Forensic Psychiatric Hospital Feasibility Study Appendices

Phase II Final Report

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Appendices

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Appendix A: Phase I Data Report

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1. Defining the Project

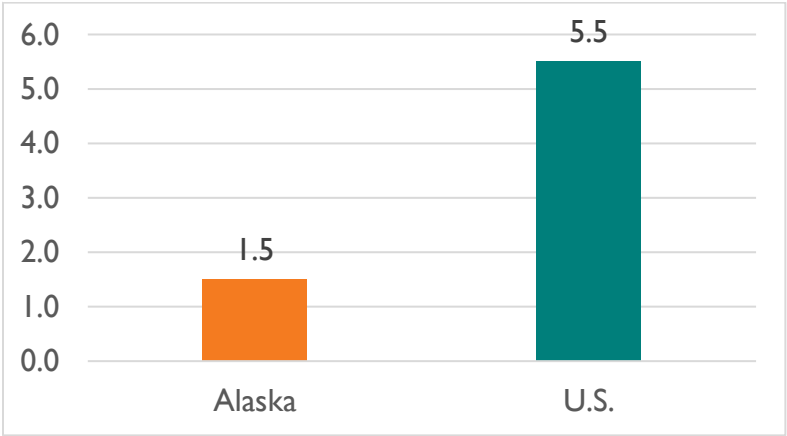
This appendix supports the main report with data from API and the Alaska Court System which helps to shape the demand for forensic psychiatric services. A table and information summarizing data sources used in this report can be found in Appendix F.

Alaska Psychiatric Institute

The Alaska Psychiatric Institute (API) is Alaska's state-run, inpatient psychiatric treatment facility. API is within the Alaska Department of Health and Social Services. There are 80 beds in the facility, with 10 beds designated for forensic patients, the facility's Taku Unit. Chilkat, another 10-bed unit, is reserved for adolescents. The remaining 60 beds are for civilly committed adults.

The Taku Unit runs at or around 96 percent capacity and has an average length of stay 5.8 times longer than API's overall average length of stay (79 days compared to 13 days).[1] In 2017, API's forensic readmission rate 30-days post-discharge is two percent, below the 3.5 percent United States forensic readmission rate; however, for 180-days post discharge, the forensic readmission rates are 28.0 percent at API, over twice that of the US rate of 11.4 percent.[2]

Figure 1: Number of Forensic Beds per 100,000 population



Source: Going, going, gone: Trends and consequences of eliminating state psychiatric beds. Arlington, VA. Treatment Advocacy Center, June 2016.

Nationally, forensic beds comprise 30.5 percent of total state hospital beds.[3] At API, however, forensic beds comprise only 12.5 percent of total bed capacity, one of the lowest proportions in the country. This is also reflected in the number of forensic beds per 100,000 population, with the national average at 5.5 beds per 100,000 in population and Alaska's average of 1.4 beds per 100,000.[4]

In addition to an increased waitlist for forensic beds at API, the facility also has a shortage of civil commitment beds. There are 60 beds available for civilly committed adults; however, staffing shortages have necessitated the closure of some units and a reduction of beds available. In 2017, API's utilization rate per 1,000 people, at 1.58, is more than three times higher than the national rate of .40. The average civil

[1] Meditech Electronic Health Records. Average Length of Stay for Discharged IST Patients + Taku Occupancy, July 1, 2015 – December 31, 2018. Public Consulting Group (PCG) Feasibility Study for the Privatization of API, January 2017. Page 34.
[2] Substance Abuse and Mental Health Services Administration Uniform Reporting System Output Tables for Alaska, 2017.
[3] Fuller, D.A., Sinclair, E., Geller, J., Quanbeck, C., and Snook, J. Going, going, gone: Trends and consequences of eliminating state psychiatric beds. Arlington, VA. Treatment Advocacy Center, June 2016.
[4] Fuller, D.A., Sinclair, E., Geller, J., Quanbeck, C., and Snook, J. Going, going, gone: Trends and consequences of eliminating state psychiatric beds. Arlington, VA. Treatment Advocacy Center, June 2016.

readmission rate across all states 30-days post-discharge is 8.3 percent, compared to API's rate of 15 percent; 180-days post-discharge readmission rate is 19.2 percent, compared to API's rate of 31.2 percent.[5]

API has a shorter average length of stay (ALOS) for all patients compared to other states, and to peer facilities in other states. According to a 2017 report for DHSS, "The average number of days a patient stayed at API in FY14 was only 13 days, compared to its peer state hospitals, which ranged from 78 to nearly 1,067 days. Adding to this, the ALOS for the small peer hospitals is 188 days, only further supporting the observation that API's ALOS is extremely low for a state hospital, even when compared to hospitals similar in size. According to this logic, API's exceptionally low ALOS, paired with high readmission rates and the lack of other sub-acute services across the Alaska's behavioral health system, suggest that the hospital may not be able to stabilize patients effectively, given the existing admissions pressure." [6]

All these data indicate a significant lack of capacity at API to provide timely and effective care, and a substantial churning among the population of individuals who require acute psychiatric care and those who are ordered to receive psychiatric treatment related to their competency to stand trial.

Target Population

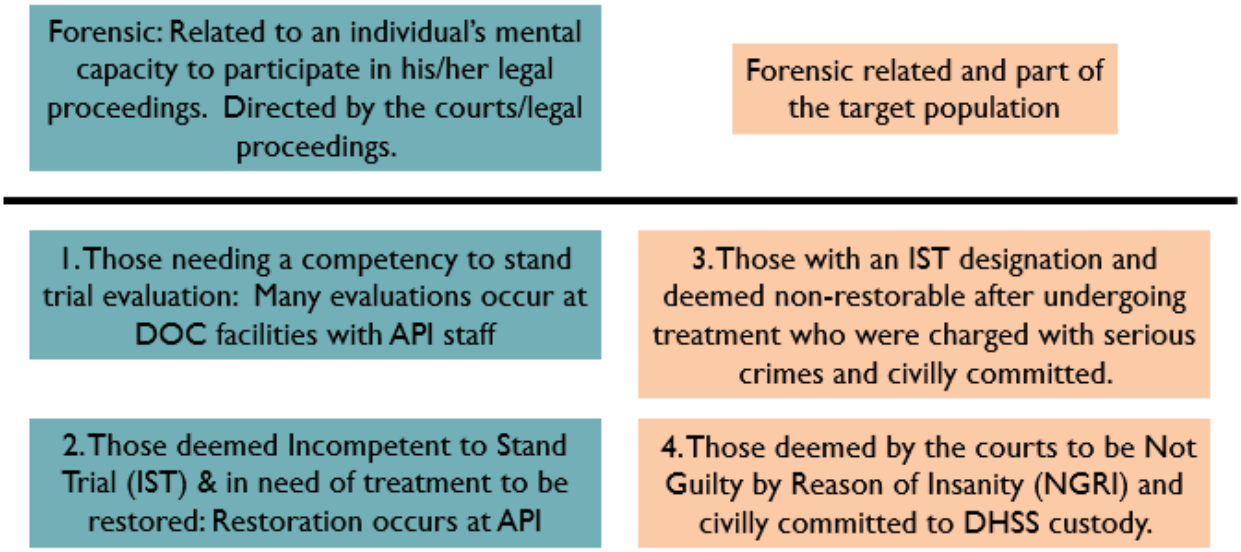
The Request for Proposals for this study identified seven possible target populations for a forensic hospital:

- Persons court-ordered for a competency to stand trial evaluation
- Persons found incompetent to stand trial (IST) and court-ordered for restoration
- Persons found non-restorable after undergoing treatment who committed serious crimes (felony and certain misdemeanors)
- Persons determined by a court to be Not Guilty by Reason of Insanity and civilly committed to Department of Health and Social Services
- Current Department of Corrections inmates with serious mental illness (SMI) or a dual diagnosis
- Current Department of Corrections inmates that are Guilty but Mentally Ill
- Civilly committed aggressive and/or complex patients who need to be separated

Through discussion with stakeholders, it was determined that Department of Corrections inmates with SMI or a dual diagnosis and those inmates who are Guilty but Mentally Ill in the custody and care of the Department of Corrections should not be considered as target populations for this study. Civilly committed aggressive patients were also removed from this study because those individuals enter API through the civil commitment process. For this reason, these populations are not discussed further in this report.

[5] Substance Abuse and Mental Health Services Administration Uniform Reporting System Output Tables for Alaska, 2017.
[6] Public Consulting Group (PCG) Feasibility Study for the Privatization of API, January 2017. Page 34.

Figure 2: Forensic Psychiatric Hospital Feasibility Study Target Population



2. Backlog in the Competency Process

This chapter provides an overview of the competency process, summarizes the current backlog and wait times and describes the types of cases, location of originating courts as well as basic demographics of those involved in the competency process. The following chapters provide additional detail about the wait times and characteristics of each stage in the process.

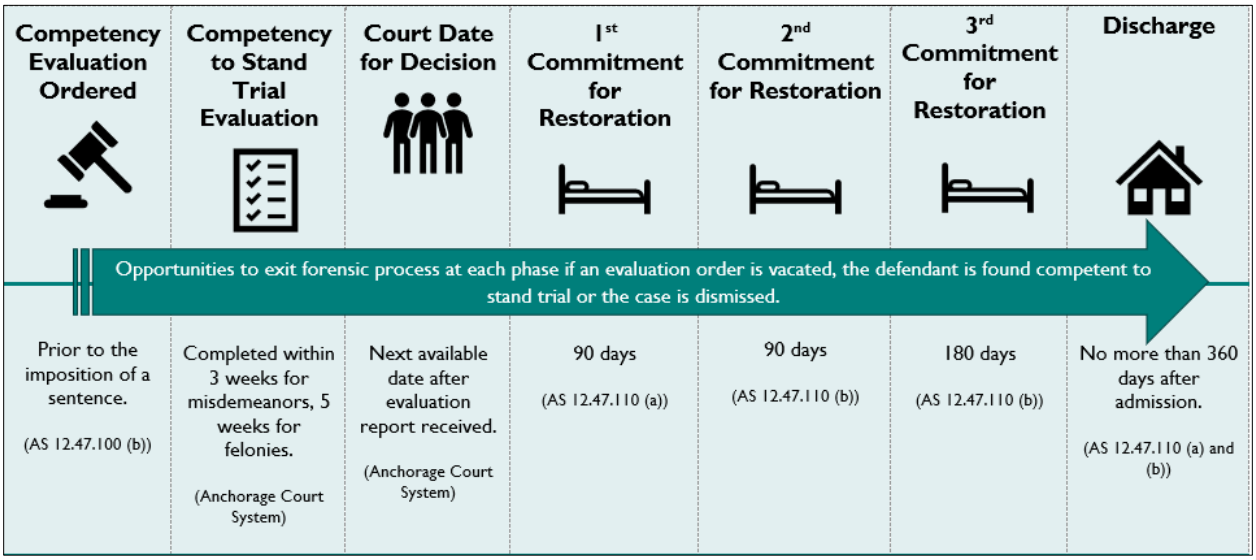
Overview of the Competency Process

Figure 3 identifies the steps in the forensic psychiatric process which begins when a competency evaluation is ordered. At numerous points in the process, the defendant may be determined competent and return to the normal court process, receive treatment to restore him or her to competency, be determined non-restorable, and/or have charges dismissed. At any point in the process, the defendant may experience delays.

Alaska Statute provides guidance on the timeframe for some stages in the competency process. AS 12.47.100(b) states "If, before imposition of sentence, the prosecuting attorney or the attorney for the defendant has reasonable cause to believe that the defendant is presently suffering from a mental disease or defect that cause the defendant to be unable to understand the proceedings or to assist in the person's own defense, the attorney may file a motion for a judicial determination of competency of the defendant. AS 12.47.110 (a) and (b) provide clearly specified time frames for restoration commitments and limits the number of days an individual can be committed for restoration to 360 days.

Timeframes for completion of evaluations and scheduling of court dates for evaluation hearings are not specified in statute. The Anchorage Competency Court has established their own timeframes, identifying that evaluations for misdemeanants must be completed within three weeks of order and evaluations for felony offenders must be completed within five weeks of order. The Anchorage Competency Court prioritizes competency evaluation hearings and after receipt of an evaluation report, will schedule a hearing on the next available date, usually within a week.

Figure 3: Steps in Forensic Psychiatric Process



Existing Backlog

There are three ways to measure demand and the overall backlog in the competency process: total individuals involved per year, total individuals waiting at any given point in time, and the length of time individuals are waiting. Data summarizing all three measures indicate a growing backlog in the competency process

Number of individuals ordered to the process on a yearly basis. As shown in Figure 12 in the following chapter, a forecasted total of 338 individuals will likely be ordered for competency evaluation during fiscal year 2019, which is based on annualizing year to date orders for evaluation. The estimated 338 in 2019 is up from 223 in fiscal year 2016 or an increase of 51 percent over three years. An additional count for evaluations completed from January 16, 2019 to May 8, 2019 identified that 60 additional evaluations had been completed with at least 14 more scheduled. The loss of full-time competency evaluators at API and the transition to contracted evaluators will likely mean a difference in the projected number of evaluations (338) and the actual number completed (229 as of May 8, 2019) in FY 2019.

Number of individuals waiting. As of December May 15, 2019, 87 individuals were waiting in at least one stage of the competency process (for an evaluation, a court order, or a restoration bed) compared to 49 at the same time in 2015, an increase of 78 percent over three years. In May of 2019, 37 individuals were waiting for one of 10 beds at Taku compared to 2 individuals waiting for one of 10 beds in December 2015. Figure 4 is a point in time count of the number of individuals waiting or participating in each part of the competency evaluation and restoration process.

Figure 4: Individuals Waiting and Admitted to Taku for Restoration, Point in Time

Status	Dec 2015	Dec 2017	Dec 2018	Mar 2019	May 2019
Number of People Waiting - Point in Time					
Waiting for Competency Evaluation	22	25	35	45	24
Waiting for Court Finding: Have been Evaluated	25	19	16	18	26
Waiting for Admission for Restoration: Court has Ruled	2	10	20	29	37
Subtotal Waiting	49	54	71	92	87
percent change from 2015		*10%*	*45%*	*88%*	*78%*
Admitted to Taku for Restoration*	**14**	**9**	**10**	**9**	**9**
Total	**63**	**63**	**81**	**101**	**96**

*In 2015, 1 juvenile was at McLaughlin Youth Center and 3 forensic patients were on the Denali unit at API for a total of 14 forensic patients. Sources: API Tuesday Reports: December 7, 2015, December 12, 2017 and December 11, 2018; Point in time counts provided by Gavin Carmichael March 18, 2019 and May 15, 2019.

Overall wait times are long. Using the 2018 API Tuesday Report, we found that on average an individual is waiting 161 days (or 23 weeks) from the date the evaluation is ordered until he or she is admitted for restoration (Figure 5). The wait time for a complete evaluation averages 52 days (or 7.5 weeks) and the wait

time to admission for those deemed incompetent to stand trial was another 113 days (or 16 weeks). At all stages of the process, the wait time for those with a misdemeanor only was slightly less than those with a felony.

Figure 5: Wait Times for Evaluation and Admission in 2018

Stage in the Process	2018 Average Days: All Charges		
	All	Anchorage	Non-Anchorage
Waiting for Evaluation	52	48	58
Waiting for Admission [1]	113	92 to 111	120
Total waiting from Date of Evaluation Order to Admission	161	140 to 158	174
	2018 Average Days: Misdemeanor Only		
	All	**Anchorage**	**Non-Anchorage**
Waiting for Evaluation	44	**34**	**52**
Waiting for Admission	113	**133**	**95**
Total waiting from Date of Evaluation Order to Admission	138	**139**	**136**
	2018 Average Days: At Least One Felony		
	All	**Anchorage**	**Non-Anchorage**
Waiting for Evaluation	56	**52**	**61**
Waiting for Admission	113	108	137
Total waiting from Date of Evaluation Order to Admission	172	165	200

[1] Data from the Anchorage Competency Court Calendar indicates a 71 day wait for admission from date of complete evaluation. This is different from the 2018 API Tuesday Reports showing a 127 day wait for Anchorage.

Source: 2018 API Tuesday Reports; data entered by contracting team

Characteristics of Individuals in Competency Process

The following data summarizes one year's worth of API Tuesday Reports for calendar year 2018.

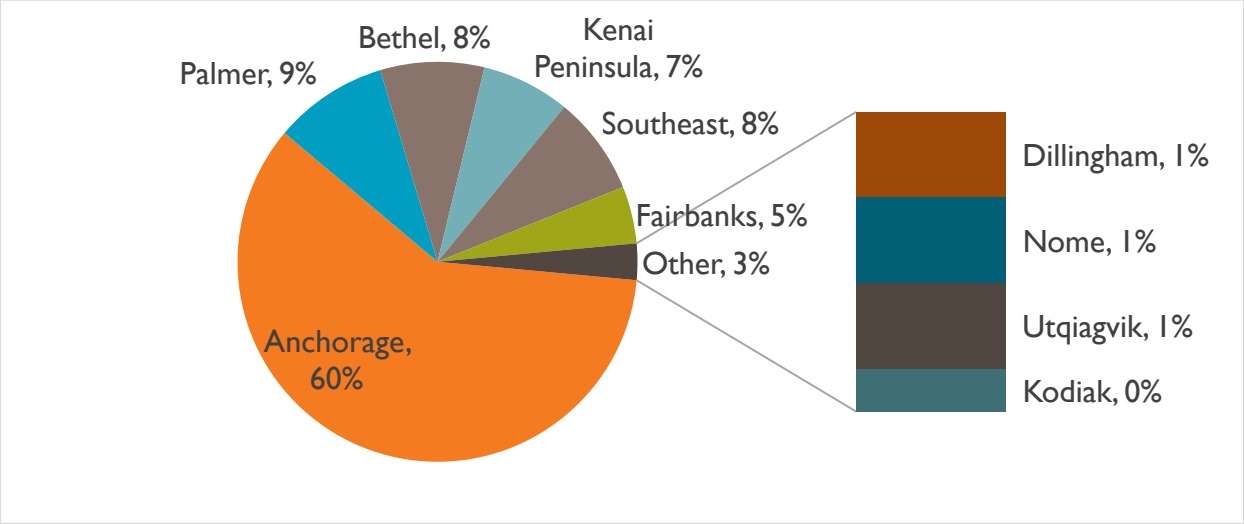
Charge Type

In 2018, 64 percent of all 2018 statewide competency cases had at least one felony charge and 36 percent had only a misdemeanor charge. Anchorage Competency Court data shows that 55 percent of all Anchorage forensic psychiatric cases between July 1, 2016 and December 31, 2018 were for misdemeanor offenses only. Forty-five percent of cases were for felony offenses or for a combination of felony and misdemeanor offenses.

Originating Court

In 2018, 60 percent of 2018 statewide competency cases originated in Anchorage. In contrast, Anchorage's total population makes up 40 percent of the total statewide population. Approximately eight percent of cases originated in each of the communities of Palmer, Bethel, Kenai Peninsula and southeast Alaska region. Five percent originated in Fairbanks and the remaining three percent originated in Dillingham (1%), Nome (1%), Utqiaġvik (1%) and Kodiak (1 case).

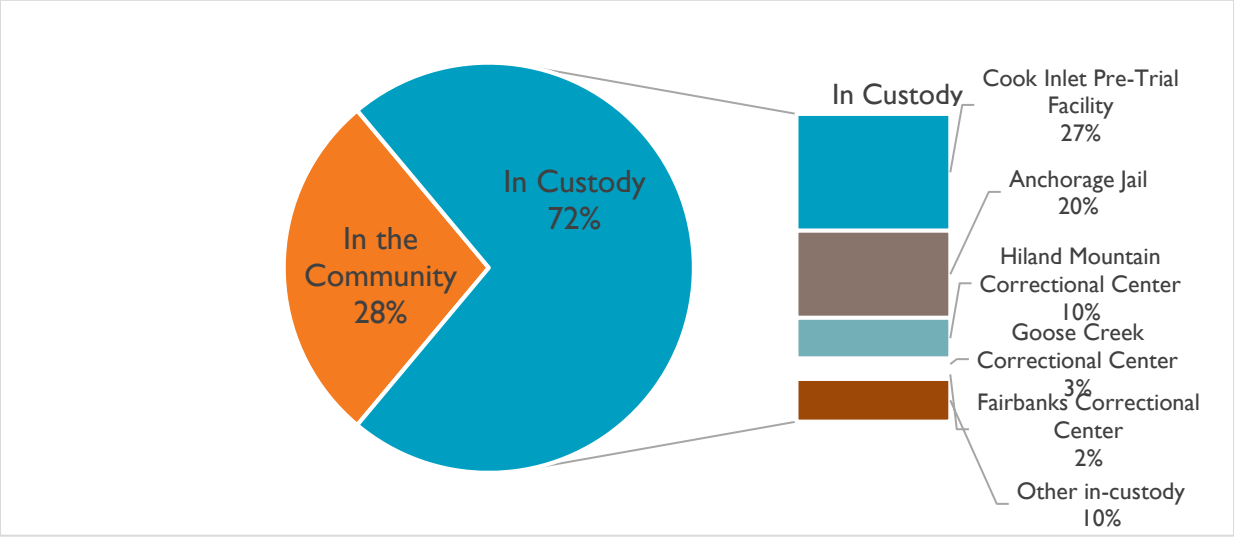
Figure 6: Originating Court



Location While Waiting

In 2018, 72 percent, or 166 cases were held in custody while they awaited a competency evaluation. Twenty eight percent, or 64 cases were in a community setting while waiting for their evaluation. Of the individuals who were held in custody, one-third were waiting in the Cook Inlet Pre-trial facility, twenty percent were waiting in the Anchorage Jail and 10 percent were waiting at Hiland Mountain Correctional Center. Goose Creek Correctional Center held three percent of the cases and Fairbanks Correctional Center held two percent of the cases. The remaining cases (10 percent) were held in other locations in custody. Other in-custody locations holding four or fewer cases included Lemon Creek Correctional Center, Wildwood Pre-trial, Alaska Psychiatric Institute, Yukon Kuskokwim Correctional Center, Anvil Mountain Correctional Center, Mat-Su Pre-trial, Bethel Youth Facility, Ketchikan Correctional Center and McLaughlin Youth Center.

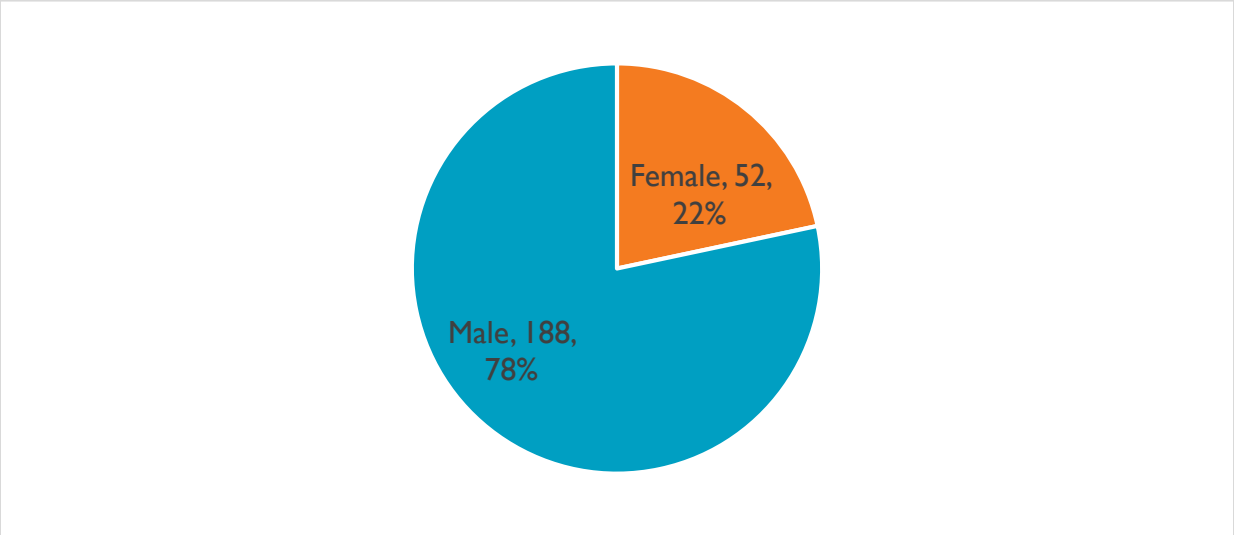
Figure 7: Location Where Individual is Waiting during the Competency Process



Sex

Men made up seventy-eight percent (188 people) of people with competency cases in 2018. Women made up 22 percent (52 people).

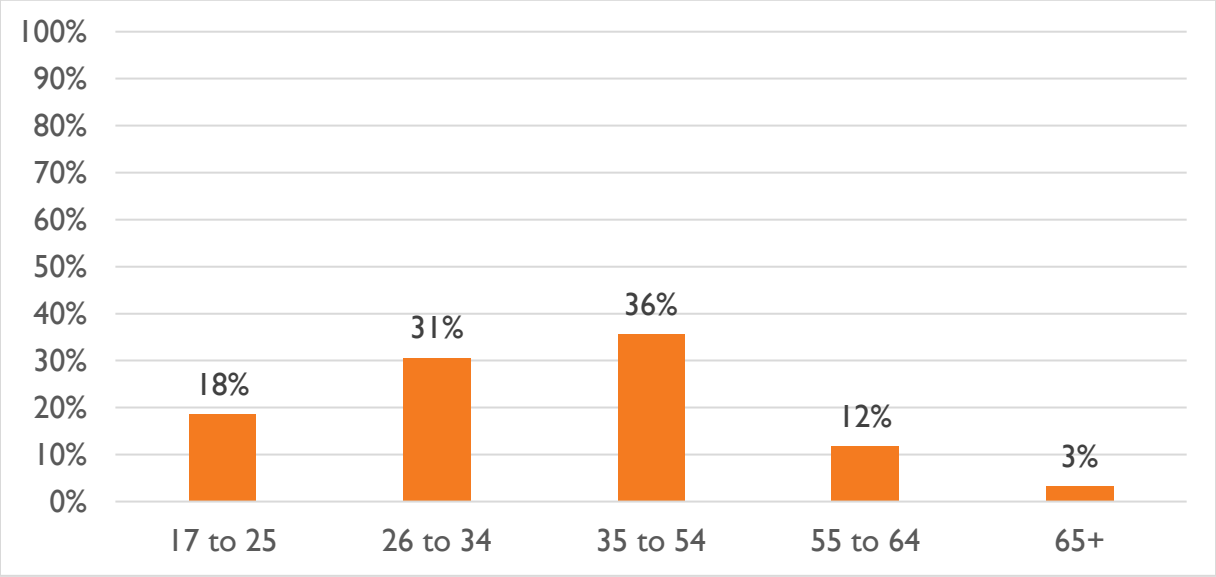
Figure 8: Sex of Competency Case Defendants



Age

Roughly half of defendants in the 238 competency cases in 2018 were under 35. The greatest percent of cases (31 percent) is attributable to the 26 to 34 age group. Seniors older than 55 made up 15 percent of cases. Transition aged youth (17 to 25) made up 18 percent of cases.

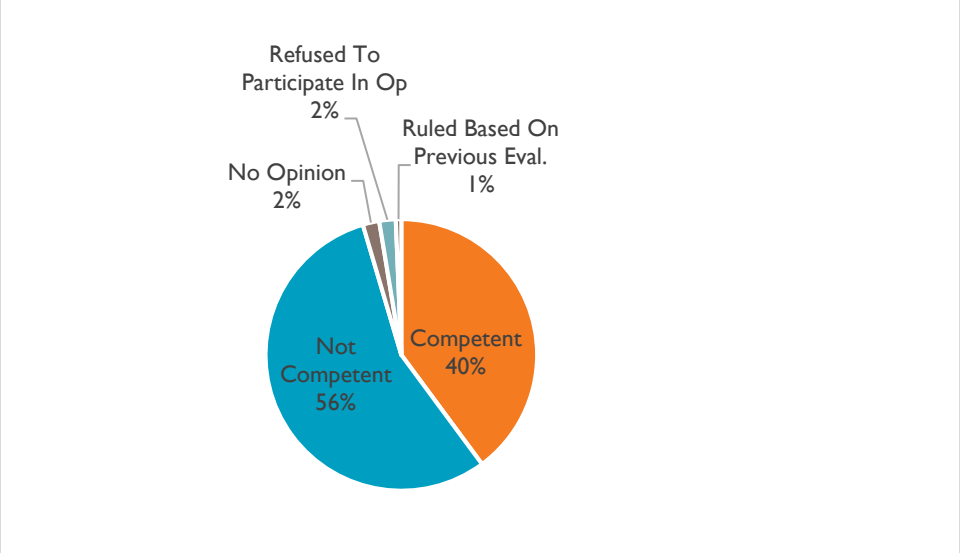
Figure 9: Age of Competency Case Defendants



Percent found Incompetent to Stand Trial (IST)

Of the 152 cases that received an evaluator opinion in 2018, 40 percent (61 people) were deemed competent to stand trial and 56 percent (85 people) were deemed not competent to stand trial.

Figure 10: Evaluator Opinion in Competency Evaluations



3. Competency to Stand Trial Evaluations

Individuals ordered to receive an evaluation for competency wait, on average, 52 days from the date the evaluation is ordered until the evaluation is complete.

Current Competency Evaluation Process

The current continuum of forensic psychiatric services starts when an individual is charged with a crime. At any point before the imposition of a sentence, a request for a competency evaluation can be made. If any of the involved parties request a competency evaluation, the forensic psychologists at the Alaska Psychiatric Institute (API) are notified and the individual is scheduled for an evaluation. Statute does not designate API's psychologists as the only individuals able to complete competency evaluations; however, evaluators outside of the API system are rarely used.

At the outset of this project in November 2018, API employed 2.5 forensic psychologists, who conducted all competency evaluations for the entire state. Dr. Kristy Becker, API's former Chief Forensic Psychologist, shared that most evaluations take 90 minutes, but that there are complex cases that may take much longer due to additional testing or observation needed. Routine evaluations are not conducted on API's inpatient unit. Most evaluations take place in a Department of Corrections (DOC) facility or in an interview room at API if the individual is not in DOC custody. Occasionally, evaluation beds are needed for individuals who refuse or are resistant to the evaluative process. Dr. Becker estimates that five patients per year may need an inpatient bed at API to complete the evaluation. The time needed for an inpatient evaluation ranges from two days to one week.[7] Juveniles are evaluated by the same staff that evaluate the adult forensic population, most often at the McLaughlin Youth Center.

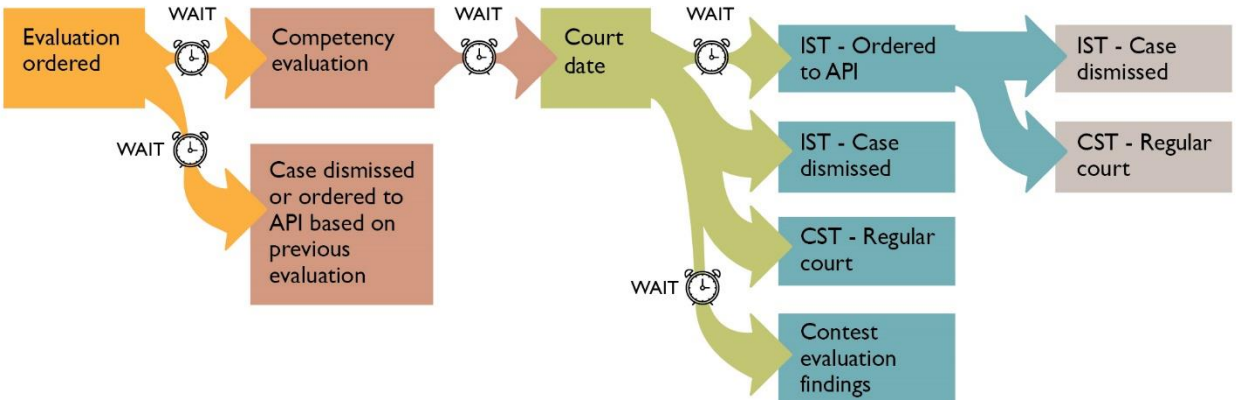
Alaska Statute 12.47.100 Incompetency to proceed governs the process for competency evaluations. Per statute, if "the defendant is unable to understand the proceedings against the defendant or to assist in the defendant's own defense may not be tried, convicted or sentenced for the commission of a crime so long as the incompetency exists". If a motion is filed for a competency determination, the court must have the defendant examined by at least one qualified psychiatrist or psychologist. Statute does not define "qualified psychiatrist or psychologist" and does not identify API as the only entity that can provide the evaluation. A defendant may be ordered for commitment "to a suitable hospital or other facility designated by the court" for the examination. Statute does not define a timeframe for completion of a competency evaluation.

After completion of a competency evaluation, the forensic evaluator writes a report and submits it to the requesting court, which then sets a court date to decide in the case. In Anchorage, competency cases are prioritized, and a hearing is scheduled for the next available date. There is incomplete data on the time required for a court order following an evaluation. Possible outcomes are for the court to accept the forensic evaluator's incompetent to stand trial (IST) finding and order the individual to

[7] Verbal communication. Dr. Kristy Becker, November 28, 2018.

API for restoration, accept the forensic evaluator's IST finding and dismiss the case, accept the forensic evaluator's competent to stand trial (CST) finding and send the case to regular court, or contest the findings.

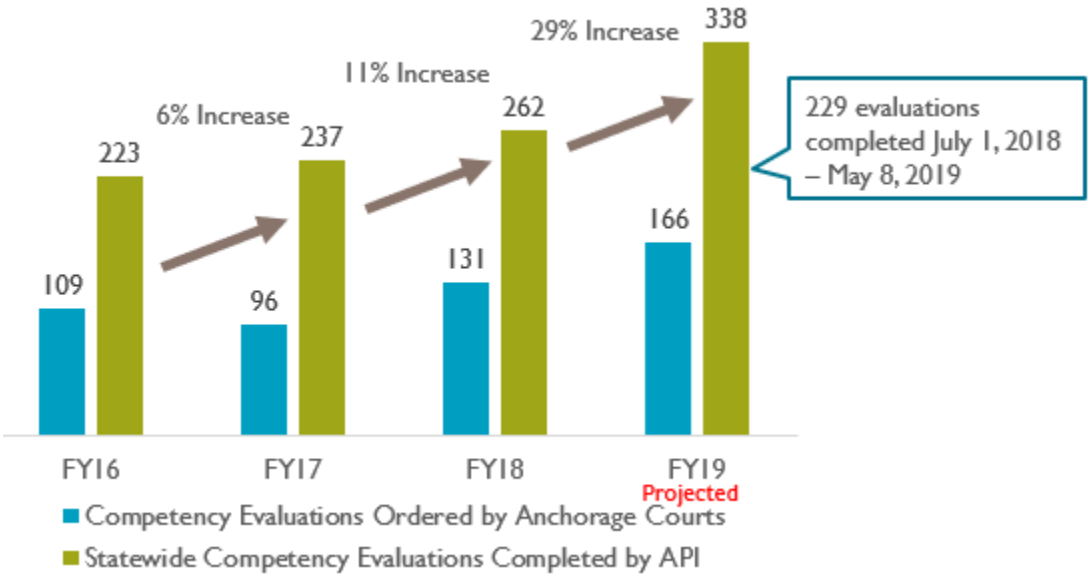
Figure 11: Competency Evaluation and Restoration Process



Number of Evaluations Ordered

Data from Anchorage's Competency Calendar show the number of evaluations ordered in Anchorage and counts from the Taku unit provide the number of evaluations completed statewide. The number of evaluations completed by API's forensic psychologists has increased steadily since fiscal year (FY) 2016, with growth ranging from 6 percent to a projected 29 percent per year. From July 1, 2018 to January 15, 2019 the forensic psychologists completed 169 evaluations and the projected total number of evaluations for FY 2019 is 338. 60 additional evaluations had been completed with at least 14 more scheduled between January 16, 2019 and May 8, 2019. The loss of full-time forensic evaluators at API and the transition to contracted evaluators will likely mean a difference in the projected number of evaluations (338) and the actual number completed (229 as of May 8, 2019) in FY 2019.

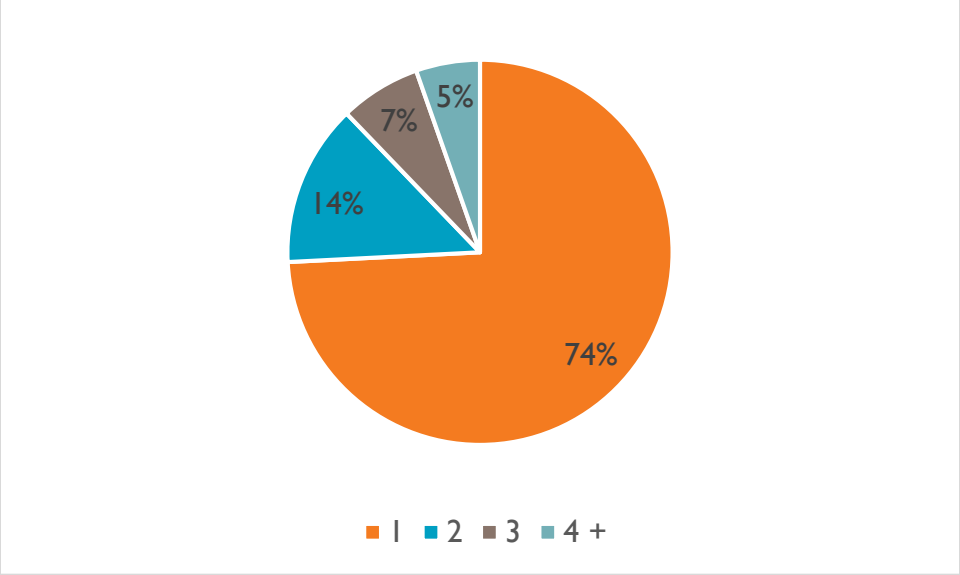
Figure 12: Growth in Evaluations Ordered and Completed, FY 2016 - FY 2019



Sources: Anchorage Court Competency Calendar Hearing Data, July 1, 2015 – December 31, 2018 and Dr. Becker and Dr. Rehn, Counts of Evaluations completed by API

Anchorage Court Competency Calendar data identified that 421 evaluations were ordered between July 1, 2015 and December 31, 2018 for 279 unique individuals. Twenty-six percent of individuals had more than one evaluation ordered during this period.

Figure 13: Percentage of individuals with one, two, three and four or more evaluations ordered



Source: Anchorage Court Competency Calendar Hearing Data, July 1, 2015 – December 31, 2018

Wait Times for Evaluations

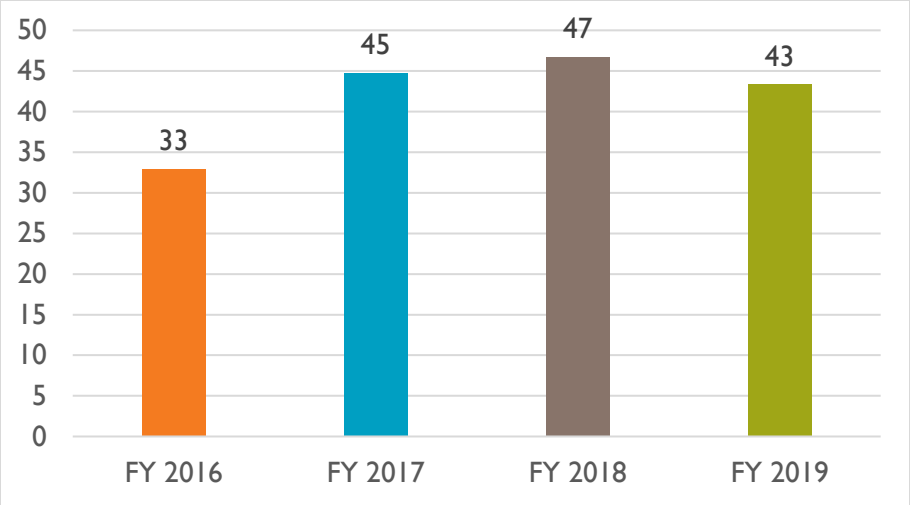
On average, individuals waiting for a competency evaluation waited for 52 days (7.5 weeks) in 2018 based on the date the evaluation was ordered and the date the forensic psychologist rendered an opinion.[8] The Anchorage District Court looked at national best practices and decided to set a timeframe of three weeks to complete a competency evaluation for misdemeanor offenses and five weeks for felony offenses. All judges and magistrates in the Anchorage district court are trained to schedule competency hearings based on these guidelines.[9] Over the past year, API's evaluators have rarely been able to complete an evaluation and report in that timeframe. During 2018, only 14 percent of misdemeanor cases received a completed evaluation in less than 3 weeks and only 25 percent of felony cases received a completed evaluation in less than five weeks. In Anchorage, an increasing number of cases have been dismissed or ordered to API for restoration based on previous competency reports.

Wait times for competency evaluation in Anchorage increased 10-14 days since FY 2016. While the number of days waiting for a competency evaluation seems to have decreased in FY 2019, it is important to note that as of December 21, 2018 there were 17 ordered evaluations that had not been completed and only days waiting for completed evaluations were included in the average.

[8] Summary of data entry of all 2018 API Tuesday Reports by Agnew::Beck.

[9] Proposal to request for funding and resources to expand the Anchorage Centralized Competency Calendar to a state-wide docket. Authored by Kate Sumey, MA Project Coordinator for the Anchorage Coordinated Resources Project (Mental Health Court) and the Anchorage Centralized Competency Calendar. October 2018.

Figure 14: Average Days Waiting for Competency Evaluation, Anchorage - Outliers Removed



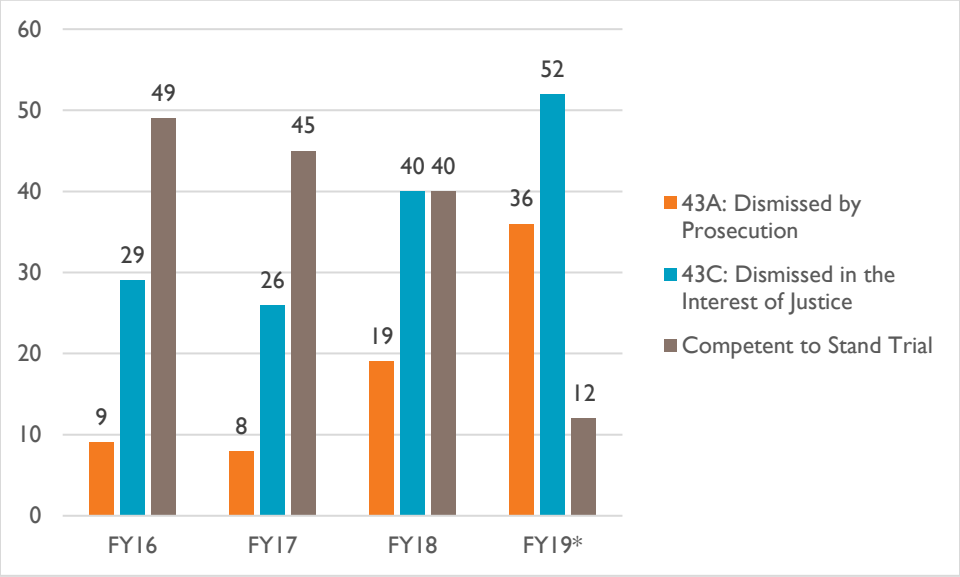
Source: Anchorage Court Competency Calendar Hearing Data, July 1, 2015 – December 31, 2018.

Court Disposition

Once an individual's evaluation is complete and the findings submitted to the court, there is a hearing to determine the next steps for the defendant. If an individual is found incompetent to stand trial, they may be ordered to API for restoration or the court may dismiss the case. The dismissal may be "43A", dismissed by the prosecution or "43C", dismissed by the court in the interest of justice. A case may be dismissed under 43A or 43C prior to restoration efforts or, if after restoration efforts, the individual is still deemed IST. If an individual is found competent to stand trial and the court agrees with this ruling, the defendant exits the forensic process and enters the regular court system. The court may also choose to rule in a case based on a prior evaluation.

Figure 15 below shows the number of Anchorage court cases with a case disposition of "43A", "43C" or "Regular Court" (CST). This chart represents the total number in each category (projected totals for FY 2019), which includes individuals who had cases dismissed before or after restoration and individuals who were found competent to stand trial before or after restoration. In Anchorage, the number of cases dismissed either by the prosecution or in the interest of justice has increased over the past four years, while the number of individuals entering the regular court system has decreased. In FY16, 49 cases went to the regular court system for trial, while 38 were dismissed. A marked reversal is expected in FY19, with just 12 cases expected to go to regular court and 88 expected to be dismissed. It should be noted that CST projections for FY 2019 may be lower than expected, due to the extent of the backlog for evaluations and restoration.

Figure 15: Anchorage Competency Cases by Disposition Type



* Projected totals for FY 2019. Source: Anchorage Court Competency Calendar Hearing Data, July 1, 2015 – December 31, 2018.

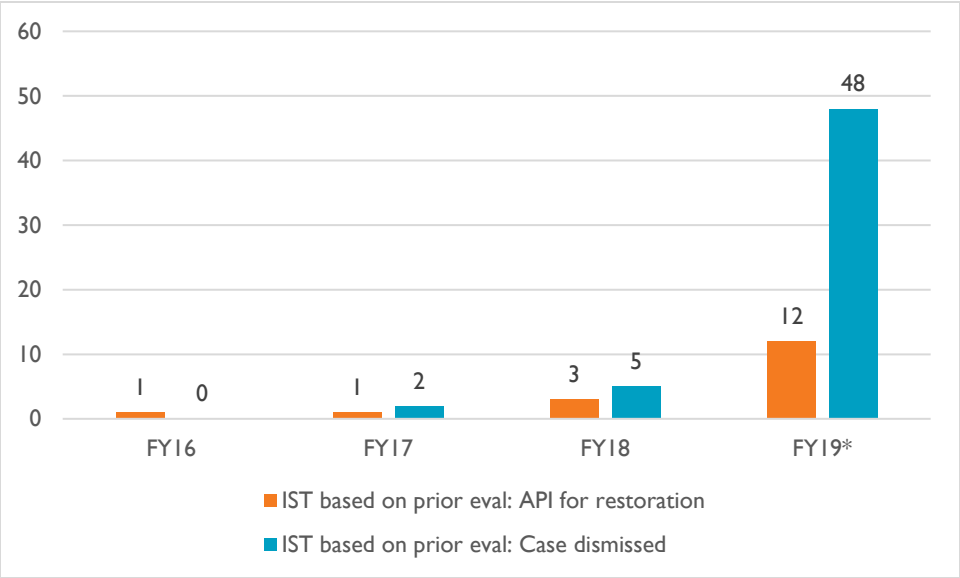
Court Disposition Based on Prior Evaluation

In Anchorage, the court seems to be relying increasingly on past competency evaluations to determine if an individual should be ordered for restoration or if the case should be dismissed. Use of a prior evaluation will depend on the attorney, the seriousness of the current and prior offense, and the date of the last evaluation; however, there is not a written standard in statute or elsewhere that specifies when a prior evaluation can be used.[10] In FY 2016, just one individual was ordered to API for restoration based on a previous evaluation, but in the first half of FY 2019 (July 1, 2018 – December 31, 2018) six individuals were (projected total for FY 2019 is 12).

The number of individuals deemed incompetent to stand trial (IST) who have had their cases dismissed based on a prior report has also soared since FY 2016. In FY 2016 there were no individuals in the Anchorage courts that were deemed IST and had their case dismissed based on a prior report, but in the first half of FY 2019, 24 individuals were determined IST and had their cases dismissed based on a prior report (FY 2019 projection is 48).

[10] Anchorage Competency Court Judges. Stakeholder Interview, January 17, 2019.

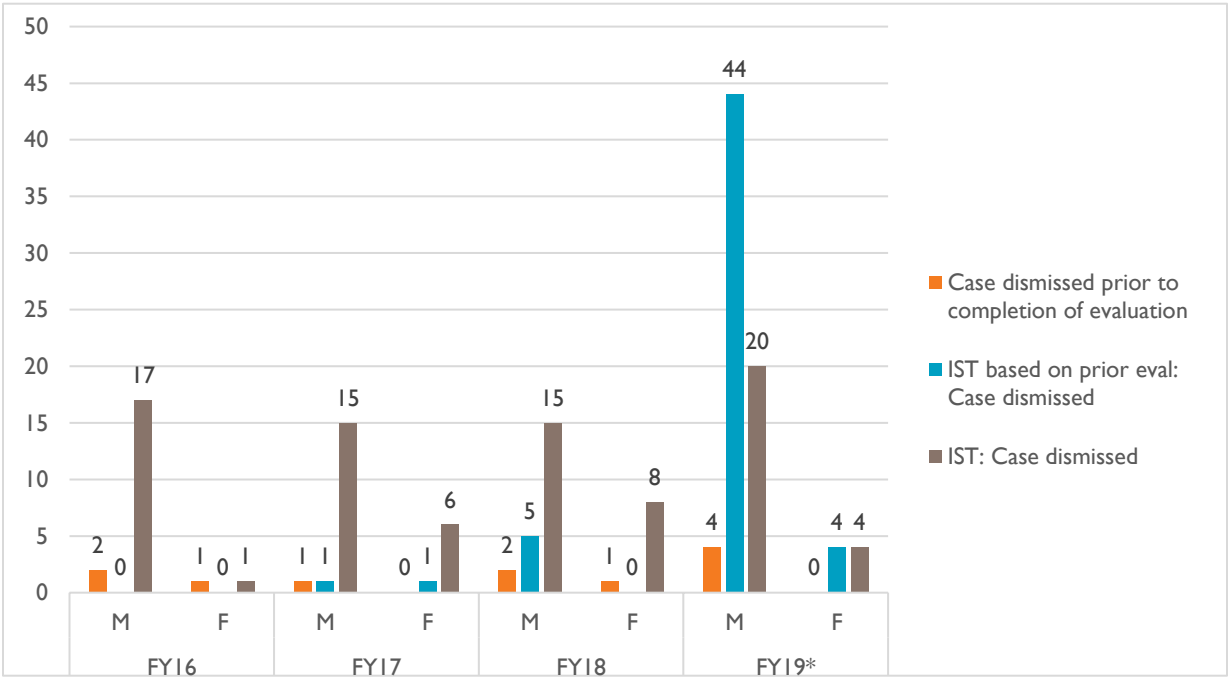
Figure 16: Case Decisions Based on Prior Evaluations, Anchorage



* Projected totals for FY19. Source: Anchorage Court Competency Calendar Hearing Data, July 1, 2015 – December 31, 2018.

In Anchorage, the number of misdemeanor cases in which the defendant is ruled incompetent to stand trial and the case is dismissed based on a prior evaluation is expected to increase significantly in FY19 from just five cases in FY18 to 44 cases by the end of the fiscal year. The number of cases dismissed prior to the completion of an evaluation and the number ruled IST and dismissed is also expected to increase in FY19.

Figure 17: Number of Cases Dismissed by Fiscal Year



* Projected totals for FY19. Source: Anchorage Court Competency Calendar Hearing Data, July 1, 2015 – December 31, 2018.

4. Competency Restoration

Current Process

API is notified after the court has ordered a defendant to API for competency restoration. By statute, restoration must occur at API. The average wait time for individuals waiting for a bed on Taku was 113 days in 2018.[11] The statutory definition of where restoration must occur creates a funnel in which all individuals deemed incompetent to stand trial and in need of treatment to be restored must be placed in one of API's 10 forensic beds.

Competency restoration typically involves psychopharmacology (medication) and/or psychoeducational training to prepare an individual to stand trial. Training elements may include but are not limited to: competency education, mock court procedures, vocabulary, behavior training and sessions with a defense attorney.[12] The primary goal of competency restoration is not to treat an individual's mental illness; however, an individual's mental condition may improve because of the restoration process. The average length of stay for patients who received restoration treatment on the Taku unit and were discharged from API in fiscal year 2018 was 75 days.[13]

The time available for restoration is limited by statute[14] and cannot last more than a total of six months for individuals who are not charged with crime involving force against a person, or more than one year for individuals who are charged with a crime against a person.[15] Under no circumstance can a defendant be confined for restoration longer than the maximum period of confinement the defendant would receive if the defendant had been found guilty of the charges.[16]

The Taku unit at API runs at or near capacity, averaging 96 percent occupancy from July 1, 2015 – December 31, 2018.[17] Annually, API sees 47 to 50 admissions for restoration treatment per fiscal year, for a total of 165 admissions over the study period (July 1, 2016 – December 31, 2018).[18] This includes forensic patients who are not placed on Taku. Admissions to the Taku unit are more varied, with 29 to 53 admissions per fiscal year, for a total of 148 admissions over the study period (July 1, 2016 – December 31, 2018).[19] During the

11 API Forensic Unit. Tuesday Reports, calendar year 2018.

12 Sperbeck, David. 2013. Clinical and Legal Practice Standards for Conducting Competency to Stand Trial Evaluations and Restoration Services. Presentation, June 25, 2013.

13 Meditech Electronic Health Records. IST Discharge Patients: Average Length of Stay, Fiscal Year 2018.

14 Alaska Statute 12.47.110

15 The analysis conducted during Phase 1 of this project identified some lengths of stay longer than these periods.

16 AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial. Douglas Mossman, Stephen G. Noffsinger, Peter Ash, Richard L. Frierson, Joan Gerbasi, Maureen Hackett, Catherine F. Lewis, Debra A. Pinals, Charles L. Scott, Karl G. Sieg, Barry W. Wall, Howard V. Zonana. Journal of the American Academy of Psychiatry and the Law Online Dec 2007, 35 (Supplement 4) S3-S72; "In Jackson v. Indiana, 406 U.S. 715 (1972), the U.S. Supreme Court held that a defendant found incompetent to stand trial may not be held indefinitely for treatment. There must be a prospect for the defendant's successful restoration within a reasonable time, and "his continued commitment must be justified by progress toward that goal" (Jackson v. Indiana, 406 U.S. 715 (1972), p 738). One can therefore interpret Jackson as placing on forensic hospitals some responsibility for developing efficient and effective treatment programs to comply with the limited periods allowed for restoration."

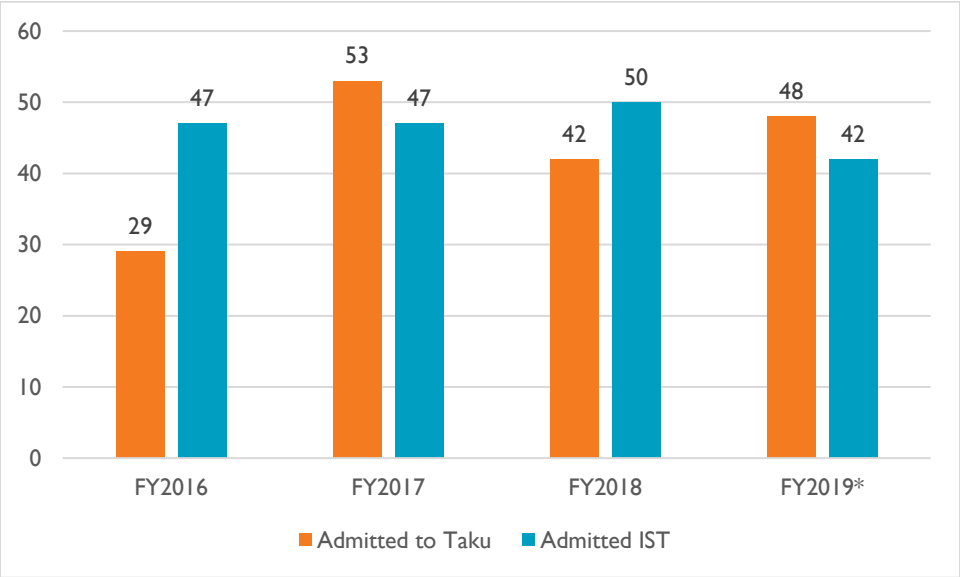
17 Meditech Electronic Health Records. Taku Occupancy, July 1, 2018 – December 31, 2018.

18 Meditech Electronic Health Records. IST Total Admissions, age 18+, July 1, 2018-December 31, 2018.

19 Meditech Electronic Health Records. Taku Total Admissions age 18+, July 1, 2018-December 31, 2018.

study period, 17 patients were admitted IST but were not admitted to Taku, likely due to lack of capacity on that unit.

Figure 18: Number of Patients Admitted IST and Admitted to Taku



* Projected totals for FY 2019. Source: Meditech Electronic Health Records. IST Total Admissions, age 18+, July 1, 2018-December 31, 2018 and Taku Total Admissions age 18+, July 1, 2018-December 31, 2018.

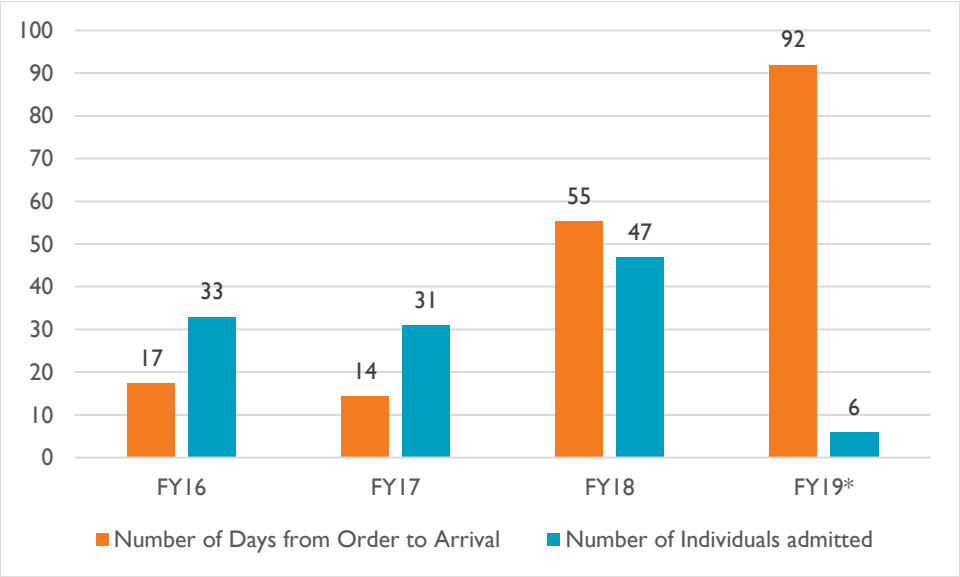
Alaska Statute

AS 12.47.110 Commitment on finding of incompetency, governs the timeframe for competency restoration. An individual may be ordered for restoration for an initial period of no longer than 90-days. The court shall conduct a hearing to determine whether the defendant remains incompetent on or before the expiration of this 90-day period. If the defendant remains incompetent, the court may recommit the defendant for a second period of 90-days. At the end of the second 90-day period, if the defendant remains incompetent, the charges against the defendant shall be dismissed (unless the crime involves force against a person) and any further commitment shall be governed by civil commitment statute. In the event the defendant is "charged with a crime involving force against a person and the court finds the defendant presents a substantial danger of physical injury to other persons and that there is a substantial probability that the defendant will regain competency within a reasonable period of time" the court may extend the period of commitment for competency restoration by an additional six months. If the defendant remains incompetent after the six-month restoration commitment, the charges against the defendant shall be dismissed and any further commitment shall be governed by civil commitment statute.

Wait Times for Restoration

As described earlier, in 2018, according to the API Tuesday reports, individuals who were found incompetent and ordered to API for restoration waited approximately 113 days or 16 weeks for a restoration bed. Anchorage Competency Calendar data provides information on how long individuals are waiting from the date the restoration order is signed, until the date the court is notified the individual has been admitted to API for restoration as well as the number of individuals admitted per fiscal year. Per court competency records, since July 1, 2018 only three individuals ordered to API by the Anchorage Courts were admitted to API and they waited an average of 92 days for admission.

Figure 19: Wait Time for Restoration Admission, Anchorage



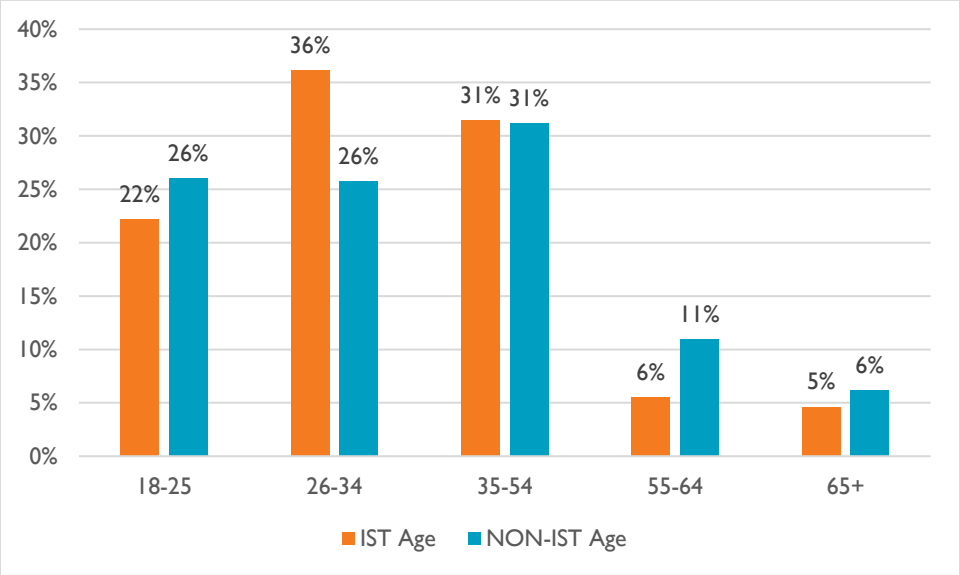
* Projected total for number of individuals admitted in FY 2019. Source: Anchorage Court Competency Calendar Hearing Data, July 1, 2015 – December 31, 2018.

Restoration Patients + Outcomes

Demographics

In the study period (July 1, 2015 – December 31, 2018), individuals committed to API for restoration were younger than the API population overall. More individuals 26-34 are committed to API for restoration than the civil population in this age group and there are fewer IST individuals over the age of 55 than in the civil population.

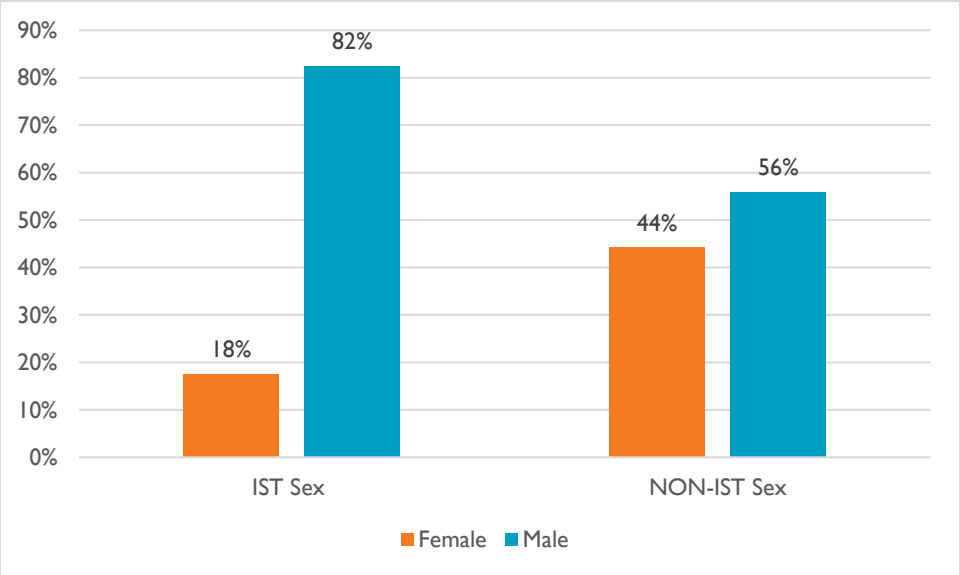
Figure 20: Age by Grouping for IST and Non-IST Residents, Unduplicated



Source: Meditech Electronic Health Records. IST and Non-IST Demographics, Unduplicated. July 1, 2015 – December 31, 2019.

Individuals committed to API for competency restoration are far more likely to be male than their civilly committed counterparts. While men are overrepresented in API as a whole, 82 percent of those who are IST and committed to API for restoration are men.

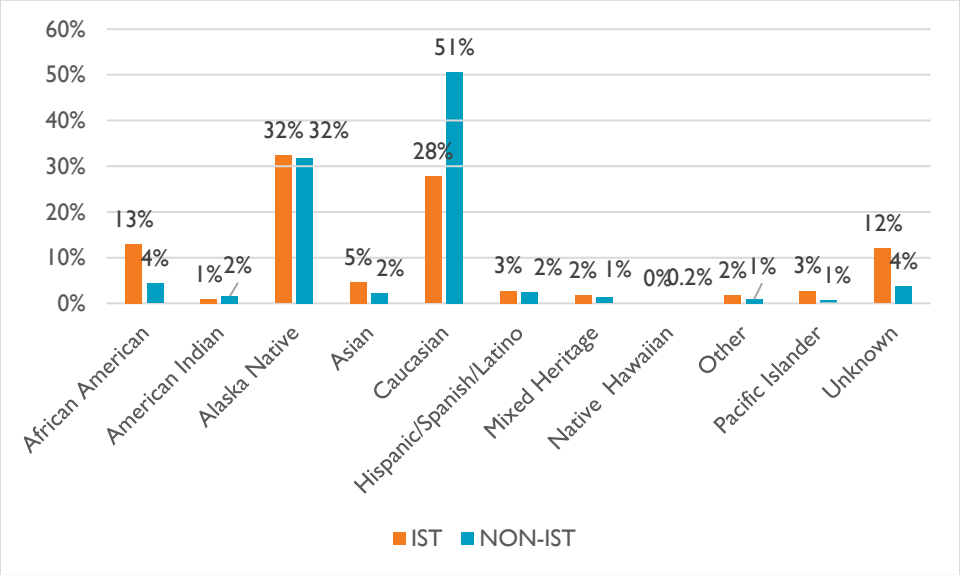
Figure 21: Sex of IST and Non-IST patients



Source: Meditech Electronic Health Records. IST and Non-IST Demographics, Unduplicated. July 1, 2015 – December 31, 2019. IST women, n= 19; IST men, n = 89. Non-IST women, n=1050; Non-IST men, n=1326.

Over half of civilly committed patients are white (51 percent) while just 28 percent of IST patients are white. Thirteen percent of the IST population in the study period were African American, over three times the proportion of four percent in the civilly committed population.

Figure 22: IST and Non-IST Patients, by Race

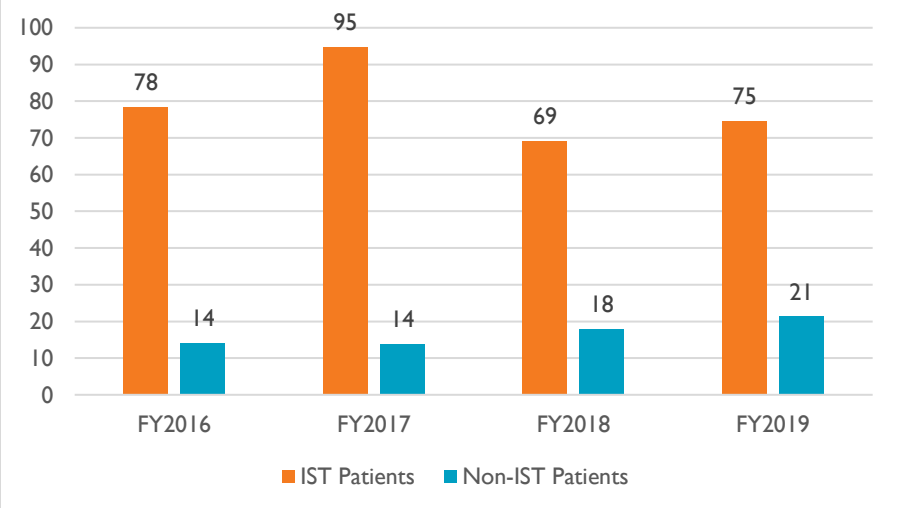


Source: Meditech Electronic Health Records. IST and Non-IST Demographics, Unduplicated. July 1, 2015 – December 31, 2019. IST white, n = 30; IST African American, n = 14; IST Alaska Native, n = 35. Non-IST white, n = 1204; IST African America, n = 104; IST Alaska Native, n = 757.

Length of Stay

The average length of stay for IST patients who have completed their stay varies by year, but typically lasts two to three months. The average length of stay for restoration patients is four to seven times longer than for civilly committed patients.

Figure 23: Average Length of Stay for IST Patients with Completed Stays, in Days

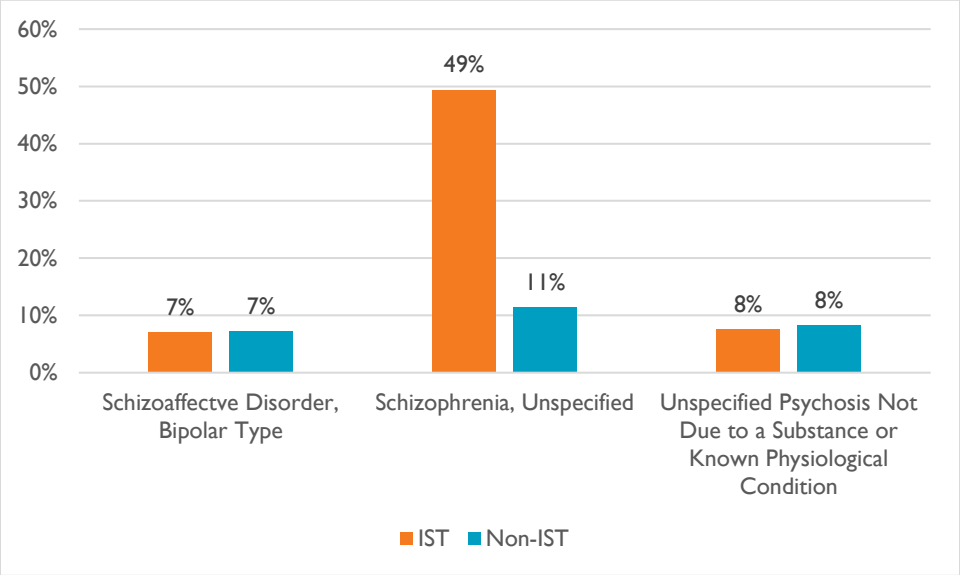


Source: Meditech Electronic Health Records. Discharged IST and non-IST, Average Length of Stay, July 1, 2015 – December 31, 2018

Clinical Characteristics

The top three diagnoses at discharge for IST patients are the same as for the civil population. However, nearly half of the IST population has a diagnosis of unspecified schizophrenia, compared to just 11 percent of the civilly committed population at API.

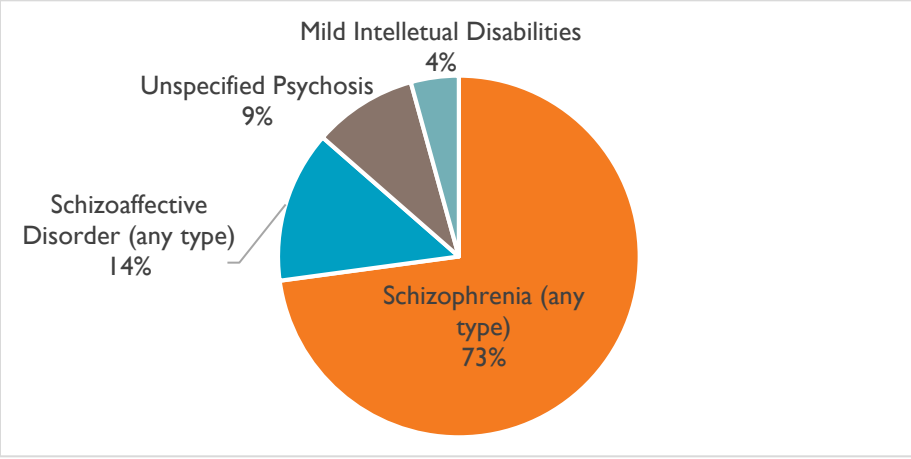
Figure 24: Top Three Diagnoses by IST and Non-IST Status



Source: Meditech Electronic Health Records. Discharge Diagnosis by IST and Non-IST Status, July 1, 2015 – December 31, 2018

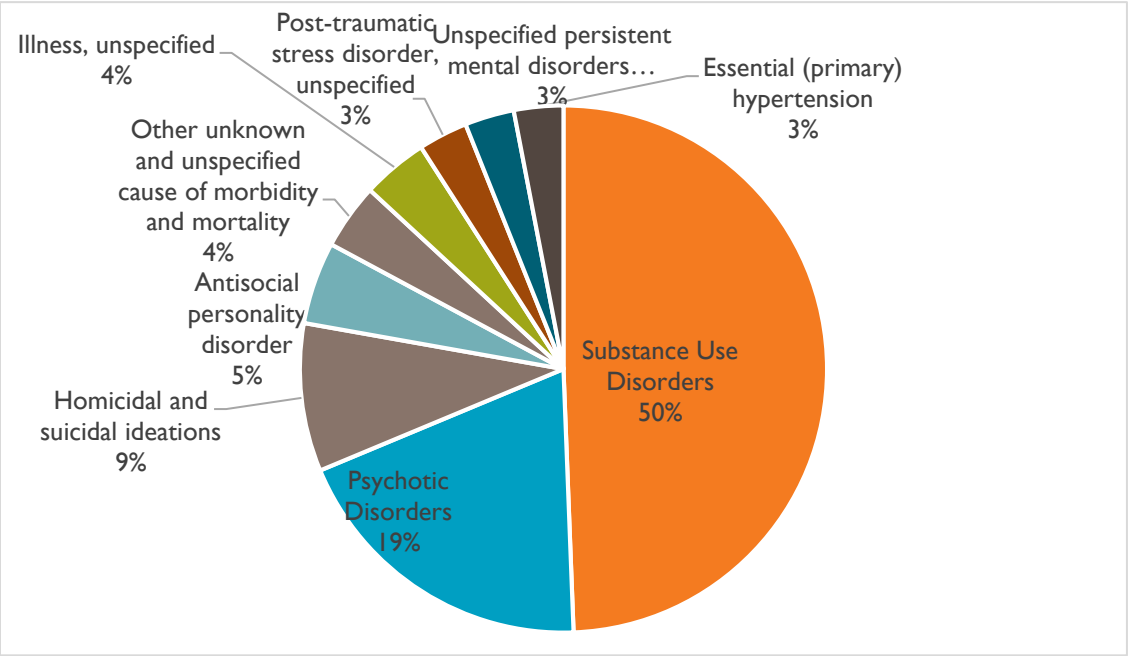
Schizophrenic disorders (when grouped together) are the most common primary diagnosis for the forensic population, while substance use disorders are most common as a secondary diagnosis. Percentages in the charts below represent diagnosis types with three or more patients with a given diagnosis.

Figure 25: Primary diagnosis for IST patients, diagnosis types with three or more patients



Source: Meditech Electronic Health Records. Discharge Diagnosis by IST and Non-IST Status, July 1, 2015 – December 31, 2018

Figure 26: Secondary diagnosis for IST patients, diagnosis types with three or more patients



Source: Meditech Electronic Health Records. Discharge Diagnosis by IST and Non-IST Status, July 1, 2015 – December 31, 2018

SPSS data from 2016-2018 identified that a Sell order for involuntary medication was sought in just 6.7 percent of cases (seven cases). Of those cases, an order was granted just twice. There were two cases where the outcome of the Sell process was unknown, one case where the order was withdrawn and two cases where the order was denied. In one of the two cases where Sell was granted, the individual was restored to competency and the individual who had the Sell order withdrawn was also restored. The other five individuals were unrestored and had their cases dismissed. Of the total number of individuals captured in this data set, it is unknown how many were taking medications voluntarily and how many could have benefited from involuntary medication, but the process was not even attempted due to low likelihood of success in obtaining an order.

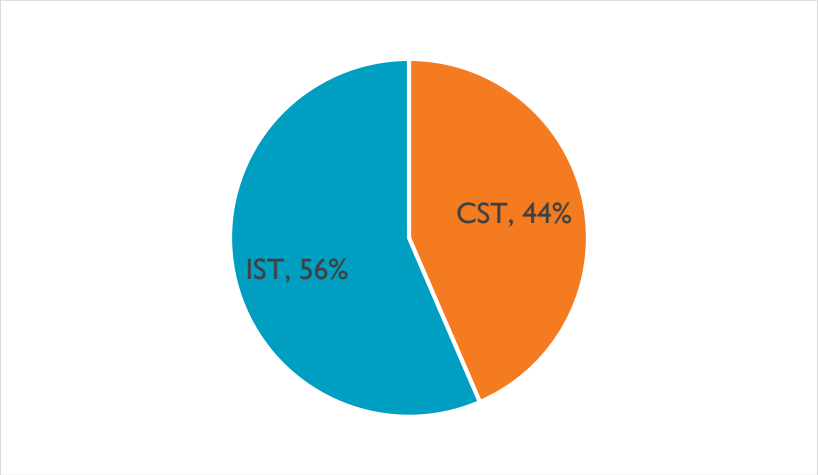
Disposition after Restoration

The percentage of API forensic patients restored to competency from 2016-2018 was just 44 percent, compared to an average restoration rate of 70 percent at inpatient facilities in other states.[20] A meta-analysis of 68 studies conducted between 1967 and 2008 identified that nationally approximately 81 percent of individuals were eventually restored.[21] Without data tracking and systems monitoring, it is difficult to understand why the rates of restoration at API are so low compared to other states.

[20] Data collection and analysis by Agnew::Beck Consulting, various case study interviews and review of outcome reports.

[21] Danzer, G., Wheeler, E., Alexander A., Wasser, T. (2019). Competency Restoration for Adult Defendants in Different Treatment Environments. Journal of the American Academy of Psychiatry and the Law. DOI: https://doi.org/10.29158/JAAPL.003819-19

Figure 27: API Evaluator Opinion After Restoration Efforts



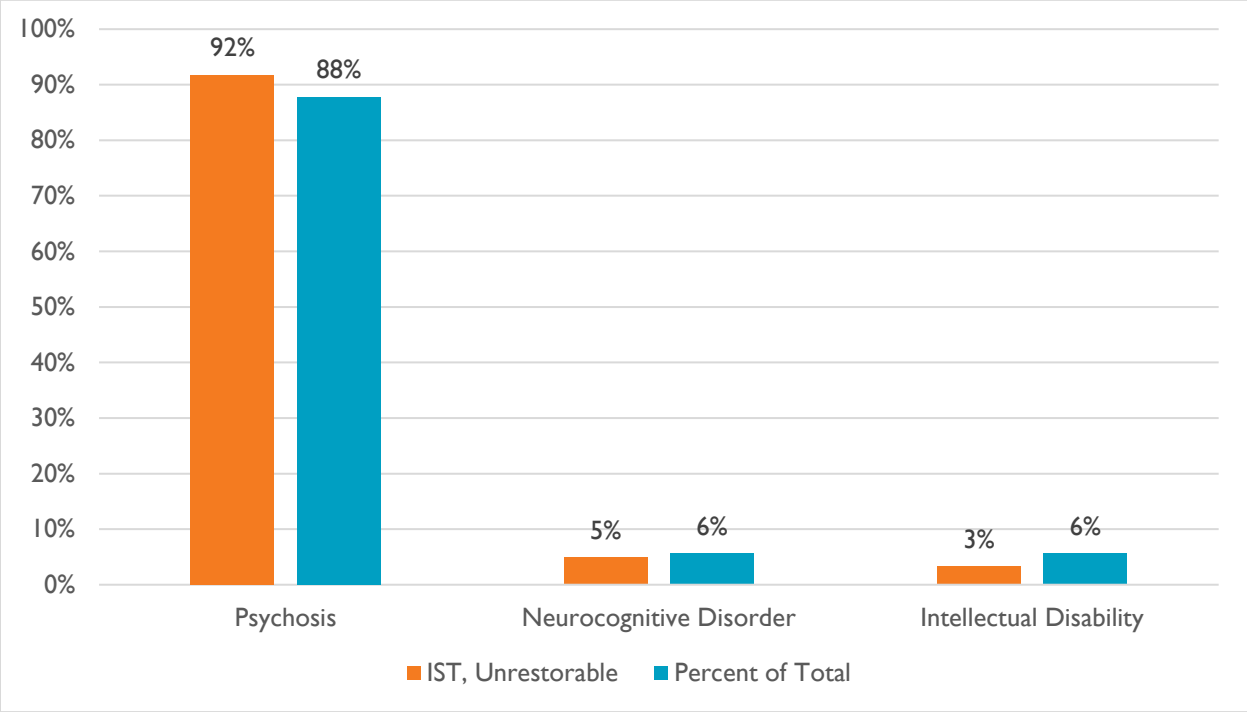
Source: API SPSS Data. Final disposition/final opinion frequency by year, 2016-2018.

Stakeholders shared that individuals with developmental disorders are more difficult to restore to competency, and the number of individuals with these issues may play a role in restoration rates in Alaska. However, API data indicates that just twelve percent of restoration patients have some type of neurocognitive disorder or intellectual disability.[22]

Recent API data suggests that individuals with psychosis are less likely to be restored. From 2016 to 2018, individuals with a thought disorder identified as their primary problem interfering with competency made up 74 percent of the total IST patient population, but 77 percent of the population that was unable to be restored, while individuals with a primary problem of cognitive deficit comprised 11 percent of the total IST patient population but just eight percent of those unable to be restored. The recent data suggests that individuals with cognitive disorders are actually more likely to be restored than those with thought disorders. Individuals identified as having both thought disorders and cognitive deficits made up 15 percent of the total population and 15 percent of those found incompetent to stand trial. Alaska statutes limits the maximum time permitted to restore an individual to competency at 360 days, which is shorter than many other states. This likely contributes to the rate of non-restorable defendants as compared to other states.

[22] API SPSS Data. Patients with final dispositions by diagnosis type, 2016-2018.

Figure 28: Total percentage of IST patients and IST unrestorable patients by diagnosis type, 2016-2018



Source: API SPSS Data. Patients with final dispositions by diagnosis type, 2016-2018.

5. Non-Restorable After Treatment

Current Process

For individuals evaluated as incompetent to stand trial who, after treatment, are deemed non-restorable, the court may dismiss the case, and/or the defendant may be civilly committed to API. According to Dr. Becker, there are currently two individuals who went through the competency and restoration process, were deemed non-restorable, and were subsequently civilly committed to API.

Alaska Statute

AS 12.47.110 Commitment on finding of incompetency governs the outcome for individuals found non-restorable after treatment. After the second 90-day period of commitment for restoration, or at the end of the six-month commitment period for defendants presenting a substantial danger to other persons, the court may choose to dismiss the case and "continued commitment of the defendant shall be governed by the provisions relating to civil commitments".

The Alaska legislature amended AS 12.47.110 to add subsection (e) in 2008 with the intent that civil commitment proceedings would automatically be initiated upon finding that a defendant is incompetent to stand trial and non-restorable. However, statute does not specify who is responsible for initiating civil commitment proceedings and this subsection is reported to be infrequently used.[23]

[23] Gordon, S., Piasecki, M., Kahn, G., Nielsen, D. (2014). Review of Alaska Mental Health Statutes. University of Las Vegas Nevada.

6. Not Guilty by Reason of Insanity

Statute

Alaska Statutes 12.47.010 and 12.47.020 govern the "not guilty by reason of insanity" defense, AS 12.47.10 through an affirmative defense and AS 12.47.020 through a diminished capacity defense. Under AS 12.47.10, this defense can only be considered after the trier of fact has found, beyond a reasonable doubt, that the defendant committed the offense.[24] Under AS 12.47.020, "if a verdict of not guilty by reason of insanity is reached under (b) of this section, the trier of fact shall also consider whether the defendant is guilty of any lesser included offense. If the defendant is convicted of a lesser included offense, the defendant shall be sentenced for that offense and shall automatically be considered guilty but mentally ill." An example of diminished capacity under AS 12.47.020(b) is a person charged with first-degree murder, but at the time the person killed the victim, the accused thought the victim's head was a lemon at that the person was squeezing a lemon.[25]

A common path to introduce evidence of mental disease or defect is the M'Naghten test. The traditional M'Naghten test examines two avenues: cognitive incapacity (inability to understand what was done at the time of the crime) and moral incapacity (inability to understand that an action was wrong).[26] From 1972 to 1982, Alaska used the Model Penal Code test, which states:

- A person is not responsible for criminal conduct if, at the time of the conduct, as a result of mental disease or defect, he lacks substantial capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of law.
- State had the burden of disproving insanity beyond a reasonable doubt if the defendant presented "some evidence" in support of the defense[27]

After statutory reforms in 1982, Alaska moved from the Model Penal Code to the M'Naghten test but limited the insanity defense to cognitive incapacity: individuals who "were unable, as a result of a mental disease or defect, to appreciate the nature and quality of that conduct" at the time of the crime (AS 12.47.010). The 1982 reform also created the diminished capacity defense (AS 12.47.020) for individuals who, at the time of the crime "did not have a culpable mental state which is an element of the crime". However, by eliminating the moral incapacity prong of the M'Naghten, AS 12.47.010 essentially duplicates the diminished capacity defense (AS 12.47.020) because if the defendant does not have diminished capacity, the defendant will be unable to establish the affirmative defense of insanity.[28] The 1982 reforms in Alaska "constructively abolished its insanity defense".[29]

Alaska Statute 12.47.090 Procedure after raising defense of insanity states "(b) If the defendant is found not guilty by reason of insanity under AS 12.47.010 or 12.47.020(b) and has not filed the notice required under (a) of this section, the court shall immediately commit the defendant to the custody of the commissioner of health and social services."

[24] Criminal Justice Commission (2017). Competency to Stand Trial, Insanity and Guilty but Mentally Ill in Alaska. Presentation.
[25] Criminal Justice Commission (2017). Competency to Stand Trial, Insanity and Guilty but Mentally Ill in Alaska. Presentation.
[26] Gordon, S., Piasecki, M., Kahn, G., Nielsen, D. (2014). Review of Alaska Mental Health Statutes. University of Las Vegas Nevada.
[27] Criminal Justice Commission (2017). Competency to Stand Trial, Insanity and Guilty but Mentally Ill in Alaska. Presentation.
[28] Criminal Justice Commission (2017). Competency to Stand Trial, Insanity and Guilty but Mentally Ill in Alaska. Presentation.
[29] Gordon, S., Piasecki, M., Kahn, G., Nielsen, D. (2014). Review of Alaska Mental Health Statutes. University of Las Vegas Nevada.

Alaska Statute 12.47.070 (a) governs that "If a defendant has filed notice of intention to rely on the affirmative defense of insanity under AS 12.47.010 or has filed notice under AS 12.47.020(a) or there is reason to doubt the defendant's fitness to proceed, or there is reason to believe that a mental disease or defect of the defendant will otherwise become an issue in the case, the court shall appoint at least two qualified psychiatrists or two forensic psychologists certified by the American Board of Forensic Psychology to examine and report upon the mental condition of the defendant."

Current Process

The 1982 statutory reforms described above essentially eliminated the affirmative insanity defense (12.47.010) and the University of Nevada Las Vegas (UNLV), 2014 report identifies that only two defendants post 1982 reform have been acquitted as NGRI. Stakeholders interviewed by the UNLV project team shared that the elimination of functional insanity defense has led to "large numbers of mentally ill defendants continuously entering the criminal justice system and having charges deferred for competency restoration or being deemed 'unrestorable'". As a result of the statutory changes in 1982, more mentally ill offenders are sentenced as Guilty but Mentally Ill and placed into the Department of Corrections custody rather than into state psychiatric custody.[30]

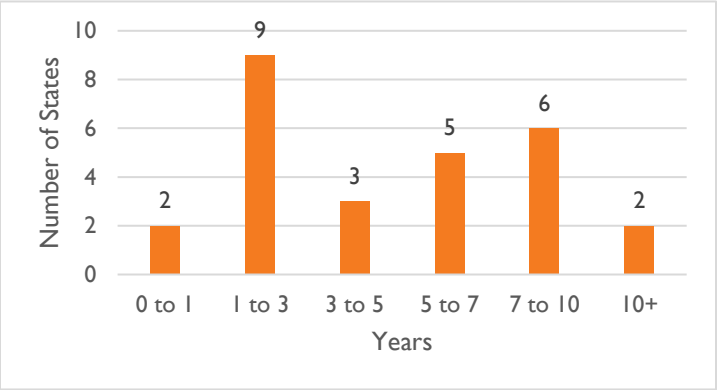
Under the provisions in Alaska Statute 12.47.090 individuals found not guilty by reason of insanity may be committed to the custody of the commissioner of health and social services if there is evidence that causes the defendant to be dangerous to the public. These individuals have been found not guilty and would therefore be admitted to the Alaska Psychiatric Institute via a civil commitment process.

The requirement that for defendants raising the insanity defense be examined by two qualified psychiatrists or two forensic psychologists certified by the American Board of Forensic Psychology adds an additional hurdle for those wishing to pursue the insanity defense. Most states only require one forensic examiner and nationally, there are only around 300 board certified forensic psychologists, making it extremely difficult for the state to provide the needed professionals to complete the evaluation.[31] A 2018 Alaska Supreme Court ruling found that API must provide the two psychiatrist or psychologists if they employ them and if API does not employ the qualified experts laid out in statute the superior court must appoint experts and the Alaska Court System must bear the cost. At the time of the ruling, API had no psychiatrists or psychologists qualified according to the statute to conduct the examination.[32]

[30] Criminal Justice Commission (2017). Competency to Stand Trial, Insanity and Guilty but Mentally Ill in Alaska. Presentation.
[31] Fox, Patrick (2016). *Alaska Psychiatric Institute: Evaluation of Forensic Services.* Western Interstate Commission for Higher Education Mental Health Program.
[32] The Supreme Court of the State of Alaska. Opinion Number 7313, November 2, 2018.

With just two individuals identified as acquitted as NGRI in Alaska since 1982, local data is not available for the average length of stay of this population in inpatient psychiatric care. A national survey found that lengths of stay for those found NGRI are generally long, over one year.[33] Following national trends, if Alaska were to have a larger NGRI population, it is likely that this population would remain at a facility for an extended period.

Figure 29: National average length of stay for NGRI patients, by State



[33] Fitch, W. L. (2014). White Paper: Forensic Mental Health Services in the United States. National Association of State Mental Health Program Directors.

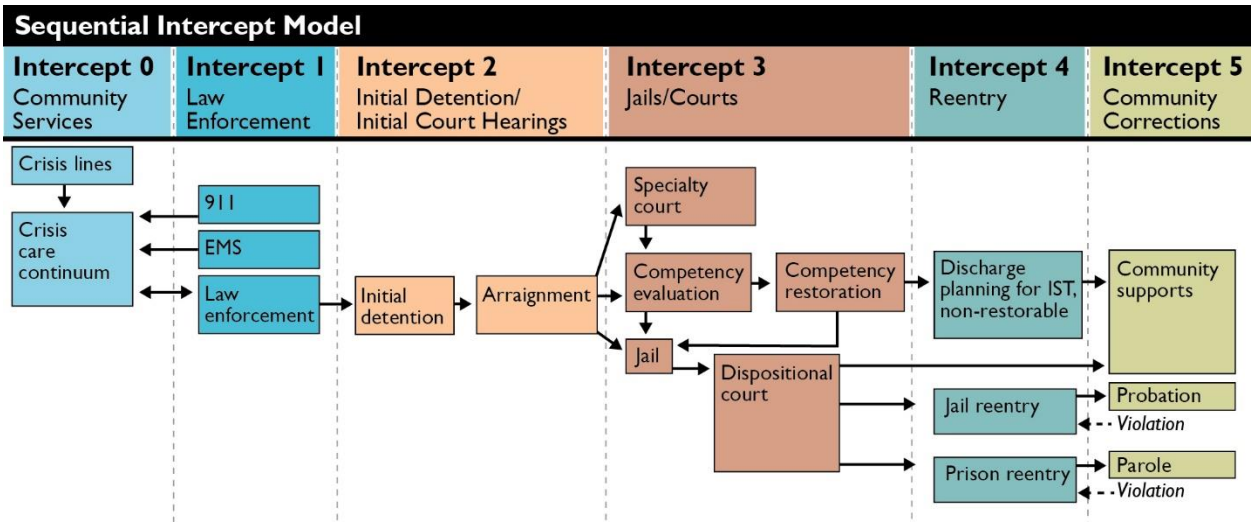
Appendix B: Types of Competency Restoration

Table of Contents

The Sequential Intercept Model + Tiered Competency Restoration

Alaska has explored and partially adopted the Sequential Intercept Model, developed by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Gather, Assess, Integrate, Network, and Stimulate (GAINS) Center, for the diversion of persons with mental health disorders from the criminal justice system as part of its comprehensive approach to reducing recidivism to Alaska's jails.[1] The model intends to divert from criminal justice involvement those persons whose behaviors and current needs are primarily driven by their mental health condition and not criminogenic factors.

Figure 1: Sequential Intercept Model[2]



While Alaska has succeeded in implementing parts of this model through the development of therapeutic courts, including mental health courts in Anchorage, Juneau, and Palmer,[3] and through a strong focus on reentry supports for individuals returning to their communities from correctional facilities, the backlog in the competency evaluation and restoration process has resulted in many individuals with serious mental health disorders spending significant time in Alaska's jails prior to being tried in court. One of the drivers for the backlog is that currently Alaska only provides restoration in the 10-bed Taku unit at the Alaska Psychiatric Institute and the average length of stay is 76 days, allowing the system to serve about 50 individuals annually. To reduce the backlog and to improve outcomes for individuals with serious mental health disorders facing criminal charges, Alaska must develop additional strategies to increase the quantity, variety and capacity of restoration programs to match the various levels of mental health need and risk to the community of the individuals served by this system.

We recommend that Alaska examine the feasibility and cost savings associated with implementing a tiered competency restoration system that includes an increase in hospital-based restoration capacity accompanied

[1] Concepts from the Sequential Intercept Model have been adopted by the Alaska Prisoner Reentry Initiative and the Alaska Criminal Justice Commission.

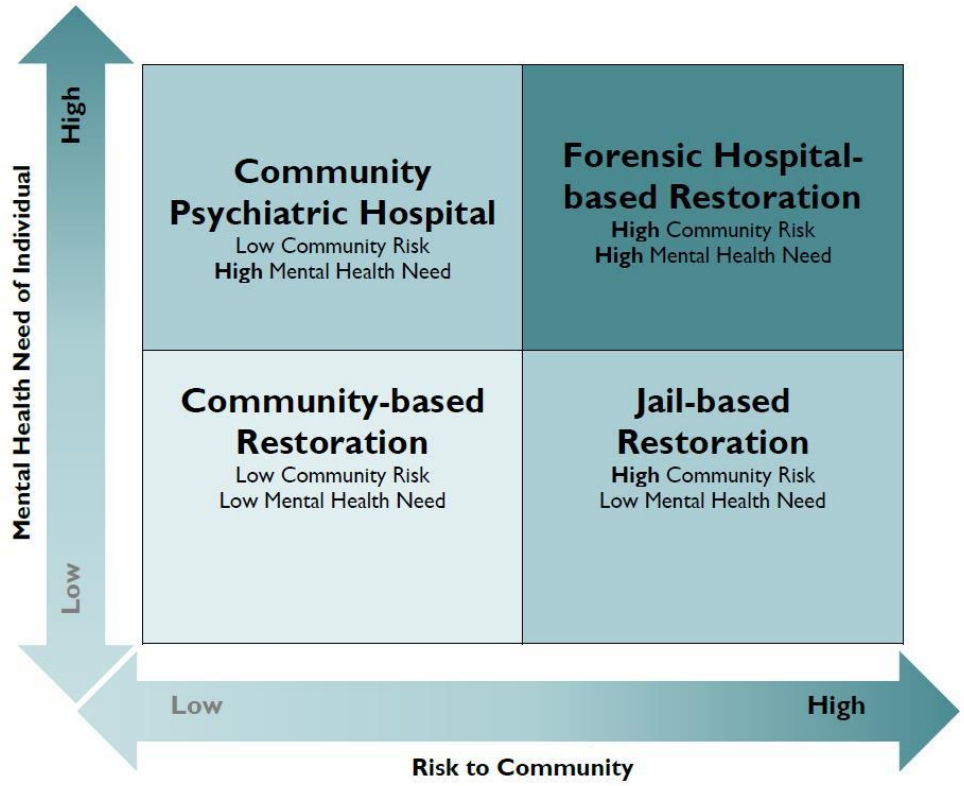
[2] Adapted from SAMHSA's GAINS Center for Behavioral Health and Justice Transformation. Developing a Comprehensive Plan for Behavioral Health and Criminal Justice Collaboration: The Sequential Intercept Model.

[3] Alaska Court System. Therapeutic Courts. http://www.courts.alaska.gov/therapeutic/index.htm

by alternative approaches to hospital-based competency restoration. This would use existing resources more effectively and efficiently while improving outcomes for individuals involved in the process.

A tiered system considers the level of the community risk posed by the defendant as well as the risk to the individual, and the defendant's acuity and complexity of mental health needs, as illustrated in Figure 2, when determining the appropriate setting for restoration. Currently, the courts use a risk assessment to determine whether a defendant should remain in custody or can be released to the community during the pre-trial phase. Seventy-two percent (72%) of individuals in the competency process were held in DOC facilities in 2018. For those in custody who are appropriate for a jail-based competency restoration program, availability of this type of restoration treatment would reduce delays in commencing competency restoration. For those in the community, a similar option could be developed through a community-based restoration program. Information on jail-based and community-based restoration are noted in this chapter.

Figure 2: Matrix of Level of Community Risk and Mental Health Need[4]



[4] Developed by Dr. Patrick Fox, formatted by Agnew::Beck.

Community-based Outpatient Competency Restoration

What is it?

"Outpatient" refers to competency restoration programs that are provided in any non-hospital community setting, including a jail or correctional setting.[5] The following includes a description of community-based ***non-jail*** outpatient competency restoration; this type of competency restoration is suitable for defendants posing low risk to the community and who, but for the finding of incompetency to proceed, could be released on bond. In addition, defendants in community-based competency restoration settings are considered amendable to treatment and can be safely treated within the community. Typically, these defendants have less severe symptoms of a mental health disorder, developmental disability, or traumatic brain injury; have less extensive criminal histories or are defendants accused of nonviolent or lesser forms of violent crime; and, have suitable community resources such as housing, social supports and available mental health treatment.

Community-based outpatient competency restoration programs vary by type and service model, eligibility criteria and operations and several models exist. Some entail one contracted entity providing both treatment and competency restoration services, while others divide responsibilities for competency restoration between different organizations, such as a community mental health center providing medication management, case management and other therapies, while a separate contracted agency provides competency restoration education services.

Community-based outpatient competency restoration programs provide varying types of legal education and training services in either one-on-one or in a group setting once or twice per week. Additionally, some programs include weekly case management services to help identify barriers to competency restoration, link defendants to appropriate service providers, if needed, and assist in coordinating care. Case management services help assure that a defendant's schedule is coordinated, appointments are made and contact with the outpatient competency restoration program is maintained.[6]

Key Findings

Community-based outpatient competency restoration has been successful in reducing the overall burden on the system by diverting those with lower community risk and low mental health needs to proper levels of care. Thirty-five states have statutes allowing for this type of restoration;[7] from 2011 to 2016 only 16 states had active community-based restoration programs.[8]

Community-based outpatient competency restoration programs have gained popularity in recent years as a cost-effective alternative to competency restoration in higher-level care settings. Rates of defendants being

[5] Wik, Amanda. (2018). Alternatives to Inpatient Competency Restoration Programs: Community-Based Competency Restoration Programs.
[6] Johnson, N.R. and Candilis, P.J. (2015). Outpatient competence restoration: A model and outcomes. World Journal of Psychiatry. 5(2): 228-233.
[7] Wik, Amanda. (2018). Alternatives to Inpatient Competency Restoration Programs: Community-Based Competency Restoration Programs.
[8] Danzer, Graham S., PsyD; Wheeler, Elizabeth M.A., PhD; Alexander, Apryl A., PsyD; and Wasser, Tobias D., MD. (2019). Competency Restoration for Adult Defendants in Different Treatment Environments. J Am Academy Psychiatry Law. 47(1).

successfully restored through community-based competency restoration range from 35-95% with an average length of time to restore competency ranging from 1-4 months up to 12 months.[9]

As with any type of program there are advantages and disadvantages. Outlined below are advantages of community-based competency restoration: [10]

- Less restrictive level of care and less likely to affect malingering;
- Less disruptive to participants' lives, allowing for continuity of housing and employment;
- High rates of restoration;
- Opportunity to provide students with forensic psychology experience and training;
- More public support and acceptance;
- Potential reduction in transportation costs and coordination issues; and,
- Cost-saving treatment option.

Disadvantages to community-based competency restoration include: [11, 12]

- Limited physical proximity of clients to treatment providers compared to other program types;
- Additional oversight and support may be needed to effectively manage individuals in the community to maximize effectiveness;
- Communication challenges in coordinating with treatment providers;
- Limited resources for psychiatrists to manage medication adherence;
- Increased access to illicit drugs and alcohol in a community environment;
- Public safety concerns; and,
- Less restrictive treatment mandates.

There are significant cost savings for outpatient programs, even though length of stay is typically longer.[13] For instance, nationally, the average cost ranges from $106 to $215 per day for community-based outpatient restoration, which is about $388 less per day than hospital-based restoration.[14, 15]

Jail-based Competency Restoration

What is it?

Over the last decade, jail-based competency restoration has emerged as an alternative to inpatient competency restoration. The increased demand for competency evaluation and restoration capacity has strained state inpatient psychiatric hospital resources, resulting in long waits in jails for individuals found incompetent to stand trial (IST). Jail-based competency restoration programs have enabled states to keep better pace with the rising demand for forensic psychiatric services in an effective and cost-efficient manner.

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[9] Ibid.
[10] Ibid.
[11] Danzer, Graham S., PsyD; Wheeler, Elizabeth M.A., PhD; Alexander, Apryl A., PsyD; and Wasser, Tobias D., MD. (2019). Competency Restoration for Adult Defendants in Different Treatment Environments. J Am Academy Psychiatry Law. 47(1).
[12] Groundswell Services, Inc. (2017). Analysis of Current Washington Competency Restoration Services.
[13] Groundswell Services, Inc. (2017). Analysis of Current Washington Competency Restoration Services.
[14] Danzer, Graham S., PsyD; Wheeler, Elizabeth M.A., PhD; Alexander, Apryl A., PsyD; and Wasser, Tobias D., MD. (2019). Competency Restoration for Adult Defendants in Different Treatment Environments. J Am Academy Psychiatry Law. 47(1).
[15] Hogg Foundation for Mental Health. (2013). Restoration of Competency to Stand Trial. What is Competency Restoration?

Jail-based competency restoration is suitable for defendants who are considered high-risk to the community or self, if released; amenable to treatment; and, do not require inpatient level of care. The American Bar Association developed guidelines indicating the suitability of different types of competency restoration services. These guidelines recommend that jail-based competency restoration be "limited to defendants who do not require inpatient level of care but are unable (e.g. dangerousness, offense type) to be released into the community pursuant to a judicial order."[16]

Jail-based competency restoration programs vary by type and service model, eligibility criteria and acuity, and operations.

Type and Service Model

Some jail-based competency restoration programs operate within a jail setting designed specifically for competency restoration such as Colorado's Restoring Individuals Safely and Effectively (RISE) program. In this model, competency restoration defendants are housed on a unit within the jail that is specifically designed for competency restoration. Programming occurs Monday through Friday from 8 a.m. to 5 p.m., with recreation and other activities scheduled on evenings and weekends. Staffing includes a multidisciplinary team consisting of a psychiatrist, a psychologist, social worker, nursing staff, peer support and re-entry specialist, deputies, and other mental health professionals.

Some states such as Utah have created jail-based competency restoration services in which defendants remain in the jail's general population and receive basic mental health services through the jail's existing mental health services. In this program, referred to as Outreach, competency restoration education services are provided by staff from the state's Forensic Services Division. This typically entails a competency restoration educator meeting with the defendant for one hour once or twice per week, and results in a significant number of defendants being found restored to competency to stand trial within 45 days.

Eligibility Criteria and Acuity

The eligibility criteria for admission to jail-based competency restoration programs vary for each program. For example, Colorado's RISE program only accepts defendants who voluntarily take medication, have no serious medical condition and are not considered to meet the state's civil commitment criteria. Eligibility criteria in other states range from accepting defendants who: are male, have no history of violent or aggressive behavior, are not more than mildly to moderately intellectually impaired, are already stabilizing, and are likely to be restored within 60 days.

The success of any competency restoration model comprised of tiered levels of service depends on the periodic assessment of defendants for progress, with referral to higher levels of care for those defendants who fail to progress at a lower level of care. In this way, the competency restoration system mirrors medical triage, wherein the most intensive services are reserved for persons whose specific conditions require it. Both inpatient and jail-based competency restoration programs can accept defendants with higher levels of charge who would pose a potential risk to the community, if released.

Operations

Jail-based competency restoration services are administered in a variety of ways depending on the resources available. Some programs are run on contractual agreements with a private company, by state psychiatric hospital workers who come into the jail setting to provide competency restoration services, or through agreements with jail providers. Programs can be run by state agencies or independent contractors or a mix of

[16] Wik, Amanda. (2018) Alternatives to Inpatient Competency Restoration Programs: Jail-Based Competency Restoration Programs.

both. Colorado's RISE program is a collaboration between Colorado's Department of Human Services, Office of Behavioral Health; the Arapahoe County Sheriff's Office; and Wellpath Recovery Solutions. Whereas, Utah's Outreach Program is run through a collaboration of state agencies including Utah's Department of Human Services, Department of Corrections and the Salt Lake County Sheriff's Office.

Key Findings

Jail-based competency restoration is a relatively new concept with most programs starting over the last decade. Currently, there are 12 states that use or have used jail-based competency restoration programs.[17]

Rates of defendants being successfully resorted utilizing this type of competency restoration range from 33-86% with the average length of time to restore competency around 2-4 months.

Outlined below are advantages to jail-based competency restoration: [18, 19, 20, 21]

- Decreased length of time to restore competence;
- Reduced waits for psychiatric hospital beds for those who need them;
- Lower costs;
- Reduction of incentives to malinger;
- Seamless transition from competence restoration to adjudication;
- Support jail staff to improve management of this subset of the jail population; and
- Can be therapeutic and effective.

Disadvantages to jail-based competency restoration are: [22, 23, 24, 25]

- Treatment in a carceral setting;
- May lack appropriate facilities and staffing including:
    - Non-therapeutic or highly-restrictive environment
    - Difficulty finding qualified staff able to/interested in providing services in a jail setting
    - Proper mechanisms for handling treatment refusal
- Limited availability of therapeutic modalities;
- No standard accreditation; and,
- Relatively new with limited public data available.

[17] Amanda Wik. (2018). Alternatives to Inpatient Competency Restoration Programs: Jail-Based Competency Restoration Programs.
[18] Ibid.
[19] Felthous, A.R., Bloom, J.D., MD. (2018). Jail-Based Competency Restoration. Journal of American Academy of Psychiatry Law. 46: 364-72.
[20] Kapoor, Reena, MD. (2011) Commentary: Jail-Based Competency Restoration. Journal of American Academy of Psychiatry Law. 39: 311-15.
[21] NAMI National Convention. (2016). Restoring Individuals Safely and Effectively (RISE): Colorado's Jail-Based Competency Restoration Program.
[22] Amanda Wik. (2018). Alternatives to Inpatient Competency Restoration Programs: Jail-Based Competency Restoration Programs.
[23] Felthous, A.R., Bloom, J.D., MD. (2018). Jail-Based Competency Restoration. Journal of American Academy of Psychiatry Law. 46: 364-72.
[24] Kapoor, Reena, MD. (2011) Commentary: Jail-Based Competency Restoration. Journal of American Academy of Psychiatry Law. 39: 311-15.
[25] NAMI National Convention. (2016). Restoring Individuals Safely and Effectively (RISE): Colorado's Jail-Based Competency Restoration Program.

The relative cost savings from adopting a tiered approach to competency restoration can be significant. For instance, in Colorado the per diem rate for competency restoration defendants at the state's forensic mental health institute is $700/day. The daily rate for the state's intensive jail-based partial hospitalization program is $310/day and estimates for the per diem rate for a program analogous to Utah's Outreach program is $70/day.

Inpatient Competency Restoration

What is it?

State psychiatric hospitals have historically been the default option for providing competency restoration treatment to defendants,[26, 27] due in part to state statutes mandating inpatient care.[28] Because of this, many states maintain long waitlists as there are not enough beds to meet rising demand. In Alaska, competency restoration treatment has been almost exclusively provided on an inpatient basis as there are no other competency restoration options in the state.

Inpatient competency restoration is suitable for defendants posing high community risk with high mental health need. This type of competency restoration includes defendants who are initially resistant to treatment, need to be medicated to assist with restoration or have other medical needs, and/or are a danger to self or others. Like outpatient and jail-based competency restoration treatment, inpatient competency restoration familiarizes defendants with legal concepts and trial processes so the defendant can understand the charges against him or her and its potential consequences; understand courtroom procedures; gain the ability to communicate rationally and effectively with counsel; and increase capacity to integrate and use this knowledge at trial or in a plea bargain. However, this education is completed in a therapeutic, inpatient medical setting.

Key Findings

Inpatient competency restoration is the default treatment environment for many states and contributes to a backlog for competency evaluations and inpatient beds for restoration purposes.

Rates of defendants being successfully restored utilizing inpatient competency restoration is around 75 percent with the average length of time to restore competency between four and six months.[29, 30]

Outlined below are the advantages to inpatient competency restoration:[31, 32]

- Treatment in a therapeutic setting oriented primarily to individuals with severe mental illness;

[26] McMahon, Susan. (2019). Reforming Competence Restoration Statues: An Outpatient Model. The Georgetown Law Journal. Vol 107:601.
[27] Danzer, Graham S., PsyD; Wheeler, Elizabeth M.A., PhD; Alexander, Apryl A., PsyD; and Wasser, Tobias D., MD. (2019). Competency Restoration for Adult Defendants in Different Treatment Environments. J Am Academy Psychiatry Law. 47(1).
[28] McMahon, Susan. (2019). Reforming Competence Restoration Statues: An Outpatient Model. The Georgetown Law Journal. Vol 107:601. Note: There are nine jurisdictions (the federal government and eight states) requiring courts to hospitalize defendants found incompetent. Three additional states mandate commitment when the defendant is accused of a felony.
[29] Washington State Institute for Public Policy. (2013). Standardizing Protocols for Treatment to Restore Competency to Stand Trial: Interventions and Clinically Appropriate Time Periods.
[30] Hogg Foundation for Mental Health. (2013). Restoration of Competency to Stand Trial. What is Competency Restoration?
[31] Danzer, Graham S., PsyD; Wheeler, Elizabeth M.A., PhD; Alexander, Apryl A., PsyD; and Wasser, Tobias D., MD. (2019). Competency Restoration for Adult Defendants in Different Treatment Environments. J Am Academy Psychiatry Law. 47(1).
[32] McMahon, Susan. (2019). Reforming Competence Restoration Statues: An Outpatient Model. The Georgetown Law Journal. Vol 107:601.

- Multiple needed services and rehabilitative interventions provided in addition to competency restoration to help address psychiatric and medical conditions and better prepare defendants to return to community in a more functional state;
- Greater resources to maintain adherence while in treatment and upon discharge;
- Provider expertise and resources typically more specialized and diversified;
- More often accredited by a governing body, e.g., Joint Commission; and,
- High rates of restoration to competency.

Disadvantages to inpatient competency restoration are:[33,34]

- Highly restrictive level of care and heightened anxiety for defendants;
- Expensive with bed resource considerations;
- Greater potential to malinger;
- Higher likelihood for defendants to be detained unnecessarily, enduring involuntary separation from their community and higher contribution to backlog for inpatient beds;
- Higher likelihood of continued cycling for defendant through inpatient and jail settings with psychotic symptoms returning if defendant refuses medication once released.

Inpatient psychiatric hospitals have higher costs than community-based and jail-based settings with costs of restoration in inpatient psychiatric hospitals ranging from $401 to $834 per defendant per day.[35]

[33] Danzer, Graham S., PsyD; Wheeler, Elizabeth M.A., PhD; Alexander, Apryl A., PsyD; and Wasser, Tobias D., MD. (2019). Competency Restoration for Adult Defendants in Different Treatment Environments. J Am Academy Psychiatry Law. 47(1).
[34] McMahon, Susan. (2019). Reforming Competence Restoration Statues: An Outpatient Model. The Georgetown Law Journal. Vol 107:601.
[35] Danzer, Graham S., PsyD; Wheeler, Elizabeth M.A., PhD; Alexander, Apryl A., PsyD; and Wasser, Tobias D., MD. (2019). Competency Restoration for Adult Defendants in Different Treatment Environments. J Am Academy Psychiatry Law. 47(1).

Appendix C: Forensic Psychiatric System Case Studies + Dashboard

Table of Contents

Executive Summary

Case studies were compiled through key informant interviews with forensic psychiatric administrative leaders in Colorado, Connecticut, Hawaii and Utah. An interview with administrative staff in Washington could not be scheduled. Online research and review of state reports supplemented information gathered in interviews, and in the case of Washington, informed the entirety of the state profile. Sources of information for each state are cited at the end of each state's profile.

Overview

Washington, Connecticut and Colorado each have specific offices or divisions that oversee forensic psychiatric services. Utah and Hawaii operate in a model more like Alaska where there is limited oversight of the forensic psychiatric system. In Alaska, there is no statewide or inter-agency system that tracks and monitors forensic psychiatric services. Forensic evaluators and treatment staff are employed by the Alaska Psychiatric Institute (API), within the Department of Health and Social Services (DHSS), and do not have a leadership structure or professional oversight that differs from employees working on civil commitment units. Utah has a Forensic Mental Health Coordinating Council which promotes communication and coordination between different agencies, evaluates and promotes changes to policies, procedures and programs and promotes judicial education. Colorado, Utah and Washington all have consent decrees in place because of lawsuits related to the backlog in their competency restoration systems. As such, each state has a court monitor in place that provides oversight.

Table 1: Forensic Psychiatric Services Coordination and Oversight

State	Coordination and Oversight
Alaska	DHSS, API. No specific entity or inter-agency oversight of forensic psychiatric system.
Colorado	Department of Human Services, Office of Behavioral Health – Forensic Services; Court monitor
Connecticut	Department of Mental Health and Addiction Services, Forensic Services Division
Hawaii	Department of Health, Adult Mental Health Division
Utah	Utah Department of Human Services, Utah State Hospital; Forensic Mental Health Coordinating Council; Court monitor
Washington	Department of Social and Health Services, Office of Forensic Mental Health Services; Court monitor

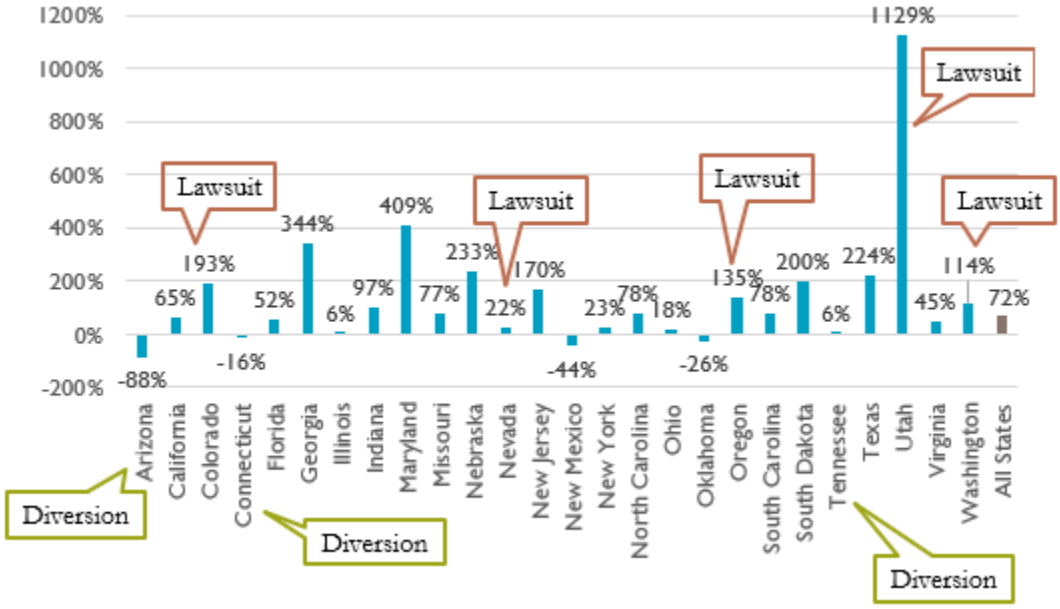
Case study research did not identify model data tracking and communications systems and indicated that these are works in progress for many states. Hawaii develops and submits an annual report with data specific to the forensic psychiatric population to the state legislature. Connecticut also releases an annual report.

Diversion

Diversion services play an important role in reducing the number of defendants with a mental illness entering the criminal justice system and potentially being referred to the competency evaluation and restoration process. States like Arizona, Connecticut and Tennessee that have robust diversion programs for this population are seeing decreases or slight increases in their inpatient forensic psychiatric population, while

states without robust diversion programs in place are seeing much greater increases, and lawsuits stemming from the backlog created by these increases. The one-day census percent change does not accurately reflect the extent of the problem as it does not capture the backlog; however, Figure 1 below indicates the nationwide increase in forensic psychiatric patients over the past 20 years.

Figure 1: IST One-Day Census Percent Change - States with Numerical Values 1999-2014



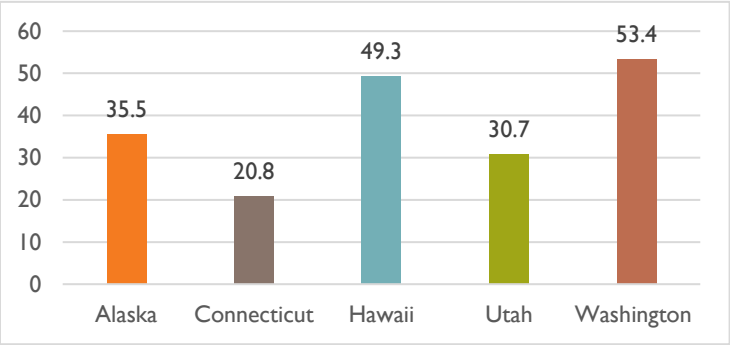
Source: Reproduced from National Association of State Mental Health Program Directors. Assessment #10: Forensic Patients in State Psychiatric Hospitals 199902016. August 2017.

Evaluations

The number of competency evaluations performed for every 100,000 residents varies greatly by state, from a low of 20.8 evaluations per 100,000 in Connecticut, to a high of 53.4 evaluations per 100,000 in Washington.[1] All states reviewed except Alaska have designated evaluators or evaluation departments independent of the restoration treatment clinicians.

[1] It should be noted that the raw numbers of evaluations performed in each state are not uniform in reporting period. Some states' numbers are by fiscal year, some by calendar year and for some states recent information is not available, so the most recent year available was used. Thus, comparisons between states are not equal. Population estimates used for each state come from the 2018 United States Census Population Estimates.

Figure 2: Number of competency evaluations per 100,000 residents



Restoration Treatment

All states reviewed except Alaska have alternatives to inpatient competency restoration. Colorado provides restoration treatment at three levels of service. Outpatient restoration is offered in Connecticut on a limited basis, but as there is no wait for inpatient restoration, alternatives are less critical. In Washington, the alternatives to inpatient restoration are offered at two residential treatment facilities with plans to expand to a third site.

Figure 3: Types of Restoration Treatment by State

State	Outpatient Restoration	Jail-Based Restoration	Inpatient Restoration
Alaska	No	No	Yes
Colorado	Yes	Yes	Yes
Connecticut	Yes (limited)	No	Yes
Hawaii	Yes	No	Yes
Utah	No	Yes	Yes
Washington	Yes (residential)	No	Yes

Alaska has the lowest ratio of designated forensic psychiatric beds per 100,000 residents of any of the states surveyed and a lower ratio than the national average. Like Alaska, Connecticut and Utah do not have significant not guilty by reason of insanity (NGRI) populations, due to statutory language that restricts the use of this verdict. Colorado, Hawaii and Washington have larger NGRI populations.

Figure 4: Number of Beds, Bed Ratio and Population Served at Inpatient Forensic Psychiatric Hospitals

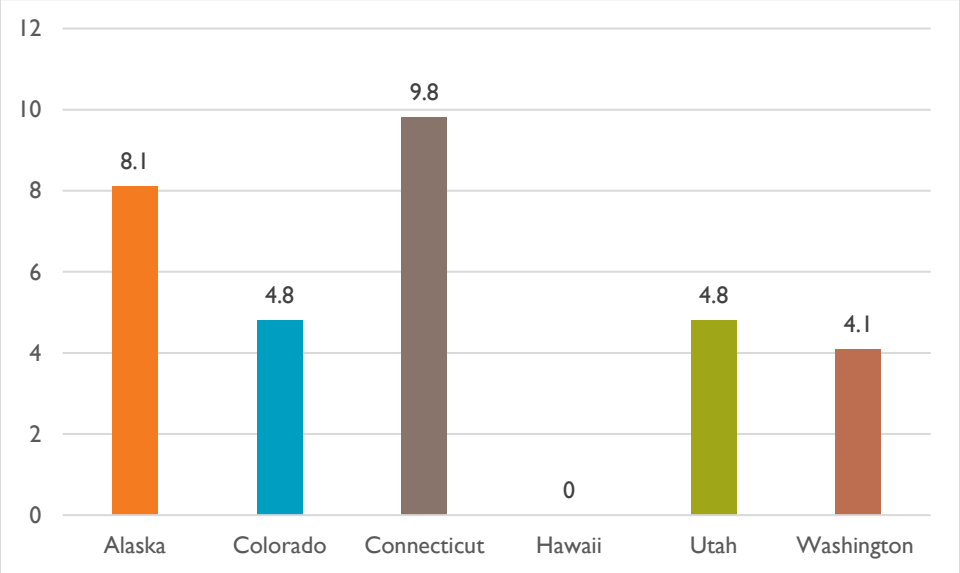
State	Number of Inpatient Forensic Psychiatric Beds	Ratio of Beds to 100,000 Residents	Population Served
Alaska	10	1.4	Restoration to competency. Limited number of: competency evaluations, DOC transfers, civil patients (typically those with acute aggression) and NGRI.
Colorado	307	5.3	Restoration to competency. Competency evaluations. NGRI.
Connecticut	229	6.4	Restoration to competency, GBMI, DOC transfers, civil patients (typically those with acute aggression)

State	Number of Inpatient Forensic Psychiatric Beds	Ratio of Beds to 100,000 Residents	Population Served
Hawaii	202	13.9	Restoration to competency. Competency evaluations. NGRI. Conditional Release Violation/Revocation.
Utah	124	3.9	Primarily restoration to competency. Limited number of GBMI and NGRI.
Washington	365	4.8	Restoration to competency. Competency evaluation. NGRI. NGRI Conditional Release.
National		5.5	Varies by facility

Discharge

Utah and Connecticut frequently transfer patients found incompetent to stand trial and not restorable to civil beds in their states. In Utah, this has resulted in "forensic creep", where approximately 20 percent of the state's civil psychiatric beds are filled with former forensic psychiatric patients. In Alaska, civil beds are used only rarely as a discharge placement. In Colorado, statute permits individuals found incompetent to stand trial to remain in inpatient psychiatric care for as long as they would have if found guilty of their crimes. This results in decreased bed turnover, even when an individual is found non-restorable. Hawaii State Hospital effectively has no beds for civil patients, and the beds they do have are generally filled with non-restorable patients who are not safe to release to the community.

Figure 5: Ratio of Civil Inpatient Psychiatric Beds per 100,000 Population



Discharge planning and community supports appear disjointed in most states. Connecticut and Hawaii appear to have the most resources available to non-restorable individuals returning to community settings. The other states studied, including Alaska, need additional community-based resources to safely return non-restorable individuals to their communities and ensure they do not rapidly re-enter the criminal justice system.

Alaska

Overview

Management of Forensic Psychiatric Population

The Alaska Department of Health and Social Services (DHSS) is the lead department for all forensic psychiatric services in the state. Alaska Psychiatric Institute (API) is an agency of DHSS and currently provides all competency evaluation and restoration services. The 10-bed Taku Unit at API is designated for forensic psychiatric patients. Alaska statute specifies that if a defendant is evaluated and found incompetent to stand trial, the court "shall commit a defendant charged with a felony, and may commit defendant charged with any other crime, to the custody of the commissioner of health and social services or the commissioner's authorized representative for further evaluation and treatment until the defendant is mentally competent to stand trial or until the pending charges against the defendant are disposed of according to law".[2]

The Department of Corrections (DOC) is a separate state entity and provides mental health services to its population including screenings, crisis intervention, sub-acute and acute treatment and release planning through four release programs. DOC is the largest provider of inpatient mental health services in Alaska, with 306 beds, compared to just 60 beds for adult civil inpatient mental health services at API.

Oversight

The Alaska Psychiatric Institute is certified by the Centers for Medicare and Medicaid Services (CMS) and accredited by the Joint Commission.

Partnerships

Evaluators from API use space at DOC facilities to conduct competency evaluations. Competency evaluation and restoration for juvenile defendants is provided by API staff at McLaughlin Youth Center, part of the Division of Juvenile Justice (DJJ). While API uses space at DOC and DJJ, there are no formal partnership agreements between the agencies related to this process.

Data Tracking + Communication

There is no shared data system between DHSS, DOC, and the Alaska Court System. A Memorandum of Agreement (MOA) for Urgent Forensic Discharge Planning is in place between the three entities, and includes the Office of Public Advocacy, Senior and Disabilities Services, and Public Assistance. The purpose of the MOA is to formalize communication between the parties, establish each party's roles, and protect the confidentiality of defendants under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) with the goal of expedited and safe discharge plans. The MOA is used for weekly coordination and communication between API and Anchorage Court staff; however, this group is not currently active and should be reconvened to review, revise and further implement the MOA.

Within the court system, the project coordinator for the Coordinated Resources Project (Mental Health Court) in Anchorage is a de facto data tracker and coordinator for competency cases. Statewide data tracking and coordination does not occur and occurs only as time permits within the Anchorage Court.

At API, data on individuals at all stages of the competency process from evaluation to restoration treatment is only available via the "Tuesday Report" a weekly report that exists only in paper format. For patients

[2] Alaska Statute Section 12.47.110. Commitment on finding of incompetency.

admitted to API for competency restoration, API's electronic health record provides additional information, but this represents just one piece of the process. An intern has recently been hired to assist with entering completed cases into the Statistic Package for the Social Sciences (SPSS) database. Establishing an electronic database will be helpful in assessing outcomes and needs at a statewide level.

Workforce for Forensic Psychiatric Services

In 2018, in efforts to reduce the backlog in the competency evaluation and restoration system and add additional clinical capacity for restoration services, API was authorized to add five forensic psychologists to their team. One of API's forensic psychologists identified that with a large enough staff, API's forensic psychological services would be able to staff a separate treatment team and an evaluation team. Currently, the same staff provide competency evaluations and restoration treatment. A position opening for multiple (3) restoration treatment clinicians was posted to Workplace Alaska on February 15, 2019 and a position opening for a forensic evaluator was posted on March 19, 2019 bringing the total number of forensic psychologist positions open in Alaska to four. The two full-time forensic psychologists at API recently resigned and various strategies to fill this gap are being discussed. The Alaska Mental Health Trust Authority has provided $150,000 to contract with a forensic psychiatrist to help clear the evaluation backlog and there is a possibility that the forensic psychologists who recently resigned will be brought on as contractors.

Forensic psychologists in Alaska are salaried at one of the lowest rates of any of the states surveyed and forensic psychologists at API are aware of this discrepancy. One forensic psychologist at API explained that her position is classified as a Mental Health Clinician III, the same as a master's level social worker, even though a doctorate and specialized forensic training is required for her position.

Diversion from the Criminal Justice System

Some officers within the police departments in Anchorage, Palmer, Wasilla, Juneau and Fairbanks as well as some Alaska State Trooper units have received Crisis Intervention Team (CIT) training. However, CITs around the state are missing the critical co-responder piece, where a mental health professional responds to calls with officers. In Anchorage, there is one social worker that co-responds to calls, but only when she is on duty and it is reported that she only responds to calls related to mental health concerns, not criminal calls that may have a mental health component. The Alaska Criminal Justice Commission recommended the expansion of the co-response CIT model around the state.

Competency Evaluation

Competency to stand trial evaluations are provided by API-employed forensic psychologists. Most initial competency to stand trial evaluations are conducted on an outpatient basis, either in jail, or, if the defendant is out on bond, by the individual reporting to API to complete the evaluation. At the start of this project in November 2018, there were 2.5 forensic psychologists performing evaluations and overseeing restoration treatment. Of all states reviewed, Alaska was the only state that had the same staff performing both evaluations and treatment. The 2016 WICHE report identified the small team size and the lack of additional diverse opinions as an area of concern. A recommendation was made to contract with forensic psychiatric consultants from outside the API system to provide guidance and objective analysis to API's forensic psychiatric team.

Orders for competency evaluations increased 11 percent from fiscal year 2017 to 262 evaluations completed in fiscal year 2018 (35.5 evaluations per 100,000 residents). The projected number of completed evaluations for fiscal year 2019 is expected to be even higher.

As of March 28, 2019, there were 45 individuals awaiting an evaluation.

Competency Restoration

As of March 28, 2019, there were 29 individuals ordered for restoration and waiting for a bed. It is estimated that three-fourths of these individuals are waiting in a DOC facility.

Inpatient

Presently, all competency restoration services are provided at Alaska Psychiatric Institute, primarily on API's 10-bed Taku Unit in Anchorage. In addition to competency restoration patients, Taku also serves a limited number of GBMI individuals, civilly committed patients (typically those with acute aggression), and transfers from the Department of Correction (DOC) either during or after a sentence. Transfers from DOC to API happen very rarely (estimated at just once in the last 20 years).

Staffing. Restoration units are staffed by a multidisciplinary team consisting of the following members: psychiatrist, psychologist, social worker, recreational therapist, nurses and paraprofessional staff.

Diagnosis + Treatment. Schizophrenic disorders are the most common primary diagnosis for competency restoration patients (73 percent), followed by schizoaffective disorder (14 percent), unspecified psychosis (nine percent) and mild intellectual disabilities (four percent). Fifty percent of this population has a secondary substance use disorder diagnosis. API staff expressed that involuntary medication is difficult to obtain for this population due to Alaska's constitutional right to privacy and recent interpretations of case law.

Specialty Populations. The Taku Unit treats individuals with traumatic brain injury (TBI), dementia, and intellectual or developmental disabilities (IDD). There is no specialized programming for these individuals on the unit and API's civil wing for dementia and long-term care patients has not been operational since 2017.

Transitions + Reentry

Discharge planning for forensic psychiatric patients is contingent on the likely outcome of the case. If API staff anticipate the individual will be released to the community after restoration treatment because they have been found not-restorable, discharge planning will include trying to find assisted living or other discharge supports for the individual. API shared that there are no specific resources available to discharge non-restorable forensic psychiatric patients, and the social worker responsible for discharge planning for Taku patients identified placements for these patients and the lack of supervision and follow-up services as significant barriers.

Outcomes

The average length of stay for inpatient restoration varies year to year but averaged 75 days in the first half of fiscal year 2019. The percentage of API forensic patients restored to competency from 2016-2018 was just 44

percent (61 individuals were not restored). This is well below national averages which suggest 70 to 81 percent of defendants are be restored to competency.

Sources

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Forensic Psychiatric Hospital Feasibility Study: Draft Phase I Report, 2019.

Colorado

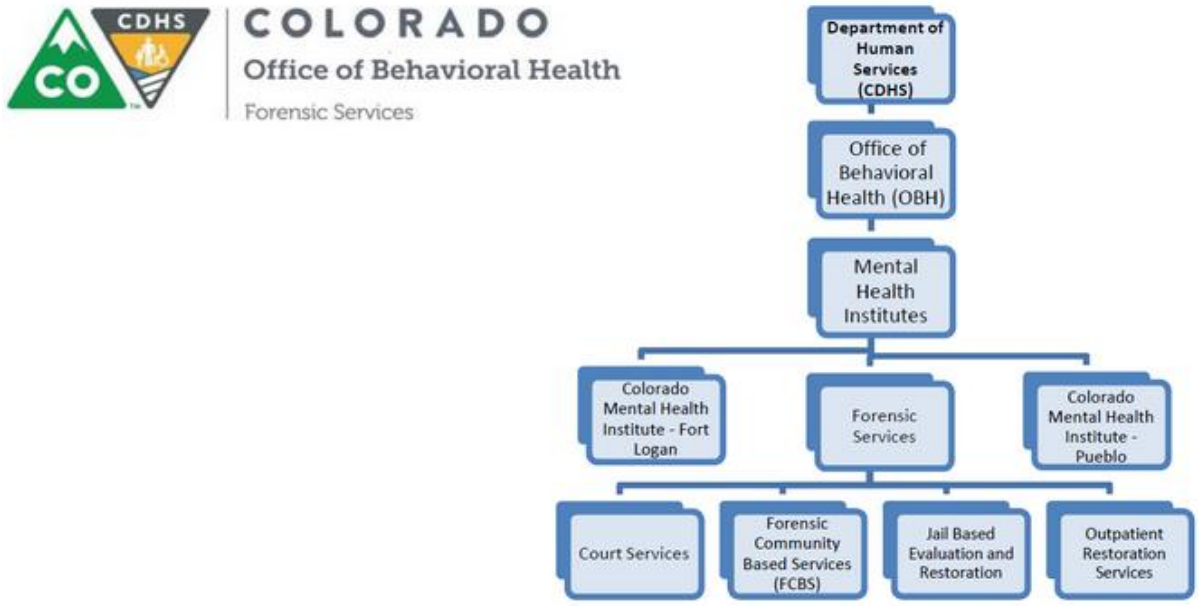
Overview

Management of Forensic Psychiatric Population

The Colorado Department of Human Services, Office of Behavioral Health, Forensic Services Division has four departments: Court Services, Forensic Community Based Services, Jail Based Evaluation and Restoration, and Outpatient Restoration Services. Inpatient forensic psychiatric services also fall under the purview of the Office of Behavioral Health and are offered at the Colorado Mental Health Institute – Pueblo. There are 307 inpatient forensic psychiatric beds at the Colorado Mental Health Institute – Pueblo and 238 beds for civil commitments between the Pueblo facility and the Colorado Mental Health Institute – Fort Logan.

Since 2011, the Colorado Department of Human Services has been sued four times over delays in the competency evaluation and restoration process. The state reports the number of people referred for competency evaluations increased by 930 percent since 2000 and the number of those needing treatment increased 431 percent.

Figure 6: Colorado Office of Behavioral Health Organizational Chart



Oversight

The Colorado Mental Health Institute at Pueblo is accredited by the Joint Commission and is certified by the Centers for Medicare and Medicaid Services. Forensic Services provides oversight for contracted jail-based evaluation and restoration treatment, and community-based restoration treatment. The Restoring Individuals Safely and Effectively (RISE) program is accredited by the National Commission on Correctional Healthcare and the American Correctional Association. The RISE program also incorporates a Stakeholder Board to review outcome data, progress, program updates, and address questions and issues. The state is currently

under a settlement agreement, with special masters overseeing compliance with the terms of the settlement agreement.

Partnerships

Forensic Services contracts with Wellpath Recovery Solutions for implementation of Colorado's jail-based restoration program, which began in 2014. Jail-based restoration is offered at the Arapaho County Jail and will soon expand to the Boulder County Jail. Forensic Services contracts with community service providers to provide outpatient restoration for adults and juveniles. Seventy-six percent of Colorado's counties have a contracted outpatient restoration provider. The Forensic Services program also offers a fellowship for Post-doctoral Forensic Psychology at the Colorado Mental Health Institute at Pueblo. The fellowship meets the criteria for the experience requirement waiver for application for board certification by the American Board of Forensic Psychology.

Data Tracking + Communication

Effective data tracking is still in development. The state is in the process of creating data management teams to better track and extract data. Senate Bill 19-223 Actions Related to Competency to Proceed requires the Department of Human Services to develop an electronic system to track the status of defendants for whom competency has been raised.

In 2018, the Colorado Judicial Department, State Court Administrator's Office, issued a request for proposals from behavioral health organizations to provide a court liaison in each of Colorado's 22 judicial districts. The purpose of these court liaisons is to facilitate connections and communication between the criminal justice and behavioral health systems. The liaisons will work directly with defendants to make connections to evaluations and treatment and educate legal professionals about available mental health services, including competency evaluation and restoration.

Workforce for Forensic Psychiatric Services

The Court Services Program is made up of 45 psychologists and professional support staff. A review of Colorado Department of Human Services job vacancies identified one vacancy for a Psychologist I, Forensic Evaluator with the Court Services Program.

The Outpatient Restoration Program is offered by contracted educators throughout Colorado. Vacancies with the various contracted outpatient restoration providers could not be identified at this time. Colorado's Director of Forensic Services reports great success in contracting with service providers in individual counties to provide outpatient restoration. Current clinical job openings identified on the Wellpath website for jail-based restoration include postings for two part-time psychiatrists, two Licensed Master of Social Work positions and a Psychologist. Current clinical job openings for provision of restoration services at the Colorado Mental Health Institute Pueblo include an opening for a psychologist candidate and two vacancies for Psychologist I positions.

Senate Bill 19-223 requires the Department of Human Services to partner with an institute of higher education to develop and provide training in competency evaluations and specifies that beginning in January 2020 competency evaluators are required to have attended training, except for certain exempt evaluators. There is also a requirement for district attorneys, public defenders and defense counsel to receive training on the competency to proceed process.

Diversion from the Criminal Justice System

Forensic Services does not offer diversion programs; however, in 2018, Senate Bill 18-249 authorized the creation of up to four pilot programs to divert individuals with low-level criminal behavior and a mental health condition to community resources and treatment. The State Court Administrator manages the mental health criminal justice diversion grant program.

Competency Evaluation

The Court Services Department provides evaluations for competency to proceed, restoration of competency, sanity and mental condition. Court Services is comprised of a team of 45 psychologists and support staff. Evaluations are offered at state psychiatric facilities, correctional facilities and in the community. An estimated 75 to 80 percent of evaluations are conducted in jail or in the community. The remaining 20 to 25 percent of evaluations are conducted on an inpatient basis. Specific information on the number of evaluations ordered and the percentage of initial evaluations with IST or CST opinions was requested but unknown at the time of this writing. Colorado Statute 19-2-1302 provides specific guidance on determination of incompetency to proceed for juveniles.

Evaluation and restoration services are separated across all settings.

Starting in July 2019, competency evaluations will include a recommendation for level of care and prioritize the patient based on their current mental health needs. The evaluation will indicate whether outpatient or inpatient restoration, which includes jail-based restoration, is most appropriate. The judge will still make the final determination, but as judges have historically relied on very little information to make this determination, having a recommendation included in the evaluation report is expected to be a helpful change.

Competency Restoration

Colorado offers competency restoration services at three different levels of care – outpatient, jail-based and inpatient. Currently, triage for the appropriate level of care occurs by staff with Court Services reviewing the documentation provided by the forensic evaluator and the court. If it is determined that the individual's needs could be better met at a different level of care, the defendant is transferred to the appropriate level of care. Individuals can move back and forth between levels of care, as needed. The same restoration curriculum is used for adults and juveniles.

In 2019, the average wait time in jail for individuals awaiting restoration services was 79 days. Under the latest settlement agreement, the most mentally ill defendants needing restoration are required to be transferred to an inpatient setting within seven days while defendants whose symptoms are less severe are required to be transferred within 21 days.

Outpatient

Forensic Services contracts with community service providers to provide outpatient restoration for adults and juveniles. Seventy-six percent of Colorado's counties have a contracted outpatient restoration provider. Forensic Services conducts outreach to judicial districts around the state to educate them about outpatient restoration. Typically, outpatient restoration providers meet with their clients for two hours per week. Management of "no-shows" is a significant factor impacting restoration in this setting. The outpatient staff providing competency education services typically have a bachelor's degree in criminal justice, education, or a related field. For individuals in need of additional services, the restoration educators connect them to mental health providers, bachelor's level case managers, and medication prescribers.

Jail-based

Forensic Services contracts with Wellpath Recovery Solutions to operate the 96-bed, three unit, Restoring Individuals Safely and Effectively (RISE) program at the Arapahoe County Detention Facility. The program operates on a designated unit and all participants sleep on the unit. The original jail-based restoration unit is 22 beds with two-person bunks located in cells. The unit is open during the day and locked at night. The other two units are set up as open bay. Clinical staff can decide which unit is more appropriate for a particular patient, as some individuals do better in a more contained unit, and individuals can be transferred between units based on their clinical needs.

Programming at RISE was designed to replicate treatment at the Colorado Mental Health Institute at Pueblo. While the units still look and feel like a jail, the units do not operate like the rest of the jail. The restoration units have their own schedules, pizza parties on Fridays, and other variations not found among the general population. Additional suicide mitigation modifications were added to the units and there is more classroom space than in general population units.

RISE program participants interact with a multidisciplinary treatment team including a psychiatrist, psychologist, social worker, recreation therapist, activity specialists and peer specialists. The correctional officers are hired specifically for the program and must go through additional mental health training and have an interest in working in this area. They serve the same function as a mental health technician or similar position would at an inpatient facility. The Director of Forensic Services stressed the importance of having correctional officers designated to the program to facilitate continuity and patient care. Due to current interpretation of state statute, involuntary medications are not currently administered at RISE; however, the state is in the process of exploring this option.

Forensic Services plans to expand the RISE program by adding 18 jail-based restoration beds at the Boulder County Jail. Once the additional beds are added, Colorado's total jail-based restoration capacity will reach 114 beds.

Inpatient

Inpatient restoration treatment is offered at the Mental Health Institute at Pueblo. There are 455 beds at the facility, with approximately 307 of those beds serving the forensic psychiatric population, including those adjudicated as NGRI.

Staffing. The Colorado Mental Health Institute at Pueblo has 959 employees to serve a patient population of 455. Treatment teams include a psychiatrist, psychologist, social worker, rehabilitation therapist, and sufficient nursing staff to meet TJC and CMS requirements. Each unit must have one licensed nurse on the unit at all times. Each unit typically operates with two licensed nurses per shift, with approximately three additional mental health technicians. This number of nursing staff on the unit can increase with increases in acuity. Additionally, the facility has peer support specialists who assist patients while in the facility and who coordinate ongoing peer support following the patient's discharge.

Diagnosis + Treatment. Diagnostic assessments are completed during the admissions process. Treatment at both mental health institutes complies with nationally recognized evidence-based practices and includes group and individual psychotherapy, cognitive behavioral therapy, dialectic behavioral therapy, psychoeducation, occupational therapy and living skills, medication management, sex offender specific treatment, electroconvulsive therapy, and competency restoration services. For defendants requiring medication over objection, the facility can petition the probate court for

involuntary medications if the defendant poses an imminent risk to self or others, or the facility can petition the criminal court if the defendant is unlikely to be restored to competency absent the administration of psychotropic medications.

Specialty Populations. The Colorado Mental Health Institute at Pueblo has an adolescent, a geriatric unit, and a unit for patients from the DOC, and those who are too dangerous to be housed with other patients. There are no specific units to treat persons with TBI or an intellectual/developmental disability at either state mental health institute. The facility modified its programming substantially in 2013, changing from units that were designed based on patients' legal status to ones that are designed to address the specific needs of the patient population. In this way, patients of various legal statuses reside on the same unit, with programming modified to meet their specific needs. The unit types include Admission and Assessment Unit, Cognitive Remediation units, Treatment and Stabilization units, and Community Transition units.

Transitions + Reentry

Formalized discharge planning and reentry supports for individuals found incompetent to stand trial and non-restorable are still in development. Forensic Services is in the process of developing a Forensic Support Team that will follow the forensic psychiatric client from the moment an evaluation is ordered, through restoration, and will coordinate discharge planning and warm hand-offs to community providers. The hope is that this team will ensure continuity of care, communication between the Office of Behavioral Health and the Judicial branch, and smoother community transitions.

Colorado statute specifies that if an individual is found not competent and not restorable, they can be held in a psychiatric facility for the maximum amount of time they would have been held if they were guilty of the offense. This policy results in fewer non-restorable individuals being discharged to the community. However, this also creates a backlog in the inpatient system as approximately 40 inpatient beds per year are used to continue to hold this population.

Outcomes

Outcome data for inpatient and community-based restoration services are unknown at the time of this writing. Outcome data for jail-based restoration was provided by Wellpath.

The restoration rate at the RISE program is 76 percent restored within 60 days and 90 percent restored within 90 days. The average length of stay in the jail-based program is 51 days.

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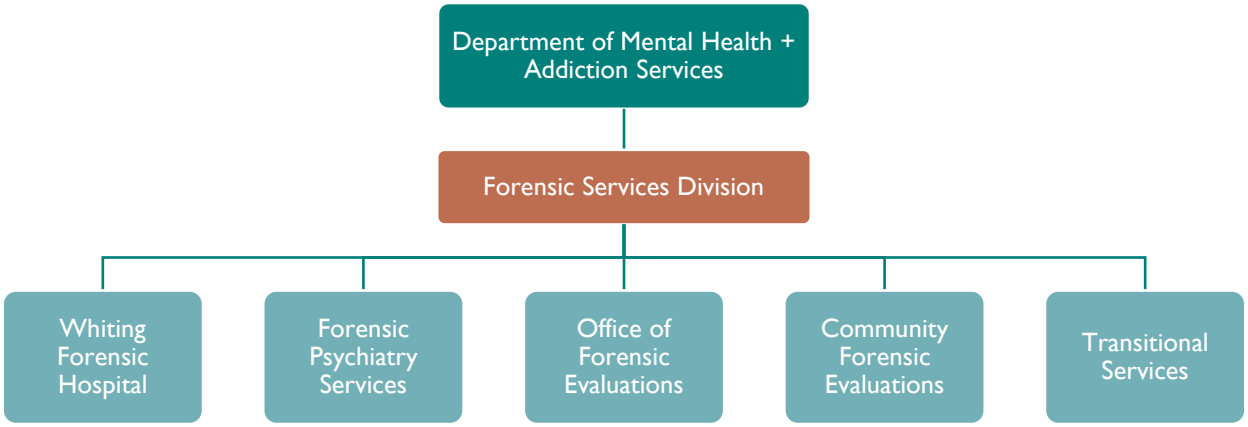
Connecticut

Overview

Management of Forensic Psychiatric Population

The Connecticut Department of Mental Health and Addiction Services (DMHAS), Forensic Services Division is the lead agency for all forensic psychiatric services in the state. The Forensic Services Division oversees five sectors: Whiting Forensic Hospital, Forensic Psychiatry Services, the Office of Forensic Evaluations, Community Forensic Services and Transitional Services. Forensic Psychiatry Services provides risk management consultations to hospital and community providers regarding safe and viable treatment plans. Descriptions of all other components of the Forensic Services Division are below.

Figure 7: Connecticut Forensic Services Division Organizational Chart



The Department of Correction (DOC) is a separate state entity and provides mental health services to its population including screenings, infirmary beds, and one facility that is nearly entirely dedicated to people with mental health problems. From approximately 2008 to 2018, DOC had a contract with the University of Connecticut to provide all mental and physical health services but after the contract ended, DOC decided to run these services themselves.

Oversight

As of 2017, Whiting Forensic Hospital is no longer certified by the Centers for Medicare and Medicaid Services (CMS). In 2017, CMS asserted that because the majority of Whiting patients are under the Psychiatric Security Review Board or Superior Court system, they do not sufficiently participate in their own discharge planning, as one of these two entities ultimately determines their discharge.

Partnerships

The Forensic Services Division supports and is supported by Local Mental Health Authorities (LMHAs), which are operated and/or funded by DMHAS, and four state-operated civil inpatient treatment facilities. The state's civil inpatient psychiatric treatment capacity is approximately 350 beds with specific units or beds designated for individuals with substance use disorders, geriatric patients, and individuals with traumatic brain injury.

DMHAS partners with Yale University psychiatrists on contract with the state to provide competency evaluations.

Evaluators from the Office of Forensic Evaluations conduct evaluations at DOC facilities and the court liaison maintains close relationships with the state's court system.

Data Tracking + Communication

There is no shared data system between DMHAS and DOC and it is unlikely that the state would permit a system that allows interdepartmental data sharing. It is even difficult for information to be shared within DMHAS as the different inpatient facilities cannot see records from other facilities, only their own. The communication between the court and DMHAS is better, using a court liaison. The court liaison is a community mental health center employee, and thus has access to mental health records. At the start of each day, this individual will review the court docket, which is public record, and compare it to a list of community mental health center clients. This communication and tracking is facilitated as part of the Forensic Services Division's diversion efforts.

Workforce for Forensic Psychiatric Services

The Forensic Services Division Director shared that in recent years they have had most of their key positions filled, but in general the labor market is tight for psychologists and psychiatrists. The director also shared that the public sector does not pay as well as the private sector, noting that a private organization in Connecticut was recently able to offer a starting salary of $240,000 for an individual just finishing psychiatric residency. This is well above the state's starting salary for a psychiatrist of $189,410. A review of the Connecticut State Department of Administrative Services identified the following open positions in the Department of Mental Health and Addiction Services Forensic Services Division:

- Forensic Services Division Behavioral Health Clinical Manager
- Whiting Forensic Hospital, Part-Time Forensic Treatment Specialist (5 vacancies)
- Whiting Forensic Hospital, Principal Psychiatrist

Diversion from the Criminal Justice System

Community Forensic Services is an office of the DMHAS Forensic Services Division focused on providing diversion from the criminal justice system and into appropriate treatment. There are seven programs offered by Community Forensic Services to meet this goal.

- **Crisis Intervention Teams**: Partnership program between local police and community providers to reduce arrests and increase connections to behavioral health treatment.
- **Jail Diversion/Court Liaison Program**: Assessment, referral and linkage to community mental health services for individuals arrested on minor offenses. The court liaison may provide a judge with additional sentencing options, for instance, securing a same day behavioral health appointment for the individual if he or she is released with charges held in abeyance.
- **Jail Diversion Substance Abuse Program:** Immediate admission to residential detox, intensive residential treatment, or intensive outpatient on the day of arraignment.
- **Women's Jail Diversion Program:** Trauma, mental health and substance abuse treatment as well as transitional housing for women referred by the court or probation and parole.
- **Alternative Drug Intervention:** Intensive outpatient substance abuse treatment.
- **Office of Pretrial Intervention:** Includes the Pretrial Alcohol Education Program and the Pretrial Drug Education Program which offer substance abuse evaluations and recommendations for varying levels of group or individual intervention programming or therapy.

- **Community Recovery Engagement Support and Treatment Center:** Intensive day program for individuals who would not otherwise be diverted or released from incarceration.
- **Advanced Supervision and Intervention Support Team:** Case management services for individuals that require judicial supervision and mental health or substance abuse services.
- **Sierra Pretrial Center:** Residential program for adults with serious psychiatric disabilities who are in jail awaiting court disposition of charges and can be safely released to a structured residential program. Case management, medication monitoring, and other behavioral health services are offered.

The division director commented that while the forensic psychiatric system sees a fair number of misdemeanants, often these cases are diverted. In the event the cases are not, the director speculates that it is because the judge has seen this individual frequently for similar charges and just wants the individual in a safe bed off the streets. The director also commented that the relationships between the jail-diversion programs and the local civil inpatient facilities may make a difference. Specifically, he noted that in New Haven, the individuals with the jail-diversion program have a good relationship with the local civil inpatient facility and thus they are able to quickly get individuals accused of crimes civilly committed. In other areas, it is not a guarantee that the person will be civilly committed, so a judge may send the defendant to the forensic psychiatric system.

Competency Evaluation

Evaluation services are provided by the Office of Forensic Evaluations within the Forensic Services Division. Evaluators complete five types of evaluations: Competence to Stand Trial, Substance Dependency, Pre-screening for post-conviction/pre-sentencing diagnostic evaluation at Whiting Forensic Hospital, Restoration to Competence to Stand Trial and Reports to the Psychiatric Security Review Board.

Initial competency to stand trial evaluations are all conducted on an outpatient basis by either a single psychiatrist or a clinical team comprised of a psychiatrist, a psychologist and a social worker. The evaluation staff are employees or contractors with DMHAS. Evaluations are typically conducted in jails or court clinic offices. There are five court clinics in the state and each of them has a full-time social worker, two full-time or per diem psychologists and a statewide total of six to seven per diem psychiatrists, including psychiatrists on contract with the state from Yale University. Orders for competency evaluations have increased slightly in recent years, to 743 in 2018 (20.8 evaluations per 100,000 residents), but overall Connecticut is seeing a downturn in evaluation orders, as yearly orders used to be over 800. The Forensic Services Division Director hypothesizes that the reduction in orders is correlated with the jail diversion and re-entry programs offered in the Division.

There are no waitlists for evaluation. Within 14 days of an order, an individual must be evaluated and within 21 days the report must be submitted to the court. The Office of Forensic Evaluations is currently able to keep up with the demand.

Competency Restoration

There is no waitlist for forensic restoration services.

Outpatient

Restoration services are available on an outpatient basis in Connecticut, but fewer than 10 percent of individuals needing restoration services are referred for this level of treatment. According to the Forensic

Services Division Director, many of the individuals who start out at this level of care do not succeed and end up transferring to inpatient restoration at Whiting Forensic Hospital.

Inpatient

Most restoration to competency services are provided a Whiting Forensic Hospital, a free-standing 229-bed facility in Middletown, Connecticut. The administrative staff at Whiting is different than that of the civil psychiatric facilities. There are 91 maximum security beds and 138 enhanced security beds in the facility. For the purposes of competency restoration, three maximum security units with 18-beds each and one 24-bed medium security unit are most commonly used. Individuals in the medium security unit typically have lower level charges, lower bond and no acutely aggressive behaviors. In addition to competency restoration patients, the facility also serves insanity acquittees committed by the Psychiatric Security Review Board, civilly committed patients (typically those with acute aggression), and transfers from the Department of Correction (DOC), either during or after a sentence. Transfers from DOC to Whiting happen only rarely, just two to three times per year.

Staffing. Restoration units are staffed by a multidisciplinary team consisting of the following members: psychiatrist, psychologist, social worker, rehab therapist, nurses, paraprofessional staff, and competency monitor. The competency monitor is usually a social worker who does the re-evaluation, report writing and court testimony for restoration patients. The typical staffing pattern is to have two nurses and three paraprofessionals on the first and second shifts and one nurse and three paraprofessionals on the third shift.

Diagnosis + Treatment. Most of the individuals in Connecticut's competency restoration program have a serious mental illness. Occasionally they will see individuals with severe personality disorders, low IQs or dementia. Medication, in addition to individual and group competency education, is a significant part of the restoration process. When involuntary medications are needed, there are two different processes for competency restoration. The first option is to go back to criminal court (Sell vs. United States). This is a lengthy process. The second option is available in response to the dicta in Sell. The practitioner can argue that the individual is incapable of informed consent and the court will appoint a special limited conservator (limited because the conservatorship dissolves as soon as the case is adjudicated). This process is much faster because it happens in probate court rather than civil court.

Specialty Populations. Whiting Forensic Hospital serves individuals with traumatic brain injury (TBI) and intellectual or developmental disabilities (IDD). There is a special civil unit for individuals with a TBI, so when these patients are referred to Whiting, they usually try to move them to the civil unit as quickly as possible. The Forensic Services Division director noted that for individuals with an IDD, the hospital does not have appropriate treatment but that it has been difficult to engage the state's Disability Services division around more appropriate care for these clients.

Transitions + Reentry

Transitional Services, within the Forensic Services Division, offers four programs with the overarching goal of facilitating recovery and community re-entry for individuals with mental illness and substance use disorders who are leaving the correctional system and returning to the community. By offering robust transitional services to offenders with mental health issues and substance use disorders the division hopes to reduce the number of individuals returning to court on new charges.

- **Criminal Justice Interagency Program**: Recovery and re-integration for people with severe psychiatric disabilities who are transitioning from state correctional facilities to the community.
- **Connecticut Offender Reentry Program**: Services for offenders with mental illness returning to specific communities after an extended period of incarceration.
- **Transitional Case Management**: Serves male inmates with significant histories of substance abuse who are discharging to four target communities.
- **Conditional Release Service Unit**: Offers oversight, consultation and training to community agencies providing temporary leave and conditional release services to individuals committed to the jurisdiction of the Psychiatric Security Review Board.

Discharge from Whiting Forensic Hospital is generally provided by the unit social worker. Transitional programs are often managed by the Forensic Services Division while the local mental health authority or housing provider offers the services. The hospital provides transportation for patients to their discharge placement.

Individuals found incompetent to stand trial and not restorable are generally either civilly committed or released to the community with supports. Typically, individuals who are civilly committed remain in the forensic psychiatric hospital before being transferred to a civil hospital; however, there are some individuals who stay at the forensic psychiatric hospital for years after their charges have been dropped because they are too low functioning, symptomatic or aggressive to be safely discharged. While there are no FACT or ACT teams in Connecticut, they do offer supportive housing, supervised housing and rental assistance. There are transitional housing, group home and supported living environments specifically for the forensic psychiatric population.

Outcomes

Seventy-five to 80 percent of individuals ordered for competency restoration are restored to competency each year. The average length of stay for inpatient restoration is 90-days with a maximum of 18 months.

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Hawaii

Overview

Management of Forensic Psychiatric Population

The Hawaii State Department of Health, Adult Mental Health Division is the lead agency for all forensic psychiatric services in the state. There are eleven programs under the Adult Mental Health Division Forensic Services arm plus a wide array of crisis services, outpatient treatment programs and community housing available through other branches of the division. There is one state psychiatric hospital (Hawaii State Hospital) and a community mental health center in each of Hawaii's four counties. Within each community mental health center is a forensic services section which offers post-booking jail-diversion programs, forensic coordinators who monitor individuals released from Hawaii State Hospital and community-based restoration.

Figure 8: Adult Mental Health Division Core Services

Source: https://health.hawaii.gov/amhd/

Oversight

Prior to 2002, the Adult Mental Health Division had no formal forensic psychiatric program or staffing. In 2003, the division hired a Forensic Services Director and started forensic psychiatric programming. Since that time, the division has developed an annual statewide service plan. Since its inception, Forensic Services focused on implementation of uniform forensic psychiatric procedures, inter-agency cooperation, developing or updating programs, and hosting an annual forensic examiners training conference. Forensic Services uses the Sequential Intercepts Model (SIM) as a blueprint for building out services in Hawaii.

Hawaii State Hospital is accredited by The Joint Commission and is licensed through the Hawaii Department of Health, Office of Health Care Assurance.

Partnerships

The Adult Mental Health Division partners with the state's Law Enforcement and Public Safety Department to provide training for first responders to effectively interact with people who are mentally ill. The division provides two Advance Practice Registered Nurses (APRNs) to staff the Honolulu Police Department Central Receiving Division. The division also partners with the District Court and Mental Health Court on Oahu to assist with assessment and referral services.

Data Tracking + Communication

The Adult Mental Health Division (AMHD) employs a Court-Based Clinician on Oahu to provide clinical assessment and referral services at the District Court and the Mental Health Court. Hawaii's state statutes require the Department of Health to submit an annual report to the Hawaii State Legislature summarizing annual data on forensic psychiatric patients served by the Hawaii State Hospital. The AMHD has a robust mechanism to gather basic information about the flow of evaluations; however, the court system does not have a good way of tracking theses services within their own courts.

A partnership with the Honolulu Police Department Central Receiving Division and the Crisis Line of Hawaii allows AMHD staff to cross-reference individuals in contact with these systems and involved in AMHD services. Information about arrests can be shared with the individual's case management team for follow up. Data is collected on the frequency of arrests for AMHD program participants and rates of homelessness for those arrested.

The state is actively working on information sharing agreements to better track high utilizers in Honolulu through use of data from the Honolulu Police Department, the local hospital and the district court.

Workforce for Forensic Psychiatric Services

Forensic evaluations are provided through the AMHD Courts and Corrections Branch which employs six full-time psychologists who conduct evaluations for misdemeanor cases and are one of three evaluators appointed in felony cases. The other two evaluators are community-based psychologists or psychiatrists from a list of approved competency evaluators. A 2007 report to the State of Hawaii Legislature identified that at that time each community-based evaluator received $500 per evaluation and travel costs to neighbor islands were not reimbursed. The report recommended that the rate per evaluation be increased to $1,000 and that travel costs be reimbursed. Current compensation for community-based evaluators is unknown.

A review of employment opportunities within the Adult Mental Health Division identified the following vacancies for forensic psychiatric services:

- Clinical Psychologist
- Psychiatrist, Hawaii State Hospital

- Forensic Coordinator, Hawaii State Hospital

Diversion from the Criminal Justice System

The AMHD Forensic Services has both a pre-booking jail diversion program and a post-booking jail-diversion program. The Pre-Booking Jail Diversion Program is operated by AMHD and the Honolulu Police Department. If a person at a crime scene is suspected of mental illness, the responding officer can request consultation from one of three Honolulu Police Department employed psychologists designated as Mental Health Emergency Workers. These psychologists are available 24 hours a day and can provide information on diversion opportunities and resources. The Post-Booking Jail Diversion Program offers case management to non-dangerous individuals with mental illness. Through this service, individuals can be connected to basic need services including food, housing, clothing, transportation and public benefits programs. Peer support and recovery services are also available. This program is available on Oahu, Hawaii, Maui, Molokai, Lanai and Kauai.

Three of Hawaii's four counties have implemented Crisis Intervention Teams (CIT).

While not directly linked to forensic psychiatric services, Hawaii's Crisis Services array may also help to divert individuals from the criminal justice system. Crisis Services offers a 24-7 crisis hotline, 24-7 mobile crisis outreach, crisis support management services to individuals in crisis who are not already linked with services and Licensed Crisis Residential Services, which are short-term, residential alternatives to psychiatric inpatient hospitalization.

Competency Evaluation

Forensic evaluations are provided through the AMHD Courts and Corrections Branch which employs seven full-time psychologists who conduct evaluations for misdemeanor cases and are one of the three evaluators appointed in felony cases. The other two evaluators are community-based psychologists or psychiatrists from a list of approved competency evaluators. In three-panel felony cases, the court sends a court order to the AMHD Courts and Corrections Branch and to the independent examiners. The judiciary pays for the independent examiners. The Courts and Corrections Branch maintains a list of certified community-based examiners. Examiners provide a variety of evaluations, including: examination of mental disease, disorder or defect; fitness to proceed (competency); penal responsibility (not guilty by reason of insanity); risk assessments; evaluations related to discharge placement; and, evaluations for juveniles ordered by Family Court.

In 2018 the Courts and Corrections Branch received 1,371 orders for evaluations. Evaluations can be conducted in the community, in jail or in a hospital. The location of the evaluation is made by the court. A small number of evaluations are conducted on an inpatient basis, just 23 in FY 2017.

Like Alaska, Hawaii struggles to provide robust community mental health resources. Prosecutors and defense attorneys sometimes use the forensic process to secure court-ordered services for individuals with mental health conditions.

On average, 60 percent of competency cases originate related to petty misdemeanor or misdemeanor charges and 40 percent of those evaluated have felony charges. Evaluators are mandated to conduct a dangerousness assessment. The courts use this information to determine if someone is appropriate for community-based restoration.

Competency Restoration

Per statute, once an individual is found to require restoration, they can no longer be held in jail. Subsequently, there is not a waitlist for competency restoration.

Historically, there was no time limit for restoration in Hawaii. In 2012, caps were put in place for misdemeanor charges. The time limit for restoration of individuals with petty misdemeanors is 60 days and the time limit for restoration of individuals with misdemeanor charges is 120 days. There is no time limit for individuals with felony charges.

Outpatient

Community-based competency restoration is available statewide and is provided by the county-based community mental health centers. Outpatient restoration began in 2007 as an alternative to inpatient restoration. The community-based restoration system is not very robust and the emphasis is on inpatient restoration.

Inpatient

Most restoration to competency services are provided Hawaii State Hospital a 202-bed facility. Inpatient psychiatric services for forensic patients are supplemented by 46 contracted beds a Kahi Mohala, a private hospital owned by Sutter Health, and four contracted beds at Columbia Regional Care Center in South Carolina, operated by Correct Care Recovery Solutions. These four beds are specifically for individuals who cannot be safely treated at Hawaii State Hospital due to intractable dangerous behaviors. The Hawaii State Legislature approved 160.5 million dollars in funding for a new 144-bed forensic psychiatric facility which is slated to open in FY 2021.

Staffing. Information not available.

Diagnosis + Treatment. The hospital's fiscal year 2017 report identified that 61 percent of individuals had previous admission to Hawaii State Hospital and 52 percent of individuals were homeless prior to admission. Co-occurring disorders were common amongst patients admitted to Hawaii State Hospital, with 58 percent using at least once substance. A 2008 report recommended revisions to court procedure, so that hearings on applications for the administration of involuntary medications would be set within 72 hours for those adjudicated as Unfit to Stand Trial. It is unknown if this recommendation went in to effect.

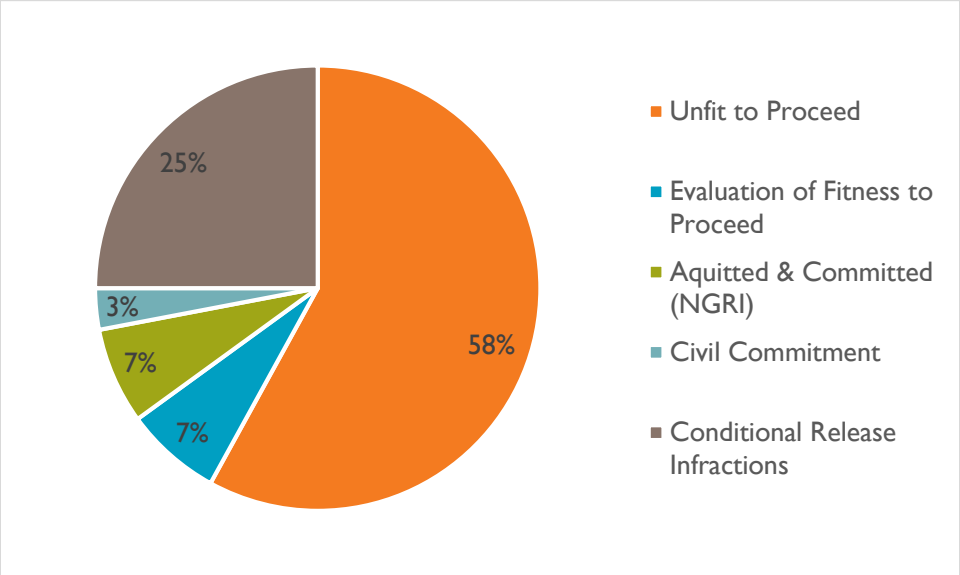
Specialty Populations. Out-of-state placement and Columbia Regional Care Center is reserved for individuals who cannot be safely treated at Hawaii State Hospital.

Broadly, there are five categories for admission: unfit to proceed (competency restoration), competency evaluation, Conditional Release infractions, not guilty by reason of insanity (NGRI), and civil commitment. A breakdown of admissions by type is found in Figure 8. Of note,

- The number of unfit to proceed (competency restoration) patients nearly doubled from FY 2008 to FY 2017. There are effectively no civil beds available at Hawaii State Hospital, with just eight civil commitments to the hospital in fiscal year 2017 (three percent of total admissions).
- Conditional release is available to NGRI patients who can be adequately controlled and given the proper care, supervision and treatment in the community. Individuals can be hospitalized on a temporary basis (72-hours to one year) for violations of conditional release or have their conditional release status revoked.

- Seven of the eight civil patients admitted in FY 2017 were forensic psychiatric patients found to be unrestorable, imminently dangerous to themselves or others, and in need of a hospital level of care. The number of civil beds available to the general population is effectively zero. Civilly committed patients are treated in regional hospitals.

Figure 9: Admissions to Hawaii State Hospital by Legal Status, FY 2017



Transitions + Reentry

Individuals found incompetent to stand trial and not restorable are generally either civilly committed or released to the community with supports. Very few forensic psychiatric patients are civilly committed upon findings of non-restorability, just seven individuals in FY 2017. There are limited discharge options specifically for individuals who are found incompetent to stand trial and non-restorable and discharge is a challenge in the state. Under Hawaii's Certified Peer Specialist Program there is a subgroup of peer specialists who have received training and certification as Forensic Peer Specialists. For GBMI individuals on conditional release, there are two discharge programs available, the Conditional Release Exit Support and Transition (CREST) Program which offers group sessions to individuals close to exiting the conditional release program and Hale Imua, a group home setting with 24-hour support.

The Adult Mental Health Division offers numerous services that patients discharging from Hawaii State Hospital may access.

- **Case management/support services:** Community-based case management, bi-lingual interpreter services, Homeless Intensive Case Management, and peer coaches.
- **Community housing programs:** a 24-hour group home, an 8-16 hour group home, semi-independent housing, Shelter Plus Care for the Homeless, supported housing, a therapeutic living program, and transitional housing
- **Psychosocial rehabilitation and treatment:** Clubhouse Program which offers employment and education services, Certified Peer Specialist Program, day treatment, outpatient, intensive outpatient and residential treatment. Also available is the Expanded Adult Residential Care Home (E-ARCH) which specifically targets AMHD consumers discharging from a hospital level of care who need an intermediate care facility level of care.

Outcomes

Outcome data for the percentage of individuals found incompetent to stand trial after restoration efforts was not available at the time of this report.

The average length of stay for individuals discharged in FY 2017 was around seven months. This includes individuals of all legal statuses, not just those admitted for competency restoration.

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Utah

Overview

Management of Forensic Psychiatric Population

Utah State Hospital, a component of the Utah Division of Substance Abuse and Mental Health is the lead agency for all forensic psychiatric services in the state. Competency evaluations are currently conducted by contract evaluators. For individuals needing restoration, three levels of service are available: Outreach, Jail-based and Inpatient restoration.

Over the past 30 years, Utah experienced a 500 percent growth in the forensic psychiatric population. In the early 2000s, after 10 years of lobbying, Utah's legislature authorized $13 million to fund a forensic psychiatric facility, far short of the $30 million requested by the department. The new facility was constructed, on a smaller scale, and was at capacity almost immediately. By 2010 the waitlist for restoration was up to 30 individuals with wait times of six to nine months. Capacity issues resulted in the Disability Law Center filing a class-action lawsuit on behalf of mentally ill inmates held in county jails for an unconstitutional delay in providing restoration treatment in 2015. A settlement agreement was reached in 2017 that specified within 18 months wait times for restoration must be reduced to 14 days. Utah's behavioral health leadership decided to avoid decreasing the availability of civil inpatient beds, recognizing that availability of civil commitment beds is a vital part of the continuum of behavioral health services.

As pressures on the state's forensic psychiatric system mounted, leaders realized the need for a continuum of services, not just inpatient beds. Some forensic restoration patients do not need the level of care offered at inpatient psychiatric facilities and this level of care is also the most expensive. Utah's Outreach Restoration Program runs on just dollars a day per client; the Jail-Based Competency Restoration Unit costs approximately $200 a day per client; and, the inpatient program at Utah State Hospital costs $600-$700 per day per client. Even with the development of alternative restoration programs, through careful data monitoring and projecting the growth of the state's forensic psychiatric population, Utah estimates it will need 30 more inpatient forensic psychiatric beds in the next year to maintain compliance with the settlement agreement and another 100 beds to sustain the state for the next 10 to 20 years.

Oversight

Utah State Hospital, the Division of Substance Abuse and Mental Health, and the Utah Department of Human Services were all named in the 2015 lawsuit by the Disability Law Center. As part of the settlement agreement, a court monitor has been assigned to the department for the next five years. Utah State Hospital is certified by the Centers for Medicaid and Medicare Services and accredited by The Joint Commission.

Partnerships

Utah State Hospital works with the Utah Department of Corrections to implement the Outreach restoration program and with the Salt Lake Metro Jail for jail-based restoration.

Data Tracking + Communication

Currently, the legal services department at Utah State Hospital partners with the Quality Resource Office to maintain a tracking spreadsheet using Google Sheets. The hospital is in discussion with Sales Force, in the hopes that this platform will become the new tracking platform for forensic psychiatric patients. The hospital recently hired an IT person within the Quality Resource Office specifically to help with recreating the forensic psychiatric data in Sales Force or another such system. This tracking mechanism will capture data on

each defendant from the time an evaluation order is received until they are discharged and will give the hospital a way to track system throughput.

The court has a Court Administration System which Department of Human Services staff can open as a read-only file. This is helpful because it allows team members to learn what happened in a particular defendant's court case and be more prepared to respond in future hearings.

To comply with HIPAA, releases of information must be signed to communicate with the Department of Corrections, attorneys, private evaluators or other parties.

Workforce for Forensic Psychiatric Services

The superintendent of Utah State Hospital shared that hiring key staff positions can be challenging. The hospital is generally able to hire social workers, but it takes 6-12 months to hire psychologists and about the same time to hire a psychiatrist, although they have been lucky to have few psychiatric vacancies. The hospital experiences a shortage of LPNs and a high turnover rate in their psychiatric technician positions. A review of employment vacancies for the State of Utah identified the following vacancies:

- Psychologist, Competency Evaluation (two vacancies)
- Psychologist, Jail-based Restoration Program
- Licensed Clinical Therapist, Jail-based Restoration Program
- Psychiatric Technician, Utah State Hospital (25 vacancies)

Diversion from the Criminal Justice System

Utah State Hospital and its overseeing division and department do not offer diversion programs.

In Salt Lake City and County, under an initiative of the Criminal Justice Advisory Council there is a program available called Operation Diversion. The goal of Operation Diversion is to separate suspected criminals who should be arrested from those who are struggling with mental illness or substance abuse issues. When law enforcement contacts a suspected offender, the officer has four options: crisis diversion to a local hospital, jail, a receiving center for a risk and needs assessment or release to the community (Figure 10). If the individual is transported to a receiving center, they have immediate access to medical screening, public defenders, risk and needs assessment and transportation to a treatment provider if appropriate. If an individual is eligible for and agrees to complete treatment instead of being charged for criminal activity, social workers provide a warm hand-off to the appropriate treatment provider.

Figure 10: Operation Diversion - Action by Law Enforcement

Source: Salt Lake County Criminal Justice Advisory Council. Operation Diversion.

Competency Evaluation

Evaluation services are provided by state contractors. The contractors are typically psychologists or doctoral-level social workers although statute does not specify a specific degree type. Moving forward, the state hopes to hire full-time competency evaluators to provide training and oversight to the evaluation staff, which is difficult under the current contract model.

Evaluations are conducted on an outpatient basis in jail, in an exam or evaluation room, or in the community. Currently there are about 30 defendants in the community awaiting evaluation or restoration. Utah finds that these cases are more difficult because the defendants can be difficult to track down. For defendants in the community, evaluations are performed at the provider's office, or at the Utah State Hospital. In FY 2018, there were 973 competency evaluations completed (30.7 per 100,000). Of those, 45 percent were found competent to stand trial and 55 percent were found incompetent to stand trial.

Competency Restoration

As of December 2018, Utah State Hospital reduced average wait times for inpatient competency restoration from 168 days to just 11 days over the course of a year. The average number of defendants waiting for an inpatient admission was just five at the end of 2018.

Jail-based

Utah provides two different jail-based restoration programs, the Outreach Restoration Program (ORP) and the Jail-based Competency Restoration Unit (JBCRU).

The Outreach Restoration Program is staffed by four LCSWs (one of which is a supervisor) and a psychologist. The psychologist is shared between the ORP and the JBCRU. This is a scattered site program at any jail in the state. The social workers conduct initial screening evaluations and make referrals to the appropriate level of restoration treatment. The evaluations must be completed within 72-hours of referral. If a defendant is appropriate for ORP, the social worker visits the individual weekly to provide competency education, works with the defendant's medical team to coordinate medications, and communicates with the court about the defendant's progress. Defendants are held in the general population and arrangements are made with the jail's commander to have a space for a social worker to meet with the defendant each week. If the defendant is not making progress in ORP, the social worker can refer to the JBCRU or Utah State Hospital. The psychologist provides re-evaluation of competency and prepares reports for the court.

The Jail-based Competency Restoration Unit operates as a 22-bed designated unit for competency restoration defendants at the Salt Lake Metro Jail. The jail is contracted to provide security

Division of Services for People with Disabilities – Forensic Liaison

During the initial screening, there are some individuals with disabilities that are deemed inappropriate for services provided by Utah State Hospital. In these cases, the Division of Services for People with Disabilities (DSPD) has a forensic liaison who takes over care and provides restoration to this population. Typically, there is just one or less referral to DSPD per month as not every individual with a mental illness and intellectual disability is eligible.

personnel, nursing staff (a nurse practitioner or RN), and medication. Utah State Hospital provides staffing for group education and competency restoration programming Monday through Friday and for four hours on Saturday. Program staff includes a director, a part-time psychiatrist, recreation therapist, case managers, social workers and a secretary. The psychiatrist develops the competency restoration plan and manages patient psychopharmacology; social workers provide therapy and lead groups; the case manager coordinates treatment, discharge and communicates with the court system; and, the secretary helps with documentation. The jail-employed security personnel are cross-trained by Utah State Hospital and all state hospital staff working in the jail are cross-trained by jail personnel to ensure safe, patient-centered care. In total, there are 15 staff that work full-time as Utah State Hospital employees within the Salt Lake Metro Jail.

Inpatient

All inpatient restoration to competency services are provided at Utah State Hospital Forensic Services, a free-standing 100-bed, four-unit facility in Provo, Utah. Twenty-four new beds were recently added to meet increasing demand for inpatient forensic restoration services. These beds are in a separate building. Total inpatient forensic psychiatric capacity is 124. The forensic building is on the same campus as the state's civil inpatient hospital for adults and pediatric behavioral health hospital and shares administrative staff. There are approximately 152 inpatient beds available for civil commitments. Most patients in the forensic services units have been found incompetent to stand trial and in need of treatment to be restored. There are a smaller number of Guilty but Mentally Ill individuals at the hospital as well as some individuals with a status of Not Guilty by Reason of Insanity (NGRI). Like Alaska, Utah restricts the use of the insanity defense, so only a small number of individuals are adjudicated as NGRI. Two beds are allocated to the Department of Corrections (DOC) for inmates who are severely mentally ill, where DOC needs assistance with assessment, diagnosis and treatment. This can be limited to one bed if more beds are needed for competency restoration.

Staffing. Restoration units are staffed by a multidisciplinary team consisting of: psychiatrists who serve as clinical directors; psychologists with forensic training; licensed clinical social workers who serve as therapists and administrative directors; occupational and recreational therapists; nurses; vocational rehabilitation experts; and, psychiatric technicians.

Diagnosis + Treatment. Programming and treatment include competency education services, medication management, substance abuse, anger management and medical illness.

Specialty Populations. Availability of units for specific populations within the Utah State Hospital system are unknown at the time of this writing.

Figure 11: Utah State Hospital, Forensic Services

Source: Utah State Hospital Map

Transitions + Reentry

Most defendants who are found incompetent to stand trial and not restorable are civilly committed to the civil building on Utah State Hospital's campus. Just 15 percent of those found not restorable are discharged

directly to the community. These are generally individuals with low-level misdemeanor charges. The civil beds at Utah State Hospital are "owned" by Local Mental Health Authorities who, in conjunction with treatment staff at Utah State Hospital develop treatment and discharge plans. Of the 152 civil beds at Utah State Hospital, approximately 30 are currently filled by non-restorable forensic psychiatric patients. The Utah State Hospital superintendent called this issue the "forensic creep" and identified addressing barriers to discharge from the civil system (such as housing in the community) as one of the next areas of focus for the state.

Outcomes

The median length of stay for defendants in the Outreach Restoration Program ranged 70 days in 2018 with 61 percent of participants restored to competency. The median length of stay for the Jail-Based Competency Restoration Unit was 89 days in 2018 with 72 percent of patients restored to competency. The median length of stay for the inpatient program was 217 days with 71 percent of patients restored to competency. As of June 2019, Utah State Hospital reduced the average length of stay for forensic psychiatric inpatient stays to 136 days and increased restoration rates to 73 percent restored.

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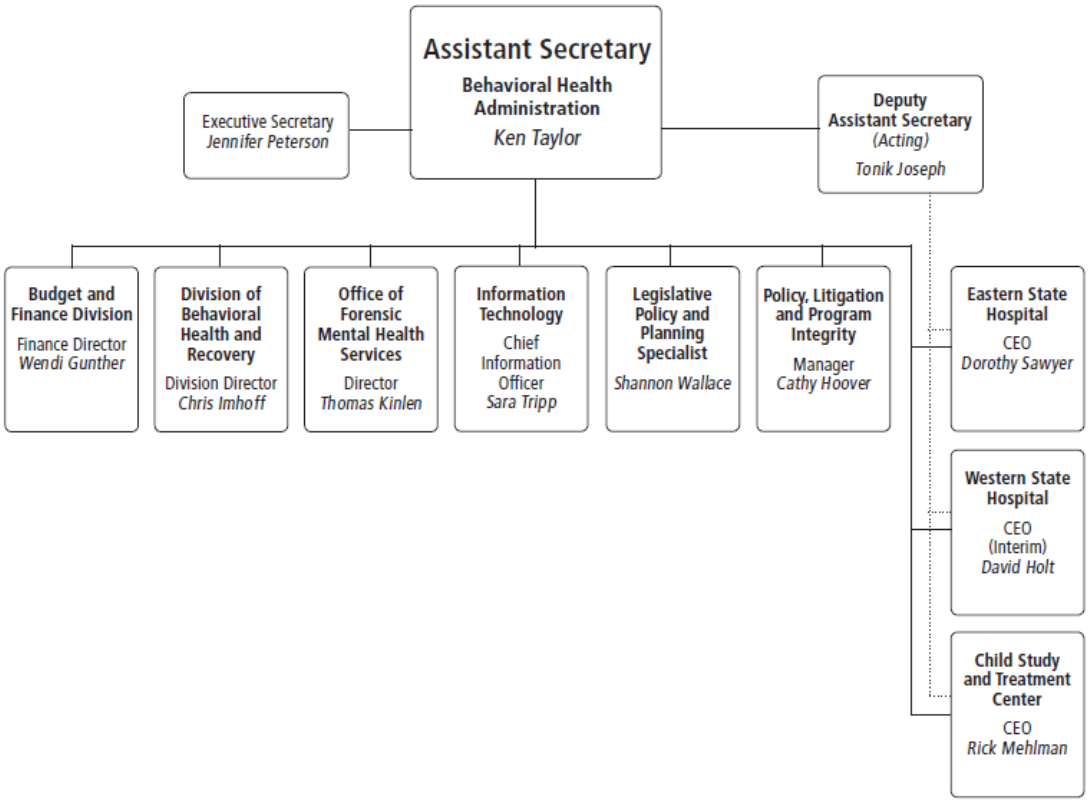
Washington

Overview

Management of Forensic Psychiatric Population

Forensic psychiatric services in Washington fall under the Department of Social and Health Services Behavioral Health Administration. The Office of Forensic Mental Health Services (OFMHS) works in seven areas: Diversion, Triage, Competency Evaluations, Competency Restoration Treatment, Not Guilty by Reason of Insanity (NGRI) Restoration and Treatment, Quality Improvement, and Workforce Development and Training. Inpatient restoration is provided by two state-run facilities that also house civil patients – Eastern State Hospital and Western State Hospital. The civil capacity at the two hospitals is approximately 312 patients and the forensic psychiatric capacity approximately 365. Restoration treatment is also offered at two residential treatment facilities with a third residential facility scheduled to open soon. The two residential treatment facilities are operated by contractors, while the new facility will be state-operated.



Oversight

The Office of Forensic Mental Health Services (OFMHS) offers oversight and system monitoring through two sections: Quality Improvement and Workforce Development and Training. The Quality Team conducts reviews of forensic psychiatric services as required by statute and focuses on best practices to inform improvements to the quality of forensic psychiatric services in the state. The OFMHS also develops, implements and oversees statewide workforce development and training programs and provides training to the courts, attorneys, legislative staff and other stakeholders.

Washington has experienced an extensive backlog in their forensic psychiatric system and a class-action lawsuit, Trueblood, et. al. was filed. After a trial in 2015, the United States District Court ordered the Department of Social and Health Services to offer competency evaluation and restoration services within seven to 14 days. The Department has been unable to comply, and tens of millions of dollars of sanctions have been imposed. A settlement agreement was reached in 2018 that continues the focus on improvements to the competency evaluation and restoration process but also emphasizes diversion, community supports, education and training and workforce development. A Trueblood Diversion Workgroup was created in 2016 using fines from the lawsuit to fund service providers to divert people with mental illness and disabilities from the criminal justice system. Because of the lawsuit, the forensic psychiatric system is overseen by a court monitor.

Western State Hospital lost its Centers for Medicare and Medicaid Services (CMS) certification in 2018. The Department of Social and Health Services contracts with Clinical Services Management, LLC to provide oversight. Eastern State Hospital is accredited by the Joint Commission and certified by CMS.

Partnerships

One of the guiding principles of Washington's Office of Forensic Mental Health Services is to "foster collaboration across systems to facilitate efficient and quality forensic mental health services". One way the office implements this principle is through partnerships with community providers for diversion services.

Data Tracking + Communication

A 2014 report identified a need to enhance data-management resources, including an information sharing system between the Department of Social and Health Services, jails and courts. Following this report, the OFMHS was created and one of the guiding principles of the office is to "develop robust and reliable data systems to better forecast demand for services, monitor program performance, and conduct effective capacity utilization". Improved data collection allows the office to report back to the legislature and stakeholders about key issues including patient information, outcomes measures at the state hospitals, measures relevant to the Trueblood case, and outcomes after discharge.

Workforce for Forensic Psychiatric Services

A 2014 report found that Washington did not employ enough evaluators to conduct all the evaluations requested. A follow up report released in 2017 identified that the state had increased evaluation capacity by 45 percent by hiring 13 additional evaluators.

A review of the state employment website identified the following openings within OFMHS:

- Psychologist, Forensic Evaluator (multiple vacancies; number not specified)
- Psychologist, Western State Hospital – Forensic and Community Mental Health
- Psychologist, Western State Hospital – Ft. Steilacoom Competency Restoration Program
- Psychologist, Western State Hospital – Treatment Team, NGRI
- Psychologist, Eastern State Hospital – Treatment Team, NGRI
- Psychiatrist, Eastern State Hospital (multiple vacancies; number not specified)
- Forensic Evaluator Supervisor

In February 2018 OFMHS released a Request for Information (RFI) from individuals interested in providing forensic psychiatric evaluations on a contract basis. The February RFI identified the notice had originally been released in February and August 2017 and was being re-released due to limited responses to the first two RFIs.

Diversion from the Criminal Justice System

The OFMHS established four goals for their diversion initiatives:

1. Prevent individuals with behavioral health issues from recidivism and frequent involvement in the criminal justice system.
2. Reduce the demand for competency services.
3. Reduce long-term incarceration of individuals with behavioral health issues; and
4. Serve defendants in the least restrictive environment.

In fiscal year 2018, the office managed three prosecutorial diversion contracts in the King, Spokane and Greater Columbia regions of the state. Three Requests for Proposals (RFP) specific to diversion services have been issued, each with their own objectives.

- Phase I RFP: Funding of post-booking diversion at Sequential Intercept Two and funding of re-entry services and community support to reduce recidivism at Sequential Intercept Four. Five providers were selected and awarded contracts under this RFP. Three of the five programs are profiled briefly below.
    - **Great Rivers Behavioral Health Trueblood Program:** Focused on Sequential Intercept Two, initial detention and court appearance, individuals eligible for the program receive an assessment of mental health need, a community support plan including warm hand-offs to behavioral health agencies, and recovery-focused case management. Services are provided by three mental health professionals who are responsible for assessments and evaluations, four local court coordinators who collaborate with criminal justice and behavioral health systems and enroll individuals in the program, and four certified diversion peer counselors who provide case management and warm hand-offs to behavioral health agencies.
    - **King County Department of Community and Human Services Legal Intervention and Network of Care (LINC) Prosecutorial Diversion Program:** The LINC program serves adults with mental health conditions and substance use disorders who are referred by a prosecutor who is willing to dismiss a charge or refrain from filing one if the individual agrees to participate. The program is appropriate for individuals with misdemeanor and low-level felony charges. LINC consists of case management, legal coordination, respite bed availability, day treatment, medication management, and peer support services.
    - **Kitsap Mental Health Services Jail Diversion Team:** Created a jail diversion team comprised of a master's level behavioral health professional, two screeners, a behavioral health court liaison, and two peer specialists. Services are provided at the Kitsap County Jail.
- Phase II RFP: This RFP was issued with the same objectives as the Phase I RFP and provided funding for three additional providers. Two of the three programs are profiled briefly below.
    - **Catholic Charities Diversion Team:** The program operates as a post-booking diversion programing offering access to mental health care including crisis follow-up, crisis response and support transitioning out of jail. The program is staffed by four mental health professionals/case managers and a team lead. Funding also covers housing and other support services.
    - **Pierce County Trueblood Diversion Program:** The program provides assessments, mental health services, substance abuse treatment, case management and employment services. In addition to funding clinical positions (mental health professionals, case coordinators, a social worker and legal professionals), the grant also provides funding for a

court resource center, supportive housing and rental assistance for individuals transitioning from jail. The county publishes program data on the website and since the program began in March 2018, 273 individuals have been diverted from the criminal justice system or traditional criminal prosecution. Of individuals eligible for an assessment five percent were diverted from the criminal justice system; 73 percent were diverted from traditional criminal prosecution; and, just 23 percent were screened but found not eligible for diversion services.

- Phase III RFP: Funding service enhancement for Crisis Intervention Teams at Sequential Intercept One and funding of community services to reduce recidivism at Sequential Intercept Five. Five providers were selected and awarded contracts under this RFP. Three of the five programs are profiled briefly below.
    - **Greater Columbia Behavioral Health and Lourdes Health Services Prosecutorial Diversion Program:** Services offered through the program include assessment of eligibility for services, development of an individualized treatment plan, and connections to service including emergency housing or respite services, day support and peer support.
    - **Frontier Behavioral Health Community Diversion Unit:** This program created four "co-deployment" teams where mental health professionals ride along with police officers and respond to calls where individuals might be in crisis. Individuals contacted through the program can be referred to Frontier Behavioral Health's stabilization unit or evaluation and treatment facilities or other community resources. The program launched in July 2018 and as of March 2019 the teams contacted 734 individuals and diverted 68 percent of those contacted from jail or emergency departments.
    - **King County Department of Community and Human Services Law Enforcement Assisted Diversion (LEAD):** Additional funding offered the opportunity to expand the LEAD program. The program offers law enforcement alternatives to booking individuals into jail. The project is managed by the Public Defender Association which processes referrals, staffs operational workgroups, and manages service provider contracts and community engagement. Services are provided through contracts with three community services providers which offer outreach, screening, case management behavioral health treatment, crisis respite and supportive housing.

Competency Evaluation

Competency evaluations are provided by OFMHS staff in jails, community and state hospitals, and residential treatment facilities. Certain counties in the state may conduct Community Competency Evaluations and are reimbursed by the Department of Social and Health Services. The state implemented a forensic psychiatric telehealth project to more efficiently complete competency evaluations and reduce wait-times for individuals waiting in jail.

In FY 2018 there were 3,732 jail-based competency evaluations completed, up from 3,409 evaluations in FY 2017. The number of inpatient competency evaluations completed decreased from 381 in FY 2017 to 293 in FY 2018. Total evaluations completed in FY 2018 were 4,025 or 53.4 per 100,000.

At the time of the Trueblood case in 2015, wait times for jail-based competency evaluations averaged 20.7 days in Western Washington and 66.5 days in Eastern Washington. Wait times for inpatient competency evaluations averaged 25.5 days in Western Washington and 91.8 days in Eastern Washington. In fiscal years 2017 and 2018, most jail-based competency evaluations were completed with 14 days, in accordance with

Trueblood. For inpatient competency evaluations, admittance is required under Trueblood within 7 days of order or 14 days from the signature of the order. Admittance for competency evaluations took longer than 14 days for most cases at Western State Hospital. At Eastern State Hospital, most evaluation patients were admitted within seven days in FY 2017, while in FY 2018 most inpatient evaluation patients took longer than 14 days to admit.

Competency Restoration

Residential Treatment Facilities

Restoration services are offered at two Residential Treatment Facilities. Maple Lane, a 30-bed facility, is run by Wellpath Recovery Solutions, and the 24-bed facility in Yakima is operated by Comprehensive Healthcare. A new 30-bed residential facility on the Western State Hospital campus will soon be operational. This program will be operated by the state. The state screens defendants for the appropriate level of service based on their needs. Individuals at the residential level of care have fewer acute clinical needs than those at the inpatient level but require a secure placement for public safety reasons.

Inpatient

Most restoration to competency services are provided at the two state-run psychiatric hospitals, Eastern State Hospital and Western State Hospital. Between the two facilities there are approximately 365 forensic psychiatric beds, or 4.8 beds per 100,000. Wait times for inpatient competency restoration services at Eastern State Hospital decreased from 54.7 days in May 2015 to 7.5 days in January 2017; and, at Western State Hospital, wait times decreased for 38.6 days to 25.8 days. Despite these improvements, 60 percent of those requiring competence restoration were not admitted within seven days as required by Trueblood. The length of initial restoration treatment depends on the type of criminal charge. Individuals with misdemeanor charges qualify for an initial restoration period of 14-29 days. Individuals charged with Class C or non-violent Class B felonies qualify for an initial restoration period of 45 days and defendants charged with violent Class B and Class A felonies are committed for an initial period of up to 90 days.

Washington instated a Triage Consultation and Expedited Admissions process as part of the OFMHS for any inmate on a court order who is awaiting forensic psychiatric services (evaluation or restoration treatment). If an individual requires additional psychiatric intervention due to psychotic symptoms or active suicidal intent, or serious self-injury they may be eligible for expedited admission to one of the state's forensic psychiatric inpatient units.

Staffing. Restoration units are staffed by a multidisciplinary team consisting of management and support staff as well as nursing, medical and treatment professionals.

Diagnosis + Treatment. Treatment components may include psychiatric medications, group and individual psychotherapy, educational treatment to increase defendant's understanding of the legal process, recreational and psychosocial group activities and medical treatment. Washington State Statute 10.77.092 Involuntary medication – Serious offenses, defines the offenses and considerations for the purposes of the court in determining authorization of involuntary medication. There is also a related act (Substitute House Bill 2195 Chapter 10, Laws of 2014) that allows courts to order involuntary medications to maintain competency for defendants in jail following a competency restoration period and discharge from a state hospital.

Specialty Populations. Western and Eastern State Hospitals each have designated forensic units as well units for specific segments of the civilly committed population. Western State Hospital's

Psychiatric Treatment and Recovery Center has units for older adult clients, units for newly admitted patients or those with acute psychotic symptoms, and units for adult clients experiencing chronic mental illnesses. Western State Hospital also has a Habilitative Mental Health Treatment Program for individuals with developmental or intellectual disabilities. Eastern State Hospital has a Geropsychiatric Unit for individuals 50 or older, those under 50 with medical concerns, and a Habilitation Mental Health Unit for patients who are dually diagnosed with a mental illness and a developmental disability.

Washington statute 10.77.086 identifies that restoration commitments beyond 90-days are not allowed in instances where the defendant's incompetence is solely the result of a developmental disability and competence is not reasonably likely to be regained during additional restoration periods. Statute 10.77.095 states that when appropriate, persons with developmental disabilities who have been charged with crimes and found incompetent to stand trial or not guilty by reason of insanity should receive habilitation services and per 10.77.0845, if appropriate, the defendant may be placed in a program specifically for the treatment and training of individuals with developmental disabilities.

Discharge

Trueblood Diversion Services funds community programs to provide reentry and recidivism reduction services to the forensic psychiatric population at Sequential Intercepts Four and Five.

Of forensic psychiatric patients discharged from Western State Hospital, 11 percent are homeless within one month and 15 percent are homeless within six months. Rates of homelessness are slightly better post-discharge from Eastern State Hospital, with six percent of individuals being homeless after one month and 11 percent within six months of discharge. Of forensic psychiatric patients discharged from Western State Hospital who are in need of substance use disorder (SUD) treatment, 17 percent are in treatment within three months, while 18 percent of those discharged from Eastern State Hospital are in treatment. Thirty-three percent of forensic patients discharged from Western State Hospital receive outpatient mental health services within seven days and 51 percent receive outpatient mental health services within 30 days. Sixty-nine percent of forensic patients discharged from Eastern State Hospital receive outpatient mental health services within seven days and 81 percent receive these services within 30 days.

Outcomes

As of January 31, 2017 restoration rates at the Yakima facility were 60 percent and the average length of stay was 48 days. Fifty-six percent of individuals at Maple Lane were deemed competent to stand trial and the average length of stay was 41 days. The rate of restoration at Western State Hospital was 52 percent, while the restoration rate at Eastern State Hospital was 57 percent. In fiscal year 2018 the average length of stay for competency restoration patients was 65 days at Western State Hospital and 48 days at Eastern State Hospital. At Western State Hospital in 2017, eight percent of forensic psychiatric patients were readmitted within 30 days and 25 percent were readmitted within 180 days. At Eastern State Hospital, readmission rates were slightly better, with six percent being readmitted within 30 days and 17 percent readmitted within 180 days.

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Case Study Dashboard

Overview	Alaska	Colorado	Connecticut	Hawaii	Utah	Washington
Management of Forensic Psychiatric Population	Alaska Department of Health and Social Services, Alaska Psychiatric Institute (API)	Colorado Department of Human Services, Office of Behavioral Health Forensic Services	Connecticut Department of Mental Health and Addiction Services, Division of Forensic Services	Hawaii State Department of Health, Adult Mental Health Division	Division of Substance Abuse and Mental Health - Utah State Hospital	Washington Department of Social and Health Services Behavioral Health Administration Office of Forensic Mental Health Services
Oversight	Centers for Medicare and Medicaid Services, the Joint Commission	Inpatient: Joint Commission, Court Monitor Jail-based: National Commission on Correctional Healthcare, American Correctional Association, Stakeholder Board	No CMS certification.	Joint Commission, Hawaii Department of Health, Office of Health Care Assurance licensure	Joint Commission, Centers for Medicare and Medicaid Services Court monitor for 5 years as part of settlement agreement with the Disability Law Center. Forensic Mental Health Coordinating Council	Court monitor, Trueblood Diversion Workgroup, Quality Improvement section, Workforce Development and Training section Western State Hospital: Clinical Services Management, LLC Eastern State Hospital: Centers for Medicare and Medicaid Services, the Joint Commission
Partnership(s)	Department of Corrections, McLaughlin Youth Center (Division of Juvenile Justice), Alaska Court System	University of Colorado at Denver Forensic Fellowship Program to provide rotations for psychiatric fellows; Wellpath Recovery Solutions; Various community service providers; Arapahoe County Sheriff and Boulder County Sheriff	Department of Correction, Connecticut Courts, local mental health authorities	Law Enforcement and Public Safety Department, Honolulu Police Department, District Court and Mental Health Court on Oahu	Salt Lake Metro Jail, Utah Department of Corrections	Contracts with community service providers for diversion services.

Data Tracking + Communication	No shared data system between partner agencies. MOA for Urgent Forensic Discharge Planning in place. New SPSS system to maintain electronic records for forensic patients being developed at API.	Development of data management teams in progress. SB 19-223 requires development of an electronic data tracking system	Data tracking across and within systems is lacking. Court liaison is an employee of DMHAS and accesses client list for community mental health centers to reference against court docket.	Court-based clinicians; annual report to state legislature	Use Google Sheets to track data currently; exploring Sales Force	Developing data systems is one of the guiding principles of the Office of Forensic Mental Health Services.
Forensic Psychiatric Workforce	All evaluations now being conducted on a contractual basis due to loss of forensic psychologist workforce at API.	Development and implementation of competency evaluation training required under SB 19-223. Court Services Program (evaluations) has 45 staff.	Positions mostly filled, in general, the market is tight and the public sector does not pay as well as the private sector.	Workforce challenges unknown.	Psychologists, LPNs hard to hire; psychiatrists also hard to hire, but not currently experiencing a shortage; high turnover for psych techs; generally able to hire social workers	Numerous vacancies; Increased evaluation capacity 45 percent between 2014-2017

Program Specifics	Alaska	Colorado	Connecticut	Hawaii	Utah	Washington
Types of restoration offered, start date	Inpatient	Community-based (2017), jail-based (2013), and inpatient	Community-based (2001), Inpatient	Community-based (2007), Inpatient	Jail-based: Outreach Restoration Program and Jail-Based Competency Restoration Unit, Inpatient	Community-based residential treatment (2 facilities) which opened as a result of *Trueblood et.al. vs Washington State DSHS* Inpatient (2 facilities)
Location	Alaska Psychiatric Institute	Community-based: 76% of counties Jail-based: RISE Program at Arapahoe County Detention Center (Centennial, CO); New program to open at Boulder County Jail Inpatient: Mental Health Institute - Pueblo	Community-based: Community mental health center Inpatient: Whiting Forensic Hospital	Community-based: Community mental health center Inpatient: Hawaii State Hospital, Kahi Mohala, Columbia Regional Care Center	Jail-based: Outreach program at jails statewide, Competency Restoration Unit at Salt Lake Metro Jail Inpatient: Utah State Hospital	Community-based: Yakima (Yakima, WA) and Maple Lane (Centralia, WA) Inpatient: Eastern State Hospital, Wester State Hospital
Eligibility	Competency evaluation, competency restoration, DOC transfers, civil patients with acute aggression, NGRI	Jail-based: Not an imminent danger to self/others; likely to be restored in 60 days or less; medication and treatment compliant; motivated; medically stable; not significant risk of self-neglect Inpatient: Those meeting civil commitment criteria or in need of nursing care for medical reasons	Competency restoration, GBMI, civil patients with acute aggression, DOC transfers	Community-based: Misdemeanor offenses or non-violent felonies Inpatient: Preferred level of service	Social workers conduct initial screenings and refer to appropriate level of services. Defendants can transfer to higher level of service if not making progress.	Screening for appropriate level of care provided by state evaluation staff. In general, individuals at the residential level of care have fewer acute care needs but require a secure placement for public safety reasons.

Maximum time allowed for restoration	180 days for most defendants 12 months for defendants charged with crimes against persons	Maximum length of sentence if defendant had been found guilty of the crime	18 months	Petty misdemeanor: 60 days Misdemeanor: 120 days Felony: No limit	3 months for most defendants 3 years for specific crimes against persons and first degree felonies	180 days for felony charges
Capacity	10 beds	Outpatient: Depends on provider Jail-based: 94 beds at current facility with 18-beds at new jail location (opening June 2019) Inpatient: 307 beds	229 beds	Outpatient: Varies by provider Inpatient: Hawaii State Hospital - 202 beds, Kahi Mohala, 46 beds, Columbia Regional Care Center, 4 beds	Outreach: Avg. of 20 JBRU: 22 Inpatient: 112	Maple Lane: 30 defendants; Yakima: 24 defendants New 30-bed residential facility to open in 2019. Inpatient: 365
Care Setting	Forensic unit in inpatient psychiatric hospital	Jail-based: Mental health pod, separate from general population Inpatient: Forensic units in inpatient psychiatric hospitals	Free standing forensic psychiatric hospital	Free standing hospital; hospital accepts civil commitments, but most are forensic. New forensic facility to be built in FY 2021.	Outreach: Standard jail cell JBRU: Designated unit Inpatient: Free-standing forensic hospital; some beds located in a hospital building that also houses civil patients	Residential treatment facilities and inpatient units designated for this population.

Restoration Staffing	Multi-disciplinary: Psychologist, psychiatrist, social worker, recreational therapist, nurse, psychiatric nursing assistant, paralegal, unit clerk	Outpatient: Bachelor's level competency educator, bachelor's level case management, medication prescriber Jail-based: Multi-disciplinary - program director, psychiatrist, psychiatric fellow, psychologist, social worker, recreation therapist, registered nurse, reentry specialist, peer specialist, office coordinator, psychology practicum students, Arapahoe County Sheriff's Office deputies Inpatient: Similar to jail-based, with healthcare techs instead of deputies working as floor staff	Court clinics: FT social worker, 2 FT psychologists + 6-7 per diem psychiatrists Restoration, each unit: Psychiatrist, psychologist, social worker, rehab therapist, nursing staff, competency monitoring staff; 2 nurses 3 paraprofessional staff on 1st and 2nd shifts; 1 nurse, 3 paraprofessional staff on 3rd shift	Specifics not known.	Outreach: Four LCSWs and a psychologist JBRU: program administrator, psychologist, psychiatrist, social workers, office specialist I, registered nurse II, psychiatric tech, therapeutic recreation tech, case worker, ASI for psychiatrists/psychologists Inpatient: psychiatrist, psychologist, licensed clinical social workers, occupational and recreational therapists, nurses, vocational rehabilitation, psychiatric technicians	Use peer support and competency intervention specialists; deputies serve as member of treatment team, crisis social worker
Evaluation/Treatment	Forensic psychologists employed by API perform evaluations and oversee restoration treatment.	Court Services Department provides staff for evaluations, treatment providers separate from evaluators	Outpatient or in jail by a single psychiatrist or a team comprise of a psychiatrist, psychologist and social worker. Hired by DMHAS	Evaluations provided through the Courts and Corrections Branch and court appointed evaluators. Restoration services provided by separate teams.	Evaluations provided by state contractors. Restoration services provided by state staff.	Washington State Department of Social and Health Services staff perform evaluations; restoration services provided separately.

Program Basics	Group competency education, medication management	Outpatient: Two hours of competency education per week Jail-based: Day treatment program (M-F, 8-4 p.m. with weekend and after hours and psychiatrist and psychologist on-call; evening and weekend programming; orientation program; behavioral interventions/responses (treatment, behavioral programs/incentives, tolerance of mental health symptoms, coaching in milieu, positive reinforcement); program support (security, med pass, food, transportation); specially assigned deputies (deputy training with treatment team, behavioral consultation includes clinical staff and deputies)	Individual and group competency education	Individual and group competency education	Competency education, medication management, substance abuse, anger management, medical illness treatment	Psychiatric medication, group and individual psychotherapy, competency education, recreational and psychosocial group activities, medical treatment

Medication Protocols and Usage	Protocol for forensic population not identified in statute. Difficult to obtain involuntary medication orders for forensic population.	Jail-based: Currently only accept medication-compliant defendants	Important part of the process. Two different processes for involuntary medications: 1. Sell - Go back to criminal court, lengthy process. 2. Dicta in Sell - Go to court to argue that defendant incapable of informed consent, court will appoint a conservator	Specifics not known.	Specifics not known.	Use of involuntary medication for restoration defined in state statute (10.77.092)

Outcomes	**Alaska**	**Colorado**	**Connecticut**	**Hawaii**	**Utah**	**Washington**
Restoration rate	44%	Outpatient: Unknown Jail-based: 76% (within 60 days), 90% (within 90 days) Inpatient: Unknown	75-80%	Unknown	Outreach: 61% Jail-based: 72% Inpatient: 73%	Residential: 56-60% Inpatient: 52-57%
Average length of stay	75 days	Outpatient: Unknown Jail Based: 51 days Inpatient: Unknown	90 days	210 days (includes forensic patients other than restoration patients)	Outreach: 70 days (median) Jail-based: 89 days (median) Inpatient: 136 days (average)	Residential: 41-48 days Inpatient: 48-65 days
Key Takeaways	Wait times are long, conditions are ripe for lawsuit.	Continuing to implement new services from diversion to discharge to address increases in competency evaluations.	Fewer evaluations in recent years, possibly related to the jail diversion and reentry programs.	Successes navigating information sharing agreements between various partners.	Alternative programs (OCR and JBCU) decreased restoration waitlist growth. Discharge of IST-NR population to civil hospital reduces number of civil beds available.	Demand for competency restoration cannot keep up with supply. Funding diversion services to decrease number of evaluations ordered.

Appendix D: Stakeholder + Partner Interviews

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Table of Stakeholder + Partner Interviews

Stakeholder/Partner Entity	Participants + Titles	Date(s) of Meeting
Alaska Court System	Pam Washington, Judge Michael Franciosi, Judge Pat Hanley, Judge Jennifer Henderson, Presiding Judge of CRP Court Lisa Fitzpatrick, Administrative Attorney Kate Sumey, Project Coordinator Paul Durfey, Intern Josie Foxglove, Administrative Program Manager Tom Flynn, Law Clerk Michelle Bartley, Therapeutic Courts Program Coordinator	January 17, 2019 May 2, 2019 May 14, 2019
Alaska Mental Health Board	Bev Schoonover, Acting Director Stephen Sundby, Provider Member Brenda Moore, Chair Charlene Tautfest, Vice-Chair	December 6, 2018
Alaska Mental Health Trust Authority	Katie Baldwin, Senior Program Officer Travis Welch, Program Officer Steve Williams, COO	December 6, 2018
Department of Corrections	Adam Rutherford, Mental Health Clinician IV Laura Brooks, Operations Manager Nancy Dahlstrom, Commissioner Kelly Goode, Deputy Commissioner	January 10, 2019 June 17, 2019 Multiple
Department of Law, Civil Division	Steven Bookman, Assistant Attorney General Stacie Kraly, Attorney	November 20, 2018 May 7, 2019
Department of Law, Criminal Division	Paul Miovas, Division Director John Skidmore, Deputy Attorney General	Jun 18, 2019
Municipality of Anchorage, Anchorage Fire Department	Mike Riley, CORE Team Lead	June 13, 2019
Municipality of Anchorage, Department of Health and Human Services	Natasha Pineda, Director	April 24, 2019
North Star Behavioral Health System	Dr. Sperbeck, Director of Psychological Services	April 17, 2019
Project team associated with Pay for Success Permanent Supportive Housing in Anchorage	Nancy Burke, Municipality of Anchorage Annie Dear, Consultant, Social Finance Eric Glatt, United Way of Anchorage	May 17, 2019
University of Alaska Anchorage, Center for Human Development, Complex Behavior Collaborative Consultants	Summer LeFebvre, Clinical Director Rebecca Parenteau, EBI Behaviorist	May 21, 2019
Wellpath Recovery Solutions	Kevin Huckshorn, Senior Consultant Clinical Director Kerry Mangold, Director of Partnership Development	April 3, 2019 April 8, 2019

	George Gintoli, Senior Vice President of Hospital Administration Karen Galin, Vice President of Behavioral Health	
Department of Health and Social Services	Laura Russell, Project Coordinator	Multiple
Alaska Psychiatric Institute	Drs. McRae, Becker and Rehn, Psychologists Gavin Carmichael, Chief Operating Officer Kate Oliver, Public Health Informaticist	Multiple
Division of Behavioral Health	Gennifer Moreau-Johnson, Director, Alysa Wooden, Program Coordinator Joni Stumpe, Program Manager for Complex Behavior Collaborative	Multiple
Division of Juvenile Justice	Tracy Dompeling, Director Shannon Cross-Azbil, Mental Health Clinician IV	January 25, 2019
Division of Senior and Disabilities Services	Deb Etheridge, Acting Director Maureen Harwood, Health Program Manager IV Corina Castillo-Shepard, Health Program Manager II	May 7, 2019
All		
Strategic Work Sessions	Most of the organizations and many of the individuals listed above participated in four strategic work sessions where the contractor team shared key findings and potential recommendations to receive feedback	February 25, 2019 April 10, 2019 May 20, 2019 June 19, 2019

Interview Themes

Below is a summary of key themes from the stakeholder interviews.

Alaska Court System

Anchorage Coordinated Resources Project

Judges and support staff involved in the Anchorage Coordinated Resources Project (CRP) and Anchorage Competency calendar report experiencing significant delays in the completion of competency evaluations and the admission of defendants for competency restoration. For the purposes of this project, judges with the Anchorage CRP were interviewed as they preside over many cases where competency evaluations are ordered. The CRP exists to divert individuals with mental health issues from the criminal justice system; however, discussion with the judges revealed that an individual cannot participate in the legal process and benefit from the mental health court diversionary programs unless they are competent to stand trial. Because the court is set up for individuals with confirmed or suspected mental health conditions, they are more likely to refer individuals for competency evaluations, which, in the current system, means lengthy waits in jail.

Orders for Evaluation

The judges interviewed are interested in competency evaluations being completed as quickly as possible because if a defendant is ordered for an evaluation, the case cannot proceed in court until an evaluation is completed. Extended waits for competency evaluations and restoration are particularly troubling in misdemeanor cases, as misdemeanants may spend more time waiting for an evaluation or restoration than they would have if they had just completed their sentence in jail.

Judges report interest in staffing solutions that will decrease the time an individual must wait for a competency evaluation, including:

- Statewide tracking by the Alaska Court System for competency evaluations to include a process for prioritization of misdemeanants for evaluation and restoration.
- Adding additional staff to complete competency evaluations through:
    - Increasing the forensic psychologist staff at API,
    - Tele-medicine contracts with out-of-state forensic psychologists,
    - Contracts with forensic psychologists licensed in Alaska to provide a set number of evaluations per year, or
    - Hiring an evaluator within the court system
- Use of an abbreviated competency evaluation for misdemeanants and/or an in-court brief screening process

Funding for additional evaluator positions is seen as a challenge, as is obtaining the required licensing for out-of-state providers to offer tele-evaluations. If full-time positions cannot be funded, judges would like to see contracts with Alaskan forensic psychologists, possibly paid for through the pooled resources of the Alaska Court System, API, DOC and the Trust.

System Capacity

The judges believe that a facility alone will not fix the system capacity issues; citing API's current staffing crisis for civilly committed patients, the judges expressed concerns that an expanded facility without staff will not be helpful. After sharing different models for care across the continuum, one judge expressed great interest in post-booking diversion programs, similar to Connecticut's model. Judges were also supportive of expanded community services such as supportive housing, assisted living and wraparound services that are more protective of the individual and of the community's safety. Judges were mixed in their views of the addition of jail-based restoration with one citing concerns about this service being provided in jail and another being supportive of a therapeutic incarceration.

Judges note that sometimes the forensic process is used to hold defendants who would otherwise be released in custody a little longer to keep them out of the community and shared that a lack of community resources and supports are drivers of the increase in requests for competency evaluations. Additional drivers for the increase in requests for competency evaluations include: individuals with repeat evaluations, new prosecutors and public defenders who do not understand the process, increase in the police force in Anchorage, rapid cycling of civilly committed patients in and out of API and an increase in substance use and drug induced psychosis. Judges and court staff voiced concern about the number of individuals who are charged with assaulting staff or other patients while at API or the Providence Psychiatric Emergency Room for behavioral health reasons and subsequently end up in the competency process.

Court staff shared that the model of acute care at API with short stays has been the norm since 2014 and is not adequate to stabilize people; community behavioral health providers have not been able to address the acuity and extremity of the behaviors. Anchorage does have an ACT team, but this model does not address

the criminal thinking linked with the behavioral health issues; a specialized FACT team is needed to simultaneously address the mental health related behaviors and the criminal aspect.

Anchorage Centralized Competency Calendar

The Anchorage Court System has a Centralized Competency Calendar and recently began assigning all competency cases to a specific judge. An Administrative Program Manager was hired to manage the calendar, track data and collaborate with partners. While this individual will initially only handle Anchorage cases, the goal is to have all judicial districts in the state sending a summary of competency evaluation and competency restoration orders to facilitate statewide tracking of this information. The newly hired program manager will also work with the Alaska Mental Health Trust Authority to convene the signers of the Urgent Forensic Discharge Memorandum of Agreement and make necessary updates.

Alaska Mental Health Board

Stakeholders from the Alaska Mental Health Board (AMHB) identified staffing as the most significant obstacle in the current system. With a larger workforce, competency evaluations could be completed more quickly, reducing the backlog in this part of the process. Stakeholders also expressed concern about the availability of appropriate and supportive community placements, believing that some of the forensic or forensic-related target populations could be better served in community placements if resources were available.

Historically, AMHB has been very concerned with the treatment and care of the forensic related target populations that are currently in DOC custody (those with serious mental illness or dual diagnosis, and those that are Guilty But Mentally Ill). Currently, with the discussion of a new facility, stakeholders expressed concern about adolescents receiving treatment in the same facility as individuals charged with or convicted of sexual offenses. Stakeholders are interested in exploring options for restoration for juveniles that allows for separation from the adult forensic psychiatric population.

Looking toward solutions, AMHB stakeholders are interested in exploring a triaged approach that addresses the mental health and safety needs of individuals and the community by level of acuity and risk. Under this model, some individuals may be eligible for outpatient or partial hospitalization services, while others would require inpatient treatment. There was not a clear consensus on whether civil patients and criminally involved patients should remain separated at the inpatient or partial hospitalization level. Due to potential funding constraints involved with building a new facility, the AMHB would also like to see an exploration of statutory changes that could alleviate some of the pressure on the current forensic system.

Alaska Mental Health Trust Authority

The Alaska Mental Health Trust Authority (Trust) is interested in the feasibility of expanded forensic psychiatric capacity because Trust beneficiaries currently spend weeks or months in jail awaiting competency evaluations and, if found incompetent to stand trial, spend additional time in jail awaiting a restoration bed to become available on API's Taku Unit.

The need for expanded capacity is just one prong of the problem, with process and statute issues also hindering responsive access to competency evaluations and restoration services.

- For individuals awaiting competency evaluations, the Trust's perspective is that the timeliness of evaluations is more of a question of API staffing and availability to conduct evaluations, involving a process or statute change, than an issue that could be solved with construction of a new facility.

Under the current process, API staff do the competency evaluations, but API staff are not statutorily required to do so. Competency evaluations could be completed via telehealth contracts, a model in use in other states.

- The Trust's understanding is that the 10-bed Taku Unit is not big enough for the forensic population in need of restoration. Those in need of restoration are the primary population that could be helped through an expanded number of beds. However, statute changes could also make it possible for this population to be served via partial hospitalization or jail-based restoration.
    - Consideration for restoration of juveniles is necessary, but unsure if it is realistic to staff a forensic program that is specific to youth at a different site (i.e. McLaughlin) than the adult facility
- For individuals with an IST designation who are deemed non-restorable after undergoing treatment, there are both process and civil facility issues. In the current system, there are issues with discharge and release planning. There is not a designated entity responsible for initiating the Title-47 process or having a discharge plan ready in the event an individual is deemed non-restorable. If the individual is identified as appropriate for a civil commitment bed at API, but there is not a bed available, there is no process for what to do with this individual.
- The Trust shared reservations about mixing current Department of Correction inmates with Serious Mental Illness (SMI), dual diagnosis, or those that are Guilty But Mentally Ill with civil patients or those who are engaged in the competency process and have not yet been convicted of a crime.

The Trust expressed a preference that if a stand-alone forensic facility is built, it be kept in the same area as API. Additionally, while the facilities reach would be state wide, the Trust would encourage an examination of process changes that would benefit rural Alaska and minimize the amount of time this population is transported back and forth from rural communities to Anchorage.

Department of Law, Civil Division

The initial meeting with Department of Law Civil Division attorneys highlighted several key takeaways:

- More beds are needed for the forensic population, but not necessarily in a new, standalone hospital
- Dementia/ADRD patients need specialized care within the hospital and a better long-term care solution
- Oversight for forensic staff is separate from civil staff and consideration should be given to increasing the knowledge of API administration about forensic patient issues as current and historic administrators have been focused primarily on the needs of the civil population
- There is a gap in the system regarding juvenile restoration, but low demand for this service. The current process in which restoration for juveniles is provided at McLaughlin seems to work well but it would be beneficial to consider more formalized solutions. Consideration could be given to mixing forensic and civil juvenile patients on API's Chilkat unit, but there are concerns about liability, exposing a vulnerable mental health population to a potentially predatory forensic youth and push back from parents who may not want their child on the same unit as a competency restoration youth.
- There is no triage system for restoration admission based on clinical acuity or criminal charge. API admits restoration clients in the order in which they are received. Standards for triaging would need to be established. Triaging defendants was identified as a heavy lift that was previously discussed but without any movement forward.

Subsequent conversations, specifically regarding involuntary medication for forensic patients identified specific barriers and areas of opportunity. There is Supreme Court case law regarding involuntary medication for the restoration of competency (Sell v. United States and United States v. Loughner), there is no statutory or case law in Alaska interpreting these judgements. One stakeholder referenced a 2015 Alaska Court of Appeals Case, M.V. v. State of Alaska that further limited API staff ability to obtain involuntary medication for forensic patients. The Sell case references "substantial likelihood" that an individual will be restored to competency as a result of medication and in the M.V. case, the testifying physician would not use the word "substantial", instead using "reasonable to believe", "more likely," and "more likely than not". The court did not find this terminology sufficiently definitive and would not order involuntary medications.[1] It is the opinion of the stakeholder that since the outcome of this case, judges are unwilling to grant involuntary medication in competency cases unless they hear the word "substantial" and that physicians are generally unwilling to use that word because it is not clinically appropriate.

Conversations identified that the discharge options for forensic patients need to be more robust. API staff try to secure public guardians, assisted living homes and outpatient appointments set up as appropriate, but frequently these resources are unavailable when someone is ready to discharge. If an individual is found not restorable but there are concerns about safety, the Taku staff will petition for civil commitment. This process works well but is not often used because of the high standard for civil commitment. Discussion of long-term residential services revealed that it would be difficult to involuntarily commit someone to such a program, but it would be nice to have voluntary residential programs or even an outpatient clinic or window at API where discharged patients could come for medication refills. Outpatient civil commitment, while allowable in statute, is not practicable in Alaska because it assumes the outpatient provider will petition the court for the commitment. The current Assistant Attorney General has used outpatient commitment just once during his tenure.

Department of Law, Criminal Division

Stakeholders with the Department of Law, Criminal Division expressed concern with the increasing number of individuals for whom competency evaluations are requested and the waitlist for evaluations and restoration. Prosecutors evaluate level of community risk and seriousness of charges when reviewing cases that require competency evaluation and restoration. Prosecutors would like to see API change its method of prioritization for competency evaluation and restoration, which is currently first come first serve, to a method that triages cases based on severity of mental health needs and legal exposure. The Criminal Division has noticed an uptick in evaluation requests from public defenders and the Office of Public Advocacy. It seems that the criteria for ordering a competency evaluation is becoming broader, sweeping more people up in to the process.

Other systemic issues include a lack of physical space to provide treatment and the providers to deliver treatment services. Diversion of this population was viewed as a challenge because generally only prosecutors are present at arraignment and the defense often does not allow prosecutors to receive information about the defendant's mental health condition. Mental health information is protected and generally not available at arraignment. For a court liaison diversion program to work, the liaison would need to be able to share health information with both the prosecutor and defense.

[1] M.V. v. State of Alaska. Court of Appeals No. A-12403. December 29, 2015.

Department of Corrections

The Department of Corrections (DOC) system reports seeing significant impacts within their facilities due to the backlog of forensic psychiatric patients awaiting competency evaluation and restoration. The Department of Corrections has 28 acute mental health beds for men in the entire state, and often individuals awaiting a restoration bed at API need an acute care bed. Even if the individual requiring restoration is not ill enough to be on the acute unit, or "Mike Mod", they still need specialty psychiatric care. Holding restoration patients in DOC's acute care beds causes a backlog in their system and for the first time, DOC is seeing a waitlist for their acute mental health beds of up to 15 individuals, while in the past the waitlist was just two or three. Due to the demand for acute mental health beds, the unit is seeing shorter lengths of stay as the focus shifts from treatment to stabilization. This rapid cycling of individuals in and out of acute care beds results in a decrease in quality of care, decreased psychiatric stability among inmates, and impacts staff safety and morale.

The Department of Corrections noted no concerns about expanding forensic capabilities in the state. Representatives from DOC offered insights and suggestions to address some of the issues they see with the current system.

- API does not have a mechanism for transporting individuals in their facility for restoration to outside medical appointments. DOC is called to transport these patients. Once an individual is admitted to API for restoration, API should be responsible for their medical and safety needs. Transportation should be taken in to account in the design and programming of a new facility.
- Specialty populations:
    - Juveniles: DOC is seeing an increase in juveniles who are being tried in the adult system in their facilities. An appropriate process should be identified for the evaluation and restoration of juveniles.
    - Dementia: Individuals with dementia awaiting competency evaluation and restoration are a relatively small group in DOC's custody but often have extended stays. Generally, these individuals have committed some sort of domestic violence offense and are clearly not competent and not restorable. However, they must wait at DOC for the competency and restoration process to occur and are ineligible for bail due to current domestic violence laws that state the perpetrator cannot return to the home of the victim. This is true even in cases when the victim is the perpetrator's spouse or caregiver and wants the perpetrator home.
    - High-utilizers: There are a number of individuals that cycle through the DOC system. Knowing that API's civil beds are perpetually full, police officers may instead charge an individual with mental health needs with disorderly conduct to get them off the streets and into a safe environment (DOC custody).
- In the past, competency evaluations were all conducted inpatient, at API. Now, nearly all competency evaluations are done outpatient, at DOC facilities or in the community. DOC wondered about best practices related to the quality and depth of outpatient evaluations and whether inpatient competency evaluations should occur.
- DOC is interested in learning more about jail-based restoration and processes used in other unified corrections system states regarding evaluation and restoration of the forensic population. Jail-based restoration would make the most sense as a central location, rather than having sites in Anchorage and outlying communities.
- Targeted education to courts in rural communities about the competency process would be useful in ensuring the appropriateness of referrals for competency evaluation.

- Exploration of outpatient restoration should be considered, including a court process to determine if inpatient versus outpatient restoration is needed, based on an individual's level of risk.
- Consideration of dedicating a public defender to forensic cases or assigning a special assistant of forensic cases to public defenders would be useful in offering better advocacy for defendants throughout the process.
- Given the high number of individuals with mental health issues in the DOC system, particularly those that could be impacted by a forensic psychiatric hospital, DOC would like to be an involved partner throughout the feasibility study process.

Department of Health and Social Services

Division of Behavioral Health

This contract is managed by DBH staff who participated in many of the stakeholder interviews and engaged in ongoing discussions with the consultant team to inform this report.

Alaska Psychiatric Institute

API staff provided a tour of the facility to the consultant team at the outset of the project. We worked closely with the forensic psychologists and API administration throughout Phase I and Phase II to gather and analyze data and to understand their priorities and concerns for this project. These are identified throughout this report.

Complex Behavior Collaborative

The Complex Behavior Collaborative (CBC) was introduced in 2012 following the 2009 WICHE report which recommended that specialized training be provided to care for five specific populations: traumatic brain injury, dementia, Intellectual and Developmental Disabilities (IDD), chronic mental illness and substance use disorders. The CBC has six board certified Applied Behavior Analysts (ABA). ABAs have had a lot of success improving behaviors of the population they work with. The CBC serves people from age six to the end of life and can serve about 30 clients per year. Stable housing is a huge issue and there are at least four individuals who are currently part of the CBC who are unable to maintain stable housing. Some individuals with complex behaviors end up at API because their behaviors are too challenging to be managed on an outpatient basis by the CBC and some individuals have never been connected to CBC services. Discharge planning at API frequently falls short, as stays are short and discharge to a homeless shelter occurs rather than connecting an individual to a full array of services.

Providers shared that the mental health system is not currently very successful at supporting individuals with psychosis whose behavior is difficult to manage in community settings. There is more success supporting those with IDD in home and community-based settings, through the 1915c Medicaid waiver. Stable housing is essential.

When we talk about diagnoses, level of functioning should be considered. Medication management is critical to a client's success but for people with complex needs, intensive behavioral supports are also needed, and these are not currently funded. A review of statute should include looking at what guardians can and cannot do regarding consenting for medication and statute should be amended to allow guardians more decisions in medication.

Needs or possible systems improvements were identified as:

- A FACT team incubated within the CBC.

- Provide clinical support to current ACT team with a medication and behavioral health clinician on call 24/7.
- Acuity rate for complex behavior clients.
- Expand services from Applied Behavior Analysts or other licensed specialists working with this population in conjunction with medication.
- Resources to implement behavior plans at assisted living homes.
- 10-bed complex behavior unit at API would be a great addition.

Case studies of Center for Human Development clients with criminal and behavioral health involvement were provided. The case studies demonstrate a pattern of cycling through API and DOC systems that is not uncommon for individuals with complex needs.

Division of Juvenile Justice

Division of Juvenile Justice (DJJ) staff met with the consultant team on January 25, 2019. While there is limited demand for juvenile competency evaluation and restoration some demand does exist and could grow in the future. There are also significant issues related to adolescents who are civilly committed to API and who are charged with a crime that occurred at API, most often an assault on a staff member, and who are then remanded to DJJ. While this population is not creating demand necessarily for competency evaluation and restoration, they are a high acuity and complexity population who are charged with a crime and for whom there is not currently an optimal placement.

Senior and Disabilities Services

Connections between the forensic population at API and services available through Senior and Disabilities Services (SDS) are limited. Individuals who do not meet criteria for an Intellectual and Developmental Disability, those with TBI, and those with more general cognitive impairment are not specifically served by most SDS programs and there are few providers who specialize in this kind of care in Alaska. Community providers are not required to take on clients, so SDS has to work hard to convince providers to take on more complex clients.

Municipality of Anchorage

Anchorage Fire Department

The Anchorage Fire Department's (AFD) Community Outreach Referral and Education (CORE) team works with high utilizers of AFD services. High utilizers are defined as individuals requiring five or more transports per year. In 2018, there were 159 individuals who met the transport criteria. The CORE team identifies individuals eligible for services through patient care report data. If eligible the team outreaches to these individuals. Participation is voluntary and if individuals want to participate, they sign releases of information so staff can start to make connections with appropriate community referrals. Due to the intensive nature of services offered, only about 16 people can be served at a time.

An estimated 70-80 percent of individuals served by the CORE team have a behavioral health or co-occurring substance use disorder. Behavioral health conditions are not typically serious mental illness. Depression and personality disorders are more commonly seen. It should be noted that the team does not have a way to track behavioral health data or diagnoses and this information is an estimate based on experience. About 40 percent of the high-utilizer population is unhoused, the median age is 56 and males and females are served about equally. Most of the individuals served by the CORE team do not have criminal involvement.

Community needs are identified as crisis stabilization, transitions between Assertive Community Treatment and lower levels of outpatient care, outreach and a hub for resources that helps to identify all available resources as well as distinguish the different services offered by similar programs.

There are other crisis response services offered in Anchorage that the CORE team interacts with including:

- **Anchorage Police Department (APD) Crisis Intervention Team (CIT):** There is one designated CIT officer in the department, although other officers are trained in CIT. This officer addresses individuals in crisis that APD interacts with, usually in very acute situations. The officer is specially trained in de-escalation. Often, the result of contact with the CIT officer is de-escalation and a transport to the Providence Psych ED if needed. The idea behind the CIT team is to bring in an officer trained in de-escalation in order to release the responding officers to cover other calls.
- **Crisis Response Team (CRT):** The CRT is comprised of the CIT police officer (described above0 and the MIT social worker (described below). When these two individuals respond to calls together, they are referred to as the CRT. They respond to APD callers in behavioral health crisis. The CIT officer brings de-escalation skills and the MIT social worker brings knowledge of community resources. The end goal of this team's response tends to be resolution of the crisis through connection to appropriate services.
- **Mobile Intervention Team (MIT):** The MIT responds exclusively to individuals who are homeless. This team spends times in camps, working in camp abatement and in coordinated entry. The MIT social worker is also part of the CIT.
- **Assertive Community Treatment (ACT):** The ACT team offers daily medication delivery, case management, clinicians and a crisis line. However, these services are only open to their clients and the team is almost always at capacity. If fully staffed, there are 10 staff who can each serve 10 clients. The program is generally understaffed (seven staff) and thus is only serving 70 individuals.

The CORE team believes that the CIT and CRT teams have more interaction with the forensic population. There is no shared data system between the various response teams to track shared clients or referrals.

Department of Health and Human Services

A crisis stabilization facility is a need in Anchorage; however, when the State of Alaska put out an RFP for crisis stabilization in the fall of 2018 there were no providers in Anchorage who had the capacity or workforce to implement this service. There is concern about funding for operations. Co-locating a crisis stabilization center with the safety center could be considered but might not serve the same populations. The are more people in crisis than we have safe places for them to be. The fire department and EMTs have completely shifted to triage, addressing people in crisis and finding housing for people which is a very expensive way to provide these services.

The Municipality is looking for a new location for the Safety Center. Due to fire code issues with the current facility, the Center went from a capacity of 100 to 44 on October 1, 2018. It could be beneficial to co-locate the Safety Center with the emergency cold weather shelter. Safety Center patrols currently do not go past International Airport Road and Dimond. The Dimond area is becoming more of a problem as more individuals are moving to this area to get out of the patrol range. The Safety Center serves approximately 25,000 duplicated clients per year. There is a large high utilizer group, perhaps around 200 individuals. Some people spend 250 nights a year at the Safety Center. The Mobile Intervention Team is provided with a list of these high utilizers and is supposed to target these individuals for outreach.

North Star Behavioral Health System

Dr. David Sperbeck was the Chief Forensic Psychologist at API from 1982-2005 and after retirement, continued to conduct forensic competency to stand trial (CST) evaluations on a contract basis from 2005-2009. He is currently the Director of Psychological Services at North Star Behavioral Health and continues to conduct forensic evaluations on a contract basis (with the Court), usually for high-profile murder cases. From 1982-2009 Dr. Sperbeck estimates he completed 2,500 CST evaluations.

Evaluation and Restoration

When Dr. Sperbeck was conducting CST evaluations he was completing the evaluation and submitting his report to the court within 7 days of order. In 1982, half of API's beds were forensic beds. Quality restoration programs benefit from psychology staff with formal training and supervised residency and internships.

Why is Alaska seeing an increase in CST evaluation orders?

As API has decreased the number of beds and their average length of stay, the number of SMI individuals on the streets has increased. Individuals who are homeless are more likely to get into situations that get them involved in the legal system.

Does Alaska's low rates of restorability have to do with our higher rates of FAS and other unalterable disorders?

No. The issue is the pressure on API staff to get people in and out quickly. API forensic staff are overburdened and have little time or support to try anything new or increase rates of restoration.

Relevant Background Research

Dr. Sperbeck shared several papers that he authored or recommended that provide a historical context for today's forensic backlog.

- The Straits of Insanity in Alaska, 1986
- Memo: Proposed Improvements in the Delivery of Forensic Mental Health Services, 1986
- Memo: A Brief History of the Criminalization of the Mentally Ill in Alaska, 1992
- Memo: Correctional Mental Health Services, 1999
- Memo: Costs, 2004
- Neurocognitive Disorders and the Criminal Justice System: Implications for Assessing and Restoring CST for Brain-Injured Defendants, 2004

Pay for Success

The Pay for Success (PFS) permanent supportive housing team for Anchorage is developing data agreements to create a centralized list that includes interaction with police, the Mobile Intervention Team, Anchorage Safety Center, and fire department. These data sources will be paired with Housing Management Information System (HMIS) to identify potential clients for permanent supportive housing. It would be great to have an ongoing data sharing agreement with DOC, but at minimum, they are working to get a current list to match against. PFS will have a by-name list of individuals qualified for services very soon. This list could potentially bring in data from API and the Anchorage Court System to identify people in the forensic evaluation and restoration system.

The team offered several suggestions related to improving the discharge process for IST non restorable patients so they do not return to or enter homelessness:

- Follow someone who has been relatively successful through this system to understand what worked for them.
- API could discharge people with 90-120 days of medication.
- API could provide outpatient services to help people maintain in the community.
- Better coordination with Anchorage Neighborhood Health Center and Anchorage Community Mental Health Services.
- Convene providers to discuss discharge planning and identify the most appropriate placement across systems.
- An issue in the current system is that if an ACMHS client goes into crisis and cannot be found, they must be discharged from services. When the person is found they must go through a new intake process. It would be helpful to have a "preservation team" who can search for a person who is missing or identify them in another system (e.g. if they have been arrested) and make sure they do not lose their services.
- Providers are discussing the creation of a housing coordinator to help match people with vouchers and other resources.
- There is a need to align all the various housing programs under one central office or convener.

Wellpath Recovery Solutions

Wellpath Recovery Solutions, a private medical and behavioral healthcare company based in Tennessee, took over management of API through a contract with the State of Alaska in February 2019. In addition to experience managing inpatient psychiatric facilities, Wellpath has experience developing and managing residential, inpatient, and jail-based competency restoration programs. At the time of the interview, Wellpath was the management company for API and given the company's experience with a wide array of forensic psychiatric programs, the Agnew::Beck team met with WellPath leaders on two occasions to share Phase I findings and learn from Wellpath's experience providing competency restoration services.

After reviewing Phase I data and reflecting on their knowledge of API and the behavioral health system in Alaska, Wellpath staff identified several issues and potential solutions.

- The evaluation backlog is related to a very small number of evaluators who conduct just two evaluations per week.
- Restoration treatment on Taku could be enhanced. Currently, just one to two groups per week are offered and there are ways to increase the number and types of groups available. Access to medication is also an important factor.
- It is not best practice for the same clinicians to conduct competency evaluations and restoration treatment.
- Discharge is a huge issue for both forensic and civil patients. Expanded ACT teams as well as funding for FACT teams would be helpful.
- There is a need for long-term placement options for individuals with dementia, organic brain disease, developmental disabilities and treatment resistant mental health conditions.

Karen Galin, Vice President of Behavioral Health for Wellpath, was integral in the design of Colorado's jail-based restoration program, Restoring Individuals Safely and Effectively (RISE). The RISE program began six years ago as a 22-bed unit and after increases over the years is about to expand to a second facility for a total of 114 beds. In the RISE program, those receiving competency restoration services live together on one unit

and attend programming together. Deputies are hired specifically for the program and are trained to have a more therapeutic, rather than disciplinary approach. The RISE program operates like a mini-hospital, where participants receive four treatment groups and one individual session a day with scheduled evening and weekend recreation. In Colorado, the state screens defendants for the appropriate competency restoration setting (jail-based or inpatient) based on certain clinical characteristics. However, in California the jail-based restoration facility managed by Wellpath operates as a receiving facility. Everyone enters the jail-based program as long as they are medically stable, and they are transferred to an inpatient facility only if needed. The average length of stay for jail-based restoration is similar to inpatient, at an average of 50-70 days. Wellpath also manages a residential competency restoration program in Washington called Maple Lane.

For individuals who are found incompetent to stand trial after restoration treatment, Wellpath employs dedicated case managers to follow up with individuals at 30 and 60 days after discharge to make sure they are following through with their appointments and aftercare plans. Wellpath also designs and operates secure residential facilities for individuals found non-restorable after treatment. They recently helped Maine design their program and are working with Hawaii to develop step-down beds.

Appendix E: Forensic Psychiatric Workforce

Table of Contents

Executive Summary

Employment Landscape

All states surveyed have current vacancies in key competency evaluation and restoration treatment positions. A summary of vacancies is provided in Table 1. This table represents a point in time count of vacancies by state but does not reflect the percentage of total vacancies per position type as this information was not readily available.

Table 1: Number of vacancies in key competency evaluation and restoration treatment positions

Location	Psychiatrists	Evaluation Psychologists	Treatment Clinicians	Administrative or Other Key Staff
Alaska	1	3	3	None identified
Colorado	2	1	6	None identified
Connecticut	1	0	0	1
Hawaii	1	0	1	1
Utah	0	2	2	None identified
Washington	1 +	1 +	3	2
Total	**6**	**7**	**15**	**4**

The United States Bureau of Labor and Statistics provides information on the number of providers by type and by state. The number of providers in each category by state is presented in the state specific chapters and ratios per 100,000 are provided in Table 2 to better show shortages by state and provider type. The Health Resources Services Administration (HRSA) identified that by 2025 the demand for psychiatric services could exceed the supply by 6,080-15,400 providers and the demand for clinical, counseling and school psychologists could exceed the supply by 8,220-57,490.[1] Among the states surveyed, Alaska's ratio of psychiatrists and psychologists per 100,000 was neither the highest nor the lowest.

Table 2: Number of providers per 100,000 population (2018 Estimates)

Location	Psychiatrists[2]	Clinical Counseling + School Psychologists[3]
Alaska	9.5	37.9
Colorado	7.9	48.6
Connecticut	17.6	47.0
Hawaii	10.6	33.1
Utah	Not reported	45.9
Washington	7.2	28.7
Nationwide	7.7	33.0

[1] United States Department of Health and Human Services, Health Resources and Services Administration. (2016). National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025.

[2] United States Department of Labor. Bureau of Labor Statistics. Occupational Employment and Wages, May 2017 – Psychiatrists.

[3] United States Department of Labor. Bureau of Labor Statistics. Occupational Employment and Wages, May 2017 – Psychologists.

Educational Institutions

A guide to graduate programs in forensic and legal psychology identified 24 Ph.D. programs, nine Psy.D. programs, and 27 masters' programs in the country that offer specialization or emphasis in forensic and/or legal psychology.[4] Alaska offers both master's level and doctoral programs in psychology at two universities. However, the closest institution to Alaska with a forensic specialization is the Pacific University School of Professional Psychology in Oregon. There are over 100 American Psychological Association accredited psychology doctoral programs nationwide.[5]

Training in forensic psychiatry is obtained through fellowship programs. The American Academy of Psychiatry and the Law Directory of Forensic Psychiatry Fellowships identified 46 fellowship programs for forensic psychiatry in 2019.[6] There are no forensic psychiatry programs in Alaska. The closest fellowship is at Oregon Health and Science University.

Continuing Education and Quality Assurance

Formal forensic training, ideally sponsored by the state, is essential for high-quality forensic evaluations. Some states (Massachusetts, Georgia, Virginia and Oregon) have a formal certification procedure.[7] There are also forensic specific trainings available in both online, and live formats through training organizations such as CONCEPT.[8]

Quality Assurance procedures for evaluators are also an important part of a high-quality evaluation system. Recommendations for a quality assurance process include:

1. Reviewing a random sample of reports from each evaluator to gauge:
    a. Adherence with ethical standards and best practices.
    b. General rates and patterns of opinions
2. Supervising and mentoring evaluators
3. Regularly surveying report consumers (judges and attorneys) regarding the quality and utility of reports.[9]

It was previously recommended that API's forensic psychologists be provided with opportunities to receive supervision and consultation with forensic specialists outside of API.[10]

Statutory Requirements for Evaluators

Qualified psychiatrist and qualified psychologist are not defined in Alaska statute. All five states surveyed for this report provide more descriptive definitions regarding who can perform competency evaluations and most

[4] Guide to Graduate Programs in Forensic and Legal Psychology, 2017-2018. University of Denver. http://ap-ls.wildapricot.org/resources/Documents/2016_2017GuidetoGraduateProgramsinForensicPsych.pdf

[5] American Psychological Association (2018). Accredited Doctoral Programs for Training in Health Service Psychology. https://www.apa.org/ed/accreditation/programs/doctoral.pdf

[6] American Academy of Psychiatry and the Law. Directory of Forensic Psychiatry Fellowships, 2018 for Fellowships Beginning July 1, 2019. http://www.aapl.org/fellowship.

[7] Groundswell Services, Inc. (2014). Forensic Mental Health Consultant Review Final Report.

[8] CONCEPT Professional Training, accessed online at https://www.concept-ce.com/training-program-overview/

[9] Groundswell Services, Inc. (2014). Forensic Mental Health Consultant Review Final Report.

[10] Fox, Patrick. 2016. Alaska Psychiatric Institute: Evaluation of Forensic Services. Western Interstate Commission for Higher Education.

specify licensure as a requirement. Reports such as WICHE's 2016 *Evaluation of Forensic Services at API*, UNLV's 2014 *Review of Alaska Mental Health Statutes* and the table below with statutory definitions from other states serve as a starting point for revisions and clarification of Alaska's competency evaluation statute.

Table 3: Statute overview, number of evaluators

State	Number of evaluators	Type of evaluator	Definition of evaluator provided?
Alaska	One	Psychiatrist or psychologist	No
Colorado	One	Psychiatrist or psychologist	Yes
Connecticut	One or a clinical team	Psychiatrist or a team (psychiatrist and social worker or master's level nurse)	Yes
Hawaii	Three for felony cases One for misdemeanor cases	Psychologist and psychiatrist for felony; One or the other for misdemeanor	Yes
Utah	Two for most felony cases One for misdemeanor cases and some felony cases	Mental health professional	Yes
Washington	One	Psychiatrist, psychologist, master's level social worker	Yes

The table below provides a more detailed overview of statutory language related to the number of evaluators required for competency evaluations and the definition of an evaluator (if one is provided). More complete statutory language can be found in the by-state chapters of this appendix.

Table 4: Statutory Requirements for Evaluators, by State

Statutory Requirements for Evaluators	
Alaska (12.47.100(b))	One qualified psychiatrist or psychologist (AS 12.47.100(b))
Colorado (16-8.5-101.(2))	"Competency evaluator" means a licensed physician who is a psychiatrist or a licensed psychologist, each of whom is trained in forensic competency assessments, or a psychiatrist who is in forensic training and practicing under the supervision of a psychiatrist with expertise in forensic psychiatry, or a psychologist who is in forensic training and is practicing under the supervision of a licensed psychologist with expertise in forensic psychology.
Connecticut (Sec. 54-56d.(d))	(1) One or more psychiatrists, or (2) Commissioner of Mental Health and Addiction Services who selects either: a. A clinical team consisting of a physician specializing in psychiatry, a clinical psychologist and one of the following: a licensed clinical social worker or a psychiatric nurse clinical specialist holding a master's degree in nursing; or b. One or more psychiatrists
Hawaii (704-404 (2))	Felony Cases: Three qualified examiners defined as at least one psychiatrist and at least one license psychologist. The third examiner may be a psychiatrist, licensed psychologist or qualified physician. One of the three examiners shall be a psychiatrist or licensed psychologist designated by the director of health from within the department of health. Nonfelony Cases: One qualified examiner defined as a psychiatrist or a licensed psychologist.

Statutory Requirements for Evaluators	
Utah 77-15-2. (4) 77-15-5. (f)	"Forensic evaluator" means a licensed mental health professional who is: (a) Not involved in the defendant's treatment; and (b) Trained and qualified by the Department of Human Services to conduct a competency evaluation, a restoration screening, and a progress toward competency evaluation. Felony Cases: Two forensic evaluators if charged with a capital felony or if charged with a noncapital felony and the court determines a need for two evaluators. Nonfelony Cases: One forensic evaluator if the most severe charge against the defendant is a misdemeanor or the defendant is charged with a felony that is not a capital felony.
Washington 10.77.010 (18) 10.77.073 (2)	"Professional person" means: (a) A psychiatrist licensed as a physician and surgeon in this state who has, in addition, completed three years of graduate training in psychiatry in a program approved by the American medical association or the American osteopathic association and is certified or eligible to be certified by the American board of psychiatry and neurology or the American osteopathic board of neurology and psychiatry; (b) A psychologist licensed as a psychologist pursuant to chapter 18.83 RCW; or (c) A social worker with a master's or further advanced degree from a social work educational program accredited and approved as provided in RCW 18.320.010. Appointment of a qualified expert or professional person under must be from a list of qualified experts or professional persons assembled with participation by representatives of the prosecuting attorney and the defense bar of the county.

Employer-Specific Requirements for Forensic Staff

Forensic Evaluator

Five of the six states surveyed had vacant forensic evaluator positions available. Of the five, four required that the evaluator has a doctorate in psychology and be licensed in the state of practice. One state, Connecticut, allowed for the evaluator position to be filled by a doctorate level psychologist, a psychiatrist or a licensed clinical social worker. Comparisons by state are found in Table 5 below.

Treatment Clinicians

Five of the six states surveyed also had restoration treatment clinician vacancies. In a survey of vacant positions, most states require a doctorate degree in psychology and a current license in the state of practice or ability to become licensed. The vacancies at API for these positions could be filled by master's level psychologists. RISE, the jail-based restoration program in Colorado, is currently hiring for a psychologist and a licensed clinical social worker to join the team. The jail-based restoration program in Utah also hires social workers as part of the restoration team.

Table 5: Forensic Evaluator and Restoration Clinician Qualifications

State	Evaluator Qualifications	Restoration Clinician Qualifications
Alaska	Doctorate in psychology, Alaska licensure or working towards licensure	Inpatient: Master's or Doctoral degree from an accredited college in psychology, social work, child guidance, nursing, vocational rehabilitation or closely related field; 4 years' experience required for those with a master's degree; Licensed as a psychologist or master's level practitioner in Alaska

Colorado	Doctorate in psychology, Colorado licensure	Inpatient: Licensed psychologist + one-year experience Jail-Based: (1) Doctorate in psychology, Colorado licensure; (2) Licensed Master of Social Work
Connecticut	Licensed clinical social worker, psychologist or psychiatrist with specialized forensic training	Information not available
Hawaii	Licensed psychologist or psychiatrist	Inpatient: Doctorate in psychology, Hawaii licensure within two years
Utah	Licensed psychologist or doctorate level licensed social worker	Jail-Based/Outreach: (1) Certified Social Worker with a master's degree or Licensed Clinical Social Worker (2) Doctorate in psychology, Utah licensure or working towards licensure, at least one year of experience conducting forensic evaluations
Washington	Doctorate in psychology, Washington licensure	Doctorate in psychology, Washington licensure or ability to become licensed

Job Duties

Forensic Evaluator

Alaska is the only state that seems to structure its forensic program in a way that the same staff conduct competency evaluations and supervise restoration treatment. Having mental health professionals serve as both forensic evaluators and treaters of defendants creates inherently conflicting roles, for in the former the professional's primary duty is to the criminal justice system, while in the latter it is to serve the interests of the defendant. The American Academy of Psychiatry and the Law recommends that independent, non-treating professionals should perform forensic evaluations of defendants rather than the defendant's treater.[11] In this way, the therapist-patient relationship is not adversely affected and the confidentiality of information obtained by the professional in treating the defendant is not jeopardized.

Per conversations with WellPath Recovery Solutions (Wellpath) staff, API's forensic psychologists conduct approximately two evaluations per week (eight per month, 62 per year). Bearing in mind API staff are currently also overseeing restoration efforts, their evaluation productivity is just under what seems to be the expectation in other states. The job description for the vacant evaluation position in Colorado identified 12 evaluations per month (144 per year) as the expectation. A 2014 report on forensic mental health services in Washington identified that forensic evaluators are expected to complete nine to 11 evaluations per month, or 99 to 121 per year. The report identified these targets as "ambitious but generally reasonable".[12] It is unknown if these targets remain the same today.

Treatment Clinician

Restoration treatment clinicians have similar job duties across states. The clinicians providing restoration treatment generally perform the following duties:

- Participate in treatment team
- Complete psychological assessments and evaluations

[11] *AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial*, Journal of the American Academy of Psychiatry and the Law, Volume 35, Number 4, 2007 Supplement S24.

[12] Groundswell Services, Inc. (2014). Forensic Mental Health Consultant Review Final Report.

- Provide case consultation
- Direct restoration programming

Administrative + Other Key Staff

Other states appear to have key coordinating staff positions that Alaska does not. Colorado, Connecticut, Hawaii and Washington all have forensic services divisions within their health and social services departments. Utah operates more like Alaska, where services are coordinated by the health and social services department and the state hospital without a distinct division for forensic services. For example, Connecticut is currently searching for a Behavioral Health Clinical Manager to provide continuing education to program staff and educate court staff about one of the state's forensic diversion programs. Additionally, this individual is expected to coordinate a workgroup to improve evaluation and service planning and propose policy and legislative changes to improve the program. In Hawaii, the state is hiring a Forensic Coordinator to coordinate forensic referrals and track patients. This individual coordinates with the Forensic Director, facilitates timeliness of forensic discharges from the state hospital and develops and refines programs to better serve the needs of the forensic population.

Compensation

Nationwide, clinical, counseling and school psychologists make an average of $81,330 per year and psychiatrists make an average of $216,090 per year. By selected states, wages are detailed in Table 6. Psychologists and psychiatrists in Alaska are paid more per year than the national average and are paid more per year, on average, than psychologists and psychiatrists in any of the other states reviewed. This data does note account for differences in the cost of living between states.

Table 6: Average Salaries for Selected Professions

State	Clinical, Counseling and School Psychologists	Psychiatrists
Nationwide	$81,330	$216,090
Alaska	$96,350	$248,440
Colorado	$79,950	$235,450
Connecticut	$88,920	$242,740
Hawaii	$95,500	$158,300
Utah	$78,970	$147,730
Washington	$72,480	$241,540

Sources: United States Department of Labor. Bureau of Labor Statistics. Occupational Employment and Wages, May 2017 – Clinical, Counseling and School Psychologists and United States Department of Labor. Bureau of Labor Statistics. Occupational Employment and Wages, May 2017 – Psychiatrists.

Only one state surveyed, Colorado, contracts with a private company for some of its forensic restoration services. Salary information for vacant positions with Wellpath, the jail-based restoration contractor in Colorado, was not available on the company's hiring website. The lack of availability of information on private company salary information means that salary differentials between private and state positions is not available as part of this analysis. However, as most states did have forensic evaluator, restoration treatment psychologist and psychiatrist positions available it was possible to compare compensation for these job types across the state sector for the states surveyed. For psychologists contracted to conduct evaluations, the per

evaluation fee established by the state ranged from $500 to $3,000 per evaluation. Alaska Court Judge Pat Hanley and a law clerk conducted brief background research on a "per evaluation rate" for competency evaluations and identified $1,500 - $3,000 per evaluation as a starting range for contract evaluators who could be recruited to address the backlog in Alaska's competency evaluation process.[13]

In three of the six states where data was available, evaluation and restoration treatment psychologists are paid at the same rate. In Washington, psychologists conducting evaluations are paid at a higher rate than the treatment psychologists. Pay differentials for evaluation and treatment psychologists are possibly related to the additional qualifications for evaluation psychologists outlined in states' statutes. Forensic psychologists in Alaska are salaried at one of the lowest rates of any of the states surveyed. Given that compensation for psychologists in Alaska overall is higher than the national average and higher than all of states surveyed, the job class for these positions in Alaska should be examined and possibly changed to something more comparable to similar positions in other settings.

Table 7: Annual salary range for key forensic positions; 6 state survey

Location	Psychiatrists	Evaluation Psychologists	Treatment Psychologists
Alaska	Unknown	$70,872	$70,872
Colorado	Unknown	$71,424 - $108,264	$71,424 - $108,264
Connecticut	$189,410-$225,912	Unknown	Unknown
Hawaii	Unknown	Unknown	Unknown
Utah	Unknown	$56,492-$97,177	$56,492-$97,177
Washington	$222,192	$90,000-$115,200	$79,548-$104,400

Benefits are fairly standard across state employers with most offering paid holiday, vacation and sick time as well as insurance, retirement plans and community discounts.

Table 8: Benefits; 6 state survey

Location	Annual Paid Holiday, Vacation + Sick time	Health Insurance	Life Insurance	Retirement Plan	Short and long-term disability	Community Discounts
Alaska	11 holidays, accrued personal + sick leave	Yes	Yes. Basic Life is employer paid.	Yes	Yes	Gym discounts
Colorado	10 holidays, 12 vacation days, 9 sick days	Yes	Yes. Basic Life is employer paid.	Yes	Yes	No
Connecticut	12 holidays, accrued personal + sick leave	Yes	Yes. Basic Life is employer paid.	Yes	Yes	Tuition reimbursement
Hawaii	13 holidays, 21 vacation days, 21 sick days	Yes	Yes. Basic Life is employer paid.	Yes	Yes	No
Utah	11 holidays, 13 vacation days, 13 sick days	Yes	Yes. Basic Life is employer paid.	Yes	Yes	Employee discount programs

[13] Possible ways to reduce the competency evaluation delays. Judge Pat Hanley, October 30, 2018. Written communication.

Washington	10 holidays, 14 vacation days, 12 sick days	Yes	Yes. Basic Life is employer paid.	Yes	Yes	No

Alaska

Employment Landscape

The Alaska Psychiatric Institute (API) currently provides all forensic competency evaluations and competency restoration for the State of Alaska. At the start of this project in November 2018 the forensic team was comprised of 2.5 FTE forensic psychologists who perform both evaluations and restoration on API's Taku Unit for individuals identified as incompetent to stand trial and in need of restoration. There is also nursing staff, a psychiatrist, a recreational therapist and a social worker to attend to the unit's needs. In addition to the clinical team, there is also a paralegal and a newly hired intern to enter data for the team.

In 2018, in efforts to reduce the backlog in the forensic competency evaluation system and add additional clinical capacity for restoration services, API was authorized to add five forensic psychologists to their team. Conversation with one of API's forensic psychologists identified that with a large enough staff, API's forensic psychological services would be able to staff a treatment team and an evaluation team. A position opening for multiple (3) forensic treatment clinicians was posted to Workplace Alaska on February 15, 2019 and a position opening for a forensic evaluator was posted on March 19, 2019 bringing the total number of forensic psychologist positions open in Alaska to four. The two full-time forensic psychologists at API recently resigned and various strategies to fill this gap are being discussed. The Alaska Mental Health Trust Authority granted funds to the Department of Health and Social Services to contract with a forensic psychiatrist to help clear the evaluation backlog and there is a possibility that the forensic psychologists who recently resigned will be brought on as contractors. Ideally, according to one API forensic psychologist, evaluation services would be staffed by three evaluators. Restoration would be staffed by 1.5 psychologists and there would be one psychologist supervisor position for the Taku unit. A psychology intern would also be available assist with both evaluations and restoration.

There are currently 228 psychologists licensed in Alaska by the Board of Psychologist and Psychological Associate Examiners.[14] This number excludes those with courtesy or temporary licenses and those licensed as psychological associates. Data from the United States Department of Labor estimate the number of clinical, counseling and school psychologists in Alaska at 280, slightly more than the number of licensed providers identified.[15] The American Academy of Forensic Psychology identifies three board certified forensic psychologists licensed to practice in Alaska.[16] There are 70 psychiatrists in Alaska, or approximately 9.5 psychiatrists per 100,000 population.[17]

Educational Institutions

The University of Alaska Anchorage offers a Bachelor of Arts and Bachelor of Science in Psychology, a Master of Science in Clinical Psychology and a PhD in Clinical-Community Psychology with a Rural and Indigenous emphasis. The Ph.D. program is accredited by the American Psychological Association. Alaska Pacific University in Anchorage offers Bachelor, Master, and Doctoral programs in Clinical Psychology. The

[14] Alaska Department of Commerce, Community and Economic Development. Corporations, Business and Professional Licensing. Search Professional Licenses. https://www.commerce.alaska.gov/cbp/main/Search/Professional. Accessed April 1, 2019.

[15] United States Department of Labor. Bureau of Labor Statistics. Occupational Employment and Wages, May 2017 – Psychologists.

[16] American Academy of Forensic Psychology. Specialist Directory. https://aafp17.wildapricot.org/. Accessed April 1, 2019.

[17] United States Department of Labor. Bureau of Labor Statistics. Occupational Employment and Wages, May 2017 – Psychiatrists.

University of Alaska Fairbanks offers Bachelor of Arts and Bachelor of Science in Psychology. None of the programs in Alaska offer focused coursework in forensic psychology.

The Alaska Psychology Internship Consortium supports paid internships for psychology students at the Alaska Psychiatric Institute. Interns can choose between the inpatient civil track and the forensic track. In an interview with a current API forensic psychologist, it was noted that all three forensic psychologists at API came to the facility through this internship program and that API probably would not have any forensic psychology staff without the program. The staff person noted that the program only brings up one intern per year and if there is not a vacant position for them or they do not want to stay in Alaska, it becomes challenging to retain a robust forensic psychology workforce.

Fellowships in forensic psychiatry are not available in Alaska.

Statutory Requirement for Evaluators

Requirements in Alaska for competency evaluators were the least well-defined of all states surveyed for this report. Alaska statue states:

> "**12.47.100 (b)** If, before imposition of sentence, the prosecuting attorney or the attorney for the defendant has reasonable cause to believe that the defendant is presently suffering from a mental disease or defect that causes the defendant to be unable to understand the proceedings or to assist in the person's own defense, the attorney may file a motion for a judicial determination of the competency of the defendant. Upon that motion, or upon its own motion, the court shall have the defendant examined by at least one qualified psychiatrist or psychologist, who shall report to the court concerning the competency of the defendant. For the purpose of the examination, the court may order the defendant committed for a reasonable period to a suitable hospital or other facility designated by the court. If the report of the psychiatrist or psychologist indicates that the defendant is incompetent, the court shall hold a hearing, upon due notice, at which evidence as to the competency of the defendant may be submitted, including that of the reporting psychiatrist or psychologist, and make appropriate findings. Before the hearing, the court shall, upon request of the prosecuting attorney, order the defendant to submit to an additional evaluation by a psychiatrist or psychologist designated by the prosecuting attorney."

Statute does not specify the need for continuing education or special certifications in forensic psychology or psychiatry.

Recommendations

Qualified psychiatrist and qualified psychologist are not defined in Alaska statute. All five states surveyed for this report provide more descriptive definitions of who can perform competency evaluations and most specify licensure as a requirement. In a review of Alaska mental health statutes, it was identified that Alaska statutes should be amended to add a requirement for evaluators to be neutral and to define qualified and neutral evaluators in statute.[18] The University of Nevada Las Vegas (UNLV) report provided recommendations to define neutral evaluators of competency:

[18] Gordon, Sara, Piasecki, Melissa, Kahn, Gil, Nielsen, Dawn. 2014. Review of Alaska Mental Health Statutes. University of Nevada Las Vegas.

> "Neutral evaluators should not be otherwise involved in either the individual's clinical treatment, or any subsequent restorative treatment. If a neutral evaluator later becomes involved in the individual's clinical treatment or restorative treatment, the statutes should require that subsequent evaluations be conducted by an additional, neutral evaluator."[19]

The UNLV report also provided recommendations to define qualified evaluators of competency:

> "A psychiatrist is a person who is licensed by the State Medical Board to practice in this state or is employed by the federal government, who has received additional training or certification in forensic psychiatry, and who is either board certified by the American Board of Psychiatry and Neurology in the subspecialty of forensic psychiatry or has received post-residency education and training specific to forensic psychiatry. A psychologist is a person who is licensed by the state Board of Psychologist and Psychological Associate Examiners. Moreover, AS § 12.47.130 and AS § 47.30.915 should require that any individual qualified to conduct a forensic examination under these statutes have forensic training and/or certification in performing competency…evaluations, including continuing education in forensic evaluations."[20]

The UNLV report is not the only report in recent years to recommend changes to the definitions of qualified psychiatrist and qualified psychologist. In an evaluation of forensic services at API, the Western Interstate Commission for Higher Education (WICHE) recommended that the definition be expanded to permit post-doctoral trainees and interns to conduct evaluations under the supervision of a qualified forensic evaluator.[21]

Employer-Specific Requirements for Forensic Staff

Job descriptions for current forensic-related positions at API do not include specifications for desired certifications, trainings, or ongoing continuing education requirements specific to forensic psychology.

Forensic Evaluator

The job description for the vacant Forensic Evaluator position at API (classified as a Mental Health Clinician III) identifies the following educational and licensing requirements:

- Doctoral degree in psychology; and
- Licensed or eligible to be licensed as a psychologist in the State of Alaska. Post-doctoral candidates who are eligible for a temporary license while obtaining supervised hours toward independent license will also be considered.

Additional qualifications include:

- Superior assessment, diagnostic and report-writing skills
- Excellent interpersonal skills and ability to communicate effectively, both orally and in writing, with judges, attorneys, and the public
- Familiarity with both severe mental illness and developmental disabilities

[19] Ibid.

[20] Gordon, Sara, Piasecki, Melissa, Kahn, Gil, Nielsen, Dawn. 2014. Review of Alaska Mental Health Statutes. University of Nevada Las Vegas.

[21] Fox, Patrick. 2016. Alaska Psychiatric Institute: Evaluation of Forensic Services. Western Interstate Commission for Higher Education.

- Ability to diagnose mental disorders consistent with the Diagnostic and Statistical Manual of Mental Disorders
- Ability to integrate clinical and factual data and with applicable legal standards
- Ability to administer and interpret psychological tests
- Knowledge of Alaska law regarding competency and culpability
- Ability to work effectively and in a professional manner when under stress and confronted with tight deadlines

Treatment Clinician

The job description for the vacant Clinician positions at API (classified as a Mental Health Clinician III) identifies the following educational and licensing requirements:

- Doctoral degree from an accredited college in psychology, social work, child guidance, nursing, vocational rehabilitation or closely related field; or,
- Master's degree from an accredited college in psychology, social work, child guidance, nursing, vocational rehabilitation or closely related field and four years of professional experience performing psychotherapeutic casework; and,
- Licensed as a psychologist or master's level practitioner in the State of Alaska (a post-doctoral psychologist must hold of have applied for a provisional psychology license).

Job Duties

Current Structure

Currently, API's forensic psychologists provide both competency evaluation and restoration treatment services.

The 2016 WICHE report identified concerns about the potential for conflicts of interest as the forensic evaluators also serve as members of the API's clinical team. There is a preference for separation of roles between forensic evaluators and forensic restoration clinicians. This concern may be addressed by the addition of a definition of a neutral evaluator into statute as defined above, or by using external forensic consultants to facilitate case reviews and oversight of API's forensic psychologists.[22] A conversation with one of API's forensic psychologists identified that with additional staffing, the team plans to form a treatment (clinical) team and an evaluation team, thus providing a more clear delineation of roles as recommended in the WICHE report.

Supervision + Oversight

Supervision and oversight of the forensic services team is provided by a Mental Health Clinician IV. In addition to supervision duties, this individual has historically carried a a restoration caseload and performed competency evaluations. The 2016 WICHE report identified the small team size and unavailability of additional diverse opinions as an area of concern. A recommendation was made to contract with forensic consultants from outside the API system to provide guidance and objective analysis to API's forensic team.[23]

[22] Fox, Patrick. 2016. Alaska Psychiatric Institute: Evaluation of Forensic Services. Western Interstate Commission for Higher Education.

[23] Fox, Patrick. 2016. Alaska Psychiatric Institute: Evaluation of Forensic Services. Western Interstate Commission for Higher Education.

Forensic Evaluator

Key responsibilities identified in the position description for the vacant Forensic Evaluator position include:

- Conduct court-ordered forensic evaluations at local correctional facilities and at API
- Diagnose mental disorders of criminal defendants
- Serve as an expert witness for the State of Alaska providing testimony regarding the psychological evaluation of defendants.
- Conduct both adult and juvenile forensic psychological assessments.
- This position may require occasional overnight travel to communities outside of the Anchorage area in order to provide in-person court testimony
- Provide clinical supervision to trainees

Treatment Clinician

Key responsibilities identified in the position description for the vacant Treatment Clinician position include:

- Serve as the clinical program manager on Taku, the hospital's 10-bed forensic unit.
- Provide individual and group treatment on an adult, forensic, in-patient psychiatric unit.
- Lead or co-facilitate at least three competency groups per day.
- Participate in interdisciplinary treatment process and assist in the identification of relevant treatment goals and evidence-based interventions.
- Maintain a therapeutic, trauma informed, milieu on the unit.
- Clinically interview patients to obtain background information, determine provisional diagnoses, and evaluate treatment needs.
- Assess patient risk for suicide, significant self-injury, or risk for violence.
- Provide individual therapy as indicated.
- Develop behavior plans, monitor the plan's implementation, and train staff as needed regarding interventions.
- Conduct adult psychological assessments and provide results to other treatment providers and treatment team members.
- Document assessments in a variety of formats.
- Provide training and support to members of other disciplines to increase their capacity for therapeutic interactions with patients.
- Provide supervision to graduate-level psychology students participating in either practicum or internship rotations at API.

Compensation

At the start of this project in November 2018, the only forensic psychologists in Alaska were employed by API, a state employer. In recent months, most of the forensic evaluations in Alaska have switched to contract-based services. Forensic psychologists conduct both competency evaluation and restoration treatment under the current system. Open job postings identify one position for a forensic psychologist evaluator and for multiple restoration treatment clinicians. The starting salary identified on the job postings

for both positions is $5,906 per month or $70,872 per year indicating that there is no pay differential for forensic evaluators versus individuals providing restoration treatment. Benefits include health insurance, employer paid basic life insurance, retirement benefits, personal leave, 11 paid holidays per year and gym discounts at participating fitness centers. Rates of compensation for contracted evaluators are unknown.

An interview with a current API forensic psychologist illuminated challenges with the current job classification system that could limit recruitment of forensic psychologists. Forensic psychologists are classified as Mental Health Clinician IIIs, which throughout the state are master's level clinicians, even though best practice for forensic evaluators requires a doctorate in psychology. The API forensic psychologist shared that master's level clinicians are qualified to provide restoration to competency treatment. However, the current job classification does not allow for more competitive pay for doctorate level evaluators than their master's level treatment counterparts.

Colorado

Employment Landscape

Data from the United States Department of Labor estimate the number of clinical, counseling and school psychologists in Colorado at 2,770.[24] The American Academy of Forensic Psychology identifies eight board certified forensic psychologists licensed to practice in Colorado.[25] There are 450 psychiatrists in Colorado, or approximately 7.9 psychiatrists per 100,000.[26] As detailed below, the estimated vacancy for key forensic staff include one forensic evaluator vacancy and eight restoration treatment vacancies.

Evaluation

The Colorado Office of Behavioral Heath Court Services Program provides statewide competency evaluations and opinions to the court regarding competency to proceed, and restoration to competency. The Court Services Program is made up of 45 psychologists and professional support staff. A review of Colorado Department of Human Services job vacancies identified one vacancy for a Psychologist I, Forensic Evaluator with the Court Services Program.

Restoration

Restoration services are offered via the Colorado Office of Behavioral Health's Outpatient Restoration Program, Jail-Based Evaluation and Restoration Program and inpatient psychiatric restoration at the Colorado Mental Health Institute at Pueblo. The Outpatient Restoration Program is offered by contracted educators throughout Colorado. Vacancies at the outpatient restoration program were not able to be identified at this time. The Director of Forensic Services identified that providers of outpatient restoration typically hold a bachelor's degree in criminal justice, education or a related field.

The Jail-Based Evaluation and Restoration Program (called RISE – Restoring Individuals Safely and Effectively) is housed in the Arapahoe County Detention Facility and services are provided by contracted vendor WellPath Recovery Solutions. It is a 96-bed facility. Current clinical job openings identified on the WellPath website include:

- Part-time psychiatrist (two vacancies)
- Licensed Master of Social Work (two vacancies)
- Psychologist

Current clinical job openings for provision of forensic restoration services at the Colorado Mental Health Institute Pueblo include an opening for a psychologist candidate and two vacancies for Psychologist I positions. The facility is a 449-bed hospital providing civil and forensic hospitalization.

Educational Institutions

There are at least five colleges and universities offering graduate degrees in Psychology in Colorado. The University of Denver offers a Master of Arts in Forensic Psychology and the University of Colorado – Colorado Springs offers an emphasis in Psychology and Law in its master's program. There are six

[24] United States Department of Labor. Bureau of Labor Statistics. Occupational Employment and Wages, May 2017 – Psychologists.

[25] American Academy of Forensic Psychology. Specialist Directory. https://aafp17.wildapricot.org/. Accessed April 1, 2019.

[26] United States Department of Labor. Bureau of Labor Statistics. Occupational Employment and Wages, May 2017 – Psychiatrists.

universities accredited by the American Psychological Association to offer doctoral programs in psychology. The Colorado Office of Behavioral Health Court Services Program contains a Postdoctoral Fellowship training program in Forensic Psychology that is recognized by the American Board of Forensic Psychology.

A fellowship program in forensic psychiatry is available through the University of Colorado.

Statutory Requirement for Evaluators

Colorado statute provides a definition for competency evaluators.

> "**16-8.5-101. Definitions** (2) "Competency evaluator" means a licensed physician who is a psychiatrist or a licensed psychologist, each of whom is trained in forensic competency assessments, or a psychiatrist who is in forensic training and practicing under the supervision of a psychiatrist with expertise in forensic psychiatry, or a psychologist who is in forensic training and is practicing under the supervision of a licensed psychologist with expertise in forensic psychology."

Employer-Specific Requirements for Forensic Staff

Forensic Evaluator

Minimum qualifications for the vacant Forensic Evaluator position with Colorado's Court Services Program include graduation from an accredited college or university with a doctorate degree in Psychology or a field qualifying for a license as a Psychologist, possession of an active Colorado Psychologist license and one year of post-doctoral experience as a practicing psychologist or psychologist candidate. A valid Colorado Drivers License is also required.

Preferred qualifications for the position include:

- Experience in conducting and writing evaluations of competency to proceed
- Experience or an interest in the clinical evaluation and/or treatment of juveniles and training in forensic assessments
- Experience evaluating chronically and pervasively mentally ill adults
- Experience working with mentally ill adults in one or more highly restrictive settings inpatient, residential, day treatment, intensive outpatient, jail)
- Experience working in a "fast-paced" office ensuring deadlines are being met
- Experience working with confidential medical information and obtaining proper authorization to release information
- Ability to work independently with little or no direction
- Clear and effective written and oral communication skills
- Ability to use independent judgment to accomplish tasks to meet deadlines

Treatment Clinician

Minimum qualifications for the vacant Psychologist I positions at the Colorado Mental Health Institute Pueblo include current, valid licensure as a psychologist from the Colorado State Board of Psychologist Examiners and one year of experience as a licensed psychologist or permitted psychologist candidate.

Minimum qualifications for the clinical positions at the Arapahoe County Detention Facility RISE program vary by type of position.

- Psychiatrist:
  - MD from an accredited university
  - At least one-year experience in clinical psychiatry
  - Licensed in the state of practice. Board certified or eligible in psychiatry
  - Successful completion of an accredited Psychiatry Residency
- Psychologist:
  - Doctorate in Psychology
  - Experience with mental health delivery systems and significant professional experience in the mental health field
  - Licensed to practice psychology in the State by the appropriate state licensing agency
- Licensed Master of Social Work:
  - Master's level degree in Social Work from an accredited college or university
  - Coursework and professional experience that indicates knowledge of mental health counseling, group and individual psychotherapy, assessment and treatment of major mental disorders, crisis intervention and mental health consultation
  - Currently licensed as a Master's Social Worker or Specialist Clinical Social Worker with the appropriate State Regulatory Board
  - Current CPR certification.

Job Duties

Forensic Evaluator

Key duties required of the candidate to fill the vacant Psychologist I, Forensic Evaluator position with Colorado's Court Services Program include:

- Assess defendants in a hospital setting, jail and other settings for competency to proceed in a criminal case. Regular in-state travel is expected;
- Prepare reports to courts;
- Provides testimony in court when directed to appear by a subpoena;
- Complete an average of 12 competency evaluations per month for full time;
- Participate in competency related in-service training annually, or as directed by the Court Services, and other training as required;
- Participates in other training required by CMHIP:
- Maintain licensure as a Psychologist in the State of Colorado;
- Performs other related job duties as assigned or required.

Inpatient Treatment Clinician

The job descriptions for the two, restoration treatment Psychologist I positions at the Colorado Mental Health Institute Pueblo require different duties. One position provides "treatment programming to inpatient psychiatric services in an intermediate to maximum security level unit consisting of ITP patients, NGRI patients and civil patients. This includes psychological assessments, psychosocial group and individual therapy

in the form of specific targeted behavioral interventions such as IBP's". The duties of the other position are to provide "psychological assessment, psychotherapeutic groups, individual psychotherapy, functional behavior analysis and specific interventions. The work includes selecting, administering and interpreting intelligence batteries, personality, neuropsychological and other psychological tests to diagnose disorders and formulate treatment plans, determining the need for involuntary mental health treatment; providing treatment and therapeutic intervention; conducting individual, group, and family rehabilitation activities; and completing various clinical and legal documents to track cases. Included is pre- and post-doctoral supervision of candidates for licensure, providing consultative services to other health care disciplines, providing expert testimony in court, and conducting program evaluation to determine the effectiveness of treatments for patient populations".

Jail-Based Treatment Clinician

The job duties for the vacant restoration treatment positions at the Arapahoe County Detention Facility RISE program vary by type of position.

- Psychiatrist: Assumes responsibility for the admission, continuing care, and discharge of patients. Our staff psychiatrist provides leadership to the multi-disciplinary treatment team and participates in performance improvement and other activities.
- Psychologist: Provide clinical mental health services to offenders/clients at correctional and detention facilities. Provides clinical supervision and direction to mental health professionals if any personnel are assigned to them. Provides mental health services consistent with expectations of professional training and experience.
- Master's Level Social Worker: Responsible to provide direct clinical and consultation services in accordance with the policies and procedures o the Facility/Unit, and in accordance with the ethics and standards of the National Association of Social Work.

Compensation

The three Psychologist I positions (two restoration treatment positions at Colorado Mental Health Institute Pueblo and one forensic evaluator position with the Court Services Program) are State of Colorado positions. The salary range for the open positions is $5,952 - $9,022 per month or $71,424 - $108,264 per year. The salary range for the Psychologist Candidate providing restoration treatment is slightly less at $5,486 - $8,316 per month or $65,832 - $99,792 per year. Benefits include retirement, medical and dental plans, paid life insurance, short and long-term disability coverage, vacation and sick leave, 10 paid holidays per year and the State of Colorado Work-Life Employee Discount Program.

Salary ranges for the WellPath positions at the Arapahoe County Detention Facility RISE program were not available on their job posting website. Benefits include medical, dental and vision insurance, flexible spending accounts, health savings account, supplemental insurance programs, paid time off, retirement plans, tuition reimbursement and college savings plans.

Connecticut

Employment Landscape

Numbers from the United States Department of Labor estimate the number of clinical, counseling and school psychologists in Connecticut at 1,680.[27] The American Academy of Forensic Psychology identifies four board certified forensic psychologists licensed to practice in Connecticut.[28] There are 630 psychiatrists in Connecticut, or approximately 17.6 psychiatrists per 100,000.[29]

Forensic psychiatric services in Connecticut are organized by the Department of Mental Health and Addiction Services Forensic Services Division. One of the primary goals is the decriminalization of mental illness, which they try to address through five major program components:

- Whiting Forensic Hospital: 91 maximum security beds and 138 enhanced security beds for individuals involved in the criminal justice system. This population includes some civilly committed patients, individuals adjudicated not guilty by reason of insanity and transfers from the Department of Corrections, as well as criminal court orders for restoration to competency to stand trial.
- Forensic Psychiatry Services: Risk management consultations to hospital and community providers to assure safe and viable treatment plans.
- Office of Forensic Evaluations: Licensed clinical social workers with specialized forensic training as well as consulting forensic psychologists and psychiatrists conduct five different types of evaluations including competence to stand trial and restoration to competence to stand trial evaluations. The office completes nearly 2000 evaluations per year, including 743 competency evaluations in 2018.
- Community Forensic Services: An array of nine programs with the overarching goals of jail diversion and reducing recidivism for individuals with mental health and substance use disorders who have had contact with the criminal justice system.
- Transitional Services: An array of four programs with the overarching goal of facilitating recovery and community re-entry for individuals with mental illness and substance use disorders who are leaving the correctional system and returning to the community.

A review of the Connecticut State Department of Administrative Services identified the following open positions in the Department of Mental Health and Addiction Services Forensic Services Division:

- Forensic Services Division Behavioral Health Clinical Manager
- Whiting Forensic Hospital, Principal Psychiatrist

Educational Institutions

There are at least nine colleges and universities offering graduate degrees in Psychology in Connecticut. None of the programs offer specializations in forensic psychology. There are three universities accredited by the American Psychological Association to offer doctoral programs in psychology.

A fellowship program in forensic psychiatry is available through Yale University.

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[27] United States Department of Labor. Bureau of Labor Statistics. Occupational Employment and Wages, May 2017 – Psychologists.

[28] American Academy of Forensic Psychology. Specialist Directory. https://aafp17.wildapricot.org/. Accessed April 1, 2019.

[29] United States Department of Labor. Bureau of Labor Statistics. Occupational Employment and Wages, May 2017 – Psychiatrists.

Statutory Requirement for Evaluators

Unlike other states surveyed for this report, Connecticut statute specifies that a psychiatrist or a clinical team consisting of a psychiatrist, psychologist, and licensed clinical social worker or psychiatric nurse must perform the forensic psychiatric evaluation.

> "**Sec. 54-56d. (d) Examination of defendant.** If the court finds that the request for an examination is justified and that, in accordance with procedures established by the judges of the Superior Court, there is probable cause to believe that the defendant has committed the crime for which the defendant is charged, the court shall order an examination of the defendant as to his or her competency. The court may (1) appoint one or more physicians specializing in psychiatry to examine the defendant, or (2) order the Commissioner of Mental Health and Addiction Services to conduct the examination either (A) by a clinical team consisting of a physician specializing in psychiatry, a clinical psychologist and one of the following: A clinical social worker licensed pursuant to chapter 383b or a psychiatric nurse clinical specialist holding a master's degree in nursing, or (B) by one or more physicians specializing in psychiatry, except that no employee of the Department of Mental Health and Addiction Services who has served as a member of a clinical team in the course of such employment for at least five years prior to October 1, 1995, shall be precluded from being appointed as a member of a clinical team. If the Commissioner of Mental Health and Addiction Services is ordered to conduct the examination, the commissioner shall select the members of the clinical team or the physician or physicians."

Employer-Specific Requirements for Forensic Staff

Forensic Evaluator

Forensic evaluators are employed by the Office of Forensic Evaluations. Evaluators must be licensed clinical social workers, psychologists or psychiatrists with specialized forensic training. There were no vacancies for evaluator positions at the time of this research, thus additional qualifications are unavailable. An interview with the Forensic Services Division Director identified that all evaluations are conducted on an outpatient basis. There are five court clinics in the state and each of them has a full-time social worker, two full-time or per diem psychologists and a statewide total of six to seven per diem psychiatrists, including psychiatrists on contract with the state from Yale University.

Treatment Clinician

Minimum qualifications for the Behavioral Health Clinical Manager position include: four years of professional experience in behavioral health care and a masters' degree in a clinical discipline, public health administration, health care administration or hospital administration; two years' experience supervising professional staff; and appropriate, current license for the degree held by the applicant.

Minimum qualifications for the Principal Psychiatrist include certification as a specialist in psychiatry by the American Board of Psychiatry and Neurology or board certification in Adult or Child and Adolescent Psychiatry, a license to practice medicine in Connecticut, and eligibility for participation in federal health care programs.

Job Duties

Forensic Evaluator

Forensic evaluators provide five types of evaluations:

- Competence to Stand Trial
- Substance dependency
- Pre-screening for a post-conviction/pre-sentencing diagnostic evaluation at Whiting Forensic Hospital
- Restoration to Competence to Stand Trial
- Reports to the Psychiatric Security Review Board

The Office of Forensic Evaluations completes nearly 2,000 evaluations per year included 743 competency to stand trial evaluations in 2018.

Treatment Clinicians

The vacant Forensic Services Division Behavioral Health Clinical Manager position is not a vacancy for restoration treatment services but is included in this report as an example of the duties performed by a manager within the Forensic Services Division. The primary responsibility of this position is to manage the Pretrial Alcohol Education Program (AEP) and Pretrial Drug Education Program (DEP), located within the Community Forensic Services component of the division.

"The selected candidate will provide training to program staff on evaluation, group curriculum, and program operation; collaboration with court; data submission; and quality improvement. The selected candidate will provide training to court staff on AEP/DEP; lead a multiagency workgroup to improve evaluation and service planning of program participants; develop and maintain budget, policies, procedures, quality improvement system; monitor performance of seven private agencies that provide evaluation and group services and three vendors that provide interpreter services; manage phone calls plus emails from clients, court staff, and attorneys; assist out of state clients with accessing appropriate programs to satisfy arrests in Connecticut; assist Connecticut residents with accessing appropriate programs in Connecticut to satisfy arrests out of state; monitor and advise the Commissioner's Office regarding legislative proposals that impact DUI and drug arrestees who use AEP/DEP; revise policies and procedures to respond to legislative changes; propose policy, protocol, and legislative changes to improve effectiveness and maintain financial viability of the programs."

The Principal Psychiatrist a Whiting Forensic Hospital performs the following duties:

"24 hour supervision to specified groups of patients and facility coverage as scheduled including on-call coverage and weekend coverage; makes rounds and provides direct care and clinical oversight of multi-disciplinary treatment teams; coordinates work of medical staff with related programs; reviews treatment plans, clinical records, diagnoses, and patient discharge plans for adherence to policies and/or The Joint Commission (TJC) and Health Care Financing Authority (HCFA) standards; provides education and training as indicated, oversees and evaluates work of staff and on-site night duty physicians and/or psychiatrists; conducts and/or participates in meetings on clinical and administrative policy, research programs, clinical program development and treatment techniques; assesses, examines and evaluates patients for admission or discharge; assesses, examines, diagnoses and prescribes appropriate medications and other biologic and psychosocial treatments for patients with psychiatric illnesses and substance abuse disorders; performs advanced level risk assessments; consults on difficult and/or complex cases; develops and implements QA

and/or QI process improvement initiatives; prepares and/or reviews reports, medical records and correspondence; performs utilization review and management functions; attends court hearings as a state witness; performs related duties as required."

Compensation

All evaluation and restoration services are provided by the Connecticut's Department of Mental Health and Addiction Services Forensic Services Division. There were no vacancies for evaluators at the time of this research, thus information on compensation for forensic evaluators was not available.

The salary range for the Behavioral Health Clinical Manager position was identified at $86,813-$118,362 per year. The salary range for the Principal Psychiatrist at Whiting Forensic Hospital was identified at $189,410-$225,912 per year. Job announcements noted that new State employees start at the minimum salary listed.

Benefits with the State of Connecticut include 12 paid holidays, accruing vacation, personal and sick leave, health and dental insurance, retirement plan, group life insurance, supplemental benefits (voluntary defined contribution plans, flexible spending accounts, supplemental benefits programs, life insurance), and State of Connecticut tuition reimbursement.[30]

In an interview, the Connecticut Forensic Services Division Director shared that the state job classification is the same for forensic and civil inpatient hospital employees. However, the state is able to offer a $10,000 per year bonus for individuals who are board certified in forensic psychology or psychiatry. The director shared that in recent years they have been lucky to have most of their key positions filled, but that in general the labor market is tight for psychologists and psychiatrist. The director also shared that the public sector does not pay as well as the private sector, noting that a private organization in Connecticut was recently able to offer a starting salary of $240,000 for an individual just finishing psychiatric residency. This is well above the state's starting salary for a psychiatrist of $189,410.

[30] State of Connecticut. General Employee Benefits. https://portal.ct.gov/DAS/smART/General-Employee-Benefits

Hawaii

Employment Landscape

Data from the United States Department of Labor estimate the number of clinical, counseling and school psychologists in Hawaii at 470.[31] The American Academy of Forensic Psychology identifies five board certified forensic psychologists licensed to practice in Hawaii.[32] There are 150 psychiatrists in Hawaii, or approximately 10.6 psychiatrists per 100,000.[33]

Forensic psychiatric services in Hawaii are provided by the State of Hawaii, Department of Health Adult Mental Health Division (AMHD). The department offers 11 different programs under forensic services in addition to inpatient competency restoration at Hawaii State Hospital. Mental health consultation and case management services are available through several different programs. Forensic coordinators provide consultation and liaison services regarding court related treatment and follow-up for persons receiving AMHD services who are also involved in the criminal justice system. Outpatient competency restoration and inpatient competency restoration are available statewide.

Forensic evaluations are provided through the AMHD Courts and Corrections Branch which employs six full-time psychologists who conduct evaluations for misdemeanor cases and are one of the three evaluators appointed in felony cases. The other two evaluators are community-based psychologists or psychiatrists from a list of approved competency evaluators.[34]

A review of employment opportunities within the Adult Mental Health Division identified the following vacancies for forensic services:

- Clinical Psychologist
- Psychiatrist, Hawaii State Hospital
- Forensic Coordinator, Hawaii State Hospital

Educational Institutions

There are at least four colleges and universities offering graduate degrees in Psychology in Hawaii. None of the programs offer specializations in forensic psychology. There are two universities accredited by the American Psychological Association to offer doctoral programs in psychology.

There are no forensic psychiatry fellowships in the state.

Hawaii's Adult Mental Health Board sponsors an annual, voluntary conference for forensic evaluators. A 2007 report to the Hawaii State Legislature recommended that AMHD establish a certification, training and oversight process for evaluators. Additionally, the report recommended funding for a Courts and Corrections Manager to oversee quality and timeliness of all examinations and reports, serve as the executive director of

[31] United States Department of Labor. Bureau of Labor Statistics. Occupational Employment and Wages, May 2017 – Psychologists.

[32] American Academy of Forensic Psychology. Specialist Directory. https://aafp17.wildapricot.org/. Accessed April 1, 2019.

[33] United States Department of Labor. Bureau of Labor Statistics. Occupational Employment and Wages, May 2017 – Psychiatrists.

[34] Robinson, R., Acklin, M. (2010). Fitness in paradise: Quality of forensic reports submitted to the Hawaii judiciary. International Journal of Law and Psychiatry. 10.1016/j.ijlp.2010.03.001.

the certification process, and provide annual training and relevant conferences to improve the quality of the services offered to the courts.[35] The current status of these recommendations is unknown.

Statutory Requirement for Evaluators

Hawaii requires three competency evaluators for felony cases, the most of any of the six states surveyed for this report. An excerpt from Hawaii statute regarding competency evaluations is as follows:

> "**704-404(2)** Upon suspension of further proceedings in the prosecution, the court shall appoint three qualified examiners in felony cases, and one qualified examiner in nonfelony cases, to examine and report upon the defendant's fitness to proceed. In felony cases, the court shall appoint as examiners at least one psychiatrist and at least one licensed psychologist. The third examiner may be a psychiatrist, licensed psychologist, or qualified physician. One of the three examiners shall be a psychiatrist or licensed psychologist designated by the director of health from within the department of health. In nonfelony cases, the court may appoint as examiners either a psychiatrist or a licensed psychologist. All examiners shall be appointed from a list of certified examiners as determined by the department of health. The court, in appropriate circumstances, may appoint an additional examiner or examiners. The examination may be conducted while the defendant is in custody or on release or, in the court's discretion, when necessary the court may order the defendant to be committed to a hospital or other suitable facility for the purpose of the examination for a period not exceeding thirty days, or a longer period as the court determines to be necessary for the purpose. The court may direct that one or more qualified physicians or psychologists retained by the defendant be permitted to witness the examination. As used in this section, the term "licensed psychologist" includes psychologists exempted from licensure by section 465-3(a)(3) and "qualified physician" means a physician qualified by the court for the specific evaluation ordered."

A 2007 report to Hawaii's state legislature identified that a task force convened to make changes to the state's system for forensic psychiatric system discussed changes to the number of evaluators required for cases involving felonies. Statute at the time, and current statute in Hawaii require three evaluators, the most required in the six states surveyed for this report. The task force did not reach a consensus on reducing the number of evaluators required for felony cases and as such did not put forth any recommendations on the topic.[36]

Employer Specific Requirements for Forensic Staff

Forensic Evaluator

The State of Hawaii, Department of Health Adult Mental Health Division, Courts and Corrections Branch maintain a list of certified competency examiners for the judiciary. There were no vacancies for evaluator positions at the time of this research, thus additional qualifications are unavailable.

[35] State of Hawaii, Department of Health, Adult Mental Health Division (2007). *Report to the Twenty-Fourth Legislature State of Hawaii.*

[36] State of Hawaii, Department of Health, Adult Mental Health Division (2007). *Report to the Twenty-Fourth Legislature State of Hawaii.*

Treatment Clinician

The vacant Forensic Services Clinical Psychologist position requires either:

a. Successful completion of all requirements for a doctoral degree from an accredited college in clinical psychology which included an internship in clinical psychology (one year of professional work experience in clinical psychology may substitute in lieu of internship requirement),
b. Successful completion of all requirements for a doctoral degree from an accredited college in a specialty related to clinical psychology which included an internship in clinical psychology or supplemented by a post-doctoral clinical internship (one year of professional work experience in clinical psychology may substitute in lieu of internship requirement),
c. A doctoral degree from a training program approved by the American Psychological Association or holds from a regionally accredited institution of higher education and meets experiential requirements for inclusion in the National Register of Health Service Providers in Psychology.
d. Holds a diplomate certification in good standing granted by the American Board of Examiners in Profession Psychology, or
e. A valid license to practice psychology in the State of Hawaii.

Within two years, the individual must meet the requirements for licensure and obtain a license from the Hawaii State Board of Psychology.

The vacant Psychiatrist position at Hawaii State Hospital requires:

a. Education: Graduate of an approved medical school in the United States or Canada or graduate of a foreign medical school and certification by the Education Council of Foreign Medical Graduates. Completion of one year of approved internship and three years of psychiatric residency training. Board certification or meets the criteria to sit for the examination of the American Board of Psychiatry and Neurology.
b. Experience: One-year experience in working with individuals who are hospitalized in a forensic setting or one year of experience in psychiatry or one year of additional post graduate training appropriate to the position is preferred.
c. License: Valid Permanent or Temporary license to practice medicine in the State of Hawaii. Valid State of Hawaii Narcotics Enforcement Administration Registration and Federal Drug Enforcement Administration Registration.

The vacant Forensic Coordinator position at Hawaii State Hospital requires:

a. Education: A Doctoral degree in clinical psychology, preferably from a university with an American Psychological Association (APA) accredited program and preferably completion of an APA accredited internship
b. Experience: Two years' experience interacting with Quality Management and Utilization Management or Behavioral Health Managed Care with knowledge of community case management interventions
c. License: Licensed in accordance with Hawaii Revised Statutes, Chapter 465-7.6

Job Duties

Forensic Evaluator

There were no vacancies for evaluator positions at the time of this report, but a description of Court Ordered Forensic Evaluation Services provided insight in to the expectations for this position. Responsibilities for statewide court ordered evaluations include:

- Examination of mental disease, disorder or defect
- Fitness to proceed
- Penal responsibility
- Risk assessments
- Examination of mental condition to assist in the court's disposition of an application for discharge
- Evaluations of juveniles in Family Court
- Preparation of relevant reports
- Testimony in support of court ordered evaluations.[37]

Treatment Clinicians

The Forensic Services Clinical Psychologist provides consultation and liaison services to treatment teams and criminal justice agencies, evaluates and monitors consumers with serious mental illness and criminal justice involvement regarding their risk level, engagement with treatment planning and adherence to court ordered conditions and provides recommendations regarding risk management and reduction strategies to support an individual's maintenance in the community.

The Psychiatrist at Hawaii State Hospital provides clinical and consultative psychiatric services for a variety of service programs and provides clinical guidance to members of interdisciplinary teams.

The Forensic Coordinator position at Hawaii State Hospital coordinates forensic referrals and tracking of forensic patients. This position also serves as a liaison to the Adult Mental Health Division Forensic Director and works with the Hawaii State Hospital-assigned attorney to facilitate timeliness and effectiveness of forensic discharge. This position develops, implements and refines programs specific to the needs of forensic patients and serves as a consultant to the hospital treatment teams.

Compensation

Most forensic services providers are employees of the State of Hawaii. Salary and benefit information for vacant positions were not identified on the position vacancies. The community-based evaluators for felony competency evaluators are selected from an approved list and are proved compensation on a per-evaluation basis. A 2007 report to the State of Hawaii Legislature identified that at that time each community-based evaluator received $500 per evaluation and travel costs to neighbor islands are not reimbursed. The report recommended that the rate per evaluation be increased to $1,000 and that travel costs be reimbursed.[38] Current compensation for community-based evaluators is unknown.

[37] Adult Mental Health Division. Array of Services by County. Updated December 15, 2017. https://health.hawaii.gov/amhd/files/2013/06/AMHD-Array-of-Services.pdf

[38] State of Hawaii, Department of Health, Adult Mental Health Division (2007). *Report to the Twenty-Fourth Legislature State of Hawaii.*

Utah

Employment Landscape

Data from the United States Department of Labor estimate the number of clinical, counseling and school psychologists in Utah at 1,450.[39] The American Academy of Forensic Psychology identifies three board certified forensic psychologists licensed to practice in Utah.[40] The United States Department of Labor does not identify the number of psychiatrists in Utah.

Forensic psychiatric services are provided by the Utah Department of Human Services which hires contracted competency evaluators, operates two jail-based restoration programs – a scattered site Outreach Restoration Program and a Jail-Based Competency Restoration Unit at the Salt Lake Metro Jail – and operates an inpatient competency restoration program at Utah State Hospital. Forensic services at Utah State Hospital primarily serve individuals committed for competency restoration in their four-unit, 124 bed building. Forensic services also provides treatment to individuals adjudicated as Guilty but Mentally Ill and a small number of Not Guilty by Reason of Insanity individuals. Utah State Hospital also provides pediatric services (three units, 72 beds) and five units (152 total beds) for adults.[41]

The superintendent of Utah State Hospital shared that hiring for key staff positions can be challenging. The hospital is generally able to hire social workers, but it takes 6-12 months to hire psychologists and about the same time to hire a psychiatrist, although they have been lucky to have minimal psychiatric vacancies. The hospital experiences a shortage of LPNs and a high turnover rate in their psychiatric technician positions.

A review of employment vacancies for the State of Utah identified the following vacancies:

- Psychologist, Competency Evaluation (two vacancies)
- Psychologist, Jail-based Restoration Program
- Licensed Clinical Therapist, Jail-based Restoration Program

Educational Institutions

There are at least four colleges and universities offering graduate degrees in Psychology in Utah. None of the programs offer specializations in forensic psychology. There are three universities accredited by the American Psychological Association offering doctoral programs in psychology.

There are no forensic psychiatry fellowship programs in Utah.

In March of 2018 the Utah Mental Health Counselors Association partnered with the National Board of Forensic Evaluators to offer a forensic mental health evaluator certification training for all licensed mental health professionals interested in working in the area of forensic mental health, including competency evaluations.

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[39] United States Department of Labor. Bureau of Labor Statistics. Occupational Employment and Wages, May 2017 – Psychologists.

[40] American Academy of Forensic Psychology. Specialist Directory. https://aafp17.wildapricot.org/. Accessed April 1, 2019.

[41] Utah Department of Human Services. Utah State Hospital. Treatment Programs. https://ush.utah.gov/treatment-programs/#forensic.

Statutory Requirement for Evaluators

The Utah State statute's definition of forensic evaluator expressly prohibits the evaluator from being involved in the defendant's mental health treatment. Defendants with misdemeanor charges and some non-capital felony charges require just one evaluator, while two evaluators are required for all defendants charged with capital felonies.

> "**77-15-2 Definitions. (4)** "Forensic evaluator" means a licensed mental health professional who is:
>
> a. Not involved in the defendant's treatment; and
> b. Trained and qualified by the Department of Human Services to conduct a competency evaluation, a restoration screening, and a progress toward competency evaluation."
>
> "**77-15-5. (f)** if the court finds that the allegations raise a bona fide doubt as to the defendant's competency to stand trial, shall order:
>
> a. The department to have the defendant evaluated by one forensic evaluator, if:
>
> i. The most severe charge against the defendant is a misdemeanor; or
> ii. The defendant is charged with a felony but is not charged with a capital felony, and the court determines, based upon the allegations in the petition, that a second competency evaluation is not necessary
>
> b. The department to have the defendant evaluated by two forensic evaluators, if:
>
> i. The defendant is charged with a capital felony; or
> ii. The defendant is charged with a felony but is not charged with a capital felony and the court determines, based upon the allegations in the petition, that a second competency evaluation is necessary; and
>
> c. The defendant to be evaluated by an addition forensic evaluator, if requested by a party, who shall:
>
> i. Select the additional forensic evaluator; and
> ii. Pay for the costs of the additional forensic evaluator"

Employer-Specific Requirements for Forensic Staff

Utah contracts with providers to conduct competency evaluations. In general, the contractors are psychologists or doctoral level social workers. Utah hopes to move towards hiring their own psychologists to do initial evaluations to be able to build in more accountability and training into the position. Psychologists working at the inpatient facility complete two to three follow-up evaluations for the court each week.

Requirements for the Licensed Clinical Therapist position at the Jail-Based Restoration Program include being a Certified Social Worker with a master's degree or a Licensed Clinical Social Worker.

The ideal candidate for the Outreach and Jail-Based Restoration Programs Psychologist position and the Forensic Evaluator Psychologist position is someone who graduated with a doctorate in clinical or counseling psychology, is licensed as a psychologist in Utah or is working towards licensure and has at least one year of experience conducting forensic evaluations. For individuals working towards licensure for these positions,

they may be filled at the Psychological Assistant II level who must work under the direction of a licensed clinician.

Job Duties

The primary duties of the Licensed Clinical Therapist for the Jail-Based Restoration Program include:

- preparing mental health assessments and evaluating the needs of patients.
- conducting individual and group therapy sessions.
- keeping detailed and accurate patient records.
- working closely with a multidisciplinary team to achieve treatment plan objectives.
- acting as an expert witness, giving testimony in court hearings as necessary.

The primary duties of the Outreach and Jail-Based Restoration Program Psychologist and the Forensic Evaluator Psychologist positions include:

- Assess, opine, and generate reports on competence to proceed, (UCA 77-15-5), Guilty with Mental Illness (UCA 77-16a-103), diminished capacity (UCA 77-16a-301), and malingering
- Select, administer, and interpret psychological tests and other psychological training and assessments
- Complete administrative paperwork
- Report results, findings and/or recommendations
- Act as an expert witness. Give testimony and /or recommendations in court cases and/or hearings
- Consult with members of a cross-disciplinary team to discuss new or unusual situations, findings, options, and recommendations on client/patient cases
- Although this position has no supervisory responsibilities, the individual may mentor Psychology Interns, or Post Doc Fellows

Compensation

Compensation for the Licensed Clinical Therapist with the Jail-Based Restoration program is $20.43 - $30.64 per hour ($42,494.40-$63,731.2 per year) for a Certified Social Worker and $21.43 - $32.21 per hour ($44,574.40-$66,996.80 per year) for a Licensed Clinical Social Worker. The salary range for the Psychologist with the Outreach and Jail-Based Restoration Programs and for the Forensic Evaluator Psychologist position is $27.16-$46.72 per hour ($56,492.80-$97,177.60 per year).

The superintendent of Utah State Hospital shared that there is a $4,000 hiring bonus for nurses and that the facility is working to decrease turnover of psychiatric technicians by offering free meals to these staff members and thinking creatively to identify other ways to stabilize this workforce.

Benefits with the State of Utah include medical, dental, life and long-term disability insurance, a retirement plan and paid leave which includes annual, sick and holiday pay. Annual and sick leave starts at 104 hours per year for new state employees and there are 11 paid holidays.

Washington

Employment Landscape

Data from the United States Department of Labor estimate the number of clinical, counseling and school psychologists in Washington at 2,160.[42] The American Academy of Forensic Psychology identifies ten board certified forensic psychologists licensed to practice in Washington.[43] The United States Department of Labor identified 540 psychologists practicing in Washington, or 7.2 per 100,000.

Following the Trueblood v. Washington State Department of Social and Health Services decision in 2016 the state created the Office of Forensic Mental Health Services (OFMHS), a division of the Behavioral Health Administration of the Department of Social and Health Services. The purpose of the office is to provide leadership and management of the forensic mental health system in the state. OFMHS coordinates the following programs: diversion, triage, competency evaluations, competency restoration treatment, Not Guilty by Reason of Insanity (NGRI) assessment and treatment, Quality Improvement Team, and workforce development and training.

A review of the state employment website identified the following openings within OFMHS:

- Psychologist, Forensic Evaluator (multiple vacancies; number not specified)
- Psychologist, Western State Hospital – Forensic and Community Mental Health
- Psychologist, Western State Hospital – Ft. Steliacoom Competency Restoration Program
- Psychologist, Western State Hospital – Treatment Team, NGRI
- Psychologist, Eastern State Hospital – Treatment Team, NGRI
- Psychiatrist, Eastern State Hospital (multiple vacancies; number not specified)
- Forensic Evaluator Supervisor

Additionally, in February 2018 OFMHS released a Request for Information (RFI) from individuals interested in providing forensic evaluations on a contract basis. The February RFI identified the notice had originally been released in February and August 2017 and was being re-released due to limited responses to the first two RFIs.[44]

A 2014 report found that Washington did not employ enough evaluators to conduct all the evaluations requested.[45] A follow up report released in 2017 identified that the state had increased evaluation capacity by 45 percent by hiring 13 additional evaluators.[46] A 2017 report on state hospital clinical staff identified shortages across all job classes, noting particularly acute shortages for nursing and psychiatry staff.[47]

Educational Institutions

[42] United States Department of Labor. Bureau of Labor Statistics. Occupational Employment and Wages, May 2017 – Psychologists.

[43] American Academy of Forensic Psychology. Specialist Directory. https://aafp17.wildapricot.org/. Accessed April 1, 2019.

[44] State of Washington. Department of Social and Health Services. Behavioral Health Administration. Office of Forensic Mental Health Services. *Request for Information #1830-683 (Reissued) Forensic Evaluation Services*. February 2018.

[45] Groundswell Services, Inc. (2014). Forensic Mental Health Consultant Review Final Report.

[46] Groundswell Services, Inc. (2017). Analysis of Current Washington Competency Restoration Services.

[47] Behavioral Health Administration. (2017). Report to the Legislature: State Hospital Clinical Staffing Model Financial Analysis.

There are at least eight colleges and universities offering graduate degrees in Psychology in Washington. None of the programs offer specialization in forensic psychology. There are five universities accredited by the American Psychological Association offering doctoral programs in psychology.

There are no forensic psychiatry fellowship programs in Washington.

Statutory Requirement for Evaluators

Washington statute provides a definition for who may perform forensic evaluations (psychiatrist, psychologist or a master's level social worker) and only one evaluator is needed regardless of the type of charge.

> "**10.77.010 Definitions** (18) "Professional person" means:
>
> a. A psychiatrist licensed as a physician and surgeon in this state who has, in addition, completed three years of graduate training in psychiatry in a program approved by the American medical association or the American osteopathic association and is certified or eligible to be certified by the American board of psychiatry and neurology or the American osteopathic board of neurology and psychiatry;
>
> b. A psychologist licensed as a psychologist pursuant to chapter 18.83 RCW; or
>
> c. A social worker with a master's or further advanced degree from a social work educational program accredited and approved as provided in RCW 18.320.010."
>
> "**10.77.073 Competency to stand trial – Evaluation – Appointment of qualified expert or professional person.** (2) Appointment of a qualified expert or professional person under this section must be from a list of qualified experts or professional persons assembled with participation by representatives of the prosecuting attorney and the defense bar of the county. The qualified expert or professional person shall complete an evaluation and report that includes the components specified in RCW 10.77.060(3)."

Employer-Specific Requirements for Forensic Staff

Forensic Evaluator

The qualifications for the Psychologist, Forensic Evaluator at OFMHS position include a doctoral degree in psychology from an accredited school or department of psychology, an active license to practice as a psychologist in Washington and successful completion of a pre-doctoral internship accredited by the American Psychological Association. The qualifications for the Forensic and Community Mental Health Psychologist are a doctorate in psychology and licensure or eligibility for licensure in Washington.

In addition to the educational qualifications – a doctoral degree in psychology from an accredited school or department of psychology, an active license to practice as a psychologist in Washington and successful completion of a pre-doctoral internship accredited by the American Psychological Association – the Forensic Evaluator Supervisor must also possess experience as a forensic evaluator, supervisory skills and experience and the ability to teach evidence-based psychological practices.

Treatment Clinician

The qualifications for the psychologist positions at the Ft. Steliacoom Restoration Program and the vacant positions with the NGRI treatment teams include a doctoral degree in psychology from an American Psychological Association accredited program and a license or license eligibility in the State of Washington.

The qualifications for the psychiatrist positions at Eastern State Hospital include a valid license to practice medicine in Washington State, eligibility for certification by the America Board of Psychiatry and Neurology, strong psychopharmacology skills and the ability to work collaboratively with other professionals.

Job Duties

A 2014 report on forensic mental health services identified that forensic evaluators in Washington are expected to complete nine to 11 evaluations per month, or 99 to 121 per year. The report identified these targets as "ambitious but generally reasonable".[48] It is unknown if these targets remain the same today.

Forensic Evaluator

The Psychologist, Forensic Evaluator at OFMHS performs the following duties:

- Conducts forensic competency to stand trial and mental state at the time of the offense evaluations for the courts of Washington State.
- Interviews pretrial defendants in custody and in the community and collaterals.
- Collects data such as treatment, education, criminal and social histories; objectively synthesizes and weighs all historical information available.
- Performs relative case specific psychological, medical and legal research as necessary.
- Administers, scores, interprets and reports the results of psychological testing.
- Submits forensic evaluations to the court.
- Analyzes relevant data and facts to formulate opinions to questions posed in a court order.
- Prepares for and provides expert witness testimony regarding forensic evaluations or as requested or subpoenaed by the courts.

The duties of the OFMHS Forensic Evaluator Supervisor are to:

- Provide ongoing clinical and management supervision of Psychologist-Forensic Evaluators conducting competency to stand trial and mental state at the time of offense evaluations.
- Assign job duties and distribute workload to ensure appropriate use of resources and effective performance of duties in support of the mission, goals and operations of OFMHS.
- Ensure Psychologist-Forensic Evaluator staff maintain appropriate standards of care and are meeting performance standards.
- Complete annual staff performance evaluations and conduct supplementary performance evaluations as needed. Respond to work performance and human resource issues to include addressing performance counseling, corrective action plans and discipline when appropriate.
- Develop, implement and monitor practice improvement initiatives for forensic evaluation services. Develop action plans, track progress and provide reports and presentations.
- Communicate regularly and in-person with subordinate staff to ensure that information provided by OFMHS and BHA leadership is communicated.
- Work with OFMHS Workforce Development Administrator and Quality Manager to develop and implement a forensic evaluation quality assurance program. Provide oversight of the program, train and coach staff, provide routine and ad-hoc reports. Monitor performance and quality

[48] Groundswell Services, Inc. (2014). Forensic Mental Health Consultant Review Final Report.

measurements and data, develop and monitor action plans resulting from analysis of the performance and quality measurements and data.

- Participate in OFMHS management team meetings and lead management team initiatives as assigned. Participate on OFMHS committees and workgroups as assigned.
- Schedule, set agendas and chair meetings for Psychologist-Forensic Evaluator staff.
- Provide leadership and clinical support to OFMHS.
- Coordinate and participate in the hiring process for Psychologist-Forensic Evaluators.
- Complete forensic evaluations as required to demonstrate mastery, knowledge and expertise.

While located at Western State Hospital, the vacant Psychologist position in Forensic and Community Mental Health is primarily an assessment position. This psychologist conducts risk assessments for patients and provides opinions regarding placement and treatment readiness, evaluations for civil commitment, conditional release and less restrictive orders and provides psychological evaluations. This individual also participates in training and mentoring activities and may supervise pre-and post-doctoral students.

Treatment Clinician

The duties of the psychologist at the Ft. Steliacoom Competency Restoration Program at Western State Hospital include:

- Serving as the psychological consultant to the Interdisciplinary team
- Providing consultation professional and direct care staff
- Facilitating the treatment planning process
- Directing psychosocial rehabilitation/Behavioral programming and Breaking Barriers programming
- Conducting psychological evaluations, as needed and comprehensive functional assessments
- Communicating with OFMHS Forensic Evaluators regarding patients' barriers to competency
- Attending and actively participating in treatment team and other programming related meetings.

The duties of the psychologist with the NGRI treatment team at both Western State Hospital and Eastern State Hospital include:

- Leading the Treatment Team staff in the process of case formulation as it relates to public safety risk and risk management planning for up to 30 NGRI patients;
- Assessing the appropriateness of NGRI patients for privileges and liberties by using evidence-based risk assessment methodology;
- Auditing aspects of the NGRI program in relation to the requirements of BHA forensic policies;
- Providing consultation and training to professional and treatment staff;
- Ensuring all documentation is completed in a timely manner; and
- Participating in clinical staff meetings and others as necessary.

The psychiatrist at Eastern State Hospital provides psychiatric care on all three wards of the hospital (Forensic, Adult and Geropsychiatric). This individual certifies medical necessity for a hospital level of care, prescribes and reviews medication, assesses the patient's response to treatment and develops a release plan or justification for continued inpatient status.

Compensation

A 2014 report identified that the existing salary structure in Washington State for forensic psychologists and psychiatrists was likely too low, given the specialized skills and training needed for these positions but did not specify what the compensation rate for these positions was or propose a revised pay scale. The report also identified that one county in Washington hired independent evaluators for $800 per evaluation, a rate the report noted was well below the market rate.[49] The report did not identify a recommended salary or per evaluation fee for state employed or contracted staff and it is unknown if increases in compensation have occurred since the report's publication. The 2018 RFI for contract forensic evaluators did not identify a per evaluation fee and instead asked individuals responding to the RFI to provide a per evaluation cost estimate.

Compensation for the Psychologist, Forensic Evaluator position with OFMHS ranges from $90,000-$115,200 per year. The Forensic and Community Mental Health Psychologist, Ft. Steliacoom Competency Restoration Program Psychologists, and NGRI Treatment Team Psychologist positions are all classified as "Psychologist 4" positions and the salary range is the same for each position at $79,548-$104,400 per year. The forensic Evaluator Supervisor position within OFMHS is salaried at $106,750-$121,452 per year.

Compensation for the Psychiatrist position at Eastern State Hospital is $222,192 plus 1.25 times regular pay for voluntary on-call hours. The Washington Department of Social and Health Services offers the following benefits for medical professionals: Relocation assistance; comprehensive medical, dental, vision and pharmacy plans, annual CME allowance, paid malpractice insurance; five-year retirement vestment, and student loan repayment programs.

[49] Groundswell Services, Inc. (2014). Forensic Mental Health Consultant Review Final Report.

Appendix F: Data Tracking + System Monitoring

Table of Contents

Overview

A 50-state survey of practices related to individuals with serious mental illness who commit major crimes found nationwide deficiencies in data collection for this population. The survey found that states capture data at point of entry to corrections, mental health and community systems, but do not track individuals as they move through these systems. Thus, data cannot be compared between systems to measure outcomes or effectiveness of practices. The report recommends state and local governments mandate data collection and analysis to track longitudinal outcomes, understand how individuals interact with the various mental health and correctional systems, evaluate program efficacy and better coordinate care across systems.[1]

Data Tracking Systems

Data tracking within and across entities involved in the forensic psychiatric system was identified as a gap across all six states surveyed for this study. A standardized platform for data collection that could be adopted in Alaska based on proven effectiveness in other states was not identified. In all states surveyed, none had a robust system in place to track individuals between the behavioral health system, correctional system, and court system. States are in various stages of development of data tracking and sharing. Some states, such as Colorado and Washington, received direction from lawsuit settlement agreements regarding data tracking, while other states use memoranda of agreement (MOA) or releases of information (ROI) to share information among entities.

While a data tracking system was not identified, reports and studies from other states provide guidance for the type of information a data tracking and reporting system should collect. Specific data points are identified below, but typically include some combination of demographic, clinical and outcome information for the forensic psychiatric population.

Annual Reporting

Connecticut and Hawaii have annual reports that compile various data points on the forensic psychiatric population that are shared with the legislature and other stakeholders. Utah published a one-page data dashboard that summarizes key data points related to the forensic psychiatric population. Alaska does not have any sort of routine reporting system.

[1] Torrey, E.F., Dailey, L., Lamb, H.R., Sinclair, E., Snook, J. (2017). *Treat or Repeat: A State Survey of Serious Mental Illness, Major Crimes and Community Treatment*. Treatment Advocacy Center. https://www.treatmentadvocacycenter.org/treat-or-repeat.

CALIFORNIA SNAPSHOT

While not included as one of the states profiled in the Case Study Appendix, research identified California as a model state for data tracking for the forensic psychiatric population. The California Department of State Hospitals conducted a literature review to identify meaningful clinical outcomes to track for state hospital patients, including those found incompetent to stand trial and in need of restoration. The information is collected and provided to the state's legislature in an annual report with the following information presented:

- Description of legal class, legal class requirements and legal statutes for discharge;
- Discharge data;
- Restoration and/or release data;
- Length of stay data for discharges; and,
- Re-admission data.

Like other states profiled, data collection for this population comes from a variety of sources and there are limited opportunities for data collection across systems. Unlike other states, California uses resources available through the Department of State Health's Data Management Office to manually compile patient level data across data collection systems, providing a more robust dataset for analysis.

Sources: Torrey, E.F., Dailey, L., Lamb, H.R., Sinclair, E., Snook, J. (2017). *Treat or Repeat: A State Survey of Serious Mental Illness, Major Crimes and Community Treatment*. Treatment Advocacy Center. https://www.treatmentadvocacycenter.org/treat-or-repeat; and California Department of State Hospitals. (2018). Report on Measures of Patient Outcomes: Supplemental Report to the Legislature.

Recommendations + Implementation Plan for Alaska Data Tracking + System Monitoring

After review of reports and recommendations in other states, current data collection activities in Alaska, and data needs identified through the course of this study, the following table of data points was created. Items in bold reflect a need for action beyond routine data entry and analysis.

Data Point	Reporting Timeframe	Collection Method	Action Needed
Number waiting at each stage of restoration process (evaluation, court decision, restoration bed)	**Weekly**	**Tuesday Report**	**Excel or other system to track totals**
Number of evaluations ordered	**Monthly**	**Tuesday Report**	**Excel or other system to track totals**
Number of evaluations completed per evaluator and total	Monthly	SPSS Face sheet	Routine entry + analysis
Length of wait at each stage (evaluation, **court decision**, restoration bed)	Quarterly	SPSS Face sheet	Routine entry + analysis; **Add a line for date of ruling on evaluation to Facesheet**
Location waiting for evaluation, location waiting for admission	**Quarterly**	**SPSS Face sheet**	**Add to Facesheet**
Originating court, district and city of charge	Quarterly	SPSS Face sheet	**Add originating court to Facesheet**
Highest charge	Quarterly	SPSS Face sheet	Routine entry + analysis
Judge ordering evaluation	Quarterly	SPSS Face sheet	Routine entry + analysis
Evaluator opinion + judge ruling	Quarterly	SPSS Face sheet	Routine entry + analysis
Sell sought, Sell granted	Quarterly	SPSS Face sheet	Routine entry + analysis
Number restored + deemed not restorable	Quarterly	SPSS Face sheet	Routine entry + analysis
Final opinion + final disposition	Quarterly	SPSS Face sheet	Routine entry + analysis
Discharge setting (specify organization)	**Quarterly**	**SPSS Face sheet**	**Add to Facesheet**
Homelessness status at intake + discharge	**Quarterly**	**SPSS Face sheet**	**Add to Facesheet**
Length of time for restoration	Annually	SPSS Face sheet	Routine entry + analysis
Total forensic admissions and discharges in the previous fiscal year	Annually	Meditech	Routine entry + analysis
Demographic characteristics: Age, Race, Sex, Diagnosis Type, Problem Category	Annually	SPSS Face sheet	Routine entry + analysis
Total number of evaluations per unique client	Annually	SPSS Face sheet	Routine entry + analysis
Number of prior forensic restoration admissions	Annually	Meditech	Routine entry + analysis
Number of prior civil commitment admissions	Annually	Meditech	Routine entry + analysis

Alaska

The following table provides an overview of the data sources used to draw conclusions about the demand for forensic evaluations and restoration. We relied on three point-in-time counts from the Alaska Psychiatric Institute (API) Tuesday reports for statewide information on overall number of individuals involved in the competency process. We also compiled one year of weekly Tuesday reports (2018) from the API Taku unit to provide descriptive statistics about those involved in the competency process.

In Phase II of this study, we received data from API's new SPSS system for calendar years 2016 to 2018. Data entry for this time period could not be confirmed as complete as files were still being located and entered. Additionally, we received three years of data from the Anchorage Competency Court calendar, which provides detailed information on those served by the Anchorage courts. In some cases, the Anchorage data is inconsistent with the API Tuesday report data. At the time of this report, the consultant team relied on hand counts conducted by API staff to identify the number of individuals waiting at each stage of the competency process from restoration through evaluation as well as the number of evaluations completed by API psychologists in each calendar year.

Figure 1: Data Sources

Data Source	Information Provided	Limitations
API Meditech	For individuals admitted for restoration: • Number Admitted + Discharged • Diagnosis • Demographics • Length of Stay	Only captures information for patients admitted for restoration.
Anchorage Court Competency Calendar Spreadsheet	For individuals with a court order from an Anchorage court for competency evaluation: • Days waiting for evaluation • Court finding + case disposition • Type of charge • Days waiting for restoration bed • Judge who ordered the evaluation • Age	Only for Anchorage. Missing data and data points not always recorded in a consistent manner.
Forensic Psychologist Counts	Number of competency evaluations completed by API forensic psychologist.	Must be hand counted. No digitized record of the number of evaluations completed.
API Tuesday Reports	Spreadsheet of individuals at multiple points in the competency process: • Age + Sex • Originating Court • Waiting location • Type of charge • Days waiting for evaluation • Days waiting for court order • Days waiting for restoration bed • Evaluator opinion	Tuesday reports are only kept in hard copy and must be entered by hand for analysis. Missing data and data points not recorded in a consistent manner.

Data Source	Information Provided	Limitations
API SPSS Reports	Statistical analysis software used to capture: • Age + Sex • Type of charge • Days waiting for evaluation • Days waiting for court order • Days waiting for restoration bed • Evaluator opinion • Diagnosis type • Sell hearings • Outcome of restoration	New database still in development. Prior records in the process of being entered, so current data set may be incomplete.

API is working to improve data collection and data entry through the development of a face sheet and corresponding SPSS database. An intern is currently working to enter data from past evaluation and restoration defendants into the database. The Alaska Court System hired an Administrative Program Manager to improve data collection and competency coordination in the 3rd Judicial District (Anchorage).

A MOA for Urgent Forensic Discharge Planning is in place between the Department of Health and Social Services, the Department of Corrections, and the Alaska Court System, and includes the Office of Public Advocacy, Senior and Disabilities Services, and Public Assistance. The purpose of the MOA is to formalize communication between the parties, establish each party's roles, and protect the confidentiality of defendants under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) with the goal of expedited and safe discharge plans. The MOA is used for weekly coordination and communication between API and Anchorage Court staff; however, this group is not currently active and should be reconvened to review, revise and further implement the MOA. One stakeholder suggested Alaska's Automated Information Management System (AKAIMS) should be explored as an option for sharing data across systems in Alaska.

Connecticut

The Forensic Services Division does not have a database that allows them to pull data by charge type. To identify the number of misdemeanants and felons, this must be hand counted. The division director speculates that they see a significant number of misdemeanants referred for evaluation and restoration.

There is no shared data system between the Department of Mental Health and Addiction Services (DMHAS) and the Department of Corrections (DOC) and t it is unlikely that the state would permit a system that allows interdepartmental data sharing. It is even difficult for information to be shared within DMHAS as the different inpatient facilities cannot see records from other facilities, only their own. DMHAS would like to have an automated matching system so that if someone with a DMHAS number enters DOC custody, they would be alerted. Currently, this does not happen in a regular, facilitated way. Both DOC and DMHAS have systems that are outdated. DMHAS currently has a bond out for funding for Epic as a platform to improve data collection.

The communication between the court and DMHAS has improved through establishing a court liaison. The court liaison is a community mental health center employee, and thus has access to mental health records. At the start of each day, this individual looks at the court docket, which is public record, and compares it to a list

of community mental health center clients. This communication and tracking is facilitated as part of the Forensic Services Division's diversion efforts.

DMHAS releases an annual statistical report, produced by their Evaluation, Quality Management and Improvement division to provide information about the services provided by the department and the individuals served. Data is collected and pulled from the DMHAS Enterprise Data Warehouse. The most recent data report for State Fiscal Year (SFY) 2018 was released in December 2018.

Hawaii

Diversion services for the forensic psychiatric population in Hawaii involves a great deal of collaboration between different departments and contractors. The Department of Health serves as the convener for data and information sharing agreements between many of the involved parties. For example, the Department of Health contracts with a provider for Crisis Mobile Outreach, the Department of Health runs the state's behavioral health crisis line, and the department has an MOU with the Honolulu Police Department. The Department of Health's involvement with each of these entities opens the door for data and information sharing when law enforcement encounters an individual who is potential in a mental health crisis. Law enforcement contacts a mental health emergency worker, who can then call the state crisis line to see if the individual is already plugged in to the behavioral health system. The crisis line can then trigger an intervention by Crisis Mobile Outreach if needed.

The Department of Health is still working on exchanging information about high utilizers between the Honolulu Police Department Receiving Division, Queens Medical Center and the Honolulu District Court. Information sharing agreements between the three entities have been in the works for the past six to 12 months. Hawaii's Forensic Chief stated that it is important to get the right people in the room, including legal representation to "silo bust" and really understand the legal ability to share information and get the information sharing agreements in place that are going to facilitate the type of communication that is needed. Agencies have certain abilities to share information and it is important to explore these options, instead of just assuming information cannot be shared because of HIPPA.

Per the Hawaii's Forensic Chief, the State Department of Health, Adult Mental Health Division has a robust system for gathering information about the flow of evaluations; however, the state's judiciary does not have a consistent or robust mechanism to track evaluations in its own courts.

The Hawaii State Department of Health produces an annual report to the state legislature, as required by Hawaii Revised Statutes 334-16. Data analysis and report production is completed by Hawaii State Hospital staff with assistance from Department of Health administrative staff. The report contains the following chapters:

- Total admissions and discharges;
- Number of Hawaii State Hospital (HSH) admissions and discharges, broken down by commitment categories;
- Number of persons committed to HSH, by each county and court;
- Number of patients in HSH on forensic status, broken down by grade of offense and category of underlying crimes;
- Length of stay in HSH; and,

- Appendix of staff injuries and assaults.[2]

Colorado

Effective data tracking is still in development. The state is in the process of creating data management teams to better track and extract data. Senate Bill 19-223 Actions Related to Competency to Proceed requires the Department of Human Services to develop an electronic system to track the status of defendants for whom competency has been raised.

In 2018, the Colorado Judicial Department, State Court Administrator's Office, issued a request for proposals from behavioral health organizations to provide a court liaison in each of Colorado's 22 judicial districts. The purpose of these court liaisons is to facilitate connections and communication between the criminal justice and behavioral health systems. The liaisons will work directly with defendants to make connections to evaluations and treatment and educate legal professionals about available mental health services, including competency evaluation and restoration.

Utah

Currently, the legal services department at Utah State Hospital partners with the Quality Resource Office to maintain a tracking spreadsheet using Google Sheets. The hospital is in discussion with Sales Force, in the hopes that this platform will become the new tracking platform for forensic patients. The hospital recently hired an IT person within the Quality Resource Office specifically to help with recreating the forensic data in Sales Force or another such system. This tracking mechanism will capture data on each defendant from the time an evaluation order is received until they are discharged and will help give the hospital a sense of system throughput.

Utah State Hospital is very interested in using data to help identify system inefficiencies. For instance, they pulled data on the number of times a hearing was delayed because of a transportation order issue. The hospital communicated with the court system and sheriff's department about this issue and then started to discuss possible solutions to decrease delays, including the hospital hiring their own staff to provide transportation to hearings.

In terms of communication with the court system, the court has a Court Administration System which Department of Human Services staff can open as a read-only file. This is helpful because it allows team members to learn what happened in a defendant's court case and be more prepared to respond in future hearings.

Utah's criminal justice reform bill, HB348, passed in 2015 requires the collection of data on recidivism rates for jail and prison populations with severe mental illness and on cost savings associated with the reduced recidivism.[3] While data is not collected specifically on the competency to stand trial population, the annual reports produced as a result of this legislation provide a helpful pulse on mental health needs within the

[2] Hawaii State Department of Health, Adult Mental Health Division. (2017). Report to the Twenty-Ninth Legislature, State of Hawaii.

[3] Torrey, E.F., Dailey, L., Lamb, H.R., Sinclair, E., Snook, J. (2017). *Treat or Repeat: A State Survey of Serious Mental Illness, Major Crimes and Community Treatment*. Treatment Advocacy Center. https://www.treatmentadvocacycenter.org/treat-or-repeat.

criminal justice system. Through a risk and needs screening process as part of criminal justice reform, it was identified that:

- Half of Utah's arrestees need a substance use referral;
- 40 percent need a mental health referral;
- Close to one third screen positive for a possible co-occurring disorder; and
- 70 percent were screened as moderate to high risk to reoffend.[4]

Washington

A 2014 report identified a need to enhance data-management resources, including an information sharing system between the Department of Social and Health Services, jails and courts.[5] Following this report, the Office of Forensic Mental Health Servcies was created and one of the guiding principles of the office is to "develop robust and reliable data systems to better forecase demand for services, monitor program performance and conduct effective capacity utilization".[6] Improved data collection allows the office to report back to the legislature and stakeholders about key issues including patient information, care measures at the state hospitals, measures relevant to the Trueblood case and outcomes after discharge.

The 2014 report identifies a list of questions that should be able to be answered from a centralized forensic psychiatric services database:

- How many competence and sanity evaluations were performed in a given time period? For what jurisdictions? What was the proportion of incompetence and insanity findings?
- Do incompetence or insanity findings differ appreciably across evaluators or jurisdictions?
- How many defendants are receiving competence restoration services, and where?
- What proportion of defendants is restored to competence, and what are the mean lengths of time until restoration?
- How many individuals are acquitted Not Guilty by Reason of Insanity (NGRI), and what proportion is hospitalized versus released? How long do such individuals spend in the hospital prior to conditional release? What is the duration of supervised conditional release, and what proportion of supervised acquittees discharge their supervision, return to the hospital, or reoffend?
- What types of community forensic programs exist? How many forensic consumers are served by them? What are the outcomes?

PIERCE COUNTY DATA DASHBOARD

The Pierce County Trueblood Diversion Program, funded by Phase II Trueblood Diversion funds, maintains an online data dashboard that tracks the number of persons diverted from the criminal justice system or criminal prosecution through their program. The dashboard can be accessed at: https://open.piercecountywa.gov/stat/goals/f8zp-hv7h/wtzy-rw46/hnc2-gkuv/

[4] Utah Commission on Criminal and Juvenile Justice. Current Criminal Justice Policies in Utah, 2018 Annual Report.

[5] Groundswell Services, Inc. 2014. Forensic Mental Health Consultant Review Final Report.

[6] State of Washington. Department of Social and Health Services. Office of Forensic Mental Health Services. https://www.dshs.wa.gov/bha/office-service-integration/office-forensic-mental-health-services

- What are the approximate costs of the services described above? Where are the areas with greatest expense and greatest opportunity for savings?[7]

A 2017 report identified additional data collection points of importance:

- Legal charges
- Type of charge (misdemeanor or felony)
- Diagnoses (intake and discharge)
- Date of admission and date of discharge
- Competency status on discharge
- Medication adherence
- Treatment adherence
- Presence of legal order for medication administration
- Rates of restoration
- Rates of findings of restorability
- Discharge disposition
- Referrals made on discharge
- Housing status (on intake and discharge)
- Employment status (on intake and discharge)[8]

Washington's court monitor worked with the Diversion Workgroup to develop a regular reporting structure to promote performance accountability and produce data for implementation and outcomes evaluation. Performance accountability measures include: number served, clients screened, admitted, retained, discharged and dropped out, individual and average length of stay, number diverted from competency services and number triaged to civil services. Data reporting includes: client demographic characteristics, diagnosis and health status, housing and employment, income and insurance, prior and current arrests and legal status, competency, and rates of participation in treatment and disability support services.[9]

[7] Groundswell Services, Inc. 2014. Forensic Mental Health Consultant Review Final Report.

[8] Groundswell Services, Inc. 2017. Analysis of Current Washington Competency Restoration Services.

[9] Mauch, Danna. 2017. Trueblood Diversion Services: Background and Implementation Status. United States District Court, Western District of Washington.

Appendix G: Inpatient and Jail-Based Restoration Bed Forecast

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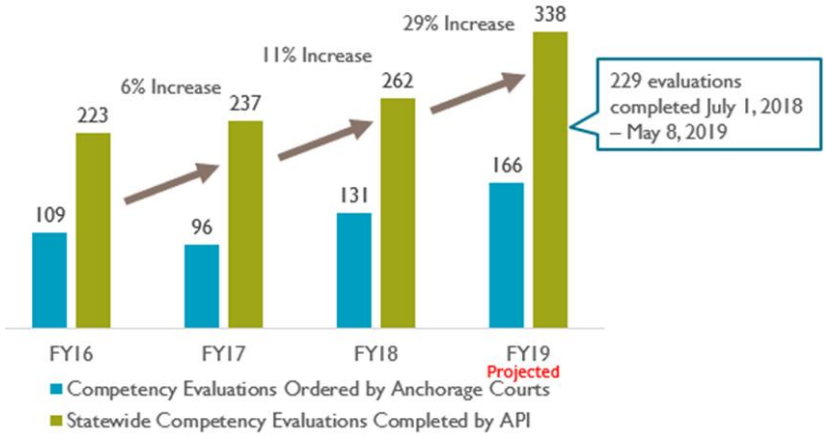
Executive Summary

Assuming an 11 percent average annual growth rate in number of competency evaluations ordered between FY 2019 and FY 2026, this study projects that Alaska will need 25 beds for inpatient restoration and 25 beds for jail-based restoration (see Figure 2). If the growth rate is lower at 6 percent, demand for 25 inpatient restoration beds is still expected but a new jail-based program could be developed at a 13-bed size. If the growth rate in evaluations follows the high scenario at 17 percent, at least 49 inpatient beds will be needed along with a minimum of 20 to 25 jail-based beds. For planning purposes, this study uses the 11 percent annual growth rate in evaluations to forecast demand for competency restoration treatment beds.

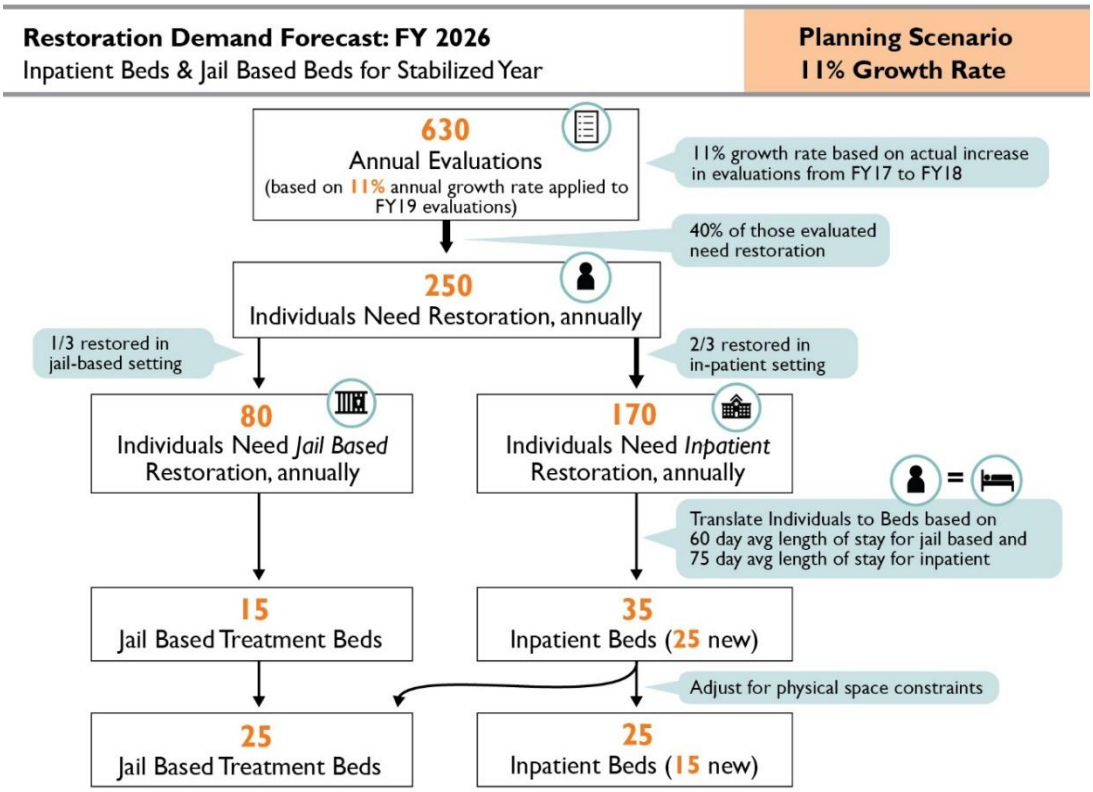
Figure 1: Annual Growth Rate in Number of Competency Evaluations, FY16-19



Methodology & Results

The methodology to estimate the number of inpatient and jail-based competency restoration beds includes the following steps depicted in Figure 2.

Figure 2: Restoration Treatment Bed Demand Forecast FY2026



Step 1 Estimate Growth in Competency Evaluations and Determine Planning Year. By FY 2026, assuming 11 percent average annual growth in evaluations, there will be a need for roughly 630 competency evaluations annually. The number of individuals requiring a competency evaluation drives the demand for restoration beds. Given data availability at the time of this study, staff at API hand counted the number of completed competency evaluations in fiscal years 2016, 2017, 2018 and 2019. Data from prior years was not available. As shown in Figure 1, there was an 11 percent in evaluations between FY 2017 and FY 2018. From FY 2016 to FY 2017, the growth rate was 6 percent and between FY 2018 and FY 2019 it is expected to reach 29 percent if the second half of the year mirrors the number of evaluations in the first half of the year. For facility planning purposes, we chose the 11 percent annual growth or the middle growth rate to forecast expected demand for restoration beds. Fiscal year 2026 is the planning year assumed in this bed forecast. The model assumes that the high average annual growth in evaluations slows to two percent after FY 2026 when the backlog in forensic evaluations and restoration is reduced and other system level recommendations are implemented to improve the capacity to serve the forensic psychiatric population.

Step 2 Estimate Number of Individuals in Need of Restoration. By FY 2026, 250 individuals will likely need restoration assuming an 11 percent average annual growth in competency evaluations. Using the API Tuesday Report data for calendar year 2018, roughly 56 percent of individuals evaluated were deemed incompetent to stand trial (IST) and 32 percent of those evaluated required restoration treatment. Not all individuals deemed IST go on to need a restoration treatment bed due to case dismissals or evaluation order reversals by the courts. With input from API forensic psychologists, a 40 percent factor was assumed as the percentage of evaluations that will require a restoration treatment bed for purposes of modeling bed demand.

Step 3 Estimate Share of Individuals in Need of Jail Based (80) versus Inpatient (170) Restoration. Currently, Alaska does not have a jail-based restoration program so there is no existing data on the number of individuals who are IST who could be served by jail-based restoration. The exact number of individuals who could receive jail-based restoration depends on the acuity level of the client and their need for one-on-one clinical supervision. Dr. Patrick Fox, a forensic psychiatrist on the consulting team for this feasibility study, identified a one-third/two-third split between jail-based and inpatient restoration as a guide for planning facility space. The consulting team verified this assumption using four years' worth of data from API on IST individuals who were on a hold for continuous observation surveillance status (COSS). A COSS indicates that the patient required a seclusion, restraint, or hold, which indicates a level of acuity that would likely not be a good candidate for jail-based restoration. From FY 2016 through FY 2019, an average of 34 percent of IST clients at Taku were on continuous observation surveillance status. The remaining patients could potentially be eligible for jail-based restoration. This indicates that assuming one-third of IST individuals could be served by jail-based restoration is realistic and possibly a higher proportion of individuals could be candidates for this type of restoration.

Step 4 Translate Number of Individuals Requiring Competency Restoration into Demand for Beds. National averages for length of stay in a jail-based restoration setting is 60 days and API's average length of stay for the Taku unit is 75 days. This means that a jail-based restoration bed turns over roughly six times per year and an inpatient bed turns over 4.85 times per year. Bed demand is estimated by dividing the number of individuals requiring competency in each restoration setting by the average length of stay for that setting. For jail-based restoration, there could be a demand for 15 beds and for the inpatient restoration care setting, there could be a demand for as many as 35 new beds. However, Step 5 adjusts the bed demand forecast to align with facility planning constraints and opportunities, as well a feasible size for a jail-based program.

Step 5 Adjust Bed Demand. We adjusted the demand for inpatient forensic beds down to 25 and shifted 10 beds to the jail-based program for the following reasons.

- **Limited expansion opportunity at API.** The physical expansion opportunities at API are limited to roughly 25 beds. While it is possible that API could add 25 beds to the existing facility for forensic psychiatric patients and maintain 10 forensic beds at Taku for a total of 35 beds, we heard from stakeholders a strong concern against substantially increasing the share of forensic beds at the expense of civil beds.
- **Feasible size for a jail-based program**. Developing a 20 to 25 bed jail-based program is a more feasible size to justify necessary staffing and administrative expenses.
- **Potential for more clients to be served by jail-based restoration.** As described under Step 3, the COSS data indicates that more than one-third of those in need of restoration could potentially be served by jail-based restoration. This allows for some of the bed demand to shift from inpatient restoration to jail-based restoration.

Other Methods

Other "rules of thumb" for estimating the need for forensic beds provide context for the bed forecast used in this feasibility study and indicate that the result is credible.

1. **Share of state mental health hospital beds dedicated to forensic patients.** Roughly one-third of state mental health hospital beds are used for forensic psychiatric patients.[1] This indicates that for an 80-bed facility like API, roughly 26 beds could be for forensic commitments. A 105-bed API (80 existing beds plus the 25-bed expansion) could yield 35 forensic beds using this metric. However, as stated above, stakeholder input strongly cautions against creating more forensic beds at the expense of civil beds where demand is also substantial.
2. **Forensic beds per capita.** Roughly 5.5 forensic beds per 100,000 people is also used as a metric for estimating demand for forensic psychiatric beds.[2] At 737,438 people in 2018, Alaska could potentially see a demand for 40 forensic psychiatric inpatient beds.

[1] Information provided by Dr. Patrick Fox

[2] Information provided by Dr. Patrick Fox

Figure 1: Restoration Demand Forecast, FY 2026, Low Growth Scenario

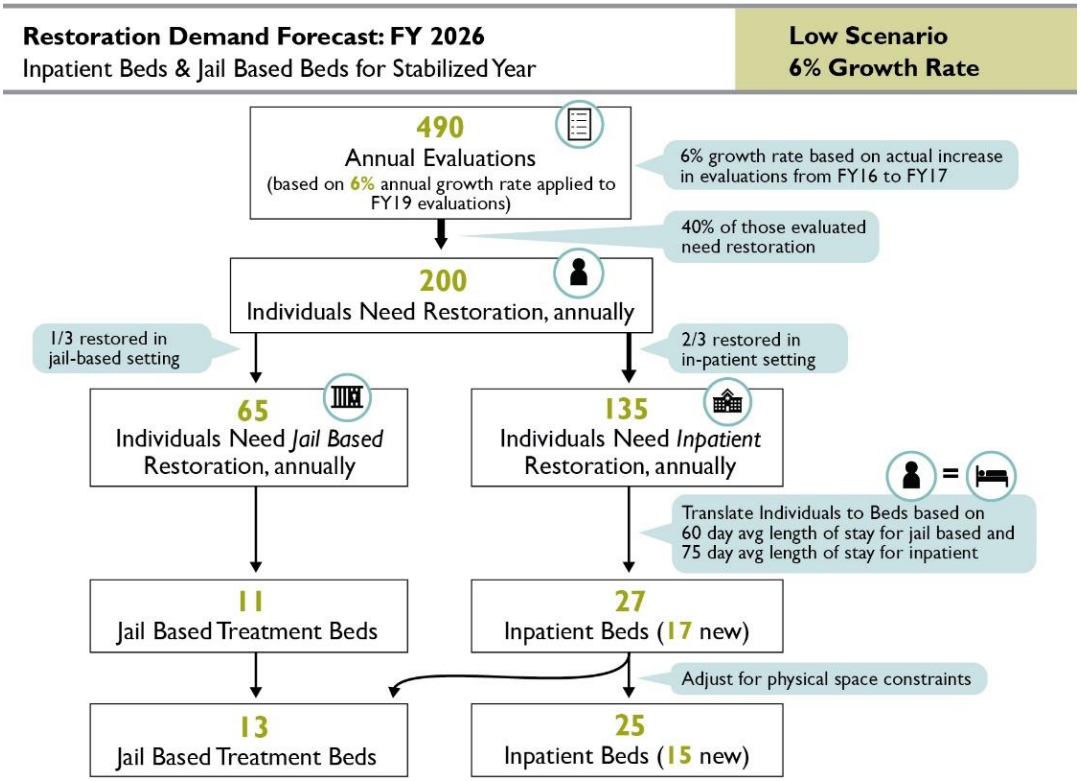
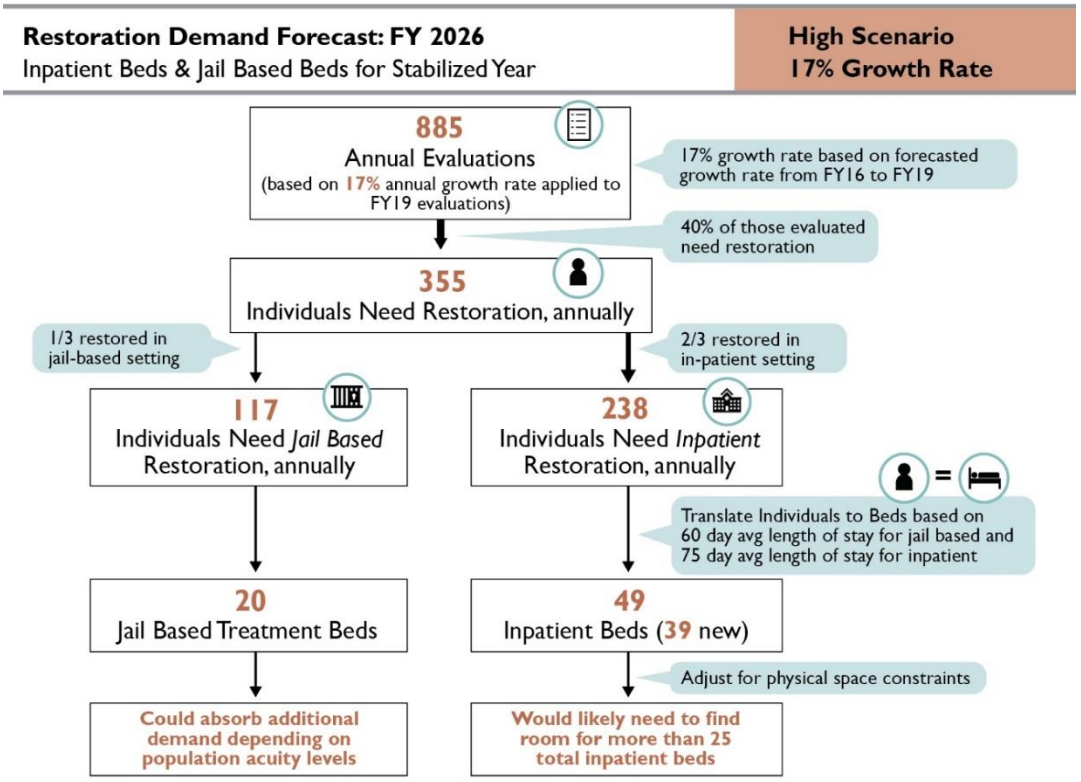


Figure 2: Restoration Demand Forecast, FY 2026, High Growth Scenario



Appendix H: Staffing Model and Operational Costs

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Overview

This Appendix estimates the operational costs for each of the following approaches to meet Alaska's need for expanded inpatient and jail-based competency restoration:

- Approach 1: 20 inpatient beds within existing Alaska Psychiatric Institute (API) footprint.
- Approach 2: 25 inpatient beds within an expanded API footprint.
- Approach 3: 25 jail-based beds within existing Anchorage Correctional Center (ACC) footprint.
- Approach 4: 25 inpatient and 25 jail-based beds within expanded ACC footprint.

Total Operational Costs per Approach: Annual and Daily

Operational costs were calculated from proposed restoration staffing patterns and associated annual personnel costs; projected administrative and additional personnel costs; and, projected non-personnel costs. The total annual costs were divided by number of beds for each approach and by 365 days to reflect a daily cost per bed, allowing for a comparison of the costs across the four approaches.

The total annual costs for each approach are also shown. The annual costs include the addition of staff to perform competency evaluations. Many of the tables in this appendix include status quo estimates for the existing inpatient competency restoration beds in the Taku Unit of API. These estimates are labeled "status quo." All costs are shown in 2019 dollars. If, and when, the State proceeds with any of the identified approaches, we recommend the State conduct a more detailed cost estimating process in future dollars for the planned implementation year.

The total projected daily costs for each program were annualized and multiplied by the number of beds identified for each approach, resulting in an overall annual and daily cost per approach, as depicted in Figure 1.

Figure 1: Total Operational Costs per Approach: Annual and Daily

Projected Operational Costs		Annual Cost					Daily Cost
		Program Staff	Share of Admin	Other Personnel	Non-Personnel Costs	Total	
Status Quo	10 inpatient at Taku	$2,157,694	$555,629	$254,709	$1,017,298	$3,985,330	$1,092
Approach 1	20 inpatient beds in existing API	$4,162,046	$555,629	$509,417	$2,034,596	$7,261,688	$995
Approach 2	25 inpatient beds @ expanded API	$4,908,292	$555,629	$636,771	$2,543,245	$8,643,938	$947
Approach 3	25 jail based beds in existing ACC	$1,945,831	$50,050	$60,753	$648,477	$2,705,111	$296
Approach 4	25 JB + 25 inpatient @ expended ACC	$6,854,124	$605,679	$697,525	$3,191,722	$11,349,049	Avg of 2&3
Evaluation	4 FTE Evaluators					$639,320	

Figure 2 and Figure 3 show the total annual cost for each of the approaches and the cost per client; per client per day; and, per bed per year. Evaluation staffing cost does not change across approaches. Figure 2 only includes program personnel; Figure 3 compares total staffing and operating costs.

Figure 2: Total Program Staffing Costs per Approach

Projected Program Staffing Costs for Each Approach	Status Quo 10 inpatient beds in API's Taku Unit	Approach 1 20 inpatient beds in existing API footprint	Approach 2 25 inpatient beds in expanded API footprint	Approach 3 25 jail-based beds in existing ACC footprint	Approach 4 25 inpatient + 25 jail-based beds in expanded ACC footprint
Cost per client	$ 44,336	$ 42,761	$ 40,342	$ 12,795	Sum of Approaches 2 and 3
Cost per client per day	$ 591	$ 570	$ 538	$ 213	
Cost per bed per year	$ 215,769	$ 208,102	$ 196,332	$ 77,833	
Annual Cost	$ 2,157,694	$ 4,162,046	$ 4,908,292	$ 1,945,831	$ 6,854,124
Plus Evaluation Staff	$ 639,320	$ 639,320	$ 639,320	$ 639,320	$ 639,320

Figure 3: Total Staffing and Operating Costs per Approach

Projected Total Staffing and Operating Costs for Each Approach	Status Quo 10 inpatient beds in API's Taku Unit	Approach 1 20 inpatient beds in existing API footprint	Approach 2 25 inpatient beds in expanded API footprint	Approach 3 25 jail-based beds in existing ACC footprint	Approach 4 25 inpatient + 25 jail-based beds in expanded ACC footprint
Cost per client	$ 81,890	$ 74,606	$ 71,046	$ 17,787	Sum of Approaches 2 and 3
Cost per client per day	$ 1,092	$ 995	$ 947	$ 296	
Cost per bed per year	$ 398,533	$ 363,084	$ 345,758	$ 108,204	
Annual Cost	$ 3,985,330	$ 7,261,688	$ 8,643,938	$ 2,705,111	$ 11,349,049
Plus Evaluation Staff	$ 639,320	$ 639,320	$ 639,320	$ 639,320	$ 639,320

Key Findings

- API's current staffing for Taku is slightly more intense than other inpatient restoration programs but very close to Utah's program, which is a similar size.
- On a per bed per day basis, jail-based competency restoration is less costly than inpatient restoration. Because the jail-based restoration program modeled in this study assumes lower acuity clients, the intensity of medical and nursing staff is reduced. Additionally, at the time this report was published, additional costs for medications for those in jail-based restoration and other expenses were still being researched. The jail-based restoration costs are subject to refinement by DOC as additional information becomes available.

Method + Sources

There were four steps in the process to estimate the operational costs for each of the approaches.

1. **Research case studies.** We learned from other states' competency restoration programs to better understand staffing patterns and intensity associated with inpatient forensic psychiatric restoration and jail-based restoration.
2. **Build a staffing model.** Using existing staffing patterns at API for inpatient restoration, case study research and interviews with existing API and Department of Corrections (DOC) staff, we

developed a proposed restoration staffing plan for each of the approaches. State of Alaska compensation levels were applied to the staffing plan to estimate annual staffing costs.

3. **Add in other costs**. After the restoration program staffing costs were complete, we estimated the other operational costs including non-personnel, administrative staffing, and other staffing including maintenance, housekeeping and food service, as well as contract services. The cost for additional staff to provide competency evaluation is also included.
4. **Derive cost per bed per day comparisons.** Once all costs were estimated, we normalized the annual operational costs on a per bed per day basis to compare the costs for each approach.

In addition to the expertise from members of the project team, the following sources formed the basis of the analysis:

- Case study interviews with other states' inpatient and jail-based competency restoration programs:
  - Connecticut: Whiting State Hospital
  - Colorado: Mental Health Institutes and the Jail-based Evaluation and Restoration Program
  - Hawaii: Hawaii State Hospital
  - Utah: Utah State Hospital Inpatient and Jail-Based Competency Restoration Programs
  - Multi-state: Wellpath's Inpatient and Forensic Psychiatric Programs
- Staffing patterns from existing programs
  - Utah State Hospital Inpatient and Jail-Based Competency Restoration Programs
  - Colorado inpatient and jail-based competency restoration programs
  - Eastern and Western Washington State Hospitals
- Interviews with current Alaska service providers
  - Alaska Psychiatric Institute (API)
  - Department of Corrections (DOC)
- Best practice research on staffing related to inpatient and jail-based competency restoration.

Case Studies and Staffing Benchmarks

Using the sources above, the project team identified the positions and number of staff to operate an inpatient or jail-based program for each of the four approaches. Considerations during this part of the analyses include:

- The Taku unit at API currently provides inpatient competency restoration and is the baseline for proposed approaches to inpatient restoration; however, the Mental Health Unit at the Anchorage Correctional Center (ACC) was not used as a baseline for the jail-based restoration approach because the intensity and purpose of treatment is different. Currently, Alaska does not have a jail-based restoration program as part of its forensic psychiatric system.

- The case study inpatient and jail-based restoration programs varied in the number of patients served. For comparison across the case studies and the baseline, API, we calculated ratios showing the number of beds for each full-time equivalent (FTE) staff to benchmark the recommended staffing intensity for each approach. As anticipated, the intensity of staffing to manage patients decreases as the size of the facility increases, which indicates that staffing efficiency increases as the total number of patients increases. The calculation of beds to FTE does not reflect staffing minimums or targets by shift; the ratios are the result of dividing the total number of beds by the total FTEs for each position category to estimate the average number of beds or patients per one FTE.

- Position titles had a high degree of variability across the case studies (e.g., a "psychiatric nurse" in one facility was identified as a "nurse" or a "registered nurse" by other facilities). This study uses the

position titles identified in the Position Classification Summary of Alaska's FY2019 Governor's Operating Budget for API and DOC, which was also used to estimate salaries later in the process.[1]

- Some positions were included in the benchmarked staffing patterns that were not included in the proposed modeling for one of two reasons: (1) the proposed modeling included these positions in the shared administrative or other personnel categories which were addressed differently and described later in this appendix; (2) the position descriptions for the benchmarked positions were incorporated into other program-related positions in the proposed approach.
- While most position categories for the proposed approaches are scheduled on a standard Monday through Friday 40-hour work week, the nursing providers and correctional officers are scheduled around the clock. The number of nursing providers or correctional officers needed to manage the unit was adjusted to address evening, night and weekend staffing needs. For each position needed to manage one shift, 2.3 FTEs are needed to ensure 24-7 coverage.

Restoration Program Personnel Cost Estimates

Program personnel costs were estimated using the "Personal Services Expenditure Details" portion of Alaska's FY2019 Governor's Operating Budget for API and the DOC, which posts the annual salaries and benefit costs for all department staff. Salaries and benefits were averaged for all staff associated with a given position and were used to calculate personnel costs for the unit. For example, the inpatient Psychiatric Nurse position could be filled by a Psychiatric Nurse II, III or IV. Therefore, the cost of salaries and benefits for all staff identified as a Psychiatric Nurse II, III or IV at API were averaged. This average was used to calculate the total costs for psychiatric nurses for inpatient approaches 1, 2 and 4. The sum of all the personal costs for each approach determined the annual program staffing costs for each approach.

Restoration Program Staffing Models + Cost Estimates

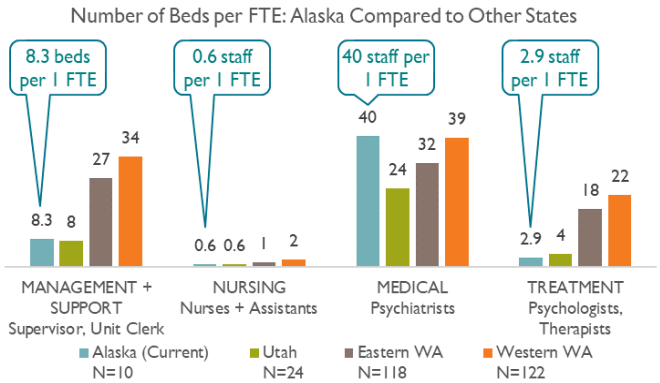
Inpatient Competency Restoration

Staffing Intensity

The number of beds per FTE for the current API Taku Unit and the benchmarked states guided decision-making for the proposed inpatient staffing models. As shown in Figure 4, Alaska's ten-bed forensic unit at Taku has a similar level of staffing compared Utah, which is a small inpatient forensic unit but still twice the size of the Taku Unit. For the larger facilities in Washington, the staffing becomes less intensive as economies of scale are realized.

Figure 4: Beds per FTE by Staffing Category for Inpatient Restoration Units – Alaska Compared to Other States

(Note: The larger the bar, the less staff intensive. Does not reflect staffing minimums or targets by shift.)



Staffing Model

Figure 5 reflects inpatient restoration staffing patterns for Approaches 1 and 2, the current API

[1] https://omb.alaska.gov/html/budget-report/department-table.html?dept=HSS&fy=19&type=Enacted

Taku unit, and the benchmarked programs. Positions are grouped by the following categories: management and support, nursing, medical and treatment positions. A total of 41.5 FTEs will be necessary for a 20-bed inpatient restoration program and 49.3 FTEs for a 25-bed program. Competency evaluation staff is considered separately.

Figure 5: Program Staffing for Inpatient Competency Restoration

Inpatient Positions and Shifts		Approach 1	Approach 2	STATUS QUO + BENCHMARKS			
		20 beds	25 beds	10 beds	24 beds	95 beds	118 beds
		Proposed FTEs	Proposed FTEs	Taku FTEs	Utah FTEs	Washington East FTEs	Washington West FTEs
Management + Support		3.0 staff	3.0 staff	1.2 staff	3.0 staff	3.5 staff	3.5 staff
		Staff : Beds	Staff : Beds	Staff : Beds	Staff : Beds	Staff : Beds	Staff : Beds
		1 to 6.7	1 to 8.3	1 to 8.3	1 to 8.0	1 to 27.1	1 to 33.7
Nursing Supervisor	**M-F days**	1.0	1.0	0.5	1.0	1.0	1.0
Unit clerk	**M-F days**	1.0	1.0	0.5	1.0	1.5	1.5
Paralegal	**M-F days**	1.0	1.0	0.2			
Medical Records Assistant	**M-F days**					1.0	1.0
Research Assistant	**M-F days**				1.0		
Nursing		32.0 staff	38.2 staff	16.3 staff	38.0 staff	68.4 staff	57.5 staff
		Staff : Beds	Staff : Beds	Staff : Beds	Staff : Beds	Staff : Beds	Staff : Beds
		1 to 0.6	1 to 0.7	1 to 0.6	1 to 0.6	1 to 1.4	1 to 2.1
Psychiatric Nurse	**24 - 7**	9.0	9.0	4.7	9.0	16.2	16.2
Psych Nursing Assistant	**24 - 7**	23.0	29.2	11.7	29.0	52.2	41.3
Medical		0.5 staff	0.8 staff	0.3 staff	1.0 staff	3.0 staff	3.0 staff
		Staff : Beds	Staff : Beds	Staff : Beds	Staff : Beds	Staff : Beds	Staff : Beds
		1 to 40.0	1 to 33.3	1 to 40.0	1 to 24.0	1 to 31.7	1 to 39.3
Psychiatrist	**M-F days**	0.50	0.75	0.25	1.0	2.0	2.0
Physician / ARNP, PA	**M-F days**					1.0	1.0
Treatment (Restoration only)		6.0 staff	7.3 staff	3.5 staff	6.0 staff	12.2 staff	12.2 staff
		Staff : Beds	Staff : Beds	Staff : Beds	Staff : Beds	Staff : Beds	Staff : Beds
		1 to 3.3	1 to 3.4	1 to 2.9	1 to 4.0	1 to 7.8	1 to 9.7
Supervising Psychologist	**M-F days**	1.0	1.0	1.0	0.0	1.0	1.0
Psychologist, MH Clinician	**M-F days**	1.0	1.3	0.5	2.0	1.0	1.0
Social Worker	**M-F days**	2.0	2.5	1.0	2.0	4.8	4.8
Recreational Therapist	**M-F days**	2.0	2.5	1.0	1.0	5.4	5.4
Occupational Therapist	**M-F days**				1.0		
	SUBTOTAL	41.5 staff	49.3 staff	21.3 staff	48.0 staff	87.1 staff	76.2 staff
Other Positions from Benchmarks		0.0 staff	0.0 staff	0.0 staff	3.0 staff	5.4 staff	5.4 staff
Guard					1.0		
Environmental Services	**24 - 7**				1.0	2.7	2.7
Dietary Aide	**M-F days**					2.7	2.7
Pharmacist Technician	**M-F days**				1.0		
	TOTAL STAFF	41.5 staff	49.3 staff	21.3 staff	51.0 staff	92.5 staff	81.6 staff

Staffing Cost Estimates

Figure 6 identifies the cost estimates for staffing the inpatient units identified in Approaches 1 and 2.

Figure 6: Inpatient Competency Restoration Staffing Cost Estimates

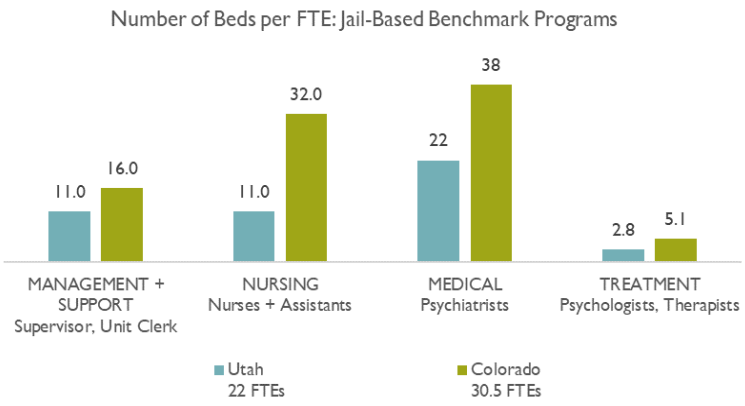
Inpatient Positions	Total Annual Costs for 1 FTE	Current (Taku)* 10 beds		Approach 1 20 beds		Approach 2 25 beds	
		# of FTE's	Total Costs per Position	# of FTE's	Total Costs per Position	# of FTE's	Total Costs per Position
Management and Support							
Nursing Supervisor	$ 133,265	0.5	$ 66,632	1.0	$ 133,265	1.0	$ 133,265
Office Assistant	$ 67,932	0.5	$ 33,966	1.0	$ 67,932	1.0	$ 67,932
Paralegal II	$ 92,281	0.2	$ 18,456	1.0	$ 92,281	1.0	$ 92,281
Nursing							
Psychiatric Nurse	$ 123,608	4.7	$ 576,836	9.0	$ 1,112,470	9.0	$ 1,112,470
Psychiatric Nurse Assistant	$ 81,911	11.7	$ 955,628	23.0	$ 1,883,952	29.2	$ 2,391,800
Medical							
Psychiatrist	$ 390,901	0.3	$ 97,725	0.5	$ 195,451	0.75	$ 293,176
Treatment							
Lead Psychologist	$ 140,205	1.0	$ 140,205	1.0	$ 140,205	1.0	$ 140,205
Psychologist, MH Clinician	$ 131,007	0.5	$ 65,504	1.0	$ 131,007	1.3	$ 170,310
Social Worker	$ 124,160	1.0	$ 124,160	2.0	$ 248,321	2.5	$ 310,401
Recreation Therapist	$ 78,581	1.0	$ 78,581	2.0	$ 157,162	2.5	$ 196,453
Other							
Guard	$ -	0.0	$ -	2.0	$ -	0.0	$ -
TOTALS		21.3	$ 2,157,694	43.5	$ 4,162,046	49.3	$ 4,908,292

Jail-based Competency Restoration

Staffing Intensity

Figure 7 shows the number of beds per FTE for the benchmark jail-based restoration programs, which guided decision-making for the proposed jail-based staffing models. As mentioned earlier, there is no existing comparable program in Alaska against which to compare benchmarks. As with the inpatient programs, the staffing becomes less intensive as economies of scale are realized.

Figure 7: Beds per FTE by Staffing Category for Jail-based Restoration Units – Alaska Compared to Other States



Staffing Model

Figure 8 identifies the jail-based restoration staffing model identified in Approaches 3 and 4, including staff for

management and support, nursing, medical, and treatment. A total of 21.75 FTE is necessary for a 25-bed jail-based restoration program.

Figure 8: Program Staffing for Jail-based Competency Restoration

Jail-Based Positions and Shifts		Proposed	Benchmarks	
		25 beds	22 beds	96 beds
		Total FTEs	Utah FTEs	Colorado FTEs
Management + Support		2.0 staff Staff : Beds 1 to 12.5	2.0 staff Staff : Beds 1 to 11.0	6.0 staff Staff : Beds 1 to 16.0
Program Administrator (MH Clinician IV)	M-F days	1.0	1.0	1.0
Clinical Supervisors	M-F days			3.0
Office Assistant	M-F days	1.0	1.0	2.0
Nursing		7.0 staff Staff : Beds 1 to 3.6	2.0 staff Staff : Beds 1 to 11.0	3.0 staff Staff : Beds 1 to 32.0
Supervising Psychiatric Nurse	M-F days	1.00		
Psychiatric Nurses (includes night nurses)	week on/off	6.0	2.0	3.0
Medical		0.8 staff Staff : Beds 1 to 33.3	1.0 staff Staff : Beds 1 to 22.0	2.5 staff Staff : Beds 1 to 38.4
Forensic Psychiatrist	M-F days	0.75	1.0	2.5
Treatment		8.0 staff Staff : Beds 1 to 3.1	8.0 staff Staff : Beds 1 to 2.8	19.0 staff Staff : Beds 1 to 5.1
Psychologist or Clinician (Masters Level)	M-F days	4.0	4.0	4.0
Social Worker	M-F days	1.0	1.0	9.0
Mental Health Technician	M-F days	2.0	2.0	4.0
Recreation Tech	M-F days	1.0	1.0	2.0
Sub-total Staff Count		17.8 staff	13.0 staff	30.5 staff
Other Positions		4.0 staff	0.0 staff	0.0 staff
Correctional Officers	week on/off	4.0	not known	not known
Total Staff Count		21.8 staff	13.0 staff	30.5 staff

Staffing Costs Estimates

Figure 9 identifies the cost estimates for staffing the jail-based units identified in Approaches 3 and 4.

Figure 9: Jail-Based Staffing Cost Estimates

Jail-Based Positions	Total Annual Costs for 1 FTE	Approach 3 25 beds	
		# of FTE's	Total Costs for Position(s)
Management + Support			
Program Administrator (MH Clinician IV)	$ 168,443	1.0	$ 168,443
Office Assistant	$ 75,344	1.0	$ 75,344
Nursing			
Supervising Psychiatric Nurse	$ 163,359	1.0	$ 163,359
Psychiatric Nurses	$ 133,532	6.0	$ 801,192
Medical			
Forensic Psychiatrist	$ 382,267	0.8	$ 286,700
Treatment			
Clinician or Psychologist (Masters Level)	$ 126,843	4.0	$ 507,371
Social Worker (case management, reentry, etc.)	$ 111,865	1.0	$ 111,865
Mental Health Technician	$ 92,308	2.0	$ 184,617
Recreation Technician	$ 92,308	1.0	$ 92,308
Other			
Correctional Officers	$ 111,272	4.0	$ 445,087
TOTALS		**13.8**	**$ 1,945,831**

Other Personnel and Non-Personnel Cost Estimates

This analysis uses the Alaska's FY2019 Governor's Operating Budgets for API and the DOC to estimate operational costs for general administrative staff (management, finance, human resources, etc.) and for non-program staff (dietician, housekeeping, etc.). Costs were calculated using annual salaries and benefits for each position normalized on a per bed per day basis. Non-personnel costs (travel, services, commodities, capital outlay, grants/benefits, and miscellaneous) were also adjusted to reflect the cost per bed per day.

This study assumed that all costs except the general administrative costs would scale with the number of beds. General administrative costs did not scale because we assumed the existing administrations at API and DOC could support the expansion. Two additional costs were added into the API non-personnel costs at the current administrator's request: (1) a food increase of $13.00 per day; and, (2) the contracted costs for covering patients needing individualized surveillance at $70.00 per bed per day.

Figure 10 shows the general administration, other personnel, and non-personnel costs added to the program personnel costs identified in the previous figures. This provides a total cost per bed per day for each of the types of competency restoration program analyzed in this study. The inpatient daily operational costs are

estimated to range from $943 per bed per day for a 25-bed unit, to $1,087 per bed per day for the current 10-bed Taku Unit; jail-based daily costs are projected at $296 per day.

Figure 10: General Administration, Other Personnel, Non-Personnel, and Total Cost Estimates for Inpatient and Jail-based Restoration, per bed per day

Other Personnel + Non-Personnel Costs	Cost per Bed per Day				
	Program Personnel	Share of Admin Personnel	Other Personnel	Non-Personnel Costs	Total
Inpatient	$538 to $591	$152	$70	$279	$943 to $1,087
Jail Based	$213	$5	$7	$71	$296

Competency Evaluation Staffing Models and Costs

Forensic competency evaluation staff conduct evaluations to determine whether a person is competent to stand trial. This study recommends that the evaluation team operate independently from the competency restoration program staff. Currently, the evaluator's job at API is combined with providing inpatient competency restoration treatment. Combining these two functions limits the number of evaluations completed per week per evaluator to two per evaluator. Best practice research and interviews with API current and previous psychologists identify that one full time evaluator can conduct three evaluations per week, including time for court appearances and reports, if that position is not also providing restoration treatment.

The demand forecast for number of evaluations to be completed assumes 11 percent per year in annual growth. Therefore, in FY2020, three evaluators will be needed to conduct 374 evaluations; in FY2026, 5 evaluators will be needed for 629 evaluations. The cost for the evaluator is equivalent to the costs for the inpatient lead psychologist position, which currently has a pay range that is equivalent to a master's level clinician III or IV. This study recommends creating a separate position classification for forensic psychologies who are overseeing treatment and conducting evaluations.

Figure 11: Competency Evaluation Staffing and Costs

Evaluator Staffing + Costs	FY2018	FY2020	FY2026
# of Evaluations	262	374	629
Evals Per Week Per Staff	2	3	3
Weeks in a Year Excluding Vacation	46	46	46
Number of Evaluators Needed	3	3	5
Annual Cost Assuming $140K per FTI	$399,279	$379,624	$639,320

Appendix 1: Approach Graphics

1. **API - DENALI & TAKU UNITS** **1" = 20'**

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FORENSIC EXPANSION
APPROACH 2

Revisions:

Drawn By: | Checked By:

Date: 6/13/19

Phase:

Job No:

SHEET TITLE:
APPROACH 1:
TAKU/DENALI

SHEET NO:
I-2

LEVEL 1 FLOOR PLAN

3/64" = 1'-0" 1:256

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FORENSIC EXPANSION APPROACH 2

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Date: 6/21/19
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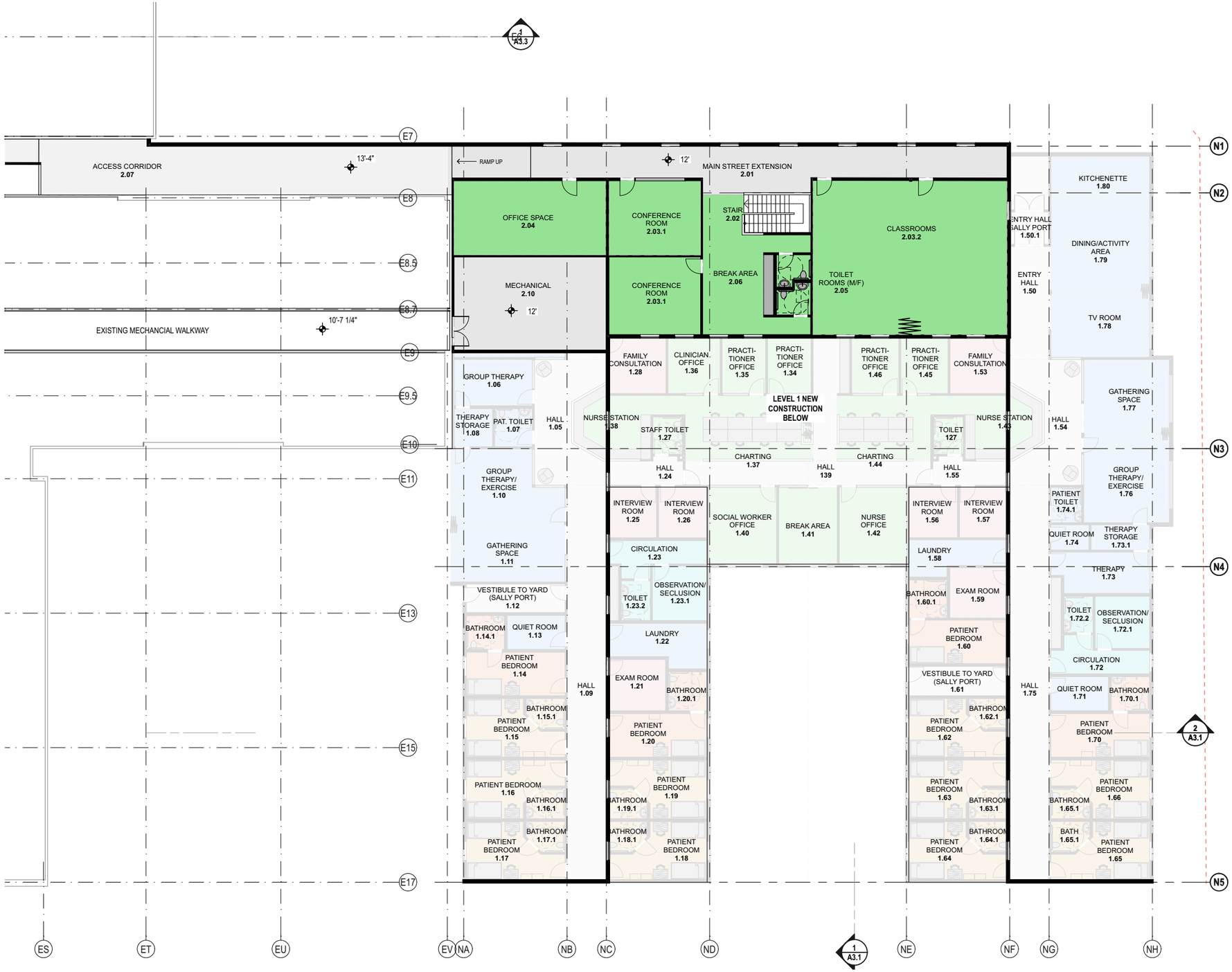
SHEET TITLE: LEVEL 1 FLOOR PLAN

SHEET NO: **A2.1**



1. **LEVEL 2 FLOOR PLAN** 3/64" = 1'-0" 1:256

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Job No:

SHEET TITLE: LEVEL 2 FLOOR PLAN

SHEET NO: **A2.2**

1 **ENLARGED PATIENT WING PLAN** 1/8" = 1'-0"

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APPROACH 2

Revisions:

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Date: 6/21/19
Phase:
Job No:
SHEET TITLE: ENLARGED PLAN
SHEET NO: **A2.3**

Space No.	Space Description	Qty	Area (SF)	Net Area (SF)	Remarks
1.01	Entry Hall	1	145	145	
1.01.1	Entry Hall Sally Port	1	100	100	
1.02	Kitchenette	1	200	200	Commercial kitchen with fire rated hood, range. Three compartment sink, hand wash sink, refrigerator.
1.03	Dining/Activity Area	1	300	300	
1.04	TV Room	1	265	265	
1.05	Hall	1	285	285	
1.06	Group Therapy	1	150	150	
1.07	Patient Toilet	1	60	60	
1.08	Therapy Storage	1	60	60	
1.09	Hall	2	630	1,260	
1.10	Group Therapy/Exercise	1	310	310	
1.11	Gathering Space	1	280	280	Natural light, comfortable seating, maybe airport style with arms.
1.12	Vestibule to Yard (Sally Port)	1	115	115	
1.13	Quiet Room	1	85	85	Calming environment. Good observation, one or two persons.
1.14	Patient Bedroom	1	180	180	Ligature resistant, Acrovyn doors, seamless durable floors, abuse resistant GWB, doors open out slowly.
1.14.1	Bathroom	1	50	50	Ligature resistant. Dead bolt on door, not able to lock from inside room, wall tile, seamless floor finish with floor drain. Fixtures similar to Whitehall WH3775 lav and WHR2142 ADA toilet.
1.15	Patient Bedroom	1	190	190	
1.15.1	Bathroom	1	45	45	
1.16	Patient Bedroom	1	190	190	
1.16.1	Bathroom	1	45	45	
1.17	Patient Bedroom	1	190	190	
1.17.1	Bathroom	1	45	45	
1.18	Patient Bedroom	1	190	190	
1.18.1	Bathroom	1	45	45	
1.19	Patient Bedroom	1	190	190	
1.19.1	Bathroom	1	45	45	
1.20	Patient Bedroom	1	177	177	
1.20.1	Bathroom	1	52	52	
1.21	Exam Room	1	120	120	
1.22	Laundry	1	155	155	
1.23	Circulation	1	100	100	
1.23.1	Observation/Seclusion	1	120	120	Minimum length 7 feet, maximum length 11 feet
1.23.2	Observation/Seclusion Toilet	1	40	40	
1.24	Hall	1	80	80	
1.25	Interview Room	1	100	100	Good observation from nurse station.
1.26	Interview Room	1	100	100	Good observation from nurse station.
1.27	Staff Toilets	2	45	90	

Space No.	Space Description	Qty	Area (SF)	Net Area (SF)	Remarks
1.28	Family Consultation	1	135	135	Acoustically private.
1.29	Medications Distribution	1	180	180	Two, side by side open stainless steel counters with med cart between the counters. Med mixing on back wall.
1.30	Circulation	1	80	80	
1.30.1	Observation/Seclusion	1	110	110	Minimum length 7 feet, maximum length 11 feet
1.30.2	Observation/Seclusion Toilet	1	50	50	
1.31	Staff Hall	1	280	280	
1.32	Medical Equipment Storage	1	300	300	
1.33	Patient Property Storage	1	200	200	Near nurse office.
1.34	Practitioners Office	1	100	100	Private office
1.35	Practitioners Office	1	100	100	Private office
1.36	Clinician Office	1	121	121	
1.37	Charting	1	350	350	Ten charting stations I open office setting.
1.38	Nurse Station	1	220	220	
1.39	Hall	1	250	250	
1.40	Social Worker Office	1	215	215	Four workstations in partitioned office suite.
1.41	Break Area	1	185	185	
1.42	Nurse Office	1	215	215	Four workstations in partitioned office suite.
1.43	Nurse Station	1	220	220	Solid surface top and face.
1.44	Charting	1	255	255	Ten charting stations in open office setting
1.45	Practitioner Office	1	100	100	Private office
1.46	Practitioner Office	1	100	100	Private office
1.47	Environmental Services	1	70	70	
1.48	Clean Linen Workroom	1	250	250	
1.49	Soiled Linen Workroom	1	180	180	
1.50	Entry Hall Sally Port	1	145	145	
1.50.1	Entry Hall Sally Port	1	100	100	
1.51	Circulation	1	100	100	
1.51.1	Observation/Seclusion	1	110	110	Minimum length 7 feet, maximum length 11 feet
1.51.2	Observation/Seclusion Toilet	1	50	50	
1.52	Medications Distribution	1	180	180	Two, side by side open stainless steel counters with med cart between the counters. Med mixing on back wall.
1.53	Family Consultation	1	135	135	Acoustically private.
1.54	Hall	1	285	285	
1.55	Hall	1	180	180	
1.56	Interview Room	1	100	100	Good observation from nurse station.
1.57	Interview Room	1	100	100	Good observation from nurse station.
1.58	Laundry	1	120	120	
1.59	Exam Room	1	120	120	
1.60	Patient Bedroom	1	175	175	
1.60.1	Patient Bath	1	60	60	
1.61	Vestibule to Yard (Sally Port)	1	120	120	

Space No.	Space Description	Qty	Area (SF)	Net Area (SF)	Remarks
1.62	Patient Bedroom	1	190	190	
1.62.1	Patient Bathroom	1	45	45	
1.63	Patient Bedroom	1	190	190	
1.63.1	Patient Bathroom	1	45	45	
1.64	Patient Bedroom	1	190	190	
1.64.1	Patient Bathroom	1	45	45	
1.65	Patient Bedroom	1	190	190	
1.65.1	Patient Bathroom	1	45	45	
1.66	Patient Bedroom	1	190	190	
1.66.1	Patient Bathroom	1	45	45	
1.70	Patient Bedroom	1	175	175	
1.70.1	Patient Bathroom	1	50	50	
1.71	Quiet Room	1	80	80	Calming environment. Good observation, one or two persons.
1.72	Circulation	1	115	115	
1.72.1	Observation/Seclusion	1	115	115	Minimum length 7 feet, maximum length 11 feet
1.72.2	Observation/Seclusion Toilet	1	45	45	
1.73	Therapy	1	160	160	
1.73.1	Therapy Storage	1	60	60	
1.74	Quiet Room	1	40	40	
1.74.1	Patient Toilet	1	45	45	
1.75	Hall	1	633	633	
1.76	Group Therapy/Exercise	1	305	305	Natural light, comfortable seating, maybe airport style with arms.
1.77	Gathering Space	1	270	270	
1.78	TV Room	1	200	200	
1.79	Dining/Activity Area	1	355	355	
1.80	Kitchenette	1	200	200	Commercial kitchen with fire rated hood, range. Three compartment sink, hand wash sink, refrigerator.
	TOTAL NET AREA			16,523	NET SQUARE FEET
	GROSSING FACTOR 1.10			1,652	INCREASE NET TO GROSS
	TOTAL GROSS AREA			18,175	GROSS SQUARE FEET
SUPPORT SPACE					
2.01	Main Street Extension	1	1,762	1,762	8 feet wide by 207 feet long.
2.01.1	Environmental Services	1	8	8	
2.02	Stair	1	150	150	Access from Main Street lobby.
2.03	Meetings/Classrooms				
2.03.1	Conference Room	2	290	580	Meeting room for up to 14.
2.03.2	Classroom	2	600	1,200	Classroom for 24. Consider folding partitions between classrooms.
2.04	Office Space	1	450	450	Open workstations for 6 staff.
2.05	Toilet Rooms (M/F)	2	55	110	

Space No.	Space Description	Qty	Area (SF)	Net Area (SF)	Remarks
2.06	Break Area	1	350	350	Small table, layout counter.
2.07	Access Corridor	1	2,000	2,000	Second level of Main Street, views to south and east.
2.08	Off Unit Patient Dining	1	820	820	Roof over and enclose existing courtyard. Heat, ventilate and make space suitable for patient dining.
2.09	Existing Office Tenant Improvemen	3	480	1,440	Convert existing second level classroom space into four workstation office suites.
2.10	Mechanical Room	1	586	586	
3.10	Warehouse Dock Expansion	1	2,400	2,400	Enclose current ramp area and remove existing dock south to enclose additional space.
	TOTAL NET AREA			11,856	NET SQUARE FEET
	GROSSING FACTOR 1.10			1,186	INCREASE NET TO GROSS
	TOTAL GROSS AREA			13,042	GROSS SQUARE FEET

1. ANCHORAGE JAIL LEVEL 3 - RESTORATION CLINIC **1/16" = 1'-0"**

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FORENSIC EXPANSION APPROACH 2

Revisions:

Drawn By: | Checked By:

Date: 6/21/19

Phase:

Job No:

SHEET TITLE:
APPROACH 3: RESTORATION CLINIC

SHEET NO:
I-10

1 **ANCHORAGE JAIL MEZZANINE - RESTORATION CLINIC** 1/16" = 1'-0"

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FORENSIC EXPANSION APPROACH 3

Revisions:

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Date: 6/21/19

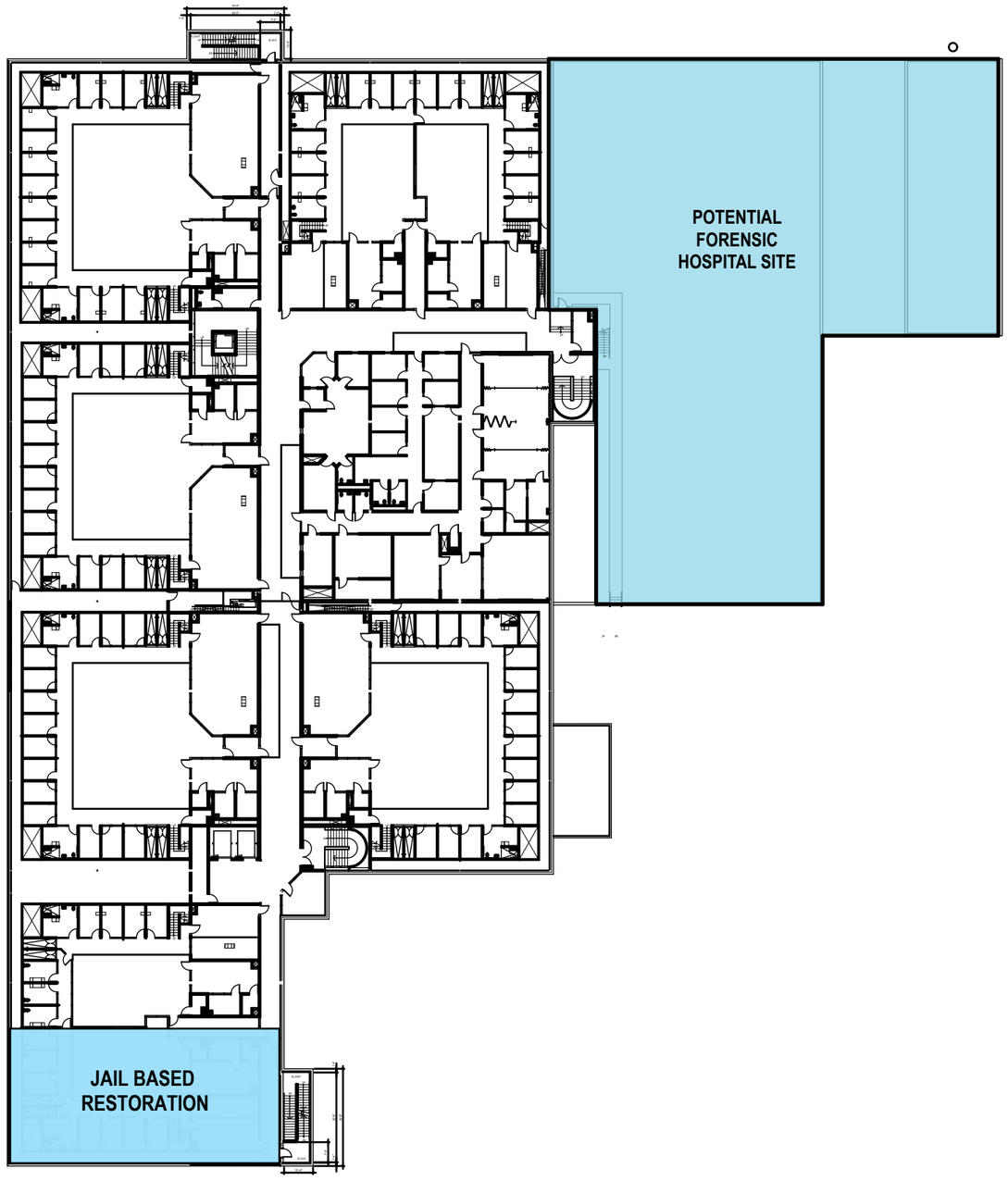
Phase:

Job No:

SHEET TITLE:
APPROACH 3: RESTORATION CLINIC MEZZANINE

SHEET NO:
I-11

NO.	SPACE DESCRIPTION	AREA (SQ.FT.)	QTY	NET (SQ. FT.)	REMARKS
01	Bedroom	80	11	880	One or two occupant bedrooms
02	Accessible Bedroom	90	1	90	One or two occupant bedroom
03	Showers	20	3	60	
04	Accessible Shower	30	1	30	Shower in bedroom
05	Janitor Closet	20	2	40	
06	Staff Restroom	40	1	40	
07	Workstation	60	1	60	Existing security workstation
08	Sally Port	40	1	40	
09	Storage	30	1	30	
10	Multipurpose Room	285	1	285	Group counseling
11	Interview	70	1	70	Counseling/interview space
12	Activity Room	285	1	285	Therapy room
13	Day Room (35'x25')	875	1	875	Open seating, chairs, tables
14	Dining	440	1	440	Within day room space
15	Telephone		3	0	Within day room space
16	Stairway	180	1	180	
17	Nurse Station	200	1	200	Multiple staff station
18	Medication Dispensary	45	1	45	In nurse station
19	Staff Work Area	160	1	160	Small work room for charting, file storage
20	Quiet Room	80	1	80	Open quiet space for 1 patient and staff
21	Seclusion Room	80	1	80	Restraint table
22	Program Administrator	—	1	—	Off unit
23	Clerk	—	1	—	Off unit
24	Psychiatric Nurse Supervisor	—	1	—	Off unit
25	Forensic Psychiatric/Psychiatric Nurse	180	1	180	On unit office for two
26	Clinician	—	1	—	Nurse station
27	Social Worker	—	1	—	Nurse station
28	Mental Health Technician	—	1	—	At nurse station
29	Program Technician	—	1	—	At nurse station
	TOTAL NET AREA			4,150	SQ. FT.



1 ANCHORAGE JAIL LEVEL 3 1" = 50'

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FORENSIC EXPANSION
APPROACH 4

Revisions:

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Date: 6/13/19

Phase:

Job No:

SHEET TITLE:
APPROACH 4: JAIL ADDITION

SHEET NO:
I-13

Appendix J: Matrix of Recommendations from Relevant Background Reports

Type of Change	Target Population	Current	Recommendation	Source
Statute	Competency Evaluation		Title 12 and Title 47 statutes should be amended to allow parties to hire a private expert or request that a second evaluator be appointed at that party's cost, in the event that the party is not satisfied with the report of the court-appointed evaluator.	UNLV, 2014
Statute	Competency Evaluation		Title 12 and Title 47 should be amended to require the Department of Heath and Social Services or its designee to assume responsibility for designating qualified and neutral evaluators.	UNLV, 2014
Statute	Competency Evaluation	AS 12.47.070 references a "defendant's fitness to proceed" or "reasons to believe a mental disease or defect of the defendant will otherwise become an issue in the case".	Remove the aforementioned references and refer instead to "a defendant's competence to proceed under AS 12.47.100".	UNLV, 2014
Statute	Competency Evaluation	AS 12.47.100 "the court shall have the defendant examined by at least one qualified psychiatrist or psychologist, who shall report to the court concerning the competency of the defendant"	Define the terms "qualified psychiatrist", "qualified psychologist", and "qualified forensic psychologist" in the Definitions section in AS 12.47.130. Include in the definition of "qualified forensic evaluator" in this section verbiage that expressly permits post-doctoral trainees and interns to conduct evaluations under the supervision of a qualified forensic evaluator.	WICHE, 2016; UNLV, 2014

Type of Change	Target Population	Current	Recommendation	Source
Statute	Competency Evaluation	AS 12.47.100 "…the attorney may file a motion for a judicial determination of the competency of the defendant. Upon that motion, or upon its own motion the court shall have the defendant examined…"	Amend AS 12.47.100 to permit the court to rely on previous and/or recent competency evaluations to determine whether a competency to proceed evaluation for the current charges is necessary, particularly for defendants well known to the court and repeatedly charged with misdemeanor offenses.	WICHE, 2016
Statute	Competency Evaluation	No statute to compel DOC to transfer evaluees promptly following completion of a competency evaluation at API.	Amend either AS 12.47.100 or AS 12.47.070 to include a specific provision that would compel DOC to transfer evaluees promptly following the completion of a competency evaluation at API.	WICHE, 2016
Statute	Competency Evaluation	Alaska does not have statutory provisions permitting the use of telemedicine, telehealth, or telebehavioral health.	Explore use of telebehavioral health. Allow for the use of telebehavioral health and evaluation via videoconferencing in AS 12.47.070 and AS 12.47.100 and throughout Title 47. Allow for the use of telebehaivoral health for forensic evaluations. Define telebehavioral health in statute.	WICHE, 2016 UNLV, 2014
Statute	Competency Evaluation	No statutory limit on the timeframe for completion of competency evaluations for misdemeanor offenses. AK Court System policy to schedule competency hearings three weeks (15 days) after an evaluation has been ordered.	Amend AS 12.47.070 to require that competency evaluations for misdemeanor charges be performed within 15 calendar days of the court order. A 15-day extension should be permitted when the defendant appears to be under the influence of alcohol or drugs at the time of the order.	UNLV, 2014
Statute	Competency Evaluation	No statutory consideration for the availability of previous and/or recent competency evaluations of the same defendant.	In misdemeanor cases where a defendant has received a full competency evaluation in the previous 12 months, the statute could allow for a more limited, follow-up competency evaluation (AS 12.47.070)	UNLV, 2014
Statute	Competency Evaluation	No statutory requirement for scheduling competency hearings. Anchorage Competency Court prioritizes competency cases and puts them on the calendar for the next available court day.	AS 12.47.070 should be amended to require that the court advance the date for the hearing on the defendant's competency to the day after the competency report is filed.	UNLV, 2014

Type of Change	Target Population	Current	Recommendation	Source
Statute	Competency Evaluation	No statutory requirement for scheduling court date for defendants for competent to proceed on a misdemeanor charge.	AS 12.47.070 should be amended to require that the court advance the date for the plea hearing or trial to the earliest possible date if a defendant is found competent to proceed on a misdemeanor charge.	UNLV, 2014
Statute	Competency Evaluation (Juveniles)	Alaska statutes provide little direction as to how juveniles should be treated in competency proceedings.	Consider the following: • Developmental immaturity as a cause of a defendant's incompetence to stand trial. • Include cognitive concepts like a juvenile's ability to understand the proceedings and assist counsel. • Avoid specifying a degree of competency in statute • Provide a separate definition for childhood mental illness • Require competency evaluations be performed within 30 calendar days of the court order for evaluation • Juvenile competency evaluations should be performed by qualified and neutral evaluators with training and experience in child psychology or psychiatry.	UNLV, 2014
Statute	Competency Restoration	Alaska statutes do not currently include provisions regarding the use of psychotropic medications to restore competency in criminal proceedings.	Evaluate practices related to Sell hearings. Amend AS 12.47.110 to allow for the court to order on a finding of incompetency to include the involuntary administration of medication, if appropriate, for treatment to competency. Amend AS 12.47.110 to include a reference to *Sell*, as well as the fact that courts should first use *Harper* factors when an incompetent defendant is dangerous and the treatment is in his medical interest.	WICHE, 2016 UNLV, 2014

Type of Change	Target Population	Current	Recommendation	Source
Statute	Competency Restoration	12.47.110(a), provides that the court "may commit a defendant charged with any other crime," for 90 days, but the statute does not provide guidelines or procedures for courts to follow with respect to competency restoration for misdemeanor crimes.	Consider amending AS 12.47.100 to allow for varying time periods for competency restoration, depending on the seriousness of the charged offense. (Ex. 60 days for class A misdemeanors, 30 days for class B misdemeanors).	UNLV, 2014
Statute	Competency Restoration	Statute does not require the court to be notified as soon as possible regarding competency.	Amend statute to require mental health professionals to notify the court as soon as they believe the defendant to be competent, even if that period is less than the total amount of time allowed for restoration.	UNLV, 2014
Statute	Competency Evaluation	Alaska has not statutorily established diversion programs for misdemeanants suffering from mental illness.	Consider adopting a new statute that allows for a screening investigation and diversion of misdemeanor defendants who are likely to be IST. This approach should only be adopted if the state is satisfied there is a valid and reliable screening tool available.	UNLV, 2014

Type of Change	Target Population	Current	Recommendation	Source
Statute	Competency Restoration (Juveniles)	AS 47.12 governs juvenile delinquency but does not include provisions related to competency restoration for juveniles.	Consider amending juvenile delinquency statutes to: • Provide for placements and services that will accomplish competency restoration in juveniles. • Provide for appropriate periodic review and designate different amounts of time for inpatient vs outpatient restoration • In cases where a juvenile is incompetent due to development immaturity or intellectually disability an restoration is inappropriate consider compromise positions • In cases where a juvenile is incompetent due to development immaturity or intellectually disability an restoration is inappropriate statutes should give juvenile courts the discretion to direct the juvenile into the appropriate social and clinical services for follow-up care.	UNLV, 2014
Statute	Non-Restorable After Treatment	Responsibility for initiating civil commitment proceedings for those found IST and unrestorable is not specified.	AS 12.47.110 (e) should require the Department of Health and Social Services or its designee to initiate inpatient or outpatient civil commitment proceedings or create a discharge plan for the defendant if the defendant is found incompetent and unrestorable or if there is not a substantial probably that the defendant will become competent. The statute should require that the court provide a notice of intent to dismiss the charges and DHSS and its designee shall have 24 hours to initiate civil commitment proceedings, if indicated, or to create a discharge plan.	UNLV, 2014

Type of Change	Target Population	Current	Recommendation	Source
Statute	Not Guilty by Reason of Insanity	AS 12.47.070 requires that for defendants raising the insanity defense "at least two qualified psychiatrists or two forensic psychologists certified by the American Board of Forensic Psychology to examine and report upon the mental condition of the defendant".	Require one qualified psychiatrist or one qualified forensic psychologist to evaluate for insanity rather than two.	WICHE, 2016; UNLV, 2014
Statute	Not Guilty by Reason of Insanity	No functional insanity affirmative defense. Alaska is the only state that limits its insanity defense to the cognitive incapacity prong of M'Naghten and this limitation deprives defendants of a true insanity affirmative defense.	Re-institute a functional insanity affirmative defense in AS 12.47.010 with both the cognitive and moral incapacity prongs of the full M'Naghten test.	UNLV, 2014
Statute	Not Guilty by Reason of Insanity		If the state chooses to re-institute a full M'Naghten test for legal insanity, it should revist and consider revisions to the procedures upon a verdict of not guilty by reason of insanity under AS 12.47.090 and the procedures after raising a defense of insanity under AS 12.47.090	UNLV, 2014
Statute	Guilty but Mentally Ill		If the state chooses to re-institute a full M'Naghten test for legal insanity, it should also consider removing the GBMI verdict from the statute (12.47.040).	UNLV, 2014
Statute	Competency Evaluation, Education	Requirements for continuing education and supervision not identified in statute and a formal process for supervision is not in place.	The Division of Behavioral Health should be designated by statute to coordinate continuing education in forensic evaluations. Continuing education should include, when possible, in-person supervision of the examiner's evaluation practices and reports.	UNLV, 2014
Process			Use forensic consultants external to API to provide guidance and objective analysis of the work of API's forensic evaluators for the purposes of professional development.	WICHE, 2016

Type of Change	Target Population	Current	Recommendation	Source
Process	Competency Evaluation/Restoration	Forensic evaluators serve two roles: Conducting forensic evaluations and serve as members of the competency restoration clinical team.	Employ forensic consultants who are not affiliated with the hospital to review case presentations and reports of the hospital's forensic evaluators to reduce chance for or perception of conflict of interest.	WICHE, 2016
Statute			Amend Title 12 and Title 47 to require that all forensic evaluations be conducted by neutral evaluators and define these terms in AS 12.47.130 and AS 47.30.915, Neutral evaluators should not be involved in the individuals' clinical or restorative treatment. If a neutral evaluator later becomes involved in an individual's treatment, statutes should require subsequent evaluations be conducted by an additional neutral evaluator.	UNLV, 2014
Process	Competency Evaluation	Statutes permit the court to appoint forensic examiners but does not expressly compel the Department of Health and Social Services to conduct the court-order evaluation.	Discussion between DHSS and the State Judicial system regarding which branch of government is responsible for providing forensic evaluators and paying for their services.	WICHE, 2016
Process	Competency Evaluation	AS 12.47.100 permits the court to commit the defendant, "for a reasonable period to a suitable hospital or other facility designated by the court." And AS 12.47.070 (a)(c) reads, "the court may order the defendant to be committed to a secure facility for the purpose of the examination.	Neither statue compels DHSS to consider only API as the facility to which defendants may be admitted. DHSS should consider placements other than API to perform forensic evaluations and competency restorations.	WICHE, 2016
Process	Competency Evaluation	API performs the same level of competency evaluation for all misdemeanor and felony defendants.	Consider a more limited competency evaluation procedure for misdemeanants, including the creation of a brief form for evaluators to complete for competency assessments in misdemeanor cases to help streamline the process.	UNLV, 2014
Process	Competency evaluation	All competency restorations are performed at API by 2 FT forensic psychologists and 1 PT forensic psychologists.	Consider implementation of jail-based competency evaluation. Add forensic psychologists and psychiatrists to augment existing capacity of API to evaluate.	WICHE, 2016 CJC Annual Report, 2018

Type of Change	Target Population	Current	Recommendation	Source
Process	Competency evaluation	No prioritization of evaluations or pre-screening process.	Employ a brief competency screening assessment for defendants **admitted for evaluation** of incompetency to proceed. If the screen identifies the evaluee as likely competent, then the incompetency to proceed evaluation is assigned and conducted by a forensic evaluator as soon as possible. The evaluee can then be returned to the jail of origin once the evaluation is completed and prior to the hearing as AS 12.47.100 (b) reads, "For the purpose of the examination, the court may order the defendant committed for a reasonable period to a suitable hospital or other facility designated by the court."	WICHE, 2016
Process	Competency restoration	Status hearing motions not routinely filed by API for defendants admitted to API for restoration to competency who are uncooperative or who refuse medications deemed necessary to restore them to competency to proceed.	API and its attorneys should routinely file motions for status hearings for defendants admitted to API for restoration to competency who are uncooperative or who refuse medications deemed necessary to restore them to competency to proceed.	WICHE, 2016
Process	Competency restoration	API provides inpatient treatment for civilly committed patients and for competency restoration. Restoration services are provided by 2 FT forensic psychologists and 1 PT forensic psychologists.	Consider reaching out to tertiary care and private, free-standing psychiatric facilities to assess their receptivity to building greater capacity to treat civil patients; thus, freeing up API's capacity to ensure timely admission of forensic patients. Add more forensic psychologists and psychiatrists to augment the existing capacity of API to treat these individuals.	WICHE, 2016 CJC Annual Report, 2018
Process	Care coordination	Limited data sharing between API, hospital emergency rooms, and the Alaska Court System.	Use data systems to identify the individuals who account for a significant number of arrests, court appearances, admissions to API, hospital emergency room contacts, and EMS calls and commit resources to address the unmet needs of this "super-utilizer" population.	WICHE, 2016
Process	Care coordination		Review current criteria for participation in intensive community treatment programs to ensure the individuals most likely to benefit from these services are eligible to receive them.	WICHE, 2016

Type of Change	Target Population	Current	Recommendation	Source
Process	Care coordination		Implement pre-arrest and post-booking/pre-arraignment jail diversion practices (corresponding with Intercepts 1 and 2 of the SAMHSA GAINS Center's Sequential Intercept Model of Jail Diversion).	WICHE, 2016 Trends and Consequences of Eliminating State Psychatric Beds, Fuller, et. al., 2016
Process	Education	Judges and attorneys are sometimes unclear as to what competency restoration entails and what treatment services and programming is available to defendants ordered to API for restoration.	API to provide in-services for the courts and consider inviting members of the court to tour API to better understand the processes there.	WICHE, 2016
Process	Education	Limited training for API treatment providers related to testifying in forensic cases.	Implement an educational curriculum for API staff who are likely to testify in court so that staff are aware of the legal requirements associated with forensic evaluations and treatment, the likely lines of inquiry, relevant case law governing competency to stand trial and the relevant factors to consider for a Sell determination.	WICHE, 2016
Facility	Competency restoration/civil commitments	No intensive care/admitting unit	The facility would benefit from an intensive care/admitting unit, staffed by employees who have the experience and ability to handle the most acute patients.	Non-Confidential Public Report of Alaska Psychiatric Institute Investigation, 2018
Continuum	Care coordination	Lack of community resources for treatment at other levels of care, including specialized services for people with developmental disabilities, dementia and autism.	Scale up community mental health resources to keep pace with the demand for services.	Non-Confidential Public Report of Alaska Psychiatric Institute Investigation, 2018

Appendix K: White Paper on Considerations Related to Accreditation of Forensic Psychiatric Hospitals

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Summary Finding

Accreditation does not appear to play a pivotal role in determining the feasibility of constructing a forensic psychiatric facility. Accreditation most likely will be pursued by any such facility, and this paper has identified TJC's approach to forensically-involved hospital patient populations. A standalone forensic psychiatric hospital is not recommended at this time. However, should the State of Alaska choose to move forward with the construction of a standalone facility, this paper provides a brief overview of necessary considerations. However, the overarching issue may not relate to accreditation of a stand-alone forensic psychiatric hospital but to the State's Return on such an Investment (ROI).

Introduction

Hospital accreditation has been defined as "a self-assessment and external peer assessment process used by hospitals to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve".[1] While adherence to established national standards is a hallmark of accreditation, accreditation is not just about standards, there are analytical and continuous self-improvement dimensions to the process. The management of risks (e.g., medication errors) is a central feature of the accreditation process and an important mechanism for maintaining patient safety.

The Joint Commission (TJC), the nation's oldest and largest standards setting and accrediting body in health care, lists several advantages of accreditation, including:

- Organizes/strengthens patient safety
- Increases community confidence in accredited hospital's quality of care
- Improves risk management and risk reduction
- May reduce liability insurance costs
- Provides deeming authority for Medicare certification
- Is recognized by insurers and other third parties
- May fulfill State regulatory requirements (such as Alaska DBH requirements)
- Aligns hospital with one of the most respected names in health care.

It is important to note, however, that there is limited evidence supporting accreditation's capacity to promote high quality and safe hospital and clinical performance.[2] Accreditation is no panacea, it is a tool to continuously improve performance across clinical, facility, and managerial domains.

[1] Greenfield D and Braithwaite J. Health sector accreditation research: a systematic review. International Journal of Quality Health Care. 2008; 20:172-183.

[2] Brubakk K, Vist G, Bukholm G, Barach P, and Tjomsland O. A systematic review of hospital accreditation: the challenges of measuring complex intervention effects. BMC Health Services Research. 2015; 15: 280.

Hospital Accreditation Organizations

For facilities like the Alaska Psychiatric Institute (API), there are two available accrediting bodies: TJC and the Commission on Accreditation of Rehabilitation Facilities (CARF). The table on the following page compares the two accrediting bodies across several dimensions. Please note that neither TJC nor CARF have specific accreditation standards for forensic hospitals. Section 3 explains how TJC accredits either stand-alone psychiatric forensic hospitals or psychiatric hospitals with forensic units.

> Neither TJC nor CARF have specific accreditation standards for forensic hospitals.

Figure 1: Comparison of The Joint Commission and the Commission on Accreditation of Rehabilitation Facilities

DOMAIN	The Joint Commission	Commission on Accreditation of Rehabilitation Facilities
Organizational summary	An independent, not-for-profit organization which accredits and certifies organizations and programs in the United States.	An Independent, non- profit accreditor of health and human services.
When organization created	1951	1966
Number organizations accredited	20,000+	6,000+
Types of organizations accredited	General, psychiatric, children's and rehabilitation hospitals, critical access hospitals, home care organizations, nursing homes, rehabilitation centers, long term facilities, behavioral health organizations, addictive services, ambulatory care providers, and independent or freestanding clinical laboratories.	Health & human service organizations
Acceptance	Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.	CARF International accreditation provides a visible symbol that assures the public of a provider's commitment to continually enhance the quality of services & programs with a focus on satisfaction of persons served.
Programs	Accreditation: Ambulatory Health Care, Behavioral Health Care, Critical Access Hospitals, Home Care, Hospitals, International Accreditation, Laboratory Services, Nursing and Rehabilitation Center, & Office-Based Surgery. Certification: Advanced Certification, Disease-Specific Care, Health Care Staffing Services, & International Certification.	Accreditation: Aging Services, Behavioral Health, Business and Services, Management Network, CARF-CCAC, Child and Youth Services, DMEPOS, Employment and Community Services, Medical Rehabilitation One-Stop Career Center, Opioid Treatment Program, & Vision Rehabilitation Services.

The Joint Commission

The Joint Commission

The Joint Commission is by far the largest hospital accrediting entity in the United States and controls over 80 percent of the accreditation market as "the accrediting agency of choice for nearly all major hospital systems."[3] For state psychiatric facilities such as API, TJC is a clear choice. It has been the overwhelmingly preferred hospital accreditation body for decades. However, CARF has also accredited hundreds of psychiatric hospitals over its 53 years of existence.

The Joint Commission is the highest regarded in the industry for hospital accreditation. Much of the reason is because hospital accreditation by TJC carries with it deeming authority for Medicare certification. Medicare is a huge reimbursement source for hospitals throughout the country. Section 1865 (a)(1) of the Social Security Act allows hospitals accredited by an approved national accreditation organization (AO) to be exempt from surveys by state survey agencies to determine compliance with Medicare conditions.[4] The Joint Commission is one of ten AOs recognized by the Centers for Medicare and Medicaid Services (CMS) and the only AO that accredits psychiatric hospitals. The Joint Commission has been recognized by CMS as having standards and a survey process that meet or exceed Medicare's requirements. Hospitals that achieve accreditation through a TJC "deemed status" survey are determined to meet or exceed Medicare (and Medicaid) requirements. API is currently accredited by TJC and enjoys deemed status.

Hospital Accreditation Standards[5]

Since there are no forensic-specific TJC Standards, it is important to know how all TJC Hospital Accreditation Standards would be applied. For each of the over 250 Hospital Accreditation Standards, the following components exist:

- **Standard** is a statement that, when achieved, facilitates safe, quality care, treatment, or services.
- **Rationale** describes the purpose of the Standard.
- **Elements of Performance** are the only items scored during surveys and identify performance expectations.
- **Two Icons** indicate whether written documentation is required to determine compliance with the Elements of Performance and Risk-indicating whether risk is assessed (often related to National Patient Safety Goals and Requirements for Improvements identified during surveys).

TJC's Hospital Accreditation Standards are categorized as follows:

- **Accreditation Participation Requirements**. Specific requirements for both participating in & maintaining accreditation.
- **Environment of Care**. Standards relating to safe, functional, & supportive environment that includes the building and its use of space, equipment, & minimizing risks. These standards are often the most challenging standards for compliance.

[3] Lam MB et al. Association between patient outcomes and accreditation in US hospitals: observational study. BMJ. 2018; 363: k4011

[4] Called Conditions of Participation (CoPs) or Conditions for Coverage (CfCs)

[5] The Joint Commission (2018). 2019 Hospital Accreditation Standards. Oakbrook Terrace, IL: Joint Commission Resources, Inc

- **Emergency Management**. Standards relating to emergency planning, mitigation, preparedness, response, and recovery. Another area that poses compliance challenges.
- **Human Resources**. Standards relating to staff qualifications, training, and competency and performance assessments.
- **Infection Prevention and Control**. Standards relating to planning, implementation, and evaluation of an infection prevention and control program.
- **Information Management**. Standards relating to privacy protection, planning for internal/external information needs, and maintaining accurate health information.
- **Leadership**. Standards relating to culture, resource availability, staff competence, and ongoing performance evaluation and improvement.
- **Life Safety**. Standards relating hospital building codes and building maintenance, fire and smoke hazards, means of egress, and other elements of the Life Safety Code. These standards are also among the most challenging standards.
- **Medication Management**. Standards relating to the hospital's medication process, such as selection/procurement, storage, ordering, preparing/dispensing, administering, monitoring, and evaluation.
- **Medical Staff**. Standards relating to credentialing/privileging, bylaws, staff structure, and guiding principles.
- **National Patient Safety Goals.** See C in the following section.
- **Nursing**. Standards relating to the leadership of the Nurse Executive.
- **Provision of Care, Treatment, & Services**. Standards relating to assessing patient needs, planning services, providing services, and coordinating services.
- **Performance Improvement**. Standards relating to data collection, analysis, and using data to make & manage performance improvements.
- **Records of Care, Treatment, & Services**. Standards relating to the components of a medical record, whether paper or electronic. These standards also pose consistent challenges.
- **Rights & Responsibilities of the Individual**. Standards relating to informing patients of their rights, helping them understand their rights, respecting patients' values/beliefs/preferences, and informing patients of their responsibilities regarding their care.

Many of these standards focus largely on structural factors and processes of care, and less on whether the hospital is achieving good outcomes (e.g., lower mortality rates). Patient safety and the management of risks relating to the proximity, probability, and severity of harm to patients has become of increasing importance to TJC. This has implications for forensic units within psychiatric hospitals (i.e., API) and stand-alone forensic psychiatric hospitals, although there are no TJC standards specific to workplace violence either.

National Patient Safety Goals (NPSG)

In 2002, TJC established National Patient Safety Goals (NPSG) to help accredited organizations address specific areas of concern regarding health care safety, and to focus on how to solve them. In order to ensure hospitals focus on preventing major sources of patient harm (e.g., medication errors), TJC regularly revises the NPSG based on their impact, cost, and effectiveness. The 2019 NPSG include a revision requiring hospitals to maintain specific protocols to prevent inpatient suicide, including conducting environmental risk

assessments, screening patients admitted for behavioral health reasons for suicide risk, and implementing tailored suicide prevention plans for high-risk patients.

The NPSG have spawned TJC's approach to Patient Safety Systems, which was developed to provide guidance to hospitals on how 32 of the existing TJC standards could be applied to improve patient safety. The table below summarizes these standards.

Figure 2: Patient Safety System of The Joint Commission

Patient Safety System Characteristic	2019 TJC Standard*
Role of leadership in creating safety culture	APR.09.01.01, APR.09.02.01, LD.02.01.01, LD.02.04.01, LD.03.01.01-03.09.01, LD.04.01.01, LD.04.01.05, & LD.04.01.10
Methods to improve processes & systems	EC.04.01.01, IC.01.03.01, MM.07.01.03, & MM.08.01.01
Interdisciplinary team standardized communication/collaboration	MS.08.01.01, MS.09.01.01, & NR.02.01.01
Safety integrated technologies	PC.03.05.19, PI.01.01.01, PI.02.01.01, PI.03.01.01, RI.01.01.01, RI.01.01.03, RI.01.02.01, RI.01.03.01, RI.01.05.01, & RI.02.01.01

*APR - Accreditation Participation Requirement; EC - Environment of Care; IC-Infection Prevention/Control; LD – Leadership; MM - Medication Management; MS - Medical Staff, NR – Nursing; PC - Provision of Care/Treatment/Services; PI—Performance Improvement; RI - Rights of Individuals.

Standards of Importance for Forensic Units & Stand-Alone Forensic Psychiatric Hospitals

All Hospital Accreditation Standards must be achieved for a forensic unit within a hospital or a stand-alone forensic psychiatric hospital to achieve TJC accreditation. Not surprisingly, the standards that are the most relevant for forensic units within hospitals or stand-alone forensic hospitals are those relating to a safe and secure hospital environment, means of egress, use of sally ports, use of physical space, emergency response, patient rights, use of seclusion & restraints, behavior management, and trained clinical staff and security staff who can implement specialized procedures (e.g., violence risk assessment). These standards are:

Environment of Care. EC.02.01.01, EC.02.02.01, 02.06.01, 03.01.01, 04.01.01- 04.01.05. These relate to risk assessment, safe environment, physical space, staff, & data.

Example: EC.02.01.01. Hospital should have a risk assessment specific to violence risks within the forensic unit/hospital to address resources for the different types of violence—patient/patient, patient/staff, patient/visitor, visitor/staff, etc.

Emergency Management. EM 02.01.01, 02.02.01-.07, 02.02.11, 03.01.01, & 03.01.03. These relate to emergencies, safety/security, communications, staff, & monitoring.

Example: EM.02.02.05. Hospital's Emergency Operations Plan should address local law enforcement's incident command structure to provide ongoing communication and coordination with that structure. In addition, forensic unit/hospital and should develop an active shooter response plan in coordination with local law enforcement.

Leadership. LD 03.01.01, 03.02.01, 03.03.01, 03.04.01, 03.06.01, 03.09.01, 04.01.01, & 04.03.11—these relate to culture, communication, staff, patient safety, & patient flow.

Example: LD.04.01.01. Hospital must comply with local, state, & federal laws, rules & regulations. The Occupational Safety & Health Administration (OSHA) is the federal agency that requires employers to maintain a safe working environment for their staff.

Life Safety. LS 01.01.01, 02.01.20, & 03.01.20). These relate to compliance & means of egress.

Example: LS.02.01.20. Doors to patient rooms are not locked unless the clinical needs of the patients require specialized security or where patients pose a security threat and staff can readily unlock doors at all times.

Provision of Care, Treatment, & Services. PC 01.01.01, 01.02.01-01.02.03, 01.02.13, 01.03.01-01.03.05, 02.01.01-02.01.05, 02.01.11, 02.01.19, & 03.05.01.19. These relate to admissions criteria assessment/reassessments, plan, behavior management, providing care, & use of seclusion/restraint.

Example: PC.01.02.13. Requires that patients receiving treatment for emotional or behavioral disorders receive an assessment that includes maladaptive or other behaviors that create a risk to patients or others.

Rights & Responsibilities of the Individual. RI 01.01.01, 01.01.03, 01.02.01, 01.03.01, 01.04.01, 01.06.03, 01.06.05, 01.06.09, 01.07.01-.05, 01.07.13, & 02.01.01. These relate to communicating rights, participating in care, informed consent, right to know providers, personal rights, & patient responsibilities).

Example. RI.01.06.03. Patients have the right to be free from neglect, exploitation, and verbal, mental, physical, & sexual abuse.

Discussion

Design Considerations

The Facility Guidelines Institute's Guidelines for Design and Construction of Hospitals (FGI) contain information on planning, designing, and constructing hospitals in the United States and is the seminal source on hospital construction. While the current version of FGI has specific guidelines relating to construction of psychiatric hospitals, there are no forensic-specific psychiatric hospital guidelines.

From an accreditation perspective, there are several important design considerations Alaska should consider in determining whether a stand-alone forensic psychiatric hospital should be constructed, including:

- What level of security will be required for which type of forensic patient?
- How will forensic patients be transported?
- What type of clinical and security staffing will be required?
- How many beds should each wing/pod include?
- Will patient doors have locks? CMS does not certify facilities with locked patient rooms.
- What extra precautions need to be taken with fire alarms, utility systems, etc.?
- Will medications be stored on units or in centralized location?
- How will basic patient rights such as right to privacy be weighed against Environment of Care standards such as use of physical space?

Treatment Considerations

From an accreditation perspective, the treatment process is the same in a forensic unit/hospital or a general psychiatric hospital. While all TJC standards relating to the provision of care, treatment, & service apply to a forensic unit/hospital, there are certain elements of forensic services that are important from a clinical and administrative decision-making perspective:

- Use of seclusion and restraint for nonclinical purposes.

- Gradations of seclusion and restraint, alone time in room, ambulatory restraints (protective assistive devices), full restraints, seclusion room, etc.
- How disciplinary restrictions are imposed.
- If and how rights are restricted.
- Discharge and transition planning.
- Length of stay.
- Behavior management interventions, particularly identification of early warning signs of deteriorating behavior.