



WEBSITE UPDATE

2007

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

Downloaded 12/31/07

Index

Executive Summary

- Figures and Tables Index

I. Introduction

II. Results Areas

- Health
- Safety
- Living with Dignity
- Economic Security

III. Current Services and Service Gaps Analysis

- Components of Care
- Current Services
 - Definitions for Levels of Community
 - Continuum of Care Matrix for Alaskans with Mental Illness or Chronic Alcoholism
Click here for additional definitions for this matrix
 - Continuum of Care Matrix for Alaskans with Developmental Disabilities
Click here for additional definitions for this matrix
 - Continuum of Care Matrix for Alaskans with Alzheimer's Disease or Related Dementia
Click here for additional definitions for this matrix
 - Matrix of Current CIMHP Services for Three or More Trust Beneficiary Groups
- Service Gaps Analysis

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

- System Strategies
- Prevention
- Integration
- Infrastructure Development
- Workforce Development
- Public Awareness

V. Emerging Issues/Trends

VI. Further Information and Acknowledgements

Endnotes

Email: compMHplan@health.state.ak.us

Executive Summary

Moving Forward, 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

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

Figures and Tables Index

- Figure 1: Days of Poor Mental Health in Past Month by Age Group
- Figure HM-1: Percent of Alaskans Reporting 11-15 Days and 16-30 Days of Poor Mental Health in Past Month
- Figure 2: U.S. and Alaska Alcohol Consumption (Ages 14 and Over)
- Figure 3: Heavy and Binge Drinkers: Alaska and U.S.
- Figure HA-2: Alcohol-induced Deaths
- Figure 4: Percentage of Women Self-reporting Alcohol Consumption During Pregnancy, Alaska 1996-2005
- Figure 5: Alaska Suicide Rate per 100,000 Population by Area, Alaska 1996-2005
- Figure 6: Alaska Suicide Rates (and Numbers) by Region, 1996-2005
- Figure HS-1: Alaska Teen Suicides (Ages 15-19)
- Figure HS-2: Non-fatal Suicide Attempts by Sex
- Figure HC-1: Estimated Number of Alaska Mental Health Trust Beneficiaries Served by DHSS Divisions
- Figure HC-2: Number of Complaints to Long Term Care Ombudsman
- Figure HC-3a: Consumers Satisfied with Public Mental Health and Substance Abuse Services -- Adults
- Figure HC-3b: Consumers Satisfied with Public Mental Health and Substance Abuse Services – Youth / Families with Youth
- Figure WS-1: Unduplicated Count of Children with Reports of Harm
- Figure 7: Number of Children with a Substantiated Report of Harm by Type of Harm
- Figure WS-2: Rate of Repeat Maltreatment of Children
- Table S-1: Domestic Violence and Sexual Assault Statistics
- Figure WS-3: Percentage of Alaskan Adults who have Experienced Domestic Violence over their Lifetime
- Table 1: Arrest Data and Days in Custody for Individuals who Participated in Jail Alternative Service (JAS)
- Figure 8A: Arrest Data for Individuals Who Participated in Jail Alternative Services (JAS)
- Figure 8B: Days in Custody and Arrest Data for Individuals Who Participated in Jail Alternative Services (JAS)
- Figure 9A: Positive Outcomes in Life Domains - Percentage of Adult Behavioral Health Consumers Improving or Maintaining Quality of Life
- Figure 9B: Positive Outcomes in Life Domains - Percentage of Youth Behavioral Health Consumers Improving or Maintaining Quality of Life
- Figure 10: Estimated Number of Homeless Alaskans: Alaska Housing Finance Corporation Statewide Winter Homeless Survey Reports
- Figure 11: High School Graduation Rates for Students Receiving Special Education Compared with Students Not Receiving Special Education
- Figure DL-1: Grade 10 Students Passing Qualifying Exams - Students Receiving Special Education and Students Not Receiving Special Education

- Figure 12: SSI/APA Payment Compared to Alaska Poverty Level
- Figure 13: Population Age 18 and Over by Income Level and Disability Status, 2005-2006
- Figure 14: Number of Trust Beneficiaries Receiving Support through Division of Vocational Rehabilitation vs. Number Employed
- Figure ES-1: MR/DD* Waiver Recipients who Receive Supported Employment Services
- Figure ES-2: Average Number of Participants in Medicaid Buy-in Option
- Table E-1: Alaska Rent-Wage Disparities
- Figure 15: Components of Care for Three or More Beneficiary Groups
- Figure 16: *Bring the Kids Home* Results by State Fiscal Year - Percent of Alaska Children Receiving RPTC Services In-State and Out-of-State
- Figure WD-1: Behavioral Health Program Degrees and Certificates Awarded at Alaska's Universities
- Figure WD-2: University of Alaska Behavioral Health Program Enrollment
- Table 2: Current CIMHP Services Matrix
- Definitions for Levels of Community
- Continuum of Care Matrix for Alaskans with Mental Illness or Chronic Alcoholism
- Continuum of Care Matrix for Alaskans with Developmental Disabilities
- Continuum of Care Matrix for Alaskans with Alzheimer's Disease or Related Dementia

I. Introduction

Plan Vision

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

Authority for Plan

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

Purpose of Plan

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

Moving Forward: Comprehensive Integrated Mental Health Plan is coordinated with plans developed by the Alaska Mental Health Board, the Governor's Council on Disabilities and Special Education, the Governor's Advisory Board on Alcoholism and Drug Abuse and the Alaska Commission on Aging, collectively called the beneficiary planning and advocacy boards, and by the Department of Corrections' 1999 plan. This plan is also linked with such DHSS plans as Healthy Alaskans 2010 and other planning initiatives. (hyperlink to <http://hss.state.ak.us/commissioner/Healthplanning/publications/assets/stateHealthPlans.pdf>)

Target Population of Plan

Moving Forward: Comprehensive Integrated Mental Health Plan has a vision of optimal quality of life for Alaskans, especially those Alaskans who receive services under the Comprehensive Integrated Mental Health Program (AS 47.30). By law, these service recipients (also called Trust beneficiaries) are Alaskans who have a mental illness, a developmental disability, experience chronic alcoholism or Alzheimer's disease or a related dementia. Efforts include prevention, to the extent possible, of these disabling

conditions. Those who may need services in the future are included in this plan since prevention is the surest way to limit human suffering and is usually the least costly strategy.

Extent of the Problem

With Alaska data and national prevalence data, we can estimate that there are currently up to 90,000 Trust beneficiaries in Alaska. (This number may include duplications due to the nature of the data available). If those with substance use disorders were counted instead of just those who are alcohol dependent, the number of Trust beneficiaries would rise to 120,000.

- Chronic mental illness (adults): 27,600
- Serious Emotional Disturbance (youth): 17,000
- Alzheimer's Disease (adults over age 65): 4,900
- Brain injured: 10,000
- Developmentally disabled: 11,500
- Alcohol dependent: 19,000

Mental Illness:

Approximately 27,600 Alaskan adults experience chronic mental illness. These are adults who have a diagnosable mental disorder that has resulted in functional impairment which substantially interferes with or limits one or more major life activities such as the ability to perform self care, personal relations, living arrangements, or work.¹

It is estimated that 17,000 young Alaskans (12 percent of the population under age 18) experience Serious Emotional Disturbance (SED). These are children and youth who have a diagnosable mental disorder that substantially interferes with or prevents them from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills such as completing their education.²

Alzheimer's Disease and Related Dementia:

An estimated one in eight Americans over age 65, and nearly half of those 85 or older, have Alzheimer's disease. From 2000 to 2004, deaths from Alzheimer's disease increased 33 percent, while deaths from heart disease, breast and prostate cancers and stroke declined.³ Although Alzheimer's disease is not a normal part of aging, the risk of developing the illness rises with age.

Using national prevalence rates, the Alaska Commission on Aging estimates that as of 2006, there were 4,916 Alaskans aged 65 and above with Alzheimer's. As of January, 2007, 57 percent of residents in Alaska Pioneer Homes had a dementia diagnosis.⁴

It is estimated that one to four family members act as caregivers for each individual with Alzheimer's disease. Nearly 10 million Americans care for a person with Alzheimer's or other dementia, and about one-third of the caregivers are aged 60 and older.⁵

It is estimated that at least 10,000 Alaskans are living with brain injury today. Every year the Alaska Department of Health & Social Services reports about 800 traumatic brain injury (TBI) cases resulting in hospitalization or fatality. The Alaska TBI rate is 28 percent higher than the national average.⁶

Developmental Disabilities:

According to national prevalence data, 1.8 percent of the national population has a developmental disability. At this rate, it is estimated that 11,500 Alaskans have developmental disabilities.⁷

According to the U.S. Department of Education and other agencies, autism is the fastest-growing developmental disability. It is the most common of the Pervasive Developmental Disorders, affecting an estimated one in 150 births.⁸ From 1993 to 2004, autism cases in ages 6-22 increased 522 percent nationwide and 685 percent in Alaska.⁹

Chronic Alcoholism:

Rates of heavy and binge drinking are consistently higher in Alaska than in the United States as a whole. In 2006, the highest prevalence of heavy and binge drinking was among young adults aged 25 to 34.¹⁰

In 2005, approximately 19,000 Alaskans were alcohol dependent and 49,000 had substance use disorders. Almost 27% of young Alaskans between the ages of 12 and 17 used alcohol in the last month, according to 2004 and 2005 statistics.¹¹ This is a significant concern, because research shows that young people who begin drinking before the age of 15 are four times more likely to develop dependence.¹²

II. Results Areas

Health

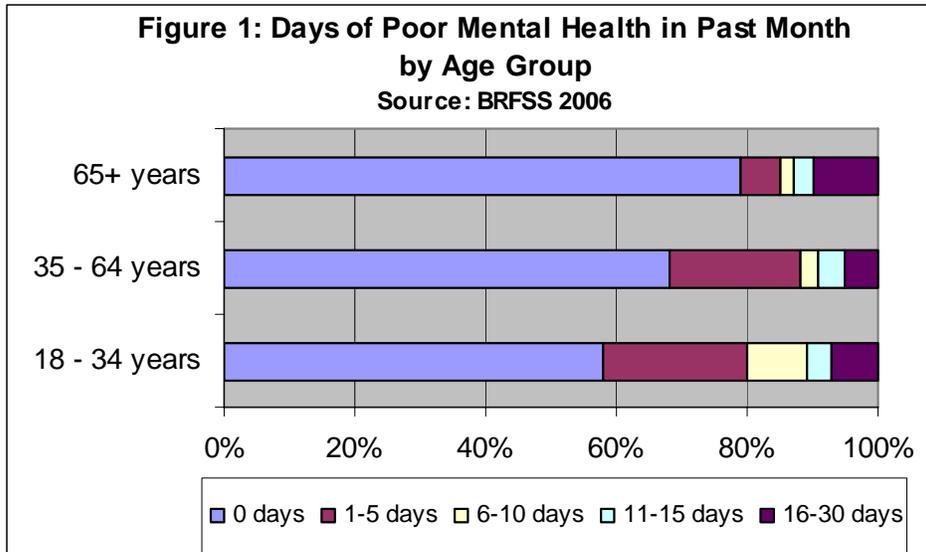
When someone is born as or becomes a Trust beneficiary, the individual and the family want the best care possible—the most helpful services close to home. Accessing behavioral health care can be difficult for Alaskans in small communities, for those who have inadequate or no health insurance, or whose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

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

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

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

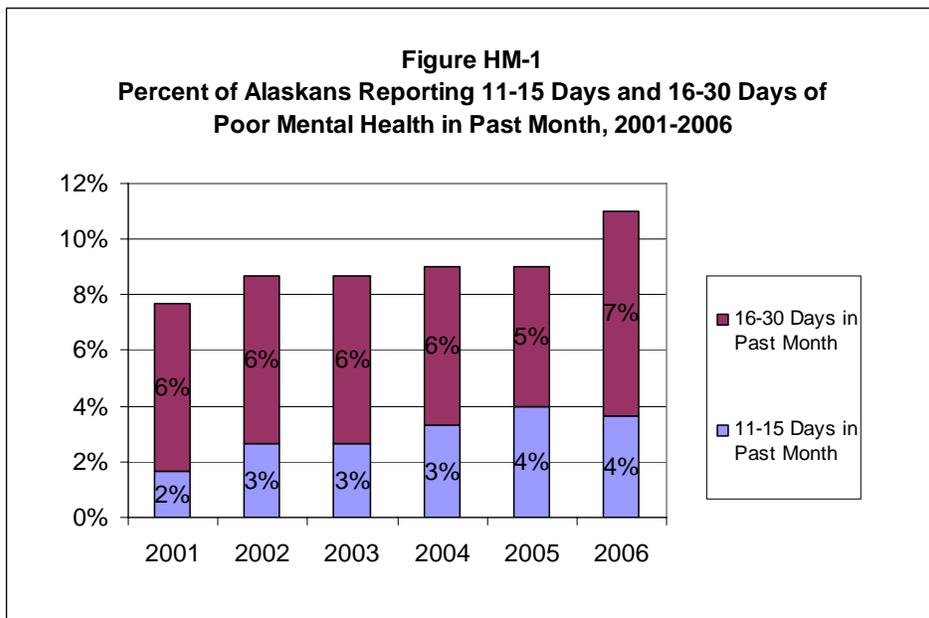
Data from the Behavioral Risk Factor Surveillance Survey⁹ show the percent of Alaskans surveyed who self-report the number of days in the prior month that they experienced "poor mental health." Fourteen percent of survey respondents reported more than five days of poor mental health during the previous month. The percentage of young adults who report that they experienced between six and 10 days of poor mental health was three times higher than other age groups.



AK DHSS Division of Public Health, Behavioral Risk Factor Surveillance System

Figure HM-1 - Percent of Alaskans Reporting 11-15 Days and 16-30 Days of Poor Mental Health in Past Month, 2001-2006

The number of Alaskans in all age groups reporting poor mental health for more than half of the past month increased in 2006. The number reporting only 11 to 15 days of poor mental health in the past month has increased gradually during the last six years.



AK DHSS Division of Public Health, Behavioral Risk Factor Surveillance System

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

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

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 has been higher than the rate in the rest of the nation during each of the last 14 years, and is well above the *Healthy Alaskans 2010* goal of 2.2 gallons or less per person per year.

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

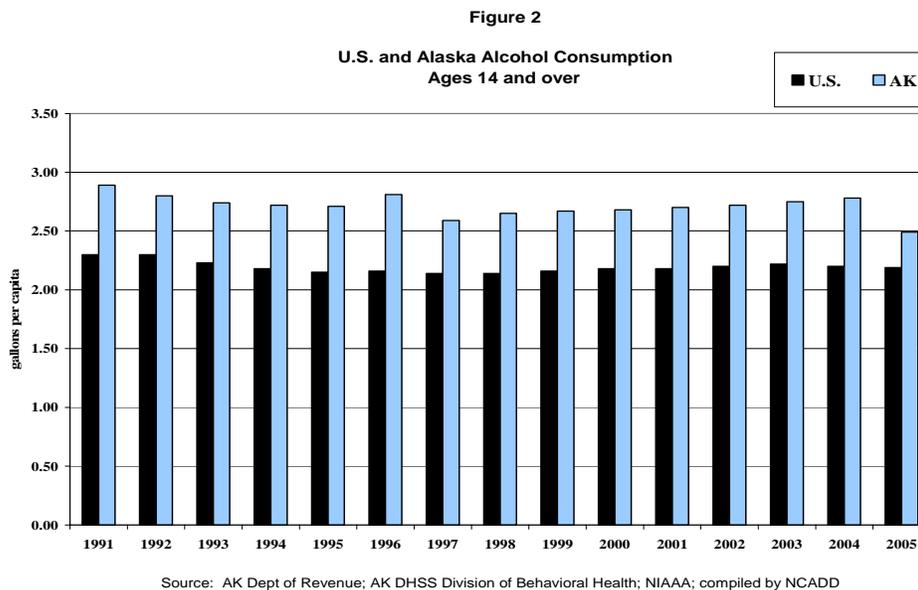
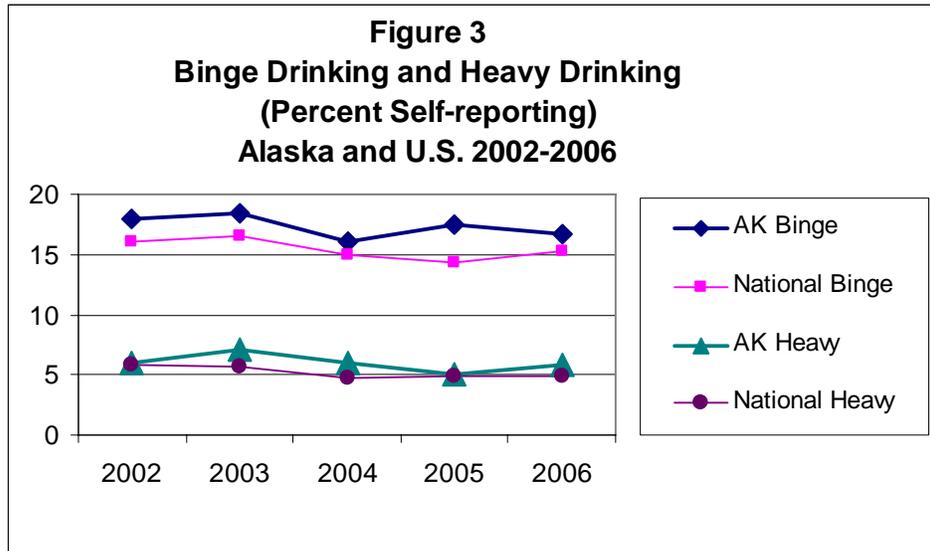


Figure 3 — Heavy and Binge Drinkers, Alaska and U.S.

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

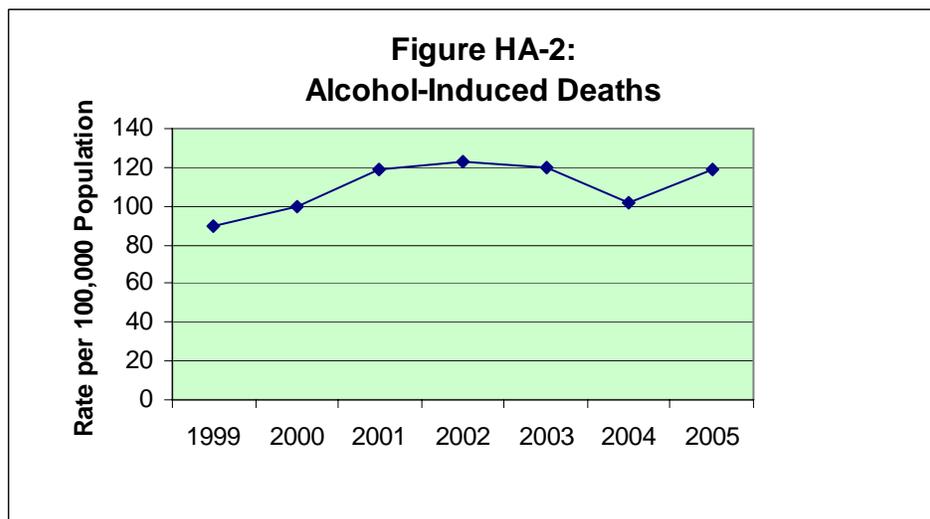
Surveillance Survey⁹ shows that binge drinking is more prevalent than heavy drinking, and each year Alaskan adults report more binge and heavy drinking than in the rest of United States. In 2006, the highest prevalence of binge (31%) and heavy (7 %) drinking in Alaska was among young adults aged 18 to 24. Overall, heavy drinking in Alaska rose slightly between 2005 and 2006.



AK DHSS Division of Public Health, Behavioral Risk Factor Surveillance System

Figure HA-2 — Alcohol Induced Deaths

Data for alcohol-induced deaths includes fatalities from alcoholic psychoses, alcohol dependence syndrome, non-dependent abuse of alcohol, alcohol-induced chronic liver disease and cirrhosis, and alcohol poisoning. It does not include deaths due to traumatic injury, such as motor vehicle crashes. There were 119 alcohol-induced deaths in Alaska in 2005.



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

On average, 16.7 years of productive life were lost for each alcohol-induced death. The rate of alcohol-induced deaths for Natives was nearly six times higher than that for whites. Alaska males were over 25 percent more likely than females to die from alcohol-induced causes, but this disparity is less than in the U.S. as a whole.¹⁵

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

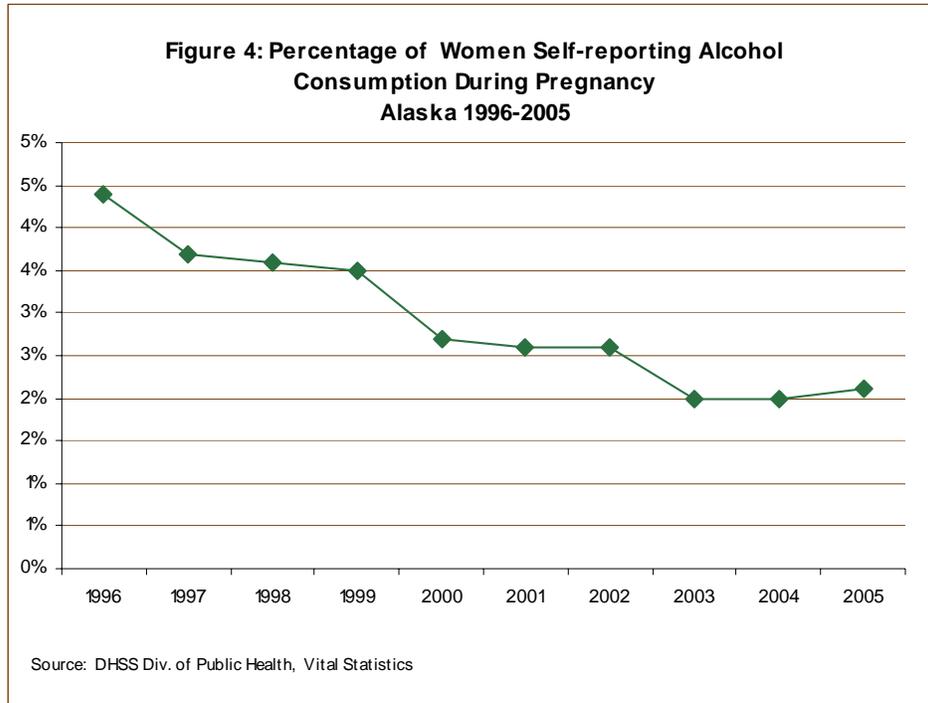
Alaska families, like those everywhere, strive to have healthy babies and provide good homes for their children. The first three years of a child's life are a time of extraordinary growth physically, mentally, emotionally, and socially. We know that environmental factors have a profound influence on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

Figure 4 — Percentage of Women Self-reporting Alcohol Consumption During Pregnancy, Alaska 1996-2005

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

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

For more information about efforts to prevent FASD, see Initiatives section.



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

In 2004, the latest year for which official data are available nationally, Alaska's suicide rate was the highest in the nation. Alaskans aged 20-29 years had the highest rate, followed by the 30-39 year old group. The estimated years of potential life lost due to suicide in Alaska was 4,686.¹⁹

Figure 5 — Alaska Suicide Rates per 100,000 Population by Area, Alaska 1996-2005

Figure 5 shows Alaska's age-adjusted suicide rates per region for the years 1996 through 2005. The regions with the lowest rates of suicide were Kodiak and the Aleutians, while the highest rates were in Nome and the Northwest Arctic.

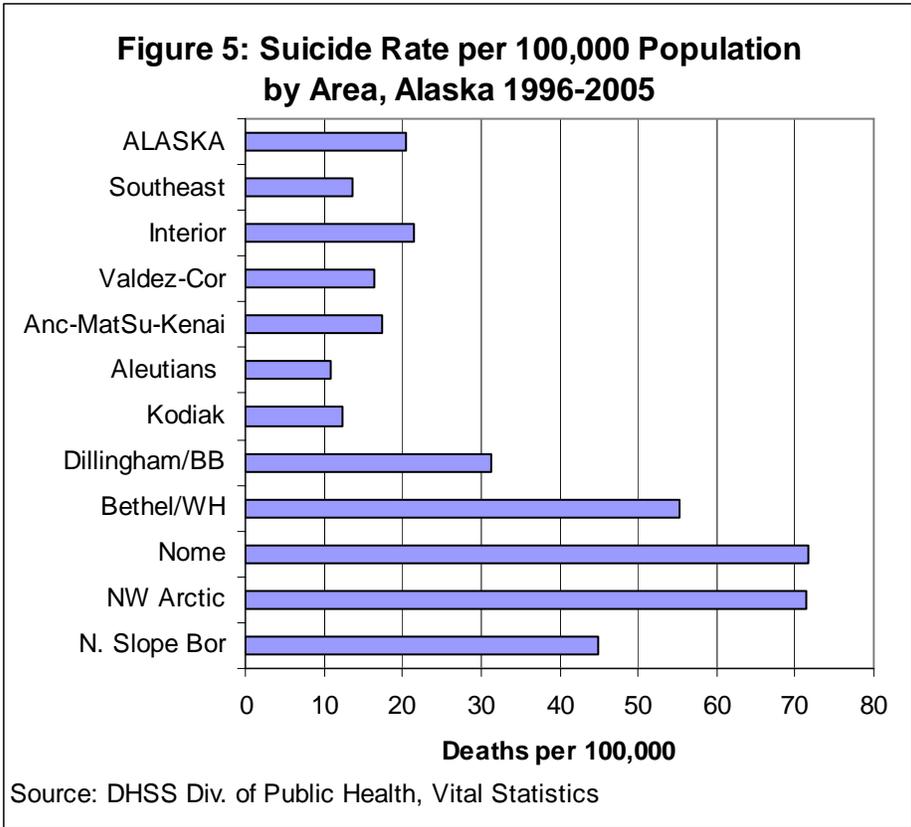
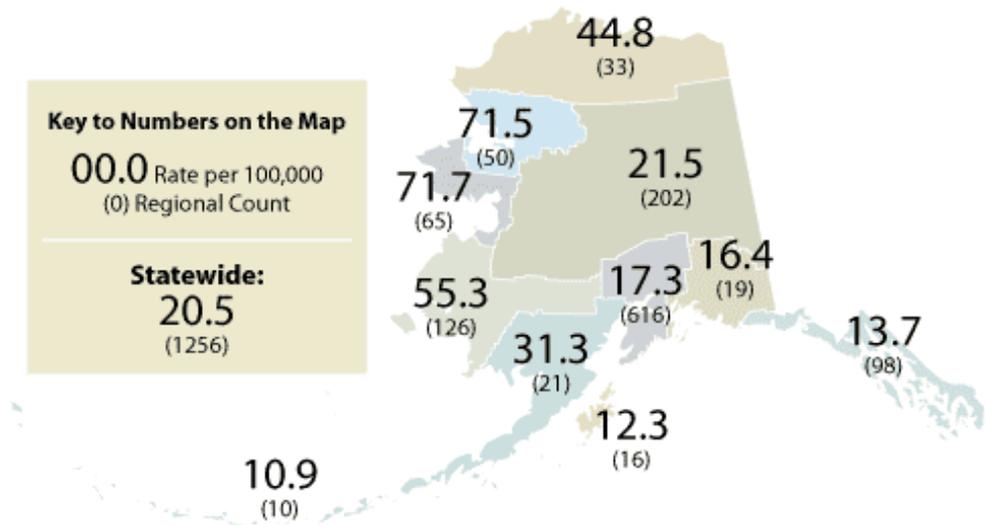


Figure 6: Alaska Suicide Rates (and Numbers) by Region, 1996-2005



Source: DHSS Div. of Public Health, Vital Statistics; compiled by Health Planning and Systems Development

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

Among the suicide cases that had a follow-back interview, a binge drinking rate of 43 percent was reported, which is 2.5 times higher than the Alaska rate and three times higher than the national estimated rate according to the 2005 BRFSS. 43percent of the interviewees said the decedents drank alcohol daily. The interviews indicated that 54 percent of the decedents had smoked marijuana within the past year. The reported rate for alcohol and drug use by Alaska Natives was exactly the same as for non-Natives. Although Alaska Natives comprise only 16 percent of the population, they accounted for 39 percent of the suicides.²¹

Figure HS-1 — Alaska Teen Suicides

Among Alaskans aged 15 to 19, there were 22 suicides in 2004 and 11 in 2005.

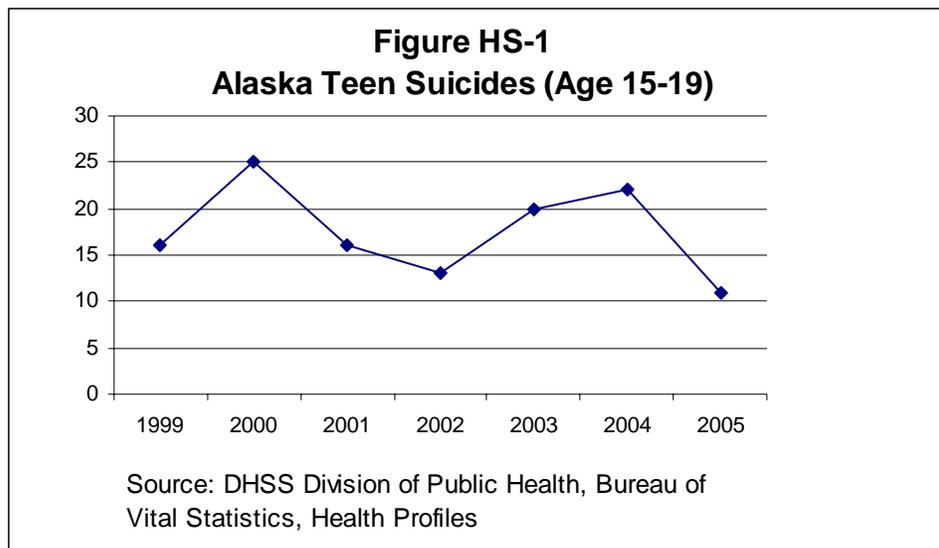
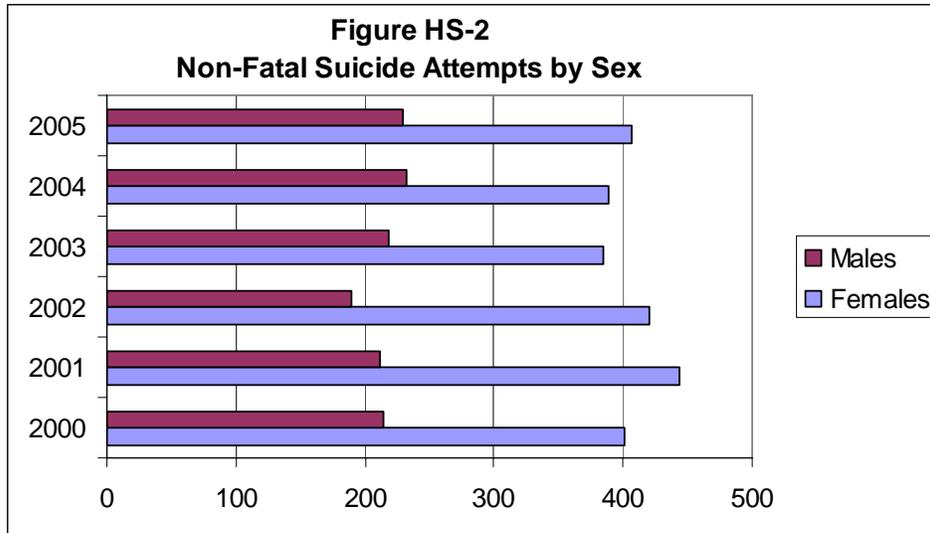


Figure HS-2 — Non-fatal Suicide Attempts by Sex

Between 2000 and 2005, non-fatal suicide attempts were almost twice as high among Alaskan women as compared to men.



Source: Alaska Trauma Registry, 2000-2005, Alaska residents (hospital admissions of 24 hours or more); DHSS DPH Section of Injury Prevention and EMS staff.

Suicidal ideation/attempts from 2003 Youth Risk Behavior Survey (YRBS²²)

- 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 %

Protective Factors

Measures that enhance resilience or protective factors are as essential as risk reduction in preventing suicide. Positive resistance to suicide is not permanent, so programs that support and maintain protection against suicide need to be ongoing.

Protective factors include:

- Effective and appropriate clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Restricted access to highly lethal methods of suicide
- Family and community support
- Support from ongoing medical and mental health care relationships
- Learned skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation instincts²³

The Current Initiatives section reflects projects to prevent suicide in Alaska.

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

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

Estimated Number of Alaska Mental Health Trust Beneficiaries Served by DHSS Divisions (Figure HC-1)

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

Figure HC-1

Estimated Number* of Alaska Mental Health Trust Beneficiaries Served by DHSS Divisions												
*Actual number may be lower - there is duplication in some of the data reported.												
Data Time Period	Division	Age 0-17		Age 18-20		Age 21-64		Age 65 +		Age not available		Total for Specified Time Period
		Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	
FY 2005	Behavioral Health (DBH) - Mental health	3397	4271	247	243	2614	1782	69	29	3	5	12,660
Source:	<i>These are state community mental health settings, state psych hospitals, and other settings. Some clients may have been served in more than one setting so would be counted twice. Source: CMHS FY 2005 Uniform Reporting System, Basic Table 3A and B.</i>											
April - Dec., 2005	DBH - FASD Diagnostic team	91		8								99
Source:	<i>This is the number of clients referred to and screened by the FASD Multidisciplinary Community Diagnostic Teams between April and December 2005. Of those screened, 3% were diagnosed with FAS or atypical FAS; 51% with static encephalopathy; 39% with neurobehavioral disorder; and 7% were found to have no evidence of organic brain damage. Source: Behavioral Health Research & Services FAS Evaluation Summary Report of the Alaska Multidisciplinary FASD Diagnostic Team Data, UAA (BHRS FAS-Related Technical Report No. 35)</i>											
FY 2005	DBH - Chronic Alcoholism			776								776
Source:	<i>Estimates drawn from State grantee residential substance abuse treatment facilities quarterly reports to DBH. Excluded from these numbers are youth and women with children.</i>											
FFY 2006	Children's Services (OCS)	444										444
Source:	<i>These are children served in out-of-home care who were mentally retarded and/or emotionally disturbed. Source: AK DHSS, Office of Children's Services. AFCARS Foster Care, Federal Fiscal Year 2006.</i>											

Data Time Period	Division	Age 0-17		Age 18-20		Age 21-64		Age 65 +		Age not available	Total for Specified Time Period
1/1/07 to 4/30/07	Juvenile Justice (DJJ) - Age 0-21										841
	Female	142									
	Male	699									
	<i>Numbers represent youth on supervision with DJJ who had at least one Axis I diagnosis, under DSM-IV-TR (clinical disorders & other conditions that may be a focus of clinical attention). Most were 17 years of age or younger. Of the total, 39% also had a co-occurring disorder (substance related disorder accompanied by a mental health disorder). Alaska Native youth had more Axis I primary diagnoses than any other group. Source: DHSS Div. of Juvenile Justice</i>										
One-day snapshot, 5/1/07	Pioneer Homes							263			263
Source:	<i>Total Pioneer Home residents with a dementia diagnosis (sorted for "dementia" in ICD-9 code). Source: Division of Pioneer Homes, Accu-Med Electronic Medical Records System</i>										
One month - April, 2007	Public Assistance (DPA) -Alaska Temporary Assistance Program (ATAP) (4/05)	3381									4,784
April, 2007	DPA- Adult Public Assistance (APA)	16,568									16,104
April, 2007	DPA - Food Stamps	22,491									21,477
Source:	<i>These figures reflect a one-month caseload for all Alaskans; this data does not break out the number of Trust beneficiaries. Not counted are the customers whose cases are managed by the tribal system. Source: DPA</i>										

Data Time Period	Division	Age 0-17		Age 18-20		Age 21-64		Age 65 +		Age not available		Total for Specified Time Period
	Senior and Disabilities Services (DSDS)											
2005	Mental Retardation Developmental Disabilities (MRDD) Waiver	57	134	36	70	335	406	8	8			1054
2005	Children with Complex Medical Conditions (CCMC) Waiver	86	101	15	17	4	10	0	0			233
Source:	Data Retrieved from FY 06 Medicaid Billing Data (STARS) on May 2, 2007. Some applicants are counted twice because of crossing age groups. Actual totals are MRDD - 1011, CCMC - 219.											
One-day snapshot, 3/23/2007	Senior grants (963 total clients)								308			308
3/23/2007	Nursing facilities (total of 715 beds)			283								
Source:	Data based on survey of providers on numbers of clients with Alzheimers or related dementia.											
2005	DSDS - Adult Protective Services			546								546
Source:	Data Retrieved from FY 06 Medicaid Billing Data (STARS) on May 2, 2007.											

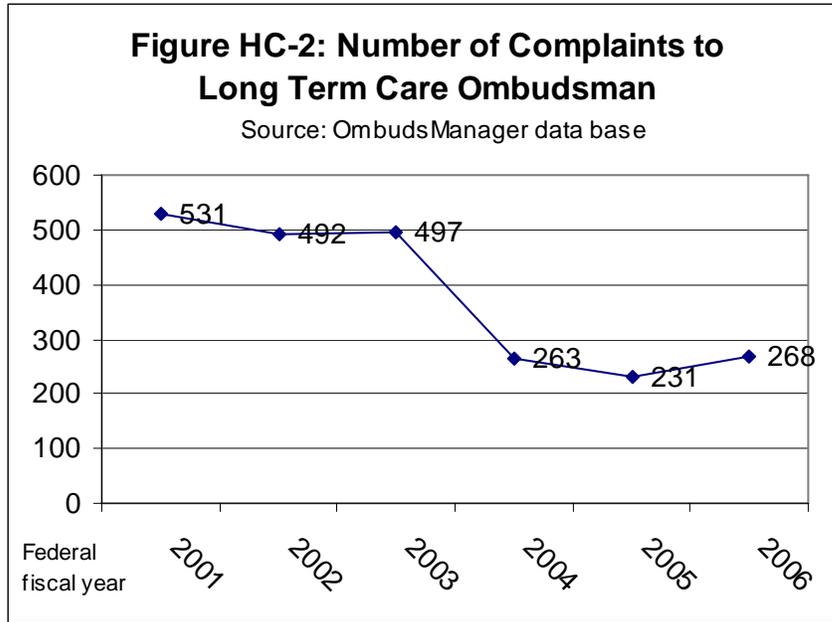
Public perceptions of care

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

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

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

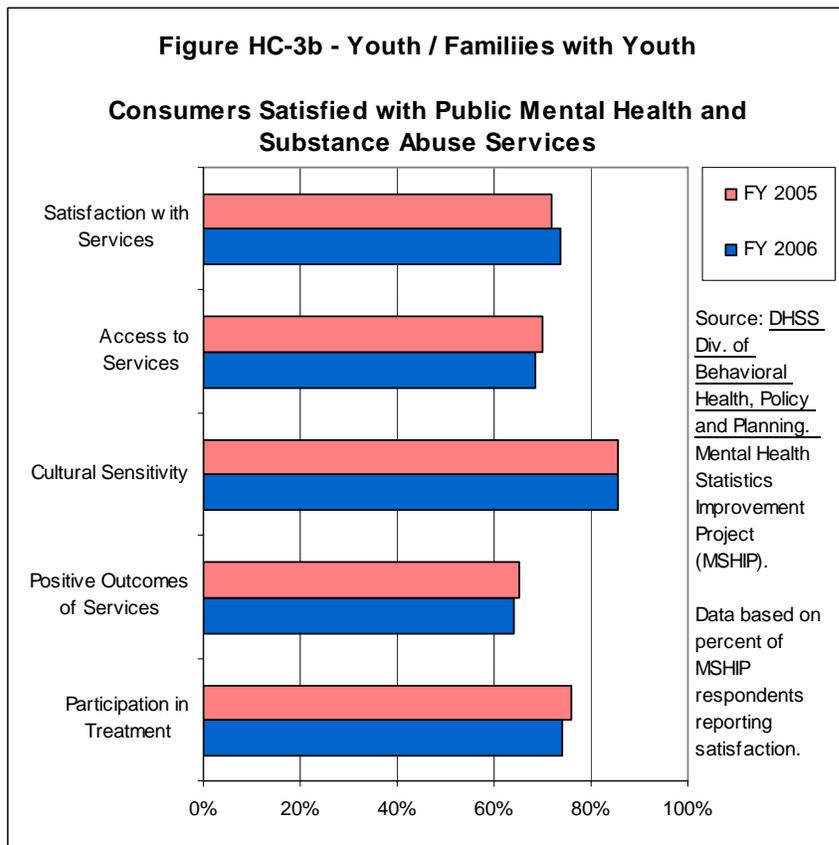
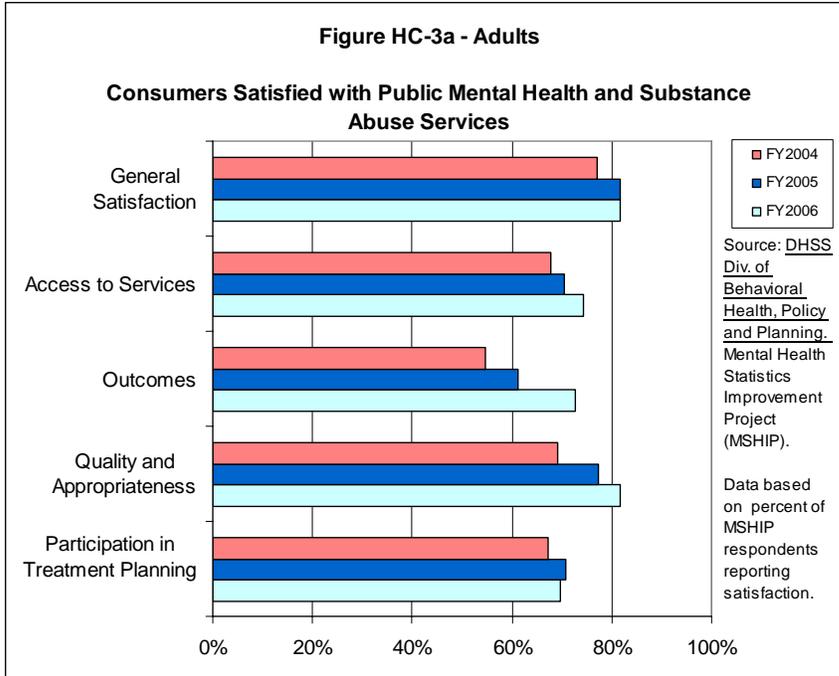
Figure HC-2 shows the number of complaints that Alaska's Office of the Long-Term Care Ombudsman received from consumers each year. Most of the complaints were against assisted living homes and nursing homes. Beginning with fiscal year 2004, fewer complaints were recorded in this data base because at that time they began counting only cases that their office was actively investigating. Before 2004 the cases they counted also included ones that they were monitoring and that were being investigated by other state agencies such as Adult Protective Services and Certification and Licensing. There have been about 250 complaints actively investigated during each of the last three years.



Alaska has one of the fastest-growing senior populations of all the states, with the number of seniors expected to more than double by 2030. While Alaska seniors have a higher mean and median income than U.S. seniors as a whole, higher living costs may consume much of that additional income. Incomes of senior households located in rural areas and those headed by Alaska Natives have substantially lower incomes. The poorest group is seniors age 85 and over, which is also the fastest-growing sub-group of the senior population. By 2030, the number of Alaskans in this age group is expected to triple.²³

Consumers Satisfied with Public Mental Health and Substance Abuse Services (Figures HC-3a and HC-3b).

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



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

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

Safety

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

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

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

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

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

Figure WS-1 — Unduplicated Count of Children with Reports of Harm

Figure WS-1 shows the unduplicated count of Alaska’s children for whom a report of harm was received by the Alaska Department of Health and Social Services Office of Children’s Services. Each child is counted only once regardless of the number of reports received. Generally, it indicates the number of children for whom individuals reported some safety concerns to the Office of Children’s Services. OCS did not investigate all reports of harm received; some did not meet OCS criteria for investigation and some were referred for another type of response. The number of children with reports of harm increased from 9,531 in state fiscal year 2004 to 12,491 in state fiscal year 2006.

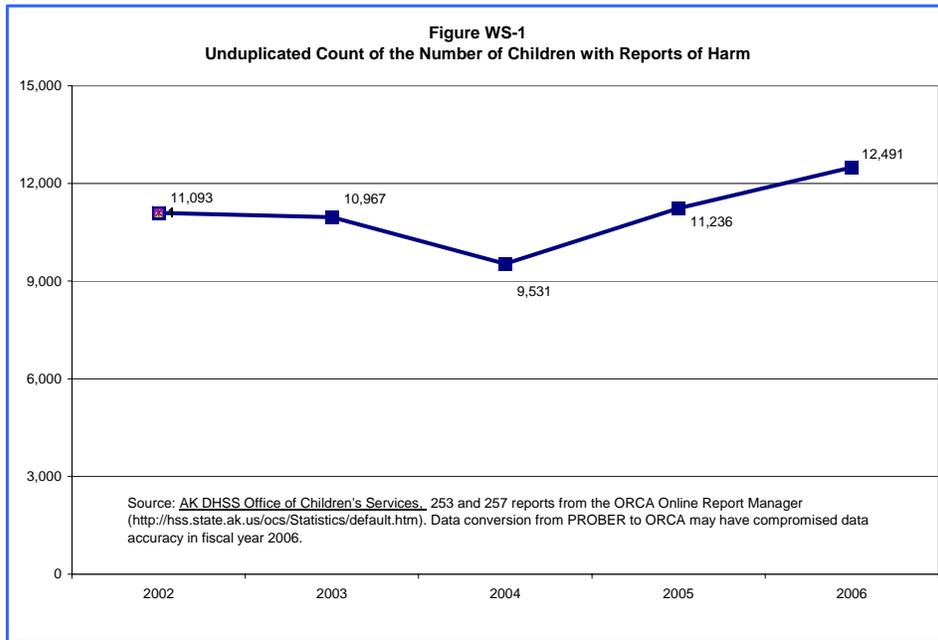


Figure 7 — Safety of Children: Number of Children with a Substantiated Report of Harm by Type of Harm

Figure 7 represents the number of Alaska’s children who were substantiated as victims of child abuse and neglect. It counts children who had a report of harm which was investigated and harm substantiated. Each child is counted once for each type of harm substantiated. Types of harm reported and substantiated include neglect, physical abuse, sexual abuse, mental injury, and abandonment. The number of substantiated reports of harm increased between state fiscal year 2005 and state fiscal year 2006.

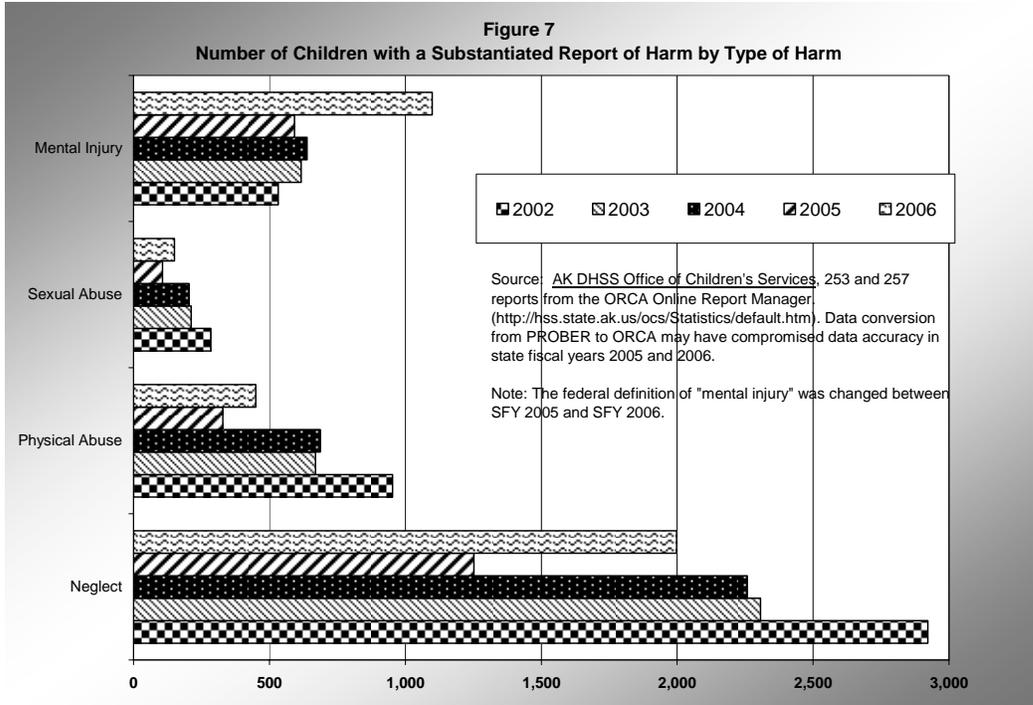
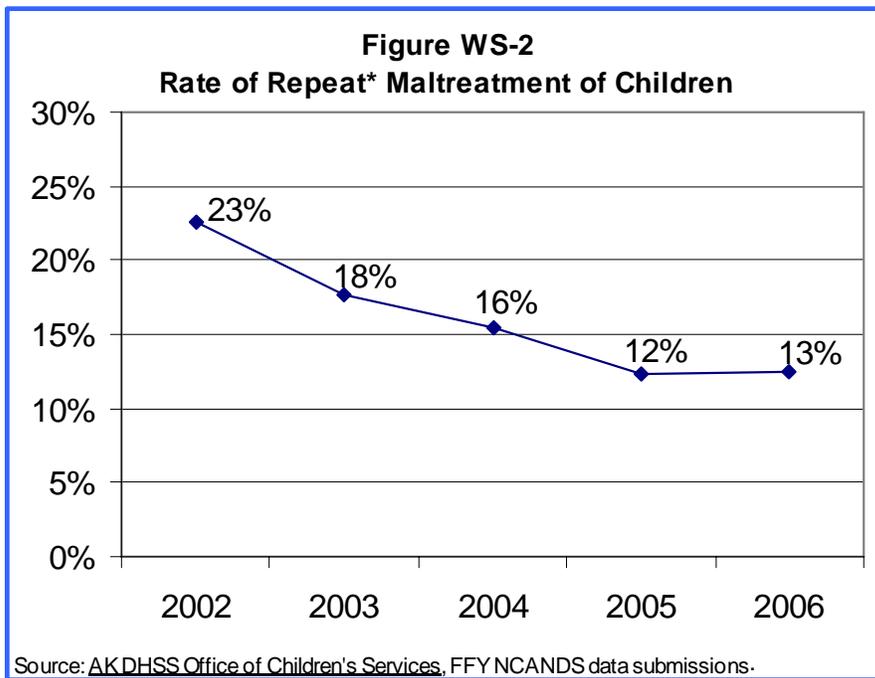


Figure WS-2 Rate of Repeat Maltreatment of Children

Figure WS-2 shows the percentage of all children who were subjects of substantiated or unconfirmed reports of harm during the first 6 months of the year and who had another substantiated or unconfirmed report of harm within 6 months. In state fiscal year 2006, the rate of repeat maltreatment was 13 percent.



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

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

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

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

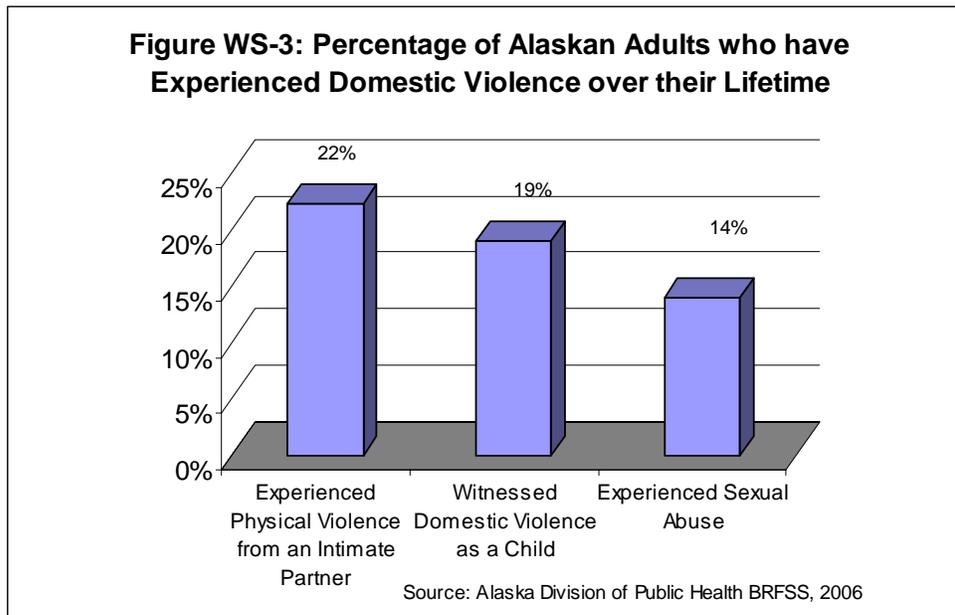
Table S-1: Domestic Violence and Sexual Assault Fiscal Year 2006 Statistics

During fiscal year 2006, Alaska shelters provided services to 8,140 clients. 25% of the clients were children. Services include safe shelter, crisis intervention, food and clothing, referrals and many other services. Table S-1 aggregates the field reports from victim service providers and shows the types of incidents experienced by the clients. The top three types of incidents were domestic violence, sexual abuse of children, and sexual assault toward adults.

Adult Molested as a Child Count	59
Assault Count	195
Child Physical Abuse Count	109
Child Sexual Abuse Count	898
Domestic Violence Count	5,257
DWI / DUI Victim Count	14
Elder Abuse (victim 60+years of age) Count	11
Other Violent Crime Count	79
Robbery Count	13
Sexual Assault (adult) Count	653
Stalking Count	139
Survivor of Homicide Victim Count	37
Grand Count	7,464

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

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



Adult Protective Services Reports of Harm

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

Adult Protective Services Investigations:

Total investigations FY 04: 1173

Total investigations FY 05: 1497

Total investigations FY 06: 1427²⁸

In fiscal year 2006, the Department of Health and Social Services was contacted about 1666 people (unduplicated) for whom an investigation was possibly warranted; 86% of these intakes were investigated.

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

Jail Diversion — Arrest History:

The Alaska Mental Health Board, the Alaska Mental Health Trust Authority, the Department of Corrections, the Court System, prosecutors, defense attorneys and community treatment providers have collaborated to implement Jail Alternative Services (JAS) and a therapeutic mental health court. JAS diverts voluntary low risk offenders to treatment instead of jail and monitors compliance with treatment.

The JAS program annually refers up to 40 eligible individuals to community treatment providers and monitors compliance with court-ordered treatment conditions. JAS is operated by the Department of Corrections for individuals sentenced through the Anchorage District Court Coordinated Resources Project “CRP” (Mental Health Court) to the JAS program.

Between July, 1998 and June, 2003, the JAS program served a total of 103 unduplicated clients. Of the 103 clients, 36 completed the program, 37 were vacated or opted out of the program after entry, and 30 were still active on the caseload. , These 103 clients had had a total of 197 misdemeanor arrests and 20 felony arrests during the 12 months prior to participation in Jail Alternative Service. During participation in JAS, arrests decreased sharply to 86 misdemeanor arrests 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 or not they have completed the program, there is no longer any legal leverage to require them to receive services. A measure of the effectiveness of the JAS 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.

Table 1 and Figures 8A and 8B show a reduction in legal recidivism as a result of the JAS program.

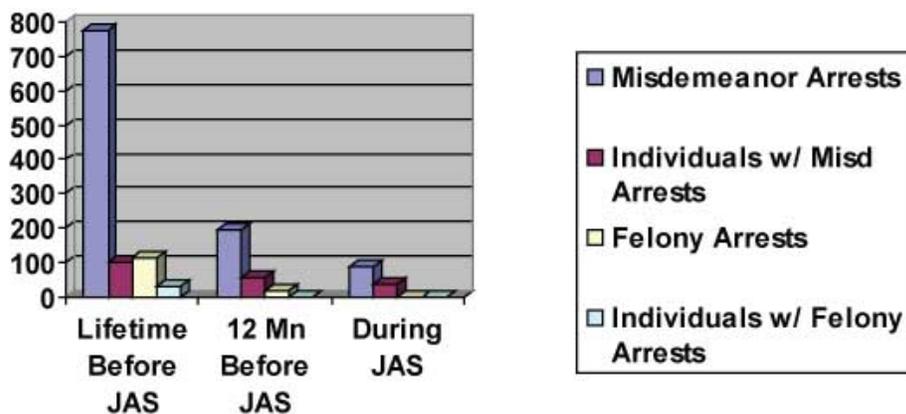
Table 1: Arrest Data for Clients not active in Jail Alternative Service (JAS)

Metric N=103	Lifetime Total Before JAS	12 Months Before JAS	During JAS
# Misdemeanor Arrests (New Charges)	773	197	86
# Individuals with Misdemeanor Arrests	(100%) 103	(55%) 57	(45.2%) 40
# Felony Arrests	113	20	2
# Individuals with Felony Arrests	(29.1%) 30		2
Average Number of Arrests/per JAS Participant		2.1	0.9
Total Days in Custody for All JAS Participants	42,720	7,732	3,264

The length of time for JAS client participation ranged from 14 days to 1,742. The median length of time under JAS supervision was 402 days.

Sources: Jail Alternative Service Program Evaluation July 1, 1998 – June 30, 2003, C&S Management Associates, 2004. Alaska Mental Health Trust Authority Status Report, Jail Alternative Services, which included data from program inception July 1, 1998 through June 30, 2003, dated April 12, 2004, by Colleen Patrick-Riley, Department of Corrections Mental Health.

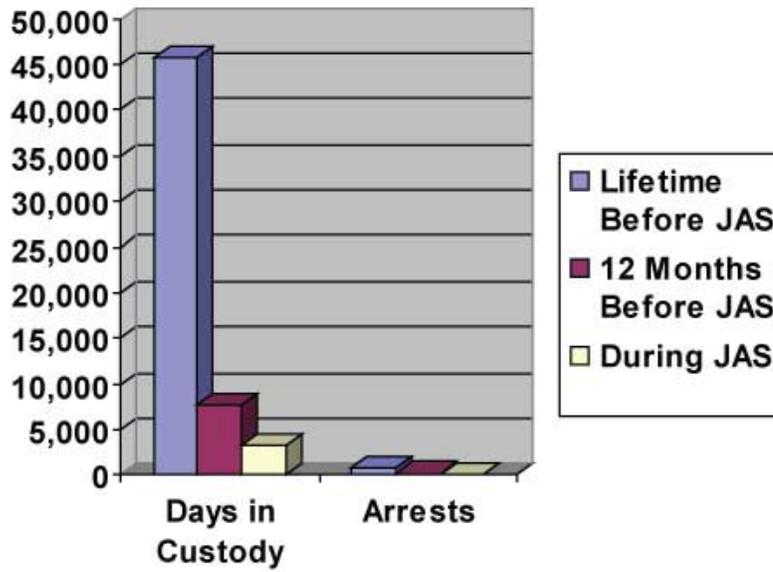
Figure 8A: Arrest Data for Individuals Who Participated in Jail Alternative Services (JAS)



(Revised February, 2007)

Source: JAS Program Evaluation, July 1, 1998-June 30, 2003; C&S Management Associates, 2004

Figure 8B: Days in Custody and Arrest Data for Individuals Who Participated in Jail Alternative Services (JAS)



(Revised February, 2007)

Source: JAS Program Evaluation, July 1, 1998-June 30, 2003; C&S Management Associates, 2004

Living with Dignity

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

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

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

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

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

The Client Status Review (CSR) tracks the quality of life of consumers of the Alaska behavioral health treatment system. When clients enter the system they are asked a series of questions about their "life domains" such as thoughts of self-harm, feelings of

connectedness, productivity, etc. For comparison, they are asked the same questions at different intervals during treatment, and at discharge. Figures 9A and 9B show the percentage of consumers who reported that their conditions were the same or better than they had been when they entered the system. Included are 1,688 consumers (419 children and 1,269 adults) in state fiscal year 2006.

Figure 9A: Positive Outcomes in Life Domains – Adults (Percentage of Adult Behavioral Health Consumers Improving or Maintaining Quality of Life)

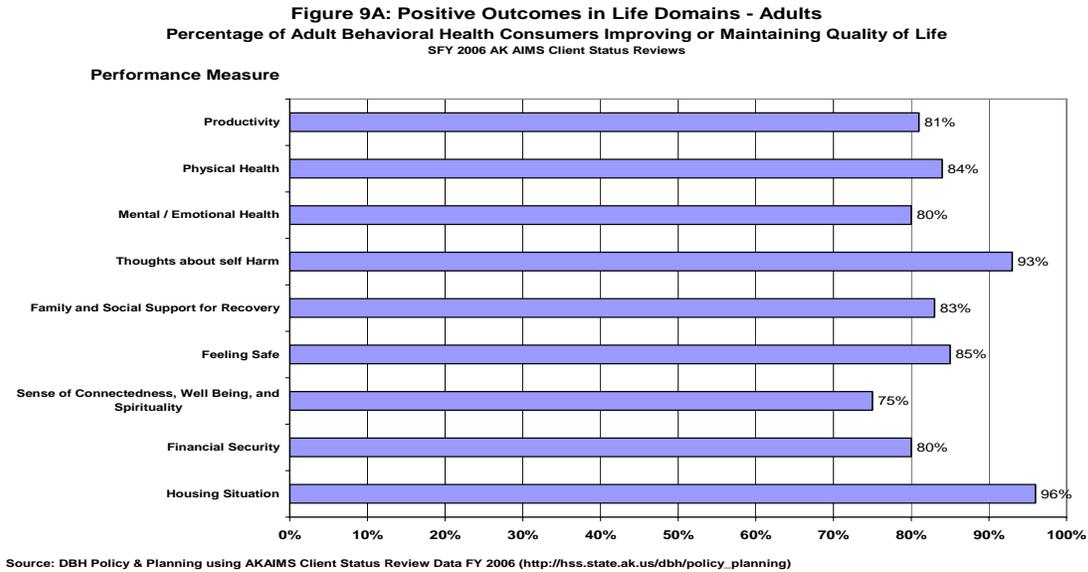
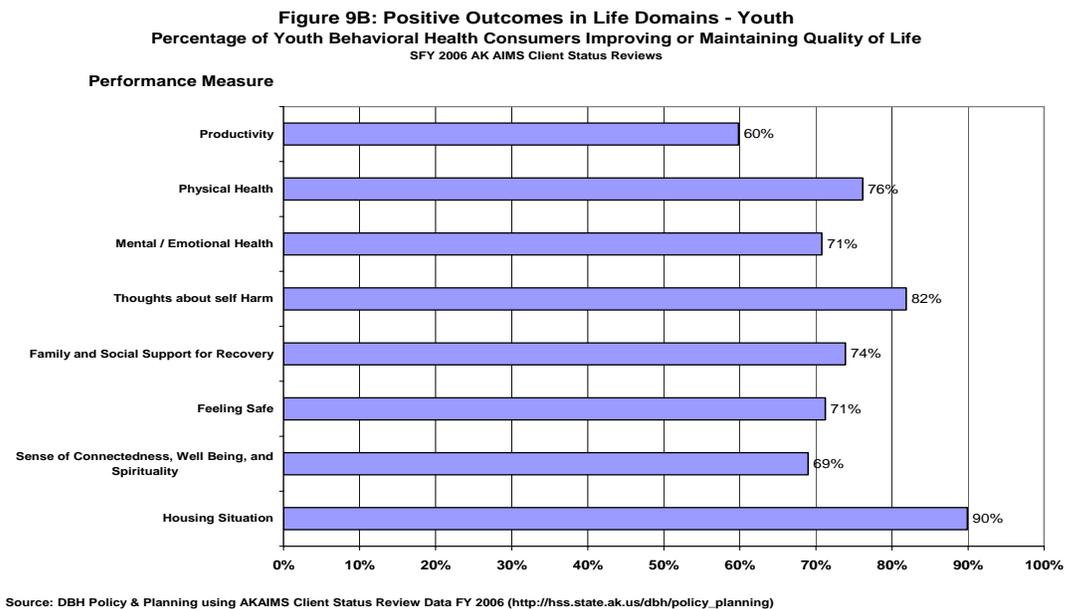


Figure 9B: Positive Outcomes in Life Domains – Youth (Percentage of Youth Behavioral Health Consumers Improving or Maintaining Quality of Life)



*Youth connectedness at levels of family, school, and community - Youth Risk Behavior Survey 2003 Report*²²

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

The 2003 Youth Risk Behavior Survey²² 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.

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

On any given night in Alaska, there are an estimated 3,500 homeless Alaskans. Of these, 35 percent suffer from chronic substance abuse problems, 21 percent are severely mentally ill, 19 percent have a dual diagnosis, and 36 percent live with a disability.³¹ At least 3000 children were homeless or inadequately housed during the 2005-2006 school year.³² These children are more likely to experience conditions of anxiety, withdrawal, depression, hunger, asthma, ear infections, stomach problems and speech problems than their peers.

Homelessness results from a complex set of circumstances that require people to choose between food, shelter, and other basic needs. Contributing factors include:

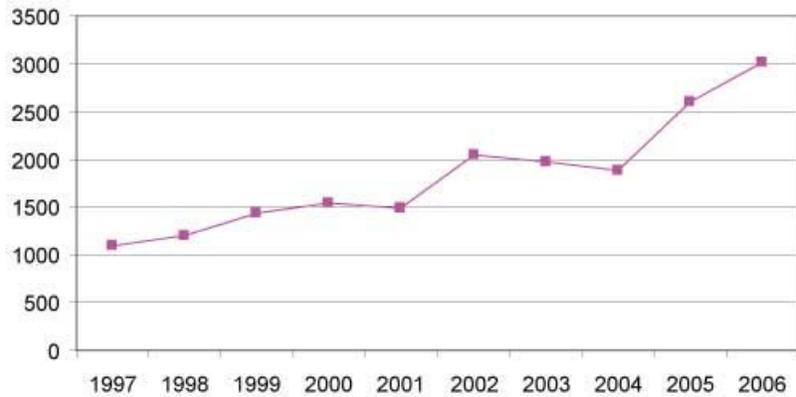
- **Inadequate income.** A 2001 study found 57% of Alaska households could not afford a median-priced home and 46% could not afford the average rent.³³ In Anchorage, a person needs to earn \$18.12 per hour to afford a modest two-bedroom apartment at the average fair market rent of \$942.³⁴ (For more information about rent-wage disparities in Alaska, please see Table E-1.)
- **Inadequate supply of affordable housing.** The private housing market alone cannot supply enough affordable housing because of high land prices and other costs. The waiting list in Alaska for publicly financed housing is over 3,000 households.³⁵

- **Catastrophic events and destabilizing forces.** A sudden economic downturn caused by illness, injury, divorce or job loss may push people into homelessness. Mental illness and addiction disorders are also destabilizing forces that can cause homelessness.

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

Figure 10 — Estimated number of homeless Alaskans: Alaska Housing Finance Corporation Statewide Winter Homeless Survey Reports

Estimated Number of Homeless Alaskans: Alaska Housing Finance Corporation Statewide Winter Homeless Survey Reports



Source: Alaska Housing Finance Corporation Homeless Service Providers Survey Reports
Data reflects total homeless numbers reported by agencies, with duplicates removed

Figure 10 shows that the estimated number of homeless Alaskans doubled between 2001 and 2006. The AHFC survey is completed semiannually on a predetermined day by providers of services for homeless people. Although the survey has many limitations, including low survey return rates, it does provide some idea of the number of homeless Alaskans and their characteristics.

Section 8 Public Housing

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

Homeless Bed Inventory

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

Supportive Housing

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

Assisted Living

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

Number of individuals discharged to homeless situations from Alaskan institutions: Alaska Psychiatric Institute (API)

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

Alaska Department of Corrections

A 2005 Department of Corrections Homeless Offender survey found that 35% of offenders did not know where they would live upon release or planned to live in a shelter or on the street³²

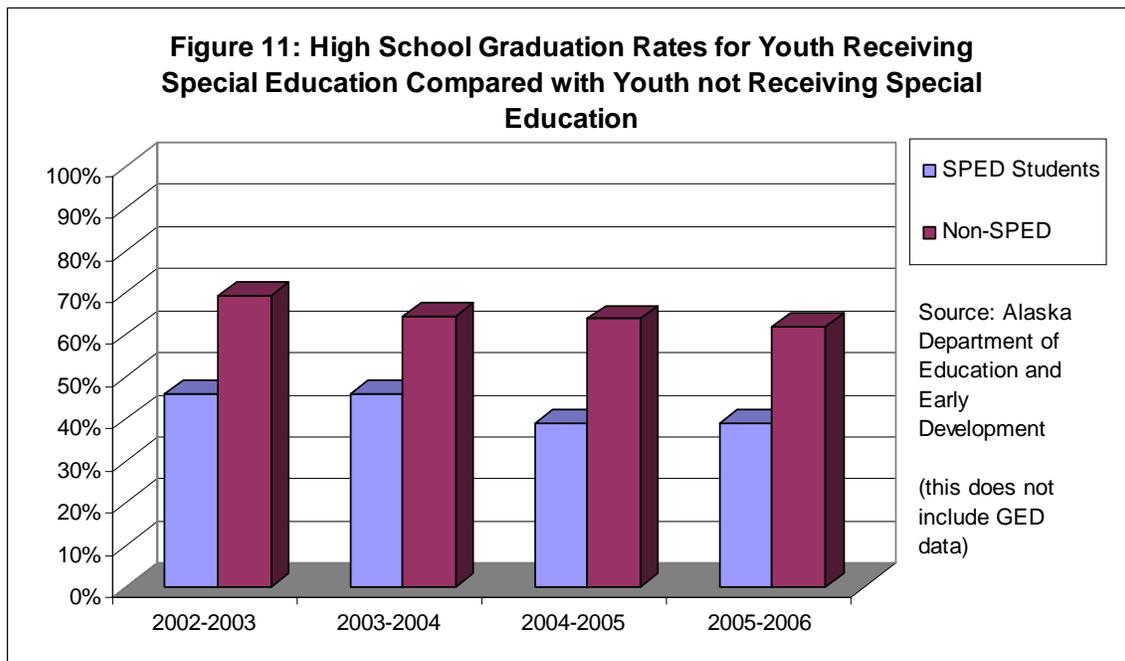
Dignity Goal #3: Assist Trust beneficiaries to receive the guidance and support needed to reach their educational goals.

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

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

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

Figure 11 shows the rate of students who graduated from Alaska’s public high schools with a regular diploma. Between 2002 and 2006 there was a slight decline in graduation rates among all students. During that time the graduation rates for Alaskans who received special education services were 18 to 23 percent lower than the rates for those who did not receive special education services.



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

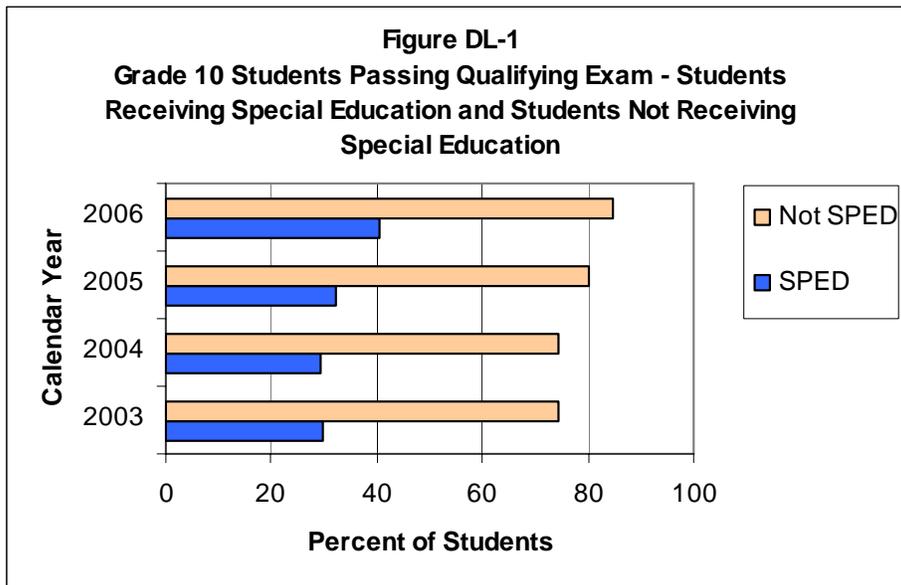
The data used to generate the graduation rate is the same for all students, whether or not they are on an Individual Education Plan. The actual yearly graduation rate is computed by determining the total number of graduates divided by the sum of the continuing 12th

grade students plus the total of yearly “drop-outs” for each of the four preceding years (i.e., a cohort model).

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

Figure DL-1 - Grade 10 Students Passing Qualifying Exams – Students Receiving Special Education Services and Students Not Receiving Special Education Services

Figure DL-1 shows the percentage of 10th Grade students enrolled in special education who scored above proficiency in reading, writing, and math on the High School Graduate Qualifying Exam, as compared to the students not receiving special education who also scored above proficiency. Overall, more students passed the exams in 2006 than in 2005. The rate of passage for those receiving special education is consistently less than half the rate for those not receiving special education. These percentages are statewide and include only the students who participated in the exams.



Economic Security

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

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

Figure 12 — SSI/APA Payment Compared to Alaska Poverty Level

The Supplemental Security Income (SSI)/Adult Public Assistance (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 \$985 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.

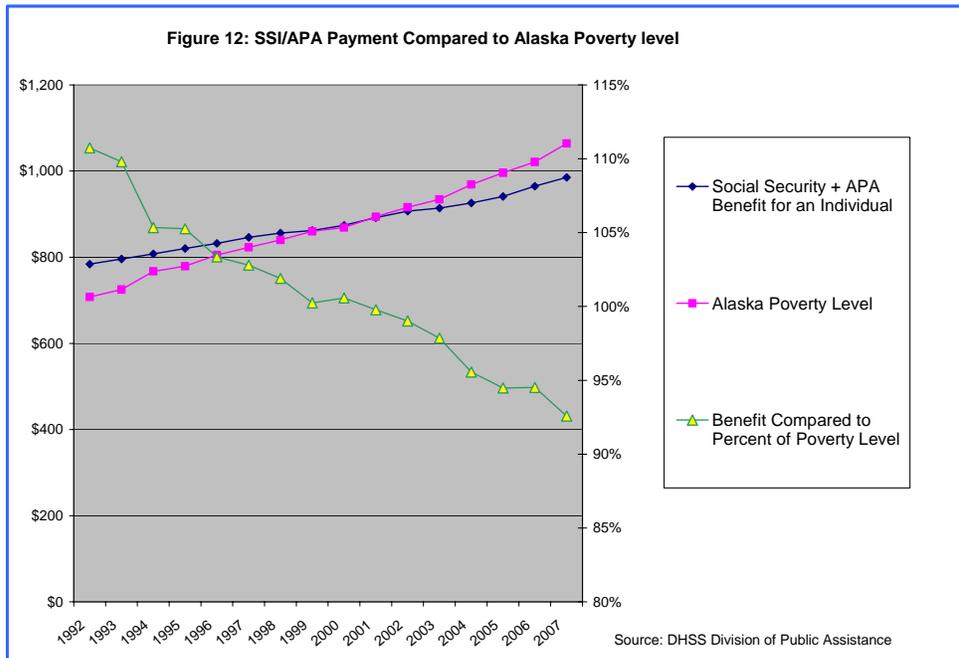


Figure 13 — Alaska Population 18 and Over by Income Level and Disability Status, 2005-2006

Behavioral Risk Factor Surveillance Survey data from 2005 and 2006 show that Alaskans experiencing a disability (i.e., limited in any way in any activities because of physical, mental or emotional problems) have a significantly lower annual income than those not experiencing a disability.

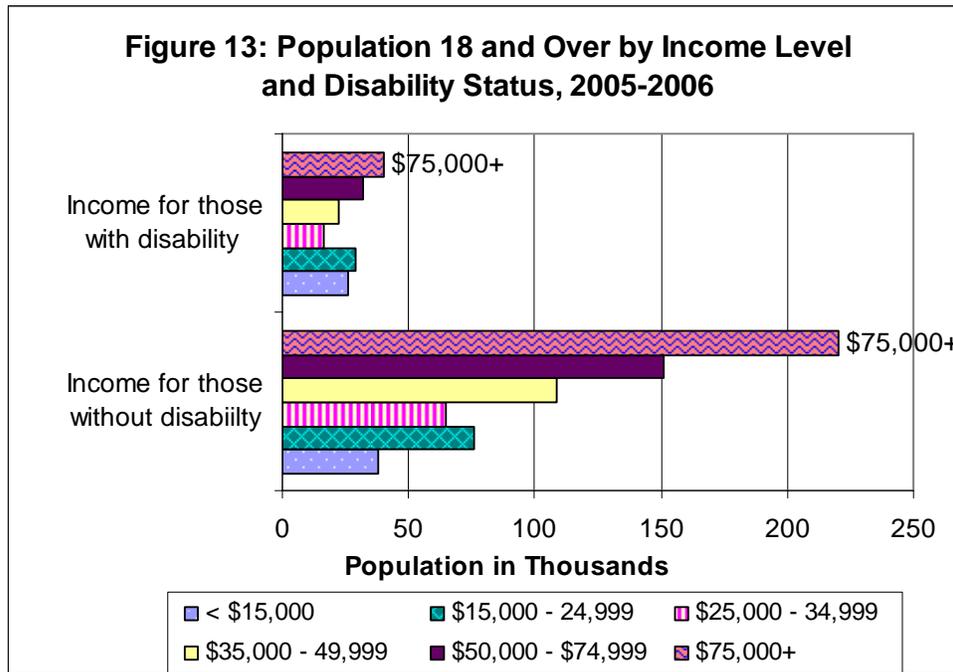
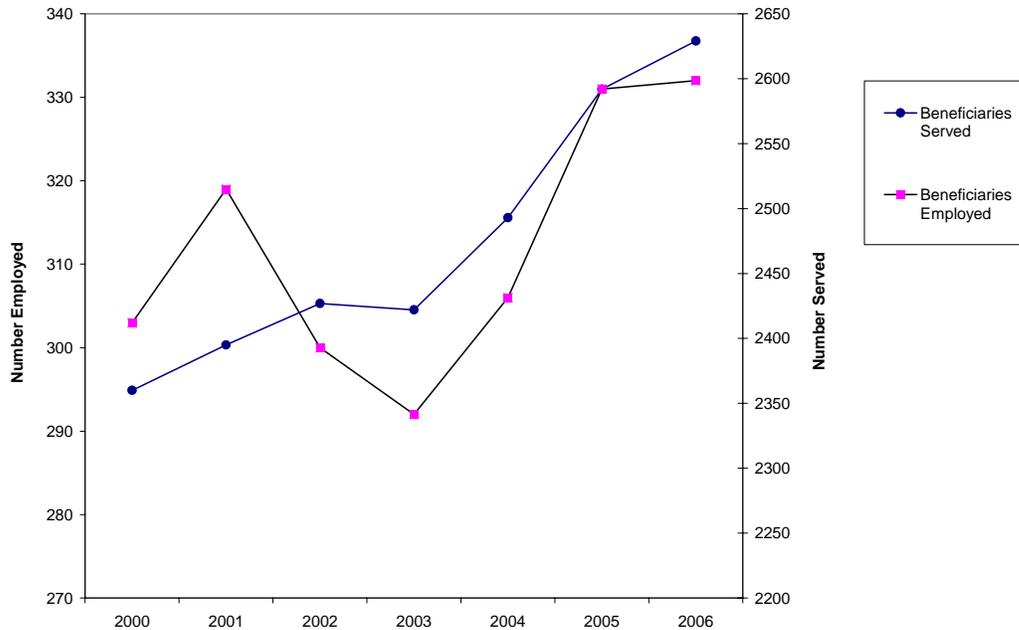


Figure 14 — Number of Trust Beneficiaries Receiving Support through Division of Vocational Rehabilitation versus Number Employed

The Division of Vocational Rehabilitation (DVR) assists individuals with a disability to obtain and maintain employment. With the proper services and supports, such as education, on-the-job training, job search, and placement services, people with disabilities can be employed. Of the total clients served by DVR in 2006, 68 percent were Trust beneficiaries. Trust beneficiaries comprised 61 percent of the total clients receiving training, and 63 percent of the total becoming employed.

Figure 14 shows that over the last six years, the number of Trust beneficiaries served by DVR has steadily grown by over 11 percent and the number who became employed grew 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.

Figure 14
Number of Trust Beneficiaries Receiving Support through
Division of Vocational Rehabilitation vs. Number Employed



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

Employment initiatives of DVR with a focus on Trust beneficiaries include the Customized Employment Grant (CEG), supported employment services, 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. Supported employment is a service delivery system within the vocational rehabilitation program to provide employment opportunities to individuals who require intensive services to gain employment and extended services to maintain employment.

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

Figure ES-1 shows that approximately 320 MR/DD waiver recipients have received supported employment services annually for the last five years. “Supported employment” is paid employment for persons with developmental disabilities for whom competitive employment at or above the minimum wage is unlikely and who, because of their disabilities, need intensive ongoing support, including supervision and training, to perform in a work setting. Medicaid covers the costs of supported employment for people with developmental disabilities, allowing participants to contribute to the community and to their own sense of self-esteem through work.

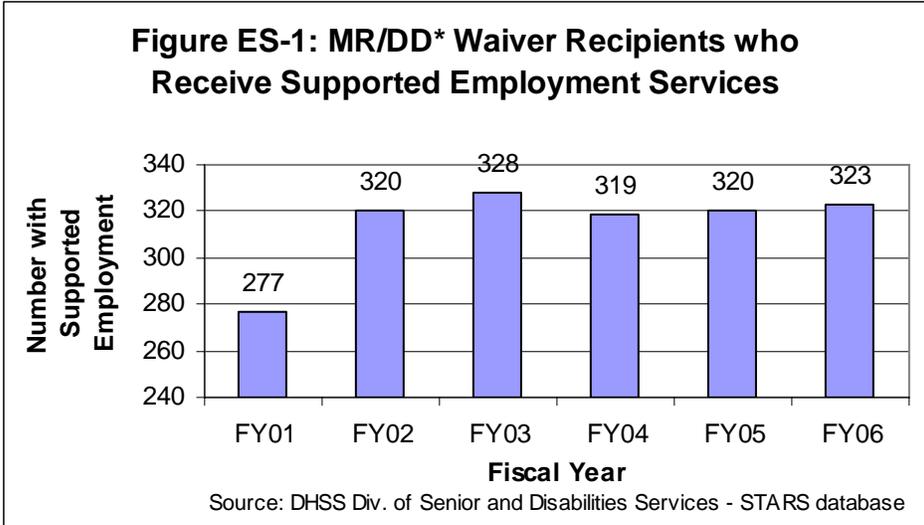
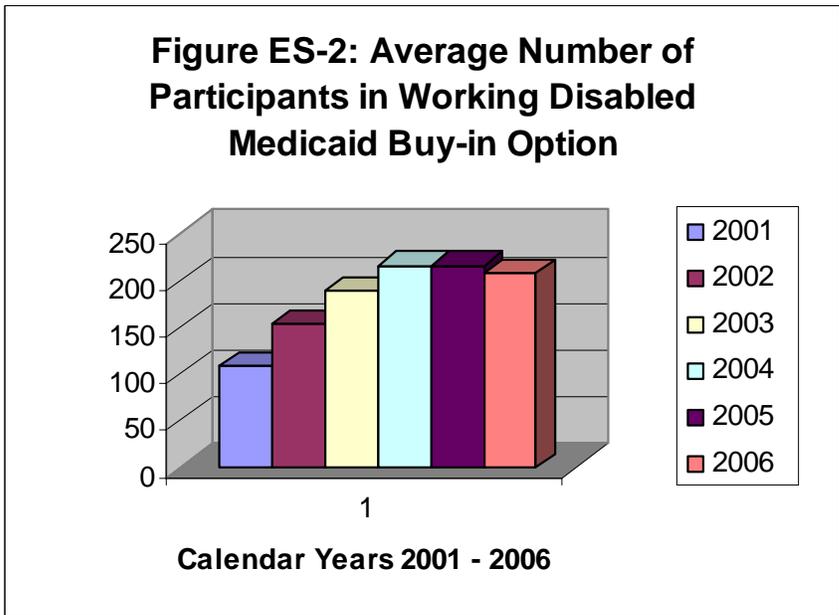


Figure ES-2 - Average Number of Participants in the Medicaid Buy-in Option

The Working Disabled Medicaid Buy-in is a category of Medicaid intended to encourage an individual with a disability to work (if they are able) by giving or extending their access to health coverage. Alaska was the first state to pass legislation that provides for this program and participation has doubled since 2001. To participate in the buy-in program, family income cannot exceed 250 percent of federal poverty guidelines for Alaska, and the individual’s monthly unearned income must be less than \$1156 (\$1390, if married) and countable assets of less than \$2000 (\$3000, if married).



Source: AK DHSS Div. of Public Assistance Eligibility Information System

Affordability of Housing

Many Alaskan families cannot afford adequate housing. A minimum wage worker in Alaska earns \$7.15 per hour. The average Fair Market Rent (FMR) for a two-bedroom apartment in Alaska is \$931. For this level of rent and utilities to be considered affordable, a minimum wage earner must work 100 hours per week, 52 weeks per year. Or, a household must include 2.5 minimum wage earner(s) working 40 hours per week year-round. A housing unit is considered affordable if it costs no more than 30 percent of one's income.

The following chart shows how much money a person in each Alaska census area would need to earn in order for them to be spending only the recommended 30 percent of their income on a typical two-bedroom rental. For instance, a person renting a two-bedroom apartment in Mat-Su would need to earn \$15.33 per hour working fulltime. But if they were only able to earn minimum wage, they would need to work 86 hours per week.

An Alaskan household must earn \$3,103 monthly or \$37,235 annually to afford the average unit. This translates into an hourly wage of \$17.90, based on a 40-hour work week, 52 weeks per year.

For more information about homelessness, please see the Living with Dignity section

TABLE ES-1 Alaska Rent-Wage Disparities					
Community	Affordable Rent*	SSI/APA Affordable Rent	2-BR FMR	Wage Needed to Afford 2-BR FMR	Hrs pr wk @ Min Wage**
			Fair Market Rent	Per Hour	
Anchorage	\$577	\$290	\$942	\$18.12	101
Barrow	\$588	\$290	\$1,104	\$21.23	119
Bethel	\$339	\$290	\$1,213	\$23.33	131
Dillingham	\$420	\$290	\$1,004	\$19.31	108
Fairbanks	\$526	\$290	\$859	\$16.52	92
Juneau	\$652	\$290	\$1,096	\$21.08	118
Kenai	\$499	\$290	\$732	\$14.08	79
Ketchikan	\$545	\$290	\$962	\$18.50	103
Kodiak	\$547	\$290	\$1,034	\$19.88	111
Mat-Su	\$528	\$290	\$797	\$15.33	86
Nome	\$407	\$290	\$1,030	\$19.81	111
Sitka	\$578	\$290	\$920	\$17.69	99
Unalaska	\$458	\$290	\$1,004	\$19.31	108
Valdez	\$559	\$290	\$907	\$17.44	98

Source: National Low Income Housing Coalition www.nlihc.org "Out of Reach" 2006 report

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

** Minimum wage of \$7.15/hr, effective 1/1/03

FMR-Fair Market Rent as issued by HUD 10/1/2006

III. Current Services and Service Gaps Analysis

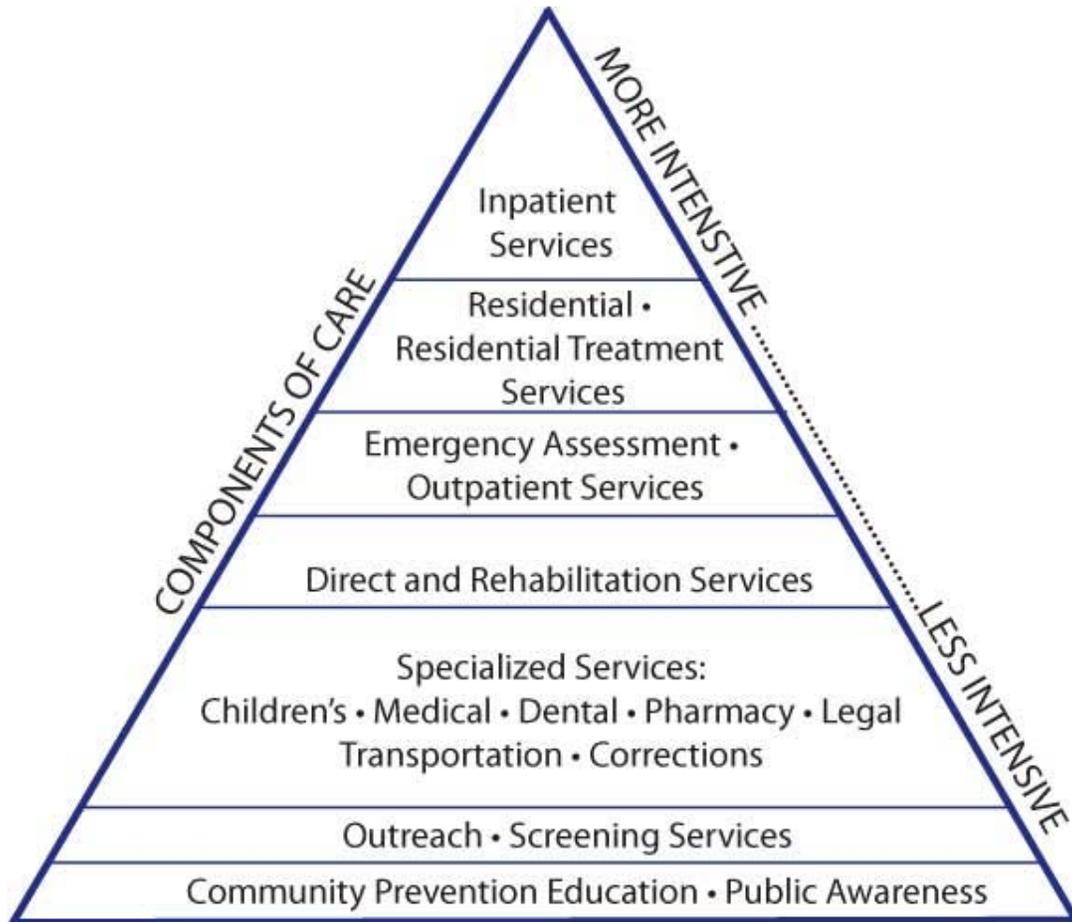
Services for Alaskans experiencing developmental disabilities, alcoholism or other drug addictions, mental or emotional illnesses, and Alzheimer’s disease or other dementias were originally shaped and frequently compartmentalized by federal funding availability and federal program requirements. Advocates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

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, which reach large audiences, are listed at the bottom of the diagram. Services in the middle of the triangle are home and community-based and are used by people requiring a less intensive level of care.

Although economies of scale restrict some services to urban areas, the Plan’s vision is that appropriate services would be available when needed across the state. The components of care listed are only those that serve three or more beneficiary groups. These are the same services listed in the Matrix on the following page.

Figure 15
Components of Care for Three or More Beneficiary Groups



Current Services

Table 2 shows the geographic availability of services that are needed by three or more Trust beneficiary groups.

Table 2— Matrix of Current CIMHP Services

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

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

Service Gaps Analysis

The matrix in Table 2 represents a first effort to analyze those similar services provided by separate service delivery systems to different Trust beneficiary groups. Planning staff (DHSS, The Trust, AMHB, ABADA, GCDSE, ACoA, and the Department of Corrections) developed this matrix by comparing service definitions used by different programs and coming to agreement about common definitional elements and suitable aggregate definitions. Next, based on the common definitions, the group assessed service availability using the Alaska Mental Health Board's Level of Community template. This

assessment was based on data and documents produced by the agencies represented by the planning staff.

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

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

Some service delivery programs, notably those for people with Alzheimer's disease or similar dementia and for people with developmental disabilities, try to meet each person's particular needs in their own homes. Ideally, this would mean that all services could be made available at each level of community. However, the reality is that resources frequently limit such delivery. Often, providers may not be available in a community, but more commonly, resources do not meet current need. For example, about 1,006 people with developmental disabilities were waiting for services at the end of fiscal year 2006.⁴⁰

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

Continuum of Care Matrices for Trust Beneficiary Groups

Definitions for Levels of Community

LEVELS OF COMMUNITY*					
Characteristics	Level I: Frontier/Village	Level II: Sub-Regional Center or Town	Level III: Regional Center or Small City	Level IV: Urban Center	Level V: Metropolitan Area
Government	Community or city council, Native Council, incorporated city or unincorporated community.	Incorporated city, may have health powers and may provide health and social services.	Incorporated city or unified municipality, may have health powers and may provide health and social services.	Incorporated, home rule city or unified municipality; may have health powers and may provide health and social services.	Incorporated, home rule city, or unified municipality; may have health powers and may provide health and social services.
Population	25+ in immediate community.	500+ in immediate community; a sub-regional population of at least 1,500.	2,000+ in immediate community, providing services to a regional population of at least 5,000	25,000+ in immediate community providing services to a larger regional or statewide population	200,000+ in immediate community.
Economy	Subsistence, government services (e.g. school)	A developing private sector, some government services; provides some service to surrounding areas.	Regional trade and service center, mixed economy with multiple private and government employers.	Major trade and service center, broad based multi-sector economy.	Principal trade and service center; broad based, multi-sector economy.

Health & Social Services	Community Health Aide, paraprofessional and itinerant services.	Health and social services may be provided by both the private and public sector, community clinic and mid-level provider or MD.	Health care and social service agencies, including both private and government programs; community hospital and physicians.	Multiple providers of health care and other services including both private and government programs; health care specialists; hospitals with full continuum of care.	Level IV plus highly specialized medical and rehabilitation services; specialized hospitals and consulting services.
Access	Usually, more than 60 minutes by year-round ground transportation from a Level II or III community; limited air and/or marine highway access to Level II or III community.	Usually less than 60 minutes by year-round ground transportation from a Level III community; marine highway or daily air access to closest Level III community; airline service to Level I communities in the area.	Daily air service to closest Level IV or V community; airline service to Level I and II communities in the region; road or marine highway access all year.	Daily airline service to Level II, III, IV, and V communities; road or marine highway access all year.	Daily airline service to Level II-IV communities; road or marine highway access all year.
Communities	Too numerous to list, includes Anvik, Eagle, Houston, Ruby, Hydaburg, Wales, Skagway, etc...	Aniak, Craig, Delta Junction, Tok, Emmonak, Fort Yukon, Galena, Haines, Hoonah, Hooper Bay, King Cove, King Salmon/Naknek, Nenana, McGrath, Metlakatla, Mt Village, St. Mary's, Sand Point, Togiak, Unalaska, Unalakleet, Glennallen/ Copper Center	Barrow, Bethel, Dillingham, Homer, Kenai/Soldotna, Ketchikan, Kodiak, Kotzebue, Nome, Palmer/Wasilla, Sitka, Cordova, Petersburg, Wrangell, Valdez, Seward	Fairbanks, Juneau	Anchorage

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

***Continuum of Care Matrix for Alaskans with Behavioral Health Disorders
(Mental Illness, Alcoholism, Drug Addictions)***

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

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

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

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

Detoxification Services	g. Detoxification i. social detox ii. outpatient detox iii. medical detox General Availability? None	g. Detoxification i. social detox ii. outpatient detox iii. medical detox General Availability? Very limited	g. Detoxification i. social detox ii. outpatient detox iii. medical detox General Availability? Very Limited	g. Detoxification i. social detox ii. outpatient detox iii. medical detox General Availability? Limited	g. Detoxification i. social detox ii. outpatient detox iii. medical detox General Availability? Limited

III. Residential Services

a. Children Services	a. Day Treatment b. Foster Homes c. Therapeutic Group Homes d. Emergency Stabilization & Assessment e. Residential Treatment f. Secure Locked Residential Care	a. Day Treatment b. Foster Homes c. Therapeutic Group Homes d. Emergency Stabilization & Assessment e. Residential Treatment f. Secure Locked Residential Care	a. Day Treatment b. Foster Homes c. Therapeutic Group Homes d. Emergency Stabilization & Assessment e. Residential Treatment f. Secure Locked Residential Care	a. Day Treatment b. Foster Homes c. Therapeutic Group Homes d. Emergency Stabilization & Assessment e. Residential Treatment f. Secure Locked Residential Care	a. Day Treatment b. Foster Homes c. Therapeutic Group Homes d. Emergency Stabilization & Assessment e. Residential Treatment f. Secure Locked Residential Care
----------------------	---	---	---	---	---

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

Definitions for Continuum of Care Matrix for Alaskans with behavioral health disorders (mental illness, alcoholism, drug addictions)

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

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

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

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

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

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

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

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

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

Note: Screening differs from assessment in the following ways:

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

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

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

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

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

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

Continuum of Care Matrix for Alaskans with Developmental Disabilities

LEVELS OF COMMUNITY*					
Characteristics	Level I: Frontier/Village	Level II: Sub-Regional Center or Town	Level III: Regional Center or Small City	Level IV: Urban Center	Level V: Metropolitan Area
I. Information and Referral	Telephonic assistance in completing eligibility applications information about and referral to services described below	Telephonic assistance in completing eligibility applications information about and referral to services described below	assistance in completing eligibility applications information about and referral to services described below	assistance in completing eligibility applications information about and referral to services described below	assistance in completing eligibility applications information about and referral to services described below
II. Direct Services	Case Management/Care Coordination Respite Specialized Medical Equipment Environmental Modifications	Case Management/Care Coordination Respite Specialized Medical Equipment Environmental Modifications	Case Management/Care Coordination Respite Specialized Medical Equipment Environmental Modifications	Case Management/Care Coordination Respite Specialized Medical Equipment Environmental Modifications	Case Management/Care Coordination Respite Specialized Medical Equipment Environmental Modifications

	Day Habilitation	Day Habilitation	Day Habilitation	Day Habilitation	Day Habilitation
	Supported Employment / Subsistence Activities	Supported Employment / Subsistence Activities	Supported Employment / Subsistence Activities	Supported Employment	Supported Employment
	Vocational Rehabilitation	Vocational Rehabilitation	Vocational Rehabilitation	Vocational Rehabilitation	Vocational Rehabilitation
	Transportation	Transportation	Transportation	Transportation	Transportation
	Educational services	Educational services	Coordinated transportation system	Coordinated transportation system	Coordinated transportation system
	Infant Learning	Infant Learning	Educational services	Educational services	Educational services
	Preschool	Preschool	Infant Learning	Infant Learning	Infant Learning
	K-12	K-12	Preschool	Preschool	Preschool
	Chore Services	Chore Services	K-12	K-12	K-12
	Intensive Active Treatment	Intensive Active Treatment	Chore Services	Chore Services	Chore Services
	Crisis Response	Crisis Response	Intensive Active Treatment	Intensive Active Treatment	Intensive Active Treatment
	Legal Services	Legal Services	Intensive Active Treatment	Crisis Response	Crisis Response
			Crisis Response		

			Medical Dental Pharmaceutical Recreation Legal Services	Medical Dental Pharmaceutical Recreation Legal Services	Medical Dental Pharmaceutical Recreation Legal Services
III. Residential Services	In-home Support Shared Care Family Habilitation Supported Living	In-home Support Shared Care Family Habilitation Supported Living	In-home Support Shared Care Family Habilitation Supported Living Group Home	In-home Support Shared Care Family Habilitation Supported Living Group Home	In-home Support Shared Care Family Habilitation Supported Living Group Home

Definitions for Continuum of Care Matrix for Alaskans with Developmental Disabilities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dental services include preventive and restorative care.

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

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

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

III. Residential Services

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

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

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

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

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

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

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

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

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

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

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

Outreach, Education, Information and Referral:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

One aim of *Moving Forward* and its related initiatives is to provide decision makers with appropriate data regarding issues that impact Trust beneficiaries. To the extent data is available or can be developed through better data collection and analysis, progress is measured for these efforts. A key strategy has been to work with partners on projects. Successful partnerships expand and enhance the resources of the Department of Health and Social Services and The Trust and further the goal of shared and integrated approaches to bettering the lives of Trust beneficiaries. Initiative efforts are largely directed toward system change. Following are examples of current initiatives, projects and activities that, in addition to the extensive day-to-day activities of the Department and The Trust, work to create system change and target improved services for Trust beneficiaries.

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, and 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

The federal Substance Abuse and Mental Health Services Administration defines prevention as:

“A proactive process that empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors.”

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. Prevention includes not only interventions that occur before a problem occurs, but also interventions that prevent behaviors from becoming more severe, relapse and secondary conditions. Early intervention can often keep children’s emotional and developmental disorders from becoming more severe.

Community-based Suicide Prevention and Rural Human Services

In 2004 (the most current year with official national data), Alaska had the highest suicide rate in the United States. Suicide was the 11th leading cause of death in the United States for all ages and third among the young. During that same period in Alaska, suicide was the fifth leading cause of death for all ages and second for those under age 50. The distribution of suicide by ethnicity shows a greater proportion of Alaska Natives taking their own life than the Caucasian or “other” racial categories. Although Alaska Natives comprise 16% of the population, they accounted for 39% of the suicides. And, the majority of suicides are occurring among our young people ages 20-29 years of age.^{20, 41}

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 2007, over 25 communities received a comprehensive behavioral health prevention grant, with a focus on suicide prevention. 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 holistic perspective. The goal is to integrate with other programming to reduce drug and alcohol use, increase connectedness and resiliency and to better recognize the signs of suicide.

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, 15 rural agencies receive funding to train and employ counselors in more than 100 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 requested and received an increment of \$550,000 in fiscal year 2007 to add ten additional human service counselors statewide. With this additional funding, the Division of Behavioral Health was able to increase funding to some existing programs to serve more villages, and add two new programs through Copper River Native Association and Cook Inlet Tribal Council, Inc.

Comprehensive Fetal Alcohol Syndrome Project

Fetal alcohol spectrum disorders (FASD) are one of the most common causes of mental retardation, and the only cause that is entirely preventable. FASD refers to all those conditions caused by prenatal exposure to alcohol, including fetal alcohol syndrome (FAS). FAS is a medical diagnosis defined by the presence of specific growth and nervous system abnormalities and other factors. Receiving an early, comprehensive diagnosis that looks at growth deficiencies, facial dysmorphology, central nervous system

functionality and maternal history of alcohol abuse provides a complete picture of the level of disability, the impaired functionality and the overall interventions and accommodations that will benefit the individual. This is the first and most important intervention—from a comprehensive diagnosis, a clear case plan can be implemented and service delivery needs can be better coordinated.

FASD is found 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.

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

- In fiscal year 2007, the Division of Behavioral Health continued funding for 20 community-based grants awarded to local nonprofit organizations across Alaska to provide services related to individuals, families and communities impacted by FASD. These grants focus on FASD prevention, training and educational services, improved services for individuals affected by FASD, diagnostic services, and treatment services for women at risk for giving birth to a child affected by prenatal exposure to alcohol.
- Since March of 1999, approximately 1,000 diagnoses have been completed by 13 Diagnostic Teams from Fairbanks to Ketchikan, providing earlier and more comprehensive assessments for those children, youth and adults who were pre-natally exposed to alcohol, causing permanent learning, behavioral, and neuro-developmental disabilities. Through early and comprehensive diagnosis, children and youth have more opportunities for services that will increase their quality of life and their ability to be healthy, productive adults.
- Two curricula were developed to give Alaska service providers (including educators, mental health clinicians, health care providers, and correctional officers) current, consistent and scientifically-based information about the affects of alcohol on a developing fetus, the impact of alcohol on the central nervous system, and the resulting disabilities. Over 50 Alaskans, representing Alaska geographically, ethnically and across various disciplines, have been trained and certified to provide training with these two curricula.
- In December 2006 the DHSS received a five-year Medicaid Waiver Demonstration Project to improve services to young Alaskans ages 14-21 with co-occurring diagnoses of SED and a FASD. This Demonstration Project will allow

Alaska to begin developing “practice to research” service delivery approaches that will improve the long-term outcomes for youth with these diagnoses.

Medicaid Disease Management Program

Based on input from the National Governors Association Chronic Disease Policy Academy, a steering committee of top Alaska Department of Health and Social Services policy makers has been convened to direct the development of a Medicaid Disease Management (DM) Program. The DM program is a system aimed at coordinated health care interventions and communications for populations with chronic conditions. DM supports the provider-patient relationship and plan of care and emphasizes prevention utilizing evidence-based practice guidelines and patient empowerment strategies. A critical component of DM is evaluating strategies designed to optimize both clinical and economic outcomes.

The steering committee has worked with DHSS staff to analyze Medicaid claims data, identify target populations, and begin designing a DM program. The committee will develop a request for inclusion in the Department’s FY 2009 budget. Within the next fiscal year, the steering committee will seek approval from the Center for Medicare and Medicaid Services for their program, and will develop a communications plan for engaging Medicaid clients and providers, develop an evaluation plan, and issue a Request for Proposals to secure a DM vendor.

The Strategic Prevention Framework

The Division of Behavioral Health, Prevention & Early Intervention Services has begun using Strategic Planning Framework from the SAMHSA Center for Substance Abuse Prevention. The purpose of the framework is to build the capacity of states, Native organizations, and communities to decrease substance use and abuse, promote mental health, and reduce disability, co-morbidity and relapse related to mental and substance use conditions.

The Strategic Prevention Framework (SPF) utilizes the following five-step process:

Assessment: *Profile population needs, resources, and readiness to address the problems and gaps in service delivery.* Communities must accurately assess their substance abuse-related problems using epidemiological data provided by the State as well as other regional and local data.

Capacity: *Mobilize and/or build capacity to address needs.* Engagement of key stakeholders at the State and community levels is critical to plan and implement successful prevention activities that will be sustained over time.

Planning: *Develop a comprehensive Strategic Plan.* Communities must develop a strategic plan that articulates not only a vision for the prevention activities, but

also strategies for organizing and implementing prevention efforts in their community

Implementation: *Implement evidence-based prevention policies, programs and policies and infrastructure development activities.* Similarly, local stakeholders will use the findings of their needs assessments to guide selection and implementation of policies, programs and practices proven to be effective in research settings and communities.

Evaluation: *Monitor process, evaluate effectiveness, sustain effective programs/activities, and improve or replace those that fail.* Ongoing monitoring and evaluation are essential to determine if the outcomes desired are achieved and to assess program effectiveness and service delivery quality.

Integration

Behavioral Health Integration Project (BHIP)

(http://hss.state.ak.us/dbh/system_redesign/service_delivery_system_headlines.htm)

The DHSS Division of Behavioral Health has been integrating the two former DHSS systems that provided community mental health and community drug and alcohol treatment into a single behavioral health system. In addition the BHIP project has worked extensively to develop co-occurring capability (services for individuals with both mental health and substance use disorders) throughout the behavioral health service system. This project, broad in scope, aims to transform the Alaska behavioral health services system. The goal of the BHIP is to develop a behavioral health services system that is welcoming, accessible, integrated, comprehensive and continuous, at a client, consumer, clinician, program and system level.

More recently, the focus of the BHIP project has been to finalize the integration of regulations for the system of care. After a significant effort to obtain input from providers and other stakeholders, the DBH is current engaged in the internal process of regulations development that will culminate in adoption of regulations to govern the Behavioral Health Service system.

Early Childhood Comprehensive Systems (ECCS) Early Childhood Mental Health Cross-Systems Workgroup

(<http://www.hss.state.ak.us/ocs/childplan/default.htm>)

Over the last year the ECCS (Early Childhood Comprehensive Systems) Early Childhood Mental Health Cross-Systems Workgroup developed recommendations to improve accessibility to appropriate, high quality mental health services for young children birth to five years of age. They are beginning the process of translating these recommendations into regulatory and policy changes.

The ECCS Workgroup is developing a viable model for mental health consultation for professionals who work with young children in Alaska. They are piloting a model over the next year which includes billing for Medicaid Administrative reimbursement. This will help build the number of Alaska's mental health practitioners who are more skilled in working with early childhood mental health issues and interventions. The ECCS Workgroup supported a two day "early childhood mental health training" for a cohort of mental health clinicians, early interventionists and child protection staff from across the state. The mental health clinicians and early interventionists will continue to participate in a "learning network" via monthly conference calls with a consultant with expertise in this area. This effort will continue and be expanded to more professionals over the coming year.

Health Care Strategies Planning Council

(<http://www.hss.state.ak.us/hspc/>)

A new Health Care Strategies Planning Council was appointed by Governor Palin to develop a statewide plan to effectively address the issues of access to, and cost and quality of, health care for Alaskans. The intent is that the council's development of a health care action plan should serve to educate all Alaskans about the myriad of public policy choices regarding health care issues and engage both governmental agencies and the private sector in finding solutions to these problems.

The council has been directed to prepare and submit to the governor and the Legislature, by January 1, 2008, a health care action plan which includes the following: (1) a description of the current health care system in Alaska; (2) an inventory and analysis of all existing private and public health care plans, reports, and initiatives in Alaska; (3) short-term and long-term statewide strategic plans designed to improve health care access, cost, and quality within the next ten years; and (4) performance measures and accountability mechanisms to provide policy makers with tools to assess the success of the strategic plans over time. In addition, the council will convene a health care conference to take public testimony on the issues of health care access, cost, and quality, and to serve as a forum to educate all Alaskans on health care issues.

The commissioner of the Department of Health and Social Services is chairing the council and the Department is providing administrative support.

Infrastructure Development

Affordable Housing Focus Area

http://www.mhtrust.org/index.cfm?fa=documents_meet-search&doctype=Focus%20Areas%20-%20Affordable%20Appropriate%20Housing

Trust beneficiaries have many unmet housing needs; therefore the Alaska Mental Health Trust Authority has identified affordable housing as a priority area for funding and advocacy. Safe, decent, affordable, accessible and appropriate housing is often the key for Trust beneficiaries in maintaining a healthy lifestyle and participating in rehabilitation

and recovery activities. The statewide shortage of affordable, safe, accessible, and appropriate housing disproportionately affects Trust beneficiaries due to the challenges associated with disabling conditions and the lack of opportunities for economic advancement. Some beneficiaries require long term supportive living situations or accommodations to meet special needs and others simply require a subsidy for a period of time to afford permanent, stable housing.

The following strategies comprise the Affordable Housing focus area's approach to increasing the number of safe, affordable housing options available to Trust beneficiaries:

- Policy advocacy for new funding resources (i.e. an affordable housing trust in Alaska, inclusion of supported housing in mainstream affordable housing, etc.)
- Adaptation of successful models and existing housing options in Alaska: increasing targeted support services for intensive needs populations, adapting successful models to support alcoholics in recovery, inclusion of special needs housing in community developments, etc.
- Increasing capital resources for supportive housing
- Increasing options for housing preservation, i.e. maintaining successfully housed Trust beneficiaries in homes as long as possible through temporary mortgage assistance, increasing options for financial literacy, etc.
- Increasing the availability of long term care supports and community based services for those beneficiaries who are at risk of institutionalization.
- Increasing the availability of technical assistance through the state's Department of Health and Social Services for development and maintenance of safe, affordable housing at the community level.

The Trust is working with several housing development groups, including Tlingit and Haida Housing Authority and Cook Inlet Housing Authority, to determine the best method for supporting beneficiaries in affordable housing. Successful projects have been supported through the Kenai Peninsula Housing Initiatives, Valley Residential Services and Anchorage Housing Initiatives.

The Bridge Home program is an example of an early success for The Trust's Affordable Housing focus area. This "housing first" program provides housing subsidies and supports to individuals with severe mental illness who have a history of repeated episodes of institutionalization. Modeled on successful supportive housing projects in Hawaii, Connecticut and New York, the Bridge Home Program assists clients to stabilize in their own homes and eventually become eligible for HUD Section 8 vouchers and a semi-independent lifestyle. As a result of the Bridge Home program, clients have decreased their rates of incarceration. Of the 31 Bridge Home clients with a history of incarceration during the pre-program period, 29 (94%) decreased their rates of incarceration and 2 (6%) increased. The clients who had no history of arrests during the pre-program period were also not arrested during the program.

Alaska Council on Homelessness (<http://www.ahfc.state.ak.us/homeless/homeless.cfm>)

The Alaska Council on the Homeless was initially established in April 2004 to develop a statewide action plan addressing homelessness in Alaska. The plan, *Keeping Alaskans Out of the Cold*, was completed and submitted in October 2005. Included in its recommendations was the appointment of a steering committee to assist the governor and the legislature to develop an affordable housing trust. The steering committee completed its work in 2006 and the current council has recommended that the Alaska Housing Trust Fund be created within the Alaska Housing Finance Corporation (AHFC) under statute.

The Alaska Council on Homelessness consists of members appointed by the governor. The council will assist with development of the Alaska Housing Trust Fund; annually evaluate housing needs and priorities to establish a statewide homeless action plan and recommend to the AHFC Board of Directors the allocation of money in the fund to implement the plan; monitor and review implementation of the statewide homeless action plan; and annually report to the governor on how state resources, in addition to the fund, may be used to end homelessness.

Alaska Housing Trust

<http://www.akhousingtrust.org/index.cfm?section=about&page=overview>

Under its Affordable Housing focus area, the Alaska Mental Health Trust Authority has been engaged in advocating and planning an Alaska Housing Trust. In May and June 2007, major funding partners, The Trust and Rasmuson Foundation, granted \$1 million each to pilot the project. The Municipality of Anchorage also plans to allocate portions of its federal grant resources to leverage these funds in the pilot program. The housing focus area workgroup will play a major role in developing supported housing projects for this trial run.

Alaska Policy Academy on Homelessness

(<http://www.hrsa.gov/homeless/State/ak.htm>)

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: (1) promoting locally delivered collaborative family-centered services; (2) increasing collaboration and coordination to end homelessness; (3) increasing safe and affordable housing stock; and (4) ensuring integrated planning for homelessness in Alaska.

Bring the Kids Home

(http://www.mhtrust.org/index.cfm?fa=documents_meet-search&doctype=Focus%20Areas%20-%20Bring%20the%20Kids%20Home)

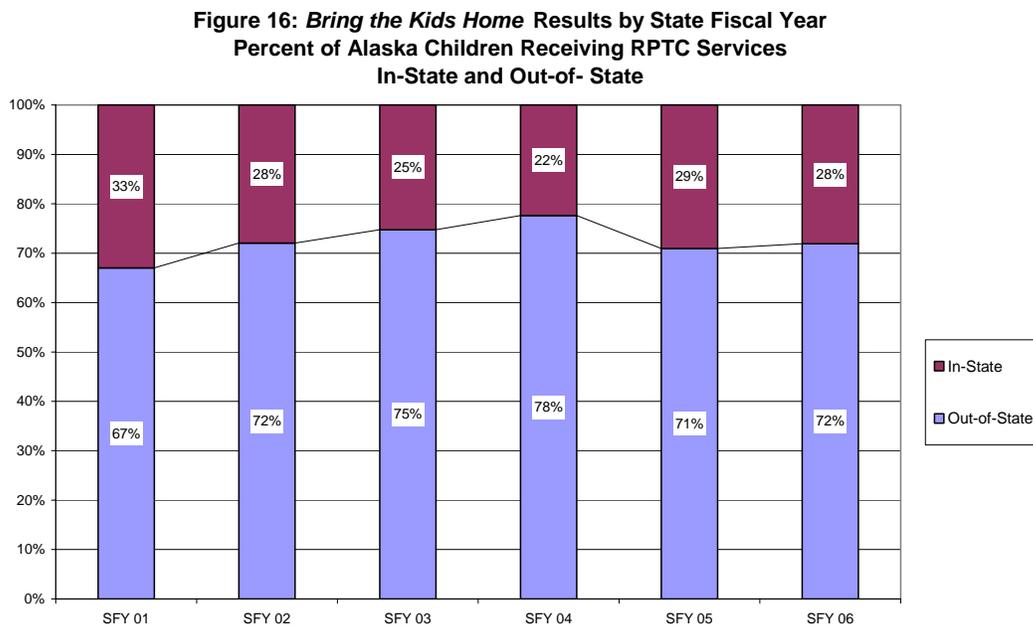
During the period of 1998 – 2004, the children’s behavioral health system in Alaska became increasingly reliant on institutional care - Residential Psychiatric Treatment

Center (RPTC) care for treatment of severely emotionally disturbed youth. Out-of-state placements in RPTC care grew by nearly 800%. At any given time, approximately 350-400 children were being served in out of state placements. Alaska Native children represent 49% of the custody children sent to out of state placements and 22% of the non-custody children sent to out of state placements.

The Department of Health and Social Services, in collaboration with the Alaska Mental Health Trust Authority initiated the “Bring the Kids Home” (BTKH) Initiative in 2004, to return children being served in out-of state facilities back to in-state residential or community-based care. The initiative intends to reinvest funding now going to out-of-state care to in-state services and develops the capacity to serve children closer to home. With financial support, this initiative will focus on successfully building upon the existing infrastructure to treat youth in their community, region and state.

The scope of this project requires that four levels of the system of care must be addressed concurrently: community, regional, in-state, and out-of-state care. Further, there are issues that are applicable to the overall system of care, i.e. policy development, management of authorization, utilization, and enhanced care coordination, workforce development, funding, expansion of facilities and infrastructure, and expansion of services.

Figure 16: Bring the Kids Home Results by State Fiscal Year -Percent of Alaska Children Receiving RPTC Services In-State and Out-of- State



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

Dental Care Access

The Trust and DHSS are committed to improving access to dental care for all Trust beneficiaries. The Trust is participating with the [Alaska Dental Access Coalition](#) (ADAC) which is focusing on policy areas of workforce, finance and reimbursement, service availability and access and prevention of oral diseases. The coalition serves in an advisory capacity to the DHSS Oral Health Program supported by a grant from CDC.

The ADAC is a multi-agency coalition with broad support and participation on dental access issues. The ADAC is chaired jointly by The Trust and the Rasmuson Foundation, and staffed by DHSS. After successfully advocating for the new adult dental Medicaid benefit (implemented April 1, 2007), the coalition is committed to tracking the progress of the adult dental Medicaid services program and preparing to advocate for the renewal of the program in FY2009 when the enabling legislation has a “sunset” provision. Additional work is proceeding in all of the focus areas outlined in the ADAC activities.

Disability Justice – Justice for Persons with Disabilities Focus Area

Beneficiaries of the Alaska Mental Health Trust are at increased risk of involvement with the criminal justice system both as defendants and as victims. Limitations and deficiencies in the community emergency response, treatment, and support systems make criminal justice intervention the default emergency response to the conditions and resulting actions of many Trust beneficiaries. The Trust’s [Justice for Persons with Disabilities Initiative](#) began in April 2004. A collaborative group, including The Trust, advisory boards, state and local government agencies, the court system, law enforcement, consumers, advocacy groups, community behavioral health providers, and others, have developed and are implementing the following several strategies to address this issue:

- increase training for criminal justice personnel;
- sustain and expand therapeutic court models and practices;
- improve continuity of care for beneficiaries involved with the criminal justice system;
- increase capacity to meet the needs of beneficiary offenders with cognitive impairments;
- develop mechanisms to address the needs of Trust beneficiaries who are victims;
- develop community-based alternatives to incarceration for beneficiaries;
- develop a range of housing options to provide for varying needs of beneficiaries involved at different stages of criminal justice system; and
- evaluation of the initiative’s impact to improve justice for beneficiaries.

Examples of Justice for Persons with Disabilities Focus Area Projects:

Judicial and legal training. A collaborative effort among The Trust, Alaska Court System, Alaska Bar Association, and the Anchorage Bar Association to provide education and training to assist judges, lawyers, and other legal professionals understand and more effectively handle cases involving persons with mental

disabilities. A six session continuing legal education (CLE) curriculum has been developed and implemented covering a variety of topics from an overview of mental health disorders to effectively communicating with persons who experience a mental disorders.

Crisis Intervention Team (CIT) training. A 40 hour training in which law enforcement personnel are educated about mental illnesses and other disabilities, medications, suicide and crisis intervention, active listening skills, de-escalation techniques, empathy, and respect. The CIT training recognizes the need for a specialized response to those who experience mental illness and other disabilities. It is a community based partnership between consumers, law enforcement, NAMI (National Alliance on Mental Illness), and community treatment providers. All have joined together to recognize the common goals of safety, service, and understanding. Currently, CIT teams exist with the Anchorage and Fairbanks police departments.

Therapeutic court principles and models. Therapeutic court principles and models focus on appropriately diverting Trust beneficiaries with mental disabilities charged with misdemeanor offenses from incarceration and into appropriate community treatment and services, preventing further contacts with the criminal justice system. There are therapeutic mental health and drug courts operating in communities throughout the State (Anchorage, Bethel, Juneau, Ketchikan, and Palmer).

Discharge planning from corrections into the community. The Department of Corrections is working with state, federal and community partners to coordinate and develop a pilot re-entry transitional services model for Trust beneficiaries being released from correctional institutions to the community. The *APIC transitional model* (Assess, Plan, Identify, and Coordinate), cited as a best-practice in the 2004 President's *New Freedom Commission Report on Mental Health*, is being adapted to meet Alaska's needs. The goal of the APIC re-entry pilot is to connect Trust beneficiaries with services prior to release and to provide intensive supports upon their initial release, to both increase their chances of success in the community and to reduce the potential for re-incarceration. The communities targeted, but not confirmed for this pilot include: Anchorage, Palmer and Wasilla, Fairbanks, and Juneau.

Victimization. Trust beneficiaries are at increased risk because they are more vulnerable to financial, physical, and sexual victimization and exploitation. However, the number of Trust beneficiaries who are victims of crime each year is unknown because victimization of persons with disabilities too often goes unrecognized and unreported or, if reported, not pursued because of the perceived limitations or lack of credibility of the victim. The University of Alaska's Center for Human Development with funding from The Trust is gathering in-state data on these issues to define the scope and extent of the problem.

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 field and facility staff across the state. Aggression Replacement Training, proven to be effective in increasing pro-social behaviors and reducing recidivism for youthful offenders, has been implemented statewide. In addition, DJJ is partnering with the Court and other stakeholders to develop a pilot mental health court in Fairbanks. Upcoming activities include the integration of the statewide DJJ facility suicide prevention policy into a statewide policy for residential providers; and the integration of three new mental health clinician positions into DJJ core services along with ensuring DJJ clinical practices are consistent statewide and comport with existing Alaska protocols supported by the Department of Health and Social Services.

The Healthy Body, Healthy Brain Campaign

The Healthy Body, Healthy Brain Campaign is an education and public awareness effort based on recent research indicating that many cases of Alzheimer's Disease and Related Disorders (ADRD) can be prevented by a healthy lifestyle that includes physical activity, good nutrition, weight management, regular socializing, and intellectual tasks such as puzzles and games. An ADRD-preventive lifestyle has much in common with the habits already associated with avoiding other chronic diseases such as diabetes, heart disease and cancer. However, people often fear the mental losses of ADRD more than they fear a heart attack, an amputation, or a round of chemotherapy. As a motivator, the prospect of developing ADRD may be particularly effective.

This prevention and health promotion project will use evidence-based social marketing techniques to reach middle-aged and older adults (directly and through workplaces, senior centers, and other organizations with which they're connected) to maximize the awareness of the public as well as health care and social services professionals of the importance and the effectiveness of a healthy, balanced lifestyle in preventing ADRD. The Healthy Body, Healthy Brain Campaign, funded by The Trust, is to be initiated in FY 08 by the Alaska Commission on Aging and the Division of Public Health.

Performance Management System Project

(http://www.hss.state.ak.us/dbh/perform_measure/perfmeasuredefault.htm)

The DHSS Division of Behavioral Health "Performance Management System" is developing a continuous quality improvement process to guide policy and decision-

making for improving the behavioral health of Alaskans. The Performance Management System has three broad components: the service delivery system, broad population planning, and DBH management indicators.

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

These performance measures feed into a continuous quality improvement process to inform and improve the delivery of effective, high quality services. Provider organizations may use the DBH performance measures and indicators for planning and evaluating performance improvement activities; for soliciting new funding; or for reallocating resources.

Traumatic Brain Injury Project

The incidence rate of identified Traumatic Brain Injuries (TBIs) in Alaska is 28% higher than the national rate. Alaska's Traumatic Brain Injury Project is focusing on the cognitive, emotional, and behavioral manifestations of traumatic brain injury. In partnership with The Trust, the Department is developing infrastructure to provide for culturally competent treatment and rehabilitation services specific to TBI survivors who experience cognitive, emotional, and behavioral manifestations as a result of head trauma. The Alaska Screening Tool screens all admissions into the public behavioral health system for possible TBI. The project has also sponsored numerous training events to assist the behavioral health system to identify TBI, make referrals, and provide basic services to TBI survivors, and has set up a management information system to eventually track the course of those interventions. The State was also recognized in 2006 for system innovation and included in a Neurobehavioral Handbook in 2007 by the National Association of Head Injury Administrators (<http://www.nashia.org/>) for these accomplishments. Regardless of these accomplishments, the need for specialized services in Alaska remains high.

The Alaska Brain Injury Network Inc. (www.alaskabraininjury.net) serves as the TBI Advisory Board as well as an information and referral source for Alaskans with brain injuries needs. ABIN works with the Alaska Mental Health Trust Authority and the Department of Health and Social Services to recommend and implement culturally competent and statewide brain injury services.

Trust Beneficiary Projects

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 projects](#) can be very cost effective and meaningful to participants. Consumers, or the ‘end users of services’, 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 beneficiary 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.

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.

Workforce Development Focus Area

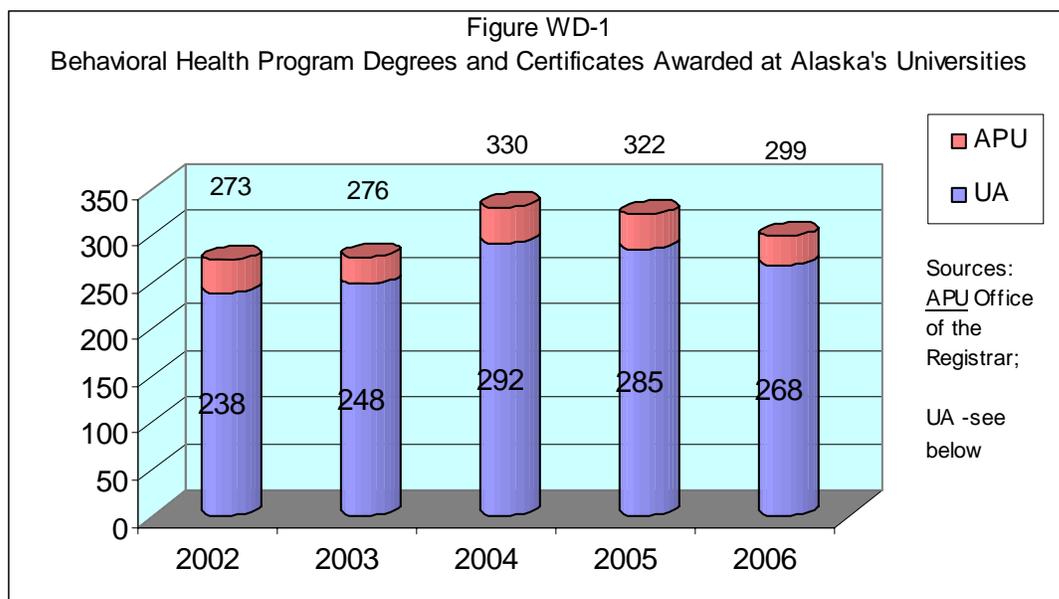
The Trust, in collaboration with the Alaska Department of Health and Social Services, other state agencies, the University of Alaska, advisory boards, service providers and Trust beneficiaries and their families, are working to develop a prioritized plan for workforce development for behavioral health and other beneficiary service provider areas. In 2006 and 2007, workgroups on recruitment, retention, and training and education developed action plans for the upcoming fiscal year.

Some examples of proposed activities to increase recruitment, retention, and training for professionals serving Trust beneficiaries include: 1) implement a grow-your-own initiative focused on youth including activities such as job shadowing and behavioral health career clubs, 2) develop marketing strategies within Alaska for beneficiary area service careers in order to recruit broader, non-traditional populations (e.g., Alaska Natives, seniors, retired persons, and persons with disability), 3) provide technical

assistance to and track the progress of 6-10 service providers interested in increasing retention efforts, 4) create a regional training collaborative that provides community-based training that complements other education and training efforts in the state. In addition to generating strategies, the plans assign responsibility for implementing and funding the strategies and for measuring the results.

In addition, DHSS and The Trust are working with University of Alaska and tribal organizations to develop certification standards for behavioral health aides, in order to boost competent and accessible care in rural Alaska communities.

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

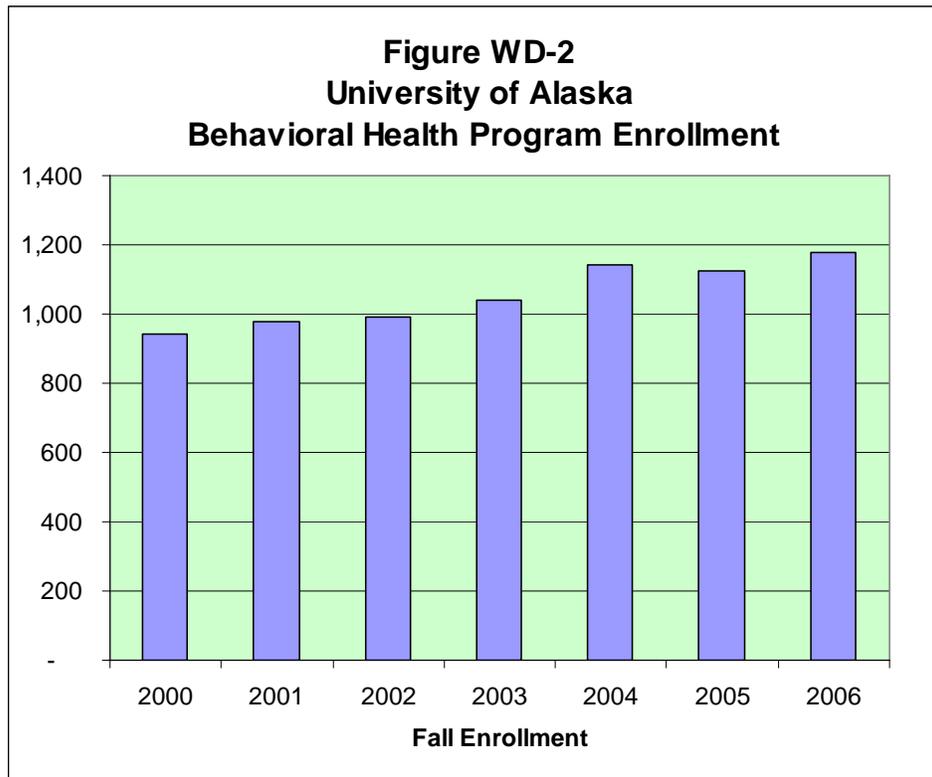


Degrees and certificates included in this data. University of Alaska: Certificate - Developmental Disabilities, Disability Services, Human Service Technology, Rural Human Services; AAS - Developmental Disabilities, Disability Services, Human Services; BA - Community and Change, Human Services, Social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

UA Source: UA Information Systems: Banner SI reporting extracts. Prepared by Statewide Institutional Research and Planning. (<http://www.alaska.edu/swoir/>)

Alaska Pacific University: www.alaskapacific.edu

Figure WD-2: Enrollment in Behavioral Health Programs at University of Alaska



Source: Information provided by MAUs via UA Information Systems: Banner SI reporting extracts.
Prepared by Statewide Institutional Research and Planning. (<http://www.alaska.edu/swoir/>)

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

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

www.alaskaworksinitiative.org

The Alaska Works Initiative is a statewide, federally-funded initiative comprised of a variety of stakeholders who are working to implement the following vision: ***Alaskans***

who experience disabilities are employed at a rate as close as possible to that of the general population. Over the next four years, initiative partners will continue to implement the following eight goals:

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

As of December 31, 2006, 1,495 individuals were served, of whom 640 or 42.8 percent secured full or part time employment.

In October 2006, the Governor's Council on Disabilities and Special Education received a three-year research and demonstration grant from the federal Office of Disability Employment Policy to increase the number of Alaskans with disabilities who are self-employed. Project goals are to:

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

It is anticipated that the following outcomes will be achieved:

- System wide assessment and identification of self-employment improvement opportunities via resource mapping (see Goal 1 above)
- Piloting and demonstration of two self-employment models (customized self-employment partnerships and business incubator) for 30 self-employed persons with disabilities (see Goal 2 and 3 above)
- Utilizing lessons learned from the pilots, development and implementation of longer term policy and training strategies to enhance Alaska's workforce system's

capacity to successfully serve people with and without disabilities so they can become successfully self-employed (see Goal 4)

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.

The Division of Public Assistance, working closely with partner agencies including the Division of Behavioral Health, Office of Children's Service, Division of Juvenile Justice, Division of Vocational rehabilitation and local community partners in Fairbanks and Mat-Su communities, have seen good outcomes through the use of these service techniques. Through the collaboration of the service providers and coordinated case management efforts, families have engaged in activities that have moved them towards self-sufficiency and improved quality of life.

The Division of Public Assistance anticipates expanding the family centric approach to all service areas in the state gradually over the next two to three years.

Public Awareness

The Trust, DHSS and beneficiary boards are committed to reducing the stigma associated with mental health problems, substance use disorders, developmental disabilities, age related dementias and brain injury. 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.

Trust 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 boards, 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.

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.

Access to Primary Care for Medicare Patients

Patients in some parts of Alaska report disturbing levels of difficulty in finding primary care providers willing to see Medicare patients. Many seniors have been terminated from care by their long-standing family physicians. Doctors say that Medicare's reimbursement rates cover less than 50% of their costs of care. After a Congressional hearing held by Senator Lisa Murkowski in Anchorage in early 2007, a resolution (SJR 3) passed by the 2007 Alaska Legislature urged Congress to order a comprehensive rewrite of the Medicare reimbursement formulas.

Access to primary care affects all Trust beneficiary groups. There are a number of dual eligibles (Medicaid and Medicare) among the developmentally disabled population, and they are experiencing the same shortage of providers.

Alaska Health Information Exchange (HIE)

The State of Alaska Department of Health and Social Services *Alaska Medical Assistance Program (Medicaid Program)* is collaborating with public and private providers throughout the state to develop a more efficient and cost effective system for communication in healthcare delivery. The goal of the initiative is to coordinate a statewide health information exchange that will improve access to clinical information by both providers and patients.

The intended outcomes of the HIE pilot project are:

- *To ensure timely access to pertinent patient information* – Providers and consumers will have access to complete patient histories in real-time, facilitating decision support, prompt treatment, and administrative efficiencies.
- *To improve health outcomes through enhanced monitoring and reporting* – Detailed, comprehensive reports can be generated through connected databases for the purposes of quality outcomes, public health monitoring, and biosurveillance.
- *To reduce costs associated with duplicative testing and administrative processes* – Providers and payers can quickly obtain the information necessary to process claims and deliver case management.
- *To actively engage patients in the management of their healthcare* – Through

personal health records, patients can utilize network resources for health monitoring and other e-clinical services such as online scheduling, clinician messaging, and access to educational materials.

- *To establish a best practices model for statewide replicability and participation* – The pilot project will demonstrate the effectiveness of HIE and offer valuable lessons learned for future expansion.

Due to the large percentage of Alaska Natives eligible for Medicaid, the State Medicaid Program has enlisted the Alaska Native Tribal Health Consortium (ANTHC) to assist with the planning and oversight of this project. ANTHC facilitated the creation of Alaska ChartLink, a group of healthcare leaders from around the state who possess extensive experience in the planning and oversight of many statewide telehealth projects.

Alaska's Uninsured

Staff of the Department of Health and Social Services, working on the State Planning Grant on insurance coverage funded by the US Department of Health and Human Services, Health Resources and Services Administration, (2005-2007), has assembled data from many sources that show that Alaska's highly seasonal employment patterns make it difficult for workers to qualify for consistent health care coverage. Focus groups conducted in 2006 and 2007 reported that those at risk of being uninsured expected to be responsible for contributing to the cost of health care coverage, but generally could afford about \$100 a month, considerably less than the cost of a health insurance policy for an individual or family.

<http://www.hss.state.ak.us/commissioner/Healthplanning/planningGrant/default.htm>

About 83 percent of Alaska residents are covered by health insurance (including government health coverage) at some time during the year.[1]The annual Current Population Survey indicates that employment-based health insurance accounts for coverage of more than half of Alaskans (52%), and public programs cover one third of Alaskans (Medicaid covers about 108,000, Military programs cover 84,000 people who are residents, Medicare covers nearly 56,000 Alaskans).

Young adults, especially males 18-24, are the most likely age-sex group to be uninsured. Part time and seasonal workers and the self-employed are also less likely than full-time workers to be insured. Although the majority of uninsured people are low-income, over a third are middle and higher income, and about half of the uninsured people are employed.

Smaller firms are less likely to offer health insurance than larger firms (according to state surveys of employers in 2001 and 2006, and US Medical Expenditure Panel Survey). Even the larger firms do not generally offer insurance to seasonal workers or to all part time employees.

Effects of Medicaid Rate Freeze

Providers of Developmental Disabilities and Senior Medicaid services have experienced significant cost increases related to fuel, health care, and worker's compensation in particular, as well as inflation in general. However, provider rates have been frozen since 2004. The rate freeze is impacting the financial stability of provider organizations as well as their workforce. Difficulties in recruiting and retaining quality staff in general are exacerbated by the freeze.

Emergency Preparedness

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

Recent disasters in the Gulf Coast of the United States made evident to the American public that emergency response and recovery systems are inadequately equipped to accommodate people with disabilities and special health care needs. A national review of emergency preparedness plans in all U.S. states and 75 major U.S. cities found that none adequately addressed special needs populations. All levels of government would benefit from increased participation of people with disabilities and disability experts in the development and execution of emergency preparedness plans, training, and exercises.

Cross training among emergency and disaster preparedness professionals, organizations providing services to Trust beneficiaries, and advocates would be beneficial. Emergency responders need information about how to accommodate Trust beneficiaries, and Trust beneficiaries would benefit from learning how to be prepared for an emergency.

There have been some activities in Alaska to address emergency preparedness for special needs populations. For example, the Municipality of Anchorage started a Special Needs Registry. Also the [Governor's Council on Disabilities and Special Education](#) has included this topic in their five-year plan and will be bringing together partners to discuss next steps and increase dialogue among disability groups and emergency preparedness staff. The [Department of Health and Social Services Public Health Preparedness Program](#) is coordinating community-specific planning to address emergency preparedness throughout the state. They are providing guidance to local communities to prepare their community-specific plans. The Division of Behavioral Health is also assisting with disaster response in communities for responders as well as victims.

Emerging Addiction Research

New studies using brain imaging have confirmed that addiction is a treatable disease. Discoveries in the science of addiction have led to advances in drug and alcohol abuse treatments that help people stop abusing drugs and resume their productive lives. Alaska's drug and alcohol treatment system is not able to take full advantage of these advances because of lack of funding and provider shortages. This imposes significant long and short term costs on individuals and society.

Emphasis on Prevention and Intervention Services

Prevention of mental health problems, brain injury, Alzheimer's disease, and substance abuse includes building positive influences and protective factors into Alaskans' lives. Interventions can prevent behaviors from becoming more severe, relapse and secondary conditions. Early intervention can often keep children's emotional and developmental disorders from becoming more severe.

A growing prevalence of children with autism spectrum disorders has raised the urgency of need for early intensive intervention. Unique to this group of children is the possibility of ameliorating symptoms. Evidence-based interventions have been shown to substantially decrease the need for special education and lifelong care when averaged over the population of children with autism spectrum disorders. Alaska lacks strong intervention programs in autism, as well as a financing mechanism to pay for such services. The lifetime cost of care for a person with autism has been estimated at \$3.2 million, yet early intensive intervention has been shown to decrease the lifetime cost of care by 75%. There is a need to develop and finance both an intervention program that is coordinated across service systems and a workforce to deliver the services.

Prevention and early intervention efforts are critical to minimize the financial and personal costs associated with Alzheimer's disease and related dementias (ADRD) in the future. With Alaska's senior population projected to grow at an unparalleled rate over the next 25 years, unprecedented demands will be placed on the state's long-term care system. A study of Medicaid costs by the Lewin Group (2006) projected that seniors' costs will begin to dominate Alaska's Medicaid program as the baby boomers age. Programs that encourage baby boomers and seniors to develop or maintain healthy lifestyle habits such as physical activity, good nutrition, regular socialization, and engagement in mentally challenging tasks will pay off in substantially lower health care and long-term care costs as well as greater well-being for seniors. Such programs can be implemented through workplaces, churches, senior centers, community organizations and many other partnerships.

Insurance for Behavioral Health Treatment

A national move to include behavioral treatment (mental health and substance use disorders) in health insurance coverage at the same level as physical health reflects the awareness that many physical health problems are tied to behavioral health problems. Senator Murkowski is cosponsoring the Mental Health Parity Act of 2007 on a national

level, but as Alaska looks at the structure of its funding for health care services, it is essential that we also look at the coverage available for behavioral health services in our state. Parity in behavioral health coverage has been shown to reduce both physical health care and societal costs.

Long-Term Care Strategic Plan

Alaska faces an enormous increase in the demand for long-term care as well as other services such as health care and affordable, appropriate housing. One of the recommendations of the Alaska Long Term Care and Cost Study (2006) was that the State of Alaska develop a three-to-five year statewide strategic plan for long-term care to ensure that it remains responsive to the needs of consumers, providers, and all other stakeholders. Such a plan would provide a blueprint with goals, strategies, and performance outcomes that can be used to guide the service system as it continues to grow and expand.

One factor driving the need for a strategic plan is the aging of the baby boomer generation. The number of seniors in Alaska is growing faster than any almost every other state's senior population. It is estimated that by 2030, Alaska will be home to more than twice as many seniors, including three times as many who are age 85 and older – the group most vulnerable to Alzheimer's disease and related dementias (ADRD).

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 intervention by 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 reimbursable by Medicaid and used by states for children in foster care and other federally mandated programs, now has stricter definitions that limit states' ability to bill for this service thus increasing state expense. We can anticipate further federal deficit reduction measures at the expense of states, such as regulations that narrowly define rehabilitative services and those that define public entities as only those with taxing authority which limits sources of available matching funds for Medicaid. In addition, stricter audit guidelines and closer financial scrutiny are driving unofficial federal policy changes that also shift costs to the state.

Alaska is projected to have a significant increase in the elderly population. The Lewin Group and ECONorthwest's February 15, 2006 report "Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025" predicted substantial growth in spending on Alaska's Medicaid program, driven by a change from serving predominantly children to one dominated by seniors. The services needed by seniors, Home and Community-based Waiver Services, behavioral health, and personal care services, were identified as major cost drivers which will cause an increase to expenditures from the general fund.

The temporary increase in Medicare physician reimbursement for Alaska has lapsed, and the reduction in reimbursement has contributed to some physicians no longer accepting 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.

The Pacific Health Policy Group (PHGP) January 2007 report to Senate Finance offered several recommendations about Medicaid reform. The PHGP details inefficiencies in the Medicaid system that result in large general fund expenditures. It identifies approximately \$220 million that is currently paid by Medicaid to non-tribal providers on behalf of American Indians and Alaska Natives. The PHGP report resulted in a \$2.3 million Legislative appropriation for the Department of Health and Social Services to further define and implement the opportunities noted by the PHGP report on defining the future of Medicaid in Alaska.

Need for Accessible Information about Available Services

The boards and commission associated with The Trust report that Trust beneficiaries needing information about long-term care and other services often say they do not know where to turn. Seniors especially would like to speak to a "live" individual when they need information, rather than leaving phone messages and receiving a return call several days later suggesting additional numbers to call. The Aging and Disability Resource Centers (ADRCs) are moving toward becoming a "one-stop shop" for information about available programs, services, and benefits for seniors and people with disabilities. The ADRCs also plan to become part of Network of Care, a nationwide system to help consumers, their caregivers, and service providers locate specific services in their communities or regions via an interactive website and/or a toll-free phone number that is staffed around the clock.

ADRC's are a collaborative effort of the U.S. Administration on Aging and the Centers for Medicare and Medicaid Services offered in Alaska through five regional offices of the Statewide Independent Living Council or SILC (in Anchorage/Mat-Su, Fairbanks, Juneau, Kotzebue, and Kenai) as information resources to help streamline access to long-term care.

Specialized Senior Behavioral Health Services

Senior services providers report a growing number of clients experiencing serious behavioral health needs. Aggressive behavior and substance abuse are becoming more common and more problematic in settings such as senior centers and independent-living senior housing. Pioneer Homes and assisted living facilities are seeing more seriously mentally ill (though previously undiagnosed) individuals, and report that they are not prepared to serve these clients in a general population setting. When behavioral health issues overlap with ADRD, treatment is particularly difficult to locate. Isolation, depression and grief issues are also common among older Alaskans. Seniors often refuse to seek help from sources such as a community mental health center or a local Alcoholics Anonymous meeting for fear of stigma. Special approaches are necessary to identify, make contact with, assess, and provide behavioral health services to seniors. In many communities, no programs are in place to meet these unique needs.

Endnotes

1. National Comorbidity Survey Replication (<http://archpsyc.ama-assn.org/cgi/content/full/62/6/593>)
2. Ibid.
3. Alzheimer's Association. *Alzheimer News* 3/20/2007.
4. Accu-Med data system, compiled by AK DHSS Division of Alaska Pioneer Homes.
5. Alzheimer's Foundation of America. (website download 4/4/07).
6. Alaska Brain Injury Network Fact Sheet (download February, 2007) and AK DHSS Division of Public Health, Section of Injury Prevention and EMS, [Alaska Trauma Registry](#).
7. Gollay, E. (1981), Summary Report on the Implications of Modifying the Definition of a Developmental Disability, U.S. Department of Health, Education and Welfare.
8. Centers for Disease Control and Prevention Autism Information Center.
9. The Governor's Council on Disabilities and Special Education (2006). Autism Issues and Needs: Preliminary Report of the Ad Hoc Committee on Autism: Findings and Recommendations.
10. Behavioral Risk Factor Surveillance Survey, 2006. 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.
11. U.S. DHHS, SAMHSA, Office of Applied Studies. [State Estimates of Substance Use from the 2004-2005 National Surveys on Drug Use & Health](#).
12. Grant, B.F. & Dawson, D.A. (1997). *Age at onset of alcohol abuse and its association with DSM-IV alcohol abuse and dependence: results from the National Longitudinal Alcohol Epidemiological Survey*, [Journal of Substance Abuse](#), , p 103-10.
13. Centers for Disease Control and Prevention, <http://www.cdc.gov/hrqol/methods.htm>.

14. The National Center on Addiction and Substance Abuse at Columbia University (CASA). *Behind Bars: Substance Abuse and America's Prison Population*.
15. AK DHSS Division of Public Health, Bureau of Vital Statistics 2004 Annual Report
16. US Department of Health and Human Services (April 1999). *Blending Perspectives and Building Common Ground: a Report to Congress on Substance Abuse and Child Protection*.
17. Alaska Department of Health and Social Services, Division of Public Health, Section of Women's, Children's, and Family Health, Alaska Maternal Child and Family Health Epidemiological Unit. *AK Maternal and Child Health Data Book 2005: Birth Defects Surveillance Edition*, p. 59.
18. 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, Centers for Disease Control and Prevention. 2003.)
19. **Centers for Disease Control and Prevention WISQARS** (Web-based Injury Statistics Query and Reporting System)- *Fatal Injury Reports*.
20. Alaska Injury Prevention Center. (February, 2007) *Alaska Suicide Follow-back Study Final Report 2006*. The *Follow-back Study* was based on interviews about 56 suicide cases of the total 426 suicide cases during the reporting period of 9/1/03 to 8/31/06. There were proportionally fewer rural and Native cases than urban and non-Native cases interviewed.
21. Ibid.
22. 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.
23. AK Department of Health and Social Services, AK Mental Health Trust Authority, Alaska Commission on Aging, and UAA Institute for Social and Economic Research. (January, 2007). *Report on the Economic Well-Being of Alaska Seniors*.
24. Michael Petit, et al. (1999). *Child Abuse and Neglect, A Look at the States: 1999 CWLA Stat Book*, (Washington, DC: CWLA Press).

25. Anda RF, Felitti VJ, Bremner JD, Walker JD, Whitfield C, Perry BD, Dube SR, and Giles WH, (November 29, 2005). The enduring effects of abuse and related adverse experiences in childhood: a convergence of evidence from neurobiology and epidemiology. *Eur Arch Psychiatry Clin Neurosci*.
26. Felitti, Vincent J. MD; Anda, Robert F. MD. (December 2003). WHO Abstract of ACE Study Presentation, Forum 7, Geneve.
27. Alaska Statute 47.24.010-900.
28. AK DHSS Division of Senior and Disabilities Services, Administrator of Adult Protective Services program (per email from Developmental Disabilities Program Specialist III, 7/12/07).
29. Scales, P. and Leffert, N. (1999). *Developmental Assets: A Synthesis of the Scientific Research on Adolescent Development*. (Search Institute).
30. Resnick, Michael, et al. (1997). Protecting Adolescents from Harm: Findings from the National Longitudinal Study on Adolescent Health. *JAMA*.278:823-832.
31. [Alaska Housing Finance Corporation Homeless Service Providers Survey Reports, Winter 2007](#)
32. [Alaska Housing Trust](#) (website download 7/12/07).
33. Center for Community Change: Home sweet Home, 2001.
34. [National Low Income Housing Coalition: *Out of Reach 2006*](#).
35. AK Housing Finance Corporation Public Housing Division report July 2, 2007 (email from Kris Duncan, MSW, July 12, 2007).
36. Alaska Housing Finance Corporation (July 12, 2007). Kris Duncan, MSW, Planner.
37. Ibid.
38. DHSS Division of Public Health, Certification and Licensing, October 2006.
39. Public Law 108-446, 108 Congress (2004).
40. [DHSS Division of Senior and Disabilities Services \(December 2006\)](#). Developmental Disabilities Waiting List Report July 1, 2005 through June 30, 2006.
41. [Alaska Injury Prevention Center, March 2007](#).