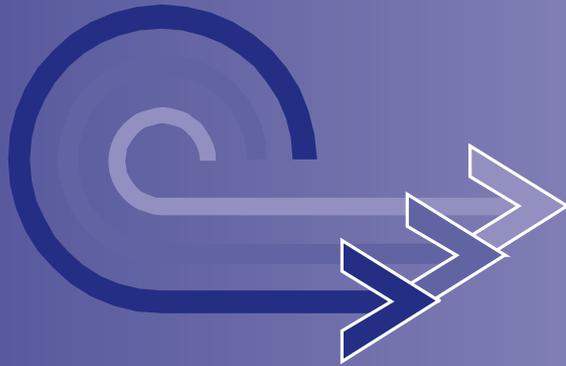


# ***Moving Forward***



## ***Comprehensive Integrated Mental Health Plan 2006–2011***

**Alaska Department of Health and Social Services  
with the  
Alaska Mental Health Trust Authority**

**Frank H. Murkowski, Governor  
Karleen K. Jackson, Commissioner  
Rev. September 2006**



Karleen K. Jackson

April 10, 2006

Dear Alaskan:

It is with great pleasure that we present to you the Alaska Comprehensive Integrated Mental Health Plan for fiscal years 2006–2011. Working together, the Alaska Mental Health Trust Authority and the Alaska Department of Health and Social Services share responsibility for planning for and providing services to Alaskans whose lives have been impacted by mental illness, alcoholism, developmental disabilities and dementias. This plan provides a way to assess our service system in terms of its impacts on the health, safety, economic security and quality of life of those who receive our services — referred to as Trust beneficiaries. The plan also looks at challenges that we face in the future as providers of services to Trust beneficiaries.



John Pugh

While the plan largely looks at services and the impact of services on the lives of Trust beneficiaries, we also focus on prevention of disabling conditions themselves. Some of the conditions of Trust beneficiaries, such as Alzheimer's disease, cannot be prevented with our current knowledge base, but its progression can be slowed if diagnosed and treated early. We are committed, to the extent possible, to preventing other disabling conditions such as fetal alcohol syndrome, mental illness, substance use, suicide, traumatic brain injury, developmental disabilities and the emotional disorders of children.

During fiscal year 2005, the Alaska Department of Health and Social Services, the Alaska Mental Health Trust Authority, the statewide advocacy boards and other key stakeholders began the process of revising the five-year Comprehensive Integrated Mental Health Plan. The broad-based Comprehensive Integrated Mental Health Plan Work Group began working on this plan in September 2004. Much thought and expertise have been given to this effort.

Our sincere thanks to those who worked on the plan and to the many talented people who continue to work on ensuring the implementation of system changes to improve services and outcomes for all Alaskans. We would like to thank you in advance for partnering with us in this important journey for Alaska.

Sincerely,

Karleen K. Jackson, Ph.D.  
Commissioner  
Alaska Department of Health and Social Services

John Pugh  
Chair, Alaska Mental Health Trust Authority



## Executive Summary

*Moving Forward*, the *Comprehensive Integrated Mental Health Plan 2006-2011* is the work of the Alaska Department of Health and Social Services, the Alaska Mental Health Trust Authority and other state agencies, boards and commissions. This plan is a response to a statutory requirement that such a plan be developed (AS 47.30.660).

The 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. By law, these recipients (also called beneficiaries) are Alaskans who have a mental illness, a developmental disability, experience chronic alcoholism or suffer from Alzheimer’s disease or a related dementia. Also included are individuals at risk of developing these conditions — for example, children who exhibit behaviors or symptoms suggesting they may develop a mental disorder.

The Comprehensive Integrated Mental Health Plan 2006-2011 looks at the status of Trust beneficiaries in four areas: health, safety, quality of life and economic security. Data are used to show long-term changes in these four areas. Another section of the Plan examines current service delivery and gaps in service. The Plan highlights current efforts to improve health, safety, living with dignity, and economic security for Trust beneficiaries and indicates future avenues for further efforts.

### Abbreviations Used in this Plan

<b>CIMHP</b> .....	Comprehensive Integrated Mental Health Plan
<b>DHSS</b> .....	Alaska Department of Health and Social Services
<b>AMHTA</b> .....	Alaska Mental Health Trust Authority
<b>AS</b> .....	Alaska Statutes
<b>AMHB</b> .....	Alaska Mental Health Board
<b>ABADA</b> .....	Advisory Board on Alcoholism and Drug Abuse
<b>ACoA</b> .....	Alaska Commission on Aging
<b>GCDSE</b> .....	Governor’s Council on Disabilities and Special Education

## Table of Contents

I.	Introduction.....	1
II.	Results Areas.....	3
	Health.....	4
	Safety .....	9
	Living with Dignity.....	12
	Economic Security.....	16
III.	Current Services and Service Gaps Analysis.....	19
	Components of Care .....	19
	Current Services.....	19
	Matrix of Current CIMHP Services for Three or More Trust Beneficiary Groups.....	20
	Service Gaps Analysis.....	21
IV.	Examples of Current Initiatives That Fill Service Gaps .....	23
	System Strategies .....	23
	Prevention .....	23
	Integration.....	25
	Infrastructure Development .....	26
	Workforce Development.....	29
	Employment.....	30
	Public Awareness .....	30
V.	Emerging Issues/Trends .....	33
VI.	Further Information and Acknowledgements .....	37



## List of Figures and Tables

<b>Figure 1</b>	Days of Poor Mental Health in Past Month by Age Group .....	4
<b>Figure 2</b>	U.S. and Alaska Alcohol Consumption Comparisons .....	5
<b>Figure 3</b>	Heavy and Binge Drinkers .....	5
<b>Figure 4</b>	Percentage of Women Reporting Alcohol Consumption During Pregnancy .....	6
<b>Figure 5</b>	Alaska Suicide Rate per 100,000 .....	7
<b>Figure 6</b>	Number of Suicides by Region .....	7
<b>Figure 7</b>	Number of Children with Substantiated Report of Harm by Type and Number of Children .....	9
<b>Figure 8</b>	Arrests per Client after JAS — Completed vs. Not Completed Program .....	11
<b>Figure 9</b>	Beneficiary Involvement in Family, School and Community Activities .....	13
<b>Figure 10</b>	Number of Homeless Alaskans .....	14
<b>Figure 11</b>	Number of Students Receiving Special Education Services who Complete High School with Diploma .....	15
<b>Figure 12</b>	SSI/APA Payment Compared to Alaska Poverty Level .....	16
<b>Figure 13</b>	Alaska Population Age 18 and Over by Income Level and Disability Status .....	17
<b>Figure 14</b>	Number of Trust Beneficiaries Receiving Support through DVR vs. Employed .....	17
<b>Figure 15</b>	Components of Care for Three or More Beneficiary Groups.....	19
<b>Figure 16</b>	Bring the Kids Home Sees Results in 2005: RPTC Services.....	27
<b>Table 1</b>	Arrest Data for Clients Not Active in JAS .....	11
<b>Table 2</b>	Current CIMHP Services Matrix.....	20



# I.

## Introduction

### *Plan Vision*

**Optimal quality of life for all Alaskans, especially those Alaskans 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 (CIMHP) 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. This Plan is coordinated with plans for specific services 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 CIMH Plan is also linked with such DHSS plans as Healthy Alaskans 2010 and other planning initiatives. These documents are available on the DHSS Web site at <http://www.hss.state.ak.us/commissioner/Healthplanning>.

### *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***

We can estimate the number of Alaskans who are Trust beneficiaries from Alaska data and national prevalence data.

**Mental Illness: 8.46 percent of Alaskans age 18 and over are considered to have a Serious Mental Illness;<sup>1</sup> 12.76 percent of those age 18-25 and 7.74 percent of those 26 and older experience this condition.<sup>2</sup>**

Between 14,000-15,000 young Alaskans experience Serious Emotional Disturbance (SED), but only 5,500 receive treatment.<sup>3</sup>

**Alzheimer's Disease and Related Dementia: An estimated one in 10 Americans over age 65 and nearly half of those 85 or older have Alzheimer's disease.<sup>4</sup>**

Although Alzheimer's disease is not a normal part of aging, the risk of developing the illness rises with age. Current research from the National Institute on Aging indicates that the prevalence of Alzheimer's disease doubles every five years beyond age 65.<sup>5</sup>

It is estimated that one to four family members act as caregivers for each individual with Alzheimer's disease.<sup>6</sup>

**Developmental Disabilities: According to national prevalence data, 1.8 percent of the national population has a developmental disability. This means that approximately 11,500 Alaskans have developmental disabilities.<sup>7</sup>**

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 166 births.<sup>8</sup> From 1993 to 2004, autism cases in ages 6-22 increased 522 percent nationwide and 685 percent in Alaska.<sup>9</sup>

**Chronic Alcoholism: Rates of binge drinking in Alaska have been consistently higher than in the United States as a whole. The highest prevalence of binge (41.2 percent) and heavy (15.1 percent) drinking in 2004 was among young adults aged 18 to 25. The peak rate of both measures occurred at age 21.<sup>10</sup>**

A 1997 study indicated that up to 37 percent of persons in custody or under supervision of the Alaska Department of Corrections has a mental illness — 12 percent with major psychiatric disorders. Most also have a co-occurring substance use disorder,<sup>11</sup> a factor substantiated in more current national research. (See page 5.)

In a study conducted on Jan. 12, 2001, 1,318 case files were reviewed for all youth involved with the Alaska juvenile justice system on one particular day (both in the institutions and in the community). The study showed that 560 of the 1,318 youth (42 percent) had at least one DSM-IV diagnosis as of that date. Of those who had a DSM-IV diagnosis, 40 percent had a co-occurring disorder (defined as a substance-related disorder accompanied with a non-substance related disorder).<sup>12</sup>



---

## II. Results Areas

### What is a Result Area?

The following 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.

**Goal: to enhance quality of life through appropriate services for people with mental and cognitive disabilities and substance use disorders**

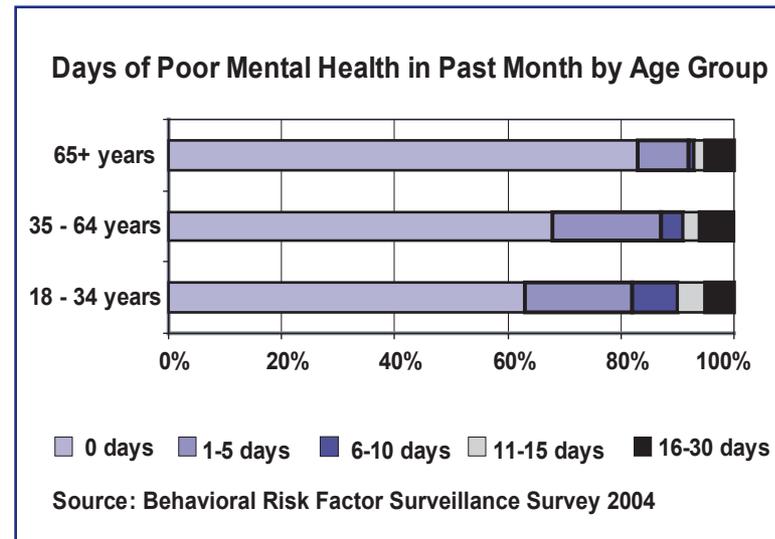
Good physical and mental health is a common measure of an individual’s well being. One way to assess a population’s overall health is with a set of measures known as “Healthy Days.”<sup>13</sup> Developed by the National Center for Disease Control, Healthy Days is one of the few population-based surveys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

### Indicators:

**Figure 1 — Days of Poor Mental Health in Past Month by Age Group**

Data from the Behavioral Risk Factor Surveillance Survey<sup>14</sup> show the percent of Alaskans surveyed who self-report the number of days in the prior month that they experienced “poor mental health.” In all age groups combined, 31 percent of survey

Figure 1



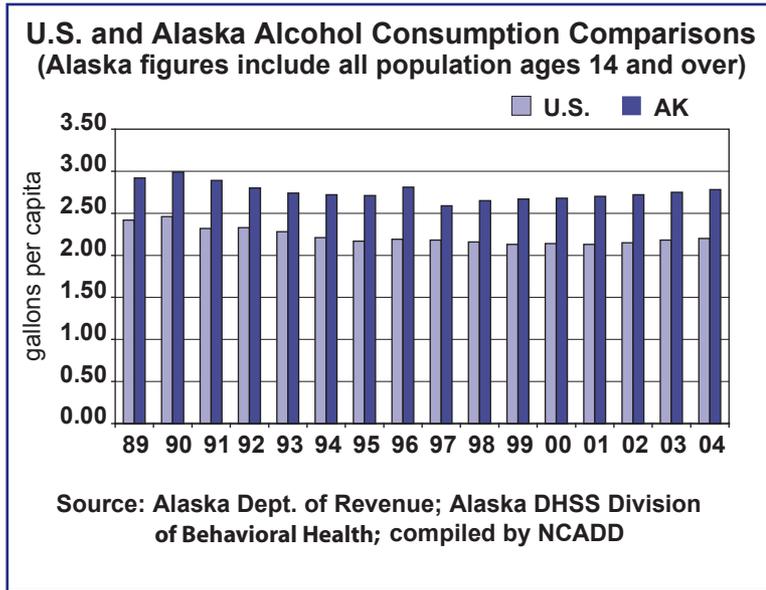
respondents reported experiencing some poor mental health during the previous month. Fifteen percent reported more than five days of poor mental health.

The percentage of young adults who report that they experience between six to 10 days of poor mental health is twice as high as other age groups.

**Goal: to 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

Figure 2



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.<sup>15</sup>

**Indicators**

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

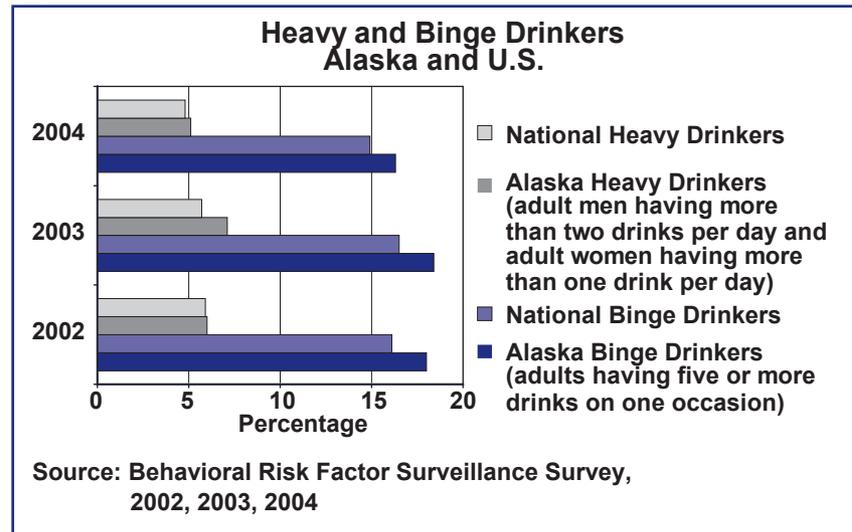
Alcohol consumption rates reflect the prevalence and severity of alcohol related problems. The alcohol consumption rate in Alaska is higher than in the rest of the nation and is well above the Healthy Alaskans 2010 goal of 2.2 gallons or less per person per year.

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). From 1997-2004 Alaska’s consumption rate increased 7.3 percent.<sup>16</sup> Consumption rates are calculated with in-state sales of alcoholic beverages and the state population of persons 14 years and older.

Figure 3 — Heavy and Binge Drinkers

Another indication of the pervasiveness of alcohol abuse is the percentage of Alaskans who report acute (binge) and chronic (heavy) drinking. The Behavioral Risk Factor Surveillance Survey<sup>17</sup> shows that binge drinking among Alaska adults has been consistently higher than in the United States, measured at 18.4 percent in 2003 compared to 16.5 for the U.S. prevalence. Alaska ranked 11th in 2003 (the most recent year with data

Figure 3





published) in acute or binge drinking. This ranking indicates an improvement over recent years, as prevalence in Alaska has remained relatively stable while prevalence has increased in other states.

In 2004, the highest prevalence of binge (41.2 percent) and heavy (15.1 percent) drinking in Alaska was among young adults aged 18 to 25. The peak rate of both measures occurred at age 21.

Heavy drinking in Alaska diminished from 7.1 percent in 2003 to 5.1 percent in 2004, while binge drinking decreased from 18.4 percent in 2003 to 16.4 percent in 2004.

**Goal: to promote healthy births and encourage early childhood interventions to reduce the risk of disability**

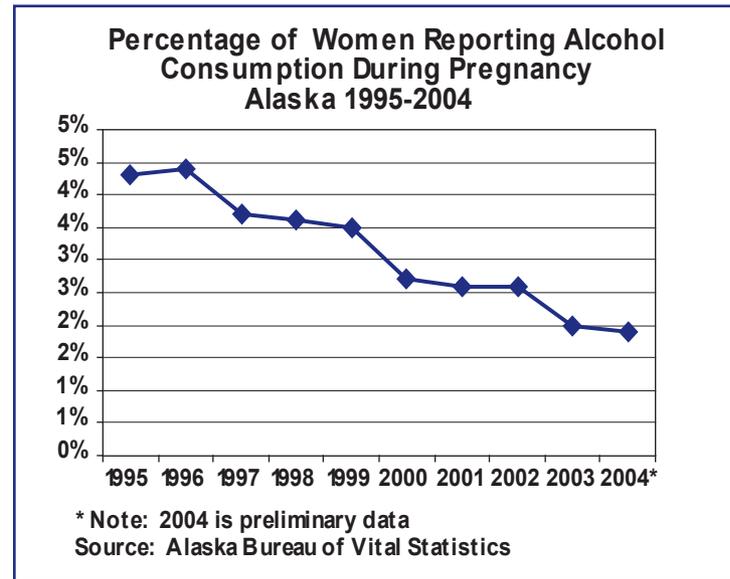
Alaska families, like those everywhere, strive to have healthy babies and provide good homes for their children. The first three years of a child’s life are a time of extraordinary growth physically, mentally, emotionally, and socially. We know that environmental factors have a profound influence on the brain. Research confirms that many children’s mental health problems are related to family violence, parents’ chemical addiction, mental illness, and poverty.<sup>18</sup> Often a number of identifiable stresses combine to create family dysfunction and to compromise the children’s development and health.

**Indicator**

**Figure 4 — Alcohol during pregnancy**

Prenatal alcohol use is linked to fetal death, low birth weight, growth abnormalities, developmental delays in children, and

Figure 4



fetal alcohol syndrome (FAS). It is also the leading preventable cause of birth defects and mental retardation.<sup>19</sup> Approximately 126 infants are born each year in Alaska who have been affected by maternal alcohol use during pregnancy.<sup>20</sup>

According to a recent national survey, 9.1 percent of pregnant women in the United States drank alcohol in the past month and 5.3 percent drank during the last trimester of pregnancy.<sup>21</sup> In 2001, the overall prevalence in Alaska was not significantly different from the nation — with 5.2 percent of Alaskan women drinking during the last three months of their most recent pregnancy.<sup>22</sup>

Alaska Bureau of Vital Statistics birth data indicates a decrease between 1995 and 2004 in alcohol use during pregnancy (Figure

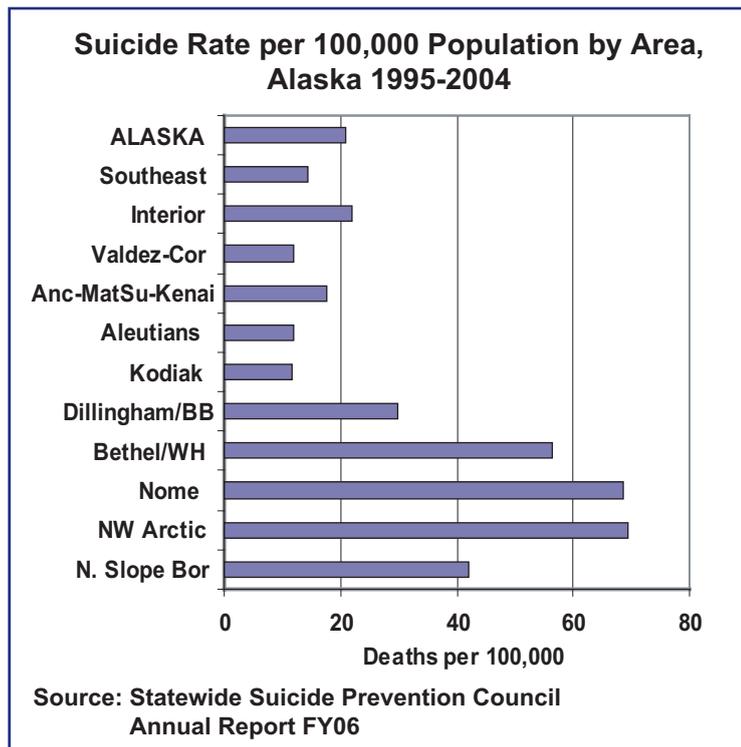
4). It is generally acknowledged that this data, self-reported by women at the time of delivery, is underreported. However, it is agreed that over the last decade, there has been a significant decline in prenatal alcohol use in Alaska.<sup>23</sup>

**Goal: to reduce the number of suicides in Alaska.**

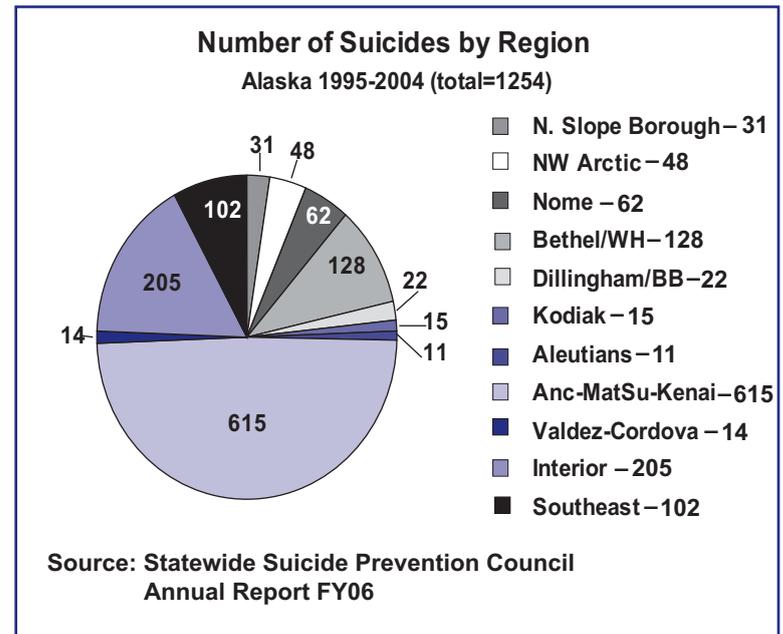
**Indicators:**

*Figure 5 — Alaska Suicide Rates per 100,000*

**Figure 5**



**Figure 6**



*Figure 6 — Alaska Suicide Rates by Region*

The suicide rate for Alaskans remains almost twice as high as the rate for the United States as a whole. In 2003, Alaska was ranked second in the United States for suicide rates in the overall population and No. 1 in the United States for the suicide rate among those ages 15–24, according to the CDC. Alaska Native males ages 15–24 died by suicide at a rate more than seven times higher than Alaska’s overall rate. In 2003, one Alaska Native suicide occurred every nine days, and, of these suicide victims, 74 percent were males. This reflects an increase of more than 500 percent in death by suicide among Alaska Native people since 1960.<sup>24</sup>



In an effort to lower the suicide rate, the Alaska Statewide Suicide Prevention Council and the Department of Health and Social Services Division of Behavioral Health have increased their suicide prevention and awareness efforts, as reflected in *Current Initiatives* discussed in Chapter IV of this publication.

***Suicidal ideation/attempts from 2003 Youth Risk Behavior Survey (YRBS<sup>25</sup>)***

- Percentage of students who actually attempted suicide one or more times during the past 12 months: 8.1
- Percentage of students who seriously considered attempting suicide during the past 12 months: 16.7

## 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.<sup>26</sup> Adults with cognitive or developmental disabilities are also vulnerable to neglect and abuse. State programs can assist in strengthening and re-building 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.

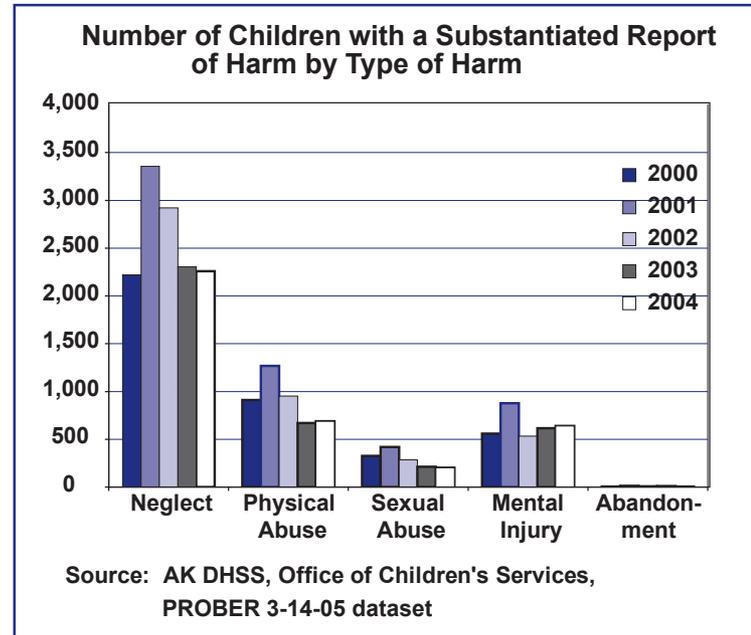
**Goal: to protect children and vulnerable adults from abuse, neglect, and exploitation.**

### Indicators:

**Figure 7 — Safety of children: Number of substantiated protective services reports of harm by type and number of children**

The number of substantiated reports of harm to Alaska children dropped significantly from fiscal year 2001 to fiscal year 2004 from a total of 5,932 to 3,790. However, this drop of over two thousand substantiated reports of harm over two fiscal years was mostly due to administrative changes in the way in which data was collected and reported. It is important to note that this is not an unduplicated count: each child is counted once for each type of harm substantiated.

**Figure 7**





Childhood maltreatment has been linked to a variety of changes in brain structure and function and stress-responsive neurobiological systems.<sup>27</sup> 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.<sup>28</sup>

***Reports of physical injury, sexual assault, and threats/injuries by weapon at school from 2003 Youth Risk Behavior Survey (YRBS<sup>29</sup>).***

- Percentage of students who 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: 4.1 percent
- Percentage of students who have ever been physically forced to have sexual intercourse when they did not want to: 8.1 percent

***Adult Protective Services reports of harm and the number of clients***

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.<sup>30</sup> Adult Protective Services in the Department of Administration 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 2004: 1173**

**Total Investigations 2005: 1497**

The number of investigations increased by 22 percent between fiscal years 2004 and 2005.

**Goal: to 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.**

***Indicators***

***Jail Diversion--Arrest History (Table 1 and Figure 8)***

The Alaska Department of Corrections' Jail Alternative Service (JAS) program is designed as a post-charge diversion program for persons who commit misdemeanors and who have a qualifying mental health diagnosis; it diverts misdemeanants from the criminal justice system into appropriate community-based services. JAS operates in conjunction with the Coordinated Resources Program (CRP), a Mental Health Court in Anchorage District Court, through which all JAS clients are processed. The program has a capacity to serve 40 individuals at any one time. Between fiscal year 1998 and the end of fiscal year 2003, a total of 103 unduplicated clients were served of whom 36 clients completed the program while another 37 did not.

In the 12 months prior to participation in Jail Alternative

**Table 1**

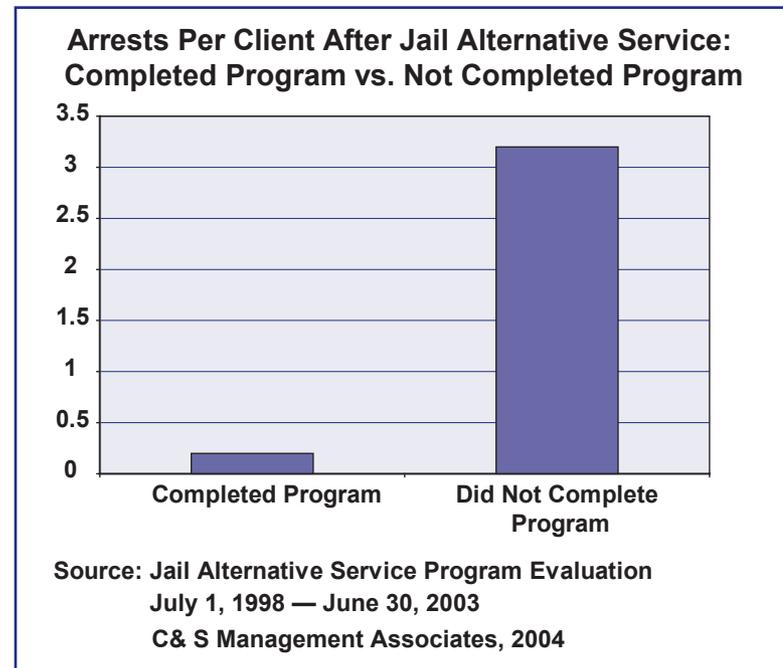
**Arrest Data for Clients Not Active in Jail Alternative Service**

Arrest Data for Clients after JAS (FY 98 – FY 03)		
Metric	Completed Program (N=36)	Did not Complete Program (N=37)
Misdemeanor Arrests	5	116
Felony Arrests	2	5
Total Arrests	7	119
Non-Criminal Incidents	0	34
Total Days in Custody	1,055	3,744
Arrests/Client	0.2	3.2
Mean / Median Length of Stay	150.71 / 8.00*	29.95/14.00
<p>The mean length of stay for clients who completed the program is severely skewed by one client with 1,008 days of incarceration. The small number of long length incarcerations does not lend itself well to comparison with other sub-groups.</p> <p>Source: Jail Alternative Service Program Evaluation July 1, 1998 – June 30, 2003, C &amp; S Management Associates, 2004</p>		

Service, the 103 clients had a total of 197 misdemeanor and 20 felony arrests. During participation in JAS, arrests decreased sharply to 86 misdemeanor and two felony arrests. In terms of total days of incarceration, there was a reduction of 4,468 inmate days related to JAS clients between the 12-month period before entry into JAS and the period while active in JAS — more than 12 years.

Once clients are no longer active in JAS, whether they completed the program or left before completing the program, there is no longer any legal leverage to require them to receive services. A measure of the effectiveness of the program, therefore, is the extent to which these clients are able to maintain the gains that were so evident while active in JAS. Table 1 clearly shows that clients who successfully complete the JAS program fare considerably better after leaving JAS than those who do not complete the program. Given the closeness of the numbers of clients in each category (36 completed and 37 not completed), the differences in the number of arrests and the total days in custody are dramatic.

**Figure 8**





## 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.

**Goal: to make it possible for Trust beneficiaries to be productively engaged in meaningful activities throughout their communities.**

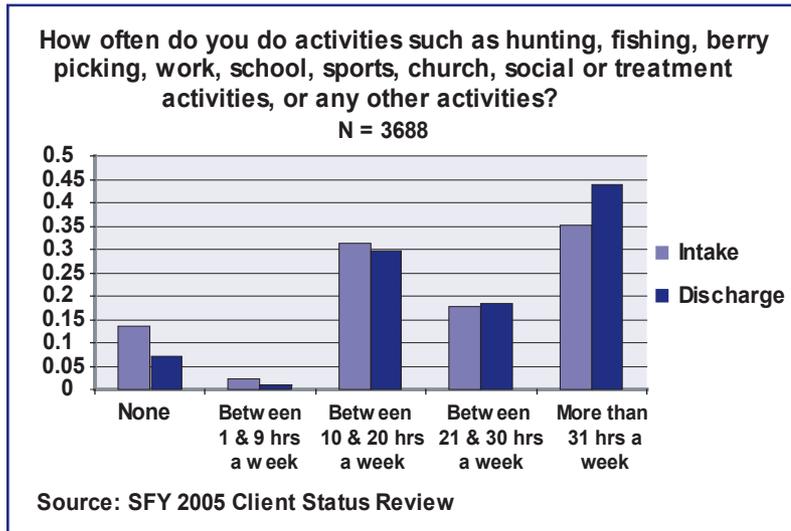
### **Indicators:**

***Figure 9 — Beneficiary involvement in family, school and community activities***

The information in Figure 9 is only for mental health and substance use disorder clients in state supported treatment programs. At intake and again at discharge consumers are asked about their involvement in activities in their communities and the outdoors.

Of the 3,688 clients surveyed, more respondents reported at discharge an increase in the number of hours spent on activities. Good mental health is reflected by more engagement in community and outdoor activities.

Figure 9



*Youth Risk Behavior Survey<sup>31</sup> 2003 Report — youth connections at levels of family, school, and community*

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).<sup>32</sup> 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.<sup>33</sup> Service activities also provide an opportunity for youth to form close relationships with caring adults.

The Youth Risk Behavior Survey shows that among Alaska high school students:

- 79.3 percent of boys and 78.1 percent of girls report they don't feel alone in life.
- Most Alaska high school students, 71.0 percent of boys and 74.6 percent of girls, believe they matter to people in their community.
- The majority of boys (60.0 percent) and girls (55.0 percent) report they have teachers who care about them and give encouragement.
- Forty-eight percent of students agree or strongly agree that in their community they feel they matter to people.

**Goal: to enable Trust beneficiaries to live in appropriate, accessible and affordable housing in communities of their choice.**

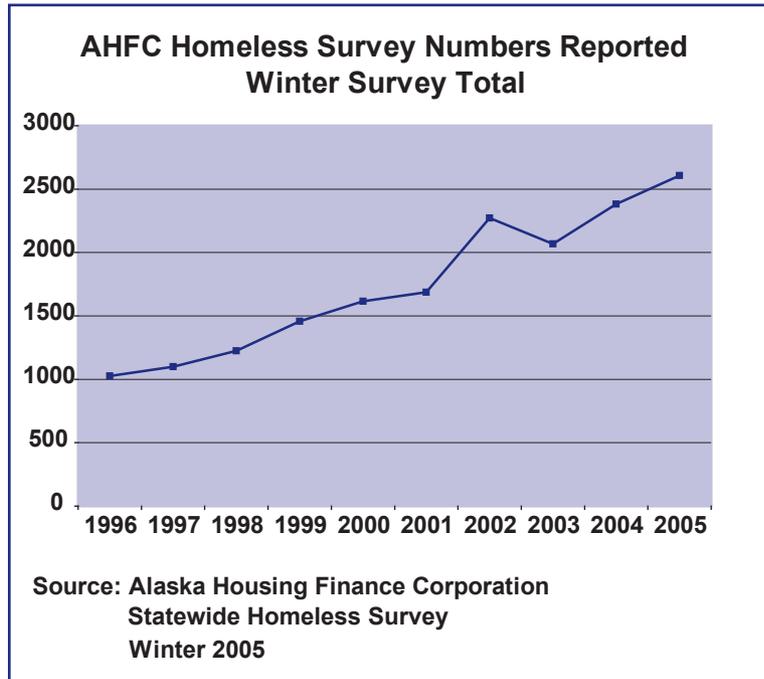
**Indicators**

*Figure 10 — Number of homeless Alaskans*

The number of homeless Alaskans reported in the Alaska Housing Finance Corporation's Homeless Survey increased two and a half times between 1996 and 2005. 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 people and their characteristics.



Figure 10



### AHFC inventory of housing for special needs populations:

Housing terminology can vary depending on the agency and population served. The following definitions<sup>34</sup> apply to this inventory.

#### Supportive Housing

There are 341 supportive housing units in Alaska.

Supportive housing is designed for persons with special needs to live as independently as practicable. In supportive housing, residents have their own housing units and lease agreements. Although support services may be available on-site, residents are not required to use those services as a term of their lease.

#### Assisted Living

There are 1,941 licensed assisted living beds in Alaska.

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.

**Goal: to assist Trust beneficiaries to receive the guidance and support needed to reach their educational goals.**

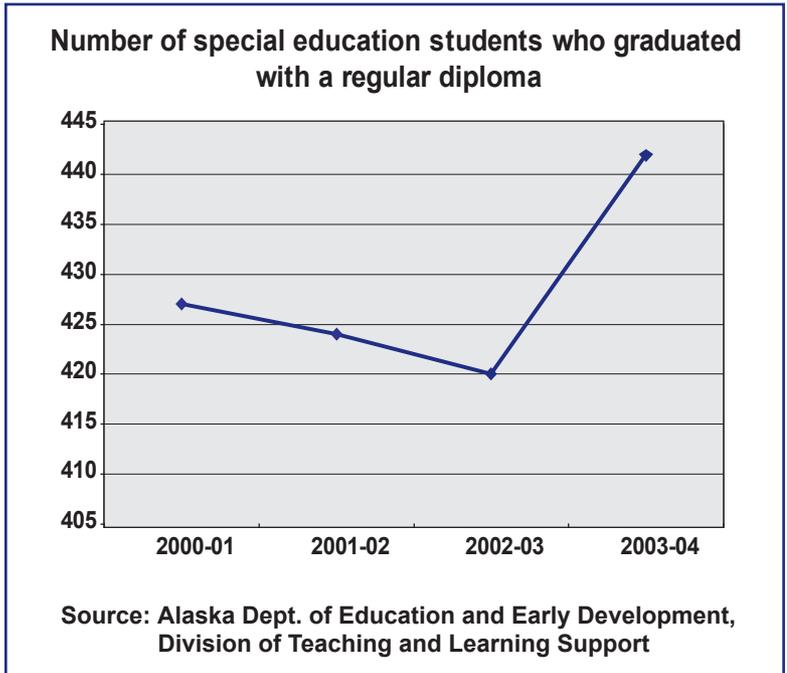
#### Indicators

*Figure 11 — Number of students receiving special education services who complete high school with a diploma*

The federal Individuals with Disabilities Education Act (IDEA)<sup>35</sup> 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

Figure 11



exit examination. This accommodation includes development of an alternate assessment for students with significant disabilities. Figure 11 shows that the number of children in Special Education who received diplomas in the 2003-2004 school year increased 5 percent over the previous year.

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.



## ECONOMIC SECURITY

“Economic security” means that people are able to provide basic necessities for themselves and their families. Many people who are Trust beneficiaries are unable to work or to engage in subsistence activities and must rely on public assistance to meet those basic needs. Unfortunately, public assistance has not kept pace with the cost of living. Poverty is all too common among Trust beneficiaries and their families. Children who grow up in poverty are more likely to suffer from poor physical and emotional health and developmental delays. Alaskans with mental health problems and developmental or cognitive disabilities who are able to work can be helped in this effort by continuation of Medicaid and assistance with expensive medications needed for the treatment of their illness.

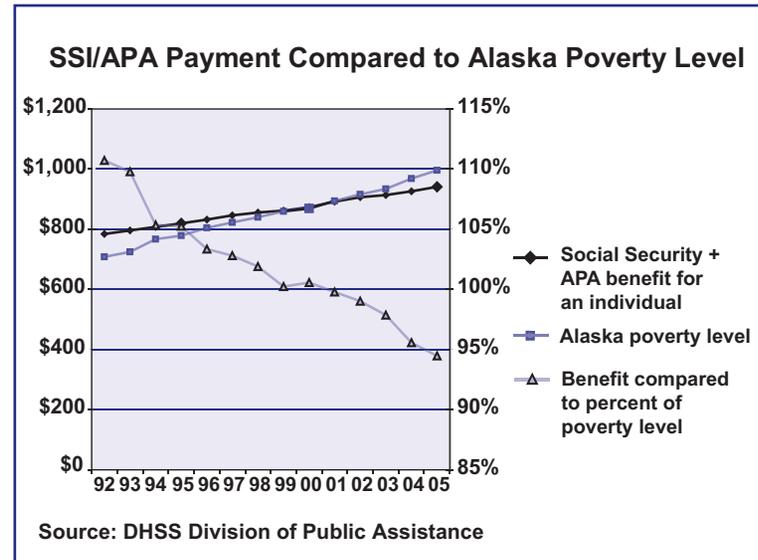
**Goal: to make it possible for Trust beneficiaries most in need to live with dignity, ensuring they have adequate food, housing, medical care, work opportunities, and consistent access to basic resources.**

### Indicators

**Figure 12 — SSI/APA payment compared to Alaska poverty level**

The SSI/APA cash benefit for people with disabilities has eroded over the years in relation to the Alaska poverty level. In Alaska, the SSI/APA programs combine to provide minimal cash assistance of \$941 dollars a month to elderly, blind, or disabled individuals. While the SSI payment is adjusted every year for inflation, the APA payment is legally capped and therefore diminishes in value every year due to inflation.

Figure 12



**Figure 13 — Alaska Population 18 and Over by Income Level and Disability Status**

Behavioral Risk Factor Surveillance Survey<sup>36</sup> data from 2003 and 2004 show that those Alaskans with 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 without a disability.

Figure 13

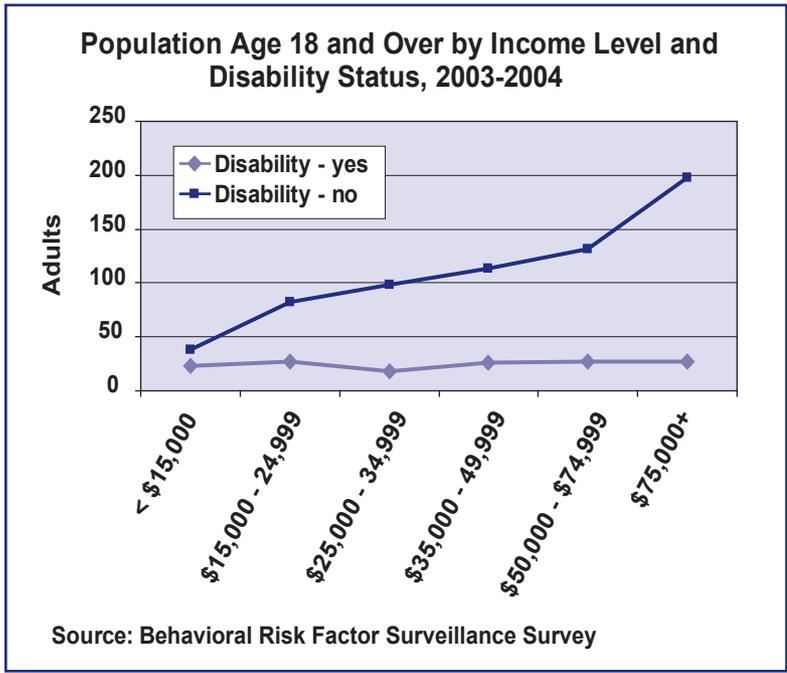


Figure 14 — Number of Trust Beneficiaries receiving support through DVR versus Employed

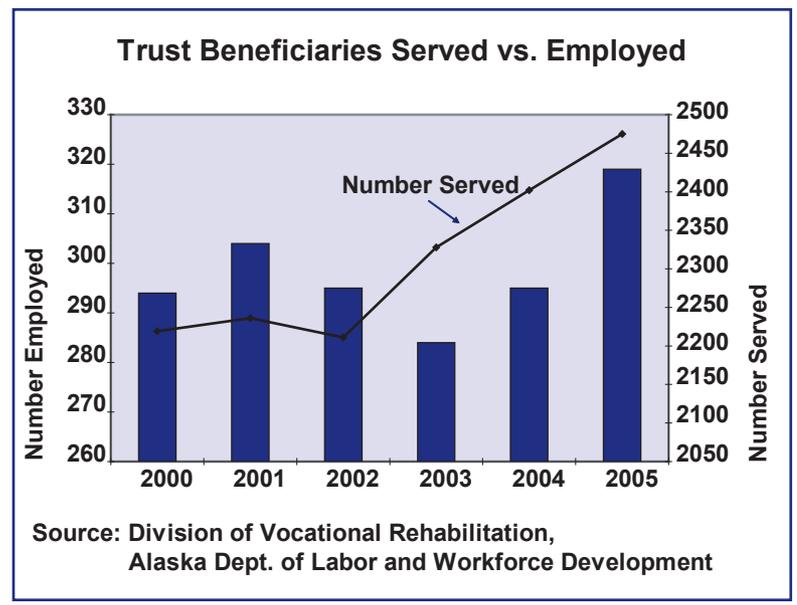
The mission of the Division of Vocational Rehabilitation (DVR) is to assist individuals with a disability to obtain and maintain employment. With the proper services and supports, such as education, on-the-job training, job search, and placement services, people with disabilities can be employed.

Over the last five years the number of Trust beneficiaries served by DVR has increased over 10 percent and the number who became employed increased approximately 8.5 percent. Although DVR has increased community outreach, cases can take years

to reach a successful outcome, thus outcomes lag behind the number served.

Employment initiatives of DVR with a focus on Trust beneficiaries include the Customized Employment Grant (CEG) and micro-enterprise grants from The Trust. The goal of the CEG is to build the capacity in Job Centers in Juneau, Kenai, Anchorage, Wasilla and Fairbanks to better serve people with severe disabilities so that they have a more responsive and individualized employment relationship based on their strengths, needs and interests, while meeting the needs of the employer. The micro-enterprise grants require DVR to match the funds and focus on self-employment ventures.

Figure 14





**INTENTIONALLY LEFT BLANK  
PRINTER REMOVE BEFORE  
PRINTING**



### III.

## Current Services and Service Gaps Analysis

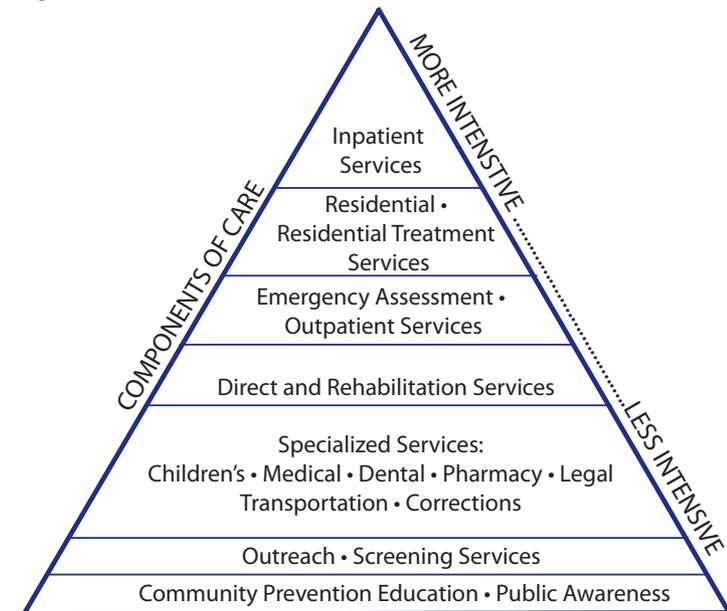
Services in Alaska for people with alcoholism or other drug addictions, for people experiencing mental or emotional illnesses, for people with Alzheimer's disease or other dementias, and for people with developmental disabilities were originally shaped and frequently compartmentalized by federal funding availability and federal program requirements. Advocates and program managers have long recognized that service integration is a first step toward higher quality services, toward increased access to services, and toward 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 Three or More 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

Figure 15



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 on the following page.

### Current Services

#### *Table 2— Matrix of Current CIMHP Services*

The following table shows the geographic availability of services used by three or more Trust beneficiary groups.



Table 2

**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	<input type="checkbox"/>	<input type="checkbox"/>	❖	◆	◆
Residential Services	<input type="checkbox"/>	<input type="checkbox"/>	◆	❖	❖
Emergency/ Assessment / Outpatient Services	◆	❖	❖	◆	◆
Direct and Rehabilitation Services	◆	❖	❖	❖	❖
<b>Specialized Services</b>					
Children's Services	◆	◆	❖	❖	❖
Medical services – specialized	<input type="checkbox"/>	<input type="checkbox"/>	◆	❖	❖
Dental services – specialized	<input type="checkbox"/>	<input type="checkbox"/>	❖	❖	◆
Pharmacy services	◆	◆	◆	◆	◆
Legal services	❖	❖	❖	❖	❖
Transportation services – specialized	◆	◆	❖	❖	❖
Corrections services	<input type="checkbox"/>	<input type="checkbox"/>	◆	❖	❖
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.



Definitions of the service terms listed in the matrix in Table 2, as well as definitions of each “level of community,” are available at the Web site: [www.hss.state.ak.us/commissioner/Healthplanning/Publications](http://www.hss.state.ak.us/commissioner/Healthplanning/Publications). This Web site also contains more specific information and matrices showing the components of care for each separate Trust beneficiary group and associated service definitions.

### **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, 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 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 1,233 people with developmental disabilities were waiting for services at the end of fiscal year 2005.<sup>37</sup>

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



**INTENTIONALLY LEFT BLANK  
PRINTER REMOVE BEFORE  
PRINTING**

## IV.

# Examples of Current Initiatives 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 find partners for projects. Successful partnerships expand and enhance the resources of DHSS 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 to create system change and to target improved services for Trust beneficiaries.

### System Strategies

Over the last few years, The Trust and DHSS have focused efforts in six areas: prevention, integration of services, infrastructure development, workforce development, employment, and public awareness. The emphasis has been to alter the systems that provide services, to organize them in more effective and efficient ways that better meet needs, while promising cost savings in the future. Increasing public acceptance of Trust beneficiaries through education is a long-term effort to improve their lives.

Below are some examples of projects that focus on changing systems through prevention, integration, infrastructure development, workforce development, employment and public awareness.

### Prevention

Some disabling conditions can be prevented from occurring in the first place. 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 dysmorphism, 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 in 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.

Mental health and substance abuse prevention activities for children and youth focus on building emotional resiliency and adding positive influences and protective factors to children's lives. Early intervention can often keep children's emotional disorders from becoming more severe. Providing any needed mental health services can remedy early emotional problems.



### ***Comprehensive Fetal Alcohol Syndrome Project***

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 2006, 20 community-based grants were awarded to local nonprofit organizations across Alaska. 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 800 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 pre-natally exposed to alcohol, causing permanent learning, behavioral, and neuro-developmental disabilities.
- 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.

### ***Youth Success Initiative***

The Youth Success Initiative, a fiscal year 2007 budget request, will fund community programs with innovative approaches to engaging young people in productive activities to better prepare them to realize their full potential. The project will create partnerships between youth service providers and DHSS to strengthen and increase the positive experiences and personal qualities that Alaska's young people need to grow up healthy, caring and responsible. Four nonprofit organizations — Boys and Girls Club of Alaska, Big Brothers/Big Sisters, Rural Alaska Community Action Program and the Alaska Association of School Boards — would work with communities to design, implement and evaluate services. The success of this effort will be evaluated using a number of indicators including: reduction in suicide attempts and rates, underage drinking and illicit use of drugs and tobacco, teen pregnancies, school drop out rates and an increase in personal resiliency and mental health well-being, family and community wellness, and job readiness and retention.

### ***Substance Abuse Prevention Proposal***

DHSS has a FY 07 budget request for \$3 million to develop



an integrated, comprehensive, community driven program to promote healthy individuals, families and communities by focusing on the prevention of underage alcohol use. The program will provide services based on federally recognized successful practices.

### ***Community-based Suicide Prevention and Rural Human Services***

Alaska's suicide rate is much greater than the national average. Our highest rates are among Alaska Natives, and specifically young men. To better address this reality, DHSS established two programs aimed at rural Alaska and at suicide prevention and early intervention. The Community-based Suicide Prevention program provides small rural Alaska communities with the resources to take ownership of community-driven solutions to high numbers of suicides, attempted suicides, depression and alcohol use. In fiscal year 2006, these grant funds were incorporated into a comprehensive behavioral health prevention and early intervention approach. Recognizing that suicide is often associated with overall mental health and alcohol and other drug use, the department requested that communities look at suicide from a more holistic approach. The goal was to integrate with other programming to reduce drug and alcohol use, increase connectedness and resiliency and to better recognize the signs of suicide. Over 30 community-based programs were funded to address suicide in a comprehensive approach to healthy communities.

In an effort to increase the number of trained human service paraprofessionals in our most rural and remote communities, the Rural Human Services Systems (RHSS) project, a partnership between the DHSS Division of Behavioral Health

and the University of Alaska Fairbanks, Rural Human Services program, trains, hires, develops and mentors local providers in communities across Alaska. The goal of “a counselor in every village” has not yet been reached, but the number of students who have completed their Rural Human Services certification and have returned to their villages as paraprofessional counselors grows each year. Through RHSS funding, 13 rural agencies receive funding to train and employ counselors in more than 90 villages across the state. These individuals serve as a community resource, a first responder, a referral source and often, the only available resource in a community dealing with suicide, substance abuse, domestic violence, child abuse, delinquent youth and more. The Department of Health and Social Services has a fiscal year 2007 budget request before the legislature to add ten additional human service counselors statewide.

### **Integration**

From 2003–2005, DHSS worked toward behavioral health services integration (mental health and substance use disorders) at various levels — clinicians, community providers, statewide, and departmental. DHSS has standardized screening and assessment processes, and is developing complementary mental health and substance use disorder licensure and credentialing, and information sharing. As DHSS worked toward this goal on the division level, it was clear that community providers would also need to integrate in whatever way they defined integration in their communities. To assist with the planning process in which each community defined integration for itself, the Division of Behavioral Health provided technical assistance. Integration did not mean the merging of all providers, unless a community specifically decided to take that approach. Rather, improving



services through system integration means that comprehensive services are planned for and put in place through partnerships of governmental, tribal and private organizations at the local, regional and statewide levels. From the clients' perspective, services should be easier to access, better focused on individuals' needs, more community-based and “seamless” — that is, without barriers between types of services or different service organizations.

### ***Behavioral Health Community Planning Project***

The Behavioral Health Community Planning Project was designed as an extension to the DHSS Division of Behavioral Health's Behavioral Health Integration Project (funded through the SAMHSA Co-occurring State Incentive Grant) to work with 16 communities across the state to develop community-based, comprehensive behavioral health services for individuals experiencing multiple disorders. These community planning processes were tailored to each community's wants and needs. For example, some communities were interested only in short-term assistance with specific issues. Others worked on their entire behavioral health systems of care, which included a number of initiatives, community meetings, training opportunities and memoranda of agreements.

### **Infrastructure Development**

*Moving Forward* discusses the need for adequate and affordable housing for Trust beneficiaries. To meet these housing needs, a special needs capital housing grant partially funded a residential facility in Juneau and three new group homes in Fairbanks. Other initiatives, such as the Alaska Policy Academy on Homelessness and the Interagency Council on Homelessness, address

different aspects of Alaska's housing and infrastructure needs. Development of infrastructure to ensure an adequate continuum of care for children and youth behavioral health needs have been consolidated under the Bring the Kids Home initiative.

### ***Alaska Policy Academy on Homelessness***

The goal of the Alaska Policy Academy on Homelessness is to enable Alaskans to live in appropriate and affordable housing as close to their community of choice as possible by:

- Promoting locally delivered collaborative family-centered services;
- Increasing collaboration and coordination to end homelessness;
- Increasing safe and affordable housing stock<sup>38</sup>; and
- Ensuring integrated planning for homelessness in Alaska.

### ***Interagency Council on Homelessness***

The Interagency Council on Homelessness<sup>39</sup> has looked at what role state government should have in addressing homelessness and explored ways to bring together other partners and stakeholders to identify actions that the state, federal, and local governments, along with nonprofits, faith-based and private organizations, could take to end homelessness in Alaska. After six meetings and formal public hearings to gather information and formulate strategies, the Interagency Council drafted a report (<http://www.ahfc.state.ak.us/homeless/homeless.cfm>) that examines homelessness in Alaska and offers potential strategies for further discussion. The report was forwarded to the Governor for recommendation and development of an implementation

team in fiscal year 2006. As a result, the Governor has appointed a steering committee to research and develop recommendations for a housing trust framework that can maintain the affordability of housing.

**Bring The Kids Home Initiative**

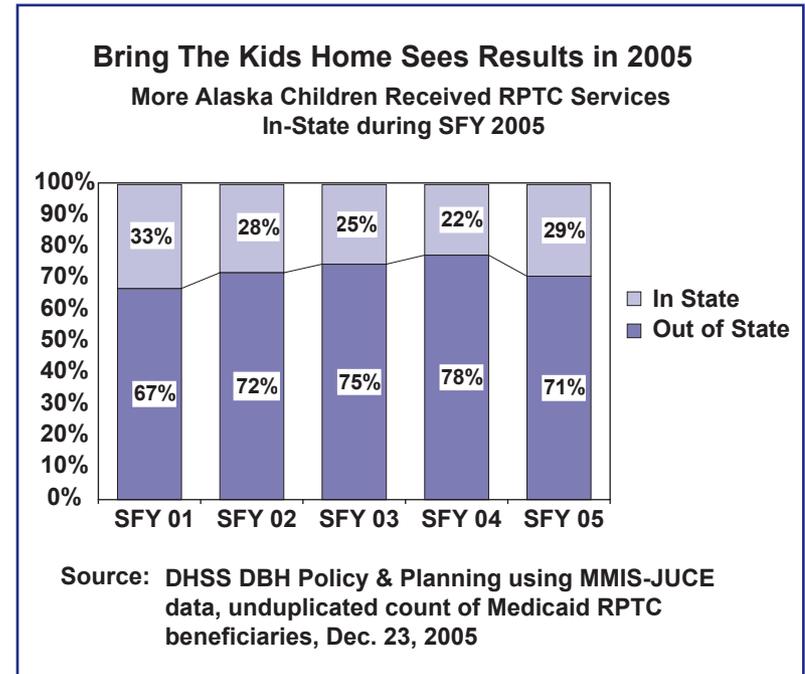
Alaska’s system of care has become increasingly reliant on institutional care for children and youth with severe emotional disturbance. Between 1998 and 2004, acute care admissions increased by one-third and total days of inpatient care increased by 90 percent. Out-of-state placements in Residential Psychiatric Treatment Centers (RPTC) grew by nearly 700 percent and in-state RPTC care grew by 145 percent from fiscal year 1998 to fiscal year 2003.

At any given time, approximately 350-400 children, ranging in age from six to seventeen, (average age between 14 and 15) are being served in out-of-state placements. Alaska Native children represent 49 percent of the children in state custody sent to out of state placements and 22 percent of the non-state custody children sent to out-of-state placements.

Between fiscal year 1998 and fiscal year 2004, out-of-state RPTC Medicaid expenditures experienced an average annual increase of 59.2 percent and an overall increase of over 1,300 percent. During the same time period, in-state RPTC Medicaid expenditures increased about 300 percent, with smaller average annual increases of 29.6 percent.

**Figure 16 — Bring The Kids Home Sees Results in 2005: RPTC Services**

**Figure 16**



Between fiscal years 2004 and 2005:

- out-of-state RPTC Medicaid expenditures increased by only 1.1 percent — the smallest annual increase since 1998;
- in-state RPTC Medicaid expenditures increased by 19.8 percent;
- total RPTC Medicaid expenditures increased by 5.5 percent — the smallest annual increase since 1998; and
- the number of in-state RPTC Medicaid recipients increased 34.7 percent.<sup>40</sup>



The Bring The Kids Home initiative, a partnership of The Trust and DHSS, is developing a continuum of care, from home-based services to residential psychiatric treatment centers, in Alaska to allow children to receive services near their homes and families. Funds spent out of state will decrease as children are moved home and supported in their communities. DHSS continues to work toward inclusion of behavioral health services in the school based services program. Early identification and treatment in the school setting helps children benefit from the educational opportunity, while receiving needed services.

### ***Long-term Care and Cost Study***

DHSS's Long Term Care and Cost Study, funded by The Trust, evaluates Alaska's Long Term Care system, including institutional and home and community based services for the following populations: aged, people with dementia, people with traumatic brain injuries, people with physical disabilities, and people with developmental disabilities.

The study will determine if Alaska's array of long-term care services offers the same opportunities as other states offer for clients to participate in home and community based services, allowing them to remain in their homes or in the least restrictive setting for long-term care. The study will develop rate setting methodologies for personal care attendants, in-home care options, case management, residential care, assisted living options, including Alaska Pioneers' and Veterans' Home, and nursing facilities. Finally, the study will make other recommendations for developing the most appropriate, sustainable array of long-term care services in Alaska.

### ***Dental Care Access***

The Trust and DHSS are committed to improving access to dental care for all Trust beneficiaries. The recently formed Alaska Dental Access Coalition focuses on the areas of workforce, finance and reimbursement, service availability and access, policy, legislation, and regulations. The Trust is advocating for passage of a bill to provide access for adults to dental services through Medicaid. In order to help alleviate concerns over the estimated cost associated with implementing this program, The Trust has agreed to provide \$5.4 million over the first five years of the program to assist in phasing in the cost of the new initiative. The Trust has also contributed \$200,000 towards partnerships with community health centers to directly purchase dental services.

### ***Disability Justice***

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 project began in April, 2004. A collaborative group, including The Trust, advisory boards, state, and local government agencies, the Court System, law enforcement, advocacy groups, community behavioral health providers, and others, have developed and are implementing several strategies:

- maintaining a sustained focus on justice for beneficiaries and implementation of improvements;



- increasing training for criminal justice personnel;
- sustaining and expanding therapeutic court models and practices;
- improving continuity of care for beneficiaries involved with the criminal justice system;
- increasing capacity to meet the needs of beneficiary offenders with cognitive impairments;
- developing mechanisms to address the needs of Trust beneficiaries who are victims;
- developing community-based alternatives to incarceration for beneficiaries;
- developing a range of housing options to provide for varying needs of beneficiaries involved at different stages of criminal justice system; and
- evaluating the results of the initiative to improve justice for beneficiaries.

### ***Beneficiary Group Initiatives***

Trust beneficiaries and their families are growing increasingly interested in accessing services that are provided by fellow consumers/clients and family members. Such services can create a sense of empowerment and promote recovery, and consumer choice often enhances service quality and sustainability.

Trust beneficiary group initiatives can be very cost effective.

Consumers have been key to innovations in the state's delivery system by conceptualizing, managing, and improving programs by and for themselves. The Trust's initiative for group projects is a method to assist beneficiaries in developing and improving services, while informing the social services field of promising practices in this area. The initiative's goals are:

- ensuring that Trust beneficiary initiated and managed

- activities are safe, effective, and sustainable;
- providing a viable avenue for organized advocacy that is rooted in community needs and addresses existing service gaps; and
- providing a technical assistance entity to support Trust beneficiary initiatives in data collection, analysis and training activities.

### ***Division of Juvenile Justice System Improvement Initiative***

For the past several years through its system improvement efforts, the Division of Juvenile Justice (DJJ) has enhanced the services provided to juvenile offenders and families who are also Trust beneficiaries. Strategies put in place by DJJ to address youth with behavioral health issues 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 with immediate behavioral health problems and alternatives to detention such as electronic monitoring and community detention. Strategies also include therapeutic services with the addition of mental health clinicians in several facilities and substance abuse counselor certification for many field and facility staff across the state.

### **Workforce Development**

Trained, experienced professionals are essential to providing the specialized care needed by people with cognitive or developmental disabilities and their families. Barriers to recruitment and retention in Alaska include workers' stress, isolation, low pay, limited benefits, burnout and turnover. Adequate pay, training, and supervision assure better quality care



and a more stable service delivery system. In order to provide appropriate services to Trust beneficiaries, an adequate and competent workforce must be recruited, trained, and retained.

### ***Behavioral Health Workforce Development***

DHSS and The Trust, in collaboration with other state agencies, the University of Alaska, advisory boards, service providers and Trust beneficiaries and their families, are working to develop a three- to five-year prioritized plan for workforce development for behavioral health and other beneficiary service provider areas. Strategies will build on current and past efforts to address recruitment, education, continuing training, and retention of the workforce necessary to fully staff the system of services for the beneficiaries of The Trust. In addition to prioritized strategies, the plan will assign responsibility for implementing and funding the strategies and for measuring the results. In addition, DHSS and The Trust are working with the university and tribal organizations to develop certification standards for behavioral health aides to boost competent and accessible care in rural Alaska communities.

### ***Employment***

*Moving Forward's* goal for economic security includes work opportunities for Trust beneficiaries. Being employed is a common experience that is not always shared by Trust beneficiaries. Employment enhances an individual's self respect and reduces public assistance. For many Trust beneficiaries the goal of employment may be reachable only through the assistance of others.

### ***Alaska Works Initiative***

The Alaska Works Initiative is a statewide, federally-funded initiative composed of a variety of stakeholders who are working to implement the vision that Alaskans who experience disabilities are employed at a rate as close as possible to that of the general population. Over the next five years, initiative partners will focus their efforts on implementing strategies to expand work opportunities, provide flexible program funding and increase public understanding. The success of the initiative will be determined by collecting individual outcome data, such as increased earnings and reduction in public assistance.

### ***Family Centered Services***

DHSS's Family Centered Services project for individuals receiving Public Assistance focuses on solving personal and environmental barriers to employment and self-reliance by using a proven, national "customized employment" model. This approach is designed to increase employment options for individuals with significant barriers to employment, such as Trust beneficiaries.

### ***Public Awareness***

The Trust and DHSS are committed to reducing the stigma associated with mental health problems, substance use disorders, developmental disabilities and age related dementias. Efforts to educate the public will decrease this barrier to necessary care and treatment. Public education to reduce stigma also makes it easier for Trust beneficiaries to participate in community life. Learning about the prevalence of disabling conditions and the availability and effectiveness of treatment can also positively impact public policy.

### ***Coordinated Communications Campaign***

Stereotypes about mental illness, addictive diseases, developmental disabilities or dementia make it harder to find work, housing and meaningful social contacts. Stigma can dissuade 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. This goal is central to the Coordinated Communications Campaign, an initiative of The Trust and its advisory groups, to reduce the stigma of beneficiary disabilities and to emphasize the concept that treatment and services work. The Coordinated Communications Campaign is multi-media, including newspaper ads, posters, TV ads, movie theater ads, trading cards and radio ads. Ramy Brooks, Iditarod musher, has been selected as a spokesperson for the campaign, which will run indefinitely.



**INTENTIONALLY LEFT BLANK  
PRINTER REMOVE BEFORE  
PRINTING**



## V. Emerging Issues/Trends

The timeframe for this *Comprehensive Integrated Mental Health Plan, Moving Forward*, is 2006-2011. During that time period, it is likely that changes in leadership and policies at both the national and state levels will impact the lives of Trust beneficiaries in ways that cannot yet be quantified. More work will be done on these issues as details become clear.

### ***Aging Population***

The aging of the Baby Boomer population will place unprecedented demands on Alaska's health and long term care systems. Policies and strategies are needed to address this growing aging population and their anticipated needs over the next 20 to 25 years. One impact will be a shortage of assisted living home beds across the state, along with a continuum of supported living options for people in long term care. Alaska will also need many more direct service workers for health, behavioral health and long term care services.

The Alaska Commission on Aging will plan for those seniors who need special care but who are not able to access care through traditional channels and, along with DHSS, for the needs of seniors with behavioral health needs. In addition, as people with developmental disabilities live longer, many will outlive the parents who currently care for them. Focus on post school individualized services may help these adults live independently longer.

### ***Alaska's Uninsured***

In order to cut costs, businesses, especially those in the service and retail sectors, increasingly do not offer health insurance to employees and their families. The Alaska Employee Benefits Survey of 2001 found that less than one third of firms with fewer than 10 employees offered health insurance benefits. The most frequent reason given was the high cost of premiums. About 26 percent of Alaska employees worked for small employers in the year 2000 (firms with fewer than 20 employees).

As more Alaskans work in economic sectors that do not offer health insurance benefits to employees, more Alaskans will rely on Medicaid or hospital "charity care" for their health care needs. During 2002-2004, on average nearly one-fifth of Alaska's population (about 117,100 Alaskans) was uninsured.<sup>41</sup> Twenty percent of the uninsured are children 18 and under, 79 percent are non-elderly adults, and 1 percent are elderly 65 and older.

Using a one year federal grant, DHSS will examine ways to make health insurance more affordable and available to those currently uninsured. DHSS and a statewide advisory group are conducting in-depth studies of policy options (including costs and benefits, political ramifications, and results from other states' initiatives), and research into which groups in the state are uninsured and why. Anticipated outcomes of this project include accessible, comprehensive data about health insurance coverage and access to health services in relation to population characteristics, region, occupation and race/ethnic group, with

comparison possible with previous data points and options for policy makers.

### ***Telehealth technology***

Telehealth technology (long distance clinical health care and distance medical education) has the ability to bring all levels of clinic based medical care, from general practitioners to specialists, to even the most remote Alaska communities. This technology bridges the health care gap experienced by many of Alaska's rural communities where there is a shortage of health care providers. Telehealth technology has the potential to expand the provision of behavioral health and addiction treatment services anywhere in the state, even when no health care provider skilled in those services lives in the community.

Currently, there are several projects in Alaska that allow mental health services to be delivered remotely through the use of video conferencing. One of these, the SouthEast Alaska Regional Health Consortium Tele-behavioral Health Program, serves 11 communities throughout southeast Alaska, focusing on providing distant learning opportunities and establishing patient treatment teams with behavioral health staffs from the villages and Sitka hub. The project allows local practitioners to increase their skills and improve patient care. In addition, psychiatric services are provided remotely to patients in the villages by the attending psychiatrist in Sitka.

In another project, Alaska Psychiatric Institute (API) provides tele-behavioral health counseling services to youth. Communities currently served include Galena, Fort Yukon, Fairbanks, Chistochina and Kenai. API is partnering to offer tele-psychiatric services to other sites nearing readiness.

The use of tele-behavioral health provides extraordinary opportunities to improve the lives of individuals who without this technology would not receive the care they need. In addition, by providing professional support and learning opportunities to local behavioral health providers, gains are made in quality of care and in retention of local counselors.

### ***Medicaid Issues***

Several upcoming Medicaid issues could result in significant general fund expenditures for the State of Alaska.

Because of federal changes to the rates at which state governments and the federal government share Medicaid costs, Alaska's Medicaid costs could increase by more than \$70 million per year beginning in federal fiscal year 2008. Due to actions of Alaska's congressional delegation, the federal government will continue to pay Medicaid costs at a rate of 57 percent and Alaska will continue paying at 43 percent until federal FY 08. At that time, the federal government is projected to pay 51.76 percent and state government 48.24 percent, an increase of more than 5 percent for the state.

Federal deficit reduction measures in Medicaid and in other social services and education programs will shift costs to states. For example, Targeted Case Management, a service formerly reimbursable by Medicaid, and used by states for children in foster care and other federally mandated programs, will soon have to be provided at increased state expense. We can anticipate further federal deficit reduction measures at the expense of states.

Alaska is projected to have a significant increase in the elderly population. Over the next 20 years the cost of providing Medicaid services, especially long term care services, will

require a significantly larger proportion of the state general fund budget.

The temporary increase in Medicare physician reimbursement for Alaska has lapsed, and the reduction in reimbursement means that some physicians no longer accept Medicare. Since Medicaid only pays after Medicare, health care access for those qualifying for both Medicaid and Medicare is impacted. In order to bring stability to this segment of the health care system, there needs to be a permanent federal adjustment made for Medicare reimbursement that reflects the significantly higher cost of providing health care in Alaska.

### ***Need for More Comprehensive Data and Information***

Good data helps show the effectiveness of strategies in reaching a goal and tells when to stay the course or when to change approaches to reaching the goal. In the Results Areas section of this Plan are data elements that are useful in making that judgment. Better data will enable better evaluation.

One strategy used recently by the Department of Health and Social Services was to work with a national consulting firm to develop a forecasting model to predict Medicaid program spending for the State of Alaska through 2025. The consulting group produced a report that describes the steps used to develop the forecasting model and provides details on the projected growth in enrollment, utilization and spending on Alaska's Medicaid program during this time period.<sup>42</sup> This forecasting model enables the department to take into account actual current expenditures when developing calculations for the future and to revise the forecast as key factors change. In the future this tool will result in innovative, data-driven health care policy decisions.



**INTENTIONALLY LEFT BLANK  
PRINTER REMOVE BEFORE  
PRINTING**



## 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](http://www.legis.state.ak.us).

## Acknowledgements

The Department of Health and Social Services and the Alaska Mental Health Trust Authority are grateful for the time and expertise of their staff members who contributed to this plan.

The participation of the Alaska Commission on Aging, the Governor's Council on Disabilities and Special Education, the Governor's Advisory Board on Alcoholism and Drug Abuse, and the Alaska Mental Health Board assures that the Comprehensive Integrated Plan is consistent with the planning efforts of these

statutory advisory and advocacy boards. In addition, we appreciate the contributions of staff members in other agencies who have assisted us: the Department of Labor, the Alaska Housing Finance Corporation, Department of Corrections, the Alaska Traumatic Brain Injury Association, and the Alaska Native Tribal Health Consortium.

## Further Information

Plan Web site link: *Moving Forward*, Comprehensive Integrated Mental Health Plan 2006–2011, with additional discussions and updated data, can be found at <http://hss.state.ak.us/commissioner/healthplanning/movingforward>.

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**

Health Planning and Systems Development

P.O. Box 110601

Juneau, Alaska 99811-0601

(907) 465-3091

[www.hss.state.ak.us/commissioner/Healthplanning](http://www.hss.state.ak.us/commissioner/Healthplanning)



**Alaska Mental Health Trust Authority**

3745 Community Park Loop, Suite 200  
Anchorage, Alaska 99508  
(907) 269-7960  
[www.mhtrust.org](http://www.mhtrust.org)

**Alaska Mental Health Board**

*(Conducts planning and advocacy for adults and children experiencing mental illness and emotional disorders)*

431 North Franklin Street  
Juneau, Alaska 99801  
(907) 465-3071

Plan in effect in 2005: **A Shared Vision II**

[www.hss.state.ak.us/amhb](http://www.hss.state.ak.us/amhb)

**Governor's Advisory Board on Alcohol and Drug Abuse**

*(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

Plan in effect in 2005: **Results Within Our Reach: Alaska State Plan for Alcohol and Drug Abuse Services 1993-2003**

[www.hss.state.ak.us/abada](http://www.hss.state.ak.us/abada)

**Governor's Council on Disabilities and Special Education**

*(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

Plan in effect in 2005: **2006 State Plan**

[www.hss.state.ak.us/gcdse](http://www.hss.state.ak.us/gcdse)

**Alaska Commission on Aging**

*(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

Plan in effect 2005: **Alaska Commission on Aging State Plan for Services**

[www.alaskaaging.org](http://www.alaskaaging.org)

**Department of Corrections**

4500 Diplomacy Drive  
Anchorage 99508  
(907) 269-7317

**Strategic Plan for Trust Beneficiaries in the Department of Corrections, 1999**



## Endnotes

1. Serious Mental Illness is defined as having a diagnosable mental, behavioral, or emotional disorder that met the criteria found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and resulted in functional impairment that substantially interfered with or limited one or more major life activities.
2. Estimates are based on a survey-weighted hierarchical Bayes estimation approach, and the 95 % prediction (credible) intervals are generated by Markov Chain Monte Carlo techniques.  
Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002 and 2003.
3. Healthy Alaskans 2010, DHSS, 2002.
4. Alzheimer's Foundation of America.
5. National Institute on Aging.
6. Alzheimer's Foundation of America.
7. E. Gollay, Summary Report on the Implications of Modifying the Definition of a Developmental Disability, U.S. Department of Health, Education and Welfare, 1981.
8. Centers for Disease Control Prevention, 2004.
9. <http://www.fightingautism.org>; [www.ideadata.org](http://www.ideadata.org) and [www.cdc.gov/nchs](http://www.cdc.gov/nchs).
10. Behavioral Risk Factor Surveillance Survey, 2004.
11. Mental Health Needs Assessment of the Individuals in the Custody of the Alaska Department of Corrections; Phil Smith & Associates, Juneau, 1997.
12. Division of Juvenile Justice, DHSS.
13. <http://www.cdc.gov/hrqol/methods.htm>.
14. The Behavioral Risk Factor Surveillance Survey (BRFSS) is a random-digit--dialed, telephone survey of the non-institutionalized U.S. population aged >18 years. Usually all 50 states, the District of Columbia, Guam, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands participate. The Alaska Division of Public Health conducts the Alaska BRFSS and tracks responses to public health measures.
15. Behind Bars: Substance Abuse and America's Prison Population ([www.casacolumbia.org](http://www.casacolumbia.org)).
16. Division of Behavioral Health, DHSS; Alaska Department of Revenue.
17. Behavioral Risk Factor Surveillance Survey, op.cit.
18. Blending Perspectives and Building Common Ground: a Report to Congress on Substance Abuse and Child Protection, US Department of Health and Human Services, April 1999.
19. AK Maternal and Child Health Data Book 2003-Alaska Division of Public Health, Section of Maternal Child and Family Health.
20. <http://www.hss.state.ak.us/fas/AKfiveyrgoal/default.htm>.
21. SAMHSA, Office of Applied Studies. National Survey on Drug Use and Health 2002. (DHHS Publication No. SMA 03-3836, NHSDA Series H-22.).
22. Beck LF, Johnson CH, Morrow B, et al. PRAMS 1999 Surveillance Report. Atlanta, GA: Division. of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion,



24. C. Brems. "Substance Use, Mental Health, and Health in Alaska: Emphasis on Alaska Native Peoples." *Arctic Medical Research* 1996; 55: 135-147.
25. The Youth Risk Behavior Survey (YRBS) is a national survey developed by the Division of Adolescent and School Health, Centers for Disease Control and Prevention (CDC) in collaboration with 71 state and local departments of education and 19 federal agencies. The survey is a component of a larger national effort to assess priority health risk behaviors that contribute to the leading causes of mortality, morbidity and social problems among youth and adults in the United States. These results are needed to evaluate the effectiveness of programs in reducing negative student behaviors. The survey provides valuable information about positive behaviors among students. In Alaska, survey participation requires parental consent.
26. Michael Petit, et al. *Child Abuse and Neglect, A Look at the States: 1999 CWLA Stat Book*, (Washington, DC: CWLA Press, 1999).
27. Anda RF, Felitti VJ, Bremner JD, Walker JD, Whitfield C, Perry BD, Dube SR, Giles WH, The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology. *Eur Arch Psychiatry Clin Neurosci*. 2005 Nov 29.
28. WHO Abstract of ACE Study Presentation, Forum 7, Geneva, December 2003, Vincent J. Felitti, MD; Robert F. Anda, MD.
29. Youth Risk Behavior Survey op.cit.
30. AS 47.24.010-900.
31. Youth Risk Behavior Survey op.cit.
32. P Scales and N Leffert. *Developmental Assets: A Synthesis of the Scientific Research on Adolescent Development*, (Search Institute, 1999).
33. Michael Resnick, et al.. "Protecting Adolescents from Harm: Findings from the National Longitudinal Study on Adolescent Health." *JAMA*. 1997; 278:823-832.
34. Kris Duncan, MSW. *Supportive Housing and Assisted Living in Alaska*, AHFC and AMHTA, Rev. 9/2005.
35. Public Law 108-446, 108 Congress (2004).
36. Behavioral Risk Factor Surveillance Survey, op.cit.
37. *Developmental Disabilities Waiting List Report July 1, 2004 through June 30, 2005*, February 2006, Division of Senior and Disabilities Services, DHSS.
38. Increasing the housing stock includes promoting local incentives for development of affordable housing and promoting the creation of a housing Trust fund.
39. The Interagency Council on Homelessness consists of eight state commissioners and representatives from the Governor's office, Lt. Governor's office, the Alaska Mental Health Trust Authority (AMHTA) and the U.S. Dept. of Housing & Urban Development (HUD). The CEO of the Alaska Housing Finance Corporation chairs the council and provides the resources and staff time necessary for the council to assess the problem and develop strategies.
40. "Bring The Kids Home Annual Report," December 2005, by DHSS/DBH and The Trust.
41. *Current Population Survey of the US Census Bureau Annual March Supplement*.
42. The Lewin Group and ECONorthwest, *Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025*. February, 2006.