Staff Notes and Meeting Sum
WORKGROUP ON BEHAVIORAL HEALTH[1]
Alaska Criminal Justice Commission
Wednesday, June 8, 2016
9:00 -11:50 AM
Location: Alaska Mental Health Trust Authority

Commissioners Attending: Stephanie Rhoades, Jeff Jessee, Brenda Stanfill
Commissioners Absent: Greg Razo, Dean Williams, Walt Monegan, John Coghill
Other Attendees: Alysa Wooden, DHSS; Paul Miovas and Steve Bookman, Dept. of Law; Steve Williams, Trust; Laura Brooks, DOC; Tony Piper and Stacy Toner, DHSS; Jerry Jenkins, Anchorage Community Mental Health; Ron Greene, Center for Drug Problems; Dave Branding, South Peninsula Behavioral Health Services;; Bill Miller, APD (joined mid-meeting); Morgen Jaco, DOC; Katie Baldwin, Trust;; Kate Burkhart, Alaska Mental Health Board; Cathleen McLaughlin, Partners for Progress; Laura Baez, Alaska Native Tribal Health Consortium; Josie Garton, Alaska Public Defender.
Staff: Mary Geddes, Giulia Kaufman.

The meeting started at 9:10 a.m.

The minutes were accepted with corrections.

Jeff Jessee first led the group through a draft of the prior meeting's findings as to barriers, assets and solutions, as identified through the Sequential Intercept Model 1-3. He noted that only one possible statutory change had been discussed, i.e. to the DV statute.

Steve Bookman asked for clarification of the proposed change to the DV statute. Judge Rhoades noted that currently there is a 20 day mandatory exclusion from a home for any individual arrested and charged with a "DV" assault. Many persons with dementia/Alzheimer's reside in nursing homes and assisted living facilities. Sometimes an assault in such context can be de minimus and the facility would be agreeable to the return of the individual sooner than the 20 days. The group had agreed that a 'carveout' for such individuals and circumstances could be appropriate. The Workgroup was not expected to draft the amendment merely identify the need for it.

Mary Geddes noted that the prior discussion had included a number of complaints about the lack of advocates for the mentally ill during the early stages of a criminal case, particularly at arraignment. Josie Garton noted that as the Alaska Constitution does not require indigent representation at the early stage of the case, a statutory change would be required if the presence of the PD would be required. Paul Miovas thought such change should be proposed, as did Laura Brooks. Stephanie Rhoades noted that she routinely sees a minimum of 2 seriously ill people at each district court arraignment. Laura Brooks noted that without a representative many individuals would just passively remain in jail. Jeff Jessee noted that fiscal notes would be required for such a fix but Paul Miovas noted that savings could be realized by more expeditious resolutions of cases at early stages of the case. The group agree to include this as a proposal to the Commission.

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

Laura Brooks asked about "jail diversion" as an intervention. She had read about the San Antonio project and wondered if the DOL is more interested now than it was years ago when there was a pilot project. Paul Miovas stated that the Department of Law is open to it and interested in the idea.

Paul Miovas mentioned his interest in having more behavioral health information included in bail and sentencing information. Laura Brooks stated that she had followed up, and is discussing with the Probation/PSR-writing head about including BH history in presentence reports.

Steve Bookman from DOL asked whether the court system should have its own forensic evaluator. Rhoades noted that the State overall has very limited numbers of qualified forensic professionals and that the only evaluators in Alaska are already employed by API. Laura Brooks noted that the UNLV review specifically addressed the need to establish and expand the state's forensic capacity overall, both for examination and restoration efforts.

The group moved onto Intercept 4, asking what are the barriers we encounter when we try to keep mentally ill and behaviorally disordered people out of jail (as opposed to prison)?

The group made several observations with respect to urban settings. Pretrial populations may be in and out of custody, which means little or no notice and little ability to plan for reentry. Services are not available for people in open cases, and funding for them is limited. IN Anchorage, the jail navigators' role has been crucial.

Brenda Stanfill noted that references to the urban/rural dichotomy is not always useful. Fairbanks isn't urban like Anchorage, but its not rural either.

Jeff Jessee suggested that it is useful to think of a continuum of service areas. More and more it will be necessary for localities to do a community specific assessment in order to obtain funding because statewide decision-makers don't necessary know what a relative reasonable constellation of services should be in place for each community. He gave the $11 million of substance abuse funding, as an example. Without knowing what's reasonable in context, we can't do good job of dealing with and identifying gaps.

With reference to jail reentry, Alysa Wooden observed that the movement of pretrial persons between facilities and communities is hugely disruptive to providing serves.

Rhoades noted that time-served dispositions, which are very common in minor cases, also make planned transitions very difficult. And a defendant's late return to the jail from a day in court may mean that a person about to be released won't get their meds because the pharmacy has already closed for the day.

Barriers also present at this stage include benefits preservation. If a person is in DOC for 30 days or more, Social Security benefits are suspended, and because of inadequate staffing at the SS office, it takes months to get the benefits rolling again.

Jerry Jenkins noted that the biggest barrier for service continuity may be that service providers don't know they are in jail.

Participants wondered if there is anything different about jail reentry challenges in rural areas. Perhaps there is less discontinuity because the information is more shared? Participants agreed that a huge gulf in services and information is created when people are moved from their home community. Josie Garton

noted that the challenges are greatest for those who are released not to their own community but to Anchorage because of legal restrictions or program requirements.

The group listed universal barriers for successful community reentry from jail:

- Housing
- Employment
- Access to treatment.
- Transportation
- Access to ID
- Lack of advocacy for culturally challenged (all Native)
- Institutional and community housing options
- Heavy institutionalization
- Learned helplessness
- Lack of timely acceptance to services (waiting lists)
- Lack of current diagnostic/assessment info
- Stigma and community hostility
- Less resources for seriously mentally ill (SMI) and co-occurring disorders
    - "IDP-Plus" population gets services (psychotic) but groups below that fall into cracks:
        - MI + TBI + FAS – low functioning population with non-psychotic disorders
- No specialized probation – Some need adaptive assistance
- No specialized clinical services to accept them
- For people with substance abuse there is insufficient, timely treatment
- For people with intellectual development disabilities – lack of information as to exactly what are the problems/needs at the time of sentencing
- The predominant model of supervision is not problem solving
- Barrier crimes
- The lack of availability of culturally appropriate treatment
- The lack of treatment for varying levels of literacy and comprehension
- In rural communities lack of housing is an eventer greater barrier.

Laura Brooks concluded that, with 12,000 releases each year, the lack of in-reach and reentry services statewide is a huge gap. Stephanie Rhoades thought the lack of integrated case management among agencies and justice system navigation were among the greatest challenges.

After a break, the group reconvened. The flip-side (assets) of the picture for the jail population are: the use of APIC, to efforts made by DHSS and ASAP to coordinate in DOC; the availability of 24-7 and other monitoring options, the policy call by the Anchorage Jail to collaborate with the narcotic drug treatment center to allow a seven day detox; the role and work done by the Jail Navigator in Anchorage, the prisoner reentry resources in Anchorage, the voluntary 12-step and psych-ed groups that are now offered at the Anchorage Jail, improved communications on releases between DOC and homeless shelters, the work of the Reentry coalitions – Anchorage, Fairbanks, Juneau, Mat-Su, the specialized probation officers (funded by the Trust?), improved collaboration between DOC and community based providers in Anchorage, new classes run by Partners and ASAP for reentering inmates at Hiland Mountain, the legislature intent language requiring a DHSS – DOC collaboration to sign up inmates for Medicaid, better communication between Court and DOC regarding upcoming discharges.

Laura Brooks noted that this last asset is really helpful, and that even getting DOC notice of a tentative plea would be helpful.

The group's recommendations for the Jail Population include an increase in reentry centers, better utilization of CRC's as true halfway houses and for programming,[2] and more data sharing between providers for evaluation purposes.

Cathleen McLaughlin noted that sharing data allows providers to transparent and honest about the services provided.

Laura Brooks said we need more in-custody release-planning staff, and to provide more reentry needs assessments for all communities. For example, DBH has a list of services that could reasonably be provided in each community. We also need a mechanism to ensure offenders do have their medical application done 30 days in advance of release. It is a 28 page application. Currently DOC can only say fill it out and mail it in.

It was noted that there are 13 areas in the state where there is a DOC institution; the total is 21 if we count community jails. Cathleen McLaughlin noted the need for a restorative justice model through which community members could invite some of these displaced offenders to return, on the community's terms. She is very concerned that we are doing little on the displaced offender issue.

Ron Greene suggested that we need more training of community providers by DOC, so that community based organizations could better understand the challenges.

Brenda Stanfill noted that the Criminal Justice Commission has sought to work with DHSS on reforming the Barrier Crimes matrix and laws.

Laura Brooks noted the frustrating gaps in case plan coordination between DOC and OCS. She would like to improve it. The goal is to better integrate OCS into case reentry planning. The Offender Management Plan should include information and goals with respect to children. Steve bookman assured the group that OCS shares that interest and endeavors to coordinate.

Another additional asset is the pilot project in Bethel at the Public Defender. The Defender office has a holistic approach to representation; Trust money is paying for a social worker to work closely with the lawyers in the office.

Josie Garton was reminded of a challenge, i.e. failures to assist the person who is mentally ill or disordered in keeping contact with family members, particularly if they have been moved out of their communities.

Laura Brooks noted that while most of the discussion has involved sharing information and providing 'soft' services, sometimes the best leg up for reentry is the provision of medical services, such as dentures. Without teeth its hard to get a job.

Alysa Wooden noted that SB91 will require a formalized in-reach for reentry providers, and the development of a 90-day reentry plan.

[2] A challenge earlier noted by Dave Branding is relevant here. Its difficult to staff CRC's and specialized care with qualified staff in non-rural areas.

A problem noted is the lack of consistency between agency waivers. Some are HIPAA compliant and some are not. One recommendation is to create a universally acceptable state agency release form compliant with 42 CFR and HIPPA.

At the next meeting on June 22 the group will continue its mapping of criminal justice intercepts, and refine its final recommendations during the second half of the meeting.

On June 29, that meeting will be reserved for discussion of the UNLV report. At 11:45 AM, Commissioner Rhoades asked for public input. There were no additional comments at this time, and the meeting ended shortly thereafter.

Criminal Justice Commission Behavioral Health Workgroup
Report and Recommendations - Draft

The Alaska Criminal Justice Commission Behavioral [1]Health Workgroup (BHWG) met on May 11, 2016. The BHWG utilized the Sequential Intercept Mapping Model to assess the interface

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[1] **Sec. 44.19.645. Powers and duties of the commission.** (a) The commission shall evaluate the

effect of sentencing laws and criminal justice practices on the criminal justice system to evaluate whether those sentencing laws and criminal justice practices provide for protection of the public, community condemnation of the offender, the rights of victims of crimes, the rights of the accused and the person convicted, restitution from the offender, and the principle of reformation. The commission shall make recommendations for improving criminal sentencing practices and criminal justice practices, including rehabilitation and restitution. In formulating its recommendations, the commission shall consider

(1) statutes, court rules, and court decisions relevant to sentencing of criminal defendants in misdemeanor and felony cases;
(2) sentencing practices of the judiciary, including use of presumptive sentences;
(3) means of promoting uniformity, proportionality, and accountability in sentencing;
(4) alternatives to traditional forms of incarceration;
(5) the efficacy of parole and probation in ensuring public safety, achieving rehabilitation, and reducing recidivism;
(6) the adequacy, availability, and effectiveness of treatment and rehabilitation programs;
(7) crime and incarceration rates, including the rate of violent crime and the abuse of controlled substances, in this state compared to other states, and best practices adopted by other states that have proven to be successful in reducing recidivism;
(8) the relationship between sentencing priorities and correctional resources;
(9) the effectiveness of the state's current methodologies for the collection and dissemination of criminal justice data; and
(10) whether the schedules for controlled substances in AS 11.71.140 - 11.71.190 are reasonable and appropriate, considering the criteria established in AS 11.71.120(c).

(b) The commission may
(1) recommend legislative and administrative action on criminal justice practices; and
(2) select and retain the services of consultants as necessary.

Sec. 44.19.646. Methodology. In making recommendations, the commission shall

(1) solicit and consider information and views from a variety of constituencies to represent the broad spectrum of views that exist with respect to possible approaches to sentencing and administration of justice in the state; and
(2) base recommendations on the following factors:
(A) the seriousness of each offense in relation to other offenses;
(B) the effect of an offender's prior criminal history on sentencing;
(C) the need to rehabilitate criminal offenders;
(D) the need to confine offenders to prevent harm to the public;
(E) the extent to which criminal offenses harm victims and endanger the public safety and order;
(F) the effect of sentencing in deterring an offender or other members of society from future criminal conduct;
(G) the effect of sentencing as a community condemnation of criminal acts and as a reaffirmation of societal norms
(H) the elimination of unjustified disparity in sentence
(I) the sufficiency of state agency resources to administer the criminal justice system of the state;
(J) the effect of criminal justice laws and practices on reducing the rate of recidivism in the state;

between Alaska's criminal justice and community behavioral health systems and to identify criminal justice/community behavioral health programs and practices to prevent the incarceration of persons with mental health disorders

Sequential Intercept Mapping Model - Intercept 1

BHWG members identified several barriers to first responders to keeping people with behavioral health disorders (defined for this purpose as Alaska Mental Health Trust beneficiaries[2]) out of the criminal justice system.

Dispatchers can sometimes resolve calls involving serious behavioral illnesses without dispatching an officer. However, often these callers call police many times, tying up the 911 lines. It takes a considerable period of time to resolve a behavioral health crisis by phone, when it can be done. If it cannot be done, there is no behavioral health response that can be directly dispatched to a call. It is police policy to dispatch officers to these calls.

Police experience community pressure to remove nuisance offenders from the streets. There is particular pressure from the urban business community to remove people who experience chronic behavioral health problems from around their businesses because they discourage potential customers. Police perceive that mental health disorders are misunderstood by the public and that there are few tools to removing behaviorally challenging people who are nuisances but are not breaking the law. For those who do, arrest for nuisance crimes relieves community pressure.

There are several assets used by first responders to keep people with behavioral health disorders out of the criminal justice system in both urban and rural areas. Crisis Intervention Training[3]and Mental Health First Aid Training[4] – especially that tailored to police - has proven

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(K) peer reviewed and data-driven research; and
(L) the efficacy of evidence-based restorative justice initiatives on persons convicted of criminal violations and offenses, the victim, and the community

[2] Alaskans who experience a:

a) Mental illness, developmental disability, chronic alcoholism or other substance-related disorders, Alzheimer's disease and related dementia, and/or a traumatic brain injury
b) Require or are at risk of institutional levels of care
c) As a result of their disorder experience a major impairment of self-care, self-direction or social and economic functioning such that they require continuing or intensive services and supports

[3] The model involves 40 hours of specialized training of 911 dispatchers and officers provided by mental health clinicians, consumer and family advocates, and police trainers. Officer training includes information on mental illnesses; treatment; co-occurring disorders; legal issues, techniques, developmental disabilities, older adult issues, trauma and excited delirium and de-escalation, presented experiential and practical skills/scenario based training formats. 911 dispatchers are trained to identify mental disturbance calls and assign these calls to CIT trained officers. CIT officers use de-escalation techniques and assess if referral (diversion) to services or transport for mental health evaluation in lieu of criminal charging is appropriate.

[4]An evidence based training involving interactive sessions which total 12 hours. It can be conducted as one two-day seminar, two one-day events spaced over a short period of time or as four 3-hour sessions. Mental Health First

effective for dispatchers and police to help understand the dynamics surrounding police calls that involve people with serious behavioral health challenges, to de-escalate them more effectively, to reduce harm to all and to divert respondents to community resources in lieu of jail where possible.

In rural areas, mental health aides are available 24/7 to co-respond to calls with a public safety officer or to respond alone when safe. The community also works to gain a sense of ownership of the problem person and to find ways to respond other than call the public safety officer into a problem situation. Behavioral health and law enforcement conduct ongoing welfare checks to prevent ongoing issues. Title 47 involuntary civil commitment is an option as well as Title 47 alcohol/mental health holds.

In urban areas, the emergency room, sleep off centers, detox beds, Title 47 alcohol/mental health holds and involuntary civil commitment, the community respite center, domestic violence shelters are some of these assets.

The gaps appear to be that current behavioral health assets are delivered in models that do not prevent criminal justice involvement for persons who are non-voluntary, such as homeless people with mental illness or substance dependence, those with antisocial tendencies. Those that are appropriate either do not exist in rural areas or lack capacity in urban ones. None of them retain people long enough to solve the community or the individual's problems. They end up back on the street swiftly, they are untreated and engage in the same behaviors. Title 47 involuntary civil commitments require meeting high legal standards, the stays are too brief and the person is returned to the community in an unstable condition, where arrest requires a lower legal standard. There is not a 'warm enough' hand off from acute high level care to community behavioral health to

Intercept 1
Recommendations – Approved by CJCBHWG – May 25, 2016

911:

- Train more dispatchers through CIT training to identify calls involving persons with behavioral illness and refer to designated, CIT trained police
- Implement a mental health response that dispatchers could directly dispatch in lieu of or with police

Police:

- Train all police and public safety officers in the state to respond to calls where behavioral illness may be a factor either through CIT training or Mental Health First Aid training

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Aid certification must be renewed every three years, and introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact and overviews common treatments.

- Provide a police-friendly drop off at local hospital, crisis unit, or triage center, or mobile crisis mental health response for direct dispatcher or police referral/drop off that can motivate non-voluntary admissions to engage in treatment or referral to treatment and other resources
- Mandatory Assisted Community Treatment for high risk persons who refuse treatment
- Provide service linkages and follow-up services to individuals with behavioral illnesses who are identified to be at high risk of criminal justice involvement

Program Examples

The CIT model and the co-responder model were based on each respective originating jurisdiction's distinct circumstances, reflecting the need for a flexible decision-making process.

Memphis (TN) police leaders, mental health professionals and advocates, city hall officials, and other key stakeholders were spurred to action following a tragic incident in which an officer killed a person with a mental illness. In response, the Memphis Police Department established the first law enforcement-based CIT in 1988, which was designed to improve safety during these encounters by enhancing officers' ability to de-escalate the situation and providing community-based treatment alternatives to incarceration.

Los Angeles and San Diego (CA) initiative leaders recognized that officers encountered many people with mental illnesses who were not receiving adequate treatments and services. To address this problem, law enforcement agencies collaborated with the mental health community to form teams in which officers and treatment professionals respond together at the scene to connect these individuals more effectively with community-based services.
*This summary of the Memphis and Los Angeles /San Diego models was drawn from Melissa Reuland, Laura

Draper, and Blake Norton, *Improving Responses to People with Mental Illnesses: Tailoring Law Enforcement Initiatives to Individual Jurisdictions,* Council of State Governments Justice Center (2010)

*See also: Statewide Law Enforcement/Mental Health Efforts: Strategies to Support and Sustain Local Initiatives***,** Council of State Governments Justice Center (2012)

Sequential Intercept Mapping Model - Intercept 2

BHWG members identified several barriers to keeping people with behavioral health disorders out of the criminal justice system at the arrest, initial detention, arraignment and bail review hearing intercepts.

Information Across the Intercepts – Barriers, Gaps:

Information collection and sharing posed a barrier at all intercepts. Even when information is known by the arresting officer, no consistent or formal mechanisms for sharing and bringing the information forward to criminal justice players at all other intercepts are in place. From the bail setting magistrate, to the jail, to the court from the jail or the transport officers, and

ultimately to the parties in the criminal case little information is consistently collected and shared. At each intercept, lack of information about the person's condition and need to have the case expedited for consideration of appropriate diversion from the criminal justice system by anyone empowered to do so posed a barrier.

Other identified barriers:
Initial Detention /Initial Court Hearings
(Committing Magistrate or Bail Schedule), Jail First Appearance Court (Arraignment):

- Once criminal case is charged, criminal justice culture militates in favor of processing the case toward a legal resolution rather than a treatment diversion
- Domestic Violence Assault statute often results in seriously mentally disabled co-residents of Assisted Living Facilities who are charged with assault being removed from their only housing option
- Committing magistrates have no civil legal alternatives to divert to treatment (civil instead of criminal commitment)
- No formal jail diversion program
- Even when bail is set very low, people with serious disorders are indigent and can't bail out
- Some or all guardians (a lot of inmates have guardians) won't post money for bail
- Communication issues: we may not know there is a problem or that they have a guardian
- The inmate is a poor historian or can't answer questions
- DOC lacks a good information repository
- DOC has no mechanism to communicate information statewide to legal players and limited ability for referrals or to expedite referrals
- 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.
- No immediate advocate to help inmate navigate bail and reconnect with natural supports - arraignment not held for 24 hours and sometimes days, if the inmate is unstable
- Hard to locate natural supports for the inmate – (guardian, family, treatment provider, etc.) to assist them to make bail
- Guardians won't post bail
- No formal jail diversion program
- No legal or other mechanism to bring case to the attention of the court or counsel for expedited attention
- Pre-trial inmates with serious disorders are excluded from lesser classifications like CRCs, as there is no medication management staffing
- Large court calendars prevent identification of people with serious disorders
- Judicial officers and lawyers are untrained in identifying people with serious disorders
- Even if trained, defense attorneys are not present at arraignment to identify

- Court dates are often not scheduled for weeks, leaving some inmates to languish since they do not self-advocate well for release
- Some defendants may not be transported for days due to their condition
- Competency for legal proceedings pose the barriers in 1) lack of forensic capacity to perform evaluations, which can take longer in some cases than a person would be sentenced to even if found guilty 2) limited hospital capacity for restoration capacity and 3) high jail cyclers who are found not competent, not capable of restoration are evaluated over and over again in each new case.

Assets - Initial Detention
(Committing Magistrate or Bail Schedule), Jail, First Appearance Court (Arraignment):

- Officer collected information is sometimes transmitted to the Magistrate and the jail. This information can help move the case toward medical and mental health treatment in DOC and toward an available specialty court. This is especially true when CIT trained officers are involved
- Magistrates, arraignment judges and DOC can directly refer cases to the mental health courts
- DOC screens for mental illness within 24 hours of arrest with evidence based tool, later for substance use disorders.

- Inmates who screen positive are referred to medical and mental health for treatment
- Jail Navigator in Anchorage employed by one of the largest community mental health centers provides early identification, information sharing, treatment continuity and swift discharge planning for exiting inmates
- AK judges have had some judicial training in mental health and substance use disorders
- Centralized competency calendar in Anchorage better uses forensic resources and then expedites cases into specialty court

Gaps – Initial Detention

- Information sharing for continuity of care/referral
- Substance Use Disorders not screened for swiftly or uniformly
- Substance Abuse treatment not consistently available pre trial
- Community treatment Jail Navigator only available in Anchorage
- Jail Diversion unavailable systematically
- Early advocacy for the person unavailable or not utilized
- No sub-acute long term or community based treatment alternatives for Incompetent/Non-restorable or others unaccepting of treatment.

Intercept 2: Initial Detention /Initial Court Hearings
Committing Magistrate or Bail Schedule), Jail, First Appearance Court (Arraignment)
Recommendations – Approved by CJCBHWG – May 25, 2016

- Amend the Alaska criminal statutes so that seriously mentally disabled persons charged with less serious assaults on Assisted Living or Nursing Facility co-residents or live in staff are not ordered out of their only housing option
- Implement formal information collection, documentation and sharing process around cases involving people with serious disorders that begins with first responder contact and continues through the life of the criminal case that do not impair criminal justice rights
- Expand the use of Jail Navigators to identify and help plan, coordinate bail release and link medically fragile/complex (like dementia; seriously mentally ill) expeditiously to natural supports in the community (this could be part of a pre-trial services and/or jail diversion effort)
- DOC to screen uniformly for substance abuse disorders and consistently treat these
- Implement a statewide jail diversion program for persons with serious behavioral health disorders through the newly established DOC Pre Trial Services Division, or other means, that identifies those eligible for diversion or needing treatment in jail through validated instrument or matching management information systems; screen at jail or at court by designated prosecutors, defense, judge/court staff and service providers; specially trained pre-trial service staff to link to comprehensive services, prompt access to benefits, health care, and housing and monitor the person in the community.
- State Medicaid and Criminal Justice reform efforts to collaborate to fund community based jail diversion services and supports
- Provide mechanism for DOC to alert courts without specialty courts that a person may be demonstrating symptoms that place competence for legal proceedings in question or that the case is in need of other problem solving

Sequential Intercept Mapping Model – Intercept 3
Jail, Specialty Court, Dispositional Court
Barriers:

- Jail cannot treat gravely disabled
  - 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
- Insufficient beds to handle the number of mentally ill coming in
  - ___? of population are mentally ill
- Little treatment available pretrial
  - some basic group interventions,
  - open group on substance abuse for those who are pretrial
- Most treatment is post sentence – probably 90 days or more out for most

- Once they are in the institution, they lose 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 community
- Inmates with serious disorders are excluded from lesser classifications like CRCs, as there is no medication management staffing
- No mechanism for DOC to expedite case for court/counsel attention
- API does not timely accept forensic commitments
- Specialty courts are not available in all jurisdictions, defense and prosecutors are not utilizing them to their capacity due to limiting legal or clinical criteria or the personalities of the lawyers involved.
- Specialty courts may be too restrictive in denying participation to adjunctive medication users
- Sentencing courts receive little information and do not know how to structure behavioral health treatment conditions
- Behavioral health sentencing requirements not driven by assessment
- Access to treatment as a court condition is limited and costly
- Court order says they can't be released until they have housing
- Even small monetary bail amounts often keeps people in jail

Intercept 3
Assets - Jail, Specialty Court, Dispositional Court

- Some treatment is provided in jail
- Centralized Competency Calendar (in Anch)
- DOC can identify cases
    - to a specialty court in Anc, Pal, Jun
    - to Centralized Competency Calendar in Anchorage
- Mental health courts identify and expedite cases
    - Identify people with mental illness from arraignment lists
    - Screen for competency
    - Expedite cases for defendant to meet lawyers, for parties to problem solve
- SB91 and SB74 – Criminal Justice and Medicaid – reforms will allow all defendants better access to out-patient treatment and those receiving treatment through specialty court programs – could also support those in a jail diversion program

Intercept 3
Gaps: Jail, Specialty Court, Dispositional Court

- Insufficient treatment capacity in DOC
- Lesser restrictive settings (CRC) unavailable
- Jail diversion unavailable systematically

- No Jail treatment for grave disability
- Low forensic examination and hospital restoration capacity
- Insufficient number of specialty courts in the state, existing courts not used to capacity, inconsistent criteria
- Judges don't have enough information or knowledge to structure treatment conditions

Intercept 3 – Jail, Specialty Courts, Dispositional Courts
Recommendations- Approved by CJBHWG June 8, 2016

- Implement a statewide jail diversion program for persons with serious behavioral health disorders through the newly established DOC Pre Trial Services Division, or other means, that identifies those eligible for diversion or needing treatment in jail through validated instrument or matching management information systems; screen at jail or at court by designated prosecutors, defense, judge/court staff and service providers; specially trained pre-trial service staff to link to comprehensive services, prompt access to benefits, health care, and housing and monitor the person in the community.
- State Medicaid and Criminal Justice reform efforts to collaborate to fund community based jail diversion services and supports
- Establish lesser restrictive CRCs for people with serious mental disabilities or create regional or multiple CRCs that just serve people with serious mental disabilities. Perhaps adding medications management capacity to existing CRCs so they can serve a broader cross section of people would be a better strategy.
- Assure mechanism for DOC or API to provide services consistent with community and public health standards, including appropriate psychiatric medications for the gravely disabled
- DOC to widely offer therapy approaches addressing criminogenic thinking/behavior along with other evidence based therapies.
- Review criteria and referral processes, examine reasons for underutilization and remove barriers to maximize use of specialty courts
- DOC and Court system to collaborate on Addictions courts referrals
- Add specialty courts where the community can support them
- Medicaid reform efforts should include Medicaid reimbursement for those services utilized by specialty court participants
- Mental Health Court users should receive service priority in community based services to motivate participation and promote timely linkage
- Pre-sentence reports to include relevant behavioral health information and specific proposed treatment conditions
- Dispositional Courts to order only assessment driven treatment conditions
- Implement Centralized Competency Calendar in each district, which could also serve as a clearing house for serious cases flagged by DOC for expedited consideration by the parties
- Expand forensic capacity for examination and restoration
- Medicaid Reform efforts to include requesting a 1115 Medicaid Waiver to benefit people with serious behavioral disorders involved in the justice system. [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

- State of Alaska SB 74 and SB 91 efforts to coordinate to provide jail diversion supports for people with serious behavioral health disorders
- Sign all DOC Medicaid eligible inmates up for Medicaid while in custody

Program Example:

San Antonio Texas

Blueprint for Success: The Bexar County Model – How to Set Up a Jail Diversion Program in Your Community

Through its unique position within the criminal justice system, the jail diversion program offers immediate alternatives to incarceration for the mentally ill. Jail diversion is accomplished by applying a step-by-step methodology. The first step is to identify individuals with mental illness along the criminal justice process, and the second step is to integrate the appropriate social and health care services and make them available to these individuals for referral. Perhaps most significantly for the community is the establishment of crisis care centers in conjunction with jail diversion programs. These centers reduce emergency room use, resulting in significant savings for the community. For Bexar County alone, jail diversion programs leading up to the creation of the Crisis Care Center brought about a savings of nearly 5 million dollars in 2006. Police officers were freed from the enormous amounts of time spent waiting in the emergency room for screening and triage of mentally ill patients under their protection. This allowed a quick return to their duties within the community. Before the establishment of crisis care centers, police officers in Bexar County spent an average of 12 to 14 hours in hospital emergency rooms waiting for psychiatric evaluations. Today, the crisis care centers provide these same services in one hour.

THERE ARE A NUMBER OF DIRECT BENEFITS PROVIDED TO THE COMMUNITY BY JAIL DIVERSION PROGRAMS:

Jail diversion programs reduce monetary costs to the community and they improve the quality of life for consumers, which arise from inadequate mental health services or even a total lack of mental health services within the prison system. Jails are not designed to provide the necessary facilities to serve the emotional and medical needs of the mentally ill. Jail diversion programs redirect mental health consumers toward the mental health service system where they and society are better served. Jail diversion programs offer judges and prosecutors much needed alternatives for disposing cases involving the mentally ill. At one time, incarceration of these individuals was the only choice, but now those in need of treatment can be placed outside the criminal justice system. Jail diversions make more jail and prison space available for violent offenders, thus enhancing public safety. These programs interrupt the endless cycle of arrest-jail back to street for many of the non-violent mentally ill who become caught up in the criminal justice system without hope of treatment. For nearly 30 years since their inception, jail

diversion programs have enjoyed wide support for their ability to reduce involvement in the criminal justice system by the mentally ill and those with substance abuse disorders. Surprisingly, to date there are few studies documenting the effectiveness of these programs. Those studies that do exist, however, demonstrate the success of diversion programs. In a 1995 Los Angeles investigation, of 101 diverted individuals, 80 were transported to a hospital with 69 remaining as mental health inpatients and only two ultimately ending up in jail. Another study of a jail based diversion program in Rochester, New York found that in the year following intervention there was a mean reduction in the number of jail days by more than half. In a multi-site research initiative sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 1997, the well-being of mentally ill individuals improved on a number of measurable points. This includes reduced days spent in psychiatric and residential treatment facilities, more time back in the community, improved mental health symptoms over time, "and more mental health treatment being received by the diverted group. Finally, in a review of four programs, two reported no savings; however, New York City reported $6,260 in savings per individual due to reduction in jail time, and Memphis, Tennessee reported $5,855 in savings. SAMHSA's conclusion was that jail diversion 'works' by reducing jail time and offering the potential of community savings.

Intercept 4-Jail Reentry/Prison Reentry

Barriers – Jail – similar to prison reentry except that a high percentage of inmates are in a "pre-trial" not sentenced status; therefore, a release date is not known. As a result discharge planning and reentry assistance does not occur in most cases. For inmates who had Medicaid and Social Security benefits prior to incarceration those benefits are suspended after 30 days of incarceration and may not be reinstated for months. Comprehensive, collaborative discharge planning can be further complicated because service providers often don't know their clients are in jail.

Barriers – Prison

- Housing (including institutional and community housing options
- Employment
- Lack of treatment capacity/ timely acceptance to services (waiting lists)
- Lack of medical and dental treatment
- Generally a lack of individual medication continuity between DOC, API, and community providers upon release
- Generally a less than adequate supply of release medications for mental health conditions
- Updated assessments (mental health, substance abuse, criminogenic, etc.) do not follow the inmate into the community
- Lack of universal release of information accepted by all agencies. Some are HIPAA and 42 CFR compliant, some are not. Some agencies prefer their own release.
- Rural reentrants are unable to return to home community because some court ordered treatment only available in urban areas
- Transportation

- Loss of ID and personal property
- Limited access to new personal identification upon release
- Lack of advocacy for persons experiencing a disability, have literacy or communication challenges and/or without the financial or personal relationship (family/friends) resources to assist in navigating the criminal justice system.
- Heavy institutionalization/learned helplessness
- Lack of current diagnostic/assessment info
- Stigma and some community resistance to welcoming released individuals back into their home community
- Lack of mental health and co-occurring substance abuse treatment/case management for those without psychotic disorders
- For people with intellectual development disabilities – lack of information as to exactly what are the problems/needs at the time of sentencing
- Barrier crimes
- The lack of availability of culturally appropriate treatment
- The lack of treatment for varying levels of literacy and comprehension
- In rural communities lack of housing is an eventer greater barrier
- Inadequate release communication and coordination between the Correctional, Institutional Probation and Field Probation Officers
- Lack of in-reach and reentry services statewide
- Lack of integrated case management among agencies and justice system navigation
- Lack of warm transfer of inmate by institutional probation to community probation
- Prisoner movement between facilities can make reentry planning a challenge
- Although recent legislative bills have included language and reference to State collaboration with Alaska Native (tribal) governments and organizations it does not carry the same weight as language directing State departments to collaborate on these issues
- Workforce challenges at every level, from direct care to case management to psychiatric positions

Intercept 5 – Probation/Parole

- The predominant model of supervision is oriented to monitoring for compliance and not for the individual's success which requires being supportive, problem solving balanced with accountability and public safety
- Few resources for seriously mentally ill (SMI) with co-occurring disorders
- Specialized probation only available in limited places and for limited population ("IDP-Plus" population eligible for specialized probation and clinical services (for psychotic disorders) but other seriously mentally disabled groups do not and fall between the cracks: Ex: Other Mental disabling mental illnesses + Intellectually disability+TBI + FAS, etc. – low functioning populations with non-psychotic disorders

Intercept 4 and 5 – Assets

- DOC – APIC (Assess, Plan, Identify, Coordinate) discharge planning for inmates with psychotic disorders
- DHSS-Alcohol Safety Action Program (ASAP) in-reach into DOC
- 24-7 monitoring
- Anchorage jail coordination with Narcotic Drug Treatment Center
- Community mental health provider embedded in the Anchorage jail complex to identify persons booked into the jail with a mental illness
- DOC Offender Management Planning (OMP)
- Prisoner reentry centers that provide reentrants with case management to link to housing, treatment, employment, probation officers and other supports and services
- Prisoner reentry coalitions to assist and partner with DOC and the returning citizen in the reentry planning, release and connection to community services/resources
- Specialized probation for persons with a severe and persistent mental illness(SPMI) in specific locations
- Homeless shelter coordination with DOC/jails
- improved collaboration between DOC and community based providers in some locations
- Reentry classes run by reentry centers in DOC (Hiland)
- DOC efforts to enroll inmates in Medicaid,
- Improved communication between the Court and DOC regarding upcoming discharges (Mental health court/centralized competency calendar in Anchorage)
- Bethel Public Defender/Alaska Legal Services Inc. holistic defense pilot project connecting civil and criminal representation as social service support around the individual

Intercept 4 and 5 Recommendations - Draft

- Continued support for DOC's Alaska Prisoner Reentry Initiative (AK-PRI)
- Improved data sharing between across community providers and with DOC
- Create a universally accepted Release of Information form that is compliant with HIPAA, 42 CFR and State confidentiality laws and require that all agencies accept the release
- Increase in-custody release-planning staff to do reentry needs assessments in all communities
- Update behavioral health and Level of Services Inventory – Revised (LSI-R) assessments for reentry
- Maintain linkage to a continuum of care for reentrants by increasing number of reentry centers/coalitions
- Increase treatment capacity for mental health and substance user disorders
- Provide access to medical and dental treatment (hard to get a job with no teeth)
- Streamline access to treatment for returning citizens
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- Increase Specialized Probation and clinical services to all areas in the state and expand eligibility to all inmates with serious mental disorders
- Utilization Community Residential Centers (CRCs) as true reentry halfway houses and provide or require in contracts programs for mental health, substance abuse, employment, etc.[5]
- Implement/improve information and data sharing between providers for identification, service and evaluation purposes.
- Conduct community specific assessment of reentry service needs in order to support obtain funding (because statewide decision-makers don't know what a relative reasonable constellation of services should be in place for each community)
- Assure that all inmates, have applied for receipt or reinstatement of Medicaid prior to release
- Cross train community providers on criminal justice/reentry legal issues
- Use restorative justice approach to promote successful reentry/reintegration for individuals to their home communities (rural and urban) so they are not displaced
- Continue to review and address identified issues with barrier crimes impacting successful reentry
- Closer collaboration between Office of Children's Services (OCS) parenting requirements and DOC reentry case planning
- Continue DOC Offender Management Planning process driven by LSI-R and behavioral health other assessments
- Train community corrections officers and community providers on the use of graduated incentives and sanctions to reinforce positive behavior and also address noncompliance with probation conditions

[5] A challenge earlier noted by Dave Branding is relevant here. It's difficult to staff CRC's and specialized care with qualified staff in non-rural areas.