



Forensic Psychiatric Hospital Feasibility Study

Phase II Final Report, Contract # 0619-006
Submitted to Division of Behavioral Health,
Alaska Department of Health and Social Services

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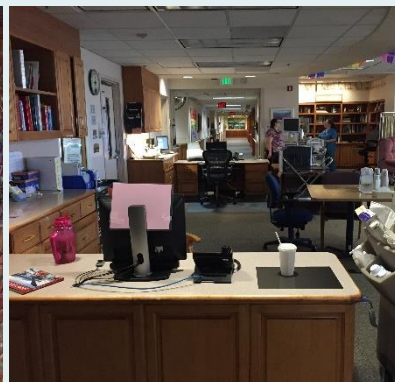
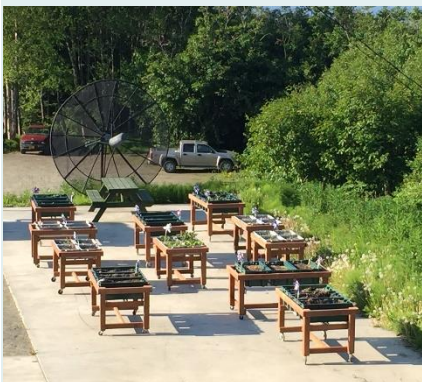


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I. Executive Summary

Scope of Work

The original goal for the Forensic Psychiatric Hospital Feasibility Study was “to explore the feasibility and potential cost of relocating and expanding the Alaska Psychiatric Institute’s (API) current forensic psychiatric unit to another facility in the Municipality of Anchorage.”¹ Through discussions with stakeholders, research, and data analysis during Phase I (November 2018 – February 2019), the research task for this study broadened to include identifying policy, process and statute changes to address the competency evaluation and restoration backlog in Alaska, and to improve the forensic psychiatric system overall.

The study conclusions from Phase I led to changed deliverables in Phase II (March 2019 – July 2019) to include research and analysis of alternatives to inpatient restoration treatment; research of the forensic psychiatric workforce in Alaska, and five other states; identification of a data tracking tool or system for monitoring statewide competency evaluations and restoration; and, refinement of estimated number of beds and approaches to meet the need for competency evaluation and restoration.

Overall, Alaska faces a constellation of issues that drive the need for this study including:

- High demand for forensic psychiatric evaluation and treatment services among people with mental illness who are justice-involved;
- Increasing volume of court-orders for competency to stand trial (CST) evaluations and incompetent to stand trial (IST) restoration treatment and a very limited number of inpatient beds to provide restoration treatment resulting in lengthy delays;
- Pressures on staff who both complete evaluations and provide restoration treatment; and,
- Very limited options to safely discharge individuals determined incompetent to stand trial (IST) following restoration treatment, contributing to some individuals cycling through the courts, corrections, API, and crisis services, increasing the risk of harm to the individual and to the community.

To address this range and complexity of issues requires a multidimensional approach. Analysis of the demand for increased forensic psychiatric bed capacity is one component of this study and its recommendations. This Phase II report draws forward key data points and findings from the Phase I report, incorporates new data and findings, and significantly expands the range of options for system improvement. This report is supported by 11 appendices, labeled A-K, and referenced throughout.

Goals for System Improvement

Based on the findings of this study, we propose the following goals to guide improvement of Alaska’s forensic psychiatric system:

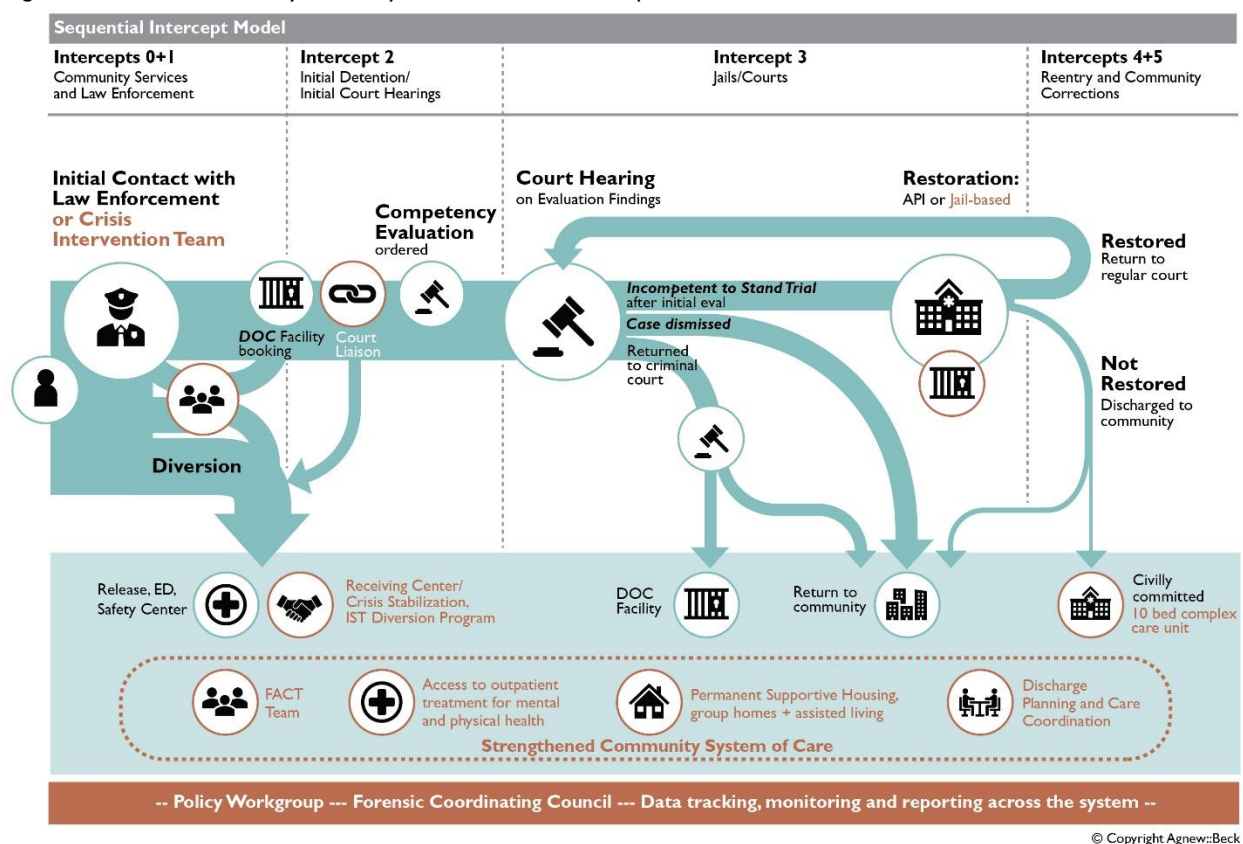
1. Increase safety for individuals with mental illness and for the community, and reduce inflow to the system, by reducing contacts with the criminal justice system that result in the initiation of competency proceedings.

¹ State of Alaska Request for Proposals RFP 190000005, Issued August 3, 2018.

2. Increase system efficiency so that individuals proceed through the process to the most appropriate disposition without delay.
3. Reduce returns to the system by connecting individuals with appropriate long-term supports to address health and social needs.

Figure 1 illustrates Alaska's forensic psychiatric system with the recommended improvements from this study to achieve the three goals identified above. These recommendations are based on the key findings of this study and are described in this chapter and throughout this report.

Figure 1: Alaska's Forensic Psychiatric System, Recommended Improvements



Background

Forensic Psychiatric System Overview

It is well-established in federal and state law, that criminal defendants must be legally competent before a criminal case against them may proceed. Competency to proceed is a central element of a defendant's right to a fair and speedy trial under the 6th and 14th Amendments to the U.S. Constitution. In *Drope v. Missouri*, the U.S. Supreme Court stated, "It has been long accepted that a person whose mental condition is such that (s)he lacks the capacity to understand the nature and object of the proceedings against him, to consult with counsel, and to assist in preparing his defense may not be subjected to a trial."²

² *Drope v. Missouri*, 420 U.S. 162. 1975; "(s)he" added.

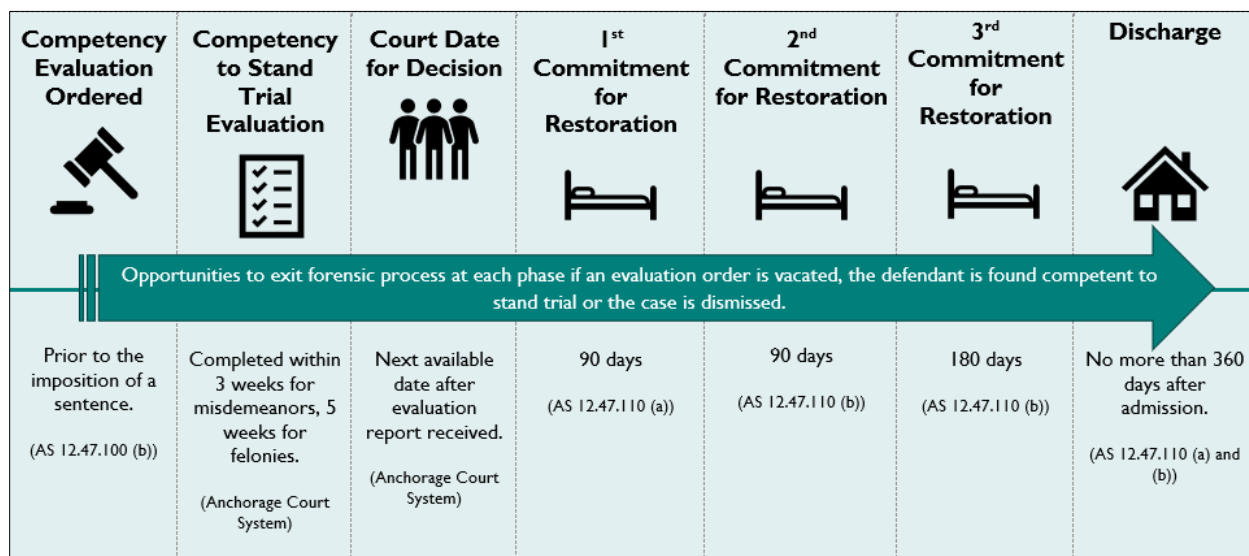
When either party, or the court, has reason to believe that a defendant lacks the capacity to understand the proceedings against him or her or to assist meaningfully in his or her defense, the court must suspend further criminal proceedings until the defendant's competency to stand trial has been determined. If the defendant is found competent to stand trial (CST), criminal proceedings may resume. If a defendant is found incompetent to stand trial (IST), the court may order that the defendant receive such services or treatment as is necessary to restore him or her to competency.

In some cases, after treatment for restoration, an individual remains incompetent to stand trial and is determined to be “non-restorable”. Because the person has not been tried for the crime for which they were charged, the person cannot continue to be held by the criminal court; these individuals have their cases dismissed and may be committed to a psychiatric hospital for treatment through a separate civil process, although in Alaska this latter course is very rare and most often, charges are dismissed without subsequent civil commitment.³

Over the past two decades across the country, there has been a significant increase in the number of competency evaluations requested, and the number of defendants found incompetent to proceed and referred for restoration. The increase in demand for competency evaluations and restorations has strained many states' inpatient resources, leading to federal lawsuits and settlements that require states to make restoration treatment available to all defendants found incompetent to stand trial within a specified timeframe, typically less than 30 days.

In Alaska, the Anchorage Court System set timeframes for the completion of competency evaluations and court hearings. These timeframes are not statutorily defined and vary by court. Alaska Statute defines the number of days and times an individual can be committed for competency restoration, capping the number of days at a total of 360. Figure 2 depicts the forensic psychiatric process in Alaska.

Figure 2: Forensic Psychiatric Process in Alaska



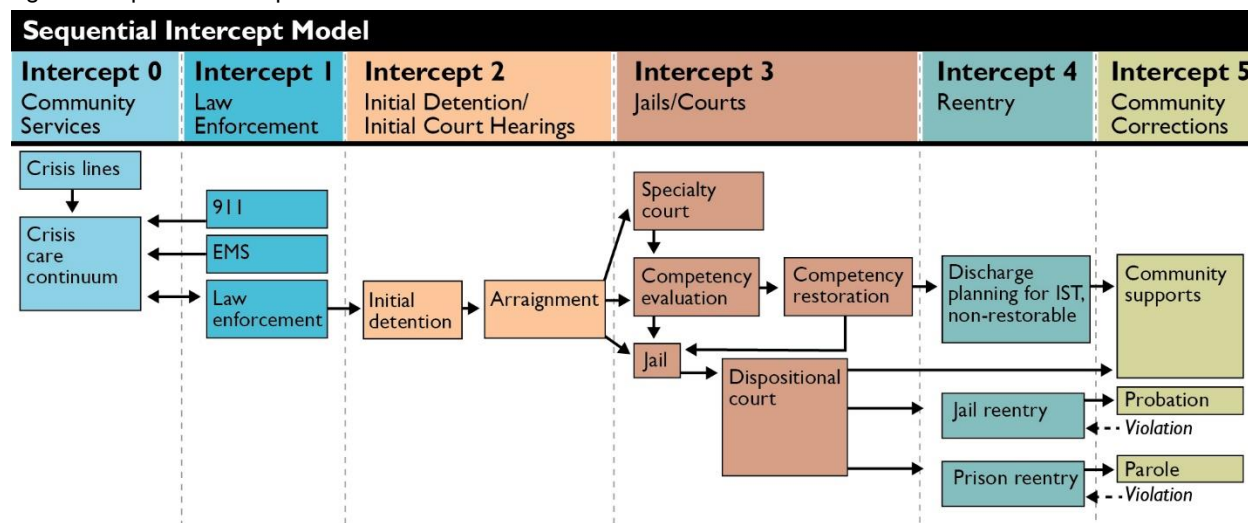
Sequential Intercept Model

Alaska has explored and adopted the Sequential Intercept Model, developed by the Substance Abuse and Mental Health Services Administration's (SAMHSA) GAINS Center, for the diversion of persons with

³ See Alaska Statute 12.47.110(b) Commitment on finding of incompetency

mental health disorders from the criminal justice system as part of its comprehensive approach to reducing recidivism to Alaska’s jails.⁴ The model intends to divert from criminal justice involvement those persons whose behaviors are primarily driven by their mental health condition and not by criminogenic factors. The model provides a useful framework to apply to the forensic psychiatric process to identify the six intercept points where potential exists to divert a person from deeper involvement in the criminal justice system, depicted in Figure 3 below.

Figure 3: Sequential Intercept Model



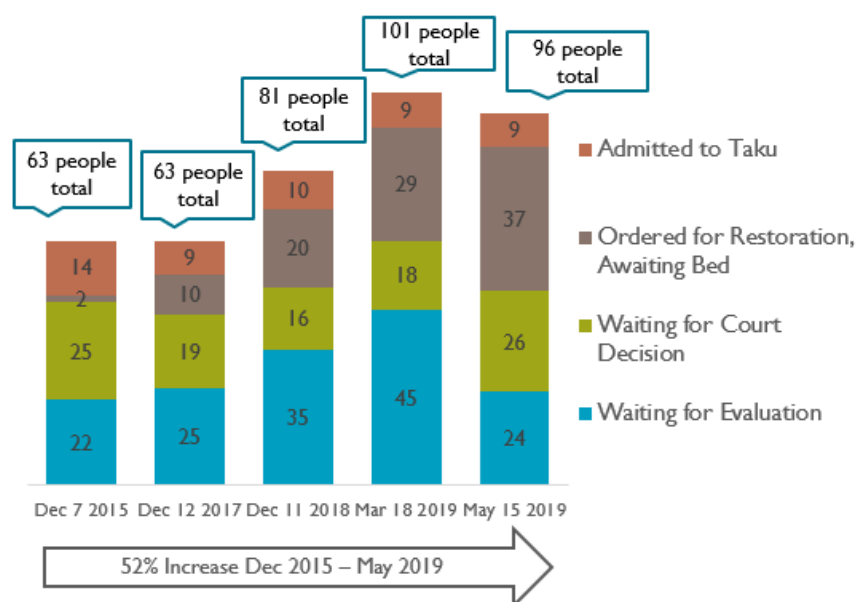
Source: Adapted from SAMHSA’s GAINS Center for Behavioral Health and Justice Transformation. Developing a Comprehensive Plan for Behavioral Health and Criminal Justice Collaboration: The Sequential Intercept Model.

Alaska’s Forensic Psychiatric System is Overloaded

The State of Alaska operates the Alaska Psychiatric Institute (API), an 80-bed psychiatric hospital, which includes the ten-bed Taku Unit for forensic psychiatric treatment. The recent addition of several contracted evaluators reduced the number of individuals waiting for an evaluation between March and May 2019, but the number of individuals waiting for a restoration bed at API has continued to increase. Demand for forensic psychiatric services grew four percent over the course of this project (December 2018 – May 2019) and demand in May 2019 is 52 percent greater than what it was in December 2015.

⁴ Concepts from the Sequential Intercept Model have been adopted by the Alaska Prisoner Reentry Initiative and the Alaska Criminal Justice Commission.

Figure 4: Alaska Forensic Psychiatric System Backlog, Point in Time Counts



Source: API Tuesday Reports, December 7, 2015, December 12, 2017, December 11, 2018; Hand counts provided by API staff March 18, 2019, May 15, 2019

In 2018, individuals waited an average of seven weeks to receive an evaluation for competency and another sixteen weeks to be admitted to API for restoration. Approximately 72 percent of individuals are held in Department of Corrections (DOC) facilities while they wait for competency evaluation and restoration.⁵

Figure 5: Wait Times for Evaluation and Admission in 2018

Stage in the Process	2018 Average Weeks: All Charges		
	All	Anchorage	Non-Anchorage
Waiting for Evaluation	7	7	8
Waiting for Admission [1]	16	13 to 16	17
Total waiting from Date of Evaluation Order to Admission	23	20 to 23	25

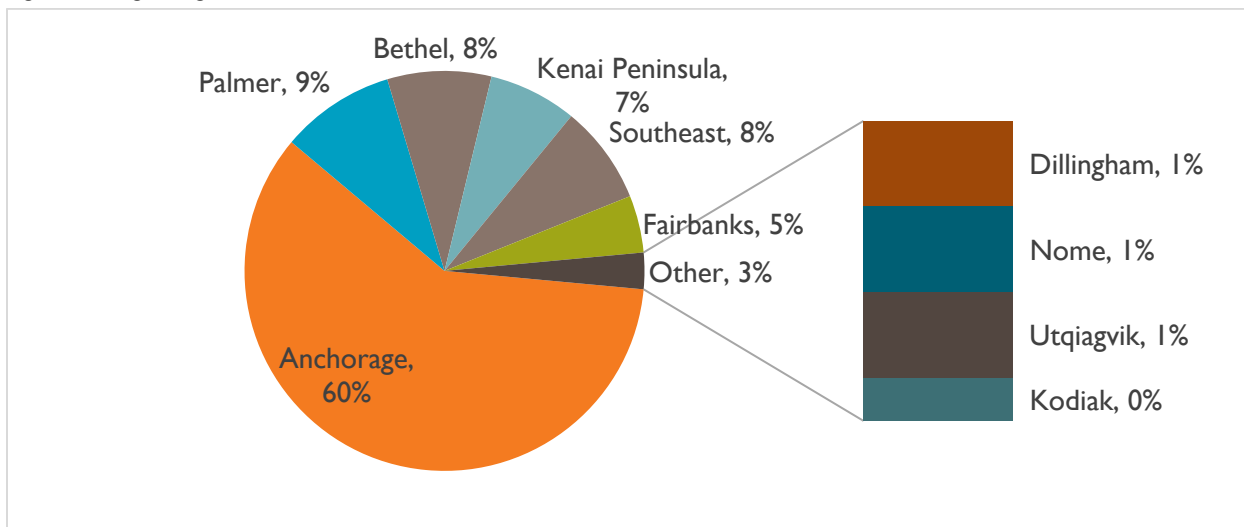
[1] Data from the Anchorage Competency Court Calendar indicates a 13 week wait for admission from date of complete evaluation. This is different from the 2018 API Tuesday Reports showing a 16 week wait for Anchorage.

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

Based on 2018 data, 60 percent of all competency evaluation orders originated in Anchorage courts and the courts in Palmer, Bethel, the Kenai Peninsula and Southeast were all responsible for between 7 and 8 percent of the total competency orders in 2018; Fairbanks originated five percent.

⁵ Data compiled and analyzed by Agnew::Beck from one year's worth of API Tuesday Reports for calendar year 2018.

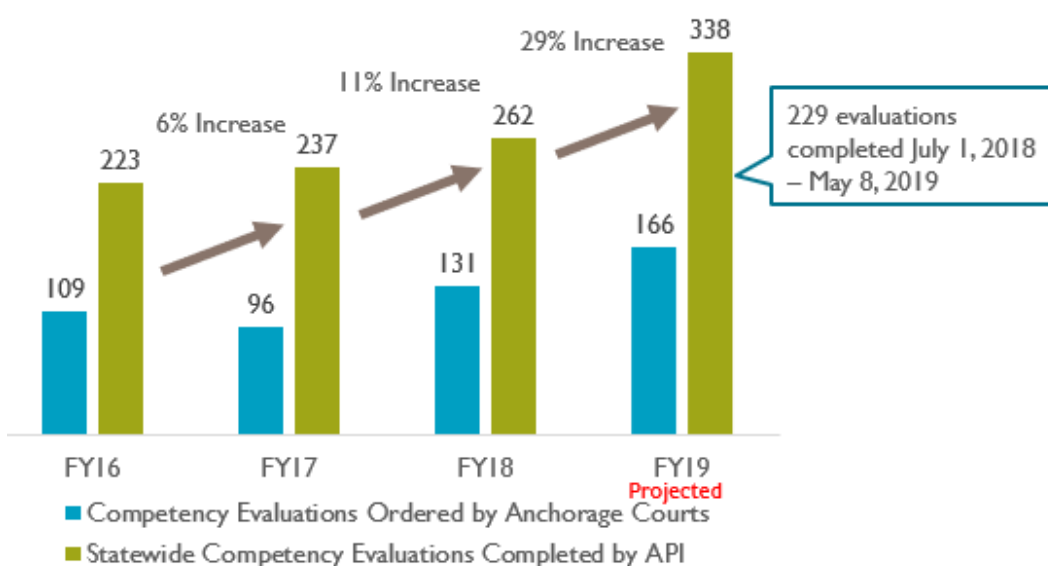
Figure 6: Originating Court



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

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 six 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.

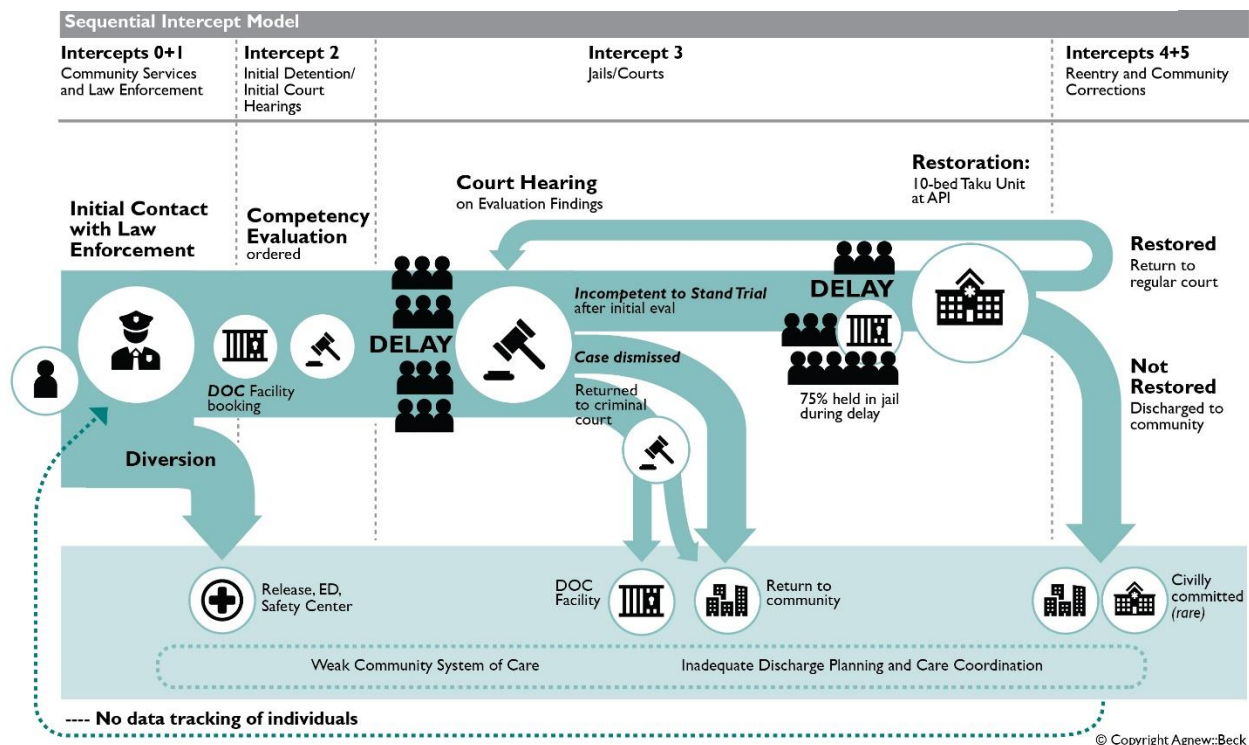
Figure 7: Growth in Evaluations Ordered and Completed, FY 2016 - FY 2019



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

The delays in Alaska's competency evaluation and restoration system are primarily due to two factors: the forensic psychologists employed by the State of Alaska at API are unable to complete evaluations at a pace that meets demand; and, the ten beds in the Taku Unit are not adequate to meet the demand for inpatient competency restoration. Additional factors that contribute to the system backlog include a lack of pre- and post-arrest diversion programs to decrease the flow of mentally ill individuals into the criminal justice system and limited options for safe and supported discharge to the community for individuals found incompetent to stand trial and not restorable. Individuals with a mental illness are often released to the community with little or no supports and are frequently arrested on new charges and returned to the forensic psychiatric process.

Figure 8: Delays in Alaska's Competency Evaluation and Restoration Process



Urgent Action is Needed

Five western states (Colorado, Nevada, Oregon, Utah and Washington) have been sued over delays in competency evaluation and restoration in recent years. The average wait times for restoration beds in the western states with lawsuits ranged from 32 days to six months at the time of the lawsuits. The average wait for a bed at API from completion of evaluation to admission was four months in 2018.

Settlement agreements in all five states limit the wait time for restoration treatment to seven to 28 days. Washington has paid tens of millions of dollars in fines since 2016, and Colorado is paying \$33,000 per day for failing to meet the terms of its settlement agreement. If Alaska were under a similar order to Colorado, the estimated cost to the state in fines in 2018 could have been at least 3.4 million dollars.⁶

⁶ Sixty-one individuals found IST multiplied by \$500 per day waiting, multiplied by 112 days waiting

Key Findings + Recommendations

The key findings from Phase I and II of this study demonstrate the need to expand capacity for competency evaluations and restoration, and to expand diversion and discharge services to reduce inflow and returns to the forensic psychiatric system. The Implementation Plan later in this chapter includes a complete list of recommendations, and each is further discussed in Chapters 2 – 6 of this report.

1. Alaska lacks services to divert people experiencing mental illness and psychiatric crisis from the criminal justice system and has an insufficient supply of treatment and behavioral management programs as well as programs that address basic needs.

While improving the competency evaluation and restoration process and expanding its capacity to reduce wait times is critical, Alaska must also reduce the inflow to the system and the rate of return to the system. Stakeholder interviews identified lack of housing, limited access to medical care and medications, and community supports to help individuals manage difficult behaviors as key gaps in the current care continuum. Without housing and appropriate supports, individuals end up cycling through the system and correctional settings become the de facto placement for people with mental illness. This is not only poor care for the individual that often leads to more trauma and a worsening of symptoms, it is also expensive and overburdens safety net providers such as hospital emergency departments, police, fire and EMS services, and the mental health treatment resources within Department of Corrections.

This study recommends additional diversion strategies that focus on Sequential Intercepts Zero, One and Two. Pre-booking diversion occurs prior to arrest and generally involves community services and law enforcement. Post-booking diversion occurs after initial detention but before initial court hearings and includes screening, assessment, negotiations with partner organizations and linkages to community services. While Alaska's therapeutic courts divert individuals from correctional settings, they can only work with defendants who are considered competent to participate in court proceedings. Because of the delays in Alaska's competency evaluation and restoration system, an individual may spend 6 months in jail and then a further 3 months at API before being deemed competent to participate in a therapeutic court. Additional points of diversion are necessary to truly divert individuals with mental illness from the criminal justice system, when it is appropriate to do so.

This study recommends a phased implementation to improve diversion from the criminal justice system, as follows:

Immediate Action (0-6 months)

- Increase availability of co-responders to Crisis Intervention Teams.

Medium-term Action (6 months – 2 years)

- Implement a Crisis Now crisis stabilization model.
- Create a court liaison pilot program in the Anchorage District Court.

2. Available competency evaluation and restoration services do not meet the demand for these services.

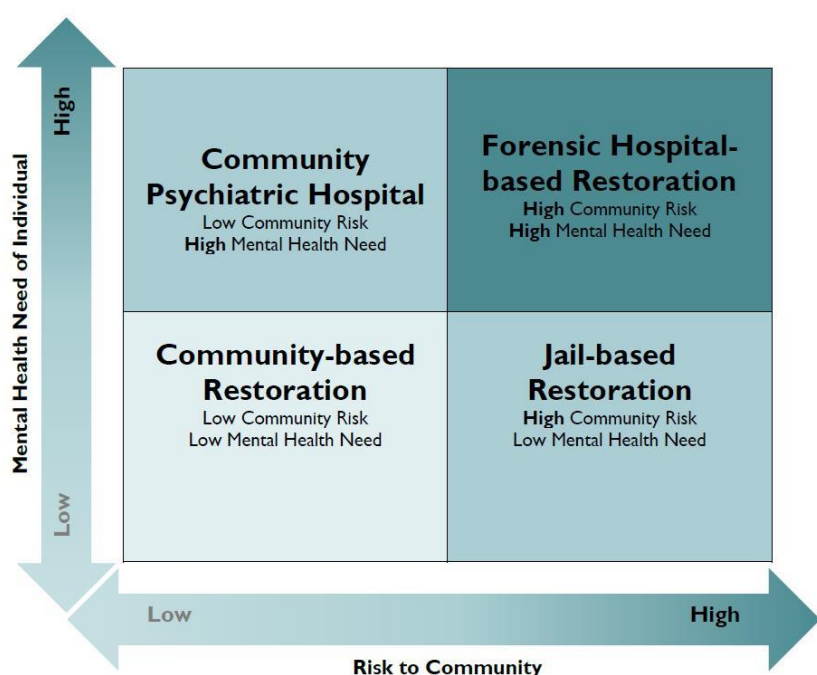
There is significant backlog in the system for those awaiting competency evaluations and restoration. Currently, individuals wait an average of 7.5 weeks to receive an evaluation for competency and another

sixteen weeks to be admitted to API for restoration.⁷ These timeframes for competency evaluation and restoration are significantly longer than most states.

To clear the backlog and keep pace with rising demand, API should be staffed with three full-time evaluators capable of completing three evaluations per week. The State should plan to fund five forensic evaluators by 2026, based on a forecasted growth rate of 11 percent per year in evaluations. Appendix H details the staffing model and costs for forensic evaluators.

Alaska will require new physical space for restoration treatment, but that space does not need to be a new and separate facility from API. This study recommends the State develop a tiered system for restoration that considers the level of community risk posed by the defendant, and the defendant’s acuity and complexity of mental health needs, as illustrated in Figure 9, when determining the appropriate setting for restoration.

Figure 9: Matrix of Level of Community Risk and Mental Health Need

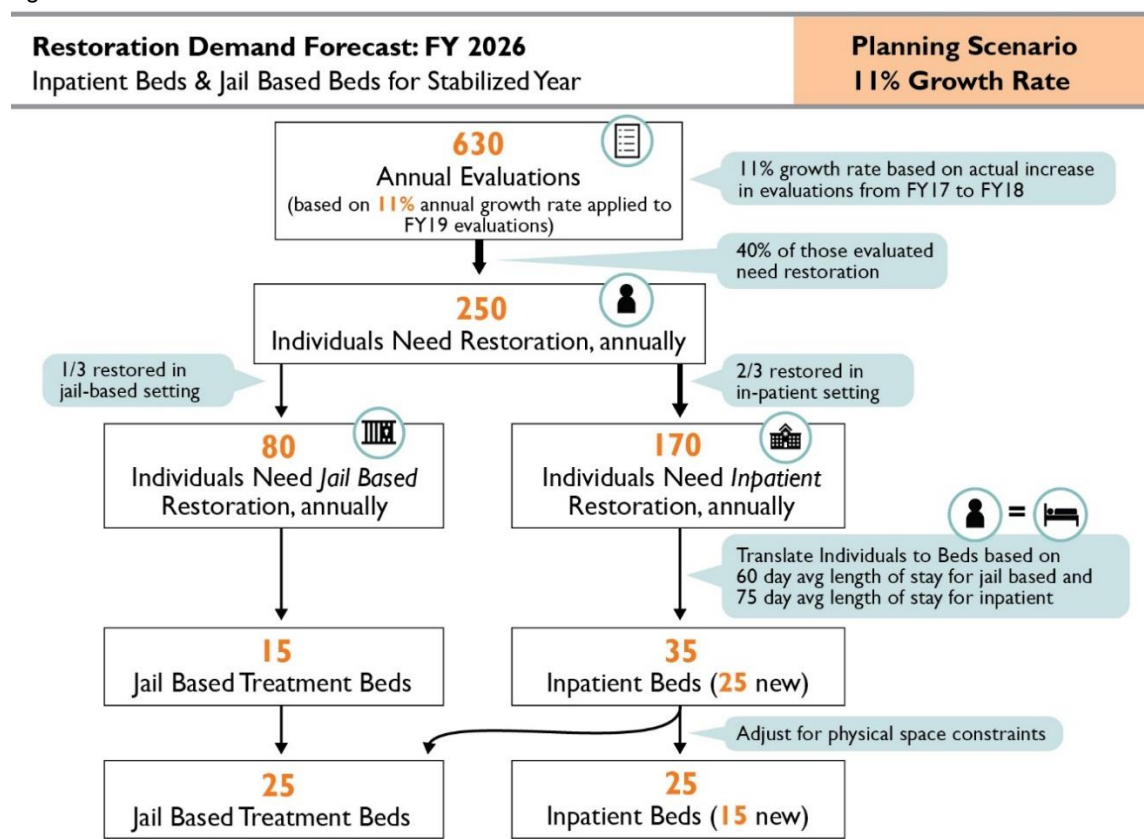


Source: Developed by Dr. Patrick Fox, formatted by Agnew::Beck

Figure 10 provides the estimates of demand for jail-based and inpatient hospital restoration beds. Annual growth in competency evaluation orders is assumed to be 11 percent, with the average annual growth rate dropping to two percent in 2026 as the backlog in the system is cleared. The full description of the method for this estimate is included in Appendix G of this report.

⁷ Anchorage Court Competency Calendar Hearing Data, July 1, 2015 – December 31, 2018.

Figure 10: Demand for New Restoration Beds



This study analyzes four possible approaches to meet the demand for inpatient restoration beds; each approach is discussed further in Chapter 7:

Approach 1: Modify one of the existing API treatment units to provide inpatient restoration treatment to 10 additional patients for a total of 20 forensic beds.

Approach 2: Expand API to add two new inpatient restoration treatment units. Move Taku patients into new space, convert Taku to civil treatment beds. New forensic count to increase from 10 to 25 patients.

Approach 3: Develop a jail-based restoration program in the Anchorage Correctional Complex. Program to include 25 patients in one of the 32-bed existing housing pods.

Approach 4: Expand the Anchorage Correctional Complex for additional inpatient restoration beds. Sized for current (25 beds) or future capacity needs. Additionally, 25 beds of jail-based restoration would be provided at the Anchorage Correctional Complex under Approach 4.

Figure 11 below summarizes the number of beds added, capital, and operating costs for each approach.

Figure 11: Summary of Approaches

Item	Approach 1	Approach 2	Approach 3	Approach 4
Beds	20 inpatient restoration beds within existing API footprint	25 inpatient restoration beds at an expanded API	25 jail-based restoration beds at the Anchorage Correctional Center	25 jail-based restoration beds & 25 inpatient restoration beds at the Anchorage Correctional Center
Capital Cost	\$1.8 million	\$27 million	\$2 million	\$2 million for jail based within existing footprint & \$27 million for 25 beds of inpatient restoration
Annual Operating Cost	\$4.1 million	\$8.6 million	\$2.7 million	\$11.3 million
Annual Operating Cost Per Day Per Bed	\$995	\$947	\$296	\$296 for jail-based restoration & \$947 for inpatient restoration beds

This study recommends a phased implementation to increase capacity for competency evaluation and restoration, as follows:

Immediate Action (0-6 months)

- Expand evaluation staffing.
- Contract for external oversight of forensic evaluation services.
- Include a screening for level of restoration treatment in initial evaluation.
- Implement Approach 1 to temporarily add 10 forensic beds to existing API footprint.
- Implement jail-based outreach restoration at the Anchorage Correctional Complex to initiate restoration treatment for some while waiting for an inpatient bed, or in place of an inpatient bed.

Medium-term Action (6 months – 2 years)

- Implement Approach 3 to designate a unit at the Anchorage Correctional Complex for jail-based restoration to provide an alternative to inpatient restoration treatment and reduce wait times.
- Evaluate current restoration programming at API.
- Amend Title 12 Statute to provide clarity on involuntary medication.
- Formalize process for restoration of juveniles.
- Implement a statewide competency calendar for Alaska courts.
- Create new psychologist job classification within State of Alaska system.

Long-term Action (2 years+)

- Implement Approach 2 to expand API by 25 beds.

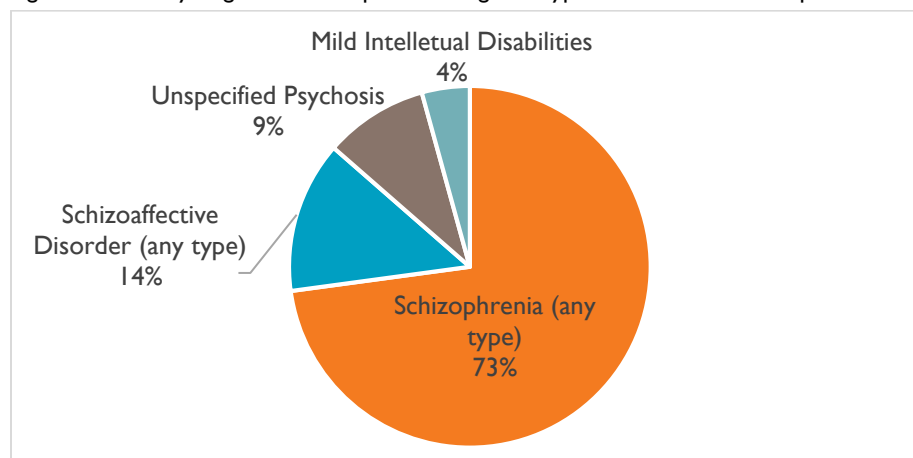
A description of community based, jail-based and inpatient restoration can be found in Appendix B.

3. Individuals committed to API for competency restoration are most likely to be a younger adult male, with a diagnosis of schizophrenia, and are more likely to be a person of color compared to the civilly committed population at API.

Eighty-two percent of those who are IST and committed to API for restoration are men, while 56 percent of API's civilly committed population are male.⁸

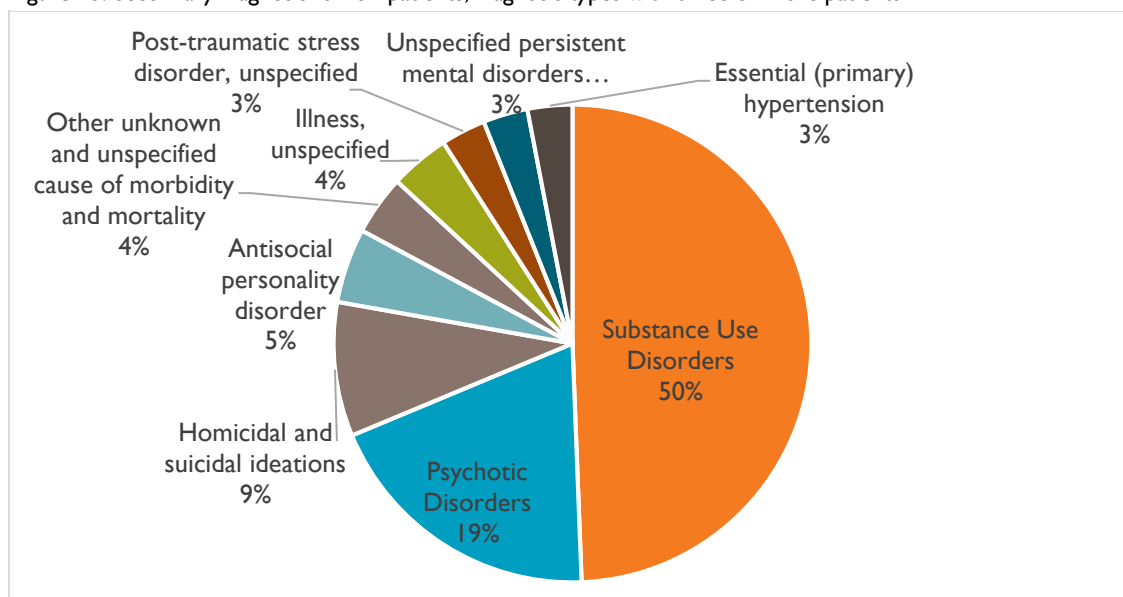
Ninety-six percent of the IST population have a psychotic disorder (schizophrenia, schizoaffective disorder or unspecified psychosis). Fifty-percent have a secondary substance use disorder diagnosis.⁹

Figure 12: 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 13: 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

⁸ API 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.

⁹ API Meditech Electronic Health Records. IST and Non-IST Discharge Diagnosis. July 1, 2015 – December 31, 2018. Diagnoses types with three or more patient with a given diagnosis. Schizophrenia diagnosis (any type), n = 102; includes schizophrenia unspecified, schizophrenia NOS, paranoid schizophrenia, undifferentiated schizophrenia and disorganized schizophrenia.

Over half of civilly committed patients at API 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, compared to just four percent in the civilly committed population. Alaska Native people comprise 32 percent of the civilly committed population at API, and 32 percent of the IST population.¹⁰

4. Nearly three-quarters of individuals who are engaged in the competency evaluation and restoration process are waiting in jail.

In 2018, 72 percent, or 166, of competency cases were held in custody while they awaited a competency evaluation. The average wait time from the date of evaluation order to date admitted to the Taku Unit is 23 weeks, which means in 2018, approximately 26,726 bed-days at DOC facilities were used by individuals engaged in the competency process.¹¹

This study recommends a phased implementation to provide jail-based restoration, as follows:

Immediate Action (0-6 months)

- Implement a jail-based outreach restoration program at the Anchorage Correctional Complex.

Medium-term Action (6 months – 2 years)

- Implement a designated jail-based restoration unit at the Anchorage Correctional Complex.

5. Nearly two-thirds of competency cases involve at least one felony charge and over 50 percent of those evaluated are found incompetent to stand trial. Delays in the competency evaluation and restoration process sometimes lead to criminal charges being dismissed.

In 2018, 64 percent of all statewide competency cases had at least one felony charge and 36 percent had only a misdemeanor charge.¹² This is contrary to many stakeholders' beliefs that most competency defendants were facing misdemeanor charges.

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 incompetent to stand trial.¹³ Long wait times for admission to API for restoration treatment lead to more cases being dismissed prior to a defendant being admitted for restoration treatment. In Anchorage, the number of cases where competency issues have been raised that were dismissed either by the prosecution or in the interest of justice has increased over the past four years, while the number of these cases being tried in criminal court has decreased. Figure 14 represents the total number of Anchorage cases in each disposition category, which includes individuals who had cases dismissed before or after restoration and individuals who were found competent to stand trial before or after restoration.

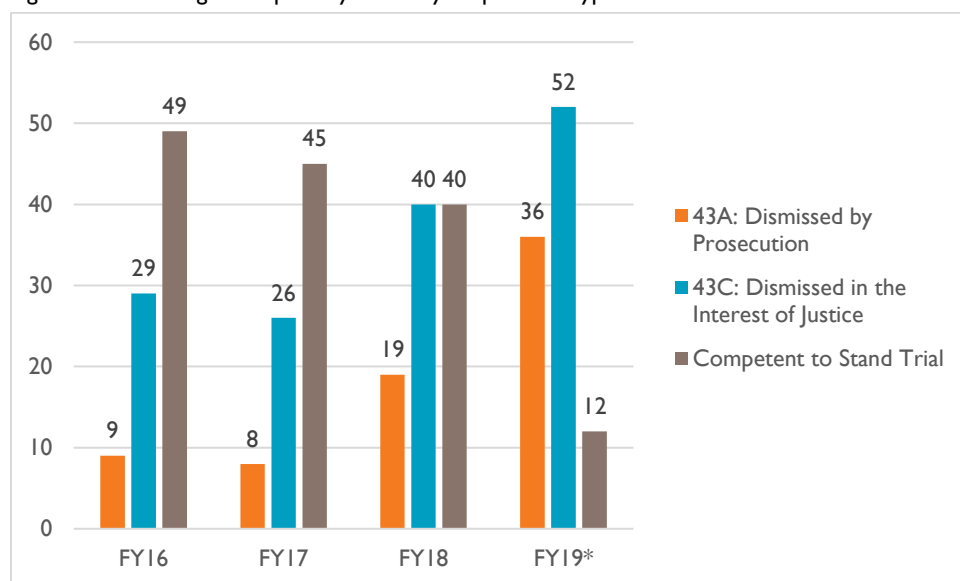
¹⁰ API Meditech Electronic Health Records. IST and Non-IST Race. July 1, 2015 – December 31, 2018. IST white, n = 30; IST African American, n = 14; IST Alaska Native, n = 35. Non-IST white, n = 1204; IST African America, n = 104; IST Alaska Native, n = 757.

¹¹ Data compiled and analyzed by Agnew::Beck from one year's worth of API Tuesday Reports for calendar year 2018.

¹² Data compiled and analyzed by Agnew::Beck from one year's worth of API Tuesday Reports for calendar year 2018.

¹³ Ibid.

Figure 14: Anchorage Competency Cases by Disposition Type



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

6. Restoration rates at API are low compared with other states and national averages.

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.¹⁴ A meta-analysis of 68 studies conducted between 1967 and 2008 in states around the nation identified that approximately 81 percent of individuals were eventually restored.¹⁵

7. There is significant cycling of patients through Corrections, the court system, and API's forensic and civil units due in part to very limited options for safe discharge from API, especially for those deemed 'non-restorable' and whose criminal charges are dismissed.

The Taku Unit runs at or around 96 percent capacity and has an average length of stay 3.8 times longer than API's civilly committed average length of stay (69 days compared to 18 days in FY 2018).¹⁶ In FY 2018, API's forensic readmission rate 30-days post-discharge was two percent; however, for 180-days post discharge, the forensic readmission rate is 23.4 percent.¹⁷ Forty-eight percent of forensic patients in FY 2018 were previously admitted to API through a civil and/or forensic commitment between FY 2015 and FY 2018.¹⁸

This study recommends a phased implementation to improve discharge options for individuals found incompetent to stand trial and not restorable, as follows:

Immediate Action (0-6 months)

¹⁴ Data collection and analysis by Agnew::Beck Consulting, various case study interviews and review of outcome reports.

¹⁵ 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>

¹⁶ Meditech Electronic Health Records. Average Length of Stay for Discharged IST Patients + Taku Occupancy, July 1, 2015 – December 31, 2018.

¹⁷ API Meditech Electronic Health Records. IST and Non-IST Demographics, Unduplicated. July 1, 2015 – December 31, 2019.

¹⁸ API Meditech Electronic Health Records. IST and Non-IST Demographics, Unduplicated. July 1, 2015 – December 31, 2019.

- Update the Urgent Forensic Discharge MOA and use statewide.

Medium-term Action (6 months – 2 years)

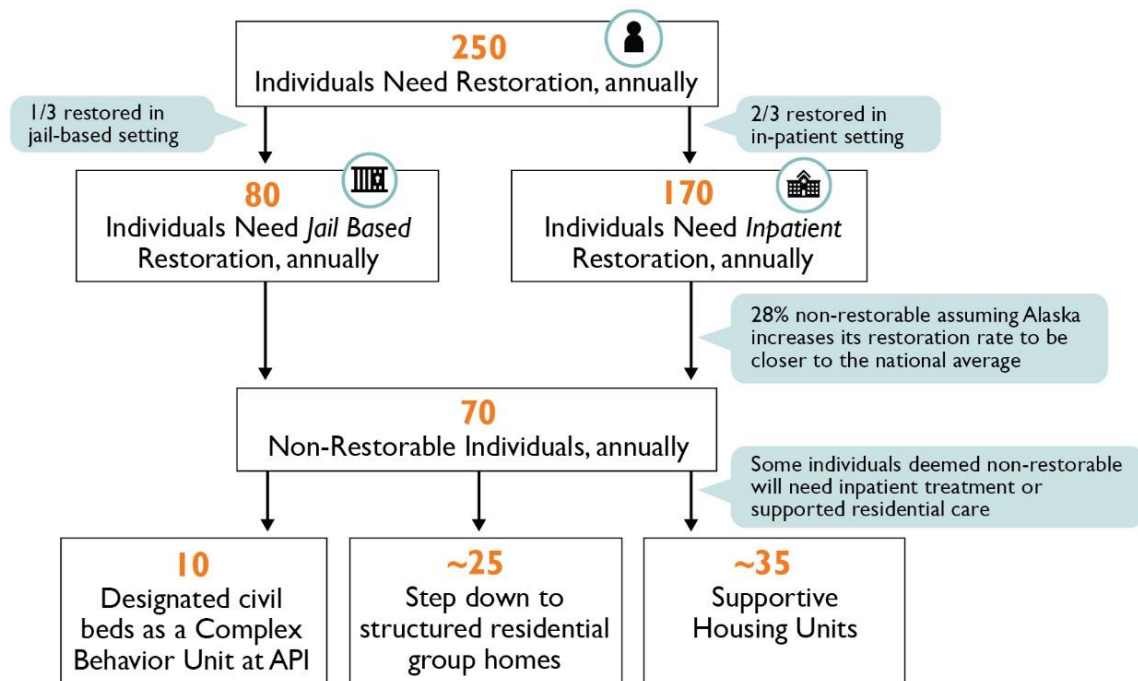
- Designate a 10-bed complex behavior unit at API for involuntary civil, voluntary civil and forensic patients who are most difficult to discharge and in need of longer-term treatment.
- Develop appropriate community supports for patients found IST after restoration, including:
 - Forensic assertive community treatment (FACT)
 - Immediate and ongoing access to medical and behavioral health care
 - Permanent supportive housing
 - Recruitment of group homes and assisted living facilities specifically for this population
 - Secure residential facility for individuals with complex behaviors

Figure 15 shows the forecasted number of individuals found unrestorable each year and considerations for inpatient and residential bed needs for these individuals.

Figure 15: Inpatient and Residential Bed Demand for IST Not Restorable Population

Non-Restorable Demand Forecast: FY 2026

Inpatient Beds, Structured Residential Group Homes & Supportive Housing



8. No comprehensive coordination of competency evaluations and restoration or data monitoring exists for this process. Fragmented and incomplete data tracking makes identifying and addressing the breakdowns in this system challenging.

Currently, there is no statewide system for coordinating or tracking competency evaluations, so, for example, if someone receives an evaluation order in Nome and then later receives an evaluation order in Anchorage, there is no way for the court system to identify that there is a recent evaluation to reference. Data is gathered by the Anchorage Courts and by API's Taku Unit, but these are not integrated with one another or with data

systems at the Department of Corrections, where most of the individuals engaged in the competency process are held. Data is not gathered or monitored from the rest of the court system statewide. Research and recommendations for data tracking improvements can be found in Appendix F.

This study recommends a phased implementation to improve statewide coordination of the competency evaluation and restoration process, as follows:

Immediate Action (0-6 months)

- Establish a forensic psychiatric coordinating council to oversee implementation of system improvements.

Medium-term Action (6 months – 2 years)

- Develop a statewide and interagency data tracking and reporting system.

Implementation Plan

The implementation plan includes immediate, medium, and long-term actions to address the findings and recommendations from this study. Additional detail on each recommendation is provided in the chapters of this report. The appendix of case study information can be found in Appendix C. A complete list of stakeholder interviews and key themes can be found in Appendix D.

Recommendations for Immediate Action (0 – 6 Months)

Strategy	System Component Targeted	Lead	Needed Resources or Next Steps
Increase availability of co-responders to CIT teams	Diversion	Alaska Mental Health Trust Authority	Funding for mental health co-responders, training in CIT model, workforce development
Expand evaluation staffing*	Court Process + Evaluation	API	In progress, contracted evaluators in place.
Contract for external oversight of forensic evaluation services	Court Process + Evaluation	API	Funding and RFP process for contractor
Include a screening for level of restoration treatment in initial evaluation	Court Process + Evaluation	API	Research best practice screening, develop screening tool and format for reporting findings to court
Temporarily add 10 forensic beds to existing API footprint*	Restoration	API	Identify unit modifications needed for forensic population, unit staffing; secure funding
Implement jail-based outreach restoration	Restoration	API, DOC	Identify program elements and staffing
Formalize process for restoration of juveniles	Restoration	API, DJJ	Develop MOA, develop restoration education curriculum for use with juvenile offenders
Update the Urgent Forensic Discharge MOA and use statewide.	Discharge	Alaska Mental Health Trust Authority	Reconvene parties named in MOA
Establish a forensic psychiatric coordinating council to oversee implementation of system improvements.	Across the Forensic System	Alaska Mental Health Trust Authority	Identify lead to establish council membership, coordinate meetings and take notes

*Program and capital cost estimating included in this study for these strategies.

Recommendations for Medium-term Action (6 Months – 2 Years)

Strategy	System Component Targeted	Lead	Needed Resources or Next Steps
Implement a Crisis Now crisis stabilization model.	Diversion	Alaska Mental Health Trust Authority, Division of Behavioral Health	Technical assistance contract with RI International to provide recommendations on development of crisis stabilization in Alaska
Create a court liaison pilot program in the Anchorage District Court.	Diversion	Anchorage District Court, community behavioral health provider	Funding for court liaison position, program model

Strategy	System Component Targeted	Lead	Needed Resources or Next Steps
Implement a statewide competency calendar	Court Process + Evaluation	Alaska Court System	Additional staff to expand Anchorage competency calendar statewide
Create new psychologist job classification	Court Process + Evaluation	DHSS	Job classification analysis
Designate a unit for jail-based restoration*	Restoration	DOC	Space within existing facility or expanded facility, staffing and programming
Evaluate current restoration programming at API	Restoration	DHSS	Funding for contracted evaluator and program improvements
Amend Title 12 Statute to provide clarity on involuntary medication	Restoration	DOL	Workgroup convening to review statutory language in other states and develop draft statute revision
Designate a 10-bed complex behavior unit at API	Discharge	API	Identify unit modifications and staffing needs
Develop appropriate community supports for patients found IST after restoration	Discharge	Alaska Mental Health Trust Authority, Division of Behavioral Health, DHSS	Funding for community supports
Develop a data tracking and reporting system	Across the forensic system	API, DOC, Alaska Court System	Select key data points, identify data tracking system and mechanism for communication

*Program and capital cost estimating included in this study for these strategies.

Recommendation for Long-term Action (2 Years +)

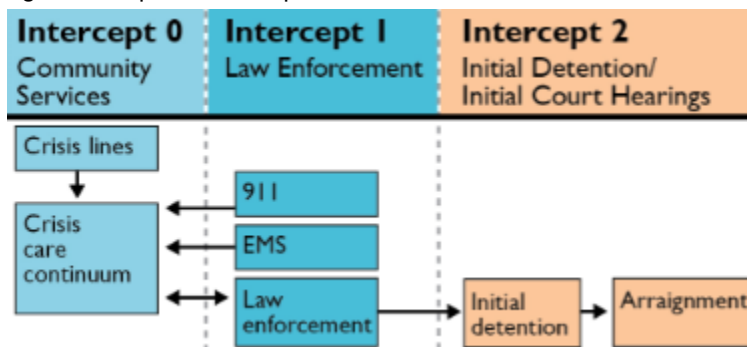
Strategy	System Component Targeted	Lead	Needed Resources or Next Steps
Expand API by 25 beds*	Restoration	DHSS	Funding, construction of new facility

*Program and capital cost estimating included in this study for these strategies.

2. Diversion

Diversion activities focus on Sequential Intercepts Zero, One and Two. Pre-booking diversion generally involves community services and law enforcement. Elements of pre-booking diversion models include mental health training for first responders, centralized diversion locations for psychiatric assessment and officer discretion to determine the necessity of an arrest.¹⁹ Post-booking diversion occurs after initial detention but before initial court hearings and includes screening, assessment, negotiations with partner organizations and linkages to community services.²⁰ Relevant gaps at Sequential Intercept 0, 1 and 2 are identified as a lack of crisis respite beds and psychiatric stabilization, and a need for mental health co-response.²¹

Figure 16: Sequential Intercepts 0, 1 and 2



Status Quo

Alaska has few pre-booking diversion options when individuals with mental health issues who are contacted by law enforcement for alleged criminal activity. Individuals with mental health issues both with and without criminal involvement are frequently transported to hospital emergency departments (ED). In 2018, 24 percent of all Alaska ED visits had a primary or secondary behavioral health diagnosis.²² Hospital emergency departments and inpatient units across the state are overwhelmed with the volume of behavioral health referrals as most are not equipped to provide appropriate crisis management, psychiatric care, and referral services for this population. Behavioral health patients in emergency departments are more than twice as likely to have ED stays of more than 12 and 24 hours when compared to those in the ED who do not have a behavioral health diagnosis.²³

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. In Anchorage, 150

¹⁹ Lattimore, P., Broner, N., Sherman, R., Firsman, L., Shafer, M. (2003). A Comparison of Pre-booking and Post-booking Diversion Programs for Mentally Ill Substance-Using Individuals with Justice Involvement. *Journal of Contemporary Criminal Justice*, Vol. 19 No 1, 30-64. DOI: 10.1177/1043986202239741

²⁰ Lattimore, P., Broner, N., Sherman, R., Firsman, L., Shafer, M. (2003). A Comparison of Pre-booking and Post-booking Diversion Programs for Mentally Ill Substance-Using Individuals with Justice Involvement. *Journal of Contemporary Criminal Justice*, Vol. 19 No 1, 30-64. DOI: 10.1177/1043986202239741

²¹ SAMHSA's GAINS Center for Behavioral Health and Justice Transformation. (2018). Sequential intercept model mapping report for Anchorage, Alaska. Delmar, NY: Policy Research Associates.

²² Alaska Health Facilities Data Reporting Program, 2018.

²³ Alaska Health Facilities Data Reporting Program, 2018.

police officers and 25 dispatchers have received CIT training.²⁴ 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 only to calls related to mental health concerns, not criminal calls that may have a mental health component. The Anchorage Police Department has just one designated CIT officer in the department, although other officers are trained in CIT. The Alaska Criminal Justice Commission recommended the expansion of the co-response CIT model around the state.

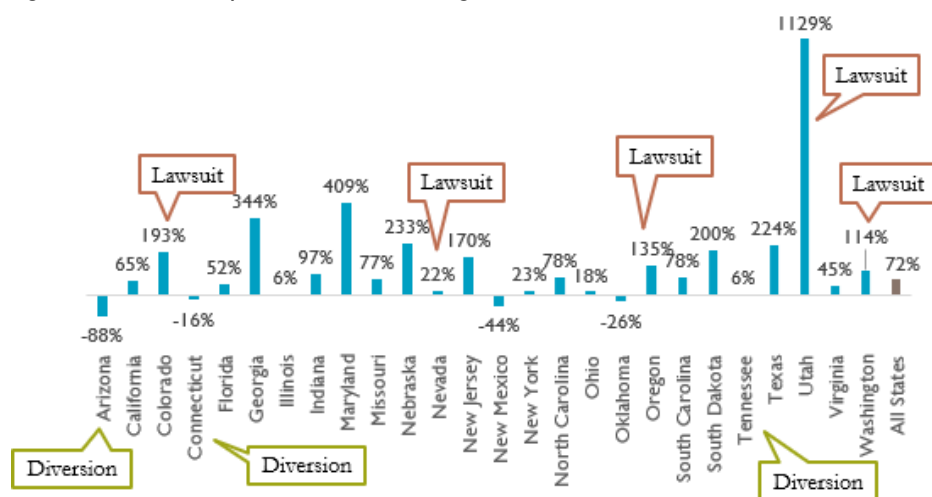
Anchorage also uses a Mobile Intervention Team (MIT) to respond to calls related to individuals who are homeless, and the Anchorage Fire Department (AFD) Community Outreach Referral and Education (CORE) team works with high utilizers of AFD services. Neither of these outreach services specifically responds to individuals with suspected mental health issues and criminal activity.

Alaska does not have any post-booking diversion programs that divert an individual from the criminal justice system prior to the initial court hearing.

Case Studies + Data

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 process. States like Arizona, Connecticut, and Tennessee that have robust diversion programs for individuals with a mental illness charged with crimes are seeing decreases or slight increases in their forensic psychiatric population, while states without robust diversion programs in place are seeing much greater increases, and lawsuits stemming from the backlog in competency evaluation and restoration. The one-day census percent change does not accurately reflect the extent of the problem as it does not capture the backlog; however, Figure 17 below provides a snapshot of the nationwide increase in forensic patients over the past 20 years.

Figure 17: 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 1999-2016. August 2017.

²⁴ SAMHSA's GAINS Center for Behavioral Health and Justice Transformation. (2018). Sequential intercept model mapping report for Anchorage, Alaska. Delmar, NY: Policy Research Associates.

Pre-booking Diversion

Crisis Intervention Teams

Crisis Intervention Teams (CIT) are partnerships between law enforcement and community services that provide training to law enforcement and a joint response to community crises involving persons with behavioral health disorders. The goal of CIT is to reduce the need for arrest in favor of referrals to appropriate treatment resources. In Connecticut, CIT is a program of the state's Forensic Services Division, Community Forensic Services to divert individuals with mental illness from the criminal justice system.

Crisis Stabilization

The Salt Lake City and County, under an initiative of the Criminal Justice Advisory Council, operates Operation Diversion. The goal of Operation Diversion is to separate suspected criminals who should be arrested from those who are struggling with mental illness and/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. 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 behavioral health treatment instead of being charged for criminal activity, social workers provide a warm hand-off to the appropriate provider. Operation Diversion acts as crisis stabilization specifically targeting individuals with suspected criminal involvement.²⁵

Figure 19: Operation Diversion



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

The Crisis Now crisis stabilization model incorporates a call center hub, mobile outreach, and sub-acute stabilization (short-term residential programs for stabilization), to achieve better outcomes for individuals experiencing behavioral health crises. The Crisis Now model posits that a robust crisis response system can reduce wait times for law enforcement to connect people in crisis with appropriate care, reduce jail bookings associated with mental illness, and end unnecessary emergency room admissions.²⁶ The essential crisis care principles and practices include: a

Figure 18: Components of Crisis Now Model



²⁵ Salt Lake County Criminal Justice Advisory Council. Operation Diversion. <https://slco.org/cjac/initiatives-priorities/operation-diversion/>

²⁶ Broadway, E., Covington, D. (2018). A Comprehensive Crisis System: Ending Unnecessary Emergency Room Admissions and jail Bookings Associated with Mental Illness. National Association of State Mental Health Program Directors.

recovery orientation, trauma-informed care, use of peer support staff, a commitment to Zero Suicide/Suicide Safer care, commitments to safety for staff and consumers, and collaboration with law enforcement.²⁷

Post-booking Diversion

Post-booking diversion programs take many forms. In Connecticut, the state Forensic Services Division provides funding and oversight for court liaisons around the state. The court liaisons are employed by community mental health centers but work at the courts. The liaisons offer 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 such as securing a same-day behavioral health appointment if the individual is released with charges held in abeyance. Each day, the court liaison compares the community mental health center client list to the court docket to identify individuals who could benefit from immediate connection to behavioral health services. The liaison is then able to work with the individual's service provider, the prosecutor, defense lawyer and judge to identify alternatives to trial and sentencing prior to the arraignment hearing.²⁸

California, recognizing the importance of post-booking diversion programs, issued a request for proposals for counties to apply for funding to increase diversion wraparound services. The state committed 100 million dollars over three years to incentivize counties and service providers to offer Forensic Assertive Community Treatment (FACT) teams, intensive case management, criminal justice coordination, crisis residential services, peer support, supportive housing, substance use disorder treatment and vocational support. Funding can also be used for post-booking assessments to provide recommendations regarding the effectiveness of diversion services for a given defendant and up to 15 days of in-jail treatment for individuals awaiting transfer to a diversion program.²⁹ Legislation accompanying the funding for this initiative allows trial court judges to refer individuals found incompetent to stand trial (IST) or who are likely to be found IST to diversion programs rather than restoration treatment. If individuals successfully complete the program to which they are referred, the judge can dismiss or reduce the defendant's charges.³⁰

Recommendations

There are several steps Alaska can take to increase diversion of individuals with behavioral health disorders from the criminal justice system, and thus, the competency process.

Increase availability of co-responders to CIT teams. Law enforcement organizations throughout the state already have officers trained in CIT. Adding mental health professionals who can respond to calls with officers will increase the resources available to individuals experiencing mental health crises. Needed resources include funding for mental health co-responders, professionals with the appropriate qualifications for these positions, and continued CIT training for law enforcement.

²⁷ National Action Alliance for Suicide Prevention: Crisis Services Task Force. (2016). Crisis Now: Transforming Services is within our Reach. Washington, DC: Education Development Center, Inc.

²⁸ Department of Mental Health and Addiction Services, Community Forensic Services. (2019). <https://www.ct.gov/dmhas/cwp/view.asp?a=2900&q=334748>

²⁹ California Department of State Hospitals. Incompetent to Stand Trial (IST) Diversion Program. Presentation, September 26, 2018.

³⁰ California Health Policy Strategies, LLC. (2018). Policy Brief: New Funding Opportunities for Reentry and Justice-Involved Individuals – Mental Health, Housing and Diversion.

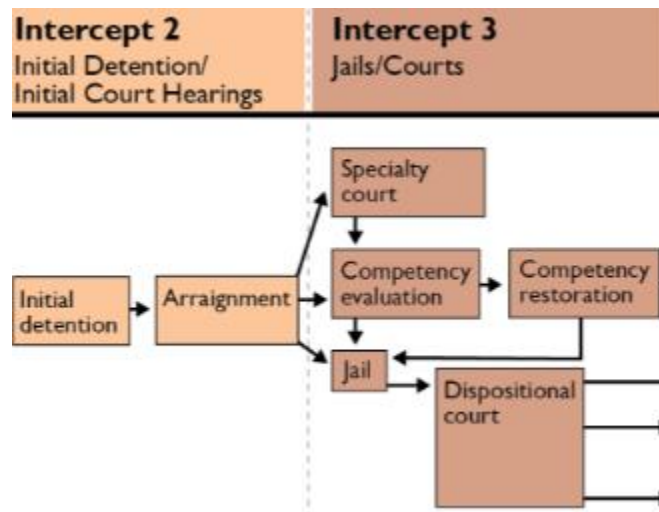
Implement a Crisis Now crisis stabilization model. The Alaska Mental Health Trust Authority and the Division of Behavioral Health are in communication with Recovery International (RI), a leader in the Crisis Now model and technical assistance provider for states interested in using the model. Next steps include contracting with RI to provide technical assistance to identify recommendations for Anchorage and Mat-Su's behavioral health crisis system. Long term needs include funding to implement the recommendations.

Create a court liaison pilot program in the Anchorage District Court. Using Connecticut's approach as a model, provide funding for a staff person to coordinate between community behavioral health providers in Anchorage and the public court docket to identify clients who have been arrested who may be good candidates for post-booking diversion.

3. Court Process + Competency Evaluation

Initial court hearings and orders for competency evaluations occur at Intercepts Two and Three. After arraignment, a defendant's case may be referred to a specialty court, a dispositional court, or an order for a competency to proceed evaluation may be filed. The limited information sharing between mental health providers, the courts, and the Department of Corrections and extended wait times for competency evaluations are identified as gaps in the 2018 Sequential Intercept Mapping Report for Anchorage.³¹

Figure 20: Sequential Intercept 2 and Intercept 3



Status Quo

Alaska Court System

The Alaska Court System does not currently track competency evaluation cases statewide, meaning, for example, that a defendant might have an evaluation ordered by one district court, go through restoration treatment, be found incompetent to stand trial after restoration attempts and be released, and then picked up on new charges in a different district. The new district does not have any way of knowing that the defendant has a recent evaluation that could be used in determining competency, so a new evaluation is ordered beginning the process again. Available data does not shed light on the extent of this issue, but there is evidence of cycling through the system as 26 percent of defendants with competency evaluations appearing before the Anchorage District Court between July 1, 2015 and December 31, 2018 had at least one additional evaluation ordered during this time.³² The lack of statewide tracking for the competency process makes it difficult to collect statewide court system data, to track defendants who cycle through the system, and to communicate between courts and API regarding evaluation orders.

A standardized court process with training opportunities regarding the competency process is not available statewide. The *Judge's Guide to Handling Cases Involving Persons with Mental Disorders* prepared by the Alaska Court

³¹ SAMHSA's GAINS Center for Behavioral Health and Justice Transformation. (2018). Sequential intercept model mapping report for Anchorage, Alaska. Delmar, NY: Policy Research Associates.

³² Anchorage Court Competency Calendar Hearing Data, July 1, 2015 – December 31, 2018.

System has not been updated since 2008. The Anchorage Court System has established a three-week timeframe for completing competency evaluations for misdemeanors and five weeks for felonies. Court staff are trained to schedule the court date for a decision on competency for the next available date after the evaluation report is received by the court. It is unclear if other district courts have adopted these protocols.

While Alaska's therapeutic courts intend to divert individuals from correctional settings, they can only work with defendants who are considered competent to participate in court proceedings. Judges in Anchorage's mental health therapeutic court, the Coordinated Resources Project (CRP), ordered sixty-one percent of the competency evaluations in the Anchorage District Court between July 1, 2015 and December 31, 2018.³³ Individuals with mental health issues are more likely to be referred to the CRP court and competency issues are more likely to be raised in a court familiar with the competency process. Due to the backlog in competency evaluations and restoration, 72 percent of these defendants wait in jail, thus funneling the mental health population to jail instead of diverting them.³⁴ This unintended consequence does not appear to be unique to Alaska as a 2014 report on the King County Mental Health Court in Washington found that the mental health court "appears to be responsible for an unusually high number of misdemeanor defendants referred for competency evaluations".³⁵

Competency Evaluations

In Alaska, API's forensic psychologists provide both evaluation and restoration services. Of the six states reviewed for this project (see Appendix C), Alaska is the only state where the same staff conduct competency evaluations and supervise restoration treatment. Mental health professionals serving as both forensic evaluators and treaters of defendants have inherently conflicting roles; in the evaluation role the professional's primary duty is to the criminal justice system, and in the restoration role 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.³⁶ 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. In Alaska, there is limited oversight of evaluators and limited peer review as the forensic team at API is small and does not access outside consultation.

The current supply of forensic evaluators (2.5 at the start of the project in November 2018) cannot keep up with the growing demand for these services. Per conversations with one API forensic psychologist, each psychologist can typically complete two evaluations per week while also managing a restoration caseload. This would mean a team of 2.5 evaluators could be expected to complete approximately 240 evaluations per year (assuming four weeks' vacation for each evaluator). The evaluation team exceeded this number in fiscal year 2018, completing 262 evaluations; however, the backlog midway through the fiscal year, in December 2017, was 25 evaluations, indicating that even with an increased pace, the team was still unable to keep up with demand.³⁷ By 2026, the demand for evaluations is estimated to grow to 630 per year, necessitating a staff of

³³ Anchorage Court Competency Calendar Hearing Data, July 1, 2015 – December 31, 2018.

³⁴ Data compiled and analyzed by Agnew::Beck from one year's worth of API Tuesday Reports for calendar year 2018.

³⁵ Gowensmith, W. N., Murrie, D. C., Packer, I. K. (2014). Forensic Mental Health Consultant Review. Groundswell Services, Inc.

³⁶ *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.

³⁷ Dr. Becker, Counts of Evaluations completed by API FY 2018 and data compiled and analyzed by Agnew::Beck from one Tuesday Report dated December 12, 2017.

4.5 five evaluators. If evaluators focus solely on evaluations, each evaluator should be able to complete three evaluations per week.

Case Studies + Data

Court System Tracking + Education

Wisconsin's Department of Health Services contracts with a non-profit organization to provide Court Liaison and Tracking Services statewide. The program provides monitoring, tracking, consultation, and training services to the circuit court system throughout the state to standardize court processes and track forensic cases. Court liaisons provide reminders to the courts to meet statutory deadlines and expedite court cases when appropriate, and provide educational resources.³⁸

Competency Evaluations

Training + Oversight

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 process.³⁹ There are also forensic specific trainings available in both online, and live formats through training organizations such as CONCEPT.⁴⁰

Quality Assurance procedures for evaluators are an important part of a high-quality competency evaluation process. Recommendations for conducting regular quality assurance 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.⁴¹

The 2016 Western Interstate Commission for Higher Education (WICHE) report evaluating API's forensic services recommended that API's forensic psychologists be provided with opportunities to receive supervision and consultation with forensic specialists outside of API.⁴²

Evaluation Components

Starting in July 2019, competency evaluations in Colorado 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

³⁸ Wisconsin Community Services. Behavioral Health Services – Court Liaison and Tracking Services. https://www.wiscs.org/programs/behavioral/release_programs/test/index.php

³⁹ Groundswell Services, Inc. (2014). Forensic Mental Health Consultant Review Final Report.

⁴⁰ CONCEPT Professional Training, accessed online at <https://www.concept-ce.com/training-program-overview/>

⁴¹ Groundswell Services, Inc. (2014). Forensic Mental Health Consultant Review Final Report.

⁴² Fox, Patrick. 2016. Alaska Psychiatric Institute: Evaluation of Forensic Services. Western Interstate Commission for Higher Education.

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.

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. 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. 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 in states' statutes.

While national data suggests higher pay for psychologists in Alaska, forensic psychologists in Alaska are salaried at one of the lowest rates of any of the six states surveyed. Under the current State of Alaska position classification and pay scale in Alaska, the starting salary for a doctoral level psychologist is the same as that of a master's level clinician. Further details on employment and compensation can be found in Appendix E.

Recommendations

There are several steps Alaska can take to decrease the backlog of individuals waiting for evaluation and improve system efficiencies. These recommendations fall in to two overarching categories: Implement a statewide competency process; and, expand and provide oversight for evaluation services.

Implement a statewide competency calendar. The Anchorage District Court recently created an Anchorage Competency Calendar to track defendants with competency issues and assigned a specific judge to hear all competency cases. The court also hired an Administrative Program Manager to schedule and vacate competency hearings, collect and synthesize data for cases heard on the calendar, communicate with partners, coordinate data collection between relevant systems, and serve as an information resource for court staff who require training, technical assistance and support to address the mental health needs of defendants. The Anchorage Competency Calendar serves as a model that could be implemented statewide, with one to two judges hearing all competency cases for the state and a Statewide Competency Program Manager to coordinate data collection, training and communication. The purpose of a statewide competency process would be to:

- Develop, implement and track competency law and process training for court system staff
- Manage the Statewide Centralized Competency Calendar
- Develop statewide data collection and tracking
- Expand current Anchorage District Court practices statewide (scheduling court hearings after initial evaluation three weeks out for misdemeanants and five weeks for felonies, expediting court hearings when updated evaluations are received, and prioritizing individuals found IST for the next court date)
- Develop system of prioritization for evaluations
- Standardize process for use of recent prior evaluations in lieu of ordering a new evaluation
- Reconvene the High Utilizers of Behavioral Health Services Workgroup
- Communicate and problem-solving with stakeholders
- Expand teleconference and video conference capability for court hearings

Expand and provide oversight for evaluation services.

Staffing. API should be staffed with three full-time evaluators capable of completing three evaluations per week to clear the backlog and keep up with rising demand. The state should plan to fund five forensic evaluators by 2026, based on a forecasted growth rate of 11 percent per year. Additionally, DHSS or the court system should maintain a list of forensic evaluators who could perform evaluations on a contract basis if the backlog reaches a certain level. In 2019 dollars and using the average compensation for existing forensic psychologists, five full time forensic psychologists will cost approximately \$639,000 per year.

Create new employment classification. A rate study is needed to create a job classification for a doctorate in psychology that adjusts the starting pay to be commensurate with educational requirements.

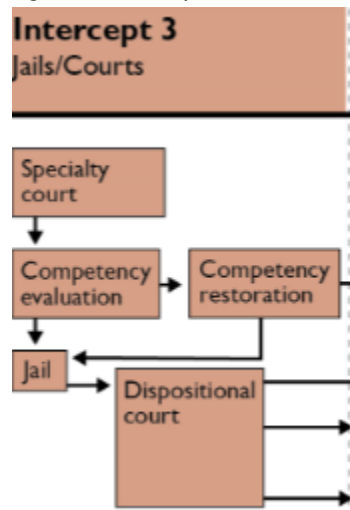
Contracted oversight. The Department of Health and Social Services or API should contract with an external provider for regular review and oversight of evaluations using best practice quality assurance procedures to ensure high-quality evaluations. It is recommended that the state consider contracting with a nationally recognized and accredited forensic psychiatry or psychology training program to ensure that the supervision provided remains current and is of high quality.

Include a screening for appropriate level of restoration in the initial evaluation. Inclusion of a screening for appropriate level of restoration, either jail-based or inpatient, will help the evaluator provide guidance to the judge about the most appropriate level of care for a given defendant. Utah has developed a screening tool for this purpose, and Colorado is in the process of developing one. Initiating this screening tool as part of the evaluation as soon as possible, even before jail-based restoration is available, will allow the state to begin to collect data on the number of defendants appropriate for each care setting and help refine bed forecasts as the addition of new restoration beds in either a jail or hospital setting are considered.

4. Competency Restoration

Competency restoration occurs at Intercept Three. The extended wait time for competency restoration is noted as a gap in the 2018 Anchorage Sequential Intercept Model Mapping Report for Anchorage.⁴³

Figure 21: Intercept 3



Status Quo

Available competency restoration programming in Alaska does not meet current or projected demand for restoration treatment. There is only one option for competency restoration, the 10-bed Taku Unit at API. Alaska lacks a clear process for restoration of juveniles with competency issues. While the number of juveniles needing competency restoration is small, when there are juveniles in need of restoration, it is performed on an ad hoc basis and is possible only because McLaughlin Youth Center's staff make accommodations so restoration education can happen on their campus, with API staff.

There is no formal process for program evaluation or systems improvement for forensic psychiatric services provided at API. Overall, data and outcomes are not consistently tracked or shared. The number of individuals waiting at each step in the process (waiting for evaluation, waiting for court decision, waiting for restoration bed, and number admitted) must be hand counted using a "Tuesday Report". Tuesday Reports are saved only in hard copy from week to week. Electronic copies are not available. Only recently has API begun to use an SPSS system to record and track data for forensic patients that is not captured by API's Meditech electronic health record system (details can be found in Appendix F). An intern has been working to enter cases from prior years to the system, allowing for better analysis of patient characteristics and outcomes than was previously available.

In Alaska, the judicial standard for forcing individuals to be given medication involuntarily is comparatively high because of Alaska's constitutional protection of personal privacy.⁴⁴ This is relevant to the competency

⁴³ SAMHSA's GAINS Center for Behavioral Health and Justice Transformation. (2018). Sequential intercept model mapping report for Anchorage, Alaska. Delmar, NY: Policy Research Associates.

⁴⁴ Alaska is one of a small group of states with a constitutional right of privacy: similar provisions can be found in the constitutions of Arizona, California, Florida, Hawaii, Illinois, Louisiana, Montana, South Carolina and Washington. It reads, "The right of the people

evaluation and restoration process because for individuals in psychiatric crisis, particularly those with severe and persistent mental illness, medication can often help to resolve the acute symptoms that limit the person's competency to stand trial. Stakeholder interviews indicated that because it is difficult to obtain orders for involuntary medication, when a person refuses medication it makes it very difficult to restore that person to competency.

Additionally, while 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.⁴⁵

The court currently uses the Order Scheduling Hearing on Motion for Involuntary Medications for Competency Restoration and Ordering Treating Physician to Appear to Testify, which lays out the specific findings that must be made to order involuntary administration of medication. Available data shows that API seeks *Sell* medications in a very limited number of cases and that *Sell* medications are granted in a small proportion of them. From 2016-2018, *Sell* medications were sought for just seven patients and *Sell* medications were granted in just two of those cases.⁴⁶ Data on medication compliance is not available from API, making it difficult to ascertain the number of individuals whose restoration is potentially impacted by medication refusal and who could potentially benefit from *Sell* medications if they were more readily available.

A recent Alaska Supreme Court decision (Opinion No. 7346, dated March 22, 2019), upheld an earlier Alaska Superior Court decision regarding concurrent civil and criminal commitments and involuntary medication. The Supreme Court held that the defendant could be concurrently committed under criminal and civil commitment statutes if each is independently justified and that the superior court could order civil involuntary medications.⁴⁷ Given this ruling, API should consider the medication implications of concurrently committing competency restoration defendants who are gravely disabled or present a likelihood of serious harm to self or others, therefore meeting civil commitment criteria and possibly being eligible for involuntary medication under civil commitment statute.

Case Studies + Data

Types of Restoration

to privacy is recognized and shall not be infringed. The legislature shall implement this section." This section was added to the constitution by amendment in 1972. It was prompted by fear of the potential for misuse of computerized information systems, which were then in their infancy. Source: Alaska's Constitution: A Citizen's Guide accessed at <https://www.commerce.alaska.gov/web/Portals/4/pub/AK%20CONSTITUTION-Citizens%27%20Guide.pdf> June 2019.

⁴⁵ *M.V. v. State of Alaska*. Court of Appeals No. A-12403. December 29, 2015.

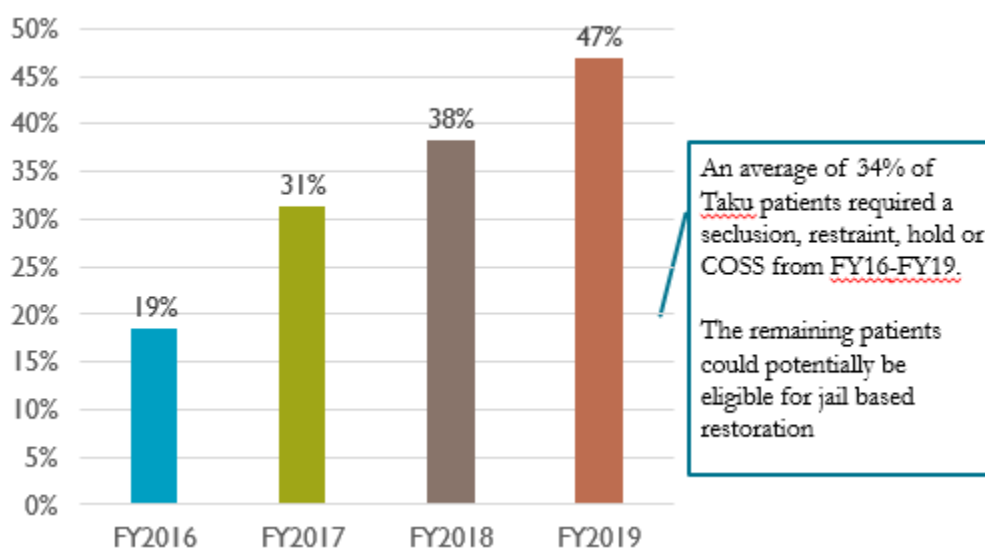
⁴⁶ API SPSS Data. Admitted IST Patients, *Sell* Sought and *Sell* Granted, 2016-2018.

⁴⁷ The Supreme Court of the State of Alaska. In the Matter of the Necessity for the Hospitalization of Linda M. Opinion No. 7346. March 22, 2019.

While other states use a combination of jail-based, residential or community-based restoration, Alaska currently relies solely on inpatient restoration services at API to restore defendants found incompetent to stand trial. Alaska's ratio of inpatient forensic psychiatric beds per 100,000 residents is also much lower than in other states and nationally, just 1.4 beds in Alaska compared to 5.5 beds per 100,000 nationally.⁴⁸

Jail-based restoration is typically most appropriate for individuals who are at high risk to the community if released but have lower mental health needs. In other states, individuals who are appropriate for jail-based restoration include those who are voluntarily taking medication, do not meet the state's civil commitment criteria and are not aggressive. Nationally, about a third of individuals needing restoration are appropriate for a jail-based setting and there is evidence to suggest that a significant number of Alaska's restoration population could be served in a jail-based setting. API data for restoration patients served from FY 2016 to FY 2019 identified that an average of 34 percent of the population required a seclusion, restraint, or hold or were required to be on Close Observation Surveillance Status (COSS) Level 2 or Level 3.⁴⁹ This indicates that 66 percent of patients' clinical needs may not be significant enough to require inpatient hospitalization. A point in time estimate of current Taku patients provided by an API forensic psychologist estimated that 50 to 60 percent of current patients could be served in a jail-based setting.

Figure 22: Percentage of Taku Patients Requiring Seclusion, Restraint, Hold or COSS Level 2 or 3



Restoration Rates + Characteristics

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.⁵⁰ A meta-analysis of 68 studies conducted between 1967 and 2008 identified that nationally approximately 81 percent of

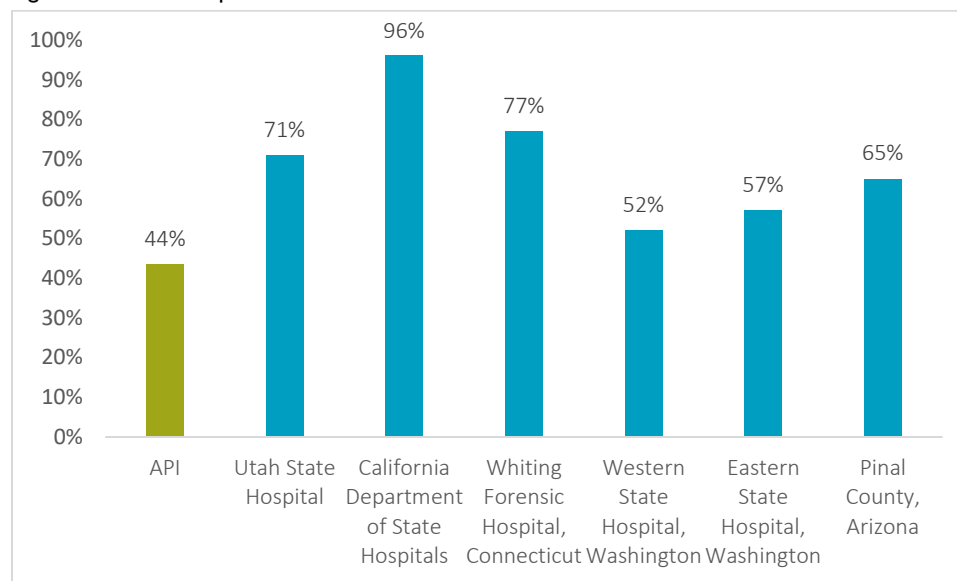
⁴⁸ Going, going, gone: Trends and consequences of eliminating state psychiatric beds. Arlington, VA. Treatment Advocacy Center, June 2016.

⁴⁹ API Meditech Data: Unique patients requiring a seclusion, restraint or hold by discharge fiscal year and API COSS Data: Unique patient events. COSS refers to individuals require a 1:1 or 2:1 staff-patient ratio.

⁵⁰ Data collection and analysis by Agnew::Beck Consulting, various case study interviews and review of outcome reports.

individuals were eventually restored.⁵¹ 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.

Figure 23: Rates of Inpatient Restoration in Alaska and other States



Source: Data collection and analysis by Agnew::Beck Consulting, compilation of case study interviews and reviews of outcome reports. Data year varies by state.

Stakeholders shared that individuals with developmental disabilities 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.⁵² Data from research studies outside of Alaska found that about one-third of developmentally disabled defendants were restored.⁵³

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 (see Figure 24). The recent data suggests that individuals with cognitive disorders are 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.

In Utah, once an order for competency restoration is received, an individual is screened within 72-hours to determine which treatment program is most suitable. During this screening, if the individual is identified as primarily experiencing an Intellectual or Developmental Disability (IDD) s/he may be referred to the

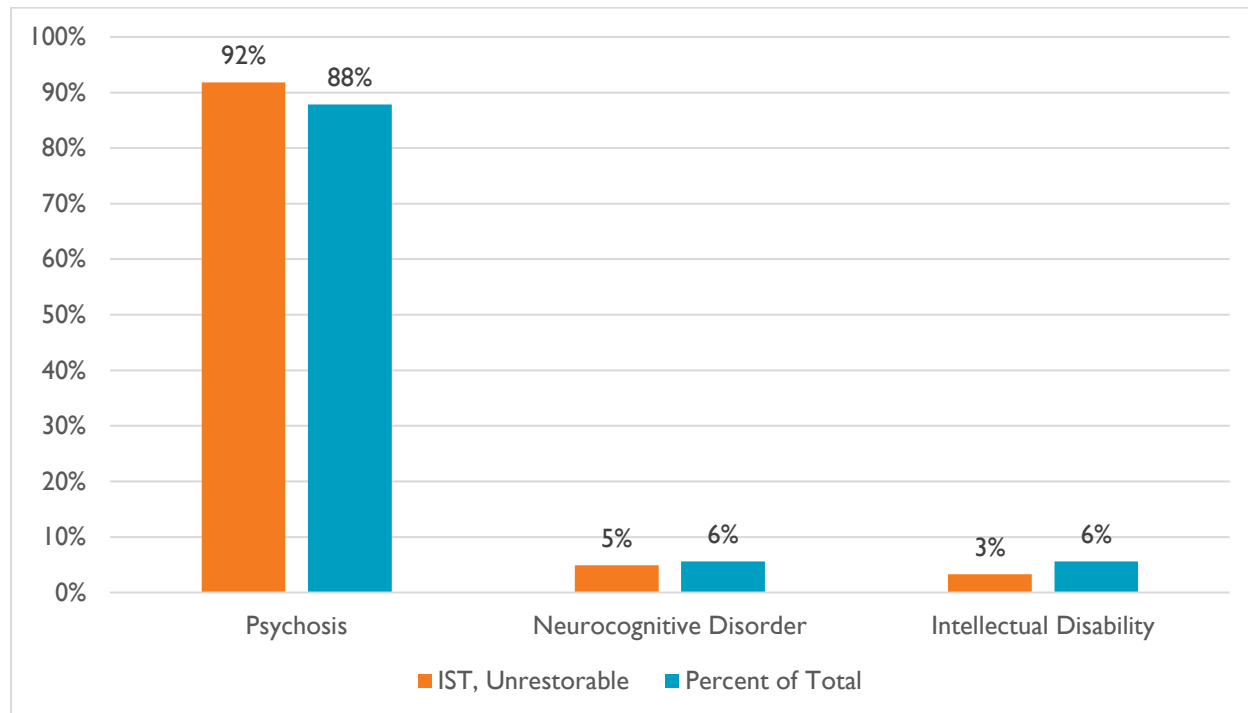
⁵¹ Danzer, G., Wheeler, E., Alexander A., Wasser, T. (2019). Competency Restoration for Adult Defendants in Different Treatment Environments. *Journal of the American Academy of Psychiatry and the Law*. DOI: <https://doi.org/10.29158/JAAPL.003819-19>

⁵² API SPSS Data. Patients with final dispositions by diagnosis type, 2016-2018.

⁵³ Zapf, P. (2013). *Standardizing Protocols for Treatment to Restore Competency to Stand Trial: interventions and Clinically Appropriate Time Periods* (Document No. 13-01-1901). Olympia: Washington State Institute for Public Policy.

Division of Services for People with Disabilities in Utah (DSPD), similar to Alaska’s Division for Senior and Disabilities Services (SDS). In Utah, this division has a forensic liaison who serves these clients and provides restoration treatment to people with an IDD. Individuals who dual mental illness with an IDD often proceed through the same 3 tier system in mental health forensics.

Figure 24: 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.

Medication

Medication is the most frequent form of treatment for restoration to competency.⁵⁴ Case study interviews with other states did not reveal significant findings related to difficulties obtaining involuntary medications. Connecticut uses two processes to obtain involuntary medication. In one process, the request goes back to criminal court. This is a lengthy process. In the second process, the state goes to probate court to argue that the individual is incapable of informed consent and should be assigned a conservator. This process is much quicker because it does not involve the criminal court. 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.

⁵⁴ Zapf, P. (2013). Standardizing Protocols for Treatment to Restore Competency to Stand Trial: interventions and Clinically Appropriate Time Periods (Document No. 13-01-1901). Olympia: Washington State Institute for Public Policy.

Recommendations

There are several steps Alaska can take to decrease the backlog of individuals waiting for restoration and improve system efficiencies. These recommendations fall in to four general categories: Expand inpatient restoration, develop jail-based restoration, improve processes, and amend Alaska's Title 12 statute related to involuntary medication.

Expand inpatient restoration. This study recommends a two-phase approach to the expansion of available inpatient restoration beds. Staffing and capital costs associated with these approaches are described in more detail in Chapter 7.

Immediate Action: Temporarily add 10 forensic beds to existing API footprint. API is not currently operating at full civil capacity. There are other 10 bed units at API (Chilkat and Denali) that could be temporarily converted to treat forensic patients to increase the number of restoration beds in the short term, and decrease wait times for those in need of restoration. The goal of this conversion would be to temporarily increase the number of forensic beds to alleviate the restoration backlog in the short term while other, longer-term options are put in to place.

Long-term Action: Expand API by 25 beds. An API expansion study was completed in 2018. The expansion study should be revisited to add in design elements and construction requirements specifically for forensic patients. This option would require three to five years to implement and significant capital funding but would allow for additional forensic restoration services without decreasing beds needed for the civilly committed population. An alternative option (shown as Approach 4 in Chapter 7) co-locates a 25-bed inpatient psychiatric hospital with a jail-based restoration program at and expanded Anchorage Correctional Center.

Develop jail-based restoration. This study recommends a two-phase approach to the expansion of the types of restoration available by first developing a jail-based outreach restoration program and then creating a designated unit for jail-based restoration either within existing DOC facilities or in an expanded facility.

Immediate Action: Implement jail-based outreach restoration. Utah provides a model where restoration treatment is provided as a scattered-site service at jails throughout the state. The restoration clinician provides weekly competency restoration education to defendants held in correctional facilities. Defendants are not confined to a specific restoration unit, but are mixed in with the general population, receiving restoration services only at specified times. This approach allows for rapid implementation of jail-based restoration as no facility modifications are required. Staffing and facility access would need to be negotiated between DHSS and DOC and a curriculum for this type of restoration would need to be developed or modified from existing resources.

Medium-term Action: Designate a unit for jail-based restoration. Jail-based restoration in a designated unit like Colorado's RISE program is emerging as a best practice. While outreach restoration should be considered as an immediate step, development of a specific unit, either within an existing DOC facility space or in an expanded facility, should be considered in the medium term. The need for jail-based restoration beds is forecasted at 25 beds. Development of a jail-based restoration unit allows for an additional level of care for individuals whose behavioral health needs do not rise to the level of inpatient psychiatric restoration treatment. In other states, jail-based and inpatient restoration programs are designed so that patients can move between the two settings as their clinical needs change.

Develop and implement a plan for process improvement.

Medium-term Action: Evaluate current restoration programming at API. Current restoration programming at API should be evaluated to determine staff and program effectiveness. Results should be used to improve restoration programming, with the goal of increasing restoration rates to be on par with national standards. API evaluation programming should be examined against national standards and best practices.

The Washington State Institute for Public Policy published a report, *Standardizing Protocols for Treatment to Restore Competency to Stand Trial*, which provides an overview of the types of interventions used for competency restoration and may serve as a resource for identifying effective interventions for Alaska. The report includes a brief overview of two program models specifically for defendants with developmental disabilities.⁵⁵ Given low rates of restorability nationally for individuals with developmental disabilities and the perception at API that these individuals are less likely to be restored, programming specifically for individuals with developmental disabilities should be considered.

Medium-term Action: Formalize process for restoration of juveniles. API and the Division of Juvenile Justice should develop a formal memorandum of understanding for the restoration of juveniles at McLaughlin to ensure that appropriate space and staffing is available when a juvenile needs restoration services. Additionally, API should identify a curriculum and establish a process for juvenile restoration. Some states, such as Louisiana and Colorado, have specific juvenile competency restoration programs, and the University of Virginia has a Juvenile Competency Attainment Research and Development Center. These, and other resources, can be used in the development of a clear process for juvenile restoration in Alaska.

Medium-term Action: Amend Title 12 Statue to provide clarity on involuntary medication for the purposes of competency restoration. The previously published report by the University of Las Vegas Nevada (UNLV) included a recommendation for an amendment to include a provision in state statute allowing the use of medication to restore competency, referencing the Sell and Harper cases.⁵⁶ The Department of Law, Criminal Division was identified as a possible lead organization for the development of a statute revision, with input from DHSS and others. Statute should also define “substantial” as it relates to the likelihood that a forensic patient will be restored as a result of medication administration to provide clarity to both judges and medical providers about the use and meaning of this term.

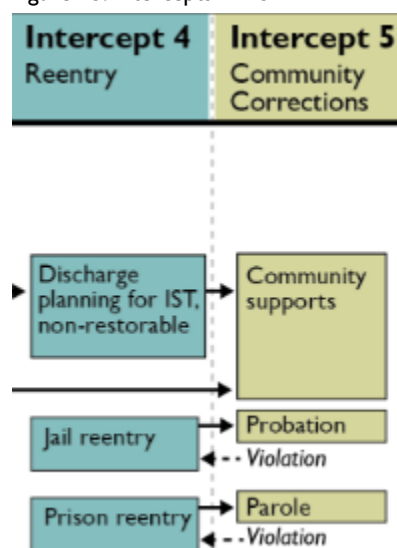
⁵⁵ Zapf, P. (2013). *Standardizing Protocols for Treatment to Restore Competency to Stand Trial: interventions and Clinically Appropriate Time Periods* (Document No. 13-01-1901). Olympia: Washington State Institute for Public Policy.

⁵⁶ Gordon, Sara, Piasecki, Melissa, Kahn, Gil, Nielsen, Dawn. (2014). *Review of Alaska Mental Health Statutes*. University of Nevada Las Vegas.

5. Discharge

If an individual is found competent to stand trial (IST) after restoration, they are returned to jail to await court proceedings. If an individual is found incompetent to stand trial and non-restorable after restoration efforts are exhausted, their charges are dismissed, and they are either civilly committed to API or re-enter the community. This chapter focuses on individuals who are found incompetent to stand trial and not restorable. Currently, because of a lack of appropriate discharge options, a significant proportion these individuals frequently cycle through the forensic and/or civil commitment systems. The lack of services for individuals deemed incompetent to stand trial and not restorable is identified as a gap in the 2018 Anchorage Sequential Intercept Model Mapping Report for Anchorage.⁵⁷

Figure 25: Intercepts 4 + 5



Status Quo

Several API staff members described difficulties in discharging individuals found IST and non-restorable due to a lack of community resources. Individuals who are homeless or difficult to house pose a particularly pressing problem and many individuals in this category have previous criminal charges which limit options for housing and assisted living placements. Alaska has a high bar for civil commitment and most forensic patients do not meet the criteria for civil commitment after their period of restoration has ended and they are found non-restorable.

There is currently an Urgent Forensic Discharge Memorandum of Agreement (MOA) in place to which the Alaska Court System, the Office of Public Advocacy, the Department of Corrections, the Department of Health and Social Services, Division of Behavioral Health, Alaska Psychiatric Institute, Senior and Disabilities Services, and Public Assistance are all parties. While numerous parties are involved and are assigned responsibilities, the MOA is primarily used to communicate discharge information between the mental health

⁵⁷ SAMHSA's GAINS Center for Behavioral Health and Justice Transformation. (2018). Sequential intercept model mapping report for Anchorage, Alaska. Delmar, NY: Policy Research Associates.

court in Anchorage, DOC and API. The MOA is not currently used to communicate about or track cases outside of Anchorage.

Community resources of note include the Division of Behavioral Health's Complex Behavior Collaborative (CBC) and the Department of Correction's Assess, Plan, Identify, Coordinate (APIC) Reentry Initiative. The CBC employs six board certified Applied Behavior Analysts who provide services to individuals aged six and older with complex needs who are often aggressive, assaultive and difficult to support. The CBC can serve approximately 30 clients per year. The APIC Reentry Initiative provides release planning and links offenders with mental illness to community services. The demand for these services is greater than the availability.

Interviews with providers who serve adults enrolled in the Complex Behavior Collaborative reported that the individuals they serve who have been admitted to API and been criminally involved often have a combination of cognitive deficit and serious mental illness. They often have behavioral issues that cannot be managed by medication alone, although medication compliance is critical to improve their functioning. To maintain functioning, these individuals require intensive ongoing supports. Currently, Alaska does not have a funding mechanism to provide these.

For example, a recent client who has had 50 + admissions to API, most recently at the end of 2018, and multiple stays in DOC facilities, has a combination of a Traumatic Brain Injury, multiple psychiatric diagnoses, and a history of trauma. His behaviors include speaking most of the time in a disorganized fashion, dysregulated sleep and eating patterns, and aggression towards others. He currently lives in an assisted living home, receives medication management from a community mental health provider, and has an OPA guardian. He has a criminal record, has transitioned through multiple living situations, and has experienced cyclical homelessness. To maintain his functioning and safety for himself and those around him, the provider recommends the following:

- 1:1 staffing 3-8 hours per day with activity-based therapy and social interactions.
- A room by himself or an apartment with staff available to minimize his impact on others; and, overnight awake staff to interact with him when he is not asleep. The staff should be trained and have clinical support 24/7.
- Regular structure and routine for accessing healthy foods at meal times with regular snacks and drinks available.
- Daily support of medication management with injections paired with positive preferred attention and small tangible rewards such as food or drinks for medication compliance.
- Transportation to the community mental health center to receive medication injections or a medication provider who can come to the subject's home 3-5 times each week.

Alaska has a robust network of home and community-based supports for target populations who would otherwise be served in skilled nursing facilities or institutions, funded primarily through Medicaid 1915c waivers that serve adults with Intellectual and Developmental Disabilities, seniors, and children with complex medical conditions.⁵⁸ The individuals with complex behaviors but who do not meet the criteria for these waivers, like the subject described above, often cannot access the level of ongoing supports that would enable them to remain stably housed with access to the health and social supports necessary to avoid institutionalization and criminal involvement.

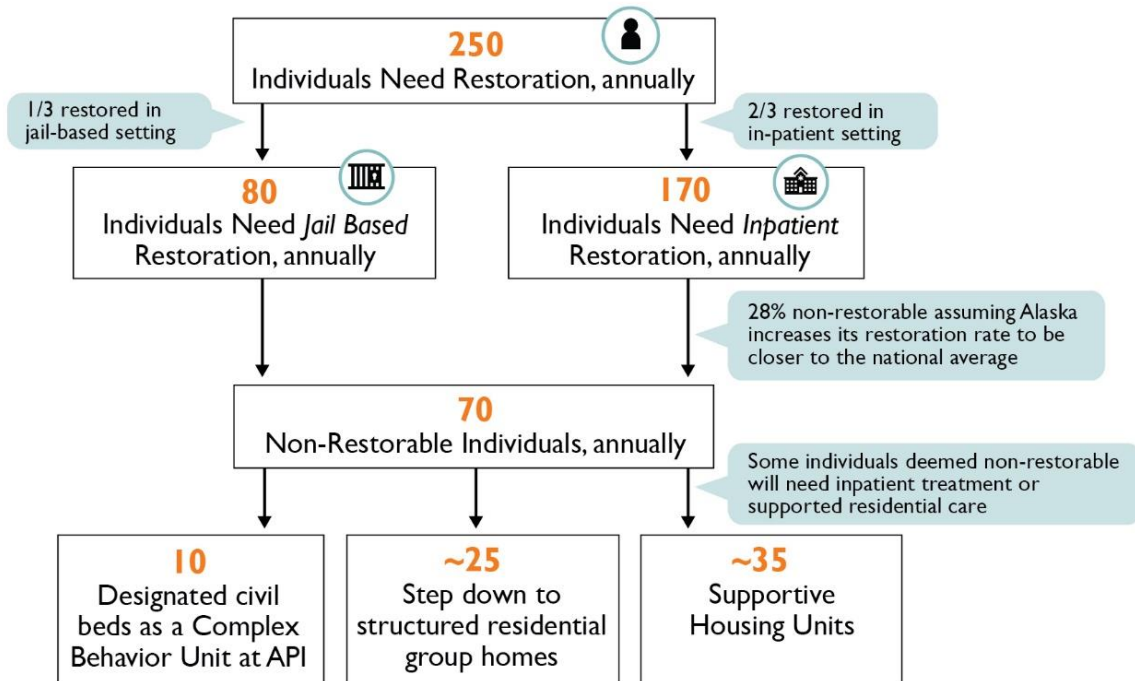
⁵⁸ Medicaid.gov. State Waivers List. <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html?sl=yes&usid=AK>

Figure 26 shows the forecasted number of individuals found unrestorable each year and estimates for inpatient and residential placement demand for these individuals.

Figure 26: Inpatient and Residential Bed Demand for IST Not Restorable Population

Non-Restorable Demand Forecast: FY 2026

Inpatient Beds, Structured Residential Group Homes & Supportive Housing



Case Studies + Data

States vary in their use of civil commitment for individuals found incompetent to stand trial and not restorable. Connecticut and Utah frequently transfer this population to a civil commitment, and as many as 85 percent of the population found non restorable in Utah are civilly committed. While using civil commitment as disposition increases forensic psychiatric inpatient capacity, it also strains the state's civil inpatient bed capacity. In Utah, approximately 30 of the 152 civil beds are occupied by discharged forensic psychiatric patients. Of the states surveyed, many report inadequate discharge options for forensic patients. Connecticut and Hawaii seem to have the widest array of services, which may include housing, rental assistance, case management, connection to peer specialists, intensive outpatient treatment, group homes and supportive living arrangements designed specifically for this population.

Data from other states suggests the IST population has significant support needs. In California, 47 percent of IST admissions were of unsheltered homeless individuals.⁵⁹ In Washington, 95 percent of the IST population were unstably housed at the time of their arrest, 62 percent had received outpatient mental health treatment during the year of arrest and 54 percent of the population had a substance abuse diagnosis, but only three percent had received treatment.⁶⁰ Housing status for the IST population before arrest or upon discharge is not available for Alaska's population; however, 50 percent of Alaska's restoration population had a substance use disorder.⁶¹ Stakeholders with the Complex Behavior Collaborative identified that stable housing is a huge issue for their client population, which overlaps with the forensic psychiatric population. Additionally, there is a need for increased community supports, like the Complex Behavior Collaborative, that can manage challenging and assaultive behaviors outside of an institutional setting.

FORENSIC PEER SPECIALISTS

Hawaii's Certified Peer Specialist Program offers specialized training and certification for Forensic Peer Specialists. These individuals provide peer support to those with psychiatric and/or co-occurring challenges who are involved with the criminal justice system. Forensic Peer Specialists can be accessed from initial contact with law enforcement through community re-entry.

Recommendations

Process and systems improvements are recommended to improve Alaska's ability to discharge individuals found incompetent to stand trial and non-restorable to appropriate placements with needed supports.

Immediate Action: Update the Urgent Forensic Discharge MOA and use statewide. The Urgent Forensic Discharge MOA is already in place but needs to be updated and the parties should re-commit to it. The Alaska Mental Health Trust Authority was identified by stakeholders as the agency designated to reconvene the parties to the MOA. Updates and implementation should be further defined by the involved parties. The

⁵⁹ California Department of State Hospitals. (2018). Incompetent to Stand Trial Diversion Program.

⁶⁰ Washington State Department of Social and Health Services. (2017) Best Practices in Forensic Mental Health.

⁶¹ API Meditech Electronic Health Records. IST and Non-IST Discharge Diagnosis. July 1, 2015 – December 31, 2018. Diagnosis types with three or more patients with a given diagnosis.

reach of the MOA should expand beyond cases heard on the Anchorage mental health court calendar to include all cases in the state.

Build out transition options for forensic patients found IST after restoration. Discharge options should be expanded for this population within the walls of API and in the community.

Medium-term Action: Designate a 10-bed complex behavior unit at API. Other states have dedicated civil units for individuals with dementia, traumatic brain injury, and developmental disabilities. API's unit for individuals with dementia has been closed for some time. It is recommended that API designate a 10-bed unit for individuals with complex behavior needs that can be accessed by involuntary civil, voluntary civil and forensic patients who are most difficult to discharge and in need of longer-term treatment.

Medium-term Action: Develop appropriate community supports for patients found IST after restoration.

Anchorage has an assertive community treatment (ACT) team, but its focus is on homeless individuals who also have a severe and persistent mental illness. The ACT model does not explicitly address criminogenic factors. Forensic assertive community treatment (FACT) is a model used in other states that could be a discharge resource for this population. Given the identified needs of the forensic population, expansion of permanent supportive housing, and recruitment of group homes and assisted living facilities specifically for this population should be considered. The development of a secure residential facility for individuals with complex behaviors who are difficult to house was identified through stakeholder interviews as a continuum of care need. Appropriate community supports for patients found IST after restoration, include:

- Forensic assertive community treatment (FACT)
- Immediate and ongoing access to medical and behavioral health care
- Permanent supportive housing
- Recruitment of group homes and assisted living facilities specifically for this population
- Secure residential facility for individuals with complex behaviors

FACT Team Elements

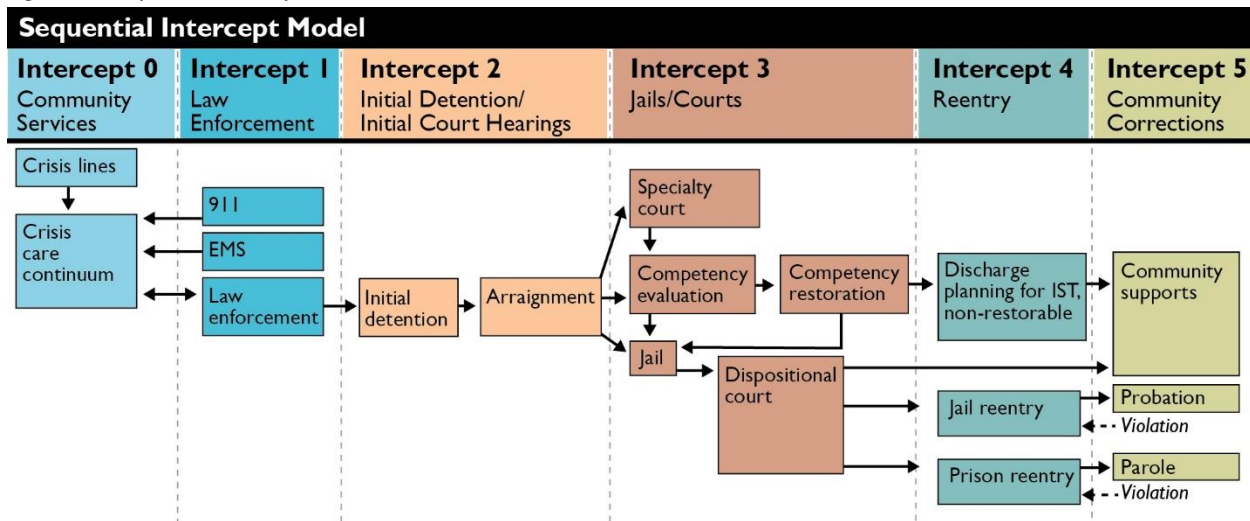
1. High fidelity to ACT model
2. Identification and targeting of criminogenic risk factors
3. Use of legal authority to promote engagement
4. Mental health – criminal justice collaboration for problem solving

Source: Community Forensic Interventions, LLC. Rochester Forensic Assertive Community Treatment model.
<http://www.comffit.org/our-services/introduction-to-rochester-forensic-assertive-community-treatment-r-fact/>

6. Across the Forensic System

Oversight, data tracking, and annual reporting are needed to improve care across the forensic psychiatric system at all six intercepts.

Figure 27: Sequential Intercept Model



Source: 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.

Status Quo

There is limited oversight of the forensic psychiatric system in Alaska. Forensic evaluators and treatment staff are employed by API, within the Department of Health and Social Services, but do not have leadership structure or oversight that differs from employees working on civil commitment units. Data from the Alaska Court System and API is not consistently collected or shared between agencies or with the legislature. Communication and collaboration between partner systems for issues specifically related to the forensic population is minimal. As mentioned in the section above, there is an Urgent Forensic Discharge MOA in place, but it is used to communication between the Court, DOC and API only for Anchorage cases.

Case Studies + Data

Washington, Connecticut and Colorado each have specific offices or divisions that oversee forensic psychiatric services. Utah and Hawaii operate a model more similar to Alaska; however, 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 Federal settlement agreements or consent decrees in place as a result of lawsuits related to the backlog in their competency restoration systems. As such, each state has a court monitor or analogous role in place that provides system oversight.

Case study research did not identify model data tracking and communications systems and indicated that these aspects of care are works in progress across the country. In Connecticut and Hawaii, the use of a court

liaison is beneficial in connecting the mental health system to the courts. Colorado has plans to introduce court liaisons to their system, as recently passed legislation funded this role within the system. Utah is considering the use of Sales Force to track forensic data. Two states (California and Hawaii) were identified as submitting annual reports to their respective legislatures with information on forensic patient characteristics and outcomes.

Recommendations

Recommendations for improvements across the forensic system include the creation of a forensic mental health coordinating council and the development of effective data tracking and reporting systems to increase system transparency and accountability.

Immediate Action: Establish a forensic psychiatric coordinating council to oversee implementation of system improvements. Alaska's population is small, and its forensic psychiatric service line is not as robust as states like Washington, Connecticut and Colorado, so a separate division for forensic psychiatric services is likely not needed at this time. However, it is recommended that Alaska adopt a model similar to Utah, where a Forensic Mental Health Coordinating Council guides the states' efforts to manage the forensic psychiatric population. The council could be used as the implementation arm for the recommendations identified in this report. The council could be structured similarly to Utah, with representatives from the following agencies: DHSS, DBH, API, DOC, Department of Law, Civil and Criminal Divisions, the Attorney General's Office, Senior and Disabilities Services, Division of Juvenile Justice, Criminal Justice Commission, state court administration, the Alaska Mental Health Trust Authority, Governor's Council on Disabilities and Special Education, and the Alaska Mental Health Board. Inclusion of community mental health provider organizations and consumers and their families should also be considered. Stakeholders identified the Criminal Justice Commission Behavioral Health Workgroup as an existing group that could take on the responsibilities of a forensic mental health coordinating council. The immediate need is to identify a lead agency or consultant to establish membership, convene monthly meetings and take notes.

The forensic psychiatric coordinating council could consider appointing a policy workgroup. The UNLV and WICHE reports both provide statute change recommendations, summarized in Appendix J, but a group has not been identified to lead the development of new or revised policies and statutes to bring before the legislature. Priority statute changes for consideration may include the following:

- Define *qualified psychologist* and *qualified psychiatrist* in statute
- Expressly permit the court to rely on previous and/or recent competency evaluations to determine whether a new evaluation is necessary and provide parameters for when a recent evaluation can be used
- Expressly permit the use of telehealth for competency evaluations and progress with restoration evaluations
- Require the courts advance the date for the hearing on a defendant's competency to the day after the competency report is filed
- Provide guidance, referencing Harper and Sell, related to the administration of involuntary medication to restore competency
- Add provisions for custody and discharge planning if an individual is found incompetent to stand trial and non-restorable

Medium-term Action: Develop a data tracking and reporting system. Alaska’s forensic psychiatric service system needs to consistently track data, review outcomes and share information with partners. Part of this goal may be achieved through updating and strengthening the Urgent Forensic Discharge MOA. If established, a data tracking and reporting workgroup could be part of the oversight body recommended above.

The first step is to identify the key data points needed, the parameters of what can be shared, timeframes for sharing, and the agency responsible for collecting the data. The state should consider the use of existing resources, such as Alaska’s Automated Information Management System (AKAIMS), to see if modules could be built in to the system that would allow reports and data to be easily shared across state systems. Information related to the forensic population should be compiled and submitted in an annual report to the legislature and partners to track progress and continued needs each year.

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, this study recommends the following data points be tracked. Items in bold reflect a need for action beyond routine data entry and analysis.

Figure 28: Data Tracking Recommendations

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 Face sheet
Location waiting for evaluation, location waiting for admission	Quarterly	SPSS Face sheet	Add to Face sheet
Originating court , district and city of charge	Quarterly	SPSS Face sheet	Add originating court to Face sheet
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 Face sheet
Homelessness status at intake + discharge	Quarterly	SPSS Face sheet	Add to Face sheet
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

More detailed information and recommendations for a data tracking and reporting system can be found in Appendix F.

7. Approaches, Staffing + Capital Costs

Forensic Psychiatric Hospital Locations + Approaches

The need to increase the number of forensic psychiatric treatment beds is apparent and the type of treatment and projected number of additional treatment slots have been identified. This section addresses recommended treatment locations and approaches to maximize the opportunities in each location. This chapter also includes an estimate of the capital costs required to achieve each approach and annual operating costs. A detailed writeup of the method to estimate operating costs is in Appendix H. Full page drawings and space lists for each approach can be found in Appendix I.

Approach I

The current API Taku forensic suite accommodates 10 patients at any given time. The original building design categorized Taku as an I-3 Condition 3 occupancy. This occupancy class allows free movement within a secured housing unit and does not require containment behind bedroom doors. The Taku unit includes a secure “sally port” (two interlocked doors) and the space itself is isolated from the rest of the building by smoke and fire compartments.

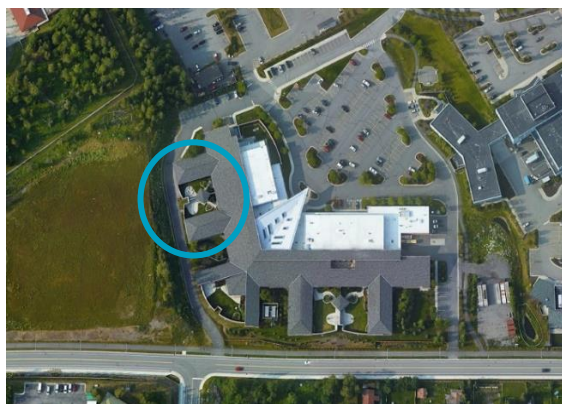
The other treatment units in API are I-2 occupancies, as typically found in psychiatric hospitals. The entry/egress doors to these units are always locked, but no sally ports are included. The building code (IBC) does not dictate forensic units be considered I-3 occupancies; this was apparently a decision made by the API planning team at the time of the hospital design. With Taku established as an I-3 occupancy a precedence has been set and the immediate response from the Building Department is that any new forensic units need to follow this expensive and limiting I-3 criteria. Through further discussions with the building officials this position is softening, and it seems likely that at least low risk offenders and misdemeanants could be housed and treated in an I-2 environment. This position allows opportunities within the existing API structure to treat appropriate forensic patients in any treatment suite within the facility. By using existing I-2 treatment space for forensic patients, the Department could quickly increase the number of forensic patients receiving treatment in a hospital setting.

Figure 29: Approach I – Interior



A likely manageable approach to increase forensic patients within the existing API footprint is to retain Taku as a secure forensic treatment unit and dedicate one additional unit to lower risk forensic patients. The Denali unit immediately west of Taku is a logical choice. Denali currently has a fire and smoke barrier in place between Taku and Chilkat, the unit that neighbors Taku to the east, and another barrier between Taku and Denali. There are no fire separation requirements for exterior walls and since barriers are already in place between Chilkat, Taku and Denali no additional fire barriers are needed. In addition to the building code issues there are several safety enhancements suggested for the Denali unit to be used by forensic patients. These include adding a sally port, hardening exterior windows, upgrading cameras, adding electronic detection to bedroom doors, and replacing the antiquated nurse call and security system. The anticipated budget for these improvements is \$1,800,000.

Figure 30: Approach 1 - Exterior



Cost of Approach 1

Item	Amount
Beds	20 inpatient restoration beds within existing API footprint
Capital Cost	\$1.8 million
Annual Operating Cost	\$4.1 million
Annual Operating Cost Per Day Per Bed	\$995

Approach 2

The Alaska Mental Health Trust Authority commissioned an investigation in 2018 to assess adding civil commitment hospital beds to the existing API. API was initially planned to expand when the need for additional beds occurred. Information about the addition was recorded in some of the construction documents, but there are no drawings or refinements of the design and the potential planned capacity was unknown.

Figure 31: Approach 2 - Exterior



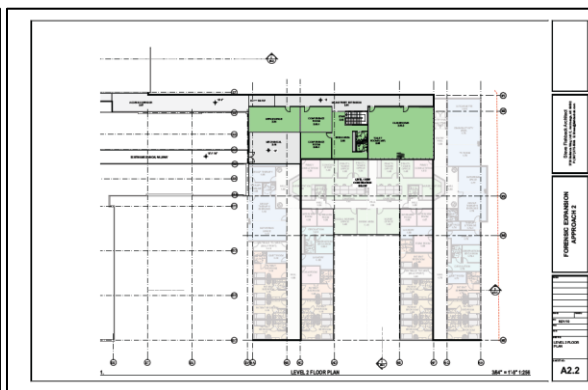
The 2018 study identified the potential of adding up to 24 hospital beds, 12 beds in two units. The expansion was also able to increase administrative and support spaces to service the 30% bed increase. As illustrated, the addition will maximize the building capacity of the API site. If the 24-bed addition was constructed as two forensic units it is likely the Taku unit would be converted to civil commitments, thus increasing the API civil bed capacity to 90 and the forensic capacity to 24 patients. Advantages of this approach include the consolidation of DHSS psychiatric patients in API

where professional and managerial staff are available in one location. The forensic capacity will be increased, but otherwise the transfer of the custody and transportation of inmates between the DOC and API will continue. The forensic hospital expansion is expected to cost approximately \$27,000,000 if built in 2021.

Figure 32: Approach 2 - Interior, Level 1



Figure 33: Approach 2 - Interior, Level 2



Cost of Approach 2

Item	Amount
Beds	25 inpatient restoration beds at an expanded API
Capital Cost	\$27 million
Annual Operating Cost	\$8.6 million
Annual Operating Cost Per Day Per Bed	\$947

Approach 3

Another location being considered for in-custody competency restoration services requires developing a new jail-based competency restoration program. The jail-based program allows inmates to receive treatment services while being held in a pre-trial facility.

A successful jail-based model is Utah's RISE treatment program. This approach designates a housing unit to serve as the jail-based restoration unit. The individuals live in the unit and participate in the program during the day. We are currently estimating 25 beds of jail-based restoration who would be housed in the Alpha Module of the Anchorage Complex East (Anchorage Jail). Alpha Module is currently housing up to 32 inmates in 16 cells. Since some forensic inmates cannot share a room, 13 cells are allocated for housing and three cells will be converted to program space. Other constructed developments include establishing a large nurse station, increasing camera coverage, reducing ligature points and other improvements that may be required for this group. A reasonable construction budget to establish this jail-based program is \$2,000,000.

Figure 34: Approach 3 - Interior, Restoration Unit



Figure 35: Approach 3 - Interior, Mezzanine



Cost of Approach 3

Item	Amount
Beds	25 jail-based restoration beds at the Anchorage Correctional Center
Capital Cost	\$2 million
Annual Operating Cost	\$2.7 million
Annual Operating Cost Per Day Per Bed	\$296

Approach 4

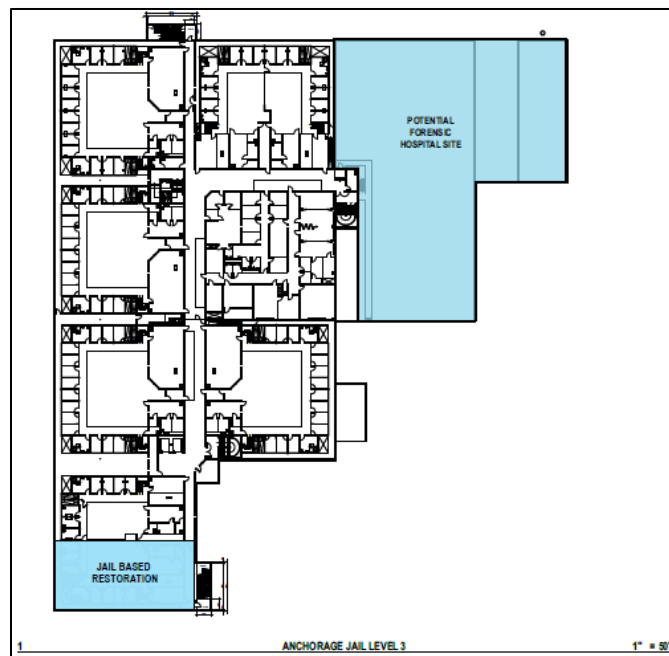
The fourth approach for expanding restoration treatment space is to expand the Anchorage Jail at the Anchorage Correctional Center onto the platform that was provided at the time of initial construction. The large one-story area was designed to provide housing for an additional 192 general population pre-trial prisoners. This area could be repurposed as a site for inpatient restoration beds that would replace the Taku unit. The disadvantages of this approach are a potential increase in management challenges for the Department of Health and Social Services and API to manage two sites, and location of psychiatric treatment at a correctional setting for those who are not in the custody of the Department of Corrections.

By incorporating the general method outlined in Approach 2, the forensic addition at API, a 25-bed hospital expansion requires approximately 25,000 sq. ft. of floor area. The construction of inpatient restoration beds in the jail building is expected to cost about the same as the API addition. The proposed site is on the second

Figure 36: Approach 4 - Exterior



Figure 37: Approach 4 - Interior



level of the east side of the Anchorage Jail building above the vehicle sally port, Anchorage Safety Center and the mechanical plant. Ideally the City's Safety Center could be relocated to a new site, thus allowing the inpatient restoration facility a first level entry, Intake, and administrative area. The new inpatient restoration facility approach can be accomplished without relocation of the Safety Center, but the ground level access is seen as an enhancement. This approach also includes 25 beds of jail-based restoration within the existing ACC footprint, as shown in Approach 3. The anticipated project cost for the new inpatient restoration beds addition on the Anchorage Jail and jail-based restoration within the existing ACC footprint is \$29,000,000.

Cost of Approach 4

Item	Amount
Beds	25 jail-based restoration beds & 25 inpatient restoration beds at the at the Anchorage Correctional Center
Capital Cost	\$2 million for jail based within existing footprint & \$27 million for 25 beds of inpatient restoration
Annual Operating Cost	\$11.3 million
Annual Operating Cost Per Day Per Bed	\$296 for jail-based restoration & \$947 for inpatient restoration beds