

**ALASKA STATE LEGISLATURE
HOUSE STATE AFFAIRS STANDING COMMITTEE**

February 13, 2020

3:02 p.m.

MEMBERS PRESENT

Representative Zack Fields, Co-Chair
Representative Jonathan Kreiss-Tomkins, Co-Chair
Representative Grier Hopkins
Representative Andi Story
Representative Steve Thompson

MEMBERS ABSENT

Representative Sarah Vance
Representative Laddie Shaw

OTHER LEGISLATORS PRESENT

Representative Gary Knopp

COMMITTEE CALENDAR

PRESENTATION: ALASKA REHABILITATION & REENTRY REPORT OVERVIEW

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

DOUG WOOLIVER, Deputy Administrative Director
Alaska Court System (ACS)
Anchorage, Alaska

POSITION STATEMENT: Provided information during the presentation, entitled "Alaska Rehabilitation & Reentry Report Overview."

LAURA BROOKS, Health Care Administrator
Division of Health and Rehabilitation Services
Department of Corrections (DOC)
Anchorage, Alaska

POSITION STATEMENT: Presented "Alaska Rehabilitation and Reentry A Report to the Legislature" with the use of a PowerPoint presentation.

JENNIFER WINKELMAN, Acting Deputy Commissioner
Department of Corrections (DOC)
Anchorage, Alaska

POSITION STATEMENT: Answered questions during the presentation, entitled "Alaska Rehabilitation & Reentry Report Overview."

TERI TIBBETT, Co-Chair
Juneau Reentry Coalition
Juneau, Alaska

POSITION STATEMENT: Provided information during the presentation, entitled "Alaska Rehabilitation & Reentry Report Overview."

JANET MCCABE, Chair
Board of Directors
Partners for Progress
Anchorage, Alaska

POSITION STATEMENT: Provided information during the presentation, entitled "Alaska Rehabilitation & Reentry Report Overview."

JOSHUA SOPKO, Director
Partners Reentry Center
Anchorage, Alaska

POSITION STATEMENT: Provided information during the presentation, entitled "Alaska Rehabilitation & Reentry Report Overview."

BARBARA MONGAR, Coordinator
MatSu Reentry Coalition
Wasilla, Alaska

POSITION STATEMENT: Provided information during the presentation, entitled "Alaska Rehabilitation & Reentry Report Overview."

BOBBY DORTON
Fairbanks Native Association
Fairbanks, Alaska

POSITION STATEMENT: Provided information during the presentation, entitled "Alaska Rehabilitation & Reentry Report Overview."

ACTION NARRATIVE

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CO-CHAIR ZACK FIELDS called the House State Affairs Standing Committee meeting to order at 3:02 p.m. Representatives Thompson, Hopkins, Story, Fields, and Kreiss-Tomkins were present at the call to order.

PRESENTATION: Alaska Rehabilitation & Reentry Report Overview

[3:02:46 PM](#)

DOUG WOOLIVER, Deputy Administrative Director, Alaska Court System (ACS), relayed that all therapeutic courts have one thing in common - they try to resolve the underlying problem that brought the person into the criminal justice system or into the Child in Need of Aid (CINA) system. Alaska's therapeutic court was started in the late 1990's by two Anchorage judges with the Alaska District Court - Judge Jim Wanamaker and Judge Stephanie Rhoades. Judge Wanamaker started Alaska's first substance abuse court - a "driving under the influence (DUI)" court in Anchorage. Judge Rhoades started one of the nation's very first mental health courts. They started the courts out of personal frustration with seeing the same people come back before them repeatedly for crimes that they saw as clearly related to their underlying substance abuse and mental health problems, and the whole system knew that that was why these people were back again and again. He offered that it made no sense to continue to send them to jail, which not only didn't address the problem and didn't stop them from committing crimes, but frequently made things worse; therefore, the judges started the two courts. He stated that currently Alaska has a total of 12 therapeutic courts around the state. Although the courts mostly engage with criminal cases - both misdemeanor and felony cases - they also engage with - to a lesser degree - people involved with the CINA system.

MR. WOOLIVER explained how the criminal courts function: They are all "post plea." "You plead guilty to the crime that you have been charged with or whatever the plea agreement is, with the understanding that if you complete therapeutic court ... you then withdraw your plea and you get the benefit of whatever the underlying agreement was." The benefits might be a significant reduction in the sentence, a reduced crime, or maybe even a dismissal of the case. He maintained that this constitutes the legal incentive to participate. The courts run generally about

18 months; and they are difficult to complete. He offered that one of the challenges of all therapeutic courts is getting offenders to participate. For a person who has been in jail many times for minor crimes, jail is not that difficult. For a 60-day, 90-day, or 120-day sentence, the offender may elect to serve the sentence rather than spend 18 months in an intensive program to address his/her underlying problems. He added that a therapeutic court is also difficult because many of these offenders are addressing lifetime addiction problems, substance abuse problems, and mental health problems, and these are hard problems to overcome. He said, "Even in the best of times and the best circumstances, these are still very difficult programs to get through."

MR. WOOLIVER relayed that there are substance abuse courts in Anchorage, Bethel, Fairbanks, Kenai, Palmer, and other communities. The [Anchorage Veterans Court] is a therapeutic court for veterans; since veterans have similar experiences and a comradery, participating in the court together is helpful to them. He continued by saying there are mental health courts in Anchorage, Juneau, and Palmer. For substance abuse courts, ACS has contracted with local providers for therapy, counseling, and treatment in all the communities with the courts; the providers must offer services within five workdays of a referral. He offered that the advantage of a substance abuse court is that due to the contract, the needs of the participant are attended to promptly. He acknowledged that there is a lengthier delay for treatment in connection with mental health courts because of the lack of availability of treatment providers. He mentioned that many of the offenders have a combination of issues - alcohol, drug, and mental health; the more issues compiled together, the more difficult they are to treat and the fewer the qualified providers available to treat them.

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MR. WOOLIVER said that another challenge is finding "safe and sober" housing for the participants. When someone leaves jail, it is not good for that person to return to the environment that facilitated the problem. It is difficult to overcome a significant substance abuse problem - "particularly when that's your whole life, those are all your friends, and your neighbors, and your roommates, and maybe your family members."

CO-CHAIR FIELDS asked whether staff at the reentry centers, such as Partners Reentry Center, are assisting therapeutic court

participants with housing, or whether a different group of people are helping them.

MR. WOOLIVER emphasized the significant role that Partners for Progress has had since the beginning of the therapeutic courts. He relayed that Janet McCabe [Chair, Board of Directors, Partners for Progress] has been a pioneer in the field and incredibly helpful to the courts.

MR. WOOLIVER continued by saying that there are currently 12 courts. The goal is to reduce recidivism: research by the Alaska Judicial Council found that within a year of being released for a misdemeanor, 9 percent of graduates of therapeutic courts were reconvicted compared with 25 percent of those who were not in the program; for felons, the statistics were 12 percent versus 23 percent. He offered that although therapeutic courts reduced recidivism, they are not a "panacea"; the offenders are still trying to overcome some significant hurdles in their lives; and many have other issues to contend with as well. He maintained that therapeutic courts offer a better system; and ACS would like to have more of them; however, there are many requirements - treatment providers in the community who are trained to work with offenders, a judge who has been trained in therapeutic courts, a prosecutor who has been trained in therapeutic courts, and a defense attorney who have been trained in therapeutic courts. Because there is constant turnover of personnel, maintaining a trained staff and continuity with clients is challenging. He mentioned budget increment requests to facilitate the system.

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REPRESENTATIVE HOPKINS stated that there is interest in starting a veterans' court in Fairbanks; there is a judge who is a former marine who is very interested. He asked whether one therapeutic court in a community facilitates starting another.

MR. WOOLIVER answered affirmatively. He said that an enthusiastic judge in Fairbanks would make it easier to start another court in the community. He contended that there are other pieces to establishing a therapeutic court; the Alaska Supreme Court must approve each new therapeutic court because it is resource intensive and it impacts how cases move through the court system. A probation officer (PO) who can handle the additional cases is needed. He maintained that the ACS therapeutic courts coordinator - Michelle Bartley - is working

with the group in Fairbanks that wishes to establish a veterans' court.

[3:14:27 PM](#)

REPRESENTATIVE STORY asked whether the therapeutic court encompasses "Youth Court."

MR. WOOLIVER responded that Youth Court is separate.

REPRESENTATIVE STORY offered her support for therapeutic courts.

CO-CHAIR KREISS-TOMKINS expressed his appreciation for the therapeutic court program. He asserted that evidence bears out that therapeutic courts are cost effective. He maintained that there must be a "financial mechanism that can be engineered that proves up in a dollars and cents way via bonding or something that accounts for the (indisc.) associated with reduced recidivism that literally makes institutions like therapeutic courts pay for themselves." He added that the Pay for Success (PFS) Social Impact Bond is an attempt to do so. He said, "It would be really wonderful if there was a way to make the dollars and cents really speak for themselves and create a self-perpetuating revenue stream that ideally could encompass or annex a greater portion of criminal justice workflow."

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LAURA BROOKS, Health Care Administrator, Division of Health and Rehabilitation Services, Department of Corrections (DOC), relayed that as a provision of HB 49 [signed into law 7/8/19], DOC was required to submit to the legislature a comprehensive review of DOC's rehabilitative efforts to address recidivism. The report is a multi-agency effort which includes the Department of Labor and Workforce Development (DOLWD), the Department of Education & Early Development (DEED), the Department of Health and Social Services (DHSS), the Alaska Mental Health Trust Authority (AMHTA), the Department of Public Safety (DPS), local governments, and community providers. She maintained that for effective reentry, it takes efforts from everyone. The report reviews current practices, up-and-coming practices, and the gaps.

MS. BROOKS turned to slide 2 and stated that Alaska's correctional system is a unified system, and there are only seven unified systems in the country. Alaska DOC serves both sentenced and unsentenced prisoners, for both felonies and

misdemeanors, in one combined system; its jails house unsentenced inmates, and its prisons house sentenced inmates. She relayed the information on slide 2: During fiscal year 2019 (FY19) Alaska had 33,813 arrests involving 21,661 individuals; there were 33,834 releases involving 19,148 individuals. She related that "someone is coming and going in DOC every eight minutes of every day all year long." She emphasized the importance of these statistics as they relate to reentry; there is a quick turnover in the incarcerated population; the unsentenced population plays a critical part in affecting DOC's ability to develop reentry plans; some of the unsentenced inmates are out in a few days or even one hour. She maintained that for reentry planning, DOC asks the questions: Who do we need to focus on? For whom do we have the best chance of developing a plan that will really affect the person's recidivism and likelihood to return? She noted that while 95 percent of the DOC population return to the community, only about 25 percent of those are released on supervision. That means that only about 25 percent of the individuals who are released have a PO who can continue to help them with their reentry plans and help them access the resources they need in the community. She said that the other 75 percent do not have POs to assist them.

MS. BROOKS turned to slide 3, to give the statutory definition of recidivism, which read:

Recidivism

AS 44.19.647

All felons released within a given year who return to incarceration within three years for any offense conviction (felony or misdemeanor) or probation/parole violation.

[3:21:47 PM](#)

MS. BROOKS explained that the most current recidivism statistics are for [calendar year (CY)] 2016, because that was the last cohort that left DOC for whom there is a three-year timeframe. She reviewed the chart on slide 4 and pointed out that after being in the upper 60th percentile for decades, Alaska is now experiencing a downward trend in recidivism; and for the first time since data collection began in 2002, Alaska is under 60 percent recidivism - 59.96 percent. That represents about a 10

percent reduction in ten years. She maintained that the success is most likely due to a combination of factors: an aggressive shift toward evidence-based programming; assessment tools that help staff focus on specific criminogenic risk factors of an individual; focused reentry planning; a shift toward administrative sanctions through the Division of Probation & Parole; and the community partnerships that have developed to extend safety nets and supports for individuals exiting the criminal justice system.

REPRESENTATIVE STORY asked what one would expect to see in states with the lowest recidivism rates.

MS. BROOKS responded that in looking at reentry efforts around the country, there is an emphasis on evidence-based practices. The rehabilitative programs that are being developed are supported by good research that demonstrates they are effective for the incarcerated population. She said Alaska's DOC has made a concerted effort toward these practices in the past three to five years; it is continuing to evaluate the programs to ensure it is meeting the best practice standards.

REPRESENTATIVE STORY asked what recidivism rates other states have achieved that have pursued the best practices programs longer than Alaska.

MS. BROOKS answered that it is difficult to compare states. Alaska has a unified system, but other states include different segments of the corrections population in their recidivism numbers. She maintained that DOC is looking for states comparable to Alaska as the department moves into other reentry practices. She mentioned the U.S. Bureau of Justice Statistics (BJS) study that reviewed 30 states and 400,000 offenders; the overall recidivism rate was 68 percent.

MS. BROOKS moved to slide 5, entitled "Rehabilitation," and stated that rehabilitation occurs from the time the inmate comes into the correctional system to the time of release and even beyond into the community. She maintained that DOC struggles with offender participation: DOC cannot require or force offenders to participate in programs; DOC puts programs in place and tries to offer incentives; however, ultimately it is up to the inmate to participate. She said that DOC ensures that the programs are evidence-based, meet industry standards, and are supported by research. She emphasized three important aspects of program delivery: the right programs to the right people at the right time.

CO-CHAIR KREISS-TOMKINS asked whether there are examples of programs that were transitioned out because they weren't evidence-based; and conversely, whether there have been new programs introduced that are evidence-based that were not previously administered.

MR. BROOKS said yes. She offered that over the years there have been several programs from different sources; however, because of the concerted effort to demonstrate that programs are evidence-based, DOC now has supporting data. She relayed that DOC has eliminated certain programs and brought in new programs. The department is currently implementing a couple of programs that address offender thinking, criminal thinking errors, and general criminal attitudes. She maintained that one issue for DOC is making sure that the program being offered is true to the fidelity of the model; DOC must ensure that the providers are properly trained. She gave the example of administering General Educational Development (GED) tests: DOC knows that it is a good program; however, DOC must ensure that staff and contractors are providing the service according to the evidence-based requirements of the program.

REPRESENTATIVE STORY asked whether DOC contracts with trainers to train staff in administering programs.

MS. BROOKS answered that it depends on the program: some programs that DOC has purchased come with a training module; for some, trainers will come to Alaska to train DOC staff; for other programs, DOC sends staff to training; some programs offer online options for training. She added that an important piece of an evidence-based model is auditing the program to ensure that it is being delivered as the training dictates.

[3:28:35 PM](#)

MS. BROOKS continued with slide 6 to review the dynamic risk factors that when changed or addressed, alter the probability that someone will re-offend. The DOC chooses evidence-based programs to address the "Central Eight" criminogenic risk factors. She listed the following factors: criminal thinking; antisocial peer groups; educational background; employment and employability; substance use; mental health; and healthy relationships.

MS. BROOKS reiterated that rehabilitation starts during the pre-trial phase and continues throughout incarceration and into

post-release supervision. The offender management plan (OMP) is put in place once an individual is sentenced to 90 days or more; it is developed from the risk assessment, and it focuses on the individual's criminogenic risk factors. Those individuals can then be referred to rehabilitative programs in the DOC system that address the identified risk factors. She stated that the OMP is updated throughout incarceration due to changes in programming. She said that 90 days prior to release, the OMP is again updated; it is a fluid document that moves with the offender out into the field; it is available to the community case managers through the coalitions and to the field POs to ensure that everyone is "on the same page" and knows where to focus the rehabilitative efforts.

REPRESENTATIVE HOPKINS asked whether DOC tracked statistics for recidivism based on new crimes versus probation violations and whether that data allows DOC to understand how probation could be adjusted to reduce recidivism.

MS. BROOKS answered, "Yes we do." She explained that DOC has information on new crime recidivism as well as the portion of recidivism that is attributable to either probation violations or petitions to revoke probation.

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JENNIFER WINKELMAN, Acting Deputy Commissioner, Department of Corrections (DOC), relayed that she oversees the Probation & Parole and Pretrial Enforcement Divisions. She responded that DOC tracks what the violations are and how often they are being committed by the same offenders or different offenders. She referred to the administrative sanctions implemented under Senate Bill 91 [passed during the Twenty-Ninth Alaska State Legislature (2015-2016) and signed into law 7/11/16], through which POs respond to violations through alternative means - ones that are internal to DOC and avoid bringing the offender back into custody or in front of the court. She maintained that the practice resulted in a reduction in petitions being filed and offenders returning to jail. She offered that with the method of tracking the recidivism rate and the significant shifts in the criminal justice system, the outcome [data] is slightly skewed.

REPRESENTATIVE HOPKINS suggested that DOC is responding to the data on violations to make adjustments that would avoid putting offenders in jail for minor probations violations.

MS. WINKELMAN concurred.

CO-CHAIR FIELDS asked for the percentage of inmates, incarcerated for more than 90 days, who participate in a rehabilitation program through an OMP.

MS. BROOKS answered that it varies significantly depending on the type of program. She said that for men, the residential substance abuse treatment (RSAT) program is full and there is always a wait list; for women, it is at about 60 percent capacity and there is no wait list.

CO-CHAIR FIELDS asked for confirmation that DOC tracks availability by program. He expressed his interest in finding out where additional [program] capacity would be helpful.

MS. BROOKS replied that DOC does track [program] capacity and waitlist information and can provide that to the committee.

CO-CHAIR FIELDS asked for the percentage of inmates, incarcerated for more than 90 days, who are actively participating in an OMP.

MS. BROOKS responded that last year 3,000 offenders had an OMP either initiated or updated more than 4,200 times. That number has grown significantly over last year and the year before last. She said that the longer the OMP has been in place, the more active participation becomes. In terms of individual participation in the OMP, it is the offender's choice to cooperate, and some do not want to cooperate even with taking the risk assessment.

CO-CHAIR FIELDS restated his question: Of the 21,661 individuals who went through DOC's system, how many were in for more than 90 days.

MS. BROOKS answered that she did not know but could provide that statistic.

CO-CHAIR FIELDS clarified his request for information: the percentage of inmates who were incarcerated for more than 90 days, and of those, the number who participated in meaningful OMPs.

CO-CHAIR KREISS-TOMKINS referred to the reentry simulation and mentioned the issue of identification (ID) for people reentering

society. He asked how DOC helps those people get IDs so that they can become functioning citizens.

MS. BROOKS responded that getting an ID would not be associated with the OMP because the plans are for individuals who have been sentenced for 90 days or more. She stated that DOC provides to any offender exiting the system a one-page document that verifies that person's identity; it is from DOC and is accepted by the Division of Motor Vehicles (DMV) as appropriate documentation to obtain a state ID from DMV. She added that DOC recognizes the importance of an ID and is trying to increase awareness that the document is available.

CO-CHAIR KREISS-TOMKINS asked whether there has been communication between DOC and DMV about having a means within DOC for an inmate to obtain an ID before release.

MS. BROOKS answered that such communication has occurred just in the last several months. She relayed that the practice has occurred in other states at their larger facilities. She said that implementing this practice in Alaska's rural communities is more challenging. She added that DOC hopes to address the need for REAL ID [Act of 2005] compliant IDs as well.

[3:39:04 PM](#)

REPRESENTATIVE STORY asked to know the caseloads for personnel managing the OMPs.

MS. BROOKS responded that the caseload depends on the size of the facility. She doesn't have that information but will provide it to the committee.

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MS. BROOKS referred to slides 8-15, which offer overviews of the rehabilitative services currently available within DOC. She reviewed the services listed on slide 8, entitled "Substance Use Disorder Services": "Screening" consists of a quick review to identify a possible substance use disorder (SUD). "Assessment" is more thorough and determines a recommendation for the level of treatment for the inmate. "Intensive outpatient substance abuse treatment (IOPSAT)" refers to a service within the DOC facility that the inmate visits to engage in the treatment; there is an 82-slot capacity for IOPSAT; and it is in three facilities - Hiland Mountain Correctional Center (HMCC) [Eagle River], Goose Creek Correctional Center (GCCC) [Wasilla], and

Anvil Mountain Correctional Center (AMCC) [Nome] - and all the Community Residential Centers (CRCs) except for the one in Bethel. She suggested that the halfway house in Bethel may have an alternate means of delivering the service.

CO-CHAIR FIELDS asked where DOC would like more SUD treatment programs.

MS. BROOKS relayed that currently the RSAT program has a 64-bed capacity; it is available at HMCC for women and at Wildwood Correctional Center (WCC) [Kenai] for men. The RSAT in Seward [Spring Creek Correctional Center (SCCC)] was closed due to a lack of substance abuse treatment providers. The department struggles with finding providers in the community for all the substance abuse treatment programs. She mentioned that DOC has issued a request for proposal (RFP) to re-establish the RSAT program at SCCC. She stated that there is a waitlist for IOPSAT at GCCC partially due to provider turnover at that facility. She maintained that all the facilities would like to have programs available for each level of treatment; there have been programs at some facilities that were not at capacity.

MS. BROOKS continued with the chart on slide 8 to explain that "Psychological Education ("PsychEd")" is a six-week educational program that speaks to the biological effects of [substance] use, the effects of long-term use, and relapse; it is provided through contract or by DOC mental health clinicians. She mentioned that DOC is evaluating its programs through its Second Chance [Act] grant to determine gaps in programming.

CO-CHAIR FIELDS asked whether these programs would be available at Palmer Correctional Facility (PCC), if reopened.

MS. BROOKS answered that PCC would be an appropriate facility for these programs, as the inmates would be sentenced offenders. She added that one of the challenges for DOC is the large number of pretrial offenders who "cycle through" the facility too quickly to participate in a six-month RSAT program. In the sentenced facilities, long-term treatment programs make sense.

[3:45:15 PM](#)

CO-CHAIR FIELDS asked for information on the medication assisted treatment (MAT) programs: the medications used; the facilities that utilize them; and the transition back to the community ensuring continuity with the treatment.

MS. BROOKS answered that the MAT for DOC started with Vivitrol. Vivitrol is an extended release injectable naltrexone; it blocks the opioid receptors in the brain; and it has been shown to be an effective treatment. She said that Vivitrol is available at all DOC facilities. The other two medications used are buprenorphine and methadone. About a year and a half ago, DOC began offering "methadone bridging" for people coming into DOC's system who were engaged in methadone treatment in the community. Without methadone these individuals would experience withdrawal symptoms in the facilities. Currently DOC offers "bridging" to short-term offenders; the outpatient providers provide the methadone for DOC to administer to the offenders. She added that increasingly, offenders are coming into the system engaged in buprenorphine treatment; therefore, DOC is starting to bridge that medication for inmates as well.

CO-CHAIR FIELDS asked whether DOC coordinates with community organizations to continue treatment for the reentrant.

MS. BROOKS relayed that DOC employs the "screening, brief intervention, and referral to treatment (SBIRT)" model. Inmates are given an injection before being released; however, a very important element of MAT is the cognitive behavioral component; therefore, the substance abuse counselors provide offenders with a list of places at which therapy treatment is available.

CO-CHAIR FIELDS asked how long the Vivitrol injections last.

MS. BROOKS responded, about 28 days.

CO-CHAIR FIELDS asked what DOC's coordination is with community providers for those released offenders [to continue treatment].

MS. BROOKS replied that DOC makes every effort to try to connect offenders to providers upon release so they can start cognitive therapy as soon as they are released.

CO-CHAIR FIELDS asked what organizations in the community give Vivitrol injections.

MS. BROOKS answered that it depends on the community; there are clinics and health practitioners in private practice that provide that service. She offered that services need to be expanded in more rural communities; currently many of the outpatient treatment clinics are only available in urban areas.

REPRESENTATIVE HOPKINS asked whether there are any urban areas with gaps in Vivitrol and other post-incarceration treatments.

MS. BROOKS answered, "There are." She said that the DOC population comes from every community in the state, but there are relatively few communities with complete MAT programs. She offered that one of goals of DHSS is to expand MAT availability in rural communities and other communities.

REPRESENTATIVE HOPKINS asked whether DOC utilizes Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) within facilities and assists inmates to transition to those programs in the community upon release.

MS. BROOKS replied that DOC has AA and NA programs in every facility; they are available to all inmates; and inmates are encouraged to participate.

CO-CHAIR FIELDS asked who pays for the programs and what can the state do to expand the programs.

MR. BROOKS answered that she does not know but would request that information from DHSS.

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REPRESENTATIVE STORY asked why substance abuse treatment programs are not at capacity and if the programs are discontinued if not full. She also asked about incentives for inmates to participation in treatment programs, such as reduced sentences.

MS. BROOKS, in response to the first question, answered that it depends on the location. She offered that it has been incredibly challenging to incentivize inmates to participate in programs that the department believes are beneficial, but inmates do not. She said that there was an IOPSAT program at Lemon Creek Correctional Center (LCCC) [Juneau]; the number of participants was very low; the contract provider could not staff the program; and DOC could not continue to pay for a program that only served two or three people. She emphasized that the reentry process is critical for ensuring that the offender has that option for treatment in the community if he/she is not engaging in the treatment at the facility.

MS. BROOKS addressed the question of incentives by saying that she was not aware of a process whereby inmates can receive

reduced sentences if they participate in treatment. She acknowledged that offering that option would help participation.

MS. BROOKS continued with slide 8 to discuss "Narcan distribution." Through a federal grant, DOC receives Narcan kits, which protect against overdosing. She relayed that DOC has started to make Narcan kits available to offenders exiting the facilities. Narcan is administered through nasal spray to someone showing signs of overdosing. The department does not track the kits and cannot gauge the impact, but national statistics demonstrate a positive effect on mortality rates. She mentioned that "video-based substance abuse education" is offered to the segregation population; "CRC direct access to treatment" is provided through contracts with providers in the community, and there are dedicated slots in the treatment programs for the inmates released to halfway houses. She added that DOC is working on some new projects for "reentry coordination" so that individuals who are exiting the DOC system have more intensive case management to ensure they are connected with treatment upon release; an RFP has been issued to locate a provider for that service.

MS. BROOKS mentioned the increasing utilization of "peer supports"; there is a growing body of evidence showing that peer supports have a positive effect on offender learning and changes in behavior; it involves using a mentor with a similar life experience to work with the offender.

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CO-CHAIR FIELDS asked to what extent DOC is operating the peer support programs versus programs being supported by DHSS or nonprofit organizations. He expressed his belief that the administration of peer support across the state is uneven.

MS. BROOKS stated that DOC has peer mentors in the mental health units; they have taken mental health first aid training to recognize the symptoms of mental illness; they combat the stigma associated with seeking mental health treatment. She added that the substance abuse units also have peer support mentors. There are community providers who, in collaboration with the reentry coalitions, bring peer supports into the DOC system. She offered that DHSS is developing a peer support certification - a 40-hour training that teaches how to best safely support the offenders.

CO-CHAIR FIELDS asked whether all the facilities have some form of peer support.

MS. BROOKS said not all do, but it is growing.

REPRESENTATIVE STORY asked, "What more do we need to be doing?" She acknowledged the workforce issue - the need for more substance abuse treatment providers - and asked whether DOC staff training is adequate to ensure that released inmates are connected to the supports they need.

MS. BROOKS responded that DHSS is aware of the problem and is drafting a workforce development plan. A large percentage of the DOC population are impacted when they cannot access the services because of workforce shortages. She relayed that the institutional POs receive training on reentry issues. She maintained that offenders get reentry information from a wide variety of sources - mental health clinicians, correctional officers (COs), and reentry classes.

REPRESENTATIVE STORY suggested that being a parole officer is a demanding profession and expressed the importance of support and training.

MR. BROOKS responded that a parole officer attends a training academy, and there are required training hours annually. She offered to provide more information.

[4:01:56 PM](#)

MS. BROOKS turned to slide 9, entitled "Institutional behavioral Health Care," and relayed that overall 65 percent of DOC's population has a diagnosable mental health disorder; about 22 percent of those have a serious and persistent mental illness, like schizophrenia or bipolar disorder. She declared, "We have a very, very sick population." She said that there are mental health clinicians in each DOC facility - either by contract or on staff. Psychiatrists and psychiatric nurse practitioners provide medication management and other types of treatment planning either onsite or through telehealth systems. Psychiatric nurses are also part of the DOC behavioral health team. There are several dedicated modules just for the mentally ill population: two acute care 24-hour hospital level psychiatric treatment units - one for men and one for women; and five sub-acute units throughout the DOC system. She stated that all together, DOC has over 300 dedicated treatment beds just for the mentally ill population in specialized housing.

CO-CHAIR FIELDS asked whether the beds are fully occupied.

MS. BROOKS answered that DOC's acute care psychiatric units are always full and they have wait lists. Most of the sub-acute units are also full; the one at GCCC is a 128-bed unit and not full; there is a unit at SCCC and two at HMCC for women. Most are at capacity.

CO-CHAIR FIELDS asked whether reopening PCC would result in an increase in dedicated beds.

MS. BROOKS answered that the best utilization of those beds would have to be determined.

CO-CHAIR FIELDS asked whether there is a subset of COs who supervise inmates in the dedicated [mental health] beds or whether it is a general duty of all COs.

MS. BROOKS replied that it is a little of both: with 65 percent of the population having a diagnosable mental illness, all COs will be working with people with mental illness. She said there are officers who work on the acute care mental health units and sub-acute units. Over the past several years, DOC has implemented several trainings to help COs be better prepared to deal with the mentally ill population - mental health first aid, trauma informed care, and crisis intervention team training.

CO-CHAIR FIELDS asked whether the Alaska Mental Health Trust Authority (AMHTA) supports the trainings.

MS. BROOKS replied that AMHTA does provide funding to DOC for mental health specific training each year; although it doesn't cover all the costs, such as for overtime.

CO-CHAIR FIELDS suggested looking to the AMHTA budget to provide needed support for DOC staff.

[4:06:29 PM](#)

MS. BROOKS continued with slide 10, entitled "Education Services," and advised the committee that lack of education is a major criminogenic factor contributing to recidivism. She said that all DOC institutions offer education supports to the offender population - placement testing, GED testing, tutoring, New Path [alternative] High School, and secondary education - both onsite and through correspondence. She added that DOC education coordinators also assist offenders in correspondence college courses. She said that the education coordinators play

a critical role in other rehabilitative efforts, such as parenting classes, cognitive skills classes, computer skills classes, and job training. They work in tandem with the institutional POs.

CO-CHAIR FIELDS mentioned the GED testing program now being completely online and asked whether that presented any technology issues for DOC.

MS. BROOKS replied that there were technology issues; DOC developed some temporary workarounds; DOC is considering making [electronic] tablets available to offenders, which would streamline the GED process as well as other processes.

CO-CHAIR FIELDS recollected that due to the technology issues, the GED completion rates decreased dramatically. He asked whether the completion rates have recovered among sentenced offenders.

MS. BROOKS responded that there has been some recovery, but the rate is not as high as DOC would like it to be. She committed to providing historical data on the rates.

CO-CHAIR KREISS-TOMKINS asked whether there is anything that prevents procuring tablets for inmates.

MS. WINKELMAN responded, "It was something that we wanted to put forward this year and we are hoping that we can get into discussions about that possibility."

CO-CHAIR KREISS-TOMKINS asked whether there is currently a blanket embargo on digital devices among the inmate population that prevents inmates from using tablets or other [electronic] devices to complete the GED.

MS. WINKELMAN answered that she is not aware of that; it is something that DOC is interested in pursuing.

CO-CHAIR KREISS-TOMKINS expressed his desire to facilitate that effort.

[4:11:15 PM](#)

CO-CHAIR FIELDS mentioned consistency of program availability across institutions - gaps in terms of equipment, capacity of the education coordinators, and demand for programs at the institutions. He asked that she discuss the differences by

institution and how DOC ensures educational services are available at each institution.

MS. BROOKS responded that the delivery of programs vary depending on the size of the facility; there are multiple education coordinators in some locations. She stated that the GED function is one of the primary functions of the education coordinators; therefore, DOC is making a concerted effort to ensure that as a priority. She said that DOC has had several hurdles slowing progress in that area; however, the education coordinators recognize [lack of education] being a key criminogenic factor and the importance of increasing participation. She maintained that DOC has the resources to increase the numbers.

REPRESENTATIVE STORY asked whether DOC considers caseloads and whether there are recommendations for the number of inmates a coordinator should serve.

MS. BROOKS answered that her understanding is that there are no waitlists for people wanting to take the GED test; therefore, that function is appropriately resourced. She offered that in contrast, vocational programs vary dramatically across the DOC system; they depend on inmate interest and the availability of specialized instructors.

REPRESENTATIVE STORY referred to the other services on slide 10 - "English as a second language (ESL)" and "job readiness skills."

MS. BROOKS mentioned that in the area of job readiness skills, DOC works with DOLWD; DOLWD provides DOC with job readiness specialists; DOLWD job centers provide "in reach" to many of the facilities around the state; every community with a correctional facility also has an [Alaska job center]. The education coordinators coordinate with community agencies, contractors, and volunteer organizations for many of the education services listed on slide 10.

[4:15:04 PM](#)

REPRESENTATIVE HOPKINS mentioned that Ms. Brooks has not referred to the Fairbanks Correctional Center (FCC). He asked whether that was because many of the services are missing at FCC or whether inmates move through the facility quickly.

MS. BROOKS answered that many services are available at AMCC, FCC, Ketchikan Correctional Center (KCC), LCCC, WCC, SCCC, HMCC, and Anchorage Correctional Complex (ACC), but services vary - particularly in facilities that are pre-trial facilities, like FCC and LCCC. It is more difficult to install more sustainable programs like a mental health unit, but that doesn't mean the facilities don't offer mental health services. A program that requires a unit - such as RSAT - will generally be in the sentenced facilities.

CO-CHAIR FIELDS mentioned businesses that employ returning offenders; many of them offer high skilled jobs that don't require a college degree. He asked whether DOC could ask those employers what kind of training programs the state could support. He maintained that there are significant state and federal resources that could support those programs and suggested the department be proactive in reaching out to those employers to ensure they have the resources they need. He added that when a returning citizen completes an apprenticeship with an employer, he/she ends up with a credential. He maintained that there are so few jobs that are living wage jobs that offer a pathway for returning citizens; the state should maximize those opportunities.

REPRESENTATIVE STORY offered that the fields of health care and computer programming are both growing and suggested training in those areas.

MS. BROOKS, in response to Representative Fields, stated that DOC does collaborate with DOLWD to connect individuals to employers in the community. Employment specialists coming into the facilities have been incredibly successful; one at HMCC connected 130-plus inmates to jobs in the community. She said that often DOC's apprenticeships and training programs are connected to community employers who are willing to accept an inmate returning to the community. She said that the effort could be expanded; it is on DOC's "radar."

CO-CHAIR FIELDS reiterated that since DOC and the reentry coalitions most likely are aware of the employers who hire returning inmates, they could ask the employers how the state could support the training programs. He suggested that DOLWD may not be maximizing investment in those training programs and the state should support those employers.

MS. BROOKS, in response to Representative Story, agreed that there are many health care shortages. She offered that DOC has

explored several programs. She acknowledged that there are barrier crimes that prevent many of the offenders from working in the health care field. She said that DOC has identified a couple of areas for a pilot project. She offered that there are several computer training programs available to inmates, and such training could be expanded.

CO-CHAIR FIELDS stated that the presentation by Ms. Brooks would be continued during a later hearing and at this time the committee would hear other testifiers.

[4:21:26 PM](#)

TERI TIBBETT, Co-Chair, Juneau Reentry Coalition, relayed that she is also the Chair of the Community Education and Outreach Workgroup. She stated that Juneau has a very active reentry coalition; it includes partners from nonprofit agencies and state agencies; it was involved with conducting the recent reentry simulation offered to legislators [1/30/20]. She said that JAMHI Health & Wellness, Inc. (JAMHI) serves as the fiscal agent for the coalition to receive funding from AMHTA for a community coordinator to serve as administrator. Funding also comes from DHSS for a case manager, who works with institutional POs to identify inmates who are interested and want to volunteer for case management. The reentry case manager helps inmates to find housing, get access to services in the community, sign up for health care, and engage in all the other activities needed for reentering society. She maintained that the effort represents a collaboration between DOC, AMHTA, DHSS, and the coalition.

MS. TIBBETT explained that there are two co-chairs: one is a community member, which is the seat she holds, and the other is a representative from LCCC. Reentry coalitions operate under the guidelines of the Alaska Community Reentry Plan; there are coalitions throughout Alaska.

MS. TIBBETT continued by mentioning other partners of the coalition: Gastineau Human Services (GHS), a halfway house in Juneau; National Alliance on Mental Illness (NAMI) Juneau, a nonprofit mental health agency working with families with mental illness; Central Council Tlingit and Haida Indian Tribes of Alaska; Southeast Regional Resource Center (SERRC); Juneau Opioid Work Group; Juneau Job Center; City and Borough of Juneau; Rotary Club of Juneau; Juneau Chamber of Commerce; and the Juneau Community Foundation. She maintained that the coalition invites the community to its community meetings every

other month to provide education on various topics and discuss the efforts of the coalition. She mentioned a statewide reentry and justice workgroup - a partnership of reentry coalitions - that meets monthly to share activities and goals and listen to testimony from reentrants.

[4:26:28 PM](#)

MS. TIBBETT stated that the coalition recently supported the therapeutic courts' request for positions that would make wrap-around support available to its clients; it supported the reentry unit proposal in the DOC budget, which would expand reentry efforts within DOC; and it supported safe and sober housing, which is the number one barrier for reentrants.

CO-CHAIR KREISS-TOMKINS asked about the expression, "safe and sober housing."

MS. TIBBETT explained that it refers to a safe place to live with an emphasis on being sober.

CO-CHAIR KREISS-TOMKINS asked what safe and sober housing means programmatically or from a policy standpoint.

MS. TIBBETT explained that GHS has a treatment wing that represents a safe and sober housing program; it is a place for the reentrants to live while they work and go about their lives but still get treatment in the form of programs or groups. It is a safe place to live where the residents don't need to worry about people using substances, which might present a temptation.

REPRESENTATIVE HOPKINS referred to the reentry simulation and asked what bureaucratic hurdles reentrants found most challenging. He specifically mentioned obtaining IDs.

MS. TIBBETT expressed that she is not qualified to answer that question. She offered that finding housing, getting access to treatment, and qualifying for Medicaid are the challenges of which she is aware.

MS. TIBBETT concluded by saying that the coalition supports better access to substance abuse and mental health treatment. She maintained that they are constant issues because the demand is greater than the supply. She offered that the primary reason for the lack of substance use and mental health treatment is the workforce issue. Alaska needs more trained individuals; there are multiple efforts around the state by different agencies and

by the University of Alaska; it is a difficult profession with burnout and often inadequate pay. She said that it is not always the fault of the agencies when they are unable to provide services but the difficulty with finding qualified people to take the jobs.

[4:32:09 PM](#)

JANET MCCABE, Chair, Board of Directors, Partners for Progress, relayed that the data demonstrates the significant role that the Partners Reentry Center has played in reducing recidivism. She said that it serves 60 people per day and has served almost 10,000 people since inception. She offered that 45 percent of the state's prisoners reenter in Anchorage, and the center sees most of the difficult-to-serve people. She stated that this week her agency has been working with DOC on a small supplemental federal grant - the Second Chance grant - in which the emphasis is on combining behind-the-walls services with case management and treatment upon release, with the goal being a smooth transition. She maintained that people who are released from prison need a "complex and humanly balanced" range of services.

[4:34:56 PM](#)

JOSHUA SOPKO, Director, Partners Reentry Center, relayed that he has been working for Partners for Progress since 2014; he was a case manager and then the deputy director; he has been the director since July 2019. He reiterated that Partners Reentry Center is a high-volume reentry center in Anchorage located a few blocks from the Anchorage jail. He said that the center is located near the Anchorage Probation Field Office and the agencies offering many of the critical services that reentrants use, including the Public Assistance Office [Division of Public Assistance, DHSS] and the Social Security Administration office.

MR. SOPKO continued by saying reentry center staff see about 60 people per day, house 120-130 people per month, and work with 300 people per month in job searches, case management, and other services. He stated that the center serves walk-ins the same day and can house them the same day. Center staff work with DOC institutional POs to get referrals of those being released. The center offers per-arranged housing for those wishing to participate - who enter into an agreement to not recidivate and to address the underlying causes resulting in incarceration. In this way offenders have an expectation of what is required of them in exchange for the assistance provided by the center. In

the first two weeks the center assists the reentrant with establishing a schedule, building a resume, engaging in job readiness activities, obtaining an ID, checking in with the PO, and following up on referrals for substance abuse assessment for treatment or sober support groups. He mentioned that the center offers Moral Reconciliation Therapy (MRT) which is a cognitive behavioral approach to group therapy that helps offenders break down criminal thinking errors and develop pro-social thinking. He related that the center also assists with transportation, clothes, and hygiene. He maintained that by handling the small barriers, the center frees the individual up to focus on addressing criminogenic needs and the challenges of becoming a stable, better person who desists from further criminal behavior. He added that the center stresses finding mentorship and finding comradery and fellowship in groups outside of the person's established social circles; peer associations are very important. One way that the center encourages this is by offering food with group meetings. He relayed that offering a chicken dinner for those completing the GED test proved to be a very successful incentive in getting people to take the test. He expressed the value of small incentives, motivational interviewing, working with the offender as a team offering support and motivation.

MR. SOPKO continued by saying that in the five years he has worked in the reentry field, he has seen a [positive] change in DOC; among the field POs, the thinking has evolved to greater focus on rehabilitation, addressing needs, giving support, and pointing the people on probation and supervision toward better directions.

[4:42:11 PM](#)

BARBARA MONGAR, Coordinator, MatSu Reentry Coalition, paraphrased from her written testimony [original punctuation provided], which read:

The Mat-Su Reentry Coalition consists of a collaboration of individuals, community stakeholders, public and none-profit [sic] agencies, faith based and business partners who are united and committed to reducing recidivism among returning citizens to the Mat-Su community.

Our Reentry Coalition is led by a Steering Team that currently consists of 10 members and includes substance abuse treatment providers, behavioral health

providers, the Mat-Su job center manager, the Mat-Su Housing & Homelessness Coordinator, an Institutional Probation Officer, a Field Probation Office, a Veteran Administration representative, a Reentrant, who is also working as a Peer mentor, and a community member. The Steering Team meets monthly to go over strategies and progress towards the Coalitions Goals to help increase reentrants well-being within the community. The Reentry Coalition also holds Quarterly Community Reentry Meetings to help educate community members on the barriers and difficulties reentrance [sic] face and how reentry services help to promote public safety and reduce recidivism.

Some of the Reentry Activities we have been doing in the Mat-Su include a Reentry Simulation, which is an activity that simulates some of the challenges that Reentrants go through once they are released from prison. After attending several Reentry Simulations in Anchorage, I was able to gather the material and tweak it to fit our community. I want to thank Senator Showers for participating the Reentry Simulation we held in the Mat-Su last November, all of the people that participated in the simulation had positive comments to say about reentry simulation and how they didn't realize some of the difficulties reentrants faced when they were released from prison.

Our Reentry Coalition also just held a Reentry Summit in January, we brought in Dr. Latessa, who is the Director and Professor of the School of Criminal Justice at the University of Cincinnati and a nationally sought-after expert in the criminal Justice Field to do the community training. The Reentry Summit was a training that was centered on improving and supporting skills shown to be effective at changing criminal behavior, developing program action planning, and reducing recidivism. The attendees of the Reentry Summit were a mixture of DOC personnel, including Education Coordinators and both Institutional and Field Probation Officers, and community service providers.

We also have a Reentry Case Manager that conducts in-reaches into the different Correctional Institutions to work with the reentrants before they are released. The Reentry Case Manager offers intensive Case

Management Services that include parole and probation supports, housing assistance, employment assistance, resource navigation and comprehensive goal and transition planning.

One of the success stories I wanted to share is about a reentrant our reentry case manager assisted who was a senior citizen that was being released after a long-term incarceration. This individual had a substance abuse issues and severe mental health problems. He was going to be releasing without any services set-up. Before his release our case manager helped him identify services and supports so he wouldn't release and have to go to a shelter in Anchorage away from his community. The Case manager helped him get his Social Security Disability Benefits going and get into supportive housing and long-term mental health care. After the reentrant was stable he was able to reconnect with his family out-of-state and we are now 12 months out from when he graduated the Mat-Su Reentry Management Program and he has not recidivated and is doing well. That is my testimony, thank you.

[4:46:30 PM](#)

BOBBY DORTON, Fairbanks Native Association, testified that he is from Northway and grew up in the Alaska Native traditions and culture. He related his experience using and selling drugs. He relayed that he went to prison in 2013, and in prison he realized he did not want to be there or continue in the criminal life. He said that at FCC and PCC he participated in prison programs including RSAT; he was able to work through issues that he had even before using drugs; he became an RSAT mentor and was in the program almost two years. He said that he was released from prison in July 2018 and placed on electronic monitoring (EM); however, he suffered panic attacks. He described a moment of decision for him when he was frustrated with finding help. Marsha Oss from the Fairbanks Reentry Center had visited the prison many times while he was there and had urged him to see her when he was released. He made the decision to see her. He said, "That was probably the best move I made."

[4:50:29 PM](#)

MR. DORTON relayed that Ms. Oss talked him through his anxieties and enrolled him in several reentry programs; she respected his desire to be a substance abuse counselor and helped him achieve

that goal. He cited the many programs and people who assisted him along the way. Today he teaches groups, volunteers at nonprofit organizations, and mentors recovering addicts. He makes good money. He has replaced bad habits with healthy habits. He has a very good relationship with his family now. He concluded, "This is what recovery has brought me; this is what reentry has brought me."

[4:56:15 PM](#)

CO-CHAIR FIELDS noted the questions that arose during the presentation:

Who are you missing now in terms of folks reentering the community who don't come through the reentry centers and why? How can we reach people who aren't being reached now?

Do you see gaps or breaks in Medicaid assisted treatment as people leave incarceration?

Has DHSS looked at the [Section] 1115 [Medicaid demonstration] waiver and/or state plan amendments from the perspective of "How can the state best support reentry and leverage Medicaid to the full extent possible to support reentry?"

Partners [Reentry Center] can find housing [for reentrants] on the same day. How do they do that? Is that something other reentry coalitions can do?

[4:57:27 PM](#)

ADJOURNMENT

There being no further business before the committee, the House State Affairs Standing Committee meeting was adjourned at 4:57 p.m.