

The Disparate Roots and Potential Development of Alaska's Public Behavioral Health System

Joseph D. Bloom, MD, and Aron S. Wolf, MMM, MD

Abstract

The community mental health center era in the United States was based on delivering services cataloged in three areas of behavioral health needs; (1) primary prevention of mental illness: the prevention of illness before it develops; (2) secondary prevention services: the early treatment of mental illness to reduce the severity of illness, and (3) tertiary prevention: treatment aimed at the reduction of the burdens of chronic mental illness. To attain these goals in a particular state in the United States has been very difficult, and Alaska, which has only been a state since 1959, is not close to attaining these goals. As a matter of fact, this paper will demonstrate that Alaska has had more trouble than most states in providing even rudimentary services in several of these areas. Yet, because of a curious constellation of factors, this paper presents the reader with a hopeful possible alignment of programs which, if more fully developed and linked in Alaska, can become an integrated public behavioral health system open to all the residents in the state.

INTRODUCTION

Alaska was purchased from imperial Russia in 1867, most likely to prevent the territory from being sold to the British or Canadian governments, and it wasn't until 1884 that the U.S. federal government made its first attempts to set up a rudimentary government consisting of several civil, judicial, and land districts in the Territory (Gruening, 1954). Significant development began in the late 1890s following the 1896 gold strikes in the Klondike region of Canada's Yukon Territory, and later the beaches of Nome.

In 1899, Congress established the first territorial criminal code for Alaska, a section of which authorized the commitment of mentally ill prisoners to an unspecified mental institution outside of the Territory. A year later, Congress established a code of civil procedure recognizing the "civilian insane" and authorizing the territorial governor to develop a contract with an asylum west of the Rocky Mountains, submitting the lowest bid, for persons legally adjudged "insane." In 1905, the Territory developed a contract with a privately owned hospital in Portland, Oregon, later named Morningside Hospital (Morningside Hospital, n.d.). This contract lasted until 1962.

In 1956 Congress designated the Alaska Territory as having fiscal and functional autonomy for the territory in the field of behavioral health which included the hospitalization of involuntary mental patients (Naske, 1960). This law also set aside one million acres of land, with the income derived from this land to be used in support of the building and operation of the new psychiatric hospital in the Territory, along with an associated community behavioral health program. Alaska became the 49th state of the United States in 1959.

Controversy surrounding the set-aside land surfaced in the late 1970s, when it became clear that the state government had never properly accounted for the revenue produced by these lands. A class action lawsuit against the state was filed, culminating in the Alaska Supreme Court decision in *Weiss v. State of Alaska* (1985). This decision ordered the state to reconstitute the land trust with the 500,000 acres of original land with an additional 500,000 acres and a cash allotment of \$200 million. It took another decade to create The Alaska Mental Health Land Trust (the Trust) to administer these lands with the income to be used for the benefit of all Alaskans with a "mental disability" (Shrader, 1987). The Trust today figures prominently in contemporary Alaska, both at the state hospital, the Alaska Psychiatric Institute (API), and in support of many statewide behavioral health programs (see below).

Building a Health and Behavioral Health Care System for Alaska Natives

In the 1954 Public Law 83-568, the U.S. Congress made major changes in the provision of health services for all Alaska Native and American Indian (AN/AI) people when it transferred the responsibility for health care from the Bureau of Indian Affairs to a new program in the United States Public Health Service, later named the Indian Health Service (IHS). This was a transfer of necessity, and nowhere in the United States were the health problems of Native peoples more dire than in Alaska (The Alaska Health Survey Team, 1954). The groundbreaking 1954 report "Alaska's health: A survey report" (also known as the "Parran Report") included a chapter on the behavioral health care provided at Morningside Hospital with very strong criticism of the Alaska commitment procedures leading patients to that hospital (The Alaska Health Survey Team, 1954).

When IHS began its work, the AN population had very severe health problems resulting from infectious diseases, particularly tuberculosis, along with childhood infectious diseases (The Alaska Health Survey Team, 1954). Over the next decade, IHS made steady progress in reducing the toll of these diseases, and by 1966 IHS developed its first small behavioral health program located in the Anchorage Area Office. This program provided psychiatric consultation to IHS hospitals in the north and west of the state and provided a liaison between IHS hospitals and API. At that time the IHS rural programs were organized around rural village health aides working with five regional hospitals located in the cities of Barrow, Kotzebue, Bethel, Dillingham, and Tanana, with a central referral hospital, the Alaska Native Medical Center (ANMC) located in Anchorage. ANMC provided specialty care to AN patients referred from the rural hospitals and as the general hospital for all AN/AI living in Anchorage. There was also a large IHS hospital located at Sitka in southeast Alaska, which provided care to AN people living in the Alaska panhandle, with some specialty care and access to AMMC as needed. Today, 99% of IHS's Alaska health services budget is allocated to tribal organizations (Indian Health Service, n.d.) to operate the prior IHS system.

The seminal event in the contemporary history of the AN population occurred with the passage of the Alaska Native Claims Settlement Act of 1971 (Jones, 1981). This law recognized 13 regional for-profit corporations and some 200 individual village corporations and provided the newly created corporations with ownership of land within the governmental structure of state and federal law. Around the same time, regional health programs, organized mainly as not-for-profit corporations, developed in each area corresponding to the large regional for-profit corporations. In 1997, the health corporations developed a central coordinating consortium, the Alaska Native

Tribal Health Consortium (ANTHC) to provide services for rural villages and hospitals at ANMC. In 2021, the Consortium had 17 members covering the entire state (ANTHC, 2021).

Today, these health entities and ANTHC provide sophisticated medical and behavioral health services to people in all areas of the state. In rural areas, they provide health services to AN/AI people living in the region and to all others wishing to use their services on an emergency or fee-for-service basis. The attached map, sourced from an ANTHC publication (ANTHC, 2021, pg. 12), delineates the approximate boundaries of all the AN health corporations.

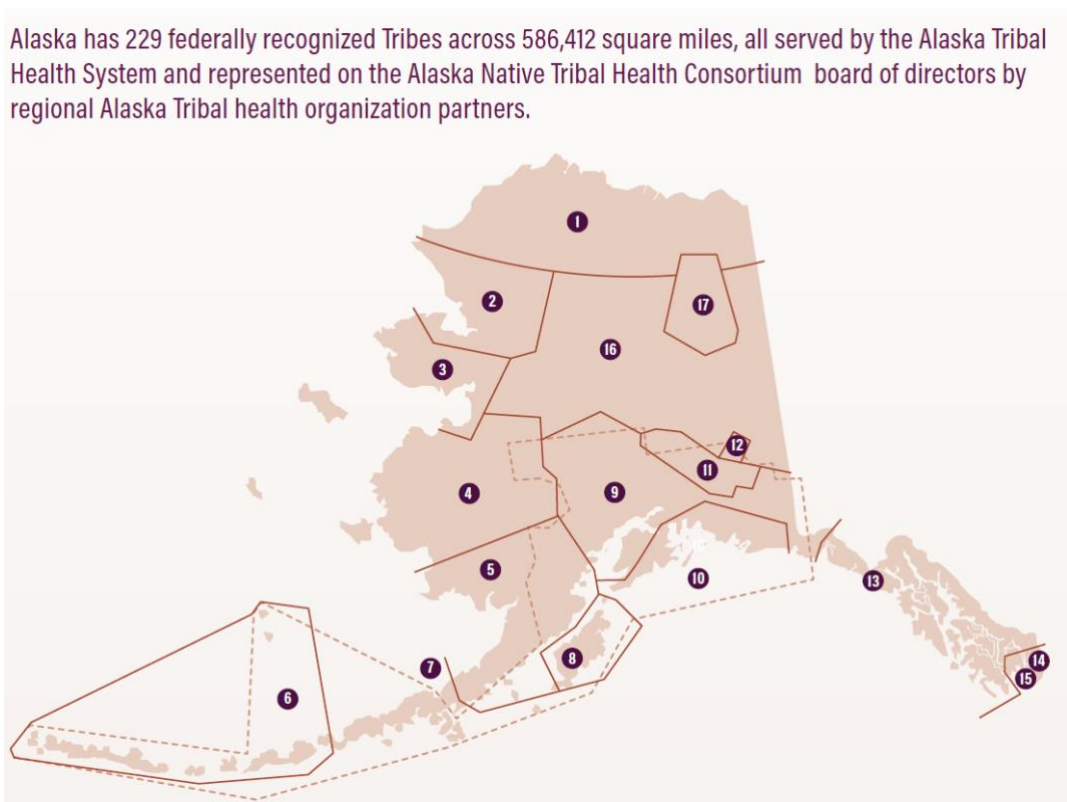


Figure 1. Alaska Tribal Health System (Source: ANTHC, 2021: *Our health in our hands*, pg. 12)

- | | |
|--|---|
| 1. Arctic Slope Native Association | 10. Chugachmiut |
| 2. Maniilaq Association | 11. Copper River Native Association |
| 3. Norton Sound Health Corporation | 12. Mt. Sanford Tribal Consortium |
| 4. Yukon-Kuskokwim Health Corporation | 13. SouthEast Alaska Regional Health Consortium |
| 5. Bristol Bay Area Health Corporation | 14. Ketchikan Indian Corporation |
| 6. Aleutian Pribilof Islands Association | 15. Metlakatla Indian Community |
| 7. Eastern Aleutian Tribes | 16. Tanana Chiefs Conference |
| 8. Kodiak Area Native Association | 17. Council of Athabascan Tribal Governments |
| 9. Southcentral Foundation (dotted line) | |

Alaska is often divided into 3 large geographic areas, the northern and western parts of the state bordering on the Arctic Ocean and the Bering Sea, South Central Alaska, and the Southeastern Alaska Panhandle. Table 1 provides further information about the major regional health corporations starting in the western part of the state and moving eastward, briefly providing general information about eight of the nine health corporations and the percentage of each area's population represented by AN/AI people. The table also includes the main cities for each corporation, the numbers of villages served, whether there is a rural hospital in the city, and the website for each corporation. Each one of these health programs is large and complex, and the reader is encouraged to review them to understand how important they are in organization and delivery of health services in all rural Alaska. We do highlight two of these corporations, the Southcentral Foundation and the SouthEast Alaska Regional Health Consortium, which have additional roles in their regions and in relation to the whole state.

Table 1
Alaska Native health corporations by regional population, West and Central Alaska

Name	Regional Population (% AN/AI)	Main Town or City	Hospital (Y/N)	Village	Websites
Arctic Slope Native Association	11,031 (52%)	Barrow	Y	5	https://arcticslope.org/
Maniilaq Association	7,793 (83%)	Kotzebue	Y	11	https://www.maniilaq.org/
Norton Sound Health Corporation	10,046 (75%)	Nome	Y	5	https://www.nortonsoundhealth.org/
Yukon-Kuskowim Health Corporation	27,000 ^a (84%)	Bethel	Y	44	https://www.ykhc.org/
Bristol Bay Area Health Corporation	± 8,000 (72%)	Dillingham	Y	28	https://www.bbahc.org/
Tanana Chiefs Conference	100,000 (8%) ^b	Fairbanks	N	39	https://www.tananachiefs.org/
Southcentral Foundation	400,000 (8%)	Anchorage	Y ^c	55	https://www.southcentralfoundation.com/
Kodiak Area Native Association	13,101 (14%)	Kodiak	Y ^d	5	https://kodiakhealthcare.org/

^a Combination of two boroughs

^b Includes Fairbanks and Anchorage region

^c Anchorage Native Medical Center (referral & specialty hospital)

^d Community hospital

The Southcentral Foundation, located in Anchorage and its populated adjacent areas, encompasses a total population of 400,000 people and provides health and behavioral health services to 55 rural villages and to all AN/AI people living in the southcentral area. Along with ANTHC, the Southcentral Foundation co-manages ANMC, the hospital responsible for delivering both general and specialty care to all AN/AI individuals in the Anchorage area and all AN/AI individuals referred from rural villages and hospitals for specialty medical services. Non-AN/AI persons are referred to physicians and the general hospitals in the private health care community. The Southcentral Foundation also provides significant psychiatric and other behavioral health services to ANMC and to the Foundation's outlying villages. The Southcentral Foundation is also one of the cooperating programs that are part of the Trust's "Crisis Now" initiative aimed at developing a new system of behavioral health crisis care in the Anchorage, Matanuska-Susitna (Mat-Su), and Fairbanks areas of the state.

Southeast Alaska is a unique part of the state, in many ways isolated from the western parts of the state. The area contains some 73,000 people, of which approximately 20% are AN/AI (Alaska Department of Labor, 2022). The area has several smaller cities, including Juneau (the state capital) and Ketchikan, each with hospitals and the area AN health corporation, the SouthEast Alaska Regional Health Consortium (SEARHC). SEARHC is large and is represented throughout all of southeastern Alaska. SEARHC is headquartered in Juneau, operates a general hospital in Wrangell and a multi-specialty hospital in Sitka, which includes a psychiatry service and a general hospital that used to be named Sitka General Hospital. SEARHC has 27 locations in its catchment area. This corporation has cooperative relationships with non-Native health facilities and treats both Native and non-Native patients in its various programs. It is part of ANTHC and has further specialty back-up with ANMC in Anchorage.

In summary, ANTHC, together with the regional health corporations, have developed significant statewide health and behavioral health programs, including recent additions of a village behavioral health aide training program and a behavioral health wellness program located in Anchorage that provides behavioral health evaluation and treatment services across the state via a telehealth network.

The State Hospital: The Alaska Psychiatric Institute (API) – 1962-present

The Alaska Psychiatric Institute (API) opened in 1962 with a capacity of 225 beds and the ability to expand to 450 beds as future need required. It was built for the treatment of all mentally

ill Alaskans, voluntary or committed, Native or non-Native, adult or child. In its first year of operation, API admitted 217 patients, 27% with developmental disabilities who were later transferred to a new facility in Valdez following the 1964 Good Friday earthquake. Seventy-eight percent of the patients in its first year were voluntary, with AN patients comprising 28% of the total admissions (Rogers, 1964). By 1966 all remaining patients at Morningside Hospital were transferred to API.

The original API functioned for over 40 years providing a broad range of services to all Alaskans. However, in the early years of this century, API was judged to have too many beds and an aging building. A new API with only 80 beds was planned and opened in 2005. Its bed limitation reflected both state fiscal constraints and national trends in state hospital bed-reduction. (Torrey et al., 2012; SitNews, 2005). The 80 beds were divided into two 25-bed units for acute voluntary and involuntary civil patients, and 3 separate 10-bed units, one each for adolescents, longer term adult patients, and for forensic patients requiring competency to stand trial evaluation or restoration services.

This second phase of API has not gone well, especially over at least the last decade. Problems were summarized in a 2018 report to the state legislature noting that the hospital was not able to keep all its 80 beds open on a consistent basis due to staff shortages, assaults against patients and staff, and structural disrepair (Burns & Hale, 2018). In 2019, the state contracted briefly with a private hospital management company to run the hospital, and in the same year, API was threatened with the loss of its CMS certification. The API Archives (API, n.d.) present detailed consultation reports that the state pursued to help resolve many of these administrative problems.

As of the writing of this paper in 2024, API continues to experience staffing, programmatic, and facility problems (Alaska Ombudsman, 2022) but remains the only facility in the state offering longer-term treatment services especially for involuntary court-committed patients. As of October 2024, the adult civil units had 60 beds in operation, with 59 in use and a waiting list of 15 individuals; the forensic unit maintained its maximum capacity of 10 beds, all occupied, and a waiting list of 56 individuals; and the adolescent unit had 7 of its 10 beds occupied with a waiting list of 2 (API, 2024). We were unable to attain any detailed longitudinal or current demographic, legal status, or length-of-stay data about these patients either in the hospital or on waiting lists. We presume that most or all of the 76 patients in the hospital were involuntary patients and that the hospital now serves very few, if any, voluntary adult patients.

It is important to note that insanity acquittees are no longer part of API's patient population following multiple homicides committed by an insanity acquittee on work release from API in 1982 (Brennan, 2001) and due to effects of the 1983 Hinckley verdict which led many states to change their insanity defenses (Steadman et al., 1993). These events quickly led to the de facto end of successful insanity defenses in Alaska (Gordon et al., 2016). This change in the state's insanity laws has now created a population of prison inmates, Native and non-Native, with severe mental illnesses in Alaska's prisons (Bloom & Kirkorsky, 2021).

The adolescent unit also needs some further explanation. Although this paper focuses on involuntary civil and criminal court adults, Alaska has significant problems with providing necessary care and treatment to its child and adolescent population, especially in providing a legally necessary range of community treatment programs particularly in the rural areas of the state. On December 15, 2022 the Civil Rights Division of the U.S. Department of Justice found that there was "reasonable cause to believe that the State of Alaska violates Title II of the Americans with Disabilities Act (ADA) 42 U.S. 12132, by failing to provide services to children with behavioral health disabilities in the most integrated setting appropriate to their needs" (United States Department of Justice, 2022). The findings were based on the United States Supreme Court decision in *Olmstead v. L.C.* (527 U.S. 581, 607 (1999)) in which the state of Georgia was found deficient in not providing hospitalized behavioral health patients with a variety of community behavioral health services which they needed in order to live successfully in the community. Although a focus on children and adolescents is not a major focus of this paper, as will be seen in the discussion, it merges very closely to the problems experienced by API's adult patients.

As mentioned, API's adult population is now almost entirely composed of involuntary patients, including those hospitalized for evaluation and treatment under Alaska's civil commitment law and those patients involuntarily hospitalized for evaluation for competency to stand trial and, where necessary, for competency for restoration services. Each area will be discussed briefly.

Civil Commitment

Alaska's civil commitment laws apply equally to all Alaskans. The very complicated civil commitment issues, legal and jurisdictional, found in civil commitment law that exist between state, federal, and tribal governments on many American Indian reservations do not apply in Alaska (Manson et al., 1987; Shore et al., 2008).

Alaska's civil commitment statutes (AS. 47.30.700 - 47.30.915, 2020) are like those in other states, except in relation to medication refusal (see below). The process begins with the initiation of an involuntary commitment petition, which in turn can lead to an Emergency Detention in an Evaluation Facility for up to 72 hours at API or in general hospitals in Fairbanks, Juneau, and in the Matanuska-Susitna Borough (Mat-Su). It is now possible to have a further 7-day extended evaluation and treatment period in these hospitals. After evaluation, the person is either discharged or scheduled for a hearing for a possible 30-day commitment. Case law and statutes make it clear that persons can only be held in jails for transport purposes while waiting for a bed in an evaluation center. Patients who are committed for 30 days usually go to API, though new provisions allow some general hospitals to retain some patients following a 30-day commitment hearing. Ninety and 180-day commitments are possible following the initial commitment period.

The authors were unable to access any system-wide longitudinal or current data, rural or urban, Native or non-Native, that report the actual numbers of and where the patients are detained and then those who are released or move on to the various levels of commitment.

Competency to Stand Trial Evaluation and Restoration Services (CST)

Alaska has a familiar statutory process for determining competency to stand trial (AS. 47.100, 2020) and possible commitment for restoration services following a finding of incompetency (AS. 12.110, 2020). If competency restoration is deemed necessary, the individual is committed to the custody of the commissioner of DHHS for up to 90 days for treatment with renewable period as necessary.

In practice the 10-bed forensic unit at API was never adequate to handle the volume of patients needing CST services. In 2018, the state and the Trust entered a contract to conduct a study focused on the adequacy of API's forensic services (Alaska Department of Health and Social Service, 2019). The report made recommendations to immediately increase the number of forensic beds at API to 20, and ultimately to 25, and to explore options for an additional jail and/or a community-based restoration program (Felthous & Bloom, 2018; Ash et al., 2020). Data presented to the Alaska Legislature, prior to these changes, noted that between FY2020-2022 there was an average of 30 individuals on the waitlist for CST restoration, most waiting in jails an average of 158 days for admission to API's 10-bed forensic unit (State of Alaska House Health and Social Services Finance Subcommittee, 2022).

As of the writing of this paper, the state has begun to initiate a 20 slot increase in the competency to stand trial cases which will include 10 outpatient slots for individuals who are on bail and 10 additional slots within the correctional system. Each of these 20 new slots may be used either for competency evaluations or restoration services. They will be staffed with appropriate professional personnel, and the new service became operational in the spring of 2024.

The Alaska Mental Health Trust and the “Crisis Now” Initiative

In 2019, as these problems continued to exist at API, the Trust, with the support of state government, focused attention on the development of new community behavioral health crisis services. The Trust contracted with Recovery Innovations, Inc., a Phoenix-based company knowledgeable in the development of these services. Their report, “Crisis Now,” focused on Alaska’s most populous areas, Anchorage, its neighboring Mat-Su Borough, and the Fairbanks North Star Borough (Recovery Innovations, Inc., 2019; see also Alaska Mental Health Trust Authority, 2020).

The major elements of the new program have significant national support, reflected in a recent conference entitled REIMAGINE (2022), which was co-sponsored by over 30 prestigious behavioral health organizations. The model endorsed the development of a model crisis program with three interlocking components. First, the regional or statewide crisis-call centers associated with the new 988 national behavioral crisis phone number would segregate behavioral health crises phone calls from the traditional 911 phone service. The crisis phone service would lead, as necessary, to a referral to a centralized 24/7 mobile crisis team, which in turn is backed by newly developed crisis stabilization and short-term treatment facilities (National Action Alliance for Suicide Prevention, 2016), which are centers that are designed, in part, to relieve the pressure on general hospital emergency departments and in-patient units. As a result, the role of general hospitals would be significantly reduced, as they would serve more as referral and/or back-up facilities for the new crisis program. State hospitals continue in their role as longer-term facilities for both voluntary and involuntary patients. A detailed “toolkit” for the development of these services was published by the federal government in 2020 (Substance Abuse and Mental Health Services Administration, 2020).

The Alaska Legislature

Important components of the “Crisis Now” model were adopted from a review of functioning behavioral crisis programs in Arizona’s Maricopa and Pima Counties. In Arizona statutes, these programs also function as civil commitment screening agencies (AZ. Rev. St. 36.520, 2022), components of Arizona’s civil commitment process (AZ. Rev. St. 36 Articles 4, 5, 2022; Balfour et al., 2016). This association between the new behavioral health crisis services and civil commitment was adopted in Alaska, and together with other elements of the program, required that the Alaska legislature pass necessary significant enabling legislation. It took two legislative sessions to finalize the new statutory provisions with the final bill passing in 2022 (AK HB 272).

The new legislation is complicated and was reviewed in detail in a Trust publication (Alaska Department of Health, Office of the Commissioner, 2022). In summary, the new statute:

1. Recognized two types of new residential facilities, a Crisis Stabilization Center, a facility where a person can be held for 24 hours, and a Crisis Residential Center with the ability to house crisis patients for treatment either voluntarily or involuntarily as a Designated Evaluation and Treatment Center (DETs) within Alaska’s civil commitment statutes (AS. 47.30.700 - 47.30.915, 2020).
2. Made changes in the definition of a “mental health worker,” specifying who can initiate an involuntary commitment petition hold in a Crisis Stabilization Center and broadened the definition of “mental health worker” to who can provide designated services in these centers.
3. Made it clear that the new centers were open to walk-in clients and to police officers who, instead of filing criminal charges, could bring an individual in a behavioral health crisis to these centers, while preserving the possibility of filing charges later if the person did not cooperate with the program.
4. Sets out criteria for the use of involuntary psychotropic medication for patients held in the new crisis facilities to be used in dangerous crisis situations, without court approval, or in continuous use with court approval. These provisions preserve Alaska’s strong position on the civil rights of involuntary institutionalized persons who refuse psychiatric medications in non-dangerous situations. This is outlined in the Alaska Supreme Court’s decision, *Myers v. Alaska Psychiatric Institute* (2006), which made it clear that in a hearing regarding treatment refusal a court would have to go beyond the typical state standard of incompetency to make treatment decisions to override a refusal

(Hinton & Forrest, 2007). *Myers*, now codified in Alaska law (AS.30.839, 2021), gives these legal rights to persons held involuntarily in the new crisis centers.

Initial Crisis Now Programs

As mentioned, initial Crisis Now funding is focused on the Anchorage, Mat-Su, and Fairbanks North Star areas. Initial seed funding came from the Trust with the expectation that long-term financing would come from Alaska's 1115 CMS Waiver provisions (Recovery Innovation, Inc., 2019). Initially, the City of Fairbanks received a \$937,000 Trust grant to develop a mobile crisis team and for associated planning for further development (Alaska Behavioral Health, n.d.). In Anchorage, the local fire department contracted with the Borough to provide mobile crisis services and planning for the development of a mobile crisis team in the Mat-Su Borough, which already has a functioning general hospital psychiatric program that participates in the civil commitment process. Also in Anchorage, the Trust funded a \$400,000 grant to the Providence Health system and a \$485,000 grant to Southcentral Foundation and ANTHC to study the development of the 24-hour crisis facilities and associated case management services (Alaska Mental Health Trust Authority, 2021). These facilities at ANMC and at Providence are now in the initial construction phase with some programming already operational.

DISCUSSION

This paper highlights four programs, AN health corporations with ANTHC, State of Alaska programs, Crisis Now, and programs for children and youth. These programs are key components of a possible future coordinated statewide behavioral health program in Alaska. Of the four, only the AN health corporations with ANTHC have developed significant current service delivery programs available to all Alaskans in rural and semi-rural areas of the state and to AN/AI individuals in Anchorage and in other cities. The responsibility for long-term hospital level treatment of severely mentally ill children and adults, especially those hospitalized involuntarily, has belonged to the state of Alaska since before API opened in 1962, with at that time a proposed maximum capacity of 450 beds. This number of beds was never achieved, and API has demonstrated significant problems since the opening of the new 80-bed API in 2005. These problems are not resolved. The third program, Crisis Now, brought forward by the Alaska Mental Health Trust, proposes a new approach to the development of behavioral crisis services designed

partly to reduce overcrowding in general hospitals, jails, and perhaps at tertiary care facilities like API. This program is in its infancy. The fourth area corresponds with the inadequacy of Alaska's child and adolescent inpatient and outpatient care in the state (United States Department of Justice, 2022). These problems are consistent with the state's clear responsibility to provide an appropriate mix of inpatient and outpatient programs for all of the serious mentally ill. Each of these four areas will be discussed.

The AN health corporations and ANTHC trace their formation to the Alaska Native Lands Claims Act of 1971. This settlement agreement was unique and broke with the past relationship between the federal government and America's Native peoples, which may be traced in part to the United States Supreme Court decision in *Cherokee Nation v. Georgia (1831)*. This decision started basically as a land dispute settled in favor of tribal sovereignty, which defined the lands in question as "domestic dependent nations" related primarily to the federal government. This decision resulted later in the formation of AI reservations across the continental United States. In contrast to the reservation system, the 1971 Alaska Settlement Act was based primarily on providing the AN people and their distinct regional and village corporations with land and fiscal resources to define their own future within the structure of settlement itself and within state and federal law.

The regional health programs together with ANTHC and ANMC represent a uniquely integrated system encompassing all areas of the state. Alaska's rural villages have health programs based on the work of designated health aides and, now in many villages, other primary care health personnel including behavioral health aides trained under the auspices of ANTHC. All have telehealth connections with regional clinics or rural hospitals. Each regional health corporation has a behavioral health program that emphasizes suicide prevention and substance abuse prevention and behavioral health treatment for a wide range of individuals and family services. Taken together, these corporations exemplify a traditional public health model of organized service delivery in catchment areas made up of people having strong cultural ties.

In Alaska, the state bears the statutory responsibility for hospital-level care for severely mentally ill patients requiring voluntary or involuntary hospitalization (Caplan, 1964). As time has progressed, there are now general hospital psychiatric beds in Fairbanks, Anchorage, Mat-Su, and in some of the cities of southeast Alaska, which mostly serve voluntary patients and (as previously described) some at the early phase of civil commitment involuntary hospitalization. But it is API, with only an 80-bed total capacity and a significant history of internal problems, which has demonstrated over many years that it has problems carrying out its statutorily directed

responsibilities, for all patient groups, but especially for involuntary children, adolescents, and adults. The problems related to involuntary adults were clearly illustrated recently in the case of *Disability Law Center v. State of Alaska* (2020). The case was filed on behalf of patients either boarded in general hospital emergency rooms, termed psychiatric boarding (Bloom, 2015), or detained in Alaskan jails while waiting for a bed at API. Judge William F. Morse issued his final order in the case in 2021 by reaffirming state law which prohibits detaining in jails patients on civil commitment petitions for any reason other than arranging for immediate transfer to the proper facilities. Instead of immediately sanctioning the state of Alaska, the Judge granted the state and the Trust time to begin implementing the new “crisis now program (*Does v. State of Alaska, 2021*).

Although the case focused primarily on civil commitment, the decision also recognized the significant problems at API in the delivery of CST services, as evidenced by the long waiting lists of jail detainees waiting for a bed at API. Similar situations have been reviewed by the Ninth Circuit District and Appeals courts, first in Oregon, (*Oregon Advocacy Ctr. v. Mink, 2003*), and later in the state of Washington (*Trueblood v. Washington State Department of Social and Health Services, 2016*). In these decisions the Ninth Circuit ordered strict limits on the number of days that detainees could be kept in jail after a court has ordered them transferred to a psychiatric hospital for competency to stand trial evaluation or restoration services. Alaska is within the jurisdiction of the Ninth Circuit Courts, and the state might have a difficult time justifying its current practice of detaining individuals in jail for long periods of time while they wait for a hospital bed at API (Bloom & Kirkorsky, 2021, Felthous & Bloom, 2018). Opening the new 10 slots within the Department of Corrections should be helpful but they will likely not pass court review if they are just custodial in nature. Active evaluation and treatment will need to take place within a therapeutic environment.

The Crisis Now programs are in their earliest phases of development in the Anchorage-Mat-Su region and in Fairbanks Boroughs. These will not be easy programs to develop and operate, and continuous advocacy will be needed. Important at the beginning is a clear realization that crisis treatment programs will only succeed if options for discharge of patients from these new facilities are readily available. API has a very important role in this calculation as the new crisis centers will also be part of the state’s civil commitment program, which has been designed to evaluate and provide short-term treatment to some involuntary patients. However, regardless of how the client entered a crisis center, if there is limited availability for discharge, the new centers will have the same boarding problems as now exist in community hospital emergency rooms and jails.

The fourth program focuses on children's programs secondary to the 2022 federal Justice Department's finding that the state of Alaska has failed in the provision of required services for children in the most integrated community-based services appropriate to their needs, (U.S. Department of Justice, 2022). In reality, the needs of adults and children are very similar; they require adequate institutional and community programs that include the provisions of the new crisis programs, as described in this paper. Currently, there are not enough hospital psychiatric beds, voluntary or involuntary, at API or other in-state facilities to provide inpatient services for either children or adults. For adults, the result is the spill over of adults from civil commitment into the criminal justice system (Hansen et al., 2023). The same is true for children and adolescents. The use of behavioral psychiatric beds increased in the private community, and when the in-state supply of beds and community programs were exhausted, the state resorted to contracting with out-of-state psychiatric residential treatment facilities (in-patient mental health treatment facilities for Medicaid-enrolled patients under 21), where there are now children and adolescents receiving services country-wide (U.S. Department of Justice, part A, 5-9, 2022).

One answer to the overuse of institutions was for the state to improve the front-end of the continuum of behavioral services outlined in the Crisis Now initiative in the Anchorage, Mat-Su, and Fairbanks areas. With the passage of necessary enabling legislation, this initiative is in a developmental state; however, there remains a question as to whether this approach for children and adults can be implemented in other parts of the state, particularly in rural Alaska.

Following the 2022 Department of Justice's investigation report, the State of Alaska's Departments of Health and Community Services formed the Behavioral Health Roadmap Project for Alaska Youth (Alaska Behavioral Health Roadmap Project, n.d.). In the fall of 2023, this Project issued a draft report that summarizes statewide meetings held in five distinctive areas of the state (Alaska Behavioral Health Roadmap Project for Alaska Youth, 2023). The report focused on the review of current regional programs and future needs necessary to bring each area of the state into compliance with the findings of the Department of Justice's earlier investigation (United States Department of Justice, 2022). The Project's draft report catalogues possible components of a suitable program for children, which already exists in some of the five areas of the state.

Earlier in the paper, the authors summarized some of the characteristics of each of the larger AN health corporations that already have the equivalent of central call centers, the ability to transport patients from villages to towns with hospitals, and tele-health links to villages and cities for psychiatric consultation as may be needed. In some of the rural towns, there are also residential

treatment programs that provide residential services for substance abuse and some chronic behavioral health patients. Currently, the rural hospitals and their physicians and advanced practice nurses provide the best approach to short-term crisis intervention and management of severe behavioral crises with eventual transfer to a longer-term crisis stabilization center in the same city or in larger cities in Alaska. With this approach, starting a crisis stabilization center in a selected rural city with a hospital and sufficient population base to support the additional requirements of these programs does seem feasible. The best fit for starting such a program might be the Arctic Slope Native Association (population 11,031) in northwest Alaska, the Yukon-Kuskokwim Health Corporation and its main town, Bethel, (regional population 18,666) in western Alaska, or the Norton Sound Health Corporation headquartered in Nome (regional population 10,489).

In conclusion, Alaska is unique in the strength and organization of its rural programs under the leadership of the AN regional health corporations and ANTHC. These programs have had many successes and can accomplish much more in the future. The Trust, a significant positive force in Alaska's behavioral health programming, has now invested in a nationally recognized approach to behavioral crisis care. It is up to the State of Alaska to further invest in building the crisis program, to fully rehabilitate API as the anchor for one end of the behavioral health program spectrum of care for the state for adults, and adequate funding for the community hospitals and other community services for local inpatient care for children and adults.

Finally, all the programs discussed in this article need to develop functional information systems both within and between these programs. This is critical for any future development of a true integrated statewide public behavioral health program for the state of Alaska.

REFERENCES

- Alaska Behavioral Health. (n.d.) About our Services. <https://alaskabehavioralhealth.org/what-we-do/about-our-services/>
- Alaska Department of Health, Office of the Commissioner. (2022). Crisis Stabilization in Alaska: Understanding HB 172. <https://health.alaska.gov/Commissioner/Documents/PDF/Crisis-Stabilization-in-Alaska-HB-172.pdf>
- Alaska Department of Health and Social Services, Division of Behavioral Health (2019). *Forensic Psychiatric Hospital Feasibility Study*. <https://dfcs.alaska.gov/API/Pages/AdminChanges.aspx>

- Alaska Department of Labor and Workforce Development. (2022). Population estimates. <https://live.laborstats.alaska.gov/pop/index.html>
- Alaska Mental Health Trust Authority. (2020). Crisis Now: Enhancing Alaska's psychiatric continuum of care: Presentation to the Alaska House Judiciary Authority. http://www.akleg.gov/basis/get_documents.asp?session=31&docid=60581
- Alaska Mental Health Trust Authority. (2021). Trust grants 885,000 to improve mental health crisis stabilization in Anchorage. <https://alaskamentalhealthtrust.org/news/trust-grants-885000-to-improve-mental-health-crisis-stabilization-in-anchorage/>
- Alaska Native Tribal Health Consortium (ANTHC). (2021). Our health in our hands. <https://www.anthc.org/wp-content/uploads/2021/01/Our-health-in-our-hands.pdf>
- Alaska Ombudsman. (2022). Public Summary Report, Ombudsman Investigation 2020-11-1469, Alaska Psychiatric Institute. https://ombud.alaska.gov/wp-content/uploads/2022/02/2020-11-1469-Ombudsman-Public-Report-API-2-7-22_Redacted.pdf
- Alaska Psychiatric Institute (API). (n.d.). Archives. <https://dhss.alaska.gov/API/Pages/AdminChanges.aspx>
- Alaska Psychiatric Institute (API). (2024). Current bed availability. <https://dfcs.alaska.gov/api/Pages/default.aspx>
- AS. 12.47.010 (2020)
- AS. 12.47.030 (2020)
- Alaska Behavioral Health Roadmap Project for Alaska Youth. (n.d.) About. <https://health.alaska.gov/Commissioner/Pages/bhroadmap/default.aspx>
- Alaska Behavioral Health Roadmap Project for Alaska Youth. (2023). Record of Regional Meetings + Thematic Analysis. https://health.alaska.gov/Commissioner/Documents/bhrm/DRAFT_BHRM_Report_2.16.24.pdf
- Ash, P., Roberts, V. C., Egan, G. J., Coffman, K. L., Schwenke, T. J., & Bailey, K. (2020). A jail-based competency restoration unit as a component of a continuum of restoration services. *The Journal of the American Academy of Psychiatry and the Law*, 48(1), 43–51. <https://doi.org/10.29158/JAAPL.003893-20>
- Balfour, M. E., Tanner, K., Jurica, P. J., Rhoads, R., & Carson, C. A. (2016). Crisis Reliability Indicators Supporting Emergency Services (CRISES): A framework for developing performance measures for behavioral health crisis and psychiatric emergency programs. *Community Mental Health Journal*, 52(1), 1-9. <http://doi.org/10.1007/s10597-015-9954-5>

- Bloom, J. D. (2015). Psychiatric Boarding in Washington State and the Inadequacy of Mental Health Resources. *Journal of the American Academy of Psychiatry and the Law*, 43(2), 218-222. <https://jaapl.org/content/43/2/218.long>
- Bloom, J. D., & Karkowski, S. E. (2021). *Mens Rea*, Competency to stand trial and guilty but mentally ill. *Journal of the American Academy of Psychiatry and the Law*, 49(2), 241-145. <https://doi.org/10.29158/JAAPL.200105-20>
- Bloom, J. D., & Karkowski, S.E. (2021). The Ninth Circuit Court of Appeals and jail-based competency evaluation and restoration. *Journal of the American Academy of Psychiatry and the Law*, 49(3), 415–421. <https://doi.org/10.29158/JAAPL.200099-20>
- Brennan, T. (2001). *Murder at 40 below: True crime stories from Alaska* (pgs. 50-64). Kenmore, WA: Epicenter Press.
- Burns, R., & Hale, R. (2018). The Alaska Psychiatric Institute, A presentation to the Health and Social Services Committee of the Alaska House of Representatives. https://www.akleg.gov/basis/Meeting/Detail?Meeting=HHSS%202018-04-10%2015:00:00#tab3_4
- Caplan, G. (1964). *Principles of preventive psychiatry*. New York, NY: Basic Books.
- Cherokee Nation v. Georgia*, 30 U.S. 1 (1831)
- Disability Law Center of Alaska, Inc., v. State of Alaska; Department of Health and Social Services; et al.* 3AN-18-9814 CI (2020). <https://www.dlcak.org/files/6515/9917/6275/3AN-18-09814CI.pdf>
- Does vs. State of Alaska, The Disability Law Center of Alaska, Inc. v. State of Alaska et al.* 3AN-18-02687PR, 3AN-18-02688PR (2021). <https://public.courts.alaska.gov/web/media/docs/dlc/order.pdf>
- Felthous, A., & Bloom, J. D. (2018). Jail based competency restoration. *Journal of the American Academy of Psychiatry and the Law*, 46(3), 364-372. <https://doi.org/10.29158/JAAPL.003772-18>
- Gordon, S., Piascki, M., Kahn, G., & Nielson, D. (2016). *Review of Alaska mental health statutes*. UNLV William S. Boyd School of Law Legal Studies Research Paper. <https://dx.doi.org/10.2139/ssrn.2771468>
- Gruening, E. (1954). *The State of Alaska, A definitive history of America's northernmost frontier*. New York, NY: Random House.

- Hansen, T. E., Blekic, A., & Bloom, J. D. (2023). COVID-19, *Mink-Bowman*, and court-ordered psychiatric services in Oregon. *Journal of the American Academy of Psychiatry and the Law Online*, 51(3), 411-420. <https://doi.org/10.29158/JAAPL.230056-23>
- Hinton, J., & Forrest, R. R. (2007). Involuntary non-emergent psychotropic medication. *Journal of the American Academy of Psychiatry and the Law*, 35(3), 396-398. <https://jaapl.org/content/35/3/396>
- Indian Health Service (IHS). (n.d.). Alaska area. <https://www.ihs.gov/alaska/>
- Jones, R. S. (1981). Alaska Native Claims Settlement Act of 1971, History and Analysis, Report No-127. http://www.alaskool.org/projects/anca/reports/rsjones1981/anca_history71.htm#:~:text=On%20December%2018%2C%201971%2C%20Public,they%20have%20lived%20for%20
- Manson, S. M., Bloom, J. D., Roger, J. L., & Neligh, G. Emerging Tribal Models for the civil commitment of American Indians. (1987). *American Indian and Alaska Mental Health Research*, 1(1), 9-25. <https://doi.org/10.5820/aian.0101.1987.9>
- Morningside Hospital. (n.d.). The history. <https://www.morningsidehospital.com/about-morningside/>
- Myers v. Alaska Psychiatric Institute*, 138 P.3d 238 (Alaska 2006)
- National Action Alliance for Suicide Prevention: Crisis Services Task Force. (2016). Crisis now: Transforming services is within our reach. Washington, DC: Education Development Center, Inc. <https://theactionalliance.org/sites/default/files/crisisnow.pdf>
- Olmstead v. L.C.*, 527 U.S. 581, 607 (1999)
- Naske, C. M. (1960). Bob Bartlett and the Alaska Mental Health Act. *Pacific Northwest Quarterly*, 71(1), 31-39. <https://www.jstor.org/stable/40490005>
- Oregon Advocacy v. Mink*, 322 F. 3d 1101 (9th Cir. 2003)
- Public Law 83-568, Chapter 658 (1954)
- Public Law 84-830, Chapter 772 (1956)
- Recovery Innovation, Inc. (2019). Crisis Now Consultation Report. <https://alaskamentalhealthtrust.org/wp-content/uploads/2020/01/RI-Crisis-Now-Alaska-Consultation-Report-12.27.19.pdf>
- REIMAGINE. (2022). A Week of Action to Reimagine Our National Response to People in Crisis. <https://reimaginecrisis.org/>

- Rogers, S. J. (1964). The Alaska Psychiatric Institute. I. The medical program and the first year of operation. *Psychiatric Services*, 15(5), 243-247. <https://doi.org/10.1176/ps.15.5.243>
- Schrader, J. L. (1987). The Alaska mental health lands. *American Journal of Psychiatry*, 144(1), 107-109. <https://doi.org/10.1176/ajp.144.1.107>
- Shore, J. H., Bloom, J. D., Manson, S. M., & Whitener, R. J. (2008). Telepsychiatry with Rural American Indians: Issues in civil commitment. *Behavioral Sciences and the Law*, 26, 287-300. <https://doi.org/10.1002/bsl.813>
- SitNews. (2000, June 7). New Alaska Psychiatric Institute dedicated. *SitNews (Stories in the News)*. http://www.sitnews.us/0605news/060705/060705_api_dedication.html
- Southcentral Foundation. (2005). Home page. <https://www.southcentralfoundation.com/>
- State of Alaska House Health and Social Services Finance Subcommittee. (2022). *Inpatient Mental Health FY2023 Overview*. http://www.akleg.gov/basis/get_documents.asp?session=32&docid=78615
- Steadman, H. J., McGreevy, M. A., Morrissey, J. P., Callahan, L. A., Robbins, P. C., & Cirincione, C. (1993). *Before and after Hinckley, Evaluating insanity defense reform*. New York, NY: The Guilford Press.
- Substance Abuse and Mental Health Services Administration. (2020). National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit. <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>
- The Alaska Health Survey Team. (1954). *Alaska's Health: A survey report (Parran Report)*. https://health.alaska.gov/Commissioner/Documents/PDF/Parran_Report.pdf
- Torrey, E. F., Fuller, D. A., Geller, J., Jacobs, C., and Ragosta, K. (2012). *No room at the inn: Trends and consequences of closing public psychiatric hospitals, 2005-2010*. Treatment Advocacy Center. https://ww1.prweb.com/prfiles/2012/07/18/9703740/No_Room_at_the_Inn-2012.pdf
- Trueblood v. Washington State Department of Social and Health Services*, 822 F. 3d 1037(9th Cir. 2016)
- United States Department of Justice, Civil Rights Division. (2022). Investigation of the State of Alaska's Behavioral Health System for Children. https://www.justice.gov/d9/press-releases/attachments/2022/12/15/2022.12.15_alaska_findings_report_0.pdf
- Weiss v. State of Alaska*, 706 P.2d 681 (1985)

ACKNOWLEDGEMENTS

The authors acknowledge the input from the staffs of the office of Alaska State Representative Andy Josephson, The Disability Law Center of Alaska, The Alaska Mental Health Trust Authority, and the Alaska Native Tribal Health Consortium.

CONFLICT OF INTEREST

The authors declare that they have no conflicts of interest.

AUTHOR INFORMATION

Joseph D. Bloom, MD, is Dean Emeritus at the School of Medicine, Oregon Health & Science University in Portland, Oregon, and Clinical Professor of Psychiatry at the University of Arizona College of Medicine in Phoenix, AZ.

Aron S. Wolf, MMM, MD, is a healthcare consultant and Clinical Professor of Psychiatry at the University of Washington, School of Medicine in Seattle, WA.