

MEETING AGENDA

Meeting: Planning Committee
Date: December 12, 2016
Time: 1:00 pm
Location: Trust Authority Building, 3745 Community Park Loop, Anchorage
Teleconference: (844) 740-1264 / Session Number: 800 168 067 # / Attendee Number: #
<http://thetrust.webex.com>
Trustees: Mary Jane Michael (Chair), Laraine Derr, Paula Easley, Larry Norene, Jerome Selby, Carlton Smith, Russ Webb

Monday, December 12, 2016

Page No.

1:00 pm	Call to order (Mary Jane Michael, Chair) Announcements Approve agenda Approval of Minutes <ul style="list-style-type: none"> October 26, 2016 	4
1:05 pm	1115 Waiver & Forensic Evaluations at API <ul style="list-style-type: none"> Katie Baldwin, Stephenie Colston (Contractor) 	12
1:25 pm	Psychiatric Disability Rights <ul style="list-style-type: none"> Katie Baldwin, Kate Burkhart (Executive Director Alaska Mental Health Board), Dave Fleurant (Executive Director, Disability Law Center of Alaska) 	
1:55 pm	Break	
2:00 pm	Pre-Development Guidelines Development <ul style="list-style-type: none"> Katie Baldwin, Chris Kowalczewski (Foraker – Pre Development) 	17
2:30 pm	Developmental Disabilities System Assessment <ul style="list-style-type: none"> Amanda Lofgren, Roy Scheller (Executive Director Hope Community Resources) 	19
3:00 pm	Preliminary Discussion of Trustee Work Session 01/04/2017 <ul style="list-style-type: none"> Greg Jones 	
3:30 pm	Adjourn	
<u>Documents for Reference</u>		
	<ul style="list-style-type: none"> API Follow-up U.S. Surgeon General's Report on Alcohol, Drugs, and Health – Executive Summary 	21 89

Future Meeting Dates

Full Board of Trustee / Planning / Resource Management / Finance
2017 / 2018 / 2019

(Updated – October 27, 2016)

Planning Committee Dates:

- January 5, **2017** (Thu)
- April 13, **2017** (Thu)
- August 1-2, **2017** (Tue, Wed)
- October 17, **2017** (Tue)
- **January 4, 2018** (Thu)
- **April 12, 2018** (Thu)
- **Jul 31- Aug 1, 2018** (Tue, Wed)
- **October 17, 2018** (Wed)
- **January 3, 2019** (Thu)
- **April 11, 2019** (Thu)
- **Jul 30-31, 2019** (Tue, Wed)
- **October 16, 2019** (Wed)

Resource Management Committee Dates:

- January 5, **2017** (Thu)
- April 13, **2017** (Thu)
- August 3, **2017** (Thu)
- October 17, **2017** (Tue)
- **January 4, 2018** (Thu)
- **April 12, 2018** (Thu)
- **Aug 2, 2018** (Thu)
- **October 17, 2018** (Wed)
- **January 3, 2019** (Thu)
- **April 11, 2019** (Thu)
- **Sep 1, 2019** (Thu)
- **October 16, 2019** (Wed)

Future Meeting Dates

Full Board of Trustee / Planning / Resource Management / Finance 2017 / 2018 / 2019

(Updated – October 27, 2016)

Finance Committee Dates:

- January 5, **2017** (Thu)
- April 13, **2017** (Thu)
- August 3, **2017** (Thu)
- October 17, **2017** (Tue)
- **January 4, 2018** (Thu)
- **April 12, 2018** (Thu)
- **August 2, 2018** (Thu)
- **October 17, 2018** (Wed)
- **January 3, 2019** (Thu)
- **April 11, 2019** (Thu)
- **Sep 1, 2019** (Thu)
- **October 16, 2019** (Wed)

Full Board of Trustee Meeting Dates:

- January 25-26, **2017** (Wed, Thu) – JUNEAU
- May 4, **2017** (Thu) – TBD
- September 6-7, **2017** (Wed, Thu) – Anchorage – TAB
- November 16, **2017** (Thu) – Anchorage – TAB
- **January 24-25, 2018** (Wed, Thu) – JUNEAU
- **May 9, 2018** (Wed) – TBD
- **September 5-6, 2018** (Wed, Thu) – Anchorage – TAB
- **November 15, 2018** (Thu) – Anchorage – TAB
- **January 30-31, 2019** (Wed, Thu) – JUNEAU
- **May 8, 2019** (Wed) – TBD
- **September 4-5, 2019** (Wed, Thu) – Anchorage – TAB
- **November 14, 2019** (Thu) – Anchorage – TAB

ALASKA MENTAL HEALTH TRUST AUTHORITY
PLANNING COMMITTEE MEETING

October 26, 2016
9:08 a.m.

Taken at:
Alaska Mental Health Trust Authority
3745 Community Park Loop, Suite 120
Anchorage, Alaska

OFFICIAL MINUTES

Trustees present:

Mary Jane Michael, Chair
Jerome Selby
Laraine Derr
Larry Norene
Paula Easley
Russ Webb
Carlton Smith

Trust staff present:

Jeff Jessee
Steve Williams
Kevin Buckland
Miri Smith-Coolidge
Amanda Lofgren
Heidi Wailand
Carley Lawrence
Luke Lind
Michael Baldwin
Carrie Predeger
Katie Baldwin-Johnson
Valette Keller

Others participating:

Kathy Craft; Kate Burkhart; Patrick Reinhart; Sherrie Wilson Henshaw; Faith Myers; Dorrance Collins; Susan Musante; Lisa Cauble; Brenda Moore; Charlene Tautfest; Michael Powell; Jim Waldinger; Coy Jones; Nancy Burke; Susanne Fleek-Green.

PROCEEDINGS

CHAIR MICHAEL calls the meeting to order and does a roll call. She states that Trustees Selby and Webb are on their way, and all the other trustees are present. She asks for any

announcements. She states that she and Trustee Easley attended the UAA Behavioral Health Workforce Summit yesterday and thought it was very well done.

MR. BALDWIN states that one of the amazing things about that summit was that the group stayed throughout the whole day. He continues that one of the “ahas” was the need for integration across interdisciplinary work across different settings, and there was a lot of dialogue around making sure there was more interdisciplinary work in development of curriculum and programming.

MS. WAILAND states that she was able to stay and participate in the breakout sessions. A number of interesting things developed in the end. The first is the recognition that the policymakers, leaders, providers and university have alignment. She continues that there was some creative thinking around how to teach in the same kind of team-like manner that is wanted around integrated care in the field. She adds that there was some very innovative and forward thinking, and other ideas that were practical and doable.

CHAIR MICHAEL moves on and asks for any changes to the agenda. There being none, she asks for a motion.

TRUSTEE DERR makes a motion to approve the agenda.

TRUSTEE EASLEY seconds.

There being no objection, the motion is approved.

CHAIR MICHAEL moves to the minutes for August 9th and 10th, 2016.

TRUSTEE DERR makes a motion to approve the minutes of the August 9th and 10th, 2016, meeting.

TRUSTEE NORENE seconds.

There being no objection, the motion is approved.

CHAIR MICHAEL states that the first presentation is the Rural Health Clinics Guidelines Update.

RURAL HEALTH CLINICS GUIDELINES UPDATE

MR. WILLIAMS states that he and Luke Lind have been looking at the history of Trust funding related to health clinics, where they have been going, and how it has happened. He continues that, historically, the Denali Commission managed the funding that went out to these health clinics. He adds that when the Denali Commission stopped managing the funding, the Trust was getting direct requests from various entities to fund health clinics. He states that there is a quick summary of this history in the background section of the memo. The context for this is around Trust funding, in general, recognizing that the State fiscal situation in revenue is declining. He explains that as that declines, there will be an anticipated increase demand in terms of grant

requests for various types of services. He talks about the revision to the guidelines for various programs to narrow the focus from what potentially could be funded through those programs, and making sure that applicants understand what is funded and the guidelines. He continues that the Web site has been updated, and webinars have been done to educate grantees. He states that one of the roles of health clinics is providing a model for a career path for individuals in their communities. Health clinics are critical for the beneficiaries out in rural Alaska, as well as the tribal health system. He goes through the guidelines, and states that the next step is figuring out how to communicate this out to the partners. He hopes to come up with a process that will ensure maintaining relations and access in rural Alaska for beneficiaries in a very targeted way.

TRUSTEE DERR asks if the Trust will not approve funding after a project has been completed.

MR. WILLIAMS replies that, in the past, applications have been received where the clinic has been completed, and we are looking for ways to add or reduce the overall cost to the individual entity that constructed the clinic.

TRUSTEE NORENE states that this answers a lot of the concerns that the trustees have expressed, and he thinks that this is the right track.

MR WILLIAMS continues that there are partnership grant guidelines, and we now will develop a similar document for health clinics.

CHAIR MICHAEL thanks both Mr. Williams and Mr. Lind, and states that the next item on the agenda is Nancy Burke and Susanne Fleek-Green.

MS. FLEEK-GREEN states that she is Mayor Ethan Berkowitz's chief of staff at the Municipality of Anchorage, and that Mayor Berkowitz is unable to be here today. She continues that bringing Ms. Burke on board as homeless coordinator has made a huge difference in the office and in the ability to face the challenges in addressing homelessness. She states that Ms. Burke will talk about the impact that the Trust support for the homeless coordinator has made at the Municipality and statewide, as well. She adds that a lot of things were done in the last year, and the Mayor is excited for what can be done next, especially with the social impact bond program and getting that launched in the next 12 months. The hope is that it becomes a model not just on homelessness, but on a lot of the other social challenges that are being faced in Anchorage and statewide.

MS. BURKE states that the presentation is a summary of where we are in terms of the program work. She continues that the single adult populations, as the areas needing the most community organization and programming support, have been identified. Groups are starting to look at families and youth and will continue focusing on veterans, along with people exiting the corrections system. She adds that it is not a complicated formula, but it is a complicated implementation because of all of the requirements that are tied to the funding.

CHAIR MICHAEL asks to go through the presentation briefly.

MS. BURKE begins by stating that there are three main partners: the Municipality, the United Way, and the Coalition to End Homelessness. She states that there is a partnership agreement,

an MOU, between these three that states all will: plan together; implement programs together; and make the best use of resources coming in to the community, because no one expects to see much by way of new government dollars going forward. She continues that the presentation is focusing on the subset of the total homeless population. She adds that needed is data collection assistance; coordination of those resources; looking at how people were accessing the services needed; and then permanence. She continues going through her presentation, explaining as she goes along. She states that the goal is zero deaths on the street this winter.

CHAIR MICHAEL asks if the people that are housed are out panhandling.

MS. BURKE replies no.

CHAIR MICHAEL asks if any planning around the need for another 160 beds has been done.

MS. BURKE replies that they have not planned around a facility because, following the spirit of the Americans with Disabilities Act and access to community resources, people need to be provided with options, and the community does need a certain number of co-located options where supportive services can be layered. She explains in greater detail.

CHAIR MICHAEL asks for any questions.

A short question-and-answer period ensues.

TRUSTEE NORENE asks about any interest generated from Native corporations.

MS. FLEEK-GREEN replies that the Mayor has had conversations with many corporations about their social responsibility; not just Native corporations. She states that AFN just passed a resolution to increase their work on homelessness, and we are reaching out to them to talk about how they would like to engage. She thinks that the answer is that everyone that is benefiting economically in Anchorage will benefit more when Anchorage is a better place for people that are struggling.

TRUSTEE SMITH asks how to increase engagement of the public.

MS. FLEEK-GREEN replies that Anchorage has a very strong and active neighborhood community council network. It is very neighborhood-centered, and they are very active in this discussion.

CHAIR MICHAEL asks where we are with Clitheroe.

MS. BURKE replies that there is a little bit of \$5 million sitting in the DHSS facilities section, and the Municipality has the first chunk of that for predevelopment to look at the sites where the Clitheroe Center is still standing. She states that the thing that is special about the Clitheroe Center is that it does dual diagnosis -- mental health and substance abuse, with a pretty special niche to make sure that is covered for the community.

MS. BALDWIN-JOHNSON states that Mat-Su Health Foundation is very interested in moving forward with essentially convening their community partners around the continuum of treatment in the community. She explains more fully.

MS. FLEEK-GREEN thanks all for being able to have Ms. Burke as someone solely addressing this issue. She states that it would not have been done otherwise.

CHAIR MICHAEL thanks all and states that the API privatization feasibility study is next on the agenda. She introduces Michael Powell who works for the Division of Behavioral Health.

MR. POWELL states that he is the project coordinator, helping to oversee the project, and providing any assistance needed in the process.

MR. WALDINGER introduces himself and his colleague, Coy Jones. He continues that they work for the Public Consulting Group which is a management consulting firm that has been around for about 30 years and works mostly with state health and human service agencies. He adds that they focus most of their time on mental health and substance abuse issues, and helping service agencies at the state and provider levels. He states that they were contracted by the State to do a feasibility assessment for API, and are kind of midstream right now.

MR. JONES adds that they are about three-fifths of the way through the work, and now have some substantial things to test out with the stakeholders. He continues that they are at a critical point in determining where it goes. He states that they are continuing to meet with community providers, as well as labor union representatives, and are finally beginning to come to a close. He explains in more detail. He continues that this will be finished in the next three or four weeks, and then the process of writing the final report will begin; presentation will be made to the DHSS and the Trust, and also legislative hearings. He asks for any questions.

TRUSTEE SMITH asks about the cost structure.

MR. JONES replies that care at API is expensive, and there is no way of getting around that.

TRUSTEE SMITH asks about the top three elements of the cost structure, and adds that labor would be one.

MR. JONES states that all the driving costs are related to labor in some way, explaining more fully.

TRUSTEE WEBB asks what elements of care have been identified as lacking that would impact the potential viability of API as a private facility.

MR. JONES replies that the next stage is looking at privatization options, and a piece of that scope is to look at how services can be distributed within the larger system. He states that API is always going to be limited to influence housing and where people can discharge to. He explains this and states that they are trying to figure out how to quantify the sorts of changes in service delivery to be able to do more with less with just kind of smart investments in the type of treatment that is being made.

CHAIR MICHAEL states that in the audience are probably the strongest advocates for patients of API, and acknowledges Dorrance Collins and Faith Myers. She encourages talking to them about any of the concerns regarding API that may contribute to the work.

MR. JONES states that they have already met with them.

MR. POWELL shares a handout from Ms. Myers with the trustees.

CHAIR MICHAEL thanks both, and calls a break.

(Break.)

CHAIR MICHAEL calls the meeting back to order and recognizes Carley Lawrence with a discussion on advocacy.

MS. LAWRENCE states that at the last board meeting Trustee Selby brought up a couple of questions about advocacy, gearing up for the legislative session, and also some specific questions about community health centers. She begins with a brief update about some of the items that staff has identified as potential advocacy issues this session. She adds that this will be discussed more at the November board meeting. She states that the items identified are: Title 4 alcohol tax; Medicaid reform; criminal justice reform, S891; and the budget. She asks Katie Baldwin-Johnson to continue.

MS. BALDWIN-JOHNSON states that this was framed informally: key things that are important for trustees to hear; what is being heard among the constituents.

MR. CHARD states that he is the executive director of the Alaska Behavioral Health Association which has about 60 members. They include for-profit, nonprofits, tribal, nontribal, community clinics ranging from small mom-and-pop shops to substance abuse and mental health treatment in the state. He continues that their annual meeting was held a few weeks ago, and Senators Kelly and Coghill were invited to talk about Senate Bill 74 and have an open conversation with membership about how this was being implemented and the role of community behavioral health providers for planning and implementation. Both senators seemed open to the concept that these are in the works and not set in stone. He adds that for membership the top priority is the budget. The Medicaid rates have been stagnant since the '90s, and that has created a community behavioral health system that is incapable of meeting the needs. He explains in greater detail the other obstacles facing membership and reiterates that the four things are: Medicaid rate grants; optional services; and the SHARP program.

MS. BURKHART continues that at the presentation in September an overview of budget reductions over the last five years was provided, and flat funding is reduced funding. She adds that this conversation about the initial rate adjustment and then the rate rebasement that is supposed to follow is all happening in the context of a system that has seen its value that was appropriated to erode over time because of that flat funding. She states that it is important, because of the nature of the state and the diversity of the communities and providers of behavioral health services vary from community to community and fluctuate over time. She

continues that it is important to talk about the need for change management and to manage expectation which requires a great deal of communication. It is also important to understand that there is a very reasonable level of anxiety and concern among providers and consumers about what is happening and what is going to happen. She wants to reinforce that the health of the system is not just about how much is paid for services or how well the providers are taken care of, or the folks that actually deliver the direct services, but we also need to be acknowledging and recognizing and managing expectations and change. She goes through and explains in greater detail.

CHAIR MICHAEL thanks Ms. Burkhart, and asks for any questions.

TRUSTEE SELBY appreciates the update and asks how their ability to take best practices from different centers around the state and share those with other folks, which give the whole idea of working smarter.

MR. CHARD replies that we have for-profits in tribal and nontribal, smaller and larger, in the room that meet twice a year face-to-face and we have monthly teleconferences. He states that he sees these connections happening all the time. He explains this more fully.

MS. BURKHART replies that they attempt to connect folks to things that are working through showcasing effective programs in the context of board meetings and other events. She gives some examples and highlights.

TRUSTEE SELBY asks if there is an organized effort on the data collection issue, to try to improve that and get that data collected.

MR. CHARD replies that the providers are approaching it from a different angle than some others. One of the things done was bringing Qualifax up to talk about clustering DHR users and similarly talking about clustering the accreditation folks so they can learn from each other using the same tools.

MS. BURKHART adds, because the Trust has allocated funds toward this, that the idea is that the information goes to a central repository and is pulled down to the stakeholder for reporting. She gives an example and thanks the Trust for the support.

TRUSTEE EASLEY asks Mr. Chard about the total amount of grant money he believes is at risk.

MR. CHARD replies that folks in Fairbanks were looking at a 25-percent reduction.

TRUSTEE EASLEY states that the problems that providers have with regulatory and paperwork requirements have been talked about and asks if there is a way to bring the Legislature into this problem and have them put some pressure on the agencies to relieve some of the requirements on the various organizations without reducing safety to the beneficiaries.

MR. CHARD replies that Representative Neuman is probably one of the legislators that is most interested in that topic. He also states that the Division of Behavioral Health and the Department

have made some serious overtures and efforts recently to revisit the streamlining initiative that the boards, providers, and the State worked on successfully back in 2014. He thinks that conversation will come out of the Legislature in working on the integration.

CHAIR MICHAEL thanks all and states that the trustees really care about what happens with the centers and we hope that all of this effort will integrate with everything that is going on with the consultants and the Department.

MR. JESSEE states that at the joint conference with the University, he is pleased to announce that Kathy Craft was given a national award for workforce advocacy from the Western Interstate Commission for Higher Education,.

(Applause.)

TRUSTEE EASLEY comments that she was impressed that the president of the University of Alaska spent the entire day with all of these organizations and introducing himself to people.

CHAIR WEBB asks Ms. Craft to give a brief talk on what happened yesterday.

MS. CRAFT states that about 100 faculty, staff, stakeholders, providers and practitioners all got together to talk about how the University can better help advance the behavioral health access initiatives and things that are going on in state government with the Department of Corrections and re-entry. She continues that it is a step in the right direction and will become a part of the president's strategic pathways. He is definitely committed to this, and it was a very good meeting.

CHAIR MICHAEL asks for a motion to adjourn.

TRUSTEE WEBB makes a motion to adjourn the Planning Committee meeting.

TRUSTEE NORENE seconds.

There being no objection, the meeting is adjourned.

(Planning Committee meeting adjourned at 11:12 a.m.)

MEMO

To: Mary Jane Michael, Planning Committee Chair
From: Katie Baldwin, Senior Program Officer
Date: December 8, 2016
Re: 1115 Waiver and Forensic competency evaluation and competency restoration services

The following document was prepared by Stephenie Colston, Trust consultant, in response to questions raised by Trustees during the August 10, 2016 Full Board of Trustee meeting. Trustee Webb inquired if the Medicaid 1115 Behavioral Health Waiver could address reimbursement of forensic and competency restoration evaluations. Ms. Colston has prepared the attached document and will be available during the December 12th Planning Committee for discussion.

MEDICAID AND FORENSIC EVALUATIONS

At the August 10, 2016 AMHTA Trustee meeting, the Chairman, Mr. Webb, asked Ms. Colston whether a Medicaid 1115 Waiver could address the reimbursement of forensic evaluations, specifically competency restoration evaluations. An additional question included whether said evaluations could occur in either an inpatient psychiatric setting or a community setting. Ms. Colston responded that the long-standing CMS IMD Exclusion policy would prevent API, for example, from receiving Medicaid reimbursement for forensic evaluations unless an 1115 Waiver authorized waiving the IMD Exclusion for API. Ms. Colston indicated that she would research the issue and get back with Mr. Webb. The short answer to the first question is yes—with caveats.

This question raises several contextual issues that are much broader than that of forensic evaluations, including the following:

1. Question--What has been Medicaid policy regarding justice-involved adults?

Answer--There have traditionally been ***limitations on Medicaid reimbursement for justice-involved individuals*** for a variety of reasons.

First, CMS policy regarding justice-involved individual has long been that incarceration alone does not make one ineligible for Medicaid. In addition, CMS has long held that individuals meeting State Medicaid eligibility criteria can be enrolled in Medicaid before, during, and after incarceration in jail or prison¹. However, most States have historically terminated Medicaid coverage for enrollees who become incarcerated—this, in spite of CMS encouragement that States suspend rather than terminate benefits during incarceration, due to the obvious delay in access to services cause by the need to re-apply for Medicaid benefits when terminated. The re-application process has traditionally been lengthy and time-consuming.

Second, federal law allows States to receive Medicaid reimbursement for inpatient services provided to incarcerated individuals by a hospital outside of a correctional facility. The IMD Exclusion obviously does not permit inpatient psychiatric hospitals with more than 16 beds to receive Medicaid reimbursement, so this provision relates only to general hospitals. However, few States have traditionally utilized this reimbursement mechanism². This may be because, as nondisabled adults without dependent children, justice-involved individuals simply did not meet States' categorical eligibility criteria, despite their low income. Thus, a small number of justice-involved individuals qualified for Medicaid reimbursement.

Third, many justice-involved patients requiring forensic evaluations (e.g., defendants hospitalized for competency restoration services, insanity acquittees, or those hospitalized for forensic evaluations) may not have met the threshold of medical necessity required for Medicaid reimbursement. However, when that threshold has been met, ***many States have allowed Medicaid reimbursement for***

forensic evaluations—typically when conducted by either a qualified psychiatrist or a qualified psychologist--and not provided in an IMD or correctional facility.

2. Question-- What changes have occurred since passage of the Affordable Care Act (ACA) that affect justice-involved individuals?

Answer—there are **several changes** that ACA spawned, including elaborating on long-standing Medicaid policies such as those mentioned in #1 above and removing some restrictions on covering justice-involved individuals after release.

First, CMS recently issued Guidelines on facilitating Medicaid reimbursement for justice-involved individuals³. The April 2016 Guidelines address how States can facilitate Medicaid enrollment before, during, and after an incarceration and make it clear that Medicaid is viewed as a mechanism to connect justice-involved individuals “to the care they need”⁴, whether those individuals are pre-incarceration, incarcerated, or post-incarceration (i.e., re-entering individuals, whether under community supervision or not).

Second, the ACA created an opportunity for States to expand Medicaid eligibility criteria to individuals under age 65 who earn up to 138% of the Federal Poverty Level (FPL), thus removing a key barrier that previously kept States from enrolling justice-involved individuals in Medicaid. As of today, 32 States have expanded Medicaid under the ACA, 6 of which used 1115 Waivers to do so (Arkansas, Indiana, Iowa, Michigan, Montana, and New Hampshire).

Third, the Guidelines make clear that benefits are extended to residents of state/local community residential facilities under correctional supervision (e.g., those in a halfway house).

Fourth, the Guidelines, while reiterating that States may not provide Medicaid coverage for health care services delivered to incarcerated individuals, make an exception for care delivered outside the correctional facility, such as at a hospital or nursing home, when a Medicaid-enrolled person has been admitted for 24 hours or more (off-site inpatient care). States that have expanded Medicaid eligibility under ACA are realizing the largest savings under this option because most inmates, as nondisabled adults without dependent children, are eligible only under the expansion. Payments for these newly eligible individuals triggers the enhanced federal match of at least 90%--Arkansas and Michigan are 2 of those States, reporting \$2.8 million and \$19 million in realized and projected savings.

3. What opportunities exist today—specifically relating to 1115 Waivers?

Answer—there are **many opportunities to increase Medicaid reimbursement for justice-involved individuals that exist relating to 1115 Waivers, HCBS Waivers, and State Plan Amendments**.

First, simply by expanding Medicaid eligibility to individuals under age 65 who earn up to 138% of the Federal Poverty Level (FPL), Alaska has laid the groundwork for increasing Medicaid reimbursement for justice-involved individuals. Requesting claims data from DHSS for individuals on probation or parole status would be a logical first step to determine the extent of existing service utilization and inform data-driven decision-making about next steps.

Second, justice-involved populations may or may not need to be specified in an Alaska 1115 Waiver application, depending on a number of factors:

- ✦ The benefit package proposed in the Waiver—for example, forensic evaluations in a community setting may be proposed,
- ✦ Whether or not a waiver of the IMD Exclusion for API is requested in the 1115 Waiver,
- ✦ Service utilization patterns of the justice-involved Expansion population—if SUD services are more utilized, it may be prudent to wait for the SUD amendment to address the needs of the justice-involved population at that time, and
- ✦ Prioritization of the population—1115 Waivers require budget neutrality and every eligible population and every proposed benefit has to have a cost associated to determine whether the neutrality threshold can be maintained.

Third, Medicaid approaches other than an 1115 Waiver should be considered—for example, the approach used by Texas in its 1915(i) HCBS Waiver for Adult Mental Health, which was approved by CMS in 2015 as a **State Plan Amendment**. Services can be provided to justice-involved individuals on probation or parole status.

In general, Medicaid State Plan amendments have the following features:

- ✦ There is no cost or budget requirement,
- ✦ The approval process generally takes 90 days, with the caveat that CMS can suspend that 90-day clock if more information from the State is required
- ✦ The duration of the approval is permanent, not time limited, unless another amendment proposed repeal of the amendment
- ✦ It is much easier from an administrative perspective
- ✦ Only optional services can be changes by SPA, not mandatory services
- ✦ There is no federal requirement that States post notices when they are changing their State Medicaid Plan.

Fourth, some States that have expanded Medicaid through an 1115 Waiver, Arkansas and Michigan as examples, now serve more justice-involved individuals. While not targeting justice-involved population in the Waiver application, these 2 States have achieved savings due to the off-site inpatient care option allowed under ACA, as mentioned above. In addition, there are lessons learned about accessing the substantial CMS Federal support available to assist State Medicaid Agencies in

meeting the needs of Medicaid-eligible justice-involved individuals. One example is the substantial Federal support that CMS has provided to upgrade State MMIS technologies if the existing MMIS hinders or prevents suspending eligibility or coverage for incarcerated individuals.

CMS clearly has signaled a change in its approach to justice-involved individuals who are eligible for Medicaid services. There are now many avenues available to increase Medicaid reimbursement for justice-involved individuals. It is an especially apt time for Alaska to take advantage of some of these opportunities, especially within the context of overall Medicaid and Criminal Justice reform efforts occurring within the State. It is recommended that several of the options mentioned in this document be considered (a State Plan Amendment in particular), not just the 1115 Waiver option.

Footnotes:

1. C. McKee, S. Somers, S. Artiga, *State Medicaid Eligibility Policies for Individuals Moving Into and Out of Incarceration*. Kaiser Family Foundation Issue Brief—August 4, 2015. <http://kff.org/report-section/state-medicare-eligibility-policies-for-individuals-moving-into-and-out-of-incarceration-issue-brief/>
2. The Pew Charitable Trusts. *How and When Medicaid Covers People under Correctional Supervision*. Issue Brief—August 2, 2016. <http://www.pewtrusts.org/en/research-and-analysis/issue-brief-how-and-when-medicare-covers-people-under-correctional-supervision>
3. Centers for Medicare & Medicaid Services, “To Facilitate Successful Re-entry for Individuals Transitioning from Incarceration to Their Communities,” Letter to State Health Officials, SHO # 16-007 (April 28, 2016). <https://www.medicare.gov/federal-policy-guidance/downloads/sho16007.pdf>
4. Ibid.

MEMO

To: Mary Jane Michael, Planning Committee Chair
From: Katie Baldwin, Senior Program Officer
Date: December 9, 2016
Re: **DRAFT process for approval of Trust funded Pre-development projects**

During the 2016 April finance committee Trustees approved allocation of \$75.0 toward the Pre Development (PreD) core operation cost from the total FY17 PreD fund of \$300.0. Trustees requested future Trust supported projects be presented to Trustees in advance for review and approval prior to commitment or expenditure of Trust PreD funds. Staff was requested to draft a process that supports advanced Trustee review that also coordinates well with existing PreD procedures in place for the PreD program. The following is an outline of the proposed internal “pre-review” process for consideration and discussion. If approved by Trustees, this process will be operationalized immediately.

- Senior Program Officer, serves on the Pre Development Oversight Committee and serves as the main Trust contact for capital requests seeking Trust sponsorship for admission to the PreD program. Staff has primary contact with organizations and vets the project with program staff and the Trust Land Office PRI staff as appropriate to ensure the organization meets the following criteria:
 - 1) The applicant organization’s primary mission is to serve Trust beneficiaries and can demonstrate through program mission and appropriate data that beneficiaries and families are the primary target population benefitting from the service.
 - 2) The organization provides critical services to Trust beneficiaries and there is reasonable evidence of community and key partner support for the program and services provided.
 - 3) The organization has presented a business plan which articulates a viable operating model.
 - 4) There is a clear budget and timeline for the planning effort for the project.
 - 5) The organization articulates a reasonable funding plan with potential funding partners to complete future stages of design and construction.
 - 6) There are other partners engage with the program and advocate for the project.
 - 7) Other PreD funding partners are supportive of the applicant and are vested in future capital funding when aligned with individual organization mission and funding priorities

If the project meets the criteria outlined above, staff will present the project to Trustees during an appropriate committee meeting or board meeting to seek approval to allocate Trust PreD funding.

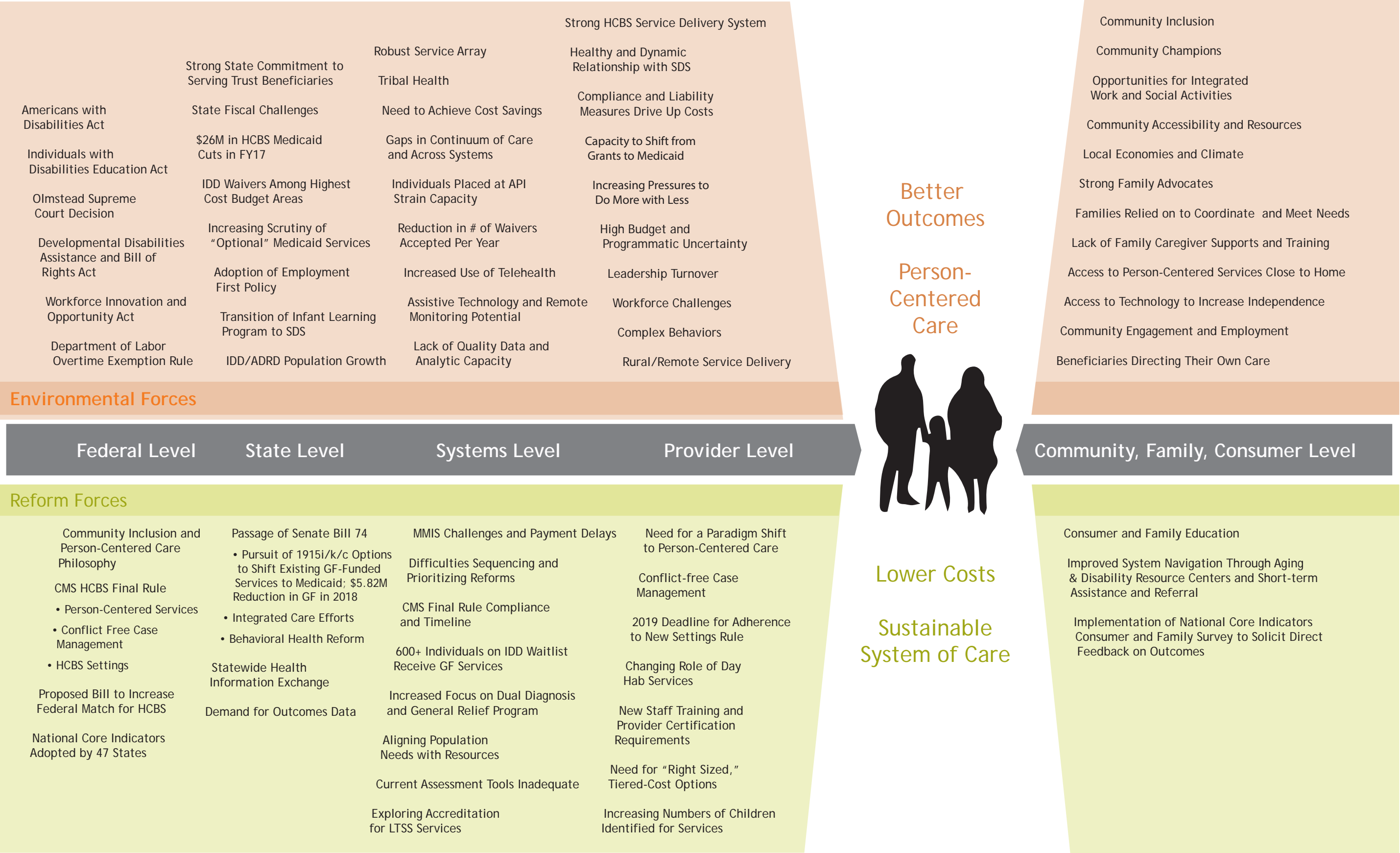
Trustees will be provided an overview of the applicant that addresses the 7 items as outlined above. In the event the review of the project is exigent, staff may engage Trustees via email or schedule a teleconference to discuss the project in order to meet more immediate timing needs.

Trustees will be provided regular updates on all Trust supported PreD projects during appropriate committee meetings.

In the event Trustee's decline support of a project moving forward, no Trust funding will be allocated through the Trust's PreD fund.

- **Recommend authorization of \$10.0 from existing PreD fund for project scoping.** PreD partners recognize there is a need for shared partner investment in a pool of funds to cover the cost of front end preliminary project scoping. This includes a relatively small pool of funds (recommendation is for each funding partner to contribute \$10.0) available to cover the expense for a PreD consultant with expertise in capital projects to have contact with the applicant agency to complete preliminary discovery on the project which is then compiled and shared with partner agencies, including the Trust, to make decisions about further PreD funding support. This is not a request for additional funding, rather a recommendation to allocate \$10.0 from existing project reserve (out of the remaining \$225) for this necessary front end project discovery.

Intellectual and Development Disabilities (IDD) Systems Assessment: Positive and Negative Forces Influencing the IDD System in Alaska



Beneficiary System Experience Mapping

Alaska Association on Developmental Disabilities (AADD) Face-to-Face Meeting 11/3/2016

'Person-centered planning is like a boat that takes you somewhere. The danger is that we get so focused on the boat, we lose sight of the destination.'

-David Pitonyak



Providers of disability services discuss the current beneficiary experience and envision what a truly person-centered experience would look like.

How do beneficiaries experience the system today? ➡ How would the experience change if the system were person-centered?	
ASSESSMENT AND PLAN OF CARE DEVELOPMENT	
Challenging to get connected to system, complex paperwork, deficit-approach, need services now but big delays, bumpy entry into system when families are in crisis <u>Emotions:</u> frustration, negative focus, overwhelming	STAR (Short-Term Assistance and Referral) coordinator conducts eligibility, person tells story one time, once eligible—focus is on goals & services (not re-evaluating if the person continues to have a disability), process is simpler, people get immediate access to support <u>Emotions:</u> relief, listened to, hopeful, empowered
INITIAL ENTRY INTO SYSTEM	
Choosing a care coordinator is overwhelming, ICAP (Inventory for Client and Agency Planning) process is consuming—necessity and purpose isn't clear, deficit-driven process, difficult to choose a provider, focus is on what provider can do instead of collaboration <u>Emotions:</u> confusion, trapped, lost, lack of understanding	Materials target different learners (i.e. videos to help choose care coordinators/providers), there's a road map to guide people through process, first question asked: what do you want and how can we help you get there? <u>Emotions:</u> ease, understanding
SERVICE DELIVERY	
Beneficiary may or may not participate in staff selection process, difficult if poor staff match—lack of relationship or low quality, often lack of alternative staff options, plan of care process is directed by the care coordinator <u>Emotions:</u> frustration	Person-centered planning takes several days, outcomes are meaningful lives, providers focus on staff/recipient relationship, staff is guide/voice/support/mentor <u>Emotions:</u> going in the direction person wants to go
EMPLOYMENT	
Where beneficiaries work is usually determined by agencies, beneficiaries don't have a lot of say in where they want to work—limited choices, comes down to providers connecting them to a job <u>Emotions:</u> disempowered, dependent	Expectation is that people will work, information is gathered about hopes and dreams, people are allowed the opportunity to fail—not kept in a bubble, concerns about people losing benefits are addressed <u>Emotions:</u> motivated
OVERALL	
No voice, we say person-centered but the beneficiary needs to think this way too, lack of information about self-determination, professionals make decisions instead of decisions driven by family and person <u>Emotions:</u> powerless, confused	A person's voice is translated into services with realistic expectations, providers are system translators—inform and then allow decisions to be made, supported decision-making empowers adults <u>Emotions:</u> empowered, shared responsibility, respected

MEMO

To: Mary Jane Michael, Planning Committee Chair
From: Jeff Jessee, Program Officer/Legislative Liaison
Date: December 8, 2016
Re: Requested project updates

In previous board meetings, trustees have requested more details on a number of efforts currently underway. Below is an update on issues related to Patient Grievance Procedures, Criminalization of Patients at API, and the recommendations prepared by the University of Nevada Las Vegas regarding specific areas in Alaska's Mental Health Statutes.

Patient Grievance Procedures

Trust staff, Alaska Mental Health Board, Advisory Board on Alcoholism and Drug Abuse, (the Boards) as well as the Disability Law Center (DLC) and the Department of Health and Social Services have been aware of the concerns raised by Faith Myers and Dorrance Collins and have worked with them for many years to improve grievance procedures for Trust beneficiaries in the mental health system. Appropriately, the Boards, DLC and the Department of Health and Social Services (DHSS) have often taken the lead with support from Trust staff. However, in certain circumstances, Trust staff initiated a number of meetings between Faith and Dorrance and other stakeholders.

Here is an outline of grievance-related activities undertaken by the Boards in direct response to their public comment, many of which had Trust staff participation and/or support.

- 2008: An ad hoc committee, which included two consumer members, was created to review all community behavioral health grantee grievance procedures. All agencies grievance procedures were reviewed for compliance with state and CMS standards. (This was before accreditation was required.) All but about three agencies were in compliance. The agencies not in compliance were forwarded to the Division of Behavioral Health (DBH) for technical assistance to help them come into compliance. Note: no complaints or public comment about Community Behavioral Health Center (CBHC) grievance procedures had been, or have been, received from active clients.
- 2008-2009: Andrea Schmook was the Boards' representative on the API Advisory Group. Due to Faith and Dorrance's persistent public comment about the hospital grievance policy, the Advisory Group: a) invited Dorrance to join as a member and b) undertook (with API management) updating the hospital's grievance procedure to better serve patients. Dorrance had direct input in that

- program improvement effort. Subsequent to that effort, the API Advisory Group had a Quality Improvement sort of subcommittee on which Andrea served. That committee met with API staff monthly to review patient grievances to ensure responsiveness and identify any persistent problems/trends. That process ended when Andrea retired in 2012.
- 2009-2010: Sen. Davis filed a patient grievance bill (SB 66) based on Faith and Dorrance's advocacy. It sought to codify the new API procedure as the standard for all mental health providers (not just hospitals). The Boards, Trust, and DLC all worked to shape that bill into something mutually acceptable to all stakeholders while also not imposing additional administrative layers on providers and consumers. The bill didn't pass.
 - 2011-2012: Sen. Davis filed another patient grievance bill (SB 55) based on Faith and Dorrance's advocacy. The Boards, Trust, and DLC all worked to shape that bill into something mutually acceptable to all stakeholders while also not imposing additional administrative layers on providers and consumers. The bill didn't pass.
 - 2014: Rep. Higgins filed a patient grievance bill (SB 66) based on Faith and Dorrance's advocacy. This is the bill that instigated the testimony and controversy involving Providence Hospital related to their treatment of a young man with a brain disease (like meningitis). The Boards, Trust, DLC, and the Alaska State Hospital and Nursing Home Association (ASHNHA) all worked to shape that bill into something mutually acceptable to all stakeholders while also not imposing additional administrative layers on providers and consumers. The bill didn't pass.
 - 2015: Based on new information from Dr. Ring about the situation at API as well as Faith and Dorrance's advocacy, the Boards provided a very public recommendation to the Board of Trustees about the need for trust staff to investigate and intervene in the issue of violence perpetrated against patients. (see below) The Boards also convened a meeting with every state entity that could possibly have oversight over API - and Faith and Dorrance - to see what sort of investigation and advocacy could be done from those angles. DLC agreed to provide more onsite staffing to help collect information and provide patients with a better avenue to outside advocacy.
 - November 2016: The Boards, Trust and DLC met with Faith and Dorrance and the API Advisory Group Chair (Brenda Moore) to establish a plan for identifying current problems and tailored solutions to those problems.

Trust staff will continue to work with Faith and Dorrance as well as the Boards, DLC and DHSS to ensure that patient rights are protected and pursue any necessary legislation and/or regulation changes.

Criminalization of Patients at API

Another critical issue that has been raised is that of API patients being criminally charged for their actions (usually alleged assaults against staff) while in custody at API to receive treatment for disabling psychiatric disorders. As Trustee Webb has stated: “Individuals with psychiatric disorders may be committed to State custody for treatment of those disorders precisely and only because they present a danger to themselves or others because of their conditions. Predictably, during the course of their treatment some of these patients exhibit aggressive or violent behavior toward hospital staff because of their illness - they are being treated precisely because of the likelihood of such behaviors.”

A disturbing increase in this criminalization pattern was reported in 2015 by a number of sources concerned about the trend including the Anchorage Police Department. Trust staff immediately investigated and came to believe that part of the issue was ongoing management/labor disputes in the hospital over staffing and work rules. Staff began to convene the relevant parties and collected extensive data on the number and disposition of these cases. Since this intervention we believe there has been a marked decline in the number of criminal justice referrals for API patients; staff has requested the latest data and will provide it to trustees as soon as it becomes available.

Review of Alaska Mental Health Statutes

The Trust commissioned University of Nevada Las Vegas (UNLV) work with leadership of the Criminal Justice Working Group (CJWG) – Title 12 Legal Competency subcommittee (T12 subcommittee), to conduct a complete review of Alaska's statutes governing commitments for determination of competency to stand trial and related involuntary civil commitments. Specifically, to conduct a comprehensive study of AS § 12.47.010–AS § 12.47.130 (Insanity and Competency to Stand Trial) and AS § 47.30.700–AS § 47.30.915 (Involuntary Admission for Treatment). In addition, the T12 subcommittee asked the UNLV team to review statutes related to mental competence evaluation and restoration for juvenile and misdemeanor offenders. Following is a timeline of activities to date on this important project.

- May 2014: The Trust, on behalf of the Criminal Justice Workgroup contracted to with UNLV to perform this work.
- Summer of 2014: UNLV began its review and analysis, and conducts information gathering interviews with identified key stakeholders.

- Fall 2014: UNLV began its review of Alaska’s legislative history, national best practices, and other states’ approaches to mental statutes.
- Spring of 2015: UNLV circulated the initial draft of the report to the T12 subcommittee and over the course of several months the UNLV team:
 - Met with the T12 Subcommittee (7x) to review the draft;
 - Held smaller meetings with members of the subcommittee (3x) to review specific sections of the draft; and
 - Met with other key individuals involved in the mental health and criminal justice system throughout the state to gather additional feedback on the draft.
- May 2015: The [Final report](#) was released to the T12 Subcommittee.
- August 2015: UNLV team made a formal presentation of the report to the full Criminal Justice Working Group. Members of the Alaska Criminal Justice Commission (the Commission), other state representatives, and members of the public were also present.
 - The Criminal Justice Working Group passed a motion to present the report and its recommendations to the Alaska Criminal Justice Commission to consider forwarding the report’s recommendations for statutory change to the legislature.
- January 2016: The Commission created a Behavioral Health workgroup (ACJC Behavioral Health workgroup) to look the intersection of the behavioral health system and the criminal justice system as well as to review the UNLV report and its recommendations.
- May - July 2016: ACJC Behavioral workgroup held six meetings. Over the course of these meetings the ACJC Behavioral workgroup:
 - Used the Sequential Intercept model to develop a comprehensive set of recommendations for system’s change.
 - Reviewed the UNLV report and its recommendations. However, timelines for having recommendations to the ACJC precluded a full analysis of possible recommendations. ACJC Behavioral Health workgroup requested that DHSS review the UNLV recommendations for fiscal impacts. Review to be complete by September 2017.
- August 2016: The ACJC Behavioral Health workgroup presented six recommendations to the Commission for its consideration.
- December 2016: The six recommendations presented are to be included in the Commission’s report to the legislature.

The reasons for the Commission not moving forward this session with UNLV’s full set of recommendations include:

- This next legislative session already lends itself to being very difficult and busy with major considerations, including: budget, revenue options, Medicaid reform, criminal justice reform.
- Some of the recommendations have fiscal note implications with insufficient time for full review of impacts; therefore gathering and analyzing this information is critical so all the information is included with the recommendations going into session.

Next Steps:

- The ACJC Behavioral workgroup will be meeting in January 2017 to further discuss the UNLV report and other identified areas for change.
- There are some recommendations that are non-controversial and no cost (changing the definition and requirements to be a “qualified” forensic examiner). The ACJC Behavioral workgroup will review the report for these “low hanging fruit” at the January meeting and work to attach any found to legislation or to find a sponsor.

Trust staff intend to continue to advance the recommendations in the report.

**RECOMMENDATION TO THE ALASKA STATE LEGISLATURE BY
THE ALASKA CRIMINAL JUSTICE COMMISSION**

Nos. 2-2016, 3-2016, 4-2016, 5-2016, 6-2016, 7-2016

Approved August 28, 2016 and October 13, 2016

Recommendations concerning behavioral health from the Criminal Justice Commission. The following recommendations are all intended to address the behavioral health needs of justice-involved individuals in Alaska. These recommendations were created by the Commission's Behavioral Health Working Group and approved by a majority of Commission members.

2-2016: Pre-trial Diversion for the behavioral health population. The Commission recommends that the Department of Corrections (DOC) establish a voluntary pretrial diversion/intervention option for Alaskans with behavioral health disorders within DOC's new Pretrial Services Program. This option would provide an alternative criminal case processing for Alaskan defendants charged with a crime that, upon successful completion of an individualized program plan, results in a dismissal of the charge(s).

Alaskans with behavioral health disorders account for more than 40% of Alaska incarcerations each year. The majority of those incarcerations are for misdemeanor offenses. Thus, the purpose of this diversion/intervention option is to enhance justice and public safety through addressing the root cause of the criminal behaviors of the defendant, reducing the stigma which accompanies a record of conviction, restoring victims, and assisting with the conservation of jail, court and other criminal justice resources. This diversion/intervention option shall develop individual diversion plans using a comprehensive behavioral health and criminogenic risk/needs assessment of the defendant to identify and address specific need(s) related to reducing future criminal behavior.

The Pretrial Services Program pretrial diversion/intervention option should create collaborative partnerships with treatment and other types of services in the community which have demonstrated effectiveness and the ability to provide culturally competent and gender-specific programming to the identified needs of the participant.

It is further recommended that the DOC Pretrial Services Program shall oversee and/or administer diversion services using either the Performance Standards and Goals for Pretrial Diversion/Intervention of the National Association of Pretrial Services Agencies, or other recognized evidence based standards for pre-trial diversion interventions.

The Commission also recommends that the Department of Corrections convene representatives from the Department of Public Safety, the Department of Law, the Alaska Court System, the Department of Health and Social Services, the Alaska Mental Health Trust Authority, the public defense bar, victims' rights groups, and local law enforcement as well as representatives from tribal and non-tribal community health and behavioral health systems to assist in the development and implementation of the diversion program. DOC and the convened representative should ensure that some Pretrial Services officers and tribal and non-tribal community service providers are trained to work with the behavioral health population and to ensure individuals are 1) swiftly identified for participation, 2) assured service priority and/or timely linkage to appropriate treatment and other services and 3) effectively monitored.

The Commission approved this recommendation unanimously.

3-2016: Allow defendants to return to a group home on bail. The Commission recommends amending AS 12.30.027(b), which involves bail conditions for those charged with crimes involving domestic violence.

The statute currently prohibits judicial officers from ordering or permitting a person charged with a crime involving domestic violence from returning to the residence of the victim of the offense for a period of 20 days. This statute affects individuals with behavioral health disorders who, as a result of their disorder, will sometimes lash out at or assault caregivers or other residents in an assisted living facility or similar group home. Under the current statute, these individuals would not be able to return home after committing the assault, and with nowhere to go, the individuals' behavioral health conditions will worsen. Often the victim of the assault – the caregiver or co-resident – is not opposed to the individual returning to live at the facility.

The Commission recommends amending the statute to allow defendants charged with assault on a co-resident or staff of an assisted living facility, nursing home, or other supported living environment to return to that living environment while on bail, provided the victim is given notice and the victim's safety can reasonably be assured.

This recommendation did not receive unanimous approval; Commissioner Steiner voted against it, concerned that the proposal did not extend to individuals with behavioral health disorders living in a family home.

4-2016: Information sharing. The Commission recommends that the legislature enact a statute creating a standardized Release of Information (ROI) form. Individuals with behavioral health needs (including those involved in the justice system) often experience delays or gaps in treatment when previous providers impose onerous requirements before releasing information.

The ROI should meet the requirements of Health Information and Portability Accountability Act (HIPAA), Title 42 CFR and state of Alaska health confidentiality laws. The statute should require that the release be universally accepted by all state funded agencies providing health and behavioral health services within the state of Alaska. This will ensure a swift and confidential information exchange about a person's identified behavioral health needs and the supports required to ensure public safety and to ensure that the individual remains in the community, in the least restrictive living environment.

The Commission approved this recommendation unanimously.

5-2016: Add behavioral health information to felony presentence reports. The Commission recommends that the legislature amend the relevant statutes and court rules to require that felony presentence reports discuss any assessed behavioral health conditions that are amenable to treatment, if such assessments exist, so that judges will have information on a defendant's behavioral health needs at sentencing. The reports should also include recommendations for appropriate treatment in the offender's community.

This recommendation did not receive unanimous approval; Commissioner Steiner voted against it, concerned that the requirement would engender more litigation due to confidentiality issues, or disputes over the content of the reports.

6-2016: Include the Commissioner of DHSS on the Commission. Given the significant number of justice-involved individuals with behavioral health needs, the Commission recommends including the Commissioner of the Department of Health and Social Services as a member of this Commission. Commission members feel that this would allow for easier communication and interaction with DHSS as it implements significant reforms related to justice reinvestment.

This recommendation did not receive unanimous approval; Commissioners Williams, Steiner, and Stanfill voted against it. Some were concerned that there would need to be another seat added in addition to the DHSS Commissioner to keep an uneven number of Commissioners, and that this would generate an unwieldy body with state agencies being disproportionately represented.

7-2016: Amend Alaska's mental health statutes. The Commission requests that the Commissioner of Health and Social Services, in concert with designated ACJC representation, review the proposed statutory changes recommended in the *Review of Alaska Mental Health Statutes* conducted by the University of Nevada Las Vegas (UNLV) under the direction of the Criminal Justice Working Group's Title 12 Legal Competency subcommittee (May 2015).

The UNLV study, funded by the Alaska Mental Health Trust, was commissioned by the Criminal Justice Working Group to review Alaska's statutes concerning competency to stand trial, guilty but mentally ill verdicts, not guilty by reason of insanity verdicts, and involuntary commitment. The UNLV team spoke to stakeholders in Alaska working in the field of behavioral health, studied national best practices and reviewed established and emerging research. The UNLV team then issued a report recommending amendment of key statutory provisions concerning behavioral health.

Since the UNLV report was issued in May 2015, several groups, including the Criminal Justice Working Group and the Alaska Criminal Justice Commission Behavioral Health Working Group, have reviewed the report and agree that at least some of the recommendations in the report should be enacted. However, implementing the recommendations would require a considerable effort on the part of the Department of Health and Social Services (DHSS), and neither working group wished to mandate these changes without DHSS's input. The Commission therefore recommends that DHSS work with the Commission to review the UNLV study.

The review shall include 1) an analysis of the proposed changes, 2) a statement of clear agreement on the language of the proposed amendments that enjoy major stakeholder support, 3) recommendations for how Title 12 and the Title 47 changes would fit into the proposed redesign of the State's behavioral health system and the Department's effort to propose an 1115 BH demonstration waiver to CMS by the middle of 2017. The report should be provided to the Commission no later than September 1, 2017.

To: Greg Razo, Chair
From: Judge Stephanie Rhoades and Jeff Jessee, Behavioral Health Workgroup Co-chairs
Date: August 22, 2016
Subject: Behavioral Health Workgroup statutory recommendations

Introduction

Below are six recommendations from the Alaska Criminal Justice Commission's Behavioral Health workgroup to the Alaska Criminal Justice Commission (the Commission) to consider for action. The recommendations were identified and developed by the Commission's Behavioral Health Work Group, a diverse set of stakeholders including commissioners of the Alaska Criminal Justice Commission, state department and division representatives, local law enforcement, rural and urban community behavioral health providers, the tribal health system and victim advocates. The workgroup met six times over the last three months and used the *Sequential Intercept Model* as the framework to identify assets, gaps and targeted intervention points to implement new or expand existing strategies to prevent persons with behavioral health disorders from contact with or provide for the appropriate diversion from Alaska's criminal justice system.

Recommendation 1:

Pretrial Services Program amendment – behavioral health diversion/intervention option

- a) The Alaska Criminal Justice Commission recommends that the legislature amend SB 91 to establish within the Department of Corrections' (DOC) *Pretrial Services Program*, a voluntary pretrial diversion/intervention option for Alaskans with behavioral health disorders. This option would provide an alternative criminal case processing for Alaskan defendants charged with a crime that, upon successful completion of an individualized program plan, results in a dismissal of the charge(s).

Alaskans with behavioral health disorders account for more than 40% of Alaska incarcerations each year. The majority of those incarcerations are for misdemeanor offenses. Thus, the purpose of this diversion/intervention option is to enhance justice and public safety through addressing the root cause of the arrest provoking behaviors of the defendant, reducing the stigma which accompanies a record of conviction, restoring victims and assisting with the conservation of jail, court and other criminal justice resources. This diversion/intervention option shall develop individual diversion plans using a comprehensive behavioral health and criminogenic risk/needs assessment of the defendant to identify and address specific need(s) related to reducing future criminal behavior.

The *Pretrial Services Program* pretrial diversion/intervention option shall create collaborative partnerships with treatment and other types of services in their community which have demonstrated effectiveness and the ability to provide culturally competent and gender specific programming to the identified needs of the participant.

It is further recommended that the DOC *Pretrial Services Program* shall oversee and/or administer diversion services following the *Performance Standards and Goals for Pretrial Diversion/Intervention, National Association of Pretrial Services Agencies* or other recognized evidence based standards for pre-trial diversion interventions. (attached)

Recommendation 1 (cont'd):

Pretrial Services Program amendment – behavioral health diversion/intervention option

- b) The Alaska Criminal Justice Commission recommends that the Department of Corrections convene representatives from the Department of Public Safety, the Department of Law, the Alaska Court System, the Department of Health and Social Services, the Alaska Mental Health Trust Authority, local law enforcement and representatives from tribal and non-tribal community health and behavioral health systems to assist in the development and implementation of the above recommended program to ensure that some Pretrial Services officers and tribal and non-tribal community service providers are trained to work with this target population. And, to ensure individuals are 1) swiftly identified for participation, 2) assured service priority and/or timely linkage to appropriate treatment and other services and 3) effectively monitored.

Recommendation 2:

Amend AS 12.30.027(b) – bail conditions for crimes involving domestic violence

- a) The Alaska Criminal Justice Commission recommends that AS 12.30.027(b), which prohibits judicial officers from ordering or permitting a person charged with a crime involving domestic violence from returning to the residence of the victim of the offense for a period of 20 days, be amended. The amendment language would allow defendants charged with assault on a co-resident or staff of an assisted living facility, nursing home, group home, other supported living environments and private residences to return to their living environment with notice to the victim and where provisions for the safety of the victim can be reasonably assured.

Recommendation 3:

Information sharing

- a) The Alaska Criminal Justice Commission recommends that the legislature enact a statute setting forth a standardized Release of Information (ROI) that satisfies the requirements of Health Information and Portability Accountability Act (HIPAA), Title 42 CFR and state of Alaska health confidentiality laws, and requiring that the release be universally accepted by all state funded agencies providing health and behavioral health services within the state of Alaska. This will ensure a swift and confidential information exchange about a person's identified relevant health and/or behavioral health disorder needs and supports required to ensure public safety and that the individual remains in the community, in the least restrictive living environment.

Recommendation 4:

Add behavioral health information and proposed conditions in felony presentence reports

- a) The Alaska Criminal Justice Commission recommends that the legislature amend the Alaska statute and court rule to require that felony Presentence Investigation reports include a section discussing assessed behavioral health conditions that are amenable to treatment along with specific recommendations for appropriate **treatment in the offender's** community.

Recommendation 5:

Establish legal and clinical eligibility standards for Alaska's Wellness and Drug Courts

- a) The Alaska Criminal Justice Commission recommends that the legislature enact a statute setting forth the legal and clinical eligibility requirements for Alaska's addiction therapeutic courts to encourage full utilization of their capacity.

Recommendation 6:

Amend Alaska's mental health statutes

- a) The Alaska Criminal Justice Commission requests that the Commissioner of Health and Social Services review the proposed statutory changes recommended in the *Review of Alaska Mental Health Statutes* conducted by the University of Nevada Las Vegas under the direction of the Criminal Justice Working Group's Title 12 Legal Competency subcommittee (May 2015). The review shall include a department fiscal analysis and impact of the proposed statutory changes recommended therein, including what recommendations could be funded through current resources or through new services developed and implemented through Medicaid reform and redesign. The report should be provided to the Commission no later than May 15, 2017.

Criminal Justice Commission
Behavioral Health Workgroup
Comprehensive Recommendations

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Introduction

The Alaska Criminal Justice Commission Behavioral Health Workgroup (BHWG) met six times between the months of May – August 2016. This was a diverse set of stakeholders including commissioners of the Alaska Criminal Justice Commission, state department and division representatives, local law enforcement, rural and urban community behavioral health providers, the tribal health system and victim advocates. The BHWG utilized the ***Sequential Intercept Model*** (SIM) to map and **assess the interface between Alaska’s criminal justice and community behavioral health systems** at specific points in the criminal justice process. This assisted the BHWG identify **assets, barriers, and gaps of Alaska’s criminal justice and community behavioral health programs and practices** for persons with mental health disorders. Ultimately, the model assisted the BHWG identify recommendations for system and program improvements at each intercept point of the criminal justice process. **Using the BHWG’s collective judgment, each recommendation was then placed in one or more of three categories: statutory, policy, and funding.** The assigned category indicates what the BHWG thought would be required to implement the specific recommendation.

What is the Sequential Intercept Model (SIM)?

Developed by Mark R. Munetz, MD, and Patricia A. Griffin, PhD, in conjunction with the GAINS Center, the ***Sequential Intercept Model*** provides a conceptual framework for communities to organize targeted strategies for justice-involved individuals with behavioral health disorders. Within the criminal justice system there are numerous intercept points — opportunities for linkage to services and for prevention of further penetration into the criminal justice system.

The ***Sequential Intercept Model*** has been used as a focal point for states and communities to assess available resources, determine gaps in services, and plan for community change. These activities are best accomplished by a team of stakeholders that cross over multiple systems, including mental health, substance abuse, law enforcement, pre-trial services, courts, jails, community corrections, housing, health, social services, peers, family members, and many others.

Alaska has experience and a history of using this model to periodically assess how justice-involved individuals with behavioral health disorders come into initial contact with the criminal justice system, how the system is serving and meeting their needs, and what interventions should be implemented to reduce the numbers of incarcerated Alaskans with behavioral health **disorders. Many of Alaska’s current systems, policies, and programs focused on this issue were identified through the use of this model.**

Summary of Recommendations

Categorization key: S—Statutory; P—Policy; F—Funding

SEQUENTIAL INTERCEPT 1: LAW ENFORCEMENT

- ☐S ☐P ☒F Provide Crisis Intervention Training (CIT) training for more dispatchers to identify calls involving persons with behavioral illness and refer to designated, CIT trained police.
- ☐S ☒P ☒F Train all police and public safety officers in the state to respond to calls where behavioral illness may be a factor either through CIT training or Mental Health First Aid training.
- ☐S ☒P ☒F Provide service linkages and follow-up services to individuals with behavioral illnesses who are identified to be at high risk of criminal justice involvement.

SEQUENTIAL INTERCEPT 2: INITIAL DETENTION / INITIAL COURT HEARINGS

- ☒S ☐P ☐F Implement formal information collection, documentation and sharing process between criminal justice and health and social service agencies (governmental and non-governmental) around cases involving people with serious disorders that begins with first responder contact and continues through the life of the criminal case that do not impair criminal justice rights.
- ☐S ☒P ☒F Expand the use of Jail Navigators to identify and help plan, coordinate bail release and link medically fragile/complex (like dementia; seriously mentally ill) expeditiously to natural supports in the community.
- ☐S ☒P ☐F Provide uniform screening and consistent treatment for substance abuse disorders.
- ☒S ☒P ☒F Implement a statewide jail diversion program for persons with serious behavioral health disorders

SEQUENTIAL INTERCEPT 3: JAILS / COURTS

- ☐S ☒P ☒F Assure mechanism for the Department of Corrections (DOC) or Alaska Psychiatric Institute (API) to provide services consistent with community and public health standards, including appropriate psychiatric medications for the gravely disabled.
- ☐S ☐P ☒F Expand specialty courts (mental health and addiction) where the jurisdiction and community can support them.
- ☐S ☒P ☐F Implement Centralized Competency Calendar in each district, which could also serve as a clearing house for serious cases flagged by DOC for expedited consideration by the parties.
- ☐S ☒P ☒F Enroll all Medicaid eligible incarcerated individuals to receive or be reinstated with Medicaid benefits upon release.

- ☒S ☐P ☒F Ensure State Medicaid and Criminal Justice reform efforts to fund community based jail diversion services and supports, and include Medicaid reimbursement for those services utilized by specialty court participants.

SEQUENTIAL INTERCEPT 4: REENTRY

SEQUENTIAL INTERCEPT 5: COMMUNITY CORRECTIONS

- ☒S ☒P ☐F Create a universally accepted Release of Information form that is compliant with HIPAA, 42 CFR and state confidentiality laws and require that all agencies accept the release.
- ☐S ☒P ☐F Improved data sharing between across community providers and with DOC for identification, service and evaluation purposes.
- ☐S ☒P ☒F Conduct community specific assessment of reentry service needs in order to obtain or support funding.
- ☐S ☐P ☒F Expand community coalitions to other communities with a correctional institution to maintain linkages to a continuum of care for reentrants.

Sequential Intercept 1: Law Enforcement

ASSETS

- Crisis Intervention Training (CIT) and Mental Health First Aid Training (MHFA)—especially tailored to police—has proven effective for dispatchers and police to help: understand the dynamics surrounding police calls that involve people with serious behavioral health challenges, to de-escalate them more effectively, to reduce harm to all and to divert respondents to community resources in lieu of jail where possible.
- Alaska statutes allow for involuntary 12 hrs. protective custody holds for persons incapacitated by alcohol or involuntary mental health commitments for persons who present an eminent a danger to themselves or others
- Rural areas:
 - A limited number of rural communities employ Behavioral Health Aides, who are often the only local provider. These individuals available 24/7 to co-respond to calls together with a public safety officer or to respond alone when personal safety is ensured.
 - On occasion, some rural communities organize all available resources (e.g., VPSOs, Tribal Police, Police Department, Mental Health Clinician, BHAs and Families) to develop comprehensive supports and a community safety net around **“high need individuals”**—including for instance, ongoing welfare checks to prevent manifestation of lifetime behavioral health illnesses. In return, coordinated efforts help maintain the individual to remain in the community other than exposing them into what started as a mental health/substance abuse problem into becoming a legal issue.
 - Bethel has a Sobering Center for persons incapacitated by alcohol or other drugs to be taken into protective custody. Nome has an emergency shelter team (N.E.S.T.) that operates during identified winter months.
- Urban areas typically have capacity in one or more of the following:
 - hospital emergency rooms
 - sleep off centers
 - detox beds
 - community respite centers
 - domestic violence shelters

BARRIERS AND GAPS

- **The process of collecting and sharing information about the person’s condition for** referral to and to preserve a continuity of care is incomplete and inconsistent.
- Dispatchers can sometimes resolve calls involving serious behavioral illnesses without dispatching an officer. However, often these callers call police many times, tying up the 911 lines. It takes a considerable period of time to resolve a behavioral health crisis by phone, when it can be done. If it cannot be done, there is no behavioral health response that can be directly dispatched to a call. It is police policy to dispatch officers to these calls.
- Police experience community pressure to remove nuisance offenders from the streets. There is particular pressure from the urban business community to remove people who experience chronic behavioral health problems from around their businesses because they discourage potential customers.

- Police perceive that mental health disorders are misunderstood by the public and that there are few tools to removing behaviorally challenging people who are nuisances but are not breaking the law. For those who do, arrest for nuisance crimes relieves community pressure.
- Many current behavioral health assets:
 - are delivered in models that do not prevent criminal justice involvement for persons who are non-voluntary, such as homeless people with mental illness or substance dependence, those with antisocial tendencies.
 - do not exist in rural areas or lack capacity in urban ones.
 - do not retain people long enough to solve the community **or the individual's** problems. They end up back on the street swiftly, they are untreated and engage in the same behaviors.
- Title 47 involuntary mental health civil commitments require meeting high legal standards, the stays are too brief and the person is returned to the community in an unstable condition, where arrest requires a lower legal standard.
- **There is not a 'warm enough' hand off from acute high level care** (corrections or psychiatric) to community behavioral health.

PROGRAM EXAMPLES

Memphis, Tennessee – Crisis Intervention Training Model

Police leaders, mental health professionals and advocates, city hall officials, and other key stakeholders were spurred to action following a tragic incident in which an officer killed a person with a mental illness. In response, the Memphis Police Department established the first law enforcement-based CIT in 1988, which was designed to improve safety during these **encounters by enhancing officers' ability to de-escalate** the situation and providing community-based treatment alternatives to incarceration.

Los Angeles and San Diego, California – Co-Responder Model

Initiative leaders recognized that officers encountered many people with mental illnesses who were not receiving adequate treatments and services. To address this problem, law enforcement agencies collaborated with the mental health community to form teams in which officers and treatment professionals respond together at the scene to connect these individuals more effectively with community-based services.

**This summary of the Memphis and Los Angeles /San Diego models was drawn from Melissa Reuland, Laura Draper, and Blake Norton, Improving Responses to People with Mental Illnesses: Tailoring Law Enforcement Initiatives to Individual Jurisdictions, Council of State Governments Justice Center (2010)*

See also: Statewide Law Enforcement/Mental Health Efforts: Strategies to Support and Sustain Local Initiatives, Council of State Governments Justice Center (2012)

BEHAVIORAL HEALTH WORKGROUP RECOMMENDATIONS

Categorization key: S—Statutory; P—Policy; F—Funding

- ☐S ☐P ☒F Provide CIT training for more dispatchers to identify calls involving persons with behavioral illness and refer to designated, CIT trained police.
- ☐S ☒P ☒F Implement a mental health response that dispatchers could directly dispatch in lieu of or with police.
- ☐S ☒P ☒F Train all police and public safety officers in the state to respond to calls where behavioral illness may be a factor either through CIT training or Mental Health First Aid training.
- ☐S ☒P ☒F Provide a police-friendly drop off at local hospital, crisis unit, or triage center, or mobile crisis mental health response for direct dispatcher or police referral/drop off that can motivate non-voluntary admissions to engage in treatment or referral to treatment and other resources.
- ☒S ☐P ☒F Mandate Assertive Community Treatment for high risk persons who refuse treatment.
- ☐S ☒P ☒F Provide service linkages and follow-up services to individuals with behavioral illnesses who are identified to be at high risk of criminal justice involvement.

Sequential Intercept 2: Initial Detention / Initial Court Hearings

ASSETS

- Officer-collected information is sometimes transmitted to magistrate and jails. This information can help move the case toward medical and mental health treatment in DOC and toward an available specialty court. This is especially true when CIT trained officers are involved.
- Magistrates, arraignment judges and DOC can directly refer cases to the mental health courts.
- DOC screens for mental illness within 24 hours of arrest with evidence based tool, later for substance use disorders.
- Inmates who screen positive are referred to medical and mental health for treatment.
- Jail Navigator position in Anchorage employed by one of the largest community mental health centers provides early targeted identification, information sharing, treatment continuity and swift discharge planning for exiting inmates.
- Alaska judges have had some judicial training in mental health and substance use disorders.
- Centralized Competency Calendar in Anchorage uses limited forensic resources efficiently and expedites cases into specialty court when appropriate.

BARRIERS AND GAPS

- **The process of collecting and sharing information about the person's condition for referral and continuity of care is incomplete and inconsistent.**
- Once criminal charged is filed against a person, criminal justice culture militates in favor of processing the case toward a legal resolution rather than a treatment diversion.
- Domestic violence assault statute often results in seriously mentally disabled co-residents of Assisted Living Facilities (ALFs) who are charged with assault being removed from their only housing option.
- Committing magistrates have no civil legal alternatives to divert to treatment (civil instead of criminal commitment).
- The lack of a formal jail diversion program option.
- No legal or other mechanism to bring cases to the attention of the court or counsel for expedited attention.
- **Even when bail is set very low, people with serious disorders are indigent and can't post bail.**
- Some or all public **guardians won't post money for bail.**
- It is hard to locate natural supports for the inmate – (public guardian, family, treatment provider, etc.) to assist them to make bail.
- Communication issues: we may not know there is a problem or that the individual may have a guardian.
- Incarcerated persons can be poor historians **or can't answer questions** accurately or thoroughly.
- DOC lacks a comprehensive, integrated electronic database and health record.
- DOC has no mechanism to communicate information statewide to legal parties and limited ability for referrals or to expedite referrals.

- The barriers to sharing information include confidentiality and HIPAA. Defense attorneys may not perceive that the client benefits from mental health processes once **initiated. PD's don't like DA and DOC talking to inmates.**
- No immediate access to an advocate to help inmate navigate bail and reconnect with natural supports – arraignment not held for 24 hours and sometimes days, if the inmate is unstable.
- Pre-trial inmates with serious disorders are excluded from placement at Community Residential Centers (CRCs), as there is no mental health staffing.
- Large court calendars decreases a judges ability to identify of people with serious disorders.
- Judicial officers and lawyers are not well trained in identifying people with serious disorders. Even if trained, defense attorneys are not present at arraignment to identify
- Future court dates are often not calendared for weeks, leaving some inmates to languish since they do not self-advocate well for release.
- Some defendants may not be transported for days due to their mental health status.
- Systemic issues related to legal competency include:
 - lack of forensic capacity to perform evaluations, which can take longer in some cases than a person would be sentenced to even if found guilty,
 - limited hospital capacity for restoration capacity, and
 - high jail cyclers who are found not competent, not capable of restoration are evaluated over and over again in each new case.
- Substance Use disorders not screened swiftly or uniformly.
- Substance abuse treatment is not consistently available to pretrial inmates.
- The Jail Navigator position is only available in Anchorage.
- Early advocacy for the incarcerated person is unavailable or not utilized.
- No sub-acute long term or community based treatment alternatives for persons found Incompetent/Non-Restorable in a criminal case or others unaccepting of treatment.

BEHAVIORAL HEALTH WORKGROUP RECOMMENDATIONS

Categorization key: S—Statutory; P—Policy; F—Funding

- | | | | |
|---------------------------------------|---------------------------------------|---------------------------------------|--|
| <input checked="" type="checkbox"/> S | <input type="checkbox"/> P | <input type="checkbox"/> F | Amend the Alaska criminal statutes so that seriously mentally disabled persons charged with less serious assaults on Assisted Living or Nursing Facility co-residents or live in staff are not automatically ordered out of their only housing option. |
| <input checked="" type="checkbox"/> S | <input type="checkbox"/> P | <input type="checkbox"/> F | Implement formal information collection, documentation and sharing process between criminal justice and health and social service agencies (governmental and non-governmental) around cases involving people with serious disorders that begins with first responder contact and continues through the life of the criminal case that do not impair criminal justice rights. |
| <input type="checkbox"/> S | <input checked="" type="checkbox"/> P | <input checked="" type="checkbox"/> F | Expand the use of Jail Navigators to identify and help plan, coordinate bail release and link medically fragile/complex (like dementia; seriously mentally ill) expeditiously to natural supports in the community (this could be part of a pre-trial services and/or jail diversion effort). |

- ☐S ☒P ☐F Implement uniform screening, evidence-based, consistent and culturally responsive treatment for substance abuse disorders.
- ☒S ☒P ☒F Implement a statewide jail diversion program for persons with serious behavioral health disorders through the newly established DOC Pre Trial Services Division, or other means. Any program should:
- identify eligible persons for diversion or needing treatment in jail through a validated instrument or by matching data from existing information systems;
 - any screening at a jail or at a court should be completed by designated prosecutors, defense, judge/court staff and service providers;
 - and, there should be specially trained pre-trial service staff to link to comprehensive services, prompt access to benefits, health care, and housing and monitor the person in the community.
- ☒S ☐P ☒F Ensure State Medicaid and Criminal Justice reform efforts fund community based jail diversion services and supports.
- ☐S ☒P ☐F Provide mechanism for DOC to alert courts without a therapeutic court that a person may be demonstrating symptoms that place competence for legal proceedings in question or that the case is in need of other problem solving.

Sequential Intercept 3: Jails / Courts

ASSETS

- There is some treatment provided in jail.
- Anchorage has a Centralized Competency Calendar.
- DOC can identify cases:
 - to a therapeutic court in Anchorage, Palmer, or Juneau and
 - to **Anchorage's** Centralized Competency Calendar.
- Mental health courts identify and expedite cases. For example:
 - identifying people with mental illness from arraignment lists
 - screening for legal competency
 - expediting cases for defendants to meet their attorney
- SB91 and SB74 – Criminal Justice and Medicaid – reforms will allow all defendants better access to out-patient treatment and those receiving treatment through therapeutic court programs and could also support those in a jail diversion program in the future.

BARRIERS AND GAPS

- **The process of collecting and sharing information about the person's condition for referral and continuity of care is incomplete and inconsistent.**
- Jail cannot treat the gravely disabled person. For example:
 - a gravely-disabled person can be 6 weeks out from their next (misdemeanor) court hearing
 - medication as a treatment tool is difficult because, Loughner (9th Circuit) held **that government's interest in being healthy enough to be determined to be competent to stand trial but that Loughner's right to be free of unwanted drugs overrode those considerations**
- There is insufficient treatment available for cases in pretrial status, for example:
 - lack of some basic group interventions
 - lack of open groups on substance abuse for those who are pretrial
- Most access to treatment services within correctional facilities is for individuals with a case in post sentence status and who will be incarcerated for at least 90 days.
- Once in the institution, individuals lose the connection they had to community treatment and might go from 2-3x a week programming to nothing.
- Community-based providers do not 'in-reach' because they can bill Medicaid for those services.
- Once a person with an appointed public guardian is incarcerated, **public guardians 'take a break'**, this severs **the person's only connection to the community**.
- Pre-trial inmates with serious behavioral health disorders are excluded from placement at Community Residential Centers (CRCs), as there is no mental health staffing.
- There is no mechanism for DOC to expedite case for court/counsel attention.
- API is not timely in accepting forensic commitments.
- Therapeutic courts are not available in all jurisdictions, defense and prosecutors are not utilizing them to their capacity due to limiting legal or clinical criteria or the personalities of the lawyers involved.
- Therapeutic courts may be too restrictive, denying participation to adjunctive medication users.

- Sentencing courts receive little information about **a defendant's existing behavioral** health needs and do not know how to structure behavioral health treatment conditions.
- Behavioral health sentencing requirements are not driven by assessment.
- Access to treatment as a court condition is limited and costly.
- Court orders can be unnecessarily very restrictive i.e. bail amounts, third party and housing requirements.
- Even small monetary bail amounts often keeps people in jail.
- There is insufficient treatment capacity within correctional facilities.
- Lesser restrictive settings (CRC) are unavailable.
- Jail diversion is unavailable systematically.
- No access to treatment for persons with a grave disability within correctional facilities.
- Insufficient forensic examination and hospital competency restoration capacity.
- Lack of access to therapeutic court alternatives statewide and underutilized capacity in some existing therapeutic courts.
- **Judges don't have enough information or knowledge to structure** appropriate behavioral health treatment conditions.

PROGRAM EXAMPLES

San Antonio, Texas – Blueprint for Success: The Bexar County Model—How to Set Up a Jail Diversion Program in Your Community

Through its unique position within the criminal justice system, the jail diversion program offers immediate alternatives to incarceration for the mentally ill. Jail diversion is accomplished by applying a step-by-step methodology:

1. identify individuals with mental illness along the criminal justice process, and
2. integrate the appropriate social and health care services and make them available to these individuals for referral.

Perhaps most significantly for the community is the establishment of crisis care centers in conjunction with jail diversion programs. These centers reduce emergency room use, resulting in significant savings for the community. For Bexar County alone, jail diversion programs leading up to the creation of the Crisis Care Center brought about a savings of nearly 5 million dollars in 2006. Police officers were freed from the enormous amounts of time spent waiting in the emergency room for screening and triage of mentally ill patients under their protection. This allowed a quick return to their duties within the community. Before the establishment of crisis care centers, police officers in Bexar County spent an average of 12 to 14 hours in hospital emergency rooms waiting for psychiatric evaluations. Today, the crisis care centers provide these same services in one hour.

Jail diversion programs reduce monetary costs to the community and they improve the quality of life for consumers, which arise from inadequate mental health services or even a total lack of mental health services within the prison system. Jails are not designed to provide the necessary facilities to serve the emotional and medical needs of the mentally ill. Jail diversion programs redirect mental health consumers toward the mental health service system where they and society are better served.

Jail diversion programs offer judges and prosecutors much needed alternatives for disposing cases involving the mentally ill. At one time, incarceration of these individuals was the only

choice, but now those in need of treatment can be placed outside the criminal justice system. Jail diversions make more jail and prison space available for violent offenders, thus enhancing public safety. These programs interrupt the endless cycle of arrest-jail back to street for many of the non-violent mentally ill who become caught up in the criminal justice system without hope of treatment.

For nearly 30 years since their inception, jail diversion programs have enjoyed wide support for their ability to reduce involvement in the criminal justice system by the mentally ill and those with substance abuse disorders. Surprisingly, to date there are few studies documenting the effectiveness of these programs. Those studies that do exist, however, demonstrate the success of diversion programs. In a 1995 Los Angeles investigation, of 101 diverted individuals, 80 were transported to a hospital with 69 remaining as mental health inpatients and only two ultimately ending up in jail. Another study of a jail based diversion program in Rochester, New York found that in the year following intervention there was a mean reduction in the number of jail days by more than half.

In a multi-site research initiative sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 1997, the well-being of mentally ill individuals improved on a number of measurable points. This includes reduced days spent in psychiatric and residential treatment facilities, more time back in the community, improved mental health symptoms over time, **“and more mental health treatment being received by the diverted group. Finally, in a review of four programs, two reported no savings; however, New York City reported \$6,260 in savings per individual due to reduction in jail time, and Memphis, Tennessee reported \$5,855 in savings. SAMHSA’s conclusion was that jail diversion ‘works’ by reducing jail time and offering the potential of community savings.**

BEHAVIORAL HEALTH WORKGROUP RECOMMENDATIONS

Categorization key: S—Statutory; P—Policy; F—Funding

- | | |
|--|---|
| <input checked="" type="checkbox"/> S <input type="checkbox"/> P <input checked="" type="checkbox"/> F | Implement a statewide jail diversion program for persons with serious behavioral health disorders through the newly established DOC Pre Trial Services Division, or other means. Any program should: <ul style="list-style-type: none"> - identify eligible persons for diversion or needing treatment in jail through a validated instrument or by matching data from existing information systems; - any screening at a jail or at a court should be completed by designated prosecutors, defense, judge/court staff and service providers; - and, there should be specially trained pre-trial service staff to link to comprehensive services, prompt access to benefits, health care, and housing and monitor the person in the community. |
| <input type="checkbox"/> S <input type="checkbox"/> P <input checked="" type="checkbox"/> F | State Medicaid and Criminal Justice reform efforts must collaborate to fund community based jail diversion services and supports. |

- ☐S ☒P ☐F Establish lesser restrictive CRCs for people with serious mental disabilities or create regional or multiple CRCs that just serve people with serious mental disabilities. Perhaps adding medications management capacity to existing CRCs so they can serve a broader cross section of people would be a better strategy.
- ☐S ☒P ☒F Assure mechanism for the Department of Corrections (DOC) or Alaska Psychiatric Institute (API) to provide services consistent with community and public health standards, including appropriate psychiatric medications for the gravely disabled.
- ☐S ☐P ☒F DOC should widely offer therapy approaches addressing criminogenic thinking/behavior along with other evidence based therapies.
- ☒S ☒P ☐F Review therapeutic court criteria and referral processes, examine reasons for underutilization and remove barriers to maximize use of therapeutic court capacity.
- ☒S ☒P ☐F DOC and Court system should collaborate on Addictions courts referrals.
- ☐S ☐P ☒F Expand therapeutic courts (mental health and addiction) where the jurisdiction and community can support them.
- ☐S ☒P ☐F Mental Health Court users should receive service priority in community based services to motivate participation and promote timely linkage.
- ☐S ☒P ☐F Pre-sentence reports should include relevant behavioral health information and specific proposed treatment conditions.
- ☒S ☐P ☐F Dispositional Courts should only order assessment driven treatment conditions.
- ☐S ☒P ☐F Implement Centralized Competency Calendar in each district, which could also serve as a clearing house for serious cases flagged by DOC for expedited consideration by the parties.
- ☒S ☐P ☒F Expand forensic capacity for examination and restoration.
- ☒S ☒P ☐F Medicaid Reform efforts to include requesting a 1115 Medicaid Waiver to benefit people with serious behavioral disorders involved in the justice system. [This is one type of available waivers authorized by the Social Security Act, giving the DHHS Secretary authority to approve experimental, pilot, or demonstration projects that promote the objectives of Medicaid. The 1115 Waiver will be a central piece of the DHSS Behavioral Health Reform and Redesign efforts, allowing the state to expand services covered by Medicaid, the way services are offered and how costs/payments will be structured.] Alaska has not yet made the decisions about what specifically we will request in our 1115 waiver request.

☒S ☒P ☐F Medicaid reform efforts should include Medicaid reimbursement for those services utilized by therapeutic court participants.

☒S ☒P ☒F Enroll all Medicaid eligible incarcerated individuals to receive or be reinstated with Medicaid benefits upon release.

Sequential Intercept 4: Reentry

Sequential Intercept 5: Community Corrections

ASSETS

- DOC has the APIC (Assess, Plan, Identify, Coordinate) reentry and discharge planning program for inmates with psychotic disorders.
- **Dept. of Health and Social Services' (DHSS)-Alcohol Safety Action Program (ASAP)** conducts in-reach into DOC.
- There is a 24-7 monitoring program.
- The Anchorage jail coordinates with the Narcotic Drug Treatment Center.
- There is a community mental health provider embedded in the Anchorage jail complex to identify persons booked into the jail with a mental illness.
- **A defendant's Offender Management Plan (OMP)** identifies community treatment needs and supports.
- The Anchorage Prisoner Reentry Center provides reentrants with referrals to housing, treatment, employment, probation officers and other supports and services.
- The local reentry coalitions assist and partner with DOC and the returning citizen in the reentry planning, release and connection to community services/resources.
- The Dept. of Corrections has the Institutional Discharge Program-Plus. This program assigns a specialized probation officer to persons with a severe and persistent mental illness (SPMI) in specific locations.
- There is increased coordination between homeless shelters and DOC.
- There is improved collaboration between DOC and community based providers in some locations.
- DOC is making efforts to enroll inmates in Medicaid.
- There is improved communication between the Court and DOC regarding upcoming discharges (mental health court/centralized competency calendar in Anchorage).
- The Bethel Public Defender and Alaska Legal Services Inc. are piloting a holistic defense project connecting civil and criminal representation as well as social service supports around the defendant.

REENTRY BARRIERS AND GAPS

- **The process of collecting and sharing information about the person's condition for** referral and continuity of care is incomplete and inconsistent.
- A high percentage of jail **inmates are in a "pre-trial" not sentenced status;** therefore, a release date is not known.
- Discharge planning and reentry assistance does not occur in most cases.
- For inmates who had Medicaid and Social Security benefits prior to incarceration those benefits are suspended after 30 days of incarceration and may not be reinstated prior to release and can take several months before being reinstated.
- Comprehensive, collaborative discharge planning can be further complicated because **service providers often don't know their clients are in jail.**
- There is a lack of housing options for returning citizens reentering the community.
- There is a lack of employment opportunities or pro-social meaningful volunteering or day activities.

- There is insufficient treatment capacity and/or timely acceptance to services (waiting lists).
- There is insufficient access to medical and dental treatment.
- There is generally a lack of individual medication continuity between DOC, API, and community providers upon release.
- There is less than adequate supply of medications upon release from DOC or API for mental health conditions.
- Updated assessments performed by DOC or API (mental health, substance abuse, criminogenic, etc.) generally do not follow the inmate into the community.
- A lack of universal release of information that is accepted by all agencies. Some are HIPAA and 42 CFR compliant, some are not. Some agencies only accept their own release.
- Rural reentrants are unable to return to home community because some court ordered treatments are only available in urban areas.
- Access to transportation is challenging.
- An individual may lose their ID and personal property during periods of incarceration.
- Limited access to new personal identification upon release
- Lack of advocacy for persons experiencing a disability, have literacy or communication challenges and/or without the financial or personal relationship (family/friends) resources to assist in navigating the criminal justice system.
- On-going periods of institutionalization can create learned helplessness for some individuals.
- There is a lack of current individual diagnostic/assessment information.
- There is stigma and some community resistance to welcoming released individuals back into their home community.
- There is a lack of mental health and co-occurring substance abuse treatment/case management for those without psychotic disorders
- For people with intellectual development disabilities – lack of information as to exactly what are the problems/needs at the time of sentencing.
- Barrier crimes
- There is insufficient access to culturally appropriate treatment.
- Treatment often does not accommodate for varying levels of literacy and comprehension.
- In rural communities lack of housing is an eventer greater barrier.
- There is inadequate release communication and coordination between the Correctional, Institutional Probation and Field Probation Officers.
- There is a lack of in-reach and reentry services statewide.
- There is a lack of integrated case management among agencies and justice system navigation.
- There is a lack of a “warm transfer” of an inmate by institutional probation to community probation.
- Prisoner movement between facilities can make reentry planning a challenge
- Although recent legislative bills have included language and reference to State collaboration with Alaska Native (tribal) governments and organizations, it does not carry the same weight as language directing State departments to collaborate on these issues.

- There are workforce challenges at every level, from direct care to case management to psychiatric positions.

COMMUNITY CORRECTIONS BARRIERS AND GAPS

- **The process of collecting and sharing information about the person’s condition for continuity of care and referral is incomplete and inconsistent.**
- The predominant model of supervision is oriented to monitoring for compliance and not for the individual’s **success which requires** a willingness to problem solve and support the individual, balanced with accountability and public safety.
- There are few resources for seriously mentally ill (SMI) with co-occurring disorders.
- Specialized **probation only available in limited places and for limited population (“IDP-Plus” population eligible for specialized probation and clinical services (for psychotic disorders) but other seriously mentally disabled groups do not and fall between the cracks:** Ex: Other Mental disabling mental illnesses + Intellectually disability + TBI + FAS, etc. – low functioning populations with non-psychotic disorders

BEHAVIORAL HEALTH WORKGROUP RECOMMENDATIONS

Categorization key: S—Statutory; P—Policy; F—Funding

- | | | | |
|---------------------------------------|---------------------------------------|---------------------------------------|---|
| <input checked="" type="checkbox"/> S | <input type="checkbox"/> P | <input checked="" type="checkbox"/> F | Continued support for DOC’s Alaska Prisoner Reentry Initiative (AK-PRI). |
| <input type="checkbox"/> S | <input checked="" type="checkbox"/> P | <input type="checkbox"/> F | Improved data sharing between across community providers and with DOC for identification, service and evaluation purposes. |
| <input checked="" type="checkbox"/> S | <input checked="" type="checkbox"/> P | <input type="checkbox"/> F | Create a universally accepted Release of Information form that is compliant with HIPAA, 42 CFR and state confidentiality laws and require that all agencies accept the release. |
| <input type="checkbox"/> S | <input checked="" type="checkbox"/> P | <input checked="" type="checkbox"/> F | Increase in-custody release-planning staff to do reentry needs assessments in all communities. |
| <input type="checkbox"/> S | <input checked="" type="checkbox"/> P | <input type="checkbox"/> F | Update behavioral health and Level of Services Inventory – Revised (LSI-R) assessments for reentry. |
| <input type="checkbox"/> S | <input type="checkbox"/> P | <input checked="" type="checkbox"/> F | Expand community coalitions to other communities with a correctional institution to maintain linkages to a continuum of care for reentrants. |
| <input type="checkbox"/> S | <input type="checkbox"/> P | <input checked="" type="checkbox"/> F | Increase treatment capacity for mental health and substance user disorders. |
| <input type="checkbox"/> S | <input checked="" type="checkbox"/> P | <input checked="" type="checkbox"/> F | Provide access to medical and dental treatment (hard to get a job with no teeth). |
| <input type="checkbox"/> S | <input checked="" type="checkbox"/> P | <input type="checkbox"/> F | Streamline access to treatment for returning citizens. |
| <input type="checkbox"/> S | <input checked="" type="checkbox"/> P | <input type="checkbox"/> F | Increase Specialized Probation and clinical services to all areas in the state and expand eligibility to all inmates with serious mental disorders. |
| <input type="checkbox"/> S | <input checked="" type="checkbox"/> P | <input type="checkbox"/> F | Use Community Residential Centers (CRCs) as true reentry halfway houses and provide or require in contracts programs for mental health, substance abuse, employment, etc. |

- ☐S ☒P ☒F Conduct community specific assessment of reentry service needs in order to obtain or support funding (because statewide decision-**makers don't know** what a relative reasonable constellation of services should be in place for each community).
- ☐S ☒P ☒F Assure that all inmates, have applied for receipt or reinstatement of Medicaid prior to release.
- ☐S ☒P ☒F Cross train community providers on criminal justice/reentry legal issues.
- ☐S ☐P ☒F Use restorative justice approach to promote successful reentry/reintegration for individuals to their home communities (rural and urban) so they are not displaced.
- ☒S ☒P ☐F Continue to review and address identified issues with barrier crimes impacting successful reentry.
- ☐S ☒P ☐F **Closer collaboration between Office of Children's Services (OCS) parenting requirements and DOC reentry case planning.**
- ☐S ☒P ☐F Continue DOC Offender Management Planning process driven by LSI-R and behavioral health other assessments.
- ☐S ☐P ☒F Train community corrections officers and community providers on the use of graduated incentives and sanctions to reinforce positive behavior and also address noncompliance with probation conditions.

CEO Report

October 1, 2016

FINANCE

Trust investments at the Alaska Permanent Fund Corporation and Department of Revenue gained \$14.4 million in total for the first two months of the fiscal year (\$13.3 million or 2.98% and \$1.1 million or 2.8%, respectively). GeFONSI interest earnings totaled \$6,500 for the two-month period ending August 31.

Unaudited Trust Net Asset Values for principal and budget reserves at the end of August totaled \$458.5 million at APFC and \$40.2 million at DOR, for a total combined total of \$498.7 million.

MEDICAID REFORM + REDESIGN

The Department of Health and Social Services kicked off their stakeholder engagement this month with a Medicaid Redesign Update webinar and key partner meeting to discuss the implementation of SB74. In the full day key partner meeting, DHSS provided an overview of key elements of SB74, roles of partners, vision and guiding principles, ER initiative, Criminal Justice Reform, Coordinated Care Demonstration projects, and Behavioral Health Systems Reform.

As part of the Behavioral Health Redesign, there are six workgroups to assist in the development of the 1115 waiver; policy, benefits, cost, quality, data and writing teams. DHSS has identified one key partner and one DHSS staff to co-lead each of the teams which include key partners. The teams have begun meeting and Trust staff are on five of the teams.

Trust staff met with DHSS/DBH leadership to seek alignment on the core elements to include in the request for proposal for the alcohol funding targeting capacity building for community alcohol related interventions including sobering centers, medical detox and residential treatment. We anticipate this RFP to be posted in the near future. The Trust coordinated with DHSS and our contractors Charley Curie and Stephenie Colston to host two video teleconference sessions with the state of Virginia and Pennsylvania which have undergone behavioral health reform and have relevant experience to share with Alaska. This provided an opportunity to learn about other states experiences as well as to gain a better understanding of how those experiences **may differ when applied to Alaska. Staff will coordinate an overview of key “take a ways” for trustees during an appropriate committee meeting as scheduling allows.**

CRIMINAL JUSTICE REFORM

Alaska Criminal Justice Commission

As mentioned in last month's CEO report, the Alaska Criminal Justice Commission (ACJC) met and considered four of the six of the Commission's Behavioral Health workgroup statutory recommendations. The final two recommendations will be discussed at the next meeting on October 13 meeting and I will provide an update on those in next month's report. However, below are the actions taken by the Commission on the first four recommendations.

Recommendation 1:

Pretrial Services Program amendment – behavioral health diversion/intervention option

- a) The Alaska Criminal Justice Commission recommends that the legislature amend SB 91 to **establish within the Department of Corrections' (DOC) Pretrial Services Program**, a voluntary pretrial diversion/intervention option for Alaskans with behavioral health disorders. This option would provide an alternative criminal case processing for Alaskan defendants charged with a crime that, upon successful completion of an individualized program plan, results in a dismissal of the charge(s).

Alaskans with behavioral health disorders account for more than 40% of Alaska incarcerations each year. The majority of those incarcerations are for misdemeanor offenses. Thus, the purpose of this diversion/intervention option is to enhance justice and public safety through addressing the root cause of the arrest provoking behaviors of the defendant, reducing the stigma which accompanies a record of conviction, restoring victims and assisting with the conservation of jail, court and other criminal justice resources. This diversion/intervention option shall develop individual diversion plans using a comprehensive behavioral health and criminogenic risk/needs assessment of the defendant to identify and address specific need(s) related to reducing future criminal behavior.

The **Pretrial Services Program** pretrial diversion/intervention option shall create collaborative partnerships with treatment and other types of services in their community which have demonstrated effectiveness and the ability to provide culturally competent and gender specific programming to the identified needs of the participant.

It is further recommended that the DOC **Pretrial Services Program** shall oversee and/or administer diversion services following the **Performance Standards and Goals for Pretrial Diversion/Intervention, National Association of Pretrial Services Agencies** or other recognized evidence based standards for pre-trial diversion interventions.

- b) The Alaska Criminal Justice Commission recommends that the Department of Corrections convene representatives from the Department of Public Safety, the Department of Law, the Alaska Court System, the Department of Health and Social Services, the Alaska Mental Health Trust Authority, local law enforcement and representatives from tribal and non-tribal community health and behavioral health systems to assist in the development and implementation of the above recommended program to ensure that some Pretrial Services officers and tribal and non-tribal community service providers are trained to work with this target population. And, to ensure individuals are 1) swiftly identified for participation, 2) assured service priority and/or timely linkage to appropriate treatment and other services and 3) effectively monitored.

Action: The Commission had significant discussion on part (a) of the recommendation focusing on whether this should be a statutory recommendation of the Commission or whether this could be accomplished through another mechanism such as regulation. Ultimately the Commission decided not to move forward with the recommendation through statute in light of the fact that SB 91 requires the Dept. of Corrections to develop and adopt regulations for a Pre-Trial Services program by 2018. However, the Commission did direct DOC to consider the proposal and focus service strategies on the behavioral health population as it develops the Pre-Trial Services program. The Commission further directed DOC **add a victims' rights advocate and a representative from the Public Defender Agency** to assist in the development and implementation of the program.

Recommendation 2:

Amend AS 12.30.027(b) – bail conditions for crimes involving domestic violence

- a) The Alaska Criminal Justice Commission recommends that AS 12.30.027(b), which prohibits judicial officers from ordering or permitting a person charged with a crime involving domestic violence from returning to the residence of the victim of the offense for a period of 20 days, be amended. The amendment language would allow defendants charged with assault on a co-resident or staff of an assisted living facility, nursing home, group home, other supported living environments and private residences to return to their living environment with notice to the victim and where provisions for the safety of the victim can be reasonably assured.

Action: The recommendation was amended deleting “private residence” from the language and subsequently approved by the Commission.

Recommendation 3:
Information sharing

- a) The Alaska Criminal Justice Commission recommends that the legislature enact a statute setting forth a standardized Release of Information (ROI) that satisfies the requirements of Health Information and Portability Accountability Act (HIPAA), Title 42 CFR and state of Alaska health confidentiality laws, and requiring that the release be universally accepted by all state funded agencies providing health and behavioral health services within the state of Alaska. This will ensure a swift and confidential **information exchange about a person's identified relevant health** and/or behavioral health disorder needs and supports required to ensure public safety and that the individual remains in the community, in the least restrictive living environment.

Action: The recommendation was considered and approved as recommended.

Recommendation 4:

Add behavioral health information and proposed conditions in felony presentence reports

- a) The Alaska Criminal Justice Commission recommends that the legislature amend the Alaska statute and court rule to require that felony Presentence Investigation reports include a section discussing assessed behavioral health conditions that are amenable to treatment along with specific recommendations for appropriate **treatment in the offender's** community.

Action: There was significant discussion by the Commission, particularly over concerns raised by the Dept. of Corrections and the Public Defender. The Dept. of Corrections was concerned about the additional work that will be placed on staff with the additional behavioral health section. Judge Rhoades and myself clarified that it was the intent that know assessments would be included in the Presentence Investigative report, not the DOC staff would be conducting new assessments. The Public Defender raised concern that the inclusion of recommended additional information could have confidentiality issues and be a point of litigation. Ultimately, the recommendation was approved by the Commission, without the **Public Defender Agency's support.**

Department of Corrections - Pretrial Services Program

The Department of Corrections has hired Geri Fox to work in the Commission's office and lead the development and implementation of the Pretrial Services Program by January 2018, as outlined in SB91. The Community Resources for Justice, Crime and Justice Institute (CRJ) is providing technical assistance to the Department throughout this process. At the end of September, Steve and other stakeholders attended an initial meeting and training led by CRJ to begin this process. I will keep Trustees up to date on major developments as this effort moves forward.

HOUSING AND LONG-TERM SERVICES & SUPPORTS

Representatives from the AADD, AgeNet, SDS, ORR, Effective Healthcare Design, and the Trust attended the National Home and Community Based Service conference in DC. The conference is an excellent opportunity learn about innovative practices, trends, implementation of key federal policies and enhance knowledge and understanding of home and community based services. The AK team presented on the rate rebasing project to highlight the power of true collaboration through a comprehensive approach to rebasing the HCBS rates.

In an effort to address the need to reduce SDS's Medicaid budget by \$26 million in FY17, the four external stakeholder workgroups have continued to meet to identify specific recommendations for 1. Day habilitation, 2. ADRD First Pilot project, 3. Enabling Technology, and 4. Supported Living. SDS will work with each other groups based on their recommendations to identify the potential cost savings and what steps will be needed to implement; e.g., regulation changes, Medicaid waiver amendment.

Hope Community Resources has received all necessary approvals from the Municipality of Anchorage to move forward with the API/ADRD pilot project and has submitted their licensing application, with anticipated opening of mid-October and key staff hired. The transition team met to discuss key elements of the project and will begin identifying beneficiaries to move in!

The Trust was invited to present at the annual Philanthropy Northwest conference to share with other regional funders how the Trust has strategically invested resources to address the growing crisis of homelessness and lack of affordable housing including; policy, community, operations, capital, and innovative approaches.

SUBSTANCE ABUSE PREVENTION & TREATMENT

Recover Alaska

- The oversight committee which has representatives of all Recover Alaska funding partners including the Trust and has been working to operationalize the decision making and administrative structure for the initiative. The committee will be walking through the existing strategic plan and creating an operational plan to include timelines, benchmarks and outcomes that will be presented to the Steering Committee in the near future.
- The Recover Alaska Communications committee submitted an op-ed about National Recovery Month which was picked up by the Juneau Empire, Matsu Frontiersman and Anchorage Press. The link to the article is available [here](#).
- DAY 001 Recovery Stories – Recover Alaska supported production of several brief film vignettes of stories of recovery. While staff intends to share these with

Trustees at an upcoming committee meeting or board meeting, these vignettes can be viewed [here](#).

Title 4

- The Title 4 Steering Committee has continued to meet monthly. The committee made progress by reaching agreement on a number of proposed statute changes that were previously identified by the various parties as problematic. We are on track to meet the November deadline for completion of this process and to forward final recommendations for bill drafting.

EVAUATION, DATA & PLANNING

Intellectual and Developmental Disabilities (IDD) Systems Assessment

This past week, the Trust team met with staff from Senior and Disabilities Services, **Governor's Council, and AADD to review and discuss the project's goals and** anticipated benefits and the proposed scope of work, roles, and timeline for the first phase of the project. The response and feedback was positive. Subsequently, staff met to discuss legislative strategy and brainstorm analyses that could help to inform legislative decision-making this session.

Data Analysis, Infrastructure and Sharing

The Alaska eHealth Network (AeHN) oversees and administers the state's health information exchange. With further reductions in state funding planned for FY18, **AeHN must find a path to financial sustainability. This month, Heidi attended AeHN's** bi-monthly board meeting and responded to their request for technical assistance with an offer that included staff and potentially contract resources to assist the organization **at this critical stage of the health information exchange's development. The board was** very enthusiastic and appreciative and formally agreed to undertake a strategic **planning effort with the Trust's assistance. The effort will include** engaging board members and stakeholders to define the role of the health information exchange and develop strategies to ensure the exchange adds value to participating agencies and results in cost savings to the system and organizations. The initial meetings and interviews are already underway.

GRANTEE SPOTLIGHT

Trustees recently approved small project funding to Anchorage re:MADE, a store that, through volunteers, re-purposes and renews donated items for resale. Their pilot project, *Dreams re:MADE*, will give Trust beneficiaries hope, help them dream, evaluate their gifts and abilities, teach new skills, problem solve, and empower them to earn income by re-purposing a donated or rescued item.

Participants in the pilot project will attend a six-week preparation class that will explore possible products to craft, through discussion of life goals and an assessment of skills and abilities. Once a product idea is developed and a simple business plan is set, participants will move to the second phase, which is a commitment to participate in a 12-week work session, focusing on making and crafting products. The end result is selling the crafted items to the community and earning an income along the way.

Upon receipt of the grant award, staff received a thank you card from the president of re:Made, *“We are overcome with joy for the award ... So many lives are going to be impacted because of your generosity. You are appreciated.”*

Staff is grateful for Anchorage re:MADE and their positive contribution to our community and beneficiaries through this innovative project. We look forward to sharing the successes of Dreams re:MADE in the near future.

CEO Report

July 1, 2016

FINANCE

Trust investments at the Alaska Permanent Fund Corporation and Department of Revenue gained \$1.6 million or 0.4% and \$219,000 or 0.6%, respectively during the month of May. Fiscal year to date (FYTD) 2016 results through May 31 were \$2.6mm or 0.6% at APFC and \$503,000 or 1.3%- at DOR. GeFONSI interest has totaled \$281,000 on a FYTD basis.

Of the total returns at APFC, \$19.6mm represented realized gains (commonly referred to as Statutory Net Income) and (\$17 mm) constituted unrealized losses. Unaudited Trust Net Asset Values (NAV) for cash assets at the end of May were \$444.4mm at APFC (earnings reserve and principal combined, after making the FY16 annual payout withdraw) and \$39.1 mm at DOR, for a total combined cash investments NAV of \$483.5mm.

Subsequent to the results identified above, public equity markets reeled late in June in response to uncertainty of implications that may result from Britain's **non-binding** national referendum held June 23 which slightly favored the country exiting from the **European Union ("Brexit")**. In the final days of June markets rebounded some but results were mixed. **In large European public equity markets, both Germany's DAX and France's CAC 40 were both down over 5% for June while the UK's FTSE 100 hit a 10-month high** largely in response to expectations that the Bank of England will introduce new stimulus and signaled interest rate cuts were likely post Brexit. Meanwhile stateside the S&P 500 and DJIA both closed up fractionally for the month.

MEDICAID REFORM + REDESIGN

- Working closely with the DHSS leadership, staff are close to finalizing the statements of intent for the Trust authorized funding for Medicaid reform activities. Staff are preparing the agreement language to include with the RSA (Reimbursable Services Agreement) which serves as the mechanism to get the funds to the Department.
- DHSS has issued a notice of intent to award Public Consulting Group as the contractor to complete the Alaska Psychiatric Institute privatization feasibility study. Contracts will be signed as soon as the 10 day protest period ends.
<http://www.publicconsultinggroup.com/>
- DHSS is soliciting proposals for a consultant to support a stakeholder engagement and public information process for implementation of the Medicaid Redesign initiative, including facilitation and reporting with key partners and workgroups. This effort will be in effect August 1, 2016 - June 30, 2017.
- Trust staff will be meeting with DHSS/DBH leadership and contractor Stephenie Colston in July to identify how best to position the Alaska Training Cooperative to

be responsive to the training needs identified through the DBH staff capacity assessment and provider assessment which will be completed over the next several months. Additionally planning will focus on the data analytic capacity and AKAIMS.

DISABILITY JUSTICE

Progress continues to be made in the coordinated partnership between the community and the Department of Corrections for reentry planning, transitioning and community monitoring. Each of the four reentry coalitions (Anchorage, Fairbanks, Juneau and Mat-Su) held half-day strategic planning meetings to assess their accomplishments over the past year (establishing coalition structure, completing community needs assessments, etc.) and set goals for the upcoming year and beyond. Steve, Katie and DOC staff participated in each of these meetings. There is still more work to be done to complete the strategic planning process, but the coalitions have a solid start. In addition to completing their strategic plans, they are developing comprehensive community reentry plans which will be used to assist connecting returning citizens to services and supports. Simultaneously, DOC has been reviewing and revising internal policies and procedures for how Offender Management Plans (OMPs) are completed for returning citizens, how that information will be shared and coordinated with the coalitions and developing in-reach procedures for identified coalition members to meet with returning citizens prior to their release date.

A private investor is actively exploring the purchase of a condominium that a local nonprofit has been leasing to provide structured, sober housing with peer supports for returning citizens. This opportunity was identified after brain storming discussions with Craig at the Trust Land Office to discuss options for purchasing the condominium from the owner (who was ready to sell), so the housing and supports for the target population could be maintained. Craig identified and reached out to a private investor to explore his interests, resulting in a meeting between the nonprofit representatives and the investor to explain the program, answer questions, and see the property. Currently, the investor and seller are in negotiations for purchase.

Alaska Criminal Justice Commission

The Alaska Criminal Justice Commission's Behavioral Health committee co-chaired by myself and fellow commissioner Judge Rhoades has been meeting to discuss and identify areas where the criminal justice and behavioral health systems intersect or should intersect. The committee is comprised of members of the ACJC, criminal justice stakeholders, community providers, members of the advisory boards and other advocates and represents both an urban and rural perspective. To facilitate the **committee's discussion**, co-chair Rhoades used the ***Sequential Intercept Model*** as the foundation. At each intercept point the committee identified how the current systems are working well, where they are not and why, and best-practice models to improve or enhance our systems, producing better outcomes. These recommendations will be winnowed and prioritized to forward to the full ACJC. In addition, the committee is currently reviewing the UNLV report (commissioned by the Criminal Justice Working

Group and funded by the Trust) outlining recommended changes to Alaska's criminal legal competency statutes (Title 12) and related civil commitment statutes (Title 47). A set of recommendations will be forwarded to the full ACJC for consideration to act upon under its statutory and policy authority outlined in legislation.

WORKFORCE DEVELOPMENT

The Alaska Training Cooperative received positive press in the National Network for Mental Health for facilitation of Mental Health First Aide training to law enforcement in Matsu Valley last month. To read the article click [here](#).

Kathy Craft assisted with planning and facilitating the Fairbanks Community Behavioral Health Needs Assessment meeting with many local stakeholders interested in behavioral health services in attendance. Tanana Chiefs Conference will be the lead agency ensuring the needs assessment is conducted in a timely manner and will convene a steering committee which will include the city and borough mayors, corrections, the hospital, behavioral health providers, and the court system. While in town, Kathy gave Laraine Derr, Randall Burns, Monique Martin and Jeff a tour of both the DeNardo and Fahrenkamp Centers.

The FY16 Workforce projects related to the Alaska Core Competencies for Direct Care Workers have been completed. The Core Competencies Adaptation for Seniors has been piloted by stakeholders and a select number of providers have been trained in the Supervisor Work-Based Learning Toolkit. Marketing plans for each are being completed and the products will be available in FY17.

The Area Health Education Center, Alaska Native Students into Engineering Program, Alaska Brain Injury Network, and Alaska Native Tribal Health Consortium (ANTHC) partnered to hold the second 5-day Middle School STEM (Science, Technology, Engineering and Math) Health Career Exploration by understanding traumatic brain injuries. 54 middle school students attended the week-long event and 15 students attended the 15-hour High School Acceleration Academy. The evaluation surveys from both events are still being analyzed. Activities included sheep brain dissections, simulated 4-wheeler accident, telemedicine exploration, health professional spotlight speakers, simulation laboratory, brain scan diagnostics, junior paramedic training, and a website project which will be published in late summer.

Kathy will work with Fred Villa, UA Associate Vice President for Workforce Programs, to organize a high level meeting with employers, representatives from health organizations and associations, leading university faculty and staff, government leaders and other key behavioral health stakeholders across the state. President Johnson would like to use the knowledge and experience of statewide behavioral health care advocates to develop a guide that will be the foundation for the University of Alaska's behavioral health workforce planning and action for the next decade.

BENEFICIARY ENGAGEMENT & EMPLOYMENT

Staff and contractors concluded the final organizational assessments for each of the beneficiary programs receiving operational funding through the Beneficiary Employment and Engagement focus area. An overview of common themes and recommendations will be shared with trustees during the July planning committee meeting scheduled for July 26.

SUBSTANCE ABUSE PREVENTION & TREATMENT

The Opioid Policy Task Force has been underway for the past couple of months, meeting twice monthly to hear from a range of experts that are connected to the issue of opioid and heroin addiction. In June, the task force met with representatives of law enforcement, Drug Enforcement Agency, and Federal Bureau of Investigation to understand how Alaska law enforcement agencies are affected by and are responding to the opioid epidemic. The last task force meeting of the month focused on the various pathways to addiction, specifically the physiological and psychosocial factors in opioid use, misuse and dependence. Future meetings will focus on the treatment and detox continuum and various models as well as prescribing practices.

GRANTMAKING

Grantee Spotlight –Alzheimer’s Disease and Related Dementias Mini Grant Program

The Alzheimer’s disease and related dementias mini grant program provides Trust beneficiaries with a broad range of equipment, supplies and services to improve their quality of life, increase independent functioning, and help Trust beneficiaries attain and maintain healthy lifestyles. This can include up to \$2,500 (per year) for medical, dental, vision, hearing services, supplies, therapeutic devices, adaptive equipment, and accessibility improvements or supplies and services not available from any other funding source. This mini grant **program is administered by Alzheimer’s Resource of Alaska**, who works with beneficiaries and their families on the application and post-approval process.

Below is a note from a family member of Gladys D., a recent grant recipient who had been experiencing dizziness on a daily basis and, as a result, was very sleep deprived. **Gladys’ family took her to an ENT who recommended a reclining bed to help her sleep** in an elevated position and also to assist in getting in and out of bed more safely. **Gladys’ family member** applied for a mini grant on her behalf in early spring. The grant funds were approved and Gladys has been enjoying safe and restful sleep in her new elevated bed ever since.

Thank you so much for your support and grant for my mother’s (Gladys) new bed. She loves it! She is very comfortable and well rested. We can’t thank you enough. Thank you for this amazing blessing.

*Sincerely,
The Family of Gladys D.*

EVAUATION, DATA & PLANNING

Alaska Justice Information Center

- Michael participated in the recent AJiC working group and steering committee meetings. The working groups and steering committee were joined by the PEW Results First team for a presentation of the current results of the initiative. The PEW team was excited and very complimentary about the progress of the initiative and noted the AJiC team had accomplished a lot in a very short time. They are on-track to meet their October target for publishing their final report.
- A total of 53 adult criminal justice programs focused on preventing recidivism were identified in Alaska. Of these:
 - **66% (n=35) of Alaska's criminal justice programs were funded wholly, or in part by the State of Alaska.**
 - **54.7% (n=29) of Alaska's adult criminal justice programs were matched to interventions that been scientifically evaluated.**
 - 96.5% (\$22.2 million) of the funds allocated by the State of Alaska to adult criminal justice programs were for programs identified in the national evidence base.
- Next steps are to estimate per-participant costs of people in the system, estimate the resource use and cost-parameters, and the establish recidivism baseline analyses.

Comprehensive Mental Health Program Plan

- Heidi shared an initial framework for Comprehensive Mental Health Program Plan with trustees at the June 15 planning committee meeting. The framework proposes a flexible structure made up of nine (or more) distinct components that would be woven together to help guide, connect, and further the system of care. The timeline for each component would vary depending on immediacy of need, system readiness, and availability of resources.
- Heidi met with Kate Burkhart, ED of AMHB/ABADA subsequent to the presentation to brainstorm options and considerations for advancing the comprehensive planning process. As a result of that conversation, Heidi invited the executive directors of the advisory boards to a discussion about the Comprehensive Mental Health Program Plan on July 5.

Data Analysis and IT Infrastructure

- Michael and Heidi held a series of meetings with **Shaun Wilhelm, DBH's Systems Chief, Michael Walker, DBH's Technology Director, and Beth Davidson, DHSS's State Health Information Technology Coordinator to begin** to brainstorm around the technology vision for the comprehensive program and to troubleshoot specific issues that have arisen with the CMS and Trust-funded effort to establish interfaces between AKAIMS and the Health Information Exchange (HIE) and behavioral health providers and the HIE. We are working with DHSS to determine the most appropriate venue to advance both of these discussions.

- Heidi met with Rebecca Madison, Executive Director of the Alaska eHealth Network (AeHN), to discuss ways that the Trust might be able to support **AeHN's efforts to improve the quality of the reports produced and provided** to participating providers and to identify a clear course toward sustainability.

Reports of Interest

- One of the on-going reports monitored by staff is the Department of Health and Social Services Medicaid Dashboard. The most current report may be found at <http://dhss.alaska.gov/HealthyAlaska/Pages/dashboard.aspx>
- **The most recently available Division of Behavioral Health's Comprehensive Daily Census Report** is attached for your review.

The next trustee planning committee will be held Tuesday, July 26 from 1-3:30pm.

COMMUNICATIONS

We are in the beginning phase of creating new materials for the fetal alcohol spectrum disorder campaign. We learned from focus groups conducted last year that there was misinformation from medical providers about the consumption of alcohol while pregnant. This campaign will aim to dispel some of those misconceptions by featuring medical providers from across the state.

OTHER

Staff continue with preparation for the July 6 & 7 stakeholder budget work session and have posted related materials on the Trust website to prepare participants for the two-day work session. These materials can be accessed through the following link: <http://mhtrust.org/impact/library/fy18-19-budget-planning/>

UNLV/UNSOM Review Of Alaska Mental Health Statutes

Sara Gordon, J.D., Project Lead
**UNLV/William S. Boyd School of
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Gil Kahn, Student, J.D. Candidate 2016
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Melissa Piasecki, M.D.
**University of Nevada School of
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Dawn Nielsen, J.D. Candidate 2016
**UNLV/William S. Boyd School of
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Scope of Work



- **AS § 12.47.010–AS § 12.47.130** (Insanity and Competency to Stand Trial)
- **AS § 47.30.700–AS § 47.30.915** (Involuntary Admission for Treatment)
- **AS § 47.12** (Juvenile Delinquency)

Methodology & Timeline

- **Summer 2014:** Interviews with Stakeholders
- **Fall 2014:** Review of legislative history, national best practices, and individual state approaches to mental health statutes
- **Spring 2015:** Initial drafts of reports; extensive conference calls with all relevant Stakeholders; input and feedback from the Competency Subcommittee, Juvenile Subcommittee, and various individuals involved in mental health throughout the state
- **Summer 2015:** Final Report to Competency Subcommittee



Collaboration Among Stakeholders

- Alaska Court System
- Alaska Mental Health Trust
- Alaska Psychiatric Institute
- Dept. of Corrections
- Dept. of Health & Social Services
- Dept. of Law
- Dept. of Public Safety
- Disability Law Center of Alaska
- Juvenile Subcommittee
- Office of Public Advocacy
- Public Defender Agency
- Private Attorneys



Structure of the Report



- Forensic Examiners & Telebehavioral Health
- Civil Mental Health Law
- Criminal Mental Health Law
- Misdemeanor Statutes
- Juvenile Statutes
- Appendices
 - Appendix 1: Proposed Involuntary Outpatient Commitment Statutes
 - Appendix 2: Proposed Statutes Regarding Disposition of Misdemeanor Charges
 - Appendix 3: Proposed Juvenile Competency and Restoration Statutes
- Redlined Statutes (Title 12 & Title 47)

Forensic Examiners – Current Law (pp. 5–6)

- **AS § 12.47.070** (insanity defense, negated mental state, competence): two qualified psychiatrists or two forensic psychologists certified by the American Board of Forensic Psychology.
- **AS § 12.47.100** (competence): at least one qualified psychiatrist or psychologist.
- **AS § 47.30.730** (civil commitment): petition for commitment must be signed by two mental health professionals, one of whom is a physician. MHP includes psychiatrist, clinical psychologist, psychological associate, registered nurse with master's degree in psychiatric nursing, marital and family therapist, professional counselor, clinical social worker, or person with masters degree in mental health with 12 months working in the field and working under supervision of another person listed above.

Forensic Examiners – Findings (pp. 6–7)

- Forensic assessment is primarily done by API. Because API is also responsible for competency restoration, stakeholders expressed concern about potential conflicts of interest.
- “Qualified” is not defined by any of the statutes.
- Requirement that examinations be conducted by two “qualified psychiatrists or two board certified forensic psychologists” has been difficult to implement due to mental health workforce shortages throughout the state.



Forensic Examiners – Recommendations (pp. 7–8)

+ QUALIFIED

+ NEUTRAL

- Qualified and neutral evaluators should perform all forensic evaluations.
- Qualified evaluators are psychologists and psychiatrists with additional training and education in forensic evaluations.
- Neutral evaluators should not otherwise be involved in the defendant’s clinical or restorative treatment.
- Titles 12 & 47 should require that forensic evaluations be performed by only one qualified and neutral evaluator.
- Agency responsibility: DBH should coordinate continuing education in forensic evaluations. DHSS should be responsible for designating qualified and neutral evaluators.

Telebehavioral Health – Current Law (p. 9)

- Alaska does not have a comprehensive telebehavioral health statute.
 - HB 281 (2014): allows for prescriptions without in-person examination.
- **AS § 8.01.062**: allows courtesy licenses
 - AAC 60.035: courtesy licenses for psychologists (30 days in 12 months; one in lifetime)
 - AAC 40.045: courtesy licenses for psychiatrists/physicians (specialty clinic, out-of-state sports team, disaster relief, supervised fellowship, accompany employer)



Telebehavioral Health – Findings (pp. 9–10)



- Staffing burdens at API and mental health provider shortages often limit the availability of evaluators and the extend the time period in which forensic evaluations can be performed.
- Research has shown that telebehavioral health produces clinical outcomes equivalent to face-to-face consultation, and that telebehavioral health is appropriate in forensic and correctional settings.

Telebehavioral Health – Recommendations (pp. 10–11)



- Adopt statutes that allow for the broad use of telehealth and define telehealth to include the practice of telebehavioral health, or to include psychologists and psychiatrists as health care providers under the statute.
- Adopt telebehavioral health statutes that allow for competency and civil commitment evaluations.
- Amend courtesy licensing regulations to relax requirements. Specifically, psychiatrists and psychologists who are licensed out-of-state should receive licenses allowing them to practice for 30 days within the state via telehealth each calendar year.

Incompetence To Stand Trial & Civil Commitment – Current Law (p. 12)

- **AS § 12.47.100(e)**: when a defendant who is charged with a felony is found incompetent to proceed, this subsection creates a rebuttable presumption that the defendant is “mentally ill and ...present[s] a likelihood of serious harm to self or others.”



Incompetence To Stand Trial & Civil Commitment – Findings (pp. 12–13)

- AS § 12.47.110(e) was added in 2008 and meant to automatically trigger a civil commitment proceeding when a defendant charged with a felony is found incompetent and nonrestorable. It creates a rebuttable presumption that a defendant found incompetent will meet civil commitment criteria.
- This section is limited to defendants charged with felonies.
- Many stakeholders report it is rarely used, but if kept it should not be limited to felony defendants.
- The rebuttable presumption is inappropriate because standards for competency to stand trial and civil commitment are distinct.

Incompetence To Stand Trial & Civil Commitment – Recommendations (p. 13)

- A finding of incompetence to stand trial should require that defendants charged with felonies and misdemeanors be evaluated for civil commitment and treatment upon dismissal of charges.
- The rebuttable presumption language should be removed from the statute.
- Agency responsibility: DHSS should be responsible for initiating inpatient or outpatient civil commitment proceedings when a defendant charged with a misdemeanor or felony is found incompetent and unrestorable. DHSS should initiate proceedings within 24 hours if appropriate, or create a discharge plan for the defendant.

Involuntary Inpatient Commitment Procedures – Current Law (pp. 14–15)

- **AS § 47.30.700**: any adult may petition for an ex parte order for 72-hour examination. Judge may conduct or order screening investigation.
- **AS § 47.30.705**: any peace officer, psychiatrist, physician, or clinical psychologist may detain the person if there is probable cause to believe she meets commitment standards. Harm to self/others or grave disability must be immediate.
- **AS § 47.30.710**: appears to govern the 72-hour examination and controls persons delivered under **AS § 47.30.700** and **AS § 47.30.705**. Also allows mental health professional to apply for ex parte order under **AS § 47.30.700**.
- **AS § 47.30.715**: further outlines requirements of 72-hour examination and orders court to set a date for the 30-day commitment hearing, if necessary.

Involuntary Inpatient Commitment Procedures – Findings (pp. 16–19)

- There is a lack of clarity in the commitment process. The stages of evaluation overlap and are non-chronological, and stakeholders expressed confusion about the process.
- The location where detention, evaluation, and hospitalization are meant to occur are unclear due to the inconsistent use of terms including “evaluation facility,” “treatment facility,” and “designated treatment facility.”
- The statutes lack timeframes in which the various stages of detention and evaluation should occur, and do not include a timeframe during which an individual held in emergency detention must be transferred to an evaluation facility.
- The statutes do not designate a custodial agent responsible for an individual detained pursuant to **AS § 47.30.705**.

Involuntary Inpatient Commitment Procedures – Recommendations (pp. 19–20)

- The title of each section (AS § 47.30.700–47.30.715) should be amended to further clarify the stages of commitment. AS § 47.30.710 and AS § 47.30.715 should be amended to clarify the various stages of commitment.
- AS § 47.30.700 should be amended to allow the judge to either direct a mental health professional to conduct a screening investigation, or to rely solely on the allegations in the ex parte petition.
- AS § 47.30.700 should include a timeframe in which ex parte orders issued must be implemented and the individual delivered to an appropriate evaluation facility.

Involuntary Inpatient Commitment Procedures – Recommendations (pp. 19–20)

- AS § 47.30.700 should explicitly authorize the use of telebehavioral health to conduct screening investigations.
- AS § 47.30.705 should identify DHSS as the custodial agent for individuals detained pursuant that section.
- AS § 47.30.710 and AS § 47.30.715 should allow for the 72-hour examination to occur at any appropriate evaluation facility.
- AS § 47.30.710 should be amended to clarify that the 72-hour evaluation period begins when the respondent meets with evaluation personnel, but that the total period of detention should not exceed five calendar days.

Involuntary Inpatient Commitment Standards – Current Law (pp. 21–24)

- **AS § 47.30.730(a)**: to be civilly committed, respondent must be mentally ill and as a result likely to either cause harm to self or others, or gravely disabled.
- **AS § 47.30.730(a)(3)**: for respondents who are gravely disabled, there must be reason to believe the condition can be improved with treatment.
- **AS § 47.30.710(b)**: governs the initial 72-hour evaluation and provides that respondents who are committed under either ground must be “in need of care or treatment.”
- **AS § 47.30.655(6)**: details purposes of revisions to Title 47 and provides that individuals who are a danger to self (but not others) must also benefit from treatment.
- ***E.P. v. Alaska Psychiatric Institute (2009)***: AK Supreme Court clarified that the need for treatment requirement only applies to grave disability.

Involuntary Inpatient Commitment Standards – Findings (pp. 21–24)

- The statutes are unclear as to whether a respondent who is committed based on a finding of danger to self or others must also be in need of treatment.
- There is confusion as to the definition of grave disability and whether that definition complies with existing Alaska case law.
- There are ambiguities in the statutes as to the timeframes of when past and future harm to self or others or grave disability must exist.



Involuntary Inpatient Commitment Standards – Recommendations (pp. 22, 25)

- Title 47 should be amended in various places to clarify the two independent commitment grounds of (1) harm to self or others, and (2) grave disability.
- Title 47 should be amended in various places to reflect the Supreme Court's decision in *E.P. v. Alaska Psychiatric Institute* and to clarify that the state must only show that the respondent's condition will be improved by treatment in cases of grave disability.
- Title 47 should be amended in various places to replace the phrase "in need of treatment" with "there is reason to believe that the respondent's mental condition could be improved by the course of treatment sought." This will make the entire code consistent and reflect existing Alaska case law.

Involuntary Inpatient Commitment Standards – Recommendations (pp. 22, 25)



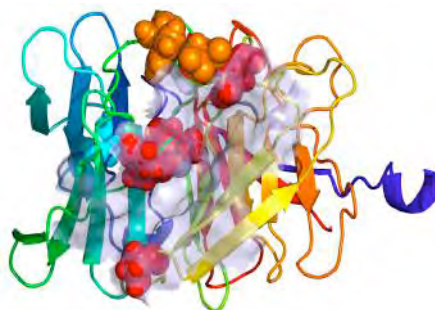
- Grave disability should be defined according to the Alaska Supreme Court's definition in *Wetherhorn v. API*.
- The definitions of "likely to cause serious harm" and "grave disability" should be defined to include a 30-day timeframe in which the relevant behavior must have occurred or is likely to occur.

Involuntary Outpatient Commitment – Current Law (p. 27)

- **AS § 47.30.735(d)**: outpatient treatment may be a less restrictive alternative to inpatient commitment and may be ordered at the 30-day commitment hearing.
- **AS § 47.30.755(b)**: seems to also allow outpatient commitment at the 90-day commitment hearing.
- **AS § 47.30.795**: individuals committed to inpatient treatment may be released to involuntary outpatient commitment if they do not pose a risk of harm to self or others and would benefit from outpatient treatment.
- **AS § 47.30.800**: the court may convert an outpatient commitment order to an inpatient order.
- No statute authorizes outpatient treatment generally, or include mechanisms and procedures for outpatient commitment.

Involuntary Outpatient Commitment – Findings (pp. 27–28)

- Involuntary outpatient commitment is rarely used in Alaska.
- The statute does not include enforcement mechanisms, consequences for non-compliance, or designated agents responsible for the administration of community-based resources and programs related to outpatient treatment.
- Due to this lack of infrastructure, outpatient providers are typically not comfortable with perceived liability.



Involuntary Outpatient Commitment – Recommendations (p. 28/Appendix I)

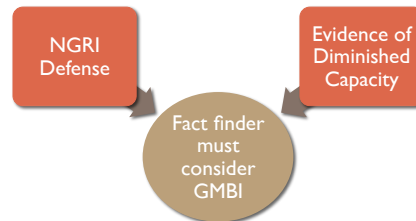
- Alaska should create a comprehensive outpatient commitment statutory scheme that includes enforcement mechanisms, consequences for non-compliance, and agents responsible for administration of community-based resources and programs.
- A robust outpatient commitment statutory scheme would require a significant investment of resources, but these statutes have been shown to improve compliance, reduce hospitalization and incarceration rates, and reduce violent behavior among individuals with serious mental illness.
- Proposed statutory language is attached as **Appendix I** to the Report.

NGRI, GBMI, & Diminished Capacity – Current Law (p. 29)

- **AS § 12.47.010** (NGRI): it is an affirmative defense to a crime if the defendant was unable to appreciate the nature and quality of his conduct due to mental disease or defect.
- **AS § 12.47.020** (diminished capacity): evidence of mental defect is admissible to show the defendant did or did not have a culpable mental state that is an element of the charged crime.
 - If a jury finds a defendant did not have a culpable mental state as a result of a mental disease or defect, and the defendant is not found guilty of a lesser included offense, the defendant will be found NGRI under **AS § 12.47.010**.
 - If a jury finds a defendant did not have a culpable mental state as a result of a mental disease or defect, and the defendant is found guilty of a lesser included offense, the defendant will be found GBMI under **AS § 12.47.030**.

NGRI, GBMI, & Diminished Capacity – Current Law (p. 29)

- **AS § 12.47.030** (GBMI): a defendant can be found GBMI if he engaged in criminal conduct, but as a result of mental disease or defect, lacked the substantial capacity to appreciate the wrongfulness or the conduct or conform that conduct to the law.
- **AS § 12.47.040**: if a defendant raises an insanity defense under **AS § 12.47.010**, or admits evidence of diminished capacity under **AS § 12.47.020**, the trier of fact must consider whether the defendant is GBMI.



NGRI & Diminished Capacity – Findings (pp. 29–31)

- Before 1982, Alaska used the MPC test for insanity. This test permits an insanity plea when a defendant, as a result of mental disease or defect, lacks the substantial capacity to understand that his conduct violates the law, or to conform his conduct to the law.
- With the 1982 reforms, Alaska changed to a modified M’Naghten test, with only a cognitive incapacity prong. This test permits an insanity offense only when a defendant, as a result of mental disease or defect, is unable to understand what he was doing when he committed the crime (i.e., is unable to “appreciate the nature and quality of his conduct.”).
- Alaska is the only state that limits its insanity defense to the cognitive incapacity prong.

NGRI & Diminished Capacity – Findings (pp. 29–31)

- Diminished capacity and Alaska’s modified M’Naghten test are redundant. If a defendant is sufficiently mentally ill to establish the M’Naghten cognitive incapacity prong, he will be able to demonstrate diminished capacity.
- Because NGRI is an affirmative defense, and diminished capacity goes to the elements of the crime the prosecutor must prove, there is little incentive for defendants to raise an NGRI defense.
- Almost all stakeholders agreed that the 1982 reforms effectively eliminated the insanity affirmative defense.

GBMI – Findings (pp. 32–34)

- Alaska’s GBMI statute incorporates both M’Naghten’s moral incapacity prong as modified by the MPC (the defendant lacks the “substantial capacity” to appreciate the wrongfulness of his conduct) and the “irresistible impulse test” contained in the MPC (the defendant is unable to conform his conduct to the requirements of the law).
- Yet because Alaska only allows for M’Naghten’s cognitive prong in insanity defenses, a defendant whose mental illness makes him lack substantial capacity to appreciate the wrongfulness of his conduct or conform that conduct to the law will not be able to establish an NGRI defense. If he is instead found GBMI, he will still be criminally responsible for his actions and receive a sentence comparable to a guilty verdict.

GBMI – Findings (pp. 32–34)

- A defendant with a mental disease or defect who is found GBMI will be placed in the DOC, where he will receive treatment, but that placement is not appropriate for individuals with serious mental illness who are unable to satisfy Alaska's strict NGRI requirements.
- Because a GBMI verdict is automatically considered when a defendant raises an insanity defense or introduces evidence of diminished capacity, stakeholders report that many defendants are deterred from raising an NGRI defense or introducing evidence of mental disease or defect.



GBMI – Findings (pp. 32–34)

- Two areas where GBMI is useful:
- **AS § 12.47.020(c)**: automatically applies the GBMI verdict to defendants convicted of a lesser offense after the diminished capacity defense results in acquittal under the more serious offense.
 - Because successful use of the defense would mitigate a defendant's sentence, the possibility of a GBMI verdict on the lesser included offense should not deter the defendant from introducing evidence of mental disease or defect.
- **AS § 12.47.060**: allows either party to seek post-conviction determination of GBMI when the defendant does not raise an NGRI affirmative defense or a diminished capacity defense.
 - This procedure does not deter defendants from introducing evidence of mental disease or defect because it may only be used if such evidence is not introduced. This section is typically used by the state, and gives prosecutors the discretion to seek a GBMI verdict for defendants who should receive mental health treatment and be prevented from gaining parole.

NGRI, GBMI & Diminished Capacity – Recommendations (pp. 31, 34)

- Alaska should institute both the cognitive and moral incapacity prongs of the full M’Naghten test.
- If Alaska chooses to re-institute a full M’Naghten test for legal insanity, it should delete the GBMI verdict from the statute.
- If Alaska retains the GBMI verdict, it should consider limiting it for acquittal under [AS § 12.47.020\(c\)](#) and post-conviction GBMI determination under [AS § 12.47.060](#).
- We do not recommend changes to [AS § 12.47.020](#), which governs diminished capacity.

Misdemeanor Diversion – Current Law (p. 39)

- Apart from [AS § 12.47.110\(e\)](#), which only applies to felonies, Alaska does not have a statute that diverts individuals charged with criminal offenses into civil commitment.



Misdemeanor Diversion – Findings (p. 39)



- Stakeholders expressed concern about the current priority for community health treatment for defendants charged with misdemeanors and found incompetent to stand trial.
- Typically these individuals are quickly released back into the community without a treatment plan or referral to community-based treatment.
- While many of these defendants might meet civil commitment criteria, there is no mechanism to divert misdemeanor defendants into civil commitment.

Misdemeanor Diversion – Recommendations (pp. 40–41/Appendix 2)

- The state should adopt a new statute that allows for a screening investigation and diversion of misdemeanor defendants who are likely to be found incompetent to stand trial.
- This screening investigation should trigger the provisions of **AS § 47.30.710**, at which time a complete 72-hour examination should be performed by a neutral and qualified evaluator.
- If the defendant meets civil commitment criteria, the criminal charges should be dismissed without prejudice.
- Suggested statutory language is attached in **Appendix 2**.

Misdemeanor Competency & Restoration – Current Law (pp. 42–45)

- Alaska law does not distinguish between competency evaluation and restoration for misdemeanor and felony defendants.
- **AS § 12.47.110** governs restorative commitment upon a finding that a criminal defendant is incompetent to stand trial. Defendants charged with felonies must be committed for up to 90 days; defendants charged with misdemeanors may be committed for up to 90 days. The statute allows further commitment for up to one year.
- The statutes do not otherwise provide guidance regarding procedures for competency restoration in misdemeanor cases.

Misdemeanor Competency & Restoration – Findings (pp. 42–45)

- Stakeholders report that many individuals charged with misdemeanors suffer from mental illness and that competency assessments for misdemeanants constitute approximately 1/3 of all assessments. Because misdemeanor charges are often dismissed when a competency evaluation and restoration would take longer than the potential sentence, these defendants are released back into the community where they often re-commit crimes and cycle in and out of the system.
- Because competency evaluation and restoration can take longer than many misdemeanor sentences, stakeholders felt that timeframes for misdemeanor competency evaluations should be shortened.
- Stakeholders also expressed a need for statutes that specify the amount of time misdemeanor defendants may be held for restoration and that this period of time should be tied to the potential sentence for the charged offense.

Misdemeanor Competence – Recommendations (pp. 42–43)



- Competency evaluations for misdemeanor defendants should be performed within 15 days of the court order for evaluation.
- The statutes should allow a more limited competency evaluation procedure for misdemeanants.
- When a misdemeanor defendant has received a full competency evaluation in the past 12 months, the statutes should allow for a more limited, follow-up evaluation.
- **AS § 12.47.070** should require that the court advance the date for the competency hearing to the day after the competency report is filed, and the date for the plea hearing to the earliest possible date if the defendant is found competent to proceed on a misdemeanor charge.

Misdemeanor Restoration – Recommendations (pp. 45–46)

- **AS § 12.47.110** should be amended to allow varying time periods for competency restoration, depending on the seriousness of the charged offense.
 - Felonies (one year); Class A misdemeanors (six months); Class B misdemeanors (three months)
- The total time period for restoration should not exceed a period of time necessary to determine if there is a substantial probability that the defendant will resume competency, and in any event it should not exceed the time listed for each category of offense.
- If a defendant is found incompetent and unlikely to be restorable at any point during the time allowed for competency restoration, or is found incompetent at the end of the allowed time period, the statute should require the court to dismiss the charges without prejudice and DHSS should be required under **AS § 12.47.110(e)** to initiate civil commitment proceedings or create a discharge plan for the defendant.
- The court should be alerted immediately if the defendant is found to be competent, even if the time period allowed for restoration has not expired.

Juvenile Statutes – Current Law (p. 47)



- **AS § 47.12** governs juvenile delinquency. This section does not contain provisions relating to juvenile restoration or juvenile competency.
- **AS § 47.12.255** allows for the placement of minors who are in state custody and requires notice to the parent or guardian.
- **AS § 47.30.690** governs commitment of minors who are not already in state custody.

Juvenile Statutes – Findings (p. 47)

- Alaska statutes provide little guidance to courts, lawyers, or mental health professions as to the appropriate handling of juvenile competence and restoration.
- Due to the lack of guidance in the juvenile statutes, stakeholders are forced to resort to adult competency standards, which do not take into account developmental immaturity and the difficulty of diagnosing mental illness in juveniles.



Juvenile Statutes – General Recommendations

- **AS § 47.30.690** should be amended to require the court to appoint a Guardian Ad Litem for all juveniles who are being treated in secure psychiatric facilities. The appointment should continue until the juvenile is discharged and reintegrated into the community.
- Alaska should implement a new statutory section within **AS § 47.12** which includes detailed standards related to juvenile competency and restoration and alternative approaches for juvenile delinquency adjudication.
- Suggested statutory language is attached in **Appendix 3**.

Juvenile Competency – Recommendations (pp. 50–51/Appendix 3)

- Developmental immaturity should be included as a cause of incompetence to stand trial in juvenile cases.
- The statutes should include a multi-tiered, aged-based system which provides greater protection for juveniles in competency proceedings based on age and developmental maturity.
- Juvenile competency statutes should focus on cognitive functions, such as ability to understand the proceedings and assist counsel.
- Juvenile competency evaluations should be performed by a qualified and neutral evaluator with training and experience in child psychology.
- Juvenile competency evaluations should be performed within 30 days of the court order for evaluation.

Juvenile Restoration – Recommendations (p. 52)



- When a juvenile is incompetent due to developmental immaturity or intellectual disability and restoration is inappropriate, the statutes should allow courts to dismiss less serious cases without prejudice and more serious cases with prejudice.
- When a juvenile is incompetent due to developmental immaturity or intellectual disability and restoration is inappropriate, the statutes should give the juvenile court judge discretion to order appropriate social and clinical services in the juvenile's community.

Other Recommendations

- **AS § 47.30.780** (early discharge from civil commitment) should be changed to distinguish it from **AS § 47.30.720** (release from expiration of 72-hour period). The title should be amended and subsection (b) should be removed. **(p. 26)**
- Title 12 should include more explicit and current definitions of intellectual disability and developmental disability. **(p. 36)**
- **AS § 12.47.110** could be amended to include a reference to the U.S. Supreme Court's decision in *Sell v. United States* (2003), as well as an explicit explanation to the fact that courts should first apply the *Washington v. Harper* (1990) factors when an incompetent defendant is dangerous to self or others and the treatment is in his medical interest. **(pp. 37–38)**
- Alternatively, **AS § 12.47.110** could simply be amended to include a provision allowing the use of medication to restore competency. **(pp. 37–38)**

UNLV/UNSOM Review Of Alaska Mental Health Statutes

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FACING ADDICTION IN AMERICA

*The Surgeon General's Report on
Alcohol, Drugs, and Health*

EXECUTIVE SUMMARY

U.S. Department of Health & Human Services

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2016

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MESSAGE FROM THE SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES



All across the United States, individuals, families, communities, and health care systems are struggling to cope with substance use, misuse, and substance use disorders. Substance misuse and substance use disorders have devastating effects, disrupt the future plans of too many young people, and all too often, end lives prematurely and tragically. Substance misuse is a major public health challenge and a priority for our nation to address.

Fortunately, we have made considerable progress in recent years. First, decades of scientific research and technological advances have given us a better understanding of the functioning and neurobiology of the brain and how substance use affects brain chemistry and our capacity for self-control.

One of the important findings of this research is that addiction is a chronic neurological disorder and needs to be treated as other chronic conditions are. Second, this Administration and others before it, as well as the private sector, have invested in research, development, and evaluation of programs to prevent and treat substance misuse, as well as support recovery. We now have many of the tools we need to protect children, young people, and adults from the negative health consequences of substance misuse; provide individuals with substance use disorders the treatment they need to lead healthy and productive lives; and help people stay substance-free. Finally, the enactment of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and the Affordable Care Act in 2010 are helping increase access to prevention and treatment services.

The effects of substance use are cumulative and costly for our society, placing burdens on workplaces, the health care system, families, states, and communities. *The Surgeon General's Report on Alcohol, Drugs, and Health* is another important step in our efforts to address the issue. This historic *Report* explains, in clear and understandable language, the effects on the brain of alcohol and drugs and how misuse can become a disorder. It describes the considerable evidence showing that prevention, treatment, and recovery policies and programs really do work. For example, minimum legal drinking age laws, funding for multi-sector community-based coalitions to plan and implement effective prevention interventions with fidelity, screening and brief intervention for alcohol use, needle/syringe exchange programs, behavioral counseling, pharmacologic interventions such as buprenorphine for opioid misuse, and mutual aid groups have all been shown effective in preventing, reducing, treating, and sustaining recovery from substance misuse and substance use disorders.

The *Report* discusses opportunities to bring substance use disorder treatment and mainstream health care systems into alignment so that they can address a person's overall health, rather than a substance misuse or a physical health condition alone or in isolation. It also provides suggestions and recommendations for action that everyone—individuals, families, community leaders, law enforcement, health care professionals, policymakers, and researchers—can take to prevent substance misuse and reduce its consequences.

Throughout, the *Report* provides examples of how individuals, organizations, and communities can partner to lessen and eliminate substance misuse. These efforts have to start now. Change takes time and long-term commitment, as well as collaboration among key stakeholders. As the Secretary of the Department of Health and Human Services, I encourage you to use the information and findings in this *Report* to take action so that we can improve the health of those we love and make our communities healthier and stronger.

Sylvia Mathews Burwell
Secretary
U.S. Department of Health and Human Services

FOREWORD FROM THE PRINCIPAL DEPUTY ADMINISTRATOR, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION



Substance misuse is one of the critical public health problems of our time. The most recent data on substance use, misuse, and substance use disorders reveal that the problem is deepening and the consequences are becoming more deadly than ever. There is an urgent need to raise awareness about the issue. At the same time, we need to spread the word that substance misuse and addiction are solvable problems. We can, and must, inspire and catalyze action on this crisis.

That's why I am so proud to support the Office of the Surgeon General in releasing this first report of its kind – *The Surgeon General's Report on Alcohol, Drugs, and Health*.

This *Report* takes a comprehensive look at the problem; covering topics including misuse of alcohol, prescription drugs, and other substances, and bringing together the best available science on the adverse health consequences of substance misuse. It also summarizes what we know about what works in prevention, treatment, and recovery. Our goal: to equip health care providers, communities, policymakers, law enforcement, and others with the evidence, the tools, and the information they need to take action to address this growing epidemic.

Now is the time for this *Report*. The substance misuse problem in America won't wait. Almost 22.5 million people reported use of an illegal drug in the prior year. Over 20 million people have substance use disorders, and 12.5 million Americans reported misusing prescription pain relievers in the past year. Seventy-eight people die every day in the United States from an opioid overdose, and those numbers have nearly quadrupled since 1999. Despite the fact that we have treatments we know are effective, only one in five people who currently need treatment for opioid use disorders is actually receiving it.

The addiction problem touches us all. We all need to play a part in solving it. *The Surgeon General's Report on Alcohol, Drugs, and Health* provides a roadmap for working together to move our efforts forward. I hope all who read it will be inspired to take action to stem the rising tide of this public health crisis and reduce the impact of substance misuse and addiction on individuals, communities, and our nation.

Kana Enomoto
Principal Deputy Administrator
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

PREFACE FROM THE SURGEON GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES



Before I assumed my position as U.S. Surgeon General, I stopped by the hospital where I had worked since my residency training to say goodbye to my colleagues. I wanted to thank them, especially the nurses, whose kindness and guidance had helped me on countless occasions. The nurses had one parting request for me. If you can only do one thing as Surgeon General, they said, please do something about the addiction crisis in America.

I have not forgotten their words. As I have traveled across our extraordinary nation, meeting people struggling with substance use disorders and their families, I have come to appreciate even more deeply something I recognized through my own experience in patient care: that substance use disorders represent one of the most pressing public health crises of our time.

Whether it is the rapid rise of prescription opioid addiction or the longstanding challenge of alcohol dependence, substance misuse and substance use disorders can—and do—prevent people from living healthy and productive lives. And, just as importantly, they have profound effects on families, friends, and entire communities.

I recognize there is no single solution. We need more policies and programs that increase access to proven treatment modalities. We need to invest more in expanding the scientific evidence base for prevention, treatment, and recovery. We also need a cultural shift in how we think about addiction. For far too long, too many in our country have viewed addiction as a moral failing. This unfortunate stigma has created an added burden of shame that has made people with substance use disorders less likely to come forward and seek help. It has also made it more challenging to marshal the necessary investments in prevention and treatment. We must help everyone see that addiction is not a character flaw – it is a chronic illness that we must approach with the same skill and compassion with which we approach heart disease, diabetes, and cancer.

I am proud to release *The Surgeon General's Report on Alcohol, Drugs, and Health*. As the first ever Surgeon General's Report on this important topic, this *Report* aims to shift the way our society thinks about substance misuse and substance use disorders while defining actions we can take to prevent and treat these conditions.

Over the past few decades, we have built a robust evidence base on this subject. We now know that there is a neurobiological basis for substance use disorders with potential for both recovery and recurrence. We have evidence-based interventions that prevent harmful substance use and related problems, particularly when started early. We also have proven interventions for treating substance use disorders, often involving a combination of medication, counseling, and social support. Additionally, we have

learned that recovery has many pathways that should be tailored to fit the unique cultural values and psychological and behavioral health needs of each individual.

As Surgeon General, I care deeply about the health and well-being of all who are affected by substance misuse and substance use disorders. This *Report* offers a way forward through a public health approach that is firmly grounded in the best available science. Recognizing that we all have a role to play, the *Report* contains suggested actions that are intended for parents, families, educators, health care professionals, public policy makers, researchers, and all community members.

Above all, we can never forget that the faces of substance use disorders are real people. They are a beloved family member, a friend, a colleague, and ourselves. Despite the significant work that remains ahead of us, there are reasons to be hopeful. I find hope in the people I have met in recovery all across America who are now helping others with substance use disorders find their way. I draw strength from the communities I have visited that are coming together to work on prevention initiatives and to connect more people to treatment. And I am inspired by the countless family members who have lost loved ones to addiction and who have transformed their pain into a passion for helping others. These individuals and communities are rays of hope. It is now our collective duty to bring such light to all corners of our country.

How we respond to this crisis is a moral test for America. Are we a nation willing to take on an epidemic that is causing great human suffering and economic loss? Are we able to live up to that most fundamental obligation we have as human beings: to care for one another?

Fifty years ago, the landmark Surgeon General's report on the dangers of smoking began a half century of work to end the tobacco epidemic and saved millions of lives. With *The Surgeon General's Report on Alcohol, Drugs, and Health*, I am issuing a new call to action to end the public health crisis of addiction. Please join me in taking the actions outlined in this *Report* and in helping ensure that all Americans can lead healthy and fulfilling lives.

Vivek H. Murthy, M.D., M.B.A.
Vice Admiral, U.S. Public Health Service
Surgeon General



EXECUTIVE SUMMARY



In 2015, over 27 million people in the United States reported current use of illicit drugs or misuse of prescription drugs, and over 66 million people (nearly a quarter of the adult and adolescent population) reported bingeⁱ drinking in the past month.¹ Alcohol and drug misuse and related disorders are major public health challenges that are taking an enormous toll on individuals, families, and society. Neighborhoods and communities as a whole are also suffering as a result of alcohol- and drug-related crime and violence, abuse and neglect of children, and the increased costs of health care associated with substance misuse. It is estimated that the yearly economic impact of substance misuse and substance use disorders is \$249 billion for alcohol misuse and alcohol use disorders and \$193 billion for illicit drug use and drug use disorders.^{2,3}

Despite the social and economic costs, this is a time of great opportunity. Ongoing health care and criminal justice reform efforts, as well as advances in clinical, research, and information technologies are creating new opportunities for increased access to effective prevention and treatment services. This *Report* reflects our commitment to leverage these opportunities to drive improvements in individual and public health related to substance misuse, use disorders, and related health consequences.

i Binge drinking for men is drinking 5 or more standard alcoholic drinks, and for women, 4 or more standard alcoholic drinks on the same occasion on at least 1 day in the past 30 days.

The Many Consequences of Alcohol and Drug Misuse

Alcohol and drug misuse can have a wide range of effects; a single instance of alcohol or drug misuse can have profound negative consequences. The specific effects associated with substance misuse depend on the substances used, how much and how often they are used, how they are taken (e.g., orally vs. injected), and other factors. Some of these effects include:

- Immediate, direct consequences: Substance misuse can have immediate, direct consequences for health ranging from effects on heart rate and regulation of body temperature to psychotic episodes, overdose, and death. Many more people now die from alcohol and drug overdoses each year than are killed in automobile accidents.⁴ The opioid crisis is fueling this trend with nearly 30,000 people dying due to an overdose on heroin or prescription opioids in 2014.⁵ An additional roughly 20,000 people died as a result of an unintentional overdose of alcohol, cocaine, or non-opioid prescription drugs.⁶⁻⁸
- Indirect consequences related to risky behaviors that often accompany alcohol and drug misuse: Alcohol and drug misuse can impair judgment, leading to risky behaviors including driving under the influence (DUI), unprotected sex, and needle/syringe sharing. Driving under the influence of alcohol or drugs contributes to thousands of deaths annually, and 10.6 percent of drivers report engaging in this hazardous behavior each year.¹ As misuse of some drugs such as prescription opioids progresses, many people seek to intensify the high by injecting them, and sharing of needles among users can result in outbreaks of HIV and hepatitis.
- Longer-term health effects on a person's physical and mental health: For example, heavy drinkingⁱⁱ can lead to hypertension, liver disease, and cancer; regular marijuana use is associated with chronic bronchitis; and use of stimulants such as cocaine can lead to heart disease.⁹⁻¹¹ In addition, substance misuse during pregnancy can result in long lasting health effects for the baby including fetal alcohol spectrum disorders (FASDs), which are estimated to affect as many as 2 to 5 percent of the population,^{12,13} and neonatal abstinence syndrome (NAS); the ongoing opioid crisis has resulted in a five-fold increase in the number of babies who are dependent on opioids at birth.¹⁴
- Longer-term societal consequences: These can include reduced productivity, higher health care costs, unintended pregnancies, spread of infectious disease, drug-related crime, interpersonal violence, stress within families, and many other direct and indirect effects on communities, the economy, and society as a whole.

Some of these consequences result from substance use disorders, which occur when a person uses alcohol or drugs to such an extent that it causes clinically significant impairments in health, social functioning, and voluntary control over substance use.ⁱⁱⁱ The majority of individuals who misuse substances do not develop a substance use disorder. However, roughly one in seven people in the United States (14.6 percent of the population) are expected to develop a substance use disorder at some point in their lives.¹⁵ A substance use disorder can be diagnosed as mild, moderate, or severe depending on the extent of a person's symptoms. In this *Report*, addiction is used to refer to substance use disorders that can be categorized as severe and are associated with compulsive or uncontrolled use of one or more substances. Addiction is a chronic brain disease that, like milder substance use disorders, has the potential for both recurrence and recovery.

In 2015, substance use disorders affected 20.8 million Americans—almost 8 percent of the adolescent and adult population. That number is similar to the number of people who suffer from diabetes,¹⁶ and more than 1.5 times the annual prevalence of all cancers combined (14 million).¹⁷ Of the 20.8 million people with a substance use disorder in 2015, 15.7 million were in need of treatment for an alcohol problem in 2015 and nearly 7.7 million needed treatment for an illicit drug problem.¹

- ii Defined by the Centers for Disease Control and Prevention (CDC) as consuming 8 or more drinks per week for women, and 15 or more drinks per week for men, and by the Substance Abuse and Mental Health Services Administration (SAMHSA), for research purposes, as binge drinking on 5 or more days in the past 30 days.
- iii This *Report* follows the Fifth Edition of the *Diagnostic and Statistical Manual of Mental Disorders*, which defines substance use disorders as “clinically and functionally significant impairments caused by substance use, including health problems, disability, and failure to meet major responsibilities at work, school, or home.”

Most Americans know someone with a substance use disorder, and many know someone who has lost or nearly lost a family member as a consequence of substance misuse. Yet, at the same time, few other medical conditions are surrounded by as much shame and misunderstanding as substance use disorders. Historically, our society has treated addiction and misuse of alcohol and drugs as symptoms of moral weakness or as a willful rejection of societal norms, and these problems have been addressed primarily through the criminal justice system. Our health care system has not given the same level of attention to substance use disorders as it has to other health concerns that affect similar numbers of people. Substance use disorder treatment in the United States remains largely segregated from the rest of health care and serves only a fraction of those in need of treatment. Only about 10 percent of people with a substance use disorder receive any type of specialty treatment.¹ Further, over 40 percent of people with a substance use disorder also have a mental health condition, yet fewer than half (48.0 percent) receive treatment for either disorder.¹

Many factors contribute to this “treatment gap,” including the inability to access or afford care, fear of shame and discrimination, and lack of screening for substance misuse and substance use disorders in general health care settings. Further, about 40 percent of individuals who know they have an alcohol or drug problem are not ready to stop using, and many others simply feel they do not have a problem or a need for treatment¹—which may partly be a consequence of the neurobiological changes that profoundly affect the judgment, motivation, and priorities of a person with a substance use disorder.

Reasons for Hope and Optimism

The problem of alcohol and drug misuse in the United States is serious and pervasive. However, despite the challenges described above, this is also a time of great hope and opportunity:

- Research on alcohol and drug use, and addiction, has led to an increase of knowledge and to one clear conclusion: Addiction to alcohol or drugs is a chronic but treatable brain disease that requires medical intervention, not moral judgment.
- Policies and programs have been developed that are effective in preventing alcohol and drug misuse and reducing its negative effects.
- Effective treatments for substance use disorders are available. Evidence-based treatments—both medications and behavioral therapies—can save lives and restore people’s health, well-being, and functioning, as well as reduce the spread of infectious disease and lessen other consequences.
- Support services such as mutual aid groups (e.g., Alcoholics Anonymous), recovery housing, and recovery coaches are increasingly available to help people in the long and often difficult task of maintaining recovery after treatment.
- Health care reform efforts are creating new opportunities to increase access to prevention and treatment services to improve public health. Health insurers that participate in the new Health Care Marketplace must now cover costs related to mental health and substance use disorder services, including behavioral health treatment, and may not apply limitations on those benefits that are more restrictive than limitations applied on the benefits for medical and surgical

services. Other incentives are encouraging general health systems to control costs, improve outcomes, and reduce readmissions by addressing patients' substance use. Transformations in the health care landscape are supporting integration of substance use disorder treatment with general health care in ways that will better address the needs of the millions of people suffering from these disorders.

- The criminal justice system is engaged in efforts to place non-violent drug offenders in treatment instead of jail, to improve the delivery of evidence-based treatment for incarcerated persons, and to coordinate care in the community when inmates are released.

Together, these changes are leading to a new landscape of care for alcohol and drug misuse problems in America, and to new hope for millions of people who suffer from them.

The Time is Right for a Surgeon General's Report

While prior Surgeon General's reports have discussed substance use disorders in certain contexts, *The Surgeon General's Report on Alcohol, Drugs, and Health* is the first Surgeon General's Report to address substance use disorders and the wider range of health problems and consequences related to alcohol and drug misuse in the United States.^{iv} Its aim is to galvanize the public, policymakers, and health care systems to make the most of these new opportunities so that the individual and public health consequences associated with alcohol and drug misuse can be addressed effectively. Only by doing so can individuals, their loved ones, and their communities be restored to full health and well-being.

The Surgeon General's Report

This *Report* reviews what we know about substance use and health and how we can use that knowledge to address substance misuse and related health consequences. First, a general [Introduction and Overview of the Report](#) describes the extent of the substance use problem in the United States. Then it lays a foundation for readers by explaining what happens in the brain of a person with an addiction to these substances. [Chapter 2 - The Neurobiology of Substance Use, Misuse, and Addiction](#) describes the three main circuits in the brain involved in addiction, and how substance use can "hijack" the normal function of these circuits. Understanding this transformation in the brain is critical to understanding why addiction is a health condition, not a moral failing or character flaw.

Few would disagree with the notion that preventing substance use disorders from developing in the first place is ideal. Prevention programs and policies are available that have been proven to do just that. [Chapter 3 - Prevention Programs and Policies](#) describes a range of programs focused on preventing substance misuse including universal prevention programs that target the whole community as well as programs that are tailored to high-risk populations. It also describes population-level policies that are

iv Tobacco and nicotine addiction are discussed only minimally in this Report because tobacco use and its health consequences have been the subject of many previous Surgeon General's Reports.

effective for reducing underage drinking, drinking and driving, spread of infectious disease, and other consequences of alcohol and drug misuse.

If a person does develop a substance use disorder, treatment is critical. Substance use disorders share some important characteristics with other chronic illnesses, like diabetes. Both are chronic conditions that can be effectively managed with medications and other treatments that focus on behavior and lifestyle. [Chapter 4 - Early Intervention, Treatment, and Management of Substance Use Disorders](#) describes the clinical activities that are used to identify people who have a substance use disorder and engage them in treatment. It also describes the range of medications and behavioral treatments that can help people successfully address their substance use disorder.

As with other chronic conditions, people with substance use disorders need support through the long and often difficult process of returning to a healthy and productive life. [Chapter 5 - Recovery: The Many Paths to Wellness](#) describes the growing array of services and systems that provide this essential function and the many pathways that make recovery possible.

Responsive and coordinated systems are needed to provide prevention, treatment, and recovery services. Traditionally, general health care and substance use disorder treatment have been provided through distinct and separate systems, but that is now changing. [Chapter 6 - Health Care Systems and Substance Use Disorders](#) explains why integrating general health care and substance use services can result in better outcomes and describes policies and activities underway to achieve that goal. The final chapter, [Chapter 7 - Vision for the Future: A Public Health Approach](#), provides concrete recommendations on how to reduce substance misuse and related harms in communities across the United States.

The following sections provide more detailed summaries of each of the chapters in the *Report*.

The Neurobiology of Substance Use, Misuse, and Addiction

Substance use disorders result from changes in the brain that can occur with repeated use of alcohol or drugs. The most severe expression of the disorder, addiction, is associated with changes in the function of brain circuits involved in pleasure (the reward system), learning, stress, decision making, and self-control.

Every substance has slightly different effects on the brain, but all addictive drugs, including alcohol, opioids, and cocaine, produce a pleasurable surge of the neurotransmitter *dopamine* in a region of the brain called the *basal ganglia*; neurotransmitters are chemicals that transmit messages between nerve cells. This area is responsible for controlling reward and our ability to learn based on rewards. As substance use increases, these circuits adapt. They scale back their sensitivity to dopamine, leading to a reduction in a substance's ability to produce euphoria or the "high" that comes from using it. This is known as *tolerance*, and it reflects the way that the brain maintains balance and adjusts to a "new normal"—the frequent presence of the substance. However, as a result, users often increase the amount of the substance they take so that they can reach the level of high they are used to. These same circuits control our ability to take pleasure from ordinary rewards like food, sex, and social interaction, and when they are disrupted by substance use, the rest of life can feel less and less enjoyable to the user when they are not using the substance.

Repeated use of a substance "trains" the brain to associate the rewarding high with other cues in the person's life, such as friends they drink or do drugs with, places where they use substances, and

paraphernalia that accompany substance-taking. As these cues become increasingly associated with the substance, the person may find it more and more difficult not to think about using, because so many things in life are reminders of the substance.

Changes to two other brain areas, the *extended amygdala* and the *prefrontal cortex*, help explain why stopping use can be so difficult for someone with a severe substance use disorder. The extended amygdala controls our responses to stress. If dopamine bursts in the reward circuitry in the basal ganglia are like a carrot that lures the brain toward rewards, bursts of stress neurotransmitters in the extended amygdala are like a painful stick that pushes the brain to escape unpleasant situations. Together, they control the spontaneous drives to seek pleasure and avoid pain and compel a person to action. In substance use disorders, however, the balance between these drives shifts over time. Increasingly, people feel emotional or physical distress whenever they are not taking the substance. This distress, known as *withdrawal*, can become hard to bear, motivating users to escape it at all costs. As a substance use disorder deepens in intensity, substance use is the only thing that produces relief from the bad feelings associated with withdrawal. And like a vicious cycle, relief is purchased at the cost of a deepening disorder and increased distress when not using. The person no longer takes the substance to “get high” but instead to avoid feeling low. Other priorities, including job, family, and hobbies that once produced pleasure have trouble competing with this cycle.

Healthy adults are usually able to control their impulses when necessary, because these impulses are balanced by the judgment and decision-making circuits of the prefrontal cortex. Unfortunately, these prefrontal circuits are also disrupted in substance use disorders. The result is a reduced ability to control the powerful impulses toward alcohol or drug use despite awareness that stopping is in the person’s best long-term interest.

This explains why substance use disorders are said to involve compromised self-control. It is not a complete loss of autonomy—addicted individuals are still accountable for their actions—but they are much less able to override the powerful drive to seek relief from withdrawal provided by alcohol or drugs. At every turn, people with addictions who try to quit find their resolve challenged. Even if they can resist drug or alcohol use for a while, at some point the constant craving triggered by the many cues in their life may erode their resolve, resulting in a return to substance use, or *relapse*.

Prevention Programs and Policies

One of the major questions about addiction is why it takes hold only in some people. The changes in the brain associated with addiction do not progress in the same way in everyone who uses alcohol or drugs. For a wide range of reasons that remain only partially understood, some individuals are able to use alcohol or drugs in moderation and not develop addiction or even milder substance use disorders, whereas others—between 4 and 23 percent depending on the substance—proceed readily from trying a substance to developing a substance use disorder.¹⁸

Understanding the factors that raise people’s risk for substance misuse (*risk factors*) and those that may offer some degree of protection from these risks (*protective factors*) and then using this knowledge to design interventions aimed at steering people away from substance misuse are the goals of *prevention science*. Between 40 and 70 percent of a person’s risk for developing a substance use disorder is genetic,¹⁹ but many

What is an Intervention?

Intervention here and throughout this Report means a professionally delivered program, service, or policy designed to prevent substance misuse or treat an individual's substance use disorder. It does not refer to an arranged meeting or confrontation intended to persuade a friend or loved one to quit their substance misuse or enter treatment—the type of “intervention” sometimes depicted on television. Planned surprise confrontations of the latter variety—a model developed in the 1960s, sometimes called the “Johnson Intervention”—have not been demonstrated to be an effective way to engage people in treatment.²⁴ Confrontational approaches in general, though once the norm even in many behavioral treatment settings, have not been found effective and may backfire by heightening resistance and diminishing self-esteem on the part of the targeted individual.²⁵

environmental factors interact with a person's genes to modify their risk. Being raised in a home in which the parents or other relatives use alcohol or drugs, for example, raises a child's chances of trying these substances and of developing a substance use disorder.^{20,21} Living in neighborhoods and going to schools where alcohol and drug use are common, and associating with peers who use substances, are also risk factors.^{20,22,23}

Another important risk factor is age at first use. The earlier people try alcohol or drugs, the more likely they are to develop a substance use disorder. For instance, people who first use alcohol before age 15 are four times more likely to become addicted to alcohol at some time in their lives than are those who have their first drink at age 20 or older.²⁶ Nearly 70 percent of those who try an illicit drug before the age of 13 develop a substance use disorder in the next 7 years, compared with 27 percent of those who first try an illicit drug after the age of 17.²⁷ Although substance misuse problems can develop later in life, preventing or even just delaying young people from trying substances is important for reducing the likelihood of more serious problems later on.

Prevention interventions also aim to support or bolster protective factors, which give people the resources and strengths they need to avoid substance use. Having strong and positive family ties and social connections, being emotionally healthy, and having a feeling that one has control over one's successes and failures are all protective factors. Being satisfied with one's life, having a sense of a positive future ahead, and emotional resilience are other examples of protective factors.²⁸

Given the overwhelming tendency for substance use to begin in adolescence (ages 12 to 17) and peak during young adulthood, most prevention interventions have focused on teens and young adults. However, effective prevention policies and programs have been developed across the lifespan, from infancy to adulthood. It is never too early and never too late to prevent substance misuse and substance-related problems. A growing number of interventions designed to reduce risk and enhance protective factors have been scientifically tested and shown to improve substance use and other outcomes. These include interventions for all age groups (including early childhood), for specific ethnic and racial groups, and for groups at high risk for substance misuse, such as youth involved in the criminal justice system. These interventions may focus all individuals in a group (*universal* interventions) or specifically on at-risk individuals (*selective* interventions).

Importantly, interventions at the environmental or policy level can also be effective at reducing substance use. This has been shown clearly with alcohol use (especially by minors) and related problems such as drunk driving. Raising alcohol prices; limiting where, when, and to whom alcohol can be sold; raising the

legal purchase age; and increasing enforcement of existing alcohol-related laws, such as the minimum legal drinking age (MLDA) of 21 and laws to prevent driving under the influence of alcohol, have successfully reduced negative alcohol-related outcomes where they have been implemented. Higher alcohol taxes have also been shown to reduce alcohol consumption.²⁹ As a growing number of states allow marijuana use recreationally³⁰ or therapeutically, research is ongoing to learn about the effects of these changes and policy levers that may mitigate potential harms, such as increased use by adolescents or impaired driving.

Evidence-based prevention interventions can also address a wider range of potential problems beyond just substance misuse. Alcohol and drug use among adolescents are typically part of a larger spectrum of behavioral problems, including mental disorders, risky and criminal behaviors, and difficulties in school. Many interventions address the common underlying risk factors for these issues and show benefits across these domains, making them powerful and, in many cases, highly cost-effective investments that pay off in reduced health care, law enforcement, and other societal costs.

In summary: *Prevention works.* However, it must be evidence-based, and there is a need for an ongoing investment in resources and infrastructure to ensure that prevention policies and programs can be implemented faithfully, sustainably, and at sufficient scale to reap the rewards of reduced substance misuse and its consequences in communities.

Early Intervention, Treatment, and Management of Substance Use Disorders

Treatment for substance use disorders can take many different forms and may be delivered in a range of settings varying in intensity. In all cases, though, the goals of treatment for substance use disorders are similar to treatment for any medical condition: to reduce the major symptoms of the illness and return the patient to a state of full functioning. Ideally, services are not “one size fits all” but are tailored to the unique needs of the individual. Treatment must be provided for an adequate length of time and should address the patient’s substance use as well as related health and social consequences that could contribute to the risk of relapse, including connecting the patient to social support, housing, employment, and other wrap-around services.

Screening for substance misuse in health care settings including primary, psychiatric, urgent, and emergency care, is the first step in identifying behaviors that put individuals at risk for harms, including for developing a substance use disorder, and to identify patients with existing substance use disorders. Screening and brief intervention for alcohol in adults has been shown to be effective;³¹ and screening for substance use and mental health problems is recommended by major health organizations for both adults and adolescents.³²⁻³⁵ Brief advice or therapy would follow a positive screen and be tailored to an individual’s specific needs; referral can be made to specialty treatment depending on severity.

Treatment for all substance use disorders—including alcohol, marijuana, cocaine, heroin or other opioid use disorders, among others—should include one or more types of *behavioral interventions* delivered in individual, group, and sometimes family settings. Evidence-based behavioral interventions may seek to increase patients’ motivation to change, increase their self-efficacy (their belief in their ability to carry out actions that can achieve their goals), or help them identify and change disrupted behavior patterns and abnormal thinking.

The intensity of substance use disorder treatment services falls along a continuum. For people with mild substance use disorders, counseling services provided through primary care or other outpatient settings with an intensity of one or two counseling sessions per week may be sufficient while residential treatment may be necessary for people with a severe substance use disorder. Residential treatment was designed to provide a highly controlled environment with a high density of daily services. Ideally, people who receive treatment in residential settings participate in step-down services following the residential stay. Step-down services may include intensive outpatient or other outpatient counseling and recovery support services (RSS) to promote and encourage patients to independently manage their condition.^{36,37}

Medications are also available to help treat people addicted to alcohol or opioids. Research is underway to develop new medications to treat other substance use disorders, such as addiction to marijuana or cocaine, but none have yet been approved by the U.S. Food and Drug Administration (FDA). The available medications do not by themselves restore the addicted brain to health, but they can support an individual's treatment process and recovery by preventing the substance from having pleasurable effects in the brain, by causing an unpleasant reaction when the substance is used, or by controlling symptoms of withdrawal and craving. Widening access to highly effective medications for treating opioid addiction—methadone, buprenorphine, and naltrexone—has been identified by United States public health authorities as an essential part of tackling America's current prescription opioid and heroin crisis.



FOR MORE ON THIS TOPIC

See "The Opioid Crisis" box in Chapter 1 - Introduction and Overview.

Medication Misconceptions

Use of medications to treat addiction has been controversial at times because of a longstanding misconception that methadone and, more recently, buprenorphine, which control opioid craving and withdrawal, merely "substitute one addiction for another." This belief has reinforced scientifically unsound "abstinence-only" philosophies (meaning abstinence from opioid-based medications as well as from illicit and misused drugs) in many treatment centers and has severely limited the use of these medications. Restrictions on how these drugs may be prescribed or dispensed have also reduced their availability for many people who could benefit from them.

Abundant scientific data show that long-term use of maintenance medications successfully reduces substance use, risk of relapse and overdose, associated criminal behavior, and transmission of infectious disease, as well as helps patients return to a healthy, functional life.³⁸⁻⁴⁰

In summary: *Treatment is effective.* As with other chronic, relapsing medical conditions, treatment can manage the symptoms of substance use disorders and prevent relapse. Rates of relapse following treatment for substance use disorders are comparable to those of other chronic illnesses such as diabetes, asthma, and hypertension.⁴¹ More than 25 million individuals with a previous substance use disorder are in remission and living healthy, productive lives.⁴²

However, many people seek or are referred to substance use treatment only after a crisis, such as an overdose, or through involvement with the criminal justice system. With any other health condition like heart disease, detecting problems and offering treatment only after a crisis is not considered good medicine. Integrating screening into general medical settings will make it easier to identify those in

need of treatment and engage them in the appropriate level of care before a crisis occurs. Overall, the need is for a stepped care model, in which mild to moderate substance use disorders are detected and addressed in general health care settings and severe disorders are treated by specialists using a chronic care model coordinated with primary care. The good news is that the existing health care system is well poised to help address the health consequences of alcohol and drug misuse and substance use disorders.

Recovery: The Many Paths to Wellness

Because the brain can take a long time to return to health following a long period of heavy substance use, risk of relapse is high at first. It can take a year of abstinence before an individual can be said to be in remission;⁴³ for people recovering from an alcohol use disorder it can take 4 to 5 years of abstinence for the risk of relapse to drop below 15 percent⁴²—the level of risk of individuals in the general population developing a substance use disorder during their lifetime. In addition, successful recovery often involves making significant changes to one's life to create a supportive environment that avoids substance use or misuse cues or triggers. This can involve changing jobs or housing, finding new friends who are supportive of one's recovery, and engaging in activities that do not involve substance use. This is why ongoing RSS in the community after completing treatment can be invaluable for helping individuals resist relapse and rebuild lives that may have been devastated by years of substance misuse.

Recovery has become an increasingly important concept for researchers and practitioners in the substance use disorder field, as well as in the community. It is central to a movement to bring greater awareness to the struggles and the successes of people fighting addiction and increase solidarity in overcoming the discrimination, shame, and misconceptions historically associated with substance use disorders. In general, the term sends a positive, hopeful message that recovery is possible, that there is life after even the most devastating struggles with addiction, and that people suffering with or recovering from an alcohol or drug use disorder have essential worth and dignity. It also provides a positive focus and construct for scientific, program, and policy-level thinking about substance use disorders.

RSS are not the same as treatment and have only recently been included as part of the health care system. Many of these services began long before the modern era of evidence-supported interventions; some have been studied and found to be effective at maintaining abstinence and promoting other positive long-term outcomes in those who take advantage of them. The most well-known approach, *mutual aid groups*, link people in recovery and encourage mutual support while providing a new social setting in which former alcohol or drug users can engage with others in the absence of substance-related cues from their former life.

The best-known mutual aid groups are 12-step programs like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). NA has not been extensively studied, but AA has been shown in many studies to have a positive effect in reducing a person's likelihood of relapse to drinking.⁴⁴⁻⁴⁸ Mutual aid groups are facilitated by peers, who share their lived experience in recovery. However, health care professionals have a key role in linking patients to these groups, and encouraging participation can have great benefit.⁴⁹ *Recovery coaches*, who offer individualized guidance, support, and sometimes case management, and *recovery housing*—substance-free living situations in which residents informally support each other as they navigate the challenges of drug- and alcohol-free living—have led to

improved outcomes for participants.⁵⁰⁻⁵⁴ Several other common RSS, *recovery community centers*, and *recovery high schools*, have not yet been rigorously evaluated.

In summary: *People can and do recover.* The recovery movement offers a valuable opportunity for people with substance use disorders and their loved ones to get the support they need to gradually return to a healthy and productive life away from the destructive impact of substance use. The movement also provides an opportunity for people to advocate for improvements in prevention and treatment services. Equally, this movement can contribute to efforts to reduce negative public attitudes as well as discrimination embedded in public policies and the health care system.

Health Care Systems and Substance Use Disorders

While services for the prevention and treatment of substance misuse and substance use disorders have traditionally been delivered separately from other mental health and general health care services, effective integration of prevention, treatment, and recovery services across health care systems is key to addressing substance misuse and its consequences; it represents the most promising way to improve access to and quality of treatment.

There are many kinds of health care systems across the United States with varying levels of integration across health care settings including primary care, specialty substance use disorder treatment (including residential and outpatient settings), mental health care, infectious disease clinics, school clinics, community health centers, hospitals, emergency departments, and others. These systems utilize wide-ranging workforces that include doctors, nurses, nurse practitioners, psychologists, licensed counselors, care managers, social workers, health educators, peer workers, and others. They incorporate diverse structural and financing models and leverage different levels of technology. These diverse health care systems have many roles to play in providing integrated care to address our nation's substance misuse and substance use disorder problems, including delivering prevention interventions; identifying patients with substance use related problems and engaging them in the appropriate level of care; treating substance use disorders of all levels of severity; coordinating care both across health care systems and with social services systems including criminal justice, housing and employment support, and child welfare; linking patients to RSS; and providing long-term monitoring and follow-up.

One of the recurring themes in this *Surgeon General's Report* is that sound scientific knowledge about how to address substance use disorders effectively has outpaced society's ability and, in some cases, willingness to implement that knowledge. Recent health care reform laws, as well as a wide range of other trends in the health care landscape, are working to address this gap. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires that the financial requirements and treatment limitations imposed by most health plans and insurers for mental and substance use disorders be no more restrictive than the financial requirements and treatment limitations they impose for medical and surgical conditions (commonly referred to as "parity"). At the same time, the Affordable Care Act is greatly expanding the number of people covered by health insurance, and requires the majority of United States health plans and insurers to offer prevention, screening, and treatment for substance use disorders. Additional policy measures are increasing the scope of substance use disorder treatment services covered under Medicaid, widening access to care for those who are most economically disadvantaged and disproportionately at risk for substance use

disorders. At the same time, health care organizations are recognizing that substance use disorders must be detected and treated like other health conditions and that it is in their best economic interests to do so. This is leading to growing integration of behavioral health and general health care and increased efforts to screen patients for substance use disorders and address them through early intervention or referral to appropriate levels of treatment.

Substance use disorders are strongly intertwined with other medical conditions, making an integrated approach to care essential. Challenges to such integration include insufficient training of health care professionals on how to identify and treat substance use disorders, an underdeveloped infrastructure, and some ingrained attitudes. For example, methadone and buprenorphine treatment remain surrounded by misconceptions and prejudices that have hindered their delivery. Similar attitudinal barriers hinder the adoption of harm reduction strategies like needle/syringe exchange programs, which evidence shows can reduce the spread of infectious diseases among individuals who inject drugs.⁵⁵

Increasing the number of insured Americans and integrating substance use disorder services with mainstream health care has the power to improve outcomes for individuals, reduce overall health care costs for them and their families, reduce health disparities among high-risk groups, and reduce costs for health care systems and communities. Studies show that greater investment in treatment will also reduce costs associated with criminal justice; child welfare, educational, and social services; and lost productivity.^{2,3} The benefits may also be felt more broadly, as the evidence suggests that improving substance use treatment can help to improve treatment success for other conditions, reduce hospital readmissions, reduce the spread of infectious diseases like HIV and hepatitis, and reduce drug-related accidents and overdoses.

Vision and Recommendations

The final chapter of this *Report* spells out concrete recommendations for how to achieve an equitable and effective, science-based public health approach to substance use and substance use disorders. A public health–based approach seeks to understand the broad individual, environmental, and societal factors that influence substance misuse and substance use disorders and applies that knowledge to improve the health, safety, and well-being of the entire population. It recognizes that substance misuse and its consequences are the result of multiple interacting factors and coordinates the efforts of diverse stakeholders to address substance misuse across the community. Current health reform efforts and technological advances can facilitate this—for example, advances in health information technology and data analytics enable researchers and practitioners to target the populations of greatest need, link different components of health care and the broader public health systems together (e.g., affordable housing, job training, recovery support), and address the risk and protective factors that are most actionable at the local level.

But the health care system alone cannot address all of the major determinants of health related to substance misuse. Community leaders should work together to mobilize the capacities of health care organizations, local governmental public health, social service organizations, educational systems, community-based organizations, religious institutions, law enforcement, local businesses, researchers, and other public, private, and voluntary entities that are part of the broader public health system.

Everyone has a role to play in addressing substance misuse and substance use disorders as a public health issue.

The concluding chapter highlights five general messages and their implications for policy and practice:

- Both substance misuse and substance use disorders harm the health and well-being of individuals and communities. Addressing them requires implementation of effective strategies.
- Highly effective community-based prevention programs and policies exist and should be widely implemented.
- Full integration of the continuum of services for substance use disorders with the rest of health care could significantly improve the quality, effectiveness, and safety of *all* health care.
- Coordination and implementation of recent health reform and parity laws will help ensure increased access to services for people with substance use disorders.
- A large body of research has clarified the biological, psychological, and social underpinnings of substance misuse and related disorders and described effective prevention, treatment, and recovery support services. Future research is needed to guide the new public health approach to substance misuse and substance use disorders.

Conclusion

By adopting an evidence-based public health approach, America has the opportunity to take genuinely effective steps to prevent and treat substance-related issues. Such an approach can prevent substance initiation or escalation from use to a disorder, and thus reduce the number of people suffering with addiction; it can shorten the duration of illness for sufferers; and it can reduce the number of substance-related deaths. A public health approach will also reduce collateral damage created by substance misuse, such as infectious disease transmission and motor vehicle crashes. Thus, promoting much wider adoption of appropriate evidence-based prevention, treatment, and recovery strategies needs to be a top public health priority.

Making this change will require a major cultural shift in the way we think about, talk about, look at, and act toward people with substance use disorders. Negative attitudes and ways of talking about substance misuse and substance use disorders can be entrenched, but it *is* possible to change social attitudes. This has been done many times in the past: Cancer and HIV used to be surrounded by fear and judgment, now they are regarded by many as simply medical conditions. This has helped people become comfortable talking about their concerns with their doctors, widening access to prevention and treatment. By coming together as a society with the resolve to do so, it is similarly possible to change attitudes toward substance misuse and substance use disorders. There is a strong scientific as well as moral case for addressing substance use disorders with a public health model that focuses on reducing both health and social justice disparities, and it aligns strongly with an economic case. Now is the time to make this change, for the health and well-being of all Americans.

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