Department of Mental Health

TRANSMITTAL LETTER

SUBJECT		
DMH Collaboration with Federal Agencies who Provide Supervision to Individuals Released from the Criminal Justice System		
POLICY NUMBER **DMH Policy 200.9**	**DATE** AUG 2 2 2012	**TL#** 177

Purpose. To set forth the Department of Mental Health (DMH) and DMH certified provider requirements to cooperate and coordinate with federal agencies to provide mental health services to District residents when mental health treatment for the individual is ordered by a court in a criminal case.

Applicability. DMH and certified Mental Health Rehabilitation Services (MHRS) providers.

Policy Clearance. Reviewed by affected responsible staff and cleared through appropriate Mental Health Authority offices.

Implementation Plans. A plan of action to implement or adhere to this policy must be developed by designated responsible staff. If materials and/or training are required to implement this policy, these requirements must be part of the action plan. Specific staff should be designated to carry out the implementation and program managers are responsible for following through to ensure compliance. Action plans and completion dates should be sent to the appropriate authority. Contracting Officer Technical Representatives (COTRs) must also ensure that contractors are informed of this policy if it is applicable or pertinent to their scope of work. *Implementation of all DMH policies shall begin as soon as possible.* This policy is effective immediately.

Policy Dissemination and Filing Instructions. Managers/supervisors of DMH and DMH contractors must ensure that staff are informed of this policy. Each staff person who maintains policy manuals must ensure that this policy is filed in the DMH Policy and Procedures Manual, and contractors must ensure that this policy is maintained in accordance with their internal procedures.

ACTION

REMOVE AND DESTROY

None

INSERT

DMH Policy 200.9

Stephen T. Baron
Director, DMH

GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF MENTAL HEALTH	Policy No. 200.9	Date AUG 2 2 2012	Page 1
	Supersedes None		

Subject: DMH Collaboration with Federal Agencies who Provide Supervision to Individuals Released from the Criminal Justice System

1. **Purpose**. To set forth the Department of Mental Health (DMH) and DMH certified provider requirements to cooperate and coordinate with federal agencies to provide mental health services to District residents when mental health treatment for the individual is ordered by a court in a criminal case.

2. **Applicability**. DMH and certified Mental Health Rehabilitation Services (MHRS) providers.

3. **Authority**. Department of Mental Health Establishment Amendment Act of 2001; and the MOU by and between CSOSA, PSA, and DMH, dated February 15, 2011.

4. **Background**. Specific conditions of release regarding mental health treatment for individuals who have mental illness are often imposed by the D.C. Superior Court, U.S. District Court, and the U.S. Parole Commission. Individuals with major mental illnesses who are under the supervision of CSOSA and PSA as a result of court action require services that are well coordinated, flexible and offered in a timely manner to help them maintain compliance with the conditions of their release. PSA and CSOSA have established special supervision units to assist those in need of mental health services and supports. These specialized units work with DMH and its provider network to best serve these individuals.

5. **Goal**. DMH, PSA and CSOSA will work together to coordinate their processes to help individuals with mental illness comply with the conditions of their release from the criminal justice system, and receive appropriate mental health services and supports.

6. **Policy**.

6a. DMH will collaborate with PSA and CSOSA to ensure that mental health services and supports are provided to consumers who are under the supervision of PSA/CSOSA and refer consumers to the most appropriate services available to meet the person's mental health needs, achieve stabilization, prevent decompensation and optimize the consumer's potential to remain safely in the community.

6b. Any release of mental health information by DMH or a mental health provider to PSA or CSOSA must be in accordance with federal and District laws. Also see Section 10 below.

7. **Definitions**. For purposes of this policy:

7a. Court Services and Offender Supervision Agency (CSOSA) – A federal agency created by Congress in 1997 that provides community supervision to D.C. offenders on probation, parole, or supervised release. It does so in coordination with the Superior Court of the District of Columbia and the U.S. Parole Commission. CSOSA's mission is to increase public safety, prevent crime, reduce recidivism, and support the fair administration of justice in close collaboration with the community.

7b. Department of Mental Health (DMH) - District of Columbia government agency responsible for ensuring access to treatment and services for District residents diagnosed with mental illness.

7c. Pretrial Services Agency (PSA) for the District of Columbia - An independent entity within the Court Services and Offender Supervision Agency. PSA assists judicial officers in the Superior Court for the District of Columbia and the United States District Court for the District of Columbia by formulating release recommendations and providing supervision and treatment services to promote community safety and future court appearance. When PSA performs these tasks effectively, unnecessary pretrial detention is minimized, jail crowding is reduced, public safety is increased, and the pretrial release process is administered fairly.

7d. U.S. Parole Commission - The mission of the U.S. Parole Commission is to promote public safety and strive for justice and fairness in the exercise of its authority to release, revoke supervision, and impose release conditions for the offenders under its jurisdiction.

8. **Access to DMH Services**.

8a. An individual who requires the services of a mental health provider will be able to access DMH services by contacting the DMH Access Helpline (AHL) to enroll in a Core Services Agency (CSA) or by contacting a CSA.

8b. DMH also provides two (2) walk-in/same day service sites for those identified by PSA or CSOSA as needing assessments or medications immediately upon release from the criminal justice system. A full-time DMH liaison is located at D.C. Superior Court to screen and evaluate individuals and work with PSA/CSOSA staff.

9. **Responsibilities and Procedures**.

9a. PSA and CSOSA responsibilities will include:

(1) Referral of individuals to DMH who need mental health services upon release from the criminal justice system (also see Section 8 above).

(a) If the individual's mental health treatment is required as a condition of release, attempt to obtain a signed release of information from the individual so that the DMH mental health provider may provide information to PSA or CSOSA on the person's mental health treatment.

(b) Initiate a referral, using the PSA/CSOSA Referral for Mental Health Services form (Exhibit 1);

(c) Provide relevant information as required in the MOU (e.g., criminal justice and employment status, address, criminal/social history, circumstances leading to referral); and

(d) Confirm that the CSA/clinical home has contact information for the Pretrial Services Officer (PSO) or Community Supervision Officer (CSO).

(2) Maintain contact with the CSA/clinical home for the purposes of effective community support and implementation of the consumer's individualized treatment plan (IRP) and participate in-person or telephonically, as necessary, in treatment team meetings that

involve material changes to the consumer's current IRP or transition to the next phase of treatment during the consumer's period of criminal justice supervision.

(3) Brief CSA/clinical home staff on any pertinent criminal justice matters that may impact the consumer's treatment, and as needed, prepare and send a monthly supervision status report to the CSA/clinical home.

9b. CSA/clinical home shall:

(1) Accept referrals from PSA/CSOSA for individuals who are eligible for MHRS in accordance with the MHRS regulations.

(2) Ensure that a DMH HIPAA Form 3 is signed by the consumer, a court order is issued authorizing release of information, or an exception recognized by law for the release of information is satisfied prior to the disclosure of protected health information (PHI) to PSA/CSOSA, consistent with the Mental Health Information Act (MHIA) (D.C. Official Code §§7- 1201.01 *et seq.*) and Health Insurance Portability and Accountability Act (HIPAA). This requirement must be satisfied prior to following 3-8 below.

(3) Collaborate with PSA/CSOSA to ensure that the appropriate mental health services are provided to consumers who are under supervision of PSA/CSOSA.

(4) Contact the CSO/PSO by phone or email within one (1) business day following the intake appointment of each consumer involved in the justice system, and provide the following to the CSO/PSO:

- Community support worker/ACT team member's telephone and fax number;
- Community support worker/ACT team member's alternate/emergency contact information;
- Community support worker/ACT team member's current work site address;
- Community support worker/Act team member's e-mail address; and
- Supervisor/team leader's telephone and fax numbers.

(5) Work with CSOSA/PSA to develop appropriate transition plans for consumers moving to different levels of care including community based services, housing, supported employment, etc.

(6) Assess and document in the IRP, the consumer's need for housing as part of intake, and contact the DMH housing division as needed to assist in locating appropriate housing.

(7) Complete the PSA/CSOSA Mental Health Compliance Report (Exhibit 2), and provide to PSA/CSOSA for consumers under PSA or CSOSA supervision, and submit a written or verbal update prior to each scheduled court date when requested by PSA/CSOSA.

(8) Notify PSA/CSOSA of any proposed or major changes in a consumer's IRP within three (3) business days of the following: reassignment, disenrollment, hospitalization and/or changes in medication regimen.

(9) Attend training coordinated by PSA/CSOSA (See Section 11 below).

(10) Attend U.S. Parole Commission sanction hearings, upon request.

10. **Confidentiality**. Mental health information is protected pursuant to federal law (HIPAA) and District law (MHIA). The MHIA requires that before DMH or a mental health provider can disclose mental health information of a consumer, the consumer must have authorized the release of information, a court order must have been issued authorizing such release of information, or an exception recognized by the law must be satisfied. Any recipient of mental health information is required to comply with the MHIA in protecting the further disclosure of the information. The authorization for release of information is voluntary and failure to give consent will not impact a person's eligibility for treatment.

11. **Training**. PSA/CSOSA will develop ongoing criminal justice training for select DMH staff, staff of the CSA/clinical home, and other community providers to help them work more effectively with individuals with mental illness who are involved in the criminal justice system.

12. **Related References**.
DMH Policy 645.1, DMH Privacy Policies and Procedures
22 DCMR A34, MHRS Provider Certification Standards

13. **Exhibits**.
Exhibit 1 – PSA/CSOSA Referral for Mental Health Services form
Exhibit 2 – PSA/CSOSA Mental Health Compliance Report

Approved By:

Stephen T. Baron
Director, DMH

8/22/12
(Signature) **(Date)**

Pretrial Services Agency for the District of Columbia (PSA)
Court Services and Offender Supervision Agency (CSOSA)

REFERRAL FOR MENTAL HEALTH SERVICES

This form is to be used when referring defendants/offenders to the mental health provider. (MHP)

Referring Supervision Agency: ☐ PSA ☐ CSOSA

Mental Health Provider:

Referral Date: ☐ New Referral ☐ Currently Receiving Services ☐ Currently connected, but inactive

Name: **Alias:**	**DOB:**	**PDID:**	**DCDC:**

Address: **Telephone:** **Homeless:** ☐ Yes ☐ No **Emergency Contact Name/Telephone:**	**Gender:** ☐ Male ☐ Female	**Race:** ☐ Asian ☐ White ☐ Black ☐ Native American ☐ Hispanic ☐ Other	**Does individual require translation services?** ☐ Yes ☐ No **Language:**

Does individual have physical impairments? ☐ Yes ☐ No **Type of impairment:** ☐ Speech ☐ Hearing ☐ Sight ☐ Mobility	**Marital Status:** ☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Separated ☐ Other:	**Children:** ☐ Yes ☐ No **#of children:**

Highest Level of Education: **Employment:** ☐ Yes ☐ No	**Insurance:** ☐ Yes **Name:** ☐ No ☐ Unknown ☐ IDA ☐ SSI ☐ Medicaid ☐ Medicare

Defendant/Offender Supervision Assignment/Status:

☐ PSA SSU (non-Options) ☐ PSA SSU (Options)	☐ PSA Mental Health Court ☐ PSA Treatment Team 1	☐ PSA Treatment Team 2 ☐ PSA Treatment Team 3	☐ PSA General Supervision ☐ PSA HISP ☐ PSA Other
☐ CSOSA Jail ☐ CSOSA Bail	☐ CSOSA Civil Protection Order (CPO) ☐ CSOSA Work Release	☐ CSOSA Probation ☐ CSOSA Parole	☐ CSOSA Supervised Release ☐ CSOSA Detention

CSOSA Special Supervision: ☐ Sex Offender ☐ Mental Health ☐ Mental Retardation ☐ Domestic Violence

CSOSA Date of Termination/Expiration: **Charges:**

Current Charges:

Mental Health/Medical Diagnosis: ☐ Unknown ☐ Known (list dx): **Date diagnosed (if known):** **Self-Reported (list dx):**	**Medication (Psychotropic/Medical):**	**History of MH Treatment:** ☐ Yes ☐ No ☐ Unknown **(If yes, last known provider):**

Currently testing positive for illicit substances ☐ Yes ☐ No **(If yes, please specify type of substance)**

Reason(s) for referral (check all that apply):

☐ Treatment/Evaluation Needed	☐ Questionable Behavior and/or Mood
☐ Self Reported Mental Health Problems	☐ Altered Mental Status
☐ History of Mental Illness	☐ Medication Issues (Non-Compliance/Side Effects)
☐ History Suicidal	☐ Other:
☐ History Homicidal Behavior	

Brief Description of Symptoms and/or History of Mental Illness:

Referral Source

PSO/CSO Name: **Supervisor Name:** **Address:**	**PSO/CSO Telephone:** **Fax:** **Email:** **Supervisor Telephone:**

Provider: Please contact the Pretrial Services Officer (PSO) or Community Supervision Officer (CSO) listed on this form as soon as possible to notify the supervision agency of the results of this referral. Thank you.

Pretrial Services Agency for the District of Columbia (PSA)
Court Services and Offender Supervision Agency (CSOSA)

MENTAL HEALTH COMPLIANCE REPORT

This form is to be completed by the mental health provider (MHP). Please complete and submit this form by fax or e-mail to the Pretrial Services Officer (PSO) or Community Supervision Officer (CSO) as designated below.

Receiving Supervision Agency: ☐ PSA ☐ CSOSA			
Mental Health Provider (MHP):			
Defendant/Offender Name:	**eCura #:**	**DOB:**	**SSN:**
Defendant/Offender Address: **Homeless:** ☐ Yes ☐ No			**Telephone:**
PSO/CSO Name: **Supervisor Name:**	**Agency/Address:**		**PSO/CSO Telephone:** **Supervisor Telephone:** **Fax:**
MHP Case Manager (CM) Name: **MHP Team Leader (TL) Name:**	**Agency/Address:**		**MHP CM Telephone:** **MHP TL Telephone:** **Fax:**

Medication(s)

Currently on Psychotropic Medications (if yes, please list names of medications):	☐ Yes	☐ No	
Reports compliance with medication regimen:	☐ Yes	☐ No	
Any recent changes with medication regimen: (If yes, provide date of change and names of new medications):	☐ Yes Date: Meds:	☐ No	

Mental Health Treatment Regimen

Attended Scheduled Appointments (If no, indicate dates of missed appointments):	☐ Yes	☐ No Dates of Missed Appts:	
Currently receiving Individual therapy: (If yes, indicate frequency)	☐ Yes ☐ 1x/wk ☐ bi-weekly ☐ 1x/month ☐ Other:		☐ No
Currently meets with psychiatrist: (If yes, indicate frequency)	☐ Yes ☐ 1x/wk ☐ bi-weekly ☐ 1x/month ☐ Other:		☐ No
Currently meets with case manager: (If yes, indicate frequency)	☐ Yes ☐ 1x/wk ☐ bi-weekly ☐ 1x/month ☐ Other:		☐ No
Treatment participation level:	☐ Active ☐ Variable ☐ Minimal ☐ None		
Treatment compliance:	☐ Full ☐ Partial ☐ Low ☐ Noncompliant		
Response to treatment:	☐ Stable ☐ Improving ☐ Decompensating ☐ Unstable ☐ Other ☐ Hospitalization (dates/location/reason)		
Current Diagnosis: Changes to diagnoses? (If yes, descibe)	☐ Yes Change:		☐ No
Changes to treatment plan? (If yes, describe)	☐ Yes Change:		☐ No
Additional Comments:			

Person Completing Report: _____ **Date:**

Print Name/Title (please initial)