Making It Work

Behavioral Health in Alaska

Advisory Board on Alcoholism

And Drug Abuse

Alaska Mental Health Board

Shared Plan 2007-2011

Our Joint Vision:

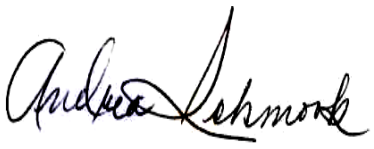
Alaskans Living Healthy, Productive Lives

June, 2007

Dear Alaskans,

This document has two purposes: to inform the reader about behavioral health – what behavioral health is, how individuals, families, and communities are affected by problems with behavioral health, and some things we might do to improve the behavioral health of Alaskans – and to develop a plan for the Advisory Board on Alcoholism and Drug Abuse and the Alaska Mental Health Board for the next four years. These Boards are responsible for identifying and advocating for the behavioral health needs of Alaskans and the system that works to deliver good behavioral health.

This plan is written in sections. We invite you to start with whatever interests you. Also, it is a dynamic plan. While there are hard copies, it is web based and will evolve with time. This is a time of rapid change, change in what is known about behavioral health and how to treat behavioral health conditions, and change in the structure of the behavioral health system in Alaska. The goal of this plan is to provide a roadmap for the two Boards to most effectively work with others in the system to promote wellness for all Alaskans. Welcome!



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Making It Work: Behavioral Health in Alaska

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Making it work: Behavioral Health in Alaska is written to guide the work of the Advisory Board on Alcoholism and Drug Abuse and the Alaska Mental Health Board through the years 2007-2011. It is the culmination of years of discussion, review of plans, drafting of strategies, and community involvement.

The Plan falls in two main parts. The first part is an overview of the behavioral health system in Alaska, focusing on the part of the system that operates with funds channeled through the state behavioral health program. This includes an explanation of behavioral health, diagnostic categories, and the number of people experiencing behavioral health problems in Alaska.

The second part is the ongoing plan which will guide the Boards' work for the next four years. Starting with our vision, we identify population results that would help achieve that vision. These population results are tied to measures of population health that are tracked in *Moving Forward*, the comprehensive, integrated mental health plan developed by the Alaska Department of Health and Social Services, the Alaska Mental Health Trust Authority, and related state agencies, boards, and commissions. Population results are followed with strategies the Boards will use to help change population health. Finally, we track activities to support those strategies through the use of a tracking matrix.

Our vision, population results, and the Board strategies to help achieve these results are:

Vision: Alaskans living healthy, productive lives

- **Desired population result:** Alaskan adults are physically, mentally, spiritually, and emotionally healthy and are engaged in healthy lifestyles to sustain well being. This is supported through development of a community-based, culturally competent behavioral health prevention and treatment service system for Alaskans.

  Strategies:

  - Identify current behavioral health system strengths and gaps.
  - Review, monitor, and evaluate behavioral health services at the community, client, provider, and state system level.
  - Advocate for a comprehensive effective behavioral health service system.

- **Desired population result:** Alaskan children, youth, and families lead safe, stable, happy, productive lives.

  Strategy:

  - Support the planning, funding, and provision of a comprehensive system of care within Alaska for children, youth, and their families.

- **Desired population result:** Alaskans live free from the negative consequences of alcohol and other drug use.

  Strategy:

  - Support a continuuum of care for those experiencing alcohol and substance use disorders and those at risk.

- **Desired population result:** Alaskans live with dignity and respect as valued members of their families and communities.

  Strategies:

  - Advocate for a safe, accessible, and affordable continuum of housing options for beneficiaries of ABADA and AMHB.
  - Advocate for increased opportunities for employment, education, and meaningful participation in activities of one's choice.
  - Advocate for and support interagency collaboration among the appropriate criminal justice, mental health, substance abuse systems, and other relevant community members or governmental agencies to prevent the unsuitable or unnecessary arrest, incarceration, and/or prosecution of persons with behavioral health problems.
  - Reduce stigma about behavioral health problems by teaching Alaskans about the importance of behavioral health, promoting wellness, and emphasizing the potential that Treatment Works, Recovery Happens.

In the section **Board Strategies and Performance Activities** (p. 40), the activities to support each strategy are listed. As in all Board planning, we break these activities down into our statutory roles: Plan, Coordinate, Educate, Advise, Evaluate, and Advocate. A "dashboard" lets us track our success in performing the activities that will lead us to our ultimate population results.

This plan is dynamic, available on the web and in a paper copy; it is expected to change as we move forward in helping to shape a useful, effective, efficient, sustainable comprehensive system of behavioral health care. Ultimately, we hope that these actions help all Alaskan citizens achieve their optimal behavioral health.

Note: The phrase "substance abuse" is increasingly recognized as stigmatizing. While it continues to be a recognized diagnostic category and is referenced when necessary, this document attempts to use the phrase "substance use disorder" to encompass the whole range of alcoholism, illicit drug use, and both dependence and abuse of these substances.

A Short History of the Boards

The Advisory Board on Alcoholism and Drug Abuse (ABADA) and the Alaska Mental Health Board (AMHB) have rich histories. The ABADA began in its current form in 1995. Prior to that, it functioned as the Governor's Advisory Board on Alcoholism. As a board composed of consumers, providers, and public members, it was responsible for advocacy, planning, and budgeting for substance use disorder treatment and prevention programs in the state. From its beginning, it was clear that the ABADA was responsible for representing both the chronic alcoholic population served by the Alaska Mental Health Trust Authority and the broader population of "all persons as they are affected by alcohol, other drug and inhalant issues."[1] The board traditionally looked at appropriate levels of care in different sized communities to determine what levels of service should be funded throughout the state.

The Mental Health Board, under different names at different times, has guided the use of both state and federal funds in serving the mental health needs of Alaskans for decades. Providers, consumers, and other stakeholders have always had involvement in these decisions. However, in a state as vast as Alaska there have been challenges in involving all who choose to have a voice. Over time, this has evolved from quarterly meetings to use of a variety of means, including teleconferencing and web sites to make sure this communication is effective. Face to face Board meetings with public involvement and comment continue to be a strong component of this exchange of ideas.

Relationship to the Alaska Mental Health Trust Authority

In 1956, the Federal government gave the Territory of Alaska one million acres of Mental Health lands to be held in trust. Revenue from this land was to be used to meet the necessary expenses of the mental health program of Alaska. A lawsuit was filed by an Alaskan on behalf of his son, who required mental health services that were not available in Alaska, and was joined by many other groups concerned about mental health in Alaska. As a result of the 1994 settlement of this suit, the Alaska Mental Health Trust Authority was established to serve four beneficiary groups. These four groups are composed of individuals with:

- Mental illnesses
- Developmental disabilities
- Chronic alcoholism
- Alzheimer's disease and related dementias

And individuals at risk of developing these conditions.

The AMHB and ABADA are two of the four boards that represent their respective beneficiary groups. In addition, the Boards represent a broader population of consumers, providers, advocates, and state agencies that serve the mental health and alcoholism and substance abuse prevention and treatment needs of Alaskans. They have a statutory responsibility to serve as planning, coordinating, and advocacy bodies for all substance abuse and mental health treatment and prevention programs in Alaska.

Representing Unique Views with a Shared Vision

From 2003-2006, the Department of Health and Social Services worked to merge the administration of mental health services with alcoholism and drug abuse services. Many grantees mirrored this transformation, merging services they offered as well. The Boards were faced with a decision of how to reflect this awareness of co-occurring disorders. They are in a unique position because of their need to represent their beneficiaries well. While acknowledging that many beneficiaries experience co-occurring disorders and benefit from treatment of both problems at the same time, others have just a substance use or mental health problem and have different needs. Also, the court decision that created the Trust referenced both Boards. To change that would require reopening the entire mental health lands settlement. The decision was made to retain both Boards, ABADA and AMHB, as autonomous boards but to merge staff and meetings. At this time, the Boards meet jointly, but have time to break out to accomplish unique business for each Board. This merger has left the Boards even stronger, increasing their ability to understand and represent a range of Alaskans.

Listening to Beneficiaries

Programs supported within the behavioral health system strive to use proven practices based on community needs and values to help all Alaskans lead healthy and productive lives. A range of programs exists so that each individual can be served at the least restrictive (and most cost efficient) level of care. The Boards review this continuum of care, assuring that the needs of consumers are being met and that the voices of providers and consumers are heard as services are planned and funded. Assuring that all stakeholders hear the ideas and requirements of those who need and use the substance use disorder and mental health systems is the primary role of the Boards. In a state with as few people as Alaska, each voice counts. The ABADA and AMHB have always relied on Alaskans to help achieve a better life for all in this state. This plan is part of that ongoing dialogue.

The Statutory Responsibilities of ABADA and AMHB

The Boards' duties are defined by federal and state statute and regulation. The Boards have adopted the following summary of these duties. These are used in later sections of this plan to organize the activities the Boards will undertake. The responsibility of the Boards is to:

Plan

The Boards will work in concert with other stakeholders to create an effective, comprehensive, continuous system of behavioral health built on a foundation of the community's culture that serves all Alaskans. They will assure that proposed programs are sustainable.

Coordinate

The Boards participate in all levels of behavioral health service delivery, from representing consumers and providers to working in unison with the Alaska Mental Health Trust, the Department of Health and Social Services, Department of Corrections, and Department of Education and Early Development. We will continue to be a part of most decision making bodies that shape behavioral health policy and practice and use our central position to help assure that the all parts of the system work together.

Educate

We can increase the knowledge of all Alaskans about the importance of behavioral health and that "Treatment Works, Recovery Happens." We work to reduce the stigma that surrounds behavioral health problems and support prevention and early intervention efforts.

Advise

In our role as the Governor's advisory boards, we will continue to help guide policy development and program planning at all levels.

Evaluate

Only with effective data can systems improve their own functioning. Only with effective data can decision makers appropriately allocate resources. The Boards will help facilitate the effort to assure that data be available for these functions and dedicate their staff to using that data in planning and decision making.

Advocate

Alaskans are a self-reliant people. But Alaskans also help each other. The Boards will use their unified voice and help amplify the voice of all behavioral health advocates to assure that necessary programs are suitably funded, administered, evaluated, and sustained.

What is Behavioral Health?

Behavioral health quick facts:

- An estimated 27,000 Alaskan adults and 17,000 children experience severe mental illness in any given year.[7]
- An estimated 124,500 Alaskan adults experience mild to severe mental health problems in any given year.[8]
- An estimated 50,000 Alaskan adults and youth reported that they experienced problems with substance abuse or dependence in 2004. Most of these problems involved alcohol. Over 35,000 people needed but did not receive treatment for alcohol use problems.[5]
- Behavioral health consumer groups in Alaska are actively developing and participating in programs to enhance their own recovery and that of other Alaskans.
- Alaska has been successful in merging many services for co-occurring disorders.

Ring, Ring….
"Hello, Advisory Board on Alcoholism and Drug Abuse and Alaska Mental Health Board."

With this greeting, we both identify our Boards and also give the range of issues that is represented by the concept of **Behavioral Health:** alcohol and drug use problems and mental health. This is a complex idea – behavioral health is impacted by biological, social, emotional, cognitive, and spiritual factors. The good news is that science and knowledge about behavioral health are growing and changing, and at best, this is reflected in the behavioral health system of services.

"Behavioral health is a state of emotional and psychological well-being in which an individual is able to use his or her cognitive and emotional capabilities, function in society, and meet the ordinary demands of everyday life."[2] Behavioral health is more than the absence of mental illness or lack of problems with substance use. Some people struggle just to survive another day because of behavioral health problems while others lead happy, healthy, productive, fulfilled lives. Understanding this full continuum helps those who advocate for and fund programs make informed decisions about an appropriate system of care.

Let's start by breaking behavioral health services down into their historic components: mental health, alcohol and substance use, and co-occurring disorders. As will be seen later, this is a somewhat artificial distinction, but it helps us understand vast areas of information. This chapter will look at the meaning of these concepts and talk about the number of Alaskans who may experience problems in these areas. Once we understand those served by the behavioral health system we can talk about making it work.

Data in the following section is derived from a variety of sources. We are becoming increasingly good at estimating prevalence (the number of Alaskans who experience a condition) based on national surveys that include a significant number of Alaskans. These numbers help us to know both the amount of service that is needed in the state and the types of service that will be most effective in producing change.

Substance use disorders:

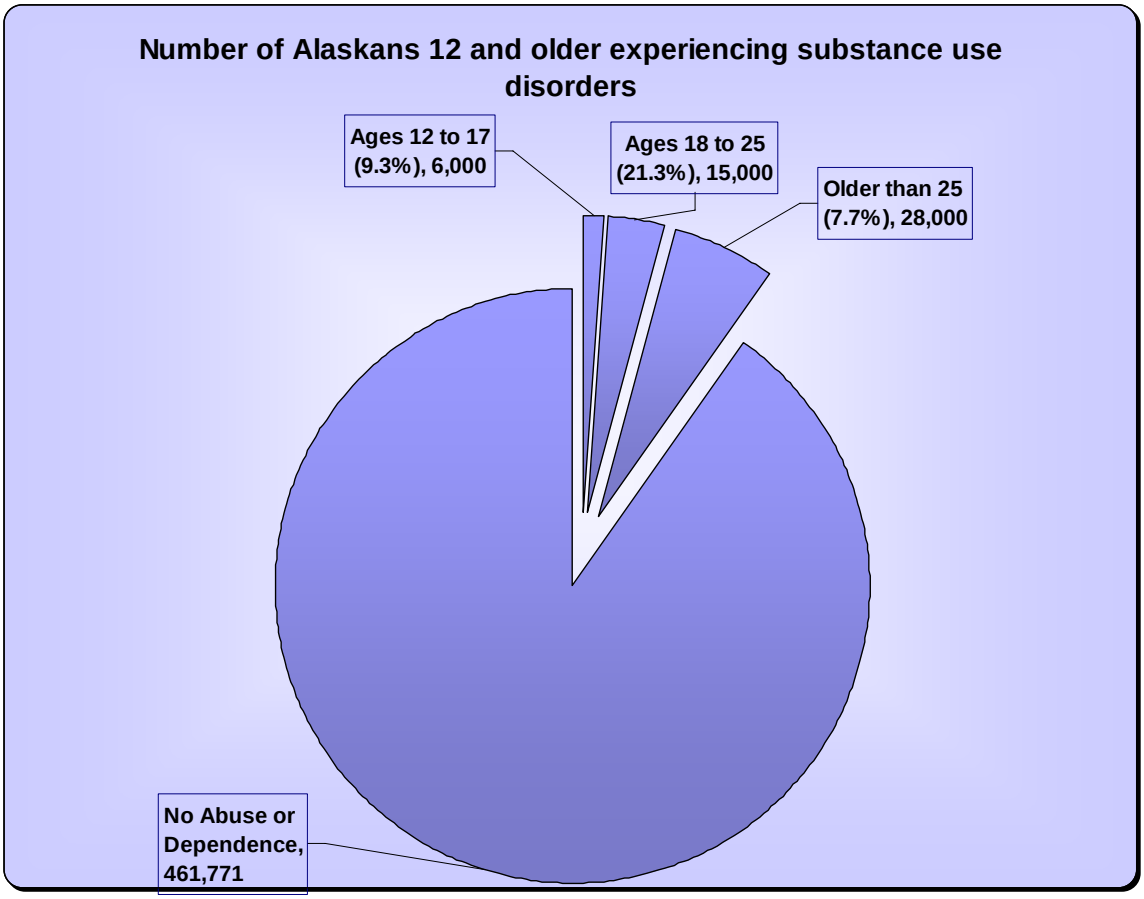

Chart 1. Estimated number of Alaskans experiencing substance use disorders by age and percent of that age group (National Survey on Drug Use and Health, 2004) [3]

Estimates of the prevalence of alcohol dependence vary depending on the definition used and upon the methods of estimation. In the United States 10 to 20 percent of men and 5 to 10 percent of women at some point in their lives will meet criteria for alcoholism, depending on the stringency of the criteria employed.[4]

The National Survey of Drug Use and Health surveys people throughout the nation on their substance use. Looking at the percentage of Alaskans who experienced problems with alcohol and drugs in 2004, almost 10% of all people over the age of 11 reported that they experienced problems with alcohol or illicit drug dependence or use, with the

biggest problems being with alcohol. It is no surprise that there are problems with drug and alcohol use. In 2004 and 2005 national surveys, Alaska had the highest rate of use of illicit drugs (12.7%) in the nation. In addition, they had the largest percentage of citizens who needed by did not receive treatment for an illicit drug use problem (3.1% of all Alaskans over the age of 12.) 35,000 Alaskan adults and youth needed but did not receive treatment for alcohol use problems in 2005. [5]

In addition the same survey shows that almost 27% of young people between the ages of 12 and 17 used alcohol in the last month. This is a significant concern, because research shows that young people who begin drinking before the age of 15 are four times more likely to develop alcohol dependence.[6] (see appendix A for further information)

Serious mental illness:

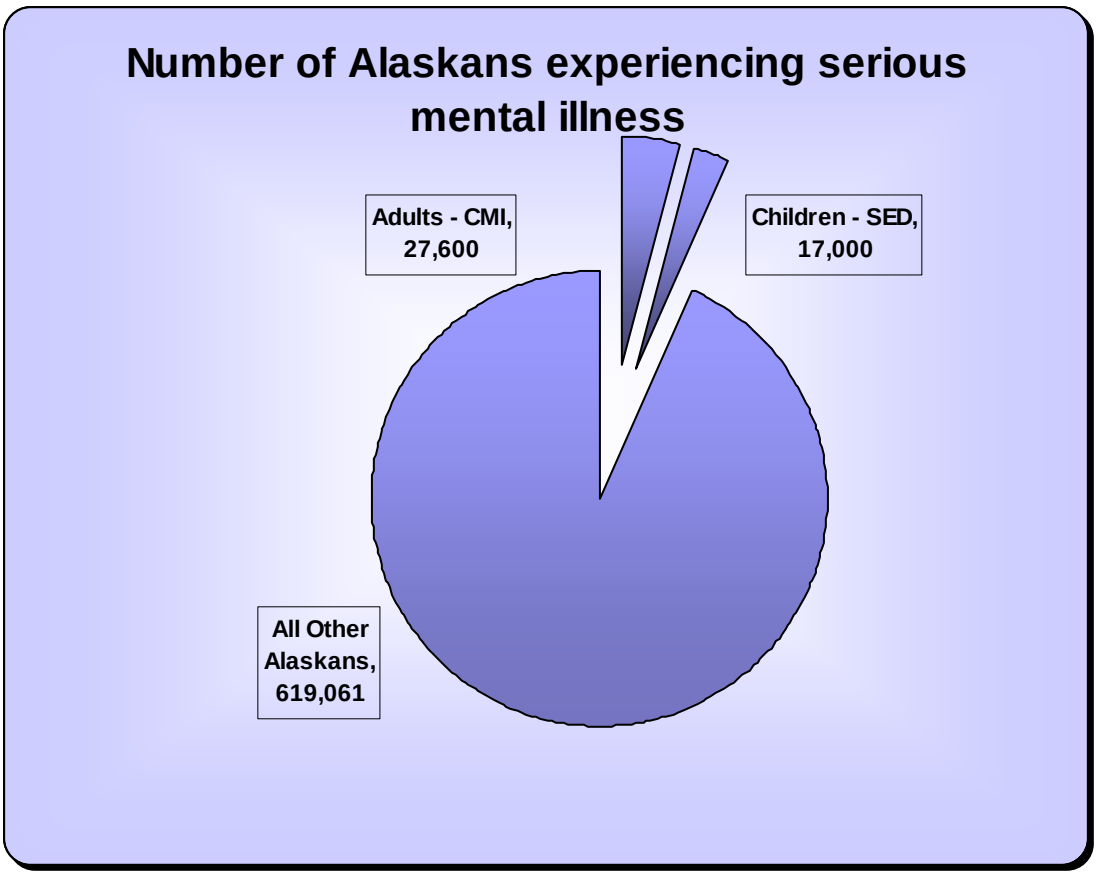

Chart 2 – Estimated number of Alaskans experiencing serious mental illness in 2004 (Data from National Comorbidity Survey Replication, 2005) [7]

The state of Alaska defines those experiencing a severe behavioral health problem that interferes with daily functioning as the top priority for state mental health services.

Priority populations to receive service in state funded programs include:

Adults with chronic mental illness: These are adults who have a diagnosable mental disorder that has resulted in functional impairment which substantially interferes with or

limits one of more major life activities such as the ability to perform self care, personal relations, living arrangements, work, or recreation. Approximately 27,000 Alaskan adults experience chronic mental illness.

Children and youth with severe emotional disturbances: These are children and youth who have a diagnosable mental disorder that substantially interferes with or prevents them from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills such as completing their education. This is a hard number to estimate, because there are few studies looking at incidence of mental illness in young children. However, the estimate here reflects children who are experiencing or at risk of severe emotional disturbance. Approximately 17,000 children and youth in Alaska fall in this group.

While we can estimate how many people fall into these categories based on national norms, these numbers don't take unique Alaskan conditions such as isolation and cost of living into account. A study to make "synthetic estimates" of prevalence of mental illness in Alaska is now underway as part of the Outcomes Identification Systems Performance Project (OISPP) involving the Boards, the Trust, and the Division of Behavioral Health. This will take national data and shape it based on Alaskan demographic information to more fully reflect Alaskan numbers.

We can also look at numbers from a survey done in Alaska, the Behavioral Risk Factor Surveillance Survey (BRFSS). In the 2005 statewide phone survey, 13% of Alaskans reported more than a week of poor mental health in the last 30 days.[8]

In addition, the National Survey of Drug use in households (NSDUH), another survey conducted in Alaska reports that 8.75% of Alaskans over the age of 12 report experiencing serious psychological distress in the last year (53,000 Alaskans over the age of 17.)

Research shows that most severe mental illnesses have biological, psychological, and social components. Like diabetes and a range of other "physical" illnesses, mental illnesses are caused by physical changes in the brain that interact with what is happening in a person's life. A variety of treatments are available, ranging from use of medication to peer based support. It is important for people with mental illness to have an active involvement in deciding which treatments are appropriate for them, individualizing their care based on their wants and needs. Recent research has shown that failure to treat less severe mental illness leads to increasing severity and possible chronicity.

Moderate to mild mental illness:

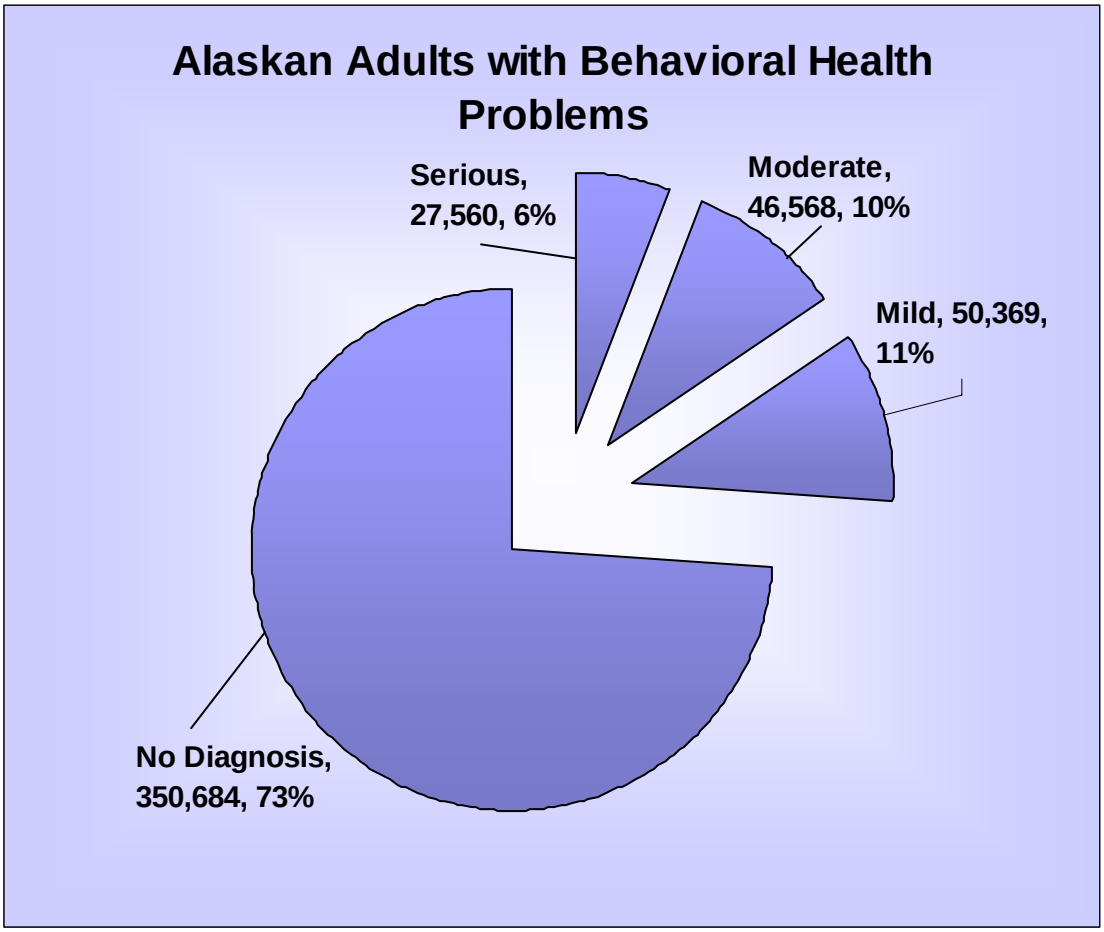

Chart 3 - Estimate of number of Alaskans over age 17 experiencing behavioral health problems within 12 month period by level of severity.
(Data from National Comorbidity Survey Replication, 2005) [9]

These numbers are based on twelve month prevalence data from the most recent national epidemiological survey which assesses the number of adults who experience a mental illness as defined by the Diagnostic and Statistical Manual – IV (DSM-IV) of the American Psychiatric Association. This includes both things such as depression and anxiety and also substance use disorders. Severity was determined from face-to-face interviews.

The estimates are conservative because they rely on voluntary responses to an individual survey (which has been shown to underestimate occurrence), and do not include homeless people, those in institutions, non-English speakers, or people who experience schizophrenia unless they also experience another disorder. People with moderate mental illness experience impairment in some parts of their lives such as impaired work performance or disruption of social functioning, while those with mild mental illness meet diagnostic criteria, but don't report significant disruption. While some people with mild or moderate mental illness improve spontaneously, others continue to have problems

or become worse. In a study of how people are affected by mild mental illness, it was found that the impact on functioning is similar to that caused by clinically significant chronic physical disorders.

In addition, the same epidemiological study estimated the percentage of people who will have a diagnosable mental illness in their lifetimes. Again, this is an underestimate, but the lifetime prevalence was 46.4%.[7] In Alaska, this translates into 308,000 of our citizens experiencing diagnosable mental illness, including major problems with substance use, during their lifetimes.

The impact of mild and moderate mental illness can be seen throughout Alaska and needs to be attended to when making policy decisions. For instance, self-reported rates of post-partum depression in Alaskan women delivering live births revealed that 60% of mothers experienced some post-partum depression.

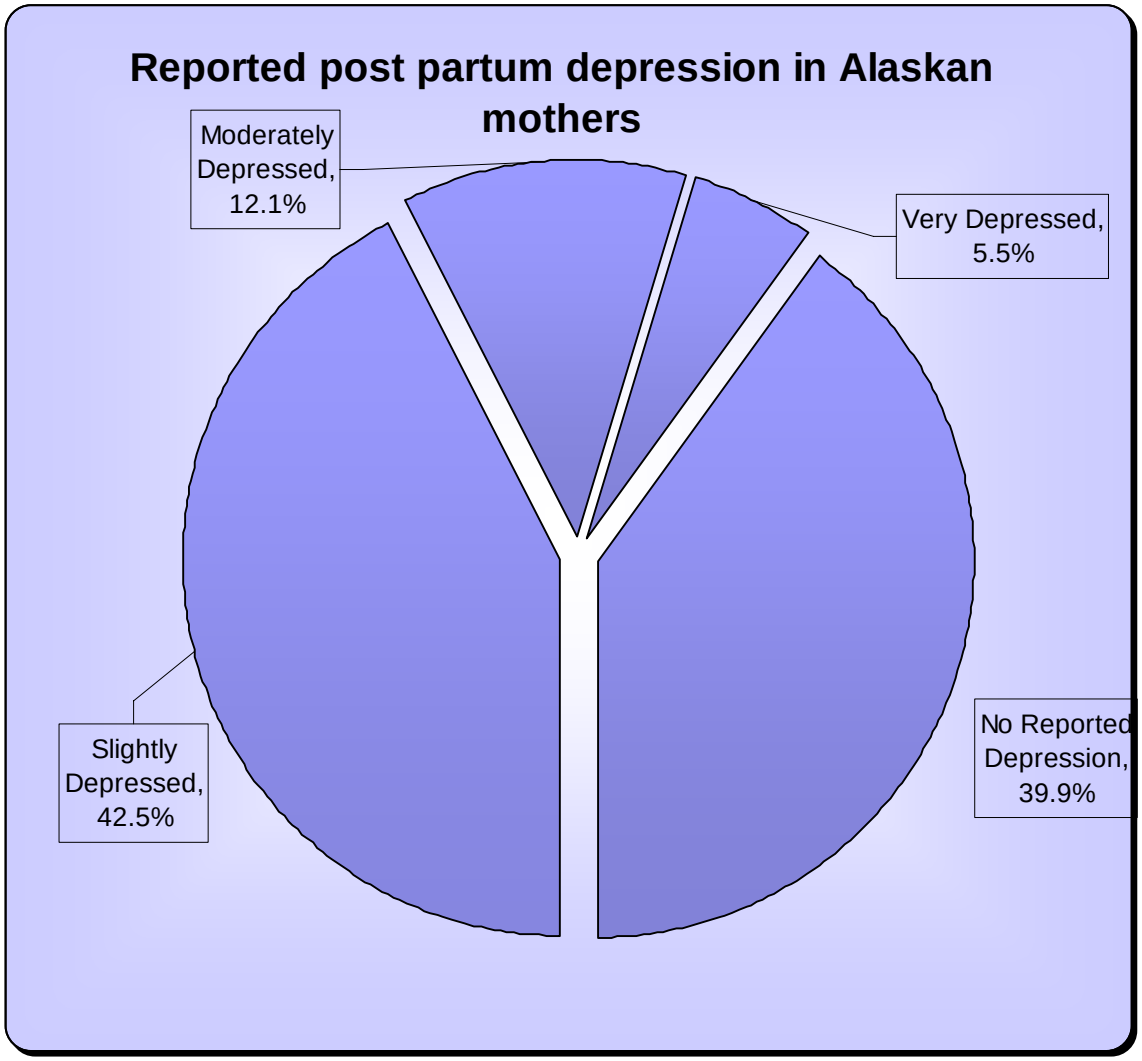

Chart 4 – Post-partum depression in Alaskan mothers
(Data from the Alaska Pregnancy Risk Assessment Monitoring System)[10]

It is imperative that primary care providers and others who interface with parents of young children are alert and watch for maternal depression and other mental health issues. By providing support to parents, we increase the odds that young children will reap the benefits of having a healthy, nurturing caregiver. If we focus only on those with the most severe problems, we miss the opportunity to intervene when the problem is most solvable.

The impact of mental illness on the correctional system is also clear. According to a 2007 study by the Alaska Judicial Council, 29% of those convicted of a felony or misdemeanor in 1999 exhibited a mental disorder, while 68% had indication of an alcohol problem and 48% had indication of a drug problem.[11] In contrast to this, only 12% of the admitted population had at least one contact with a mental health clinician over the course of their DOC history. [12] Offenders had 13% higher three year recidivism rate if they had an alcohol problem and a 14% higher recidivism rate if they had a mental health problem than those with no such problems. If treatment can reduce recidivism, we are missing a real opportunity to lower the social and fiscal costs of incarceration.

The same issues can be seen in juvenile corrections. To get a sense of the number of youth in the Alaska juvenile justice system with mental health issues, the Division of Juvenile Justice examined the records of all of the 1,463 youth under the Division's supervision or custody on January 12, 2001. Youth were considered to have a mental health disorder if they had received a formal clinical diagnosis, as defined in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition. 42.5% of youth were found to have a mental health disorder. 40.2% of these had co-occurring mental health and substance use disorders. The results point to the need for adequate mental health care and substance abuse treatment services for youth who commit crimes. [13] While our juvenile justice system incorporates treatment, there is still a need for further resources both in the institution and in the community.

Co-occurring disorders

Co-occurring disorders can encompass everything from a person with developmental disabilities who also has emotional problems to an alcoholic who experiences depression. A yearly national survey of substance abuse treatment facilities showed that 40% of those receiving services for substance use issues also received mental health services.[14] The Alaska Screening Tool showed that 52% of those presenting for services from state grant programs identified themselves as experiencing some form of co-occurring disorder.[15] In Alaska, we have realized that treating all problems at the same time increases the probability of success. The merging of substance abuse and mental health service at the state level reflects this awareness. The Boards work with all involved in planning and delivering services to make sure that there is "no wrong door," that people who come for help can find that help, no matter what their diagnosis or need.

Positive Behavioral Health

As discussed above, behavioral health is more than just the lack of problems with substance abuse or mental illness. Yet, we focus more on treating the problems than we do on creating positive behavioral health. This needs to change. Quality of life factors affect not only substance use and mental illness; they affect physical health, ability to learn, and the overall good of society. If we can move beyond our focus on "fixing" behavioral illness and incorporate attempts to ensure positive behavioral health, the numbers seen above (308,000 Alaskans experiencing a behavioral health problem in their lifetimes) will be reduced for our children.

Since the discovery of medication that addressed behavioral health problems, there has been an increasing dependence on the medical model to understand and treat these problems. This tendency is increased even more by the use of Medicaid which is an entitlement program focused on the medical model. To receive Medicaid reimbursement, it is essential to show medical necessity to deliver services.

The identification of behavioral health problems as diseases much like heart disease or diabetes was a great step forward. The appropriate use and choice by consumers of medications has freed many people from lives of struggle. But reliance on medical explanations for behavioral health problems misses much of the picture. Behavioral health involves the body, the emotions, and the community in which a person functions. Some of the most effective treatments focus on families, community supports, and self and peer help. We need to move our system beyond the narrow focus of "mental illness," "substance dependence," and medication management.

In addition, it has been realized that people can recover from these problems. Use of a continuum of care which includes a variety of peer and consumer based programs can lead to better results. Professionals still have a lot to offer within the system, but consumers also bring unique strengths to helping their peers. Looking at broader social issues and focusing on assets and resiliency is also essential if Alaska is to have true behavioral health. The Division of Behavioral Health awards grants that focus on these issues of resiliency.

There is more and more research into how to treat behavioral health problems, and ensure quality behavioral health. This can help guide decisions about how to provide treatment and prevention services in Alaska. However, it is important to realize that we are a unique state. Practices must be chosen that work within our individual lives, cultural, and societal framework.

This plan is not only about finding ways to fix problems, it is about working towards a vision of how Alaska could be. The Boards are dedicated to the dual role of identifying what will work in the present situation and planning for how to sustain and improve programs in the future. Our children, youth, and families as well as Alaskan adults deserve the opportunity to experience optimum behavioral health, to lead healthy and productive lives.

Common behavioral health problems

Based on national surveys[16], in order of probability, the most common adult mental illness diagnoses are:

Anxiety disorders (18.1 % of adults have experienced an anxiety disorder during the last year) These include everything from panic attacks to post traumatic stress disorder and obsessive compulsive disorder. They are all characterized by inappropriate experiences of anxiety. Common signs of acute anxiety include:

• Feelings of fear or dread
• Trembling, restlessness, and muscle tension
• Rapid heart rate
• Lightheadedness or dizziness
• Perspiration
• Cold hands/feet
• Shortness of breath

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Mood disorders (9.5% of adults have experienced a mood disorder during the last year) The best known of these disorders are major depression and bipolar disorder. These disorders not only cause depressed or extremely elevated mood, they affect all of life including sleeping, eating, and ability to think about the future realistically. The national cost of depression in the workplace is estimated to be as much as $55 billion in lost productivity alone.[18] The toll on daily life, including parenting, family functioning, and community involvement is uncountable. One of our biggest concerns in Alaska is stemming the tide of suicides and suicide attempts. Many of these are directly related to the experience of depression. Also there is a clear relationship between substance abuse and depression in many people. Symptoms of depression include:

• Persistent sadness or despair
• Insomnia (sometimes hypersomnia)
• Decreased appetite
• Psychomotor retardation
• Inability to experience pleasure, social withdrawal
• Irritability
• Hopelessness
• Poor self-esteem, feelings of helplessness
• Suicidal ideation

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Impulse control disorders (8.9 % of adults have experienced an impulse control disorder during the last year) This is a fairly new area for treatment. Impulse control disorders include attention deficit disorder, intermittent explosive disorder, and other disorders that have an acting-out component. Treatment for these disorders is becoming more effective. Appropriate intervention can improve quality of life and divert people from involvement with the criminal justice system at times.

Psychosis (around 1.3% of adults experienced schizophrenia during the last year.) – This includes schizophrenia and also the more extreme expressions of mood disorders and other conditions where the person experiences disturbances of perception and thought. The best known of these symptoms are hallucinations, but flat affect, disorganized thoughts, delusions, and agitation are all also seen in psychosis.

While these are the most prevalent mental illnesses, the variety of other cognitive and emotional disorders include autism, Asperger's syndrome, pervasive developmental disorders, dementias, and personality disorders. These all are seen in a part of the population and impact quality of life in Alaska.

Substance Dependence (9.8% of all Alaskans over the age of 12 reported that they experienced substance dependence or use disorders in 2004, 21.33% of Alaskans between 18 and 25 reported problems with substance abuse or dependence[20]) This includes the range of substance dependence from alcoholism to dependence on a variety of drugs. It is defined as a maladaptive pattern of substance use that leads to clinically significant impairment or distress including at least three symptoms such as:

- needing increased amounts of the substance,
- withdrawal syndrome if the substance is discontinued,
- a great deal of time spent procuring or using the substance,
- preoccupation with substance use and curtailment of other activities, and
- continuing use of the substance despite the negative impact it has on physical or psychological health.[21]

Substance Abuse - This is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress and at least one other symptom such as:

- failure to fulfill major role obligations because of substance use,
- recurrent use in situations in which it is physically hazardous,
- recurrent substance related legal problems, or
- continued use despite having persistent social or interpersonal problem caused or exacerbated by the use. [22]

Major substances involved in substance dependence and abuse include:
Alcohol (49.36% of Alaskans used in one month in 2004)
Marijuana (15.83% of Alaskans used in 2004)
Cocaine (2.48% of Alaskans used in 2004)
Tobacco (29.59% of Alaskans used in one month in 2004)
Heroin (no percentages available)
Methamphetamines (no data, but reported to be a growing problem)[23]

Behavioral Health Services in Alaska

Behavioral health services quick facts:

- Services are provided by a variety of providers including state funded programs, tribal health services, school districts, clergy, physical health providers, and other nonprofit and government entities.
- More services are needed in all areas and across service types with the goal of developing a comprehensive system of behavioral health care.
- Decisions about priorities for funding differ based on philosophy of treatment and experience with current services.
- It is essential that the behavioral health and physical health system work together to improve the whole spectrum of health for all Alaskans.
- Services need to be developed and supported by the community in which Alaskans live.
- Services need to involve youth, families, and adults.

To understand delivery of behavioral health services in Alaska, it is necessary to look at a broad range of providers. While this current version of the plan will briefly list providers outside of the state system, future addenda will expand on the broader behavioral health delivery system.

State funded behavioral health programs

State statute (AS 47.30.056 – see appendix B) defines the requirements for a comprehensive mental health system. The system is to include services ranging from prevention and education to inpatient care and crisis stabilization.

These services are delivered by recipients of state grants throughout Alaska. Most of these programs are private, non-profit organizations. As will be discussed further in the funding chapter, changes in funding have resulted in shifts in the types of services provided. At the beginning of the state mental health and substance use disorder treatment system, programs were funded solely by state grants, federal funding, and local match. Decisions about what services to offer were often left to the community board or agency governing body and the desire of whoever was running the program. It was generally made clear (as referenced in the sidebar on the next page) that anyone coming to the center should be served. There were few private services outside of the largest communities, and community mental health and substance use disorder services served all. Private insurance helped pay the bill sometimes, but most people paid little for the services they received. The range of services included outreach and prevention, a lot of early intervention – generally in the form of counseling for people with mild or moderate mental health or substance use problems, and limited services for people with chronic

behavioral health problems. Inpatient services were available in some community hospitals, with Alaska Psychiatric Institute used fairly extensively when inpatient services were needed.

With the advent of Medicaid as a way to pay for services, a shift in the system occurred. Services for the chronically mentally ill were covered more fully for the first time. While there were limitations on what services could be offered, if a person had Medicaid because of his or her disability, he or she had access to funding for a range of clinical and rehabilitative services.[24] Because of this concentration of funding for more intense services for people with serious mentally illness, funding for general community mental health services for people with less severe problems decreased or stayed flat. In the same way, funding for substance use disorder treatment, most of which is funded through grant programs, also decreased.

One of the first state plans

The state of Alaska led a two year comprehensive community behavioral health planning effort from 1964 to 1965. The report on this effort[1] lists over 400 members of 9 different planning committees and 19 community planning groups. At this time, many patients were still sent to Morningside, a psychiatric facility in Oregon, for treatment. The report called for mental health beds and day hospitalization programs in all hospitals in the state. It said that alcoholism was the most serious problem in the state and was both the cause and the result of mental illness. They endorsed the "no wrong door" policy, recommending: "that (in) facilities designated as mental health centers that any type of problem not be excluded (meaning delinquents, alcoholics, psychotics, neurotics, retarded, or any other diagnostic category under psychoneurotic and neurological disorders.)" Many of the problems haven't changed, and many of the solutions are still relevant.

Through its grant programs, the Division of Behavioral Health funds the following components. Program descriptions are available in Appendix C.[25]

Prevention and Early Intervention:

The Alaska Fetal Alcohol Syndrome (FAS) Program
Alcohol Safety Action Program (ASAP)
Community Comprehensive Prevention & Early Intervention Grants
Rural Services and Suicide Prevention

Treatment and Recovery:

Behavioral Health Medicaid Services
Behavioral Health
Psychiatric Emergency Services

Services for the Seriously Mentally Ill
Designated Evaluation and Treatment
Services for Youth with Severe Emotional Disturbance (SED)

Other components directly operated by the Division of Behavioral Health:

Alaska Psychiatric Institute
Behavioral Health Administration

The total appropriation for these behavioral health components is just over $240 million dollars from all sources. This is divided between components as follows:

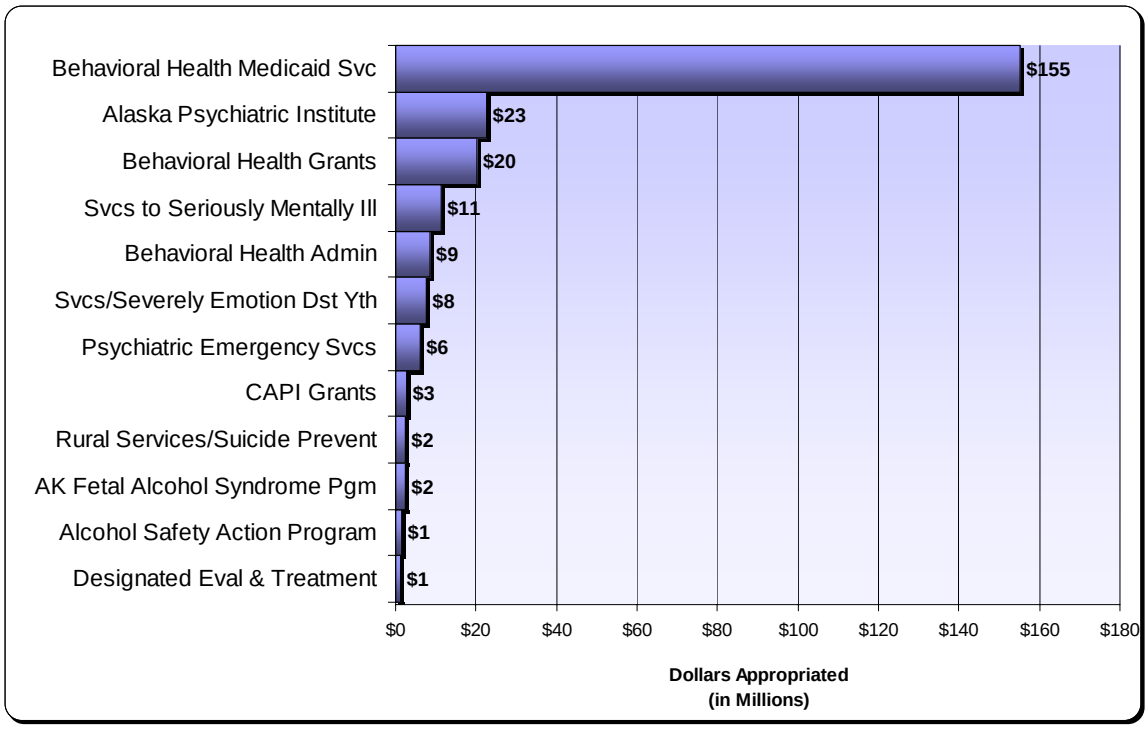


Chart 5- Total appropriated funding for Behavioral Health programs, 2007 [26]

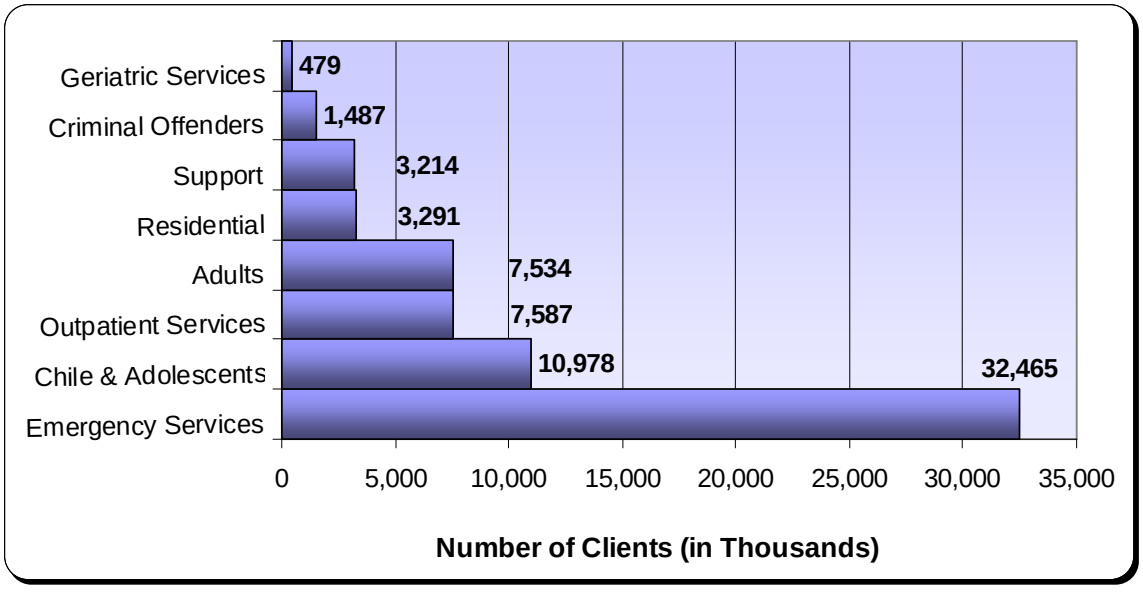


Chart 6 – Clients by service category – FY04 [27]

Although the Alaska Automated Information Management System (AKAIMS) is still being completed, we have some data about how many people are being served and which services are being used. The department asked programs to report how many people they served in FY2004 in a number of categories.[28] Although incomplete, this "snapshot" showed that there were over 32,000 emergency contacts in FY04. Data from FY 06 showed over 45,000 emergency contacts.[29] Further data from provider reports for FY06 will be available shortly and will be included in the update of this plan.
Briefly, client behavioral health services provided by state grant or medicaid funded programs are (in order of frequency): [30]

Emergency Services: Community mental health center emergency services, crisis hotline, crisis intervention/outreach, crisis/respites, suicide prevention, substance abuse detox services, substance use disorder inpatient treatment, designated evaluation and treatment, designated evaluation and stabilization, acute care hospitalization.

Child and Adolescent Services: Outpatient services for seriously emotionally disturbed children, school based mental health services, children's crisis respite services, family centered services, mental health day treatment, mobile adolescent treatment teams, peer helper/mentoring programs, high risk behaviors prevention services, and fetal alcohol syndrome diagnostic services.

Outpatient Services: Outpatient substance treatment, co-occurring disorders outpatient treatment, abuse, neglect, domestic violence outreach, homeless outreach, intensive outpatient substance use disorder treatment, specialized traumatic brain injury services.

Adult Services: Co-occurring disorders treatment, itinerant outpatient mental health services for seriously mentally ill adults, outpatient services for seriously mentally ill adults, intensive case management, seriously mentally ill employment supports, psychiatric nursing services, transitional supported living housing, day treatment, fetal alcohol assessment services, seriously mentally ill client pre-vocational training.

Residential Services: Therapeutic group homes, substance use disorder intermediate care, substance use disorder inpatient care, diagnostic and treatment centers, assisted living homes, homeless shelters, therapeutic foster homes, permanent housing, co-occurring disorders intermediate care, supervised apartments, emergency detox, transitional housing, geriatric long term care-assisted living, group homes, and adult foster homes.

Support Services: Transportation, consumer run businesses, consumer clubhouses.

Criminal Offender Services: Alcohol safety action program, case management, psychiatric nursing, Department of Corrections institutional mental health services, community holding facility or jail, Department of Corrections intensive case management, therapeutic courts, juvenile alcohol safety action program, wellness courts, mental health courts, Department of Corrections crisis respite.

Geriatric Services: Mental health services, mental health outreach, day care services, respite services.

Implications of funding decisions

As we look at the distribution of services, the impact of the decision to limit grant funding for treatment and recovery services becomes clear. Many client contacts provide emergency services rather than ongoing integrated treatment. The decision to switch to Medicaid funding from grant funding and the consequent emphasis on serving people who are experiencing severe disabilities leads to a failure to prevent Alaskans from developing increasing behavioral health problems.

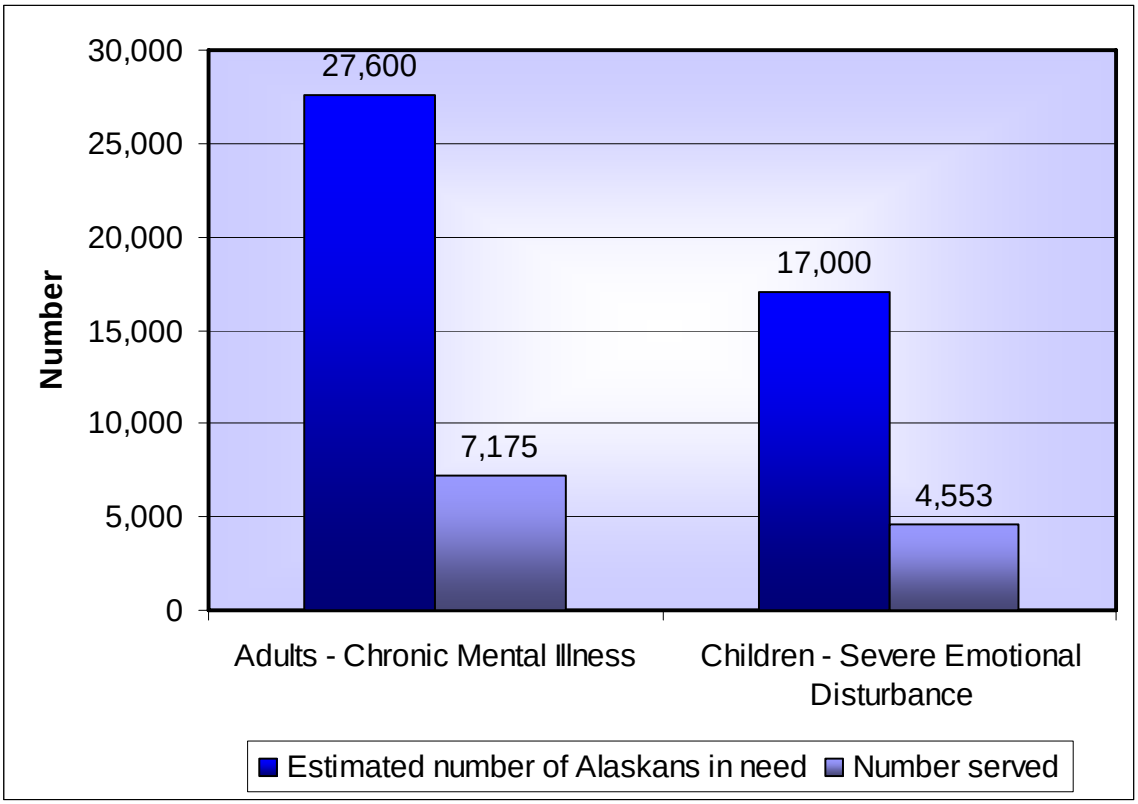


Chart 7 - Alaskans with SED and CMI needing services as estimated by NCS-R and the number served from BH grantee reports
Fiscal Year 2006

In the next chapter, Chart 8 demonstrates how Alaska depends much more on Medicaid for funding than most states. This allows us to leverage federal Medicaid dollars with state match, but leaves us with less money available for the full continuum of care.

Service Availability

As part of its comprehensive integrated mental health plan, *Moving Forward*, the Department of Health and Social Services with its partners, the Alaska Mental Health Trust Authority and the partner boards, has developed a matrix of services using the community levels developed by the Alaska Mental Health Board (Appendix D). It is apparent from this plan that, while we have some services available at this time, many services are lacking. Even in areas where services were identified as adequate, there are

gaps and waiting lists for these services. The Boards have a primary purpose of identifying what services are needed and advocating for their development. In this case, so many things are needed that it becomes necessary to determine priority services. Identifying these priorities, finding the best response to them, and advocating that the gaps are filled is a primary responsibility of the Boards.

Other Behavioral Health Providers

Tribal health services

There are 229 federally recognized tribes in Alaska. The state is divided into nine Alaska Native tribal health care delivery areas (or service units) – each area is as large as a state in the lower 48 with a low population density, no road systems, extreme weather conditions, and a very high cost of living. In each service unit, the tribes have selected an entity to provide the health care services for the region, although some tribes have chosen to retain provision of local health care services. Rural Alaskans live in 360 rural and bush communities throughout the state.

Most tribal health care programs include mental health and substance use disorder programs and some level of home and community based services supporting the elderly and disabled within their community of residence. These may include Home and Community Based Waivers, and/or the Personal Care Attendant program through the Division of Senior and Disabilities Services and Home Health through the Division of Health Care Services.[31]

The State and the Mental Health Trust Authority provide funds that are used to hire local village-based counselors and support their attendance and completion of the Rural Human Services program through the University of Alaska Fairbanks. The goal is to have a counselor in every village. As of June 2005, more than 200 students had graduated from the program at university campuses in Fairbanks, Bethel, Nome, and Kotzebue. In fiscal year 2006, the grant program provided services to 13 agencies, providing local counselors in approximately 90 villages.[32] With 289 villages in all, there is still a long ways to go.

The reader is urged to consult the Rural Behavioral Health Needs Assessment [33] completed in December 2004 by ANTHC and a consortium of the state and tribal entities. Parts of its findings will be utilized in this planning document, but much more information is available that we will not try to reproduce. The general conclusions drawn from this assessment were that most communities lack a range of services. While many providers and communities want more intensive services, such as residential treatment for children and youth, these may not be the best use of resources, both because it is not possible to make such services available in all communities and because residential treatment has not been shown to be a particularly effective treatment modality for children. The report urged the extension of early intervention and general mental health and substance use disorder services, integration of health and behavioral health services as a way to reduce stigma, and careful planning about which services to include in larger communities.

The physical health system

Based on the most recent national data, it is clear that general medical providers are primary providers of behavioral health treatment. Of respondents who had been identified as having a diagnosable mental illness (including substance abuse and dependence), more were treated by a general medical provider than by a non-psychiatrist mental health specialist or by a psychiatrist.[34] Median length of treatment by general medical providers was 1.7 visits. This is less then the recommended length of treatment to achieve best results.

While we have no similar data for Alaska, it is clear that many Alaskans both receive and are referred for behavioral health services through their physical care provider. For many people, stigma is reduced if they can get services in a general primary health care setting. This may be especially true for senior citizens and those living in rural remote areas. In addition, many people are identified as having behavioral health problems after presenting for possible physical health problems. The importance of this service sector to behavioral health diagnosis and treatment delivery has not been fully realized. Behavioral health and physical health providers need to work together to enhance both behavioral and physical health for Alaskans. The Boards will address this further in their planned activities over the next four years.

School mental health and special education services

The need for behavioral health services in educational settings starts early in a child's life. 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.[35] At the other end of the spectrum, in Alaska, for every 100 9th graders, only a little over 60 graduate from high school, about 28 enter college and only 6 graduate within six years.[36] All these numbers are lower than the national average and those from nearby states. Behavioral health and educational attainment are highly correlated. We can look at educational attainment as a protective factor for positive behavioral health as well as for many other life successes.

With 55 independent school districts in the state, it is hard to talk about unified policies for delivery of behavioral health services. Many children and youth qualifying for special education have behavioral health problems, either as the primary problem (such as a child diagnosed as severely emotionally disturbed) or as part of a larger issue, such as the emotional problems experienced by a child with a severe learning disability. Schools are almost always the first point of contact for identifying problems of children, youth, and families. Yet, they frequently lack resources or referral links to respond fully to the problems. Concerns about how to share funding, lack of awareness of behavioral health diagnosis and treatment, and lack of time to respond to the overwhelming demands placed on school systems all lead to a breakdown in service coordination between schools and behavioral health providers. In at least one instance Lower Kuskokwim School District has hired social workers to provide counseling, family support, and consultative services as well as referral to the behavioral health program. We need many more such programs. Through an education work group, the Boards, the state, and the Mental Health Trust are trying to address this issue now, but there is much that needs to be done.

Local, faith-based, and nonprofit, non-state supported programs

A wide variety of services are offered by programs which rely on foundation grants and individual contributions, as well as programs funded by local government and churches. Peer support programs such as Alcoholics Anonymous and Alanon also fall in this category. Other peer support programs are developing within the consumer community as well. As we face uncertain funding in the future, the work of programs that depend on a flow through of funds from the state is not sufficient to serve the need of Alaskans. Many times, these other programs have flexibility to provide services that may be prohibited or limited under the more restrictive requirements of state or federal funding.

Other parts of the state system

A significant percentage of Alaskans have behavioral health needs each year. And those needs are met, with varying degrees of success, by many parts of the system. As discussed briefly above, behavioral health services are needed and, to some extent, provided within the state Department of Corrections. The Division of Vocational Rehabilitation serves disabled behavioral health beneficiaries. The Alaska Housing Finance Corporation provides funds for housing. The Office of Children's Services and Division of Juvenile Justice are partners in working with many of the same children and youth as the Division of Behavioral Health. Public Health is a partner in providing prevention strategies throughout the state. Cash benefits provided through Public Assistance give people a step up. The Statewide Suicide Prevention Council and the Brain Injury Network as well as the other beneficiary boards: The Governor's Council on Disabilities and Special Education, the Alaska Council on Aging, all share in work to improve the lot of Alaskans who may experience behavioral health problems.

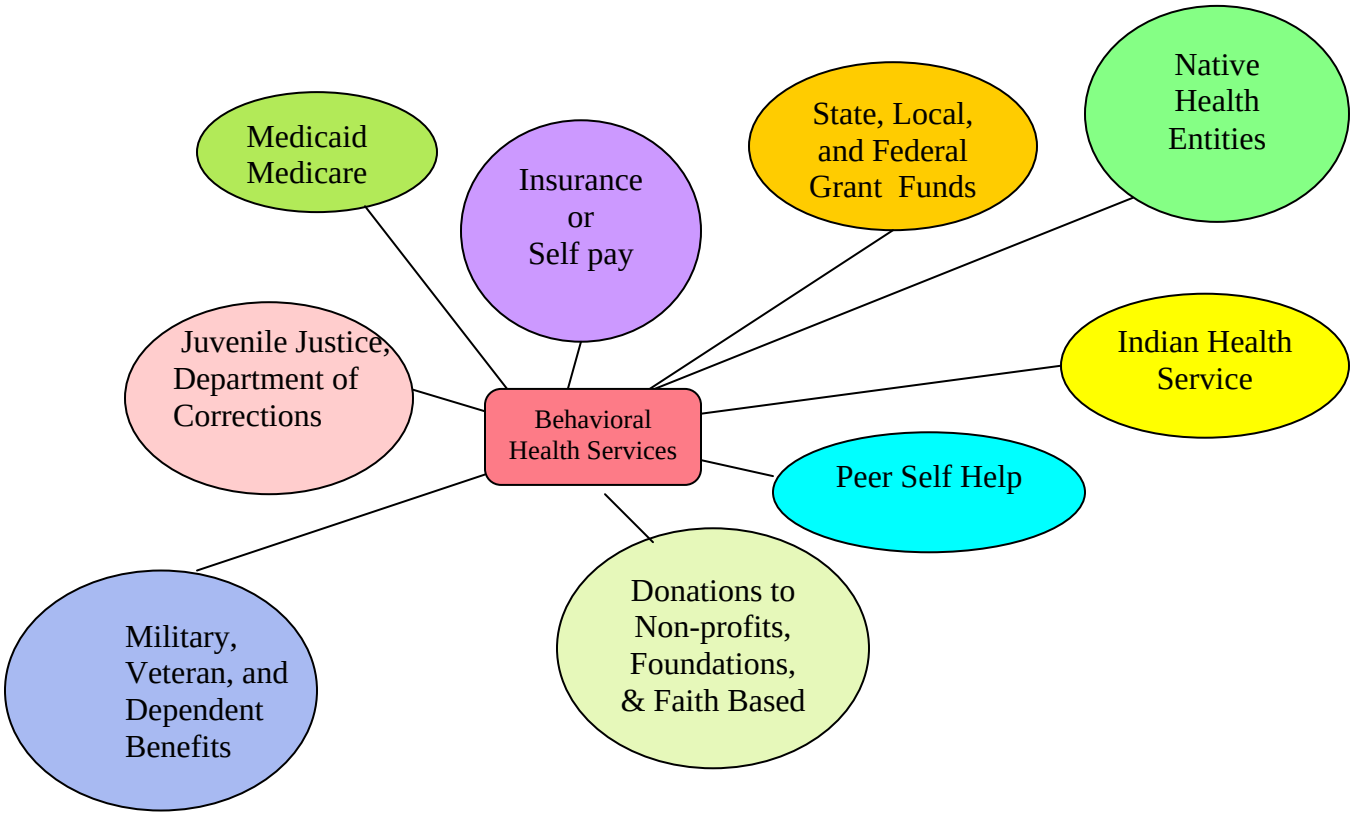
The Boards partner with many of these programs. With representatives of many parts of the above-mentioned system serving as ex-officio members of the Boards we are able to engage in dialogue and planning about the best ways to provide services to all Alaskans. In the future, even more work will go towards enhancing this collaborative function of the Boards.

How to Pay for It

Funding quick facts:

- Alaska ranks 6th in the nation in its reliance on Medicaid for behavioral health services.
- Less than 6% of the Medicaid budget goes to fund behavioral health outpatient services.
- Medicaid funding for placing children in residential psychiatric treatment centers almost equals all Medicaid funding for all nonresidential behavioral health services.
- Many Alaskans have no insurance. If they do have insurance, it frequently funds behavioral health at a lesser percentage than physical health. Behavioral health parity would solve this deficit.
- The declining poverty eligibility levels for Denali KidCare places Alaska as one of the bottom states in its commitment to funding children's health insurance.

Just as we have a multi-systemic approach to provision of behavioral health services, there are many ways to pay for these services. To look at just a few of them helps us see how we can optimize funding while ensuring that quality services are provided.



In this chapter of the plan, we will look mainly at state funding. However, future additions to the plan will look more closely at alternative funding sources.

State and federal funding

The majority of funding for behavioral health services in the state comes directly or indirectly from government sources. The direct source of this is federal and state government expenditures in the form of state grants and Medicaid funded through a state/federal partnership. In addition, almost a quarter of Alaskans are eligible for health care services through Federal military or Indian Health Services care facilities. The Alaska Area Native Health Service works in conjunction with nine tribally operated service units to provide comprehensive health services to 120,000 Alaska Native people. Federally recognized Alaska tribes administer 99 percent of the Indian Health Service funds earmarked for Alaska. [37]

The Division of Behavioral Health's budget encompasses funding from a variety of sources, including state general funds, Alaska Mental Health Trust funding, federal funds, and money from alcohol taxes. A decision was made a few years ago to increasingly switch behavioral health funding to Medicaid billing as a way to optimize the receipt of federal funds. This has been successful; Alaska ranks 6th in the nation in the percentage of their mental health budget funded by Medicaid.

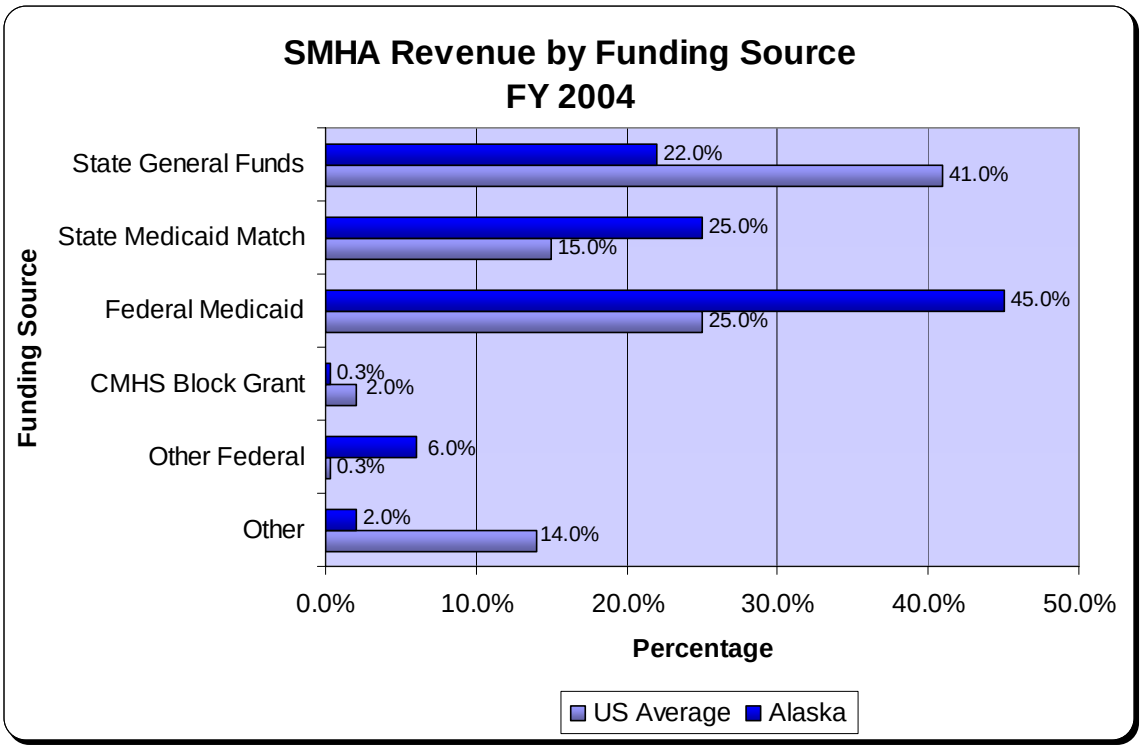


Chart 8 - State Mental Health Authority revenue by funding source, 2004 [38]

Thus, the way that Medicaid funding is distributed greatly affects the types of programs that are offered.

- Only 13% of the state Medicaid budget is used for mental health and substance use disorder services. Most of this provides services for adults with chronic mental illness and children with severe emotional disturbance. Because of federal limitations, few people seeking substance use disorder treatment in this state are covered by Medicaid.

- Of the amount of Medicaid spent on behavioral health services, 12% of these funds are spent on adult inpatient treatment while 43% of the behavioral health funds goes to fund "Residential Psychiatric Treatment" (RPTC) placements for children and youth with severe emotional disturbances. Most of these children are placed out of state. The number of children in RPTC's has doubled between 2000 and 2006. The "Bring the Kids Home" effort is working to reverse this trend.

- Less than 6% of the total Medicaid budget is used for outpatient behavioral health services.[39] Many people can no longer get mental health services when their problems begin. Instead, we are spending more and more to try to solve problems after they have become severe.

Other funding sources:

While **Medicaid** provides services for some of the most needy, it is available only to children, poor families, and the disabled. Many populations in great need, such as young men over the age of 18 (one of the groups with the greatest problems with substance dependence and death by suicide) are not able to use Medicaid funding. State grant funds cover some of the gaps in services, but they don't reach far enough to cover all that are needed. Lack of adequate funding leads to long wait lists in many communities for basic behavioral health services, if they are available at all. A client released from alcohol detox may have to wait several months before entering treatment. The Mental Health Courts have found that they cannot use their power fully because there are no places to refer people for treatment, so clients must be incarcerated instead.

Another source of funding, which becomes particularly valuable when we consider the number of clients who use their primary health care provider as a behavioral health provider, is **individual insurance**. Yet, many Alaskans don't have health insurance. Even when they do, the amount of behavioral health coverage limits the utility of this funding source. Alaska has no behavioral health parity law. This means that many of the biggest insurers fail to fund behavioral health services at the same level as physical health. Often, preauthorization is required, even for a single visit to a provider. There are limits on how much service can be provided and many of the services require a 50% co-pay instead of the 10 to 20% required for most physical health services. All of these policies raise barriers to seeking behavioral health services and place an added burden on state funded programs. Current research shows that overall health care costs are reduced when behavioral health care needs are met. Because of this, requiring that behavioral health insurance coverage is comparable to physical health coverage has a negligible

effect on overall insurance costs. In the past, the Boards have spearheaded efforts to establish behavioral health parity and will continue to provide leadership in this area.

The most recent survey data from the Department of Health and Social Services showed that 117,000 Alaskans (18% of the population) were uninsured on the average in 2002-2004. 20% (23,000) of the uninsured were children 18 and under.[40] The income cut-off level for children to become eligible for Denali KidCare, the state and federally funded insurance of last resort for most children, has dropped from 200% of the federal poverty level (FPL) in 2003 to 154% of FPL for Alaska in 2007.[41] In contrast to this, 41 other states funded similar programs at or above 200% of FPL. Because the eligibility level is frozen at 2003 income levels, the eligibility thresholds for Alaskan children will continue to drop each year unless new legislation is passed. In addition, if the state drops below 150% of the poverty level in funding this program, it stand to lost more federal match funding. This is a significant loss of funding for all forms of health care support, including a variety of behavioral health interventions.

When primary insurance coverage is not available for both physical and behavioral health needs, people tend to rely on emergency rooms for their care. This results in much more expensive care, pressure on the emergency services system, and poor follow-up and primary care in all areas.

Visions and Issues

As Board members and staff traveled around the state talking to consumers and providers, one theme was heard again and again – there is a need for a vision of what behavioral health should be, an integrated approach to services, sustainable funding, and big-picture, clear ideas about how to offer the best possible life for Alaskans. There are many strengths in the system and in the people of Alaska. Most clients report getting better and are positive about the services they receive. The service providers are dedicated and thoughtful about how to do the best job possible. Yet, from the national level down to small villages, there is a cry for a system that sustains families and individuals, fosters resiliency, and addresses the terrible problems of alcoholism, family violence, suicide, and alienation from self and society. Until we find ways to address or prevent the big problems, we will have small successes, but fail to create the Alaska we all crave.

We have looked briefly at some of the needs, service delivery systems, and funding mechanisms in our state. But if we stop at this level of analysis of the system, we lose sight of the bigger goals. In the long run, people don't serve on ABADA or AMHB because they want to learn about the percentages of people who are served by Medicaid or how many people with alcohol problems there are in Alaska. They serve because they want to make the state a better place for themselves, their neighbors, and those who follow them. In the same way, legislators, program administrators, and everyday citizens have a vision of what life could be like, but get stuck in the minutiae of delivering services, making administrative decisions, and balancing funding decisions so that they rarely have time to look at the bigger picture.

There is an opportunity for the ABADA and AMHB to take a lead in defining this vision. The view of an effective behavioral health system could have many facets, and everyone will probably see the picture a little differently. But, in a way, all of us are experts. Each of us has people in our lives who have experienced the impact of behavioral health problems. And, each of us has known times when we felt that we were functioning well and enjoying our lives. Finding a way to increase that experience for every Alaskan is a noble goal.

This section proposes a few issues to be addressed over the next four years as the Boards work at their task of helping to plan, coordinate, educate, advise, evaluate, and advocate so that Alaskans can lead healthy, productive lives. Steps to address these issues will be proposed in the next section.

Community based services

The Alaska Behavior Health Integration Project provided a great first step to providing integrated services in the community. Program providers met together in communities around the state and began or continued a dialogue about how they could work together. In some cases, they signed memoranda of agreement to facilitate working together, some groups drew up a needs assessment, and some groups continue to meet to try to achieve

services integration in their community. While this was a strong start, it was only a start. Alaska is too small for services to be as fractured as they are. This occurs at all levels. Attempts to do things such as write integrated regulations will help integration, but the bigger issues remain. At the state level, administrators have to work across division and department lines to identify common citizens they serve. In communities, citizens, local government, private business, faith-based groups, and behavioral health programs must work together to make sure that those in need are served. Advocating for enhancement and continuation of the process started through the integration project is a good first step. The Boards have a significant role to play in bringing people together to further these goals.

Peer directed services

The idea of consumers helping consumers is not new. In the Alaska state mental health plan written in 1987, one of the objectives to improve treatment at Alaska Psychiatric Institute was "API will develop training for former patients and other volunteers who are willing to participate in the care and treatment of current patients." We have gotten a little more sophisticated in the last 20 year about how peer help and guidance is useful, but the basic idea hasn't changed. It is time for the state to join the tide of funding consumer run and directed services to serve people with behavioral health problems. In the same way, we need to realize that the best "therapists" for children are often their parents or another involved adult. Focusing on giving these people skills, insight, respite, and support to help their children will have immeasurable benefits.

Joining physical and behavioral health services

Because family doctors, health aides, and general medical personnel and provide so many behavioral health services, it is important that they have access to training and support to do it well. This includes making sure that children are screened for learning, social, and emotional difficulties the same way they are screened for hearing or physical problems. It means that every physician should know how to objectively screen for depression and what to do if it is detected. It means that village health aides know how to provide support and work with the behavioral health aid to share in treating the problems they both encounter. It means that every physician's assistant who sees an elderly person screens for medication induced problems.

But, it also means that physical health treatment relies on behavioral health knowledge. We need to identify best practices in areas as wide spread as treating obesity to getting exercise. At its best, this is the province of behavioral health. It is exciting to think of our state championing a system that weds the skills and knowledge of the medical world with the wisdom and evidence-based practices of the behavioral health world. This could form the basis for an increasingly healthy populace and reduce much of the burden we see on Medicaid and insurance because of behaviorally linked illness.

Providing the basics – A safety net for all Alaskans

No treatment can be fully effective in helping a client if that person is not sure whether he or she will have a roof over their head that night. Too many of our most impaired clients live with uncertainty about where they will live. In addition, the right to engage in

meaningful work or appropriate education is central to most people's sense of themselves. Finding ways to be sure that all Alaskans have a home and a chance to work when at all feasible is central to assuring good behavioral health. One of the areas where this need is most apparent is with clients with severe impairments. We tend to want to "cure" people and push them on up the system. We need to acknowledge that some clients may need behavioral health support for a long time. Making sure that those supports are effective, available at all times, and shaped by the need of the client, not the funding source, will go a long way to answering many of the issues of chronic behavioral health problems. The client who "fails" is not the problem; the program that helps them has just not yet been tried. This attitude of unconditional care, of continuing until we find answers, is at the core of humane service.

MAKING IT WORK

ACHIEVING THE DESIRED RESULTS

As a way to make informed decisions about how to fund and deliver services, the State of Alaska has begun to move towards results based service delivery as described in the model developed by Mark Friedman.[42] The first step in this process is to identify desired results in the population as a whole. While the Boards don't directly provide services that affect population results, their role is to improve the life of Alaskans through their statutory responsibility to plan, coordinate, educate, advise, evaluate, and advocate.

Desired Population Results and Indicators

As demonstrated in the following diagram, the Boards have identified population results that reflect the vision of "Alaskans Leading Healthy, Productive Lives."

To track these results, the Boards will rely on the population indicators used by the Department of Health and Social Services' comprehensive integrated mental health plan, *Moving Forward*. The reader is referred to *Moving Forward* for a review of all of these indicators and measurement of progress in the areas they assess. Sample indicators are presented below. These are quality of life issues that affect all Alaskans. These indicators will be tracked over time to see if there is any change in the population as a whole, either because of specific programs or because of broad social variables. This data collection allows us to keep an eye on the big picture and remember the ultimate goal of our programs. This information can be found online at http://www.dhss.state.ak.us/commisioner/Healthplanning/movingforward/areas/health.htm

Examples of the indicators that are tracked in *Moving Forward* include:

- Days of poor mental health in past month by age group
- Alaska Suicide Rate per 100,000
- Jail diversion – arrest history
- Number of trust beneficiaries receiving support through DVR versus employed
- Number of suicide attempts (Alaska trauma registry)
- Percentage of women reporting alcohol consumption during pregnancy
- Number of substantiated protective services reports of harm by type and number of children
- Reports of physical injury, sexual assault, and threats/injuries by weapon at school from YRBS
- U.S. and Alaska Alcohol Consumption Comparison
- Heavy and Binge Drinkers
- SSI/APA payments compared to Alaska poverty level

The Boards cannot make changes in these indicators in isolation. Our role is to support the implementation and continuation of programs that work towards the goal of improving

these behavioral indicators. Population indicators usually take a long time to change, and programs that serve only a part of the population may not have a measurable impact on these broader measures. This may be particularly true of ABADA and AMHB since they do not provide direct service and thus need to point to their role in making the system work to achieve these population results. Thus, while it is important to track these population variables, it is also important to realize that programmatic success may not be rapidly reflected in these population variables. There are many other factors operating in a community that affect the lives of Alaskans.

The Role of the Boards

The Advisory Board on Alcoholism and Drug Abuse and the Alaska Mental Health Board have important statutory duties that help make the behavioral health system work well. The following section is a plan for how ABADA/AMHB can play that role in achieving the desired population results. The role of the Boards is to plan, coordinate, educate, advise, evaluate, and advocate to achieve the best behavioral health for all Alaskans. This plan is a roadmap on how to do this and how to assess our effectiveness.

The Plan

In the following plan, desired results within the population of all Alaskans are listed followed by specific Board strategies to move towards these results. These strategies are derived from the years of planning that went into this document. Then the activities to achieve these strategies are listed. The "product" of these activities is used as a performance measure to assess how we are doing. When the product is completed, we will know we have effectively implemented that activity. To measure the effectiveness of the Boards' effort, an activity tracking matrix will chart how we are doing at implementing these activities. This will tell us if we are getting a "green light" for success, a "yellow light" for moving forward, or a "red light" for not implementing the strategy. By regularly updating this list, we can assess how we are doing and have a roadmap for future action.

Board members have signed on to specific activities which they will work on with staff members and other stakeholders. As the activity working groups progress, timelines and products will be revised.

Again, this is a living document. As programs, societal issues, Board members, and staff change, it is expected that some strategies will also change. This document will be updated at least one time a year to assure that we are tracking our success and moving ahead on items where we need to act.

We welcome your involvement in this process. Achieving the broad population results will take the shared effort of every Alaskan. We trust that the Boards can play a significant role in this effort.

Making It Work: Behavioral Health in Alaska
Advisory Board on Alcoholism and Drug Abuse
Alaska Mental Health Board

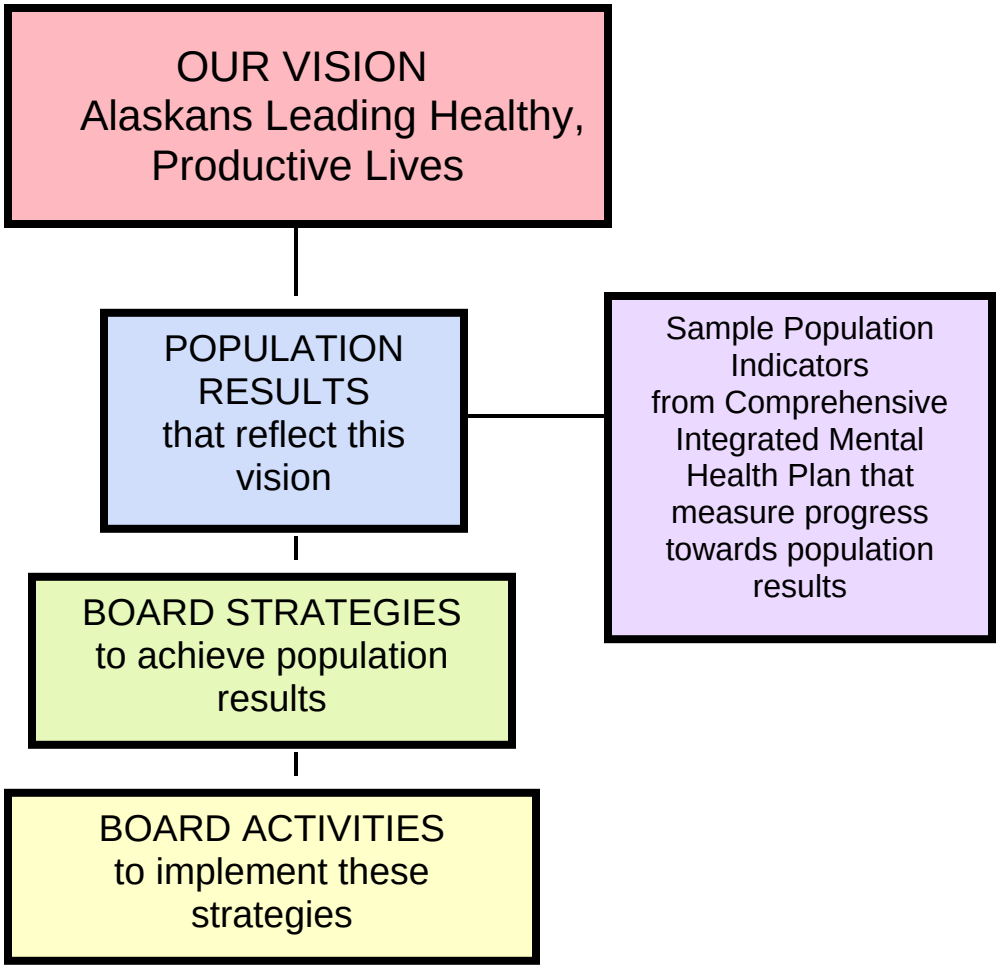


Chart 9 Accountability building blocks

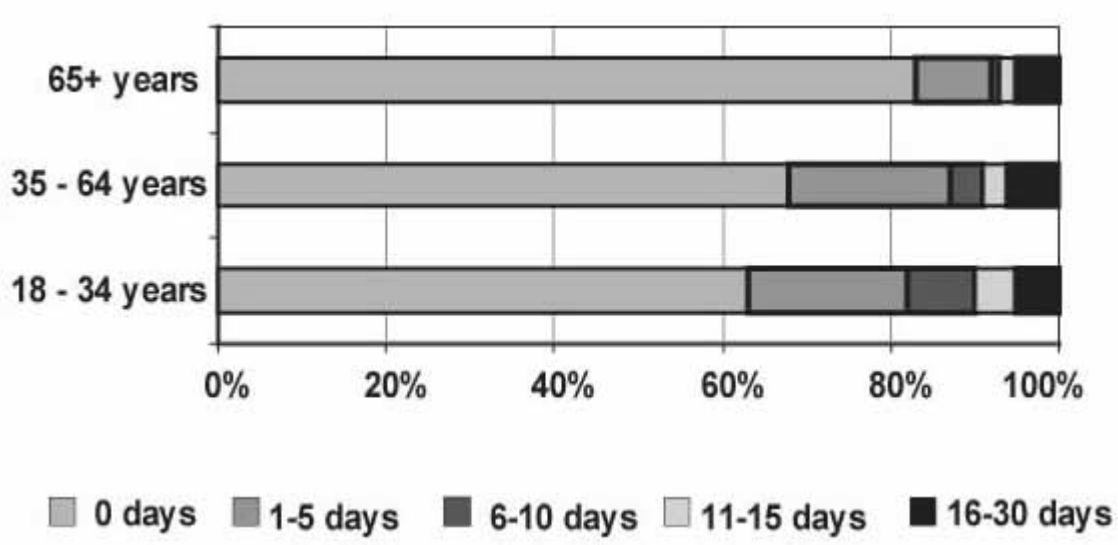
ABADA/AMHB DESIRED POPULATION RESULT

Alaskan adults are physically, mentally, spiritually, and emotionally healthy and are engaged in healthy lifestyles to sustain well being

One population indicator from the Comprehensive Integrated Mental Health Plan that shows if Alaska is achieving this desired population result is:

Chart 10

Days of Poor Mental Health in the Past Month by Age Group



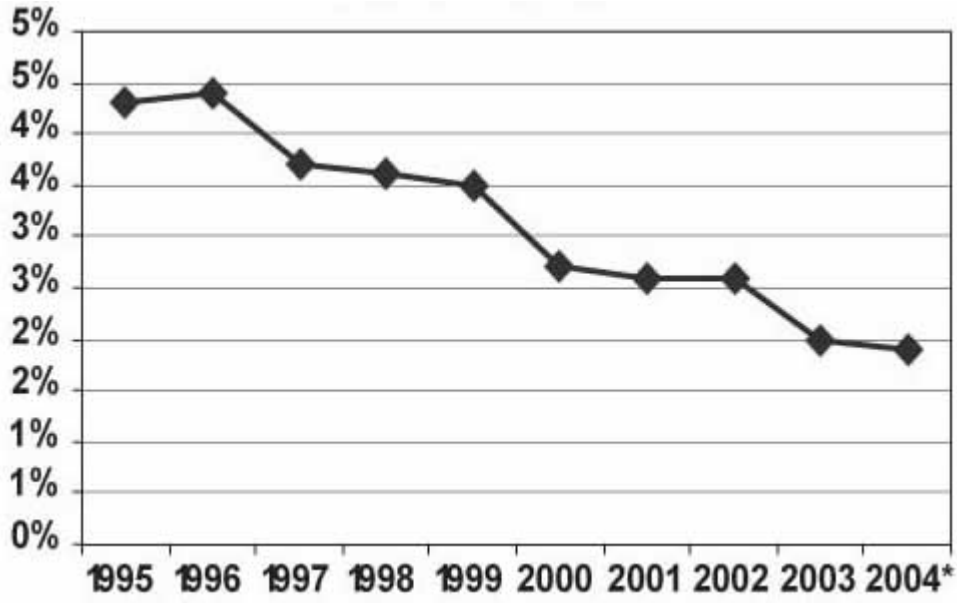
ABADA/AMHB DESIRED POPULATION RESULT

Alaskan children, youth, and families lead safe, stable, happy, productive lives

One population indicator from the Comprehensive Integrated Mental Health Plan that shows if Alaska is achieving this desired population result is:

Chart 11

Percentage of Women Reporting Alcohol Consumption During Pregnancy, Alaska 1995-2004



Note: 2004 is preliminary data

Source: Alaska Bureau of Vital Statistics

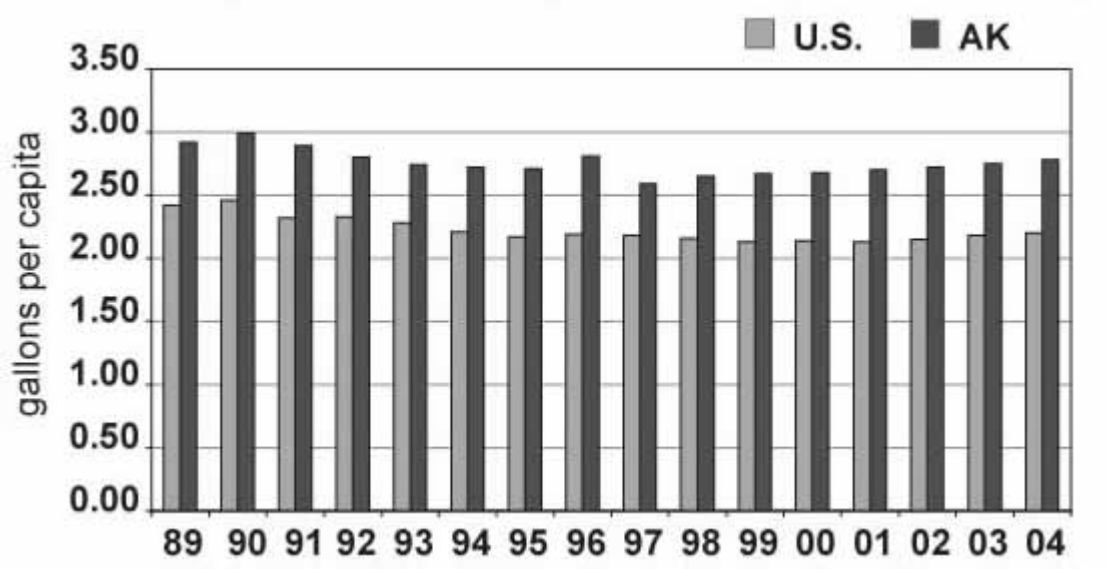
ABADA/AMHB DESIRED POPULATION RESULT

Alaskans live free from the negative consequences of alcohol and other drug use

One population indicator from the Comprehensive Integrated Mental Health Plan that shows if Alaska is achieving this desired population result is:

Chart 12

U.S. and Alaska Alcohol Comsumption Comparisons (Alaska figures include all populations ages 14 and over)



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

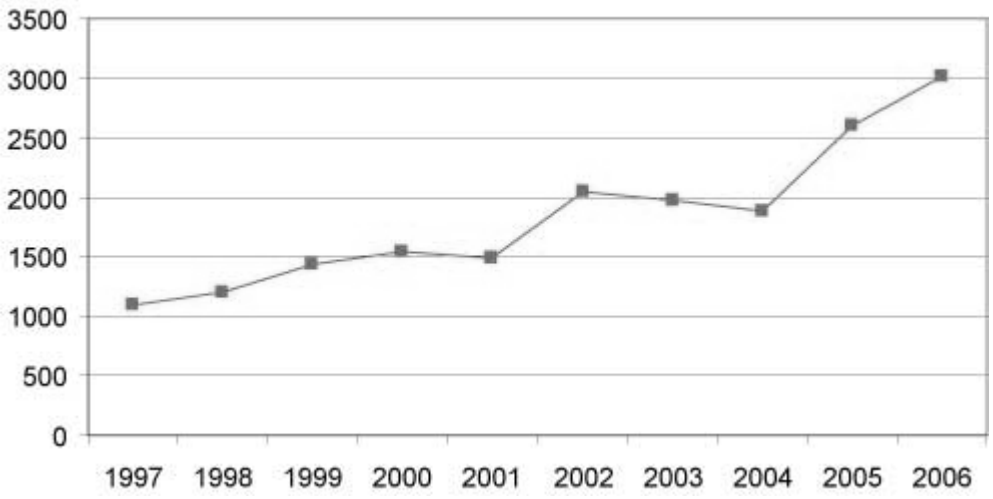
ABADA/AMHB DESIRED POPULATION RESULT

Alaskans live with dignity and respect as valued members of their families and communities

One population indicator from the Comprehensive Integrated Mental Health Plan that shows if Alaska is achieving this desired population result is:

Chart 13

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



Source: Alaska Housing Finance Corporation Homeless Service Providers Survey Reports

Data reflects total homeless numbers reported by agencies, with duplicates removed

WHAT ABADA AND AMHB WILL DO TO HELP ACHIEVE THESE RESULTS: BOARD STRATEGIES AND ACTIVITIES

The following strategies reflect how the Boards will act to achieve better lives for all Alaskans. They provide a road map for Board action for the next four years. Activities to implement these strategies are presented in an activity tracking matrix. This matrix will be used to keep us on that road. Board members and other interested Alaskans are invited to identify activities where you can best use your interests and skills to further our strategies. Together, we can make a difference in these essential issues for all Alaskans.

How to use the activity tracking matrix: The following pages present strategies and the activities to achieve them. The matrix will be used to assess our progress. The measures will be reviewed on a quarterly basis and progress will be recorded. The tracking matrix includes the following elements:

Activity: Activities are listed under the statutory Board responsibilities to Plan, Coordinate, Educate, Advise, Evaluate, and Advocate. Activities are subject to change as conditions change, but form the basis of what the Boards will do for the next four years.

Product (unit of measure): This is how we will know we are making progress. In some cases, the product may be an accounting of how many meetings were attended. In other cases, the product will be something more tangible such as a document, change in law, or new program initiation.

Who: This column is your invitation to get involved. Those on the Board who want to pursue a particular activity can sign on and help us account for how we work on these chosen activities. Staff will also be assigned to track their performance on these activities. Other stakeholders may join us in these efforts as well. This is an opportunity, inviting your participation.

Timeline: In a time of competing priorities, setting a deadline to review how we are doing is important. This timeline may contain both long-term and short-term outcomes. For instance, it could identify an ongoing project or a task that should reach completion by 2009. Checking to see if we are accomplishing activities on our chosen timeline lets us and others know how we are doing.

Track in print version of plan, a gauge is used): Green - Activities are on target and going well. Yellow – These activities are moving forward, but need continued attention and fine tuning. Red – Little is happening on this activity; is there a need to get moving? At times activities will be red because they are not being worked on. However, if nothing changes, why is it on the list? We need to reassess its value and identify any barriers to accomplishing this activity. Combining the tracking information, we can get a picture of how we are doing in following through on our strategies. This will be published on our website as a way to hold ourselves accountable. (www.hss.state.ak.us/amhb/ or www.hss.state.ak.us/abada/)

Desired Result 1: Alaskans are physically, mentally, spiritually, and emotionally healthy and are engaged in productive lifestyles to sustain well being.

Strategy A: The Boards will identify current behavioral health system strengths and gaps.

Discussion: An effective behavioral health system depends on clear identification of needs, effective programs, and priorities. While many needs assessments have been done in the state, too often they are used sporadically to justify a request for funding or put on the shelf and forgotten. The Boards will use existing needs assessments as well as new documents as they are produced to identify needs for service within the state. In addition, we will use a variety of other means including town hall meetings, provider meetings, teleconferences, surveys, and involvement in a variety of committees, conferences, and discussions to identify both strengths and areas where services are needed. Once needs have been identified, the Boards will use this information to guide advocacy around support of a comprehensive system of behavioral health care.

Desired Result: Alaskans are physically, mentally, spiritually, and emotionally healthy and are engaged in productive lifestyles to sustain well being.

Strategy: Identify current behavioral health system strengths and gaps

Activity by statutory role:	Product	Who	Timeline	Track
Plan				

• Continue to review existing needs assessments across the behavioral health service spectrum. Identify programs that work and where there are unmet needs. Specific current examples of this include:
  • Work with other agencies to find ways to reduce the Alaska Psychiatric Institute census pressure, including identifying appropriate community resources to prevent readmission to API.
  • Identify how a continuum of care for alcoholism and substance abuse prevention, assessment and treatment is being implemented in Alaska.
  • Using data from the current grant/Medicaid funding study being conducted by Information Insights and other information, identify the appropriate mix of services to serve the full range of behavioral health conditions - including prevention, early intervention, and care for those who experience chronic mental illness.
	Needs assessment documents reviewed, written and in use		ongoing	

• Work with the Division of Behavioral Health, the Mental Health Trust, consumers, and providers to continue the development of a clear vision of an effective behavioral health system. This vision should be used to guide policy and funding decisions. Use information about existing system strengths to advocate for continuing effective programs.	MOA's Annual meeting including key people to assess this activity			
Coordinate				
• Use monthly consumer Family Voice teleconferences to identify ongoing needs within the system.	# of teleconferences completed		monthly	

Activity by statutory role:	Product	Who	Timeline	Track
• From public testimony at Board meetings, site visits, and community meetings, identify ongoing needs and strengths within the system.	Number of meetings and summary of testimonies		ongoing	
• Coordinate with the other Boards, the Trust, providers, consumers, and DBH through the Connecting Systems Project to identify places in the service delivery system where clients fail to get services because of falling between programs and, thus, not being eligible for any services.	Position paper identifying recommended changes and timeline. Reports on timeline implementation at Board meetings.		8/ 2007 position paper complete	
• Develop and maintain working relationships with tribal health corporations, private providers, and providers of behavioral health services in other parts of the human service system to identify how all of these systems serve Alaskans and gaps in the larger system.	Attendance at meetings, Number of joint projects		ongoing	
Educate				
• Increase policy makers' knowledge about our present system of care and identification of strengths and gaps in the system.	Documents used to inform policy makers		2008	
• Increase knowledge in the public about available services	Resource Guide, Shared KABB survey results			
Advise				
• Use the Alaska Mental Health Trust funding recommendations process to build on continued communication with providers and consumers regarding system needs.	Record of Request for Recommendation communication with providers, consumers, and DBH. Trust funding request		Yearly, by RFR due date	
Evaluate				
• Get feedback from public hearings and community meetings about how the system is working in their community. .	Minutes from meetings		ongoing	
• Work with the Outcomes Identification and System Performance Project (OISPP) to identify prevalence rates for mental illness and substance use disorder in Alaska.	Involvement in OISPP, data documents, use of data in planning		ongoing	

Activity by statutory role:	Product	Who	Timeline	Track
• With developed methods, measure resiliency and protective factors in communities.	Resiliency measures		ongoing	
Advocate				
• Survey legislators and staff about perceived behavioral health gaps and strengths in their districts.	Survey results		12/ 2007	

Desired Result 1: Alaskans are physically, mentally, spiritually, and emotionally healthy and are engaged in productive lifestyles to sustain well being.

Strategy B: Review, monitor and evaluate behavioral health services at the community, client, provider and state system level.

Discussion: It is not enough to provide services, it is important to assess the effectiveness of services being delivered. The Boards play an important role in monitoring and assessing the effectiveness of the Behavioral Health System. The Mental Health Board has a federal and state mandate to monitor and evaluate provision of Mental Health services (AS 47.30.666), while the Advisory Board on Alcoholism and Drug Abuse is required to evaluate the effectiveness of alcohol and drug abuse programs by state statute (AS44.29.140).

Desired Result: Alaskans are physically, mentally, spiritually, and emotionally healthy and are engaged in productive lifestyles to sustain well being.

Strategy: Review, monitor and evaluate behavioral health services at the community, client, provider and state system level.

Activity by statutory role:	Product	Who	Timeline	Track
Coordinate				
• Work with members of the behavioral health system to continue to assure that training and administrative support is provided for behavioral health program integration as identified in the behavioral health model a all levels.	Number of programs that effectively provide integrated services		Ongoing	
• Coordinate with Department of Health and Social Services, the Mental Health Trust, and other partners to define behavioral health standards of care, regulations, performance measures, standardized evaluation tools an an ongoing system for evaluation of services at the community, client, provider and state level. • Work with Division of Behavioral Health to assure that new regulations regarding record keeping reflect the minimum requirements for Medicaid compliance as a way to reduce audit exceptions.	Effective performance based management tools in use Understand-able regulations that can be complied with by all programs		2009	
Evaluate				
• Participate in continuing the development of a program of community program review that utilizes program on-site review, substantial consumer involvement and feedback, and provision of support and technical assistance to optimize program function. Identify sustainable funding mechanisms for this program. .	Community program review program in place		2008	
• Participate in the OISPP's (Outcomes Identification and System Performance Project) creation, implementation, monitoring and evaluation of outcomes data.	Number of OISPP meetings attended		ongoing	
• Monitor and review AKAIMS reports – the data management information system.	Use of AKAIMS data in Board documents			

Activity by statutory role	Product	Who	Timeline	Track
• Participate in the revision and review of regulations, data systems, and grant requirements to confirm that they assure quality services while taking minimal resources from service delivery.	Participation in appropriate meetings, including Rasmussen grant revision.			
• Utilize data from a variety of sources including the Behavior Risk Factor Surveillance Survey and the Youth Risk Behavior Survey to identify system strengths and gaps and to assess system performance.	Reports from Boards on issues related to these performance measures			
Advocate				
• Advocate for top-level management involvement in AKAIMS (Alaska Automated Information Management System) until it is successfully deployed. Participate at all levels to make sure that the voices of consumers and providers are adequately represented in decision making regarding data management.	Effective AKAIMS system		ongoing	
• Advocate for the training in and use of evidence-based practices and other proven approaches to behavioral health prevention and treatment and assure that they are used in culturally and community appropriate ways.	List of evidence-based and other proven practices used in state		ongoing	
• Advocate for Alaskan principles-based practices to be funded and evaluated to become proven practices	List of Alaskan principles based practices used in state		ongoing	

Desired Result 1: Alaskans are physically, mentally, spiritually, and emotionally healthy and are engaged in productive lifestyles to sustain well being

Strategy C: Advocate for a comprehensive behavioral health service system

Discussion: Once needs have been identified and a means to assess the existing system exists, the next step is to assure that the behavioral health system addresses the gaps in services while sustaining those parts of the system that work well. This requires a comprehensive vision of what the behavioral health system should look like and advocacy for creating and funding this system. The Boards have a responsibility to look, not only at the state-funded system, but at the whole range of behavioral health services in the state. In addition, while the State system is of necessity now focused on the needs of adults with chronic mental illness and children and youth with serious emotional disturbance as well as Alaskans with substance use disorders as their priority population, the Boards must look at the broader needs of the state. Promotion, prevention, early intervention, and broad system wide awareness of behavioral health needs are all essential parts of the system. The Boards advocate for a system that embodies this full continuum, including consumer and family directed services with focus on recovery. Advocacy efforts are directed towards putting such a system in place and providing sustainable funding and other resources.

Desired Result: Alaskans are physically, mentally, spiritually, and emotionally healthy and are engaged in productive lifestyles to sustain well being

Strategy: Advocate for a comprehensive behavioral health service

Activity by statutory role	Product	Who	Timeline	Track
Plan				
• Work with other parts of the system to ensure that the Comprehensive Integrated Mental Health Plan, Moving Forward, is implemented.	Participation in CIMHP implementation		ongoing	
• Actively participate with DBH in the continuing development of the Mental Health and Substance Abuse Prevention and Treatment Block Grants.	Completed Block Grant submission		Block Grant deadlines	
• Explore the funding of behavioral health services in the larger framework of health services funding. Identify if funding mechanisms such as parity, single party payor, or other approaches could better provide for behavioral health access within the physical health system.	Connecting Systems Project final paper Position papers		June, 2007	
Coordinate				
• Assure that memoranda of agreement are executed between behavioral health providers and school districts and that quality assurance activities monitor the efficacy of these agreements.	Existence of MOA's assessed during site visits		ongoing	
• Work with the Alaska Commission on Aging to continue to identify and support best practices to deliver behavioral health services to seniors.	Joint meetings, existence of appropriate services		ongoing	
• Support continuing development of working relationships with tribal health entities, private providers, and providers of behavioral health services in other parts of the human service system to identify how all of these systems serve Alaskans and gaps in the larger system	Attendance at meetings, Number of joint projects		ongoing	
Educate				
• Increase lawmakers' knowledge and awareness of the activities and successes of the behavioral health system.	Plan and updates		ongoing	

Activity by statutory role	Product	Who	Timeline	Track
• Present information related to the behavioral health system and advocacy at available trainings and conferences such as the Annual School on Addictions, the Rural Behavioral Health Conference, and the Health Summit.	Number and list of presentations		ongoing	
• Continue to explore the possibility of wrap-around long term services for those who cycle through the system because of chronically mental illness and substance use disorders, such as the evidence-based plan for assertive community treatment model (ACT).	Budget increment and plan for Assertive Community Treatment Program		2009 budget	
• Advocate for a state wide national screening day and availability of mental health and substance use disorder screening instruments for all physicians.	Number of physicians who receive materials to screen for depression		2009	
• Develop Continuing Medical Education program to provide information to physicians about behavioral health issues.	Number of CME presentations		2008	
Advise				
• Continue to collaborate with the Division of Behavioral Health, the Governor's office, and other policy makers to identify behavioral health system strengths and needs.	Documents assessing these strengths and needs		ongoing	
Evaluate				
• Monitor the use of formularies for psychotropic medication, Identify best practices to educate general practice physicians about behavioral health problems, best medication approaches, and other appropriate interventions.	Review of satisfaction with availability of psychotropic medication and its use, MD efficacy in BH referral		Ongoing	
Advocate				
• Advocate for a system that reflects a resilience and recovery approach to behavioral health services	Advocacy materials		Ongoing	
• Monitor relevant legislation throughout the session	Legislative tracking meetings		Ongoing	

Activity by statutory role	Product	Who	Timeline	Track
• Lead an advocacy committee that informs stakeholders of legislative opportunities and coordinates advocacy efforts	Legislative tracking meetings		Ongoing	
• Continue to mobilize consumers and Board members to advocate for programs that are supportive of their recovery.	Participation in Human Services Coalition		Ongoing	
• Identify legislative priorities and organize an advocacy campaign to support these.	Participation in Human Services Coalition		Ongoing	
• Use the Trust request for funding recommendations process to advocate for sustaining effective behavioral health services while innovating in areas where there is existing need.	RFR proposals		Ongoing	
• Advocate for an appropriate mix of funding that maximizes federal funding while sustaining the program flexibility available through the state grant process.	Participation in Information Insights review		Ongoing	

Desired Result 2: Alaskan children, youth, and families lead safe, stable, happy, productive lives.

Strategy A: Support the planning, funding, and provision of a comprehensive system of care within Alaska for children, youth, and their families.

Discussion: Providing full funding for necessary services and supports for our children and youth is not only humane, it also saves costs to the system in the future. Alaska's children and youth are greatly at risk for a variety of reasons. Many of them grow up in homes with alcohol and drug abuse present. 40% of them who make it to 9th grade fail to finish high school. Their risk of suicide attempt or completion is much higher than the national average. Alaska has been a leader in the past in providing a system of care for its children, but this was dismantled several years ago. The result has been having over 800 children and youth a year placed out of state in residential psychiatric treatment. Bring the Kids Home initiative is addressing some of the changes in the system needed to accomplish this result, but many more changes are needed. The formal behavioral health system cannot by itself create a society in which children flourish. The Boards can be a clear and consistent voice for creating an Alaska where the future looks even brighter than the present for our children.

Desired Result: Alaskan children, youth, and families lead safe, stable, happy, productive lives.

Strategy: Support the planning, funding, and provision of a comprehensive system of care within Alaska for children, youth, and their families.

Activity by statutory role	Product	Who	Timeline	Track
Plan				
• Participate in the early childhood mental health work group to develop a program that assures earlier identification and intervention of mental health disorders of children birth to 21, supporting the use of standardized screening and assessment tools.	Implementation of early childhood mental health consultation and screening program		ongoing	
• Implement the activities to assess need, monitor quality, and develop advocacy outlined above for adult behavioral health programs for programs that serve children and youth as well.	See above		ongoing	
Coordinate				
• Actively participate in the Bring the Kids Home Initiative and the four sub-committees: care coordination; home and community-based services; client tracking/monitoring**;** and workforce development	Record of participation in BTKH initiative		ongoing	
• Work with the Department of Health and Social Services and Department of Education and Early Development on the implementation of effective, culturally appropriate practices by providers and school districts across the state. Find ways to further integrate behavioral health service provision with schools.	Joint meetings, existence of appropriate services		ongoing	
• Identify partners across all state departments and tribal organizations to support a seamless system of care for Alaskan children and youth and encourage their support and advocacy when needed	Working documents		2009	
• Chair the Family Voice working group that oversees funding for family and youth involvement in the behavioral health system.	Documentation of meetings		December 2007	
• Continue to work with the Suicide Prevention Council and other parties to address the issue of youth suicide in Alaska. Use results from the track-back study to identify programs that may address this issue.	Review of track back study and integration into planning		ongoing	

Activity by statutory role	Product	Who	Timeline	Track
• Work with Division of Juvenile Justice to assure that comprehensive behavioral health programs are available to children and youth involved with the correctional system.	Cooperative meetings between Boards and DJJ		2008	
• Support the development of a early childhood mental health consultation and education model to extend behavioral health services for this population.	Implementation of early childhood model		2009	
Educate				
• Develop and initially chair a monthly teleconference that involves family, youth, and adult consumers. This teleconference combines education and consumer discussion of programs and has an action component to involve consumers in addressing system problems.	Number of teleconferences, minutes		ongoing	
• Support community coalitions/planning teams centered around promotion, prevention, and BTKH treatment for early childhood needs working towards positive behavioral health.	Community teams that support these activities		2009	
Evaluate				
• Work with OISPP and other data groups to use data to assess the effectiveness of the continuum of services for children, youth, and families	Participation in OISPP meetings			
Advocate				
• Support full funding for SCHIP federal youth insurance funding and Denali Kid Care program at the state and federal level	Implementation of SCHIP expansion		2007-8	
• Identify and advocate for programs, regulations, and funding that support transition age youth.	Presence of transition age youth programs		ongoing	
• Advocate for full implementation of the Department of Health and Social Services Early Childhood Comprehensive Systems Plan, focusing on the parts that involve maternal and child mental health. [43]	Implementation of this system		ongoing	
• Advocate for increased early intervention services for children and families through age 21	Presence of early intervention services for children and families		ongoing	

Desired Result 3: Alaskans live free from the negative consequences of alcohol and other drug use.

Strategy A: Support a continuum of care for those experiencing alcohol and substance abuse disorders and those at risk.

Discussion: While all of the activities directed at developing an effective behavioral health system address this desired result, substance abuse is also unique in some ways. It tends to be perceived as part of the Alaskan lifestyle, and this normalization of substance abuse behavior places many people at risk.

- Children in alcohol-abusing families are almost four times more likely to be maltreated, and 10 times more likely to be neglected; 81% of all reports of harm against Alaska children involve substance abuse.

- In 2003, the cost of alcohol and drug abuse to Alaska's economy was estimated to be $738 million in lost productivity, accidents, health care, criminal justice and public assistance.[44]

- Between FY 2002 and FY 2007, state funding for substance abuse prevention and treatment dropped by 56.2% or $18.6 million.

- In 2004, over 35,000 Alaskans who needed treatment for alcohol abuse could not receive it.[45]

- While there has been a decline in the number of women who report drinking while pregnant, Fetal Alcohol Syndrome continues to be a major problem in Alaska.

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Desired Result: Alaskans live free from the negative consequences of alcohol and other drug use.

Strategy: Support a continuum of care for those experiencing alcohol and substance abuse disorders and those at risk.

Activity by statutory role	Product	Who	Timeline	Track
Plan				
• Support provision of substance abuse services to the estimated 90% of incarcerated Alaskans who have experienced a problem with substance abuse.	Involvement in APIC and other intitiatives		ongoing	
• Identify best practices for prevention and treatment of methamphetamine abuse and advocate for their funding and use.	Advocacy for implementation of these practices		2008	
• Identify ways to expand community prevention and treatment, especially addressing the effects of substance abuse on families and children	Programs to reduce substance use in families		2009	
• Support identification and implementation of practices for prevention and early intervention of inhalant and prescription drug abuse.	Presence of prevention programs		2008	
Coordinate				
• Work closely with the Prevention section of Division of Behavioral Health to review grants, identify best practices, and decrease substance abuse in adults and youth.	Documentation of cooperation		ongoing	
Educate				
• Review information on the Fetal Alcohol Syndrome program that was funded in Alaska, and use lessons learned to shape future program planning.	FASD initiatives supported		September 2007	
• Educate our children on the risks of alcohol and drug consumption leading to addiction and abuse	Curriculum in place		ongoing	

Activity by statutory role	Product	Who	Timeline	Track
Advise				
• Inform Division of Behavioral Health, the Governor's office, and other policy makers of system strengths and needs.	State plan and addenda		onging	
• Review plans for revision of Title 47 holds and advocate for appropriate use of this legislation to serve chronic substance users.	Passage of legislation		2007	
• Continue to be involved in development of regulations that support parity for substance abuse programs and professionals in the behavioral health arena.	Advocacy for parity		ongoing	
Advocate				
• Identify and continue to advocate for solutions to substance abuse issues for Alaska's aging population	Cooperative work with Alaska Council on Aging		2008	
• Advocate for sufficient services to allow immediate access to substance abuse treatment after completing detox.	Implementation of services		ongoing	
• Advocate for use of alcohol tax dollars to expand substance abuse treatment and prevention.	Use of dollars to expand treatment and prevention		ongoing	
• Work with legislators to introduce appropriate legislation to reduce driving while intoxicated offenses.	Passage of legislation		ongoing	
• Strengthen and support the local ordinance law for communities including better follow-up.	Effective local ordinance laws		ongoing	

Desired Result 4: Alaskans live with dignity and respect as valued members of their families and communities.

Strategy A: The Boards will advocate for a safe, accessible, and affordable continuum of housing options for the ABADA and AMHB beneficiaries.

Discussion: Adequate housing is the cornerstone for appropriate care for people with multiple impairments such as dually diagnosed individuals. Individuals with mental illness and/or substance abuse problems are more likely to return to institutional care if they are not provided with adequate, safe housing. For those with alcohol and drug problems, including those dually diagnosed, maintaining sobriety may be impossible without adequate housing. Individuals with FAS and their family members need help finding adequate, sustainable housing options.

Transitional housing programs assist people who are ready to move beyond a restrictive treatment environment as a step out into a more independent living situation. This type of program allows individuals and families to further develop the stability, confidence, and coping skills needed to sustain permanent housing. A housing continuum ranges from participants living in apartment-style quarters, to group settings where several families or individuals share a home. Transitional Housing programs currently include housing in a structured living environment that offers activities and services related to substance abuse recovery. This housing is time-limited offering residents housing for up to two years with the idea that the additional support will teach them what they need to know to move into permanent homes.

Some beneficiaries will require housing coupled with wrap around services that continue for many years. Provision of these services ensures that beneficiaries can live with dignity in the least restrictive environment and also reduces the cost to other parts of the system.

Respite housing is an important resource to keep some beneficiaries in their homes or to ease times of stress or transition. Again, provision of this full range of services, reduces the impact on other, more restrictive and expensive parts of the system.

Desired Result: Alaskans live with dignity and respect as valued members of their families and communities.

Strategy: The Boards will advocate for a safe, accessible, and affordable continuum of housing options for the ABADA and AMHB beneficiaries.

Activity by statutory role	Product	Who	Timeline	Track
Coordinate				
• Actively participate in the Alaska Mental Health Trust's housing focus groups and its subcommittees.	Record of participat-ion		ongoing	
Educate				
• Promote efforts to increase the number of assisted living beds available for persons with a severe mental illness being released from state-funded institutions by monitoring the housing and supportive service resources in Alaska	Increase in assisted living beds		2008	
Advocate				
• Advocate for formal discharge policies within all state-funded in-patient or residential programs that require identification of a written discharge plan and agency referral for persons needing long-term care to include identification and referral to appropriate housing.	Presence of discharge policies		2008	
• Through the Advocacy coordinator, mobilize statewide stakeholders to advocate and support the development of a range of housing options.	Advocacy efforts		ongoing	
• Advocate for increased affordable housing such as the Oxford House Models.	Advocacy efforts		ongoing	
• Support the development of the Alaska Mental Health Trust's Housing Trust Initiative.	Implement-ation of Trust		2007	

Desired Result 4: Alaskans live with dignity and respect as valued members of their families and communities.

Strategy B: The Boards will advocate for increased opportunities for employment, education, and meaningful participation in activities of one's choice.

Discussion: Consumers identify meaningful participation in work, education and other productive activities as an important part of recovery and quality of life. In addition, this allows those with substance abuse and mental health problems to become increasingly independent, reducing fiscal and social strains on the system. A combination of effective treatment, housing availability, and increasing involvement in meaningful activities leads to optimum functioning for all beneficiaries. The Boards help participate with a variety of other stakeholders in development of and advocacy for these programs.

Desired Result: Alaskans live with dignity and respect as valued members of their families and communities.

Strategy: The Boards will advocate for increased opportunities for employment, education, and meaningful participation in activities of one's choice.

Activity by statutory role	Product	Who	Timeline	Track
Plan				
• Support an employer initiative to increase recruitment, employment, advancement, and retention of people with mental illness, addiction and/or co-occurring disorders.	Implementation of initiative		2009	
Coordinate				
• Encourage Division of Behavioral Health to work with the Department of Labor as partners to promote the use of customized employment strategies.	Cooperation between divisions		2008	
• Work with the representative of Vocational Rehabilitation on the Board to coordinate programs that serve beneficiaries.	VR board attendance, contact between meetings		ongoing	
Educate				
• Promote the seamless transition of youth with serious emotional disturbances from school to post-secondary opportunities and/or employment.	Implementation of programs		2010	
Advise				
• Continue to provide recommendations on how to improve relevant beneficiary oriented education and employment opportunities to the Governor, the Trust, the Department, the Legislature and interested stakeholders.	Track membership of appropriate work groups		ongoing	
Evaluate				
• Review, track and monitor through AKAIMS consumers/clients increased satisfaction with employment, education, and/or activities.	Involvement in OISPP		ongoing	

Desired Result 4: Alaskans live with dignity and respect as valued members of their families and communities.

Strategy C: The Boards will advocate for and support interagency collaboration among the appropriate criminal justice, mental health, substance abuse systems and other relevant community members or governmental agencies to prevent the unsuitable or unnecessary arrest, incarceration, and/or prosecution of persons behavioral health problems.

Discussion: The Corrections system is a significant part of the substance abuse and mental illness treatment system. However, there is a failure to adequately address behavioral health issues within this system. This results in beneficiaries cycling through mental health and substance abuse programs, prisons and jails, and other high cost programs. Addressing the behavioral health needs of inmates and others who come in contact with the corrections system would result in increased quality of life for the beneficiaries and reduced societal costs.

Desired Result: Alaskans live with dignity and respect as valued members of their families and communities.

Strategy: The Boards will advocate for and support interagency collaboration among the appropriate criminal justice, mental health, substance abuse systems and other relevant community members or governmental agencies to prevent the unsuitable or unnecessary arrest, incarceration, and/or prosecution of persons with behavioral health problems.

Activity	Product	Who	Timeline	Track
Plan				
• Continue to participate with Department of Corrections in APIC and other program planning efforts that lead to better transitions from the corrections system for beneficiaries.	Development of transitional programs from corrections		May, 2008	
Coordinate				
• Review, monitor, and track the Department of Corrections (DOC) mental health and alcohol and drug programs through presentations from Board ex-officio members and through participation in shared DOC/DBH working groups	DOC attendance at Board meetings, # of meetings attended		ongoing	
Advocate				
• Advocate for expansion of mental health, substance abuse, family, and wellness courts to divert beneficiaries into treatment.	Funding and support for courts		FY08 budget	
• Advocate for expanded behavioral health diagnosis and treatment options within the corrections system.	Increase in funding for diagnosis and treatment		FY08 budget	
• Advocate for the continuance of CIT (crisis intervention team) training for Alaska police officers and village public safety officers.	Number of CIT trainings and number trained		FY08 budget	
• Advocate for further training for corrections staff, both outside and inside the prison system to better understand mental illness, TBI, substance abuse, and FASD	Training programs for correctional officers		2010	

Desired Result 4: Alaskans live with dignity and respect as valued members of their families and communities.

Strategy D: The Boards will reduce stigma about behavioral health issues by teaching Alaskans about the importance of behavioral health, promoting wellness, and emphasizing the potential that Treatment Works, Recovery Happens.

Discussion: Even in our enlightened era, we still attach blame and shame to behavioral health problems. Instead of seeking ways to enable people to get better, this leads to further problems and diminishes our society. The stigma that surrounds behavioral health problems has many negative impacts. It reduces the probability that people will seek help, it lowers the self esteem of people just when they most need to believe in themselves, and it separates those who are currently experiencing some kind of problem from those who feel immune. Looking at the statistics, it is absurd for anyone in society to see themselves as separate from those who are currently struggling with behavioral health challenges. Many people will experience these at some point in their life; all will be touched by those they care for having some kind of problem.

The recovery and resilience movement teaches us that, with respect and support, people can regain control of their lives. Reducing stigma through media, public contact, and the example of our respectful treatment of these subjects, we can make it easier for all to succeed.

Desired Result: Alaskans live with dignity and respect as valued members of their families and communities.

Strategy: The Boards will reduce stigma about behavioral health issues by teaching Alaskans about the importance of behavioral health, promoting wellness, and emphasizing the potential that Treatment Works, Recovery Happens.

Activity by statutory role	Product	Who	Timeline	Track
Educate				
• Present information on behavioral health, existing programs, and future directions in public forums such as conferences, health fairs, and other public gatherings.	Record of involvement		ongoing	
• Support the use of the "**You KNOW Me, But did you know**" anti stigma campaign to reduce stigma surrounding BH beneficiaries.	Data on campaign		2007	
Advocate				
• Work within the system to change the way we talk about clients. Eliminate the word "patient" from most discussions. Be sure that language reflects the person, not the problem.	Review of documents, etc. to identify stigmatizing language		ongoing	

Appendix A: Percentage of Alaskans experiencing alcohol and/or drug problems

Measure	Total 12 or Older	AGE GROUP (Years)		
		12-17	18-25	26 or Older
Illicit Drug[1] Dependence	2.16	3.11	6.08	1.26
Illicit Drug[1] Dependence or Abuse	3.35	6.17	8.95	1.79
Alcohol Dependence	3.43	2.33	6.51	3.06
Alcohol Dependence or Abuse	7.47	5.69	16.31	6.15
Alcohol or Illicit Drug Dependence or Abuse	9.77	9.28	21.33	7.69
Needing But Not Receiving Treatment for Illicit Drug Use	3.48	5.61	8.49	2.15
Needing But Not Receiving Treatment for Alcohol Use	6.93	5.19	15.75	5.60
Serious Psychological Distress	8.75	--	13.43	7.87

National Survey of Drug Use and Health, 2004 [46]

Appendix B: State behavioral health statutes

State statute (AS 47.30.056) defines that a comprehensive mental health system includes, at a minimum, each of the following services as appropriate:

(A) emergency services on a 24-hour basis;
(B) screening examination and evaluation services required to complete the involuntary commitment process under AS 47.30.700 - 47.30.815;
(C) inpatient care;
(D) crisis stabilization services, which may include:
- **(i)** active community outreach;
- **(ii)** in-hospital contact;
- **(iii)** mobile crisis teams of mental health professionals;
- **(iv)** crisis beds to provide a short term residential program for persons experiencing an acute episode of mental illness that requires temporary removal from a home environment;

(E) treatment services, which may include
- **(i)** diagnosis, testing, and evaluation of medical needs;
- **(ii)** medication monitoring;
- **(iii)** physical examinations;
- **(iv)** dispensing psychotropic and other medication;
- **(v)** detoxification;
- **(vi)** individual or group therapy;
- **(vii)** aftercare;

(F) case management, which may include
- **(i)** evaluation of needs;
- **(ii)** development of individualized treatment plans;
- **(iii)** enhancement of access to available resources and programs;
- **(iv)** development of interagency contacts and family involvement;
- **(v)** advocacy;

(G) daily structure and support, which may include
- **(i)** daily living skills training;
- **(ii)** socialization activities;
- **(iii)** recreation;
- **(iv)** transportation;
- **(v)** day care services;
- **(vi)** client and care provider education and support services;

(H) residential services, which may include
- **(i)** crisis or respite care;
- **(ii)** board and care;
- **(iii)** foster care, group homes, halfway houses, or supervised apartments;
- **(iv)** intermediate care facilities;
- **(v)** long-term care facilities;
- **(vi)** in-home care;

(I) vocational services, which may include
- **(i)** prevocational services;
- **(ii)** work adjustment;
- **(iii)** supported work;
- **(iv)** sheltered work;
- **(v)** training in which participants achieve useful work experience;

(J) outpatient screening, diagnosis, and treatment services, including individual, family, and group psychotherapy, counseling, and referral;
(K) prevention and education services, including consultation with organizations, providers, and the public; and
(L) administrative services, including appropriate operating expenses of state agencies and other service

Advisory Board on Alcoholism and Drug Abuse Statutory Authority: AS 44.29.140 states the duties of the Advisory Board on Alcoholism and Drug Abuse:

(a) The board shall :

(1) act in an advisory capacity to the legislature, the governor, and state agencies in the following matters:

(A) special problems affecting mental health that alcoholism or drug abuse may present;

(B) educational research and public informational activities in respect to the problems presented by alcoholism or drug abuse;

(C) social problems that affect rehabilitation of alcoholics and drug abusers;

(D) legal processes that affect the treatment and rehabilitation of alcoholics and drug abusers;

(E) development of programs of prevention, treatment, and rehabilitation for alcoholics and drug abusers; and

(F) evaluation of effectiveness of alcoholism and drug abuse programs in the state;

]

(2) provide to the Alaska Mental Health Trust Authority for its review and consideration recommendations concerning the integrated comprehensive mental health program for the people who are described in AS 47.30.056 (b)(3), and concerning the use of money in the mental health trust settlement income account in a manner consistent with regulations adopted under AS 47.30.031 .

(b) The board is the planning and coordinating body for purposes of federal and state laws relating to alcohol, drug, and other substance abuse prevention and treatment services.

(c) The board shall prepare and maintain a comprehensive plan of services

(1) for the prevention and treatment of alcohol, drug, and other substance abuse; and

(2) for persons described in AS 47.30.056 (b)(3).

Alaska Mental Health Board Statutory Authority: AS 47.30.666 states that the AMHB is the state planning and coordinating agency for the purposes of federal and state laws relating to the mental health program of the state. The purpose of the board is to assist the state in ensuring an integrated comprehensive mental health program. At least one half of the members of the Alaska Mental Health Board must be people with a mental disorder or members of their family.

On behalf of persons with mental disorders, the Board shall:

(1) prepare and maintain a comprehensive plan of treatment and rehabilitation services;

(2) propose an annual implementation plan consistent with the comprehensive plan and with due regard for the findings from evaluation of existing programs;

(3) provide a public forum for the discussion of issues related to the mental health services for which the board has planning and coordinating responsibility;

(4) advocate the needs of persons with mental disorders before the governor, executive agencies, the legislature, and the public;

(5) advise the legislature, the governor, the Alaska Mental Health Trust Authority, and other state agencies in matters affecting persons with mental disorders, including, but not limited to,

(A) development of necessary services for diagnosis, treatment, and rehabilitation;

(B) evaluation of the effectiveness of programs in the state for diagnosis, treatment, and rehabilitation;

(C) legal processes that affect screening, diagnosis, treatment, and rehabilitation;

(6) provide to the Alaska Mental Health Trust Authority for its review and consideration recommendations concerning the integrated comprehensive mental health program for those persons who are described in AS 47.30.056 (b)(1) and the use of money in the mental health trust settlement income account in a manner consistent with regulations adopted under AS 47.30.031 ; and

(7) submit periodic reports regarding its planning, evaluation, advocacy, and other activities.

Appendix C: Program components funded through Division of Behavioral Health

Through its grant programs, the Division of Behavioral Health funds the following components.[47]

Prevention and Early Intervention:

The Alaska Fetal Alcohol Syndrome (FAS) Program: This project seeks to prevent alcohol-related birth defects, increase diagnostic services in Alaska, improve the delivery of services to those individuals already affected by Fetal Alcohol Spectrum Disorders (FASD), and to evaluate the outcomes of statewide efforts. Services include training, public education, development of statewide diagnostic services, community support through grants and contracts, and the ongoing development of partnerships with other divisions, departments, community agencies, Alaska Native Health Corporations and parents/caregivers to decrease the prevalence of FAS and the secondary disabilities that occur when appropriate services are not provided. With the support of a federal grant that ran from 2000 to 2005, diagnostic teams identified 850 Alaskans with prenatal exposure to alcohol. Referrals were made to support services. While diagnostic teams continue to function with state funds, because of decreases in funding, services must be provided within the framework of general mental health services.

Alcohol Safety Action Program (ASAP): This program screens, refers and monitors both adult and juvenile offenders to ensure that they complete their substance use disorder education or treatment program that is prescribed by the courts, Division of Motor Vehicles, and/or Division of Juvenile Justice.

Community Comprehensive Prevention & Early Intervention Grants: The goal of this component is to ensure that effective community-based prevention and early intervention services are available statewide. These services strive to incorporate research-based strategies that demonstrate positive outcomes for individuals and communities. The intent is to provide the foundation funding for Alaska's effort to decrease substance abuse and its harmful effects within the State and to increase resilience with a focus on preventing youth from experimenting with and becoming addicted to alcohol and other drugs.

Rural Services and Suicide Prevention: Programs funded through this component include the Community-Based Suicide Prevention Program (CBSPP), which provides small grants directly to communities; and the Rural Human Services System Project (RHSSP) which provides funds to regional agencies to hire, train and supervise village-based counselors. These counselors provide integrated substance use disorder and mental
health outpatient, aftercare and support services as well as prevention and education activities. The RHSSP training program is administered by the University of Alaska, College of Rural Alaska and an additional part of the mission is to encourage rural Alaskans to pursue higher degrees in human services fields. Both the Community-Based Suicide Prevention Program and the Rural Human Services System Project focus on ensuring that needed services are both available in and culturally appropriate to the villages and towns of rural Alaska. CBSPP coordinators provide a wide range of prevention and intervention services. RHS trained village-based counselors provide a full range of paraprofessional services from screening to aftercare under the supervision of more advanced practitioners. They also provide prevention and education programs in their communities.

Treatment and Recovery:

Behavioral Health Medicaid Services: A combination of federal and state matching Medicaid funds support behavioral health services to Medicaid eligible individuals with a mental disorder or illness and/or a substance use disorder in both inpatient and outpatient settings.

Behavioral Health Grants: These grants are provided to reduce alcoholism and substance use disorders and to treat mental illness by funding prevention, intervention and treatment services through local non-profit social service or government organizations. They also provide funds for services to assist individuals who suffer from a traumatic brain injury to attain their highest possible functioning level. These publicly funded programs primarily serve those Alaskans without insurance or the ability to pay for services. Prevention services delivered by the local providers include information, general education, alternative activities, problem identification and referral, community based processes, and environmental strategies.

Psychiatric Emergency Services: This funding supports competitive grants to community behavioral health agencies for services intended to aid people in psychiatric crisis. The service array may include crisis intervention, brief therapeutic interventions for stabilization, and follow-up services. Specialized services such as outreach teams
and residential crisis/respite services are also included.

Services for the Seriously Mentally Ill: Competitive grant funding is made available to community behavioral health agencies for an array of support services for adults with severe mental illnesses. This is the population that impacts the census limits at Alaska Psychiatric Institute (API) and services delivered in the community are critical to keeping this population out of the hospital. Past formal, published evaluations of services to this population have proved the effectiveness of these services to keeping people out of API and correctional facilities. Core services are assessment, psychotherapy, case management, and rehabilitative services. Specialized services include residential services, vocational services and drop-in centers.

Designated Evaluation and Treatment: The state, as a payer-of-last resort, makes these funds available to designated local community and specialty hospitals for evaluation and treatment services for people under court-ordered commitment and to people who meet those criteria, but have agreed to accept services voluntarily in lieu of commitment.
Using this funding, a local facility may provide up to 72-hour inpatient psychiatric evaluations, up to 7 days of crisis stabilization, or up to 40 days of inpatient hospital services close to the consumers home, family, and support system. Component funding also supports consumer and escort travel to designated hospitals and back to their home community.

Services for Youth with Severe Emotional Disturbance (SED): This component provides competitive grant funding to community behavioral health agencies for a range of services for severely emotionally disturbed youth and their families. Core services provided are assessment, psychotherapy, chemotherapy, case management and rehabilitation. Specialized services include individual skill building, day treatment, home-based therapy, residential services and individualized services. SED grants prioritize services in the least restrictive environment and as close to home and family as possible. In FY2006 changes were made to this component to enhance the in-state service continuum for children with SED and decrease the number of children moving into out of state placements and restrictive in-state environments: 1) Funding was increased on an

"as needed" basis to support individualized services required to divert children from out of state/out of community placements. 2) Requirements for collaboration, planning and coordination of care were increased. 3) 10 new grants were awarded for start up pilot projects to increase in-home services and residential alternatives for children at risk of movement into more restrictive care and/or stepping down from out of state care. Recognizing the occurrence of dual disorders, programs are beginning to serve these dual needs.

Other components directly operated by the Division of Behavioral Health are:

Alaska Psychiatric Institute: Alaska Psychiatric Institute provides twenty-four hour inpatient psychiatric care to individuals from all regions of the state. API serves Alaskans with severe and persistent psychiatric disorders or serious maladaptive behaviors including adults and adolescents whose need for psychiatric services exceeds the capacity of local service providers. API also provides longer-term care for organic or highly complex and difficult to place patients and provides court-ordered competency valuations of persons accused of crimes, and treatment for patients found incompetent to stand trial or not guilty by reason of insanity.

Behavioral Health Administration: This component supports the administrative operation of the Division and the programmatic oversight of all programs and services funded by the Division, with the exception of services delivered at API. The more than 230 million dollars granted, contracted or otherwise utilized by the Division to provide services to individuals and their families are managed, awarded, disbursed, and monitored by this component.

Appendix D: Service availability matrix

Matrix of Current Comprehensive Integrated Mental Health Plan Services for Three or More Trust Beneficiary Groups					
Service	**Level 1: Village**	**Level 2: Sub-regional Center or Town**	**Level 3: Regional Center or Small City**	**Level 4: Urban Center**	**Level 5: Metropolitan Area**
Population	***25+ in Intermediate Community***	***500+ in intermediate community; a sub-regional population of at least 1,500***	***2,000+ in intermediate community providing services to a regional population of at 5,000***	***25,000+ in intermediate community providing services to a larger regional or statewide population***	***200,000+ in intermediate Community***
Inpatient Services	**4**	**4**	**2**	**1**	**1**
Residential Services	**4**	**4**	**3**	**2**	**2**
Emergency/Assessment/Outpatient Service	**3**	**2**	**2**	**1**	**1**
Direct & Rehabilitation Services	**3**	**2**	**2**	**2**	**2**
Specialized Services					
Children's Services	**3**	**3**	**2**	**2**	**2**
Medical Services - Specialized	**4**	**4**	**1**	**2**	**2**
Dental Services - Specialized	**4**	**4**	**2**	**2**	**1**
Pharmacy Services	**3**	**1**	**1**	**1**	**1**
Legal Services	**2**	**2**	**2**	**2**	**2**
Transportation Services - specialized	**3**	**3**	**2**	**2**	**2**
Corrections Services	**4**	**4**	**3**	**2**	**2**
Outreach/Screening	**3**	**3**	**2**	**2**	**2**
Community Prevention, Education, Public Awareness	**3**	**3**	**2**	**2**	**2**

1 Available (adequate): the service is widely available and meets most needs.

2 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.

3 Minimally available (needed): the service is mostly unavailable.

4 There is not general agreement that these services are feasible at this level of community [48]

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The Advisory Board on Alcoholism and Drug Abuse
The Alaska Mental Health Board

Shared Plan FY 2007-2011
1st edition

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