Alaska Criminal Justice Commission
Behavioral Health Standing Committee

Meeting Summary

August 8, 2019
Alaska Mental Health Trust + Teleconference

Commissioners: Steve Williams, Beth Goldstein, John Skidmore (serving as proxy for Attorney General Clarkson), Albert Wall (serving as proxy for Commissioner Crum), Laura Brooks (serving as proxy for Commissioner Dahlstrom), Sean Case, Stephanie Rhodes

Participants: Laura Russell, Cody Chip, Teri Tibbet, Araceli Valle, Travis Welsh, Gennifer Moreau-Johnson, Brad Myrstol, Katie Baldwin-Johnson, Eric Boyer

Staff: Barbara Dunham

Agenda and Meeting Summary

The committee approved the agenda and the summary of the previous meeting without opposition. Steve Williams said he had small changes to the meeting summary, which he would send to Barbara Dunham.

Overview – Sequential Intercept Model (SIM)

Steve said that he wanted to walk quickly through the Sequential Intercept Model (SIM). He believed the committee should know what efforts are happening with all of the relevant agencies and community partners in regards to behavioral health, and how those efforts link together, how they fit in the SIM, and how they fit with the Crisis Now model. Some of these efforts have been using the SIM.

Steve added that DHSS Deputy Commissioner Al Wall had also just volunteered to put together a list of all the work that DHSS is doing that relates to Titles 12 and 47, and how that work interfaces with the SIM. Al Wall said that he planned to include on that list what progress has been made and what needs to be done to complete those projects. Steve noted that when this committee had come up with its comprehensive list of recommendations 2016, those recommendations were also based on the SIM and used a similar approach, highlighting what kind of action needed to be taken to address each item.

Steve explained that the SIM was first developed in the 1990s with intercepts 1-6. Intercept 0 was added later as people using the SIM saw a need for it. Intercept 0 is discussed frequently these days because there is a growing recognition that primary care and preventative efforts are the best way to tackle behavioral health problems and prevent people from coming into contact with the criminal justice system in the first place. Intercept 0 focuses on things like supportive housing and employment. Some of this work is being done in Anchorage for people with severe mental illnesses.

Programs within intercept 0 include the Crisis Now model. This model uses a receiving and recovery center with a "no wrong door" policy – the center does not turn anyone away. A person can be there 3 to 24 hours, or longer. The goal is to divert people from the criminal justice system and to relieve pressure on hospital ERs and law enforcement. There have been state agency and community discussions on how to get such a center set up in Anchorage, which was also a topic for later in the meeting.

Sean Case said he was involved in some of those discussions. The idea is not a new one but historically there have been barriers to its implementation in Alaska. One of the reasons why people have only been talking about this idea for so long is the difficulty in identifying the population to be served. For him, the key part of these most recent discussions was the notion that no one/no specific population would be turned away.

Gen Moreau-Johnson noted that the 1115 Waiver will allow reimbursement for 23-hour services for crisis stabilization—which is exactly what Crisis Now uses. The goal for the waiver is to have crisis services available statewide. She wanted to put this on the radar for future discussions. Cody Chip said he wanted to acknowledge how key that will be, since it will ensure that crisis services are financially sustainable. The waiver will be transformative, and is the reason the Crisis Now model is feasible now.

Steve said that within intercept 1, which involves initial law enforcement contact, there is Crisis Intervention Training (CIT) for law enforcement officers. There is already some CIT being done in Alaska. CIT can interface with Crisis Now; they can be compatible services. Katie Baldwin-Johnson added that CIT proponents also endorse Crisis Now as a way to establish a continuum of care.

John Skidmore asked whether it was accurate to summarize that CIT was a form of training, while Crisis Now involved establishing a physical location. Steve said that was broadly correct; CIT was a training that started in Memphis; the process will ultimately result in those who need it being dropped off at the most appropriate location. Without any other option, this is often the hospital. Crisis Now involves having a location to receive people in crisis, including people identified by law enforcement as part of their CIT training. A key metric for the model is to get the law enforcement officer back out on duty within 4-7 minutes of brining someone to the receiving center.

Laura Brooks wondered if this was essentially the same model as the psych ER. Steve said that the psych ER was more of a gateway to API. Katie said that the receiving center would not be like an ER with a medical focus; the receiving center would be more calming, and welcoming. The idea is that people who are now being sent to the ER can be sent there. They do not need a medical clearance to go in. Eric Boyer added that in existing facilities using this model, 80-85% of people brought to the facility don't have to go to higher level of care such as the ER.

Steve continued with his overview of the SIM. He explained that intercept 2 was about early diversion and alternate interventions. Intercept 3 concerns those who make it further into the criminal justice system, and involves specialty courts and jail-based programming. Intercepts 4 and 5 focus on post-conviction programming and formal or informal probation, and the need to ensure people are connected to services when they leave prison.

Steve said that when DHSS compiles its list of projects it is working on, it could start by looking at this committee's previous recommendations using the SIM, and note which recommendations might be in the works within the department, including what more needs to be done to complete those projects. Laura Russell said she appreciated the suggestion. Gen asked whether this would be a similar task what was done about a year ago. Steve said it was, and that Al (who had left the meeting by this point) had told him prior to this meeting starting that more was happening now. Gen said they could probably start with updating the documents from that previous effort.

John asked whether the plan for the committee was to look at the 2016 recommendations and the report from Agnew::Beck on the forensic feasibility study and to think about the two in concert. Steve said it was; DHSS and the Trust worked with Agnew::Beck for the study and it used the SIM as a foundation.

John thought it would be helpful for DHSS to also note in its report which of the recommendations from Agnew::Beck recs are being worked on. Gen said that she would ensure that.

Overview – Forensic Feasibility Study

Steve said that Agnew::Beck had completed its study on the options for a forensic psychiatric hospital (Forensic Feasibility Study), and the he had sent out the study's executive summary to the committee; DHSS also posted an even shorter study on its website. The purpose of the study was to identify any location in Anchorage where a standalone forensic psychiatric hospital would be feasible. It was commissioned by DHSS in recognition of the fact that the Taku unit at API was insufficient to meet the need for forensic psychiatric beds, which contributes to the backlog of defendants being held in DOC facilities awaiting competency restoration.

Steve explained that the study contained short-term and long-term recommendations. Several recommendations relate to things that need to be concurrently implemented in the community, such as enhanced law enforcement co-responses and a receiving center for crisis stabilization. It also looked at possibilities for long-term restoration needs at either API, and/or a special mod at DOC.

Steve said he wanted to alert this group to the study because it overlapped with previous efforts, including the UNLV report. This was just an overview; it could warrant a full presentation to this committee or the commission as a whole.

Laura Brooks said that developing jail-based restoration would raise big questions for DOC; it would be a hard ask with DOC's current resources and in the current budget climate, although she had no resistance to the idea in theory. Any next steps should involve getting those practical realities addressed. She though many people recognized the need already— what was needed now was to figure out how to make these recommendations happen.

Judge Rhoades said she thought it was important to update existing reports given the new environment – budget cuts may make a difference to previous recommendations, and the upcoming 1115 Waiver also will change things. Steve agreed. Laura Brooks said she also agreed, and added that it was not just about resource use but about changing how the whole system/state looks at these issues, outside of these work groups.

Barbara said further to Steve's earlier comment that she thought the full Commission could benefit from a presentation on this study.

Steve wrapped up this discussion by bringing it back to intercept 0, and the importance of community services. Those at this meeting know what needs to happen, and know that many people are cycling though the criminal justice system where they are not best served. Community leaders are talking about how to ease these pressures and get people to the resources they need and to get better outcomes. Laura Brooks' comments about resources were well taken, and he thought the most appropriate use of resources would be to invest in community care and diversion. Addressing needs at intercepts 0 and 1 will help prevent resource-intensive pressures on DOC and law enforcement. He thought there was energy to address those issues in the community.

Public Comment

There was an opportunity for public comment but none was offered.

Overview: Crisis Systems of Care / Crisis Now Model

Eric Boyer introduced himself as a program officer for the Trust. He explained that treatment for people experiencing a mental health crisis was pressing need but was not getting attention. This was an issue not just in Alaska but nationwide; places around the country were experiencing identical problems such as hospitals overflowing with patients experiencing a mental health crisis.

Eric explained that some years ago, the national Substance Abuse and Mental Health Services Administration reached out to stakeholders about how to address this issue. One result was the statewide suicide prevention lines, which includes the Careline in Alaska. Organizations helping with this effort include the National Action Alliance and Recovery International. They are moving toward a three-digit line to get people help, because seconds count. They are also looking at best practices: call centers, dashboards, mobile crisis teams, receiving centers (ranging between 23-hour and 7-day care), as well as what are the principles behind the best practices, such as trauma-informed care.

Many places are now using the Crisis Now model with receiving centers. The idea for these centers is to accept everyone, and aim for a 5-minute turnaround for law enforcement officers who drop people off. It is a "living room" model with recliners, and uses a peer support person: someone with lived experience, who can provide trauma-informed support. These centers can have more than 16 beds. If someone needs to stay longer than 24 hours, they can be handed off to a 16-bed (sub acute) facility.

Eric said that no one location has done all of this perfectly. Arizona did this first, but their model is not perfect. Georgia has a great call center, which can organize scheduling. If a peer support person can follow up on getting people to scheduled appointments, it can save the ER a lot of money. More of these are opening up around the country. There is a culture shift happening.

DHSS put out an RFP, and got Recovery International to come assess the crisis system of care in Anchorage and the Mat-Su. Developing these things must be done deliberately, engaging all partners. Eric pointed out that the Commission's three behavioral health recommendations from 2018 would all fit perfectly into the crisis now model: data sharing, crisis training, and a crisis stabilization center.

Laura Brooks asked whether other people can bring people in to the recovery receiving center? Eric said yes, the center should take absolutely anyone—even self-referrals. Best practice is "don't say no."

Katie added that this was not about replacing any care; the model is designed for addressing the crisis and making a referral.

John asked whether, if someone is brought to the center as a form of criminal justice diversion, if the victim is included in the process. Katie said she thought the state will get some ideas on that from Recovery International- things that have worked for prosecutors elsewhere (as well as other stakeholders).

Laura Brooks asked whether Recovery International would be doing a gap analysis, for example, there was no good option for mid-level (sub-acute) care in Alaska. Katie said yes, understanding Alaska's needs would be part of their process.

Brad Myrstol asked from a diversion perspective, what kind of volume might be expected. Would this be a way to take the diagnostic pressure off law enforcement officers? Sean Case said that APD responds to calls for about 170 people per month who have behavioral health problems; they bring them to the hospital, even though many do not actually need emergency care. Many people who are arrested also have mental health issues. Officers will need to shift their thinking about who needs to go where. APD is

already trained in some forms of diversion. People who commit low-level crimes who have mental health problems would fit in to the diversion model; APD sees plenty of those cases every day.

Judge Rhoades noted that some people will contact law enforcement on purpose, committing low-level crimes with no victim; they just need a place to go. This is the kind of population that would be diverted via the receiving centers. Crimes against people or other crimes involving victims would be treated differently. Laura Brooks noted that the receiving center would also provide a stopgap measures for families, who sometimes need a place for intervention with a loved one in crisis.

Cody asked whether the Recovery International project would place an emphasis on Anchorage/ the Mat-Su. Katie said it would initially, and it would also include a third community to be determined, perhaps Fairbanks. Katie said the RFP was for an initial process; the department would then look at other places. Cody suggested they consider inviting someone from Bethel/YKHC or NSHC to at least sit in on the process and learn what the project is doing; those organizations could maybe capitalize on some of the ideas. He also asked whether the center would be for all ages. Katie thought that Crisis Now was, for now, an adults-only model.

Brad asked if it was correct to assume that Crisis Now was a form of crisis escalation prevention. Eric said that it was both a form of escalation prevention and then subsequent de-escalation. Katie said that it was also about providing an intervention for people according to their level of need. Laura Brooks noted that, for example, some people will need to go directly to the PsychER. Katie said that was true, and people will get initial assessment to screen for that when they show up. It would be the primary stop. She also reminded the group about the call center component of Crisis Now, which would be available to determine both needs and service capacity.

Steve said that crisisnow.com had a three-minute video of how Crisis Now works – he said he would send the link to the group. He noted that there had already been one preliminary meeting on this to get the ball rolling, but they definitely wanted to engage anyone and everyone who wanted to be engaged in this conversation.

Alaska Criminal Justice Commission
Behavioral Health Standing Committee

Meeting Summary

May 31, 2019
Alaska Mental Health Trust + Teleconference

Commissioners present: Steve Williams, Stephanie Rhoades, Beth Goldstein (PDA), Laura Brooks (serving as proxy for Commissioner Nancy Dahlstrom), Lt. Brian Wilson-APD (serving as proxy for Commissioner Sean Case), Laura Russell (serving as proxy for Commissioner Adam Crum)

Participants: Cody Chip (ANTBHD), Travis Welch (the Trust), Katie Baldwin-Johnson (the Trust), Matt Dammeyer (API), Beverly Schoonover (AMHB), Farina Brown (DBH)

Staff: Barbara Dunham

Agenda and previous meeting's summary

The agenda and previous meeting's summary were approved without objection. Chair Steve Williams explained that at the Commission's upcoming plenary meeting, Commission Chair Claman planning to discuss what the Commission should focus its energy on in the future, and he imagined that would involve looking at what interest there is to move into working on mental/behavioral health issues. He thought the group could address that today. He also wanted to make sure everyone attending was up to speed as there were some new faces.

Highlights from the 2019 CCJ/COSCA Summit

Steve explained that in the previous week, he attended the Conference of Chief Justices/Conference of Chief Court Administrators western region summit, along with Trust staff member Travis Welch, Lisa Fitzpatrick, Deputy DHSS Commissioner Al Wall, and Judges Henderson, Morse, McDonald, and Gandbhir. The summit titled "Improving the Court and Community Response to those with Mental Illness" and was entirely focused on the intersection of behavioral health and criminal justice, and how to use state resources effectively. The conference used the Sequential Intercept Model (SIM), which this group has been using, and highlighted programs from other states, identifying successful programs at each intercept.

Travis said that the highlight for him was hearing about successful Crisis Intervention Training (CIT) and stabilization centers in other jurisdictions. Those two programs can have a huge effect in the community when managed properly. Another highlight was hearing about reentry coalitions focused on "day one" connection to services.

Steve added that the crisis stabilization centers Travis was referring to were more than just sleep-off centers like the Anchorage Safety Center. States have implemented these services by capitalizing on Medicaid waivers. One of the keynote on first night was a psychiatrist who spoke about strategies for mental health and law enforcement collaboration; Steve said he could forward her information to the group.

Steve said that another focus of the conference was on competency, and attendees learned that there is a national trend of competency orders increasing exponentially, much like what we've seen in Alaska. There is a similar trend for restoration orders. In Alaska, wait times for initial evaluation are trending down, but wait times for restoration trending up. Two summers ago, there was a facilitated workshop in Anchorage

that walked participants through the SIM model, and it brought in data and examples of what other states are doing in the area of competency and restoration. For example, in other states, qualification standards for those conducting evaluations and restoration are not as high; some states used licensed clinicians, and don't require a psychiatrist working on every case. Some states use an abbreviated form or tool, and can turn an evaluation around in three days, and move into restoration within a week or so. Some states just don't use competency procedures for low level cases with little potential jail time.

Beth Goldstein asked whether, in places that have lower qualification standards, there was any concern about the quality of the services? Steve said there wasn't, but there was an emphasis on training. Competency evaluation and restoration requires a special skill set, training for which is not necessarily included even for advanced degree programs. A practitioner's degree is important but their training is equally if not more important.

Adam Rutherford noted that in states with these lower qualification standards, there is often a clinical supervisor with higher qualifications overseeing those clinicians. Laura Brooks pointed out that Alaska already uses this model in some places, for example in the area of sex offender management.

Current state efforts

Steve said that the issues discussed at the conference were all issues this group has talked about, including identifying problems and some solutions. This group might want to look at what's already identified and pick things to focus on. He also noted that the UNLV report identified and made recommendations for amending statutes. He thought that there didn't need to be a total rewrite of Title 12—the group should be able to find a few things that are noncontroversial and push them forward.

Adam explained that the state was currently doing a statewide Comprehensive Behavioral Health Management Services Plan. He wondered how much of that plan had incorporated the SIM model and the Commission's work. State statute requires DBH to have a management plan; the Trust has been collaborating with DBH on the next version, with the hope that the plan will lead to action. Steve added that this has traditionally been a 5 year plan, and the new idea is to make it a working document that can be updated regularly.

Judge Rhoades wondered what relation this plan had to do with the Shared Vision that had been formulated in the past. Steve explained that it was the same thing. Judge Rhoades said that that past effort had used stakeholder subcommittees, including a mentally ill offender group, which went on to create the mental health court. She thought it would be good to look at this new iteration to make sure it was not redoing wheel, and suggested it might want to reference UNLV report.

Steve explained that the workgroup for the Comprehensive Behavioral Health Management Services Plan, stakeholders have been consulted and public comment solicited. The idea was to put the plan online to make it a working document. One element of the plan is about criminal justice-involved individuals. The group has also been pulling from existing plans— for example, strategic plans for various agencies and plans required by other grants—hopefully the comprehensive plan will be able to link to those.

Laura Russell explained that this was something her counterpart in Juneau was working on. Laura Brooks said that DOC has been working with the group developing the plan too.

Introductions – Matt Dammeyer

Steve asked Matt Dammeyer, the new CEO of API, to introduce himself. Matt explained that he was a clinical psychologist and had worked a lot in acute care. He was new to the criminal side of things.

His recent focus has been working on finding ways to prevent people from coming into API in the first place. His long-term focus is on looking at ways to treat people where they are. For example, when people arrive at a hospital with a mental health crisis, they are not treated like patients experiencing a physical crisis; they are shuffled around, and told to wait. Mental health patients should be met where they're at.

Education of Commission, legislators

Steve explained that he had emailed several items to the group, including the New Yorker article, "My Brother Tom's Schizophrenia," which was written by the sister of a man who was living homeless in Anchorage with mental illness. Steve said he thought the story was poignant, and thought everyone in the group could recognize the story. Everything in the article hit on places in the system where things didn't work, and he thought it was important to remember how imperfections in the behavioral health system can affect an individual. He encouraged the group to share the story with colleagues.

Steve explained that the timeline of Tom's story from getting arrested, through restoration, to, finally, suicide was February through October or November, so eight months or so. His care providers were DOC and API, and prior to that just family and friend supports. Many people don't have those supports. Without changing things, the number of Trust beneficiaries at DOC will go up, and the demands on API will go up; but neither institution should be a primary care provider.

Steve said the legislature has indicated that after passing HB 49, they want to focus on access to treatment. He thought this committee should focus on letting them know that that treatment needs to happen before prison, which he didn't think was on the legislature's radar. Beth said that in this session's discussions, they started talking about taking a holistic approach. She thought the legislators were open to it, and she would like to see that conversation expand.

Laura Brooks thought that one hurdle in the legislative session this year was the complete lack of understanding of the serious gaps in the behavioral health workforce. Treatment and rehabilitative services are things that DOC has funding for, but there are no providers. Legislators expressed their disappointment to DOC because DOC was not treating individuals or releasing them to treatment, but legislators need to understand that the services are just not there.

Judge Rhoades said she thought the 1115 waiver will help the system generally, but it will also require higher standards for the workforce, and may exacerbate the problem. Looking at next steps, she thought the group need to educate itself. Every time there's an administration change we have to reinvent the wheel. She thought the group would benefit from doing a SIM workshop, which could use Tom's case as an overlay. Alaska's biggest issue is with intercept 0. The state is doing a lot of things once a person is in contact with the criminal justice system. She thought part of the problem was also that providers are not willing to serve this high-needs population, perhaps because Medicaid doesn't pay enough. There needed to be a pre-charge drop-off center to peel some people off to treat them before they become justice-involved. Alaska also doesn't have community inreach. Community mental health centers are arranged to suit providers, not those with the most needs; they serve people who can make appointments best. But if someone is not that ordered, and living on the streets, community mental health doesn't work because they're not coming to them. It was also fairly obvious that with recent legislation, there will be a wider net bringing people into DOC, and future efforts were going to be about diversion.

Steve said he also discussed with conference participants whether they should have a conference on the model or on parts of the model. He thought the Commission could discuss this on Friday. He wanted to make sure it would not be duplicating any current or previous efforts though.

Laura Brooks agreed that it was wise to make sure this group is not duplicating existing efforts. HSS is looking at diversion on several levels, crisis stabilization and forensic feasibility. Part of the problem is Medicaid itself— community mental health centers used to do the kind of inreach necessary to treat the high-needs population but Medicaid will not pay for it. She thought that most stakeholders know what needs to be done, and thought maybe a summit should focus on how to do it. People in this group are all adequately educated and able to take action now.

Steve agreed that many people within this group and elsewhere already know what needs to be done, but it was also his experience at the conference that most people from the Alaska delegation were not familiar with the SIM and what services were available in Alaska. He thought it was indicative of a need for ongoing education and inclusion. There might be a need to spend some time getting people up to speed to then focus on action.

Adam suggested that the two things didn't necessarily have to be separate events—one even can educate participants and discuss taking action at the same time. He agreed that taking action needed to be a component.

Public comment

There was an opportunity for public comment but none was offered.

Next steps

Katie Baldwin-Johnson said that the forensic feasibility study will be producing recommendations and data, and will likely have many items that might be actionable. She added that there was also a Trust-funded project, in collaboration with the Alaska State Hospitals and Nursing Homes Association (ASHNHA) and Agnew Beck as the contractor, that was looking at ways to improve emergency departments, including how they interface with API; that project also had a lot of overlap with this conversation. That group has been discussing a model called Crisis Now, which isn't focused on the justice-involved population, but it looks at the continuum of crisis services with eye toward prevention. She believed that group will have some kind of summit or gathering.

Judge Rhoades agreed with Laura Brooks that this group knows what needs to be done. But there were knowledge gaps at the various agencies and within the Commission. She noted there are also national best practices for the SIM, and thought it would be helpful to give a summary of those practices to the commission including what's being done in Alaska.

Matt said that he had been involved in the Trust-ASHNHA project, and noted that he was asked to talk at the annual meeting of emergency physicians. Emergency departments are really feeling the effects of this crisis, and it would be good for them to become more engaged. He added that in terms of taking action, if you look at where resources are being spent, it's all in acute care—there are tremendous resources in non-behavioral health acute care. He suggested one reason there is a workforce shortage was because stakeholders are not looking at where the resources are. There is not necessarily a resource problem - everyone has a payer source, but it's all going to acute care, which is where the workforce is necessarily drawn. The question is how to tap into those resources.

Judge Rhoades noted that it's also a small percentage of population using the most resources. Alaska doesn't collect data in a way that can identify who exactly is in this population.

Steve said that based on this discussion, he saw four potential next steps:

1) Basic education for the full Commission on the SIM;

2) Identify current efforts to ensure no one is recreating the wheel: the ASHNHA project, the forensic feasibility study, the 1115 waiver, the Crisis Now model (which includes crisis stabilization and has a model for data sharing across systems);

3) Educate the Commission about how the community behavioral health system works;

4) Generate a broad-based educational plan for the Commission, and for legislators re: mental health and addiction.

Regarding item four, Steve said that some in the legislature seem to believe that treatment in incarceration will stabilize people, which is an indication of a lack of education. Policy should be based on good information.

Brian Wilson reiterated the need for crisis stabilization, noting that APD deals with an average of one person every shift who is in need of that service. It would be great to get those people into treatment before they get to DOC custody.

1115 Waiver update

Farina Brown from DBH gave the group an update on the 1115 Waiver. DBH hopes to have emergency regulations out in June, and has sent a letter out to providers regarding proposed services; they will include SUD care coordination and case management. This is phase one of the rollout, and phase two will be forthcoming with proposed rates and more.

Cody Chip recalled that there was an RFP in the fall for SUD crisis stabilization—would that be included in the first phase of 1115 waiver? Farina said she knew it was still on table, but was not sure of the details.

Judge Rhoades said she knew that up to now, smaller SUD providers couldn't bill Medicaid because they were not grantees, would this be addressed? Farina said they were giving a provisional designation to smaller providers. The whole point of the waiver is to extend the continuum of care, and she recognized the grantee system has been something of a hindrance. Part of the idea is also to network providers.

Laura Brooks asked how that would work. Farina said that SUD care coordinators will make connections between DOC and other agencies. They can be employed within agencies. Judge Rhoades observed that the devil is always in the details, and the problem with adding additional services is the potential for creating another silo—she was concerned about implementation in each place in state. She hoped that more people would be asking questions to make this work.

Katie suggested that a future meeting, Farina could describe how the new Administrative Services Organization (ASO) will work. Farina explained briefly that an ASO would be similar to managed care, and its objectives are to organize the provider network and identify gaps. If a provider can help cover a gap, the ASO can help step up that service. There was no set date yet for when it will start. Adam noted that in other states, ASOs play a big role in rolling out changes in Medicaid waivers, and it should be implemented very carefully because it will change the way Alaska does things.

Judge Rhoades agreed that she would like education on the ASO, and was curious to know whether it would look like ASOs in other states.

Laura Brooks asked what the timeline was for implementation. Farina said that it will begin July 1, when the new bill codes will be available. From there, the provider community will then need to hire staff to provide the new services. The rates will be coming out shortly.

Next meeting

Steve said he would set a date for the next committee meeting after Friday's plenary session.

Alaska Criminal Justice Commission
Behavioral Health Standing Committee

Meeting Summary

March 1, 2019
Alaska Mental Health Trust + Teleconference

Commissioners present: Steve Williams, Stephanie Rhoades, Sean Case

Participants: Michael Duxbury (serving as proxy for Commissioner Amanda Price), Al Wall (serving as proxy for Commissioner Adam Crum), Laura Brooks (serving as proxy for Commissioner Nancy Dahlstrom), Rob Henderson (serving as proxy for Commissioner Kevin Clarkson), Gennifer Moreau, Laura Russel, Cody Chip, Andy Jones, Travis Welch

Staff: Barbara Dunham

Agenda and previous meeting's summary

The agenda and previous meeting's summary were approved without objection.

2019 Workplan

Steve Williams explained that the focus of the meeting would be to come up with a work plan for the Standing Committee for 2019. He noted that there were some new Commissioners and participants in the Committee since the last meeting, and pointed out that he had put the Committee's charge at the top of the agenda. He had also provided the memo detailing the recommendations from the Committee to the full Commission from fall 2018, and a complete list of all the recommendations the Commission has made to date. Essentially, this Committee was focused on the intersection of the behavioral health and criminal justice systems, looking at ways to divert justice-involved people with behavioral health problems to services outside the criminal justice system while maintaining public safety. Part of this also involved looking at the interplay between Title 12 and Title 47.

Steve said that one question for the meeting was whether the group wanted to (A) focus on the implementation of current (outstanding) recommendations or (B) start looking into other issues. He noted that the Commission's annual report would be due by November 1, meaning any recommendation from this group should be compiled and sent to the full Commission by the end of summer.

Sean Case said he was curious to know what the group's feelings were about Title 47 holds. From a local law enforcement perspective, APD was planning to take the Title 47 mandate very literally as they needed to free up officers who had been devoting a lot of man hours to people covered by Title 47. The issue was that those needing a Title 47 hold due to alcohol involvement would be taken to jail on a noncriminal hold or to the Anchorage Safety Patrol, and those needing a hold due to mental health issues would be taken to Providence Psych ER or API, both of which involved a lengthy process. There was no quick drop facility. The statute itself would seem to indicate that people in this category should be taken to a hospital, which then begged the question of what should happen if all hospitals were on divert status.

Steve said that acute car had been a longstanding issue, that could be addressed in a number of ways— statutes, capacity/resource allocation, quality of available care. The question was how the Commission could support any of those efforts.

Al Wall thought that this issue should be addressed in all of those ways. There were different groups looking at these issues and DHSS was putting together a task force looking at the UNLV report. He thought the Commission could pull together people working on the civil and criminal side of things and suggested involving ASHNHA (Alaska State Hospitals and Nursing Homes Association). DHSS has a short-term plan in place now and is working on a mid- and long-term plan, and they were committed to rapid positive change. There have been many recommendations made over the years that were never acted upon.

Judge Rhoades noted that obviously there had been an administration change, and wanted to inform or remind the group that the Commission had discussed whether Title 47 was in the Commission's purview and that the Commission had decided that the interplay between Title 12 and Title 47 brought the latter within the Commission's purview. She thought another question was whether this committee wanted to revisit the UNLV report, which might be somewhat outdated after the passage of SB 91. She also wanted to know what DOC was doing about reentry.

Michael Duxbury had two examples pertinent to this discussion. The first was a person in Southeast Alaska who was off his meds and believed that schoolchildren boarding a bus were ninjas. He'd been shooting weapons outside his house and clearly needed an intervention, but Title 47 only goes so far and this person knew what to say to be released from a Title 47 hold quickly. Another example was a man in Wasilla who worried his parents with his behavior, had been making serious threats to neighbors, and had obtained weapons and was escalating his behavior. These were examples of people who need intervention, not jail—they needed to be dropped off at a crisis intervention center for evaluation. Troopers often get called back to respond to the same people—there needed to be a warm handoff to ensure people in this situation could get lasting help.

Steve noted that the Committee had been talking about such issues for a long time, and that people experiencing a behavioral health crisis should not go through the criminal justice system because there was nowhere else for them to go. Al thought this was really the crux of the matter—there was a real need for a crisis stabilization center. The problem was finding funding and someone to run it.

Sean thought there could be an interim response until funding could be found for a permanent center, something like a mobile response project. That could be a way to deescalate a person in crisis. Al agreed and said he was essentially describing the ACT team model. Sean said that regarding funding, the 1115 waiver could provide Medicaid reimbursement for these services.

Michael said there was also a problem of medical professionals feeling as though they can't talk about their patients because of HIPPA. Law enforcement needs their help to intervene. Al said it was HIPPA but also an issue of liability. With an ACT team, their activities would come under the umbrella of the Department of Public Safety, which is usually not as concerned about litigation.

Judge Rhoades said it sounded like the group needed an agenda. She proposed that item #1 on the agenda should be looking at non-criminal justice interventions for the acute needs of the behavioral health population, whether a crisis stabilization center or mobile crisis response. Steve thought it sounded like there was agreement on that; there was no objection from the rest of the Committee.

Judge Rhoades said that the first agenda item could also include jail diversion, and that other potential agenda items might be competency and restoration, treatment in jail, and reentry and discharge planning.

Laura Brooks asked to clarify whether the Committee's discussion of Title 47 would include alcohol holds, noting those are a tremendous burden on law enforcement and DOC. Steve said he thought

it was both, and noted that it was often hard for first responders to distinguish between an alcohol-induced crisis and mental health crisis. It was something to keep in mind. Judge Rhoades thought that the Committee should look at anyone who was going to jail but should be going to a different intervention instead.

Steve asked whether there was any objection to Judge Rhoades' list.

Michael added that treatment in jail was very important, and that it also related to release planning. Treatment in jail should be more than just a Vivitrol shot; with continuing therapy those leaving prison will be less likely to return. Steve said he thought that the two were very connected and that access to treatment was very important, but also wondered where it would be best to start first. There also had to be treatment readily available in the community so that people could continue their treatment after leaving prison.

Cody Chip from ANTHC thought it was a good agenda and urged the Committee to keep rural Alaska in mind, including the issue of transportation to an intervention or treatment—transportation is a huge issue for rural Alaska. Michael agreed, saying that was one reason law enforcement officers struggled with Title 47 holds in rural areas. Often the transport would have to be secure, in handcuffs, because there was no other option and this would be traumatic for the person. Cody said that the Committee also might want to think about the interaction with federal probation; as a practitioner, he saw a lot of people who had federal probation, particularly for drug crimes.

Gen Moreau thought the agenda was good but didn't want to overlap with existing efforts; she suggested that once this group dials down into the details some things might be referred out to other groups making similar efforts. Steve agreed and thought this Committee's role might be to support and inform those efforts.

Cody asked whether the Committee ever discussed juveniles. Steve said historically not, with the exception of juveniles treated as adults for competency purposes.

Steve said it sounded like he was hearing there was a consensus around Judge Rhoades' list. He said he would report briefly to the full Commission on the following Monday and would write up the list and send it to the group.

Public Comment

There was an opportunity for public comment but no comment was made.

Alaska Criminal Justice Commission
Behavioral Health Standing Committee

Meeting Summary

August 29, 2018
Alaska Mental Health Trust + Teleconference

Commissioners present: Steve Williams, Quinlan Steiner, Stephanie Rhoades, Sean Case

Participants: Randall Burns, Rick Allen, Gennifer Moreau-Johnson, Kristy Becker, Karen Cann, Kim Stone, Paul Maslakowski, Teri Tibbett, Araceli Valle, Linda Stetterberg

Staff: Barbara Dunham

Agenda, Announcements, Summary of Previous Meeting

Sean Case moved to approve the minutes and Randall Burns seconded the motion. Steve Williams and Teri Tibbetts suggested minor changes. There was no objection to approving the agenda so amended.

Judge Rhoades asked to add an item to the agenda to discuss the status of the pre-trial diversion program planning. There was no objection to the agenda so amended.

Report Out from Seattle and San Francisco Site Visits

Steve Williams explained that Rick Allen, Gennifer Moreau-Johnson, Sean Case, and Dean Williams had all gone to Seattle and San Francisco to investigate the law enforcement diversion programs in those cities, and they had agreed to report out on their trip.

Sean Case explained that Seattle and San Francisco were both doing the same program, Law Enforcement Assisted Diversion (LEAD). Seattle had been doing it for six years and San Francisco had been doing it for about 1 year. The intent in going to observe these programs was not necessarily to replicate what they were doing but to get ideas for implementing a similar program in Alaska and to see how such a program operates in real life.

The Seattle program had been designed as a diversion for street-level possession and prostitution crimes. San Francisco had expanded the scope of the program and Seattle was planning to do so as well. Washington criminalizes possession as a felony while California penalizes it as a misdemeanor, so it was interesting to compare the effect of having a bigger stick in Washington versus California.

Sean said his main takeaway from both sites was that he thought that Alaska can do diversion more efficiently and effectively than either. In both locations not all officers were on the same page; those who were carrying out the program as "boots on the ground" had issues with it and didn't necessarily see what they were doing as worthwhile.

Sean also noted that many participants in each program had severe and longstanding drug abuse problems with co-occurring mental health problems, which made this a very difficult population to work with. He recommended targeting a smaller population with fewer needs first, then expanding the program to other populations once a working model is found. He still favors diversion but it needs a case

management component to address individual needs, and the model must involve a warm handoff from the officer to the case manager.

Steve asked what kind of case management either site had. Sean said that each community had different needs. In San Francisco housing was a huge issue. It also depended on whether the case opened as an arrest contact or a service contact. In Seattle, program participants would be assigned a case manager within 30 minutes. It was not so immediate in San Francisco, which left a gap in time in which a potential participant could return to reoffending or abusing substances. Where services are not immediately available, each program will do whatever is possible- e.g. a hot meal, a photo ID, etc. Getting participants to a place where they were stabilized was an extended process that would take some time. This was particularly the case when a participant was not ready to make the needed change.

Steve asked whether officers would stay with the participants until the case manager arrived. Sean said yes, they would typically put the participant in a squad car. Rick Allen added that the Seattle officers estimated that as many as 70%-90% of LEAD participants entered the program as a social contact rather than an arrest contact. Sean noted that social contacts involved less paperwork for the officers. Randall Burns asked how social contacts were initiated. Sean said they could just approach the officer, or the officer could approach a person who looked like they might want to be in the program. It used to be that people who wanted to be in the program would purposely offend in front of the officer, so they added the social contact option for entering the program.

Sean explained that unfortunately the officers in Seattle didn't have hard data on participants or on how successful the program was. They had gotten lax in data tracking. It would be nice to have data on whether the threat of jail time works as an effective stick or whether participation in the program is more driven by a participant's internal motivation to change, and the threat of a stick is irrelevant.

Gen Moreau-Johnson agreed and said she was shocked that there was not a lot of data. The site visits had made her think differently about diversion and she agreed that Alaska should have a different model. She thought Seattle was doing better than San Francisco. The latter had quite a significant homeless population, rendering the city almost unrecognizable. She noted that there was no buy-in from the officers in San Francisco, and it seemed like the program was imposed on them; they had no clear guidance for what they were supposed to do and they were not tracking fidelity. It seemed as though those implementing the program had invested too heavily in the idea of "meeting the participant where they are"—ultimately the purpose of an intervention should still be to make a change in a person's life.

Gen added that Seattle seemed to have more of a critical mass of officers who understood and believed in the program. Rick said officers could opt-in to the program while in San Francisco it was just assigned depending on the beat. Sean added that the Seattle program also had vans that would proactively approach potential participants.

Rick said that the officers in Seattle were very candid—data collection is difficult, and the program was now written into the budget, meaning there was little incentive for them to demonstrate improved outcomes. Gen added, however, that Johns Hopkins was planning to help them conduct a study of the program. Randall wondered whether the DAs might have data. Rick said he was not sure they would keep track of participants that entered the program as social contacts. Gen noted that the case managers have information that they will not/are not able to share with law enforcement or prosecutors.

Steve asked Gen whether she gleaned anything helpful to Alaska in light of the pending Medicaid reform. Gen replied that intensive case management is not really the kind of thing Medicaid covers. Something like that would have to be grant-funded. She also noted that measuring recidivism was tricky

when essentially the participants were no longer being arrested by virtue of their participation in the program. She said the part of the program that excited her the most was that information was being shared between the case manager and the parole officer.

Judge Rhoades said that this discussion reminded her of when she went to San Francisco to visit their mental health court in anticipation of establishing one in Alaska. She noted that the needed services were never going to be fully Medicaid covered. The needs of the behavioral health population vary widely, and will need varied resources. The role of a centralized program is to coordinate resources and monitor participants. The program needn't worry about where the funding would come from for every single piece.

Steve said he was hearing that it was really important to identify the target population for a diversion program. It sounded like Seattle had expanded its target population and in San Francisco it was never really well-defined. He agreed that it was important to focus on a small population and not worry about getting every piece of the program funded immediately.

Judge Rhoades said that there were populations around which new initiatives were being built, such as homeless youth. The key was to figure out the population for which there was a lot of energy and find the best way to tap into that.

Rick said he was surprised about the high number of participants entering the Seattle program via social contacts. The conventional wisdom is that you need both a carrot and a stick to incentivize an individual to change, but the Seattle program seemed to be all carrot. Judge Rhoades noted that many people came on their own to CRP because it was a way for them to access services they could not access on their own. Randall said it made sense that people ready to change would seek change.

Sean said the key was figuring out how to incentivize the people who don't want help—to figure out a way to get to them. Dr. Kristy Becker said that there will always be that population for whom neither a carrot nor a stick work.

Rick noted that there were "wet" housing models in Seattle that didn't require residents to be sober and supported them in their transition to sobriety. Steve said these models were effective in reducing substance abuse. Kristy said they were also effective in reducing hospitalizations. Rick said that they were also effective in reducing victimizations.

Steve asked what the next steps were. Sean said that he'd like to start a pilot program with a population for whom services are available. After tracking the progress of the program, it could be expanded. He also thought that it was possible to start now—there was no reason to wait for things to come on line.

Rick noted that 50% of the LEAD program participants in Seattle were women, though they were only 16% of all arrestees. Kristy said that made sense since women were less likely to be arrested for a violent crime and it sounded like the eligible population for the program was people convicted of non-violent crimes.

Gen said it was correct that violent crimes were excluded from LEAD. She also noted that the DA gets final approval of participants. Rick added that there was one DA devoted exclusively to LEAD who does not have any cases. Gen said that the program had a group data platform to share information on participants, though not all information was shared.

Status of Pre-Trial Diversion Program Planning

Judge Rhoades wondered whether there was any movement to build on Mary Geddes' work, and noted there had been talk at the last plenary meeting of the Commission of using BJA funding to hire someone to continue that work. Sean said he thought the next step was to hire someone to identify a target population. He would prefer to target DV offenders, though would need more information on potential service provider partners, the cost, and the anticipated benefits. He noted the high rates of DV in Alaska.

Steve said he understood this was on the agenda for the next plenary meeting on September 24. He had been chatting to Sean about this and had suggested also using the BJA money to identify what services would need to be in place to address the needs of the behavioral health population.

Steve asked Sean whether the idea was to get a pilot program ready for Anchorage. Sean said that eventually he'd like such a program to go statewide, but APD was willing to carry this out and Anchorage was large enough to find a suitable target population. Teri Tibbett added that community readiness was an important component—whether the community was able to handle a new program.

Judge Rhoades noted that clinical and legal eligibility were different considerations. People who commit DV crimes make up a large population; some can have a mental health diagnosis. She would like to see some data on this population.

Randall added that DBH had issued an RFP for a crisis stabilization center. If there was a response from Anchorage, the two projects could be coordinated as there would be a lot of overlap in terms of police involvement.

Judge Rhoades asked what the next steps were. She imagined that if this were to be a DOC project they would need to develop a proposal with a budget.

Karen Cann said that she was not sure DOC would take the lead on this. She knew that Sean wanted to move forward with law enforcement diversion and this would address a population who would then never get to DOC's door. They were happy to help support Sean and APD in this effort. Steve added that he had talked to Dean Williams and Sean about potential uses for the BJA money and it sounded like the previous idea about cross-training with COs from Norway was now off the table.

Barbara Dunham explained that the Commission had two tasks at its next plenary meeting. One would be to discuss how to use the BJA grant money, for which Alaska was eligible by virtue of going through the JRI process. The Commission would apply to BJA for that grant and it would be administered by the Crime and Justice Institute (CJI), Alaska's technical assistance provider for JRI. The Commission could decide on its own how this money should be used though the legislature would need to approve of the receipt of federal funds by a state agency. The other task was to make recommendations to the legislature regarding how reinvestment funds (i.e. state dollars) should be spent.

Sean said he had a draft of the Seattle LEAD program description that he could use as a template for applying for BJA funds for a pilot program in Anchorage. Steve said he would follow up with committee members individually to make sure that all elements were defined. Karen said she could also forward the position description for Mary's position as there would be overlap.

2018 Committee Recommendations

Steve noted that the discussion thus far had addressed only one intercept in the SIM and asked what the will of the committee was regarding making recommendations that perhaps addressed the other early intercepts. At the last meeting there was some interest in developing a crosswalk with the committee's 2016

recommendations and the more recent SIM workshop recommendations. He noted that the report from the recent workshop was still not finalized. Karen added that DOC had received a draft from the TA provider the previous week but they were still working on revising it. She could send out the draft once it was revised.

Steve said he had gone over his notes from the SIM workshop and recalled that the workshop had identified five primary recommendations:

- Crisis drop-off center(s)
- Crisis Intervention Training (CIT) with a co-response element
- Data sharing
- Intensive case management (non-Medicaid services)
- Peer mentoring with a forensic training component.

Steve noted that the first three of these had also been identified in this committee's 2016 recommendations. He also noted that DBH's RFP for a crisis stabilization center might overlap somewhat with the drop-off center idea; the drop-off center was not intended to be a residential center but a safe indoor waiting facility. Randall said the RFP was flexible enough to cover a drop-off center too. The idea was that people would be there for 24-72 hours, perhaps a maximum of 5 days.

Steve said he thought the committee could forward support of the crisis drop-off idea to the full Commission, noting that it was already part of several different plans. Judge Rhoades asked what the committee needed to weigh in on. Steve said that there were people other than commissioners on the committee and that it would be valuable to get their input. The committee could identify priorities for the Commission; he noted that Rep. Claman and Sen. Coghill had said it would be helpful to get focused recommendations from the Commission rather than a laundry list.

Kristy said she thought it made sense to start incrementally. For example, it wouldn't make sense to have a CIT with a co-response without a drop-off center. Judge Rhoades agreed and suggested identifying what things could be moved forward now and were priorities. Karen agreed and thought it would be best to ask for the Commission's support for things that were achievable near-term.

Judge Rhoades said she thought it sounded like the committee could support a crisis drop-off; it sounded like DHSS was on board. There was no objection; the committee agreed to forward this idea as recommendation to the Commission.

Judge Rhoades said she also thought it sounded like there was support for improved data sharing. Karen said she agreed and that there was movement on that in other areas, including at DOC. There was no objection to also forwarding this idea.

Judge Rhoades noted that CIT with a co-response (such as a case manager who responds alongside law enforcement) was one alternative for effective CIT; the other was CIT with a drop-off center. She wondered if Alaska needed both. Steve observed that the Public Safety Action Plan just recommends expanded CIT training without an additional element. Judge Rhoades said that law enforcement's biggest complaint with CIT was that there was no place to send people in crisis. There had to be some mechanism to take these people of law enforcement's hands.

Kristy thought you could have both models without redundancy. There will need to be some place for people to go, but a mobile response can also do triage—not everyone will be going to the drop-off center.

Judge Rhoades asked if the committee could agree on forwarding both the CIT with a co-response and the crisis drop-off center ideas as either/or recommendations for the Commission. There was no objection.

Teri said she thought this made a lot of sense; these ideas would also address the public concerns about "catch and release" and there not being any place to put individuals who are causing trouble. It would also address some of the law enforcement frustration with criminal justice reform.

Steve said, in summary, that the committee would generate a short memo to the Commission explaining that these three ideas – CIT with a co-response, a crisis drop-off center, and improved data sharing – are the committee priorities.

Randall asked whether there would be any recommendation regarding the BJA funding for a diversion consultant. Judge Rhoades asked whether the committee could also make a recommendation about that. Steve asked whether there were any thoughts on including the behavioral health element [e.g. identifying what services would be needed to support a diversion program for the behavioral health population] in the BJA funding proposal. Randall said he thought that made sense.

Steve said that he and Barbara would work on drafting a memo with these recommendations and send it around to the group. If need be these ideas could be fleshed out more later in advance of the Commission's report, due November 1.

Public Comment

There was an opportunity for public comment but none was offered.

Alaska Criminal Justice Commission
Behavioral Health Standing Committee

Meeting Summary

June 6, 2018
Alaska Mental Health Trust + Teleconference

Commissioners: Steve Williams, Greg Razo, Stephanie Rhoades, Karen Cann for Dean Williams, Brenda Stanfill, Amanda Daly for Sean Case, Rob Henderson for Jahna Lindemuth

Participants: Araceli Valle, Mary Geddes, Gennifer Moreau-Johnson, Teri Tibbet, Paul Maslakowski, Randall Burns, Chris Cavanaugh, Travis Welch, Kim Stone, Autumn Vea, Ben Irvin, Karen Forrest

Staff: Barbara Dunham, Susanne DiPietro

Announcements and Agenda

Steve Williams called the meeting to order. Rob Henderson introduced Kim Stone, the Dept. of Law's new point person for the Public Safety Action Plan. Steve Williams introduced Travis Welch, a new Trust staff member who will be taking on some of Steve's duties. [Later in the meeting, Steve also introduced Autumn Vea, another new Trust staff member.] There was no objection to the agenda or to approving the previous meeting's summary.

Debrief on the Sequential Intercept Model Workshop

Karen Cann explained that DOC had arranged for facilitators to lead a 1.5-day workshop with Alaska stakeholders to walk through the Sequential Intercept Model to map out gaps and needs in the criminal justice system. She thought the workshop went well and was quite productive. The workshop participants came up with 14 priorities, and identified the top four priorities along with next steps. The facilitators will write up a summary of the workshop's progress and DOC will send it out once they have it. This workshop also ties into DOC's Second Chance Grant application process and statewide Reducing Recidivism plan.

Karen noted that one idea that came out of the workshop was a crisis intervention/diversion model for the population of people dealing with mental illness. Anchorage has applied for a grant to start a pilot program in this area and Mary Geddes is working with the muni's anti-homelessness coordinator Nancy Burke on this project.

Steve said, as a reminder, that this group had expressed interest in the Sequential Intercept Model workshop. He also thought the workshop was productive, and noted that while most participants were based in Anchorage, he was hoping the ideas developed at the workshop could be applied statewide.

Judge Stephanie Rhoades said she had also attended and also thought the facilitators were great. She agreed that there were mainly people from Anchorage at the workshop but thought that the ideas developed there had statewide applicability. She noted that DOC seemed focused more on the reentry side of things and thought this group could focus on the first three intercepts. She added that she thought the future of the Commission lies in making reinvestment recommendations and developing alternatives to incarceration to divert people out of the system and break the cycle of repeat incarceration.

Gen Moreau-Johnson noted that in terms of alternatives for individuals with behavioral health needs, people often tend to discuss the need for more treatment beds, but as some have observed, the more beds there are, the more beds will be filled. Breaking the cycle would not come from increasing capacity for residential treatment alone but also developing ancillary services.

Update on the 1115 Medicaid Expansion Waiver

Gen reminded the group that the 1115 Waiver gives the state the authority to avoid Medicaid rules to try doing things differently. The state must demonstrate that the plan for the waiver will meet Medicaid outcomes and be budget-neutral (i.e. not cost the federal government any more money). Alaska's proposal stated that the goals of the waiver plan were to reduce reliance on acute care, make more use of early interventions and community care, and add more accountability to the system.

Gen explained that Alaska's proposal identified three target populations that comprised the most consumers of acute care. They are:

1. Children and adolescents (and their parents) at risk for substance use disorder (SUD)
2. Youth and adults with acute mental health needs
3. Adolescents and adults with substance use disorders

Gen noted that while justice-involved individuals weren't explicitly listed among the target populations there would be significant overlap.

For population 1, new services will include standardized behavioral health screenings, community and home-based outpatient treatment services, intensive case management services, 23-hour crisis stabilization services, residential treatment services, therapeutic foster caser services, and community recovery and support services. For population 2, new services will include all of the above plus peer-based crisis intervention services and crisis residential/stabilization services. For population 3, new services will include the services offered to population 1 plus medication-assisted treatment (MAT) with care coordination, ambulatory withdrawal services, and additional residential treatment services.

Gen said that Alaska's waiver application had been accepted by the Centers for Medicare and Medicaid Services (CMS) and DHSS is now in negotiations with CMS. They meet weekly and she estimated this part of the process would take another 6-8 months. That said, CMS indicated it would be open to fast-tracking the SUD services so those could possibly come on line sooner.

Steve noted that some of the ideas in the application have been identified by this and other groups as priority ideas. He said that the need for intensive case management had often been noted as a gap and asked Gen to explain that further. Gen said that the Medicaid rules are ordinarily very specific about what case management services will and will not be reimbursed; DHSS is working with CMS to get approval for case management across the continuum of care.

Gen also explained that MAT with care coordination was listed because the two services together were linked with improved outcomes over MAT alone. Randall Burns added that CMS is very hesitant to approve MAT because there is a trend to employ MAT without counseling at the same time; they want to ensure that patients will also be engaged in counseling while on MAT to address the underlying issues surrounding their substance use disorder.

Randall also explained that DHSS has a contract with the Alaska Mental Health Trust (Trust) to fund an architect to go to the 14 regional hubs and look at their infrastructure with an eye toward the anticipated new services. That should be completed within the next six months. For all 14 locations DHSS will identify workforce needs and advertise those needs explicitly with recruiters, providers, and educators—including outlining numbers of staff needed and their titles.

Chris Cavanaugh from the Alaska Native Tribal Health Consortium (ANTHC) said he wanted to make sure that DHSS knew that the consortium and the tribal health providers would be available to support this effort and would want to be involved.

Update: Medicaid Reform (SB74)/Criminal Justice Reform (SB91) Integration Workgroup

Gen noted that SB74, the Medicaid reform bill, was intended to bring about behavioral health reform and be a complement to criminal justice reform. SB74 mandated that DHSS apply for the 1115 Waiver. The SB74/SB91 integration workgroup was comprised of an array of stakeholders from all of the agencies involved in behavioral health and criminal justice policy. The workgroup has a number of objectives, which were summarized in a handout provided to the group. She noted the handout was a work in progress.

One of the problems with integrating the behavioral health and criminal justice systems was that there was no justice-involved flag for individuals in the behavioral health/DHSS system, because criminal justice involvement was not linked to any one eligibility population. For example they do not have a good sense of how the new laws have affected Medicaid enrollment. They know that over 800 reentrants were enrolled in Medicaid in FY17, but they lack context to understand that number, as they do not know how many were eligible.

In FY18 to date, Medicaid has covered 48 hospitalizations for people in DOC custody. However, it is difficult to say how much money that has saved the state because Medicaid is billed at a different rate.

The integration workgroup also has a subcommittee devoted to the Alaska Medicaid Coordinated Care Initiative, which tracks “superutilizers” of Medicaid services. There is also a data-sharing subcommittee, which is developing MOUs to share data between agencies and is also

working on a universal ROI. (Gen noted that DHSS asked CMS if there was any template for a universal ROI used in other states and CMS said that no other state has a universal ROI.)

Gen said there was $12 million allocated in the FY19 budget for behavioral health at part of the Public Safety Action Plan, and the integration group will work on allocating those funds. There was a provisional plan in place but that will need to be revised as the amount budgeted was $6 million less. Randall said DHSS had envisioned funding five different kinds of services and may pursue issuing block grants in each of those categories. They are working on the RFPs now. There is definitely a need for withdrawal management in Anchorage and the Mat-Su, and a concurrent need for more residential treatment if more withdrawal management beds are added.

Chris asked whether there would be any effect on Medicaid reimbursement for MAT if someone used or smuggled suboxone into prison. Karen Cann said that while people are incarcerated DOC pays for MAT. She noted that in prison suboxone strips can be worth $600 when they normally have a $6 street value.

Discussion on Committee Priorities

Steve explained that many of the action items identified by the previous iteration of this group in 2016 (using the SIM) have also been identified as action items in other plans from other groups. Some of the work is in fact being done and he want to find a way to supplement that work and fill in any gaps and not derail existing productive efforts.

Judge Rhoades said she would like to see a crosswalk of which groups or agencies are doing what. Barbara Dunham noted she was working on something similar for the Commission's reinvestment discussion but it was not limited to behavioral health action items. Judge Rhoades said she would like to see something like that but on a more "micro" level with the detailed behavioral health proposals from 2016. Karen Cann agreed. Judge Rhoades thought that this group could determine which items had some forward momentum and could use the backing of the Commission.

Steve noted that, for example, crisis intervention training was listed in the 2016 document and that corresponded to action item #44 on the Public Safety Action Plan (PSAP). He thought that was one area where there had been some movement and there was some energy.

Rob thought there was value to this group throwing its weight behind proposals such as that because the PSAP only applies to state agencies, whereas this group has a broader reach—for example APD was represented. Steve agreed and thought there was a way to use this group to leverage the PSAP and bridge the state-local divide.

Steve also said that there are many worthy items on the 2016 list and the group could feasibly pick one thing that pops out to everyone, especially since the group does not have time for a laundry list of action items. Judge Rhoades said that if the group was going to pick just one thing it should be as early an intervention as possible.

Karen Forrest said that one thing that jumped out to her on the 2016 list was the call to expand the state's forensic capacity, as that was also on the PSAP. DHSS has also received funding this year to do a feasibility study for building a forensic hospital. Steve wondered, on that note, what had happened to the discussion on qualifications for forensic examiners. Karen and Randall explained that once they looked into it further the qualification requirement was not really the issue and that there was a workaround.

Judge Rhoades asked where DOC was on pretrial diversion. Karen Cann said that DOC is looking into models but wanted to finish getting the Pretrial Enforcement Division off the ground first. Diversion would be the next area of focus, probably six to eight months away.

Judge Rhoades remarked that there was a large number of people in DOC custody and in reentry who probably needed residential treatment. Karen Cann agreed and said that was a high focus area and one of the reasons DOC wants to approach reentry housing and the halfway house model differently. Steve said that overlapped with one of the recommendations under intercept 3 in the 2016 list.

Karen Cann also noted that she would like to see the 2016 list updated or overlapped with the most recent 2018 SIM workshop results. Rob Henderson agreed and said a lot has changed since 2016 and thought the 2016 document could be updates. Steve said he wasn't sure they would entirely overlap. It was something staff could do but he wondered if it was a good use of time. Rob then wondered how the group should come up with its recommendations then.

Judge Rhoades proposed that each agency at the table should come up with its priorities under the first three intercepts and which of those priorities could use the assistance of the Commission. The group could then see what items align. Steve said it would also be useful to know where the priority ideas were in terms of readiness. Susanne DiPietro said that it would also be interesting to know what the agencies might be working on in this area that were not outlined in the 2016 document. Judge Rhoades noted that not all agencies were represented in the group today and that staff would need to conduct stakeholder interviews.

The group discussed what the timing should be on this project. Karen Cann said the results of the 2018 workshop would likely be returned by the end of the month. Rob said that late summer and early fall were when the state agencies make their budget requests. Judge Rhoades noted that staff and group members would need to do a lot of work behind the scenes to get a comprehensive list together. The group agreed to meet next on August 29 from 2:30-4:30.

Teri Tibbet said that the Juneau Reentry Coalition and the Alaska FASD [Council?] both had a slate of behavioral health recommendations that she would forward to Steve and Barbara.

Public Comment

There was an opportunity for public comment but no public comment was offered.

Alaska Criminal Justice Commission
Behavioral Health Standing Committee

Meeting Summary

April 13, 2018
Alaska Mental Health Trust + Teleconference

Commissioners: Steve Williams, Stephanie Rhoades, Karen Cann for Dean Williams, Brenda Stanfill, Amanda Daly for Sean Case, Rob Henderson for Jahna Lindemuth

Participants: Araceli Valle, Mary Geddes, Gennifer Moreau-Johnson, Chad Holt, Teri Tibbet, Pam Cravez, Norah Morse, Paul Maslakowski

Staff: Barbara Dunham

Announcements and Agenda

Steve Williams called the meeting to order. Judge Rhoades asked to add a brief item at the end of the meeting. There was no objection to the agenda so amended or to approving the previous meeting's summary.

DOC Updates – Diversion Planner

Mary Geddes provided the group with an update on her research into diversion. Diversion can be a broad or narrow concept, but generally refers to a mechanism that diverts an offender from the traditional criminal justice process.

She has identified some "easy" populations that would be suitable for diversion, and has a plan in circulation for diversion of people charged with per se DUI. She has also been looking at the young adult population. She has traveled to Fairbank and Kenai, and spoken with folks from Barrow. She noted that while APD has CIT training, there is interest but no manpower or funding to do CIT training in other jurisdictions. The troopers would like to get the same training as APD.

There is a lot of national interest in law enforcement-led diversion. BJA is promoting 6 locations across the US as learning sites for law enforcement-led mental health diversion. BJA is offering training and technical assistance for other law enforcement agencies to visit and model these sites. The sites are: Madison, LA, Salt Lake, University of Florida (2 sites), and Portland ME. They all have mental health workers stationed alongside LEOs—in some cases they are master's students in social work who use the experience for training. Mary will inform agencies across Alaska that this training is available—and at no cost.

She is also looking at the statutory schemes in five states as a model for statute-based diversion for the mental health population. The states are: Washington, Nevada, Mississippi, Indiana, and California. She can compile and share her notes on theses statutory schemes if group members are interested.

Indiana is the state that has the most promise for being replicated in Alaska. Indiana decided that diversion was best developed on a local level by practitioners familiar with local resources. Any community can opt into the scheme. The local community will form a "forensic advisory board" which looks similar to the teams on the mental health courts in Alaska. The team evaluates candidates for diversion, and the diversion can happen pre- or post-conviction.

Mary's research has shown that when the court participates in a diversion program, statutory authorization is required to help the program avoid separation of powers problems. Some of the models look like deferred sentencing, and allow participation in the program for up to three years, with failure resulting in conviction. Some programs are entirely pre-adjudication, and failure results in prosecution. In Mississippi, the statute authorized creation of pilot programs operating under a centralized board.

Judge Rhoades commented that in Alaska, the therapeutic courts do not have clinicians and services are referred out to clinicians. She wondered if the local advisory board would need to have a clinician if the board was involved in admission to the program and needed assessments. Mary said her reading of the statute was that the board was comprised of a judge, a public defender, a parole officer, a district attorney, a drug court judge, a substance abuse professional, and a mental health professional. She needed to do more research on how the board functions in reality. There are some legal exclusions. The program runs 2 years for misdemeanors and 3 years for felonies.

Brenda Stanfill asked if they included a victim's representative on the board. Mary wasn't sure but would look into it. Steve asked if the Indiana program operated on the county level. Mary said she thought so.

Steve noted that there had been discussions in the past about using statutory authorization for therapeutic courts, so this wasn't a new concept for Alaska. He thought this was something this group should look at—it could be a recommendation for the full Commission.

Judge Rhoades said that in regards to the per-se DUI project, she would caution that Das have not been willing to allow DUI offenders in to mental health court; there was a culture built up against it, perhaps because the first-time crime is a necessary predicate for the higher penalties for subsequent crimes. Regarding CIT, she noted that even though APD has the training, Anchorage lacks the co-response of immediate treatment to make it effective.

Judge Rhoades also encouraged Mary to keep looking at the young adult population for diversion, as she thought that was very palatable. She had discussed this population with DJJ before and noted that they had specific needs related to ACES—anxiety, PTSD, and substance use-disorder. They were generally not a severely mentally ill population.

Regarding the legislative approach to diversion, Judge Rhoades thought the upside was that it could include funding and it could be a way to get the public defenders and prosecutors to the table, and would be a uniform way to communicate policy calls. On the other hand, legislation was difficult to achieve, and could result in unfunded mandates. The result of previous discussions around statutory authorization for mental health courts was to instead go in the direction of MOUs. She liked the idea of a statewide therapeutic court standard that could ensure the use of evidence-

based practices and evaluations for fidelity. She thought the 2 and 3-year time periods were too long considering the standard now for the therapeutic courts was to have a shorter program. It wouldn't be helpful to have an early diversion program that was more onerous than later a later diversion opportunity like the therapeutic courts.

Judge Rhoades believed there was a way to back-bill Medicaid 30 days, and that more services would be available under the 1115 waiver. She thought that could be tied into early diversion efforts. Gennifer Moreau-Johnson said that was correct and noted that the federal authorities were looking closely at how DHSS's waiver application affected criminal justice populations.

Judge Rhoades also noted that there was an SB74-SB91- integration group at DHSS and wondered if Gennifer could give an overview of that group and the 1115 waiver application. Gennifer said she could but that anything in the application was subject to negotiations, so she would hate to promise coming services. Judge Rhoades said she would also like to hear what other needs have been identified in the integration group. Steve said he would put it on the agenda for the next meeting.

APD Jail Diversion pilot program

Norah Morse with APD gave an overview and update on APD's jail diversion program. APD initially had hoped to implement a street-level diversion program for people who would be charged with low-level nuisance/citation crimes – the things the public was complaining about. The idea was to hook these participants up with needs-based services. They worked with Partners for Progress to arrange immediate housing options and assess the participants for further needs. They had 16 officers working in two shifts on this project and had 10 initial participants, one of which was successful and is now employed.

APD quickly discovered that the real need for many of the eligible population was for detox beds. Other barriers included a need for transportation and other basic necessities, but the detox need was what stalled the program out. They are talking with the local hospitals about setting up dedicated beds for APD.

They are also looking to embed a social worker in the program and expand it to all officers on shift, and to open the program up to other crimes. With the really low-level crimes there wasn't much of an incentive to participate. They are working with Seneca Theno to see what other crimes might be suitable. Right now they are just using the municipal code offenses.

Steve asked what the detox was needed for- alcohol or drugs? Norah said it was mostly heroin/opiates. Steve also wondered what the criminal history of the participants was. Norah said they hadn't been looking too closely at that, but for trespassing typically someone would have already offended at that location to get trespassed. There also had to be some kind of criminal history for the participant to be eligible to receive services from Partners.

Judge Rhoades thought this effort was really commendable, and was an example of what CIT was supposed to be. The problem of a lack of services was not unexpected. It highlighted the need for a coordinated effort for the justice-involved population at large. All diversion and alternative resolution efforts would probably like to have dedicated detox beds. She noted that the Native Hospital used to be able to do community-based detox.

Steve added that there was also a need for detox for non-justice-involved people as well, and any detox effort would need a connection to follow-up/long-term treatment. He thought this group should track APD's efforts and help them troubleshoot where necessary.

Judge Rhoades asked if APD had looked into using Vivitrol with their program. Norah said they hadn't but were interested.

Teri Tibbet said that it was important to track the individuals in this population. She noted that she knew of one individual in Juneau whose barrier was a need for mental health counseling—someone he could call to help navigate the system to prevent him from becoming overwhelmed by the system.

Sequential Intercept Model technical assistance

Karen Cann noted that DOC planned to have their technical assistance workshop for the Sequential Intercept Model (SIM) on May 17 and 18. They had sent out many save the date memos to a variety of stakeholders across the state. The idea is that by the end of the workshop they will have a plan which will be part of the statewide recidivism reduction plan.

Steve reminded the group that at the last meeting, the group had discussed adding time onto the workshop to focus on earlier interventions. Since the last meeting he has met with Karen and Morgen Jaco as well as the technical assistance provider, and they agreed that because this group was already invited to the training, there was no need for an additional effort that might overlap with the existing effort. The workshop as is will focus on the whole SIM, and if any additional assistance was needed after that, the TA provider could follow up. Steve anticipated having a report out on the workshop at this group's next meeting, followed by a discussion of how this group could support that effort.

Committee workplan for 2018

Steve suggested developing recommendations for the 2018 report over the next three months, and asked the group for their thoughts on that timeline. Brenda agreed with that timeline. Rob did as well and thought it was important to keep the efforts of other committees in mind too. Karen thought that the group could set that timeline at the next meeting at which point they will have an idea of what ideas have come out of the SIM workshop.

Judge Rhoades thought there was still a need to discuss competency. She also wanted to loop in the reinvestment discussion. She noted this was on the agenda for the next full Commission meeting. She felt this committee was the place to keep the barometer of criminal justice reform,

and was a place to develop a strategic plan around reinvestment. She was not sure she would be at the next Commission meeting so she encouraged the other Commissioners to bring this up and suggest that this committee or another ad hoc group be formed to develop a strategic plan around reinvestment.

Barbara noted that ideally the Commission would hear this committees recommendations at the August Commission meeting so that the recommendations could make their way into the annual report. She also updated the group that at the April Commission meeting, the sentencing group would forward a proposal on release procedures for guilty but mentally ill prisoners.

Steve noted that civil commitment was also on the Public Safety Action Plan and he has been meeting with PD and OPA representatives about this. He will update this group when any decisions are made on that front.

Public Comment

There was an opportunity for public comment but none was offered.

Alaska Criminal Justice Commission
Behavioral Health Standing Committee

Meeting Summary

January 30, 2018
Alaska Mental Health Trust + Teleconference

Commissioners: Steve Williams, Stephanie Rhoades, Dean Williams, Brenda Stanfill, Sean Case

Participants: Rob Henderson, Araceli Valle, Emma Pokon, Mary Geddes, Ben Urban, Morgan Jaco, Laura Brooks, Gennifer Moreau-Johnson, Chad Holt, Teri Tibbet, Pam Cravaz,

Staff: Barbara Dunham

Announcements and Agenda

Steve Williams called the meeting to order. There was no objection to the agenda. For the summary of the last meeting, Rob Henderson noted that Emma Pokon was present. Judge Rhoades noted two typos. There was no objection to approving the summary as amended.

Overview of Current Criminal Justice Reform/Reinvestment-Related Efforts

Steve referred to the handout describing the various criminal justice reform efforts on behavioral health and noted that it was the product of last meeting's discussion. A Venn diagram proved unworkable, so he settled for a set of tables which identify four major efforts and where they overlap in terms of membership and focus. The four efforts were this group, the Public Safety Action Plan (PSAP), the Criminal Justice Working Group (CJWG) Title 12 Competency Subcommittee, and the CJWG Therapeutic Courts Subcommittee.

Judge Rhoades asked where the centralized competency calendar and the Trust's disability justice initiative would fall. Steve said that the competency calendar was hanging out between this group and the CJWG subcommittee, and the disability justice initiative's efforts were captured in each of the four groups. Judge Rhoades said it was important to be comprehensive as this document could help save time for the various members.

Teri Tibbet wondered if it should also include the Mental Health Board and Advisory Board on Alcoholism and Drug Abuse, as those groups have also identified criminal justice reform as a priority. Steve said he wanted to focus on the groups whose main focus was criminal justice reform.

DOC Updates – Diversion Planner

Dean Williams explained that Mary Geddes had been hired to be DOC's diversion planner. He would like her to look for ways to divert those who would not be suitable for drug court or mental health courts, and was envisioning a larger scale of diversion than those models. He was

interested in seeing what's done in other states and he believed there was room in the budget to take a small team on a site visit if one model looked particularly promising.

He was interested in all types of diversion, and particularly diversion for those addicted to opioids (and/or other drugs) who would not have committed a crime but for their addiction. He would like a thorough process set up to reach all potential participants, not just a piecemeal program to be done on a case-by-case basis. He was interested in giving defendants a "door 2" option as soon as possible to give them a way to reduce their charges substantially or participate in a civil process instead.

Steve said it was understandable to want to concentrate on those addicted to opioid, but thought it was also important to remember that people with mental illness – or who had mental illness co-occurring with a substance use disorder – were overrepresented in the incarcerated population and driving up bed usage at DOC. This is the population that is also challenging for community mental health treatment providers. He also thought that the diversion didn't necessarily need to be pretrial.

Judge Rhoades noted that she her entire career had focused on ways to divert those with severe mental illness from the criminal justice system. She agreed that the number of people with severe mental illness and co-occurring disorders was a big driver of the inmate population, and this group of people can be treated using less resources.

Brenda Stanfill seconded Judge Rhoades' thoughts and added that in a recent listening session the Commission had learned that opioids are often not abused alone but in conjunction with other substances, and thought it was important to address this.

Rob said it was necessary to look at the available resources, and that to his mind there were three main groups that typically come up in the diversion conversation: the low-level offenders, the opioid/substance abusers, and those with mental health problems. The diversion program should not target the low-level offenders as they do not need heavy-handed intervention. He thought focusing on the mental health population might give the most bang for the buck.

Sean Case said that to his mind, the focus should be on diverting people to alternatives as quickly as possible, before they even get to the corrections system so they can avoid the negative consequences of incarceration, and get their underlying conditions addressed. He thought it was best to take a holistic approach, as many of these issues all occur together.

Steve said that it sounded like everyone agreed that substance use disorders can often co-occur with mental health disorders, and that it was important not to lose focus on any one group. Dean agreed, and noted that people have overlapping concerns. He thought the charge for Mary was to find the easiest bite at the apple. He thought if there was anything that was simply a process issue that didn't require funding, that should be done first, and then DOC can work outward from there. His primary goal was just to get to first base.

DOC Updates – Sequential Intercept Model Technical Assistance

Steve said this led into the discussion on the Sequential Intercept Model (SIM). At the last meeting it was decided it would be helpful to revisit this group's work on the SIM in 2016 as a way to identify some low-cost process reforms. He explained that DOC had received a grant for technical assistance in this area.

Morgen Jaco explained that DOC was in the preliminary stages of planning for the grant. Right now they were looking at a 1.5 day workshop in April to look at intercepts 4 and 5, focused on Anchorage. The technical assistance (TA) would help with resource mapping, crisis intervention training, and help refocus and realign reentry efforts. It may become the foundation for another second chance grant. The workshop would be open to 50 participants (and others may listen in if they wish). Nothing was yet set in stone; they were tentatively looking at April 12 or 13, or alternatively in May.

Steve asked to clarify: would the TA help the workshop walk through the whole SIM but focus on intercepts 4 and 5? Morgen confirmed this and said the TA provider they were working with was Mathew Robbins. Steve said it sounded like the Committee could also participate in the workshop, and wondered if the Committee could reach out to the TA provider about extending the length of the workshop (perhaps with funds from the Trust) to work on the earlier intercepts with the Committee. He thought it would be helpful to have the TA provider walk through what the Committee has already done and offer any insights.

Morgen clarified that though DOC applied for the TA grant, it was intended to benefit the whole community and anyone could participate. The 50 slots in the workshop were intended for policymakers and community providers from all over. She thought DOC could work with the Committee on developing the workshop to also suit the Committee's needs.

Rob said he appreciated the opportunity to learn more about the SIM and would appreciate learning more about the earlier intercepts. He noted the Commissioners had expressed interest in moving up intervention as much as possible. The PSAP also included looking into Washington State's law enforcement diversion program.

Sean agreed and said that he had also looked into those models. The problem with implementing them was that they seemed to be getting people who aren't going to reoffend anyway—the lowest-level offenders. So the trick was to implement a program that would get those resources to the population that needs a lot of intervention, where it will have more impact.

Judge Rhoades noted that each intercept is an opportunity to remove people from the criminal justice system to community resources. The earlier that happens, the less expensive the programming will be. The first intercept is the best place to do this, because the second intercept involves more players – DAs, PDs, DOC, the courts, etc. This is why it is important to use the SIM to focus resources and use this Committee to find commitments at each intercept from the various system participants.

Steve said he though everyone was in favor of walking through the SIM—the question is whether they wanted to take the option to tag onto DOC's TA effort or work independently. Judge

Rhoades moved to leverage Trust funding to get DOC's TA provider to assist the Committee in looking at intercepts 1-3 in particular. Sean seconded the motion. The Commissioners present unanimously agreed, and the motion passed. Steve said he would work with Morgen to implement this idea. Judge Rhoades asked to be involved as well.

Alaska SUD Prevention and Treatment Overview

Steve said that he had collected several documents from DHSS that explain the various levels of treatment, how treatment is funded, and what programs exist where in Alaska. The latter was shown in a series of maps; Steve noted that these maps revealed that most of the state has adequate capacity for the lower levels of care, but this capacity diminishes as the intensity of care increases.

Arrest and Intoxication Update

Steve said that also tied into the next agenda item, the Commission's efforts on the arrested/intoxicated population. This had been the subject of a separate subcommittee chaired by Sean Case, but they had agreed to fold that group into this one.

Sean explained that this topic concerned the population of people who are not intoxicated enough for Title 47 but are nonetheless too intoxicated to be safely released once arrested. SB 54's bail fix helped with this somewhat, but that measure was just a band-aid; once this population is assessed and released, there is no help for them. There needed to be a step between jail and the street, and a way to start addressing the arrestee's underlying issues.

Rob summarized: they were talking about people who are not so highly intoxicated as to be Title 47 holds, but are intoxicated, have been cited, and need a place to go. Sean confirmed this. They are going to DOC now, per the new bail schedule, but jail is really not the right place for them.

Steve noted that Barbara had spoken with a representative at the Anchorage Safety Center (ASC), and had found that ASC's population was not the same as the arrested/intoxicated population. ASC took Title 47 holds. This other population is comprised of people who have been contacted and should not be left alone; there needed to be a way to get that population into services.

Rob asked how this related to the population in intercept 1. Sean said there was a good deal of overlap; the two populations may end up using the same road map.

Judge Rhoades asked what the effect was of the new bail schedule after SB 54. Sean said that if they arrest someone who is normally an OR release, but has a BRAC of more than .08 they can take them to jail. It is a band-aid, not a permanent solution. Rob agreed.

Laura Brooks explained they have instituted a process for this population as follows: they BRAC these offenders upon remand, then continue to monitor their BRAC until they reach a .08. Those under at Title 47 hold are not included in the new bail schedule provision. This is a problem because Title 47 only allows a 12-hour hold and there is no way to hold those brought in under Title 47 past the 12 hour mark, even if they are still above a .08.

Prioritizing Tasks and Meeting Dates

Steve noted that the Commission's chair had asked each subcommittee to identify their priorities for the year and their meeting schedule. For priorities, he suggested:

- Secure technical assistance to walk through the Sequential Intercept Model to focus on intercepts 0-3, identifying solutions for Alaska,
- Work with Mary/ DOC on diversion coordinating, and
- Arrest + Intoxication population: solutions for early intervention with this population.

He also noted that the group had previously talked about legal competency capacity issues and revisiting the UNLV report recommendations in light of new developments post-SB 91.

Judge Rhoades said she thought the group had agreed last time not to work on the UNLV report as a whole package but to use it as a resource to consult in walking through the SIM. She also noted that Karen Forrest had said DHSS could work on implementing the standardized Release Of Information and thought that should be kept on the group's radar. She also recalled the Commission had been talking about treatment capacity and thought that would come up as the group walked through the SIM. Steve agreed.

As to timing, Steve wondered if it would be beneficial to meet before the TA provider arrived. Dean Williams said it would be nice to find some low-hanging fruit on the diversion front sooner rather than later. Rob suggested getting an overview from Mary on diversion options at some point before the TA process. Steve agreed and said he would schedule a meeting accordingly once the TA piece was scheduled.

Public Comment

There was an opportunity for public comment but none was offered.

Alaska Criminal Justice Commission
Behavioral Health Standing Committee

Meeting Summary

December 15, 2017
Alaska Mental Health Trust + Teleconference

Commissioners: Steve Williams, Valerie Davidson, Walt Monegan, Stephanie Rhoades

Participants: Karen Forrest, Randall Burns, Rob Henderson, Araceli Valle, Emma Pokon

Staff: Barbara Dunham

Announcements and Agenda

Steve Williams called the meeting to order. Judge Rhoades suggested amending the agenda to include a discussion on barriers to accessing behavioral health treatment. There was no objection to the agenda so amended. Judge Rhoades moved to approve the previous meeting's summary and Rob Henderson seconded the motion. There was no objection.

UNLV Report and Public Safety Action Plan

Randall Burns said that the list of DHSS's reactions to the UNLV report submitted to the Commission in August still represented DHSS's position on the report's recommendations; he thought it was up to the Commission whether it wanted to do anything with the list.

Steve recalled from the August meeting that the Commission had expressed interest in getting a fuller briefing on the UNLV recommendations. Specifically he thought the Commission had wanted the standing committee to look through the "green arrow" recommendations for possible consensus, and to look at what DHSS was doing with the 1115 Medicaid waiver and whether that dovetailed with any of the UNLV recommendations. Barbara Dunham added that the Commission had seemed interested in getting a more holistic package rather than looking at the recommendations and peeling them off one at a time.

Rob said that his impression was also that it would be difficult to reach a broad consensus. Steve said further to that, there was also an issue of pulling intertwined threads; often changing one provision affects many statutes. The discussion would need to include whether there are large chunks that can be broken off. He added that at the last meeting in June, the group had discussed hearing from the UNLV reporters themselves to get everyone caught up on what's in the report.

Judge Rhoades said that a lot of time had passed since the report came out. She didn't think that there was any consensus on recommending the whole report and she thought that piecemeal-ing the recommendations was problematic. She suggested it might be better to look at the impetus for the report itself—whether the problems identified in the report were still problems. For example, the wait for competency evaluations for misdemeanants was identified as a big problem, but SB 91 shortened jail time for many misdemeanors so perhaps it is not as much of a problem.

In short, she suggested going back to the drawing board and identifying any underlying issues and whether there was enough will to tackle them. Randall and Steve agreed.

Steve noted there were also a lot of overlapping efforts in this area; the Public Safety Action Plan (PSAP), for example, called for timely competency hearings. This subcommittee walked through a lot of what is in the PSAP when it went through the sequential intercept model in 2016. He wanted to make sure that the committee was not going to be duplicating efforts and creating excessive meetings.

Rob said that the PSAP was about identifying actionable steps—some involve large policy discussions but it was largely a list of nuts and bolts. The Plan does not discuss civil commitment, for example. The vision for the PSAP was that it would work in partnership with this group and others. He agreed that it was not likely the group would find consensus on the UNLV report as it had been discussed for several years now.

Val Davidson said she thought it would be helpful to have a Venn diagram of what different groups in Alaska were working on which problems. Steve said that he had done something like that before and could develop one again to help identify where the state's efforts are going and where the gaps are. Commissioner Davidson suggested then following up with who will take the lead with each effort. Judge Rhoades agreed—it was hard to track the different efforts on this front and it would be good to see what progress has happened where.

Walt Monegan noted that most of the members of the Criminal Justice Working Group were also members of the Commission but the CJWG was really the forum to get into the weeds about implementation.

Karen Forrest said she agreed, and thought that this group was for high-level policy decisions. This group can always look to the UNLV report for guidance. For some action items in identified in the PSAP, it would be good to have broad support for their implementation and this group could also be a forum for that.

Committee Process

Steve said that the above discussion also touched on another agenda item which was to discuss this group's process. One thing the Commission struggles with is how to put policies into effect. This group has toggled between policy and programming; for example, the group was going to help guide DOC's jail diversion planner (who had not yet been hired). The question was how far to get into the weeds to see that the policies coming out of this group were implemented.

Judge Rhoades said she thought it was best to go back to the original mission of the group, which was to address the overrepresentation of individuals with behavioral health needs in the criminal justice system. To this end she thought the group should go back to the sequential intercept model that the group had gone through last year and identify what can be changed in law and what can be changed in process. The latter can be done without going back to the full Commission. She thought this group was capable of achieving changes on its own. She suggested asking each agency to identify its priorities.

Rob said he had looked at the list of current recommendations on the agenda and wondered what more the group could do now that the recommendations had been made to the legislature. Steve said the question was how much the group wanted to shepherd those recommendations through to make sure they are implemented. There are enough agency representatives in this group to make sure that can happen.

Judge Rhoades said the release of information (ROI) issue is an example of a topic that is more in the weeds but ultimately will get people through the system quicker. It was a legislative recommendation but didn't necessarily need to go through the legislature first, as it could be driven by DHSS action. The same would be true of other issues—things this group could do that don't necessarily result in a Commission recommendation.

Existing Recommendations

Commissioner Davidson asked what the status was of the existing recommendations. Steve suggested going through each of them.

The first was the jail diversion recommendation for behavioral health populations in DOC custody. No one from DOC was at the meeting, so the group was not sure whether a coordinator had been hired. Rob asked if the group could get an update from DOC at the next meeting as this was one of the recommendations he was most interested in. Steve said he would try to make sure they were at the next meeting and noted that the Commission had approved restructured funding for that position at the last meeting. Barbara said that she thought that the funding period had been extended by that vote but she wasn't sure, and would check.

The next was the recommendation to amend the bail statute to allow a resident of a group home to return to that home on bail for a DV assault. Steve explained this needed legislative action and no legislator had yet picked it up. Judge Rhoades said this begged the question of what the Commission will do to promote its recommendations. She didn't think this group could do anything on this. Steve said this group could remind the full Commission this recommendation exists. Judge Rhoades agreed and said that the report to the full Commission could include a summary of recommendations that have yet to be acted on. Steve said this fits in with what the chair had called for at the last meeting, and could be a part of each workgroup's report.

The next recommendation was regarding the standardized ROI. The recommendation was for a statutory change but this group had been working on developing one. Randall Burns said there was nothing new on the ROI—he needed to follow up with the AG he was working with. Steve said DHSS could adopt the ROI without a legislative change, and if the ROI seems to be working, the legislature could put it in statute. Karen Forrest agreed, saying that as DHSS implements the 1115 waiver, it will bring in the Administrative Services Organization that could incorporate a new ROI—it would be just the kind of thing to bring on line at the same time. The 1115 waiver process will take the rest of the year but the ROI can be included. Steve said he would keep this item on the agenda as a check-in.

The next existing recommendation was to add existing behavioral health information to presentence reports (PSRs). Steve said he thought this would require both a statute and court rule

change, and no action had been taken on it. Rob wondered whether this idea had legs; he thought it was important, and suggested making a recommendation to the Supreme Court too if it involved a court rule. Barbara agreed to look into what the Supreme Court could do on its own with a rule change. She noted that the all the outstanding recommendations had been highlighted in the annual report to the legislature. Rob wondered if the Commission should prioritize the outstanding recommendations in its communications to the legislature. Barbara said she would bring this idea up with the chair. Judge Rhoades said that the PD had disagreed with this on so it might not be worth the time pursuing.

The next recommendation was to include the DHSS Commissioner on the Criminal Justice Commission—this was included in the bill that just passed, though the Commissioner was made a nonvoting member.

The final recommendation was to have DHSS take a further look at the UNLV report. DHSS had done so, having given its preliminary thoughts in August. The group agreed, per the discussion above, that as so much had happened since the report came out, the group would not review the report as a package. The group will identify any relevant current policy issues discussed in the report but not try to move the report's recommendations as a bloc.

Barriers to Accessing Behavioral Health Treatment

Judge Rhoades said she would like the group to look at why the behavioral health population was overrepresented in the criminal justice system and suggested going through the sequential intercept model to identify the behavioral health issues that need to be addressed at each intercept. The group should look closer at who should be in treatment and who should be in DOC custody. There were more barriers to accessing treatment than just a lack of capacity. She thought each agency should identify the most pressing issues at each intercept.

Steve noted that DOC just got a grant to look at diversion, reentry and supervision in terms of the sequential intercept model, but he was not sure of the details. This was another thing to check in with DOC about, and it would be good to know if DOC wanted to involve stakeholders on that project.

Judge Rhoades said that the Commission keeps discussing the treatment side of reform, especially in the context of reinvestment, which she thought should be planned and targeted. It was great that DOC was doing a lot of work in this area but she thought it would be good to coordinate efforts and get a strategic plan.

Next Steps

Steve encouraged everyone in the group to follow the link on the agenda to DHSS's 1115 waiver application and read through the application, as it provided a good snapshot of what the issues are and why the Department is going in that direction. Commissioner Davidson added that the public comment period for the waiver closes on December 29. The emphasis in the application is on community care, early intervention, and behavioral health system accountability (expectations, benchmarks, evidence-based care).

Commissioner Davidson said, that there were many paths to treatment – for example there are more medications for medication-assisted-treatment than just Vivitrol. MAT should not focus on just one brand as there is no evidence to limit it to just one medication and treatments will work for some people but not others. The importation issue [importing contraband into prison] is significant for suboxone but that doesn't mean it should never be used. There are many ways to look at a problem. She agreed there was a need to develop a strategic plan.

Steve said he would get an update from DOC and try to make sure someone from DOC attended the next meeting. He will work with Judge Rhoades on the sequential intercept model and the comprehensive recommendations and get something out to the group so each agency can identify what their concerns are. He will send a Doodle poll to schedule the next meeting so the group can meet again before the next Commission meeting [February 6].

Public Comment

There was an opportunity for public comment but none was offered.

Alaska Criminal Justice Commission
Behavioral Health Standing Committee

Meeting Summary

June 26, 2017
Alaska Mental Health Trust + Teleconference

Commissioners: Steve Williams, Walt Monegan, Greg Razo, Stephanie Rhoades, Brenda Stanfill, Dean Williams

Participants: Rick Allen, Laura Baez, Kristy Becker, Randall Burns, Karen Cann, Pam Cravez, Rob Henderson, Gennifer Moreau-Johnson

Staff: Susanne DiPietro, Barbara Dunham

Announcements and Agenda

Steve Williams called the meeting to order. Greg Razo moved to approve the agenda and Dean Williams seconded the motion. The motion passed unanimously. Judge Rhoades moved to approve the previous meeting's minutes and Greg Razo seconded the motion. Steve Williams suggested amending the summary to add Rick Allen's name to those working on the questionnaire, and to clarify that Brenda was referring to reinvestment grantees on page 5. There was no objection to approving the summary so amended.

Jail Diversion for Behavioral Health Populations

Dean Williams said that the diversion position was approved by the legislature and anticipated being able to hire someone soon. Rob Henderson asked if there was a target date to have someone start. Dean said there was not but he expected to move quickly once the grant money comes in; he would let the committee know.

Steve Williams explained that there were only three responses from committee members to the questionnaire that was sent out. Dean said he appreciated the good work that Judge Rhoades, Karen Cann, and Rick Allen had done on the questionnaire but he wanted to take a step back before setting up parameters that might prove to be too limiting in hindsight. He wanted to approach the topic with an open mind. He thought everyone could agree to start from the concept that there are people in custody who are being made worse by being in custody, and that is the impetus for diversion.

Dean explained that while it would be good to give the new planner/coordinator on information gathered by the group, he didn't want the coordinator to begin from preconceived notions of what diversion should look like. He gave an example from creating a juvenile expulsion school—the biggest limitation to implementing the program was the preconceived ideas that people had about the participants—that they were too "troubled."

Steve asked Judge Rhoades, Rick, and Karen what their process was in creating the questionnaire. His understanding was that it was meant to ask questions, not necessarily answer them.

Judge Rhoades said they began by going to the national evidence base, and looking at problem statements from national programs to see whether they applied locally. They wanted to differentiate jail diversion from other diversion programs. The purpose was not to limit the approach but to address any preconceived ideas of what people *don't* want, so that the coordinator would know what barriers there might be and how to work with them.

Greg Razo asked whether there were clinicians to consult that were experts in diversion. Judge Rhoades said that there were many examples of diversionary practices already happening in Alaska, from the formal mental health courts to law enforcement officers making a decision not to arrest. Diversion can happen within many different agencies and at different intercept points. Because diversion can be such a broad concept, she thought there was a need to get a good sense of the type that the group was looking at – a jail-based program.

Dean said that everyone seemed to be in the same book but on different pages. He knew there were law enforcement chiefs who would like permission to divert known repeat offenders to alternative programs, so the diversion program wouldn't necessarily have to be located within DOC.

Judge Rhoades noted that many law enforcement officers in the state have gone through crisis intervention training but there was still a need for service providers to bring people to. She had thought that the diversion coordinator was going to plan a jail diversion program; she also thought that the pretrial services program would be a good venue to swiftly identify people who would be suitable for diversion. She didn't think anything was off the table but thought pre-trial was a good place to start.

Steve Williams agreed there was a wide continuum of opportunities for diversion but not necessarily the resources to divert people at every point. He thought pretrial and post-incarceration—people who have no advocate—was a place to start.

Randall Burns asked if there was any talk about a pilot program or how DOC was going to roll out the diversion program. Dean said he would prefer a pilot program to see if the program works. He agreed with Judge Rhoades that pretrial is the area where people have energy right now.

Randall wondered whether there was anything in statute that would keep pretrial defendants in the community. Susanne DiPietro noted that most would stay in the community as long as they can show up for court and not commit new criminal activity. Judge Rhoades pointed out that any pretrial diversion program must be voluntary, and that people would not want to sign up for diversion if it meant being sent somewhere else.

Walt Monegan confirmed that DPS did just do a crisis intervention training in the Valley and they would like to take it statewide. He agreed the problem is finding caregivers and alternative

places for people to go. DPS will continue to do crisis intervention training regardless of what happens with the diversion program. Greg said that was gratifying to hear, and asked if the future trainings will include VPSOs. Walt said that the training in the Valley did include medics and first responders so that would be appropriate.

Steve asked how the group wanted to proceed. Rob Henderson suggested getting more ground level: identify a pilot location, assess what resources are available there and see what the Commission can do to close service gaps. From the Department of Law's perspective, he couldn't answer any questions about a defendant's legal eligibility until he knew more about the resources—i.e. whether there were resources available for defendants who are high risk or have a particular treatment need.

Dean said he was focused on diverting the offenders who were using the most resources, meaning he didn't necessarily want to exclude violent offenders. Rob agreed.

Susanne noted that service providers have been expressing discomfort about criminal justice-involved individuals overwhelming resources, and this added a dimension to the capacity issue. Dean said there has been movement in terms the tribes and federal grants that might help develop capacity.

Judge Rhoades suggested looking at need first, then corralling the resources to address the need. She suggested getting numbers from DOC—talking to prison providers about where individuals with behavioral health needs are and what services they would need in the community. That might also help develop identify a pilot program location.

Dean asked how to identify the individuals to count. Judge Rhoades suggested going back to the questionnaire, and identify the clinical issue to tackle. Greg said that since it was known that there were not enough resources for everyone, the question is then what level of severe mental illness (SMI) or substance use disorder (SUD) justifies diversion. Judge Rhoades said that SMI is the most costly—those individuals that are using the beds in Mike Mod, for example.

Greg suggested talking to the clinicians in Mike Mod to get a sense of the population and risk level they present. Judge Rhoades said that those clinicians don't do LSI-Rs and that population might not necessarily be high risk. The clinicians will know the medical and clinical needs for obvious SMI individuals, but it would be difficult to identify individuals with more moderate mental illness and SUD, especially pretrial. She suggested figuring out who is costing the most, what they need, and what their risk factors are.

Rob said if the group can identify the resources needed, that will give a better sense of the legal eligibility picture. He suggested giving information on what services a defendant needs to the DA—they typically don't get LSI-R type data. Judge Rhoades suggested that some programs might divert early enough not to involve the DA.

Randall Burns said the resource issue was important. It would be impossible to reorganize the whole state—providers would be overwhelmed. That is why a pilot program would be

important. Teri Tibbet said that one concern from providers is being able to get assessments done—this is currently very difficult.

Steve said he thought a one-month snapshot from DOC will help start to paint the picture of the target population and will help guide the diversion planner. Judge Rhoades suggested giving the questionnaire to the planner, who could then give it out to stakeholders. Gennifer Moreau-Johnson suggested including people with intellectual/developmental disabilities in the snapshot. Teri suggested also including those with cognitive impairments such as dementia, TBI, and FASD. Steve noted that the latter was a historically difficult group to identify.

It was suggested that the group consult with clinicians on this. Laura Baez asked whether the clinicians from the SAMSHA grants were still around. Judge Rhoades said there was one, and the other moved on. Dr. Becker noted there was a small number of clinicians in the state who have the training for this kind of screening—ideally someone doctorally trained in forensic/criminal psychology. Teri suggested contacting Tom Chard of the Alaska BHA as he is in touch with providers.

Standardized Release of Information

Steve Williams noted that Randall Burns had provided an example of a potential universal Release of Information (ROI) to the group. Randall said it was a template that is one page (plus instructions) and is all that is required to meet HIPAA. The AG's office is looking into whether potential changes to 42 CFR might affect this however. Susanne DiPietro asked whether this template worked. Dr. Becker said that it did but the question is whether it can be sent to others. Judge Rhoades explained that this was an issue originally raised by Alysa Wooden because of issues in reentry—each provider was requiring a different ROI. Karen Cann noted that DOC now has one form for reentry efforts.

Judge Rhoades asked whether the Commission should recommend that this ROI be required by statute. Susanne suggested looking at the recent statute regarding a standardized power of attorney (that would have to be accepted by all banks) as an example. Dean Williams asked whether it could be just adopted by regulation. Judge Rhoades thought it might need to be a statute—not all providers might accept it and they are wary of being sued.

Susanne suggested putting out feelers to stakeholders to see if they would accept it – e.g., Medicaid grantees. Rob Henderson suggested asking local health care lawyers. Randall noted there had previously been a group formed to address the needs of 100 "high untilizers" of state services in Anchorage—and that group gave up because they couldn't agree on an ROI. He agreed to reach out to the former members to get more information. Susanne also suggested making acceptance and use of the ROI a condition of being a grantee.

Randall said he would check in with the grantees and get a problem statement as to the difficulties the disbanded task force had. Walt Monegan suggested talking to other states. Steve and Randall will confer on this.

Greg said that if it was an issue of building support for the existing Commission recommendation, AFN might be able to throw some support behind this and other recommendations.

UNLV Report

Steve Williams explained that Barbara Dunham had provided the group with a summary of the recommendations in the UNLV report that had not met with any opposition when last year's behavioral health workgroup went through it. Randall said that if the group could agree on which of these to focus on, he could get a fiscal analysis for the next meeting.

[Below is a summary of the consensus recommendations, followed by the Committee's discussion.]

Forensic examiners

- Amend wording of AS 12.47.070 ("Psychiatric examination") to read "if there is reason to doubt the defendant's competence to proceed under AS 12.47.100."
- Amend Titles 12 and 47 to require neutral evaluators for forensic evaluations.
- Amend Titles 12 and 47 to require qualified forensic evaluators with term "qualified" defined as licensed psychiatrist or licensed psychologist who is trained or certified in forensic examination.
- Amend Titles 12 and 47 to require only one forensic evaluator.
- DBH should coordinate continuing education in forensic evaluations for psychiatrists and psychologists in the state.
- Amend Titles 12 and 47 to require DHSS to designate qualified and neutral evaluators.

Greg Razo said he thought these made sense. Randall said he was not sure about neutral evaluators but that defining forensic evaluators and moving to one evaluator would be okay. Dr. Becker said there was a debate about the neutral evaluators. Evaluations should be unbiased, and some jurisdictions presume that state evaluators are neutral – for example the federal system does this. The problem in Alaska comes down to having only 2.5 evaluators plus an intern. She said that in an ideal world, the evaluators would only do evaluations (instead of both evaluating and treating). This is how it is done in Washington. Randall said that to accomplish that here, the court system would have to hire evaluators. He noted that DHSS and DOC were talking about creating a forensic hospital.

Judge Rhoades said that the small workforce for forensic psychology was a problem. With the volume increasing, it wasn't healthy to have so few trained professionals—there was a professional vacuum. Dr. Becker agreed, there was a professional vacuum; there were far fewer qualified evaluators per capita than other states. Also, for a state to require a board-certified psychologist, such as Alaska does, is rare—and there are none in Alaska. Other states just require someone qualified.

Steve asked whether the Committee could agree on the other recommendations. Rob suggested compromising by requiring a neutral evaluator only if one was funded. He recalled this had been an issue in the past. Dr. Becker said that made sense and would continue the conversation on neutrality.

Greg moved to bring the above recommendations, amended as suggested by Rob, to the full Commission. Rick Allen seconded the motion. There was no objection. Randall agreed to draft the problem statement to bring to the next Commission meeting.

Competency

There was no consensus on the UNLV report's recommendations on competency in last year's workgroup. Judge Rhoades asked why this was; Barbara could not remember specifically but said she would send the meeting notes to Judge Rhoades.

Civil commitment

The group discussed the civil commitment recommendations, and whether there could be anything done about committing people who cannot be treated. Randall said that the question for a lot of the recommendations is what it would mean practically. He didn't disagree with a lot of the report in theory. Judge Rhoades said she thought it was important to address.

Further information and next steps

Steve thought that the group seemed to be thrashing a bit at that point. He noted that not everyone in this Committee had been in last year's workgroup or participated in the UNLV process. He noted that the UNLV report was comprehensive and aside from the forensic examiners recommendations, were more nuanced and difficult to understand.

Dean asked whether there was any particular timeframe to make a decision on these. Steve said there was not and it could be done over time. Dean said he would like to add Title 47/sobriety holds to the agenda—the laws were written 30 years ago. Bringing intoxicated persons into the DOC system is a real problem.

Steve asked if the group should continue going over points where consensus had previously been reached, or if the group should stop here and pause to get everyone up to speed on the UNLV report. He recommended either having everyone familiarize themselves with the report or having the authors come explain it, and then resuming the discussion.

Rob asked to centralize the information out there- he knew that the various departments wrote memos on the report, but had not read them.

Dean asked what the focus of this group is regarding the report. Steve said that the purpose is to address in statute areas where mentally ill individuals are languishing in the system or taking repeated trips through state facilities, or where there are gaps in services. Judge Rhoades said the issue was there were people waiting around to have their basic rights addressed.

Steve said he would contact the UNLV folks to get them to do an overview; meanwhile, the committee will still move forward with the forensic evaluators piece.

Steve also said he would add items suggested by Laura Baez and Rick Allen to the agenda.

Public Comment

There was an opportunity for public comment but none was offered.

Next meeting

The next meeting was scheduled for July 20 from 9-11.

Alaska Criminal Justice Commission
Behavioral Health Standing Committee

May 18, 2017
Alaska Mental Health Trust
Meeting Summary

Commissioners: Steve Williams, Stephanie Rhoades, Brenda Stanfill, Dean Williams

Participants: Rick Allen, Pam Cravez, Kristy Becker, Karen Cann, Randall Burns, John Skidmore, Gennifer Moreau-Johnson

Staff: Barbara Dunham

- **Announcements and Agenda**

Steve Williams called the meeting to order and informed the group that he was the new Criminal Justice Commission designee for the Trust, and also the chair of this standing committee. Steve also introduced Gennifer Moreau-Johnson, the new Behavioral Health Policy Advisor, replacing Diane Casto. The BH Policy Advisor serves as a lynchpin between the state's reentry, Medicaid, and corrections efforts in the area of behavioral health.

John Skidmore moved to approve the agenda and the previous meeting's minutes. Dean Williams seconded both motions, and they passed unanimously.

- **Identification of Committee Priorities**

Steve Williams said that he had looked back at previous meeting minutes and consulted with Susanne DiPietro about Commission timing. The Committee needs to forward recommendations to the Commission by the end of August to have them included in the Annual Report. Barbara Dunham explained that any recommendations would have to be approved at the Commission's August meeting so they could be incorporated into a draft of the annual report to be approved at the October meeting. Barbara said that was the timeline for inclusion in the annual report. The Committee can forward recommendations to the Commission at any time, and the Commission can forward recommendations to the legislature at any time. But the legislature is more likely to pay attention to recommendations in the annual report.

a.) UNLV Report

Randall Burns said that DHSS's fiscal analysis of the UNLV report may not be finished by August. Steve wondered whether DHSS could prioritize the recommendations so that some of it could be completed; for example, focusing on the recommendations regarding forensic examiners. Randall noted that DHSS had tried to propose changes to the forensic examination process before but the governor had turned them down; it might help to have the ACJC behind another attempt.

John Skidmore noted that several recommendations in the UNLV report had the unanimous consent of the Behavioral Health Working Group (the previous iteration of this group). He suggested that DHSS could concentrate on those recommendations. Randall agreed it would help to narrow the focus of the fiscal analysis.

Dean Williams asked which recommendations had been unanimously supported. Randall noted that the forensic evaluator was one; under the current statute there are only so many people able to perform a competency evaluation in Alaska. Dr. Kristy Becker added that Alaska law requires a forensic examiner to be "board certified" in forensic psychology, but there is no one with that qualification working in Alaska. At API they have to routinely respond to court orders saying they technically can't comply with the request because of this rule and have to get leave from the court to do the evaluation—this all takes time. No other state requires a "board certified" forensic psychologist. It is also unnecessary to have two forensic examiners complete the evaluation, as is the requirement under the law in Alaska.

John said that another consensus recommendation was to automatically refer a defendant to civil commitment proceedings if the defendant is found incompetent to stand trial; another was a proposal for involuntary outpatient commitment with an enforcement mechanism of some kind. Randall said he was not opposed to the latter, but he thought that it might not help achieve anything.

Steve proposed identifying the consensus recommendations and using that to make a list of priorities to forward to the Commission.

b.) Jail Diversion

Dean Williams informed the group that DOC was on track to get legislative approval for the pretrial diversion coordinator position. The key is to keep the ball rolling on this project. Pretrial diversion has been discussed in Alaska for a long time; now is the time to hammer out the details, hence the need for a coordinator. The grant money may include funds for field trips to see how other jurisdictions achieve pretrial diversion. He envisioned diversion as a program for both those with serious behavioral health issues as well as addicts. He believed the expertise on this committee could help guide the coordinator.

Rick Allen asked whether Dean had a candidate. He said he didn't although some people came to mind. He thought it might be an ideal project for someone who is retired. He was looking either for someone with a good deal of expertise in the field, or a generalist with a track record of getting big projects done. Judge Rhoades opined that it would be good to get someone who has a good understanding of criminal justice in Alaska.

Steve Williams suggested that the next steps might be to pencil out the scope of work for the coordinator, including timelines and a target population. Brenda Stanfill noted that the UAF Justice Center had been doing similar work focused just on Fairbanks. They ran into pushback on that and the project has stalled, but it might be good to check in with them. Steve said the coordinator would also need to know what data and resources are available – this committee could

get that lined up. Judge Rhoades said that the pre-trial services workgroup, which had met in 2014-2015, had done some of this work too.

Judge Rhoades also suggested that the committee put together a general conceptual agreement. The committee could start by having each agency list their target populations. Dean said that the committee should try to challenge itself on such criteria, to make room to contemplate things that haven't been contemplated before. Part of the learning curve will be to take in what works elsewhere and what the data show is effective. He wanted to keep his mind wide open, perhaps thinking beyond just psychological disorders and drug use. Judge Rhoades added that it might be a good idea though to know what is palatable to the various stakeholders and make sure that is on the table.

Randall Burns asked whether DOC was thinking of going all in from the beginning or starting small. Dean said they were thinking of going all in. He has spoken with the Department of Law about this and thought it was a good opportunity to link up with the justice reinvestment effort. DOC is not going to be getting any more funding, and needs to be very strategic about who it is putting in a cell.

Judge Rhoades said there was also a need to talk about behavioral health treatment capacity to get to a place where Alaska can guarantee treatment on demand. Dean agreed, and said there was also a need to align treatment offerings with demand. For example he met a sex offender in Kodiak who had a job and a stable life in Kodiak, but had to go complete sex offender treatment in Anchorage. Looking at capacity might also involve reexamining assumptions about treatment.

On that note, Randall said that the Medicaid waiver should help, but that largely relies on the Medicaid expansion, so it will be a bit nerve-wracking to see what happens in the US Senate.

Steve pointed out that increased treatment capacity did not necessarily mean residential treatment, but increased outpatient treatment would also likely require increased housing options.

John Skidmore said that the Dept. of Law was very interested in pre-trial diversion and also looking at successful models from other jurisdictions. The parameters of Alaska's program might be guided by the example of other models. Dean noted that he was taking a delegation to Norway in September to see how their prison system worked.

Regarding housing, Dean said that it was easier to put people on electronic monitoring rather than furlough, so it would be good to rethink housing models that are smaller and more community-based, where offenders and still "do time."

Judge Rhoades noted that people decry having DOC as the largest mental health provider in the state, yet commend DOC for its treatment programs. Mental health treatment is provided in DOC because it is the default and there are no other options.

It was decided that Judge Rhoades would work with Karen Cann and Rick Allen on drafting a questionnaire to send out to Committee members in order to develop a definition of diversion

and get a sense of some of the basic parameters of the diversion program. Elements such as the target population and data required might come later.

c.) Universal Release of Information

Randall Burns said that DHSS can work with the legal team in the AG's office to draft an ROI. It could be made part of a regulation but if providers are willing to use it they might just distribute it and encourage all providers to move to the new forms.

- **Other Committee Recommendations to the Commission**

Steve Williams asked what other topics the Committee would like to take up to forward to the Commission; he noted that Dean Williams had identified some statutory roadblocks for DOC. Dean replied that he had, though he needed to crystalize his thoughts a bit more. There are limitations on furloughs that were created in a different era. DOC is trying to move away from the 100-bed Geo models for halfway houses. He thought DOC could instead use that money for outpatient-type models with a different security model. Karen Cann suggested creating a working group to identify these roadblocks.

Judge Rhoades suggested another potential recommendation could be to assess the progress of reinvestment and identify further needs for reinvestment. Steve asked what this would look like, whether the Committee would invite reports from stakeholders, target certain areas, or report to the Commission. Judge Rhoades said she thought the Committee should get more details on needs, and can filter anything requiring a statutory fix up to the Commission.

Randall Burns cautioned that it was not possible to get all offenders with behavioral health problems out of DOC custody. There is talk about community-based funding for behavioral health as the ideal but DHSS tried this in the past and it didn't work. Some people are going to end up in DOC custody and it is the state's responsibility to get those people treatment. The system must work in harmony to serve those in custody and those who aren't. It won't be perfect, but the Committee needs to be realistic.

Steve asked whether the group could agree to start from a few general principles:

- That there are too many people in DOC facilities with mental health and substance abuse issues who should be treated out of custody.
- That the community-based behavioral health system was inadequately funded to address the need.
- That there are some people with mental health or substance use disorders who are appropriately in custody.
- That resources should be used to get the number of people who are *in*appropriately in DOC custody out to the extent possible.

There was general assent. Gennifer Moreau-Johnson added that, regarding the community-based treatment, the problem was also that the system was fragmented as well as underfunded.

John Skidmore said that he agreed with the above, and that not everyone should be automatically diverted. He thought there should first be a discussion about who needs to be where, and then a discussion about resources. Rick Allen agreed and noted that politics will have to come into it—some things just won't be palatable to the general public.

Dean noted that at the same time, there are plenty of areas that are not controversial. Judge Rhoades suggested revisiting the sequential intercept model as some of the problem is in talking about different intercepts which require different responses. In many cases it is clear how to deal with offenders and improve current practices.

Rick suggested taking a look at the Public Guardian system. There is a problem with the private Assisted Living Facilities (ALFs) – they won't take some public wards who have been incarcerated, and Alaska is having to pay to send these wards out of state to facilities that can handle them (residential psychiatric centers). He noted a recent case of a ward who is a sex offender, who had to be sent to a facility in Idaho. Dr. Becker added that the person had spent 18 months at API before going to Idaho. There are a number of people like him who are not competent to stand trial and can't be let out of API, because there is nowhere else in Alaska for them to go.

Randall noted that in some cases the state is having to pay the private ALFs four times the going rate. Rick added that there is a place for private ALFs, but they are not appropriate for people with very serious behavioral health needs. Judge Rhoades added that with an aging population, there will be more offenders with dementia who will present similar problems. She suggested that the Committee should make recommendations based on need and that funding was not the Committee's responsibility.

Randall added that DHSS was working to get everyone on the same page with the Medicaid waiver—for example Medicaid coverage for those in halfway houses. Judge Rhoades noted that even with the waiver, some private providers may be blocked—for example there is a requirement that there be someone on staff at a facility who can write prescriptions. Randall thought it might be an issue of record-keeping—the regulations are in place to ensure that providers are up to snuff. Steve noted that in addition to a funding problem there is also a workforce problem.

- **Data and knowledge-gathering**

Steve Williams suggested the Committee expand its knowledge base by getting an environmental scan of sorts, to survey the field. Judge Rhoades suggested hearing a quick update from Partners for Progress, and the Reentry Coalitions. She also suggested getting an office like the Alcohol Safety Action Program (ASAP) to poll providers about needs and gaps in coverage (e.g., how many can bill Medicaid?) Brenda Stanfill suggested requesting information from reinvestment grantees.

Steve suggested that each group member come up with three topics related to the work of the Committee they would like to know more about.

- **Public Comment**

There was an opportunity for public comment but none was offered.

- **Summary and Next meetings**

Actions to take before the next meeting:

- Steve Williams and Barbara Dunham will identify the consensus recommendations from the UNLV report.
- Randall Burns will report out on the status of getting a universal ROI drafted.
- Judge Rhoades, Rick Allen and Karen Cann will work on a questionnaire to send out to group members about pretrial diversion.
- Each group member will identify three topics about which they would like more data or information.

Next meetings:

- Monday, June 26 from 9:00-12:00
- Thursday, July 20 from 9:00-11:00

Alaska Criminal Justice Commission
Behavioral Health Standing Committee

March 9, 2017
Alaska Mental Health Trust
Meeting Summary

Commissioners: Jeff Jessee, Stephanie Rhoades, Quinlan Steiner, Dean Williams

Participants: Rick Allen, Steve Williams, Pam Cravez, Kristy Becker, Karen Forest, Randall Burns, Teri Tibbett

Staff: Susanne DiPietro, Barbara Dunham

Agenda

Judge Rhoades noted that at the reentry conference she spoke at the previous day, the issue of getting SUD evaluations for people in DOC custody was brought up; she suggested adding this to the agenda. The group agreed. [Note: the group did not return to this topic by the end of the meeting.]

Development of a jail diversion program for behavioral health populations

Judge Rhoades noted that Geri Fox, director of the Pretrial division at DOC, was working on this issue. When it is up and running, the Pretrial Unit will identify people appropriate for diversion, but there needs to be a workgroup convened to develop a diversion program [as recommended by the Commission last fall]. Judge Rhoades asked whether the Standing Committee should be that workgroup.

Susanne DiPietro asked what sort of program Judge Rhoades was thinking about. Judge Rhoades noted that there were many programs around the country that Alaska could use as a model. The first step would be to determine the target population. Some diversion programs target offenders with severe mental illness, and some target opioid users. Essentially it would be like the Coordinated Resources Project (aka mental health court) but front-end; typically when the offender successfully completes the program the benefit is that the case is dismissed.

Randall Burns asked whether the program would accept offenders charged with any crime so long as they were diagnosed with severe mental illness or substance use disorder.

Judge Rhoades explained that previously the DAs had not been interested in a general statewide diversion program. This would be a DOC program for those who create the greatest dilemma for DOC— those whose needs could not be met by DOC and who would be better off if they were diverted to services- people with an Axis 1 diagnosis, developmental disabilities, TBIs, FASD, etc. Susanne asked if this could include those with substance use disorder. Judge Rhoades said it could—the workgroup would have to identify the target population.

Randall asked what SB 91 required. Susanne replied that it required DOC to identify offenders appropriate for diversion. There was no timing requirement.

Susanne said that whatever the program was, it would need prosecutorial buy-in. It was her understanding that some DAs were doing pilot diversion programs, and they may not want any additional diversion programs. Jeff Jessee noted that he and John Skidmore had been attempting to connect about this but had not actually found time to talk. Steve Williams noted that the ACJC recommendation asked DOC to convene representatives from the various departments—including Law. Since the Commission vote on that recommendation was unanimous, one could assume that Law was in favor of such a program. The question was whether DOC wanted to take the lead on forming the group mentioned in the recommendation or just designate this group.

Commissioner Williams said that developing this program now would be timely, even for just a pilot program. This group could be the right tool if the right people were on board. He would probably recommend Karen Cann, Deputy Commissioner for Transitions at DOC, to head up the effort for DOC. He supports this idea but would want to be sure to include opioid addicts as well as the severely mentally ill.

Judge Rhoades said she liked the idea of a pilot program. Randall suggested placing the pilot program in a smaller community, somewhere other than Anchorage. Judge Rhoades suggested that DOC could identify the appropriate community.

Judge Rhoades will follow up with Rob Henderson at Law as well as Karen Cann and will provide the group with an update at the next meeting.

CIT Training

The group noted that Commissioner Monegan had not joined the meeting, and that this agenda item was to keep the group updated on getting CIT training for law enforcement and dispatchers. Steve said he could get this information; he was aware that troopers have generally expanded their hours in behavioral health training. Hans Brinke in the Valley is organizing a full 40-hour training.

Randall noted that DPS and the FBI have met twice recently to discuss the lessons to be learned from the Santiago case.

Judge Rhoades will follow up with Commissioner Monegan for an update.

Release of Information (ROI) forms

Judge Rhoades noted that the previous iteration of the group had received a lot of feedback on the problem of releases of information (ROIs) not being accepted by all providers. The Commission recommended that the legislature enact a statute creating a universal ROI. She asked whether this group or a sub-group should develop the universal ROI. There was general agreement.

Randall noted that the AG would have to approve any ROI and that the state's main HIPAA authority was AAG Kelly Hendrickson. Judge Rhoades said that the Commission approved the ROI recommendation unanimously, and that vote included the AG, so that would be enough for AG approval.

Teri Tibbett noted that the Juneau Reentry Coalition was working on an ROI with Alysa Wooden from DHSS. Susanne suggested this could be used as a draft.

Access to medication and mental health treatment for pre-trial detainees

DOC would like to treat mentally ill detainees pre-trial, but needs a way to do this without violating due process. Commissioner Williams was not sure of the scope of the problem—he assumed DOC would treat everyone short of force-feeding them medication. He will follow up with Laura Brooks and Adam Rutherford on this.

Dr. Becker said she gets requests on this regularly. Defendants come into custody in a variety of stages of medication compliance. The question is whether these defendants can be involuntarily medicated. The *Harper* case allows it for defendants who are a danger to themselves or others. The interpretation of the case hinges on the meaning of "grave disability." She has also seen court orders to keep defendants status quo at the point of their arrival.

Judge Rhoades agreed that the issue was whether to involuntarily administer medication pretrial, and what to do with people who don't meet the *Harper* standard. The committee did not identify any future action steps.

Centralized competency calendar

Steve noted he had brought this issue up to the Criminal Justice Working Group (CJWG). Christine Johnson from the Court System will ascertain the judges' thoughts and Steve will update the group when he hears back.

Randall and Dr. Becker noted that having separate competency calendars for each district would not solve the problem—API already gets information by judicial district.

Judge Rhoades suggested getting the CJWG Competency Committee back together to coordinate efforts and address other efficiency issues between the Court System and API. Randall suggested this might be a good idea because DHSS won't be able to look at the UNLV report and begin its review until after it applies for the Medicaid waiver in July. Steve stated he would make a report out at the next Criminal Justice Working Group meeting on this discussion and set a future meeting with small group to identify the issues and develop a plan to address them.

Review of the UNLV report

Steve noted that the only item in the UNLV report being addressed at the CJWG was the competency calendar. The previous iteration of this group had suggested that doing a fiscal impact analysis for DHSS was the next step. Barbara noted that the Commission's Presumptive Sentencing Workgroup was looking at the Guilty But Mentally Ill and Not Guilty by Reason of Insanity statutes.

Judge Rhoades suggested that before DHSS reports back on UNLV's recommendations that the UNLV report be revisited in light of SB 91 and the Western Interstate Commission on Higher Education (WICHE) report. She proposed reviving the CJWG's Title 12/47 Efficiency

Committee for this purpose. Steve stated he would make a report out at the next Criminal Justice Working Group meeting on this discussion and identify next steps forward.

Alaska's substance abuse treatment capacity

Randall noted that DHSS has this data from Medicaid claims, and the report is online in a tool called the Drive. He also noted that Medicaid expansion covers residential substance abuse treatment at facilities which have 16 beds or fewer.

Susanne noted there had been recent testimony at the Legislature that treatment providers were struggling with an influx of justice-involved patients. Randall hadn't heard this but would ask Tony Piper.

Judge Rhoades said it would be good not only to know about beds but also who's in them. She suggested tapping the reentry coalitions for information about capacity and demand.

Next meeting

The next meeting was set for May 18 at 9:00 a.m. It was agreed that the group will decide at that point what to report out to the Commission in July.

Alaska Criminal Justice Commission
Behavioral Health Standing Committee

January 12, 2017
Alaska Mental Health Trust
Meeting Summary

Participants: Jeff Jessee, Randall Burns, Stephanie Rhoades, Steve Williams, Laura Baez, Kristy Becker, Karen Forrest, Walt Monegan, Quinlan Steiner, Steven Bookman

Staff: Susanne DiPietro, Barbara Dunham

Introductions

Jeff Jessee called the meeting to order and asked participants to introduce themselves.

Judge Rhoades brought the group up to speed on the efforts of the previous iteration of this group, the Behavioral Health Working Group. The Working Group had used a tool called the Sequential Intercept Model to identify areas in the criminal justice system where the needs of individuals with behavioral health issues could be better addressed. The Working Group came up with a comprehensive list of recommendations, and forwarded seven of them to the full Commission. The rest of the recommendations either were not statutory fixes or needed more time for consideration—thus the creation of a Standing Committee. The idea with having a Standing Committee was to have the policy-level decision makers at the table to get broad based support for recommendations.

Membership & Participation

The group discussed ensuring the participation of a victims' advocate, as this was included in the motion to create the standing committee. It was decided that Jeff will reach out to Brenda Stanfill, Alaska Network on Domestic Violence and Sexual Assault (ANDVSA) board member and Commission member, to gauge her interest in participation or seek her recommendation for a victims' advocate participant.

The motion to create the committee also envisioned participation from rural tribal health providers and urban health providers who would have a practical perspective on the day-to-day operations of behavioral health systems.

Review of Previous Recommendations

Judge Rhoades reviewed the comprehensive list of recommendations developed by the Behavioral Health Workgroup in 2016. These recommendations followed the Sequential Intercept Model (SIM), identifying areas for improvement at each stage of a person's involvement in the criminal justice process. The workgroup had developed a number of recommendations for each intercept, and forwarded seven of these recommendations to the full Commission.

Intercept 1

The first intercept was contact with law enforcement. The recommendations in this area were to provide crisis intervention training for dispatchers and law enforcement, and to provide linkages to services for those identified through this training to have behavioral health disorders. Jeff asked Commissioner Monegan whether there was centralized training for dispatchers. Commissioner Monegan replied that there wasn't exactly- there are two larger training centers in Fairbanks and Soldotna. All dispatchers have to go through an academy. He also noted that for dispatchers, it's hard to assess potential mental health conditions on the phone.

Barbara noted that there had been a law enforcement leadership conference in December where there had been a presentation on the crisis intervention model. Many of the law enforcement leaders had expressed concern that even if a behavioral health condition was identified, there were no services to meet those needs—no place for these individuals to go. Dr. Becker added that there was no mental health crisis drop off facility. Jeff said that even without the needed follow up services, the training was better than nothing.

Judge Rhoades said she was doing this training with local and state law enforcement officers this coming spring, and had already done one in Anchorage. She was hoping to have one in Fairbanks as well. She noted there was also improved training in the trooper academy. There was a need to constantly keep up with this kind of training because of staff turnover. The main concern is having a co-response to this training—having a drop-off point to bring individuals with such needs. Steve Williams said that the Trust is working with people in Juneau to develop a co-response there. Judge Rhoades then wondered whether this was something best left to localities or whether this was something the Committee should address.

Randall Burns noted that the weeklong training required for crisis intervention training was expensive, and if the Committee decided to take up this issue it would need to look at funding. Commissioner Monegan suggested keeping this item on the agenda to maintain some attention to this issue. Jeff Jessee noted that it was the responsibility of the Commission to make recommendations and not necessarily worry about the details of implementation. Susanne mentioned that the Commission can also make recommendations for use of reinvestment money for things like this. Randall also suggested working with the Municipal League on this.

Next steps:

- **Add CIT training (inclusive of dispatchers and a co-response model) as item for committee work**

Intercept 2

The group then turned to the second sequential intercept: initial detention and court hearings. Possible interventions at this stage include mental health screenings, treatment and medication handoffs, and diversion. SB 91 has a provision requiring DOC to implement a pretrial diversion process.

Judge Rhoades noted there is Trust funding for pretrial diversion—currently some of that money is being used by the Mental Health Court. Steve explained that the Discharge Incentive Grant (DIG) funding for release planning being used for the Court. There are also Assess, Plan Identify, and Coordinate (APIC) funds which are used for release planning for misdemeanor cases targeting individuals not involved in a therapeutic court.

Jeff suggested that if this area was going to stay on the agenda that the group should invite Geri Fox from DOC. Judge Rhoades also suggested bringing in a prosecutor; there would need to be prosecutor buy-in for a pretrial diversion program. Randall asked what was happening now with the pre-trial implementation group, and wondered whether these efforts might be duplicative. Judge Rhoades suggested it could be a joint conversation. Karen Forest said that Diane Casto had been sitting in on the pretrial implementation meeting and found that to be a useful linkage. The group decided to keep pre-trial diversion on the agenda although it would not be an urgent agenda item—just something to keep tabs on what the pre-trial group is doing.

The group also discussed information sharing at this intercept stage. Commissioner Monegan noted there was a need for dispatchers to have mental health information, but Health Insurance Portability and Accountability Act (HIPAA) rules complicated things. Judge Rhoades noted that in Anchorage, some of this information is on Alaska Public Safety Information Network (APSIN), but it is observational, not clinical information. Commissioner Monegan thought that if there was more information sharing at this

stage, fewer people would fall through the cracks. He noted the Santiago case might have benefitted from this. Judge Rhoades said this was an indication to have something more broad than just an officer safety flag in APSIN. It was suggested that a smaller workgroup could form to draft the release of information (ROI).

Next steps:

- Add development of jail diversion program, within DOC's pre-trial services, for persons with behavioral health disorders as item for committee work
- Add development/implementation of a standardized release of information form to be used by State funded community providers as an item for committee work of select members

Intercept 3

The group then turned to intercept 3, which involves jail time and court cases. The comprehensive list of recommendations for this intercept included ensuring up-to-standard treatment services and medication for inmates, expansion of specialty courts, implementing a centralized competency calendar in each district, and connecting inmates to Medicaid so that benefits are received or reinstated on reentry or during participation in specialty court or diversion programs.

Regarding treatment and medication for inmates, the group noted that a big issue here was that there was no way to order an un-sentenced person to complete treatment pretrial. There was probably a need to have someone from DOC also involved in this conversation. Dr. Becker suggested that there was a need for statutory clarification here- they need to know when they can medicate people.

Regarding the centralized competency calendar, it was noted that this worked well in Anchorage. Dr. Becker said that in other areas of the state Alaska Psychiatric Institute (API) runs into problems in other districts where this is outside the normal practice of certain judges and attorneys. Judge Rhoades moved that the Criminal Justice Working Group take up this topic.

It was also noted that there was a Criminal Justice Working Group subcommittee devoted to specialty courts. Karen Forest informed the group that the Medicaid enrollment/reinstatement initiatives were being implemented.

Next steps:

- Include on the next meeting agenda the discussion of access to medication and mental health treatment for persons under the care/custody of DOC, inclusive of those who are gravely disabled
- Revisit the progress/status of expanding the Third Judicial District's centralized competency calendar model to other judicial districts after September 2017

Intercept 4/5

Intercepts 4 and 5 focused on reentry and community corrections. The Commission already recommended the first proposal on the comprehensive list, which was to draft a universal ROI. It was suggested that a smaller workgroup could form to draft the release of information (ROI).

Next Steps:

- See Sequential Intercept #3

UNLV Report

The group turned to discussing the UNLV report (May 2015). Judge Rhoades informed the group that DBH was looking into the report per the request of the Commission and that a report on their findings was due in September. She also noted that the UNLV report's findings were reinforced by the findings in the Western Interstate Commission for Higher Education (WICHE) report, which was recently released.

Randall Burns said that he had also been looking at the WICHE report and noted that it was looking whole cloth at behavioral health systems. He suggested putting the UNLV study on the agenda later once Division of Behavioral Health (DBH) has submitted its report.

Next Steps:

- Add the committee's review of the UNLV report recommendations as a future agenda item

Drug treatment and treatment capacity

The group decided to keep monitoring the state's substance abuse treatment capacity on the table so as to make recommendations as to how future criminal justice reinvestment funding may be implemented. Susanne thought it would be useful to look into capacity for treatment. Karen explained that the $6 million for gap funding of substance use disorder treatment was about to go out. There were more applicants for the money than grants. Judge Rhoades noted that there was a difference between substance abuse treatment capacity and mental health treatment capacity.

The group also discussed ways to get drug offenders and others with addiction issues into treatment if they aren't being sentenced to jail time. Susanne thought there should be a way to get these misdemeanants an assessment. Commissioner Monegan noted that with the budget cuts, these types of offenses are not being investigated let alone prosecuted.

Next Steps:

- Add monitoring the state's substance abuse treatment capacity as a standing agenda item

The next meeting for the Committee was set for March 9, 2017 (10:30 – 12:00p). The group will meet the 2nd Thursday of every other month.

DRAFT Notes and Meeting Summary
WORKGROUP ON BEHAVIORAL HEALTH[1]

Alaska Criminal Justice Commission

Wednesday, July 9, 2016
9:00 a.m. - Noon
Location: Alaska Mental Health Trust Authority

Commissioners Attending: Stephanie Rhoades, Jeff Jessee, Kris Sell, Walt Monegan

Commissioners Absent: Greg Razo, Dean Williams, John Coghill, Brenda Stanfill

Other Attendees:

Steve Williams, MHTA; Josie Garton, PDA; Cathleen McLaughlin, Partners for Progress; Alysa Wooden, DHSS; Paul Miovas and Steve Bookman, Dept. of Law; Laura Brooks, DOC; Tony Piper, ASAP; Rob Wood, DJJ; Brad Myrstol & Araceli Valle, Alaska Justice Information Center, Diane Casto, DHSS; Kate Burkhart, Alaska Mental Health Board; Teri Tibbett DBH, Alyssa Wooden, DHSS

Staff: Susie Dosik, Giulia Kaufmann

The meeting began at 9:10 a.m.

The previous meeting summary was discussed. Two clarifications were proposed by Steven Bookman and accepted by the group. The meeting summary was accepted as corrected with no objection.

The group continued its review of the analysis and recommendations from the report entitled "Review of Alaska Mental Health Statutes" authored by consultants from the University of Nevada Schools of Law and Medicine.

1. Misdemeanor statutes.

Recommendations on pages 42-43. The group discussed the recommendations on pages 42-43 of the report. Because SB 91 now caps incarceration for most misdemeanor offenses at 30 days, the group agreed that the recommendations were not as relevant as when they were drafted.

Note: The group reached a general conceptual agreement that misdemeanors should have a different time frame. If the Criminal Justice

[1] Throughout the continuum of care in the criminal justice system.

Commission accepts the Behavior Health Workgroup's recommendation to make the workgroup a standing committee, Stephanie Rhoades and Jeff Jesse volunteered to rewrite these recommendations in light of the changes in SB 91.

Note: The group was generally concerned with people charged with misdemeanors who were "cycling" through the court system. They noted it generally took 6-8 weeks to get a competency evaluation done. If not found competent, the court could order restoration. The group noted that evaluations were expensive and restoration was not being used for treatment purposes because treatment conditions could not be enforced. Restoration could take six months, for a 30 day possible sentence. They noted that tremendous resources were being used for evaluation and restoration in misdemeanor cases. Stephanie Rhoades reiterated that the UNLV report was based on the goals of expediting competency evaluations, and providing an alternative (such as an update) to full competency evaluations if a recent evaluation had been performed. The group discussed options of civil commitment, mandated diversion, a 15-day evaluation requirement, creating a presumption for "cycling" individuals who could be held civilly, and standards for "outpatient commitment." The group also discussed and acknowledged constitutional requirements for civil and criminal holds, and mandated medication. Kate Burkhart noted that the mental health provider community did not agree about whether involuntary outpatient treatment was appropriate. Stephanie Rhoades noted that current statutes did not allow for involuntary outpatient treatment but if the statutes were changed, services would be created and contracted, so providers could decide whether or not to buy in.

No consensus was attempted or reached on these options.

2. Juvenile Statutes.

A. Civil Commitment of Juveniles and Placement in a Psychiatric Facility

Recommendations on pages 47. The group discussed the recommendation on page 47. It agreed that the wording should be changed as follows:

Recommendation**:** AS § 47.30.690 should be amended to require the court to appoint a Guardian Ad Litem for all juveniles subject to treatment in a ~~secure psychiatric~~ designated treatment facility or residential psychiatric treatment center

and this appointment should continue until the minor is discharged and reintegrated into the community.

The group also recommended that the legislature consider a parallel revision to the language of AS 47.12. 255 and AS 47.12.990(14).

B. Competency to Stand Trial in Juvenile Delinquency Proceedings

Recommendations on pages 50-51.

The group adopted **Recommendations 1-7** as written without objection.

C. Restoration of Incompetent Juvenile Defendants

Recommendations on page 52:

The group adopted **Recommendations 1-4** as written without objection.

Note: Paul Miovas of Department of Law voiced concerns about the language in Recommendation 3 stating, “In cases where a juvenile is incompetent due to developmental immaturity or intellectual disability and restoration is inappropriate, Alaska could consider a compromise position, where cases involving less serious offenses are dismissed with prejudice: cases involving more serious offenses could be dismissed without prejudice.” He noted that dismissal with prejudice was an extremely unusual and constrictive remedy. The group discussed the concern and concluded that it would adopt the recommendation because it was a general recommendation only that “Alaska could consider a compromise position.”

DRAFT Notes and Meeting Summary
WORKGROUP ON BEHAVIORAL HEALTH[1]

Alaska Criminal Justice Commission

Wednesday, June 29, 2016
9:00 a.m. - Noon
Location: Alaska Mental Health Trust Authority

Commissioners Attending

Stephanie Rhoades, Jeff Jessee, Brenda Stanfill, Kris Sell

Commissioners Absent

Greg Razo, Dean Williams, Walt Monegan, John Coghill

Other Attendees

Steve Williams, MHTA; Jocie Garton, PDA; Cathleen McLaughlin, Partners for Progress; Alysa Wooden, DHSS; Paul Miovas and Steve Bookman, Dept. of Law; Laura Brooks, DOC; Tony Piper, ASAP; Jerry Jenkins, Anchorage Community Mental Health; Diane Casto, DHSS; Trina Sears, OVR; Bill Miller, APD; Kate Burkhart, Alaska Mental Health Board; Christine Johnson, Alaska Court System; Heidi Weiland, MHTA; Brad Myrstol & Araceli Valle, Alaska Justice Information Center.

Staff: Susanne DiPietro

Next meeting: July 13 from 9 a.m. to noon.

The meeting began at 9:10 a.m.

The group reviewed the analysis and recommendations from the report entitled "Review of Alaska Mental Health Statutes" authored by consultants from the University of Nevada Schools of Law and Medicine.

1. Forensic examiners.

Recommendations on pages 7-8. The group had no objections to the recommendations on pages 7-8 of the report. Those will be forwarded to the commission for its consideration.

Note: Department of Law raised the question of whether and when telephonic testimony of forensic examiners should be permitted. The group felt that issue was outside the scope of its work and recommended that the

[1] Throughout the continuum of care in the criminal justice system.

Department of Law and the Public Defender Agency ask the Alaska Court System to consider changing the court rule regarding telephonic testimony.

2. Competency to stand trial.

Recommendations on pages 13-14. The Department of Law objected to removal of the rebuttable presumption in **recommendation 1** for some serious classes of felony offenses (for example, A, Unclassified, SAM). It was decided to bring **recommendations 1 and 2** directly to the commissioners with Law's objection and without a recommendation from the workgroup.

Note: In r**ecommendation 2 on page 13**, it was suggested that DHHS' designee should be understood to include its grantees.

Note: The question was raised whether the civil commitment process envisioned by **recommendations 1 and 2** is appropriate for defendants found incompetent and not restorable by virtue of a mental disability, because API does not treat cognitive disabilities.

3. Civil Commitment

Recommendations on pages 19-20. The group agreed that these 9 recommendations should be discussed further with DHSS before the workgroup or the commission will take action.

Recommendations on page 22. The group generally agreed with the rationale of the four recommendations that folks who cannot be treated (for example, because of a cognitive disability) should not be committed. However, Department of Law questioned those portions of **recommendations 3 and 4 on page 22** that require a finding on the "need for care and treatment" at the .710 (initial) hearing, on the grounds that it is not feasible for all petitioners to be able to present evidence/information on this issue at the .710 hearing. Although petitioners with medical backgrounds probably would be able to present evidence on this point, family members or other non-medical petitioners likely would not be able to supply evidence, and the judicial officer would then be unable to make the finding.

No objections were voiced regarding **recommendations 1 and 2 on page 22** of the report.

The group agreed that AS 47.30.730 should be amended to require the state to show only that the respondent's condition could be improved by the course of treatment proposed, as cited in **recommendation 3 on page 22**.

The group agreed that AS 47.30.700(a) also should be amended to require the state to show only that the respondent's condition could be improved by the course of treatment proposed, as described in **recommendation 3 on page 22**.

4. Imminence & Grave Disability

The group expressed no concerns with **recommendations 1 and 2 on page 25**. Regarding **recommendation 3 on page 25**, the group agreed that the emphasis on recency of behavior as a factor for determining imminence of harm is problematic. For example, defendants who have been receiving treatment while incarcerated are often judged by evaluators to pose no risk of imminent harm, although they might become a danger once released. The group did not agree with the solution suggested by **recommendation 3 on page 25** that "recent behavior" be defined as behavior within the past 30 days; however, no alternative solutions were reached. It was agreed to form a subgroup consisting of Department of Law, Public Defender Agency, API, and Department of Corrections to propose a "totality of the circumstances" test that would include such factors as current environment, likely future environment, patterns of behavior, etc.

5. Early discharge from civil commitment

Recommendations 1 & 2 on page 26. No objections were voiced to **recommendation 1**. It was agreed to **reject recommendation 2**, on the grounds that the VRA arguably requires the state to notify the victim of early discharge, and this recommendation would hamper the state's ability to do that.

6. Outpatient commitment **(page 28)**

The group did not object to the recommendation to create an outpatient commitment program; however, the following issues were raised: need to address liability and possible immunity for community providers; need to carefully define "non-compliance"; need for a fiscal impact analysis, including a description of expected savings such a system could create in other areas (e.g. Medicaid).

7. Guilty but mentally ill **(page 34)**

No recommendation – there was no consensus and the number of defendants affected is not large.

8. Diminished capacity **(page 35)**

No recommendation.

9. Intellectual and developmental disability definitions **(page 36)**

The group agreed with Department of Law's suggestion that there should be a larger list of things that relate to intellectual functioning other than the ability to obtain a driver's license or testify as a witness. The group disagreed with the suggestion in **recommendation 3** to delete those items, opting instead to enlarge the list. No objections to **recommendations 1 and 2.**

10. Competency restoration and involuntary medication

The group reach no consensus on **recommendations 1 and 2 on page 38** and it was agreed to discuss these issues further**.** The Department of Law objected to changing the current situation in which the prosecutor decided whether to file or not to file a motion for an involuntary medication hearing. Regarding **recommendation 2**, the Department of Law preferred the alternative ("the statute could simply allow for the involuntary administration of medication to restore competency and rely on …*Sell* and *Harper* to guide the courts' analysis.")

The meeting was adjourned at noon.

Staff Notes and Meeting Summary
WORKGROUP ON BEHAVIORAL HEALTH[1]
Alaska Criminal Justice Commission
Wednesday, June 22, 2016, 9:00 -12:00 PM
Location: Alaska Mental Health Trust Authority

Commissioners Attending: Stephanie Rhoades, Jeff Jessee, Brenda Stanfill, Kris Sell
Other Attendees: Alysa Wooden, DHSS; Paul Miovas and Steve Bookman, Dept. of Law; Steve Williams, Trust; Adam Rutherford, DOC; Tony Piper and Stacy Toner, DHSS; Jerry Jenkins, Anchorage Community Mental Health; Dave Branding, South Peninsula Behavioral Health Services; Morgen Jaco, DOC; Cathleen McLaughlin, Partners for Progress; Trina Sears, OVR; Josie Garton, Alaska Public Defender; Heidi Wailand, Agnew-Beck.
Staff: Mary Geddes

Relevant Materials:

Behavioral Health SQ 1-5 Recommendations, previously distributed

Also referenced:
Alaska Behavioral Health Systems Assessment Final Report (linked)[2]

Meeting Summary

The meeting began at 9:10 A.M.

Criminal Justice Commissioners Jeff Jessee and Stephanie Rhoades reviewed past recommendations. Rhoades noted that the recommendations need to be categorized so as to better organize them for presentation. ACJC has a particular mission oriented to statutory and administrative reform of criminal justice laws and practices. One example of a reform discussed in the Workgroup which is well suited to ACJC's mission is the idea of requiring presentence report writers to include behavioral health information; this could be categorized as a statutory reform.

Jerry Jenkins, Adam Rutherford, Dave Branding and Tony Piper discussed the 'categories': statutory, regulatory or policy. A policy might require agencies to work together to improve access to treatment. The group began to identify categories for each recommendation under the sequential intercepts model which identifies barriers to mental health services in each phase of the criminal justice system. [These notations are not necessarily recounted in this summary]

One problem was noted at the outset: when a person is denied immediate access to or a certain level of treatment because of "no assessment" having yet been conducted by that particular agency, even though there may be another assessment that has been done. How to fix this? A regulatory change might accomplish it but it could be a policy change requiring Memoranda of Understanding that require contractors to accept individuals for treatment even if they don't agree with an initial assessment. Steve Bookman suggested that maybe MOU's state that acceptance is required but then commit the agencies to a dispute resolution. Agencies really don't trust each other's assessments.

[1] Throughout the continuum of care in the criminal justice system.
[2] http://mhtrust.org/mhtawp/wp-content/uploads/2015/11/BH-Systems-Assessment-Report_Updated-1.22.2016_email.pdf

Jerry Jenkins noted how easy it is in Anchorage, relatively speaking, with a single point of entry like Partners. For Progress. An assessment can be done right then and there at the Reentry Center. However, with respect to Implementing a formal collection of information and then sharing that same information, statutory change will need to take place. Funding and policy changes are likely involved as well.

At Intercept 1, Kris Sell asked if the review had covered Title 47's. Rhoades indicated it did not because Title 47's are involuntary. The question had been whether a person who could make a choice could 'choose' treatment at this early stage of contact with the criminal justice process. It was recognized that sometimes the choice does not seem particularly voluntary (go to treatment or else).

Rhoades said that she wasn't entirely sure the extent to which SB91 addressed pretrial diversion. A statewide pretrial diversion program is needed for mentally ill people. SB91 mentioned pretrial diversion only in the context of pretrial services (yet to be developed by DOC) that may allow pretrial services officers to recommend diversion to courts and prosecutors. An additional question was asked about the extent to which pretrial assessments will be conducted. Kris Sell noted that there was a lot of misinformation about Sb91 flying around. Rhoades noted that the Commission will be tasked with oversight of its implementation. Jenkins asked whether ACJC oversight will be able to cover the waterfront of behavioral health issues which will need to be monitored. Rhoades said that it is better to have statutory standards for pretrial diversion because then the programs don't ebb and flow with the particular administration. Mary Geddes asked if pretrial diversion has in fact been implemented. Paul Miovas indicated that there is discretion but really no standards.

Rhoades said that the pretrial services program will be a huge reform and a great opportunity for effective "jail diversion" of BH populations. Perhaps jail diversion could be tied to assessments. Pretrial services officers could be able to plan for each person, using performance standards for effective pretrial intervention. Rhoades asked if the Commission could recommend a jail diversion component of pretrial services. Josie Garton identified the need to create such a program by statute, in order to obtain uniform implementation. Sell asked about those who wouldn't want to participate in treatment. Rhoades agreed it would be voluntary only. Rhoades suggested that DOC could look to standards developed by the National Association of Pretrial Services Agencies for pretrial interventions. Miovas asked if the DA have veto over jail diversions. Rhoades suggested that if the program would be effective, it would have to capture more than a few people Larger programs in bigger jurisdictions may depend on statutory framework and certain exclusions; where there are smaller populations and communities, decisions can be more individualized. Miovas noted that the DA would want some discretion regarding admission. Rhoades responded that discretion can be class based, rather than making judges on a wholly individual basis. Garton suggested that eligibility could be agreed to by criminal history and other criteria.

The group then discussed the previously-identified need for a mechanism through which DOC can alert the courts as to the needs/problems of an individual; it seems that many individuals really languish. Rhoades asked what kind of fix is needed? Adam Rutherford wondered if the new pretrial services officers might provide that partial screening and alert the court. Garton stated that the defenders would prefer to be contacted. Rutherford said that DOC does sometimes contact attorneys to no avail. Rhoades mentioned a defendant who had been charged with felony assault on co-resident in a MH facility; he was consequently not eligible for MH Ct. As a result of a court hearing, the attorney got a better handle on the individual's status, the resources and the law. Lots of defenders don't know what options exist when dealing with a mentally ill defendant. Kris Sell asked if there was some way to deal these in-court

discussions so that defense attorneys won't perceive that their clients are disadvantaged by candid discussions.

Rhoades said that she wanted to see better utilization of therapeutic courts. She wondered if we need standards which would reduce the impact of decision-making (exclusions) by individual DA's. We should also promote best practices. Rutherford believes DOC 'under-refers' to specialty courts.

Rhoades noted that addicts are poorly served by the current intake process for the wellness court. Mental health courts are different because the courts can take direct referrals from anyone, and conditional-opt in allows for assessment purposes. In contrast , addiction courts do not allow conditional opt in. Paul Miovas expressed concern that the wellness court will dry up because of the change in SB91 to MISC 4 (current, to be former felony statute for drug possession) . Rhoades said that the first and second timers shouldn't be in the therapeutic courts. The courts should be dealing with the higher risk folks, but they are being excluded. Criteria should be codified in statute to take the political pressure off the DA's. There is a need to expand the categories of offenders who can benefit. Miovas noted in response that the current system does use standards that were collaboratively developed but those standards allow Heather to be the funnel and have the final say. Palmer has the same set-up, with one DA making the call. Rutherford noted that people can't get into treatment/services when they need to, i.e. shortly after release. DOC only gives meds for one week at release and capacity may be limited outside the therapeutic court context. Therapeutic court participants are given priority admission to services.

Dave Branding noted some differences in re-entry scenario for a community like Homer. Accesses in that community are well-integrated, so people don't get lost. His organization has residential services for SMI and TBI, there are integrated substances abuse services, 90% of the folks who walk in can get same day access to services. And one funding stream helps support the other. Jeff Jesse noted that there is better funding for developmental disabilities than for behavioral health. The reimbursement system is such that in a rural area, better easier to become dual provider. Rhoades asked if regulation or statute requires BH patient to receive care in the least restrictive setting.

In response to a question from Judge Rhoades, Jerry Jenkins noted that Anchorage Community Health are taking releases from DOC and API who are bipolar as well as those patients who are seriously mentally ill (SMI). Adam noted that there are capacity problems when we rely on community based organizations to do more. Jerry Jenkins noted that he had been here 14 years now, and there is less money and greater census pressure now with SMI. His network encompasses Anchorage Community Health and Fairbanks. They do take all bipolar patients referred from DOC and API, if they have capacity. He was asked what the statutes say about who gets services. Jerry said that with SMI, the standard is based on functionality. Southcentral provides services but not case management; Indian health resources are limited unless a person can get into Quyana House. Elsewhere: SED sees children, in Juneau, the organization is JAMI, on the Kenai its Central Peninsula, and in the Valley. Free-standing case management can be provided by Akeela, Hope, ARC, 9-Star, and Choices.

Rhoades asked if ACT (Assorted Community Treatment) grants disappearing is a barrier. Dave Branding said that there is an inconsistency among communities. ACT teams can fund a person in a community. It is a seven day a week service allowing intervention when the client starts to decompensate. It is hard to translate this service into the cubbyhole of community based services, but an argument can be made to pay for this through a Medicaid waiver.

Rhoades asked what are those things that are missing that keep people from re-entering jail? Someone said: certified community BH residential units, including "crisis respite" which is a higher, enriched level of care for a few days, without meeting involuntary standard. Our biggest gap in communities may be there is no place to drop off people, and an inadequate service array. Jeff Jessee – Assorted Community Treatment

Jessee agreed that inadequate crisis response is big gap. That the "living room" concept is a good one as far as law enforcement has been concerned: allowing anyone to come in, 24/7 staffing, nurses, peers, telemedicine link to ER, 1 block from Detox. This should be a calm environment – not hospital based, thus maintaining the connection to community services. This arrangement allows for a better collaboration between ER, LE and MH system. This could in theory help those displaced because of DV, or other housing cries. Often he crisis resolves within a few hours. PepR does a great job but it is a hospital. So how do we get one? It may be a policy. One barrier might be privacy concerns. Another barrier is funding because you need to buy capacity not services.

Kris Sell liked the concept for Juneau. While we have CIT training, we have no other services and resources. She noted a limited capacity at Rainforest to deal with alcohol related problems, and that they have a hard time keeping their staff, because people need to be well compensated to stay with this population.

Jenkins noted that the same problem exists in Fairbanks. SR Something other than hospital is needed. Heidi Wailand qualified her agreement: noted that a short-term crisis stop is really important, but also a supportive housing situation. Without that, its like throwing money out the window to bring them back. Brad Myrstol asked if the fundamental barrier here isn't economic because the consumer cannot afford the services without government insurance. Rhoades appreciated Brad's observation, noting that the average monthly income of a person on SSI Disability is $900/month. Jessee did not disagree but said there is great opportunity because of Medicaid waivers and Justice Reinvestment.

Branding thought his communities' biggest issues include the workforce. They have two residential programs, but can't attract workers who can pass criminal record checks. Plus, rates haven't changed in 8 years, only the "recipient support system" keeps us in the black. Adam Rutherford noted that this funding line item is crucial for many CBO.

Miovas asked if grant writing was a need. Jessee responded that grants really are not the way to support critical services because grants are not sustainable. There is an ongoing General Fund appropriation among all BH centers. Miovas asked if the effort in getting grants worth it in the short term. Jessee noted that grant money is usually a small fraction of revenue compared to Medicaid. Rhoades noted that grants don't do bread and butter work, typically run only three years. Cathleen McLaughlin noted that they were program-centric rather than individual-centric.

At the close of the meeting, noting the intensive and productive effort, Rhoades asked if there was interest in continuing on beyond (6-29) next week's meeting on mental health statutes. She stated that she thought it was crucial for an ACJC BH group to continue to be active Those interested in continuing are: Jessee, Rhoades, Brad Myrstol, Tony Piper, Cathleen McLaughlin, Adam Rutherford.

There was time allowed for additional public comment. There was none. The meeting adjourned at 11:55 AM.

Staff Notes and Meeting Sum
WORKGROUP ON BEHAVIORAL HEALTH[1]
Alaska Criminal Justice Commission
Wednesday, June 8, 2016
9:00 -11:50 AM
Location: Alaska Mental Health Trust Authority

Commissioners Attending: Stephanie Rhoades, Jeff Jessee, Brenda Stanfill
Commissioners Absent: Greg Razo, Dean Williams, Walt Monegan, John Coghill
Other Attendees: Alysa Wooden, DHSS; Paul Miovas and Steve Bookman, Dept. of Law; Steve Williams, Trust; Laura Brooks, DOC; Tony Piper and Stacy Toner, DHSS; Jerry Jenkins, Anchorage Community Mental Health; Ron Greene, Center for Drug Problems; Dave Branding, South Peninsula Behavioral Health Services;; Bill Miller, APD (joined mid-meeting); Morgen Jaco, DOC; Katie Baldwin, Trust;; Kate Burkhart, Alaska Mental Health Board; Cathleen McLaughlin, Partners for Progress; Laura Baez, Alaska Native Tribal Health Consortium; Josie Garton, Alaska Public Defender.
Staff: Mary Geddes, Giulia Kaufman.

The meeting started at 9:10 a.m.

The minutes were accepted with corrections.

Jeff Jessee first led the group through a draft of the prior meeting's findings as to barriers, assets and solutions, as identified through the Sequential Intercept Model 1-3. He noted that only one possible statutory change had been discussed, i.e. to the DV statute.

Steve Bookman asked for clarification of the proposed change to the DV statute. Judge Rhoades noted that currently there is a 20 day mandatory exclusion from a home for any individual arrested and charged with a "DV" assault. Many persons with dementia/Alzheimer's reside in nursing homes and assisted living facilities. Sometimes an assault in such context can be de minimus and the facility would be agreeable to the return of the individual sooner than the 20 days. The group had agreed that a 'carveout' for such individuals and circumstances could be appropriate. The Workgroup was not expected to draft the amendment merely identify the need for it.

Mary Geddes noted that the prior discussion had included a number of complaints about the lack of advocates for the mentally ill during the early stages of a criminal case, particularly at arraignment. Josie Garton noted that as the Alaska Constitution does not require indigent representation at the early stage of the case, a statutory change would be required if the presence of the PD would be required. Paul Miovas thought such change should be proposed, as did Laura Brooks. Stephanie Rhoades noted that she routinely sees a minimum of 2 seriously ill people at each district court arraignment. Laura Brooks noted that without a representative many individuals would just passively remain in jail. Jeff Jessee noted that fiscal notes would be required for such a fix but Paul Miovas noted that savings could be realized by more expeditious resolutions of cases at early stages of the case. The group agree to include this as a proposal to the Commission.

[1] Throughout the continuum of care in the criminal justice system.

Laura Brooks asked about "jail diversion" as an intervention. She had read about the San Antonio project and wondered if the DOL is more interested now than it was years ago when there was a pilot project. Paul Miovas stated that the Department of Law is open to it and interested in the idea.

Paul Miovas mentioned his interest in having more behavioral health information included in bail and sentencing information. Laura Brooks stated that she had followed up, and is discussing with the Probation/PSR-writing head about including BH history in presentence reports.

Steve Bookman from DOL asked whether the court system should have its own forensic evaluator. Rhoades noted that the State overall has very limited numbers of qualified forensic professionals and that the only evaluators in Alaska are already employed by API. Laura Brooks noted that the UNLV review specifically addressed the need to establish and expand the state's forensic capacity overall, both for examination and restoration efforts.

The group moved onto Intercept 4, asking what are the barriers we encounter when we try to keep mentally ill and behaviorally disordered people out of jail (as opposed to prison)?

The group made several observations with respect to urban settings. Pretrial populations may be in and out of custody, which means little or no notice and little ability to plan for reentry. Services are not available for people in open cases, and funding for them is limited. IN Anchorage, the jail navigators' role has been crucial.

Brenda Stanfill noted that references to the urban/rural dichotomy is not always useful. Fairbanks isn't urban like Anchorage, but its not rural either.

Jeff Jessee suggested that it is useful to think of a continuum of service areas. More and more it will be necessary for localities to do a community specific assessment in order to obtain funding because statewide decision-makers don't necessary know what a relative reasonable constellation of services should be in place for each community. He gave the $11 million of substance abuse funding, as an example. Without knowing what's reasonable in context, we can't do good job of dealing with and identifying gaps.

With reference to jail reentry, Alysa Wooden observed that the movement of pretrial persons between facilities and communities is hugely disruptive to providing serves.

Rhoades noted that time-served dispositions, which are very common in minor cases, also make planned transitions very difficult. And a defendant's late return to the jail from a day in court may mean that a person about to be released won't get their meds because the pharmacy has already closed for the day.

Barriers also present at this stage include benefits preservation. If a person is in DOC for 30 days or more, Social Security benefits are suspended, and because of inadequate staffing at the SS office, it takes months to get the benefits rolling again.

Jerry Jenkins noted that the biggest barrier for service continuity may be that service providers don't know they are in jail.

Participants wondered if there is anything different about jail reentry challenges in rural areas. Perhaps there is less discontinuity because the information is more shared? Participants agreed that a huge gulf in services and information is created when people are moved from their home community. Josie Garton

noted that the challenges are greatest for those who are released not to their own community but to Anchorage because of legal restrictions or program requirements.

The group listed universal barriers for successful community reentry from jail:

- Housing
- Employment
- Access to treatment.
- Transportation
- Access to ID
- Lack of advocacy for culturally challenged (all Native)
- Institutional and community housing options
- Heavy institutionalization
- Learned helplessness
- Lack of timely acceptance to services (waiting lists)
- Lack of current diagnostic/assessment info
- Stigma and community hostility
- Less resources for seriously mentally ill (SMI) and co-occurring disorders
    - "IDP-Plus" population gets services (psychotic) but groups below that fall into cracks:
        - MI + TBI + FAS – low functioning population with non-psychotic disorders
- No specialized probation – Some need adaptive assistance
- No specialized clinical services to accept them
- For people with substance abuse there is insufficient, timely treatment
- For people with intellectual development disabilities – lack of information as to exactly what are the problems/needs at the time of sentencing
- The predominant model of supervision is not problem solving
- Barrier crimes
- The lack of availability of culturally appropriate treatment
- The lack of treatment for varying levels of literacy and comprehension
- In rural communities lack of housing is an eventer greater barrier.

Laura Brooks concluded that, with 12,000 releases each year, the lack of in-reach and reentry services statewide is a huge gap. Stephanie Rhoades thought the lack of integrated case management among agencies and justice system navigation were among the greatest challenges.

After a break, the group reconvened. The flip-side (assets) of the picture for the jail population are: the use of APIC, to efforts made by DHSS and ASAP to coordinate in DOC; the availability of 24-7 and other monitoring options, the policy call by the Anchorage Jail to collaborate with the narcotic drug treatment center to allow a seven day detox; the role and work done by the Jail Navigator in Anchorage, the prisoner reentry resources in Anchorage, the voluntary 12-step and psych-ed groups that are now offered at the Anchorage Jail, improved communications on releases between DOC and homeless shelters, the work of the Reentry coalitions – Anchorage, Fairbanks, Juneau, Mat-Su, the specialized probation officers (funded by the Trust?), improved collaboration between DOC and community based providers in Anchorage, new classes run by Partners and ASAP for reentering inmates at Hiland Mountain, the legislature intent language requiring a DHSS – DOC collaboration to sign up inmates for Medicaid, better communication between Court and DOC regarding upcoming discharges.

Laura Brooks noted that this last asset is really helpful, and that even getting DOC notice of a tentative plea would be helpful.

The group's recommendations for the Jail Population include an increase in reentry centers, better utilization of CRC's as true halfway houses and for programming,[2] and more data sharing between providers for evaluation purposes.

Cathleen McLaughlin noted that sharing data allows providers to transparent and honest about the services provided.

Laura Brooks said we need more in-custody release-planning staff, and to provide more reentry needs assessments for all communities. For example, DBH has a list of services that could reasonably be provided in each community. We also need a mechanism to ensure offenders do have their medical application done 30 days in advance of release. It is a 28 page application. Currently DOC can only say fill it out and mail it in.

It was noted that there are 13 areas in the state where there is a DOC institution; the total is 21 if we count community jails. Cathleen McLaughlin noted the need for a restorative justice model through which community members could invite some of these displaced offenders to return, on the community's terms. She is very concerned that we are doing little on the displaced offender issue.

Ron Greene suggested that we need more training of community providers by DOC, so that community based organizations could better understand the challenges.

Brenda Stanfill noted that the Criminal Justice Commission has sought to work with DHSS on reforming the Barrier Crimes matrix and laws.

Laura Brooks noted the frustrating gaps in case plan coordination between DOC and OCS. She would like to improve it. The goal is to better integrate OCS into case reentry planning. The Offender Management Plan should include information and goals with respect to children. Steve bookman assured the group that OCS shares that interest and endeavors to coordinate.

Another additional asset is the pilot project in Bethel at the Public Defender. The Defender office has a holistic approach to representation; Trust money is paying for a social worker to work closely with the lawyers in the office.

Josie Garton was reminded of a challenge, i.e. failures to assist the person who is mentally ill or disordered in keeping contact with family members, particularly if they have been moved out of their communities.

Laura Brooks noted that while most of the discussion has involved sharing information and providing 'soft' services, sometimes the best leg up for reentry is the provision of medical services, such as dentures. Without teeth its hard to get a job.

Alysa Wooden noted that SB91 will require a formalized in-reach for reentry providers, and the development of a 90-day reentry plan.

[2] A challenge earlier noted by Dave Branding is relevant here. Its difficult to staff CRC's and specialized care with qualified staff in non-rural areas.

A problem noted is the lack of consistency between agency waivers. Some are HIPAA compliant and some are not. One recommendation is to create a universally acceptable state agency release form compliant with 42 CFR and HIPPA.

At the next meeting on June 22 the group will continue its mapping of criminal justice intercepts, and refine its final recommendations during the second half of the meeting.

On June 29, that meeting will be reserved for discussion of the UNLV report. At 11:45 AM, Commissioner Rhoades asked for public input. There were no additional comments at this time, and the meeting ended shortly thereafter.

Criminal Justice Commission Behavioral Health Workgroup
Report and Recommendations - Draft

The Alaska Criminal Justice Commission Behavioral [1]Health Workgroup (BHWG) met on May 11, 2016. The BHWG utilized the Sequential Intercept Mapping Model to assess the interface

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[1] **Sec. 44.19.645. Powers and duties of the commission.** (a) The commission shall evaluate the

effect of sentencing laws and criminal justice practices on the criminal justice system to evaluate whether those sentencing laws and criminal justice practices provide for protection of the public, community condemnation of the offender, the rights of victims of crimes, the rights of the accused and the person convicted, restitution from the offender, and the principle of reformation. The commission shall make recommendations for improving criminal sentencing practices and criminal justice practices, including rehabilitation and restitution. In formulating its recommendations, the commission shall consider

(1) statutes, court rules, and court decisions relevant to sentencing of criminal defendants in misdemeanor and felony cases;
(2) sentencing practices of the judiciary, including use of presumptive sentences;
(3) means of promoting uniformity, proportionality, and accountability in sentencing;
(4) alternatives to traditional forms of incarceration;
(5) the efficacy of parole and probation in ensuring public safety, achieving rehabilitation, and reducing recidivism;
(6) the adequacy, availability, and effectiveness of treatment and rehabilitation programs;
(7) crime and incarceration rates, including the rate of violent crime and the abuse of controlled substances, in this state compared to other states, and best practices adopted by other states that have proven to be successful in reducing recidivism;
(8) the relationship between sentencing priorities and correctional resources;
(9) the effectiveness of the state's current methodologies for the collection and dissemination of criminal justice data; and
(10) whether the schedules for controlled substances in AS 11.71.140 - 11.71.190 are reasonable and appropriate, considering the criteria established in AS 11.71.120(c).

(b) The commission may
(1) recommend legislative and administrative action on criminal justice practices; and
(2) select and retain the services of consultants as necessary.

Sec. 44.19.646. Methodology. In making recommendations, the commission shall

(1) solicit and consider information and views from a variety of constituencies to represent the broad spectrum of views that exist with respect to possible approaches to sentencing and administration of justice in the state; and
(2) base recommendations on the following factors:
(A) the seriousness of each offense in relation to other offenses;
(B) the effect of an offender's prior criminal history on sentencing;
(C) the need to rehabilitate criminal offenders;
(D) the need to confine offenders to prevent harm to the public;
(E) the extent to which criminal offenses harm victims and endanger the public safety and order;
(F) the effect of sentencing in deterring an offender or other members of society from future criminal conduct;
(G) the effect of sentencing as a community condemnation of criminal acts and as a reaffirmation of societal norms
(H) the elimination of unjustified disparity in sentence
(I) the sufficiency of state agency resources to administer the criminal justice system of the state;
(J) the effect of criminal justice laws and practices on reducing the rate of recidivism in the state;

between Alaska's criminal justice and community behavioral health systems and to identify criminal justice/community behavioral health programs and practices to prevent the incarceration of persons with mental health disorders

Sequential Intercept Mapping Model - Intercept 1

BHWG members identified several barriers to first responders to keeping people with behavioral health disorders (defined for this purpose as Alaska Mental Health Trust beneficiaries[2]) out of the criminal justice system.

Dispatchers can sometimes resolve calls involving serious behavioral illnesses without dispatching an officer. However, often these callers call police many times, tying up the 911 lines. It takes a considerable period of time to resolve a behavioral health crisis by phone, when it can be done. If it cannot be done, there is no behavioral health response that can be directly dispatched to a call. It is police policy to dispatch officers to these calls.

Police experience community pressure to remove nuisance offenders from the streets. There is particular pressure from the urban business community to remove people who experience chronic behavioral health problems from around their businesses because they discourage potential customers. Police perceive that mental health disorders are misunderstood by the public and that there are few tools to removing behaviorally challenging people who are nuisances but are not breaking the law. For those who do, arrest for nuisance crimes relieves community pressure.

There are several assets used by first responders to keep people with behavioral health disorders out of the criminal justice system in both urban and rural areas. Crisis Intervention Training[3]and Mental Health First Aid Training[4] – especially that tailored to police - has proven

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(K) peer reviewed and data-driven research; and
(L) the efficacy of evidence-based restorative justice initiatives on persons convicted of criminal violations and offenses, the victim, and the community

[2] Alaskans who experience a:

a) Mental illness, developmental disability, chronic alcoholism or other substance-related disorders, Alzheimer's disease and related dementia, and/or a traumatic brain injury
b) Require or are at risk of institutional levels of care
c) As a result of their disorder experience a major impairment of self-care, self-direction or social and economic functioning such that they require continuing or intensive services and supports

[3] The model involves 40 hours of specialized training of 911 dispatchers and officers provided by mental health clinicians, consumer and family advocates, and police trainers. Officer training includes information on mental illnesses; treatment; co-occurring disorders; legal issues, techniques, developmental disabilities, older adult issues, trauma and excited delirium and de-escalation, presented experiential and practical skills/scenario based training formats. 911 dispatchers are trained to identify mental disturbance calls and assign these calls to CIT trained officers. CIT officers use de-escalation techniques and assess if referral (diversion) to services or transport for mental health evaluation in lieu of criminal charging is appropriate.

[4]An evidence based training involving interactive sessions which total 12 hours. It can be conducted as one two-day seminar, two one-day events spaced over a short period of time or as four 3-hour sessions. Mental Health First

effective for dispatchers and police to help understand the dynamics surrounding police calls that involve people with serious behavioral health challenges, to de-escalate them more effectively, to reduce harm to all and to divert respondents to community resources in lieu of jail where possible.

In rural areas, mental health aides are available 24/7 to co-respond to calls with a public safety officer or to respond alone when safe. The community also works to gain a sense of ownership of the problem person and to find ways to respond other than call the public safety officer into a problem situation. Behavioral health and law enforcement conduct ongoing welfare checks to prevent ongoing issues. Title 47 involuntary civil commitment is an option as well as Title 47 alcohol/mental health holds.

In urban areas, the emergency room, sleep off centers, detox beds, Title 47 alcohol/mental health holds and involuntary civil commitment, the community respite center, domestic violence shelters are some of these assets.

The gaps appear to be that current behavioral health assets are delivered in models that do not prevent criminal justice involvement for persons who are non-voluntary, such as homeless people with mental illness or substance dependence, those with antisocial tendencies. Those that are appropriate either do not exist in rural areas or lack capacity in urban ones. None of them retain people long enough to solve the community or the individual's problems. They end up back on the street swiftly, they are untreated and engage in the same behaviors. Title 47 involuntary civil commitments require meeting high legal standards, the stays are too brief and the person is returned to the community in an unstable condition, where arrest requires a lower legal standard. There is not a 'warm enough' hand off from acute high level care to community behavioral health to

Intercept 1
Recommendations – Approved by CJCBHWG – May 25, 2016

911:

- Train more dispatchers through CIT training to identify calls involving persons with behavioral illness and refer to designated, CIT trained police
- Implement a mental health response that dispatchers could directly dispatch in lieu of or with police

Police:

- Train all police and public safety officers in the state to respond to calls where behavioral illness may be a factor either through CIT training or Mental Health First Aid training

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Aid certification must be renewed every three years, and introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact and overviews common treatments.

- Provide a police-friendly drop off at local hospital, crisis unit, or triage center, or mobile crisis mental health response for direct dispatcher or police referral/drop off that can motivate non-voluntary admissions to engage in treatment or referral to treatment and other resources
- Mandatory Assisted Community Treatment for high risk persons who refuse treatment
- Provide service linkages and follow-up services to individuals with behavioral illnesses who are identified to be at high risk of criminal justice involvement

Program Examples

The CIT model and the co-responder model were based on each respective originating jurisdiction's distinct circumstances, reflecting the need for a flexible decision-making process.

Memphis (TN) police leaders, mental health professionals and advocates, city hall officials, and other key stakeholders were spurred to action following a tragic incident in which an officer killed a person with a mental illness. In response, the Memphis Police Department established the first law enforcement-based CIT in 1988, which was designed to improve safety during these encounters by enhancing officers' ability to de-escalate the situation and providing community-based treatment alternatives to incarceration.

Los Angeles and San Diego (CA) initiative leaders recognized that officers encountered many people with mental illnesses who were not receiving adequate treatments and services. To address this problem, law enforcement agencies collaborated with the mental health community to form teams in which officers and treatment professionals respond together at the scene to connect these individuals more effectively with community-based services.
*This summary of the Memphis and Los Angeles /San Diego models was drawn from Melissa Reuland, Laura

Draper, and Blake Norton, *Improving Responses to People with Mental Illnesses: Tailoring Law Enforcement Initiatives to Individual Jurisdictions,* Council of State Governments Justice Center (2010)

*See also: Statewide Law Enforcement/Mental Health Efforts: Strategies to Support and Sustain Local Initiatives***,** Council of State Governments Justice Center (2012)

Sequential Intercept Mapping Model - Intercept 2

BHWG members identified several barriers to keeping people with behavioral health disorders out of the criminal justice system at the arrest, initial detention, arraignment and bail review hearing intercepts.

Information Across the Intercepts – Barriers, Gaps:

Information collection and sharing posed a barrier at all intercepts. Even when information is known by the arresting officer, no consistent or formal mechanisms for sharing and bringing the information forward to criminal justice players at all other intercepts are in place. From the bail setting magistrate, to the jail, to the court from the jail or the transport officers, and

ultimately to the parties in the criminal case little information is consistently collected and shared. At each intercept, lack of information about the person's condition and need to have the case expedited for consideration of appropriate diversion from the criminal justice system by anyone empowered to do so posed a barrier.

Other identified barriers:
Initial Detention /Initial Court Hearings
(Committing Magistrate or Bail Schedule), Jail First Appearance Court (Arraignment):

- Once criminal case is charged, criminal justice culture militates in favor of processing the case toward a legal resolution rather than a treatment diversion
- Domestic Violence Assault statute often results in seriously mentally disabled co-residents of Assisted Living Facilities who are charged with assault being removed from their only housing option
- Committing magistrates have no civil legal alternatives to divert to treatment (civil instead of criminal commitment)
- No formal jail diversion program
- Even when bail is set very low, people with serious disorders are indigent and can't bail out
- Some or all guardians (a lot of inmates have guardians) won't post money for bail
- Communication issues: we may not know there is a problem or that they have a guardian
- The inmate is a poor historian or can't answer questions
- DOC lacks a good information repository
- DOC has no mechanism to communicate information statewide to legal players and limited ability for referrals or to expedite referrals
- The barriers to sharing information include confidentiality and HIPAA. Defense attorneys may not perceive that the client benefits from mental health processes once initiated. PD's don't like DA and DOC talking to inmates.
- No immediate advocate to help inmate navigate bail and reconnect with natural supports - arraignment not held for 24 hours and sometimes days, if the inmate is unstable
- Hard to locate natural supports for the inmate – (guardian, family, treatment provider, etc.) to assist them to make bail
- Guardians won't post bail
- No formal jail diversion program
- No legal or other mechanism to bring case to the attention of the court or counsel for expedited attention
- Pre-trial inmates with serious disorders are excluded from lesser classifications like CRCs, as there is no medication management staffing
- Large court calendars prevent identification of people with serious disorders
- Judicial officers and lawyers are untrained in identifying people with serious disorders
- Even if trained, defense attorneys are not present at arraignment to identify

- Court dates are often not scheduled for weeks, leaving some inmates to languish since they do not self-advocate well for release
- Some defendants may not be transported for days due to their condition
- Competency for legal proceedings pose the barriers in 1) lack of forensic capacity to perform evaluations, which can take longer in some cases than a person would be sentenced to even if found guilty 2) limited hospital capacity for restoration capacity and 3) high jail cyclers who are found not competent, not capable of restoration are evaluated over and over again in each new case.

Assets - Initial Detention
(Committing Magistrate or Bail Schedule), Jail, First Appearance Court (Arraignment):

- Officer collected information is sometimes transmitted to the Magistrate and the jail. This information can help move the case toward medical and mental health treatment in DOC and toward an available specialty court. This is especially true when CIT trained officers are involved
- Magistrates, arraignment judges and DOC can directly refer cases to the mental health courts
- DOC screens for mental illness within 24 hours of arrest with evidence based tool, later for substance use disorders.

- Inmates who screen positive are referred to medical and mental health for treatment
- Jail Navigator in Anchorage employed by one of the largest community mental health centers provides early identification, information sharing, treatment continuity and swift discharge planning for exiting inmates
- AK judges have had some judicial training in mental health and substance use disorders
- Centralized competency calendar in Anchorage better uses forensic resources and then expedites cases into specialty court

Gaps – Initial Detention

- Information sharing for continuity of care/referral
- Substance Use Disorders not screened for swiftly or uniformly
- Substance Abuse treatment not consistently available pre trial
- Community treatment Jail Navigator only available in Anchorage
- Jail Diversion unavailable systematically
- Early advocacy for the person unavailable or not utilized
- No sub-acute long term or community based treatment alternatives for Incompetent/Non-restorable or others unaccepting of treatment.

Intercept 2: Initial Detention /Initial Court Hearings
Committing Magistrate or Bail Schedule), Jail, First Appearance Court (Arraignment)
Recommendations – Approved by CJCBHWG – May 25, 2016

- Amend the Alaska criminal statutes so that seriously mentally disabled persons charged with less serious assaults on Assisted Living or Nursing Facility co-residents or live in staff are not ordered out of their only housing option
- Implement formal information collection, documentation and sharing process around cases involving people with serious disorders that begins with first responder contact and continues through the life of the criminal case that do not impair criminal justice rights
- Expand the use of Jail Navigators to identify and help plan, coordinate bail release and link medically fragile/complex (like dementia; seriously mentally ill) expeditiously to natural supports in the community (this could be part of a pre-trial services and/or jail diversion effort)
- DOC to screen uniformly for substance abuse disorders and consistently treat these
- Implement a statewide jail diversion program for persons with serious behavioral health disorders through the newly established DOC Pre Trial Services Division, or other means, that identifies those eligible for diversion or needing treatment in jail through validated instrument or matching management information systems; screen at jail or at court by designated prosecutors, defense, judge/court staff and service providers; specially trained pre-trial service staff to link to comprehensive services, prompt access to benefits, health care, and housing and monitor the person in the community.
- State Medicaid and Criminal Justice reform efforts to collaborate to fund community based jail diversion services and supports
- Provide mechanism for DOC to alert courts without specialty courts that a person may be demonstrating symptoms that place competence for legal proceedings in question or that the case is in need of other problem solving

Sequential Intercept Mapping Model – Intercept 3
Jail, Specialty Court, Dispositional Court
Barriers:

- Jail cannot treat gravely disabled
  - a gravely-disabled person can be 6 weeks out from their next (misdemeanor) hearing
  - Loughner (9th Circuit) held that government's interest in being healthy enough to be determined to be competent to stand trial but that Loughner's right to be free of unwanted drugs overrode those considerations
- Insufficient beds to handle the number of mentally ill coming in
  - ___? of population are mentally ill
- Little treatment available pretrial
  - some basic group interventions,
  - open group on substance abuse for those who are pretrial
- Most treatment is post sentence – probably 90 days or more out for most

- Once they are in the institution, they lose the connection they had to community treatment. The individual might go from 2-3x a week programming to nothing
- Community-based providers do not 'in-reach' in part because they can bill outside, but not inside DOC.
- Once they are inside institution, public guardians 'take a break' but often a guardian is the person's only connection to the community
- Inmates with serious disorders are excluded from lesser classifications like CRCs, as there is no medication management staffing
- No mechanism for DOC to expedite case for court/counsel attention
- API does not timely accept forensic commitments
- Specialty courts are not available in all jurisdictions, defense and prosecutors are not utilizing them to their capacity due to limiting legal or clinical criteria or the personalities of the lawyers involved.
- Specialty courts may be too restrictive in denying participation to adjunctive medication users
- Sentencing courts receive little information and do not know how to structure behavioral health treatment conditions
- Behavioral health sentencing requirements not driven by assessment
- Access to treatment as a court condition is limited and costly
- Court order says they can't be released until they have housing
- Even small monetary bail amounts often keeps people in jail

Intercept 3
Assets - Jail, Specialty Court, Dispositional Court

- Some treatment is provided in jail
- Centralized Competency Calendar (in Anch)
- DOC can identify cases
    - to a specialty court in Anc, Pal, Jun
    - to Centralized Competency Calendar in Anchorage
- Mental health courts identify and expedite cases
    - Identify people with mental illness from arraignment lists
    - Screen for competency
    - Expedite cases for defendant to meet lawyers, for parties to problem solve
- SB91 and SB74 – Criminal Justice and Medicaid – reforms will allow all defendants better access to out-patient treatment and those receiving treatment through specialty court programs – could also support those in a jail diversion program

Intercept 3
Gaps: Jail, Specialty Court, Dispositional Court

- Insufficient treatment capacity in DOC
- Lesser restrictive settings (CRC) unavailable
- Jail diversion unavailable systematically

- No Jail treatment for grave disability
- Low forensic examination and hospital restoration capacity
- Insufficient number of specialty courts in the state, existing courts not used to capacity, inconsistent criteria
- Judges don't have enough information or knowledge to structure treatment conditions

Intercept 3 – Jail, Specialty Courts, Dispositional Courts
Recommendations- Approved by CJBHWG June 8, 2016

- Implement a statewide jail diversion program for persons with serious behavioral health disorders through the newly established DOC Pre Trial Services Division, or other means, that identifies those eligible for diversion or needing treatment in jail through validated instrument or matching management information systems; screen at jail or at court by designated prosecutors, defense, judge/court staff and service providers; specially trained pre-trial service staff to link to comprehensive services, prompt access to benefits, health care, and housing and monitor the person in the community.
- State Medicaid and Criminal Justice reform efforts to collaborate to fund community based jail diversion services and supports
- Establish lesser restrictive CRCs for people with serious mental disabilities or create regional or multiple CRCs that just serve people with serious mental disabilities. Perhaps adding medications management capacity to existing CRCs so they can serve a broader cross section of people would be a better strategy.
- Assure mechanism for DOC or API to provide services consistent with community and public health standards, including appropriate psychiatric medications for the gravely disabled
- DOC to widely offer therapy approaches addressing criminogenic thinking/behavior along with other evidence based therapies.
- Review criteria and referral processes, examine reasons for underutilization and remove barriers to maximize use of specialty courts
- DOC and Court system to collaborate on Addictions courts referrals
- Add specialty courts where the community can support them
- Medicaid reform efforts should include Medicaid reimbursement for those services utilized by specialty court participants
- Mental Health Court users should receive service priority in community based services to motivate participation and promote timely linkage
- Pre-sentence reports to include relevant behavioral health information and specific proposed treatment conditions
- Dispositional Courts to order only assessment driven treatment conditions
- Implement Centralized Competency Calendar in each district, which could also serve as a clearing house for serious cases flagged by DOC for expedited consideration by the parties
- Expand forensic capacity for examination and restoration
- Medicaid Reform efforts to include requesting a 1115 Medicaid Waiver to benefit people with serious behavioral disorders involved in the justice system. [This is one type of available waivers authorized by the Social Security Act, giving the DHHS Secretary

authority to approve experimental, pilot, or demonstration projects that promote the objectives of Medicaid. The 1115 Waiver will be a central piece of the DHSS Behavioral Health Redesign and Reform efforts, allowing the state to expand services covered by Medicaid, the way services are offered and how costs/payments will be structured.] Alaska has not yet made the decisions about what specifically we will request in our 1115 waiver request

- State of Alaska SB 74 and SB 91 efforts to coordinate to provide jail diversion supports for people with serious behavioral health disorders
- Sign all DOC Medicaid eligible inmates up for Medicaid while in custody

Program Example:

San Antonio Texas

Blueprint for Success: The Bexar County Model – How to Set Up a Jail Diversion Program in Your Community

Through its unique position within the criminal justice system, the jail diversion program offers immediate alternatives to incarceration for the mentally ill. Jail diversion is accomplished by applying a step-by-step methodology. The first step is to identify individuals with mental illness along the criminal justice process, and the second step is to integrate the appropriate social and health care services and make them available to these individuals for referral. Perhaps most significantly for the community is the establishment of crisis care centers in conjunction with jail diversion programs. These centers reduce emergency room use, resulting in significant savings for the community. For Bexar County alone, jail diversion programs leading up to the creation of the Crisis Care Center brought about a savings of nearly 5 million dollars in 2006. Police officers were freed from the enormous amounts of time spent waiting in the emergency room for screening and triage of mentally ill patients under their protection. This allowed a quick return to their duties within the community. Before the establishment of crisis care centers, police officers in Bexar County spent an average of 12 to 14 hours in hospital emergency rooms waiting for psychiatric evaluations. Today, the crisis care centers provide these same services in one hour.

THERE ARE A NUMBER OF DIRECT BENEFITS PROVIDED TO THE COMMUNITY BY JAIL DIVERSION PROGRAMS:

Jail diversion programs reduce monetary costs to the community and they improve the quality of life for consumers, which arise from inadequate mental health services or even a total lack of mental health services within the prison system. Jails are not designed to provide the necessary facilities to serve the emotional and medical needs of the mentally ill. Jail diversion programs redirect mental health consumers toward the mental health service system where they and society are better served. Jail diversion programs offer judges and prosecutors much needed alternatives for disposing cases involving the mentally ill. At one time, incarceration of these individuals was the only choice, but now those in need of treatment can be placed outside the criminal justice system. Jail diversions make more jail and prison space available for violent offenders, thus enhancing public safety. These programs interrupt the endless cycle of arrest-jail back to street for many of the non-violent mentally ill who become caught up in the criminal justice system without hope of treatment. For nearly 30 years since their inception, jail

diversion programs have enjoyed wide support for their ability to reduce involvement in the criminal justice system by the mentally ill and those with substance abuse disorders. Surprisingly, to date there are few studies documenting the effectiveness of these programs. Those studies that do exist, however, demonstrate the success of diversion programs. In a 1995 Los Angeles investigation, of 101 diverted individuals, 80 were transported to a hospital with 69 remaining as mental health inpatients and only two ultimately ending up in jail. Another study of a jail based diversion program in Rochester, New York found that in the year following intervention there was a mean reduction in the number of jail days by more than half. In a multi-site research initiative sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 1997, the well-being of mentally ill individuals improved on a number of measurable points. This includes reduced days spent in psychiatric and residential treatment facilities, more time back in the community, improved mental health symptoms over time, "and more mental health treatment being received by the diverted group. Finally, in a review of four programs, two reported no savings; however, New York City reported $6,260 in savings per individual due to reduction in jail time, and Memphis, Tennessee reported $5,855 in savings. SAMHSA's conclusion was that jail diversion 'works' by reducing jail time and offering the potential of community savings.

Intercept 4-Jail Reentry/Prison Reentry

Barriers – Jail – similar to prison reentry except that a high percentage of inmates are in a "pre-trial" not sentenced status; therefore, a release date is not known. As a result discharge planning and reentry assistance does not occur in most cases. For inmates who had Medicaid and Social Security benefits prior to incarceration those benefits are suspended after 30 days of incarceration and may not be reinstated for months. Comprehensive, collaborative discharge planning can be further complicated because service providers often don't know their clients are in jail.

Barriers – Prison

- Housing (including institutional and community housing options
- Employment
- Lack of treatment capacity/ timely acceptance to services (waiting lists)
- Lack of medical and dental treatment
- Generally a lack of individual medication continuity between DOC, API, and community providers upon release
- Generally a less than adequate supply of release medications for mental health conditions
- Updated assessments (mental health, substance abuse, criminogenic, etc.) do not follow the inmate into the community
- Lack of universal release of information accepted by all agencies. Some are HIPAA and 42 CFR compliant, some are not. Some agencies prefer their own release.
- Rural reentrants are unable to return to home community because some court ordered treatment only available in urban areas
- Transportation

- Loss of ID and personal property
- Limited access to new personal identification upon release
- Lack of advocacy for persons experiencing a disability, have literacy or communication challenges and/or without the financial or personal relationship (family/friends) resources to assist in navigating the criminal justice system.
- Heavy institutionalization/learned helplessness
- Lack of current diagnostic/assessment info
- Stigma and some community resistance to welcoming released individuals back into their home community
- Lack of mental health and co-occurring substance abuse treatment/case management for those without psychotic disorders
- For people with intellectual development disabilities – lack of information as to exactly what are the problems/needs at the time of sentencing
- Barrier crimes
- The lack of availability of culturally appropriate treatment
- The lack of treatment for varying levels of literacy and comprehension
- In rural communities lack of housing is an eventer greater barrier
- Inadequate release communication and coordination between the Correctional, Institutional Probation and Field Probation Officers
- Lack of in-reach and reentry services statewide
- Lack of integrated case management among agencies and justice system navigation
- Lack of warm transfer of inmate by institutional probation to community probation
- Prisoner movement between facilities can make reentry planning a challenge
- Although recent legislative bills have included language and reference to State collaboration with Alaska Native (tribal) governments and organizations it does not carry the same weight as language directing State departments to collaborate on these issues
- Workforce challenges at every level, from direct care to case management to psychiatric positions

Intercept 5 – Probation/Parole

- The predominant model of supervision is oriented to monitoring for compliance and not for the individual's success which requires being supportive, problem solving balanced with accountability and public safety
- Few resources for seriously mentally ill (SMI) with co-occurring disorders
- Specialized probation only available in limited places and for limited population ("IDP-Plus" population eligible for specialized probation and clinical services (for psychotic disorders) but other seriously mentally disabled groups do not and fall between the cracks: Ex: Other Mental disabling mental illnesses + Intellectually disability+TBI + FAS, etc. – low functioning populations with non-psychotic disorders

Intercept 4 and 5 – Assets

- DOC – APIC (Assess, Plan, Identify, Coordinate) discharge planning for inmates with psychotic disorders
- DHSS-Alcohol Safety Action Program (ASAP) in-reach into DOC
- 24-7 monitoring
- Anchorage jail coordination with Narcotic Drug Treatment Center
- Community mental health provider embedded in the Anchorage jail complex to identify persons booked into the jail with a mental illness
- DOC Offender Management Planning (OMP)
- Prisoner reentry centers that provide reentrants with case management to link to housing, treatment, employment, probation officers and other supports and services
- Prisoner reentry coalitions to assist and partner with DOC and the returning citizen in the reentry planning, release and connection to community services/resources
- Specialized probation for persons with a severe and persistent mental illness(SPMI) in specific locations
- Homeless shelter coordination with DOC/jails
- improved collaboration between DOC and community based providers in some locations
- Reentry classes run by reentry centers in DOC (Hiland)
- DOC efforts to enroll inmates in Medicaid,
- Improved communication between the Court and DOC regarding upcoming discharges (Mental health court/centralized competency calendar in Anchorage)
- Bethel Public Defender/Alaska Legal Services Inc. holistic defense pilot project connecting civil and criminal representation as social service support around the individual

Intercept 4 and 5 Recommendations - Draft

- Continued support for DOC's Alaska Prisoner Reentry Initiative (AK-PRI)
- Improved data sharing between across community providers and with DOC
- Create a universally accepted Release of Information form that is compliant with HIPAA, 42 CFR and State confidentiality laws and require that all agencies accept the release
- Increase in-custody release-planning staff to do reentry needs assessments in all communities
- Update behavioral health and Level of Services Inventory – Revised (LSI-R) assessments for reentry
- Maintain linkage to a continuum of care for reentrants by increasing number of reentry centers/coalitions
- Increase treatment capacity for mental health and substance user disorders
- Provide access to medical and dental treatment (hard to get a job with no teeth)
- Streamline access to treatment for returning citizens
-

- Increase Specialized Probation and clinical services to all areas in the state and expand eligibility to all inmates with serious mental disorders
- Utilization Community Residential Centers (CRCs) as true reentry halfway houses and provide or require in contracts programs for mental health, substance abuse, employment, etc.[5]
- Implement/improve information and data sharing between providers for identification, service and evaluation purposes.
- Conduct community specific assessment of reentry service needs in order to support obtain funding (because statewide decision-makers don't know what a relative reasonable constellation of services should be in place for each community)
- Assure that all inmates, have applied for receipt or reinstatement of Medicaid prior to release
- Cross train community providers on criminal justice/reentry legal issues
- Use restorative justice approach to promote successful reentry/reintegration for individuals to their home communities (rural and urban) so they are not displaced
- Continue to review and address identified issues with barrier crimes impacting successful reentry
- Closer collaboration between Office of Children's Services (OCS) parenting requirements and DOC reentry case planning
- Continue DOC Offender Management Planning process driven by LSI-R and behavioral health other assessments
- Train community corrections officers and community providers on the use of graduated incentives and sanctions to reinforce positive behavior and also address noncompliance with probation conditions

[5] A challenge earlier noted by Dave Branding is relevant here. It's difficult to staff CRC's and specialized care with qualified staff in non-rural areas.

Staff Notes and Meeting Sum
WORKGROUP ON BEHAVIORAL HEALTH[1]
Alaska Criminal Justice Commission
Wednesday, May 25, 2016
9:00 -11:50 AM
Location: Alaska Mental Health Trust Authority

Commissioners Attending: Rhoades, Jeff Jessee, Kris Sell (joined mid-meeting)
Commissioners Absent: Greg Razo, Dean Williams, Gary Folger, John Coghill
Other Attendees: Alysa Wooden, DHSS; Paul Miovas, Dept. of Law; Steve Williams, Trust; Laura Brooks and Rutherford, DOC; Tony Piper and Stacy Toner, DHSS; Diane Casto, DHSS; Karen Forrest, DHSS; Jeff Jessee, Trust; Jerry Jenkins, Anchorage Community Mental Health; Ron Green, Center for Drug Problems; Dave Branding, South Peninsula Behavioral Health Services; Tina Woods, Alaska Native Tribal Health Consortium; Bill Miller, APD (joined mid-meeting); Morgen Jaco, DOC; Janet McCabe, Partners; Katie Baldwin, Trust; Brad Myrstol and Aricelle Valle, UAA; Kate Burkhart, Alaska Mental Health Board.
Staff: Mary Geddes, Giulia Kaufman.

Materials/Links provided in advance of meeting:
Power Point on Sequential Intercepts (now on ACJC Resource page)

The workgroup began with introductions and a return to the PowerPoint for Sequential Intercepts planning. The group reviewed the draft circulated of our Intercept 1 related recommendations. There were no corrections offered and everyone agreed to use it.

Intercept 2 INITIAL DETENTION/INITIAL COURT HEARINGS

This interception involves:

- Initial detention
- Jail bookings
- Pretrial detention

Presenting question how much information about a mentally ill person which is possessed by the police officer gets communicated, first to the jail and second to the magistrate?

Paul Miovas noted that information is lacking even earlier in the process. There can be an entry in APSIN that someone is "violent, " indicating some basis for concern, but the same entry might say nothing about schizophrenia, etc. Ideally DPS would provide such information and have such information centralized.

Furthermore, even when an officer knows or has gleaned that there is a mental illness or a history of mental illness, his information may not always be conveyed in an appearance before a

[1] Throughout the continuum of care in the criminal justice system.

magistrate, and no one is flushing that out on the record. Miovas wondered if this is a training issue. Could magistrates be trained to ask a list of questions which might identified the issue?

Laura Brooks stated that the problem for DOC can begin with an arresting officer. Information is not getting passed along at when the inmate is transported to the jail. Rutherford agreed that if DOC could know, right from the get-go, that there is a behavioral health problem, it would be helpful.

With respect to the bail setting, Stephanie Rhoades noted that officers are able to rely on now statewide bail schedules, and that most offenses do not require that the magistrate personally set bail. However, for some crimes, offenders do go before a magistrate for bail setting. Persons may evince symptoms which may cause the judge to feel that he or she can't release them. Magistrates perceive that they have no alternative to monetary bail. They have no mechanism allowing them to switch the case to a civil matter. (There needs to be a petitioner.) Once an initial bail is set, there is an inertia that sets in, and it is hard to get the initial bail changed. Notably once a person is incarcerated, the need for a civil commitment goes away because DOC has them in their care.

Brooks noted that there are two barriers thereafter: inmates are often unable to pay even small amounts of bail , and there is often no place for the person to go to when released. DOC will often see bail orders that state people can be released when they have an appropriate living arrangement. Rhoades was curious about such orders. Brooks and Rutherford said that they had seen such orders in cases when the person is either seriously mentally ill or has dementia.

Barriers at this Intercept were identified:

1. Court order says they can't be released until they have housing
2. Even small monetary bail amounts often keeps people in jail
3. Some or all guardians (and a lot of inmates have guardians) won't post money for bail
4. Communication issues: we may not know there is a problem or that they have a guardian
5. The inmate is a poor historian or can't answer questions
6. We lack a good information repository
7. We have no mechanism for us to communicate information statewide
8. We have limited capacity for referrals or to expedite referrals
9. The barriers to sharing information include confidentiality and HIPAA. Defense attorneys may not perceive that the client benefits from mental health processes once initiated. PD's don't like DA and DOC talking to inmates.

Adam Rutherford noted that inmates often have poor contact with their attorneys. For example, inmates may remand in Bethel but end up in Anchorage. There is no one that can help our inmates communicate with their attorneys. And the time between hearings can be lengthy so courts may not be aware of any problem either. How long is it before some who has been arrested has a scheduled hearing? For felonies it will be one week, but for misdemeanors, it can

be six weeks before a hearing is scheduled. It is critical that courts learn about a persistent mental health problem but it is too infrequently communicated at the outset.

Brad Myrstol asked about the DOC in-reach done by Anchorage Community Mental Health. Rutherford noted that, at remand, in Anchorage DOC health personnel consult their internal list which they use to try identify people with mental illness. Their second step is to confer with Mental Health for their own review of intakes. The third step is for ACMH to plan for the continuation of medications and care for the person while they are in DOC institution. The problem/barrier here is that this is not possible on a statewide basis and therefore timely.

Regarding the barrier of bail, Rhoades asked about the group's familiarity with jail diversion programs. Any interest in this national best practice? Miovas indicated that while there may be interest in a team approach to jail diversion, it is a resource issue. Rhoades noted that they had a SAMSHA (Substance Abuse and Mental Health Services Administration) jail diversion project, but it was too small; prosecutors were not willing to make a greater number of referrals to the program. Tina Woods indicated that there are good models in juvenile justice and that she had been active in youth diversion with Tom Begich.

Rutherford mentioned the nationally renown jail diversion program in San Antonio, TX. [See http://www.fairfaxcounty.gov/policecommission/subcommittees/materials/jail-diversion-toolkit.pdf. In the first 5 years, more than 4,000 individuals with mental illness from incarceration to treatment and saving the county at least $5 million annually for jail costs and $4 million annually for inappropriate admissions to the emergency room.]

Myrstol stated that he was doing work concerning the intersection of homelessness and criminal justice. He wondered if we could take advantage of booking as an opportunity to intervene, and whether there is opportunity at bail reviews, even if the defense attorney's role early on does not typically involve the sharing of information about prior acts and hospitalizations.

Rhoades noted that attorneys don't know (if? how?) they can put together packages of recommendations for bail releases. Either they have no time or limited education about doing it. Jeff Jessee asked Steve about the Bethel pilot projects funded by the Trust. A social worker has been funded to work at the Bethel Public Defender. Social workers are of great use in such contexts, locating community resources for clients. Rhoades agreed that there is information-related barrier because attorneys are NOT necessarily well informed as to DOC resources, for example.

Brooks said that she was frustrated because DOC can see someone time and again who has been determined not to be competent and not restorable. Jeff Jessee noted that the role for defense attorneys is to get their clients out the door in a quick disposition and not tie them up for a competency hearing two months from now or restoration processes lasting 6 months.

Steve Williams asked if these cases be dealt with differently. The higher volume systems prevent discovery of underlying issues. Often the judge lacks experience or training so that they judges are attuned to "proxies" for mental health issues.

Rhoades noted that the point of interception is often one where there is no trained advocate. It's been years and years since the PD's had duty attorneys at initial intake or arraignment proceedings. And the courts don't want to be pro-active before any attorney is involved. Mary Geddes noted that a statute requiring the early appointment/appearance of attorneys might be a statutory fix.

Miovas noted that there are challenges (in making early release decisions) as there are no real mechanisms by which one can ensure that a high-cycler mentally ill person will not be a danger, especially when they have nowhere to go. Rhoades noted that there are national models to deal with high cyclers.

There was a question concerning DOC current screening practices. The 'jail screen' is not a best practice. The DOC intake does not screen for substance abuse disorders, although DOC does conduct a breath alcohol test and ask what they have consumed. Within 5 days, DOC screens for substance use as well. But not all of DOC facilities have a 24/7 mental health staff and there may be no mental health person to see them in the first 24 hours. In DOC-contracted community jail, there is rarely medical, no mental health staff, nor do all have contracts with local MH. They often consist of 2-4 cells. If a person is obviously symptomatic, video or audio on call services can be used.

It was also noted that in many rural communities, the 'DOC' mental health providers are actually the community mental health providers. These providers are not only very part-time, but their understanding of legal issues may be very limited. They usually have limited or no experience with forensic/competency questions.

Review of assets:

Arraignments can provide opportunity

- DOC could identify case
  - to a specialty court
  - request expediting
- Mental health courts can be pro-active
  - In Anchorage, we look at lists for arraignments, we let people know, and inform attorney so they can attend

Prosecutors – provide training so they can

- Request mental health screening from DOC
- Request the matter be calendared to wellness court
  - Anchorage - court meets MTW
  - Palmer – court meets 2 times per week
  - Juneau – court meets 1 time per week
  - None in Fairbanks

Ron Green, speaking about his clients on medication-assisted therapy, indicated that more could be served in the therapeutic courts but they have been categorically disallowed by DOC while on methadone or suboxone. Janet McCabe noted that the perceived problem is the potential for street sales with any self-administered drug. Ron has been in contact with therapeutic court coordinator Michelle Bartley, who has stated that she may approve on an individual basis.

Intercept 3: JAIL, SPECIALTY COURTS, DISPOSITIONAL COURT

Outlining the barriers under this intercept:

- There are barriers to providing treatment pretrial
    - E.g., a gravely-disabled person can be 6 weeks out from their next (misdemeanor) hearing
    - Loughner (9th Circuit) held that government's interest in being healthy enough to be determined to be competent to stand trial but that Loughner's right to be free of unwanted drugs overrode those considerations
- We don't have enough beds to handle the number of mentally ill coming in
    - 65% of population are mentally ill
- Little treatment available
    - some basic group interventions,
    - open group on substance abuse for those who are pretrial
- Most treatment is post sentence – probably 90 day outs for most
- Once they are in the institution, they lack the connection they had to community treatment. The individual might go from 2-3x a week programming to nothing
- Community-based providers do not 'in-reach' in part because they can bill outside, but not inside DOC.
- Once they are inside institution, public guardians 'take a break' but often a guardian is the person's only connection to the outside world
- DOC can do a better job of thinking about the wellness courts as a resource

Rutherford: While we might imagine that half way houses (CRCs) are a theoretical option, most of the mentally ill inmates are excluded from CRCs because they have no medical staff, and the inmate needs to be able to exercise enough initiative to get their meds from the CRC staff who hold them. There are other reasons why CRC's might not be a good fit for this group of inmates, e.g. their staff people don't have skill set to integrating people who have behavioral health problems and the CRC's would not right now meet national standards for their care-taking. However, this is worth thinking about as a source because CRCs are eligible for Medicaid now, and 15 years ago we did have a mental health CRC. Such a specialized facility could accommodate mix of pretrial with post trial.

We do have a capacity problem. API is not truly evaluating, and it is not a setting where competency can be restored. Jim Jenkins noted that there are other places that provide (criminal) restorative services in a community based setting, except for capital cases. Rhoades noted that

our statutes require institution-based competency restoration, and the amount of time for misdemeanor evaluation is as long as for felons.

MORE BARRIERS

Miovas noted that the biggest barrier to release is that there are few services downstream. It would be better if we know that once released back to community, the person is going to get services. Barriers identified by Rhoades from his discussion were no long term care, and no mandated out patient care.

The alternative to having such interventions in place is recriminalization. Jeff Jessee noted that there had been a bump with lot of cases which had a genesis at API. Person would be the subject of a competency order, would be sent to API, at API the person would get a new charge and go back to jail. Jeff thought it was related to API union staffing issues at the time.

Rutherford stated that another problem is that our referrals are going to community based providers who aren't using evidenced based interventions.

Rhoades notes that DOC is not offering MRT therapies for pretrial defendants.

Janet McCabe stated that another possible barrier is that a lack of early identification and referral to addiction courts; I note that there are courts that have underutilized capacities. Concerns were then expressed about too few individuals not allowed into Anchorage's wellness courts by the Department of Law. Tony Piper noted that the Fairbanks courts were always full. Miovas of Law noted that Law decided to consolidate the decision-making in Anchorage to one person for consistency's sake. Not everyone would make the same calls. This observation prompted Steve Williams' question about other jurisdictions' experience in making such determinations.

Rutherford thought that one barrier is a shared confusion in many locations is about what services can be provided.

Rhoades thought the cost of services for a psychiatric evaluation and for treatment is a barrier.

BRAINSTORMING ASSETS

Rhoades noted that we have strong operational therapeutic courts that can be used (Rhoades) Therefore we should recommend actions that expand/use capacity of courts. Rutherford asked how can cases be handled in more rural courts? Miovas noted that the DOL's model was to require people to be in community where services are.

Rhoades suggested that we consider the displacement that results from that model. We need to expand our capacity at least through training of judges and other professionals. The consequences of poor training is profound. For example the verdict of guilty but mentally ill was

sought for a person who stole a car. The draconian consequence of this decision was probably not anticipated.

Rutherford suggested that Alaska needs a 'FACT' team: Forensic, Community, Treatment with a small caseload, providing wrap around services and ongoing contact. Brooks responded that DOC did not formally convene on, but we have done this on an individual basis. We didn't formally convene, but did it on an individual basis. The goal of the team is to keep the person out of jail. Janet McCabe was reminded of the similar concept utilized by the Wellness Team in Kenai involving both the court and the Kenaitze Tribe which involved community members. Rhoades distinguished between a FACT 'service' team and circles which are typically limited to one or a few disposition hearings. Tina Woods noted that tribal courts implementing "Restorative Justice" do engage in creative case management in communities numbering from 20 -500. In one particular case she was thinking of there had been involvement from regular police, VSPO's and tribal police. We all needed education to help keep him home. Rhoades agreed that smaller communities had an asset that sometimes larger communities didn't: in smaller places, the deciders and providers were all in the same place.

Myrstol began a discussion about the potential asset of presentence reports. He noted that presentence reports apparently are lack information about community resources, but if they included it would be a great aid. If course, many cases don't have them at all, and DHSS/DBH "probation officers" aren't certified.

Jeff Jessee noted that SB91 and SB74 – Medicaid – reforms will allow defendants to better access out-patient treatment and support referrals to specialty court and jail diversion programs

Myrstol noted that the pretrial tools and processes under SB91 will hopefully allow for pretrial officers to disseminate the information about services.

Diane Casto stated that at DHSS, we are looking at linkages (SB91/SB74) in integrated fashion, i.e. how to get those Medicaid eligible people services before court involvement and when they come out on the other end.

BARRIERS SPECIFIC TO ARRAIGNMENTS

Rhoades noted:

- Sometimes judges lack information about why defendants are not brought to court – we are told "we are on hold" – there is no description provided through DOC/DPS/Judicial Services
- DOC never says don't transport, for example, in a suicide watch situation. We inform DPS and DOS makes the call.
- We have had people not brought over for 9 – 10 days, and we don't know why

Brooks noted that the issue is the holding cell at the court doesn't have a camera; that's why DPS doesn't want to bring them.

Williams noted that the time allowed for arraignment doesn't allow the court or others time to explore what happened.
Miovas mentions that defense attorneys often rebuff any inquiries to defendants at this stage of the process.

Myrstol identified as challenges: diagnostic capacity, and the statewide network of private and public providers. Police and law enforcement and courts perceive there is a structural disadvantage to releasing defendants, and it is hard to make progress without full buy in on the part of those partners

Brooks is concerned with those cases in which the DV laws have an unintended consequence. The defendant may be a resident at an assisted living facility or at home, with dementia, and has to be arrested under the law. The home or the care provider may be good with the defendant's return to the home. But the law prohibits it.

Miovas noted that there is an 'out' allowing the person to go home, but it requires consultation with a DA. Miovas noted that this person will probably not have an attorney or will not have meaningful contact with them for several days. Brooks stated that there is no meaningful advocacy in this crucial stage of the case.

Rhoades recommended that the statute defining domestic violence should be changed to exclude assisted living and nursing facilities in cases of dementia.

Diane Casto mentioned the State's interest in requesting a 1115 Medicaid Waiver. [This is one type of available waivers authorized by the Social Security Act, giving the DHHS Secretary authority to approve experimental, pilot, or demonstration projects that promote the objectives of Medicaid. The 1115 Waiver will be a central piece of the DHSS Behavioral Health Redesign and Reform efforts, allowing the state to expand services covered by Medicaid, the way services are offered and how costs/payments will be structured.] Alaska has not yet made the decisions about what specifically we will request in our 1115 waiver request

Time for public comment was allowed, but none was provided at this time.

Staff Notes and Meeting Summary (revised 5/24)
WORKGROUP ON BEHAVIORAL HEALTH[1]
Alaska Criminal Justice Commission
Wednesday, May 11, 2016
9:00 -11:50 AM
Location: Alaska Mental Health Trust Authority

Commissioners Attending: Stephanie Rhoades, Jeff Jessee, Kris Sell
Commissioners Absent: Greg Razo, Dean Williams, Gary Folger, John Coghill
Other Attendees: Steve Williams, Trust; C N. McLaughlin, Partners for Progress; Laura Brooks, DOC; Randall Burns, DHSS; Tony Piper, DHSS; Alysa Wooden, DHSS; Diane Casto, DHSS; Karen Forrest, DHSS; Jeff Jessee, Trust; Jerry Jenkins, Anchorage Community Mental Health; Ron Green, Narcotics Treatment Center; Dave Branding, South Peninsula Behavioral Health Services; Tina Woods, Alaska Native Tribal Health Consortium; John Skidmore and Steve Bookman, DOL; Bill Miller, APD; Tayler S. Matthews, Central Peninsula Behavioral Health Services; Mike Eldridge, Alkermes (Vivitrol); Morgen Jaco, DOC; Janet McCabe, Partners; Katie Baldwin, Trust.
Staff: Mary Geddes, Giulia Kaufman, Susanne DiPietro

Materials/Links provided in advance of meeting:
Power Point on Sequential Intercepts (now on ACJC Resource page)
"Trust Beneficiaries in Alaska's Department of Corrections," Hornby-Zeller, May 2014
UNLV Review of Alaska Mental Health Statutes

Introduction: The meeting began Commissioner Jessee, co-chair of the Workgroup, provided an introduction to the Workgroup's origins, relationship to the Commission, and function. The Alaska Criminal justice Commission (ACJC) , with a three year mission, has been tasked with a three year mission to evaluate the efficacy of interventions and treatment programs which may be alternatives to incarceration. Hopefully, the Workgroup can reach consensus statutory, policy, practice or funding recommendations to forward to the full Commission and administration for action.

Also, the Commission needs input from the Workgroup with respect to a second task. The Commission has been asked by the Criminal Justice Working Group to look at the recommendations made by the University of Nevada Law School (a contractor for the Trust) for reforms to the state's mental health statutes, concerning involuntary commitment, competency and insanity statutes relating to criminal process.

The plan for the Workgroup as formulated by co-chairs Jeff Jessee and Stephanie Rhoades, is to compress the group's work into a two month block, and to begin its work by using the Sequential Intercepts model as a way to structure discussion. One goal is to inventory existing BH programs and practices which help prevent any unnecessary incarceration of persons, and to figure out how to do better. We need to fill in the gaps.

[1] Throughout the continuum of care in the criminal justice system.

The Schedule: Jessee identified the schedule going forward for this intensive two month effort, and noted that all meetings will be at the Mental Health Trust.

Behavioral Health Workgroup	Wednesday, May 25 9:00 AM-12:00 PM	Alaska Mental Health Trust Authority 3745 Community Park Loop # 200, Anchorage
Behavioral Health Workgroup	Wednesday, June 8, 9:00 AM- 12:00 PM	Alaska Mental Health Trust Authority 3745 Community Park Loop # 200, Anchorage
Behavioral Health Workgroup	Wednesday, June 22 9:00 AM- 12:00 PM	Alaska Mental Health Trust Authority 3745 Community Park Loop # 200, Anchorage
Behavioral Health Workgroup	Wednesday, June 29 9:00 AM- 12:00 PM	Alaska Mental Health Trust Authority 3745 Community Park Loop # 200, Anchorage

The Sequential Intercepts Model: Commissioner Rhoades thanked all for coming and participating.

> **Agreement #1:** She asked if we could begin with a fundamental agreement: that there are some people in jail who don't need to be in jail but need treatment, as well as some people who need to be in jail but also need treatment. (There was agreement.) She said that the idea of using the Sequential Intercepts Model is to 'cross-train' and educate each other as to resources and barriers. She walked the group through the model.
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> **Agreement #2**: Rhoades said that the model required a second principal agreement: that people who are amendable to treatment should get it, no matter where in the model they are , e.g. pretrial, post-sentencing, or in between.

PowerPoint: Steve Williams took the group through a PowerPoint presentation.[2] Stopping at slide 11, he noted that we have both significant urban and rural populations and challenges. In discussing slide 13, he noted that the Hornby Zeller Associates study defined Trust beneficiaries, based on DOC, Medicaid, ORCA, Juvenile Justice ('Jonas') and API databases, as well as regular contacts with Alaska community mental health centers. Williams also noted that there had been some decline in recidivism stats for this group, as well as the larger DOC population; the working assumption is reduction is due to DOC efforts in programming and reentry efforts.

Population at risk: A question was raised about the numbers and percentages identified as Trust beneficiaries, as opposed to the much larger numbers and percentages of alcohol and drug involved individuals in DOC. Sell noted that virtually all calls except for a few fender benders involve alcohol or drugs. Sell noted that we have not previously related or equated the treatment of substance abuse with the treatment of mental health issues, and perhaps we need to do that.

[2] This Power Point presentation can be found under the Behavioral Health heading on the ACJC Resource webpage.

Bookman asked if the model extends to sexual disorders; Rhoades said she didn't know. Susanne DiPietro said that the ACJC has received a special directive from the legislature to do a report on sex offending and that a separate work group will be convened for that purpose. Commissioner Sell suggested that we do not discuss sex offending in this work group but reserve it for that separate study. Rhoades clarified that we would be discussing clinically treatable Axis II disorders, mental disorder sand substance abuse, Jeff Jenkins indicated he was happy with separating out fire starts and sex offenders because these are really separate populations. Laura Brooks also suggested that we also distinguish sex offending from gender issues like sexual dysphoria.

Cathleen McLaughlin said she was troubled by the exclusion of sex offenders in this discussion. Many of this large group seen at Partners for Progress have alcohol issues that had a role in the sexual offense. Fully half of these individuals are from rural areas. There are often co-occurring disorders. Laura Brooks noted that sex offender treatments have not been designed around co-occurring disorders (sex offense and substance abuse), but there certainly is a need for such specialized treatment.

Stats reviewed: (Slides 17-20)

No of API beds:
Title 47 Civil = 70 Title 12 Forensic = 10

	T47	T47 ALOS	T12	T12 ALOS
Admits	1596		59	
Discharges	1601		51	
LOS 0-90 days	1584	9.06	36	52.14
LOS <90> 365 days	15	162	14	128.07
LOS>365 days	2	567.5	1	1533

Number of API competency evaluations conducted FY 15:

	Misdemeanor	Felony
Competency	111	106
Culpability		5

Adult Outpatient/Intensive Outpatient state funded treatment
Total 1173 slots

	Anchorage Region	Southeast Region	Southcentral Region	Northern Region
OP/IOP	165	297	732	589
Methadone	300	-	-	40

Statewide Substance Abuse Treatment Capacity
Adult Residential state funded treatment:
Total 223 beds

	Men	Women	W0men w./Children	Co-ed	Dual Diagnosis
Anchorage	12	12	28	28	18
Bethel	-	-	-	16	-
Dillingham	-	-	-	14	-
Fairbanks	-	-	12	10	-
Juneau	-	-	-	16	-
Kenai	-	-	-	10	-
Ketchikan	-	-	-	15	-
Old Minto	-	-	-	10	-
Wasilla	-	-	-	22	-

Timing of intervention: The review of the slides progressed. At slide 24 Diane Casto noted that the earlier a person was identified the better and that Medicaid reform will help. Earlier interventions are CINA, DJJ. Janet McCabe asked how can we break the intergenerational chain.

Crisis interventions: Captain Miller stated he thinks an overhaul of Title 47 might be in order. Perhaps the barrier to civil commitment is too high. APD itself has sought less than a half-dozen involuntary commitments to API. It's a tremendous amount of work. There has to be a real risk of someone being hurt. They only go that route with the most severe of cases. One of those cases involved a person with whom APD had a year-long involvement. Eventually they had to call out the SWAT team because of threats to blow up a building; nevertheless it was a strictly mental health case and they had that background with him. The APD Crisis Intervention Team get hundreds of calls, many bizarre, and from people complaining about unwanted contacts. Miller said the police are often reacting to public pressure in these cases. Sometimes its neighbors who are concerned or find someone has entered their homes.

Using the Sequential Intercepts Mode, Intercept 1 is the initial community contact (911, e.g.) What are the barriers to keeping persons with Behavioral Health disorders out of the criminal justice system for: 911 dispatchers and police responders?

Anchorage Police Department has resources that helps them identify people with mental health issues. People are certified for CIT at different levels. #1 basic, and #2 with academy training. They have a dedicated full-time CIT position that looks for solutions. We don't have a mobile crisi unit, but we do have CIT dispatchers. The default is to send an officer, but most calls don't go through to an officer. The dispatchers do often resolve the calls. The barrier here is that these calls can take a tremendous amount of time. One person can call 30x an hour, or every time they use alcohol. There aren't enough CIT trained officers. Another barrier is public pressure. Mental health disorders are wildly misunderstood. So we have lots of complaints from people who want someone jailed. We take a lot of flak for not arresting. Public seemingly wants punishment.

For in-person contacts in crisis, APD uses the "Pepper" (Providence Psychiatric Emergency Services, a partnership with Anchorage Community Mental Health) for up to 24 hour periods, but it's only a triage, there is not long-term follow-up. He thinks that one significant barrier is the limited number of beds at API. "Pepper" has wrought a vast improvement in the response picture, that a single point of entry into the mental health system is crucial because it means that the experts can deal with the question of where they go next.

Rhoades stated that person can go to API for acute intervention buts it's not long enough and there is not enough of a 'catch' with Community Mental Health.

Randall Burns noted there are other resources: No. Star, Providence Crisis Recovery Center as well as Providence Mental Health Unit. He also noted that there are very few direct entries into API and all are through Pepper. "Pepper" is successful in transitioning some cases to services, like to Ernie Turner for detox, however Turner is almost always full. They have used AWAIC, and often North Star Artic Patriot Program if the patient is active service. Out of "Pepper's" admissions, only 20% end up at API.

Miller said that jail is a typical backup to "Pepper," particularly with co-occurring disorders, as Providence won't touch drug-alcohol cases. Sleep-off is voluntary, overnight, and non-criminal

'holds' are also allowed until they sober up or up to 12 hours. APD has 3000 noncriminal committals a year; they are termed "protective custody holds." The vast majority of these are substance abuse related and not mental health cases.

Tina Woods stated that the threshold for committal is too difficult, and the turn-around at API too quick. She also noted that in rural areas, there is no alternative to noncriminal holds. For example, when an individual is praying on the runway, it falls on the BH provider or the police to petition. There is a high standard for commitment. If its voluntary and often it is, the person is often returned in a state less than stable because they don't want to be away.

Burns explained that, upon your admission to API, the first question asked is if you want the commitment to be voluntary. If you convert to voluntary status you are not going to court. When you next express a desire to go home, and are no longer in a high state of crisis, you will be released.

Woods agreed. She said, we have to do a better job of making people understand that it is not illegal to be mentally ill. The best practice in the community is around the clock checks. But this is really tough, really demanding. I can think of one case where a person with schizophrenia back in the community drank constantly and required hourly checks. The Title 47 bar is so high that it doesn't deal with chronic problems and our rural communities in particular are hard pressed to deal with them.

Sell stated that there are legal limits and also more resistance to DOC putting chronically inebriated into custody because of medical problems. In Juneau, the barriers are substantial. Juneau APD has no mental health partners, no real resources to help us; staffing in Juneau is a huge issue. The members of the public who are the most angry are shop owners near areas where mentally disordered or alcoholics hang out. So another barrier is that there is no other place to be.

Burns said we do need clarity as to what number of holds are under Title 47 (mental health) and what holds are under Title 37 (alcohol).

Inventory of Assets: Rhoades asked the group "What and where are our assets? What helps keep people out of jail?" Title 47 and 12-hour holds were then identified as assets. Williams added that the Anchorage Safety Center ("sleep off") is an asset for up to 12 hours. It is voluntary and there can be no violence. Additionally there are approximately 14 detox beds in Anchorage. Burns identified the Crisis Recovery Center as an asset, although maybe not for the police. Sell identified the assets in her community: families (although the mentally ill have often burned those bridges) and CIT trained staff. Tina Woods identified the training program "Mental Health First Aid," providing a two day program, was a new asset. [Ed.: I have attached an article mentioning this program to the summary.]

Inventory of Gaps: The next question asked by Rhoades was why aren't our assets working? Sell said a lack of capacity. She also identified the need to motivate young males in particular to get

treatment; jail isn't motivating them, perhaps because it is not uncomfortable enough? McLaughlin noted a lack of timely acceptance into programming. Casto stated there is a lack of consistent approaches across the state. Brandy, attending by phone from Homer, stated that there was no police training on mental health issues. Someone stated that there needs to be more mental health for the homeless. Miller said that APD's biggest problem are the anti-social disordered; that there needs to be 'a hammer' for getting them into treatment. Rhoades summarized: a stick or a carrot is needed.

Williams noted that currently there is very short-term response, Pepper (up to 24 hours) , API (up to 30 days or voluntary), and jail (up to 12 hours), but nothing more intermediate. What we lack a short term crisis or respite arrangement. We used to have 15 beds staffed by Southcentral. Burns noted that it still exists (Crisis Recovery Center), but 8 beds are for adults and 8 beds are for adolescents. Rhoades asked if there is a longer-term (more than 12-24 hours) stabilization center that law enforcement can use? Karen Forrest referenced the Juvenile Justice experience ("we ended up changing the statute"). DJJ provided grants for non-secure shelters. DJJ learned that they needed places to which the police could directly take folks.

Rhoades asked about the noncompetent, non-treatable population. Is mandatory outpatient commitment a need? Laura Brooks noted that there is a growing population with dementia. DOC is seeing more of them. A lot of DV assaults can result from dementia; family members want them back but may be foreclosed by statutes in helping them immediately. Miller agreed that this is a huge problem. There are 400 assisted living facilities who seemingly have no security plan except to call the Anchorage Police Department.

Woods noted that she is concerned with treatment planning that does not account for TBIs and lack of skills.

NEXT MEETING : Rhoades noted that we will continuing the mapping. ARRESTS will be one of the points of interceptions at our next meeting. Be prepared!

The workgroup will reserve one of its future meetings for the UNLV report after we have fully discussed the intercepts model.

Public comment: There being no additional public comment offered at this time, the meeting was adjourned.

The meeting ended at 11:50 a.m.

Staff Notes and Meeting Summary
WORKGROUP ON BEHAVIORAL HEALTH[1]
Alaska Criminal Justice Commission
Thursday, February 18, 2016
9:00 -10:15 AM
Location: Atwood Building, 550 W. 7th Avenue, Rooms 102 and 104

Commissioners Attending: Stephanie Rhoades, Jeff Jessee, Greg Razo, Brenda Stanfill, Trevor Stephens, Alex Bryner, Kris Sell.

Other Attendees: Bob Linton (DOL), Janet McCabe (Partners), Steve Williams (MH Trust), Areceli Valle (AJIC), Alysa Wooden (DHSS), Laura Brooks (DOC).

Staff: Mary Geddes, Teri Carns, Giulia Kaufman, Susanne DiPietro

Materials provided in advance of meeting:
"Trust Beneficiaries in Alaska's Department of Corrections," Hornby-Zeller, May 2014
UNLV Review of Alaska Mental Health Statutes
First-Episode Incarceration: Creating a Recovery Informed Framework for Integrated Mental health and Criminal Justice Responses (Vera Institute of Justice)
White Paper 2015: Medicaid Expansion and the Alaska Department of Corrections
*Online Powerpoint: "The Sequential Intercept Model: A Systematic Approach to keeping People with Mental Illness Out of the Criminal Justice System"

Due to difficulties with teleconferencing, the meeting had a delayed start around 9:20 AM.

Leadership. Greg Razo stood in as temporary chair because it was the Workgroup's first meeting. Jeff Jessee and Stephanie Rhoades were proposed and agreed to be the Workgroup's co-chairs.

Relationship of topic to SB64 Mandates. Brenda Stanfill noted that Behavioral Health is an appropriate and immediate topic because SB64 directed the Commission to consider the adequacy and availability of treatment programs, and to consider alternatives to incarceration.

Important parties to engage in future Workgroup meetings: DOC, DHSS (most likely Acting Director of Division of Behavioral Health Randall Burns), Tribal providers such as Southcentral Foundation. Alex Bryner mentioned that Corrections involvement was crucial. At this point, it was noted that Laura Brooks from DOC had joined the meeting.

Workgroup planning: The staff proposal to limit all committee work to intensive two-month blocks was viewed as unrealistic for the scope of this committee's work. It was agreed that the committee work on this topic should be delayed until after the end of the regular Legislative session because of the number of Commissioners tied up in Juneau. There was additional discussion on how its work would proceed.

[1] Throughout the continuum of care in the criminal justice system.

Mary Geddes suggested that the BH group could start its work with the review of the UNLV Report on Mental Health Statutes since the analysis was relatively complete and recommendations for changes had been made. Noting that there had been consensus in the CJWG subgroup on some of those recommendations, she asked if the Workgroup would like staff to prepare a synopsis. Jeff Jessee observed that UNLV had essentially done what the JRI staffers had done in terms of compiling the relevant research. Alex Bryner, who had seen the UNLV presentation, remembered that much of UNLV's recommendations reflected "best practices" and not necessarily evidence-based reforms; consequently, he wondered if those recommendations would be hard to translate into cost-benefit analysis. Stephanie Rhoades said there were evidence based recommendations included, but she thought there are reasons to delay consideration of the report. Stephanie Rhoades said that the members of the Workgroup have to be first educated about the existing mental health system and interstices.

Resolved: She and Jeff Jessee as co-chairs will be responsible (rather than staff); they will advance an agenda and a "fully-baked" opening meeting in May. At that meeting, to include a larger number of stakeholders, the Workgroup members will get the necessary overview of the flow of BH beneficiaries in and out of the criminal justice system.

TO DO:

- Rhoades and Jessee should contact staff regarding the scheduling and location of the May meeting.
- Rhoades and Jessee will plan the meeting.
- Staff will send out notice of the meeting and any materials in advance to the invitees.

Public comment

There being no additional public comment, the meeting was adjourned.