Alaska Criminal Justice Commission

Rehabilitation, Reentry, and Recidivism Reduction Workgroup

The Mission of the RRRR Workgroup is to assess and propose ways to reduce recidivism for people who are justice-involved, including: treatment and programming (both behind the walls and in the community), rehabilitation and incarceration models, and reentry planning.

Meeting Summary

Thursday, August 13, 2020, 1:00pm-4:00pm

Via Zoom

Commissioners Present: Stephanie Rhoades, Steve Williams, Shelley Hughes

Participants: Marsha Oss, Adam Barger, Linda Setterberg, Will Fanning, Don Habeger, Janice Weiss, Karl Clark, Tracy Dompeling, Talia Eames, Joshua Wilson, Laura Brooks, Laura Russell, Travis Welch, Ray Michaelson, Buddy Whitt, Jonathan Pistotnik, Alysa Wooden, Justin Hatton, Ellen Hackenmueller, Natasha McClanahan, Teresa Capo, Tom Duggan, Cathleen McLaughlin, Barbara Mongar, Michael Powell

Staff: Staci Corey, Barbara Dunham

Civil Detention Recommendation

Laura Russell from the Department of Health and Social Services (DHSS) explained that DHSS definitely does not want the civil detention population in correctional facilities but also didn't want an absolute rule that doesn't take into account realities of people in rural areas who have no other safe place to be. She had made edits to the proposed recommendation so that instead of "shall not be placed," the recommendation read that civil detainees "are not placed" in correctional facilities "except for protective custody purposes and only while awaiting transportation to a treatment facility." With this wording, both conditions would have to be met (needing protective custody and awaiting transport) for a civil detainee to be held in a correctional facility. She also suggested taking out the language about DOC facilities being "punitive and anti-therapeutic," because DOC has clinical staff who work hard to provide quality care, and she didn't want to discount their efforts. Saying that housing civil detainees in correctional facilities can cause them harm gets the point across.

Laura Brooks from DOC said she appreciated Laura R.'s edits. She noted that DOC has a responsibility to provide care for and treat everyone in their facilities, regardless of legal status, to the extent possible.

Commissioner/Senator Shelley Hughes wondered whether the draft should read "except for protective custody purposes *or* while awaiting transportation," instead of "*and* while awaiting transportation." Laura B. said that people can only be held in DOC facilities if they have criminal charges or are in protective custody, so civil detainees wouldn't be in a DOC facility unless it was for protective custody. Laura R. agreed and added that including "and only while awaiting transportation" would ensure that they were being held in a DOC facility only if transportation was being arranged. This would ensure that the process to have the person transported out of a DOC facility has started.

Commissioner and workgroup chair Judge Stephanie Rhoades asked whether civil detainees would have access to all the usual medications and treatment they would need. Laura B. said they are treated in the same way as a criminal detainee but for criminal detainees they can have an internal hearing and possibly give the person forced medication, which they can't do for civil detainees. Medications are always prescribed at the discretion of the treating psychiatrist who will make a treatment plan.

Josh Wilson from the Alaska Correctional Officers' Association said he understood the reasoning behind the changes to the recommendation but still didn't like them and would prefer to leave in the "shall not be placed". He explained that he represents correctional officers who have had to supervise people who don't know why they are in prison and the CO can't tell them why; sometimes they are detained for over a month. He also suggested leaving in "punitive and anti-therapeutic" which he felt was accurate.

Laura B. explained that civil detainees coming into DOC facilities on a Title 47 hold are placed in the psychiatric units. But if the psychiatric beds are filled with civil detainees, that means that criminal detainees who would otherwise be placed there are instead held in booking. She thought everyone could agree that people who should be in a hospital shouldn't be in jail. She thought that the changes happening with DHSS should alleviate some of these issues.

Commissioner Steve Williams from the Mental Health Trust said he had gone back and forth on the "punitive and anti-therapeutic" sentence. He noted that the sentence was not talking about DOC's healthcare services, but was saying that the environment itself is punitive and anti-therapeutic. He suggested adding the word "environment".

Sen. Hughes suggested "correctional facilities can cause irreparable harm as they are designed to be punitive and anti-therapeutic." Laura B. suggested just ending the sentence at "punitive." Laura R. said she was not comfortable with "anti-therapeutic but could be more comfortable with "punitive".

Teresa Capo from the BBNA Reentry Task Force suggested moving the phrase "in jail" in the first sentence of the second paragraph to clarify the language.

Judge Rhoades said that while DOC does have treatment it is not the same as what someone would get in a hospital or therapeutic setting. Nothing about sitting in jail is therapeutic. DOC provides constitutionally mandated care, but that is not the same standard of care as a hospital environment. She thought the intent of the "punitive and anti-therapeutic" phrase was to make the distinction that there is something about the prison environment that causes harm. Laura B. thought Sen. Hughes' suggestion clarified that.

Adam Barger suggested "can cause irreparable harm, as it is a punitive and anti-therapeutic environment." He agreed that it was anti-therapeutic, and said that treatment in a DOC facility is different than treatment at API. It was hard to explain why a person was in prison if they haven't committed a crime; being in prison would be the most anti-therapeutic thing that could happen to them.

Don Habeger of the Juneau Reentry Coalition pointed out that the real purpose of this document was to get the legislature to act. Just having the phrase "irreparable harm" was enough to get the point across. He liked the cleaner version but could live with the additional language.

The final language the group settled on was "can cause them irreparable harm, because correctional facilities are designed to be punitive." Judge Rhoades asked if anyone in the group opposed that language or the "are not placed in a jail or other correctional facility except for protective custody purposes and only while awaiting transportation to a treatment facility" language. There was no opposition.

APIC/IDP+

Laura B. explained that IDP+ was a program that started many years ago and was later adopted by DOC when DOC developed its own mental health department. IDP+ has two staff clinicians who are dedicated to linking prisoners experiencing mental illness to treatment programs in Anchorage. It is an Anchorage-based program but DOC has put in for a BJA grant to expand it. The IDP+ clinicians work with a reentrant's probation officer and treatment providers to ensure compliance with court ordered conditions of probation. Sometimes people who have a mental illness will stop following their treatment program if no one is checking up on them. IDP+ was designed to keep this population closely monitored so they remain in their treatment plans. Participants have to be on felony probation and experiencing a major mental illness with a history of psychosis to qualify. These are highest-risk, highest needs people. The program has a caseload of 80-100 people per year.

Laura B. explained that APIC (Assess, Plan, Identify, Coordinate) was similar, and had been in place for about 13 to 14 years. The program arranges for treatment for mental health and co-occurring disorders, and helps participants transition into the community. It allows community providers (mental health and substance use disorder treatment providers) to come in 90 days before a person is due to be released, and those providers can then bill APIC. APIC also has funds for 60 days after release, which provides for clinical care coordination between systems, getting benefits reinstated, and coordinating housing, food, and clothes. Funding is provided by the Trust.

Laura B. said she also wanted to let the group know about a new program: an RFP just closed for a substance use disorder reentry coordinator. DOC was looking for someone who can do what APIC does but for substance use disorder treatment. The contract was awarded to Set Free Alaska. The program will pay for some gap services, and allow participants to get assessments and find treatment beds in the community. Right now the program will be located in Anchorage and the Mat-Su, but Laura anticipated following APIC and expanding to other communities.

Judge Rhoades asked whether, with the 1115 waiver coming in, this program would be able to leverage that to pay for some services. She also asked if the program would be able to provide housing and transportation supports. Laura B. said yes, and that the waiver services have been a great addition but won't replace everything. Clinicians are well-versed in the 1115 waiver and how to use it. The program would mostly provide treatment but other DOC funds (such as the Second Chance grants) can fund things like housing and transportation. The program will be working with Janice's office.

Universal Release of Information Recommendation

Judge Rhoades noted that the Commission had looked at a universal release of information (ROI) before and had made a similar recommendation; this version was geared toward reentry. She wondered if this was needed.

Laura B. said DOC had something like this years ago, and observed that it was a time saver and really does streamline processes. DOC has to fill out an ROI for every single community provider and fax it in. A universal ROI would make that process on DOC's end much more efficient, and she thought it would also be helpful for community providers. She would suggest not limiting the ROI to behavioral health; other health agencies should be included—people need access to all health agencies.

Judge Rhoades wondered whether the ROI should be even broader and apply to other community supports Laura B. said that when DOC developed its ROI only covered medical and behavioral health; most other providers for services such as housing didn't need that information. There are federal agencies that won't accept any other ROI such as Medicaid or Social Security. Another way to broaden the

recommendation would be to consider including all providers whether they are state-funded or not. Judge Rhoades said she lifted the language limiting the recommendation to state-funded providers from the earlier recommendation. She thought that language had been included because the state can't require private providers to do this. She asked the group if there was any objection to adding medical providers to the recommendation. There was none.

Judge Rhoades asked if there were any thoughts on the "state-funded" language. Barbara guessed that the reason that language was included in the earlier recommendation had something to do with the state not having the ability to tell private actors what to do, though she was not sure because she was not part of the discussion the first time around. Steve confirmed that was the reason, that the Commission had concluded that state funding provided a direct link, while other providers would be in more of a grey area. Judge Rhoades agreed that it would be much simpler if the requirement could be included in contracts with the state. There would be relief from liability if this requirement was in statute; it was a way to get providers to get on board. If there was no objection she suggested leaving it in, and if the legislature wanted to do something different it could do so.

Don said that one way to link private providers to state requirements would be through the Title 8 licensure process, which all medical professionals need to go through. He was not necessarily advocating for or against that idea but it was an option.

Michael Powell from DBH said that this had been used to require all providers to be enrolled in the background check unit, so there have been examples of requirements made of providers regardless of whether they are state-funded.

Marsha Oss, case manager for the Fairbanks Reentry Coalition, noted that she attended a federal training two weeks ago on changes to 42 CFR regarding SUD treatment client records, at which the federal trainers said they were working on something like a universal ROI.

Steve suggested that the recommendation just say "health" rather than specifying behavioral and medical health, as he didn't want to exclude, for example, people with intellectual or developmental disabilities. The draft recommendation was changed accordingly. Judge Rhoades asked if there was any objection to the draft in its modified form. There were none. Alysa Wooden from DBH/DHSS said that they would want a look at this recommendation. Barbara said she would send the meeting draft of the recommendation to Alysa who would have DHSS leadership review it in advance of the next plenary meeting.

Reentry Coalitions/Case Management

Judge Rhoades noted that there were currently no written recommendations for reentry programming. She encouraged group members to come forward with ideas.

Travis Welch from the Alaska Mental Health Trust explained that Trust beneficiaries are at a higher risk of becoming a defendant or victim in a criminal case, so the Trust funds services to assist people in both. Trust beneficiaries who are justice-involved are also at higher risk of recidivism. He and the other presenters would be focusing on the Trust-funded coalitions as well as coalitions that receive support from DBH.

Alysa introduced Michael Powell and Will Fanning, who were new to DBH and would provide reentry case manager support. Alysa explained that SB 64 created the recidivism reduction program under DHSS. DHSS collaborates with DOC to work on funding for reentry providers. They also work with other

treatment providers specific to the justice-involved population. SB 91 added some requirements and funding to the program. Their services are divided into three areas:

- Community direct service (reentry case management, the Partners reentry center, coordinated care initiatives, housing and home voucher partnerships);
- Diversion/early intervention (rural community reentry coalitions, local and state funding partnerships such as their work with APD on mobile crisis response);
- Program infrastructure (data tracking and information sharing, which helps providers).

The local reentry coalitions are a cross section of people representing the services and supports available to reentrants in the community. The Trust-funded coalitions are in Anchorage, Fairbanks, the Mat-Su, and Juneau. Don explained that each coalition had a reentry coordinator, and he was the reentry coordinator for Juneau. The reentry coordinators serve as a hub of information for reentry coalition members and the local community. They also perform community assessments and community reentry plans.

Marsha explained that Reentry Case Managers work with DOC to coordinate services over a nine-month period that ideally begins in the DOC facility three months prior to release and continues for approximately six months after release. If available, the case manager will refer the reentrant to peer support after that time because they usually still need support after six months. Case managers also:

- Develop transition plans and aftercare plans to help reentrants stay focused on the goals and objectives outlined in the DOC Release Plan and address high risk areas identified by the LSI-R.
- Track all services provided and reentrant contacts in AKAIMS to generate Quarterly Reports and writes Mini-Grants to supplement the Grant Funds that cover direct services.
- Facilitate in-reach in the local DOC facility in order to educate reentrants about the local coalition and case management.
- Network with landlords, behavioral health providers, employers, and other community organizations to support reentrants.

Marsha explained that her caseload capacity was 40 clients, and she had never been under capacity. When she started she didn't have ACOMS to identify participants, so she just went out and found people. She is now also starting to see people referred through the Second Chance grant, and they are still part of that 40-client capacity—she was not sure how she would manage that. She has a volunteer to help right now. That could be the subject of a recommendation.

Judge Rhoades wondered if there was any difference in the Second Chance population compared to the DHSS reentry case management population. Marsha said that different services were covered. Second Chance grant participants have more services available and more is required for their cases, meaning they can be more time-consuming for case managers.

Linda Setterberg from the Fairbanks Reentry Coalition added that the two groups had the same eligible population. Both are voluntary programs. Second Chance participants are high risk and DHSS participants are medium to high risk. Marsha added that Second Chance participants have to sign up inside the institution, and that can mean they are more motivated. For the DHSS population, they can sign up inside but can also be referred by a PO.

Adam asked whether all case managers were averaging between 35 and 40 clients. Alysa said that different locations have different numbers; in Fairbanks the caseload has been consistently high. DHSS also pays for program administration of programs as well as services—that funding is limited. They need to be

equitable—some locations really need staff and funds. They are always looking for recommendations as to how to improve the system. Marsha noted that the Second Chance grant does not provide administrative fees.

Adam asked whether any of the funds went to smaller or more isolated populations. Alysa said that yes, that was something the Commission had been concerned about; there are now coalitions in Nome, Bristol Bay, Ketchikan, and Kenai. DHSS is also looking at more ways to support people in rural areas.

Steve noted that statewide, the need is greater than what the case management services can provide. When they started out, they set the capacity number deliberately low. A caseload of 40 is a national best practice. It was a strategic decision, knowing they can't get everyone, but want to see the most impact.

Judge Rhoades noted that a lot of this relied on Trust funding and wondered if there was anything to focus on for a recommendation. Steve said there was, and noted that some Trust funding, such as the funding for APIC, was provided in partnership with UGF.

Marsha said she wouldn't be able to do what she does without Linda or the peer support program. She wondered whether there was a way to supplement funding, such as through Medicaid.

Alysa agreed that sustainable funding for reentry programs is crucial. The 1115 waiver is one way to streamline services for this population more in line with traditional services.

Adam asked how much of the total reentry budget is state-funded versus Trust-funded. Judge Rhoades thought that it would be difficult to parse out which parts of each budget are dedicated to reentry. Alysa noted it was possible to track the recidivism reduction funds. Steve suggested it would be possible to do a ballpark estimate. Adam thought that stable funding was key.

Don thought funding recidivism reduction programs using marijuana tax revenue was a stroke of genius and suggested a recommendation encouraging the Legislature to retain it. Judge Rhoades said that it was already in statute and the Commission may not need to make statement.

Linda said that technical assistance would really help the reentry coalitions. There are several different reentry programs, and they need TA to become sustainable, and access Medicaid funds through the 1115 waiver. Judge Rhoades thought there was going to be training on the 1115 waiver. Alysa said there was, and the DHSS wanted to train new types of providers and also wanted to support existing providers. Marsha said that Medicaid requirements could be onerous and overwhelming. There was training before Covid hit, which was beneficial.

Cathleen McLaughlin offered information about the Partners Reentry Center, where she formerly was the director. She said there was a need have programs that incentivize and restore people in real time. PRC accepts people at the door, and gives them housing right away. Their key to success is that it is client-driven, and the programs are client-based programs. They meet people where they are at. Cathleen was currently working for Beans running the mass shelter at the arena. Around 70-80% of people sheltered there are justice-involved, and some of them are people she worked with at Partners. Clients are not going to stay in housing programs if providers are not working with them where they are at. For example at Beans they have a low barrier hiring plus accountability program. She would urge funding to be driven by the client in terms of a recommendation.

Judge Rhoades wondered what that recommendation would look like. Cathleen said that PRC's success was in paying for a head in a bed. Providers get paid for services already rendered at the end of the month; this forces collaboration and accountability. Judge Rhoades recalled that at one point CITC had a

voucher program. Participants would get vouchers for day care, bus passes, classes and other outpatient programs. She recalled it was very successful.

Cathleen offered to write up a recommendation.

Discussion

Judge Rhoades said that the group had heard some ideas during this meeting for recommendations, and if anyone thought there were things the Commission could assist with, she asked them to write the recommendation down and send it to Barbara. This group would need to meet once more. She also wanted to talk about specialty courts, pretrial enforcement (PED), and pretrial electronic monitoring (EM). She had heard reports that EM was being ordered for many pretrial defendants experiencing severe mental illness who were not able to maintain their EM devices. When the device is not regularly charged, PED will arrest them for violating the conditions of release. Steve said that was really concerning. He thought only some class of crimes mandate arrest. Judge Rhoades said that this issue started when PED got the authority to arrest defendants for VCOR.

In the chat bar, Don suggested the following recommendation: "The Commission recommends that the legislature ensures stable funding for reentry at the agency, community, and individual reentrant level. Recent gains in the reduction of the State's recidivism rate increase public safety and funding, if not sustained, will jeopardize increased public safety."

Also in the chat bar, group members commented that giving reentry service providers some form of virtual access to do inreach into DOC facilities. Group members suggested using Zoom, or a pre-recorded presentation to be shown on the CCTV to let people in DOC facilities know about reentry services.

Justin Hatton from the Alaska Native Justice Center thought this was a really good thing to address; with the youth reentry program, ANJC has been able to do virtual inreach, and it has been working. He suggested that providers collaborate with DOC to help prerelease groups get in touch with these services.

Judge Rhoades noted the group had discussed a computer access recommendation and wondered where the group had left off with that. Barbara said it was not finished, as Laura B. said that she wanted to take another look at it.

Jonathan Pistotnik from the Anchorage Reentry Coalition said that computer access for people in prison was a different issue, and thought that the group was expressing interest in looking at ways to get the providers in front of the future reentrants. It was not necessarily about inmate access but getting providers into prisons. Right now providers are completely shut out. There had been some Skype interation but that seemed to have trailed off. He suggested a recommendation for DOC to work with providers to get them connected to reentrants. Getting something set up would help things now, to accommodate the pandemic, but would also be useful regardless of the pandemic for people like Karl Clark, the reentry case manager for BBNA in Dillingham who didn't have easy access to the facilities anyway. Karl agreed.

Alysa noted that HB 49 required DOC to coordinate with reentry providers (33.30.011(a)(9)(D)).

Adam said that when Alaska prisoners were housed in Colorado, they had video visits with family, so it was possible to have that infrastructure. Marsha noted that in Idaho, correctional facilities have specialized devices that enable inmates to talk to people.

Judge Rhoades said she didn't think that DOC would be opposed to people coming in virtually, but there might be a problem with putting people in room together to look at a screen. Janice Weiss from DOC

said that was right. The rule right now is that provider interactions have to be one on one. But DOC is are all for getting providers inside to get their messages in. Steve asked if DOC had the ability to set up virtual meetings. Janice said it was possible to set up phone appointments like with an attorney. Judge Rhoades observed that providers wouldn't know which inmates to contact for appointments unless they can advertise their programs. Janice thought that this could be facilitated by the education coordinators.

Public Comment

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

Wrap up and action items

Judge Rhoades suggested she could work with Jonathan on a provider inreach proposal, and she would try to get DOC's final comments on the computer access recommendation. She encouraged group members to send any recommendations to Barbara or herself. The next meeting would be scheduled after the next plenary meetings.