Evaluation of Forensic Services at the Alaska Psychiatric Institute

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Scope of Work

This report is written pursuant to a request by the Alaska Psychiatric Institute for an evaluation of its forensic services and recommendations for how the system may be improved. Specifically, I was asked to conduct a review of forensic processes, to evaluate current practices within the Institute's competency restoration program, to provide case discussion and recommendations regarding complex cases, and to evaluate practices related to *Sell* hearings.

Methodology

This evaluation consisted of a review of all relevant statutes (AS 12.47.010 et seq.) concerning competency to stand trial, mental disease or defect negating culpable mental state and examination of mental culpability, and guilty but mentally ill. In addition, I familiarized myself with the state's civil commitment statutes (AS 12.30.700 et seq.). I conducted an on-site consultation and survey of the Alaska Psychiatric Institute from 10/5/2016-10/7/2016. As a component of my consultation I met with key personnel from the state's Department of Health and Social Services, including staff from the Division of Behavioral Health and the Alaska Psychiatric Institute. I also spoke by phone with the Honorable Stephanie Rhoades, presiding judge for the Anchorage Mental Health Court to obtain information from the court's perspective.

During my consultation and subsequently I received additional reference materials including:

- Western Interstate Commission for Higher Education report entitled, *Alaska Forensic, Competency Evaluation and Restoration Processes; WICHE Technical Assistance Quality Improvement Report for API*, dated April 2011
- *Review of Alaska Mental Health Statutes*, UNLV William S. Boyd School of Law. 2015
- *Feasibility Study for the Privatization of Alaska Psychiatric Institute; Legal Review and Baseline Analysis*, Public Consulting Group, dated September 23, 2016.
- HIPAA-compliant, redacted sample reports of competency to proceed and examination of mental culpability evaluations completed by forensic psychology evaluators at API.

Review of Relevant Statutes and Forensic Processes

The state statutes governing the examination of defendants for mental culpability and incompetency to proceed are found in AS 12.47.070 and AS 12.47.100 respectively. For defendants raising the insanity defense, statute requires that the court appoint, "at least two qualified psychiatrists or two forensic psychologists certified by the American Board of Forensic Psychology to examine and report upon the mental condition of the defendant." When a defendant's competency to proceed is raised, the court, "shall have the defendant examined by at least one qualified psychiatrist or psychologist, who shall report to the court concerning the competency of the defendant."

While the central purpose of the examinations and their impact on the court case differs, the rationale for the discrepancy in the number of evaluators required to conduct sanity versus competency evaluations is unclear. Most states require only one forensic examiner for court-ordered sanity examinations. Nationally, there are only approximately 300 Forensic Psychologists certified by the American Board of Professional Psychology, making it very difficult for the state to provide the requisite number of qualified professionals without retaining the services of qualified professionals from outside the state of Alaska. I have reviewed the 2017 Departmental Legislative Proposal Form submitted by Director Burns to amend AS 12.47.070 to require one qualified psychiatrist or one qualified forensic psychologist to evaluate for insanity rather than two, and agree with this suggested statutory revision. Amending this statute in no way limits either defense counsel or the prosecuting attorney from securing its own forensic mental health expert.

Although reducing the number of required examiners for insanity evaluations will reduce the workload burden on DHSS to provide forensic evaluations for the courts, the relief is not substantial enough to address the overall burden on the system. The continued rise in the number of court-ordered forensic evaluations over the past five years has made it increasingly difficult for the Institute's few forensic psychologists to meet the rising demand. Additionally, the dearth of qualified forensic psychiatrists and psychologists has necessitated the use of psychologists and psychology interns who do not meet the required statutory qualifications.

I recommend that the Department consider several strategies to address the challenges associated with meeting the demand for forensic evaluations. First, consider having a broader discussion with State Judicial as to which branch of government is responsible for providing an

adequate pool of forensic evaluators and paying for their services. The statutes permit the court to appoint forensic examiners, but does not expressly compel the Department of Health and Social Services to conduct the court-ordered evaluation. Based on my careful review of the statute, a court could appoint a forensic examiner of its own choosing rather than relying on the forensic examiners provided by API and the DHSS. The Department may already receive financial compensation to provide court ordered forensic evaluations and competency restoration. If it does, the Department should reconsider whether this appropriation should remain with DHSS or should be transferred to the Alaska Court System. If the Department opts to continue to provide the forensic evaluations for the court, it should conduct a careful cost accounting to ensure that the Department is adequately compensated for the services it provides, accounting for the increase in demand for these evaluations in recent years and adjusted for inflation.

Second, Judge Rhoades had indicated to me that current law (AS 12.47.10(b)) provides the courts with little to no discretion in determining whether a competency to proceed evaluation is needed under the current circumstances for which the defendant is charged. If an attorney or the court has reasonable cause to believe that the defendant is unable to understand the proceedings or to assist in his/her defense, the parties *may* (emphasis added) file a motion for a judicial determination of competency. Upon the filing of a motion, the court *must* (emphasis added) have the defendant examined with respect to the defendant's competency to proceed. The State should consider amending AS 12.47.100 to permit the court to rely on previous and/or recent competency evaluations to determine whether a competency to proceed evaluation for the current charges is necessary, particularly for defendants well known to the court and repeatedly charged with misdemeanor offenses. For example, if a defendant is currently charged with a misdemeanor and has been examined for competency to stand trial ten times in the previous year for minor offenses, the court should be permitted to rely on the totality of information gleaned from those prior evaluations to determine whether a competency to stand trial evaluation is necessary in the instant offense. For this recommendation to be effective, the courts would need timely access to the prior competency evaluation reports.

Third, the Department should consider placements other than the Alaska Psychiatric Institute to perform forensic evaluations and competency restorations. AS 12.47.100 permits the court to commit the defendant, "for a reasonable period to a suitable hospital or other facility designated by the court." AS 12.47.070(a)(c) reads, "the court may order the defendant to be

committed to a secure facility for the purpose of the examination…" Neither statute compels the Department to consider only API as the facility to which defendants may be admitted. The pressure imposed on API by the increase in forensic admissions adversely impacts other units within the Institute. The use of alternative placements to effect forensic evaluations will have a beneficial impact on the forensic and civil units at API.

The Department of Health and Social Services is challenged to meet the behavioral health needs of the state with the 80 beds available at the Alaska Psychiatric Institute. The 80 beds provide 10.8 state psychiatric beds for every 100,000 residents. A recent survey of state psychiatric beds conducted by the Pew Charitable Trusts has found that a shortage of state psychiatric beds has led to psychiatric patients with severe symptoms that require hospitalization being held for lengthy periods of time in emergency rooms and jails.[1] This may be a contributing factor to API's increase in competency evaluation referrals. This creates a Catch 22. Insufficient capacity to meet the needs of the civil population leads to a rise in the number of individuals detained in jails for minor nuisance offenses. Competency evaluations are ordered for these defendants as required in statute, and the individuals are then admitted to API for competency evaluation or restoration. Addressing this increased demand for forensic services and inpatient capacity is best solved with a multi-pronged approach.

By improving flow through the hospital system and increasing capacity in other facilities outside API, Alaska can better meet the needs of the civil and forensic populations that are currently admitted to API. I conceptualize the mental health system flow issue by likening it to a plumbing system, where the faucet represents the referrals and demands for admission, the sink basin represents the bed capacity of various facilities (hospital based and non-hospital based) to manage the population served, and the drain represents the opportunities to discharge patients from the facilities, making available those beds for new referrals. (See Attachment A) If the rate of referrals exceeds the rate of discharges, a backlog is created that needs to be remedied by either restricting or diverting referrals into the system, increasing the bed capacity, or optimizing discharges from the system. In the next section I will offer strategies at each of these points in the continuum to assist the state's behavioral health system in improving system flow and meeting the current demand.

[1] http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/08/02/amid-shortage-of-psychiatric-beds-mentally-ill-face-long-waits-for-treatment

Strategies to reduce hospital admissions

Nearly all states are experiencing an increase in the number of forensic admissions to its state hospital system. There are a number of hypotheses for this trend, from increased awareness by the courts of the need to properly assess the competency of criminal defendants, to policing practices that have limited officer discretion in making arrests, to identified inadequacies of community mental health systems that result in greater symptom severity and increased law enforcement encounters. Efforts to reduce criminalization of persons with mental illness should seek to address each of these identified contributing factors as well as other practices that result in admissions to the state hospital for persons who would not have historically met admission criteria, i.e., do not meet civil commitment criteria. By limiting admissions to the state hospital to those persons whose clinical condition necessitates that intensive level of care, the state can best manage this limited resource.

Strategies to reduce forensic admissions to API should consist of:

- Identifying the individuals who account for a significant number of arrests, court appearances, admissions to API, hospital emergency room contacts, and EMS calls. While the latter two sources of information may be constrained by HIPAA, DOC and the Alaska Court System should be able to provide a list of individuals who account for a disproportionate number of law enforcement and criminal court contacts. Once identified, the state can then commit resources to address the person's unmet needs, such as: housing, medical care, substance abuse treatment, mental health treatment, employment assistance, food assistance and a structured schedule of activities. The National Governor's Association held a Policy Academy in 2013 to develop best practice models for state-level management of "super-utilizers". Resources to aid the state in implementing these practices can be found at:

http://www.nga.org/cms/home/nga-center-for-best-practices/meeting--webcast-materials/page-health-meetings-webcasts/col2-content/main-content-list/developing-state-level-capacity.html

- Leveraging existing community mental health resources by reviewing current criteria for participation in intensive community treatment programs to ensure that the individuals most likely to benefit from these services are eligible to receive them.

- Implementing pre-arrest and post-booking/pre-arraignment jail diversion practices. These correspond to Intercepts 1 and 2 of the SAMHSA GAINS Center's Sequential Intercept Model of Jail Diversion.[2] Maximizing implementation of diversion practices at earlier stages of the criminal justice continuum reduces the burden on systems further downstream, such as mental health courts, enabling them to address only those persons for whom the earlier diversion efforts were either inappropriate (severity of charge) or unsuccessful (continued criminal recidivism). For diversion practices at Intercepts 1 and 2 to be effective, sufficient community mental health resources need to be allocated to be able to effectively engage in treatment those who are diverted from the criminal justice system.

  Implementation of effective pre-arrest jail diversion requires that law enforcement agencies are committed to the outcomes that jail diversion intends to achieve. Law enforcement personnel should be trained to identify signs and symptoms of a behavioral health disorder and how to effectively interact with a person in a behavioral health crisis. Many law enforcement agencies that utilize pre-arrest jail diversion train their officers in Crisis Intervention Training or Mental Health First Aid. Some jurisdictions have developed co-responder models, where law enforcement officers and mental health professionals respond to calls together, each benefitting from the expertise of the other. The US Department of Justice's Bureau of Justice Assistance has created a Police Mental Health Collaboration Toolkit. Link can be found at:

  https://pmhctoolkit.bja.gov/?utm_source=redirect&utm_medium=web&utm_campaign=PMHC

  Court diversions of pre-arrest and pre-arraignment misdemeanants who meet civil commitment criteria reduces the burden on the courts but may impose an increased burden on the state's inpatient psychiatric hospital beds. While jail diversion may reduce the number of forensic admissions, there may be a concomitant increase in the number of patients referred for admission on a civil commitment. Generally, the length of stay for patients civilly committed is substantially shorter than for those on a forensic commitment, resulting in a net reduction in the admissions burden, reducing costs

[2] http://www.samhsa.gov/criminal-juvenile-justice/samhsas-efforts

associated with court administration, and reducing the number of arrests/convictions that diverted persons would have otherwise had.

Connecticut has created a comprehensive post arrest/pre-booking Criminal Justice Diversion Program that has been shown to be effective in reducing criminal recidivism. Further information about their model is included in Attachment B.[3]

- Nationally, it is not uncommon for incompetency to proceed evaluations to be ordered by the court to ensure that defendants have access to adequate mental health services, as some jails provide limited mental health services that do not adequately meet the needs of the inmates in their custody. Working with the Alaska Department of Corrections to identify gaps in its continuum of care for mental health services may reduce reliance on court ordered evaluations to ensure adequate treatment. The per diem cost to treat persons with a mental illness in a psychiatric hospital is significantly higher than a jail's per diem cost due to the extensive regulatory requirements for psychiatric facilities imposed by CMS and The Joint Commission. By delivering timely and comprehensive jail-based behavioral health services, inmates can maintain or improve their clinical stability, reducing the potential need for an evaluation of competency.

Strategies to increase system bed capacity

API has only ten beds allocated to forensic patients on the secure forensic unit (Taku). The current demand for forensic beds exceeds the capacity of this unit. When the Taku unit is at full census, additional forensic patients are either admitted to civil units within the facility or their admission is delayed until a bed on the forensic unit becomes available. Restricting forensic admissions solely to the forensic unit has resulted in a backlog of jailed criminal defendants opined incompetent to stand trial and awaiting admission to API for competency restoration. In recent years, numerous state advocacy organizations have prevailed in federal lawsuits alleging that delays in forensic evaluation and treatment for jailed defendants violates the defendants' constitutional rights. The Department should consider alternatives to hospitalization such as jail-based competency evaluation and restoration as an effective alternative to state hospital admission. Colorado and several other states have implemented

[3] http://www.ct.gov/dmhas/LIB/dmhas/publications/jaildiversion.pdf

jail-based competency restoration programs and have shown them to be cost effective, effective in reducing the burden on the state hospital, and demonstrating equal efficacy in restoring defendants to competency to stand trial when compared with competency restoration units at their state hospital. In Colorado, the per diem bed cost for the jail-based competency restoration program is $308 as compared to $676 per day for a forensic bed at the state hospital.

There are several models of jail-based competency restoration, ranging from units within existing jails that are solely dedicated to competency evaluation and restoration where patients are separated from other defendants housed within the facility, to programs that provide individualized assessment and restoration services to defendants housed within a correctional facility's general population (jail in-reach services). Should the Department have an interest in learning more about each of these models, I can provide further details, including comparative per diem costs, advantages and disadvantages of each, as well as sample legislative decision items, requests for proposal and contracts.

To address the relative shortage of beds at API, I recommend that DHSS and other stakeholders reach out to tertiary care and private psychiatric hospitals to assess their receptivity to create additional inpatient psychiatric bed capacity at their facilities. This is especially relevant now that the Centers for Medicare and Medicaid Services in April 2016 published the final rule for 42 CFR § 438.3(u), providing an exception to the Institution for Mental Disease payment exclusion for Medicaid enrollees ages 22 through 64 who are admitted to an IMD for fewer than 15 days. This IMD exclusion exception can also be included as a component of the state's 1115 waiver if applied for and approved by CMS.

Strategies to facilitate hospital discharges

Efficiencies in triaging and conducting competency evaluations can reduce lengths of stay for incompetency to proceed evaluations and enable API to make optimal use of its limited forensic beds on the Taku unit. Other states such as Colorado have employed a brief competency screening assessment for defendants admitted for evaluation of incompetency to proceed. These screening evaluations are conducted by a forensic psychologist who conducts a cursory review of the provided collateral materials and meets with the defendant for approximately 20 minutes. The screenings are designed to identify defendants referred to evaluate incompetency to proceed who are most likely competent. If the screening identifies the evaluee as likely

competent, then the incompetency to proceed evaluation is assigned and conducted by a forensic evaluator as soon as is practicable. The evaluee can then be returned to the jail of origin once the evaluation is completed and prior to the hearing. AS 12.47.100(b) reads, "For the purpose of the examination, the court may order the defendant committed for a reasonable period to a suitable hospital or other facility designated by the court." Since the defendant is admitted to hospital for the purpose of conducting the evaluation, the purpose of the admission has been satisfied once the evaluator has completed the assessment. Continued involuntary confinement of a competent defendant in a psychiatric hospital is unnecessary, and returning the defendant to the jail of origin makes available a bed that can be used to evaluate and treat a defendant who has been adjudicated incompetent to proceed or whose clinical condition warrants continued confinement in a hospital setting. By employing this approach in Colorado, the length of stay for defendants screened and later found to be competent was substantially reduced.

When I inquired, API staff reported delays in transporting defendants back to their jail of origin once the forensic evaluation is completed. Currently Department of Corrections (DOC) staff is responsible for scheduling and arranging this transport. API staff should meet with DOC administration to emphasize the magnitude of the bed census pressures on the hospital and the need to minimize delays in transporting defendants back to their jail of origin. The Department could consider amending either AS 12.47.100 or AS 12.47.070 to include a specific provision that would compel the DOC to transfer evaluees promptly following completion of the evaluation to improve the efficiency of bed utilization. Additionally, the Department could consider contracting with a security service or hiring its own qualified transport to transport defendants. The efficiencies gained by expedited transfers should more than offset the costs associated with employing qualified, secure transporters.

In certain instances, it may be preferable for API to hold defendants opined not incompetent to proceed but agreeable to treatment and request an expedited hearing rather than return them to jail to await the hearing. With the defendant's informed consent, restoration services can be initiated prior to the hearing and the length of time to restore the defendant to competency can be lessened when compared to initiating restoration services only after a judicial finding of incompetency to proceed.

For defendants admitted to API for restoration to competency who are uncooperative or who refuse medications deemed necessary to restore them to competency to proceed, API and its attorneys should file a motion with the court of jurisdiction for a status hearing, as the defendant was admitted to API for the express purpose of competency restoration and the purpose of the hospitalization is not being met. In my conversation with Judge Rhoades, she indicated that the hospital has not routinely filed motions for a status hearing under these circumstances and, with prompt notification, the court could schedule a hearing to determine the most appropriate next steps. This should result in a reduced length of stay and improve bed turnover.

Evaluate Current Practices within the Competency Restoration Program

My consultation with Forensic Services at the Alaska Psychiatric Institute consisted of meetings with Kristy Becker, Ph.D., Chief Forensic Psychologist at API as well as other members of the Psychology Department who serve as forensic evaluators. At my request, I was provided with several redacted incompetency to proceed and insanity evaluations that had been submitted to the court so that I could assess the quality of the reports. The reports I reviewed are of good quality and the assessments comply with the American Academy of Psychiatry and the Law's Practice Guideline for the Forensic Assessment.[4] The reports had sufficient detail and included the information on which the evaluator relied to form his/her opinion. The reports I reviewed did not include extraneous information or offer opinions other than those specifically requested by the court, and comply with the requirements for psychiatric examination of the defendant as outlined in AS 12.47.070 and AS 12.47.100.

While the quality of the forensic reports is adequate, reliance on a small cohort of forensic evaluators who are primarily trained by a single supervisor increases the potential for members of the group to approach the evaluation, analysis of data and completion of reports similarly. While the reliability of the forensic evaluations produced by the group may be high, forensic evaluators benefit from presenting their material to a group of peers with diverse backgrounds and training so that their results can be scrutinized and the potential for "group think" can be

[4] Glancy G, Ash P, Bath E, et al. AAPL Practice Guideline for the Forensic Assessment, Journal of the American Academy of Psychiatry and the Law, 43:2, 2015 Supplement, June 2015.

minimized, resulting in evaluations with high validity. When I shared this observation with Dr. Becker she agreed that the potential for "group think" exists, as all the evaluators currently working at API are supervised exclusively by her. She also acknowledged that she and the other forensic evaluators recently completed their own training or are currently still in training, and would benefit from the opportunity to confer with colleagues with more experience. She was welcoming of my suggestion that API consider ways in which consultation and discussion of cases could be accomplished with the assistance of experienced forensic evaluators from outside the system. I strongly encourage API to explore the use of forensic consultants external to API to provide guidance and an objective analysis of the work of API's forensic evaluators, as this will aid in the professional development of API's evaluators and help to minimize potential sources of bias.

Forensic evaluators are currently serving two roles, conducting forensic evaluations and serving as members of the facility's clinical teams. While the psychologists do not conduct forensic evaluations on defendants admitted to their hospital unit or with whom they have a patient-therapist relationship, balancing the competing requirements and demands of the forensic and clinical therapeutic roles can be challenging. "The potential for a conflict of interest, or even the appearance of one, can compromise objectivity."[5] It is generally preferred that there be a clear delineation of roles between forensic evaluators and clinicians to address the perceived and real potential for administrative bias. For example, a clinician who is assigned to perform a forensic evaluation at their facility may be aware of pressures on the facility's administrators to make beds available for patients awaiting admission. The forensic evaluator's awareness of this pressure may bias the evaluator in such a way to result in an opinion that has the effect of reducing the census pressure on the facility.

While workforce challenges may prevent a state's mental health system from clearly separating the forensic evaluator role from the clinician-treater role administratively (i.e.: prohibiting hospital clinicians from conducting forensic evaluations and creating a division of forensic evaluations that it administratively separate from the mental health institute), the potential for administrative bias can be reduced by employing forensic consultants who are not affiliated with the hospital to review the case presentations and reports of the hospital's forensic evaluators.

[5] Glancy G, Ash P, Bath E, et al. AAPL Practice Guideline for the Forensic Assessment, Journal of the American Academy of Psychiatry and the Law, 43:2, 2015 Supplement, June 2015. Pg S6.

Significant time, cost and energy are expended to conduct forensic evaluations in areas of the state where evaluators do not currently reside. Evaluators are required to fly to remote regions of the state to conduct incompetency to proceed evaluations. I recommend the state consider the use of tele-evaluations as an alternative. Little has been published about the use and effectiveness of tele-forensic evaluations. There are limitations to its use in some cases, as psychological assessment instruments require administration under a specific set of conditions that have not included test administration via video broadcast. For a subset of the total number of evaluation referrals there may be some utility in employing tele-evaluations, even as a screening tool to determine which defendants may require admission to API for assessment based on the defendant's current clinical needs.

Judges and attorneys have expressed being unclear as to what competency restoration entails and what treatment services and programming is available to defendants ordered to API for restoration to competency. I recommend that API provide in-services for the courts and consider inviting members of the court to tour API to better understand the processes there. Additionally, API should consider convening stakeholder meetings to highlight the challenges DHSS faces in meeting the increased demand for forensic evaluations and competency restoration, emphasizing that the responsibility for managing this population is a responsibility shared by the Executive and Judicial branches, and working collaboratively to develop strategies to address the issue.

Evaluate Practices Related to *Sell* Hearings

Involuntarily medicating non-consenting persons for the sole purpose of restoring that person to competency to stand trial is governed by the holding in the US. Supreme Court's 2003 opinion in Sell vs. U.S. (539 US 166). In *Sell*, the Court held that the state may medicate a criminal defendant charged with a non-violent crime against that defendant's will only in limited circumstances. The State must prove that an important governmental interest exists, that the recommended treatment is medically appropriate, likely to restore the defendant to competency, the least restrictive means to do so, and unlikely to produce side effects that would adversely affect the trial's fairness.[6] Additionally, the Court indicated in Part III of the

[6] *Sell v. US*, 539 US 166, 2003

majority's opinion that the court could authorize the use of involuntary medication on alternative grounds, such as dangerousness. The Court stated, "If a court authorizes medication on these alternative grounds, the need to consider authorization on trial competence grounds will likely disappear."[7]

In instances in which a defendant is admitted to API for restoration to competency and meets criteria for the involuntary administration of medications based on a compelling state interest such as dangerousness, API should consider petitioning the probate court or invoking an administrative procedure rather than pursuing a *Sell* hearing, where the request for involuntary medication is more narrowly confined to competency restoration. In forming the basis of its opinion, API will need to consider the factors as articulated in Myers v. Alaska Psychiatric Institute, including whether medications are in the patient's best interests.[8]

At either hearing to determine the need for involuntary medication, judges are aided in their decision by hearing testimony from the patient's treatment providers from API. In my discussion with Judge Rhoades, she indicated that there has been wide variability in the quality of testimony provided by treaters from API, not just about the administration of involuntary medication to restore competency but also about the likelihood of a defendant being restored to competency. Many of the treatment providers at API have not been formally trained in forensic mental health. I recommend that API consider implementing an educational curriculum for staff who are likely to testify in court so that such staff are aware of the legal requirements associated with forensic evaluations and treatment, the lines of inquiry likely to be raised at a hearing, relevant state and national case law governing competency to stand trial, the relevant factors to consider for a Sell determination, and have opportunity to engage in mock trial exercises to improve their skills as an expert or lay witness. Ensuring that staff are properly educated as to the specific issues related to Sell hearings may improve API's success when petitioning the criminal court for involuntary medication to restore a defendant's competency to stand trial. For more complex or high profile cases, I recommend that API consider consulting with forensic experts nationally to provide additional expertise and advice.

[7] *Sell v. US*, 539 US 166, 2003

[8] *Myers v. Alaska Psychiatric Institute*, 138 P. 3d 238 (Alaska 2006)

Conclusion

My evaluation of forensic services at the Alaska Psychiatric Institute identified a number of opprtunities to improve efficiencies and patient flow, ensure high quality restoration services, reduce potential for evaluator bias while enhancing professional development, and improve outcomes for persons with a behavioral health disorder who are involved with the criminal justice system. Statutory amendments include revision of AS 12.47.070 to require one qualified psychiatrist or one qualified forensic psychologist to conduct insanity evaluations rather than two. Statutes AS 12.47.070 and AS 12.47.100 leave open to interpretation whether the Department has a duty to provide forensic evaluations for the courts. Given the increased demand for forensic evaluations across the state and the limited financial resources to adequately compensate for the increased demand, the Department should consider the extent to which it will continue to satisfy this need. Such discussions should involve critical decision-makers from the Alaska Court System.

Appreciating that API's fixed number of psychiatric beds are a valuable and limited resource, API should work with other stakeholders to limit admissions to API to those persons whose clinical condition necessitates a hospital level of care and to provide restoration services for defendants who are less symptomatic in other types of facilities, such as jail-based competency restoration services. Jail-based competency restoration programs can provide restoration outcomes equal to or greater than those obtained in a hospital setting at substantially reduced cost. The Department should seek further opportunities to with the Department of Corrections to ensure that it has the resources necessary to provide timely and effective treatment of arrestees. Effective mental health treatment in jail may provide clinical improvement sufficient to negate the need for a competency evaluation. Additionally, the Department should consider reaching out to tertiary care and private, free-standing psychiatric facilities to assess their receptivity to building greater capacity to treat civil patients. If successful, some of the beds currently dedicated for civil patients could be used to ensure timely admission of forensic patients.

A relatively small number of misdemeanor recidivists account for a significant proportion of the forensic referrals and court appearances. Pre-arrest jail diversion programs and expansion of community mental health services for justice-involved persons can reduce recidivism, reduce total costs and improve outcomes for this population. There are a number of evidence-based

jail-diversion programs and programs to identify and manage super-utilizers. If the Department is interested in pursuing these strategies I can provide additional assistance and reference materials.

Efficiencies in the hospital's processes for evaluating defendants and transporting them back to their jail of origin once the purpose of the evaluation has been satisfied can improve patient flow and make best use of the Institute's beds. For admitted restoration defendants who are uncooperative with treatment, prompt filing of a motion for a status hearing will enable the court to take appropriate next steps and should reduce the time that defendants remain at API but are not receiving meaningful restoration services.

The sampling of forensic reports I reviewed complied with the American Academy of Psychiatry and the Law's Practice Guideline for the Forensic Assessment as well as the requirements for psychiatric examination of the defendant as outlined in AS 12.47.070 and AS 12.47.100. Given the relative inexperience of forensic evaluators, DHSS should create opportunities for forensic evaluators to confer with forensic mental health professionals from outside the API system. Additionally, DHSS and API should strive to establish a clear delineation of roles between forensic evaluators and clinicians to address the perceived and real potential for administrative bias.

Based on the comments I had received from Judge Rhoades who indicated that many court personnel are unclear as to what competency restoration services at API entails, I recommend that API provide in-services for the courts and consider inviting members of the court to tour API. API should also implement a training curriculum for staff who have occasion to testify in court on matters of competency restoration and involuntary administration of medication to restore defendants to competency to stand trial.

Attachment A: Diagram of Behavioral Health/Hospital System Flow

Increased flow
(Referrals)

Too Small
(Bed Capacity)

Drainage
(D/C Barriers)

Attachment B

Connecticut's Criminal Justice Diversion Program: A Comprehensive Community Forensic Mental Health Model

By Linda Frisman, Gail Sturges, Madelon Baranoski, and Michael Levinson, Contributing Writers

Connecticut, like many other states, is coming to terms with an apparent increase in the number and proportion of inmates of the Department of Correction (DOC) who need mental health services. Approximately 12% of state inmates are in need of services (Solnit, 2000). This estimate is consistent with national studies such as Teplin's (1994) showing that over 6% of male inmates have a current severe mental disorder and that the rate of severe mental illness among women prisoners is about 15% (Teplin et al., 1996). The number of inmates wanting mental health care is about 16%, according to recent data from the U.S. Department of Justice (1999).

Connecticut's diversion program was originally a response to problems recognized in the courts. In 1994, court personnel in the Geographic Area (GA) 14 court in Hartford and staff members from Capitol Region Mental Health Center met to address problems related to defendants with serious mental illnesses. No one-not the judge, the public defender, nor the state's attorney-felt that justice was done by imprisoning offenders whose mental disorders were more serious than their crimes. The court could not access mental health treatment for defendants, except through an order for an evaluation of competency to stand trial. These evaluations, which had to be completed within three weeks, often did result in commitment to inpatient care. But they represented a back door to needed treatment, and one that made poor use of resources. Defendants might wait more than 14 days to be evaluated at all, and then were usually hospitalized for 90 days - much longer than the amount of hospital time typically needed to stabilize a person in crisis. Leadership at the mental health center, a facility of the Connecticut Department of Mental Health (now the Department of Mental Health and Addiction Services, or DMHAS) recognized the inefficient use of resources and the poor care resulting from this back door to the system. To remedy the situation, clinicians were deployed to work at the court and address the needs of defendants with mental illness.

Program Goals

In addition to avoiding unnecessary competency evaluations, DMHAS sought to provide clinical alternatives to arrest and incarceration, to ensure continuity of care for those who are incarcerated, and to facilitate community reintegration for those who are sentenced. Thus, the program does much more than divert people from jail. The diversion name has persisted

because of the widespread use of that term, and because the court-based activities are most familiar within the Judicial Branch. More appropriately, it would be described as the community forensic services program.

Program Structure

Currently, DMHAS has diversion programs in six mental health centers, covering nine courts. Five of these mental health centers are operated by DMHAS. The remaining center, a private non-profit agency, is a DMHAS-funded local mental health authority. This center receives money from DMHAS to operate the diversion program. In contrast, most of the state-operated programs did not receive new funding to run their diversion programs. These mental health centers recognized the value of having staff members who are knowledgeable about the criminal justice system, and the efficiency of basing clinicians in courts, especially

since so many of their clients were arrested.

The diversion teams consist of one to three clinicians who spend from one to five days in the court per week. They focus primarily on arraignments of persons with mental disorders, but may become involved in all of the phases of their clients' court cases, as appropriate. The team may play a role at the time of plea, or sentencing, in addition to arraignment. (In Connecticut, arraignment is an activity of all of the GA courts, and is not necessarily in a distinct courtroom or at a particular time, unless the court is unusually large.)

Diversion team clinicians are employees of the mental health center who are able to work fairly independently. Usually this skill is reflected in their training and/or clinical license. The fact that they are employed by the mental health center, rather than the court, is an especially important one. They follow the rules of the mental health center with respect to the goals of their work (to assist the client, and not the court) and the rules of treatment consent and confidentiality. Thus, they must obtain permission from the client to work on his or her behalf. They also must obtain written permission in order to discuss the case with the court. Diversion clinicians do not share content of the case with people in the criminal justice system; i.e., they do not relate the diagnosis, and information about the nature of the mental illness. Rather, they describe the treatment plan and the ability of the mental health system to meet the client's needs. They do not coerce the client into treatment by promising to obtain a lighter sentence, or threatening that he or she must stay in treatment or go to jail. Their role is strictly that of mental health clinician.

The Diversion Process

Typically, the arraignment list is faxed to diversion clinicians on a daily basis to be checked against DMHAS's statewide information system. This cross-check enables the teams to identify current or recent clients of the mental health system. These clients generally have a serious mental disorder, such as schizophrenia, bipolar disorder, or major depression.

In addition to known clients, the team will assist defendants identified by the judge, the sheriff, the public defender, the bail commissioner, or the state's attorney. With the client's permission, the diversion clinician conducts a brief, unstructured assessment, usually in the lock-up area of the court. The nature of this assessment is to establish the types of symptoms the person is having, whether the defendant has been prescribed medication and is taking it, and whether and where the person is in treatment. Current treating agencies are usually contacted to ask for additional information, if the client does not object.

Diversion Not Automatic. Clients are not automatically diverted from the criminal justice system because they fall within any particular eligibility criteria. To aid in this process, the clinician considers the seriousness of the charge, the treatment plan indicated for the client, the risk posed by the client, and the extent to which the offense was related to the mental disorder. Similarly, the judge must weigh factors concerning the seriousness of the offense and the reasonableness of the options presented by the diversion team. The diversion team does not make the decision to divert; rather, it offers options to the judges. Most of the clients diverted have minor charges, including misdemeanors and lower-level felonies. However, clients with more serious charges may receive other services from the team.

Treatment Planning. If the person is willing to have the clinician share information with the court, the diversion team and the client can proceed to make a treatment plan. Diverted clients may be hospitalized, sometimes under a commitment paper. They may also receive

ambulatory care in a wide variety of settings. On the day of arraignment, the immediate treatment plan is presented by the clinician to the court, which may then be accepted or rejected. Most often, the judge releases the defendant on a written Promise To Appear with the condition that the client participate in the proposed treatment plan, and orders another pre-trial hearing two to three weeks later. At subsequent hearings, the case may again be continued, or prosecution may be dropped and the case nolled. If the court is concerned that the client will not follow through with treatment, or if the case is more serious, it may go to plea, resulting in the likelihood of the defendant being placed on probation with a treatment condition.

On return trips to court, the diversion clinician's role is to report whether or not the client is continuing in treatment. If a client is not attending treatment, there is no "punishment" for the failure to follow through. Rather, the case is returned to the regular docket and the court proceeds as if there had not been a diversion effort.

The services to which a diverted client is referred are individualized. While Connecticut has a fairly rich array of services, the number of program slots is often inadequate to serve people immediately. It may take from a few days to a few weeks to arrange for needed services for diversion program clients. During this period, the case may be continued. The most frequent services used by diverted clients are mental health hospitalizations and ambulatory mental health services.

Integrated Treatment Available. An advantage of the Connecticut system is that there is a single state agency in charge of both mental health and substance abuse. DMHAS is moving toward integrated treatment. While integrated treatment for co-occurring disorders is not available statewide, many clinicians in the mental health system have received training in treatment of substance use disorders. The community mental health centers of the two largest cities (Bridgeport and Hartford) have Assertive Community Treatment teams that specialize in integrated treatment, using the New Hampshire model of care (Drake, McHugo, Clark, et al., 1998).

Services Available to Non-Diversion Clients

Despite its name, the Diversion Program in Connecticut is a comprehensive forensic model that encompasses many other activities. Because not all clients can be diverted, it is especially important to connect clients entering correctional facilities with needed services. The team calls the mental health staff at the jail to which a client is being admitted to ensure that the jail personnel are aware of medications and other treatments needed by the client. They may also make recommendations about placement in DOC specialty programs. The diversion teams also work with clients being released from correctional facilities, to ensure a smooth transition back into community-based mental health services. In addition to these efforts made on behalf of individual clients, diversion teams often work with the police to educate officers about mental illness and to avert unnecessary arrests.

Contrast With Other Diversion Efforts

Connecticut's efforts to divert people with treatment needs pre-date the diversion program. The Division of Court Support Services in the Judicial Branch contracts with a large number of community substance abuse treatment providers and offers alternative sanctions for persons who have substance use disorders. This system was originally developed for offenders who were about to be sentenced, but it has been expanded to include defendants

at earlier stages of the court process (e.g., at arraignment, during pre-sentence proceedings, etc.) This system works well, but is not available to clients with serious mental disorders. It was especially important for the state to develop a diversion program to provide similar opportunities to clients with mental disorders.

Although mental health courts do not represent a uniform model, there are several ways in which the Connecticut diversion program is distinct from mental health courts. First, defendants stay on the regular criminal docket, rather than being referred to a courtroom with specialized mental health staff; thus the potential of stigmatization is reduced. Second, defendants who are interested in being served by the team have ready access to assistance, since there are few restrictions on the population to be served. However, not all clients served are diverted from jail. Third, the diversion team is employed by the mental health center, and does not relay information about the person's situation except the treatment plan and the compliance with that plan. The diversion team connects the client with services that will

continue as long as they are needed and wanted; these services do not terminate with the end of the court's involvement in the case. Finally, Connecticut's diversion model is simpler and less costly to implement than mental health courts, because the judicial system does not need new staffing or training, as required by mental health courts. Moreover, the diversion team performs other important forensic work besides diversion.

Update

Since this article was originally published, the Connecticut legislature and Governor's Office approved funding to enable DMHAS to enhance existing diversion programs and to create new programs so that jail diversion would be available to all 22 G.A. courts. The decision to provide such funding was based in part to the following factors: (1) legislative concern regarding prison overcrowding and the desire to seek innovative alternatives to building more prisons; (2) a report to the legislature, "The Cost & Effectiveness of Jail Diversion", which was based on a collaboration by DMHAS, DOC, the Judicial Branch and NAMI. This report demonstrated a reduction in jail days for defendants in courts where a jail diversion program existed, compared with similarly situated defendants in courts without such a program. (3) Strong advocacy by NAMI, and other advocacy groups concerned with the criminalization of persons with mental illness.

Based on this report, $3.1 million was provided to DMHAS to expand the jail diversion programs. DMHAS determined each community provider's allocation based on the volume of criminal cases seen annually by their area court(s). Each program includes one or more of the following: a licensed clinician on site at the court, a forensic case manager, and a transitional or respite bed. Additionally, a project director position was funded to oversee implementation, provide quality monitoring, and to assure best practices through the development of a training curriculum. As of June 2001 DMHAS provides jail diversion programs statewide on site at all 22 G.A. courts. - Gail Sturges

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