



Forensic Psychiatric Hospital Feasibility Study

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

February 1, 2019

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I. Executive Summary

Background

Forensic Psychiatric Process Overview

It is well-established in federal and state law, that criminal defendants must be mentally competent to proceed before a criminal case against them may proceed. Competency to proceed is a central element of a defendant's right to a fair and speedy trial under the 6th and 14th Amendments to the U.S. Constitution. In *Drope v. Missouri*, the U.S. Supreme Court stated, "It has been long accepted that a person whose mental condition is such that he lacks the capacity to understand the nature and object of the proceedings against him, to consult with counsel, and to assist in preparing his defense may not be subjected to a trial."¹

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

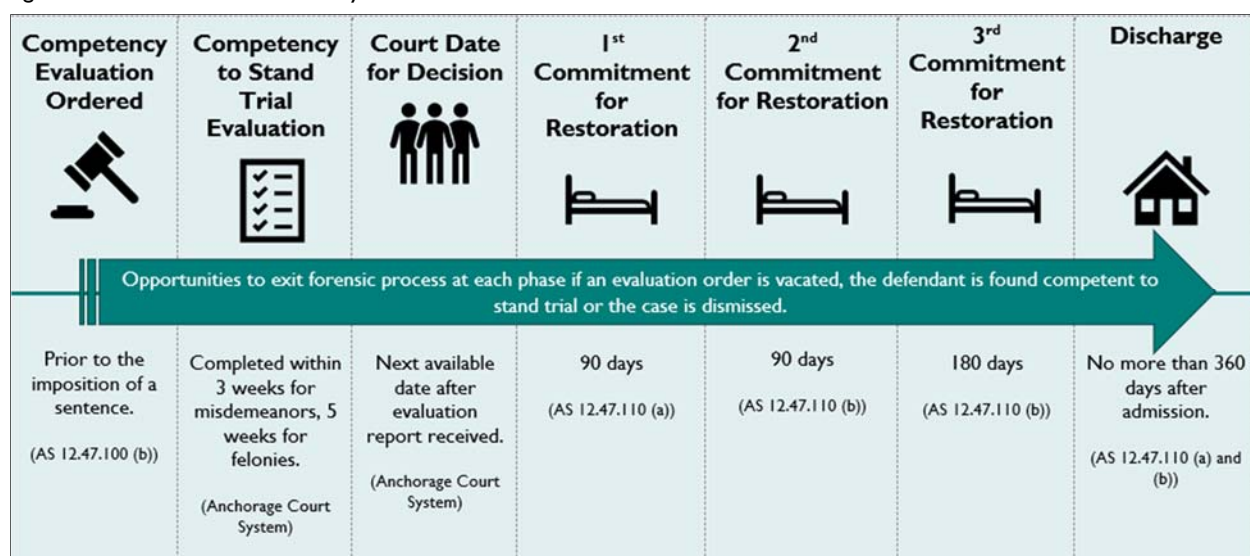
In some cases, after treatment for restoration, an individual remains incompetent to stand trial and is determined to be "non-restorable". Because the person has not been tried for the crime for which they were charged, the person cannot continue to be held by the criminal court; these individuals may have their cases dismissed or may be committed to a psychiatric hospital for treatment through a separate civil process.

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

In Alaska, the Anchorage Court System has timeframes for the completion of competency evaluations and court hearings. These timeframes are not statutorily defined and vary by court. Alaska Statute defines the number of days and times an individual can be committed for competency restoration, capping the number of days at a total of 360. Figure 1 depicts the forensic psychiatric process in Alaska.

¹ *Drope v. Missouri*, 420 U.S. 162. 1975

Figure 1: Continuum of Forensic Psychiatric Process in Alaska

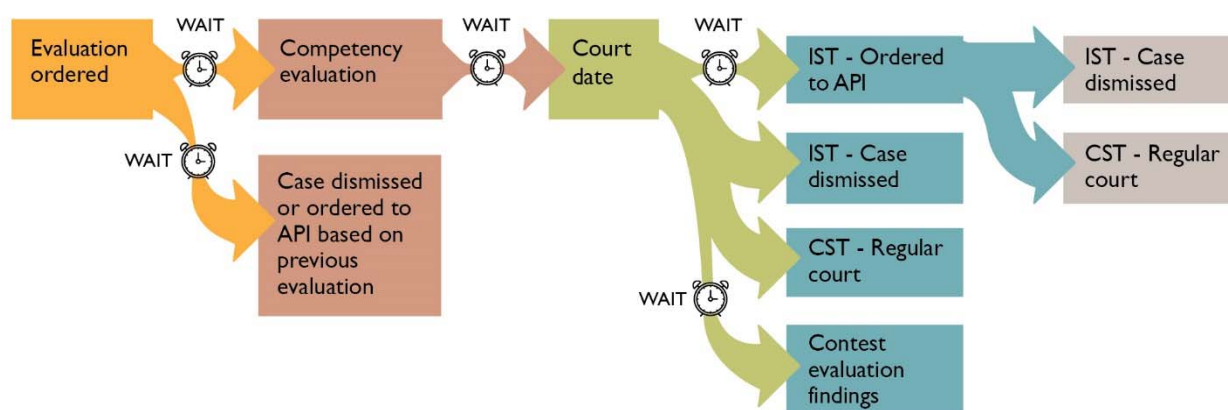


Alaska's Forensic System is Overloaded

The State of Alaska operates the Alaska Psychiatric Institute (API), an 80-bed psychiatric hospital, which includes a ten-bed Taku unit for forensic psychiatric treatment. Currently, individuals wait an average of 7.5 weeks to receive an evaluation for competency and another sixteen weeks on average to be admitted to API for restoration. Approximately 72 percent of individuals are held in Department of Corrections (DOC) facilities while they wait for competency evaluation and restoration services to become available.

The delays in Alaska's system that serves individuals charged with criminal offenses whose mental health condition is such that their competency to stand trial is questioned is due primarily to two factors: the two forensic psychologists employed by the State of Alaska at API are unable to complete evaluations at a pace that meets demand; and, the ten beds in the Taku unit are not sufficient to meet the demand for forensic psychiatric treatment.

Figure 2: Delays in the Competency Evaluation and Restoration Process



Is a New Forensic Psychiatric Facility Needed in Alaska?

The State of Alaska hired Agnew::Beck Consulting and its team of subcontractors to assess the feasibility and potential cost of relocating and expanding the Alaska Psychiatric Institute's (API) current forensic psychiatric unit to another facility in the Municipality of Anchorage. The first phase of this process includes 1) compiling

and analyzing available data to estimate the demand for competency evaluations and restoration treatment beds; and, 2) interviewing stakeholders to determine the demand for the forensic competency process and options for increasing capacity.

The Phase I report provides a quantitative assessment of demand, identifies the extent of the backlog in today's forensic system, regions and types of offenders driving the demand, and extent to which individuals are cycling through the forensic system. Key partners and stakeholders were identified and meetings with these groups informed the refinement of the target population and helped to highlight key issues and concerns. The Phase I report also incorporates the findings of previous reports and research. A matrix of recommendations from previous studies can be found in the Appendix.

It is important to note, this Phase 1 report provides initial estimates and analyses in draft form, subject to adjustment pending review by the client team, internal quality control and additional research. During Phase 2, we recommend developing a more detailed cost and operating plan for an expanded API for forensic restoration, increased evaluation capacity, jail-based restoration, as well as policy, statute, and procedural changes as identified throughout this report.

Key Findings

The results of the Phase 1 analysis demonstrate a need to expand capacity for both competency evaluations and for providing treatment for competency restoration.

Alaska needs additional capacity for competency evaluation and restoration.

There is significant backlog in the system for those awaiting competency evaluations and restoration. Currently, individuals wait an average of 7.5 weeks to receive an evaluation for competency and another sixteen weeks on average to be admitted to API for restoration.²

There is a need for new physical space for restoration, but that space does not necessarily require a new and separate facility from API. Stakeholders have not indicated a need for a separate new facility and it may be possible to increase capacity for restoration beds at API through an expansion of the existing facility. Additional statute, policy and procedural changes identified in this report could also improve the forensic competency process and increase capacity.

Figure 3 provides the results of our initial analysis for estimating the demand for restoration beds. Annual growth in requests for evaluations is assumed to be 11 percent, with the average annual growth rate dropping to two percent in 2026 as the backlog in the system is cleared. The full description of the method for this estimate is included in Section 5 of this report.

² Anchorage Court Competency Calendar Hearing Data, July 1, 2015 – December 31, 2018.

Figure 3: Demand for Forensic Restoration Beds

	Current Planning Design			Implementation Years						
Items	Year 1 FY19	Year 2 FY20	Year 3 FY21	Year 4 FY22	Year 5 FY23	Year 6 FY24	Year 7 FY25	Year 8 FY26	Year 9 FY27	Year 10 FY28
Demand for Restoration Beds										
Number of Evaluations [1]	338	374	413	457	505	558	617	629	642	655
% of Evals Requiring Restoration	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%
Restoration Demand From New Evaluations	135	149	165	183	202	223	247	252	257	262
Restoration Demand due to Lack of Capacity in Prior Year	34	119	219	334	176	83	35	-	1	2
Subtotal: Individuals in Need of Restoration	169	269	384	516	378	306	282	252	258	264
% Requiring Restoration in a Hospital Setting [2]	100%	100%	100%	67%	67%	67%	67%	67%	67%	67%
Demand for Restoration Beds: Individuals	169	269	384	346	253	205	189	169	173	177
Estimated Individuals Served in Jail-Based Restoration				170	125	101	93	83	85	87

Figure 4 provides the results of our initial analysis for estimating the needed supply for restoration beds. Twenty-five new beds are recommended, assuming jail-based restoration is provided.

Figure 4: New Restoration Beds Needed

Items	Current Planning Design			Implementation Years							
	Year 1 FY19	Year 2 FY20	Year 3 FY21	Year 4 FY22	Year 5 FY23	Year 6 FY24	Year 7 FY25	Year 8 FY26	Year 9 FY27	Year 10 FY28	
Demand for Restoration Beds: Individuals	169	269	384	346	253	205	189	169	173	177	
<i>Estimated Individuals Served in Jail-Based Restoration</i>				<i>170</i>	<i>125</i>	<i>101</i>	<i>93</i>	<i>83</i>	<i>85</i>	<i>87</i>	
<u>Capacity for API Restoration in Hospital</u>											
Current API Restoration Capacity - Individuals Served	50	50	50	50	50	50	50	50	50	50	
New API Restoration Capacity - Individuals Served	-	-	-	120	120	120	120	120	120	120	
Subtotal API Restoration Capacity - Individuals Served	50	50	50	170	170	170	170	170	170	170	
Surplus (Deficit) of Capacity - Individuals Served	(119)	(219)	(334)	(176)	(83)	(35)	(19)	1	(3)	(7)	
Total Beds Needed [3]	35	55	79	71	52	42	39	35	35	36	
Existing Beds	10	10	10	10	10	10	10	10	10	10	
New Restoration Beds Needed	25	45	69	61	42	32	29	25	25	26	

There is significant cycling of patients through Corrections, the court system, and API's forensic and civil units. API's readmission rate is high, and length of stay is short, which indicates that current treatment available does not meet the needs of individuals who require longer-term treatment.

- Forty-eight percent of forensic patients in fiscal year (FY) 2018 were previously admitted to API through a civil and/or forensic commitment between FY 2015 and FY2018.³
- The Taku Unit runs at or around 96 percent capacity and has an average length of stay 3.8 times longer than API's civilly committed average length of stay (69 days compared to 18 days in FY2018).⁴
- In FY18, API's forensic readmission rate 30-days post-discharge was two percent; however, for 180-days post discharge, the forensic readmission rate is 23.4 percent.⁵
- API has a shorter average length of stay (ALOS) for all patients compared to other states, and to peer facilities in other states. According to a 2017 report for DHSS, "The average number of days a patient stayed at API in FY14 was only 13 days, compared to its peer state hospitals, which ranged from 78 to nearly 1,067 days. Adding to this, the ALOS for the small peer hospitals is 188 days, only

³ API Meditech Electronic Health Records. IST and Non-IST Demographics, Unduplicated. July 1, 2015 – December 31, 2019.

⁴ Meditech Electronic Health Records. Average Length of Stay for Discharged IST Patients + Taku Occupancy, July 1, 2015 – December 31, 2018.

⁵ API Meditech Electronic Health Records. IST and Non-IST Demographics, Unduplicated. July 1, 2015 – December 31, 2019.

further supporting the observation that API's ALOS is extremely low for a state hospital, even when compared to hospitals similar in size. According to this logic, API's exceptionally low ALOS, paired with high readmission rates and the lack of other sub-acute services across the Alaska's behavioral health system, suggest that the hospital may not be able to stabilize patients effectively, given the existing admissions pressure."⁶

Nearly three-quarters of individuals who are engaged in the competency evaluation and restoration process are waiting in jail. The average wait time from date of evaluation order to admission for restoration in 2018 was 161 days.

- In 2018, 72 percent, or 166 cases were held in custody while they awaited a competency evaluation. The average wait time from date of evaluation order to date admitted to the Taku unit is 161 days, which means in 2018, approximately 26,726 bed-days at DOC facilities were used by individuals engaged in the competency process.⁷

Delays in the competency evaluation and restoration process sometimes lead to criminal charges being dismissed.

- In 2018, 64 percent of all 2018 statewide competency cases had at least one felony charge and 36 percent had only a misdemeanor charge.⁸
- Of the 152 cases that received an evaluator opinion in 2018, 40 percent (61 people) were deemed competent to stand trial and 56 percent (85 people) were deemed not competent to stand trial.⁹
- Long wait times lead to more cases being dismissed prior to individual being admitted for restoration treatment. In Anchorage, the number of cases dismissed either by the prosecution or in the interest of justice has increased over the past four years, while the number of individuals entering the regular court system has decreased.

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

- 82 percent of those who are IST and committed to API for restoration are men, compared to 56 percent of API's population who are male.¹⁰
- Over half of civilly committed patients at API are white (51 percent) while just 28 percent of IST patients are white. Thirteen percent of the IST population in the study period were African American, compared to just four percent in the civilly committed population. Alaska Native people comprise 32 percent of the civilly committed population at API, and 32 percent of the IST population.¹¹

⁶ Public Consulting Group (PCG) Feasibility Study for the Privatization of API, January 2017. Page 34.

⁷ Data compiled and analyzed by Agnew::Beck from one year's worth of API Tuesday Reports for calendar year 2018.

⁸ Ibid.

⁹ Ibid.

¹⁰ API Meditech Electronic Health Records. IST and Non-IST Demographics, Unduplicated. July 1, 2015 – December 31, 2019.

¹¹ Ibid.

- The top three diagnoses at discharge for IST patients are the same as for the civil population. However, nearly half of the IST population has a diagnosis of unspecified schizophrenia, compared to just 11 percent of the civilly committed population at API.¹²

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

- Currently, there is no statewide system for coordinating or tracking competency evaluations, thus if someone receives an evaluation order in Nome and then later in the year receives an evaluation order in Anchorage, there is no way for the court system to identify that there is a recent evaluation that they could refer to.
- Data is gathered by the Anchorage Courts and by API's Taku unit, but these are not integrated with one another or with data systems at the Department of Corrections, where most of the individuals engaged in the competency process are held while they wait for each step in the process.
- Data is not gathered or monitored from the rest of the court system statewide.
- Data for individuals awaiting an evaluation or a bed at API is managed separately from API's electronic health record and is manually compiled on a weekly basis without aggregation or tracking over time.

Summary of Recommendations

Competency to Stand Trial Evaluations

- Add one new forensic psychologist at API.
- Add the option to employ in-state or out-of-state forensic psychologists using telemedicine through a contract that the court system would control to increase capacity at times when the backlog reaches a certain level. Alternatively, employ one forensic evaluator at the Anchorage District Court.
- Develop a Statewide Centralized Competency Calendar for competency evaluations, and centralized data monitoring for individuals in this process.
- Allow courts to prioritize competency evaluations based on risk for legal exposure and other factors.
- Update Alaska statutes as identified by the 2016 WICHE report to API and the 2014 Review of Alaska Statutes completed by the team from UNLV.¹³

Treatment for Restoration to Stand Trial

- To increase capacity for competency restoration, we estimate approximately 25 additional treatment beds are needed.
- We also propose exploring a jail-based restoration program in Phase 2 of this project to absorb some demand for restoration and reduce delays, for those individuals who are appropriate for a jail-based restoration program.

¹² API Meditech Electronic Health Records. IST and Non-IST Discharge Diagnosis. July 1, 2015 – December 31, 2019.

¹³ Fox, Patrick. 2016. Alaska Psychiatric Institute: Evaluation of Forensic Services. Western Interstate Commission for Higher Education. And, Gordon, Sara, Piasecki, Melissa, Kahn, Gil, Nielsen, Dawn. 2014. Review of Alaska Mental Health Statutes. University of Nevada Las Vegas.

- There is no designated space for juveniles needing competency evaluation and restoration. While there is minimal demand from juveniles, this need should be further explored in Phase 2.

Those Deemed Non-Restorable Who Require Psychiatric Treatment through Civil Commitment

- API's reduced capacity to provide long-term treatment to civilly committed patients also reduces its ability to receive those deemed non-restorable who require treatment through a civil commitment in a timely manner.
- The State should expedite strategies to increase capacity in hospitals around Alaska to provide short-term inpatient psychiatric treatment, so that beds at API can be prioritized for those with the most complex treatment needs who are difficult to serve in other settings.

2. Defining the Project

Scope of Work

The stated goal in the Request for Proposals for the Forensic Psychiatric Hospital Feasibility Study is “to explore the feasibility and potential cost of relocating and expanding the Alaska Psychiatric Institute’s (API) current forensic psychiatric unit to another facility in the Municipality of Anchorage.”¹⁴ Through discussions with stakeholders since the start of the project in November 2018, we believe that the research task for this study includes expanded capacity at API for forensic-related clients as well as the implementation of policy and statute changes to improve the competency evaluation and restoration backlog the State faces.

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

- High demand for forensic psychiatric evaluation and treatment services among justice-involved mentally ill populations;
- Significant volume of court-orders for competency to stand trial (CST) evaluations and incompetent to stand trial (IST) restoration treatment;
- Limited forensic psychiatric bed capacity in a state hospital facility with among the lowest average lengths of stay and the highest readmission rates in the country;
- Pressures on staff who are pulled from conducting forensic evaluations to appear in court to explain why individuals with active orders for admission are not admitted; and,
- State statutes that allow court-ordered treatment in the community but a limited capacity to implement alternative community-based forensic approaches.

To address this range and complexity of issues requires a multidimensional approach. Analysis of the need to expand forensic hospital capacity is an important first step to address the many challenges facing Alaska’s forensic psychiatric system today.

Data Sources

The following table provides an overview of the data sources used to draw conclusions about the demand for forensic evaluations and restoration. We relied on three point-in-time counts from the API Tuesday reports for statewide information on overall number of individuals involved in the competency process. We also compiled one year of weekly Tuesday reports (2018) from the API Taku unit to provide descriptive statistics about those involved in the competency process. Additionally, we received three years of data from the Anchorage Competency Court calendar, which provides detailed information on those served by the Anchorage courts. In some cases, the Anchorage data is inconsistent with the API Tuesday report data.

¹⁴ State of Alaska Request for Proposals RFP 190000005, Issued August 3, 2018.

Figure 5: Data Sources

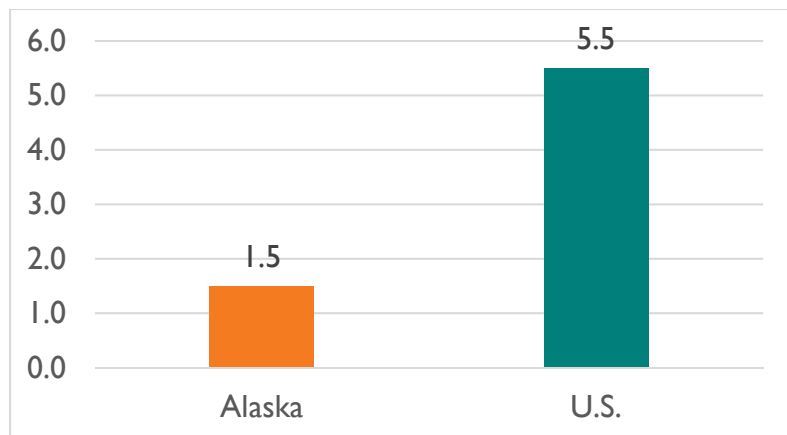
Data Source	Information Provided	Limitations
API Meditech	<p>For individuals admitted for restoration:</p> <ul style="list-style-type: none"> • Number Admitted + Discharged • Diagnosis • Demographics • Length of Stay 	<p>Only captures information for admitted patients for restoration.</p>
Anchorage Court Competency Calendar Spreadsheet	<p>For individuals with a court order from an Anchorage court for competency evaluation:</p> <ul style="list-style-type: none"> • Days waiting for evaluation • Court finding + case disposition • Type of charge • Days waiting for restoration bed • Judge who ordered the evaluation • Age 	<p>Only for Anchorage.</p> <p>Missing data and data points not always recorded in a consistent manner.</p>
Dr. Becker's Counts	<p>Number of competency evaluations completed by API forensic psychologist.</p>	<p>Must be hand counted. No digitized record of the number of evaluations completed.</p>
API Tuesday Reports	<p>Spreadsheet of individuals at multiple points in the competency process:</p> <ul style="list-style-type: none"> • Age + Sex • Originating Court • Waiting location • Type of charge • Days waiting for evaluation • Days waiting for court order • Days waiting for restoration bed • Evaluator opinion 	<p>Tuesday reports are only kept in hard copy and must be entered by hand for analysis.</p> <p>Missing data and data points not recorded in a consistent manner.</p>

Alaska Psychiatric Institute

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

The Taku Unit runs at or around 96 percent capacity and has an average length of stay 5.8 times longer than API's overall average length of stay (79 days compared to 13 days).¹⁵ In 2017, API's forensic readmission rate 30-days post-discharge is two percent, below the 3.5 percent United States forensic readmission rate; however, for 180-days post discharge, the forensic readmission rates are 28.0 percent at API, over twice that of the US rate of 11.4 percent.¹⁶

Figure 6: Number of Forensic Beds per 100,000 population



Nationally, forensic beds comprise 30.5 percent of total state hospital beds.¹⁷ At API, however, forensic beds comprise only 12.5 percent of total bed capacity, one of the lowest proportions in the country. This is also reflected in the number of forensic beds per 100,000 population, with the national average at 5.5 beds per 100,000 in population and Alaska's average of 1.4 beds per 100,000.¹⁸

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

In addition to an increased waitlist for forensic beds at API, the facility also has a shortage of civil commitment beds. There are 60 beds available for civilly committed adults; however, staffing shortages have necessitated the closure of some units and a reduction of beds available. In 2017, API's utilization rate per 1,000 people, at 1.58, is more than three times higher than the national rate of .40. The average civil readmission rate across all states 30-days post-discharge is 8.3 percent, compared to API's rate of 15 percent; 180-days post-discharge readmission rate is 19.2 percent, compared to API's rate of 31.2 percent.¹⁹

API has a shorter average length of stay (ALOS) for all patients compared to other states, and to peer facilities in other states. According to a 2017 report for DHSS, "The average number of days a patient stayed at API in FY14 was only 13 days, compared to its peer state hospitals, which ranged from 78 to nearly 1,067 days. Adding to this, the ALOS for the small peer hospitals is 188 days, only further supporting the observation that API's ALOS is extremely low for a state hospital, even when compared to hospitals similar in size. According to this logic, API's exceptionally low ALOS, paired with high readmission rates and the lack of other sub-acute services across the Alaska's behavioral health system, suggest that the hospital may not be able to stabilize patients effectively, given the existing admissions pressure."²⁰

¹⁵ Meditech Electronic Health Records. Average Length of Stay for Discharged IST Patients + Taku Occupancy, July 1, 2015 – December 31, 2018. Public Consulting Group (PCG) Feasibility Study for the Privatization of API, January 2017. Page 34.

¹⁶ Substance Abuse and Mental Health Services Administration Uniform Reporting System Output Tables for Alaska, 2017.

¹⁷ Fuller, D.A., Sinclair, E., Geller, J., Quanbeck, C., and Snook, J. Going, going, gone: Trends and consequences of eliminating state psychiatric beds. Arlington, VA. Treatment Advocacy Center, June 2016.

¹⁸ Fuller, D.A., Sinclair, E., Geller, J., Quanbeck, C., and Snook, J. Going, going, gone: Trends and consequences of eliminating state psychiatric beds. Arlington, VA. Treatment Advocacy Center, June 2016.

¹⁹ Substance Abuse and Mental Health Services Administration Uniform Reporting System Output Tables for Alaska, 2017.

²⁰ Public Consulting Group (PCG) Feasibility Study for the Privatization of API, January 2017. Page 34.

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

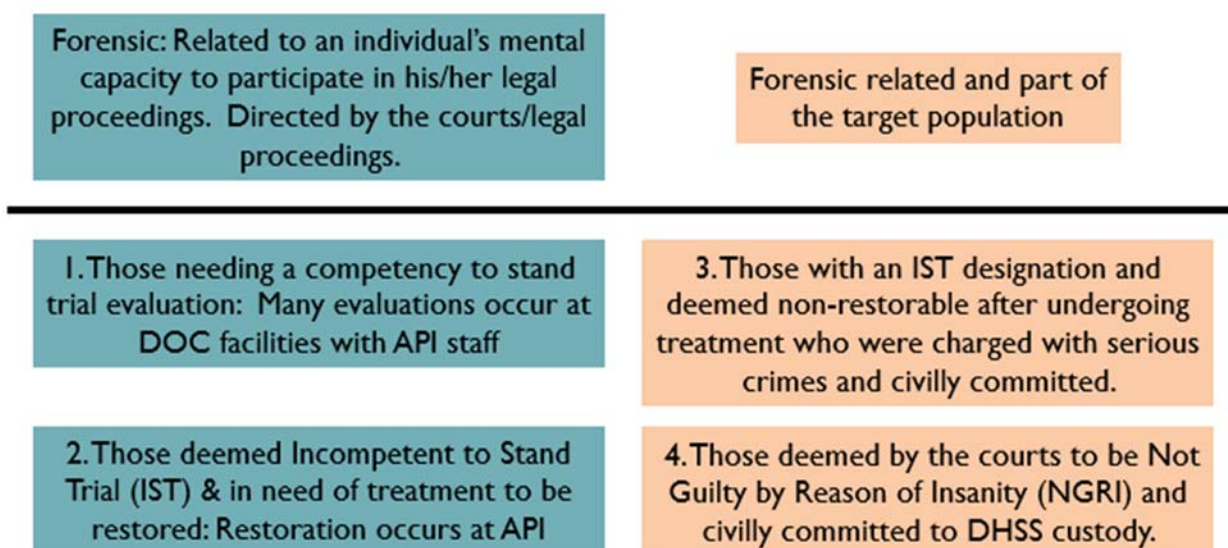
Target Population

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

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

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

Figure 7: Forensic Psychiatric Hospital Feasibility Study Target Population



3. Backlog in the Competency Process

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

Overview of the Competency Process

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

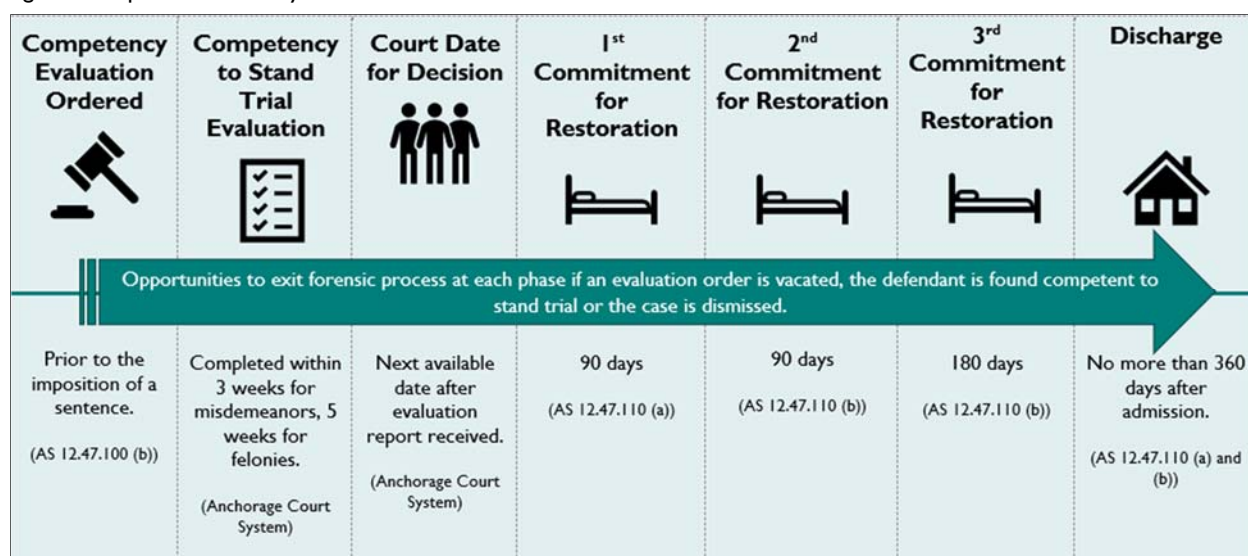
Timeframes for completion of evaluations and scheduling of court dates for evaluation hearings are not specified in statute. The Anchorage Competency Court has established their own timeframes, identifying that evaluations for misdemeanants must be completed within three weeks of order and evaluations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

Figure 8 identifies the steps in the forensic psychiatric process which begins when a competency evaluation is ordered. At numerous points in the process, the defendant may be determined competent and return to the normal court process, receive treatment to restore him or her to competency, be determined non-restorable, and/or have charges dismissed. At any point in the process, the defendant may experience delays.

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

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

Figure 8: Steps in Forensic Psychiatric Process



Existing Backlog

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

Number of individuals ordered to the process on a yearly basis. As shown in Figure 17 in the following chapter, a forecasted total of 338 individuals will likely be ordered for competency evaluation during fiscal year 2019, which is based on annualizing year to date orders for evaluation. The estimated 338 in 2019 is up from 223 in fiscal year 2016 or an increase of 51 percent over three years.

Number of individuals waiting. As of December 11, 2018, 71 individuals were waiting in at least one stage of the competency process (for an evaluation, a court order, or a restoration bed) compared to 49 at the same time in 2015, an increase of 45 percent over three years. In December of 2018, 20 individuals were waiting for one of 10 beds at Taku compared to 2 individuals waiting for one of 10 beds during the same month in 2015, an increase of 45 percent over three years. Figure 5 is a point in time count of the number of individuals waiting or participating in each part of the competency evaluation and restoration process.

Figure 9: Individuals Waiting and Admitted to Taku for Restoration, Point in Time December 2015, 2017 and 2018

Status	Dec 2015	Dec 2017	Dec 2018
Number of People Waiting - Point in Time			
Waiting for Competency Evaluation	22	25	35
Waiting for Court Finding: Have been Evaluated	25	19	16
Waiting for Admission for Restoration: Court has Ruled	2	10	20
Subtotal Waiting	49	54	71

	percent change from 2015		
		10%	45%
Admitted to Taku for Restoration*	14	9	10
Total	63	63	81

*In 2015, 1 juvenile was at McLaughlin Youth Center and 3 forensic patients were on the Denali unit at API for a total of 14 forensic patients. Source: API Tuesday Reports: December 7, 2015, December 12, 2017 and December 11, 2018

Overall wait times are long. Using the 2018 API Tuesday Report, we found that on average an individual is waiting 161 days (or 23 weeks) from the date the evaluation is ordered until he or she is admitted for restoration (Figure 10). The wait time for a complete evaluation averages 52 days (or 7.5 weeks) and the wait time to admission for those deemed incompetent to stand trial was another 113 days (or 16 weeks). At all stages of the process, the wait time for those with a misdemeanor only was slightly less than those with a felony.

Figure 10 Wait Times for Evaluation and Admission in 2018

Stage in the Process	2018 Average Days: All Charges		
	All	Anchorage	Non-Anchorage
Waiting for Evaluation	52	48	58
Waiting for Admission [1]	113	92 to 111	120
Total waiting from Date of Evaluation Order to Admission	161	140 to 158	174

Stage in the Process	2018 Average Days: Misdemeanor Only		
	All	Anchorage	Non-Anchorage
Waiting for Evaluation	44	34	52
Waiting for Admission	113	133	95
Total waiting from Date of Evaluation Order to Admission	138	139	136

Stage in the Process	2018 Average Days: At Least One Felony		
	All	Anchorage	Non-Anchorage
Waiting for Evaluation	56	52	61
Waiting for Admission	113	108	137
Total waiting from Date of Evaluation Order to Admission	172	165	200

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

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

Characteristics of Individuals in Competency Process

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

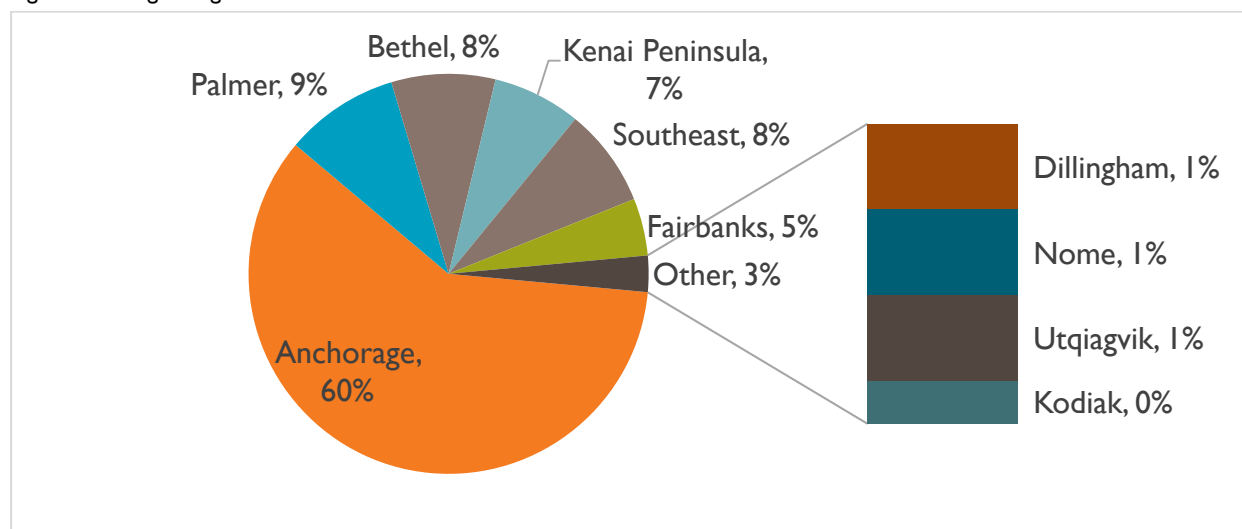
Charge Type

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

Originating Court

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

Figure 11: Originating Court

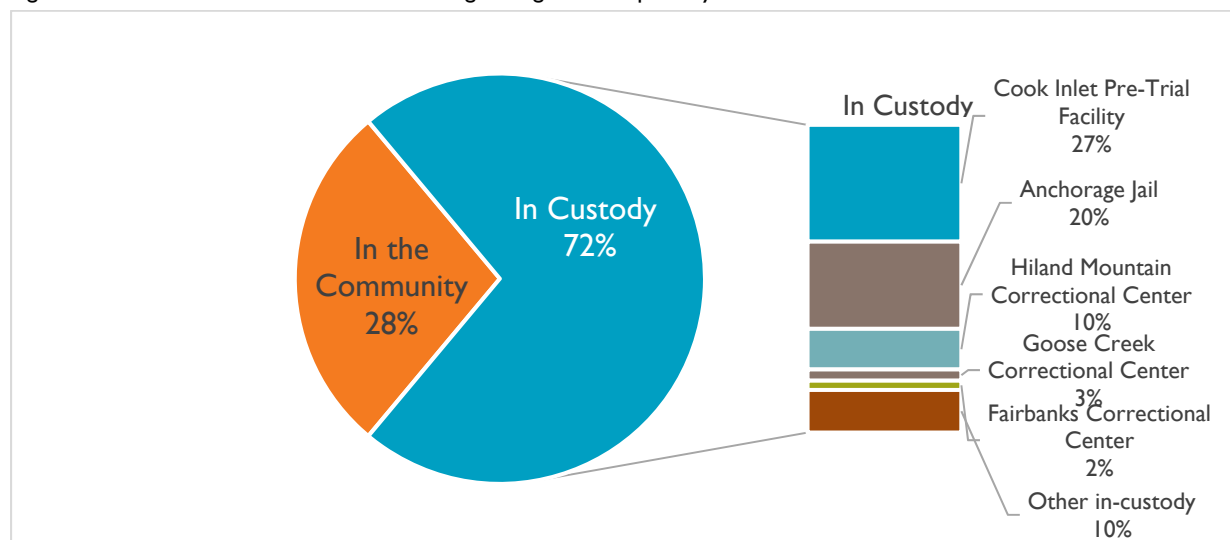


Location While Waiting

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

Center, Mat-Su Pre-trial, Bethel Youth Facility, Ketchikan Correctional Center and McLaughlin Youth Center.

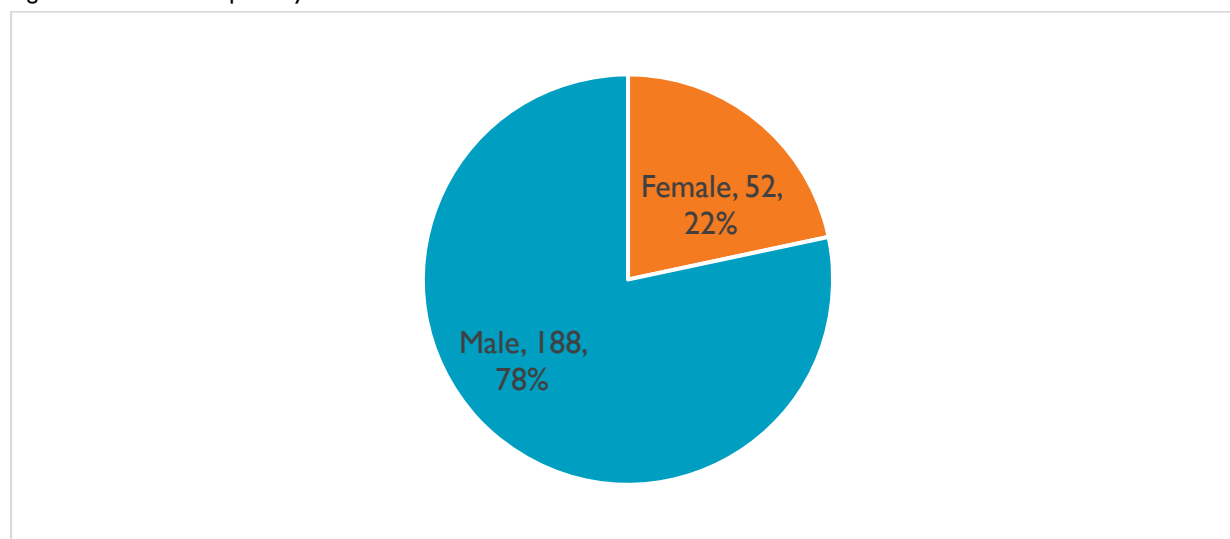
Figure 12: Location Where Individual is Waiting during the Competency Process



Sex

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

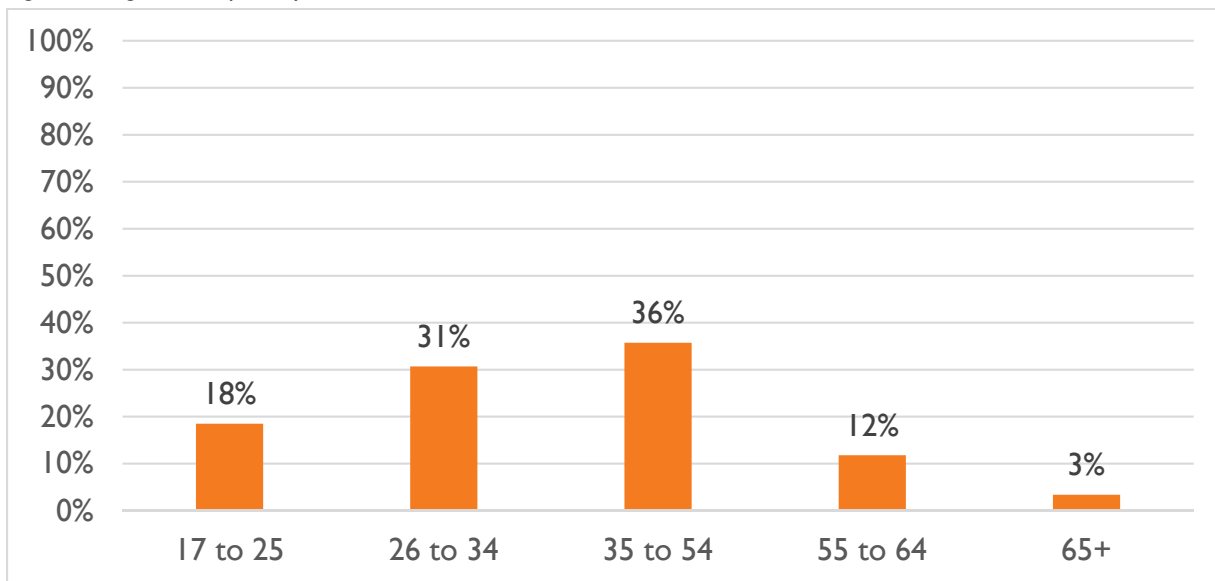
Figure 13: Sex of Competency Case Defendants



Age

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

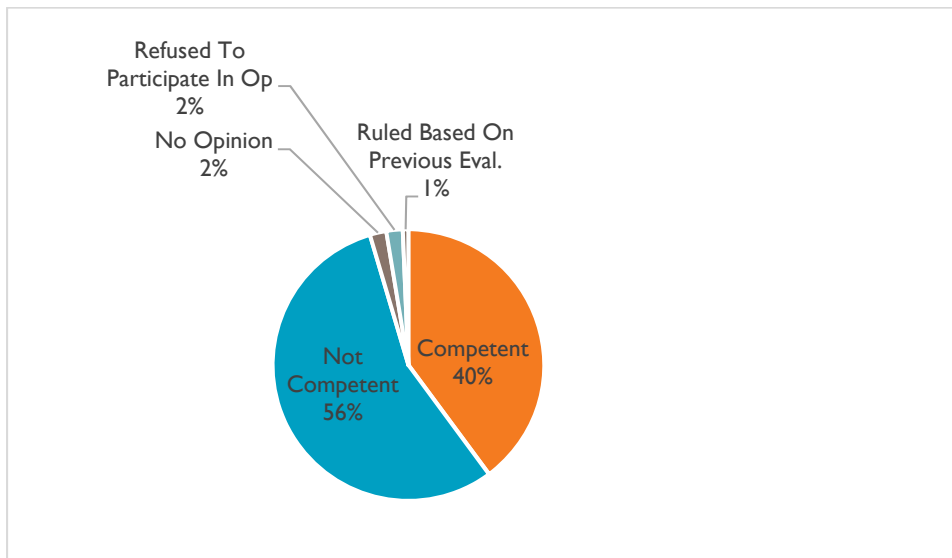
Figure 14: Age of Competency Case Defendants



Percent found Incompetent to Stand Trial (IST)

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

Figure 15: Evaluator Opinion in Competency Evaluations



4. Competency to Stand Trial Evaluations

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

Current Competency Evaluation Process

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

API employs 2.5 forensic psychologists, who conduct all competency evaluations for the entire state. Dr. Kristy Becker, API's Chief Forensic Psychologist, shared that most evaluations take 90 minutes, but that there are complex cases that may take much longer due to additional testing or observation needed. Routine evaluations are not conducted on API's inpatient unit. Most evaluations take place in a Department of Corrections (DOC) facility or in an interview room at API if the individual is not in DOC custody. Occasionally, evaluation beds are needed for individuals who refuse or are resistant to the evaluative process. Dr. Becker estimates that five patients per year may need an inpatient bed at API to complete the evaluation. The time needed for an inpatient evaluation ranges from two days to one week.²¹ Juveniles are evaluated by the same staff that evaluate the adult forensic population, most often at the McLaughlin Youth Center.

After completion of a competency evaluation, the forensic evaluator writes a report and submits it to the requesting court, which then sets a court date to decide in the case. In

Anchorage, competency cases are prioritized, and a hearing is scheduled for the next available date. There is incomplete data on the time required for a court order following an evaluation. Possible outcomes are for the court to accept the forensic evaluator's incompetent to stand trial (IST) finding and order the individual to

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

²¹ Verbal communication. Dr. Kristy Becker, November 28, 2018.

Figure 16: Competency Evaluation and Restoration Process

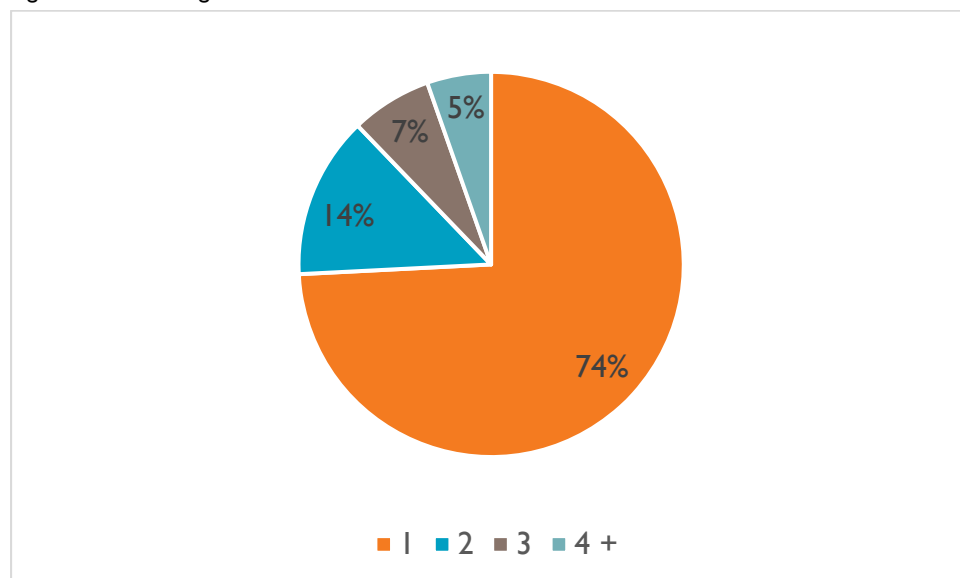


Figure 17: Competency Evaluations Ordered, Anchorage, and Competency Evaluations Completed, Statewide, FY 2016-19



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

Figure 18: Percentage of individuals with one, two, three and four or more evaluations ordered



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

Wait Times for Evaluations

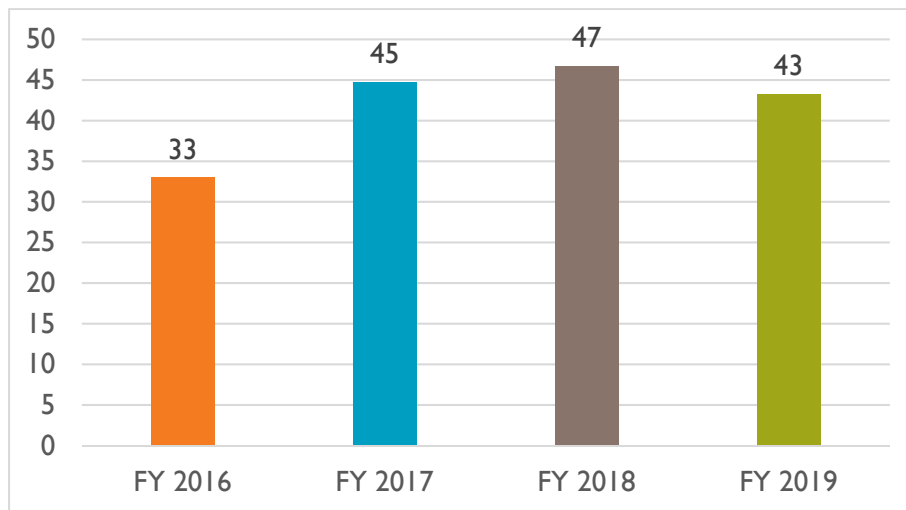
On average, individuals waiting for a competency evaluation waited for 52 days (7.5 weeks) in 2018 based on the date the evaluation was ordered and the date the forensic psychologist rendered an opinion.²² The Anchorage District Court looked at national best practices and decided to set a timeframe of three weeks to complete a competency evaluation for misdemeanor offenses and five weeks for felony offenses. All judges and magistrates in the Anchorage district court are trained to schedule competency hearings based on these guidelines.²³ Over the past year, API's evaluators have rarely been able to complete an evaluation and report in that timeframe. During 2018, only 14 percent of misdemeanor cases received a completed evaluation in less than 3 weeks and only 25 percent of felony cases received a completed evaluation in less than five weeks. In Anchorage, an increasing number of cases have been dismissed or ordered to API for restoration based on previous competency reports.

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

²² Summary of data entry of all 2018 API Tuesday Reports by Agnew::Beck.

²³ Proposal to request for funding and resources to expand the Anchorage Centralized Competency Calendar to a state-wide docket. Authored by Kate Sumey, MA Project Coordinator for the Anchorage Coordinated Resources Project (Mental Health Court) and the Anchorage Centralized Competency Calendar. October 2018.

Figure 19: Average Days Waiting for Competency Evaluation, Anchorage - Outliers Removed



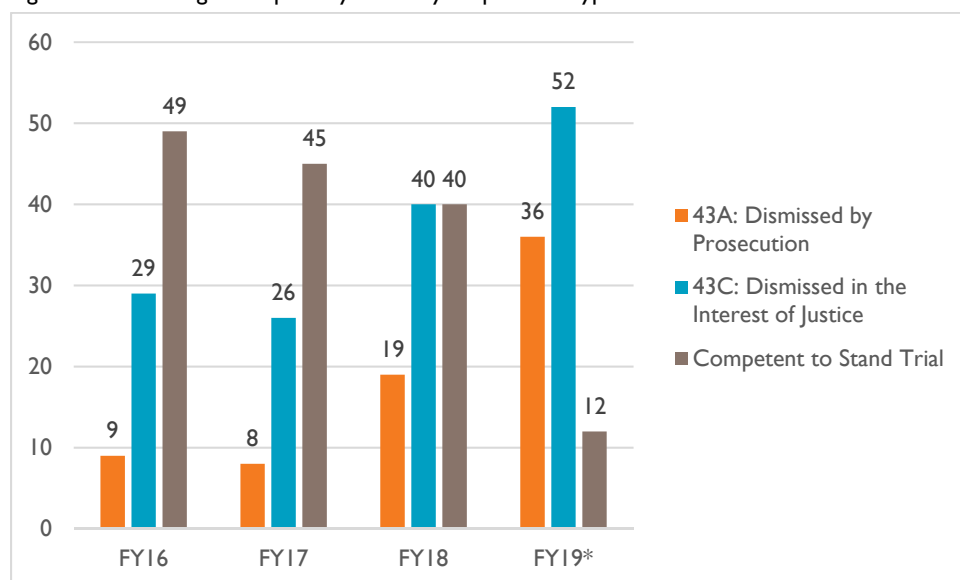
Source: Anchorage Court Competency Calendar Hearing Data, July 1, 2015 – December 31, 2018.

Court Disposition

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

Figure 20 below shows the number of Anchorage court cases with a case disposition of "43A", "43C" or "Regular Court" (CST). This chart represents the total number in each category (projected totals for FY 2019), which includes individuals who had cases dismissed before or after restoration and individuals who were found competent to stand trial before or after restoration. In Anchorage, the number of cases dismissed either by the prosecution or in the interest of justice has increased over the past four years, while the number of individuals entering the regular court system has decreased. In FY16, 49 cases went to the regular court system for trial, while 38 were dismissed. A marked reversal is expected in FY19, with just 12 cases expected to go to regular court and 88 expected to be dismissed. It should be noted that CST projections for FY 2019 may be lower than expected, due to the extent of the backlog for evaluations and restoration.

Figure 20: Anchorage Competency Cases by Disposition Type



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

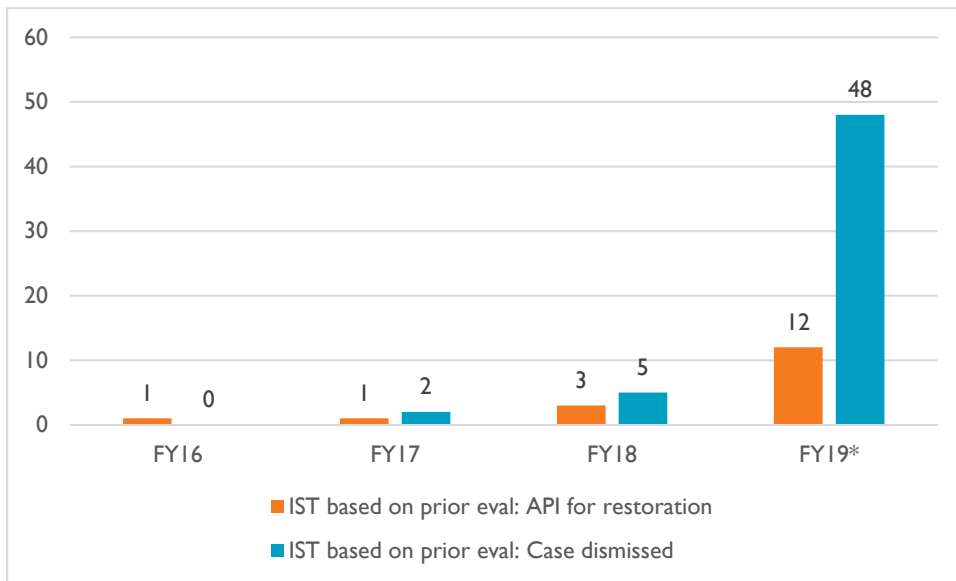
Court Disposition Based on Prior Evaluation

In Anchorage, the court seems to be relying increasingly on past competency evaluations to determine if an individual should be ordered for restoration or if the case should be dismissed. Use of a prior evaluation will depend on the attorney, the seriousness of the current and prior offense and the date of the last evaluation. However, there is not a written standard in statute or elsewhere that specifies when a prior evaluation can be used.²⁴ In FY 16, just one individual was ordered to API for restoration based on a previous evaluation, but in the first half of FY 2019 (July 1, 2018 – December 31, 2018) six individuals were (projected total for FY 2019 is 12).

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

²⁴ Anchorage Competency Court Judges. Stakeholder Interview, January 17, 2019.

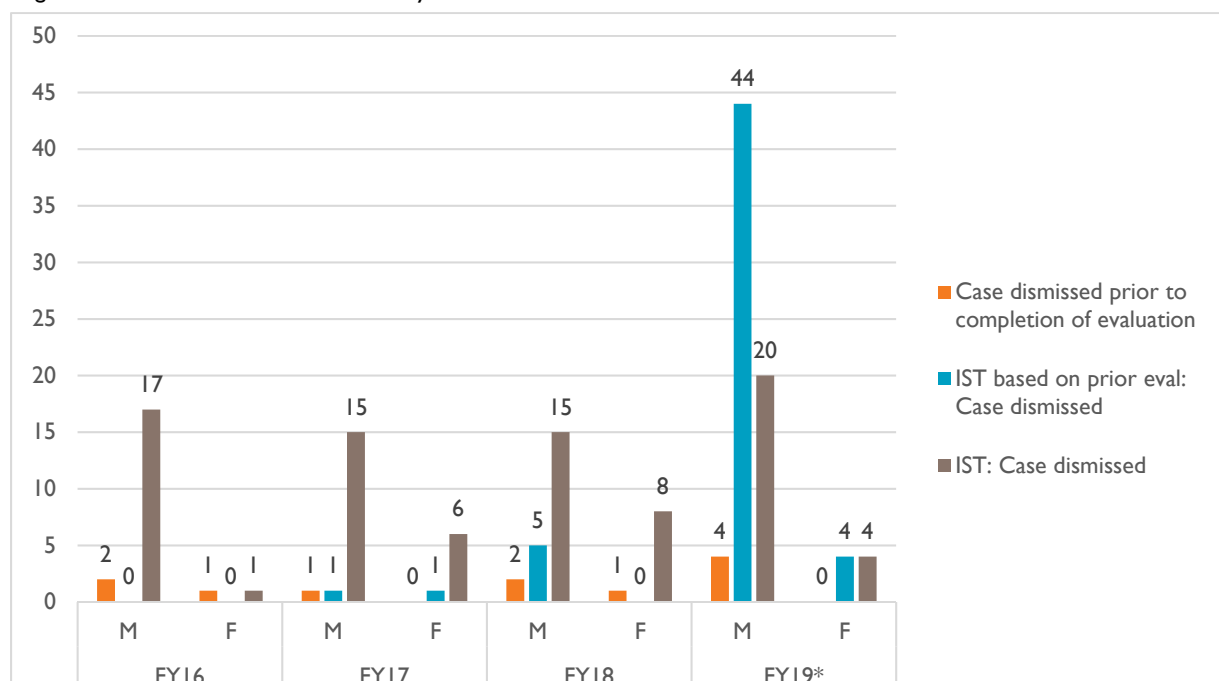
Figure 21: Case Decisions Based on Prior Evaluations, Anchorage



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

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

Figure 22: Number of Cases Dismissed by Fiscal Year



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

Recommendations

Facility, staffing and process change recommendations are guided by the recommendations from previous studies, stakeholder interviews and data which highlights critical areas for intervention.

Recommended statutory changes are informed by previous studies that have looked specifically at statute changes related to the forensic psychiatric population. A full list of statute change recommendations from previous reports can be found in the Appendix. Referenced reports include:

- Fox, Patrick. 2016. Alaska Psychiatric Institute: Evaluation of Forensic Services. Western Interstate Commission for Higher Education.
- Gordon, Sara, Piasecki, Melissa, Kahn, Gil, Nielsen, Dawn. 2014. Review of Alaska Mental Health Statutes. University of Nevada Las Vegas.

Facility

In the current process, most competency evaluations are not performed at API and do not require an inpatient bed. Consequently, adding more beds will not be effective at reducing the wait times for competency evaluations. In an interview with the Department of Corrections, one partner shared that 15-20 years ago all competency evaluations happened inpatient at API. Individuals needing a competency evaluation were taken to API for anywhere from one to five days for a very thorough evaluation and observation period. DOC expressed concern about the thoroughness of outpatient evaluations lasting just a few hours and suggested that competency evaluations could indeed be a facility issue.

There is tremendous pressure on the forensic psychiatric system nationwide, and across the country fewer competency evaluations are conducted in inpatient settings. Considering a reversal of this trend in Alaska would have significant impacts on the number of beds needed for a new or expanded facility.

Staffing

Stakeholder interviews with Anchorage Competency Court judges and staff identified several possible staffing solutions. Overall, the judges felt the most acute issue is staffing to conduct evaluations; without a competency evaluation, the court process stalls and with a growing frequency, cases are dismissed. The Criminal Justice Commission's 2018 Annual Report also recommended growing the number of forensic psychologists and psychiatrists to increase API's current evaluation capacity. There are several possible staffing solutions to consider.

Add forensic psychologists at API

There are currently 2.5 forensic psychologists and a paralegal employed by API to provide forensic evaluations and support. These same forensic psychologists also provide restoration services to those ordered to API for this purpose. Orders for competency evaluations in the Anchorage court system alone increased 21 percent between FY 2016 and FY 2018 without an increase in staffing to address the growing demand.

Telemedicine contracts with out-of-state forensic psychologists

While not specifically identified in AS 12.47.100 Incompetency to proceed (statute governing competency to stand trial evaluations), tele-psychology is permitted in the State of Alaska by AS 08.86.204(c). However, all persons practicing psychology must hold an Alaska professional license, which may be a barrier to quick recruitment and on-boarding of tele-evaluators from outside of Alaska.

Telemedicine is a practice that has matured significantly in recent years. Initial concerns about encryption, privacy and the conditions under which a patient is being evaluated have been largely addressed. Forensic telepsychiatry services have emerged and are especially helpful in providing evaluations in areas in which is impractical or not possible to conduct an in-person forensic evaluation. Courts have recognized the use of forensic telepsychiatry as a valid and reliable means of conducting a forensic evaluation, and several companies have emerged to meet the demands of this emerging market. Alaska should consider amending AS 12.47.100 and AS 12.47.070 to define forensic telepsychiatry and the circumstances in which it may be used and to expressly permit evaluations to be conducted by this method.

While there are ethical, technological and cost factors to consider, telemedicine remains an option to increase the staff capacity of API's forensic psychologists. Both the 2016 WICHE report and the 2014 UNLV report recommend exploring the use of tele-evaluations for the forensic psychiatric population.

Contracts with Alaska-licensed forensic psychologists

Psychologists licensed in Alaska have previously conducted competency evaluations on a contract basis. Coordinated outreach to Alaska psychologists to identify those who are qualified for and interested in contract work to conduct competency evaluations is one possible solution that would ease the pressure on API's forensic psychologists to provide an increasing number of evaluations. A contract for 20-30 evaluations per year could be offered and multiple agencies (API, the Alaska Court System, and DOC) could potentially pool resources to fund this contract.

Add a forensic evaluator to the Alaska Court System

Forensic evaluations are not required by statute to be conducted by API staff. In other states, forensic evaluators are housed in the court system. Alaska Court System judges state that funding is not currently available to hire a forensic evaluator. The 2016 WICHE report recommended discussion between the Department of Health and Social Services and the Alaska Court System regarding which branch of government is responsible for providing forensic evaluators and paying for their services.

Process

Prioritization

Alaska Court System judges in Anchorage would like to implement statewide tracking and coordination of competency evaluations to include a process for prioritization of misdemeanants for evaluation and restoration. Currently, there is no statewide system for coordinating or tracking competency evaluations, thus if someone receives an evaluation order in Nome and then later in the year receives an evaluation order in Anchorage, there is no way for the court system to identify that there is a recent evaluation that they could refer to. Additionally, the court would like to see individuals with misdemeanor charges prioritized for evaluation and restoration, based on their risk for legal exposure.

The court system believes they should be responsible for prioritizing individuals for evaluation and restoration and should be able to provide API with a prioritized list. To this end, the court system put forward a proposal for a statewide competency administrative position, but implementation of this position is dependent on funding and collaboration with API.²⁵ Two judges with experience in mental health competency law would hear cases on the statewide competency docket, per the proposal.

Brief screening

Currently, API performs the same level of competency evaluation for all defendants, regardless of offense type or acuity of symptoms. The 2014 UNLV report suggested the consideration of a more limited competency evaluation for misdemeanants. The Anchorage Court system, in conjunction with a behavioral health provider created an abbreviated competency evaluation form for use with misdemeanants. Forensic evaluators at API were not in favor of this approach because they state that the level of a person's charged offense does not necessarily indicate that person's complexity of mental health issues. For example, a person with severe mental illness and acute symptoms may be charged with a relatively low-level offense but the severity of their illness could require significant restoration to be competent to stand trial.

Education and supervision

Education for relevant members of the court may be helpful to clarify competency restoration and explain which treatments, services, and programming are available at API for the forensic psychiatric population. The 2016 WICHE report recommended that API provide in-services for the courts and consider inviting members of the court to tour API to better understand the processes there. Judges with the Anchorage Court Competency calendar suggested targeted education, specifically to courts in rural communities, about the competency process to ensure the appropriateness of referrals for competency evaluations, citing that they see cases originating in rural courts that are not always appropriate for the process.

²⁵ Proposal to request for funding and resources to expand the Anchorage Centralized Competency Calendar to a state-wide docket. Authored by Kate Sumey, MA Project Coordinator for the Anchorage Coordinated Resources Project (Mental Health Court) and the Anchorage Centralized Competency Calendar. October 2018.

Currently, forensic evaluators at API serve two roles: they conduct the forensic evaluations and serve as members of the competency restoration clinical team. Use of forensic consultants external to API to provide guidance and objective analysis of the work of API's forensic evaluators for the purposes of professional development and to reduce the chance for or perception of a conflict of interest should be considered. See Appendix for relevant recommendations from previous studies.

Statute

The terms “qualified psychiatrist”, “qualified psychologist” and “qualified forensic psychologist” are not currently defined in statute, and statute does not expressly permit trainees and interns to conduct evaluations. Defining terms and broadening the definition brings more clarity to who may perform competency evaluations and broadens the pool of potential evaluators.

- Define the terms “qualified psychiatrist”, “qualified psychologist” and “qualified forensic psychologist” in the Definitions section in AS 12.47.130. Include in the definition verbiage that expressly permits post-doctoral trainees and interns to conduct evaluations under the supervision of a qualified forensic evaluator. (WICHE, 2016; UNLV, 2014)

Per Alaska Court System judges, the use of a prior evaluation depends on the attorney, the seriousness of current and prior offenses and the date of the last evaluation; however, there is not a written standard for when prior evaluations should be used.

- Amend AS 12.47.100 to permit the court to rely on previous and/or recent competency evaluations to determine whether a competency to proceed evaluation for the current charges is necessary, particularly for defendants well-known to the court and repeatedly charged with misdemeanor offenses and/or allow for the use of a more limited, follow-up competency evaluation in misdemeanor cases where a defendant has received a full competency evaluation in the previous 12 months. (WICHE, 2016; UNLV, 2014)

Alaska does not have statutory provisions expressly permitting the use of telemedicine, telehealth, or tele-behavioral health.

- Allow for the use of tele-behavioral health and evaluation via videoconferencing in AS 12.47.070 and AS 12.47.100 and throughout Title 47. Allow for the use of tele-behavioral health for forensic evaluations. Define tele-behavioral health in statute. (WICHE, 2016; UNLV, 2014)

There is not a statutory limit on the timeframe for completion of competency evaluations for misdemeanor offenses. Misdemeanants may spend longer awaiting a competency evaluation than they would if they had just served their time in prison.

- Amend AS 12.47.070 to require that competency evaluations for misdemeanor charges be performed within 15 calendar days of the court order. A 15-day extension should be permitted when the defendant appears to be under the influence of alcohol or drugs at the time of the order. (UNLV, 2014)

There is no statutory requirement for scheduling competency hearings. The Anchorage Competency Court prioritizes competency cases and puts them on the calendar for the next available court day, but this is not a practice that is mandated statewide.

- Amend statute to require that the court advance the date for the hearing on the defendant's competency to the day after the competency report is filed. (UNLV, 2014)

Alaska statute provides little direction as to how juveniles should be treated in competency proceedings.

- Amend statute to include specific mention of juveniles, considering the following factors: developmental immaturity as a cause of the defendant's incompetence to stand trial, inclusion of cognitive concepts like a juvenile's ability to understand the proceedings and assist counsel, provision of a separate definition for childhood mental illness, requirement that the evaluation be performed within 30 calendar days of the court order for evaluation, inclusion of a requirement that the evaluator have training and experience in child psychology or psychiatry. (UNLV, 2014)

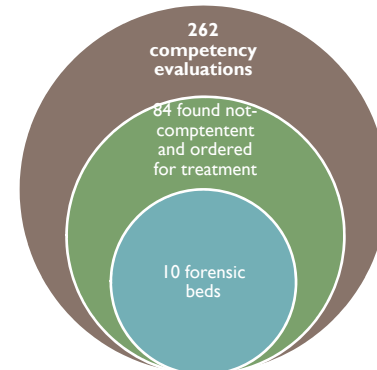
Requirements for continuing education and supervision are not identified in Alaska statute for forensic evaluators.

- The Division of Behavioral Health should be designated by statute to coordinate continuing education in forensic evaluations. Continuing education should include, when possible, in-person supervision of the examiner's evaluation practices and reports. (UNLV, 2014)

5. Competency Restoration

Current Process

API is notified after the court has ordered a defendant to API for competency restoration. By statute, restoration must occur at API. The average wait time for individuals waiting for a bed on Taku was 113 days in 2018.²⁶ The statutory definition of where restoration must occur creates a funnel in which all individuals deemed incompetent to stand trial and in need of treatment to be restored must be placed in one of API's 10 forensic beds.



Competency restoration typically involves psychopharmacology (medication) and/or psychoeducational training to prepare an individual to stand trial. Training elements may include but are not limited to: competency education, mock court procedures, vocabulary, behavior training and sessions with a defense attorney.²⁷ The primary goal of competency restoration is not to treat an individual's mental illness; however, an individual's mental condition may improve because of the restoration process. The average length of stay for patients who received restoration treatment on the Taku unit and were discharged from API in fiscal year 2018 was 75 days.²⁸

The time available for restoration is limited by statute²⁹ and cannot last more than a total of six months for individuals who are not charged with crime involving force against a person, or more than one year for individuals who are charged with a crime against a person.³⁰ Under no circumstance can a defendant be confined for restoration longer than the maximum period of confinement the defendant would receive if the defendant had been found guilty of the charges.³¹

The Taku unit at API runs at or near capacity, averaging 96 percent occupancy from July 1, 2015 – December 31, 2018.³² Annually, API sees 47 to 50 admissions for restoration treatment per fiscal year, for a total of 165

²⁶ API Forensic Unit. Tuesday Reports, calendar year 2018.

²⁷ Sperbeck, David. 2013. Clinical and Legal Practice Standards for Conducting Competency to Stand Trial Evaluations and Restoration Services. Presentation, June 25, 2013.

²⁸ Meditech Electronic Health Records. IST Discharge Patients: Average Length of Stay, Fiscal Year 2018.

²⁹ Alaska Statute 12.47.110

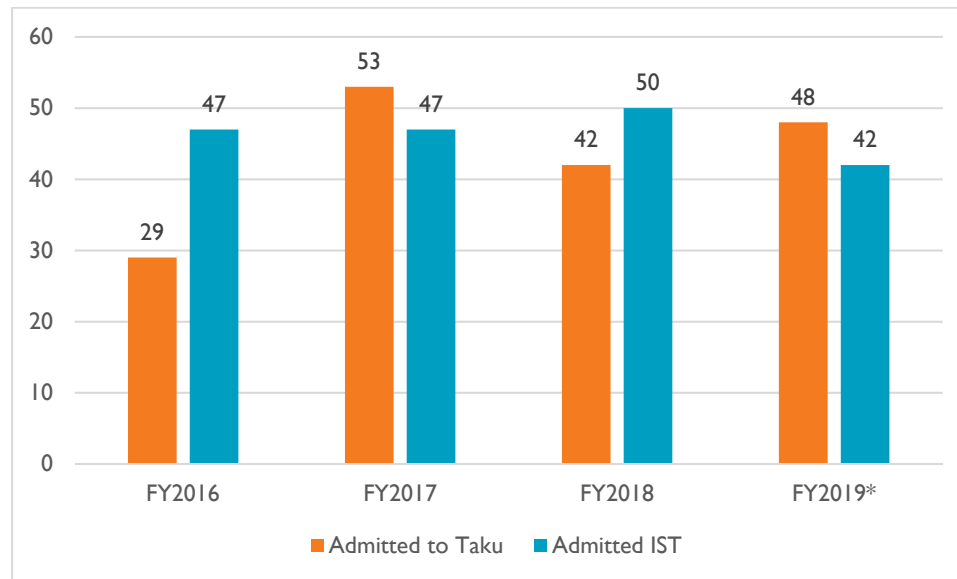
³⁰ The analysis conducted during Phase 1 of this project identified some lengths of stay longer than these periods.

³¹ AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial. Douglas Mossman, Stephen G. Noffsinger, Peter Ash, Richard L. Frierson, Joan Gerbasi, Maureen Hackett, Catherine F. Lewis, Debra A. Pinals, Charles L. Scott, Karl G. Sieg, Barry W. Wall, Howard V. Zonana. Journal of the American Academy of Psychiatry and the Law Online Dec 2007, 35 (Supplement 4) S3-S72; "In Jackson v. Indiana, 406 U.S. 715 (1972), the U.S. Supreme Court held that a defendant found incompetent to stand trial may not be held indefinitely for treatment. There must be a prospect for the defendant's successful restoration within a reasonable time, and "his continued commitment must be justified by progress toward that goal" (Jackson v. Indiana, 406 U.S. 715 (1972), p 738). One can therefore interpret Jackson as placing on forensic hospitals some responsibility for developing efficient and effective treatment programs to comply with the limited periods allowed for restoration."

³² Meditech Electronic Health Records. Taku Occupancy, July 1, 2018 – December 31, 2018.

admissions over the study period (July 1, 2016 – December 31, 2018).³³ This includes forensic patients who are not placed on Taku. Admissions to the Taku unit are more varied, with 29 to 53 admissions per fiscal year, for a total of 148 admissions over the study period (July 1, 2016 – December 31, 2018).³⁴ During the study period, 17 patients were admitted IST but were not admitted to Taku, likely due to lack of capacity on that unit.

Figure 23: Number of Patients Admitted IST and Admitted to Taku



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

Alaska Statute

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

³³ Meditech Electronic Health Records. IST Total Admissions, age 18+, July 1, 2018-December 31, 2018.

³⁴ Meditech Electronic Health Records. Taku Total Admissions age 18+, July 1, 2018-December 31, 2018.

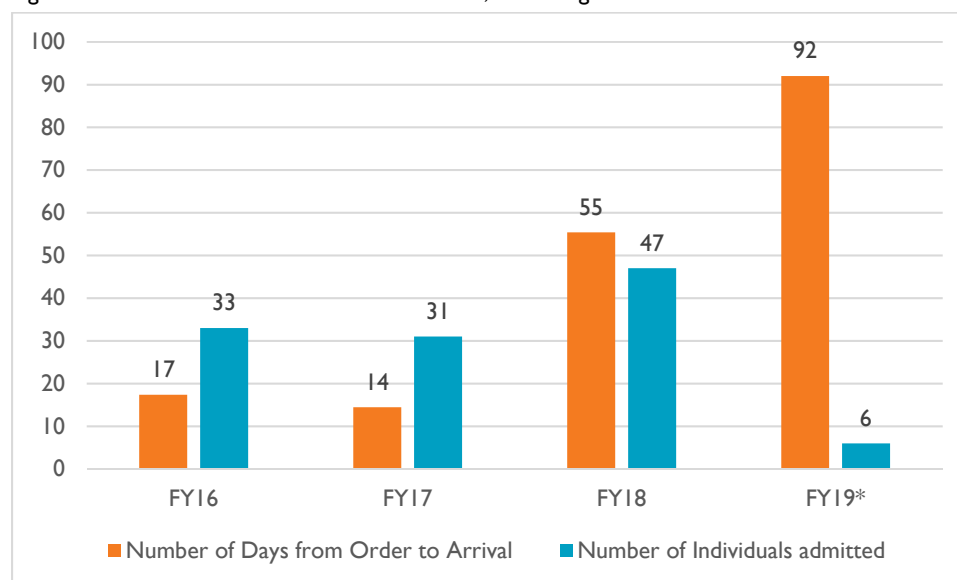


Wait Times for Restoration

As described earlier, in 2018, according to the API Tuesday reports, individuals who were found incompetent and ordered to API for restoration waited approximately 113 days or 16 weeks for a restoration bed.

Anchorage Competency Calendar data provides information on how long individuals are waiting from the date the restoration order is signed, until the date the court is notified the individual has been admitted to API for restoration as well as the number of individuals admitted per fiscal year. Per court competency records, since July 1, 2018 only three individuals ordered to API by the Anchorage Courts were admitted to API and they waited an average of 92 days for admission.

Figure 24: Wait Time for Restoration Admission, Anchorage



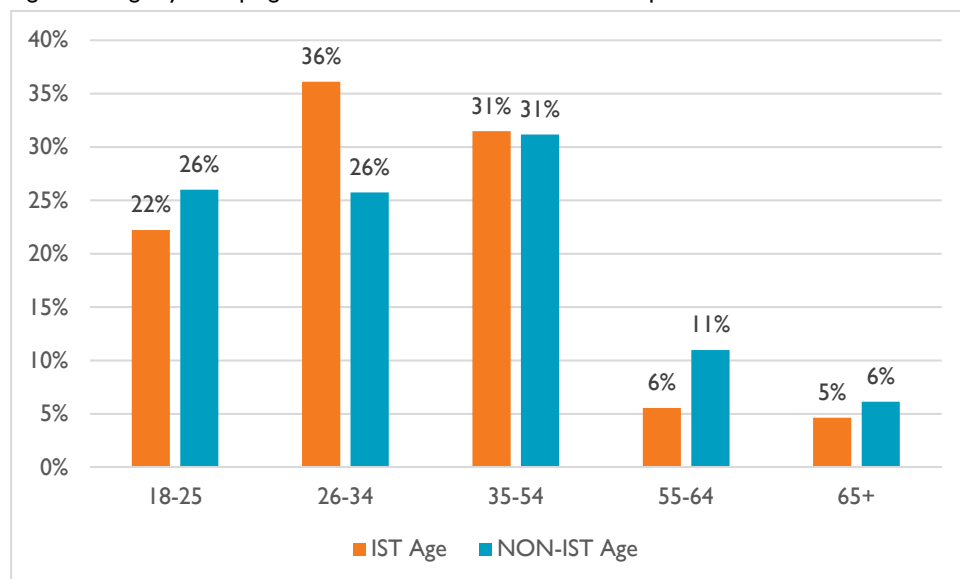
* Projected total for number of individuals admitted in FY 2019. Source: Anchorage Court Competency Calendar Hearing Data, July 1, 2015 – December 31, 2018.

Restoration Patients + Outcomes

Demographics

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

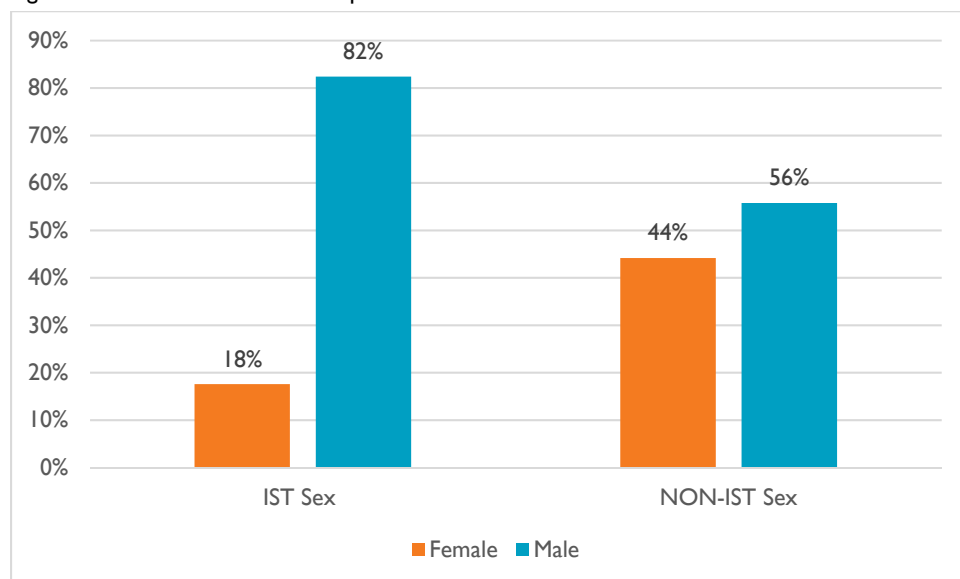
Figure 25: Age by Grouping for IST and Non-IST Residents, Unduplicated



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

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

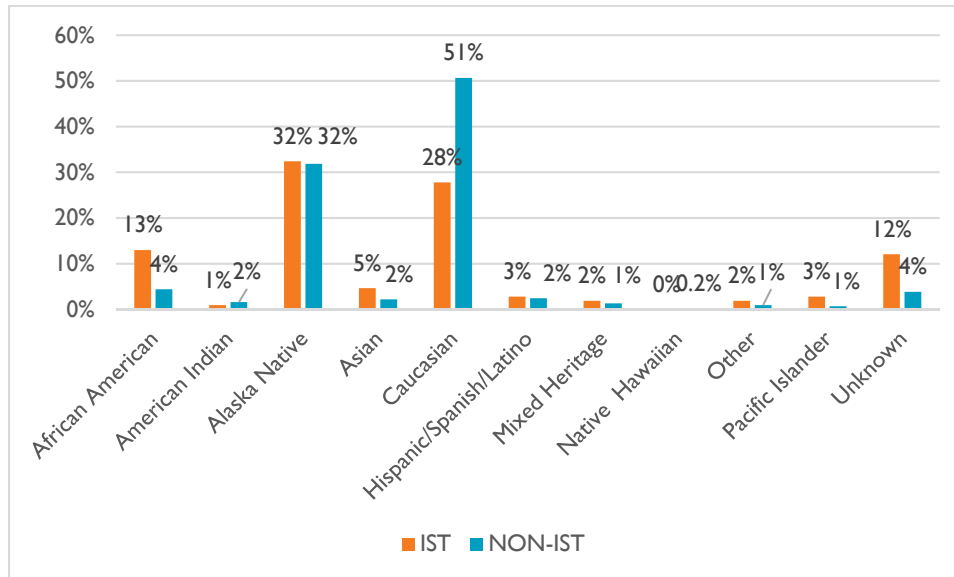
Figure 26: Sex of IST and Non-IST patients



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

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

Figure 27: IST and Non-IST Patients, by Race

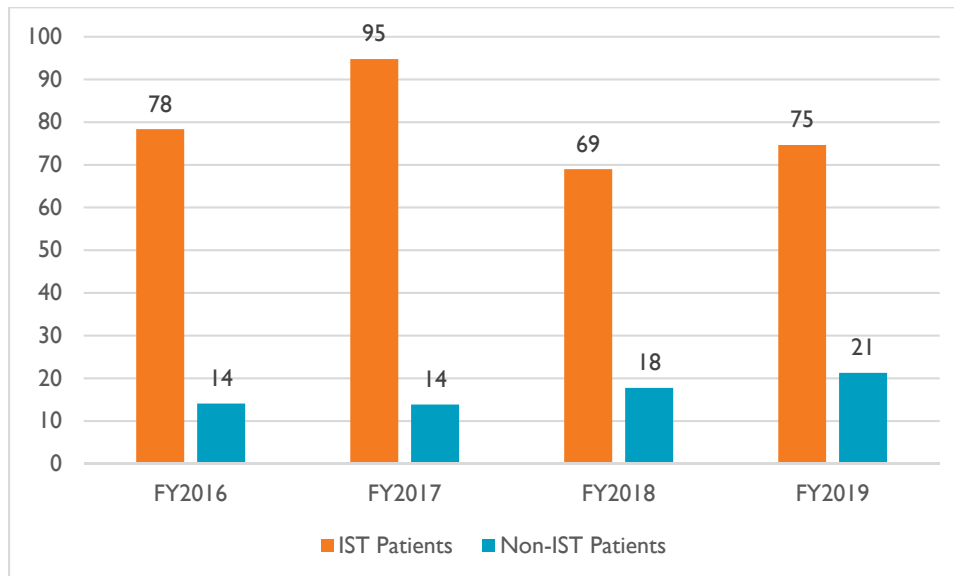


Source: Meditech Electronic Health Records. IST and Non-IST Demographics, Unduplicated. July 1, 2015 – December 31, 2019.

Length of Stay

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

Figure 28: Average Length of Stay for IST Patients with Completed Stays, in Days

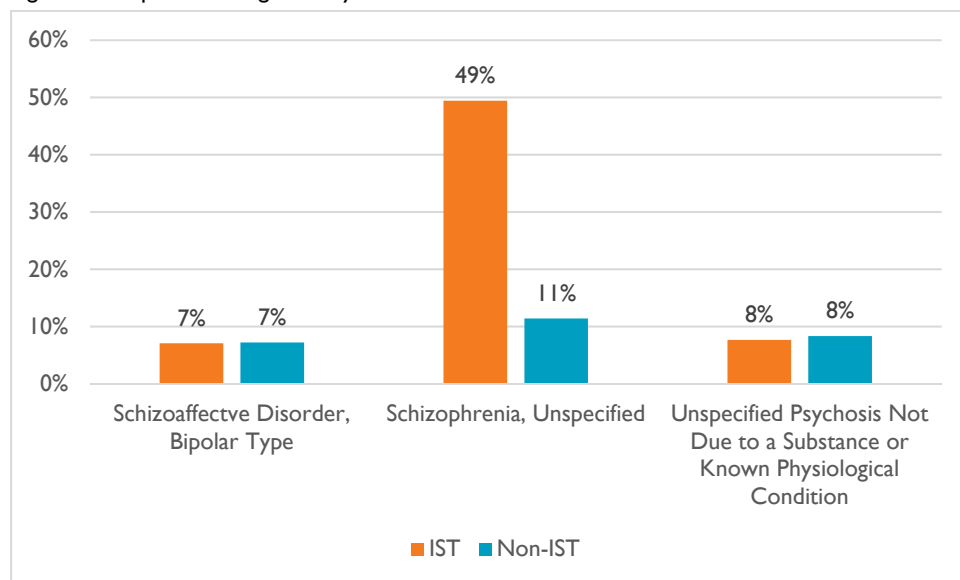


Source: Meditech Electronic Health Records. Discharged IST and non-IST, Average Length of Stay, July 1, 2015 – December 31, 2018

Clinical Characteristics

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

Figure 29: Top Three Diagnoses by IST and Non-IST Status

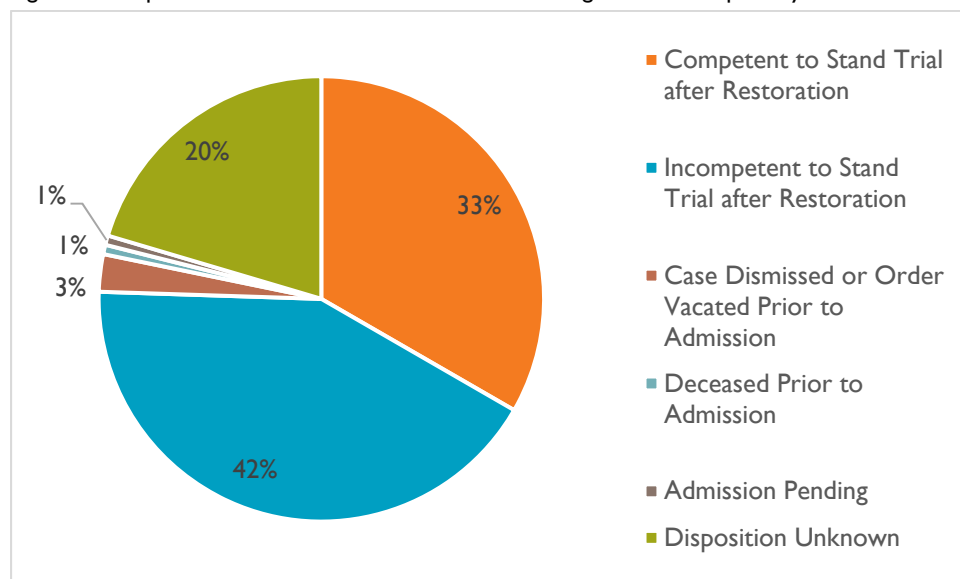


Source: Meditech Electronic Health Records. Discharge Diagnosis by IST and Non-IST Status, July 1, 2015 – December 31, 2018

Disposition after Restoration

Between July 1, 2015 and December 31, 2018 (FY16 to the first half of FY19) there were 147 cases ordered by Anchorage Courts to API for restoration. Of those 147 cases, five percent did not result in an admission to API (in three cases the order was vacated prior to restoration, one case was dismissed after the order but prior to restoration, one individual died prior to admission and there is one admission pending). Of individuals who were ordered to API for restoration 33 percent were found competent to stand trial after restoration, while 42 percent were found incompetent to stand trial after restoration and their cases were dismissed. Missing data, where the disposition after restoration is unknown, accounts for 20 percent of Anchorage cases.

Figure 30: Disposition of Cases after Restoration, Anchorage Court Competency Calendar



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

Recommendations

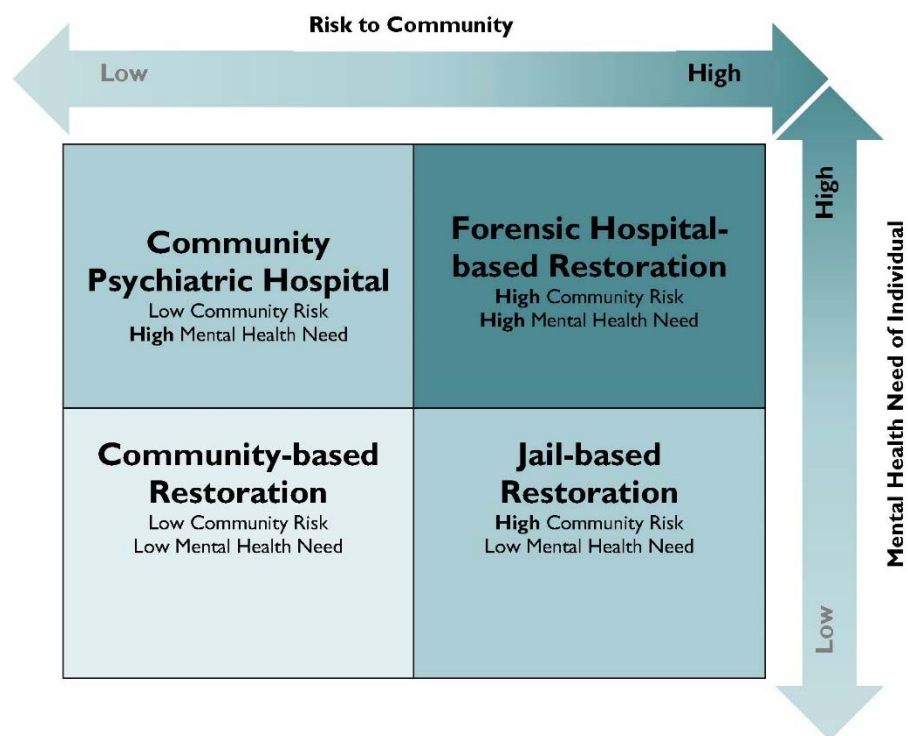
Alaska has explored and adopted the Sequential Intercept Model, developed by the Substance Abuse and Mental Health Services Administration's (SAMHSA) GAINS Center, for the diversion of persons with mental health disorders from the criminal justice system as part of its comprehensive approach to reducing recidivism to Alaska's jails.³⁵ The model intends to divert from criminal justice involvement those persons whose behaviors and current needs are primarily driven by their mental health condition and not criminogenic need.

We recommend that Alaska examine the feasibility and cost savings associated with implementing a tiered competency restoration system, that includes an increase in hospital-based restoration accompanied by implementation of alternative approaches to hospital-based competency restoration, would use existing resources more effectively and efficiently while improving outcomes for individuals involved in the process.

A tiered system considers the level of community risk posed by the defendant, and the defendant's acuity and complexity of mental health needs, as illustrated in Figure 31, when determining the appropriate setting for restoration. Currently, the courts use a risk assessment to determine whether a defendant should remain in custody or in the community during the pre-trial phase. As described above, 72 percent of individuals in the competency process were held in DOC facilities in 2018. For those in custody, who are appropriate for a jail-based restoration program, engagement in such a program would reduce delays in the process. For those in the community, a similar option could be developed through a community-based restoration program.

³⁵ Concepts from the Sequential Intercept Model have been adopted by the Alaska Prisoner Reentry Initiative and the Alaska Criminal Justice Commission.

Figure 31: Matrix of Level of Community Risk and Mental Health Need³⁶



Facility and Program

Community-based Outpatient Restoration

Outpatient competency restoration programs are suitable for defendants who pose low risk to the community and who, but for the finding of incompetency to proceed, could be released on bond. Typically, these defendants have less severe symptoms of a mental health disorder and suitable community resources such as housing, social supports and available mental health treatment. Several models of community-based competency restoration exist. Some entail one contracted entity providing both treatment and competency restoration services, while others divide responsibilities for competency restoration between different organizations, such as a community mental health center providing medication management, case management and other therapies, while a different contracted agency provides competency restoration education. Community-based competency restoration programs have been successful in reducing the overall burden on the system by diverting those with lower community risk and mental health needs to the proper level of care.

Jail-based Competency Restoration

Over the past decade, jail-based competency restoration has emerged as an alternative to inpatient restoration and has enabled states to better keep pace with the rising demand for forensic beds in an effective and cost-efficient manner.

Jail-based competency restoration programs can be quite varied in design. Some operate as a partial hospital program within a jail. In this model, restoration defendants are housed on a unit within the jail setting that is

³⁶ Developed by Dr. Patrick Fox, formatted by Agnew::Beck

specifically designed for competency restoration. Programming occurs Monday through Friday from 8am to 5pm, with recreational activities scheduled on weekends. Staffing includes a full treatment team consisting of a psychiatrist, a psychologist, social worker, nursing staff and other mental health professionals.

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

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

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

Hospital-based Competency Restoration

While additional research is needed working with staff at API, DOC, Department of Law (DOL) and the court system to refine assumptions and develop an expanded forecast for new forensic capacity, we have developed an initial forecast for new forensic beds to provide an estimate for beginning Phase 2 of the project. This initial forecast is shown in Figure 3: Figure 3 and summarized below.

Demand for Competency Evaluations and Treatment beds for Restoration

- **Number of new beds.** Adding approximately 25 new inpatient beds for competency restoration would substantially reduce the current and projected backlog in the evaluation and restoration process. This also assumes that jail-based restoration will be developed to absorb some of the demand. This would bring the total number of forensic restoration beds to 35. We recommend that we explore providing this additional bed capacity at API, while discussing options for jail-based restoration with DOC.
- **Estimated growth in evaluations is expected to continue until overall competency backlog is reduced.** During fiscal year 2019, the forensic psychologists are on track to complete 338 evaluations based on the number of competency evaluations completed in the first half of the year. If they reach that number, this will be a 29 percent increase in evaluations over fiscal year 2018. However, the increase in evaluations from FY 2016 to FY 2017 was 6 percent and the increase between FY 2017 and FY 2018 was 11 percent. In our model, we assume an 11 percent annual increase in evaluations between FY 2019 and FY 2026 as the backlog in evaluations and long wait times continues. After FY 2026, we forecast that the growth in evaluations will drop to about two percent per year as the backlog clears.

Contributing Factors

- **Evaluations drive the need for restoration beds.** Based on one year's worth of API Tuesday reports, it appears that 32 percent of those evaluated require a restoration bed. This is lower than the share of

individuals who are deemed incompetent to stand trial (56%) because some cases are dismissed at any point in the competency process, sometimes prior to a restoration bed becoming available. After communications with API forensic staff, we determined that it is reasonable for forecasting purposes to assume 40 percent of those evaluated require a restoration bed.³⁷

- **Jail-based restoration is part of the solution.** Between one-third and one-half of individuals in need of restoration can typically receive services in a jail-based restoration setting.³⁸ This is determined by their mental health acuity and treatment needs. Currently, Alaska does not administer jail-based restoration but going forward we recommend this be part of the solution.³⁹ The bed forecast assumes that one-third of those in need of restoration receive treatment in a jail-based setting with the remaining two-thirds receiving treatment in an inpatient forensic psychiatric hospital setting. This assumption needs further refinement and discussion with DOC to determine whether and how to integrate jail-based restoration, and the project team, including API staff, to understand whether this assumption is reasonable for the client population at Taku.
- **Average length of stay drives number of beds needed.** The current average length of stay for those at Taku is 75 days, which means that beds turnover about 4.9 times per year and roughly 50 individuals are served yearly in the ten Taku beds. Our forecast assumes a need to serve approximately 175 individuals each year in a hospital setting, when the system stabilizes, and the backlog is reduced; this translates to a need for approximately 35 total hospital beds (or 25 new beds). Another 85 individuals would be served in jail-based restoration, on an annual basis.
- **Addressing the backlog is critical.** The forecast model assumes new inpatient and jail-based restoration does not come online until fiscal year 2022, which allows for 2.5 years for planning, design, funding, and construction. By 2022, the backlog in those needing restoration beyond available capacity will reach 334 individuals. As new capacity comes online, we expect the backlog to clear by year 8 (or FY 2026).

Alternative Forecasts

- **Alternative forecasts bracket the estimate of needed beds.** We calculated needed beds using two alternative methods; one based on the relative share of forensic beds to psychiatric beds nationally and the other based on the number of forensic beds per 100,000 population nationally. Using the relative share of forensic beds to psychiatric beds yields a need for 15 new beds and using the method that increases Alaska's forensic beds to the national per capita average results in a need for 31 new beds. Our forecast of 25 new beds is in the middle of these two alternative approaches, which provides a reasonable range for overall restoration capacity needed. Again, the forecast for 25 new beds assumes one-third of those in need of restoration are served in jail-based restoration, which is not currently an option in Alaska's current system.

³⁷ Email communication with Dr. Becker of API

³⁸ Conversations with Dr. Patrick Fox; part of the contractor team.

³⁹ Moving forward with jail-based restoration may require a statute change as current statute (AS 12.47.110 (a)) commits individuals found incompetent to stand trial to the custody of the commissioner of health and social services or the commissioner's authorized representative. Potentially, the DHSS commissioner could authorize DOC to provide restoration or authorize an operator to provide restoration at DOC facilities.

Figure 32: Demand for Restoration Beds and Projected Number of New Beds Needed

Items	Current	Planning	Design	Implementation Years						
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027	FY 2028
Demand for Restoration Beds										
Number of Evaluations [1]	338	374	413	457	505	558	617	629	642	655
% of Evals Requiring Restoration	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%
Restoration Demand From New Evaluations	135	149	165	183	202	223	247	252	257	262
Restoration Demand due to Lack of Capacity in Prior Year	34	119	219	334	176	83	35	-	1	2
Subtotal: Individuals in Need of Restoration	169	269	384	516	378	306	282	252	258	264
% Requiring Restoration in a Hospital Setting [2]	100%	100%	100%	67%	67%	67%	67%	67%	67%	67%
Demand for Restoration Beds: Individuals	169	269	384	346	253	205	189	169	173	177
Estimated Individuals Served in Jail-Based Restoration				170	125	101	93	83	85	87
Capacity for API Restoration in Hospital										
Current API Restoration Capacity - Individuals Served	50	50	50	50	50	50	50	50	50	50
New API Restoration Capacity - Individuals Served	-	-	-	120	120	120	120	120	120	120
Subtotal API Restoration Capacity - Individuals Served	50	50	50	170	170	170	170	170	170	170
Surplus (Deficit) of Capacity - Individuals Served	(119)	(219)	(334)	(176)	(83)	(35)	(19)	1	(3)	(7)
Total Beds Needed [3]	10	10	10	35	35	35	35	35	35	35
Existing Beds	10	10	10	10	10	10	10	10	10	10
New Restoration Beds Needed	0	0	0	25	25	25	25	25	25	25
[1] Assumes 11% annual growth in evals between FY 2019 and FY 2025, which was the growth rate between FY 2017 and FY 2018 and slightly less than the 3 year avg. growth rate of 17%. Starting in FY 2026, the assumed average annual growth rate drops to 2 percent as backlog is cleared in the system.										
[2] It can be assumed that between 1/3 and 50% of those needing competency restoration can be accommodated in jail based restoration, with the balance needing inpatient restoration in a hospital setting. This model assumes 67% of those needing restoration require an inpatient setting and/or jail based restoration capacity is limited to serving 33% of the clients. This assumption requires further discussion with API and DOC.										
[3] Current length of stay for forensic patients at API averages 75 days, which means that each bed turns over an average of 4.9 times per year.										
Alternative Method 1: Relative Share of Forensic Beds			Alternative Method 2: Forensic Beds per Capita							
National % of State Hospital Beds for Forensic Use	31%			National Rate of Forensic Beds per 100,000 Population					5.5 per 100,000 people	
Total API Beds	81			State of Alaska Population: 2017					739,795	
Total Forensic Beds Needed in Alaska	25			Forensic Beds Needed in Alaska					41	
New Restoration Beds Needed in Alaska	15			New Restoration Beds Needed in Alaska					31	

Staffing

In Phase 2 of this study, we will develop a comprehensive staffing plan and financial pro forma for the recommended scenario to include the facility-based and community-based restoration options selected.

Statute

Many of the recommendations in this section were included in the 2016 WICHE report entitled, Alaska Psychiatric Institute, Evaluation of Forensic Services that Dr. Fox authored, as well as the 2014 UNLV report.⁴⁰

Involuntary Administration of Medication

Some defendants ordered to API for competency restoration refuse recommended psychotropic medications, and lack decisional capacity to do so. In 2003, the United States Supreme Court articulated in *Sell v. U.S.* the circumstances in which a criminal defendant could be involuntarily medicated for the purposes of restoring the defendant to competency to proceed. In the wake of *Sell*, many states amended their statutes to include the *Sell* criteria for involuntary administration of medication. The state should consider amending AS

⁴⁰ Fox, Patrick. 2016. Alaska Psychiatric Institute: Evaluation of Forensic Services. Western Interstate Commission for Higher Education. And, Gordon, Sara, Piasecki, Melissa, Kahn, Gil, Nielsen, Dawn. 2014. Review of Alaska Mental Health Statutes. University of Nevada Las Vegas.

12.47.110 to permit the court to order the administration of medication over the defendant's objection to restore the defendant to competency if the Sell criteria are met.⁴¹

⁴¹ See Appendix for specific recommendations.

6. Non-Restorable After Treatment

Current Process

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

Alaska Statute

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

The Alaska legislature amended AS 12.47.110 to add subsection (e) in 2008 with the intent that civil commitment proceedings would automatically be initiated upon finding that a defendant is incompetent to stand trial and non-restorable. However, statute does not specify who is responsible for initiating civil commitment proceedings and this subsection is reported to be infrequently used.⁴²

Recommendations

Facility

Individuals who are deemed non-restorable after treatment may be civilly committed to API. API's reduced capacity to provide long-term treatment to civilly committed patients also reduces its ability to receive those deemed non-restorable who require treatment through a civil commitment in a timely manner. The State should expedite strategies to increase capacity in hospitals around Alaska to provide short-term inpatient psychiatric treatment, so that beds at API can be prioritized for those with the most complex treatment needs who are difficult to serve in other settings.

Statute

Responsibility for initiating civil commitment proceedings or discharge planning for those found incompetent to stand trial and un-restorable after treatment is not specified in Alaska statutes. The 2014 UNLV report recommended that the Department of Health and Social Services or its designee should be specified in statute as the entity who assumes responsibility for this process. Specifically, UNLV recommends that AS 12.47.100 (e) “should be amended to provide that when an individual is found to be incompetent and un-restorable in misdemeanor or felony cases, the individual should be evaluated for inpatient or outpatient civil commitment and treatment if charges are dismissed due to incompetency”.⁴³ However, incompetence to stand trial should

⁴² Gordon, S., Piasecki, M., Kahn, G., Nielsen, D. (2014). Review of Alaska Mental Health Statutes. University of Las Vegas Nevada.

⁴³ Gordon, S., Piasecki, M., Kahn, G., Nielsen, D. (2014). Review of Alaska Mental Health Statutes. University of Las Vegas Nevada.

not automatically indicate that the individual meets criteria for civil commitment. The statute should further specify that the court must “provide a notice of intent to dismiss the charges against the defendant and that the Department of Health and Social Services or its designee shall have 24-hours to initiate inpatient or outpatient civil commitment proceedings, if indicated, or to create a discharge plan for the individual.”⁴⁴

⁴⁴ Gordon, S., Piasecki, M., Kahn, G., Nielsen, D. (2014). Review of Alaska Mental Health Statutes. University of Las Vegas Nevada.

7. Not Guilty by Reason of Insanity

Statute

Alaska Statutes 12.47.010 and 12.47.020 govern the “not guilty by reason of insanity” defense, AS 12.47.10 through an affirmative defense and AS 12.47.020 through a diminished capacity defense. Under AS 12.47.10, this defense can only be considered after the trier of fact has found, beyond a reasonable doubt, that the defendant committed the offense.⁴⁵ Under AS 12.47.020, “if a verdict of not guilty by reason of insanity is reached under (b) of this section, the trier of fact shall also consider whether the defendant is guilty of any lesser included offense. If the defendant is convicted of a lesser included offense, the defendant shall be sentenced for that offense and shall automatically be considered guilty but mentally ill.” An example of diminished capacity under AS 12.47.020(b) is a person charged with first-degree murder, but at the time the person killed the victim, the accused thought the victim’s head was a lemon at that the person was squeezing a lemon.⁴⁶

A common path to introduce evidence of mental disease or defect is the M’Naghten test. The traditional M’Naghten test examines two avenues: cognitive incapacity (inability to understand what was done at the time of the crime) and moral incapacity (inability to understand that an action was wrong).⁴⁷ From 1972 to 1982, Alaska used the Model Penal Code test, which states:

- A person is not responsible for criminal conduct if, at the time of the conduct, as a result of mental disease or defect, he lacks substantial capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of law.
- State had the burden of disproving insanity beyond a reasonable doubt if the defendant presented “some evidence” in support of the defense⁴⁸

After statutory reforms in 1982, Alaska moved from the Model Penal Code to the M’Naghten test but limited the insanity defense to cognitive incapacity: individuals who “were unable, as a result of a mental disease or defect, to appreciate the nature and quality of that conduct” at the time of the crime (AS 12.47.010). The 1982 reform also created the diminished capacity defense (AS 12.47.020) for individuals who, at the time of the crime “did not have a culpable mental state which is an element of the crime”. However, by eliminating the moral incapacity prong of the M’Naghten, AS 12.47.010 essentially duplicates the diminished capacity defense (AS 12.47.020) because if the defendant does not have diminished capacity, the defendant will be unable to establish the affirmative defense of insanity.⁴⁹ The 1982 reforms in Alaska “constructively abolished its insanity defense”.⁵⁰

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

⁴⁵ Criminal Justice Commission (2017). Competency to Stand Trial, Insanity and Guilty but Mentally Ill in Alaska. Presentation.

⁴⁶ Criminal Justice Commission (2017). Competency to Stand Trial, Insanity and Guilty but Mentally Ill in Alaska. Presentation.

⁴⁷ Gordon, S., Piasecki, M., Kahn, G., Nielsen, D. (2014). Review of Alaska Mental Health Statutes. University of Las Vegas Nevada.

⁴⁸ Criminal Justice Commission (2017). Competency to Stand Trial, Insanity and Guilty but Mentally Ill in Alaska. Presentation.

⁴⁹ Criminal Justice Commission (2017). Competency to Stand Trial, Insanity and Guilty but Mentally Ill in Alaska. Presentation.

⁵⁰ Gordon, S., Piasecki, M., Kahn, G., Nielsen, D. (2014). Review of Alaska Mental Health Statutes. University of Las Vegas Nevada.

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

Current Process

The 1982 statutory reforms described above essentially eliminated the affirmative insanity defense (12.47.010) and the University of Nevada Las Vegas (UNLV), 2014 report identifies that only two defendants post 1982 reform have been acquitted as NGRI. Stakeholders interviewed by the UNLV project team shared that the elimination of functional insanity defense has led to “large numbers of mentally ill defendants continuously entering the criminal justice system and having charges deferred for competency restoration or being deemed ‘unrestorable’”. As a result of the statutory changes in 1982, more mentally ill offenders are sentenced as Guilty but Mentally Ill and placed into the Department of Corrections custody rather than into state psychiatric custody.⁵¹

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

The requirement that for defendants raising the insanity defense be examined by two qualified psychiatrists or two forensic psychologists certified by the American Board of Forensic Psychology adds an additional hurdle for those wishing to pursue the insanity defense. Most states only require one forensic examiner and nationally, there are only around 300 board certified forensic psychologists, making it extremely difficult for the state to provide the needed professionals to complete the evaluation.⁵² A 2018 Alaska Supreme Court ruling found that API must provide the two psychiatrist or psychologists if they employ them and if API does not employ the qualified experts laid out in statute the superior court must appoint experts and the Alaska Court System must bear the cost. At the time of the ruling, API had no psychiatrists or psychologists qualified according to the statute to conduct the examination.⁵³

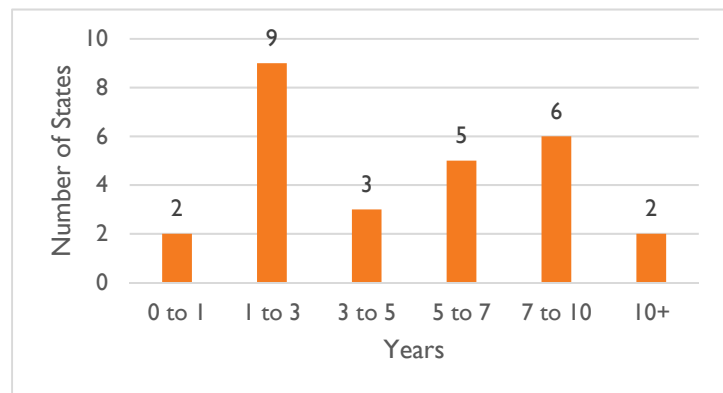
⁵¹ Criminal Justice Commission (2017). Competency to Stand Trial, Insanity and Guilty but Mentally Ill in Alaska. Presentation.

⁵² Fox, Patrick (2016). *Alaska Psychiatric Institute: Evaluation of Forensic Services*. Western Interstate Commission for Higher Education Mental Health Program.

⁵³ The Supreme Court of the State of Alaska. Opinion Number 7313, November 2, 2018.

With just two individuals identified as acquitted as NGRI in Alaska since 1982, local data is not available for the average length of stay of this population in inpatient psychiatric care. A national survey found that lengths of stay for those found NGRI are generally long, over one year.⁵⁴ Following national trends, if Alaska were to have a larger NGRI population, it is likely that this population would remain at a facility for an extended period.

Figure 33: National average length of stay for NGRI patients, by State



Recommendations

Facility

Without statute changes, the number of individuals who are NGRI will likely remain low. An increase in forensic facility space to accommodate this population should only be considered if corresponding statute changes are also made.

Statute

Under the current process, the NGRI population as statutorily defined is essentially eliminated. With only two individuals being acquitted under this defense since 1982, the impact of this population on demand for a facility is negligible. However, recommended statute changes have been proposed and, if implemented, could significantly alter the demand for bed space for this population. The UNLV report proposed the following recommendations:

1. “Alaska should re-institute a functional insanity affirmative defense with both the cognitive and moral incapacity prongs of the full M’Naghten test.
2. If the state chooses to re-institute a full M’Naghten test for legal insanity, it should also consider removing the guilty but mentally ill verdict from the statute.
3. If the state chooses to re-institute a full M’Naghten test for legal insanity, it should revisit and consider revisions to the procedures upon a verdict of not guilty by reason of insanity under AS 12.47.090 and the procedures after raising a defense of insanity under AS 12.47.090.”

It should be noted that the Department of Law, Criminal Division opposed these recommendations, while the Office of Public Advocacy and the Public Defender Agency supported these recommendations.

Both the UNLV report and the Western Interstate Commission for Higher Education report recommend changes to the statutory requirement that defendants raising the insanity defense be examined by two qualified psychiatrists or two forensic psychologists certified by the American Board of Forensic Psychology.

⁵⁴ Fitch, W. L. (2014). White Paper: Forensic Mental Health Services in the United States. National Association of State Mental Health Program Directors.

Reducing the required number from two to one would reduce the staffing burden and challenges faced in completing evaluations for this population.

The UNLV report made an additional recommendation for clarification in Alaska Statute 12.47.070(a), identifying that the reference a “defendant’s fitness to proceed, or there is reason to believe that a mental disease or defect of the defendant will otherwise become an issue in the case” should be removed and replaced with “a defendant’s competence to proceed under AS 12.47.100”.

8. Interview Themes

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

Department of Law, Criminal Division

This interview is still being scheduled.

Department of Corrections

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

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

- API does not have a mechanism for transporting individuals in their facility for restoration to outside medical appointments. DOC is called to transport these patients. DOC’s believes that once an individual is admitted to API for restoration, API should be responsible for their medical and safety needs. Transportation should be taken in to account in the design and programming of a new facility.
- Specialty populations:
 - Juveniles: DOC is seeing an increase in juveniles who are being tried in the adult system in their facilities. An appropriate process should be identified for the evaluation and restoration of juveniles.
 - Dementia: Individuals with dementia awaiting competency evaluation and restoration are a relatively small group in DOC’s custody but often have extended stays. Generally, these individuals have committed some sort of domestic violence offense and are clearly not competent and not restorable. However, they must wait at DOC for the competency and restoration process to occur and are ineligible for bail due to current domestic violence laws that state the perpetrator cannot return to the home of the victim. This is true even in cases when the victim is the perpetrator’s spouse or caregiver and wants the perpetrator home.
 - High-utilizers: There are a number of individuals that cycle through the DOC system. Knowing that API’s civil beds are perpetually full, police officers may instead charge an individual with mental health needs with disorderly conduct to get them off the streets and into a safe environment (DOC custody).

- In the past, competency evaluations were all conducted inpatient, at API. Now, nearly all competency evaluations are done outpatient, at DOC facilities or in the community. DOC is concerned about the quality and depth of outpatient evaluations and would like the possibility of inpatient competency evaluations to be considered.
- DOC is interested in learning more about jail-based restoration and processes used in other unified corrections system states regarding evaluation and restoration of the forensic population. Jail-based restoration would make the most sense as a central location, rather than having sites in Anchorage and outlying communities.
- Targeted education to courts in rural communities about the competency process would be useful in ensuring the appropriateness of referrals for competency evaluation.
- Exploration of outpatient restoration should be considered, including a court process to determine if inpatient versus outpatient restoration is needed, based on an individual's level of risk.
- Consideration of dedicating a public defender to forensic cases or assigning a special assistant of forensic cases to public defenders would be useful in offering better advocacy for defendants throughout the process.
- Given the high number of individuals with mental health issues in the DOC system, particularly those that could be impacted by a forensic psychiatric hospital, DOC would like to be an involved partner throughout the feasibility study process.

Alaska Court System

Judges and support staff involved in the Anchorage Coordinated Resources Project (CRP) and Anchorage Competency calendar report experiencing significant delays in the completion of competency evaluations and the admission of defendants for competency restoration. For the purposes of this project, judges with the Anchorage CRP were interviewed as they preside over many cases where competency evaluations are ordered. The judges interviewed are interested in competency evaluations being completed as quickly as possible because if a defendant is ordered for an evaluation, the case cannot proceed in court until an evaluation is completed. Extended waits for competency evaluations and restoration are particularly troubling to judges in misdemeanor cases, as misdemeanants may spend longer waiting for an evaluation or restoration than they would have if they had just completed their sentence in jail.

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

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

Funding for additional evaluator positions is seen as a challenge, as is obtaining the required licensing for out-of-state providers to offer tele-evaluations. If full-time positions cannot be funded, judges would like to see contracts with Alaskan forensic psychologists, possibly paid for through the pooled resources of the Alaska Court System, API, DOC and the Trust. The judges believe that a facility alone will not fix the system capacity issues; citing API's current staffing crisis for civilly committed patients, the judges expressed concerns that an expanded facility without staff will not be helpful.

Judges note that sometimes the forensic process is used to hold defendants who would otherwise be released in custody a little longer to keep them out of the community and shared that a lack of community resources and supports are drivers of the increase in requests for competency evaluations. Additional drivers for the increase in requests for competency evaluations include: individuals with repeat evaluations, new prosecutors and public defenders who do not understand the process, increase in the police force in Anchorage, rapid cycling of civilly committed patients in and out of API and in increase in substance use and drug induced psychosis.

Alaska Mental Health Trust Authority

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

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

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

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

Alaska Mental Health Board

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

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

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

Municipality of Anchorage

This interview will be scheduled at a later phase in the project.

Department of Health and Social Services

Division of Behavioral Health

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

Alaska Psychiatric Institute

API staff provided a tour of the facility to the consultant team at the outset of the project. We have worked closely with the forensic psychologists and API administration throughout Phase 1 to gather and analyze data and to understand their priorities and concerns for this project. These are identified throughout this report.

Division of Juvenile Justice

Division of Juvenile Justice (DJJ) staff met with the consultant team on January 25, 2019. While there is limited demand for juvenile competency evaluation and restoration some demand does exist and could grow

in the future. There are also significant issues that will be further explored in Phase 2 related to adolescents who are civilly committed to API and who are charged with a crime that occurred at API, most often an assault on a staff member, and who are then remanded to DJJ. While this population is not creating demand necessarily for competency evaluation and restoration, they are a high acuity and complexity population who are charged with a crime and for whom there is not currently an optimal placement. This should be further explored in Phase 2 to identify ways for McLaughlin Youth Center and API to combine areas of expertise to better serve adolescents, both criminally charged and civilly committed.

9. Appendices

1. White Paper on Considerations Related to Accreditation of Forensic Psychiatric Hospitals, Stephenie Colston
2. Matrix of Recommendations from Relevant Background Reports
3. List of Stakeholder Interviews Conducted in Phase 1

Appendix: Considerations Related to Accreditation of Forensic Psychiatric Hospitals

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Summary Finding

Accreditation does not appear to play a pivotal role in determining the feasibility of constructing a forensic psychiatric facility. Accreditation most likely will be pursued by any such facility, and this paper has identified TJC's approach to forensically-involved hospital patient populations. However, the overarching issue may not relate to accreditation of a stand-alone forensic psychiatric hospital but to the State's Return on such an Investment (ROI).

Introduction

Hospital accreditation has been defined as “a self-assessment and external peer assessment process used by hospitals to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve”.¹ While adherence to established national standards is a hallmark of accreditation, accreditation is not just about standards, there are analytical and continuous self-improvement dimensions to the process. The management of risks (e.g., medication errors) is a central feature of the accreditation process and an important mechanism for maintaining patient safety.

The Joint Commission (TJC), the nation's oldest and largest standards setting and accrediting body in health care, lists several advantages of accreditation, including:

- Organizes/strengthens patient safety
- Increases community confidence in accredited hospital's quality of care
- Improves risk management and risk reduction
- May reduce liability insurance costs
- Provides deeming authority for Medicare certification
- Is recognized by insurers and other third parties
- May fulfill State regulatory requirements (such as Alaska DBH requirements)
- Aligns hospital with one of the most respected names in health care.

It is important to note, however, that there is limited evidence supporting accreditation's capacity to promote high quality and safe hospital and clinical performance.² Accreditation is no panacea, it is a tool to continuously improve performance across clinical, facility, and managerial domains.

Hospital Accreditation Organizations

¹ Greenfield D and Braithwaite J. Health sector accreditation research: a systematic review. *International Journal of Quality Health Care*. 2008; 20:172-183.

² Brubakk K, Vist G, Bukholm G, Barach P, and Tjomsland O. A systematic review of hospital accreditation: the challenges of measuring complex intervention effects. *BMC Health Services Research*. 2015; 15: 280.

For facilities like the Alaska Psychiatric Institute (API), there are two available accrediting bodies: TJC and the Commission on Accreditation of Rehabilitation Facilities (CARF). The table on the following page compares the two accrediting bodies across several dimensions. Please note that neither TJC nor CARF have specific accreditation standards for forensic hospitals. Section 3 explains how TJC accredits either stand-alone psychiatric forensic hospitals or psychiatric hospitals with forensic units.

Neither TJC nor CARF have specific accreditation standards for forensic hospitals.

Figure 1: Comparison of The Joint Commission and the Commission on Accreditation of Rehabilitation Facilities

DOMAIN	The Joint Commission	Commission on Accreditation of Rehabilitation Facilities
Organizational summary	An independent, not-for-profit organization which accredits and certifies organizations and programs in the United States.	An Independent, non- profit accreditor of health and human services.
When organization created	1951	1966
Number organizations accredited	20,000+	6,000+
Types of organizations accredited	General, psychiatric, children's and rehabilitation hospitals, critical access hospitals, home care organizations, nursing homes, rehabilitation centers, long term facilities, behavioral health organizations, addictive services, ambulatory care providers, and independent or freestanding clinical laboratories.	Health & human service organizations
Acceptance	Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.	CARF International accreditation provides a visible symbol that assures the public of a provider's commitment to continually enhance the quality of services & programs with a focus on satisfaction of persons served.
Programs	<p>Accreditation: Ambulatory Health Care, Behavioral Health Care, Critical Access Hospitals, Home Care, Hospitals, International Accreditation, Laboratory Services, Nursing and Rehabilitation Center, & Office-Based Surgery.</p> <p>Certification: Advanced Certification, Disease-Specific Care, Health Care Staffing Services, & International Certification.</p>	Accreditation: Aging Services, Behavioral Health, Business and Services, Management Network, CARF-CCAC, Child and Youth Services, DMEPOS, Employment and Community Services, Medical Rehabilitation One-Stop Career Center, Opioid Treatment Program, & Vision Rehabilitation Services.

The Joint Commission

A. The Joint Commission

The Joint Commission is by far the largest hospital accrediting entity in the United States and controls over 80 percent of the accreditation market as “the accrediting agency of choice for nearly all major hospital systems.”³ For state psychiatric facilities such as API, TJC is a clear choice. It has been the overwhelmingly preferred hospital accreditation body for decades. However, CARF has also accredited hundreds of psychiatric hospitals over its 53 years of existence.

The Joint Commission is the highest regarded in the industry for hospital accreditation. Much of the reason is because hospital accreditation by TJC carries with it deeming authority for Medicare certification. Medicare is

³ Lam MB et al. Association between patient outcomes and accreditation in US hospitals: observational study. BMJ. 2018; 363: k4011

a huge reimbursement source for hospitals throughout the country. Section 1865 (a)(1) of the Social Security Act allows hospitals accredited by an approved national accreditation organization (AO) to be exempt from surveys by state survey agencies to determine compliance with Medicare conditions.⁴ The Joint Commission is one of ten AOs recognized by the Centers for Medicare and Medicaid Services (CMS) and the only AO that accredits psychiatric hospitals. The Joint Commission has been recognized by CMS as having standards and a survey process that meet or exceed Medicare's requirements. Hospitals that achieve accreditation through a TJC "deemed status" survey are determined to meet or exceed Medicare (and Medicaid) requirements. API is currently accredited by TJC and enjoys deemed status.

Hospital Accreditation Standards⁵

Since there are no forensic-specific TJC Standards, it is important to know how all TJC Hospital Accreditation Standards would be applied. For each of the over 250 Hospital Accreditation Standards, the following components exist:

- **Standard** is a statement that, when achieved, facilitates safe, quality care, treatment, or services.
- **Rationale** describes the purpose of the Standard.
- **Elements of Performance** are the only items scored during surveys and identify performance expectations.
- **Two Icons** indicate whether written documentation is required to determine compliance with the Elements of Performance and Risk-indicating whether risk is assessed (often related to National Patient Safety Goals and Requirements for Improvements identified during surveys).

TJC's Hospital Accreditation Standards are categorized as follows:

- **Accreditation Participation Requirements.** Specific requirements for both participating in & maintaining accreditation.
- **Environment of Care.** Standards relating to safe, functional, & supportive environment that includes the building and its use of space, equipment, & minimizing risks. These standards are often the most challenging standards for compliance.
- **Emergency Management.** Standards relating to emergency planning, mitigation, preparedness, response, and recovery. Another area that poses compliance challenges.
- **Human Resources.** Standards relating to staff qualifications, training, and competency and performance assessments.
- **Infection Prevention and Control.** Standards relating to planning, implementation, and evaluation of an infection prevention and control program.
- **Information Management.** Standards relating to privacy protection, planning for internal/external information needs, and maintaining accurate health information.
- **Leadership.** Standards relating to culture, resource availability, staff competence, and ongoing performance evaluation and improvement.
- **Life Safety.** Standards relating hospital building codes and building maintenance, fire and smoke hazards, means of egress, and other elements of the Life Safety Code. These standards are also among the most challenging standards.

⁴ Called Conditions of Participation (CoPs) or Conditions for Coverage (CfCs)

⁵ The Joint Commission (2018). 2019 Hospital Accreditation Standards. Oakbrook Terrace, IL: Joint Commission Resources, Inc

- **Medication Management.** Standards relating to the hospital’s medication process, such as selection/procurement, storage, ordering, preparing/dispensing, administering, monitoring, and evaluation.
- **Medical Staff.** Standards relating to credentialing/privileging, bylaws, staff structure, and guiding principles.
- **National Patient Safety Goals.** See C in the following section.
- **Nursing.** Standards relating to the leadership of the Nurse Executive.
- **Provision of Care, Treatment, & Services.** Standards relating to assessing patient needs, planning services, providing services, and coordinating services.
- **Performance Improvement.** Standards relating to data collection, analysis, and using data to make & manage performance improvements.
- **Records of Care, Treatment, & Services.** Standards relating to the components of a medical record, whether paper or electronic. These standards also pose consistent challenges.
- **Rights & Responsibilities of the Individual.** Standards relating to informing patients of their rights, helping them understand their rights, respecting patients’ values/beliefs/preferences, and informing patients of their responsibilities regarding their care.

Many of these standards focus largely on structural factors and processes of care, and less on whether the hospital is achieving good outcomes (e.g., lower mortality rates). Patient safety and the management of risks relating to the proximity, probability, and severity of harm to patients has become of increasing importance to TJC. This has implications for forensic units within psychiatric hospitals (i.e., API) and stand-alone forensic psychiatric hospitals, although there are no TJC standards specific to workplace violence either.

National Patient Safety Goals (NPSG)

In 2002, TJC established National Patient Safety Goals (NPSG) to help accredited organizations address specific areas of concern regarding health care safety, and to focus on how to solve them. In order to ensure hospitals focus on preventing major sources of patient harm (e.g., medication errors), TJC regularly revises the NPSG based on their impact, cost, and effectiveness. The 2019 NPSG include a revision requiring hospitals to maintain specific protocols to prevent inpatient suicide, including conducting environmental risk assessments, screening patients admitted for behavioral health reasons for suicide risk, and implementing tailored suicide prevention plans for high-risk patients.

The NPSG have spawned TJC’s approach to Patient Safety Systems, which was developed to provide guidance to hospitals on how 32 of the existing TJC standards could be applied to improve patient safety. The table below summarizes these standards.

Figure 2: Patient Safety System of The Joint Commission

Patient Safety System Characteristic	2019 TJC Standard*
Role of leadership in creating safety culture	APR.09.01.01, APR.09.02.01, LD.02.01.01, LD.02.04.01, LD.03.01.01-03.09.01, LD.04.01.01, LD.04.01.05, & LD.04.01.10
Methods to improve processes & systems	EC.04.01.01, IC.01.03.01, MM.07.01.03, & MM.08.01.01
Interdisciplinary team standardized communication/collaboration	MS.08.01.01, MS.09.01.01, & NR.02.01.01
Safety integrated technologies	PC.03.05.19, PI.01.01.01, PI.02.01.01, PI.03.01.01, RI.01.01.01, RI.01.01.03, RI.01.02.01, RI.01.03.01, RI.01.05.01, & RI.02.01.01

*APR - Accreditation Participation Requirement; EC - Environment of Care; IC-Infection Prevention/Control; LD – Leadership; MM - Medication Management; MS - Medical Staff, NR – Nursing; PC - Provision of Care/Treatment/Services; PI—Performance Improvement; RI - Rights of Individuals.

Standards of Importance for Forensic Units & Stand-Alone Forensic Psychiatric Hospitals

All Hospital Accreditation Standards must be achieved for a forensic unit within a hospital or a stand-alone forensic psychiatric hospital to achieve TJC accreditation. Not surprisingly, the standards that are the most relevant for forensic units within hospitals or stand-alone forensic hospitals are those relating to a safe and secure hospital environment, means of egress, use of sally ports, use of physical space, emergency response, patient rights, use of seclusion & restraints, behavior management, and trained clinical staff and security staff who can implement specialized procedures (e.g., violence risk assessment). These standards are:

Environment of Care. EC.02.01.01, EC.02.02.01, 02.06.01, 03.01.01, 04.01.01- 04.01.05. These relate to risk assessment, safe environment, physical space, staff, & data.

Example: EC.02.01.01. Hospital should have a risk assessment specific to violence risks within the forensic unit/ hospital to address resources for the different types of violence—patient/ patient, patient/ staff, patient/ visitor, visitor/ staff, etc.

Emergency Management. EM 02.01.01, 02.02.01-.07, 02.02.11, 03.01.01, & 03.01.03. These relate to emergencies, safety/security, communications, staff, & monitoring.

Example: EM.02.02.05. Hospital's Emergency Operations Plan should address local law enforcement's incident command structure to provide ongoing communication and coordination with that structure. In addition, forensic unit/ hospital and should develop an active shooter response plan in coordination with local law enforcement.

Leadership. LD 03.01.01, 03.02.01, 03.03.01, 03.04.01, 03.06.01, 03.09.01, 04.01.01, & 04.03.11—these relate to culture, communication, staff, patient safety, & patient flow.

Example: LD.04.01.01. Hospital must comply with local, state, & federal laws, rules & regulations. The Occupational Safety & Health Administration (OSHA) is the federal agency that requires employers to maintain a safe working environment for their staff.

Life Safety. LS 01.01.01, 02.01.20, & 03.01.20). These relate to compliance & means of egress.

Example: LS.02.01.20. Doors to patient rooms are not locked unless the clinical needs of the patients require specialized security or where patients pose a security threat and staff can readily unlock doors at all times.

Provision of Care, Treatment, & Services. PC 01.01.01, 01.02.01-01.02.03, 01.02.13, 01.03.01-01.03.05, 02.01.01-02.01.05, 02.01.11, 02.01.19, & 03.05.01.19. These relate to admissions criteria assessment/reassessments, plan, behavior management, providing care, & use of seclusion/restraint.

Example: PC.01.02.13. Requires that patients receiving treatment for emotional or behavioral disorders receive an assessment that includes maladaptive or other behaviors that create a risk to patients or others.

Rights & Responsibilities of the Individual. RI 01.01.01, 01.01.03, 01.02.01, 01.03.01, 01.04.01, 01.06.03, 01.06.05, 01.06.09, 01.07.01-.05, 01.07.13, & 02.01.01. These relate to communicating rights, participating in care, informed consent, right to know providers, personal rights, & patient responsibilities).

Example: RI.01.06.03. Patients have the right to be free from neglect, exploitation, and verbal, mental, physical, & sexual abuse.

Discussion

Design Considerations

The Facility Guidelines Institute's Guidelines for Design and Construction of Hospitals (FGI) contain information on planning, designing, and constructing hospitals in the United States and is the seminal source on hospital construction. While the current version of FGI has specific guidelines relating to construction of psychiatric hospitals, there are no forensic-specific psychiatric hospital guidelines.

From an accreditation perspective, there are several important design considerations Alaska should consider in determining whether a stand-alone forensic psychiatric hospital should be constructed, including:

- What level of security will be required for which type of forensic patient?
- How will forensic patients be transported?
- What type of clinical and security staffing will be required?
- How many beds should each wing/pod include?
- Will patient doors have locks? CMS does not certify facilities with locked patient rooms.
- What extra precautions need to be taken with fire alarms, utility systems, etc.?
- Will medications be stored on units or in centralized location?
- How will basic patient rights such as right to privacy be weighed against Environment of Care standards such as use of physical space?

Treatment Considerations

From an accreditation perspective, the treatment process is the same in a forensic unit/hospital or a general psychiatric hospital. While all TJC standards relating to the provision of care, treatment, & service apply to a forensic unit/hospital, there are certain elements of forensic services that are important from a clinical and administrative decision-making perspective:

- Use of seclusion and restraint for nonclinical purposes.
- Gradations of seclusion and restraint, alone time in room, ambulatory restraints (protective assistive devices), full restraints, seclusion room, etc.
- How disciplinary restrictions are imposed.
- If and how rights are restricted.
- Discharge and transition planning.
- Length of stay.
- Behavior management interventions, particularly identification of early warning signs of deteriorating behavior.

Matrix of Recommendations from Relevant Background Reports

Type of Change	Target Population	Current	Recommendation	Source
Statute	Competency Evaluation		Title 12 and Title 47 statutes should be amended to allow parties to hire a private expert or request that a second evaluator be appointed at that party's cost, in the event that the party is not satisfied with the report of the court-appointed evaluator.	UNLV, 2014
Statute	Competency Evaluation		Title 12 and Title 47 should be amended to require the Department of Health and Social Services or its designee to assume responsibility for designating qualified and neutral evaluators.	UNLV, 2014
Statute	Competency Evaluation	AS 12.47.070 references a "defendant's fitness to proceed" or "reasons to believe a mental disease or defect of the defendant will otherwise become an issue in the case".	Remove the aforementioned references and refer instead to "a defendant's competence to proceed under AS 12.47.100".	UNLV, 2014
Statute	Competency Evaluation	AS 12.47.100 "the court shall have the defendant examined by at least one qualified psychiatrist or psychologist, who shall report to the court concerning the competency of the defendant"	Define the terms "qualified psychiatrist", "qualified psychologist", and "qualified forensic psychologist" in the Definitions section in AS 12.47.130. Include in the definition of "qualified forensic evaluator" in this section verbiage that expressly permits post-doctoral trainees and interns to conduct evaluations under the supervision of a qualified forensic evaluator.	WICHE, 2016; UNLV, 2014
Statute	Competency Evaluation	AS 12.47.100 "...the attorney may file a motion for a judicial determination of the competency of the defendant. Upon that motion, or upon its own motion the court shall have the defendant examined..."	Amend AS 12.47.100 to permit the court to rely on previous and/or recent competency evaluations to determine whether a competency to proceed evaluation for the current charges is necessary, particularly for defendants well known to the court and repeatedly charged with misdemeanor offenses.	WICHE, 2016

Matrix of Recommendations from Relevant Background Reports

Statute	Competency Evaluation	No statute to compel DOC to transfer evaluatees promptly following completion of a competency evaluation at API.	Amend either AS 12.47.100 or AS 12.47.070 to include a specific provision that would compel DOC to transfer evaluatees promptly following the completion of a competency evaluation at API.	WICHE, 2016
Statute	Competency Evaluation	Alaska does not have statutory provisions permitting the use of telemedicine, telehealth, or telebehavioral health.	Explore use of telebehavioral health. Allow for the use of telebehavioral health and evaluation via videoconferencing in AS 12.47.070 and AS 12.47.100 and throughout Title 47. Allow for the use of telebehavioral health for forensic evaluations. Define telebehavioral health in statute.	WICHE, 2016 UNLV, 2014
Statute	Competency Evaluation	No statutory limit on the timeframe for completion of competency evaluations for misdemeanor offenses. AK Court System policy to schedule competency hearings three weeks (15 days) after an evaluation has been ordered.	Amend AS 12.47.070 to require that competency evaluations for misdemeanor charges be performed within 15 calendar days of the court order. A 15-day extension should be permitted when the defendant appears to be under the influence of alcohol or drugs at the time of the order.	UNLV, 2014
Statute	Competency Evaluation	No statutory consideration for the availability of previous and/or recent competency evaluations of the same defendant.	In misdemeanor cases where a defendant has received a full competency evaluation in the previous 12 months, the statute could allow for a more limited, follow-up competency evaluation (AS 12.47.070)	UNLV, 2014
Statute	Competency Evaluation	No statutory requirement for scheduling competency hearings. Anchorage Competency Court prioritizes competency cases and puts them on the calendar for the next available court day.	AS 12.47.070 should be amended to require that the court advance the date for the hearing on the defendant's competency to the day after the competency report is filed.	UNLV, 2014
Statute	Competency Evaluation	No statutory requirement for scheduling court date for defendants for competent to proceed on a misdemeanor charge.	AS 12.47.070 should be amended to require that the court advance the date for the plea hearing or trial to the earliest possible date if a defendant is found competent to proceed on a misdemeanor charge.	UNLV, 2014

Matrix of Recommendations from Relevant Background Reports

Statute	Competency Evaluation (Juveniles)	Alaska statutes provide little direction as to how juveniles should be treated in competency proceedings.	<p>Consider the following:</p> <ul style="list-style-type: none"> • Developmental immaturity as a cause of a defendant's incompetence to stand trial. • Include cognitive concepts like a juvenile's ability to understand the proceedings and assist counsel. • Avoid specifying a degree of competency in statute • Provide a separate definition for childhood mental illness • Require competency evaluations be performed within 30 calendar days of the court order for evaluation • Juvenile competency evaluations should be performed by qualified and neutral evaluators with training and experience in child psychology or psychiatry. 	UNLV, 2014
Statute	Competency Restoration	Alaska statutes do not currently include provisions regarding the use of psychotropic medications to restore competency in criminal proceedings.	<p>Evaluate practices related to Sell hearings.</p> <p>Amend AS 12.47.110 to allow for the court to order on a finding of incompetency to include the involuntary administration of medication, if appropriate, for treatment to competency.</p> <p>Amend AS 12.47.110 to include a reference to <i>Sell</i>, as well as the fact that courts should first use <i>Harper</i> factors when an incompetent defendant is dangerous and the treatment is in his medical interest.</p>	<p>WICHE, 2016</p> <p>UNLV, 2014</p>
Statute	Competency Restoration	12.47.110(a), provides that the court "may commit a defendant charged with any other crime," for 90 days, but the statute does not provide guidelines or procedures for courts to follow with respect to competency restoration for misdemeanor crimes.	Consider amending AS 12.47.100 to allow for varying time periods for competency restoration, depending on the seriousness of the charged offense. (Ex. 60 days for class A misdemeanors, 30 days for class B misdemeanors).	UNLV, 2014

Matrix of Recommendations from Relevant Background Reports

Statute	Competency Restoration	Statute does not require the court to be notified as soon as possible regarding competency.	Amend statute to require mental health professionals to notify the court as soon as they believe the defendant to be competent, even if that period is less than the total amount of time allowed for restoration.	UNLV, 2014
Statute	Competency Evaluation	Alaska has not statutorily established diversion programs for misdemeanants suffering from mental illness.	Consider adopting a new statute that allows for a screening investigation and diversion of misdemeanor defendants who are likely to be IST. This approach should only be adopted if the state is satisfied there is a valid and reliable screening tool available.	UNLV, 2014
Statute	Competency Restoration (Juveniles)	AS 47.12 governs juvenile delinquency but does not include provisions related to competency restoration for juveniles.	<p>Consider amending juvenile delinquency statutes to:</p> <ul style="list-style-type: none"> • Provide for placements and services that will accomplish competency restoration in juveniles. • Provide for appropriate periodic review and designate different amounts of time for inpatient vs outpatient restoration • In cases where a juvenile is incompetent due to development immaturity or intellectually disability an restoration is inappropriate consider compromise positions • In cases where a juvenile is incompetent due to development immaturity or intellectually disability an restoration is inappropriate statutes should give juvenile courts the discretion to direct the juvenile into the appropriate social and clinical services for follow-up care. 	UNLV, 2014

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Statute	Non-Restorable After Treatment	Responsibility for initiating civil commitment proceedings for those found IST and unrestorable is not specified.	AS 12.47.110 (e) should require the Department of Health and Social Services or its designee to initiate inpatient or outpatient civil commitment proceedings or create a discharge plan for the defendant if the defendant is found incompetent and unrestorable or if there is not a substantial probability that the defendant will become competent. The statute should require that the court provide a notice of intent to dismiss the charges and DHSS and its designee shall have 24 hours to initiate civil commitment proceedings, if indicated, or to create a discharge plan.	UNLV, 2014
Statute	Not Guilty by Reason of Insanity	AS 12.47.070 requires that for defendants raising the insanity defense “at least two qualified psychiatrists or two forensic psychologists certified by the American Board of Forensic Psychology to examine and report upon the mental condition of the defendant”.	Require one qualified psychiatrist or one qualified forensic psychologist to evaluate for insanity rather than two.	WICHE, 2016; UNLV, 2014
Statute	Not Guilty by Reason of Insanity	No functional insanity affirmative defense. Alaska is the only state that limits its insanity defense to the cognitive incapacity prong of M’Naghten and this limitation deprives defendants of a true insanity affirmative defense.	Re-institute a functional insanity affirmative defense in AS 12.47.010 with both the cognitive and moral incapacity prongs of the full M’Naghten test.	UNLV, 2014
Statute	Not Guilty by Reason of Insanity		If the state chooses to re-institute a full M’Naghten test for legal insanity, it should revisit and consider revisions to the procedures upon a verdict of not guilty by reason of insanity under AS 12.47.090 and the procedures after raising a defense of insanity under AS 12.47.090	UNLV, 2014
Statute	Guilty but Mentally Ill		If the state chooses to re-institute a full M’Naghten test for legal insanity, it should also consider removing the GBMI verdict from the statute (12.47.040).	UNLV, 2014

Matrix of Recommendations from Relevant Background Reports

Statute	Competency Evaluation, Education	Requirements for continuing education and supervision not identified in statute and a formal process for supervision is not in place.	The Division of Behavioral Health should be designated by statute to coordinate continuing education in forensic evaluations. Continuing education should include, when possible, in-person supervision of the examiner's evaluation practices and reports.	UNLV, 2014
Process			Use forensic consultants external to API to provide guidance and objective analysis of the work of API's forensic evaluators for the purposes of professional development.	WICHE, 2016
Process	Competency Evaluation/Restoration	Forensic evaluators serve two roles: Conducting forensic evaluations and serve as members of the competency restoration clinical team.	Employ forensic consultants who are not affiliated with the hospital to review case presentations and reports of the hospital's forensic evaluators to reduce chance for or perception of conflict of interest.	WICHE, 2016
Statute			Amend Title 12 and Title 47 to require that all forensic evaluations be conducted by neutral evaluators and define these terms in AS 12.47.130 and AS 47.30.915, Neutral evaluators should not be involved in the individuals' clinical or restorative treatment. If a neutral evaluator later becomes involved in an individual's treatment, statutes should require subsequent evaluations be conducted by an additional neutral evaluator.	UNLV, 2014
Process	Competency Evaluation	Statutes permit the court to appoint forensic examiners but does not expressly compel the Department of Health and Social Services to conduct the court-order evaluation.	Discussion between DHSS and the State Judicial system regarding which branch of government is responsible for providing forensic evaluators and paying for their services.	WICHE, 2016
Process	Competency Evaluation	AS 12.47.100 permits the court to commit the defendant, "for a reasonable period to a suitable hospital or other facility designated by the court." And AS 12.47.070 (a)(c) reads, "the court may order the defendant to be committed to a secure facility for the purpose of the examination.	Neither statute compels DHSS to consider only API as the facility to which defendants may be admitted. DHSS should consider placements other than API to perform forensic evaluations and competency restorations.	WICHE, 2016

Matrix of Recommendations from Relevant Background Reports

Process	Competency Evaluation	API performs the same level of competency evaluation for all misdemeanor and felony defendants.	Consider a more limited competency evaluation procedure for misdemeanants, including the creation of a brief form for evaluators to complete for competency assessments in misdemeanor cases to help streamline the process.	UNLV, 2014
Process	Competency evaluation	All competency restorations are performed at API by 2 FT forensic psychologists and 1 PT forensic psychologists.	Consider implementation of jail-based competency evaluation. Add forensic psychologists and psychiatrists to augment existing capacity of API to evaluate.	WICHE, 2016 CJC Annual Report, 2018
Process	Competency evaluation	No prioritization of evaluations or pre-screening process.	Employ a brief competency screening assessment for defendants admitted for evaluation of incompetency to proceed. If the screen identifies the evaluatee as likely competent, then the incompetency to proceed evaluation is assigned and conducted by a forensic evaluator as soon as possible. The evaluatee can then be returned to the jail of origin once the evaluation is completed and prior to the hearing as AS 12.47.100 (b) reads, "For the purpose of the examination, the court may order the defendant committed for a reasonable period to a suitable hospital or other facility designated by the court."	WICHE, 2016
Process	Competency restoration	Status hearing motions not routinely filed by API for defendants admitted to API for restoration to competency who are uncooperative or who refuse medications deemed necessary to restore them to competency to proceed.	API and its attorneys should routinely file motions for status hearings for defendants admitted to API for restoration to competency who are uncooperative or who refuse medications deemed necessary to restore them to competency to proceed.	WICHE, 2016

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Process	Competency restoration	API provides inpatient treatment for civilly committed patients and for competency restoration. Restoration services are provided by 2 FT forensic psychologists and 1 PT forensic psychologists.	Consider reaching out to tertiary care and private, free-standing psychiatric facilities to assess their receptivity to building greater capacity to treat civil patients; thus, freeing up API's capacity to ensure timely admission of forensic patients.	WICHE, 2016
			Add more forensic psychologists and psychiatrists to augment the existing capacity of API to treat these individuals.	CJC Annual Report, 2018
Process	Care coordination	Limited data sharing between API, hospital emergency rooms, and the Alaska Court System.	Use data systems to identify the individuals who account for a significant number of arrests, court appearances, admissions to API, hospital emergency room contacts, and EMS calls and commit resources to address the unmet needs of this "super-utilizer" population.	WICHE, 2016
Process	Care coordination		Review current criteria for participation in intensive community treatment programs to ensure the individuals most likely to benefit from these services are eligible to receive them.	WICHE, 2016
Process	Care coordination		Implement pre-arrest and post-booking/pre-arraignment jail diversion practices (corresponding with Intercepts 1 and 2 of the SAMHSA GAINS Center's Sequential Intercept Model of Jail Diversion).	WICHE, 2016 Trends and Consequences of Eliminating State Psychiatric Beds, Fuller, et. al., 2016
Process	Education	Judges and attorneys are sometimes unclear as to what competency restoration entails and what treatment services and programming is available to defendants ordered to API for restoration.	API to provide in-services for the courts and consider inviting members of the court to tour API to better understand the processes there.	WICHE, 2016
Process	Education	Limited training for API treatment providers related to testifying in forensic cases.	Implement an educational curriculum for API staff who are likely to testify in court so that staff are aware of the legal requirements associated with forensic evaluations and treatment, the likely lines of inquiry, relevant case law governing competency to stand trial and the relevant factors to consider for a Sell determination.	WICHE, 2016

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Facility	Competency restoration/civil commitments	No intensive care/admitting unit	The facility would benefit from an intensive care/admitting unit, staffed by employees who have the experience and ability to handle the most acute patients.	Non-Confidential Public Report of Alaska Psychiatric Institute Investigation, 2018
Continuum	Care coordination	Lack of community resources for treatment at other levels of care, including specialized services for people with developmental disabilities, dementia and autism.	Scale up community mental health resources to keep pace with the demand for services.	Non-Confidential Public Report of Alaska Psychiatric Institute Investigation, 2018

List of Stakeholder Interviews Conducted in Phase 1

Stakeholder/Partner Entity	Participants + Titles	Date of Meeting
Department of Corrections	Adam Rutherford, Mental Health Clinician IV Laura Brooks, Operations Manager	January 10, 2019
Alaska Mental Health Trust Authority	Katie Baldwin, Senior Program Officer Travis Welch, Program Officer Steve Williams, COO	December 6, 2018
Alaska Mental Health Board	Bev Schoonover, Acting Director Stephen Sundby, Provider Member Brenda Moore, Chair Charlene Tautfest, Vice-Chair	December 6, 2018
Department of Law, Civil Division	Steven Bookman, Assistant AG Stacie Kraly, Attorney	November 20, 2018
Alaska Court System	Pam Washington, Judge Michael Franciosi, Judge Pat Hanley, Judge Jennifer Henderson, Presiding Judge of CRP Court Lisa Fitzpatrick, Administrative Attorney Kate Sumey, Project Coordinator	January 17, 2019
Department of Health and Social Services		
Division of Behavioral Health	Gennifer Moreau-Johnson Laura Russell Alysa Wooden	Ongoing
Alaska Psychiatric Institute	Drs. McRae and Becker Gavin Carmichael Kate Oliver	Ongoing
Division of Juvenile Justice	Tracy Dompeling, Director Shannon Cross-Azbil, Mental Health Clinician	January 25, 2019