release. The unit supervises adults with mental illness, mild mental retardation, personality disorders, and co-occurring disorders. Individuals are eligible for the SSU regardless of their criminal history (the program accepts those with histories of violence) and regardless of the presence of substance use disorders. Individuals are identified as potential candidates for the SSU during the initial bail interview. Individuals may also be referred to the unit after initial release by a PSO from another supervision unit if the client is believed to have a mental health issue. Within SSU, PSOs

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kidnapping, robbery, burglary, arson, extortion or blackmail accompanied by threats of violence, carrying a pistol without a license, carrying a dangerous weapon, attempt or conspiracy to commit any of the above offenses, felony threats, possession of a firearm during a crime of violence/possession while armed, any felony while armed, violent misdemeanor (assaults, threats, or stalking), any violent felony, or any weapons offense. Offenders also cannot have a previous violent felony conviction within the last 10 years

provide supervision of release conditions and conduct drug testing, as well as act as case managers who connect and reconnect defendants to DMH agencies, refer clients to psychiatric testing, and make recommendations to other specific agencies.

The Options program is part of the SSU.[39] It is administered by DMH, PSA, and a core service agency and has a capacity of 35 people at any given time. It serves non-violent, mentally ill misdemeanants and felons who are non-functioning and not connected with other services. PSA recommends a person for Options after DMH assessment and release. The court places a client into Options.[40] The program has strict requirements for admission, including:

1. No current or pending dangerous, violent, or weapons offense (simple assaults are allowed);
2. No conviction or supervision in the past five years for dangerous, violent, or weapons offense (simple assaults are allowed);
3. No existing connection to a DMH core service agency;
4. No primary substance abuse disorder (known drug use in the past thirty days excludes a defendant from the program.); and
5. The client's voluntary participation in the program.

Defendants with mental health issues are placed into two SSU tracks:

1. Those who meet the eligibility criteria for the Options program will be identified to the court as eligible for the **Specialized Supervision Unit Options Track**.
2. Those who fail to meet Options eligibility criteria will be identified to the court as eligible for the **Specialized Supervision Unit Regular Track**.[41]

In the first three quarters of FY 2003, 539 defendants were screened for the Options program, and 447 were found ineligible. Table 3.1 details the eligibility requirements and captures the number of people excluded for each reason in the first three quarters of FY 2003.

TABLE 3.1
Options Screening Results

Reasons why the defendant was ineligible for the program:	Total
Already connected to DMH	165
Current or past charges	173
Drug history	55
Violence potential	23
Out-of-area	9
No mental illness	9
Liaison declining admission	2
Other	11
Total ineligible	**447**

Source: PSA 8/31/03

Of the 92 found to be eligible for Options during this time, only 46 were placed in Options. The other 46 did not enter the program — 27 declined services and 19 could not be placed due to temporary program closure.

[39] PSA hopes to make Options a diversion program within the SSU for defendants with mental health issues. However, the USAO has not yet approved Options for diversion.
[40] A person may also be recommended to the program at a status hearing.
[41] People with severe mental health issues that are also in need of detoxification services may be referred to a private inpatient provider.

Once enrolled in Options, the offender receives a case manager. Services provided include psychiatric services, medication management, housing, hospitalization, psychosocial rehabilitation, employment services, and connection to permanent mental health services. Options will and has placed program participants in substance abuse treatment programs (for those participants who have a secondary substance abuse disorder). While enrolled, the Options participant is required to abide by release conditions and is monitored by a PSO.

PUBLIC DEFENDER SERVICE-OFFENDER REHABILITATION DIVISION (PDS-ORD): ANOTHER RESOURCE FOR DEFENDANTS FROM PRETRIAL AND BEYOND

PDS-ORD offers a variety of counseling and referral services to defendants in Washington, D.C. Defense attorneys refer most clients to PDS-ORD. However, the judge, PSO, probation officer, a friend, or the prosecutor may suggest a defendant visit PDS-ORD, pending the defense attorney's approval. Once a defendant becomes a client of PDS-ORD, he or she is always a client. He or she may even receive services post-release. Specific services available for offenders with mental health and/or substance abuse issues include the following:

- Counseling (including home visits)
- Substance abuse and mental health assessments (one-on-one interviews and collateral record collection)
- Treatment readiness programs
- Case management
- Court advocacy
- Referrals and placement in substance abuse, mental health, and residential programs (including religious organizations and other community providers not certified by DMH or APRA)
- Family support services and referrals to primary care facilities.

3.5.A.3. Other Services for Defendants with Mental Health or Substance Abuse Issues

Defendants not selected for the in-house SCDIP, New Directions, or Options programs, but released under supervision, may still be recommended for release conditions that include substance abuse and/or mental health treatment. Some of these defendants will be supervised by the SSU described above and others will be placed under general supervision. Regardless, further assessments, treatment services, and social services will be conducted by PSA's contract providers or by externally funded, community-based providers. To receive treatment through PSA and its contractors, the defendant will move through the following process:

1. PSA recommends releasee for treatment (optional).
2. Judge places releasee in treatment (mandatory to receive treatment through PSA).
3. PSO asks the contracting technical representative (or COTR) from DMH to place the person in a treatment slot.
4. COTR receives monthly or weekly reports about the client from the service provider.
5. The PSO receives reports from the COTR and reports drug test results and treatment updates to the judge.

6. At any time during court processing, the PSO, public defender, or judge can order further assessments and recommend or require additional treatment or supervision conditions.

As of September 2003, there were 14 substance abuse treatment providers contracting with PSA for services, of which five were dual diagnosis capable. An additional 20 service providers (including APRA) are non-PSA funded drug treatment programs that will take referrals from PSA. The latter agencies are typically only used toward the end of the fiscal year when PSA treatment dollars are drained. The Public Defender Service — Offender Rehabilitation Division (PDS-ORD) provides an additional resource for offenders seeking treatment during court processing (see sidebar PDS-ORD: Another Resource for Defendants).

3.6. INCARCERATION

Figure 3.4 depicts substance abuse and mental health treatment options for incarcerated individuals either in the D.C. Detention Center (the Jail) or prison from Washington, D.C..

3.6.A. D.C. Department of Corrections

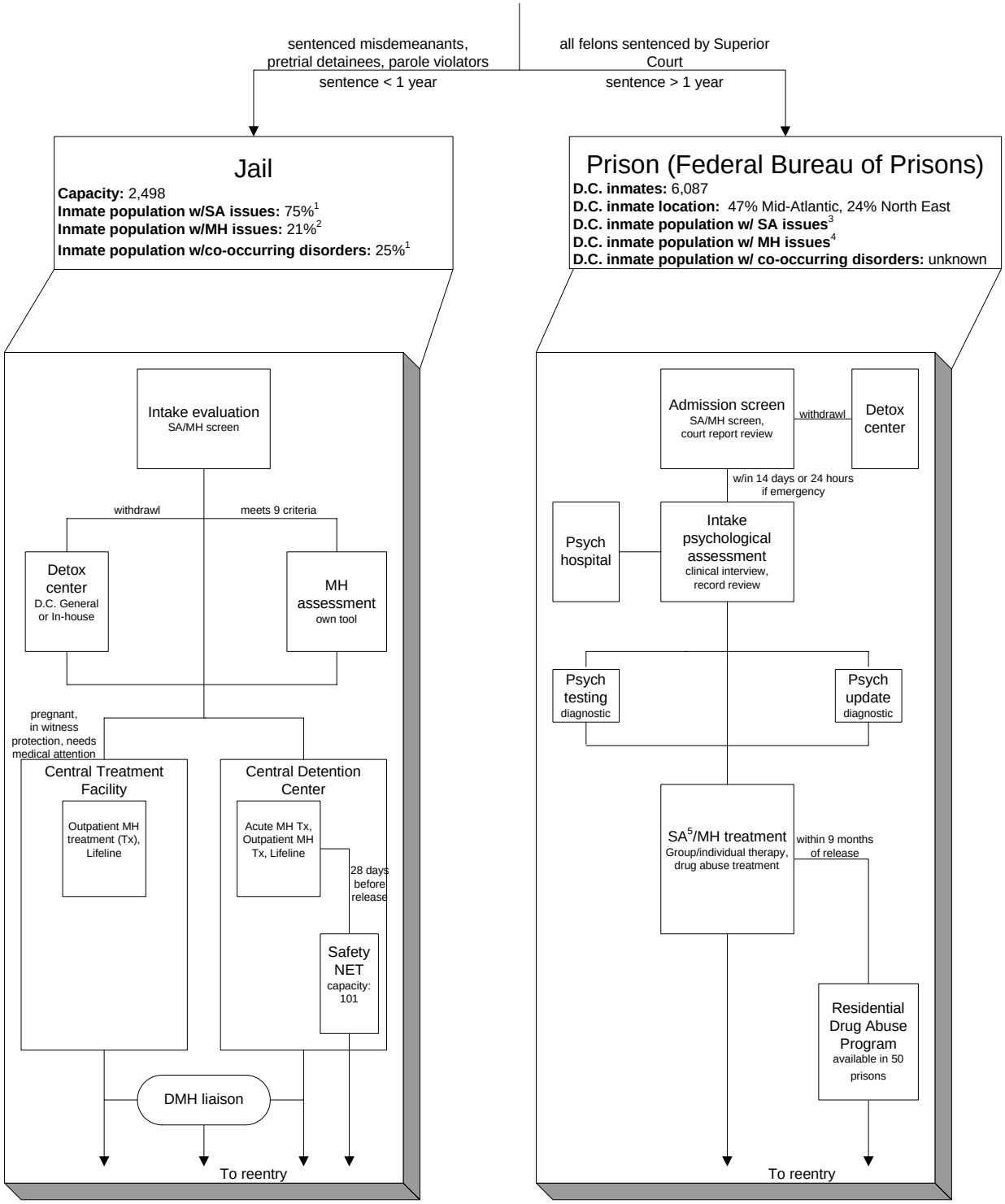
The D.C. Jail's two facilities—the Central Detention Center (referred to as the "jail") and the Central Treatment Facility (CTF)[42]— have the capacity to house 2,498 and 925 inmates respectively. Both facilities operate at or over capacity on a daily basis. In a single year, D.C. Jail staff estimate that 17,000 to 18,000 offenders move through the D.C. Jail.

When an offender enters the jail, he or she receives an intake evaluation that includes a medical, substance abuse, and mental health screening. A mental health assessment is performed within 72 hours if an offender is flagged for mental health follow-up or if the offender meets one of nine criteria: (1) first time in jail, (2) prior mental health issue, (3) juvenile, (4) entered with a court alert, (5) behavioral issues, (6) self-request, (7) recent loss, (8) family history of suicide, and (9) own history of suicide or self injury. The assessment is completed by a Center for Correctional Health and Policy Studies (CHPS) staff psychologist or social worker that uses an assessment tool developed for the D.C. Jail specifically. If the inmate needs further assessment, he or she is referred to a staff psychiatrist. If an offender is flagged for substance abuse issues, the offender is provided with the appropriate treatment if it is critical (such as being sent to detoxification at D.C. General for acute cases or sent through detoxification on site) or placed on the waiting list for one of the inmate-led support groups.

The initial screening is self-reported, and intake has limited access to a person's medical history. Limited sources for information about an inmate's medical history include: sentencing reports or court alerts, data collected from past (inmate-identified) treatment providers, and data for

[42] Only offenders with medical needs, offenders in the witness protection program, and pregnant offenders are assigned to the Central Treatment Facility. The rest are assigned to the jail. Any inmate (regardless if he or she would normally go to CTF) who needs acute (inpatient) mental health treatment goes to the jail. Mental health and substance abuse services in the jail are provided by the Center for Correctional Health and Policy Studies. Substance abuse services in the CTF are provided by the Correction Corporation of America (building proprietor).

Figure 3.4. Criminal Justice Process for People with Substance Abuse (SA) and/or Mental Health (MH) Disorders at the Incarceration Stage



1. Data provided by on-site medical contractors.
2. In June 2000, DCDOC provided MH therapy and counseling to 21 percent of its population (BJS).
3. Data for D.C. unavailable. Thirty percent of BOP inmates nationwide receive a diagnosis of substance abuse.
4. Data for D.C. unavailable. Eight percent of BOP inmates nationwide receive a diagnosis of mental illness.
5. No substance abuse treatment is conducted prior to three years before release.

inmates with previous stays at D.C. Jail. Despite the limited information D.C. Jail personnel have on an offender's medical history at intake, they believe that they follow-up with or assess everyone with a substance abuse or mental health issue who enters the jail.

Once an inmate is assessed, they are assigned to treatment. Treatment options available to inmates in D.C. Jail are documented in table 3.2.

Table 3.2
Programs Available in D.C. Jail for Mental Health (MH) and Substance Abuse (SA)

Program	Type	Access	Specifics	Capacity
SafetyNET	SA	Court ordered	SA Treatment Readiness Program in separate unit of jail for a minimum of 45 but not more than 60 days before release, after which the inmate becomes inpatient at a community-based treatment provider. MH provides some treatment to inmates in this program.	80 men 21 women Operates at full capacity most days
Detox Center	SA	Arriving inmates in severe alcohol withdrawal or those with severe heroin addictions	At D.C. General Hospital. Once completed, the inmates return to jail.	80
Acute Mental Health Treatment	MH	By assessment	A separate unit of the jail provides 24-hour nursing, counseling, and medication (CHPS).	
"Outpatient" Mental Health Treatment	MH	By assessment, for stable inmates	Individual and group therapy, medication administration in both CTF and the jail.	
Life-line	SA	By assessment	Inmate-led, 30-day, 60-day, and 90-day support groups.	There is a waitlist

The jail uses memoranda of understanding with APRA and in-house staff to provide treatment services (including counseling, education, treatment readiness, and methadone maintenance) to inmates suffering from mental health and substance abuse disorders. An inmate has the right to refuse treatment and assessment at any time. However, D.C. Jail staff believe most inmates accept everything offered to them. There are sanctions for inmates who refuse to be screened or tested—the inmate could be sent to solitary lockdown.

For inmates returning to the community, release programming includes SafetyNET, which provides substance abuse treatment readiness to about 100 people per year. After completing the 45 to 60 days of programming in jail, the inmate becomes an inpatient client at a community-based treatment provider. An inmate returning to the community facing mental health issues may find help through the on-site DMH liaison. The DMH liaison tries to reconnect inmates who used the public mental health system before jail with their previous provider. The DMH liaison also tries to place new clients with providers. The liaison is more successful at the former task than the latter, and providing inmates with truly continuous care from the jail to the community is yet to be accomplished. Additionally, housing is a major issue: many providers will not take recently released inmates.

The D.C. Department of Corrections also operates Community Corrections Facilities (CCFs) – or halfway houses – to help inmates reintegrate themselves back into the community before being released from formal custody. DCDOC contracts with three organizations to provide these services. The houses offer a number of programming options, including case management, individual and group counseling, substance abuse intervention through referral and in-house Narcotics Anonymous and Alcoholics Anonymous programs, as well as other educational, employment, social, and family services.

3.6.B. Federal Bureau of Prisons

Before an offender is placed in a prison facility,[43] a Bureau of Prison's (BOP) community corrections manager will review the offender's court report, including court documents, probation files and attorney notes, to determine the level and immediacy of treatment required and the safety risk presented by the offender. The offender will then be placed in an appropriate, available facility. For D.C. offenders, the appropriate facility may be anywhere in the United States. In July 2003, the three facilities with the largest D.C. inmate populations and their locations were Rivers Correctional Institution in North Carolina, Lee United States Prison in Virginia, and Atlanta United States Prison in Georgia.

All prisoners are given a comprehensive Psychological Intake Assessment within 14 days (or 24 hours in the case of emergency) of arrival at a facility. The assessment includes the modified Texas Christian University Drug Screen II and the DSM-IV-R (for substance abuse and for mental health). Follow-up services include psychiatric and psychological services, education and vocational training, group and individual treatment for depression, and drug and alcohol programs.

Prisoners with substance abuse issues may participate in the Residential Drug Abuse Program (RDAP). RDAP treatment begins nine months prior to release. It includes three to four hours of drug treatment, five days a week, as well as education, skills training, and other programming. Only prisoners who meet the DSM-IV diagnostic criteria for an alcohol or illicit drug use disorder are eligible for the program.[44] Prisoners must be willing and able to participate in the program in its entirety. RDAP is offered at 50 BOP institutions. Each program is limited to 24 inmates (McWay 2001). BOP inmates who complete RDAP should move to a CCF for at least

[43] In the District, BOP takes responsibility for all felons sentenced by both federal and local courts.
[44] Eligible inmates may receive a judicial recommendation for residential treatment or simply volunteer.

180 days prior to release. Prisoners may also receive non-residential programs while incarcerated.

Because specific programming varies by facility, intra-system transfers may occur as new or different issues arise, assessments change, or a prisoner needs a particular type of treatment program or service (e.g., a drug abuser also needs sex offender treatment) (McWay 2001). When a prisoner is transferred, previously collected information on that prisoner is available to staff at the new facility through the SENTRY and Psychological Data Systems. Psychologists review files on all transfers and recommend follow-up services and evaluations.

Not all prisoners requiring mental health and substance abuse treatment will receive it. National statistics show that three-quarters of returning offenders have a substance abuse issue and 16 percent have a mental health issue. Of those, only one out of every three received treatment while incarcerated (Feldman 2003).

When their return to the community nears, all prisoners within the BOP system should have a pre-release evaluation assessing addiction severity. This assessment should be completed approximately six months prior to release. The assessment, the treatment plan, and treatment summaries should be shared with CSOSA for ease of transition to community supervision.

Like DCDOC, the BOP operates CCFs – or halfway houses – to help inmates reintegrate themselves back into the community before they are released from formal custody. The agency contracts with six organizations to provide these transitional services that are similar to those provided by DCDOC CCFs. (Three agencies are supported by both BOP and DCDOC.)

3.7. COMMUNITY SUPERVISION AND REENTRY

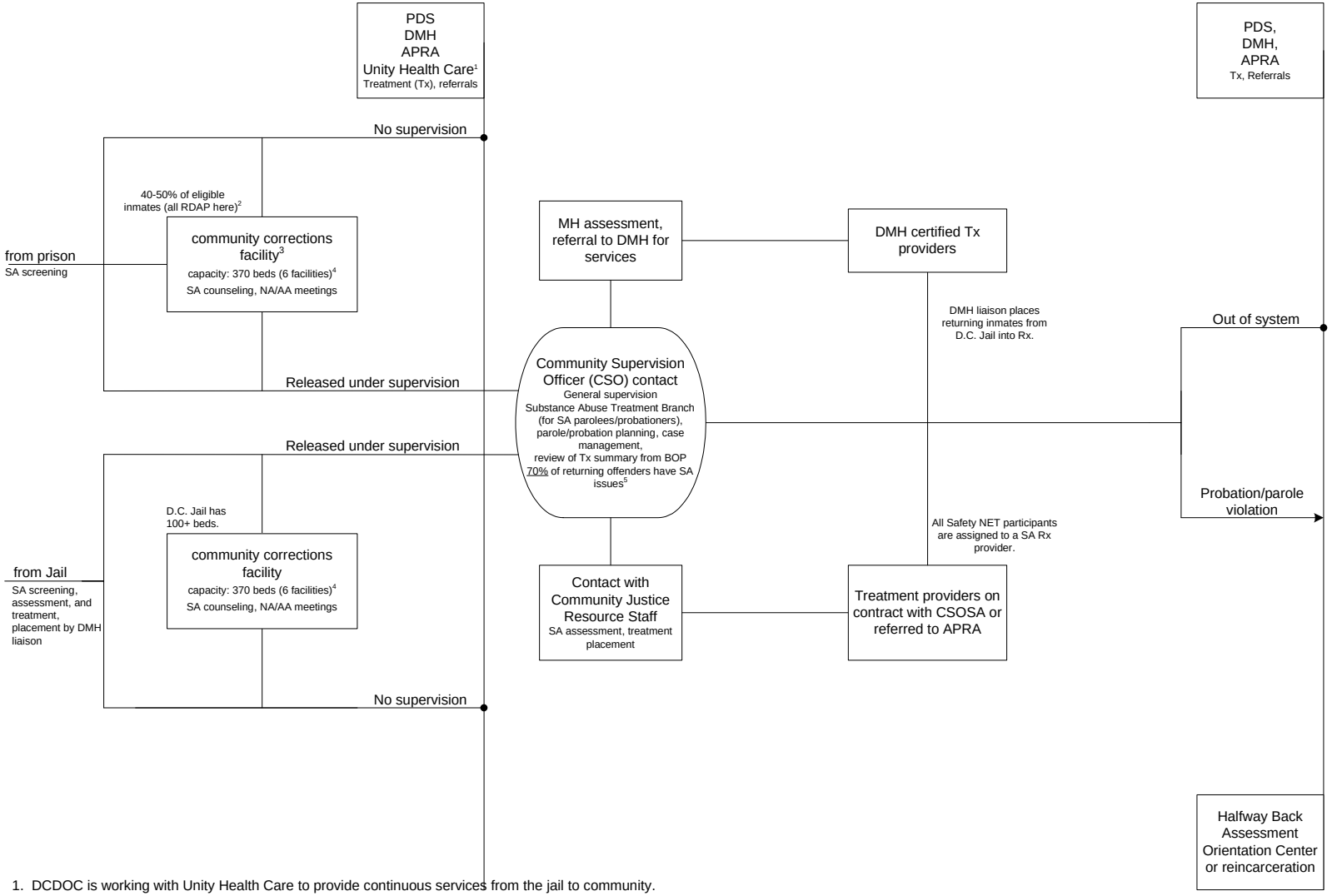
Figure 3.5 illustrates the community supervision and reentry process that D.C. offenders move through before final release from the system.

3.7.A. Court Services and Offender Supervision Agency

CSOSA monitors offenders returning from jail or prison under supervision who cases were adjudicated in D.C. Superior Court. CSOSA supervises approximately 15,000 people on any given day (CSOSA 2004). In FY 2003, CSOSA supervised nearly 21,000 offenders, some multiple times (Johnson 2004). A prisoner or inmate at D.C. Jail may be released and sent directly home without supervision. This report does not follow the path of these people, unless they become involved with the public behavioral health systems. This report also does not follow federal cases disposed in US District Court and sentenced to community supervision. They receive US Probation and are not monitored by CSOSA.

Approximately 70 percent of the offenders under CSOSA's supervision have substance use

Figure 3.5. Criminal Justice Process for People with Substance Abuse (SA) and/or Mental Health (MH) Disorders at the Community Supervision and Reentry Stage



1. DCDOC is working with Unity Health Care to provide continuous services from the jail to community.
2. CSOSA estimate, June 2004. Some BOP eligibility requirements to transition through CCFs are as follows: > six month sentence, non-sex offender, not in-need of inpatient psychiatric Tx.
3. Offender serves final 10 percent (or less) of prison term here.
4. Bannum, Inc. was scheduled to open in March, 2003. The facility would add 150 halfway house beds. Opening has been delayed due to legal issues. CCFs are funded by both DCDOC and BOP.
5. CSOSA, 2003.

problems (CSOSA 2003).[45] In recent years, the agency has received increases in funding to address the substance abuse treatment needs of its clients. However, funding issues still remain, as CSOSA was only able to provide treatment for 57 percent of those in need during FY 2002 (CSOSA 2003).

When CSOSA conducts a pre-sentencing investigation, cases are sent directly to the central intervention team (CIT) from the court or from diagnostic community supervision officers (CSOs). The CIT screens and assesses each offender, including those detained at D.C. Jail, and forwards a copy of the evaluation results to the court or the diagnostic CSO as appropriate. Once the case is sentenced, the CIT will receive the case's judgment and commitment order so treatment can be coordinated in accordance with the order. Two CIT staff members are assigned to work on pre-sentencing investigations.

For those people who are transitioning into parole, the transitional intervention for parole supervision (TIPS) process is followed. TIPS cases are handled one of two ways. For those individuals in CCFs, a TIPS CSO will schedule an assessment appointment with the CIT for the offender to be evaluated. CIT staff recommendations from the evaluation are forwarded to the CSO, who incorporates them into the parole plan. For detained offenders, the TIPS team provides information about the case to the CIT, and the CIT makes a recommendation for treatment and arranges for placement. Placement information is provided back to the TIPS team to include in the parole plan. Two CIT staff members are assigned to work on TIPS cases. CSOSA estimates that 40 to 50 percent of parolees who are released under supervision now transition through CCFs. Some jail inmates will also transition through CCFs. [46]

All treatment placements for supervised offenders are voluntary unless the treatment programs are specifically ordered by the court in the judgment and commitment order or by the United States Parole Commission as part of the parole plan. Offenders are given the right to refuse all CSOSA's recommended treatments. Case "staffings" – or meetings with the offender and the relevant CSOSA staff – offer the offender an opportunity to refuse treatment. If he or she refuses to participate in treatment, the offender signs a form, and the CSO usually forwards that form to the releasing authority for guidance on how the case should be handled. CSOSA works with the judges by providing specific examples of language for orders that give CSOs the flexibility to impose treatment on probationers without having to return to court for an amended judgment and commitment order. The judge may also include specific recommendations from pre-sentencing investigation findings when available, but will leave the language open so the treatment can be altered as necessary.

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[45] CSOSA reportedly has been actively working toward improving its services and supervision capabilities. In 2001, CSOSA convened a citywide reentry symposium to discuss reentry in DC and to develop goals, strategies, and plans for providing transitioning offenders with a continuum of services. A comprehensive reentry strategy for adults in the District of Columbia (CSOSA 2003) resulted from the symposium. Specific goals include the following: provide each reentering offender with a reentry team comprised of BOP or DCDOC staff and CSOSA staff for reentry planning purposes; teach family members and court staff about RDAP and enrollment processes; establish a Reentry and Sanctions Center; and establish a comprehensive mental health screening system and ensure needed medication and services are available upon release.

[46] CSOSA is currently piloting videoconferencing as a means of screening reentering prisoners flagged for substance abuse problems. The idea is to provide prisoners housed all over the country (who will not be transitioning through CCFs) with an introduction to substance abuse treatment in DC and allow CSOSA to prepare for those returning prisoners in need of substance abuse assessment and treatment. The program is currently piloted at Rivers Correctional Institution in North Carolina.

After the initial contact in prison, in jail, or at the CCF with the CSO, the paths for probationers and parolees with substance abuse and/or mental health issues who are released into the community under supervision are similar. CSOs and in-house mental health contractors follow treatment. CSOs monitor supervision conditions under the General Supervision Branch and the Substance Abuse Treatment Branch (for people with substance abuse issues).

Offenders with substance abuse issues (as identified before or during incarceration or post-release) will receive treatment screening and assessment and treatment planning through the staff of the Office of the Director — Community Justice Programs. CSOSA does not provide any direct services; rather they refer out to and reimburse providers for services. Treatment options available on referral include residential and outpatient services, as well as detoxification services. CSOSA may also refer clients to APRA for treatment. Services also target specific groups, including drug-addicted sex offenders, women with children, and offenders with co-occurring disorders. Community Justice Program staff provides treatment tracking and offender monitoring. When supervision requirements expire while an offender is still in substance abuse treatment, CSOSA offers offenders the opportunity to finish their current treatment module at CSOSA's expense. However, CSOSA reports most offenders opt not to stay in treatment.

Offenders with mental health issues, as identified by CSOs, court order, or the releasing authority, receive a psychiatric screening and assessment from one of six mental health professionals under contract with CSOSA. The assessment is conducted post release at the CSOSA offices. In-house follow-up services provided by contractors include aftercare counseling, medical compliance education groups, and a full battery of neuropsychological assessments. Other direct services are provided through DMH upon referral.

If a person has co-occurring disorders, the mental health issue will be stabilized first. Then, substance abuse treatment will proceed as detailed above. CSOSA currently has two long-term residential treatment facilities that are dually diagnosed capable under contract.

If an offender is sanctioned for probation or parole (supervisory or treatment) violations, the offender may still receive treatment while under heightened supervision or while he or she is being sanctioned. One placement option for parole or probation violators is the Assessment Orientation Center. This center was developed as a 33-day residential treatment readiness program for chronic substance abusing offenders. The center began as a pilot program and originally served 28 male offenders. The center is currently funded by CSOSA, which intends to use the center as an option for people transitioning out of incarceration and for parole or probation violators. It will serve 108 offenders. CSOSA intends the center to provide a more structured environment than "halfway back," an option in CSOSA's current sanctioning scheme. It will serve higher risk probation and parole violators.

Community Court in Washington, D.C.

While the target population of the community courts does not directly coincide with the target population of this report, we highlight the courts because of their unique philosophy and the array of services they provide to certain sentenced misdemeanants in D.C..

There are two community courts in D.C.: the traffic community court (D.C.) and the East of the River Community Court (federal). Both courts have been open for approximately two years. They are built on the premises that offenders should give back to the community and that attempts should be made to rehabilitate low-level offenders who are in frequent contact with the criminal justice system. Thus far, the court has identified three problems—substance abuse issues, mental health issues, and unemployment—that plague the chronic system users they see.

People are sent to the community court if they are charged with a misdemeanor arising from an arrest east of the Anacostia River. This is the way people get into community court and everyone meeting this condition is sent to community court, unless their charge is related to domestic violence.

Community Court is not a diversion program. Rather, people moving through community courts are offered deferred prosecution agreements and probation conditions that include community service, direct services, and social programs. Special services offered through this court (meaning the services are conditions of probation, are monitored by PSA and through "review hearings," and providers have slots available for community court defendants) include life skills and job readiness programs, detoxification services, and mental health screening and referrals to residential services. A sentence in community court also bears a community service requirement. The community service requirement is usually 40, 60, or 80 hours and is completed through the Department of Public Works or the Department of Parks and Recreation, among others. The community service must be completed in D.C., and preferably in the Anacostia Community (wards 6D and 7D). Again, this is set up and monitored by PSA.

3.8. INFORMATION SHARING BETWEEN CRIMINAL JUSTICE SYSTEM AGENCIES

Information is collected in numerous data systems in D.C. (see table 3.3) and the valuable information gathered during one stage of the criminal justice process in D.C. does not always follow an individual to the next stage of the process. For example, information collected during the pretrial process does not always follow the offender through the other stages of the criminal justice process and to the other agencies and service providers the offender will encounter (Universal Screening Subcommittee 2004).

Establishing a means for information sharing may increase efficiency, saving time and money. Because information sharing remains impeded by the use of numerous different systems and sharing regulations or conflicts of interest, CJCC facilitated efforts to create the Justice Information System for the District of Columbia (JUSTIS). Proposed in 1998 and currently being implemented, the system will provide an interface for both federal and local justice

agencies in D.C. to share data. This is a major effort to facilitate information sharing among agencies, to decrease duplicative data entry, and to minimize data errors. As of June 2004, the following agencies had signed sharing agreements signifying their commitment to JUSTIS: Superior Court of D.C., Office of the Corporation Counsel (OCC), MPD, PSA, CSOSA, DCDOC, USAO, D.C. Corrections Trustees, Public Defender Service (PDS), U.S. Parole Commission, Chief Technology Officer for D.C., and the Department of Human Services' Youth Services Administration (YSA).

JUSTIS is not a data warehouse.[47] Rather, JUSTIS is an Internet platform that connects certain data elements from various agencies' systems and provides real-time downloadable data to participant agencies. An individual record in JUSTIS contains a tracking number, core MPD data, and subsequent data contributions from other agencies. Combined, these elements provide a chronological record of an individual's movement through the justice system.

More specifically, JUSTIS data elements include the following:

1. Core data elements from the arrest report: arrest, lockup, and defendant and victim information. (Core data elements are only available on the JUSTIS system for 15 days.)

2. Agency data: CSOSA parole and probation data, PSA pretrial charge and release data, USAO and D.C. Superior Court charge and sentencing data, US Parole Commission decision data, case assignment data from OCC and PDS, inmate location and infraction data from DCDOC, and identification data from YSA.

In addition, CSOSA is working with PSA to find a way to share PSA's assessment results for offenders. For some offenders (especially probationers), PSA assessment information is quite timely and CSOSA would not need to reassess such people. Currently, CSOSA does receive information on any treatment an offender received through PSA if the person is sentenced straight to probation. The treatment costs are no longer funded by PSA but are transitioned to CSOSA.

3.9. CONCLUSIONS

D.C.'s criminal justice system is complex and involves numerous agencies. As evident from the above descriptions, agencies interface in a number of ways to move offenders through the system and to identify offenders' needs related to substance abuse and mental health issues. Each agency currently has some procedure to address the needs of offenders in these areas, with some agencies offering more screenings, assessments, and treatment options than others. The next chapter provides information about the capacity of the public behavioral health system to serve individuals in the criminal justice system who have co-occurring mental health and substance abuse issues.

[47] Other agencies currently use JUSTIS as a data resource. Agencies may limit access to their data to any agency they choose. Public access to the JUSTIS system remains limited.

Table 3.3 Data Systems by Agency		
Agency	**Data system name**	**Data system contents**
APRA	Client Data Set (CDS)	Includes demographic information.
DMH	Ecura	Includes patient information including sex, race and contact information. It also contains clinical information, such as the provider and diagnosis.
MPD	Criminal Justice Information System (CJIS) and Washington Area Law Enforcement System (WALES)[48]	Includes incident, processing, and offender information
PSA	Automated Bail Agency Database (ABADABA), Drug Testing Management System (DTMS), Pretrial Real Time Information System Manager (PRISM), SATIS	Include offender demographic information, pre-release diagnostic and assessment information, and drug test outcomes
D.C. Department of Corrections	Logician	Captures an inmate's stay from intake through release. Includes assessment and treatment data for individuals.
BOP	SENTRY and Psychological Data System (PDS)	Include personal and case records and psychological data.
CSOSA	SMART	Contains both supervision and treatment information (including assessment information and treatment history).
PDS	Not applicable	Electronic system in process.

[48] MPD staff utilize a variety of other databases, including national crime and arrest databases, a local crime index database, and an investigations system. They are not detailed here because they contain limited information about substance use problems and mental illness or because they are rarely utilized by first responders. Next year, MPD plans to release an automated field reporting and records management system.

Chapter 4. Substance Abuse and Mental Health Services in the District of Columbia

4.1. INTRODUCTION

A major goal of this project was to understand the mental health and substance abuse treatment provider service network that exists in the District of Columbia (D.C.). The Criminal Justice Coordinating Council, Substance Abuse and Mental Health Workgroup (the Workgroup) members wanted to learn what types of services are available and in what quantity. To this end, we conducted a survey of treatment providers in D.C. to examine services for people with mental health and substance abuse issues, and co-occurring disorders.

To begin this task, we created a comprehensive list of treatment providers to survey. Our list included all certified providers through the Addiction Prevention and Recovery Administration (APRA) and through the Department of Mental Health (DMH). We also included providers that the Pretrial Service Agency (PSA) and the Court Services and Offender Supervision Agency (CSOSA) contract with to serve their clients. Some of the providers identified by PSA and CSOSA had already been identified by APRA and DMH because such agencies are not only certified providers in D.C. but also contract separately with the criminal justice agencies. Altogether, 58 treatment providers were identified, of which 23 agencies primarily provide substance abuse treatment and 31 agencies primarily provide mental health services (appendix A lists all 58 treatment providers identified). We completed surveys with 54 of the 58 treatment providers, a response rate of 93 percent. The remaining four providers were contacted multiple times, but surveys were not successfully completed.[49]

The survey was conducted via phone interview and took about 20 to 45 minutes to complete, depending on the amount of information an individual agency representative provided. The survey included questions about the types of services agencies provided, the average length of services, the capacity for each service, if juveniles could access services, if the agency accepted referrals or funding from criminal justice system agencies, if the agency provided services for individuals with co-occurring mental health and substance abuse disorders, estimates of the number of clients served that have co-occurring disorders, and estimates of the number of clients served that are in the criminal justice system.

The results of the survey of service providers are presented below. First, we present an overview of mental health and substance abuse services in D.C. Second, we describe the services available for individuals with co-occurring mental health and substance abuse disorders. Finally, we provide information on the extent to which agencies accept criminal justice referrals and serve people who are in the system. Each of these topics includes information as reported by the service providers themselves.

[49] The four remaining treatment providers were contacted at least 4 times and up to 12 times, but we were unable to complete surveys with representatives from these agencies.

4.2. MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES AVAILABLE IN THE DISTRICT OF COLUMBIA

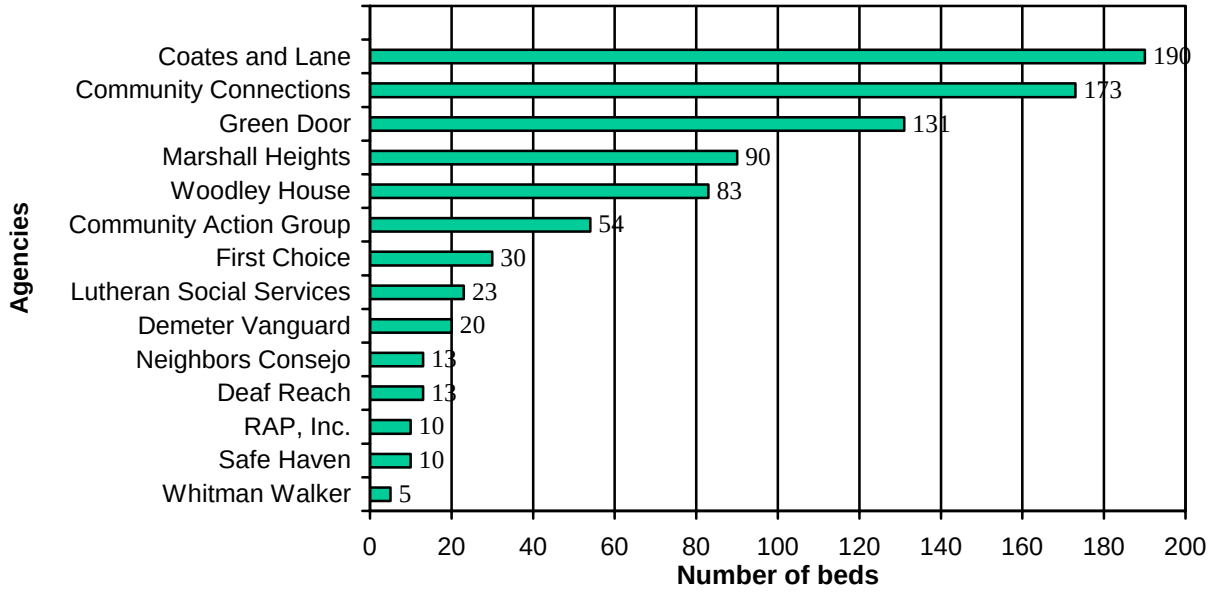
Mental health and substance abuse treatment providers offer services for both juveniles and adults in D.C. Of the 54 agencies interviewed, 30 (56 percent) provide services only to adults, 9 (17 percent) provide services only to juveniles, and 15 (28 percent) provide services to both adults and juveniles. Mental health and substance abuse treatment providers in D.C. offer a wide variety of services to their clients including case management, therapy, individual and group counseling, drug screening, employment services, relapse prevention, educational programs, residential treatment, detoxification, life skills development, and much more. Data on services reported by each agency are shown in appendix B, including the types of services provided, the capacity for each type of service, the average duration of treatment, if the agency serves both adults and juveniles, how many treatment slots are not filled on average, if there is a waitlist for services, the number of people on the waitlist for services, if the agency provides housing assistance, and the number of beds available if the agency provides housing for each of the 54 agencies surveyed. Quantifying services of these types can be difficult given the nature of the interventions and varying definitions of what "counts" as one "session" or "service provided." We allowed agencies to respond based on their own definitions of how they counted services and their capacity for each of these.

Appendix C synthesizes the information presented for each specific agency in appendix B and documents the extent to which services are available in D.C. To understand the total amount of services available in D.C., we added agency reports of their capacity for each type of service. Some highlights from appendix C are:

- The most frequently reported type of service available is case management and community support services, with 27 of 54 agencies (50 percent) reporting they provide these services. Combined, these agencies reported the capacity to provide case management to over 2,610 individuals at any given time.
- Eight agencies (15 percent) provide inpatient mental health services with a total capacity of over 651.
- Eight agencies (15 percent) provide inpatient substance abuse treatment with a total capacity of 470.
- Four agencies (7 percent) provide medical detoxification with the capacity to serve over 104 individuals.
- Twenty-one providers (39 percent) reported medication management services.
- Three providers (6 percent) reported providing methadone maintenance services.

Additionally, numerous agencies reported providing therapy or counseling services of some type. Twenty agencies (37 percent) reported providing individual counseling or therapy, 16 agencies (30 percent) reported providing family counseling or therapy, and 15 agencies (28 percent) reported providing group counseling or therapy. Another six agencies (11 percent) reported providing therapy but did not specify the type, and another five agencies (9 percent) reported providing counseling but did not specify the type.

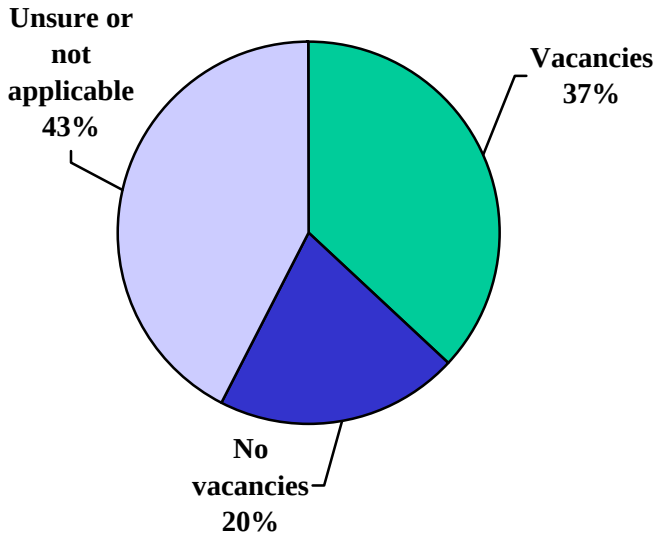
Figure 4.1. Housing Programs in D.C.



Housing was identified in chapter 2 as a critical service to provide to individuals dealing with mental health issues, substance abuse issues, or both. Some providers in D.C. provide housing assistance to clients and some are actually housing programs. A total of 33 agencies (61 percent) reported providing housing assistance to clients, including providing referrals for housing or advocacy services to assist clients in finding housing. Fifteen agencies (28 percent) reported providing housing in the form of beds. Figure 4.1 shows 14 of the 15 agencies reporting housing and the number of beds in each program, representing a combination of emergency, transitional, and permanent supportive housing. Six agencies have more than 50 beds in their housing programs with three having more than 100 beds. One agency, Latin American Youth Center, did not estimate the number of beds.

Only 22 agencies (41 percent) reported providing diagnostic testing or assessment to clients, but we believe this number is an underestimate given that assessment is required of all APRA and DMH certified agencies. This underestimate may have resulted from agencies not reporting such work due to assessments conducted at APRA's Central Intake Division or DMH's Access Help Line, or because our survey question was not clear to providers.

Figure 4.2. Treatment Program Vacancies



Once we learned the service capacity of the programs in D.C., we wanted to know the extent to which agencies were operating at that level. If agencies consistently operate at capacity, then the supply of services in D.C. would perhaps be inadequate, indicating a need for more programs. We found that agencies in D.C. operate at a mix of levels, with some reporting program vacancies and some reporting waitlists for services. Figure 4.2 illustrates the number of agencies that reported having vacancies in treatment programs. A total of 23 agencies (43 percent) were unable to estimate the number of vacant slots in their program. Twenty agencies (37 percent) reported having vacancies in the program on a regular basis and 11 (20 percent) reported not having vacancies in their program. Four agencies reported having 10 slots open, five agencies reported having 20 slots open, five agencies reported having 30 slots open, and five agencies reported having 50 or more treatment slots open.

Alternatively, 12 agencies (22 percent) reported having to keep a waitlist for services. Of these, six agencies were able to estimate the number of people on their waitlist: two reported having one person on their waitlist, two reported 15 people on their waitlist, one reported 20 people, and one reported 36 people. Three agencies were not able to estimate the number of people on their waitlist and three agencies reported that the waitlist was only for certain types of service within their agency, but not for their entire treatment program.

4.3. SERVICES FOR PEOPLE WITH CO-OCCURRING SUBSTANCE ABUSE AND MENTAL HEALTH DISORDERS IN THE DISTRICT OF COLUMBIA

We asked treatment providers about services available for individuals with co-occurring mental health and substance abuse disorders. Appendix D summarizes each agency's description of the services they provide for such individuals, as well as the proportion of their clients identified as having co-occurring disorders and which other agencies they refer their clients to for appropriate services. The large majority of agencies assess their incoming clients for co-occurring disorders

(47 agencies or 88 percent). Of the seven agencies that do not assess clients for co-occurring disorders, three do not do so because clients are referred by another agency, such as the APRA Central Intake Division, which has already conducted an assessment of this kind.

Figure 4.3. Percentage of Clients with Co-Occurring Disorders

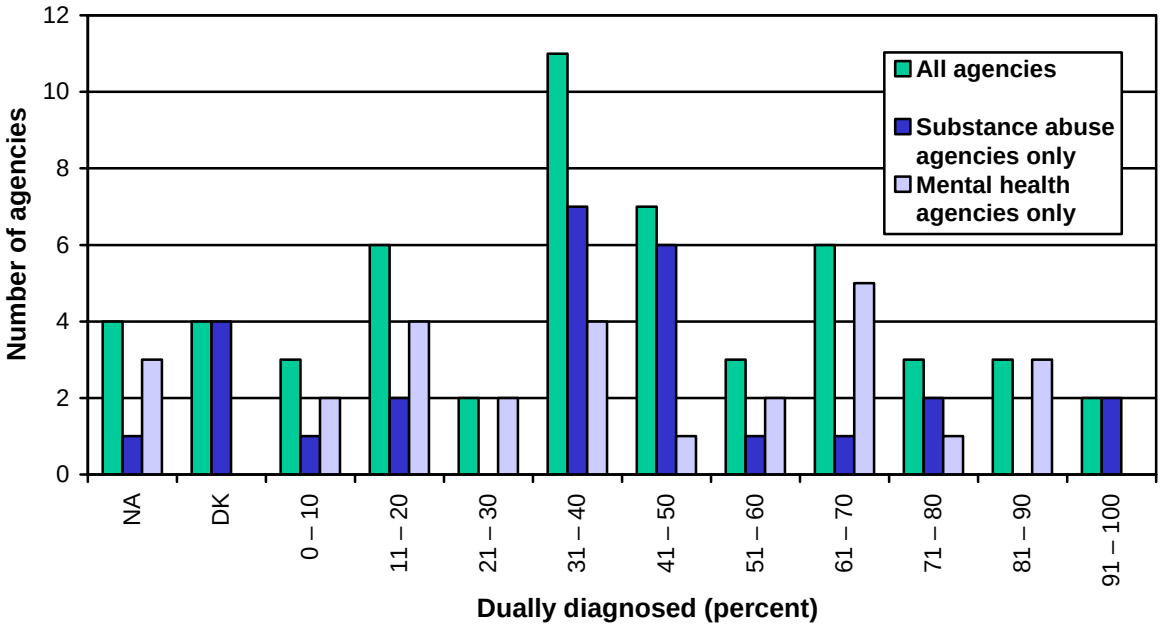
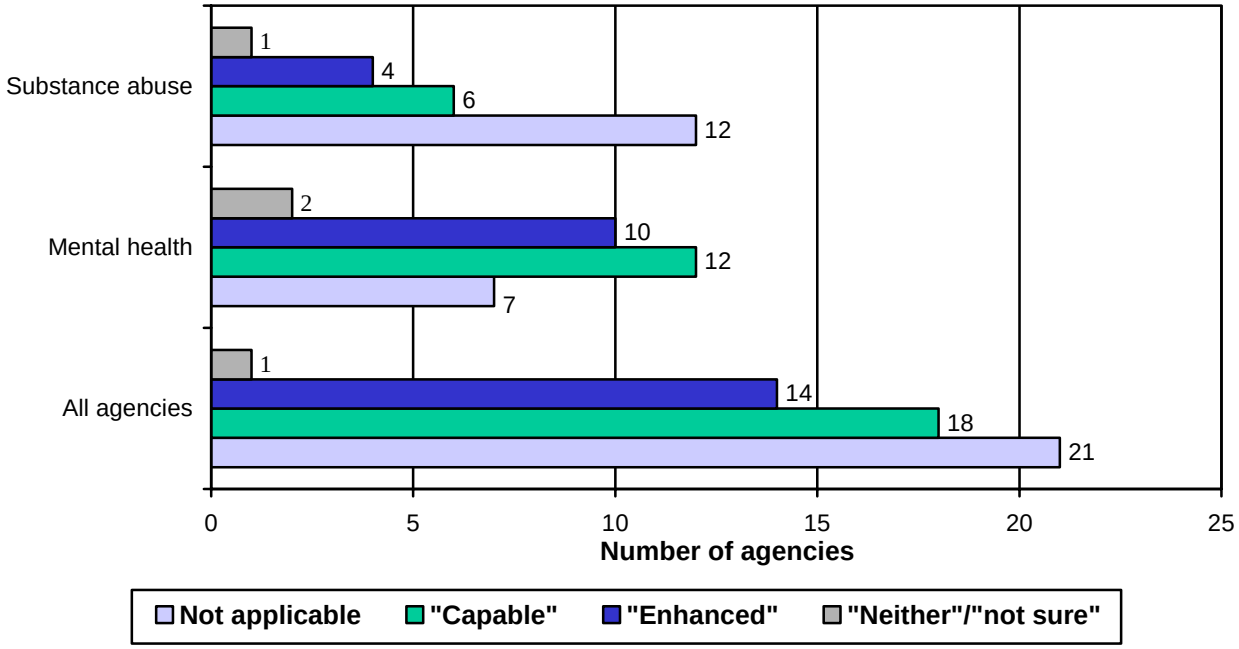


Figure 4.3 illustrates the percent of clients at treatment providers that are identified as having co-occurring mental health and substance abuse disorders. Forty-six of the 54 agencies (85 percent) were able to provide estimates of the percentage of clients they serve with co-occurring disorders. Many agencies' estimates were the respondent's best guess as to how many clients have co-occurring disorders based on their experience. For other agencies, estimates were based on information tracked by agency staff. Among these 46 providers, the average rate of clients assessed with co-occurring disorders was 49 percent, both for agencies that were primarily mental health treatment providers and for agencies that were primarily substance abuse treatment providers.

Once clients are identified as having co-occurring disorders, agencies take a number of routes to address these issues. Thirty-one agencies (57 percent) reported they refer individuals with co-occurring disorders to other agencies for some or all identified cases. Thirty-four agencies (63 percent) reported they treat dually diagnosed clients on-site (23 of the primarily mental health treatment providers and 11 of the primarily substance abuse treatment providers). Some of these agencies simply provide assessment for co-occurring disorders and refer the client to another provider for the non-primary issue while continuing to serve the client on site. Other agencies provide additional special services for dually diagnosed individuals; for example, a substance abuse treatment provider may have a resident psychiatrist on staff or provide mental health support groups (see appendix D). While others agencies do not provide any special services focused specifically on people with co-occurring disorders, they still serve this population's

needs through their core service activities which address *both* substance abuse and mental health issues (core services are detailed in appendix B).

Figure 4.4. Agency Capacity to Serve Co-Occurring Disorders



We asked agencies to tell us if they considered their services to be dually diagnosed capable (that is, providers recognize both mental health and substance abuse issues, but treat one as the primary issue and only provide limited support for the secondary issue), dually diagnosed enhanced (that is, providers recognize both mental health and substance abuse issues as primary and are able to provide a full set of services to treat both simultaneously), or neither. Figure 4.4 illustrates how agencies categorized their services. Eighteen agencies (33 percent) view their services as dually diagnosed capable; of these agencies, 12 primarily provide mental health treatment and 6 primarily provide substance abuse treatment. Another 14 agencies (26 percent) view their services as dually diagnosed enhanced; of these, 10 primarily provide mental health treatment and 4 primarily provide substance abuse treatment. One agency was not sure which classification fit them best and two agencies reported that although they treat individuals with co-occurring disorders, they were neither dually diagnosed capable nor enhanced.

However, while 18 agencies reported being dually diagnosed capable, only nine agencies (five primarily mental health treatment providers and four primarily substance abuse treatment providers) offered services related to the non-primary issue of focus. These services may be specifically geared toward people with co-occurring disorders or may be a part of their core set of services that include services for mental health *and* substance abuse treatment.

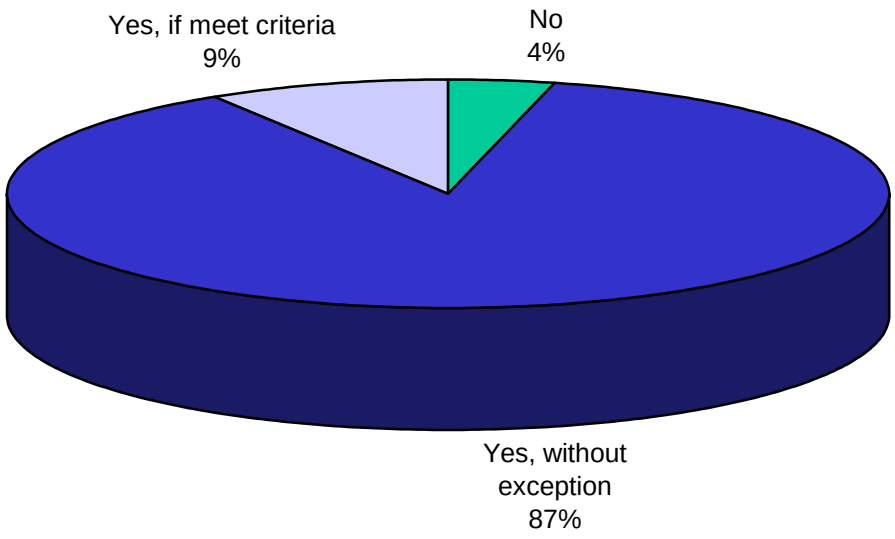
Similarly, 14 agencies reported being dually diagnosed enhanced, but only eight offered any services related to the non-primary issue of focus, such as addiction counseling at a mental health provider or psychiatric treatment at a substance abuse provider. Of these eight, only three

appeared to be providing extensive services for both mental health and substance abuse treatment.

4.4. MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES AVAILABLE FOR PEOPLE IN THE CRIMINAL JUSTICE SYSTEM IN THE DISTRICT OF COLUMBIA

As figure 4.5 demonstrates, most agencies (47 agencies or 87 percent) are willing to unconditionally accept clients who are involved in the criminal justice system. Four agencies (9 percent) will accept some of these individuals but not all, and this is mostly due to the charge associated with the crime. Such agencies are not willing to serve people who have committed violent crimes such as homicide or sex offenses. Only two agencies do not accept any clients who are involved with the criminal justice system. Of the agencies that serve clients in the criminal justice system, only four reported that they would put such people on their waitlists. Other agencies would accommodate these clients immediately. Appendix E documents each agency's willingness to serve individuals in the criminal justice system, as well as the points during the criminal justice system process from which referrals are accepted, funding sources from criminal justice system agencies, and the proportion of clients they serve that are involved in the criminal justice system.

Figure 4.5. Agency Willingness to Accept Clients Involved in the Criminal Justice System

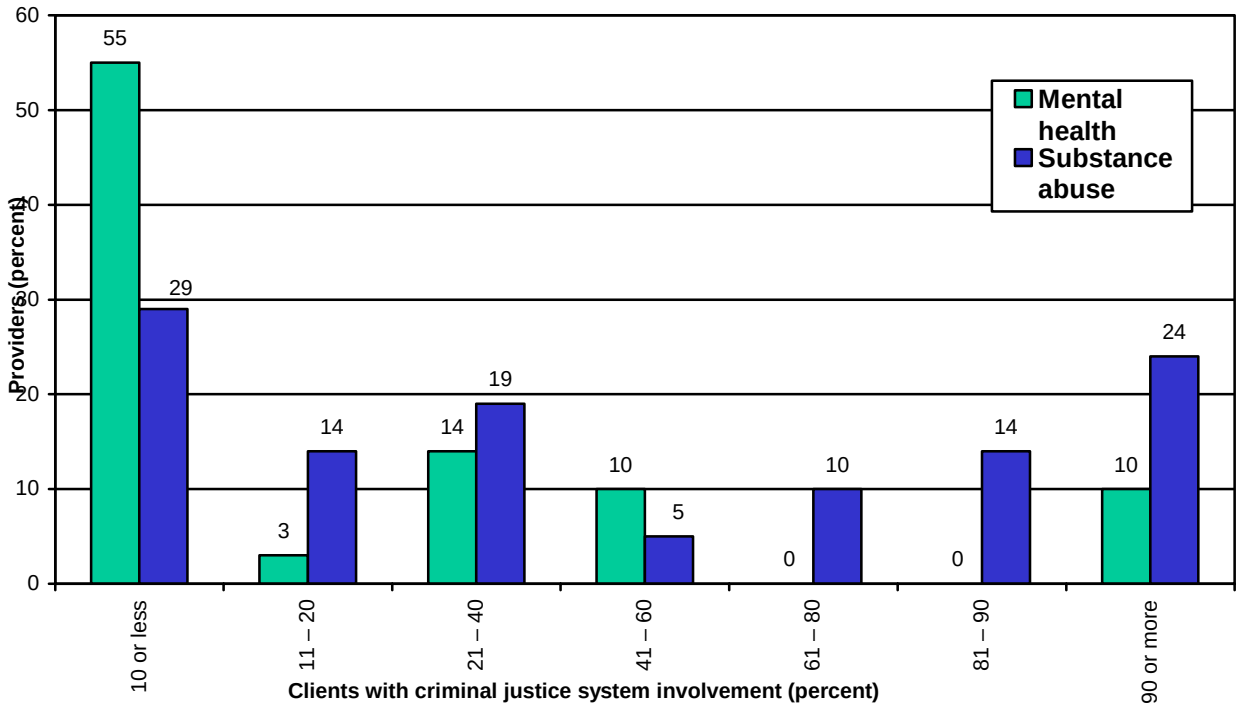


Most agencies were not receiving funding directly from criminal justice system agencies to serve clients involved in the system. Only sixteen agencies reported receiving funding from criminal justice agencies, such as PSA or CSOSA. Many agencies that work with the criminal justice population do so with funding from APRA or DMH.

Agencies provided estimates of the proportion of clients who are in the criminal justice system. For some, estimates were the respondent's best guess, and for others, this information is

specifically tracked.[50] Figure 4.6 illustrates the proportion of clients reported to have criminal justice system involvement either currently or in the past. Substance abuse treatment providers appear to be serving more of these clients than mental health treatment providers. Ten percent of mental health treatment providers and 24 percent of substance abuse treatment providers reported that 90 percent or more of their clients were involved in the criminal justice system. Only 10 percent of mental health treatment providers reported 60 percent or more of their clients are in the criminal justice system, while 48 percent of substance abuse treatment providers reported the same. At the other end of the spectrum, 55 percent of mental health treatment providers and 29 percent of substance abuse treatment providers reported that 10 percent or less of their clients were in the criminal justice system. Thirteen agencies (24 percent) were willing to serve juveniles in the criminal justice system, two of which reported 80 percent or more of their juvenile clients as being in the criminal justice system.

Figure 4.6. Proportion of Clients in the Criminal Justice System

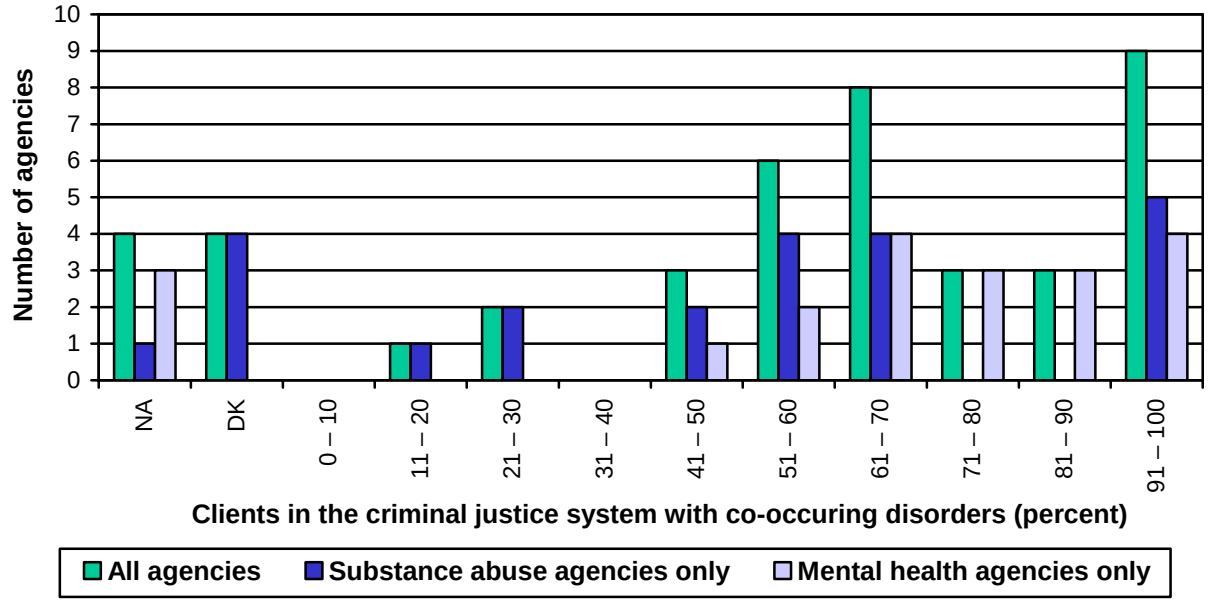


To examine this population further, we asked providers to estimate the proportion of their clients who are in the criminal justice system and who also have co-occurring substance abuse and mental health disorders. Thirty-five of the 54 agencies were able to give these estimates. Again, for some these are estimates based on "best guesses" and for others this information is tracked. Figure 4.7 reports the percentage of clients in the criminal justice system who have co-occurring disorders for all agencies and separately for substance abuse and mental health treatment agencies. Among the 35 agencies reporting estimates, the average proportion of clients involved with the criminal justice system and thought to have co-occurring disorders was 66 percent. For

[50] Four agencies did not provide estimates of client criminal justice system involvement because this information is tracked through APRA Central Intake Division and they do not ask for this information from clients again.

the 18 substance abuse treatment providers the average rate was 59 percent, and for the 17 mental health treatment providers the average rate was 73 percent. Nine agencies (five substance abuse and four mental health) estimated that over 90 percent of their clients that were in the criminal justice system also had co-occurring disorders. In fact, 29 of the 35 agencies reported that at least 50 percent of the criminal justice population also had co-occurring disorders. Only three substance abuse treatment providers reported that 30 percent or less of clients in the criminal justice system also had co-occurring disorders.

Figure 4.7. Proportion of Clients in the Criminal Justice System with Co-Occurring Disorders



4.5. CONCLUSIONS

Based on the results of our survey of mental health and substance abuse treatment providers in D.C., a number of service options exist for people with issues in these areas. Treatment options seem to be available as few agencies reported waitlists and some reported program vacancies. In addition, most agencies are willing to and currently do serve clients in the criminal justice system.

Information from the survey also demonstrates a clear need for services for people who have co-occurring mental health and substance abuse disorders. D.C. providers estimated that, on average, approximately half of their clients have co-occurring disorders. For the subpopulation involved in the criminal justice system, the average rate increases: providers estimate that two-thirds of these clients have co-occurring disorders.

In response to this, many agencies address co-occurring disorders in some way. Most agencies assess clients for co-occurring disorders. Over half reported referring dually diagnosed clients to

other agencies for appropriate services, and nearly two-thirds provide some services for dually diagnosed clients. Despite this, it is not clear how many agencies are actually dually diagnosed capable or dually diagnosed enhanced. Although more than half of agencies identified themselves in one of these two categories, our survey results show that many are not providing any particular services to address both mental health and substance abuse issues. Consequently, the capacity to serve individuals with co-occurring disorders may be over-estimated.

Additional Service Providers in DC

This chapter summarizes service provisions available through providers that are under contract with DC's criminal justice agencies and/or certified by DMH or APRA. Three other vendors provide significant amounts of assistance to people in the criminal-justice-system with co-occurring disorders in DC.

Unity Health Care provides people in D.C. with various medical and human services, regardless of their ability to pay. As a result, Unity Health Care's clients are primarily homeless or medically underserved. Specific services provided by Unity include primary and specialty medical services for adult men and women, HIV testing/treatment, tuberculosis screening, case management, psychiatric and other mental health counseling services, social services, substance abuse counseling and referrals, and diabetic education. Unity has at least a dozen sites citywide and provides primary health care for homeless individuals on site at area shelters.

So Others May Eat (SOME) is an interfaith community-based organization that provides affordable housing, food, clothing, job training, addiction treatment and counseling to poor, homeless or mentally ill individuals in DC. Specific programming for mentally ill people includes individual and group counseling. SOME also supports Isaiah House, a day program providing social-work services, hot meals, counseling, life-skills classes, education, arts and crafts activities, and recreation to mentally ill, homeless men and women. Substance abuse treatment programming includes two 90-day, in-patient, addiction recovery programs and a continuing care program, which provides support to individuals transitioning from homelessness and addictions back into society.

Bread for the City, a private, non-profit organization, provides D.C. residents with free food, clothing, medical care, legal and social services. Specific social services offered by Bread for the City include case management, assistance with applications for federal and D.C. benefit programs, and counseling services for adults without insurance. In addition, Bread for the City, in conjunction with DMH, provides a Representative Payee Program to D.C. residents who need assistance managing their personal finances. Clients are referred to the payee program by their DMH case manager or by a DMH affiliated Core Service Agency. Once a client is enrolled in the program, Bread for the City staff work with the client's mental health service providers, his or her DMH case manager, the social security administration, or the Office of Personnel management to meet the client's financial obligations. The client also receives individual budgeting lessons.

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Appendix A:

District of Columbia Service Providers

Agencies reported by: the Addiction Prevention and Recovery Administration, the Department of Mental Health, the Pretrial Services Agency, and the Court Services and Offender Supervision Agency

Primarily Substance Abuse:

1. ALPHA (APRA Dual Diagnosis Program)*
2. Andromeda
3. APRA Adams Mill Alcohol Center
4. APRA Adult Abstinence
5. APRA Aftercare
6. APRA Concerned Citizens Clinic
7. APRA Detox Center
8. APRA Model Treatment Program
9. APRA Youth Abstinence Program
10. Clean and Sober Streets
11. Community Action Group (CAG)
12. Cornell Abraxis
13. Demeter Vanguard
14. Federal City Recovery
15. **Jimmie Hayden****
16. La Clinica del Pueblo
17. Neighbors Consejo
18. **Next Step****
19. Phoenix House
20. RAP (Regional Addiction Prevention)
21. Riverside Treatment Services, Inc.
22. Seton House (Providence Hospital)
23. UMOJA (Providence Hospital)
24. **United Planning Organization****
25. Whitman Walker
26. Women's Services, D.C. General Hospital

Primarily Mental Health:

1. Anchor Mental Health
2. Care Co Mental Health Services
3. Center for Mental Health
4. Coates and Lane Enterprise, Inc
5. Community Connections
6. D.C. Community Service Agency
7. Deaf Reach
8. Family and Medical Counseling Services
9. **Family Preservation Services****
10. Fihankra Place
11. First Choice
12. First Home Care
13. Green Door
14. Hillcrest Children's Center
15. Institute for Behavioral Change and Research
16. Kidd International Home Care, Inc
17. Latin American Youth Center
18. Life Stride
19. Lutheran Social Services
20. Marshall Heights Community Development
21. McClendon Center
22. Pride Youth Services, Inc.
23. Psychiatric Center Chartered
24. Psychiatric Institute
25. Psychotherapeutic Outreach Services
26. Safe Haven Outreach Ministries
27. Scruptes Corporation
28. Second Genesis
29. Saint Elizabeths Hospital
30. Universal Healthcare Management Services
31. Washington Hospital Center
32. Woodley House

*APRA Dual Diagnosis program technically does not have a primary focus of substance abuse only.
**__Bold__ agencies were not interviewed.

Appendix B: An Overview of Substance Abuse and Mental Health Treatment in the District of Columbia

(responses to the Urban Institute survey of D.C. service providers, N=54)

Organization	NGO or city agency?	Services provided	Capacity[1]	Average duration of treatment[2]	Population served?	Average number of treatment slots not filled	Average number on waitlist for service	Provide housing assistance?	Number of beds
ALPHA (APRA Dual Diagnosis Program)	City agency	Individual therapy	150	DK[3]	Adults	30	No waitlist	No	NA[4]
		Group therapy	150	DK	Adults				
		Medication management	150	DK	Adults				
		Community-related therapy	150	DK	Adults				
Anchor Mental Health	NGO	Diagnostic/Assessment	DK	DK	Adults	DK	No waitlist	DK	DK
		Medication management	DK	DK	Adults				
		Counseling (individual, group, family)	DK	DK	Adults				
		Case management	DK	DK	Adults				
Andromeda	NGO	Substance abuse outpatient treatment for HIV and people living with AIDS	65	3 months	Both	0	15	No	NA
		Mental health diagnostic	65	3 months	Both				
		Support group for families	65	3 months	Both				
APRA Adams Mill Alcohol Center	City Agency	Breathalyzer	120	NA	Adults	80	No waitlist	No	NA
		ATOD education	120	4 months	Adults				
		Relapse prevention	120	4 months	Adults				
		DWI (driving while intoxicated) classes	120	6 months	Adults				
		Men's RAP	120	4 months	Adults				

Organization	NGO or city agency?	Services provided	Capacity[1]	Average duration of treatment[2]	Population served?	Average number of treatment slots not filled	Average number on waitlist for service	Provide housing assistance?	Number of beds
		Women's RAP	120	4 months	Adults				
		Positive pressure (self-esteem training)	120	4 months	Adults				
		Case management	120	4 months	Adults				
		NA and AA classes	120	4 months	Adults				
APRA Adult Abstinence	City agency	Breathalyzer	120	NA	Adults	55	No waitlist	No	NA
		ATOD education	120	4 months	Adults				
		Relapse prevention	120	4 months	Adults				
		DWI (driving while intoxicated) classes	120	6 months	Adults				
		Men's RAP	120	4 months	Adults				
		Women's RAP	120	4 months	Adults				
		Positive pressure (self-esteem training)	120	4 months	Adults				
		Case management	120	4 months	Adults				
		NA and AA classes	120	4 months	Adults				
APRA Aftercare	City agency	Relapse prevention	50	6 months	Adults	25	No waitlist	No	NA
		Case management	50	6 months	Adults				
		Employment referrals	50	6 months	Adults				
		Job partnership opportunities	50	6 months	Adults				
		Social, technological, and life enrichment courses	50	6 months	Adults				
		Health education	50	6 months	Adults				
		Individual counseling	50	6 months	Adults				
		Mental health referrals	50	6 months	Adults				
		On-site day care	50	6 months	Adults				
		On-site Narcotics Anonymous	50	6 months	Adults				

Organization	NGO or city agency?	Services provided	Capacity[1]	Average duration of treatment[2]	Population served?	Average number of treatment slots not filled	Average number on waitlist for service	Provide housing assistance?	Number of beds
		On-site Alcoholics Anonymous	50	6 months	Adults				
		Outreach Services	50	6 months	Adults				
APRA Concerned Citizens Clinic	City agency	Individual substance abuse treatment	30	DK	Adults	17	No waitlist	Referral services	NA
		Group substance abuse treatment	30	DK	Adults				
		Case management	30	DK	Adults				
		Medication management	30	DK	Adults				
APRA Detox	City agency	Medical detoxification	80	1 week	Adults	0	No waitlist	No	NA
APRA Model Treatment Program	City agency	Individual therapy	322	48 months	Adults	NA	No waitlist	No	NA
		Group therapy	DK	48 months	Adults				
		Methadone maintenance	DK	48 months	Adults				
		Detox	DK	2 weeks	Adults				
APRA Youth Abstinence Program	City agency	Full assessment (psychosocial, environmental, legal)	DK	3-4 hours	Juveniles	50	No waitlist	No	NA
		Individual therapy	75	DK	Juveniles				
		Group therapy	75	DK	Juveniles				
		Drug screening	DK	DK	Juveniles				
		Urinalysis	DK	DK	Juveniles				
		Case management	60	DK	Juveniles				
Care Co	NGO	Community residential facilities (mental health group homes)	62	DK	Adult	0	No waitlist	No	NA
		Mental health rehab services with community support	80	NA	Adult				
Center for Mental Health	NGO	Individual therapy	DK	DK	Both	DK	No waitlist	The case managers arrange transitional housing for their client.	DK
		Group therapy	DK	DK	Both				

Organization	NGO or city agency?	Services provided	Capacity[1]	Average duration of treatment[2]	Population served?	Average number of treatment slots not filled	Average number on waitlist for service	Provide housing assistance?	Number of beds
		Family therapy	DK	DK	Both				
		Medication management	DK	DK	Both				
		Case management	DK	DK	Both				
Clean and Sober Streets	NGO	Chemical dependency inpatient	80	8 months	Adults	0	No waitlist	No	NA
		Transitional housing	80	8 months	Adults				
		Residential treatment	150	15 months	Adults				
Coates and Lane Enterprise, Inc	NGO	Case management and Community support services	200	27 months	Adults	0	DK	Transitional housing	140
		Diagnostic assessment	NA	NA	Adults			Permanent supportive housing	50
		Medication	200	33 months	Adults				
		Individual therapy	60	6 months	Adults				
		Group therapy	200	6 months	Adults				
Community Action Group (CAG)	NGO	Men's SA treatment program	25	2 months	Adults	20	No waitlist	Referral assistance and housing for patients who successfully complete the program	54
		Men's transition program	25	1.5 months	Adults				
		DWI/DUI program	50	DK	Adults				
		In-patient SA treatment	50	DK	Adults				
		Outpatient SA program	50	DK	Adults				
Community Connections	NGO	Diagnostic/Assessment	20	NA	Both	DK	No waitlist	Group homes	160
		Medication management	960	NA	Both			"2 Options" houses	13
		Counseling Day Services (more intense counseling—for a few hours per day)	120	12 months	Both			Managed apartments	DK
Cornell Abraxis	NGO	Outpatient	50	6 months	Juveniles	0	No waitlist	No	NA
		Individual therapy	50	6 months	Juveniles				

Organization	NGO or city agency?	Services provided	Capacity[1]	Average duration of treatment[2]	Population served?	Average number of treatment slots not filled	Average number on waitlist for service	Provide housing assistance?	Number of beds
		Group	50	6 months	Juveniles				
		Family	10	1.5 months	Juveniles				
		Urine monitoring	50	6 months	Juveniles				
		Life skills development	50	6 months	Juveniles				
		Substance abuse education	50	6 months	Juveniles				
		Parenting	50	1.5 months	Juveniles				
D.C. Community Service Agency	City Agency	Diagnostic/assessment	25	NA	Both	DK	DK	No	NA
		Medication management	DK	DK	Both				
		Individual therapy	DK	DK	Both				
		Group therapy	DK	DK	Both				
		Family therapy	DK	DK	Both				
		Case management	DK	DK	Both				
Deaf Reach	NGO	MHRS	50	Decades	Adults	NA	No waitlist	Residential	DK
		Group homes (CRF)	DK	Decades	Adults			Supported living (HUD grant)	DK
		Supported employment	50	Decades	Adults				
		HIV prevention	400	NA	Adults				
		Rehabilitation services Administration	15	24 months	Adults				
		Supported independent living	DK	72 months	Adults				
Demeter Vanguard	NGO	Residential substance abuse treatment	24	6 months	Both	DK	DK	Transitional housing	20 beds
Family and Medical Counseling Services	NGO	Assessment (ASI, psychological, psychosocial, psychoeducational, psychiatric)	DK	DK	Both	DK	DK *(list is only for children's mental health counseling. In crisis situations, children always receive treatment right away)*	No	NA

Organization	NGO or city agency?	Services provided	Capacity[1]	Average duration of treatment[2]	Population served?	Average number of treatment slots not filled	Average number on waitlist for service	Provide housing assistance?	Number of beds
		Individual	DK	DK	Both				
		Group	DK	DK	Both				
		Family	DK	DK	Both				
		Medication management	DK	DK	Both				
		Case management	DK	DK	Both				
		HIV prevention and education – outreach services in schools and community	DK	DK	Both				
		HIV/AIDS outreach	DK	DK	Both				
		HIV counseling and testing program	DK	DK	Both				
		Nutrition counseling and foodbank for HIV positive patients	DK	DK	Both				
		HIV/AIDS support group	DK	DK	Both				
		Parenting skills classes	DK	DK	Both				
		Urinalysis	DK	DK	Both				
Federal City Recovery	NGO	Residential	55	4 months	Both	17	No waitlist	Referral services	NA
		Outpatient	100	4 months	Both				
Fihankra Place	NGO	Diagnostic/assessment	20	DK	Juveniles	10	No waitlist	No	NA
		Medication management	40	DK	Juveniles	35			
		Individual counseling	30	DK	Juveniles	23			
First Choice	NGO	Diagnostic assessment	100	NA	Juveniles	NA	NA	Yes	30
		Medication management	100	NA	Juveniles				
		Therapy	100	1 hour	Juveniles				
		Community support services	100	DK	Juveniles				

Organization	NGO or city agency?	Services provided	Capacity[1]	Average duration of treatment[2]	Population served?	Average number of treatment slots not filled	Average number on waitlist for service	Provide housing assistance?	Number of beds
First Home Care	NGO	Traditional therapy	84	24 months	Juveniles	50	No waitlist	No	NA
		Medication management	40	Months to years	Juveniles				
		Assessment and diagnosis	DK	NA	Juveniles				
		Community support	340	DK	Juveniles				
Green Door	NGO	Diagnostic/assessment	10	3 hour minimum mandated by DMH	Adults	NA	No waitlist	Independent living apartments	26
		Medication management	300	DK	Adults			Community residential facility	95
Hillcrest Children's Center	NGO	Diagnostic/assessment	80	3 hours	Both	DK	No waitlist	No	NA
		Medication management	20	DK	Both				
		Family counseling	60	1 hour	Both				
		Individual counseling	68	1 hour	Both				
		Group counseling	DK	1 hour	Both				
		Community support	80	DK	Both				
Institute for Behavioral Change and Research	NGO	Outpatient	75	4 months	Juveniles	15	No waitlist	No	NA
Kidd International Home Care, Inc[5]	NGO	Therapy for Child and Family Services patients	DK	DK	Both	NA	NA	NA	NA
La Clinica del Pueblo	NGO	SA program outpatient Level 1 (certified by APRA)	100	DK	Both	0	36	No	NA
		Elderly project	100	DK	Adults				
		Children therapy	100	4 months	Juveniles				
		Group therapy	100	5 months	Both				
		Domestic violence	50	4 months	Both				
		HIV treatment	30	DK	Adults				
		Open Door	75	DK	Both				

Organization	NGO or city agency?	Services provided	Capacity[1]	Average duration of treatment[2]	Population served?	Average number of treatment slots not filled	Average number on waitlist for service	Provide housing assistance?	Number of beds
Latin American Youth Center	NGO	Screening assessment	65	12 months	Juveniles	15	No waitlist	Transitional living program	DK
		Referral services	65	12 months	Juveniles	15		Host homes program	DK
		Individual therapy	65	12 months	Juveniles	15		Street outreach program (shelter)	DK
		Group family therapy	65	12 months	Juveniles	15			
		Case management	65	12 months	Juveniles	15			
		Drug testing	65	12 months	Juveniles	15			
		Psychiatric evaluation	65	12 months	Juveniles	15			
Life Stride	City Contractor	Day services	100	6 months	Adults	58	**3** (*for female group home)*	No	NA
		Group homes	80	DK	Adults				
		Community Service Agency	120	DK	Adults				
Lutheran Social Services	NGO	Individual	10	DK	Adults	DK	No waitlist	SRR housing	23
		Family therapy	300	DK	Adults				
		Community support (case management)	DK	DK	Adults				
		Medication management	DK	DK	Adults				
		NA	DK	DK	Adults				
		AA	50	DK	Adults				
		Spiritual	DK	DK	Adults				
		Group therapy	50	DK	Adults				
Marshall Heights Community Development	NGO	Adult cay services (mental health)	100	DK	Adults	0	No waitlist	Special needs housing	90
		Rehabilitation and socialization (mental health)	100	DK	Adults				
		Job training	DK	DK	Adults				
		Work development	DK	DK	Adults				

Organization	NGO or city agency?	Services provided	Capacity[1]	Average duration of treatment[2]	Population served?	Average number of treatment slots not filled	Average number on waitlist for service	Provide housing assistance?	Number of beds
		GED program	DK	DK	Adults				
		Adult education	DK	DK	Adults				
		Technical assistance for needy families	DK	DK	Adults				
		Special needs housing	DK	21 months	Adults				
		Building affordable housing	DK	DK	Adults				
McClendon Center	NGO	Monday through Friday day program for the chronically mentally ill	50	DK	Adults	NA	No waitlist	No	NA
		Day program services (curriculum-driven program):	50	DK	Adults				
		Psychological consultation	50	DK	Adults				
		Health education	50	DK	Adults				
		Life skills education	50	DK	Adults				
		Communication skills class	50	DK	Adults				
		Basic socialization class	50	DK	Adults				
Neighbors Consejo	NGO	In-patient	19	6 months	Adults	DK	No waitlist	Have a memorandum agreement with La Casa shelter for 7 beds. Also have six beds on site.	13
		Mental health for families	40	3 months	Both				
		Outpatient	12	2 months	Adults				
Phoenix House	NGO	Substance abuse counselor	DK	DK	Adults	NA	No waitlist	No	NA
		Psychiatric evaluation	DK	DK	Adults				
Pride Youth Services, Inc.	NGO	Individual, group and family counseling for adolescents	50	24 months	Juveniles	10	No waitlist	No	NA
		Youth Development Program (counseling/prevention programs)	50	4.5 months	Juveniles				

Organization	NGO or city agency?	Services provided	Capacity[1]	Average duration of treatment[2]	Population served?	Average number of treatment slots not filled	Average number on waitlist for service	Provide housing assistance?	Number of beds
Psychiatric Center Chartered	NGO	Diagnostic assessment	100	3 — 4 hours	Adults	DK	No waitlist	No	NA
		Individual counseling	45	DK	Adults				
		Family counseling	45	DK	Adults				
		Community support (case management)	100	DK	Adults				
		Day services (MRDD)	70	DK	Adults				
		Employment services	240	DK	Adults				
		Senior services	20	DK	Adults				
Psychiatric Institute	NGO	Short term inpatient mental health treatment	31	10 days	Adults	DK	No waitlist	No	NA
		Partial hospitalization for MH treatment	DK	Two weeks	Adults				
		Intensive outpatient MH treatment	DK	3 weeks	Adults				
		Lambda Center (offers in and outpatient treatment for the LGBT community)	10	10 days	Adults				
		Center for Post-Traumatic Stress Disorder (PTSD)	12	10 days	Adults				
Psychotherapeutic Outreach Services	NGO	Assertive Community Treatment (ACT): Program for individuals transitioning out of residential treatment	90	DK	Adults	0	No waitlist	No, provide referrals to Department of Mental Health	NA
		Community support (according to locus score assigned during assessment, clients are placed in community support if not qualified for ACT)	125	DK	Adults				
		Individual therapy	100	DK	Adults				
		Substance abuse group therapy	30	DK	Adults				

Organization	NGO or city agency?	Services provided	Capacity[1]	Average duration of treatment[2]	Population served?	Average number of treatment slots not filled	Average number on waitlist for service	Provide housing assistance?	Number of beds
		Medication education group	25	DK	Adults				
		Medication management	70	DK	Adults				
		Case management	90	DK	Adults				
		Family group support	12	DK	Adults				
RAP (Regional Addiction Prevention)	NGO	Residential substance abuse	120	NA	Adults	24	No waitlist	Yes	10
		Outpatient care	120	NA	Adults	24			
		Primary care	90	NA	Adults	DK			
		Emergency shelter for men	10	NA	Adults	DK			
		Case management	110	NA	Adults	DK			
		Nutritional services	110	NA	Adults	DK			
Riverside Treatment Services, Inc.	NGO	Acute psychiatric care	50	NA	Juveniles	0	15	No	NA
		Residential mental health treatment	72	24 months	Juveniles	DK			
		Residential substance abuse treatment	72	4 months	Juveniles	DK			
Safe Haven Outreach Ministries	NGO	Case management	50	Depends on funder	Adults	0	20	Housing for those who successfully complete the program	10
		Relapse prevention	50	Depends on funder	Adults				
		Aftercare	50	Depends on funder	Adults				
		GED prep	50	Depends on funder	Adults				
		Psychological evaluation (doctor and psychiatrist on-site)	50	Depends on funder	Adults				
		SPINS program (HIV/AIDs)	DK	10 months	Adults				

Organization	NGO or city agency?	Services provided	Capacity[1]	Average duration of treatment[2]	Population served?	Average number of treatment slots not filled	Average number on waitlist for service	Provide housing assistance?	Number of beds
		Initial Assessment	50	Depends on funder	Adults				
Scruptes Corporation	NGO	Diagnostic assessment	150	DK	Both	DK	No waitlist	Advocate for those who need housing and accompany them to an interview if necessary	DK
		Psychotherapy	150	DK	Both				
		Counseling	150	DK	Both				
		Community	150	DK	Both				
		Medication somatic	150	DK	Both				
Second Genesis	NGO	Residential	300	8 months	Adults	25	No waitlist	No	NA
		Therapeutic community	300	8 months	Adults				
		Outpatient	100	3 months	Both				
Seton House (Providence Hospital)	NGO	Outpatient substance abuse treatment	30	6 months	Adults	DK	DK	No	NA
		Detox	12	1 week	Adults				
		Partial day substance abuse treatment	12	Two weeks	Adults				
		Outpatient detox	12	1 week	Adults				
		Methadone maintenance program	320	DK	Adults				
		28 day substance abuse treatment program	19	1 month	Adults				
Saint Elizabeths Hospital	City Agency	Diagnostic assessment	10	Few hours	Adults	"A few"	No waitlist	No	NA
		Medication management	240	2.5 months	Adults				
		Individual counseling	DK	DK	Adults				
		Group counseling	217	DK	Adults				
		Family counseling	DK	DK	Adults				
		Case management	DK	DK	Adults				

Organization	NGO or city agency?	Services provided	Capacity[1]	Average duration of treatment[2]	Population served?	Average number of treatment slots not filled	Average number on waitlist for service	Provide housing assistance?	Number of beds
UMOJA (Providence Hospital)	NGO	Psychotherapy	320	27 months	Adults	10	No waitlist	No	NA
		Psychopharmacological therapy (medication management and methadone maintenance)	320	27 months	Adults				
		Group therapy	320	27 months	Adults				
		Case management	320	27 months	Adults				
		Group education classes	320	27 months	Adults				
Universal Healthcare Management Services	NGO	Individual counseling	153	DK	Both	NA	No waitlist	No	NA
		Family counseling	119	DK	Both				
		Medication management	102	DK	Both				
		Community support (similar to case management)	170	DK	Both				
		Crisis management (24hr/day)	NA	DK	Both				
Washington Hospital Center	NGO	Diagnostic/assessment	75	1 to 4 hours	Both	DK	For the initial assessment, the wait is roughly 7 days	No	NA
		Medication management	500	DK	Both				
		Individual counseling	DK	DK	Both				
		Group counseling	DK	DK	Adults				
		Marriage counseling	DK	DK	Adults				
		Family therapy	DK	DK	Both				
		Inpatient treatment	38	3 days	Adults				
		Traffic Alcohol Program (administered through CSOSA)	25	DK	Adults				
		Day program	70	DK	Adults				

Organization	NGO or city agency?	Services provided	Capacity[1]	Average duration of treatment[2]	Population served?	Average number of treatment slots not filled	Average number on waitlist for service	Provide housing assistance?	Number of beds
Whitman Walker	NGO	Addiction treatment	70	11 months	Adults	10	DK	Yes	DK
		Psychiatric treatment	DK	11 months	Adults				
Women's Services, D.C. General Hospital	NGO	Inpatient treatment	50	2 months	Adults	DK	No waitlist	No	NA
		Outpatient treatment	50	2 months	Adults				
		DWI/DUI program	50	2 months	Adults				
		AA and NA groups	50	2 months	Adults				
		Life skills	50	2 months	Adults				
		Educational groups	50	2 months	Adults				
		Social groups	50	2 months	Adults				
		Grooming groups	50	2 months	Adults				
Woodley House	NGO	Diagnostic/assessment	DK	3 hours	Adults	30	No waitlist	Supportive independent living apartments	63
		Medication management	120	DK	Adults			Crossing Place (temporary housing for between 2 to 4 weeks)	DK
		Individual therapy	35	1 hour	Adults			Transition group home	20
		Community support	160	DK	Adults			CRF	DK

Prepared for the D.C. Criminal Justice Coordinating Council by the Justice Policy Center, The Urban Institute

[1] Due to the nature of certain counseling and diagnostic services, many respondents were unable to estimate their capacity, and others felt they had no set capacity as they could simply hire more staff to increase capacity.

[2] Because of the inherent difficulty in estimating treatment duration due to the extreme variation of individualized treatment plans, many providers declined or were unable to estimate average treatment duration.

[3] DK indicates the respondent did not know the answer.

[4] NA indicates the question is 'not applicable.'

[5] Kidd International Home Care, Inc. was recently certified as a D.C. mental health service provider and does not have any mental health or substance abuse services in place yet.

Appendix C: A Summary of the Types of Services and Capacities for Substance Abuse and Mental Health Treatment in the District of Columbia

Sorted by the number of agencies offering each service type to emphasize the most common services offered (responses to the Urban Institute survey of D.C. service providers, N=54)

Services Provided	Number of agencies offering this service	Number of MH agencies offering this service	Number of SA agencies offering this service	Total[1] capacity for this service	Number of agencies providing no capacity estimate	Total capacity of MH agencies for this service	Total capacity of SA agencies for this service	Number of agencies providing this service to adults	Number of agencies providing this service to juveniles	Number of agencies providing this service to both	Average duration of treatment[2]
Case management and community support services	27	19	8	2610+	6	1800+	810+	17	4	6	5 reporting, 11 months
Diagnostic/assessment	22	18	4	870+	6	780+	90+	10	5	7	
Medication management	21	17	4	3217+	5	2712+	500+	11	7	3	
Therapy (individual)	10	5	5	857+	2	260+	597+	5	3	2	4 reporting, 18 months
Counseling (individual)	10	9	1	373+	7	323+	50	4	4	2	
Counseling (family)	9	8	1	263+	3	253+	10	4	2	3	
Therapy (group)	9	3	6	895+	3	350+	645+	5	1	3	
Inpatient substance abuse treatment	8	0	8	470	0	0	470	5	1	2	
Inpatient mental health treatment	8	5	3	651+	1	379	272	6	2	0	
Educational programs	8	4	4	570+	2	100+	470+	8	0	0	4 reporting, 10 months
Housing	8	6	2	232+	4	142+	90	8	0	0	
Drug screening	7	2	5	355+	3	50+	290+	2	4	1	
Therapy (family)	7	5	2	430+	4	65+	365+	1	1	5	
Therapy (various)	6	4	2	764	0	514	250	3	3	0	3 reporting, 12 months
Employment services	6	4	2	390+	2	290+	100	6	0	0	
Counseling (group)	6	5	1	284+	3	234+	50	2	2	2	

Services Provided	Number of agencies offering this service	Number of MH agencies offering this service	Number of SA agencies offering this service	Total[1] capacity for this service	Number of agencies providing no capacity estimate	Total capacity of MH agencies for this service	Total capacity of SA agencies for this service	Number of agencies providing this service to adults	Number of agencies providing this service to juveniles	Number of agencies providing this service to both	Average duration of treatment[2]
HIV/AIDS outreach	6	5	1	430+	4	400+	30	2	0	4	
DWI/DUI program	5	1	4	365	0	25	340	5	0	0	3 reporting, 5 months
Day services	5	5	0	390	0	390	0	5	0	0	
Substance abuse treatment	5	5	0	174	0	0	174	5	0	0	3 reporting, 5 months
NA and AA groups	5	1	4	390+	1	50+	390	5	0	0	4 reporting, 4 months
Counseling	5	4	1	320+	2	320+	DK	2	1	2	
Relapse prevention	4	1	3	320	0	50	290	4	0	0	3 reporting, 5 months
Medical detoxification	4	0	4	104+	1	0	104+	4	0	0	
Outpatient mental health treatment	4	4	0	185+	1	185+	0	2	1	1	4 reporting, 2 months
Life skills development	3	1	2	150	0	50	100	2	1	0	
Substance abuse education	3	3	0	290	0	0	290	2	1	0	3 reporting, 5 months
Methadone maintenance	3	0	3	320+	1	0	320+	3	0	0	2 reporting, 37 months
Socialization programming	2	2	0	150	0	150	0	2	0	0	
Elderly services	2	1	1	120	0	20	100	2	0	0	
Mental health rehabilitation services	2	2	0	130	0	130	0	2	0	0	
Positive pressure (self-esteem training)	2	0	2	240	0	0	240	2	0	0	2 reporting, 4 months
Psychotherapy	2	1	1	470	0	150	320	1	0	1	
RAP	2	0	2	240	0	0	240	2	0	0	2 reporting, 4 months

Services Provided	Number of agencies offering this service	Number of MH agencies offering this service	Number of SA agencies offering this service	Total[1] capacity for this service	Number of agencies providing no capacity estimate	Total capacity of MH agencies for this service	Total capacity of SA agencies for this service	Number of agencies providing this service to adults	Number of agencies providing this service to juveniles	Number of agencies providing this service to both	Average duration of treatment[2]
Socialization and rehabilitation	2	1	1	150	0	150	0	2	0	0	
Transition program	2	1	1	115	0	90	25	2	0	0	
Nutritional services	2	1	1	110+	1	DK	110	1	0	1	
Parenting skills classes	2	1	1	50+	1	DK	50	0	1	1	
Psychiatric treatment	2	1	1	65+	1	65	DK	1	1	0	2 reporting, 12 months
Center for Post-Traumatic Stress Disorder	1	1	0	12	0	12	0	1	0	0	10 days
Communication skills class	1	1	0	50	0	50	0	1	0	0	
HIV/AIDs (SPINS program)	1	1	0	DK	1	DK	0	1	0	0	10 months
Rehabilitation services administration	1	1	0	15	0	15	0	1	0	0	24 months
Spiritual	1	1	0	DK	1	DK	0	1	0	0	
Technical assistance for needy families	1	1	0	DK	1	DK	0	1	0	0	
Grooming groups	1	0	1	50	0	0	50	1	0	0	2 months
Mental health referrals	1	0	1	50	0	0	50	1	0	0	6 months
On-site day care	1	0	1	50	0	0	50	1	0	0	6 months
Outreach services	1	0	1	50	0	0	50	1	0	0	6 months
Primary care	1	0	1	90	0	0	90	1	0	0	
Social groups	1	0	1	50	0	0	50	1	0	0	2 months
Crisis management (24hr/day)	1	1	0	DK	1	DK	0	0	0	1	
Foodbank (HIV Positive patients)	1	1	0	DK	1	DK	0	0	0	1	
Medication somatic	1	1	0	150	0	150	0	0	0	1	
Domestic violence	1	0	1	50	0	0	50	0	0	1	4 months

Services Provided	Number of agencies offering this service	Number of MH agencies offering this service	Number of SA agencies offering this service	Total[1] capacity for this service	Number of agencies providing no capacity estimate	Total capacity of MH agencies for this service	Total capacity of SA agencies for this service	Number of agencies providing this service to adults	Number of agencies providing this service to juveniles	Number of agencies providing this service to both	Average duration of treatment[2]
Mental health for families	1	0	1	40	0	0	40	0	0	1	3 months
Open Door	1	0	1	75	0	0	75	0	0	1	
Referral services	1	1	0	65	0	65	0	0	1	0	12 months

Prepared for the D.C. Criminal Justice Coordinating Council by the Justice Policy Center, The Urban Institute

[1] Due to the nature of certain counseling and diagnostic services, many respondents were unable to estimate their capacity, and others felt they had no set capacity as they could simply hire more staff to increase capacity. The "+" in this column indicates some providers were unable to estimate a capacity, thus actual capacity is higher than the reported number.

[2] Because of the inherent difficulty in estimating treatment duration due to the extreme variation of individualized treatment plans, many providers declined or were unable to estimate average treatment duration. For services that few agencies attempted to estimate an average duration, no average duration is reported.

Appendix D: Estimates of Services for People with Co-Occurring Substance Abuse and Mental Health Disorders as Reported By Providers in the District of Columbia

(responses to the Urban Institute survey of D.C. service providers, N=54)

Organization	Assess patients for co-occurring disorders?	Patients with co-occurring disorders (percent)	CJ[1] involved patients with co-occurring disorders (percent)	Patients with co-occurring disorders treated on-site	Agencies referred to for other treatment services	Dually diagnosed capable or dually diagnosed enhanced ?	Additional services provided specifically to dually diagnosed?	Capacity[2]	Average duration of treatment	Service provided to adults, juveniles or both?
ALPHA (APRA Dual Diagnosis Program)	No	100	100	Yes		Enhanced	All services	NA[3]	NA	NA
Anchor Mental Health	Yes	DK[4]	DK	No	All core service agencies	Capable	NA	NA	NA	NA
Andromeda	Yes	33	55	Yes		Enhanced	Support group	65	3 months	Both
APRA Adams Mill Alcohol Center	Yes	50	85	No	Saint Elizabeths Hospital or APRA ALPHA Dual Diagnosis Program	NA	NA	NA	NA	NA
APRA Adult Abstinence	Yes	75	85	No	Saint Elizabeths Hospital or APRA ALPHA Dual Diagnosis Program	NA	NA	NA	NA	NA
APRA Aftercare	Yes	1	0	No	APRA Agencies	NA	NA	NA	NA	NA
APRA Concerned Citizens Clinic	Yes	33	DK	No	D.C. Department of Mental Health, Saint Elizabeths Hospital, and Washington Hospital.	NA	NA	NA	NA	NA
APRA Detox Center	Yes	50	50	No	Saint Elizabeths Hospital or Community Connections	NA	NA	NA	NA	NA

Organization	Assess patients for co-occurring disorders?	Patients with co-occurring disorders (percent)	CJ[1] involved patients with co-occurring disorders (percent)	Patients with co-occurring disorders treated on-site	Agencies referred to for other treatment services	Dually diagnosed capable or dually diagnosed enhanced ?	Additional services provided specifically to dually diagnosed?	Capacity[2]	Average duration of treatment	Service provided to adults, juveniles or both?
APRA Model Treatment Program	No	20	DK	No	APRA ALPHA Dual Diagnosis program	NA	NA	NA	NA	NA
APRA Youth Abstinence Program	Yes	60	60	No	D.C. certified providers	NA	NA	NA	NA	NA
Care Co Mental Health Services	No	10	NA	No	D.C. Department of Mental Health	NA	NA	NA	NA	NA
Center for Mental Health	Yes	20	60	Yes		Enhanced	STARS Program	DK	17 months	Adults
Clean and Sober Streets	Yes	35	35	Yes		Capable	No*	NA	NA	NA
Coates and Lane Enterprise, Inc	Yes	60	70	Yes	Green Door, D.C. Dept. of Mental Health, Life Stride	Capable	No*	NA	NA	NA
Community Action Group (CAG)	Yes	50	50	No	D.C. Department of Mental Health or UNITY.	NA	NA	NA	NA	NA
Community Connections	Yes	65	90	Yes	*In treatment facilities*: Washington Hospital, Saint Elizabeths Hospital, Providence Hospital, George Washington Hospital, Georgetown Hospital, Greater Southeast Hospital, Howard Hospital; *Outpatient facilities*: Green Door, Washington Hospital Center	Capable	No*	NA	NA	NA
Cornell Abraxis	Yes	DK	DK	Yes	Youth Services Administration	Neither	No	NA	NA	NA
D.C. Community Service Agency	Yes	85	95	Yes	APRA	Neither	No	NA	NA	NA

Organization	Assess patients for co-occurring disorders?	Patients with co-occurring disorders (percent)	CJ[1] involved patients with co-occurring disorders (percent)	Patients with co-occurring disorders treated on-site	Agencies referred to for other treatment services	Dually diagnosed capable or dually diagnosed enhanced ?	Additional services provided specifically to dually diagnosed?	Capacity[2]	Average duration of treatment	Service provided to adults, juveniles or both?
Deaf Reach	Yes	30	85	Yes		Capable	No*	NA	NA	NA
Demeter Vanguard	Yes	50	50	Yes		Capable	Resident psychiatrist	24	6 months	Both
							Mental health support groups	24	6 months	Both
Family and Medical Counseling Services	Yes	40	60	Yes	Depends on referral contract	Enhanced	No*	NA	NA	NA
Federal City Recovery	Yes	35	35	No	Commission of Mental Health	NA	NA	NA	NA	NA
Fihankra Place	Yes	25	NA	No		NA	NA	NA	NA	NA
First Choice	Yes	NA	NA	Yes	Extensive number of the certified provider agencies	Capable	No*	NA	NA	NA
First Home Care	Yes	20	50	Yes	Hillcrest, Center for Mental Health, NHS Mid-Atlantic, Coates and Lane, Woodley House	Capable	Substance abuse counseling	15	DK	Juveniles
Green Door	Yes	70	90	Yes		Capable	Outpatient substance abuse treatment	25	DK	Adults
Hillcrest Children's Center	Yes	35	60	Yes	D.C. certified subproviders	Capable	Group and individual counseling	70	DK	Juveniles
Institute for Behavioral Change and Research	Yes	35	55	Yes		Enhanced	No*	NA	NA	NA

Organization	Assess patients for co-occurring disorders?	Patients with co-occurring disorders (percent)	CJ[1] involved patients with co-occurring disorders (percent)	Patients with co-occurring disorders treated on-site	Agencies referred to for other treatment services	Dually diagnosed capable or dually diagnosed enhanced ?	Additional services provided specifically to dually diagnosed?	Capacity[2]	Average duration of treatment	Service provided to adults, juveniles or both?
Kidd International Home Care, Inc[5]	No	NA	NA	NA	NA	NA	NA	NA	NA	NA
La Clinica del Pueblo	Yes	20	90	Yes		Capable	No*	NA	NA	NA
Latin American Youth Center	Yes	85	90	Yes		Enhanced	No*	NA	NA	NA
Life Stride	Yes	70	50	Yes	Paul Wells and Diversified Medical	Capable	No*	NA	NA	NA
Lutheran Social Services	Yes	55	80	Yes		Enhanced	No*	NA	NA	NA
Marshall Heights Community Development	Yes	Refused to give out information	Refused to give out information	No	NA	NA	NA	NA	NA	NA
McClendon Center	Yes	20	NA	No	APRA or the D.C. Department of Mental Health.	NA	NA	NA	NA	NA
Neighbors Consejo	Yes	70	90	Yes	Anchor	Capable	No*	NA	NA	NA
Phoenix House	No	NA	NA	No		NA	NA	NA	NA	NA
Pride Youth Services, Inc.	No	DK	DK	No	APRA	NA	NA	NA	NA	NA
Psychiatric Center Chartered	Yes	70	70	No	Did not specify	NA	NA	NA	NA	NA
Psychiatric Institute	Yes	40	40	Yes		Enhanced	No*	NA	NA	NA
Psychotherapeutic Outreach Services	Yes	50	60	Yes	APRA	Enhanced	Substance abuse group therapy	25	DK	Adults
							Medication education group	25	DK	Adults

Organization	Assess patients for co-occurring disorders?	Patients with co-occurring disorders (percent)	CJ[1] involved patients with co-occurring disorders (percent)	Patients with co-occurring disorders treated on-site	Agencies referred to for other treatment services	Dually diagnosed capable or dually diagnosed enhanced ?	Additional services provided specifically to dually diagnosed?	Capacity[2]	Average duration of treatment	Service provided to adults, juveniles or both?
							Medication management	75	DK	Adults
RAP (Regional Addiction Prevention)	Yes	50	20	Yes		Capable	No*	NA	NA	NA
Riverside Treatment Services, Inc.	Yes	75	75	Yes		Enhanced	No*	NA	NA	NA
Safe Haven Outreach Ministries	Yes	95	95	Yes	Emergency Prevention Response Unit, Saint Elizabeths Hospital	Enhanced	No*	NA	NA	NA
Scruptes Corporation	Yes	5	NA	Yes	Affiliation agreements with PIW, Family Preservation, Marshall Heights	Capable	Addiction counseling	DK	DK	Both
Second Genesis	Yes	70	70	Yes		Enhanced	Residential	39	8 months	Adults
							Psychiatric	39	8 months	Adults
							Vocational education	39	8 months	Adults
Seton House (Providence Hospital)	Yes	15	15	Yes		Capable	Inpatient psychiatric care	29	DK	Adults
							Outpatient psychiatric care	DK	DK	Adults
St. Elizabeth's Hospital	Yes	90	95	Yes		DK	No	NA	NA	NA
UMOJA (Providence Hospital)	No	35	DK	No	UNITY or APRA ALPHA Dual Diagnosis Program	NA	NA	NA	NA	NA

Organization	Assess patients for co-occurring disorders?	Patients with co-occurring disorders (percent)	CJ[1] involved patients with co-occurring disorders (percent)	Patients with co-occurring disorders treated on-site	Agencies referred to for other treatment services	Dually diagnosed capable or dually diagnosed enhanced ?	Additional services provided specifically to dually diagnosed?	Capacity[2]	Average duration of treatment	Service provided to adults, juveniles or both?
Universal Healthcare Management Services	Yes	DK	DK	Yes	APRA	Enhanced	No*	NA	NA	NA
Washington Hospital Center	Yes	72	90	Yes	Other contracted service providers	Capable	No*	NA	NA	NA
Whitman Walker	Yes	95	95	Yes	Lambda Center	Enhanced	Psychotherapy	DK	Same	Adults
Women's Services, D.C. General Hospital	Yes	50	50	No	UNITY or D.C. Department of Mental Health.	NA	NA	NA	NA	NA
Woodley House	Yes	40	75	Yes	Private Hospitals or APRA	Capable	No*	NA	NA	NA

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*Although some agencies report no additional services *specifically* provided for the dually diagnosed, this answer may not reflect the agencies ability to treat dually diagnosed patients because they may treat such individuals through their core services detailed in appendix B.

[1] CJ refers to Criminal Justice.

[2] Due to the nature of certain counseling and diagnostic services, many respondents were unable to estimate their capacity, and others felt they had no set capacity as they could simply hire more staff to increase capacity

[3] NA indicates the question is not applicable.

[4] DK indicates the respondent did not know the answer.

[5] Kid International Home Care, Inc. was recently certified as a D.C. mental health service provider and does not have any mental health or substance abuse related services in place yet.

Appendix E: An Overview of Substance Abuse and Mental Health Treatment for People in the Criminal Justice System in the District of Columbia

(responses to the Urban Institute survey of D.C. service providers, N=54)

Organization	Accept people in the CJ[1] System?	Point of referral from CJ system	Notes on the referral process	Accept self-referrals?	Organization tracks CJ involvement at intake?	Clients referred by CJ system (percent) [2]	Clients under 18 and adjudicated delinquents (percent)	CJ involved people wait-listed?	Funding received from CJ agencies?
ALPHA (APRA Dual Diagnosis Program)	Yes	Referrals to ALPHA program come from APRA Central Intake, APRA agencies, APRA contracted service providers.	Clients must be diagnosed with both a mental health and substance abuse issue by APRA.	No	NA[3]	DK[4]	0	NA	None
Anchor Mental Health	Yes	Typically pre-trial		Yes	No	8	NA	NA	None
Andromeda	Yes	DK		No	No	55	20	No	None
APRA Adams Mill Alcohol Center	Yes	DK	Referrals handled by APRA Central Intake	No	No	DK	NA	NA	None
APRA Adult Abstinence	Yes	DK	Referrals handled by APRA Central Intake	No	No	DK	NA	NA	None
APRA Aftercare	Yes	Probation	Referrals handled by APRA Central Intake	No	No	<5	NA	NA	None
APRA Concerned Citizens Clinic	Yes	Any point in CJ the process	Referrals handled by APRA Central Intake	Yes	No	33	NA	NA	None
APRA Detox Center	Yes	DK	Referrals handled by APRA Central Intake	No	No	30	NA	NA	None
APRA Model Treatment Program	Yes	Pretrial	Primarily pretrial referrals with some from probation	Yes	No	<10	NA	NA	None

Organization	Accept people in the CJ[1] System?	Point of referral from CJ system	Notes on the referral process	Accept self-referrals?	Organization tracks CJ involvement at intake?	Clients referred by CJ system (percent) [2]	Clients under 18 and adjudicated delinquents (percent)	CJ involved people wait-listed?	Funding received from CJ agencies?
APRA Youth Abstinence Program	Yes	DK	Referrals handled by APRA Central Intake	No	No	DK	DK	NA	None
Care Co Mental Health Services	No	NA	Mainly from Saint Elizabeths Hospital	No	No	0	NA	NA	None
Center for Mental Health	Yes	Any point in the CJ process; typically PSA and probation	Do not generally accept serious offenders (i.e., violent and sex offenders)	Yes	No	10	DK	NA	Yes
Clean and Sober Streets	Yes	Prefer pretrial, but accept referrals at all points		Yes	Detected by screening	10	NA	NA	PSA, CSOSA
Coates and Lanes Enterprise, Inc.	Yes	Typically through John Howard at Saint Elizabeths Hospital	Referral records not strictly maintained, hard to tell when CJ agencies refer an individual	No	No	10	NA	Yes	None
Community Action Group (CAG)	Yes	Any point in CJ the process	Referrals not from CJ agencies are typically from Holy Comforter St. Cyprian	Yes	No	90	0	NA	CSOSA, PSA
Community Connections	Yes (only for Options Program)	Any point in CJ the process	*Pre-trial*: jail, John Howard, court house; *Post-trial:* provisional releases; probation; not guilty by reason of insanity	Yes	No	30	NA	NA	None
Cornell Abraxis	Yes	Any point in CJ the process	Typically from Youth Services Administration	Yes	Detected by screening	90	80	NA	None
D.C. Community Services Agency	Yes	Pretrial or post-trial	Pretrial referrals from PSA, judge's order. Post-trial referrals from CSOSA.	Yes	Detected by screening	40	DK	NA	None
Deaf Reach	Yes	Any point in CJ the process	Most Deaf Reach clients were CJ-involved before beginning treatment	No	No	0	0	NA	None
Demeter Vanguard	Yes	Any point in CJ the process	CSOSA contract	No	No	33	0	NA	CSOSA

Organization	Accept people in the CJ[1] System?	Point of referral from CJ system	Notes on the referral process	Accept self-referrals?	Organization tracks CJ involvement at intake?	Clients referred by CJ system (percent) [2]	Clients under 18 and adjudicated delinquents (percent)	CJ involved people wait-listed?	Funding received from CJ agencies?
Family and Medical Counseling Services, Inc.	Yes	Typically CSOSA or D.C. Superior Court; sometimes Corporation Counsel	Most youth referrals are from Youth Services Admin.	Yes	No	55	15	No	CSOSA, D.C. Superior Court, Corporation Counsel
Federal City Recovery	Yes	Pretrial, courts, parole/probation	Referral process varies	Yes	Detected by screening	99	1	NA	PSA
Fihankra Place	Yes	Post trial	Fihankra is only a recently certified D.C. treatment provider	NA	NA	NA	NA	NA	Youth Services Administration
First Choice	Yes	Any point in the CJ process	CJ-involved youths referred through Youth Services Administration. Once First Choice Community is fully operational as a core service agency, more agencies may refer CJ-involved individuals	NA	DK	50	50	NA	Youth Service Administration and Child and Family Services
First Home Care	Yes	Pretrial and Probation/Parole	Referrals normally through DMH Access Help line	Yes	No	20	20	NA	None
Green Door	Yes	Any point in CJ the process	Pretrial referrals come from John Howard	Yes	No	40	NA	NA	None
Hillcrest Children's Center	Yes	Contract with D.C. Superior Court	Many referrals from Family and Child Services	Yes	No	8	4	NA	D.C. Court
Institute for Behavioral Change and Research	Yes	Any point in the CJ process		Yes	No	75	85	NA	None
Kidd International Home Care[5]	NA	NA	NA	NA	NA	NA	NA	NA	NA
La Clinica del Pueblo	Yes	Any point in CJ the process		Yes	DK	3	12	Yes	None

Organization	Accept people in the CJ[1] System?	Point of referral from CJ system	Notes on the referral process	Accept self-referrals?	Organization tracks CJ involvement at intake?	Clients referred by CJ system (percent) [2]	Clients under 18 and adjudicated delinquents (percent)	CJ involved people wait-listed?	Funding received from CJ agencies?
Latin American Youth Center	Yes	Any point in the CJ process	Multiple ways of being referred	Yes	Detected by screening	10	10	NA	None
Life Stride	Yes	Any point in CJ the process		Yes	No	1	NA	NA	None
Lutheran Social Services	Yes	DMH	Referrals must go through DMH. LSS does not typically take sex offenders.	Yes	No	10	NA	NA	None
Marshall Heights Community Development	Yes	Pre-trial, courts, probation/parole		Yes	No	1	0	NA	CSOSA, DOJ
McClendon Center	No	Yes	Only accepts referrals (which are rare) from public defender's office.	No	No	0	0	NA	None
Neighbors Consejo	Yes	Any point in CJ the process	Receive referrals from court, halfway house, probation, pretrial, etc.	Yes	Detected by screening	10	0	NA	None
Phoenix House	Yes	Receive very few referrals		Yes	No	5	NA	NA	None
Pride Youth Services, Inc.	Yes	Pretrial or during probation/parole	Pride Youth Services is trying to develop ties with juvenile justice system.	Yes	No	60	50-60	NA	none
Psychiatric Center Chartered	Yes	Probation	Referrals from CJ agencies are rare and must have an Access 1 diagnosis.	Yes	No	10	0	NA	None
Psychiatric Institute	Yes	Most from APRA or CSOSA	Adults typically referred during probation; juveniles typically referred post-adjudication.	No	DK	40	40	NA	
Psycho-therapeutic Outreach Services	Yes	DMH Access Help line	No direct referrals from CJ agencies or the court.	No	NA	0	0	NA	None

Organization	Accept people in the CJ[1] System?	Point of referral from CJ system	Notes on the referral process	Accept self-referrals?	Organization tracks CJ involvement at intake?	Clients referred by CJ system (percent) [2]	Clients under 18 and adjudicated delinquents (percent)	CJ involved people wait-listed?	Funding received from CJ agencies?
RAP (Regional Addiction Prevention)	Yes	Typically from PSA	Accepts referrals at any point in the process.	No	No	80	0	NA	PSA
Riverside Treatment Services, Inc.	Yes	Typically Youth Services Admin. or other CJ agency post-adjudication	Handful of referrals pretrial from YSA or other CJ agency.	Yes	No	40	40	Yes	None
Safe Haven Outreach Ministry	Yes	CSOSA, PSA		Yes	Detected by screening	90	0	No	CSOSA, PSA
Scruptes Corporation	Yes	NA		Yes	No	0	0	NA	None
Second Genesis	Yes	Pretrial, courts, parole/probation	Most referrals are through the court.	Yes	Detected by screening	95	33	No	PSA
Seton House (Providence Hospital)	Yes	Pretrial and post trial	Contracts with CSOSA, PSA, and others.	Yes	No	90-95	0	No	Various CJ Agencies
Saint Elizabeths Hospital	Yes	Any point of the CJ process	Courts refer most clients pretrial or post-adjudication: guilty by reason of insanity or judges orders.	Yes	No	99	NA	NA	None
UMOJA (Providence Hospital)	Yes	CJ involved clients referred by APRA	APRA has records on clients' CJ involvement.	Yes	No	<5	0	NA	None
Universal Healthcare Management Services	Yes	None	Exact proportion of CJ-involved is unknown.	No	NA	0	DK	DK	None
Washington Hospital Center	Yes	CSOSA, DMH	No violent offenders.	Yes	DK	3	DK	Yes	CSOSA
Whitman Walker	Yes	Usually pre-trial or diversion	No one convicted of homicide.	Yes	Data collected by ASI	5	DK	NA	None

Organization	Accept people in the CJ[1] System?	Point of referral from CJ system	Notes on the referral process	Accept self-referrals?	Organization tracks CJ involvement at intake?	Clients referred by CJ system (percent) [2]	Clients under 18 and adjudicated delinquents (percent)	CJ involved people wait-listed?	Funding received from CJ agencies?
Women's Services, D.C. General Hospital	Yes	Typically CSOSA pretrial	APRA also refers a significant number.	No	No	90	NA	NA	CSOSA
Woodley House	Yes	Most referred pre-trial through John Howard. Post-trial/post-release referrals rare	Most clients referred through DMH Access Help line. No direct CJ referrals.	Yes	DK	2	NA	NA	None

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[1] CJ refers to Criminal Justice.

[2] Figures represent respondent's best estimates where exact figures are not known.

[3] NA indicates the question is not applicable.

[4] [c]DK indicates the respondent did not know the answer.

[5] Kid International Home Care, Inc. was recently certified as a D.C. mental health service provider and does not have any mental health or substance abuse related services in place yet.