Alaska Criminal Justice Commission
Behavioral Health Standing Committee

Meeting Summary

August 8, 2019
Alaska Mental Health Trust + Teleconference

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

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

Staff: Barbara Dunham

Agenda and Meeting Summary

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

Overview – Sequential Intercept Model (SIM)

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

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

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

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

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

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

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

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

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

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

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

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

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

Overview – Forensic Feasibility Study

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

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

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

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

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

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

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

Public Comment

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

Overview: Crisis Systems of Care / Crisis Now Model

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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