Staff Notes and Meeting Sum
WORKGROUP ON BEHAVIORAL HEALTH[1]
Alaska Criminal Justice Commission
Wednesday, May 25, 2016
9:00 -11:50 AM
Location: Alaska Mental Health Trust Authority

Commissioners Attending: Rhoades, Jeff Jessee, Kris Sell (joined mid-meeting)
Commissioners Absent: Greg Razo, Dean Williams, Gary Folger, John Coghill
Other Attendees: Alysa Wooden, DHSS; Paul Miovas, Dept. of Law; Steve Williams, Trust; Laura Brooks and Rutherford, DOC; Tony Piper and Stacy Toner, DHSS; Diane Casto, DHSS; Karen Forrest, DHSS; Jeff Jessee, Trust; Jerry Jenkins, Anchorage Community Mental Health; Ron Green, Center for Drug Problems; Dave Branding, South Peninsula Behavioral Health Services; Tina Woods, Alaska Native Tribal Health Consortium; Bill Miller, APD (joined mid-meeting); Morgen Jaco, DOC; Janet McCabe, Partners; Katie Baldwin, Trust; Brad Myrstol and Aricelle Valle, UAA; Kate Burkhart, Alaska Mental Health Board.
Staff: Mary Geddes, Giulia Kaufman.

Materials/Links provided in advance of meeting:
Power Point on Sequential Intercepts (now on ACJC Resource page)

The workgroup began with introductions and a return to the PowerPoint for Sequential Intercepts planning. The group reviewed the draft circulated of our Intercept 1 related recommendations. There were no corrections offered and everyone agreed to use it.

Intercept 2 INITIAL DETENTION/INITIAL COURT HEARINGS

This interception involves:

- Initial detention
- Jail bookings
- Pretrial detention

Presenting question how much information about a mentally ill person which is possessed by the police officer gets communicated, first to the jail and second to the magistrate?

Paul Miovas noted that information is lacking even earlier in the process. There can be an entry in APSIN that someone is "violent, " indicating some basis for concern, but the same entry might say nothing about schizophrenia, etc. Ideally DPS would provide such information and have such information centralized.

Furthermore, even when an officer knows or has gleaned that there is a mental illness or a history of mental illness, his information may not always be conveyed in an appearance before a

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

magistrate, and no one is flushing that out on the record. Miovas wondered if this is a training issue. Could magistrates be trained to ask a list of questions which might identified the issue?

Laura Brooks stated that the problem for DOC can begin with an arresting officer. Information is not getting passed along at when the inmate is transported to the jail. Rutherford agreed that if DOC could know, right from the get-go, that there is a behavioral health problem, it would be helpful.

With respect to the bail setting, Stephanie Rhoades noted that officers are able to rely on now statewide bail schedules, and that most offenses do not require that the magistrate personally set bail. However, for some crimes, offenders do go before a magistrate for bail setting. Persons may evince symptoms which may cause the judge to feel that he or she can't release them. Magistrates perceive that they have no alternative to monetary bail. They have no mechanism allowing them to switch the case to a civil matter. (There needs to be a petitioner.) Once an initial bail is set, there is an inertia that sets in, and it is hard to get the initial bail changed. Notably once a person is incarcerated, the need for a civil commitment goes away because DOC has them in their care.

Brooks noted that there are two barriers thereafter: inmates are often unable to pay even small amounts of bail , and there is often no place for the person to go to when released. DOC will often see bail orders that state people can be released when they have an appropriate living arrangement. Rhoades was curious about such orders. Brooks and Rutherford said that they had seen such orders in cases when the person is either seriously mentally ill or has dementia.

Barriers at this Intercept were identified:

1. Court order says they can't be released until they have housing
2. Even small monetary bail amounts often keeps people in jail
3. Some or all guardians (and a lot of inmates have guardians) won't post money for bail
4. Communication issues: we may not know there is a problem or that they have a guardian
5. The inmate is a poor historian or can't answer questions
6. We lack a good information repository
7. We have no mechanism for us to communicate information statewide
8. We have limited capacity for referrals or to expedite referrals
9. The barriers to sharing information include confidentiality and HIPAA. Defense attorneys may not perceive that the client benefits from mental health processes once initiated. PD's don't like DA and DOC talking to inmates.

Adam Rutherford noted that inmates often have poor contact with their attorneys. For example, inmates may remand in Bethel but end up in Anchorage. There is no one that can help our inmates communicate with their attorneys. And the time between hearings can be lengthy so courts may not be aware of any problem either. How long is it before some who has been arrested has a scheduled hearing? For felonies it will be one week, but for misdemeanors, it can

be six weeks before a hearing is scheduled. It is critical that courts learn about a persistent mental health problem but it is too infrequently communicated at the outset.

Brad Myrstol asked about the DOC in-reach done by Anchorage Community Mental Health. Rutherford noted that, at remand, in Anchorage DOC health personnel consult their internal list which they use to try identify people with mental illness. Their second step is to confer with Mental Health for their own review of intakes. The third step is for ACMH to plan for the continuation of medications and care for the person while they are in DOC institution. The problem/barrier here is that this is not possible on a statewide basis and therefore timely.

Regarding the barrier of bail, Rhoades asked about the group's familiarity with jail diversion programs. Any interest in this national best practice? Miovas indicated that while there may be interest in a team approach to jail diversion, it is a resource issue. Rhoades noted that they had a SAMSHA (Substance Abuse and Mental Health Services Administration) jail diversion project, but it was too small; prosecutors were not willing to make a greater number of referrals to the program. Tina Woods indicated that there are good models in juvenile justice and that she had been active in youth diversion with Tom Begich.

Rutherford mentioned the nationally renown jail diversion program in San Antonio, TX. [See http://www.fairfaxcounty.gov/policecommission/subcommittees/materials/jail-diversion-toolkit.pdf. In the first 5 years, more than 4,000 individuals with mental illness from incarceration to treatment and saving the county at least $5 million annually for jail costs and $4 million annually for inappropriate admissions to the emergency room.]

Myrstol stated that he was doing work concerning the intersection of homelessness and criminal justice. He wondered if we could take advantage of booking as an opportunity to intervene, and whether there is opportunity at bail reviews, even if the defense attorney's role early on does not typically involve the sharing of information about prior acts and hospitalizations.

Rhoades noted that attorneys don't know (if? how?) they can put together packages of recommendations for bail releases. Either they have no time or limited education about doing it. Jeff Jessee asked Steve about the Bethel pilot projects funded by the Trust. A social worker has been funded to work at the Bethel Public Defender. Social workers are of great use in such contexts, locating community resources for clients. Rhoades agreed that there is information-related barrier because attorneys are NOT necessarily well informed as to DOC resources, for example.

Brooks said that she was frustrated because DOC can see someone time and again who has been determined not to be competent and not restorable. Jeff Jessee noted that the role for defense attorneys is to get their clients out the door in a quick disposition and not tie them up for a competency hearing two months from now or restoration processes lasting 6 months.

Steve Williams asked if these cases be dealt with differently. The higher volume systems prevent discovery of underlying issues. Often the judge lacks experience or training so that they judges are attuned to "proxies" for mental health issues.

Rhoades noted that the point of interception is often one where there is no trained advocate. It's been years and years since the PD's had duty attorneys at initial intake or arraignment proceedings. And the courts don't want to be pro-active before any attorney is involved. Mary Geddes noted that a statute requiring the early appointment/appearance of attorneys might be a statutory fix.

Miovas noted that there are challenges (in making early release decisions) as there are no real mechanisms by which one can ensure that a high-cycler mentally ill person will not be a danger, especially when they have nowhere to go. Rhoades noted that there are national models to deal with high cyclers.

There was a question concerning DOC current screening practices. The 'jail screen' is not a best practice. The DOC intake does not screen for substance abuse disorders, although DOC does conduct a breath alcohol test and ask what they have consumed. Within 5 days, DOC screens for substance use as well. But not all of DOC facilities have a 24/7 mental health staff and there may be no mental health person to see them in the first 24 hours. In DOC-contracted community jail, there is rarely medical, no mental health staff, nor do all have contracts with local MH. They often consist of 2-4 cells. If a person is obviously symptomatic, video or audio on call services can be used.

It was also noted that in many rural communities, the 'DOC' mental health providers are actually the community mental health providers. These providers are not only very part-time, but their understanding of legal issues may be very limited. They usually have limited or no experience with forensic/competency questions.

Review of assets:

Arraignments can provide opportunity

- DOC could identify case
  - to a specialty court
  - request expediting
- Mental health courts can be pro-active
  - In Anchorage, we look at lists for arraignments, we let people know, and inform attorney so they can attend

Prosecutors – provide training so they can

- Request mental health screening from DOC
- Request the matter be calendared to wellness court
  - Anchorage - court meets MTW
  - Palmer – court meets 2 times per week
  - Juneau – court meets 1 time per week
  - None in Fairbanks

Ron Green, speaking about his clients on medication-assisted therapy, indicated that more could be served in the therapeutic courts but they have been categorically disallowed by DOC while on methadone or suboxone. Janet McCabe noted that the perceived problem is the potential for street sales with any self-administered drug. Ron has been in contact with therapeutic court coordinator Michelle Bartley, who has stated that she may approve on an individual basis.

Intercept 3: JAIL, SPECIALTY COURTS, DISPOSITIONAL COURT

Outlining the barriers under this intercept:

- There are barriers to providing treatment pretrial
    - E.g., a gravely-disabled person can be 6 weeks out from their next (misdemeanor) hearing
    - Loughner (9th Circuit) held that government's interest in being healthy enough to be determined to be competent to stand trial but that Loughner's right to be free of unwanted drugs overrode those considerations
- We don't have enough beds to handle the number of mentally ill coming in
    - 65% of population are mentally ill
- Little treatment available
    - some basic group interventions,
    - open group on substance abuse for those who are pretrial
- Most treatment is post sentence – probably 90 day outs for most
- Once they are in the institution, they lack the connection they had to community treatment. The individual might go from 2-3x a week programming to nothing
- Community-based providers do not 'in-reach' in part because they can bill outside, but not inside DOC.
- Once they are inside institution, public guardians 'take a break' but often a guardian is the person's only connection to the outside world
- DOC can do a better job of thinking about the wellness courts as a resource

Rutherford: While we might imagine that half way houses (CRCs) are a theoretical option, most of the mentally ill inmates are excluded from CRCs because they have no medical staff, and the inmate needs to be able to exercise enough initiative to get their meds from the CRC staff who hold them. There are other reasons why CRC's might not be a good fit for this group of inmates, e.g. their staff people don't have skill set to integrating people who have behavioral health problems and the CRC's would not right now meet national standards for their care-taking. However, this is worth thinking about as a source because CRCs are eligible for Medicaid now, and 15 years ago we did have a mental health CRC. Such a specialized facility could accommodate mix of pretrial with post trial.

We do have a capacity problem. API is not truly evaluating, and it is not a setting where competency can be restored. Jim Jenkins noted that there are other places that provide (criminal) restorative services in a community based setting, except for capital cases. Rhoades noted that

our statutes require institution-based competency restoration, and the amount of time for misdemeanor evaluation is as long as for felons.

MORE BARRIERS

Miovas noted that the biggest barrier to release is that there are few services downstream. It would be better if we know that once released back to community, the person is going to get services. Barriers identified by Rhoades from his discussion were no long term care, and no mandated out patient care.

The alternative to having such interventions in place is recriminalization. Jeff Jessee noted that there had been a bump with lot of cases which had a genesis at API. Person would be the subject of a competency order, would be sent to API, at API the person would get a new charge and go back to jail. Jeff thought it was related to API union staffing issues at the time.

Rutherford stated that another problem is that our referrals are going to community based providers who aren't using evidenced based interventions.

Rhoades notes that DOC is not offering MRT therapies for pretrial defendants.

Janet McCabe stated that another possible barrier is that a lack of early identification and referral to addiction courts; I note that there are courts that have underutilized capacities. Concerns were then expressed about too few individuals not allowed into Anchorage's wellness courts by the Department of Law. Tony Piper noted that the Fairbanks courts were always full. Miovas of Law noted that Law decided to consolidate the decision-making in Anchorage to one person for consistency's sake. Not everyone would make the same calls. This observation prompted Steve Williams' question about other jurisdictions' experience in making such determinations.

Rutherford thought that one barrier is a shared confusion in many locations is about what services can be provided.

Rhoades thought the cost of services for a psychiatric evaluation and for treatment is a barrier.

BRAINSTORMING ASSETS

Rhoades noted that we have strong operational therapeutic courts that can be used (Rhoades) Therefore we should recommend actions that expand/use capacity of courts. Rutherford asked how can cases be handled in more rural courts? Miovas noted that the DOL's model was to require people to be in community where services are.

Rhoades suggested that we consider the displacement that results from that model. We need to expand our capacity at least through training of judges and other professionals. The consequences of poor training is profound. For example the verdict of guilty but mentally ill was

sought for a person who stole a car. The draconian consequence of this decision was probably not anticipated.

Rutherford suggested that Alaska needs a 'FACT' team: Forensic, Community, Treatment with a small caseload, providing wrap around services and ongoing contact. Brooks responded that DOC did not formally convene on, but we have done this on an individual basis. We didn't formally convene, but did it on an individual basis. The goal of the team is to keep the person out of jail. Janet McCabe was reminded of the similar concept utilized by the Wellness Team in Kenai involving both the court and the Kenaitze Tribe which involved community members. Rhoades distinguished between a FACT 'service' team and circles which are typically limited to one or a few disposition hearings. Tina Woods noted that tribal courts implementing "Restorative Justice" do engage in creative case management in communities numbering from 20 -500. In one particular case she was thinking of there had been involvement from regular police, VSPO's and tribal police. We all needed education to help keep him home. Rhoades agreed that smaller communities had an asset that sometimes larger communities didn't: in smaller places, the deciders and providers were all in the same place.

Myrstol began a discussion about the potential asset of presentence reports. He noted that presentence reports apparently are lack information about community resources, but if they included it would be a great aid. If course, many cases don't have them at all, and DHSS/DBH "probation officers" aren't certified.

Jeff Jessee noted that SB91 and SB74 – Medicaid – reforms will allow defendants to better access out-patient treatment and support referrals to specialty court and jail diversion programs

Myrstol noted that the pretrial tools and processes under SB91 will hopefully allow for pretrial officers to disseminate the information about services.

Diane Casto stated that at DHSS, we are looking at linkages (SB91/SB74) in integrated fashion, i.e. how to get those Medicaid eligible people services before court involvement and when they come out on the other end.

BARRIERS SPECIFIC TO ARRAIGNMENTS

Rhoades noted:

- Sometimes judges lack information about why defendants are not brought to court – we are told "we are on hold" – there is no description provided through DOC/DPS/Judicial Services
- DOC never says don't transport, for example, in a suicide watch situation. We inform DPS and DOS makes the call.
- We have had people not brought over for 9 – 10 days, and we don't know why

Brooks noted that the issue is the holding cell at the court doesn't have a camera; that's why DPS doesn't want to bring them.

Williams noted that the time allowed for arraignment doesn't allow the court or others time to explore what happened.
Miovas mentions that defense attorneys often rebuff any inquiries to defendants at this stage of the process.

Myrstol identified as challenges: diagnostic capacity, and the statewide network of private and public providers. Police and law enforcement and courts perceive there is a structural disadvantage to releasing defendants, and it is hard to make progress without full buy in on the part of those partners

Brooks is concerned with those cases in which the DV laws have an unintended consequence. The defendant may be a resident at an assisted living facility or at home, with dementia, and has to be arrested under the law. The home or the care provider may be good with the defendant's return to the home. But the law prohibits it.

Miovas noted that there is an 'out' allowing the person to go home, but it requires consultation with a DA. Miovas noted that this person will probably not have an attorney or will not have meaningful contact with them for several days. Brooks stated that there is no meaningful advocacy in this crucial stage of the case.

Rhoades recommended that the statute defining domestic violence should be changed to exclude assisted living and nursing facilities in cases of dementia.

Diane Casto mentioned the State's interest in requesting a 1115 Medicaid Waiver. [This is one type of available waivers authorized by the Social Security Act, giving the DHHS Secretary authority to approve experimental, pilot, or demonstration projects that promote the objectives of Medicaid. The 1115 Waiver will be a central piece of the DHSS Behavioral Health Redesign and Reform efforts, allowing the state to expand services covered by Medicaid, the way services are offered and how costs/payments will be structured.] Alaska has not yet made the decisions about what specifically we will request in our 1115 waiver request

Time for public comment was allowed, but none was provided at this time.