Alaska Criminal Justice Commission
Behavioral Health Standing Committee

Meeting Summary

May 31, 2019
Alaska Mental Health Trust + Teleconference

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

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

Staff: Barbara Dunham

Agenda and previous meeting's summary

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

Highlights from the 2019 CCJ/COSCA Summit

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

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

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

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

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

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

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

Current state efforts

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

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

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

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

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

Introductions – Matt Dammeyer

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

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

Education of Commission, legislators

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

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

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

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

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

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

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

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

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

Public comment

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

Next steps

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

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

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

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

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

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

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

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

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

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

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

1115 Waiver update

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

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

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

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

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

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

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

Next meeting

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