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AK DHSS DPH Section of Health Planning & Systems Development

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 – Continuum of Care Matrices for Beneficiary Groups
- 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

- Substance Abuse
- Health and Wellness
- Health Care Reform
- Long-Term Care
- Vulnerable Populations

V. Emerging Issues/Trends

VI. Further Information and Acknowledgements

Endnotes

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

- **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
- **CIMHP** — Comprehensive Integrated Mental Health Plan
- **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, 2009
- Figure HM-1: • Figure HM-1: Percent of Alaskans Reporting Frequent Mental Distress, 2001-2009
- Figure HM-2: Mean Number of Days in Past Month when Mental Health was not Good, Alaska and U.S., 2001-2009
- Figure 2: Adults who Engage in Heavy Drinking Alaska and U.S., 2003-2009
- Figure 3: Adults who Engage in Binge Drinking, Alaska and U.S., 2003-2009
- Figure HA-2: Rate of Alcohol-induced Deaths, Alaska and U.S. by Year, 2001-2009
- Figure HA-3: Illicit Drug Use, Alaska and U.S., Ages 12 and Older
- Figure 4: Percentage of Mothers Reporting Having Any Alcoholic Drinks during Last 3 Months of Pregnancy
- Figure HA-4: FASD Prevalence by Birth Year, Alaska Birth Defects Registry, 1998 - 2003
- Figure 5: Suicide Rate by Year, Alaska and U.S., 2001 – 2009
- Figure 6: Alaska Suicide Rates (and Numbers) by Region, 1999-2008 (map)
- Figure HS-1: Alaska Teen Suicides (Ages 15-19), 2000-2008
- Figure HS-2: Non-fatal Suicide Attempts by Sex, 2001-2008
- Figure HS-3: Non-Fatal Suicide Attempts Requiring Hospitalization, Alaska and U.S. by Year, 2001-2007
- 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 7: Number of Children with a Protective Service Report by Maltreatment Type
- Figure WS-1: Rate of Child Maltreatment (0-17 Years), Alaska and U.S.
- Figure WS-2: Rate of Repeat Maltreatment of Children, SFY 2007 - 2010
- Table S-1: Domestic Violence and Sexual Assault Statistics by State Fiscal Year
- Figure WS-3: Percentage of Alaskan Adults who have Experienced Domestic Violence over their Lifetime
- Figure WS-4: Non-Fatal Hospitalized Injuries due to Falls, Age 65+, Alaska and U.S
- Figure 9: Positive Outcomes in Life Domains, All Ages (Percent of Behavioral Health Consumers Improving or Maintaining Quality of Life), SFY 2009-2010
- Figure 10: Estimated Rate of Homelessness in Alaska by Year, 2001-2010
- 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: Monthly SSI/APA Payments: Percent Below Alaska Poverty Level by Year, 2000-2010
- Figure 13: Population Age 18 and Over by Income Level and Disability Status, 2009
- 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
- Figure ES-3: Average Annual Unemployment Rate, Alaska and U.S. by Year, 1999-2009

- Table E-1: Alaska Rent-Wage Disparity by Census Area, 2009
- Figure 15: Components of Care for Three or More Beneficiary Groups
- Figure 16A: Children Admitted to Residential Psychiatric Treatment Centers, In-State and Out-of-State by Year, 2001-2008
- Figure 16B: Recidivism Rate for RPTC Care
- 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' plans. This plan is also linked with such DHSS plans as Healthy Alaskans 2010 and other planning initiatives.

Target Population of Plan

Moving Forward: Comprehensive Integrated Mental Health Plan has a vision of optimal quality of life for Alaskans, especially those Alaskans who receive services under the Comprehensive Integrated Mental Health Program (AS 47.30). By law, these service recipients (also called Trust beneficiaries) are Alaskans who have a mental illness or a developmental disability, experience chronic alcoholism or Alzheimer's disease or a related dementia, or could be diagnosed with a comparable disorder due to either a general medical condition such as brain injury or a substance-induced disorder (AS 47.30.056 and 20 AAC 40.510). 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.

Prevalence of Trust Beneficiary Populations

With Alaska data and national prevalence data, we can estimate that there are currently up to 86,421 Trust beneficiaries in Alaska, as follows. There are unavoidable duplications in this estimate (e.g. some individuals are in more than one beneficiary group, so they are counted more than once).

- Serious mental illness (adults): 21,754¹
- Serious Emotional Disturbance (youth): 12,725¹
- Alzheimer's Disease and Related Disorders (ages 55+): 7,581⁵
- Brain injured: 11,900⁶
- Developmentally disabled: 12,461⁹
- Alcohol dependent (ages 12 to 17): 1,000¹¹
- Alcohol dependent (ages 18+): 19,000¹¹

Mental Illness:

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

The [2007 National Surveys on Drug Use and Health](#) estimates that 53,000 Alaskan adults (age 18 and older) experienced serious psychological distress and 36,000 had at least one major depressive episode (annual averages based on 2006-2007 NSDUHs). The NSDUH survey did not include an assessment of how the disorder affected a person's ability to function in everyday life. "Major Depressive Episode" is defined as a period of at least two weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of the symptoms for depression as described in the DSM IV. "Serious psychological distress" is defined as having a score of 13 or higher on the K6 scale.²

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

Alzheimer's Disease and Related Dementia.

Alzheimer's disease is now the seventh leading cause of death in the United States, and the fifth leading cause of death for Americans age 55 and older. An estimated 5.3 million Americans of all ages are living with Alzheimer's disease; one in eight people age 65 and older has the disease. Almost half of those age 85 and older are affected.³

The Alaska Commission on Aging estimates that as of 2009, there were roughly 7,581 Alaskans with **Alzheimer's Disease and Related Dementia** (6,008 Alaskans aged 65 and above and 1,573 aged 55 to 64).⁴ This estimate does not include those with brain injury. As of October, 2010, 53 percent of residents in the Alaska Pioneer Homes had a dementia diagnosis.⁵

An estimated 10.9 million Americans provide unpaid care for people with Alzheimer's or other dementia. In 2009, they provided 12.5 billion hours of unpaid care, a contribution

to the nation valued at \$144 billion. In Alaska, an estimated 16,313 caregivers provided over 18.5 million hours of unpaid care, valued at nearly \$213 million.³

The number of Americans with Alzheimer's disease is increasing each year due to the aging of the population. Because of pipeline-era (1970s and 80s) in-migration of young and middle-aged workers, Alaska now has the fastest-growing population age 65 and older in the United States. The number of older Alaskans with Alzheimer's Disease is projected to nearly triple by 2030.⁶

Traumatic Brain Injury. An estimated 11,900 Alaskans are living with disability due to a Traumatic Brain Injury.⁷ The highest rates of TBI are among Alaska Natives, residents of rural Alaska, youth ages 15-19 in motor vehicle crashes, and elders who fall. Each year the Alaska Department of Health & Social Services reports about 800 traumatic brain injury (TBI) cases resulting in hospitalization or death.⁸ The number of people with TBI who are not seen in an emergency department or who receive no care is unknown.

According to the Alaska Brain Injury Network, the available TBI data does not include service-related injuries, but it is estimated that 20 to 30% of service members returning to Alaska from Iraq and Afghanistan will need TBI services.

Developmental Disabilities:

According to national prevalence data, 1.8 percent of the national population has a developmental disability. At this rate, it is estimated that 12,461 Alaskans have developmental disabilities.⁹

According to the U.S. Department of Education and other agencies, autism is the fastest-growing developmental disability. It is the most common of the Pervasive Developmental Disorders, affecting an estimated one in 110 births.¹⁰

Chronic Alcoholism:

Rates of heavy and binge drinking are consistently higher in Alaska than in the United States as a whole. According to the [2008 National Surveys on Drug Use and Health \(NSDUH\)](#), the estimated number of Alaskans abusing or depending on alcohol or other substances was:

- Alcohol dependence (age 18 or older): 19,000
- Alcohol dependence (ages 12-17): 1,000
- Alcohol dependence or abuse (age 18 or older): 38,000
- Alcohol dependence or abuse (age 12 to 17): 3,000¹¹

Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).¹¹

According to the 2009 [Youth Risk Behavior Survey](#), 22 percent of Alaska's high school students engaged in binge drinking. The high prevalence of alcohol use among Alaska teens is a significant concern, because research shows that young people who begin drinking before the age of 15 are four times more likely to develop dependence.¹²

The 2008 National Surveys on Drug Use and Health also found the following about use of illicit drugs:

- Illicit drug dependence (age 12 or older): 11,000

- Illicit drug dependence or abuse (age 12 or older): 16,000

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

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II. Results Areas

What is a Result Area?

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

Result Area Topics

- [Health](#)
- [Safety](#)
- [Living with Dignity](#)
- [Economic Security](#)

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.

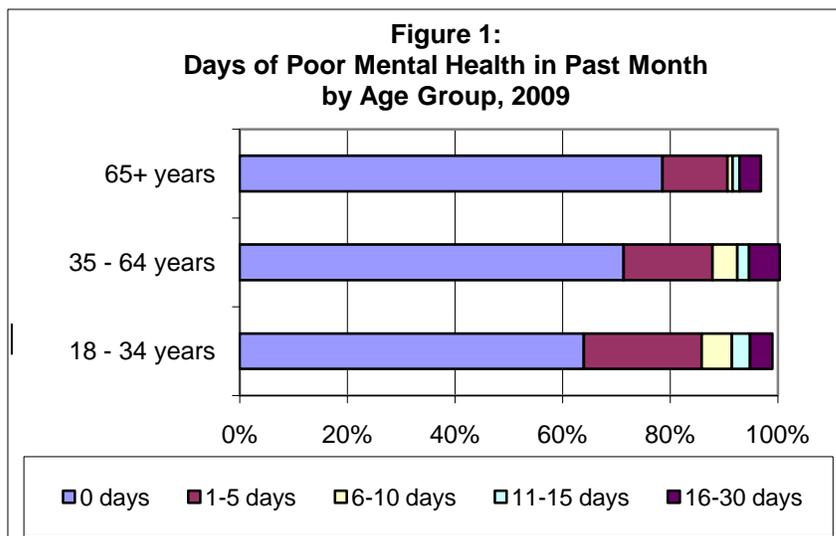
Health Goal #1: Enhance quality of life through appropriate services for people with mental and cognitive disabilities and substance use disorders

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, 2009

Data from the [Behavioral Risk Factor Surveillance Survey](#) show the percent of Alaskan adults surveyed who self-report the number of days in the prior month that they experienced “poor mental health.”

In 2009, thirteen percent of survey respondents reported more than five days of poor mental health during the previous month and six percent reported poor mental health for over half the time. Those aged 65 and above reported the best mental health.

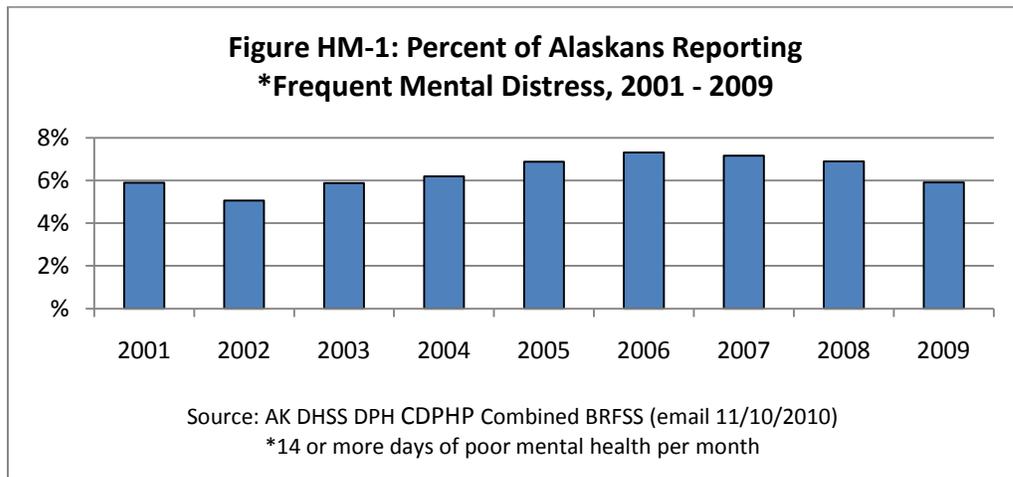


Source: DHSS DPH Standard and Supplemental Behavioral Risk Factor Surveillance Surveys (email 10/7/10)

BRFSS does not collect data from individuals living in an institutional setting. Consequently, those who are experiencing bad mental health days and are living in an institutional setting, are not included in this data.

Figure HM-1 — Percent of Alaskans Reporting Frequent Mental Distress, 2001–2009

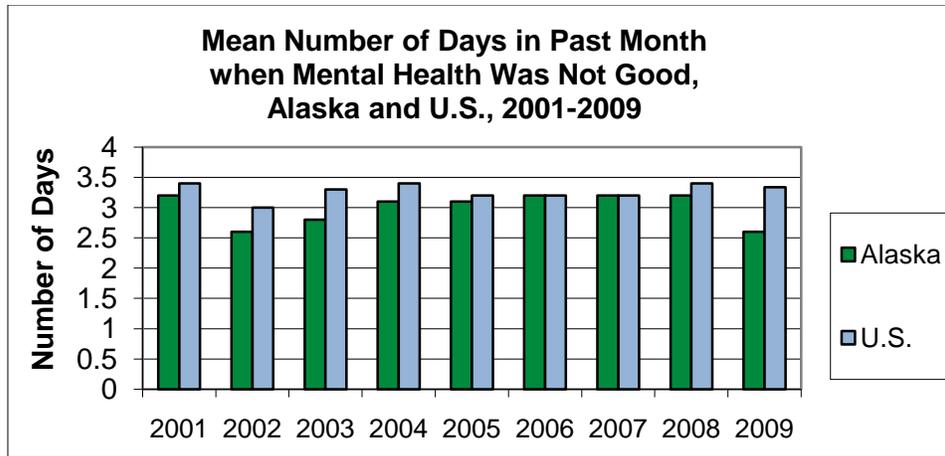
Figure HM-1 indicates that each year from 2001 to 2009, 5 to 7 percent of Alaskan adults experienced frequent mental distress, (poor mental health for 14 or more days during prior month). In 2009, the Alaska rate was 5.9 percent and the national rate was 10 percent.



BRFSS does not collect data from individuals living in an institutional setting. Consequently, those who are experiencing bad mental health days and are living in an institutional setting, are not included in this data.

Figure HM-2 — Mean Number of Days in Past Month when Mental Health Was Not Good, Alaska and U.S.

Although the average number of days of poor mental health for Alaskan adults decreased in 2009, six percent of Alaskan adults reported mental distress more than half the time. (AK DHSS Div. of Public Health, Standard and Supplemental Behavioral Risk Factor Surveillance Survey (BRFSS))



Source: AK DHSS Div. of Public Health, Standard and Supplemental Behavioral Risk Factor Surveillance Survey (BRFSS) and U.S. CDC

In 2008, eight percent of BRFSS respondents indicated current moderate to severe depression. Significantly more Alaskan females than males reported moderate to severe depression in 2008.

Other Alaskans who reported more moderate to severe depression include those:

- in the near poor income group (vs. middle/high income group)
- who receive social support sometimes, rarely, or never
- who reported a disability
- with fair or poor general health

The BRFSS does not collect data from those who are living in an institutional setting. Consequently, those who are experiencing bad mental health days and are living in an institutional setting are not included in this data.

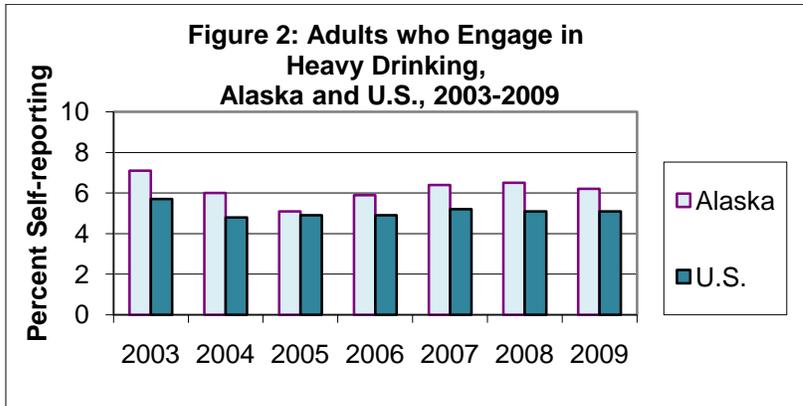
Health Goal #2: Reduce the abusive use of alcohol and other drugs to protect Alaskans’ health, safety, and quality of life.

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 —Adults who engage in Heavy Drinking, Alaska and U.S., 2003–2009

According to the 2009 Behavioral Risk Factor Surveillance System (BRFSS), Alaska ranks number 7 in the U.S. for heavy drinking, with 6.2% of Alaskans classified as heavy drinkers.

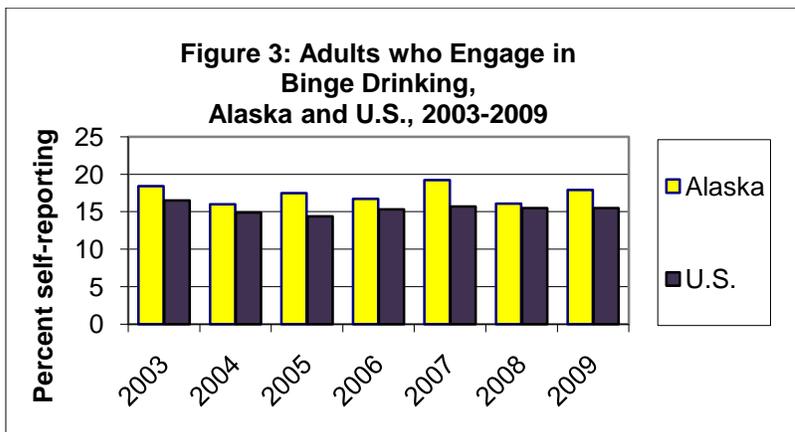
The CDC [National Center for Chronic Disease Prevention & Health Promotion](#) defines heavy drinking as more than 2 alcoholic drinks for men or more than 1 drink for women *each* day during the past 30 days. The Centers for Disease Control found that these are the levels at which mortality increases.



For data about public inebriate pick-up in Anchorage, transport and sleep-off, see [Anchorage Community Service Patrol 2009 Data Summary & Analysis](#). Community Service Patrol van staff take persons incapacitated by alcohol (in public places) into protective custody and transport them to the sleep-off facility (TS) located in the Anchorage Jail Complex. Clients are assessed using basic physiological parameters, and those falling outside safe standards for sleep-off are taken to hospitals for medical clearance or further care. From 2007 to 2009, Sleep-Off Intakes increased by 18%.

Figure 3 — Adults who engage in Binge Drinking, Alaska and U.S., 2003–2009

The CDC [National Center for Chronic Disease Prevention & Health Promotion](#) defines binge drinking as 5 or more drinks (men) or 4 or more drinks (women) on one or more occasions in the past 30 days. According to the [Behavioral Risk Factor Surveillance System](#), Alaska’s ranking for binge drinking in 2009 rose from number 21 in the U.S. to number 11.



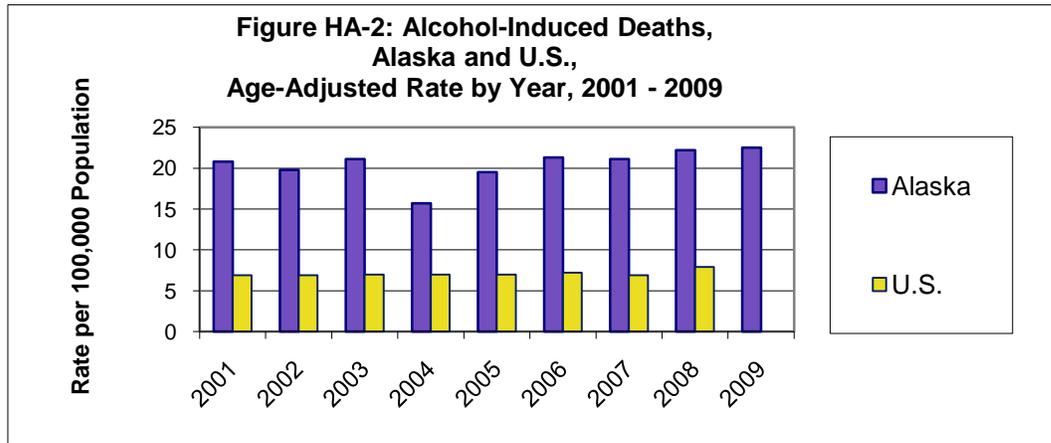
Source: [Behavioral Risk Factor Surveillance Survey \(BRFSS\)](#) and [Centers for Disease Control](#)

The prevalence of binge drinking in Alaska is highest among males, those who are employed, and those who are divorced or separated. (*Alaska BRFSS 2008 Annual Report*)

According to the *2009 Youth Risk Behavior Survey*, 22 percent of Alaska's high school students engaged in binge drinking (5 or more drinks of alcohol in a row within a couple of hours, on at least one day during the 30 days before the survey). Youth who begin drinking at age 14 or younger are 4 times more likely to develop dependence.²¹

Figure HA-2 — Rate of Alcohol-Induced Deaths, Alaska and U.S., 2001–2009

Between 2006 and 2008, Alaska's rate of alcohol-induced deaths was approximately 3 times the U.S. rate. The alcohol-induced death rate is significantly higher for Alaska Natives than for non-Natives.

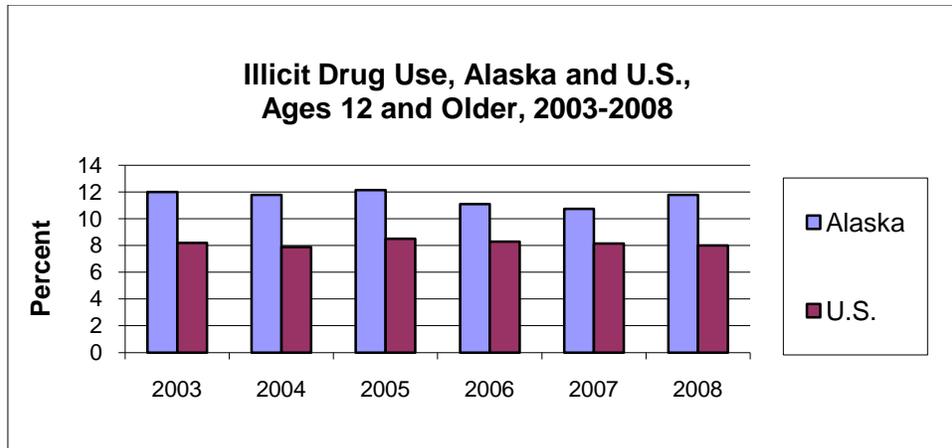


Sources: *DHSS Division of Public Health, Bureau of Vital Statistics* (email 8/25/10)

Alcohol-induced deaths include fatalities from causes such as degeneration of the nervous system due to alcohol, alcoholic liver disease, gastritis, myopathy, pancreatitis, poisoning, and more. It does not include accidents, homicides, and other causes indirectly related to alcohol use¹⁵

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

The percentage of illicit drug users ages 12 and older in Alaska is consistently at least 30% above the national percentage. In 2008, Alaska ranked number 4 in the U.S. for illicit drug use. (*NSDUH Table B.1. Illicit Drug Use in Past Month by Age Group and State*) Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically. (*NSDUH*)



Source: SAMHSA, Office of Applied Studies, National [Survey on Drug Use and Health](#). (2007-2008 NSDUH), Table 4.

Marijuana is the most commonly used illicit drug. (NSDUH) In Alaska, those aged 18 to 25 have the highest rates of illicit drug use. (NSDUH) According to the [2009 Youth Risk Behavior Survey](#) of Alaska high school students:

- 23 percent had used marijuana one or more times during the 30 days preceding being surveyed
- 21 percent had used unprescribed drugs one or more times during their life
- 10 percent had sniffed glue, breathed the contents of aerosol spray cans, or inhaled paint or sprays to get high one or more times during their life.

Risk and Protective Factors:

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

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

Fetal Alcohol Spectrum Disorders

- Fetal Alcohol Spectrum Disorder is a permanent birth defect syndrome caused by women drinking while pregnant
- FASDs are one of the most common causes of developmental disability and the only cause that is entirely preventable.
- FAS is a medical diagnosis defined by the presence of specific growth and nervous system abnormalities and other factors.
- Alaska has the highest rate of FAS in the nation among states that track this data. As many as 200 children are reported to the Alaska Birth Defects Registry each year with a suspected FASD.
- There is no known safe amount of alcohol to consume during pregnancy. Alcohol can cause damage to a developing fetus even before a woman knows she is pregnant.
- FASD is found among all races and all socio-economic groups – wherever women drink alcohol, FASD can exist.

- Alaska tracks the rate of FAS and FASD to identify risks associated with these conditions and improve prevention programs by targeting groups at risk.
- A state and federally funded Alaska Comprehensive Fetal Alcohol Syndrome Project has expanded the state’s diagnostic capability, developed a multimedia public education campaign, and improved training for service providers in Alaska to help them better understand and serve affected individuals and their families.
- Like all disabilities, improvements can be made in how a person adjusts to their disability.
- With a comprehensive diagnosis, parents and providers can identify which services will most help children with an FASD in school and social settings.
- With the right diagnosis, support and understanding, many individuals with FASD can live happy and full lives.

The exact number of people in the U.S. with FASD is not known. CDC studies have shown that 0.2 to 1.5 cases of fetal alcohol syndrome (FAS) occur for every 1,000 live births in certain areas of the United States. Other studies using different methods have estimated the rate of FAS at 0.5 to 2.0 cases per 1,000 live births. ([Centers for Disease Control](#))

For more information, see Alaska DHSS Division of Behavioral Health “[Information on FASD](#)”.

Figure 4: Percentage of Mothers Reporting Having Any Alcoholic Drinks during Last 3 Months of Pregnancy

Between 2000 and 2008, 4 to 6 percent of mothers in Alaska reported having alcoholic drinks during the last three months of pregnancy. In 2008, Alaska’s rate was among the lowest of the 29 states reporting this data, with only 6 states showing lower rates. [[CDC Pregnancy Risk Monitoring System \(PRAMS\) CPONDER](#)]

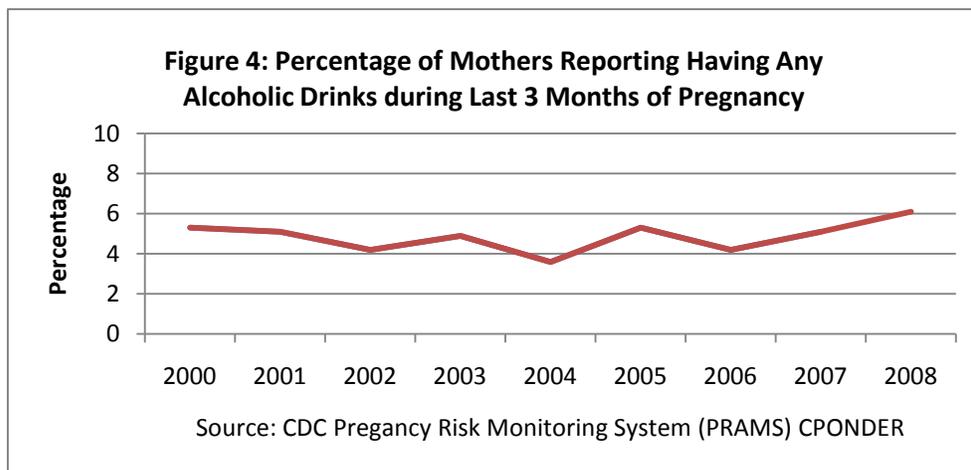
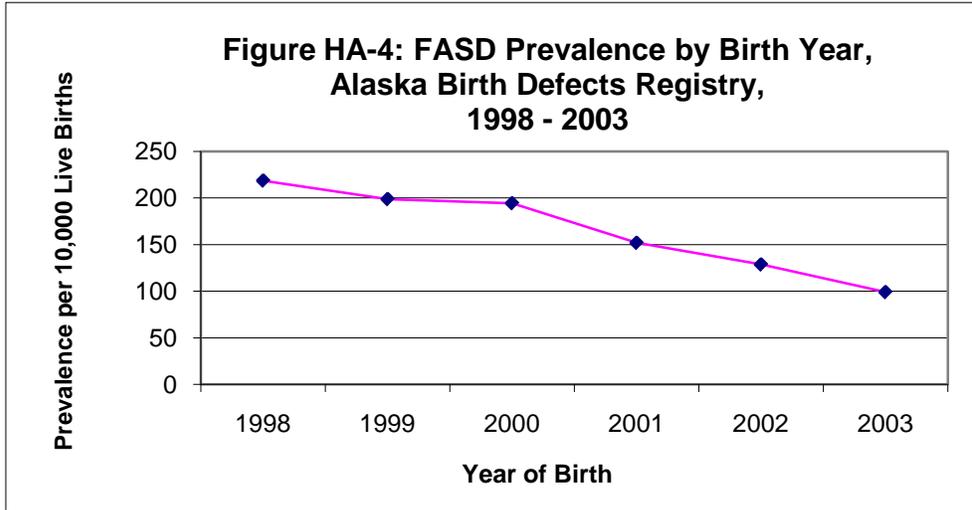


Figure HA-4: FASD Prevalence by Birth Year, Alaska Birth Defects Registry, 1998 - 2003

Figure HA-4 shows the unduplicated number of children reported to the [Alaska Birth Defects Registry](#) with ICD9 code 760.71 (fetus or newborn affected by maternal alcohol

use), by their 6th birthday, and matched to an Alaska birth certificate. (The chart shows children reported by 8/2/10). Since 1998, the numbers have continually declined.



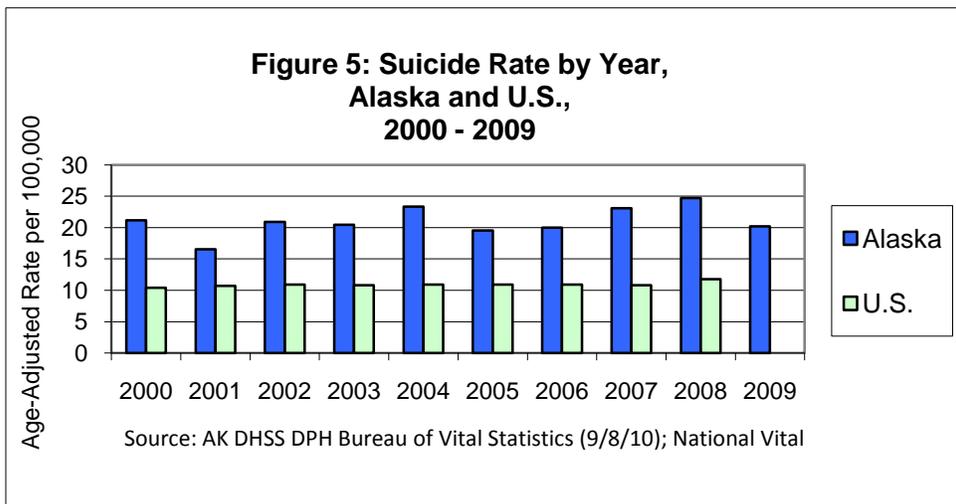
Children are often not identified and reported as FAS/D until around age six, when they are entering school; this is why 2003 is the most recent birth year reported. Challenges in the diagnosis of FAS and related conditions include the lack of specificity related to the ICD9 code and variations in the age at which the characteristics become evident.

Source: Alaska DHSS DPH Section of Women’s Children’s and Family Health, MCH EPI Unit, Alaska Birth Defects Registry Coordinator (email 9/13/10)

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

Alaska’s suicide rate has consistently remained among the highest rates in the nation and almost twice the national average. Between 2001 and 2009, the age-adjusted rate for suicides in Alaska increased 22 percent, from 16.5 to 20.2 deaths per 100,000.

Figure 5 — Suicide Rate by Year, Alaska and U.S., 2001 – 2009 (Age Adjusted Rate per 100,000)

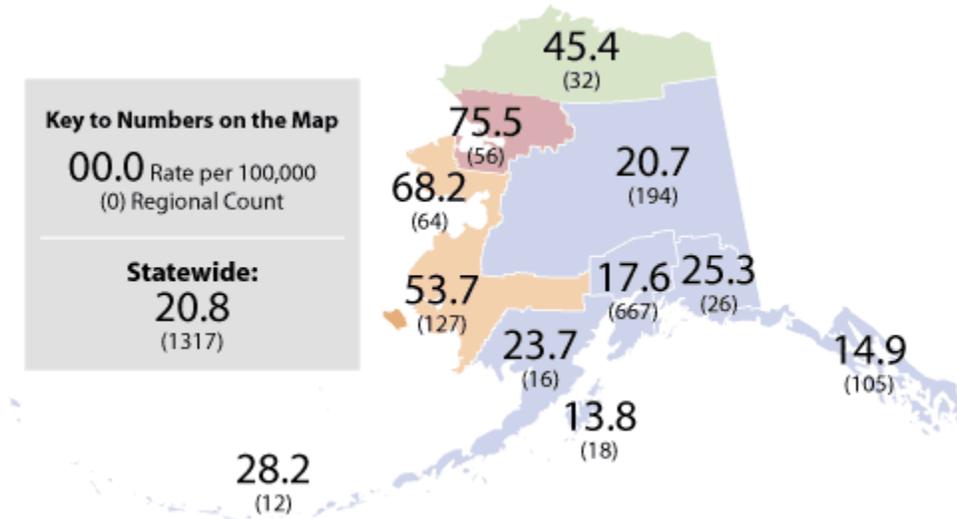


The suicide rate among Alaska Natives in 2008 was almost double the rate for Caucasians. Intentional self-harm or suicide remained the sixth leading cause of death in Alaska. Between 1999 and 2008, on average 36.1 years of life were lost prematurely for each suicide death. Firearms was the leading manner of suicide death.

Figure 6 — Alaska Suicide Rates (and Numbers) by Region, 1999-2008 (Map)

Figure 6 shows Alaska's age-adjusted suicide rates per region for the years 1999 through 2008. The regions with the lowest rates of suicide were Kodiak and Southeast, while the highest rates were in Nome and the Northwest Arctic.

**Figure 6
Alaska Suicide Rates (and Numbers) by Region, 1999-2008**

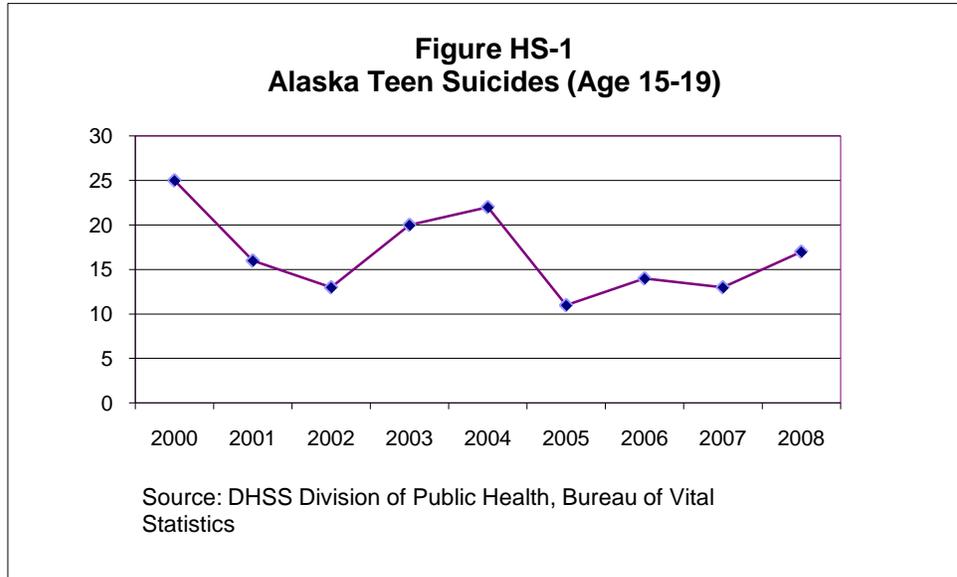


More than 70	Northwest Arctic
50-70	Nome Census area Bethel/Wade Hampton
30-50	North Slope Borough
Less than 30	<ul style="list-style-type: none"> Dillingham/Bristol Bay/ Lake and Peninsula Borough Aleutians Interior Valdez-Cordova Anchorage/Mat-Su Borough/ Kenai Peninsula Southeast Kodiak

For the years 1999 through 2008, the regions with the lowest rates of suicide were Kodiak and Southeast, and the highest rates were Nome census area and the Northwest Arctic

Figure HS-1 — Alaska Teen Suicides, 2000-2008

The number and rate of deaths by suicide among Alaskans aged 15 to 19 rose slightly between 2007 and 2008. Between 1999 and 2006, the rate of teen suicide (ages 15 to 19) in Alaska averaged 4 times the U.S. rate for this age group. (U.S. data for 2007 and 2008 is still incomplete.)



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

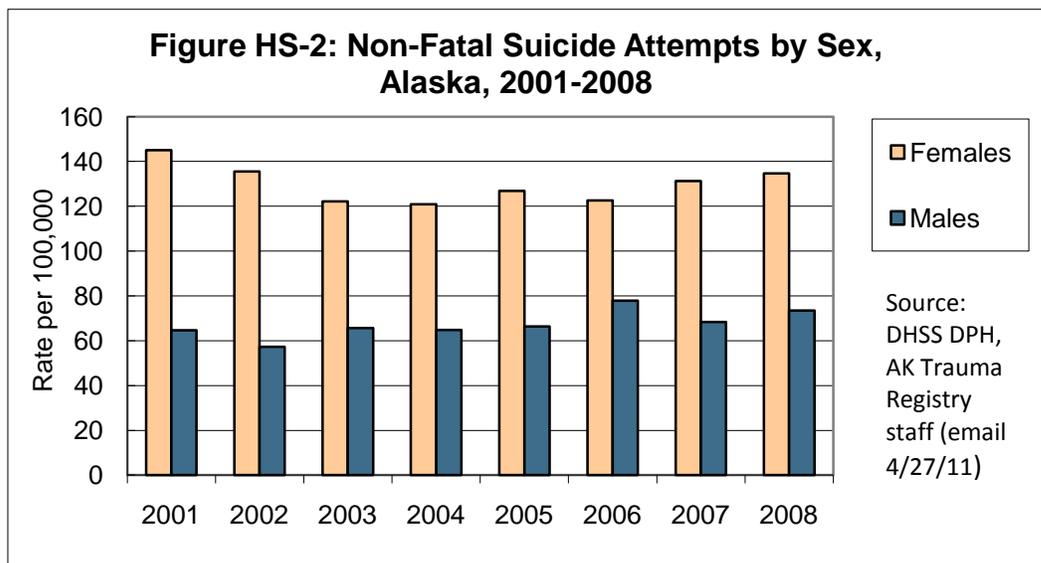
Among the suicide cases that had a follow-back interview, a binge drinking rate of 43 percent was reported, which is 2.5 times higher than the Alaska rate and three times higher than the national estimated rate according to the 2005 BRFSS. The interviews indicated that 54 percent of the decedents had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

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

- Percentage of students who seriously considered attempting suicide during the past 12 months:
 - 2003 YRBS: 16.7 %
 - 2007 YRBS: 16.5%
 - 2009 YRBS 13.9%
- Percentage of students who actually attempted suicide one or more times during the past 12 months:
 - 2003 YRBS: 8.1%
 - 2007 YRBS: 10.7 %
 - 2009 YRBS 8.5%

Figure HS-2 — Non-fatal Suicide Attempts by Sex, 2001-2008

In Alaska, almost twice as many females attempt suicide as males (non-fatal). The rate of attempts by Alaskan females age 15 to 24 has been significantly higher than in any other population group. Figure HS-2 shows the rate of non-fatal suicide attempts in Alaska that required hospitalization for at least 24 hours.

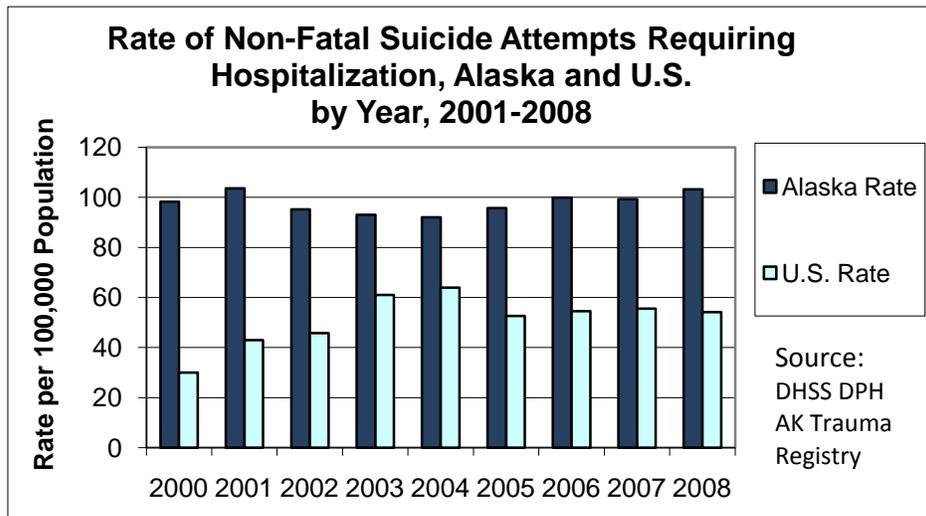


Source: CDC WISQARS Nonfatal Injury Reports

In both Alaska and the U.S. the rate of nonfatal suicide attempts is noticeably higher for females than for males, but in Alaska the difference between the rates for males and females is even more striking. In 2009 the U.S. rate for nonfatal attempts by females was 45 percent higher than for males, but in Alaska the rate for females was 83 percent higher than for males. (CDC WISQARS Nonfatal Injury Reports – attempts requiring hospitalization for at least 24 hours)

Figure HS-3 - Non-Fatal Suicide Attempts Requiring Hospitalization, Alaska and U.S. by Year, 2001-2007

Alaska's rate of non-fatal suicide attempts requiring hospitalization for at least 24 hours is almost twice the U.S. rate. Between 2000 and 2006, Alaskans age 15 to 24 had the highest rates of attempted suicide. (DHSS DPH Alaska Trauma Registry)



Suicide Protective Factors

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

Protective factors include:

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

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.

Estimated Number* of Alaska Mental Health Trust Beneficiaries Served by DHSS Divisions												
*Actual number may be lower - there is duplication in some of the data reported.												
Time Period	Division	Age 0-17		Age 18-20		Age 21-64		Age 65 +		Age not available		Total
		Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	
FFY 2007	Children's Services (OCS)	170	220	17	20							427
<i>These are children served in out-of-home care diagnosed as mentally retarded and/or emotionally disturbed. Source: AK DHSS, Office of Children's Services, Online Resources of the Children of Alaska.</i>												
7/1/07 to 6/30/08	Juvenile Justice (DJJ) - Age 0-20											870
	Female	1										
	Male	7										
<i>Numbers represent youth on supervision with DJJ who had at least one Axis 1 diagnosis, under DSM-IV-TR (clinical disorders & other conditions that may be a focus of clinical attention). Most were 17 years of age or younger. Of the total, 51% also had a co-occurring disorder (substance related disorder accompanied by a mental health disorder). Source: DHSS Div. of Juvenile Justice FY08 data</i>												
One-day snapshot, 4/1/08	Pioneer Homes							249				249
<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>												

Time Period	Division	Age 0-17	Age 18-20	Age 21-64	Age 65 +	Age not available	Total					
One month - April, 2008	Public Assistance (DPA) - Alaska Temporary	3,2						3,203				
April, 2008	DPA- Adult Public Assistance	16,7						16,743				
April, 2008	DPA - Food Stamps	23,0						23,045				
Source:	<i>These figures reflect a one-month caseload for all Alaskans; this data does not break out the number of Trust beneficiaries. Not counted are the customers whose cases are managed by the tribal system. Source: DHSS Division of Public Assistance</i>											
	Senior and Disabilities Services (SDS)											
2008	Mental Retardation Developmental Disabilities (MRDD)	34	115	29	60	350	503	11	11			1113
2008	Children with Complex Medical Conditions (CCMC) Waiver	73	96	12	14	7	9	0	0			211
Source:	Data Retrieved from FY 08 Waiver Program Data (DS3) on October 16, 2008.											
3/23/2007	Senior grants (963 total clients)							308				308
3/23/2007	Nursing facilities (total of 715 beds)			2								
Source:	Data based on survey of providers on numbers of clients with Alzheimers or related dementia.											
2005	DSDS - Adult Protective Services			5								546
Source:	Data Retrieved from FY 06 Medicaid Billing Data (STARS) on May 2, 2007.											

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

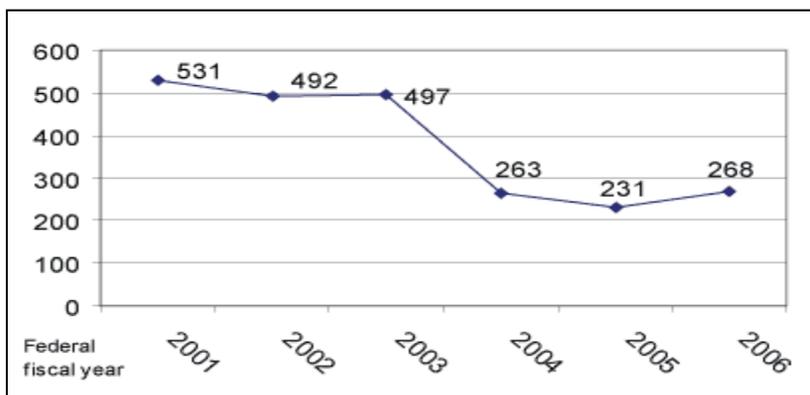
Public perceptions of care

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

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

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

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



Source: [AK Office of the Long Term Care Ombudsman](#), OmbudsManager data base

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

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.

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

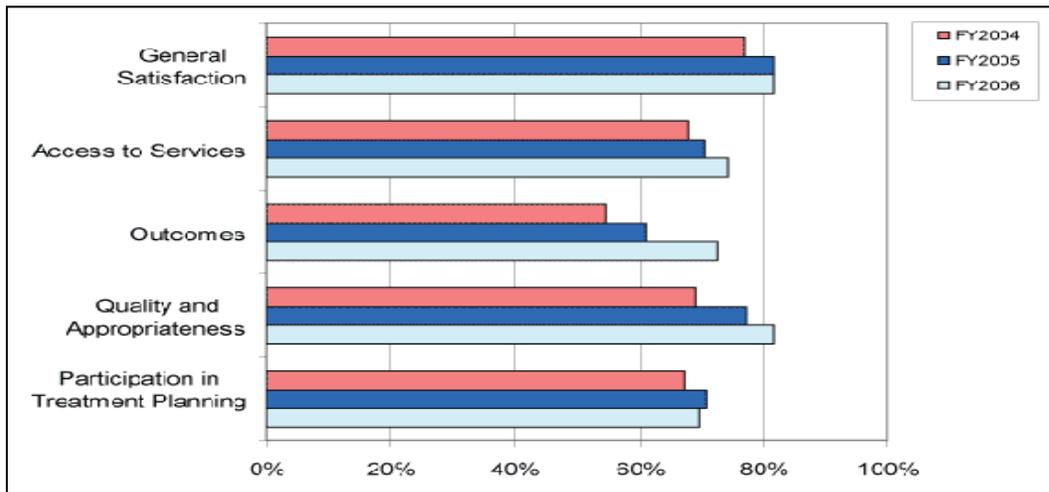
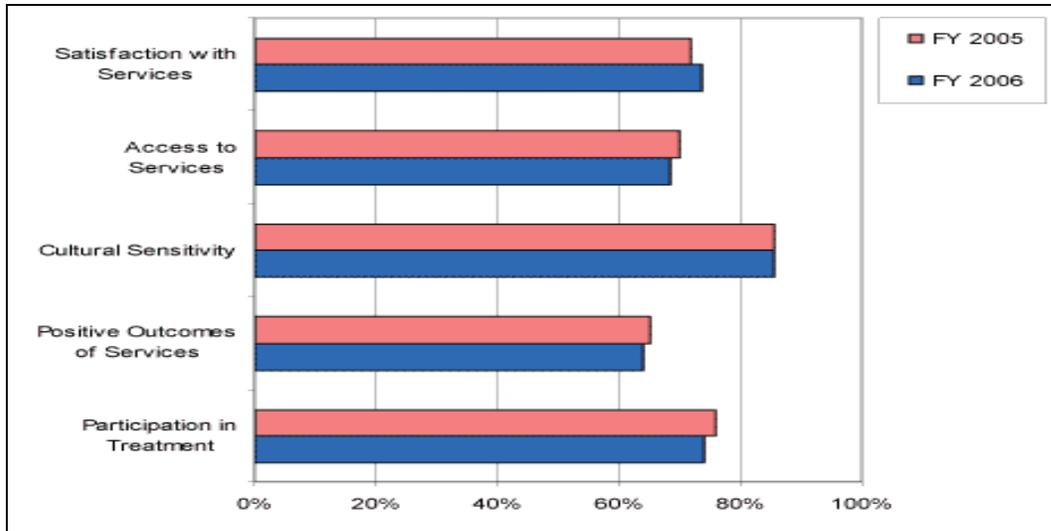


Figure HC-3b: Consumers Satisfied with Public Mental Health and Substance Abuse Services



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 re-building families, providing treatment, and providing guardianship for adults with mental impairments.

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

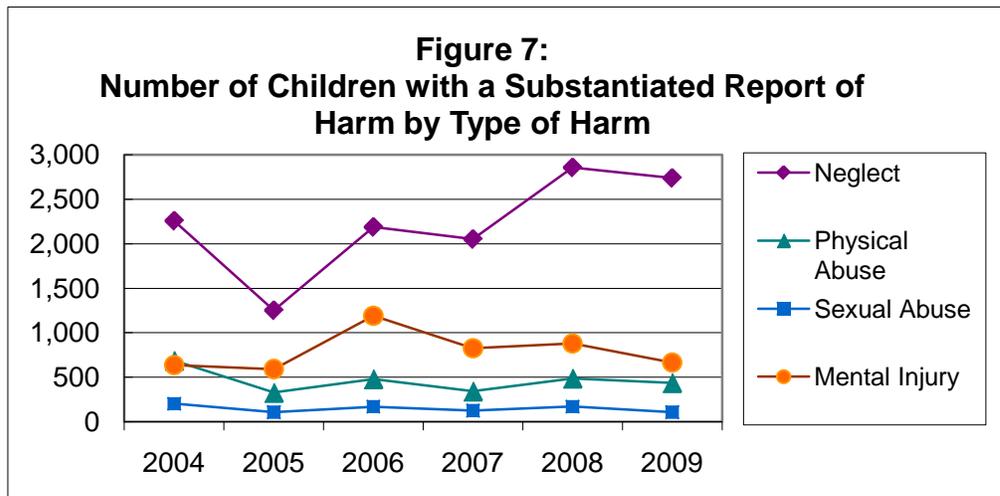
Safety Goal #1: Protect children and vulnerable adults from abuse, neglect, and exploitation

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 provides 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 7: Children with a Substantiated Report of Harm by Type of Harm

Figure 7 represents the number of Alaska's children who were substantiated with the DHSS Division of Children's Services as victims of child abuse and neglect. Counted in this data are children who had a report of harm which was investigated and harm substantiated. The total number of substantiated reports of harm decreased between 2008 and 2009. In 2009 there were 3,397 unique victims with allegations substantiated.

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



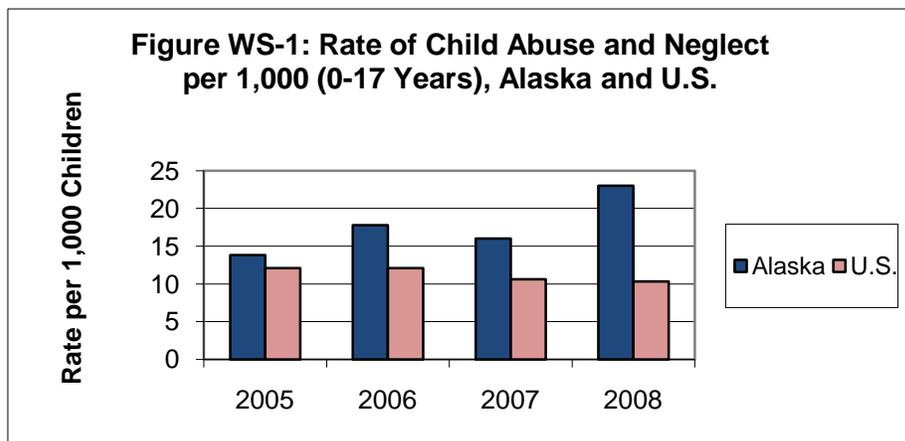
Source: DHSS Office of Children's Services (email 12/28/10)

Figure WS-1: Rate of Child Abuse and Neglect per 1,000, Alaska and U.S.

Figure WS-1 shows that the rate of child abuse and neglect is consistently higher in Alaska than in the rest of the U.S. Child abuse and neglect is defined as:

- Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or
- An act or failure to act which presents an imminent risk of serious harm.

The rate was based on the unique count of victims divided by the state's child population, multiplied by 1,000. [U.S. DHHS Administration for Children and Families]



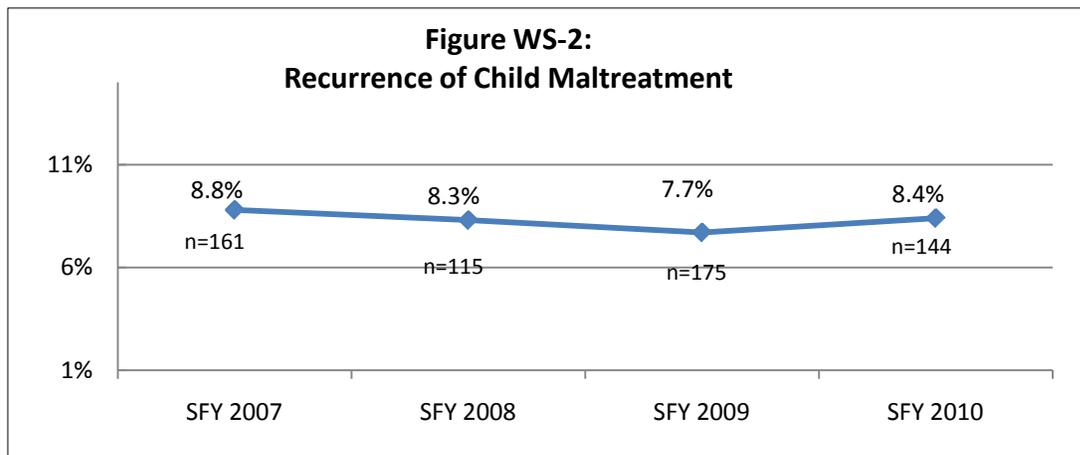
Source: US Department of Health and Human Services, Administration for Children and Families, Children's Bureau, Child Maltreatment 2007, Chapter 3, Table 3-3

According to the U.S. DHHS, Administration for Children and Families, Alaska's rate of child abuse and neglect is number 3 in the U.S. (*Child Maltreatment 2009*, Chapter 3,

Table 3-5 Child Victims, p. 33) Caution should be used in interpreting this figure. Although the differences among state rates may reflect actual abuse/neglect they can also be impacted by state-to-state variation in statutory jurisdiction, agency screening processes and definitions, and the ability of states to receive, respond to, and document electronically investigations. [Alaska SCAN Program Director, DHSS DPH EPI Unit (email 10/20/09)]

Figure WS-2 — Recurrence of Child Maltreatment

Figure WS-2 shows the percentage of all Alaskan 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. The rate of recurring child maltreatment increased slightly in state fiscal year 2010.



Source: AK DHSS Office of Children's Services (email 1/5/11)

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

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

- **Percent of students who did not go to school on one or more of the past 30 days because they felt unsafe at school or on their way to or from school:**
 - 2003 Youth Risk Behavior Survey: 4.1 %
 - 2007 Youth Risk Behavior Survey: 5.5 %
 - 2009 Youth Risk Behavior Survey: 6.0% (Alaska) and 5% (U.S.)

- **Percent of students who have ever been physically forced to have sexual intercourse when they did not want to:**
 - 2003 Youth Risk Behavior Survey: 8.1 %
 - 2007 Youth Risk Behavior Survey: 9.2 %
 - 2009 Youth Risk Behavior Survey: 10.1% (Alaska) and 7.4% (U.S.)

Domestic Violence and Sexual Assault Statistics

The 2010 Alaska Victimization Survey reports that 3.6% of Alaska adult women experienced alcohol or drug involved sexual assault in the past year. Nine percent experienced intimate partner violence (defined as physical violence or threats of physical violence by a romantic or sexual partner). Almost half (48%) of Alaska adult women have experienced intimate partner violence in their lifetime.

In state fiscal year 2009, the Alaska Council on Domestic Violence and Sexual Assault (CDVSA) funded a network of 21 victim service programs in eighteen Alaska communities.

During fiscal year 2009, programs provided services to 8,550 clients. Twenty seven percent of the clients were children. Services provided included 24-hour emergency support, safe shelter, crisis intervention, children’s services, food and clothing, referrals and many other services.

Table S-1 —Domestic Violence and Sexual Assault Statistics by State Fiscal Year

State Fiscal Year	2006	2007	2008	2009
Participants Served Statewide	7,464	7,975	8,253	8,550

Sources: State Fiscal Years 2006, 2007: Alaska Council on Domestic Violence and Sexual Assault Annual Report to Governor Palin. SFY 2008: preliminary CDVSA aggregate victim service data. SFY 2009, Alaska Council on Domestic Violence and Sexual Assault Program Coordinator

* Slight changes in data classifications and definitions may be reflected between fiscal years.

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

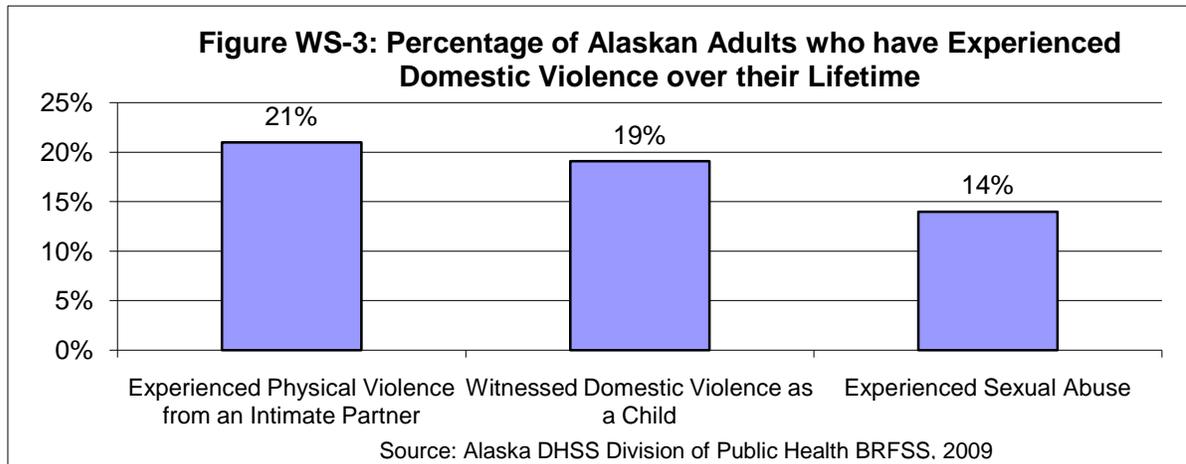


Figure WS-3 shows the percentage of participants in the most recently-available Behavioral Risk Factor Surveillance Survey (BRFSS)¹⁴ who responded that they had witnessed domestic violence in their family as a child, experienced physical violence from an intimate partner, or been sexually abused during their lifetime. In 2009, twenty-one percent of Alaskan adults had experienced physical violence from an intimate partner; nineteen percent had witnessed domestic violence as a child; and fourteen percent had experienced sexual abuse. These percentages are almost exactly the same as those reported in the 2006 BRFSS.

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.

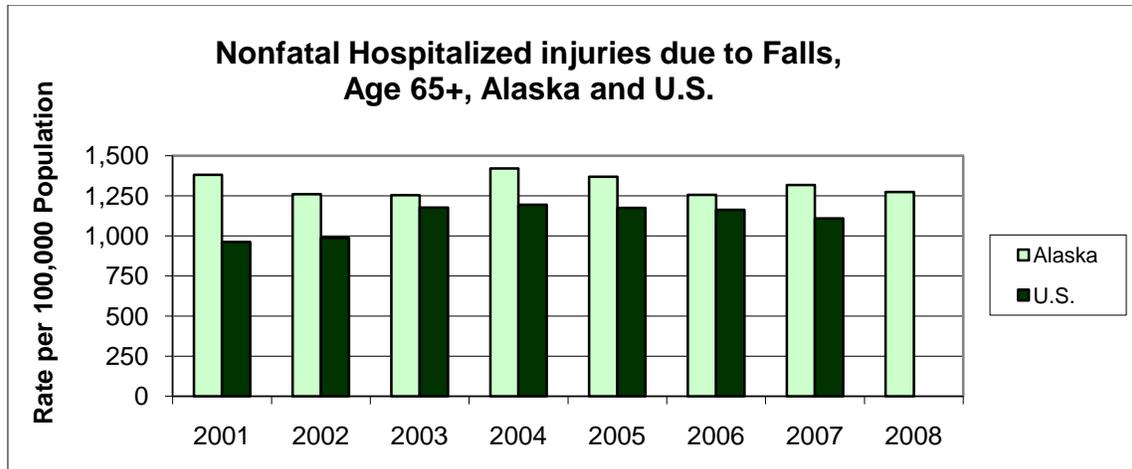
Adult Protective Services Investigations

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

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

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

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



Source: DHSS DPH Alaska Trauma Registry

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

Percent of Incarcerated Alaskans (Adults) who are Trust Beneficiaries

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

Statewide Criminal Recidivism Rates for Incarcerated Beneficiaries

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

For more information, see *Five-Year Prisoner Reentry Strategic Plan, 2011 - 2016 (March 2011)*

Living with Dignity

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

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

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

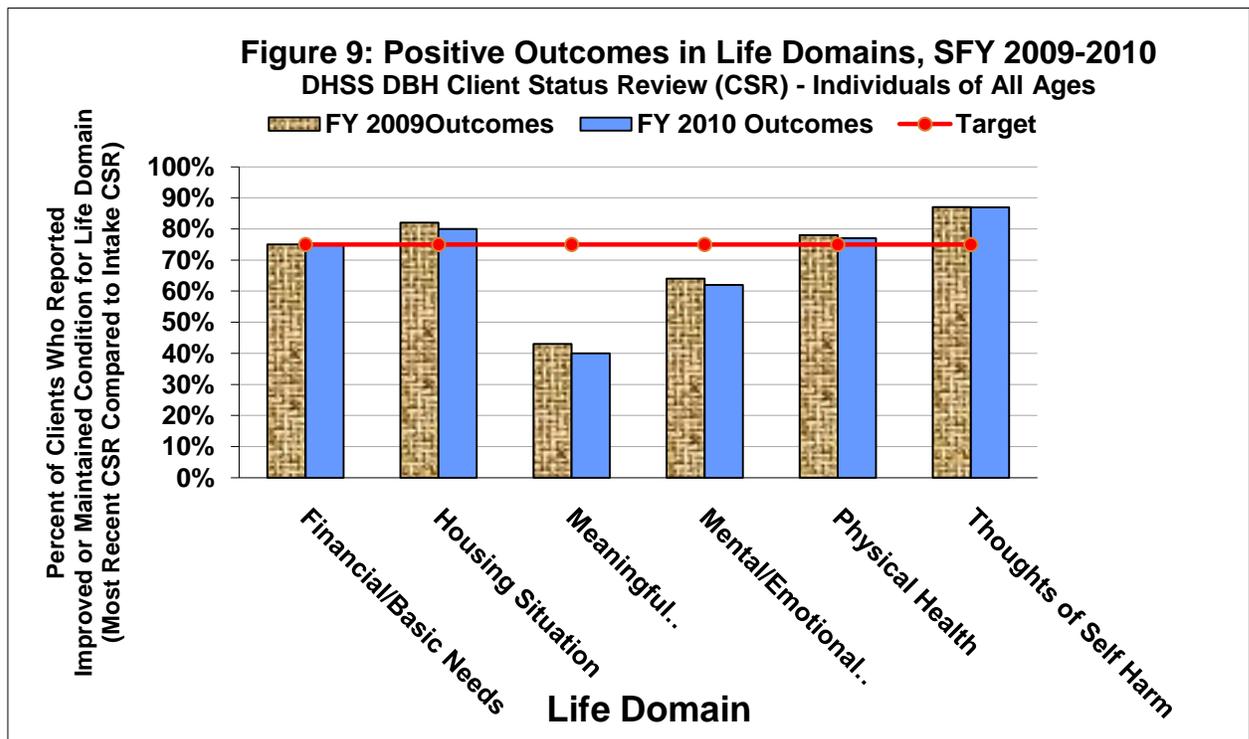
Gaining new skills and experiences in supported environments can prepare adolescents and adults with cognitive or developmental disabilities for jobs and participation in community life. All children are entitled to a public school education where they learn the social, academic and practical skills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

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

The Client Status Review (CSR) tracks the quality of life of consumers of the Alaska behavioral health treatment system. When clients enter the system they are asked a series of questions about their "life domains" such as thoughts of self-harm, feelings of connectedness, productivity, etc. For comparison, they are asked the same questions at different intervals during treatment, and at discharge.

**Figure 9: Positive Outcomes in Life Domains – All ages, SFY 2009 & 2010
(Percentage of Behavioral Health Consumers Improving or Maintaining Quality of Life)**

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



Source: [FY 12 DHSS Budget Overview](#), Division of Behavioral Health. Page 146

In fiscal years 2009 and 2010, at least 75% of individuals who received Behavioral Health community-based services and completed a follow-up Client Status Review reported “functioning well” for the following four life domains: Financial/Basic Needs, Housing Situation, Physical Health, and Thoughts of Self Harm. Less than 75% of individuals reported functioning well for two life domains: Meaningful Activities/Employment and Mental/Emotional Health.

The DHSS Division of Behavioral Health target is for 75% of individuals who receive Behavioral Health community-based services to report functioning well for each of the six life domains (Financial/Basic Needs, Housing, Activities/Employed, Mental/Emotional Health, Physical Health, & Thoughts of Self Harm)

Youth Connectedness at Levels of Family, School, and Community - Youth Risk Behavior Survey²²

Connectedness is a key protective factor correlated with a decrease in youth risk behaviors (use of tobacco, alcohol and other drugs, suicide ideation, violence and early sexual activity).²⁹ The term "connectedness," in this context, refers to the feeling of support and connection youth feel from their school and their community.

Youth who help others or who are engaged in community service activities are less likely to be involved in anti-social behaviors, to be suspended from school or to become pregnant.³⁰ Service activities also provide an opportunity for youth to form close relationships with caring adults.

Results from 2009 Youth Risk Behavior Survey²² of Alaska high school students:

- 17 percent agree or strongly agree that they feel alone in their life.
- 59 percent agree or strongly agree that they have teachers who really care about them and give them a lot of encouragement.
- 54 percent agree or strongly agree that in their community they feel they matter to people.
- 52 percent spend one or more hours helping or volunteering at school or in the community during an average week.
- 83 percent said they would feel comfortable seeking help from one or more adults besides their parents if they had an important question affecting their life.

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

Alaska Housing Finance Corporation Winter Survey Reports show that the number of homeless Alaskans increased 65 percent between 2006 and 2010. In 2010, approximately 11 percent of the homeless individuals had severe mental illness, 16 percent experienced chronic substance abuse, six percent were victims of domestic violence, and two percent were unaccompanied youth (under 18 years). Of the total homeless individuals, 57 percent were in families with children.³¹

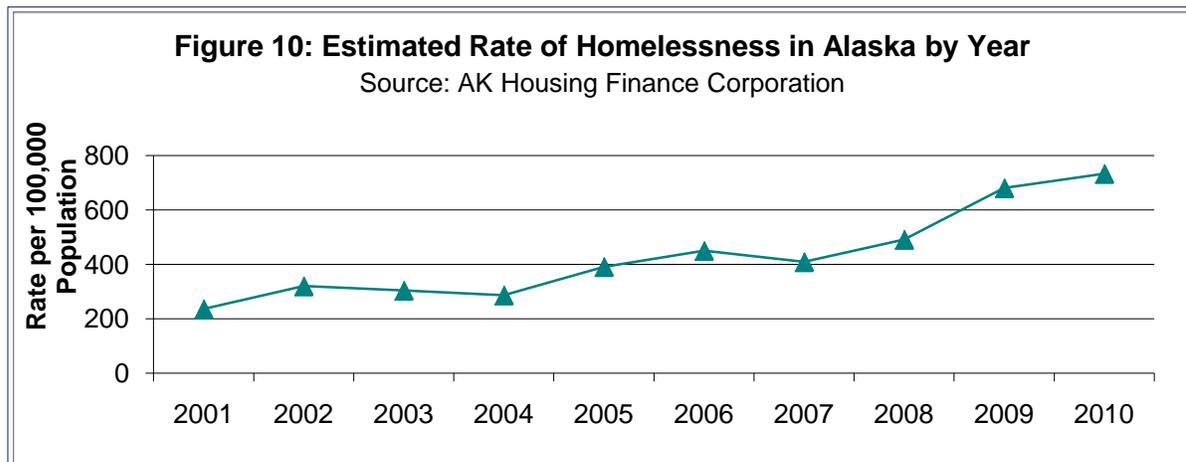
According to the [Alaska Housing Trust](#), homeless children are more likely to experience conditions of anxiety, withdrawal, depression, hunger, asthma, ear infections, stomach problems and speech problems than their peers.³² Homelessness results from a complex set of circumstances that require people to choose between food, shelter, and other basic needs. Contributing factors include:

- **Inadequate income.** A 2001 study found 57% of Alaska households could not afford a median-priced home and 46% could not afford the average rent.³³ In Anchorage, a person needs to earn \$19.83 per hour to afford a modest two-bedroom apartment at the average fair market rent of \$1031.³⁴ (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 Rate of Homelessness in Alaska by Year, 2001 - 2010

Figure 10 is an estimate based on the Alaska Housing Finance Corporation Winter Survey Reports. According to the Alaska Housing Finance Corporation, the following factors may have contributed to the recent increase in homelessness: (1) rising rent and utility costs, (2) stagnant wages & benefits; and (3) lack of available rental assistance.³⁵



The AHFC survey is completed annually on a predetermined day by providers of services for homeless people and community volunteers. 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.³⁶

Section 8 Public Housing

Approximately 4,275 Alaska residents currently are using Section 8 public housing vouchers. In addition, as of July 1, 2010, there were 5,850 households still waiting for Section 8 vouchers. Public housing vouchers are allocated from the U.S. Department of Housing and Urban Development to the Alaska Housing and Finance Corporation’s Public Housing Division. Based on the average per unit cost to assist a household in Alaska, the amount of funds received by HUD can actually support approximately 4,077 households. To absorb this deficit, AHFC issued very few vouchers in State Fiscal Year 2010.³⁵

Homeless Bed Inventory

According to the Alaska Housing and Finance Corporation, the 2010 Homeless Bed Inventory showed 1,081 year-round emergency shelter beds and 730 transitional housing beds for a total of 1,811 temporary beds in Alaska.³⁶

Supportive Housing

There are approximately 506 supportive housing units statewide. These units, designed for those who are homeless with special needs, enable people to live as independently as practicable. In supportive housing, residents have their own housing units and lease agreements.³⁶

Assisted Living

Throughout Alaska there are 3,408 assisted living beds in 612 licensed facilities. (*Assisted Living Home List* rev. 2/2011)³⁷ Assisted living is a more structured and regulated form of special needs housing. Often 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.

Living Situation at Discharge from API: January to December 2010³²

Homeless (11 of 1281)	0.86%
Shelter (37 of 1281)	2.89%

Alaska Department of Corrections:

When individuals are released from prison or jail, the ability to access safe and secure housing within the community is crucial to their successful reentry. Studies have shown that the first month after release is a vulnerable period during which the risk of becoming homeless and/or returning to criminal justice involvement is high. Yet, in most communities to which individuals return after incarceration, accessible and affordable housing is in exceedingly short supply. The additional challenges unique to people with criminal histories make it even more difficult for them to obtain stable housing. (Alaska Prisoner Reentry Task Force *Five-Year Prisoner Reentry Strategic Plan, 2011 - 2016*, p.

65. For more information and strategies, see *Five-Year Prisoner Reentry Strategic Plan, 2011 - 2016*, Chapter Seven: Housing Newly Released Prisoners, pp. 64-71.).

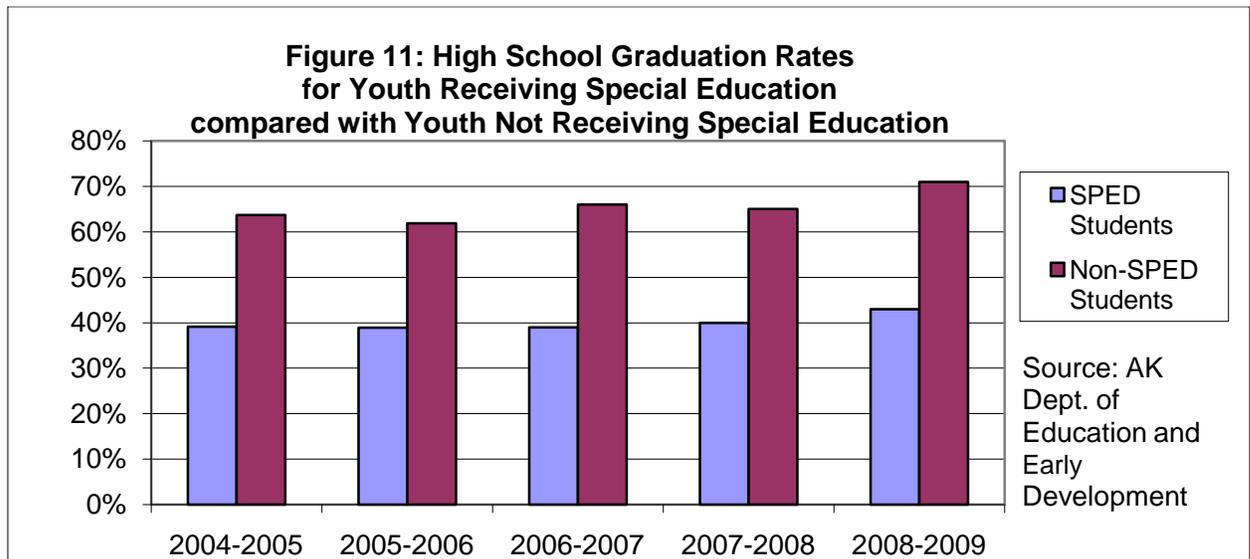
For more information on affordable, appropriate housing: Alaska Mental Health Trust Authority *Affordable Housing Focus Area Fact Sheet*

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

The federal Individuals with *Individuals with Disabilities Education Act (IDEA)*³⁸ is the primary law that entitles children with disabilities to a free and appropriate education. IDEA requires states to provide special education and related services to students who meet eligibility requirements. To be eligible, a student must meet criteria established in the law and the condition must adversely affect his or her educational performance. Children with disabilities must be taught in the least restrictive environment and among non-disabled children to the maximum extent appropriate.

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

Figure 11 — High School Graduation Rates for Students Receiving Special Education compared with Students not Receiving Special Education



Source: Alaska Department of Education and Early Development, Assessments and Accountability, Special Education Part B Data (email 9/30/10)

The 2009 graduation rate for Alaska high school students receiving special education services was 43 percent, and the rate for those not receiving special education was 71

percent. This data includes only students graduating with a regular diploma and not a GED.

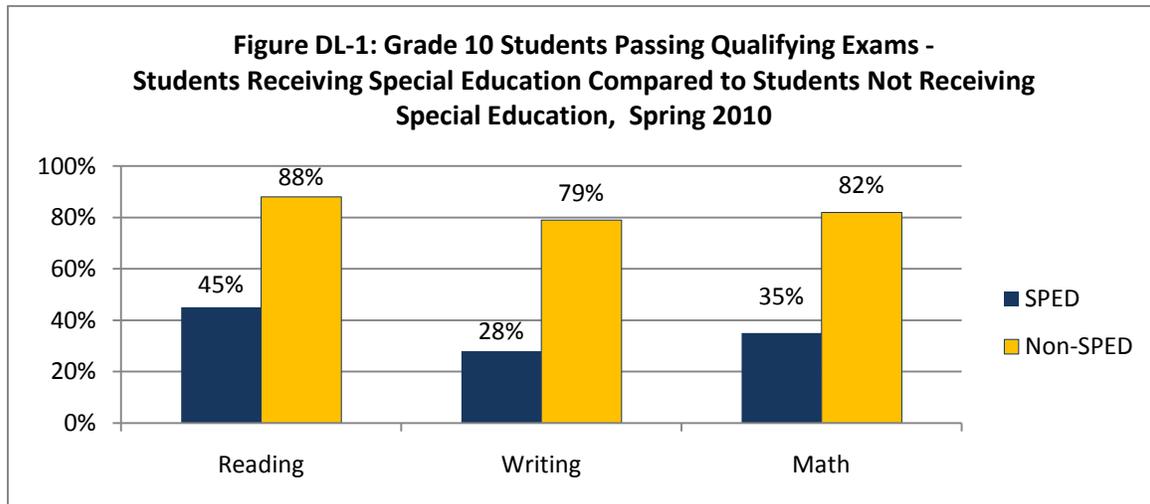
Alaska loses a significant number of students over their four years of high school. Reasons for discontinuing school include pursuing a GED, entering the military, becoming employed, facing family problems, illness, pregnancy, or alcohol/drug dependency, failing, truancy, being expelled due to behavior, 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).

For information about students who received special education services and are now employed or enrolled in post-secondary education, please see the *Alaska Scorecard: Key Issues Impacting Alaska Mental Health Trust Beneficiaries*

Figure DL-1 - Grade 10 Students Passing Qualifying Exams – Students Receiving Special Education Services and Students not Receiving Special Education Services, Spring 2010

The High School Graduation Qualifying Examination (HSGQE) measures minimum competencies of essential skills in reading, writing, and mathematics. Passing all three sections of the HSGQE is part of the requirements to receive a diploma in the State of Alaska. Students must take the HSGQE for the first time in the spring of the 10th grade.



Source: AK Department of Education and Early Development Assessments, Statewide Spring 2010 HSGQE

Figure DL-1 provides information about Alaska students in 10th Grade statewide who participated in the High School Graduation Qualifying Exam. In 2010, the percentage of students receiving special education services and scoring above proficiency in reading, writing, and math was 48% to 64% lower than the percent of students not receiving special education and scoring above proficiency.

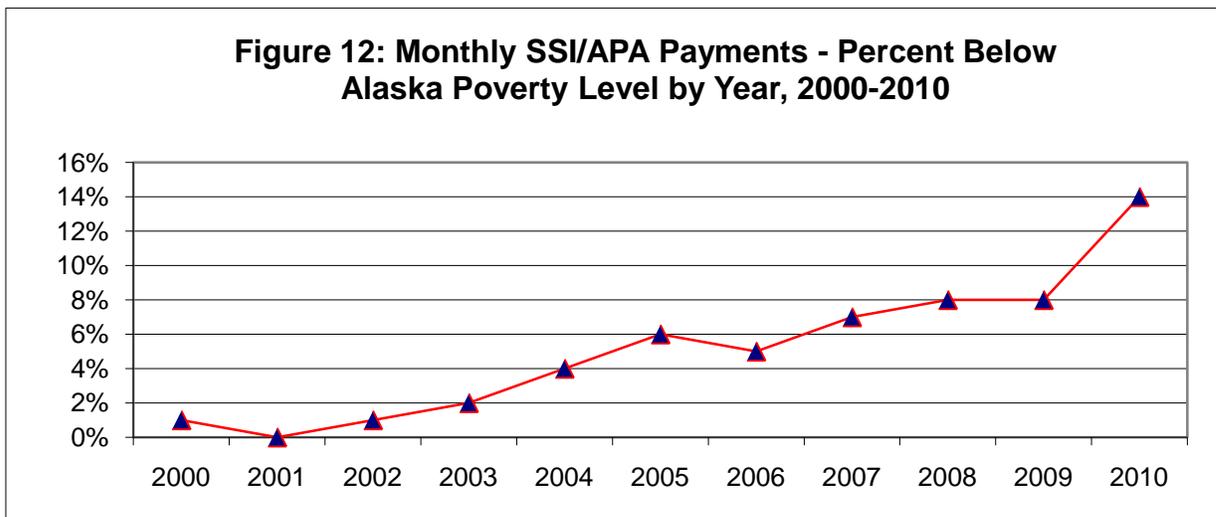
Economic Security

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

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

Figure 12 — Monthly SSI/APA Payments: Percent below Alaska Poverty Level by Year

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

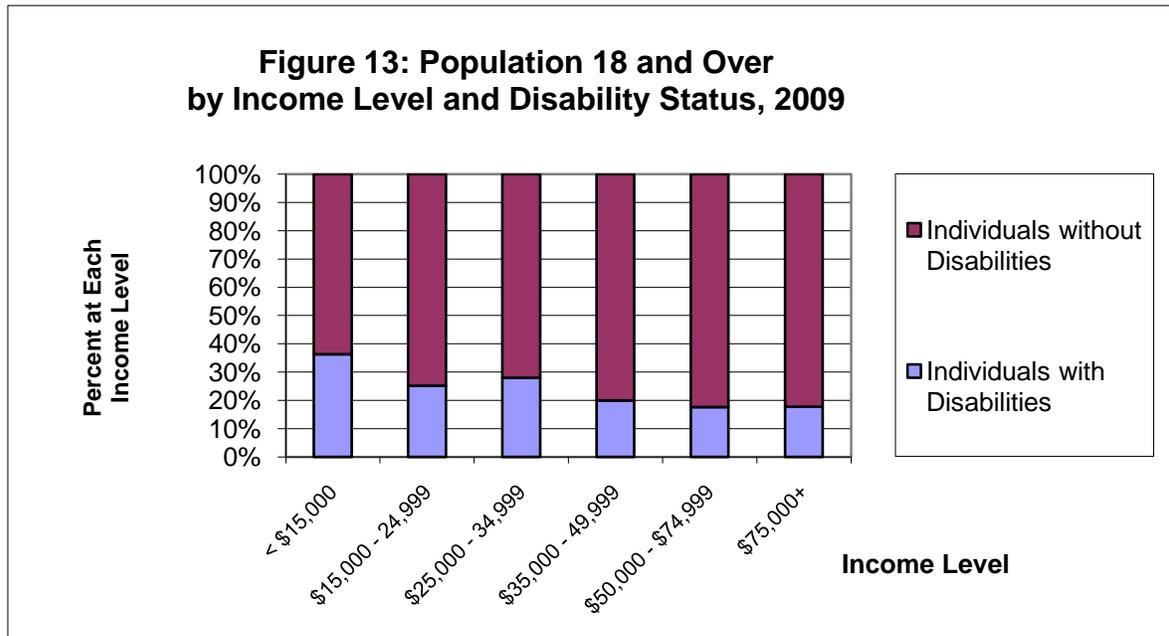


Source: DHSS Division of Public Assistance (email 10/25/10)

Figure 12 shows that the SSI/APA payment has eroded over the years in relation to the level of income that is defined each year as the Alaska poverty level. The monthly level of income defined as “poverty” in 2010 was \$1128, but the monthly SSI/APA payment was \$972.³⁹ The federal poverty guidelines remain unchanged from 2009.³⁹

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

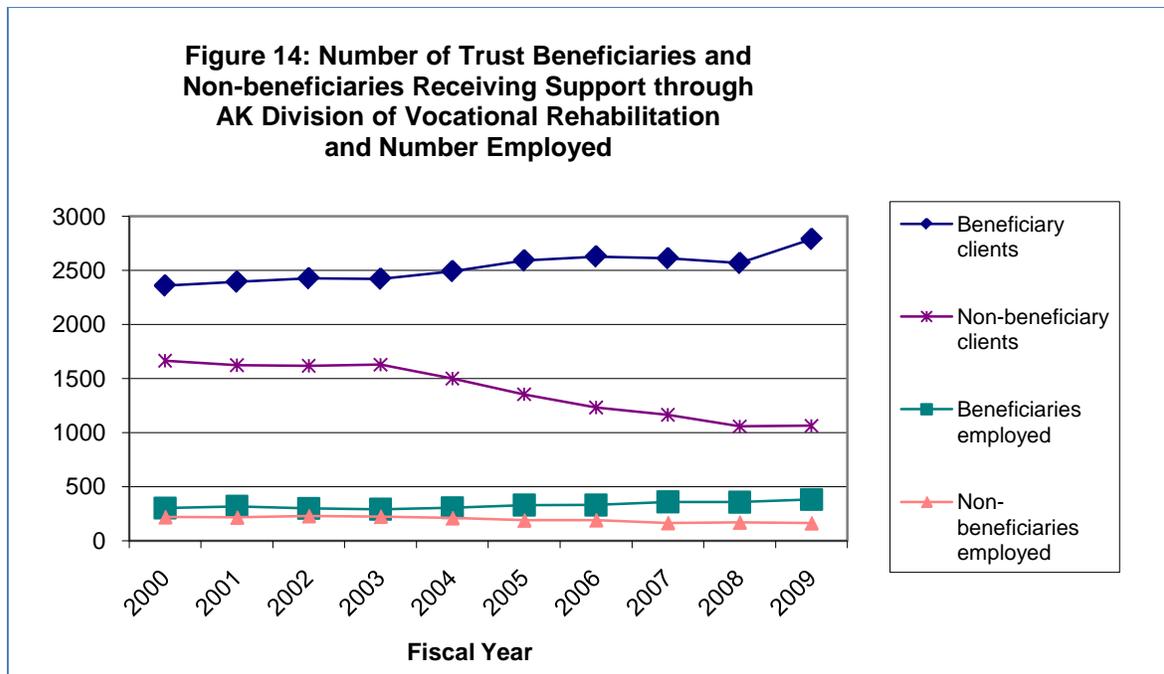
Behavioral Risk Factor Surveillance Survey data from 2007 and 2008 show that Alaskans experiencing a disability (i.e., limited in any way in any activities because of physical, mental or emotional problems) have a significantly lower annual income than those not experiencing a disability. Of the total number of BRFSS respondents making less than \$15,000 per year, 43% of them experienced a disability.⁹



Source: Behavioral Risk Factor Surveillance Survey, Standard and Supplemental (email 10/7/10)

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 2009, 72 percent were Trust beneficiaries.⁴⁵

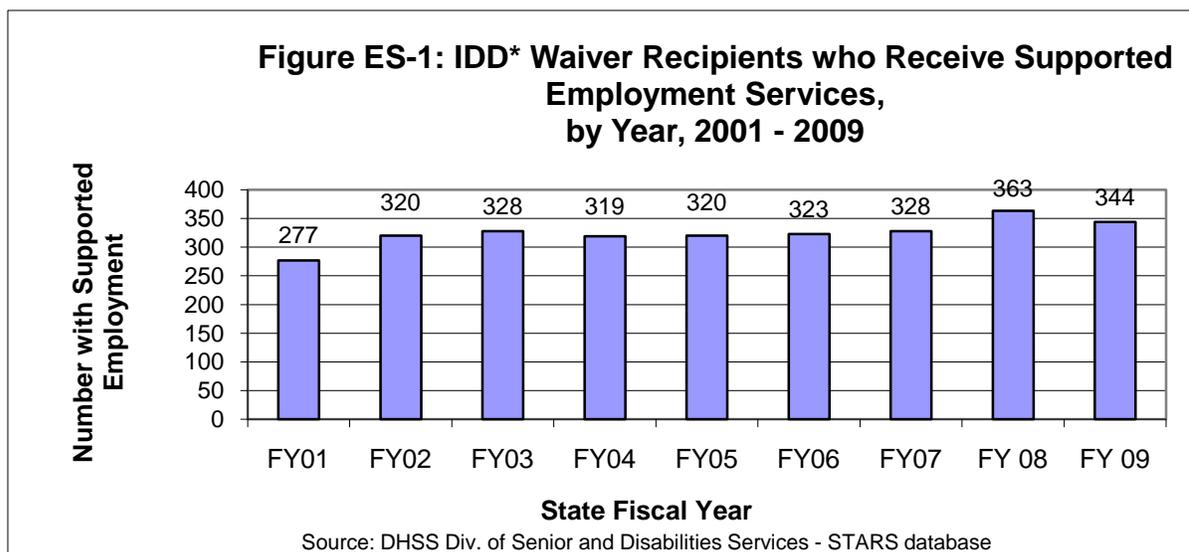


Source: AK Dept of Labor & Workforce Development, Division of Vocational Rehabilitation

Figure 14 shows that the number of Trust beneficiaries served by DVR has increased and the number of non-beneficiaries served has decreased during recent years. Between 2000 and 2009, the number of Trust beneficiaries served by DVR who became employed grew approximately 18 percent.⁴⁵

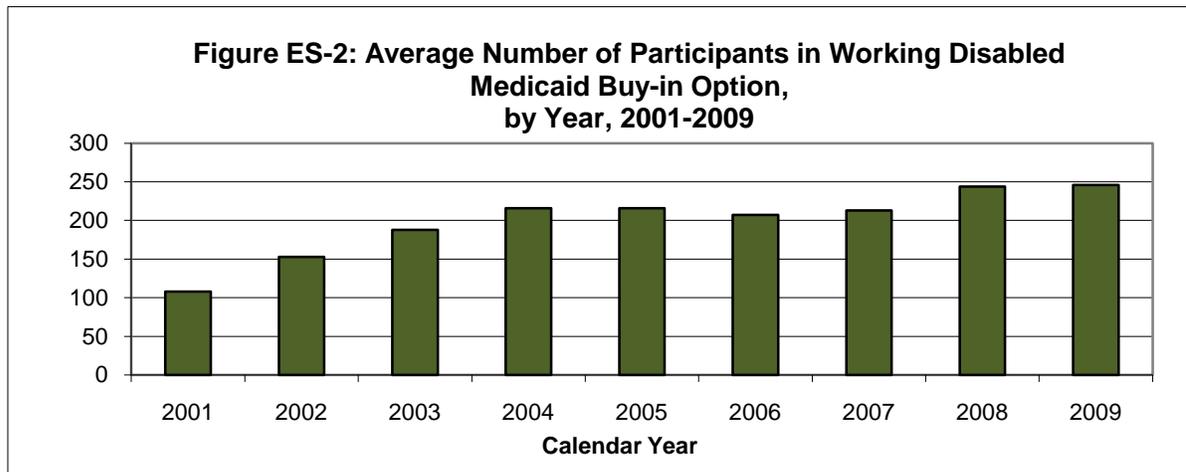
Figure ES-1: IDD Waiver Recipients who Receive Supported Employment Services

Figure ES-1 shows that the number of Intellectual and Developmental Disability (IDD) waiver recipients receiving supported employment has ranged from a low of 277 in fiscal year 2001 to a high of 363 in fiscal year 2008.



“Supported employment” is paid employment for persons with intellectual and 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, allowing participants to contribute to the community and to their own sense of self-esteem through work.⁴⁶

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

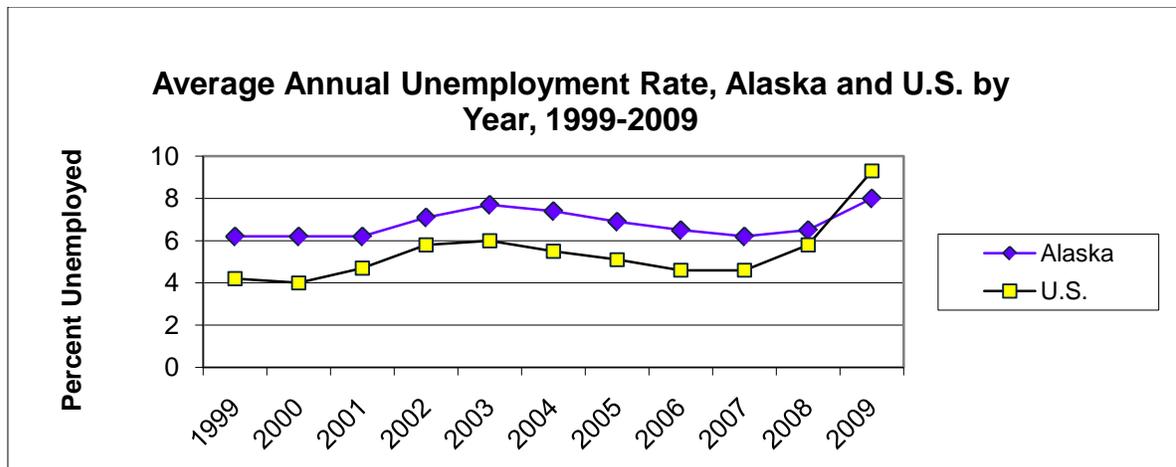


Source: AK DHSS Div. of Public Assistance Eligibility Information System (email 10/25/10)

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 \$1252 (\$1854, if married) and countable assets of less than \$10,000 (\$15,000, if married).³⁹

Figure ES-3: Average Annual Unemployment Rate, Alaska and U.S. by Year,

The unemployment rate for both Alaska and the U.S. increased between 2008 and 2009. In this data, persons are classified as unemployed if they do not have a job, have actively looked for work in the prior 4 weeks, and are currently available for work. Persons who were not working and were waiting to be recalled to a job from which they had been temporarily laid off are also included as unemployed. The unemployment rate represents the number unemployed as a percent of the labor force.⁴⁷



Source: Alaska Dept of Labor and Workforce Development, Research and Analysis Section, [Labor Force Statistics by Month](#) and U.S. Dept of Labor, Bureau of Labor Statistics, [Labor Force Statistics from the Current Population Survey](#)

Affordability of Housing

Many Alaskan families cannot afford adequate housing. The Fair Market Rent (FMR) for a two-bedroom apartment in Alaska is \$1,013. In order to afford this level of rent and utilities, without paying more than 30 percent of income on housing, a household must earn \$3,375 monthly or \$40,504 annually. (A unit is considered affordable if it costs no more than 30% of the renter's income.) Assuming a 40-hour work week, 52 weeks per year, this level of income translates into a Housing Wage of \$19.47.

In Alaska, a minimum wage worker earns an hourly wage of \$7.15. In order to afford the FMR for a two-bedroom apartment, a minimum wage earner must work 109 hours per week, 52 weeks per year. Or, a household must include 2.7 minimum wage earner(s) working 40 hours per week year-round in order to make the two-bedroom FMR affordable.

Monthly Supplemental Security Income (SSI) payments for an individual are \$674 in Alaska. If SSI represents an individual's sole source of income, affordable rent (30% of \$674) is \$202. However, the Fair Market Value for a one-bedroom rental is \$806.

Table E-1 - Alaska Rent-Wage Disparity by Census Area,

Table E-1 shows how much money a person in each Alaska census area would need to earn in order for them to be spending only the recommended 30 percent of their income on a typical two-bedroom rental. For instance, a person renting a two-bedroom apartment in Anchorage would need to earn \$19.04 per hour working regular fulltime hours. But if they were only able to earn minimum wage at \$7.15 per hour, they would need to work 107 hours per week.³⁴

For more information about homelessness, please see the [Living with Dignity](#) section of this plan.

Table E-1 Alaska Rent-Wage Disparities, 2009

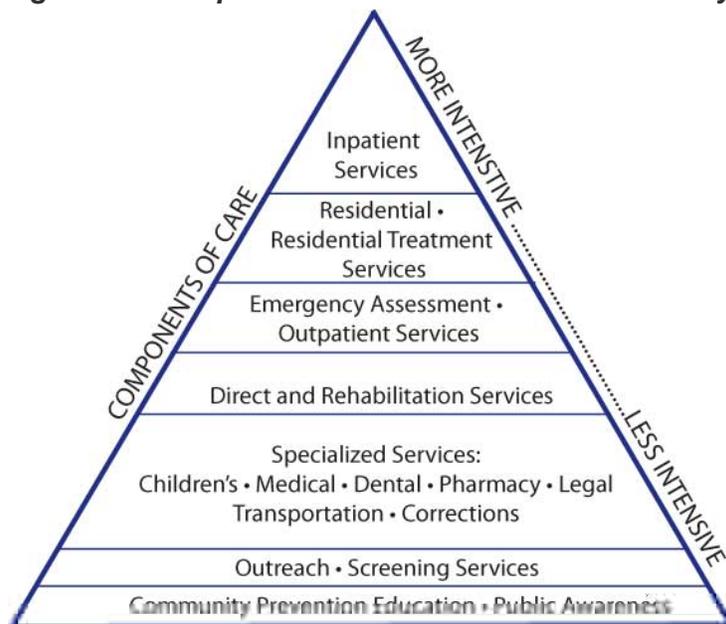
Community	Affordable Rent *	SSI/APA Affordable Rent	2-BR FMR	Wage Needed to Afford 2-BR FMR	Hrs pr wk @ Min Wage**
			Fair Market Rent	Per Hour	
Anchorage	\$606	\$202/\$109	\$990	\$19.04	107
Barrow	\$620	\$202/\$109	\$1,232	\$23.69	133
Bethel	\$352	\$202/\$109	\$1,352	\$26.00	145
Dillingham	\$440	\$202/\$109	\$1,120	\$21.54	120
Fairbanks	\$560	\$202/\$109	\$957	\$18.40	103
Juneau	\$686	\$202/\$109	\$1,222	\$23.50	131
Kenai	\$527	\$202/\$109	\$815	\$15.67	88
Ketchikan	\$578	\$202/\$109	\$1,072	\$20.62	115
Kodiak	\$570	\$202/\$109	\$1,154	\$22.19	124
Mat-Su	\$547	\$202/\$109	\$935	\$17.98	101
Nome	\$428	\$202/\$109	\$1,149	\$22.10	124
Sitka	\$605	\$202/\$109	\$1,024	\$19.69	110
Unalaska	\$703	\$202/\$109	\$1,120	\$21.54	120
Valdez	\$587	\$202/\$109	\$1,008	\$19.38	108

III. Current Services and Service Gaps Analysis (2006)

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

Components of Care

Figure 15: Components of Care for Trust Beneficiary Groups



The Trust and the Department of Health and Social Services support the components of care illustrated in Figure 15, ranging from prevention at the bottom to acute care at the top for people requiring intensive care. Public education and prevention services reach large audiences. Services in the middle of the triangle are home and community based and used by those people requiring a less intensive level of care.

Although economies of scale restrict some services to urban areas, the Plan's vision is that appropriate services would be available when needed across the state.

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

Current Services

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

Table 2: Current Comp MH Plan Services Matrix

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

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

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

Service Gaps Analysis

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

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

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

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

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

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

Definitions for “Levels of Community”

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

		community clinic and mid-level provider or MD.	community hospital and physicians.	and government programs; health care specialists; hospitals with full continuum of care.	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
Mental Illness and/or Substance Use Disorders**

LEVELS OF COMMUNITY*					
Characteristics	Level I: Frontier/Village	Level II: Sub-Regional Center or Town	Level III: Regional Center or Small City	Level IV: Urban Center	Level V: Metropolitan Area
I. Community Prevention / Education	I. Community Prevention & Education 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	II. 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	III. 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	IV. 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	b. Emergency Services	b. Emergency Services	b. Emergency Services	b. Emergency Services	b. Emergency Services

Services	i. 24 hour telephone screening, assessment, triage ii. Crisis Intervention & Stabilization General Availability? Very limited	i. 24 hour telephone screening, assessment, triage ii. Crisis Intervention & Stabilization General Availability? Good capacity	i. 24 hour telephone screening, assessment, triage ii. Crisis Intervention & Stabilization General Availability? Good capacity	i. 24 hour telephone screening, assessment, triage ii. Crisis Intervention & Stabilization General Availability? Very good capacity	i. 24 hour telephone screening, assessment, triage ii. Crisis Intervention & Stabilization General Availability? Very good capacity
c. Assessment	c. Assessment i. screening ii evaluation & referral General Availability? Very limited	c. Assessment i. screening ii evaluation & referral General Availability? Good capability	c. Assessment i. screening ii evaluation & referral General Availability? Good capability	c. Assessment i. screening ii evaluation & referral General Availability? Excellent capability	c. Assessment i. screening ii evaluation & referral General Availability? Excellent capability
d. Outpatient Services (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 services v. Supported Living vi. Individualized services vii. Intensive outpatient services General Availability? None	e. Rehabilitation & Recovery Services i. Case Management ii. Skill Development iii. Day Treatment iv. School/home-based services v. Supported Living vi. Individualized services vii. Intensive outpatient services General Availability? Very limited	e. Rehabilitation & Recovery Services i. Case Management ii. Skill Development iii. Day Treatment iv. School/home-based services v. Supported Living vi. Individualized services vii. Intensive outpatient services General Availability? Good capacity	e. Rehabilitation & Recovery Services i. Case Management ii. Skill Development iii. Day Treatment iv. School/home-based services v. Supported Living vi. Individualized services vii. Intensive outpatient services General Availability? Excellent capability	e. Rehabilitation & Recovery Services i. Case Management ii. Skill Development iii. Day Treatment iv. School/home-based services v. Supported Living vi. Individualized services vii. Intensive outpatient services General Availability? Excellent capacity
f. Medical Services	f. Medical Services i. Psychiatric Assessment ii. Pharmacological Management iii. Medical Comorbidity	f. Medical Services i. Psychiatric Assessment ii. Pharmacological Management iii. Medical Comorbidity	f. Medical Services i. Psychiatric Assessment ii. Pharmacological Management iii. Medical Comorbidity General	f. Medical Services i. Psychiatric Assessment ii. Pharmacological Management iii. Medical Comorbidity	f. Medical Services i. Psychiatric Assessment ii. Pharmacological Management iii. Medical Comorbidity

	General Availability? None	General Availability? Limited	Availability? Good capacity	General Availability? Good capacity	General Availability? Good capacity
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 General Availability? None	a. Day Treatment b. Foster Homes c. Therapeutic Group Homes d. Emergency Stabilization & Assessment e. Residential Treatment f. Secure Locked Residential Care General Availability? Very limited	a. Day Treatment b. Foster Homes c. Therapeutic Group Homes d. Emergency Stabilization & Assessment e. Residential Treatment f. Secure Locked Residential Care General Availability? Limited Capacity	a. Day Treatment b. Foster Homes c. Therapeutic Group Homes d. Emergency Stabilization & Assessment e. Residential Treatment f. Secure Locked Residential Care General Availability? Good capacity	a. Day Treatment b. Foster Homes c. Therapeutic Group Homes d. Emergency Stabilization & Assessment e. Residential Treatment f. Secure Locked Residential Care General Availability? Good capacity
b. Adult Services	a. Crisis Respite	a. Crisis Respite	a. Crisis Respite	a. Crisis Respite	a. Crisis Respite

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

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

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

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

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

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

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

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

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

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

Intake Assessment, Drug/Alcohol Assessment, Psychiatric Assessment, Psychological Assessment, Neuron-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 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	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	Telephonic 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 Day Habilitation Supported Employment / Subsistence Activities Vocational Rehabilitation	Case Management & Care Coordination Respite Specialized Medical Equipment Environmental Modifications Day Habilitation Supported Employment / Subsistence Activities General Availability?	Case Management & Care Coordination Respite Specialized Medical Equipment Environmental Modifications Day Habilitation Supported Employment / Subsistence Activities Vocational Rehabilitation	Case Management & Care Coordination Respite Specialized Medical Equipment Environmental Modifications Day Habilitation Supported Employment Vocational Rehabilitation Transportation	Case Management & Care Coordination Respite Specialized Medical Equipment Environmental Modifications Day Habilitation Supported Employment Vocational Rehabilitation Transportation

	Transportation	Vocational Rehabilitation	Transportation	Coordinated transportation system	Coordinated transportation system
	Educational services	Transportation	Coordinated transportation system	Educational services	Educational services
	Infant Learning	Educational services	Educational services	Infant Learning	Infant Learning
	Preschool	Infant Learning	Infant Learning	Preschool	Preschool
	K-12	Preschool	Preschool	K-12	K-12
	Chore Services	K-12	K-12	Chore Services	Chore Services
	Intensive Active Treatment	Chore Services	Chore Services	Intensive Active Treatment	Intensive Active Treatment
	Crisis Response	Intensive Active Treatment	Intensive Active Treatment	Crisis Response	Crisis Response
	Legal Services	Crisis Response	Crisis Response	Medical	Medical
		Legal Services	Medical	Dental	Dental
			Dental	Pharmaceutical	Pharmaceutical
			Pharmaceutical	Recreation	Recreation
			Recreation	Legal Services	Legal Services
			Legal Services		
III. Residential Services	In-home Support	In-home Support	In-home Support	In-home Support	In-home Support
	Shared Care	Shared Care	Shared Care	Shared Care	Shared Care
	Family Habilitation	Family Habilitation	Family Habilitation	Family Habilitation	Family Habilitation
	Supported Living	Supported Living	Supported Living	Supported Living	Supported Living
			Group Home	Group Home	Group Home

Definitions - Continuum of Care Matrix for Alaskans with Developmental Disabilities

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

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

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

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

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

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

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

Supported Employment services are provided at a work site in which individuals without disabilities are employed. They include the adaptations, supervision and training needed by

individual unlikely to obtain competitive employment at or above the minimum wage. Supported employment is for individuals who need intensive, ongoing support, supervision and training to perform in a work setting. Supported employment may include subsistence activities.

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

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

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

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

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

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

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 Alaskans with Alzheimer’s Disease and Related Dementias and Older Alaskans

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

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

	limited, not available in most villages	limited, not available in all towns	dependent on workforce availability	dependent on workforce availability	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 – congregated 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 – congregated and home-delivered, one or both available in some communities	Meals – congregated and home-delivered available	Meals – congregated and home-delivered available
vii. Assisted transportation	Not available	Not available	Assisted transportation - limited availability	Assisted transportation	Assisted transportation
viii. Environmental modifications	Environmental modifications – rarely available due to lack of local contractors	Environmental modifications – dependent on availability of local contractors	Environmental modifications – dependent on availability of local contractors	Environmental modifications	Environmental modifications
ix. Specialized medical equipment	Specialized medical equipment – limited availability	Specialized medical equipment – limited availability	Specialized medical equipment	Specialized medical equipment	Specialized medical equipment
f. Family Caregiver Support	Family caregiver support – very limited, not available in most	Family caregiver support – limited, not	Family caregiver support – dependent on	Family caregiver support – dependent on	Family caregiver support – dependent on

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

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

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

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

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

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

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

Personal Care Attendants: Personal Care Services are designed to assist seniors in need of assistance with Activities of Daily Living (e.g. bathing, eating etc.) in their own homes. This service provided through Medicaid can be utilized in two distinct ways: Agency Based services allow for a certified provider to manage the hiring and supervision of a Personal Care Attendant for a senior while Consumer Directed PCA allows for that attendant to be hired and supervised by the senior or their legal representative receiving the services with minimal assistance from an agency.

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

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

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

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

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

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

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

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

Legal Service: Legal services for seniors consist primarily of guardianships and other minor legal problems. Through funding from the U.S. Administration on Aging and the State of Alaska,

a provision of legal services is provided for seniors and their caregivers through Alaska Legal Services Corporation.

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

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

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

IV. Examples of Current Initiatives, Projects, and Activities That Fill Service Gaps (updated 2010)

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

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

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

For more information on initiatives, see:

- [Department of Health and Social Services Annual Report 2009](#)
- [DHSS Winter Update 2009-10](#)
- [Trust 2009 Annual Report](#)
- [Beneficiary-related Boards'/Commissions' Reports](#)
 - [AK Commission on Aging FY 2009 Annual Report](#)
 - [2009 Annual Report for AMHB and ABADA](#)
 - GCDSE [2007-2011 State Plan](#)

Overview – List of Initiatives, Projects and Activities (2010)

DHSS Priority Area: Substance Abuse

- Comprehensive Fetal Alcohol Syndrome Project
- Rural Substance Abuse Prevention

DHSS Priority Area: Health and Wellness

- Alaska Suicide Prevention Initiative
- Alaska Tuberculosis (TB) Program
- Autism Initiative
- ECCS Early Childhood Mental Health Cross-Systems Workgroup
- HIV/STD Program
- Senior Behavioral Health
- Senior Fall Prevention
- Traumatic Brain Injury Project

DHSS Priority Area: Health Care Reform

- Bring the Kids Home, Trust Focus Area
- Juvenile Justice System Improvement Initiative
- Justice for Persons with Disabilities, Trust Focus Area
- Medicaid Waiver Rates
- Workforce Development

DHSS Priority Area: Long-Term Care

- Aging and Disability Resource Centers
- Supporting Family Caregivers

DHSS Priority Area: Vulnerable Alaskans

- [Affordable Appropriate Housing](#), Trust Focus Area
- Alaska Works Initiative
- [Division of Behavioral Health Performance Management System Project](#)
- Families First! / Family Centered Services
- Public Health Nurses Addressing Domestic and Family Violence
- Start Up Alaska Project
- Trust Beneficiary Projects, Trust Focus Area
- Trust Coordinated Communications Campaign

DHSS Priority Area: Substance Abuse

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 those conditions caused by prenatal exposure to alcohol, including fetal alcohol syndrome (FAS).

FAS is a medical diagnosis defined by the presence of specific growth and nervous system abnormalities and other factors. Receiving an early, comprehensive diagnosis that looks at growth deficiencies, facial dysmorphism, central nervous system functionality and maternal history of alcohol abuse provides a complete picture of the level of disability, the impaired functionality, and the overall interventions and accommodations that will benefit the individual. This is the first and most important intervention—from a comprehensive diagnosis, a clear case plan can be implemented and service delivery needs can be better coordinated.

FASD is found among all races and all socio-economic groups – wherever women drink alcohol, FASD can exist. 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.

Recent Accomplishments

- Recent data released by the Alaska Birth Defects Registry indicates that FAS birth prevalence in Alaska declined by 32% during 1996-2002. (Children are often not identified and reported as FAS/D until around age six, when they are entering school; this is why 2002 is the most recent birth year reported.) The FAS birth prevalence declined by almost 50% among Alaska Natives. This data suggests that the FAS prevention efforts started by the Office of FAS and continued by the Behavioral Health [Office of Prevention and Early Intervention](#) have made an impact in reducing the incidence of FAS in the Alaska population. For data, see [Comp MH Plan Figure HA-4](#).
- A new diagnostic team has recently been established in Anchorage to serve residents in Anchorage and outlying communities. ASSETS, Inc. of Anchorage will begin offering diagnostic services to the Anchorage area in March of 2010. The presence of the new team in Anchorage will significantly increase the State of Alaska's diagnostic capacity for FAS.

- Alaska's 3-M Project of Modeling, Mentoring, and Monitoring for Alaskan youth with an FASD has increased in capacity in the last year. In the last year, they have recruited many new providers in communities throughout Alaska and have offered comprehensive, wrap-around training to those providers on topics related to FASD. It is expected that enrollment in the 3-M Waiver Project will increase in the coming year.

Recent Challenges

- There continues to be a lack of services for individuals with an FASD after they receive their diagnosis. These clients often do not meet qualifications for services through Developmental Disability, while other social services are not structured in a way that accommodates the needs of those with an FASD. Expansion of specialized FASD services would reduce the number of individuals with FASD entering the criminal justice system, the inpatient mental health system and other emergency based services; all of which are very costly to the State of Alaska.
- While training around FASD has expanded in the last year, there continues to be a lack of appropriate training in how to most effectively work with individuals who live with a FASD. The Behavioral Health Office of Prevention and Early Intervention has addressed this need with the development of FASD 101 and FASD 201 training. At this time, over 60 Alaskans are trained to provide the FASD 101 training in their communities. By April of 2010, the State will begin training trainers in the use of the newly revised FASD 201 training. While this training offers providers an introduction to effective processes of supporting those with an FASD, more intensive, role-specific training is needed for social service professionals throughout the state. The development and delivery of this training would increase providers' efficacy in offering accommodations to people with an FASD, thereby lowering service costs and recidivism.
- FAS is 100% preventable when a woman refrains from drinking during pregnancy. Despite this fact, there continues to be a notable lack of needed substance abuse treatment services for pregnant women who suffer from chronic alcoholism. Environmental strategies for FASD prevention, such as public service announcements and brochures in doctor's office will not help these women. They need intensive substance abuse treatment. Currently, the Advisory Board on Alcoholism and Drug Abuse and the Division of Behavioral Health are addressing this need by putting forth an increment for the FY 2011 budget that would increase funding for substance abuse treatment for pregnant women. While the placement and disbursement of this increment would help in the effort of offering support to this population, more funding is needed to adequately prevent FASD.

Rural Substance Abuse Prevention

The Alaska Department of Health and Social Services Division of Behavioral Health was awarded a five-year grant from the Substance Abuse and Mental Health Services Administration (SAMSHA) [Strategic Prevention Framework State Incentive Grant \(SPF SIG\) program](#). The grant targets rural Alaska's ability to promote communities' behavioral health – a term that includes both mental health and substance abuse prevention.

The Behavioral Health Division and its partners will develop more than a dozen regional training and support teams to serve the 200-plus villages and communities in remote Alaska. The grant will give the

smallest communities an unprecedented opportunity to build on their strengths and use prevention strategies that have been researched and found to be successful in Alaska.

Due to the SAMHSA grant requirements, the first year will be spent analyzing data and resources to develop a statewide rural substance abuse prevention plan; once completed, grant funds will then be available to communities. To build the prevention plan, the Division of Behavioral Health, Prevention and Early Intervention Services section will work with Tribal and health organizations, other state agencies, schools, private non-profits, the University of Alaska, and others.

The Strategic Prevention Framework State Incentive Grant (SPF SIG) program provides funding to States and federally recognized Tribes and Tribal organizations to implement SAMHSA's Strategic Prevention Framework in order to:

- prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking,
- reduce substance abuse-related problems in communities, and
- build prevention capacity and infrastructure at the State/Tribal and community levels.

The Strategic Prevention Framework is built on a community-based risk and protective factors approach to prevention and a series of guiding principles that can be operationalized at the Federal, State/Tribal and community levels.

DHSS Priority Area: Health and Wellness

Alaska Suicide Prevention Initiatives

According to a 2006 national study of suicides in the United States, Alaska ranks second among states with the highest suicide rate in the country. Alaska had approximately 167 suicides in 2008. Suicide is the second leading cause of death among Alaskans under age 50. According to the [2009 Youth Risk Behavior Survey](#), approximately nine percent of high school students had attempted suicide in the past 12 months. Historically, the most suicides are occurring among our young people ages 20-29 years and are equally represented among both rural and urban communities. During 2008, there were also many suicides among veterans, accounting for 27 deaths. (VDRS – verify and add references)

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

Recent Accomplishments

- ***Rural Suicide Prevention Planning Grant Project.*** The Alaska Department of Health and Social Services Division of Behavioral Health received a one-time FY09 state general fund allocation of \$200,000 for suicide prevention planning in rural areas with high rates of suicide. Areas awarded

grants included Nome, Kotzebue, Dillingham, Bristol Bay and Lake and Peninsula, and Akiachak and surrounding villages of Tuluksak, Kwethluk and Akiak. Those regions are continuing to plan and implement key strategies including use of evidence-based and other best practices to address suicide in their villages, communities and regions.

- ***Alaska Youth Suicide Prevention Project.*** The Alaska Department of Health and Social Services awarded three \$339,000 regional grants as part of the Alaska Youth Suicide Prevention Project. This project carries the message to communities that youth suicide is preventable, and targets high-risk youth for prevention, intervention and follow-up. Grants were awarded to regional agencies to develop suicide prevention teams that will be responsible for building a strategic plan tailored to their region. The plans include steps to 1) prevent youth suicide by promoting positive activities, 2) intervene by identifying youth at risk and referring them to help, and 3) follow up in the wake of a suicide attempt. Plans are required to include Gatekeeper training, a “first responder” training that teaches paraprofessionals and community members how to identify risk factors and warning signs associated with suicide and how to connect youth at risk to community supports and professional resources. Other components of the plan are decided by each region. The Division of Behavioral Health, Prevention and Early Intervention Services section is coordinating the awards.
- ***Comprehensive Behavioral Health Prevention and Early Intervention Services Grant.*** The Division of Behavioral Health, Prevention and Early Intervention Services section also is coordinating the *Comprehensive Behavioral Health Prevention and Early Intervention Services Grant* program which includes Alaska Careline, 24/7 crisis hotline and community-based suicide prevention projects and grant programs in both urban and rural/remote communities throughout the state. The section also coordinates the ***Alaska Gatekeeper Suicide Prevention Training Program*** which trains instructors in the delivery of suicide prevention awareness, education and intervention models to a wide variety of both professional and community based health providers, youth serving organizations, Tribal organizations, educators, clergy, first responders as well as community members or laypersons.

Recent Challenges

- Challenges facing these initiatives and strategies are how to balance identified needs and resources with the understanding that 1) suicide prevention requires a multi-faceted approach, integrated into Alaska’s continuum of care; 2) efforts must be targeted simultaneously at the community, family and individual level; and 3) for any of these efforts to be successful, there must be community involvement. That may require an assessment of readiness to address suicide prevention at the community level. Through capacity development at both the community and regional level, we can expect that suicide prevention strategies that utilize effective practices will be both culturally responsive and sustainable in the long term.
- A key challenge is identifying and developing effective and accurate methods of data surveillance in the State in order to learn more about potential areas for improvement within the various systems of health care. Local and community data could also help us understand community based processes that may rely on informal supports or services that often bridge the gap between medical models based on disease prevention and community prevention efforts that may rely more on public health models and the advancement or promotion of health and

wellness. This is especially key in areas of the state that experience high rates of suicides and have little access to formal systems of care.

Alaska Tuberculosis (TB) Program

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

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

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

Recent Accomplishments

- The statewide TB rate remained stable in 2008.

Recent Challenges

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

Outcome Data: Summary information about tuberculosis in Alaska: 2004-2008

	2004	2005	2006	2007	2008
No. of TB cases	43	59	70	50	50
No. of cases associated with outbreaks	0	0	28	9	6
Alaska population	656,834	663,253	670,053	676,987	676,987
Alaska case rate (per 100,000)	6.6	8.9	10.4	7.4	7.4
USA case rate (per 100,000)	4.9	4.8	4.6	4.4	4.2
Alaska population 0-14 years	160,722	160,376	160,168	161,576	161,576
No. 0-14 yrs old (% total)(cases/100,000)	6 (14%) (3.7)	7 (12%) (4.4)	7 (10%) (4.4)	4 (8%) (2.5)	4 (8%) (2.5)
No. foreign born (% total)	9 (21%)	17 (29%)	12 (17%)	8 (16%)	12 (24%)
No. homeless in Anchorage(cases/100,000)	0 (0)	1 (25)	28 (650)	9 (225)	6 (150)
No. with isoniazid-resistant TB	2	2	2	0	1
No. with multiple drug resistant TB (MDR-TB)*	0	0	1	0	0
No. offered HIV testing (% of total)	33 (77%)	46 (78%)	51 (73%)	36 (71%)	31 (62%)
No. TB cases infected with HIV	2	0	1	1	1
No. drug use (IV & non-IV) (% total)	4 (9%)	2 (3%)	2 (3%)	6 (12%)	4 (8%)
No. excessive alcohol use (% total)	12 (28%)	8 (14%)	30 (43%)	20 (39%)	16 (32%)

Autism Initiative

The prevalence of autism spectrum disorders has increased dramatically in recent years. A recent study by the Centers for Disease Control and Prevention suggests that 1 in 150 children have an autism spectrum disorder.¹⁰

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

Recent Accomplishments

- As a result of the Council's advocacy, the State Board of Education and Early Development added advanced nurse practitioners to the list of medical personnel that can make an autism diagnosis for special education purposes (adopted 6/12/09).
- The DHSS Division of Public Health received a federal grant which focuses on increasing access to screening and diagnosis for children residing in rural and remote areas of the state. Children in these areas are typically diagnosed with autism one to three years later than children who reside in urban communities.
- The Center for Human Development at the University of Alaska Anchorage has developed a system to assist and train advanced graduate professionals to secure national credentials as Board Certified Applied Behavioral Analysts (BCBA); board certification requirements include completion of five graduate-level courses, 1,500 hours of field experience and passing the national examination. Based on current population size, Alaska has need for at least 30 BCBA specialists. A program is also being developed to train undergraduate and paraprofessional direct service personnel. The first annual week-long Summer Institute for professionals and paraprofessional was held in the summer of 2009. In addition the Office of Children Services through its Early Intervention/Infant Learning Program will be offering training on evidence-based strategies to promote social and communication skill acquisition by very young children, starting in summer 2010.

Recent Challenges

- Studies have shown that some children with autism who receive intensive, autism-specific intervention services (at least 25 hours per week) for three or more years, need significantly fewer, or even no supports as they progress through school and into adulthood. Currently, there are four ways families typically receive services: 1) through the Infant Learning Program up to age three; 2) through the school district from ages 3-21; 3) through the Division of Senior & Disabilities Services (home and community-based Medicaid waivers or grant-funded services; and 4) through private therapists and/or paraprofessionals. Recommended time-limited, intensive early interventions as described above are generally not available in Alaska. The

Department is currently exploring a variety of options for providing time-limited intensive early intervention services (i.e., new waiver, modification of current waivers, provisions of the Deficit Reduction Act).

- Some individuals with autism will require long-term supports available through a waiver. These services include but are not limited to social skills training, facilitated communications, positive behavioral support and intensive therapy services (e.g., speech/language therapy). These services could potentially be added to current waivers or some might be able to be included under existing services such as intensive active treatment.
- Although more and more states are passing bills mandating private insurance coverage for autism, currently insurance plans in Alaska do not include coverage for autism. HB 187 and SB 250, if passed, will require private insurance coverage of autism services, including Applied Behavior Analysis, up to \$36,000 per year through age 21.

Outcome Data

- Recent autism diagnostic clinic data shows a 44% increase in children served over the 2007 baseline, which suggests that adding services and a provider were effective expansion tactics.
- The Alaska Autism Resource Center provided general training to 1,750 individuals and provided information and referral services to approximately 3,000 individuals at 30 community health fairs.
- A total of 15 individuals are being supported to secure their national credentialing as Board Certified Applied Behavior Analysts. It is anticipated that a new cohort of at least six individuals will begin their two-year studies in fall 2010.

Early Childhood Mental Health Cross-Systems (ECCS) Workgroup

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

The more risk factors young children experience, the more likely they are to experience adverse mental health outcomes as children and to be negatively impacted as adults. Neuroscience calls special attention to the potential risks to healthy social and emotional development for young children facing toxic levels of stress that accompany such things as abuse and neglect, traumatic events, and poor parenting. According to the Office of Children's Services, approximately 65% of the children in out-of-home placements in Alaska are children from birth through eight years of age. In the 2004 Alaska Market Rate survey of child care programs, 38 percent of programs reported asking families to withdraw a child under the age of 6 with social/emotional problems. In FY 08, almost 18% of children enrolled in the Infant Learning Program had social/ emotional delays of 50% or more. Alaska Medicaid data shows that in FY 07, 2621 young children below the age of 8 years had Medicaid mental health billings claims.

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

Recent Accomplishments

- The Early Childhood Mental Health Institute was held in May 2009 to improve the skills of mental health practitioners already working in the early childhood field. Training was provided on “Responding to Infant and Early Childhood Mental Health Needs Within the Context of Relationships”, “Helping Young Children and Families Impacted by Trauma: A Components-Based Intervention Approach”, “Identification of Sensory Processing Difficulties and Intervention with Young Children and their Families”, and “Infant Mental Health and DIR Approach (Developmental, Individual-Difference, Relationship-Based)”
- The ECCS (Early Childhood Comprehensive Systems) Early Childhood Mental Health Cross-Systems Workgroup obtained approval for mental health providers to use the DC: 0-3R (Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood) to diagnosis children birth through five. A cross walk from the DC: 0-3R to the ICD9 billing codes was created for Medicaid billing.
- Many parents are working outside the home, and children are spending more and more time in out-of-home care. Too often children with behavioral or social emotional concerns move from program to program because early childhood staff members are not trained to deal with their difficult behaviors and work with their families. To address these concerns, an early childhood mental health consultation grant was awarded to Anchorage Community Mental Health Services. ACMHS is working in partnership with *thread* (formerly Child Care Connection) to respond to requests from early childhood programs and parents in the Anchorage area with concerns about individual children. The intended outcomes for this project are to help to stabilize a child’s placement, increase the quality of care and link families to needed services.

Recent Challenges

- There continues to be a lack of understanding about the importance of addressing childhood mental health concerns as early as possible and about the long term impact when problems go undetected or unsupported. When problems are not addressed, they grow in magnitude and severity, taking their toll on families and creating the need for more costly interventions later on.
- There is a lack of funding directed toward this population. Funding strategies need to be developed and utilized that include pooling or reallocating existing resources, integrating services into to programs that families typically use, bringing children and families into the service system early, and decreasing the need for more intensive services at a later date.

HIV/STD Program

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

The HIV/STD Program funds partner services for newly reported HIV/AIDS clients and funds the targeted HIV prevention activities through grants to various agencies statewide. These efforts target those at highest risk to acquire HIV, programs in 2010 include: (1) targeting young and Alaska Native men who have sex with men (MSM) ; (2) targeted outreach to homeless and runaway youth, injection drug users, and heterosexual adults at increased risk; (3) HIV counseling and testing in community release centers and correctional facilities, and to social networks targeting highest risk individuals; (5) educational, support, and social groups for HIV-positive persons; (6) individual HIV prevention counseling for HIV-positive persons in medical care; and (7) social marketing campaign for rural Alaska on HIV prevention. HIV Care services are directed to individuals who are in need of medical care through state HIV care grants to community-based organizations for individualized case management; client advocacy; access to HIV-related medications; and payment for outpatient medical, dental, mental health, and other supportive services for individuals and families affected by HIV.

Recent Accomplishments

- HIV/STD Program staff have established and enhanced HIV Care services through collaborative partnerships with public and private medical services providers across the state. Included are the Alaska Native Tribal Health Consortium Early Intervention Services for HIV Care, Anchorage Neighborhood Health Center, Interior Community Health Center (Fairbanks), Department of Corrections, and private medical providers. Coordination and collaboration across agencies helps individuals with HIV to receive comprehensive individualized medical services.
- STD Program staff have built and maintained collaborative working relationships with numerous public, private, and non-profit agencies (Municipality of Anchorage Reproductive Health Center, Department of Corrections, Department of Education and Early Development, Alaska Native Regional Health Centers, Alaska Native Tribal Health Consortium, Planned Parenthood, Section of Nursing, Division of Juvenile Justice, etc.) to further our shared goal of reducing the burden of sexually transmitted diseases in Alaska.
- The internet has successfully provided outreach, counseling, and referral to hard to reach MSM and high risk youth in Alaska.

Recent Challenges

- Statewide delivery of STD services with an inadequate public health infrastructure continues to present a significant challenge for STD prevention activities.
- Alaska may not be able to meet the demand of providing medication to all eligible individuals in the near future. There continues to be a growing population of individuals with HIV infection due to a longer life span for infected individuals and a steady rate of new infections each year.

Newly approved antivirals are more expensive. The new treatment guidelines recommend starting individuals on antiretrovirals earlier in their infection; therefore more individuals are in need of increasingly costly medications.

Office of Minority Health Planning Project

The Office of Minority Health Planning Project is an initiative to increase the overall awareness of health disparities of racial and ethnic minorities in Alaska and assess the feasibility of establishing an Office of Minority Health within the Alaska Department of Health and Social Services.

In 2008 an Alaska site visit from the US DHHS Secretary and multiple conversations at local and regional levels resulted in resources for a feasibility study about developing an Office of Minority Health. In January 2009, the US DHHS Office of Minority Health awarded the Alaska Department of Health and Social Services a \$50,000 one-year planning grant.

The funds received from the United States Department of Health and Social Services (USDHHS) Office of Minority Health provide a framework for action to improve the health and well-being of racial, ethnic, and other disadvantaged populations in Alaska by: (1) increasing knowledge and understanding of health conditions and risk factors; (2) developing strategies in partnership with other entities to improve health promotion, disease prevention and access to quality health care; (3) assessing the need for and viability of an Alaska Office of Minority Health; and (4) improving partnerships for reducing health disparities.

The Alaska HSS is making progress in identifying how it currently addresses minority health and how an “office” (or other entity) will enhance existing efforts. The next phase of the planning project will provide clarity in how to define “minority” health and provide tangible and measurable goals and outcomes for a potential office.

Recent Accomplishments

- State leaders have established a project working group with a varied representation across all minority health sectors throughout the State.
- Held and summarized key informant interviews conducted to 1) examine strengths and challenges in establishing an Office of Minority Health in Alaska, and 2) offer recommendations for next steps and further considerations.
- Compiled and documented current efforts, resources, and data

Recent Challenges

- Concerns by key informants about (1) specifically designating an office to address racial and ethnic minority health, especially when DHSS has a variety of initiatives already designed to address these areas; and (2) the definition of a “minority” group needs clarification as persistent health disparities exist among the rural versus urban Alaska population. Alaska is a diverse state with many unique challenges and it will be important to consider how to define and address minority health.

- Given the small state population and smaller racial and ethnic minority population, it is difficult to measure health indicators specific to race and ethnicity and assess the needs of other populations by geographic area (e.g. rural, urban communities), and special populations and disparities (e.g. seasonal workers, young children, elderly, gay, lesbian, bisexual, transgender, etc.)

Senior Behavioral Health

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

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

Recent Accomplishments

- Funding was received beginning in FY 2009 for the SOAR (Senior Outreach, Assessment, and Referral) Project, an effort based in the Division of Behavioral Health (DBH) to use special approaches to target seniors in need of behavioral health assistance. The first SOAR grants to local agencies are being distributed in FY 2010.
- The Trust has worked with Chugachmiut and SEARHC to implement IMPACT (Improving Mood, Promoting Access to Collaborative Treatment for Late Life Depression) and SBIRT (Screening, Brief Intervention, Referral to Treatment) programs, with pilot programs in Kake, Seward, Port Graham, and Anchorage Neighborhood Health Center (ANHC). (. IMPACT and SBIRT are programs for depression and substance abuse, respectively, which combine the involvement of primary care physicians with behavioral health approaches. This model has been shown to be especially effective with seniors, who are less likely to seek help directly from more conventional sources. Between June 1 and July 31, 2009, ANHC screened approximately 225 patients for depression.

Recent Challenges

- Pioneer Homes are facing increasing pressure to find solutions in caring for residents with extreme behavioral health problems. They are not licensed to care for them, nor is API an option for long-term residential care. A 2007 survey of assisted living homes indicated that administrators and staff are in need of training to help them cope with aggressive behaviors by clients experiencing ADRD or other behavioral health conditions.

Outcome data

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

Senior Fall Prevention

The Alaska Senior Fall Prevention Coalition, including the Alaska Commission on Aging (ACOA), began a senior fall prevention campaign in September, 2009. All Alaska senior centers received a fall prevention tool kit from the Coalition, including a poster, slideshow, checklists, and more. A new set of materials will be sent out regularly by the Coalition. The tool kit is also available on the ACOA's website.

Accidental, and usually preventable, falls are the number one cause of injury to Alaskans age 65 and older, often causing serious injury such as brain trauma or hip fracture. Approximately one-third of older Alaskans will fall each year, and an average of 579 seniors will be hospitalized as a result. Even minor fractures increase a senior's risk of dying within the next five to ten years, according to recent research. Falling and the fear of falling can lead to depression, loss of mobility, and reduced independence in seniors.

The Senior Fall Prevention Coalition encourages Alaskan communities to commit to reducing risks for seniors and people with disabilities by keeping sidewalks and parking lots free of snow, ice, gravel, and uneven pavement, and by offering education, home modification programs, and exercise classes to improve seniors' strength and balance.

Traumatic Brain Injury Project

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

Recent Accomplishments

- The [Alaska Brain Injury Network](#) (ABIN) and its partners have begun an update to the 10 year state plan for TBI in Alaska. The 10-year plan outlines strategies for reducing the incidence of brain injury and minimizing the disabling condition through the expansion of services and supports for TBI survivors and their families.
- [DHSS Senior and Disabilities Services](#) and ABIN collaborated in the development of a state TBI Case Management Program, the first direct service program for TBI survivors administered by the Department of Health and Social Services. Funded with MHTAAR, the program will serve adults with TBI who might benefit from case management services including service linkages and monitoring, problem-solving and compensatory strategies.
- The Alaska Mental Health Trust Authority continues to grant funds to support the development of a comprehensive system of care for Alaskans with brain injury. Grants currently support the Alaska Brain Injury Network to serve as the State TBI Advisory Board as well as provide

information and referral to over 500 Alaskans. Funds have also supported workforce development activities including the development of the distance-delivered “Introduction to Brain Injury” 3-credit academic course, which has been offered to 40 professionals, paraprofessionals, and consumers across the state. Upcoming courses include a specialty workshop for vocational counselors and an advanced brain functions/case studies 8-week course for rural providers.

- ABIN received federal funding to support the hiring of a TBI Program Coordinator, workforce trainings, and a TBI study focusing on regional data for Alaska Natives and non-Natives.

DHSS Priority Area: Health Care Reform

Bring the Kids Home: A Trust Focus Area

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

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

Recent Accomplishments

A primary BTKH goal is to increase access to home and community-based services within Alaska. Several strategies have been successful:

- New grants for in-state community-based services expanded services to 519 youth in FY2008 and 944 youth in FY2009. Of the FY2009 youth receiving services, 41 were accepted from out-of-state RPTC, 129 were diverted from out-of-state RPTC and 219 were diverted from more restrictive in-state care.
- Individualized Service Agreements (ISA) paid for services to stabilize a child at risk of movement into residential treatment in a community setting. For SFY 2009 less than 1% of ISA recipients were subsequently admitted to an RPTC (5 out of 506).
- Peer navigation provided support, parenting classes, and resource facilitation for families. For SFY 2008 and 2009, over 90% of the youth served who were at risk of out-of-home placement were able to remain in their own communities.

BTKH performance measures show the impact of these strategies:

- Between FY08 and FY09, admissions¹ to out-of-state residential psychiatric treatment centers (RPTC) decreased by 45.5% (from 202 children to 110 children). The total decrease between FY04 (the high year for admissions) and FY09 was 85.4% (from 752 children to 110 children).

¹ Children admitted during a fiscal year only: does not include those admitted a previous year.

- Despite this decrease in admissions, the recidivism rate to RTPC decreased between FY08 and FY09 from 8.4% to 4%. This rate is significantly lower than the 20% recidivism rate during FY04 (the high year for recidivism).
- BTKH accomplishments impacted Medicaid expenditures:
 - Medicaid expenditures for out-of-state RTPC decreased by 51.3% between SFY 2006 (the high year for expenditures) and SFY 2009 (\$40 M to \$19.48 M).
 - Medicaid expenditures for in-state RTPC increased by 739% from SFY 1998 to SFY 2009 (\$2.82 M - \$20.87M).

Recent Challenges

- Building sufficient in-home and community-based services and supports for children with severe emotional disturbances and their families remains a priority.
- Enhancing school-based services to support mental wellness and support youth working on recovery while remaining in school.
- Developing early intervention services and treatment services that are accessible and appropriate for young children and their families to reduce the need for higher levels of care at a later age.
- Ensuring adequate services for transition age youth with behavioral health challenges aging out of the children’s system of care.
- Improving access to behavioral health services in rural areas and through tribal providers.

Outcome Data

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

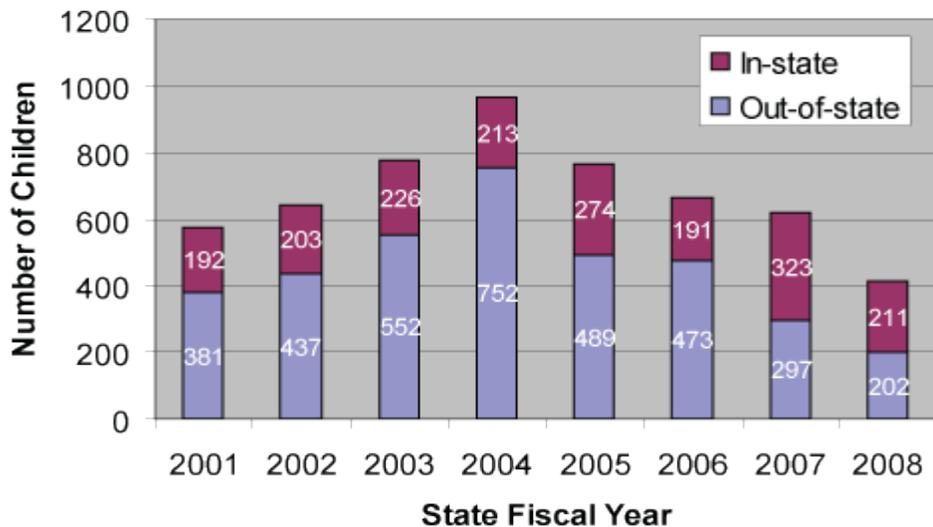
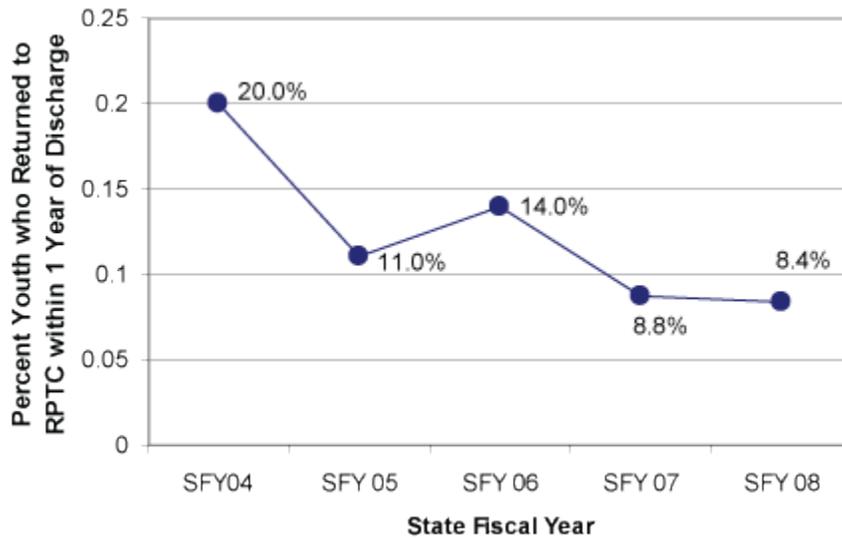


Figure 16b: Recidivism Rate for RPTC Care



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

Justice for Persons with Disabilities Focus Area

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

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

Recent Accomplishments

- The proven success of the *Alaska Adult Guardianship Mediation* pilot project led the legislature in 2009 to include funding in the court system's FY2010 budget to continue the program. The *Alaska Adult Guardianship Mediation* project was created by the Alaska Court System in 2006

with the support of the Mental Health Trust Authority, to provide mediation in appropriate adult guardianship and conservatorship cases.

- Alaska's first juvenile therapeutic court accepted its first participant in September 2008. The Fairbanks Juvenile Treatment Center (FJTC) is a voluntary therapeutic court, targeting juvenile offenders whose mental illness likely contributed to the commission of their offense.
- FY2009 marked the second year the Department of Corrections (DOC) operated a re-entry pilot project focused on Trust beneficiaries. The project is being piloted in Anchorage, Fairbanks, Juneau and the Mat-Su Valley. It is patterned after the evidenced-based practice Assess, Plan, Identify, and Coordinate (APIC).

Recent Challenges

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

Outcome Data - Alaska Adult Guardianship Mediation project

- Program participants reached agreement on some or all of the issues in 87 percent of the cases mediated.
- Ninety-one percent of the participants were satisfied with their agreements.
- As a result of mediation, the court system avoided as many as 90 contested hearings over the pilot period, reducing the number of superior court cases and associated costs required to determine guardianship appointments.

The full evaluation report can be found at:

Alaska Judicial Council website <http://www.ajc.state.ak.us/reports/adultguard.pdf>

Juvenile Justice System Improvement Initiative

In 2003 the Division of Juvenile Justice launched an effort to ensure that Alaska's juvenile justice system uses data and research-based practices effectively to inform its decisions—whether to ensure quality case management of individual juveniles or to help determine how to best allocate resources statewide. This effort continues on a variety of fronts:

To address the high incidence of behavioral health issues among system-involved youth, the Division hired more mental health clinicians at youth facilities; each of the Division's eight secure youth facilities has at least one clinician on staff, with additional clinicians at larger facilities. A mental health clinician

position in Anchorage will also assist probation officers in working effectively with youth who are not in youth facilities but living at home or other community-based settings.

Also through its participation in the Bring the Kids Home Initiative, the Division is facilitating community-based behavioral health services for youth and their families, enabling them to receive treatment and services close to home. For example, by using Bring the Kids Home funding and partnering with other Division is introducing the Parenting with Love and Limits program to Alaska. This evidence-based family coaching and therapy program will provide families with the tools they need to better manage their children's behavior.

Due to a steady increase in the recidivism rate among youth released from the Division's secure treatment facilities, the Division is looking more closely at the characteristics of these youth and the services received to determine how to better serve them. The Division has formed two work groups that have made recommendations on working better with Alaska Natives and standardizing services for youth transitioning from institutions to their home communities.

The Division has developed and implemented a comprehensive Suicide Prevention Policy and Procedure for all secure juvenile facilities statewide. Suicide prevention training was developed by Juvenile Justice mental health clinicians and is provided for all Juvenile Justice officers and facility nurses.

A group of behavioral health specialists completed an analysis of alcohol and other drug services provided in our youth facilities at the Division's request. Their recently completed report has been presented to senior Division managers who will determine how to better direct substance abuse services to improve outcomes for youth in Division facilities.

Recognizing the role of substance abuse as a factor contributing to delinquent behavior, the Division has implemented a screening instrument, the CRAFFT, to help identify potential substance abuse problems among youth when they first enter the juvenile justice system. This six-question screen is performed by probation officers, who can then make referrals based on responses to the questions.

Recent Accomplishments

- **Step Up Program:** This collaboration among the Anchorage School District, Nine Star Education and Employment Service, and the Division of Juvenile Justice, will provide educational services for youth who have been expelled from school or have otherwise exhausted all their educational options. The Step-Up Program opened in Fall 2009 with a small group of students and expects to expand in the coming years.
- The Division received three awards of financial support from the U.S. Office of Juvenile Justice and Delinquency Prevention to examine critical areas of agency operations: workloads of juvenile probation staff; training of all Division staff; and quality assurance. The awards enabled the Division to have experts nationally recognized in these subject areas examine Alaska's strengths and challenges in meeting workload demands, training needs, and quality assurance, and will result in recommendations that will help guide Division operations and management in the coming years.
- **Interstate Compact for Juveniles:** The Division assisted the Alaska Legislature and Governor's Office in passing House Bill 141 into law in 2009. The bill adopts a new agreement, developed

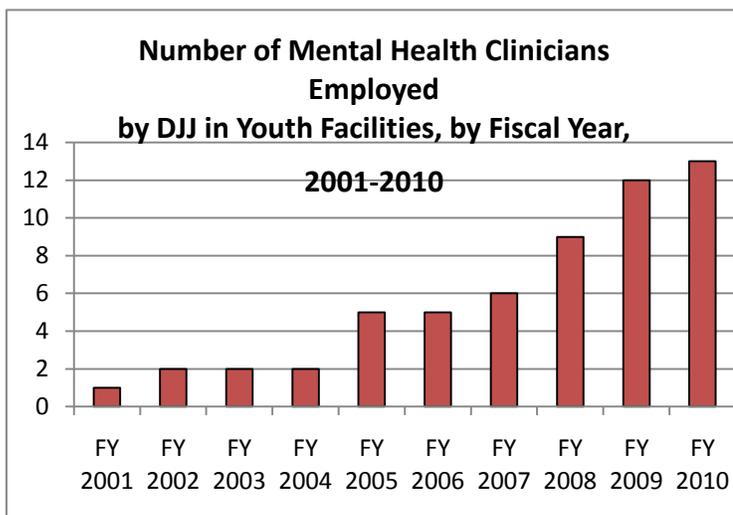
by the U.S. Council of State Governments, that guides and facilitates the movement of adjudicated juveniles across state lines. Alaska now joins a majority of other states and territories that have adopted the new compact, enhancing the ability to track and monitor juveniles under court supervision that leave and enter Alaska.

- **Culinary Arts Program:** By partnering with the Alaska Department of Labor’s Workforce Investment Act program, and a local cooking school and catering business, the Johnson Youth Center in Juneau launched a culinary arts program for youth in the facility. In FY2009, thirteen youth received a certificate of completion from the culinary program, and the program is on course to continue in FY2010. During the 8-week class, students learn not just how to prepare and cook meals but also master techniques in managing kitchen and developing a budget. The students contributed culinary services to several community organizations and events.

Recent Challenges

- There is a continuing need for adequate assessment and community-based services for juvenile-justice youth, particularly those with mental health, substance abuse, and sexually offending behavior. In addition, community-based options such as crisis respite services are needed for youths with (or at risk of) severe emotional disorders, as they are sometimes placed in secure detention due to a lack of community-based options.
- The need for crisis intervention and treatment options for families is critical. Two particular groups with needs are families with youth who have behavioral health disorders, and those in homes where family crises result in domestic violence. Services for families are resource-intensive, as needs range from training staff to work with and advocate for these families to implementing models that touch on various service systems. Yet meeting such needs is necessary if the state is going to interrupt the cycles of abuse, violence, and despair these families face.

Outcome Data



Medicaid Waiver Rates

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

Advocacy groups are seeking a formal change in DHSS policy which would provide for automatic regular reviews of waiver reimbursement rates similar to those now received by hospitals and nursing homes. Senate Bill (SB) 32 was introduced during Alaska's 26th Legislative Session.

Recent Accomplishments

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

Recent Challenges

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

Workforce Development

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

Following the summit, several major entities within Alaska partnered together to address current and future demand for behavioral health professionals. The partners include the University of Alaska, the Alaska Mental Health Trust Authority, and the State of Alaska, Department of Health & Social Services, Division of Behavioral Health.

The Trust, University of Alaska and DHSS are in their second year of jointly funding a workforce development coordinator who focuses on behavioral health workforce initiatives across the partnership. Additional partners, such as WICHE (Western Interstate Commission on Higher Education) and the Annapolis Coalition have been involved in the planning and implementation of strategies to address workforce needs of the beneficiaries.

Some of the ongoing activities to increase recruitment and retention are:

- Credentialing and Quality Standards;
- Loan repayment
- Marketing and a media campaign; and
- Wages & benefits

Training and education activities include:

- [Trust Training Cooperative](#);
- [Alaska Rural Behavioral Health Training Academy](#);
- Ph.D. Internship accreditation;
- [Disability Justice](#) trainings focusing on cognitively impaired offenders;
- Autism capacity building;
- “Grow Your Own”; and
- [Distance MSW](#) and BSW programs.

Recent Accomplishments

- **Alaskan Core Competencies for Direct Care Workers in Health and Human Services** - WICHE (Western Interstate Commission on Higher Education) and the Annapolis Coalition worked with the three partners and finalized the Alaskan Core Competencies for Direct Care Workers. The competencies are designed to guide skill development with direct care workers, who are also referred to as direct support workers, direct support professionals, para-professionals, or technicians.
- **New loan repayment program** -[Supporting Access to Healthcare Repayment Program \(SHARP\)](#) provides a new state-managed loan repayment opportunity for primary care and behavioral health providers working in designated health professional shortage areas. Providers include physicians, nurse practitioners, physician assistants, social workers, counselors, psychologists, dentists, and dental hygienists.
- **Alaska Psychology Internship Consortium (AK-PIC)** – Alaskan providers with facilitation by WICHE (Western Interstate Commission on Higher Education) have developed a consortium that will allow Ph.D. students to complete accredited internships within Alaska. The first cohort will begin in the summer 2010.
- **Alaska Psychiatric Residency** – A coalition of government agencies, UA, hospitals and clinicians have partnered to address the critical shortage of psychiatrists in Alaska. A feasibility study and business plan has been completed.

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Recent Challenges

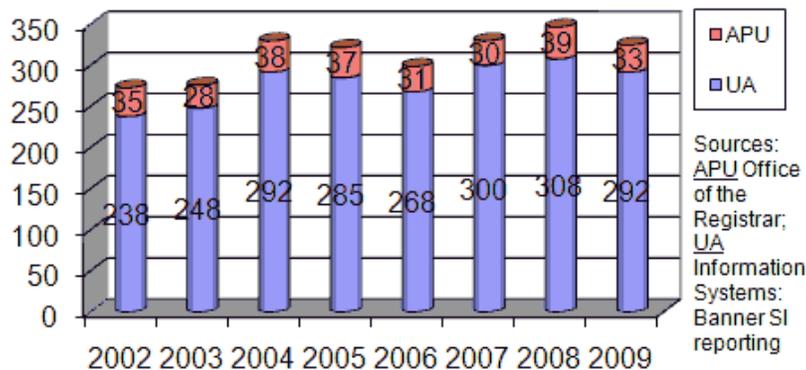
- **Recruitment and Retention.** Alaska continues to have a significant need for additional health care providers that serve Trust beneficiaries, especially in rural areas. (See [2009 Alaska Health Workforce Vacancy Study](#)). Across the state there is an immediate need for all levels of home and community-based, long-term care and behavioral health workers, from direct care to psychiatrists. While workforce recruitment and retention efforts are underway, we have been

unable to directly impact the current crisis for additional direct care service workers across the state. Additionally, with the aging of the population, it is anticipated that the future will bring more demand for providers.

- **Training and Education.** Alaska has quality academic training and education available across the state but what is lacking is sufficient funding to provide a uniform and regulated process. Resources are needed to assist providers, agencies, workers and institutions with paying for training that might be currently available and/or required and to develop specialty training for direct care service workers that does not exist.
- **Long Range Strategic Plan for the Health Industry Workforce.** The State of Alaska needs a long range strategic plan for planning, implementing and funding workforce efforts. The future roles and responsibilities of the State of Alaska (DHSS, DOLWD, EED, AWIB), The Trust and the University of Alaska regarding workforce development (recruitment, retention, training and education) and the roles of each entity in the coordination, implementation, and funding for recruitment, training, professional development and academics. Currently plans are being drafted by the Alaska Health Care Workforce Coalition and the Alaska Health Care Commission.

Outcome data

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

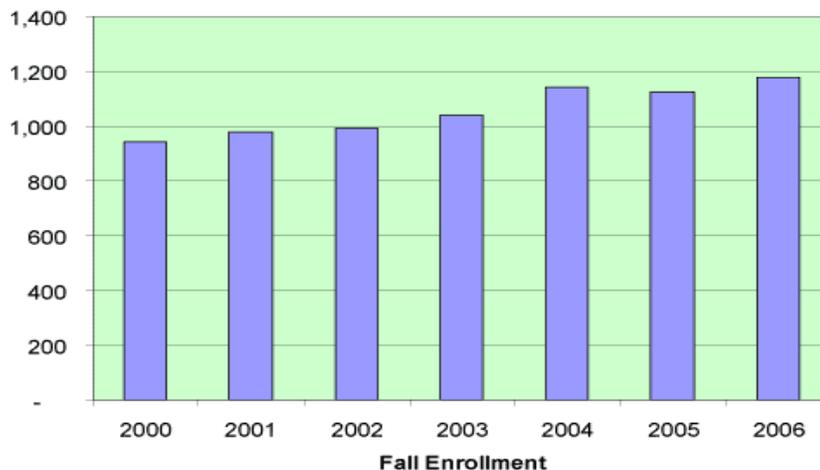


Degrees and certificates included in this data:

- **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.

Sources: APU Office of the Registrar; UA Information Systems: Banner SI reporting extracts

Figure WD-2: University of Alaska Behavioral Health Program Enrollment



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.

Source: Information provided by MAUs via [UA Information Systems](#): Banner SI reporting extracts. Prepared by Statewide Institutional Research and Planning.

DHSS Priority Area: Long-Term Care

Aging and Disability Resource Centers

Aging and Disability Resource Centers serve as a visible, trusted place for older adults and people of all ages with disabilities to go for information and assistance. The ADRC initiative is a part of a nationwide effort to restructure community based services and supports while ensuring informed choice and accessibility. ADRC activities include efforts to remove barriers to community living in support of Alaska's call to meet the requirements of the Olmstead decision and the President's New Freedom Initiatives.

The goal of the program is to have a minimum of six fully functioning ADRC's providing statewide coverage; the current funding supports three sites. SDS will request applications for more sites should additional funds become available. The Aging and Disability Resource Center Grants are managed by staff in the SDS Grants Unit. Over the next three years, this staff will work to further streamline access for consumers and centralize intake, eligibility, and assessment processes for Medicaid, Grant, and Private Pay Long term Care services.

The ADRC Coordinator at each site works with local providers and hospital discharge planners to (1) link the target population to services and supports in their community; (2) reduce dissemination of inaccurate and/or duplicated information; and (3) identify and address gaps in long term care services with the guidance and support of SDS. Alliance on Information and Referral Services (AIRS) certified staff, located in ADRC centers, will provide information, referral, and access to services well as community outreach and education.

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

Recent Accomplishments

- An ADRC Operational Guide was developed
- ADRC signed an MOA with 211
- SDS received a federal grant whose main goals are to expand existing ADRC infrastructure and develop a plan for sustainability.
- Funding for 3 new sites will be available March 2010-2013.

Recent Challenges

- The Interior, Northern Alaska and Southwestern Alaska are unserved by ADRCs
- The 3 original ADRC's were funded for only one full time ADRC Specialist. Federal grant funds for expansion paid for .5 FTE in each of the 3 sites
- Outreach and marketing to providers and consumers about ADRC's is a challenge
- Sustainability of the ADRC's is an on-going issue.

Outcome Data

Alaska's ADRCs served 4623 individuals during FY 2009, the highest number since the program's inception in FY 2005.

Supporting Family Caregivers

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

Recent Accomplishments

- There is an increase in the numbers of Grandparents raising grandchildren served

Recent Challenges

- Funding for statewide programs
- Lack of services in rural areas

Outcome data

Alaska's National Family Caregiver Support program provided over 17,507 hours/units of service in FY 2009 to 3,557 caregivers throughout the state.

Vulnerable Alaskans

Affordable Appropriate Housing: A Trust Focus Area

The Affordable Appropriate Housing Focus Area is working to reduce the rates of homelessness and displacement of Trust beneficiaries. The Trust and state agencies, non-profit service organizations and housing advocates worked together to simplify and coordinate the state's housing and social support programs and increase the assistance available for housing providers serving individuals with a disability, chronic addiction or mental illness. Retooling these programs allows for adequate supportive services and rental subsidies so Trust beneficiaries and other vulnerable Alaskans can afford housing.. With integration of these strategies into the core housing programs at Alaska Housing Finance Corporation (AHFC) and the Department of Health and Social Services, it is anticipated that more assistance will be provided to the growing number of families and adults with disabling conditions who are homeless.

Recent Accomplishments

- **Homeless Assistance Increased.** The Trust, AHFC, the Alaska Council on the Homeless, housing providers and advocates gained legislative support in 2009 for an additional \$2.5 million to retool AHFC's ongoing Homeless Assistance Program to better serve the state's most challenging populations. The Trust committed \$1 million to the program and, with federal and state funding pooled, the overall funds available for homeless assistance in FY2009 totaled more than \$8 million and assisted more than 13,000 Alaskans.
- **Special Needs Housing Improved.** The Special Needs Housing Grant program, administered by AHFC, assisted approximately 250 Trust beneficiaries with intensive needs in FY2009. During the year, the program offered the following components necessary for sustainability:
 - A three-year renewal cycle to allow housing providers more planning time and the ability to create infrastructure for future supported housing projects.
 - Financial assistance in the construction or remodeling of 53 units
 - Operations assistance to 50 units to help with recurring expenses (rent, utilities and building operation), bringing the rent for each unit to an affordable level while maintaining the safety of the residents

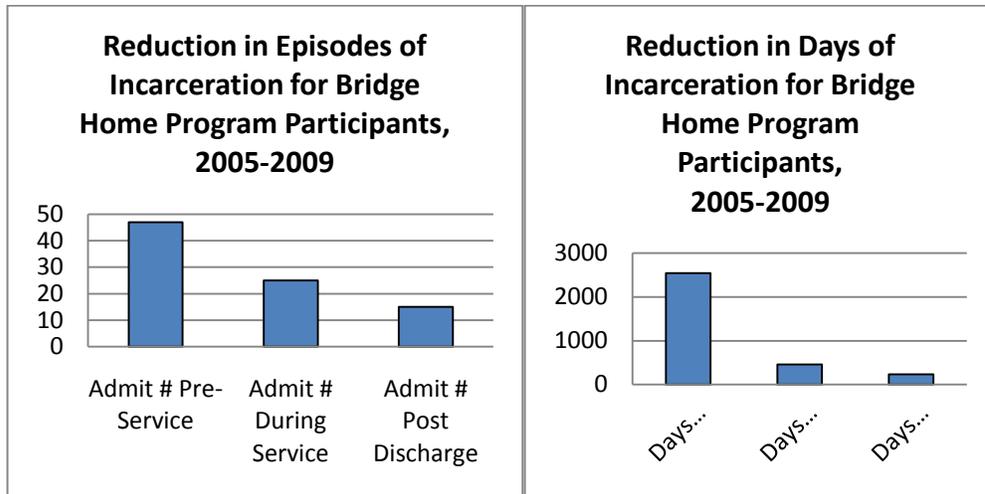
- Social services assistance for 230 units to ensure there are social services available to assist residents with financial issues, social-skill building, problem solving and crisis management, thereby preventing evictions and promoting stability and safety for residents.
- **Bridge Home Continued Successes.** The Bridge Home program creates a safe, affordable housing environment with support services to help stabilize Trust beneficiaries who have been cycling through the Department of Corrections, Alaska Psychiatric Institute, emergency facilities and other higher cost services. The program includes a behavioral health center to provide additional case management, consumer resources and any “extra” that can assist the person in remaining successfully housed. In a two-year analysis of program participants, admissions and lengths of stay in the Department of Corrections were reduced. (See the chart below for details on Department of Corrections admissions and stays).
- **Technical Assistance for supported housing providers:** Trust beneficiaries with intensive mental health or multiple disabling conditions require additional assistance to remain successfully housed, and these needs can strain social service agencies’ ability to maintain or afford ownership of housing units. For the past three years, the Trust and the State Department of Health and Social Services’ Office of Supported Housing have collaborated to provide grant resources and technical assistance to behavioral health providers struggling to maintain housing units or placements. This work has assisted our technical assistance team in better understanding the needs of social service providers who are sponsoring housing projects and to translate the areas of concern into improvements in the housing funding programs through Alaska Housing Finance Corporation.

Recent Challenges

- In the recent economy, housing is becoming more difficult to provide at a reasonable rate, especially if renters require additional assistance to remain successfully housed. Trust beneficiaries with the highest needs are frequently represented in the lowest income bracket due to challenges with mental illness, addiction and multiple diagnoses.
- The economy has also impacted the amount of capital funding that is available for housing project in the state.
- State resources for non-Medicaid eligible activities such as social support and skill development in the home have dwindled over the past 10 years. This void leaves landlords and housing providers with a larger share of the costs to house people in low income brackets.

Outcomes

For Bridge Home program participants, admissions and lengths of stay in the Department of Corrections decreased between 2005 and 2009.



Alaska Works Initiative

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

- Goal 1: Transform disability support programs to emphasize employment and meet the needs of working Alaskans with disabilities.
- Goal 2: Ensure access to resources needed by Alaskans with disabilities to secure and maintain employment.
- Goal 3: Collaborate with business and industry to assist youth and adults with disabilities to secure and obtain employment in Alaska’s labor market.

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

Recent Accomplishments

Governor Palin co-sponsored the Disability Employment Policy Summit February 6, 2008. The purpose of the summit was to discuss and prioritize recommendations associated with three major issues impacting the employment of Alaskans with disabilities: 1) state government as a model employer, 2) assets building, and 3) integrated services and resources. As a result of these recommendations, workgroups were formed for each area and are addressing the specific recommendations in each area.

- A workgroup developed a strategic plan to develop stronger relationships and policies that support employment as an expectation within the State divisions of vocational rehabilitation

and behavioral health. A Memorandum of Understanding was developed and signed by directors of both agencies in May 2009. Pilot sites in Juneau and Kenai that are using collaborative strategies to enhance employment outcomes and supports for individuals with behavioral health disabilities.

- A website has been developed to support asset building activities including utilization of Individual Development Accounts and the Earned Income Tax Credit; and to assist providers with accessing financial literacy curricula designed to meet the needs of individuals with disabilities.
- The Supported Employment Task Force developed a set of recommendations for improving supported employment services provided to individuals with developmental disabilities. Staff charged with overseeing the implementation of these recommendations is in the process of being hired.

Recent Challenges

- Expanding the number and availability of Individual Development Account programs for low-income individuals within the State of Alaska to access education, purchase a home or start a small business.
- Integrating work as an expectation across service delivery systems.
- Collecting outcome data across service delivery systems.

Outcome Data

In calendar 2008, 1,947 individuals were supported by *Alaska Works Initiative* activities; approximately 640 secured full or part time employment. In the previous year, 1,200 individuals were supported by *Alaska Works Initiative* activities and approximately 514 secured full or part time employment.

Division of Behavioral Health Performance Management System Project

The DHSS Division of Behavioral Health maintains an ongoing commitment to the development of a “Performance Management System” to function as a continuous quality improvement process to guide policy and decision-making for improving the behavioral health of Alaskans. The Performance Management System Impacts at several levels:

- *The public service delivery system* – The performance measures address the following: how much did we do; how well did we do it; it anybody better off as a result.
- *Population planning* – the performance management system addresses the following questions: are Alaskans who need services getting them, and able to get them conveniently; do Alaskans with behavioral health disorders live with a high quality of life; and are efforts taking place to prevent or lessen problems that result in consumers needing services.

Recent Accomplishments

- A key component of the Performance Management System, is the method of distributing treatment funding based on provider performance and outcomes, i.e., Performance-Based

Funding (PBF). For FY09, the PBF effort successfully developed the performance measures of grants management scoring; substance abuse utilization; the consumer service evaluation survey; data / record completeness; and client outcomes. The results were used in the determination of FY'10 treatment and services grant awards.

- In partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA), Research Technology Inc. (RTI), the Division of Behavioral Health completed a one-year plan for the Alaska Automated Information Management System (AKAIMS). This new version update enhances the division's ability to fulfill Federal reporting requirements. It provides significant enhancements to the functionality of the AKAIMS, including group note functionality, electronic signature, profile set up for multiple users, State Outcomes Measurement and Management System (SOMMS) reporting, and a Contracts Management module. This upgrade also established the groundwork for future billing capability.
- The DBH implemented a new feature of the Alaska Automated Information Management System (AKAIMS) that is worth highlighting. Specifically, the "SQL Server Reporting Services" (SSRS) module, also known as the "ad hoc reporting", has been made available to grantee agencies. The functionality of the AKAIMS SSRS reporting capability is an important contribution to the division's goal of a data driven Performance Management System. Some of the many benefits to this system include the ability to:
 1. Access a sophisticated suite of pre-developed reports, which includes client level detail information for aggregate counts.
 2. Create agency specific reports and data dumps for analysis in third party software packages.

Recent Challenges

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

- **Performance Management System:**
A performance oriented system requires a correlate data infrastructure system. Related challenges involve the budgeting for appropriately skilled research staff in order to maximize the necessary data collection, analysis, reporting, and application to business and service delivery practices. In addition, this system realignment absorbs a significant amount of leadership time and energy that, in effect, limits our resources for new program development and we will need to address this shortfall in upcoming budget cycles.
- **Information Management System Enhancement & Maintenance:**
The Alaska Automated Information Management System (AKAIMS) is the data collection and reporting system for the division's *Performance Management System*. The AKAIMS has been successfully implemented with 100% of grantee provider agencies now submitting data to the division. The grantee provider user network includes 70 agencies, with a combined individual user group membership of 1,965. System development, enhancements and maintenance of a management information system is standard and expected business practice. Challenges involve

budgeting for this standard life cycle of the MIS system with adequately skilled technical and training staff.

- **Performance Based Funding:**

A key component of the *Performance Management System* is the method of distributing prevention and treatment funding, based on provider performance and outcomes (i.e. performance based funding). Mandated by the 2007 legislature, PBF was successfully implemented by the DBH with significant positive outcomes in the management of the behavioral health system of care. However, as the sophistication of the PBF effort continues, the workload implications for current and future development is better understood. Challenges involve budgeting for adequately skilled personnel for ongoing development, maintenance and application.

Outcome Data

- **Performance Based Funding**

The performance of 58 behavioral health providers was measured with the following results in the allocation of FY 10 grant funds:

- The SFY10 process was based on both agency performance and agency scores on the grant application.
- 20 of 58 (34%) of grantees had an increase in their grant funding, totaling \$16,136.
- 38 of 58 (66%) of grantees had a decrease in their grant funding, totaling \$16,136.

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

In FY 09, 12,966 screenings using the AST were conducted. This resulted in:

- 8,295 (64.4%) cases identified with Substance Abuse (SA) needs;
- 10,392 (80.1%) cases identified with mental health needs;
- 4,184 (34.5%) cases indicated suspected Traumatic Brain Injury;
- 1,155 (8.9%) cases indicated suspected Fetal Alcohol Spectrum Disorder; and
- 6,949 (53.6%) cases indicated suspected dual diagnosis.
- 66% of grantees had a decrease in their grant funding, totaling \$16,136.

- **Program Enrollments**

During FY09, the behavioral health system of care provided 4,096 enrollments in Severely Emotionally Disturbed (SED) programs, 8,443 enrollments in Severely Mentally Ill (SMI) programs, and 6,605 enrollments in substance use disorders (SUD) programs, for a total of 19,144 program enrollments. Program enrollments are not an unduplicated count of individuals served, as one person may be enrolled in several programs.

Improvements in data collection have resulted in greater measurement of program enrollments.

From FY08 to FY09:

- The reported number of SED program enrollments increased 53.0% from 2677 in FY08 to 4096 in FY09.
- The reported number of SMI program enrollments increased 23.3% from 6848 in FY08 to 8443 in FY09.
- The reported number of SUD program enrollments increased 27.5% from 5180 in FY08 to 6605 in FY09.

- **The Behavioral Health Consumer Survey**

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

- Seventy-eight percent (77%) of adults evaluated services positively;
- Seventy-seven percent (79%) of teens/young adults ages 13-17; and
- Seventy-four percent (77%) of parents and caregivers of children ages 0-17.

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

For FY 2009, the CSR outcomes indicate the following findings:

- For each of three life domains (housing situation, physical health, and thoughts of self harm), more than 75% of individuals who received services through the comprehensive, integrated Behavioral Health Service System reported improvement or maintaining condition.
- For each of the remaining three life domains (financial/basic needs, meaningful activities/employment, and mental/emotional health), less than 75% of individuals reported improvement or maintaining condition.

Families First! / Family Centered Services

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

Families First! focuses on helping families address challenges to employment and self-reliance by using a proven, national "customized employment" model. The model relies on close collaboration with other

agencies and service providers working as a multi-disciplinary team with the family to develop comprehensive and integrated service plans designed to mitigate barriers and engage family members in activities that help move families towards employment, self-sufficiency, and an improved quality of life.

This reflects the Department's goals to coordinate and integrate services among agencies serving common clients to reduce redundancy, share information, identify barriers, and improve client outcomes.

Recent Accomplishments

- Six project assistants have been hired to be Families First Facilitators. The facilitators stationed in Fairbanks, Nome, Kenai, Mat-Su, Anchorage, and Sitka are organizing local implementation teams, community meetings, and partner training sessions. Training sessions held in each community provide partners with the fundamental principles of the "customized employment" model central to the service delivery model.

Recent Challenges

- None to report

Public Health Nurses Addressing Domestic and Family Violence

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

Recent Accomplishments

- Public health nurses completed approximately 18,000 screenings for domestic violence in FY 2009. This is an increase from the previous year when they completed approximately 14,000 screenings.
- Routine universal screening for domestic/interpersonal violence for public health clients was implemented in 2007.
- All public health nurses have received in-service education to increase their knowledge and strengthen their skills in addressing interpersonal violence.

Recent Challenges

- Lack of resources to support violence victims, particularly in small, rural communities.

- In some cases interpersonal violence is viewed as a social norm
- Need for ongoing education and support for health care providers to further implementation of routine DV screening and counseling.

Outcome data

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

Start Up Alaska Project

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

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

It is anticipated that the following outcomes will be achieved:

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

Recent Accomplishments

- The customized self employment and virtual business incubator model has been operating in full for nearly two years and these services are now being purchased by Vocational Rehabilitation agencies for clients seeking self employment.
- A distance based delivery system of business supports (virtual business advisor) was established for entrepreneurs and microenterprise site facilitators across the state.

- A self employment policy summit involving the Divisions of Vocational Rehabilitation, Employment Security, Behavioral Health and Public Assistance along with the U.A.A. Centers for Human Development and Economic Development and the Small Business Development Center took place in February of 2010. A plan for sustainability of Customized Self Employment services and supports is being developed based on partner input from the summit.

Recent Challenges

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

Policy discussions were held individually with partners prior to the summit which facilitated productive cross-systems discussions about how to align programs better in a sustainable self-employment delivery system.

Outcome Data

- To date, 73 individuals have been served and 33 businesses have been launched.
- From October of 2008 to October of 2009, 20 entrepreneurs completed business plans (150% increase over the previous year), 15 completed a business feasibility study (50% increase), 19 received startup financing (138% increase), 13 new businesses were created (63% increase) and 16 new businesses made their first sale or contract (23% increase).

Trust Beneficiary Projects Initiative

In FY09, the Trust authorized \$3.8 million for the Beneficiary Projects Initiative (BPI) Focus area, which supports and funds grassroots, beneficiary-driven, peer-to-peer programs. It also includes a grants program that improves the lives of Trust beneficiaries with support for individual services, one-time projects and adult dental care. The initiative is founded on the belief that people who participate in the decisions that affect their lives are much more likely to act in their own best interest.

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

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

Trust funded BPI programs provide a range of peer support services. A few examples of such programs include the Juneau Polaris Club House for persons with mental illness, the Alaska Mental Health Consumer Web in Anchorage, which operates a drop-in center for people experiencing mental illness, substance abuse and homelessness and the Alaska Women's Recovery Project which provides peer support for women in recovery from alcoholism and drug addiction.

Recent Accomplishments

- Since inception of the BPI Focus area in 2005, the Trust has supported development and stabilization of more than 20 consumer-operated programs that allow beneficiaries to actively engage in their recovery and long-term wellbeing.
- In 2009 the Trust funded 12 consumer organizations. With technical assistance from the Trust, 66 percent of the grantees diversified their funding, receiving additional support through competitive state grants, federal funding and donor contributions.
- The Trust completed a 3-year commitment of \$4.2 million in matching funds for the Adult Dental Medicaid Program for preventative and restorative dental service. Reauthorized as a permanent program by the 2009 legislature, the total cost was transitioned from Trust funding to the Department of Health and Social Services general fund/mental health budget for FY2010.

Recent Challenges

- Establishing a stable reoccurring funding base for peer support programs in GF/MH budget
- Continuing need for technical assistance targeting organizational capacity building of peer-support programs
- Limited funds are available, other than Trust grants, for peer programs.

Outcome Data

- Since inception of the BPI Focus area in 2005, the Trust has supported development and stabilization of more than 20 consumer-operated programs that allow beneficiaries to actively engage in their recovery and long-term wellbeing.
- In 2009 the Trust funded 12 consumer organizations. With technical assistance from the Trust, 66 percent of the grantees diversified their funding, receiving additional support through competitive state grants, federal funding and donor contributions.

More information about the BPI Focus area can be found on The Trust website under Focus Areas. (<http://www.mhtrust.org>.)

Trust Coordinated Communications Committee

Stereotypes about mental illness, addictive diseases, developmental disabilities and dementia make it harder for people with these conditions to find work, housing and meaningful social contacts.

Additionally, stigma often dissuades people from seeking the care they need. *Moving Forward's* goal is to reduce the stigma associated with mental illness, alcohol abuse, developmental disabilities and age-related dementia. The Coordinated Communications and Advocacy Committee is an initiative funded by the [Alaska Mental Health Trust Authority](#) in partnership with beneficiary advisory boards (Alaska Mental Health Board, Advisory Board on Alcoholism and Drug Abuse, Governor's Council on Disabilities and Special Education, Alaska Commission on Aging, Alaska Brain Injury Network and Statewide Suicide Prevention Council). The goals of the committee are to reduce the stigma associated with mental disabilities, to promote the concept that treatment and services work, and to gain public support, especially among policymakers, for funding necessary to provide services for Trust beneficiaries.

Each year the committee collaborates on a multi-media campaign to address the goals, including developing brochures, DVDs, posters, and newspaper, TV, radio and movie theater ads. The overall theme of the campaign is "*You Know Me*," which points out that the issues addressed by The Trust touch nearly every Alaskan, whether it is a family member, a neighbor or a coworker.

Recent Accomplishments:

- During FY2009, a new *You Know Me* TV spot was produced that focused on passage of federal mental health parity legislation. The TV ad and a companion print ad ran in media outlets across the state, including on *Gavel to Gavel Alaska*, a cable television service that provides coverage of state government activities.
- The advisory boards each ran individual anti-stigma and awareness campaigns during the year to supplement *You Know Me*. These included:
 - a print ad during Mental Illness Week highlighting the loss of productivity employers experience related to absenteeism due to depression;
 - a series of print ads promoting community events planned during Alcohol Awareness Month;
 - a series of print and radio ads providing a detection checklist for depression and alcoholism among seniors as part of Older Americans Mental Health Week;
 - a series of movie theater ads highlighting treatment and services related to traumatic brain injury, alcoholism and suicide.
 - a public education video entitled "*Treatment works. Recovery happens.*" for use by members of the Alaska Mental Health Board and the Advisory Board on Alcoholism and Drug Abuse when making presentations about mental illness and alcohol/substance to civic organizations and other outreach efforts.
 - a public information video regarding brain injuries produced by the Alaska Brain Injury Network to educate brain injury survivors and their families and policymakers. It features the personal stories of two young people, including a former Miss Alaska contestant, who all have experienced a traumatic brain injury.
- Issues related to suicide and suicide prevention were highlighted in a breakout session presentation produced for the annual Elders and Youth Conference, which is sponsored by the First Alaskans Institute. The event was attended by approximately 1,000 youth and elders from communities throughout Alaska. This is the third year The Trust and its partner boards have been invited to participate. The presentation included the premiere of a 12-minute DVD on suicide prevention entitled "*Building Resilience*," which was funded by The Trust and co-produced with the Statewide Suicide Prevention Council.

Recent Challenges and Outcomes

Public opinion surveys conducted by The Trust 2006 and 2008 showed that more than 50 percent of respondents knew that Trust beneficiaries are people with mental illness, developmental disabilities, brain injury, Alzheimer's disease and alcoholism.

Compared to the 2006 poll, the 2008 poll showed a slight decline in awareness about each of The Trust beneficiary groups except for the beneficiary group with mental illness. Of the 612 Alaskans randomly surveyed in 2006, 74.5% were aware that people with mental illness are beneficiaries of The Trust, as compared to 78.7% of the 252 randomly surveyed in 2008. The largest decline in awareness in the two-year period was about people with alcoholism. In 2006, 55.5% of those surveyed identified this group as Trust beneficiaries compared to 50.7% in 2008.

The Trust is committed to continuing the ongoing *You Know Me* campaign and other awareness measures to increase knowledge and understanding of The Trust and to raise awareness of who Trust beneficiaries are and what issues impact their lives.

V. Emerging Issues/Trends (2010)

Access to Care for Medicaid and Medicare Patients

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

Additionally, community mental health providers who serve people who are dually eligible for Medicare and Medicaid are reimbursed for clinic services at Medicare rates, which are lower than Medicaid rates. A number of community mental health centers, especially the urban centers that serve large numbers of adults with severe mental illness, experience financial hardship because of this federal billing requirement.

After a Congressional hearing held by Senator Lisa Murkowski in Anchorage in early 2007, a resolution (SJR 3) passed by the 2007 Legislature urged Congress to order a comprehensive rewrite of the Medicare reimbursement formulas. In summer 2008, Congress passed legislation which included an increase in the physician reimbursement rates for Alaska to begin in 2009.

Eligibility Disparity for Early Special Education Services

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

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

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

Returning Service Members with Brain Injury and Mental Health Conditions

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

Researchers found many treatment gaps exist for those with PTSD and depression. Just 53 percent of service members with PTSD or depression sought help from a provider over the

past year, and of those who sought care, roughly half got minimally adequate treatment. (RAND Corporation, April 17, 2008).

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

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

VI. Further Information and Acknowledgements

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

Authority for Plan

[AS 47.30.660](#)

Mental Health Funding Statutes

[AS 37.14.010-.099](#)

[AS 47.30.046-.056](#)

Beneficiaries of The Trust

[AS 47.30.056](#)

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

Acknowledgements

The Department of Health and Social Services and the Alaska Mental Health Trust Authority are grateful for the time and expertise of their staff members who contributed to this plan. The participation of the Alaska Commission on Aging, the Governor's Council on Disabilities and Special Education, the Governor's Advisory Board on Alcoholism and Drug Abuse, and the Alaska Mental Health Board assures that the Comprehensive Integrated Plan is consistent with the planning efforts of these statutory advisory and advocacy boards. In addition, we appreciate the contributions of staff members in other agencies who have assisted us: the [Alaska Department of Labor and Workforce Development](#); the [Alaska Department of Labor and Workforce Development](#), the [Alaska Housing Finance Corporation](#), [Department of Corrections](#), the [Alaska Brain Injury Network](#), and the [Alaska Native Tribal Health Consortium](#).

Further Information

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

Alaska Department of Health and Social Services

Division of Public Health

Section of Health Planning and Systems Development

P.O. Box 110601

Juneau, Alaska 99811-0601

(907) 465-3091

Alaska Mental Health Trust Authority

3745 Community Park Loop , Suite 200
Anchorage , Alaska 99508
(907) 269-7960

Alaska Mental Health Board

(Conducts planning and advocacy for adults and children experiencing mental illness and emotional disorders)
431 North Franklin Street
Juneau, Alaska 99801
(907) 465-3071

Governor's Advisory Board on Alcohol and Drug Abuse

(Conducts planning and advocacy for prevention and treatment of alcoholism and drug abuse)
431 North Franklin Street
P.O. Box 110608
Juneau, Alaska 99801
(888) or (907) 465-8920

Governor's Council on Disabilities and Special Education

(Conducts planning and advocacy for children and adults experiencing a developmental or cognitive disability)
3601 C Street #740
Anchorage, Alaska 99524
(888) or (907) 269-8990

Alaska Commission on Aging

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

Department of Corrections

4500 Diplomacy Drive
Anchorage 99508
(907) 269-7317

Alaska Brain Injury Network

Office: (907) 274 - 2824
Toll-free (888) 574 - 2824 (in Alaska)

Endnotes

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