

5. *Mental Health*

Goal:

Improve mental health and ensure access to appropriate, quality mental health services.



5. Mental Health

Health Goal for the Year 2010: Improve mental health and ensure access to appropriate quality mental health services.					
	Indicator	Alaska Data Source	U.S. Baseline	Alaska Baseline	Alaska Target Year 2010
1	Reduce the suicide rate (suicide deaths per 100,000 population).	ABVS	10.6 (1999)	17.2 (1999)	11
	Alaska Native	ABVS		32.6 (1999)	11
2	Reduce the rate of suicide attempts among adolescents (percent of high school students grades 9-12 who attempted suicide requiring medical attention in the past 12 months).	YRBS	2.6% (1999)	2.7% (1999)	1%
	Alaska Native	YRBS		4.1% (1999)	1%
3	Decrease the number of days adults report being mentally unhealthy (mean number of days in past month when mental health not good, reported by adults aged 18 years and older).	BRFSS	3 (1998)	2.3 (1998)	2
4	Increase the proportion of persons aged 18 years and older with serious mental illnesses who are employed.	BRFSS (potential)	42% (1994)	Developmental	
5	Increase the number of children and youth seen in primary health care settings who receive mental health screening and assessment.	Medicaid Denali KidCare EPSDT	Developmental	Developmental	
6	Increase the percentage of juveniles in the juvenile justice system with a diagnosed mental illness who receive appropriate mental health services .	DHSS/DJJ	Developmental	Developmental	
7	Increase the percentage of correctional facility inmates with a diagnosed mental illness who receive appropriate mental health services.	DOC		Developmental	
8	Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment using an integrated treatment model.	DHSS/ DMHDD, DHSS/ADA	Developmental	Developmental	
9	Increase the proportion of mentally ill adult offenders diverted from jail.	DOC	Developmental	Developmental	
10	Begin to track consumers' satisfaction with the mental health services they receive including the cultural competency.	MHSIP AMHB	Developmental	Developmental	
11	Identify and implement best practices for mental health crisis interventions, ongoing screening, and treatment services for elderly persons.	DHSS DMHDD		Developmental	
12	Increase health insurance programs having parity between physical and mental health coverage.	DCED Division of Insurance		Developmental	
13	Increase the number of individuals with severe or chronic mental illness receiving case management services.	ARORA DHSS/ DMHDD		Developmental	

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14	Increase the number of rural human services workers in rural Alaska.	UAF		136 in 88 communities (2000)	Trained workers in 200 communities

ABVS - Alaska Bureau of Vital Statistics

YRBS - Alaska Youth Risk Behavior Survey. Alaska sample for 1999 did not include Anchorage. High school data for 1999 are weighted and representative of the state student population excluding Anchorage.

BRFSS - Alaska Behavioral Risk Factor Surveillance System. All US BRFSS data are age-adjusted to the 2000 population; the Alaska BRFSS data have not been age adjusted, so direct comparisons are not advised. See Technical Notes.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment

DHSS/DJJ - Department of Health and Social Services/Division of Juvenile Justice

DOC - Alaska Department of Corrections

DHSS/DMHDD - Department of Health and Social Services/Division of Mental Health and Developmental Disabilities

DHSS/ADA - Department of Health and Social Services/Division of Alcoholism and Drug Abuse

MHSIP -Mental Health Statistics Improvement Program

AMHB - Alaska Mental Health Board

DCED - Alaska Department of Community and Economic Development

ARORA - Mental health database obtained from mental health direct service providers

UAF - University of Alaska, Fairbanks

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Overview

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. Mental health is indispensable to personal well-being, family and interpersonal relationships, and contribution to community or society. Mental illness is the term that refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) which are associated with distress and/or impaired functioning and spawn a host of human problems that may include disability, pain, or death.

Mental disorders vary in severity and in their impact on people’s lives. Schizophrenia, major depression, bipolar illness, obsessive-compulsive disorder, and panic disorder can all be intensely disabling. The impact of mental illness on overall health and productivity in the United States and around the world is under-recognized.¹

In December 1999, the first Surgeon General’s report on mental health was released. The science-based report emphasizes that mental health is fundamental to overall health, that mental disorders are real health conditions, and that a solid research base must guide the development of policies. A review of the research supports two main findings: the efficacy of mental health treatments is well documented, and a range of treatments exist for most mental disorders.²

The report relays the importance of information, policies, and actions that will reduce and eventually eliminate the cruel and unfair stigma attached to mental illness and the importance of a solid research base for every mental health and mental illness intervention. Additional themes that run through the report include:

- ❖ The need for a public health perspective that focuses on epidemiologic surveillance, health promotion, disease prevention, and access to services.
- ❖ Mental health disorders are disabling; in the United States mental illness is the second leading cause of disability and premature mortality. Mental disorders collectively account for more than 15 percent of the overall burden of disease from all causes and slightly more than the burden associated with all forms of cancer.

- ❖ Mental health and mental illness are points on a continuum. Mental health is indispensable to personal well-being, family and interpersonal relationships, and contribution to community or society.

- ❖ Mental health and physical health are inseparable.

The former Surgeon General, Dr. David Satcher, called for ensuring accessibility to mental health services and reducing financial barriers to treatment for people with mental illnesses. Treatment is key and the report recognizes the need for state-of-the-art treatment, individualized treatment, and improving public awareness of effective treatment. In the United States, one in 10 children and adolescents suffer from mental illness severe enough to cause some level of impairment. Fewer than 1 in 5 of these children receive treatment in any given year.³

Issues and Trends in Alaska

The population with mental illness in Alaska is estimated using a national formula, which counts only individuals whose mental illness causes significant functional impairments in daily living (Table 5-1).

Estimates project about 10 percent of Alaska’s children and youth (age 5-18) have severe emotional disturbances (SED), and 6.2 percent of Alaska’ adult population under age 55 suffer from severe mental illness (SMI). The adults with severe mental illnesses are further divided into two subgroups: those with a persistent, disabling, psychotic disorder (a Chronic Mental Illness) and those with a persistent, disabling, non-psychotic disorder (a Severely Emotionally Disturbed adult).

Table 5-1

Estimates of Mental Illness In Alaska, 1998	
1998 Alaska Population	621,400
Total SMI/SED population	43,200
Children and Youth (age 5-18)	15,400
Adults (age 19 and over)	23,600
Adults (age 19 and over) with CMI	6,200
Adults (age 19 and over) who are SED adults	17,400
Institutional/homeless	4,200
Source: Alaska Mental Health Board & DMHDD SMI - severely mentally ill SED - seriously emotionally disturbed CMI - chronically mentally ill	

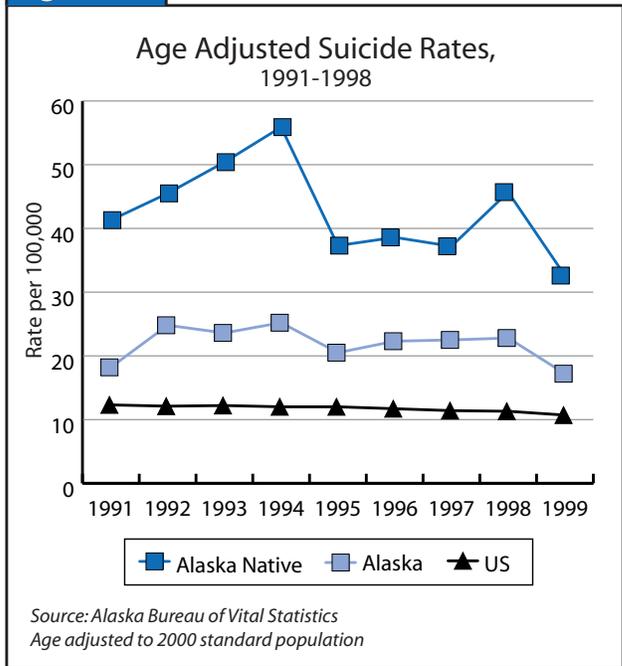
Mental disorders occur across the lifespan, affecting persons of all racial and ethnic groups, both sexes, and all educational and socioeconomic groups.¹ Mental and emotional disorders are most prevalent in children and youth. Alaskans ages 6-17 comprise less than one quarter of the state's population, but about one-third of 1996 admissions to community mental health centers (CMHCs). Males are over-represented in admissions to CMHCs for ages 6-17 and Alaska Natives represent almost 30 percent of public mental health service clients even though they make up about 16.5 percent of Alaska's population. Data from 1999 continue to show that there is an over-representation of Alaska Natives in the state correctional facilities, Alaska Psychiatric Institute (API), and Medicaid. Estimates indicate that 14,000 to 15,000 Alaskan young people experience SED, but only 5,500 receive treatment. Furthermore, many of the children under 18 with a SED who receive mental health services may be receiving inappropriate services.⁴

Suicide

Suicide is a complex behavior that can be prevented in many cases by early recognition and treatment of mental disorders.¹ Suicide is legally defined as the act of voluntarily and intentionally taking one's own life. Most people who commit suicide do not want to die, but rather want to escape unbearable pain. Suicide is found among people who have experienced stressful life events and mental and physical illness. Persistent patterns of suicide and suicide attempts are powerful indicators of the poor mental health status of individuals and communities.⁵

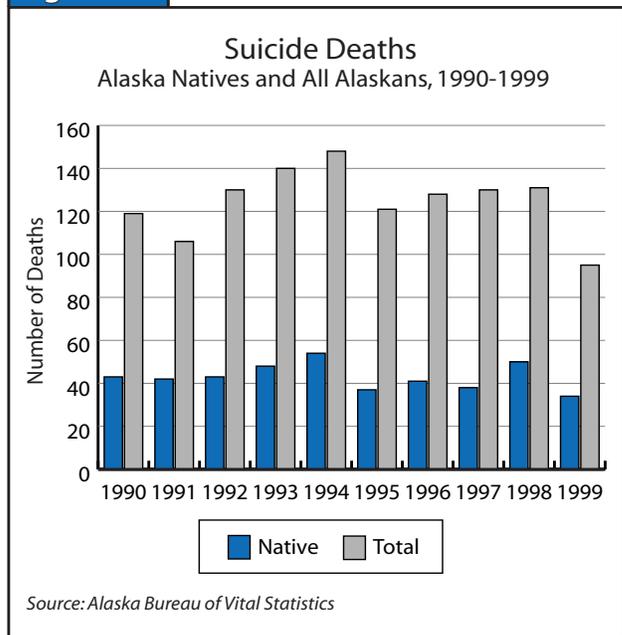
Alaskans commit suicide at a much greater rate than Americans as a whole. The suicide mortality rate, which is 100 percent higher than the national rate, did not decline during the 1990s and did not reach the goal of a 25 percent reduction proposed in *Healthy Alaskans 2000*. In 1989, one Alaska Native suicide occurred every 10 days and of these suicide victims, 79 percent had detectable levels of blood alcohol; 87 percent were males. This reflects a 500 percent increase in incidence of suicide among Alaska Native people since 1960.⁶ In 1998, Nevada had the highest age-adjusted rate of suicide deaths, with Alaska a close second. 5 Rates are highest among young men and among Alaska Natives. In 1998, the suicide rate for Alaska Natives was 40 per 100,000, while the rate for all Alaskans was 23 per 100,000 (Figure 5-1).

Figure 5-1



Suicide ranked as the fifth leading cause of death in Alaska in 1998 with 131 deaths, up from 129 suicide deaths in 1997. Although the total number of suicides decreased to 95 in 1999, there was an increase in deaths attributed to "undetermined intent". There is no clear trend in suicide deaths across the decade (Figure 5-2).

Figure 5-2



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Together, accidents and suicides accounted for about 72 percent of all deaths in the 15-34 age group. After accidents and adverse effects, suicide in 1998 accounted for the greatest number of years of life lost (3,696).⁷

At least 90 percent of all people who kill themselves have a mental or substance abuse disorder, or a combination of disorders. However, most people with a mental or substance abuse disorder do not kill themselves; thus, other factors contribute to suicide risk. Risk factors include prior suicide attempt, stressful life events, and access to lethal suicide methods. Risk is heightened when the person is under the influence of alcohol or other abused substances. The risk is further increased by Alaskans' easy access to guns, a fact of rural and subsistence life. Gunshot is the most common method of committing suicide. In the United States 59 percent of suicides are by firearms, whereas in Alaska 67 percent were by firearms in 1998.⁵

Suicides have traumatic emotional effects on the surviving friends and loved ones in all communities. But impacts are overwhelming in small villages because of the face to face nature of all social relations and strong traditional values of interdependence.⁵

Suicide is difficult to predict; therefore, preventive interventions focus on risk factors. Reduction in access to lethal methods and screening and treatment of mental and substance abuse disorders are among the most promising approaches to suicide intervention. More targeted approaches should consider risk factors most appropriate for select populations.

Access To Care

Access to needed mental health services is limited by inadequate financing of the mental health system, by lack of client finances, and by personnel shortages. While 32 state supported community mental health centers provide treatment on a sliding fee scale to Alaskans in all areas of the state, often even emergency services may be restricted to phone calls, due to the constraints of distance and personnel shortages. Low pay, burn-out and high staff turnover rates create chronic personnel problems for the public mental health system. Many centers maintain wait lists for treatment and rehabilitation needs in their communities. Long-term care and housing options for people with severe mental illness are in very short supply, especially for such difficult to serve populations as mentally ill offenders being released from prison and for people with co-occurring mental illness and substance abuse disorders. Lack of

support services for people with chronic or severe mental illness frequently results in repeated contacts with the criminal and legal systems. The Department of Corrections (DOC) is the single largest provider of mental health care in Alaska.

Despite federal law changes to improve parity between physical and behavioral health care benefits in insurance plans, most Alaskans' health insurance provides limited or no coverage for mental health services.

Access is also limited by the social stigma associated with mental illness, which prevents many people from seeking needed care.

Mental Disorders of the Elderly

An estimated 25 percent of Americans aged 65 and older experience mental disorders that are not a normal part of aging. Examples are depression, anxiety, substance abuse, and dementia. Alzheimer's disease is thought to be responsible for 60 percent to 70 percent of all cases of dementia.¹ The elderly population in Alaska is increasing at a dramatic rate and these diseases of old age will become more of a concern in the future.

Rural Services

Many challenges face rural Alaska, such as lack of resources and the difficulties in recruiting, training, and retaining qualified personnel. In rural Alaska, at least 175 villages have no local mental health services other than the occasional itinerant provider. Many more have only part-time workers helping with mental health needs. During 1999, 25 new counselors were added to the existing 60 rural human services workers, but still serious gaps exist.⁴

Treatment and Rehabilitation

Nearly half of all people with severe mental illness do not seek treatment. Yet, newer medications and more effective treatment are allowing people to live successfully in their communities and have more control over their lives. Alaska's service system is relatively well developed for CMI adults, but not for SED adults. The DOC remains Alaska's largest institutional provider of mental health services. In 1997, an assessment identified 29 percent of Alaska's prison population as beneficiaries of the Alaska Mental Health Trust, twice the national rate. DOC serves 2,100 adults with serious mental illnesses annually while API serves about 1,200.⁴

Co-occurring Disorders

The co-occurrence of substance abuse and mental disorders is the rule rather than the exception in treatment services across the United States.⁸ One study found approximately 15 percent of all adults who have a mental disorder in a year have a co-occurring substance abuse disorder. In a study by the DOC 37 percent of severely mentally ill inmates had a co-occurring substance abuse problem.⁵

Current Strategies and Resources

The Division of Mental Health and Developmental Disabilities (DMHDD) administers a program in Alaska that provides a continuum of services for people experiencing mental illness and developmental disabilities. These services include an array of outpatient, residential, and locally provided inpatient services provided by 32 local non-profit providers (CMHCs) and 24 specialty service providers. The CMHCs are funded through a competitive grant process and are responsible for a specific set of communities with the intention of assuring every Alaskan access to mental health care. The DMHDD provides statewide inpatient psychiatric services through API. In addition, several community hospitals provide emergency and short-term in-patient care.

The Alaska Mental Health Board (AMHB) plans state mental services, advocates for people with mental illness, and evaluates the state mental health program. The Board collaborates with state agencies that deliver or fund mental health services (Departments of Correction, Education, Administration, and Health and Social Services), the Alaska Mental Health Trust Authority, service consumers, and providers to develop an integrated and comprehensive mental health program.

Children and Youth Services

Early intervention programs help identify children who are at risk of developing significant mental health disorders as a result of genetic, neurological or biological disorders as well as those children affected by trauma, abuse, and/or neglect. Promoting public awareness of children's mental health issues, reducing the stigma associated with emotional disorders, and improving the assessment and recognition of mental health needs in children is the first step. We need to help families understand that these problems are real, that they often can be prevented and that effective treatments are available.⁹

Some priorities for Alaska children and youth services include:

- Increase the number of children and youth screened in primary health care settings who then go on to receive a mental health screening and assessment.
- Ensure that all children and youth in state custody receive a mental health screening and assessment.
- Better educate front-line providers – teachers, health care workers, child care providers, Head Start staff, school counselors and coaches, faith-based workers, and clinicians of all disciplines– to recognize mental health issues in children.

Mental and behavioral disorders and serious emotional disturbances in children and adolescents can lead to school failure, alcohol or illicit drug use, violence, or suicide. Children's services in Alaska are provided in various treatment modalities ranging from less restrictive to very restrictive environments. While many examples of excellent children's programs exist across Alaska, delivery is fragmented and characterized by serious service gaps. It has become clear a unified system of care will better serve children experiencing serious emotional disorders and their families.⁴ Efforts to coordinate services for youth transitioning to adult services and for out of home placements for the increasing numbers of children and youth in state custody need to be addressed.

Recent state efforts to improve services for children, especially very young children, include establishing the Infant Toddler Behavioral Health Committee and hiring a state children's behavioral health coordinator in DHSS, Division of Public Health. The Behavioral Health Committee has begun a comprehensive initiative to address appropriate mental health services for children birth through age eight. The committee has also sponsored a three phase statewide Behavioral Health Initiative for primary caregivers and service providers of young children.

Access to Care

In FY 2002, the legislature approved a funding "floor" of \$200,000 for each community mental health center for more effective emergency services in remote areas. Ways to increase the availability of staff for civil commitment processes were also under discussion. The Twentieth Legislature had a special committee

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to review and recommend statutory changes to assure parity in health insurance plans. While legislation did not pass, many people have become more aware of this pressing need. Denali KidCare has significantly expanded the number of low-income children and adolescents with access to mental health services.

Rural Services

In Alaska, the State has long supported efforts to assure cultural relevancy of mental health services delivered to Alaskan Natives. Use of village selected and university trained paraprofessionals to deliver behavioral health care in Alaskan villages has received national attention. The Rural Human Services program has more than 70 graduates employed in villages throughout Alaska. The Department of Health and Social Services endorses the goal of “a counselor in every village.”

Diversion from the Criminal Justice System

The Alaska Mental Health Board (AMHB) has identified the following needs related to decriminalizing mental illness:

- A full continuum of care for incarcerated mentally ill adults.
- Collaboration between the criminal justice and community mental health systems.
- Expansion of community services that prevent incarceration.

Despite the large numbers, very few specialized services are available to incarcerated youth with mental or emotional disorders, and adult services are limited. In 2000, 16 of the 24 state correctional facilities reported providing some mental health screening at intake. Eleven percent of inmates received therapy or counseling services, and 9 percent received psychotropic drugs.¹⁰

Some programs help link offenders with community services, such as Jail Alternative Services (JAS). JAS diverts misdemeanants in Anchorage to community programs in conjunction with a nationally recognized mental health court which coordinates judicial, legal, and social resources. Housing options are needed for both individuals being released from incarceration and those diverted from jail.⁴

Suicide Prevention

The State of Alaska has implemented several policies and programs specifically designed to reduce the in-

cidence of suicide. State-funded CMHCs place the highest priority on emergency or crisis intervention services and can be contacted 24 hours a day. The community based suicide prevention program (CB-SPP) was initiated in 1988 and issues grants for small community projects with the goals of reducing self-destructive behavior and suicide and increasing individual and community wellness. Often the activities are designed to foster pride in and increase knowledge of Native culture and use elders as teachers. Other projects offer support groups, counseling, crisis intervention and similar prevention, intervention, treatment, and aftercare activities. Rural Human Services workers are trained paraprofessionals located in about a third of Alaska’s villages and are a frontline response to suicide risk. They are able to provide crisis intervention and support services in villages remote from CMHC offices.

Treatment and Rehabilitation

Mental health treatment works. However, research shows that various select populations use mental health services differently. They may not seek mental health services in the formal system, drop out of care, or seek care at much later stages of illness, driving the service cost higher. Accessible mental health services are those, which are, among other factors, culturally relevant or sensitive to their clients. Accessible community based care helps to reduce the disproportionate numbers of minorities receiving in-patient care in state hospitals or in emergency rooms.

Psycho-social rehabilitation is an essential part of care for adults with severe mental illness. To promote independent living, rehabilitation programs often evaluate and place people in jobs. The state has initiated the Alaska Works project that encompasses several initiatives aimed at moving people with psychiatric disabilities into employment. Chief among these is a study identifying barriers to employment and recommending means to remove those barriers. Also a series of pilot projects tests employment programs for individuals with serious disabilities.

A Shared Vision II

Adopted in 1999, A Shared Vision II describes a comprehensive, consumer-centered system which identifies service needs. Two major elements of *A Shared Vision II* are:

- Mental health consumers have a primary role in defining their individualized needs and have choices among services that address those needs.

- Consumers are actively involved in shaping policies and laws affecting persons experiencing mental illness.

Suicide Prevention Council

Native, religious, community leaders, state officials, suicide prevention specialists, legislative leaders and a young suicide survivor were all appointed by Governor Knowles in 2001 to head up the new Suicide Prevention Council. The 15 member board will advise the governor and the legislature on ways of preventing suicide and develop a statewide plan to strengthen existing and form new partnerships between public and private entities to help suicide prevention efforts in the state. The board will also serve to increase public awareness of suicide and its risk factors, enhance suicide prevention services and programs throughout the state, and develop healthy communities.

The Community Mental Health/ API 2000 Project

The Community Mental Health/API 2000 Project is geared primarily toward improving treatment and referral for individuals with both substance abuse and mental health concerns who reside in the greater Anchorage area. The “project” aims at better serving persons facing mental health crises by developing a network of local, private services, and replacing the aging API with a new, smaller facility.⁴

Data Issues and Needs

The DMHDD and the AMHB completed a multi-year project to identify meaningful performance measures for the state’s mental health system, to verify sources for the collection of this data, to identify key implementation issues and recommend implementation strategies for the gathering of performance measures. In the spring of 2001, the project entered its pilot phase to test the instruments identified as data collection sources. Statewide implementation of the performance measurement project is anticipated in 2002-03.

Performance measures have been identified in the areas of access to services, appropriateness of services, and quality of services. Three instruments collect data: some demographic and management information similar to data fields in the state’s CMHC mental health database; information about clients’ outcomes through periodic functional assessments, and consumer satisfaction information through a survey based on the na-

tional Mental Health Statistics Improvement Program (MHSIP).

The health care industry is increasingly using consumer opinion to gain information on service needs and changes. Patient satisfaction studies are becoming standard practice for many health care organizations. The MHSIP has pioneered the development of a consumer-oriented mental health report card that includes a consumer survey designed to address questions of access, appropriateness, quality, and outcome of care.¹

The DMHDD, the AMHB, and providers and consumers of mental health services have worked together to define a consumer satisfaction survey that will give consumers and system stakeholders important information about consumers’ perceptions of services delivered by publicly supported mental health services. The survey is based on the MHSIP Consumer Report Card and was piloted during FY 01-02. In addition, the Anchorage Co-morbidity Services Evaluation Study administered the MHSIP Report Card to consumers of mental health services in the Anchorage area in order to develop baseline consumer satisfaction information. Other performance measure data will be collected using other instruments.

Information on mental health needs and treatment in the criminal justice, juvenile justice, and substance abuse treatment systems would require baseline data collection and on-going analysis from a variety of agencies and institutions. The DOC and Division of Juvenile Justice could develop estimates of the prevalence of mental illness from intake screenings and report the percentage of inmates and juveniles receiving care or referrals for treatment as well as those enrolled in diversion programs. Data on the number of dual-diagnosis clients who receive integrated treatment for substance abuse and mental illness and evaluation of treatment outcomes requires a collaborative effort between the DMHDD and Division of Alcoholism and Drug Abuse. Integration of these two data systems has been adopted as a departmental goal.

Analysis of hospital discharge data has the potential to provide new information on the burden of acute mental illness and suicide attempts in the state. The Behavioral Risk Factor Surveillance System (BRFSS) can provide regional estimates of mental illness and its impact on other health risks and employment. A survey of health insurance plans could identify the proportion of Alaskans who have parity between physical and mental health service coverage.

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Suicide is a major public health issue in Alaska, and data on completed suicides and attempts would be useful in designing prevention and intervention programs. State Medical Examiner records include details on risk factors, site investigations, and the manner of death. Review of these records could complement Vital Statistics data on suicide deaths and identify missed opportunities for intervention.

Treatable illnesses, such as depression and substance abuse, are associated with most suicides. The stigma attached to these illnesses may make it difficult for people to seek treatment. Research on cultural interpretations of mental illness, substance abuse, and treatment would enable communities to plan appropriate prevention plans.

Related Focus Areas

A variety of objectives in other *Healthy Alaskans* chapters are linked to objectives in *Mental Health*.

- *Substance Abuse*
- *Violence and Abuse Prevention*
- *Injury Prevention*
- *Maternal, Infant, and Child Health*
- *Disability*

Some indicators in *Substance Abuse* refer to follow-up care, treatment, and screening for substance abuse problems, since a percentage of substance abusers have mental illnesses as well. *Violence and Abuse Prevention* is linked to *Mental Health*. Some people with untreated mental illness may exhibit violent behavior. More often, people with mental illness are likely to be the victims of violence.

Reducing assault, partner abuse, rape, and attempted rape, goals in *Violence and Abuse Prevention*, would also reduce mental health problems among survivors of violence. Decreases in suicide attempts decreases injuries such as firearm, poisoning, and head and spinal cord injuries. *Maternal, Child, and Infant Health* is linked to mental health since parental mental health is critical to the well-being of children. People with disabilities who have sufficient emotional support and report to be happy and not depressed are less likely to develop mental health problems.

Endnotes

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³ Report of the Surgeon General's Conference on Mental Health, U.S. Department of Health and Human Services, December 1999-January 2001.

⁴ Alaska Mental Health Board: 1999 Annual Report. Available online at <http://www.amhb.org>.

⁵ Comprehensive Integrated Mental Health Plan – In Step, Department of Health and Social Services, 2001.

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Mental Health Association of Alaska

www.alaska.net/~mhaa/indexnf.html

Alaska Mental Health Trust

www.mhtrust.org/

National Alliance for the Mentally Ill – Alaska

www.nami-alaska.org/

Community Based Suicide Prevention Program

www.hss.state.ak.us/dada/SUICIDE/SUICIDE.HTM

DHSS: Community Mental Health Services Program

www.hss.state.ak.us/dmhdd/mh/

NIMH: Mental Health at the Frontier Alaska, 1999

www.nimh.nih.gov/research/aksummary.cfm

The Alaska Mental Health Board

www.alaska.net/~amhb/

Alaska Mental Health Consumer Web

www.akmhcweb.org/

National

HRSA: Mental Health and Substance Abuse in Rural Areas - Information Resources

www.nal.usda.gov/ric/richs/menhea.htm

Substance Abuse and Mental Health Services Administration (SAMHSA)

www.samhsa.gov/

Mental Help Net

mentalhelp.net/

Surgeon General's Report: Mental Health: Culture, Race, and Ethnicity

www.surgeongeneral.gov/library/mentalhealth/cre/

National Strategy for Suicide Prevention

www.mentalhealth.org/suicideprevention

Bright Futures in Practice: Mental Health

www.brightfutures.org/mentalhealth/

Chapter Notes

