Staff Notes and Meeting Summary
WORKGROUP ON BEHAVIORAL HEALTH[1]
Alaska Criminal Justice Commission
Wednesday, June 22, 2016, 9:00 -12:00 PM
Location: Alaska Mental Health Trust Authority

Commissioners Attending: Stephanie Rhoades, Jeff Jessee, Brenda Stanfill, Kris Sell
Other Attendees: Alysa Wooden, DHSS; Paul Miovas and Steve Bookman, Dept. of Law; Steve Williams, Trust; Adam Rutherford, DOC; Tony Piper and Stacy Toner, DHSS; Jerry Jenkins, Anchorage Community Mental Health; Dave Branding, South Peninsula Behavioral Health Services; Morgen Jaco, DOC; Cathleen McLaughlin, Partners for Progress; Trina Sears, OVR; Josie Garton, Alaska Public Defender; Heidi Wailand, Agnew-Beck.
Staff: Mary Geddes

Relevant Materials:

Behavioral Health SQ 1-5 Recommendations, previously distributed

Also referenced:
Alaska Behavioral Health Systems Assessment Final Report (linked)[2]

Meeting Summary

The meeting began at 9:10 A.M.

Criminal Justice Commissioners Jeff Jessee and Stephanie Rhoades reviewed past recommendations. Rhoades noted that the recommendations need to be categorized so as to better organize them for presentation. ACJC has a particular mission oriented to statutory and administrative reform of criminal justice laws and practices. One example of a reform discussed in the Workgroup which is well suited to ACJC's mission is the idea of requiring presentence report writers to include behavioral health information; this could be categorized as a statutory reform.

Jerry Jenkins, Adam Rutherford, Dave Branding and Tony Piper discussed the 'categories': statutory, regulatory or policy. A policy might require agencies to work together to improve access to treatment. The group began to identify categories for each recommendation under the sequential intercepts model which identifies barriers to mental health services in each phase of the criminal justice system. [These notations are not necessarily recounted in this summary]

One problem was noted at the outset: when a person is denied immediate access to or a certain level of treatment because of "no assessment" having yet been conducted by that particular agency, even though there may be another assessment that has been done. How to fix this? A regulatory change might accomplish it but it could be a policy change requiring Memoranda of Understanding that require contractors to accept individuals for treatment even if they don't agree with an initial assessment. Steve Bookman suggested that maybe MOU's state that acceptance is required but then commit the agencies to a dispute resolution. Agencies really don't trust each other's assessments.

[1] Throughout the continuum of care in the criminal justice system.
[2] http://mhtrust.org/mhtawp/wp-content/uploads/2015/11/BH-Systems-Assessment-Report_Updated-1.22.2016_email.pdf

Jerry Jenkins noted how easy it is in Anchorage, relatively speaking, with a single point of entry like Partners. For Progress. An assessment can be done right then and there at the Reentry Center. However, with respect to Implementing a formal collection of information and then sharing that same information, statutory change will need to take place. Funding and policy changes are likely involved as well.

At Intercept 1, Kris Sell asked if the review had covered Title 47's. Rhoades indicated it did not because Title 47's are involuntary. The question had been whether a person who could make a choice could 'choose' treatment at this early stage of contact with the criminal justice process. It was recognized that sometimes the choice does not seem particularly voluntary (go to treatment or else).

Rhoades said that she wasn't entirely sure the extent to which SB91 addressed pretrial diversion. A statewide pretrial diversion program is needed for mentally ill people. SB91 mentioned pretrial diversion only in the context of pretrial services (yet to be developed by DOC) that may allow pretrial services officers to recommend diversion to courts and prosecutors. An additional question was asked about the extent to which pretrial assessments will be conducted. Kris Sell noted that there was a lot of misinformation about Sb91 flying around. Rhoades noted that the Commission will be tasked with oversight of its implementation. Jenkins asked whether ACJC oversight will be able to cover the waterfront of behavioral health issues which will need to be monitored. Rhoades said that it is better to have statutory standards for pretrial diversion because then the programs don't ebb and flow with the particular administration. Mary Geddes asked if pretrial diversion has in fact been implemented. Paul Miovas indicated that there is discretion but really no standards.

Rhoades said that the pretrial services program will be a huge reform and a great opportunity for effective "jail diversion" of BH populations. Perhaps jail diversion could be tied to assessments. Pretrial services officers could be able to plan for each person, using performance standards for effective pretrial intervention. Rhoades asked if the Commission could recommend a jail diversion component of pretrial services. Josie Garton identified the need to create such a program by statute, in order to obtain uniform implementation. Sell asked about those who wouldn't want to participate in treatment. Rhoades agreed it would be voluntary only. Rhoades suggested that DOC could look to standards developed by the National Association of Pretrial Services Agencies for pretrial interventions. Miovas asked if the DA have veto over jail diversions. Rhoades suggested that if the program would be effective, it would have to capture more than a few people Larger programs in bigger jurisdictions may depend on statutory framework and certain exclusions; where there are smaller populations and communities, decisions can be more individualized. Miovas noted that the DA would want some discretion regarding admission. Rhoades responded that discretion can be class based, rather than making judges on a wholly individual basis. Garton suggested that eligibility could be agreed to by criminal history and other criteria.

The group then discussed the previously-identified need for a mechanism through which DOC can alert the courts as to the needs/problems of an individual; it seems that many individuals really languish. Rhoades asked what kind of fix is needed? Adam Rutherford wondered if the new pretrial services officers might provide that partial screening and alert the court. Garton stated that the defenders would prefer to be contacted. Rutherford said that DOC does sometimes contact attorneys to no avail. Rhoades mentioned a defendant who had been charged with felony assault on co-resident in a MH facility; he was consequently not eligible for MH Ct. As a result of a court hearing, the attorney got a better handle on the individual's status, the resources and the law. Lots of defenders don't know what options exist when dealing with a mentally ill defendant. Kris Sell asked if there was some way to deal these in-court

discussions so that defense attorneys won't perceive that their clients are disadvantaged by candid discussions.

Rhoades said that she wanted to see better utilization of therapeutic courts. She wondered if we need standards which would reduce the impact of decision-making (exclusions) by individual DA's. We should also promote best practices. Rutherford believes DOC 'under-refers' to specialty courts.

Rhoades noted that addicts are poorly served by the current intake process for the wellness court. Mental health courts are different because the courts can take direct referrals from anyone, and conditional-opt in allows for assessment purposes. In contrast , addiction courts do not allow conditional opt in. Paul Miovas expressed concern that the wellness court will dry up because of the change in SB91 to MISC 4 (current, to be former felony statute for drug possession) . Rhoades said that the first and second timers shouldn't be in the therapeutic courts. The courts should be dealing with the higher risk folks, but they are being excluded. Criteria should be codified in statute to take the political pressure off the DA's. There is a need to expand the categories of offenders who can benefit. Miovas noted in response that the current system does use standards that were collaboratively developed but those standards allow Heather to be the funnel and have the final say. Palmer has the same set-up, with one DA making the call. Rutherford noted that people can't get into treatment/services when they need to, i.e. shortly after release. DOC only gives meds for one week at release and capacity may be limited outside the therapeutic court context. Therapeutic court participants are given priority admission to services.

Dave Branding noted some differences in re-entry scenario for a community like Homer. Accesses in that community are well-integrated, so people don't get lost. His organization has residential services for SMI and TBI, there are integrated substances abuse services, 90% of the folks who walk in can get same day access to services. And one funding stream helps support the other. Jeff Jesse noted that there is better funding for developmental disabilities than for behavioral health. The reimbursement system is such that in a rural area, better easier to become dual provider. Rhoades asked if regulation or statute requires BH patient to receive care in the least restrictive setting.

In response to a question from Judge Rhoades, Jerry Jenkins noted that Anchorage Community Health are taking releases from DOC and API who are bipolar as well as those patients who are seriously mentally ill (SMI). Adam noted that there are capacity problems when we rely on community based organizations to do more. Jerry Jenkins noted that he had been here 14 years now, and there is less money and greater census pressure now with SMI. His network encompasses Anchorage Community Health and Fairbanks. They do take all bipolar patients referred from DOC and API, if they have capacity. He was asked what the statutes say about who gets services. Jerry said that with SMI, the standard is based on functionality. Southcentral provides services but not case management; Indian health resources are limited unless a person can get into Quyana House. Elsewhere: SED sees children, in Juneau, the organization is JAMI, on the Kenai its Central Peninsula, and in the Valley. Free-standing case management can be provided by Akeela, Hope, ARC, 9-Star, and Choices.

Rhoades asked if ACT (Assorted Community Treatment) grants disappearing is a barrier. Dave Branding said that there is an inconsistency among communities. ACT teams can fund a person in a community. It is a seven day a week service allowing intervention when the client starts to decompensate. It is hard to translate this service into the cubbyhole of community based services, but an argument can be made to pay for this through a Medicaid waiver.

Rhoades asked what are those things that are missing that keep people from re-entering jail? Someone said: certified community BH residential units, including "crisis respite" which is a higher, enriched level of care for a few days, without meeting involuntary standard. Our biggest gap in communities may be there is no place to drop off people, and an inadequate service array. Jeff Jessee – Assorted Community Treatment

Jessee agreed that inadequate crisis response is big gap. That the "living room" concept is a good one as far as law enforcement has been concerned: allowing anyone to come in, 24/7 staffing, nurses, peers, telemedicine link to ER, 1 block from Detox. This should be a calm environment – not hospital based, thus maintaining the connection to community services. This arrangement allows for a better collaboration between ER, LE and MH system. This could in theory help those displaced because of DV, or other housing cries. Often he crisis resolves within a few hours. PepR does a great job but it is a hospital. So how do we get one? It may be a policy. One barrier might be privacy concerns. Another barrier is funding because you need to buy capacity not services.

Kris Sell liked the concept for Juneau. While we have CIT training, we have no other services and resources. She noted a limited capacity at Rainforest to deal with alcohol related problems, and that they have a hard time keeping their staff, because people need to be well compensated to stay with this population.

Jenkins noted that the same problem exists in Fairbanks. SR Something other than hospital is needed. Heidi Wailand qualified her agreement: noted that a short-term crisis stop is really important, but also a supportive housing situation. Without that, its like throwing money out the window to bring them back. Brad Myrstol asked if the fundamental barrier here isn't economic because the consumer cannot afford the services without government insurance. Rhoades appreciated Brad's observation, noting that the average monthly income of a person on SSI Disability is $900/month. Jessee did not disagree but said there is great opportunity because of Medicaid waivers and Justice Reinvestment.

Branding thought his communities' biggest issues include the workforce. They have two residential programs, but can't attract workers who can pass criminal record checks. Plus, rates haven't changed in 8 years, only the "recipient support system" keeps us in the black. Adam Rutherford noted that this funding line item is crucial for many CBO.

Miovas asked if grant writing was a need. Jessee responded that grants really are not the way to support critical services because grants are not sustainable. There is an ongoing General Fund appropriation among all BH centers. Miovas asked if the effort in getting grants worth it in the short term. Jessee noted that grant money is usually a small fraction of revenue compared to Medicaid. Rhoades noted that grants don't do bread and butter work, typically run only three years. Cathleen McLaughlin noted that they were program-centric rather than individual-centric.

At the close of the meeting, noting the intensive and productive effort, Rhoades asked if there was interest in continuing on beyond (6-29) next week's meeting on mental health statutes. She stated that she thought it was crucial for an ACJC BH group to continue to be active Those interested in continuing are: Jessee, Rhoades, Brad Myrstol, Tony Piper, Cathleen McLaughlin, Adam Rutherford.

There was time allowed for additional public comment. There was none. The meeting adjourned at 11:55 AM.