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ALASKA STATE LEGISLATURE

LEGISLATIVE BUDGET AND AUDIT COMMITTEE

Division of Legislative Audit



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SUMMARY OF: A Special Report on the Department of Corrections, Internal Controls Related to Cash and Negotiable Instruments for the Offender Financial Accounting System, May 18, 1999.

PURPOSE OF THE REPORT

In accordance with Title 24 of the Alaska Statutes and a special request by the Legislative Budget and Audit Committee, this report summarizes a review of internal controls over cash and negotiable instruments such as checks and money orders, involving funds belonging to individuals incarcerated in the State's correctional facilities. Additionally, the procedures followed by the Department of Corrections' Division of Administrative Services (DAS) in accounting for these funds held in trust for incarcerated individuals, were reviewed and evaluated.

REPORT CONCLUSIONS

The facilities' internal control procedures over cash and negotiable instruments are weak

Most of the discussion in the Findings and Recommendations section of this report reflects the central objective of our review. The internal controls over cash and negotiable instruments at the various correctional facilities administered by the Department of Corrections (DOC) are weak. The discussion reflects our conclusion that DOC facilities do not follow some of the basic tenets of internal controls. After making a general recommendation that DOC take measures to improve controls on an overall basis in Recommendation No. 2, specific internal controls, as follow, are discussed further in other recommendations:

1. Ensure record keeping data entry is accurate.
2. Develop and consistently follow good cash handling procedures.
3. Critical controls such as segregation of duties, limited access, and regular reconciliations are also important in situations involving cash.
4. Improve physical controls over assets.

DOC's central accounting for inmate funds must be improved

In addition to the variety of internal control weaknesses at the various facilities, we also determined DAS should improve its accounting for inmate funds maintained in the department's Offender Financial Accounting (HOFA) system. As set out in the Objectives,

Scope, Methodology section, the second set of objectives dealt with problems DAS was having in reconciling the subsidiary HOFA system to the State's overall accounting records.

As noted in the Background Information section, DOC currently cannot account for approximately \$200,000 of HOFA funds held in trust by the State. Periodic reconciliation and follow-up is an important internal control procedure. This procedure has not always been done by DAS in past years. In Recommendation No. 1 we discuss various aspects of the current HOFA balance, and offer our suggestions about what DAS should consider as it goes about bringing its reconciliation process current.

Structure of DOC contributes to lack of recognized and consistently followed procedures

Prison facilities, located around the State, are under the direction of the Division of Institutions within DOC. A superintendent at each facility acts as chief administrator. The offender trust accounting system is maintained and supervised by DOC's DAS, which is primarily located in Juneau. Given this dispersed organizational structure, it is difficult, although important, to implement a system that effectively secures and accounts for funds held in trust by the State on behalf of incarcerated individuals.

The nature and structure of DOC has made it difficult to put in place and effectively monitor a set of appropriate internal control practices that are consistently followed at each facility. The impact of poor controls is most apparent when viewed on a statewide basis. Accordingly, it is difficult to gain an appreciation for developing and enforcing effective controls at the correctional facility level. Despite difficulties that DOC's organizational structure presents, appropriate oversight of inmate funds is a responsibility of departmental management.

The problems set out in the Findings and Recommendations section of this report reflect this dichotomous situation. Superintendents are primarily interested in maintaining security of their facility, with the requirements of record keeping presenting a secondary concern. However, the day-to-day record keeping is critical for DAS to be able to reconcile and control the many accounts that make up the HOFA system.

Establishing and following procedures is central to DOC meeting its trust responsibilities

FINDINGS AND RECOMMENDATIONS

The shortcomings set out in the Findings and Recommendations section are numerous. By design we enumerated virtually all of the internal control deficiencies noted in the course of the review. Our eight recommendations are set out with a great deal of specificity. This was done in order to give DOC specific direction regarding the deficiencies identified. Many of the deficiencies, when viewed separately, seem inconsequential. However, collectively these deficiencies create a situation where DOC is not adequately and consistently accounting for, nor safeguarding the assets it holds in trust for incarcerated individuals.

To: Annette

From: Debbie

Date: 9/29/99

Re: Corrections Subcommittee Meeting of 9/28/99 @ 12:00 noon in room 670

1. Materials: 9/21 Minutes, materials requested from DOC – 7pgs + Chase Riveland Study, DOC Audit #20-4597-99
2. Faxed: Audit to Juneau & Mat Su
3. Mailed: Greg Pease/Juneau and Barbara Miller/Mat Su

DEPARTMENT OF CORRECTIONS PRIVATIZATION

SUBCOMMITTEE MEETING

SEPTEMBER 21, 1999

1. **Members Present:** Sharon Anderson, Garland Warren, Russell Lewis, Mary Pate, Gail Schubert. Subcommittee member Barbara Miller was present via phone from the Mat-Su LIO. Greg Pease Also present were Senator Ward and Representative Dyson.

- DOC personnel present via phone from Juneau: Dr. Mel Henry, Bruce Richards, Bill Parker, and Betsy Robson.

2. **Substance Abuse Presentation by Sarah Williams (DOC)**

3. **General Points**

- 85% of inmates have a problem with substance abuse: i.e. either alcohol, drugs, or both.
- 13 institutions within the system as well as the Point Mackenzie Work Farm. All of these have some sort of substance abuse program.
- The programs are focused on two areas: an education program and an outpatient program.
- Goal is to a) reduce threat to public safety; b) help the inmates make the transition from drug-free structured environment back to society; and c) to provide a springboard for further treatment once the inmate is released.
- All of the DOC treatment services are contracted out.
- The length of any given inmate's stay will affect the amount and success of the treatment that inmate receives.

4. **Program Highlights**

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Minutes prepared by C. Russell Lewis

(907) 258-0106

- The programs (education and outpatient) are designed to be culturally relevant, although significant work is still needed.
- Because of the diverse mission and location of the DOC institutions in Alaska, a major challenge is trying to create standardized programs.
- Programs consist of several topics.
- There are 9 topics covered in the Education Program
- There are 23 substance abuse counselors around the state, but more are needed to fill specific needs.
- Whenever an inmate enters a substance abuse program, the records of participation in that program stay with that inmate the rest of the time he or she is in DOC custody.
- Time spent in a program is totaled and provided on the inmates discharge summary.
- It is important to note that the programs are not designed (or capable) of being a complete treatment in and of themselves. The programs are designed to be a starting point. Inmates will need to continue treatment upon release because of the extra stressors placed upon them once they have ready access to drugs again.

5. Focus on Female Program at Hiland Mountain:

- 78% of female offenders are mothers, 73 % of those have children under the age of 19.
- The best treatment program is one that stops offenders at a young age.
- This particular program encourages participants by teaching them how to "be a mom" again. The promise of "being a mom" again is not enough, the female offender must be taught to be a mother again.
- 1/3 of the female offender population has mental health problems.

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- Native inmates may retreat if the proper communication style is not used.
- The female offender program at Hiland Mountain provides a "culture day" for Native female offenders.

6. Senator Ward Seeks Cost/Benefit Information: How much do these programs cost and how is success measured?

- \$863,000
- The Women's Treatment Program at Hiland Mountain appears to be the only program with any cost measurement. That program used \$236,000 in federal dollars and \$82,000 in Alaska matching funds.
- Of the \$863,000 budget, 82% of that is contracted out. There is only 1 state employee full-time in the substance abuse program.
- Results are measured by a pre- and post- participation-testing scheme.
- Marker tests are used: one at 6-months after release and one at 2-years after release. The 2-year test has not happened yet.
- <Senator Ward reiterates the question: "Has the money that has been spent kept anyone out of jail?">
- Sarah Williams responds that there are difficulties in measuring this kind of question.
- Sarah Williams points out that the Women's Program at Hiland Mountain cost the state only \$86,000 where it takes approximately \$37,000 just to house one inmate for a year.
- Sarah Williams discusses follow-up: NO follow-up in outpatient programs. DOC needs new MIS to perform follow-up tasks. Forms don't work. Each program keeps records, but there is no record of follow-up work or what the inmates do after the programs.

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- Senator Ward asks if the contractors could track inmates and their treatment.
- Sarah Williams responds that it is very cumbersome to track inmates.
- Senator Ward voices his concern over the \$150,000,000 being spent on DOC without measurable results.
- Sarah Williams notes that the improvement of DOC is fraught with challenge.

7. Discussion Regarding Bidding: Representative Dyson asks if "for-profit" concerns are prohibited from bidding on any services or group of services offered by DOC

- Sarah Williams and Betty Robson state that bidding on all services is open and based on competitive bids and the Alaska procurement code.
- Representative Dyson states that Health and Human Services does not allow bids by for-profit organizations: what about DOC?
- Sarah Williams indicates that the only criteria is that CARF or JCOAH (spelling???) approval is needed as a prequalification to bid on some items.
- Representative Dyson wants to know if the accrediting organizations prohibit for-profit organizations from bidding on services? Sharon Anderson indicates that the organizations do not prohibit bids by for-profit concerns.

8. Discussion Regarding Program Participation Tracking:

- Gail Schubert comments that contractors and service providers should be tasked with tracking participation in the various programs and not DOC.
- Representative Dyson notes that DOC needs a system to track participation in a program.

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- Sarah Williams notes that OBSIS can provide limited tracking information on inmates. Ms. Williams also notes that DOC provides services to "very needy" individuals and the treatment does not fulfill all of those needs.
- Recidivism cannot be tied to any particular treatment program.
- Garland Warren asks if the substance abuse budget has been reduced. Senator Ward and Sarah Williams reply that it has not been reduced.
- Sarah Williams notes that the substance abuse counselors are stressed because of the workload they are under.

9. Questions Regarding the Effectiveness of the Substance Abuse Program:

- Russell Lewis asks if there are any measures of success available for the substance abuse program.
- Sarah Williams replies that UA testing shows a decline on an institution-by-institution basis. Some programs show a 100% decline in dirty UA tests.
- Garland Warren points out that this could be a problem of poor contract drafting and privatization in general.
- Sarah Williams notes that the contract is good, but that it doesn't really address tracking participation or recidivism.
- Representative Dyson expresses concern regarding whether the sub-committee will finish its mission.

10. Discussion Regarding Drug Use in Prison:

- Senator Ward expresses his concern over drug use in prison.
- Sarah Williams notes that drugs are a big problem and that inmates will find a way to get contraband.

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- Sharon Anderson notes that the halfway houses have drug treatment programs. Sarah Williams mentions the Cordova Center, which has an eight-bed furlough drug treatment program.
- Sharon Anderson notes that a halfway house is not really a stable institution.
- Betty Robson notes that inmates at a halfway house are encouraged to prepare for re-entry into the community and to participate in community activities.

11. Discussion Regarding Audit and Review of DOC:

- Barbara Miller asks if there has ever been a management review of DOT
- Bill Parker responds that he is not sure what a management audit is, but that he doesn't recall one being conducted.
- Bill Parker notes that DOC is reviewed by legislative finance committee(s) every year.
- Senator Ward repeats that DOC and its institutions are scrutinized every year by the legislature.
- It is an open question whether there is an evaluation of DOC management.
- Representative Dyson asks for copies of the legislative audits of DOC for the past 10 years.

12. Discussion Regarding Focus of the Sub-Committee

- Representative Dyson concerned about losing focus on the major issues.
- Gail Schubert (referring to the substance abuse program) comments that one person managing a program sounds like success.

- Garland Warren notes his concern about the contracts issued by the DOC, including acceleration clauses, duration of contracts and the drafting of these contracts.

13. Culturally Relevant Programs:

- Senator Ward asks if there are culturally relevant elements in place for the substance abuse programs
- Sarah Williams replies that all of the institutions try to implement culturally relevant programs, but are limited by lack of resources.

14. Discussion Regarding DOC Budget:

- Barbara Miller asks what portion of the DOC budget goes into management.
- Bill Parker asks for a definition of management

15. General Discussion:

- Greg Pease interjects a question of whether the report is done yet. (Report by former Washington state DOC commissioner on AK. DOC efficiency)
- Bill Parker will look into the report. The contract was over by its terms one year ago.
- Greg Pease states that privatization is equivalent to a partnership and that some states are significantly ahead of Alaska.
- Representative Dyson notes that DOC should invite the private sector in to identify programs that could be done by the private sector.
- Garland Warren notes his concern that DOC should not rush into privatization and notes that Fort Richardson does a two-year study before privatizing any services. Mr.

Warren reiterates his concern with escalation clauses in any contracts issued by DOC.

- Greg Pease state that there are no escalation clauses in the contracts. Mr. Pease also notes that there are sizable providers of prison services in other states and that the sub-committee should focus on streamlining the State's business.
- Garland Warren notes his concern about profits going to private citizens.
- Senator Ward comments that a survey might be necessary wherein each DOC employee provides a statement of what they do. Senator Ward notes that this strategy is used by the military.
- Senator Ward also notes that Canada has turned its entire correction system over to private industry.
- Gail Schubert asks if DOC has put together a list of areas that can be privatized.
- Bill Parker notes that there is no list but that the medical area is an example of partnering.
- Senator Ward wants to see hard dollar figures as to why DOC cannot privatize.
- Mary Pate expresses concern about identifying areas for privatization since there is currently no measuring stick to assess the current performance.
- Senator Ward notes that he does not want to use a "meat ax" approach, but would rather selectively privatize.
- Sharon Anderson thanks the DOC personnel for helping.
- Barbara Miller asks if the _____ report will be made available. Sharon Anderson notes that copies will be provided.

16. Discussion Regarding Funding Sources:

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- Gail Schubert asks if third-party contractors might have access to funding sources that the state cannot reach.
- Sarah Williams notes that inmates don't qualify for certain types of coverage.
- Senator Ward asks about the availability of coverage through Alaska Native Service or related agencies.
- Betty Robson says that there is no funding or coverage available through ANS or Alaska Native Health Service.
- Senator Ward asks for an explanation and exploration of this issue. Senator Ward states that there should be a letter opinion explaining that ANHS benefits are not available to inmates if that is indeed the case.
- Gail Schubert notes that there is law that allows DOC to seek reimbursement for care given to indigent persons.
- (Dr.??) Mel Henry notes that most 3d party programs will not pay for inmates in the care of the DOC.
- Senator Ward notes that the federal government has the first responsibility to care for Alaska Natives.

17. Closing: Senator Ward asks and Sharon Anderson concurs that everyone provide suggestions as to how to proceed from this point.

Meeting adjourned at 1:42 p.m.



DEPARTMENT OF HEALTH & HUMAN SERVICES
PUBLIC HEALTH SERVICE

May 17, 1991

Sarah Mathews
Dept. of Corrections
Major Medical
2200 E. 42nd Ave.
Anchorage, Alaska 99508

Dear Ms. Mathews:

The Alaska Native Medical Center wishes to inform all local correctional facilities that its policy is not to accept prisoners for medical or dental treatment. This is based on national Indian Health Service and Alaska Area Native Health Service policy. Only in cases of emergency or other exceptional circumstances will treatment be provided. In these cases prior approval is required from the ANMC Medical Director.

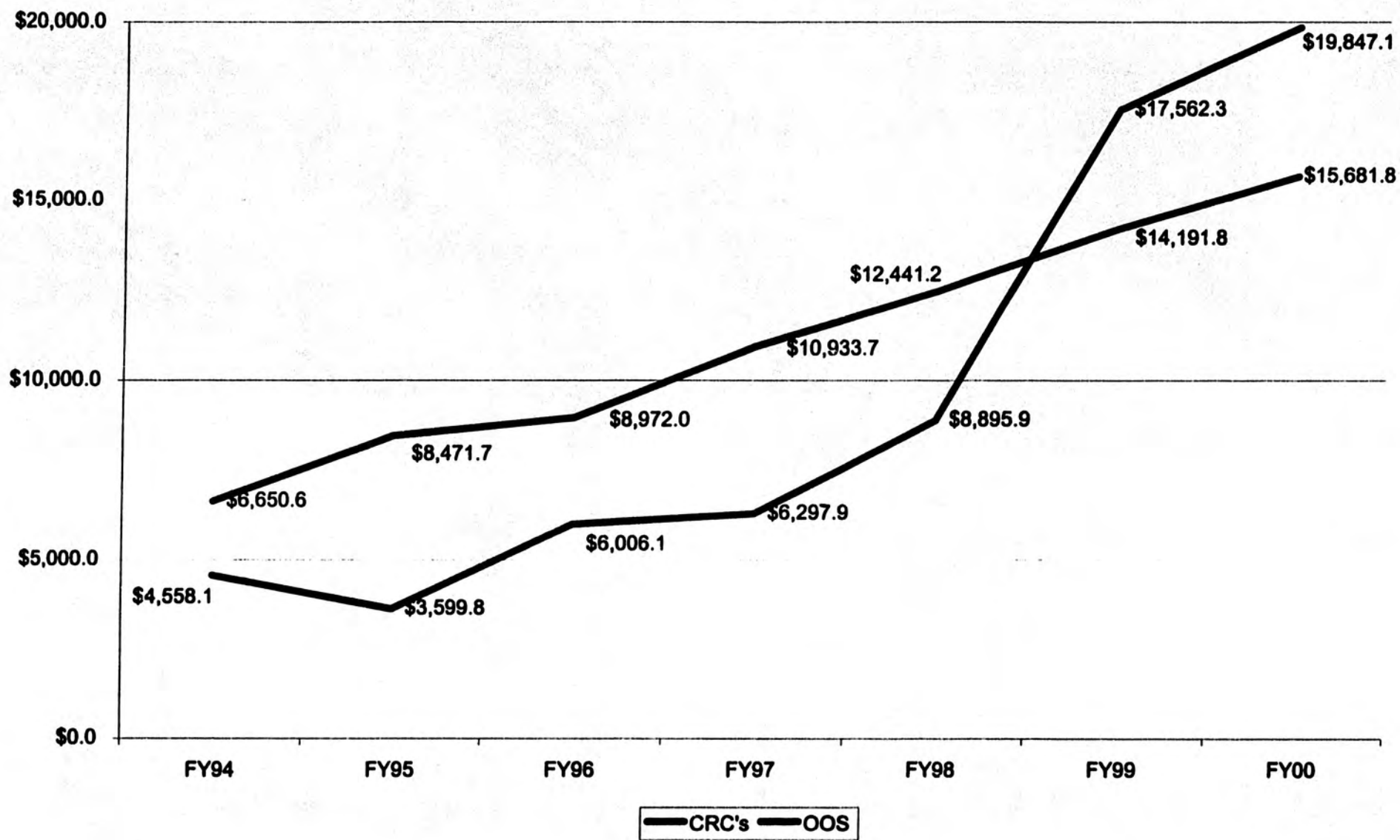
Thank you for your cooperation.

Sincerely,

Steven Breithaupt

Steven Breithaupt
Hospital Environmental Control Officer

Total CRC and Out of State



DOC Annual Budgets FY 94 - 00

	FY94	FY95	FY96	FY97	FY98	FY99	FY00
Admin. & Ops	\$108,278.9	\$114,330.1	\$116,715.1	\$116,311.8	\$118,264.7	\$118,159.3	\$116,604.5
Alternative Housing	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$300.0	\$200.0
CRC's	\$6,650.6	\$8,471.7	\$8,972.0	\$10,933.7	\$12,441.2	\$14,191.8	\$15,681.8
OOS	\$4,558.1	\$3,599.8	\$6,006.1	\$6,297.9	\$8,895.9	\$17,562.3	\$19,847.1
Community Jails	\$0.0	\$0.0	\$4,811.7	\$4,812.1	\$4,801.4	\$4,800.3	\$4,766.6
Pt. MacKenzie	\$1,512.0	\$1,571.3	\$1,916.2	\$1,981.7	\$1,909.7	\$1,992.1	\$2,122.9
VPSO	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$115.0	\$0.0
Facility Maintenance (I/A non-	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$7,780.5
Food Service Apprenticeship	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$96.1
Y2K	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$1,090.0	\$0.0
Cultural Relevance Study	\$0.0	\$0.0	\$0.0	\$0.0	\$50.0	\$0.0	\$0.0
Totals	\$120,999.6	\$127,972.9	\$138,421.1	\$140,337.2	\$146,362.9	\$158,210.8	\$167,099.5
		\$6,973.3	\$10,448.2	\$1,916.1	\$6,025.7	\$11,847.9	\$8,888.7

	FY94	FY95	FY96	FY97	FY98	FY99	FY00	Total Increase
Admin & Ops		\$6,051.2	\$2,385.0	(\$403.3)	\$1,952.9	(\$105.4)	(\$1,554.8)	\$8,325.6
Alternative Housing		\$0.0	\$0.0	\$0.0	\$0.0	\$300.0	(\$100.0)	\$200.0
CRC		\$1,821.1	\$500.3	\$1,961.7	\$1,507.5	\$1,750.6	\$1,490.0	\$9,031.2
Out of State		(\$958.3)	\$2,406.3	\$291.8	\$2,598.0	\$8,666.4	\$2,284.8	\$15,289.0
Community Jails		\$0.0	\$4,811.7	\$0.4	(\$10.7)	(\$1.1)	(\$33.7)	\$4,766.6
Pt. MacKenzie		\$59.3	\$344.9	\$65.5	(\$72.0)	\$82.4	\$130.8	\$610.9
VPSO		\$0.0	\$0.0	\$0.0	\$0.0	\$115.0	(\$115.0)	\$0.0
Facility Maintenance (I/A non-add)		\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$7,780.5	\$7,780.5
Food Service Apprenticeship		\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$96.1	\$96.1
Y2K		\$0.0	\$0.0	\$0.0	\$0.0	\$1,090.0	(\$1,090.0)	\$0.0
Cultural Relevance Study		\$0.0	\$0.0	\$0.0	\$50.0	(\$50.0)	\$0.0	\$0.0
TOTALS		\$6,973.3	\$10,448.2	\$1,916.1	\$6,025.7	\$11,847.9	\$8,888.7	\$46,099.9

**Professional and Non-Professional Services Contracts FY 99
(Excluding Out of State and CRC contracts)**

Following numbers are from prior year actual expenditures:

Inmate Health Care - contractual (& contract) expenditures for Medical/Dental Hospital and treatment services = 6,806.1

Inmate Programs - expenditures for Education, Substance Abuse, Sex Offender Treatment and Batterers Treatment = 2,154.4

Institution Director's Office - Contract training and E.M. = 5.7

12 Institutions - Small contract services and Food = 4,144.2

Community Jail Contracts = 4,717.1

Probation/Parole contract services for UA testing, monitoring, education, and substance abuse contracts = 237.9

Point MacKenzie - small contract services, food and education/substance abuse contracts = 246.6

Psychological Testing contract for CO and PO applicants = 54.9

Rise Alaska contract (Management/Consultation Svcs.) = 154.6

TOTAL = 18,521.5

CONTRACT AWARDS BY NUMBER

AS OF: 09/24/99

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#

CA #	VENDOR	DESCRIPTION	FROM	TO	FACILITY	OPTIONS	CURRENT	NOTES
20001A	COMTEC BUSINESS SYSTEMS	TELE. UPGRADE/MAINT	01/16/99	01/31/01	PALMER CC	NONE	2004099	UPGRADE, & 24 MTH MAINT
2018306	COMTEC BUSINESS SYSTEMS	TELEPHONE SYSTEM/MNT	06/28/98	06/28/01	WWCC	1 YR MAINT	20-183-98	EXERCISE MAINT OPT. 6/00
24382	ANCHORAGE COLD STORAGE	SODA DISPENSING	09/16/99	09/15/00	PALMER CC	5 OF 5	20-023-00	
24383	ANCHORAGE COLD STORAGE	SODA DISPENSING	09/16/99	09/15/00	HMCC	3 OF 3	20-024-00	
24306	FOOD SERVICES OF AMER.	SE GROCERIES	02/01/99	01/31/00	SE REGION	4 OF 4	20-060-98	KCC, LCCC, ADD 34 4/12/99
24441	INTERSTATE BRANDS CORP	MISC BAKERY GOODS	02/01/99	01/31/00	DEPARTMENT	3 OF 3	20-046-98	ANCH, PALM., EAG. RIV, BETHEL
24440	PEPSI-COLA	SODA DISPENSING	07/01/99	06/30/00	WWCC	3 OF 3	20-007-00	
24467	WINTER TELECOMM	NEW TEL. SYSTEM	09/05/97	09/04/99	SCCC	NONE	20-116-97	INSTALL SYSTEM
24476	SECURITY TELECOMM CORP	INMATE TELEPHONE SYS	05/29/97	06/28/04	DEPARTMENT	NONE	20-	INSTALL & REVENUE
24483	FOOD SERVICES OF AMERICA	CENTRAL PRODUCE	09/11/99	09/10/00	FBKS CC	2 OF 4	20-025-00	FCC PRODUCE ITEMS
24484	FOOD SERVICES OF AMERICA	S.C. REGION PRODUCE	09/11/99	09/10/00	SC REGION	2 OF 4	20-008-98	ALL SC REGION PRODUCE
24485	FOOD SERVICES OF AMERICA	S.E. REGION PRODUCE	09/11/99	09/10/00	LCCC, KCC	2 OF 4	20-026-00	LCCC, KCC PRODUCE ITEMS
24488	PETERKIN DISTRIBUTORS	DAIRY PRODUCTS	08/17/98	09/16/00	VARIOUS	1 OF 3	20-014-00	SIXTH, HMCC, CIPT
24602	PETERKIN DISTRIBUTORS	MISC. DAIRY PRODUCTS	09/01/99	07/31/00	WWCC	3 OF 3	20-006-99	
27542	BEHRING DIAGNOSTICS	DRUG TESTING SUPPLY	12/01/97	11/30/98	DEPARTMENT	3 OF 3	20-039-98	EXPIRED
27629	KNIGHTWATCH SECURITY	UNARMED GUARD SERVICE	month	month	COMM OFF	M TO M	20-	SPAM CAN GUARD \$19.07/MTH
27831	AMERIGAS PROPANE	PROPANE KEEP FULL	01/01/99	12/31/99	PT MAC/PCC	4 OF 4	20-032-98	PT MAC & PCC
27861	ANACOMP	MICROFILM SERVICES	01/01/99	12/31/99	SERO	3 OF 4	20-036-98	
27892	ECOLAB INC	MISC CHEMICALS	06/01/99	05/31/00	DEPARTMENT	3 OF 3	20-052-99	LNDRY, WAREWASH, MISC CLEAN
27732	AURORA GAS INC	NATURAL GAS	01/01/99	12/31/99	VARIOUS	2-1 YR	20-082-97	CIPT, PTMAC, HMCC, MSPT, WWCC
DOC002	WAVE WHOLESALE CO	MISC. DAIRY PRODUCTS	09/14/99	09/13/00	VARIOUS	2 OF 3	20-060-97	PCC, MSPT, PT MAC.
DOC003	PEPSI-COLA BOTTLING	SODA DISPENSING	09/01/98	08/31/99	FCC	1 OF 4	20-002-98	CANCEL EFF. 8/31/99
DOC004	REGAL FOODS LLC	MISC BAKERY PRODUCTS	08/16/99	08/14/00	WWCC	2 OF 4	20-114-97	
DOC005	ODOM CO. (COCA-COLA)	SODA DISPENSING	04/01/99	03/31/00	LCCC	1 OF 4	20-013-98	LCCC
DOC006	ANCHORAGE COLD STORAGE	SODA DISPENSING	04/01/99	03/31/00	SCCC	1 OF 4	20-027-98	SCCC
DOC007	VALLEY WHOLESALE	MISC DAIRY PRODUCTS	04/16/99	04/15/00	LCCC	1 OF 3	20-082-98	
DOC008	WAVE WHOLESALE COMPANY	SC GROCERY	07/28/00	07/27/00	SC REGION	1 OF 4	20-062-98	
DOC009	WAVE, DBA HUB FOODS	C GROCERY	07/28/99	07/27/00	FCC	1 OF 4	20-083-98	
DOC010	FOOD SERVICES OF AMERICA	MISC MEAT ITEMS	09/01/99	08/31/00	C REGION	1 FO 4	20-030-00	FCC ONLY
DOC011	FOOD SERVICES OF AMERICA	MISC MEAT ITEMS	09/01/99	08/31/00	SC REGION	1 OF 4	20-028-00	NINE INST & PT MAC
DOC012	FOOD SERVICES OF AMERICA	MISC MEAT ITEMS	09/01/99	08/31/00	SE REGION	1 OF 4	20-028-00	LCCC & KCC
DOC013	FOOD SERVICES OF AMERICA	MISC DAIRY PRODUCTS	09/01/99	08/31/00	FCC	1 OF 3	20-027-00	
DOC014	PEPSI COLA	SODA DISPENSING	10/15/98	10/14/99	PT MAC	4-1 YR	20-022-98	
DOC015	PENAIR	AIRCRAFT CHARTERS	11/12/98	10/29/99	SCRO	3-1 YR	20-020-99	PRISONER TRANSPORT
DOC016	TEAMWORKS INC	SECURITY GUARDS	02/19/99	12/31/99	DEPARTMENT	3-1 YR	20-036-99	UNARMED
DOC017	DETECNATIONAL SECURITY	SECURITY GUARDS	02/19/99	12/31/99	DEPARTMENT	3-1 YR	20-036-99	UNARMED
DOC018	KNIGHTWATCH SECURITY	SECURITY GUARDS	02/19/99	12/31/99	DEPARTMENT	3-1 YR	20-036-99	UNARMED
DOC019	PETERKIN DISTRIBUTORS	MISC DAIRY PRODUCTS	03/22/99	03/21/00	SCCC	3-1 YR	20-041-99	
DOC020	WORLD WIDE MOVERS	FREIGHT & MISC SVCS	05/19/99	05/15/00	ACI	4-1 YR	20-034-99	

Professional Services Contracts:

The department's professional service contracts for the most part do not contain language that would allow cost escalators for inflation. The department manages approximately 200 contracts per year. The majority of these contracts have either a firm annual dollar amount, or they provide for an hourly rate for services to be provided by the contractor, and establish a do not exceed amount during the term.

There are currently three contracts that the department maintains that contain price adjustment language. One of these three contracts is for out of state prisoner care (Arizona), and allows for the bed prices to be adjusted up or down, not to exceed 2% per year, and is to be based on changes in the nationwide CPI.

The other two contracts are for the purchase of furniture components and related services for the Alaska Correctional Industries program. The two vendors provide chair and systems furniture components to ACI. The contract's pricing structure establishes the amount of discount from the manufacturer's list price. While the discounted amount cannot change during the life of the contract, the manufacturer's list price can be adjusted at the time of renewal. Contractor must request the increase in writing, and must also provide sufficient justification for the increase.

Non-professional Services Contracts:

The department maintains approximately 45 contract awards per year. All of these contracts are established using formal bidding procedures. Most of these contracts are for food items and do contain language that allows annual price adjustments based on CPI or PPI fluctuations.

Thirty days before annual renewals each contractor must request any increases to their prices in writing. They must also provide justification why the increase is necessary. The department will determine if the request is justified and whether or not to accept the request. If the department determines that the increase is not justified we may cancel and re-bid the contract. A few of the contracts may be adjusted upon written request any time during the contract period, and are to be based on justifiable CPI fluctuations.

Nine of the contracts are for produce, meat, and groceries. These contracts are the larger volume food contracts and provide the department with the majority of our food items. Pricing is at the vendor's cost for the item, in addition to a pre-set management fee. The vendor's costs of the items may change (either weekly or monthly) but the management fee cannot change during the current term. Although these nine contracts allow for inflation increases, they only provide for increases to the freight portion of the management fee. Increases are based on fluctuations to Sealand or Tote tariffs and may be considered periodically, and no more than monthly. The freight rates may be adjusted if the department determines the increase is justified.

FY99 - Anticipatory Revocation Hearings**Alaska Board of Parole**

<u># Hearings</u>		<u>Decision</u>
1	-	Violation Withdrawn
2	-	Not Guilty
1	-	Reprimand and Warn
2	-	Revoke & Reparole
12	-	Continue
<u>14</u>	-	Revoke & Deny
32	-	TOTAL HEARINGS

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~~CORRECTIONS~~ Subcommittee Meeting

Commission on Privatization

Meeting Date: 9/28

Meeting Time: 12:00 noon

Number of Pages: 36

Final Report and Recommendations

submitted to the

Alaska Department of Corrections

by

**Chase Riveland
Riveland Associates**

June 21, 1997

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General Overview

An initial sense of urgency driven by a possible several million dollar budget cut dissipated somewhat at the conclusion of the 1997 Legislative session as the final cutback was considerably less onerous. However, the Department of Corrections faces critical times yet as the expectations of it and its projected population growth in both its jail, prison, probation and parole populations are continuing to rise. There appears to be no relief in sight for the Department either in the form of policy modifications to mitigate the growth, nor the resources to properly manage the growth.

Alaska's "natural challenges" of: expansive geography; a diverse population; fluctuating economy; distinct population centers--but also remote and isolated communities provide unique challenges to the Alaska Department of Corrections also. The Department's thirty-two institutions and field offices are spread out over distances that exceed those of any correctional jurisdiction in the country. The special needs of the Native Alaskan citizens, transient populations, large numbers of tourists and the military each add to the Department's challenges. The fluctuating economy, particularly when lagging, create resource problems for the states fastest growing state agency. And, although the bulk of the population to be

served resides in five boroughs (Anchorage, Fairbanks, Juneau, Kenai Peninsula, and Matanuska-Susitna boroughs), correctional supervision and services must be provided in reasonable form to the remainder of the population.

The political climate the Department of Corrections is operating in is not wholly unlike that being experienced by correctional agencies across the country. Several years of enhanced sentencing changes have driven correctional populations--and costs--markedly upward. This also is true of Alaska. The Department of Corrections is consuming an increasingly higher percentage of the state general fund. This of course, not being an attractive investment for elected officials, creates a situation in which they look for any alternative that is "cheaper". Certainly options such as expanded use of community residential centers, privatization, alternatives to incarceration should be addressed, but should be done in a rational and thoughtful manner. Contrastingly, it appears that the agenda in Alaska has been to cut the administrative portions of the Department of Corrections budget or to withhold funds that are critically needed to responsibly manage the agency. Ironically, some of the gaps in the Department's resources hinder the ability of the state to make the rational decisions that would result in an efficient, yet effective and responsive correctional agency. Investments in a reliable management information system, adequate staffing

for planning and evaluation, and additional resources in facility management are but a few examples of investments that would pay off for the state of Alaska in the future.

Over the last several years the Alaska Department of Corrections has been remarkably free of serious incidents (disturbances and assaults) in it's correctional facilities, but many of the conditions that have contributed to such difficulties in other jurisdictions are beginning to be present in the Alaska Department of Corrections: overcrowding accompanied by a reduction in programming and activity levels. To date, the "Cleary Final Order" and it's continual monitoring have resulted in relatively manageable population levels. A continued reduction in resources could put the system at some risk.

As mentioned in the May 29, 1997 "Observations" report (see Appendix C), the Alaska Department of Corrections has been the subject of many formal studies, master plans, business plans, and audits over the last several years. Those efforts have regularly described shortfalls in staffing, particularly in the areas of internal audit, research, planning and evaluation, management information, data processing, and several agency functional management areas. Seldom have the resources been made available to remedy the identified organizational weaknesses nor to carry out master

or business plan recommendations. Indeed, the recent budget reductions, although not nearly severe as originally feared, continue to erode the management base necessary to properly administer this fast growing agency.

Much has been studied and written about the absence of a reliable information system in the Department of Corrections. The Department accomplished an extraordinary feat last year in installing a system-wide LAN/WAN to at least provide the capability to bring much of the staff on line with E-Mail. Particularly in a jurisdiction with such unique geographic challenges, this is a significant enhancement. Of critical importance, however, is the need to significantly improve or replace the OBSCIS, HOFA, and general management information capability. Other problems in the Department continue to compound the longer these enhancements are delayed. Planning, evaluation, and simple provision of information to policymakers and the public cannot be data or fact driven until these improvements are made. Efficiency and effectiveness would be byproducts of these technological advancements.

Federal dollars available to the states, including Alaska, are decreasing in an amount and available only with more strings attached, and generally are limited to capital construction or other specified limited uses. Alaska's

potential acceptance as a site for the National Institute of Corrections "Criminal Justice System Project" could allow the state of Alaska to develop a thoughtful plan for the future with the assistance of Federal resources.

Overall, the Department of Corrections faces a very challenging future. It's diverse geography and population, political climate, and resource limitations magnify that challenge.

The remainder of this report will include discussions of and recommendations for the following topics, while keeping in mind the issues of task assignments, reporting and coordinating relationships, geographic locations of positions, and centralization vs. decentralization:

- ◊Organizational design

- ◊

- ◊Division of Human Resources

- ◊

- ◊Division of Community Corrections

- ◊

- ◊Division of Institutions

- ◊

- ◊Division of Administration

- ◊

- ◊Commissioner's Office

- ◊

- ◊Other issues identified during the review

Organizational Design

The Alaska Department of Corrections has undergone several changes in organizational design since its inception. The most radical was the creation of "mixed regions" and the subsequent return to a more traditional arrangement. Under the best of circumstances, a correctional Department providing the full range of correctional services that the Alaska Department of Corrections does, to include: probation and parole services; pre-sentence investigation services; pretrial detention; jail and prison services; correctional industries; community jail coordination; and all of the incumbent peripheral services that accompany these, would align with at least five operating divisions. They would normally be a Division of Institutions; a Division of Community Corrections; a Division of Administration; a Division of Human Resources; and a Division of Program Coordination. The Alaska Department of Corrections eliminated its program coordination division just a short time ago.

The reason many correctional agencies operate with a program coordination division is to assure that those programs that cross the operating division's (Divisions of Institutions and Community Corrections) boundaries, are coordinated department-wide, and not subject to organizational territoriality,

competing priorities, and lack of emphasis. Historically, operating divisions have been so consumed with fulfilling their basic obligations of supervision and security that program development, provision, and evaluation are largely relegated to a secondary status.

Many corrections departments create separate Human Resources Divisions in recognition of the complexities organizations face in dealing with their workforce issues. Recruitment, retention, training, safety, affirmative action, labor relations, promotions, grievances, disciplinary actions, etc., all are complex issues requiring enormous amounts of managerial and organizational time and resources. When aligned as a separate Division it simply highlights the importance of these activities in today's correctional organizations. The typical correctional manager spends as much of his or her time dealing with workforce issues as with operational issues relating to inmates, probationers, or parolees. Organizing with a Division of Human resources not only gives visibility to one of the most critical functions of today's organization, but also puts the reporting relationship directly to the director of the agency.

However, the Alaska Department of Corrections is restricted in its ability to organize itself by the limitations of the number of positions available to fulfill its obligations. In my opinion, the central management group of the Department is not sufficiently staffed to allow for an organizational

design that would allow it to fully manage all of its statutory, judicially driven, or "best practices" responsibilities. Therefore, the recommendations being made reflect the necessity to organize in a manner that may be more efficient, but not necessarily the most effective.

In addressing organizational design, reporting relationships, and job functions it is imperative to address the major activities attributed to and expected of the managers and management of an organization. Traditionally those activities are: leading, controlling, planning and forecasting, organizing, and coordinating. Obviously the management of an organization cannot, nor should not, provide equal amounts of these activities at any point in time. The environment the organization is operating in, its priorities, and its challenges may determine the mix of these activities. An organization should make some conscious attempt to determine which of these activities is most critical at a given point in time, and around which issues. Too frequently in correctional agencies the organizing and coordination is replaced, often by necessity, by control. This typically happens when human and technological resources are insufficient to allow for logical decentralization with central coordination and monitoring. This is true of the Alaska Department of Corrections in several areas, to include: time accounting, classification, compliance monitoring, health and mental health services, policy and procedure development, etc.

Several assumptions are being made in looking at organizational design:

- It is critical to organize in a manner that not only does not require new positions but that overall can free up positions, that may be deployed to higher priority needs, or to go unfilled to assist in budget cutbacks.
- Major geographic changes of personnel between Juneau and Anchorage are not being recommended. The costs of transfer and moving of people would not be commensurate with any gain in ability to manage or supervise due to physical proximity. On the other hand, whenever a vacancy occurs at either of the locations the intended function should be evaluated to determine which location it may be most useful. The Department of Corrections has serious communications problems it must address throughout the state-- the communication issues between Juneau and Anchorage being some of the easiest to resolve.
- Many of the major challenges, problems, and activities of the Department at present, and in the future, will be in the area of Human resources.
- Like functions should be consolidated into workgroups or into the Divisions that they dominantly relate to so that backup and crosstraining can be enhanced and efficiencies gained through focus of activity.
- Reporting relationships should be clear. Although matrix management is appropriate for some organizations, the Alaska Department of Corrections faces too many challenges, with too few resources, to have less than clear reporting relationships.
- Training will be of paramount importance to the Department in the future. Not only will basic and skill enhancement training be important, but a great deal of training is needed in the use of the present information and E-mail system, and much more will be required when the Department upgrades its management information capacity.
- Although traditional management theory would suggest that span of control for any single supervisor or manager should be no more than eight, more contemporary theory would suggest that if the functions of the subordinates is basically the same, that span of control--in numbers can be extended considerably.
- Some attention should be given in any organizational arrangement to the way the Department of Corrections may wish to--or have to--do business in the future.

For purposes of organizational design I am also making the assumption that the position of Deputy Commissioner is congruent with and carries the authority of that of the Commissioner in her absence. The location of the Deputy Commissioner in Anchorage, assures a presence of the Commissioner's office in each location. It typically is the domain of the commissioner in such situations to determine how their total workload and responsibilities will be divided. For the purpose of this discussion I will assume that Division Directors formally report to the Commissioner with day-to-day working relationships evolving from their determination of priorities, influence of location, and personal strengths and skills.

Although it is frequently true in organizations that everyone feels they should report to the top boss, I would recommend that as few non-Division Directors as possible report to the Commissioner, other than her immediate support staff. Too many daily operational issues can detract from other critical responsibilities. The gauge should be the question: Does the position clearly directly support the Commissioner's specific responsibilities?

I am recommending that the Divisions of Community Corrections, Institutions, and Administrative Services be retained, with some modifications that will be enumerated later. I am also recommending the creation of a fourth division, the Division of Human Resources. The recommended

changes will follow with a discussion of each of the Divisions.

Division of Human Resources

I am recommending the creation of a separate Division of Human Resources that would also incorporate the responsibility for Department-wide training, along with all present human resources functions and activities. This would require moving the Training Officer III position; the Training Officer II positions; a Correctional Officer III position; and a Administrative Clerk II position (all located in Anchorage) in a reporting relationship to the Director, Division of Human Resources. I am making the recommendation for creation of this Division for the following reasons:

- ♦ The present functions performed by personnel officers and personnel assistants for the Department are terribly critical. Their ability to provide "one-stop-shopping" by handling a wide variety of personnel functions is to be commended. The personnel function is so critical to agency operations that the emphasis gained by having the Human Resources Director reporting directly to the Commissioner makes a clear statement, internally and externally.
- ♦ A human resources director with Division Director status should have enhanced status in working with external agencies such as the state personnel department and others.
- ♦ Recent delegation of authority of several personnel decisions from the state authority to the departments creates the need for greater prominence in the organization and access to the Commissioner for the human resources function.
- ♦ Issues such as affirmative action, promotion policy, etc. require direct attention from the Commissioner's office.

- ♦ This reorganization can occur without new positions.
- ♦ Training is an integral part of a human resources function. Although each of the other Divisions do some internal training and position-specific training, training such as basic training for correctional officers and generic training that applies across the Department is better managed as a part of an entire human services program.
- ♦ The probability that the Department of Corrections will have a much larger role in collective bargaining makes a case for greater prominence of the human resources/personnel function.
- ♦ A subsidiary benefit of this move would be to give some workload relief to the Director of Administrative Services, who probably can well use that capacity and time to deal with the upcoming major projects in the information services area.

Overall I was most impressed with the amount of service the personnel officers, personnel assistants, and training officers are able to provide the Department, with the small amount of staff available. I did not observe any positions that could be eliminated easily in the personnel nor training sections. Contrastingly, they may need bolstering as the workforce grows, more authority is delegated to the Department, and the collective bargaining responsibilities expand.

Division of Community Corrections

It is my opinion that a much greater role for the Community Corrections Division should be a part of the Department's vision for the future. I will, however relate to that in the section of this report entitled "Other Issues Identified During the Review".

Although not desirable, there are two positions that could be cut or reassigned in the Division of Community Corrections. Based on present day "enhanced span of control", the position of Deputy Director could be eliminated, leaving the Director with the supervision of the Probation Officer V's; the Criminal Justice Planners; the Administrative Manager II; and a Secretary I. The second position would be to free up a position by reorganizing to two regions from three. This would free up one Probation Officer V position and a corresponding clerical position. Obviously this position would have to be either the Juneau Probation Officer V position or the Fairbanks Probation Officer V position. This would retain acceptable span of control numbers, and equalize workloads between the Anchorage Probation Officer V and the remaining region. A case can be made for either Juneau or Fairbanks.

I would also recommend moving two positions to the Division of Community Corrections. First, I would recommend transferring the Community Jails Program Coordinator position to the Division, reporting to the Director or if retained, to the Deputy Director. The objectives for this program are much more consistent with those of the Community Corrections Division than those of the Administrative Services Division. Probation and parole staff around the state, particularly in the fifteen communities where the community jails are located could be of assistance in building relationships between the local officials and the Department.

Secondly, I would recommend moving the Rural Affairs Coordinator position to the Division of Community Corrections, reporting to the Director (or the Deputy Director). Again, the responsibilities of this position complement and are consistent with the mission of the Division. Many gains can be made by enhancing the working relationship between this position and the field staff of the Division of Community Corrections.

THE DIVISION OF INSTITUTIONS

The Institutions Division is presently operating with a lot of dotted line relationships, particularly with sections that are integral to its day-to-day operations. Although there are strong arguments to be made in correctional agencies for keeping such functions as classification centralized and out of the institutions divisions, a dearth of resources and a present need for more control would suggest the need to strengthen several reporting relationships in the Division of Institutions. I would recommend that there be two Deputy Director positions in the Division. The present Deputy for Operations should continue to have the twelve institution superintendents report to him as well as retaining responsibility for the recently transferred Community Residential Centers. The second deputy, a retitling of the present Assistant Director, should have reporting to her, in addition to her present

Duties, the Adult Classification Officer position, along with the two Adult Probation Officer IV positions, the Statistical Clerk position, and the Administrative Clerk II position. The Transportation Section should also report to this position, with the Correctional Officer III and four Correctional Officer II's being clearly in the Department of Institutions. I would also recommend that the Correctional Industries Manager II position report to this Deputy. Although many correctional agencies --for good reason-- prefer to keep Industries separate from their Institutions Division, it seems to me that at this time the Alaska Department of Corrections needs clear chain of command and control in it's organization. The functions mentioned above deal almost exclusively with the Division of Institutions and by organizing clearly, may enhance the ability of the Division to meet it's day-to-day operational responsibilities.

Division of Administrative Services

On the most recent organization chart for the Division of Administrative Services fourteen positions show as reporting to the Director. In a Division with such diverse responsibilities and activities this is arguably too expansive a span of control. Earlier recommendations, if followed, would

remove the human resources and community jails responsibility from this position, along with the existing staff and positions. It also appears that the former Grants Administrator position may have been lost in the legislative budget process. Consideration should be given to two possible consolidations or mergers. First, merging the Contracts Section (located in Anchorage) with the Procurement Section (located in Juneau) under one Contracts and Procurement Manager (created from either the Procurement Specialist III position or the Procurement Specialist IV position) would not save on overall positions initially, but would enhance the coordination of the procurement/contracting process, as well as lowering the number of direct-reports to the Director. It also could strengthen the cross-training of the staff involved in these activities.

The second possible consolidation would be to return to a structure that existed once previously in the Division--that is to merge the Budget/Revenue section with the Accounting Section. Although there are arguments against such a design, communication between the sections can be enhanced and one of the manager positions could be saved or diverted to alternate use.

If all of the changes were to occur it would reduce the Director's direct-reports to seven and at least one position could be saved or redirected.

addressed is the glaring shortfall in the Department for planning and evaluation. I would recommend adding two positions, either two of the existing Criminal Justice Planner positions located throughout the Department, or two vacancies created by earlier recommendations or other means and place them along with the Research Analyst IV position in a new section located in the Data Processing Unit with the lead position of the three reporting to the Data Processing. With evaluation, planning, and research relying so heavily these days on information systems, more agencies are linking these functions organizationally. The Alaska Department of Corrections has a glaring need for a planning and evaluation capacity, this being but a small step in meeting that need--the greatest boost potentially coming from the planned improvement in their management information system.

Commissioner's Office

If all earlier recommendations were followed the Commissioner's office organization chart dated 12-16-96 would be changed by the removal of the Training Section, the Classification Section, the Transportation Section, Correctional Industries, and the Rural Affairs Coordinator position. I would recommend the retention of the Compliance, Investigation, and Audit Unit in the Commissioners Office reporting directly to the Deputy Commissioner. It, for purposes of efficiency and focus should be staffed

by whatever number of auditors are available as well as the compliance officer for the Cleary monitoring. Remaining in the Commissioner's Office would be the Deputy Commissioner (in Anchorage), an Executive Secretary II (in Juneau), a Special Assistant (in Juneau), and a Secretary II (in Anchorage). With the Commissioner and Deputy Commissioner relieved of many day-to-day issues, it would allow them more time to address the policy and external issues.

Other Issues Identified During The Review

The following are issues I would like to offer some comments on as a result of observations made during my onsite visit and review of a large amount of materials:

- The future of community corrections.
- Communications.
- Institution classification.
- Time accounting.
- Contracting with other agencies.

The Future of Community Corrections: The Alaska probation, parole, and community corrections system has progressed much as the other probation and parole systems around the country. In an attempt to standardize services throughout a state, manage workload, and assure at least minimal levels of supervision, standards of supervision were developed. These standards normally consist of minimal reporting or contacts for probationers or parolees based on risk or need, or both. They are generally expected on a statewide basis. Likewise, other community corrections programs are frequently cloned statewide. This approach has served many jurisdictions well for many years. Some jurisdictions are now rethinking that approach. Some have found that with resources not meeting need, they have difficulty in meeting their own standards. Others found that they were being held liable civilly for not meeting their own standards. But more significantly, some jurisdictions are recognizing that the communities in their state have vastly different needs, problems, and fears--and need, and desire different solutions. The jurisdictions moving in this direction are involving local officials and citizens in determining the priority for investment of correctional resources in their community--within available resources. This means new roles for probation and parole officers, but new roles that many find attractive because they intuitively have felt this all along, and find greater reliability on their professional judgment to be refreshing and rewarding. With the great diversity of people, communities,

Communications: The singular issue I heard about from nearly every person I interviewed or talked to at the Alaska Department of Corrections, was their desire for better communication from their chain-of-command, from other work units, and particularly from the top administrators. Admittedly the interviews took place during an anxiety-filled time where major budget cuts were being threatened toward the end of the legislative session. But the expressed concerns seemed to be more endemic than as a result of those anxieties. I would recommend a concerted effort on the part of the Department's management to address those concerns. Newsletters, regular system-wide E-Mail, personal site visits, internal "town meetings", and more frequent staff meetings are but a few options that could go a long way.

Institution Classification: The present institution classification system may be working adequately on a day-to-day basis but is not serving the Department of Corrections well in the long run. Little information is available that can assist in planning or forecasting by custody level. Other types of classification issues that could help the Department operate and plan more effectively and efficiently, simply are not achieved through the present classification system. I would recommend that the Department seriously consider implementing an objective, behaviorally driven system. The merit in doing so may be even more timely with the effort to enhance the management information system capability.

Time Accounting: Time accounting of offender sentences in Alaska is a very confusing and rigorous process due to the wide variety of sentencing schemes over the years and the amount of discretion judges have in the types of sentence "mixes" they can mete out. Only a few Department staff are highly skilled in the technicalities of figuring out the more complex cases accurately. The short term solution is probably to assure that those are skilled train additional staff, but the long term solution appears to include automating all portions that are possible. The sooner this investment in automation is made the better.

Contracting with other agencies: Aside from pure privatization issues, the Department of Corrections may wish to explore the possibility of contracting with other governmental agencies to provide or supplement some of its generic "support needs". Such activities as planning, auditing, personnel services, etc. are frequently purchased from other state or local agencies in other jurisdictions. The advantages can be in purchasing only during peak times of need or during times that positions are not available, but some cash can be found.

Appendix A

Appendix A: Materials Reviewed by Consultant

Cleary "Final Order" and supporting documents

6 year Capital Plan (FY 98 Budget Submittal)

Affidavit of Commissioner Pugh: Cleary Case

Facilities Management Allocation Report

Responsibilities and Functions Manual: Facilities Management Unit

Facilities Projects Requirements List

Legislative Audit Report: Division of Community Corrections

FY 98 Budget Recommendations: Governor; House; and Senate

DOC Policies and Procedures re: Furloughs

FY Action Plan for Population Management

Sample Compliance Reports re: Cleary

Legislative Audit Report re: Medical Services

FY 98 DOC Operating Budget Request to Governor

KPMG Peat Marwick "Organizational Review of DOC"--1991

Murray & Associates Master Plan: 1992--Volume 1

Murray & Associates Master Plan: 1992--Volume 2

DOC--Division of Community Corrections BRU

DOC--Division of Institutions BRU

DOC--Community Jails BRU

DOC--Inmate Programs BRU

DOC--Correctional Industries BRU

DOC--Administration and Support BRU

DOC--Inmate Health Care BRU

State of Alaska: Annual Financial Report

DOC Business Strategy and Implementation Plan

Appendix A: Continued

Classification Policies and Procedures

Time Accounting Manual

**Legislative Audit: Division of Community Corrections
Recommendations**

**Legislative Audit: Correctional Officer Work Schedule Issues and
Costs**

**Legislative Audit: Spring Creek Corrections Center Safety and Staffing
Issues**

Bargaining Agreement: Labor and Trades Unit

Legislative Audit: Board of Parole

Legislative Audit: Highland Mountain and Meadow Creek

Legislative Audit: DCC--Anchorage, Probation and Parole ISP

Multiple Position Description Questionnaires (over 50)

Bargaining Agreement: Supervisory Unit

Bargaining Agreement: General Government Unit

OMB Report of Internal Audit Function

OMB Audit of DOC Procurement Function

Summary of TQM Training

DOC Response to Peat Marwick Study

OMB Review of DOC Personnel Functions

Documents and Statutes: Retirement Incentive Program

Multiple Status Reports re: Cleary Case

DOC Internal Audit Plan

Various Daily and Monthly Population Reports

DOC and Divisional Organizational Charts

Appendix B

Appendix B: DOC Staff Personally Interviewed

Margaret Pugh.....Commissioner
Joe Reeves.....Administrative Services Manager
Jeanette Osborn.....Finance Officer
Al Szpanski.....Procurement Specialist
Annette Smith.....Data Processing Manager
Robert Cole.....Director, Administrative Services
Gary Wilson.....Micro/Network Technician
Sharleen Halstad.....Budget/Revenue Manager
Dianne Corso.....Human Resource Manager
Wally Roman.....Correctional Industries Manager
Barbara Murray.....Community Jails Coordinator
Ted Kinney.....Facilities Manager
M.A. Higgins.....Facilities Manager
Frank Sauser.....Director, Division of Institutions
Allen Cooper.....Deputy Director Institutions
Lynda Zaugg.....Director, Division of Community Corrections
Sam Trivette.....Chief Probation Officer, Southeast Region
Vikki Deakin.....Deputy Director, Community Corrections
Ted Stanfield.....Prisoner Transportation
Jim LaBelle.....Rural Affairs Coordinator
Linda Hoff.....Contracts Administrator
Barbara Miklos.....Health Care Administrator
Steve Schwartz.....Research Analyst
Robert Spinde.....Classification Officer

Appendix B: Continued

Jim Hancock.....Internal Auditor

Doug Lloyd.....Training Officer

Chris Lyou.....Compliance Officer

Bert Matsumoto.....Adult Probation Officer

Betsy Robson.....Deputy Director, Institutions

Tom Martin.....Adult Probation Officer

Pete Spivey.....Special Assistant

Appendix C

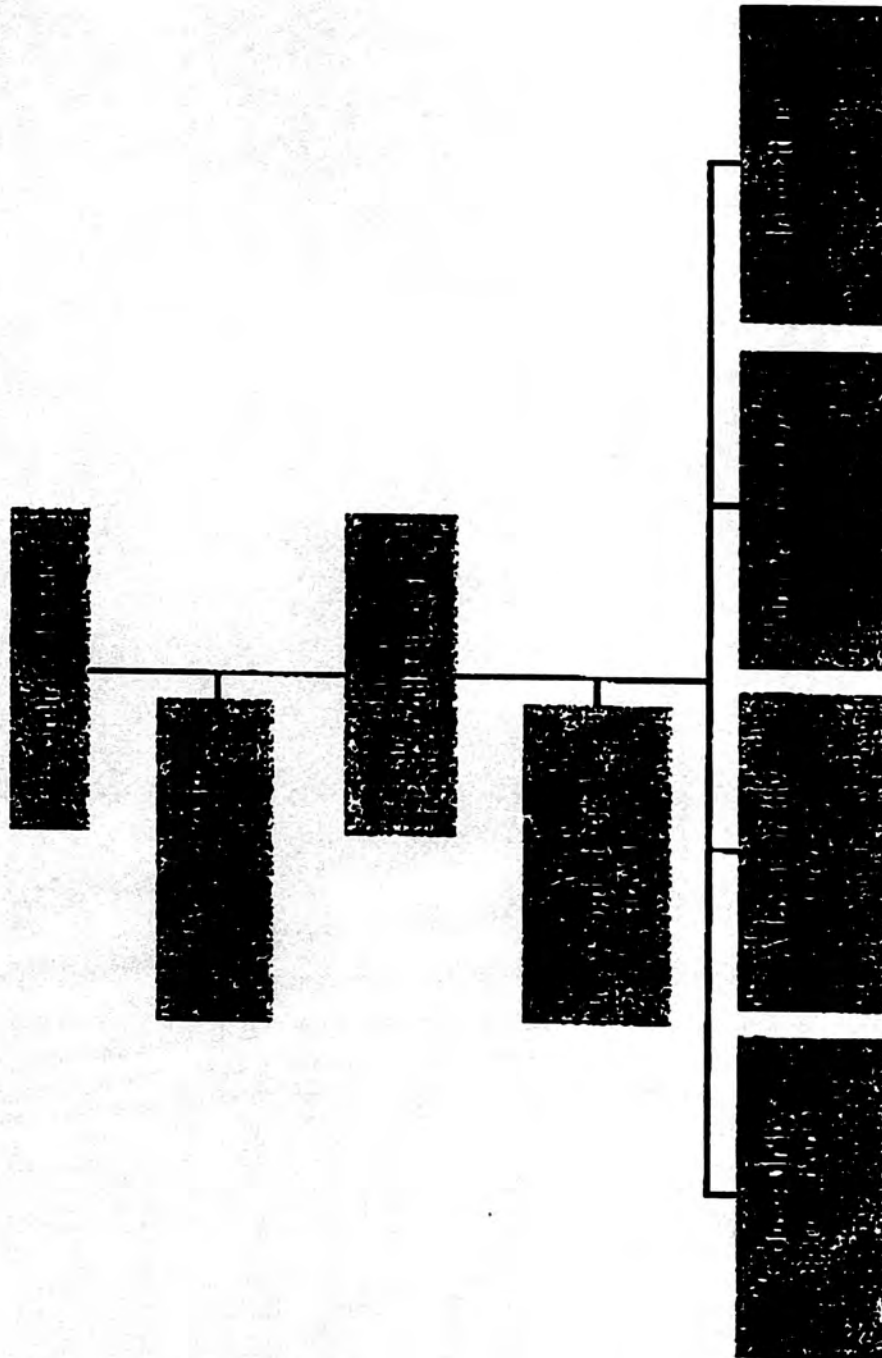
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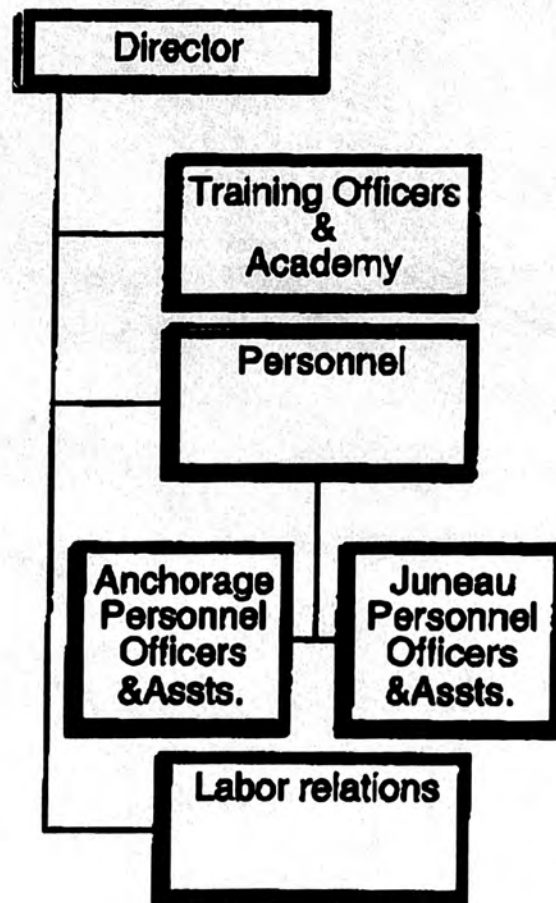
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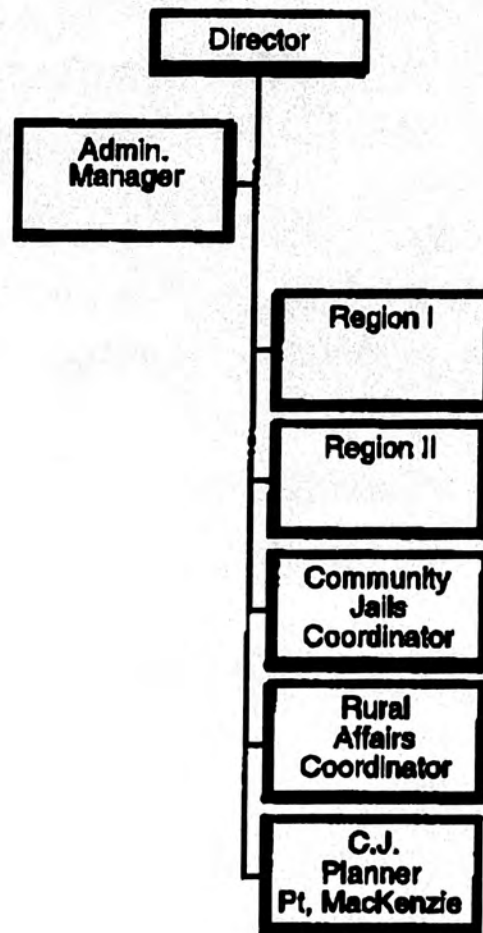
Proposed Organization



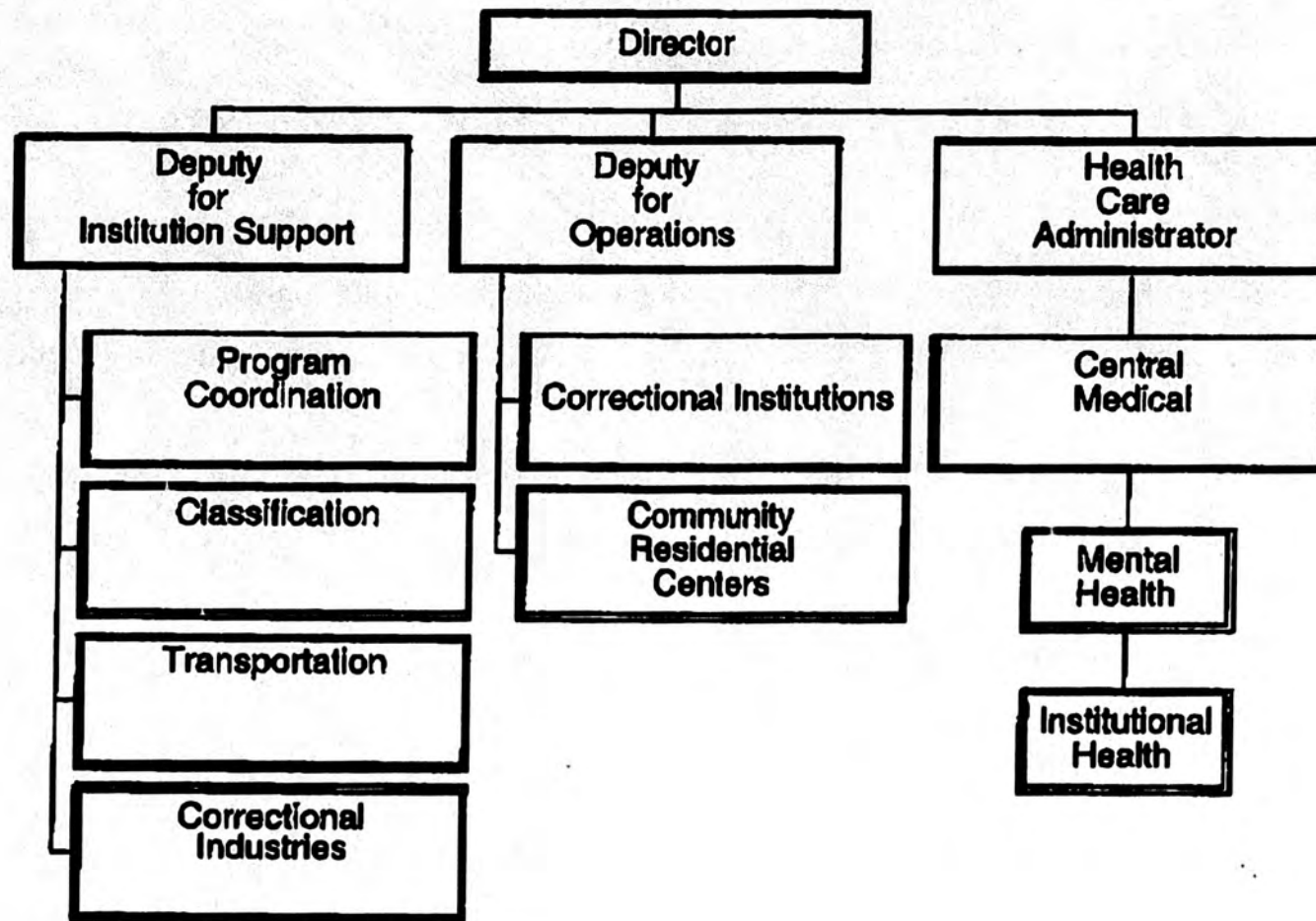
Proposed Division of Human Resources



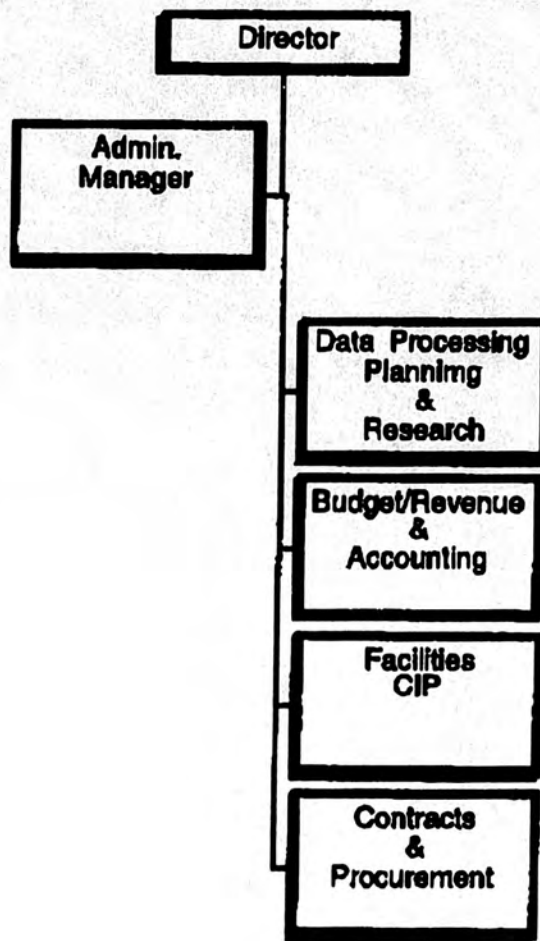
Proposed Division of Community Corrections



Proposed Division of Institutions



Proposed Division of Administrative Services



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CORRECTIONS Subcommittee Meeting
Commission on Privatization
Meeting Date: 9/28
Meeting Time: 12:00 noon
Number of Pages: 29

May 18, 1999

Members of the Legislative Budget
and Audit Committee:

In accordance with the provisions of Title 24 of the Alaska Statutes, the attached report is submitted for your review.

DEPARTMENT OF CORRECTIONS
INTERNAL CONTROLS RELATED TO CASH
AND NEGOTIABLE INSTRUMENTS FOR
THE OFFENDER FINANCIAL ACCOUNTING SYSTEM

May 18, 1999

Audit Control Number

20-4597-99

In this audit report we assess the status of internal controls in place at various correctional facilities in the State that safeguard the cash and other negotiable instruments belonging to incarcerated individuals. These funds are tracked through the Offender Financial Accounting System (HOFA) which maintains account balances for each individual housed in a state correctional facility. HOFA funds represent assets held by the State in trust for incarcerated individuals. Accordingly, the nature and extent of controls over these funds is an important aspect of the State's fiduciary responsibility in its trust capacity. The report sets out several ways and areas where we suggest controls can be improved.

The audit was conducted in accordance with generally accepted government auditing standards. Fieldwork procedures utilized in the course of developing the findings and discussion presented in this report are discussed in the Objectives, Scope, and Methodology section.

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Legislative Auditor

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OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Title 24 of the Alaska Statutes and a special request by the Legislative Budget and Audit Committee, this report summarizes a review of internal controls over cash and negotiable instruments such as checks and money orders, involving funds belonging to individuals incarcerated in the State's correctional facilities. Additionally, the procedures followed by the Department of Corrections' Division of Administrative Services in accounting for these funds held in trust for incarcerated individuals were reviewed and evaluated.

Objectives

Specifically stated, our review had six objectives. Three audit objectives relate directly to the handling of cash and negotiable instruments collected from, or on behalf of, incarcerated individuals at State of Alaska prison facilities. These objectives were:

- To evaluate the internal control environment at the Department of Corrections (DOC), including various pre-trial and correctional facilities throughout the State.
- To evaluate procedures currently in place and determine if any cost-effective procedures could be put into place to improve controls at specific institutions.
- To evaluate compliance with written procedures.

Three audit objectives relate to controls and procedures at the DOC Division of Administrative Services (DAS). These audit objectives were:

- To report on the control account balance of the Offender Financial Accounting (HOFA) system compared to the funds on deposit and cash-on-hand at all the correctional facilities within DOC.
- To identify any shortfall between the amount of the funds as shown on HOFA and the actual amount of funds available and to determine alternatives that exist to address the shortfall.
- To evaluate the adequacy of DOC's efforts to effectively account for the funds held in trust for incarcerated individuals.

Scope and Methodology

We contracted for this audit with a certified public accountant, who worked at our direction, in developing the scope and methodology of our review in order to accomplish the objectives listed above. In order to address our audit objectives, we observed procedures, interviewed

management and staff, and examined records related to the handling of cash and negotiable instruments at the following nine correctional institutions during April and May 1999:

- Anvil Mountain Correctional Center, Nome
- Cook Inlet Pre-Trial Facility, Anchorage
- Fairbanks Correctional Center, Fairbanks
- Hiland Mountain Correctional Center, Eagle River
- Lemon Creek Correctional Center, Juneau
- Mat-Su Pre-Trial Facility, Palmer
- Spring Creek Correctional Center, Seward
- Wildwood Correctional Center, Kenai
- Yukon-Kuskokwim Correctional Center, Bethel

We interviewed, by telephone and in person, personnel who supervise and perform the duties related to the handling of funds and records. We interviewed the superintendent of each facility, as well as correction officers, assistant superintendents, administrative managers, and administrative staff.

We observed prisoner booking, release and transfer activity; the processing of inmate funds received in the mail and from visitors; and activities related to the maintenance of cash on hand and in the bank. We also examined written procedures related to these activities.

Tests of controls were performed at each institution, and included tracing inmate receipts and disbursements from the computerized HOFA system to source documents, and the reverse. Cash drawer reconciliation records were examined, as well as bank reconciliations, bank statements, canceled checks, and check registers. Booking records, release records, and documentation of inmate complaints/inquiries were examined in the inmate files.

Various types of transactions can either increase or decrease an inmate's HOFA account. Our review involved many, but not all, of the possible types of transactions. Since we were primarily concerned with controls involving cash and other negotiable instruments, we reviewed the following types of receipt and disbursement transactions.

Receipts

1. Cash and negotiable instruments on their person at the time of booking.
2. Cash and negotiable instruments received through the mail.
3. Cash and negotiable instruments received from visitors to the facility.
4. Cash and negotiable instruments received from craft sales.

Disbursements

1. Cash and/or a check disbursed to an inmate when released.
2. Funds transferred on behalf of the inmate when he/she is transferred to a facility which is not part of the HOFA system (a half-way house, Alaska Psychiatric Institute, etc.).

3. Checks written on behalf of inmates to family, friends, or vendors.

Records for payroll, medical charges, commissary and other transactions that are posted to inmate accounts, but do not involve the transfer of cash or other negotiable instruments, were not examined.

Personal checks made out to inmates are not placed in the cash drawer and are not added to the inmate's HOFA account. They are considered to be valuables and are secured as such with the inmate's personal property. The security of these personal checks was reviewed as part of the audit.

We also interviewed management and staff and examined records at DAS in Juneau. We interviewed the director of administrative services, the deputy director of administrative services, the finance officer, and an analyst/programmer who works with HOFA. We also reviewed applicable sections of DOC policy and procedures.

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ORGANIZATION AND FUNCTION

The Department of Corrections (DOC) was created by Executive Order No. 55 on March 9, 1984. DOC is constitutionally mandated to protect the public by incarcerating prisoners and reforming institutionalized offenders. To carry out these responsibilities, the department:

- Enforces court ordered pre-trial supervision and detention of those accused of unlawful behavior prior to adjudication.
- Maintains the integrity of law by administering sanctions and punishment imposed by courts for unlawful behavior.
- Offers a wide range of correctional options, including community corrections, institutions, and community residential center services necessary to meet the needs of both society and offenders.
- Provides work and educational programs for offenders that will enhance community integration and economic self-sufficiency. These programs are to be administered in a just and equitable manner within the least restrictive environment consistent with public safety.

In addition, the department is responsible for housing persons held for federal offenses or on city ordinance charges.

DOC is composed of three divisions and the commissioner's office. Discussed below is the mission of each division as well as the programs administered within each division.

Commissioner's Office: The commissioner's office is responsible for direct oversight of classification, population management, training, prisoner transportation, compliance, audits, policy and procedures, victims' advocacy and rural affairs, as well as establishing policy for the three divisions. This office also coordinates inter-governmental affairs with other federal, state, and local governments, courts, legislature, media, public and special interest groups.

Division of Community Corrections: The mission of this division is to provide for the reintegration and supervision of offenders in the community; pre-sentence investigation and oversight of community programs. This division oversees the administration of the community residential centers, the adult probation program, and provides information to the Alaska Court System to be used in determining the offenders' appropriate sentencing.

Division of Administrative Services: This division provides services in the areas of budget, human resources, accounting, procurement and data processing in such a manner that allows DOC divisions or components to accomplish their respective missions.

Division of Institutions: The mission of this division is to provide safe and secure housing, reformation opportunities, essential health care, and to operate facilities consistent with sound correctional management in the most cost-effective manner.

Listed below are the 13 correctional facilities managed by DOC:

<u>Correctional Center or Facility</u>	<u>Location</u>
Anvil Mountain Correctional Center	Nome
Cook Inlet Pre-Trial Facility	Anchorage
Fairbanks Correctional Center	Fairbanks
Highland Mountain Correctional Center	Eagle River
Meadow Creek Correctional Center	Eagle River
Ketchikan Correctional Center	Ketchikan
Lemon Creek Correctional Center	Juneau
Mat-Su Correctional Center	Palmer
Palmer Correctional Center	Palmer
Sixth Avenue Correctional Center	Anchorage
Spring Creek Correctional Center	Seward
Wildwood Correctional Center/ Wildwood Pre-Trial Facility	Kenai
Yukon-Kuskokwim Correctional Center	Bethel

Each of the above institutions are managed by a superintendent who oversees all operational aspects of the correctional facility. Correctional facility operations include administration, as well as prisoner security, prisoner education programs, and prisoner medical services. DOC is responsible for over 3,000 prisoners residing in both out-of-state institutions and in-state correctional facilities. In addition, the State is also responsible for over 400 individuals who are currently residing in community residential centers.

The Cleary Final Settlement Order, which was approved by the Alaska Superior Court, is an agreement between the State of Alaska and inmates that requires DOC to provide minimum services and living conditions.

BACKGROUND INFORMATION

When an individual is "booked" into the Alaska prison system, the cash they have at the time of booking and any funds earned or received while incarcerated are held in trust by the State of Alaska. The Offender Financial Accounting (HOFA) system is the management information computer system that records transactions and maintains balances for each incarcerated individual. The offender trust accounting system is made up of HOFA and the related record-keeping procedures used to maintain the offender trust account and to provide a record of the liability to the State of Alaska for those funds held in trust. Transactions are initiated at each of the 13 prison facilities administered by the Department of Corrections (DOC).

Each prison facility (institution) maintains a cash drawer for storage of cash and negotiable instruments received from, or on behalf of, inmates. All deposits to, and withdrawals from, the cash drawer are recorded in HOFA. A supply of cash is maintained in the drawer in order to give cash to inmates upon release. Negotiable instruments and excess cash are regularly removed from the cash drawer and deposited into a single offender trust bank account which is maintained and reconciled by DOC's Division of Administrative Services (DAS). These 13 cash drawers and the offender trust bank account are the main depositories of inmate funds.

In addition to the depositories described above, each institution maintains a commissary bank account. These local bank accounts exist to allow institutions to write checks to, or on behalf of, inmates. Weekly transfers from the offender trust bank account are made by DAS to the thirteen commissary bank accounts, based on net disbursement transactions recorded in HOFA for the prior week.

When an inmate is released from the system they are paid in full the balance reported in their HOFA account. That payment can be made using cash from the cash drawer, a check from the local commissary bank account, or both. Cash payments made to inmates at the time of release cause cash drawers to eventually become depleted. When a cash drawer becomes too low to meet the upcoming needs of inmates on the release roster, the institution calls DAS and requests a cash drawer replenishment. DAS then transfers funds from the offender trust bank account to the institution's local commissary bank account. Cash, in the same amount as the transfer, is withdrawn by the institution from the local bank account and placed in the cash drawer.

The 13 commissary bank accounts were reportedly established with a mix of DOC operating and offender trust account funds. The accounts are used to make initial vendor payments which are subsequently reimbursed by the offender trust account. Reportedly, DOC operating funds have also been used to supplement the cash in some of these accounts over the years if funds have become depleted for any reason. In theory, the commissary bank account at each institution could be reconciled to the amount of initial funds and any subsequent supplements. However, no records exist to identify the source or amount of initial funds (see Recommendation No. 1).

There is currently a shortage of approximately \$200,000 in HOFA funds

At the end of March 1999, the net HOFA account balance was \$698,526. When compared to the \$460,536 made up of the amount in the fund's checking account, cash drawers at the institutions, and a \$123,700 still pending transfer from other operating accounts to cover inmate payroll already recorded in HOFA, an unaccounted for shortage of \$237,990 remained. This compared to calculated shortages that fluctuated over the previous 12 months. The month-end shortages, as calculated by DAS, ranged from \$176,837 to \$245,443 – with the average being just over \$211,000.

REPORT CONCLUSIONS

As set out in the Objectives, Scope, and Methodology section we addressed six specific objectives in our review. The objectives were further divided into two components – those involving the internal controls at the various correctional facilities across the State, and those related to how the inmate trust funds were accounted for.

Our review results are reflected in the nature and extent of the findings presented in the next section of this report, Findings and Recommendations. Given the objectives of our report and our findings, we present the following summary conclusions and observations.

The facilities' internal control procedures over cash and negotiable instruments are weak

Most of the discussion in the Findings and Recommendations section of this report reflects the central objective of our review. The internal controls over cash and negotiable instruments at the various correctional facilities administered by the Department of Corrections (DOC) is weak. The discussion reflects our conclusion that DOC facilities do not follow some of the basic tenets of internal controls. After making a general recommendation that DOC take measures to improve controls on an overall basis in Recommendation No. 2, specific internal controls, as follow, are discussed further in other recommendations:

1. **Ensure record keeping data entry is accurate.** It is important that measures are in place to promote accurate data entry. Such measures promote accountability by ensuring information is entered consistently and accurately in the management information system being used to account for, and summarize financial activity. The need for improved data entry and record keeping and steps that could be taken to address the problems we found at various facilities are discussed in Recommendation Nos. 3 and 4.
2. **Develop and consistently follow good cash handling procedures.** When handling cash, it is important that procedures be in place to track the transfer of cash at every step of the process. When receiving and disbursing cash, it is important that receipts be used to establish a "paper trail" in order that the sequence of control over funds can be documented. See Recommendation No. 5 for further discussion.
3. **Critical controls such as segregation of duties, limited access, and regular reconciliations are also important in situations involving cash.** In maintaining control over cash, it is important to have different individuals receiving the cash and reconciling the cash drawer to written "paper trail" receipts. It is important to limit the number of individuals authorized to receive and handle the cash. Additionally, cash receipts and supporting documentation should be regularly reconciled. Lack of these central control procedures involving both cash and facility checking accounts are identified and discussed further in Recommendation Nos. 6 and 7.

4. Improve physical controls over assets. Physical safeguarding of assets is also an important element of good internal control procedures. In a correctional facility this basic control procedure takes on even more importance. Specific concerns and recommendations regarding deficiencies in physical controls are discussed on a facility-by-facility basis in Recommendation No. 8.

DOC's central accounting for inmate funds must be improved

In addition to the variety of internal control weaknesses at the various facilities, we also determined DOC's Division of Administrative Services (DAS) should improve its accounting for inmate funds maintained in the department's Offender Financial Accounting (HOFA) system. As set out in the Objectives, Scope, and Methodology section, the second set of objectives dealt with problems DAS was having in reconciling the subsidiary HOFA system to the State's overall accounting records.

As noted in the Background Information section, DOC currently cannot account for approximately \$200,000 of HOFA funds held in trust by the State. As discussed above, periodic reconciliation and follow-up is an important internal control procedure. This procedure has not always been done by DAS in past years. In Recommendation No. 1 we discuss various aspects of the current HOFA balance, and offer our suggestions about what DAS should consider as it goes about bringing its reconciliation process current.

Structure of DOC contributes to lack of recognized and consistently followed procedures

Prison facilities located around the State, are under the direction of the Division of Institutions within DOC. A superintendent at each facility acts as chief administrator. The offender trust accounting system is maintained and supervised by DOC's DAS, which is primarily located in Juneau. Given this dispersed organizational structure, it is difficult, although important, to implement a system that effectively secures and accounts for funds held in trust by the State on behalf of incarcerated individuals.

The nature and structure of DOC has made it difficult to put in place and effectively monitor a set of appropriate internal control practices that are consistently followed at each facility. The impact of poor controls is most apparent when viewed on a statewide basis. Accordingly, it is difficult to gain an appreciation for developing and enforcing effective controls at the correctional facility level. Despite difficulties that the organizational structure of the department presents, management and appropriate oversight of inmate funds is a responsibility of departmental management.

The problems set out in the Findings and Recommendations section of this report reflect this dichotomous situation. Superintendents are primarily interested in maintaining security of their facility, with the requirements of record keeping presenting a secondary concern. However, the day-to-day record keeping is critical for DAS to be able to reconcile and control the many accounts that make up the HOFA system.

Establishing and following procedures is central to the DOC meeting its trust responsibilities

Receiving, securing, and accounting for the funds of individuals incarcerated in its correctional facilities places the State in a fiduciary, or trust situation. As noted in the Background Information section, DOC cannot account for more than \$200,000 in inmate funds. It is the responsibility of the State to secure and account for these funds. In order to effectively do so, DOC must have in place procedures that address the security over, and the record keeping involved with, the funds. Especially the cash and "near-cash" negotiable instruments belonging to inmates.

The shortcomings set out in the Findings and Recommendations section are numerous. By design we enumerated virtually all of the internal control deficiencies noted in the course of the review. We set out our recommendations with a great deal of specificity in order to give DOC clear direction regarding the deficiencies identified. Many of the deficiencies, when viewed separately, seem inconsequential. However, collectively these deficiencies create a situation where DOC is not adequately and consistently accounting for, nor safeguarding the assets it holds in trust for incarcerated individuals.

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FINDINGS AND RECOMMENDATIONS

Recommendation No. 1

The Department of Corrections (DOC), Division of Administrative Services (DAS) should determine the value of the liabilities and assets related to its Offender Trust Accounting System (HOFA), using generally accepted accounting principles (GAAP). Additionally, DAS should develop and document a system for monthly reconciliation of cash assets.

An accurate accounting for the assets and liabilities of the offender trust account has not been maintained. Existing information provided by DAS with regard to the offender trust account is unreliable. Neither the HOFA system nor any accounting system in place at DOC provides the information needed to determine the amount of the liability, or the assets available to satisfy that liability.

It is expected that liabilities exceed assets, due to a history of weak internal controls over cash assets and a known embezzlement of approximately \$256,000 between 1994 and 1997. A HOFA balance sheet prepared by DAS, dated March 31, 1999, indicates a shortfall of \$237,991. The amount of the shortfall, however, has not been reliably determined. The current methodology used to develop the balance sheet shows large, unexplained variances from month-to-month in the estimated shortfall. DAS is unable to adequately explain the methodology that was used to prepare the balance sheet, and the following issues have not been resolved:

- There is no evidence that a reconciliation has ever been made between cash drawer assets, the offender trust account, and the commissary bank accounts.
- An assessment has not been made of the various items reported in the HOFA liability balance at year-end. Therefore, some inmate account balances may not actually represent an asset or liability to the State. Such an assessment would require an analysis of "holds" and negative balances, as well as the 2,169 account balances as of May 17, 1999 that exist for inmates who have been released.
- It has not been determined whether or not the use of operating funds to seed and supplement the commissary bank accounts creates a liability to the offender trust account.
- Uncleared checks up to six years old written from commissary bank accounts have not been reclassified. This was an issue at four of the nine facilities reviewed. Reclassification will likely result in an increase to the HOFA liability.

Without resolution of these issues, the existence or amount of unfunded liability as a result of errors, misuse, or theft of funds cannot reliably be determined at this time. We understand that DOC's DAS is currently working with the Department of Administration, Division of

Risk Management to determine if insurance funds are available to recover losses due to the embezzlement at the Mat-Su Pre-Trial Facility. Other alternatives to fund the suspected shortfall cannot reasonably be offered until information regarding the amount and the cause is available.

Reconciliation of bank and cash records, and maintenance of an accounting system, is an essential step in safeguarding assets from loss by error, misuse, or misappropriation. Until these procedures are established and maintained, the cash assets of the offender trust fund, as well as state operating funds that are intermingled in the system, are not adequately safeguarded.

The recommendation of urgency for determining and reconciling balances is due in part to the lack of controls for the commissary bank accounts. Urgency is also stressed in light of the upcoming installation of a new management information system for the offender trust account, due to be installed in 1999. Beginning balances and account data will need to be entered into this new system. Unless the necessary reconciliations and analyses take place, with improved accounting procedures established before the new system is installed, unreliable and unreconciled balances will be transferred into the new system.

Recommendation No. 2

The Department of Corrections should develop, adopt, and implement internal controls designed to safeguard funds held in trust for inmates, and state funds on deposit at prison facilities.

There has been limited priority placed on the security of funds held in trust for inmates. Controls at prison facilities remain weak despite a known embezzlement of funds from 1994 - 1997 and numerous audit findings and recommendations.

The Division of Legislative Audit conducted an audit of DOC fiscal operations and compliance with state laws and regulations, dated July 19, 1996. The report included recommendations to:

- Enhance the internal controls for cash handling.
- Establish procedures necessary to address the existing out-of-balance condition between the HOFA system controlling bank account balance and the HOFA system liability balance.
- Enhance internal controls at each institution for the commissary bank accounts.

Corrective action has not been taken, which is evidenced by a repeat of the concerns in this report.

Embezzlement at Mat-Su Pre-Trial Facility highlights lack of sufficient concern

Lack of concern for safeguarding cash assets is also evidenced by DOC's failure to take appropriate action in light of the misappropriation of funds at the Mat-Su Pre-Trial Facility. The embezzlement of offender trust account funds at the Mat-Su Pre-Trial Facility over a four-year period was a serious incident, resulting in the misappropriation of approximately \$256,000. A change in procedure was instituted at DAS in Juneau, which will, if followed, detect a fraud that was perpetrated in the same manner as the incident at Mat-Su Pre-Trial Facility. However, DOC did not advise superintendents of the scheme, conduct institutional reviews, or require additional or revised procedures at the prison facilities to reduce the risk of similar incidents. As a result, controls at some prison facilities remain weak, and the risk for misuse of funds is high.

DOC should develop and maintain written procedures for all transactions related to inmate funds. At seven of the nine institutions we visited for our review, written procedures were either not present, not readily available, not used, or did not adequately address the various types of cash handling transactions with regard to internal control objectives.

Recommendation No. 3

The Division of Administrative Services should update the HOFA system so that it provides meaningful and reliable information. DAS should also train users to correct data entry errors without recording false events.

The information provided by HOFA is misleading and unreliable, and lacks sufficient detail. For example:

- Recorded transactions do not represent events that actually occurred.
- Negative balances may or may not represent a debt to the State.
- Inmates who have been released appear on the active roster.
- HOFA computerized display forms do not show the facility at which a transaction was recorded.
- Summarized activity printouts do not list transactions in the order they occurred.

In some cases, incorrect data in the system is due to user attempts at data entry error correction. Either the system does not accommodate error correction, or users do not understand how to use the system. In any event, in our view, these are critical aspects of maintaining control over HOFA accounts, and should be addressed in the upcoming upgrade of the department's offender accounting system.

Recommendation No. 4

DOC should establish and maintain standards for recording and filing information related to inmate funds.

Inmate files are transferred from facility-to-facility along with the individual. Inmate files are eventually archived in Juneau. However, document use and filing procedures are not consistent statewide. Therefore, an inmate's file may or may not contain:

- An acknowledgement by the inmate of the amount of cash removed from him/her at the time of booking or transfer from another facility.
- Copies of receipts for gifts from friends and relatives, or proceeds from craft sales.
- Copies of authorized disbursement to third parties.
- A signed acknowledgement of the amount of funds returned to (or transferred with) the inmate at the time of release or transfer to another facility.

Because of these inconsistencies, the inmate file does not provide the information necessary to determine events or review or verify transactions. Source documents are scattered throughout various facilities, and signatures on documents, or the lack thereof, have a variety of meanings.

The inmate file should provide information that can be consistently interpreted, and should provide documentation of events and transactions. Although DOC's policy and procedures provide some standards for record-keeping, compliance is not monitored or enforced.

DOC policy should also clearly prohibit the use of altered documents to authorize events and transactions. Our review showed instances in four of nine facilities where records such as control logs, reconciliation reports, receipt copies, booking records, requests for disbursements, and bank deposit slips had been altered without initials. All persons handling documents that authorize or acknowledge transactions involving inmate accounts should be made aware that alterations serve to void a document unless all signers can initial material changes. Procedures should be put in place to regularly monitor this practice for compliance.

Good record keeping practices and procedures are central to providing informative and appropriate documentation of HOFA activity. For the department to bring the HOFA accounts of inmates under control, the appropriate use and retention of documents and records must be made enough of a priority so that facility superintendents will take steps to make improvement.

Recommendation No. 5

DOC should develop, distribute, and administratively enforce cash-handling procedures necessary to improve controls at the time of booking and release.

When an inmate is booked or released from a facility, cash changes hands between the inmate and a correction officer. At this time, inmate funds are at particularly high risk for misuse, misappropriation, and error. The following recommendations address the concerns noted during our review:

1. DOC should establish and maintain booking procedures to ensure that the cash and negotiable instruments removed from individuals at the time of booking are deposited intact in the cash drawer. At most institutions, there is no requirement for officers to segregate duties during the booking process. Inmate funds are at high risk for misappropriation at the time of booking. The officer responsible for the cash drawer is often the same officer who enters the amount of funds in the individual's HOFA account, with no verification by another officer.

Inmates are asked to sign the booking form during the booking process, verifying the amount of funds they had when entering the facility. However, many inmates are either too intoxicated or too uncooperative to provide that verification. In this case, no control exists to confirm that all funds relinquished by the individual were recorded in HOFA and placed in the cash drawer.

For adequate segregation of duties, the officer who removes cash, negotiable instruments, and valuables from an inmate should prepare, sign, and date a list of these items. That list, along with the funds removed, should be transferred to a second officer who inputs the information in HOFA and signs the booking form. The signed list should be made part of the inmate file. If the inmate is too intoxicated or uncooperative to sign the booking form and acknowledge the amount of funds removed, an officer other than the one who signs the booking form should sign a confirmation stating the reason the inmate's signature was not obtained.

2. DOC should develop and maintain procedures which allow inmates to confirm their HOFA balance at the time of release and/or transfer, and positively acknowledge receipt of their funds. Evidence of confirmations should be made part of the inmate file, with a copy retained at the releasing institution. Release documents do not provide a positive acknowledgement by the inmate of the amount of funds disbursed to him or her at the time of release, and procedures at many institutions do not require an officer to provide the inmate with a copy of his/her HOFA balance printout. Although some institutions do inform the individual of the balance, the document is often placed in the inmate file and transferred to another institution or to Juneau; therefore, no evidence of the process is available at the institution.

Procedures and forms should be developed that allow the inmate to identify, and verify or deny, receipt of total HOFA funds. Records that confirm this process should be retained in both the inmate file, and at the institution.

Recommendation No. 6

Superintendents at various facilities should improve controls over access to and accountability over cash drawers.

It is important that policy and procedures for cash handling and maintenance of the offender trust accounts should be developed and monitored by the Department of Corrections on a statewide level, using identified internal control objectives as a basis. However, until that is fully accomplished, superintendents at the various facilities we reviewed should improve and implement better procedures to enhance controls. Specific concerns we have regarding cash drawer controls are detailed in the following recommendations and observations:

1. Superintendents should establish policy and procedures which require that only one cash drawer key be in circulation at any one time, and clearly designate individual responsibility for the key and the cash drawer. At three of the nine facilities reviewed, multiple keys to the cash drawer were in circulation. If funds were missing from the cash drawer, it would be impossible to determine responsibility.

Such controls are important to establishing and maintaining accountability over cash at a place when it is most vulnerable to theft. By not taking care to limit access to the cash drawer, it becomes difficult, if not impossible, to isolate who may be responsible in the event there is a shortage. By not having clear accountability, a situation is created where suspicion may be cast over all staff if cash turns up missing.

2. Superintendents should establish procedures which require cash drawer reconciliation documents to be signed and dated by the person performing the reconciliation. The procedures should also require calculator tapes and/or cash count forms to be retained as part of the reconciliation documents. In six of the nine facilities reviewed, the cash drawer reconciliation documents were not consistently signed. It was not possible to positively determine who performed the reconciliation, or to pinpoint responsibility in case of an error or irregularity.
3. Superintendents at the Hiland Mountain Correction Center (HMCC) and Wildwood Correctional Center (WCC) should establish procedures which require cash drawer reconciliations to be verified daily. Existing cash drawer procedures at HMCC and WCC do not adequately safeguard the funds in the cash drawer. At Wildwood Correctional Center, the HOFA clerk who manages the cash drawer performs the cash reconciliation unobserved and without verification. At Hiland Mountain Correctional Center, the

administrative supervisor performs the cash reconciliation unobserved and without verification.

A verification process should be made part of the cash drawer reconciliation. The best method of verification is for a second individual to perform the cash count daily and confirm the results. Each individual involved with the reconciliation process should sign, date, and attach tapes to reconciliation documents. All reconciliations should be reviewed by a manager and filed in his or her office.

4. The superintendent at the Mat-Su Pre-Trial Facility should establish procedures that require the cash drawer in the booking area to remain locked when not actively in use. The cash drawer in the booking area was not kept locked. Although the area is secure, several people have authorized access, including corrections officers, administrative personnel, and arresting officers. When the drawer is unlocked, cash is susceptible to theft and responsibility for the cash drawer cannot be pinpointed.
5. The superintendent at the Yukon-Kuskokwim Correctional Center (YKCC) should establish procedures which require all bills, checks, and money orders to be individually counted during a cash reconciliation. Cash drawer reconciliation is the primary function for safeguarding cash and other negotiable instruments in the cash drawer. At YKCC, cash in the cash drawer is not adequately inspected and counted. Some bills and negotiable instruments are banded loosely and counted as a bundle. The amount of each bundle is informally written on a piece of scrap paper, and that amount is used to reconcile cash. There is no verification that the amount recorded on the scrap paper is correct, or that the bundle still contains the amount of cash specified. If money was missing, there would be no way to determine when the event occurred, or who was responsible.

The maintenance of cash funds at the individual facilities is perhaps the weakest point of control in the entire system that records and tracks an individual's HOFA account. Increased vigilance in this area should help protect corrections officers from inappropriate allegations of theft and misuse.

Recommendation No. 7

Superintendents at various facilities should improve controls involving the use of checking accounts over which facility staff have control.

Facilities maintain and control checking accounts which are used to expedite the purchase of various goods on behalf of inmates and provide a ready source of cash to "restock" the facility's cash drawer. Superintendents at the various facilities must be aware of good internal control procedures that must be followed involved with safeguarding checking accounts.

Specific concerns we have regarding the controls at various facilities involving checking accounts are as follows:

1. Superintendents should be sure to remove check-signing authority for the commissary bank accounts from staff who prepare checks, reconcile the bank accounts, or otherwise have access to bank records. At five of the nine facilities we reviewed, we noted a critical lack of segregation of duties involving commissary checking accounts. We had concerns about the structure of duties at Anvil Mountain Correctional Center (AMCC), Cook Inlet Pre-Trial Facility, Lemon Creek Correctional Center (LCCC), Mat-Su Pre-Trial Facility, and the Yukon-Kuskokwim Correctional Center.

At both AMCC and Mat-Su Pre-Trial Facility, one individual has the authority to sign checks without a counter-signature and is solely responsible for the monthly bank reconciliation. These individuals also have access to HOFA records. At Cook Inlet Pre-Trial Facility, Lemon Creek Correctional Center, and YKCC, an individual who is responsible for preparing checks is also a signer on the checking account and reconciles the bank records. These individuals also have access to HOFA records.

When an individual has access to both cash assets and cash records, segregation of duties is not adequate to safeguard the cash in the bank.

2. Superintendents should establish procedures which require positive confirmation that all checks written for the purpose of cash replenishment are deposited into the cash drawer. In addition, they should immediately prohibit the use of checks payable to "Cash". At five of the nine facilities we reviewed, we identified less than adequate procedures over the use of the commissary checking account. Specifically, we identified weaknesses involving the use of the checking accounts at Anvil Mountain Correctional Center, LCCC, Mat-Su Pre-Trial Facility, WCC and the Yukon-Kuskokwim Correctional Center.

Funds on deposit in the commissary bank accounts at these institutions are not adequately safeguarded. At AMCC, Mat-Su Pre-Trial Facility, Wildwood Correctional Center, and Yukon-Kuskokwim Correctional Center, checks are commonly made out to "Cash" for purposes of replenishing the cash drawer, and/or to resolve errors. At Lemon Creek Correctional Center, checks for cash replenishment are made out to the records officer who writes checks from and reconciles the commissary bank account. At all of these institutions, backup for the disbursement does not include a signed request from a cash drawer manager, and no procedures are in place to verify that cash received from the bank was placed in the cash drawer and recorded in HOFA.

When a check is made payable to "Cash," it becomes a bearer instrument and anyone with possession of the check has access to the cash assets in the bank. This provides an opportunity for access to inmate funds by unauthorized individuals. Accountability for the handling of the check and proceeds is also diminished. If a check is handled inappropriately, it would be difficult to determine the circumstances and to pinpoint responsibility.

The person who signs a check for the purpose of cash replenishment should verify that the funds are promptly deposited into the cash drawer intact. The check signer should be someone other than the person who balances the bank statement or has control over other cash asset records. Backup for the disbursement should include a signed memo from the officer or clerk who is responsible for cash drawer management. All checks for cash replenishment should be made payable to the individual who is designated to cash the check. The individual who cashes the check should not have control over bank records.

3. The superintendent at the Spring Creek Correctional Center (SCCC) should develop procedures which require the commissary bank account to be reconciled monthly. The procedures should include a review of the reconciliation by management. Bank reconciliations for the commissary bank account at SCCC have not been completed since May 1998. The HOFA clerk hired approximately one year ago was not properly informed of the duties of her position, and supervision was not adequate to ensure that all critical duties were performed. Therefore, bank reconciliations have not been completed for the past 12 months. As a result, no review has been done to determine if deposits, withdrawals, and charges to the commissary bank account were authorized and correctly recorded, and the funds in the account have not been adequately safeguarded.

The assistant superintendent in charge of HOFA is currently installing software to assist with bank reconciliations. Once she has re-established the procedure and completed the reconciliations through the current month, she will train and supervise the HOFA clerk to perform the reconciliations on a monthly basis.

Recommendation No. 8

At some facilities, measures should be taken to better safeguard the property, cash, and other assets of inmates.

In our review of controls at various correctional facilities we identified instances where improvements could be made in how the property and assets of the inmates are protected. Specifically we noted and recommend the following:

1. The superintendent at the Anvil Mountain Correctional Center should establish procedures that require inmate funds received in the mail or in person to be kept in a locked container. In addition, the superintendent should establish procedures to verify that logged receipts are recorded properly in HOFA and receipt funds are deposited intact to the cash drawer. Cash and negotiable instruments received in the administrative area are kept in a locking file drawer. However, the drawer is not kept locked throughout the day. The file cabinet is used for purposes other than as a storage area for cash, so the drawer remains unlocked to allow access. Cash could be easily removed or misplaced.

In addition, no procedures exist to verify that the cash received in the administrative area was properly posted to HOFA. A receipt log is kept in the reception area, but no verification is made that the funds received are actually posted. Cash receipts should be recorded in a separate log and a verification process should be established to ensure that all logged receipts are entered on HOFA.

2. The superintendent at AMCC should require negotiable instruments in the cash drawer to be deposited to the offender trust bank account. AMCC staff is currently depositing negotiable instruments to the local commissary bank account. They then withdraw those same funds with a check payable to "Cash" and deposit the cash in the cash drawer. This method of replenishing the cash drawer is inappropriate. It increases the amount of funds in the commissary bank account, which is, due to current procedures, susceptible to misuse and misappropriation. In addition, it eliminates controls that DOC has in place to determine errors and irregularities in the cash replenishment process. Thus, the current process serves to remove some of the safeguards that protect the cash in the account.
3. The superintendent at the Cook Inlet Pre-Trial Facility should establish procedures that require cash, negotiable instruments, and other valuables belonging to people who are detained at the facility to be reasonably secured. Individuals are not immediately booked when intoxicated or uncooperative. In this case, cash is placed in a small plastic bag on the counter or the floor in the booking area, sometimes without being counted. The uncounted and unsecured funds can remain in the bag for as many as seven hours, and are subject to access by any number of employees who frequent the booking area.

Cash, negotiable instruments, and valuables should be reasonably safeguarded at all times. If the booking process is delayed, valuables should be secured in a locked area that is accessible by only one position.
4. The superintendent at the Yukon-Kuskokwim Correctional Center should establish procedures which require inmate valuables, including personal checks, to be stored in a locked container. Personal checks and other negotiable instruments which will not be cashed are considered property, and classified as valuables. Valuables are placed in an envelope and kept in a safe in the booking area. However, the safe is not locked. All corrections officers and administrative staff have access to this area and the safe. Therefore, valuables are virtually unguarded and could easily be removed. Without limited access, there is no way to pinpoint responsibility if an item is missing.
5. The superintendent at YKCC should establish procedures that allow only one officer per shift to receive and receipt funds from visitors. Cash receiving activities at YKCC are not limited to as few hands as possible. Any one of five corrections officers per shift receive cash from visitors on behalf of inmates. If several people are receiving funds, it is not possible to pinpoint responsibility if a problem occurs.

The control deficiencies identified in this report not only present opportunities for theft and misuse of funds by dishonest staff, but fail to protect honest staff from suspicion and inappropriate allegations. We encourage superintendents and DOC central management to take these concerns and deficiencies seriously, and take action to tighten controls over funds for which the State has a trust responsibility.

(Intentionally left blank)

August 31, 1999

Alaska State Legislature
Legislative Budget and Audit Committee
Division of Legislative Audit
Attn: Pat Davidson, Legislative Auditor
P.O. Box 113300
Juneau, Alaska 99801-3300

Dear Ms. Davidson:

RE: The Department of Corrections,
Internal Controls Related To Cash and
Negotiable Instruments For The Offender
Financial Accounting System, May 18, 1999.

Recommendation #1

The Division of Administrative Services (DAS) should determine the value of the liabilities and assets related to the Offender Trust Account System (HOFA), using generally accepted accounting principles (GAAP). Additionally, DAS should develop and document a system for monthly reconciliation of cash assets.

Agency Response

The Department of Corrections agrees with this recommendation. The DOC is working diligently to determine the value of the liabilities and assets of the Offender Trust Account System (HOFA) system using generally accepted accounting principles (GAAP) and to address other issues brought up by the audit.

Recommendation #2

The Department of Corrections should immediately develop, adopt and implement internal controls designed to safeguard funds held in trust for inmates, and state funds on deposit at prison facilities.

Agency Response

The Department of Corrections agrees with this recommendation. The Agency's Policy and Procedures Manual, Section 302.12, Fiscal Management, Prisoner Accounts, has been revised to implement new cash handling procedures that will ensure that each institution's internal commissary account will be reconciled monthly and reviewed to ensure that prisoner funds are safeguarded at every level.

Recommendation #3

The Division of Administrative Services (DAS) should update the HOFA system so that it provides meaningful and reliable information. DAS should also train users to correct data entry errors without recording false events.

Agency Response

The Department of Corrections agrees with this recommendation. The current HOFA system, which is in the process of being replaced, is such that we cannot void transactions when an error is made nor are they batched to catch errors before posting. The only way to make a correction in the current HOFA system is make another HOFA transaction and try to make a clear trail with descriptions of the events. The new HOFA system which will be brought on-line by the end of October 1999 has been designed to address transaction errors, and to provide meaningful and reliable inmate financial information. Training on the new HOFA system will be provided to every institution's HOFA staff.

Recommendation #4

DOC should establish and maintain standards for recording and filing information related to inmate funds.

Agency Response

The Department of Corrections agrees with this recommendation. The existing standards in-place for inmate record keeping will be monitored to ensure that compliance of these inmate record standards are enforced at each institution.

Recommendation #5

DOC should develop, distribute, and administratively enforce cash-handling procedures necessary to improve controls at the time of booking and release.

Agency Response

The Department of Corrections agrees with this recommendation. As mentioned in the response to Audit Recommendation #2, our existing Policy and Procedures on Fiscal Management of Prisoner Accounts has been revised to improve controls of funds and property of individuals incarcerated in state institutions.

Recommendation #6

Superintendents at various facilities should improve controls over access to and accountability over cash drawers.

Agency Response

The Department of Corrections agrees with this recommendation. Revised Policy and Procedures to improve cash drawer controls have been adopted by Institutions to segregate HOFA duties and ensure that inmate funds are safeguarded at every level.

Recommendation #7

Superintendents at various facilities should improve controls involving the use of checking accounts over which facility staff have control.

Agency Response

The Department of Corrections agrees with this recommendation. Revised Policy and Procedures to improve cash and checking account controls have been adopted by Institutions to ensure that inmate funds are safeguarded

Recommendation #8

At some facilities, measures should be taken to better safeguard the property, cash, and other assets of inmates.

Agency Response

The Department of Corrections agrees with this recommendation. The revised Policy and Procedures for Fiscal Management of Prisoner Accounts has been adopted by Institutions will provide the safeguards recommended by the audit in all DOC institutions.

Thank you for the opportunity to comment on this audit. If you need more information, please feel free to contact me.

Sincerely,

Margaret M. Pugh
Commissioner

CC: Dwayne B. Peeples, Director/Division of Administrative Services
Allen J. Cooper, Director/Division of Institutions

To: Annette

From: Debbie

Date: 9/21/99

Re: Corrections Subcommittee Meeting of 9/21/99 @ 12:00pm

1. Materials – 9/21 and 9/14 Handouts
2. Mailed Materials – Greg Pease/Juneau & Barbara Miller/Mat-Su LIO
3. Other – Member changes
 1. Daniel Wayne/Juneau – wants to be removed. He serves on the Admin. Sub and that is where his interests lie. Would be happy to act as a resource to subcommittee if needed.
 2. Wade Ray/Anchorage – wants to be removed. He said he doesn't have the time. He has not attended any meetings.
 3. Greg Utterback/Anchorage – will replace David Morrison from Cornell Corrections. David has left the State. Greg is his replacement @ Cornell, so business info will be the same.

9/21/99
done

DEPARTMENT OF CORRECTIONS PRIVATIZATION

SUBCOMMITTEE MEETING

SEPTEMBER 14, 1999

1. **Members Present:** Sharon Anderson, Russell Lewis, Garland Warren, Gail Schubert, Mary Pate, and Mel Tipton (telephonic)
- Greg Pease, Dwayne Peeples, Charlene Griffin in Juneau
 - Barbara Miller via phone from Wasilla

Senator Ward was present

Betsy Robson, Bruce Richards, Bill Parker, all DOC were present.

2. **Betsy Robson spoke on Inmate Education for the first part of the meeting.**

- **Education Programs Present at All Facilities:** amount of education services varies by facility; type of programs is tailored to each facility.
- **Programs Include:** Adult Basic Education/G.E.D.; Lifeskills Programs; Literacy; Vocational Education and Apprenticeship;
- **Program Numbers:** 961 Students in ABE/GED; 35 students in English as a Second Language; 426 inmate/students have 8 years or less of education. 500 were studying at secondary level, 185 earned GED in FY 1998
 - **(NOTE):** These numbers only include incarcerated persons, not prisoners in Arizona or persons at CRC's
- **Baseline Education:** DOC has tried to establish a baseline level of education. There is not enough data to establish a true baseline, but the data indicates that less than 48% of inmates have a high school diploma or equivalent.
- **Lifeskills Class:** duration ranges from 1-2 hours to several weeks (depending on the length of prisoner incarceration at any given facility); involves human relations workshops;

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Minutes prepared by C. Russell Lewis

(907) 258-0106

Cross Cultural programs exist within Lifeskills classes; CPR and stress reduction are taught within these classes.

- **Senator Ward:** Asks how the lack of a Rural Affairs Coordinator affects cross-cultural issues in inmate education?
- **Betsy Robson:** Lack of an RAC does not affect programs since the RAC was not directly involved in the education programs.
- **Additional Numbers:** In FY 99: 5465 inmates in lifeskills classes; 3771 inmates completed the class
 1. Transient population affects completion percentage
 2. No recidivism data is available
 3. Data that is available doesn't reflect interrelation of lifeskills programs and recidivism.
 4. National data reflects information that lifeskills teaching reduces recidivism.
 - General Discussion re: Collecting Data with OBSIS #'s
 - B. Richards: OBSIS # stays with any given inmate for life
 - Gail Schubert: Are computers available and used to track inmates?
 - B. Richards: Computer system is an out-of-date system designed for a narrow purpose. The current system is very cumbersome to try to use as a database.
 - Betty Robson: OBSIS #'s not used in data collection efforts.
- **Senator Ward expresses concern regarding the "lack of outcome measures" General Discussion on COST/EFFECTIVENESS/APPROPRIATENESS follows**
 - ❖ Senator Ward: Is there a measurable benefit to the education program:
 - ❖ B. Robson: Notes that many of the education services are contracted out to the private sector.
 - ❖ Senator Ward asks if those private contractors would have outcome data?
 - ❖ B. Robson: No. The only available data is regarding the pre- and post- program educational level of the inmates.
 - ❖ R. Lewis: Is education ever a part of the sentence?
 - ❖ B. Robson: Not very often. National data (only source available) supports the following

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*Minutes prepared by C. Russell Lewis
(907) 258-0106*

1. Recidivism reduced by education
 2. (remember Cleary settlement requires educational effort)
 3. Education can be a tool to manage the institutions by keeping the problem populations separated and keeping violence down.
- ❖ Sharon Anderson questions whether the length of stay acts as a deterrent to involvement in the education program?
 - ❖ B. Robson: programs are tailored to the length of average stay at each facility. Both pre-programming and shortened programs are used.
 - ❖ B. Robson/B. Richards: New MIS will allow greater tracking of inmate progress/education/recidivism
 - ❖ Senator Ward: What is cost of education effort?
 - ❖ B. Robson: \$316,000 is allocated from DOC budget. 50-55% of that figure goes to private contractors. The rest goes to books and supplies.
 - ❖ Gail Schubert asks if university credits are given and if so, who pays for them?
 - ❖ B. Robson: Because of the recent PELL grant cuts, the inmates must pay on their own for any university classes they take.
 - ❖ Gail Schubert questions the private pilot lessons being offered at certain facilities.
 - ❖ Barbara Miller asks how many state employees are in the education program
 - ❖ B. Robson: Two in central administration, at least one in each facility.
 - ❖ Barbara Miller: How many total? B. Robson: 17
 - ❖ Barbara Miller: What is the cost for the 17 employees?
 - ❖ B. Robson: Unclear. These particular employees are funded through the institution budgets, not the education budgets.
 - ❖ Garland Warren asks why there are no certified programs at the Yukon-Kuskokwim Correctional Center?
 - ❖ B. Robson: Most inmates stay only a short time in that facility.
 - ❖ Mel Tipton asks if written testing is done. Bruce Richards replies that it is done for Adult Basic Education.
 - ❖ Mel Tipton: Is there written testing after or during other classes? B. Robson: Only pre- and post- class testing to measure the change in abilities.
 - ❖ Mel Tipton: Are written tests used to measure results?

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- ❖ B. Robson: Any certified classes use testing at the completion of the class.
- ❖ Senator Ward: Are classes relevant? Are the results of the education worth the effort? Senator Ward reiterates his desire to see some measurement of value from the tax dollars being spent on education in the prison system.
- ❖ Mary Pate asks how the schedule of which classes to offer is determined?
- ❖ B. Robson: Education Coordinator at each facility determines classes to offer.
- ❖ Mary Pate: Is then any relationship between classes offered and the jobs available upon release?
- ❖ B. Robson: The DOC's Criminal Justice Planner coordinates with DOL regarding the potential job market.
- ❖ B. Robson: National data indicates that Alaska is 4th from bottom in education spending on a per capita basis.
- ❖ Bruce Richards: New MIS will allow better tracking of dollars and inmates: can't be done now.
- ❖ Greg Pease: What correctional assessment tool(s) will be used to determine if programs work? Greg Pease offers to provide them to the DOC and the committee.
- ❖ Senator Ward is of the opinion that if people are trained and have a job, they won't re-offend. Senator Ward is certain that the data can be compiled, manually if need be.
- ❖ Garland Warren expresses concern about Alaska's low position in regards to the education dollars being spent on inmates.
- ❖ Barbara Miller wants inmates restricted to a total of 13 years of education services.
- ❖ Bill Parker (DOC) expresses his belief in the need to educate since the inmates will eventually return to society.
- ❖ Barbara Miller expresses doubts as to whether education will prevent recidivism when inmates do return to society.
- ❖ B. Robson expresses her belief that education is the key to prevent recidivism and that the new MIS will allow the date to be gathered to show that.
- ❖ Gail Schubert points out the age of some of the statistics and asks if the budget and the numbers have changed in recent years.
- ❖ Gail Schubert points out that most if not all of the crimes committed by indigenous peoples involve substance abuse: shouldn't most of the education dollars be directed at substance abuse prevention/treatment?

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- ❖ Sharon Anderson concurs with the need for outcome measures.
- ❖ Garland Warren states his opinion that as Alaska is only spending \$350/year/inmate on education, any further cuts would mean that the program should just be dismantled.
- ❖ Mel Tipton asks if there could be greater selectivity about persons entering the education programs. Mel also notes that testing might be a proper means of assessing entry screening and measuring progress in the programs.
- ❖ Russell Lewis asks for the total money spent on education in the prison system. B. Robson will get that information together.
- ❖ Senator Ward asks the DOC personnel to assemble outcome information on all the programs.

3. Sex Offender Treatment Programs: The second part of the meeting was devoted to a discussion of the sex offender treatment programs, again presented by Betty Robson.

- The Sex Offender program has a total of 260 slots: Meadow Creek, 78 slots; Lemon Creek, 24 slots; Fairbanks, 10 community spaces; Anchorage, 60 community spaces; Juneau, 15 community spaces; Kenai, 8-10 community spaces; Ketchikan, 8-10 community spaces.
- B. Robson discusses the 1996 Study at Hiland Mountain. This study produced "good news" and "bad news":
 - Good news: Rapists do not appear to be reoffending
 - Bad news: Alaska Natives are not progressing in the program and have low numbers in the treatment programs compared to the number of offenders.
 - Results and Procedures from study: DOC will reevaluate the aspects of culturally relevant programs, the length of the Sex Offender treatment programs, and restructure the programs so that more people can be treated.
 - "Summit" Meeting of DOC staff and care providers was held to discuss: 1) shortening of the Sex Offender treatment program to 17 months; 2) identify specific needs of treatment; and 3) do as much pre-program work as possible to improve chances of success in the program.

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- B. Robson discussed a study recently done by DOC evaluating the revised Sex Offender program. This study evaluated the results from 5/1/98 to 5/1/99 after the (some/all ???) of the above changes were implemented in the above program. This study revealed:
 - Rate of completion improved by 20%: up to 1 inmate per month completing the program.
 - Other inmates benefited from the program, even if not completing it.
 - Participation rate improved in the program from 38% to 57% (of offenders???)
- Gail Schubert asks questions regarding the completion rate and the completion rate of Alaska Natives specifically.
- B. Robson states that 23 Alaska Natives were discharged from the program: 15 quit or were discharged; five completed the program; and three left when their sentence expired.
- B. Robson noted that the national dropout rate is 50%-60%.
- Gail Schubert asks how many of the slots in the sex offender treatment program are occupied by Alaska Natives. B. Robson responds that 50% of the Meadow Creek Correctional Center Sex Offender population is Alaska Native. There apparently are no numbers available on the population make-up of the community slots.
- Gail Schubert asks if there is a waiting list for entry to the Sex Offender program at any given facility. B. Robson responds that there is a two or three month wait for Meadow Creek and a period of a few months at Hiland Mountain. B. Robson indicates that wherever there is a waiting list, the facility tries to offer treatment prior to actual entry into the program.
- Barbara Miller asks why individuals leave treatment. B. Robson responds that there are several reasons for leaving treatment. Some people refuse treatment, some have their parole revoked, some are kicked out.
- Senator Ward asks for information on the five Alaska Natives that completed the program. What was the cost of their

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(907) 258-0106

treatment? Have they reoffended? Senator Ward would like to see a comparison of cost for treatment and the reduction in repeated offenses, if there is such a reduction.

- B. Robson indicates that the Sex Offender treatment program is 88% contracted out. The annual budget is \$1,000,000, which includes elements in the facilities budgets as well as the community treatment budget.
- Barbara Miller asks how many state employees are involved with the Sex Offender program. B. Robson indicates that there is one part-time criminal justice planner and that there are no full-time employees dedicated to the Sex Offender treatment program.
- B. Robson indicates that psychological/psychiatric testing is included in the 12% of the Sex Offender program budget that is not contracted out.
- Gail Schubert asks if the inmates pay any part of their treatment. B. Robson responds that inmates in the community slots pay part of the cost of their treatment.
- Russell Lewis asks if the DOC personnel could assemble statistics on what part of the parole board's time is spent doing revocation hearings for sex offenders.

4. General Discussion Regarding Inmate Monies:

- Garland Warren asks for data on inmate funds; i.e. how inmates earn funds and how those funds are segregated and maintained.
- Bruce Richards indicates that there is some data on inmate funds, but it is hard to get. All inmates have a HOFA (???) fund.
- Senator Ward indicates that he would like to see copies of any HOFA fund audit.
- Garland Warren expresses his concern about letting offenders back into society without either money or training.

- Gail Schubert expresses her concern regarding any money building up in inmate accounts: is it safe and do the prisoner's have access to it???

5. General Items of Concern to Committee Members:

- Greg Pease states his belief that substance abuse/addiction problems need to be addressed prior to addressing other problems, since substance abuse seems to be the impetus in many crimes.
- Greg Pease expresses his renewed concern over DOC's failure to use assessment tools to measure inmate education progress.
- Sharon Anderson asks Greg Pease to provide the committee with information on the assessment tools.
- Garland Warren asks what monies are being paid to CRC's and other privately run facilities. Senator Ward responds that \$15,000,000 to \$18,000,000 is being spent annually.

6. Closing Issues:

- Sharon asks the committee if DOC should present information on substance abuse programs at this meeting or if it should be postponed.
- The committee members indicate the need to fully address substance abuse issues, so that topic will be presented on September 21, 1999.
- Mel Tipton asks that the committee re-focus on any cost differential between private facilities and the current DOC operations.

Meeting adjourned at 1:29 p.m.

Some Commonly Asked Questions About Department of Corrections Substance Abuse Programs

1. Why does DOC provide substance abuse programs in its institutions?

DOC recognizes that approximately 85% of the inmate population has a problem with substance abuse. These inmates are either chemically dependent upon alcohol and other drugs (addicted) or they have a history of abusing alcohol and other drugs. It is DOC's belief, supported by the Alaska Legislature, that it has a responsibility to provide a continuum of care to inmates who are in our custody, so that public safety will be enhanced upon their release to the community.

2. What is the continuum of care and who provides it?

There are four levels of substance abuse programs in DOC's institutions: education, education plus an introduction to treatment, outpatient treatment, and residential treatment.

DOC contracts with state approved community substance abuse treatment providers for the delivery of all of its substance abuse programs. The current providers include: Akeela Treatment Services, Salvation Army Clitheroe Center, Gastineau Human Services, City of Ketchikan Gateway Center for Human Services, Mat-Su Council, Northern Lights Recovery Center, and the Regional Center for Alcoholism and Drug Abuse (FNA). The contracts are amended yearly for up to three years. Every three years a formal bidding process occurs for these services.

3. Does DOC provide treatment beds in the community?

DOC provides twenty-seven residential treatment beds in eight state approved substance abuse treatment agencies in Alaska. The beds provide services to twenty-two furloughees and five probationers/parolees. The Division of Alcoholism and Drug Abuse receives the funding for these treatment slots from the Legislature.

4. Are inmates required to enroll in substance abuse programs if their crimes are related to substance abuse?

The Inmate Substance Abuse Treatment Programs are voluntary; however, many inmates are Court ordered into substance abuse treatment while they are incarcerated. If they refuse to participate, they can lose good time as well as furlough eligibility, and they may even have their probation revoked. The purpose for Court ordered treatment during incarceration is to reduce the risk of new substance abuse related crimes and victims in the community when the offender is released.

5. Does substance abuse treatment in inmate programs "count", or do offenders have to start all over in treatment when they are released to the community?

Substance abuse treatment in Alaska's prisons does "count". All of DOC's substance abuse programs are state approved. An inmate on probation/parole may need to be reassessed for treatment upon release. During the assessment credit is given for the inmate program participation. The discharge summary from the inmate program is a part

of the collateral information obtained for the community assessment. For many individuals who have completed treatment behind bars, the next step is aftercare in the community. (They do not start from scratch.)

6. Are DOC's substance abuse treatment programs culturally relevant to Alaska Natives?

DOC is making the effort to attract Alaska Natives to the Inmate Substance Abuse Program by presenting topics relevant to the Native culture. Especially in rural areas, DOC encourages the hiring of Native counselors whenever possible. If they are not certified at level II at the time of hiring, they may be allowed to achieve this requirement while performing as the Inmate Substance Abuse Program Counselor if they already have sufficient experience. Native counselors are valuable role models for our high percentage of Native offenders.

7. Do the Alaska prisoners who are sent to Arizona have a substance abuse treatment program similar to those found in Alaska's prisons? Who provides it?

The Corrections Corporation of America has as a part of their contract with the Alaska DOC, the provision of substance abuse treatment services for Alaska inmates housed at the Central Arizona Detention Center. They are currently providing a day treatment level of care to inmates in two separate pods or living areas. The treatment staff in Arizona have been equipped with materials to enhance substance abuse treatment for Alaska Natives.

Highlights of the CASA Report
"Behind Bars; Substance Abuse and America's Prison Population"

- Drugs or alcohol and sometimes both played a role in the crimes of 80% of the country's 1.7 million inmates.
- While the number of inmates needing treatment rose 5% between '95 and '96, those receiving treatment declined by 11%.
- 80 percent of the men and women behind bars--some 1.4 million individuals--are seriously involved with drug and alcohol abuse and the crime it spawns (1).
- 81 percent of state inmates, 80 percent of federal inmates, and 77 percent of local jail inmates have:
 - Used an illegal drug regularly
 - Been incarcerated for drug selling or possession, driving under the influence of alcohol or another alcohol abuse violation
 - Were under the influence of alcohol or drugs when they committed their crime
 - Committed their offense to get money for drugs
 - Have a history of alcohol abuse (1-2)
- Inmates who are alcohol and drug abusers and addicts are the most likely to be reincarcerated-again and again (3).
- Many of today's prisoners can be rehabilitated with appropriate treatment for substance abuse and addiction, and continuing aftercare once they leave prison (3).
- Substance use is tightly associated with recidivism. The more prior convictions an individual has, the more likely that individual is a drug abuser (4).
- Alcohol is more closely associated with crimes of violence than any other drug (4).
 - One-fifth (21 percent) of state prison inmates incarcerated for violent crimes were under the influence of alcohol--and no other substance--when they committed their crime (5).
- In state and federal prisons, the gap between available substance abuse treatment--and inmate participation--and the need for such treatment and participation is enormous and widening (5).
- In 1996, 70-85% of state inmates needed some level of substance abuse treatment, but only 13% were receiving such treatment (5).
- As the number of inmates in need of treatment has risen in tandem with the prison population, the proportion receiving treatment has declined (5).
- Well-designed prison-based treatment can reduce post-release criminality and drug and alcohol relapse, especially when combined with pre-release training and planning and community-based aftercare services, including assistance with housing, education, employment, and health care (6).
- Most inmates who are drug and alcohol addicts and abusers also need medical care, psychiatric help, and literacy and job training. Without help in prison acquiring these skills, once released these inmates have little chance of resisting a return to lives of drug and alcohol abuse and crime (7).
- Issues for substance-abusing inmates (7)
 - 15-20% have a history of physical/sexual abuse
 - 61% in state prisons did not complete high school
 - 36% in state prisons were unemployed in the month preceding their offense
- Issues for drug and alcohol-abusing female inmates (8):
 - More likely than male inmates to have suffered from physical and sexual abuse
 - More than two-fifths of substance-involved women in state prison and local jails have been victims of such abuse.
- Children of Substance-involved inmates are at high risk for addiction and incarceration (8).
- Prevention is the first line of defense against drug-and alcohol-related crime.
 - Giving youth the will and skill to say no are critical to keeping them out of the criminal justice system (9).



International Community Corrections Association

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of Canada Liaison
James Murphy
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FOR IMMEDIATE RELEASE

PRESS RELEASE

February 17, 1998

FOR FURTHER INFORMATION CONTACT

Carl Wickland, Executive Director, APPA (606) 244-8216; or
Peter Kinziger, Executive Director, ICCA (608) 785-0200

THE AMERICAN PROBATION AND PAROLE ASSOCIATION (APPA) AND THE INTERNATIONAL COMMUNITY CORRECTIONS ASSOCIATION (ICCA) CALL FOR INCREASED USE OF TRANSITIONAL AND COMMUNITY-BASED ALCOHOL AND OTHER DRUG TREATMENT SERVICES

Mario A. Paparozzi, Ph.D., President of the American Probation and Parole Association and Richard J. Billak, Ph.D., President of the International Community Corrections Association, said that, "the recent report by Columbia University, Behind Bars: Substance Abuse and America's Prison Population, does not go far enough and place sufficient weight on recommending that community resources be provided in the form of treatment and aftercare programs and services."

The two prestigious community correction organizations commended Columbia University's National Center on Addiction and Substance Abuse (CASA) for the timeliness and subject content of the three-year study, especially the area that calls for the elimination of mandatory sentences. They agree that judges and prosecutors need the flexibility to divert substance-abusing offenders into treatment, drug courts, coerced abstinence or other alternatives to prison when appropriate but said that, "the report's recommendations and conclusions did not place enough emphasis on the extreme importance of post-release treatment services within the community."

*Dedicated to Promoting and Enhancing Community Corrections
Formerly International Association of Residential & Community Alternatives*



International Community Corrections Association

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"The ICCA and the APPA have focused considerable attention on the international research and empirical data supporting the increased use of community resources to augment any prison-based programming. For the past three years our annual conferences and publications have focused extensively on this issue. Without the essential components of effective community-based transitional and aftercare services, the full potential of institutionally delivered substance abuse treatment and the goal of community safety and justice, will not be realized", said Paparozzi and Billak.

*Dedicated to Promoting and Enhancing Community Corrections
Formerly International Association of Residential & Community Alternatives*

PRESS RELEASE

FOR IMMEDIATE RELEASE:

10 AM January 8, 1998

Contact: Alyse Booth
(212) 841-5260 or Bob
Neuman (202) 628-2075

Website
<http://www.casacolumbia.org>

CASA* STUDY SHOWS ALCOHOL AND DRUGS IMPLICATED IN THE CRIMES AND INCARCERATION OF 80% OF MEN AND WOMEN IN PRISON

Taxpayers Spent \$30 Billion in 1996 to Incarcerate Inmates for Drug- and Alcohol-Involved Crimes

Califano calls for Second Front in War on Crime--In Our Prisons

Drug and Alcohol Treatment in Prison Will Save Billions of Dollars and Significantly Reduce Crime

Behind Bars: Substance Abuse and America's Prison Population, a 281-page report released today by The National Center on Addiction and Substance Abuse at Columbia University (CASA), shows that the explosion in America's prison population---between 1980 and 1996, the number of inmates in state, federal and local prisons tripled, from 500,000 to 1.7 million--is due overwhelmingly to criminal activity linked to drug and alcohol abuse. The study reveals that drug and alcohol abuse and addiction are implicated in the incarceration of 80%--1.4 million--of the 1.7 million men and women behind bars today. Among the 1.4 million substance-involved inmates are parents of 2.4 million children, many of them minors.

The report, the culmination of three years work, finds that in 1996 \$30 billion of taxpayer dollars were spent to incarcerate individuals who have a history of drug or alcohol abuse and addiction or are serving time for drug- or alcohol-related crimes and that alcohol is more closely associated with violent crime than any illegal drug.

"This report is a call to open in the nation's prisons a second front in the war on crime," said Joseph A. Califano, Jr., CASA president and former Secretary of Health, Education and Welfare. "It is a call for a revolution in how we view those offenders whose core problem is alcohol

* The National Center on Addiction and Substance Abuse at Columbia University is neither affiliated with, nor sponsored by, the National Court Appointed Special Advocate Association (also known as "CASA") or any of its member organizations, or any other organization with the name of "CASA"

Prison Study, p. 2

and drug abuse--a call to identify them, assess their treatment and training needs, separate them from criminal incorrigibles and give them the hand up they need to become productive citizens and responsible parents. If we answer that call, we will save billions of dollars, reduce crime, and reclaim thousands of individuals to live as responsible parents, hard workers, taxpayers and law-abiding citizens. The choice is ours as well as theirs," he said.

Behind Bars describes how substance abuse and addiction has shaped the criminal histories of 80% of prisoners today: 81% of the 1,076, 625 state inmates, 80% of the 105,544 federal inmates and 77% of the 518,492 local jail inmates¹ violated drug or alcohol laws, were high at the time they committed their crimes, stole property to buy drugs, or have a history of drug and alcohol abuse and addiction--or share some combination of these characteristics.

Currently, one of every 144 American adults is behind bars for a crime in which drugs or alcohol is involved. One out of every 60 men is currently incarcerated; one out of every 14 black men and one out of every 34 Hispanic men. If rates of incarceration continue to rise at their current pace, one in every 20 Americans born in 1937-- one in every 11 men and one in every four black men-- will serve time in prison during their lifetime.

"The case for change, revealed in the report, is urgent and overwhelming. Reducing alcohol and drug abuse and addiction is the key to the next major reduction in crime and the prison population provides an enormous missed opportunity," said Califano.

"Failure to use the criminal justice system to get non-violent drug- and alcohol-abusing offenders into treatment and training is irrational public policy and a profligate use of public funds. Releasing drug- and alcohol-abusing and addicted inmates without treating them is tantamount to visiting criminals on society. Releasing drug-addicted inmates without treatment helps maintain the market for illegal drugs and support drug dealers," added Califano.

Behind Bars is the most comprehensive analysis ever undertaken of the relationship of drug and alcohol abuse and addiction to the character and size of America's prison population. For three years, CASA has examined all available data on the people in prison including the U.S. Department of Justice surveys of inmates, surveyed and interviewed state and federal corrections officials, prosecutors and law enforcement officers, tested programs for substance-abusing offenders and reviewed relevant studies and literature.

The CASA study documents the shattering impact of substance abuse on America's correctional systems:

- By the year 2000 if current trends continue, the nation will break the \$100 million-dollar-a-day barrier in spending to incarcerate individuals with serious drug and alcohol problems.

¹ Local jails generally house individuals convicted of misdemeanors and sentenced to less than one year in prison and individuals who are awaiting trial.

Prison Study, p. 3

- Between 1980 and 1996, the number of men in prison increased 229% from 477,706 to 1,570,231; the number of women increased 439% from 24,180 to 130,430.
- Between 1995 and 1996, state corrections budgets jumped 28%, the most rapidly growing expense for all states.
- Inmates who are alcohol and drug abusers and addicts are the most likely to be reincarcerated--again and again--and length of sentences increase for repeat offenders.
- The number one substance abuse crime in America is drunk driving, accounting for 1.4 million arrests in 1995 at a cost of \$5.2 billion for arrests and prosecutions.
- 81% of individuals selling drugs test positive at the time of arrest, including 56% for cocaine and 13% for heroin.
- Incidence of new AIDS cases among state and federal inmates in 1994 was 17 times higher than among the general population and most of these cases are drug related.

The explosion of the inmate population over the last sixteen years is largely attributable to drug law violations:

- From 1980 to 1995, drug law violators accounted for 30% of the increase in the state prison population and 68% of the increase in the federal prison population, making drug law violators by far the largest group of federal inmates.
- Arrests for drug law violations grew at more than 10 times the rate of property crime arrests and more than twice the rate of violent crime arrests.

Recidivism and Substance Abuse: Joined at the Hip

The report found that inmates who are alcohol and drug abusers and addicts are the most likely to be reincarcerated repeatedly:

- The more prior convictions an individual has, the more likely he is a drug abuser. In state prisons, 41% of first offenders have used drugs regularly compared to 63% of inmates with two prior convictions and 81% of inmates with five or more prior convictions.
- 50% of state parole and probation violators were under the influence of drugs, alcohol or both when they committed their new offense.
- State prison inmates with five or more prior convictions are three times likelier than first-time offenders to be regular crack users.

Alcohol: The First Cousin of Violent Crime

Alcohol is more closely associated with crimes of violence than any other drug. It is a bigger culprit in connection with murder, rape, assault and child and spouse abuse than any illegal drug:

Prison Study, p. 4

- 21% of state inmates incarcerated for violent crimes were under the influence of alcohol (and no other substance) when they committed their crime compared with 3% under the influence of cocaine or crack alone and 1% under the influence of heroin alone.
- Violent crimes among jail inmates are also more closely linked to alcohol than to any other drug, with 26% of violent offenders under the influence of alcohol alone at the time of their crime, versus 4% under the influence of crack or cocaine alone and none under the influence of heroin.

It Runs in the Family

The CASA study also examines the common characteristics and histories of substance-involved offenders. Regular drug users are twice as likely to have parents who abused drugs and alcohol than inmates who are not regular drug users. They are also likelier than the general inmate population to have a family member who served prison time.

- 15% in state prison and 20% in jail have been physically and sexually abused.
- More than 40% of female state and local inmates have been victims of physical and sexual abuse.

The Treatment Gap: Need vs. Availability and Participation

The report concludes that in state and federal prisons, the gap between available substance abuse treatment – and inmate participation – and the need for such treatment is enormous and widening. State officials estimate that 70 to 85% of inmates need some level of substance abuse treatment. But in 1996, only 13% of state inmates were in any treatment.

As the number of inmates in need of treatment has risen, the proportion receiving it has declined. CASA estimates that states spend an average of 5% of their annual prison budgets on drug and alcohol treatment. In 1997, the Federal Bureau of Prisons spent \$25 million--0.9% of the federal prison budget on drug treatment. In 1996, there were 840,000 state and federal inmates in need of treatment and about 150,000 inmates actually received treatment, and much of that treatment was inadequate. From 1995 to 1996, the number of inmates in treatment decreased by 18,360 as inmates in need of treatment rose by 39,578.

The study suggests that many prisoners can be rehabilitated with well-designed prison based treatment programs and literacy training, combined with prerelease planning and community-based aftercare services, including assistance with housing, education, employment and medical care. Residential prison treatment combined with appropriate aftercare can reduce relapse and recidivism.

Prison Study, p. 5

Missed Opportunity: Reducing Crime and Costs to Taxpayers

In examining the increasing cost of incarcerating prisoners, CASA found that 80% or \$30 billion of the \$38 billion dollars spent in 1996 to build and operate the nation's prisons and jails is spent to incarcerate substance-involved offenders.

The CASA study estimates that it would take approximately \$6,500 per year, in addition to usual incarceration costs, to provide an inmate with residential treatment in prison and include vocational and educational training, psychological services and aftercare case management. For each offender who successfully completes treatment and returns to the community as a sober citizen with a job, it is estimated that an economic benefit of \$68,800, in reduced crime, arrest, prosecution and incarceration costs, health care savings and potential earnings, will accrue during the first year after release.

There are 1.2 million inmates who are drug and alcohol abusers and addicts (the other 200,000 of the substance-involved inmates are dealers who do not use drugs). If only 10% of those inmates--120,000--are successfully treated and trained, the economic benefit in the first year of work after release would be \$8.6 billion. That is a surplus of \$456 million over the \$7.8 billion treatment and training costs for all 1.2 million inmates. Thereafter, the economic benefit would be more than \$8 billion each year.

The Second Front in the War on Crime

To open a second front in the war on crime, the CASA report sets out a plan of action to cut taxpayer costs and reduce recidivism, including:

Research:

- A major investment in research to improve the cost-effectiveness of treatment

Pre-Prison:

- Assess the substance abuse involvement of potential inmates at the time of arrest.
- Provide police, prosecutors and judges with flexibility so that non-violent offenders who are addicted to alcohol and drugs can be diverted from prison into treatment, drug courts, coerced abstinence or other programs.
- Get rid of mandatory sentences for nonviolent offenders with no chance of parole.

Prison:

- Train correction officers to better prevent the use of alcohol and drugs in prison and assist inmates with recovery
- Expand random drug testing of prisoners and keep jails and prisons alcohol and drug free, employing sanctions against inmates caught abusing these substances.

Prison Study, p. 6

- Provide treatment in prison to all who need it and give incentives (reduced prison time) to inmates who successfully complete treatment.
- Increase the availability of religious and spiritual activity and counseling and provide an environment that encourages such activity.

Post-Prison:

- Provide pre-release planning for treatment and aftercare services for parolees who need them.
- Provide job placement services for inmates upon release.
- Train parole and probation officers to deal with alcohol and drug abuse and assist parolees with finding services they need to remain clean once they leave prison, such as drug-free housing, literacy training and social services.

The National Center on Addiction and Substance Abuse at Columbia University is the only national organization that brings together under one roof all the professional disciplines needed to study and combat all types of substance abuse as they affect all aspects of society. CASA's missions are to: inform Americans of the economic and social costs of substance abuse and its impact on their lives; assess what works best in prevention, treatment and law enforcement; encourage every individual and institution to take responsibility to combat substance abuse and addiction; provide those on the front lines with tools they need to succeed; and remove the stigma of substance abuse and replace shame and despair with hope.

###

**COMMUNITY RESIDENTIAL SUBSTANCE ABUSE
TREATMENT BEDS FOR DOC CLIENTS
FY'99**

Treatment Beds	Furloughees	Probationers/Parolees
Clitheroe Center (Anchorage)	11	2
ANARC (Anchorage)	2	0
Akeela House (Anchorage)	4	0
Gastineau House (Juneau)	0	2
RCAOA (Fairbanks)	2	1
Maniilaq (Kotzebue)	1	0
Hope House (Kodiak)	1	0
PATC (Bethel)	1	0
Total Beds	22	5

Rev: 9/99

Recommendations for Trust Beneficiaries in DOC: Six Guiding Principles

- ⦿ Prevent Trust Beneficiaries from Entering the Criminal Justice System.
- ⦿ Provide Appropriate and Effective Treatment for Trust beneficiaries in Department of Corrections.
- ⦿ Program Effectiveness and Management Information Systems.
- ⦿ Planning and Research.
- ⦿ Partnerships.
- ⦿ Training and Education.
- * *Only the second and fourth guiding principles are reviewed in this presentation.*



Data Highlights

Trust Beneficiary DOC Needs Assessment Snapshot Data:

- 29% (883) of the inmates in correctional facilities are mentally ill on a given day.
12% (373) of the inmates in correctional facilities are severely mentally ill.
- 8% (258) of the inmates in correctional facilities are chronic alcoholics with psychosis on a given day.
- There are 12 developmentally disabled inmates in DOC institutions on a given day.
- On the day the Needs Assessment was conducted researchers found another 1,219 inmates who had indicators of significant alcohol and drug involvement.



Data Highlights

Fiscal Year 1997 DOC Service Data:

- 1,988 unduplicated inmates treated by DOC mental health staff.
- Up to 77% of the inmates treated by DOC mental health staff had co-occurring substance abuse disorders.
- Duplicated ISAT data shows that ISAT counselors: conducted 1,577 clinical assessments, admitted 1,681 inmates to substance abuse education and 807 inmates to institutional outpatient treatment.
- In Fiscal Year 1997, there were 2,585 Title 47 non-criminal holds statewide.



CULTURE DIVERSITY SERVICES FOR ISAT

TRAINING AGENDA

DAY 1

1998

- 0830-0900 Registration & Coffee
 0900-0915 Opening Remarks
 Speakers: Jim LaBelle, Project Manager, DOC
 Sarah Williams, Project Coordinator, ISAT, DOC
 John Baertschy, Ph.D., Director, Interior & Northern Regional Tng. Ofc.
 0915-1000 Exercise [2] Open Format Talking Circles @ 18 Students per circle
 Topic: "Hopes & Fears of Diversity Training Next Three Days"
 1000-1015 Break
 1015-1030 Exercise: Conduct a "Culture Diversity Questionnaire" Discuss results
 In Pairs Dyadic Format then process in group.
 1030-1100 Lecture: "Introduction to the [10] element Generic Model of Multi-Cultural
 Understanding". "Self-Awareness & Dominant Culture Worldviews"
 Speaker: John Baertschy, Ph.D., Clinical Sociologist
 1100-1200 Lecture: "Alaskan Native & Native American Model of Multi-Cultural
 Understanding - [10] Elements".
 Speaker: "Cookie" Rose, Yupik Consultant or T.B.A.
 1200-0100 Lunch
 0100-0150 Audiocassette: Harold Napoleons' Statewide Interview on Book: Yuuyaraq: The Way
 Of The Human Being.
 0200-0240 Exercise: Divide Into Four Groups @ [9] students each and discuss Yuuyaraq
 Tasks: Identify main themes of book, How can concepts be integrated
 into DOC ISAT Counseling awareness and discuss concepts of PTSD
 and loss of identity and spirituality.
 0240-0300 Exercise: Report Out on Products of above exercise to entire class.
 0300-0315 Break
 0315-0400 Lecture: "Historical Influences on Alaska Native People and Process
 Of Deculturation".
 Speaker: "Cookie" Rose, Yupik Consultant or TBA
 0400-0500 Video: "Tanana River Rat" & Discussion

DAY 2

1998

- 0900-0930 Video: "Inter-Ethnic Communication". Ron Scollon UAA Language Center KUAC TV
 0930-1000 Lecture: "Communication Patterns Between Natives & Non Natives Gatekeeping
 Gateopening".
 Speaker: John Baertschy, Ph.D., Clinical Sociologist/Regional Trainer
 1000-1015 Break
 1015-1045 Lecture: "The Culturally Skilled Counselor: Four Conditions Process/Goals"
 Speaker: John Baertschy, Ph.D., Clinical Sociologist
 1045-1200 Lecture: "Barriers to Effective Cross-Cultural Counseling" & "Intake/Assessment"
 Speaker: Dean Zuelsdorf, Psy.D., Clinical Psychologist Private Practice
 Proposed or TBA
 1200-0100 Lunch
 0100-0200 Lecture: "Counseling the Post Traumatic Stress Disordered Alaskan
 Native and Clinical Understanding/Interventions".
 Speaker: Dean Zuelsdorf, Psy.D., Clinical Psychologist Proposed or TBA
 0200-0300 Video: "Healing The Hurts"., Canadian film on PTSD Boarding Schools
 0300-0315 Film Discussion
 0315-0330 Break
 0330-0500 Lecture: "Justice, Law Enforcement Alternative Sentencing & Healing
 and Alaska Native Commission Report"
 Speaker: Rupert Ross Canadian Attorney or Criminal Justice Professor
 University of Alaska, Fairbanks or Anchorage Proposed or TBA

CULTURE DIVERSITY SERVICES FOR ISAT

TRAINING AGENDA

DAY 3

1998

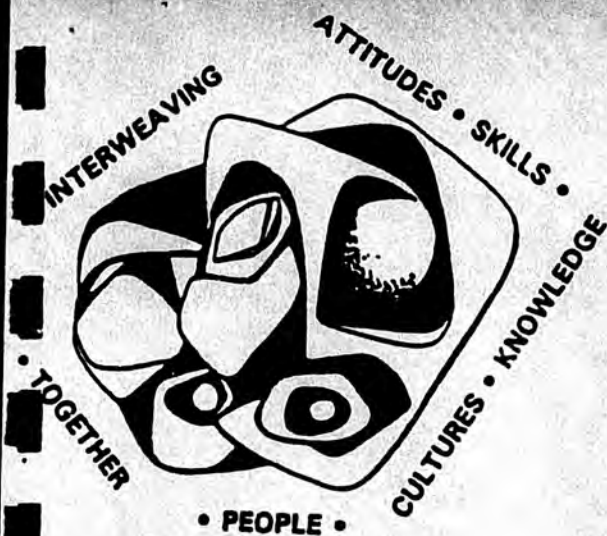
- 0900-0950 Lecture: "Public Health Concerns Related To Substance Abuse: AIDS/FAS/FAE Sexual Abuse & Domestic Violence"
Speaker: ADA Health Facility Surveyor TBA Proposed.
- 0950-1000 Break
- 1000-1050 Lecture: "Model Programs in Rural Alaska the Old Minto Family Recovery Camp TCC and Graf Healing Center Integrating Spirituality, Subsistence and Native Identity into Treatment Programming".
Video: "The Healing Place Fort Yukon Spirit Camp"
Speaker: Victor Joseph, Director Old Minto Family Recovery Camp TCC Proposed Or TBA Native Speaker
- 1100-1200 Lecture: "The Role of Elders In Native Communities & Reentry Issues for DOC Clients Returning to Village Life".
Speaker: Oscar Kavagley, Proposed Native Author UAF Professor
- 1200-0100 Lunch
- 0100-0200 Lecture: "Clinical Issues Differences & Similarities Between Alaska Native and Western Counseling Skills".
Speaker: Peter Baertschy, M.S.W., Director, FNA/TCC Graf Healing Center Proposed or TBA Clinician from Anchorage area.
Video: "Traditional Counseling Interview" Elder to Native Client Film
Video: "Profiles In Spirit" Barrow film
- 0230-0245 Break
- 0245-0500 Lecture: "Special Case Management Issues in Rural Alaska for ISAT Counselors Returning to Villages DOC Clients".
Issues: Relapse Prevention, Re-Entry, Developing Support Systems Dependency Issues, Coerced Sobriety and Relapse Cue Extinction Tools, Cultural Relevance Issues.
Video: "Profiles In Spirit" Barrow film
Speaker: TBA Clinician
- 0500 Post Course Evaluation & Adjournment

Notation: Vendor proposes that two textbooks be purchased and pre-mailed to all students prior to training:

1. Yuuyaraq: The Way Of The Human Being., Harold Napoleon
2. Returning To The Teachings: Exploring Aboriginal Justice., Rupert Ross

Recommended Additional Readings:

1. Dancing With A Ghost: Exploring Indian Reality., Rupert Ross



**INTERIOR & NORTHERN REGIONAL TRAINING OFFICE
REGIONAL CENTER FOR ALCOHOL & OTHER ADDICTIONS
FAIRBANKS NATIVE ASSOCIATION**

201 1ST AVE., 2ND FLOOR
FAIRBANKS, AK 99701
TELEPHONE: (907) 452-1648

February 19, 1998

**TO: ACCDPC[ALASKA COMMISSION FOR CHEMICAL DEPENDENCY
PROFESSIONALS CERTIFICATION]
JIM LABELLE, PROJECT MANAGER, DEPT. OF CORRECTIONS**

COURSE SYLLABUS:

**SUBMITTED BY: JOHN BAERTSCHY, PH.D., DIRECTOR
INTERIOR & NORTHERN REGIONAL TRAINING OFFICE**

COURSE TITLE: CULTURE DIVERSITY SERVICES FOR ISAT PROFESSIONALS

COURSE NUMBER: 250

DEPARTMENT: HST[HUMAN SERVICES TECHNOLOGY]

TRIAL: TRIAL COURSE FIELD TEST

LOCATION: ANCHORAGE, ALASKA

CREDITS: [01] PROPOSED OPTION FOR ACADEMIC CREDIT THROUGH UA-FAIRBANKS

SCHEDULED DATES: APRIL 19-17, 1998 0900-0500 PM

**GRADING POLICY: [OPTIONAL] LETTER GRADE POST TEST 50%
CLASS PARTICIPATION 50%**

1.0 COURSE DESCRIPTION:

The primary purpose of this course is to increase a greater awareness and enhancement of multicultural relevance in delivery of chemical dependency services to Alaskan Native Inmates to include awareness of attitudes, values, skills and knowledge of the diverse impact of delivering those services to Native People. A ten element of a multicultural model will be introduced generically and then specific issues for Native Americans will be discussed to include: acculturation, poverty and economic concerns, history of oppression, language and arts, racism and prejudice, sociopolitical factors, child rearing practices, religious practices, family structure and dynamics and lastly cultural values and attitudes. After this conceptual overlay, the elements of the "Culturally Skilled Counselor" will be introduced for the culturally different client and four conditions of exposure: appropriate process, appropriate goals, condition one, appropriate process and inappropriate goals, condition two, inappropriate process and appropriate goals, condition three and worse case scenario, inappropriate process and inappropriate goals. Understanding of the world view of the culturally different client and guidelines for culturally congruent substance abuse services will be delineated. Differences in communication patterns, differences in values and cultural patterns will be highlighted along with specific barriers and gate opening and gate keeping functions of counseling differences between Western and traditional concepts will be addressed, outlined and discussed and exemplified.

2.0 COURSE OBJECTIVES:

SECTION A: MULTICULTURAL MODEL OF UNDERSTANDING

Student will be able to

- 2.1 Identify the [10] elements of multicultural understanding to include: acculturation, poverty, economic concerns, history of oppression, language and arts, racism and prejudice, sociopolitical factors, child rearing practices, religious practices, family structure and dynamics and listly cultural values and attitudes.
- 2.2 Identify those same [10] elements now specific to Native Americans and a delineation of Native values to include: sharing, cooperation, noninterference, time orientation, extended family orientation, harmony with nature, etc and a comparison with Inupiaq values and middle class non native values.
- 2.3 Gain self-awareness of their own values, personal biases and interests through the use of taking a "Cultural Diversity Questionnaire" and sharing the results with a peer student and discussing the instrument.
- 2.4 Gain understanding of how their own values relate to the five components of culture and how they relate to the [14] themes and value orientations of the dominant culture.

SECTION B: COMMUNICATION PATTERNS OF NATIVES AND NON NATIVES

Student will be able to

- 3.1 Understand differences between the communication patterns of Natives and Non Natives.
- 3.2 What's confusing to Natives about Non-Native presentation of self, distribution of talk and contents.
- 3.3 What confusing to English speakers about Native presentation of self, distribution of talk and contents.
- 3.4 Understand Native communication patterns through participation in an open "Talking Circle" exercise and discussion to application in correctional counseling.
- 3.5 Understand a four element Native Generational Diagnosis and Placement and Conflicts Resolution Scale from the Native American Rehabilitation Assoc.

SECTION C: CULTURALLY SKILLED COUNSELING

Student will be able to

- 4.1 Identify relevant processes and goals in cross cultural counseling and identify four possible conditions: Condition I, Appropriate process and appropriate goals, Condition II, Appropriate Process and Inappropriate Goals, Condition III, Inappropriate Process and Appropriate Goals and lastly Condition IV, Inappropriate Process and Inappropriate Goals(worse case senario).
- 4.2 Identify the barriers to effective cross-cultural counseling and sources of conflict and misinterpretation in counseling to include: culture bound values, individual centeredness, verbal-emotional-behavioral expressiveness, insight, self-disclosure, cause effect orientations, distinctions between mental and physical functioning, ambiguity, class bound values, language barriers, and role of stereotypes and some cautions.

2.0 COURSE OBJECTIVES CONTINUED:

SECTION D: PROCESSES OF DECULTURATION

Student will be able to

- 5.1 Identify the historical influences that have influenced Alaska's Native People to include: "The Great Death" flue epidemic, religion and boarding school relocations and missionaries and relocation policies of 1940, Western education, Molly Hootch Schools, Alaska Native Settlement Claims Act of 1971, The "Great Society", Oil Boom, Oil Spill and how this relates to alcohol abuse epidemic, and PTSD[Post Traumatic Stress Syndrome] and the loss of "Indianness" and identify and loss of spirituality and its role to both functional and dysfunctional codependency.

SECTION E: PUBLIC HEALTH CONCERNS & 1994 ALASKA NATIVE COMMISSION REPORT

Student will be able to

- 6.1 Understand alcohol's carnage in the Native community with the epidemiology Native death statistics, Native suicides as an affliction of the young, gender gap, the role of its relationships to FAS/FAE and alcohol and Native sex offenses and a breakdown in parenting roles and how alcohol is related to self-medication, effects on Natives' mental health and spiritual well being, physical well being, effects on functioning communities and the lack of adequate and appropriate treatment factors which need to address unique "binge drinking" and the role of family-clans-tribes in treatment versus the traditional twelve step disease concept of individual treatment.

SECTION F: MODEL PROGRAMS

Student will be able to

- 7.1 Outline the historical development of the "Spirit Camp Movement" in Alaska rural settings within the Tanana Chiefs Conference Region.
- 7.2 Describe the "Model Programs" of the TCC Old Minto Family Recovery Camps and the Graf Adolescent Treatment Program and the role of "Spirituality" working with clients referred from corrections and unique role of aftercare and familial community involvement and how spirituality is integrated into treatment programming.

SECTION G: ROLE OF ELDERS

Student will be able to

- 8.1 Understand historical role of elders in the community as it relates to indigenous healing patterns, role of story telling and how elders can be used in aftercare treatment and unique problems of "re-entry" back into both urban and rural settings in Alaska and what are the views of elders as it relates to substance use and abuse and how elders can play a role in alternative criminal justice programs through "Healing Circles".

2.0 COURSE OBJECTIVES CONTINUED:

SECTION H: JUSTICE, LAW ENFORCEMENT & CORRECTIONS ALASKA NATIVE COMMISSION REPORT

Student will be able to

- 9.1 Understand fundamental values and influences: ethic of truth telling and self disclosure, ethic of non-interference, ethic of non-confrontation.
- 9.1a Unique case management issues of re-entry and relapse prevention-aftercare.
- 9.2 Understand problems related to the Legal System: over-representation of Natives, law enforcement and judiciary and corrections, probation and parole and analysis of problems and probable causes.
- 9.3 Outline issues related to local control, village governance, local ordinances, tribal courts and "alternative punishment" at the village level and recommendations for changes in law enforcement and probation and parole and counseling programs within corrections per the commission report.

3.0 COURSE CONTENT: Reference following agenda covering [21] hours of instruction.

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Special Topics Request Course: (393) Alaska Native Counseling & Culture Specifics
Expanded Course Description: pg. 4

7.0 STUDENT EVALUATIONS:

Final Essay Examinations	200 points
Synopsis Paper	100 points
	300 points total straight scale grading policy

- a. Each student will be required to write a synopsis paper which reflects what they have learned, how they plan to use it and their change in culture awareness as it relates to cross cultural counseling. The paper must be a minimum of five pages or a fifteen minute cassette. It must be submitted NLT October 9, 1987 and will be deducted 10 points for every week submitted past the due date.

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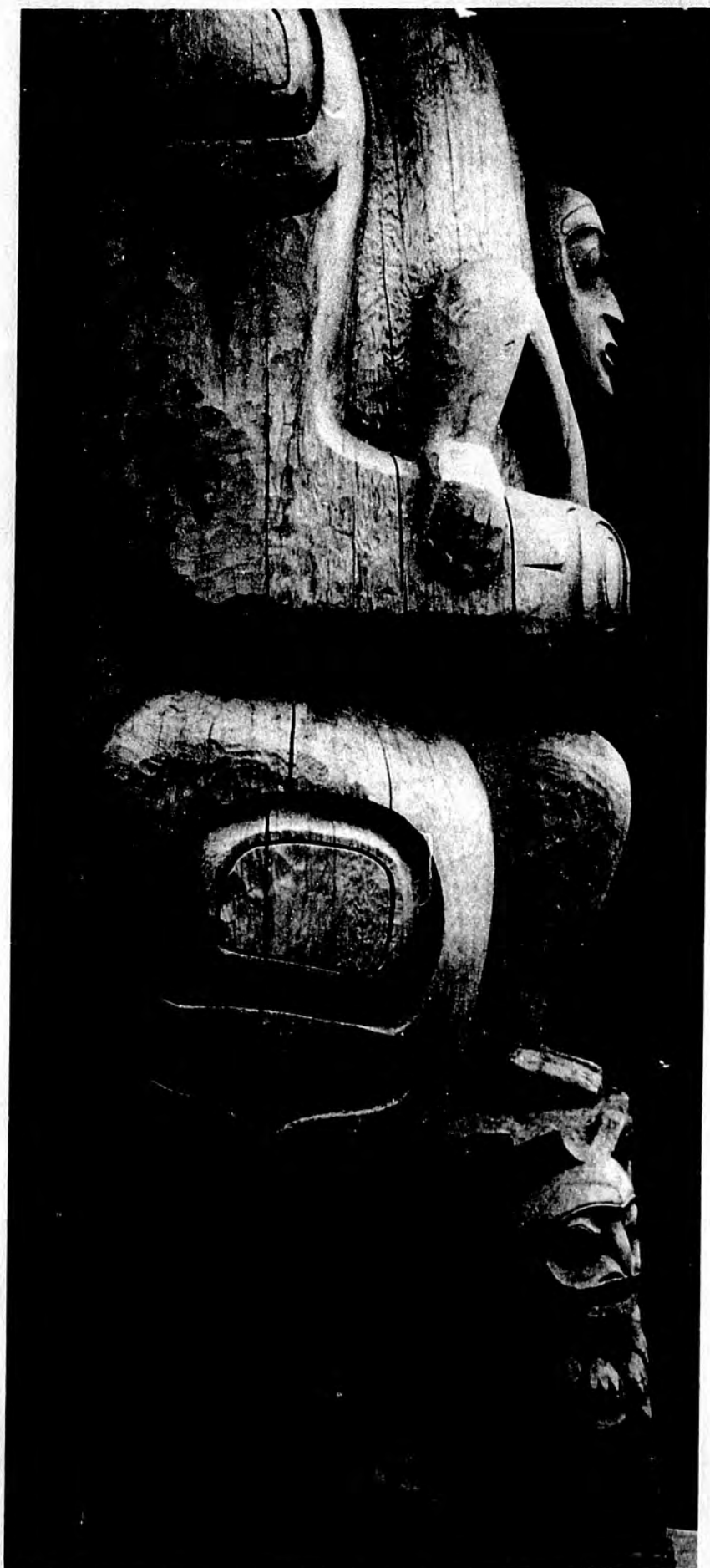
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RESULTS WITHIN OUR REACH

**Alaska
State Plan for
Alcohol and
Drug Abuse
Services**

1999-2003

COVER PHOTO

**WITH THANKS AND GRATEFUL ACKNOWLEDGEMENT TO
STAN MARSDEN AND THE PEOPLE OF CRAIG, ALASKA.**

**THEIR UNIQUE PARTNERSHIP IN CREATING
THE HEALING HEART TOTEM
OFFERS HOPE AND INSPIRATION TO ALL ALASKANS.**

(PHOTO BY ANNE SCHULIZ)

State of Alaska
ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE
240 MAIN STREET, SUITE 101
JUNEAU, AK 99801
907 465-8920 ♦ 888 464-8920



Message from the Chair

DT: January 1999

TO: Fellow Alaskans

FR: Cheryl Mann, Chair
Advisory Board on Alcoholism and Drug Abuse

RE: Partnerships for a Healthy Alaska

There is no greater foundation for the implementation of this new state plan for delivery of alcohol and drug abuse services than partnerships at the local, regional or state level. You will find the creation of partnerships and the nurturing of new coalitions to be a common thread throughout this plan.

One of the enduring values of partnership development is that frequently more intangible resources are required than funding resources. Commitment, time and sharing of leadership are some of the most vital requirements. When Alaskans give freely of these assets, from themselves and their organizations, we will be able to stretch existing resources and focus new resources on our most urgent needs in the most beneficial and cost effective ways.

The Advisory Board can take great pride in its ground-breaking work in establishing treatment outcomes and raising awareness among providers and allied health professionals. Over the next decade we will continue to firmly embrace our mission to significantly reduce the devastating consequences of substance abuse on individual Alaskans, families and communities.

We invite each of you to find ways in which you can be a partner in achieving that desired result. If we can help you to identify other individuals and organizations that share your concerns please be sure to ask for our assistance.

Advisory Board on Alcoholism and Drug Abuse
PO Box 110608
Juneau AK 99811-0608

The Advisory Board's toll free telephone number is 1-888-464-8920. Assistance may also be requested by e.mail to Anne_Schultz@health.state.ak.us

Advisory Board Roster

As of January 1999, the Advisory Board on Alcoholism and Drug Abuse is composed of the following members, appointed by the Governor:

Cheryl Mann, Anchorage CHAIR

Gerry Kasiak, Ketchikan CHAIR-ELECT

Delfin Lopez, Sterling RECORDER-TREASURER

Sebastian Cowboy, St. Marys

C. Joe DiMatteo, Anchorage, appointed December 1998

Donna R. Galbreath, Fairbanks

Alice Johnstone, Sitka

Loren Jones, Juneau

Anne Kinter, Juneau, appointed December 1998

Banarsi Lal, Fairbanks

Henrietta Nugen, Wasilla

Don Peter, Fort Yukon

Valerie M. Therrien, Fairbanks

Eric Tomasino, Palmer

Cristy Willer Tilden, Dillingham

The Advisory Board acknowledges the contributions made to the strategic planning process by members whose terms expired or who moved from Alaska before the plan was completed: Roseanne Turner, Anchorage; and Suzanne Drapeaux, Juneau.

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Mission and Guiding Principles

MISSION

In partnership with the public, the Advisory Board on Alcoholism and Drug Abuse plans and advocates for policies, programs and services that help Alaskans achieve healthy and productive lives, free from the devastating effects of the abuse of alcohol and other substances.



GUIDING PRINCIPLES

The philosophy of the Advisory Board on Alcoholism and Drug Abuse is to create an environment in which individuals can explore and expand their human potential by recognizing that:

1. Alaskans have the right to seek a life free of the devastating effects of alcohol and substance abuse.
2. The fatal diseases of alcoholism and drug addiction are both preventable and treatable.
3. Sobriety is a positive lifestyle choice for Alaskans.
4. Prevention is as important a public health concern as treatment is.
5. Services must respect personal and community needs in a holistic way that acknowledges cultural and gender differences.
6. Rights and dignity of the client must be respected at all times.
7. Best practice standards must be used by those who provide treatment and prevention services.
8. Success will be measured by improvement in health and well-being and by the elimination of substance abuse and the harm it causes.
9. Partnerships between communities, public and private organizations, families and individuals are the key to success in fulfilling our mission.
10. All decisions and actions must focus on positive impacts on future generations.

Executive Summary

Results that will significantly reduce the negative consequences of alcohol use by Alaskans is the focus of **Results Within Our Reach**, the Alaska state plan for alcohol and drug abuse services. The plan covers the years 1999-2003.

A statewide work group with expertise from many disciplines joined the Advisory Board as stakeholders in this planning effort. They brought commitment and urgency to the development of this plan. The group was able to build upon the solid foundation laid in **Meeting the Challenge**, the strategic plan for the Division of Alcoholism and Drug Abuse published in 1994.

This plan reflects the Advisory Board's commitment to results-based service delivery. It incorporates the use of indicators, strategies and performance measures that will help to monitor service delivery effectiveness.

The Advisory Board framed the process by identifying its mission and guiding principles. These emphasize the necessity for public awareness of the scope of the problem, a broad range of partnerships and personal responsibility. To ascertain attitudes of key informants throughout the state, the Advisory Board asked more than 1,000 stakeholders to indicate their level of agreement with statements about alcohol and drug abuse issues. More than fifty percent responded, with remarkably favorable levels of agreement. The Board is confident that this plan is well grounded and reflects community awareness of the scope of the problem it seeks to remedy.

This plan focuses on the overarching result desired for all Alaskans: that they live free from the negative consequences of alcohol and other drug use. It identifies six indicators that will be used to track progress over the coming years. Each is supported by sufficient data collection to calculate trends over time. The Advisory Board looked to staff of the Division of Alcoholism and Drug Abuse for the collaborative development of strategies and performance measures with which to implement the plan. Public testimony was solicited. Eighteen strategies emerged, each with a set of performance measures. The strategies recognize the essential role partnerships play in changing attitudes, behaviors, and community norms. The strategies identify special populations that require greater service capacity, accessibility and intensity. A specific strategy addresses the needs of chronic alcoholics with psychosis, who are beneficiaries of the Alaska Mental Health Trust.

In order to walk the walk that is talked about in the plan, continuous attention must be paid to data development. The Data Agenda section gives a comprehensive review of the benefits and constraints of data collection and spells out the additional

data that will be required in the future. This ongoing data collection effort is imperative if the plan is to achieve its desired level of accountability.

The prevention and treatment strategies identified in the plan will be implemented by the Division of Alcoholism and Drug Abuse, which has responsibility for managing service delivery in Alaska. The Division's Request for Proposals (RFP) process will incorporate strategies implementation into funding allocation decisions. Successful grantees will develop proposals that reflect the Division's guidelines and this plan.

Both the Advisory Board and the Division will work assertively to ensure wide distribution of the plan during the coming months.

The Division will monitor performance measures to assess the level, quality and effectiveness of effort. Over the next several years the Division and the Board will be able to ascertain the effectiveness of selected strategies. This monitoring will guide course corrections during the updating of the plan as the year 2003 approaches.

Each year the Advisory Board will collect the required indicator data to determine the extent to which the strategies have influenced desired results. The Board undertakes this process being mindful that it will be necessary to view data over time before definitively assessing effectiveness over the long term.

The Advisory Board will work with the Department of Health and Social Services, Alaska Mental Health Trust Authority and the Trust's other beneficiary advocacy boards to ensure an effective integration of this plan into the Comprehensive Integrated Mental Health Plan for the state.

Background

Strategic planning is an ongoing process. Each phase builds on previous work and lays the foundation for future planning efforts. In 1994, the Alaska Division of Alcoholism and Drug Abuse published a comprehensive strategic plan, Meeting the Challenge: A Strategic Plan for the Division of Alcoholism and Drug Abuse. This plan identified trends in the external environment as well as goals and strategies for the Division in the 1990s.

The 1994 plan focused on four major trends that would affect the Division and service delivery through the end of the decade.

- Level and extent of alcohol, other drug, and inhalant abuse in Alaska;
- Special needs and barriers for specific populations such as rural residents, pregnant women, persons with co-existing mental illness, and women with dependent children;
- Funding sources and restrictions; and
- Increased emphasis on service delivery outcomes.

A series of strategies and goals were developed to address the needs of Alaskans within the context of these trends. As predicted, these trends have played a major role in program development and service delivery in the latter part of the decade. Furthermore, these factors are predicted to play an even greater role in the future.

Of the four major trends, the emphasis on outcomes is a pivotal factor in both program development and funding allocation. In 1996, the Division of Alcoholism and Drug Abuse and the Advisory Board on Alcoholism and Drug Abuse brought together a workgroup to identify desired outcomes for both treatment and prevention efforts. In the Request For Proposals (RFP) issued in 1997, the Division mandated the use of outcome targets along with more traditional process measures. To support this move, standardized outcome measures were developed. They are currently being incorporated into the Division's management information system (MIS).

In 1994, the Mental Health Lands Trust claims were settled after years of litigation. The Alaska Mental Health Trust Authority was formed. Its Trustees are charged by statute with managing the assets of the Trust, and providing resources for services to beneficiaries. Trust beneficiaries are defined as Alaskans who experience one or more of the following:

- a mental illness;
- mental retardation or similar disability;
- Alzheimer's disease or related dementia;
- chronic alcoholism with psychosis.

Four boards are responsible for addressing the needs of these beneficiary groups: the **Alaska Mental Health Board**, the **Governor's Council on Disabilities and Special Education**, the **Alaska Commission on Aging** and the **Advisory Board on Alcoholism and Drug Abuse**.

The Advisory Board on Alcoholism and Drug Abuse plans and advocates for the needs of chronic alcoholics with psychosis. It also plans and advocates for substance abuse service needs of all Alaskans. To fulfill these responsibilities, the Advisory Board has completed this 12-month strategic planning effort. Many Alaskans have made valuable contributions to the process.

First, the Board invited a group of 25 Alaskans with special interest and expertise in substance abuse issues to participate in the Strategic Planning Work Group. They met initially in September 1997 for orientation to the Advisory Board's guiding principles and mission, and to become acquainted with the results-based model developed by Mark Friedman. Mr. Friedman is a policy consultant to the Alaska Legislature, the Office of Management and Budget, and the Alaska Mental Health Trust Authority. The work group participants are gratefully acknowledged in Appendix A.

To test the assumptions on which to base the revised plan, the Advisory Board sent a fifteen-question survey to more than 1,000 key informants throughout the state. With a response rate of 51%, the results indicated an overwhelming sense that substance abuse, particularly alcoholism, is the most pressing health problem in the state.

The Work Group formed three teams: the Results Team, the Indicators Team, and the Strategies and Performance Measures Team. Over a seven-month period, the teams developed a set of desired results and indicators, each team building on the work of the previous group. In July 1998, the full Advisory Board, Division of Alcoholism and Drug Abuse staff, and other key stakeholders jointly developed strategies and performance measures.

In this manner, the desired results, indicators of their achievement, strategies for success and performance measures were identified. With these key elements in place, sources of reliable data were examined and baseline data collection began. The draft plan was reviewed by the original Work Group in September 1998. Public testimony and comment were received in November and December 1998. This final document reflects the Advisory Board's plan based on those thoughtful and collaborative efforts.

About this plan...

This strategic plan will serve a number of purposes over the next four years. Most importantly, it will guide the Advisory Board and the Division in planning efforts to eliminate the negative consequences of alcohol and other drug use. It is the framework for continuing assessment of service needs throughout Alaska. It will help track the extent and quality of our efforts. Finally, it offers strategies that encourage stakeholders, clients, and communities to address issues forthrightly in ways that will achieve and sustain local benefits.

This plan is organized in the following manner:

The Model. The model was developed by Mark Friedman, of the Fiscal Policy Institute, Baltimore, Maryland. One of the compelling reasons for using this model is that it is also being used by other State agencies and the Legislature as a method for developing budgets and programs based on desired results.

Results and Indicators. Desired results are in this section. The indicators will measure progress toward achieving these results. Each indicator includes a graphic representation of recent trends and the source of the data used to create the chart or graph.

Strategies and Performance Measures. The strategies that have been selected to move us toward desired results are in this section. Each strategy includes a series of performance measures that will help chart progress.

Data Agenda. Some valuable data are not available. The data agenda identifies desirable data that support existing indicators and data that would support other potentially advantageous indicators.

Implementation. This section identifies the four distinct implementation efforts that are required in order for the plan to remain a useful tool over time.

Results and Indicators¹

The beginning point for development of the strategic plan for alcohol and drug abuse services is to identify the desired results or outcomes. Appropriate strategies and performance measures flow from those results.

Results are conditions of well being in individuals, families, and communities, according to Friedman. Desired results are abstract and not easily measurable. They are also of an enduring nature. They are not expected to change quickly. These desired results will be the focus for the planning and service delivery effort at the state level over a period of years.

Indicators are markers that give some distinct indication of progress. These are measures for which data are readily available. While there are many sources and types of available data, only those measures that score high in data power, proxy power, and communication power are used.

Data power is an indication of the accuracy, availability, and consistency of data across the diverse regions of the state. It also takes into account the regularity with which the data is collected.

Proxy power is an indication of how well the data says something of central importance about the result.

Communication power is an indication of how well the indicator is understood by the desired audience. When the indicators are published, decision-makers as well as the general public must be able to make the connection between the results that are desired and the data reported.

¹ Mark Friedman, Fiscal Policy Institute, Turning the Curve, 1996

Desired Results

Alaskans live free from the negative consequences of alcohol and other drug use.

The Advisory Board's vision of a healthy, productive, and happy society is one that is free from the negative consequences of alcohol and other drug use. The foundation of this plan rests on the Board's commitment to significant reduction in those negative consequences. The consequences are apparent in per capita consumption, DUI convictions, alcohol or drug related convictions, alcohol-related injuries, 12-hour protective custody holds and the rate of binge or chronic drinking by adults.

Other desired results:

- ***Alaskans are physically, mentally, spiritually, and emotionally healthy and are engaged in health lifestyles to sustain well being.***
- ***Alaskans are safe in their homes and communities.***
- ***Alaskans achieve their highest possible level of self-sufficiency.***
- ***Alaskans live with dignity and respect as valued members of their families and communities.***

Indicator One

Per capita consumption of alcohol.

The rate of consumption per person, 14 years and older, based on excise taxes collected at the wholesale level.

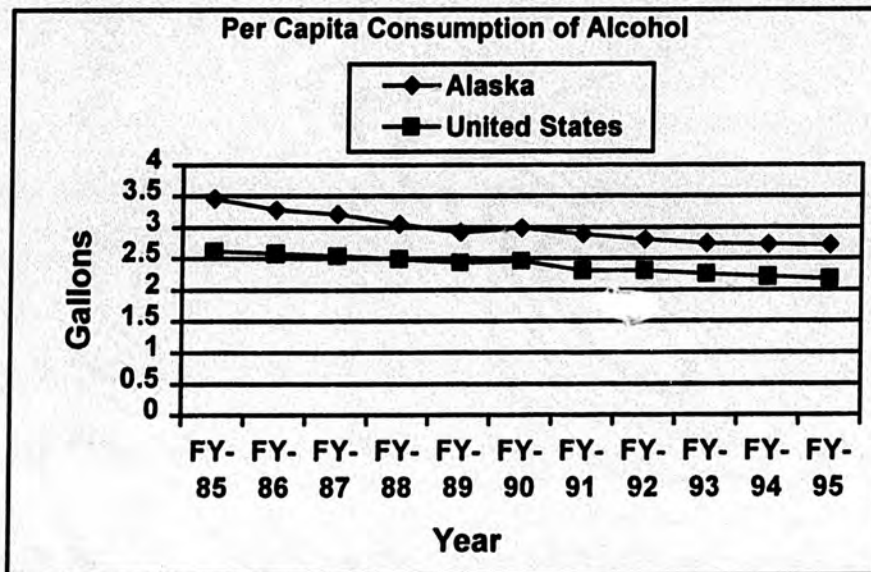


Figure 1 Source: Division of Alcoholism and Drug Abuse

The story behind the indicator headline...

The prevalence and severity of alcohol-related problems among Alaskans is directly related to the amount of alcohol consumed. The data, as collected, are based on total alcohol purchased at the wholesale level and the number of Alaskans who are 14 years of age and older. If this number were adjusted downward to remove those who completely abstain from alcohol, then per capita consumption would be greater. Although the figure for Alaska is higher than the national average, both sets of data indicate that consumption is decreasing. The population data does not acknowledge the state's significant visitor population. The consumption decrease by Alaska residents may be even greater than shown. The strategies that impact this indicator most readily are those that address public policy issues such as the number of licensed outlets and their hours of operation.

Indicator Two

Number of convictions for Driving Under the Influence of alcohol (DUI).

The number of convictions in state district and superior courts on charges of driving while under the influence of alcohol.

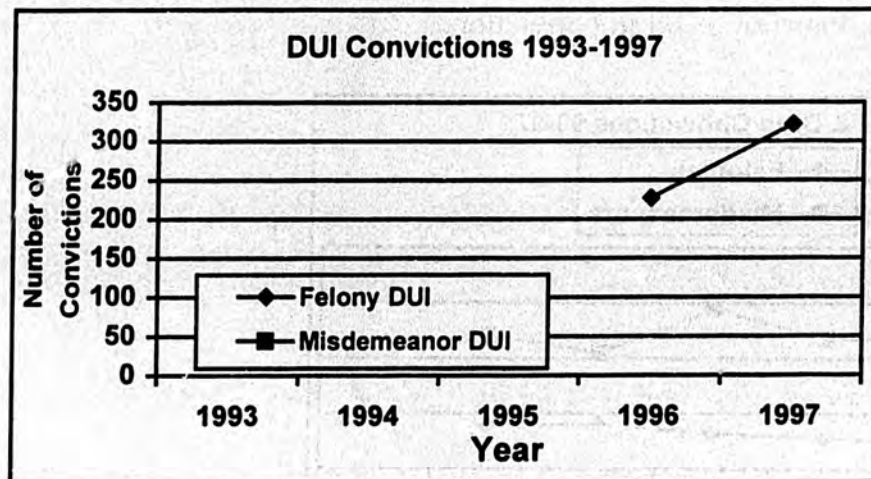


Figure 2 Source: Alaska Court System

The story behind the indicator headline...

Driving while under the influence of alcohol is one of the strongest indicators of the negative consequences associated with alcohol misuse. Data for 1997 show that 30 percent of all automobile accident fatalities had alcohol or drugs as the major contributing factor². There are many variables that impact this data, including enforcement effort and prosecutor case loads. The data correlate with successful prevention efforts, particularly in terms of public awareness of the consequences of Driving Under the Influence (DUI). Driving under the influence of alcohol impacts lives, not only in accidents, injuries, and deaths, but also in family suffering, employment problems, and social functioning. Persons convicted of DUI also represent one of our most well defined target populations: individuals whose use of alcohol has directly caused negative consequences. DUI convictions are categorized by both felony and misdemeanor offenses.

² Alaska Department of Transportation and Public Facilities, 1997 Alaska Traffic Accidents, July 1998

Indicator Three

Number of state criminal convictions on alcohol or drug-related charges.

The number of convictions on charges which include possession or distribution of drugs, misconduct involving alcohol or other drugs, and failure to take a breath test. The indicators are based on data published by the state court system and do not include arrest data that does not result in convictions.

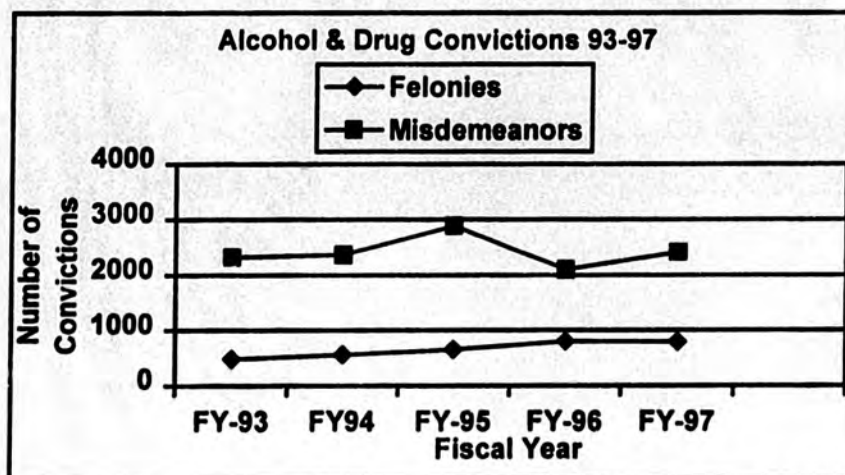


Figure 3 Source: Alaska Court System

The story behind the indicator headline...

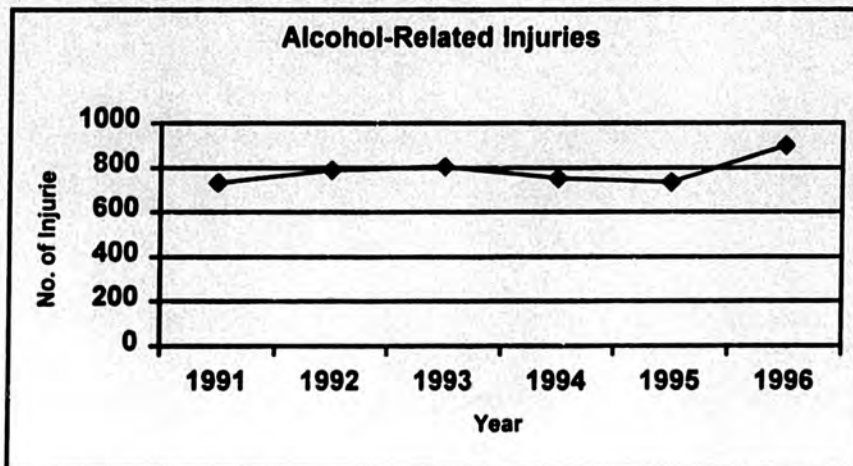
Convictions for drug and alcohol-related offenses, like DUI convictions, offer a clear picture of the negative consequences of use of alcohol and other drugs. Between fiscal years 1993 and 1997, felony convictions increased from 478 to 791. Misdemeanors have varied but show no clear increase or decrease trends. There are a number of factors that may impact this indicator including State Trooper and local police department enforcement, changes in laws, and prosecution efforts. Intervention and treatment services play a major role in decreasing the amount of alcohol and drug-related crime. Collaborative efforts have demonstrated that early intervention and appropriate, timely treatment for offenders can reduce the number of alcohol and drug-related crimes.

Indicator Four

Alcohol-related injuries requiring hospitalization.

Injuries treated in a hospital for which alcohol was determined to be a contributing factor.

Figure 4



Source: Alaska Trauma Registry

The story behind the indicator headline...

Injuries involving the use of alcohol represent a significant and costly negative consequence. The Alaska Trauma Registry, which collects information from every hospital in the state, tracks all injuries requiring hospitalization. It has special fields within its database to indicate the involvement of alcohol. The number of injuries seemed to peak in 1993 and start a downward trend. However, the number of injuries in 1996 showed a sharp increase. These injuries typically involve young people. They affect the injured individuals, families, and sometimes entire villages. They require the most expensive level of medical care: that provided in an emergency department or trauma center. The efforts that are most likely to impact this indicator are those which seek to restrict access to alcohol or other drugs through public policy advocacy. A recent study indicated that Alaska Natives living in "wet" villages were almost three times more likely to die from an alcohol-related injury than those living in "dry" villages³. Early intervention and treatment services have also been shown to have a positive impact on this indicator.

³ Alaska Child Protection Review Team, Report to the Governor, 1997

Indicator Five

The number of 12-hour protective custody holds.

The number of alcohol-incapacitated persons held in protective custody for up to 12 hours at State correctional facilities or community jails.

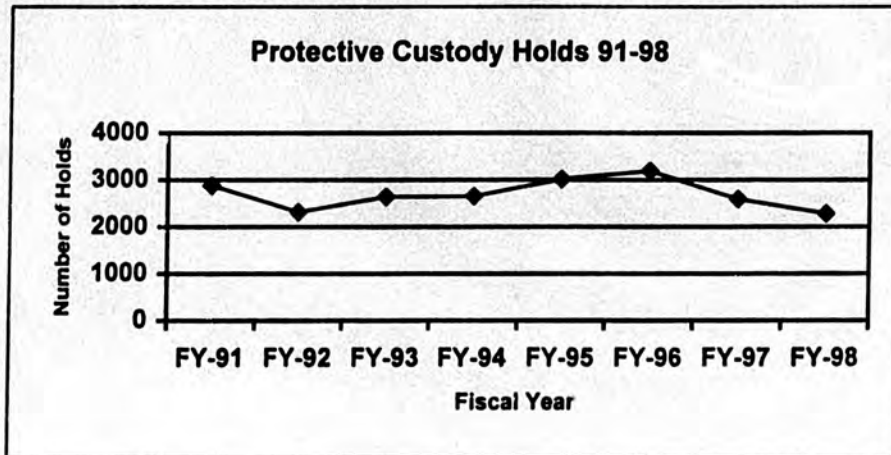


Figure 5 Source: Alaska Department of Corrections

The story behind the indicator headline...

Alaska Statute 47.37 provides that persons incapacitated by alcohol may be taken into custody in order to protect them and others from the negative consequences of their incapacitation. If suitable detoxification facilities are not available, they are taken to Department of Corrections facilities. They are held until protective custody is no longer necessary or up to twelve hours. As treatment programs work with communities to provide more appropriate services and timely interventions, the number of protective custody holds decreases. During 1995 and 1996, the Division of Alcoholism and Drug Abuse began to place more emphasis on early intervention for late stage, chronic alcoholics. This is the population most likely to require protective custody. Additional resources for detoxification have expanded community response. As a result, the number of protective custody holds has begun to decrease. During this period, the Advisory Board conducted training on the use of involuntary commitment of persons whose alcoholism is life-threatening. Community partnerships, resource expansion and community training in involuntary commitment procedures are contributing to the reduction in 12-hour protective custody holds.

Indicator Six

The rate of binge or chronic drinking by adults.

The percentage of Alaskans who self report acute or binge drinking in response to the annual Behavior Risk Factor Survey.

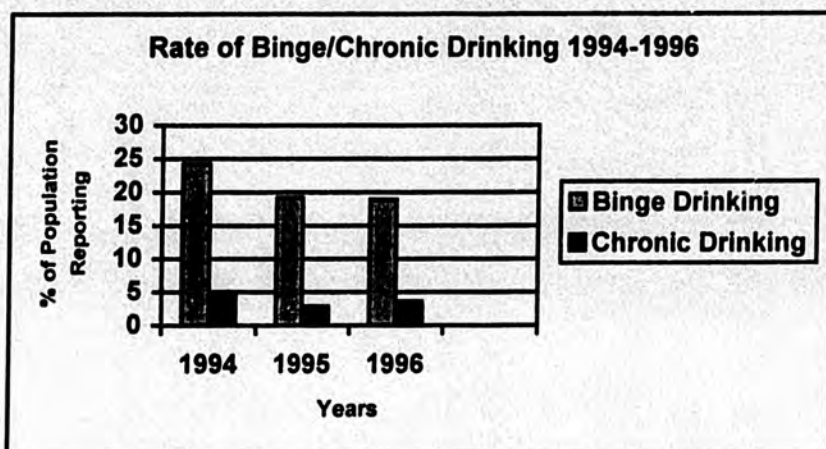


Figure 6 Source: Alaska Behavioral Risk Factor Surveillance System

The story behind the indicator headline...

Each year, the State of Alaska conducts a telephone survey to obtain information on behavioral risks prevalent among Alaskans. The interviews are conducted with a random sample of 1,535 residents, 18 years of age or older. One of the categories is the percentage of population engaged in binge or chronic drinking. **Binge drinking**, for purposes of this survey, refers to drinking five or more drinks on one occasion, at least once in the month preceding the survey. **Chronic drinking** refers to drinking an average of 60 or more alcoholic drinks in the month preceding the survey. There is a high correlation between these drinking patterns and many of the negative consequences associated with alcohol abuse – particularly medical, family, and employment problems. The strategies that will have the most immediate impact on this indicator will be those that provide intervention and treatment services to chronic, late stage alcoholics. Early intervention services are also required to impact individuals whose disease progression has not reached the point of chronic or binge drinking.

Three sets of strategies converge to drive the plan's implementation. No single strategy is most important. The overarching focus is on partnerships, both community-based and statewide. Partnerships play a key role in the delivery of both prevention and treatment services. There is a major commitment to decreasing the negative consequences of alcohol and drug abuse by ensuring access to the appropriate range of quality treatment services for all Alaskans who need them. Additionally, we know that multiple strategies consistently targeting various populations over periods of time are more effective than strategies with a single focus.

Strategy One

Support community-based processes that build partnerships and provide more effective prevention and treatment services.

What this means...

Partnerships and collaboration are the keys to success in achieving desired results. If partnerships and collaboration are to become more than lofty goals, then communities must provide processes that nurture them. These processes include needs assessments, planning for services, integrated activities, and broad-based evaluation. Programs and activities must be relevant to the particular community. They must be conducted in a manner that respects community norms and values.

How will we measure our performance?

<u>Performance Measure 1:</u>	Number of agencies and groups participating.
<u>Performance Measure 2:</u>	Extent of participation in effort.
<u>Performance Measure 3:</u>	Number of new initiatives.
<u>Performance Measure 4:</u>	Percentage change in desired community results.

Strategy Two

Encourage activities and initiatives that will change community standards and emphasize healthy lifestyles.

What this means...

Community behaviors and activities usually reflect local standards and attitudes. These are "unwritten rules" that define what is appropriate or tolerable. Shaping these norms and values is an evolutionary process. One of the most familiar results of such a strategy is the decline in tolerance for driving under the influence of alcohol. Mothers against Drunk Drivers (MADD) started out as a small local advocacy group. Thousands of local initiatives have brought about sustained positive change because of MADD's vision and persistence. The Advisory Board will support and nurture programs that seek to influence the standards and attitudes of communities by encouraging and promoting sobriety as a healthy lifestyle choice.

How will we measure our performance?

<u>Performance Measure 1:</u>	Number of agencies, groups, and individuals involved in proactive partnerships.
<u>Performance Measure 2:</u>	Extent of participation in effort.
<u>Performance Measure 3:</u>	Number of new initiatives and diversity of support.
<u>Performance Measure 4:</u>	Percentage change in desired community results

Strategy Three

Distribute useful and effective information to targeted populations.

What this means...

The Advisory Board will encourage distribution of accurate and relevant information to help policy makers, individuals, families, and communities make wise decisions. All available research indicates that for information to be effective its message must address a specific audience. It must be relevant for particular age groups and cultures. It must be developed with a clear understanding of the desired response. Examples of this strategy are distribution of new research findings and outcome information to policy makers, promotion and advertising of available treatment services, and public information campaigns targeted to women of childbearing age.

How will we measure our performance?

<u>Performance Measure 1:</u>	Quantity of material developed and/or distributed.
<u>Performance Measure 2:</u>	Quality of material for a particular target audience.
<u>Performance Measure 3:</u>	Number of target group members reached.
<u>Performance Measure 4:</u>	Percent of target group with increased awareness.

Strategy Four

Promote the benefits of treatment, recovery, and sober lifestyle.

What this means...

Despite best efforts and positive outcomes for treatment services, members of the general public often have negative attitudes about the value and appropriateness of chemical dependency treatment. The Advisory Board will support efforts and strategies that raise public awareness of the positive benefits of chemical dependency treatment, recovery, and a life of sobriety. The Board will work to eliminate stigma and denial. Examples of these strategies include program alumni organizations, public awareness campaigns, and advocacy for recognition of the contribution the sober lifestyle makes to the welfare of all Alaskans.

How will we measure our performance?

<u>Performance Measure 1:</u>	Number of self-referrals.
<u>Performance Measure 2:</u>	Increased number of advocacy groups.
<u>Performance Measure 3:</u>	Cost-benefit data.
<u>Performance Measure 4:</u>	Positive benefits of treatment – in life domain areas of health, family, self-sufficiency, and transportation.

Strategy Five

Encourage traditional and alternative social activities that are alcohol and drug free.

What this means...

Alaskans are frequently encouraged to consume alcohol and other substances at social, athletic and other community events. In addition to providing safer and healthier alternatives for youth, alcohol and drug free activities can also help redefine community norms and values to those that support sobriety. The Advisory Board will support efforts that offer organized alcohol-free and drug-free activities involving a broad spectrum of the community.

How will we measure our performance?

<u>Performance Measure 1:</u>	Number of alternative activities developed and delivered.
<u>Performance Measure 2:</u>	Percent of target population participating.
<u>Performance Measure 3:</u>	Number of target group involved in planning and implementation.
<u>Performance Measure 4:</u>	Percent of activities initiated and/or led by target group.

Strategy Six

Advocate for positive change through legal and regulatory initiatives.

What this means...

All available research points to the conclusion that public policy decisions regarding alcohol and other substances have a major impact on the prevalence and severity of substance abuse problems in communities. Examples of such policy decisions are raising the minimum legal drinking age to 21 and lowering blood alcohol legal limits for drivers. Other legal and regulatory initiatives include limiting bar and tavern hours, restricting the number of alcoholic beverage outlets in an area, supporting enforcement of existing laws, and consistent consequences for youth who engage in use of alcohol or other drugs. A less obvious benefit of these strategies is the positive impact on community norms and values. As these initiatives impact public policy decisions, communities become more aware of the negative consequences associated with alcohol and drug abuse.

How will we measure our performance?

<u>Performance Measure 1:</u>	Number of initiatives introduced as legislation or local ordinances.
<u>Performance Measure 2:</u>	Variety of responses that indicate support, such as public opinion messages, letters, telephone calls.
<u>Performance Measure 3:</u>	Number of such initiatives passed.
<u>Performance Measure 4:</u>	Percentage change in desired community results.

Strategy Seven

Ensure the delivery of quality services by offering appropriate continuing education and training for chemical dependency treatment professionals.

What this means...

High quality service delivery depends on recruitment and retention of well-qualified treatment professionals. The Advisory Board will support funding for training programs, a statewide training coordination agency, programs which provide training components, and annual training events. The Board will support the certification process for chemical dependency professionals to ensure that persons providing services hold the highest qualifications. The Board will also support an accreditation process for programs which mandates high levels of qualification for professional staff.

How will we measure our performance?

<u>Performance Measure 1:</u>	Increase in the number of certified counselors in Alaska.
<u>Performance Measure 2:</u>	Increase in the number of certified counselors working in the field.
<u>Performance Measure 3:</u>	Salaries for chemical dependency professionals that are comparable to others performing comparable work.
<u>Performance Measure 4:</u>	Reduction in rate of staff turnover.
<u>Performance Measure 5:</u>	Increase in staff training opportunities.
<u>Performance Measure 6:</u>	Greater collaboration with post-secondary and other training systems.

Strategy Eight

Expand awareness of substance abuse issues for allied health professionals, educators and other helping agents.

What this means...

If related service or education providers are to deliver consistent, appropriate, and accurate information to target populations, they must first receive the most recent factual information. Programs to implement this strategy range from an organized regimen of in-service training to carefully designed formal course curricula for professionals. With a strong emphasis on collaboration, it is critical to consider a wide diversity of professionals including

- medical staff and other health care professionals;
- domestic violence advocates;
- educators, teachers and aides
- mental health professionals;
- senior services providers;
- disability services providers;
- public assistance caseworkers and employment specialists
- juvenile and adult corrections staff;
- family service workers.

How will we measure our performance?

<u>Performance Measure 1:</u>	Number of target group participating in training.
<u>Performance Measure 2:</u>	Percentage of target group completing training.
<u>Performance Measure 3:</u>	Number of target group showing increased knowledge and awareness.
<u>Performance Measure 4:</u>	Percent of target group positively impacted as shown by pre/post tests.

Strategy Nine

Use education strategies to help youth improve critical life and social skills.

What this means...

Research indicates that development of life and social skills is more effective than didactic drug and alcohol education in helping young people avoid high risk behaviors. The Advisory Board will support programs that offer education and skill-building activities targeted to youth. These programs will help youth make appropriate decisions and avoid activities and behaviors with negative consequences. Multiple strategies that are age, culture, and gender specific are more effective than single, broad strategies. The education, information and messages targeted at youth must evolve with them as they mature.

How will we measure our performance?

<u>Performance Measure 1:</u>	Number of target group participating.
<u>Performance Measure 2:</u>	Number of target group completing.
<u>Performance Measure 3:</u>	Number of target group showing positive change or decrease in risk factors/increase in protective factors.
<u>Performance Measure 4:</u>	Percent of target group learning new skills, as shown by pre/post tests.

Strategy Ten

Identify people with problems as early as possible and refer them for appropriate services.

What this means...

This strategy is based on the premise that early problem identification and prompt action greatly enhances the likelihood of successful intervention. Programs that support this strategy would be located within organizations and agencies that are most likely to contact "at-risk" individuals at an early stage. Examples are schools, places of employment, and family and youth services. In these programs, individuals who are identified as "at-risk" for developing problems, or are engaging in behaviors that produce negative consequences, will be assessed and referred for appropriate services.

How will we measure our performance?

<u>Performance Measure 1:</u>	Number of at-risk individuals identified.
<u>Performance Measure 2:</u>	Percent of target group contacted.
<u>Performance Measure 3:</u>	Number of appropriate referrals made.

Strategy Eleven

Improve interdisciplinary coordination and collaboration at local, regional and statewide levels.

What that means...

Substance abuse professionals have a great stake in early problem identification. They recognize that they are usually not in the best position to identify these problems and intervene early. They depend on the abilities and collaboration of community members, helping agents, and other professionals to recognize the behaviors and symptoms and make prompt appropriate referrals. The Advisory Board will support efforts that foster collaboration among the various groups of professionals and programs in communities. These efforts will lead to earlier intervention and more appropriate treatment plans for clients.

How will we measure our performance?

<u>Performance Measure 1:</u>	Increase in number of referrals to and from providers.
<u>Performance Measure 2:</u>	Increase in number of referral services to and from providers.
<u>Performance Measure 3:</u>	Referral sources report improved outcomes.

Strategy Twelve

Support a continuum of care for chronic alcoholics with psychosis that focuses on intervention, treatment and the client's long term life domain requirements.

What that means...

Chronic alcoholics with psychosis are beneficiaries of the Alaska Mental Health Trust, established in Alaska Statute 47.30.056(b)(3). The Advisory Board on Alcoholism and Drug Abuse has a special responsibility to this group, described in AS 44.29.140. The Advisory Board must provide the Alaska Mental Health Trust Authority with specific recommendations to ensure that the service needs of chronic alcoholics with psychosis are met.

Chronic alcoholism is a problem that pervades every part of Alaskan life. It places an excessive burden on scarce medical, legal and public safety resources. Use of alcohol by chronic alcoholics with psychosis destroys their physical health and emotional and spiritual well-being. It seriously damages family and community life. This population has traditionally been underserved by health and social service agencies. The state has both a legal and moral responsibility to provide comprehensive and coordinated services for this population. These services must be delivered with respect for clients and their families, in a manner that ensures positive, measurable results.

How will we measure our performance?

<u>Performance Measure 1:</u>	Increase in treatment capacity and services for chronic alcoholics with psychosis.
<u>Performance Measure 2:</u>	Increase in admissions to treatment for chronic alcoholics with psychosis.
<u>Performance Measure 3:</u>	Improved treatment retention and outcomes for chronic alcoholics with psychosis.
<u>Performance Measure 4:</u>	Increased availability of long term support services in life domain areas of health, housing, transportation and self-sufficiency.

Strategy Thirteen

Develop sufficient resources to meet community needs for appropriate levels of treatment for adults, youth and special populations.

What that means...

It is not possible to deliver every service component in every community. However, it is possible to have access to all components in a full continuum of care. Effective service delivery at the community level is determined by problem prevalence, demand, and service utilization. Examples of this strategy include establishment of detoxification facilities in hub communities, strategic placement of long term and domiciliary care facilities around the state, and development of special programs such as inhalant abuse treatment where appropriate. It is also critical that all providers understand the entire service delivery system and utilize the available resources in the best interests of clients and their families.

How will we measure our performance?

Performance Measure 1:

Increase in new services developed where needed.

Performance Measure 2:

Increase in number of communities seeking additional resources or services (financial or otherwise) using innovative approaches.

Strategy Fourteen

Identify and remove barriers that prevent clients from entering treatment.

What this means...

While some people are unwilling to seek treatment, many barriers prevent others from receiving the services that they want and need. Some of these barriers are present for all clients, such as waiting lists and financial resources. Other barriers reflect the lack of programs to address the needs of special populations. The Advisory Board will support those programs that implement strategies designed to remove barriers for those seeking treatment. Examples of these efforts include streamlined intake procedures, increased capacity based on prevalence and demand, and special programs where indicated.

How will we measure our performance?

<u>Performance Measure 1:</u>	Improved access, as reported in client satisfaction surveys.
<u>Performance Measure 2:</u>	Decreased time between first contact and admission to treatment.
<u>Performance Measure 3:</u>	Capacity to ensure that everyone who asks for treatment receives it.
<u>Performance Measure 4:</u>	Increased number of client admissions.

Strategy Fifteen

Support community efforts to establish involuntary commitment procedures and to use them when appropriate.

What this means...

For a small number of chemically dependent persons, timely and intensive services are necessary in order to prevent death. For this special population, involuntary commitment to treatment is the only remaining alternative. In order to use the involuntary commitment procedures defined by Alaska Statute 47.37, communities need to work together in collaborative partnerships. The Advisory Board will continue to support community efforts to organize and develop local plans and procedures for initiating involuntary commitments. These efforts include community training, funding for legal assistance, travel and transportation assistance, and technical assistance.

How will we measure our performance?

<u>Performance Measure 1:</u>	Increased number of involuntary commitments.
<u>Performance Measure 2:</u>	Improved treatment outcomes for those committed involuntarily.
<u>Performance Measure 3:</u>	Increased number of communities using involuntary commitment procedure when necessary.
<u>Performance Measure 4:</u>	Measurable reduction in inappropriate emergency services for public inebriates.
<u>Performance Measure 5:</u>	Reduction in number of 12-hour protective custody holds.

Strategy Sixteen

Provide appropriate services for underserved Alaskans.

What that means...

There are a wide variety of programs that address the chemical dependency treatment needs of Alaskans. However, a substantial number of special populations are not adequately served. These groups include:

- Alaska Natives;
- youth;
- women with children;
- seniors;
- dually-diagnosed clients;
- clients with disabilities.

Treatment success with these populations depends on program design uniquely appropriate to their needs. Examples of such programs include special services for poly-diagnosed clients, special programs for women with children, and Alaska Natives.

How will we measure our performance?

<u>Performance Measure 1:</u>	Increased capacity for underserved Alaskans.
<u>Performance Measure 2:</u>	Increased admissions of underserved Alaskans.
<u>Performance Measure 3:</u>	Improved treatment outcomes for underserved Alaskans.

Strategy Seventeen

Use relevant research to identify and incorporate key variables that contribute to successful treatment outcomes.

What this means...

It is often difficult to predict how any particular individual with chronic disease will respond to treatment. For many clients, certain variables are significant indicators for success. Examples of such variables are a strong post-treatment support system, employment opportunities, and alcohol/drug free housing. Monitoring emerging research and assessing the client with regard to key variables will increase the probability of client success. This strategy will require collaborative relationships with other helping professions. Many of the variables involve services and issues not directly provided by chemical dependency treatment programs. Examples of these efforts include drug and alcohol-free transitional housing, vocational and educational referrals, and services designed to strengthen families.

How will we measure our performance?

Performance Measure 1:

Decrease in relapse rates.

Performance Measure 2:

Percentage of clients with improvement in life domains.

Strategy Eighteen

Address the treatment needs of persons in the criminal justice system.

What this means...

All available data and research indicate that drugs and alcohol are prevailing factors in crime in Alaska. The vast majority of the incarcerated population has drug and/or alcohol problems. In order to decrease recidivism in this population, drug and alcohol treatment needs must be addressed. Drug courts and other diversion strategies identify and provide appropriate services to individuals before they are incarcerated. Depending on the nature of the offense, treatment can be ordered in lieu of incarceration. This approach leads to a more appropriate allocation of scarce corrections resources.

How will we measure our performance?

<u>Performance Measure 1:</u>	Increased percent of offender population with substance abuse problems accessing treatment services.
<u>Performance Measure 2:</u>	Decreased recidivism among alcohol and drug-related criminal offenders.
<u>Performance Measure 3:</u>	Increased number of inmates in treatment programs.
<u>Performance Measure 4:</u>	Increased number of treatment options for offender population.
<u>Performance Measure 5:</u>	Increased percentage of treatment completion and improvement in treatment outcomes
<u>Performance Measure 6:</u>	Increased number of drug courts and other diversion programs.

Data Agenda

- I. **Introduction.** Consistent and reliable data are a key element in the planning process. Information about existing conditions helps to develop baselines or reference points. As this plan is implemented, reliable and consistent data will be used to measure performance and results. Careful analysis of indicator and performance measure data will help decision-makers modify strategies to achieve the best results.
- II. **General Data Agenda.** There are a number of issues regarding data collection and analysis that apply to the entire planning process.
 - A. **Timeliness of Data.** Much of the data to be used as indicators is collected and published annually by state agencies. While this makes data collection somewhat straightforward, effectiveness is compromised by the time lag between events and data publication. Most data is typically available two years after the fact. Efforts will be made to obtain the data prior to its normal publication schedule whenever possible. Patience will be required. Data that indicate effectiveness will not be available until at least two years after the implementation of a strategy. For some strategies that seek to impact community norms and values, this time period may be even longer.
 - B. **Data Storage and Maintenance.** Planning is an ongoing process. Data must consistently support this process. There must be an organized, reliable system for data storage and maintenance. The data, if properly maintained, will be useful in the ongoing strategic planning process and in the annual planning processes of the Advisory Board and the Division. The greater the detail of collected data, the more diverse and useful its applications will be.
 - C. **Data Analyses.** The degree of effort required to collect, store, and maintain data will be driven, in large part, by the analyses desired. The use of spreadsheets, databases, or statistical programs to analyze data requires rigorous formatting. The effort is even greater if data from different sources are to be integrated for analyses. During the first year of this plan a data collection, maintenance and analysis plan will be developed to support this effort. This plan will identify data sources and format, integration and analyses desired and appropriate computer software applications.

III. Indicator Data Agenda. Each of the six headline indicators is supported by data that rate high in proxy, data, and communication power. Despite this, each of the indicator data sets has variables that should be acknowledged during the analysis.

A. Per Capita Consumption of Alcohol. The per capita consumption of alcohol data is straightforward. There are some factors, however, which diminish its usefulness.

1. Age Applicability – The per capita consumption data are based on total population, 14 years of age and older. They do not account for drinking by youth under age 14.
2. Persons Who Abstain from Alcohol – The data do not take into account those individuals who choose to abstain from alcohol. As this population segment grows, it will lower per capital consumption. It is possible that those who drink alcoholic beverages may be drinking more while the data indicates a decrease in per capita consumption.
3. Consumption by Visitors – The per capita consumption data are based on state population. If visitors significantly impact the amount of alcohol consumed, the per capita consumption data could show an increase when, in fact, there was no increase in consumption by Alaska residents.
4. Effects of Wholesale Distribution vs. Consumption – The per capita consumption data are based on state excise tax collected at the wholesale point in the alcohol distribution chain. While this is considered a good surrogate marker for consumption, there are sales that do not result in Alaska consumption. Some residents purchase Alaska-brewed beer as gifts that are shipped out of state. Although this is probably not significant, we do not know the exact extent of this practice.

B. DUI Convictions. Driving Under the Influence (DUI) conviction data are collected and maintained by the State of Alaska Court System. Felony DUI data are included as a separate conviction category in regularly published reports. Misdemeanor DUI conviction data, however, are included with other misdemeanor traffic violation convictions. In order to obtain these data, a special request must be made to the Court System. An agenda item for the first year of this plan is to ask the Court System to begin separating misdemeanor DUI convictions in their published reports. Another problem with these data is that they do not include arrests that do not result in convictions. Enforcement effort, prosecution workload and strategies, and trends toward plea bargains for other charges also impact these data.

- C. **Drug and Alcohol Related Convictions.** This data set has some of the same limitations present in DUI conviction data. It does not reflect arrests for which there is no conviction, or plea bargains to other charges. An additional complication is that many drug charges are prosecuted in federal court as violations of federal law. Regularly published reports show drug and alcohol convictions at the national level and overall federal convictions at the state level. Specific drug and alcohol conviction data for specific states require a special data run at the federal level. A data agenda item will be to work with the federal court system to encourage reporting of data in a useful format.
- D. **Alcohol Related Injuries.** The State of Alaska Emergency Medical Services Section maintains the Alaska Trauma Registry. The registry collects data relating to injuries that are treated at hospitals throughout the state. There are fields within the registry that identify whether or not alcohol was involved. Although there is not a standard published report, the staff that maintains the registry can produce a custom report that includes desired information. Injuries that are not treated in an emergency room are not included in the registry. The data agenda item relating to this indicator is to determine exactly what information is desired from the registry each year and to work with the Emergency Medical Services staff to obtain that data.
- E. **12-Hour Protective Custody Holds.** Data for 12-hour protective custody holds are collected by the State Department of Corrections. These data reflect the number of Title 47 non-criminal holds in state correctional facilities. At present, community jails, operated by municipalities and boroughs, are not contractually required to record data on 12-hour protective custody holds. The data agenda item for this indicator is to work with the Department of Corrections to develop a standard annual report that includes all Corrections facilities and community jails.
- F. **Rate of Binge/Chronic Drinking.** The percentage of Alaskans reporting binge or chronic drinking is obtained from the annual Behavior Risk Factor Surveillance Survey. It is conducted using a random sample of 1,535 adult Alaskans. The survey results are published annually by the Alaska Division of Public Health. One of the contributing factors to the reliability of this data set is that the survey questions were rigorously developed at the national level. These same questions are also used in a national survey. This indicator can be tracked over time for trend analysis.

- IV. **Performance Measures.** Each strategy selected by the strategic planning work group has a series of measures for evaluating performance. The data for these measures are collected and analyzed by the Division of Alcoholism and Drug Abuse and used to assess the level and quality of effort. Most of the data will be collected from grantees that are required to submit data relevant to their programs. The data from individual grantees will be consolidated to provide an assessment of statewide effort. Most data come from two sources: quarterly reports on goals and objectives and program reports to the Division's Management Information System (MIS). Despite this effort, there are some measures for which data are not now readily available. The data agenda for the Division of Alcoholism and Drug Abuse over the next two years is to examine these specific measures and explore means for obtaining supporting data.
- V. **Other Data Agenda.** Beyond those indicators selected to measure progress toward results and the performance measures for strategies, there are other data and information that would be useful in assessing needs and evaluating program performance. For a variety of reasons those data are not useable at present. This provides yet another set of issues for the data agenda.
- A. **Youth Behavior Risk Survey.** Every two years, the State of Alaska of conducts a survey in the education system to assess attitudes and behaviors that constitute risks to health. While this survey provides useful data, it is not administered in all areas of the state. Participation is determined by local School Boards and is voluntary. The areas not participating are significant enough that the results may not be generalized to the entire state. The data agenda for the next two years is to advocate with the Legislature and the Department of Education to require statewide participation in this valuable survey effort.
- B. **Prevalence Studies.** During 1997 and 1998 the Division of Alcoholism and Drug Abuse participated in a federally-funded comprehensive effort to measure prevalence of alcoholism and alcohol abuse in the general population. This massive, expensive effort involved random sample telephone surveys using rigorously developed survey instruments. The results obtained from this effort have proven extremely valuable in assessing needs and barriers to meeting those needs. Although it is not practical to undertake every year, such a survey conducted at five-year intervals would be very useful in assessing results. The data agenda item for this issue is to advocate at both state and federal levels for consistent periodic surveys of this nature.

- C. Consumption of Alcohol by Pregnant Women.** The Alaska Division of Public Health, Section of Maternal and Family Health, conducts an annual survey of women who give birth during the year. This survey uses an instrument developed by the U. S. Centers for Disease Control. The survey is conducted by mail using a stratified random sample methodology. The response rate for this survey has traditionally been extremely high, which makes it a valuable tool. Among the questions in the survey are a series on alcohol use during pregnancy. Given the significant negative consequences associated with drinking during pregnancy (Fetal Alcohol Syndrome and Fetal Alcohol Effect), the trends in this area would be most useful in assessing prevention efforts. Although routine reports are not published, the staff responsible for this effort is able to produce custom reports. The data agenda item for this issue is to work with the Section of Epidemiology to identify key information from the survey that can be provided annually.
- D. Alcohol-Related Deaths.** Consistent data on alcohol-related deaths is not readily available. This is primarily because of the many ways in which alcohol and other drugs can cause death. The cause of death usually associated with alcohol consumption is cirrhosis of the liver. However, there are other fatal medical conditions related to alcohol consumption such as heart disease and esophageal cancer. Many accidents and homicides are also associated with alcohol abuse. This is compounded by the fact that these causes of death are associated with other factors as well as alcohol consumption. The same difficulties are present with consumption of other drugs. The State of Alaska Bureau of Vital Statistics reports on causes of death annually. In 1996, for example, the Bureau of Vital Statistics reported a total of 110 deaths due to alcohol use or abuse⁴. The Bureau also reports separately for deaths due to cirrhosis and other diseases. The data agenda item for this issue is to work with the Bureau of Vital Statistics over the next five years to develop a useable method of identifying death due to alcohol or other drug consumption.
- E. Department of Health and Social Services Data Warehouse.** The Alaska Department of Health and Social Services is currently working on a project to provide easier access to data across Divisions. The Advisory Board on Alcoholism and Drug Abuse will monitor these efforts and assist as appropriate in developing a system that will meet the data needs of the State and providers as well as protecting the privacy and confidentiality of consumers.

⁴ Alaska Bureau of Vital Statistics, 1996 Annual Report, 1998

Implementation

This strategic plan will succeed to the extent that it is consistently implemented and updated. Four distinct implementation efforts are required in order for the plan to remain a useful tool over time.

1. **Implementation of Strategies.** The prevention and treatment strategies identified in this plan will be implemented by the Division of Alcoholism and Drug Abuse, which has responsibility for managing service delivery in Alaska. The Advisory Board on Alcoholism and Drug Abuse and the Division will share responsibility for implementation of strategies that address public policy, advocacy and legal/legislative initiatives. The implementation of service delivery strategies will be accomplished primarily through the Request for Proposals (RFP) process. This process leads to funding allocation to support specific strategies. Successful grantees will develop proposals that reflect the Division's guidelines and this plan. Future Requests For Proposals (RFPs) from the Division will incorporate experience and knowledge gained by monitoring indicators and performance measures as well as emerging research. Both the Division and the Advisory Board will share responsibility for wide distribution of the plan. Each will work assertively to educate providers, stakeholders, and the public about the plan's contents and significance in reducing negative consequences of alcoholism and drug abuse for all Alaskans.
2. **Monitoring of Performance.** As strategies are implemented, the Division will monitor performance measures to assess the level, quality, and effectiveness of effort. The data required for monitoring performance will be reported by programs and collected independently by the Division. By monitoring performance in a timely manner, the Division and the Advisory Board will be able to gauge whether the selected strategies are the right ones and whether the level of effort is sufficient to impact the indicators as desired.
3. **Monitoring of Indicators.** Each year, the Advisory Board will collect the required indicator data to determine the extent to which the strategies have influenced the desired results. There are several confounding factors in this task. First, indicator data are impacted by variables beyond the control of the Division or the Advisory Board. Care must be exercised when deciding how much the data have been impacted by the strategies and how many intervening variables have impacted them. Second, the data reflected in the indicators are often one to two years old before publication. There could be a lag of three or four years after the implementation of a strategy before indicator data are available from which to draw conclusions. Once the data

are available, it will be necessary to view several years of data before assessing effectiveness.

4. **Ongoing Planning.** Only one desired result was examined during this planning phase. The planning work group identified four other desired results for all Alaskans. The ongoing planning effort will follow two parallel tracks. The first track focuses on review of the performance measure and indicator data and refinement of the strategies as necessary. The second track focuses on developing indicator data, strategies and performance measures for the other results. It is recommended that the planning work group convene every third year to update the plan, building on the ongoing efforts indicated above.
5. **Integration into the Comprehensive Integrated Mental Health Plan.** The Advisory Board will work with the Department of Health and Social Services, the Mental Health Trust Authority, and the three other beneficiary boards to ensure a smooth integration of this plan into the Comprehensive Integrated Mental Health Plan.

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Glossary

Abuse of alcohol, other drugs, or inhalants: A persistent pattern of use of alcohol, other drugs or inhalants with which health consequences and/or impairment in social functioning are associated. This is different from dependence, which has such manifestations as craving, tolerance and physical dependence. Abuse is any use of a legal or illegal drug or substance that causes physical, mental, emotional or social harm, whether mild or severe.

Accountability: Responsibility for performance and results; holding political leaders and agency managers accountable for results according to agreed upon performance standards.

Addict: A person who is physically dependent on one or more psychoactive substances, whose chronic use has produced tolerance, who cannot control his or her intake, and who would have withdrawal symptoms if drug use were discontinued.

Alaska Mental Health Trust Authority (AMHTA): The Alaska Mental Health Trust Authority administers the Mental Health Trust established in perpetuity. It has a fiduciary responsibility to its beneficiaries to enhance and protect the Trust and to provide leadership in advocacy, planning, implementing, and funding of a comprehensive integrated mental health program to improve the lives and circumstances of its beneficiaries.

Alcohol: The active ingredient in beer, wine and distilled spirits; ethyl alcohol or ethanol.

Alcohol Dependence: A psychic and usually physical state resulting from taking alcohol. It is characterized by behavioral and other responses that always include compulsion to take alcohol on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence. The person may or may not have developed a tolerance for alcohol. A person may be dependent on alcohol and other drugs. "Alcohol dependence" is often used interchangeably with the term "alcoholism."

Alcoholism: A **primary**, chronic **disease** with genetic, psychosocial and environmental factors influencing its development and manifestations. The disease is **often progressive and fatal**. It is characterized by continuous or periodic **impaired control** over drinking, **preoccupation** with the drug alcohol, use of alcohol despite **adverse consequences**, and distortions in thinking, most notably **denial**. Each of these symptoms may be continuous or periodic.

- **Primary** refers to the nature of alcoholism as a disease entity, in addition to, and separate from other pathophysiologic states which may be associated with it. It suggests that alcoholism, as an addiction, is not a symptom of an underlying disease state.
- **Disease** means an involuntary disability. It represents the sum of the abnormal phenomena displayed by a group of individuals. These phenomena are associated with a specific common set of characteristics by which these individuals differ from the norm, and which places them at a disadvantage. Use of the term involuntary in defining disease is descriptive of this state as a discrete entity that is not deliberately pursued. It does not suggest passivity in the recovery process nor does use of the term imply the abrogation of responsibility in the legal sense.
- **Often progressive and fatal** means that the disease persists over time with physical, emotional, and social changes that are often cumulative and may progress as drinking continues. Alcoholism causes premature death through overdose, organic complications involving the brain, liver, heart and many other organs, and by contributing to suicide, homicide, motor vehicle crashes and other traumatic events.
- **Impaired control** means the inability to limit alcohol use or to consistently limit, on drinking occasions, the duration of the drinking episode, the quantity of alcohol consumed, and/or the behavioral consequences.
- **Preoccupation** used in association with alcohol use indicates excessive, focused attention given to the drug alcohol, its effects, and/or its use. The relative value thus assigned by the individual often leads to a diversion of energies away from important life concerns.
- **Adverse consequences** are alcohol-related problems or impairments in such areas as physical health (e.g., alcohol withdrawal syndromes, liver disease, gastritis, anemia, and neurological disorders,) psychologic functioning (e.g., impairments in cognition, changes in mood and behavior,) interpersonal functioning (e.g., marital problems, child abuse, troubled social relationships,) occupational functioning (e.g., scholastic or job problems,) and legal, financial or spiritual problems.
- **Denial** is used here not in the psychoanalytic sense of a single psychological defense mechanism disavowing the significance of events, but more broadly to include a range of psychological maneuvers that decrease awareness of the fact that alcohol use is the cause of a person's problems rather than a solution to those problems. Denial becomes an integral part of the disease and is nearly always a major obstacle to recovery.

ASAM: The American Society of Addiction Medicine, a national medical specialty society of physicians dedicated to improving the treatment of alcoholism and other drug dependencies.

ASAM Placement Criteria: American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders, a clinical guide for matching patients diagnosed as having a substance use disorder to appropriate levels of care based on an assessment of:

1. acute intoxication and/or withdrawal potential;
2. biomedical conditions and complications;
3. emotional/behavioral conditions and complications;
4. treatment acceptance/resistance;
5. relapse potential;
6. recovery environment.

Beneficiary (AMHTA): The beneficiaries of the Alaska Mental Health Trust Authority are Alaskans who experience mental illness; mental retardation or similar disabilities; chronic alcoholism with psychosis and/or Alzheimer's disease or related dementia.

Binge Drinking: Having five or more drinks on an occasion one or more times in the past month.

Chemical Dependency: Physiological or physical dependence on a psychoactive substance.

Chronic Alcoholic with Psychosis: As defined in AS 47.30.056(b)(3), this group includes persons with the following disorders:

1. alcohol withdrawal delirium (delirium tremens);
2. alcohol hallucinosis;
3. alcohol amnesiac disorder;
4. dementia associated with alcoholism;
5. alcohol-induced organic mental disorder;
6. alcoholic depressive disorder;
7. other severe and persistent disorders associated with a history of prolonged or excessive drinking or episodes of drinking out of control and manifested by behavioral changes and symptoms similar to those manifested by persons with disorders listed in this subsection.

Chronic Drinking: An average of 60 or more drinks a month.

Culturally Sensitive: Awareness of unique aspects and nuances of one's own culture and of other cultures.

Detoxification: Treatment to restore physiologic function after it has been seriously disturbed by the overuse of alcohol or other drugs.

Drug Dependence: A psychic and sometimes physical state resulting from taking a drug. It is characterized by behavioral and other responses. These always include a compulsion to take a drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence. The person may or may not have developed a tolerance for the drug. A person may be dependent on more than one drug.

Dually-Diagnosed: Persons suffering from co-existing mental illness and alcohol or drug dependence.

Early Intervention: Services designed to identify individuals who are at high risk for developing alcohol or other drug-related problems. These services are also directed toward persons who are experiencing adverse effects of alcohol or other drug use but are not dependent. Services seek to modify alcohol or drug use behaviors and attitudes.

Fetal Alcohol Syndrome (FAS): Fetal Alcohol Syndrome and other alcohol-related birth defects refer to a group of physical and mental birth defects resulting from a woman's alcohol consumption during pregnancy. FAS is the leading known cause of mental retardation and is 100 percent preventable.

Fetal Alcohol Effect (FAE): FAE is similar to FAS but lacks the physical symptoms of FAS. FAE neurological abnormalities, development delays, intellectual impairments and learning/behavior disabilities are similar to, and sometimes more severe than, those of FAS.

Guiding Principles: These define what the organization stands for and are used as the foundation on which to develop a strategic plan of action.

Inhalants: Any volatile substance that can produce an intoxicating state when inhaled. A volatile substance becomes a gas at normal room temperature. Examples include common household products such as fast-drying glues and cements; paints, lacquers and varnishes; thinner and removers; lighter and dry cleaning fluids; kerosene, gasoline, lantern and stove fuel; fingernail, shoe and furniture polish; typewriter correction fluids; felt-tip pens; aerosol products; refrigerants such as freon.

Involuntary Commitment: A legal process defined in Alaska law (AS 47.37.190) whereby a person addicted to alcohol may be committed to a treatment facility without the person's permission if the person lacks self control in using alcohol and presents a danger to others or is incapacitated by alcohol.

Indicator or Benchmark: A measure, for which data is available, that helps to quantify the achievement of a desired result or outcome.

Mission Statement: This states the purposes served by an organization's mission. By defining its mission, an organization can decide upon appropriate outcomes and performance measures.

Misuse of alcohol, drugs or inhalants: Use of alcohol, other drugs, or inhalants in a way that is illegal or deviates from medically accepted use.

Performance Measure: A measure of effectiveness of agency or program service delivery.

Results-oriented Government: A government that values results and qualitative outcomes over expenditures and inputs. It is concerned with accountability and performance measurement.

Result or Outcome: A condition of well-being for children, families or communities.

Sobriety: A positive, healthy and productive way of life, free from the negative effects of alcohol or other drug misuse or abuse.

Strategic Planning: A process of defining the vision, mission, goals and objectives of an organization. Through the planning process the organization identifies the results it seeks to achieve through its programs and the specific means by which it intends to achieve these results.

Tolerance: Physiologic adaptation to the effect of a drug, diminishing the effect of constant dosages.

Treatment Capacity: The amount of substance abuse services that are readily accessible.

Vision: The ideal mission of a governmental jurisdiction and/or agency, and the ideal way it must operate to accomplish its mission and best serve its clients.

Selected Resources and References

The following are only a few the very board range of references and resources available to those with an interest in eliminating the negative consequences of alcohol and drug abuse.

Advisory Board on Alcoholism and Drug Abuse. Annual reports of the Advisory Board's activities, and selected reports on programs and projects, as well as additional copies of this plan. (907) 465-8920 or 1-888-464-8920.

Alaska State Library bibliography on Alcohol and Drug Abuse Treatment. Call 907 465-2916 to request a free copy. Also available from <http://www.educ.state.ak.us/lam/library.html>.

Alcoholics Anonymous. <http://www.alcoholics-anonymous.org/>

Center for Science in the Public Interest "Booze News" <http://www.cspinet.org>

Center for Substance Abuse Prevention maintains a Clearinghouse on Alcohol and Drug Information at 1-800-729-6686. Its website may be reached at <http://www.health.org>.

Division on Alcoholism and Drug Abuse. In the coming months, the final reports of federally-funded research projects relating to prevalence in Alaska will become available. (907) 465-2071 or 1-800-478-2072.

Dual Diagnosis Website, focuses on mental illness, drug addiction and alcoholism. <http://www.erols.com/ksciacca/>

Higher Education Center for Alcohol and other Drug Prevention, sponsored by the U. S. Department of Education. <http://www.edc.org/hec/>

Join Together Online Organizations working together to combat substance abuse and violence. <http://www.jointogether.org/>

National Institute on Alcohol Abuse and Alcoholism. Offers a wealth of information, publications and databases on both treatment and prevention. <http://silk.nih.gov/niaaa1/>

The National Library of Medicine, PubMed. A very large range of medical topics, including Clinical Alerts of the National Institutes of Health, a journal database browser and links to many other sources. <http://www.ncbi.nlm.nih.gov/pubmed/>

National Organization for Fetal Alcohol Syndrome. <http://www.nofas.org/>

**Printed in Juneau, Alaska
at a cost of \$1.81 per copy.**

**Additional copies are available upon request.
Please call 907 465-8920 or 1-888-464-8920.**



Strategic Plan for Trust Beneficiaries
in the Department of Corrections

Strategic Plan for Trust Beneficiaries in the Department of Corrections

43

STATE OF ALASKA

DEPARTMENT OF CORRECTIONS

TONY KNOWLES, GOVERNOR

REPLY TO:

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PHONE: (907) 269-7350

May 14, 1999

Dear Alaskans:

The Department of Corrections is pleased to present its Strategic Plan for Alaska Mental Health Trust Authority beneficiaries. The Plan was developed by an Interagency Committee composed of members of the: Advisory Board on Alcoholism and Drug Abuse, Alaska Mental Health Board, Governor's Council on Disabilities and Special Education, Division of Mental Health and Developmental Disabilities, Division of Alcoholism and Drug Abuse, Department of Corrections, and the Alaska Mental Health Trust Authority.

The Plan highlights the progress Alaska has made in its treatment of Trust beneficiaries who enter the criminal justice system, and details new initiatives to help prevent beneficiaries from entering corrections. It also provides an overview of mental health and substance abuse treatment services available in correctional facilities, and offers recommendations for improving services to Trust beneficiaries.

The interagency planning process has resulted in a comprehensive Strategic Plan. The Department of Corrections is appreciative of the time, expertise, and information provided by members of the Interagency Review Committee. The Committee was chaired by the Trust Authority which also provided the majority of the funding for the Planner who coordinated the project and drafted the Plan. The Department looks forward to opportunities to begin implementing the Strategic Plan recommendations over the next several years.

Sincerely,



Margaret Pugh
Commissioner

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Executive Summary

A Needs Assessment demonstrated that 37 percent of the inmates in correctional facilities are Trust beneficiaries.

In 1997, the Alaska Mental Health Trust Authority funded a Needs Assessment to determine the prevalence and treatment needs of their beneficiaries in the custody of the Department of Corrections. The Trust Authority wanted to know how many inmates in the correctional system were beneficiaries by virtue of a mental illness, developmental disability, chronic alcohol disorder with psychosis, and/or Alzheimer's Disease and Related Disorders. The Needs Assessment demonstrated that **37 percent** of the inmates in correctional facilities are Trust beneficiaries. The study also confirmed that the programming available to even the most chronic and acute inmates is limited. The study was the impetus for many changes that have taken place since then.

Shift in the Burden of Care

Alaska is mirroring a national trend where state psychiatric hospitals downsize, and the numbers of mentally ill in correctional facilities rise.

The process of de-institutionalizing the mentally ill has had the unfortunate and unforeseen consequence of re-institutionalizing many mentally ill persons into prison facilities. The primary cause of this criminalization of the mentally ill is generally believed to be a lack of adequate community-based programs, including assisted housing, support staff, and an emergency response system of mental health care that includes alternatives to incarceration. The prevalence of alcohol and drug abuse and the shortage of effective dual diagnosis treatment programs have resulted in unprecedented numbers of mentally ill and organically impaired persons being arrested for longer periods of time. Both mental illness and substance abuse contribute to the revolving door syndrome, where many of the same individuals frequently cycle in and out of jail.

Many of the mentally ill now in Alaska's correctional facilities would have been treated at the Alaska Psychiatric Institute (API) in the past. In 1983, the state narrowed the criteria for the insanity defense, and created the guilty but mentally ill defense, that actually precludes early parole or probation. Many of the mentally ill people now coming into DOC would have gone to API sixteen years ago as not guilty by reason of insanity patients.

On the day that the Needs Assessment was conducted, the census at API was **79** and there were **373** seriously mentally ill inmates in correctional facilities. DOC is treating an increasing number of mentally ill inmates. In Fiscal Year 1997, DOC treated nearly **2,000** unduplicated inmates with chronic and acute illnesses, up 16 percent from Fiscal Year 1995.

Partnerships/Community Involvement

The Department of Corrections is partnering with other agencies to:

- ☐ Prevent Trust beneficiaries from entering the correctional system.
- ☐ Provide appropriate and effective care for Trust beneficiaries who are incarcerated.
- ☐ Assist Trust beneficiaries to successfully transition into the community upon release.

**Because
DOC has
limited treat-
ment re-
sources only a
small percent-
age of the
inmates who
need treat-
ment receive
treatment.**

The Department of Corrections has worked with an interagency team of individuals from the beneficiary boards, the Division of Alcoholism and Drug Abuse, the Division of Mental Health and Developmental Disabilities, and the Trust Authority to develop this Strategic Plan for Trust Beneficiaries in the Department of Corrections. To implement the recommendations contained in the Strategic Plan, DOC must continue to collaborate with other state agencies and the community.

Community Continuum of Care

Although the focus of the Strategic Plan is to improve care for beneficiaries in correctional institutions, an effective community continuum of care is also critical to prevent some beneficiaries from entering the correctional system. Community-based services that are accessible to offenders transitioning from institutions to the community are also essential for reducing recidivism. There are some specific gaps in services that must be filled if Trust beneficiaries are to stay out of correctional facilities. These are identified in the DOC Strategic Plan and in the beneficiary board's planning documents.

DOC has been a strong supporter of all community-based programs that are effective in reducing clinical and ultimately criminal recidivism. The current plan to further reduce API to 54 beds requires an effective, well-funded community-based system to prevent even more beneficiaries entering the correctional system.

Non-Criminal Holds

The Department of Corrections continues to house individuals who have not committed crimes, but who are placed in correctional facilities because of a mental health and/or substance abuse emergency. These holds are often the result of a lack of adequate community-based services, such as detox facilities and mental health emergency services. In Fiscal Year 1998, there were **2,273** Title 47 non-criminal mental health and substance abuse holds statewide. Individuals who have not committed crimes continue to take up expensive hard beds that should be reserved for serious criminals.

Continuum of Care in DOC

Because the Department of Corrections has limited mental health, substance abuse and other treatment resources, only a small percentage of the inmates who need treatment receive treatment. As one member of the Interagency Review Committee explained: "There is a huge need for services in DOC facilities. The array of services though pretty good in scope, is tremendously short in capacity, and only the most critical conditions are dealt with." All Interagency Review Committee members also recognize that effective and timely services in the community assist probationers and parolees in being successful under supervision.

Mentally Ill Inmates

DOC mental health staff prioritize scarce resources to treat mentally ill inmates whose conditions are chronic or acute. The number of mentally ill beneficiaries in correctional facilities far exceeds the Department's resources. There are **883** mentally ill inmates in DOC institutions on a given day that qualify as Trust beneficiaries. However, DOC primarily treats those mentally ill inmates who are the first statutory responsibility of the Trust Authority. These include individuals who are at risk for hospitalization or experience such major impairments in self-care that

they require intensive services or create a management problem for a correctional facility. With the transfer of many stable inmates to an out of state facility in Arizona, Alaskan facilities are experiencing a much higher concentration of psychiatrically and behaviorally disturbed inmates. This presents an increasing challenge and clear need for additional resources within the Alaska correctional system.

To provide more effective mental health services in corrections, the Interagency Review Committee has developed a series of recommendations that are outlined in the Strategic Plan. The highest priority recommendation for mental health services is a sub-acute care unit for mentally ill men. However, even a new sub-acute unit for men will not be enough to meet the treatment needs of all male inmates who experience a mental illness. The Department's capacity for treating its chronic and acutely mentally ill male inmates is inadequate. On a given day, there are **337** severely mentally ill men in correctional facilities statewide. The Department has **29** acute care beds for mentally ill men at Cook Inlet Pre-Trial Mike Module, and **50** beds at Spring Creek for chronically mentally ill men who are stable. Seventy nine beds is inadequate to meet the need. An additional program is needed in the Anchorage area.

Alaska is one of the few states that provides forensic services without a forensic hospital. There is a critical need to ensure that a full spectrum of acute care psychiatric services for mentally ill offenders is addressed somewhere in the Department of Corrections or Department of Health and Social Services' system. The Interagency Review Committee has requested that this issue be addressed in future planning sessions.

Inmates with Substance Abuse Disorders

The DOC Inmate Substance Abuse Treatment Program (ISAT) is also unable to keep pace with the treatment needs of a growing inmate population. There are waiting lists for substance abuse treatment in most facilities, and substantial waiting lists for clinical assessments in all facilities.

On the sample day, just **258** inmates meet the Trust Authority's precise definition of a chronic alcoholic with psychosis. However, it is estimated that at least **80 percent** of inmates are involved in Alaska's criminal justice system because of problems with alcohol and drug abuse.

The ISAT program is only able to treat a small percentage of the inmates who could benefit from substance abuse treatment. National studies demonstrate that although **70-80 percent** of inmates need substance abuse treatment, only **13 percent** actually receive such treatment (National Center on Addiction and Substance Abuse, 1998). The National Commission on Correctional Health Care reports that **72-90 percent** of mentally ill inmates have co-occurring substance abuse disorders. There is a critical need for treatment for inmates with co-occurring disorders.

DOC is currently unable to provide services to all inmates who need substance abuse treatment, and offers a full continuum of care only in its female institution. The Department does not offer a complete continuum of care for male inmates with severe substance abuse disorders. The Interagency Review Committee's highest priority recommendation for substance abuse treatment in DOC is to provide residential substance abuse treatment for male inmates.

**Creating a
sub-acute
care unit for
mentally ill
men and
residential
substance
abuse
treatment for
men are two
high
priorities.**

There is a need to identify and provide specialized treatment to inmates with developmental disabilities, co-occurring disorders, FAS/FAE, dementias and juveniles.

Alaska's Advisory Board on Alcoholism and Drug Abuse confirms that there is a critical need for more substance abuse treatment in correctional facilities. The board has recommended that DOC conduct standardized screenings on all inmates to assess the extent of alcohol and drug abuse problems. The board has further called for appropriate treatment for all inmates who are screened as having substance abuse disorders.

Crime Rates and Recidivism

Empirical evidence and common wisdom suggest that substance abuse is a major contributing factor to the crime rate in Alaska. Studies also demonstrate that substance abuse is a key component in recidivism. The Advisory Board on Alcoholism and Drug Abuse has called for early intervention and appropriate and timely treatment for offenders to help reduce alcohol and drug-related crimes and recidivism.

Specialized Populations

DOC recognizes the need to identify and provide specialized treatment to inmates with developmental disabilities, Fetal Alcohol Syndrome (FAS)/ Fetal Alcohol Effect (FAE), dementias and inmates with co-occurring disorders.

National prevalence estimates would suggest that there are as many as **185** inmates with developmental disabilities in Alaska's correctional institutions on any given day. Typically, only inmates with severe developmental disabilities are identified and referred for treatment and management recommendations by DOC mental health staff. DOC has a limited number of programs specifically designed for developmentally disabled inmates. The Interagency Review Committee has recommended improved screening mechanisms for developmentally disabled individuals entering DOC as well as more specialized services.

The actual number of inmates with FAS/FAE is unknown. A complex medical diagnosis, FAS/FAE has historically been under-diagnosed and under-reported in the community at large. However, the state is planning to conduct surveys to establish the baseline number of inmates with FAS/FAE. While DOC does not conduct any specific screening for FAS/FAE, DOC is working on FAS/FAE prevention through a cooperative program with the Department of Health and Social Services/Division of Maternal Child and Family Health.

Up to **77** percent of the seriously mentally ill inmates in DOC have co-occurring substance abuse disorders. Currently, the only specialized programs for dually diagnosed individuals are the substance abuse groups held on the DOC men's and women's mental health units. DOC is exploring additional options for dual diagnosis treatment, as recommended in the Strategic Plan.

The Department anticipates planning for services for inmates with Alzheimer's and other dementias as its prison population ages. Given lengthy sentences, it is anticipated that some of the Department's aging population will experience dementias, and will need specialized services.

Juveniles

Another growing inmate population that requires specialized services are juveniles in adult corrections. On February 1, 1999 there were 402 inmates age 21 and under in correctional institutions and halfway houses. The Department needs to create a separate unit for inmates age 18 and under, with specialized education, mental health and substance abuse programming.

**DOC is using
telemedicine
to provide
psychiatric
services at
several
correctional
facilities.**

Legal Issues

The Department of Corrections completed its conversion of Hiland Mountain Correctional Center (HMCC) into the state's designated female facility in October of 1998. DOC has made significant progress toward resolving issues in Clery v. Smith related to program parity for women. In January of 1998, DOC initiated the women's psychiatric treatment unit. In November of 1998, DOC created the women's Residential Substance Abuse Treatment program (RSAT). LINKS (Living in New Knowledge Successfully), a special transition project for women with children, was also developed to assist graduates of the RSAT program succeed in the community.

Mentally ill female inmates are now afforded the same treatment opportunities that mentally ill male inmates have had since 1991. Prior to the creation of the women's psychiatric treatment unit, mentally ill women were often housed at Sixth Avenue in segregation cells for extended periods of time. Women with substance abuse disorders now have a more complete continuum of care than male inmates with alcohol and drug abuse problems, through the RSAT program and the LINKS discharge project.

MIS

The Department of Corrections' new Management Information System should assist in identifying and tracking Trust beneficiaries throughout the correctional system. DOC wants to have the capacity to provide unduplicated counts and demographic information on Trust beneficiaries. It is hoped that the MIS system could eventually enable the Department to more efficiently track outcomes and performance measures.

Telemedicine

The Department of Corrections implemented a statewide telepsychiatry project in November of 1997. DOC is using telemedicine to provide psychiatric services in seven of its facilities. DOC is also participating in the Alaska Telehealth Advisory Commission to help develop a coordinated and integrated statewide telehealth and telemedicine system. In the future, DOC may use telemedicine like systems for sex offender treatment in rural areas and for supervision of probationers and parolees.

A unique opportunity exists in DOC to create an effective continuum of care that meets the needs of Trust beneficiaries.

Future Vision

A unique opportunity exists in Alaska for the Department of Corrections to work closely with community treatment providers, the legal community, planning boards and the Trust to create an effective continuum of care that truly meets the needs of Trust beneficiaries. Cooperative agreements across Departments, access to mental health and dual diagnosis treatment, and pilot programs designed to stop the revolving door are but a few examples of the direction that the Department is working toward. The creation of the DOC Strategic Plan for Trust Beneficiaries is an example of the results of such collaborative efforts.

Synopsis of Recommendations

Housing and effective dual diagnosis treatment are necessary to help prevent beneficiaries from entering DOC.

The Department of Corrections has identified six guiding principles that underlie recommendations for improving services to Trust beneficiaries entering the criminal justice system. All of the guiding principles and associated recommendations require coordination with stakeholders including the: Alaska Mental Health Trust Authority, Department of Education, Department of Health and Social Services, Department of Law, Department of Public Safety, Advisory Board on Alcoholism and Drug Abuse, Alaska Commission on Aging, Alaska Mental Health Board, Governor's Council on Disabilities and Special Education, Court system, Legal system, Alaska State Troopers, Police Departments and Village Public Safety Officers, community treatment providers, Legislature, Criminal Justice Assessment Commission, Native Organizations, and the U.S. Department of Justice.

I. Prevent Trust Beneficiaries from Entering the Criminal Justice System

Appropriate state Departments and agencies may explore options and additional resources to ensure that Trust beneficiaries are provided appropriate treatment through an effective continuum of care in the community.

For the Mental Health Community-Based Continuum of Care:

- Increase the continuum of housing options for seriously mentally ill offenders.
- Create additional and effective dual diagnosis treatment programs.
- Increase the number of enhanced day treatment programs for mentally ill offenders.
- Expand emergency and respite services for mentally ill individuals in the community.
- Provide adequate numbers of accessible Designated Evaluation and Treatment (DET) beds.
- Provide intensive case management services for mentally ill offenders.
- Create community-based treatment services for organically impaired individuals.
- Ensure that mentally ill offenders have access to vocational training, employment education and financial assistance.
- Provide specialized sex offender treatment for mentally ill individuals.
- Ensure that staff in detox centers are trained to recognize dual diagnoses.

For the Substance Abuse Community-Based Continuum of Care:

- Create additional dual diagnosis treatment beds.
- Increase access to detox beds to meet the need in each community.
- Provide additional substance abuse transitional housing options.
- Create additional community residential substance abuse treatment beds for DOC clients.
- Increase transitional care services in the community for offenders who have participated in substance abuse treatment while incarcerated.
- Offender support services; increase access to safe and appropriate housing, food, clothing, medication services, and vocational training.

Treatment for chronic and acutely mentally ill men, additional mental health staff, and better telepsychiatry equipment are top priorities.

For offenders with developmental disabilities and Alzheimer's Disease and Related Disorders, DOC will work with the beneficiary boards to identify gaps in the continuum of care.

New Initiatives:

- Support the creation of a single point of entry system and 23 hour crisis stabilization program for the Anchorage area.
- Based upon positive outcomes, continue and expand the pilot program, Jail Alternative Services (JAS), and consider replicating it in other areas of the state.
- Utilize the Court Coordinated Resources Project (mental health court) in Anchorage for misdemeanor cases involving individuals with mental illness, developmental disabilities or organic brain disorders, and consider replicating in other judicial districts.
- The court system will study the feasibility of creating drug courts.

The Department of Corrections will continue to advocate for an adequate and effective community-based continuum of care for Trust beneficiaries. The Department of Corrections recognizes that primary efforts to prevent beneficiaries from entering the criminal justice system must rely upon an effective system of community-based treatment. DOC will continue to advocate for such services in partnership with service providers.

II. Provide Appropriate and Effective Treatment for Trust Beneficiaries in Department of Corrections

Mental Health Treatment Recommendations

Department of Corrections will explore options and additional resources to implement the following prioritized recommendations. Prioritization is based upon clinical necessity.

- Create a Sub-Acute Care Unit for chronic and acutely mentally ill male inmates in Anchorage with dedicated staff.
- Increase mental health staffing levels.
- Ensure that psychiatric resources are sufficient to meet the needs of the chronic and acutely mentally ill inmates.
- Enhance the portability and quality of DOC telepsychiatry equipment.
- Provide additional transitional care services for mentally ill inmates released from specialized treatment units to the general prison population, including psychosocial rehabilitative opportunities.
- Provide additional dual diagnosis treatment.
- Develop an integrated quality assurance system.
- Provide additional educational/vocational rehabilitative opportunities for mentally ill inmates.
- Provide additional mental health services to inmates in halfway houses.
- Continue to provide specialized discharge planning services for mentally ill offenders:
 - Enhance and expand the resources to help mentally ill offenders succeed in the community.
 - Provide additional day treatment resources for Institutional Discharge Program Plus (IDP+) and Jail Alternative Services (JAS) clients. Enhance the success of IDP+ clients who transition to rural Alaska.

- Based upon positive outcomes, continue and expand Jail Alternative Services (JAS), and consider replicating it in other areas of the state.
- Designate additional Specialized Probation Officers to work with probationers and parolees with mental illness and other chronic and acute disorders in the community.
- Provide specialized sex offender treatment.
- Provide additional culturally relevant programming.
- Expand outpatient care for non-chronic/non-acutely mentally ill inmates whose behavior does not pose a management problem.
- Provide transitional care services for non-chronic/non-acutely mentally ill inmates transitioning to community care.

More intensive substance abuse treatment for male inmates, standardized screenings of all inmates, and additional substance abuse treatment staff are recommendations.

Substance Abuse Treatment Recommendations

Department of Corrections will explore options and additional resources to implement the following prioritized recommendations. Prioritization is based upon clinical necessity.

- Enhance the continuum of substance abuse treatment services in DOC institutions for male inmates. Provide a residential treatment program for male inmates who have severe and chronic substance abuse histories.
- Create a specialized discharge project for male inmates who complete residential substance abuse treatment.
- Conduct post conviction/sentencing screenings to identify inmates who need substance abuse treatment.
- Ensure that clinical resources and funding levels keep pace with the growing numbers and needs of substance abusing inmates.
- Enhance institutional outpatient substance abuse treatment services.
- Provide dual diagnosis treatment for inmates with substance abuse disorders and developmental disabilities and/or mental illness.
- Increase coordination between DOC medical staff and contract substance abuse treatment providers to identify and refer inmates in need of substance abuse treatment.
- Expand substance abuse education services in DOC institutions where there is a half-time substance abuse treatment counselor.
- Based upon successful project outcomes, expand the Living In New Knowledge Successfully (LINKS) discharge project for women, and replicate it in other Alaskan communities.
- Continue to provide culturally relevant programming and training.

Recommendations for Developmentally Disabled Inmates

The Department of Corrections does not have any staff specifically dedicated to the needs of developmentally disabled inmates. Recommendations would require new staff and additional resources for implementation.

Department of Corrections will explore options and additional resources to implement the following recommendations based upon the continuum of care.

- Create a screening, identification and referral system for developmentally disabled inmates.
- Provide additional specialized services for developmentally disabled inmates including: substance abuse treatment services, educational/vocational services, and sex offender treatment.

Specialized services are needed for inmates with developmental disabilities, Alzheimer's Disease and Related Disorders, and juveniles.

- Notify the Division of Mental Health and Developmental Disabilities (DMHDD) prior to the release of a developmentally disabled inmate.
- Coordinate with other agencies to obtain transitional care services for developmentally disabled inmates releasing from correctional institutions into the community, including assistance with housing and employment.

Recommendations for Inmates with Alzheimer's Disease and Related Disorders

Department of Corrections will explore options and additional resources to implement the following recommendations.

- Develop improved methods of identifying and tracking inmates with Alzheimer's Disease and Related Disorders (ADRD).
- Coordinate with the Alaska Commission on Aging (ACoA) to develop population projections on the number of inmates with ADRD in correctional facilities.
- Identify the types of care required for the ADRD population in corrections and explore options for the provision of such care.
- Educate and train Department of Corrections staff on Alzheimer's Disease and Related Disorders.
- Provide medical parole for inmates with Alzheimer's Disease and Related Disorders.

Recommendations for Juvenile Offenders

Department of Corrections will explore options and additional resources to implement the following recommendations.

- Establish a discrete unit for inmates age 18 and under, with specialized programming and dedicated treatment staff.
- Continue to implement and refine as necessary the Memorandum of Agreement with the Department of Education for the provision of special education services to eligible inmates under the age of 22.

III. Program Effectiveness and Management Information Systems

Department of Corrections will explore options and additional resources for developing a Management Information System that allows the Department to:

- Identify and track Trust beneficiaries.
- Provide aggregate demographic and diagnostic information on Trust beneficiaries.
- Provide unduplicated data on Title 47 non-criminal mental health and substance abuse holds.
- Track the service needs of Trust beneficiaries.
- Measure program effectiveness and client outcomes.
- Track recidivism rates.
- Interface with other state Management Information Systems to provide unduplicated data on Trust beneficiaries across state systems.

IV. Planning and Research

Department of Corrections will explore options and additional resources to:

- Hire a health care services Research Analyst.
- Conduct an annual review of recommendations for Trust beneficiary services.
- Conduct a periodic profile of inmates to identify beneficiary needs and services.
- Continue to participate in the: Comprehensive Integrated Mental Health Plan (CIMHP), the API Community Implementation Plan, beneficiary board strategic planning processes, and the Decriminalizing the Mentally Ill Subcommittee of the Criminal Justice Assessment Commission and related activities.
- Continue to utilize the National GAINS Center for the Treatment of Co-Occurring Disorders in the Justice System for technical assistance in developing and evaluating programs.
- Utilize the Substance Abuse Need for Treatment Among Arrestees (SANTA) study and the Arrestee Drug Abuse Monitoring (ADAM) data to assess the substance abuse treatment needs of Alaskan inmates.

A new MIS system, an emphasis on planning and research, collaboration with partners, and training are all part of the DOC Strategic Plan.

V. Partnerships

The Department of Corrections will continue to collaborate with the:

- Trust Authority.
- Beneficiary Boards.
- State Departments.
- Community Treatment Providers.
- Criminal Justice System.
- Native Organizations.
- U.S. Department of Justice.

VI. Training and Education

The Department of Corrections will explore options and additional resources to:

- Train criminal justice system personnel (judges, lawyers, police and probation officers) on identification, referral and treatment options for Trust beneficiaries.
- Provide training for the Trust Authority, beneficiary boards, state Departments, and treatment providers on the criminal justice system.
- Train communities on the needs of mentally ill and other special needs offenders.
- Provide additional training opportunities for Department of Corrections staff.

Complete recommendations are detailed in the Recommendations section on pages 41 to 62.

Overview — Alaska Department of Corrections

Department of Corrections Mission

In partnership with the citizens of Alaska, the mission of the Department of Corrections is to protect the public and foster offender rehabilitation through humane, safe and cost-effective confinement and supervision. The Department will respect the rights of victims and recognize the dignity inherent in all human beings as it pursues this mission.

The Alaska Department of Corrections is responsible for all jails, prisons, and probation and parole supervision within the state of Alaska. The Department is divided into three functional units including the Division of Institutions, Division of Community Corrections and the Division of Administrative Services.

The Division of Institutions manages 13 state correctional facilities and contracts with 15 local governments for additional holding facilities (community jails). The state also has an agreement with a private vendor to hold up to 1,000 prisoners outside of the state, most of whom are held at the Central Arizona Detention Center. The Department has an emergency prison/jail capacity of 2,691. The emergency capacity of the individual facilities varies from 53 to 486 beds. The inmate count in Alaska correctional facilities on December 31, 1998 was 2,472 not counting the Alaskan inmates in Arizona. In Fiscal Year 1997, 30,129 inmates were admitted into DOC correctional facilities. The Department's Fiscal Year 1997 "Inmate Profile" demonstrated that approximately 33% of the incarcerated inmates were Native Americans.

Limited institutional programming is available to qualifying inmates including: mental health treatment, substance abuse treatment, medical services, educational programs, sex offender treatment (Meadow Creek Correctional Center and Lemon Creek Correctional Center), chaplaincy services, prison batterer programs (Fairbanks Correctional Center, Lemon Creek Correctional Center, and Palmer Correctional Center), and cultural diversity services.

The Department contracts with private vendors throughout the state for 681 halfway house beds. The facilities house misdemeanor inmates, felony furlougees, community corrections offenders and some pre-trial offenders. The Department utilizes 27 community residential substance abuse treatment beds at eight different treatment agencies statewide for offenders on furlough or on probation and/or parole. In addition, the Department operates a farm that has the capacity to hold up to 112 inmates.

On December 31, 1998, there were a total of 4,106 offenders under the custodial care of the Alaska Department of Corrections.

The Alaska Department of Corrections is responsible for all jails, prisons, and probation and parole supervision within the state.

Offenders as of 12/31/98

State Correctional Facilities	2,472
Sentenced Men	1,423
Unsentenced Men	829
Sentenced Women	133
Unsentenced Women	87
Out of State Facilities	883
Halfway Houses	625
Treatment Beds	31*
Point Mackenzie	95
TOTAL	4,106

*Treatment beds are over-utilized

The number of inmates in the state's custody on any given day of the year has been increasing dramatically from 2,700 in 1990 to over 4,100 in 1998.

On December 31, 1998 there were 4,375 offenders statewide supervised by the Division of Community Corrections.

On February 1, 1999 there were 402 inmates age 21 and under in state facilities and halfway houses. The Department formed a task force to examine the housing, security, and programming needs of juvenile offenders. The task force has recommended creating a discrete unit for these inmates with specialized programming and staff.

Trust beneficiaries are present throughout the correctional system. A 1997 survey of the Department of Corrections demonstrated that:

- 37% (1,154) of the correctional institutional population are Trust beneficiaries.
- 29% (883) of the correctional institutional population is mentally ill.
 - 12% (373) of the correctional institutional population is seriously mentally ill.
- 8% (258) of the correctional institutional population are chronic alcoholics with psychosis.
- 0.4% (12) of the correctional institutional population are developmentally disabled.
- 14% (68) of the offenders in Community Residential Centers are Trust beneficiaries.
- 15% (614) of a sample of the probation and parole population are Trust beneficiaries.

The Department of Corrections' bookings have remained fairly level this decade, averaging around 32,000 a year. The number of inmates in the state's custody on any given day of the year, however, has been increasing dramatically, from 2,700 in 1990 to over 4,100 in 1998. There are several complex forces that have contributed to the dramatic growth in the prisoner population including the: state population growth, presumptive sentencing, mandatory minimum sentences for DWI offenders, juvenile waiver law, rise in the violent crime rate in Alaska during the first half of the decade, and alcohol abuse.

Accomplishments

Background: In 1997 the Alaska Mental Health Trust Authority identified a need to enhance services for beneficiaries in the Department of Corrections. The Trust began its process by funding a study to examine the incidence and needs of beneficiaries in the correctional system. The Trust also provided resources to assist the Department in coordinating with the beneficiary boards in the yearly Request for Recommendations process. The result of collaboration between the Trust, Departments and boards is a Strategic Plan for Trust beneficiaries in the Department of Corrections, and several new projects designed to enhance the continuum of care. There is also an increasing recognition that the Department of Corrections is integral to the state of Alaska's comprehensive integrated mental health planning and budgeting process.

Trust Beneficiary DOC Needs Assessment: The Department of Corrections contracted with Care Systems North to survey the inmate population to determine the number of Trust beneficiaries in its custody. The study demonstrated that on a given day 37 percent of the Department's institutional population are Trust beneficiaries. *The Trust Beneficiary DOC Needs Assessment was funded by the Trust Authority.*

Mental Health Trust Authority Coordinator/Planner: A planning position was created to enhance the Department's ability to collaborate with the Trust Authority and the beneficiary boards in their budgeting and planning processes. The planner was also hired to draft a Strategic Plan for Trust beneficiaries in the correctional system. *The Trust Authority provided full funding for the initial year of the position and partial funding for two subsequent years.*

Participation in Multiple Planning Processes: The Department of Corrections has contributed to the Comprehensive Integrated Mental Health Plan, the Alaska Mental Health Board's strategic plan: "A Shared Vision II," the Alaska Psychiatric Institute 2000 community implementation plan, and the Advisory Board on Alcoholism and Drug Abuse's strategic plan.

Criminal Justice Assessment Commission: Representatives from the Department of Corrections, Department of Public Safety, Native Justice Center, Court and Legal system, Department of Health and Social Services, Trust Authority, Alaska Mental Health Board and the Legislature are collectively working to: promote responsible alternative options and community solutions to incarceration, make the criminal justice system more cost effective without compromising public safety, and promote system efficiencies to relieve prison overcrowding. Through the Decriminalizing the Mentally Ill Subcommittee of the Criminal Justice Assessment Commission, the Department of Corrections and the Alaska Mental Health Board have collaborated with the legal community and community treatment providers to develop Jail Alternative Services (JAS) and the Court Coordinated Resources Project in Anchorage.

Jail Alternative Services (JAS) is a pilot project providing specialized sentencing, diversion, and monitoring for mentally ill misdemeanants in Anchorage. Jail Alternative Services utilizes a Case Coordinator to identify, coordinate and link 40 men-

The results of collaborative efforts are a Strategic Plan for Trust beneficiaries and new projects designed to enhance the continuum of care.

A pilot diversion project for mentally ill misdemeanants and a mental health court are recent steps forward.

tally ill misdemeanor offenders with community services. These recommendations then become conditions of probation in sentencing. The Case Coordinator also performs the role of monitor to ensure that probation conditions are satisfied. Together with the Decriminalizing the Mentally Ill Subcommittee and the Alaska Mental Health Board, the Department of Corrections will assess the effectiveness of the program, and will explore opportunities for expanding the project in Anchorage and replicating it in other communities. *At the request of the Alaska Mental Health Board, the Trust Authority is fully funding this demonstration project.*

The **Court Coordinated Resources Project** is a process whereby two Anchorage district court judges hear cases involving mentally ill, developmentally disabled or organically impaired misdemeanor offenders on an expedited basis. The goal of the project is to identify eligible defendants, coordinate criminal justice and community mental health resources in the case, and divert individuals from jail by linking them with community services and ordering these services as conditions of probation with suspended jail time imposed.

Gains Center Technical Assistance: The Department of Corrections and the Decriminalizing the Mentally Ill Subcommittee received technical assistance from the Gains Center for the Treatment of Co-Occurring Disorders in the Justice System. Dr. Henry Steadman, a national expert and author on jail diversion programs, toured Anchorage area correctional facilities and API and provided the Subcommittee with recommendations for implementing a successful program. Members of the Decriminalizing the Mentally Ill Subcommittee also participated in a national Gains Center training and will continue to receive training and technical assistance.

Cleary v. Smith: In 1981, the Cleary v. Smith lawsuit was filed in the Alaska superior court in Anchorage and challenged the conditions of confinement and the practice of utilizing federal prisons to house state prisoners. A provision of the 1990 Final Settlement Order (FSO) of Cleary v. Smith, was the appointment of a court appointed Compliance Monitor to oversee both parties' compliance with the Order. In 1991, the court ordered continued oversight in such areas as the treatment of female inmates, the status of a new women's facility, overcrowding and mental health services.

Substance Abuse Treatment Services: The 1990 Final Settlement Order outlined the Department of Corrections' need to provide a minimum of substance abuse education and short-term counseling in all facilities, and at a minimum, individual counseling, education, and group counseling in all sentenced facilities.

Substantially Equivalent Programs for Women: In October of 1998, the Department of Corrections converted Hilland Mountain Correctional Center into its long-term sentenced facility for women. The conversion of the facility has assisted the Department of Corrections in providing substantially equivalent programs and treatment for women, including mental health and substance abuse treatment.

Mental Health Treatment Services: The Department has worked to resolve remaining Cleary compliance issues in the area of mental health programming. Recent enhancements in mental health treatment services for inmates are outlined below.

DOC has enhanced its mental health and substance abuse treatment services for female inmates.

Women's Psychiatric Treatment Unit: In January of 1998, the Department of Corrections initiated an 18 bed inpatient unit for mentally ill female offenders at Hiland Mountain Correctional Center. The creation of the unit represented an historic step toward resolving parity issues in the treatment of mentally ill female inmates. The development of the unit was made possible through the collaborative efforts of the Trust Authority, Legislature and the Alaska Mental Health Board. *The Alaska Mental Health Board selected the project for prioritized funding and recommended that the Trust Authority provide the start up funding for the unit. The Trust was instrumental in advocating for a "shared funding plan" with the Legislature for Fiscal Years 1999 and 2000.*

HMCC Women's Special Needs Wing: In January of 1998, the Department of Corrections developed a 15 bed Special Needs Wing for mentally ill female offenders transitioning off of the inpatient psychiatric unit at Hiland Mountain Correctional Center. The unit also houses developmentally disabled, organically impaired and other special needs offenders.

Expanded Psychiatric Coverage: The Department of Corrections expanded its psychiatric coverage by installing telemedicine hardware at: Anvil Mountain, Fairbanks, Ketchikan, Lemon Creek, Spring Creek, Wildwood and Yukon Kuskokwim correctional centers. The Department is also able to provide an additional day per week of psychiatric coverage through the University of Washington psychiatric residency program.

Expansion of Sixth Avenue Correctional Center's Mental Health Clinical Services: The Department of Corrections recently enhanced mental health services for Sixth Avenue Correctional Center, increasing the half-time Mental Health Clinician to full-time, beginning Fiscal Year 1999. Sixth Avenue Jail is the busiest intake facility in the State of Alaska, with over 10,000 bookings per year.

Central Arizona Detention Center: The Department of Corrections has increased its mental health coverage for Alaskan inmates housed at the Central Arizona Detention Center (CADC), and has implemented standardized procedures for mental health care. DOC has also incrementally increased its substance abuse treatment staff as the Alaskan inmate population has grown at CADC. There are currently seven substance abuse counselors. CADC has developed two 34 bed substance abuse segregated living areas for inmates participating in substance abuse programming.

Residential Substance Abuse Treatment Services for Female Inmates: The Department of Corrections initiated a residential substance abuse treatment program for female offenders through the Office of Justice Programs. The Department has dedicated one house at Hiland Mountain Correctional Center (HMCC) for residential substance abuse treatment services. *The project is funded by federal RSAT monies and Trust Authority matching funds.*

Living In New Knowledge Successfully (LINKS): An interdisciplinary team composed of representatives from the Department of Corrections, the Division of Alcoholism and Drug Abuse, the Advisory Board on Alcoholism and Drug Abuse, the Division of Family and Youth Services and community-based substance abuse treatment providers created a discharge program for female inmates with children who are graduates of the HMCC Residential Substance Abuse Treatment Program. *The team created the project by coordinating existing resources and services.*

DOC continues to collaborate with the beneficiary boards on strategic planning, budgeting, and joint projects.

Cultural Diversity Training for Inmate Substance Abuse Counselors: The Department of Corrections provided cultural relevance training for its substance abuse Counselors and Institutional Probation Officers. Information on Alaska Native tribes and history, culturally specific intake and assessment techniques, treatment strategies designed to incorporate traditional Native values, case management in rural areas, and the role of Native elders in the sobriety movement were components of the training. A resource manual of culturally relevant substance abuse treatment services was published.

Alaska Mental Health Board: The Alaska Mental Health Board recently created an Ex-Officio position for the Department of Corrections to advise Board members on issues related to mentally ill beneficiaries in the correctional system.

Advisory Board on Alcoholism and Drug Abuse: The Advisory Board on Alcoholism and Drug Abuse has included the DOC Substance Abuse Program Coordinator as a member of its Program Evaluation Committee. The Advisory Board also recently drafted a resolution regarding the need for substance abuse treatment among Alaskan inmates.

Governor's Council on Disabilities and Special Education: The Governor's Council on Disabilities and Special Education has included the Department of Corrections in its Board membership.

Juvenile Initiative: The Department of Corrections has created a task force to examine the housing, security, and programming needs of juvenile offenders. The task force has recommended creating a discrete unit for inmates age 18 and under with dedicated treatment staff and specialized programming.

Title 47 Work Groups: The Department of Corrections has participated in community efforts in Bethel and Fairbanks to reduce the number of Title 47 non-criminal mental health and substance abuse holds at the Yukon Kuskokwim and Fairbanks correctional centers.

Existing Services for Trust Beneficiaries

Trust beneficiaries can participate in institutional programs and medical services that are available to the general population. General services are described in the section entitled "Additional Services Available to Trust Beneficiaries," located in the Appendix. Specialized services for Trust beneficiaries are offered through DOC mental health and substance abuse programs, and are described below.

Mental Health Treatment Services in the Department

Department of Corrections Mental Health Services Mission:

Provide treatment and appropriate support to acutely and chronically mentally ill inmates who cannot function adequately in the general prison population. Identify, stabilize and treat chronic and acutely mentally ill inmates in order to reduce suffering and promote participation in rehabilitative programs. Promote integrated treatment services that will assist mentally ill individuals to transition effectively into the community.

In Fiscal Year 1997 Department of Corrections mental health staff treated 1,988 inmates with severe mental illnesses, other psychotic or severe persistent disorders, and primary substance abuse disorders, with a staff of fourteen Mental Health Clinicians, four Psychological Counselors, one and three-quarter staff Psychiatrists. Additional staff include twelve Psychiatric Nurses who work directly with patients on the two DOC mental health units. A 1997 survey demonstrated that on a given day 29% (883) of the correctional institutional population is mentally ill as defined in AS 47.30.056. Although there are many inmates in correctional institutions who are mentally ill Trust beneficiaries, the Department of Corrections prioritizes treatment for those individuals with chronic or acute mental illness or severe personality and other disorders who present significant behavior and management problems in the institutions. DOC does not have the mental health staff or resources to treat less severe disorders which include the majority of the personality disorders. DOC mental health does, however, provide crisis intervention and supportive counseling to individuals who are suicidal or experience a traumatic personal loss, such as a death in the family or divorce, that impacts their behavior in the institution. DOC mental health staff address some of the needs of the non-chronic/non-acute population through counseling groups offered to the general prison population and the 48 week offender treatment program.

Department of Corrections mental health staff also treat non-mentally ill individuals who qualify as Trust beneficiaries and who require behavioral management and clinical interventions. These include some inmates who are developmentally disabled, brain injured, and who have severe symptoms of Fetal Alcohol Syndrome/Fetal Alcohol Effect (FAS/FAE). Mental health staff perform assessments, provide treatment, and coordinate appropriate institutional placements for these inmates.

In addition, up to 77% of the inmates treated by DOC mental health staff have co-occurring substance abuse disorders. Mental health staff provide mentally ill/chemically addicted (MICA) groups on the men's and women's inpatient mental health units.

**In Fiscal
Year 1997
DOC
mental
health
staff
treated
1,988
inmates
with
mental
illnesses
and other
disorders.**

All inmates booked into DOC facilities receive a medical and mental status screening by nursing staff within 24 hours of arrest.

The Department of Corrections offers a continuum of care that includes: general mental health services, sheltered living, inpatient care, and community-based services.

I. General Mental Health Services

Title 47 Non-Criminal Mental Health Holds

Department of Corrections medical and mental health staff provide safe and secure custody to individuals brought into Department of Corrections facilities on non-criminal Title 47 mental health holds pending transfer to the Alaska Psychiatric Institute or other Designated Evaluation and Treatment (DET) facilities.

Crisis Intervention

The Department of Corrections provides emergency mental health services to any individual booked into a state correctional facility. Suicide assessments, mental health screenings and crisis interventions are provided by mental health and medical staff at all correctional institutions. Cells equipped with cameras are available to help ensure the safety of inmates requiring crisis intervention services.

Mental Status Screenings and Diagnostic Evaluations

All inmates booked into Department of Corrections facilities receive a medical and mental status screening by nursing staff within 24 hours of arrest. If an inmate reports a mental illness or need to continue medication prescribed in the community, or nursing staff observe psychiatric symptoms, the inmate is referred to the institutional Mental Health Clinician who will research records, conduct a diagnostic evaluation and make recommendations for treatment or behavior management.

Mental Health Housing Assessments

Mental health staff assess the impact of mentally ill inmates' housing assignments on their mental illness. When staff find that a housing change is medically necessary, they complete a mental health housing assessment and forward their evaluation to the institutional Superintendent. Mental health staff provide input for classification staff to ensure inmates are held in the facility most appropriate for security and treatment needs.

Medication Prescription and Monitoring

The Department of Corrections is responsible for determining if an inmate has a condition that warrants medication and for prescribing medications to inmates as needed. At arrest, the institutional Nurse or Mental Health Clinician confirms prescriptions by community providers after obtaining a release of information. It is DOC policy to continue appropriate prescriptions for a confirmed diagnosis when an inmate is initially incarcerated until reviewed by a DOC Psychiatrist. DOC Psychiatrists provide periodic assessment and monitoring of all inmates on psychotropic medications. Dispensing and monitoring of medications occurs at all correctional facilities.

Telepsychiatry

Telemedicine hardware is installed in correctional centers in: Bethel, Fairbanks, Juneau, Kenai, Ketchikan, Nome and Seward. The telemedicine service includes screenings and emergency consultations in between regularly scheduled facility visits by DOC Psychiatrists.

Coordination with API

The Department of Corrections' central office mental health staff coordinates with API on the treatment needs and processing of Title 12 criminal patients, Title 47 civil patients transferred between the Department of Corrections and API, and court ordered psychiatric examinations. DOC and API mental health staff meet weekly to review cases and to coordinate pending referrals and treatment plans.

Prevention and Education Services

The Department of Corrections mental health staff provide suicide prevention and mental health training to correctional officers and other DOC staff in institutions statewide.

Transitional Care

Transitional care is provided for individuals transferring from API to a DOC institution, and from Mike Module or the Hiland Mountain Correctional Center Women's Psychiatric Treatment Unit or the Special Needs Wing to a less specialized or general population setting. Transitional care may include monitoring by the institutional Mental Health Clinician, medication if prescribed, counseling as needed, and temporary placement in a protected living situation such as a single or segregation cell or small dorm.

Discharge Planning to the Community

Department of Corrections mental health staff provide discharge planning for chronic or acutely mentally ill offenders transitioning to the community upon release. The Department of Corrections coordinates with community mental health centers in the intake, treatment and release planning process and refers mentally ill inmates to community treatment agencies for continued treatment after release from DOC institutions. For mentally ill inmates with short lengths of stay in correctional facilities, Mental Health Clinicians attempt to alert community treatment agencies of an inmates' pending release; however, there is not always sufficient time to fashion comprehensive release plans.

48 Week Offender Mental Health Treatment Program

Purpose and Rationale

The 48 week offender program is designed to alter criminal behavior and reduce violent reoffenses by using therapeutic interventions to reduce criminal behavior. The program targets general population inmates who are repeat violent offenders and is available to non-chronic/non-acutely mentally ill inmates. For optimal efficacy, participants must complete the entire program. The program is offered at sentenced facilities as space and resources allow.

Treatment Components

The 48 week offender program consists of four separate treatment phases. Each phase is twelve weeks in duration, with group treatment sessions two hours each week. Each treatment phase addresses a specific deficit area of the offender population. The specific treatment phases of the program include: anger management, criminal thinking errors, values clarification and moral reasoning, and rational problem solving. Preliminary results for the program show a marked improvement in institutional functioning and change in anger management skills and thinking errors for program participants.

DOC mental health staff provide discharge planning for chronic or acutely mentally ill offenders transitioning to the community upon release.

**There are
Men's and
Women's
Special Needs
Wings for
mentally ill,
developmentally
disabled,
organically
impaired and
other special
needs
offenders.**

II. Sheltered Living

Hiland Mountain Correctional Center Women's Special Needs Wing

The Department of Corrections created a Special Needs Wing at Hiland Mountain Correctional Center for mentally ill female offenders who are unable to successfully live in the general prison population. The wing also houses developmentally disabled and organically impaired or other special needs women when needed. The Special Needs Wing is a 15 bed mental health milieu in a medium security setting, emphasizing rehabilitation and supportive care for graduates from the inpatient unit and for women who require a sheltered living level of care. Patients can be moved back and forth between the women's psychiatric treatment unit and the wing as needed.

Patients receive individual and group psychotherapeutic services to improve their skills in healthy living, conflict resolution, moral reasoning, family and parenting issues, communication, relapse prevention, and impulse control. Aftercare plans and referrals to community mental health providers are completed for each patient prior to their release from custody.

Spring Creek Correctional Center Men's Special Needs Wing

Mentally ill male felons with lengthy sentences who have been stabilized on the men's inpatient unit (Mike Module) can be transferred to Spring Creek Correctional Center. Most of these inmates are housed on Echo Module along with general population inmates, in double bed cells, with 24 hour supervision by correctional officers, and added mental health weekday daytime programming. The DOC staff Psychiatrist is available through telepsychiatry and makes site visits for psychiatric follow up on a monthly basis. When acutely mentally ill, inmates are transferred back to Mike Module for restabilization.

At Spring Creek Correctional Center (SCCC), the chronically mentally ill population includes many individuals who are unable to compete with general population inmates for institutional jobs. SCCC mental health staff have created sheltered workshop employment for the mentally ill inmates. Inmates work in a protected environment where there is no risk of competition or failure and where the tasks are attenuated. The program utilizes job coaches, and is designed to assist inmates who have little or no job history or experience.

Lemon Creek Correctional Center "J" Segregation

Lemon Creek Correctional Center has four cells equipped with cameras that are reserved for mentally ill inmates who require stabilization and close observation. Utilization of the cells are at the discretion of Lemon Creek mental health staff.

III. Inpatient

Cook Inlet Pretrial (CIPT) Mike Module

Hiland Mountain Correctional Center (HMCC) Women's Psychiatric Treatment Unit

CIPT Mike Module and the HMCC Women's Psychiatric Treatment Unit are designed to treat acutely and chronically mentally ill offenders who require psychiatric treatment and programming in a highly structured therapeutic milieu. Mike Module is for mentally ill men, and the HMCC Unit is for mentally ill females.

Each unit is a highly structured therapeutic environment where patients are taught to build upon successes and prepare for functioning in other settings. The units are staffed 24 hours a day by mental health and security staff. The daily treatment programs emphasize restorative and basic psychosocial therapies.

Capacity

Mike Module has the capacity to treat up to 29 mentally ill men in need of acute psychiatric treatment.

The HMCC Women's Unit has the capacity to treat up to 18 mentally ill women in need of acute psychiatric treatment.

Admission

The most common reasons that inmates require assessment and treatment on Mike Module are: suicide risk, depression, psychosis, manic states, and delirium. Up to 70% of the inmates treated on Mike Module have co-occurring substance abuse disorders, and a small percentage of the inmates have organic impairments and developmental disabilities.

The most common diagnoses for female inmates treated on the Women's Unit are: depressive disorders, substance abuse disorders, schizophrenia and schizoaffective disorders, and personality disorders. Up to 76% of the mentally ill women treated on the unit have co-occurring substance abuse disorders. Some of the female inmates also have co-occurring developmental disorders, FAS/FAE and organic impairments.

Average Length of Stay

The average length of stay for inmates treated on Mike Module is 60 days; however, patients with severely debilitating conditions may remain on the unit for more extended periods of time.

The average length of stay for inmates treated on the Women's Psychiatric Treatment Unit is 51 days.

Treatment Unit Goals

The immediate goal is to stabilize severely psychotic, unpredictable, and aggressive behaviors to promote participation in rehabilitation programs designed to reduce criminal recidivism. The long term goal of the psychiatric units is to provide greater public safety by improving patient psychosocial functioning and by preventing clinical and legal recidivism.

**The Men's and
Women's
Psychiatric
Treatment
Units are
designed to
treat acutely
and
chronically
mentally ill
offenders.**

The treatment team, under the direction of the DOC Psychiatrist, provides patients with an individualized treatment plan.

Treatment Components

The treatment team, under the direction of a Department of Corrections' Psychiatrist, provides patients with an individualized treatment plan. Each patient's treatment plan specifies therapeutic issues and expectations for participation in the therapeutic milieu programs. The treatment plans further specify privileges that are used to encourage successful participation in the treatment program.

Point and Level System

Most patients are placed on the point and level system according to their treatment plan. The point and level system is designed to provide the patient with the structure necessary for making positive changes. The point and level system has the flexibility to match the individual clinical needs of each patient and is designed to reinforce positive social behaviors and increase adaptive coping skills.

Psychotropic Medication and Management

Psychotropic medications are prescribed when indicated in the treatment of psychiatric conditions. With 24 hour psychiatric staff, it is possible to start patients on medication, assess effectiveness, and make medication adjustments when warranted.

Therapy Groups and Activities

Therapy groups and activities on Mike Module and the HMCC Women's Psychiatric Treatment Unit include: anger management, communication skills, conflict resolution, substance abuse education and treatment, gym, healthy living, impulse control, life skills, parenting skills, problem solving, psychosocial education, school, self esteem, stress management, talking circles, and thinking errors. The Hiland Mountain Correctional Center Women's Psychiatric Treatment program incorporates women's issues into the context of therapeutic activities.

Aftercare Plans

Aftercare plans and referrals to community mental health providers are completed for each patient prior to their release from custody.

Other Acute Care

Medical and administrative segregation and single or small dorm housing are utilized in facilities other than Cook Inlet Pretrial and Hiland Mountain Correctional Center to provide assessment and monitoring for acutely psychiatrically and behaviorally disturbed individuals. Mental health and medical staff are responsible for clinical care.

IV. Community-Based Services

Institutional Discharge Program Plus

The Institutional Discharge Program Plus (IDP+) was created to enhance the intensity and scope of community based services for seriously mentally ill offenders released on felony probation with court-ordered conditions mandating treatment. IDP+ staff coordinate with community agencies to provide treatment, support and housing for mentally ill offenders and offenders with other severe disabilities who are releasing from DOC institutions and returning to the community. While the majority of IDP+ clients have a psychotic diagnosis, some clients have a history of organic brain injury or a severe developmental disability. DOC has a reciprocal service agreement with the Department of Health and Social Services/Division of Mental Health and Developmental Disabilities to provide these services. IDP+ represents a collaborative effort between two Departments to meet the post-incarceration needs of mentally ill felons. The program is designed to foster continuity of clinical care and legal supervision, and to ensure client and public safety. The IDP+ program works to reduce clinical and legal recidivism and facilitate the return of clients to their home communities across the state. Program goals are to connect clients with community services and increase compliance with mental health treatment and probation conditions once released.

IDP+ staff coordinate with community agencies to provide treatment, support and housing for mentally ill offenders and offenders with other severe disabilities.

Target Population

The target population for the IDP+ program are felony offenders who have a major mental illness and clearly established conditions of probation imposed at the time of release from a correctional institution. Most IDP+ clients will have been treated on the DOC mental health inpatient units. Patients are accepted into the IDP+ program only if they are stable and are assessed as appropriate for community placement.

Referral Process

Department of Corrections provides written referrals and aftercare recommendations to the IDP+ Coordinator who then arranges for services with the appropriate community service providers.

IDP+ Services

IDP+ services include: initial consultations, evaluations, group therapy, case management, community support services, psychiatric care and medication, and ongoing monitoring of client participation and progress. Financial assistance and facilitation of transitions to home communities are provided when indicated.

Additional special programs within IDP+ include:

- **Day Treatment:** A day treatment program designed and funded by DOC at Southcentral Counseling Center offers up to 10 IDP+ clients group therapy, daily living skills training, physical activity, and community work service. Groups include: anger management, criminal thinking errors, mentally ill/chemically addicted (MICA), moral development, and relapse prevention.
- **Housing:** A supported housing program through Southcentral Foundation's Qu yana House has been established through IDP+ program funding. IDP+ staff also attempt to locate temporary or long-term housing for clients by using all community resources.

**Jail
Alternative
Services
identifies and
monitors
mentally ill
misdemeanants
who are
released from
jail on court
ordered
probation to
community-
based
treatment.**

Team Approach

The client's treatment and support network is a critical component of post-incarceration adjustment. The coordinated IDP+ team approach gives mentally ill felons the best chance of successfully transitioning into the community and maintaining themselves without reoffending. Typical treatment planning teams and sessions include: the client, Probation Officer, the community mental health provider, DOC mental health staff, guardians and conservators, family members, and the IDP+ Coordinator.

Halfway House Services

Department of Corrections provides mental health services for confined misdemeanants and misdemeanor and felon furloughees at Akeela, Cordova, Glenwood, and Parkview Halfway Houses in Anchorage. A Department of Corrections Psychiatrist and Mental Health Clinician provide medication monitoring and perform mental status examinations.

Specialized Probation Services for Mentally Ill Felons

In the Anchorage area, a Specialized Probation Officer supervises mentally ill offenders on felony probation or parole. The Probation Officer meets weekly with the Department of Corrections and the Division of Mental Health and Developmental Disabilities on Institutional Discharge Program Plus (IDP+) referrals, and reports on the status of those on probation. Frequent and regular meetings are held with the client, the IDP+ Coordinator, and community treatment providers. Outside of Anchorage, the cases are assigned to Probation Officers as part of the regular caseload, with the Probation Officer meeting and coordinating with local community treatment providers as needed.

Jail Alternative Services

Jail Alternative Services (JAS) is a three-year pilot project designed to identify and monitor up to 40 mentally ill misdemeanants who are released from jail on court ordered probation to community-based treatment services. Jail Alternative Services will be assessed for continuation and expansion in the Anchorage area and replication in other Alaska communities at the conclusion of the third year.

The impetus for the project came from the legal community and treatment providers, the Alaska Mental Health Board, Trust Authority, and the Department of Corrections' desire to address the problem of the criminalization of the mentally ill. It is presumed that a combination of reduced bed space at API and a lack of community resources has led to increasing numbers of mentally ill individuals incarcerated in Alaska's correctional facilities. Mentally ill individuals arrested on misdemeanor charges have become a growing problem. Intensive community treatment for mentally ill individuals is less expensive, more effective, and more humane than either incarceration or hospitalization at API.

Eligibility

The project targets mentally ill misdemeanants who are seriously mentally ill or who have an organic brain impairment. While the majority of clients must be offenders with a history of psychosis, the project will also serve up to five individuals with an organic impairment. The mentally ill misdemeanor and defense counsel must agree to participate in Jail Alternative Services. DOC staff assess an individual's suitability for JAS by researching current mental status,

recent compliance with mental health treatment in the community, risk factors, and likelihood of compliance with available mental health treatment in the community.

One of the goals of Jail Alternatives Services is to reduce recidivism for JAS clients.

A Mental Health Clinician Coordinates the Project by:

- Determining individuals who are eligible for the project. DOC Mental Health Clinicians in Anchorage area correctional facilities, and the prosecution and defense Attorneys, or the court can identify mentally ill misdemeanants to the coordinator.
- Providing information and recommendations to counsel and the court for use in sentencing and court-ordered conditions of probation.
- Referring JAS clients to mental health and substance abuse treatment providers.
- Monitoring compliance with court ordered conditions of probation through contact with treatment providers and JAS clients.
- Filing affidavits of non-compliance and obtaining warrants for rearrest when indicated.

Project Goals:

- Improved identification of mentally ill misdemeanants arrested in Anchorage.
- Improved access to mental health and substance abuse treatment services in the community for mentally ill misdemeanants.
- Improved treatment compliance (through court-ordered conditions to comply with mental health treatment).
- Reduced clinical and legal recidivism for JAS clients.
- Identification of gaps in the services available in the community for the target population.

**The Inmate
Substance
Abuse
Treatment
program
provides
substance
abuse
treatment to a
small
percentage of
the inmates
who need such
services.**

Substance Abuse Treatment Services in the Department

Department of Corrections Inmate Substance Abuse Program Mission:

Inmates impacted by substance abuse and chemical dependency should be provided with the opportunity for education, treatment and recovery in order to prevent relapse and recidivism. The Department of Corrections will provide substance abuse services through the Inmate Substance Abuse program in all institutions.

The Department of Corrections offers substance abuse treatment services to a range of individuals with substance abuse disorders including those inmates who qualify as Trust beneficiaries by virtue of a diagnosis of chronic alcoholism with psychosis. A 1997 independent survey demonstrated that 8% (258) of the inmates in DOC institutions are chronic alcoholics with psychosis on a sample day. Researchers identified an additional 1,219 inmates who did not qualify as beneficiaries, but who had indicators of significant alcohol and drug involvement such as a diagnosis of substance abuse dependence and previous involvement in treatment. Researchers recommended providing treatment to these inmates to prevent them from becoming chronic alcoholics with psychosis beneficiaries. The Department of Corrections provides substance abuse treatment services to a larger group of inmates than the Trust beneficiaries.

Fiscal Year 1997 duplicated data demonstrates that Inmate Substance Abuse Program (ISAT) counselors performed 1,577 clinical assessments, admitted 1,681 inmates to the educational component of the ISAT program and admitted 807 inmates to the outpatient treatment. The National Center on Addiction and Substance Abuse reported that although 70-85 percent of inmates in state and federal prisons need some level of substance abuse treatment, in 1996 only 13 percent of inmates were receiving such treatment.

The current Alaska DOC Inmate Substance Abuse Treatment Program (ISAT) provides substance abuse treatment to a small percentage of the inmate population that is estimated to need such treatment services. There are currently waiting lists for substance abuse services in most facilities, and there is a substantial waiting list in all facilities for clinical substance abuse assessments. In addition, DOC does not currently have the resources to provide the intense level of substance abuse treatment that a substantial number of its most chronically addicted offenders need. In their 1999 state plan, the Advisory Board on Alcoholism and Drug Abuse explains that drugs and alcohol are prevailing factors in Alaska's crime rate, as the vast majority of the incarcerated population has substance abuse problems. The board indicates that the revolving door syndrome (inmates cycling in and out of the correctional system) can be addressed through timely and effective substance abuse treatment during incarceration and following release into the community.

Although DOC offers a continuum of substance abuse treatment services, the capacity to treat inmates in need of services is extremely limited. Providing adequate substance abuse treatment services in a timely manner is critical for reducing clinical and legal recidivism. In addition, for at least the last seven years the funding level for Inmate Substance Abuse Treatment Programs has not increased.

Inmate Substance Abuse Program (ISAT) Philosophy

- All ISAT programs support the philosophy that chemical dependency is a multifaceted disease which affects an individual physically, psychologically, cognitively, socially, spiritually and emotionally. Chemical dependency is characterized by loss of control and a need to use in spite of past and probable future consequences, and is further characterized by a tendency to relapse.
- All ISAT programs endorse the theory that although a chemically dependent individual may not be responsible for their disease, they are responsible for their own recovery.
- The treatment of chemical dependency must incorporate the concept of abstinence.
- All ISAT programs endorse the use of positive support groups such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, Christian 12 Steps, and Adult Children of Alcoholics. Every institution has at least one of these support groups available to inmates. Substance abuse treatment is enhanced by consistent participation in positive support groups. A support group consists of a group of recovering alcoholics and/or addicts who meet on a regular basis and whose meetings are based on written principles which support a plan of recovery.
- Any inmate who completes ISAT treatment will need some level of aftercare in the community.
- The ISAT program places an emphasis upon culturally relevant programming.

**There is an
Inmate
Substance
Abuse
program in
all
correctional
facilities.**

Overview of the Inmate Substance Abuse Treatment Program

There is an Inmate Substance Abuse Program (ISAT) in each of DOC's thirteen institutions, as well as at the Point MacKenzie work farm and the Central Arizona Detention Center (CADC). Services are provided through contract with six state approved agencies who collectively employ 25 Counselors, some of whom are part time. In addition, the Central Arizona Detention Center has seven substance abuse Counselors. Programs vary due to the different functions and locations of the correctional facilities. For example, a pre-trial facility with a rapid population turnover such as the Sixth Avenue Correctional Center, has an ISAT education program staffed by one part-time ISAT Counselor. In contrast, Spring Creek Correctional Center, a sentenced long-term facility with a relatively slow population turnover, provides institutional outpatient treatment through two full-time ISAT Counselors. Although all institutions provide assessments and basic alcohol and drug education courses, there are waiting lists for these services.

The continuum of care in DOC institutions includes: emergency services, basic alcohol and drug education, education with an introduction to treatment, institutional outpatient services, and residential substance abuse treatment services. The residential level of care is only available for female inmates.

ISAT programs are not specifically designed for treating inmates with co-occurring disorders of substance abuse and mental illness or developmental disabilities. One exception is the Women's Residential Substance Abuse Treatment program which is capable of providing specialized treatment to some female inmates with co-occurring disorders. Mentally ill inmates who are stable and developmentally disabled inmates may be accepted into the program on a case by case basis. Inmates who are court-ordered to substance abuse treatment programs are given

The education program provides inmates with information on substance abuse and chemical dependency.

priority for receiving services in DOC. If inmates are court-ordered to participate in substance abuse treatment they can lose good time and furlough eligibility or have their probation revoked if they refuse to participate in treatment. For other inmates participation in substance abuse treatment is voluntary. These inmates are placed on waiting lists after court-ordered inmates. Most institutions have waiting lists for substance abuse treatment, and all institutions have waiting lists for clinical assessments.

I. Emergency Services

Title 47 Non-Criminal Holds

The Department of Corrections provides crisis intervention services to individuals brought into correctional facilities on non-criminal Title 47 substance abuse holds. Department medical staff provide monitoring for these individuals to ensure their safety. All booking facilities have holding cells for Title 47 non-criminal placements.

Intravenous Drug Users and Pregnant Women

Typically ISAT programs have waiting lists for services, however, if an inmate is an intravenous drug user or is pregnant, they are seen as soon as possible by an ISAT Counselor if they are releasing into the community. Intravenous drug users are provided with referrals and information associated with health risks and needle use. Pregnant offenders are provided referrals and health information on such issues as Fetal Alcohol Syndrome and Fetal Alcohol Effect.

II. Education

The education level of care is offered at the following institutions by the following providers:

Ketchikan	Akeela Treatment Services	1 half-time ISAT Counselor
Mat-Su Pretrial	Mat-Su Council	1 half-time ISAT Counselor
Point Mackenzie	Mat-Su Council	1 full-time ISAT Counselor
Sixth Avenue	Clitheroe Center	1 half-time ISAT Counselor
Yukon-Kuskokwim	Akeela Treatment Services	1 full-time ISAT Counselor

Program Description

The ISAT education programs are designed for the short-term high turnover inmate population. The education program strives to provide inmates with information on substance abuse and chemical dependency, and to provide inmates with clinical assessments and referrals to community based treatment. Education may also set the stage for treatment in a sentenced facility or in the community by giving inmates a knowledge base of substance abuse treatment issues.

Referral Process

Inmates request substance abuse education services, are placed on a waiting list, and are screened by an ISAT Counselor. Inmates are enrolled in the education program on a first come first serve basis, regardless of the intensity of their treatment needs.

Components

All ISAT education programs include a minimum of twenty hours of class work on specified subjects, however programs may extend beyond the basic education requirements. Pre and post tests of an inmate's knowledge base in substance abuse are also conducted as part of the education program.

III. Education with an Introduction to Treatment

The education with an introduction to treatment level of care is provided at the following institutions by the following treatment agencies:

Cook Inlet Pre-Trial	Clitheroe Center	1 ISAT Counselor
Fairbanks Correctional Center	RCOA	2 ISAT Counselors

Program Description

Education with an introduction to treatment is the level of care that offers more than substance abuse education, but does not include complete outpatient treatment. The programs act as a springboard to treatment in the community or to treatment in a long-term facility for those inmates who need more than substance abuse education.

Referral Process

Inmates are referred to the program by Institutional Probation Officers, or they may make a request to participate in the program themselves. Inmates are screened by the ISAT Counselor for substance abuse or chemical dependence, treatment needs, and are placed on a waiting list for services.

Components

At Cook Inlet Pre-Trial, individual counseling and an individualized treatment plan are provided in conjunction with the educational component. At Fairbanks Correctional Center an advanced education component that introduces treatment concepts, begins after the basic education program and is presented in a group format.

Community Transitions

ISAT participants at CIPT and FCC who are pending immediate release, are provided with information regarding community resources for treatment and support systems for the recovery process. For those ISAT participants who are in the program for a longer period of time, formal referrals to community treatment providers are made.

Education with an introduction to treatment offers more than substance abuse education, but does not include complete outpatient treatment.

Institutional outpatient treatment includes substance abuse education, primary care and aftercare.

IV. Institutional Outpatient Substance Abuse Treatment Services

Institutional outpatient care is provided at the following institutions by the following treatment agencies:

Anvil Mountain	Northern Lights Recovery Center	1 ISAT Counselor
Arizona Detention Ctr.	Arizona Detention Center	7 CADC Counselors
Lemon Creek	Gastineau Human Services	1 ISAT Counselor
Meadow Creek	Clitheroe Center	1 ISAT Counselor
Palmer	Mat-Su Council	3 ISAT Counselors
Spring Creek	Akeela Treatment Services	2 ISAT Counselors
Wildwood	Akeela Treatment Services	2 ISAT Counselors

Program Description

Inmates who are clinically assessed by ISAT Counselors as needing an outpatient level of care are eligible to receive treatment. The institutional outpatient level of treatment consists of four phases: substance abuse education, primary care, and aftercare. The duration of the program varies depending upon the nature of the institution. For example, at Spring Creek which is a long-term facility, the program is greater in duration than at the Palmer Correctional Center where the outpatient program is shorter and more intensive due to the quick turnaround of the inmate population.

Referral Process

Inmates are referred to the program by Institutional Probation Officers, or they may make a request to participate in the program themselves. Inmates are screened by the ISAT Counselor for substance abuse or chemical dependence, treatment needs, and are placed on a waiting list for services.

Components

All institutional outpatient treatment programs include clinical assessments, substance abuse education, individualized treatment plans, individual and group counseling, and aftercare. Additional treatment topics include: identifying treatment issues, denial, identifying and understanding the impact of alcohol and drug abuse on the individual, and relapse prevention.

Discharge Summaries

ISAT Counselors provide discharge summaries for each inmate who completes treatment or who is removed from the treatment program (due to disciplinary, transfer, or release). The discharge summary includes the client's progress in treatment, and recommendations for aftercare or further treatment either in the community or in another correctional facility.

Community Transitions

Counselors strive to assist ISAT participants to successfully transition into the community when they are eligible for release. ISAT Counselors refer inmates to community substance abuse treatment programs and other resources as needed. All graduates of the institutional outpatient ISAT program will need at least aftercare services when they make the transition to the community, because although inmates may be program complete, they are not treatment complete.

Probation/Parole Conditions

The offender's participation in an ISAT program counts toward fulfilling a treatment condition of probation or parole. Offenders will need to be re-evaluated in the community, with recognition of treatment progress in the institution.

V. Residential Substance Abuse Treatment Services

The Department initiated a Residential Substance Abuse Treatment Program for its female offenders at Hiland Mountain Correctional Center (HMCC) in November of 1998. The Residential program allows the Department to provide intensive treatment to 64 female inmates at a time. It estimated that the Department will treat up to 100 female inmates throughout the course of a year.

DOC has designated one of the four houses at HMCC to the Residential Substance Abuse Treatment Program. Enhanced treatment services are provided through five contract Inmate Substance Abuse (RSAT/ISAT) Counselors and a Treatment Coordinator. Each of the four wings of the house holds sixteen female inmates involved in one of the three phases of substance abuse treatment.

Women's Residential Substance Abuse Treatment Program

<u>Wing</u>	<u>Treatment Phase</u>	<u>Duration</u>	<u>Inmates</u>
Wing I	Phase I: Education	60 Days	16
Wings II&III	Phase II: Treatment	180 Days	32
Wing IV	Phase III: Transitional Care	120 Days	16

The RSAT/ISAT Counselor on the education wing provides a 60 day education program to Phase I inmates who are being assessed for HMCC's Residential Substance Abuse Treatment Program. Two wings are devoted to Phase II of treatment which is 180 days in duration. Women have individualized treatment plans and attend individual and group therapy sessions. The fourth wing houses women in Phase III transitional care, which is provided for approximately 120 days. At least one female in transitional care resides in each of the other three wings serving as a role model for women who are more recently in recovery. Throughout all phases the women participate in institutional jobs and educational/vocational classes with inmates in the general population.

Treatment Components

- Assessments.
- Individualized treatment planning.
- Urinalysis screenings.
- Individual and group counseling:
 - Cognitive skill building.
 - Sober living skills.
 - Parenting skills.
 - Family counseling (children and other family members visit and participate in programming when appropriate).
 - Conflict resolution.
 - Values clarification.
 - Criminal thinking/behavior.

DOC initiated a Residential Substance Abuse Treatment Program for female offenders at Hiland Mountain Correctional Center.

There are residential substance abuse treatment beds throughout the state that are available for individuals on furlough and probation and parole.

Project Goals

- An increase in the number of female inmates receiving substance abuse treatment services including assessments, substance abuse education, treatment, and referrals.
- A reduction in the waiting list for women requiring and requesting substance abuse treatment at HMCC.
- An increase in the number of program completions.
- An increase in the number of women who are connected with community based services.

VI. Community Based Services

Community Residential Substance Abuse Treatment Beds

The Division of Alcoholism and Drug Abuse provides funding for residential substance abuse treatment beds throughout the state that are available for individuals on furlough and probation and parole. In Fiscal Year 1995, a total of 39 beds were designated for DOC clients. Since that time there has been a reduction in residential treatment options for offenders. There are currently 27 beds designated for DOC clients: 22 beds are reserved for furloughees and 5 beds are reserved for probationers and parolees. There are waiting lists for all programs with designated beds.

Inmates who are in a Department of Corrections' ISAT program and are assessed as needing a greater level of care than the program provides, may be furloughed to a residential substance abuse treatment bed if available. Field Probation/Parole Officers refer probationers and parolees to these beds when offenders have court or parole conditions that specify completion of residential treatment. If a probationer or parolee relapses and violates the condition that they not use alcohol or drugs, a clinical assessment may be required. If the assessment indicates a need for residential treatment, the court or Parole Board may choose to refer the probationer or parolee to a residential treatment bed instead of returning to incarceration.

Enhanced Probation/Parole Services

The Department of Corrections' Division of Community Corrections operates Enhanced Probation/Parole Services (EPPS) in Anchorage. The Parole Board and Probation Officers refer offenders to the EPPS program. EPPS offers enhanced programming, supervision and surveillance to stabilize offenders who are engaging in behavior that can lead to recidivism. The EPPS program targets probationers and parolees who are substance abusers and/or who have domestic violence behavior, and who have current non-felonious violations of their community supervision conditions. Components of the EPPS program include: substance abuse programming, victim impact classes, cognitive self-change, education, life and social skills classes, enhanced surveillance and case management. The Enhanced Probation/Parole program serves as an effective intermediate sanction and supervision strategy that falls between full incarceration and regular probation/parole supervision.

Department of Health and Social Services/Alcohol Safety Action Program (ASAP)

The Department of Health and Social Services' Alcohol Safety Action Program provides alcohol screening, referral, and monitoring of court-ordered conditions in civil and criminal misdemeanor cases. To qualify for ASAP services, individuals

must have a current or pending civil or criminal justice case. Most clients are referred directly from the court as a condition of the suspended portion of their sentence, although they may be assigned to ASAP prior to their conviction as a condition of release. The principle function of ASAP is to provide case monitoring and accountability for DWI and other alcohol/drug related misdemeanor cases. ASAP screens cases referred from the district court into drinker classification categories, and manages and monitors cases throughout education and/or treatment assignments. Individuals classified as non-problem drinkers are referred to an alcohol information school approved by the Department of Public Safety. Problem drinkers are referred to state approved alcohol and drug treatment agencies.

If clients fail to complete their required assignments, a noncompliance affidavit is filed with the prosecution, which may result in a Petition To Revoke Probation (PTRP) being filed with the court. Once filed, the magistrate or judge may issue an order to show cause or a bench warrant, and require further hearings to determine the appropriate sanctions.

VII. Special Projects

LINKS (Living In New Knowledge Successfully) Discharge Project

The mission of LINKS is to provide successful transitions that enhance recovery and permanency planning (reunification, relative placement, guardianship, and adoption) for female offenders with children completing the Hiland Mountain Correctional Center Women's Residential Substance Abuse Treatment Program and returning to the greater Anchorage community.

An interdisciplinary team composed of representatives from the Department of Corrections, the Division of Alcoholism and Drug Abuse, the Advisory Board on Alcoholism and Drug Abuse, the Division of Family and Youth Services, and community-based substance abuse treatment providers has created enhanced discharge services for female inmates with children who are graduates of the HMCC Residential Substance Abuse Treatment Program (RSAT). The project team also developed operational guidelines to delineate roles and responsibilities of Departments and agencies. Discharge planning for the target population occurs through a coordinated team approach from the HMCC RSAT Social Worker, institutional and field Probation Officers, RSAT/ISAT Counselors, community treatment providers, and the Division of Family and Youth Services.

LINKS provides the support necessary for female offenders to successfully transition into the community. The rationale for the project is that the transition into the community must support the recovery process initiated in the institution. The transition process for women can be particularly critical, as they often need to re-establish parental relationships, find economic support, safe and sober housing, and comply with DOC Probation Officer and DFYS requirements. It is anticipated that the project will assist in reducing clinical and legal recidivism.

**LINKS
provides
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Residential
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Treatment
Program.**

The data from the ADAM survey will show the connections between drug use and specific crimes.

Substance Abuse Need for Treatment Among Arrestees (SANTA)

The Department of Corrections, the Division of Alcoholism and Drug Abuse, and the state Department of Epidemiology conducted the Substance Abuse Need for Treatment Among Arrestees (SANTA) study. Voluntary interviews and urinalysis testing were conducted on arrestees at Sixth Avenue Correctional Center, Cook Inlet Pretrial facility, Fairbanks Correctional Center and Yukon Kuskokwim Correctional Center for five months in 1997. Information was also collected on inmates' substance abuse histories, and their previous involvement in treatment programs. Due in part to the success of the SANTA study, the National Institute of Justice selected Alaska for participation in the Arrestee Drug Abuse Monitoring Program (ADAM).

Arrestee Drug Abuse Monitoring Program (ADAM)

The Alaska Department of Corrections and Division of Alcoholism and Drug Abuse (ADA) are participating in the Arrestee Drug Abuse Monitoring Program (ADAM) study sponsored by the National Institute of Justice. The principle goals of ADAM are to identify the levels of drug use among arrestees, track changing drug use patterns, identify specific drugs of abuse in different communities, and provide research for drug-related policy initiatives. Data will be collected from inmate interviews and urinalysis screenings of arrestees at the Sixth Avenue Correctional Center and the Cook Inlet Pretrial Facility, for two weeks each quarter from 1998 through 2,000. Data collection began on September 17, 1998. The Division of Alcoholism and Drug Abuse administers the project and will provide the results of the project to law enforcement officials. The program may be extended to areas outside of Anchorage through an amendment to the original survey. The data from the ADAM survey is designed to demonstrate the connections between drug use and specific crimes. It will also assist DOC, ADA, and law enforcement entities in addressing issues related to substance abuse and crime in the state of Alaska.

Fetal Alcohol Syndrome and Fetal Alcohol Effect Prevention

The Department of Corrections has begun to collaborate with the Department of Health and Social Services/Division of Maternal Child and Family Health to identify high risk/short-term female inmates in order to provide health care and substance abuse education and prevention services. The goals are to educate, intervene, and link high risk women with health care and substance abuse treatment programs in the community, in an effort to prevent Fetal Alcohol Syndrome and Fetal Alcohol Effect.

Recommendations for Trust Beneficiaries

I. Prevent Trust Beneficiaries from Entering the Criminal Justice System

The Department of Corrections will continue to advocate for an adequate and effective continuum of community-based care for Trust beneficiaries. DOC recognizes that effective community-based mental health, substance abuse, and other treatment services are essential to help prevent beneficiaries from entering the criminal justice system. The Alaska Mental Health Board has recommended enhancing community support systems for the mentally ill to help prevent imprisonment. The Advisory Board on Alcoholism and Drug Abuse has recommended developing sufficient resources to meet community needs by providing a full continuum of care that offers appropriate levels of treatment for adults, youth, and communities. The Department of Corrections in conjunction with other state Departments and agencies is considering and may recommend specific new initiatives to help prevent beneficiaries from entering DOC.

Effective community-based mental health, substance abuse, and other treatment services are essential to help prevent beneficiaries from entering the criminal justice system.

Mental Health Community-Based Continuum of Care for Mentally Ill Offenders

The following is the proposed community-based continuum of care for mentally ill offenders adopted by the Alaska Mental Health Board's Forensic Action Team and contained in the current AMHB plan "A Shared Vision II." Underlined items are currently missing from the delivery system. The effectiveness of the proposed continuum, and efforts to divert and successfully treat and maintain mentally ill individuals in the community, will rely on all pieces of the continuum being operational. While it is recognized that the recommended additions to the continuum are not the responsibility of the Department of Corrections, they are critical components to reducing clinical and legal recidivism among mentally ill offenders. It is recommended that appropriate state Departments and agencies work to ensure that an adequate continuum of care for mentally ill offenders exists in the community based upon each community's needs and abilities. The Department of Corrections will continue to advocate for such services and partner with agencies responsible for community-based services.

Prevention

- Community mental health center programs ranging from emergency care to outpatient support to intensive 24 hour supervised care in the community, including a full range of housing options.
- Access to hospital treatment beds.
- Mentally ill inpatient stay at hospital long enough to be stabilized.
- Long term or tertiary care in a structured setting for the severely chronically mentally ill.
- Specialized substance abuse treatment for the mentally ill emphasizing relapse prevention to be offered in the community.

An adequate continuum of housing options available to seriously mentally ill offenders releasing into the community must be provided.

Initial Contact with Law Enforcement

- Dependent on the nature of the offense and the presenting mental status and behavior of the individual that comes to the attention of the law enforcement officer, the officer may:
 - a. Make a decision to charge.
 - b. Consider prearrest diversion.
 - 1. Obtain screening, assessment, and referral by community service gatekeeper in larger communities.
 - 2. Directly transfer the individual for assessment by outpatient mental health providers, hospital or detox facility.

Post Release Treatment and Services

- A variety of community based care providers with responsibility for monitoring and case management.
- Specialized Probation Officers for mentally ill male and female felons, and some form of supervised monitoring.
- Options in housing ranging from 24 hour structured supervised housing, to group homes, to independent apartments with case management.
- Programs that provide daily structure, support, rehabilitation, treatment, and supervision. These could include partial hospitalization, specialized work programs, clubhouses, therapeutic/recreational activities, life skills, and anger management as needed by the individual.
- Specialized substance abuse treatment for the mentally ill (emphasizing relapse prevention), including residential, outpatient, transitional, and long-term specialized housing.
- Option of intensive case management with daily outreach contact.
- Specialized sex offender treatment for mentally ill offenders (modified relapse prevention model).

Needed Service Expansion in the Mental Health Community-Based Continuum of Care for Mentally Ill Offenders

Appropriate state Departments and agencies may explore options and additional resources for:

Housing:

An adequate continuum of housing options available to seriously mentally ill offenders releasing into the community must be available. Although this population continues to grow steadily, the number of community programs and beds has not. A continuum of housing options for mentally ill beneficiaries should include: 24 hour structured supervised housing, group homes, and independent apartments with case management.

Immediate access to housing is critical for mentally ill offenders to successfully transition into the community. Currently there are no facilities that provide guaranteed transitional housing for mentally ill offenders releasing from DOC institutions. Frequently, these individuals are released directly from structured treatment in correctional facilities to a motel room or a shelter. These facilities cannot provide the support, supervision and safety that is essential for mentally ill offenders to successfully transition into the community. Many assisted living centers and other housing programs are forced to deny access to DOC clients because of restrictive

statutes and regulations. Often the very people who need structured supervised placement the most are denied access and are, therefore, at a greater risk for reoffending.

Dual Diagnosis Treatment Beds:

Effective dual diagnosis treatment programs are critically needed to prevent relapse of mentally ill offenders released to the community. Up to 77% of the mentally ill inmates treated in DOC have co-occurring substance abuse disorders. Substance abuse is a major contributing factor in probation violations and new offenses, both of which can result in rearrest and booking into correctional facilities. The number of accessible and effective treatment beds is currently inadequate. Given the prevalence of substance abuse problems among the mentally ill offender population, there is an immediate need for dual diagnosis treatment beds and aftercare that will accept mentally ill offenders. Current statutes and zoning regulations often prohibit residential programs from accepting individuals with an assault or arson history, or untreated sex offenders. Developing culturally relevant flexible programs that will keep individuals from 30 to 180 days is essential to effectively meet the treatment needs of the diverse population. Dual diagnosis treatment programs must have staff with expertise in mental illness and substance abuse disorders, with an ability to incorporate a variety of treatment modalities to address the needs of this difficult to manage population. Adequate psychiatric supervision and training are also essential.

Effective dual diagnosis treatment programs are critically needed to prevent relapse of mentally ill offenders released to the community.

Enhanced Day Treatment Services:

The Department of Corrections supports the Alaska Mental Health Board's recommendation to create and increase the number of programs that provide daily structure, support, rehabilitation, treatment and supervision. These could include partial hospitalization, specialized work programs, clubhouses, therapeutic/recreational activities, life skills, and anger management. Additional day treatment slots are currently needed for Institutional Discharge Program Plus(IDP+) and Jail Alternative Services (JAS) clients.

Emergency and Respite Services:

Emergency and respite services for mentally ill individuals in the community must be expanded. It is also critical to ensure that such services are accessible to mentally ill offenders, including those with a history of assault or aggressive behavior. Community Mental Health Centers need to provide adequate emergency and crisis intervention services to reduce the need for hospitalizations.

Designated Evaluation and Treatment (DET) Beds:

Ensuring that there are adequate numbers of Designated Evaluation and Treatment (DET) beds in individual communities is essential. With the downsizing of API projected in API 2000, additional DET beds must be created in the Anchorage area and in regional centers throughout the state, so that alternatives to API exist for acute care needs. It is critical to provide Designated Evaluation and Treatment beds that keep mentally ill individuals long enough to ensure that they are stable before release, and to assist with effective transitions to community-based services. This may require treatment for 30 or more days for individuals who require further psychiatric stabilization.

**Community
based services
for organically
impaired
individuals are
necessary.**

Intensive Case Management:

Intensive case management services are often not available from community mental health centers for high risk individuals. Daily case management services for mentally ill offenders in combination with supported housing options and enhanced day treatment services are critical components to successful re-integration and reduced recidivism.

Treatment for Organic Brain Disorders:

Community based services for organically impaired individuals must be created. Currently, no agency or programs are specifically designated to treat and manage individuals with organic brain syndromes. Estimates are that at least 25-30 organically impaired individuals are arrested annually in the Anchorage area who are occupying DOC beds and are released into the community with minimal or non-existent community support services. There is a critical need for case management, treatment, and housing resources for this population. Funding and policy decisions by state planning agencies are necessary before agencies can develop appropriate programs for the population.

Vocational Training, Employment, Education, Financial Assistance:

Mentally ill offenders should have access to vocational training, employment opportunities, education (including GED completions), and financial assistance to increase their ability to function in the community, and to enhance their self-esteem.

Specialized Sex Offender Treatment:

There is a need to provide specialized sex offender treatment for mentally ill individuals in the community. Such programs could provide intensive monitoring for mentally ill sex offenders, and assist individuals to recognize relapse symptoms and reduce at-risk behaviors.

Enhanced Detoxification Services:

Staff in detox centers need training to recognize symptoms of detox, suicide and mental illness. Mechanisms for effective referral and linkage to continued community based treatment are also necessary.

The Department of Corrections will continue to advocate for an adequate and effective community-based continuum of care for mentally ill offenders.

Substance Abuse Community-Based Continuum of Care

In their 1999 state plan, the Advisory Board on Alcoholism and Drug Abuse (ABADA) recommends providing a full continuum of care with appropriate levels of treatment for adults, youth, and communities. The board explains that it is not possible for every community in Alaska to have all elements in the continuum of care. ABADA's goal is to have the full continuum of care available to all Alaskans, and to ensure that each community has the appropriate levels of care as determined by problem prevalence, demand, and utilization of services. Examples of this strategy include establishment of detoxification facilities in hub communities, strategic placement of long term and domiciliary care facilities around the state, and development of special programs such as inhalant abuse treatment where appropriate.

ABADA explains that it is critical that all providers understand the entire service delivery system and utilize the available resources in the best interest of the clients and their families.

The substance abuse community-based continuum of care should be designed so that any individual seeking care can access care that is clinically appropriate. As this is not always possible, each community needs to have a method to provide access to the appropriate care as needed

Statewide Substance Abuse Community-Based Continuum of Care

Outreach

- Education
- Prevention
- School-Based Counseling Programs
- Employer-Based Counseling Programs

Emergency Care

- Community Health Providers
- Community Service Patrols
- Sleep-off Shelters
- Social Setting Detoxification
- Medical Setting Detoxification

Assessment - Evaluation

Treatment

• Residential

- Short Term
- Long Term
- Specialized
- Youth
- Women and Children
- Therapeutic Community
- Dual Diagnosed
- Prison Based
- Halfway House-Transitional Living

• Outpatient

- Day Treatment
- Intensive
- Non-Intensive
- Methadone Maintenance

- Continuing Care - Aftercare
- Self Help-Peer Support Groups

Within the substance abuse community-based continuum of care, there is often outside supervision such as: the Alcohol Safety Action Program (ASAP), Department of Corrections Probation/Parole, court system, EAP's, Division of Family and Youth Services and Public Assistance.

The substance abuse community-based continuum of care should be designed so that any individual seeking care can access care that is clinically appropriate.

Increased access to detox beds to meet the need in each community is essential.

Needed Service Expansion in the Statewide Substance Abuse Community-Based Continuum of Care

Appropriate state Departments and agencies may explore options and additional resources for:

Dual Diagnosis Treatment Beds:

Additional community-based treatment alternatives for individuals in the criminal justice system who have a substance abuse disorder and either: a mental illness, developmental disability, or organic impairment must be created. Ensuring that offenders have access to these services is also important. Current statutes and zoning regulations often prohibit residential programs from accepting individuals with an assault or arson history, or untreated sex offenders.

Detox Beds:

Increased access to detox beds to meet the need in each community is essential. For example, in Bethel there is currently a need for detox beds, as Yukon Kuskokwim Correctional Center has the second highest number of Title 47 non-criminal holds (the majority of which are substance abuse holds) in the state, with 633 holds in Fiscal Year 1998.

Transitional Housing:

Additional substance abuse transitional housing options for DOC clients are necessary. Safe and sober living situations will help DOC clients maintain sobriety and treatment goals and may ultimately assist in reducing recidivism.

Residential Substance Abuse Treatment Beds:

Additional community residential substance abuse treatment beds for DOC clients are needed. Current utilization statistics demonstrate that there are more correctional clients who need this level of treatment than there are designated beds. For example, in August of 1998, there was an average bed utilization rate of 133%, with utilization rates as high as 490% at Yukon Kuskokwim Health Corporation in Bethel.

Transitional Care Services:

It is critical to provide transitional care services in the community for offenders who have participated in substance abuse treatment while incarcerated. When an offender is placed on probation or parole, typically they have a condition of probation or parole that they receive a substance abuse treatment evaluation, and that they follow through with treatment recommendations. Currently, it is difficult for offenders to receive evaluations in a timely fashion, due to waiting lists for community programs. The time period following release from incarceration is critical, as many reoffenses occur within the first three months post-incarceration.

Offender Support Services:

There is a need for access to safe and appropriate housing, food, clothing, medication services, and employment and vocational training to help promote recovery in the community.

Department of Corrections will continue to advocate for an adequate and effective substance abuse community-based continuum of care.

The Department of Corrections in conjunction with other state Departments and state agencies may explore new initiatives to help prevent beneficiaries from entering the criminal justice system.

Two Anchorage district court judges now hear cases involving mentally ill, developmentally disabled and organically impaired individuals.

Single Point of Entry and 23 Hour Crisis Stabilization Program:

The Alaska Psychiatric Institute (API) Community Implementation Plan includes provisions for developing a 24 hour single point of entry system for all hospital and community-based emergencies in Anchorage. The Alaska Mental Health Board explains that in large communities a single point of entry, or one place where law enforcement can bring people experiencing mental difficulties may be a partial solution to the criminalization of the mentally ill. With a single point of entry, police may no longer feel that an individual needs to be booked into a correctional facility in order to provide for their safety and linkage with treatment resources. The establishment of a single point of entry system is designed to streamline the admission process for inpatient services and help identify appropriate community based alternatives to hospitalization and incarceration. The API plan also includes a provision for developing a 23 hour crisis stabilization program with observation and stabilization capabilities.

Specialized Sentencing Programs for Trust Beneficiaries:

Jail Alternative Services (JAS) is a pilot program designed to divert mentally ill misdemeanants in Anchorage whose crimes result from their illness from the criminal justice system to community based treatment. The JAS program links and monitors client compliance with court-ordered treatment in the community. The Department of Corrections, Decriminalizing the Mentally Ill Subcommittee of the Criminal Justice Assessment Commission, Alaska Mental Health Board, and Trust Authority will evaluate Jail Alternative Services for continuation and expansion in the Anchorage area and replication in other Alaskan communities. Opportunities for serving other categories of beneficiaries with such programs may also be explored.

Court Coordinated Resources Project (Mental Health Court):

The Court Coordinated Resources Project is a process whereby two Anchorage district court judges hear cases involving mentally ill, developmentally disabled and organically impaired individuals. The goal of the project is to identify eligible defendants, coordinate criminal justice and community mental health resources in the case, and divert individuals from jail by linking them with community services and ordering the services as conditions of probation with suspended jail time imposed. Based upon positive outcomes, the court system may consider replicating the project in other judicial districts.

Drug Courts:

The Alaska court system received a planning grant to explore options for utilizing drug courts to divert first time drug offenders. There are many different models of drug courts across the country. They can be utilized to create sentencing options for substance-abusing offenders who have had previous convictions. Drug courts may also be utilized for individuals already under the supervision of the Department of Corrections who need intervention, such as probationers who relapse. Drug court judges can intervene and fashion treatment-oriented sentences and special conditions.

The continuum of mental health services in DOC includes general mental health services, sheltered living, inpatient care and community-based services.

II. Provide Appropriate and Effective Treatment for Trust Beneficiaries in Department of Corrections

Existing Mental Health Continuum of Care in DOC

General Mental Health Services

- Title 47 non-criminal mental health holds.
- Crisis intervention.
- Mental status examinations and diagnostic evaluations.
- Mental health housing assessments.
- Medication prescription and monitoring.
- Telepsychiatry.
- Coordination with API.
- Prevention and education services.
- Transitional care within institutions.
- Discharge planning to the community.
- 48 week offender treatment program.

Sheltered Living

- Hiland Mountain Correctional Center Women's Special Needs Wing.
- Spring Creek Correctional Center Men's Special Needs Wing.
- Lemon Creek Correctional Center "J" Segregation.

Inpatient

- Cook Inlet Pre-Trial Mike Module.
- Hiland Mountain Correctional Center Women's Psychiatric Treatment Unit.
- Other acute care in outlying institutions.

Community-Based Services

- Institutional Discharge Program Plus (IDP+).
- Halfway House services.
- Specialized probation services.
- Jail Alternative Services.

Mental Health Treatment Recommendations

The Department of Corrections will explore options and additional resources to implement the following prioritized recommendations. Prioritization is based upon clinical necessity.

Men's Sub-Acute Care Unit:

There is currently a need for additional sub-acute care beds for mentally ill male inmates. The Department of Corrections needs to explore options for creating a 20-25 bed sub-acute care unit for mentally ill men, with staffing levels comparable to those on its acute care unit.

Although there is a sheltered living wing for mentally ill men, it is not located in the same facility or in geographic proximity to the men's acute care unit. The men's acute care unit is located at Cook Inlet Pretrial facility in Anchorage. The sheltered living wing (Echo Module) is located at Spring Creek Correctional Center in Seward. The wing can house up to 50 mentally ill men. With the conversion of Hilland Mountain Correctional Center to a female institution, men have had to be transferred to outlying institutions or other institutions around the state. The sheltered living wing formerly housed at HMCC is no longer available for Anchorage mentally ill male inmates. Another unit needs to be re-established in a new location.

A sub-acute care unit for mentally ill men is needed; on a given day there are 337 seriously mentally ill male inmates in DOC facilities.

In the 1997 Trust Beneficiary DOC Needs Assessment, researchers found that on a sample day there are 337 seriously mentally ill (SMI) men in DOC institutions. The number of SMI men far exceeds the capacity of Cook Inlet Pretrial Mike Module to meet their specialized treatment needs. While Mike Module should be reserved for the most acute inmates in the system, sub-acute care beds should be available to handle: Mike Module graduates, sub-acute/seriously mentally ill inmates, and those inmates who are unable to handle the general prison population and are in need of special care and monitoring. Given the magnitude of their ongoing specialized housing and treatment needs, a sub-acute unit with enhanced programming and adequate staffing levels is a clinical necessity.

Proposed Program

20-25 Bed Men's Sub-Acute Care Unit

Proposed Staffing

1 Mental Health Clinician III
1 Psychological Counselor
5 Registered Nurses

Mental Health Staffing Levels:

The Department of Corrections must continue to provide mental health treatment to chronic and acutely mentally ill inmates. As the overall statewide inmate population continues to increase, the number of seriously mentally ill inmates will also rise. A review of the Department's yearly mental health caseload statistics demonstrates that the number of mentally ill inmates requiring treatment services continues to increase. From Fiscal Year 1995 to Fiscal Year 1997, there was a 16 percent increase in the number of mentally ill inmates treated by DOC mental health staff. With the transfer of the stable inmate population to an out-of-state facility, Alaskan facilities have a much higher concentration of psychiatrically and behaviorally disturbed inmates. The Department of Corrections will require additional mental health staff to keep pace with the growing numbers and needs of mentally ill inmates.

A 1997 study of the Department of Corrections' inmate population demonstrated that 29 percent (883 inmates on a sample day) of the institutional population are mentally ill Trust beneficiaries, including 373 seriously mentally ill inmates. The Department's own data collection for Fiscal Year 1997 demonstrated that its mental health staff treated 1,781 mentally ill inmates and an additional 207 inmates whose primary problem was substance abuse. (The Fiscal Year 1997 data reflect only those inmates treated by mental health staff and is therefore not a complete count of all mentally ill inmates entering Department of Corrections facilities). As these numbers continue to increase, the Department will be required to enhance its mental health clinical staffing levels. It is anticipated that DOC will require the following additional staff for existing programs:

DOC will require additional mental health staff to keep pace with the growing numbers and needs of mentally ill inmates.

Existing Facility/Program

- HMCC Women's Special Needs Wing
- Mat-Su Pre-Trial Facility
- Palmer Correctional Center (PCC)
- Spring Creek Correctional Center (SCCC)
- Wildwood Correctional Center (WCC)

Proposed Additional Staff

- I Psychological Counselor
- I Mental Health Clinician II
- I Psychological Counselor
- I Psychological Counselor
- I Psychological Counselor

Proposed mental health staffing levels and configurations are dependent upon institutional counts and the Department's mechanisms for handling overcrowding.

Women's Special Needs Wing: The Department of Corrections added a sheltered living level of care for mentally ill female inmates at Hiland Mountain Correctional Center. The mental health staff at Hiland are able to transfer mentally ill female inmates from the Women's Psychiatric Treatment Unit to the Special Needs Wing as the inmates are stabilized. If inmates on the Special Needs Wing again require acute care, they can readily be transferred back to the Psychiatric Unit. The Wing also houses developmentally disabled and organically impaired or other special needs women when needed. It is recommended that the Department of Corrections assign a mental health staff person to the Special Needs Wing to provide appropriate treatment for mentally ill and other special needs female inmates.

Mat-Su Pre-Trial, PCC, SCCC, WCC: Each of these facilities have had an increased number of seriously mentally ill inmates. Additional staff resources are needed to effectively monitor and address the acute and ongoing treatment needs of the mentally ill population.

Psychiatric Coverage:

In addition to one staff Psychiatrist, the Department added a three-quarter time Psychiatrist, and will provide an additional day per week of psychiatric coverage through the University of Washington psychiatric residency program. DOC also installed telemedicine hardware in seven of its institutions. Despite these enhancements, the Department still only has the full time equivalent of one and three-quarter staff Psychiatrists. DOC continues to use contract Psychiatrists to provide clinical assessments in some outlying institutions. DOC will need to ensure that its psychiatric resources are sufficient to meet the needs of the growing number of chronic and acutely mentally ill inmates in correctional institutions.

Telepsychiatry:

The Department of Corrections increased the availability of psychiatric services through the installation of telemedicine hardware at seven facilities. The Department will continue to utilize telepsychiatry to provide psychiatric services to outlying facilities. Given the reality of few staff, increasing numbers of clients, and geographic distances, creative options are needed to address the needs of the mentally ill in all correctional facilities. Based upon positive outcomes of the current telepsychiatry project, DOC mental health staff may explore opportunities for enhancing the portability and quality of the telemedicine equipment.

Transitional Care:

The Department of Corrections may explore opportunities for providing additional follow-up care for Trust beneficiaries released from specialized units to the general

institutional prison population. In addition to routine monitoring, a spectrum of services should be available in each DOC facility, including: Mentally Ill/Chemically Addicted (MICA) groups, and anger management and life skills classes. DOC may explore options for providing additional psychosocial rehabilitative services to mentally ill inmates. Enhancing life skills can improve mentally ill inmates' ability to function in the general prison population and in the community.

Treatment of Co-Occurring Disorders:

It is recommended that the Department of Corrections explore options for providing more dual diagnosis treatment. Up to 77% of the chronic and acutely mentally ill inmates treated by Department of Corrections mental health staff have co-occurring substance abuse disorders, and 60% of the re-arrests of Institutional Discharge Program Plus (IDP+) clients are due to substance abusing behaviors. The Department seeks to ensure that specialized substance abuse treatment services are provided to dually diagnosed inmates. Substance abuse treatment is currently provided on Mike Module and the HMCC Women's Psychiatric Treatment Unit. Additional resources will be required to provide Mentally Ill/ Chemically Addicted (MICA) groups for mentally ill offenders in other institutions.

Integrated Quality Assurance Process:

The Department of Corrections may explore options for developing an integrated quality assurance system. DOC will examine the possibility of creating a Nurse Supervisor position to provide training, conduct medical records audits, and oversee other mental health nurses. DOC will review and assess the feasibility of incorporating the recommendations from the National Commission on Correctional Health Care: Standards for Health Services in Prisons. DOC will also review the Division of Mental Health and Developmental Disabilities Quality Assurance Steering Committee plan to assess the feasibility of implementing some of the recommendations.

Education/Vocational Rehabilitation:

The Department of Corrections may explore opportunities for providing additional institutional-based jobs for mentally ill inmates. Employment is a strong deterrent to re-offense, and vocational and pre-vocational training and services assist inmates to effectively transition into the community. DOC may further explore options for enhancing the educational services provided to seriously mentally ill inmates.

Mental Health Services for Inmates in Halfway Houses:

There is a need to provide additional mental health services for mentally ill offenders on furlough and confined misdemeanor status.

Discharge Planning:

The Department of Corrections will continue to ensure that its Mental Health Clinicians provide discharge planning for mentally ill inmates transitioning from acute care and specialized treatment units to the general prison population and for mentally ill inmates transitioning to the community upon release. DOC staff refer releasing mentally ill inmates to existing community-based services. DHSS and DOC recognize that the existing continuum of care is inadequate and must be expanded to effectively meet the needs of mentally ill offenders in the community.

Dual diagnosis treatment is needed. Up to 77 percent of the mentally ill inmates have co-occurring substance abuse disorders.

Additional day treatment slots are needed for Institutional Discharge Program Plus and Jail Alternative Services clients.

The Department currently refers some of its seriously mentally ill felons who have formal conditions of probation to the Institutional Discharge Program Plus (IDP+). The IDP+ program began a pilot project offering day treatment services for ten IDP+ individuals. The initiative has been successful in improving life skills and reducing recidivism for IDP+ clients. Additional day treatment slots are needed for Institutional Discharge Program Plus (IDP+) and Jail Alternative Services (JAS) clients. There is also a need to enhance the success of IDP+ clients who transition to areas outside of Anchorage. A disproportionate number of the IDP+ clients have been re-arrested in rural settings, and enhanced coordination and planning is necessary to ensure successful transitions. Success will also require commitments from communities to provide supervised housing and supports for clients.

Jail Alternative Services (JAS) is a pilot project administered through the Department of Corrections. The project employs a Case Coordinator to identify, coordinate and link 40 mentally ill misdemeanor offenders with community services. Compliance with treatment becomes a condition of probation in sentencing. The Case Coordinator also performs the role of monitor to ensure that probation conditions are satisfied. Based upon positive outcomes, the Department of Corrections and associated stakeholders may explore options for continuing and expanding the project in Anchorage and replicating it in other communities.

Specialized Probation Officers:

The Department of Corrections may explore options for designating additional Specialized Probation Officers to work with probationers with mental illness and other chronic and acute disorders in the community. Specialized Probation Officers can assist in providing information to the legal system on the behaviors and needs of the mentally ill and other special needs offenders, so that sanctions and supports can be applied in a meaningful manner. Probation Officers can also be a meaningful part of a mentally ill offender's treatment team. Additional training could assist all Probation Officers dealing with mentally ill offenders to recognize symptoms and effectively manage them in the community.

Specialized Sex Offender Treatment for the Mentally Ill:

There is a need to provide specialized treatment for mentally ill sex offenders that focuses on relapse prevention. Participating in and completing treatment is often a requirement for acceptance into housing and substance abuse treatment services. The Parole Board or court can revoke good time for offenders who have not successfully completed sex offender treatment. Providing specialized sex offender treatment for mentally ill offenders could make them eligible for parole or furlough if legally and clinically indicated. A recent review of the Mike Module caseload statistics demonstrates that approximately 23% of the chronic and acutely mentally ill male inmates are sex offenders.

Cultural Relevance:

The Department of Corrections will continue its practice of providing culturally relevant programming for mentally ill inmates treated on Mike Module. Mentally ill inmates treated on Mike Module are offered talking circles, and DOC seeks to provide similar services for mentally ill women treated on the Hilland Mountain Correctional Center Women's Psychiatric Treatment Unit.

Outpatient Services for Non-Chronic and Non-Acutely Mentally Ill Beneficiaries:

Currently, Department of Corrections' mental health staff address some of the needs

of the non-chronic/non-acutely mentally ill population through counseling groups offered to the general prison population and the 48 week offender treatment program. DOC may explore additional resources for providing services to non-chronic and non-acutely mentally ill Trust beneficiaries in correctional institutions who do not pose a management problem.

**There is a need
to enhance
substance
abuse
treatment
services in
DOC.**

Transitional Care Services for Non-Chronic and Non-Acutely Mentally Ill

Beneficiaries:

The Department of Corrections may explore resources for providing transitional care services for non-chronic and non-acutely mentally ill inmates transitioning to community care.

Existing Substance Abuse Continuum of Care in DOC

Emergency Services

- Title 47 Non-Criminal Holds.
- Education and prevention services for intravenous drug users and pregnant women who are pending immediate release.

Prevention/Education

- The basic alcohol and drug education program as well as the education with an introduction to treatment program, is for inmates with short sentences or for inmates entering treatment. Critical prevention topics covered by in the education program include: Fetal Alcohol Syndrome/Fetal Alcohol Effect and HIV/AIDS/STD's and other communicable diseases.

Treatment

- Screenings: substance abuse counselors screen inmates for entry into the ISAT program.
- Clinical Assessments: substance abuse counselors assess, diagnose, and provide treatment recommendations for inmates in the Inmate Substance Abuse Program.
- Institutional outpatient treatment in the institutions.
- Residential Substance Abuse Treatment in the institution for female inmates.

Discharge Planning/Transitional Care

- Referral to community substance abuse treatment providers.
- Referral to the LINKS (Living In New Knowledge Successfully) release project for women.

Substance Abuse Treatment Recommendations

The Department of Corrections will explore options and additional resources to implement the following prioritized recommendations. Prioritization is based upon clinical necessity.

The Department of Corrections will continue to work to ensure that an appropriate continuum of substance abuse treatment services exists in correctional facilities. Contract substance abuse providers will continue to provide substance abuse assessments and education in all correctional facilities, and institutional outpatient treatment in long term facilities. The Department recognizes that there is a critical need to enhance the scope and intensity of substance abuse treatment services in its correctional institutions.

A residential treatment program for male inmates with a history of chronic substance abuse and criminal activity is needed.

Residential Substance Abuse Treatment for Male Inmates in DOC Institutions:

The Department of Corrections does not currently provide a complete continuum of substance abuse treatment services for male inmates. The Department of Corrections will explore options for creating a residential treatment program for male inmates with a history of chronic substance abuse and criminal activity. Residential treatment would require an array of contract treatment staff including a Clinical Director, an Assessment Specialist, Counselors and support staff. Three separate surveys demonstrated that approximately 100 inmates on a given day need this level of intensive treatment. The surveys included inmates serving sentences of at least four years. The surveys did not include sex offenders, mentally ill inmates, or inmates with serious medical conditions.

Substance Abuse Discharge Project for Male Inmates:

In the event that the Department of Corrections develops a residential treatment program for male inmates, options need be explored for transitional care in the community for graduates of the program. Aftercare/ transitional care in the community will be critical for positive program outcomes.

Substance Abuse Post Conviction/Sentencing Screenings:

All inmates who have been convicted/sentenced should be screened by DOC for substance abuse treatment needs at the onset of serving out their sentences. Developing a standardized screening mechanism would assist the correctional system in identifying inmates who need substance abuse treatment. It would also assist DOC in directing inmates to the Inmate Substance Abuse Program (ISAT), where a full clinical assessment for the appropriate level of care can be conducted. A standardized screening mechanism would help DOC to demonstrate the prevalence of alcohol and drug abuse among inmates. In a 1998 resolution for substance abuse treatment among offenders, the Advisory Board on Alcoholism and Drug Abuse recommended that DOC establish the universe of inmates needing services by conducting standardized screenings.

Clinical Resources and Funding Levels:

As the inmate population continues to grow, DOC will require additional substance abuse treatment staff to provide the minimal continuum of care now available. Any enhancements to the substance abuse continuum of care in DOC institutions will require additional resources and staff. It is also critical for DOC to keep Substance Abuse Counselors who have gained institutional experience and knowledge of the correctional clientele. In order to retain counseling staff, DOC should ensure that the Inmate Substance Abuse Program is adequately funded.

Institutional Outpatient Substance Abuse Treatment Services:

The Department of Corrections currently provides outpatient substance abuse treatment services through its Inmate Substance Abuse Program (ISAT). It is estimated that DOC provides outpatient treatment to a small percentage of the inmates who need such treatment. The Department of Corrections may explore possibilities for augmenting its outpatient substance abuse treatment services in correctional institutions. The Department of Corrections will continue to evaluate the Inmate Substance Abuse Program to determine which facilities and programs may require additional treatment staff.

Dual Diagnosis Treatment Program:

The Department of Corrections may explore options for providing dual diagnosis treatment to inmates with substance abuse disorders and developmental disabilities or mental illness. Recognizing that up to 77% of mentally ill inmates have co-occurring substance abuse disorders, there is a critical need for dual diagnosis treatment. Results for the Institutional Discharge Program Plus (IDP+) further demonstrate that 60% of the re-arrests for IDP+ clients are due to substance abuse involvement.

**There is a need
to augment
outpatient
substance
abuse
treatment in
correctional
institutions.**

Coordination with Medical Staff:

Increased coordination between DOC medical staff and contract substance abuse treatment providers could assist in identifying inmates with substance abuse problems. Through the health care screening process, nurses may refer inmates with acute alcohol and drug treatment needs to contract substance abuse treatment staff. DOC may also utilize the medical screening forms to gather data on the prevalence of alcohol and drug problems among inmates booked into DOC facilities.

Substance Abuse Education Services:

There is a need to augment substance abuse education services in correctional intake facilities. An institution such as Sixth Avenue Correctional Center is the busiest intake facility in the state of Alaska, with approximately 10,000 bookings per year. The current half-time substance abuse counseling position for the institution is inadequate given the volume and needs of the inmates who are typically misdemeanants with substance abuse problems who could benefit from education and referrals to treatment in the community.

Living in New Knowledge Successfully (LINKS) Release Project for Women:

The Department of Corrections, the Division of Alcoholism and Drug Abuse, the Division of Family and Youth Services, the Advisory Board on Alcoholism and Drug Abuse, and community treatment providers have created a mechanism to assist graduates of the HMCC substance abuse treatment program, who have children, successfully transition into the community of Anchorage. Based upon positive outcomes, entities involved in creating and implementing LINKS may explore options for expanding the project to other communities.

Culturally Relevant Programming:

The Department of Corrections will continue to ensure that culturally relevant programming is provided to inmates in the ISAT program. It will also strive to provide cultural diversity training to ISAT counselors so that they will have the resources and knowledge to make their programs culturally meaningful. Information on Alaska Native tribes and history, culturally specific intake and assessment techniques, treatment strategies designed to incorporate traditional Native values, case management in rural areas, and the role of Native elders in the sobriety movement should be components of future training programs.

Improved screening, identification, treatment and referral of developmentally disabled inmates is needed.

Recommendations for Developmentally Disabled Inmates

The Department of Corrections does not have staff specifically dedicated to the needs of developmentally disabled inmates in its institutions. Consequently, recommendations will require significant levels of new staff and resources for implementation.

The Department of Corrections will explore options and additional resources to implement the following recommendations based upon the continuum of care.

Screening, Treatment and Referral:

The Department of Corrections may collaborate with the Division of Mental Health and Developmental Disabilities (DMHDD) and the Governor's Council on Disabilities and Special Education (GCDSE) to develop screening, assessment, treatment and referral protocols for developmentally disabled inmates in DOC institutions. Currently, inmates with an obvious or severe developmental disability are referred to DOC mental health, medical or education staff for assessment and treatment recommendations. However, the Department of Corrections recognizes that there are far more individuals with developmental disabilities than are currently identified or who receive special services in the system. Involvement of DMHDD and the GCDSE is recommended. Improved screening and identification would result in a more thorough picture of the prevalence and service needs of inmates with developmental disabilities.

Proposal for Screening, Identification and Referral:

1. DOC screens and identifies inmates who may have a developmental disability.
2. DOC refers inmates who appear to have a developmental disability to mental health, medical, or education staff (or)
3. DOC refers inmates who appear to have a developmental disability to DMHDD.
4. DMHDD conducts an eligibility examination on inmates identified through the DOC screening process, and if eligible places them on a wait list for services in the community.
5. DOC notifies DMHDD prior to the release of a previously identified developmentally disabled inmate.

Specialized Services:

The Department of Corrections may work with the Division of Mental Health and Developmental Disabilities and the Governor's Council on Disabilities and Special Education to enhance the programming and services for developmentally disabled inmates in correctional institutions. The Department of Corrections may explore options and resources for providing specialized substance abuse treatment services, additional educational/vocational services, and sex offender treatment for developmentally disabled inmates.

Transitional Care Services:

The Department of Corrections may coordinate with other agencies to obtain improved transitional care services for developmentally disabled inmates releasing from correctional institutions into the community. There is currently a need for additional housing and employment opportunities for developmentally disabled offenders releasing from correctional institutions.

Recommendations for Inmates with Alzheimer's Disease and Related Disorders

Individuals arrested with dementias usually are found incompetent to stand trial, and committed to the custody of the Department of Health and Social Services. Inmates who develop dementias after they are convicted, will need special care or may be eligible for medical parole to nursing homes in the community.

As the state of Alaska's general population ages, so too will Alaska's inmate population. The Alaska Commission on Aging's (ACoA) projections suggest that by the year 2,000, 6 percent of Alaskans will be 65 years of age and older. Risk projections suggest that by year 2,000, more than 500 Alaskans will be at risk for Alzheimer's Disease, and by 2,015, over 1,500 Alaskans will be at risk.

Currently DOC medical staff monitor and make appropriate referrals for inmates with Alzheimer's Disease and Related Disorders (ADRD) when indicated. The Department of Corrections will explore options and additional resources to:

- Develop improved methods for identifying and tracking inmates with Alzheimer's Disease and Related Disorders.
- Coordinate with the Alaska Commission on Aging (ACoA) to develop population projections on the number of ADRD inmates in institutions, halfway houses and on probation and parole who will require care.
- Identify the types of care required by the ADRD population in DOC.
- Provide care to inmates with Alzheimer's Disease and Related Disorders in DOC institutions.
- Train Department of Corrections' staff to identify and manage inmates with Alzheimer's Disease and Related Disorders.
- Provide medical parole for inmates with Alzheimer's Disease and Related Disorders.

Recommendations for Juvenile Offenders

On February 1, 1999, there were 402 inmates age 21 and under in state facilities and halfway houses. The Department formed a task force to examine the housing security, and programming needs of juvenile offenders. The task force has recommended creating a discrete unit for some of these inmates with education, mental health and substance abuse programming.

The Department of Corrections will explore options and additional resources to:

- Establish a discrete unit for inmates age 18 and under, with specialized mental health, substance abuse and educational programming and treatment staff.
- Provide additional psychiatric services for juvenile inmates.
- Coordinate with the Department of Education to implement and refine as necessary the Memorandum of Agreement (MOA) for providing special education services to eligible inmates under the age of twenty two.
- Collaborate with the Department of Education to develop mechanisms for obtaining the records of inmates qualifying for special education services.

A separate unit with specialized programming is needed for some of the 402 inmates age 21 and under.

A new MIS system will help DOC identify Trust beneficiaries in its system, and collect demographic and diagnostic information.

III. Program Effectiveness and Management Information Systems

The Department of Corrections is required to demonstrate the effectiveness of its services for treating Trust beneficiaries. The Trust Authority requires the Department to report on indicators and performance measures for Trust funded projects and General Fund/Mental Health increments. To improve its ability to measure the effectiveness of programs, the Department of Corrections must create an enhanced Management Information System. It is critical that the new Management Information System have the capability to provide the numerical and demographic data requested by the Trust Authority, Legislature, federal government and the beneficiary boards.

The Department of Corrections will explore options and additional resources for developing a Management Information System that:

- Enables DOC to identify all Trust beneficiaries at any point in time.
- Provides aggregate demographic and diagnostic information on Trust beneficiaries.
- Tracks the unduplicated number of Title 47 non-criminal mental health and substance abuse holds.
- Tracks the service needs of Trust beneficiaries.
- Enables DOC to effectively and efficiently measure program performance and client outcomes.
- Enables DOC to track recidivism rates.
- Interfaces with other state Departments' Management Information Systems to provide unduplicated data on Trust beneficiaries across state systems.

IV. Planning and Research

The Department of Corrections will explore options and additional resources to:

- Hire a health care services Research Analyst to assist with data collection, statistical analysis and information requests specific to Trust beneficiaries.
- Conduct a yearly review of recommendations for Trust beneficiary services.
- Conduct a periodic profile of inmates to identify beneficiary needs and services. Surveys should include prevalence statistics, and a determination of the comprehensive treatment needs of beneficiaries. Future studies may also include the prevalence and service needs of non-chronic and non-acute beneficiaries who are not currently receiving treatment in DOC.
- Continue to participate in the State Comprehensive Mental Health Plan (CIMHP), the API planning process, the beneficiary board strategic planning processes, and the Decriminalizing the Mentally Ill subcommittee of the Criminal Justice Assessment Commission and similar activities.
- Continue to utilize the National GAINS Center for the Treatment of Co-Occurring Disorders in the Justice System, for technical assistance in developing and evaluating programs.
- Utilize data from the Substance Abuse Need for Treatment Among Arrestees

(SANTA) study and the Arrestee Drug Abuse Monitoring (ADAM) project to assess the substance abuse treatment needs of Alaskan inmates, and to plan for services.

V. Partnerships

The Department of Corrections will continue to collaborate with:

It is essential that DOC continue to partner with the Trust Authority and the beneficiary boards in their planning and budgeting processes.

The Trust Authority

- The Department of Corrections will continue to participate in the Trust Authority Request for Recommendations budget process by submitting yearly budget requests and bi-annual status reports on Trust funded projects and General Fund/Mental Health increments.
- The Department of Corrections will strive to enhance the beneficiary-specific data provided to the Trust Authority as part of the yearly Request for Recommendations process.
- The Department of Corrections will continue to refine its accounting systems to more accurately reflect mental health expenditures.
- The Department of Corrections will continue to explore opportunities for funding partnerships with the Trust Authority and the Department of Justice for substance abuse treatment services for incarcerated inmates.
- The Department of Corrections will continue to collaborate with the Trust Authority to advocate for services for its beneficiaries.

Beneficiary/Advocacy Boards

- The Department of Corrections will continue to participate in the beneficiary boards' budgeting and planning processes.
- The Department of Corrections will submit yearly budget and data information to the beneficiary boards.
- The Department of Corrections will continue to participate in the boards' strategic planning processes and related planning activities.
- The Department of Corrections will increasingly coordinate with the Governor's Council on Disabilities and Special Education.
- The Department of Corrections will increasingly coordinate with the Alaska Commission on Aging.

State Departments

DOC will collaborate with other state Departments:

Department of Health and Social Services

- Fetal Alcohol Syndrome (FAS)/Fetal Alcohol Effect (FAE) prevention and education, and the development of a statewide FAS plan of action. The Departments will also collaborate to survey the inmate population to establish a baseline number of inmates with FAS/FAE.
- The Institutional Discharge Program Plus (IDP+).
- The LINKS (Living in New Knowledge Successfully) women's release project.
- Substance abuse surveys and studies.
- The Department of Corrections will continue to collaborate with the Division of Mental Health and Developmental Disabilities staff, including API and mental health grantees.

DOC will continue to collaborate with DHSS on FAS/FAE prevention and education and other joint projects.

- The Department of Corrections will continue to collaborate with the Division of Alcoholism and Drug Abuse through the Oversight Committee.
- The Department of Corrections and the Department of Health and Social Services may explore options for linking their respective Management Information Systems.

Department of Education

- The Department of Corrections will continue to coordinate with the Department of Education to provide special education services to eligible inmates under age twenty two. Further refinement of procedures with individual school districts may be necessary.
- The Department of Corrections will continue to collaborate with the Department of Education to develop mechanisms for obtaining the educational records of inmates qualifying for special education services.

Community Treatment Providers

The Department of Corrections will continue to collaborate with community treatment providers to:

- Coordinate treatment and release plans for inmates with chronic and acute illnesses.
- Advocate for necessary community-based services for all Trust beneficiaries.

Criminal Justice System

DOC will coordinate with the Criminal Justice System on:

- Specialized Sentencing Projects.
- Court Coordinated Resources Project (Mental Health Court).
- Drug Courts.
- Trainings for criminal justice system personnel.
- The Criminal Justice Assessment Commission, and the Decriminalizing the Mentally Ill Subcommittee and associated Subcommittees.
- Title 47 Issues and Workgroups:
 - Anchorage involuntary commitment committee.
 - Bethel Title 47 work group.
 - Fairbanks Interagency work group.
 - Other Title 47 work groups as developed.

Native Organizations

The Department of Corrections will:

- Consult with Native organizations on inmate programming.
- Encourage cultural diversity trainings for treatment providers.
- Provide potlaches and other cultural activities.
- Provide a role for culture-based sobriety activities, including elder visits, talking circles, and utilizing Native speakers as role models.

U.S. Department of Justice

The Department of Corrections will collaborate with the U.S. Department of Justice on:

- Program development.
- Technical assistance.
- Trainings.
- Fiscal support.

**DOC will
continue to
encourage
cultural
diversity
training for
its treatment
providers.**

VI. Training and Education

The Department of Corrections will coordinate with stakeholders to explore options and additional resources to:

- Train criminal justice system personnel (judges, lawyers, police and probation officers) on identification, referral, and treatment options for Trust beneficiaries.
- Educate the Trust Authority, beneficiary boards, state Departments and treatment providers on the criminal justice system.
- Train communities on the needs of mentally ill and special needs offenders.

Training for Department of Corrections Personnel

The Department of Corrections will explore options and additional resources to:

- Train staff on results, indicators and performance measures and developing evaluation components for programs.
- Train staff on the new Management Information System.
- Ensure that treatment staff are trained to provide culturally relevant treatment services.
- Provide cross-training for substance abuse and mental health treatment providers.
- Ensure that mental health staff have training opportunities on effective treatment modalities.
- Educate and train correctional staff on identifying and intervening with inmates with mental illness, developmental disabilities, acute substance abuse disorders, Alzheimer's Disease and Related Disorders, and organic impairments.

Data on Trust Beneficiaries in the Department

I. Mental Health Trust Authority Beneficiary Definitions

Trust beneficiaries include individuals who are:

- Mentally Ill
- Chronic Alcoholics with Psychosis
- Developmentally Disabled, and
- Individuals who have Alzheimers Disease and Related Disorders

The Alaska Mental Health Board (AMHB) utilizes the ten diagnostic categories established in statute, and breaks these down into nearly 200 specific DSM IV diagnostic codes to identify mentally ill Trust beneficiaries. The diagnostic categories for mentally ill beneficiaries include: Schizophrenia, Delusional Disorders, Mood Disorders, Anxiety Disorders, Somatoform Disorders, Organic Mental Disorders, Personality Disorders, Dissociative Disorders, other Psychotic or Severe and Persistent Mental Disorders, and Childhood Disorders.

The Advisory Board on Alcoholism and Drug Abuse (ABADA) counts as their Trust beneficiaries those individuals who fall into seven diagnostic categories and ten specific DSM IV diagnostic codes. The diagnostic categories include: Alcohol Withdrawal Delirium, Alcohol Hallucinoses, Alcohol Amnesic Disorder, Dementia Associated with Alcoholism, Alcohol-Induced Organic Mental Disorder, Alcoholic Depressive Disorder, and other Severe and Persistent Disorders. ABADA also utilizes an operational definition to track its Trust beneficiaries through the Division of Alcoholism and Drug Abuse Management Information System. The operational definition includes three criteria: alcohol is the first drug of choice, the individual is assessed as either dysfunctional or dependent, and the individual reports consuming alcohol at least six days per week.

The Governor's Council on Disabilities and Special Education (GCDSE) utilizes seven diagnostic categories to identify their beneficiaries which include: Cerebral Palsy, Epilepsy, Mental Retardation, Autistic Disorder, Severe Organic Brain Impairment, significant developmental delay during early childhood indicating a risk of developing the disorders, and other severe and persistent mental disorders. The GCDSE also utilizes the state and federal definition of developmental disability and delay. The state defines individuals as developmentally disabled when they experience a severe and chronic disability that is: attributable to a mental or physical impairment or combination of mental and physical impairments, is manifested before age 22, is likely to continue indefinitely, results in substantial functional limitations, and reflects a need for lifelong care.

The Alaska Commission on Aging (ACoA) plans and advocates for individuals who have the following diagnoses as defined in statute: Primary Degenerative Dementia of the Alzheimer type, Multi-Infarct Dementia, Senile Dementia, Presenile Dementia, and other severe and persistent mental disorders. The ACoA also utilizes a functional definition to identify their beneficiaries.

**Trust
beneficiaries
include
individuals who
are: mentally
ill,
chronic
alcoholics with
psychosis,
developmentally
disabled, and
individuals
who have
Alzheimer's.**

II. Number of Trust Beneficiaries in Department of Corrections—Fiscal Year 1997

The Department of Corrections does not currently have a Management Information System that allows for unduplicated counts of Trust beneficiaries. Estimates as to the prevalence of Trust beneficiaries for the purposes of this document are taken from two principle sources: the 1997 Trust Beneficiary DOC Needs Assessment, and national prevalence rates (some of which are used by the beneficiary boards) applied to the DOC institutional population on 1/15/97

The national prevalence estimates for the four categories of beneficiaries are based upon different methodologies.

	CONFIRMED	ESTIMATES
	Trust Beneficiary DOC Needs Assessment: 3,091 Inmates in DOC Institutions on 1/15/97	National Prevalence Estimates applied to DOC Institutional population of 3,091 Inmates on 1/15/97
Mentally Ill Severely Mentally Ill	29% (883 inmates) 12% (373 inmates)	10% (309 inmates) National Commission on Correctional Health Care cites prevalence rates of 6-14% for inmates with major psychiatric disorders. 10% is the average.
Chronic Alcoholics with Psychosis	8% (258 inmates)	6.55% (202 inmates) Gallup Poll
Developmentally Disabled	0.4% (12 inmates)	1.8% (56 inmates) National prevalence rate for the general population. 6% (185 inmates) National Commission on Correctional Health Care cites prevalence rates of 2-10% for inmates with mental retardation, 6% is the average.
Alzheimer's Disease	1 inmate	4% (2 inmates) National Prevalence Rate for individuals age 65-74 is applied to the 51 inmates age 60+ in DOC in 1/15/97

Trust Beneficiary DOC Needs Assessment

Researchers conducted the Trust Beneficiary DOC Needs Assessment by surveying the Department of Corrections' population in institutions and halfway houses, and by sampling the probation and parole population. The Needs Assessment numbers are based on individuals in DOC custody on 1/15/97, identified as potential beneficiaries by DOC staff, whose diagnoses could be confirmed in DOC chart audits. The researchers utilized January 15, 1997 as the point in time to survey the correctional population. Researchers utilized the Trust Authority's statutory definitions of Trust beneficiaries as well as the board's operational definitions for beneficiary categories. Presented above and discussed below, are the researchers' findings regarding the number of Trust beneficiaries in DOC institutions. Trust beneficiaries accounted for 37 percent of the DOC institutional population on January 15, 1997.

The National Commission on Correctional Health Care reports that 6 to 14 percent of inmates have a major psychiatric disorder.

Mentally Ill

Of the 3,091 individuals incarcerated in the state's thirteen correctional facilities on 1/15/97, 883 individuals or 29 percent of the institutional population were identified as mentally ill Trust beneficiaries, including individuals with personality disorders. Of these, 373 individuals (337 men and 36 women) or 12 percent of the total incarcerated population were identified as suffering from a severe mental illness.

Chronic Alcoholics with Psychosis

As the chart above demonstrates, 8 percent (258) of the DOC institutional population were chronic alcoholics with psychosis on the sample day. Researchers explained, however, that there were an additional 490 inmates who they identified as either "dependent" or "dysfunctional" (two of the three operational criteria for chronic alcoholism with psychosis) but who were not counted as beneficiaries as they did not use on a daily basis.

Developmentally Disabled

Researchers noted that as IQ tests are not systematically conducted in any institution or program other than the Meadow Creek Correctional Center sex offender treatment program, it is likely that the number of developmentally disabled beneficiaries is under-reported in the Trust Beneficiary DOC Needs Assessment.

Alzheimers Disease and Related Disorders

Researchers identified one inmate with Alzheimer's Disease in DOC institutions on 1/15/97.

Beneficiary Board and National Prevalence Estimates

Alaska Mental Health Board Prevalence Estimates

In the National Commission on Correctional Health Care 1997 Report: Standards for Health Care Services in Prisons, it is explained that 6 to 14 percent of inmates have "a major psychiatric disorder." National prevalence estimates for the incarcerated seriously mentally ill (SMI) population do not typically include personality disordered individuals. The Trust Beneficiary DOC Needs Assessment finding that 29 percent (883 inmates) were mentally ill on 1/15/97 in Alaska correctional facilities includes personality disordered individuals. The Alaska Mental Health Board explains that in all states, the percent of mentally ill in correctional facilities is higher than the 6.3 percent national prevalence estimate for the general population.

National prevalence estimates show that there are up to 185 developmentally disabled inmates in DOC.

Advisory Board on Alcoholism and Drug Abuse Prevalence Estimates

The Advisory Board on Alcoholism and Drug Abuse utilized a Gallup Poll telephone survey of 8,000 Alaskans to estimate the prevalence of chronic alcoholics with psychosis in Alaska. The poll demonstrated that 3.7 percent of Alaskans have diagnoses of severe alcohol dependence, and 5.7 percent have diagnoses of mild to moderate substance dependence. ABADA concluded that all of the Alaskans with severe dependence disorders are beneficiaries, and half of the moderately dependent individuals (2.85 percent) are beneficiaries, for a prevalence rate of 6.55 percent. Applying the 6.55 percent prevalence rate to inmates in correctional institutions on 1/15/97, results in an estimate of 202 inmates with chronic alcoholism with psychosis on the sample day. It should be noted that the 6.55 percent prevalence estimate is for the general population, and is not a rate specifically designed for the incarcerated population.

Governor's Council on Disabilities and Special Education Prevalence Estimates

The Governor's Council on Disabilities and Special Education utilizes the national prevalence rate of 1.8 percent to estimate the number of Alaskans with developmental disabilities. The GCDSE notes that due to Alaska's high rates of accidents, deafness, head injuries, and Fetal Alcohol Syndrome, the national prevalence rate may underestimate the number of developmentally disabled Alaskans.

When the 1.8 percent prevalence rate is applied to the DOC institutional population, it appears that the Trust Beneficiary DOC Needs Assessment may have under-represented the number of developmentally disabled inmates. Needs Assessment researchers explained that there were a group of 30 inmates in their study who were "potentially" developmentally disabled, but who had not been formally diagnosed or screened, and were therefore not confirmed as beneficiaries. It should be noted, however, that the 1.8 percent figure is the prevalence estimate for the general population, with no specific adjustments made for the prison population. The National Commission on Correctional Health Care estimates that 2-10 percent of the incarcerated population includes individuals with mental retardation.

Alaska Commission on Aging Prevalence Estimates

When the national prevalence estimate of a 4 percent rate for ADRD among individuals age 65-74 is applied to the 51 inmates age 60 and older in DOC institutions on 1/15/97, two inmates would be expected to have ADRD in DOC institutions. *(The Trust Beneficiary DOC Needs Assessment age category of 60+ is the closest match to the 65-74 age category used in the national statistics.)*

III. Demographics of Beneficiaries

The Department of Corrections does not have the ability to gather aggregate socioeconomic and demographic information on beneficiaries, and is utilizing the Trust Beneficiary DOC Needs Assessment sample as representative of its Trust beneficiary population as a whole. The following pages (5-7) depict demographic information on Trust beneficiaries in correctional facilities on 1/15/97. Demographic information is not provided for the one inmate with Alzheimer's Disease, to protect the confidentiality of the individual.

**Demographics of Mentally Ill Trust Beneficiaries in Department of
Corrections Institutions on
1/15/97**

**Trust Beneficiary DOC Needs Assessment
(Unduplicated)**

Age Groups	Number	Percentage
6 - 17 years	0	0.0%
18 - 21 years	31	3.5 %
22 - 59 years	834	94.5%
60 + years	14	1.6%
Unknown	4	0.4%
Total	883	100%
Sex	Number	Percentage
Female	78	8.8%
Male	805	91.2%
Total	883	100%
Race	Number	Percentage
Asian	13	1.5%
Black	106	12.0%
Hispanic	20	2.3%
Indian	39	4.4%
Native	235	26.6%
Unknown	0	0.0%
White	470	53.2%
Total	883	100%
Educational Status	Number	Percentage
< 12 years	424	48.0%
High school	343	38.8%
Some college	76	8.6%
College degree	9	1.0%
Post-bachelor's	4	0.5%
Unknown	27	3.1%
Total	883	100%
Marital Status	Number	Percentage
Unknown	183	20.7%
Cohabiting	1	0.1%
Divorced	67	7.6%
Separated	8	0.9%
Married	131	14.9%
Single	485	54.9%
Widowed	8	0.9%
Total	883	100%

Demographics of Chronic Alcoholics with Psychosis

Trust Beneficiaries in Department of Corrections Institutions on 1/15/97

Trust Beneficiary DOC Needs Assessment (Unduplicated)

Age Groups	Number	Percentage
6 - 17 years	0	0.0%
18 - 21 years	8	3.1%
22 - 59 years	245	95.0%
60 + years	5	1.9%
Unknown	0	0.0%
Total	258	100%
Sex	Number	Percentage
Female	22	8.5%
Male	236	91.5%
Total	258	100%
Race	Number	Percentage
Asian	1	0.4%
Black	20	7.8%
Hispanic	3	1.2%
Indian	16	6.2%
Native	114	44.2%
Unknown	0	0.0%
White	104	40.3%
Total	258	100%
Educational Status	Number	Percentage
< 12 years	123	47.7%
High school	103	39.9%
Some college	16	6.2%
College	0	0.0%
Post-bachelor's	6	2.3%
Unknown	10	3.9%
Total	258	100%
Marital Status	Number	Percentage
Unknown	41	15.9%
Cohabiting	2	0.7%
Divorced	25	9.7%
Separated	0	0.0%
Married	33	12.8%
Single	157	60.9%
Widowed	0	0.0%
Total	258	100%

Demographics of Developmentally Disabled Trust Beneficiaries in

Department of Corrections

Institutions & Community

Residential Centers on 1/15/97

Trust Beneficiary DOC Needs Assessment (Unduplicated)

Age Groups	Number	Percentage
6 - 17 years	0	0.0%
18 - 21 years	1	6.7%
22 - 59 years	14	93.3%
60 + years	0	0.0%
Unknown	0	0.0%
Total	15	100%
Sex	Number	Percentage
Female	1	6.7%
Male	14	93.3%
Total	15	100%
Race	Number	Percentage
Asian	1	6.7%
Black	1	6.7%
Hispanic	1	6.7%
Indian	1	6.7%
Native	4	26.6%
Unknown	0	0.0%
White	7	46.6%
Total	15	100%
Educational Status	Number	Percentage
<12 years	8	53.3%
High school	4	26.7%
Some college	2	13.3%
College degree	0	0.0%
Post-bachelor's	0	0.0%
Unknown	1	6.7%
Total	15	100%
Marital Status	Number	Percentage
Unknown	2	13.3%
Cohabiting	0	0.0%
Divorced	3	20.0%
Separated	0	0.0%
Married	3	20.0%
Single	7	46.7%
Widowed	0	0.0%
Total	15	100%

DOC primarily treats those inmates with chronic or acute mental illness or severe personality disorders.

IV. DOC Fiscal Year 1997 Service Data

Fiscal Year 1997 Total Number of Unduplicated Inmates Served by Mental Health Staff in DOC Correctional Facilities

<u>Diagnostic Category</u>	<u>Numbers Served</u>
Schizophrenia	313
Delusional/Paranoid Disorders	24
Mood Disorders	688
Anxiety Disorders	54
Somatoform Disorders	4
Organic Mental Disorders	52
Personality Disorders	329
Dissociation Disorders	0
Other Psychotic/Severe Disorders*	317
Primary Substance Abuse Disorders*	207
Total:	1,988

**Other Psychotic/Severe Disorders*

Inmates identified as Other Psychotic/Severe and treated by DOC mental health staff includes: Psychotic Disorders Not Otherwise Specified, assessments at staff or inmate request for mental illness or suicidal ideation, Fetal Alcohol Syndrome, mental retardation, and Attention Deficit Disorder among others.

**Substance Abuse Disorders*

Department of Corrections tracked the number of mentally ill individuals with a primary or secondary diagnosis of substance abuse or dependence. DOC mental health staff treated 207 inmates with a primary diagnosis of substance abuse/dependence, and 979 inmates with a secondary diagnosis of substance abuse/dependence. The actual number of inmates with co-occurring substance abuse disorders is under-reported, because mental health staff may only record the primary diagnosis of the mentally ill inmates they are treating. There is currently no systematic recording of all mentally ill individuals who have co-occurring substance abuse disorders in the correctional system. However, the Department of Corrections is engaged in efforts to standardize its mental health assessments to obtain more reliable and consistent data on co-occurring disorders.

Department of Corrections primarily treats only those individuals with chronic or acute mental illness or severe personality disorders who present significant behavior and management problems in the institutions. DOC does not have the mental health staff or resources to treat less severe disorders, which include the majority of the personality disordered individuals. However, crisis intervention and supportive counseling services are provided to individuals who are suicidal or experience a traumatic personal loss, such as a death in the family or divorce. In addition, DOC offers a 48-week offender mental health treatment program which is available to beneficiary and non-beneficiary individuals in DOC facilities. Although participant numbers are not reflected on these charts or included in the overall count of mentally ill Trust beneficiaries served by DOC, 140 inmates participated, with 61 completing the treatment program. Preliminary results show a marked improvement in institutional functioning and change in anger management skills and thinking errors for program participants

Department of Corrections
Inmate Substance Abuse Treatment Program/DOC Institutions
Fiscal Year 1997 Duplicated Data

<u>Treatment Activity</u>	<u>Totals*</u>
Formal Clinical Assessments	1,577
Basic Alcohol and Drug Education Admissions	1,681
Institutional Outpatient Treatment Program Admissions	807
Institutional Outpatient Treatment Program Completions	485**
Referrals to ISAT Aftercare Program or Community Aftercare Program	359
Referrals to Community Substance Abuse Treatment Programs	826

*Totals do not reflect an unduplicated count.

**Other inmates in treatment were transferred to other institutions, released, or discharged for non-compliance.

Inmates Treated by DOC Mental Health Staff in Fiscal Year 1997 with Primary and Secondary Substance Abuse Disorders

Correctional Centers	Number of Mentally Ill	Percent of Mentally Ill with Co-Occurring Substance Abuse Disorders	Substance Abuse Primary Disorder	Total Number of Inmates Treated by Mental Health	Percent of Inmates with Substance Abuse Disorders Treated by Mental Health
Anvil Mountain	73	52%	6	79	50%
Cook Inlet Pretrial	333	55%	9	342	56%
Fairbanks	185	72%	43	228	78%
Hiland Mountain	91	57%	2	93	58%
Ketchikan	62	34%	9	71	42%
Lemon Creek	112	54%	10	122	57%
Palmer/Mat-Su Pretrial	159	64%	23	179	73%
Sixth Avenue	383	67%	66	449	72%
Spring Creek	164	15%	2	166	16%
Willowood	113	51%	14	127	57%
Yukon-Kuskokwim	79	27%	23	102	43%
Institutional Discharge Program Plus	30	77%	0	30	77%
TOTAL	1,781	55% (979/1,781)	207	1,988	60% (1,186/1,988)

Data is unduplicated

The IDP+ program has proven effective in reducing legal and clinical recidivism for its clients.

V. Institutional Discharge Program Plus (IDP+)

Institutional Discharge Program Plus (IDP+)

Summary of March 1998 IDP+ Program Evaluation

IDP+ Caseload: Since its inception in 1994, 76 clients have been referred to the IDP+ program, and 68 clients have been accepted into the program.

Co-Occurring Substance Abuse Disorders: 87 percent (59/68) of the IDP+ clients have co-occurring substance abuse disorders. In Fiscal Year 1997, 77 percent of the IDP+ clients had co-occurring substance abuse disorders.

Legal Recidivism: 33 of the 68 IDP+ clients (48 percent) have been arrested since the inception of the program. However, only six arrests were for new charges, and only one of these arrests was a new felony charge.

IDP+ Re-Arrests

- 27 Probation Violations.
- 5 New Misdemeanor Charges.
- 1 New Felony Charge.

Although arrest on a probation violation is not viewed as a desirable outcome, it is one of the tools available to help clients adjust to the community and conform their behavior to acceptable standards. It is for the enforcement value of probation conditions that one of the main eligibility criteria for IDP+ is the existence of formal conditions of probation. It is highly probable that enforcement of probation conditions results in reduced numbers of new offenses being committed.

Substance Abuse

- 87 percent (59/68) of IDP+ clients have a co-occurring substance abuse disorder.
- 94 percent (32/34) of IDP+ clients re-arrested have substance abuse disorders.
- 59 percent (20/34) of the IDP+ re-arrests were directly related to clients engaging in substance abusing activities.

Clinical Recidivism and API Admissions

Although statistical analysis has not been performed to correct for the time differential (three and a half years of IDP+ versus clients' lifetimes) it is apparent that IDP+ involvement has significantly reduced admissions for this group of frequent users of Alaska Psychiatric Institute (API). API admission rates for IDP+ clients dropped from a pre IDP+ rate of 85 percent with an average number of admissions per total client population of 5.2, to an admission rate of 19 percent with an average number of admissions per total client population of .3 while engaged in IDP+.

	IDP+ Caseload	Number of Clients Admitted to API	Total Number of Admissions to API	Average Admissions/Client
Prior to IDP+	68	57 (85%)	348	5.2
During IDP+	68	13 (19%)	20	.3

VI. Title 47 Non-Criminal Holds

Individuals may be placed in correctional facilities as Title 47 non-criminal substance abuse and mental health holds, if they are incapacitated by alcohol or present a mental health emergency. DOC medical and mental health staff provide interim services to individuals brought into Department of Corrections facilities on non-criminal Title 47 mental health holds pending transfer to the Alaska Psychiatric Institute or other designated evaluation and treatment facilities. Individuals who are incapacitated by alcohol or drugs and who require protection for health and safety purposes can be taken into state or municipal detention facilities for up to 12 hours if no treatment facilities or emergency medical services are available.

**In Fiscal Year
1997 there
were 2,585
Title 47 Non-
Criminal
mental
health and
substance
abuse holds in
DOC.**

The Department of Corrections has tracked Title 47 non-criminal admission data since Fiscal Year 1991, and although the statewide numbers are on a downward trend, DOC still had **2,585** Title 47 admissions in Fiscal Year 1997. Fairbanks Correctional Center and Yukon Kuskokwim Correctional Center in Bethel have recently had the highest and second highest number of Title 47 holds. Interagency workgroups have been formed in these communities to begin developing the mechanisms and resources for reducing the number of holds in correctional facilities. The Department of Corrections does not currently have the capability to statistically separate the mental health holds from the substance abuse holds, but estimates from DOC staff suggest that up to 90 percent of the holds are alcohol-related. In their 1999 state plan, the Advisory Board on Alcoholism and Drug Abuse has recommended that the Department of Corrections produce an annual report on Title 47 holds that includes data from the 15 community jails (operated by local municipalities/boroughs), and that DOC distinguish between the type of holds.

Title 47 Non-Criminal Holds

Location	FY 1997 Total
Anchorage—6th Avenue	315
Anvil Mountain	290
Fairbanks	999
Ketchikan	17
Lemon Creek	228
Mat Su Pre-Trial	13
Wildwood	43
Yukon-Kuskokwim	680
Total	2,585

48 percent of the inmates interviewed and tested for the SANTA study were abusing or dependent on alcohol.

VII. Substance Abuse Need for Treatment Among Arrestees (SANTA) Study

The SANTA study was conducted at Fairbanks Correctional Center, Yukon Kuskokwim Correctional Center, Cook Inlet Pretrial, and Sixth Avenue Correctional Center from March through July of 1997. Voluntary interviews and urinalysis testing were conducted on arrestees within 48 hours of booking. Information was also collected on inmates' substance abuse histories, and their previous treatment history.

Division of Alcoholism and Drug Abuse Summary of the SANTA Study

Study Method

- Study conducted at four state correctional facilities (March – July 1997)
—Fairbanks, Bethel, Cook Inlet Pretrial, Sixth Avenue
- All volunteers – arrested within 48 hours of interview
- Both interviews conducted and urine samples collected

Sample Size

- Although 658 individuals were interviewed, the sample size only includes the 503 inmates who were both interviewed and had urine collected.
n=503
 - 48% abusing or dependent on alcohol
(48.3% of males – 50.3% of females)
 - 18.5% abusing or dependent on cocaine
(14.3% of males – 31.3% of females)
 - 13.1% abusing or dependent on marijuana
(15.2% of males – 6.7% of females)
- Percentage of inmates testing positive for drugs n=503

Positive Drug	Fairbanks n=121	Bethel n=46	6th Ave. n=259	CIPT n=77	Test Sample n=503
—Any Drug	51.2%	47.8%	62.9%	61.0%	
—Cocaine	15.7%	0%	36.7%	40.3%	
—Marijuana	37.2%	47.8%	32.8%	28.6%	

- Treatment history/need for treatment among inmates who tested positive for drugs

	All	Male	Female
Treated in past year	21.4%	19.6%	26.3%
Need treatment	37.3%	32.9%	50.0%

*Information on treatment history and need for treatment is derived from inmate self-reports.

History and Milestones

1956: The Alaska Mental Health Enabling Act is passed and a land grant of one million acres is created for the necessary expenses of mental health programs in Alaska.

- 1899:** Congress passes the Criminal Code of 1899. Allows the Territorial Governor to contract with a western asylum for the psychiatric treatment of mentally ill Alaskans.
- 1901-1904:** Psychiatric patients from Alaska are sent to the Oregon State Insane Asylum in Salem.
- 1904-1962:** Alaskan psychiatric patients receive treatment at Morningside Hospital in Portland.
- 1949:** Department of Interior commissions two studies to examine the mental health needs in Alaska. Teams of research experts recommend constructing a psychiatric hospital in Alaska.
- 1953:** Third Avenue Correctional Center opens.
- 1956:** Alaska Mental Health Enabling Act is passed. Responsibility for mental health programs is transferred from the federal Government to the Territory of Alaska, and a land grant of one million acres is created for the necessary expenses of the mental health programs of Alaska.
- 1959:** Alaska Statehood Act. Responsibility for management of the Trust is transferred to the state.
- 1962:** Alaska Psychiatric Institute is constructed. No provisions are made for criminally committed patients, such as the Not Guilty by Reason of Insanity (NGI), in the design or construction of the hospital.
- 1962:** Palmer Correctional Center opens.
- 1965:** Alaska Psychiatric Institute expands to 225 beds.
- 1967:** Fairbanks Correctional Center opens.
- 1967:** Harborview Developmental Center opens with a 96 bed capacity for the developmentally disabled/mentally challenged, and special needs nursing care populations.
- 1969:** Not Guilty by Reason of Insanity Patients who were housed at the Norman Beatty Hospital in Indiana, are returned to Alaska.
- 1969:** Lemon Creek Correctional Center opens.
- 1972:** Atascadero State Hospital in California agrees to temporarily take Alaska's Not Guilty by Reason of Insanity patients.
- 1972:** Legislature creates the state Office of Alcoholism and a separate Office of Drug Abuse. Legislation is modeled after the federal Uniform Alcoholism and Intoxication Treatment Act.

1978: Rust v. State. Standards for the provision of mental health services in the correctional system are defined by the Alaska Supreme Court.

- 1973:** Sixth Avenue Annex opens.
- 1974:** Hiland Mountain Correctional Center opens.
- 1975:** Community Mental Health Services Act is passed. Act is designed to assist communities in planning, organizing, and financing community mental health services through locally developed, administered, and controlled community mental health programs.
- 1977:** A 14 bed Psychiatric Security Unit at API is constructed, and is immediately filled with in-state criminally committed patients.
- 1977:** The state Office of Alcoholism and state Office of Drug Abuse are merged into the state Office of Alcoholism and Drug Abuse (SOADA).
- 1978:** State of Alaska redesignates Mental Health Trust Lands as general grant lands through AS 37.14.070.
- 1978:** Rust v. State. Standards for the provision of mental health services in the correctional system are defined by the Alaska Supreme Court. The Court concludes that prisoners in DOC custody are entitled to receipt of psychological and psychiatric treatment.
- 1978:** Department of Law obtains a Law Enforcement Administration Act grant to establish a pre-trial diversion program in Anchorage.
- 1980:** Atascadero requests arrangement for return of Not Guilty by Reason of Insanity patients to Alaska.
- 1980:** Alaska adopts Presumptive Sentencing, wherein mandatory sentences are established for certain crime categories. Contributes to significant rise in Alaska's inmate population.
- 1980:** Legislature provides funding for statewide expansion of the pretrial diversion program.
- 1981:** Legislature provides funding for three Substance Abuse Counselor positions for the Division of Corrections.
- 1981:** Meadow Creek Correctional Center and Ridgeview open. From 1981 to 1985, Ridgeview is utilized as a lower security facility for those with DWIs, and for many of the female offenders.
- 1981:** Cleary v. Smith is filed in the Alaska Superior court in Anchorage challenging: the conditions of confinement, the adequacy of rehabilitative programs, and the policy of utilizing federal prisons to hold state prisoners.
- 1981-82:** Atascadero patients are returned to Alaska, and transferred to an 18 bed unit at API.
- 1982:** A Title 12 patient at API (Charles Meach) murders four teenagers in Anchorage while on a work pass.

- 1982:** Weiss et. al. v. State of Alaska. Lawsuit filed by Vern Weiss alleging that the 1978 redesignation of Trust Lands was a breach of the state's responsibility under the 1956 Alaska Mental Health Enabling Act.
- 1982:** Legislature appropriates funds to the Department of Health and Social Services for the development of a Forensic Treatment Program for all classes of criminally committed patients.
- 1982:** First phase of the state Forensic Treatment Program is implemented with the transfer of Court Ordered Examination patients from API to a Secure Treatment Unit at Hilland Mountain Correctional Center. This same year, however, the Division of Adult Corrections advises Division of Mental Health and Developmental Disabilities that it cannot turn house one at Hilland Mountain into a Forensic Treatment Program, due to acute shortages of secure correctional beds.
- 1982:** Transitional Living Center opens in Anchorage. Targets individuals coming out of API, by providing transitional, crisis respite, and rehabilitative housing and services.
- 1983:** Forensic Consultation Team is formed. Department of Health and Social Services provides the Division of Corrections with a team of mental health professionals. Primary duty of the Team is to perform court appointed examinations, secondary function is to provide clinical care for the mentally ill offender in DOC.
- 1983:** Revision of Insanity Statutes. Alaska's Insanity Defense is modified and extensively narrowed, and the Guilty But Mentally Ill (GBMI) defense is created.
- 1983:** Department of Health and Social Services' operating budget is cut, and the Forensic Treatment Program budget is impacted accordingly.
- 1983:** State substance abuse counseling positions for DOC are deleted, and substance abuse treatment services for DOC are provided through contract providers. Clitheroe oversees all contract substance abuse service providers working in DOC.
- 1983:** Department of Corrections' statewide offender tracking system is implemented.
- 1983:** Nygren v. State outlines regulations for granting offenders credit for time spent in rehabilitation facilities.
- 1983:** Cook Inlet Pretrial, Ketchikan Correctional Center, and Wildwood Correctional Center open.
- 1984:** Department of Corrections is created, pursuant to Executive Order No. 55, from the former Division of Corrections under the Department of Health and Social Services. Roger Endel is the first Commissioner.

**1983:
Forensic
Consultation
Team is
formed.
Department of
Health and
Social Services
provides the
Division of
Corrections
with a team of
mental health
professionals.**

**1984:
Department of
Corrections is
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Corrections.**

- 1984:** The new Seward Correctional Center is considered and rejected as the location for a forensic unit.
- 1984:** Goose Bay and Yukon-Kuskokwim Correctional Centers open.
- 1985:** Susan Humphrey-Barnett, Director of Statewide Programs for the Department of Corrections initiates the process of developing a parallel system within DOC, (to that of DH&SS) of mental health services. Humphrey-Barnett hires five Mental Health Clinicians to provide treatment in the institutions in Anchorage, Fairbanks, Juneau, and Palmer.
- 1985:** Wildwood Pretrial Facility and Anvil Mountain Correctional Center open.
- 1986:** President Reagan signs Public Law 99-660, the Mental Health Planning Act of 1986, authorizing grants to states for the development and implementation of Comprehensive Mental Health Plans for persons with severe and disabling mental illnesses.
- 1986:** Mat-Su Pretrial facility opens.
- 1986:** Harborview Developmental Center opens a 16 bed nursing care unit for the dually diagnosed with nursing and psychiatric and/or behavioral management needs.
- 1986:** State de-funds the pre-trial diversion program, particularly impacts the mentally ill misdemeanor.
- 1986-1992:** Closure of several boarding homes for the mentally ill.
- 1987:** Alaska Mental Health Board (AMHB) is formed to create a Comprehensive and Integrated Mental Health Program for the state of Alaska. The AMHB assumes responsibility for planning and evaluative services for mentally ill Alaskans under AS 47.30.661-669.
- 1987:** Mentally Ill Offender Task Force is created to define the needs of the mentally ill offender, and to recommend necessary services for the mentally ill offender.
- 1988:** A Memorandum of Agreement is signed between the Department of Corrections and the Department of Health and Social Services. The MOA addresses the state's responsibility for caring for the mentally ill offender, and delineates Departmental roles for providing care.
- 1988:** The Advisory Board on Drug Abuse and the Review Board on Alcoholism are merged through Executive Order.
- 1988:** Spring Creek Correctional Center opens.
- 1989:** A Memorandum of Agreement is signed between the Department of Corrections and the Department of Health and Social Services outlining the terms and conditions under which substance abuse treatment services are to be provided to incarcerated inmates.

1990: Cleary v. Smith Final Settlement Order contains provisions related to mental health services, counseling, specialized women's services, and rehabilitation services.

- 1989:** The Mentally Ill Offender Task Force estimates that there are two-three times as many mentally ill in the Department of Corrections as are hospitalized in the Alaska Psychiatric Institute (API). Task Force explains that DOC is the largest provider of institutional services to the mentally ill in Alaska.
- 1990:** Cleary v. Smith Final Settlement Agreement and Order contains provisions related to mental health services, counseling, life skills and educational services, specialized women's services, and rehabilitation services, including substance abuse programming.
- 1990:** First allocation of Mental Health Trust Funds to the Department of Corrections.
- 1990:** Institutional Discharge Project (IDP) is created by the Department of Health and Social Services from the Long Term Care Task Force. The project targets individuals from API, Designated Treatment Facilities, or correctional facilities who have severe mental illnesses and require augmented services to live successfully in the community.
- 1990:** The Division of Alcoholism and Drug Abuse (ADA) is established through Executive Order, replacing the State Office of Alcoholism and Drug Abuse (SOADA). The Division is statutorily charged with planning and implementing statewide substance abuse treatment programs and establishing standards to ensure quality services.
- 1990:** Bureau of Justice Assistance researchers recommend that the Alaska Department of Corrections develop a standardized statewide plan for substance abuse programs. Researchers issue a series of recommendations for substance abuse treatment including enhanced funding for substance abuse treatment services, and the development of a substance abuse Management Information System.
- 1991:** The Forensic Consultation Team is transferred from the Department of Health and Social Services to the Department of Corrections. The primary mission of the Team is to create, implement and oversee a system of correctional mental health services.
- 1991:** Mike Module at Cook Inlet Pretrial Facility opens with 28 beds to provide assessment and treatment for acutely and severely mentally ill male inmates.
- 1991:** The Substance Abuse Oversight Committee composed of members from the Division of Alcoholism (ADA) and the Department of Corrections is formed. ADA staff provides technical assistance to DOC.
- 1991:** Department of Corrections receives a federal grant for a Program Coordinator position to oversee its substance abuse treatment programs.
- 1991:** Department of Corrections' four-year plan includes projections for increasing numbers of special needs populations, including chronically mentally ill inmates and female offenders.

**1994:
Settlement of
the Mental
Health Lands
Trust
Litigation.**

- 1991:** State of Alaska has the fourth highest incarceration rate in the United States.
- 1992:** Transitional Living Center closes. The Transitional Living Center was the largest mentally ill halfway house in Alaskan history.
- 1992:** Alaska Mental Health Board creates a Forensic Action Team to examine the need for acute care beds within the correctional system, and to plan for a full continuum of mental health care within DOC institutions, and for mentally ill offenders transitioning into the community.
- 1992:** With a blend of funding from DOC and DMHDD, the Department of Corrections contracts for a 16 bed Halfway House for the mentally ill.
- 1993:** Department of Corrections Division of Statewide Programs is dissolved, and Medical, Mental Health, Substance Abuse, Education, Vocational, and Sex Offender programming are placed under the Division of Institutions.
- 1993:** Alaska Mental Health Board (AMHB) issues its Forensic Action Team plan. The plan is adopted by the board as part of its strategic plan, "A Shared Vision." The plan includes recommendations for a continuum of care for mentally ill offenders, and provides objectives, strategies, and action plans for enhancing services. The forensic population is one of four mentally ill populations addressed in the plan.
- 1993:** Point Mackenzie Facility opens.
- 1994:** Settlement of the Mental Health Lands Trust Litigation. Trust is reconstituted through: one million acres of land, a \$200 million permanent trust fund and a seven-member Trust Authority to protect and administer these assets. The Legislation also provides the Trust Authority with the responsibility for developing a Comprehensive Integrated Mental Health Program for the state, as well as the authority to produce a separate annual appropriation bill for the Governor and legislature to fund the program.
- 1994:** Department of Corrections' contract Halfway House for the Mentally Ill closes.
- 1994:** Institutional Discharge Program Plus (IDP+) is developed and initiated by the Department of Corrections and the Division of Mental Health and Developmental Disabilities to provide individualized treatment services for the mentally ill offender releasing into the community on felony probation.
- 1994:** Division of Alcoholism and Drug Abuse creates its strategic plan "Meeting the Challenge." The Division outlines the connections between crime and substance abuse, and recommends providing substance abuse prevention and treatment for offenders to help reduce crime.
- 1996:** Department of Corrections is awarded a federal Byrne grant to provide Enhanced Probation/Parole Services (EPPS) in the Anchorage field supervision office. The program targets probationers and parolees who are substance abusers and/or who have domestic violence behavior, and who have non-felonious violations of their community supervision conditions.

1999: The beneficiary boards identify mental health and substance abuse treatment for inmates as priorities in their state plans.

- 1998:** Alaska Mental Health Trust Authority provides the Department of Corrections with funding to create an 18 bed Women's Psychiatric Treatment Unit at Hiland Mountain Correctional Center.
- 1998:** Department of Corrections converts Hiland Mountain Correctional Center into the state's designated female facility.
- 1998:** Department of Corrections creates a Special Needs Wing for female mentally ill offenders. The Wing also houses developmentally disabled, organically impaired and other special needs female offenders.
- 1998:** Alaska Mental Health Trust Authority provides funding for a DOC Planner to coordinate with the beneficiary boards and the Trust, and to draft a strategic plan for Trust beneficiaries in the correctional system.
- 1998:** Alaska Mental Health Trust Authority provides funding to the Department of Corrections to initiate a pilot project, Jail Alternative Services to provide sentencing recommendations, links to community resources, and monitoring for mentally ill misdemeanants in Anchorage.
- 1998:** The Anchorage district court initiates the Coordinated Resources Project (Mental Health Court) to provide specialized sentencing for mentally ill, developmentally disabled, and organically impaired misdemeanants.
- 1998:** Department of Corrections initiates a Residential Substance Abuse Treatment Program for female inmates at Hiland Mountain Correctional Center, through a combination of funding from the Office of Justice Programs and the Trust Authority.
- 1998:** An interagency team creates LINKS, a special discharge project for women with children transitioning from the Hiland Mountain Correctional Center Residential Substance Abuse Treatment Program into the community.
- 1998:** Department of Corrections' Health Care Administrator becomes an Ex-Officio member of the Alaska Mental Health Board (AMHB), and the Governor's Council on Disabilities and Special Education (GCDSE) adds DOC staff to its board membership.
- 1999:** The Alaska Mental Health Board (AMHB) creates "A Shared Vision II," its strategic plan for mental health services. The plan identifies criminalization of the mentally ill as a key concern, and quantifies and identifies the services and needs of the mentally ill offender. The forensic population continues to be one of four mentally ill populations targeted by the board.
- 1999:** The Advisory Board on Alcoholism and Drug Abuse creates "Results Within Our Reach," its state plan for alcohol and drug abuse services. The board identifies appropriate substance abuse treatment for inmates as critical.

A complete description of this history is available in the Department of Corrections document: "History of the State's Care for Trust Beneficiaries in the Correctional System."

Additional Services Available to Beneficiaries

Inmate Medical Services

Inmate Medical Mission: To provide essential cost-effective physical and mental health services for persons incarcerated under the custody of the Department of Corrections.

Inmate Medical's Relationship to Beneficiaries in DOC: Department of Corrections medical staff play a critical role in connecting Trust beneficiaries to essential mental health services. Medical staff conduct the initial mental health status screenings on all inmates booked into Correctional facilities. If the mental status exams indicate a need for mental health treatment, medical staff refer inmates to DOC mental health staff for further assessment, diagnosis, and treatment recommendations. Medical staff are critical to the successful identification and triage of seriously mentally ill and suicidal inmates, and in some facilities, medical staff are the primary mental health providers.

Essential Health Care: Health care is considered essential when a health care provider, with reasonable medical certainty and exercising ordinary skill and care at the time of observation, concludes: that the prisoner's symptoms indicate a serious disease or injury; treatment could cure or substantially alleviate the disease or injury; the potential for harm, if treatment is delayed or denied, could be substantial; or services are needed to alleviate pain and suffering. This includes procedures necessary to aid in increasing the level of functioning throughout the prisoner's sentence to a level which would allow participation in rehabilitative services.

Medical Services: Routine medical services are provided at the institutions on a daily basis through contact with nurses and written requests to see a health practitioner (contract Physician, Physician Assistant or Nurse Practitioner). Inmates are seen within three days, depending on the urgency of the request.

Pharmacy: The Department of Corrections has a central pharmacy operation staffed by one Pharmacist and two Pharmacy Assistants. The pharmacy serves the needs of the entire DOC inmate population, including mentally ill beneficiaries, and inmates with acute detoxification needs.

Dental Services: The Department has one staff Dentist who, along with an assistant and a hygienist, provide essential dental services to inmates at Cook Inlet Pre-trial and residents of the Anchorage Community Residential Centers. Dental services are provided in other locations by contract providers or on a fee-for-service basis in the local communities.

Emergency Care: Institutional medical staff handle medical and traumatic emergencies where possible, and transfer more serious cases to emergency departments.

Medical Advisory Committee: The Medical Advisory Committee oversees all medical care provided by the Department of Corrections, approves medical policy and protocols, approves formulary drugs, and reviews requests for routine surgeries.

DOC medical staff play a critical role in connecting Trust beneficiaries to essential mental health services.

**Enhancing
educational
and vocational
opportunities
for
beneficiaries is
important.**

medical and dental prosthetics and other diagnostic procedures. The Committee is chaired by the Department's Health Care Administrator.

Medical Staff: Department of Corrections Medical Division has a staff of 100 Departmental and contract medical staff. The total does not include the medical staff on the mental health units.

Inmate Educational Programs

Mission: *The Department of Corrections is committed to encouraging prisoners to continue their education.*

Relationship of Inmate Education Program to DOC Beneficiaries: Enhancing educational and vocational opportunities for beneficiaries is critical to improving the quality of their lives, as well as the chances for successful rehabilitation upon release.

Education Program Eligibility Criteria: All inmates who are incarcerated for ten or more days are eligible for education programs. In many institutions, education programs are held in both the day and evening to maximize the availability of the programs. When an inmate requests entry into an educational program at any of the facilities, the Education Coordinator conducts an assessment of the inmate's academic background and educational needs. This may include obtaining school records, as well as conducting screening tests and academic counseling.

Inmate Education Staff: At each correctional facility, there are Education Coordinators who plan, develop, and implement the prisoner education program. Coordinators also provide academic and vocational counseling to prisoners and teach classes on a limited basis. Larger correctional facilities have two Education Coordinators and smaller facilities have one Coordinator. Due to limited educational staff at correctional facilities, the Educational Coordinators are unable to provide direct inmate services on a full time basis. Depending upon the subject areas addressed, courses may be taught by Education Coordinators, contractors, or volunteers. The vocational and apprenticeship programs are taught by contract employees who are specifically trained in the subject areas. Most institutions do not conduct routine educational assessments of all inmates upon entry into facilities. In the pretrial facilities, it is typical that inmates are not assessed unless they enroll in an education class. In some of the larger sentenced facilities, efforts are made to conduct an educational assessment on new prisoners, however, this effort has been somewhat hampered in recent times due to the high population turnover. Inmates with severe developmental disabilities and mental retardation are typically assessed and treated by DOC mental health staff, and receive specialized services from education staff.

The Department has an Administrator who provides oversight and coordination for all education and vocational programs in state correctional facilities.

**The DOC
Education
Program
provides five
core
curriculum
areas for
inmates.**

Overview of the Department of Corrections' Inmate Education Program

The Department of Corrections provides five core curriculum areas for inmates, including: Adult Basic Education (ABE), General Equivalency/Diploma (GED) preparation, life skills programming, post secondary education, and vocational education.

Adult Basic Education includes academic instruction in reading, writing, and computational skills below the ninth-grade level. The basic education program also includes English as a second language (ESL) and literacy instruction.

General Equivalency Degree (GED) includes instruction above the eighth-grade level and below the college level for adults whose inability to speak, read or write the English language and/or perform basic math computations prevents their functioning at the highest level of their ability. GED preparation includes instruction in the areas of writing, science, social studies, reading and mathematics.

Life Skills Programming includes learning opportunities directed at independent living through practical preparation in a variety of areas. The program offers classes, services and other activities in four core curriculum areas including:

- **Health and Safety;** includes programs in anger and stress management, CPR/first aid, personal hygiene, and decision making.
- **Communication Skills;** includes programs in interpersonal relationships, parenting, and values clarification.
- **Cultural Activities;** includes programs and activities in cross-cultural communication, Native languages, and cultural awareness.
- **Pre-Release/Pre-Employment Preparation;** includes programs in career planning, budgeting and money management, consumer education, job-seeking skills, and resume writing.

Post-Secondary Education Program includes college-level courses that inmates may enroll in through correspondence. Expenses for these courses are paid by inmates, although the Education Coordinators assist inmates with applications and tutoring as needed.

Vocational Education Programs includes a sequence of courses designed to prepare individuals for employment in occupations that do not require a Bachelors or an advanced degree. Apprenticeship programs which meet the requirements of the U.S. Department of Labor are also offered as part of the vocational education programming.

Special Education Services for Juveniles in Adult Corrections: In 1997, a Memorandum of Agreement between the Department of Corrections and the Department of Education was developed to provide special education and related services to incarcerated individuals in adult correctional facilities through age 21. Local school districts inform correctional facilities when students who have current Individualized Educational Plans (IEP's) are incarcerated in an adult correctional facility. Through local school districts, the Department of Education conducts educational evaluations and develops and implements IEP's for qualified inmates in collaboration with DOC educational staff.

DOC provides sex offender treatment at Lemon Creek Correctional Center, Meadow Creek Correctional Center, and in the community.

Sex Offender Treatment Programs

Mission/Philosophy of Treatment: *The Department of Corrections operates sex offender treatment programs based upon the premise that sex offenders can change, and are therefore treatable, but that the process is complex and difficult. It is further believed that the process of treatment can significantly lower, but not completely eliminate the sex offenders' risk to the community.*

The Department of Corrections provides sex offender treatment at Lemon Creek Correctional Center (LCCC), Meadow Creek Correctional Center (MCCC), and in the community.

Pre-Treatment/Pre-Release Program (LCCC). The program has two primary purposes: to prepare high custody inmates for entry into the program at Meadow Creek Correctional Center, and to provide assessment and orientation to community-based treatment for offenders who do not have a long-enough sentence to enter the institutional treatment program at MCCC. The pre-treatment/pre-release program houses up to 24 inmates at a time who participate in comprehensive assessments and psycho-educational groups.

Comprehensive Treatment Program (MCCC). The comprehensive treatment program provides intensive treatment in a milieu setting at Meadow Creek Correctional Center. The program was recently moved from Hilland Mountain Correctional Center to MCCC. It has been restructured to reflect goals that are more offense-specific. The program consists of two parts, the Core Program and Additional Treatment goals. All offenders must complete the Core Program which includes assessment, taking responsibility for the offense, self-regulation, relapse prevention planning and other modules necessary for all sex offenders. Additional treatment goals are assigned as necessary, based upon individual issues and problems such as substance abuse, unclear sexual orientation, and conflicts in close relationships that directly relate to the behavior patterns found in the offense. At MCCC group therapy occurs daily, and inmates involved in the program reside together. The MCCC program houses a social skills wing that accommodates lower functioning individuals. While there is a Therapist trained on working with mentally ill and developmentally disabled sex offenders in the social skills wing, there is a need to expand services for this population. Services are provided to female sex offenders by program staff on an as needed basis.

Community Sex Offender Treatment Programs are currently offered in Anchorage, Fairbanks, Juneau, Ketchikan and Kenai. In community programs, group therapy typically is provided once per week, with individual treatment provided one to two times per month, as well as assessment and educational modules as needed.

Referral: Offenders may be referred to sex offender treatment through order by the court or Parole Board, or by correctional staff. Offenders may also request sex offender treatment. Offenders are initially referred as part of the sentenced classification procedures and are transferred to a specific site for treatment, as spaces are available. Offenders on probation or parole in the community are referred by their probation officer to an approved community provider.

Therapists: Treatment is provided by trained professional Therapists who are approved by the Department of Corrections to provide treatment to offenders using a relapse prevention model. Therapists must have a minimum of a Masters Degree in the Behavioral Sciences, must be licensed in their respective field, and must have experience working with sex offenders. At Meadow Creek Correctional Center, there are specially-trained correctional officers who work in conjunction with the Therapists to provide overall management and assist in the treatment of offenders. In the community sex offender treatment programs, the Probation Officers may work in conjunction with the Therapist on treatment issues, particularly in the area of risk issues.

The DOC Sex Offender Treatment Program provides some specialized services for developmentally disabled and mentally ill sex offenders.

Treatment Components:

- Assessments (including risk assessments).
- Education classes.
- Group and individual therapy.
- Family or marital counseling.
- Treatment teams and treatment planning.

Special Needs Inmates: Although most sex offenders have an average or above average intellectual ability, some sex offenders are limited in their intellectual functioning. Treatment for these offenders is similar to that provided for other offenders; however, the presentation of treatment concepts is simplified. The MCCC program has a wing designated to provide specialized services for up to eleven special needs sex offenders. Additionally, some community providers have become skilled in working with these offenders. Two approved providers in the community currently operate specialized programs for developmentally disabled and/or mentally ill sex offenders and correctional clients may be accepted into these programs.

Eligibility Criteria: The Department of Corrections is committed to providing the opportunity for all inmates committed to DOC for a sexual crime to be considered for sex offender treatment services. In order to establish uniform criteria for eligibility into any of the sex offender treatment programs, DOC has adopted the following minimum mandatory criteria for acceptance.

- Inmate requests to participate in the program.
- Inmate is of average or better intelligence, although some inmates may be treatable on the social skills wing at Meadow Creek Correctional Center.
- Inmate is able to speak and understand the English language, although arrangements have been made for mentors to work with those inmates with limited English skills.
- Inmate has engaged in sexual offending behavior.
- Inmate is not appealing his sex offense conviction.
- The inmate did not engage in sadistic/ritualistic behaviors with his victim(s).
- The inmate is not actively psychotic or suffering from a disabling major mental disorder, with symptoms so severe as to preclude him from benefiting from treatment.
- The inmates' sentence structure provides adequate time for him to benefit from the prison treatment program.

The prison batterer programs provide services to inmates who have been perpetrators of domestic violence.

Program Model: The Department of Corrections utilizes a Relapse Prevention treatment model as the core of its treatment approach. The Relapse Prevention model is a maintenance oriented, self-control program based upon cognitive-behavioral principles. Sex offenders are taught their high risk to re-offend situations, self destructive behaviors, and their deviant cycle patterns. The model is believed to offer the best protection for the community and effective treatment for the sexual offender.

Chaplaincy

Mission: *The mission of the Department's Chaplaincy program is to provide opportunities for prisoner reformation and rehabilitation by offering religious services and programs to encourage responsible behavior, promote spiritual growth and moral development, and improve relationships with God, family, self, and community. DOC's Chaplaincy program offers pastoral care and support to prisoners, furloughees, probationers and parolees, and provides opportunities for the exercise of religious freedom and practice as guaranteed by the U.S. Constitution.*

Chaplaincy Program's Relationship to DOC Beneficiaries: The Chaplaincy program can assist DOC beneficiaries to improve their psychosocial level of functioning. The Chaplaincy program can provide a positive source of support for beneficiaries by addressing their spiritual needs. If a positive and ongoing relationship is established between a religious volunteer and a beneficiary, the volunteer may assist the individual to transition back into their home community.

The correctional Chaplaincy program provides structured opportunities for religious practice, spiritual and moral development, and pastoral care. The Chaplaincy services are designed to address the pluralistic spiritual and moral needs and interests of inmates. The Chaplaincy program provides denominational and non-denominational worship services, Bible and religious studies, administration of sacraments ordinances and other religious rites, pastoral care and counseling, lay counseling, group counseling, visitation ministry, crisis intervention, religious/sacred music, and other special projects and events. There is also a prison match program whereby religious volunteers are matched with inmates who receive little or no visits from family and friends.

Prison Batterer Programs

The prison batterer programs provide services to inmates in correctional facilities who have been perpetrators of domestic violence, whether or not that is the crime for which they are incarcerated. The program utilizes a psychodynamic model that focuses on correcting learned behaviors. Prison batterer programs offer lethality assessments and psycho-educational groups focusing on decreasing violence. The program staff also routinely conduct safety checks with the offender's victims. Batterer programs are provided at Fairbanks Correctional Center, Lemon Creek Correctional Center, and Palmer Correctional Center through a Memorandum of Agreement with the Council on Domestic Violence and Sexual Assault. The program is funded by DOC and operated by the Council on Domestic Violence and Sexual Assault.

Cultural Diversity

The Department of Corrections' Rural Affairs Coordinator works to ensure that the Department's programs are culturally relevant for Alaska Native inmates. The Department recently provided cultural diversity training to its Inmate Substance Abuse Counselors to assist in the delivery of treatment services to Alaska Native inmates.

**The Rural
Affairs
Coordinator
ensures that
DOC programs
are culturally
relevant for
Alaska Native
inmates.**

The Department of Corrections has also engaged in the following activities aimed at enhancing culturally relevant programming:

- **Sobriety Potlatches:** The Department has worked with Native Culture Clubs to sponsor sobriety potlatches at correctional facilities in Bethel, Eagle River, Fairbanks, Juneau, Kenai, Ketchikan, Nome, Palmer and Seward.
- **Culturally Relevant Halfway Houses:** Halfway house contractors collaborate with the Department of Corrections to enhance the cultural relevance of their services. The Department has contracted with the North Slope Borough for a culturally relevant halfway house in Barrow, and with Maniilaq Association Inc. for a culturally relevant halfway house in Kotzebue. The Department also intends to contract for a culturally relevant halfway house in Nome.
- **Native Issues Work Group:** The Department of Corrections has developed a Native Issues Work Group to address such issues as alcohol abuse and dependency among Alaska Native inmates, and to develop solutions for keeping Native sex offenders enrolled in the Department's sex offender treatment programs.
- **Meadow Creek Sex Offender Treatment Program:** The program has incorporated several culturally-oriented elements including: an Alaska Native support group, a mentor program, and outreach to families.

Community Jails

There are fifteen community jails on contract with the state of Alaska in: Barrow, Bristol Bay, Cordova, Craig, Dillingham, Haines, Homer, Kodiak, Kotzebue, Petersburg, Seward, Sitka, Unalaska, Valdez, and Wrangell.

Mission: The mission of the community jails is to provide short term local facilities suitable for the detention and confinement of persons held under the authority of state law. These facilities are operated by local borough or city authority and house state prisoners through a state contract for jail services. To carry out this mission, community jails will confine persons under authority of state law:

- (a) who are committed in order to secure their attendance as witnesses in criminal cases;
- (b) who are charged with a crime and awaiting court proceedings;
- (c) who are sentenced to confinement with 30 days or less to serve;
- (d) who are sentenced and awaiting transport to a state Correctional facility;
- (e) who are committed for contempt, or upon civil process, or by other authority of law including immigration or other federal agencies;
- (f) who are sentenced prisoners within 30 days of release and returning to the local community; or
- (g) who are held under AS 47

**There are
fifteen
community
jails on
contract with
the state of
Alaska.**

Performance Measures

- Percentage of community jails meeting community jails standards by passing annual compliance reviews.
- Percentage of prisoners arrested and presented but unable to be housed in community jails.

Recommendations for Trust Beneficiaries in Community Jails

Community jails may house Trust beneficiaries for brief detentions, and currently have a need for emergency mental health and psychiatric triage services to help prevent suicides and to ensure the safe management of chronic and acutely mentally ill detainees arrested for misdemeanor crimes. The jails are also utilized for Title 47 non-criminal mental health and substance abuse holds.

Department of Corrections in conjunction with other state Departments and agencies will explore options to:

- Train community jail staff on suicide assessment, prevention and intervention.
- Train community jail staff to link mentally ill individuals to community treatment resources.
- Track the number of Title 47 non-criminal mental health and substance abuse holds, as well as the referral of these individuals to community treatment resources.
- Create processes for reducing the number of Title 47 non-criminal mental health and substance abuse holds.
- Utilize telepsychiatry to provide emergency suicide screening and mental health services, and to create links between community jails and community mental health centers.

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**This publication was released by the Department of Corrections,
produced at a cost of \$7.00 per copy to provide strategic planning, and
printed in Anchorage, Alaska.**

**Additional copies are available upon request.
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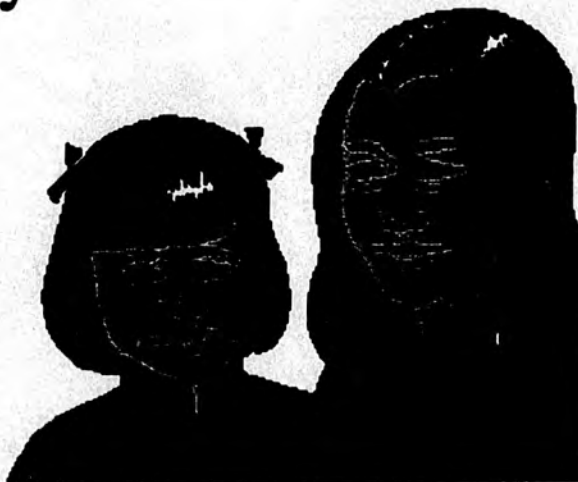
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STATE OF ALASKA
DEPARTMENT OF CORRECTIONS

LINKS

Living in New Knowledge
Successfully



Operational Guidelines

Mission Statement

Our mission is to provide successful transition that enhances recovery and permanency planning (reunification, relative placement, guardianship, and adoption) for female offenders with children completing the Hiland Mountain Correctional Center Women's Residential Substance Abuse Treatment Program and returning to the greater Anchorage community.

LINKS Operational Guidelines

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History

LINKS (Living in New Knowledge Successfully) is a release project for women with children who are transitioning into the community after receiving treatment in the Hiland Mountain Correctional Center (HMCC) Residential Substance Abuse Treatment Program. The concept of the project was inspired and initiated by Loren Jones, Director of the Division of Alcoholism and Drug Abuse (ADA), Department of Health and Social Services.

Background Information: In March of 1998, the Inmate Substance Abuse Treatment Program Oversight Committee began discussion of how to better serve women inmates as HMCC was in the process of becoming the Department of Corrections' designated women's facility. At the Advisory Board on Alcoholism and Drug Abuse meeting in March, the Board agreed to participate in the release project via the Board's Program Evaluation Committee. In late April, representatives of the Division of Alcoholism and Drug Abuse, the Board, and Department of Corrections met to further discuss the scope of the project. After the legislative session ended and the planned Therapeutic Community in Valdez was postponed, Department of Corrections proposed a major change in the scope of substance abuse services at HMCC.

Need for Treatment: In Phil Smith & Associates, March, 1998 "Assessment of the Needs of Women Offenders in Custody of the Alaska Department of Corrections", researchers interviewed 118 female inmates statewide and found two thirds of the respondents (N=79) were under the influence of drugs or alcohol when they committed their crimes. Researchers further reported that 96% of the women who committed substance abuse related crimes self-reported that they were under the influence of drugs or alcohol at the time of the crime. In addition, 60% of the respondents self-reported that their substance abuse was a problem. The needs of this target population were found to be multiple and complex.

Need for LINKS Release Project: The Women's RSAT Program approach has been validated to be an effective means of addressing the substance abuse treatment needs of women inmates. However, much of the benefit of such an approach is threatened if the transition into the community is not supportive of the recovery process started in the institution.

For a woman, especially if she has children, this transition can be especially critical. Regaining the custody of her children and/or resuming her parenting role, is an incentive to complete treatment. Without support, this incentive can be an additional burden and threaten her recovery and transition back into the community.

She needs to re-establish her parental relationship, find economic support, safe housing and a sober environment. She also will most likely need to comply with the conditions of furlough or probation/parole and the expectations of the Division of Family & Youth Services. For some women decision making may include participation in developing a plan for permanent, nonparental placement of their children.

Department of Corrections Response: The Department of Corrections submitted a proposal to the Federal Office of Justice Programs for Residential Substance Abuse Treatment (RSAT). Funding was requested to upgrade the existing outpatient treatment program for women at HMCC to a residential substance abuse treatment program. The award was granted. On October 2, 1998, the State Legislature gave the Department of Corrections receipt authority for the RSAT matching funds provided by the Mental Health Trust Authority.

The Inmate Substance Abuse Program Oversight¹ Committee established a Project Team to address the transitional needs of these women. The team members created the mission, goal, objectives, as well as the LINKS Operational Guidelines. They will continue to serve as a resource for oversight and support while the project is implemented.

The Project Team asked the women in treatment at the HMCC to submit names for the release project. Of the several excellent submissions the team members chose LINKS, the acronym for Living in New Knowledge Successfully.

LINKS Project Team Members:

Jason Allen, Anchorage Field Probation Office, P.O. II
Ken Braz, DOC, P.O. IV, Assistant Classification Officer
Marion Brown, Alaska Women's Resource Center, Program Director
Patti Bruce, ADA, Associate Coordinator
Melinda Freemon, Clitheroe Center, Program Director
Bernita Hamilton, DFYS, Statewide Evaluation Unit Supervisor
Cheryl Mann, Chair of the Advisory Board on Alcoholism and Drug Abuse, Associate Professor of Human Services at UAA
Dave Sager, DFYS, Program Evaluator
Viki Wells, Clitheroe Center, Anchorage RSAT Coordinator
Sarah Williams, DOC, Substance Abuse Program Coordinator

¹ ISAP is the Inmate Substance Abuse Program funded by the State and available in every DOC institution statewide. RSAT is the federally funded women's treatment program at HMCC.

Mission - Goals and Objectives

Mission: Our mission is to provide successful transition that enhances recovery and permanency planning (reunification, relative placement, guardianship, and adoption) for female offenders with children completing the HMCC Women's Residential Substance Abuse Treatment Program and returning to the greater Anchorage community.

LINKS currently focuses on women transitioning into the Anchorage area because the majority of women being released from prison in Alaska return to Anchorage. Anchorage LINKS serves as the prototype for future release projects. In time it is hoped that the project will grow to include other communities in Alaska. The Project Team thought it wise to concentrate efforts in one community, since this is the first project of its kind in Alaska.

The reason why the Project Team used "permanency planning" instead of simply "reunification" in the mission statement is because it did not want a woman using LINKS to feel that her participation in the project was "unsuccessful" if she decided that she could not be the legal custodian of her children. It wanted her to feel supported in making the best decision possible for her children and her own recovery whether it is to regain custody or use another placement option.

Goal: To develop and maintain a transitional program for female offenders through a system of community collaboration.

Objectives:

1. Maintain gains made in the HMCC Women's Residential Substance Abuse Treatment Program.
2. Remove barriers to transition into the community. These barriers include but are not limited to:

Child Care	Transportation	Housing
Parenting	Family Counseling	Special Needs
Child Support Payments	Respite Care	Vocational Needs
3. Develop Memorandums of Agreement with Community agencies for their participation in the LINK project.

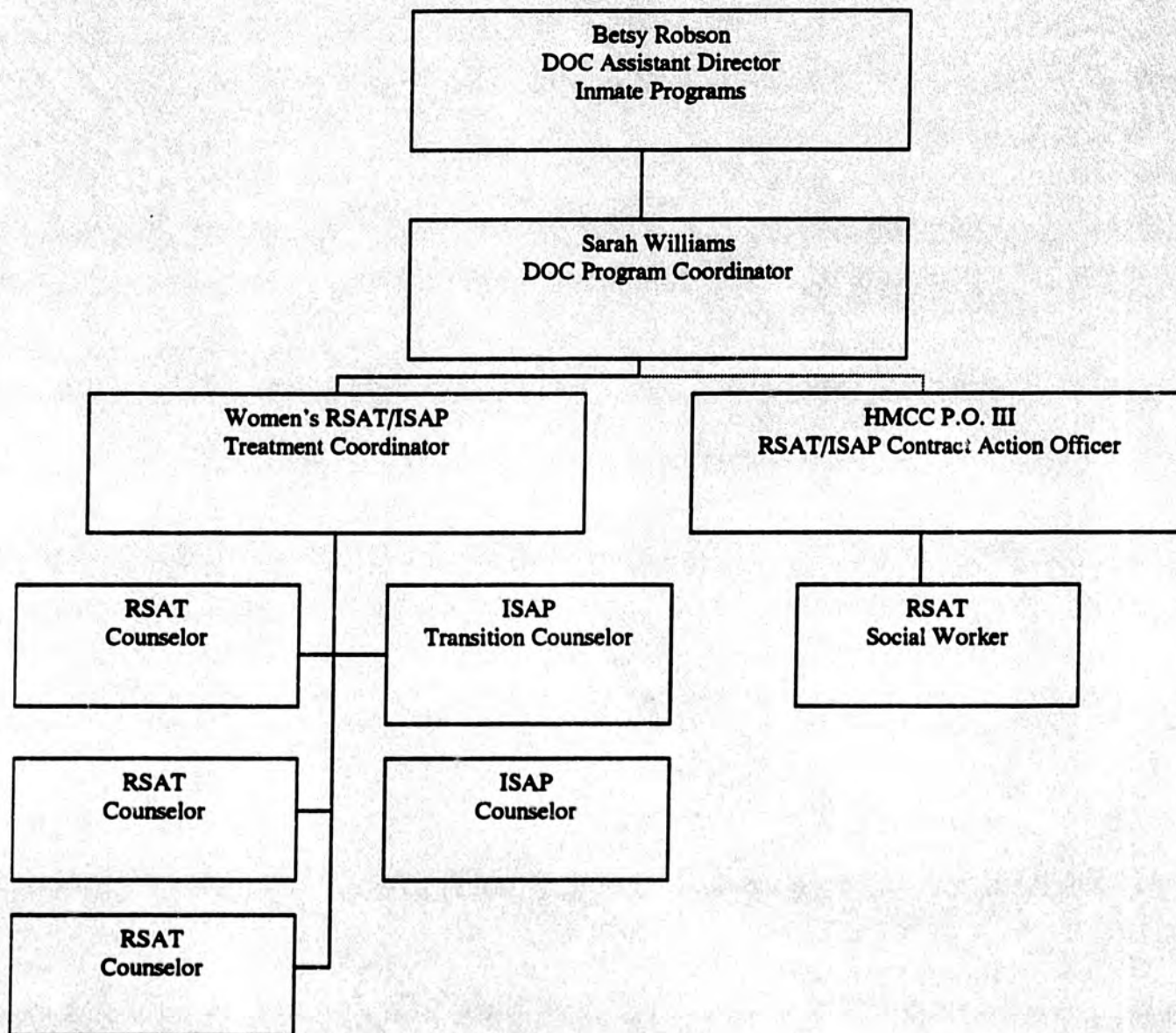
Program Description

Program Site: The LINKS Program is co-located with the HMCC's RSAT Program. One of the four houses at HMCC is the site for the Women's RSAT Program. Each of the four wings will have sixteen female inmates involved in one of the three levels of treatment, for a total of 64 participants. The three levels include substance abuse education, primary care, and transitional care. The contract treatment provider delivers services during the day and into the evening. The correctional staff maintains a presence 24 hours a day and debriefs with treatment staff at various times during the day. The treatment team consists of five certified substance abuse counselors and a treatment coordinator. The six to twelve month long program is structured so that a woman may participate in institutional jobs and educational/vocational classes as a part of her treatment plan. This gender specific treatment program will also address recovery as it relates to issues of parenting and children.

Staff: The key staff in the daily operation of LINKS are the HMCC Treatment Coordinator, the Transition Counselor, and the RSAT Social Worker. The other professionals are incorporated in LINKS depending upon the individual case. Each woman using LINKS will have a Social Worker at the Division of Family & Youth Services, an Aftercare Counselor from a substance abuse treatment agency in the community, an Institutional Probation Officer, a Furlough Officer or a Field Probation/Parole Officer, and other support identified as her transitional needs become apparent.

The LINKS Project Team remains in the background ready to provide guidance to LINKS if needed.

Organizational Chart



Service Plan:

- At least six months prior to the woman's release (during level III), the client, the Transition Counselor, the DFYS Caseworker, the RSAT/ISAP Counselor and the Institution and Field Probation Officer will meet to develop a release plan.
- The release plan will address the woman's living arrangement; DOC conditions of release; the DFYS case plan; vocational plan and substance abuse continuing care plan.
- Three months prior to release from HMCC, the client will begin participating in the LINKS bridge transition group which focuses on identifying and building community support. The group will meet on a regularly scheduled basis. Speakers from community programs will present information about their services to the bridge group. The group will be facilitated by the Transition Counselor.
- Upon release the Transition Counselor will continue to meet with the women to monitor their progress.
- The Transition Counselor will participate in case review meetings to monitor the woman's progress with her release plan. The Transition Counselor will ensure that any modifications in the release plan are recorded.
- The release plan will accompany the woman into community aftercare treatment. It will serve as the basis for evaluating her progress in meeting her goals for recovery.

Inmate Orientation to LINKS: All inmates arriving at HMCC are assigned to the Orientation wing of the intake-housing unit. During the first two weeks, the inmate is required to participate in an orientation program, structured to acquaint the inmate with the rules, behavioral expectations, and program offerings of the Correctional Center. The Probation Officer III/Program Director meets with the Orientation group every two weeks providing an overview of the programs that are available to the inmate population and the choices of tracks for sentenced inmates.

Program Review: Within 60 days after sentencing, a Program Review is held to inform the inmate of track options. The members of the Program Review Team are the Correctional Officer III who is the House Supervisor for HMCC Houses 1,2,3, and 4, the Institutional Probation Officer, the Education Coordinator, the Institutional Social Worker, and the inmate. The House Supervisor describes the programs and levels of participation available to the inmate while serving the sentence. They include Track I, the Cognitive Track, Track II, the Work Education Track, and Track III, the Non- Productively Involved Track (NPI).

Track Options:

1. The programs included in this track are characterized by the members participating in morning groups. The **Cognitive Track** includes the "self-change" programs, designed for an offender to initiate lasting changes of behavior that would place them at reduced risk to reoffend in the community. Currently the programs offered in this track are the Institutional Residential Substance Abuse Program, the Female Offender/Cognitive Self Change Program, and the Mental Health Special Needs Group.

As criminal thinking errors are a focus of each of these groups, there is a tendency for these program participants to be the more model inmates in the prisoner population, and can be expected to be at lower risk to relapse or reoffend upon release from the structured institutional environment. Members of the cognitive track may work an institutional job, and participate in education and other programs offered.

2. The **Work/Education Track** includes inmates who choose to participate in a minimum of 40 hours a week of any combination of educational programs and institutional jobs.

3. The **Non-Productively Involved Track** includes inmates who do not wish to commit to the requirements of the other tracks, do not wish to have any participation beyond serving their sentence, or have been removed from one of the other tracks due to disruptive behavior or insufficient participation.

Admission Criteria:

Admission into the LINKS program will be based on the following criteria:

- Women who are participants in the Women's RSAT Program at HMCC.
- Women who will be living in Anchorage upon release.
- Women who have children in DFYS custody or other's care.

Discharge Criteria:

Discharge from the LINKS program will be based on the following criteria:

- Successful completion of client program goals.
- Administrative discharge: significant noncompliance with one or more areas of release plan.
- Against Treatment Advise: client leaves the LINKS program prior to meeting goals as stated in the release plan.

Confidentiality:

As with all of DOC's substance abuse treatment providers, the provider at the HMCC Women's RSAT Program will abide by the federal confidentiality regulations CFR 42, Part II. Please refer to the LINKS Operational Guidelines Appendix for the complete regulation provisions.

The substance abuse treatment team staff at the HMCC RSAT and the correctional staff both work toward rehabilitation of the offender. The correctional staff maintains the security of the program in the institution 24 hours a day, while the treatment staff provides the clinical services during the day and early evening. The correctional staff does not participate in clinical activities or have access to clinical records, but they have an important role in the treatment milieu. They debrief the treatment staff on program developments or particular offender behavior that transpired overnight or on weekends. They are aware of the program's goals and objectives and support them on a day-to-day basis. The treatment staff also keep the correctional staff aware of program activities and offender behavior that may impact security. Together the treatment team and the correctional personnel form a cohesive unit through consistent communication and coordination.

The relationship between the treatment staff and security staff described above also applies to the operations of LINKS, which is a part of the treatment program. Because LINKS focuses on using community resources to assist offenders to make a successful transition into the community, confidentiality protocol for communicating with other agencies has been established.

Confidentiality Protocol:

- During the intake and orientation session, the RSAT Counselor will provide a brief overview of the Residential Substance Abuse Program and LINKS. The RSAT Counselor will review the Consent to Release Confidential Information with the client, taking care to assure that the client understands the information and that the form is completed appropriately. The Consent to Release Confidential Information will remain in the client's case file.
- It is the policy of the Residential Substance Abuse Treatment program to thoroughly assess the ongoing needs of the incarcerated individual, and to assist the individual in obtaining services from other agencies when those services are not available from RSAT or can be better met by an outside provider. Outside providers will adhere to established confidentiality standards.
- The RSAT staff will involve the individual being served in all decisions regarding referral, exit/discharge and follow-up processes, and will document such services with a written discharge summary and follow-up summary. No information concerning the individual shall be released without a signed consent by the individual.

Child Protection Statute Interface: The LINKS project has as its primary goal the reuniting of mothers and children after a period of incarceration. The children, who are in state custody and the care of DFYS, may be in placement with relatives or in licensed foster homes.

The program will attempt to facilitate this goal through case management activities that will include visitation with children and other family support systems coordinated with the DFYS

worker. In view of the changes in the new child protection law, the communication between the LINKS Social Worker and the DFYS Social Worker is essential for the success of the program.

The changes in the child protection law, effective September 1998 have several main principles. Safety of children is of primary concern. When children are placed in foster care, it should be considered a temporary resolution. Permanency planning will begin immediately, as soon as a placement occurs. Permanency planning means developing a placement for a child in a permanent home through adoption or guardianship.

Coordinated approaches by service providers and improved linkages between them are essential for resolution of placement issues and determination of continued placement or return home.

For the purposes of the LINKS project, the most important aspects of the child protection law that will effect the desired result of reunifying mothers who are incarcerated with their children, are the new standards that have very specific time frames for decision making. The time frames are radically changed and now require a permanency determination be made within 12 months instead of 18 months. There will be a permanency court hearing when the child has been in care for one year. Termination of parental rights proceedings will be initiated for children who have been in care for 15 of the last 22 months.

While reaffirming that reunification is a viable option for families, the time frames push the system to move faster and not allow children to languish in foster care. Also, the changes require parents to show progress with their case plans to avoid the termination track.

For a parent in the LINKS program who is serving a long sentence and has children in the foster care system, it is possible for the termination process to be activated. This is especially true when the children are young. If a participant of the LINKS program is making progress in all phases of treatment, then this should be brought to the attention of the DFYS worker in regularly scheduled contacts. As the law also requires reasonable visitation between child and family when there is removal, then this will also necessitate close contact and regular communication between the case managers to set up the appropriate schedule of visitation.

Successful reunification is a hoped for result of clients' participation in the LINKS project. However, the child's needs for stability and safety have to be balanced with the parent's rights for service. It is through the crucial linkage between case managers of LINKS and DFYS that determination will be made regarding the permanent plan for a child.

Community Partnerships: Partnerships with LINKS and community agencies will be necessary to develop a comprehensive support system for each woman. In order to formalize these partnerships, memorandums of agreement (MOA) will be drawn up with agencies being used on a routine basis. One of the primary MOA's needed by LINKS is between the Department of Corrections and the Division of Family and Youth Services. A specific MOA has been developed for use between these two programs (Appendix C). A template MOA has been developed for use with other agencies. A list of community resources with whom MOA's may be desirable has been developed (Appendix B). LINKS will use the "Alaska Resource Manual",

produced by Access Alaska, for detailed information about the agencies currently on the list, and for seeking out other services and agencies which may not already be on the list.

Evaluation of LINKS

PROCESS EVALUATION:

The women participating in LINKS will be in the transition phase of the HMCC Women's RSAT Program. The program as a whole will be continually involved in process evaluation. In addition to offender profile information we will know at what junctures the women are discharged from the treatment program and why. We will know how many women are on the waiting list for treatment inside and outside of twelve months.

OUTCOME EVALUATION:

Short-term outcome: Short-term evaluation will provide information early on regarding how well the program is doing. For instance, urinalysis testing will be conducted. Each woman will receive a base-line UA when she enters the treatment program as well as a random UA once a month for the duration of her program participation. The treatment staff will also score the women on pre and post-tests for the substance abuse educational components.

Intermediate-term outcome: DOC is interested in how the treatment program, including LINKS, effects relapse and recidivism in the community. Six months after the offender has been released to the community either on furlough, probation or parole, a follow-up will be conducted by the DOC Substance Abuse Program Coordinator. All graduates will be studied with the LINKS participants clearly identified. The Furlough/Probation/Parole Officer will be asked the following questions regarding the program graduates.

1. How well is the offender complying with conditions of furlough, probation, parole? (A scale will indicate the choices of poorly, somewhat poorly, reasonably well, and extremely well.)
2. Has the offender violated conditions of supervision resulting in the filing of a Petition to Revoke Probation/Parole Violation Revocation, or a return to incarceration if a furloughee? If yes, was a positive urinalysis test result involved?
3. Did she enter the treatment program she was referred to for aftercare services?
4. Is the offender productively engaged? (Options include job, school, other)
5. Does she have adequate/safe housing?
6. If she participated in LINKS, is she still living with her children?

Long-term outcome: In July of 2000, or approximately two years after program start-up, DOC will conduct a study to determine how many of the treatment program graduates have been

reincarcerated. The LINKS graduates will also be identified in the study. It would be ideal to also obtain arrest and conviction records. Because the DOC information system cannot currently provide this data, the court system would need to be accessed. If resources allow, such a study could be conducted.

SUBCHAPTER A—GENERAL PROVISIONS

PART 1 [RESERVED]

PART 2—CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

Subpart A—Introduction

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AUTHORITY: Sec. 408 of Pub. L. 92-255, 86 Stat. 79, as amended by sec. 303 (a), (b) of Pub. L. 93-282, 83 Stat. 137, 138; sec. 4(c)(5)(A) of Pub. L. 94-237, 90 Stat. 244; sec. 111(c)(3) of Pub. L. 94-581, 90 Stat. 2852; sec. 509 of Pub. L. 96-88, 93 Stat. 695; sec. 973(d) of Pub. L. 97-35, 95 Stat. 598; and transferred to sec. 527 of the Public Health Service Act by sec. 2(b)(16)(B) of Pub. L. 98-24, 97 Stat. 182 and as amended by sec. 106 of Pub. L. 99-401, 100 Stat. 907 (42 U.S.C. 290ee-3) and sec. 333 of Pub. L. 91-616, 84 Stat. 1853, as amended by sec. 122(a) of Pub. L. 93-282, 88 Stat. 131; and sec. 111(c)(4) of Pub. L. 94-581, 90 Stat. 2852 and transferred to sec. 523 of the Public Health Service Act by sec. 2(b)(13) of Pub. L. 98-24, 97 Stat. 181 and as amended by sec. 106 of Pub. L. 99-401, 100 Stat. 907 (42 U.S.C. 290dd-3), as amended by sec. 131 of Pub. L. 102-321, 106 Stat. 368, (42 U.S.C. 290dd-2).

SOURCE: 52 FR 21809, June 9, 1987, unless otherwise noted.

Subpart A—Introduction

§2.1 Statutory authority for confidentiality of drug abuse patient records.

The restrictions of these regulations upon the disclosure and use of drug abuse patient records were initially authorized by section 408 of the Drug Abuse Prevention, Treatment, and Rehabilitation Act (21 U.S.C. 1175). That section as amended was transferred by Pub. L. 98-24 to section 527 of the Public Health Service Act which is codified

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at 42 U.S.C. 290ee-3. The amended statutory authority is set forth below:

§ 290ee-3. CONFIDENTIALITY OF PATIENT RECORDS.

(a) *Disclosure authorization*

Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any drug abuse prevention function conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e) of this section, be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

(b) *Purposes and circumstances of disclosure affecting consenting patient and patient regardless of consent*

(1) The content of any record referred to in subsection (a) of this section may be disclosed in accordance with the prior written consent of the patient with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to subsection (g) of this section.

(2) Whether or not the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the content of such record may be disclosed as follows:

(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(c) *Prohibition against use of record in making criminal charges or investigation of patient*

Except as authorized by a court order granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) of this section may be used to initiate or substantiate any criminal charges against a

patient or to conduct any investigation of a patient.

(d) *Continuing prohibition against disclosure irrespective of status as patient*

The prohibitions of this section continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he ceases to be a patient.

(e) *Armed Forces and Veterans' Administration; interchange of records; report of suspected child abuse and neglect to State or local authorities*

The prohibitions of this section do not apply to any interchange of records—

(1) within the Armed Forces or within those components of the Veterans' Administration furnishing health care to veterans, or

(2) between such components and the Armed Forces.

The prohibitions of this section do not apply to the reporting under State law of incidents of suspected child abuse and neglect to the appropriate State or local authorities.

(f) *Penalty for first and subsequent offenses*

Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined not more than \$500 in the case of a first offense, and not more than \$5,000 in the case of each subsequent offense.

(g) *Regulations; interagency consultations; definitions, safeguards, and procedures, including procedures and criteria for issuance and scope of orders*

Except as provided in subsection (h) of this section, the Secretary, after consultation with the Administrator of Veterans' Affairs and the heads of other Federal departments and agencies substantially affected thereby, shall prescribe regulations to carry out the purposes of this section. These regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders under subsection (b)(2)(C) of this section, as in the judgment of the Secretary are necessary or proper to effectuate the purposes of this section, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.

(Subsection (h) was superseded by section 111(c)(3) of Pub. L. 94-581. The responsibility of the Administrator of Veterans' Affairs to write regulations to provide for confidentiality of drug abuse patient records under Title 38 was moved from 21 U.S.C. 1175 to 38 U.S.C. 4134.)

§ 2.2 Statutory authority for confidentiality of alcohol abuse patient records.

The restrictions of these regulations upon the disclosure and use of alcohol

abuse patient records were initially authorized by section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (42 U.S.C. 4582). The section as amended was transferred by Pub. L. 98-24 to section 523 of the Public Health Service Act which is codified at 42 U.S.C. 290dd-3. The amended statutory authority is set forth below:

§ 290dd-3. CONFIDENTIALITY OF PATIENT RECORDS

(a) Disclosure authorization

Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to alcoholism or alcohol abuse education, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e) of this section, be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

(b) Purposes and circumstances of disclosure affecting consenting patient and patient regardless of consent

(1) The content of any record referred to in subsection (a) of this section may be disclosed in accordance with the prior written consent of the patient with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to subsection (g) of this section.

(2) Whether or not the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the content of such record may be disclosed as follows:

(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to

the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(c) Prohibition against use of record in making criminal charges or investigation of patient

Except as authorized by a court order granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) of this section may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

(d) Continuing prohibition against disclosure irrespective of status as patient

The prohibitions of this section continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he ceases to be a patient.

(e) Armed Forces and Veterans' Administration; interchange of record of suspected child abuse and neglect to State or local authorities

The prohibitions of this section do not apply to any interchange of records—

(1) within the Armed Forces or within those components of the Veterans' Administration furnishing health care to veterans, or

(2) between such components and the Armed Forces.

The prohibitions of this section do not apply to the reporting under State law of incidents of suspected child abuse and neglect to the appropriate State or local authorities.

(f) Penalty for first and subsequent offenses

Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined not more than \$500 in the case of a first offense, and not more than \$5,000 in the case of each subsequent offense.

(g) Regulations of Secretary: definitions, safeguards, and procedures, including procedures and criteria for issuance and scope of orders

Except as provided in subsection (h) of this section, the Secretary shall prescribe regulations to carry out the purposes of this section. These regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders under subsection (b)(2)(C) of this section, as in the judgment of the Secretary are necessary or proper to effectuate the purposes of this section, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.

(Subsection (h) was superseded by section 111(c)(4) of Pub. L. 94-581. The responsibility of the Administrator of Veterans' Affairs to write regulations to provide for confidentiality of alcohol abuse patient records under Title 38 was moved from 42 U.S.C. 4582 to 38 U.S.C. 4134.)

§2.3

§2.3 Purpose and effect.

(a) *Purpose.* Under the statutory provisions quoted in §§2.1 and 2.2, these regulations impose restrictions upon the disclosure and use of alcohol and drug abuse patient records which are maintained in connection with the performance of any federally assisted alcohol and drug abuse program. The regulations specify:

(1) Definitions, applicability, and general restrictions in subpart B (definitions applicable to §2.34 only appear in that section);

(2) Disclosures which may be made with written patient consent and the form of the written consent in subpart C;

(3) Disclosures which may be made without written patient consent or an authorizing court order in subpart D; and

(4) Disclosures and uses of patient records which may be made with an authorizing court order and the procedures and criteria for the entry and scope of those orders in subpart E.

(b) *Effect.* (1) These regulations prohibit the disclosure and use of patient records unless certain circumstances exist. If any circumstance exists under which disclosure is permitted, that circumstance acts to remove the prohibition on disclosure but it does not compel disclosure. Thus, the regulations do not require disclosure under any circumstances.

(2) These regulations are not intended to direct the manner in which substantive functions such as research, treatment, and evaluation are carried out. They are intended to insure that an alcohol or drug abuse patient in a federally assisted alcohol or drug abuse program is not made more vulnerable by reason of the availability of his or her patient record than an individual who has an alcohol or drug problem and who does not seek treatment.

(3) Because there is a criminal penalty (a fine—see 42 U.S.C. 290ee-3(f), 42 U.S.C. 290dd-3(f) and 42 CFR 2.4) for violating the regulations, they are to be construed strictly in favor of the potential violator in the same manner as a criminal statute (see *M. Kraus & Brothers v. United States*, 327 U.S. 614, 621-22, 66 S. Ct. 705, 707-08 (1946)).

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§2.4 Criminal penalty for violation.

Under 42 U.S.C. 290ee-3(f) and 42 U.S.C. 290dd-3(f), any person who violates any provision of those statutes or these regulations shall be fined not more than \$500 in the case of a first offense, and not more than \$5,000 in the case of each subsequent offense.

§2.5 Reports of violations.

(a) The report of any violation of these regulations may be directed to the United States Attorney for the judicial district in which the violation occurs.

(b) The report of any violation of these regulations by a methadone program may be directed to the Regional Offices of the Food and Drug Administration.

Subpart B—General Provisions

§2.11 Definitions.

For purposes of these regulations:

Alcohol abuse means the use of an alcoholic beverage which impairs the physical, mental, emotional, or social well-being of the user.

Drug abuse means the use of a psychoactive substance for other than medicinal purposes which impairs the physical, mental, emotional, or social well-being of the user.

Diagnosis means any reference to an individual's alcohol or drug abuse or to a condition which is identified as having been caused by that abuse which is made for the purpose of treatment or referral for treatment.

Disclose or disclosure means a communication of patient identifying information, the affirmative verification of another person's communication of patient identifying information, or the communication of any information from the record of a patient who has been identified.

Informant means an individual:

(a) Who is a patient or employee of a program or who becomes a patient or employee of a program at the request of a law enforcement agency or official; and

(b) Who at the request of a law enforcement agency or official observes one or more patients or employees of

the program for the purpose of reporting the information obtained to the law enforcement agency or official.

Patient means any individual who has applied for or been given diagnosis or treatment for alcohol or drug abuse at a federally assisted program and includes any individual who, after arrest on a criminal charge, is identified as an alcohol or drug abuser in order to determine that individual's eligibility to participate in a program.

Patient identifying information means the name, address, social security number, fingerprints, photograph, or similar information by which the identity of a patient can be determined with reasonable accuracy and speed either directly or by reference to other publicly available information. The term does not include a number assigned to a patient by a program, if that number does not consist of, or contain numbers (such as a social security, or driver's license number) which could be used to identify a patient with reasonable accuracy and speed from sources external to the program.

Person means an individual, partnership, corporation, Federal, State or local government agency, or any other legal entity.

Program means:

(a) An individual or entity (other than a general medical care facility) who holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment; or

(b) An identified unit within a general medical facility which holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment; or

(c) Medical personnel or other staff in a general medical care facility whose primary function is the provision of alcohol or drug abuse diagnosis, treatment or referral for treatment and who are identified as such providers. (See § 2.12(e)(1) for examples.)

Program director means:

(a) In the case of a program which is an individual, that individual;

(b) In the case of a program which is an organization, the individual designated as director, managing director, or otherwise vested with authority to

act as chief executive of the organization.

Qualified service organization means a person which:

(a) Provides services to a program, such as data processing, bill collecting, dosage preparation, laboratory analyses, or legal, medical, accounting, or other professional services, or services to prevent or treat child abuse or neglect, including training on nutrition and child care and individual and group therapy, and

(b) Has entered into a written agreement with a program under which that person:

(1) Acknowledges that in receiving, storing, processing or otherwise dealing with any patient records from the programs, it is fully bound by these regulations; and

(2) If necessary, will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by these regulations.

Records means any information, whether recorded or not, relating to a patient received or acquired by a federally assisted alcohol or drug program.

Third party payer means a person who pays, or agrees to pay, for diagnosis or treatment furnished to a patient on the basis of a contractual relationship with the patient or a member of his family or on the basis of the patient's eligibility for Federal, State, or local governmental benefits.

Treatment means the management and care of a patient suffering from alcohol or drug abuse, a condition which is identified as having been caused by that abuse, or both, in order to reduce or eliminate the adverse effects upon the patient.

Undercover agent means an officer of any Federal, State, or local law enforcement agency who enrolls in or becomes an employee of a program for the purpose of investigating a suspected violation of law or who pursues that purpose after enrolling or becoming employed for other purposes.

[52 FR 21809, June 9, 1987, as amended by 60 FR 22297, May 5, 1995]

§ 2.12 Applicability.

(a) **General**—(1) **Restrictions on disclosure.** The restrictions on disclosure in

these regulations apply to any information, whether or not recorded, which:

(i) Would identify a patient as an alcohol or drug abuser either directly, by reference to other publicly available information, or through verification of such an identification by another person; and

(ii) Is drug abuse information obtained by a federally assisted drug abuse program after March 20, 1972, or is alcohol abuse information obtained by a federally assisted alcohol abuse program after May 13, 1974 (or if obtained before the pertinent date, is maintained by a federally assisted alcohol or drug abuse program after that date as part of an ongoing treatment episode which extends past that date) for the purpose of treating alcohol or drug abuse, making a diagnosis for that treatment, or making a referral for that treatment.

(2) *Restriction on use.* The restriction on use of information to initiate or substantiate any criminal charges against a patient or to conduct any criminal investigation of a patient (42 U.S.C. 290ee-3(c), 42 U.S.C. 290dd-3(c)) applies to any information, whether or not recorded which is drug abuse information obtained by a federally assisted drug abuse program after March 20, 1972, or is alcohol abuse information obtained by a federally assisted alcohol abuse program after May 13, 1974 (or if obtained before the pertinent date, is maintained by a federally assisted alcohol or drug abuse program after that date as part of an ongoing treatment episode which extends past that date), for the purpose of treating alcohol or drug abuse, making a diagnosis for the treatment, or making a referral for the treatment.

(b) *Federal assistance.* An alcohol abuse or drug abuse program is considered to be federally assisted if:

(1) It is conducted in whole or in part, whether directly or by contract or otherwise by any department or agency of the United States (but see paragraphs (c)(1) and (c)(2) of this section relating to the Veterans' Administration and the Armed Forces);

(2) It is being carried out under a license, certification, registration, or other authorization granted by any de-

partment or agency of the United States including but not limited to:

(i) Certification of provider status under the Medicare program;

(ii) Authorization to conduct methadone maintenance treatment (see 21 CFR 291.505); or

(iii) Registration to dispense a substance under the Controlled Substances Act to the extent the controlled substance is used in the treatment of alcohol or drug abuse;

(3) It is supported by funds provided by any department or agency of the United States by being:

(i) A recipient of Federal financial assistance in any form, including financial assistance which does not directly pay for the alcohol or drug abuse diagnosis, treatment, or referral activities; or

(ii) Conducted by a State or local government unit which, through general or special revenue sharing or other forms of assistance, receives Federal funds which could be (but are not necessarily) spent for the alcohol or drug abuse program; or

(4) It is assisted by the Internal Revenue Service of the Department of the Treasury through the allowance of income tax deductions for contributions to the program or through the granting of tax exempt status to the program.

(c) *Exceptions—(1) Veterans' Administration.* These regulations do not apply to information on alcohol and drug abuse patients maintained in connection with the Veterans' Administration provisions of hospital care, nursing home care, domiciliary care, and medical services under title 38, United States Code. Those records are governed by 38 U.S.C. 4132 and regulations issued under that authority by the Administrator of Veterans' Affairs.

(2) *Armed Forces.* These regulations apply to any information described in paragraph (a) of this section which was obtained by any component of the Armed Forces during a period when the patient was subject to the Uniform Code of Military Justice except:

(i) Any interchange of that information within the Armed Forces; and

(ii) Any interchange of that information between the Armed Forces and

those components of the Veterans Administration furnishing health care to veterans.

(3) *Communication within a program or between a program and an entity having direct administrative control over that program.* The restrictions on disclosure in these regulations do not apply to communications of information between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of alcohol or drug abuse if the communications are

(i) Within a program or

(ii) Between a program and an entity that has direct administrative control over the program.

(4) *Qualified Service Organizations.* The restrictions on disclosure in these regulations do not apply to communications between a program and a qualified service organization of information needed by the organization to provide services to the program.

(5) *Crimes on program premises or against program personnel.* The restrictions on disclosure and use in these regulations do not apply to communications from program personnel to law enforcement officers which—

(i) Are directly related to a patient's commission of a crime on the premises of the program or against program personnel or to a threat to commit such a crime; and

(ii) Are limited to the circumstances of the incident, including the patient status of the individual committing or threatening to commit the crime, that individual's name and address, and that individual's last known whereabouts.

(6) *Reports of suspected child abuse and neglect.* The restrictions on disclosure and use in these regulations do not apply to the reporting under State law of incidents of suspected child abuse and neglect to the appropriate State or local authorities. However, the restrictions continue to apply to the original alcohol or drug abuse patient records maintained by the program including their disclosure and use for civil or criminal proceedings which may arise out of the report of suspected child abuse and neglect.

(d) *Applicability to recipients of information—(1) Restriction on use of information.* The restriction on the use of any information subject to these regulations to initiate or substantiate any criminal charges against a patient or to conduct any criminal investigation of a patient applies to any person who obtains that information from a federally assisted alcohol or drug abuse program, regardless of the status of the person obtaining the information or of whether the information was obtained in accordance with these regulations. This restriction on use bars, among other things, the introduction of that information as evidence in a criminal proceeding and any other use of the information to investigate or prosecute a patient with respect to a suspected crime. Information obtained by undercover agents or informants (see § 2.17) or through patient access (see § 2.23) is subject to the restriction on use.

(2) *Restrictions on disclosures—Third party payers, administrative entities, and others.* The restrictions on disclosure in these regulations apply to:

(i) Third party payers with regard to records disclosed to them by federally assisted alcohol or drug abuse programs;

(ii) Entities having direct administrative control over programs with regard to information communicated to them by the program under § 2.12(c)(3); and

(iii) Persons who receive patient records directly from a federally assisted alcohol or drug abuse program and who are notified of the restrictions on redisclosure of the records in accordance with § 2.32 of these regulations.

(e) *Explanation of applicability—(1) Coverage.* These regulations cover any information (including information on referral and intake) about alcohol and drug abuse patients obtained by a program (as the terms "patient" and "program" are defined in § 2.11) if the program is federally assisted in any manner described in § 2.12(b). Coverage includes, but is not limited to, those treatment or rehabilitation programs, employee assistance programs, programs within general hospitals, school-

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based programs, and private practitioners who hold themselves out as providing, and provide alcohol or drug abuse diagnosis, treatment, or referral for treatment. However, these regulations would not apply, for example, to emergency room personnel who refer a patient to the intensive care unit for an apparent overdose, unless the primary function of such personnel is the provision of alcohol or drug abuse diagnosis, treatment or referral and they are identified as providing such services or the emergency room has promoted itself to the community as a provider of such services.

(2) *Federal assistance to program required.* If a patient's alcohol or drug abuse diagnosis, treatment, or referral for treatment is not provided by a program which is federally conducted, regulated or supported in a manner which constitutes Federal assistance under §2.12(b), that patient's record is not covered by these regulations. Thus, it is possible for an individual patient to benefit from Federal support and not be covered by the confidentiality regulations because the program in which the patient is enrolled is not federally assisted as defined in §2.12(b). For example, if a Federal court placed an individual in a private for-profit program and made a payment to the program on behalf of that individual, that patient's record would not be covered by these regulations unless the program itself received Federal assistance as defined by §2.12(b).

(3) *Information to which restrictions are applicable.* Whether a restriction is on use or disclosure affects the type of information which may be available. The restrictions on disclosure apply to any information which would identify a patient as an alcohol or drug abuser. The restriction on use of information to bring criminal charges against a patient for a crime applies to any information obtained by the program for the purpose of diagnosis, treatment, or referral for treatment of alcohol or drug abuse. (Note that restrictions on use and disclosure apply to recipients of information under §2.12(d).)

(4) *How type of diagnosis affects coverage.* These regulations cover any record of a diagnosis identifying a patient as an alcohol or drug abuser

which is prepared in connection with the treatment or referral for treatment of alcohol or drug abuse. A diagnosis prepared for the purpose of treatment or referral for treatment but which is not so used is covered by these regulations. The following are not covered by these regulations:

(i) Diagnosis which is made solely for the purpose of providing evidence for use by law enforcement authorities; or

(ii) A diagnosis of drug overdose or alcohol intoxication which clearly shows that the individual involved is not an alcohol or drug abuser (e.g., involuntary ingestion of alcohol or drugs or reaction to a prescribed dosage of one or more drugs).

[52 FR 21809, June 9, 1987; 52 FR 42061, Nov. 2, 1987, as amended at 60 FR 22297, May 5, 1995]

§2.13 Confidentiality restrictions.

(a) *General.* The patient records to which these regulations apply may be disclosed or used only as permitted by these regulations and may not otherwise be disclosed or used in any civil, criminal, administrative, or legislative proceedings conducted by any Federal, State, or local authority. Any disclosure made under these regulations must be limited to that information which is necessary to carry out the purpose of the disclosure.

(b) *Unconditional compliance required.* The restrictions on disclosure and use in these regulations apply whether the holder of the information believes that the person seeking the information already has it, has other means of obtaining it, is a law enforcement or other official, has obtained a subpoena, or asserts any other justification for a disclosure or use which is not permitted by these regulations.

(c) *Acknowledging the presence of patients: Responding to requests.* (1) The presence of an identified patient in a facility or component of a facility which is publicly identified as a place where only alcohol or drug abuse diagnosis, treatment, or referral is provided may be acknowledged only if the patient's written consent is obtained in accordance with subpart C of these regulations or if an authorizing court order is entered in accordance with subpart E of these regulations. The regulations permit acknowledgement

of the presence of an identified patient in a facility or part of a facility if the facility is not publicly identified as only an alcohol or drug abuse diagnosis, treatment or referral facility, and if the acknowledgement does not reveal that the patient is an alcohol or drug abuser.

(2) Any answer to a request for a disclosure of patient records which is not permissible under these regulations must be made in a way that will not affirmatively reveal that an identified individual has been, or is being diagnosed or treated for alcohol or drug abuse. An inquiring party may be given a copy of these regulations and advised that they restrict the disclosure of alcohol or drug abuse patient records, but may not be told affirmatively that the regulations restrict the disclosure of the records of an identified patient. The regulations do not restrict a disclosure that an identified individual is not and never has been a patient.

§2.14 Minor patients.

(a) *Definition of minor.* As used in these regulations the term "minor" means a person who has not attained the age of majority specified in the applicable State law, or if no age of majority is specified in the applicable State law, the age of eighteen years.

(b) *State law not requiring parental consent to treatment.* If a minor patient acting alone has the legal capacity under the applicable State law to apply for and obtain alcohol or drug abuse treatment, any written consent for disclosure authorized under subpart C of these regulations may be given only by the minor patient. This restriction includes, but is not limited to, any disclosure of patient identifying information to the parent or guardian of a minor patient for the purpose of obtaining financial reimbursement. These regulations do not prohibit a program from refusing to provide treatment until the minor patient consents to the disclosure necessary to obtain reimbursement, but refusal to provide treatment may be prohibited under a State or local law requiring the program to furnish the service irrespective of ability to pay.

(c) *State law requiring parental consent to treatment.* (1) Where State law re-

quires consent of a parent, guardian, or other person for a minor to obtain alcohol or drug abuse treatment, any written consent for disclosure authorized under subpart C of these regulations must be given by both the minor and his or her parent, guardian, or other person authorized under State law to act in the minor's behalf.

(2) Where State law requires parental consent to treatment the fact of a minor's application for treatment may be communicated to the minor's parent, guardian, or other person authorized under State law to act in the minor's behalf only if:

(i) The minor has given written consent to the disclosure in accordance with subpart C of these regulations or

(ii) The minor lacks the capacity to make a rational choice regarding such consent as judged by the program director under paragraph (d) of this section.

(d) *Minor applicant for services lacks capacity for rational choice.* Facts relevant to reducing a threat to the life or physical well being of the applicant or any other individual may be disclosed to the parent, guardian, or other person authorized under State law to act in the minor's behalf if the program director judges that:

(1) A minor applicant for services lacks capacity because of extreme youth or mental or physical condition to make a rational decision on whether to consent to a disclosure under subpart C of these regulations to his or her parent, guardian, or other person authorized under State law to act in the minor's behalf, and

(2) The applicant's situation poses a substantial threat to the life or physical well being of the applicant or any other individual which may be reduced by communicating relevant facts to the minor's parent, guardian, or other person authorized under State law to act in the minor's behalf.

§2.15 Incompetent and deceased patients.

(a) *Incompetent patients other than minors—*(1) *Adjudication of incompetence.* In the case of a patient who has been adjudicated as lacking the capacity, for any reason other than insufficient age, to manage his or her own affairs,

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any consent which is required under these regulations may be given by the guardian or other person authorized under State law to act in the patient's behalf.

(2) *No adjudication of incompetency.* For any period for which the program director determines that a patient, other than a minor or one who has been adjudicated incompetent, suffers from a medical condition that prevents knowing or effective action on his or her own behalf, the program director may exercise the right of the patient to consent to a disclosure under subpart C of these regulations for the sole purpose of obtaining payment for services from a third party payer.

(b) *Deceased patients—(1) Vital statistics.* These regulations do not restrict the disclosure of patient identifying information relating to the cause of death of a patient under laws requiring the collection of death or other vital statistics or permitting inquiry into the cause of death.

(2) *Consent by personal representative.* Any other disclosure of information identifying a deceased patient as an alcohol or drug abuser is subject to these regulations. If a written consent to the disclosure is required, that consent may be given by an executor, administrator, or other personal representative appointed under applicable State law. If there is no such appointment the consent may be given by the patient's spouse or, if none, by any responsible member of the patient's family.

§ 2.16 Security for written records.

(a) Written records which are subject to these regulations must be maintained in a secure room, locked file cabinet, safe or other similar container when not in use; and

(b) Each program shall adopt in writing procedures which regulate and control access to and use of written records which are subject to these regulations.

§ 2.17 Undercover agents and informants.

(a) *Restrictions on placement.* Except as specifically authorized by a court order granted under § 2.67 of these regulations, no program may knowingly

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employ, or enroll as a patient, any undercover agent or informant.

(b) *Restriction on use of information.* No information obtained by an undercover agent or informant, whether or not that undercover agent or informant is placed in a program pursuant to an authorizing court order, may be used to criminally investigate or prosecute any patient.

[52 FR 21809, June 9, 1987; 52 FR 42061, Nov. 2, 1987]

§ 2.18 Restrictions on the use of identification cards.

No person may require any patient to carry on his or her person while away from the program premises any card or other object which would identify the patient as an alcohol or drug abuser. This section does not prohibit a person from requiring patients to use or carry cards or other identification objects on the premises of a program.

§ 2.19 Disposition of records by discontinued programs.

(a) *General.* If a program discontinues operations or is taken over or acquired by another program, it must purge patient identifying information from its records or destroy the records unless—

(1) The patient who is the subject of the records gives written consent (meeting the requirements of § 2.31) to a transfer of the records to the acquiring program or to any other program designated in the consent (the manner of obtaining this consent must minimize the likelihood of a disclosure of patient identifying information to a third party); or

(2) There is a legal requirement that the records be kept for a period specified by law which does not expire until after the discontinuation or acquisition of the program.

(b) *Procedure where retention period required by law.* If paragraph (a)(2) of this section applies, the records must be:

(1) Sealed in envelopes or other containers labeled as follows: "Records of [insert name of program] required to be maintained under [insert citation to statute, regulation, court order or other legal authority requiring that records be kept] until a date not later than [insert appropriate date]"; and

(2) Held under the restrictions of these regulations by a responsible person who must, as soon as practicable after the end of the retention period specified on the label, destroy the records.

§2.20 Relationship to State laws.

The statutes authorizing these regulations (42 U.S.C. 290ee-3 and 42 U.S.C. 290dd-3) do not preempt the field of law which they cover to the exclusion of all State laws in that field. If a disclosure permitted under these regulations is prohibited under State law, neither these regulations nor the authorizing statutes may be construed to authorize any violation of that State law. However, no State law may either authorize or compel any disclosure prohibited by these regulations.

§2.21 Relationship to Federal statutes protecting research subjects against compulsory disclosure of their identity.

(a) *Research privilege description.* There may be concurrent coverage of patient identifying information by these regulations and by administrative action taken under: Section 303(a) of the Public Health Service Act (42 U.S.C. 242a(a) and the implementing regulations at 42 CFR part 2a); or section 502(c) of the Controlled Substances Act (21 U.S.C. 872(c) and the implementing regulations at 21 CFR 1316.21). These "research privilege" statutes confer on the Secretary of Health and Human Services and on the Attorney General, respectively, the power to authorize researchers conducting certain types of research to withhold from all persons not connected with the research the names and other identifying information concerning individuals who are the subjects of the research.

(b) *Effect of concurrent coverage.* These regulations restrict the disclosure and use of information about patients, while administrative action taken under the research privilege statutes and implementing regulations protects a person engaged in applicable research from being compelled to disclose any identifying characteristics of the individuals who are the subjects of that research. The issuance under subpart E of these regulations of a court order

authorizing a disclosure of information about a patient does not affect an exercise of authority under these research privilege statutes. However, the research privilege granted under 21 CFR 291.505(g) to treatment programs using methadone for maintenance treatment does not protect from compulsory disclosure any information which is permitted to be disclosed under those regulations. Thus, if a court order entered in accordance with subpart E of these regulations authorizes a methadone maintenance treatment program to disclose certain information about its patients, that program may not invoke the research privilege under 21 CFR 291.505(g) as a defense to a subpoena for that information.

§2.22 Notice to patients of Federal confidentiality requirements.

(a) *Notice required.* At the time of admission or as soon thereafter as the patient is capable of rational communication, each program shall:

(1) Communicate to the patient that Federal law and regulations protect the confidentiality of alcohol and drug abuse patient records; and

(2) Give to the patient a summary in writing of the Federal law and regulations.

(b) *Required elements of written summary.* The written summary of the Federal law and regulations must include:

(1) A general description of the limited circumstances under which a program may acknowledge that an individual is present at a facility or disclose outside the program information identifying a patient as an alcohol or drug abuser.

(2) A statement that violation of the Federal law and regulations by a program is a crime and that suspected violations may be reported to appropriate authorities in accordance with these regulations.

(3) A statement that information related to a patient's commission of a crime on the premises of the program or against personnel of the program is not protected.

(4) A statement that reports of suspected child abuse and neglect made under State law to appropriate State or local authorities are not protected.

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(5) A citation to the Federal law and regulations.

(c) *Program options.* The program may devise its own notice or may use the sample notice in paragraph (d) to comply with the requirement to provide the patient with a summary in writing of the Federal law and regulations. In addition, the program may include in the written summary information concerning State law and any program policy not inconsistent with State and Federal law on the subject of confidentiality of alcohol and drug abuse patient records.

(d) *Sample notice.*

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser *Unless:*

- (1) The patient consents in writing;
- (2) The disclosure is allowed by a court order; or
- (3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

(See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR part 2 for Federal regulations.)

(Approved by the Office of Management and Budget under control number 0930-0099)

§ 2.23 Patient access and restrictions on use.

(a) *Patient access not prohibited.* These regulations do not prohibit a program from giving a patient access to his or her own records, including the opportunity to inspect and copy any records that the program maintains about the

patient. The program is not required to obtain a patient's written consent or other authorization under these regulations in order to provide such access to the patient.

(b) *Restriction on use of information.* Information obtained by patient access to his or her patient record is subject to the restriction on use of his information to initiate or substantiate any criminal charges against the patient or to conduct any criminal investigation of the patient as provided for under § 2.12(d)(1).

Subpart C—Disclosures With Patient's Consent

§ 2.31 Form of written consent.

(a) *Required elements.* A written consent to a disclosure under these regulations must include:

- (1) The specific name or general designation of the program or person permitted to make the disclosure.
- (2) The name or title of the individual or the name of the organization to which disclosure is to be made.
- (3) The name of the patient.
- (4) The purpose of the disclosure.
- (5) How much and what kind of information is to be disclosed.
- (6) The signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent under § 2.14; or, when required for a patient who is incompetent or deceased, the signature of a person authorized to sign under § 2.15 in lieu of the patient.
- (7) The date on which the consent is signed.

(8) A statement that the consent is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer.

(9) The date, event, or condition upon which the consent will expire if not revoked before. This date, event, or condition must insure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.

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(b) *Sample consent form.* The following form complies with paragraph (a) of this section, but other elements may be added.

1. I (name of patient) ☐ Request ☐ Authorize;
2. (name or general designation of program which is to make the disclosure)
3. To disclose: (kind and amount of information to be disclosed)
4. To: (name or title of the person or organization to which disclosure is to be made)
5. For (purpose of the disclosure)
6. Date (on which this consent is signed)
7. Signature of patient
8. Signature of parent or guardian (where required)
9. Signature of person authorized to sign in lieu of the patient (where required)
10. This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon: (specific date, event, or condition)

(c) *Expired, deficient, or false consent.* A disclosure may not be made on the basis of a consent which:

- (1) Has expired;
- (2) On its face substantially fails to conform to any of the requirements set forth in paragraph (a) of this section;
- (3) Is known to have been revoked; or
- (4) Is known, or through a reasonable effort could be known, by the person holding the records to be materially false.

(Approved by the Office of Management and Budget under control number 0930-0099)

§ 2.32 Prohibition on redisclosure.

Notice to accompany disclosure. Each disclosure made with the patient's written consent must be accompanied by the following written statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR

part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

[52 FR 21809, June 9, 1987; 52 FR 41997, Nov. 2, 1987]

§ 2.33 Disclosures permitted with written consent.

If a patient consents to a disclosure of his or her records under § 2.31, a program may disclose those records in accordance with that consent to any individual or organization named in the consent, except that disclosures to central registries and in connection with criminal justice referrals must meet the requirements of §§ 2.34 and 2.35, respectively.

§ 2.34 Disclosures to prevent multiple enrollments in detoxification and maintenance treatment programs.

(a) *Definitions.* For purposes of this section:

Central registry means an organization which obtains from two or more member programs patient identifying information about individuals applying for maintenance treatment or detoxification treatment for the purpose of avoiding an individual's concurrent enrollment in more than one program.

Detoxification treatment means the dispensing of a narcotic drug in decreasing doses to an individual in order to reduce or eliminate adverse physiological or psychological effects incident to withdrawal from the sustained use of a narcotic drug.

Maintenance treatment means the dispensing of a narcotic drug in the treatment of an individual for dependence upon heroin or other morphine-like drugs.

Member program means a detoxification treatment or maintenance treatment program which reports patient identifying information to a central registry and which is in the same State as that central registry or is not more than 125 miles from any border of the State in which the central registry is located.

(b) *Restrictions on disclosure.* A program may disclose patient records to a

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central registry or to any detoxification or maintenance treatment program not more than 200 miles away for the purpose of preventing the multiple enrollment of a patient only if:

(1) The disclosure is made when:

(i) The patient is accepted for treatment;

(ii) The type or dosage of the drug is changed; or

(iii) The treatment is interrupted, resumed or terminated.

(2) The disclosure is limited to:

(i) Patient identifying information;

(ii) Type and dosage of the drug; and

(iii) Relevant dates.

(3) The disclosure is made with the patient's written consent meeting the requirements of §2.31, except that:

(i) The consent must list the name and address of each central registry and each known detoxification or maintenance treatment program to which a disclosure will be made; and

(ii) The consent may authorize a disclosure to any detoxification or maintenance treatment program established within 200 miles of the program after the consent is given without naming any such program.

(c) *Use of information limited to prevention of multiple enrollments.* A central registry and any detoxification or maintenance treatment program to which information is disclosed to prevent multiple enrollments may not re-disclose or use patient identifying information for any purpose other than the prevention of multiple enrollments unless authorized by a court order under subpart E of these regulations.

(d) *Permitted disclosure by a central registry to prevent a multiple enrollment.* When a member program asks a central registry if an identified patient is enrolled in another member program and the registry determines that the patient is so enrolled, the registry may disclose—

(1) The name, address, and telephone number of the member program(s) in which the patient is already enrolled to the inquiring member program; and

(2) The name, address, and telephone number of the inquiring member program to the member program(s) in which the patient is already enrolled. The member programs may communicate as necessary to verify that no

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error has been made and to prevent or eliminate any multiple enrollment.

(e) *Permitted disclosure by a detoxification or maintenance treatment program to prevent a multiple enrollment.* A detoxification or maintenance treatment program which has received a disclosure under this section and has determined that the patient is already enrolled may communicate as necessary with the program making the disclosure to verify that no error has been made and to prevent or eliminate any multiple enrollment.

§2.35 Disclosures to elements of the criminal justice system which have referred patients.

(a) A program may disclose information about a patient to those persons within the criminal justice system which have made participation in the program a condition of the disposition of any criminal proceedings against the patient or of the patient's parole or other release from custody if:

(1) The disclosure is made only to those individuals within the criminal justice system who have a need for the information in connection with their duty to monitor the patient's progress (e.g., a prosecuting attorney who is withholding charges against the patient, a court granting pretrial or posttrial release, probation or parole officers responsible for supervision of the patient); and

(2) The patient has signed a written consent meeting the requirements of §2.31 (except paragraph (a)(8) which is inconsistent with the revocation provisions of paragraph (c) of this section) and the requirements of paragraphs (b) and (c) of this section.

(b) *Duration of consent.* The written consent must state the period during which it remains in effect. This period must be reasonable, taking into account:

(1) The anticipated length of the treatment;

(2) The type of criminal proceeding involved, the need for the information in connection with the final disposition of that proceeding, and when the final disposition will occur; and

(3) Such other factors as the program, the patient, and the person(s)

who will receive the disclosure consider pertinent.

(c) *Revocation of consent.* The written consent must state that it is revocable upon the passage of a specified amount of time or the occurrence of a specified, ascertainable event. The time or occurrence upon which consent becomes revocable may be no later than the final disposition of the conditional release or other action in connection with which consent was given.

(d) *Restrictions on redisclosure and use.* A person who receives patient information under this section may redisclose and use it only to carry out that person's official duties with regard to the patient's conditional release or other action in connection with which the consent was given.

Subpart D—Disclosures Without Patient Consent

§ 2.51 Medical emergencies.

(a) *General Rule.* Under the procedures required by paragraph (c) of this section, patient identifying information may be disclosed to medical personnel who have a need for information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention.

(b) *Special Rule.* Patient identifying information may be disclosed to medical personnel of the Food and Drug Administration (FDA) who assert a reason to believe that the health of any individual may be threatened by an error in the manufacture, labeling, or sale of a product under FDA jurisdiction, and that the information will be used for the exclusive purpose of notifying patients or their physicians of potential dangers.

(c) *Procedures.* Immediately following disclosure, the program shall document the disclosure in the patient's records, setting forth in writing:

- (1) The name of the medical personnel to whom disclosure was made and their affiliation with any health care facility;
- (2) The name of the individual making the disclosure;
- (3) The date and time of the disclosure; and

- (4) The nature of the emergency (or error, if the report was to FDA).

(Approved by the Office of Management and Budget under control number 0930-0099)

§ 2.52 Research activities.

(a) Patient identifying information may be disclosed for the purpose of conducting scientific research if the program director makes a determination that the recipient of the patient identifying information:

- (1) Is qualified to conduct the research;
- (2) Has a research protocol under which the patient identifying information:

(i) Will be maintained in accordance with the security requirements of § 2.16 of these regulations (or more stringent requirements); and

(ii) Will not be redisclosed except as permitted under paragraph (b) of this section; and

(3) Has provided a satisfactory written statement that a group of three or more individuals who are independent of the research project has reviewed the protocol and determined that:

(i) The rights and welfare of patients will be adequately protected; and

(ii) The risks in disclosing patient identifying information are outweighed by the potential benefits of the research.

(b) A person conducting research may disclose patient identifying information obtained under paragraph (a) of this section only back to the program from which that information was obtained and may not identify any individual patient in any report of that research or otherwise disclose patient identities.

[52 FR 21809, June 9, 1987, as amended at 52 FR 41997, Nov. 2, 1987]

§ 2.53 Audit and evaluation activities.

(a) *Records not copied or removed.* If patient records are not copied or removed, patient identifying information may be disclosed in the course of a review of records on program premises to any person who agrees in writing to comply with the limitations on redisclosure and use in paragraph (d) of this section and who:

(1) Performs the audit or evaluation activity on behalf of:

(i) Any Federal, State, or local governmental agency which provides financial assistance to the program or is authorized by law to regulate its activities; or

(ii) Any private person which provides financial assistance to the program, which is a third party payer covering patients in the program, or which is a peer review organization performing a utilization or quality control review; or

(2) Is determined by the program director to be qualified to conduct the audit or evaluation activities.

(b) *Copying or removal of records.* Records containing patient identifying information may be copied or removed from program premises by any person who:

(1) Agrees in writing to:

(i) Maintain the patient identifying information in accordance with the security requirements provided in § 2.16 of these regulations (or more stringent requirements);

(ii) Destroy all the patient identifying information upon completion of the audit or evaluation; and

(iii) Comply with the limitations on disclosure and use in paragraph (d) of this section; and

(2) Performs the audit or evaluation activity on behalf of:

(i) Any Federal, State, or local governmental agency which provides financial assistance to the program or is authorized by law to regulate its activities; or

(ii) Any private person which provides financial assistance to the program, which is a third party payer covering patients in the program, or which is a peer review organization performing a utilization or quality control review.

(c) *Medicare or Medicaid audit or evaluation.* (1) For purposes of Medicare or Medicaid audit or evaluation under this section, audit or evaluation includes a civil or administrative investigation of the program by any Federal, State, or local agency responsible for oversight of the Medicare or Medicaid program and includes administrative enforcement, against the program by the agency, of any remedy author-

ized by law to be imposed as a result of the findings of the investigation.

(2) Consistent with the definition of program in § 2.11, program includes an employee of, or provider of medical services under, the program when the employee or provider is the subject of a civil investigation or administrative remedy, as those terms are used in paragraph (c)(1) of this section.

(3) If a disclosure to a person is authorized under this section for a Medicare or Medicaid audit or evaluation, including a civil investigation or administrative remedy, as those terms are used in paragraph (c)(1) of this section, then a peer review organization which obtains the information under paragraph (a) or (b) may disclose the information to that person but only for purposes of Medicare or Medicaid audit or evaluation.

(4) The provisions of this paragraph do not authorize the agency, the program, or any other person to disclose or use patient identifying information obtained during the audit or evaluation for any purposes other than those necessary to complete the Medicare or Medicaid audit or evaluation activity as specified in this paragraph.

(d) *Limitations on disclosure and use.* Except as provided in paragraph (c) of this section, patient identifying information disclosed under this section may be disclosed only back to the program from which it was obtained and used only to carry out an audit or evaluation purpose or to investigate or prosecute criminal or other activities, as authorized by a court order entered under § 2.66 of these regulations.

Subpart E—Court Orders Authorizing Disclosure and Use

§ 2.61 Legal effect of order.

(a) *Effect.* An order of a court of competent jurisdiction entered under this subpart is a unique kind of court order. Its only purpose is to authorize a disclosure or use of patient information which would otherwise be prohibited by 42 U.S.C. 290ee-3, 42 U.S.C. 290dd-3 and these regulations. Such an order does not compel disclosure. A subpoena or a similar legal mandate must be issued in order to compel disclosure. This mandate may be entered at the same

time as and accompany an authorizing court order entered under these regulations.

(b) *Examples.* (1) A person holding records subject to these regulations receives a subpoena for those records; a response to the subpoena is not permitted under the regulations unless an authorizing court order is entered. The person may not disclose the records in response to the subpoena unless a court of competent jurisdiction enters an authorizing order under these regulations.

(2) An authorizing court order is entered under these regulations, but the person authorized does not want to make the disclosure. If there is no subpoena or other compulsory process or a subpoena for the records has expired or been quashed, that person may refuse to make the disclosure. Upon the entry of a valid subpoena or other compulsory process the person authorized to disclose must disclose, unless there is a valid legal defense to the process other than the confidentiality restrictions of these regulations.

[52 FR 21809, June 9, 1987; 52 FR 42061, Nov. 2, 1987]

§ 2.62 Order not applicable to records disclosed without consent to researchers, auditors and evaluators.

A court order under these regulations may not authorize qualified personnel, who have received patient identifying information without consent for the purpose of conducting research, audit or evaluation, to disclose that information or use it to conduct any criminal investigation or prosecution of a patient. However, a court order under § 2.66 may authorize disclosure and use of records to investigate or prosecute qualified personnel holding the records.

§ 2.63 Confidential communications.

(a) A court order under these regulations may authorize disclosure of confidential communications made by a patient to a program in the course of diagnosis, treatment, or referral for treatment only if:

(1) The disclosure is necessary to protect against an existing threat to life or of serious bodily injury, including circumstances which constitute sus-

pected child abuse and neglect and verbal threats against third parties;

(2) The disclosure is necessary in connection with investigation or prosecution of an extremely serious crime, such as one which directly threatens loss of life or serious bodily injury, including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, or child abuse and neglect; or

(3) The disclosure is in connection with litigation or an administrative proceeding in which the patient offers testimony or other evidence pertaining to the content of the confidential communications.

(b) [Reserved]

§ 2.64 Procedures and criteria for orders authorizing disclosures for noncriminal purposes.

(a) *Application.* An order authorizing the disclosure of patient records for purposes other than criminal investigation or prosecution may be applied for by any person having a legally recognized interest in the disclosure which is sought. The application may be filed separately or as part of a pending civil action in which it appears that the patient records are needed to provide evidence. An application must use a fictitious name, such as John Doe, to refer to any patient and may not contain or otherwise disclose any patient identifying information unless the patient is the applicant or has given a written consent (meeting the requirements of these regulations) to disclosure or the court has ordered the record of the proceeding sealed from public scrutiny.

(b) *Notice.* The patient and the person holding the records from whom disclosure is sought must be given:

(1) Adequate notice in a manner which will not disclose patient identifying information to other persons; and

(2) An opportunity to file a written response to the application, or to appear in person, for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order.

(c) *Review of evidence: Conduct of hearing.* Any oral argument, review of evidence, or hearing on the application must be held in the judge's chambers or in some manner which ensures that patient identifying information is not

disclosed to anyone other than a party to the proceeding, the patient, or the person holding the record, unless the patient requests an open hearing in a manner which meets the written consent requirements of these regulations. The proceeding may include an examination by the judge of the patient records referred to in the application.

(d) *Criteria for entry of order.* An order under this section may be entered only if the court determines that good cause exists. To make this determination the court must find that:

(1) Other ways of obtaining the information are not available or would not be effective; and

(2) The public interest and need for the disclosure outweigh the potential injury to the patient, the physician-patient relationship and the treatment services.

(e) *Content of order.* An order authorizing a disclosure must:

(1) Limit disclosure to those parts of the patient's record which are essential to fulfill the objective of the order;

(2) Limit disclosure to those persons whose need for information is the basis for the order; and

(3) Include such other measures as are necessary to limit disclosure for the protection of the patient, the physician-patient relationship and the treatment services; for example, sealing from public scrutiny the record of any proceeding for which disclosure of a patient's record has been ordered.

§ 2.65 Procedures and criteria for orders authorizing disclosure and use of records to criminally investigate or prosecute patients.

(a) *Application.* An order authorizing the disclosure or use of patient records to criminally investigate or prosecute a patient may be applied for by the person holding the records or by any person conducting investigative or prosecutorial activities with respect to the enforcement of criminal laws. The application may be filed separately, as part of an application for a subpoena or other compulsory process, or in a pending criminal action. An application must use a fictitious name such as John Doe, to refer to any patient and may not contain or otherwise disclose patient identifying information unless

the court has ordered the record of the proceeding sealed from public scrutiny.

(b) *Notice and hearing.* Unless an order under § 2.66 is sought with an order under this section, the person holding the records must be given:

(1) Adequate notice (in a manner which will not disclose patient identifying information to third parties) of an application by a person performing a law enforcement function;

(2) An opportunity to appear and be heard for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order; and

(3) An opportunity to be represented by counsel independent of counsel for an applicant who is a person performing a law enforcement function.

(c) *Review of evidence: Conduct of hearings.* Any oral argument, review of evidence, or hearing on the application shall be held in the judge's chambers or in some other manner which ensures that patient identifying information is not disclosed to anyone other than a party to the proceedings, the patient, or the person holding the records. The proceeding may include an examination by the judge of the patient records referred to in the application.

(d) *Criteria.* A court may authorize the disclosure and use of patient records for the purpose of conducting a criminal investigation or prosecution of a patient only if the court finds that all of the following criteria are met:

(1) The crime involved is extremely serious, such as one which causes or directly threatens loss of life or serious bodily injury including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, and child abuse and neglect.

(2) There is a reasonable likelihood that the records will disclose information of substantial value in the investigation or prosecution.

(3) Other ways of obtaining the information are not available or would not be effective.

(4) The potential injury to the patient, to the physician-patient relationship and to the ability of the program to provide services to other patients is outweighed by the public interest and the need for the disclosure.

(5) If the applicant is a person performing a law enforcement function that:

(i) The person holding the records has been afforded the opportunity to be represented by independent counsel; and

(ii) Any person holding the records which is an entity within Federal, State, or local government has in fact been represented by counsel independent of the applicant.

(e) *Content of order.* Any order authorizing a disclosure or use of patient records under this section must:

(1) Limit disclosure and use to those parts of the patient's record which are essential to fulfill the objective of the order;

(2) Limit disclosure to those law enforcement and prosecutorial officials who are responsible for, or are conducting, the investigation or prosecution, and limit their use of the records to investigation and prosecution of extremely serious crime or suspected crime specified in the application; and

(3) Include such other measures as are necessary to limit disclosure and use to the fulfillment of only that public interest and need found by the court.

[52 FR 21809, June 9, 1987; 52 FR 42061, Nov. 2, 1987]

§ 2.66 Procedures and criteria for orders authorizing disclosure and use of records to investigate or prosecute a program or the person holding the records.

(a) *Application.* (1) An order authorizing the disclosure or use of patient records to criminally or administratively investigate or prosecute a program or the person holding the records (or employees or agents of that program or person) may be applied for by any administrative, regulatory, supervisory, investigative, law enforcement, or prosecutorial agency having jurisdiction over the program's or person's activities.

(2) The application may be filed separately or as part of a pending civil or criminal action against a program or the person holding the records (or agents or employees of the program or person) in which it appears that the patient records are needed to provide ma-

terial evidence. The application must use a fictitious name, such as John Doe, to refer to any patient and may not contain or otherwise disclose any patient identifying information unless the court has ordered the record of the proceeding sealed from public scrutiny or the patient has given a written consent (meeting the requirements of § 2.31 of these regulations) to that disclosure.

(b) *Notice not required.* An application under this section may, in the discretion of the court, be granted without notice. Although no express notice is required to the program, to the person holding the records, or to any patient whose records are to be disclosed, upon implementation of an order so granted any of the above persons must be afforded an opportunity to seek revocation or amendment of that order, limited to the presentation of evidence on the statutory and regulatory criteria for the issuance of the court order.

(c) *Requirements for order.* An order under this section must be entered in accordance with, and comply with the requirements of, paragraphs (d) and (e) of § 2.64 of these regulations.

(d) *Limitations on disclosure and use of patient identifying information:* (1) An order entered under this section must require the deletion of patient identifying information from any documents made available to the public.

(2) No information obtained under this section may be used to conduct any investigation or prosecution of a patient, or be used as the basis for an application for an order under § 2.65 of these regulations.

§ 2.67 Orders authorizing the use of undercover agents and informants to criminally investigate employees or agents of a program.

(a) *Application.* A court order authorizing the placement of an undercover agent or informant in a program as an employee or patient may be applied for by any law enforcement or prosecutorial agency which has reason to believe that employees or agents of the program are engaged in criminal misconduct.

(b) *Notice.* The program director must be given adequate notice of the application and an opportunity to appear and be heard (for the limited purpose of

Pt. 2a

providing evidence on the statutory and regulatory criteria for the issuance of the court order), unless the application asserts a belief that:

(1) The program director is involved in the criminal activities to be investigated by the undercover agent or informant; or

(2) The program director will intentionally or unintentionally disclose the proposed placement of an undercover agent or informant to the employees or agents who are suspected of criminal activities.

(c) *Criteria.* An order under this section may be entered only if the court determines that good cause exists. To make this determination the court must find:

(1) There is reason to believe that an employee or agent of the program is engaged in criminal activity;

(2) Other ways of obtaining evidence of this criminal activity are not available or would not be effective; and

(3) The public interest and need for the placement of an undercover agent or informant in the program outweigh the potential injury to patients of the program, physician-patient relationships and the treatment services.

(d) *Content of order.* An order authorizing the placement of an undercover agent or informant in a program must:

(1) Specifically authorize the placement of an undercover agent or an informant;

(2) Limit the total period of the placement to six months;

(3) Prohibit the undercover agent or informant from disclosing any patient identifying information obtained from the placement except as necessary to criminally investigate or prosecute employees or agents of the program; and

(4) Include any other measures which are appropriate to limit any potential disruption of the program by the placement and any potential for a real or apparent breach of patient confidentiality; for example, sealing from public scrutiny the record of any proceeding for which disclosure of a patient's record has been ordered.

(e) *Limitation on use of information.* No information obtained by an undercover agent or informant placed under this section may be used to criminally in-

42 CFR Ch. I (10-1-97 Edition)

vestigate or prosecute any patient or as the basis for an application for an order under § 2.65 of these regulations.

**PART 2a—PROTECTION OF
IDENTITY—RESEARCH SUBJECTS**

Sec.

2a.1 Applicability.

2a.2 Definitions.

2a.3 Application; coordination.

2a.4 Contents of application; in general.

2a.5 Contents of application; research projects in which drugs will be administered.

2a.6 Issuance of Confidentiality Certificates; single project limitation.

2a.7 Effect of Confidentiality Certificate.

2a.8 Termination.

AUTHORITY: Sec. 3(a), Pub. L. 91-513 as amended by sec. 122(b), Pub. L. 93-282; 84 Stat. 1241 (42 U.S.C. 242a(a)), as amended by 88 Stat. 132.

SOURCE: 44 FR 20384, Apr. 4, 1979, unless otherwise noted.

§ 2a.1 Applicability.

(a) Section 303(a) of the Public Health Service Act (42 U.S.C. 242a(a)) provides that "[t]he Secretary [of Health and Human Services] may authorize persons engaged in research on mental health, including research on the use and effect of alcohol and other psychoactive drugs, to protect the privacy of individuals who are the subject of such research by withholding from all persons not connected with the conduct of such research the names or other identifying characteristics of such individuals. Persons so authorized to protect the privacy of such individuals may not be compelled in any Federal, State, or local civil, criminal, administrative, legislative, or other proceedings to identify such individuals." The regulations in this part establish procedures under which any person engaged in research on mental health including research on the use and effect of alcohol and other psychoactive drugs (whether or not the research is federally funded) may, subject to the exceptions set forth in paragraph (b) of this section, apply for such an authorization of confidentiality.

(b) These regulations do not apply to:

APPENDIX B

Potential Community Resources for LINKS

Akeela House
Alaska Native Medical Center
Alaska North Alcohol Recovery Center
Alaska Regional Hospital
Alaska State Housing Authority
Alaska Women's Aid in Crisis
Alaska Women's Resource Center
Alternatives
Anchorage Center for Families
Association of Retarded Children
Big Brothers and Big Sisters
Health)
Campfire Girls
Catholic Social Services
Charter North Hospital
Child Care Connection
Day Care Assistance (Municipality)
Dena A Coy
Department of Corrections
Division of Alcoholism and Drug Abuse
Division of Family & Youth Services

Division of Public Assistance
Family Planning
Four A's
Girl Scouts
Head Start
Hope Cottages
Job Training Partnership Act
Mary Magdalene
Office of Public Advocacy
Providence Hospital
Public Health (Maternal, Child, Family

Safe City (Municipality)
South Central Counseling Center
South Central Foundation
Standing Together Against Rape
The Salvation Army
Veteran's Association
Volunteers of America
Women, Infants, and Children (Municipality)
YWCA

APPENDIX C

MEMORANDUM OF AGREEMENT

Between Department of Corrections and Department of Health and Social Services

Purpose: To facilitate collaboration between departments to insure program and case coordination for women participating in the LINKS Program.

Agreement: Program Managers will meet as needed to coordinate services. Service coordination will include the following elements.

1. The parties agree to obtain appropriate "Client Consents for the Release of Confidential Information".
2. The parties agree to coordinate case planning at least quarterly, which will include services to facilitate community transition.
3. The parties agree to maintain communications regarding client case progress to insure service coordination.
4. The parties agree to share statistical data to facilitate program planning and accountability.
5. The parties agree to share training, which may be beneficial to either program.

It is understood by both parties to this Agreement that client confidentiality will be insured pursuant to the Code of Federal Regulations 42, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and Alaska Statute 47.10.090, 7 AAC 36.010, Title 7, Chapter 36, Section 10 of the Alaska Administrative Code, and 45 CFR 205.50, Title 45, Part 205, Section 50 of Code of Federal Regulations.

Length of Agreement: Either party may request in writing a revision of this Memorandum of Agreement if deemed necessary. This agreement will be in effect until canceled by one or both parties. A written 30-day notice is required for revocation of this agreement.

Authorized Representative of

Date

Authorized Representative of

Date

APPENDIX D

MEMORANDUM OF AGREEMENT
(Template)

Between _____ and _____

Purpose: To facilitate the case coordination of women participating in the LINKS Program who are receiving services from

_____ and _____.

Agreement: Program Managers from _____ and

_____ will meet as need is indicated to coordinate programming.

Service Coordination:

6. The parties agree to obtain appropriate "Client Consents for the Release of Confidential Information".
7. The parties agree to coordinate case planning at least quarterly, which will include services to facilitate community transition.
8. The parties agree to maintain communications regarding client case progress to insure service coordination.
9. The parties agree to share statistical data to facilitate program planning and accountability.
10. The parties agree to share training, which may be beneficial to either program.

It is understood by both parties to this Agreement that client confidentiality will be insured pursuant to the Code of Federal Regulations 42, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and Alaska Statute 47.10.090, 7 AAC 36.010, Title 7, Chapter 36, Section 10 of the Alaska Administrative Code, and 45 CFR 205.50, Title 45, Part 205, Section 50 of Code of Federal Regulations.

Length of Agreement: Either party may request in writing a revision of this Memorandum of Agreement if deemed necessary. This agreement will be in effect until canceled by one or both parties. A written 30-day notice is required for revocation of this agreement.

Authorized Representative of

Date

Authorized Representative of

Date

APPENDIX E

Roles and Responsibilities

Transition Counselor

The Transition Counselor is one of the certified substance abuse counselors working in the Women's RSAT Program who will spend time in the community providing case management to the women participating in LINKS who have transitioned into the community either on furlough or probation/parole. The role is critical in providing a bridge from the institution into the community. For the community case management activities there will be a workstation at the RSAT treatment provider's outpatient office in Anchorage.

The Transition Counselor will maintain a caseload of LINKS clients before and after release from HMCC, and will implement a phased model of support that will allow clients to decrease their contact over a period of time as their integration into the community becomes complete. Treatment will be provided to the women participating in LINKS while they are still in the institution, but once they move out of the institution, community substance abuse treatment agencies will provide them with aftercare services. The Transition Counselor will be the case manager and primary contact person for the LINKS women in the community. They will be met with individually and in a group setting to follow-up on their community referrals and to provide support. The Transition Counselor will also modify their LINKS release plans as necessary to accommodate revised goals and objectives and will be responsible for disseminating the revised plan to all members of her treatment team.

The Transition Counselor will be a key player in developing and implementing the LINKS project and will establish MOA's with appropriate service agencies in Anchorage.

Institutional RSAT Social Worker

The RSAT Social Worker is a member of the female offender management team comprised of Correctional Officers, Probation Officers, contract Program staff, and the Education Coordinator. The Social Worker is involved with inmates participating in the Women's RSAT Program, and is the institutional coordination of the LINKS Program.

Inmates within three months of completion of the RSAT Program may advise the RSAT Social Worker of her interest in participation in the LINKS Program. To develop a viable release plan, the RSAT Social Worker reviews the inmate file, interviews the inmate, and investigates the status of the custody and custodial arrangements of the inmate's children. The RSAT Social Worker prepares a case plan and reviews it with the inmate. The inmate must commit to working with the agencies involved with the case plan. The RSAT Social Worker co-ordinates the development of the case plans with the community agencies, with the Transition Counselor following up with the inmate's adherence to the plan.

Institutional Probation Officer III/Program Director

The Institutional Probation Officer III position is known as the Program Director in Alaska's Correctional Centers. At HMCC/MCCC, The Program Director supervises the Probation/Parole Officer I/II positions, the Education Coordinators, the RSAT Social Worker, and oversees business associated with the Offender Programs, including program development and monitoring.

Institutional Probation Officer I/II

The Institutional Probation Officer I/II positions manage inmate caseloads. They participate in Program Reviews, and monitor the behaviors and progress of inmates in programs. The Probation Officer makes recommendations to the Board of Parole and the Furlough Officer on inmate requests for Parole and Furlough consideration. The Probation Officer bases the recommendations on the inmate's efforts to reduce their risk of reoffending, their institutional behavioral record, severity of the current offense, and their criminal history. The Probation Officer attends Program Reviews, provides the team with background social and criminal information, and advises the inmate of expected program involvement while incarcerated. The Probation Officer and the RSAT Social Worker share information on LINKS program involvement, discharge issues and planning. The inmate has the choice of pursuing the recommendation of the Probation Officer and the team.

STATE OF ALASKA /

DEPARTMENT OF CORRECTIONS

Alaska Correctional Industries

MEMORANDUM

P.O. Box 112000

Juneau, Alaska 99811-2000

Phone (907) 465-3317 Fax (907) 465-311

TO: General Distribution
Correctional Industries Commission

DATE: August 24, 1999

PHONE: 465-3309

FROM: Wally F. Roman
General Manager/ACI

SUBJECT: Commission Meeting Agenda
Juneau- 9/99

AGENDA

ALASKA CORRECTIONAL INDUSTRIES COMMISSION

QUARTERLY MEETING

FRIDAY, SEPTEMBER 24, 1999

FAIRBANKS REGIONAL PUBLIC HEALTH CENTER

1025 W. BARNETTE STREET

FIRST FLOOR CONFERENCE ROOM

FAIRBANKS, ALASKA

907-452-1776

8:30 AM to 9:30 AM

Call to Order

Introductions

Approval of Minutes

Initial Announcements

9:30 AM to 10:15 AM

Preliminary Evaluations of Proposed Product Lines

ACI Wood Products Mfg.-Spring Creek C.C.

-Burial Urns & Flag Cases

-Church Pews & Communion Rails

-Library Shelving

10:15 AM to 10:30 AM

BREAK

10:30 AM to 11:30 AM

Preliminary Evaluations of Proposed Product Lines (cont.)

ACI Garment Shop-Hiland Mountain C.C.

-Transfer of Product Lines

-Introduction of Initial Product Line

-Private Cooperative Venture

11:30 AM to 12:00 PM

Budget & Legislative Issues

Current Operating Budget

9/14
Coll

12:00 PM to 1:00 PM

***** LUNCH *****

1:00 PM to 2:00 PM

**Marketing Report
Alaska Product Preference Program
Marketing/Sales Reports
State Agency Purchase Waivers**

2:00 PM to 3:00 PM

**Status of Current Operations
Private Industries Enhancement Program
-Alaska Sterile Laundry
Mt. McKinley Meats
-Alaska Producers Cooperative
-Cut & Wrap Pricing
FCC Garment/Flat Goods Shop**

3:00 PM to 3:15 PM

*****BREAK*****

3:15 PM to 4:00 PM

**Status of Current Operations (cont.)
SCCC/WWCC Furniture Factories
-Production Schedules
LCCC Laundry Operation
-RSA & Delivery Service/AMHS
PCC Body Fender Repair
-Transportation Renovation Project**

4:00 PM to 4:30 PM

**Summary of Recommended Actions
Future Meeting Schedule
Meeting Guidelines/Closure**

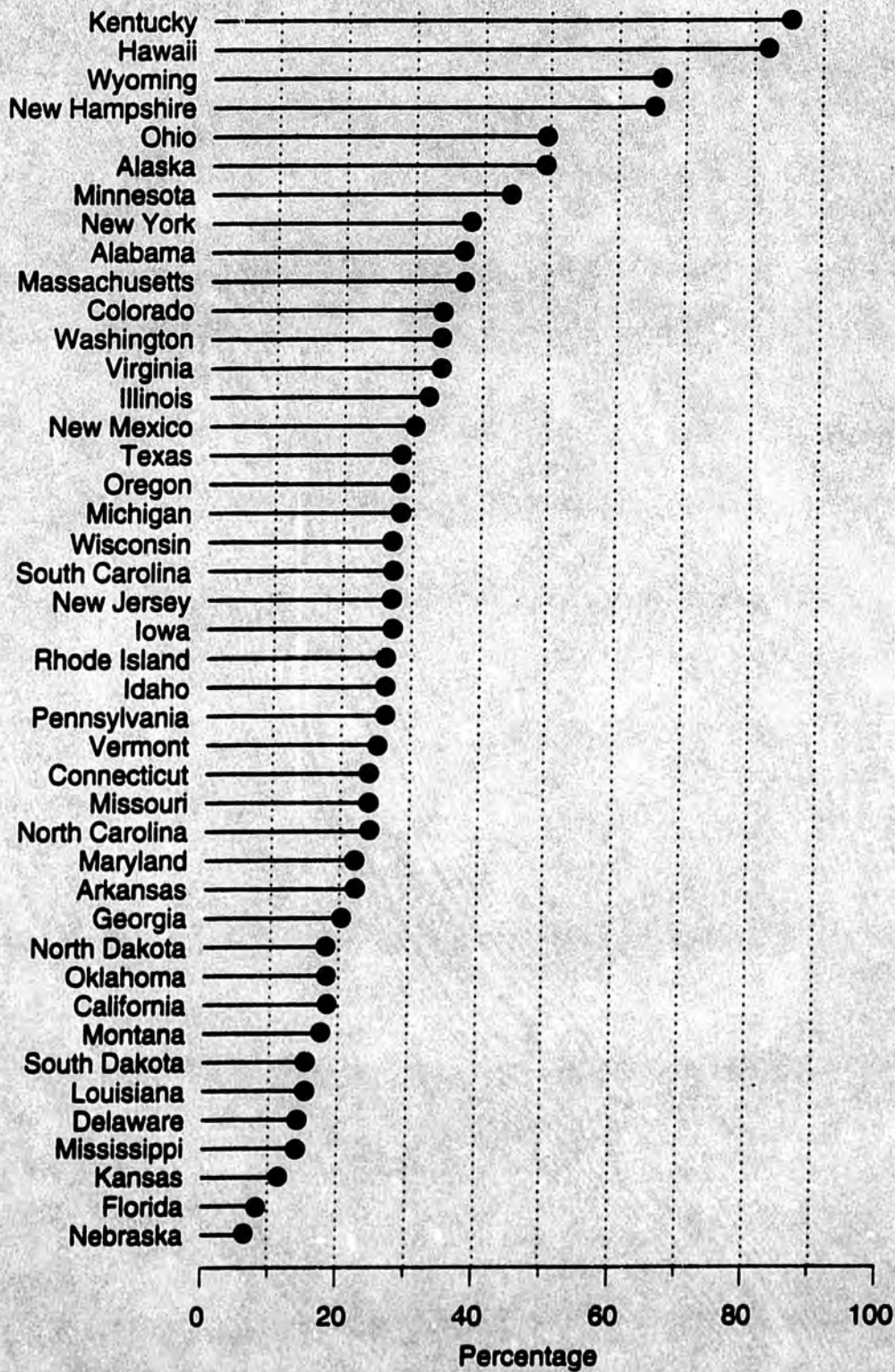
PRELIMINARY FY99 CORRECTIONAL INCARCERATION COST REPORT

In response to an informational request from the Commission on Privatization, Corrections Subcommittee, chaired by Sharon Anderson, the Department of Corrections has conducted a preliminary analysis of FY99 state and contract correctional facility expenditures. The subcommittee requested a report of expenditures for the contract facility operated by Corrections Corporation of America in Florence, Arizona compared with state operated facilities in Alaska. The attached report represents identifiable expenditures recorded in the state accounting system. These expenditures should not be interpreted as a cost comparison, but as a general analysis of what the department expended on incarceration of inmates in Alaska and Arizona. An in-depth analysis could be conducted through an audit taking under consideration the issues raised in the U.S. General Accounting Office, Report to the Subcommittee on Crime, Committee on the Judiciary, U.S. House of Representatives, Studies "Comparing Operational Costs and/or Quality of Service".

ESTIMATED PER DAY COST OF IN STATE / OUT OF STATE FACILITIES FY99 EXPENDITURES AND OBLIGATIONS AS OF 8/31/1999				
Correctional Institution Associated Expenditure Item	Out of State Contract CCA		In State Incarceration	
	Per Bed-Day	FY99 Total	Per Bed-Day	FY99 Total
Bed Day Cost [CCA & State Correctional Facilities]	\$55.81	\$15,807,199.54	\$78.79	\$76,761,595.51
Parole Board Costs	\$0.48	\$135,020.51	\$0.48	\$487,249.37
Transport Costs (CCA and all other)	\$2.56	\$724,726.19	\$0.71	\$726,427.79
Health Care Admin. Costs (all mandays)	\$0.39	\$111,851.48	\$0.39	\$501,712.55
Health Care Direct Services Costs (CCA and all other)	\$2.51	\$710,762.46	\$8.74	\$11,098,023.94
Institution Directors Office Costs (all mandays)	\$0.46	\$129,015.82	\$0.46	\$561,786.83
ACI Admin. (Instate facilities - product cost not included)	-		\$1.22	\$1,191,257.05
In-State Programs	-		\$2.09	\$2,654,966.73
In-State Mental Health Administration	-		\$3.14	\$3,983,710.59
	\$2.41	\$682,608.40	\$2.41	\$3,061,856.80
TOTAL	\$64.61	\$18,301,184.39	\$98.42	\$100,596,838.76
Expenditures Not Included				
Return Inmate to point of Arrest as required by law		\$319,075		
Gate Money upon release as required by law		\$234,450		

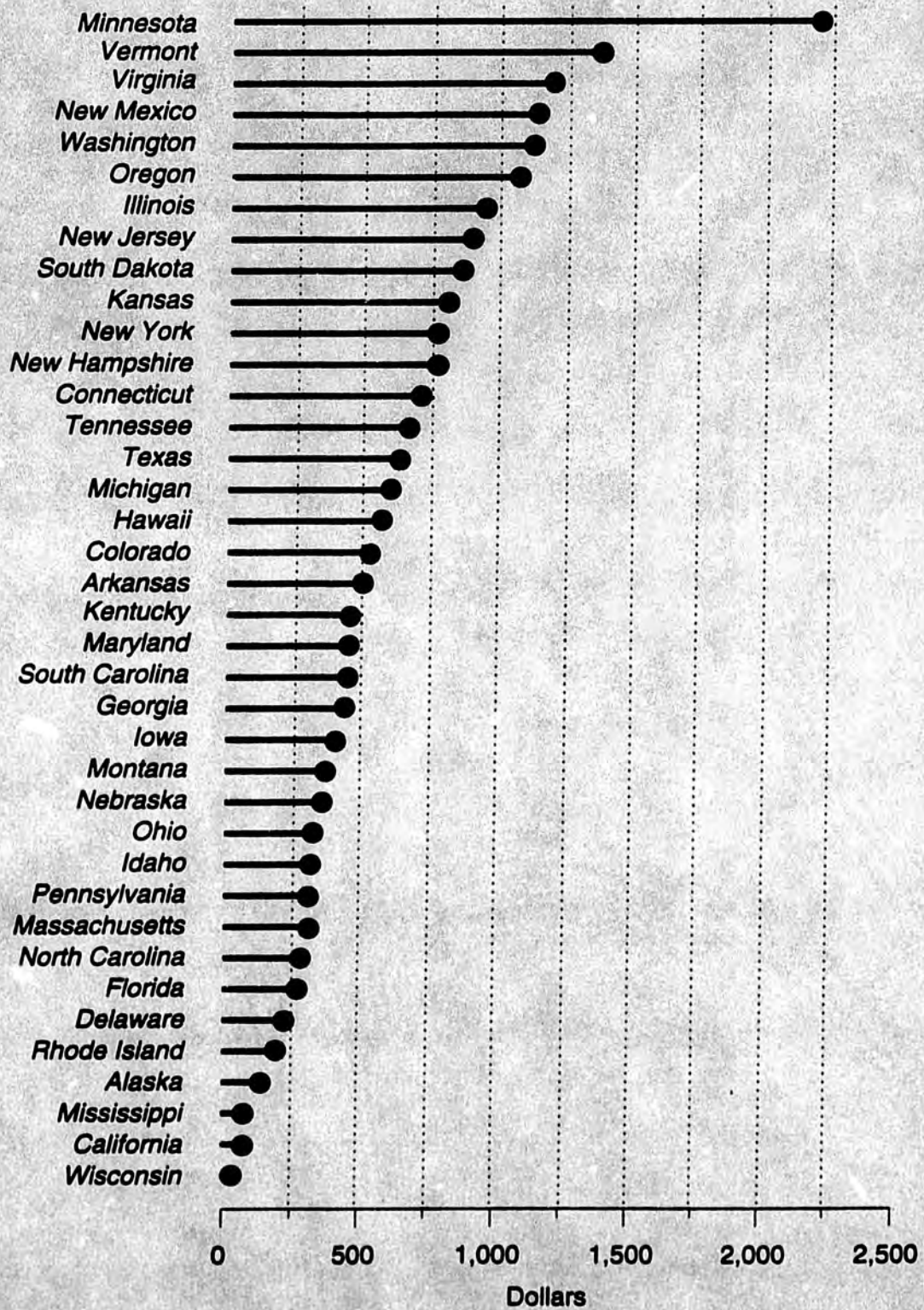
Figure 5

Percentage of Inmates Enrolled in Education Programs, by State



Source: *Corrections Compendium*, Volume XIX, No. 3, March 1994.

Figure 3
Total Education Budget Per Inmate, 1993-1994



Source: *Corrections Compendium*, Volume XIX, No. 3, March 1994.
 Missouri, Oklahoma, and Wyoming are not included because their reported budgets do not include personnel costs.

INMATE EDUCATION PROGRAMS

Provided at all facilities:

Adult Basic Education - includes basic academic instruction in reading, writing and computational skills below the ninth-grade level. ABE services are provided to adults whose inability to speak, read, or write the English language and/or perform basic math computations prevents their functioning at the highest level of their ability to meet family, job and societal responsibilities. ABE includes English as a Second Language (ESL) instruction for prisoners whose primary language is other than English and who have a need to improve speaking, reading and writing. Additionally, ABE includes Literacy instruction for prisoners whose reading and writing skills are below fourth-grade level. ABE instruction is provided on both an individual and small class basis.

General Equivalency Degree(GED) - includes instruction above the eighth-grade level and below the college level in the areas of writing, reading, science, social studies, and mathematics. GED programs provide pre-testing, instructional classes, and GED testing.

Life Skills – there are four core curriculum areas provided in the Life Skills area, including Health and Safety, Communications Skills, Cultural Activities, and Pre-Release/Pre-Employment Preparation. Topics vary by institution within the core areas. The individual institution list below provides specific information on the courses being offered at the current time.

SPECIFIC EDUCATION PROGRAMS (by facility)

Pretrial facilities:

<u>Institution</u>	<u>Life Skills</u>	<u>Certified Vocational Programs</u>	<u>Non-Certified Vocational</u>	<u>Post-Secondary</u>
6th Avenue CC	Human Relationships Women's Issues (as needed) CPR/First Aid Stress Reduction Men's Issues Cross-Cultural Issues Parenting&Family Skills Employment Skills Money Mgmt&Consumer Educ. Safer Sex & Health Issues	None	Career Counseling Educ. Opportunities Center (EOC)	Correspondence Only

<u>Institution</u>	<u>Life Skills</u>	<u>Certified Vocational Programs</u>	<u>Non-Certified Vocational</u>	<u>Post-Secondary</u>
Cook Inlet	Cross-Cultural Communication Anger & Stress Mgmt. CPR/1 st Aid Men's Issues AIDS Awareness Career Development Resumes & Job Skills Parenting and Family Skills Presentation Skills Business Entrepreneurship Financial Aid/AKCIS	None	Career Couns By EOC	Correspondence Only- various colleges
Mat-Su Pretrial	Computer Skills Anger&Stress Mgmt AIDS/HIV & other STD's Intro to CPR/ 1 st Aid Communication Parenting Skills Cultural Awareness Money Management Time Management Job Skills Health & Nutrition Blood-Bourne Pathogens Critical Thinking Decision Making Goal Setting Life Planning Various Writing, Art, Literature, History	None	None	Correspondence Only

<u>Institution</u>	<u>Life Skills</u>	<u>Certified Vocational Programs</u>	<u>Non-Certified Vocational</u>	<u>Post-Secondary</u>
WildWood Pre-Trial	Women's Anger Management Women's Self Esteem Men's Anger Management Stress Management (men & women) First Aid/ CPR (men & women) Computer Skills	None	None	Correspondence Only
Yukon- Kuskokwim C.C.	Nutrition Anger&Stress Mgmt. Basic 1st Aid/CPR Various Arctic/Winter Survival Tobacco Free AIDS/STD Education Communications Across Cultures Family & Parenting Couples Skills Family Secrets How to Deal With Difficult People Interpersonal Relationships AK Native Cultural Activities (Potlatches, Elder Visits) Computer Skills Job Seeking/Training Opportunities Budgets & Money Mgmt/Consumer Education	None	None	None
Ketchikan C.C.	Parenting Assertiveness; Decision Making Anger&Stress Mgmt Cross-Culture awareness Basic Computer Skills Job Seeking Skills	US Coast Guard(1988) Boating Safety	None	Correspondence Only

<u>Institution</u>	<u>Life Skills</u>	<u>Certified Vocational Programs</u>	<u>Non-Certified Vocational</u>	<u>Post-Secondary</u>
Anvil Mountain C.C.	CPR/1 st Aid Parenting Nutrition Beading/Quilting/Painting Animal First Aid Eskimo Dancing & Drumming Net Mending & Hanging Ivory Carving & Scrimshaw Small Business Operations Intro. to Photography Arctic Survival FAS/FAE	Div. of Public Health: Emergency Trauma Tech. Board of Nursing: Nurse Aid DEC: Wastewater Tx Plant Operator	Small Engine Repair Snowmachine/ 4-wheeler repair Welding	UAF NW Campus Correspondence & Audioconf.

Sentenced Facilities:

<u>Institution</u>	<u>Life Skills</u>	<u>Certified Vocational Programs</u>	<u>Non-Certified Vocational</u>	<u>Post-Secondary</u>
Hiland Mountain CC	Self Esteem Health Issues Interpersonal Psychology Women's Issues in Film Literature Pre-Release Cognitive Restructuring Grief & Loss Budgeting & Consumer Math Personal Growth Current Events Career Tracking/AKCIS Parenting Motherhood Domestic violence Mary Magdalene groups	UAA Comm&Tech College: Intro to Computers Horticulture Program Building Maintenance Program Job Savvy Program (goals, values, Customer service, etc) What's Out There? (job-hunting) <i>Cert. by: AK Postsecondary Commission</i>	None	Correspond & distance-various colleges

<u>Institution</u>	<u>Life Skills</u>	<u>Certified Vocational Programs</u>	<u>Non-Certified Vocational</u>	<u>Post-Secondary</u>
Spring Creek CC	Parenting CPR/1 st Aid Native Heritage Group Computers (indep study) Creative Writing Anger & Stress Mgmt Starting a Business Marketing & Finance Intro to Business Pre-Release Typing	DOL Certified: Building Maintenance Repairer Materials Coordinator Cook Baker AVTEC (AK Post-Sec Commission) Instruction for Apprenticeships	None	UAA: CLEP/DANTES Testing Various Indep. Study
Wildwood C.C.	Anger & Stress Mgmt CPR/1st Aid Parenting Computer Skills Communication Skills Native Culture Awareness Pre-Release	OSHA certified: Oilfield Health & Safety Oilfield Confined Spaces	Intro Basic Comp. Private Pilot Ground School & Instrumentation	KPC- AutoCAD (comp.assisted drafting) Various independent study
Palmer C.C.	Anger Management Art Classes CPR/1st Aid Newspaper Personal Finance	OSHA Certified: Hazardous Materials Handling DOL Certified: Butcher/Meat Cutter (1/90) Baker (1/90) Building Maintenance Custodial Maintenance	AutoCAD Building Maint.	Correspondence Only

<u>Institution</u>	<u>Life Skills</u>	<u>Certified Vocational Programs</u>	<u>Non-Certified Vocational</u>	<u>Post-Secondary</u>
Fairbanks C.C.	Job Preparation Skills Creative Writing Parenting Native Culture Club Personal Finance Small Businesses Personal Hygiene Stress Management Basic Computer skills Native History Health & AIDS Awareness Options/Cog. Restructuring	Div. of Public Health: Emergency Trauma Tech DOL Certified: Cook Baker Materials Coordinator Div. of Forestry: Wild Land Firefighter Red Card Certification	None	UAF - 1 cr. computer course Misc. Correspondence
Lemon Creek C.C.	Stress Management Assertiveness Training Health Issues Native Culture Club Parenting Guitar classes CPR/1 st Aid Employment Skills Job Readiness Computer Basics/Keyboarding	Office Skills Program- AK Computer Inst (cert. by AK Post-Sec Comm) 7/91 DOL pgms: Landscape Technician	Basic Construction Basic Electricity CDL Study & Testing	Correspondence Various Univ.
Point McKenzie Project	Resume Workshop CPR/1 st Aid Computer fundamentals Typing/keyboarding Word perfect Employment Skills AK Drivers License	Microsoft Certification Course Wildland Firefighting (DOF) Pesticide Handling (EPA) HazWoper Commercial Driving License	Food Svc.Sanitation Swine Mgmt. IBM Dos Trng. Mastercook Comp.	Misc correspond Elect. Journeyman Facilitation

11/4/98

General Government Division

B-261797

August 16, 1996

The Honorable Bill McCollum
Chairman
The Honorable Charles E. Schumer
Ranking Minority Member
Subcommittee on Crime
Committee on the Judiciary
House of Representatives

Since 1991, when we issued our earlier report on private prisons,¹ various jurisdictions and levels of government have made or planned greater use of this alternative to publicly run correctional facilities. At the federal level, plans for privatization of correctional facilities have changed in recent years. For example, the administration's fiscal year 1996 budget proposal reflected a commitment to increase the use of privatized correctional facilities in the federal Bureau of Prisons (BOP). Specifically, under the BOP privatization initiative presented in the budget request, the bureau proposed to contract with private firms, where most appropriate, to operate the majority of all future federal pretrial detention facilities as well as the majority of all future federal minimum- and low-security correctional facilities. The Department of Justice's fiscal year 1997 budget justification projected the activation of two privatized facilities in that year. However, in June 1996, the Justice Department reversed its plans for using private contractors to operate the facilities identified in the 1996 and 1997 budget proposals. In explaining its decision to staff these facilities with BOP employees, the Justice Department noted that it was "unable contractually to reduce the risk of a strike or walk out" of correctional officers employed by private firms.²

Proponents of privatization assert that the experiences of several states demonstrate that private contractors can operate prisons at less cost than the government, without reducing the levels or quality of service. In contrast, other observers say there is little or no valid evidence that privatization of corrections is a cost-effective alternative to publicly run facilities.

To help frame the continuing deliberations of the Justice Department's privatization plans, we self-initiated this review to (1) identify studies

¹Private Prisons: Cost Savings and BOP's Statutory Authority Need to Be Resolved (GAO/GGD-91-21, Feb. 7, 1991).

²Letter, dated June 5, 1996, from the Assistant Attorney General for Administration, Department of Justice, to various congressional committee and subcommittee chairmen and ranking minority members.

(completed since 1991) comparing the operational costs and/or the quality of service³ of private and public correctional facilities; (2) determine, based on these studies, what could be concluded regarding the operational costs and/or quality of service of comparable private and public facilities; (3) assess whether the reported results are generalizable to correctional systems in other jurisdictions; and (4) identify lessons learned to help guide future comparative studies of private and public correctional facilities. Our work basically was a form of evaluation synthesis whereby we assessed existing studies, particularly with respect to the strength of evidence supporting the reported findings. Appendix I presents further details about our objectives, scope, and methodology.⁴ We are addressing this report to you because of your Subcommittee's interest in prison issues, as exemplified by the hearings you held on June 8, 1995.

We conducted our work from June 1995 to June 1996 in accordance with generally accepted government auditing standards. We received oral comments on a draft of this report from BOP and written comments from the Department of Justice's Office of Justice Programs; the National Council on Crime and Delinquency; and a Northeastern University (Boston, MA) professor of criminal justice, who is a nationally recognized authority on corrections administration. These comments and our evaluation of them are discussed at the end of this letter.

Results in Brief

On the basis of literature searches and discussions with correctional officials and criminal justice researchers, we identified five studies completed since 1991 that compare private and public correctional facilities in relation to operational costs and/or quality of service. Three states sponsored comparative studies of correctional facilities in their states—Texas, California, and Tennessee. The National Institute of Justice, the Bureau of Prisons, and the National Institute of Corrections funded a comparative study that focused mainly on facilities in New Mexico. Washington state studied facilities in Tennessee, Louisiana, and Washington state. The correctional facilities that were the focus of these studies varied in terms of geographic location and the types of inmates

³As discussed in appendix I, we did not attempt to generically define "quality of service." Rather, we accepted the definition and/or evaluation criteria used in each applicable study that we reviewed. Some studies, for instance, used a variety of quality measures or outcomes, such as safety and incident data and the extent of treatment programs for inmates.

⁴Although not addressed in this report, the privatization of corrections has, at times, raised various other issues besides cost and quality of service issues. For example, there has been some debate over the issue of whether administration of justice (which includes the operation of prisons) is an inherently governmental function not appropriately delegable to the private sector.

housed. There was also variation in the methodologies and measurements employed by the researchers.

Three of the studies we reviewed (California, Tennessee, and Washington) made comparisons of costs between reasonably matched private and public facilities that were operating within each state that was studied. Of the four private/public comparisons reported in these three studies, two showed no significant differences in operational costs, one showed a 7-percent difference in favor of the private facility, and the other reported the private facility to be more costly than one public facility but less costly than another public facility. One additional study (Texas) reported a 14- to 15-percent savings from privatization; however, the analysis for the Texas study was problematic because the comparison was based on hypothetical public facilities, not existing ones. We could not conclude from these studies that privatization of correctional facilities will not save money. However, these studies do not offer substantial evidence that savings have occurred.

Two studies (New Mexico and Tennessee) assessed a wide variety of factors in their reviews of comparative quality of private and public facilities. These factors, among others, included measures of safety, personnel qualifications, physical conditions of the facilities, health care, and inmate activities. One of these two studies (Tennessee) reported no difference between private and public facilities. The other study (New Mexico) reported a higher quality score for one private facility compared with two public facilities. However, on the inmate survey portion of the assessment, one public facility had higher scores in all of the areas that were assessed, except one. One additional study (Washington), using a less detailed approach to assessing comparative quality, found no differences between private and public facilities.

These studies offer little generalizable guidance for other jurisdictions about what to expect regarding comparative operational costs and quality of service if they were to move toward privatizing correctional facilities. First, several of the studies focused on specialized inmate populations, such as those in prerelease situations, that limited their generalizability to a wider inmate population. Second, methodological weaknesses in some of the comparisons—such as using hypothetical facilities or nonrandom survey samples—make some findings questionable, even for the study setting. Third, a variety of differences in other states and regions could result in experiences far different from those of the states that were studied. For example, cost of living and a state's correctional philosophy

could affect the comparative costs and quality of private and public facilities from state to state. Finally, the age or maturity of the private system could affect the relationship between private and public facilities in terms of costs and quality.

From a methodological standpoint, the five studies provide some lessons learned for future comparisons of private and public correctional facilities. The importance of focusing on both operational costs and quality of service, comparing institutions (both private and public) that are actually in operation, and using multiple measures of quality are attributes that worked well in selected studies.

Background

A generally accepted evaluation criterion is that any comparative study of private and public prisons should be based upon the selection and analysis of similar facilities. For example, the private and public prisons selected for comparison should be as similar as possible regarding design and capacity, security level, and types of inmates. Otherwise, any comparative analysis of operational costs or quality of service could be skewed. On a per-inmate basis, for instance, higher security prisons can be expected to have higher operating costs than lower security prisons because the former type of facilities generally have higher staff-to-inmate ratios.

Even if similar private and public prisons are available for study, a comparison of operational costs can still present difficulties in ensuring that all costs, direct and indirect, are consistently and fully quantified. Possible difficulties can arise due, in part, to differences in budgeting and accounting practices between and even within the private and public sectors. Determining the appropriate allocation of corporate headquarters overhead and government agency overhead, for instance, can be particularly difficult.

Comparing the quality of service at private and public prisons also presents challenges and, in fact, can be more difficult than comparing costs. The concept of "quality" is neither easily defined nor measured. For example, although the American Correctional Association (ACA) sets accreditation standards for prisons, accredited facilities can vary widely in terms of overall quality. According to ACA officials, such variances occur because ACA accreditation means that a facility has met minimum standards.

Generally, however, assessments of quality can take several approaches. For example, one is a compliance approach, that is, assessing whether or to what extent the prisons being compared are in compliance with applicable ACA standards and/or other relevant policy and procedural guidelines and/or court orders and consent decrees. Another approach is to assess performance measures.⁵ For example, measures of safety could include assault statistics, safety inspection results, and accidental injury reports.

The difficulties of comparatively assessing private and public prisons—regarding operational costs and/or quality of service—are further complicated if the prisons are not located in the same state. Each state and its correctional system have characteristics and conditions that must be recognized in conducting interstate analyses. For example, economic conditions and cost-of-living factors can vary by state and by regions of the nation. Similarly, each state's correctional system may be somewhat unique regarding the extent of overcrowding, the history of court intervention, the emphasis given to ACA accreditation, and the presence or influence of various other factors. As an illustration, with respect to the five studies we reviewed, appendix III presents state-specific details regarding some relevant factors that could affect interstate comparisons of prison costs and/or quality of service.

Five Comparative Studies Completed Since 1991

On the basis of extensive literature searches and inquiries with knowledgeable corrections officials and criminal justice researchers (see app. I), we identified five studies completed since 1991 that compared private and public prisons in reference to operational costs and/or quality of service. The following is a brief overview of each study:⁶

- **Texas study (1991):** Conducted by the Texas Sunset Advisory Commission, this study compared (1) the actual costs of operating four privately managed prerelease minimum-security facilities for male prisoners and (2) the estimated costs of operating similar but hypothetical public facilities in Texas. The study did not empirically assess quality of service.

⁵Charles H. Logan, "Criminal Justice Performance Measures for Prisons," *Performance Measures for the Criminal Justice System*, U.S. Department of Justice, Oct. 1993.

⁶As presented, each study is introduced with a short title showing the sponsoring state and/or the state wherein the compared facilities are located. Also, the studies are listed in chronological order by the date of completion or publication indicated in parentheses. Appendix II provides a more detailed overview of these five studies.

- **New Mexico study (1991):** Funded by the National Institute of Justice, the Bureau of Prisons, and the National Institute of Corrections, this study compared the quality of service at three multicustody facilities (minimum- to maximum-security levels) for women, i.e., a private prison and a state-run prison in New Mexico and a federal prison in West Virginia. The study did not include a detailed analysis of operational costs.
- **California study (1994):** Conducted by California State University with funding from the California Department of Corrections, this study focused on three community correctional facilities for males. All three facilities were operated (under contracts with the state) as for-profit alternatives to state-operated prisons. One facility (medium-security) was operated by a private corporation, the second (high-security) by a local police department, and the third (low- to medium-security) by a city administration. The study compared operational and construction costs and quality of service. More specifically, regarding costs, the study compared the three facilities (1) with one another and (2) with other state correctional facilities. Both operational and construction costs were included in the comparison of the three facilities with one another. The statewide comparison did not include construction costs for the California Department of Corrections facilities. Regarding quality of service, the study compared the three facilities with two state facilities.
- **Tennessee study (1995):** Conducted in two parts, one for operational costs and one for quality of service, by the Tennessee state legislature, this study compared three of Tennessee's multicustody (minimum- to maximum-security) prisons for male inmates. One prison was privately managed, and the other two were state-run prisons.
- **Washington study (1996):** At the time of this study, the state of Washington had no privately run prisons but was considering the feasibility of such. Therefore, the study, conducted by the Washington State Legislative Budget Committee, analyzed pertinent information available in other states. Regarding operational costs, for example, the study looked at the three Tennessee facilities (mentioned above) as well as three multicustody male prisons in Louisiana (two private and one public).⁷ Regarding quality of service, the study compared the three Tennessee facilities, the three Louisiana facilities, and two Washington facilities.

⁷As discussed in appendix II, the Washington study also included some interstate comparisons of operational and construction costs.

In summary, the California, Tennessee, and Washington studies assessed operational costs and quality of service.⁹ The Texas study analyzed operational costs only, and the New Mexico study analyzed quality of service only.

Drawing Conclusions From the Five Studies

While the five studies varied in terms of methodological rigor, they do, to differing degrees, offer some indication of comparative operational costs and/or quality of service in the specific settings they assessed. However, regarding operational costs, because the studies reported little difference and/or mixed results in comparing private and public facilities, we could not conclude whether privatization saved money. Similarly, regarding quality of service, of the two studies that made the most detailed comparative assessments, one study (New Mexico) reported equivocal findings, and the other study (Tennessee) reported no difference between the compared private and public facilities.

Comparisons of Operational Costs Indicated Little Difference And/or Mixed Results

Four of the five studies (Texas, California, Tennessee, and Washington) assessed operational costs of private and public correctional facilities. In three of the studies (California, Tennessee, and Washington), comparisons of private and public facilities indicated little or some differences in operational costs. Only the Texas study reported finding substantially lower (14- to 15-percent) operational costs for private versus public correctional facilities.

Using fiscal year 1990 data, the Texas study reported average daily operational costs of \$36.76 per inmate for the private facilities, compared with estimates of \$42.70 to \$43.13 for the public facilities. However, the results of the Texas study are not fully based on actual experience. Rather, the study compared existing private facilities (prerelease institutions) to hypothetical public facilities. This type of hypothetical comparison does not allow for consideration of any unanticipated changes in components such as staffing levels, other expenses, rate of occupied bed space, or many other factors that could affect actual costs. Changes in any single assumption, or set of assumptions, for the hypothetical institutions could

⁹The authors of the California study noted, however, that their findings regarding quality of service were based upon a small, nonrandom sample of inmates.

change the size or even the direction of the differences in the comparative operational costs.⁹

Based upon our experience in designing and assessing evaluation methodologies, we found the Tennessee study (of the studies we reviewed) to have the most sound and detailed comparison of operational costs of private and public correctional facilities. The study compared three mixed-population (minimum- to maximum-security) institutions (one private and two public). All three facilities were located in Tennessee, and all three had relatively comparable inmate populations, in terms of numbers and most demographics, except race. Also, direct and indirect costs were considered in the analysis, and representatives from both the private and the public facilities agreed on the cost components and relevant adjustments prior to data collection. The analysis showed very little difference in average inmate costs per day among the three facilities—\$35.39 for the private facility and \$34.90 and \$35.45, respectively, for the two public facilities.

The Washington study, which made intrastate comparisons of correctional facilities (minimum- and maximum-security populations) in Tennessee and Louisiana, also found very little difference in the operational costs of private and public facilities. For Tennessee, the private facilities' average daily operational costs per inmate (\$33.61) were lower (about 7 percent) than the comparable costs for the two public facilities studied (\$35.82 and \$35.28, respectively). It should be noted that the Tennessee facilities, which were analyzed and reported on in the 1996 Washington state study, were the same facilities that are discussed in the 1995 Tennessee study cited above. For Louisiana, the average inmate costs per day for the two private facilities studied were \$23.75 and \$23.34, respectively, and the comparable daily operational costs for the public facility studied were \$23.55 per inmate.¹⁰

The 1994 California study compared three for-profit community correctional facilities located in that state—one run by a private firm and two run by local governments. The study found that the private facility's average annual costs per inmate (\$15,578) were higher than comparable

⁹Moreover, in response to competition from the private sector, public prisons could, over time, become more cost efficient. As discussed later, this was one of the conclusions of the Washington study.

¹⁰As presented in the study, the costs for the Tennessee and Louisiana facilities were calculated after an adjustment to equalize prison inmate population numbers. The adjustment was necessary because, among other things, comparisons of per-capita costs should be based upon equivalent levels of capacity. Otherwise, a facility operating at less than full capacity, for example, generally will show higher per-capita costs than a facility operating above its rated capacity.

costs for one of the government-run facilities (\$13,195) but were lower than such costs for the other government-run facility (\$16,627). The lower cost government-run facility had a disproportionate share of drug offenders, which could have affected overall costs. Further, the authors of the study noted that the results of this study must be viewed with some additional caution because of inconsistencies in the underlying or supporting cost figures obtained from different sources within the state.

Comparisons of Quality Are Unclear

Although comparative costs are very important, they are not the only factors considered by policymakers in deciding the direction or extent of corrections privatization. A principal concern is whether private contractors can operate at lower costs to the taxpayers, while providing the same or even a better level of service as the public sector, particularly with respect to safety and security issues.

Of the studies we reviewed, two (New Mexico and Tennessee) assessed the comparative quality of service between private and public institutions in much greater detail than the other studies. Both studies used structured data-collection instruments to cover a variety of quality-related topics, including safety and security, management, personnel, health care, discipline reports, escapes, and inmate programs and activities. The New Mexico study reported equivocal findings, and the Tennessee study reported no difference in quality between the compared private and public institutions.

The findings in the New Mexico study are difficult to interpret. On the basis of surveys of correctional staff and reviews of institutional records, the study reported that the private prison "outperformed" the public facilities on most of the measured quality dimensions. However, the author noted that the results from one of the data-collection instruments—the inmate surveys—showed an opposite result, with one of the public facilities "outperforming" the private facility on every dimension except inmate activities (e.g., work and training programs).

The Tennessee study, in assessing the quality of service at one private and two public prisons, reported that "all three facilities were operated at essentially the same level of performance." This conclusion was largely based on the results of an operational audit conducted at each of the facilities by an inspection team. Composed of private and public sector members, the team used a structured survey instrument to conduct a

detailed review of records, observe operations and practices, and conduct interviews.

The Texas study did not empirically assess the quality of service at the private correctional facilities. Rather, the study noted that all four of the privately operated prerelease facilities were in general compliance with 11 of the 16 mandates of court rulings applicable to Texas prisons. Also, the study noted that two of the four private facilities had received ACA accreditation, and the other two were still involved in the accreditation process. ACA officials told us, however, that ACA accreditation means that a facility has met minimum standards and that accredited facilities can vary widely in terms of overall quality. To reiterate, because it was based on hypothetical public facilities, the Texas study made no attempt to comparatively assess the quality of service across private and public facilities in Texas.

The California study, in assessing quality of service, used inmate and staff surveys to compare the three community correctional facilities with two state prisons. However, the results could not be generalized to the inmate or staff populations of the respective facilities because small, nonrandom samples were used.

The California study also attempted to compare the three community correctional facilities with the state's other correctional institutions with respect to recidivism rates. The study reported that, of the three community correctional facilities, one of the publicly managed facilities was "most impressive" in performance based on recidivism rates. Sufficient data were not available to adequately complete the analysis comparing the inmates released from the community correctional facilities with inmates released from other correctional institutions in the state.

The Washington study assessed the quality of service at the three facilities (one private and two public) in Tennessee, three facilities (two private and one public) in Louisiana, and two facilities (both public) in Washington. While not as detailed as the New Mexico and the Tennessee studies, the Washington study concluded that the private and public prisons studied within the respective states (Tennessee and Louisiana) were generally similar in quality of service. However, the study noted that Washington's two state-run facilities had more counselors per inmate than the other states' facilities.

Generalizability of the Studies' Results

The few studies that have compared the operational costs and/or the quality of service of private and public prisons provide little information that is widely applicable to various correctional settings. For example, while these studies compared private and public facilities that generally were similar (in terms of capacities, inmate demographics, etc.), the selected facilities were not necessarily typical or representative of prisons in either the state studied or other jurisdictions. Also, a variety of factors that relate to a given location or correctional system may render the experience of one jurisdiction with private prisons very different from that of another. Further, the passage of time could alter the relationship between private and public correctional facilities in terms of costs and quality. For these reasons, among others, the few studies that we reviewed do not permit drawing generalizable conclusions about the comparative operational costs and/or quality of service of private and public prisons.

Jurisdictions, such as states, vary on several dimensions that could have an impact on the comparative costs of private versus public prisons and, in turn, affect the generalizability of a given study's results. First, other states' correctional philosophies could differ from that of the states studied. Some state correctional philosophies are more punitive in nature (as reflected, for example, by higher incarceration rates), whereas other states are less punitive and more inclined toward treatment.¹¹ California, for example, which is one of the states discussed in the five studies we reviewed, generally has had incarceration rates above the national average. Also, the Washington study noted that the adjusted estimated per-bed costs for a state-run facility in Washington (\$60,400) were almost double Florida's costs (\$33,900) due, in part, to state differences in operating and programming approaches.

Second, jurisdictions also vary in relation to a variety of economic factors that could affect the relationship between private and public prison costs. Differences in the costs of living could affect both private and public prison costs, but in some jurisdictions, one more than the other. For example, a labor shortage could result in higher operational costs for private and public prisons.

Third, in some jurisdictions, the inmate population to be incarcerated in private facilities may be different from those inmate populations in the five studies. Three of the five studies focused on inmate populations that were

¹¹The rate of incarceration is the number of sentenced prisoners (per 100,000 resident population) in correctional facilities. Since the mid-1980s, according to Bureau of Justice Statistics data, the southern and western regions of the nation have had higher incarceration rates than the northeastern and midwestern regions.

not representative of the broader prison population—prerelease prisoners (Texas study), female prisoners (New Mexico), and those housed in community correctional facilities (California). Only two studies (Tennessee and Washington) focused on costs in relation to facilities housing a more mainstream prisoner population.

Finally, regarding both operational costs and quality of service, the comparative performance of private versus public correctional facilities is not likely to be static. Changes over time could alter the comparative performance. For example, the first year of a new prison—either private or public—could reflect expenses for training inexperienced staff as well as hiring replacements for those unsuited to the work. Inexperienced staff could also have a negative effect on some measures of quality. Also, in the initial years of managing a prison, a private firm may choose to bill for its services at rates below costs to obtain or extend a contract. As time goes by, however, to remain a viable business entity, the contractor's cost-recovery practices would have to change. Similarly, over time, public prisons could become more cost efficient in response to competition from the private sector. For instance, this conclusion was reached by the Washington study, which was commissioned to help the state determine the potential benefits of privatization.

Lessons Learned for Future Comparative Studies

The results of studies comparing private and public prisons obviously are of interest to any jurisdiction whose policymakers are deciding whether or to what extent corrections should be privatized. Ideally, to be most useful, such studies should be based upon representative samples of prisons, with sufficient statistical controls in place to measure and account for any differences. However, because the number of private correctional facilities is still relatively small (see app. IV)—and, given the fact that each stand-alone facility (whether private or public) may have some unique characteristics—conducting a truly optimal comparative evaluation may be impractical.

Nonetheless, the five studies completed since 1991 offer several lessons learned to guide future studies, even if such studies focus on comparing only one private facility and one public facility. In reviewing the relative strengths and weaknesses of each study to formulate lessons learned, we largely relied on our extensive experience in designing and assessing evaluation methodologies—that is, our experience with generally accepted methodological standards and practices. Specifically, on the basis of our review of the five studies, we identified the following lessons learned:

- In considering the extent to which corrections should be privatized, a key question is whether private contractors can operate at lower costs to taxpayers, while providing at least the same level of service as the public sector, particularly with respect to security and safety issues. Thus, it is important that any study focus on both operational costs and quality of service. Two of the studies we reviewed (Texas and New Mexico) did not have this dual focus.
- The best approach for evaluating operational costs is to study existing comparable facilities, not hypothetical facilities. One of the studies we reviewed (Texas) used hypothetical similar public facilities.
- Generally, there is more than one way to objectively measure or compare prison security, safety, order, and various other dimensions that constitute quality of service. In this regard, it is important to use multiple indicators or data sources to provide cross-checks. The New Mexico study, for example, illustrates that divergent results can be reached by using one data source (e.g., inmate surveys) versus another source (e.g., staff surveys).
- Comparative findings with respect to operational costs and/or quality of service in any given year may not hold true for other years. Similarly, because trends are not self-perpetuating, even findings based on multiyear comparisons must be carefully considered. Nonetheless, all other factors being equal, comparative evaluations based upon several years' data potentially have more value than evaluations based upon 1 or 2 years of data. Nearly all five of the studies we reviewed were based upon 1 or 2 years of data.

These lessons learned could be particularly applicable to BOP if, in the future, it resumes its plans for contracting with private companies to operate selected federal correctional facilities.¹² For instance, according to April 1995 congressional testimony by the BOP Director, BOP's privatization initiative, if implemented, would provide an opportunity to undertake some thorough comparative evaluations:

"I know that the Attorney General and . . . [the Office of Management and Budget] are very interested in working carefully with us in the Bureau of Prisons to track, on these new contracts, very carefully, what the cost impact truly is, because there are a lot of hidden costs in privatization . . . [T]here has never been, we don't believe, a real good cost analysis

¹²For example, the Justice Department's budget justification for fiscal year 1997 projected the activation of two privatized facilities in that year—a detention facility (677 beds) in Seattle, WA, and a multicustody (minimum- and low-security) facility (2,048 beds) in Elkton, OH. Departments of Commerce, Justice, and State, the Judiciary, and Related Agencies Appropriations for 1997: Hearings before a Subcomm. of the House Comm. on Appropriations, 104th Cong., 2d Sess. 1855 (1996). However, in June 1996, the administration announced that plans to privatize these facilities were being suspended.

to determine, apples to apples, what is the cost of a traditional prison system and private contracting. The private contractors claim they can do it at great savings, and so we are very interested in monitoring the ones that we have projected for the next few years and determining . . . how well the taxpayers are being served on either side."¹³

The BOP Director noted that by contracting out the management of selected facilities incarcerating general inmate populations, BOP was moving to the "next level of privatization," which would provide a good basis for comparative evaluations focusing on "like or similar institutions." In this regard, the lessons learned from previous comparative studies should be useful to BOP if the federal privatization initiative is revisited.

Comments and Our Evaluation

We obtained oral comments on a draft of this report from BOP and written comments from the Department of Justice's Office of Justice Programs; the National Council on Crime and Delinquency; and a Northeastern University (Boston, MA) professor of criminal justice, who is a nationally recognized authority on corrections administration.

BOP commented that the report was accurate, well done, and useful.

The Office of the Assistant Attorney General, Office of Justice Programs, concurred with the report and noted that additional study of the privatization of correctional facilities is needed. The National Institute of Justice, a component agency of the Office of Justice Programs, commented that the report appeared "to be as comprehensive as the available data permits." Also, the Institute commented that the report's discussion of the strengths and weaknesses of the five studies "is excellent."

In commenting on the draft, the Executive Vice President, National Council on Crime and Delinquency, said that the report is accurate in concluding that few studies have been completed to date and that these studies have methodological problems that limit understanding the actual cost-benefits of privatization. He noted, however, that our report could place more emphasis on the Tennessee study, which is the most rigorous study to date. Although we concur with the reviewer's assessment of the study, our objective was to provide similar information for each of the studies reviewed. Further, he noted that the report could add more emphasis to evaluating the claims of private providers that they can

¹³Departments of Commerce, Justice, and State, the Judiciary, and Related Agencies Appropriations for Fiscal Year 1996: Hearings on H.R. 2076 before a Subcomm. of the Senate Comm. on Appropriations, 104th Cong., 1st Sess. 303, 308 (1995).

construct new facilities faster and cheaper than public entities. Since the studies reviewed did not assess these claims, this issue was beyond the scope of our work.

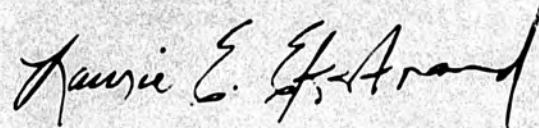
The Northeastern University reviewer¹⁴ commented that (1) our evaluation synthesis was an important contribution to the corrections field, (2) the report's conclusion that the five studies offer little generalizable guidance for other jurisdictions regarding the comparative cost and quality of service of private and public correctional facilities was "right on point," and (3) our cautions concerning interstate comparisons were "well-founded."

However, the reviewer underscored the need also to focus privatization research on crime reduction and various philosophical questions underpinning the privatization debate. These issues were beyond the scope of our work. In addition, the reviewer suggested that it would be valuable to the corrections field if the report included a short, concise statement describing the critical dependent and independent variables that should be considered in comparative analyses of private and public corrections facilities. Because of variations in available data and possible measurement adjustments required in specific research situations, we are hesitant to prescribe what variables should be studied. The studies reviewed, however, suggest possible variables. Furthermore, citing the difficulties researchers have in accessing data from private firms, the reviewer proposed that the report contain a recommendation that would facilitate researchers' access to proprietary information needed for evaluation of private corrections. In the case of federal corrections-related contracts, we would likely have access to data, but we have considerably less jurisdiction at the state level.

We are providing copies of this report to the Chairman and Ranking Minority Member of the House Judiciary Committee, the Attorney General; the Director, BOP; and other interested parties. Copies will also be made available to others upon request.

¹⁴Dr. Edith Elisabeth Flynn, College of Criminal Justice, Northeastern University, Boston, Massachusetts.

The major contributors to this report are listed in appendix V. Please contact me on (202) 512-8777 if you or your staff have any questions.

A handwritten signature in cursive script, reading "Laurie E. Ekstrand".

Laurie E. Ekstrand
Associate Director, Administration
of Justice Issues

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Abbreviations

ACA	American Correctional Association
BOP	Federal Bureau of Prisons

Objectives, Scope, and Methodology

In initiating this review, our specific objectives were to answer the following key questions:

- What studies, completed since 1991, have compared the operational costs and/or the quality of service of private and public prisons?
- From these studies, what can be concluded with respect to the operational costs and/or the quality of service of comparable private and public facilities?
- Are the results of these studies generalizable to correctional systems in other jurisdictions?
- From these studies, what are the "lessons learned" to help guide future comparative studies of private and public prisons?

Identification of Comparative Studies

To identify relevant studies, we requested and obtained literature searches from the National Criminal Justice Reference Service and the National Institute of Corrections. Also, within the Department of Justice, we contacted knowledgeable officials of the component agencies responsible for managing federal correctional facilities—the Federal Bureau of Prisons (BOP), U.S. Marshals Service, and Immigration and Naturalization Service.

Similarly, to query knowledgeable state agency officials, we first contacted the Director of the Private Corrections Project at the University of Florida's Center for Studies in Criminology and Law to obtain information about the number of privatized facilities in each state (see app. IV).¹ Then, for each applicable state, we contacted officials at the state's corrections department and/or corrections research agency and inquired about any completed, ongoing, or planned studies comparing private and public prisons. Further, we contacted the National Council on Crime and Delinquency and various nationally recognized researchers in academia.

Assessment of Studies

We assessed each of the five relevant studies that we identified. Our work in assessing the conclusions or results of each study and the generalizability of same—as well as identifying any lessons learned—can be characterized as a form of evaluation synthesis. By definition, an evaluation synthesis is a systematic procedure for organizing findings from several disparate evaluation studies. That is, the procedure addresses key questions or issues by assessing existing studies or evaluations, rather than by conducting primary data collection.

¹Established in 1988 to conduct policy-relevant research on corrections privatization, the Private Corrections Project publishes (semiannually) the Private Adult Correctional Facility Census.

In reviewing the studies, we focused on the findings and conclusions of each study and evaluated these in relation to the methodology used by the respective study.² As an initial and fundamental inquiry, for instance, we focused on the similarity of the private and public facilities being compared in each study. That is, we wanted to determine (1) if the facilities were reasonably well matched in relation to design and capacity, security level, inmate demographics, and other relevant institutional characteristics and (2) whether the facilities were actually in operation and, if so, for what length of time prior to the comparative evaluation.

In reviewing each applicable study's comparative evaluation of operational costs, we focused on whether (1) both direct and indirect cost components were considered for the private and public facilities, (2) actual data versus estimates were used, and (3) consistent cost components were used. We did not independently verify any of the cost data presented in the studies.

In reviewing each applicable study's comparative evaluation of quality of service, we focused on whether the private and the public facilities were consistently evaluated in the respective study. That is, in reference to both the private and the public facilities compared in a given study, we were interested in whether the same or similar methodology and data sources were used to evaluate quality of service. Thus, we did not attempt to generically define "quality of service;" rather, we accepted the definition and/or evaluation criteria used in each applicable study. Also, we did not independently verify the reported quality measures or outcomes, such as safety and incident data and the extent of rehabilitation and treatment programs for inmates.

We reviewed the relative strengths and weaknesses of each study to formulate lessons learned for future comparative studies. In doing so, we largely relied on our extensive experience in designing and assessing evaluation methodologies—that is, our experience with generally accepted methodological standards and practices.

Private Sector Contacts

Initially, in September 1995, to obtain a practical understanding of privatization issues, we visited two privately operated facilities housing federal inmates. These facilities, which held deportable aliens, are located in west Texas and were operated by private firms under the general

²Two of our staff—senior analysts with specialized training and years of experience in designing and assessing evaluation methodologies—independently reviewed each of the five studies.

Appendix I
Objectives, Scope, and Methodology

authority of intergovernmental agreements entered into by BOP and the respective city governments of Big Spring and Eden. We toured the facilities and interviewed managers and staff of the private firms. Also, we interviewed the on-site federal monitors.

Further, to obtain additional overview information on privatization issues, we interviewed a senior executive (the Director for Strategic Planning) of one of the nation's largest private corrections firms. This official was a former director of BOP.

Description of Studies Comparing Private and Public Prisons

We identified five studies completed since 1991 that compare private and public correctional facilities in relation to operational costs and/or quality of service. Table II.1 briefly describes each of these studies. Following the table, separate sections respectively provide more details about each study.

Table II.1: Citation, Evaluation Parameters, and Reported Results of Five Studies Comparing Private and Public Prisons

State	Study citation	Evaluation parameters	Reported results
Texas	"Information Report on Contracts for Correction Facilities and Services," Recommendations to the Governor of Texas and Members of the Seventy-Second Legislature, Sunset Advisory Commission, Final Report, Texas Sunset Advisory Commission (Austin: 1991).	Operational costs were studied.	The private prisons' operational costs were 14 to 15 percent less than the costs of the hypothetical state facilities.
		Four private, prerelease, minimum-security prisons (500 beds each) for males were compared with hypothetical public facilities in Texas. Fiscal year 1990 data were analyzed. An empirical assessment of quality of service was not conducted.	The study noted that two of the four private facilities had received ACA accreditation, and the other two were still involved in the accreditation process. Also, the study noted that all four facilities were in compliance with 11 of the 16 mandates of court rulings applicable to Texas prisons.
New Mexico	Charles H. Logan, <u>Well Kept: Comparing Quality of Confinement in a Public and a Private Prison</u> , National Institute of Justice (1991).	A detailed analysis of operational costs was not conducted.	Not applicable.
		Quality of service was studied. Three multicustody facilities (minimum- to maximum-security) for women were compared: a private prison and a state-run prison in New Mexico and a federal prison in West Virginia. The data analyzed for the private facility covered June 1989 through November 1989; data for the state facility covered June 1988 through November 1988; and the federal data covered December 1987 through May 1988.	The results of the study depended on the data-collection instruments that were employed. For example, data from staff surveys and official records showed that the private prison "outperformed" the state and federal prisons across nearly all dimensions. However, inmate survey data showed that one of the public facilities "outperformed" the private facility on every dimension except "activity" (e.g., work and training programs).

(continued)

**Appendix II
Description of Studies Comparing Private
and Public Prisons**

State	Study citation	Evaluation parameters	Reported results
California	Dale K. Sechrest and David Shichor, <u>Final Report: Exploratory Study of California's Community Corrections Facilities</u> , California State University (San Bernardino: 1994).	Operational and construction costs were studied.	The private facility's average annual costs per inmate (\$15,578) were higher than comparable costs for one of the government-run facilities (\$13,195) but were lower than such costs for the other government-run facility (\$16,627).
		Three for-profit community correctional facilities—one managed privately (medium-security) and two managed by local governments (low-to medium- and high-security)—for males were compared with one another and with other state correctional facilities.	Due to methodological limitations, conclusions could not be reached by comparing the three for-profit community correctional facilities with other state correctional facilities. For example, different cost components were used for the two sets of facilities in the comparison. In addition, it is likely that the universe of the state's correctional facilities reflected wide-ranging differences concerning inmate populations and services.
		Fiscal year 1991-1992 data were analyzed.	
		Quality of service was studied.	Due to methodological limitations, conclusions could not be reached by comparing the community correctional facilities with two state facilities. For example, the results could not be generalized to the inmate or staff populations of the facilities because small, nonrandom samples were used.
		The same three community correctional facilities for males were compared with two state correctional facilities.	
		Data were collected in summer 1992.	
Tennessee	<u>Cost Comparison of Correctional Centers</u> , Tennessee Legislature Fiscal Review Committee (Nashville: 1995).	Operational costs were studied.	There was little difference in the average daily operational costs per inmate across the three facilities—\$35.39 for the private facility, versus \$34.90 and \$35.45, respectively, for the two public facilities.
		Three multicustody prisons (minimum- to maximum-security) for males were compared: one private and two state-run prisons.	
		Data from July 1993 through June 1994 were analyzed.	
	<u>Comparative Evaluation of Privately Managed CCA Prison and State-Managed Prototypical Prison</u> , Tennessee Legislature Select Oversight Committee on Corrections (Nashville: 1995).	Quality of service was studied.	There was no difference in quality of service between the private and public facilities.
		The same three multicustody prisons for males were compared.	
		Data from March 1991 through September 1994 were analyzed.	
Washington	<u>Department of Corrections Privatization Feasibility Study, Report 96-2</u> , State of Washington Legislative Budget Committee (Olympia: 1996).	Operational costs of the same three Tennessee facilities mentioned above were studied.	The average daily operational costs per inmate for the private facility (\$33.61) were slightly lower than such costs for the two public facilities (\$35.82 and \$35.28, respectively).
		Data from July 1993 through June 1994 were analyzed.	

(continued)

Appendix II
Description of Studies Comparing Private
and Public Prisons

State	Study citation	Evaluation parameters	Reported results
		Operational costs of three multicustody facilities in Louisiana (two private and one state-run) for males were studied. Projected data for July 1995 through June 1996 were analyzed.	The average daily operational costs per inmate for the two private facilities were \$23.75 and \$23.34, respectively, compared with \$23.55 for the public facility.
		Operational costs of a Washington state prison were compared with the costs for one Tennessee state prison and a Louisiana state prison. Data analyzed for Washington state covered calendar year 1995; time frames for Tennessee and Louisiana data are mentioned above.	The average daily operational costs per inmate for the Washington facility (\$44.52) were higher than such costs for the Tennessee and Louisiana facilities (\$37.07 and \$24.04, respectively).
		Construction costs were studied. The estimated costs for Washington state to construct a planned multicustody public prison for males were compared with a private company's costs for constructing a similar facility in Florida. Data analyzed for Washington state were based on projected July 1998 cost figures; and data analyzed for the Florida facility were based on projected July 1998 cost figures.	The estimated cost per bed for the Washington state facility (\$60,400) was approximately double the estimated cost per bed for the Florida facility (\$33,900).
		Quality of service was studied. Three multicustody male facilities in Tennessee (mentioned above), three multicustody male facilities in Louisiana (mentioned above), and two multicustody male facilities in Washington were compared. Data analyzed for Tennessee covered 1994 (for review of institutional records) and 1995 (for on-site visits); data analyzed for Louisiana covered 1995; data analyzed for Washington covered 1995.	Site visits showed that all prisons were "clean and appeared to be orderly." Additional data indicated that the prisons generally were similar regarding quality of service. However, the Washington facilities had more counselors per inmate than the Tennessee and Louisiana facilities.

Source: GAO summary of information reported in the cited studies.

Texas Study (1991)

Conducted by the Texas Sunset Advisory Commission, this study involved a comparative assessment of operational costs; an empirical assessment of quality of service was not conducted. The actual costs of operating four privately managed prerelease minimum-security facilities (500 beds each) for male prisoners were compared with the estimated costs of operating similar but "hypothetical" public facilities in the state of Texas. Two of the four prerelease facilities were managed by Corrections Corporation of America, and the other two were managed by Wackenhut Corrections Corporation.

The study considered direct and indirect costs to compute operational costs for private and public sector management of the prerelease facilities. Direct costs included items such as salaries and fringe benefits, food, medical services, utilities, and supplies. Also, the study recognized that another direct cost would be the expense of having state corrections agency staff on-site to monitor the contractor's performance. Indirect costs included salaries and expenses for corrections department executive personnel, an annual audit of facilities, and "other administration items" attributable to the private or state facilities. Construction costs were excluded because the state built the private facilities. Also, the study did not include depreciation expenses and capital outlays, but debt service for construction was included.

The study concluded that the state achieved savings from the privatized facilities. Based on requirements specified in state statute, the state estimated the costs of operating similar state-run prerelease facilities. Specifically, because similar state-run facilities did not exist, the state estimated the costs of operating hypothetical state-run prerelease facilities. Contract provisions stipulated that contractors would receive at least 10 percent less than the estimated costs for the state to operate each facility.¹ Therefore, in a sense, 10-percent "savings" to the state was guaranteed. Cost data for fiscal year 1990 were analyzed. The state estimated that the privatized facilities achieved 14- to 15-percent cost savings (taking into consideration tax revenues paid to state and local

¹Texas state statutory provisions authorize the Texas Department of Corrections to contract with private vendors and county commissioners to finance, construct, operate, maintain, or manage secure correctional facilities. The provisions establish guidelines by which the state can enter into a contract for such services. Among other things, the provisions specify that a contract proposal must provide the state with a savings of at least 10 percent below the costs of similar state-operated facilities.

authorities)² compared with hypothetically equivalent state-run facilities. The average daily operational costs per inmate for the private facilities were \$36.76. Because of staffing and construction differences between the contractors, separate costs were estimated for the hypothetical state operation of a facility for each contractor. The estimated average daily operational costs per inmate for the hypothetical state-run facilities were \$42.70 for one contractor and \$43.13 for the other. However, because the state did not operate any prerelease facilities nor did any of its existing facilities have prerelease components, the cost estimates for the state-run facilities were not based on actual state experience. The method assumed no unanticipated changes in components such as salary and other expenses. Thus, an error in one or more assumption could have resulted in different cost estimates, changing the size or even the direction of estimated differences in private versus public management costs.

An empirical assessment of the quality of service was not conducted due to the absence of comparable state facilities. However, the study noted that two of the four private facilities had received ACA accreditation, and the other two were still involved in the accreditation process. Additionally, the study noted that all four facilities were in general compliance with 11 of the 16 mandates of court rulings applicable to Texas prisons.

New Mexico Study (1991)

Funded by the Department of Justice's National Institute of Justice, Bureau of Prisons, and National Institute of Corrections, this study, of the five we reviewed, made the most systematic effort to address quality of service. However, a detailed cost analysis was not included. The study compared three multicustody (minimum- to maximum-security) women's facilities—a privately run facility and a state-run facility in New Mexico and a federal facility in West Virginia—across eight dimensions of quality.³

²According to the Texas study, the private prisons have paid an estimated \$400,000 per prison in state and local sales taxes and payments in lieu of property taxes. The study noted that because the state owned the prisons, property taxes were not assessed. Rather, the private contractor paid the local taxing authorities an annual amount, which generally approximated the taxes that would have been owed if the property were privately owned.

³The New Mexico study used a "confinement model" of imprisonment to develop quality assessment criteria. The model defined eight distinct dimensions or performance measures on which to evaluate the quality of a correctional facility. According to the study, these dimensions are based on the premise that confinement "carries with it an obligation to meet the basic needs of prisoners at a reasonable standard of decency," including standards to evaluate health care, safety, sanitation, and nutrition, as well as constitutional standards to ensure due process and fairness. Examples of those dimensions are (1) security (e.g., facility design and security procedures); (2) safety (e.g., personal injury and harm); (3) order (e.g., discipline and control standards); (4) care (e.g., health care and counseling); (5) activity (e.g., work and training programs); (6) justice (e.g., discipline and grievance procedures); (7) conditions (e.g., food services); and (8) management (e.g., staff turnover and job satisfaction).

Data analyzed for the private facility covered June 1989 through November 1989, data for the state facility covered June 1988 through November 1988, and data for the federal facility covered December 1987 through May 1988.

The study recognized, at least indirectly, that differences among the facilities regarding age, architecture, and inmate programs made comparisons somewhat difficult to interpret. For example, the private facility was new, the state facility was 4 years old, and the federal facility was about 60 years old. The respective inmate populations were 170 (private), 143 (state), and 814 (federal). The inmates at the New Mexico facilities were nearly similar with respect to characteristics of age, race, and offense type. However, they differed from the federal inmates in race and offense type. The study indicated that one of the factors enhancing the comparability of the two New Mexico institutions was that both were applying for accreditation by the American Correctional Association (ACA). However, ACA officials told us that ACA accreditation means that only minimum standards are met, and since there can be wide variations among facilities in exceeding minimum standards, accreditation should not be used to assume that two or more facilities are comparable.

In assessing and comparing the quality of service at the three facilities, the study derived multiple indicators for each of eight quality dimensions. Data sources for all three facilities included various institutional records,⁴ such as incident and disciplinary reports as well as work and education records. Also, staff surveys were conducted at all three facilities, and inmate surveys were conducted at the private and the state facilities. In total, the study made 595 comparisons among the institutions using 333 indicators. All of the indicators were available for the private and state prisons, while 131 indicators were available for the federal prisons. Thus, the study made three-way comparisons for 131 of the 333 indicators and two-way comparisons (private/state) for 202 of the indicators.

The study concluded, generally, that "the private prison 'outperformed' the state and federal prisons, often by quite substantial margins, across nearly all dimensions." It noted, however, that results varied by data source. For example, contrary to other sources used in the study, inmate survey data showed that the state facility "outperformed" the private facility in every dimension except "activity" (e.g., work and training programs).

While the study did not include a detailed analysis of operational costs, it suggested that the better performance of the private facility was

⁴The study noted that fewer official records were collected for the federal prison.

accomplished at lower cost. However, the study offered little evidence to support this assertion. For instance, the full report consisted of 291 pages, with only 2 pages devoted to costs. Without providing any detailed analysis, the report noted that the average daily operational costs per inmate for the private facility were \$69.75 in fiscal year 1989-1990, the average daily costs of housing an inmate in federal facilities (nationwide) were \$39.67 in 1988, the average daily costs for New Mexico state facilities (statewide) were \$68.00 in 1988, and the average daily costs for the particular state facility studied were \$80.00 in fiscal years 1988-1989. Although no detailed cost analysis was attempted, the study appeared to base the perception of lower costs of private facilities on the fact that "financial analysts in the New Mexico Corrections Department believed that the [private] contract was saving the state money."

California Study (1994)

Conducted by California State University, this study was neither supportive nor critical of private facilities. To assess costs and quality of service, the study compared three for-profit community correctional facilities for males—one privately managed (medium-security) and two publicly managed by local governments (one low-to medium-security and one high-security).⁵ Specifically, the study compared the three facilities with one another and with other state correctional facilities. Both operational and construction costs were included in the comparison of the three facilities with one another. The statewide comparison did not include construction costs for the California Department of Corrections facilities. Also, the study attempted to compare the quality of service of the three facilities with two other California Department of Corrections facilities.

The three community correctional facilities were generally comparable. For instance, the inmates were nearly similar with respect to characteristics of age, race, and offender status. However, one of the public facilities had a greater percentage of drug offenders⁶ and Anglo- and African-American inmates and a smaller percentage of Hispanics. The private facility housed 400 inmates, compared with about 420 and about 450 housed at the public facilities. For the period studied, the number of admissions was 1,498 for the private facility versus 392 and 1,073,

⁵Correctional facilities that are operated for-profit by a private corporation under contract with the California Department of Corrections are referred to as "private proprietary facilities." Correctional facilities that are operated for-profit by local government agencies under contract with the California Department of Corrections are referred to as "public proprietary facilities."

⁶This public community correctional facility housed narcotics offenders who were sentenced under a "civil addict program" and subsequently violated parole.

respectively, for the two public facilities. The two public facilities were relatively new (operational by mid-1991), while the study referred to the private facility as "older."

Using fiscal year 1991-1992 data, construction and operational cost comparisons of the private and the two public facilities revealed some differences. For example, the study found that the private facility's average annual costs per inmate (\$15,578) were higher than comparable costs for one of the government-run facilities (\$13,195) but were lower than such costs for the other government-run facility (\$16,627). Construction and operational costs, including overhead and capitalization costs, were calculated for the three facilities. Costs were based on contracts negotiated with the facilities and included capitalization, lease, renovation, program development, and liability insurance. Costs that were not included in the calculations were Parole Division overhead costs (for community correctional facilities), state monitoring, medical costs allocated to the California Department of Corrections, inmate clothing, inmate pay, miscellaneous contracts, interest payments, and possible tax breaks. Also, there were inexplicable inconsistencies in the cost data obtained from two agencies within the California Department of Corrections. These inconsistencies may have affected the reliability of the cost estimates.

Attempts to compare the costs of the three community correctional facilities and other state correctional facilities were not fully successful. The cost calculations for the other state facilities used different components than did the calculations for the community correctional facilities. The latter costs included construction costs; however, the data for the other state facilities did not. Therefore, these cost calculations were not directly comparable. Further, given the unique characteristics of community correctional facilities, the usefulness of comparing these facilities to all other correctional facilities in California—many of which are likely to be very different from the community-based facilities—is questionable.

To assess quality of service, inmate and staff surveys were conducted at the three community correctional facilities and at two state prisons. However, due to small, nonrandom samples, the results could not be generalized to the inmate or staff populations at any of the facilities.

The California study also attempted to compare the three community correctional facilities and the state's other correctional institutions in

reference to recidivism rates. The study reported that, of the three community correctional facilities, one of the publicly managed facilities was "most impressive" in performance based on recidivism rates. Sufficient data were not available to adequately complete the analysis comparing the inmates released from the community correctional facilities to inmates released from other correctional institutions in the state.

In summary, the California study's methodological limitations prohibit drawing any overall conclusions about quality of service. The study acknowledged that any future comparative studies in California should "incorporate more inclusive and better-selected survey samples."

Tennessee Study (1995)

The Tennessee state legislature conducted a two-part study. One part was a cost assessment, and the other was an assessment of quality. Overall, this effort was the most systematic attempt of all the studies we reviewed to assess both the costs and quality of service. Three multicustody (minimum- to maximum-security) prisons in Tennessee were compared—one privately managed prison (Corrections Corporation of America) and two state-run prisons.

The facilities were generally comparable. All three were new (e.g., operational by mid-1992), and all had been accredited by ACA also had met other applicable professional standards. The inmates were similar on all demographic characteristics mentioned, except race. No information was provided on capacity level, but the institutions housed approximately the same numbers of inmates—private (961) and state (929 and 1,029).⁷ The study did not report any information regarding the inmate-to-staff ratios for the facilities.

Similar criteria were used to compare the operational costs of the facilities. The cost components and relevant adjustments—for direct and indirect costs—were agreed to by all parties (private and public) prior to data collection. Direct costs included salaries and fringe benefits, food, professional services, equipment, maintenance, travel, utilities, and supplies. Also, there was a cost provision for state employees to monitor the private prison. Costs for medical and mental health services were excluded. Indirect costs included salaries and expenses for corrections department administration and overhead, and interest on working capital.

⁷These data reflect the second year of operation.

Using data that covered July 1993 through June 1994, the study concluded that the costs of operating the private and both state facilities were virtually identical. Specifically, the comparison showed that the average daily operational costs per inmate for the private prison were \$35.39, versus \$34.90 and \$35.45, respectively, for the two public prisons.

The quality of service assessment consisted of three components—an audit (given a weight of 60 percent), a security and safety index (a weight of 25 percent), and a program and activity index (a weight of 15 percent). The study period for the quality of service assessment was March 1991 through September 1994.

An operational audit was conducted at each of the facilities by an inspection team, consisting of selected staff from the Tennessee Department of Corrections and the Corrections Corporation of America. The staff had varying degrees of expertise in major functional areas, such as administration, safety and physical plant, health services, treatment, and security. The team used a structured survey instrument to conduct a detailed review of records, observe operations and practices, and conduct interviews. By using the survey instrument, the team attempted to assess compliance with the various programs and practices within each of the functional areas. Examples of those programs and practices were administration (e.g., fiscal management and affirmative action); safety and physical plant (e.g., fire and occupational safety and sanitation); health services (e.g., dental care and pharmacy services); treatment (e.g., inmate orientation and social programs); and security (e.g., firearms and armory control).

The security and safety index considered many factors, including disciplinary reports, use-of-force incidents, assaults, deaths, injuries, and escapes. These reports were counted over a 15-month period (from July 1993 through September 1994) for each facility.

The program and activity index measured the percentage of inmates who were eligible for a work or program assignment but remained inactive and unassigned. The data used in this review were derived from monthly reports that measured actual numbers of prisoners assigned to the particular program or activity and the percent unassigned.

The results of the quality of service assessment stated that "all three facilities were operated at essentially the same level of performance." No differences were found among the facilities on the security and safety

index or on the program and activity index. All estimated variation across the facilities was due to differences in audit scores. The overall performance scores were 98.49 for the private facility and 97.17 and 98.34, respectively, for the two public facilities.

Washington Study (1996)

When the Washington State Legislative Budget Committee conducted this study, the state had no privately run prisons but was considering the feasibility of such. Therefore, using pertinent information available in other states, this study made several intrastate and interstate comparisons of correctional facilities. For example, the study compared the operational costs of the three Tennessee facilities (mentioned above) as well as three multicustody male facilities in Louisiana. Of the three facilities in Louisiana, two were privately operated (Corrections Corporation of America and Wackenhut, respectively), and the other was state operated. All three Louisiana facilities were in full operation by the beginning of 1991.

Each of the Tennessee prisons had a rated capacity for 1,336 inmates, and each of the Louisiana prisons had a rated capacity for 1,474 inmates. The average daily inmate population at each of the Tennessee prisons was slightly over 1,300, compared with a range of over 1,300 to more than 1,400 at the Louisiana prisons. Also, within each state, there was little difference among the prisons' inmates with respect to demographics such as education, age, offense types, and sentence lengths.

Several cost comparisons were made between the private and public facilities. First, the operational costs of the one private and the two public prisons in Tennessee (actual data for July 1993 through June 1994) were compared, as were the operational costs of the two private prisons and the one public prison in Louisiana (estimated data for July 1995 through June 1996). The unadjusted operational costs of the three Tennessee facilities were similar. However, after adjustments to equalize the numbers of inmates, the private facility's average daily operational costs per inmate (\$33.61) were slightly lower than the comparable costs for the two public facilities (\$35.82 and \$35.28, respectively). For the Louisiana facilities, the average daily operational costs per inmate for the two private prisons were \$23.75 and \$23.34, respectively, versus \$23.55 for the public facility.

The Washington study also compared the operational costs of one Washington state prison with the operational costs of one Tennessee state prison and the operational costs of one Louisiana state prison. The three

facilities were similar on some characteristics; however, adjustments were made to the costs and number of beds of the Tennessee and Louisiana facilities to further equalize the comparison. The study showed that the average daily operational costs per inmate for the Washington facility (\$44.52) were higher than the costs for the Tennessee (\$37.07) and the Louisiana (\$24.04) facilities.

The comparison of the Washington facility with the Tennessee and the Louisiana facilities was problematic. While the facilities were similar in capacity, there were differences in inmate demographics, such as race and offense type. Other factors (e.g., cost-of-living differences) served to complicate further the interstate comparisons. In any event, these interstate cost comparisons involved state-run facilities only and did not consider any private facilities.

Further, the Washington study looked at construction costs by comparing the estimated costs for Washington state to construct a planned multicustody public prison for males with a private company that was constructing a similar facility in Florida.⁸ In making the interstate comparison, the study noted that it focused on the "major elements contributing to capital costs," which included amounts and types of facility space, actual construction costs, and ancillary construction costs such as design and administration.⁹

Although the Washington study noted that the facilities were comparable in terms of size and inmate mix (e.g., "large multicustody"), it made cost and space programming adjustments to the facilities to further equalize the comparison. For instance, land and site-related costs, taxes, and unique local costs were excluded from the comparison. For the Florida facility, the study made upward cost adjustments to account for differences between the two facilities in labor and material costs, the later completion (about 2 years of construction inflation) of the Washington facility, and state oversight of the construction. For the Washington facility, the study made downward cost adjustments to account for differences between the two facilities, such as budget reductions of 20 percent, and space reductions of 18 percent to account for differences in inmate security levels and other space allocations. In addition, the study made downward cost and space adjustments to reflect the Florida facility's lower mix of close custody beds.

⁸When completed, the Florida facility is to be operated by Wackenhut.

⁹The private prisons in Tennessee and Louisiana could not be used for capital costs comparisons because the prisons were state built rather than privately built.

The study indicated that there were other differences in the space programming between the two facilities, for which no adjustments were made. For example, the Washington facility assumed single cells for "Close Housing and Administrative Segregation," while the Florida facility assumed double cells for those beds. Also, the Washington facility's minimum-security beds had relatively high per-bed space allocations, reflecting the incorporation of service and program space in the housing calculation. The space allocations for the Florida facility, however, reflected medium-security beds with centralized program and service space.

The study showed that the adjusted estimated per-bed cost for the Washington state facility (\$60,400 per bed) was approximately double the estimated cost for the Florida facility (\$33,900 per bed). The cost difference was explained largely as due to different operating and programming approaches or philosophies between the two states.

The Washington study concluded that privatization per se would not result in cost savings to the state. Rather, the report noted that savings could be accomplished through privatization or through changes in the state's operational policies and practices. For example, savings directly related to privatization would be due primarily to a private company's flexibility to operate outside state rules and procedures, collective bargaining agreements, and the state's employee compensation system.

Finally, the Washington study comparatively assessed the quality of service at the selected private and public prisons in Tennessee and Louisiana and two multicustody male facilities in Washington. While this portion of the study was not as detailed or as comprehensive as the portion involving costs, the quality assessment included visiting the prisons and reviewing institutional records for several topics, such as escapes, major disturbances, and inmate infractions. The study concluded that the private and public prisons studied within the respective states (Tennessee and Louisiana) generally were similar in quality of service. However, the study noted that Washington's two state-run facilities had more counselors per inmate than the facilities in the other states.

Factors That Could Affect Interstate Comparisons of Prison Costs And/or Quality of Service

Several factors could affect interstate comparisons of prison costs and/or quality of service. In addition to cost-of-living and other economic differences among the nation's geographic regions and states, these factors include the (1) extent of prison overcrowding, (2) history of court interventions, (3) status of ACA accreditation of facilities, (4) rate of incarceration (as an indicator of the punitiveness of the corrections system), and (5) rights of correctional employees to organize and bargain collectively.

Regarding the studies that we reviewed, the sponsoring states—Texas, New Mexico, California, Tennessee, and Washington—are located in the southern or western regions of the United States, the areas where most privatized facilities are located (see app. IV). Regional differences, such as cost of living, may affect comparisons with other states or regions. For example, the Washington state study adjusted Tennessee's operational costs upward by 20 percent to account for regional cost-of-living differences between the two states.

By definition, prison overcrowding¹ occurs when the number of inmates actually incarcerated exceeds the rated capacity² of the correctional facility. As table III.1 shows, the extent of overcrowding (if any) varied among the five states studied—at the time of initial privatization of selected correctional facilities within the respective state.³ For example, on January 1, 1991, California's prisons held 94,050 inmates, which was 41,352 inmates (or 78.5 percent) above the total rated capacity (52,698). In comparison, at that time, the average state correctional system was operating at 12.6 percent above rated capacity.

Texas was not reporting overcrowding on January 1, 1989. However, most states, including Texas and the other states studied, have been involved, at some point, in litigation challenging various conditions of confinement, such as overcrowding, in their prisons. The following general descriptions are examples of prison litigation that have occurred in the states studied:

¹Overcrowding, in and of itself, is not a violation of the Eighth Amendment's prohibition of cruel and unusual punishment unless specific effects flowing from that condition form the basis for a violation. See *Hoptown v. Ray*, 683 F.2d 1237, 1249 (9th Cir. 1982).

²The term "rated capacity" refers to the maximum number of beds or inmates assigned by a rating official to institutions within the jurisdiction.

³At the time of its study, the state of Washington had no privatized prisons. Thus, for the purposes of table III.1, we present data for Louisiana rather than for Washington. The Washington study included a comparative evaluation of three multicustody prisons (two private and one state-run) in Louisiana, as discussed in appendix II.

**Appendix III
Factors That Could Affect Interstate
Comparisons of Prison Costs And/or Quality
of Service**

- In Texas, the Ruiz v. Estelle⁴ line of decisions includes a 1980 ruling, which found that various conditions (such as overcrowding and inadequate sanitation, recreational facilities, and health care) within the Texas Department of Corrections violated the U.S. Constitution. Thus, the court appointed special masters and monitors to supervise the implementation of and compliance with its decree.
- In New Mexico, the Duran v. Apodaca⁵ line of cases includes a 1980 consent decree that contained mandatory and prohibitive injunctions relating to conditions and practices at the state's penitentiary. Among other subjects, the consent decree addressed living conditions, medical and mental health care, and inmate discipline.
- In California, various court decisions in the 1980s addressed segregation procedures, double-celling, and other conditions of confinement at several prisons located in northern areas of the state.
- In Tennessee, the 1982 Grubbs v. Bradley⁶ decision found that certain practices and conditions of confinement at the state's adult penal institutions were unconstitutional.
- In Louisiana, in the 1977 Williams v. Edwards⁷ decision, the court held that conditions at the state penitentiary at Angola violated the U.S. Constitution and certain state laws.

Another factor that could be considered in making interstate comparisons of correctional facilities is the extent of ACA accreditation. Obtaining ACA accreditation signifies that a facility has met minimum standards. ACA officials told us that, at the time of the respective state's initial privatization efforts, Texas and Louisiana had no ACA-accredited facilities; but New Mexico, California, and Tennessee had "some" accredited facilities. For these latter three states, the ACA officials were unable to specifically quantify the number of accredited facilities that existed when the respective state began its privatization efforts. However, the officials were able to tell us that, as of 1989, the state-run women's facility in New Mexico was not accredited by ACA.

⁴503 F. Supp. 1265 (S.D. Tex. 1980), aff'd in part and vacated in part, 679 F.2d 1115, amended in part, 688 F.2d 266 (5th Cir. 1982), cert. denied, 460 U.S. 1042 (1983).

⁵C.A. No. 77-721-C (D.N.M. July 14, 1980).

⁶552 F. Supp. 1052 (M.D. Tenn. 1982).

⁷547 F.2d 1206 (5th Cir. 1977).

Appendix III
Factors That Could Affect Interstate
Comparisons of Prison Costs And/or Quality
of Service

The degree of punitiveness of a corrections system, as reflected, for example, by the system's incarceration rate,⁸ may affect operating and programming approaches, and therefore, expectations of service. States with higher incarceration rates tend to be found in the west and south, although there is variation within regions. On December 31, 1988, Texas and New Mexico had incarceration rates of 240 and 180, respectively, while the national average rate for state institutions was 227. On December 31, 1990, the incarceration rates in California (311) and Louisiana (427) were higher than the national average rate for state institutions (227); Tennessee's incarceration rate, however, was lower (207). Furthermore, the Washington study found differences in programming (e.g., education and work programs) when comparing Washington with Tennessee and Louisiana.

Both opponents and proponents of privatization have suggested that active correctional employees' unions can affect whether a state decides to privatize corrections; for example, union agreements with the state may be a disincentive to privatization. According to the results of an April 1994 ACA survey of state adult correctional departments, the public employees of such organizations in the five states studied shown in table III.1 had the right to organize. However, the percentage of such correctional employees represented by unions in two of the states was 20 percent or below and one state did not provide data; in three states, the correctional employees could not bargain collectively; and in none of the states did the correctional employees have the right to strike.

Table III.1: Factors That Could Affect Comparisons With States Studied

Factors	States studied				
	Texas	New Mexico ^a	California	Tennessee	Louisiana
Year of initial operation of private facilities ^b	1989	1989	1991	1991	1991
Geographic region ^c	South	West	West	South	South
All state facilities^d					
Rated capacity	41,252	2,878	52,698	8,700	15,006
Inmate population	39,525	2,932	94,050	8,380	13,849
Under or (over) capacity	1,727	(54)	(41,352)	320	1,157

(continued)

^aAs defined earlier, the rate of incarceration is the number of sentenced prisoners (per 100,000 resident population) in correctional facilities.

Appendix III
Factors That Could Affect Interstate
Comparisons of Prison Costs And/or Quality
of Service

Factors	States studied				
	Texas	New Mexico ^a	California	Tennessee	Louisiana
Status of ACA accreditation of state correctional facilities ^c	none accredited	some accredited	some accredited	some accredited	none accredited
Incarceration rate ^d	240	180	311	207	427
Unions^e					
Right to organize	yes	yes	yes	yes	yes
Right to bargain	no	yes	yes	no	no
Right to strike	no	no	no	no	no
Percent of correctional employees represented	not applicable	20 percent	83 percent	55 percent	12 percent

^aThe New Mexico data apply to all state facilities, while the New Mexico study (see app. II) focused on women's correctional facilities.

^bThe year that inmates were first sent to privatized facilities in the respective state.

^cThe Bureau of Justice Statistics groups all 50 states and the District of Columbia into four regions—northeast (CT, ME, MA, NH, NJ, NY, PA, RI, VT), midwest (IL, IN, IA, KS, MI, MN, MO, NE, ND, OH, SD, WI), south (AL, AR, DE, D.C., FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV), and west (AK, AZ, CA, CO, HI, ID, MT, NV, NM, OR, UT, WA, WY).

^dTexas and New Mexico data are for January 1, 1989. California, Tennessee, and Louisiana data are for January 1, 1991.

^eACA provided us information on the general accreditation status of state facilities in each state studied at the time of privatization; specific numbers were not available.

^fIncarceration rates for Texas and New Mexico are for December 31, 1988. Incarceration rates for California, Tennessee, and Louisiana are for December 31, 1990.

^gResponses shown are from an ACA-sponsored survey of state adult correctional departments (April 1994) and refer only to public, state-level employees. Regarding the percentage of correctional employees represented by unions in Texas, the term "not applicable" was not defined. The data refer only to adult correctional departments.

Source: Data on geographic region and incarceration rates are from Kathleen Maguire and Ann L. Pastore, eds., *Sourcebook of Criminal Justice Statistics*, 1993, Department of Justice, Bureau of Justice Statistics, 1994. Data on overcrowding are from the *Corrections Yearbook*, 1989 and 1991, Criminal Justice Institute, Inc., 1989 and 1991. Data on accreditation status and union rights and representation are from ACA.

Use of Private Corrections in States

As table IV.1 shows, as of March 1996, a total of 47 private correctional facilities (secure facilities for adults) were being operated or being planned for operations by private companies in various states. These 47 private correctional facilities are located in 12 states. However, the most use (actual or planned) of privatized correctional facilities is in 3 states—Texas, with 21 facilities; Florida, with 7 facilities; and California, with 5 facilities.

Table IV.1: Private Adult Secure Correctional Facilities Operating or Planned, as of March 1996

State	Number of private facilities ^a	Security classification of facilities	Total rated capacity ^b
Arizona	2	minimum to medium	850
Colorado	1	medium	752
California	5	minimum	1,446
Florida	7	minimum/medium to medium	4,636
Kentucky	3	minimum	1,300
Louisiana	2	medium/maximum	2,948
Mississippi	2	medium	2,034
New Mexico	1 ^c	all security levels	322
Tennessee	1	medium	1,506
Texas	21	minimum to maximum	15,702
Utah	1	minimum/medium	400
Virginia	1	medium	1,500
Total	47		33,396

Note: According to the author of the data, the information presented is subject to change and represents the number of actual or planned facilities at a particular point in time only. We did not verify the accuracy or completeness of the information.

^aThe information presented includes only state-sponsored private facilities that primarily house inmates from the sponsoring state's correctional system.

^bThe term "rated capacity" refers to the maximum number of beds or inmates assigned by a rating official to institutions within the jurisdiction.

^cThis is an all-women's facility.

Source: Charles W. Thomas, Private Corrections Project, Center for Studies in Criminology and Law, University of Florida. Private Adult Correctional Facility Census, 9th ed. (Gainesville, FL: Mar. 1996).

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