



2008 Update

<http://hss.state.ak.us/dph/healthplanning/movingforward/>

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For more information, see *Alaska Scorecard: Key Issues Impacting Alaska Mental Health Trust Beneficiaries* (<http://hss.state.ak.us/dph/healthplanning/scorecard>)

I. Introduction

Plan Vision

The vision of the Comprehensive Integrated Mental Health Plan is optimal quality of life for all Alaskans, especially those experiencing mental and emotional illness, cognitive and developmental disabilities, alcoholism and substance use disorders, and Alzheimer's disease or similar dementia.

Authority for Plan

[Alaska Statute 47.30.660](#) requires the [Department of Health and Social Services](#), in conjunction with the [Alaska Mental Health Trust Authority](#), to develop and revise a plan for a comprehensive integrated mental health program for Alaska. Under the statute, the preparation of this plan is to be coordinated with federal, state, regional, local, and private entities involved in mental health services.

Purpose of Plan

The purpose of this Comprehensive Integrated Mental Health Plan (Comp MH Plan) is to guide resource allocation decisions in the development of services, workforce, and facilities to meet the needs of Trust beneficiaries. The overall goal is a service system that quickly meets the needs of each individual, where highly qualified staff from state, federal, tribal and private agencies have the resources necessary to work together to provide seamless care for the best outcome possible for each person. Another goal is to reduce the incidence of Trust beneficiaries' disabling conditions through prevention and early intervention, to the extent possible.

Moving Forward: Comprehensive Integrated Mental Health Plan is coordinated with plans developed by the [Alaska Mental Health Board](#), the [Governor's Council on Disabilities and Special Education](#), the [Governor's Advisory Board on Alcoholism and Drug Abuse](#) and the [Alaska Commission on Aging](#), collectively called the beneficiary planning and advocacy boards, and by the [Department of Corrections' 1999 plan](#). This plan is also linked with such DHSS plans as [Healthy Alaskans 2010](#) and [other planning initiatives](#).

Target Population of Plan

Moving Forward: Comprehensive Integrated Mental Health Plan has a vision of optimal quality of life for Alaskans, especially those Alaskans who receive services under the [Comprehensive Integrated Mental Health Program \(AS 47.30\)](#). By law, these service recipients (also called Trust beneficiaries) are Alaskans who have a mental illness, a developmental disability, experience chronic alcoholism or Alzheimer's disease or a related dementia. Efforts include prevention, to the extent possible, of these disabling conditions. Those who may need services in the future are included in this plan since prevention is the surest way to limit human suffering and is usually the least costly strategy.

Extent of the Problem

With Alaska data and national prevalence data, we can estimate that there are currently up to 85,664 Trust beneficiaries in Alaska, as follows. There are unavoidable duplications in this estimate (e.g. some individuals are in more than one beneficiary group, so they are counted more than once).

- Serious mental illness (adults): 21,754¹
- Serious Emotional Disturbance (youth): 12,725¹
- Alzheimer's Disease and Related Disorders (adults over age 65): 5,100⁵
- Brain injured: 11,900⁶
- Developmentally disabled: 12,185⁹
- Alcohol dependent: 22,000¹¹

Mental Illness:

A recent report on behavioral health prevalence estimates in Alaska estimates that in the year 2006, 4.6 percent (21,754) of Alaskan adults in households had a Serious Mental Illness and 7.2 percent (12,725) of Alaska youth had Serious Emotional Disturbance. The adult estimates include only those with a diagnosable DSM IV disorder that has persisted over one year and is associated with significant impairment. ¹

The 2006 National Survey of Drug Use and Health estimated that 52,000 Alaskans experienced serious psychological distress and 37,000 had at least one major depressive episode (annual averages based on 2005-2006 NSDUHs). The NSDUH survey did not include an assessment of how the disorder affected a person's ability to function in everyday life. "Major Depressive Episode" is defined as a period of at least two weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of the symptoms for depression as described in the DSM IV. ² "Serious psychological distress" is defined as having a score of 13 or higher on the K6 scale. ³

Alzheimer's Disease and Related Dementia (including Brain Injury):

Alzheimer's Disease

Alzheimer's disease is now the sixth leading cause of death in the United States, according to the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics. An estimated 5.2 million Americans of all ages are living with Alzheimer's disease; 13 percent of persons age 65 and older has the disease. ⁴

Using national prevalence rates, the Alaska Commission on Aging estimates that as of 2007, there were 5,100 Alaskans aged 65 and above with Alzheimer's Disease and Related Dementia (this estimate does not include brain injury). DHSS Division of Alaska Pioneer Homes reports that, as of April, 2008, 54 percent of residents in the Homes had a dementia diagnosis. ⁵

In 2007, 9.8 million family members, friends and neighbors provided 8.4 billion hours of unpaid care to a person with Alzheimer's Disease or a related dementia nationwide. This

contribution can be valued at \$89 billion. In Alaska, the estimated number of caregivers was 14,400.⁴

Brain Injury

According to a 2003 study by the University of Alaska, an estimated 11,900 Alaskans were living with brain injury.⁶ Each year the Alaska Department of Health & Social Services reports about 800 traumatic brain injury (TBI) cases resulting in hospitalization or death. The rates of brain injury in rural Alaska are twice as high as the non-rural rates.⁷

According to the [National Center for Injury Prevention and Control](#), traumatic brain injuries contribute to a substantial number of deaths and cases of permanent disability. CDC estimates that at least 5.3 million Americans currently have a long-term or lifelong need for help to perform activities of daily living as a result of a TBI.⁸

Of the 1.4 million who sustain a TBI each year nationwide:

- 50,000 die;
- 235,000 are hospitalized; and
- 1.1 million are treated and released from an emergency department.⁸

The number of people with TBI who are not seen in an emergency department or who receive no care is unknown.

Developmental Disabilities

According to national prevalence data, 1.8 percent of the national population has a developmental disability. At this rate, it is estimated that 12,185 Alaskans have developmental disabilities.⁹

According to the U.S. Department of Education and other agencies, autism is the fastest-growing developmental disability. It is the most common of the Pervasive Developmental Disorders, affecting an estimated one in 150 births.¹⁰

Chronic Alcoholism

Rates of heavy and binge drinking are consistently higher in Alaska than in the United States as a whole. In 2006, the estimated number of Alaskans abusing or depending on alcohol or other substances was:¹¹

- Alcohol dependence (age 12 or older): 22,000
- Alcohol dependence or abuse (age 12 or older): 41,000
- Alcohol dependence or abuse (age 12 to 17): 4,000
- Illicit drug dependence or abuse (age 12 or older): 52,000

The high prevalence of alcohol use among Alaska teens is a significant concern, because research shows that young people who begin drinking before the age of 15 are four times more likely to develop dependence.¹²

II. Results Areas

What is a Result Area?

This section is divided into four result areas: **health**, **safety**, **living with dignity** and **economic security**. These are called “results areas” because *Moving Forward: Comprehensive Integrated Mental Health Plan* seeks to change the lives of Trust beneficiaries in these four areas. Services and new initiatives, discussed later in this plan, target one or more of these “results areas.” Each result area has indicators (data or measures) that are relevant to the goals and for which historical data exist. We will continue to collect this data so that over time we will see whether strategies are making progress in improving the lives of Alaskans.

Health

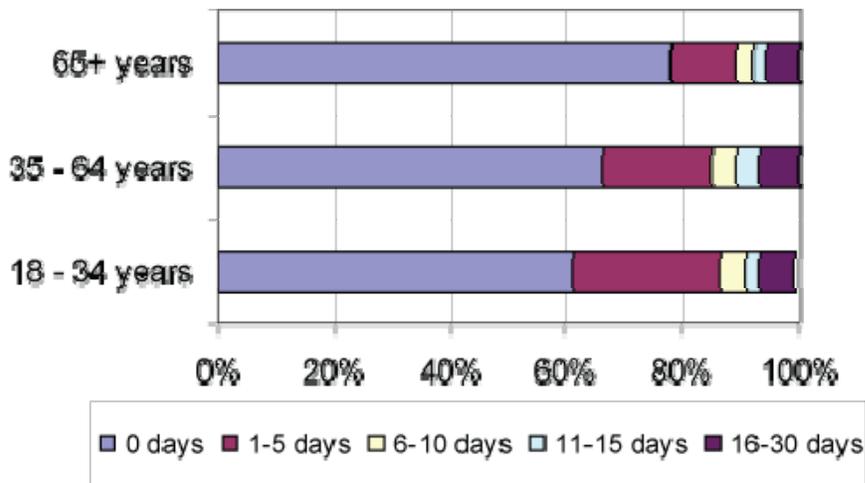
When someone is born as or becomes a Trust beneficiary, the individual and the family want the best care possible — the most helpful services close to home. Accessing behavioral health care can be difficult for Alaskans in small communities, for those who have inadequate or no health insurance, or whose access to information is limited. Not all communities, even larger ones, have a range of treatment programs and other needed supportive services. Without strong support and treatment services, people may not get the services they need, may become homeless, or become involved with the justice system.

Health Goal #1: Enhance quality of life through appropriate services for people with mental and cognitive disabilities and substance use disorders

Poor Mental Health Days

Good physical and mental health is a common measure of an individual's well being. One way to assess a population's overall health is with a set of measures known as "Healthy Days."¹³ Developed by the National Center for Disease Control, Healthy Days is one of the few population-based surveys of mental health status. It measures individuals' self-evaluation of their physical and mental health within the past 30 days.

Figure 1: Days of Poor Mental Health in Past Month by Age Group, 2007

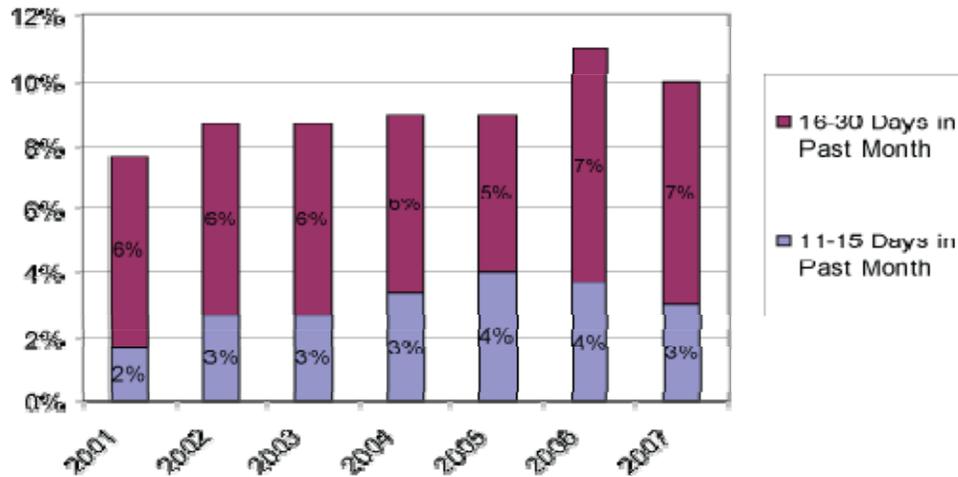


Source: AK DHSS Division of Public Health, Behavioral Risk Factor Surveillance Survey (BRFSS) 2007

Data from the Behavioral Risk Factor Surveillance Survey²¹ show the percent of Alaskans surveyed who self-reported the number of days in the prior month that they experienced "poor mental health." In 2007, thirteen percent of survey respondents reported more than five days of poor mental health during the previous month. Young adults reported the most poor mental health days.

BRFSS data is based on a phone survey, so it does not include those who are experiencing bad mental health days while institutionalized.

Figure HM-1: Percent of Alaskans Reporting 11-15 Days and 16-30 Days of Poor Mental Health in Past Month, 2001-2007



Source: AK DHSS Division of Public Health, [Behavioral Risk Factor Surveillance Survey \(BRFSS\) 2007](#)

The “mean” number of days of poor mental health was slightly lower in Alaska than it was in the U.S. for each year between 2001 and 2005. However, in 2006 and 2007, Alaska’s days of poor mental health increased and those in the U.S. decreased, making them equal during those years.

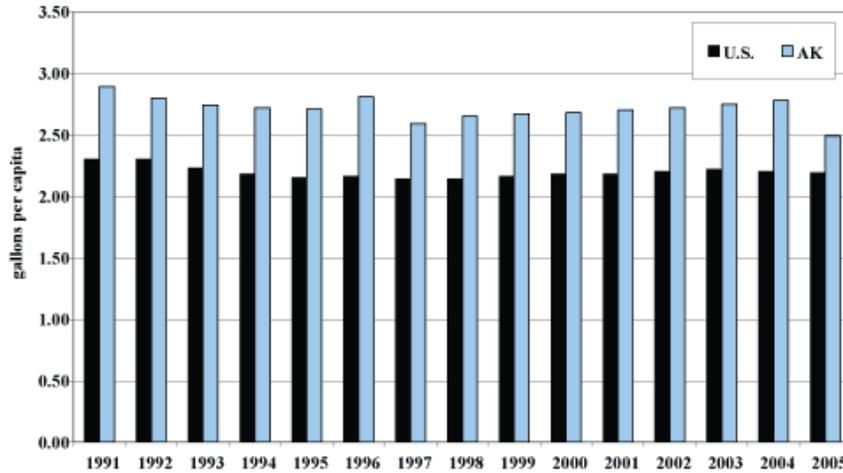
Health Goal #2: Reduce the abusive use of alcohol and other drugs to protect Alaskans’ health, safety, and quality of life.

Alcoholism and chemical dependency have long been recognized as Alaska’s number one behavioral health problem. Alcoholism and other addictive diseases not only compromise individuals’ health but also create profound social problems. The social cost of alcohol abuse is seen in rates of related injuries, chronic disease, and deaths. National research shows that substance abuse has been implicated in 70 percent of all cases of child abuse and that 80 percent of the men and women behind bars are there because of drug or alcohol related crime.¹⁴

Alcohol Consumption

Alcohol consumption rates reflect the prevalence and severity of alcohol related problems. The alcohol consumption rate in Alaska has been higher than the rate in the rest of the nation during each of the last 14 years, and is well above the [Healthy Alaskans 2010](#) goal of 2.2 gallons or less per person per year.

Figure 2: U.S. and Alaska Alcohol Consumption Comparisons



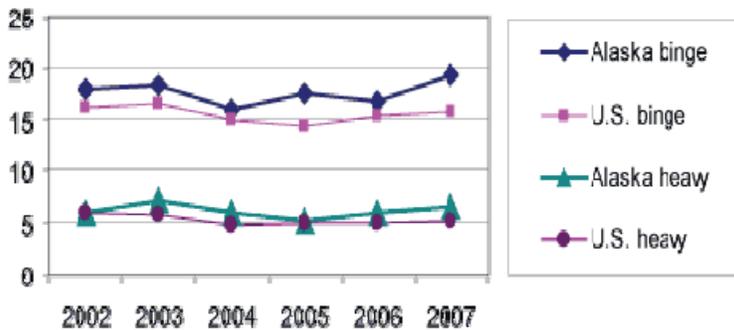
Source: Alaska Department of Revenue; Alaska DHSS Division of Behavioral Health; compiled by NCADD

Data from the [National Institute on Alcohol Abuse and Alcoholism \(NIAAA\)](#) indicates that Alaska remains in the highest group for alcohol consumption in the nation (per capita ethanol consumption per 10,000 people aged 14 and over). Consumption rates are calculated with in-state sales of alcoholic beverages and the state population of persons 14 years and older.

Binge Drinking and Heavy Drinking

The Behavioral Risk Factor Surveillance Survey²¹ shows that binge drinking is more prevalent than heavy drinking, and each year Alaskan adults report more binge drinking than in the rest of United States. Between 2002 and 2007, binge drinking in Alaska rose 1.2 percent and heavy drinking rose .4 percent.

Figure 3: Binge Drinking and Heavy Drinking (Percent Self-reporting), Alaska and U.S. 2002-2007

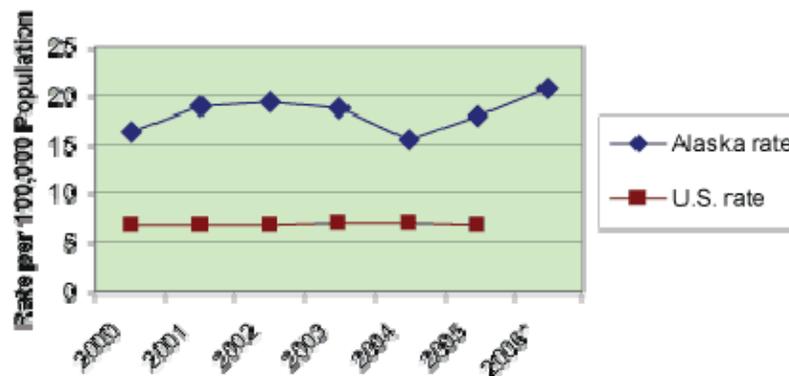


Source: Behavioral Risk Factor Surveillance Survey (BRFSS) 2007 and Centers for Disease Control

Alcohol-Induced Deaths

The rate of alcohol-induced deaths in Alaska increased 16 percent between 2005 and 2006. Alaska's rate has consistently remained about 2.5 times higher than the U.S. rate since 2000. On average, 14.2 years of productive life were lost for each alcohol-induced death in Alaska in 2005. Nearly half of the alcohol-induced deaths were by Alaska Natives.¹⁵

Figure HA-2: Rate of Alcohol-induced Deaths, Alaska and U.S. by Year, 2000-2006



Source: Alaska data: DHSS Division of Public Health, Bureau of Vital Statistics

U.S. data: CDC National Vital Statistics Reports, Volume 56, Number 10, April 24, 2008.

*U.S. data for 2006 is not yet available

Data for alcohol-induced deaths includes fatalities from alcoholic psychoses, alcohol dependence syndrome, non-dependent abuse of alcohol, alcohol-induced chronic liver disease and cirrhosis, and alcohol poisoning. It does not include deaths due to traumatic injury, such as motor vehicle crashes.

Risk and Protective Factors

For information about risk and protective factors in Alaska, see [Influences on Substance Use in Alaska: Significant Risk and Protective Factors Influencing Adolescent Substance Use and Their Indicators](#) (November, 2007)

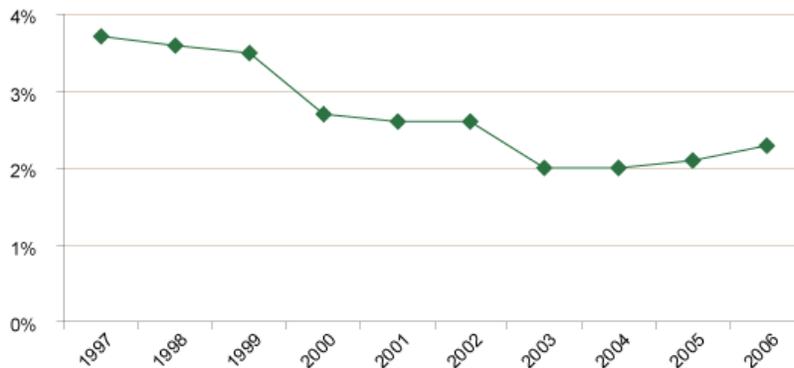
Health Goal #3: Promote healthy births and encourage early childhood interventions to reduce the risk of disability

Alaska families, like those everywhere, strive to have healthy babies and provide good homes for their children. The first three years of a child's life are a time of extraordinary growth physically, mentally, emotionally, and socially. We know that environmental factors have a profound influence on the brain. Research confirms that many children's mental health problems are related to family violence, parents' chemical addiction, mental illness, and poverty.¹⁶ Often a number of identifiable stresses combine to create family dysfunction and to compromise the children's development and health.

Indicator:

Alcohol Consumption during Pregnancy

Figure 4: Percentage of Women Self-reporting Alcohol Consumption during Pregnancy, Alaska 1997-2006



Source: AK DHSS Division of Public Health, Bureau of Vital Statistics

Alaska Bureau of Vital Statistics birth data indicates an overall decrease in self-reported alcohol use during pregnancy between 1996 and 2005 and a slight increase from 2004 to 2005 (Figure 4). It is generally acknowledged that this data, self-reported by women at the time of delivery, is underreported. However, it is agreed that over the last decade, there has been a significant decline in prenatal alcohol use in Alaska.¹⁸

The U.S. Substance Abuse and Mental Health Services Administration estimates the prevalence of FASD at about 100 per 10,000 live births. Brain damage can occur when alcohol crosses the placenta and damages developing tissues. The result may be mild to severe cognitive impairment, mental retardation, social and emotional problems, learning disabilities, visual impairment, neurobehavioral problems and other structural birth defects. Approximately 126 infants are born each year in Alaska who have been affected by maternal alcohol use during pregnancy.¹⁷

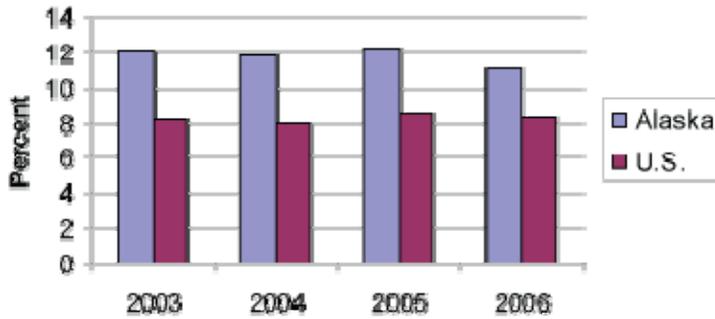
For more information about efforts to prevent FASD, see Section IV on [Initiatives](#).

Illicit Drug Use

According to SAMHSA's National Survey on Drug Use and Health, illicit drug use among those ages 12 and older has been consistently higher in Alaska than in the U.S. as a whole. In 2006, Alaska ranked number 2 in the nation for illicit drug use.

Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically.

Figure HA-3: Illicit Drug Use, Alaska and U.S., Ages 12 and Older

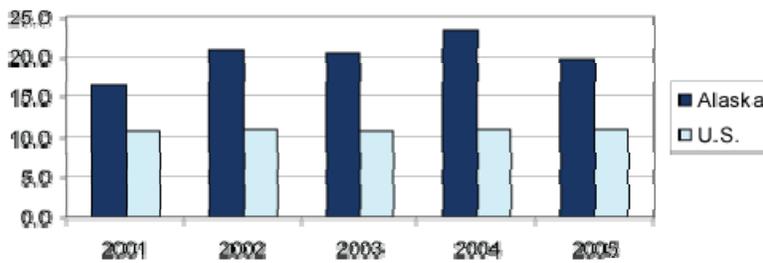


Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health

Health Goal #4: Reduce the number of suicides in Alaska.

Suicide Rates

Figure 5: Suicide Rate by Year, Alaska and U.S., 2001-2005 (Age Adjusted Rate per 100,000)

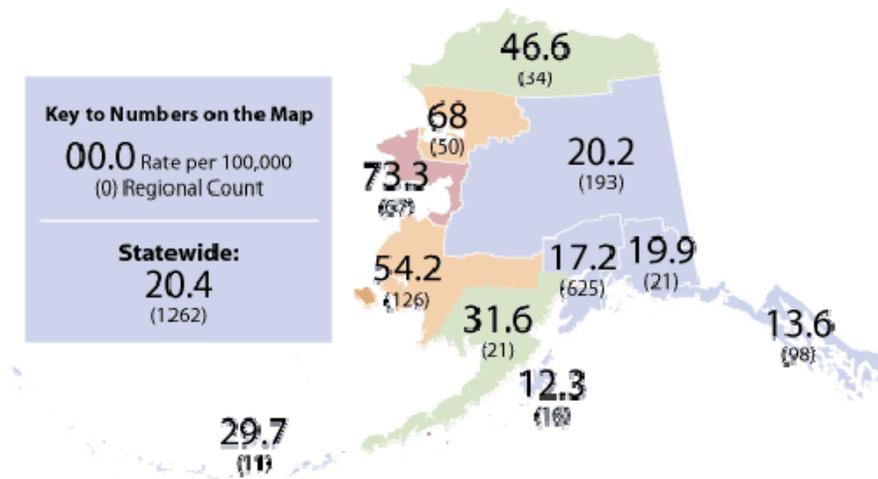


Source: AK DHSS, Division of Public Health, Bureau of Vital Statistics

Figure 5 compares Alaska's suicide rate to that of the U.S. Between 2000 and 2006, the age-adjusted rate of death by suicide in Alaska averaged almost twice the U.S. rate.

In 2005, Alaska's suicide rate was the third highest in the nation. Alaskans aged 20-29 years had the highest rate, followed by the 30-39 year old group.¹⁹

Figure 6: Alaska Suicide Rates (and Numbers) by Region, 1997-2006



Suicide Rates by Region

More than 70	Nome Census area
50-70	Northwest Arctic Bethel/Wade Hampton
30-50	North Slope Borough Dillingham/Bristol Bay/ Lake and Peninsula Borough
Less than 30	Aleutians Interior Valdez-Cordova Anchorage/Mat-Su Borough/ Kenai Peninsula Southeast Kodiak

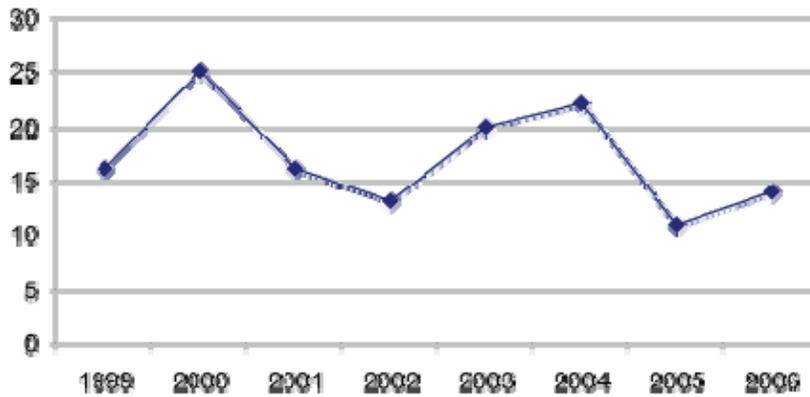
Source: DHSS Division of Public Health Bureau of Vital Statistics

Figure 6 shows Alaska’s age-adjusted suicide rates per region for the years 1997 through 2006. The regions with the lowest rates of suicide were Kodiak and Southeast, while the highest rates were in Nome and the Northwest Arctic.

The *Alaska Suicide Follow-back Study* contains information from interviews with the families of some of Alaska’s suicide victims from 2003 to 2006. According to the interviews, more than half (54%) of the decedents had a disability or illness that made it difficult for them to take care of normal daily activities. Almost two-thirds (62%) of decedents were reported to have had current prescriptions for mental health medications at the time of their death but many were not taking the medications as prescribed.²⁰

Among the suicide cases that had a follow-back interview, a binge drinking rate of 43 percent was reported, which is 2.5 times higher than the Alaska rate and three times higher than the national estimated rate according to the 2005 BRFSS. Forty-three percent of the interviewees said the decedents drank alcohol daily. The interviews indicated that 54 percent of the decedents had smoked marijuana within the past year. The reported rate for alcohol and drug use by Alaska Natives was exactly the same as for non-Natives. Although Alaska Natives comprise only 16 percent of the population, they accounted for 39 percent of the suicides.²⁰

Figure HS-1: Alaska Teen Suicides (Ages 15-19)



Source: Alaska DHSS Bureau of Vital Statistics

The number of deaths by suicide among Alaskans aged 15 to 19 dropped by half between 2004 and 2005, then rose again slightly in 2006, when there were 14 deaths.

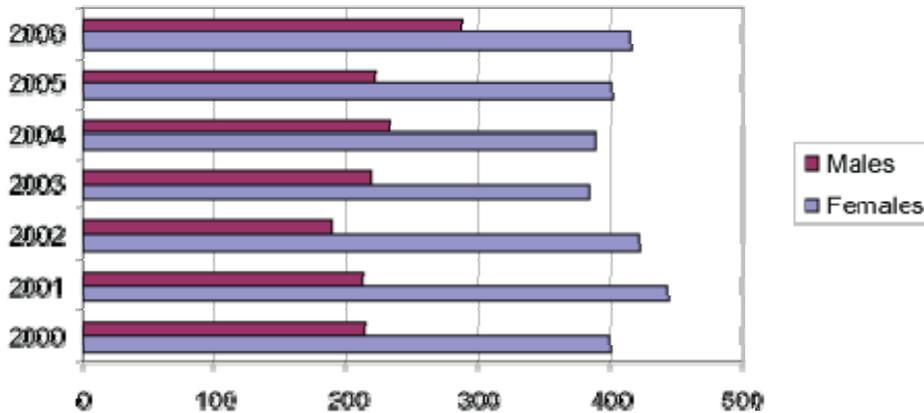
Suicidal ideation/attempts from Youth Risk Behavior Survey (YRBS²²)

- Percentage of students who seriously considered attempting suicide during the past 12 months:
 - 2003 YRBS: 16.7 %
 - 2007 YRBS: 16.5%
- Percentage of students who actually attempted suicide one or more times during the past 12 months:
 - 2003 YRBS: 8.1%
 - 2007 YRBS: 10.7 %

Suicide Attempts

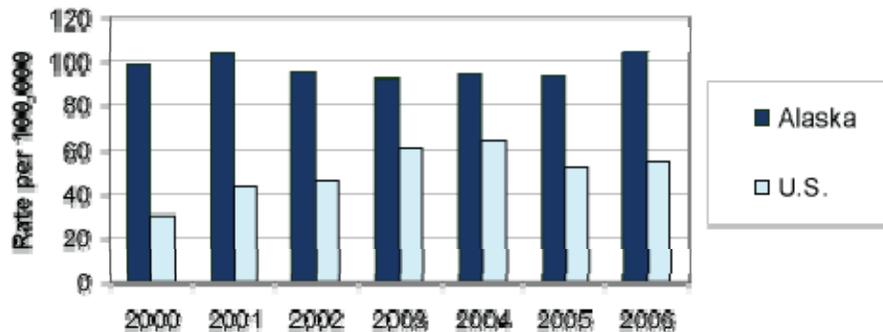
Figure HS-2 shows the rate of non-fatal suicide attempts in Alaska that required hospitalization for at least 24 hours. Between 2000 and 2005, attempts were almost twice as high among Alaskan women as compared to men. In 2006, the number of attempts by men rose significantly.

Figure HS-2: Non-fatal Suicide Attempts by Sex



Source: Alaska Trauma Registry staff

Figure HS-3: Non-fatal Suicide Attempts Requiring Hospitalization, Alaska and U.S. by Year, 2000-2006



Source: DHSS Division of Public Health, Trauma Registry and CDC WISQARS

Alaska's rate of attempted suicides requiring hospitalization continues to be significantly higher than the U.S. rate. In 2006, Alaska's rate per 100,000 was 105, while the U.S. rate was 54.

Suicide Protective Factors

Measures that enhance resilience or protective factors are as essential as risk reduction in preventing suicide. Positive resistance to suicide is not permanent, so programs that

support and maintain protection against suicide need to be ongoing.

Protective factors include:

- Effective and appropriate clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Restricted access to highly lethal methods of suicide
- Family and community support
- Support from ongoing medical and mental health care relationships
- Learned skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation instincts ⁴²

For information about suicide prevention projects in Alaska, see the [Current Initiatives](#) section of this Plan.

Health Goal #5: Access: ensure high quality treatment, recovery and support services are provided as close to one's home community as possible.

The Department and The Trust aim to provide sustainable, comprehensive behavioral health services that are based in local communities so that residents can be served as close to their home as possible. Some of the current initiatives that address this goal are the [Bring the Kids Home Initiative](#), the [Community-based Suicide Prevention and Rural Human Services project](#), the [Comprehensive Fetal Alcohol Syndrome Project](#), and [Workforce Development](#).

Numbers Served

Estimated Number of Alaska Mental Health Trust Beneficiaries Served by DHSS Divisions (Figure HC-1) (See pages 21 and 22)

The Department of Health and Social Services serves many Trust beneficiaries in its various programs throughout the state. An estimate of the number of Trust beneficiaries served by each division within the Department is shown in Figure HC-1. Since people served remain anonymous, and the same person may have been served by more than one program or division during the same year, there is not a way to avoid duplication in the numbers.

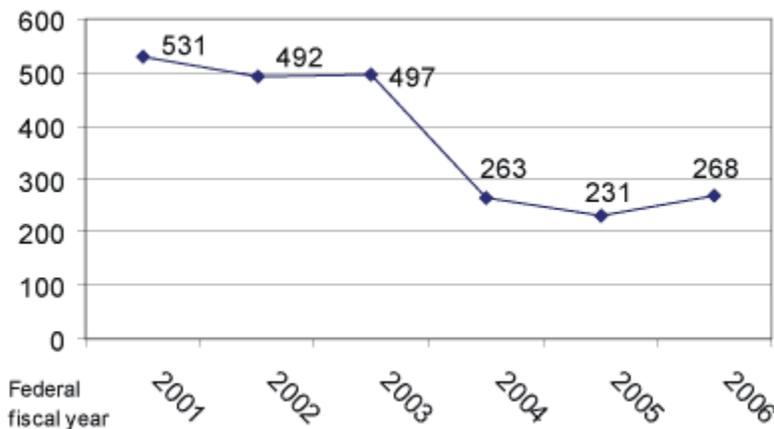
Public perceptions of care

The public behavioral health system is responsible for providing safe and effective care. The system has changed with consumers' increasing involvement in choosing the types of treatment and other services they receive. Today, many agencies include consumers on their boards of directors. Consumers participate in quality assurance reviews for mental health, developmental disabilities, and early intervention/infant learning programs. Consumer satisfaction surveys are included in most provider reviews conducted by the Department of Health and Social Services.

Public perceptions of care as indicated through number of complaints to the Long-Term Care Ombudsman (Figure HC-2)

In 1978, the federal Older Americans Act began requiring every state to have a Long Term Care Ombudsman Program to identify, investigate and resolve complaints and advocate for seniors. The ombudsman investigates complaints about nursing homes, assisted living homes, and senior housing units as well as concerns about individuals' care and circumstances. Consumers, family members, administrators, and facility staff can make complaints regarding the health, safety, welfare, or rights of a long-term care resident. The Alaska ombudsman's office is administratively managed by and resides in the office of the Alaska Mental Health Trust Authority. The majority of funding for the office comes from grants through the federal Administration on Aging.

Figure HC-2: Number of Complaints to Long Term Care Ombudsman



Source: AK Office of the Long Term Care Ombudsman, OmbudsManager data base

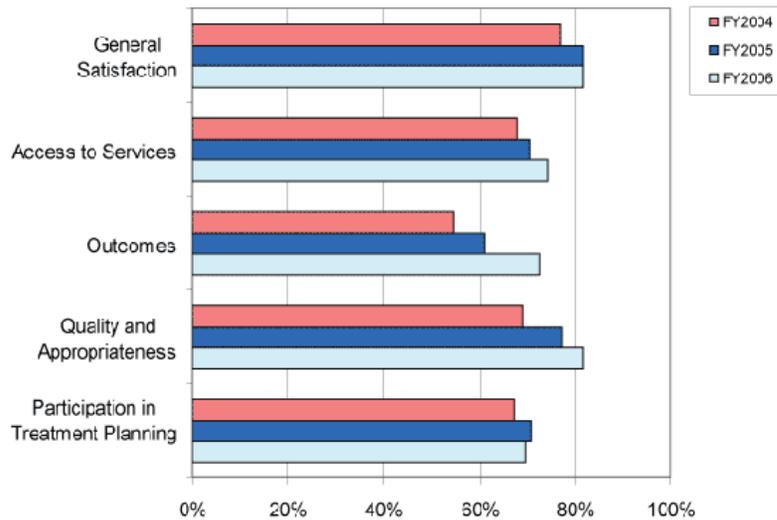
Figure HC-2 shows the number of complaints that Alaska's Office of the Long-Term Care Ombudsman received from consumers each year. Most of the complaints were against assisted living homes and nursing homes. Beginning with fiscal year 2004, fewer complaints were recorded in this data base because at that time they began counting only cases that their office was actively investigating. Before 2004 the cases they counted also included ones that they were monitoring and that were being investigated by other state agencies such as Adult Protective Services and Certification and Licensing.

There have been about 250 complaints actively investigated during each of the last three years. In 2007 the major complaint categories were 1) medication management; 2) dignity/respect (staff attitudes); 3) food; 4) falls/improper handling, unexplained accidents; 5) legal problems (guardianships, powers of attorney, conservatorships, wills)

Alaska has one of the fastest-growing senior populations of all the states, with the number of seniors expected to more than double by 2030. While Alaska seniors have a higher mean and median income than U.S. seniors as a whole, higher living costs may consume much of that additional income. Incomes of senior households located in rural

areas and those headed by Alaska Natives have substantially lower incomes. The poorest group is seniors age 85 and over, which is also the fastest-growing sub-group of the senior population. By 2030, the number of Alaskans in this age group is expected to triple.²³

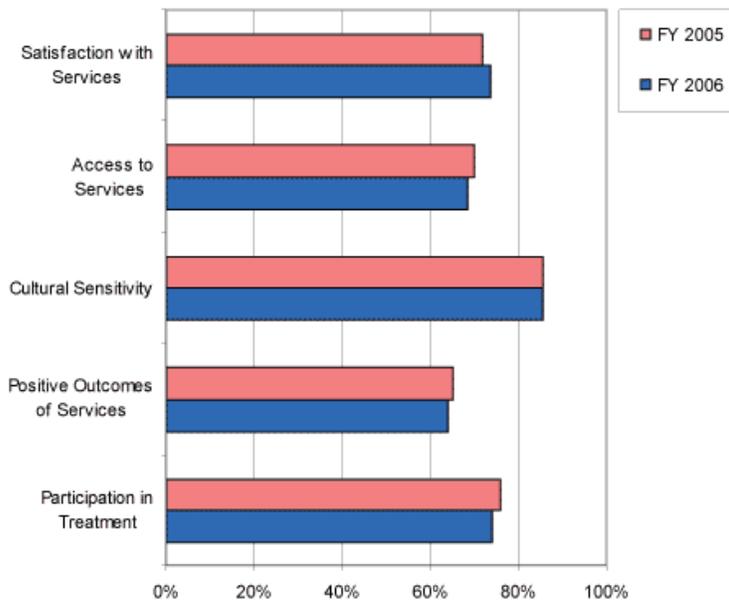
Figure HC-3a: Consumers Satisfied with Public Mental Health and Substance Abuse Services - Adults



Source: DHSS Div. of Behavioral Health, Policy and Planning. Mental Health Statistics Improvement Project (MSHIP). Data is based on percent of MSHIP respondents reporting satisfaction

Figures HC-3a and b show the results of a cooperative effort between the DHSS Division of Behavioral health and providers to ask consumers to evaluate services. Questions were asked about satisfaction with services, quality and outcomes, participation in treatment outcomes, access to services, and cultural sensitivity. For interviews in fiscal year 2006, satisfaction ranged from 70 to 82 percent.

Figure HC-3b: Consumers Satisfied with Public Mental Health and Substance Abuse Services - Youth



Source: DHSS Div. of Behavioral Health, Policy and Planning. Mental Health Statistics Improvement Project (MSHIP). Data is based on the percent of MSHIP respondents reporting satisfaction.

Public perceptions of care as indicated through agencies with family members or consumers on governing/advisory boards

A majority of the behavioral health and developmental disability agencies now include consumers on their governing boards. All 84 agencies providing behavioral health services met the review standard of having consumers or family members in sufficient numbers on the agency governing body or board to ensure their meaningful participation. Consumers of publicly funded behavioral health and developmental disabilities services demand increased involvement in their treatment and care. Consumers or family members of consumers also sit on each of the four statewide advocacy boards and commission.

Estimated Number* of Alaska Mental Health Trust Beneficiaries Served by DHSS Divisions

*Actual number may be lower - there is duplication in some of the data reported.

Time Period	Division	Age 0-17		Age 18-20		Age 21-64		Age 65 +		Age not available		Total
		Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	
FFY 2007	Children's Services (OCS)	170	220	17	20							427
Source:	<i>These are children served in out-of-home care diagnosed as mentally retarded and/or emotionally disturbed.</i>											
	<i>Source: AK DHSS, Office of Children's Services, Online Resources of the Children of Alaska.</i>											
7/1/07 to 6/30/08	Juvenile Justice (DJJ) - Age 0-20											870
	Female	158										
	Male	712										
	<i>Numbers represent youth on supervision with DJJ who had at least one Axis 1 diagnosis, under DSM-IV-TR (clinical disorders & other conditions that may be a focus of clinical attention). Most were 17 years of age or younger. Of the total, 51% also had a co-occurring disorder (substance related disorder accompanied by a mental health disorder). Source: DHSS Div. of Juvenile Justice FY08 data</i>											
One-day snapshot, 4/1/08	Pioneer Homes							249				249
Source:	<i>Total Pioneer Home residents with a dementia diagnosis (sorted for "dementia" in ICD-9 code). Source: Division of Pioneer Homes, Accu-Med Electronic Medical Records System</i>											
One month - April, 2008	Public Assistance (DPA) - Alaska Temporary Assistance Program (ATAP) (4/05)									3,203		3,203
April, 2008	DPA- Adult Public Assistance (APA)									16,743		16,743
April, 2008	DPA - Food Stamps									23,045		23,045
Source:	<i>These figures reflect a one-month caseload for all Alaskans; this data does not break out the number of Trust beneficiaries. Not counted are the customers whose cases are managed by the tribal system. Source: DHSS Division of Public Assistance</i>											

	Senior and Disabilities Services (SDS)											
2008	Mental Retardation Developmental Disabilities (MRDD) Waiver	34	115	29	60	350	503	11	11			1113
2008	Children with Complex Medical Conditions (CCMC) Waiver	73	96	12	14	7	9	0	0			211
Source: Data Retrieved from FY 08 Waiver Program Data (DS3) on October 16, 2008.												
3/23/2007	Senior grants (963 total clients)							308				308
3/23/2007	Nursing facilities (total of 715 beds)						283					
Source: Data based on survey of providers on numbers of clients with Alzheimers or related dementia.												
2005	DSDS - Adult Protective Services						546					546
Source: Data Retrieved from FY 06 Medicaid Billing Data (STARS) on May 2, 2007.												

Behavioral Health: Active Client Count of Individuals Receiving Behavioral Health Services				
Fiscal Year 08	SED Youth [1]	SMI Adult [2]	SUD Youth & Adult [3]	Total SED, SMI, SUD
Qtr1	3,475	2,562	985	7,022
Qtr2	3,873	4,003	1,348	9,224
Qtr3	3,978	3,907	1,422	9,307
Qtr4	4,042	4,063	1,612	9,717
[1] Severely Emotionally Disturbed Youth [2] Severely Mentally Ill Adult [3] Substance Use Disorder Youth/Adult				

Safety

Thousands of Alaskans with mental and developmental disabilities are incarcerated each year because they do not get the services they need through Alaska's treatment and support systems. Police and court responses are often the only available resolution to crises or to public displays of untreated mental health problems, when appropriate treatment to prevent or respond to these situations was either unavailable or inaccessible.

Alaska has a high rate of child abuse and domestic violence. Experiencing or even witnessing violence may result in developmental delays, emotional disorders and substance use disorder.²⁴ Adults with cognitive or developmental disabilities are also vulnerable to neglect and abuse. State programs can assist in strengthening and rebuilding families, providing treatment, and providing guardianship for adults with mental impairments.

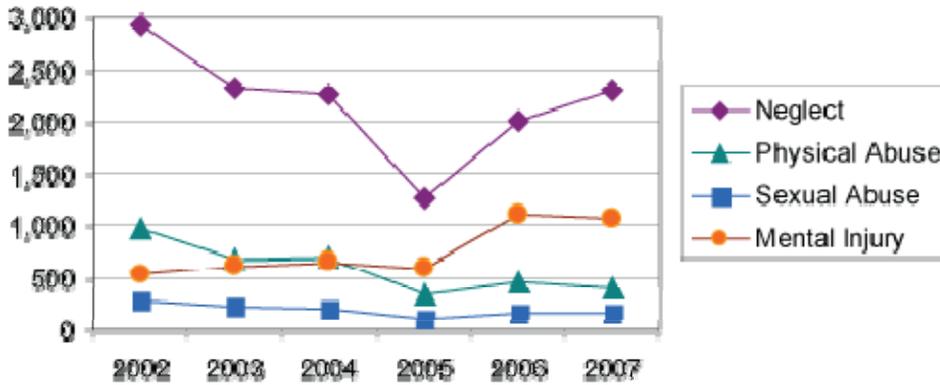
Filling the gaps in treatment and support services, both in communities and within the correctional system, can prevent crises that bring people with mental and developmental disabilities into contact with the criminal justice system and contribute to their repeated incarceration. Training for police, court and prison personnel can help divert many people into appropriate treatment in communities or provide effective treatment when people with mental health problems or developmental disabilities are unavoidably or necessarily incarcerated.

Safety Goal #1: Protect children and vulnerable adults from abuse, neglect, and exploitation

Childhood maltreatment has been linked to a variety of changes in brain structure and function and stress-responsive neurobiological systems.²⁵ The Adverse Childhood Experiences (ACE) Study provided evidence that adverse childhood experiences cast a major shadow on health and well-being in peoples' lives even 50 years later. "Adverse childhood experiences" include repeated physical abuse; chronic emotional abuse; and growing up in a household where someone was alcoholic or a drug user; a member was imprisoned; a mother was treated violently; someone was mentally ill, chronically depressed, or suicidal; or parents were separated or divorced during childhood.²⁶

Youth at Risk

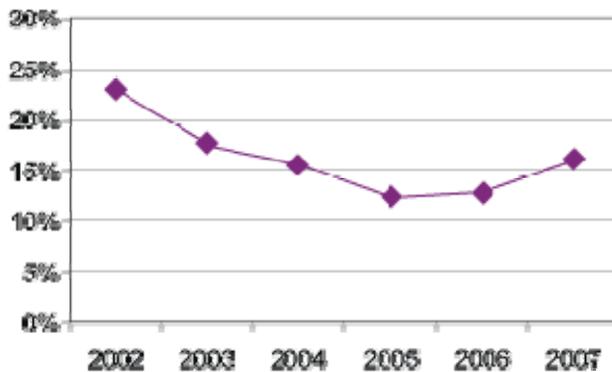
Figure 7: Number of Children with a Protective Service Report by Maltreatment Type



Source: DHSS Office of Children's Services (ORCA ALLEGATION table; ORCA CPS_REPORT table; Research Unit INVESTIGATION table)

Figure 7 represents the number of Alaska's children who were substantiated with the DHSS Division of Children's Services as victims of child abuse and neglect. Counted in this data are children who had a report of harm which was investigated and harm substantiated. The total number of substantiated reports of harm decreased between state fiscal year 2006 and state fiscal year 2007. In state fiscal year 2007 there were 8,746 alleged victims screened by OCS and 3,207 unique victims with allegations substantiated.

Figure WS-2: Rate of Repeat Maltreatment of Children



Source: AK DHSS Office of Children's Services, (ORCA ALLEGATION table; ORCA CPS_REPORT table; Research Unit INVESTIGATION table)

Figure WS-2 shows the percentage of all children who were subjects of substantiated or unconfirmed reports of harm during the first 6 months of the year and who had another substantiated or unconfirmed report of harm within 6 months. In state fiscal year 2007, the rate of repeat maltreatment increased by three percent.

Reports of physical injury, sexual assault, and threats/injuries by weapon at school from Youth Risk Behavior Survey²²

According to the Youth Risk Behavior Survey, the number of high school students reporting threats and sexual abuse has increased since 2003.

- 2003 Youth Risk Behavior Survey
 - 4.1 percent of students did not go to school on one or more of the past 30 days because they felt unsafe at school or on their way to or from school.
 - 8.1 percent of students have been physically forced to have sexual intercourse when they did not want to

- 2007 Youth Risk Behavior Survey
 - **5.5** percent of students did not go to school on one or more of the past 30 days because they felt unsafe at school or on their way to or from school.
 - **9.2** percent of students have been physically forced to have sexual intercourse when they did not want to.

Domestic Violence and Sexual Assault

The Alaska Council on Domestic Violence and Sexual Assault funds a network of nineteen victim service programs in eighteen Alaska communities, collectively serving 235 communities throughout the state. During fiscal year 2007, they provided services to 7,511 clients. Twenty-eight percent of the clients were children and one percent were adults aged 60 and over. Services provided included 24-hour emergency support, safe shelter, crisis intervention, children's services, food and clothing, referrals and many other services.

Table S-1 aggregates the field reports from victim service providers and shows the types of incidents experienced by the clients. The top three types of incidents were domestic violence, sexual abuse of children, and sexual assault toward adults.

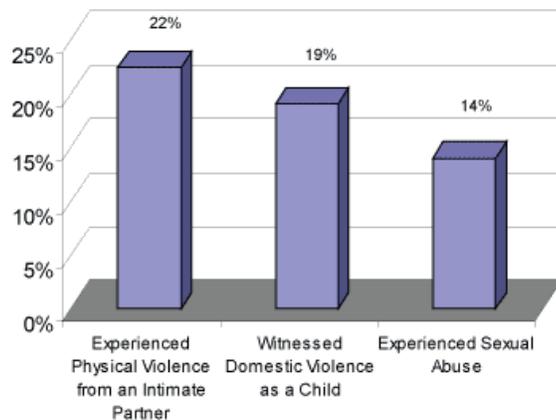
Table S-1: Domestic Violence and Sexual Assault Statistics, Fiscal Year 2007

Type of Victim Incident	<u>FY 06</u>	<u>FY07</u>
Adult Molested as a Child Count	59	146
Assault Count	195	219
Child Physical Abuse Count	109	231
Child Sexual Abuse Count	898	892
Domestic Violence Count	5,257	5,357
DWI / DUI Victim Count	14	8
Elder Abuse (victim 60+years of age) Count	11	76
Other Violent Crime Count	79	120
Robbery Count	13	21
Sexual Assault (adult) Count	653	740
Stalking Count	139	140
Survivor of Homicide Victim Count	37	25
Grand Count	7,464	7,975

Source: [Alaska Council on Domestic Violence and Sexual Assault](#) *Annual Report to Governor Palin*, Fiscal Year 2007

Figure WS-3 shows the percentage of participants in the most recently-available Behavioral Risk Factor Surveillance Survey (BRFSS)¹⁴ who responded that they had witnessed domestic violence in their family as a child, experienced physical violence from an intimate partner, or been sexually abused during their lifetime. In 2006, twenty-two percent of Alaskan adults had experienced physical violence from an intimate partner; nineteen percent had witnessed domestic violence as a child; and fourteen percent had experienced sexual abuse.

Figure WS-3: Percentage of Alaskan Adults who have Experienced Domestic Violence over their Lifetime



Source: AK DHSS Division of Public Health Behavioral Risk Factor Surveillance Survey

Adult Protective Services

Alaska law defines vulnerable adults as persons 18 years of age or older who, because of a physical or mental impairment or condition, are unable to meet their own needs or to seek help without assistance.²⁷ **Adult Protective Services** in the Department of Health and Social Services receives and investigates reports of harm. Harm includes abandonment, abuse, exploitation, and neglect (the most common report). More than half of the clients are female.

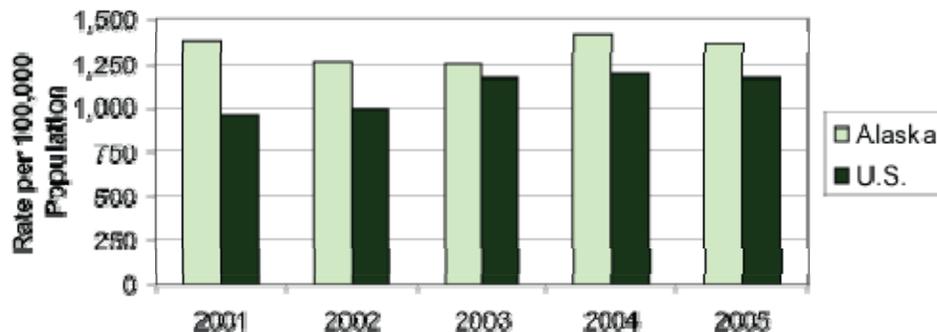
Adult Protective Services Investigations

- Total investigations FY 04: 1,173
- Total investigations FY 05: 1,497
- Total investigations FY 06: 1,668
- Total investigations FY 07: 1,783²⁸

In fiscal year 2007, the Department of Health and Social Services was contacted about 1,982 people (unduplicated) for whom an investigation was possibly warranted; 90% of these intakes were investigated.

Injuries

Figure WS-4: Nonfatal Hospitalized Injuries due to Falls, Age 65+, Alaska and U.S.



Sources: *CDC National Center for Injury Prevention and Control*, *WISQARS Nonfatal Injury Reports* Alaska Brain Injury Network Director (emails 5/12/08, 6/13/08)

The rate of falls requiring hospitalization for individuals age 65 and over is consistently higher in Alaska than it is in the U.S.⁴³ Falls are the leading cause of nonfatal injury in the elderly and are Alaska's leading cause of hospitalization for traumatic brain injury.⁴⁴

Safety Goal #2: Prevent and reduce inappropriate or avoidable arrest, prosecution, incarceration and recidivism of persons with mental health problems or developmental disabilities through appropriate treatment and supports.

Percent of Incarcerated Alaskans (Adults) who are Trust Beneficiaries

Nationwide, people with mental illness and cognitive impairments have been over-represented in the criminal justice system compared to their prevalence in society. Of the adults incarcerated in the Alaska correctional system, approximately 42 percent are Trust beneficiaries, mostly with mental illness and/or substance abuse disorders, incarcerated for misdemeanors. By default, the Alaska Department of Corrections had become the largest provider of mental health services in the State of Alaska. Alaska has the highest growth rate for incarceration per capita in the USA.²⁸

Statewide Criminal Recidivism Rates for Incarcerated Beneficiaries

Trust beneficiaries (36%) are more likely to recidivate than other offenders released from Alaska Department of Corrections (22% recidivism rate). Beneficiaries are also more likely to recidivate sooner and spend more time in ADOC custody. Inmates with severe mental illness were less likely to recidivate than inmates with mild mental illness or substance-related disorders who had a far higher rate of recidivism.²⁸

Note: For more information, see Section IV. on Initiatives, *Justice for Persons with Disabilities Focus Area*.

Living with Dignity

Living with dignity can be defined as being valued and appreciated by others for the choices and contributions one makes and being able to take advantage of the opportunities available to all Alaskans. The Comprehensive Plan focuses on three issues related to life with dignity: community participation, housing, and education and training.

To be part of a neighborhood, live in acceptable housing and attend the public school are marks of community membership. Alaskans experiencing mental illness, substance use disorders, developmental disabilities, and age-related dementia need to engage with family, friends, and neighbors and participate in their communities. Social contributions can include volunteer or paid work, subsistence activities, active membership in spiritual and other community organizations, and successful school attendance. People with cognitive or developmental disabilities may need support and assistance to connect with and become contributing members of their communities. Prejudice may limit social acceptance in school, religious organizations and volunteer activities. In some communities, unavailability of transportation services can limit participation in community life.

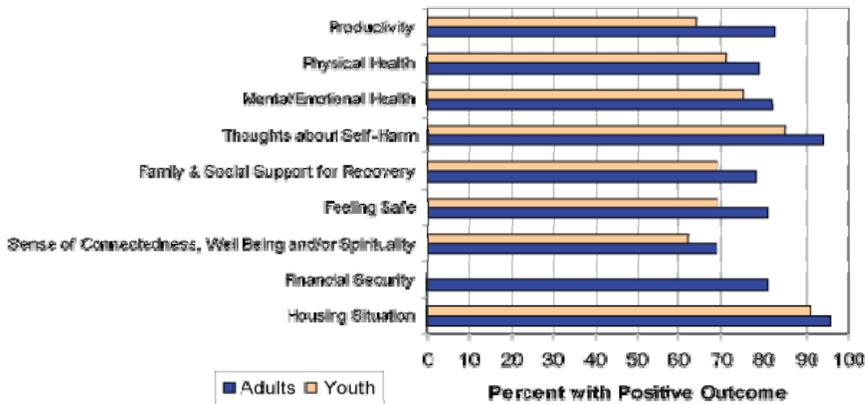
While many Alaskans struggle to find decent, affordable housing, people with cognitive or developmental disabilities and their families often find it especially difficult to obtain appropriate housing because they are more often poor and because they face discrimination. Poverty makes a person particularly vulnerable to homelessness: an individual may be less than a paycheck away from losing shelter. Many of Alaska's homeless are people with mental, developmental or cognitive disabilities or addictive diseases. Once people are homeless, finding and keeping a treatment schedule becomes even more difficult.

Gaining new skills and experiences in supported environments can prepare adolescents and adults with cognitive or developmental disabilities for jobs and participation in community life. All children are entitled to a public school education where they learn the social, academic and practical skills needed to become adults who are as independent as possible. Children can progress further when developmental delays are identified and addressed early. Schools can also help in identifying students with emotional disturbances and referring them to behavioral health care providers. Schools can educate all children about addictive disorders and healthy lifestyles.

Dignity Goal #1: Make it possible for Trust beneficiaries to be productively engaged in meaningful activities throughout their communities.

The Client Status Review (CSR) tracks the quality of life of consumers of the Alaska behavioral health treatment system. When clients enter the system they are asked a series of questions about their "life domains" such as thoughts of self-harm, feelings of connectedness, productivity, etc. For comparison, they are asked the same questions at different intervals during treatment, and at discharge. Figure 9 shows that at discharge, most consumers reported that their conditions were the same or better than they had been when they entered the system.

Figure 9: Positive Outcomes in Life Domains, Adults and Youth, FY 2007
(Percent of Behavioral Health Consumers Improving or Maintaining Quality of Life)



Source: DHSS Division of Behavioral Health Policy and Planning using AKAIMS Client Status Review data SFY 2007

*Youth Connectedness at Levels of Family, School, and Community - Youth Risk Behavior Survey 2007 Report*²²

Connectedness is a key protective factor correlated with a decrease in youth risk behaviors (use of tobacco, alcohol and other drugs, suicide ideation, violence and early sexual activity).²⁹ The term "connectedness," in this context, refers to the feeling of support and connection youth feel from their school and their community. Youth who help others or who are engaged in community service activities are less likely to be involved in anti-social behaviors, to be suspended from school or to become pregnant.³⁰ Service activities also provide an opportunity for youth to form close relationships with caring adults.

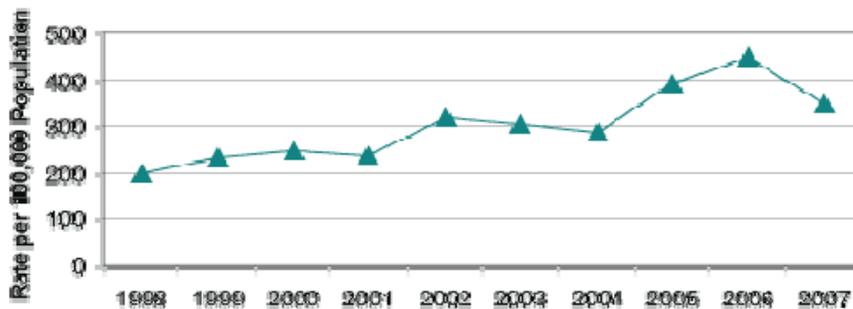
Results from 2007 Youth Risk Behavior Survey²² of Alaska high school students:

- 13 percent of boys and 19 percent of girls agree or strongly agree that they feel alone in their life.
- The majority of boys (59 percent) and girls (54 percent) report they have teachers who really care about them and give them a lot of encouragement.
- 51 percent of students agree or strongly agree that in their community they feel they matter to people.
- 51 percent of students spend one or more hours helping or volunteering at school or in the community during an average week.
- 87 percent of students said they would feel comfortable seeking help from one or more adults besides their parents if they had an important question affecting their life.

Dignity Goal #2: Enable Trust beneficiaries to live in appropriate, accessible and affordable housing in communities of their choice.

Alaska Housing Finance Corporation Winter Survey Reports estimate that the number of homeless Alaskans increased from 2,050 to 2,356, or fifteen percent, in the last five years. Each year about 21 percent of the homeless individuals had severe mental illness, 35 percent experienced substance abuse, and 19 percent had dual diagnosis. Of the total homeless individuals, 630 were in families with children.³¹

Figure 10 —Estimated Number of Homeless Alaskans by Year, 1998 - 2007



Source: [Alaska Housing Finance Corporation Homeless Service Providers Survey Reports](#)

The AHFC survey is completed semiannually on a predetermined day by providers of services for homeless people. Although the survey has many limitations, including low survey return rates, it does provide some idea of the number of homeless Alaskans and their characteristics.

At least 3,000 children were homeless or inadequately housed during the 2005-2006 school year. These children are more likely to experience conditions of anxiety, withdrawal, depression, hunger, asthma, ear infections, stomach problems and speech problems than their peers.³² Homelessness results from a complex set of circumstances that require people to choose between food, shelter, and other basic needs. Contributing factors include:

- **Inadequate income.** A 2001 study found 57% of Alaska households could not afford a median-priced home and 46% could not afford the average rent.³³ In Anchorage, a person needs to earn \$18.65 per hour to afford a modest two-bedroom apartment at the average fair market rent of \$970.³⁴ (For more information about rent-wage disparities in Alaska, please see [Table E-1](#).)
- **Inadequate supply of affordable housing.** The private housing market alone cannot supply enough affordable housing because of high land prices and other costs. The waiting list in Alaska for publicly financed housing is over 3,000 households.³⁵
- **Catastrophic events and destabilizing forces.** A sudden economic downturn caused by illness, injury, divorce or job loss may push people into homelessness. Mental illness and addiction disorders are also destabilizing forces that can cause homelessness.

- **Insufficient supportive services.** In Alaska, homeless prevention services, case management services, after-hours mental health counseling and other housing retention services are not widely available. Once special needs clients have been placed in housing, there is a great need for “house calls” by occupational therapists or other providers to help the client retain the housing.³⁷

Section 8 Public Housing

Over 4,000 Alaska residents currently are using Section 8 public housing vouchers, which are allocated from the U.S. Department of Housing and Urban Development to the Alaska Housing and Finance Corporation’s Public Housing Division. In addition, as of July 2, 2007, there were 3,020 households still waiting for Section 8 vouchers. The number of vouchers allocated from HUD to AHFC is currently limited to 4,183, thus the need is greater than the supply.³⁵

Homeless Bed Inventory

According to the Alaska Housing and Finance Corporation, the 2007 Homeless Bed Inventory showed 1,265 emergency shelter beds and 690 transitional housing beds for a total of 1,955 temporary beds in Alaska.³⁶

Supportive Housing

There are approximately 538 supportive housing units statewide. These units, designed for those who are homeless with special needs, enable people to live as independently as practicable.³⁷ In supportive housing, residents have their own housing units and lease agreements.

Assisted Living

Throughout Alaska there are 2702 assisted living beds in 506 licensed facilities.³⁸ Assisted living is a more structured and regulated form of special needs housing. More often than not, the landlord and service provider are the same and housing tenancy is tied to using the services provided. Many of these required services are related to activities of daily living. In Alaska, virtually all of the special needs housing for persons with developmental disabilities are licensed assisted living homes.

Number of individuals discharged to homeless situations from Alaskan institutions:

Alaska Psychiatric Institute (API):

When Alaska Psychiatric Institute patients return to their home community, staff works to identify appropriate living arrangements whenever possible. Those who are homeless at discharge are typically referred to shelters in the community. Over the last six years, an average of 88 discharges a year have led to homeless status.³²

Alaska Department of Corrections:

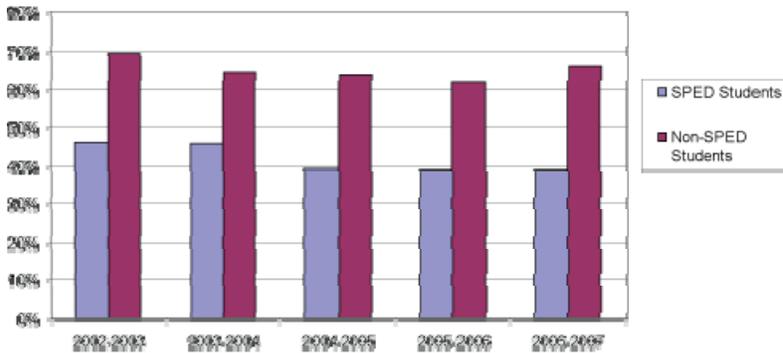
A 2005 Department of Corrections Homeless Offender survey found that 35% of offenders did not know where they would live upon release or planned to live in a shelter or on the street.³²

Dignity Goal #3: Assist Trust beneficiaries to receive the guidance and support needed to reach their educational goals.

The federal Individuals with Disabilities Education Act (IDEA)³⁹ is the primary law that entitles children with disabilities to a free and appropriate education. IDEA requires states to provide special education and related services to students who meet eligibility requirements. To be eligible, a student must meet criteria established in the law and the condition must adversely affect his or her educational performance. Children with disabilities must be taught in the least restrictive environment and among non-disabled children to the maximum extent appropriate.

IDEA requires schools to provide necessary accommodations, as identified in each student’s required Individual Education Plan, for special education students to participate in the high school exit examination. This accommodation includes development of an alternate assessment for students with significant disabilities. It is critical for children to participate in school and complete a high school course of study as part of their preparation for a life as independent as possible.

Figure 11: High School Graduation Rates for Students Receiving Special Education Compared with Students Not Receiving Special Education



Source: [Alaska Department of Education and Early Development](#)
(Data does not include GED)

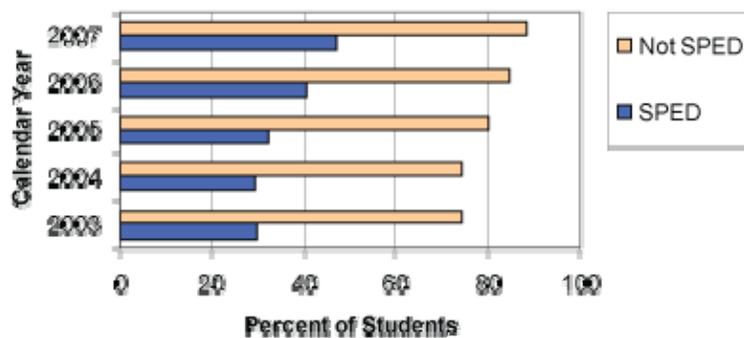
Figure 11 shows the rate of students who graduated from Alaska’s public high schools with a regular diploma. The graduation rate for high school students not receiving special education services rose by four percent in 2007. The graduation rate for students receiving special education services has remained at 39 percent for the last three school years. Between 2002 and 2007, the graduation rates for those in special education were 18 to 23 percent lower than the rates for those who did not receive special education services.

Alaska loses a significant number of students over their four years of high school. Reasons for discontinuing school include pursuing a GED, entering the military, becoming employed, facing family problems, illness, pregnancy, or alcohol/drug dependency, failing, truancy, being expelled due to behavior, transferring to non-district sponsored home schooling, or leaving for unknown reasons without a formal request for transfer of records. Part of the recent decline in overall graduation rates may be tied to better record keeping and reporting in the districts.

The data used to generate the graduation rate is the same for all students, whether or not they are on an Individual Education Plan. The actual yearly graduation rate is computed by determining the total number of graduates divided by the sum of the continuing 12th grade students plus the total of yearly “drop-outs” for each of the four preceding years (i.e., a cohort model).

In the 2003-04 school year, the state offered a one-year waiver to all special education students so that if they met all other graduation requirements in their district, they were granted a diploma without having passed the High School Graduate Qualifying Exam (HSGQE- high school exit exam). This caused a one -year spike in the Special Education graduates. The 2004-05 graduate counts returned to the historical norm.

Figure DL-1: Grade 10 Students Passing Qualifying Exams — Students Receiving Special Education Compared to Students Not Receiving Special Education



Source: [Alaska Department of Education and Early Development](#) (Data includes those graduating with regular diploma only)

Figure DL-1 provides information about 10th Grade students statewide who participated in the High School Graduate Qualifying Exam. It compares the percentage of students receiving special education services who scored above proficiency in reading, writing, and math, to the percent of students not receiving special education who also scored above proficiency.

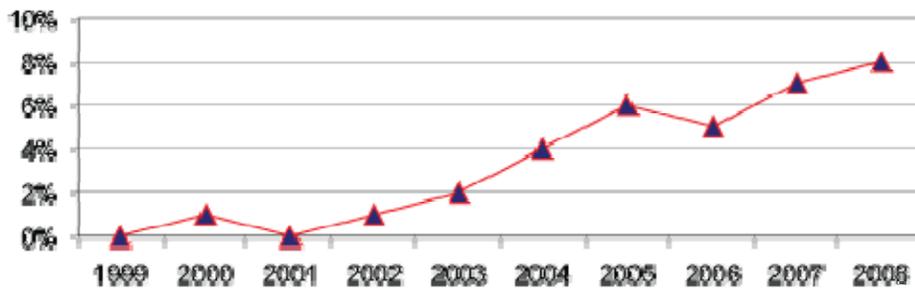
Overall, more students passed the exams in 2007 than in 2006. The rate of passage for those receiving special education rose over seven percent in 2007. Since 2002, this rate has been about 50% lower than the rate for those not receiving special education. Starting in 2006, new regulations changed some of the score thresholds needed for passing, which could have resulted in slightly higher passage rates.

Economic Security

“Economic security” means that people are able to provide basic necessities for themselves and their families. Many Trust beneficiaries must rely on public assistance to meet basic needs because they are unable to work or engage in subsistence activities. Unfortunately, public assistance has not kept pace with the cost of living, and poverty is common among Trust beneficiaries and their families. Alaskans living with mental health problems and developmental or cognitive disabilities who are able to work can be helped in this effort by continued Medicaid and assistance with expensive medications needed for the treatment of their illness.

Economic Security Goal #1: Make it possible for Trust beneficiaries most in need to live with dignity, ensuring they have adequate food, housing, medical care, work opportunities, and consistent access to basic resources.

Figure 12: Monthly SSI/APA Payments: Percent below Alaska Poverty Level by Year, 1999-2008

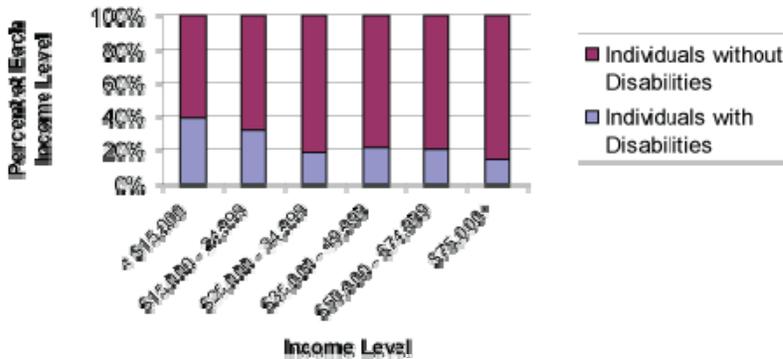


Source: AK DHSS Division of Public Assistance

The Social Security Income and Alaska Public Assistance programs provide a small amount of cash each month to assist elderly, blind, or disabled Alaskans. While the SSI payment is adjusted every year for inflation, the APA payment has not been keeping up with inflation because it is legally capped.

Figure 12 shows that the SSI/APA payment has eroded over the years in relation to the level of income that is defined each year as the Alaska poverty level. The monthly level of income defined as “poverty” in 2008 was \$1084, but the monthly SSI/APA payment was \$999.

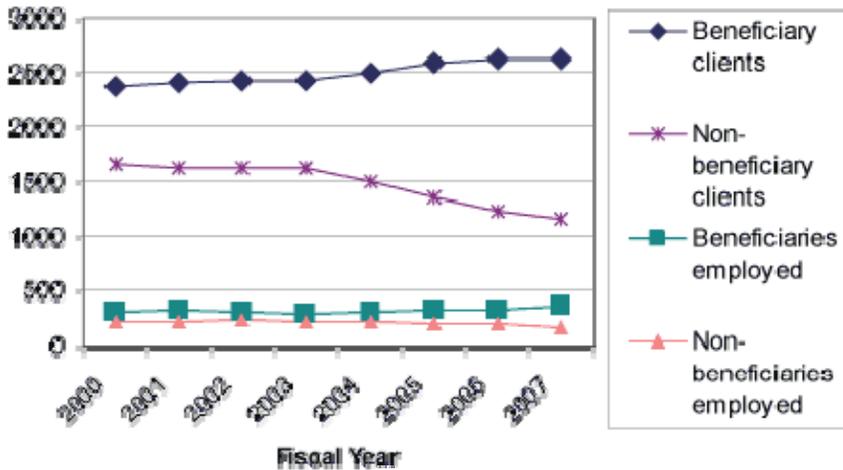
Figure 13: Alaska Population 18 and Over by Income Level and Disability Status, 2006-2007



Source: AK DHSS Division of Public Health Behavioral Risk Factor Surveillance Survey

Behavioral Risk Factor Surveillance Survey data from 2006 and 2007 show that Alaskans experiencing a disability (i.e., limited in any way in any activities because of physical, mental or emotional problems) have a significantly lower annual income than those not experiencing a disability.⁹

Figure 14: Number of Trust Beneficiaries Receiving Support through Division of Vocational Rehabilitation versus Number Employed



Source: Alaska Department of Labor and Workforce Development, Division of Vocational Rehabilitation

The Division of Vocational Rehabilitation (DVR) assists individuals with a disability to obtain and maintain employment. With the proper services and supports, such as education, on-the-job training, job search, and placement services, people with disabilities can be employed. Of the total clients served by DVR in 2007, 69 percent were Trust beneficiaries.

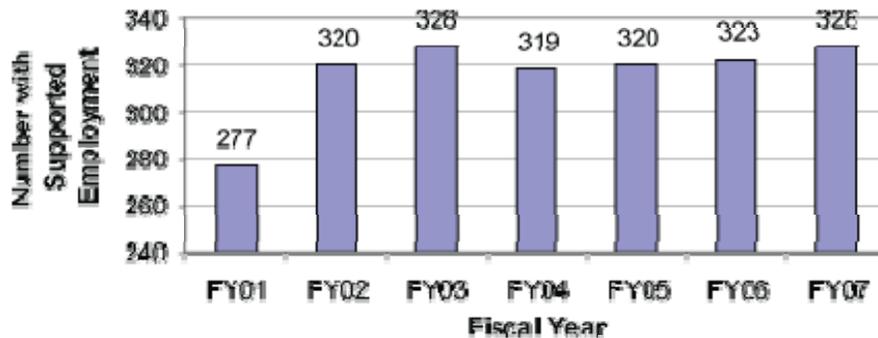
Figure 14 shows that the number of Trust beneficiaries served by DVR has increased and the number of non-beneficiaries served has decreased during recent years.

Between 2000 and 2007, the number of Trust beneficiaries served by DVR who became employed grew approximately 19 percent.

Current DVR employment initiatives targeting Trust beneficiaries include the Disability Program Navigators, the Alaska Mental Health Court project, collaboration with community treatment programs, and the Alaska Start-Up grant. This latter's focus is on micro-enterprise development.

Other initiatives of DVR with a focus on Trust beneficiaries during this period have included the Customized Employment Grant (CEG), supported employment services, and micro-enterprise grants from The Trust. The goal of the CEG was to build the capacity in Job Centers to serve people with severe disabilities so that they have more responsive and individualized employment. The micro-enterprise grants required DVR to match the funds and focus on self-employment ventures. Supported employment is a service delivery system within the vocational rehabilitation program to provide employment opportunities to individuals who require intensive services to gain employment and extended services to maintain employment.

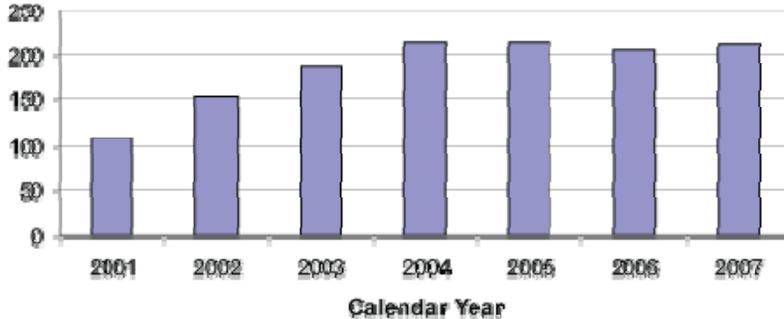
Figure ES-1: MR/DD Waiver Recipients who Receive Supported Employment Services



Source: [DHSS Div. of Senior and Disabilities Services](#)

Figure ES-1 shows that the number of Mental Retardation/Developmental Disability waiver recipients receiving supported employment has ranged from 277 in fiscal year 2001 to 328 in fiscal year 2007. “Supported employment” is paid employment for persons with developmental disabilities for whom competitive employment at or above the minimum wage is unlikely and who, because of their disabilities, need intensive ongoing support, including supervision and training, to perform in a work setting. Medicaid covers the costs of supported employment for people with developmental disabilities, allowing participants to contribute to the community and to their own sense of self-esteem through work.

Figure ES-2: Average Number of Participants in the Medicaid Buy-in Option



Source: AK DHSS Div. of Public Assistance

The [Working Disabled Medicaid Buy-in](#) is a category of Medicaid intended to encourage an individual with a disability to work (if they are able) by giving or extending their access to health coverage. Alaska was the first state to pass legislation that provides for this program and participation has doubled since 2001. To participate in the buy-in program, family income cannot exceed 250 percent of federal poverty guidelines for Alaska, and the individual's monthly unearned income must be less than \$1183 (\$1422, if married) and countable assets of less than \$2000 (\$3000, if married).

Affordability of Housing

Many Alaskan families cannot afford adequate housing. The Fair Market Rent (FMR) for a two-bedroom apartment in Alaska is \$970. In order to afford this level of rent and utilities, without paying more than 30 percent of income on housing, a household must earn \$3,233 monthly or \$38,797 annually. (A unit is considered affordable if it costs no more than 30% of the renter's income.) Assuming a 40-hour work week, 52 weeks per year, this level of income translates into a Housing Wage of \$18.65.

In Alaska, a minimum wage worker earns an hourly wage of \$7.15. In order to afford the FMR for a two-bedroom apartment, a minimum wage earner must work 104 hours per week, 52 weeks per year. Or, a household must include 2.6 minimum wage earner(s) working 40 hours per week year-round in order to make the two-bedroom FMR affordable.

Monthly Supplemental Security Income (SSI) payments for an individual are \$637 in Alaska. If SSI represents an individual's sole source of income, affordable rent (30% of \$637) is \$191. However, the Fair Market Value for a one-bedroom rental is \$772.

Table E-1: Alaska Rent-Wage Disparities by Census Area, Alaska, 2007

Community	Affordable Rent*	SSI/APA Affordable Rent	2-BR Fair Market Rent (FMR)	Wage Needed to Afford 2-BR FMR	Hrs per week at Min Wage
			Fair Market Rent	Per Hour	
Anchorage	\$583	\$191/\$109	\$930	\$17.88	100
Barrow	\$593	\$191/\$109	\$1,202	\$23.12	129
Bethel	\$341	\$191/\$109	\$1,319	\$25.37	142
Dillingham	\$416	\$191/\$109	\$1,093	\$21.02	118
Fairbanks	\$535	\$191/\$109	\$934	\$17.96	100
Juneau	\$653	\$191/\$109	\$1,192	\$22.92	128
Kenai	\$500	\$191/\$109	\$795	\$15.29	86
Ketchikan	\$547	\$191/\$109	\$1,047	\$20.13	113
Kodiak	\$548	\$191/\$109	\$1,126	\$21.65	121
Mat-Su	\$515	\$191/\$109	\$879	\$16.90	95
Nome	\$409	\$191/\$109	\$1,121	\$21.56	121
Sitka	\$579	\$191/\$109	\$999	\$19.21	107
Unalaska	\$660	\$191/\$109	\$1,093	\$21.02	118
Valdez	\$560	\$191/\$109	\$984	\$18.92	106

Source: *National Low Income Housing Coalition "Out of Reach" 2007-2008.*

Table E-1 shows how much money a person in each Alaska census area would need to earn in order for them to be spending only the recommended 30 percent of their income on a typical two-bedroom rental. For instance, a person renting a two-bedroom apartment in Mat-Su would need to earn \$16.90 per hour working regular fulltime hours. But if they were only able to earn minimum wage, they would need to work 95 hours per week.

**"Affordable rent" means monthly rent affordable to a household earning 30% of Annual Median Income, applying the generally accepted standard of spending not more than 30% of income on housing costs.

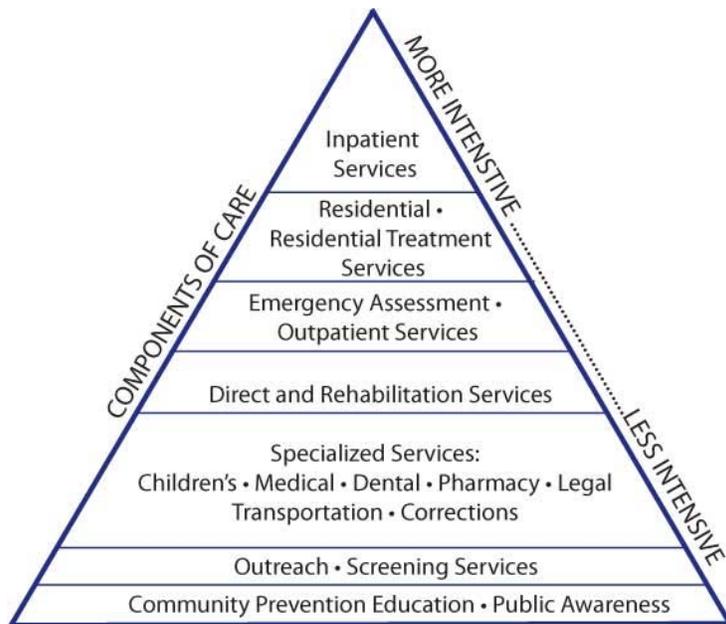
III. Current Services and Service Gaps Analysis

Note: This section has not been updated since the original Moving Forward plan was written in 2006.

Services for Alaskans experiencing developmental disabilities, alcoholism or other drug addictions, mental or emotional illnesses, and Alzheimer’s disease or other dementias were originally shaped and frequently compartmentalized by federal funding availability and federal program requirements. Advocates and program managers have long recognized that service integration is a first step toward higher quality services, increased access to services, and greater cost savings. In addition, many people experience more than one beneficiary disability during the course of their lifetimes. Simplifying and coordinating services for people with multiple cognitive or developmental disabilities is both cost effective and provides better care. [Initiatives](#), discussed in a later section, address gaps in service delivery systems.

Components of Care

Figure 15: Components of Care for Trust Beneficiary Groups



The Trust and the Department of Health and Social Services support the components of care illustrated in Figure 15, ranging from prevention at the bottom to acute care at the top for people requiring intensive care. Public education and prevention services reach large audiences. Services in the middle of the triangle are home and community based and used by those people requiring a less intensive level of care. Although economies of scale restrict some services to urban areas, the Plan’s vision is that appropriate services would be available when needed across the state.

The components of care listed are only those that serve three or more beneficiary groups. These are the same services listed in the Matrix in Table 2.

Current Services

Table 2 shows the geographic availability of services used by three or more Trust beneficiary groups

Table 2: Current Comp MH Plan Services Matrix

Matrix of Current CIMHP Services for Three or More Trust Beneficiary Groups

Service	Level 1: Village	Level 2: Subregional Center or town	Level 3: Regional Center or Small City	Level 4: Urban Center	Level 5: Metropolitan Area
Population	25+ in immediate community.	500+ in immediate community; a sub-regional population of at least 1,500.	2,000+ in immediate community, providing services to a regional population of at least 5,000	25,000 + in immediate community providing services to a larger regional or statewide population	200,000 + in immediate community.
Inpatient services	☐	☐	❖	◆	◆
Residential Services	☐	☐	•	❖	❖
Emergency/ Assessment / Outpatient Services	•	❖	❖	◆	◆
Direct and Rehabilitation Services	•	❖	❖	❖	❖
Specialized Services					
Children's Services	•	•	❖	❖	❖
Medical services – specialized	☐	☐	◆	❖	❖
Dental services – specialized	☐	☐	❖	❖	◆
Pharmacy services	•	◆	◆	◆	◆
Legal services	❖	❖	❖	❖	❖
Transportation services – specialized	•	•	❖	❖	❖
Corrections services	☐	☐	•	❖	❖
Outreach/Screening	•	•	❖	❖	❖
Community Prevention, Education, Public Awareness	•	•	❖	❖	❖

- ◆ Available (adequate): the service is widely available and meets most needs
- ❖ Sometimes available (gaps exist): the service is currently available in many communities of that size but not in all such communities, or is not available to all eligible individuals due to inadequate resources.
- Minimally available (needed): the service is mostly unavailable.
- ☐ There is not general agreement that these services are feasible at this level of community.

Service Gaps Analysis

The matrix in Table 2 represents a first effort to analyze those similar services provided by separate service delivery systems to different Trust beneficiary groups. Planning staff (DHSS, The Trust, AMHB, ABADA, GCDSE, ACoA, and the Department of Corrections) developed this matrix by comparing service definitions used by different programs and coming to agreement about common definitional elements and suitable aggregate

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definitions. Next, based on the common definitions, the group assessed service availability using the Alaska Mental Health Board's Level of Community template. This assessment was based on data and documents produced by the agencies represented by the planning staff.

Development of the matrix assists in considering collaborative approaches and in determining priorities for service needs. Several observations can be made from the matrix:

- Many commonalities exist among services to beneficiaries, especially in such specialized services as medical, dental and pharmacy services.
- The more specialized the service, the more likely it is to have substantial gaps in delivery. For example, even in Alaska's metropolitan area (Anchorage), gaps exist in direct and rehabilitation care, the foundation of personal support and recovery: even when a service is available, "gaps" may reflect a lack of capacity to serve all who need that service.
- Access to care and participation in community life may require specialized transportation, a service that is needed across all levels of community.
- The matrix also shows that despite efforts to develop services in regional centers, this strategy has not yet produced a full range of adequate care in those areas.
- Below the regional center level, many gaps exist, both for individualized services and for facility based care.
-

Some service delivery programs, notably those for people with Alzheimer's disease or similar dementia and for people with developmental disabilities, try to meet each person's particular needs in their own homes. Ideally, this would mean that all services could be made available at each level of community. However, the reality is that resources frequently limit such delivery. Often, providers may not be available in a community, but more commonly, resources do not meet current need. For example, about 1,006 people with developmental disabilities were waiting for services at the end of fiscal year 2006. ⁴⁰

The Trust and the Department have targeted development of infrastructure and resources for many of these services.

Definitions for “Levels of Community”

LEVELS OF COMMUNITY*					
Characteristics	Level I: Frontier/Village	Level II: Sub-Regional Center or Town	Level III: Regional Center or Small City	Level IV: Urban Center	Level V: Metropolitan Area
Government	Community or city council, Native Council, incorporated city or unincorporated community.	Incorporated city, may have health powers and may provide health and social services.	Incorporated city or unified municipality, may have health powers and may provide health and social services.	Incorporated, home rule city or unified municipality; may have health powers and may provide health and social services.	Incorporated, home rule city, or unified municipality; may have health powers and may provide health and social services.
Population	25+ in immediate community.	500+ in immediate community; a sub-regional population of at least 1,500.	2,000+ in immediate community, providing services to a regional population of at least 5,000	25,000+ in immediate community providing services to a larger regional or statewide population	200,000+ in immediate community.
Economy	Subsistence, government services (e.g. school)	A developing private sector, some government services; provides some service to surrounding areas.	Regional trade and service center, mixed economy with multiple private and government employers.	Major trade and service center, broad based multi-sector economy.	Principal trade and service center; broad based, multi-sector economy.
Health & Social Services	Community Health Aide, paraprofessional and itinerant services.	Health and social services may be provided by both the private and public sector, community clinic and mid-level provider or MD.	Health care and social service agencies, including both private and government programs; community hospital and physicians.	Multiple providers of health care and other services including both private and government programs; health care specialists;	Level IV plus highly specialized medical and rehabilitation services; specialized hospitals and consulting services.

				hospitals with full continuum of care.	
Access	Usually, more than 60 minutes by year-round ground transportation from a Level II or III community.; limited air and/or marine highway access to Level II or III community.	Usually less than 60 minutes by year-round ground transportation from a Level III community; marine highway or daily air access to closest Level III community; airline service to Level I communities in the area.	Daily air service to closest Level IV or V community; airline service to Level I and II communities in the region; road or marine highway access all year.	Daily airline service to Level II, III, IV, and V communities; road or marine highway access all year.	Daily airline service to Level II-IV communities; road or marine highway access all year.
Communities	Too numerous to list, includes Anvik, Eagle, Houston, Ruby, Hydaburg, Wales, Skagway, etc...	Aniak, Craig, Delta Junction, Tok, Emmonak, Fort Yukon, Galena, Haines, Hoonah, Hooper Bay, King Cove, King Salmon/Naknek, Nenana, McGrath, Metlakatla, Mt Village, St. Mary's, Sand Point, Togiak, Unalaska, Unalakleet, Glennallen/ Copper Center	Barrow, Bethel, Dillingham, Homer, Kenai/Soldotna, Ketchikan, Kodiak, Kotzebue, Nome, Palmer/Wasilla, Sitka, Cordova, Petersburg, Wrangell, Valdez, Seward	Fairbanks, Juneau	Anchorage

**Levels of Community Care is a document created by the Alaska Mental Health Board (rev.8/93).*

***Continuum of Care Matrix for Alaskans with
Mental Illness and/or Substance Use Disorders***

LEVELS OF COMMUNITY*					
Characteristics	Level I: Frontier/Village	Level II: Sub-Regional Center or Town	Level III: Regional Center or Small City	Level IV: Urban Center	Level V: Metropolitan Area
I. Community Prevention / Education	I. Community Prevention/Education	I. Community Prevention/Education	I. Community Prevention/Education	I. Community Prevention/Education	I. Community Prevention/Education
	a. Advocacy/self-help	a. Advocacy/self-help	a. Advocacy/self-help	a. Advocacy/self-help	a. Advocacy/self-help
	b. Prevention and intervention	b. Prevention and intervention	b. Prevention and intervention	b. Prevention and intervention	b. Prevention and intervention
	c. Community education	c. Community education	c. Community education	c. Community education	c. Community education
	d. Peer, Consumer, and Client Support	d. Peer, Consumer, and Client Support	d. Peer, Consumer, and Client Support	d. Peer, Consumer, and Client Support	d. Peer, Consumer, and Client Support
	Services	Services	Services	Services	Services
	General Availability?	General Availability?	General Availability?	General Availability?	General Availability?
None	Very limited	Limited capacity	Some capacity	Greatest capacity	

II. Behavioral Health Services (a-g)					
a. Outreach	a. Outreach General Availability? None	a. Outreach General Availability? Very Limited	a. Outreach General Availability? Limited capacity	a. Outreach General Availability? Some capacity	a. Outreach General Availability? Greatest capacity
b. Emergency Services	b. Emergency Services i. 24 hour telephone screening, assessment, triage ii. Crisis Intervention & Stabilization General Availability? Very limited	b. Emergency Services i. 24 hour telephone screening, assessment, triage ii. Crisis Intervention & Stabilization General Availability? Good capacity	b. Emergency Services i. 24 hour telephone screening, assessment, triage ii. Crisis Intervention & Stabilization General Availability? Good capacity	b. Emergency Services i. 24 hour telephone screening, assessment, triage ii. Crisis Intervention & Stabilization General Availability? Very good capacity	b. Emergency Services i. 24 hour telephone screening, assessment, triage ii. Crisis Intervention & Stabilization General Availability? Very good capacity
c. Assessment	c. Assessment i. screening ii evaluation/referral General Availability?	c. Assessment i. screening ii evaluation/referral General Availability?	c. Assessment i. screening ii evaluation/referral General Availability?	c. Assessment i. screening ii evaluation/referral General Availability?	c. Assessment i. screening ii evaluation/referral General Availability?

	Very limited	Good capability	Good capability	Excellent capability	Excellent capability
d. Outpatient (Clinic-Based) Services	d. Outpatient Services i. Screening ii. Face-to-Face assessment & triage (SA;MH; TBI) iii Treatment Planning iv. Counseling (1:1; Group) General Availability? None	d. Outpatient Services i. Screening ii. Face-to-Face assessment & triage (SA;MH; TBI) iii Treatment Planning iv. Counseling (1:1; Group) General Availability? Limited capacity	d. Outpatient Services i. Screening ii. Face-to-Face assessment & triage (SA;MH; TBI) iii Treatment Planning iv. Counseling (1:1; Group) General Availability? Good capacity	d. Outpatient Services i. Screening ii. Face-to-Face assessment & triage (SA;MH; TBI) iii Treatment Planning iv. Counseling (1:1; Group) General Availability? Excellent capability	d. Outpatient Services i. Screening ii. Face-to-Face assessment & triage (SA;MH; TBI) iii Treatment Planning iv. Counseling (1:1; Group) General Availability? Excellent capability
e. Rehabilitation & Recovery Services	e. Rehabilitation & Recovery Services i. Case Management ii. Skill Development iii. Day Treatment iv. School/home-based services	e. Rehabilitation & Recovery Services i. Case Management ii. Skill Development iii. Day Treatment iv. School/home-based services	e. Rehabilitation & Recovery Services i. Case Management ii. Skill Development iii. Day Treatment iv. School/home-based services	e. Rehabilitation & Recovery Services i. Case Management ii. Skill Development iii. Day Treatment iv. School/home-based services	e. Rehabilitation & Recovery Services i. Case Management ii. Skill Development iii. Day Treatment iv. School/home-based services

	<p>v. Supported Living</p> <p>vi. Individualized services</p> <p>vii. Intensive outpatient services</p> <p>General Availability?</p> <p>None</p>	<p>v. Supported Living</p> <p>vi. Individualized services</p> <p>vii. Intensive outpatient services</p> <p>General Availability?</p> <p>Very limited</p>	<p>v. Supported Living</p> <p>vi. Individualized services</p> <p>vii. Intensive outpatient services</p> <p>General Availability?</p> <p>Good capacity</p>	<p>v. Supported Living</p> <p>vi. Individualized services</p> <p>vii. Intensive outpatient services</p> <p>General Availability?</p> <p>Excellent capacity</p>	<p>v. Supported Living</p> <p>vi. Individualized services</p> <p>vii. Intensive outpatient services</p> <p>General Availability?</p> <p>Excellent capacity</p>
f. Medical Services	<p>f. Medical Services</p> <p>i. Psychiatric Assessment</p> <p>ii. Pharmacological Management</p> <p>iii. Medical Co-morbidity</p> <p>General Availability?</p> <p>None</p>	<p>f. Medical Services</p> <p>i. Psychiatric Assessment</p> <p>ii. Pharmacological Management</p> <p>iii. Medical Co-morbidity</p> <p>General Availability?</p> <p>Limited</p>	<p>f. Medical Services</p> <p>i. Psychiatric Assessment</p> <p>ii. Pharmacological Management</p> <p>iii. Medical Co-morbidity</p> <p>General Availability?</p> <p>Good capacity</p>	<p>f. Medical Services</p> <p>i. Psychiatric Assessment</p> <p>ii. Pharmacological Management</p> <p>iii. Medical Co-morbidity</p> <p>General Availability?</p> <p>Good capacity</p>	<p>f. Medical Services</p> <p>i. Psychiatric Assessment</p> <p>ii. Pharmacological Management</p> <p>iii. Medical Co-morbidity</p> <p>General Availability?</p> <p>Good capacity</p>

<p>Detoxification Services</p>	<p>g. Detoxification i. social detox ii. outpatient detox iii. medical detox General Availability? None</p>	<p>g. Detoxification i. social detox ii. outpatient detox iii. medical detox General Availability? Very limited</p>	<p>g. Detoxification i. social detox ii. outpatient detox iii. medical detox General Availability? Very Limited</p>	<p>g. Detoxification i. social detox ii. outpatient detox iii. medical detox General Availability? Limited</p>	<p>g. Detoxification i. social detox ii. outpatient detox iii. medical detox General Availability? Limited</p>
<p>III. Residential Services</p>					
<p>a. Children Services</p>	<p>a. Day Treatment b. Foster Homes c. Therapeutic Group Homes d. Emergency Stabilization & Assessment e. Residential Treatment f. Secure Locked Residential Care</p>	<p>a. Day Treatment b. Foster Homes c. Therapeutic Group Homes d. Emergency Stabilization & Assessment e. Residential Treatment f. Secure Locked Residential Care</p>	<p>a. Day Treatment b. Foster Homes c. Therapeutic Group Homes d. Emergency Stabilization & Assessment e. Residential Treatment f. Secure Locked Residential Care</p>	<p>a. Day Treatment b. Foster Homes c. Therapeutic Group Homes d. Emergency Stabilization & Assessment e. Residential Treatment f. Secure Locked Residential Care</p>	<p>a. Day Treatment b. Foster Homes c. Therapeutic Group Homes d. Emergency Stabilization & Assessment e. Residential Treatment f. Secure Locked Residential Care</p>

	General Availability? None	General Availability? Very limited	General Availability? Limited Capacity	General Availability? Good capacity	General Availability? Good capacity
b. Adult Services	a. Crisis Respite b. Residential Treatment General Availability? None	a. Crisis Respite b. Residential Treatment General Availability? None	a. Crisis Respite b. Residential Treatment General Availability?	a. Crisis Respite b. Residential Treatment General Availability?	a. Crisis Respite b. Residential Treatment General Availability?
IV. Inpatient Services (Acute)	a. Acute Psychiatric Care b. DET / DES General Availability? None	a. Acute Psychiatric Care b. DET / DES General Availability? None	a. Acute Psychiatric Care b. DET / DES General Availability? Very limited	a. Acute Psychiatric Care b. DET / DES General Availability? Limited	a. Acute Psychiatric Care b. DET / DES General Availability? Good

Definitions - Continuum of Care Matrix for Alaskans with Mental Illness and/or Substance Use Disorders

Community Prevention/Education: Community interventions and education that ward off the initial onset or risk of a substance use or mental disorder or emotional or behavioral problem, including prevention of co-occurring substance use and mental health disorder. Community prevention/education examples include peer/consumer and client support services; community education; advocacy/self-help; and prevention.

Outreach: Facilitate entry into treatment or meeting the individual within their community, job, home or school setting to engage in treatment or support services for either a substance use or mental disorder or for those individuals experiencing co-occurring mental health and substance use disorders.

Emergency Services: are provided in a crisis situation during an acute episode of a substance use, mental, emotional or behavioral disorder. Emergency services are intended to reduce the symptoms of the disorder, prevent harm to the recipient or others; prevent further relapse or deterioration of the recipient's condition; or to stabilize the recipient. Inpatient Medical Detox is also included in this section. This level of detoxification provides the highest level of monitoring. Placement criteria are defined by the presence of high risk factors for complicated withdrawal: high risk biomedical complications, psychiatric or behavioral complications.

Detoxification Services: Detoxification is a process involving multiple procedures for alleviating the short-term symptoms of withdrawal from drug dependence. The immediate goals of detoxification are 1) to provide a safe withdrawal from the drug(s) of dependence and enable the client to become drug free; 2) to provide withdrawal that is humane and protects the client's dignity; and 3) prepares the client for ongoing treatment of alcohol or drug dependence.

Social Detox: This is a model of detoxification that requires no medication, and allows the client to withdraw from abused chemicals in a safe environment.

Outpatient Detox : The client is at minimal risk from severe withdrawal, which requires moderate levels of medication and monitoring.

Medical Detox: This level of detoxification provides the highest level of monitoring. Placement criteria are defined by the presence of high risk factors for complicated withdrawal: high risk biomedical complications, psychiatric or behavioral complications.

Assessment: A face-to-face, computer assisted, or telephone interview with the person served to collect information related to his or her history and needs, preferences, strengths, and abilities in order to determine the diagnosis, appropriate services, and /or referral for services to address substance use and or mental disorders. The type of assessment is determined by the level of entry into services and the qualified staff delivering the service: Intake Assessment, Drug/Alcohol Assessment, Psychiatric Assessment, Psychological Assessment, Neuro-Psychological Testing and Evaluation.

Outpatient (Clinic-Based) Services: Refers to a range of facility based behavioral health services that can include assessment, individual, family, and group therapy. These services are designed to treat substance use disorders, mental illness, behavioral maladaptation, or other problems: to remove, modify, or retard existing symptoms, attenuate or reverse disturbed patterns of behavior and promote positive recovery, rehabilitation, and personality growth and development.

Note: Screening differs from assessment in the following ways:

Screening is a process for evaluating the possible presence of a particular problem; and,

Assessment is a process for defining the nature of that problem and developing specific treatment recommendations for addressing the problem.

Rehabilitation and Recovery Services: Refers to a range of services that are available to clients who meet criteria based on levels of functioning in multiple spheres. Services can include a functional assessment, case management, individual/family/group skill development, and recipient support services. A functional assessment assists the client in identifying areas of need in developing a treatment plan. Case management services assist the recipient in accessing and coordinating needed services, such as medical, substance use, psychiatric, and behavioral health care. Skill development services help the recipient develop or improve specific self-care skills, self-direction, communication and social interaction skills necessary for successful community adjustment and interaction with persons in the recipient's home, school, work, or community environment. Recovery is a treatment philosophy that provides the framework of service delivery. A recovery model offers hope that the restoration of a meaningful life is possible and achievable.

Medical Services: Refers to a range of behavioral health services that are delivered by trained medical staff, and can include psychiatric assessment and pharmacological management, and medical co-morbidity.

Residential Services: Is a licensed 24 hour facility (not licensed as a hospital) which offers behavioral health services which include treatment for substance use disorders; settings range from structured facilities, resembling psychiatric hospitals or drug/alcohol treatment facilities, to those that function as group homes or halfway houses; therapeutic foster care and foster care, family teaching homes, crisis beds, therapeutic group homes, staff-secure crisis/respite group homes, residential case managements specialized drug/alcohol, evaluation/treatment and specialized vocational rehabilitation.

Inpatient Services: Inpatient hospitalization is the most restrictive type of care in the continuum of behavioral health services; it focuses on ameliorating the risk of danger to self or others in those circumstances in which dangerous behavior is associated with substance use or mental disorder. Services include facility-based crisis respite, community hospitals, Designated Evaluation and Treatment (DET) beds, and the Alaska Psychiatric Institute (API).

Continuum of Care Matrix for Alaskans

with Developmental Disabilities

LEVELS OF COMMUNITY*					
Characteristics	Level I: Frontier/Village	Level II: Sub-Regional Center or Town	Level III: Regional Center or Small City	Level IV: Urban Center	Level V: Metropolitan Area
I. Information and Referral	Telephonic <ul style="list-style-type: none"> assistance in completing eligibility applications information about and referral to services described below 	Telephonic <ul style="list-style-type: none"> assistance in completing eligibility applications information about and referral to services described below 	Telephonic <ul style="list-style-type: none"> assistance in completing eligibility applications information about and referral to services described below 	Telephonic <ul style="list-style-type: none"> assistance in completing eligibility applications information about and referral to services described below 	Telephonic <ul style="list-style-type: none"> assistance in completing eligibility applications information about and referral to services described below
II. Direct Services	<ul style="list-style-type: none"> Case Management/Care Coordination 				

	<ul style="list-style-type: none"> • Respite • Specialized Medical Equipment • Environmental Modifications • Day Habilitation • Supported Employment / Subsistence Activities • Vocational Rehabilitation • Transportation • Educational services <ul style="list-style-type: none"> ○ Infant Learning ○ Preschool ○ K-12 • Chore Services • Intensive Active Treatment • Crisis Response • Legal Services 	<ul style="list-style-type: none"> • Respite • Specialized Medical Equipment • Environmental Modifications • Day Habilitation • Supported Employment / Subsistence Activities • Vocational Rehabilitation • Transportation • Educational services <ul style="list-style-type: none"> ○ Infant Learning ○ Preschool ○ K-12 • Chore Services • Intensive Active Treatment • Crisis Response • Legal Services 	<ul style="list-style-type: none"> • Respite • Specialized Medical Equipment • Environmental Modifications • Day Habilitation • Supported Employment / Subsistence Activities • Vocational Rehabilitation • Transportation • Coordinated transportation system • Educational services <ul style="list-style-type: none"> ○ Infant Learning ○ Preschool ○ K-12 • Educational services <ul style="list-style-type: none"> ○ Infant Learning ○ Preschool ○ K-12 • Chore Services • Intensive Active Treatment • Crisis Response • Medical • Dental • Pharmaceutical • Recreation • Legal Services 	<ul style="list-style-type: none"> • Respite • Specialized Medical Equipment • Environmental Modifications • Day Habilitation • Supported Employment • Vocational Rehabilitation • Transportation • Coordinated transportation system • Educational services <ul style="list-style-type: none"> ○ Infant Learning ○ Preschool ○ K-12 • Chore Services • Intensive Active Treatment • Crisis Response • Medical • Dental • Pharmaceutical • Recreation • Legal Services 	<ul style="list-style-type: none"> • Respite • Specialized Medical Equipment • Environmental Modifications • Day Habilitation • Supported Employment • Vocational Rehabilitation • Transportation • Coordinated transportation system • Educational services <ul style="list-style-type: none"> ○ Infant Learning ○ Preschool ○ K-12 • Chore Services • Intensive Active Treatment • Crisis Response • Medical • Dental • Pharmaceutical • Recreation • Legal Services
III. Residential Services	<ul style="list-style-type: none"> • In-home Support 	<ul style="list-style-type: none"> • In-home Support 	<ul style="list-style-type: none"> • In-home Support 	<ul style="list-style-type: none"> • In-home Support 	<ul style="list-style-type: none"> • In-home Support

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	<ul style="list-style-type: none">• Shared Care• Family Habilitation• Supported Living	<ul style="list-style-type: none">• Shared Care• Family Habilitation• Supported Living	<ul style="list-style-type: none">• Shared Care• Family Habilitation• Supported Living• Group Home	<ul style="list-style-type: none">• Shared Care• Family Habilitation• Supported Living• Group Home	<ul style="list-style-type: none">• Shared Care• Family Habilitation• Supported Living• Group Home
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Definitions - Continuum of Care Matrix for Alaskans with Developmental Disabilities

I. Information and Referral is a service whereby individuals and families can learn about the generic and specialized types of services and supports available in Alaska. Assistance in acquiring and completing eligibility paperwork can be provided, and referrals can be made to agencies offering the types of services an individual or family is seeking. This service is provided by a variety of agencies, including Infant Learning and Early Intervention Programs, school districts, Head Start, Public Health Centers, the Department of Health & Social Services, and various non-profit agencies that provide services to individuals and families.

II. Direct Services described below are available to eligible individuals depending on availability of funding.

Case Management/Care Coordination assists persons in gaining access to needed medical, social, educational and other services regardless of the funding source for the services to which access is gained. Case management links persons with complex personal circumstances to appropriate services and insures coordination of those services. This service may include referral services, routine monitoring and support, and/or review and revision of the habilitation plan.

Respite provides relief to caregivers from the everyday stress of caring for an individual who experiences a disability. Respite care can be provided in a variety of settings. Providers are trained in first aid, CPR, behavior and physical management, and information specific to the recipient's needs. Respite care cannot be used for regular childcare or adult day care except for short-term emergency situations.

Specialized Medical Equipment and Supplies are devices, controls or appliances that enable an individual to increase their ability to perform activities of daily living, or to perceive, control or communicate with the environment in which the individual lives. They are also supplies and equipment necessary for the proper functioning of the above medical equipment.

Environmental Modifications are physical adaptations to an individual's home, which are necessary to ensure the health, welfare and safety of the recipient.

Day Habilitation services assist with acquisition, retention or improvement in self-help, socialization and adaptive skills, and may include pre-vocational training or subsistence activities. These services take place in a nonresidential setting, separate from the home in which the individual lives.

Supported Employment services are provided at a work site in which individuals without disabilities are employed. They include the adaptations, supervision and training needed by individual unlikely to obtain competitive employment at or above the minimum wage. Supported employment is for individuals who need intensive, ongoing support, supervision and training to perform in a work setting. Supported employment may include subsistence activities.

Vocational Rehabilitation services include job counseling, referral, on-the-job training, tests and tools to evaluate an individual's talents, short-term job try-out, job search and placement services, interpreter, reading and tutoring services. In some cases additional services may be covered.

Transportation services enable an individual and necessary escort to gain access to home and community-based waiver services or other community services and resources. Transportation may be provided as part of a coordinated transportation system, with public buses, accessible, door-to-door vans and/or taxi service. In smaller communities this service may be provided through social service agencies.

Educational Services are provided to eligible children birth to 3 through the Infant Learning Program, from 3-5 through the school districts and/or Head Start and from 5-22 through the school districts.

Infant Learning Program services include developmental screening, evaluation, and information about the child's strengths and needs, home visits to help the family or caregivers guide their children in learning new skills, physical, occupation or speech therapy, specialized equipment and resources, and assistance in getting other specialized services and care.

Preschool Special Education services are provided to children ages three through five in order to meet their individual needs identified either through the Infant Learning Program or designed by an interdisciplinary team working through an Alaskan school district. These services are developmentally appropriate and include needed physical, occupational and/or speech therapy, and needed adaptive equipment. Services are designed to prepare children for an inclusive kindergarten placement.

Special Education and Related Services encompass the provision of a free and appropriate education to children aged 3-21 who experience a disability and require specialized instruction in the least restrictive environment. Certified special educators and aides provide a range of services including adaptive physical education, individualized help with all school subjects and classes. Public schools are charged with transitioning students to adult life beginning at age 16. The overall goal of special education is to prepare students for independent living and employment.

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Chore Services include regular cleaning and heavy household chores within an individual's residence, snow shoveling to provide safe access and egress, and other services necessary to maintain a clean, sanitary and safe environment in the individual's residence.

Intensive Active Treatment are time-limited specific treatments or therapies to address a family problem or a personal, social, behavioral, mental, or substance abuse disorder in order to maintain or improve effective functioning of an individual. These are designed and provided by a professional or paraprofessional working under a professional.

Crisis Response is offered as short-term assistance to people with developmental disabilities and their families. The purpose is to stabilize circumstances in order to keep the family unit intact, prevent an out-of-home placement, or to maximize an individual's ability to function independently in a difficult situation by providing immediate but limited relief. Examples include ground and/or air transportation and lodging, emergency car repairs needed to maintain employment, and emergency utility expenses if there is an immediate health and safety issue.

Medical services include screening, assessment, diagnosis, and treatment. Specialist and sub-specialist care is available in a limited number of larger communities.

Dental services include preventive and restorative care.

Pharmaceutical services provide access to prescribed medications, nutritional supplements, and durable medical supplies and equipment.

Recreational services are frequently offered by parks and recreation programs. Therapeutic and inclusive recreation and the loan of adaptive recreational equipment are also available.

Legal advocacy services for people with disabilities are available. The state's protection and advocacy program provides training in self-advocacy, disability rights, and special education, assists individuals and family members in advocating for their rights, provides legal representation when problems cannot be resolved by other means, and investigates complaints of abuse, neglect and denial of rights. Private attorneys may also provide representation for a fee.

III. Residential Services

In-home Support services are designed to help individuals overcome or cope with functional limitations.

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Shared Care is an arrangement whereby an individual spends more than 50% of the time in the home of an unpaid primary caregiver, and the remainder of the time in an assisted living home.

Family Habilitation services are provided to individuals who live more than 50% of the time in an assisted living home or foster home, receiving care from a paid caregiver who is not a member of the individual's family. This residential arrangement does **not** require the natural family to give up custody or parental rights. Families and the individual may help choose the Family Habilitation home.

Group Homes are provided to individuals 18 years of age or older who live in an assisted living home. Habilitation plans frequently include goals designed to develop relationships and skills that lead toward increased independence.

Supported Living services are provided to individuals 18 years of age or older in the recipient's private residence by a caregiver who does not reside in that residence. Habilitation plans identify the various levels of training and supervision needed by adults moving into or living in settings that maximize their independence.

Continuum of Care Matrix for Alaskans with Alzheimer’s Disease and Related Dementias and Older Alaskans

Levels of Community Care					
Characteristics	Level I: Frontier/Village	Level II: Sub-Regional Center or Town	Level III: Regional Center or Small City	Level IV: Urban Center	Level V: Metropolitan Area
I. Services for Individuals with Alzheimer’s Disease and Related Dementias					
a. Outreach & Education	Information and referral available statewide through SeniorCare toll-free number. Literature, audio/video resources available through Alzheimer’s Resource or Geriatric Ed Centers	Information and referral available statewide through SeniorCare toll-free number. Literature, audio/video resources, some trainings available through Alzheimer’s Resource or Geriatric Ed Centers	Information and referral available statewide through SeniorCare toll-free number. Aging and Disability Resource Center in Kenai. Literature, audio/video resources, some trainings available through Alzheimer’s Resource or Geriatric Ed Centers	Information and referral available statewide through SeniorCare toll-free number. Aging and Disability Resource Center in Juneau . Literature, audio/video resources, trainings available through Alzheimer’s Resource or Geriatric Ed Centers	Information and referral available statewide through SeniorCare toll-free number. Literature, audio/video resources, trainings available through Alzheimer’s Resource or Geriatric Ed Centers. Statewide conferences.
b. Assessment	Assessment – targeted, personal service.	Assessment – targeted, personal service.	Assessment – targeted, personal service.	Assessment – targeted, personal service.	Assessment – targeted, personal service.

c. Medical	Community Health Aides	Health Clinics, Physician's Assistants, Public Health Nurses	Health Clinics, Physician's Assistants, Public Health Nurses, Nurse Practitioners, physicians, some small communities have hospitals	Health Clinics, Physician's Assistants, Public Health Nurses, Nurse Practitioners, physicians, hospitals	Health Clinics, Physician's Assistants, Public Health Nurses, Nurse Practitioners, physicians, hospitals
d. Pharmaceutical	Prescription medications available primarily through village-based IHS clinics or dispensaries.	Prescription medications available primarily through IHS clinics and some private pharmacies, physicians and nurse practitioners.	Prescription medications available through IHS clinics, hospitals, private pharmacies, physicians and nurse practitioners.	Prescription medications available through IHS clinics, hospitals, private pharmacies, physicians and nurse practitioners.	Prescription medications available through IHS clinics, hospitals, private pharmacies, physicians and nurse practitioners.
e. Home and Community Based Services					
i. Care coordination	Care coordination – targeted, personal service, dependent on available workforce	Care coordination – targeted, personal service, dependent on available workforce	Care coordination – targeted, personal service, dependent on available workforce	Care coordination – targeted, personal service, dependent on available workforce	Care coordination – targeted, personal service, dependent on available workforce
ii. Personal care attendant	Personal care attendant – very limited, not available in many villages due to workforce shortage	Personal care attendant – targeted, personal, very limited, not available in many towns due to workforce shortage	Personal care attendant – targeted personal, dependent on available workforce	Personal care attendant – targeted personal, dependent on available workforce	Personal care attendant – targeted personal, dependent on available workforce
iii. Chore services	Chore services – very limited, not available in	Chore services – limited, dependent	Chore services – dependent on	Chore services – dependent on	Chore services – dependent on

	most villages due to workforce shortage	on workforce availability	workforce availability	workforce availability	workforce availability
iv. Respite	Respite – very limited, not available in most villages	Respite – limited, not available in all towns	Respite – dependent on workforce availability	Respite – dependent on workforce availability	Respite – dependent on workforce availability
v. Adult day programs for individuals with ADRD. 15 programs across state, two which coordinate with community mental health centers for assessment, referral and medication management.	not available	not available	Adult day programs – limited availability	Adult day programs	Adult day programs
vi. Meals – congregate and home-delivered	Congregate meals very limited, not available in most villages/home delivered meals not available	Congregate meals limited, not available in all towns/ home delivered meals not available	Meals – congregate and home-delivered, one or both available in some communities	Meals – congregate and home-delivered available	Meals – congregate and home-delivered available
vii. Assisted transportation	Not available	Not available	Assisted transportation - limited availability	Assisted transportation	Assisted transportation
viii. Environmental modifications	Environmental modifications – rarely available due to lack of local contractors	Environmental modifications – dependent on availability of local contractors	Environmental modifications – dependent on availability of local contractors	Environmental modifications	Environmental modifications
ix. Specialized medical equipment	Specialized medical equipment – limited availability	Specialized medical equipment – limited availability	Specialized medical equipment	Specialized medical equipment	Specialized medical equipment
f. Family Caregiver	Family caregiver support	Family caregiver	Family caregiver	Family caregiver	Family caregiver

Support	– very limited, not available in most villages	support – limited, not available in all towns.	support – dependent on workforce availability	support – dependent on workforce availability	support – dependent on workforce availability
g. Legal Service (AoA funded through Alaska Legal Services)	Phone and internet assistance available	Phone and internet assistance available	Legal Service – in person and phone and internet assistance available	Legal Service – in person and phone and internet assistance available	Legal Service – in person and phone and internet assistance available
h. Residential Care					
i. Assisted Living Homes	Not available	Not available	Assisted Living Homes – limited availability	Assisted Living Homes	Assisted Living Homes
ii. Pioneers Homes	Not available	Not available	Pioneers Homes – Ketchikan , Palmer, Sitka	Pioneers Homes – Fairbanks and Juneau	Pioneers Home - Anchorage
iii. Nursing Homes	Not available	Not available	Nursing Homes – limited availability	Nursing Homes	Nursing Homes
II. Specialized Behavioral Health Services for Seniors					
a. Mental Health	Not available	Mental Health for Seniors – limited assessment and referral	Mental Health for Seniors – limited assessment and referral	Mental Health for Seniors – limited assessment and referral	Not available
b. Chemical Dependency	Not available	Chemical Dependency – limited assessment and referral	Chemical Dependency – limited assessment and referral	Chemical Dependency – limited assessment and referral	Chemical Dependency Treatment – Inpatient elders program

Definitions - Continuum of Care Matrix for Alaskans with Alzheimer's Disease and Related Dementias

Outreach, Education, Information and Referral: This category of service provides for outreach, education, information and referral of issues related to ADRD for individuals and their caregivers. This is accomplished through the Senior Centers, the Aging and Disability Resource Centers (provided through regional independent living centers), State SeniorCare Office, and State Care Coordination and Education grants. State grant funds from The Alaska Mental Health Trust Authority (AMHTA), the U.S. Administration on Aging and State of Alaska general funds are used to fund projects offered through private non-profits, tribal and government entities.

Assessment: Assessments are completed under the Medicaid Waiver Program, the Medicaid Personal Care Attendant Program, the Medicaid Long Term Care Program and grant funds from the MHTA and the State of Alaska. These assessments are used to access services and to assist in developing a plan of care for the individual. This service is provided by private non-profits, for profit, tribal and government entities.

Medical Services: This includes any medical treatment for individuals with ADRD by health care professionals or paraprofessionals: i.e., Community Health Aides (CHA's), Certified Nursing Assistants, Registered Nurses (including Public Health Nurses), Physicians Assistants, Nurse Practitioners, and Physicians. Treatment is provided in patients' homes, in health clinics, private provider offices, hospitals and nursing homes.

Pharmacy Services: This service provides medications for both physical and mental health needs of seniors. The Medicaid Personal Care Assistance program provides medication management for those people who qualify with physical needs. State and federal funds are provided on a limited basis for this service through an Anchorage Senior Center and Mental Health Trust Authority funded grant in Southeast.

Care Coordination: This service makes available an "expert" who is available to navigate the system of care a senior receives through the Waiver or other services. The Care Coordinator works with the senior and her Caregivers to establish a Plan of Care and helps assure that services are delivered adequately to their client. These services are provided by private non-profits, for profit, and tribal entities.

Personal Care Attendants: Personal Care Services are designed to assist seniors in need of assistance with Activities of Daily Living (e.g. bathing, eating etc.) in their own homes. This service provided through Medicaid can be utilized in two distinct ways:

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Agency Based services allow for a certified provider to manage the hiring and supervision of a Personal Care Attendant for a senior while Consumer Directed PCA allows for that attendant to be hired and supervised by the senior or their legal representative receiving the services with minimal assistance from an agency.

Chore Services: Services under this category allow for housekeeping and other services in a senior's own home. This program is both a Medicaid Waiver and grant program with funding from the state of Alaska and the U.S. Administration on Aging. Providers of all types offer these services.

Respite Services: Relief to a primary Caregiver in order to reduce caregiver stress is the primary purpose of this service. This service provided under the Medicaid Waiver, U.S. Administration on Aging - National Family Caregiver Program and state grant programs. Providers of all types offer these services.

Adult Day Services: Adult day Programs offer facility based programs, which provide recreational, health and social opportunities for seniors who are frail or experience ADRD. These programs are funded through State of Alaska funds and the Medicaid Waiver programs.

Congregate and Home Delivered Meals: These programs offer one third of the recommended daily allowances (RDA) for adults. Congregate meals are provided in senior centers and schools throughout the state. Home Delivered meals are provided for those seniors unable to easily leave their homes. These programs are provided by private non-profits, for profit, tribal and government entities through the Medicaid Waiver, U.S. Administration on Aging and State of Alaska funds.

Assisted Transportation: Assisted Transportation services are those, which take a senior from their home to appointments and back with door-to-door assistance. Transportation services are provided through the U.S. Administration on Aging, State of Alaska grant funds and the Medicaid Waiver programs through private non-profits, for profit, tribal and government entities. These services include assisted and unassisted rides.

Environmental Modifications: Refers to converting or adapting the environment to make tasks easier, reduce accidents, and support independent living for frail seniors and/or individuals with disabilities. Examples of home modification include lever door handles that operate easily with a push; handrails on both sides of staircase and outside steps; ramps for accessible entry and exit; walk-in shower; grab bars in the shower, by the toilet, and by the tub; hand-held, flexible shower head ; and lever-handed faucets that are easy to turn on and off.

Specialized Medical Equipment and Supplies: Specialized equipment and supplies include devices, controls, or appliances specified in the plan of care which enable clients to increase their ability to perform activities of daily living, or to perceive, control or communicate with their environment.

Family Caregiver Programs: These programs offer a wide range of services for family caregivers of seniors with the focus solely on the caregiver's needs. The U.S. Administration on Aging funds programs, which are designed to support Caregivers of seniors recognizing their unique role in the continuum of care. Grants are made to private non-profits to execute these programs.

Legal Service: Legal services for seniors consist primarily of guardianships and other minor legal problems. Through funding from the U.S. Administration on Aging and the State of Alaska, a provision of legal services is provided for seniors and their caregivers through Alaska Legal Services Corporation.

Assisted Living Homes: Assisted Living homes provide 24-hour care to seniors in a non-institutional setting outside a senior's home. Assisted Living homes are operated by private non-profits, for profit, and tribal entities using funds from the Medicaid Waiver Program and the State of Alaska grant funds. These homes provide twenty-four hour care for seniors and others in non-institutional settings often in or near the seniors community.

Pioneers' Homes: Located in six communities (Sitka, Ketchikan, Juneau, Anchorage, Palmer and Fairbanks) the Alaska Pioneers' Homes provide up to 600 beds of assisted living services for seniors in Alaska. Open to any senior over 65 years of age these homes are funded through the Medicaid Waiver and State of Alaska funds and operated by the Department of Health and Social Services. They have developed a specialty in serving those people who experience ADRD as well as other frail seniors. They have a Registered Nurse on site 24 hours a day and provide a centralized pharmacy, which includes a high level of medication oversight.

Nursing Homes: Skilled Nursing Facilities provide intensive services for those at the highest level of care. Funded through Medicaid they offer both short and long-term placements for senior who require significant nursing interventions each day. In many cases, through Medicare funding these facilities provide for rehabilitation services for senior returning to their homes from acute hospitalizations.

IV. Examples of Current Initiatives, Projects, and Activities That Fill Service Gaps

One aim of *Moving Forward* and its related initiatives is to provide decision makers with appropriate data regarding issues that impact Trust beneficiaries. To the extent data is available or can be developed through better data collection and analysis, progress is measured for these efforts. A key strategy has been to work with partners on projects. Successful partnerships expand and enhance the resources of the Department of Health and Social Services and The Trust and further the goal of shared and integrated approaches to bettering the lives of Trust beneficiaries.

Initiative efforts are largely directed toward system change. Following are examples of current initiatives, projects and activities that, in addition to the extensive day-to-day activities of the Department and The Trust, work to create system change and target improved services for Trust beneficiaries.

The following examples of initiatives, projects and activities are grouped under the [2009 Alaska Department of Health and Social Services Priority Areas](#).

DHSS Priority Area: Substance Abuse

- [SHIELDS for Families Program](#)
- [Comprehensive Fetal Alcohol Syndrome Project](#)
- [Primary Care & Behavioral Health Integration](#)

DHSS Priority Area: Health and Wellness

- [Living Well Alaska](#)
- [ECCS Early Childhood Mental Health Cross-Systems Workgroup](#)
- [Senior Behavioral Health](#)
- [Alaska Suicide Prevention Initiative](#)
- [Autism Initiative](#)
- [Traumatic Brain Injury Project](#)
- [Dental Health Access and Workforce](#)
- [Healthy Body, Healthy Brain Campaign](#)
- [HIV/STD Program](#)
- [Alaska Tuberculosis \(TB\) Program](#)
- [Emergency Medical Services](#)
- [Emergency Preparedness for Special Populations](#)
- [Health Impact Assessments](#)

DHSS Priority Area: Health Care Reform

- [Bring the Kids Home](#)
- [Juvenile Justice System Improvement Initiative](#)

- Justice for Persons with Disabilities Focus Area
- Medicaid Waiver Rates
- Children's Mental Health Curriculum Initiative

DHSS Priority Area: Long-Term Care

- Long-Term Care Strategic Planning
- Aging and Disability Resource Centers
- Supporting Family Caregivers

DHSS Priority Area: Vulnerable Alaskans

- Workforce Development
- Health Care Professions Loan Repayment & Incentive Program
- Families First! / Family Centered Services
- Performance Management System Project
- Public Health Nurses Addressing Domestic and Family Violence
- Alaska Works Initiative
- Start Up Alaska Project
- Trust Beneficiary Projects
- Abuse and Neglect of Vulnerable Adults
- Alaska Housing Trust
- Trust Coordinated Communications Campaign

DHSS Priority Area: Substance Abuse

SHIELDS for Families Program

Due to the prevalence of substance abuse in Alaska and the lack of comprehensive family-focused treatment services available, the Alaska Department of Health and Social Services has recognized that the SHIELDS for Families treatment model is ideally suited to meet the needs of Alaskans experiencing substance abuse problems. A national evaluation through the Center for Substance Abuse Treatment (CSAT) has shown the SHIELDS program to be an effective, best practice model.

The SHIELDS program's purpose is to assist families in achieving economic and social self-sufficiency by providing parents and children all necessary support and treatment services at the same location where they live (such as in an apartment complex). It provides comprehensive care for women, children and other appropriate family members. Services include counseling, child development, vocational services, mental health, medical care, family support and family reunification.

Recent outcomes of the California-based SHIELDS program show an 81.2% treatment completion rate, compared to the average national completion rate of 25%; a family reunification rate of 85%; and 100% of consumers being successful at obtaining a high school diploma. The program has been recognized by SAMHSA for their experience and success in securing, managing, and sustaining multiple funding sources; implementing a broad array of services for women, children, and families; and achieving positive outcomes for the individuals and families they serve. Alaska aims to replicate this model in order to provide outstanding services to consumers and reduce the harmful effects of substance abuse.

Recent Accomplishments

- A *SHIELDS for Families* Workgroup was established. The Court Improvement Program Substance Abuse Sub-Committee, comprised of representatives from the court system, the Department of Health and Social Services, the Office of Public Advocacy, Vocational Rehabilitation, Cook Inlet Tribal Council, the Mental Health Trust Authority and other invested stakeholders have begun initial planning of the SHIELDS program in Anchorage.
- A logic model was developed to help guide the focus and the work that needs to be accomplished. The overarching goal is to achieve healthy, safe and self-sufficient families.
- Through the collaboration of the team, funding through the Court Improvement Program and CITC family preservation will be used to hire a program coordinator responsible for pre-development planning.

Recent Challenges

- Securing funding from various sources to ensure the program is implemented successfully and maintains the best practice model integrity.

- Securing funding and a building or building site in Anchorage.
- Overcoming zoning challenges associated with a unique treatment facility.

Outcome Data

There is currently no outcome data available due to the initial stages of planning for the program implementation.

Comprehensive Fetal Alcohol Syndrome Project

Fetal alcohol spectrum disorders (FASD) are one of the most common causes of mental retardation and the only cause that is entirely preventable. FASD refers to all those conditions caused by prenatal exposure to alcohol, including fetal alcohol syndrome (FAS). FAS is a medical diagnosis defined by the presence of specific growth and nervous system abnormalities and other factors. Receiving an early, comprehensive diagnosis that looks at growth deficiencies, facial dysmorphology, central nervous system functionality and maternal history of alcohol abuse provides a complete picture of the level of disability, the impaired functionality, and the overall interventions and accommodations that will benefit the individual. This is the first and most important intervention—from a comprehensive diagnosis, a clear case plan can be implemented and service delivery needs can be better coordinated.

FASD is found among all races and all socio-economic groups – wherever women drink alcohol, FASD exists. With the right diagnosis, support and understanding, many individuals with FASD can live happy and full lives.

Alaska's [Comprehensive Fetal Alcohol Syndrome Project](#), is an example of an effort to prevent a developmental disability, to improve services for individuals with an alcohol-related disability and to enhance alcohol treatment services for women at risk of drinking alcohol during pregnancy. With state and federal funds, the Alaska FAS Project developed community-based teams that diagnose and refer children for services, developed a multimedia public education campaign to raise awareness about the danger of drinking alcohol during pregnancy, and improved training for all service providers in Alaska to better understand and serve affected individuals and their families. Alaska's FAS Project has enhanced the state's surveillance of alcohol-related births, thereby improving the state's data related to FAS prevalence rates.

- In fiscal year 2007, the Division of Behavioral Health continued funding for 20 community-based grants awarded to local nonprofit organizations across Alaska to provide services to individuals, families and communities impacted by FASD. These grants focus on FASD prevention, training and educational services, improved services for individuals affected by FASD, diagnostic services, and treatment services for women at risk for giving birth to a child affected by prenatal exposure to alcohol.
- Since March of 1999, approximately 1,000 diagnoses have been completed by 13 diagnostic teams from Fairbanks to Ketchikan, providing earlier and more comprehensive assessments for those children, youth and adults who were prenatally exposed to alcohol, causing permanent learning, behavioral, and

- neuro-developmental disabilities. Through early and comprehensive diagnosis, children and youth have more opportunities for services that will increase their quality of life and their ability to be healthy, productive adults.
- Two curricula were developed to give Alaska service providers (including educators, mental health clinicians, health care providers, and correctional officers) current, consistent and scientifically-based information about the affects of alcohol on a developing fetus, the impact of alcohol on the central nervous system, and the resulting disabilities. Over 50 Alaskans, representing Alaska geographically, ethnically and across various disciplines, have been trained and certified to provide training with these two curricula.
 - In December 2006, DHSS received a five-year Medicaid Waiver Demonstration Project to improve services to young Alaskans ages 14-21 with co-occurring diagnoses of Serious Emotional Disturbance (SED) and a Fetal Alcohol Spectrum Disorder. This Demonstration Project will allow Alaska to begin developing “practice to research” service delivery approaches that will improve the long-term outcomes for youth with these diagnoses.

Primary Care & Behavioral Health Integration

The integration of Primary Care & Behavioral Health (PC-BH) has emerged as an important topic within the national healthcare system. Reasons include: (1) a large portion of clientele are actually found in both systems; (2) not only are there high rates of co-morbidity, but one health problem may worsen the other; (3) resource management has increasingly required that efficiencies in sharing assets are needed; (4) referral rates are enhanced when primary care and behavioral health services are more integrated; and thus (5) holistic care is much more possible.

The topic of primary care behavioral health integration is still new to the Alaskan system. However, there has developed substantial literature and experience elsewhere. Much national evidence suggests that a broad spectrum of behavioral health consumers benefit when primary care and behavioral health services are co-located or otherwise integrated within the system of care. In Alaska, efforts are underway to: (1) summarize PC-BH integration practices presently occurring in other states and in Alaska; (2) assess likely prospects for use or expansion in Alaska; and (3) formulate recommended alternative action steps for the State of Alaska to pursue during coming years.

Many Trust beneficiaries experience significant co-morbidities, wherein one presenting problem regards behavioral health (e.g. serious mental illness) and another is medical disease (e.g. diabetes, kidney impairment, etc). Primary care behavioral health integration may offer possibilities for the sharing of providers, administrators, and support staff. Also, there may be occasional opportunities to share space, and this may aid in capital campaigns.

Recent Accomplishments

- Analysis: Interdisciplinary groups within DHSS have examined, and continue to examine: (a) national perspectives on the issue; (b) Alaskan case studies (e.g. Soldotna); and (c) state leadership perspectives. Briefings have been prepared (e.g. Dec, 2007), holistic data-analysis is occurring (e.g. Alaska Health Care Data

Book, 2007) and the Primary Care Council (PCC) made "Expansion of behavioral healthcare" one of the five top priorities.

- **Case Studies:** Examples of Primary Care-Behavioral Health integration exist in the state, though their levels of development vary considerably. These include: (a) Alaska Islands Community Services, (b) Central Peninsula Health Services, (c) City of Galena's program; (d) Mat-Su Health Services; and (e) the Southcentral Foundation. Further, the Denali Commission funded extensive build-out of CHC's across the state, including facilities that now have "behavioral health space". The "Soldotna project" is providing a readily available (key) case study.
- **Visibility:** The Primary Care-Behavioral Health integration issue is starting to be presented and discussed in assorted Alaskan forums. Illustrative examples include (a) a PC-BH interagency panel at the Alaska Public Health Association (ALPHA, Dec 2007) and (b) the Central Peninsula ("Kenai") Statewide teleconference (Aug 2007) and a panel at the Alaska Public Health Association (ALPHA, Dec. 2008) that highlighted integrated PC-BH organizations such as Central Peninsula Health Services.
- **IMPACT and SBIRT programs:** From FY 09 through FY 11, The Trust is piloting the IMPACT/SBIRT combined model in select rural villages in Alaska, and the IMPACT- only model at the Anchorage Neighborhood Health Center. IMPACT connects primary care with behavioral health care for depression by creating clinic teams that work closely with each other to maintain frequent client engagement, encourage clients to get out of their home and into the community, and insist on client progress as measured by a simple assessment tool. SBIRT (Screening, Brief Intervention, Referral to Treatment) similarly uses the primary care-behavioral health connection to screen for problem drinking, provide brief counseling interventions to reduce or stop the problem use, and if necessary ensure a smooth transition to outpatient or residential treatment.

Because of the extensive prevalence of both depression and alcohol abuse in rural Alaska, the models will be integrated in the pilot communities of Kake, Klawock, Port Graham and Seward. The collaborators on this project are The Trust, Rasmuson Foundation, University of Washington, Southeast Area Regional Health Corporation (SEARHC), Chugachmiut Health Corporation, Alaska Native Tribal Health Corporation (ANTHC), Alaska Commission on Aging, Alaska Mental Health Board, Advisory Board on Alcoholism and Drug Abuse and the Department of Health and Social Services.

DHSS Priority Area: Health and Wellness

Living Well Alaska

Living Well Alaska is a series of workshops that help people with chronic illnesses learn ways to self manage their condition and take charge of their life. These workshops are being held throughout the state for people with all kinds of chronic illnesses, such as arthritis, diabetes and heart disease. Since the program is specifically designed to be presented by non-professional health workers, it extends disease self-management beyond the reach of traditional partners. Workshops cover a range of health topics such as healthy eating, relaxation techniques, managing fatigue, low impact exercising, and managing medications.

Research on this program has shown that participants are able to manage their symptoms better and communicate more easily with their doctors and loved ones. People who take the program feel better, are less limited by their illness, and may spend less time at the doctor or in the hospital. *Living Well Alaska* is subsidized by the Alaska Diabetes and Arthritis programs.

Recent Accomplishments

- Recruited patients and health care providers to be trained as leaders and trainers
- Trained 2 master trainers and 49 course leaders in 2007
- Twenty-one 6-session classes have been provided, reaching over 229 Alaskans with chronic diseases, including classes at 9 community health centers and two senior centers

Recent Challenges

- Alaska does not have enough health professionals to provide diabetes self-management education. Currently there are only 30 certified diabetes educators to serve approximately 24,500 Alaskans diagnosed with diabetes, with numbers that have increased by about 10% each three-year period from 2002 to 2006.
- Alaska BRFSS²¹ results indicate that 87% of Alaskan adults with diabetes are overweight or obese and 34% reported no physical activity in the past month. These results provide evidence that many Alaskans with diabetes are at increased risk for diabetes complications due to lifestyle choices. (Behavioral Risk Factor Surveillance Survey 2004-2006)

Outcome Data

- In evaluations at the end of the classes, participants rated their self-management skills as 7.8 and their likelihood of using what they learned in the class in their daily lives as 8.9 on a scale of 1 (low) to 10 (high).

Early Childhood Mental Health Cross-Systems Workgroup

The early years represent a period of tremendous opportunity and risk for children. Although all periods of development are important, brain growth and development are most profound during the first few years of a child's life. The foundation for intellectual, emotional and moral development established during these early years becomes the basis for future growth and learning. Children who do not receive the care and nurturing required for optimum development early on may have difficulty making up for the lost opportunities later.

The more risk factors young children experience, the more likely they are to experience adverse mental health outcomes as children and to be negatively impacted as adults. Neuroscience calls special attention to the potential risks to healthy social and emotional development for young children facing toxic levels of stress that accompany such things as abuse and neglect, traumatic events, and poor parenting. According to the Office of Children's Services, 35% of protective services reports in Alaska are for children from birth to five years of age. In the 2004 Alaska Market Rate survey of child care programs, 38 percent of programs reported asking families to withdraw a child under the age of 6 with social/emotional problems. In FY 08, almost 18% of children enrolled in the Infant Learning Program had social/ emotional delays of 50% or more. Alaska Medicaid data shows that in FY 07, 2621 young children below the age of 8 years had Medicaid mental health billings claims.

We know that we can intervene successfully to improve outcomes for children. Research and science have dramatically increased our understanding about the types of supports and programs that are helpful to young children and their families. There is no longer any question about the long term impact of early experiences on young children. The relationships young children have, the environments they live in, and the circumstances surrounding their families all influence the long term outcomes for children.

Recent Accomplishments

- As in many other states, Alaska is plagued by a lack of mental health practitioners experienced in early childhood mental health issues and interventions. There has been a targeted effort to bring up the skills of practitioners already working in the field. In FY 08 mental health clinicians and early interventionists participated in a "Learning Network" via monthly conference calls facilitated by an expert from Georgetown University. In June 2008, the Early Childhood Mental Health Institute was held. Training was provided on screening, assessing and observing young children's socio-emotional development, diagnosing young children with mental health issues using the *Diagnostic Classification of Mental Health Disorders of Infancy and Early Childhood, Revised Edition (DC 0-3R)* and providing high-quality, effective clinical interventions and supports.
- The ECCS (Early Childhood Comprehensive Systems) Early Childhood Mental Health Cross-Systems Workgroup refined recommendations to improve access to appropriate, high quality mental health services for young children (birth to five

- years of age). These recommendations will be translated into regulation and policy change. A cost-benefit analysis was conducted using Medicaid data.
- The early childhood mental health consultation project was continued with Juneau Youth Services. Many parents are working outside the home, and children are spending more and more time in out-of-home care. Too often children move from program to program because early childhood staff members are not trained to deal with their difficult behaviors and to support and work with their families. Consultation for early childhood programs can help to stabilize a child's placement, increase the quality of care and link families to needed services.

Recent Challenges

- There is generally a lack of understanding about the long term impact of early childhood mental health concerns going undetected or responded to.
- The lack of resources for prevention and early intervention services can be a barrier to assisting children and families prior to problems becoming quite serious. Funding strategies need to be developed and utilized that include pooling or reallocating existing resources, bringing children and families into the service system early, and decreasing the need for more intensive services at a later date.

Senior Behavioral Health

Senior services providers report a growing number of clients experiencing serious behavioral health needs. Aggressive behavior and substance abuse are becoming more common and more problematic in settings such as senior centers and independent-living senior housing. Pioneer Homes and assisted living facilities are seeing more seriously mentally ill (though often previously diagnosed) individuals, and report that they are not prepared to serve these clients in a general population setting. When behavioral health issues overlap with ADRD, treatment is particularly difficult to locate.

Isolation, depression, and grief issues are also common among older Alaskans. Seniors often refuse to seek help from sources such as a community mental health center or a local Alcoholics Anonymous meeting because of the stigma. Special approaches are necessary to identify, make contact with, assess, and provide behavioral health services to seniors. In many communities, no programs are in place to meet these unique needs.

Recent Accomplishments

- Funding was received beginning in FY 2009 for the SOAR (Senior Outreach, Assessment, and Referral) Project, an effort based in DBH to use special approaches to target seniors in need of behavioral health assistance.

Recent Challenges

- Pioneer Homes are facing increasing pressure to find solutions in caring for residents with extreme behavioral health problems. They are not licensed to care for them, nor is API an option for long-term residential care.

- A 2007 survey of assisted living homes indicated that administrators and staff are in need of training to help them cope with aggressive behaviors by clients experiencing ADRD or other behavioral health conditions.

Outcome Data

SOAR, IMPACT and SBIRT service data will be available as projects come online.

Alaska Suicide Prevention Initiative

According to a 2005 national study of suicides in the United States, Alaska continues to rank among the top highest suicide rates in the country. Alaska had approximately 146 suicides in 2007. Suicide is the 2nd leading cause of death among Alaskan's under 50. Approximately 11% of high school students report that had attempted suicide in the past 12 months. The majority of suicides are occurring among our young people ages 20-29 years and are equally represented among both rural and urban communities.

The distribution of suicide by ethnicity shows Alaska Natives comprise 16% of the population, however they accounted for 39% of the suicides. The highest rate of suicide in Alaska is among Alaska Native male teens and young adults 15 – 29 years of age. Older adults and returning war veterans are also at an increased risk as well as those with chronic medical illness, trauma, substance abuse and mental illness most commonly, depression.

Recent Accomplishments

The Division of Behavioral Health, Prevention and Early Intervention Services section has recently released the *Alaska Suicide Prevention Initiative 5 - year plan* to the state legislature for review. The initiative was initially introduced in the proposed mental health budget for FY 2008. The initiative is designed to expand the [Community-based Suicide Prevention program](#) and enhance the state's *Comprehensive Behavioral Health Prevention and Early Intervention Services Grants* including the Alaska Careline, 24/7 crisis hotline and community-based suicide prevention projects, Alaska Gatekeeper Suicide Prevention Training program, capacity development of Regional Suicide Prevention Teams in conjunction with the new three-year 1.5 million federally funded *Alaska Youth Suicide Prevention Project*. This is a new project that will increase the state's capacity to balance needs and resources with a youth targeted strategic planning approach. In addition, the initiative proposed research activities to better support and monitor local, regional and statewide data and information.

As a result of the initiative, DBH received a one-time FY09 state general fund allocation of \$200,000 to begin planning a strategic approach with emphasis on rural areas of the state with high rates of suicide. Nine regions were identified with rates higher than the state average of 21 suicides per 100,000 persons and were solicited to submit planning grant proposals. DBH received five submissions of interest and proposals are currently being negotiated with the state with a projected award date in mid-January of 2009. Planning grants will require these regions to submit a strategic regional suicide prevention plan to DBH by June 30th 2009 and continuation of these planning grants are contingent on future state, federal and or combination of local and regional resources.

Recent Challenges

Challenges facing this initiative are to balance identified needs and resources with the understanding that 1) Suicide prevention requires a multi-faceted approach, integrated into Alaska's continuum of care; 2) Efforts must be targeted simultaneously at the community, family and individual level; and 3) For any of these efforts to be successful, there must be community involvement. That may require an assessment of readiness to address suicide prevention at the community level. Through capacity development at both the community and regional level, we can expect that suicide prevention strategies that utilize effective practices will be both culturally responsive and sustainable in the long term.

Autism Initiative

The prevalence of autism spectrum disorders has increased dramatically in recent years. A recent study by the Centers for Disease Control and Prevention suggests that 1 in 150 children have an autism spectrum disorder.

The Governor's Council on Disabilities & Special Education formed an Ad Hoc Committee to develop recommendations for the administration and the legislature related to autism spectrum disorders. This group identified and prioritized needs, developed recommendations for meeting high priority needs, discussed numerous issues related to identification, screening, and services for autism, and developed a strategic plan and timeline for meeting priority needs. The Committee's top priority recommendations, which operate interdependently as a five-part package, include 1) universal screening; 2) expanded diagnostic clinics; 3) enhanced resources, referral and training; 4) workforce development capacity building; and 5) time-limited intensive early intervention.

Recent Accomplishments

- Alaska is currently participating in the national Academy for State Health Policy's ABCD Screening Academy. A pilot that includes screening for autism is currently underway in two pediatricians' offices in Anchorage and at the Alaska Native Medical Center. To date, there have been tremendous increases in the use of standardized screening instruments although information on the number of referrals is still being gathered and analyzed.
- The DHSS Division of Public Health received a federal grant which focuses on increasing access to screening and diagnosis for children residing in rural and remote areas of the state. Children in these areas are typically diagnosed with autism one to three years later than children who reside in urban communities.
- Expanded diagnostic clinics are currently being funded with \$375,000 in legislative increments and \$125,000 from the Alaska Mental Health Trust Authority. The Division of Public Health, Section of Maternal, Child and Family Health awarded a grant to Providence Health System Alaska (PHSA) to deliver statewide pediatric neurodevelopmental screening, evaluation and diagnostic services for autism and co-occurring neurodevelopmental and other medical needs using an interdisciplinary team model of care.

- The Special Education Service Agency coordinates the Alaska Autism Resource Center (AARC), staffed by autism professionals who provide information about autism to families, professionals, teachers, and others about effective intervention approaches and available resources. In FY09 the Autism Resource Center continues to be funded by the Mental Health Trust Authority, the Department of Education & Early Development and the Office of Children's Services, Infant Learning Program.
- Stone Soup Group received a federal earmark to provide social skills training for individuals with autism and support services for their families.
- The legislature and the Alaska Mental Health Trust Authority each provided \$125,000 for FY09 for the Division of Public Health to workforce development capacity building. Funds will be used to contract with national experts in both behavioral and developmental evidence-based autism interventions. The experts will be responsible for assisting the Center for Human Development at the University of Alaska Anchorage to develop an in-state infrastructure for training a core group of providers (Master's level and above) in fields such as psychology, special education, speech therapy, social work and other related fields. The national experts will maintain clinical oversight of these practitioners until in-state expertise is developed. This trained group will, in turn, be responsible for oversight of paraprofessionals who deliver one-on-one intensive early intervention with young children with autism. This will establish a three-tiered intervention system, used successfully across the country.

Recent Challenges

- Studies have shown that some children with autism who receive intensive, autism-specific intervention services (at least 25 hours per week) for three or more years, need significantly fewer, or even no supports as they progress through school and into adulthood. Currently, there are four ways families typically receive services: 1) through the Infant Learning Program up to age three; 2) through the school district from ages 3-21; 3) through the Division of Senior & Disabilities Services (home and community-based Medicaid waivers or grant-funded services; and 4) through private therapists and/or paraprofessionals. Recommended time-limited, intensive early interventions as described above are generally not available in Alaska. The Department is currently exploring a variety of options for providing time-limited intensive early intervention services (i.e., new waiver, modification of current waivers, provisions of the Deficit Reduction Act).
- Some individuals with autism will require long-term supports available through a waiver. These services include but are not limited to social skills training, facilitated communications, positive behavioral support and intensive therapy services (e.g., speech/language therapy). These services could potentially be added to current waivers or some might be able to be included under existing services such as intensive active treatment.
- Although more and more states are passing bills mandating private insurance coverage for autism, for the most part, insurance plans in Alaska do not include coverage for autism. The Council will seek legislative sponsors for a similar bill in Alaska.

Outcome Data

- Recent autism diagnostic clinic data shows a 44% increase in children served over the 2007 baseline, which suggests that adding services and a provider were effective expansion tactics.
- The Alaska Autism Resource Center provided general training to 1,750 individuals and provided information and referral services to approximately 3,000 individuals at 30 community health fairs.

Traumatic Brain Injury Project

Every day someone is involved in a car crash, a fall, a sports injury or other incident that results in a traumatic brain injury (TBI) that alters the way he or she may live over a lifetime. Alaska has one of the highest TBI rates in the nation. Of recent concern is a significant, but as of yet unknown, number of Alaskan service members returning with diagnosed and undiagnosed brain injury. With appropriate and available care, rehabilitation, community and family supports, even the individual who is most severely injured can live at home, return to school or work, or engage in meaningful and productive life activities.

Recent Accomplishments

- In May 2008, The Trust approved \$100,000 for Brain Injury Training for Providers to be administered by Department of Health and Social Services, Division of Behavioral Health. Plans are to incorporate this new effort into existing Center for Human Development, (UAA) initiatives, such as the Trust Training Cooperative. An Introduction to Traumatic Brain Injury curriculum will be developed by June 30, 2009.
- The Alaska Brain Injury Network and its partners have developed a 10 year state plan for TBI in Alaska for the purpose of reducing the incidence of brain injury and minimizing the disabling condition through the expansion of services and supports for TBI survivors and their families.
- Since November 2007, ABIN has held monthly meetings with the leaders from the 3rd Medical Unit at Elmendorf Air Force Hospital, Behavioral Health Division of the Veterans Clinic, National Guard, the Marines, the Veterans Centers, community mental health center representative, Department of Health and Social Services and the Alaska Mental Health Trust Authority. The fact-sharing has been helpful to identify the needs of returning service members and to coordinate planning for all TBI survivors, service members and civilians, statewide

Outcome Data

The rate of TBI has fluctuated over time but appears to be declining since 2001. The TBI rate due to motor vehicle crashes on the highway has decreased 38 percent from 2001 to 2005, due in part to the enactment of the primary seatbelt law.

Dental Health Access and Workforce

The Trust and the Alaska Department of Health and Social Services are committed to improving access to dental care for all Trust beneficiaries. Both are participating with the Alaska Dental Access Coalition (ADAC) to focus on the policy areas of workforce, finance and reimbursement, access to care, and prevention of oral diseases. The ADAC serves on an advisory council to the DHSS Oral Health Program supported by a grant from US Centers for Disease Control. The ADAC is a multi-agency coalition with broad support and participation on dental access issues.

The ADAC is chaired jointly by representatives of The Trust and the Rasmuson Foundation and is staffed by DHSS. One key area is the new adult dental Medicaid benefit (implemented April 1, 2007), for which the ADAC successfully advocated. The coalition is now focused on tracking the progress of the adult dental Medicaid services program and preparing to advocate for renewal of the program in FY2009 (during which enabling legislation is scheduled to sunset).

Dental Care Access

In 2000, the U.S. Surgeon General noted that despite dramatic improvements in the reduction of dental decay through community water fluoridation and topical fluorides, there remains “what amounts to a ‘silent’ epidemic of dental and oral diseases affecting some populations...Those who suffer the worst oral health are found among the poor of all ages, with poor children and poor older Americans particularly vulnerable.” [*Oral Health in America: A Report of the U.S. Surgeon General*]. In the U.S. and in Alaska higher rates of dental disease can be found among the poor, in racial/ethnic minority populations, and individuals with disabilities. [See: *Alaska Oral Health Plan: 2008-2012*, and, the *Alaska Health Care Data Book: Selected Measures, 2007*]. Access to dental care is among the issues to reduce these oral health disparities.

Medicaid provides dental coverage for eligible children, but typically only 1 in 3 children enrolled in Medicaid receive any dental service and only 1 in 5 receive a dental treatment service. Lack of private dental participation in the Medicaid program is part of the issue, and provider vacancies in tribal and community health center programs also contribute to difficulties in accessing dental services. Other issues such as transportation can also make it hard for eligible children to access services. Children with special health care needs are at increased risk for oral infections. National surveys have indicated the most common unmet need is dental care (NHIS 1994-1995), however these children often face additional barriers to care.

In Alaska, 66% of all adults and 57% of Alaska seniors report having seen a dentist in the past year (BRFSS, 2006). Adults with disabilities face barriers to care due to lack of financial resources and difficulties finding dentists that feel adequately trained to treat medically-complex individuals. The Trust has indicated a significant use of their mini-grant program is for dental services showing the unmet dental needs of Trust beneficiaries. As noted above, the Department and Trust supported legislation to

provide preventative and routine restorative dental services to adult Medicaid recipients to address these unmet dental needs.

ADAC is also working with DHSS and the Alaska Dental Society to identify issues affecting private dental participation in Medicaid to increase access for eligible children and adults.

Dental Workforce

Recruitment, retention and the demographics of dental providers play a role in dental access. A main concern regarding oral healthcare access is the reported vacancy rates for dental personnel and an aging dental workforce. Additionally, there are problems with the distribution of the workforce because most dental hygienists, dentists and dental specialists practice in more urban areas of the state.

There are several growing challenges to securing an adequate dental health workforce. Private dental participation in Medicaid/SCHIP is limited, and also the shortage of dentists is likely to worsen as the workforce ages. Nationally it is anticipated that the rate of dentists retiring will surpass the rate of dentists graduating from dental school, so recruitment will become more difficult.

Recent Accomplishments

- Enhanced dental services, including preventative and routine restorative dental services, were implemented April 1, 2007. FY2008 represents the first full year of coverage for these services for adult Medicaid recipients.
- The DHSS Division of Health Care Services implemented a Medicaid dental reimbursement increase on July 1, 2008. Dental reimbursement for most dental services had not increased since 1999 (based on 1997 Medicaid claim information).
- HRSA Grant: The Section of Health Planning & Systems Development, within the Division of Public Health, in collaboration with the Alaska Oral Health Program successfully applied for a federal HRSA grant to assess dental workforce issues in Alaska and create selected innovative dental workforce programs (HRSA-08-134, CFDA 93.236). The project includes building on the recent work of the Alaska Dental Action Coalition, further developing and implementing the “Alaska Oral Health Plan,” conducting data analyses to support the plan, and analyzing workforce and Medicaid dental provider participation. The grant activities will also support initial steps for policy development and/or implementation of initiatives to address identified dental workforce needs.
- ADAC has met with DHSS and the Alaska Dental Society to identify issues affecting private dental participation in the Medicaid program – next steps are to prioritize issues and take action in addressing these concerns where it is feasible.

Recent Challenges

- The encounter rate reimbursement method utilized by Federally Qualified Health Centers has restricted Community Health Center (CHC) dental program participation in providing some of the enhanced dental services for adult Medicaid recipients (e.g., crowns and dentures). The difficulty is a substantially

lower encounter reimbursement than the Medicaid fee-for-service rate for these dental services and, in the short-term, the inability for the CHC dental program to offset these services with increased lower-cost encounters.

- Tribal dental participation in the adult Medicaid dental services has been lower than had been anticipated due to Tribal dental provider vacancies and overall capacity/resource issues which result in prioritizing dental services for children.
- Recruiting and training dentists and dental hygienists, especially in underserved areas.

Outcome Data

- During FY 2008, about 7,600 adults received treatment under the enhanced dental services for adult Medicaid recipients.
- Since the April 1, 2007 implementation through September 30, 2008, about 2,400 adults have received denture services under this program.

Healthy Body, Healthy Brain Campaign

The Healthy Body, Healthy Brain Campaign is an education and public awareness effort based on recent research indicating that many cases of Alzheimer's disease and related disorders (ADRD) can be prevented by a healthy lifestyle that incorporates physical activity, good nutrition, weight management, regular socializing, and intellectual tasks such as puzzles and games.

This prevention and health promotion project uses social marketing techniques to reach middle-aged and older adults to maximize the awareness of the public, as well as health care and social services professionals, of the effectiveness of a healthy, balanced lifestyle in preventing ADRD.

With the aging of the large baby boomer age group, Alaska can expect to see a tripling of its ADRD population by 2030 if current prevalence rates prevail. An investment in brain-healthy lifestyle practices now will pay off in lowered costs of care in the future.

Recent Accomplishments

- Worked with the Municipality of Anchorage and the Anchorage Senior Center to hold a public event on May 1, 2008 (honoring the 25th anniversary of the Anchorage Senior Center) at which Healthy Body, Healthy Brain materials were distributed to approximately 200 participants
- Developed a section of the Alaska Commission on Aging website which features the latest findings linking ADRD with lifestyle risk factors; produced and distributed Healthy Body, Healthy Brain bookmarks which direct readers to our website for the most recent updates on this rapidly-evolving field of research; produced posters featuring both seniors and baby boomers engaged in brain-healthy activities and distributed them to senior centers and community centers statewide; ran eye-catching full-screen ads in movie theatres; and purchased a set of brain games suitable for seniors in community settings for each senior center.

- Developed a partnership with the Alzheimer's Disease Resource Agency of Alaska in which their staff presents information from the Healthy Body, Healthy Brain Campaign during their community outreach activities directed at seniors, family caregivers, and the public as a whole; audience members are introduced to the results of studies showing that an ADRD-preventive lifestyle has much in common with the habits associated with avoiding other chronic diseases such as diabetes, heart disease, and cancer.

Recent Challenges

- There is a lack of data indicating which segments of Alaska's population are most in need of increased awareness about ADRD risk factors; a one-page survey developed by ACoA was given to several hundred people during FY 2008, but results (which may have been skewed by the survey's distribution at health fairs and meetings) showed a high level of knowledge about ADRD among all age groups. A question on ADRD risk factor awareness was added to the BRFSS 2008 questions for Alaska; we expect population-based data on the results to be available by mid-2009.

HIV/STD Program

Prevention and intervention activities undertaken by the HIV/STD Program for sexually transmitted diseases (STD) include surveillance of reportable conditions (chlamydia, gonorrhea, syphilis); support of screening and testing programs; ensuring treatment of all individuals diagnosed with a reportable condition; and partner services for STD. Additionally, the Program provides STD medical and epidemiological consultation, technical assistance, capacity-building services, and clinical and partner service training for health care providers in Alaska.

The HIV/STD Program funds partner services for newly reported HIV/AIDS clients and funds the following HIV prevention activities: (1) a community level evidence based intervention targeting young and Alaska Native men who have sex with men (MSM) ; (2) targeted outreach to homeless and runaway youth, injection drug users, and heterosexual adults at increased risk; (3) HIV counseling and testing (HIVCT) in community release centers and correctional facilities; (4) HIV counseling and testing through social networks targeting highest risk individuals; (5) educational, support, and social groups for HIV-positive persons; and (6) individual HIV prevention counseling for HIV-positive persons in medical care.

Recent Accomplishments

- STD Program staff have built and maintained collaborative working relationships with numerous public, private, and non-profit agencies (Municipality of Anchorage Reproductive Health Center, Department of Corrections, Department of Education and Early Development, Alaska Native Medical Center, Southcentral Foundation, Covenant House, Planned Parenthood, Forensic Nursing Services of Providence, Four A's, Division of Juvenile Justice, etc.) to further our shared goal of reducing the burden of sexually transmitted diseases in Alaska.

- An HIV prevention social marketing campaign was conducted in rural Alaska, utilizing village-based Americorps volunteers.
- The internet has successfully provided outreach, counseling, and referral to hard to reach MSM in Alaska.

Recent Challenges

- Evidence-based interventions for HIV prevention were developed and tested in cities with specific community features (for example: gay bars, housing projects, concentrated ethnic neighborhoods) and with larger populations and higher HIV prevalence than Alaska. Recruiting the intended population and achieving fidelity to the model are challenging where the conditions of the original model are not present.
- Statewide delivery of STD services with an inadequate public health infrastructure continues to present a significant challenge for prevention activities.

Alaska Tuberculosis (TB) Program

The **Alaska Tuberculosis (TB) Program** provides TB screening activities throughout the state. In rural Alaska the TB Program partners with regional Public Health Nurses and Community Health Aides to place TB skin tests and collect sputum samples. Villages where active tuberculosis has recently been detected are the highest priority communities.

Persons at highest risk for TB and latent TB infection are those with a history of substance abuse, mental health problems and those who are homeless. Some individuals face all three of these life challenges. The AlaskaTB Program provides screening and any recommended treatment free of charge. Treatment for TB is delivered using directly observed therapy (DOT) where each dose of medication is observed by a DOT aide. This service is also free of charge.

In Anchorage, the Alaska TB Program partners with the Municipality of Anchorage Department of Health and Human Services (MOA DHHS) to screen homeless persons. An outbreak of TB among homeless people began in 2006 and has involved persons with alcoholism and mental health diagnoses. The Alaska TB Program and the MOA DHHS have provided housing, TB medications, and DOT services free of charge.

Recent Accomplishments

- Anchorage TB outbreak among homeless persons is coming under control.
- The statewide TB rate declined 28% between 2006 and 2007.
- The Alaska TB Program has built strong partnerships with Alaska Native Health Corporations and the MOA DHHS.

Recent Challenges

- Providing screening and treatment in rural and remote Alaska requires dedicated personnel and considerable funds.
- It is sometimes difficult to find adequate mental health services for individuals, both those who are beneficiaries of the IHS system and non-beneficiaries who do not have insurance.
- Persons who suffer from substance abuse and mental health problems can be non-compliant with screening and treatment recommendations.
- [Summary information about tuberculosis in Alaska: 1998-2007](#)

Emergency Medical Services

Emergency Medical Services are often the only means of health care access for rural populations. The DHSS Division of Public Health Emergency Medical Services Unit does the following:

- Certifies Emergency Medical Technicians (EMTs), EMT Instructors, ground and air ambulance services;
- Manages programs to improve emergency medical services for children in pre hospital and hospital services;
- Provides trauma and other medical training for pre-hospital and hospital emergency services;
- Collects information for the trauma registry;
- Designates trauma centers; and
- Provides data and research assistance for injury assessment and prevention to other sections, boards and councils that help work with Trust beneficiaries.

Recent Accomplishments

- In 2008, the implementation of a new EMS pre hospital data and trauma collection system pilot.
- Revamped the EMT certification data system which improved certification services.
- Completed the Applied Suicide Intervention System Training for EMTs and EMS State Symposium.

Recent Challenges

- Maintaining and reducing the time necessary to process EMT certifications and increasing the number of available volunteers
- Measuring the effectiveness of programs in maintaining expected standards of patient care
- Need for regular data input by EMS providers and conversion of old software to new systems

Outcome Data

The new data programs being developed and implemented through 2011 will allow us to determine the impact and effectiveness of EMS programs on specific beneficiary groups such as elders, children and others requiring special considerations or treatment by EMS providers. It will allow the review and implementation of better patient care as well as improved prevention and intervention strategies.

Emergency Preparedness for Special Populations

Frail, elderly individuals and those with special health care needs and disabilities are extremely vulnerable during and after a community emergency or disaster. Particularly important are issues of notification, evacuation/transportation, sheltering, having access to power (e.g., for ventilators, electric wheelchairs, suctioning equipment, and refrigeration), medications, mobility equipment, and accessible information. For those who are technology-dependent, being without power, durable medical equipment, medical supplies, and pharmaceuticals can be life-threatening. Shelters may not be prepared for people who are deaf, people with mental illness, and those who cannot transfer onto a low-lying cot or drink out of a cup without a straw.

Recent Accomplishments

- The Municipality of Anchorage began a registry for people with special needs so that emergency responders know where to find them and what they will need in the event of a disaster.
- Both the Governor's Council on Disabilities and Special Education and the Alaska Commission on Aging have included this topic in their current state plans and are addressing the issue with their partners and other agencies.
- DHSS Senior and Disabilities Services mandates that each Medicaid waiver recipient's Plan of Care includes an emergency response plan.

Recent Challenges

- Resources to prepare those with special needs for possible emergencies are limited in most communities.
- Residents of many communities do not know what to do or where to go in the event of an earthquake, tsunami, fire, or other community-wide emergency, nor do emergency responders know where to find those with special needs.
- Need better coordination between agencies and interest groups.

Health Impact Assessments

Health impact assessments have been used worldwide to examine the potential effects of proposed land-use development projects on the health of a population and to develop strategies to manage those effects. Land-use development such as mining and oil & gas projects can exert a powerful influence not only on environmental factors such as air and water quality, but on local economy and employment patterns, population and demographics, community infrastructure and services, social organization and culture,

mental health and social cohesion, and distribution of and access to subsistence resources — factors which, in turn, shape the health of surrounding communities. Careful planning is essential to maximize the potential benefits for communities, and to minimize any potential harm. Collaboration between public health and environmental planning and regulatory agencies offers a tremendous opportunity to pursue the goal of healthy, sustainable communities.

In the U.S., the CDC National Center for Environmental Health has recently begun an HIA initiative, but Alaska has already established itself as a leader in the United States, with the first efforts to formally integrate HIA into the federal environmental regulatory process. The Environmental Public Health Program within the Section of Epidemiology has been working collaboratively with other state agencies (especially the DNR), the Alaska Native Tribal Health Consortium, and other stakeholders to develop a framework to more adequately address health issues during the project permitting process.

Recent Accomplishments

- Co-sponsored an interagency workshop on September 8-10, 2008: “Planning for a Healthy Future: Workshop on Health Impact Assessment in Alaska”
- Participated in an interagency workgroup that developed a public health chapter for the draft Supplemental Environmental Impact Statement for the Red Dog Mine expansion
- Participating on an ongoing interagency Health Impact Assessment workgroup to establish a framework and technical methodology for HIAs developed in Alaska.

Recent Challenges

- There are insufficient staff resources to handle the HIA workload. At least one new position needs to be established within DHSS to perform HIA work. Multiple large extractive industry projects are in the permitting process and need HIA work, and program development needs are significant
- A long-term stable funding source is needed to support an ongoing HIA program.
- There are technical scientific challenges — many health status indicators are difficult to quantify accurately due to the small population sizes of affected communities.

DHSS Priority Area: Health Care Reform

Bring the Kids Home

Bring the Kids Home is an initiative to return children with severe emotional disturbances (SED) from out-of-state residential facilities to treatment in Alaska and to keep new children from moving into out-of-state care.

Three primary goals guide the initiative:

1. Significantly reduce the number of children and youth in out-of-state care and ensure that the future use of out-of-state facilities is kept to a minimum.
2. Build the capacity within Alaska to serve children with all intensities of need.
3. Develop an integrated, seamless system that will serve children in the most culturally competent and least restrictive setting as close to home as possible.

Recent Accomplishments

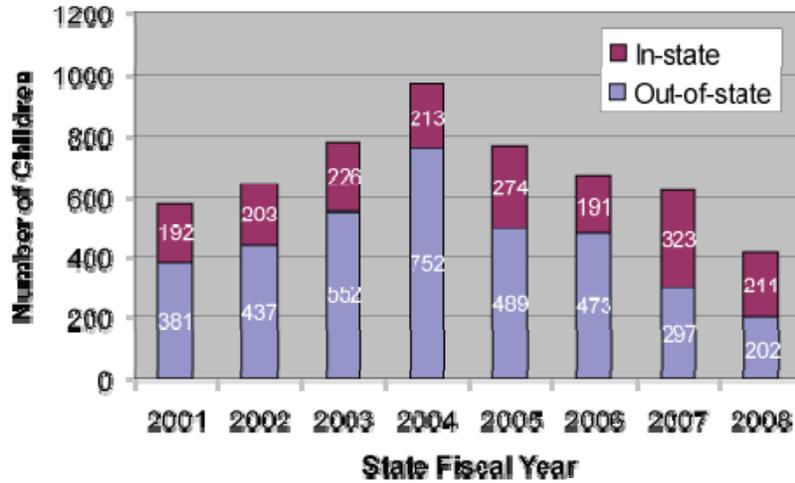
- Between FY07 and FY08, the admissions to out-of-state residential psychiatric treatment centers went down from 297 children to 202 children. This is a decrease of 32%. From FY04 to FY08 there was an overall decrease in admissions of 73%.
- Despite the 32% decrease in admissions to RPTC care, the recidivism rate to RPTC care remained essentially the same between FY07 and FY08 at 8.4%. This rate is significantly lower than the 20% recidivism rate during FY04.
- During FY08 over \$2.5 million in Mental Health Trust Authority and state General Funds were put into Bring the Kids Home grants for projects to develop community based care. These grants went to 18 different agencies in communities across Alaska including both urban (Anchorage, Fairbanks, MatSu) and rural (Metlakatla, Kotzebue and Kenai) communities.

Recent Challenges

- Building in-home, school and community services and supports for children with severe emotional disturbances and their families.
- Developing early intervention services and treatment services that are accessible and appropriate for young children and their families to reduce the need for higher levels of care at a later age
- Ensuring adequate services for transitional aged youth who are soon to age out of the children's system of care

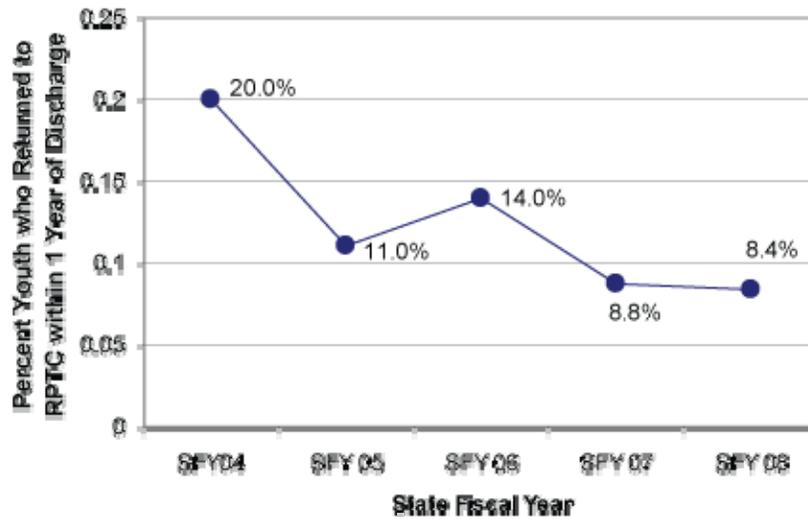
Outcome Data

Figure 16A: Children Admitted to Residential Psychiatric Treatment Centers, In-State and Out-of-State by Year, 2001-2008



Source: DHSS Div. of Behavioral Health Policy and Planning using MMIS-JUCE data, unduplicated count of Medicaid RPTC beneficiaries.

Figure 16B: Recidivism Rate for RPTC Care



Source: DHSS Div. of Behavioral Health Policy and Planning using MMIS-JUCE data, unduplicated count of Medicaid RPTC beneficiaries.

Juvenile Justice System Improvement Initiative

For the past several years the Division of Juvenile Justice has enhanced the services provided to juvenile offenders and families who have behavioral health problems. Current strategies range from services that are community-based, to facility detention and treatment services, to re-entry or aftercare services. These include, for example, non-secure shelters for youth who may have immediate behavioral health difficulties and alternatives to detention, such as electronic monitoring and community detention. Strategies also include provision of therapeutic services with the addition of mental health clinicians in six of the eight secure DJJ facilities, with plans to add part-time mental health clinicians in two more facilities in FY09.

Juvenile Justice continues to sponsor chemical dependency counselor certification for field and facility staff and 52 employees are currently participating in the program, either working towards or maintaining certification.

Aggression Replacement Training, proven to be effective in increasing pro-social behaviors and reducing recidivism for youthful offenders, has been implemented statewide. As of June 2008, approximately 500 youth on probation or in Juvenile Justice facilities have received ART. A pilot project, the Fairbanks Juvenile Treatment Court, was recently developed in partnership with the Alaska Court System and other stakeholders.

Recent Accomplishments

- Development and implementation of a comprehensive Suicide Prevention Policy and Procedure for all secure juvenile facilities statewide. This critical policy and procedure addresses all eight core components as required by national standards. Further, suicide prevention training was developed by Juvenile Justice mental health clinicians and is provided for all Juvenile Justice officers and facility nurses.
- An increase in the therapeutic behavioral health services offered to juveniles in custody due to the addition of mental health clinicians in juvenile facilities. This ranges from increased screening and assessment services to crisis intervention, therapy and referral, along with consultation and training provided for Juvenile Justice staff.
- Provision of family therapy for youths returning to their home communities following release from secure placement in the Nome, Bethel and Juneau youth facilities. Much of this has been possible due to funding from the Bring The Kids Home Initiative, in partnership with the Division of Behavioral Health.
- Completion of a successful five year project funded by the Robert Wood Foundation titled *Reclaiming Futures*, centered in Anchorage. The program helps teens who have been arrested two or more times. It increases treatment and services delivered to teens in need; improves planning and communication among internal agencies; and strengthens collaboration with the community. Partners included Division of Juvenile Justice, Anchorage probation, Volunteers of America, the Juvenile Court system, volunteers from Native American tribes and other cultural groups, and several other partners. The project was evaluated by the Urban Institute, Portland State University and the University of Alaska.

- [Urban Institute evaluation](#)

Recent Challenges

- Implementation of an integrated DHSS review protocol for residential and psychiatric treatment centers for youth.
- Adequate community-based services for youth with mental health and substance abuse needs. This includes a need for better risk/need assessment and community treatment options for sex offending youths. In addition, community-based options such as crisis respite services are needed for youths with (or at risk of) severe emotional disorders, as they are sometimes placed in secure detention due to lack of community-based options.
- Family treatment options for youths with behavioral health disorders and their families, both in the community and within secure facilities, in order to enhance their success upon release as they transition home. Family treatment models are resource-intensive, from the funds needed to train individual staff; to bring youth, families and clinicians together; and to implement one or more family treatment models statewide across service systems.

Justice for Persons with Disabilities Focus Area

Beneficiaries of the Alaska Mental Health Trust are at increased risk of involvement with the criminal justice system both as defendants and as victims. Limitations and deficiencies in the community emergency response, treatment, and support systems make criminal justice intervention the default emergency response to the conditions and resulting actions of many Trust beneficiaries.

The Trust's Justice for Persons with Disabilities Initiative began in 2004. A collaborative group, including The Trust, advisory boards, state and local government agencies, the court system, law enforcement, consumers, advocacy groups, community behavioral health providers, and others, has developed and is implementing the following strategies: (1) increase training for criminal justice personnel; (2) sustain and expand therapeutic court models and practices; (3) improve continuity of care for beneficiaries involved with the criminal justice system; (4) increase capacity to meet the needs of beneficiary offenders with cognitive impairments; (5) develop mechanisms to address the needs of Trust beneficiaries who are victims; (6) develop community-based alternatives to incarceration for beneficiaries; (7) develop a range of housing options to provide for varying needs of beneficiaries involved at different stages of criminal justice system; and (8) evaluate the initiative's impact to improve justice for beneficiaries.

Recent Accomplishments

- A comprehensive study of Trust beneficiaries in the Alaska Department of Corrections was conducted.
- Evaluations of the Anchorage and Palmer Coordinated Resources Project (aka mental health therapeutic courts) were conducted.
- The Barrow Resources Court was implemented and began accepting referrals.

Recent Challenges

- Access to comprehensive community based mental health and substance abuse treatment.
- Access to safe, sober, and affordable housing with comprehensive wrap-around case management support.
- Cross system coordination for discharge planning for Trust Beneficiaries being released from the Alaska Department of Corrections and the Alaska Psychiatric Institution into Alaska's communities.

Outcome Data - Mental Health Courts

- The combined institutional savings generated by the Anchorage and Palmer Mental Coordinated Resources Projects exceeds the estimated annual operational costs of the program. In Anchorage, it is estimated to be almost two and one-half times the annual operational costs of the program.
- Diverting Trust Beneficiaries with severe mental illness from incarceration into either Anchorage or Palmer Coordinated Resources Projects poses less of a risk to public safety than traditional adjudication.
- Participants from both the Anchorage and the Palmer Coordinated Resources Projects were less likely to engage in new criminal conduct after exiting the program than an equivalent group of people experiencing mental illness also involved in the criminal justice system. Graduates were least likely to re-offend overall.
- Full evaluation reports
 - [Anchorage Coordinated Resource Project Evaluation](#)
 - [Palmer Coordinated Resources Project](#)

Medicaid Waiver Rates

Providers of Medicaid waiver services for seniors and individuals with disabilities have experienced significant cost increases related to energy, health coverage, and workers' compensation in particular, as well as overall inflation. Reimbursement rates had been frozen for years until providers received a very modest (4% to 6%) increase for FY 2009, but it does not compensate them for the full range of increased costs.

Advocacy groups are seeking a formal change in DHSS policy which would provide for automatic regular reviews of waiver reimbursement rates similar to those now received by hospitals and nursing homes.

Recent Accomplishments

- For FY 2009, advocated for and received a small increase in Medicaid waiver rates.
- Regular rate reviews (Medicaid and grant funded services) included in 2009 advocacy priorities for Trust-associated boards.
- DHSS receptive to discussions on incorporating regular reviews of waiver reimbursement rates.

Recent Challenges

- Providers are having a progressively difficult time remaining solvent in the face of un-reimbursed cost increases; if services' viability is threatened, seniors and others may suffer.
- Unclear whether provision for regular reviews should be statutory or regulatory.
- Budget restraints due to low price of oil may inhibit commitment to regular rate adjustments.

Children's Mental Health Curriculum Initiative

The goal of the Children's Mental Health Curriculum Initiative, funded by The Trust, is to increase and expand the University of Alaska's ability to train behavioral health professionals in the field of Children's Mental Health. The University sought feedback from child and family mental health providers across the state and learned that faculty knowledge, courses, and course content in these areas are lacking. Based on this input several strategies were developed to increase faculty knowledge as well as expand and develop new curriculum.

Outcome Measures

- Up to five faculty will complete graduate certificate program in Children's Mental Health from University of South Florida (USF)
- Complete environmental scan of University system-wide course content in children's mental health and key informant perceptions of University's ability to address workforce needs in this area
- Greater content in key areas of childhood development, systems of care, and childhood mental health will be infused into UA system behavioral health curricula
- Develop interdisciplinary course on Children's Mental Health that can be offered at any campus
- Assess viability of creating a UA certificate in Children's Mental Health

Indirectly, this program will prepare students to work in behavioral health careers involving children and families.

Recent Accomplishments

- Two full-time and two adjuncts faculty members are enrolled in the University of South Florida's Children's Mental Health Certificate program. Upon completion of the certificate each person will teach courses in Systems of Care and Children's Mental Health
- A week-long Children's Mental Health and Systems of Care training was conducted by faculty from USF in August, 2008 with 15 people completing the entire training and a total of 17 attending

- Participants at the summer intensive developed values, action steps, and workgroups for addressing a Children's Mental Health (CMH) workforce initiative under on-going consultation from USF faculty member
- Environmental scan of State of Alaska and provider behavioral health key informants regarding workforce educational needs is complete
- On-going planning with State Early Childhood Department to address workforce needs and explore creation of University-wide certificate in Early Childhood Mental Health Consultation.

Recent Challenges

- Faculty needs for USF training modules exceed budget.

Outcome Data

- Total number of participants during past year: 20

DHSS Priority Area: Long-Term Care

Long-Term Care Strategic Planning

Alaska operates a wide variety of programs that provide long term care services, ranging from institutional care to home and community-based services. However, the growing cost of providing long term care services is a critical issue facing Alaska's Medicaid program.

The Department of Health and Social Services contracted with HCBS Strategies to analyze the Alaska Medicaid program's long term care services and make recommendations for the development of a Long Term Care Plan. Their recommendations are aimed at making Alaska's long term care programs more cost-effective. A three-year action plan will examine services used by older adults and individuals with physical or developmental disabilities. This includes individuals who are receiving services from nursing facilities, Pioneer Homes, Home and Community Based Services (HCBS) Waivers, and Medicaid State Plan personal Care Services and an exploration of options for potentially underserved populations, such as individuals with brain injuries, Alzheimer's Disease or Related Disorders, or individuals with a mental illness in conjunction with a disability.

- See [Recommendations for the Alaska Long Term Care Plan](#)

The Department has also been working with the tribal health care system on long term care. The long term care planning undertaken by both Alaska Native Tribal Health Consortium and Yukon Kuskokwim Health Corporation, collaborating with the Department, has focused on the specifics of the tribal regions and membership. They have identified services not presently offered or available by tribal health programs, barriers to service, and referral systems; included an assessment and time line of each individual tribal health program's readiness to expand into the services; and developed an implementation work plan with necessary steps and timelines for tribal health programs to implement the services and service arrays based on priority.

Recent Accomplishments

- HCBS Strategies completed [Recommendations for the Alaska Long Term Care Plan](#)
- Phase I of the Statewide Tribal Long Term Care Facility Plan has been outlined and endorsed by the Tribal Health Directors; this includes working on business plans for the Anchorage (100 bed), Kotzebue (18bed), and Bethel (18 bed) facilities
- The Department finalized recommendations for numbers of beds by region and sub-region and developed requests for Phase II (SFY 10) Tribal Long Term Care Facility projects
- The Fairbanks North Star Borough completed a study in 2008 which explored the long term needs of seniors and baby boomers in that area.

Recent Challenges

- Many communities, particularly in rural areas and small towns, lack assisted living and other long-term care institutions that would allow seniors to remain in their communities when their care needs increase.
- Some long-term care insurance plans marketed to State retirees and others are not use-able for common services in Alaska due to requirements for RNs on site, etc. While most seniors who meet a nursing home level of care can spend down or use a trust to qualify for Medicaid services. Medicaid may not cover the home and community-based services and supports needed for seniors who have not yet reached that level of care.
- Programs are threatened by higher long term care expenditures and a growth in the number of people who need them. The number of seniors in Alaska is growing faster than almost every other state's senior population.

Aging and Disability Resource Centers

Aging and Disability Resource Centers serve as a visible, trusted place for older adults and people of all ages with disabilities to go for information and assistance. The ADRC initiative is a part of a nationwide effort to restructure community based services and supports while ensuring informed choice and accessibility. ADRC activities include efforts to remove barriers to community living in support of Alaska's call to meet the requirements of the Olmstead decision and the President's New Freedom Initiatives. In 2008, Alaska's ADRC program successfully transitioned from the State Independent Living Council (SILC) to Alaska DHSS Senior and Disability Services (SDS). The goal of the program is to have a minimum of six fully functioning ADRC's providing statewide coverage; the current funding supports three sites. SDS will request applications for more sites should additional funds become available.

Each of the funded sites is required to dedicate at least one full time staff person to serve as the ADRC Coordinator. The primary duties of the ADRC Coordinator include coordinating with local providers and hospital discharge planners to reduce confusion and time it takes to successfully link the target population to services and supports in their community, to reduce dissemination of inaccurate and/or duplicated information, and to identify and address gaps in long term care services with the guidance and support of SDS. Alliance on Information and Referral Services (AIRS) certified staff, located in ADRC centers, will provide information, referral, and access to services for people seeking services as well as community outreach and education.

The Aging and Disability Resource Center Grants are managed by staff in the SDS Grants Unit. Over the next three years, this staff will work closely with ADRC Advisory Council, SDS Health Program Unit Manager, the Lewin Group, and ADRC grantees to develop standardized best practices, policies and procedures specific to ADRC's that will further streamline access for consumers and centralize intake, eligibility, and assessment processes for Medicaid, Grant, and Private Pay Long term Care services. Distribution of additional ADRC funds will be considered by the ADRC Advisory and awarded through the departments Grant Procurement process. Advisory Council will meet quarterly to discuss the development of the ADRC project and will evaluate performance outcomes annually. Advisory Council membership will include

representation from: State Independent Living Council, Alaska Mental Health Trust Authority, Alaska Commission on Aging, Alaska Housing Finance Corporation, Governor's Council on Disabilities and Special Education, the Alaska Native Tribal Health Consortium, and United Way 211 Project.

Recent Accomplishments

- 1-800 number on-line
- ADRC screening and intake tool developed
- SDS received a federal grant to develop a standardized hospital discharge planning tool, with the ADRCs to provide follow-up contacts to ensure that consumers' needs are met.

Recent Challenges

- Funding (Alaska's ADRCs are currently funded for only one full-time staff person in each of three regions)
- Most of the state is unserved by ADRCs, specifically the Interior, northern Alaska and southwestern Alaska
- Outreach and marketing to providers and consumers about ADRC's

Outcome Data

- Alaska's ADRCs served 979 individuals age 60 and over during FY 2008, the highest number since the program's inception in FY 2005.

Supporting Family Caregivers

DHSS Senior and Disability Services has been providing support for Family Caregivers of individuals 60+ and Grandparents (55+) raising grandchildren through the National Family Caregiver Support Program (NFCSP) (Federal Administration on Aging/Older Americans Act funding) since its inception in FY2001. Through this program, Family Caregivers are provided information, assistance, education, counseling, support groups, respite and supplemental services to assist them in extending the time they can care for their loved one in their homes. Alaska's NFCSP provides services statewide to meet the needs of caregivers specifically.

Recent Accomplishments

- Implementation of SAMS reporting database
- Increase in the numbers of Grandparents raising grandchildren served
- Evidence based education program "Savvy Caregiver" implemented
- ADRC's expansion to increase Information and Assistance for caregivers.

Recent Challenges

- Funding for statewide programs

- Lack of services in rural areas

Outcome data

In FY 2008 over 5700 caregivers received assistance “extending their care” through these innovative grants.

DHSS Priority Area: Vulnerable Alaskans

Workforce Development

In May 2004 a summit was held to develop a strategic plan for addressing the supply of workers in Alaska with a focus on behavioral health. Policy direction from that meeting included: (1) increase the supply of workers at all degree levels; (2) improve course and program articulation across all campuses; (3) increase cultural competence skills of the workforce, and (4) ensure curriculum reflects new practice trends including integration of substance abuse and mental health practices.

Following the summit, several major entities within Alaska partnered together to address current and future demand for behavioral health professionals. The partners include:

- University of Alaska - as the state's public university, UA has the responsibility to address state needs through education, training and research.
- Alaska Mental Health Trust Authority - unique in the nation, the Trust is a publicly endowed authority designed to administer land and assets to fund mental health and other needed services to Alaskans.
- State of Alaska, Department of health & Social Services, Division of Behavioral Health - DBH is statutorily charged to deliver service to those in need of behavioral health prevention, intervention, and treatment.

In the last year, The Trust has assumed a greater leadership role in workforce development, partnering with the University of Alaska and the Department of Health and Social Services, advisory boards, service providers and consumer groups to develop strategies to address workforce shortages and training needs for services for Trust beneficiaries. The Trust, University of Alaska and DHSS partnered this year to share a workforce development coordinator who focuses on behavioral health workforce initiatives across the partnership. Additional partners, such as WICHE (Western Interstate Commission on Higher Education) and the Annapolis Coalition have been involved in the planning and implementation of strategies to address workforce needs of the beneficiaries.

Some of the ongoing activities to increase Recruitment and Retention are:

- Credentialing and Quality Standards;
- Loan repayment;
- Marketing; and,
- Wages & Benefits

Training and Education activities include:

- Trust Training Cooperative;
- Alaska Rural Behavioral Health Training Academy;
- "Grow Your Own"; and,
- Distance MSW and BSW programs.

Recent Accomplishments

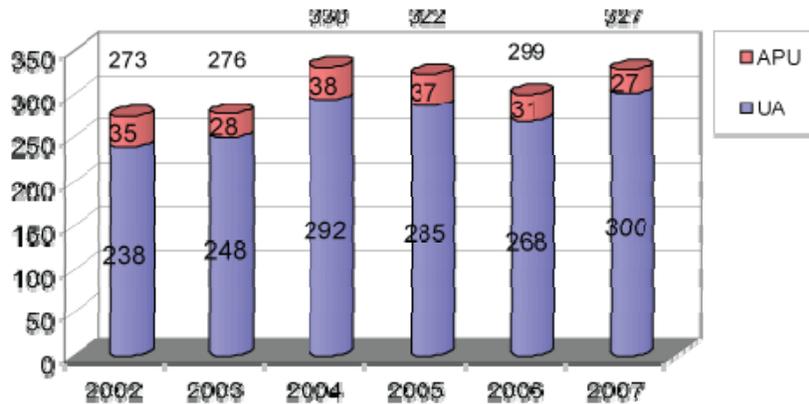
- **Behavioral Health Workforce Development Coordinator** - OMB approved a shared position between the following 3 institutions: Department of Health and Social Services, University of Alaska and the Alaska Mental Health Trust Authority to be the single point of contact and liaison for all behavioral health workforce efforts and initiatives.
- **Credentialing and Quality Standards (CQSS)** - WICHE (Western Interstate Commission on Higher Education) and the Annapolis Coalition is working with the three partners to develop a CQSS process for direct care workers.
- **Trust Training Cooperative**, a project housed in the Center for Human Development, is focused on improving training coordination and assisting to make training available to smaller organizations and rural areas through distance delivery techniques.

Recent Challenges

- **Long Range Strategic Plan for Behavioral Health Workforce Development.** The State of Alaska needs a long range strategic plan for planning, implementing and funding workforce development and retention. The future roles and responsibilities of the State of Alaska (DHSS, DOL, EED), The Trust and the University of Alaska regarding workforce development; recruitment, retention, training and education must be determined and supported. Decisions must be made regarding the roles of each entity in the coordination, implementation, and funding for academics, training and professional development. And at what point do the lead institutions engage employers, employees and other stakeholders in forming a consortium to ensure elements of consistent and regulated training and development?
- **Recruitment & Retention.** Across the state there is an immediate need and void for all levels of behavioral health workers from direct care to psychiatrists. While workforce development efforts are underway, we have been unable to directly impact the current crisis for additional behavioral health workers across the state.
- **Training and Education.** Alaska has quality training and education available across the state but what is lacking is sufficient funding to provide a uniform and regulated process. Resources are needed to assist providers, agencies, workers and institutions with paying for training that is currently available and/or required and on occasion, to develop specialty training that does not exist

Outcome data

Figure WD-1: Behavioral Health Program Degrees and Certificates Awarded at Alaska's Universities



Sources: [APU Office of the Registrar](#); [UA Information Systems](#): Banner SI reporting extracts.

Degrees and certificates included in this data. University of Alaska: Certificate - Developmental Disabilities, Disability Services, Human Service Technology, Rural Human Services; AAS - Developmental Disabilities, Disability Services, Human Services; BA - Community and Change, Human Services, Social Work; BA/BS Psychology; MS - Clinical Psychology, Counseling Psychology. Alaska Pacific University: Counseling Psychology, Human Services, Psychology.

Health Care Professions Loan Repayment & Incentive Program

In Alaska there are substantial healthcare workforce shortages, and practitioners are not available in many communities. With assistance from an Alaska Mental Health Trust Authority grant award, DHSS Division of Public Health, Section of Health Planning & Systems Development is investigating the possibility of a state-sponsored “loan repayment” option for healthcare providers. In national studies, loan repayment has been found to be a successful strategy to recruit and retain health care professionals. Studies have shown that there are several benefits which can accrue from loan repayment programs, including: (a) high position-fill rates, (b) high service-completion rates, and (c) high retention rates after program.

Alaska does not yet have a robust, state-sponsored support-for-service program, while most other states do. Alaska is competing with other states and nations for the finite pool of available healthcare professionals, and this competition will intensify as the growth of supply continues to fall behind that of demand.

Recent Accomplishments

- Interagency Planning Group: For SFY 2008, a large & broad-based “Interagency Planning Group” (IPG) was formed to discuss and plan for a state-sponsored HCPLRIP. The following program elements were defined: (a.) organizational support, (b.) oversight, (c.) fiduciary agent, (d.) practitioner eligibility, (e.) site eligibility, (f) repayment details, (g.) program design & management, and (g) program evaluation. The eligible practitioner-types include - Tier-1: Dentists,

Pharmacists & Physicians (MD & DO); and, Tier-2: Nurse Practitioners, Physician Assistants, Nurses, Physical Therapists, Psychologists, Social Workers (MSW), and Dental Hygienists.

- Reports & Visibility: Four documents have been produced: (a) a substantive “Issues-Paper”; (b) a “Briefing” paper; (c) a “workforce funnel graphic”; and (d) a substantive “program summary”. These analyses have benefited from the ongoing consultation of national expert, Donald Pathman (School of Medicine, University of North Carolina). Public presentations have been given Alaska Public Health Association, Northwest Regional Rural Health Conference, the Alaska Primary Care Council, and others.
- The Trust has begun a loan repayment program for behavioral health professionals with masters level or higher degrees that was targeted in the first two years to rural behavioral health providers with high vacancy rates. \$200,000 per year in Trust funds has been budgeted for the first two years with individuals committing to work for two years receiving up to \$20,000 per year in loan repayment.

Recent Challenges

- Need for program funding
- Need for successful program start-up
- Addressing tax liability for state loan repayment programs

Families First! / Family Centered Services

Families First! is the name of a new departmental initiative based on the promising outcomes of the family centered services pilot project conducted in Wasilla and Fairbanks. Adults that participated in the pilot were long-term recipients of the Alaska Temporary Assistance Program who were having difficulty meeting the program’s work requirements. At the end of the pilot, participating families showed marked improvements in key indicators such as hours of participation in work activities, employment and wages.

Families First! focuses on helping families address challenges to employment and self-reliance by using a proven, national “customized employment” model. The model relies on close collaboration with other agencies and service providers working as a multi-disciplinary team with the family to develop comprehensive and integrated service plans designed to mitigate barriers and engage family members in activities that help move families towards employment, self-sufficiency, and an improved quality of life.

This reflects the Department’s goals to coordinate and integrate services among agencies serving common clients to reduce redundancy, share information, identify barriers, and improve client outcomes. The Division of Public Assistance anticipates statewide implementation of Families First! by July 2009.

Recent Accomplishments

- Creation of a strong collaboration and commitment to integrated services for shared clients of the Divisions of Public Assistance, Behavioral Health, Juvenile Justice, and the Office of Children's Service.
- Use of the Master Client Index to identify families served by multiple agencies within DHSS.
- Initiated recruitment and hiring in Fairbanks, Nome, Kenai, Wasilla, Anchorage and Southeast of project assistants responsible for managing and monitoring local implementation of the initiative.

Recent Challenges

- None to report

Outcome Data

- Outcome data will not be available until after July 2009.

Performance Management System Project

The DHSS Division of Behavioral Health maintains an ongoing commitment to the development of a "Performance Management System" to function as a continuous quality improvement process to guide policy and decision-making for improving the behavioral health of Alaskans. The Performance Management System has three broad components: **the service delivery system**, broad population planning, and DBH management indicators.

In the public service delivery system, the performance measures address whether the services are of high quality; whether the behavioral health system is efficient, productive, and effective; and whether services produce the desired impact on the quality of life of consumers.

To support behavioral health planning for the broader population, the project addresses the following questions: (1) are Alaskans who need services getting them, and able to get them conveniently; (2) do Alaskans with behavioral health disorders live with a high quality of life; and (3) are efforts taking place to prevent or lessen problems that result in consumers needing services. The DBH Management Indicators component will address performance indicators useful for the management of the service delivery system, including accountability and documented outcomes to provide transparency in the use of public funds.

Accomplishments

- For FY 2009, the Performance Based Funding (PBF) effort successfully applied the performance measures of grants management scoring; cost per client;

substance abuse utilization; the consumer survey; data / record completeness; and client outcomes.

- Completed and applied “prevalence estimations” of need for priority populations.
- Initiated a “mapping” process to apply prevalence estimations with “clients served” by regions of the state for policy and planning.

Challenges

The ongoing planning and implementation of the Performance Management System involves multiple challenges that include:

- the development of a Performance Based Funding methodology of measurement that reflects the diversity of providers in varied geographical areas and diversity of clients seeking services;
- provider resources in maintaining staff who are skilled in data gathering and data submission through the AKAIMS; and
- resources of technology in data gathering, management, and reporting.

Outcome Data

- **Performance Based Funding**

The performance of 61 behavioral health providers was measured with the following results:

- 64% of all providers were awarded grant increments in one or more measures with high performance, in the amount of \$1,034,452; and
- 82% of all providers received decreases in grant awards in one or more measures with low performance, in the amount of \$781,762.

- **The Alaska Screening Tool (AST)**

In FY 08, 8,613 screenings using the AST were conducted. This resulted in:

- 5,544 (64.4%) referrals to substance abuse services;
- 6,904 (80.2%) referrals to mental health services;
- 2,970 (34.5%) indicated suspected Traumatic Brain Injury;
- 738 (8.6%) indicated suspected Fetal Alcohol Spectrum Disorder; and
- 4,529 (52.6%) indicated suspected dual diagnosis.

- **The Behavioral Health Consumer Survey**

The FY2008 survey represents the third Behavioral Health Consumer Survey (BHCS) for the state. The percent of respondents evaluating services positively over all was:

- Seventy-eight percent (78%) of adults evaluated services positively;
- Seventy-seven percent (77%) of teens/young adults ages 13-17; and
- Seventy-four percent (74%) of parents and caregivers of children ages 0-17.

- **The Client Status Review of Life Domains**

For FY 2008, the CSR outcomes indicate the following findings:

- In four life domains (housing situation, financial/basic needs, thoughts about self harm, and physical health), more than 75% of individuals reported improvement or maintaining condition within the specified domain; and

- In two life domains (mental/emotional health and productive activity/employment), less than 75% of individuals reported improvement or maintaining condition within the specified domain.
- **Active Client Count of Individuals Receiving Behavioral Health Services**

Public Health Nurses Addressing Domestic and Family Violence

Alaska's public health nurses provide a wide variety of health promotion and disease and injury prevention services to Alaskans in their communities. Over the past three years this has included a concentrated focus on addressing domestic and family violence issues. Activities include: screening all clients for domestic/interpersonal violence, date rape prevention education, enhancing community awareness and education related to the effects of interpersonal violence, and mobilizing community efforts to address domestic and family violence.

Recent Accomplishments

- Routine universal screening for domestic/interpersonal violence for public health clients was implemented in 2007.
- All public health nurses have received in-service education to increase their knowledge and strengthen their skills in addressing interpersonal violence.
- Public health nurses completed approximately 14,000 screenings for domestic violence in FY 2008.

Recent Challenges

- Lack of resources to support violence victims, particularly in small, rural communities.
- Interpersonal violence viewed as a social norm in some families and communities.
- Need for ongoing education and support for health care providers to further implementation of routine DV screening and counseling.

Outcome Data

Due to the nature of domestic violence, outcomes often are not seen for several years. In the meantime work continues toward the goals of developing zero community tolerance for interpersonal violence, providing education about healthy relationships, and mobilizing additional community partnerships to advocate for safe shelters and services for victims of DV, and for support services for children exposed to DV.

Alaska Works Initiative

The *Alaska Works Initiative (AWI)* is a statewide, federally-funded initiative comprised of a variety of stakeholders who are working to implement the following vision: *Alaskans who experience disabilities are employed at a rate as close as possible to that of the general population.* Initiative partners through the leadership of the Governor's Council on Disabilities & Special Education are working together to implement the following eight goals:

Work expectations and incentives are built into programs and services for people with disabilities.

- Success in employment is regularly measured and analyzed.
- Awareness, understanding and use of employment-related resources by Alaskans with disabilities are increased.
- Service providers have the capacity to meet the employment-related needs of Alaskans with disabilities.
- Resources are blended and braided.
- A variety of funds including under-utilized and non-traditional resources, are being used to fund needed services.
- Job seekers with disabilities are routinely connected to needed resources, including the workforce investment system.
- Services and resources are coordinated as a part of everyday activities.

The Governor's Council on Disabilities & Special Education received a new grant from the Centers for Medicare & Medicaid Services (CMS) to continue AWI activities, build on prior accomplishments and address identified challenges in calendar years 2009 and 2010.

Recent Accomplishments

Governor Palin co-sponsored the Disability Employment Policy Summit February 6, 2008. The purpose of the summit was to discuss and prioritize recommendations associated with three major issues impacting the employment of Alaskans with disabilities: 1) state government as a model employer, 2) assets building, and 3) integrated services and resources.

- The Supported Employment Task Force developed a set of recommendations for improving supported employment services provided to individuals with developmental disabilities. In 2009, the Division Senior & Disabilities Services will receive AWI funds to employ staff to help the division implement these recommendations
- The Division of Behavioral Health and the Division of Vocational Rehabilitation, with the assistance of AWI staff, service providers and a consultant, developed and are implementing an action plan to increase the employment of individuals with severe mental illness.

Recent Challenges

- Integrating work as an expectation across service delivery systems

- Increasing the percent of people with disabilities who are employed in high wage, high growth industries
- Collecting outcome data across service delivery systems

Outcome Data

- In calendar 2007, 1,200 individuals were supported by *Alaska Works Initiative* activities; approximately 514 secured full or part time employment.

Start Up Alaska Project

In October 2006, the Governor's Council on Disabilities and Special Education received a three-year research and demonstration grant from the federal Office of Disability Employment Policy to increase the number of Alaskans with disabilities who are self-employed. A part of the overall *Alaska Works Initiative*, this *Start up Alaska Project* has the following goals:

- Update and expand resource mapping and needs assessments to identify strengths and limitations of existing resources and ascertain training, technical assistance and policy needs.
- Develop, test, evaluate and disseminate a customized self-employment model at the one-stop job centers in Anchorage, Fairbanks and Southeast Alaska.
- Establish a business incubator program
- Modify and/or develop policy that facilitates permanent, systemic change that results in increased numbers of Alaskans with disabilities becoming self-employed.

It is anticipated that the following outcomes will be achieved:

- System wide assessment and identification of self-employment improvement opportunities via resource mapping (see Goal 1 above)
- Piloting and demonstration of two self-employment models (customized self-employment partnerships and business incubator) for 30 self-employed persons with disabilities (see Goal 2 and 3 above)
- Utilizing lessons learned from the pilots, development and implementation of longer term policy and training strategies to enhance Alaska's workforce system's capacity to successfully serve people with and without disabilities so they can become successfully self-employed (see Goal 4)

Recent Accomplishments

- Revising self-employment policy proposed by the Division of Vocational Rehabilitation to make it more user-friendly to individuals interested in being self-employed
- Ensuring that self-employment was implicitly listed as an option under supported employment in the waiver for youth with severe emotional disturbances and fetal alcohol syndrome disorders

- Using a portion of the Alaska Mental Health Trust-funded micro-enterprise grant funds to provide ongoing business assistance to entrepreneurs after their businesses are launched

Recent Challenges

- Working with state agencies to develop policy that promotes self-employment
- Changing attitudes about the potential for self-employment by people with disabilities
- Sustaining the program when federal funds end

Project staff is currently working with partners and contractors to address these challenges.

Outcome Data

To date, 51 individuals have been served and 16 businesses have been launched.

Trust Beneficiary Projects Initiative

The Trust has dedicated \$1.75 million annually since FY06 in a targeted program to help beneficiaries conceive and manage programs that focus on peer-to-peer support. They have found that people who participate in the decisions that affect their lives are much more likely to act in their own best interest – making appropriate decisions and succeeding with training and employment. This is the principle upon which the Beneficiary Projects Initiative was founded.

The initiative is structured around three broad goals, all of which are designed to make progress toward self-directed programs which result in an improved quality of life for beneficiaries. When these goals are achieved, beneficiaries will be able to participate in projects that are sustainable, demonstrate positive outcomes and cost efficiencies, and eventually transition to a continuing funding source. These goals are:

1. Provide a source of funding and technical assistance to beneficiary group initiated and managed projects and activities;
2. Ensure that Trust beneficiary group initiated and managed activities are safe, sustainable and effective; and
3. Provide a viable avenue for Trust beneficiary group initiated advocacy that is rooted in community needs and addresses existing service gaps

The programs emphasize prevention, education and early intervention to help participants find their own path to recovery and wellness.

Recent Accomplishments

- Polaris House in Juneau is a program for people with mental illness. It is based on the “clubhouse” model which offers an environment where members can begin engaging in pre-vocational training and reintegrating into society. People come to Polaris House to rebuild their lives. The members get help finding employment, housing, training and health care. Together they manage the clubhouse and set its rules and policies. They prepare meals, maintain the property, plan activities, celebrate each other’s successes, and provide encouragement for members who have set-backs.
- Successful social support programs for women in recovery from addiction, like the Alaska Women’s Recovery Project.
- Programs targeting homeless engagement services and those focused on family to family support such as the Alaska Youth and Parent Foundation and the Stone Soup Group.

The Trust has long term projects that are also included in the larger umbrella of “Beneficiary Projects” that target increased resources directly to beneficiaries: the mini-grant program and the micro-enterprise and asset building projects. The small projects program is also under this umbrella, given the focus in this program on making small grants, under \$10,000.00, to non-profits or government entities that will have a direct impact on beneficiaries in the project area. A good example of this funding strategy is the grant made in Kenai to a consumer group at a mental health center who wished to generate income for consumer activities through funds received from a vending machine. The Trust was able to assist the beneficiaries in purchasing a vending machine through the small projects grant program.

Outcome Data

Progress toward BPI goals will be measured against four desired outcomes:

1. Increase in statewide capacity, sustainability and local access to peer support services and advocacy;
2. Increase in the quality of life for Trust beneficiaries through participation in peer support services and advocacy;
3. Increase in capacity for beneficiary control in service delivery; and
4. Increase in successful interventions at the local level through peer support services and activities.

More information about the [Beneficiary Projects Initiative](#), including the grants awarded and a dashboard showing outcomes, can be found on The Trust website under Focus Areas.

Abuse and Neglect of Vulnerable Adults

Older Alaskans and Alaskans with disabilities are vulnerable to many forms of abuse and neglect, from physical abuse to neglect of their needs to financial exploitation. The perpetrators may be family members, caregivers, others in the community with whom they have contact, or unknown persons who contact the person by phone or email.

Public awareness of the varieties of abuse and neglect and how to report suspicious situations must be increased.

Recent Accomplishments

- The Long-Term Care Ombudsman's Office is steadily increasing the number of volunteer ombudsmen in each region of the state. These helpers visit residents of long-term care facilities to ensure that all their needs are met and that they are being treated respectfully.
- The ACoA is seeking funding for the COMPAN Project (Communities Prevent Abuse and Neglect) to start in FY 2010. This project will include educational activities to increase the public's awareness of abuse and neglect.
- DHSS Senior and Disabilities Services is upgrading the data base used to track incidents of abuse and neglect involving vulnerable adults so that information on age, type of abuse, and other characteristics will be available soon.

Recent Challenges

- Because Adult Protective Services (APS) is under-funded and understaffed, prompt response to complaints may not be possible at all times.
- The public may be unaware of the signs that a vulnerable adult may be experiencing abuse, neglect, or financial exploitation
- Many Alaskans may not know how to report suspicious conditions they encounter in the course of their jobs or neighborhood encounters.

Outcome Data

- A new APS data base will ensure more comprehensive data in the future.

Affordable Appropriate Housing

Safe, decent, affordable, accessible and appropriate housing is often the key for Trust beneficiaries to maintain a healthy lifestyle and participate in rehabilitation and recovery activities. The statewide shortage of safe and affordable housing disproportionately affects Trust beneficiaries due to the high costs of rent and utilities, along with challenges associated with disabling conditions.

Some beneficiaries require long term supportive living situations or accommodations to meet special needs, and others simply require a subsidy for a period of time during recovery to transition to permanent stable housing. When a person lives with disabling conditions, the housing challenges often include accessibility and design layout; additional social support services to maintain safety; and difficulties in securing economic advancement opportunities such as employment.

Recent Accomplishments

- Trust beneficiaries with high needs require additional assistance to remain successfully housed, and these needs can strain agencies' ability to maintain housing units. Recently the Trust housing workgroup and the Department of Health and Social Services intervened with housing providers to assist with extra needed services and training for high needs beneficiaries. Fairbanks Community Behavioral Health Services worked with staff from the Department Division of Behavioral Health and The Trust to re-open 24 units of housing. Maintaining this resource in Fairbanks is a major success and remains a priority for activities in 2009.
- Additional communities are beginning to participate with the housing workgroup in examining reimbursement methods and funding subsidies for special needs housing. In 2009, the housing work group will work with agencies in both urban and rural communities to maintain housing that has been established for Trust beneficiaries.
- The Bridge Home program provides housing subsidies and supports to individuals with severe mental illness who have a history of repeated episodes of institutionalization in the Department of Corrections facilities or in Alaska Psychiatric Institute. Modeled on successful intensive outreach and supportive housing projects in Hawaii, Connecticut, Colorado, and New York, the Bridge Home Program assists clients to stabilize in their own homes immediately following release from identified institutions. The goal is for participants to eventually become eligible for HUD Section 8 vouchers and maintain a semi-independent lifestyle as their recovery continues.

Recent Challenges

- In the recent economy, housing is becoming more difficult to provide at a reasonable rate, especially if renters require additional assistance to remain successfully housed. Trust beneficiaries with the highest needs are frequently represented in the lowest income bracket due to challenges with mental illness, addiction and multiple diagnoses.
- State resources for non-Medicaid eligible activities such as social support and skill development in the home have dwindled over the past 10 years. This void leaves landlords and housing providers with a larger share of the costs to house people in low income brackets.
- A housing trust fund is needed to supplement housing projects with supportive services and adequate rental subsidies so Trust beneficiaries can afford safe, healthy housing. The Trust, the Rasmuson Foundation, and the Municipality of Anchorage funded pilot projects that demonstrate the efficacy of a housing trust model and will continue to develop these pilot projects in FY2009.

Outcome Data

- As a result of the Bridge Home program, clients have decreased their rates of incarceration and psychiatric hospitalization.

Trust Coordinated Communications Campaign

Stereotypes about mental illness, addictive diseases, developmental disabilities and dementia make it harder for people with these conditions to find work, housing and meaningful social contacts. Stigma often dissuades people from seeking care when they need it. *Moving Forward's* goal is to reduce the stigma associated with mental illness, alcohol abuse, developmental disabilities and age-related dementia. The Coordinated Communications Campaign, an initiative of The Trust (<http://www.mhtrust.org>) and the advisory boards, is aimed at reducing the stigma of beneficiary disabilities while emphasizing the concept that treatment and services work. The campaign is multi-media, including brochures, DVDs, posters and newspaper, TV, radio and movie theater ads. The theme of the campaign is "*You Know Me*," which points out that the issues addressed by The Trust touch nearly every Alaskan, whether it is a family member, a neighbor or a coworker.

Recent Accomplishments

- During FY2008, a new TV spot was produced which featured representatives from the Alaska Mental Health Trust Authority Board of Trustees and all the advisory boards speaking out about the issues that affect Trust beneficiaries. Running statewide, the spot appeared more than 900 times in high-visibility time slots, including morning and evening news broadcasts.
- A series of new print ads was produced as part of the *You Know Me* campaign. The series included two ads with messages similar to the "Speaking Out" TV spot and two ads with specific beneficiary issues related to brain injuries and alcoholism. The series appeared in 13 newspapers statewide, including dailies and weeklies, reaching 132,000 people per ad for four weeks, for a total of 528,000 exposures.
- The advisory boards each ran individual anti-stigma and awareness campaigns during the year to supplement *You Know Me*. *These included:*
 - a print ad during Mental Illness Week highlighting the loss of productivity employers experience related to absenteeism due to depression;
 - a print ad promoting treatment and recovery during Alcohol Awareness Month;
 - a print ad aimed at increasing awareness of brain injury during Brain Injury Month; and
 - a series of print ads promoting Careline, the statewide, toll-free suicide prevention and help line.
- Issues related to suicide also were highlighted in a keynote presentation produced for the annual Alaska Federation of Natives conference. The event was attended by approximately 1,000 people and was also simulcast on ARCS, the state-owned satellite system that broadcasts TV programming to 235 communities around Alaska. The presentation was later produced as a DVD entitled "Building Resilience." More than 800 copies were distributed to schools, non-profit groups, and Native organizations.

Recent Challenges

- Despite the ongoing campaign to increase awareness and understanding of Trust beneficiary issues, a public opinion poll in early FY2009 showed that while more and more Alaskans are aware of where they can go to get treatment or services for mental illness or disabilities, only about half of all Alaskans are familiar with the role of The Trust and who its beneficiaries are. The Trust is committed to continuing the ongoing *You Know Me* and other awareness measures to increase knowledge and understanding of The Trust, Trust beneficiaries, and the issues that impact their lives.

V. Emerging Issues/Trends

Access to Care for Medicaid and Medicare Patients

Access to primary care affects all Trust beneficiary groups. Patients in some parts of Alaska report disturbing levels of difficulty in finding primary care providers willing to see Medicare patients. Many seniors have been terminated from care by their long-standing family physicians. Doctors say that Medicare's reimbursements cover less than 50% of their costs of care.

Additionally, community mental health providers who serve people who are dually eligible for Medicare and Medicaid are reimbursed for clinic services at Medicare rates, which are lower than Medicaid rates. A number of community mental health centers, especially the urban centers that serve large numbers of adults with severe mental illness, experience financial hardship because of this federal billing requirement. In summer 2008, Congress passed legislation which included an increase in the physician reimbursement rates for Alaska to begin in 2009.

Eligibility Disparity for Early Special Education Services

To meet state eligibility criteria for services under the Individuals with Disabilities Education Act (IDEA) Part C, children from birth to three years old must have a 50% delay in one or more developmental domains. This is a stricter requirement than for children ages 3-22, which requires only a 25% delay in at least one developmental domain to access special education services through Part B of this same Act.

This disparity means that for children birth to three with developmental delays between 25-50%, services are delayed until they are eligible for special education services from their school district no earlier than their third birthday.

According to DHSS Office of Children's Services, this disparity is at odds with what we know about the importance of both early identification and early intervention, particularly for vulnerable children with multiple risk factors. Many of these children with moderate delays of 25-49% will continue to fall behind their peers while waiting to access these vital services, and this will increase needs and the costs when they enter services under Part B.

Returning Service Members with Brain Injury and Mental Health Conditions

According to the RAND Corporation, nearly 20 percent of military service members who have returned from Iraq and Afghanistan report symptoms of post-traumatic stress disorder or major depression. In addition, 19 percent report possible brain injury and 7 percent report both a probable brain injury and current PTSD and major depression. (See RAND Corporation News Release April 17, 2008. [*One in Five Iraq and Afghanistan Veterans Suffer from PTSD or Major Depression.*](#))

Researchers found many treatment gaps exist for those with PTSD and depression. Just 53 percent of service members with PTSD or depression sought help from a provider over the past year, and of those who sought care, roughly half got minimally adequate treatment. (RAND Corporation, April 17, 2008).

According to the RAND Corporation project co-leader, if PTSD and depression go untreated or are under-treated, there is a cascading set of consequences including drug use, suicide, marital problems and unemployment. "There will be a bigger societal impact if these service members go untreated. The consequences are not good for the individuals or society in general."

The Alaska Brain Injury Network reports that the 3rd Medical Unit at Elmendorf Air Force Hospital has developed a Mild Traumatic Brain Injury clinic to address the brain injury needs of returning service members in addition to the programs for PTSD or major depression.

VI. Further Information and Acknowledgements

The Department of Health and Social Services and the Alaska Mental Health Trust Authority share responsibility for the development of the Comprehensive Integrated Mental Health Plan for services described in statute as the Comprehensive Integrated Mental Health Program. These roles are detailed in the Alaska Statutes:

Authority for Plan

[AS 47.30.660](#)

Mental Health Funding Statutes

[AS 37.14.010-.099](#)

[AS 47.30.046-.056](#)

Beneficiaries of The Trust

[AS 47.30.056](#)

These Alaska Statutes can be found at www.legis.state.ak.us .

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Further Information

For those who wish further information, following is a list with contact information for the agencies responsible for this plan and for the advisory and advocacy boards whose planning efforts coordinate with the Comprehensive Plan.

Alaska Department of Health and Social Services

Section of Health Planning and Systems Development

P.O. Box 110601

Juneau, Alaska 99811-0601

(907) 465-3091

www.hss.state.ak.us/dph/Healthplanning

Alaska Mental Health Trust Authority

3745 Community Park Loop, Suite 200

Anchorage , Alaska 99508

(907) 269-7960
www.mhtrust.org

Alaska Mental Health Board

<http://www.hss.state.ak.us/amhb/>
(Conducts planning and advocacy for adults and children experiencing mental illness and emotional disorders)
431 North Franklin Street
Juneau, Alaska 99801
(907) 465-3071

Governor's Advisory Board on Alcohol and Drug Abuse

<http://www.hss.state.ak.us/abada/>
(Conducts planning and advocacy for prevention and treatment of alcoholism and drug abuse)
431 North Franklin Street
P.O. Box 110608
Juneau, Alaska 99801
(888) or (907) 465-8920

Governor's Council on Disabilities and Special Education

<http://www.hss.state.ak.us/gcdse/>
(Conducts planning and advocacy for children and adults experiencing a developmental or cognitive disability)
3601 C Street #740
Anchorage, Alaska 99524
(888) or (907) 269-8990

Alaska Commission on Aging

<http://www.alaskaaging.org/>
(Responsible for planning and advocacy for people with Alzheimer's disease or related disorders)
P.O. Box 110693
150 Third Street
Juneau, Alaska 99801
(907) 465-3250

Alaska Department of Corrections

<http://www.correct.state.ak.us/>
4500 Diplomacy Drive
Anchorage 99508
(907) 269-7317

Alaska Brain Injury Network

<http://www.alaskabraininjury.net/>
Office: (907) 274 - 2824
Toll-free (888) 574 - 2824 (in Alaska)

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