Alaska's Behavioral Health Crisis Continuum, Civil and Forensic

Key Findings and Recommendations from:

ASHNHA Acute Behavioral Health Care Improvement Project +

DBH Forensic Psychiatric Hospital Feasibility Study

Prepared for the Alaska Mental Health Trust Authority
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Engage Plan Implement

AGNEW ::BECK

Overview of the Projects

Alaska's Behavioral Health Crisis Continuum: Civil and Forensic

The Trust recently partnered to complete two studies of Alaska's acute behavioral health system:

- Alaska State Hospital and Nursing Home Association's Acute Behavioral Health Care Improvement Project
  - Civil: individuals with behavioral health needs in emergency departments and may require civil commitment.
- Division of Behavioral Health's Forensic Psychiatric Hospital Feasibility Study
  - Forensic: individuals with behavioral health needs in the legal system who may be court ordered to the competency to stand trial evaluation and restoration process.

Alaska's Behavioral Health Crisis Continuum: Civil and Forensic

Two pressing issues in need of immediate action and long-term solutions:

- Psychiatric boarding in emergency departments
- Backlog in competency to stand trial evaluations and restoration in the forensic psychiatric system

Two studies provide valuable data, stakeholder input, case studies, and recommendations to address deficiencies and improve the acute behavioral health system in Alaska.

Alaska's Behavioral Health Crisis Continuum: Civil and Forensic

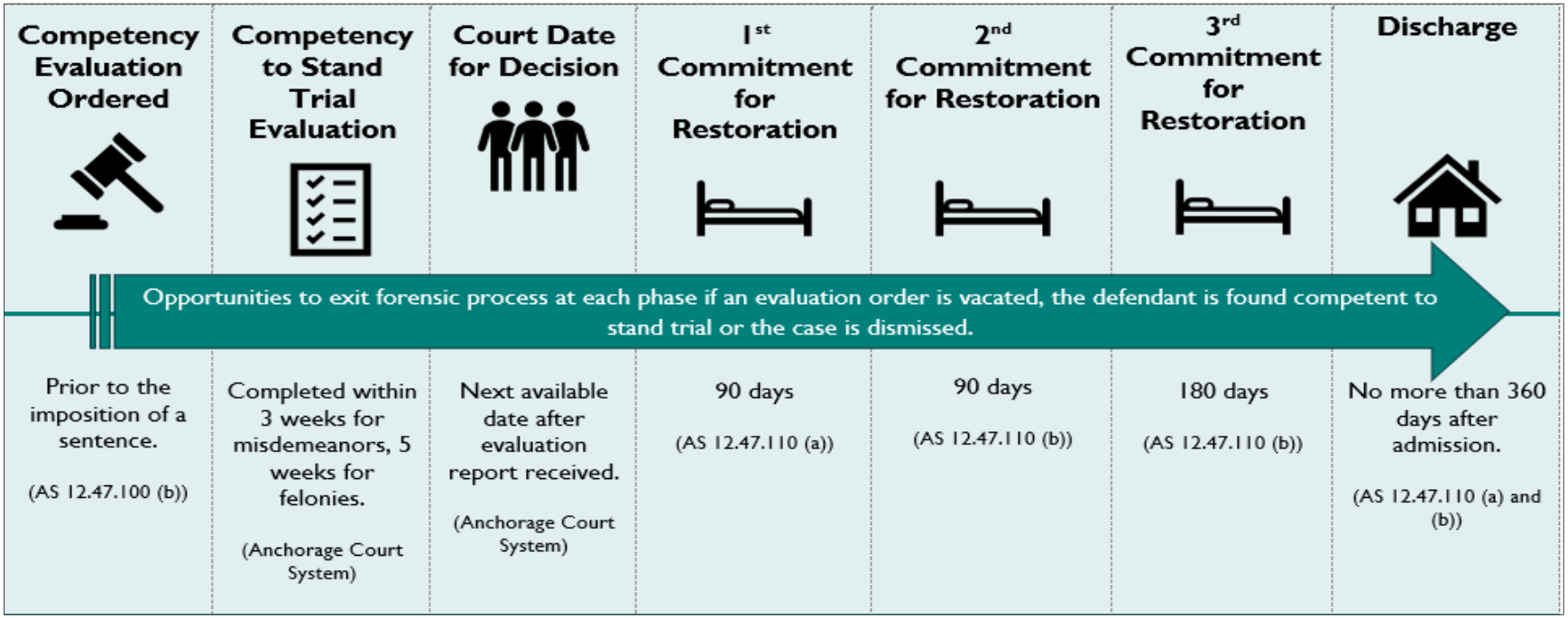
Psychiatric boarding occurs when an individual with a mental health condition is kept in a hospital emergency department for several hours because appropriate mental health services are unavailable.

There are a number of factors that contribute to the prevalence of psychiatric boarding including:

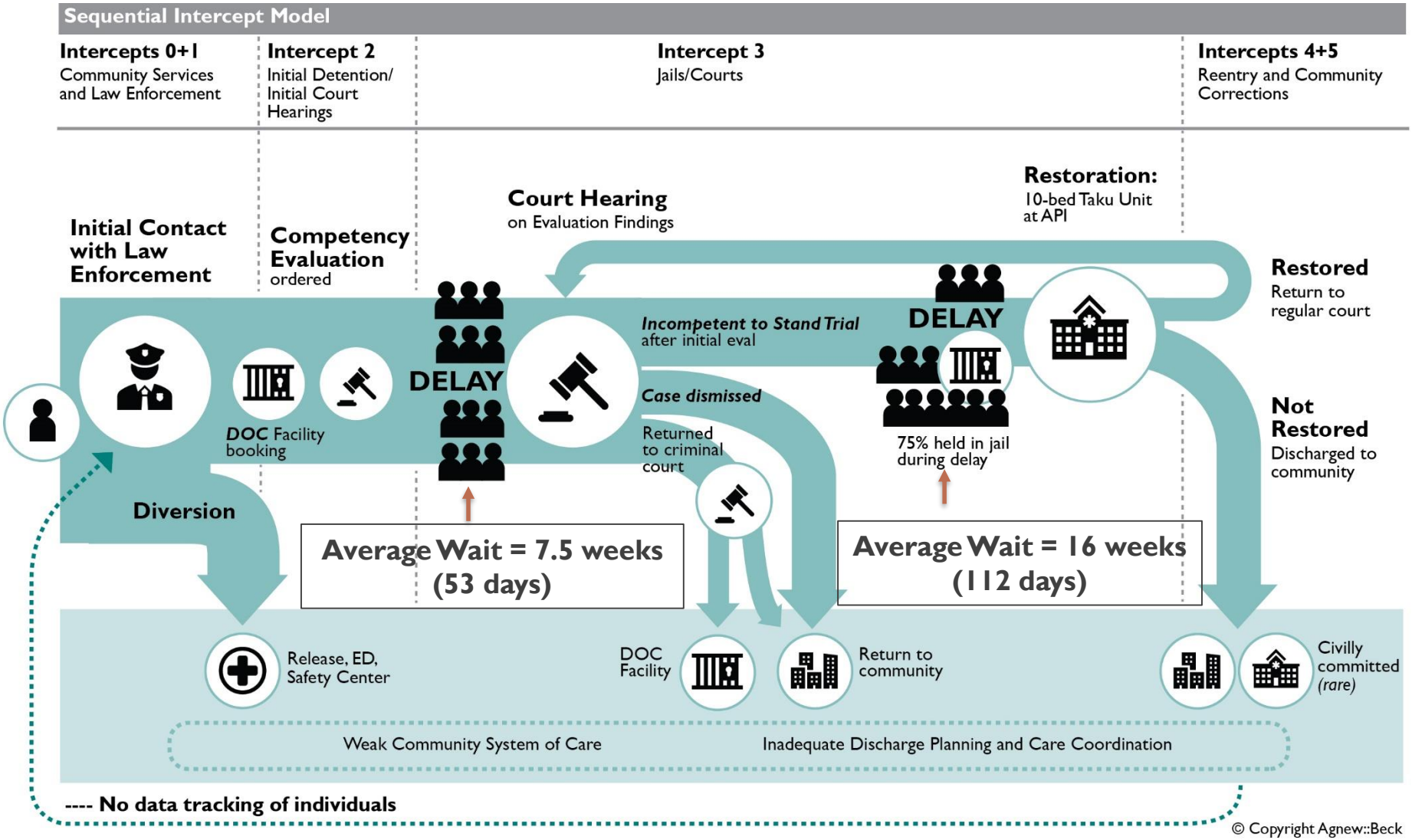
- Lack of outpatient resources and treatment coordination
- Lack of inpatient capacity,
- Psychiatric services are relatively unprofitable and often perceived as less of a need.

Alaska's Forensic Psychiatric Process

Competency to Stand Trial Evaluation and Restoration



Alaska's Forensic Psychiatric System



Scopes of Work

ASHNHA Acute Behavioral Health Care Improvement Project

1. Convene stakeholders to identify goals and strategies to improve acute behavioral health services and address gaps and delays in the continuum of care;
2. Prioritize solutions for short and long term implementation.

Scopes of Work

DBH Forensic Psychiatric Feasibility Study

1. Explore feasibility and cost of relocating and/or expanding API's current forensic psychiatric unit.
2. Identify policy, process and statute changes to address the competency evaluation and restoration backlog at multiple points in the system.
3. Research and analysis of alternatives to inpatient restoration, the forensic psychiatric workforce in Alaska, and improvements to data tracking.

Project Goals: Civil (ASHNHA)

1. Improve patient outcomes and experience of care within the ED and inpatient care settings for patients presenting with behavioral health conditions.
2. Improve staff safety within ED and inpatient care settings.
3. Decrease avoidable ED visits for individuals with behavioral health issues who present to the ED.
4. Decrease avoidable ED re-visits for individuals with behavioral health conditions who present to the ED.

Project Goals: Forensic (DBH)

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.
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.

Target Populations

Civil:

- Individuals experiencing acute behavioral health crisis presenting at an emergency department who could require admission to API or other inpatient psychiatric care setting

Forensic:

- Those needing a competency to stand trial evaluation
- Those deemed incompetent to stand trial (IST) and in need of treatment to be restored to competency
- Those non-restorable after treatment who were charged with serious crimes who may be civilly committed
- Those deemed by the courts to be Not Guilty by Reason of Insanity and civilly committed to DHSS custody (very few)

Data Sources

Civil:

- Alaska Health Facilities Data Reporting (HFDR)
- Alaska Court System data for ex parte orders

Forensic:

- API
  - Electronic health record (Meditech)
  - Counts by forensic psychologists
  - Tuesday reports
  - SPSS tracking system
- Anchorage Court Competency Calendar spreadsheet

Stakeholders + Key Informants

Both:

- Department of Health and Social Services (API, DBH, DJJ, SDS)
- Alaska Mental Health Trust Authority

Civil:

- Alaska State Hospital and Nursing Home Association (ASHNHA) and member hospitals and providers
- Alaska Behavioral Health Association
- Anchorage Community Mental Health Services
- Alaska Public Defender Agency

Forensic:

- Alaska Court System
- Alaska Mental Health Board
- Department of Corrections
- Department of Law (Civil, Criminal)
- Municipality of Anchorage
- United Way of Anchorage
- WellPath Recovery Solutions
- Utah, Colorado, Hawaii, Connecticut forensic psychiatric system leaders

Methods

Both:

- Data collection and analysis
- Best practice research
- Stakeholder and partner interviews
- Stakeholder meetings + strategic sessions

Civil:

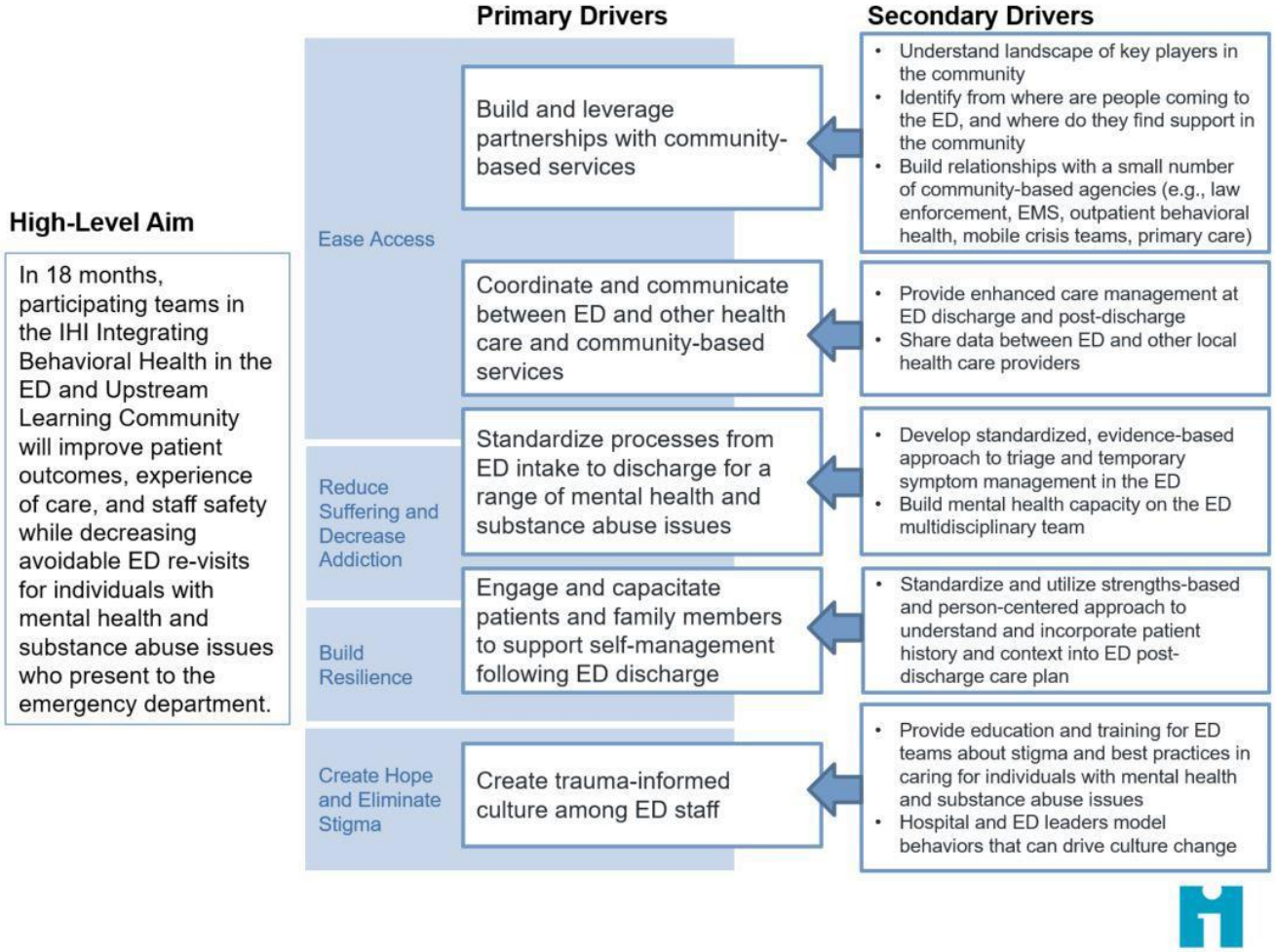
- Institute of Healthcare Improvement (IHI) *Integrating Behavioral Health in the Emergency Department and Upstream* theory of change
- Data analysis modeled on Arizona Hospital and Healthcare Association study of psychiatric boarding
- Stakeholder identification and prioritization of strategies

Forensic:

- Sequential Intercepts Model
- Case study interviews with Utah, Colorado, Hawaii, Connecticut forensic psychiatric system leaders
- Consultation with forensic psychiatrist Dr. Patrick Fox
- Demand forecast for restoration beds
- Detailed models for staffing, operations and capital costs

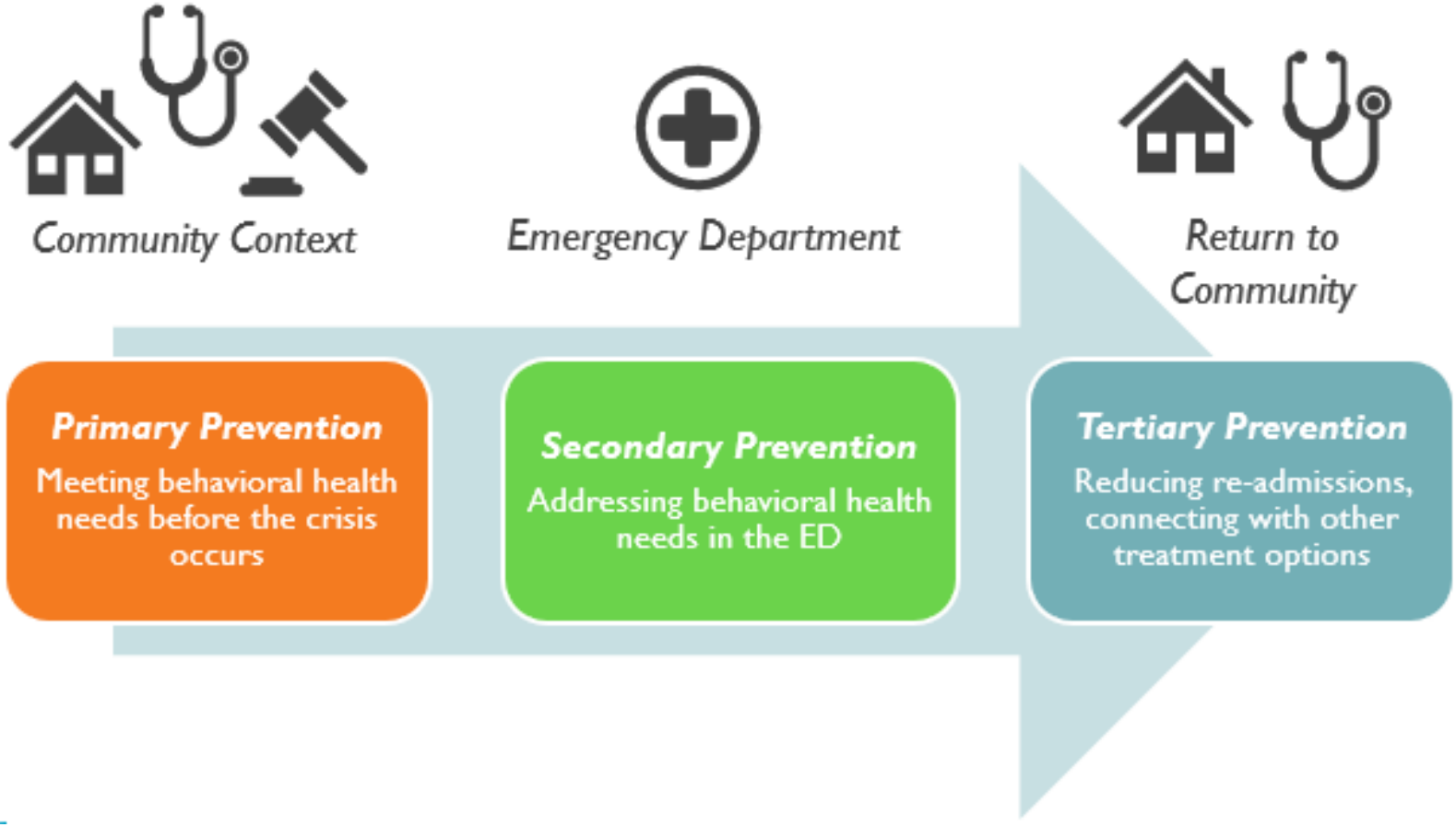
Theory of Change: Civil

Institute for Healthcare Improvement: ED and Upstream Driver Diagram for Integrating Behavioral Health in the ED



Theory of Change: Civil

From Crisis to Stabilization to Follow-up Care



Source: Laderman M, Dasgupta A, Henderson R, Waghray A, Bolender T, Schall M. *Integrating Behavioral Health in the Emergency Department and Upstream*. IHI Innovation Report. Boston, Massachusetts: Institute for Healthcare Improvement; 2018.

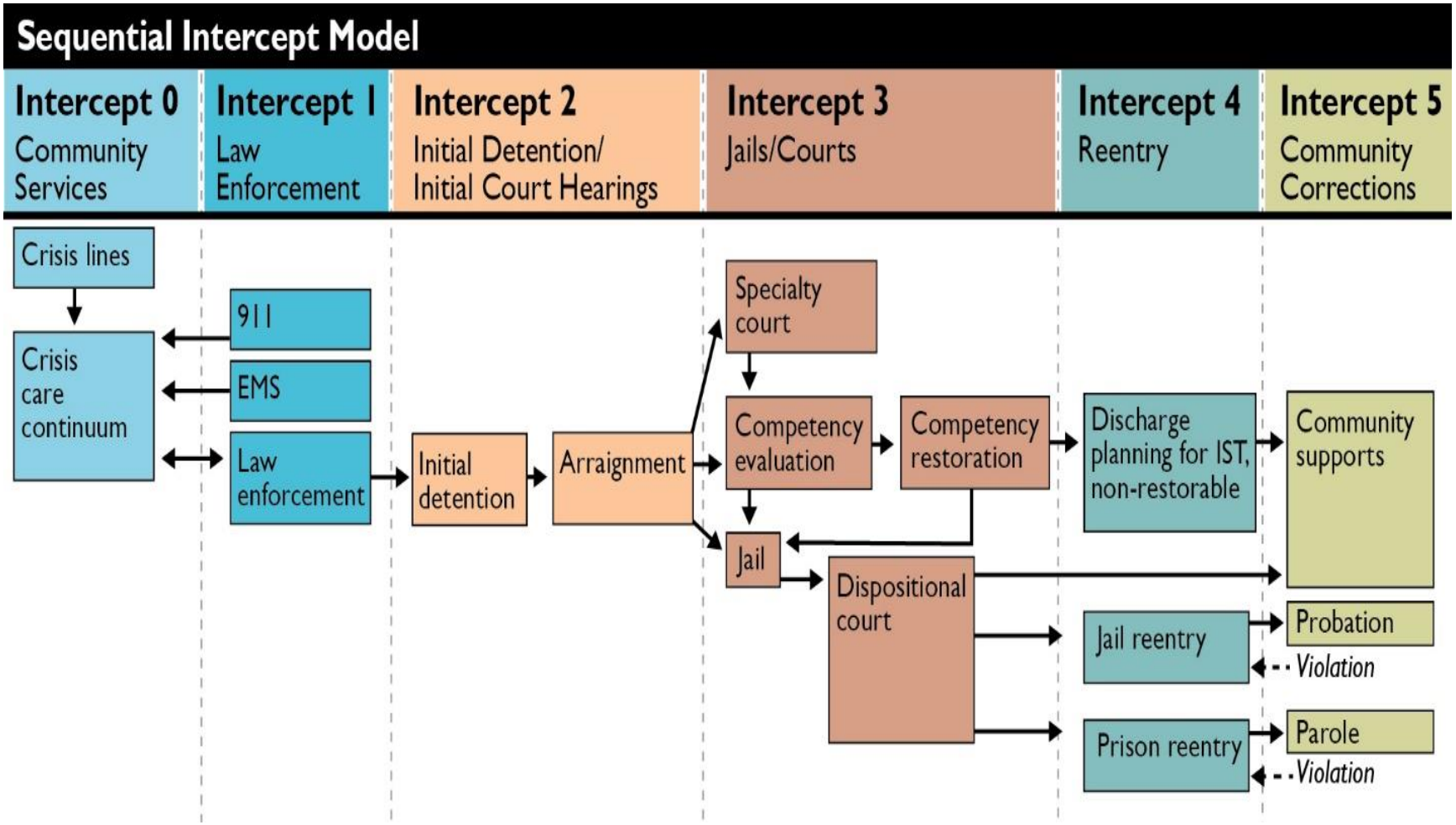
Theory of Change: Civil

Institute for Healthcare Improvement: ED and Upstream

	Primary (before presenting)	**Secondary** (when at the ED)	**Tertiary** (reduce re-admission)
1. Build and leverage partnerships with community-based services.	✓		✓
2. Coordinate and communicate between the ED and other health care and community-based services.	✓	✓	✓
3. Standardize processes from ED intake to discharge for a range of behavioral health issues.		✓	
4. Engage patients and family members to support self-management following ED discharge.		✓	✓
5. Create a trauma-informed culture among ED staff.		✓	
6. Expand or modify system of care.	✓	✓	✓

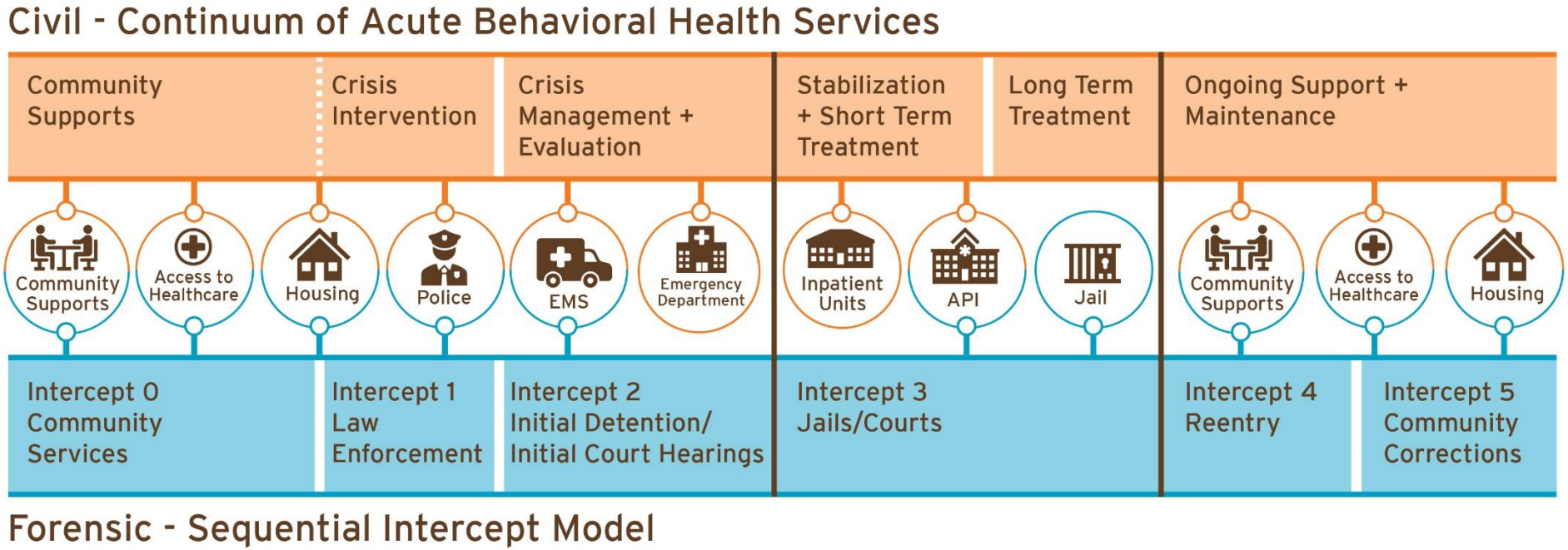
Source: Adapted from: Laderman M, Dasgupta A, Henderson R, Waghray A, Bolender T, Schall M. *Integrating Behavioral Health in the Emergency Department and Upstream*. IHI Innovation Report. Boston, Massachusetts: Institute for Healthcare Improvement; 2018.

Theory of Change: Forensic



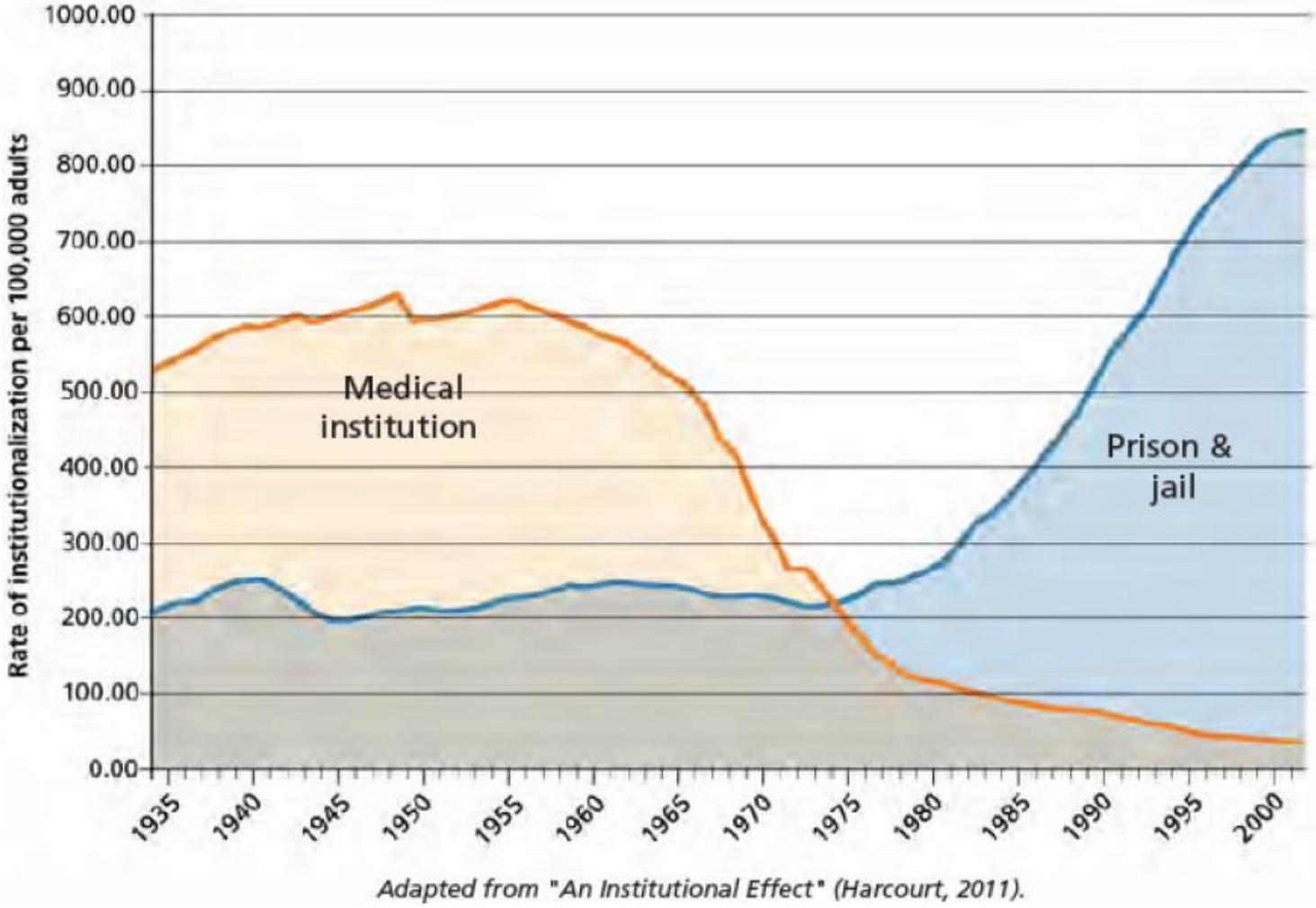
Source: Adapted from SAMHSA's GAINS Center for Behavioral Health and Justice Transformation. Developing a Comprehensive Plan for Behavioral Health and Criminal Justice Collaboration: The Sequential Intercept Model.

Civil + Forensic Psychiatric Continuums of Care



Alaska and National Context for Behavioral Health Crisis Continuum: Civil and Forensic

Deinstitutionalization of inpatient psychiatric patients



Source: Reproduced from Cravez, Pamela. "Alaska's Lack of Psychiatric Beds and Consequences." University of Alaska Justice Center, May 21, 2018. Updated version of article originally published in Alaska Justice Forum 34:1 (2017).

Behavioral Health Crisis in the ED: a **National** Issue

1 in 5
ED visits are related to a primary behavioral health diagnosis.

EDs have seen a 44% increase
in acute behavioral health visits between 2006 to 2014.

Vulnerable populations are disparately impacted
Low income, Medicaid enrollees, individuals with bipolar, depression or anxiety diagnoses.

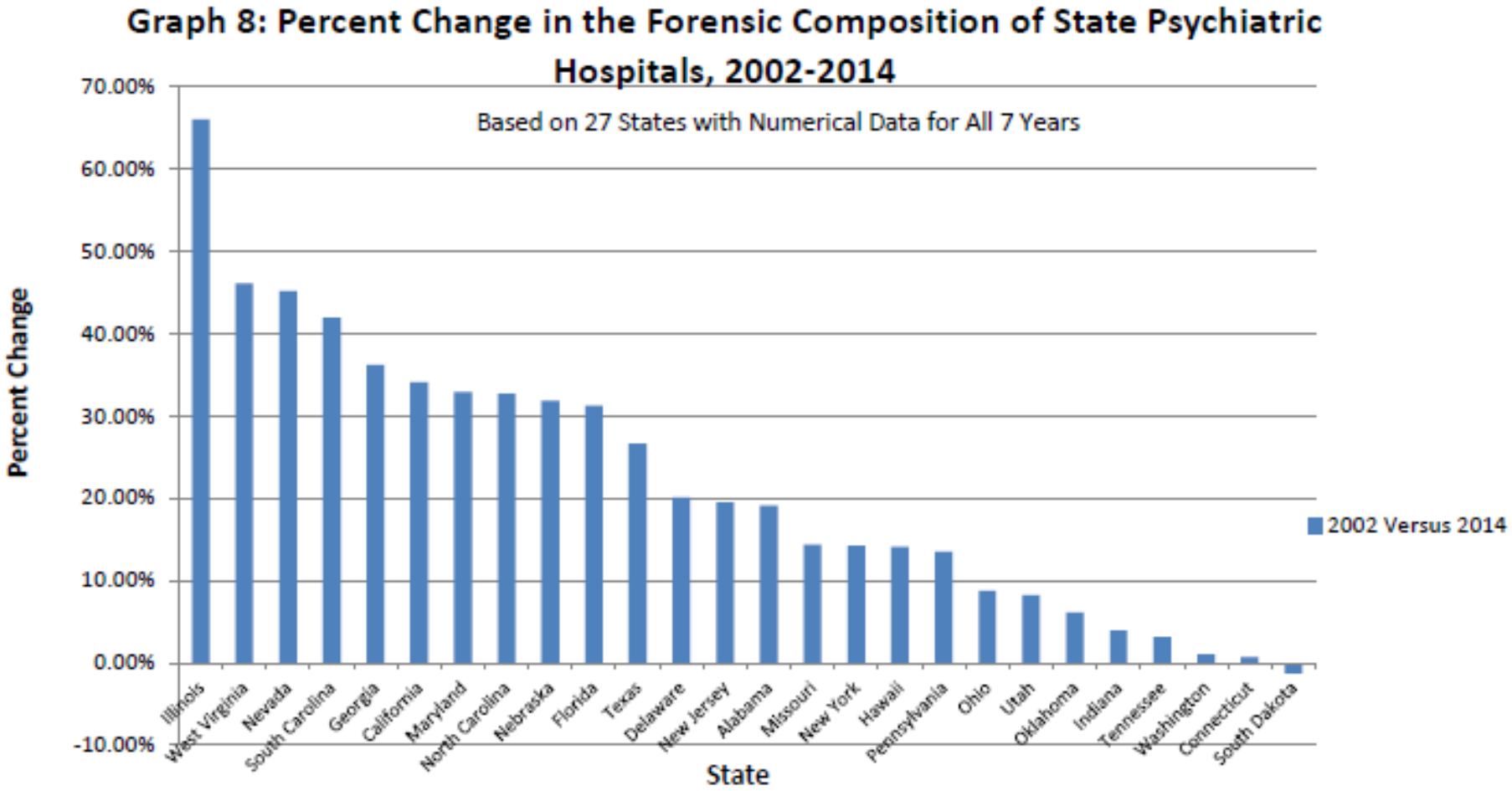
Patients spend 3 times longer
in the ED than those with a medical diagnosis.

ED staff spend twice as long
locating inpatient beds for psychiatric patients.

There are not enough inpatient psychiatric beds or community based behavioral health services to meet the need.

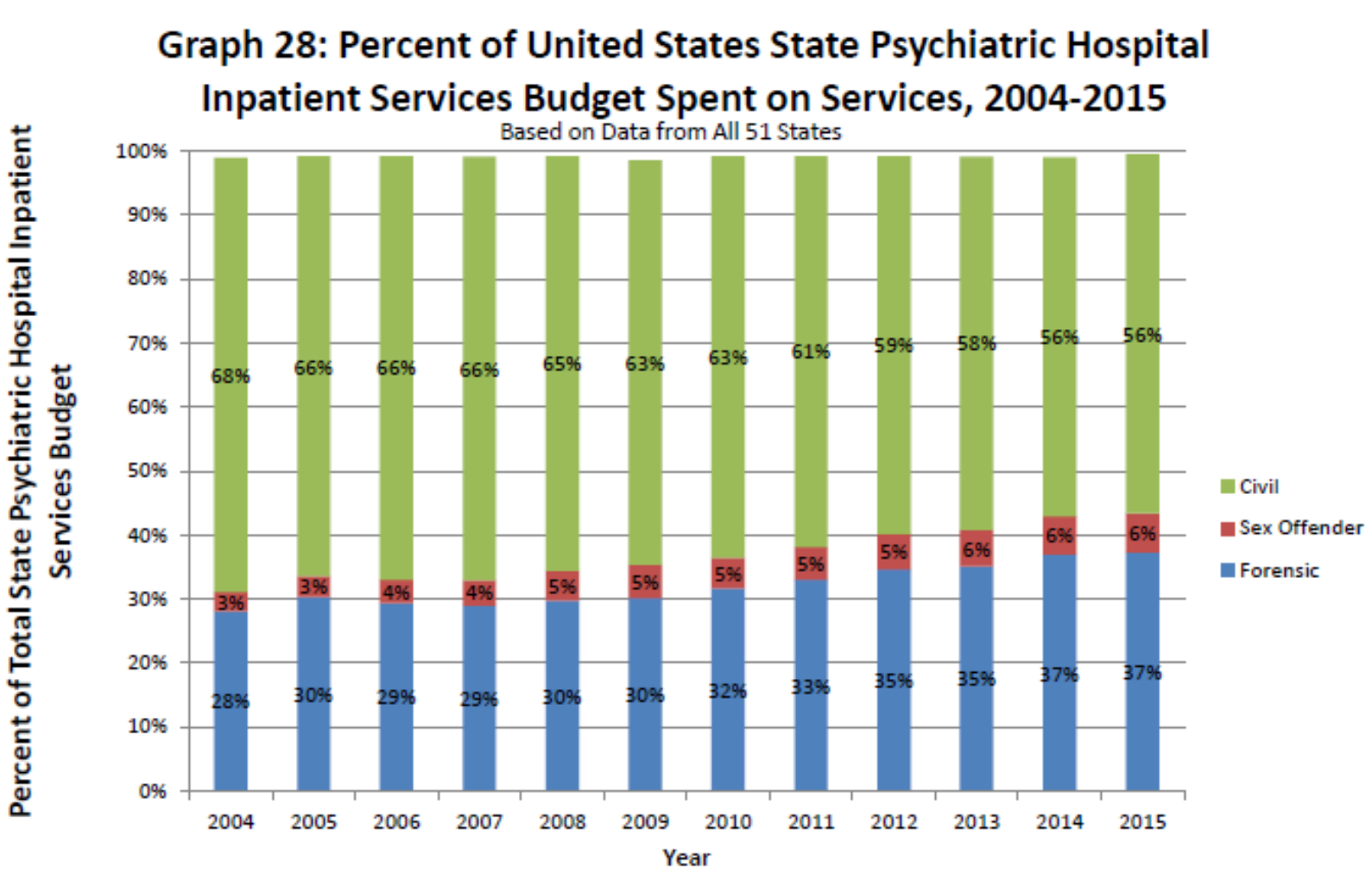
Source: Laderman M, Dasgupta A, Henderson R, Waghray A, Bolender T, Schall M. *Integrating Behavioral Health in the Emergency Department and Upstream*. IHI Innovation Report. Boston, Massachusetts: Institute for Healthcare Improvement; 2018.

Increase in Forensic Patients in State Psychiatric Hospitals



Source: Wik, A., Hollen, V., Fisher, W. H. (2017) Forensic Patients in State Psychiatric Hospitals: 1999-2016. National Assocaition of State Mental Health Program Directors. Alexandria, VA.

National expenditures for forensic psychiatric population increased 9% from 2004-2015 and decreased 12% for the civil population over the same period.



Source: Wik, A., Hollen, V., Fisher, W. H. (2017) Forensic Patients in State Psychiatric Hospitals: 1999-2016. National Assocaition of State Mental Health Program Directors. Alexandria, VA.

In Alaska…

- API's civil readmission rate is high and length of stay is short
- API's Taku Unit (forensic) has an average length of stay 3.8 times longer than API's civil units (69 days compared to 18 days in FY18)
- API's civil units (60 beds for adults, 10 beds for youth) have not been operating at full capacity for years; Taku has consistently remained open and at or near capacity.
    - The number of behavioral health patients discharged from EDs to psychiatric hospitals decreased from 17% in 2017 to just 8% in 2018
- Stakeholders shared that the lack of access to behavioral health treatment at the community or inpatient levels increases number of individuals involved in the forensic psychiatric system.

ASHNHA: Gaps

Psychiatric Capacity

Evaluation + consultation about medication and treatment in the ED

Standard Processes + Protocols in the ED

Well-defined processes to care for psychiatric patients

ED Staff Capacity

Team trained and ready to care for psychiatric patients

ED Coordination with Community Providers

Next-day follow up appointments, share care plans

Short-Term Treatment Beds

Inpatient capacity for short-term psychiatric treatment

Long-Term Treatment Beds

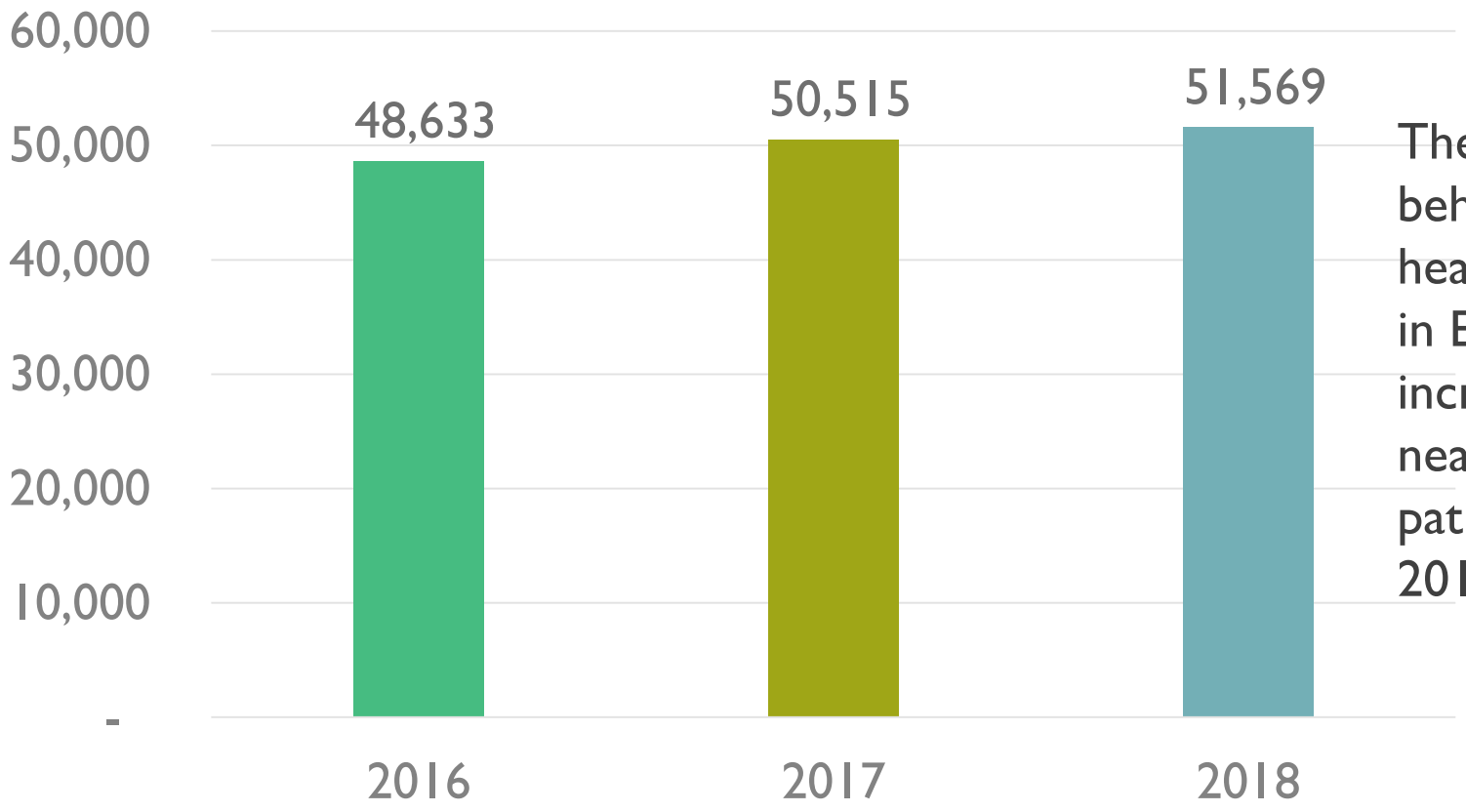
Inpatient capacity for long-term psychiatric treatment

Patient Characteristics

Patient Characteristics: Volume

Civil

Total number of patients with a primary and/or secondary behavioral health diagnosis presenting to the ED



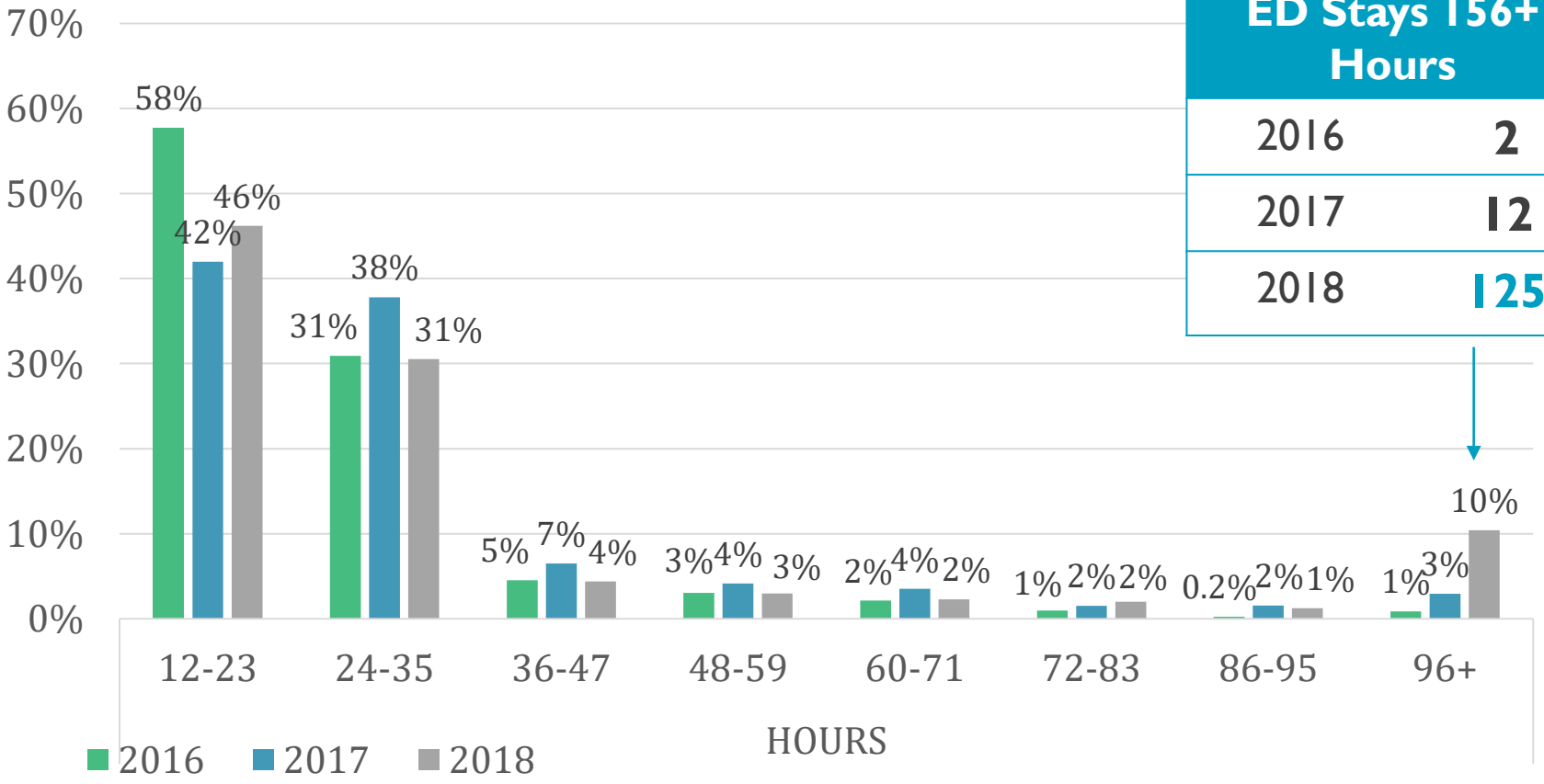
The number of behavioral health patients in EDs increased by nearly 3,000 patients from 2016 – 2018.

Source: Alaska Health Analytics and Vital Records, Health Facilities Data Reporting Program

Patient Characteristics: Volume

Civil

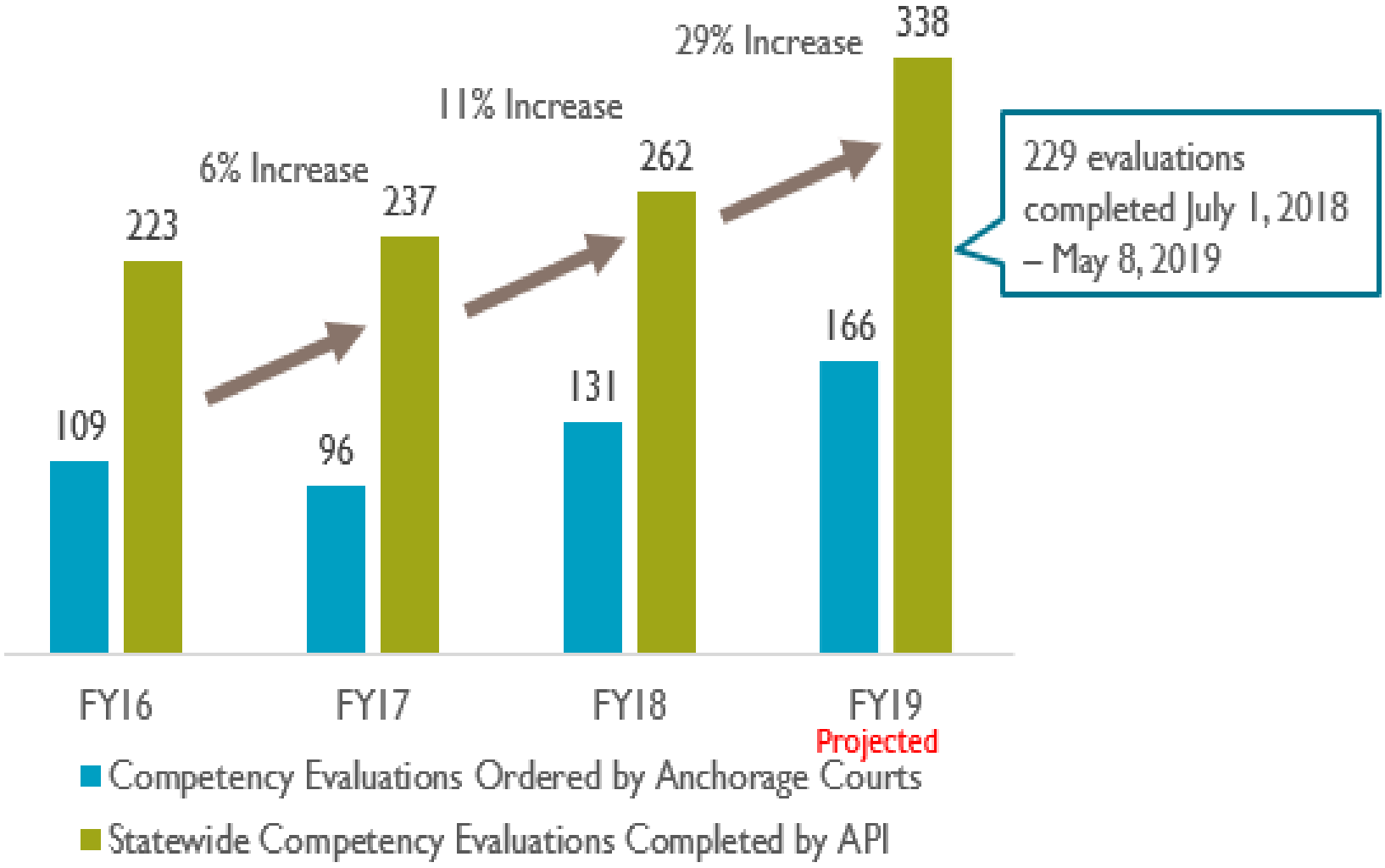
Behavioral health patients are waiting longer in 2018 than in 2016. A growing number are waiting more than 156 hours (6.5 days)



Number of BH ED Stays 156+ Hours	
2016	2
2017	12
2018	125

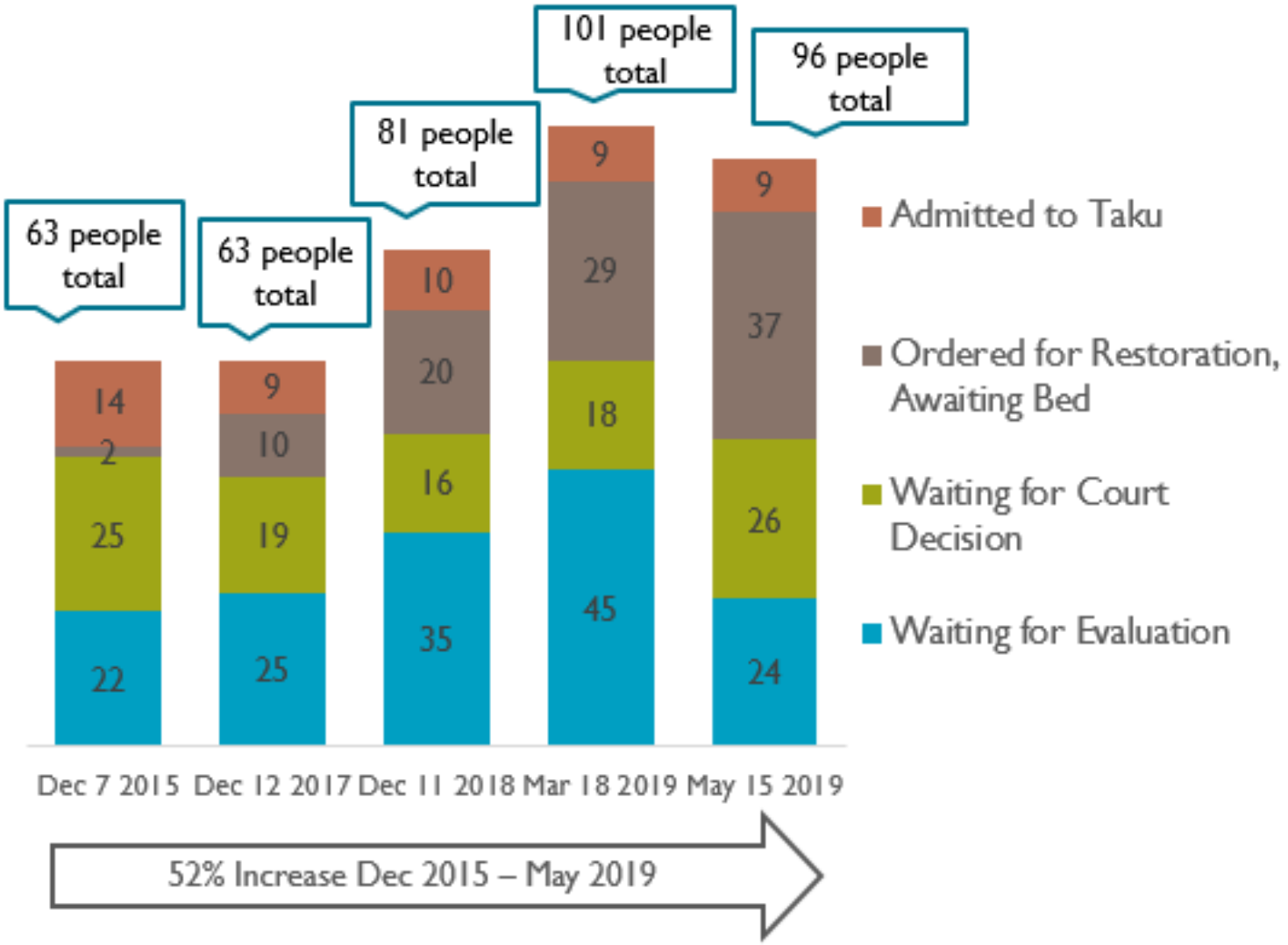
Patient Characteristics: Volume

Forensic



Patient Characteristics: Volume

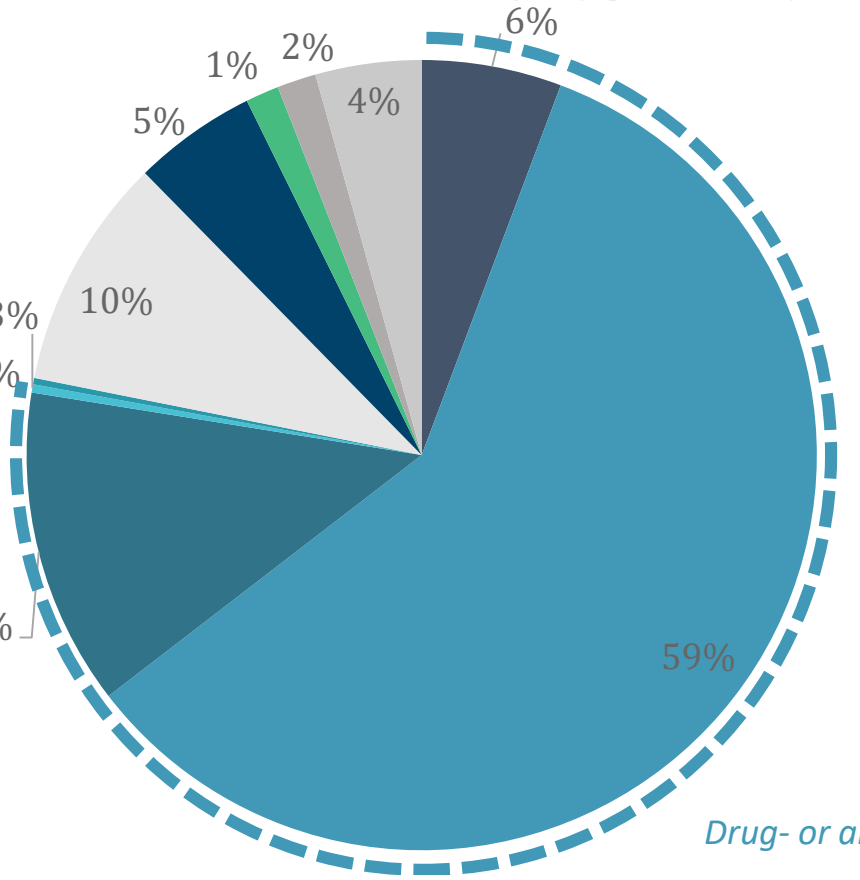
Forensic



Patient Characteristics: Diagnoses

Civil

Percentage of patients by diagnosis type, 2018



- Alcohol dependence syndrome
- Drug dependence
- Nondependent abuse of drugs
- Delusional disorders
- Other nonorganic psychoses
- Anxiety, dissociative & somatoform disorders
- Episodic mood disorders
- Schizophrenic disorders
- Altered Mental Status
- Other

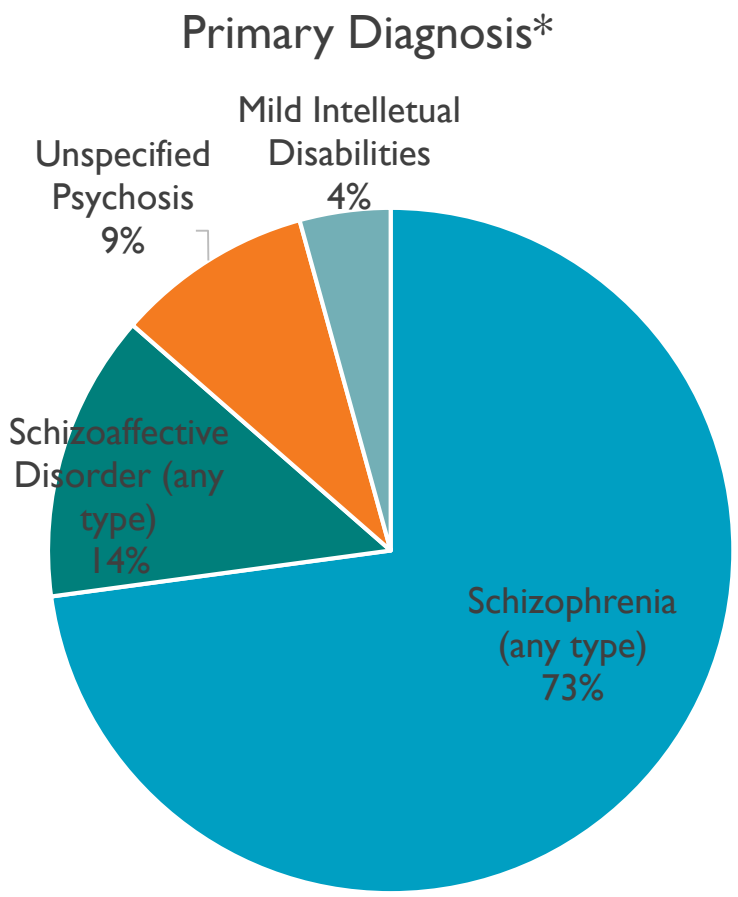
Longest waits

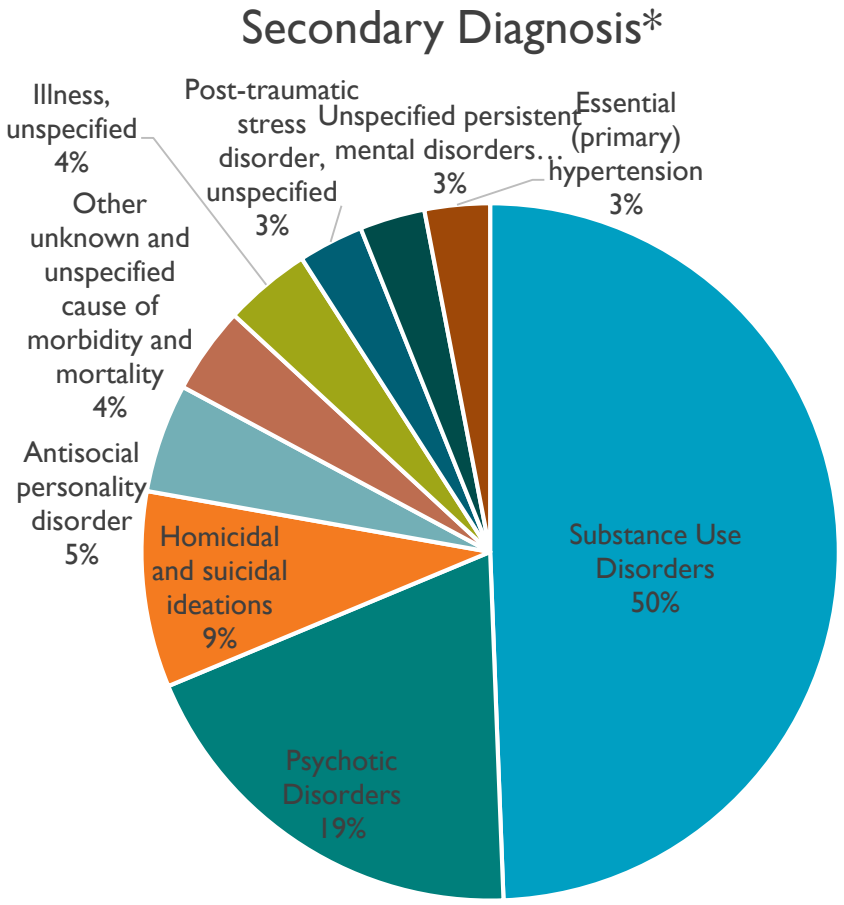
Drug- or alcohol-related diagnosis

Most behavioral health patients in EDs (78%) have a primary or secondary diagnosis in the category of drug dependence.

Patient Characteristics: Diagnoses

Forensic



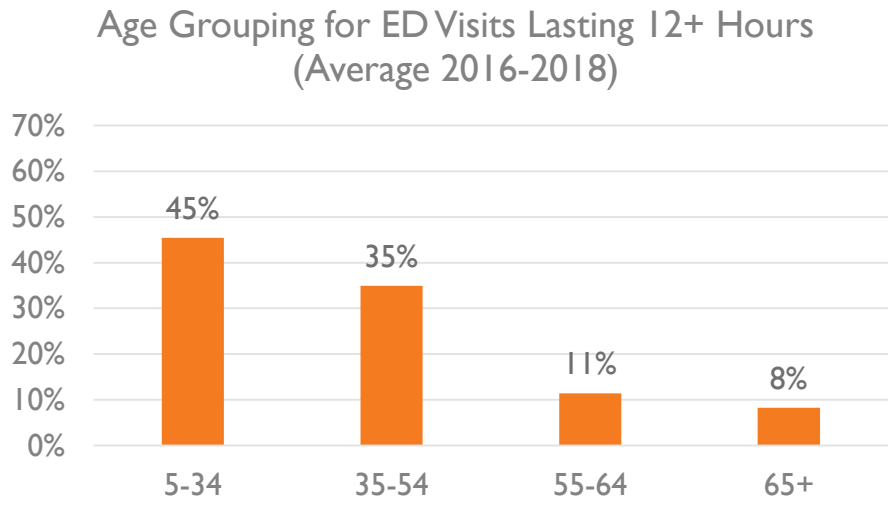


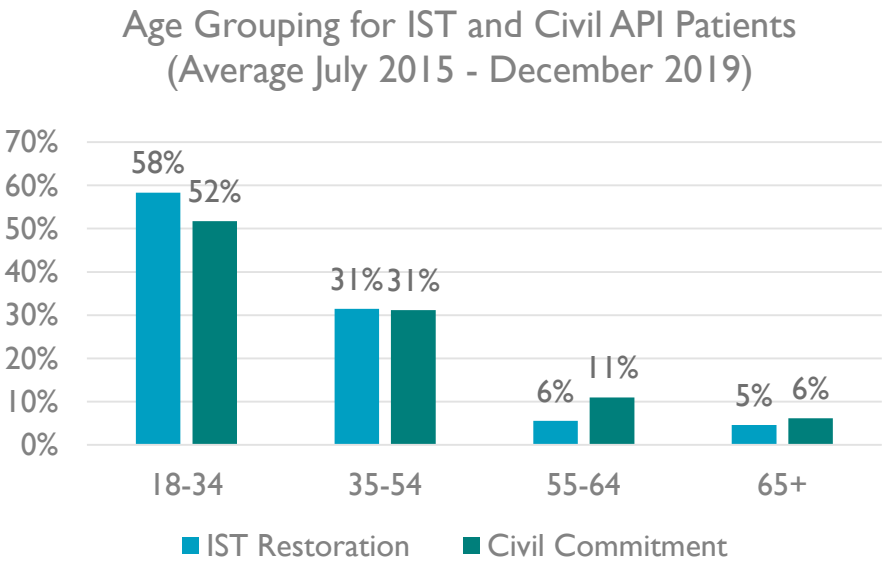
Among forensic psychiatric patients, schizophrenic disorders are the most common primary diagnosis, while substance use disorders are most common as a secondary diagnosis.

*Diagnosis types with three or more patients with a given diagnosis.

Patient Characteristics: Age

Civil and Forensic

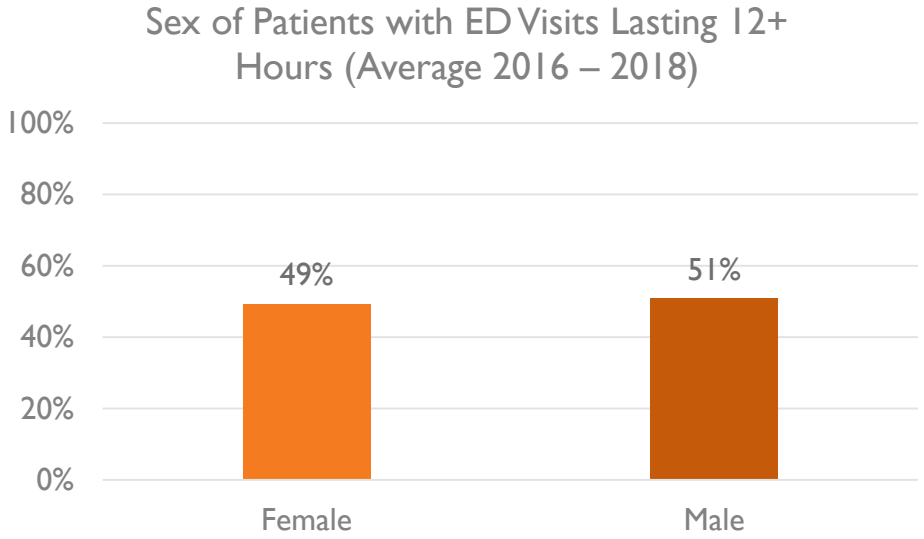


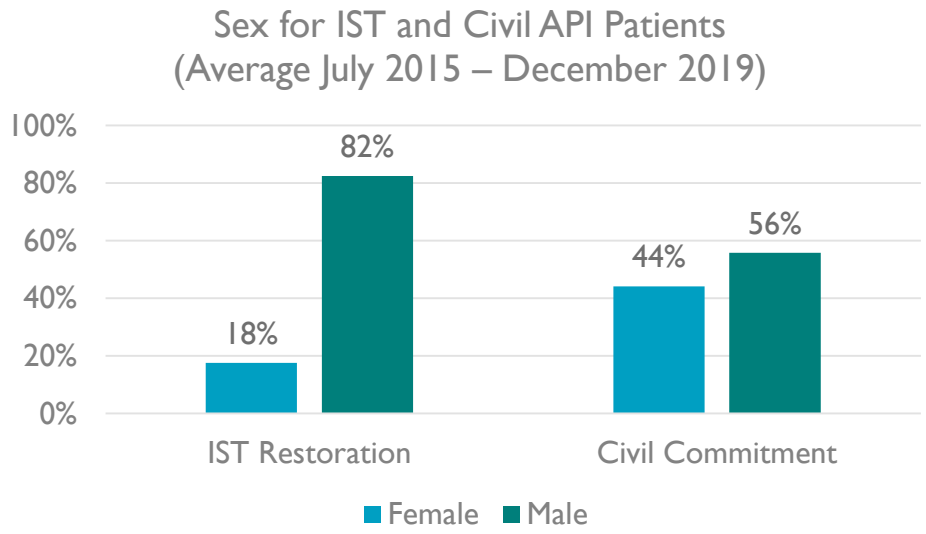


API's forensic psychiatric population is **younger** than the population seen for 12+ hour behavioral health stays in hospital EDs and the civil API patient population.

Patient Characteristics: Sex

Civil and Forensic

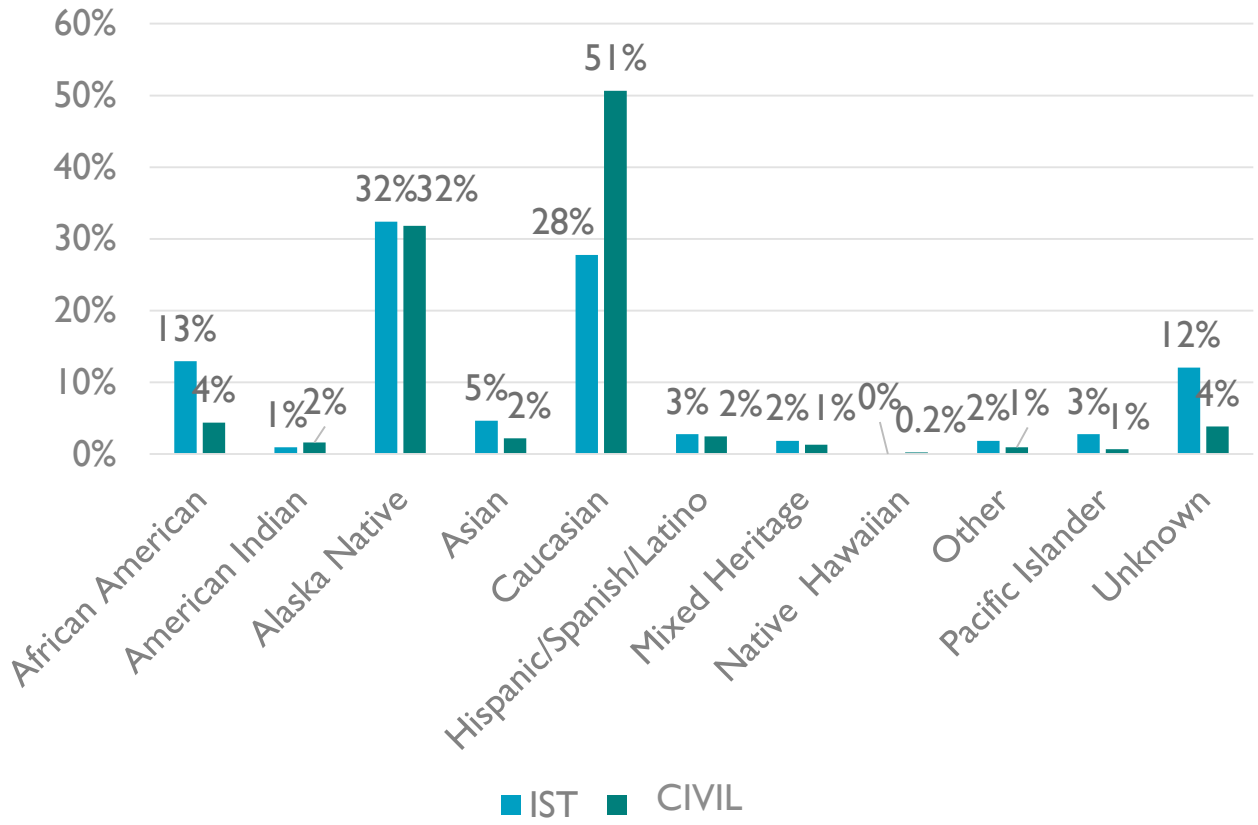




Men and women are represented nearly equally in ED stays of 12+ hours; however, **men are more likely** to be civil commitment patients at API and significantly more likely to be IST restoration patients.

Patient Characteristics: Race

Forensic



Forensic psychiatric patients are **more likely to be people of color** than civilly committed patients. Race data not available for ED patients.

Key Findings + Recommendations

Civil

Title 47 / Ex Parte Orders, 2008 to 2018

Year	# Ex Parte Orders	1 Year Change (#)	1 Year Change (%)
2008	511	N/A	N/A
2009	600	89	17%
2010	1,008	408	68%
2011	1,330	322	32%
2012	1,891	561	42%
2013	2,108	217	11%
2014	2,003	(-105)	(-5%)
2015	2,135	132	7%
2016	2,119	(-16)	(-1%)
2017	2,321	202	10%
2018	2,529	208	9%

- In 2009-2011, API policy changed: they would no longer accept Peace Officer Admissions (POAs).
- Significant increase in ex parte orders in 2010-2011, corresponding with changes to API admission policy.
- Another significant, but smaller, increase in number of orders in 2017-2018.

API Functions Differently Than Other States' Psychiatric Hospitals

- API provides short term stabilization, not long-term treatment.
- Compared with other states' psychiatric hospitals, API functions more like an acute care hospital.

Median Length of Stay (Days), Discharged Adult Patients	FY13	FY14	FY15	FY16	FY17
API	5	5	5	6	6
US State Psychiatric Hospitals	79	68	75	77	79

Alaska Mental Health Nation Outcome Measures: CMHS Uniform Reporting System, SFY 2013-2017.

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

In summary…

- There are approximately **50,000** patients presenting to the ED with a behavioral health diagnosis each year.
- Only a small proportion of BH patients spend 12+ hours in the ED: approximately **5%**, or **2,500** people.
- There has been a notable increase in those staying 156+ hours in 2018 (**125**).
- Almost **80% (~40,000 people)** of patients have **alcohol or drug-related diagnosis**. This group stays 4 hours on average.
- A small number of patients **(less than 1%, ~300 people)**, most diagnosed with **schizophrenia, delusional disorders or other non-organic psychoses,** have the longest ED stays.
- Alaska is not **effectively stabilizing and treating** psychiatric patients, and does not have capacity for **long term treatment** or **effective discharge to community services**.

Best Practices for Acute Behavioral Health Patients in the Emergency Department

Individual in behavioral health crisis presenting to the ED

Intake, Medical Evaluation + Triage	Initial Behavioral Health Consult	De-Escalation + Stabilization	Observation + Ongoing Re-assessment	Disposition	Discharge: Return to Home + Community
1. Standardized assessment tool to quickly identify BH patients 2. Standardized medical clearance 3. Access from other care settings to patient's history, care plans + medication orders	1. Initial behavioral health assessment performed by a licensed behavioral health clinician to identify initial plan of action 2. Timely access to psychiatric evaluation, within facility or using telehealth, if indicated in clinician assessment.	1. Verbal de-escalation 2. Limited use of seclusion and restraints 3. Standing orders for stabilizing psychiatric medications 4. Initiate ex parte order, if needed	1. Dedicated area(s) for BH patients 2. Enhanced monitoring and security 3. Rescind ex parte order, when possible 4. Discharge to home safely, when possible	1. Admit to inpatient unit for short-term treatment, if needed 2. Develop care plan with patient, family, care coordinators, public guardians + other provider(s)	1. Nurse follow-up by phone after safe discharge 2. Arrange next-day appointment with community behavioral health or primary care provider 3. Refer to Coordinated Entry for people at risk of homelessness 4. Assess for home and community -based waiver services + connect to providers

5 Keys to Transforming Care for Behavioral Health Patients in the ED

1. Trauma informed policies and protocols for working with behavioral health patients
2. Staff training and education, including security personnel
3. Strong integrated care team, including security personnel
4. Regular access to psychiatric consult, onsite or through telehealth
5. Case management across transitions in care and post-discharge

Strategies to Strengthen Alaska's Continuum of Acute Behavioral Health Services

Recommendations of the ASHNHA Acute Behavioral Health Workgroup, February 2019

Crisis Intervention	Crisis Management + Evaluation	Stabilization + Short Term Treatment	Long Term Treatment	Ongoing Support + Maintenance
				

Emergency Departments

1. Improve process for post-discharge follow-up
2. Increase designated observation units in EDs and inpatient
3. Guide implementation of Project BETA best practices
4. Hire psychiatric nurses and/or mental health aides in EDs
5. Initiate Medication Assisted Treatment in EDs
6. Implement brief intervention protocols (SBIRT) in EDs
7. Expand psychiatric ED model in Anchorage and Mat-Su

API

1. Advocate for API to provide both acute and longer-term treatment in a safe and secure setting.
2. Increase average length of stay and reduce recidivism to API.

Home and Community Settings

1. Secure agreements for next-day behavioral health follow-up appointments post-ED.
2. Create a behavioral health Medicaid high utilizer program, with required participation
3. Increase step-down programs to avoid discharge back to homelessness: permanent supportive housing, group homes, recovery support
4. Increase intensive case management and assertive community treatment (ACT)
5. Advocate for integration of behavioral health services in primary care settings
6. Advocate for additional provider types to bill Medicaid.

Hospital Inpatient Units

1. Identify a reliable Medicaid reimbursement methodology for hospitals to increase inpatient capacity for short-term treatment.
2. Advocate for a stable policy and reimbursement environment.
3. Develop a statewide triage system for transfers of civil involuntary commitments to API to ensure highest acuity prioritized for transfer.
4. Staff hospitals with case managers to coordinate, help access resources.
5. Evaluate and potentially revise the Mental Health Treatment Assistance Program to optimize resources for treatment beds and secure transport.

ACROSS THE BEHAVIORAL HEALTH CONTINUUM

1. Develop a shared tele-psychiatry contract among hospitals for psychiatric consults in ED and inpatient units. Remove barriers to licensing for providers.
2. Implement use of EDie across hospital, behavioral health and primary care providers, starting with addressing API's barriers to using EDie.
3. Evaluate the need for changes to Alaska statutes regarding civil commitment, length of commitment, and use of involuntary commitment process to facilitate a patient's access to psychiatric treatment.

Top Priorities: Emergency Departments

1. Support and guide implementation of Project BETA.
2. Support Medication Assisted Treatment (MAT) in EDs.
3. Improve process for post-discharge follow-up.

Top Priorities: Hospital Inpatient Units

1. Identify reimbursement methods for short-duration treatment.
2. Advocate for a stable policy and reimbursement environment.

Top Priorities: API

1. Advocate for API to provide both acute and longer-term treatment.

Top Priorities: Home + Community

1. Advocate for additional provider types to bill Medicaid.
2. Advocate for supportive housing for medical and mental health.
3. Advocate for increased intermediate care and prevention.

Top Priorities: Across the Continuum

1. Develop a shared tele-psychiatry contract.
2. Increase EDie implementation with behavioral health and primary care providers.
3. Address legal framework: commitment, evaluation and guardianship.

Key Findings + Recommendations

Forensic Psychiatric

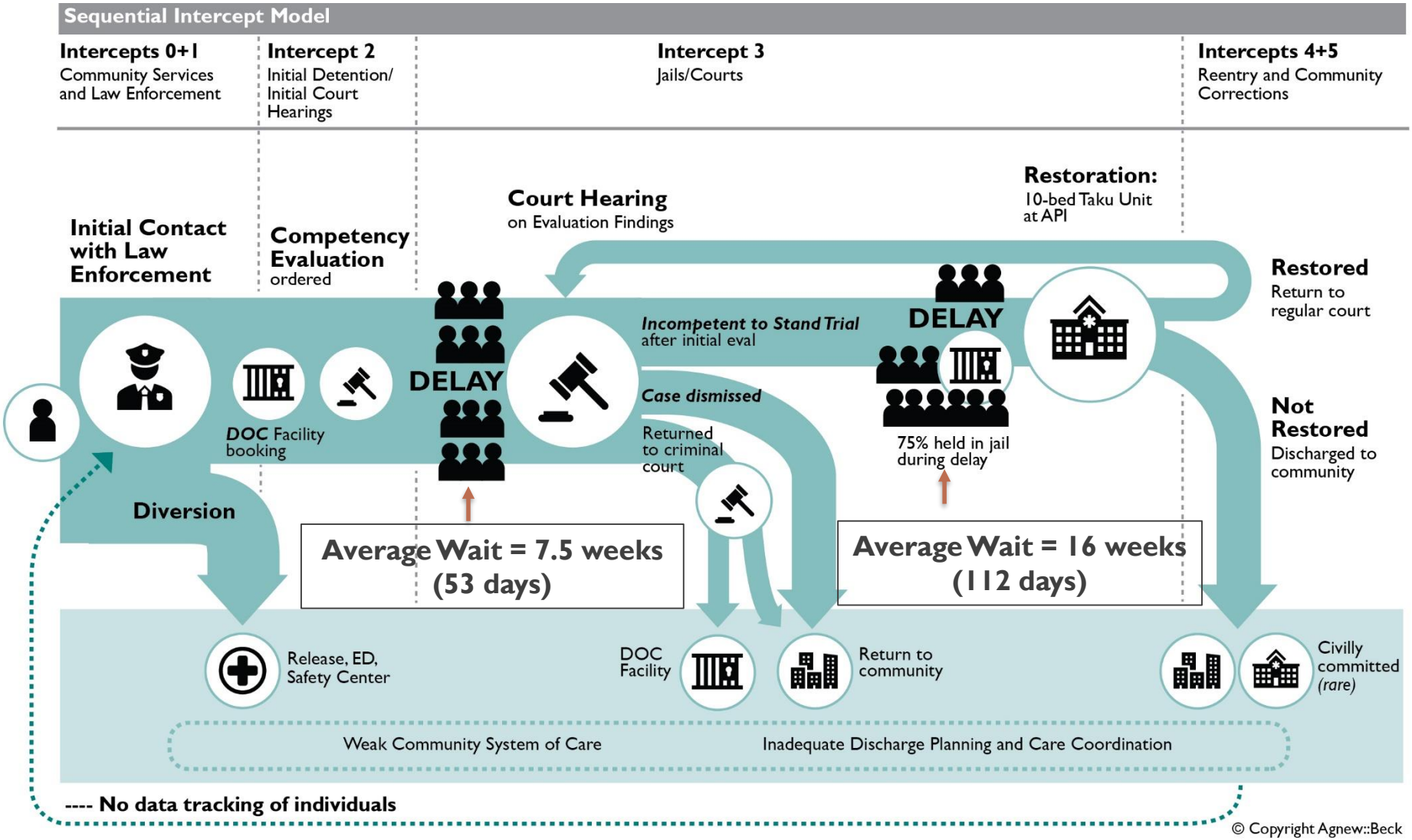
Key Findings: Forensic Psychiatric

1. Alaska needs to **divert** more people experiencing mental illness and psychiatric crisis from the criminal justice system to appropriate behavioral health programs, and address basic needs.
2. Alaska needs **additional capacity** for competency evaluation and restoration.
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.
4. Nearly ¾ of individuals engaged in the competency evaluation and restoration process are **waiting in jail**.

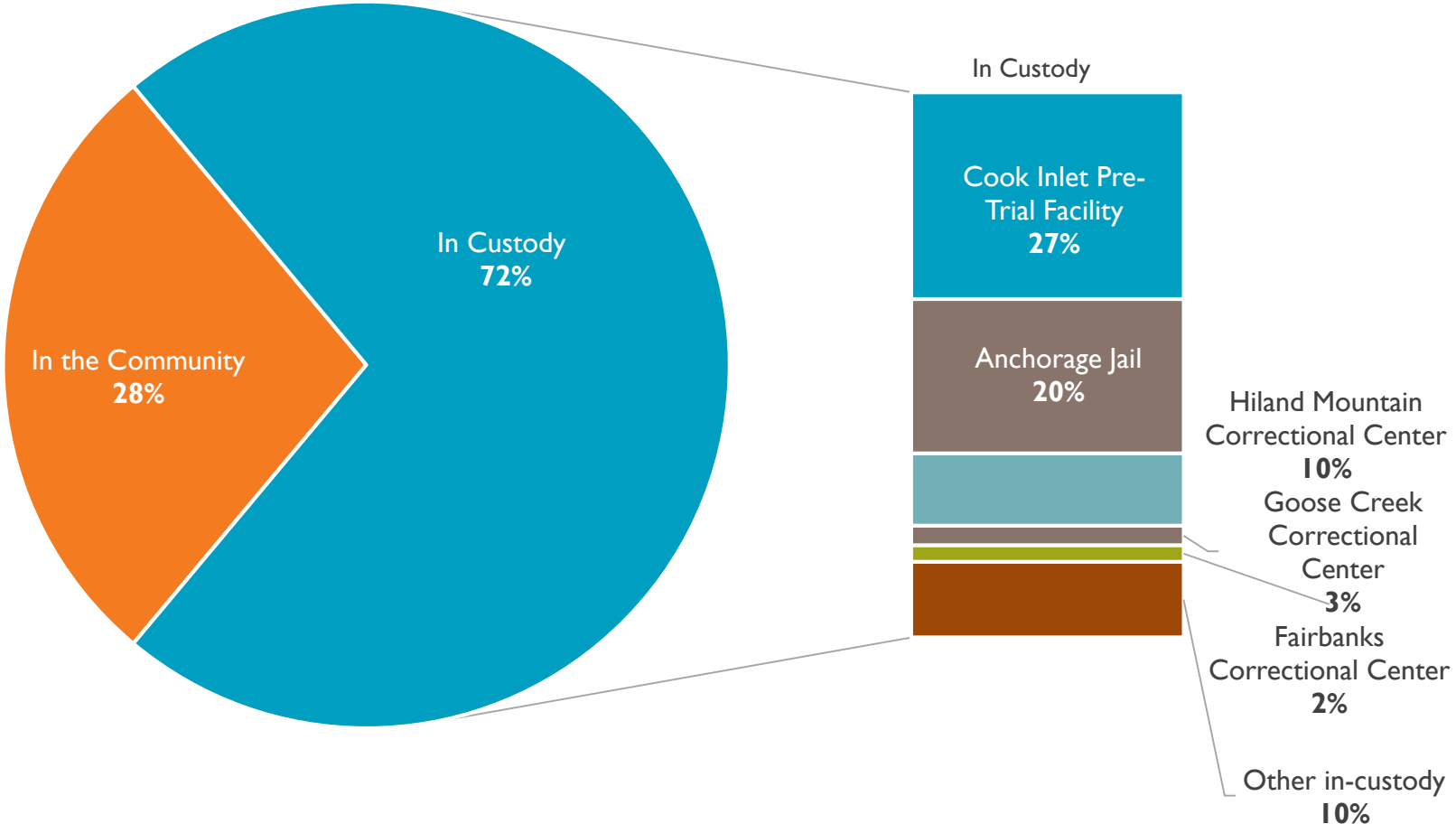
Key Findings: Forensic Psychiatric

5. Nearly 2/3 of competency cases involve at least one felony charge and over 50% of those evaluated are found incompetent to stand trial. Delays in the competency evaluation and restoration process sometimes lead to **criminal charged being dismissed**.
6. The **restoration rates at API are low** compared with other states and national averages.
7. There is a **significant cycling of patients** through DOC, the court system, and API's forensic and civil units due in part to limited options for safe discharge, especially for those deemed "non-restorable" and whose criminal charges are dismissed.

Current Forensic Psychiatric System

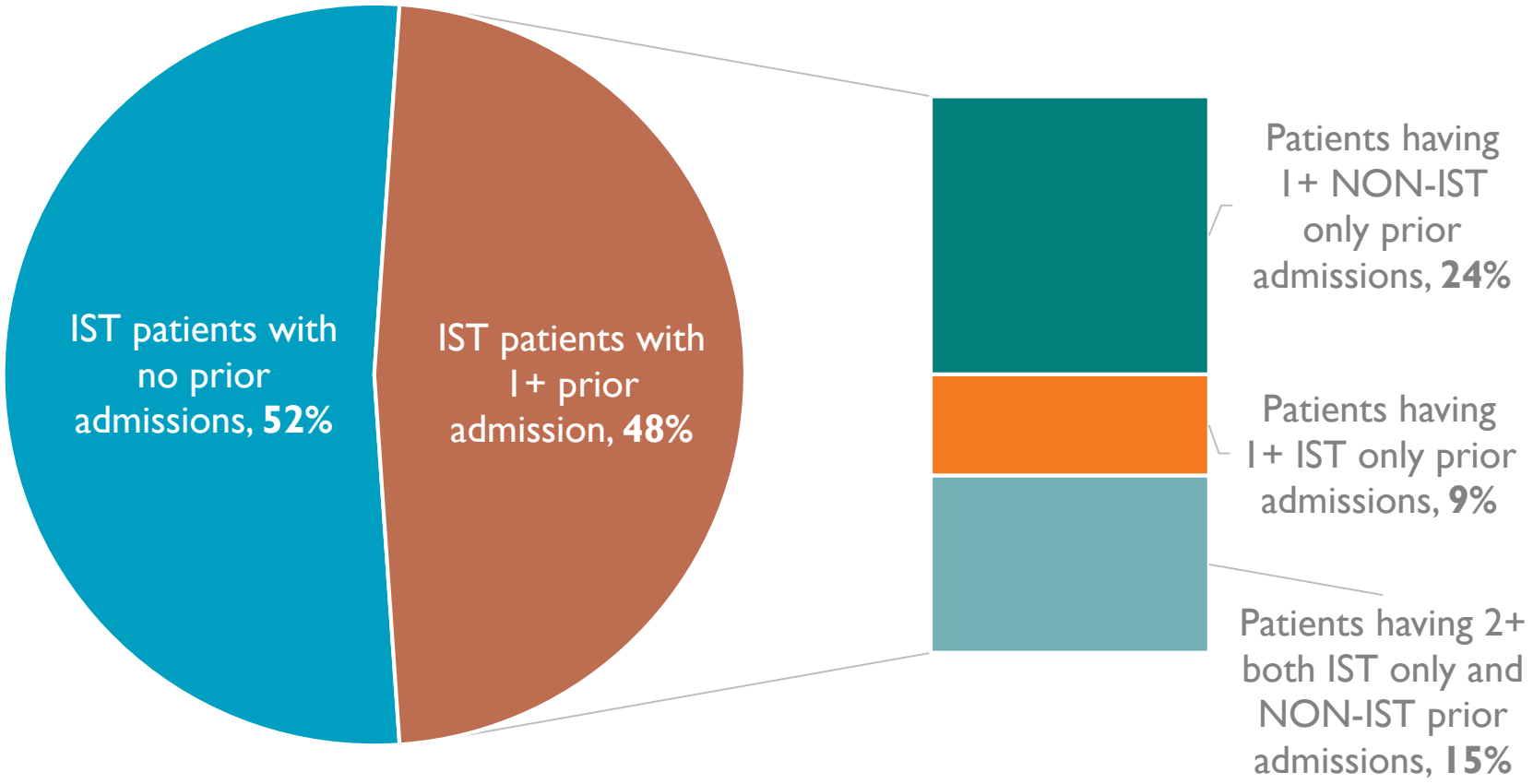


72% of individuals were held in custody while awaiting a competency evaluation.



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

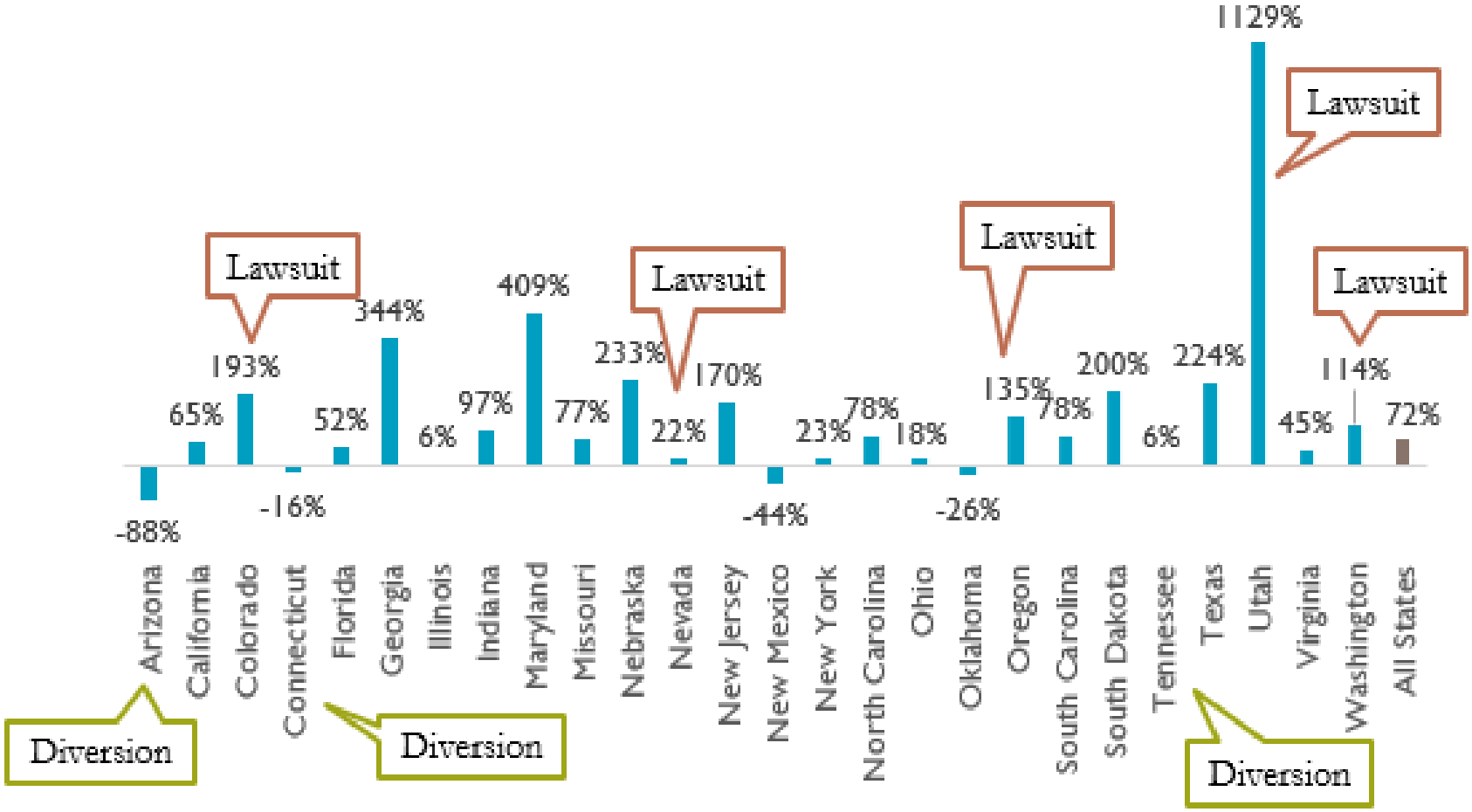
48% of forensic patients admitted in FY18 had a prior civil and/or forensic commitment to API between FY15 and FY18.



Source: Meditech Electronic Health Records. Fiscal Year 2018 IST Patients with Prior Admissions, Fiscal Year 2015 – Fiscal Year 2018. IST = Incompetent to Stand Trial (forensic) Non-IST = Civil commitment.

From 1999-2014 there was a 72% increase in IST inpatient census among states surveyed

IST One-Day Census Percent Change – States with Numerical Values 1999-2014



Reproduced from: National Association of State Mental Health Program Directors. Assessment #10: Forensic Patients in State Psychiatric Hospitals 19990216. August, 2017.

Of states studied, Alaska was the only state not offering alternatives to inpatient restoration.

State	Outpatient Restoration	Jail-Based Restoration	Inpatient Restoration
Alaska	✗	✗	✓
Colorado	✓	✓	✓
Connecticut	✓	✗	✓
Hawaii	✓	✗	✓
Utah	✗	✓	✓
Washington	✓	✗	✓

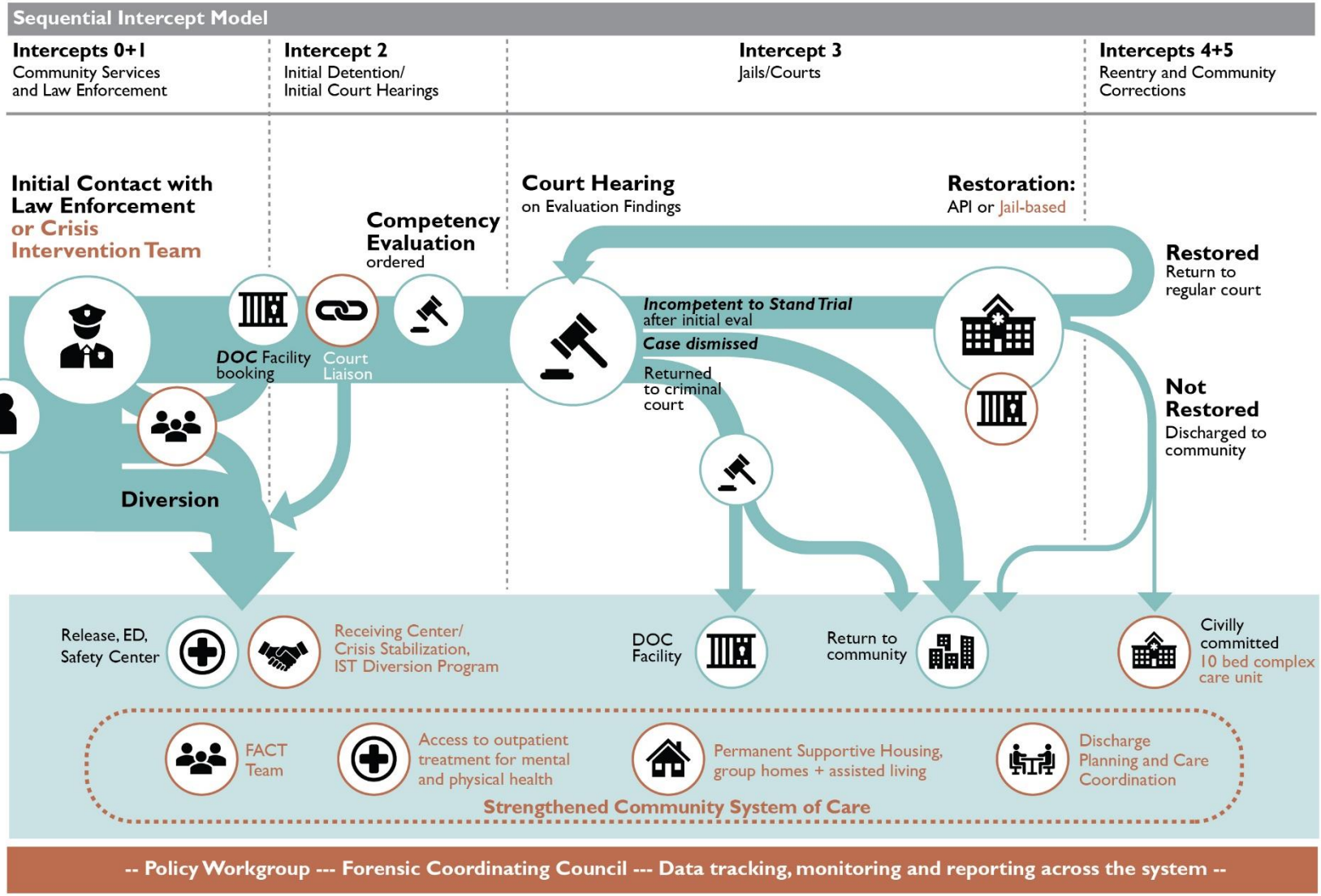
Alaska's ratio of forensic beds to 100,000 residents is lower than the national rate and of states studied.

State	Number of Inpatient Forensic Beds	Ratio of Beds to 100,000 Residents	Population Served
Alaska	10	1.4	Restoration to competency. Limited number of: competency evaluations, GBMI, DOC transfers, civil patients (typically those with acute aggression) and NGRI.
Colorado	307	5.3	Restoration to competency. Competency evaluations. NGRI.
Connecticut	229	6.4	Restoration to competency, GBMI, DOC transfers, civil patients (typically those with acute aggression)
Hawaii	202	13.9	Restoration to competency. Competency evaluations. NGRI. CR Violation/Revocation.
Utah	124	3.9	Primarily restoration to competency. Limited number of GBMI and NGRI.
Washington	335	4.8	Restoration to competency. Competency evaluation. NGRI.
National		5.5	Varies by facility

Urgent Action is Needed

- **Five** Western states (Colorado, Nevada, Oregon, Utah, Washington) have been sued over delays in competency evaluation and restoration in recent years.
- Average wait times for restoration beds ranged from **32 days – 6 months** at time of lawsuits. Average wait for bed at API, from completion of evaluation to admission, was **4 months** in 2018.
- Settlement agreements in all five states limit time waiting for beds to **7-28 days**.
- Washington has paid **tens of millions** in fines since 2016 and Colorado is paying $33,000 per day for failing to meet the terms of the settlement agreement.
- At **$500 or more per person per day waiting,** if Alaska were under a similar order as Colorado, the estimated cost to the state in fines in 2018 could have been at least **$3.4 million** (61 people found IST * $500 * 112 days or 16 weeks)

Improved Forensic Psychiatric System



Diversion


Intercept 0
Crisis Lines
Crisis Care
Continuum
Intercept 1
Police
Hospitals
Emergency
Services
Intercept 2
Post-arrest
Initial detention
Initial hearings
Pre/post
arraignment

Diversion: Status Quo

- Hospital EDs and inpatient units overwhelmed with behavioral health patients needing acute care
- Limited Crisis Intervention Team (CIT) availability
- Limited crisis stabilization

Pre-Booking Diversion:

Potential Solutions

- Diversion occurs prior to arrest
- Elements of pre-booking diversion models:
  - Mental health training
  - Centralized diversion location for psychiatric assessment
  - Officer discretion to determine necessity of arrest

  (Source: Deane, et. al., 1999)
- Case Study + National Examples
  - Crisis Intervention Teams (Connecticut)
  - Receiving Center or Crisis Stabilization (Utah or Crisis Now Model)

Crisis Intervention Teams

What it is: Partnership program between the local police and the community provider network that provides training to law enforcement personnel and provides for a joint response to crisis in the community 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.

Who is responsible: A program of the Forensic Services Division, Community Forensic Services.

CONNECTICUT

Operation Diversion

What it is: Triage system to separate suspected criminals who should be arrested from those struggling with mental illness or substance abuse issues.

Receiving Center:

- Medical screening
- Public defender
- Risk and needs assessment
- Transportation to a treatment provider if appropriate

Crisis Stabilization: Crisis Now Model

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
- End unnecessary emergency room admissions

Incorporate essential crisis care principles and practices throughout the system.

Post-Booking Diversion

Potential Solutions

- Diversion occurs after booking
- Elements of post-arrest diversion models
  - Behavioral health screening
  - Evaluate eligibility
  - Negotiate with partners
  - Link to services

  (Source: Washington State Department of Social and Health Services, Best Practices in Forensic Mental Health)
- Case Study + National Examples
  - Court Liaison Program (Connecticut)
  - Wraparound Services (California, RFP for wraparound diversion services for forensic population)

Jail Diversion/Court Liaison Program

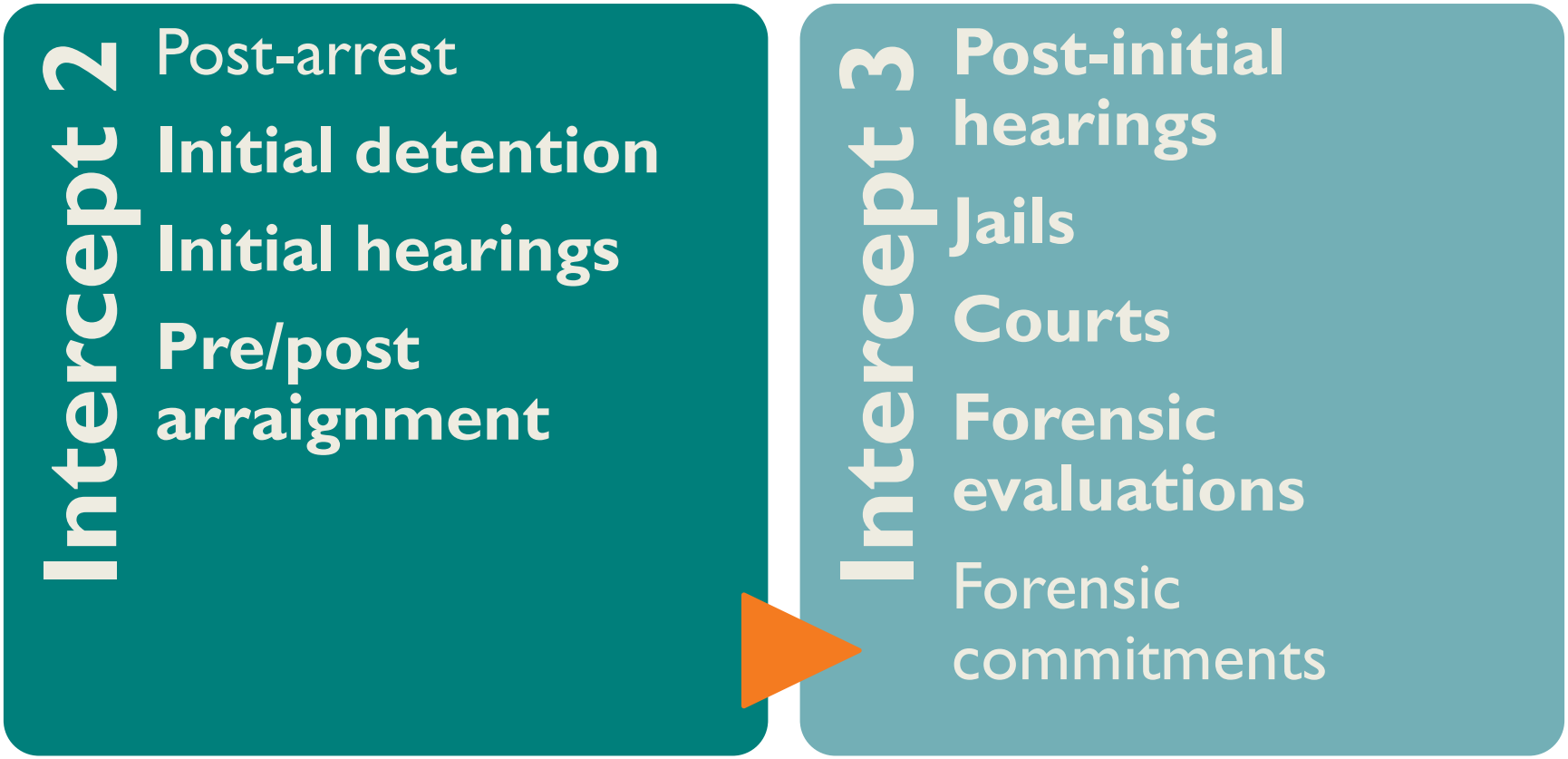
What it is: Assessment, referral and linkage to community mental health services for individuals arrested on minor offenses. The court liaison may provide a judge with additional sentencing options, i.e. securing a same day behavioral health appointment for the individual if he or she is released with charges held in abeyance.

Who is responsible: A program of the Forensic Services Division. The court liaisons are employed by community mental health centers around the state.

Diversion: Recommendations

Strategy	Lead	Needed Resources or Next Steps	Timeframe
Increase availability of co-responders to CIT teams	Trust	Funding for mental health co-responders, training in CIT model, workforce development	Immediate
Implement a Crisis Now crisis stabilization model	Trust, DBH	Technical assistance contract with RI International to provide recommendations on development of crisis stabilization in Alaska	Medium
Create a court liaison pilot program in the Anchorage District Court	Anchorage District Court, Community behavioral health provider	Funding for court liaison position, program model	Medium

Court Process + Evaluation



Court Process and Competency Evaluation: Status Quo

- Forensic psychologists provide both evaluation and treatment services
- Current supply of evaluators cannot keep up with demand
- Limited oversight
- Court system does not track cases statewide
- No statewide standardization of court process
  - Limited data sharing, tracking and communication across the system

Court Process + Evaluations: Recommendations

Strategy	Lead	Needed Resources or Next Steps	Timeframe
Expand evaluation staffing*	API	In progress, contracted evaluators in place	Immediate
Contract for external oversight of forensic evaluation services	API	Funding and RFP process for contractor	Immediate
Include a screening for level of restoration treatment in initial evaluation	API	Research best practice screening, develop screening tool and format for reporting findings to court	Immediate
Implement a statewide competency calendar	Alaska Court System	Additional staff to expand Anchorage competency calendar statewide	Medium

* Items include a capital and operating cost estimate, as part of this study

Restoration

Intercept 3

Post-initial hearings

Jails

Courts

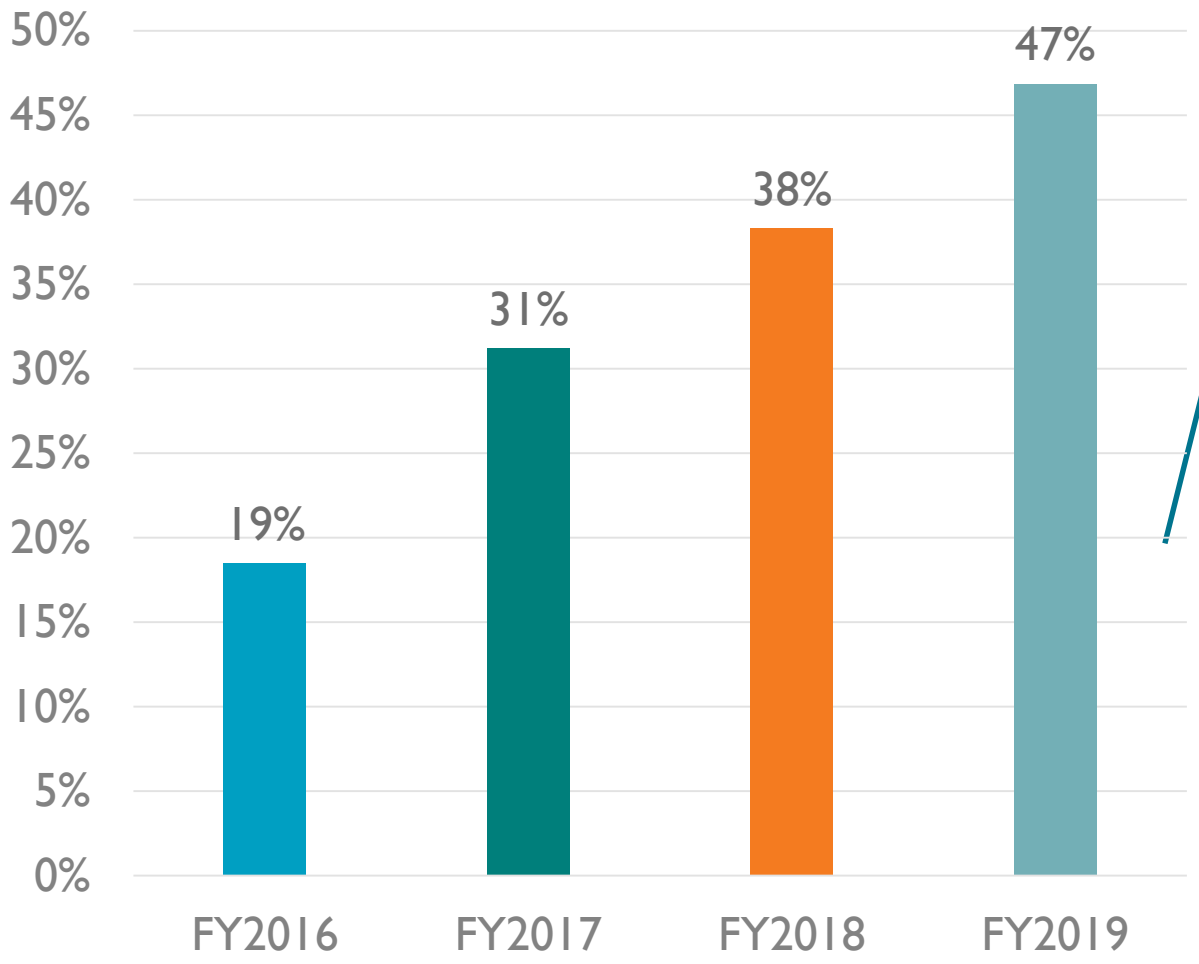
Forensic evaluations

Forensic commitments

Restoration Status Quo

- Only one option for competency restoration: 10-bed Taku Unit at API
- No clear process for restoration of juveniles with competency issues
- No formal process for program evaluation or system improvements
- Difficult to obtain orders for involuntary medication
- Data and outcomes not consistently tracked or shared

% of Taku Patients Requiring Seclusion, Restraint, Hold or Close Observation Surveillance Status (COSS) Level 2 or 3



An average of 34% of Taku patients required a seclusion, restraint, hold or COSS (Level 2 or 3) from FY16-FY19.

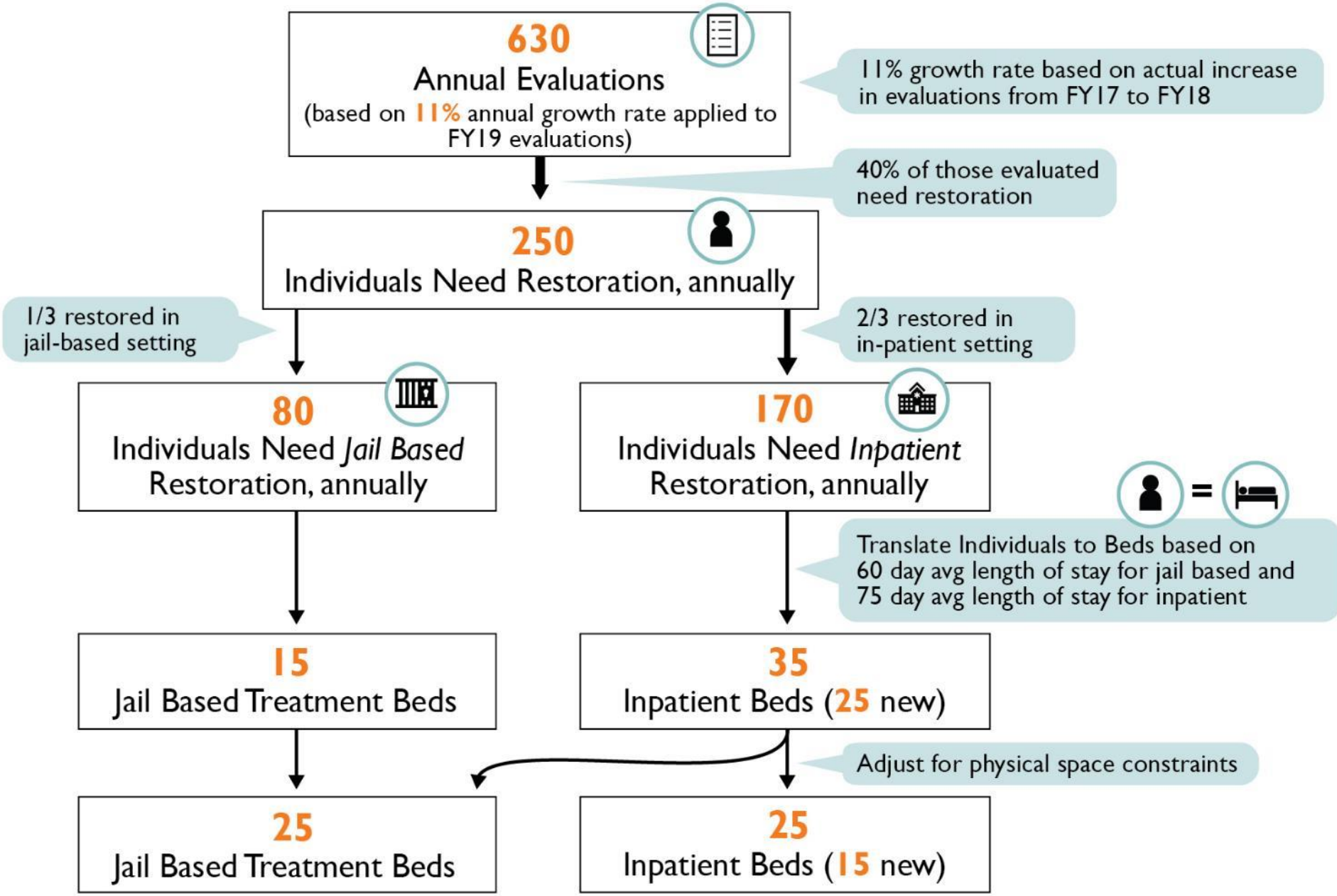
The remaining patients could potentially be eligible for jail based restoration

Sources: API Meditech Data: Unique patients requiring a seclusion, restraint or hold by discharge fiscal year and API COSS Data: Unique patient events

Restoration Demand Forecast: FY 2026

Inpatient Beds & Jail Based Beds for Stabilized Year

Planning Scenario
11% Growth Rate



Involuntary Medication

The court can only order involuntary medications after specific findings made on the record as to the necessity for involuntary medication, based on testimony and other evidence and observations where appropriate, using the following criteria:

1. The court must find that important governmental interests are at stake, namely, the interest in rendering the defendant competent to stand trial.
2. The court must conclude that involuntary medication will significantly further those concomitant state interests.
3. The court must conclude that involuntary medication is necessary to further those interests.
4. The court must conclude that administration of the drugs is medically appropriate.

Source: Order Scheduling Hearing on Motion for Involuntary Medications for Competency Restoration and Ordering Treating Physician to Appear to Testify.

Restoration Recommendations

Strategy	Lead	Needed Resources or Next Steps	Time-frame
Temporarily add 10 forensic beds to existing API footprint*	API	Funding and RFP process for contractor	Immediate
Implement jail-based outreach restoration	API & DOC	Funding for additional staff	Immediate
Formalize process for restoration of juveniles	API & DJJ	Memorandum of Agreement	Immediate
Designate a unit for jail-based restoration*	DOC & API	Funding and RFP process for contractor	Medium
Amend Title 12 statute to provide clarity on administration of involuntary medication	DHSS, Criminal Justice Commission	Revive Behavioral Health Workgroup	Medium
Expand API by 25 beds to create 25 forensic beds*	API	Funding and RFP process for contractor	Long-Term

* Items include a capital and operating cost estimate, as part of this study

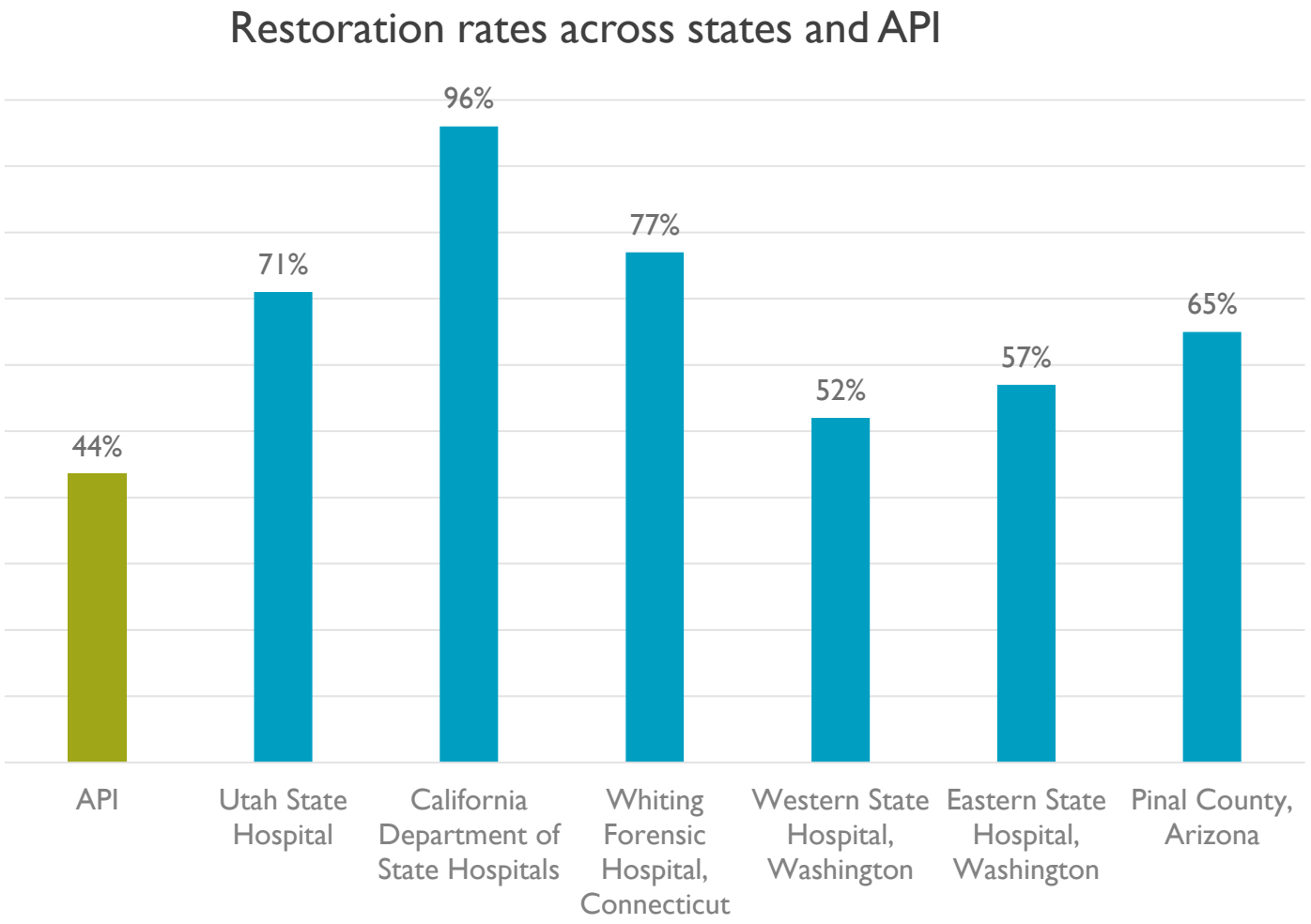
Discharge


Intercept 4
Re-entry from jails, state prisons and forensic hospitalizations
Intercept 5
Community corrections
Community support

Discharge Status Quo

- Limited discharge options for forensic patients found IST after restoration, especially those who are homeless and difficult to house.
- Low rates of restoration compared to nation.
- Not all forensic patients meet criteria for civil commitment.

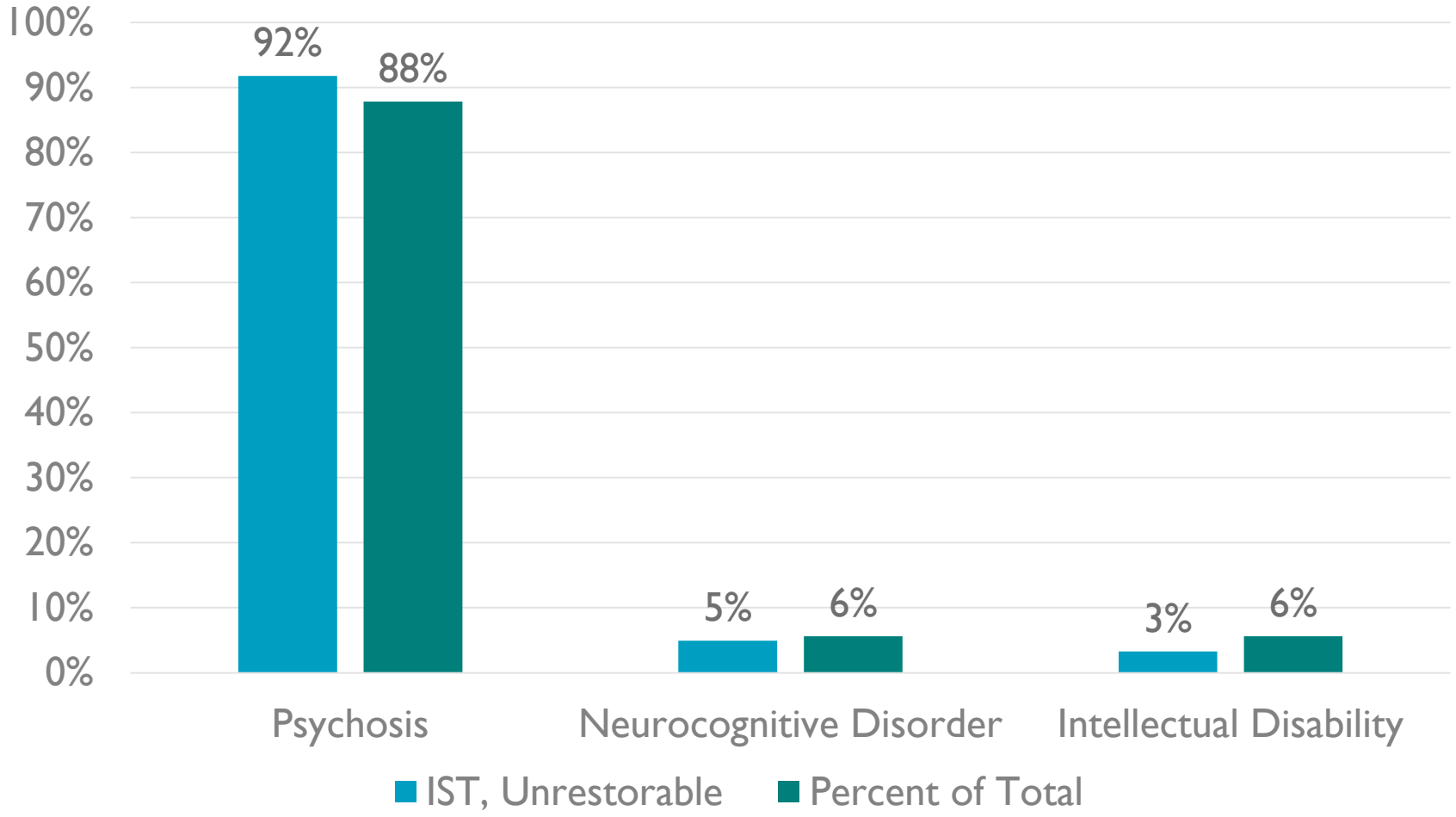
Rates of restoration at API are low compared to other states.



61 people not restored at API from 2016-2018

70% average restoration rate for all other states.

Today, individuals with a primary diagnosis of psychosis are less likely to be restored.



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

Community Needs of the IST Population

- California: 47% of IST admissions were of unsheltered homeless individuals

  (Source: California Department of State Hospitals. Incompetent to Stand Trial Diversion Program, 2018)

- Washington:
  - 95% unstably housed or homeless at time of arrest
  - 62% received outpatient mental health treatment during year of arrest
  - 54% had a substance abuse diagnosis, but only 3% had substance abuse treatment

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

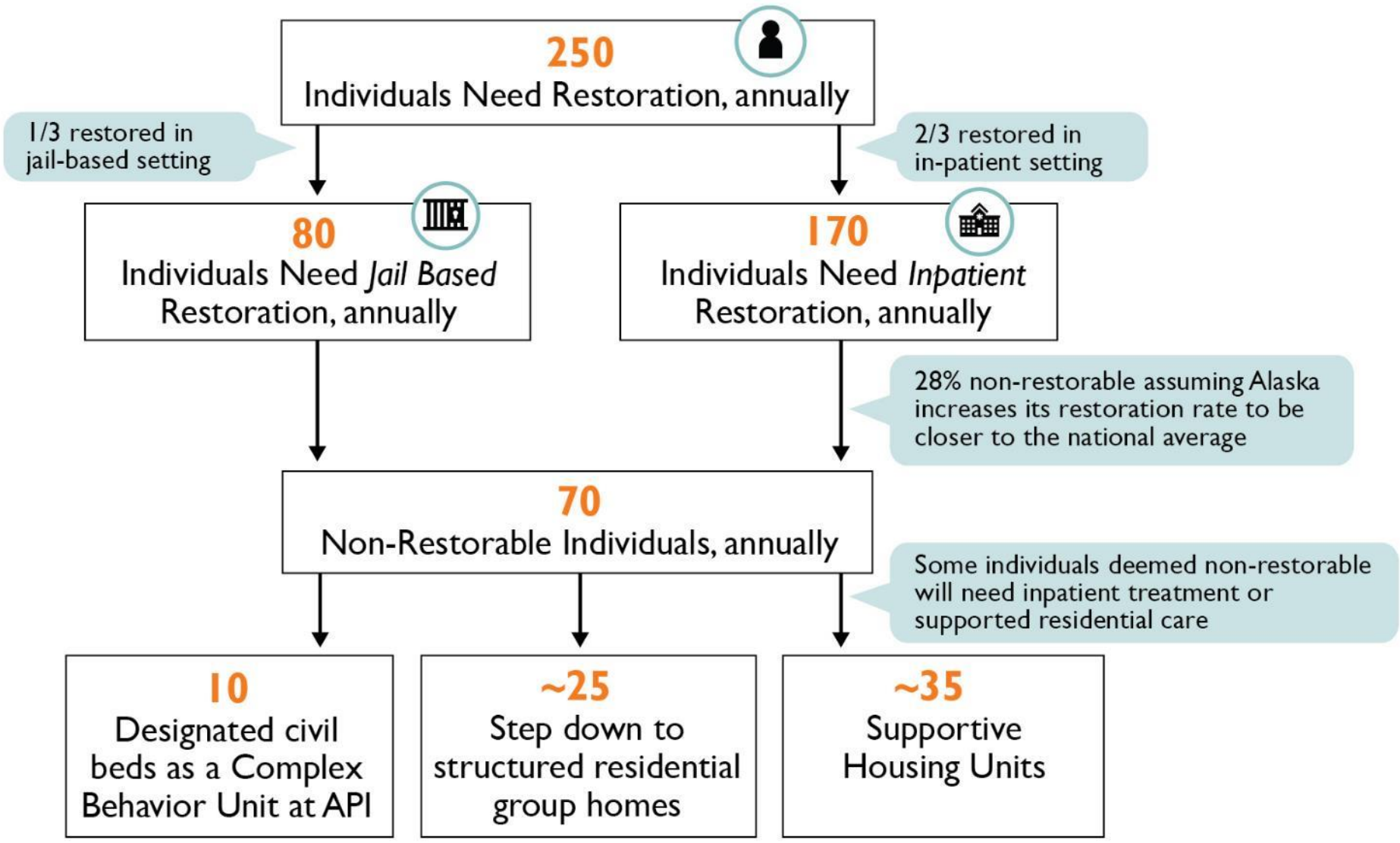
Proposed Improvement: Urgent Forensic Discharge MOA

- Currently in place but needs refreshment.
- Update weekly the statewide list of individuals needing evaluations and use to prioritize (3 weeks to completion for misdemeanors, 5 weeks for felony)
- Discharge planning focuses on 3 questions:
  - Do they meet civil commitment?
  - Are they taking meds as prescribed?
  - Is there a discharge plan? Have they been referred to DOC APIC program or the special discharge program?

Proposed Lead: Alaska Court System/The Trust **IMMEDIATE**

Non-Restorable Demand Forecast: FY 2026

Inpatient Beds, Structured Residential Group Homes & Supportive Housing

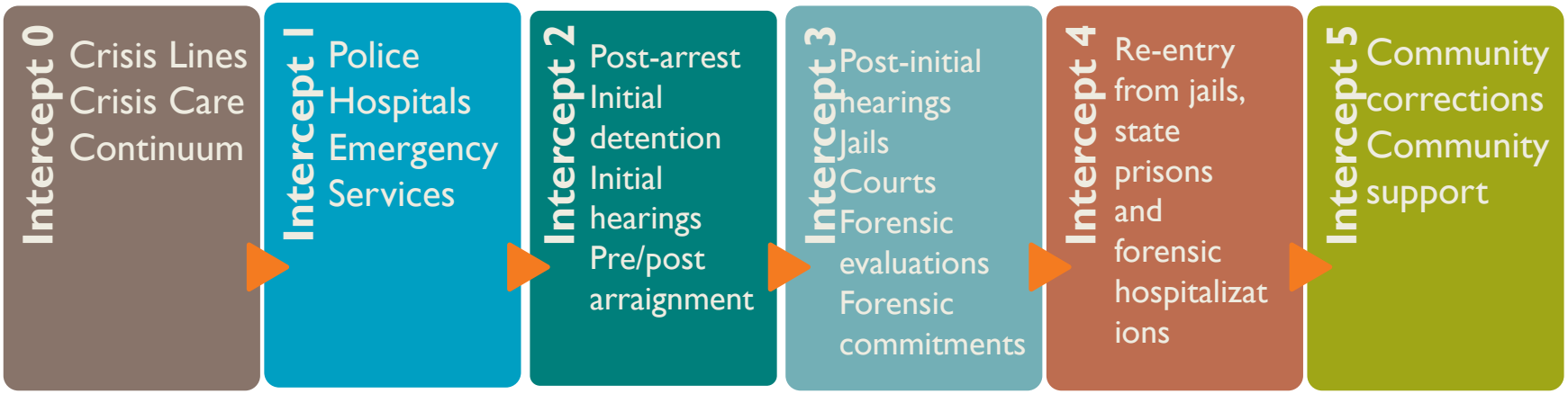


Discharge Recommendations

Strategy	Lead	Needed Resources or Next Steps	Timeframe
Update the Urgent Forensic Discharge MOA and use statewide	The Trust	Reconvene parties named in MOA	Immediate
Designate a 10-bed complex behavior unit at API	API	Identify unit modifications and staffing needs	Medium
Develop appropriate community supports for patients found IST after restoration *	DHSS	Funding for community supports	Medium

* FACT team, Permanent Supportive Housing, group homes + assisted living, access to outpatient mental and physical healthcare, Secure residential facility for individuals with complex behaviors who are difficult to house

Across the Forensic System



System Status Quo

- Limited oversight for forensic system
- No coordinated data tracking and reporting

System Recommendations:

Strategy	Lead	Needed Resources or Next Steps	Timeframe
Establish a Forensic Mental Health Coordinating Council	The Trust, DHSS	Identify members and convene a coordinating council	Immediate
Develop a data tracking and reporting system	API, DOC, Alaska Court System	Select key data points, identify data tracking system and mechanism for communication	Medium

Recommended Data Points + Timeframe for Sharing

Data Point	Reporting Timeframe
Number waiting at each stage of restoration process	Weekly
Length of wait at each stage	Quarterly
Number restored + deemed not restorable (jail-based and inpatient)	Quarterly
Location/setting of discharge	Quarterly
Length of time for restoration	Annually
Total admissions and discharges in the previous fiscal year	Annually
Demographic characteristics: Age, Race, Sex, Diagnosis	Annually
Number of individuals with repeat evaluations over previous three fiscal years	Annually
Number of patients with repeat forensic and/or civil commitments over previous three fiscal years	Annually

Summary: Immediate Actions (0-6 Months)

1. Increase availability of co-responders to CIT teams
2. Expand competency evaluation staffing (already doing)
3. Contract for external oversight of competency evaluation
4. Include a screening for level of restoration treatment in initial evaluation
5. Temporarily add 10 forensic beds to existing API footprint
6. Implement jail-based outreach restoration
7. Formalize process for restoration of juveniles
8. Update the Urgent Forensic Discharge MOA and use statewide
9. Establish a Forensic Mental Health Coordinating Council

Summary: Medium-Term Action (6 mo. – 2 yr.)

1. Implement the Crisis Now crisis stabilization model
2. Create a court liaison pilot program in the Anchorage District Court
3. Implement a statewide competency calendar
4. Designate a unit for jail-based restoration
5. Evaluate current restoration programming at API
6. Amend Title 12 statute to provide clarity on involuntary medication
7. Designate a 10-bed complex behavior unit at API
8. Develop appropriate community supports for patients for IST after restoration
9. Develop a data tracking and reporting system
10. Create new psychologist job classification

Summary: Long-Term Action (2 Years +)

1. Expand API by 25 beds

Approaches, Capital + Operation Costs

Approach 1: Taku and Denali

Taku continues to house 10 forensic patients and another existing 10 bed unit is converted to house forensic patients. No facility modification is required, although for staff and patient safety some enhancements are recommended.

Suggested modifications:

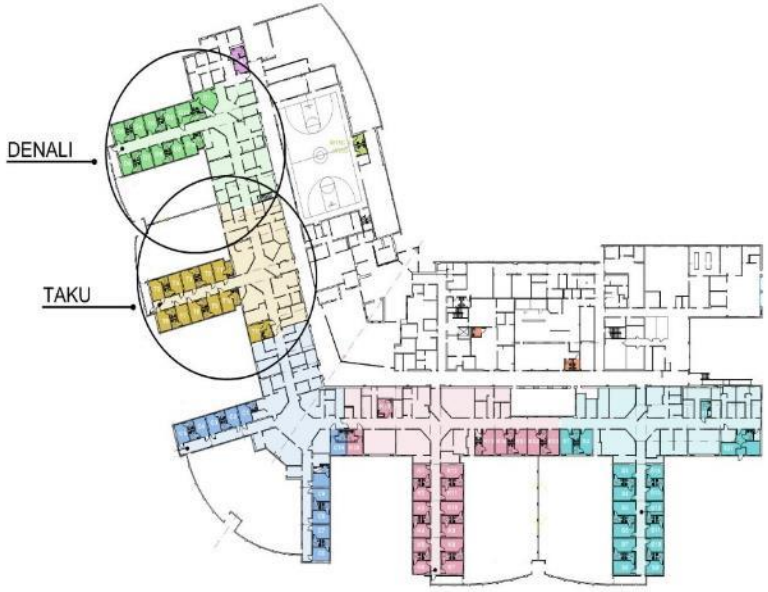
- Secure sally port to be developed in Denali
- Windows hardened in Denali
- Denali's electronic security is enhanced.

Advantages

- Doubles forensic capacity to 20 patients (within 6 months of funding)
- Easily converted back to civil patients as needed.

Disadvantages

- Lowers civil commitment capacity of API.



Capital Cost: $1,800,000

Approach 2: Expansion of current API facility

Construct API expansion as a forensic hospital for 25 patients.

Required modifications:

- Build addition as a self-contained forensic hospital that is supported by the existing API utilities, food service, administration and maintenance.

Advantages

- Increase API footprint to maximize site.
- Does not disrupt API operation.
- Taku becomes available allowing an increase of 10 civil beds
- Expansion specifically designed and constructed to house forensic patients.

Disadvantages

- Takes 3 – 5 years to implement.
- Costly
- May find public opposition.

Cost:
$27,000,000

Approach 3: Jail-based restoration at Anchorage Correctional Center (Anchorage Jail)

32-bed Alpha Mod in Anchorage Jail becomes restoration clinic.

Required modifications:

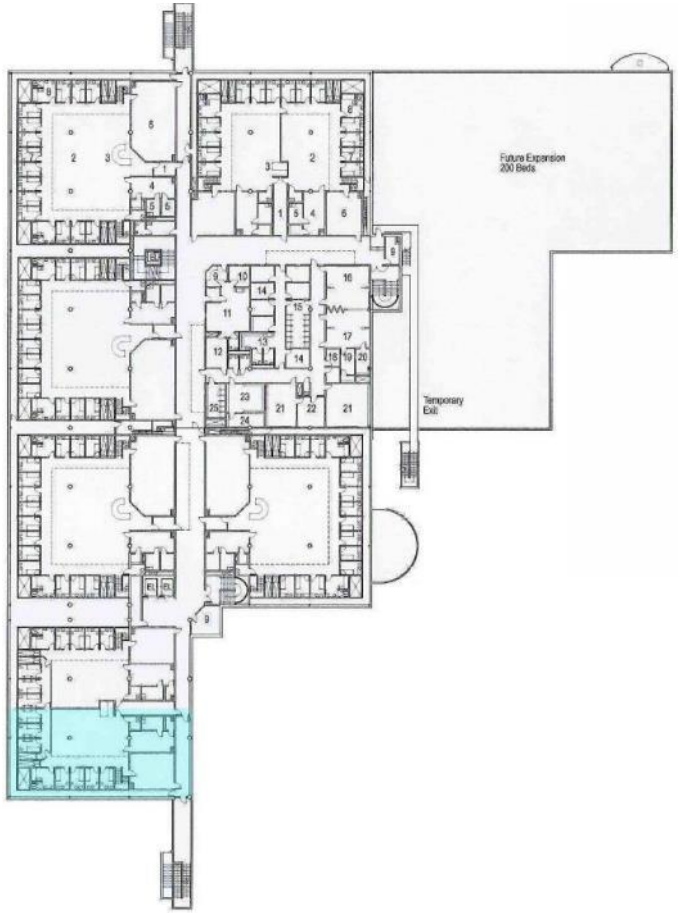
- Alpha Mod modifications – Tenant improvements required.

Advantages

- Increases forensic capacity quickly with minimal capital cost.
- Competency evaluations could be conducted on jail forensic unit.

Disadvantages

- Not appropriate for all patients.
- Not able to medicate patients who refuse medication/treatment.



Cost: $2,000,000

Approach 4: Jail-based restoration and inpatient restoration at Anchorage Correctional Center

Develop replacement satellite forensic hospital at Anchorage Jail.

Required modifications:

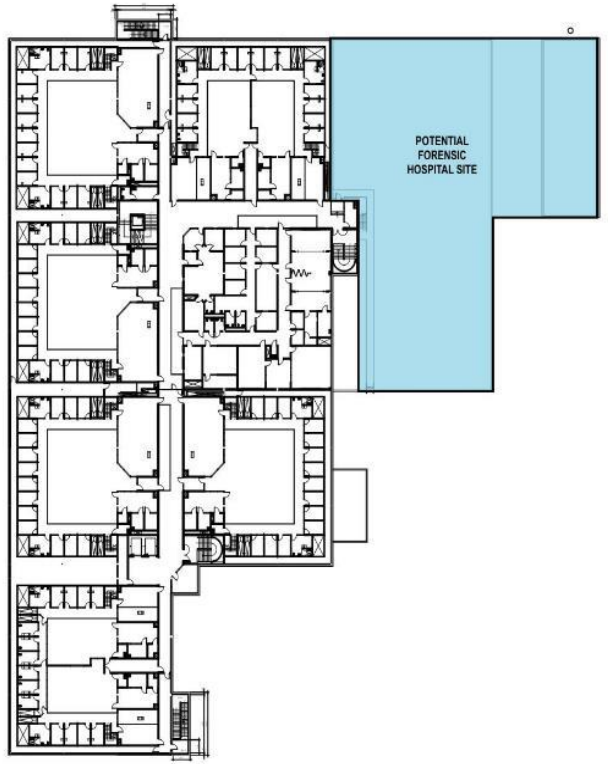
- Develop new 25-bed forensic hospital on planned jail expansion site, as a satellite facility to API
- TI improvements for jail based restoration from Approach 3.

Advantages

- Consolidates in-patient forensic treatment at one site.
- Reduces transportation cost/risk.

Disadvantages

- May increase management challenges for DHSS/API to manage two sites.
- Locates psychiatric treatment at a correctional setting for those who are not in DOC custody.



Cost: $27,000,000 + $2,000,000

Operating Costs By Approach

	Status Quo Taku	Approach 1 20 Beds Inpatient Within Existing API Footprint	Approach 2 25 Beds Inpatient Expanded API Footprint	Approach 3 25 Beds Jail Based Restoration Within Existing ACC Footprint	Approach 4 25 Inpatient Beds & 25 Jail Based Beds; ACC Expansion
Cost per client	$ 81,890	$ 74,606	$ 71,046	$ 17,683	Sum of Approach 2 & 3
Cost per client per day	$ 1,092	$ 995	$ 947	$ 295	
Cost per bed per year	$ 398,533	$ 363,084	$ 345,758	$ 107,573	
Annual Cost	**$ 3,985,330**	**$ 7,261,688**	**$ 8,643,938**	**$ 2,689,317**	**$ 11,333,255**
Plus Evaluataion Staff	$639,320	$639,320	$639,320	$639,320	$639,320

Based on estimated demand in FY 2026; in 2019 dollars

Operating Costs by Category & Approach

Daily Cost

Beds	Program Staff	Share of Admin	Other Personnel	Non-Personnel Costs	Total
Inpatient	$538 to $591	$152	$70	$279	$943 to $1,087
Jail Based	$212	$5	$7	$71	$295

Annual Cost

Item	Beds	Program Staff	Share of Admin	Other Personnel	Non-Personnel Costs	Total	Daily Cost
Status Quo	10 inpatient at Taku	$2,157,694	$555,629	$254,709	$1,017,298	$3,985,330	$1,092
Approach 1	20 inpatient beds in existing API	$4,162,046	$555,629	$509,417	$2,034,596	$7,261,688	$995
Approach 2	25 inpatient beds @ expanded API	$4,908,292	$555,629	$636,771	$2,543,245	$8,643,938	$947
Approach 3	25 jail based beds in existing ACC	$1,930,037	$50,050	$60,753	$648,477	$2,689,317	$295
Approach 4	25 JB + 25 inpatient @ expended ACC	$6,838,329	$605,679	$697,525	$3,191,722	$11,333,255	Sum of 2&3
Plus Evaluation Staff	4 FTE					$639,320	

Other personnel and non-personnel costs scale with number of beds. General admin costs do not scale. Assumed existing administrative system at API can support expansion.

Civil + Forensic Psychiatric Continuums of Care