



TRUST BENEFICIARIES IN ALASKA'S DEPARTMENT OF CORRECTIONS

Produced for the Alaska Department of Corrections
by Hornby Zeller Associates, Inc.

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EXECUTIVE SUMMARY

A growing body of research shows what correctional personnel have long suspected, that a significant portion of individuals in correctional facilities have behavioral health problems—mental health or substance use disorders, or both.¹ Hundreds of thousands of people are affected; in a 2006 Special Report, the Bureau of Justice Statistics (BJS) estimated that 705,600 mentally ill adults were incarcerated in State prisons, 78,800 in Federal prisons and 479,900 in local jails. Researchers have found that people with mental illnesses are overrepresented in probation and parole populations as well, with rates ranging from two to four times the general population.²

There are many reasons that people with mental illness find themselves in the corrections system: the closure of many state psychiatric hospitals, the introduction of restrictive managed care policies, the resistance of some people with mental illness to accept treatment or to continue with their medications once they are feeling better, and the widespread abuse of substances.

Recognizing the enormous burden associated with mental illness and substance abuse and the need to improve the response to persons who fall under their supervision, the Alaska Department of Corrections (ADOC), in collaboration with the Alaska Mental Health Trust Authority (The Trust), took a proactive step to update its 2007 study of all persons characterized as Trust Beneficiaries who were in an Alaska correctional facility at any point during the state fiscal years (SFY) 2009 through 2012. This current report expands on the previous effort by using additional data sources from the Department of Health and Social Services, Office of Children’s Services and Division of Juvenile Justice (DJJ); using an expanded definition of Trust Beneficiaries; analyzing a broader sample of the correctional population; updating the information on the progress and reforms in Alaska’s system; and relating a model of practice developed by the National Institute of Corrections to Alaska’s system.³

One difficulty facing Alaska that goes *beyond* the burdens imposed by people with mental illness, substance abuse and other disorders is the overall expansion of the prison population. Since 2000, the number of sentenced inmates in Alaska has increased each year an average of two percent (2.4%) per year, higher than the national average.⁴

¹ Osher, F., D’Amora, D.A., Plotkin, M., Jarrett, N. Eggleston, A. (2012). *Adults with Behavioral Health Needs under Correctional Supervision: a Framework for Reducing Recidivism and Promoting Recovery*. Council of State Governments Justice Center.

² Prins, S. & Draper, L. (2009). *Improving Outcomes for People with Mental Illnesses Under Community Corrections Supervision: A Guide to Research-Informed Policy and Practice*, Council of State Governments, New York.

³ Osher et al., *op cit*.

⁴ Carson, E. A., & Sabol, W. J. (2012). *Prisoners in 2011*. Washington, DC: Bureau of Justice Statistics.

The researchers, Hornby Zeller Associates, Inc. (HZA), analyzed 60,247 individuals who entered, exited, or resided in an Alaska Department of Corrections facility between July 1, 2008 and June 30, 2012. On a given day, in this case June 30, 2012, Trust Beneficiaries constituted 65 percent of ADOC’s population, a rate significantly higher than the 42 percent identified on a given date in the 2007 study. The differences can be attributed in part to the broader definition used to identify Trust Beneficiaries this time, which includes more substance use disorders; the expanded ability to identify Trust Beneficiaries by using data from the community mental health database (AKAIMS) to see who had extensive treatment in the community before entering the corrections system; and the methodology of including in the target population people who entered a correctional agency before the study start date if they were still incarcerated during the study period. We believe these changes in methodology provide for a more accurate portrayal of the magnitude of the problem.

In addition to the one-day analysis, this report provides details on the characteristics of Trust Beneficiaries, analyzes information on the services available to this population both in the correctional system and in the community, identifies barriers to treatment, discusses research on evidence-based practices that are showing improved client outcomes and recidivism reductions across the country, and provides an analysis of the costs and benefits of implementing effective treatment services. Following the Methodology, the study is presented in five parts:

PART I.	DESCRIPTION OF TRUST BENEFICIARIES
PART II.	TRUST BENEFICIARY OUTCOMES IN CORRECTIONS
PART III.	PROGRAMS AND SERVICES FOR TRUST BENEFICIARIES
PART IV.	NATIONAL MODELS AND PRACTICES
PART V.	VISION FOR THE FUTURE

Within Part I, the section on *Trust Beneficiary Characteristics* reports that 60,247 unique individuals entered, exited, or resided in an Alaska Department of Corrections facility between July 1, 2008 (beginning of SFY 2009) and June 30, 2012 (end of SFY 2012), of which 30.4 percent or 18,323 were identified as Trust Beneficiaries. Alaska Natives are a disproportionate share of the Trust Beneficiary population, representing over one third of the total (38.5%) compared to their share of the State’s general population in the community (15%). In addition, Trust Beneficiaries account for more than 40 percent of the incarcerations each year, and the median length of a jail/prison stay for Trust Beneficiaries is significantly longer than for other offenders.

Also within Part I, the section on *Trust Beneficiaries in Other Public Systems* found that nearly one in five had an admission to API between July 1996 and January 2013. In addition, one-third of the Trust Beneficiaries (6,118 individuals) were involved with the child welfare system (children’s services), and nearly one-quarter (23.5%) had a history in the juvenile justice system.

Trust Beneficiaries previously in the juvenile justice system showed a higher recidivism rate (48.4%) than Trust Beneficiaries not involved (38.0%).

Within Part II, the section on *Trust Beneficiary Reentry and Recidivism Outcomes* reports that within the first year after release Trust Beneficiaries recidivate *at nearly twice the rate of other offenders* (40.9% vs. 22.0%). While recidivism rates remained higher for Trust Beneficiaries, their rates were declining by the end of the current study period. In fact the drop over the four years since the last report was released, from 45.6 percent to 38.9 percent, is statistically significant. Even with this decline in recidivism, Trust Beneficiaries who recidivated cost Alaska over \$92.8 million more on average over the four years than other offenders due to their higher numbers and longer lengths of stay.

After analyzing the entire offender population (60,247), the characteristics of offenders most likely to recidivate are as follows, in order of magnitude: whether the offender had committed a felony in the past, whether the offender was a Trust Beneficiary, whether the offender was an Alaska native, the number of offenses the offender had committed previously, whether the offender was in the Juvenile Justice system, whether he or she was in the child welfare system, whether the offender was male, and if the offender was young.⁵ These characteristics can be used in a screening tool to predict recidivism and modify the offender's program upon entering an institution.

Part III discusses the progress in treatment and services. The study finds that ADOC has taken some important steps in concert with recommendations in the last study and findings of the Alaska Prisoner Reentry Task Force to improve services to Trust Beneficiaries, both in facilities and in the community. Behavioral health contacts with incarcerated offenders have increased by one-third over the past four years. The Department of Corrections recently adopted use of the Substance Abuse and Mental Health Services Administration (SAMHSA) Brief Jail Mental Health Screening Tool which meets National Institute of Corrections standards regarding screening for mental illness. ADOC has increased its mental health clinical staff by 12 positions and has expanded sub-acute unit beds. In addition, ADOC expanded services to provide more substance abuse assessments and treatment programs, as well as adding capacity and programming to help offenders with mental illness and substance use disorders to transition back to the community. Finally, a host of therapeutic courts, now 13 in all, provide a means for people to get treatment rather than incarceration provided they follow strict conditions of conduct and maintain their treatment regimens.

Part IV steps away from Alaska to review the literature and approaches used across the country specifically for the populations represented by Trust Beneficiaries.

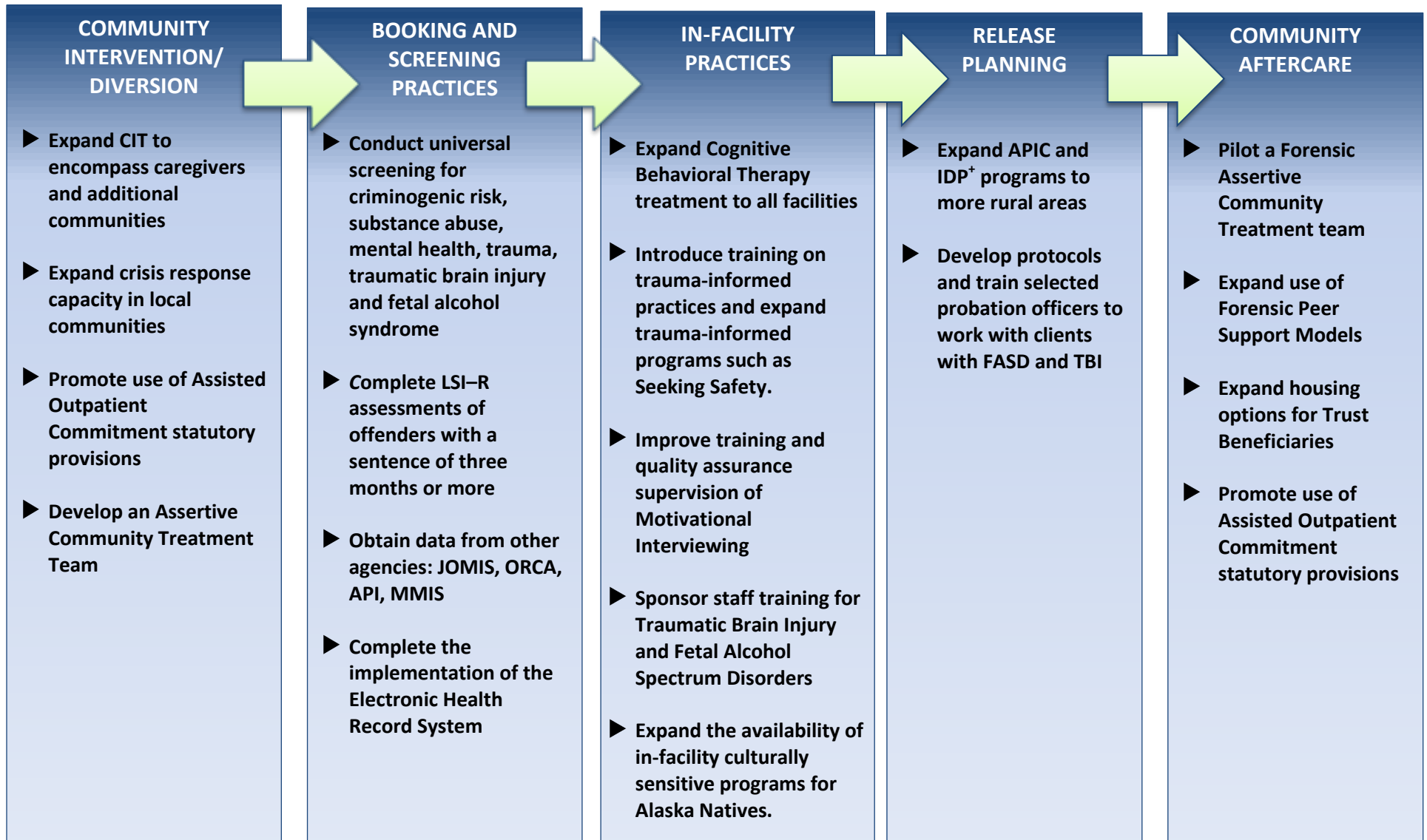
⁵ Age was treated as a continuous variable in a logistic regression analysis to determine the effect of an offender's age on future recidivist behavior. The analysis found that the younger the individual, the more likely he or she was to be readmitted to an ADOC facility. (See Table 17 on page 39 for age demographics related to criminal recidivism.)

Part V presents the culmination, a *Vision for the Future*, which provides a framework and recommendations for the next phases of reform. To address the overlapping objectives of the corrections and behavioral health fields, a framework for integrated supervision and treatment is required. The National Institute of Corrections has developed a framework based on the three dimensions of: 1) criminogenic risk, 2) need for substance abuse treatment, and 3) need for mental health treatment. The framework builds on the work previously done by the behavioral health field to parse out responsibility for ways the mental health and substance abuse systems can collaboratively address the complex treatment needs of diverse groups of individuals with co-occurring disorders. Adding the third dimension of criminogenic risk is meant to help promote individual recovery while improving public safety outcomes. Such a framework can be divided into five stages and can serve as a model for Alaska.

1. Early Intervention/Diversion
2. Booking and Screening Practices
3. In-Facility Practices
4. Release Planning
5. Community Aftercare

The following recommendations, which are explained in the full report, are grouped by the five stages in the model, which is depicted on the following page.

RECOMMENDATIONS FOR A COMPREHENSIVE MODEL FOR ALASKA MENTAL HEALTH TRUST BENEFICIARIES IN CORRECTIONS SYSTEM:



Early Intervention/Diversion

Recommendation 1: Law enforcement, mental health and substance abuse providers and advocates such as the National Alliance on Mental Illness (NAMI) should work together to enhance and expand the use of Crisis Intervention Teams.

Recommendation 2: The Department of Health and Social Services (DHSS) should continue its efforts to expand the state’s Designated Evaluation and Treatment component to more hospitals; to establish Crisis Respite Provider Agreements; to provide mental health crisis prevention and intervention training to rural hospital staff; and to promote the program’s use with the CITs and other first responders.

Recommendation 3: The State should promote use of the outpatient commitment provisions of Alaska Statutes also known as Assisted Outpatient Treatment (AOT).

Recommendation 4: DHSS in collaboration with other state agencies and community providers should support the development and implementations of an Assertive Community Treatment (ACT) team.

Booking and Screening Practices

Recommendation 5: ADOC should expand screening of offenders for both criminogenic risks and mental health needs (including trauma) within 72 hours of arrest and institute formal screening practices for traumatic brain injury and fetal alcohol spectrum disorder.

Recommendation 6: Complete a full Level of Service Inventory-Revised (LSI–R) assessment of offenders with a sentence of three months or more.

Recommendation 7: ADOC should continue to work to develop data-sharing agreements between and among state agencies that work with Trust Beneficiaries involved in the criminal justice system.

Recommendation 8: ADOC should continue supporting the timely completion and implementation of the Electronic Health Record system.

In-Facility Practices

Recommendation 9: ADOC should expand use of evidence-based practices such as Cognitive Behavioral Therapy (CBT) for clients with a mental illness, substance use disorders and co-occurring disorders to all facilities.

Recommendation 10: ADOC should provide training to all correctional staff, both community-based and facility, on trauma-informed correctional practices and it should expand the use of trauma-specific programming to encompass all facilities with mental health and substance abuse units.

Recommendation 11: ADOC should expand and enhance the use of Motivational Interviewing techniques with frontline correctional staff.

Recommendation 12: ADOC should conduct facility training of staff for Traumatic Brain Injury (TBI) and Fetal Alcohol Spectrum Disorders (FASD).

Recommendation 13: ADOC should expand the availability of in-facility culturally sensitive programs for Alaska Natives.

Release Planning

Recommendation 14: ADOC and its community partners should expand the existing capacity of the Assess, Plan, Identify, and Coordinate (APIC) and Institutional Discharge Program (IDP+) as well as provide these services to more rural areas of the state.

Recommendation 15: ADOC and DHSS should develop increased protocols and training for selected probation officers working with clients with Severe and Persistent Mental Illness (SPMI), FASD, and TBI.

Community Aftercare

Recommendation 16: DHSS should work with ADOC and partner agencies to pilot a Forensic Assertive Community Treatment (FACT) team.

Recommendation 17: ADOC and The Trust should partner with community organizations to expand current Peer Support models to include Forensic Peer Support.

Recommendation 18: State and local agencies should partner in the continuing development of a continuum of affordable, safe, sober, and supportive housing options for Trust Beneficiaries exiting the Alaska Department of Corrections.

METHODOLOGY

The methodology for this study involves four critical elements: the data sources, the method for determining who counts as a Trust Beneficiary, the differences between this study and the study completed in 2007, and the definition of recidivism.

Data Sources

This study uses multiple data sources, some from ADOC and some from various branches of the Department of Health and Social Services. Table 1 summarizes each of the sources by the agency using the system and the content relevant to this report.

Table 1: Data Sources for Identifying Trust Beneficiaries

Data Source	Agency	Content	Time Frame
Alaska Correctional Offender System (ACOMS)	ADOC	Offender correctional history record in ADOC	SFY 2009-2012
ADOC Mental Health Database (CONCON)⁶	ADOC	Offender mental health assessments, diagnoses and treatments	2000-2013
Forensic Log	ADOC	Electronic list of all offenders treated by ADOC mental health staff	1998-2013
Residential Substance Abuse (RSAT) and Life Success Substance Abuse Treatment (LSSAT)	ADOC	Offenders who participated in either residential substance abuse treatment or LSSAT while in ADOC custody	SFY 2010-2012
Alaska Psychiatric Institute (API)	DHSS	Patients of API	1996-2013
Alaska Automated Information Management System (AKAIMS)	DHSS	Persons receiving community mental health services	2004-2013
Medicaid Management Information System (MMIS)	DHSS	Behavioral health services paid by Medicaid	2006-2013
Online Resource for the Children of Alaska (ORCA)	DHSS	Parents and children involved in the child welfare system	2004-2013
Juvenile Offender Management Information System (JOMIS)	DHSS	Youth involved with the Division of Juvenile Justice (DJJ)	2002-2013

⁶ There is substantial overlap between the Forensic Log and the clinical assessments electronically entered into the CONCON database. Everyone treated by ADOC clinical staff has an electronic record containing a minimum set of person identifiers that can be accessed in the Forensic Log. That is, everyone who has an electronic version of their clinical assessment in the CONCON database can be located in the Forensic Log, but not vice versa. The difference between the two is primarily those inmates treated by ADOC-contracted service providers who maintain clinical assessments in hardcopy form only. In addition, all ADOC prescriber telemedicine consults and all ADOC contract service provider notes are handwritten and not entered into CONCON.

Information from the ADOC systems, from the Alaska Psychiatric Institute (API), the Alaska Automated Information Management System (AKAIMS), and the Medicaid Management Information System (MMIS) were used to identify Trust Beneficiaries based on their previous diagnoses and service histories for those offenders who were in the custody of Alaska's thirteen correctional institutions⁷ over the four-year time period beginning July 1, 2008 and ending June 30, 2012. The other two systems, the Online Resource for the Children of Alaska (ORCA) and the Juvenile Offender Management Information System (JOMIS), were used to determine the extent to which offenders encountered other public agencies providing involuntary services⁸ (child welfare and juvenile justice) and in what roles.

As with any research using secondary data sources, completeness and accuracy of the data is an issue. For example, three different datasets from API had to be used to match clients from ADOC data, many of whom had inconsistent names and social security numbers. In some cases, the date of an API visit was unable to be determined. HZA also received matched data from MMIS, AKAIMS and ORCA within DHSS; depending on the data source and the data elements available, there was a degree of inconsistency in how the matching process occurred.

Identification of Trust Beneficiaries

Because there is no individualized list of Trust Beneficiaries, researchers had to develop criteria based on the legal definition which would permit identification of Beneficiaries from the available data sets. Offenders having any of the following were considered Trust Beneficiaries in this study:

- 1) clinical diagnosis of a mental illness, developmental disability, chronic alcoholism or other substance-related disorders, Alzheimer's disease and related dementia, or a traumatic brain injury,
- 2) admission to API, or
- 3) receipt of community services of significant duration and intensity⁹ either where a mental health and/or substance abuse diagnosis had been made or where the service itself was clearly related to mental health and/or substance abuse.

With multiple datasets and overlapping criteria, identification of Trust Beneficiaries occurred according to a strictly linear process. First, any offender with one of the above conditions recorded in any of ADOC's databases was deemed a Trust Beneficiary. Then, any offender not

⁷ Records were not reviewed for individuals in custody of the ADOC who were housed in community residential centers or in the out-of-state detention facility in Colorado.

⁸ Some in-home child welfare cases are not strictly speaking involuntary if there is no court order requiring parents to accept them.

⁹ Researchers used AKAIMS to identify service modality types that were deemed intensive, possibly intensive and non-intensive. Individuals receiving intensive services or possibly intensive services for more than 24 months were categorized as a Trust Beneficiary. Beneficiaries were also identified in MMIS by whether the individual received at least three services within a six-month period by a Community Behavioral Health provider, or were an ongoing client with one provider for at least 24 months, or were hospitalized at either a Psychiatric Hospital or a Residential Psychiatric Treatment Service.

identified by ADOC but who had been admitted to API was added to the list. The third added group consisted of offenders unknown to either ADOC or API as having mental health and/or substance abuse issues but who had a clinical diagnosis recorded in Medicaid. AKAIMS supplies the final group, all those not identified by the other sources who have received mental health or substance abuse services of sufficient duration and intensity. Table 2 displays the number of unique offenders added to the list of Trust Beneficiaries through each step of the process.

Table 2: Trust Beneficiaries Identified by Data Source

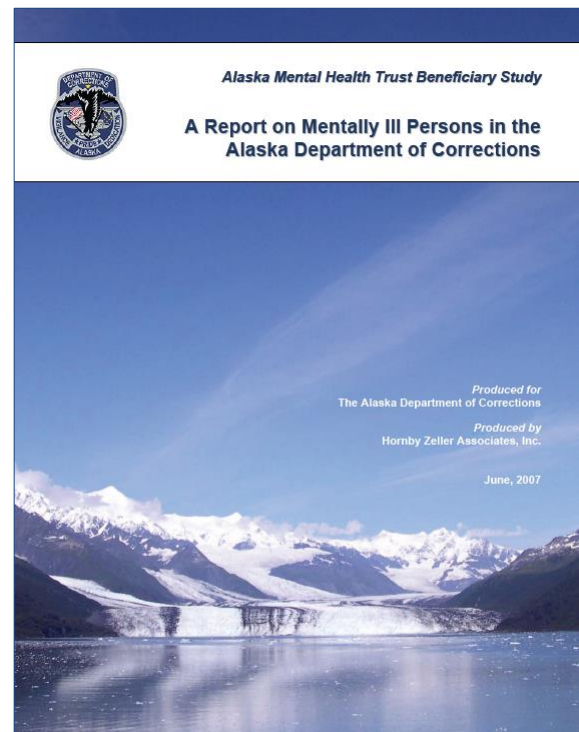
Data Source	Number of Trust Beneficiaries Identified
ADOC	11,678
API	1,323
MMIS	2,109
AKAIMS	3,213
Total	18,323

Differences from the 2007 Study

It is important to exercise caution when comparing the findings in this report to the one issued in 2007 as each report used a different definition of the universe from which Trust Beneficiaries were identified. The 2007 study examined only individuals who entered *AND* were released from an Alaska state facility between SFY2003 and SFY2006, identifying 39,899 offenders. The new study includes all offenders, released *OR* not released, so long as they were incarcerated for any part of the period under review. In essence, the most recent cohort is a broader sample of the population than that previously considered and equals 60,247 individuals.

The reason for this expansion is that it allows for a more robust analysis of Trust Beneficiaries re-entering the community, especially those who had served a longer sentence. The previous study was unable to examine individuals being released from prison if their sentences were greater than four years. It also provides a more accurate view of offenders in facilities at any given time, by not excluding long-term inmates (those entering before the start of the study period).

The second important difference between this study and the previous one is the demonstration of the overlap between the offender population and the populations of other public programs. The 2007 study indicated that Trust Beneficiaries touch multiple public sector systems. This report determines the number and percentage of Trust Beneficiaries who appear in specific Department



of Health and Social Services datasets, such as those reflecting child welfare and juvenile justice involvement.

The third important difference between the two studies is the current report expands the identification of Trust Beneficiaries to include individuals with other substance-related disorders, beyond those with chronic alcoholism.

As noted earlier, 60,247 individuals were incarcerated in ADOC facilities one or more times between SFY 2009 and SFY 2012. Table 3 provides a comparison of the demographic characteristics of offenders identified for inclusion in each of the studies.

Table 3: Comparison of ADOC Population between the Two Study Periods

	Total (SFY2003-2006)		Total (SFY2009-20012)	
Gender	N	%	N	%
Male	30,492	76.4%	43,902	72.9%
Female	9,407	23.6%	16,344	27.1%
Total	39,899	100.0%	60,247	100.0%
Race¹⁰	N	%	N	%
White	22,412	56.4%	32,045	53.2%
Black	3,197	8.0%	4,591	7.6%
AK Native	9,486	23.9%	18,560	30.8%
Other	4,625	11.6%	5,051	8.5%
Sub-Total	39,720	100.0%	60,247	100.0%
Unknown	179	N/A	N/A	N/A
Total	39,899	100.0%	60,247	100.0%
Age	N	%	N	%
Under 21	5,983	15.4%	11,625	19.5%
21-30	13,126	33.7%	20,201	33.9%
31-40	9,681	24.9%	11,770	19.7%
41-50	7,555	19.4%	10,639	17.7%
Over 50	2,566	6.6%	5,393	9.0%
Sub-Total	38,911	100.0%	59,628	100.0%
Unknown	988	N/A	619	N/A
Total	39,899	100.0%	60,247	100.0%

A higher share of women and Alaskan Natives are a part of the ADOC population in the most recent cohort period. While the increase of Alaska Natives is significant, the basic finding is still

¹⁰ Race categories in the report follow the U.S. Census definitions.

the same, that is, there is significant minority overrepresentation (30.8%) within the ADOC compared to their share of the State's general population (15%).¹¹

Recidivism

The definition of recidivism used in this report is drawn from work completed by the Alaska Judicial Council (AJC), which has examined recidivism among both felony and misdemeanor offenders in the state. In its 2011 study, AJC researchers used ACOMS data to measure remands to incarceration, including remands for new arrests, and for probation and parole violations.¹² For this study, recidivism is defined as a *post-conviction, re-incarceration within one year of exiting ADOC custody*.

¹¹ U.S. Census Bureau. (2013). *State and County QuickFacts*, retrieved from <http://quickfacts.census.gov/qfd/states/02000.html>.

¹² Alaska Judicial Council. (2011). *Criminal Recidivism in Alaska, 2008 and 2009*. Anchorage, AK.



Part I:
**DESCRIPTION OF
TRUST BENEFICIARIES**

Trust Beneficiary Characteristics

Key Findings

- Sixty-five percent of the ADOC population in a correctional facility on June 30, 2012 was a Trust Beneficiary.
- 60,247 individuals entered, exited, or resided in an Alaska Department of Corrections facility between July 1, 2008 (beginning of SFY 2009) and June 30, 2012 (end of SFY 2012) of which 30.4 percent or 18,323 were identified as Trust Beneficiaries.
- Trust Beneficiaries account for more than 40 percent of the incarcerations each year.
- Of Trust Beneficiaries with reported clinical characteristics, 70.1 percent were substance abuse-related.
- More than half of Trust Beneficiaries (61.3%) were found to have more than one Axis I mental health diagnosis, and 30.8 percent have both Axis I disorder(s) and Axis II personality disorder(s).
- Alaska Natives are a disproportionate share of the Trust Beneficiary population, representing over one third of the total (38.5%) compared to their share of the State's general population in the community (15%).
- Females represent a higher share of the Trust Beneficiary population than the non-Trust offender group.
- Trust Beneficiaries were significantly more likely to be convicted of felony crimes (34.6%) than the rest of the ADOC inmate population (21.4%).
- The median length (or mid-point) of stay for Trust Beneficiaries is significantly longer than for other offenders. For those committing felonies, it is double that of a non-Trust offender; for misdemeanors, it is 150 percent longer.

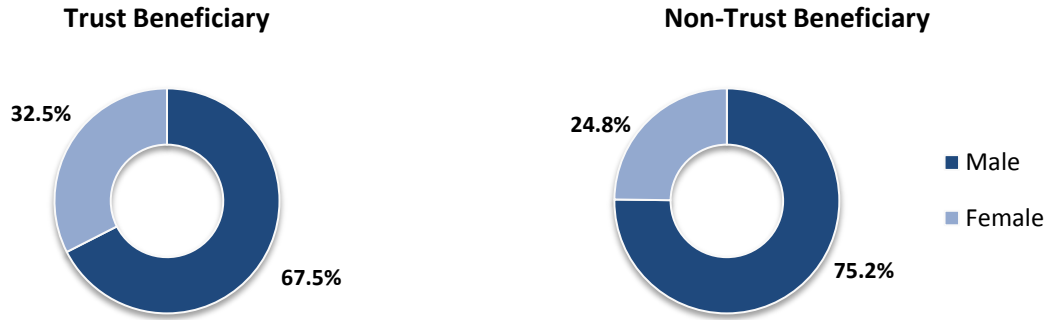
Demographics of the ADOC Population

HZA analyzed 60,247 individuals who entered, exited, or resided in an Alaska Department of Corrections facility between July 1, 2008 (beginning of SFY 2009) and June 30, 2012 (end of SFY 2012) of which 30.4 percent or 18,323 were identified as Trust Beneficiaries. More than two thirds (67.5%) of the Trust Beneficiary population are males and half (50.4%) are white. Alaska Natives were a disproportionate share of the Trust Beneficiary population, representing over one third of the total (38.5%).

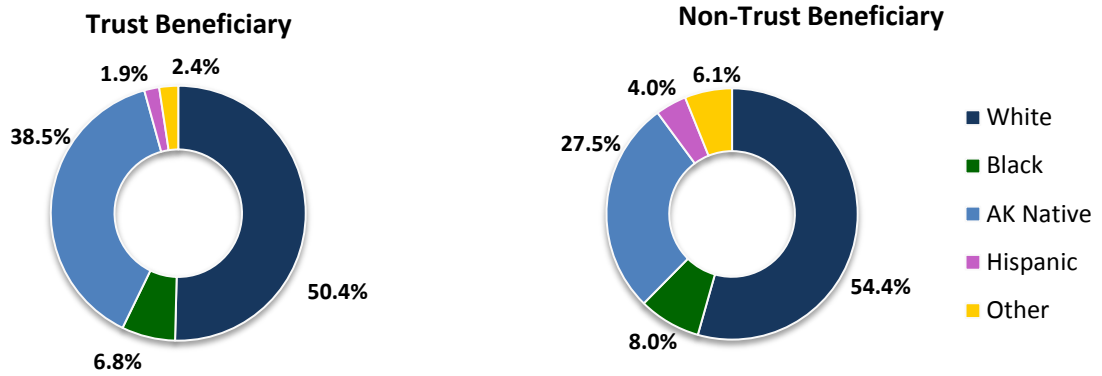
Figure 1 compares the demographic characteristics of Trust Beneficiaries to the rest of the correctional population.

Figure 1: Demographic Characteristics for Trust Beneficiaries and Non-Trust Beneficiaries

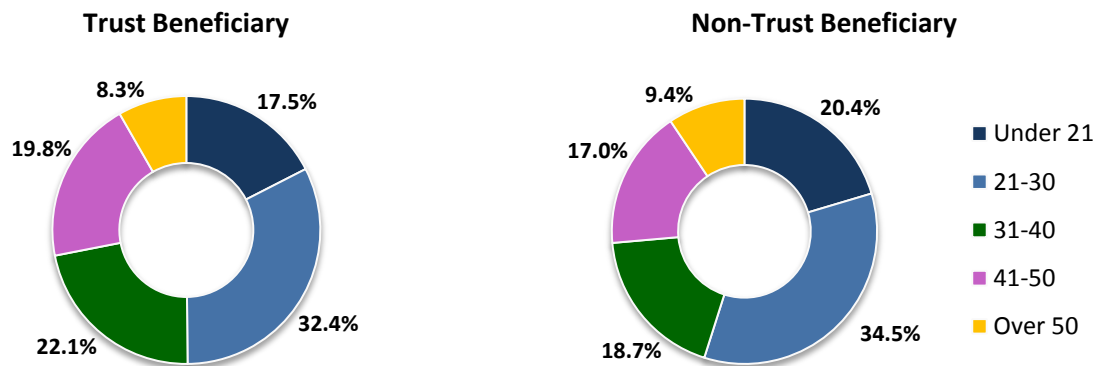
GENDER



RACE



AGE

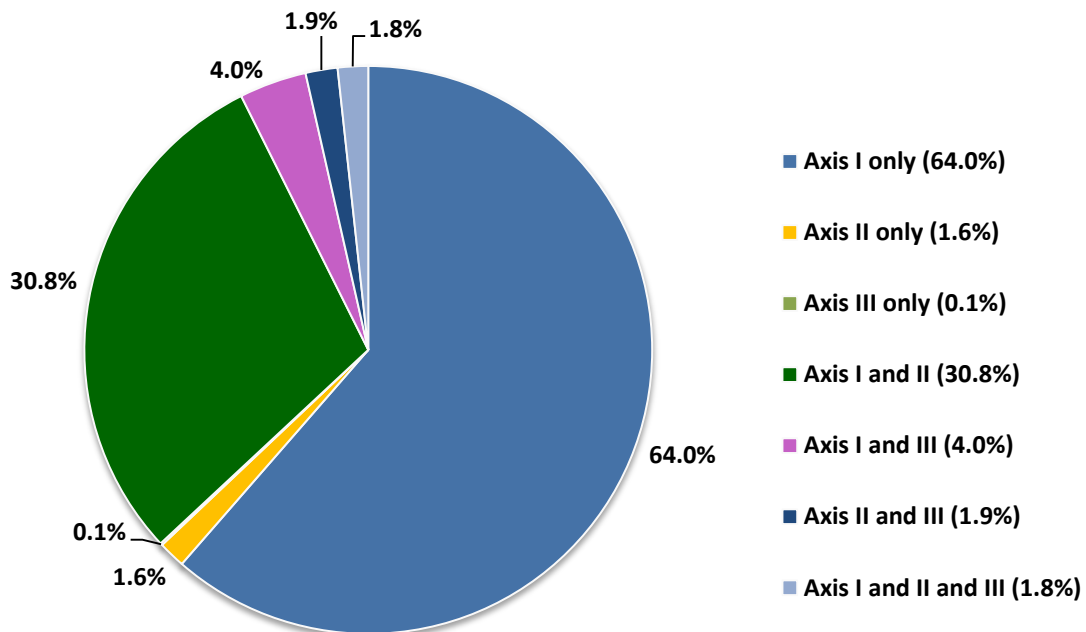


Clinical Characteristics

This report uses API, CONCON and MMIS to identify Trust Beneficiaries by diagnosis. Of the 11,265 Trust Beneficiaries whose clinical characteristics could be determined, 27,362 mental health disorders were identified, of which 70 percent were substance abuse related. As noted in the discussion of Trust Beneficiary groupings, many of the Trust Beneficiaries with a substance abuse disorder also had a co-occurring mental health disorder. In addition, more than a third (34.4%) had a mood disorder. These findings mirror the 2007 study, which found mood disorders and substance abuse conditions represent the majority of disorders (56%).¹³

Figure 2 displays the mental health and substance use disorders of Trust Beneficiaries. Nearly two-thirds (64%) of offenders have an Axis I disorder,¹⁴ and 30 percent (30.8%) have both Axis I disorder(s) and Axis II disorder(s).¹⁵

Figure 2: DSM-IV-TR Classifications for Trust Beneficiaries (n=11,265)



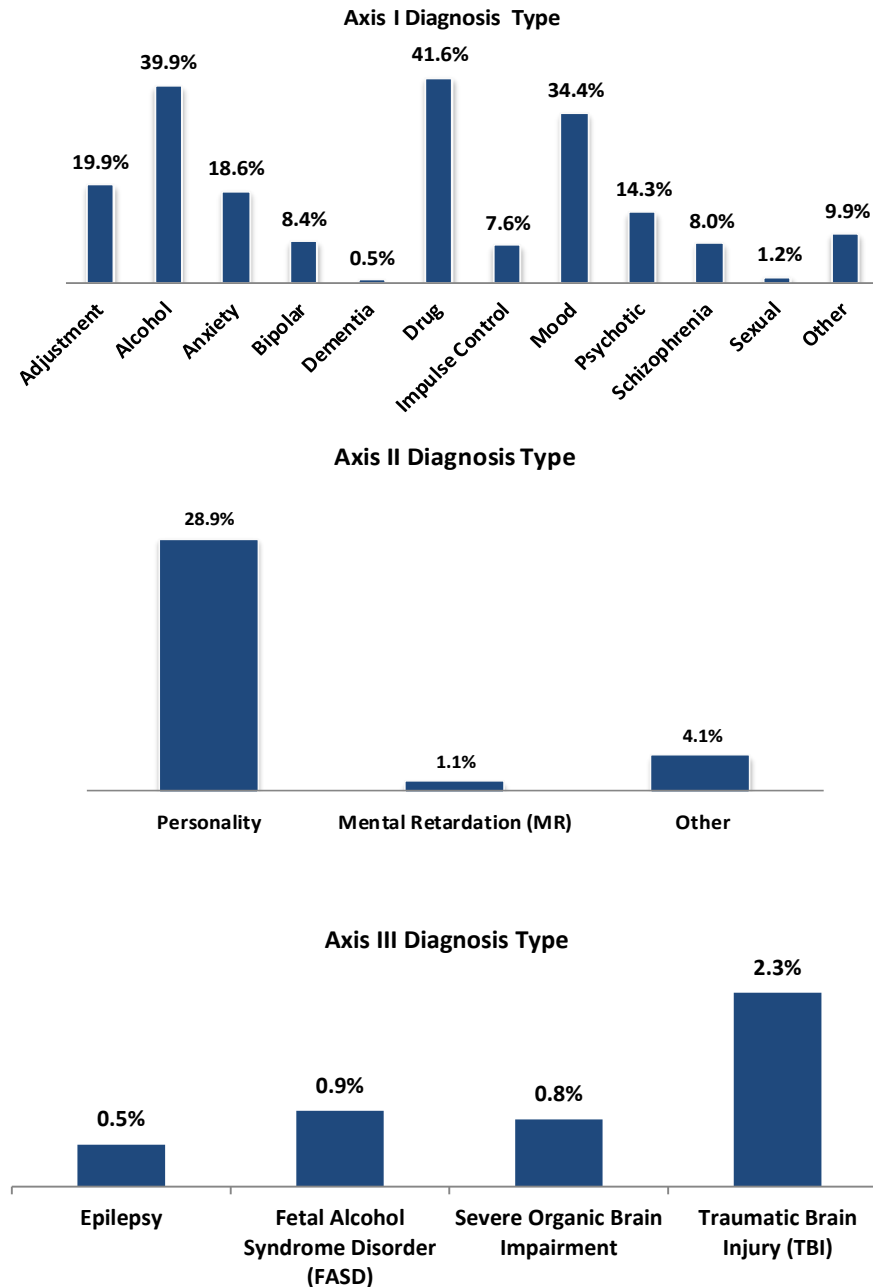
¹³ American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.).doi:10.1176/appi.books.9780890423349. For a full definition of Axis I, II and III disorders, please see Appendix C.

¹⁴ Axis I assesses an individual's present clinical status/condition, and includes clinical syndromes that may be the focus of clinical attention, such as Schizophrenia, Generalized Anxiety Disorder, Major Depressive Disorder, or substance dependence. Axis I conditions are roughly analogous to illnesses/diseases in general medicine.

¹⁵ Axis II includes Personality Disorders, longstanding personality traits (which may or may not be involved in the development of Axis I disorders), and encompasses problematic ways of relating to world, such as histrionic personality disorder, paranoid personality disorder, and antisocial personality disorder. Axis II Disorders also include Mental Retardation and other developmental disabilities.

Figure 3 shows the proportion of Trust Beneficiaries with each particular type of Axis disorder. The majority of Trust Beneficiaries (61.3%) have more than two Axis I diagnoses, with drug, alcohol and mood being most prevalent. Among Axis II disorders, a personality disorder is the most prevalent. Traumatic brain injury is the most seen Axis III disorder and occurs in 2.3 percent of the cases.

Figure 3: Diagnosis Type by Axis¹⁶



¹⁶ The charts by Axis type include any diagnosis linked to a client, not just the primary diagnosis. The “Other” category includes a wide array of diagnoses such as bereavement and malingering.

Part of the purpose of this report is to help guide the planning decisions of the ADOC, Alaska Mental Health Trust Authority, the Department of Health and Social Services, other state departments and other community providers for future planning. As written into statute, The Trust prioritizes funding to persons who, as a result of a cognitive impairment or substance abuse illness, may require or be at risk of hospitalization, or require continuing or intensive services.¹⁷ The Trust identifies five groups of Trust Beneficiaries for funding support.

Table 4 groups the clinical characteristics of the ADOC population into Trust Beneficiary categories. It shows that 83.3 percent of the Trust Beneficiaries have a mental illness and can be grouped into Group 1, and 70.1 percent have a substance abuse disorder, Group 3. Individuals who could be placed in both Groups 1 and 3 (i.e., they suffer from a co-occurring disorder) represent 54.8 percent of the population. The three other groups have much smaller percentages, although some of these conditions, such as Fetal Alcohol Disorders or Traumatic Brain Injuries, are typically under-reported.

Table 4: Trust Beneficiary Categories SFY09-SFY12

Trust Beneficiary Categories		Total (n=11,265)	
		Number	Percent
Group 1	Mental Illness	9,383	83.3%
Group 2	Developmental Disabilities	752	6.7%
Group 3	Chronic Alcoholism (and other substance-related disorders)	7,899	70.1%
Group 4	Alzheimer's Disease and Related Disorders	60	0.5%
Group 5	Traumatic Brain Injury	264	2.3%
Groups 1 and 3	Co-Occurring Disorder (Offenders found in both Group 1 and 3)	6,178	54.8%

Population Dynamics

As noted above, over a four-year period Trust Beneficiaries comprise 30 percent of the offenders in ADOC facilities. Examining the population at different time intervals, however, provides insight into how that population changes, as well as into the reason for those changes.

Table 5a examines bookings (or arrests) and Table 5b examines the population in custody; both tables show the information by total population and the Trust Beneficiary sub-population for each year covered in the study. Two points are immediately obvious. First, Trust Beneficiaries account for more than 40 percent of bookings and more than 40 percent of the total population each year, even though over the four years they represent only 30 percent of unique incarcerated individuals served by ADOC. Second, and equally important, Trust Beneficiaries make up a smaller proportion of the unduplicated count in a given year than they do of the total count, meaning they are more likely to enter multiple times within a given year.

¹⁷ See Alaska Statute AS47.30.056 for a detailed definition of the Trust Beneficiary categories.

**Table 5a: Overall Number of Bookings by Trust Beneficiary Status
Over Four-Year Study Period**

	FY 2009	FY 2010	FY 2011	FY 2012
Bookings				
Total Bookings	34,767	35,584	31,578	29,813
Trust Beneficiary Bookings	14,743	14,857	13,127	12,308
Trust Beneficiary Percent	42.4%	41.8%	41.6%	41.3%
Unique Offenders	22,499	22,921	21,563	20,404
Unique Trust Beneficiaries	8,105	8,262	7,870	7,381
Trust Beneficiary Percent	36.0%	36.0%	36.5%	36.2%

**Table 5b: Overall Distribution of Trust Beneficiaries
in Custody of the Alaska Department of Corrections Over Time**

	FY 2009	FY 2010	FY 2011	FY 2012
Populations				
Total Populations	38,337	39,135	35,164	33,617
Trust Beneficiary Population	16,976	17,176	15,505	14,839
Trust Beneficiary Percent	44.3%	43.9%	44.1%	44.1%
Unique Offenders	24,833	25,283	24,014	23,003
Unique Trust Beneficiaries	9,541	9,798	9,466	9,086
Trust Beneficiary Percent	38.4%	38.8%	39.4%	39.5%

The difference between the 36 percent of offenders who are Trust Beneficiaries and the roughly 42 percent of bookings involving Trust Beneficiaries reveals that Trust Beneficiaries, even within the space of a single year, are more likely to be arrested and booked multiple times than are other offenders, at a rate more than 25 percent higher (26.6%). Trust Beneficiaries experience an average of 1.74 bookings each year, compared to 1.38 for non-Trust Beneficiary offenders.

Moreover, the difference between the 30 percent of offenders who are Trust Beneficiaries over a four-year span and the roughly 36 percent who experience at least one new incarceration during a given year reinforces that picture, indicating that the pattern of multiple arrests of Trust Beneficiaries does not occur just in short periods of time but extends at least over several years.

A one-day examination of the ADOC facility population provides an additional piece of information. In both 1997 and 2007, ADOC examined the population on January 15, 1997 and June 30, 2006, respectively.^{18,19} Results of the 1997 study revealed that on that day, 37.0 percent of inmates housed within the ADOC constituted Beneficiaries of the Trust (n=1,154). The results of the 2007 study indicated that approximately 42.0 percent were Trust Beneficiaries (n=1,524) on June 30, 2006. In other words, there was significant growth in the prevalence of Trust Beneficiaries within ADOC. Between 1998 and 2006, the growth rate in the number of Trust Beneficiaries within the ADOC was higher than the general ADOC population by a factor of nearly two to one.²⁰

On June 30, 2012, the proportion has risen even further. Of the 3,701 persons who were in one of ADOC's correctional institutions in Alaska,²¹ approximately 65.0 percent were Trust Beneficiaries (n=2,407). As noted previously, much of this change is due to better identification of Trust Beneficiaries, both within ADOC and from the additional data sources used for this study. Beyond any indication of growth in the Trust Beneficiary population, however, the real importance of the one day figure is two-fold. First, it means that every day ADOC is handling an offender population of whom two thirds have a mental health, substance abuse or cognitive impairment problem. Second, it also indicates that Trust Beneficiaries are generally incarcerated for longer periods of time than are other offenders, as will be discussed in the section on sentencing. The difficulties of managing and treating that population are illustrated by the facts that they are arrested more often and remain incarcerated longer than other offenders.

The proportion of the offender population which consists of Trust Beneficiaries on a single day is presented for each correctional institution in Figure 4.²² As shown, the prevalence of Trust Beneficiaries at a single point in time varies considerably from facility to facility, ranging from a low of 55 percent at the Fairbanks Correctional Center, to a high of 80 percent at the Hiland Mountain Correctional Center (which houses the women's acute and sub-acute mental health units for ADOC). Overall, four of Alaska's twelve institutional correctional centers²³ have prevalence rates above the statewide average with Alaska's largest correctional institution, the Anchorage Correctional Complex (ACC-E), ranking second to the lowest at 55.1 percent.

¹⁸ Moras, A. (2004). Mentally Ill Inmates in Alaska Prisons. *Alaska Justice Forum* 21(1): 3.

¹⁹ Hornby Zeller Associates, Inc. (2007). *A Study of Trust Beneficiaries in the Alaska Department of Corrections*. Portland, ME.

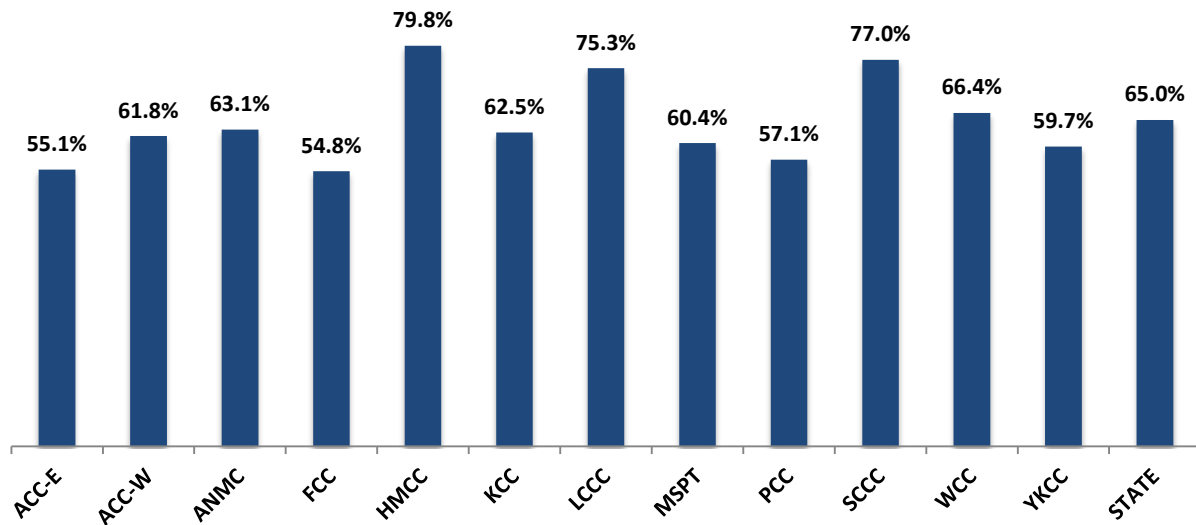
²⁰ Between the two study periods, the rate of growth in the Department of Corrections general population was approximately 16 percent (3,119 in 1997 versus 3,628 in 2006) compared to a 32 percent rate of growth in the Trust Beneficiary population (1,154 in 1998 versus to 1,524 in 2006).

²¹ 16.5 percent are housed out of state.

²² Appendix D provides numeric totals of Trust Beneficiaries by facility.

²³ Point McKenzie is not included in this chart.

Figure 4: Point in Time Study of the Prevalence of Trust Beneficiaries in Custody of the Alaska Department of Corrections on June 30th 2012



Criminal Profiles

Over their correctional histories, both Trust Beneficiaries and non-Trust Beneficiaries had the same median number of convicted offenses (both one) for a felony and misdemeanor, although the mean number of convicted offenses was higher for a Trust Beneficiary (1.88) than other offenders (1.54). The number of offenses ranged up to 31 misdemeanors and 40 felony convictions for a non-Trust Beneficiary, and 58 misdemeanors and 26 felonies for a Trust Beneficiary. Trust Beneficiaries also had a higher median number of probation violations (two) than other offenders (one) and a range of probation violations²⁴ up to 26 compared with 18.

Figures 5 and 6 display the share of offenses committed by Trust Beneficiaries and non-Trust Beneficiaries, broken out by severity and type.²⁵ Between SFY2009 and SFY2012, Trust Beneficiaries were significantly more likely to be convicted of felony crimes (34.6%) than the rest of the ADOC inmate population (21.4%). Trust Beneficiaries were also significantly more likely to be convicted of crimes against a person (21.4% vs. 17.8%), property-related crimes (17% vs. 10.6%) and violating conditions of probation or parole (18.9% vs. 11.7%). Conversely, inmates not identified as Trust beneficiaries were significantly more likely to be convicted of drug/alcohol-related crimes (35.0% vs. 18.1%).

²⁴ Probation violations can range from a failure to appear for an appointment, to a failed drug/alcohol test to a new criminal event.

²⁵ These charts reflect the total number of *offenses*, not the total number of *offenders*. All offenses are counted as discrete units.

Figure 5: Offense Severity by Trust and Non-Trust Beneficiaries

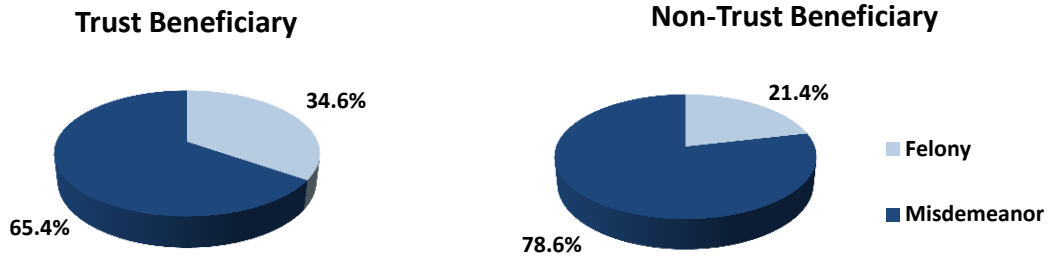
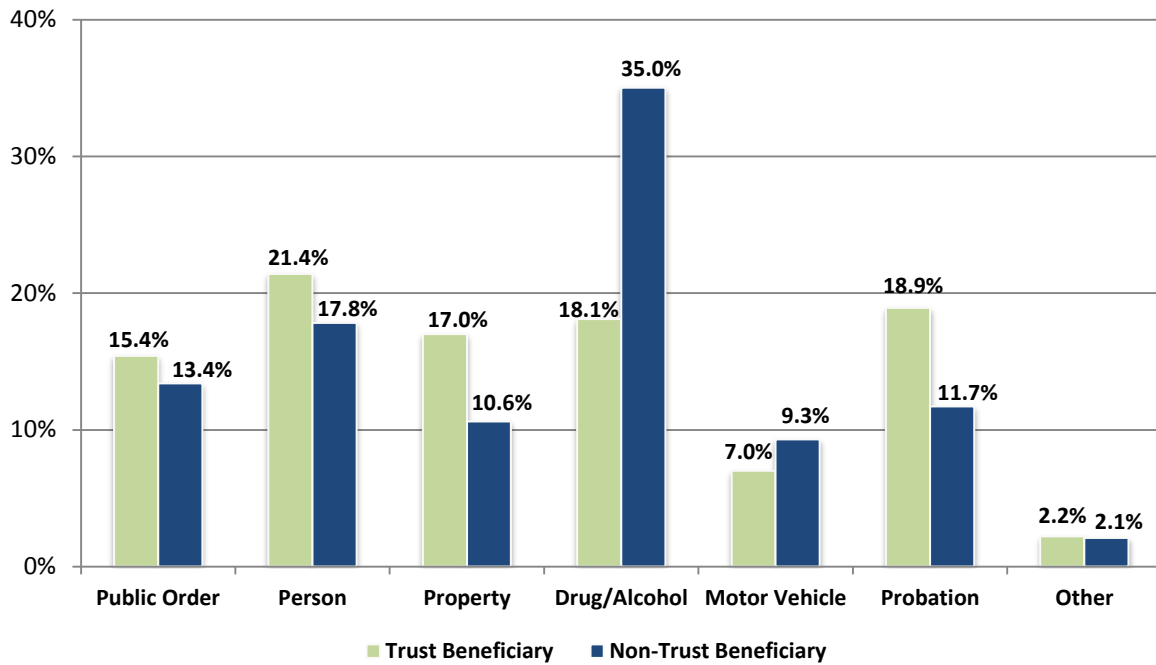


Figure 6: Offense Type by Trust and Non-Trust Beneficiaries



According to the Bureau of Justice Statistics’ estimates of state prison facilities across the United States, offenders with mental illness serve sentences for more serious and violent crimes, are more likely to be charged with violating institutional rules, and typically spend significantly more time in custody than the rest of the inmate population.²⁶ The findings here in Alaska support those same conclusions.

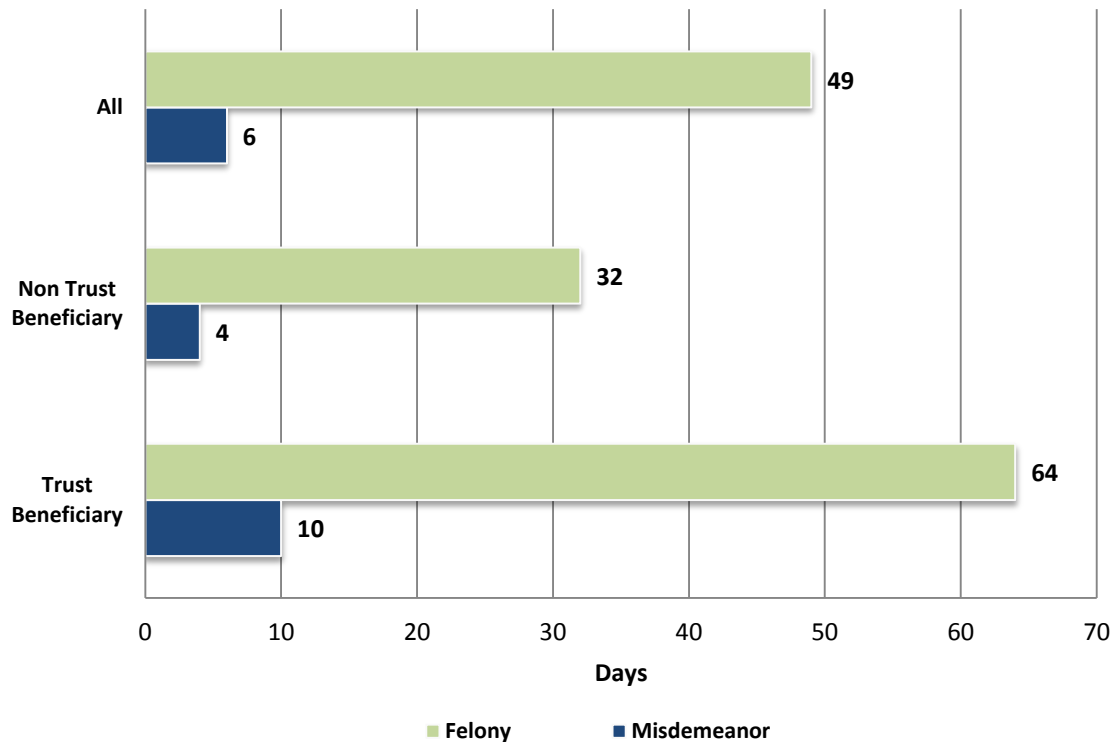
²⁶ James, D.J., & Glaze, L.E. (2006). *Mental Health Problems of Prison and Jail Inmates*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. Retrieved from: <http://bjs.ojp.usdoj.gov/content/pub/pdf/mhppij.pdf>.

Length of Stay

Throughout the country, adults who are mentally ill tend to receive longer lengths of stay than others. Nationally, state prisoners who had a mental health problem reported a mean maximum sentence that was five months longer than State prisoners without a mental health problem.²⁷

The data from the four-year period covered here show comparable trends. While the range of lengths of stay extends from a low of one day to a high of life imprisonment for both Trust Beneficiaries and others, the median length of stay for sentenced Trust Beneficiaries is significantly longer than for other offenders.²⁸ For those Trust Beneficiaries who have committed felonies, the length of stay is 32 days longer or double that of a non-Trust offender; for misdemeanors it is six days longer or 150 percent. The differences are illustrated in Figure 7.

Figure 7: Median Length (Days) of Stay by Offense Severity for Sentenced Trust and Non-Trust Beneficiaries

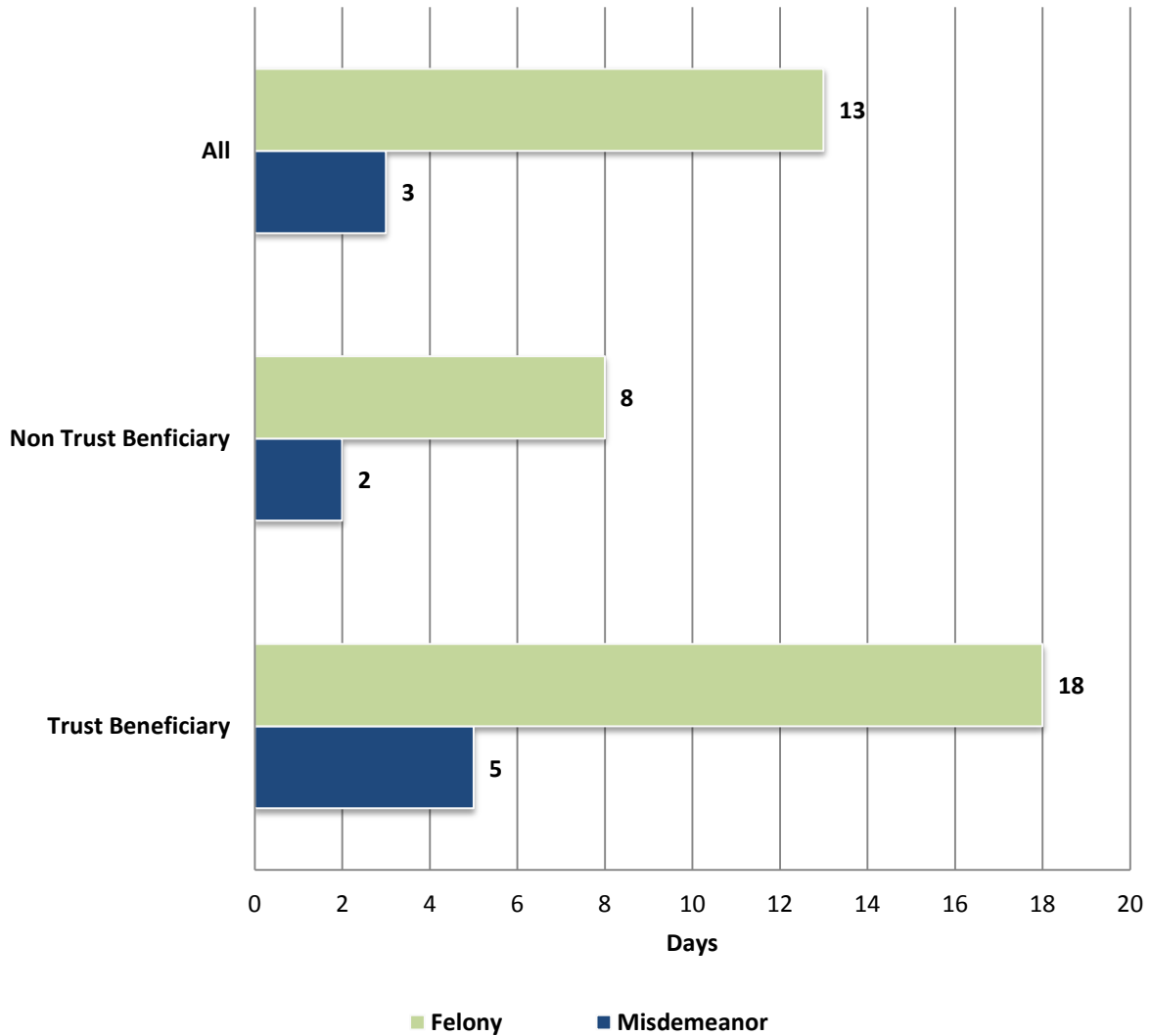


²⁷ James, D.J., & Glaze, L.E. (2006). *Mental Health Problems of Prison and Jail Inmates*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.


²⁸ Because of the wide variation in time served, the median or mid-point rather than the average is illustrated above. However, the disparities are comparable when using the averages: the average time incarcerated for sentenced Trust Beneficiaries is 52.6 days for a misdemeanor and 165.9 days for a felony. This compares to 23.5 days (less than half) for a non-Trust Beneficiary committing a misdemeanor and 108.9 days (less than two-thirds) for a non-Trust Beneficiary committing a felony.

These trends hold up for unsentenced offenders as well: Trust Beneficiaries remain in jail longer than do non-Beneficiaries even prior to being sentenced, as shown in Figure 8.²⁹

Figure 8: Median Length (Days) of Jail/Prison Stay by Offense Category for Unsentenced Trust and Non-Trust Beneficiaries



²⁹ The disparities hold up here as well when looking at average rather than median lengths of stay for people not yet sentenced. The average length of stay for unsentenced Trust Beneficiaries charged with a misdemeanor is 26 days, compared to 15 days for a non-Trust Beneficiary. The average for a Trust Beneficiary charged with a felony is 54 days, compared to 38 for a non-Trust Beneficiary.



**TRUST BENEFICIARIES
REMAIN IN JAIL
LONGER THAN
NON-TRUST BENEFICIARIES,
EVEN PRIOR TO BEING SENTENCED.**

Trust Beneficiaries in Other Public Systems

Key Findings

- Nearly one in five Trust Beneficiaries identified in this study (3,498 of 18,323) had an admission to API between 1996 and the beginning of 2013.
- Of all the stays at API during the study period, roughly 21 percent (20.5%) were for less than three days.
- One-third of the Trust Beneficiaries (6,118 individuals) have been involved with the child welfare system (children’s services), with the vast majority (5,426) having a record as a parent of a child and 1,378 as an abused or neglected child him/herself. Over 600 have been both.
- Clients known to Children’s Services have significantly higher one-year recidivism rates (35.5%) than individuals not involved in the system (27.8%).
- Nearly one-quarter of the Trust Beneficiaries (4,309 individuals) had a history in the juvenile justice system. Trust Beneficiaries previously in the juvenile justice system showed a higher recidivism rate (48.4%) than Trust Beneficiaries not involved (38.0%).
- After leaving an ADOC facility, Trust Beneficiaries with Schizophrenia, developmental disorders, and impulse control had higher average Medicaid costs associated with behavioral health treatment than those with other diagnoses.
- Anchorage had the highest share of community mental health enrollments representing nearly half of all enrollments, and five times more than the next highest location, Fairbanks.

One of the unique features of this study is the examination of the overlaps between the Trust Beneficiary population found in ADOC facilities and other public systems. The following paragraphs quantify the population receiving services from multiple systems, including ADOC, API, Medicaid, community mental health, child welfare and juvenile justice.

Alaska Psychiatric Institute

As a percentage of the overall Trust Beneficiary population, 19.1 percent (3,498 individuals) had been admitted to API between July, 1996 and January, 2013. Overall, 2,913 Trust Beneficiaries recorded 7,868 admissions to API, or about 2.7 admissions per person. As displayed in Table 6,³⁰ 2,647 (90.9%) had more than two admissions on average before reaching ADOC. A far smaller portion of offenders had an API commitment after ADOC entry, and an even smaller share was sent to API during an ADOC stay. The API admissions during an ADOC stay were the result of a court order for a psychiatric evaluation.

³⁰ For nearly a fifth of the individuals to API, there was no admission date within the API dataset. Therefore, they were excluded from the analysis in Table 6.

Table 6: Timing of API Admissions with ADOC Entry

Timing of API Admission			
	Offenders	Admission	Admission per Offender
Admission to API <i>before</i> ADOC entry	2,647	6,789	2.56
Admission to API <i>after</i> ADOC entry	992	2,106	2.12
Admission to API <i>during</i> ADOC entry	223	232	1.04

The median length of time following a release from ADOC that the offender was either admitted to API or re-arrested was 36 days. When an offender was released from API, the median length of time to an API re-admission or a re-arrest was 157 days.

Examining the admission flow between API and ADOC proved challenging as API changed databases in 2009, and some clients in API did not have personal identifiers (such as social security numbers) to easily match to ADOC data. In addition, it was impossible to determine specific incidents within API, such as the number of criminal incidents that occurred within the facility. As a proxy, the number of entries to an ADOC facility on the same day of an API release showed 202 events during the study period. Upon further review with ADOC staff, it was concluded that many of these same-day releases were the result of court-ordered evaluations being transported between API and ADOC.

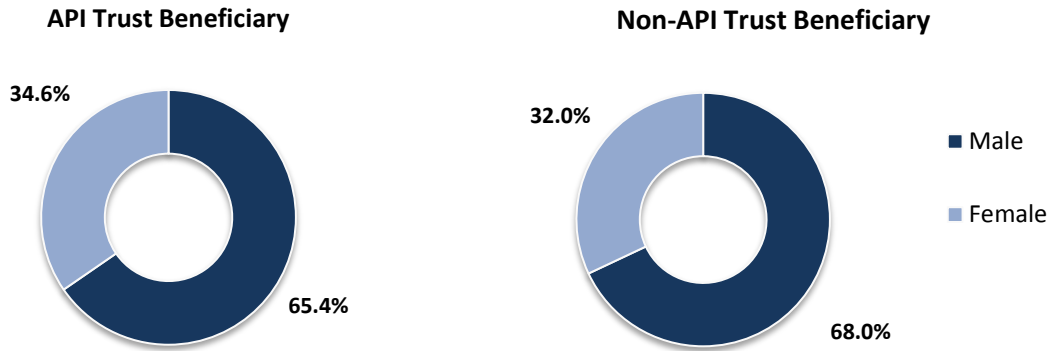
Of all the stays at API during the study period, roughly 21 percent (20.5%) were for less than three days. Looking specifically at civil (T-47) and criminal (T-12) involuntary commitments from ADOC, 228 commitments were reported in the four-year study period, with T-12s representing 85 percent (194) of the commitments.³¹ T-12 commitments are the result of a court order for a psychiatric evaluation for legal competency or culpability or for competency restoration during criminal proceedings, while T-47 civil commitments are initiated outside of the criminal process because someone in the community has concerns about an individual’s psychiatric stability; that is, the potential for posing a danger to him or herself or to others, or of being gravely disabled.

Females and Alaska Natives represented significantly higher shares of the Trust Beneficiary population who spent time in API, compared to Trust Beneficiaries who did not incur a psychiatric hospitalization. The age difference between the two groups was minimal, with both cohorts having the same median age (31) and with an average age difference of roughly nine months. The demographic characteristics are illustrated in Figure 9.

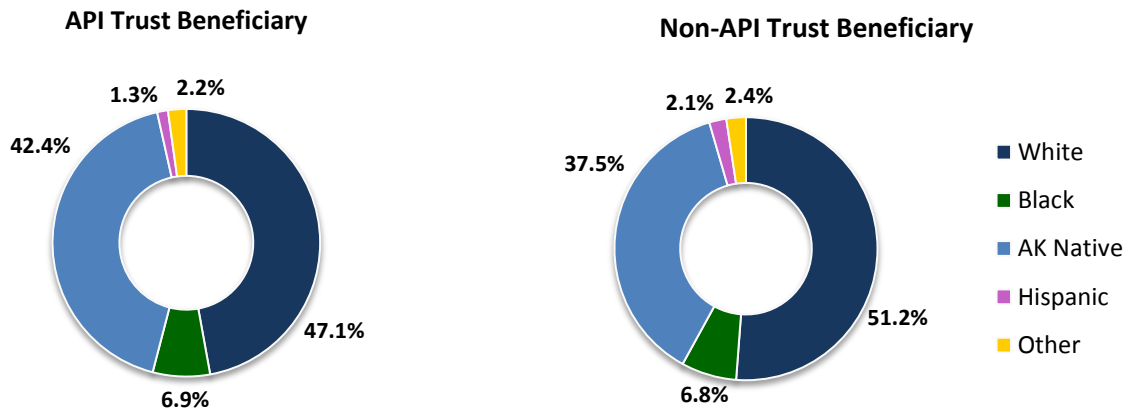
³¹ T-12 and T-47 totals were derived from API datasets and not ADOC records.

Figure 9: Demographics of Trust Beneficiaries by API status

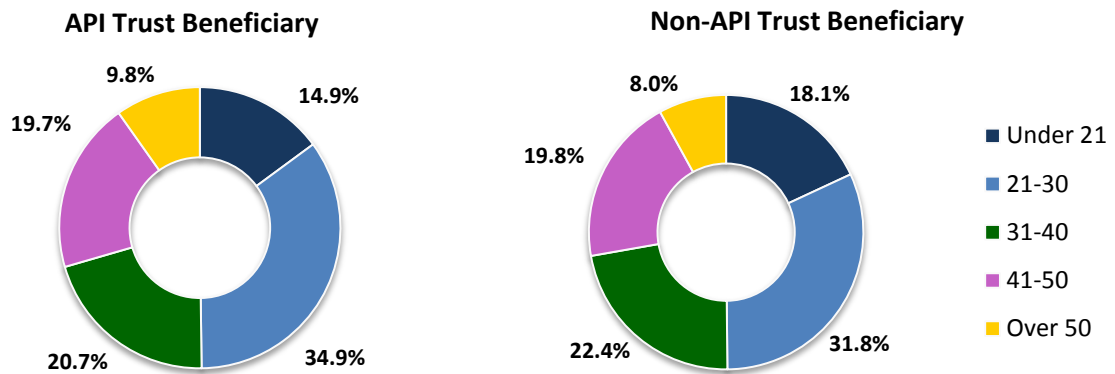
GENDER



RACE



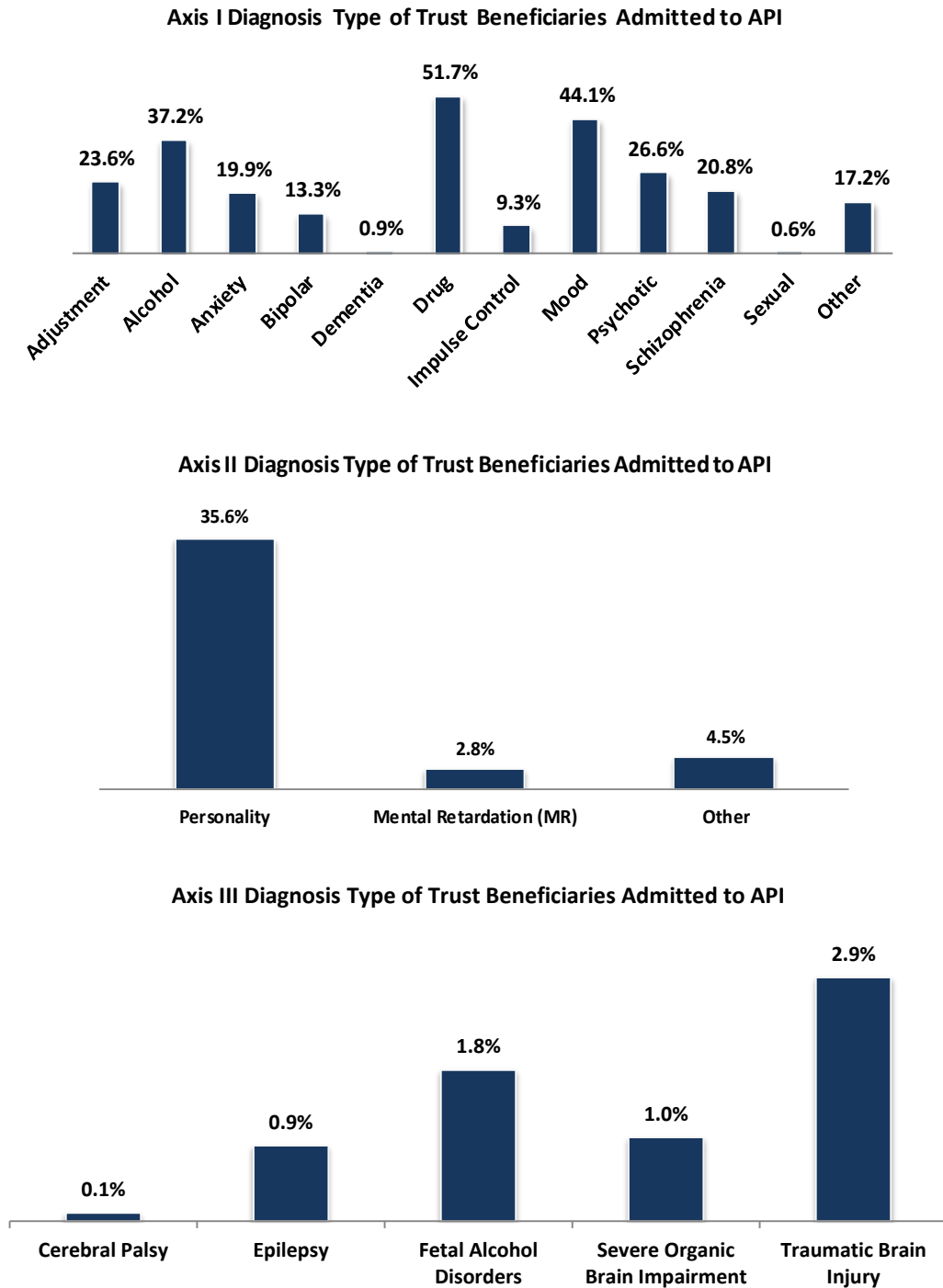
AGE



The clinical characteristics of Trust Beneficiaries who entered API are shown in Figure 10. API Trust Beneficiaries are far more likely to suffer from serious and persistent mental illnesses such as Bipolar, Psychosis and Schizophrenia. The percentage of API Trust Beneficiaries with a personality disorder was nine points higher than Trust Beneficiaries who did not enter the

hospital. More than three-quarters (77.4%) of API Trust Beneficiaries had multiple Axis I type disorders and nearly two-thirds (65.9%) had a co-occurring substance-related disorder, compared with 55.9 percent of non-API Trust Beneficiaries with multiple Axis I disorders and half (50.9%) with a co-occurring disorder.

Figure 10: Clinical Characteristics of Trust Beneficiaries Admitted to API



Medicaid

The cross-match between the ADOC data and MMIS yielded a total of 4,178 Trust Beneficiaries, 22.8 percent of all the Trust Beneficiaries in ADOC between SFY2009 and SFY2012. While there were no significant differences in the racial composition between the two groups, Trust Beneficiaries who could be identified through Medicaid were disproportionately female (44.6%) compared to Beneficiaries not identified by Medicaid (28.9%). This difference is probably explained by Medicaid's eligibility requirements, which are specified for low-income target groups such as pregnant women and people who are eligible to receive federally assisted income maintenance payments, such as Temporary Aid to Needy Families (TANF). Trust Beneficiaries identified through Medicaid were also disproportionately younger. Nearly forty percent (38.4%) were under the age of 21, compared to only 11.0 percent of those not identified through Medicaid. Again, this is explained by eligibility rules for Denali KidCare, which provides health insurance coverage for children and teens through age 18, and for pregnant women who meet income guidelines.

Overall, 5,187 of the study's Trust Beneficiaries received Medicaid services prior to their first arrest (dating to January 2, 2007) and 6,096 of them accessed Medicaid services after their last release. It is important to note that the number of Trust Beneficiaries *receiving* services is higher than the number *identified* through Medicaid, because some Trust Beneficiaries (who were identified through other databases) used Medicaid services that did not classify them as a Beneficiary through MMIS.

Of the 5,187 Trust Beneficiaries who received Medicaid services before their first arrest, 1,436 (27.7%) received behavioral health services 365 days before their first entry into ADOC during the study period. Information in Table 7 provides the behavioral health care expenditures among Medicaid-eligible Trust Beneficiaries before and after exiting from ADOC custody within one year. One year prior to entering the ADOC, 1,436 Medicaid-eligible Trust Beneficiaries received Federal entitlements worth \$3,776,509 in behavioral health services, for an average cost of \$2,630 per person.

After exiting ADOC custody, 1,525 Beneficiaries of the Trust continued to receive behavioral health services one year after. The cost of behavioral health services for treating those released offenders increased to an average of \$2,960 per person, from \$2,630, but the average billing cost declined an average of \$1.09. The increase in the average cost per person is due to the

increased service use of Trust Beneficiaries, with an average increase of 3.6 billing charges to Medicaid per client. However, the actual cost for each billing declined as Trust Beneficiaries used less intensive services and lower-cost services, post-ADOC custody.

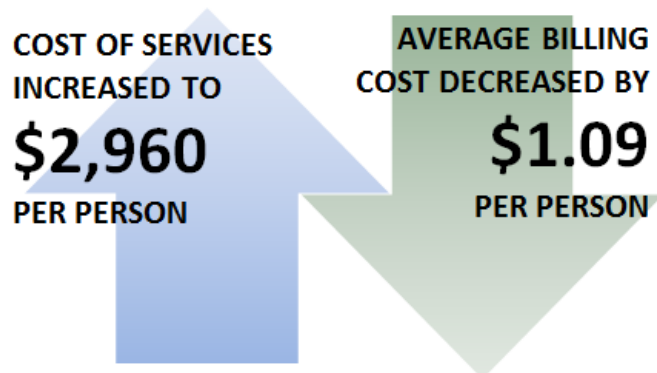
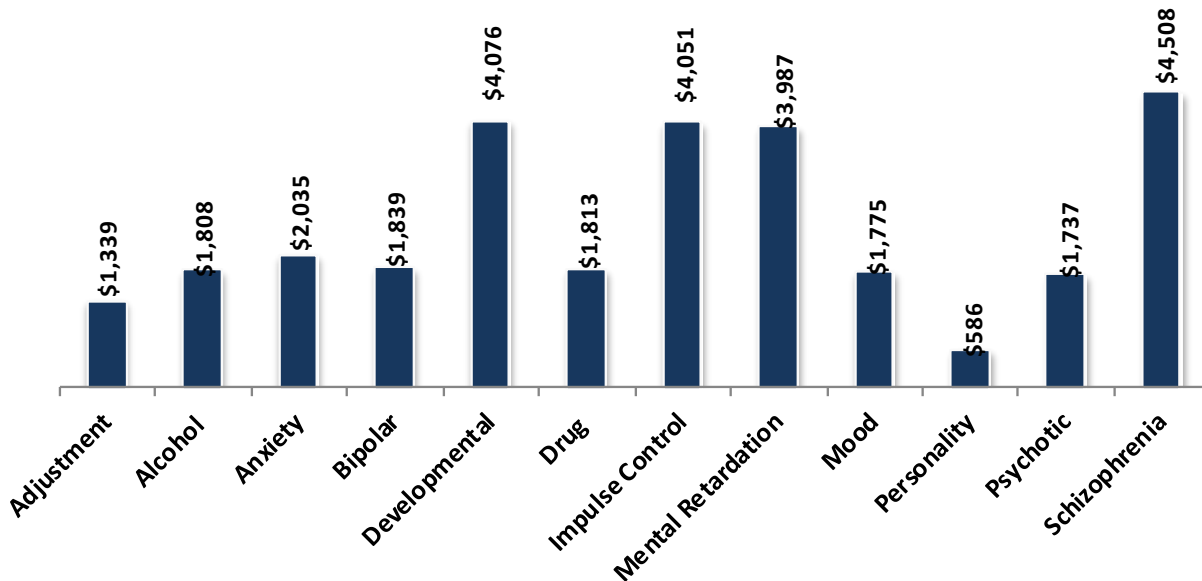


Table 7: Cost of Behavioral Health Treatment among Medicaid-eligible Trust Beneficiaries one year-prior and one year-post ADOC involvement

Services	Before	After	Difference
Behavioral Health Treatment			
People	1,436	1,525	89
Total Cost	\$3,776,509	\$4,515,417	\$738,908
Cost per Person	\$2,629.88	\$2,960.93	\$331.05
Billings	37,501	45,331	7,830
Total Cost	\$3,776,509	\$4,515,417	\$738,908
Average Cost per Billing	\$100.70	\$99.61	-\$1.09

The next analysis addresses the average behavioral health costs by diagnostic category among Medicaid-eligible Trust Beneficiaries one year after release from their last ADOC stay. Information presented in Figure 11 shows that Trust Beneficiaries with Schizophrenia, developmental disorders, and impulse control had average behavioral health costs above \$4,000 per client.³²

Figure 11: Behavioral Health Costs Among Medicaid-eligible Trust Beneficiaries Released from the ADOC by Diagnostic Category, After Incarceration Within One Year



³² Severe organic brain impairment had far higher average behavioral health costs than those with other diagnoses after leaving an ADOC facility. However, this category had only three clients, and one client’s billing record skewed the average costs significantly, making the analysis unreliable for discussion.

Community Mental Health

AKAIMS is a web-based application that allows behavioral health provider grantees to meet reporting requirements to the Division of Behavioral Health and provides basic capabilities for clinical information management. The AKAIMS data allow for an examination of the behavioral health services history of Trust Beneficiaries. Overall, 10,623 of the 18,323 Trust Beneficiaries enrolled in a behavioral health service in the community between 2004 and 2013. Of those who enrolled in a behavioral health service, 7,879 Trust Beneficiaries were matched between ADOC's data and AKAIMS. As noted with MMIS, some Trust Beneficiaries were identified by other systems, but used community mental health services sparingly or in a way that did not classify them as a Beneficiary through AKAIMS.

One limitation with AKAIMS is that not all grantees use the system in the same manner. Some providers use AKAIMS only as a management information system (MIS), while other use it as both an MIS database and as an electronic medical record (EMR). Providers that use AKAIMS only as an MIS system report "core" data elements, whereas those using AKAIMS as an EMR are required to report additional elements to ensure compliance with Medicaid standards of care.

A total of 5,707 Trust Beneficiaries were connected to behavioral health community services prior to their first arrest, (i.e., their first arrest occurring during the study period), and 5,179 of them were connected after their last release. Of the 5,707 Trust Beneficiaries enrolled in 8,230 behavioral health community services dating to 2004, half of the services were for substance abuse treatment, as seen in Table 8 below. After their last contact with ADOC, Trust Beneficiaries were more likely to receive substance abuse treatments and assessments. Mental health enrollments declined, which may suggest improved interventions and stabilization among Trust Beneficiaries in ADOC (see Table 10 for modality types).

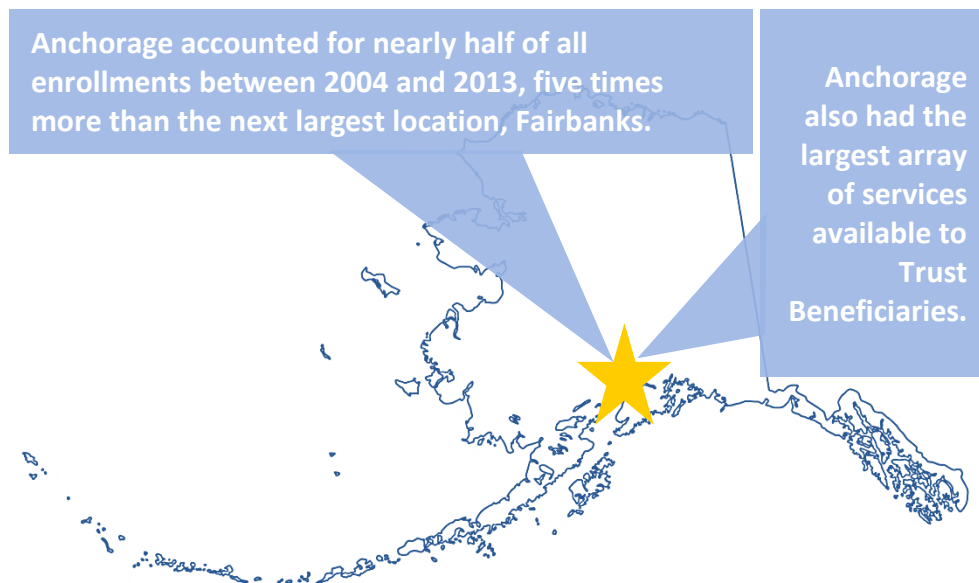
Table 8: Types of Service Enrollments among Trust Beneficiaries (AKAIMS) Before and After ADOC Stay

Program Category	Before	After	Difference
Assessment Only	312	601	289
Behavioral Rehabilitation Services	470	520	50
Legal Assistance	14	12	-2
Mental Health Treatment	3,325	2,390	-935
Substance Abuse Treatment	4,109	4,226	117

As Table 9 shows, Anchorage had by far the highest share of enrollments in the period between 2004 and 2013, representing nearly half of all enrollments, and five times more than the next largest location, Fairbanks. Anchorage also had a greater array of services available to Trust Beneficiaries. Beneficiaries enrolled in nineteen different service types in Anchorage, compared with the statewide average of 2.6 service types.

Table 9: Enrollments of Trust Beneficiaries by Location in Community Behavioral Health Programs

City	Trust Beneficiary enrollments	Share of enrollments	Number of Treatment Modalities
Anchorage	14,293	48.0%	19
Fairbanks	2,918	9.8%	17
Juneau	2,618	8.8%	11
Soldotna	1,455	4.9%	7
Bethel	1,404	4.7%	8
Nome	1,327	4.5%	5
Ketchikan	1,081	3.6%	11
Wasilla	958	3.2%	9
Kenai	865	2.9%	6
Sitka	790	2.7%	7



By modality type, mental health outpatient and non-intensive substance abuse outpatient treatment were the most prevalent enrollments for Trust Beneficiaries, as shown in Table 10. Taken together they represent half of all enrollments. The top ten modality types show multiple substance abuse treatment options. Across modalities, substance abuse treatment represented nearly sixty percent (59.3%) of all enrollments, followed by mental health treatment (34.5%). The remainder was behavioral rehabilitation services, clinical assessment and legal assistance.

**Table 10: Enrollments of Trust Beneficiaries by
Community Behavioral Health Programs**

Modality Type	Program Category	Trust Beneficiary enrollments	Share of enrollments
Mental Health Outpatient Treatment	Mental Health Treatment	9,936	31.8%
Substance Abuse Outpatient –Non-Intensive	Substance Abuse Treatment	6,115	19.6%
Detoxification, 24-Hour Service, Free-Standing Residential	Substance Abuse Treatment	3,489	11.2%
Substance Abuse Outpatient –Intensive	Substance Abuse Treatment	3,349	10.7%
Rehabilitation/Residential, Mid-Term (31-90 Days)	Substance Abuse Treatment	2,075	6.6%
Rehabilitation/Residential, Long-Term (91 Days or More)	Substance Abuse Treatment	1,073	3.4%
Assessment Only	Mental Health and Substance Abuse Assessment Services	846	2.7%
Dual Diagnosis Residential Long-Term (91 Days or More)	Substance Abuse Treatment	607	1.9%
EBP–Supported Employment	Rehabilitation Services	551	1.8%
Rehabilitation/Residential, Short-Term (30 Days or Fewer)	Substance Abuse Treatment	533	1.7%

Child Welfare

Trust Beneficiaries in ADOC custody between SFY2009 and SFY2012 were matched to records in the Online Resource for the Children in Alaska (ORCA) to determine whether they were parents/perpetrators in a child welfare case or had been child victims in reports of child maltreatment.³³ Because the ORCA data system did not go into effect until 2004, individuals in the ADOC data under the age of 25 are the only age cohort potentially identified as victims. Overall, 6,118 (33.4%) Trust Beneficiaries were identified in ORCA, of which 1,378 had a record as a child and 5,426 had a parent record. Of those who had a child record, almost half (686) also had a parent record in ORCA, which helps to illustrate the intergenerational problem of child welfare system involvement.

³³ The matching process was a one-time process that used a record match strength algorithm to match ADOC data to ORCA person records. When only one or two of the variables matched the records were reviewed manually. Ultimately about 14,000 records (Trust and non-Trust) met the criteria for a parent and less than 3,000 met the criteria for a child. This match rate should not be considered surprising considering that ORCA was created in 2004 and only a minimal conversion of person/CPS data from the legacy system was completed.

Figure 12 shows females representing a significantly larger share of the ORCA matched group (46.9%) than of the non-ORCA group (25.2%). Whites accounted for 44.0 percent of the ORCA matched population. Alaska Natives were a disproportionate share of individuals matched in ORCA, representing 45.4 percent of the population. A further analysis to identify Beneficiaries in the ADOC who had a child record in ORCA found that over half (55.7%) were Alaska Natives (see Table 11 on the following page).

Figure 12: Demographics of Trust Beneficiaries by ORCA status

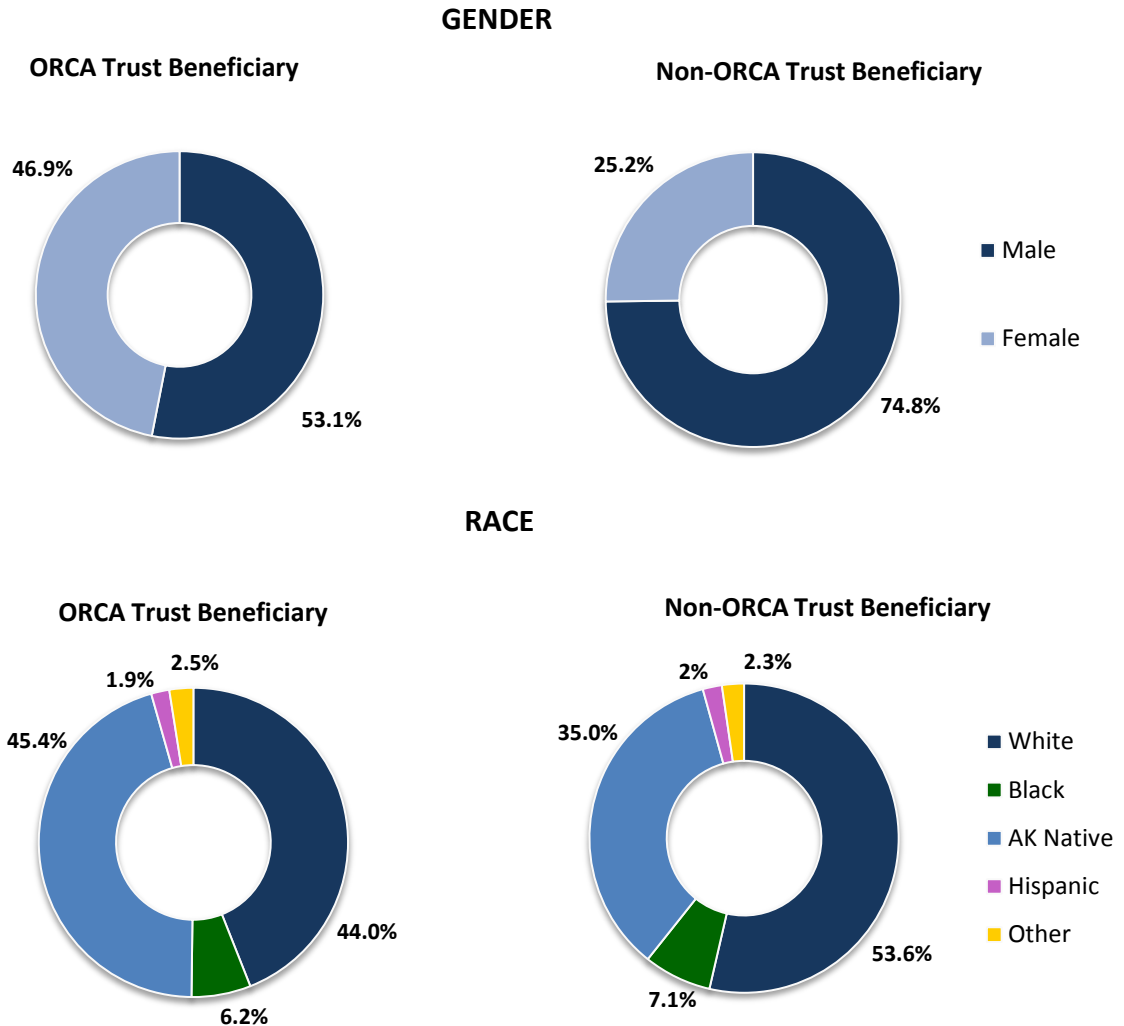


Table 11 shows the distribution of Trust Beneficiaries found in ORCA either as a child or a parent. As noted, Alaska Natives and females represented the disproportionate share of each group. Parents in a child welfare case were on average slightly younger (31.3) than individuals not found in ORCA (33.9).

Table 11: Demographics of Trust Beneficiaries as Parent or Child in ORCA

	Trust Beneficiaries found as Parent in ORCA		Trust Beneficiary found as Child in ORCA		Trust Beneficiary found as Child and Parent in ORCA	
Gender	N	%	N	%	N	%
Male	2,777	51.2%	783	56.8%	311	45.3%
Female	2,649	48.8%	595	43.2%	375	54.7%
Total	5,426	100.0%	1,378	100.0%	686	100.0%
Race	N	%	N	%	N	%
White	2,449	45.1%	457	33.2%	216	31.5%
Black	336	6.2%	95	6.9%	51	7.4%
AK Native	2,407	44.4%	767	55.7%	394	57.4%
Hispanic	104	1.9%	22	1.6%	8	1.2%
Other	130	2.4%	37	2.7%	25	3.7%
Total	5,426	100.0%	1,378	100.0%	686	100.0%
Age	N	%	N	%	N	%
Under 21	749	13.8%	1,092	79.2%	457	66.6%
21-30	2,265	41.8%	286	20.8%	186	27.1%
31-40	1,536	28.3%	NA	NA	28	4.1%
41-50	775	14.3%	NA	NA	15	2.2%
Over 50	99	1.8%	NA	NA	NA	NA
Total³⁴	5,424	100.0%	1,378	100.0%	686	100.0%

When an allegation was made on behalf of an alleged child maltreatment victim, roughly half (50.8%) of the Trust Beneficiary cases were screened out as not requiring further investigation, compared to the overall rate of 45.5 percent. Of those that were screened in and assessed by a Children’s Services’ caseworker, 30.3 percent were substantiated, compared to 28.8 percent of all cases in ORCA. The remainder was either not substantiated (48.2%) or closed without a finding (21.1%).

Trust Beneficiaries in ADOC’s system were also matched to ORCA’s parent allegation file, which had 43,000 records dating back to July 2004. Within the parent allegation records, nearly 59.9 percent of those allegations were assigned for further assessment, of which 35.3 percent were substantiated. Among the substantiated cases displayed in Table 12 on the following page, three-quarters (76.3%) were based on neglect, followed by mental injury, physical abuse and sexual abuse.

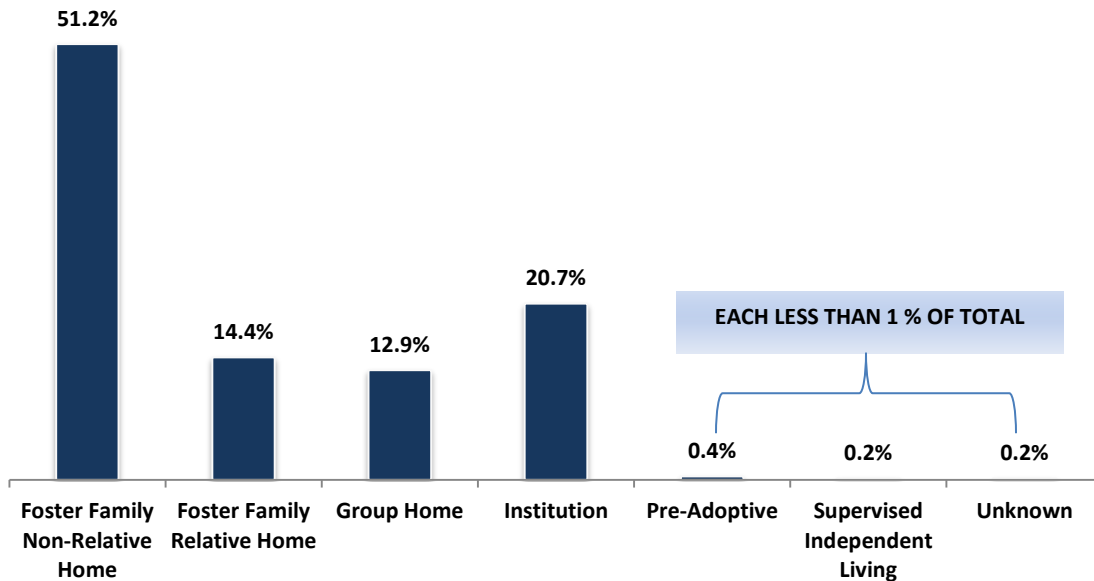
³⁴ There were two missing cases.

Table 12: Trust Beneficiary Cases Screened for Child Abuse from Parent Allegation File

Trust Beneficiary Cases Previously Screened for Child Abuse		
Allegation	N	%
Mental Injury	649	13.9%
Neglect	3,564	76.3%
Physical Abuse	322	6.9%
Sexual Abuse	135	2.9%
Total	4,670	100.0%

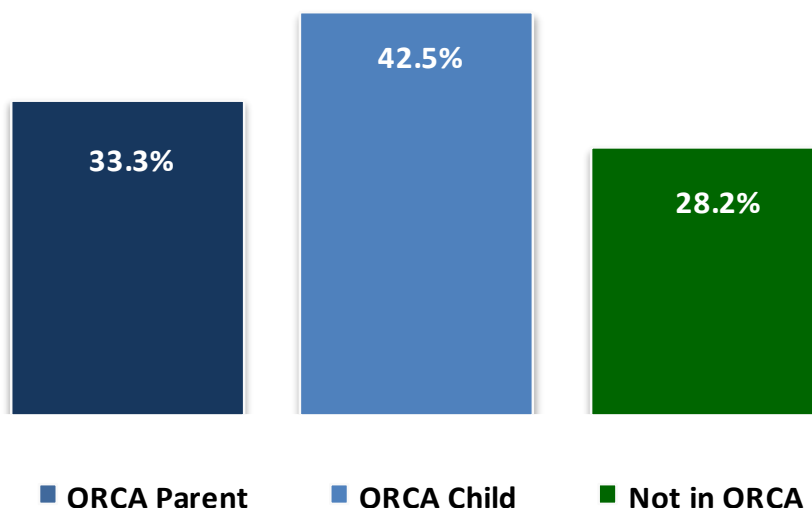
Nearly eight percent (371) of the Trust Beneficiary child victims were removed from their homes a total of 527 times. Of those removals displayed in Figure 13, over half were placed in a non-relative foster family home; this rate is slightly higher than the overall placement rate to a non-relative foster family home, at 46 percent. Trust Beneficiaries were also more likely to be placed in an institution (20.7%) than the overall average at eight percent. The most prevalent reasons for removal were neglect (36%), child behavior (35%), alcohol abuse by the parent (20%) and the physical abuse (12%). In five percent of the cases, the removal was due to the parent’s incarceration.

Figure 13: Childhood Foster Care Placements of Trust Beneficiaries



Criminal recidivism rates by whether the individual was in the child welfare system as either a parent or a child show distinct patterns. As shown in Figure 14, clients known to Children’s Services had significantly higher one-year recidivism rates than individuals not involved in the system.

Figure 14: One-year Recidivism Rates of ADOC Clients as Parent or Child in ORCA



Juvenile Justice

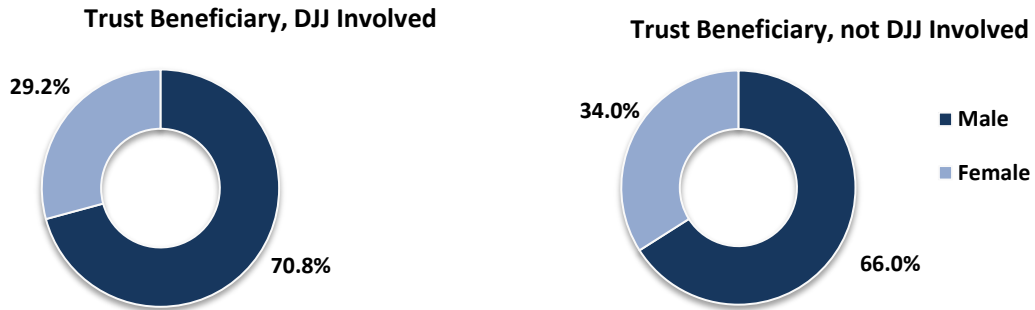
This report offers an opportunity to identify Trust Beneficiaries who had previous experience in the juvenile justice system as well. Overall, a total of 4,309 Trust Beneficiaries (23.5% of all Trust Beneficiaries)³⁵ from the ADOC database were located in Juvenile Offender Management Information System (JOMIS). The share of Trust Beneficiaries found in JOMIS was nearly twice as high as the share of non-Trust Beneficiaries who had previous juvenile justice involvement (13%).

There were gender differences between the cohorts. As shown in Figure 15, nearly three-quarters (70.8%) of juvenile justice-involved Trust Beneficiaries were male, and Alaska Natives were the largest share of Beneficiaries matched in JOMIS, representing 46.6 percent of the cohort. Beneficiaries who had previous juvenile justice involvement were disproportionately younger. The mean age of Trust Beneficiaries with prior juvenile justice involvement was 23 years old, compared to 36 for Beneficiaries with no prior involvement with the Juvenile Justice system.

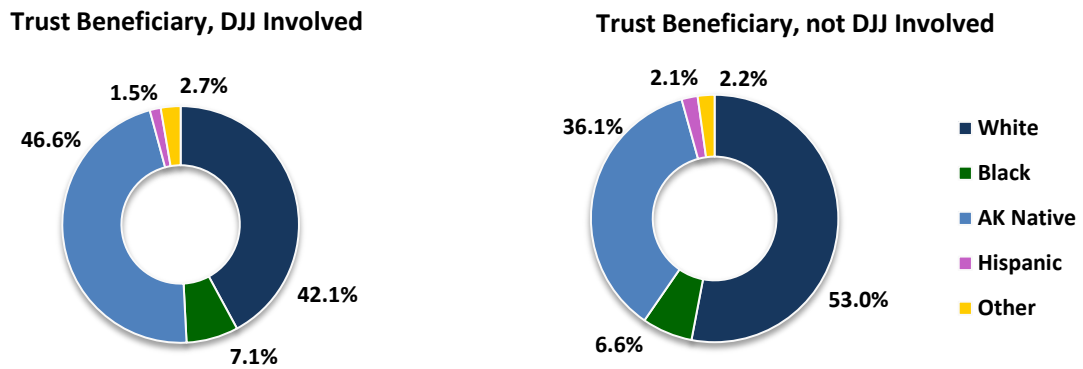
³⁵ 297 Trust Beneficiaries were unable to be matched from ADOC to JOMIS datasets due to missing information. These cases were treated as missing.

Figure 15: Demographics of Trust Beneficiaries as Separated by DJJ Involvement

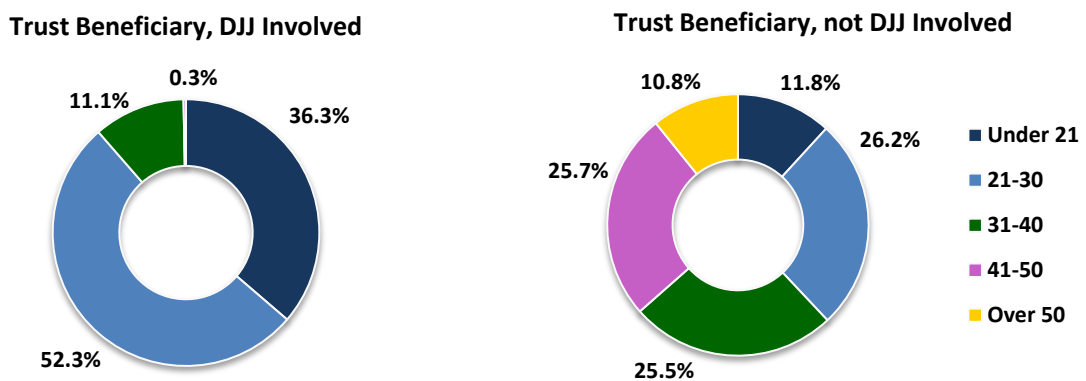
GENDER



RACE

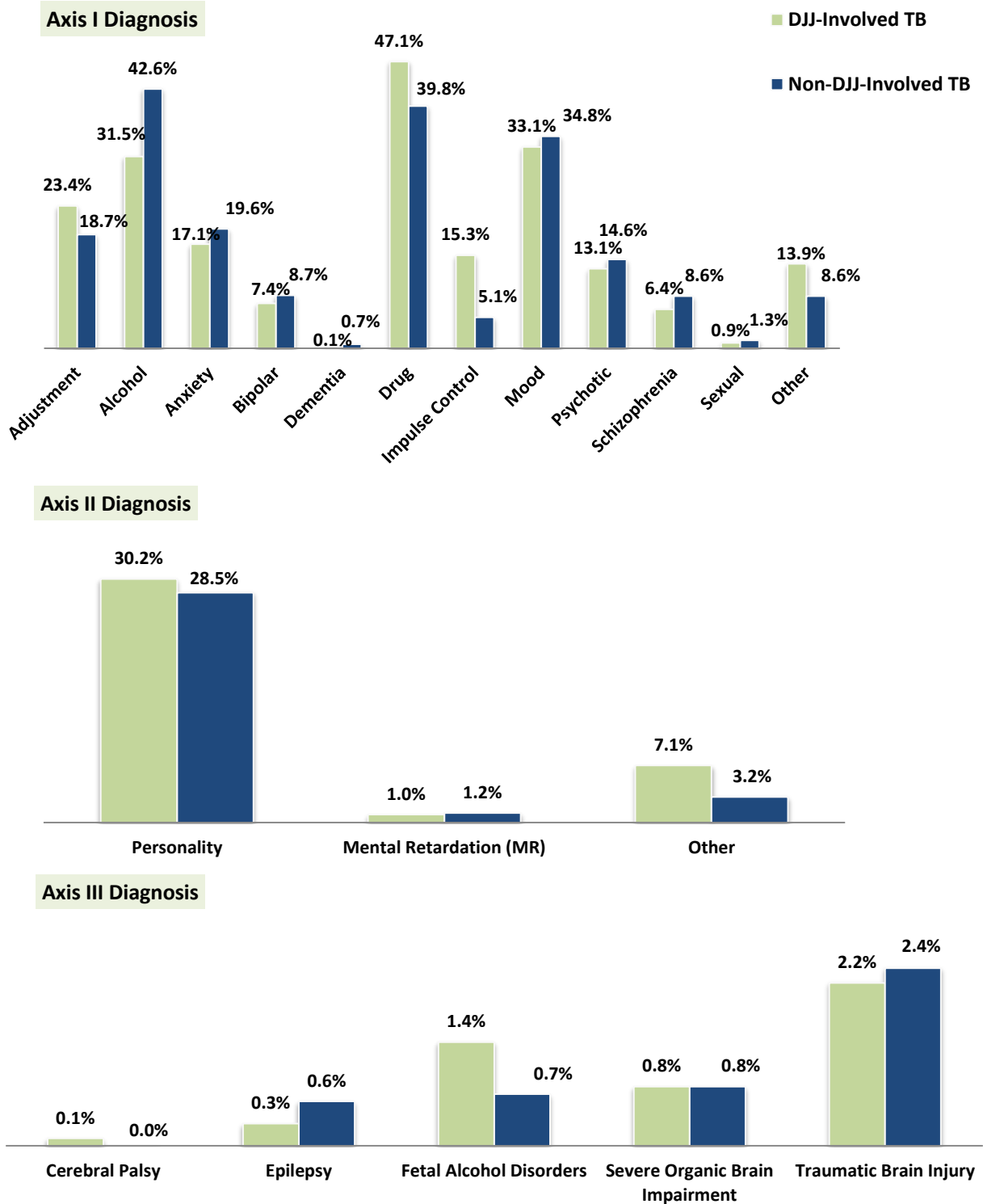


AGE



The clinical characteristics of Trust Beneficiaries who had involvement in the juvenile justice system are shown in Figure 16. For the majority of diagnoses, JOMIS Trust Beneficiaries with juvenile justice involvement had a similar profile to Beneficiaries without any involvement. Juvenile justice-involved Beneficiaries suffered from a drug abuse diagnosis and from impulse control at significantly higher rates than other Beneficiaries. Juvenile justice-involved Trust Beneficiaries also had higher rates of a developmental disorder (listed as “other” in the Axis II chart) than other Beneficiaries.

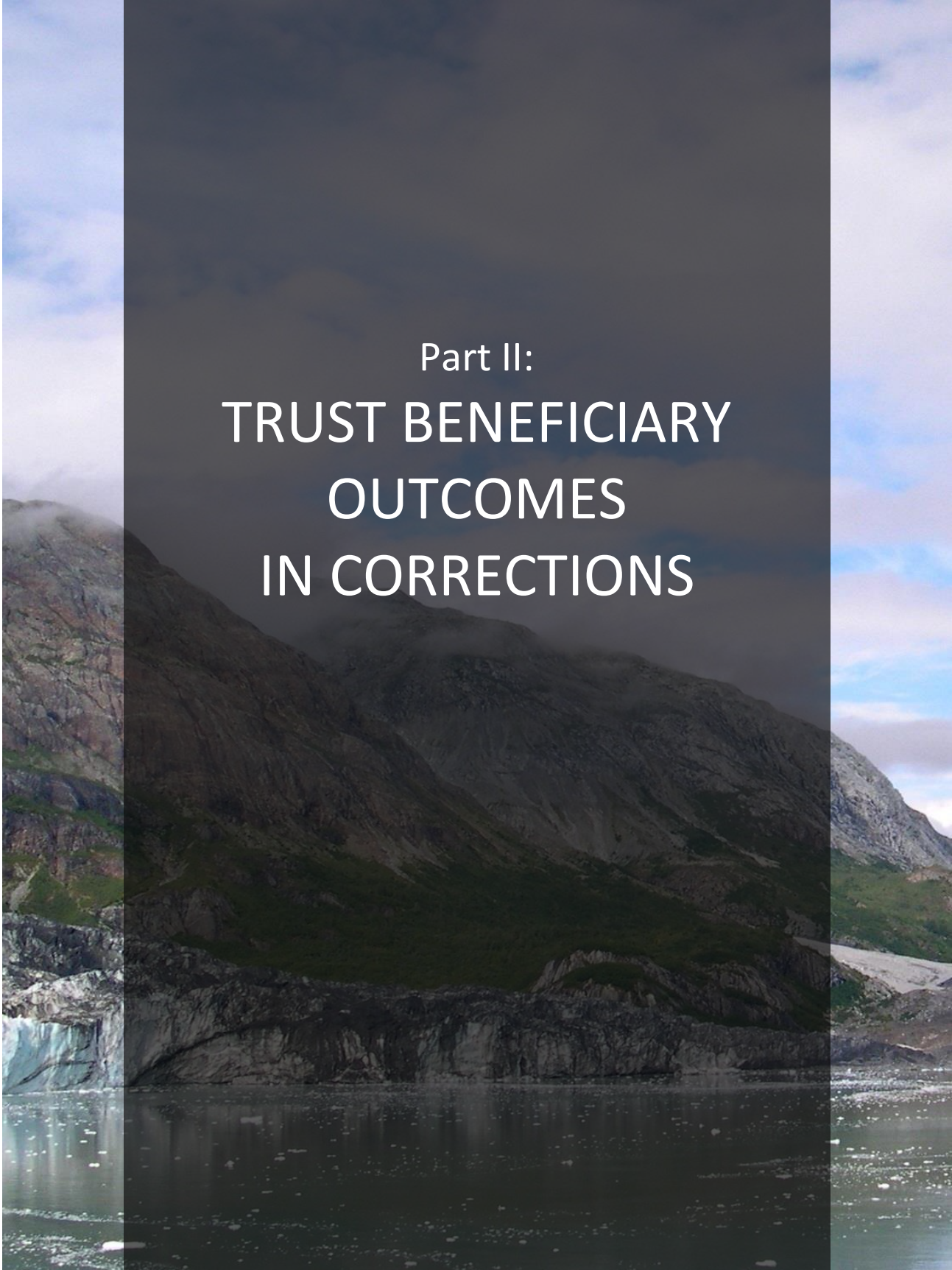
Figure 16: ADOC and MMIS Clinical Characteristics of Trust Beneficiaries with a History of Juvenile Justice Involvement³⁶



³⁶ These diagnoses were made after the individual exited the juvenile justice system.

Adult Trust Beneficiaries previously involved in the Juvenile Justice system show a higher recidivism rate (48.4%) than those adults who were not involved in the Juvenile Justice system (38.0%). Even controlling for age and Trust Beneficiary status, those with a juvenile justice history still show increased recidivism rates for offenders compared to those without such history. For Trust Beneficiaries under the age of 21, half of the offenders found in JOMIS recidivated within one year compared with 40.6 percent of those adults who did not have juvenile history. For offenders aged 21 to 30, the recidivism rates of juvenile justice-involved individuals was 47.7 percent, compared to 39.8 percent of offenders without such involvement.

ADULT TRUST BENEFICIARIES WHO WERE PREVIOUSLY INVOLVED IN THE JUVENILE JUSTICE SYSTEM SHOW A HIGHER RECIDIVISM RATE THAN THOSE WHO WERE NOT, EVEN IF WE CONTROL FOR AGE AND TRUST BENEFICIARY STATUS.

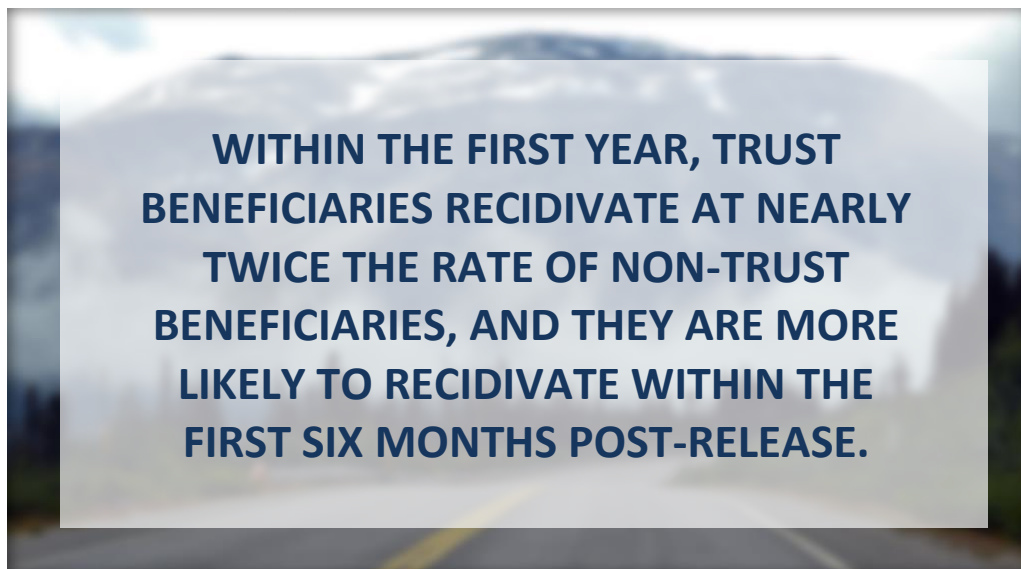


Part II:
**TRUST BENEFICIARY
OUTCOMES
IN CORRECTIONS**

Trust Beneficiary Reentry and Recidivism Outcomes

Key Findings

- Having a criminal history and a substance abuse disorder increased the odds of a Trust Beneficiary recidivating.
- Over half (55.8%) of the recidivists were under the age of 30.
- Within the first year after release Trust Beneficiaries recidivate at nearly twice the rate of those who are not Trust Beneficiaries (40.9% vs. 22.0%).
- Recidivism rates for both groups have declined since 2007 when they were 45.6 and 24.0 percent, respectively.
- The speed of the recidivism for each group tracks the rate; i.e., at any given point within the first year, about half as many non-Beneficiaries have recidivated as Beneficiaries.
- Trust Beneficiaries are more likely to recidivate during the first six months post-release.
- The characteristics of offenders most likely to recidivate are as follows in order of magnitude: whether the offender had committed a felony in the past, whether they were a Trust Beneficiary, whether the offender was an Alaska native, the number of offenses they had committed previously, whether they were in the Juvenile Justice system, whether they were in the child welfare system, whether they were male, and if the offender was young.³⁷
- It cost Alaska over \$4,000 more to re-incarcerate the average Trust Beneficiary than other offenders.



³⁷ Please see Footnote 5 on page *iii* of the Executive Summary for a definition of “young.”

Reentry Trends

Between SFY2009 and SFY2012, there were 33,189 post-sentence exits³⁸ from an ADOC facility. Half of these involved Trust Beneficiaries (one person can have multiple exits if he or she had more than one entrance). Table 13 shows the lowest proportion of a facility's exits attributable to Trust Beneficiaries occurred in the Fairbanks Correctional Center (37.5 %), while Spring Creek Correctional Center had the highest (70.1%).

Table 13: Post-Sentence Exits of Trust Beneficiaries by Facility SFY2009-SFY2012

	Trust Beneficiary exits	Non-Trust Beneficiary exits	Percent Trust Beneficiary exits
Correctional Facility			
Anchorage CC East	2,842	2,963	49.0%
Anchorage CC West	1,036	761	57.7%
Anvil Mountain CC	788	713	52.5%
Fairbanks CC	1,900	3,170	37.5%
Hiland Mountain CC	2,621	1,526	63.2%
Ketchikan CC	396	507	43.9%
Lemon Creek CC	1,028	701	59.5%
Matsu Pretrial	497	552	47.4%
Palmer CC	2,238	1,710	56.7%
Pt. Mackenzie CF	314	450	41.1%
Spring Creek CC	474	202	70.1%
Wildwood CC	1,666	1,865	47.2%
Yukon-Kuskokwim CC	878	1,391	38.7%

For Trust Beneficiaries leaving prison after a sentence, more than one quarter (26.5%) or 4,415 were women. In addition, 79 percent of Trust Beneficiaries with a clinical profile leaving a facility post-sentence had a substance abuse problem; 62 percent of those were co-occurring with a mental illness.

Since specific facilities are selected to house offenders based on a combination of factors, including length of sentence and security risk level, the report examines the court the offender was sentenced from as an indicator of the community to which he or she is most likely to return. Based on that framework, over the four fiscal year period, more than forty percent (42.6%) of Trust Beneficiary exits, or 6,953, are likely to have returned to Anchorage.

³⁸ An exit was a post-sentence discharge from the correctional system or to probation supervision. These totals exclude transfers between facilities.

As shown in Table 14,³⁹ the top ten cities from which people were sentenced account for nearly 95 percent (94.5%) of the Trust Beneficiary returns.

Table 14: City From Which Trust Beneficiaries Were Sentenced, SFY2009-SFY2012

	Trust Beneficiary returns	Share of returns
City		
Anchorage	6,953	42.6%
Fairbanks	2,260	13.8%
Palmer	1,277	7.8%
Kenai	1,146	7.0%
Bethel	1,128	6.9%
Juneau	826	5.1%
Nome	697	4.3%
Ketchikan	515	3.2%
Kotzebue	417	2.6%
Dillingham	205	1.3%

One-year Recidivism Rates

Given that the first year after release is the period when much of the recidivism occurs (generally accounting for nearly two-thirds of all recidivism),⁴⁰ the analyses are based upon the rate of reentry into the ADOC that occurred within one year of the initial date of discharge for all persons exiting the ADOC between SFY 2009 and SFY 2012. Using the one-year definition of recidivism is consistent with work from the Alaska Judicial Council⁴¹ and allows for the preservation of a much larger sample from which to draw more conclusive outcomes and associated correlates both in the statewide aggregate and at the institutional level. If recidivism was measured on a longer time frame for this report, more recent cohorts (2011 and 2012) would not be included in the analysis due to an insufficient monitoring period.

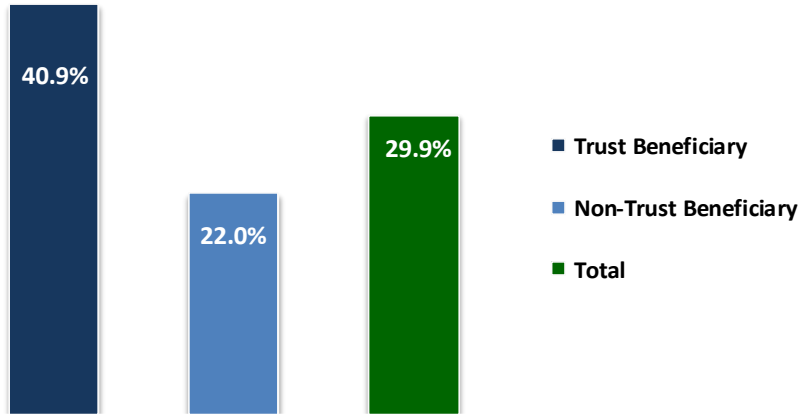
Figure 17 shows that the overall rate of recidivism for the Trust Beneficiary population is 40.9 percent, compared to 22.0 percent for all other offenders, a rate nearly double (85.9%) that of non-Trust Beneficiaries. The overall one-year rate for both populations combined is just short of 30 percent. Recidivism rates are also influenced by the type of crime the offender has committed. Of those who have committed at least one felony, the one-year recidivism rate was 41.8 percent, compared with 14.6 percent for offenders who only committed a misdemeanor.

³⁹ Table 14 includes only individuals discharged from the correctional system without supervision or those placed on probation.

⁴⁰ Langan, P., & Levin, D. (2002). *Recidivism in Prisoners Released in 1994*. Washington, DC: Bureau of Justice Statistics.

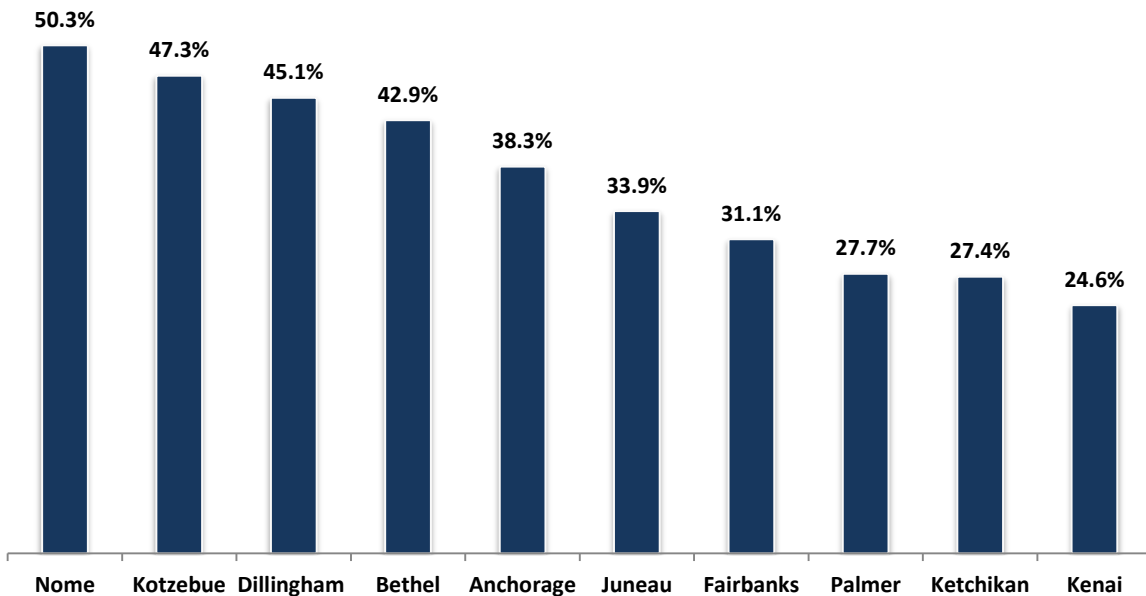
⁴¹ Remands to incarceration, including remands for new arrests, and for probation and parole violations.

Figure 17: Statewide Comparison of Recidivism Outcomes for Trust Beneficiaries and Other Inmates



The one-year recidivism rates by which city or town the offender returns to is shown in Figure 18 below. Nome had the highest recidivism rate at 50.3 percent, followed by Kotzebue (47.3%), Dillingham (45.1%) and Bethel (42.9%). The city with lowest recidivism rate was Kenai at roughly 25 percent, followed by Ketchikan (27.4%) and Palmer (27.7%).

Figure 18: One Year Recidivism Rates by City of Origin, SFY2009-SFY2012



In Table 15, the one-year recidivism rates declined for both Trust Beneficiaries and non-Trust offenders over the four-year period. Non-Trust Beneficiary offenders experienced a decline of nine percent, while Trust Beneficiary offenders experienced a 15 percent decline in recidivism following one year from discharge.

Table 15: One-year Recidivism Rates by Offender and Cohort

	SFY2009		SFY2010		SFY2011		SFY2012 ⁴²		Overall
Offender Type	N	%	N	%	N	%	N	%	%
Trust Beneficiary	2,305	45.6%	1,977	38.9%	1,877	39.2%	1,056	38.9%	40.9%
Non-Trust Beneficiary	1,684	24.0%	1,535	20.6%	1,413	21.6%	763	21.8%	22.0%
Total	3,989	33.0%	3,512	28.0%	3,290	29.0%	1,819	29.3%	29.9%

Length of Time to Recidivism

This analysis uses the same methodology as the 2007 study to compare the timing of re-entry between Trust Beneficiaries and others released from the ADOC. Trust Beneficiaries are more likely to re-enter the ADOC sooner than non-Trust Beneficiaries.

As shown below, the overall rate of recidivism is nearly twice that for Trust Beneficiaries as others. Table 16 on the following page provides a more detailed picture of when recidivism is occurring. The two-to-one rate shows up at every time interval. Within 90 days of release, 13.6 percent of Trust Beneficiaries recidivate compared to 6.9 percent of the others. By six months 25.0 of the Trust Beneficiaries have recidivated while 12.8 percent of the others have. The pattern continues very consistently, such that by the end of one year, 40.9 percent of Trust Beneficiaries have recidivated compared to 22.0 percent of the others.

The difference in recidivism rates reflects both higher rates of probation violations and specific characteristics of Trust Beneficiaries. Many Beneficiaries have previous felony convictions and involvement with the child welfare and juvenile justice system. As discussed in the upcoming Predictive Analysis section, these characteristics are factors to future recidivist behavior.

⁴² 2012 cohort is not a full Fiscal year, due to an insufficient follow-up period. The 2012 cohort consists of offenders released from prison between July 1, 2011 and December 31, 2011.

Table 16: Recidivism Rates within Year One (Cumulative)

Days in Year One	Trust Beneficiary Percentage Recidivated	Non-Trust Beneficiary Percentage Recidivated
90	13.0%	6.9%
180	25.0%	12.8%
270	33.9%	17.8%
365	40.9%	22.0%
Average	153	160

Differences between Recidivist Populations

Table 17 examines the recidivism rates by demographic characteristics of Trust Beneficiaries and non-Beneficiaries.⁴³ By gender, recidivism rates are twice as high for female Trust Beneficiaries compared to non-Beneficiaries and nearly twice as high for men.

Alaska Natives also had the highest recidivism rate of any race category at 47.4 percent followed by African American and Caucasian Trust Beneficiaries. The recidivism rates of Trust Beneficiaries were approximately 15 to 20 points higher for each race category.

Compared to non-beneficiaries, recidivism rates are twice as high for female Trust Beneficiaries, and almost twice as high for male Trust Beneficiaries.



⁴³ This study identifies differences among offenders using chi-square analyses. A chi-square test involves analyzing two variables for the purpose of determining the relationship between them.

Table 17: Characteristics of One-year Recidivists

	Trust Beneficiary		Non-Trust Beneficiary		Total	
	Recidivists	Recidivism Rate	Recidivists	Recidivism Rate	Recidivists	Recidivism Rate
Gender						
Male	5,678	44.0%	4,639	23.6%	10,317	31.7%
Female	1,537	32.5%	756	15.5%	2,293	23.9%
Race						
White	2,816	35.1%	2,059	16.5%	4,875	23.8%
Black	458	40.9%	470	24.9%	928	30.9%
Hispanic	99	33.1%	130	16.9%	229	21.4%
AK Native	3,726	47.4%	2,492	30.5%	6,218	38.8%
Other	116	35.1%	244	20.0%	360	23.2%
Age						
Under 21	1,170	47.5%	1,026	26.3%	2,196	34.5%
21-30	2,751	43.4%	2,008	22.0%	4,759	30.8%
31-40	1,546	38.6%	1,005	21.4%	2,551	29.3%
41-50	1,283	37.1%	999	22.0%	2,282	28.5%
Over 50	377	32.8%	302	14.6%	679	21.1%
Mean Age	31.4 years		31.1 years		31.2 years	
Median	29 years		28 years		28 years	

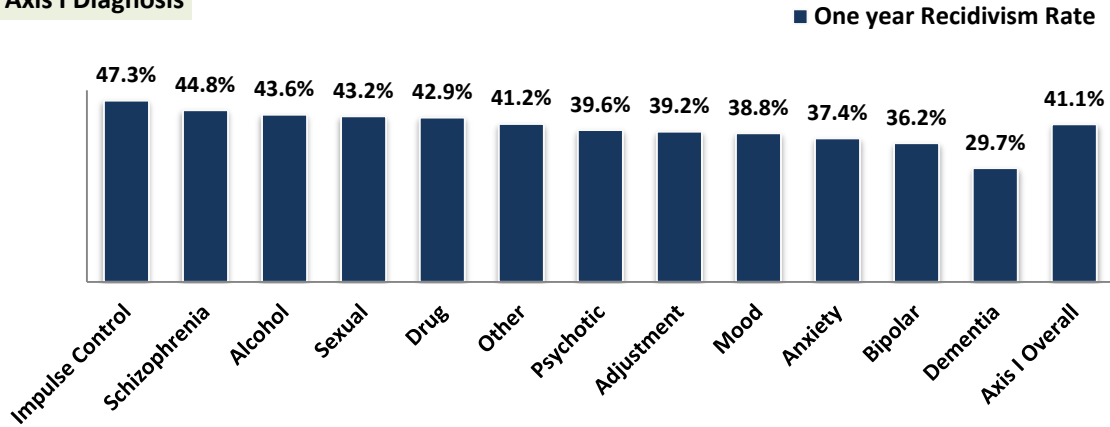
Trust Beneficiaries under the age of 21 were far more likely to reoffend (47.5%) than offenders in other age cohorts. As Trust Beneficiaries got older, the recidivism rates declined to a low of 32.8 percent for offenders over the age of 50. The pattern of declining recidivism rates holds for non-Trust Beneficiaries, although the three middle age groups had roughly the same one-year recidivism rate. Finally, and not surprisingly, over half of the recidivists were under the age of 30. Distinguishing these demographic differences is important in determining which offenders might be suitable for either diversion from the criminal justice system or, conversely, require more intensive supervision or treatment once leaving an ADOC facility.

In addition to age, this study explores correlations between recidivism and other potential determinants. Figure 19 examines Trust Beneficiaries by clinical diagnosis, based on data from CONCON and MMIS, and identifies the proportion of recidivists with each type of mental illness. The figure below shows few differences in the recidivism rates in most Axis I categories. Impulse control had the highest recidivism rate at 47.3 percent, followed by Schizophrenia, Alcohol, Sexual, and Drugs. Trust Beneficiaries with a Personality Disorder had higher recidivism rates than other Axis II disorders. These results are consistent with findings that show

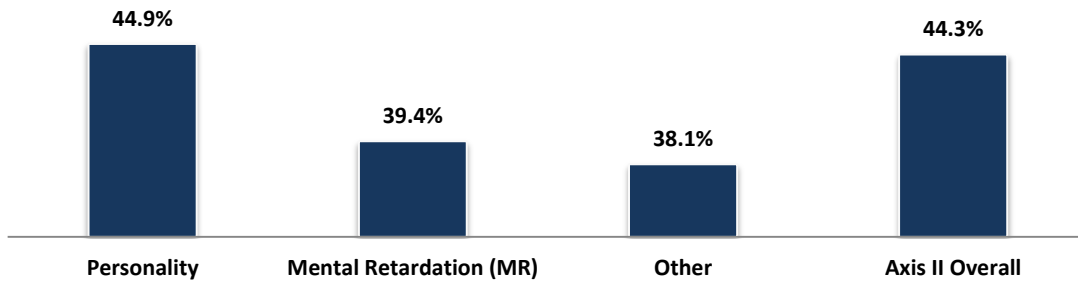
impulsivity, substance abuse and personality disorders have an influence on recidivism outcomes.⁴⁴

Figure 19: Recidivism Outcomes for Trust Beneficiaries by Clinical Characteristic⁴⁵

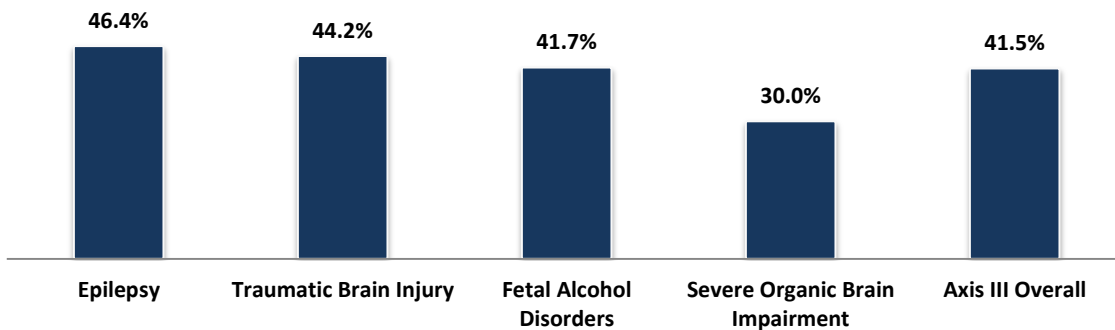
Axis I Diagnosis



Axis II Diagnosis



Axis III Diagnosis



⁴⁴ Gendreau, P., Little, T., & Goggin, C. (1996). A meta-analysis of the predictors of adult offender recidivism: What works! *Criminology*, 34, 575-607.

⁴⁵ Cerebral Palsy was not included in Axis III reporting, as there were less than 10 cases.

Predictive Analysis

These analyses were performed on two populations, all offenders and Trust Beneficiaries alone.

All Offenders

Examination of the demographic and clinical characteristics of all offenders provides a framework to determine the strength of each variable's influence on offenders' likelihood of recidivating within one year. This analysis used binary logistic regression to identify certain factors that increased the odds of recidivism. As the model below shows, eight variables are significant factors explaining an offender's recidivism: offender's age, whether the offender was an Alaska native, his or her gender, whether the offender had committed a felony in the past, the number of offenses committed previously, whether in the Juvenile Justice system, whether in the child welfare system, and whether a Trust Beneficiary.

As Table 18 below shows, having a felony conviction doubled the odds of recidivating within one year (113%), while being a Trust Beneficiary increased the odds by 44 percent. For every year older (above the age of 18) the likelihood of recidivating was reduced by two percent. The other variables had less of an impact, although it is interesting to note that child welfare and juvenile justice involvement were significant factors, suggesting that early childhood outcomes increase the odds for adult recidivism.

Table 18: Re-incarceration Outcomes—Odds Predicting Correctional Re-entry Outcomes

Variables	Odds
Age (per year)	-2%
Alaska Native	29%
Male	8%
Prior Felony Conviction	113%
Number of prior Convictions	12%
Juvenile Justice Involved	11%
Involvement in Child Welfare System	10%
Identified as a Trust Beneficiary	44%

N=34,064

Within the Trust Beneficiary category, specific Axis I conditions are predictive: substance abuse (alcohol and drugs), anxiety, impulse and Schizophrenia. These findings are consistent with evidence-based practices in corrections which identify criminal history, substance abuse and impulsivity (low self-control) as important factors for future recidivist behavior.

Trust Beneficiaries

When the analysis focuses specifically on Trust Beneficiary offenders, five variables can be considered significant in explaining a Beneficiary’s recidivism: age, Alaska Native, prior felony conviction, number of priors, and a diagnosis of a Substance Abuse (alcohol or drugs) issue. Table 19 shows the chances for recidivating within one year increased by 48 percent if the offender had a prior felony conviction, and increased by 10 percent with each prior conviction.

In addition, having a Substance Abuse disorder increased the chances for recidivism by 27 percent for Trust Beneficiaries and by 18 percent if the offender was an Alaska Native. Age was also a predictive factor. For every year older, a Trust Beneficiary offender’s chance for recidivating declined by three percent.

**Table 19: Re-incarceration Outcomes for Trust Beneficiaries—
Odds Predicting Correctional Re-entry Outcomes**

Variables	Odds
Alaska Native	18%
Age (per year)	-3%
Prior Felony Conviction	48%
Number of prior Convictions	10%
Substance Abuse Diagnosis	27%

N=9,754

These findings suggest that many of the predictors for recidivism among non-Trust Beneficiaries are the same as for Trust Beneficiaries. **Prior criminal history and substance abuse are stronger predictors than having most Axis I diagnoses, or an Axis II disorder.** This finding is supported by a large body of evidence indicating that the relationship between serious mental illness and criminal behavior is weak. A meta-analysis was conducted to examine whether the predictors of recidivism for “mentally disordered” offenders are different from the predictors for “non-disordered” offenders. The results showed that the major predictors of recidivism were the same across the two groups. Criminal history variables were the best predictors, and diagnostic variables had the smallest effect.⁴⁶

⁴⁶ Bonta, J., Law, M., & Hanson, C. (1998). The prediction of criminal and violent recidivism among mentally disordered offenders: A meta-analysis. *Psychological Bulletin* 123, 123–142.

The Cost of Recidivism

The average daily cost in 2013 to house an inmate is \$147.21 per day, with the cost for housing an offender in a mental health unit being significantly higher. The Trust Beneficiaries who returned to ADOC custody for new sentences collectively stayed on average 81 days over the four-year study period.⁴⁷ Multiplying the daily rate by the number of days spent incarcerated after a recidivism conviction, the average cost was \$12,024 per Trust Beneficiary for the average stay. Other offenders who returned to ADOC spent an average of 52 days in custody, for an average of \$7,716 per person. Consequently, the average cost to re-incarcerate the average Beneficiary was \$4,307 more than other offenders.

If Alaska could reduce recidivism rates to that of the rate of non-Trust Beneficiaries it would theoretically realize a net savings of up to \$20,672,150 per year using a \$147.21 cost per day and assuming an 81 day stay. A mere 10 percent reduction in recidivism for Trust Beneficiaries would theoretically mean an average savings of \$4,593,790 per year. We use the term theoretically because the daily rate includes both fixed and variable costs. If the number of incarcerated offenders was reduced the daily rate would be somewhat higher because the fixed costs would be spread across fewer people.

It cost Alaska approximately \$4,307 more to re-incarcerate the average Trust Beneficiary than other offenders.

An illustration featuring a stack of green banknotes tied together with a black band. A large, light blue arrow points upwards from behind the stack, symbolizing an increase in cost or a significant financial figure.

⁴⁷ Unlike previous analyses, the length of time for the subsequent incarceration is measured as actual jail/prison time rather than as sentence length.



Part III:
**PROGRAMS
AND SERVICES
FOR
TRUST BENEFICIARIES**

Alaska's Initiatives for Treating Offenders with Mental Illness and Other Disorders

Key Findings

- Behavioral health contacts with incarcerated offenders have increased by one-third over the past four years.
- The Department of Corrections recently adopted use of the Substance Abuse and Mental Health Services Administration (SAMHSA) Brief Jail Mental Health Screening Tool which meets National Institute of Corrections standards regarding screening for mental illness.
- More staff and services have been dedicated to offenders with either a substance abuse or mental illness over the last five years.
- ADOC's community-based programming for offenders with mental illnesses has increased in Alaska, but is currently over-capacity.
- ADOC staff have worked closely with local partners to increase access to Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) for eligible adults.
- The Alaska Court System, along with a host of state agencies and non-profit treatment providers, currently operates 13 therapeutic courts, many of which benefit Trust Beneficiaries.

Since completion of the 2007 study, a considerable number of initiatives were undertaken in Alaska to address the issues and gaps identified. One significant challenge has been that many of Alaska's proven programs to reduce recidivism have small capacity, making it difficult to significantly impact the overall recidivism issue facing ADOC. Recognizing the need to improve the response to persons who fall under their supervision, the Alaska Prisoner Reentry Taskforce released a Five-Year Prisoner Reentry Strategic Plan in 2011. The Plan addressed ways to reduce the number of adult offenders who return to custody, whether for a new crime or for a violation of probation or parole by adopting "best practices."

The strategic plan was conceived to stem a twenty-five year trend of increases in Alaska's prison population, yielding a 152 percent increase in Alaska's prison population between 1982 and 2007. This Five-Year Plan also identified the strategies currently in place to help former prisoners successfully integrate back into their communities. The plan notes that the most successful efforts currently in place, although with very limited capacity, target the mentally ill and cognitively impaired offenders with co-occurring disorders leaving prison.

This section addresses the programming and enhancements that have been made within ADOC facilities; the enhancements made to community or transitional services and the challenges which remain.

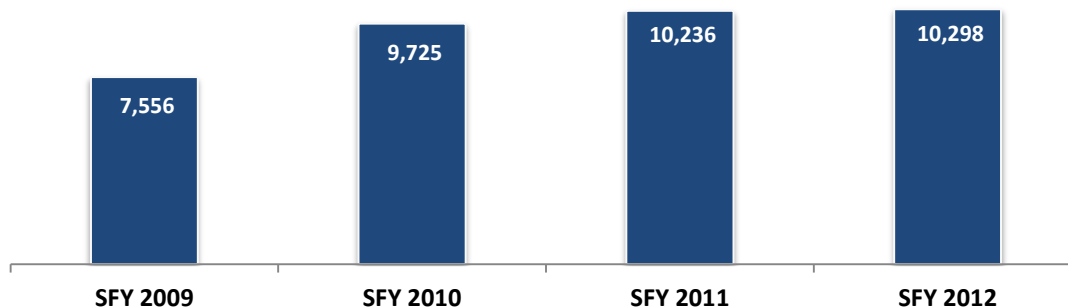
ADOC Institutional Programming and Enhancements

ADOC is, by default, the largest mental health providers in the state. It serves people through a combination of telemedicine and on-site clinical and psychiatric services inside its institutions. Listed below is the roster of institutional programming found in ADOC facilities as of June 30, 2012. (Appendix F provides descriptions of each program).

- 48-Week Offender Management Program
- Acute Psychiatric Unit
- Alaska Native-Based Substance Abuse Treatment (ANSAT)
- Alaska Reentry
- Anger Management
- Batterer's Intervention Program
- Choosing Change
- Cognitive Restructuring
- Contracted Clinical Services
- Criminal Attitudes Program (CAP)
- Healthy Living
- Life Success Substance Abuse Treatment (LSSAT)
- On-site Clinical Services
- On-site Dual Diagnosis Clinical Services.
- On-site Psychiatric Services
- Parenting
- Reentry-DOLWD Workplace & Community Transition Program
- Relapse Prevention Program
- Residential Sex Offender Treatment
- Residential Substance Abuse Treatment (RSAT)
- Sub-Acute Psychiatric Unit
- Tele-psychiatry
- Thinking Errors
- Transformational Living Community (TLC)

The demand for these services continually increases, as reflected in Figure 20, which shows a 36.2 percent rise in behavioral health contacts over the four-year study period. By SFY2012 ADOC staff had more than 10,000 contacts with offenders.

Figure 20: Total Number of Contacts with Behavioral Health Staff



From interviews with stakeholders and a review of internal ADOC documents, there have been positive changes since 2007 in the services that ADOC provides, both in facilities and in the community to offenders with mental illness, substance abuse disorders and cognitive impairments. Respondents credited the efforts made by the Department of Corrections' Commissioner Joe Schmidt and the last two state administrations in rebuilding the in-house programming for Trust Beneficiaries. Listed below are both programmatic initiatives and infrastructure changes ADOC has undertaken to better manage its Trust Beneficiary population.

Brief Mental Health Screening Tool

One of the most far-reaching changes was implementing a mental health screening for all offenders within 24 hours of their arrest in 2011, in an attempt to identify those with a mental illness as they enter the system.

The Brief Jail Mental Health Screening (BJMHS) tool is a nationally validated instrument that has eight yes or no questions, takes about two to three minutes, and requires minimal training to administer. It asks six questions about current mental disorders plus two questions about history of hospitalization and medication for mental or emotional problems. ADOC had used another screening tool to assess mental health prior to 2011, but the introduction of the BJMHS has allowed facility staff to more quickly identify offenders for intensive services in the facilities, and thus potentially stabilize the offenders' conditions.

Increases in Clinical Staffing Patterns

Since 2007, the acuity levels of the mental illnesses suffered by ADOC inmates have increased, along with the number of mentally ill incarcerated individuals. ADOC has two inpatient psychiatric treatment units, which provide 24-hour hospital level care to the most seriously mentally ill and suicidal offenders. Both men's and women's acute-care units continue to operate at or near capacity, forcing these entities to focus on stabilizing rather than treating behaviors.

Over the last three years, the daily census at the women's mental health unit at Hiland Mountain Correctional Center (HMCC) has increased by 33 percent and at the Anchorage Correctional Complex–West facility (ACC–W) men's unit by 44 percent. At the ACC–W facility,

there have been 281 admissions per year over the last five years, with offenders spending roughly 28 days in the unit. Of those admitted to the acute care unit, 73 percent have co-occurring disorders.⁴⁸ At the women’s acute unit at Hiland Mountain, the five-year average of admission was 187 per year, with an average length of stay of 24 days. Similar to the profile at ACC–W, three quarters of the admitted women have a co-occurring disorder.

To help address these population increases, ADOC has increased its mental health clinical staff by 12 positions between 2007 and 2012. Starting in SFY2009 The Trust funded two additional clinical positions at ADOC facilities, one Mental Health Clinician and one Psychological Counselor. As shown in Table 20, additional institutional and release programming clinical staff were added over the five year period.

Table 20: Clinical Staffing by Type between 2007 and 2012

	2007	2012
Position		
Psychiatrists	2	2
Psychiatric ANP	1	1
Institutional Psychiatric Nursing	11	11
Mental Health Clinician IV	1	1
Institutional Clinical Staff	21	30
Release Programming Clinician Staff	5	8
Total Staff	41	53

These positions have allowed for further development of rehabilitation programming within the facilities including group classes such as Healthy Living, Relapse Prevention, Anger Management, Criminal and Addictive Thinking and Parenting. These positions also allow for an increase in the number of Trust Beneficiaries who can be served while incarcerated. ADOC also increased the number of clinical staff for release programming, as ADOC added a second clinician in 2011 to help manage the IDP⁺ caseload of high-risk probationers. In addition, ADOC, with the support of The Trust, received funding for a second APIC position in 2009.⁴⁹

Facility Growth

In addition to acute services provided in the facilities by ADOC, the Department has four sub-acute units. These units are located at the Anchorage Correctional Complex–West, Spring Creek Correctional Center (Seward), Hiland Mountain Correctional Center, and the Palmer Correctional Center providing in-patient residential treatment for mentally ill offenders who are transitioning back to open population or the community, and for those who simply cannot function safely in the general population. In January 2011, ADOC expanded the number of sub-

⁴⁸ Internal memo on updates in behavioral health from Chief Mental Health Officer, February, 2013.

⁴⁹ Alaska Prisoner Reentry Task Force. (2011). *Five Year Prisoner Reentry Strategic Plan, 2011–2016*. Retrieved from <http://www.correct.state.ak.us/commish/docs/StrategicPlan.pdf>

acute unit beds for men by opening Lima Mod in the Anchorage Correctional Complex-West (ACC-W), accommodating up to 36 additional offenders. Lima was full the first week it opened and has remained at capacity since, with 238 total admissions over its first year.

Substance Abuse Treatment Growth

Over the last five years, ADOC has expanded its programs and services geared toward assisting offenders in overcoming their substance abuse related problems. These services have the ability to provide over 1,000 assessments and referrals per year. At the assessment and referral stage, ADOC orients the newly incarcerated offender on substance abuse treatment options within ADOC institutions and in the community. The comprehensive substance abuse assessment includes referrals based upon assessment results. The assessment and referral services are offered in Anchorage (both in the community and in the ACC-E and ACC-W) and the Mat-Su Pretrial Facility. ADOC's most intensive treatment option for offenders with substance abuse issues is Residential Substance Abuse Treatment (RSAT), and serves 60 offenders per year. Finally, the Life Success Substance Abuse Treatment (LSSAT) program is a less intensive program than RSAT, and serves 733 offenders per year.

ADOC Transitional Programming and Enhancements

Community-based programming for offenders with mental illness has increased in Alaska. For those with severe mental health disorders, ADOC—in conjunction with the Alaska Court System (ACS), the DHSS Division of Behavioral Health (DBH), other State agencies and local providers—ran four mental health release programs during the study period. These programs operate with seven mental health clinicians and one psychological counselor to aid mentally ill prisoners with their reentry needs. Aside from their collaboration with the courts and DHSS, ADOC has a number of programs to help mentally ill offenders transition from the facility into the community, which are discussed in greater detail below.

Institutional Discharge Project Plus (IDP⁺)⁵⁰

IDP⁺ provides services to mentally ill felons with a psychotic disorder who are being released to probation or parole in Alaskan communities. Started in 1994 by ADOC and the Division of Mental Health and Developmental Disabilities, IDP⁺ seeks to reduce recidivism by providing individualized treatment supervision and case management services to offenders returning to Alaskan communities. An ADOC mental health clinician, in conjunction with two DOC mental health probation officers and other community behavioral health or other identified agency representatives, develops a treatment and monitoring plan for the releasing prisoner. Since 2002 when ADOC assumed full responsibility for the IDP+ program, the initial caseload of 30 increased to 80 to 90. Since SFY2011, IDP⁺ has been offered only in Anchorage.

Assess, Plan, Identify and Coordinate (APIC)

Based on a national evidence-based re-entry model, the Alaska APIC program links offenders with mental illness and co-occurring disorders to needed community services in Anchorage,

⁵⁰ Although not a new program, this is worth noting to understand the range of services available.

Fairbanks, Juneau and the Mat-Su Valley. Jointly funded by ADOC and The Trust, the APIC program contracts with community agencies for release planning services for up to 90 days prior to release, and for community agency treatment services up to 60 days after release (with the possibility of extension in certain cases). APIC works to ensure public safety and success for the individual through continuity of care while they are transitioning back into the community. The APIC transitional re-entry program connects Trust Beneficiaries to services, medications, housing, benefits or jobs if able to work.

APIC is a voluntary program available to both felony and misdemeanor offenders who are in custody at the time of referral. Connecting APIC participants to needed community-based support services has resulted in reduced recidivism rates for this population.

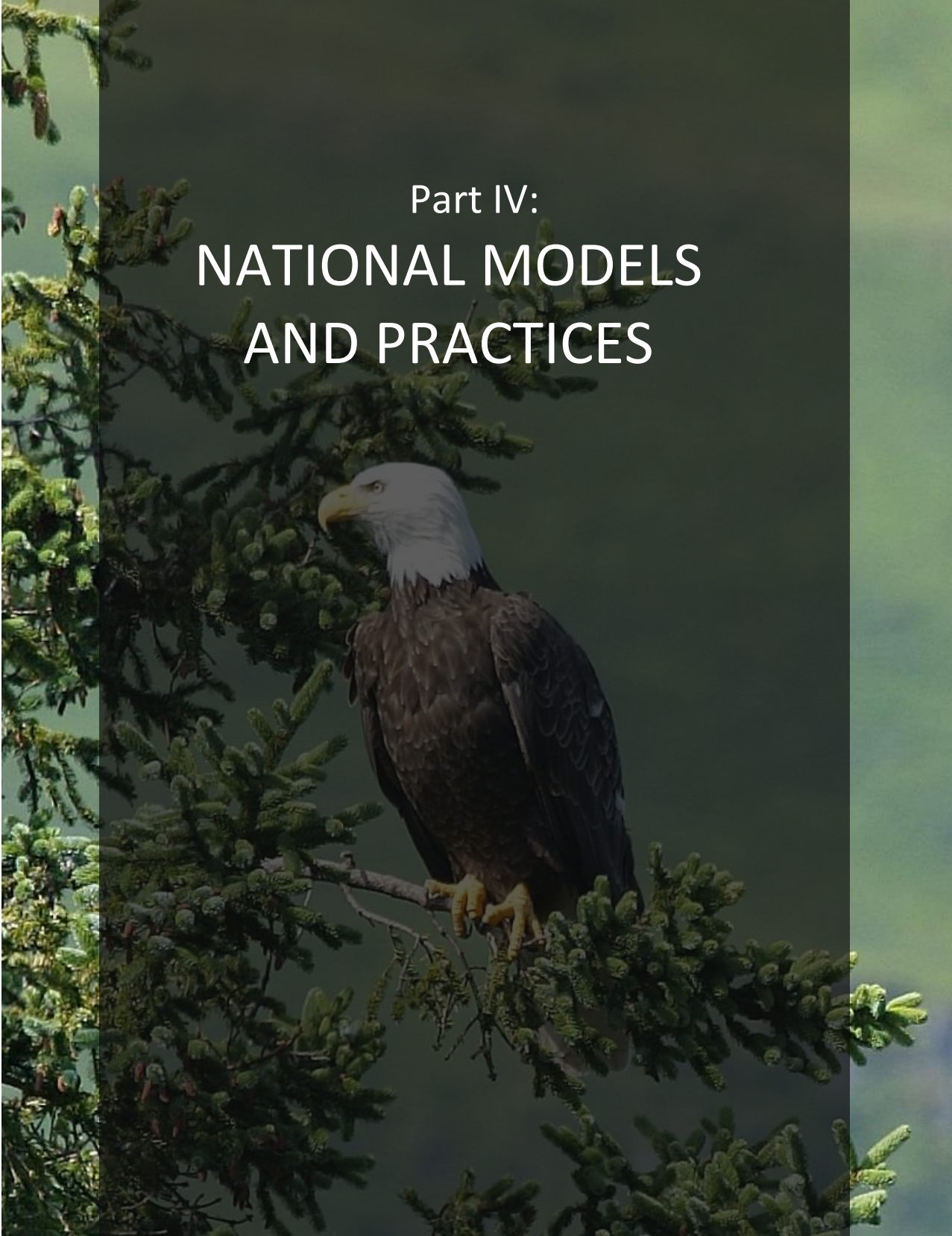
APIC facilitates benefit applications for eligible participants. Building on a 2004 ADOC Memorandum Of Agreement with Social Security, APIC staff either directly assist the participant with an application to Social Security and to the Alaska Division of Public Assistance for disability benefits, or refers to a community agency to assist with benefit applications. Community agencies can use the SOAR application process, a national social security benefit application process that was implemented in Alaska in 2008. Since APIC contracts started in 2007, the number of program participants has increased each year, from an original expectation of 60 at program inception to 188 clients served in SFY12, all released with a transition plan.

Therapeutic Courts

Other related efforts at reducing the number of Trust Beneficiaries in the correctional system have been enhanced in the last five years. The Alaska Court System, along with a host of state agencies and non-profit treatment providers, have collaborated in the development and operation of 13 therapeutic courts throughout Alaska. These include mental health courts and Wellness Courts, which place focus on offenders with underlying addictions. Serving mentally ill misdemeanants, mental health courts in Alaska were first implemented in Anchorage in 1998, while Palmer Mental Health Court began operation in 2005. Most recently, Juneau implemented this national best practice model with its eligible offenders in 2012.

The primary goal for the mental health courts is to maintain offender stability as well as success as law-abiding, self-sustaining members of the community. They do so by linking Beneficiaries with community-based services appropriate to meet their individual needs and monitoring their compliance with the services as well as conditions from the courts and probation.

Monitoring an offender's adherence to the case plan and conditions of participation is done by Case Coordinators, who are typically probation officers from DHSS-ASAP – the Alcohol Safety Action Program for the majority of therapeutic court participants in locations around the State. Alaska Department of Corrections has two Mental Health Clinicians who serve as Case Coordinators in Anchorage Mental Health Court, each with caseloads of up to 30 participants with serious mental illness or complex organic impairment who are incarcerated at the time of referral.

A bald eagle is perched on a branch of a pine tree. The eagle has a white head and neck, a yellow beak, and dark brown feathers on its body. It is looking to the left. The background is dark and out of focus, with some green pine needles visible. The text "Part IV: NATIONAL MODELS AND PRACTICES" is overlaid on the image in white, bold, sans-serif font.

Part IV:
**NATIONAL MODELS
AND PRACTICES**

Evidence-based Practices Across the Country

The previous sections have provided a profile of Trust Beneficiaries in Alaska’s correctional system, and some of the initiatives supported by ADOC. The ongoing efforts at reducing recidivism and diverting offenders with long-standing mental health and substance abuse issues are not unique to Alaska. This section of the report identifies programs outside of Alaska that have shown positive outcomes for justice involved individuals with a mental illness. Across the country, there is a growing body of research on treatment strategies for people with mental illness who have been or are currently involved with criminal justice.

Within the healthcare field, where the term originated, evidence-based practice is considered to be both a standard and a philosophical framework for making clinical decisions.⁵¹ Sackett offers the following definition: “Evidence-based practice is the integration of best research evidence with clinical expertise and patient values.”⁵² While evidence-based practice emerged in the field of healthcare, it is commonly used in corrections to refer to specific intervention models or principles that research has proven to lead to desirable outcomes, such as recidivism reduction and increased public safety.⁵³

The Washington State Institute of Public Policy (WSIPP) conducted a review of all evaluation studies of adult correction programs to determine if, on average, a specific treatment model/modality program achieves a positive outcome. It found that for drug involved offenders, intensive community supervision that had a treatment focus (instead of a surveillance model of looking for infractions) and a therapeutic community model for mentally ill offenders showed positive (reduced recidivism) results.⁵⁴ In addition, the Institute of Social and Economic Research (ISER) at the University of Alaska, Anchorage found that if the state spent an additional \$4 million a year to expand programs it already has, the prison population in 2030 might be 10 percent smaller than projected—about 1,050 fewer inmates, saving Alaska \$321 million over the subsequent 20 years.⁵⁵

⁵¹ Scott, W. (2008). *Effective Clinical Practices in Treating Clients in the Criminal Justice System*. Criminal Justice Institute for the National Institute of Corrections, Department of Justice. Accessed at <http://static.nicic.gov/Library/023362.pdf>.

⁵² Sackett, D.L., Straus, S.E., Richardson, W.S., Rosenberg, W., & Haynes, R.B. (2000). *Evidence-based medicine: How to practice and teach EBM*. New York: Churchill Livingstone.

⁵³ Bogue, B., Campbell, N., Carey, M., Clawson, E., Florio, K., Joplin, L. Keiser, G., Wasson, B., & Woodard, W. (2004). *Implementing evidence-based practice in community corrections: The Principles of Effective Intervention*. Aurora, Colorado: National Institute of Corrections. Available at: <http://www.nicic.org/Library/019342>.

⁵⁴ Aos, S., Miller, M., & Drake, E. (2006). *Evidence-Based Adult Corrections Programs: What Works and What Does Not*. Washington State Institute for Public Policy, Olympia, WA.

⁵⁵ Martin, S., & Colt, S. (2009). *The Cost of Crime: Could The State Reduce Future Crime and Save Money by Expanding Education and Treatment Programs?* Research Summary No. 71, Institute of Social and Economic Research, University of Alaska, Anchorage.

Researchers have also noted the need for appropriate and supportive structured living.⁵⁶ Under the behavioral contracting model, the individual is informed of the requirements of the treatment plan and consequences for violating them. The requirements may include medication compliance, keeping therapy and case management appointments, refraining from using drugs and alcohol, submitting to blood and urine screening, living in specified residences, seeking and maintaining employment, and not contacting victims. Under this highly structured and monitored practice, any deviations from the treatment plan are reported to the court and the offender risks consequences such as incarceration. This approach is widely used by the Alaska Mental Health Courts and ADOC's IDP⁺ program. Even so, some interview respondents recommended wider use of this approach in Alaska.

Detailed below is a series of national evidence-based practices that are the most effective with mentally ill and substance abusing offenders in the criminal justice system. Some of these initiatives are currently used by ADOC. The programs listed are offered to reinforce the ongoing work by providers in Alaska and as potential enhancements to what is currently being offered:

- Specialty Caseloads in Probation,
- Supported Employment and Supportive Housing,
- Assertive Community Treatment,
- Illness Management Recovery,
- Trauma Specific Interventions,
- Cognitive Behavioral Therapy,
- Motivational Interviewing,
- Forensic Peer Support, and
- Modified Therapeutic Community.

Specialty Caseloads in Probation

Specialty Caseloads provide officers with the resources to gain better access to mental health services, respond to minor violations with intermediate sanctions, and promote re-entry into the community. Specialty Caseloads provide an alternative to the typical probation or parole regimen by allowing officers to spend more time managing fewer cases to ensure the needs of their clients are met. Several conditions are required for Specialty Caseloads to be effective. First, officers must supervise only one type of probationer. When regular probationers or other types are mixed into the caseload, resources are diluted.⁵⁷

⁵⁶ Wack, R. C. (1993). Treatment services at Kirby forensic psychiatric center. *International Journal of Law & Psychiatry* 16: 83-104.

⁵⁷ Skeem, J.L. & Louden, J.E. (2006). Toward Evidence-Based Practice for Probationers and Parolees Mandated to Mental Health Treatment. *Psychiatric Services* 57:3, 337.

Second, officers with Specialty Caseloads need to have a reduced number of clients. The rule of thumb is Specialty Caseloads should be on average one-third the size of a standard caseload (i.e. somewhere between 25 and 45). Smaller caseloads allow officers the necessary time to assess and address the risks and needs of their clients.⁵⁸ Third, officer training is essential, ideally 20 to 40 hours of mental health training annually to ensure they are knowledgeable of relevant issues. Coordination and integration with both internal and external resources is essential to ensure clients are getting the resources they need and for which they are eligible. Finally, the use of problem-solving strategies is important. If, for example, a probationer does not want to take a prescribed medication, the Specialty Caseload officer needs to talk respectfully with the probationer and come to an acceptable understanding and perhaps reach a middle ground. The officer will not threaten clients with incarceration or remind them of the rules unless it is absolutely necessary.

IDP⁺ is a Specialty Caseload program that employs many of the attributes listed as best practice in probation supervision. Moving forward, ADOC should evaluate its IDP⁺ program against the standards listed above. It was reported that case load sizes may exceed ideal standards for specialty probation. In addition, officers should receive ongoing training to work with Trust Beneficiaries, in light of the new research emerging on what works with this population to reduce recidivism.

In Connecticut, a dramatic increase in the prison population and concern over the number of probation technical violators being sentenced to prison led to the piloting of a specialized probation program targeting high risk offenders. An evaluation of the Probation Transition Program's (PTP) effect on probation technical violations and new arrests found significant decreases in technical violations in the participation group.⁵⁹

Supported Employment and Supportive Housing

The concept of Supported Employment assumes that all people are capable of doing meaningful, productive work, regardless of disability severity.⁶⁰ It can be defined as "competitive work in integrated settings, for individuals for whom competitive employment has not traditionally occurred...services available; but not limited to provision of skilled job trainers, on-the-job training, systematic training, job development, follow-up services..."⁶¹

⁵⁸ Skeem, J.L. & Loudon, J.E. (2006). Toward Evidence-Based Practice for Probationers and Parolees Mandated to Mental Health Treatment. *Psychiatric Services* 57:3, 337.

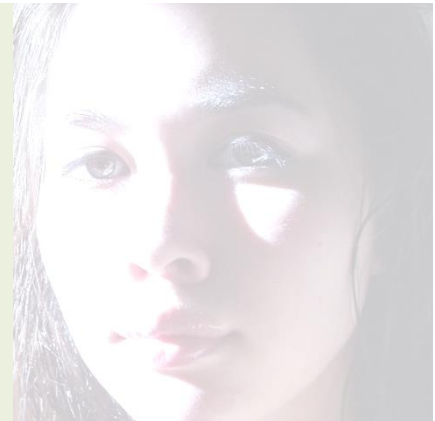
⁵⁹ Cox, S. M., Bantley, K., Roscoe, T., & Hill, B. (2008). The Effects of Connecticut's Probation Transition Program on Reducing Technical Violations. *Justice Research and Policy*, 10(1), 1-20.

⁶⁰ Anthony, W. A., & Blanch, A. (1987). Supported employment for persons who are psychiatrically disabled: An historical and conceptual perspective. *Psychosocial Rehabilitation Journal* 11:2, 5-23.

⁶¹ Jordán de Urries, FdB. (2013). Supported Employment. In: JH Stone, M Blouin, editors. *International Encyclopedia of Rehabilitation*.

Mental health treatment alone will not play a role in successful employment outcomes; therefore Supported Employment can play an important role in helping people find jobs, even if the positions are part-time and flexible. Employment is a stabilizing factor for justice involved people, and Supported Employment can play an essential role in helping individuals gain and maintain a healthy and productive lifestyle.⁶²

Employment and housing are stabilizing factors for justice-involved people.



Building from that premise, Supported Employment programs provide supports for as long as needed after the person has obtained a competitive job, and allow individuals to more quickly find job placements without the extensive job preparation common in sheltered workshops. As an example, the Howie the Harp Advocacy Center in New York City is a peer-run agency that provides employment resources to people with histories of psychiatric disabilities.⁶³ The peer training program is designed for people with a history of psychiatric diagnoses who are seeking employment in the Human Services field to use their personal experience to help others seek recovery services within the mental health system. Participants come from diverse backgrounds including histories of incarceration, substance abuse, and/or homelessness. Programs focus on job skills training, life development skills, and workforce preparation and includes over 500 hours of classroom instruction in a wide variety of areas including resume writing and interview skills, computer literacy, cultural competence, and peer advocacy and activism, to name just a few.⁶⁴ The program is free and open to any individual receiving mental health services in New York City. Graduates have gone on to jobs in hospitals, prisons, and other human services agencies as well as non-human service agencies, and many graduates pursue higher education opportunities. Graduates have lifetime access to job placement assistance and services.⁶⁵

Housing is another stabilizing factor. Studies have found that people with mental illness who experience housing instability are more likely to have contact with police and/or be charged

⁶² Anthony and Blanch, *op cit*.

⁶³ Howie the Harp Advocacy Center website. (2013). Available at <http://www.communityaccess.org/what-we-do/hth-peer-advocacy-ctr9>.

⁶⁴ Anthony, W. A., & Blanch, A. (1987). Supported employment for persons who are psychiatrically disabled: An historical and conceptual perspective. *Psychosocial Rehabilitation Journal* 11:2, 5-23.

⁶⁵ Anthony and Blanch, *op cit*.

with a criminal offense than those who have stable housing.⁶⁶ As evidenced by this study's interviews with stakeholders, housing is a large concern for offending Trust Beneficiaries in Alaska. They cite that insufficient access to affordable, safe, sober, and supported housing contributes to an over-representation of people who are homeless and have mental illnesses in correctional facilities. To be successful, a continuum of options must be available from fully self-sufficient housing to full dependent care.⁶⁷ Supportive housing is a permanent housing option that is coupled with support services. There are two approaches to supportive housing for people with mental illness who have had contact with the criminal justice system: 1) Housing First and 2) Housing Ready.

Housing First offers direct placement to housing with robust support services available. This model typically targets individuals with longstanding addictions to alcohol and sometimes other substances who have had multiple unsuccessful alcohol treatment episodes and often complex medical needs. Housing First provides for immediate placement into a stabilized home environment while longer term engagement and customized therapeutic interventions can be explored. Case management, housekeeping assistance, nursing care, personal care assistance and daily monitoring are conducted in the housing program. Treatment plans are very individualized and can be modified by the tenant as long as the basic rules of the housing program are followed. Basic principles of most housing programs include: 1) on-time payment of rent; 2) no violence toward self or others; 3) no damage to the property; and 4) be a good neighbor in the building. A service provider in this model is obligated to provide robust social services on site and to be creative and flexible with the approach to tenants.⁶⁸

One example is Karluk Manor, a 46-unit housing residence located in downtown Anchorage. At Karluk Manor, tenants with longstanding alcohol addictions are provided permanent housing with supportive services on site through both the housing provider and the local behavioral health provider. In 2012, the Trust, along with Alaska Housing Finance Corporation and the Department of Health and Social Services promoted a partnership between Tanana Chiefs Conference, a tribal consortium of 42 Alaska villages, and a private business owner in Fairbanks to develop 47 residential units for chronically homeless individuals with addictions or other conditions, along with supportive employment opportunities.

Recent evaluations suggest positive outcomes for clients in Housing First facilities. A Housing First program in California showed that people with criminal justice involvement who also had mental illness were likely to experience housing stability regardless of the seriousness of their mental health, history of arrest, or incarceration history, as long as they received adequate support.⁶⁹ Similarly, in Seattle, WA, a study examining housing outcomes for 347 homeless

⁶⁶ Roman, C.G. (2009). *Moving Toward Evidence-Based Housing Programs for Persons with Mental Illness in Contact with the Justice System*. The CMHS National Gains Center.

⁶⁷ *Ibid.*

⁶⁸ *Ibid.*

⁶⁹ *Ibid.*

adults with disabilities and behavioral health disorders in a supportive housing program found that criminal history did not predict housing success or failure.⁷⁰

Another study was done to evaluate the cost savings of providing supportive housing to chronically homeless individuals who had severe alcohol addictions at 1811 Eastlake, a Housing First facility in Seattle, after which the Karluk Manor was modeled.⁷¹ The study demonstrated significant cost savings and reductions in alcohol use for housed individuals over the course of the first year. Cost offsets for Housing First participants at six months, in comparison with wait-list controls, averaged \$2,449 per person per month. At 12 months, the total costs of supporting 95 housed individuals were reduced by 50 percent (more than \$4 million) compared with the year prior to enrollment. Total per person per year costs were \$42,964 per person per year, compared with a cost of \$13,440 per person per year to administer the housing program.

The study also demonstrated that individuals in the housed group experienced reductions in their alcohol use and likelihood of drinking to intoxication over time. The intervention was associated with substantial declines in drinking despite no requirement to abstain from or reduce drinking to remain housed. This study showed decreases in the use of expensive crisis-oriented systems like hospitals and jails.

Housing Ready, on the other hand, starts with treatment and progresses through a series of progressively less intensive service options with the goal of permanent supportive housing once people become ready for it.

Re-entry programs typically use the Housing Ready approach. Six of the seven programs reviewed by Roman, were designed with a treatment focus.⁷² Re-entry populations typically were given little service or housing choice at the beginning of the program.⁷³ There was typically 24-hour supervision and surveillance and onsite service teams present during the day for mandated sessions and activities.⁷⁴ Surveillance and supervision decreased as the clients went through the program, and at least three of the seven programs reviewed offered permanent housing.⁷⁵

Beginning in 2006, The Cook County Jail in Illinois started the Returning Home Initiative in collaboration with the Corporation for Supportive Housing (www.csh.org). The pilot program links people with long histories of homelessness, mental illness and incarceration to supportive

⁷⁰ Malone, D.K. (2009). Assessing Criminal History as a Predictor of Future Housing Success for Homeless Adults with Behavioral Health Disorders. *Psychiatric Services*, 60:224-230.

⁷¹ Larimer M.E., Malone D.K., Garner, M.D., et al. (2009). Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons With Severe Alcohol Problems. *JAMA* 301(13):1349-1357. doi:10.1001/jama.2009.414

⁷² Roman, C.G. (2009). *Moving Toward Evidence-Based Housing Programs for Persons with Mental Illness in Contact with the Justice System*. The CMHS National Gains Center.

⁷³ *Ibid.*

⁷⁴ *Ibid.*

⁷⁵ *Ibid.*

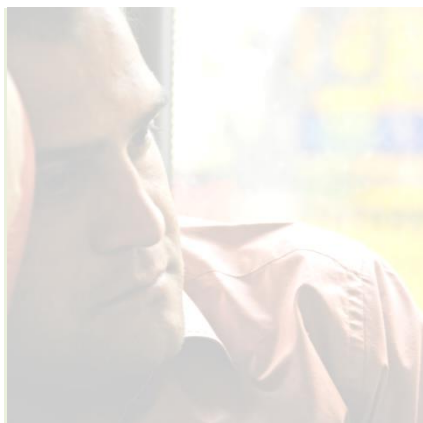
housing. People who have a history of repeated homelessness after they are released from jail, have been engaged in the jail's mental health services or state mental health system at least four times, and have a diagnosed serious mental illness such as Schizophrenia or bipolar disorder are provided with permanent affordable housing and comprehensive mental health and long-term support services.⁷⁶

Assertive Community Treatment

Assertive Community Treatment (ACT) is a delivery model where treatment is provided by a team with service providers determined to fit a client's needs for as long as services are needed.⁷⁷ ACT was recommended in the 2007 report, but has not yet been implemented in Alaska.

Many of the stakeholders interviewed as part of the current study believe that ACT is needed. ACT services may include treatment, rehabilitation and support services such as mental health counseling, substance abuse treatment and vocational rehabilitation among other services, provided by a self-contained clinical team made up of providers from mixed disciplines. Working as a team, ACT providers function on a 24/7 basis to provide services that will help the client gain the skills needed for success in real-life settings.

ACT is intended for clients who have severe mental illness and are at high risk of inpatient hospitalization. Forensic Assertive Community Treatment (FACT) is the subset of ACT focused on keeping people with severe mental illness out of jail and prison.



ACT is intended for clients who have severe mental illness and are at high risk of inpatient hospitalization. Working as a team, ACT providers function on a 24/7 basis to provide services that will help the client gain the skills needed for success in real-life settings.

⁷⁶ Roman, C.G. (2009). *Moving Toward Evidence-Based Housing Programs for Persons with Mental Illness in Contact with the Justice System*. The CMHS National Gains Center.

⁷⁷ Phillips, S.D., et al. (2001). Moving Assertive Community Treatment into Standard Practice. *Psychiatric Services* 52:6, 771-779.

While there is little standardization in FACT at this time, there are four core elements which set it apart from standard ACT:

1. The goal of preventing arrest and incarceration;
2. Requirements that all clients admitted have a criminal justice history;
3. Accepting the majority of referrals from criminal justice agencies; and
4. The development and incorporation of a supervised residential treatment component for high risk consumers, particularly those with co-occurring disorders.⁷⁸

Two studies of FACT programs, one of Project Link in Rochester, NY and another of the Thresholds State County Collaborative Jail Link of Linkage Project (CJLP) in Chicago, IL, have shown a reduction in jail days, arrests, days spent in hospitals, and hospitalizations.⁷⁹ The one-year study of Project Link also showed a reduced yearly service cost per client.⁸⁰ The pre-post studies of CJLP showed reduced jail and hospital costs.⁸¹ Project Link was developed by the Department of Psychiatry at the University of Rochester which continues to oversee the project.⁸² A 1993 study by the Monroe County Office of Mental Health identified a group of individuals with mental illness who were repeatedly having stays in the local jail and inpatient hospitals over the course of a three-year period and Project Link was created as a way to respond to this finding.⁸³ Consumers are referred through state and local jails and prisons, police, public defenders offices, hospitals, emergency rooms and other avenues and are supervised by case advocates.

CJLP uses counselors to visit members in jail, accompany them to court, and occasionally secure early release into their custody.⁸⁴ Once clients are out of jail and participating in CJLP, they are expected to take prescribed medication and work with mental health treatment professionals. CJLP finds the client an apartment, and staff members visit clients regularly in their homes to provide case management and monitor medication compliance.⁸⁵ CJLP staff do not have individual caseloads; a multidisciplinary team is used to share responsibility for all participants which allows for flexibility in meeting the day-to-day needs of participants and enhances

⁷⁸ Morrissey, J & Meyer, P. (2008). *Extending Assertive Community Treatment to Criminal Justice Settings*. CMHS National Gains Center.

⁷⁹ *Ibid.*

⁸⁰ Weisman, R.L., Lamberti, J.S., & Price, N. (2004). Integrating Criminal Justice, Community Healthcare, and Support Services for Adults with Severe Mental Disorders. *Psychiatric Quarterly*, 75(1):71-85.

⁸¹ McCoy, M.L., Roberts, D.L., Hanrahan, P., Clay, R., & Luchins, D.J. (2004). Jail Linkage Assertive Community Treatment Services for Individuals with Mental Illnesses. *Psychiatric Rehabilitation Journal*, 27(3), 243-259.

⁸² Project Link. Accessed at http://consensusproject.org/program_examples/project_link.

⁸³ *Ibid.*

⁸⁴ Linkage, C. C. J. (2001). Helping mentally ill people break the cycle of jail and homelessness. *Psychiatric Services*, 52(10), 1380.

⁸⁵ *Ibid.*

continuity of care (i.e. someone is always available in the event of an emergency).⁸⁶ Service and treatment plans are individualized and special attention is paid to help identify reasons for past treatment failures.

While the FACT model has shown to reduce jail and hospital costs, the model itself is a high-intensity, high-cost intervention, and therefore its use should be limited to only those who are the highest risk.⁸⁷

Following a legislative mandate in California, the Mentally Ill Offender Crime Reduction Grant (MIOCRG–II) allowed for proliferation of local FACT programs. Outcomes from one such program revealed the FACT group had significantly more outpatient visits and fewer days hospitalized at both 0–12 and 13–24 months follow-up than a “treatment as usual” comparison group. The FACT group also experienced significantly fewer jail bookings during the first 12 months.⁸⁸

As noted previously, the 2007 report recommended ADOC consider expanding its partnership with community agencies by implementing additional evidence-based services such as FACT to target the population most at risk. The report noted that if ADOC improved efforts to ensure that Medicaid eligibility is sustained upon release and if the high risk Trust Beneficiary population had access to evidence-based services such as Forensic Assertive Community Treatment Teams or Forensic Intensive Case Managers, the State would ultimately realize net institutional savings while at the same time improving public safety and generating better quality-of-life outcomes for that population.

Illness Management Recovery

Illness Management and Recovery (IMR) is a set of specific evidence-based practices that teaches people with severe mental illness how to manage their disorder in collaboration with professionals and significant others in order to achieve personal recovery goals.⁸⁹ Clients learn about the nature and treatment of mental illness, how to prevent relapses and re-hospitalizations, and how to effectively cope with symptoms in order to gain greater control over their treatment and their lives.⁹⁰

⁸⁶ Linkage, C. C. J. (2001). Helping mentally ill people break the cycle of jail and homelessness. *Psychiatric Services*, 52(10), 1380.

⁸⁷ Morrissey, J. & Meyer, P. (2008). *Extending Assertive Community Treatment to Criminal Justice Settings*. CMHS National Gains Center.

⁸⁸ Cusack, K., Morrissey, J., Cuddeback, G., Prins, A., & Williams, D. (2010). Criminal justice involvement, behavioral health service use, and costs of forensic assertive community treatment: A randomized trial. *Community Mental Health Journal*, 46 (4), 356-363.

⁸⁹ Mueser, K. & MacKain, S. (2008). *Illness Management and Recovery in Criminal Justice*. CMHS National Gains Center.

⁹⁰ *Ibid.*

Multiple controlled studies have identified five evidence-based practices that are included in IMR:

1. Teaching information about mental illness and its treatment using structured approaches which improve clients understanding of their disorders and their capacity for informed treatment decision-making.
2. Behavioral tailoring to help clients fit taking medication into daily routines by building in natural reminders such as putting their toothbrush next to their medication, thereby improving medication adherence and leading to reduced relapses and re-hospitalizations.
3. Relapse prevention training that teaches clients how to recognize situations that may lead to relapses and early warning signs of a relapse as well as developing a plan for responding to those signs before the situation becomes a crisis.
4. Coping skills training that strengthens clients' abilities to deal with persistent symptoms by helping them identify and practice coping strategies.
5. Social skills training to help clients strengthen their social supports and bonds with others by practicing interpersonal skills through role playing and real life situations.⁹¹

Four published studies of programs in Washington, North Carolina, and California have shown IMR to work successfully with criminal justice-involved individuals.⁹²

In 2005, IMR was adapted for use with the Bronx Mental Health Court. The Court used a deferred sentence model for diverting individuals who had serious mental illness and had committed either misdemeanors or felonies to community based treatment. Experts in IMR assisted in modifying the program to fit with the court-ordered treatment plans for the mental health court participants, and additional modules were developed to focus on the effects of prison and jail cultures on thinking and behavior.⁹³ These additional modules addressed processing jail and prison experiences, counterproductive adaptations to incarceration, thinking styles, and difficulty with negative emotions.⁹⁴

Because time in jail is typically brief, jail is the most appropriate place to conduct mental health screenings, educate people about basic facts regarding mental health and mental health treatment, and encourage motivation for learning mental illness self-management skills.⁹⁵ Subsequent work can be accomplished in either outpatient or prison settings. IMR programs

⁹¹ Mueser, K. & MacKain, S. (2008). *Illness Management and Recovery in Criminal Justice*. CMHS National Gains Center.

⁹² *Ibid.*

⁹³ *Ibid.*

⁹⁴ Rotter, M. & Boyce, K.O. (2007). *Bronx Mental Health Court/Illness Management and Recovery*. CMHS National Gains Center Expert Panel on Adapting Evidence-Based Practices to Criminal Justice Settings, Bethesda, MD.

⁹⁵ Mueser, K. & MacKain, S. (2008), *op. cit.*

could also be implemented in prison settings because people are typically facing longer sentences and there is a built-in group of consumers who can facilitate the engagement of inmates in group or individual work to improve illness self-management skills.⁹⁶

Once clients are released, work can continue in a community corrections and/or community mental health setting. Topic areas emphasizing skills such as building social support, using medication effectively, coping with stress, and getting one's mental health needs met are most relevant at this point.⁹⁷ Peers are important to help clients with criminal justice involvement develop the motivation and IMR-related skills to avoid incarceration, or for those who have been released from jail or prison and are now adjusting to life outside of institutions.

Four published studies of programs in Washington, North Carolina, and California have shown Illness Management and Recovery (IMR) to work successfully with criminal justice-involved individuals.



Trauma-Specific Interventions

A number of trauma-specific interventions include an integration of trauma awareness into service delivery across all levels of treatment and support. Treatment options should be both trauma-informed and trauma-specific. "Trauma-informed" refers to an acknowledgement that people with trauma histories may have particular needs and the treatment or service will work to promote empowerment as well as an acknowledgement of the impact of trauma on people's lives. "Trauma-specific" services are "interventions designed to address the specific behavioral, intra-psychic, and interpersonal consequences of exposure to sexual, physical, and prolonged emotional abuse."⁹⁸ Four trauma-specific interventions that have empirical evidence on their effectiveness are described in greater detail below.

Seeking Safety

Seeking Safety is a present-focused intervention that uses five key principles to aid in the recovery of people with histories of trauma, primary post-traumatic stress disorder, and substance abuse. The five key principles are:

⁹⁶ Mueser, K. & MacKain, S. (2008). *Illness Management and Recovery in Criminal Justice*. CMHS National Gains Center.

⁹⁷ *Ibid.*

⁹⁸ Substance Abuse and Mental Health Services Administration. *Cooperative Agreement to Study Women with Alcohol, Drug Abuse, and Mental Health (ADM) Disorders Who Have Histories of Violence*. No.T100-003.

1. safety;
2. integrated treatment;
3. a focus on ideals (i.e. restore clients' feeling of potential for a better future);
4. four content areas: cognitive, behavioral, interpersonal, and case management; and
5. attention to clinician processes.

Seeking Safety consists of 25 modules which can be presented in any order, with topics ranging from learning grounding techniques to self-care and coping with triggers.⁹⁹

One study of *Seeking Safety* found PTSD symptoms decreased from pre- to post-treatment for the 17 incarcerated women involved in the study.¹⁰⁰ Similar results were found in a randomized controlled study of incarcerated women with substance abuse disorders and posttraumatic stress disorder when examining women who received *Seeking Safety* and treatment as usual, compared to women who received only treatment as usual.¹⁰¹

Trauma Affect Regulation: Guide for Education and Therapy (TARGET)

TARGET is a trauma-specific intervention that uses a seven-step psycho-educational skills approach: focus, recognize triggers, emotion self-check, evaluate thoughts, define goals, options, and make a contribution (FREEDOM). TARGET has been adapted for use with people who are justice-involved.¹⁰²

Trauma Recovery and Empowerment Model (TREM)

TREM is a female-specific group intervention designed to address sexual, physical and emotional abuse. TREM uses cognitive restructuring, psycho-educational, and skills training techniques over the course of 29 group sessions. The model addresses coping skills, social support, mental health, and substance abuse.¹⁰³ A 24-session adaptation for men has been developed (M-TREM) as well as an adaptation for veterans (V-TREM). TREM and its subsequent adaptations have been used in a variety of settings including corrections and jail diversion settings.¹⁰⁴

⁹⁹ Najavits, L.M., Schmitz, M., Gotthardt, S., & Weiss, R.D. (1998). Seeking Safety Plus Exposure Therapy: An Outcomes Study on Dual Diagnosis Men. *Journal of Traumatic Stress, 11*,437-456.

¹⁰⁰ Zlotnick, C., Najavits, L.M., Rohsenow, D.J., & Johnson, D.M. (2003). A Cognitive-Behavioral Treatment for Incarcerated Women with Substance Abuse Disorder and Posttraumatic Stress Disorder: Finding From a Pilot Study. *Journal of Substance Abuse Treatment, 25*, 99-105.

¹⁰¹ Zlotnick, C., Johnson, J., and Najavits, L.M. (2009). Randomized Controlled Pilot Study of Cognitive-Behavioral Therapy in a Sample of Incarcerated Women with Substance Use Disorder and PTSD. *Behavior Therapy, 40*, 325-336, 2009.

¹⁰² University of Connecticut Health Center. (2011). *Trauma Affect Regulation: Guide for Education and Therapy: Overview*.

¹⁰³ Harris, M. & Community Connections Trauma Workgroup. (1998). *Trauma Recovery and Empowerment: A Clinician's Guide for Working with Women in Groups*. New York: The Free Press.

¹⁰⁴ The SAMHSA National GAINS Center. (2011). *Trauma-Specific Interventions for Justice-Involved Individuals*.

Prolonged Exposure (PE) Therapy for Posttraumatic Stress Disorders

PE Therapy for Posttraumatic Stress Disorders is a cognitive behavioral treatment program that focuses on thoughts, and feelings related to a traumatic event. PE Therapy entails four components:

1. education about the nature of trauma and trauma reactions,
2. training in controlled breathing,
3. repeated discussion and talking over of the traumatic event, and
4. exposure practice in situations that are safe but which the individual has been avoiding as a result of the traumatic event.¹⁰⁵

Trauma-specific interventions have been implemented in correctional facilities and jail diversion programs across the United States. The Vermont Jail Diversion and Trauma Recovery–Priority to Veterans grant, titled MHISSION–VT, states as its purpose “to assist Vermont veterans and other adults at risk of becoming involved with the criminal justice system, divert them from incarceration, and guide them in obtaining needed care and treatment for trauma related disorders.” The pilot program serves veterans and other adults with trauma-related disorders, traumatic brain injury, and related behavioral health issues by diverting them from the justice system to a network of providers.

MHISSION–VT relies on a network of partners to identify potential participants to the program. Potential participants are identified at pre-booking (via law enforcement, the Vermont Veterans Outreach Team, and others), post-booking (via the courts, rapid arraignment program, the Vermont Army National Guard, and others), and violators of probation or parole (via the Vermont Department of Corrections). After screening, a MHISSION–VT veteran peer navigator is assigned a referral and performs an intake and needs assessment. After establishing each participant’s priority needs, they are linked to appropriate treatment and support services. The navigator monitors a participant’s progress in treatment and follows up as needed.

Cognitive-behavioral Therapy

Cognitive-behavioral therapy (CBT) is an intervention for dealing with distressing feelings, disturbing behavior, and the thoughts from which these behaviors and feelings spring. Symptoms such as anxiety and depression are targeted through identifying and addressing the automatic thoughts which generate those feelings. Behavior techniques such as skills training and role-playing have been established as positive ways of addressing phobias and post-traumatic reactions. These techniques also help clients develop coping mechanisms.

CBT is effective in reducing recidivism when used with moderate to high-risk individuals. Their criminogenic needs are the focus of the intervention and the intervention method is responsive to their style of learning.¹⁰⁶ While recidivism-focused CBT was not initially developed to be used

¹⁰⁵ The SAMHSA National GAINS Center. (2011). *Trauma-Specific Interventions for Justice-Involved Individuals*.

¹⁰⁶ Andrews, D.A. & Bonta, J. (1998). *The Psychology of Criminal Conduct*, 2nd Edition, Cincinnati, OH: Anderson Lipsey.

with individuals who also have mental illness, it is a structured approach focused on problem behavior and criminogenic needs and therefore is an appropriate intervention.¹⁰⁷ Using homework assignments, role-playing and multimedia presentations, recidivism-focused CBT can improve relevant areas of cognitive functioning such as critical thinking, assertiveness, interpersonal problem solving, negotiation skills, and pro-social values.¹⁰⁸

CBT interventions that have been developed for use in correctional settings include:

- Thinking for a Change;¹⁰⁹
- Moral Reconciliation Therapy;¹¹⁰
- Lifestyle Change;¹¹¹
- Reasoning and Rehabilitation;¹¹² and
- Options.¹¹³

A 2003 REPORT ON THE ANCHORAGE WELLNESS COURT'S IMPLEMENTATION OF MRT FOUND A REDUCED RE-ARREST RATE FOR PARTICIPANTS VERSUS THOSE WHO DID NOT PARTICIPATE IN MRT.

Dialectical-behavioral therapy (DBT) and schema-focused therapy (SFT) are two CBT-related programs that were developed within traditional mental health services and were later applied to forensic settings.¹¹⁴ DBT is an empirically supported treatment that has been successful at reducing self-harm behaviors and emotional instability in individuals who have been diagnosed with borderline personality disorder.

¹⁰⁷ Rosenfeld, B., Galietta, M., Ivanoff, A., Garcia-Mansilla, A., Martinez, R., Fava, J., Fineran, V., & Green, D. (2007). Dialectical Behavioral Therapy for the Treatment of Stalking Offenders. *International Journal of Forensic Mental Health, 6*, 95-103.

¹⁰⁸ *Ibid.*

¹⁰⁹ Golden, L. (2002). *Evaluation of the Efficacy of a Cognitive Behavioral Program for Offenders on Probation: Thinking for a Change*. Retrieved 3/29/2012 from <http://www.nicic.org/pubs/2002/018190.pdf>.

¹¹⁰ Little, G.L. & Robinson, K.D. (1988). Moral Reconciliation Therapy: A Systematic Step-by-Step Treatment System for Treatment Resistant Clients. *Psychological Reports, 62*, 135-151.

¹¹¹ Walters, G.D. (1999). Short-term Outcome of Inmates Participating in the Lifestyle Change Program. *Criminal Justice and Behavior, 26*, 322-337.

¹¹² Ross, R.R., Fabiano, E.A., & Ewles, C.D. (1988). Reasoning and Rehabilitation. *International Journal of Offender Therapy and Comparative Criminology, 32*, 29-35.

¹¹³ Bush, J. and Bilodeau, B. (1993). *Options: A Cognitive Change Program*. Longmont, CO: National Institute of Corrections.

¹¹⁴ Rotter, M. & Carr, A. (2010). *Targeting Criminal Recidivism in Justice-Involved People with Mental Illness: Structured Clinical Approaches*. The CMHS National GAINS Center.

When used in a forensic psychiatric setting, DBT has been associated with fewer violent incidents and a reduction in self-reported anger.^{115,116} SFT is an integrative long-term psychotherapeutic treatment that combines cognitive, behavioral, psychodynamic, and humanistic elements. It is also designed to be used with people who are diagnosed with personality disorders in an individual setting. A 2008 study found that rates of approved, supervised leave were significantly greater for people who completed the treatment, but the criminal justice outcomes of SFT have yet to be studied.¹¹⁷

Moral Reconciliation Therapy (MRT) is currently used in Alaska. A 2003 report on the Anchorage, Alaska Wellness Court's implementation of MRT found a reduced re-arrest rate for participants versus those who did not participate in MRT (26% versus 63%).¹¹⁸ The Wellness Court program was designed for misdemeanor defendants who had been charged with alcohol related offenses or who had demonstrable alcohol problems.

Corrections departments across the country, including ADOC, use cognitive behavioral treatment. The WSIPP measured the cost benefits of cognitive behavioral programs across the country (regardless of type) for offenders rated moderate to high risk of recidivism and found the benefit per client was \$9,283 per client.¹¹⁹ That figure was based on the cost savings of recidivism reduction.

Motivational Interviewing

Motivational Interviewing (MI) is a style of communicating that helps people explore and resolve ambivalence about changing specific behaviors. Extensive research shows that applications of MI can be effective in assisting various client populations with challenging problems related to alcohol, methamphetamines, cocaine, opioids, sex offending, institutional conduct, and treatment compliance.¹²⁰ From intake to transition planning, correctional staff can use MI skills at almost every stage in the process of correctional management.

¹¹⁵ Evershed, S., Tennant, A., Boomer, D., Rees, A., Barkham, M., & Watson, A. (2003). Practice-based Outcomes for Dialectical-Behavioral Therapy Targeting Anger and Violence, with Male Forensic Patients: A Pragmatic and Non-Contemporaneous Comparison. *Criminal Behavior and Mental Health, 13*, 198-213.

¹¹⁶ Berzins, L.G. & Trestman, R.L. (2004). The Development and Implementation of Dialectical Behavior Therapy in Forensic Settings. *International Journal of Forensic Mental Health, 3*, 93-103.

¹¹⁷ Bernstein, D.P. (2008). *A New Method for Rating Schema Modes in Forensic Patients*. Presented at the Annual Fall Congress of the Vereniging voor Gedrags en Cognitieve Therapie, Eindhoven, The Netherlands.

¹¹⁸ Little, G.L. (2005). Meta-Analysis of Moral Reconciliation Therapy Recidivism Results From Probation and Parole Implementations. *Cognitive-Behavioral Treatment Review, 14*, 14-16. Available at <http://www.moral-reconciliation-therapy.com/Resources/metaMRTprob.pdf>.


¹¹⁹ Lee, S., Aos, S., Drake, E., Pennucci, A., Miller, M., & Anderson, L. (2012). Return on investment: Evidence-based options to improve statewide outcomes (Document No. 12-04-1201). Olympia, WA: Washington State Institute for Public Policy.

¹²⁰ Bogue, B. M., & Nandi, A. (2012). *Motivational interviewing in corrections: A comprehensive guide to implementing MI in corrections*. US Department of Justice, National Institute of Corrections.

MI can be implemented in two fundamentally different ways. First, it can be used as a general approach for working with offenders, where specific skills associated with MI augment the staff's supervision or communication skills. MI can also be employed as a formal intervention consisting of one or several sessions to increase a person's motivation to engage in treatment.¹²¹

Successful MI techniques include reflecting, rather than reacting to, resistant statements, helping clients improve communication effectiveness by providing them with feedback about perceived resistance, and exploring clients' natural ambivalence about changing their behavior. These techniques lay the foundation from which corrections staff can build a collaborative working alliance with inmates.¹²² In line with the findings from psychology, applied criminology researchers have determined that the staff-offender relationship is paramount, and helping to build a working relationship between the two can provide a practical and valuable alternative to escalating the use of authority and control.

MI's focus on eliciting motivation to change can also help staff prioritize an inmate's criminogenic needs. Many high-risk offenders have multiple criminogenic needs, requiring them to change more than one target behavior at any time. One way to prioritize these needs is for staff to use MI's active listening skills to determine which behaviors the inmate is most motivated to change at a particular time. Staff can then prioritize behaviors and target them accordingly for further discussion about the inmate's ambivalence about making changes.



A META-ANALYSIS FOUND THAT MOTIVATIONAL INTERVIEWING (MI) CAN LEAD TO IMPROVED RETENTION IN TREATMENT, ENHANCED MOTIVATION TO CHANGE, AND REDUCED OFFENDING.

As clients feel supported by a working alliance with staff, and as they have the chance to resolve more of their ambivalence about behavior change, the MI approach helps staff identify and strengthen areas in which clients are motivated. Staff can use MI to draw out clients' statements expressing their desire, ability, reasons, need, and commitment to making particular changes.¹²³

¹²¹ Bogue, B. M., & Nandi, A. (2012). *Motivational interviewing in corrections: A comprehensive guide to implementing MI in corrections*. US Department of Justice, National Institute of Corrections.

¹²² Bambling, M., King, R., Raue, P., Schweitzer, R., & Lambert, W. (2006). Clinical supervision: Its influence on client-rated working alliance and client symptom reduction in the brief treatment of major depression. *Psychotherapy Research, 16*(03), 317-331.

¹²³ Bogue, B. M., & Nandi, A. (2012). *Op. Cit.*

As a formal intervention, MI is now internationally recognized as an evidence-based practice (EBP) intervention for alcohol and drug problems and a wide variety of other health problems (e.g., obesity, unsafe sex, and health regimes for medical recovery).¹²⁴ In a meta-analysis of 13 published studies and six dissertation abstracts, researchers found that MI can lead to improved retention in treatment, enhanced motivation to change, and reduced offending, although there were variations across studies. Part of that variation was due to the integrity of treatment in its application. Maintaining high fidelity to motivational interviewing practices therefore needs to be assured.¹²⁵

Forensic Peer Support

Forensic Peer Support involves trained peer specialists with a history of mental illness and criminal justice involvement. One of the most important functions of Forensic Peer Support Specialists is to instill hope and serve as credible models of the possibility of recovery. They also help individuals engage in treatment and other support services and anticipate and address psychological, social, and financial challenges people may face when they leave incarceration. Forensic Peer Support Specialists can serve many roles such as community guides, coaches, and advocates all the while modeling useful skills and effective problem-solving strategies. Working alongside professional staff, they share their experiences; provide information and advice, coach, support engagement in mental health and substance abuse treatments, and train professional staff on engaging consumers with criminal justice history.¹²⁶

Pennsylvania's strategic plan to reduce the number of individuals with a mental illness involved with the criminal Justice system relied on the use of forensic peer support to help guide offenders to treatment and away from the corrections system.¹²⁷

Modified Therapeutic Community

Traditionally, Therapeutic Communities (TC) have been used to treat inmates with drug and alcohol use problems, with inmates enrolled in the TC placed on specialized units and segregated from the general population.¹²⁸ Based on this model for treatment, Modified Therapeutic Community (MTC) was developed as a framework to treat offenders with mental

¹²⁴ Vasilaki, E. I., Hosier, S. G., & Cox, W. M. (2006). The efficacy of motivational interviewing as a brief intervention for excessive drinking: a meta-analytic review. *Alcohol and Alcoholism, 41*(3), 328-335.

¹²⁵ McMurrin, M. (2009). Motivational interviewing with offenders: A systematic review. *Legal and Criminological Psychology, 14*(1), 83-100.

¹²⁶ Davidson, L. & Rowe, M. (2008). *Peer Support within Criminal Justice Settings: The Role of Forensic Peer Specialists*. The CMHS National GAINS Center.

¹²⁷ Pennsylvania Department of Public Welfare and the Council of State Governments Justice Center. (2007). *Developing a statewide, strategic plan to guide Pennsylvania's response to people with mental illnesses involved with the criminal justice system*. Available at

[http://www.parecovery.org/documents/Adult Justice Strategic Plan.pdf](http://www.parecovery.org/documents/Adult_Justice_Strategic_Plan.pdf).

¹²⁸ National Institute of Corrections. (2004). *Effective prison mental health services*. U.S. Department of Corrections.

illness and co-occurring substance abuse diagnoses.¹²⁹ MTCs typically contain psycho-education, cognitive behavioral treatment, conflict resolution groups, dual recovery groups, and medication management. A meta-analysis of MTCs compared the outcomes of MTC to treatment as usual and found MTC had a significant positive impact on mental health, substance abuse, and criminal behavior.¹³⁰

Additionally, reentry MTCs (RMTC) were piloted with inmates with a mental illness and a co-occurring substance abuse disorder released from nine Colorado prisons.¹³¹ The randomized control study evaluated the effectiveness of this program versus treatment as usual (traditional supervision) and found participants in the RMTC had significantly less recidivism. Additionally, the researchers discovered the offenders who participated in the MTC while incarcerated benefited the most from the program, suggesting continuity in treatment was beneficial while transitioning.

Groups that might benefit from a RMTC are clients with Traumatic brain injuries (TBI) or Fetal Alcohol Spectrum Disorders (FASD). These populations require both intensive and structured supervision, and Anthony Wartnik, a retired judge, provides three suggestions to best serve those with FASD who are being released into their community:

1. Live in a group home or facility with a structured regiment such as when to get up, when to eat, and so forth.
2. Get a very structured job. Part-time is okay. Employment provides people with FASD something regularized that they need to do every day.
3. Create a daily schedule with the individual that will be overseen by a parent, advocate or sponsor.¹³²

¹²⁹ Sullivan, C. J., Sacks, S., McKendrick, K., Banks, S., Sacks, J. Y., & Stommel, J. (2007). Modified therapeutic community treatment for offenders with co-occurring disorders: Mental health outcomes. *Journal of Offender Rehabilitation, 45*(1-2), 227-247.

¹³⁰ Sacks, S., McKendrick, K., Sacks, J. Y., & Cleland, C. M. (2010). Modified therapeutic community for co-occurring disorders: Single investigator meta-analysis. *Substance Abuse, 31*(3), 146-161.

¹³¹ Sacks, S., Chaple, M., Sacks, J. Y., McKendrick, K., & Cleland, C. M. (2012). Randomized trial of a reentry modified therapeutic community for offenders with co-occurring disorders: Crime outcomes. *Journal of Substance Abuse Treatment, 42*(3), 247-259.

¹³² Wartnik, A.P. (2007). *Stopping the Revolving Door of the Justice Systems-Ten Principles for Sentencing Other Disposition of People with a FASD*. Retrieved from <http://fasdconnections.ca/id84.htm>.

Other research has provided the following recommendations for working with people with FASD to ensure they receive a continuity of care:

- “Working out an agreement for money management
- Securing safe, affordable housing or a subsidized residential placement
- Providing in-home support to help the individual live as independently as possible
- Teaching and modeling parenting skills if the individual has children
- Referring the individual for specialized vocational training and/or job placements
- Ensuring medical care
- Arranging for a case manager to help individuals with FASD and their families access necessary services
- Organizing drug and alcohol treatment for the individual, if needed
- Serving as an advocate to ensure recommendations are implemented
- Acknowledging the individual’s limitations, strengths and skills
- Accepting the FASD-impacted individual’s ‘world’”¹³³

Within correction facilities, many researchers recommend the use of integrated treatment models to meet both the mental health and substance abuse needs in a consistent and comprehensive manner. MTCs are an example of a treatment model that can provide integrated treatment, in addition to aligning with recommendations that mentally ill offenders be housed in therapeutic environments while incarcerated.




FETAL ALCOHOL SPECTRUM DISORDERS (FASD) ARE A GROUP OF CONDITIONS THAT CAN OCCUR IN A PERSON WHOSE MOTHER DRANK ALCOHOL DURING PREGNANCY. THESE EFFECTS CAN INCLUDE PHYSICAL PROBLEMS AND PROBLEMS WITH BEHAVIOR AND LEARNING.

SAMHSA

A modified Therapeutic Community program is provided in Hiland Mountain Correctional Center, the women’s facility. It serves 32 women at any one time, with each of them having approximately six months in treatment.

¹³³ Schacht, R.M. & LaDue, R.A. (2007). *Fetal Alcohol Syndrome and Associated Disabilities: A Training Manual to Aid in Vocational Rehabilitation and Other Non-medical Services*. Flagstaff, AZ: American Indian Rehabilitation Research and Training Center. Cited on <http://fasdjustice.ca/community-support/corrections/community-support.html>.

A photograph of the Aurora Borealis (Northern Lights) over a snowy landscape. The sky is dark with vibrant green and purple aurora curtains. The ground is covered in snow, with several evergreen trees in the foreground. The text "Part V: VISION FOR THE FUTURE" is centered in white.

Part V:
VISION FOR THE FUTURE

Summary

This study provides an analysis of the Trust Beneficiary population in the Alaska Department of Corrections system between July 1, 2008 and June 30, 2012. The study found that recidivism rates remained higher for Trust Beneficiaries, but the rates were declining by the end of the study period. These trends reflect both policy and practice changes by the ADOC together with new and expanded resources. The good news is tempered by the growing number of inmates in the corrections system itself, making it difficult for the initiatives to keep pace with the demand. Since 2000, the number of sentenced inmates in Alaska has increased each year an average of two (2.4) percent per year, higher than the national average. Alaska's odds of a seriously mentally ill person being in prison compared to being in a hospital are 3.6 to 1, slightly higher than the national average (3.2 to 1).¹³⁴

Adding to the difficulties, people with mental illness pose challenges to mental health and social services providers in the community. Many are known to have refused referrals, skipped appointments, failed to adhere to their medication regimen, and refused appropriate housing.¹³⁵ Compounding these issues, traditional services may be inappropriate for this population. While patients are expected to participate in outpatient clinic services, this group may need outreach services where professionals come to them. Interview respondents in Alaska point out that due to formulary differences or lack of communication among providers, it is not uncommon for inmates who cycle in and out of either community or correctional facilities to have their medications changed.

Adding to the challenges, professionals who work in treatment facilities do not have the authority and leverage of the criminal justice system. Their interventions may not have adequate structure for the population.

In view of the literature on evidence-based practices in corrections, in order to achieve significant reductions in recidivism rates, offenders at high risk for reoffending should be placed into sufficiently intensive interventions that target their specific criminogenic needs.¹³⁶ These criminogenic needs are dynamic risk factors that, when addressed or changed, can positively affect the offender's risk for recidivism.¹³⁷ Based on an assessment of the offender, these criminogenic needs can be prioritized to focus services on the most serious.

¹³⁴ Torrey, E. F., Kennard, A. D., Eslinger, D., Lamb, R., & Pavle, J. (2010). *More mentally ill persons are in jails and prisons than hospitals: A survey of the states*. Arlington, VA: Treatment Advocacy Center. Retrieved from <http://tacreports.org/storage/documents/2010-jail-study.pdf>.

¹³⁵ Feder, L. (1991). A Comparison of the Community Adjustment of Mentally Ill Offenders with those from the General Prison Population: an 18-month Follow-up. *Law and Human Behavior*, 15:477-493.

¹³⁶ Gendreau, P., Little, T., & Goggin, C. (1996). A meta-analysis of the predictors of adult offender recidivism: What works! *Criminology*, 34, 575-607.

¹³⁷ Examples of criminogenic needs are: criminal personality; antisocial attitudes; criminal peers; substance abuse; and family.

Recent directions in managing offenders with a co-occurring disorder (having one or more disorders relating to the use of alcohol and/or other drugs of abuse as well as one or more mental health disorders) in the corrections system have focused on tools and practice models in which criminogenic risk and need are used to guide criminal justice professionals in prioritizing and matching treatment services for individuals most likely to commit future crimes. People who have high criminogenic risks, high levels of substance abuse and serious mental health issues will have different needs than people who have low risks in these areas or some combination. By using assessment tools and strategies, correctional officers and service providers can ensure their clients are being matched up with the appropriate programs or services.

Additionally, when there is a lack of services or resources, long wait times, or other issues creating barriers to accessing services, risk or needs assessments can be helpful in determining priority for who will benefit from various services the most.

An Approach to Managing Offenders with Substance Abuse, Mental Health or Co-occurring Disorders

To address the overlapping objectives of the corrections and behavioral health fields, a framework for integrated supervision and treatment is required. The National Institute of Corrections has developed a framework based on the three dimensions of: 1) criminogenic risk, 2) need for substance abuse treatment, and 3) need for mental health treatment. The framework builds on the work previously done by the behavioral health field to parse out responsibility for how the mental health and substance abuse systems can collaboratively address the complex treatment needs of diverse groups of individuals with co-occurring disorders. Adding the third dimension of criminogenic risk is meant to help promote individual recovery while improving public safety outcomes. Such a framework can be sub-divided into five stages and can serve as a model for Alaska, noting that some of what is described in each of these stages already exists:

1. Early Intervention/Diversion
2. Booking and Screening Practices
3. In-Facility Practices
4. Release Planning
5. Community Aftercare

Early Intervention/Diversion

Pre-booking diversion programs have become increasingly more common and generally have had the goal of reducing the proportion of offenders with mental illness in jails and prisons. Among the most common types of early diversion are Crisis Intervention Teams (CIT). CIT started in Memphis, Tennessee in 1988 and was launched in Anchorage in 2001. CITs typically consist of teams of police officers, or interdisciplinary teams, who receive specialized training in recognizing mental illness and availability of community resources. Most CITs have the goal of resolving the situations without the use of hospitalization or arrest. From interviews with key informants, CIT trainings have expanded from police officers to all first responders, including firemen, Emergency Medical Technicians, probation officers, and families.

The large number of Trust Beneficiaries being arrested in the four-year study period suggests the need for expansion of the CIT model in Anchorage and to other parts of the state. Key informants suggest CIT training for family members would be useful to help de-escalate conflicts without getting the police involved.

Researchers have also noted that an effective pre-booking diversion effort needs to have a “no-refusal” policy, regarding psychiatric facilities.¹³⁸ One idea offered by key informants was to have two inpatient beds on hold for diversion in each community. Other states (such as Maine) have created statewide crisis intervention capacity for people with mental illness, since the closing of most large psychiatric hospitals has reduced significantly the number of available beds. Such a diversion strategy may reduce the number Beneficiaries entering ADOC facilities with low-level (misdemeanors) infractions.

Booking and Screening Practices

Research suggests that offenders with either a mental illness or substance abuse disorder should be systematically assessed not only for psychiatric problems, but also for criminogenic risk. As a matter of public safety, criminogenic risk, or the likelihood of reoffending, must be a primary concern in assigning offenders and setting a course of action. A risk assessment tool that is well-validated for this purpose is the Level of Service Inventory–Revised/Case Management Inventory (LSI–R and LS/CMI), which assess eight risk factors to predict recidivism, whether one is mentally ill or not. ADOC uses the LSI–R for offenders on probation and is moving toward LSI–Rs for all offenders with a sentence of six months or more.

One drawback of the LSI–R and another risk assessment tool, the Correctional Offender Management Profiling for Alternative Sanctions (COMPAS), is that both require a personal interview that takes between 45 minutes to two hours. ADOC, which oversees both jails and prisons, would not have the resources to conduct such a lengthy assessment of all intakes.

¹³⁸ Teplin, L. A. (2000). Keeping the peace: Police discretion and mentally ill persons. [Department of Justice, Washington D. C. National Institute of Justice]. *National Institute of Justice Journal* (244), 8-15.

However, using the data from the predictive model analysis conducted for this study, ADOC could start to build a simple risk assessment tool to identify potential populations for diversion or intensive services. Such a screening tool could help target discharge planning services toward incarcerated individuals most likely to re-offend (and thus most in need of these services) to help them prepare for release to the community. It could also identify candidates who don't need intensive supervision and services and are best suited for diversion from the criminal justice system.

The New York City Department of Corrections (NY-DOC), the agency responsible for operating the city's jail system In New York City, sought a way to target social services and treatment toward those who most needed support to address problems that contributed to their involvement with the justice system. Researchers from the Vera Institute of Justice used information that the NY-DOC maintained in its administrative data systems to develop a tool to assess people's risk of recidivism, called the Service Priority Indicator (SPI). The SPI draws information on charge, age, and prior jail admissions to assign everyone entering the jail to one of five service priority levels. The NY-DOC is currently using the SPI to inform its decisions about who gets reentry services, as it implements its discharge planning process.¹³⁹

Using the findings from the logistic regression, a value of 1 could be assigned to each variable that predicted readmission (Alaska Native, male, under the age of 30, had a prior felony conviction, had more than three prior convictions, had involvement in the juvenile justice system, was in the child welfare system and was a Trust Beneficiary). A person's final risk reflects the sum of all eight factors. The scores, which range from 0 to 8, could be grouped into four service priority levels, as illustrated in Table 21 below.

Table 21: Risk Group Based on Predictive Factors for Recidivism

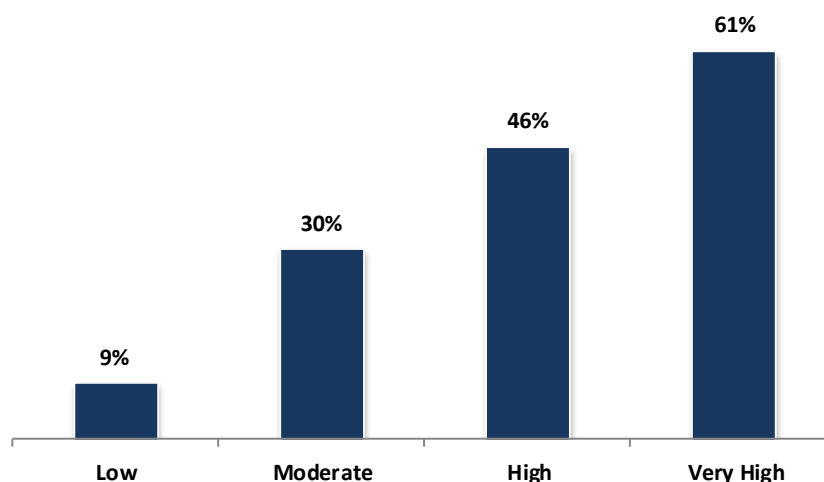
Risk Group	Number of Predictive Factors
Low	0-1
Moderate	2-4
High	5-6
Very high	7-8

Figure 21 shows the correlation between the risk groupings and the rate of re-incarceration for a new crime or probation violation. The risk group successfully distinguished those with a low risk of ADOC readmission from those with high or very high risk of future ADOC involvement. For example, nine percent of the 11,955 people in the low service priority group (a risk score of

¹³⁹ Wei, Q., & Parsons, J. (2012). *Using administrative data to prioritize jail reentry services*. Available at http://www.vera.org/sites/default/files/resources/downloads/CTPP-research_brief.pdf.

zero) were readmitted to ADOC custody within a year of release compared to 61 percent of those with a very high risk score (a score of 7-8).

Figure 21: Recidivism Rate by Risk Group



Utilizing this risk typology for 34,444¹⁴⁰ releases from ADOC custody after serving a sentence between July 1, 2008 and December 31, 2011, 1,523 (4.4 percent) were classified as very high service risk, equivalent to slightly more than one person a day. At this rate, it seems feasible to conduct a comprehensive needs assessment with the very high risk group without overwhelming ADOC resources, enabling the ADOC to provide tailored services for those at the greatest risk of readmission with the aim of preventing their future criminal justice involvement. If there is capacity to assess and screen more, services could easily be expanded to include some of those in the high service priority group (7,683), who also experienced higher than average rates of readmission. The results of this analysis suggest that developing a risk groupings typology can successfully distinguish those with low risk of ADOC readmission from those with a higher risk of readmission.

In-Facility Practices

As noted earlier, research indicates specific criminogenic risk factors called influence future criminal behavior.¹⁴¹ Researchers have identified eight criminogenic factors as predictors for crime, four of which (the “Big Four”) are an established criminal history, an antisocial personality pattern (low self-control, hostility), antisocial cognition (attitudes, values, and thinking styles supportive of crime; e.g., misperceiving benign remarks as threats, demanding instant gratification), and antisocial associates. Four additional, moderate risk factors are

¹⁴⁰ This number includes only inmates released after serving a sentence between July 1, 2008 and December 31, 2011 who had at least a year of follow-up time to be re-incarcerated.

¹⁴¹ Andrews, D., Bonta, J., & Wormith, S. (2006). The recent past and near future of risk and/or need assessment. *Crime and Delinquency*, 52, 7-27.

substance abuse, employment instability, family problems, and low engagement in pro-social leisure pursuits.

These results are consistent with this report's findings that show substance abuse and criminal history having an influence on recidivism outcomes. At present, studies show criminogenic needs seem to take a distinct back seat to psychiatric symptoms as treatment targets for this population. One study examined 83 audio-taped meetings between specialty mental health probation offenders and their supervisees found that officers were much more likely to discuss the probationer's general mental health and treatment needs than criminal attitudes and other major risk factors for recidivism.¹⁴²

A service framework targeting high-risk offenders for intensive supervision and treatment requires adding evidence-based treatment principles and programs that are explicitly designed to reduce criminal behavior, and improve outcomes for Trust Beneficiaries in Alaska.

A cognitive-behavioral treatment (CBT) element should be sustained if not expanded within existing programming, or created as a stand-alone program in all facilities. CBT programs explicitly address the strongest risk factors for recidivism, which offenders with serious mental illness share with other offenders. CBT programs are structured, applicable in groups, and achieve the largest and most consistent effect sizes in reducing criminal recidivism.¹⁴³ As noted in the section on Evidence-based Practices, across the country a variety of specific brands of CBT are available, including Reasoning & Rehabilitation, Moral Reconciliation Therapy, and Thinking For a Change. However, all appear equally effective in reducing recidivism.¹⁴⁴

Alaska currently has the Criminal Attitude Program (CAP), which is a cognitive-behavioral course (up to 16 weeks in duration) designed to assist offenders with altering their criminal attitudes and behaviors. In addition, the Life Success Substance Abuse Treatment (LSSAT) program also uses a cognitive behavioral approach. Inmates are required to participate for a minimum of three months.

Among the mental health services provided is a 48-Week Offender Program, which targets antisocial attitudes, values and beliefs (personal cognitive supports for crime.) This program focuses on the specific dynamic risk factors of impulsivity, egocentrism, weak problem-solving/self-regulation skills, aggressiveness and deficits in critical reasoning and abstract thinking.

¹⁴² Eno Loudon, J., Skeem, J. L., Camp, J., Vidal, S., & Peterson, J. (2012). Supervision practices in specialty mental health probation: What happens in officer-probationer meetings? *Law and human behavior*, 36(2), 109.

¹⁴³ Lipsey, M.W., Chapman, G. & Landenberger, N.A. (2001). Cognitive-behavioral programs for offenders. *Annals of the American Academy of Political and Social Science*, 578, 144–157.

¹⁴⁴ Aos, S., Miller, M., & Drake, E. (2006). Evidence-based adult corrections programs: What works and what does not. Olympia, WA: Washington State Institute for Public Policy.

In addition, the treatment principles of Risk, Need and Responsivity (RNR) should be consistently applied to existing programming for ADOC clients.¹⁴⁵ Research indicates that offenders are less likely to recidivate when programs match the intensity of treatment to their level of risk for recidivism (Risk), target their criminogenic needs (Need), and match modes of treatment to their abilities and styles (Responsivity). If they are applied to high-risk offenders, CBT programs go far in embodying RNR, since they target needs closely related to criminality, and are delivered in structured formats that are generally appropriate for the learning styles of offenders.

Although this report is emphasizing the benefits of adding and expanding CBT and RNR, it is important to underscore that mental health services are an essential element of the expanded policy model. Even when mental health services have little effect on recidivism, they can achieve crucial public health outcomes for offenders with a mental illness (e.g., reducing symptoms and hospitalization). Moreover, for some offenders, mental health services will act in concert with valid treatments like CBT for reducing recidivism. Specifically, mental health services may reduce specific barriers (such as hallucinations) that will interfere with some acutely ill offenders' abilities to benefit from CBT sessions that target criminal thinking.

Release Planning

Upon release from incarceration, offenders with serious mental illness experience substantial difficulties. Not only do they experience higher rates of unemployment and homelessness, but they also experience significantly more emergency room visits and hospitalizations and most do not receive sufficient mental health treatment.¹⁴⁶ Both the ADOC IDP⁺ and APIC programs are rated over capacity, and given the scope of the number of Trust Beneficiaries leaving the facilities post-sentence, each of those services need to be expanded across Alaska. As noted in the recidivism section, the highest recidivism rates are found in more rural areas. Supporting the expansion may prove cost effective. The Washington State Institute of Public Policy (WSIPP) has issued numerous cost benefit analyses on evidence based practices to reduce offender recidivism. The latest analysis was released in April, 2012¹⁴⁷ and found a number of exit programs showing huge cost savings for offenders who have similar profiles to Trust Beneficiaries.

Washington's Offender Re-entry Community Safety (ORCS) program, formerly known as the Dangerously Mentally Ill Offender program, identifies mentally ill prisoners who pose a threat to public safety and provides them opportunities to receive mental health treatment and other

¹⁴⁵ Andrews, D., Bonta, J., & Wormith, S. (2011). The Risk-Need-Responsivity (RNR) Model: Does Adding the Good Lives Model Contribute to Effective Crime Prevention? *Criminal Justice and Behavior*, 38:7, 735-755.

¹⁴⁶ Baillargeon, J., Hoge, S. K., & Penn, J. V. (2010). Addressing the challenge of community reentry among released inmates with serious mental illness. *American Journal of Community Psychology*, 46(3-4), 361-375.

¹⁴⁷ Lee, S., Aos, S., Drake, E., Pennucci, A., Miller, M., & Anderson, L. (2012). *Return on investment: Evidence-based options to improve statewide outcomes* (Document No. 12-04-1201). Olympia, WA, Washington State Institute for Public Policy.

services for up to five years after their release from prison. The annual cost is \$31,552 per client per year, but the benefits accrued were reported at \$70,535 per year.

Community Aftercare

Based on the reentry trends, large numbers of Trust Beneficiaries are exiting ADOC facilities. In Anchorage alone that number averaged roughly 1,750 per year. Given the numbers and supported by key informant interviews, there appears to be a lack of community resources, specifically housing, and case management.

Respondents identified housing as a critical need for Trust Beneficiaries, especially those involved in the criminal justice system. One theme repeated by respondents was that the mix of housing options was not optimal, meaning that there are few options between a secure facility and an assisted living facility. Often those facilities that are available are not the structured environment needed by Trust Beneficiaries transitioning back into the community. Respondents stressed a need for the development of sub-acute facilities in the community that can bridge the gap between a secure, acute care facility (such as API) and independent rental units.

The success of Housing First and Housing Ready models offers evidence for collaborative efforts to expand the housing availability for Trust Beneficiaries. The Trust in SFY2012 provided funds through the Housing Incentive Grants for DOC Discharge for 69 individuals, including 66 in Anchorage, two in Palmer and one in Fairbanks.



HOUSING WAS IDENTIFIED AS A CRITICAL NEED FOR TRUST BENEFICIARIES, ESPECIALLY FOR THOSE INVOLVED IN THE CRIMINAL JUSTICE SYSTEM.

Both interview respondents and the data suggest that a lack of case management services for Trust Beneficiaries leaving a DOC facility (either jail or prison) is hindering successful reentry outcomes. Felons and misdemeanants may receive connection to community services through APIC, but those services are not statewide and are already over capacity. Peer support models and forensic peer support programs may be potentially good models for replication to strengthen the transition from facility to the community.

In addition to a lack of transitional planning and intensive case management services, continuity of medication upon release is also problematic. The standard practice for ADOC is to provide one week's worth of psychotropic medication upon release. Once they are in the community, clients are expected to connect with providers on their own, but it typically takes more than one week to get into a community mental health service, resulting in a potential medication gap.

Recommendations

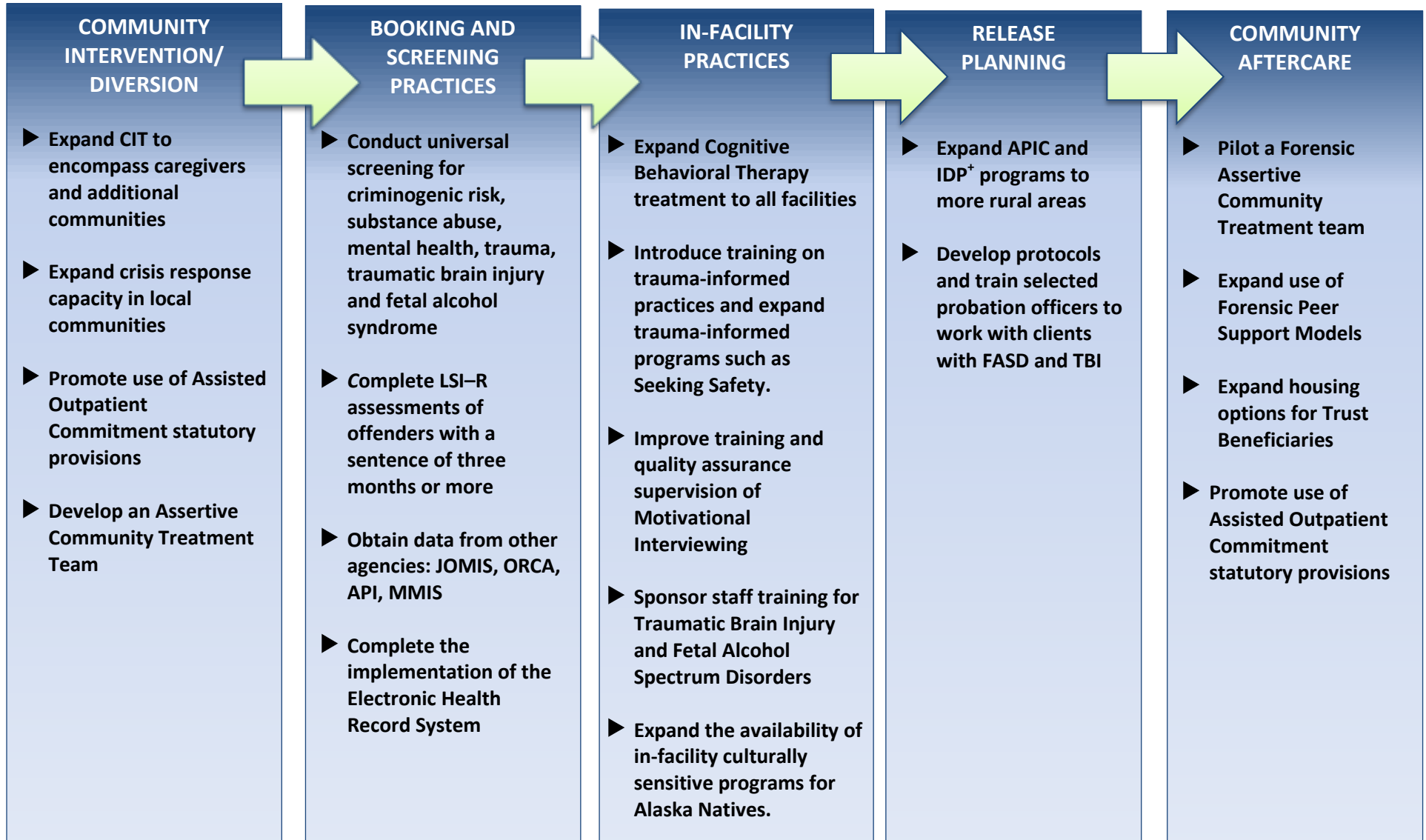
In response to the major findings presented in this report, HZA encourages the Alaska Departments of Corrections and Health and Social Services, the Mental Health Trust Authority, and community stakeholders and providers to consider the recommendations presented below. The five-stage model presented in Vision for the Future serves as the framework for the recommendations. Figure 22 presents the framework with the recommendations summarized at each stage.

The overall cost of recidivism for all offenders is 21.2 percent of ADOC's operating budget, or \$68,658,159 per state fiscal year. Trust Beneficiaries offend at a higher rate and spend more time in custody. The cost of an average stay for a re-offending Trust Beneficiary is \$12,024 compared to other offenders, at \$7,716. Therefore targeting programs and services towards Trust Beneficiaries will have the largest impact in reducing recidivism costs.

Although the recommendations are presented discretely, their effects are cumulative, necessitating more than one to be implemented at a given stage of the model to perceive a more robust impact. A concern echoed by several interview respondents was that engaging in only partial change to limited elements of the system will result in fewer noticeable changes in the system as a whole, making it appear as though the attempted changes were unsuccessful in reducing incarceration and recidivism rates of Mental Health Trust Beneficiaries.

The model encompasses five stages: early intervention/diversion; booking and screening practices; in-facility practices; release planning; and community aftercare. The first and last stages are not the responsibility of ADOC, but rather other agencies and community institutions such as the police and behavioral health agencies. Recommendations at these stages are included here for two reasons; one is that Mental Health Trust Beneficiaries live largely in the community and their experiences before and after engagement with the criminal justice system will have an impact on whether they do get re-engaged. That leads to the second reason: early intervention and community aftercare will have a positive impact on ADOC, which is the focus of this study.

Figure 22: RECOMMENDATIONS FOR A COMPREHENSIVE MODEL FOR ALASKA MENTAL HEALTH TRUST BENEFICIARIES IN CORRECTIONS SYSTEM:



Early Intervention/Diversion

Recommendation 1: Law enforcement, mental health and substance abuse providers and advocates such as the National Alliance on Mental Illness (NAMI) should work together to enhance and expand the use of Crisis Intervention Teams.

Anchorage and Fairbanks have Crisis Intervention Teams (CIT), police trained to respond to people with mental health crises. Equally important, CIT programs provide a forum for partner organizations to coordinate diversion from jails to mental health services. Over 100 officers have been trained in Anchorage alone over the past dozen year.

This recommendation has three components. One is to build in the Mental Health Clinician aspect of the Memphis CIT model, described above, in the Anchorage and Fairbanks teams.

The second is to expand the training to family members and other caregivers of Trust Beneficiaries with the focus being techniques to de-escalate crisis situations without law enforcement involvement. The third is to expand the CIT model to other communities throughout the state while considering using police officers from Anchorage and Fairbanks as members of the training team.

Recommendation 2: The Department of Health and Social Services (DHSS) should continue its efforts to expand the state’s Designated Evaluation and Treatment component to more hospitals; to establish Crisis Respite Provider Agreements; to provide mental health crisis prevention and intervention training to rural hospital staff; and to promote the program’s use with the CITs and other first responders.

The purpose of this recommendation is to expand the capacity of local communities to deal with mental health crises without transporting people to Anchorage. The means is to create local crisis units and provide additional crisis intervention training to health and behavioral health staff in emergency rooms or other community settings where people present themselves with a psychiatric emergency. Alaska already has needed components in place such as a law permitting both involuntary and voluntary treatment and prototype Crisis Respite Provider Agreements. However, DHSS is having trouble getting providers to respond to requests for expanding the services to areas outside major cities.¹⁴⁸

The Designated Evaluation and Treatment (DET) program operated by the DHSS Division of Behavioral Health provides fee for service funding on a “payer-of-last-resort” basis to designated local community hospitals which provide **involuntary** evaluation and treatment services to people court-ordered under Alaska Statute 47.30.655–47.30.915 and to people who

¹⁴⁸ State of Alaska, FY2014 Governor’s Operating Budget, Department of Health and Social Services, Designated Evaluation and Treatment, Component Budget Summary, December 14, 2012; State of Alaska, FY2013 Governor’s Operating Budget, Department of Health and Social Services, Designated Evaluation and Treatment, Component Budget Summary, December 15, 2011.

meet commitment criteria but who have agreed to **voluntary** services in lieu of commitment under Alaska Statute 47.31.010(b)(1)(B). S 47.30.655–47.30.915.

The program includes a treatment component and a stabilization component. The treatment component can occur only in a hospital with a mental health unit which may provide up to 72 hours of inpatient psychiatric evaluation and up to 40 days of in-patient psychiatric hospital service as close to the person's home as possible. The stabilization component may provide up to 72 hours of inpatient psychiatric evaluation services and up to seven days of crisis stabilization and treatment services.

The programs exist at Fairbanks Memorial Hospital and Bartlett Regional Hospital in Juneau. DHSS's efforts to recruit additional hospitals in the Mat-Su Valley and Anchorage bowl, areas that are the source of over 80 percent of API's annual admissions, have not been successful.¹⁴⁹ Another tool is the Crisis Respite Provider Agreement which encourages community behavioral health centers to develop or re-establish local crisis respite capacity. Again, DHSS has not been successful in expanding this agreement to health centers around the state.¹⁵⁰

DHSS and partners in the community should determine the specific barriers to participation and what incentives could be used to overcome them. Areas for consideration are: the feasibility of for-profit providers performing the service if existing agencies will not; having larger agencies in Anchorage provide branch services in remote communities, even using local facilities; exploring whether there is risk aversion to treating these issues locally and how to address that; and exploring whether financial or other incentives would help.

DHSS has provided crisis prevention and intervention training in places such as Ketchikan and Homer. DHSS should continue its efforts to provide crisis prevention and intervention training at rural hospitals and behavioral health centers throughout the state. It should promote the use of existing Designated Evaluation and Treatment services with CITs and other first responders in those communities where the programs exist. Further, it should explore why community agencies will not come forth to establish crisis stabilization and respite services and develop strategies to address these issues.

¹⁴⁹ State of Alaska, FY2013 Governor's Operating Budget, *Ibid*, p. 3.

¹⁵⁰ The following is a quotation from State of Alaska, FY2014 Governor's Operating Budget, Department of Health and Social Services, Designated Evaluation and Treatment, Component Budget Summary, p. 4: "Unfortunately, despite our intention that the Crisis Respite Provider Agreement would interest behavioral health grantees, no agency took advantage of this program in FY2012, nor have any to date in FY3013. We continue to strategize to encourage providers to establish this local service option."

Recommendation 3: The State should promote use of the outpatient commitment provisions of Alaska Statutes also known as Assisted Outpatient Treatment (AOT).

Assisted Outpatient Treatment (AOT) is another option for front-end diversion. Recommended by several interview respondents, this program, used in 44 states, is also called outpatient commitment. AOT is court-ordered treatment (including medication) for individuals who have a history of medication noncompliance, as a condition of their remaining in the community. Studies and data from states using AOT prove that it is effective in reducing the incidence and duration of hospitalization, homelessness, arrests and incarcerations, victimization, and violent episodes. AOT also increases treatment compliance and promotes long-term voluntary compliance, while reducing stress on caregivers.

AOT involves a judge ordering a person with mental illness who fits the state's criteria to follow a court-ordered treatment plan. While the length of time in involuntary outpatient varies from client to client, the overall goal remains the same: to encourage participation in intensive, outpatient case management services and medication management, thereby increasing the likelihood of the Trust Beneficiary remaining in the community and reducing recidivism as well as hospital stays.

Alaska, like every state, has its own civil commitment laws that establish criteria for determining when court-ordered treatment is appropriate for individuals with severe mental illness who are too ill to seek care voluntarily. The state authorizes both inpatient (hospital) and outpatient (community) treatment. Alaska is one of the 27 states whose involuntary treatment standard is based on a person's "need for treatment," rather than only the person's likelihood of being dangerous to self or others. For both inpatient and outpatient care a person must meet one of the following criteria: be a danger to self/others; be in danger from an inability to provide basic needs for food, clothing, shelter, or personal safety; or without treatment, suffer severe and abnormal mental, emotional, or physical distress causing deterioration of ability to function independently.

Expanding the use of AOT in Alaska may help to reduce the number of Trust Beneficiaries entering ADOC facilities and API. However, such use is dependent on the availability of support services, such as housing, and community mental health services to help meet the individual's needs.

Recommendation 4: DHSS in collaboration with other state agencies and community providers should support the development and implementations of an Assertive Community Treatment (ACT) team.

Developing an Assertive Community Treatment (ACT) Team was recommended in the 2007 report but has not yet been implemented in Alaska. Many of the stakeholders interviewed for the current study believe that ACT continues to be needed. The ACT model, described above, serves very high-needs people with mental health and co-occurring disorders through a team approach. An ACT team could serve as a diversion for a high-risk client or provide another

option to a judge for a Trust Beneficiary who has been charged with a non-violent offense, either on a voluntary or involuntary basis under the DET provisions discussed above.

Booking and Screening Practices

Recommendation 5: ADOC should expand screening of offenders for both criminogenic risks and mental health needs (including trauma) within 72 hours of arrest and institute formal screening practices for traumatic brain injury and fetal alcohol spectrum disorder.

The National Institute of Corrections recommends that every correctional agency take into account individuals' criminogenic risk factors and their functional impairments¹⁵¹ resulting from substance abuse, mental health and trauma. Criminogenic risk factors are those that help predict recidivism and are used to select treatment modalities and prioritize need among offenders. People with high criminogenic risks, high levels of substance abuse, and serious mental health issues will have different needs than people with low risks or some combination of risks.

ADOC currently screens for mental health and substance abuse, employing the Brief Jail Mental Health Screen and the Simple Screening Instrument for Substance Abuse—Revised (SSI—R) completed before the end of the fifth day of incarceration. What is missing from current screening practices is tools for recidivism (criminogenic risk), trauma history, traumatic brain injury and fetal alcohol syndrome, the last two being Trust Beneficiary categories.

ADOC could cover all these bases except criminogenic risk by replacing the existing Brief Jail Mental Health Screen and the Simple Screening Instrument for Substance Abuse—Revised (SSI—R)¹⁵² with the Alaska Screening Tool adapted and used by DHSS¹⁵³ (which appears in Appendix G). Since the Alaska Screening Tool has only one fetal alcohol syndrome question it could be supplemented if the condition were suspected. Expanded Screening for FASD should include: 1) confirmed prenatal exposure; 2) facial dysmorphia; 3) growth problems (confirmed prenatal or postnatal height or weight or both at or below the 10th percentile, adjusted for age, sex, gestational age, race, ethnicity); and 4) central nervous abnormalities (structural, neurological, functional). If FAS is suspected, the individual should be referred for a full evaluation and diagnosis; an FAS diagnosis requires all three of the following: documentation of three types of facial abnormalities; documentation of growth deficits; documentation of central nervous system abnormalities.¹⁵⁴

¹⁵¹ Osher, F., D'Amora, D.A., Plotkin, M., Jarrett, N., & Eggleston, A. (2012). *Adults with Behavioral Health Needs Under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery*. Council of State Governments Justice Center and Criminal Justice/Mental Health Consensus Project.

¹⁵² The Alaska Screening Tool has one potential FASD question: did your mother drink during her pregnancy with you (paraphrase); it seems unlikely the person would know unless FASD had already been identified as an issue to the person being screened.

¹⁵³ DHSS/Division of Behavioral Health Performance Management System Version Date: June 21, 2010.

¹⁵⁴ National Center on Birth Defects and Developmental Disabilities. (2004). *Fetal Alcohol Syndrome: Guidelines for Referral and Diagnosis*. United States Centers for Disease Control and Prevention.

The last area, criminogenic risk, should be addressed in one of two ways. The first is to use the risk factors identified specifically for this study based on the comparative analysis of recidivists and non-recidivists. The characteristics of offenders most likely to recidivate are as follows in order of magnitude: whether the offender has committed a felony in the past, whether he or she is a Trust Beneficiary, whether the offender is an Alaska native, the number of offenses previously committed, whether he or she was in the Juvenile Justice system, whether in the child welfare system, whether male, and if the offender was young. The tools would ask the questions above.

The second is to use an existing tool. Two primary candidates are the Ohio Risk Assessment System–Prison Intake Tool (ORAS PIT) (see Appendix G)¹⁵⁵ or the Level of Service Inventory Revised Screening Form (LSI–R:SV). The LSI–R:SV is a screening instrument that is used where it may not be feasible to complete the Level of Service Inventory–Revised (LSI–R) or Level of Service Inventory/Case Management Inventory (LS/CMI) assessment for every offender. Research conducted with the LSI–R:SV shows that it is predictive of a variety of outcomes that are essential in offender management. The LSI–R:SV is able to predict violent recidivism and violations among probation samples while under community supervision, and institutional misconduct among incarcerated offenders. The LSI–R:SV consists of eight items that were selected from the LSI–R. Results provide a complete summary of dynamic risk areas that may require further assessment and possibly intervention. The LSI–R:SV is available in hand-scored and software formats, the latter being able to provide a profile report upon completing the assessment.

Recommendation 6: Complete a full Level of Service Inventory-Revised (LSI–R) assessment of offenders with a sentence of three months or more.

ADOC uses the LSI–R for offenders on probation and is moving toward screening all inmates with a sentence of at least *six months*. This recommendation suggests conducting the assessment for offenders with a sentence of at least *three months*, so as to include more high-risk offenders for treatment. This recommendation is tied to the screening process (Recommendation 5) as offenders who are deemed low risk from the screening process would not be assessed using the more comprehensive risk assessment tool.

As noted earlier, many risk factors are the same for people with or without co-occurring disorders. The rationale for performing the risk assessment is to match the level of services provided to an individual's likelihood of committing a crime. Known as the risk principle, a person who is at high risk for criminal activity receives more resources targeting criminogenic needs than a person who is at low risk. In part, this is a resource allocation strategy. Research has also shown that low-risk individuals do not need high levels of risk-reduction services. Moreover, when low-risk individuals receive a high level of service, it may actually increase

¹⁵⁵ Latessa, E. Smith, P., Limke, R., Makarios, M., & Lowenkamp, C. (2009). *Creation and Validation of the Ohio Risk Assessment System Final Report*. School of Criminal Justice Center for Criminal Justice Research, Cincinnati, Ohio.

criminal risk. The LSI–R helps determine how to target interventions so as to reduce criminal risk.

Recommendation 7: ADOC should continue to work to develop data-sharing agreements between and among state agencies that work with Trust Beneficiaries involved in the criminal justice system.

HZA analyzed 60,247 individuals who entered, exited, or resided in an Alaska Department of Corrections facility between July 1, 2008 and June 30, 2012 of which 30.4 percent or 18,323 were identified as Trust Beneficiaries. Of these 10,453 were identified by ADOC. The others came from records of diagnosis and treatment in other databases: API, AKAIMS and MMIS. This finding underscores the continued need for data sharing.

Data sharing implies the ability of ADOC either to query the databases of these other agencies, as in a data warehouse, or to routinely send names of newly committed people for the other agencies to check their histories. One way to facilitate data sharing is to implement a common identifier for all Department databases. The APSIN number, already in use in some places, would be the logical candidate for a common identifier for all people with criminal histories. Legal counsel should review agreements to make sure they comply with the Health Insurance Portability and Accountability Act and 42 Code of Federal Regulations.

ADOC is participating in the Multi-Agency Justice Integration Consortium (MAJIC) formed in 2004 to improve the sharing of data and other information among state justice agencies. This group, which includes representatives from twenty state justice-related agencies, is focusing on establishing data practices and systems that will make the input of justice data more efficient across separate agency databases. However, it does not include a treatment focus. It is identifying ways to capture information once, at the source, and then share it using open standards that permit agencies to communicate with one another regardless of the technology selected by each agency. The consortium is also promoting the adoption of an individual identification number. Despite this effort which is nearly a decade old, the essential issue still exists.

Trust Beneficiaries are not being identified based on their involvement in other systems. Data sharing would help to identify Trust Beneficiaries earlier, to make use of existing assessments and diagnoses, and provide continuity of care and maintain medication regimens.

Recommendation 8: ADOC should continue supporting the timely completion and implementation of the Electronic Health Record system.

This recommendation specifically addresses data sharing within ADOC. ADOC needs an Electronic Health Record to improve the internal management of its cases. If an offender moves from one facility to another, accessing his or her record and service history will be a seamless process with an electronic health record. Moreover, it will store critical information on medications. A practical problem, lacking such a system, is that medications are unknown or

altered as people cycle in and out of ADOC and community mental health. Over the past four years ADOC has put the parameters in place to create an Electronic Health Record system, but the actual system has not yet been implemented.

In-Facility Practices

Recommendation 9: ADOC should expand use of evidence-based practices such as Cognitive Behavioral Therapy (CBT) for clients with a mental illness, substance use disorders and co-occurring disorders to all facilities.

ADOC should expand its use of evidence-based practices, starting with the implementation of Cognitive Behavioral Therapy (CBT) in all of its facilities as a standard treatment. CBT is both effective and cost-effective and has been tested with offender populations.

CBT is a form of treatment that focuses on examining the relationships between thoughts, feelings and behaviors. By exploring patterns of thinking that lead to self-destructive actions and the beliefs that direct these thoughts, people with criminogenic thought patterns, substance abuse and mental illness can modify their patterns of thinking to improve coping. CBT is different from traditional psychotherapy in that the therapist and the patient actively work together to help the patient recover.

As discussed above, CBT is effective with juvenile and adult offenders; substance abusing and violent offenders; and probationers, prisoners and parolees. It is effective in various criminal justice settings, both in institutions and in the community, and addresses a host of problems associated with criminal behavior. CBT includes a variety of “brand name” programs (Moral Reconciliation Therapy, Reasoning and Rehabilitation, and Thinking For a Change).

Cost benefit studies from the Washington State Institute for Public Policy specifically for high- and moderate-risk adult offenders have shown a cost benefit of \$9,283 per person receiving CBT.¹⁵⁶

Recommendation 10: ADOC should provide training to all correctional staff, both community-based and facility, on trauma-informed correctional practices and it should expand the use of trauma-specific programming to encompass all facilities with mental health and substance abuse units.

In the section on National Models and Practices we draw the distinction between trauma-informed practice and trauma-specific programming. Trauma-informed practice is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. The high prevalence of offenders who have been in the child welfare system in Alaska is a testament to that since child

¹⁵⁶ Lee, S., Aos, S., Drake, E., Pennucci, A., Miller, M., & Anderson, L. (2012). *Return on investment: Evidence-based options to improve statewide outcomes, April 2012* (Document No. 12-04-1201). Olympia: Washington State Institute for Public Policy.

abuse and even the act of forcefully removing a child from home is characterized in the literature as a traumatic experience. Trauma-informed practices should not have the effect of causing trauma in and of themselves. As an example, strip searches can be traumatic, especially for females, and especially for those who have been physically or sexually abused. A trauma-informed facility would consider what steps can be taken to minimize the negative impact of a strip search.

Trauma-informed training serves to sensitize staff to the trauma histories of offenders, to the impact of these histories on their attitudes and behaviors, on the practices that may trigger these reactions, and on the steps that can be taken to avert more harm. Such training should be made available to all correctional staff even people responsible for food service or transportation.

Trauma-specific services are “interventions designed to address the specific behavioral, intrapsychic, and interpersonal consequences of exposure to sexual, physical, and prolonged emotional abuse.”¹⁵⁷ As stated earlier in the report, there are a number of trauma-specific interventions (such as Seeking Safety, TARGET, TREM and PE) that include an integration of trauma awareness into service delivery across all levels of treatment and support. ADOC has implemented Seeking Safety on a limited basis in a few facilities. It is a good choice as this model addresses both trauma and substance abuse and has been tested in both residential and community settings. ADOC should provide this or a similar program in all facilities with a mental health unit once or twice a year.

Recommendation 11: ADOC should expand and enhance the use of Motivational Interviewing techniques with frontline correctional staff.

ADOC should expand and enhance its Motivational Interviewing (MI) training program for line staff and probation officers. Motivational Interviewing (MI) encompasses a series of techniques that correctional officers use with offenders. These techniques require staff training as well as supervision in the form of observation, feedback, coaching, and supervision to ensure it is being used proficiently.¹⁵⁸

That is, training in motivational interviewing is not sufficient. To maintain a high level of fidelity ADOC should consistently incorporate both training and quality assurance practices.

Supervisors play an important role in supporting the successful implementation of MI. They can create a learning environment that lowers the barriers to practicing the skill, observing the practice and providing feedback to correctional staff until the practice becomes ingrained. They

¹⁵⁷ Substance Abuse and Mental Health Services Administration. *Cooperative Agreement to Study Women with Alcohol, Drug Abuse, and Mental Health (ADM) Disorders Who Have Histories of Violence*. No.T100-003.

¹⁵⁸ Bogue, B., Campbell, N., Carey, M., Clawson, E., Florio, K., Joplin, L. Keiser, G., Wasson, B., & Woodard, W. (2004). *Implementing evidence-based practice in community corrections: The Principles of Effective Intervention*. Aurora, Colorado: National Institute of Corrections. Available at: <http://www.nicic.org/Library/019342>.

can also provide resources helpful for learning and supporting the formation of communities of practice, such as peer coaching groups. ADOC should develop an approach, through supervision and quality assurance, to reinforce MI throughout the system.

Recommendation 12: ADOC should conduct facility training of staff for Traumatic Brain Injury (TBI) and Fetal Alcohol Spectrum Disorders (FASD).

ADOC staff, regardless of correctional setting, should have a solid understanding of both Traumatic Brain Injury (TBI) and Fetal Alcohol Spectrum Disorders (FASD), their manifestations, the challenges that people with these conditions face, and how to manage the offender's behavior in a correctional environment. At a minimum three to five people in a hundred in ADOC custody have them now, as measured by this study.

Whether from sports, military service, an assault or an accident, TBI is far more prevalent among the offender population than recognized in the past, and is no doubt under-reported in this study. Prisoners with TBI have a higher rate of disciplinary incidents; they also take more time to adapt to prison life and comply with prison rules.¹⁵⁹ In addition, in a recent study the incidence of FASD was ten times greater among the offenders screened than the general public.¹⁶⁰

Frontline ADOC correctional staff in the institutions and probation officers should be properly educated in the consequences and symptoms of TBI as well as the strategies to use in managing offenders with TBI.¹⁶¹

Recommendation 13: ADOC should expand the availability of in-facility culturally sensitive programs for Alaska Natives.

This report again documents that Alaska Natives are over-represented within the criminal justice system in Alaska. While there are numerous factors that are associated with the disproportionate arrest and detainment of Alaska Natives, ADOC should consider introducing more culturally sensitive programming into the services it provides, especially to offenders with co-occurring conditions.

Although culturally specific programs are available within some ADOC facilities, ADOC programming options are inconsistent from facility to facility. A fairly recent programmatic development (October, 2012) in ADOC was the creation of the Alaska Native-based Substance Abuse Treatment (ANSAT) program. ANSAT provides substance abuse treatment services from

¹⁵⁹ Bogue, B., Campbell, N., Carey, M., Clawson, E., Florio, K., Joplin, L. Keiser, G., Wasson, B., & Woodard, W. (2004). *Implementing evidence-based practice in community corrections: The Principles of Effective Intervention*. Aurora, Colorado: National Institute of Corrections. Available at: <http://www.nicic.org/Library/019342>.

¹⁶⁰ Ferguson, P.L., Pickelsimer, E.E., Corrigan, J.D., Bogner, J.A., & Wald, M. (2012). Prevalence of Traumatic Brain Injury Among Prisoners in South Carolina. *Journal of Head Trauma Rehabilitation*. 27:3, E11-E20.

¹⁶¹ MacPherson, P. & Chudley, A. (2007). *FASD in a Correctional Population: Preliminary Results from an Incidence Study*. Webcast and PowerPoint presentation available from www.motherisk.org/fas6/webcast/index.html.

an Alaska Native cultural perspective to incarcerated individuals. Generally, inmates in the program are required to participate for a minimum of four weeks (12-16 hours per week). The ANSAT services are offered at the Yukon-Kuskokwim Correction Center in Bethel and the Anvil Mountain Correctional Center in Nome. It is expected the number of clients served per year will be 180.

Expanding programming to more ADOC facilities with high Alaska Native populations such as in Fairbanks will help improve the design and delivery of behavioral health and substance abuse programs to this population.

Release Planning

Recommendation 14: ADOC and its community partners should expand the existing capacity of the Assess, Plan, Identify, and Coordinate (APIC) and Institutional Discharge Program (IDP+) as well as provide these services to more rural areas of the state.

Both IDP⁺ and APIC programs are rated over capacity and showing great promise at reducing recidivism rates. Given the current location of each program and the high rates of recidivism in outlying areas, ADOC should expand each program to more rural communities and work with local providers to support the expansion efforts.

Recommendation 15: ADOC and DHSS should develop increased protocols and training for selected probation officers working with clients with Severe and Persistent Mental Illness (SPMI), FASD, and TBI.

ADOC and DHSS should train selected probation officers on techniques and supervision practices that help provide structure to clients with SPMI, FASD and TBI, as well as develop protocols with community providers that can provide the necessary supports for this population (e.g. housing, health care, supportive employment) upon release from a facility. Research shows the role of probation officers for people with FASD is particularly important in the first weeks and months following their release from incarceration.¹⁶² Relationship-building and close monitoring are essential to identifying any needs or problems quickly, to effectively serve as the offender's advocate, and to connect the individual with services, activities, housing, and employment.¹⁶³

This training could be a special component of the training in Recommendation 12 above.

¹⁶² *Community Support. Fetal Alcohol Spectrum Disorder and Justice.* Available at <http://fasdjustice.ca/community-support/corrections/community-support.html>. Accessed 4/9/13.

¹⁶³ *Ibid.*

Community Aftercare

Recommendation 16: DHSS should work with ADOC and partner agencies to pilot a Forensic Assertive Community Treatment team.

The 2007 report recommended ADOC consider expanding its partnership with community agencies by implementing additional evidence-based services such as FACT to target the population most at risk. That recommendation was not completed and it is recommended again that DHSS, ADOC and provider agencies such as Anchorage Community Mental Health Services, Inc. or a counterpart elsewhere to work together to develop and support a FACT team or Forensic Intensive Case Management program for the high-risk Trust Beneficiary population who exit ADOC facilities.

Two studies of FACT programs, one of Project Link in Rochester, NY and another of the Thresholds State County Collaborative Jail Link of Linkage Project (CJLP) in Chicago, IL, have shown a reduction in jail days, arrests, days spent in hospitals, and hospitalizations.¹⁶⁴ While the FACT model has shown to reduce jail and hospital costs, the model itself is a high-intensity, high-cost intervention, and therefore its use should be limited to only those who are the highest risk.¹⁶⁵ Since case management is a reimbursable service under Medicaid and the FACT team would be provided to offenders after discharge when their Medicaid benefits, if applicable, have been reinstated, that should make this recommendation more cost effective.

Recommendation 17: ADOC and The Trust should partner with community organizations to expand current Peer Support models to include Forensic Peer Support.

Alaska already has networks of peer support agencies around the state, some supported by federal and state groups including the Alaska Mental Health Trust Authority. This recommendation is asking ADOC and The Trust to expand the capabilities of these providers to include forensic peer support, that is, trained peer specialists with a history of mental illness and criminal justice involvement. Forensic Peer Support Specialists instill hope and serve as credible role models; they are able to provide critical aid to persons in the early stages of re-entry, in much the same way that peer specialists provide support to peers with mental illness alone (i.e., without criminal justice system involvement). Forensic Peer Support providers can serve as community guides, coaches, and/or advocates to provide support as individuals plan and focus on their paths to recovery. Since the Peer Support network is already widespread, this recommendation can assist re-entry on a statewide basis, especially if ADOC and the Peer Support Network partner in assuring that all high risk Trust Beneficiaries are assigned a peer mentor upon release.

¹⁶⁴ *Community Support. Fetal Alcohol Spectrum Disorder and Justice.* Available at <http://fasdjustice.ca/community-support/corrections/community-support.html>. Accessed 4/9/13.

¹⁶⁵ Morrissey, J & Meyer, P. (2008). *Extending Assertive Community Treatment to Criminal Justice Settings.* CMHS National Gains Center.

Recommendation 18: State and local agencies should partner in the continuing development of a continuum of affordable, safe, sober, and supportive housing options for Trust Beneficiaries exiting the Alaska Department of Corrections.

Housing remains a primary issue of concern in Alaska. Not only is more affordable housing needed, but so is structured housing tailored to serving specific Trust Beneficiaries populations (such as those with TBI). Trust Beneficiaries have unique needs, often stemming from cognitive impairments and their living environment must be able to meet those needs. The success shown by Karluk Manor and other Housing First initiatives across the country suggests the need for a collective effort by the Trust, ADOC, DHSS and local community agencies to find ways to expand the number of units across the state.

In addition to structured housing programs, there is currently a gap between facilities (such as API or an ADOC facility) and independent housing units. The magnitude of the gap needs to be assessed in each part of the state. Once Trust Beneficiaries are released, they often have nowhere to go except to live on their own or with family. Because they are often unprepared to do so, the gap in an intermediate assisted living facilities results in Beneficiaries re-offending. A more gradual reintegration to living in the community is suggested to help mitigate the problem.

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Appendix A: Alaska Mental Health Trust Authority Trust Beneficiary Definition

The Alaska Mental Health Trust Authority coordinates with state agencies about programs that affect Beneficiaries, proposes budgets for the state's comprehensive integrated mental health program and reports to the legislature, governor, and the public about Trust activities.

The five categories of Trust Beneficiaries¹⁶⁶ and the respective disorders that are covered are as follows:

1) People with Mental Illness include persons with the following mental disorders:

- Schizophrenia;
- Delusional (paranoid) disorder;
- Mood disorders;
- Anxiety disorders;
- Somatoform disorders;
- Organic mental disorders;
- Personality disorders;
- Dissociative disorders;
- Other psychotic or severe and persistent mental disorders manifested by behavioral changes and symptoms of comparable severity to those manifested by persons with mental disorders listed above;
- Persons who have been diagnosed by a licensed psychologist, psychiatrist, or physician licensed to practice medicine in the state and, as a result of the diagnosis, have been determined to have a childhood disorder manifested by behaviors or symptoms suggesting risk of developing a mental disorder.

2) People with Developmental Disabilities include persons with the following neurologic or mental disorders such as:

- Cerebral palsy;
- Epilepsy;
- Mental retardation;
- Autistic disorder;
- Severe organic brain impairment;
- Significant developmental delay during early childhood indicating risk of developing a disorder;
- Other severe and persistent mental disorders manifested by behaviors and symptoms similar to those manifested by persons with disorders listed above.

¹⁶⁶ See the following for more information: <http://www.mhtrust.org/index.cfm/About-Us/Trust-Beneficiaries>

3) People with Chronic Alcoholism and Other Substance Abuse Disorders include persons with the following disorders:

- Alcohol withdrawal delirium (delirium tremens);
- Alcohol hallucinosis;
- Alcohol amnesiac disorder;
- Dementia associated with alcoholism;
- Alcohol-induced organic mental disorder;
- Alcoholic depressive disorder;
- Other severe and persistent disorders associated with a history of prolonged or excessive drinking or episodes of drinking out of control and manifested by behavioral changes and symptoms similar to those manifested by persons with disorders listed above.

4) People with Alzheimer's Disease and Related Disorders includes persons with the following mental disorders:

- Primary degenerative dementia of the Alzheimer type;
- Multi-infarct dementia;
- Senile dementia;
- Pre-senile dementia;
- Other severe and persistent mental disorders manifested by behaviors and symptoms similar to those manifested by persons with disorders listed in this subsection.

5) People with a Traumatic Head Injury Resulting in Permanent Brain Injury includes head injuries that result in cognitive impairment.

Appendix B: Characteristics of Identified Trust Beneficiaries, SFY 2009-SFY 2012

	Trust Beneficiary identified by ADOC (n=11,678)		Trust Beneficiary found in other datasets ¹⁶⁷ (n=6,645)		All Trust Beneficiaries (n=18,323)	
Gender¹⁶⁸	N	%	N	%	N	%
Male	8,604	73.7%	3,771	56.7%	12,375	67.5%
Female	3,074	26.3%	2,874	43.3%	5,948	32.5%
Total	11,678	100.0%	6,645	100.0%	18,323	100.0%
Race	N	%	N	%	N	%
White	6,242	53.5%	2,989	45.0%	9,231	50.4%
Black	882	7.6%	369	5.6%	1,251	6.8%
AK Native	4,052	34.7%	2,996	45.1%	7,048	38.5%
Hispanic	247	2.1%	109	1.6%	356	1.9%
Other	255	2.2%	182	2.7%	437	2.4%
Total	11,678	100.0%	6,645	100.0%	18,323	100.0%
Age Group	N	%	N	%	N	%
Under 21	1,238	10.8%	1,930	29.2%	3,168	17.5%
21-30	3,762	32.8%	2,092	31.7%	5,854	32.4%
31-40	2,833	24.7%	1,156	17.5%	3,989	22.1%
41-50	2,617	22.8%	957	14.5%	3,574	19.8%
Over 50	1,036	9.0%	467	7.1%	1,503	8.3%
Sub-Total	11,486	100.0%	6,602	100.0%	18,088	100.0%
Unknown	192	N/A	43	N/A	235	N/A
Total	11,678	100.0%	6,645	100.0%	18,323	100.0%

¹⁶⁷ AKAIMS, API, MMIS

¹⁶⁸ One case had no gender label.

Appendix C: Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)—Multi-axial Classifications

The DSM-IV-TR organizes each psychiatric diagnosis into five levels (axes) relating to different aspects of disorder or disability:

Axis I: Clinical disorders, including major mental disorders as well as developmental and learning disorders.

Common Axis I disorders include depression, anxiety disorders, bipolar disorder, ADHD, and schizophrenia.

Axis II: Underlying pervasive or personality conditions, as well as mental retardation.

Common Axis II disorders include borderline personality disorder, schizotypal personality disorder, antisocial personality disorder, narcissistic personality disorder and mental retardation.

Axis III: Acute medical conditions and physical disorders.

Axis IV: Psychosocial and environmental factors contributing to the disorder.

Axis V: Global Assessment of Functioning or Children’s Global Assessment Scale for children under the age of 18 (on a scale from 100 to 0).

Appendix D: Distribution of Trust Beneficiaries in Custody of the Alaska Department of Corrections by Facility by Year

	ACC-E	ACC-W	AMCC	FCC	HMCC	KCC	LCCC	MSPF	PCC	PMCF	SCC	WCC	YKCC
SFY 2009													
Total Admissions ¹⁶⁹	18,632	3,257	2,037	7,298	2,460	974	2,236	3,623	3,472	608	1,419	3,816	2,748
Trust Beneficiary Admissions	8,529	1,982	995	2,742	1,715	478	1,257	1,619	1,966	255	997	1,885	1,234
Trust Beneficiary Percent	45.8%	60.9%	48.8%	37.6%	69.7%	49.1%	56.2%	44.7%	56.6%	41.9%	70.3%	49.4%	44.9%
SFY 2010													
Total Admissions	18,556	3,075	2,031	8,278	3,044	961	2,471	3,910	3,549	577	1,338	3,813	3,313
Trust Beneficiary Admissions	8,525	1,848	1,052	2,849	2,035	503	1,538	1,780	2,102	272	970	1,997	1,426
Trust Beneficiary Percent	45.9%	60.1%	51.8%	34.4%	66.9%	52.3%	62.2%	45.5%	59.2%	47.1%	72.5%	52.4%	43.0%
SFY 2011													
Total Admissions	18,582	2,891	2,057	7,275	3,052	1,011	2,488	4,303	3,642	581	1,213	3,846	3,631
Trust Beneficiary Admissions	8,503	1,851	1,063	2,605	2,141	492	1,485	1,891	2,063	264	887	1,961	1,555
Trust Beneficiary Percent	45.8%	64.0%	51.7%	35.8%	70.2%	48.7%	59.7%	43.9%	56.6%	45.4%	73.1%	51.0%	42.8%
SFY 2012													
Total Admissions	18,261	2,854	2,345	6,893	2,872	1,045	2,539	3,911	4,010	543	1,213	4,216	3,069
Trust Beneficiary Admissions	8,297	1,819	1,263	2,593	2,031	499	1,407	1,573	2,252	249	884	2,251	1,382
Trust Beneficiary Percent	45.4%	63.7%	53.9%	37.6%	70.7%	47.8%	55.4%	40.2%	56.2%	45.9%	72.9%	53.4%	45.0%

Facility Codes:

ACC-E = Anchorage Correctional Complex East
 ACC-W = Anchorage Correctional Complex West
 AMCC = Anvil Mountain Correctional Center
 FCC = Fairbanks Correctional Center
 HMCC = Hiland Mountain Correctional Center

KCC = Ketchikan Correctional Center
 LCCC = Lemon Creek Correctional Center
 MSPF = Mat-Su Pretrial Facility
 PCC = Palmer Correctional Center
 PMCF = Pt. McKenzie Correctional Facility

SCC = Spring Creek Correctional Center
 WCC = Wildwood Correctional Center
 YKCC = Yukon-Kuskokwim Correctional Center

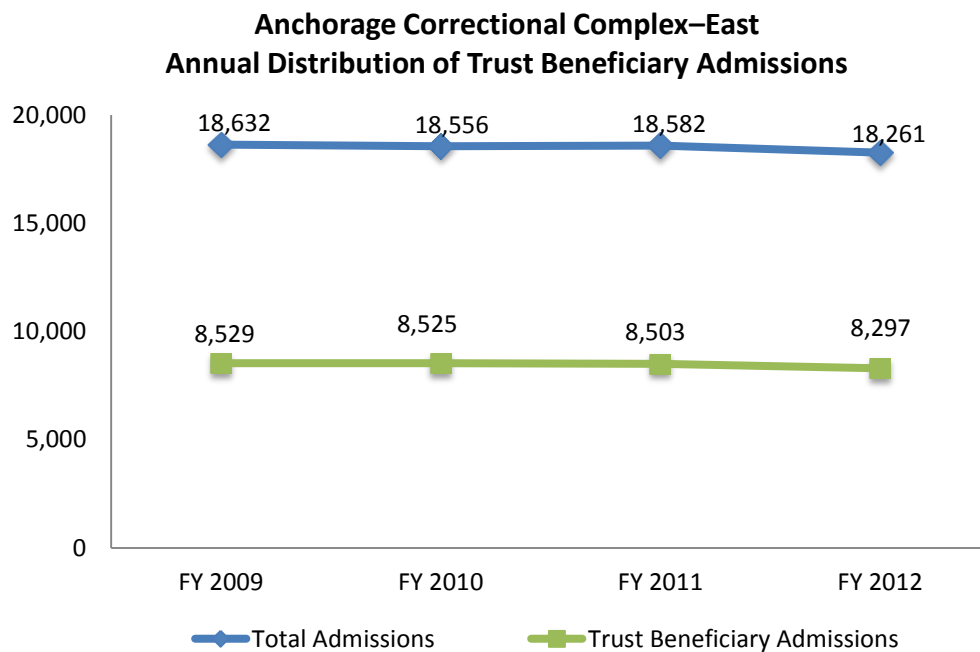
¹⁶⁹ "Admissions," for the purposes of this section, refers to those individuals being booked into a facility, those being transferred from one facility to another, or those who were already in residence at a facility at the beginning of the study period. One individual may be counted multiple times due to offender movement.

Anchorage Correctional Complex–East

Facility Description: ACC East (formerly known as the Anchorage Jail) is the largest booking facility in Alaska. ACC East has an operating capacity of 380 inmates, serving male and female misdemeanants and felons. While male inmates may remain in the facility, female inmates are transferred to Hiland Mountain Correctional Center in Eagle River the same or next day.

Programs:

- Anger Management
- Healthy Living
- On-site Clinical Services
- On-site Psychiatric Services
- Substance Abuse Assessment and Referral Services
- While not a program, DOC added a contract in 2011 with Anchorage Community Mental Health Services to provide a staff person who works in ACCE to function as a mental health discharge planner connecting individuals to ACMHS and other provider services.



**Table 1: Demographics of Anchorage Correctional Complex–East Population,
SFY09–SFY12**

	Trust Beneficiary		Non-Trust Beneficiary		Total	
Gender	N	%	N	%	N	%
Male	7,563	69.4%	16,259	75.8%	23,822	73.7%
Female	3,331	30.6%	5,185	24.2%	8,516	26.3%
Total	10,894	100.0%	21,444	100.0%	32,338	100.0%
Race	N	%	N	%	N	%
White	5,304	48.7%	10,838	50.5%	16,142	49.9%
Black	1,016	9.3%	2,500	11.7%	3,516	10.9%
AK Native	3,945	36.2%	4,817	22.5%	8,762	27.1%
Hispanic	228	2.1%	1,253	5.8%	1,481	4.6%
Other	401	3.7%	2,036	9.5%	2,437	7.5%
Total	10,894	100.0%	21,444	100.0%	32,338	100.0%
Age Group	N	%	N	%	N	%
Under 21	1,735	16.1%	4,256	20.0%	5,991	18.7%
21-30	3,559	33.1%	7,772	36.6%	11,331	35.4%
31-40	2,404	22.4%	4,041	19.0%	6,445	20.2%
41-50	2,173	20.2%	3,441	16.2%	5,614	17.6%
Over 50	876	8.2%	1,733	8.2%	2,609	8.2%
Total	10,747	100.0%	21,243	100.0%	31,990	100.0%

**Table 2: Clinical Characteristics of Trust Beneficiaries, Alaska
Correctional Complex–East, SFY09-SFY12**

Presenting Diagnoses	Total (n=7,006)	
	Number	Percent
Axis I		
Adjustment	1,347	19.2%
Alcohol	2,927	41.8%
Anxiety	1,201	17.1%
Bipolar	580	8.3%
Dementia	43	0.6%
Drug	2,989	42.7%
Impulse Control	545	7.8%
Mood	2,190	31.3%
Psychotic	954	13.6%
Schizophrenia	633	9.0%
Sexual	106	1.5%
Other	679	9.7%
Axis II		
Personality	2,243	34.6%
Mental Retardation (MR)	86	1.2%
Other	261	3.7%
None	4,361	62.2%
Axis III		
Cerebral Palsy	2	0.0%
Epilepsy	27	0.4%
Fetal Alcohol Disorders	66	0.9%
Severe Organic Brain Impairment	54	0.8%
Traumatic Brain Injury	180	2.6%

**Table 3: Extrapolation of Clinical Characteristics of Trust Beneficiaries Releases,
Alaska Correctional Complex–East, SFY09-SFY12**

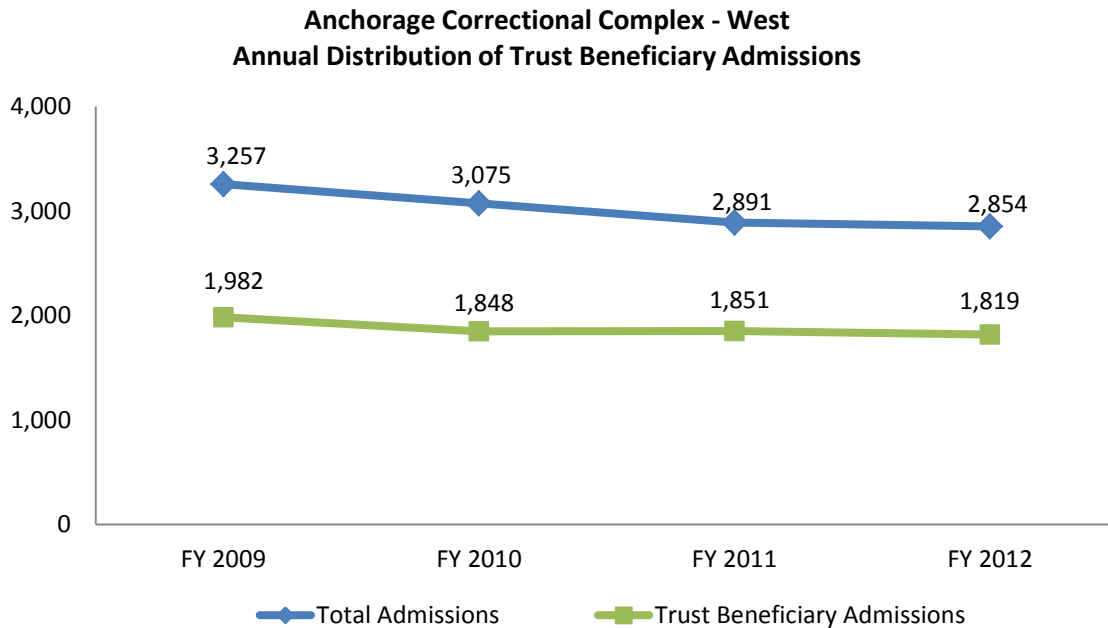
Presenting Diagnoses	Presenting Diagnoses	2009 Trust Beneficiary Releases (n=2,387)	2010 Trust Beneficiary Releases (n=2,422)	2011 Trust Beneficiary Releases (n=2,384)	2012 Trust Beneficiary Releases (n=2,239)
		Percent	Number	Number	Number
Axis I					
Adjustment	19.2%	458	465	458	430
Alcohol	41.8%	998	1012	997	936
Anxiety	17.1%	408	414	408	383
Bipolar	8.3%	198	201	198	186
Dementia	0.6%	14	15	14	13
Drug	42.7%	1,019	1,034	1,018	956
Impulse Control	7.8%	186	189	186	175
Mood	31.3%	747	758	746	701
Psychotic	13.6%	325	329	324	305
Schizophrenia	9.0%	215	218	215	202
Sexual	1.5%	36	36	36	34
Other	9.7%	232	235	231	217
Axis II					
Personality	34.6%	826	838	825	775
Mental Retardation (MR)	1.2%	29	29	29	27
Other	3.7%	88	90	88	83
None	62.2%	1,485	1,506	1,483	1,393
Axis III					
Cerebral Palsy	0.0%	0	0	0	0
Epilepsy	0.4%	10	10	10	9
Fetal Alcohol Disorders	0.9%	21	22	21	20
Severe Organic Brain Impairment	0.8%	19	19	19	18
Traumatic Brain Injury	2.6%	62	63	62	58

Anchorage Correctional Complex–West

Facility Description: ACC West (formerly known as the Cook Inlet Pretrial) has an operating capacity of 400 inmates and serves males in pretrial and sentenced status. ACC West also has the only state acute inmate mental health unit for males, and has a sub-acute unit with programming for individuals with mental and organic impairments.

Programs:

- 28-Bed Acute Psychiatric Unit
- 36-Bed Sub-Acute Psychiatric Unit
- Anger Management
- Healthy Living
- On-site Clinical Services
- On-site Psychiatric Services
- On-site Dual Diagnosis Clinical Services
- Short Term Substance Abuse Treatment (SSAT)
- Substance Abuse Assessment and Referral Services
- Alaska Reentry Course
- Criminal Attitudes Program (CAP)
- Parenting Classes



**Table 1: Demographics of Anchorage Correctional Complex–West Population,
SFY09–SFY12**

	Trust Beneficiary		Non-Trust Beneficiary		Total	
	N	%	N	%	N	%
Gender						
Male	3,495	99.9%	2,543	99.8%	6,038	99.9%
Female	3	0.1%	5	0.2%	8	0.1%
Total	3,498	100.0%	2,548	100.0%	6,046	100.0%
Race						
White	1,684	48.1%	1,038	40.7%	2,722	45.0%
Black	396	11.3%	475	18.6%	871	14.4%
AK Native	1,209	34.6%	606	23.8%	1,815	30.0%
Hispanic	98	2.8%	164	6.4%	262	4.3%
Other	111	3.2%	265	10.4%	376	6.2%
Total	3,498	100.0%	2,548	100.0%	6,046	100.0%
Age Group						
Under 21	440	12.7%	373	14.8%	813	13.6%
21-30	1,319	38.0%	1,000	39.7%	2,319	38.7%
31-40	805	23.2%	548	21.7%	1,353	22.6%
41-50	656	18.9%	443	17.6%	1,099	18.4%
Over 50	247	7.1%	157	6.2%	404	6.7%
Total	3,467	100.0%	2,521	100.0%	5,988	100.0%

**Table 2: Clinical Characteristics of Trust Beneficiaries, Alaska
Correctional Complex–West, SFY09-SFY12**

Presenting Diagnoses	Total (n=2,112)	
	Number	Percent
Axis I		
Adjustment	352	16.7%
Alcohol	805	38.1%
Anxiety	244	11.6%
Bipolar	169	8.0%
Dementia	13	0.6%
Drug	989	46.8%
Impulse Control	182	8.6%
Mood	480	22.7%
Psychotic	250	11.8%
Schizophrenia	269	12.7%
Sexual	35	1.7%
Other	162	7.7%
Axis II		
Personality	989	46.8%
Mental Retardation (MR)	30	1.4%
Other	49	2.3%
None	1,082	51.2%
Axis III		
Cerebral Palsy	1	0.0%
Epilepsy	5	0.2%
Fetal Alcohol Disorders	30	1.4%
Severe Organic Brain Impairment	12	0.6%
Traumatic Brain Injury	69	3.3%

**Table 3: Extrapolation of Clinical Characteristics of Trust Beneficiaries Releases,
Alaska Correctional Complex–West, SFY09-SFY12**

Presenting Diagnoses	Presenting Diagnoses	2009 Trust Beneficiary Releases (n=597)	2010 Trust Beneficiary Releases (n=557)	2011 Trust Beneficiary Releases (n=562)	2012 Trust Beneficiary Releases (n=640)
	Percent	Number	Number	Number	Number
Axis I					
Adjustment	16.7%	100	93	94	107
Alcohol	38.1%	227	212	214	244
Anxiety	11.6%	69	65	65	74
Bipolar	8.0%	48	45	45	51
Dementia	0.6%	4	3	3	4
Drug	46.8%	279	261	263	300
Impulse Control	8.6%	51	48	48	55
Mood	22.7%	136	126	128	145
Psychotic	11.8%	70	66	66	76
Schizophrenia	12.7%	76	71	71	81
Sexual	1.7%	10	9	10	11
Other	7.7%	46	43	43	49
Axis II					
Personality	46.8%	279	261	263	300
Mental Retardation (MR)	1.4%	8	8	8	9
Other	2.3%	14	13	13	15
None	51.2%	306	285	288	328
Axis III					
Cerebral Palsy	0.0%	0	0	0	0
Epilepsy	0.2%	1	1	1	1
Fetal Alcohol Disorders	1.4%	8	8	8	9
Severe Organic Brain Impairment	0.6%	4	3	3	4
Traumatic Brain Injury	3.3%	20	18	19	21

Anvil Mountain Correctional Center

Facility Description: Anvil Mountain Correctional Center (AMCC) is a regional facility for sentenced and unsentenced adult felons and misdemeanants, both male and female, with an operating capacity of 126. It provides Nome and the surrounding region with pre-trial and short-term sentenced incarceration and offers a variety of education, life skills and Reentry programs. AMCC opened in November of 1985, replacing the old Territorial Jail located in the Federal Building.

Programs:

- Alaska Native-Based Substance Abuse Treatment (ANSAT)
- Alaska Reentry Course
- Criminal Attitudes Program (CAP)
- Parenting Classes
- Contracted Clinical Services
- Tele-psychiatry

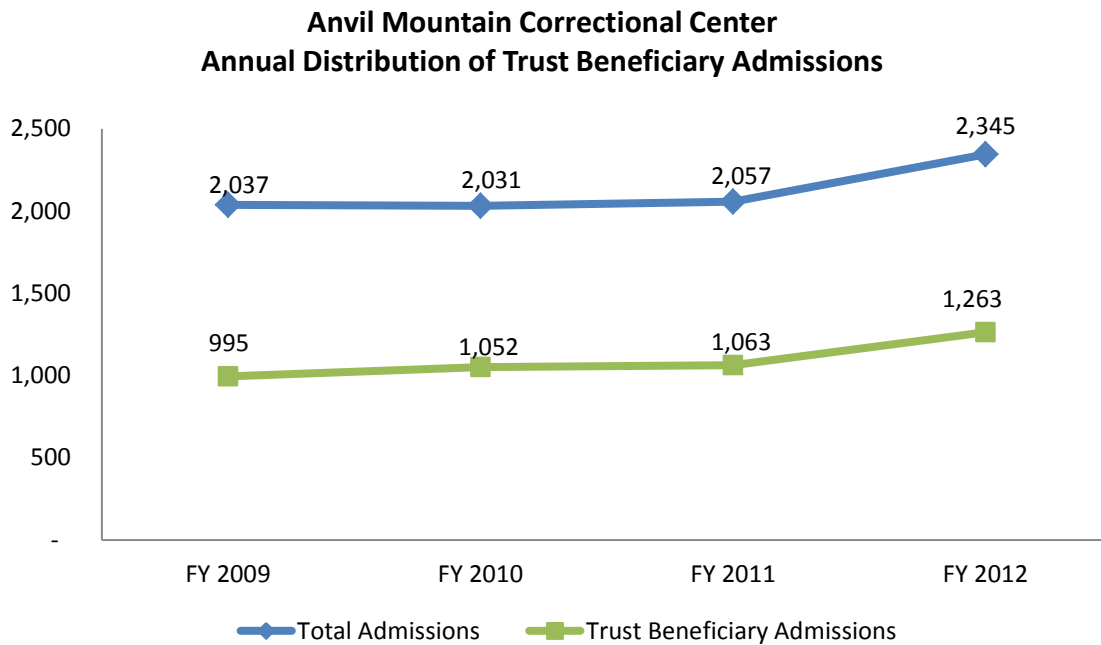


Table 1: Demographics of Anvil Mountain Correctional Center, SFY09–SFY12

	Trust Beneficiary		Non Trust Beneficiary		Total	
Gender	N	%	N	%	N	%
Male	843	75.3%	1,226	74.8%	2,069	75.0%
Female	277	24.7%	413	25.2%	690	25.0%
Total	1,120	100.0%	1,639	100.0%	2,759	100.0%
Race	N	%	N	%	N	%
White	31	2.8%	121	7.4%	152	5.5%
Black	10	0.9%	11	0.7%	21	0.8%
AK Native	1,071	95.6%	1,484	90.5%	2,555	92.6%
Hispanic	1	0.1%	3	0.2%	4	0.1%
Other	7	0.6%	20	1.2%	27	1.0%
Total	1,120	100.0%	1,639	100.0%	2,759	100.0%
Age Group	N	%	N	%	N	%
Under 21	242	21.9%	354	21.9%	596	21.9%
21-30	460	41.6%	524	32.5%	984	36.2%
31-40	213	19.2%	269	16.7%	482	17.7%
41-50	152	13.7%	303	18.8%	455	16.7%
Over 50	40	3.6%	163	10.1%	203	7.5%
Total	1,107	100.0%	1,613	100.0%	2,720	100.0%

**Table 2: Clinical Characteristics of Trust Beneficiaries,
Anvil Mountain Correctional Center, SFY09-SFY12**

Presenting Diagnoses	Total (n=476)	
	Number	Percent
Axis I		
Adjustment	113	23.7%
Alcohol	225	47.3%
Anxiety	57	12.0%
Bipolar	12	2.5%
Dementia	0	0.0%
Drug	177	37.2%
Impulse Control	42	8.8%
Mood	171	35.9%
Psychotic	68	14.3%
Schizophrenia	33	6.9%
Sexual	3	0.6%
Other	50	10.5%
Axis II		
Personality	105	22.1%
Mental Retardation (MR)	8	1.7%
Other	15	3.2%
None	356	74.8%
Axis III		
Cerebral Palsy	0	0.0%
Epilepsy	1	0.2%
Fetal Alcohol Disorders	13	2.7%
Severe Organic Brain Impairment	0	0.4%
Traumatic Brain Injury	11	2.3%

**Table 3: Extrapolation of Clinical Characteristics of Trust Beneficiaries Releases,
Anvil Mountain Correctional Center, SFY09-SFY12**

Presenting Diagnoses	Presenting Diagnoses	2009 Trust Beneficiary Releases (n=394)	2010 Trust Beneficiary Releases (n=409)	2011 Trust Beneficiary Releases (n=419)	2012 Trust Beneficiary Releases (n=490)
	Percent	Number	Number	Number	Number
Axis I					
Adjustment	23.7%	93	97	99	116
Alcohol	47.3%	186	193	198	232
Anxiety	12.0%	47	49	50	59
Bipolar	2.5%	10	10	10	12
Dementia	0.0%	0	0	0	0
Drug	37.2%	147	152	156	182
Impulse Control	8.8%	35	36	37	43
Mood	35.9%	141	147	150	176
Psychotic	14.3%	56	58	60	70
Schizophrenia	6.9%	27	28	29	34
Sexual	0.6%	2	2	3	3
Other	10.5%	41	43	44	51
Axis II					
Personality	22.1%	87	90	93	108
Mental Retardation (MR)	1.7%	7	7	7	8
Other	3.2%	13	13	13	16
None	74.8%	295	306	313	367
Axis III					
Cerebral Palsy	0.0%	0	0	0	0
Epilepsy	0.2%	1	1	1	1
Fetal Alcohol Disorders	2.7%	11	11	11	13
Severe Organic Brain Impairment	0.4%	2	2	2	2
Traumatic Brain Injury	2.3%	9	9	10	11

Fairbanks Correctional Center

Facility Description: With an operating capacity of 248, the Fairbanks Correctional Center is a close security institution serving as an intake facility for Northern Alaska and providing sentenced prisoner housing. The institution houses male and female, pre-trial and sentenced prisoners of all custody levels. Prisoners are provided an opportunity for reformation through a variety of programs including educational courses, substance abuse treatment and alternatives to violence instruction.

Programs:

- Anger Management
- Healthy Living
- On-site Clinical Services
- Tele-psychiatry
- Life Success Substance Abuse Treatment Services (LSSAT)
- Alaska Reentry Course
- Criminal Attitudes Program (CAP)
- Parenting Classes
- Batterer's Intervention Program

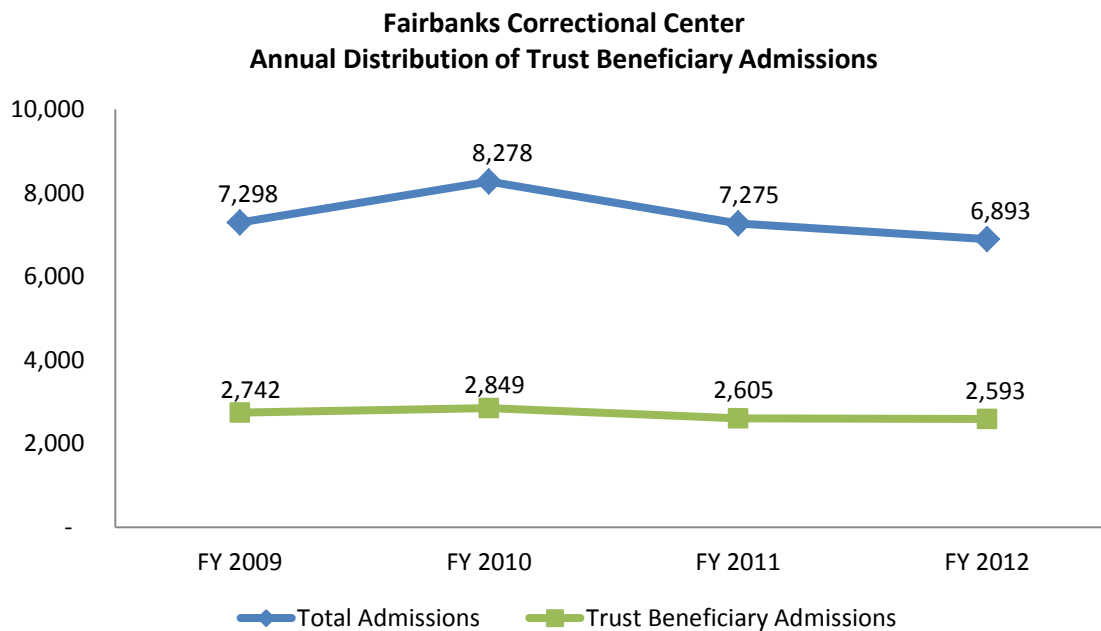


Table 1: Demographics of Fairbanks Correctional Center, SFY09–SFY12

	Trust Beneficiary		Non Trust Beneficiary		Total	
Gender	N	%	N	%	N	%
Male	1,738	69.6%	6,143	75.2%	7,881	73.9%
Female	758	30.4%	2,024	24.8%	2,782	26.1%
Total	2,496	100.0%	8,167	100.0%	10,663	100.0%
Race	N	%	N	%	N	%
White	1,201	48.1%	4,813	58.9%	6,014	56.4%
Black	178	7.1%	694	8.5%	872	8.2%
AK Native	1,046	41.9%	2,199	26.9%	3,245	30.4%
Hispanic	25	1.0%	237	2.9%	262	2.5%
Other	46	1.8%	224	2.7%	270	2.5%
Total	2,496	100.0%	8,167	100.0%	10,663	100.0%
Age Group	N	%	N	%	N	%
Under 21	441	17.8%	1,831	22.6%	2,272	21.5%
21-30	798	32.3%	2,878	35.6%	3,676	34.8%
31-40	528	21.4%	1,382	17.1%	1,910	18.1%
41-50	491	19.9%	1,246	15.4%	1,737	16.4%
Over 50	213	8.6%	757	9.4%	970	9.2%
Total	2,471	100.0%	8,094	100.0%	10,565	100.0%

Table 2: Clinical Characteristics of Trust Beneficiaries, Fairbanks Correctional Center, SFY09-SFY12

Presenting Diagnoses	Total (n=1,406)	
	Number	Percent
Axis I		
Adjustment	298	21.2%
Alcohol	540	38.4%
Anxiety	278	19.8%
Bipolar	129	9.2%
Dementia	7	0.5%
Drug	520	37.0%
Impulse Control	122	8.7%
Mood	477	33.9%
Psychotic	221	15.7%
Schizophrenia	98	7.0%
Sexual	20	1.4%
Other	127	9.0%
Axis II		
Personality	367	26.1%
Mental Retardation (MR)	11	0.8%
Other	62	4.4%
None	419	29.8%
Axis III		
Cerebral Palsy	0	0.0%
Epilepsy	10	0.7%
Fetal Alcohol Disorders	13	0.9%
Severe Organic Brain Impairment	18	1.3%
Traumatic Brain Injury	32	3.2%

Table 3: Extrapolation of Clinical Characteristics of Trust Beneficiaries Releases, Fairbanks Correctional Center, SFY09-SFY12

Presenting Diagnoses	Presenting Diagnoses	2009 Trust Beneficiary Releases (n=1,490)	2010 Trust Beneficiary Releases (n=1,462)	2011 Trust Beneficiary Releases (n=1,168)	2012 Trust Beneficiary Releases (n=1,238)
	Percent	Number	Number	Number	Number
Axis I					
Adjustment	21.2%	316	310	248	262
Alcohol	38.4%	572	561	449	475
Anxiety	19.8%	295	289	231	245
Bipolar	9.2%	137	135	107	114
Dementia	0.5%	7	7	6	6
Drug	37.0%	551	541	432	458
Impulse Control	8.7%	130	127	102	108
Mood	33.9%	505	496	396	420
Psychotic	15.7%	234	230	183	194
Schizophrenia	7.0%	104	102	82	87
Sexual	1.4%	21	20	16	17
Other	9.0%	134	132	105	111
Axis II					
Personality	26.1%	389	382	305	323
Mental Retardation (MR)	0.8%	12	12	9	10
Other	4.4%	66	64	51	54
None	29.8%	444	436	348	369
Axis III					
Cerebral Palsy	0.0%	0	0	0	0
Epilepsy	0.7%	10	10	8	9
Fetal Alcohol Disorders	0.9%	13	13	11	11
Severe Organic Brain Impairment	1.3%	19	19	15	16
Traumatic Brain Injury	3.2%	48	47	37	40

Hiland Mountain Correctional Center

Facility Description: The Hiland Mountain Correctional Center is the State of Alaska's dedicated facility for housing female prisoners. It is a multi-level adult correctional facility located in Eagle River, Alaska. The institution includes 11 buildings, containing approximately 120,000 square feet of space. It sits on approximately 62.7 acres of land adjacent to Eagle River, Alaska. It has the capacity for approximately 400 prisoners. Hiland houses the only acute mental health unit in the state for women.

Programs:

- 18-Bed Acute Psychiatric Unit
- 20-Bed Sub-Acute Psychiatric Unit
- Anger Management
- Healthy Living
- Thinking Errors
- 48 Week Offender Program
- On-site Clinical Services
- On-site Psychiatric Services
- On-site Dual Diagnosis Clinical Services
- Residential Substance Abuse Treatment Services
- Residential Sex Offender Treatment
- Reentry-DOLWD Workplace & Community Transition Program
- Alaska Reentry Course
- Criminal Attitudes Program (CAP)
- Parenting Classes
- Transformational Living Community (TLC)

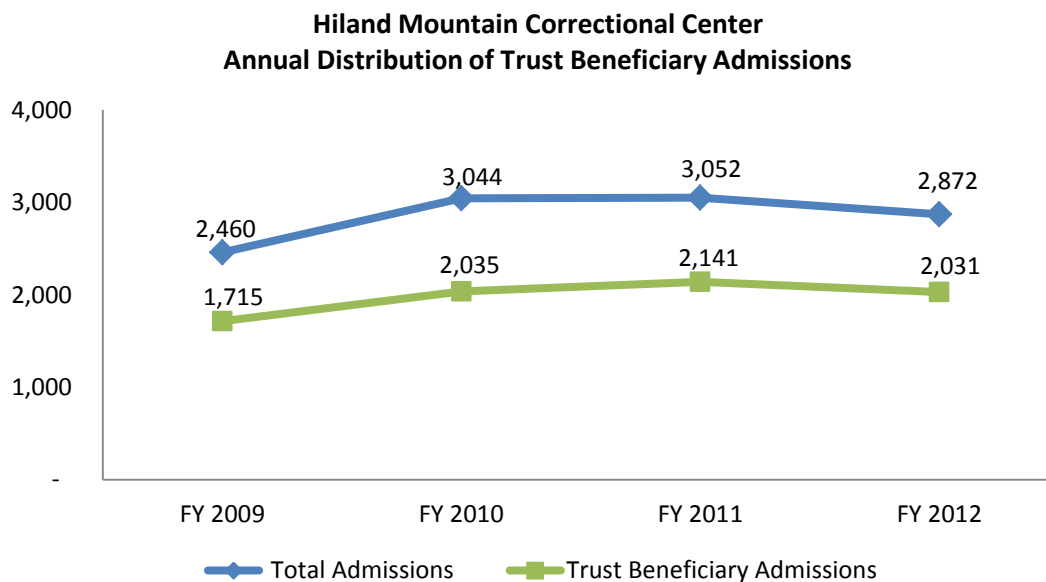


Table 1: Demographics of Hiland Mountain Correctional Center, SFY09–SFY12

	Trust Beneficiary		Non Trust Beneficiary		Total	
Gender	N	%	N	%	N	%
Male	1	0.0%	4	0.2%	5	0.1%
Female	2,792	100.0%	1,907	99.8%	4,699	99.9%
Total	2,793	100.0%	1,911	100.0%	4,704	100.0%
Race	N	%	N	%	N	%
White	1,415	50.7%	929	48.6%	2,344	49.8%
Black	179	6.4%	142	7.4%	321	6.8%
AK Native	1,095	39.2%	653	34.2%	1,748	37.2%
Hispanic	44	1.6%	57	3.0%	101	2.1%
Other	60	2.1%	130	6.8%	190	4.0%
Total	2,793	100.0%	1,911	100.0%	4,704	100.0%
Age Group	N	%	N	%	N	%
Under 21	413	15.3%	375	20.1%	788	17.3%
21-30	940	34.9%	699	37.5%	1,639	36.0%
31-40	658	24.4%	358	19.2%	1,016	22.3%
41-50	537	19.9%	333	17.9%	870	19.1%
Over 50	147	5.5%	99	5.3%	246	5.4%
Total	2,695	100.0%	1,864	100.0%	4,559	100.0%

**Table 2: Clinical Characteristics of Trust Beneficiaries,
Hiland Mountain Correctional Center, SFY09-SFY12**

Presenting Diagnoses	Total (n=1,922)	
	Number	Percent
Axis I		
Adjustment	400	20.8%
Alcohol	814	42.4%
Anxiety	517	26.9%
Bipolar	228	11.9%
Dementia	11	0.6%
Drug	965	50.2%
Impulse Control	102	5.3%
Mood	790	41.1%
Psychotic	263	13.7%
Schizophrenia	136	7.1%
Sexual	16	0.8%
Other	198	10.3%
Axis II		
Personality	574	29.9%
Mental Retardation (MR)	22	1.1%
Other	71	3.7%
None	1,291	67.2%
Axis III		
Cerebral Palsy	0	0.0%
Epilepsy	5	0.3%
Fetal Alcohol Disorders	20	1.0%
Severe Organic Brain Impairment	15	0.8%
Traumatic Brain Injury	32	1.7%

**Table 3: Extrapolation of Clinical Characteristics of Trust Beneficiaries Releases,
Hiland Mountain Correctional Center, SFY09-SFY12**

Presenting Diagnoses	Presenting Diagnoses	2009 Trust Beneficiary Releases (n=1,339)	2010 Trust Beneficiary Releases (n=1,361)	2011 Trust Beneficiary Releases (n=1,320)	2012 Trust Beneficiary Releases (n=1,362)
	Percent	Number	Number	Number	Number
Axis I					
Adjustment	20.8%	279	283	275	283
Alcohol	42.4%	568	577	560	577
Anxiety	26.9%	360	366	355	366
Bipolar	11.9%	159	162	157	162
Dementia	0.6%	8	8	8	8
Drug	50.2%	672	683	663	684
Impulse Control	5.3%	71	72	70	72
Mood	41.1%	550	559	543	560
Psychotic	13.7%	183	186	181	187
Schizophrenia	7.1%	95	97	94	97
Sexual	0.8%	11	11	11	11
Other	10.3%	138	140	136	140
Axis II					
Personality	29.9%	400	407	395	407
Mental Retardation (MR)	1.1%	15	15	15	15
Other	3.7%	50	50	49	50
None	67.2%	900	915	887	915
Axis III					
Cerebral Palsy	0.0%	0	0	0	0
Epilepsy	0.3%	4	4	4	4
Fetal Alcohol Disorders	1.0%	13	14	13	14
Severe Organic Brain Impairment	0.8%	11	11	11	11
Traumatic Brain Injury	1.7%	23	23	22	23

Ketchikan Correctional Center

Facility Description: Ketchikan Correctional Center, located in Ketchikan, Alaska, a community of approximately 9,000 people, serves southern Southeast Alaska from Craig and Klawock on Prince of Wales Island to Hyder on the mainland and Petersburg and Wrangell south to Dixon Entrance. It is a 58-bed prison institution with a jail component and functions primarily as a pre-trial facility. The Education Department is comprised of a classroom/library, computer lab with six IBM-compatible computers, a small conference room for tutoring, testing, and small group studies, and an office for the Coordinator with storage for educational materials.

Programs:

- Alaska Reentry Course
- Criminal Attitudes Program (CAP)
- Parenting Classes
- Contracted Clinical Services
- Tele-psychiatry

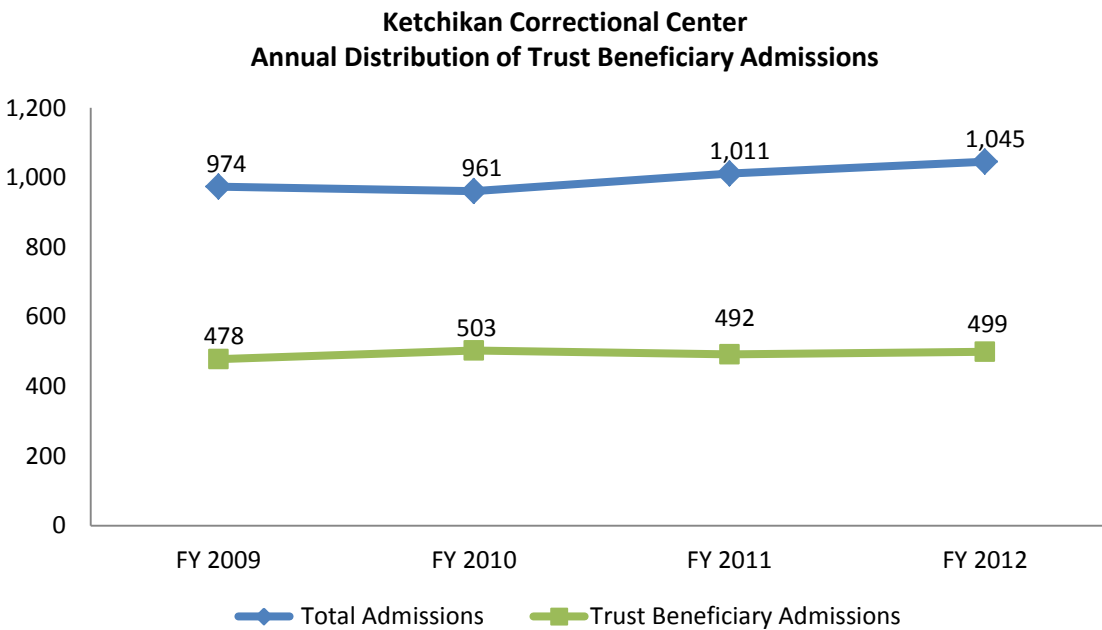


Table 1: Demographics of Ketchikan Correctional Center, SFY09–SFY12

	Trust Beneficiary		Non Trust Beneficiary		Total	
	N	%	N	%	N	%
Gender						
Male	433	69.2%	864	79.9%	1,297	75.9%
Female	193	30.8%	218	20.1%	411	24.1%
Total	626	100.0%	1,082	100.0%	1,708	100.0%
Race						
White	335	53.5%	648	59.9%	983	57.6%
Black	15	2.4%	26	2.4%	41	2.4%
AK Native	258	41.2%	321	29.7%	579	33.9%
Hispanic	7	1.1%	38	3.5%	45	2.6%
Other	11	1.8%	49	4.5%	60	3.5%
Total	626	100.0%	1,082	100.0%	1,708	100.0%
Age Group						
Under 21	129	20.9%	196	18.2%	325	19.2%
21-30	211	34.1%	333	30.9%	544	32.1%
31-40	142	23.0%	210	19.5%	352	20.8%
41-50	107	17.3%	224	20.8%	331	19.5%
Over 50	29	4.7%	115	10.7%	144	8.5%
Total	618	100.0%	1,078	100.0%	1,696	100.0%

**Table 2: Clinical Characteristics of Trust Beneficiaries,
Ketchikan Correctional Center, SFY09-SFY12**

Presenting Diagnoses	Total (n=328)	
	Number	Percent
Axis I		
Adjustment	89	27.1%
Alcohol	122	37.2%
Anxiety	85	25.9%
Bipolar	37	11.3%
Dementia	1	0.3%
Drug	151	46.0%
Impulse Control	32	9.8%
Mood	133	40.5%
Psychotic	54	16.5%
Schizophrenia	36	11.0%
Sexual	1	0.3%
Other	52	15.9%
Axis II		
Personality	78	23.8%
Mental Retardation (MR)	3	0.9%
Other	32	9.8%
None	229	69.8%
Axis III		
Cerebral Palsy	0	0.0%
Epilepsy	2	0.6%
Fetal Alcohol Disorders	4	1.2%
Severe Organic Brain Impairment	3	0.9%
Traumatic Brain Injury	5	1.5%

**Table 3: Extrapolation of Clinical Characteristics of Trust Beneficiaries Releases,
Ketchikan Correctional Center, SFY09-SFY12**

Presenting Diagnoses	Presenting Diagnoses	2009 Trust Beneficiary Releases (n=279)	2010 Trust Beneficiary Releases (n=308)	2011 Trust Beneficiary Releases (n=288)	2012 Trust Beneficiary Releases (n=275)
	Percent	Number	Number	Number	Number
Axis I					
Adjustment	27.1%	76	83	78	75
Alcohol	37.2%	104	115	107	102
Anxiety	25.9%	72	80	75	71
Bipolar	11.3%	32	35	33	31
Dementia	0.3%	1	1	1	1
Drug	46.0%	128	142	132	127
Impulse Control	9.8%	27	30	28	27
Mood	40.5%	113	125	117	111
Psychotic	16.5%	46	51	48	45
Schizophrenia	11.0%	31	34	32	30
Sexual	0.3%	1	1	1	1
Other	15.9%	44	49	46	44
Axis II					
Personality	23.8%	66	73	69	65
Mental Retardation (MR)	0.9%	3	3	3	2
Other	9.8%	27	30	28	27
None	69.8%	195	215	201	192
Axis III					
Cerebral Palsy	0.0%	0	0	0	0
Epilepsy	0.6%	2	2	2	2
Fetal Alcohol Disorders	1.2%	3	4	3	3
Severe Organic Brain Impairment	0.9%	3	3	3	2
Traumatic Brain Injury	1.5%	4	5	4	4

Lemon Creek Correctional Center

Facility Description: The Lemon Creek Correctional Center is a multi-function, state operated adult correctional institution located in Juneau, Alaska. The institution has a capacity of 222 male and female inmates and employs 80 staff. Lemon Creek Correctional Center serves both as an intake and a long-term male facility. At any given time, 20% to 30% of the population is composed of inmates in pre-trial status. Approximately 80% of the population is composed of sentenced felons.

Programs:

- Anger Management
- Healthy Living
- 48-Week Offender Program
- On-site Clinical Services
- Tele-psychiatry
- Life Success Substance Abuse Treatment (LSSAT)
- Residential Sex Offender Treatment
- Alaska Reentry Course
- Criminal Attitudes Program (CAP)
- Parenting Classes
- Batterer's Intervention Program

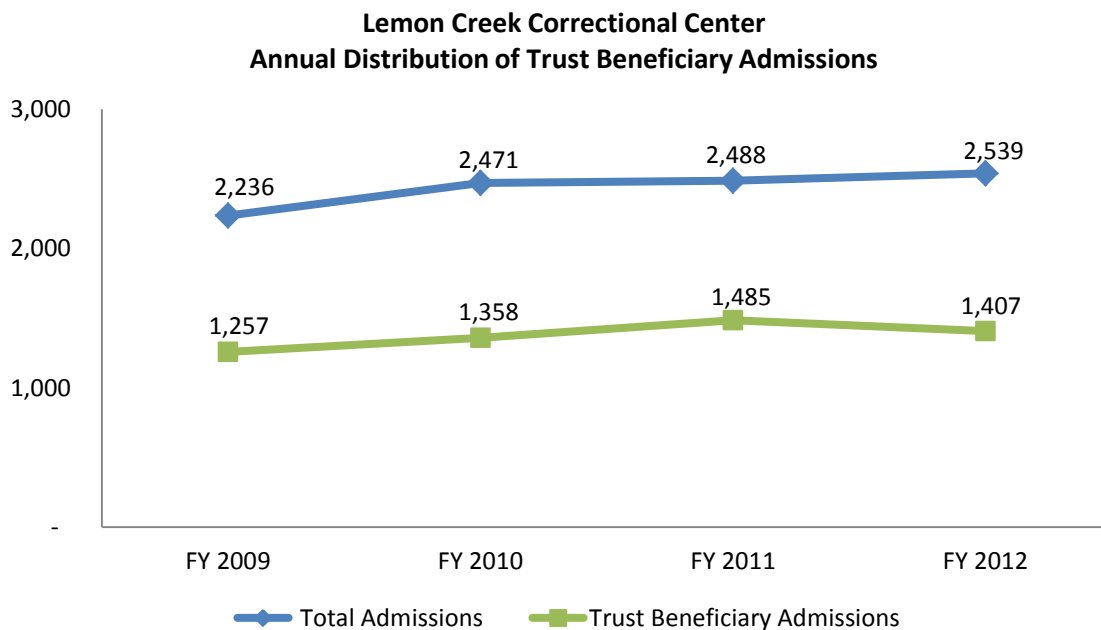


Table 1: Demographics of Lemon Creek Correctional Center, SFY09–SFY12

	Trust Beneficiary		Non Trust Beneficiary		Total	
Gender	N	%	N	%	N	%
Male	1,222	73.8%	1,581	78.7%	2,803	76.5%
Female	434	26.2%	429	21.3%	863	23.5%
Total	1,656	100.0%	2,010	100.0%	3,666	100.0%
Race	N	%	N	%	N	%
White	867	52.4%	1,094	54.4%	1,961	53.5%
Black	60	3.6%	72	3.6%	132	3.6%
AK Native	674	40.7%	639	31.8%	1,313	35.8%
Hispanic	28	1.7%	102	5.1%	130	3.5%
Other	27	1.6%	103	5.1%	130	3.5%
Total	1,656	100.0%	2,010	100.0%	3,666	100.0%
Age Group	N	%	N	%	N	%
Under 21	260	16.0%	372	18.7%	632	17.5%
21-30	524	32.2%	697	35.1%	1,221	33.8%
31-40	365	22.4%	431	21.7%	796	22.0%
41-50	336	20.7%	318	16.0%	654	18.1%
Over 50	142	8.7%	168	8.5%	310	8.6%
Total	1,627	100.0%	1,986	100.0%	3,613	100.0%

Table 2: Clinical Characteristics of Trust Beneficiaries, Lemon Creek Correctional Center, SFY09–SFY12

Presenting Diagnoses	Total (n=1,061)	
	Number	Percent
Axis I		
Adjustment	197	18.6%
Alcohol	445	41.9%
Anxiety	241	22.7%
Bipolar	93	8.8%
Dementia	7	0.7%
Drug	456	43.0%
Impulse Control	68	6.4%
Mood	406	38.3%
Psychotic	122	11.5%
Schizophrenia	89	8.4%
Sexual	3	0.3%
Other	80	7.5%
Axis II		
Personality	260	24.5%
Mental Retardation (MR)	8	0.8%
Other	43	4.1%
None	765	72.1%
Axis III		
Cerebral Palsy	0	0.0%
Epilepsy	5	0.5%
Fetal Alcohol Disorders	14	1.3%
Severe Organic Brain Impairment	9	0.8%
Traumatic Brain Injury	21	2.0%

**Table 3: Extrapolation of Clinical Characteristics of Trust Beneficiaries Releases,
Lemon Creek Correctional Center, SFY09–SFY12**

Presenting Diagnoses	Presenting Diagnoses	2009 Trust Beneficiary Releases (n=657)	2010 Trust Beneficiary Releases (n=688)	2011 Trust Beneficiary Releases (n=605)	2012 Trust Beneficiary Releases (n=602)
	Percent	Number	Number	Number	Number
Axis I					
Adjustment	18.6%	122	128	113	112
Alcohol	41.9%	275	288	253	252
Anxiety	22.7%	149	156	137	137
Bipolar	8.8%	58	61	53	53
Dementia	0.7%	5	5	4	4
Drug	43.0%	283	296	260	259
Impulse Control	6.4%	42	44	39	39
Mood	38.3%	252	264	232	231
Psychotic	11.5%	76	79	70	69
Schizophrenia	8.4%	55	58	51	51
Sexual	0.3%	2	2	2	2
Other	7.5%	49	52	45	45
Axis II					
Personality	24.5%	161	169	148	147
Mental Retardation (MR)	0.8%	5	6	5	5
Other	4.1%	27	28	25	25
None	72.1%	474	496	436	434
Axis III					
Cerebral Palsy	0.0%	0	0	0	0
Epilepsy	0.5%	3	3	3	3
Fetal Alcohol Disorders	1.3%	9	9	8	8
Severe Organic Brain Impairment	0.8%	5	6	5	5
Traumatic Brain Injury	2.0%	13	14	12	12

Mat-Su Pretrial Facility

Facility Description: Located in Palmer, the Mat-Su Pretrial Facility has 98 beds and serves a highly transitory, short-term population of inmates, accommodating both male and female pretrial, as well as sentences felons and misdemeanants who are awaiting transfer to other facilities or correctional programs.

Programs:

- Substance Abuse Assessment and Referral Services
- Anger Management
- Healthy Living
- On-site Clinical Services
- On-site Psychiatric Services
- Alaska Reentry Course
- Criminal Attitudes Program (CAP)
- Parenting Classes
- Choosing Change

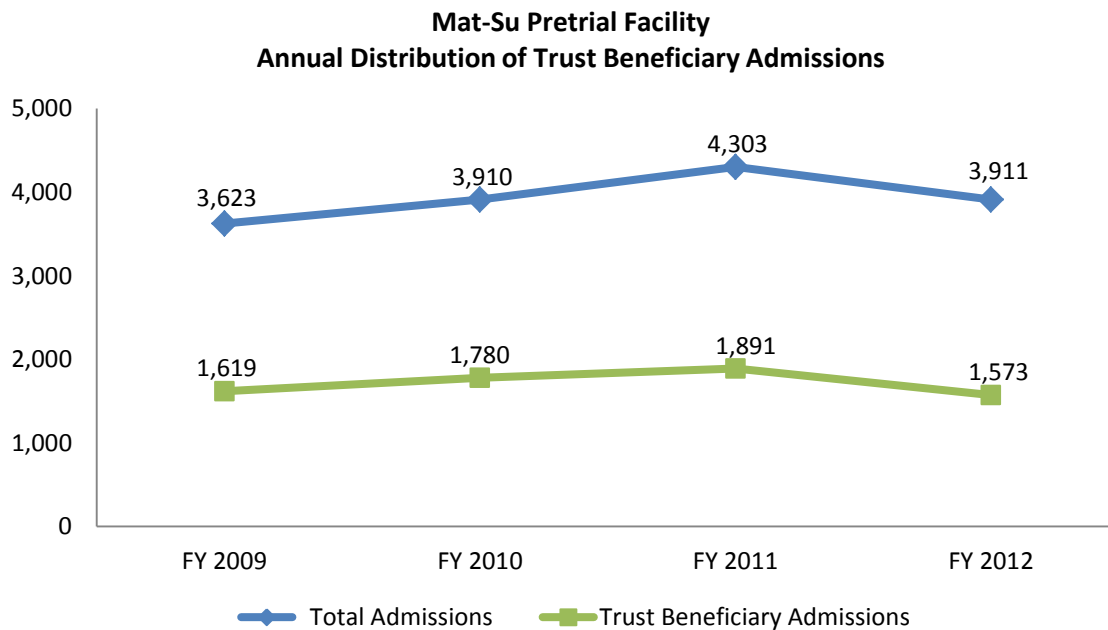


Table 1: Demographics of Mat-Su Pretrial Facility, SFY09–SFY12

	Trust Beneficiary		Non Trust Beneficiary		Total	
Gender	N	%	N	%	N	%
Male	1,647	65.9%	4,056	78.8%	5,703	74.6%
Female	853	34.1%	1,091	21.2%	1,944	25.4%
Total	2,500	100.0%	5,147	100.0%	7,647	100.0%
Race	N	%	N	%	N	%
White	1,913	76.5%	4,244	82.5%	6,157	80.5%
Black	74	3.0%	151	2.9%	225	2.9%
AK Native	448	17.9%	539	10.5%	987	12.9%
Hispanic	27	1.1%	83	1.6%	110	1.4%
Other	38	1.5%	130	2.5%	168	2.2%
Total	2,500	100.0%	5,147	100.0%	7,647	100.0%
Age Group	N	%	N	%	N	%
Under 21	419	12.6%	1,003	23.7%	1,422	18.8%
21-30	1,724	52.0%	869	20.5%	2,593	34.3%
31-40	567	17.1%	984	23.2%	1,551	20.5%
41-50	453	13.7%	944	22.3%	1,397	18.5%
Over 50	155	4.7%	438	10.3%	593	7.8%
Total	3,318	100.0%	4,238	100.0%	7,556	100.0%

**Table 2: Clinical Characteristics of Trust Beneficiaries,
Mat-Su Pretrial Facility, SFY09-SFY12**

Presenting Diagnoses	Total (n=1,640)	
	Number	Percent
Axis I		
Adjustment	285	17.4%
Alcohol	605	36.9%
Anxiety	353	21.5%
Bipolar	163	9.9%
Dementia	6	0.4%
Drug	727	44.3%
Impulse Control	133	8.1%
Mood	527	32.1%
Psychotic	196	12.0%
Schizophrenia	92	5.6%
Sexual	10	0.6%
Other	149	9.1%
Axis II		
Personality	548	33.4%
Mental Retardation (MR)	19	1.2%
Other	81	4.9%
None	1,026	62.6%
Axis III		
Cerebral Palsy	0	0.0%
Epilepsy	5	0.3%
Fetal Alcohol Disorders	15	0.9%
Severe Organic Brain Impairment	14	0.9%
Traumatic Brain Injury	47	2.9%

**Table 3: Extrapolation of Clinical Characteristics of Trust Beneficiaries Releases,
Mat-Su Pretrial Facility, SFY09–SFY12**

Presenting Diagnoses	Presenting Diagnoses	2009 Trust Beneficiary Releases (n=517)	2010 Trust Beneficiary Releases (n=541)	2011 Trust Beneficiary Releases (n=482)	2012 Trust Beneficiary Releases (n=459)
	Percent	Number	Number	Number	Number
Axis I					
Adjustment	17.4%	90	94	84	80
Alcohol	36.9%	191	200	178	169
Anxiety	21.5%	111	116	104	99
Bipolar	9.9%	51	54	48	45
Dementia	0.4%	2	2	2	2
Drug	44.3%	229	240	214	203
Impulse Control	8.1%	42	44	39	37
Mood	32.1%	166	174	155	147
Psychotic	12.0%	62	65	58	55
Schizophrenia	5.6%	29	30	27	26
Sexual	0.6%	3	3	3	3
Other	9.1%	47	49	44	42
Axis II					
Personality	33.4%	173	181	161	153
Mental Retardation (MR)	1.2%	6	6	6	6
Other	4.9%	25	27	24	22
None	62.6%	324	339	302	287
Axis III					
Cerebral Palsy	0.0%	0	0	0	0
Epilepsy	0.3%	2	2	1	1
Fetal Alcohol Disorders	0.9%	5	5	4	4
Severe Organic Brain Impairment	0.9%	5	5	4	4
Traumatic Brain Injury	2.9%	15	16	14	13

Palmer Correctional Center

Facility Description: Palmer Correctional Center has minimum and medium custody facilities with a combined operating capacity of approximately 400 inmates and serves only male felons and misdemeanants in sentenced status.

Programs:

- 30-Bed Sub-Acute Psychiatric Unit
- Anger Management
- Healthy Living
- 48-Week Offender Program
- On-site Clinical Services
- On-site Psychiatric Services
- Life Success Substance Abuse Treatment (LSSAT)
- Alaska Reentry Course
- Criminal Attitudes Program (CAP)
- Parenting Classes
- Transformational Living Community (TLC)
- Batterer's Intervention Program

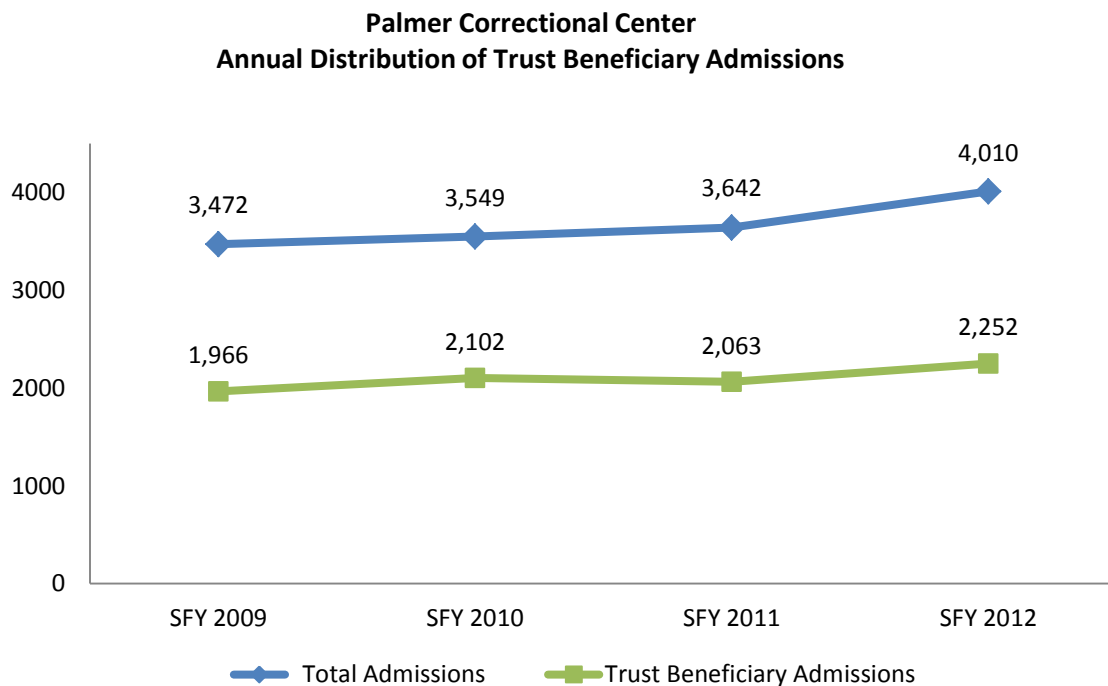


Table 1: Demographics of Palmer Correctional Center, SFY09–SFY12

	Trust Beneficiary		Non Trust Beneficiary		Total	
Gender	N	%	N	%	N	%
Male	4,525	100.0%	3,864	100.0%	8,389	100.0%
Female	0	0.0%	1	0.0%	1	0.0%
Total	4,525	100.0%	3,865	100.0%	8,390	100.0%
Race	N	%	N	%	N	%
White	2,251	49.8%	1,946	50.4%	4,197	50.0%
Black	352	7.8%	408	10.6%	760	9.1%
AK Native	1,746	38.6%	1,196	30.9%	2,942	35.1%
Hispanic	87	1.9%	104	2.7%	191	2.3%
Other	89	2.0%	211	5.5%	300	3.6%
Total	4,525	100.0%	3,865	100.0%	8,390	100.0%
Age Group	N	%	N	%	N	%
Under 21	521	11.6%	492	12.8%	1,013	12.2%
21-30	1,622	36.1%	1,440	37.5%	3,062	36.8%
31-40	1,129	25.1%	818	21.3%	1,947	23.4%
41-50	878	19.6%	776	20.2%	1,654	19.9%
Over 50	342	7.6%	310	8.1%	652	7.8%
Total	4,492	100.0%	3,836	100.0%	8,328	100.0%

**Table 2: Clinical Characteristics of Trust Beneficiaries,
Palmer Correctional Center, SFY09-SFY12**

Presenting Diagnoses	Total (n=2,568)	
	Number	Percent
Axis I		
Adjustment	405	15.8%
Alcohol	1,116	43.5%
Anxiety	260	10.1%
Bipolar	136	5.3%
Dementia	8	0.3%
Drug	1,145	44.6%
Impulse Control	194	7.6%
Mood	646	25.2%
Psychotic	201	7.8%
Schizophrenia	165	6.4%
Sexual	46	1.8%
Other	166	6.5%
Axis II		
Personality	1,161	47.2%
Mental Retardation (MR)	24	0.9%
Other	56	2.2%
None	1,260	49.1%
Axis III		
Cerebral Palsy	0	0.0%
Epilepsy	2	0.1%
Fetal Alcohol Disorders	23	0.9%
Severe Organic Brain Impairment	9	0.4%
Traumatic Brain Injury	93	3.6%

Table 3: Extrapolation of Clinical Characteristics of Trust Beneficiaries Releases, Palmer Correctional Center, SFY09-SFY12

Presenting Diagnoses	Presenting Diagnoses	2009 Trust Beneficiary Releases	2010 Trust Beneficiary Releases	2011 Trust Beneficiary Releases	2012 Trust Beneficiary Releases
		(n=603)	(n=584)	(n=697)	(n=655)
	Percent	Number	Number	Number	Number
Axis I					
Adjustment	15.8%	95	92	110	103
Alcohol	43.5%	262	254	303	285
Anxiety	10.1%	61	59	70	66
Bipolar	5.3%	32	31	37	35
Dementia	0.3%	2	2	2	2
Drug	44.6%	269	260	311	292
Impulse Control	7.6%	46	44	53	50
Mood	25.2%	152	147	176	165
Psychotic	7.8%	47	46	54	51
Schizophrenia	6.4%	39	37	45	42
Sexual	1.8%	11	11	13	12
Other	6.5%	39	38	45	43
Axis II					
Personality	47.2%	285	276	329	309
Mental Retardation (MR)	0.9%	5	5	6	6
Other	2.2%	13	13	15	14
None	49.1%	296	287	342	322
Axis III					
Cerebral Palsy	0.0%	0	0	0	0
Epilepsy	0.1%	1	1	1	1
Fetal Alcohol Disorders	0.9%	5	5	6	6
Severe Organic Brain Impairment	0.4%	2	2	3	3
Traumatic Brain Injury	3.6%	22	21	25	24

Point Mackenzie Correctional Farm

Facility Description: The Point MacKenzie Rehabilitation Program began operation in 1993. Located in Wasilla, the Point McKenzie Correctional Farm (PMCF) is a non-traditional minimum security, minimum custody facility with an operating capacity of 112 males in sentenced status. The PMCF's primary mission is to provide a transition between traditional correctional centers and the community for the offender. The PMCF strives to complement this transition by engaging inmates in industrial, agricultural, service and technological-oriented enterprises which can provide more meaningful employment opportunities upon release.

Programs:

- Alaska Reentry Course
- Criminal Attitudes Program (CAP)
- Parenting Classes
- Batterer's Intervention Program

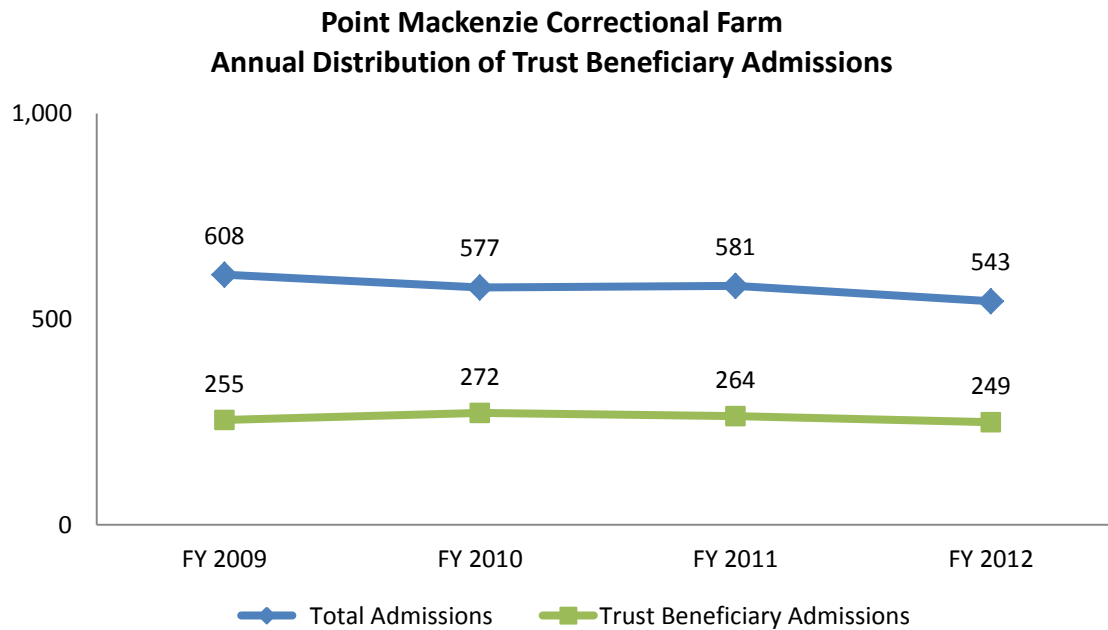


Table 1: Demographics of Point Mackenzie Correctional Farm, SFY09–SFY12

	Trust Beneficiary		Non Trust Beneficiary		Total	
Gender	N	%	N	%	N	%
Male	733	100.0%	867	100.0%	1,600	100.0%
Female	0	0.0%	0	0.0%	0	0.0%
Total	733	100.0%	867	100.0%	1,600	100.0%
Race	N	%	N	%	N	%
White	368	50.2%	463	53.4%	831	51.9%
Black	53	7.2%	105	12.1%	158	9.9%
AK Native	275	37.5%	223	25.7%	498	31.1%
Hispanic	16	2.2%	26	3.0%	42	2.6%
Other	21	2.9%	50	5.8%	71	4.4%
Total	733	100.0%	867	100.0%	1,600	100.0%
Age Group	N	%	N	%	N	%
Under 21	93	12.8%	138	16.0%	231	14.5%
21-30	309	42.6%	338	39.2%	647	40.7%
31-40	167	23.0%	192	22.3%	359	22.6%
41-50	133	18.3%	147	17.1%	280	17.6%
Over 50	24	3.3%	47	5.5%	71	4.5%
Total	726	100.0%	862	100.0%	1,588	100.0%

**Table 2: Clinical Characteristics of Trust Beneficiaries,
Point Mackenzie Correctional Farm, SFY09-SFY12**

Presenting Diagnoses	Total (n=358)	
	Number	Percent
Axis I		
Adjustment	54	15.1%
Alcohol	164	45.8%
Anxiety	31	8.7%
Bipolar	13	3.6%
Dementia	0	0.0%
Drug	163	45.5%
Impulse Control	26	7.3%
Mood	75	20.9%
Psychotic	16	4.5%
Schizophrenia	7	2.0%
Sexual	9	2.5%
Other	30	8.4%
Axis II		
Personality	150	41.9%
Mental Retardation (MR)	3	0.8%
Other	6	1.7%
None	202	56.4%
Axis III		
Cerebral Palsy	0	0.0%
Epilepsy	0	0.0%
Fetal Alcohol Disorders	1	0.3%
Severe Organic Brain Impairment	0	0.0%
Traumatic Brain Injury	8	2.2%

**Table 3: Extrapolation of Clinical Characteristics of Trust Beneficiaries Releases,
Point Mackenzie Correctional Farm, SFY09-SFY12**

Presenting Diagnoses	Presenting Diagnoses	2009 Trust Beneficiary Releases (n=81)	2010 Trust Beneficiary Releases (n=66)	2011 Trust Beneficiary Releases (n=84)	2012 Trust Beneficiary Releases (n=87)
	Percent	Number	Number	Number	Number
Axis I					
Adjustment	15.1%	12	10	13	13
Alcohol	45.8%	37	30	38	40
Anxiety	8.7%	7	6	7	8
Bipolar	3.6%	3	2	3	3
Dementia	0.0%	0	0	0	0
Drug	45.5%	37	30	38	40
Impulse Control	7.3%	6	5	6	6
Mood	20.9%	17	14	18	18
Psychotic	4.5%	4	3	4	4
Schizophrenia	2.0%	2	1	2	2
Sexual	2.5%	2	2	2	2
Other	8.4%	7	6	7	7
Axis II					
Personality	41.9%	34	28	35	36
Mental Retardation (MR)	0.8%	1	1	1	1
Other	1.7%	1	1	1	1
None	56.4%	46	37	47	49
Axis III					
Cerebral Palsy	0.0%	0	0	0	0
Epilepsy	0.0%	0	0	0	0
Fetal Alcohol Disorders	0.3%	0	0	0	0
Severe Organic Brain Impairment	0.0%	0	0	0	0
Traumatic Brain Injury	2.2%	2	1	2	2

Spring Creek Correctional Center

Facility Description: Spring Creek Correctional Center is a maximum security, state operated adult correctional institution located in Seward, Alaska. The institution has a capacity of over 500 male inmates and employs more than 200 staff. While much of Spring Creek’s inmate population serve long term sentences, the institution also houses prisoners serving sentences from three to ten years. Rehabilitative programs include ABE/GED, parenting, cognitive skills, anger management, substance abuse, and prerelease programs.

Programs:

- 60-Bed Sub-Acute Psychiatric Unit
- Anger Management
- Healthy Living
- 48-Week Offender Program
- On-site Clinical Services
- Tele-psychiatry
- On-Site Dual Diagnosis Psycho-education
- Victim Impact Classes
- Life Success Substance Abuse Treatment (LSSAT)
- Alaska Reentry Course
- Criminal Attitudes Program (CAP)
- Parenting Classes

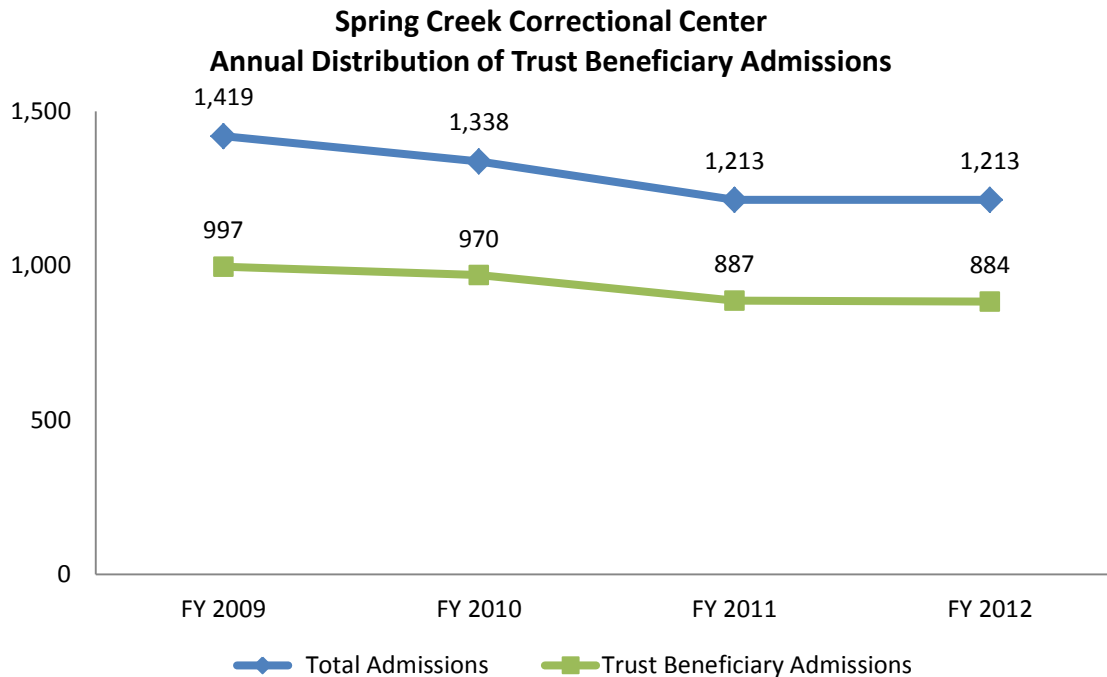


Table 1: Demographics of Spring Creek Correctional Center, SFY09–SFY12

	Trust Beneficiary		Non Trust Beneficiary		Total	
Gender	N	%	N	%	N	%
Male	1,723	100.0%	729	100.0%	2,452	100.0%
Female	0	0.0%	0	0.0%	0	0.0%
Total	1,723	100.0%	729	100.0%	2,452	100.0%
Race	N	%	N	%	N	%
White	809	47.0%	276	37.9%	1,085	44.2%
Black	196	11.4%	124	17.0%	320	13.1%
AK Native	627	36.4%	241	33.1%	868	35.4%
Hispanic	39	2.3%	25	3.4%	64	2.6%
Other	52	3.0%	63	8.6%	115	4.7%
Total	1,723	100.0%	729	100.0%	2,452	100.0%
Age Group	N	%	N	%	N	%
Under 21	172	10.1%	100	13.9%	272	11.2%
21-30	679	39.7%	258	35.8%	937	38.6%
31-40	394	23.1%	130	18.1%	524	21.6%
41-50	342	20.0%	154	21.4%	496	20.4%
Over 50	122	7.1%	78	10.8%	200	8.2%
Total	1,709	100.0%	720	100.0%	2,429	100.0%

**Table 2: Clinical Characteristics of Trust Beneficiaries,
Spring Creek Correctional Center, SFY09-SFY12**

Presenting Diagnoses	Total (n=876)	
	Number	Percent
Axis I		
Adjustment	153	17.5%
Alcohol	277	31.6%
Anxiety	76	8.7%
Bipolar	47	5.4%
Dementia	1	0.1%
Drug	428	48.9%
Impulse Control	66	7.5%
Mood	196	22.4%
Psychotic	58	6.6%
Schizophrenia	65	7.4%
Sexual	9	1.0%
Other	60	6.8%
Axis II		
Personality	453	51.7%
Mental Retardation (MR)	11	1.3%
Other	13	1.5%
None	412	47.0%
Axis III		
Cerebral Palsy	0	0.0%
Epilepsy	0	0.0%
Fetal Alcohol Disorders	12	1.4%
Severe Organic Brain Impairment	0	0.0%
Traumatic Brain Injury	31	3.5%

**Table 3: Extrapolation of Clinical Characteristics of Trust Beneficiaries Releases,
Spring Creek Correctional Center, SFY09-SFY12**

Presenting Diagnoses	Presenting Diagnoses	2009 Trust Beneficiary Releases (n=147)	2010 Trust Beneficiary Releases (n=107)	2011 Trust Beneficiary Releases (n=105)	2012 Trust Beneficiary Releases (n=127)
	Percent	Number	Number	Number	Number
Axis I					
Adjustment	17.5%	26	19	18	22
Alcohol	31.6%	46	34	33	40
Anxiety	8.7%	13	9	9	11
Bipolar	5.4%	8	6	6	7
Dementia	0.1%	0	0	0	0
Drug	48.9%	72	52	51	62
Impulse Control	7.5%	11	8	8	10
Mood	22.4%	33	24	24	28
Psychotic	6.6%	10	7	7	8
Schizophrenia	7.4%	11	8	8	9
Sexual	1.0%	1	1	1	1
Other	6.8%	10	7	7	9
Axis II					
Personality	51.7%	76	55	54	66
Mental Retardation (MR)	1.3%	2	1	1	2
Other	1.5%	2	2	2	2
None	47.0%	69	50	49	60
Axis III					
Cerebral Palsy	0.0%	0	0	0	0
Epilepsy	0.0%	0	0	0	0
Fetal Alcohol Disorders	1.4%	2	1	1	2
Severe Organic Brain Impairment	0.0%	0	0	0	0
Traumatic Brain Injury	3.5%	5	4	4	4

Wildwood Correctional Complex

Facility Description: The Wildwood Correctional Complex consists of the following: a pre-trial facility with the capacity to serve 110 offenders and a medium custody facility with the capacity to serve 352 offenders. The complex houses adult misdemeanor and felony offenders.

Programs:

- Anger Management
- Healthy Living
- 48-Week Offender Program
- Thinking Errors
- On-site Clinical Services
- Tele-psychiatry
- Relapse Prevention Program
- Life Success Substance Abuse Treatment (LSSAT)
- Alaska Reentry Course
- Criminal Attitudes Program (CAP)
- Parenting Classes

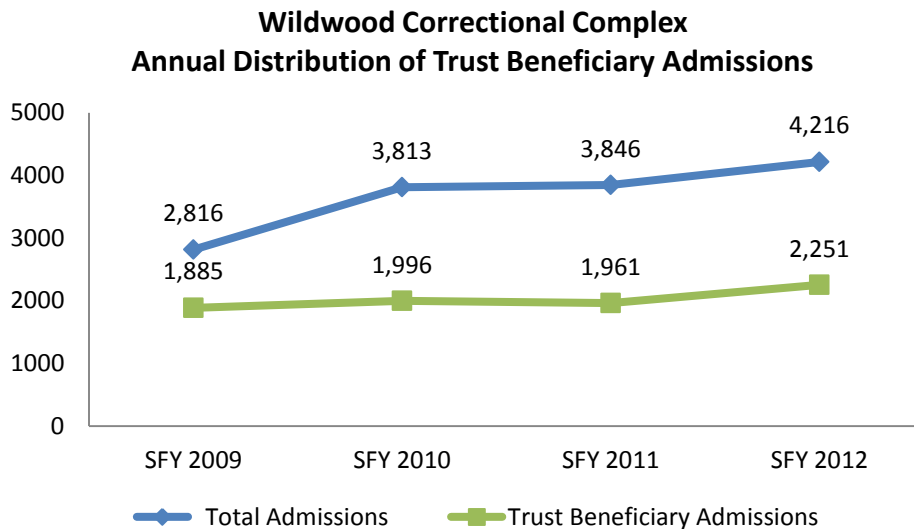


Table 1: Demographics of Wildwood Correctional Complex, SFY09–SFY12

	Trust Beneficiary		Non Trust Beneficiary		Total	
Gender	N	%	N	%	N	%
Male	3,208	84.3%	4,018	86.0%	7,226	85.2%
Female	597	15.7%	654	14.0%	1,251	14.8%
Total	3,805	100.0%	4,672	100.0%	8,477	100.0%
Race	N	%	N	%	N	%
White	2,558	67.2%	3,652	78.2%	6,210	73.3%
Black	144	3.8%	144	3.1%	288	3.4%
AK Native	1,000	26.3%	639	13.7%	1,639	19.3%
Hispanic	53	1.4%	100	2.1%	153	1.8%
Other	50	1.3%	138	3.0%	188	2.2%
Total	3,805	100.0%	4,673	100.0%	8,478	100.0%
Age Group	N	%	N	%	N	%
Under 21	536	14.3%	798	17.3%	1,334	15.9%
21-30	1,279	34.0%	1,424	30.8%	2,703	32.3%
31-40	884	23.5%	948	20.5%	1,832	21.9%
41-50	741	19.7%	913	19.8%	1,654	19.7%
Over 50	321	8.5%	535	11.6%	856	10.2%
Total	3,761	100.0%	4,618	100.0%	8,379	100.0%

**Table 2: Clinical Characteristics of Trust Beneficiaries,
Wildwood Correctional Complex, SFY09-SFY12**

Presenting Diagnoses	Total (n=2,299)	
	Number	Percent
Axis I		
Adjustment	344	15.0%
Alcohol	955	41.5%
Anxiety	366	15.9%
Bipolar	164	7.1%
Dementia	11	0.5%
Drug	1,093	47.5%
Impulse Control	114	5.0%
Mood	806	35.1%
Psychotic	268	11.7%
Schizophrenia	117	5.1%
Sexual	16	0.7%
Other	202	8.8%
Axis II		
Personality	671	29.2%
Mental Retardation (MR)	19	0.8%
Other	61	2.7%
None	1,578	68.6%
Axis III		
Cerebral Palsy	1	0.0%
Epilepsy	11	0.5%
Fetal Alcohol Disorders	14	0.6%
Severe Organic Brain Impairment	12	0.5%
Traumatic Brain Injury	60	2.6%

**Table 3: Extrapolation of Clinical Characteristics of Trust Beneficiaries Releases,
Wildwood Correctional Complex, SFY09-SFY12**

Presenting Diagnoses	Presenting Diagnoses	2009 Trust Beneficiary Releases	2010 Trust Beneficiary Releases	2011 Trust Beneficiary Releases	2012 Trust Beneficiary Releases
		(n=921)	(n=910)	(n=885)	(n=958)
	Percent	Number	Number	Number	Number
Axis I					
Adjustment	15.0%	138	137	133	144
Alcohol	41.5%	382	378	367	398
Anxiety	15.9%	146	145	141	152
Bipolar	7.1%	65	65	63	68
Dementia	0.5%	5	5	4	5
Drug	47.5%	437	432	420	455
Impulse Control	5.0%	46	46	44	48
Mood	35.1%	323	319	311	336
Psychotic	11.7%	108	106	104	112
Schizophrenia	5.1%	47	46	45	49
Sexual	0.7%	6	6	6	7
Other	8.8%	81	80	78	84
Axis II					
Personality	29.2%	269	266	258	280
Mental Retardation (MR)	0.8%	7	7	7	8
Other	2.7%	25	25	24	26
None	68.6%	632	624	607	657
Axis III					
Cerebral Palsy	0.0%	0	0	0	0
Epilepsy	0.5%	5	5	4	5
Fetal Alcohol Disorders	0.6%	6	5	5	6
Severe Organic Brain Impairment	0.5%	5	5	4	5
Traumatic Brain Injury	2.6%	24	24	23	25

Yukon Kuskokwim Correctional Center

Facility Description: The Yukon Kuskokwim Correctional Center is a multi-function, adult correctional institution. The institution has a capacity of 207 male and female inmates and employs a staff of 45. The center serves both as an intake and a short-term facility. At any given time, 75% to 85% of the population is composed of inmates in pretrial status.

Programs:

- Tele-psychiatry
- Alaska Native-Based Substance Abuse Treatment (ANSAT)
- Alaska Reentry Course
- Criminal Attitudes Program (CAP)
- Parenting Classes

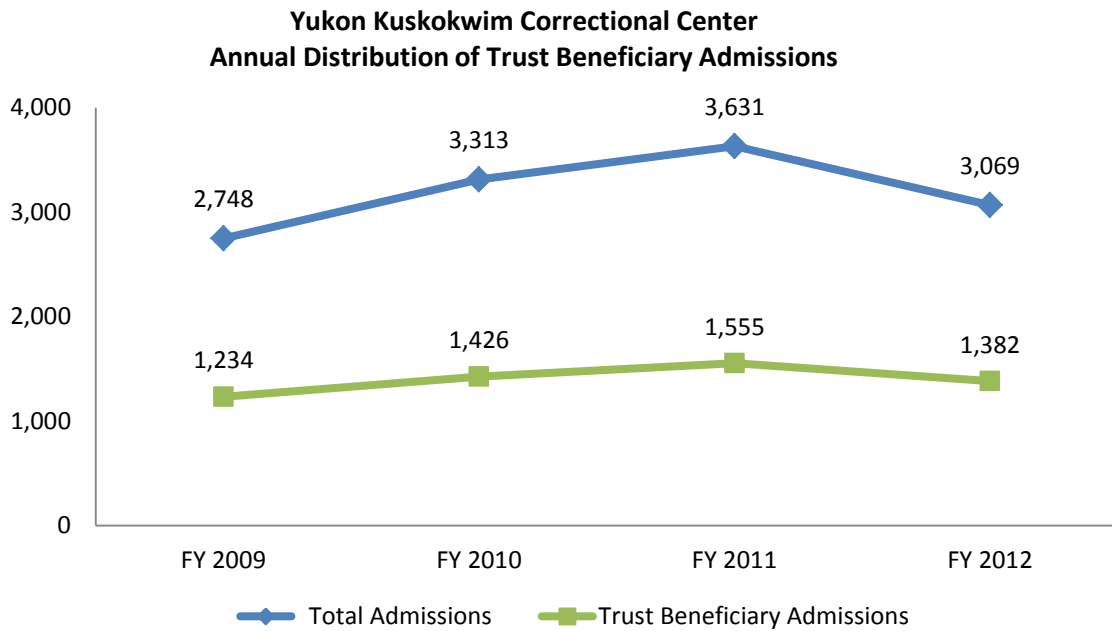


Table 1: Demographics of Yukon Kuskokwim Correctional Center, SFY09–SFY12

	Trust Beneficiary		Non Trust Beneficiary		Total	
Gender	N	%	N	%	N	%
Male	1,033	75.5%	2,009	72.1%	3,042	73.2%
Female	335	24.5%	776	27.9%	1,111	26.8%
Total	1,368	100.0%	2,785	100.0%	4,153	100.0%
Race	N	%	N	%	N	%
White	34	2.5%	85	3.1%	119	2.9%
Black	13	1.0%	14	0.5%	27	0.7%
AK Native	1,310	95.8%	2,656	95.4%	3,966	95.5%
Hispanic	2	0.1%	10	0.4%	12	0.3%
Other	9	0.7%	20	0.7%	29	0.7%
Total	1,368	100.0%	2,785	100.0%	4,153	100.0%
Age Group	N	%	N	%	N	%
Under 21	325	23.9%	602	21.7%	927	22.4%
21-30	518	38.1%	884	31.8%	1,402	33.9%
31-40	259	19.0%	511	18.4%	770	18.6%
41-50	184	13.5%	507	18.3%	691	16.7%
Over 50	75	5.5%	272	9.8%	347	8.4%
Total	1,361	100.0%	2,776	100.0%	4,137	100.0%

**Table 2: Clinical Characteristics of Trust Beneficiaries,
Yukon-Kuskokwim Correctional Center, SFY09-SFY12**

Presenting Diagnoses	Total (n=643)	
	Number	Percent
Axis I		
Adjustment	177	27.5%
Alcohol	228	35.5%
Anxiety	83	12.9%
Bipolar	13	2.0%
Dementia	4	0.6%
Drug	266	41.4%
Impulse Control	70	10.9%
Mood	262	40.7%
Psychotic	112	17.4%
Schizophrenia	46	7.2%
Sexual	1	0.2%
Other	81	12.6%
Axis II		
Personality	134	20.8%
Mental Retardation (MR)	12	1.9%
Other	24	3.7%
None	484	75.3%
Axis III		
Cerebral Palsy	0	0.0%
Epilepsy	2	0.3%
Fetal Alcohol Disorders	13	2.0%
Severe Organic Brain Impairment	2	0.3%
Traumatic Brain Injury	12	1.9%

**Table 3: Extrapolation of Clinical Characteristics of Trust Beneficiaries Releases,
Yukon–Kuskokwim Correctional Center, SFY09-SFY12**

Presenting Diagnoses	Presenting Diagnoses	2009 Trust Beneficiary Releases (n=539)	2010 Trust Beneficiary Releases (n=642)	2011 Trust Beneficiary Releases (n=605)	2012 Trust Beneficiary Releases (n=519)
	Percent	Number	Number	Number	Number
Axis I					
Adjustment	27.5%	148	177	166	143
Alcohol	35.5%	191	228	215	184
Anxiety	12.9%	70	83	78	67
Bipolar	2.0%	11	13	12	10
Dementia	0.6%	3	4	4	3
Drug	41.4%	223	266	250	215
Impulse Control	10.9%	59	70	66	57
Mood	40.7%	219	261	246	211
Psychotic	17.4%	94	112	105	90
Schizophrenia	7.2%	39	46	44	37
Sexual	0.2%	1	1	1	1
Other	12.6%	68	81	76	65
Axis II					
Personality	20.8%	112	134	126	108
Mental Retardation (MR)	1.9%	10	12	11	10
Other	3.7%	20	24	22	19
None	75.3%	406	483	456	391
Axis III					
Cerebral Palsy	0.0%	0	0	0	0
Epilepsy	0.3%	2	2	2	2
Fetal Alcohol Disorders	2.0%	11	13	12	10
Severe Organic Brain Impairment	0.3%	2	2	2	2
Traumatic Brain Injury	1.9%	10	12	11	10

Appendix E: Comparison of Trust Beneficiary Offense Characteristics with Other Inmates SFY09-SFY12

	Trust Beneficiary		Non-Trust Beneficiary		Total	
	Number	Percent	Number	Percent	Number	Percent
Offense Severity						
Felony	12,098	34.6%	8,767	21.4%	20,865	27.5%
Misdemeanor	22,892	65.4%	32,108	78.6%	55,000	72.5%
Total	34,990	100.0%	40,875	100.0%	75,865	100.0%
Felony						
Public Order	924	7.6%	807	9.2%	1,731	8.3%
Person	1,744	14.4%	1,180	13.5%	2,924	14.0%
Property	1,718	14.2%	1,086	12.4%	2,804	13.4%
Drug/Alcohol	2,048	16.9%	1,728	19.7%	3,776	18.1%
Motor Vehicle	259	2.1%	133	1.5%	392	1.9%
Probation	5,152	42.6%	3,583	40.9%	8,735	41.9%
Other	253	2.1%	250	2.9%	503	2.4%
Total	12,098	100.0%	8,767	100.0%	20,865	100.0%
Misdemeanor						
Public Order	4,450	19.4%	4,652	14.5%	9,102	16.5%
Person	5,729	25.0%	6,104	19.0%	11,833	21.5%
Property	4,227	18.5%	3,266	10.2%	7,493	13.6%
Drug/Alcohol	4,298	18.8%	12,592	39.2%	16,890	30.7%
Motor Vehicle	2,196	9.6%	3,678	11.5%	5,874	10.7%
Probation	1,475	6.4%	1,208	3.8%	2,683	4.9%
Other	517	2.3%	608	1.9%	1,125	2.0%
Total	22,892	100.0%	32,108	100.0%	55,000	100.0%
Overall						
Public Order	5,374	15.4%	5,459	13.4%	10,833	14.3%
Person	7,473	21.4%	7,284	17.8%	14,757	19.5%
Property	5,945	17.0%	4,352	10.6%	10,297	13.6%
Drug/Alcohol	6,346	18.1%	14,320	35.0%	20,666	27.2%
Motor Vehicle	2,455	7.0%	3,811	9.3%	6,266	8.3%
Probation	6,627	18.9%	4,791	11.7%	11,418	15.1%
Other	770	2.2%	858	2.1%	1,628	2.1%
Total	34,990	100.0%	40,875	100.0%	75,865	100.0%

Appendix F: Institutional Programming Descriptions

48-Week Offender Management Program: Programming designed to target antisocial attitudes, values and beliefs. This program uses a variety of cognitive behavioral interventions focused on the specific dynamic risk factors of impulsivity, egocentrism, weak problem-solving/self-regulation skills, aggressiveness and deficits in critical reasoning and abstract thinking.

Acute Psychiatric Unit: Inpatient mental health unit that provides 24-hour hospital-level psychiatric care for acutely and chronically mentally ill offenders. Offenders are admitted to these units for observation, assessment, and stabilization. Offenders admitted to these units may suffer from a wide array of mental health diagnosis and/or acute crisis. These units provide a safe, highly structured therapeutic environment where an offender may receive medication management, individual and/or group therapy focused on providing the skills needed to function in other, less restrictive settings. (See also: **Sub-Acute Psychiatric Unit.**)

Alaska Native-Based Substance Abuse Treatment (ANSAT): Substance abuse treatment services designed to incorporate an Alaska Native cultural perspective. This program is based on a modified Intensive Outpatient Treatment (ASAM PPC-2R Level II.I criteria) model. Offenders are required to participate for a minimum of four weeks (12-16 hours per week).

Alaska Reentry: Utilizing the Alaska Reentry manual, offenders prepare for reintegration and transition back into the community.

Anger Management: SAMHSA's 12-session, evidence-based anger management program, designed to aid offenders in managing their anger by addressing the following areas: Events and Cues: A Conceptual Framework for Understanding Anger; Anger Control Plans: Helping Group Members Develop a Plan for Controlling Anger; and The Aggression Cycle: How to Change the Cycle.

Batterer's Intervention Program: This 32-week program provides education for men serving time for a domestic violence conviction. The program is based on the Duluth Model, which is a nationally recognized victim-safety centered program that uses skill-building for the offender to learn how to have a healthy non-violent relationship.

Choosing Change: A program designed to examine criminal thinking errors, tactics to avoid change, and barriers to positive changes. This program provides instruction and skill building exercises to help offenders lead a more pro-social life.

Cognitive Restructuring: The A-B-C-D Model and Thought Stopping; Assertiveness Training and Conflict Resolution Model: Alternatives to Expressing Anger and Anger and the Family: How Past Learning Can Influence Present Behavior. Along with class participation, each individual is required to complete homework assignments and develop an Anger Management Plan incorporating the skills they obtained throughout the program.

Contracted Clinical Services: Institutional mental health services provided by a local community mental health clinician. Services include suicide assessment and intervention, crisis intervention, diagnostic assessment and ongoing mental health services.

Criminal Attitudes Program (CAP): A cognitive behavioral course (6 to 16 weeks in duration) designed to assist offenders with altering their criminal attitudes, thinking and behaviors.

Healthy Living: An ongoing open ended group designed to assist offenders in adjusting to incarceration and provide basic tools for overall healthy living.

Life Success Substance Abuse Treatment (LSSAT): Programming based on the Intensive Outpatient Treatment (ASAM PPC-2R Level II.I criteria) model. The services provided use a cognitive behavioral approach. Offenders in the program are required to participate for a minimum of three to four months.

On-site Clinical Services: Institutional mental health services provided by on-site Department of Corrections' mental health staff. Services offered include suicide assessment and intervention, crisis intervention, diagnostic assessment, psychiatric referral, treatment planning, counseling, medication monitoring, community treatment referral and release planning.

On-site Dual Diagnosis Clinical Services: Institutional clinical services provided by on-site DOC staff. Services offered focus specifically on assessment, treatment and release planning for offenders diagnosed with a severe and persistent mental illness in conjunction with a substance abuse diagnosis.

On-site Psychiatric Services: Institutional psychiatric services provided by on-site Department of Corrections staff. Services included medication assessment and ongoing monitoring by Psychiatrist or psychiatric provider.

Parenting: Programming that provides practical and innovative ways to help overcome the physical and psychological challenges that incarcerated parents face both inside and outside of prison.

Reentry-DOLWD Workplace & Community Transition Program: A partnership with Alaska Department of Labor. Instructors provide reentry and transition training to meet the needs of the offenders trying to enter into today's job market.

Relapse Prevention Program: Programming designed to assist offenders in maintaining positive changes in their lives.

Residential Sex Offender Treatment: This program is a two year, evidence-based group therapy that uses cognitive behavioral techniques to help convicted sex offenders lower their risk to re-offend. The therapist and offender identify criminogenic needs and high-risk

situations that lead to re-offending. The offender is then given the skills or tools to avoid or deal with the identified high risk situations.

Residential Substance Abuse Treatment (RSAT): Programming based on the Residential/ Intensive Inpatient Treatment (ASAM PPC-2R Level III.I criteria) model. This comprehensive and intensive program uses a cognitive behavioral approach designed to intervene and treat substance use disorders using a Therapeutic Community model. Offenders in this program are expected to participate for a minimum of six months.

Sub-Acute Psychiatric Unit: Step-down inpatient mental health unit that provides a structured therapeutic environment for offenders diagnosed with a severe and persistent mental illness. Offenders placed on this are unable to function well in general population due to limitation placed on them by their mental illness. These units provide a safe environment where offenders can receive medication management, individual and/or group therapy focused on providing the skills needed to function in other, less restrictive settings.

Tele-psychiatry: Psychiatric services are provided remotely by Psychiatrist or psychiatric provider.

Thinking Errors: Psycho-educational programming designed to assist offenders in the identification and correction of thinking errors.

Transformational Living Community (TLC): A multi-phase, intensive 12-18 month program that is designed to provide a spiritual based approach to correctional rehabilitation. The offenders live together in a supportive community environment and are expected to embrace personal accountability, responsibility, and commitment to change in all aspects of their life.

Appendix G: Screening Tools

OHIO RISK ASSESSMENT SYSTEM – PRISON INTAKE TOOL (ORAS-PIT)

Name: _____ Date of Assessment: _____

Case#: _____ Name of Assessor: _____

Age at Time of Assessment

0=24+

1=18-23

1.0 CRIMINAL HISTORY

1.1. Most Serious Arrest Under Age 18

0=None

1=Yes, Misdemeanor

2=Yes, Felony

1.2. Prior Commitment as a Juvenile to Department of Youth Services

0=No

1=Yes

1.3. Number of Prior Adult Felony Convictions

0=None

1=One or Two

2=Three or more

1.4. Arrests for Violent Offense as an Adult

0=No

1=Yes

1.5. Number of Prior Commitments to Prison

0=None

1=One

2=Two or More

1.6. Ever Received Official Misconduct while Incarcerated as an Adult

0=No

1=Yes

1.7. Ever Had Escape Attempts as Adult

0=No

1=Yes

Total Score in Criminal History:

2.0 SCHOOL BEHAVIOR AND EMPLOYMENT

- 2.1. Ever Expelled or Suspended from School
0= No
1= Yes
- 2.2. Employed at the Time of Arrest
0=Yes
1=No
- 2.3. Employed Just Prior to Incarceration
0=Yes Full-time or Disabled
1=Not Employed or Employed Part-time
- 2.4. Attitudes toward Boss/Employer
0=Good Relationship
1=Poor Relationship
- 2.5. Longest Length of Employment Past Two Years
0=18 Months or More
1=1-17 Months
1= None
- 2.6. Better Use of Time
0=No, Most Time Structure
1=Yes, Lots of Free Time

Total Score in School Behavior and Employment: **3.0 FAMILY AND SOCIAL SUPPORT**

- 3.1. Current Marital Status
0= Married or Cohabiting
1= Single (Married but Separated), Divorced, Widowed
- 3.2. Living Situation Prior to Incarceration:
0=Significant Other
1=Parents, Friends, or Other
2=Alone or Shelter
- 3.3. Stability of Residence Prior to Incarceration
0=Stable
1=Not Stable
- 3.4. Emotional and Personal Support Available from Family or Others
0=Strong Support
1=None or Weak Support
- 3.5. Level of Satisfaction with Current Level of Support from Family or Others
0=Very Satisfied
1=Not Satisfied

Total Score for Family and Social Support:

4.0 SUBSTANCE ABUSE AND MENTAL HEALTH

- 4.1. Longest Period of Abstinence from Alcohol
0= Six Months or Longer
1= Less than Six Months
- 4.2. Age at First Illegal Drug Use
0=16 or Older
1=Under 16
- 4.3. Problems with Employment due to Drug Use:
0=No
1=Yes
- 4.4. Problems with Health due to Drug Use
0=No
1=Yes
- 4.5. Ever Diagnosed with Mental Illness/Disorder
0=No
1=Yes

Substance Abuse and Mental Health:

5.0 CRIMINAL LIFESTYLE

- 5.1. Criminal Activities
0= Prosocial
1= Mixture
2=Criminal Activities
- 5.2. Current Gang Membership
0= No, Never
1= Yes, but Not Current
2= Yes, Current
- 5.3. Ability to Control Anger
0= Good Control
1= Poor Control
- 5.4. Uses Anger to Intimidate Others
0=No
1=Yes
- 5.5. Acts Impulsively
0=No
1=Yes
- 5.6. Feels Lack of Control Over Events
0= Controls Events
1= Sometimes Lacks Control
2= Generally Lacks Control
- 5.7. Walks Away from a Fight
0= Yes
1= Sometimes
2= Rarely

Total Score for Criminal Lifestyle:

TOTAL SCORE:

Risk Categories for MALES			Risk Categories for FEMALES		
Scores	Rating	Percent of Failures	Scores	Rating	Percent of Failures
0-8	Low	17%	0-12	Low	17%
9-16	Moderate	32%	13-18	Moderate	33%
17-24	High	58%	19+	High	63%
25+	Very High	71%			

Domain Levels					
1.0 Criminal History			2.0 School Behavior and Employment		
	Score	Failure		Score	Failure
_____	Low (0-3)	30%	_____	Low (0-3)	29%
	Med (4-6)	47%		Med (4-5)	44%
	High (7-10)	57%		High (6-7)	55%
3.0 Family and Social Support			4.0 Substance Abuse and Mental Health		
	Score	Failure		Score	Failure
_____	Low (0-2)	28%	_____	Low (0-1)	33%
	Med (3-4)	45%		Med (2-3)	44%
	High (5-6)	60%		High (4-5)	60%
5.0 Criminal Lifestyle					
	Score	Failure			
_____	Low (0-2)	29%			
	Med (3-5)	46%			
	High (6-11)	60%			

Professional Override:

Reason for Override
(note overrides should not be based solely on offense)

Other Areas of Concern. Check all that Apply:

Low Intelligence*
 Physical Handicap
 Reading and Writing Limitations*
 Mental Health Issues*
 No Desire to Change/Participate in Programs*
 Language
 Ethnicity
 Cultural Barriers
 History of Abuse/Neglect
 Interpersonal Anxiety
 Other _____

If these items are checked it is strongly recommended that further assessment be conducted to determine level or severity.

ALASKA SCREENING TOOL

Client Name: _____ Client Number: _____

Staff Name: _____ Date: _____

Info received from: (include relationship to client) _____

Please answer these questions to make sure your needs are identified. Your answers are important to help us serve you better. If you are filling this out for someone else, please answer **from their view**. Parents or guardians usually complete the survey on behalf of children under age 13.

SECTION I – Please estimate the number of days in the **last 2 weeks**

(enter a number from 0-14 days):

0-14 days

1. Over the last two weeks, how many days have you felt little interest or pleasure in doing things?..... _____
2. How many days have you felt down, depressed or hopeless?..... _____
3. Had trouble falling asleep or staying asleep or sleeping too much?..... _____
4. Felt tired or had little energy?..... _____
5. Had a poor appetite or ate too much?..... _____
6. Felt bad about yourself or that you were a failure or had let yourself or your family down? _____
7. Had trouble concentrating on things, such as reading the newspaper or watching TV? _____
8. Moved or spoken so slowly that other people could have noticed?..... _____
9. Been so fidgety or restless that you were moving around a lot more than usual?..... _____
10. Remembered things that were extremely unpleasant?..... _____
11. Were barely able to control your anger? _____
12. Felt numb, detached, or disconnected?..... _____
13. Felt distant or cut off from other people? _____

SECTION II – Please check the answer to the following questions based on **your lifetime**.

14. I have lived where I often or very often felt like I didn't have enough to eat, had to wear dirty clothes, or was not safe Yes No
15. I have lived with someone who was a problem drinker or alcoholic, or who used street drugs Yes No
16. I have lived with someone who was seriously depressed or seriously mentally ill Yes No
17. I have lived with someone who attempted suicide or completed suicide Yes No
18. I have lived with someone who was sent to prison..... Yes No
19. I, or a close family member, was placed in foster care Yes No
20. I have lived with someone while they were physically mistreated or seriously threatened..... Yes No
21. I have been physically mistreated or seriously threatened Yes No
 - a. If you answered **"Yes"**, did this involve your intimate partner (spouse, girlfriend, or boyfriend)? Yes No

ALASKA SCREENING TOOL

SECTION III – Please answer the following questions based on your lifetime. (D/N = Don't Know)

22. I have had a blow to the head that was severe enough to make me lose consciousness Yes No D/N

23. I have had a blow to the head that was severe enough to cause a concussion . Yes No D/N

If you answered "Yes" to 22 or 23, please answer a-c:

a. Did you receive treatment for the head injury? Yes No

b. After the head injury, was there a permanent change in anything? Yes No D/N

c. Did you receive treatment for anything that changed?..... Yes No

24. Did your mother ever consume alcohol? Yes No D/N

a. **If Yes**, did she continue to drink during her pregnancy with you? Yes No D/N

SECTION IV – Please answer the following questions based on the past 12 months.

25. Have you had a major life change like death of a loved one, moving, or loss of a job? Yes No

26. Do you sometimes feel afraid, panicky, nervous or scared? Yes No

27. Do you often find yourself in situations where your heart pounds and you feel anxious and want to get away? Yes No

28. Have you tried to hurt yourself or commit suicide? Yes No

29. Have you destroyed property or set a fire that caused damage?..... Yes No

30. Have you physically harmed or threatened to harm an animal or person on purpose? ... Yes No

31. Do you ever hear voices or see things that other people tell you they don't see or hear? Yes No

32. Do you think people are out to get you and you have to watch your step?..... Yes No

SECTION V – Please answer the following questions based on the past 12 months.

33. Have you gotten into trouble at home, at school, or in the community, because of using alcohol, drugs, or inhalants? Yes No

34. Have you missed school or work because of using alcohol, drugs, or inhalants? Yes No

35. In the past year have you ever had 6 or more drinks at any one time? Yes No

36. Does it make you angry if someone tells you that you drink or use drugs, or inhalants too much? Yes No

37. Do you think you might have a problem with alcohol, drug or inhalant use?..... Yes No

THANK YOU for providing this information! Your answers are important to help us serve you better.