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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Stats reviewed: (Slides 17-20)

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

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

Number of API competency evaluations conducted FY 15:

	Misdemeanor	Felony
Competency	111	106
Culpability		5

Adult Outpatient/Intensive Outpatient state funded treatment
Total 1173 slots

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The meeting ended at 11:50 a.m.