ALASKA MENTAL HEALTH BOARD

TONY KNOWLES, GOVERNOR
STATE OF ALASKA

431 N. Franklin Street
Juneau, Alaska 99801
Office: (907) 465-3071
Fax: (907) 465-3079

January 27, 1999

Dear Alaskans,

Alaska Statutes establish the Alaska Mental Health Board (AMHB) as the state planning agency for mental health services in Alaska. In 1991, the AMHB began a strategic planning process focusing on improving the statewide mental health system with an emphasis on strengthening community based services.

The 1991 document, *A Shared Vision: The Alaska Mental Health Strategic Plan for the 90s,* met with wide acceptance among Alaskans concerned with the delivery of mental health services. With the close of the 90s, the AMHB decided to convene a large planning group to explore mental health issues and goals impacting service delivery through the year 2003. Many volunteers, representing a wide range of Alaskans concerned about mental health services, have participated in the production of the plan, *A Shared Vision II, The Alaska Mental Health Strategic Plan 1999-2003.*

We hope that this document will be useful for Alaskans who want to understand the direction of mental health care in our state, for public and private agencies interested in the evolution of services in Alaska, and for state and federal funding agencies. The AMHB will use this plan in establishing budget priorities for funding requests to the Alaska Mental Health Trust Authority and the State Legislature.

If you have questions, comments, or wish to participate in future planning efforts, please contact the AMHB office at the above address.

Sincerely,

Susan Humphrey-Barnett

Susan Humphrey-Barnett
Chair

Table of Contents

INTRODUCTION

Major Trends

The years since 1991, when the first *A Shared Vision: The Alaska Mental Health Strategic Plan for the 90s* was begun, have been marked by significant changes in the national and state mental health service delivery systems. Nationally, and in Alaska, state hospitals have been reorganized and downsized. In 1991 the bed capacity of the Alaska Psychiatric Institute (API), Alaska's only state mental health hospital, was 160. In 1997, the bed capacity was 79. The theory of downsized hospitals is that savings will be reinvested in community services. In most states, these savings have not gone to support community based care.

Nationally, many states are engaging in planning for or implementing privatization of some aspect of their state operated mental health system. In Alaska private enterprise has begun to take on more components of mental health care services. Though the system is still largely public and non-profit, there has been planning and implementation for greater use of community hospitals for in-patient psychiatric services.

While Alaska labored under the difficulty of resolving the Mental Health Trust Lands Litigation, settled in 1994, half the United States' mental health agencies were involved in class action lawsuits regarding mental health services. In Alaska, the changes brought about by the legal settlement include a reorganization of the planning, budgeting and advocacy board structure and some additional funds into services. For many, there has also been a realization that significant additional funds for mental health services will not be forthcoming, but that there is a possibility of reorganizing service delivery to be more comprehensive and integrated.

Some of the biggest changes in national mental health services go under the heading of "managed care." This heading covers many fundamental system changes, some of which are beginning to be experienced in Alaska. The last decade of the 20th century has seen the commodification of mental health. Mental health services have gone from being a public health concern, largely provided by public mental health agencies, to a commodity that is sold to the lowest bidder through managed care contracts. The emergence of managed care in the public mental health

system has raised ethical issues for states, including how to deal with the implicit incentives to underutilize treatment, fiduciary responsibility, and whether to reinvest savings into the mental health system.

The closing years of the decade have seen an increased focus on children's mental health services. National studies have shown the significant underfunding of children's services and the resultant poor quality of care. Alaska has focused attention on the need for greater access to mental health services for children and the need for more effective early intervention. The strategies developed to focus on these needs highlight cross agency collaboration efforts as a means to increase efficiency in service delivery and to treat the children and youth holistically.

The decade of the 90s has seen the welfare reform revolution. This rubric covers broad shifts in public expectations about social and personal responsibility. Many people who have disabilities have found their "entitlement" disappear, while their disabilities which keep them from working have not. Those who continue to receive public benefits receive them in an environment that sometimes appears hostile or lacking in compassion for those whose lives are shattered by psychiatric disabilities.

Criminalization of the mentally ill has become a significant national concern in the last decade. Jails and prisons throughout the states have seen an increase in the number of people with psychiatric disorders who are sentenced to time in correctional facilities. Jails in all states are used too frequently as holding centers when community based mental health care is unavailable or non existent. Alaska, due to the Cleary class action settlement, began to focus attention on this problem earlier than many other states. However, we have been slow to find solutions to this situation and a significant number of mental health consumers find themselves in Alaska's correctional facilities when appropriate community care may have prevented this criminalization.

Among the most welcome changes in mental health services nationally and in Alaska since 1991 has been the growth of the consumer movement. The consumer movement has focused on the need for consumers and their families to be more involved in mental health services from the policy level to the treatment plan level. Alaska has encouraged consumers/families to participate at all levels of policy development, planning and service delivery and we look forward to expansion of this trend in the next decade. Another new focus of the consumer movement has been the "recovery movement"--a shift in our perceptions about

psychiatric disorders to emphasize the extent to which people may recover from these illnesses, especially with the support and modeling of others who have had similar experiences. The media has reflected this theme with many new books by people who have recovered from mental illnesses. And public figures can now be heard discussing their own or family members' struggles with psychiatric disorders. This openness is a tribute to the efforts of the consumer movement.

The consumer movement, along with federal imperatives, have required states to develop "outcomes" approaches to measuring the effectiveness of mental health services. This has meant not only "consumer satisfaction" measures, but also the development by many states of "report cards" and other measures of the impact of public mental health services on the conditions and well being of consumers. Alaska has been part of this effort to shift attention away from such measures as the numbers of treatment sessions to measurable changes in quality of life and the functional level of those who experience psychiatric disorders.

Since 1991, the Alaska Mental Health Board (AMHB) has used its mental health services planning process to bring together the various mental health system stakeholders to achieve consensus on the needed direction and priorities for the development of mental health services in Alaska. The first plan, *A Shared Vision: The Alaska Mental Health Strategic Plan for the 90s* has been used by the Board for determining policy and planning initiatives, as well as budget priorities. System stakeholders have used it for a variety of service planning and funding strategies.

The Alaska Mental Health Board started the development of a plan to replace the first *A Shared Vision* in 1996. When the Board recognized the need for a new consensus on system direction in 1997, the Board identified the "guiding principles" to be used in the development of the plan and those "system stakeholders" whose efforts and concerns needed to be part of the planning process. This group met in Anchorage in March 1997 to identify issues and goals for Alaska's mental health system over the next few years. Subsequently, the group broke into Action Teams to which other stakeholders were added. The teams were: Children's Services Action Team, Rural Action Team, and Adult Services Action Team which formed two additional sub-groups, Forensic Services Action Team and Senior Services Action Team. The Teams met over the next nine months, producing a first draft in December, 1997. The AMHB arranged many opportunities for public response. The last, an "open telephone" time, was held on June 3, 1998.

Mission for *A Shared Vision II*

To establish a service and advocacy plan which maximizes the ability of mental health consumers to lead positive and productive lives within our society.

Guiding Principles for the Mental Health System under *A Shared Vision II*

1. Consumer Centered Services: Mental health consumers have a primary role in defining their individualized needs and have choices among services which address those needs.
2. Consumer Rights: Respect for consumer dignity and rights, including confidentiality and the unique cultural framework for each consumer, underlies all services.
3. Consumer Directed Policy Development: Consumers are actively involved in shaping policies and laws affecting persons experiencing mental illnesses.
4. Comprehensive System: Services which address fundamental life needs--such as housing, employment, education, health care, and transportation--are included in addition to comprehensive mental health services.
5. Integrative/Collaborative System: Consumers, family members, advocates, providers and government agencies work in partnership to integrate diverse services and minimize service barriers.
6. Strengths Perspective: Services incorporate and build upon the strengths of consumers, family members, friends and natural community supports.
7. Home and Community Focus: Services are provided as close to the consumer's home and community as possible, and local communities take active ownership in providing needed and least restrictive services.
8. Preventive Services: An emphasis on prevention and early intervention helps reduce the need for more intensive, crisis oriented services.
9. Outcome Based System: Consumer satisfaction and other measurable outcomes help define "success" and promote accountability for service providers.
10. Cost Effectiveness: Services are effectively managed to maximize resources, promote efficiency and minimize duplication.

Planning Group Member List

John Battaglia, M.D., Division of Mental Health and Developmental Disabilities, Department of Health and Social Services
Kelly Behen, Alaska Mental Health Board
Barbara Bennett, Alaska Coalition on Housing and Homelessness
James Berner, M.D., Alaska Area Native Health Service
Daniel Bill, Alaska Mental Health Board
Mike Boyd, Alaska Community Mental Health Services Association
Randall Burns, Alaska Psychiatric Institute
Pat Clasby, Alaska State Hospital and Nursing Home Association
Kathy Craft, Alaska Community Mental Health Services Association
Kate Cross-Das, National Alliance for the Mentally Ill, Fairbanks
Nancy Dodge, Governor's Council on Disabilities and Special Education
Charlene Fisher, Council of Athabascan Tribal Governments
Marilee Fletcher, Division of Alcohol and Drug Abuse, Department of Health and Social Services
Duane French, Division of Vocational Rehabilitation, Department of Education
Ellen Ganley, Alaska Public Health Association
Robert Gorder, Department of Public Safety
Ken Helander, Southcentral Counseling Center
Glen Herbst, Police Department, Unalaska
Dorcas Jackson, Office of Public Advocacy
Sandra Juneby, Alaska Mental Health Board
Nina Kinney, Division of Family and Youth Services, Department of Health and Social Services
Jan MacClarence, Alaska Mental Health Board
Jim Maley, Alaska Association of Homes for Children
Vicki Turner-Malone, National Alliance for the Mentally Ill, Alaska
Sarah McConnell, Children and Youth Task Force
Jan McGillivary, Alaska Mental Health Association
Robert Morgan, Alaska Native Foundation
Pat Murphy, Alaska Mental Health Board
Cynthia Parker, Anchorage Neighborhood Association
Colleen Patrick Riley, Department of Corrections
Mike Renfro, Division of Mental Health and Developmental Disabilities, Department of Health and Social Services
Mary Elizabeth Rider, Alaska Mental Health Trust Authority
Laura Rorem, Alaska Mental Health Board
Agnes Rychnovsky, Alaska Mental Health Board
Jill Sandleben, Alaska Commission on Aging

Planning Group Member List (Continued)

Ann Schultz, Governor's Advisory Board on Alcoholism and Drug Abuse
Richard Smiley, Department of Education
Mark Snipes, Rural Alaska Program Directors Association
Rick Tessandore, Disability Law Center
Dave Wagner, Mental Health Consumer of Alaska
Roberly Waldron, Alaska Mental Health Board
Russ Webb, Department of Health and Social Services
Scott Wheat, Alaska Psychiatric Institute Governing Board
Dave Williams, Division of Medical Assistance, Department of Health and Social Services
Dick Wilson, National Association for the Mentally Ill, Sitka

STATE OF THE STATE

Introduction

The Alaska Mental Health Board (AMHB) is charged in Alaska Statutes with planning for mental health services in Alaska. This direction encompasses all mental health services, regardless of provider. In Alaska, mental health care is provided by three systems: state supported services, federally supported services, and private services. The AMHB in *A Shared Vision II* brought together representatives of these three systems and attempted to ensure that the broad directions and goals for mental health care were agreeable to all. The document also addresses the need for integration and coordination among these providers.

Although we recognize the need to address the total service spectrum, *A Shared Vision II* focuses on the state supported service delivery system. This focus results, in part, from the fact that the only data available to the AMHB has to do with providers and consumers of state supported services. This data is limited; one of the ongoing goals of the AMHB is to assure the development of adequate management information systems that can provide us with timely and reliable data.

In the pages following the *Who Do We Serve* section, we have collected information about mental health services by service area, in which specific community mental health centers have responsibility. Service availability is not consistent throughout Alaska. We hope that the *State of the State* tables displaying service availability and capacity will set a context for the goals and actions in the strategic plan part of this document.

Prevalence of Mental Illness

Methodologies adopted by the Center for Mental Health Services (CMHS), the federal agency with mental health oversight responsibilities, provide the tools used to estimate the overall prevalence of mental illness in Alaska. In 1997, the CMHS published methods for identifying the portion of each state's total population of adults experiencing serious mental illness (SMI) and of children experiencing serious emotional disturbance (SED).

The key questions in assessing the applicability of the CMHS approaches were two. First, how does CMHS define Serious Mental Illness and Serious Emotional Disturbance? Second, how does CMHS count those it defines as experiencing Seriously Mentally Ill and Seriously Emotionally Disturbed?

CMHS defines children with serious emotional disturbance as persons:

> *From birth up to age 18, who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet DSM diagnostic criteria that resulted in functional impairment substantially interfering with or limiting the child's role or functioning in family, school, or community activities.*

CMHS defines functional impairments as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally-appropriate social, behavioral, cognitive, communicative, or adaptive skills. The definition includes functional impairments of episodic, recurrent, and continuous duration unless these are temporary and expected responses to stressful events.

The CMHS definition of Serious Mental Illness essentially mirrors its Serious Emotional Disturbance definition except that it applies to persons age 18 and over.

CMHS reviewed epidemiological research from across the United States (relatively little such research has been done nationwide and none in Alaska). With this research as its basis, CMHS teams of experts developed overall estimates of Serious Mental Illness and Serious Emotional Disturbance prevalence. For Serious Mental Illness prevalence, the CMHS team identified a number of demographic and socio-economic factors

associated with mental illness. Those factors were applied to produce Serious Mental Illness estimates for every state. CMHS estimated the Alaskan Serious Mental Illness rate at 6.3% of the household population (which excludes institutional and homeless populations), seventh highest in the nation.

For children and youth, CMHS does not estimate state by state Serious Emotional Disturbance prevalence. Instead the agency posits an Serious Emotional Disturbance range of 9%-13% of children age 9-17, based on a substantial functional impairment (compared to a range of 5%-9% for those with an extreme functional impairment). An individual state's placement within this range depends upon that state's poverty rate.

The CMHS methodology complicates determining Alaska's Serious Emotional Disturbance overall prevalence. First, CMHS only estimates the Serious Emotional Disturbance rate for ages 9-17, citing insufficient evidence for estimating prevalence in younger children. The simple approach is to assume the 9-17 Serious Emotional Disturbance rate roughly reflects the rate for children age 8 and under. Alaska's low statewide poverty rate, suggests that our Serious Emotional Disturbance prevalence should be toward the lower end of the range, but the higher cost of living mitigates that. In our judgment, a 10% prevalence balances those two considerations. Unfortunately, the extant research did not allow CMHS to consider other factors, such as substance abuse rates or cultural diversity, in prevalence calculations. Our 10% figure accords with a 1993 study by Norman Dinges on Serious Emotional Disturbance prevalence in Alaska which found that "the public mental health sector will have to provide services for approximately 10% of the school age youth."

Serious Mental Illness and Serious Emotional Disturbance prevalences provide the tools to tally the number of Alaskans with Serious Mental Illness or Serious Emotional Disturbance. Table 1 on the next page displays the results of those calculations (to the nearest hundred). In 1997, we estimate that about 44,500 Alaskans had a serious mental illness or serious emotional disturbance. Some did so for the first time, but many have had chronic illness for a large part of their lives. This 44,500 includes 14,700 children (10% of the age 5 to 18 population) and 25,600 adults (6.3% of the 19 and over population). Estimates of the Serious Mental Illness/Serious Emotional Disturbance segment of institutional and homeless populations originate from several sources and add up to 4,200 individuals.

1997 Prevalence of SMI/SED in Alaska

1997 Alaska Population	**611,300**
Total SMI/SED population	**44,500**
Children and Youth (age 5-18)	14,700
Adults (age 19 and over)	25,600
Institutional/homeless	4,200

Table 1

Absent Alaskan epidemiology, these prevalence estimates represent the best available information. But view the numbers with some caution for the reasons discussed below.

- Serious Emotional Disturbance and Serious Mental Illness estimates may mask higher prevalence rates in rural Alaska. Lower socioeconomic status strongly associates with mental and emotional disorders. Other indicators, such as substance abuse and suicide rates, also suggest that prevalence, particularly among children, may be underestimated in rural Alaska.
- Alaska's urban population is increasing as a share of the state's population. Urban population density is a valid predictor of serious mental illness among adults and Alaska can look for added upward pressure on prevalence rates as its urban population continues to grow. CMHS estimates Anchorage, Fairbanks, and Juneau Serious Mental Illness rates to be higher than the statewide figure of 6.3%.
- Age is an important factor in mental illness; younger people are more likely to suffer mental illness, which CMHS estimates for Alaska take into account. However, Alaska's Native and black populations are both substantially younger than Alaska's population at large and thus at greater risk.
- A 1997 study estimates that 5,000 to 6,000 Alaskans have organic brain syndrome (OBS); many are without appropriate services.

Who Do We Serve? Mental Health Consumer Characteristics

Demographic and diagnostic information about consumers of state supported mental health services originates with four data sources representative of the overall mental health consumer population.

1. Alaska Psychiatric Institute (API) admissions
2. Community mental health center (CMHC) admissions
3. Department of Health & Social Services (DHSS) Medicaid mental health clients
4. Department of Corrections (DOC) institutional mentally ill offender population

These sources represent a sample including the large majority of clients of the public mental health system and significant number of mental health consumers served by private providers. The data provides a good picture of the overall mental health consumer population. Charts 1-3 in this section display only diagnostic categories associated with 1% or more of a mental health consumer population.

The charts make apparent some differences in the disorders of these four populations. Child and youth admissions to CMHCs fall mainly into four diagnostic groups, with two, mood disorders and other psychotic or severe disorders, accounting for 90% of admissions. The latter class accounts for fully two-thirds of all admissions for individuals under 22 years of age. Significant diagnostic features of other groups include:

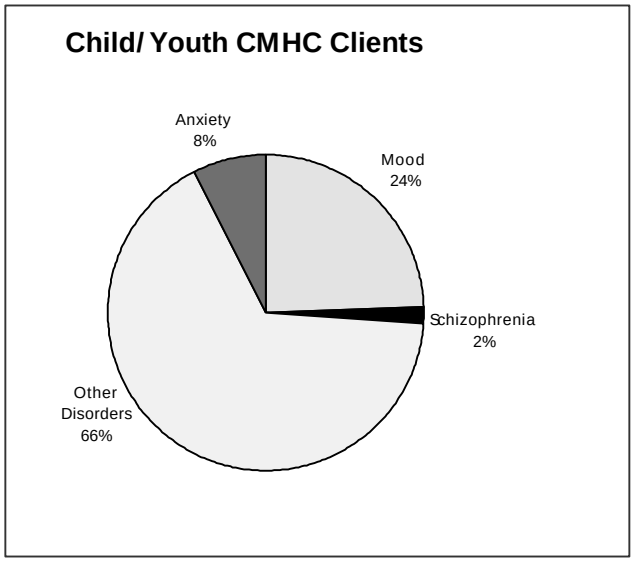


Chart 1

- About 78% of adult CMHC clients are in the same diagnostic groups as clients under 22. Nearly half of adult diagnoses are mood disorders.

Alaska Psychiatric Institute admissions reflect the mission of an inpatient institution. As with CMHCs, adolescent admissions to API concentrate in the other psychotic or severe disorder and mood disorder categories. However, one-sixth of adolescents admitted to API suffer from schizophrenia, one of the most serious and persistent mental illnesses. Adults were predominantly afflicted with schizophrenia (57%) and mood disorders (35%).

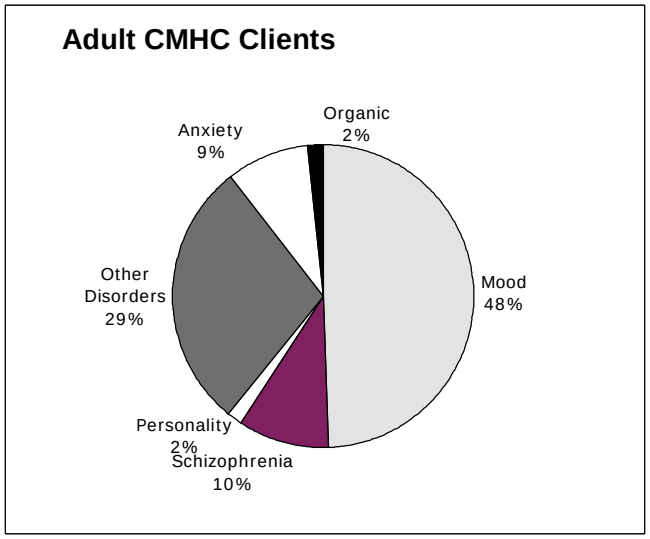


Chart 2

- Over half of Department of Corrections (DOC) inmates with mental illness fall into the diagnostic categories of schizophrenia and mood disorders, also prominent in Alaska Psychiatric Institute populations. In contrast to other groups, over 27% of Department of Corrections mentally ill offenders carry a personality disorder diagnosis. Anxiety disorders and organic mental disorders each represent about 8% of the DOC population.

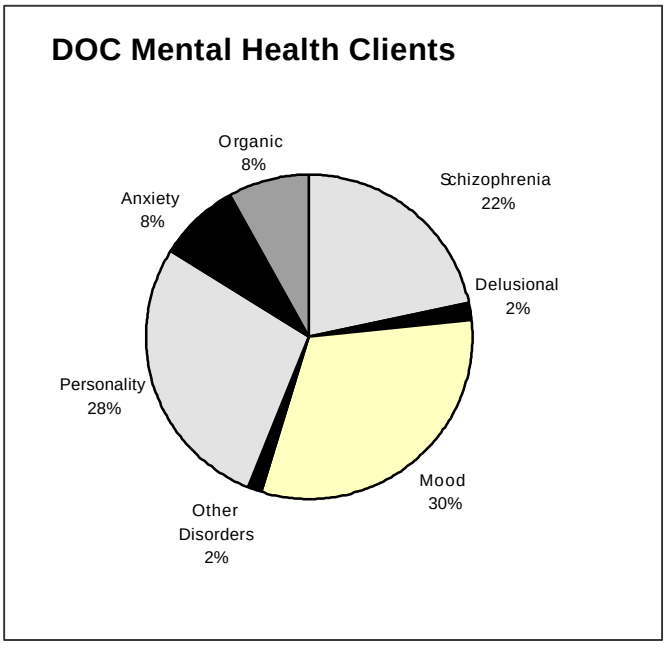


Chart 3

Poly Diagnoses

Consumers of state supported mental health services often may have additional diagnoses. For people with mental illness, dual diagnosis is most likely to involve substance abuse. National prevalence data suggests that about 27% of individuals with chronic serious mental illness abuse substances and that about 15% of individuals with serious mental illness

also abuse substances. The experience of Alaskan providers suggests the co-occurrence of serious substance abuse is much higher.

Alaskan data is available from two principle sources. Medicaid files indicate that 8% of mental health consumers also have chronic alcoholism with psychoses. A 1997 Bristol Observatory report puts the number of community mental health center admissions also admitted to substance abuse programs at 21%, which accords with national dual diagnosis estimates. In addition, 44% of mental health consumers receiving Medicaid benefits are also identified as mental health consumers receiving services for developmental disabilities.

Alaskans and Mental Health Consumers

A brief look at selected demographic indicators demonstrates that consumers of state supported mental health services exhibit important distinctions in key life domains compared to Alaskans as a whole. Some items in particular stand out.

- Children and adolescents are over-represented in the mental health consumer population compared to the population as a whole. For example, children ages 6 through 17 make up about 21% of Alaska's population. They represent over 30% of community mental health center mental health consumer admissions and 33% of Medicaid beneficiaries. On the other hand, Alaskans over age 60 account for over 7% of the state's population, but less than 2% of community mental health center and Alaska Psychiatric Institute admissions.
- Mental health consumer gender composition does not match that of the state population. Males outnumber females in Alaska for all population cohorts under age 60. Females represent about 47% of the 22 to 59 cohort at large, but 60% of community mental health center admissions and over 73% of Medicaid clients. Males are over-represented for ages 6 through 17.
- The racial make-up of the mental health consumer population also differs from that of Alaska at large (see Chart 4). Alaska Natives and Native Americans make up about one-sixth of the entire population, but much larger segments of mental health consumer samples–32% of under age 22 community mental health center admissions; 30% of under age 22 Alaska Psychiatric Institute admissions; 25% of under 22 Medicaid clients. Similar numbers hold true for adults, for example, 30% of mental health consumers in correctional institutions are Native Alaskans or Native Americans.

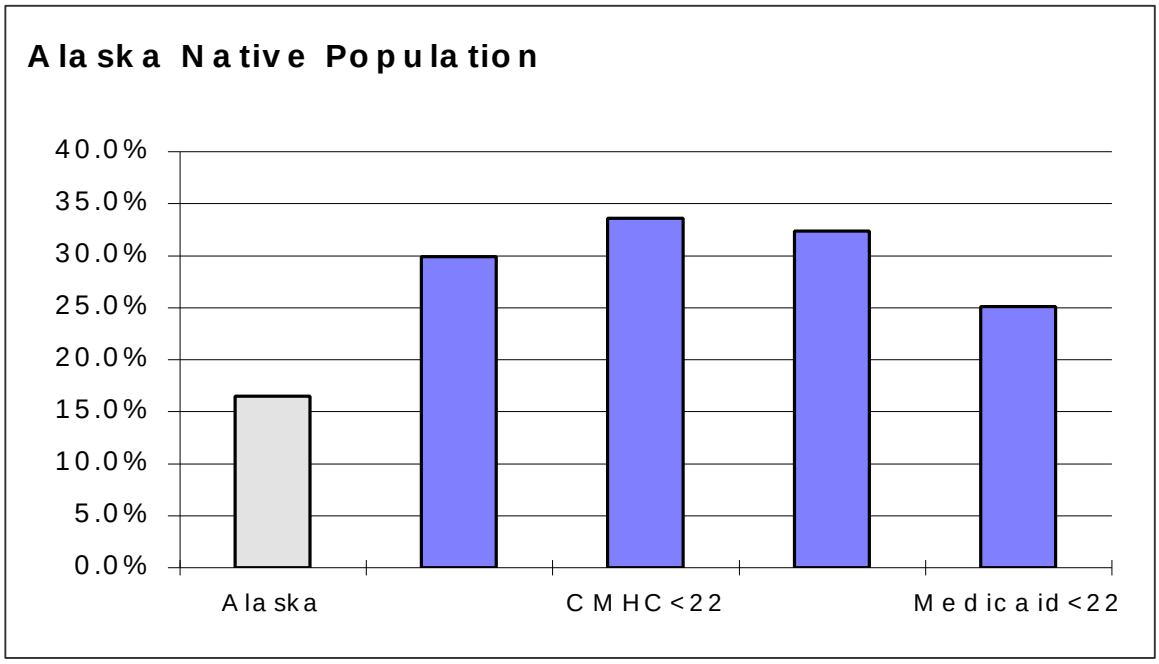


Chart 4

There are some important differences between the circumstances and achievements of mental health consumers and Alaskans as a whole as well.

- Alaska's 1996 median household income was about $48,000. Consumers of state supported mental health services earned substantially less. Over 80% of people admitted to community mental health centers report incomes under $40,000. The same held true for under age 22 Alaska Psychiatric Institute admissions. Household income for over 90% of age 22 and older API admissions was less than $20,000.
- Consumers of state supported mental health services' educational attainment lags behind that of other Alaskans as well, as shown in Chart 5. Nearly 58% of adult mental health

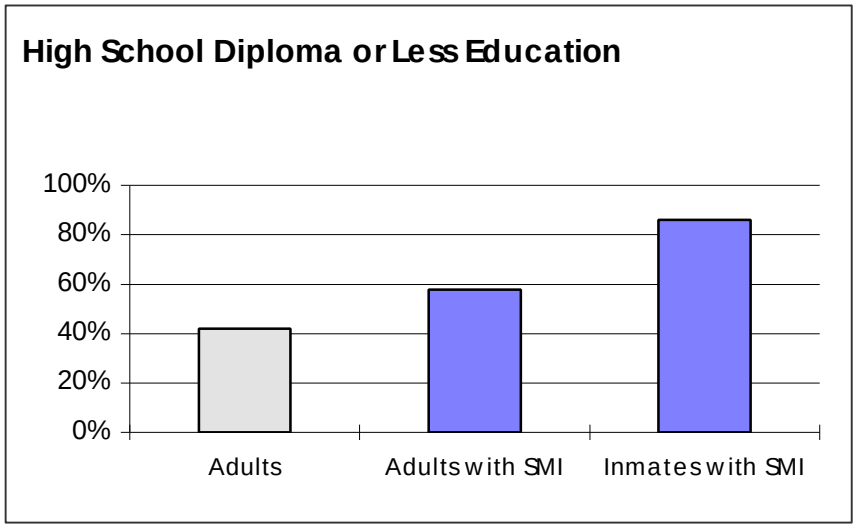


Chart 5

consumers progressed no further than a high school diploma, compared to 42% of all Alaskan adults. Half of adult Alaskans have some college or an undergraduate degree; only 28% of mental health consumers do. Educational attainment for Department of Corrections' mentally ill offenders was strikingly limited–48% do not possess a high school diploma and another 38% have not advanced beyond high school.

- Mental health consumers are less likely to work than are other Alaskans. About two-thirds of Alaskans over age 16 work. Only one-fourth of adult mental health consumers admitted to community mental health centers are employed full-time and 13% report part-time or subsistence/seasonal work. About one-tenth reported they were unable to work. Alaska Psychiatric Institute patients, reflecting the more serious nature of their illnesses, are much more likely to be unemployed (nearly 40%) and unable to work (almost 43%).
- About 60% of adult community mental health center admissions were single, divorced or separated, compared to only 29% that were married. Three-fourths of Alaska Psychiatric Institute patients were single, separated, or divorced and only 18% married. Only 15% of mentally ill offenders in correctional institutions are married.
- Information concerning living situations is available for community mental health center and Alaska Psychiatric Institute admissions. Most CMHC child and adolescent mental health consumers live with relatives, but about 7% are in foster care situations. More than twice that percentage of API adolescent admissions come from foster care. In addition, over 8% of API adolescent patients list jail or correctional institutions as their immediate prior living circumstance. A similar number of adolescents entered Alaska Psychiatric Institute from crisis/respite facilities. The most common living situation for adults is with relatives (about half). Under 4% of adult community mental health center admissions are homeless. The homeless population at API is larger, more than 5% of adolescents and about 13% of adults.

The data show clearly that consumers of state supported mental health services lead different lives than other Alaskans. Employment, living situation, income, domestic relations, ethnic composition, and educational attainment–the standards and conditions of the Alaskan mental health consumer population all differ markedly from those of the larger population.

Who Was Served During FY 1997?

Alaskans with mental illness seek services from a diverse set of providers. These providers include members of two service constellations which overlap to some extent–the public system and the private system. Collecting and collating the data required to present a coherent picture of services sought, provided, and needed involves piecing together data from diverse sources, as well as figuring out how to fill in gaping holes in the information universe.

Estimating the number of Alaskans served during FY 1997 requires data from several sources. Some service providers and agencies do maintain data and supplied that. Others, while collecting data, have never aggregated it in a form suitable for our purposes. Still others simply do not collect data nor maintain databases useful for system-wide analysis.

The data we present for FY 97 has limitations over preceding years' data, due to the following:

- The transition from the Division of Mental Health and Developmental Disabilities (DMHDD) management information system (MIS) to the ARORA MIS experienced delays that have resulted in an incomplete and unusable FY 1997 data set.
- DMHDD grantees were reluctant to provide client identifying information that they felt would compromise confidentiality. The Division of Mental Health and Developmental Disabilities believes reporting incorporates adequate safeguards.

As a consequence, we are unable to present details of service delivery. Some important pieces remain missing and some important relationships only vaguely traceable. A prime reason for these tenuous links is that the management information system cannot reliably unduplicate client counts across many discrete databases. Nor can information be extracted about service, either intensity or outcome, from most of the data available.

Non-State Mental Health Services

The two significant components of Alaska's mental health system, other than the state mental health program, are federal programs and private providers. Information about clients served by federal programs such as the Indian Health Service (IHS) have yet to be obtained. These elements

represent a relatively small part of the overall mental health system, with the exception of the IHS. In 1995, about 7% of the state's population was eligible for IHS services only (meaning not dually eligible for IHS and Medicaid). Most individuals eligible for IHS services are served by community mental health centers, however.

In examining private sector services, two points are important. Private psychiatric hospitals, residential centers, clinics, physicians, and psychiatrists provide Medicaid reimbursed services to a significant number of Alaskans. Second, several local hospitals provide psychiatric evaluation and/or treatment services under contract to the state. Other than these, private mental health services paid from other sources (private insurance, personal funds, etc.) are not captured in our data sources.

How significant a gap does this lack of information concerning private sector services represent? A clue may be found in 1996 CMHS national statistics.

- 75% of full-time equivalent staff employed in mental health organizations in 1994 were employed in organizations funded in full or in part by state mental health agencies.
- 72% of total 1994 episodes (ambulatory, residential, or inpatient) occurring in mental health organizations took place in organizations funded in whole or in part by state mental health agencies

CMHS statistics do not include "private office-based practices of psychiatrists, psychologists...and other mental health providers." How that exclusion affected the percentages noted above is unknown. However, Medicaid annually pays significant amounts to just such providers in Alaska. Medicaid mental health payments account for perhaps 45% of public mental health funding in Alaska. While this is speculation, it stands to reason that community mental health grants and Medicaid combined provide the great preponderance of all mental health services in Alaska. We estimate that the public system in Alaska accounts for well in excess of the 72% of all episodes nationally.

Mental Health Services and Users

Any attempt to estimate how many Alaskans use mental health services becomes entangled in two problems which have historically plagued such efforts.

1. Service data originates with a variety of sources producing neither consistent nor comparable data.
2. Many individuals use multiple services and appear in multiple databases, which we cannot reliably unduplicate.

The first problem can be dealt with by assuming that clients, cases, and other means of tallying mental health service users are essentially equivalent units. In reality these generally are not equivalent, but on a system level, these measures can probably be aggregated without distorting the picture any more seriously than any other approach.

The unduplication issue is less tractable, although progress has been made towards solving it. The Department of Health and Social Services' efforts to institute a unique client identifier and data warehouse will eventually produce an acceptable solution. A 1997 Department of Health and Social Services project matched Medicaid clients with users of some other programs. Unfortunately, those programs did not include community mental health programs for lack of keys to match the Division of Mental Health and Developmental Disabilities (DMHDD) records with Medicaid and other program records.

Chart 3 displays state-funded mental health service use, based on a 1998 DMHDD grantee survey. It shows clients unduplicated within individual grantee agencies (an unknown level of cross-agency duplication occurs, particularly in larger communities such as Anchorage and Fairbanks) in each category. We estimate that community mental health grantees served some 21,500 Alaskans during FY 97; about 14,900 adults and 6,600 youth.

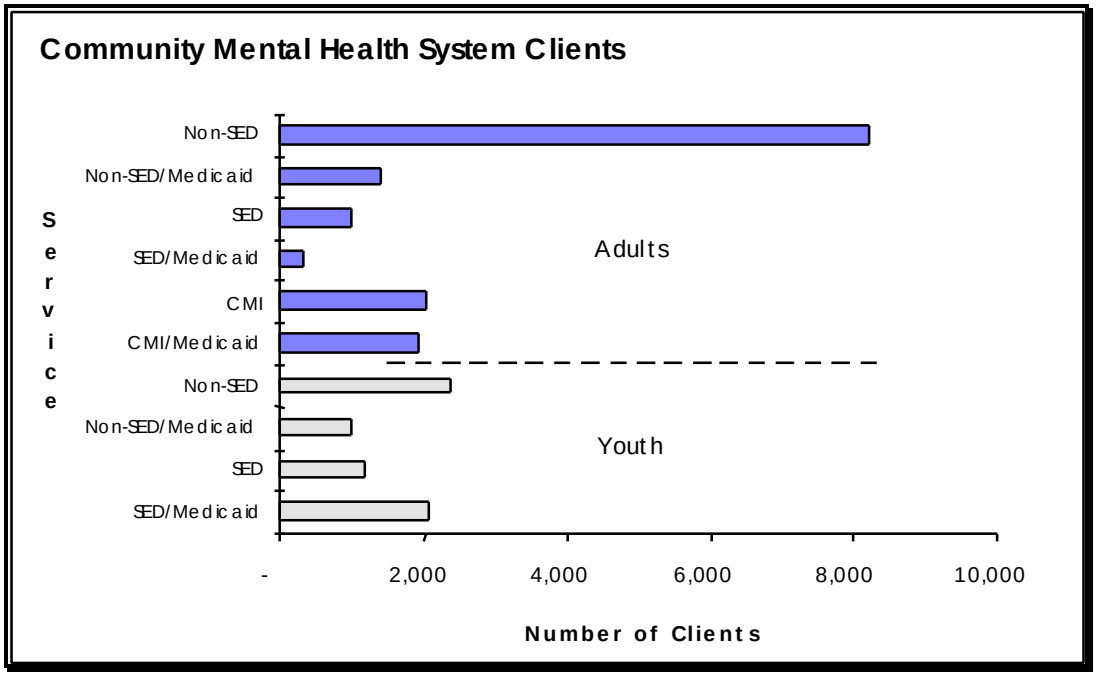


Chart 6

The services provided by community mental health grantees to these clients fall into the general categories described below.

- **Crisis Intervention Services (CIS)**: All 32 community mental health centers in Alaska offer some level of 24 hour per day, seven day per week emergency services, including screening, assessment, crisis intervention, referral, transport to designated inpatient evaluation facilities and brief therapy for problem resolution. During FY 97, about 15,000 Alaskans used crisis services. Community mental health centers responded to about 30,000 crisis contacts from employers, police, and the public, as well as direct service users and their families.
- **Services for Adults with Chronic Mental Illness (CMI)**: Community support programs for adults with severe mental illness are available through community mental health centers and 10 limited service providers. Services include identification and outreach, case management, medical, vocational, family/community education, peer support, protection and advocacy, crisis intervention, residential, and psychosocial rehabilitation. Other services provided to chronically mentally ill adults include consumer-run advocacy and support, family education and support, and legal advocacy. The Institutional Discharge

Project serves adults released from institutions such as psychiatric hospitals and correctional facilities.

- **Services for Youth with Severe Emotional Disturbance (SED)**: All community mental health centers and five limited service providers serve seriously emotionally disturbed children and youth. Specialized services include case management, day treatment, outreach and home-based therapy, residential treatment, individual and family therapy, and support services. Services for youth with the most severe problems are provided through the Alaska Youth Initiative (AYI), an individualized wrap-around service program that served 128 youth during FY 97.
- **General Mental Health Services (GMH)**: 16 community mental health centers and 2 limited service providers serve people experiencing depression, suicidal ideation or behavior, or other serious individual or family psychiatric dysfunction. Services include evaluation and diagnosis, brief strategic individual and family therapy, psychiatric and nursing services, and case consultation. Other general mental health services are community organization, public education, and advocacy.

In addition to services offered through community organizations, the state provides inpatient services through both the Alaska Psychiatric Institute and local hospitals, as described below.

- **Evaluation and Designated Treatment (DET)**: Designated community hospitals provide inpatient services for individuals involuntarily committed under Alaska law, providing court ordered evaluation and brief hospital care close to clients' homes with minimal disruption to clients' lives. Eight hospitals evaluated 85 clients and four treated 25 clients during FY 97.
- **Alaska Psychiatric Institute (API)**: API provides inpatient psychiatric care to adults and adolescents who are psychiatrically disturbed and whose needs exceed the local service capacity. A special security unit evaluates and treats forensic patients who need services for competency to stand trial, or who cannot be managed in a prison setting. The service array encompasses comprehensive assessments, physical exams, individual, group, and family therapy, and medication management. API admitted 1,258 patients during FY 97.

These overall service use figures, combined with some more specific data discussed immediately following, seem to indicate that Alaska's community mental health system serves about one-half of the state's

adults experiencing serious mental illnesses. This reflects estimates nationally of SMI service penetration. Between one-fifth and one-quarter of Seriously Emotionally Disturbed children and youth receive community mental health center services, well below national levels of about one-third of that population served.

Other Mental Health Services

A number of agencies and organizations outside the community mental health grantee system supply services to Alaskans with mental or emotional disorders. Data provided by some of these agencies and from other sources are reviewed in this section. This information is valuable, but must be viewed with previously noted cautions concerning comparability and duplication in mind.

The Department of Health and Social Services identified and matched FY 96 Medicaid recipients with several other Department of Health and Social Services programs. Nearly 11,000 Medicaid recipients were identified as recipients of other Department of Health and Social Services programs, except for state mental health programs.. Despite this, the Department of Health and Social Services report enlightens in several ways:

- 1,900 mental health consumers (17.4%) appear in DFYS records.
- 501 mental health consumers, or 4.6% of the Medicaid total, also appear in the Alcohol and Drug Abuse management information system and thus are dually diagnosed or dually served.
- 125 mental health consumers are also served by the Infant Learning Program, thus indicating not only mental health services, but developmental disability services.

These numbers are reliable, but incomplete. We can only speculate how many non-Medicaid beneficiaries were served in Department of Health and Social Services programs and about what portion of the nearly 11,000 Medicaid beneficiaries also received grant funded mental health services. We find clues to the second item in two sources. The Bristol Observatory report identifies about 38% of those admitted to community mental health centers during FY 94-96 as Medicaid eligible at some time during the period. FY 98 data gathered by the Division of Mental Health and Developmental Disabilities indicates that 31% of community mental health center clients were Medicaid recipients.

The AMHB annually obtains data from some other agencies serving people with psychiatric disorders. Again we caution that this data originates with independent sources. As a consequence, we hesitate to make any effort to aggregate the data into an overarching count of the clients served. The data does indicate the status of services in these life domain areas.

- Rural Human Services projects currently number seven statewide. FY 97 case data are available from two regions, which reported 480 individual cases, including crisis encounters. Village counselors from three reporting regions recorded nearly 1,700 outreach and crisis intervention encounters (with individuals not counted as cases). These three regions staged some 1,400 public information, education, and skill building presentations and community building activities. A total of 11,880 people attended these events.
- The Office of Public Advocacy (OPA) caseload included 255 individuals with mental illness in FY 97. Most are ages 22 to 59, although 14% are 60 or over.
- Jobs top of the list of needs expressed by individuals with chronic mental illnesses. A resource at hand for them is the Division of Vocational Rehabilitation, which carries about 500 open cases for individuals with psychosis, neurosis, and other mental and emotional disorders. These people received services including:

    1. Counseling and guidance
    2. Placement
    3. College
    4. Adjustment
    5. Transportation
    6. Job referral
    7. Vocational training
    8. On the job training

- The Department of Corrections (DOC) housed 1,741 mentally ill offenders in correctional facilities, including about 30 Institutional Discharge Project Plus (IDP+) participants, during FY 97. A single day snapshot counted 1,493 mentally ill offenders, including those in community residential centers and on probation. The DOC mental health unit offers a range of services for inmates with "chronic or acute mental illness or severe personality disorders who present significant behavior and management problems."
- Local school districts provide special education programs for students with a variety of disabilities including serious emotional disturbance

(SED). Including preschool ages 3 to 5, local schools provided special education services to about 850 SED children and adolescents as of December 1997. Even combining this number with the 3,300 SED clients served by community mental health centers and the 1,900 children in Division of Family and Youth Services custody receiving Medicaid services (and assume no duplication across data sources) yields a low number of children served (6,000) compared to our estimate of 14,900 SED youth.

- Three private hospitals (Providence, Charter North, and Fairbanks Memorial) providing psychiatric inpatient services reported some 2,850 psychiatric admissions during FY 96.. Please note this data was preliminary and should be replaced by better numbers soon.
- The Healthy Families Alaska program serves 303 families with children from birth to age 5 at risk of neglect and abuse. Services include prevention and early intervention for both mental health problems and substance abuse. The Division of Public Health estimates that 5,100 families are eligible for the program annually.
- Housing is a critical necessity for chronically mentally ill Alaskans. DMHDD supported residential settings represent a diversity of choices for Alaskans with psychiatric disorders thanks to efforts to bring together resources from the Alaska Housing Finance Corporation, non-profit agencies, federal and state agencies and advocacy organizations. As of July 1996, over 1,000 consumers occupied supported housing in 17 communities. The options ranged from owned homes to supported apartments to board and care facilities.

These data fragments reinforce two traits of the "system". First, it encompasses varied and valuable resources, many of which are outside what most consider the traditional mental health system. Second, as a consequence, the overall system may not be ideally cohesive or coherent.

The Big Picture

Currently over 40,000 Alaskans experience a mental illness, a significant portion of the state's population. Numbers are expected to increase at a pace equaling and perhaps exceeding that of the larger population. The total should approach 50,000 by 2010. How many receive services of some type? We estimate about half or slightly more receive some state funded service. Table 2 displays the numbers of mentally ill Alaskans served by state and other agencies or funded by sources for which we were able to obtain data. We do not total these numbers, because we cannot yet

Mentally Ill Client Count, Selected Programs

Service Component	Number
Community Mental Health Grantees	19,200
Department of Corrections	1,781
Alaska Psychiatric Hospital	812
Private Hospitals (3 reporting)	2,420
Medicaid (all agencies except DFYS, ADA, DMHDD)	8,881
Medicaid/DFYS	1,900
Medicaid/ADA	350
Local School Districts	850
Rural Human Services Providers (2 reporting)	480
Office of Public Advocacy	216
Division of Vocation Rehabilitation	425
Disability Law Center	75

Table 2

unduplicate client counts across discrete databases, the periods represented are not consistent, and because our information remains incomplete.

Looking at the broader picture, the data in this chapter suggests a fundamental characteristic of the state mental health system:

Perhaps 15,000 to 20,000 mentally ill Alaskans were not served in 1997 by any state program. Some likely were served by other systems, but the vast majority likely received no services.

Regional Services

A Table Listing Mental Health and Related Services by Region

Note: The information contained in these regional summaries reflects the state of services as of January 1998.

Service Area 1: North Slope Borough	**1997 Population: 7,403**	**Area: 87,860 sq. miles**	**DMHDD Grantees: North Slope Borough Community Counseling Center**
Service type	**Yes/No**	**Extent/location**	**Comments**
EMERGENCY SERVICES			
Crisis/Respite	Yes	Barrow - 8 beds	
Acute Care Hospital	Yes	Barrow Hospital	IHS - 1 bed
Acute Care Hospital - evaluation	Yes	Barrow	
Acute Care Hospital - treatment	No		
CMHC Emergency Services	Yes		Boroughwide 800#
Detox Facility	Yes	Barrow - 5 beds	NSB Substance Abuse Services
Suicide Prevention Grants	No		
CHILDREN AND YOUTH SERVICES			
DFYS Residential	Yes	Barrow - 10 beds	NSB RCC
Day Treatment	Yes		Day respite program
DFYS Family Centered Srvcs	Yes	Barrow	Home based
Therapeutic Foster Homes	No		
AYI	No		
Outreach to Homeless Youth	Yes		Thru Children & Youth Services & School (Home Based Program)
Abuse, Neglect, Domestic Violence Program/Outreach	Yes		Thru Home Based Program
DMHDD SED Grant	Yes	$14,800	FY 98
Residential Diagnostic and Treatment Center	No		
Peer Helper Program	No		
Other School-based Mental Health Services	No		Only coordinate with schools

Service type	Yes/No	Extent/location	Comments
ADULT SERVICES			
DFYS Licensed Adult Foster Homes	No		
Residential	No		
CSP-Day Treatment	No		
CSP-Vocational Rehab, Training, or Work Supports	Yes	Minimal	Case management, those cases sent to DVR
CSP-Supervised Apts	No		
CSP-Group Homes	Yes	Barrow - 5 beds	3 NSB funded; 2 DMHDD funded SMI
Homeless Shelter or Outreach	N/R		
CSP-Board & Care Homes	No		
GMH - Outpatient	Yes		
GMH Itinerant Outpatient	Yes		IHS
FORENSIC SERVICES			
MIO Transitional Housing	No		
Community Holding Facility or Jail	Yes	Barrow - 9 beds	18 day detention limit
DOC Institutional MH Services	No		
DOC CRC MH Services	Yes	Barrow - 6 beds	Aullaqisaatqigvik
SENIOR SERVICES			
Geriatric Mental Health Program or Outreach	Yes	Barrow	Through NSBCCC
Adult Day Services	No		
Respite Services	Yes	Wainwright	

Service type	Yes/No	Extent/location	Comments
STAFFING			
Numbers of Grant Funded FTEs and of Total FTEs	Yes	(1) state grant; (9) state FTEs	
Number of Psychiatrist FTEs	Yes	Barrow - 3 days/qtr.	PT psychiatrist
Child Interagency Team	Yes		Not always active
Mobile Crisis/Respite Team	No		
Itinerant PHS Psychiatrist	Yes	2 days/qtr.	
Tribal, Health Corp., or Local Gov't Behavioral Aides	No		
Rural Human Services Workers	No		
TRANSPORTATION			
Public Transportation	No		
Coordinated Human Services Transportation	No		
Dedicated Transportation for Mentally Ill	No		

Service Area 2: Maniilaq	**1997 Population: 6,844**	**Area: 37,300 sq. miles**	**DMHDD Grantees: Maniilaq Counseling Services**
Service type	**Yes/No**	**Extent/location**	**Comments**
EMERGENCY SERVICES			
Crisis/Respite	Yes	Kotzebue-4 bed	As needed - crisis/respite w/o walls - SMI
Acute Care Hospital	Yes	Kotzebue	
Acute Care Hospital - evaluation	Yes	Kotzebue	Evaluate clients; try to txt & return home.
Acute Care Hospital - treatment	Yes	Kotzebue	
CMHC Emergency Services	Yes		24 hr 800 # & on-call therapist
Detox Facility	Yes	Kotzebue	
Suicide Prevention Grants	Yes	5 communities	Noorvik, Ambler, Selawik, Kiana, Buckland
CHILDREN AND YOUTH SERVICES			
DFYS Residential	Yes	Kotzebue	Emergency shelter
Day Treatment	No		
DFYS Family Centered Srvcs	No		
Therapeutic Foster Homes	No		
AYI	No		
Outreach to Homeless Youth	N/R		
Abuse, Neglect, Domestic Violence Program/Outreach	Yes	Kotzebue	Emergency Shelter
DMHDD SED Grant	No		
Residential Diagnostic and Treatment Center	No		
Peer Helper Program	Yes	All villages	Trained by Health Educ. at Maniilaq Health Center
Other School-based Mental Health Services	Yes	All villages	Itinerant school counselors coordinate with MCS to provide total services

Service type	Yes/No	Extent/location	Comments
ADULT SERVICES			
DFYS Adult Foster Homes	No		
Residential	Yes	Kotzebue	Lake Street House - DD
CSP-Day Treatment	No		
CSP-Vocational Rehab, Training, or Work Supports	Yes	Kotzebue & all villages	School district provides and pays. Coordinates with DD and DVR
CSP-Supervised Apts	No	Private home -1, private apts - 20	All SMI
CSP-Group Homes	No		
Homeless Shelter or Outreach	Yes	Kotzebue	Emergency Shelter
CSP-Board & Care Homes	No		
GMH - Outpatient	Yes		
GMH Itinerant Outpatient	Yes		Regular schedule
FORENSIC SERVICES			
MIO Transitional Housing	No		
Community Holding Facility or Jail	Yes	Kotzebue - 14 beds	18 days detention
DOC Institutional MH Services	No		
DOC CRC MH Services	No		
SENIOR SERVICES			
Geriatric Mental Health Program or Outreach	No		
Adult Day Services	No		
Respite Services	Yes	Kotzebue	

Service type	Yes/No	Extent/location	Comments
STAFFING			
Numbers of Grant Funded FTEs and of Total FTEs	14.0 FTE	18.0 FTE total	5.5 FTE-state & local, 1.5 FTE-IHS, 8.0 FTE DD and local funds
Number of Psychiatrist FTEs	Yes	0.1	contracted for clinics held in Kotzebue
Child Interagency Team	Yes		Meet monthly
Mobile Crisis/Respite Team	No		Utilize present staff
Itinerant contract Psychiatrist	Yes		bi-monthly clinics in Kotzebue
Tribal, Health Corp., Local Gov't Behavioral Aides	N/R		
Rural Human Services Workers	Yes		Ambler, Buckland, Deering, Kiana, Kivalina, Kobuk, Noorvik, Noatak, Shungnak, Selawik
TRANSPORTATION			
Public Transportation	Yes	Kotzebue	
Coordinated Human Services Transportation	No		
Dedicated Transportation for Mentally Ill	No		

Service Area 3: Norton Sound	**1997 Population: 9,178**	**Area: 28,276 sq. miles**	**DMHDD Grantees: Norton Sound Community Mental Health, Nome Receiving Home**
Service type	**Yes/No**	**Extent/location**	**Comments**
EMERGENCY SERVICES			
Crisis/Respite	No		
Acute Care Hospital	Yes	Nome-19 acute, 15 LTC	
Acute Care Hospital - evaluation	Yes	Part-time	
Acute Care Hospital - treatment	No		
CMHC Emergency Services	Yes		Regionwide 800 #
Detox Facility	No	Nome	Closed
Suicide Prevention Grants	Yes	Brevig Mission, Wales, Elim, Koyuk, Golovin,	Gambell, Shishmaref, Diomede, Savoonga, St. Michael, Shaktoolik, Stebbins, White Mountain.
CHILDREN AND YOUTH SERVICES			
DFYS Residential	Yes	Nome - 5	Receiving home - temporary placement
Day Treatment	No		
DFYS Family Centered Srvcs	Yes	Nome Community Center	
Therapeutic Foster Homes	No		
AYI	Yes	Nome	Nome Receiving Home
Outreach to Homeless Youth	N/R		
Abuse, Neglect, Dom. Violence Program/Outreach	N/R		
DMHDD SED Grant	No		
Residential Diagnostic and Treatment Center	No		
Peer Helper Program	Yes	Nome High School	
Other School-based Mental Health Services	No		

Service type	Yes/No	Extent/location	Comments
ADULT SERVICES			
DFYS Adult Foster Homes	No		
Residential	No		
CSP-Day Treatment	No		
CSP-Vocational Rehab, Training, or Work Supports	No		
CSP-Supervised Apts	No	3	SMI live-in supervised apts
CSP-Group Homes	No		
Homeless Shelter or Outreach	N/R		
CSP-Board & Care Homes	No		
GMH - Outpatient	Yes	?	
GMH Itinerant Outpatient	Yes	?	Regular schedule
FORENSIC SERVICES			
MIO Transitional Housing	No		
Community Holding Facility or Jail	No		
DOC Institutional MH Services	Yes	Nome	Anvil Mountain
DOC CRC MH Services	No		
SENIOR SERVICES			
Geriatric Mental Health Program or Outreach	No		
Adult Day Services	Yes	Nome	
Respite Services	Yes	Gambell, Wales, Savoonga,	Unalakleet, St. Michael, Shaktoolik

Service type	Yes/No	Extent/location	Comments
STAFFING			
Numbers of Grant Funded FTEs and of Total FTEs	3	8 FTE (est.)	FY 95
Number of Psychiatrist FTEs	Yes	1 Nome	
Child Interagency Team	Yes		Non-operational
Mobile Crisis/Respite Team	No		
Itinerant PHS Psychiatrist	No		
Tribal, Health Corp., Local Gov't Behavioral Aides	No		
Rural Human Services Workers	N/R		
TRANSPORTATION			
Public Transportation	No		
Coordinated Human Services Transportation	No		
Dedicated Transportation for Mentally Ill	No		

Service Area 4: Interior	**1997 Population: 96,876**	**Area: 201,219 sq. mi.**	**DMHDD Grantees: TCC, Yukon Tanana, Yukon Flats, Yukon Koyukuk, Fbks CMHC, Tok, Railbelt, 4 Rivers, FCSA**
Service type	**Yes/No**	**Extent/location**	**Comments**
EMERGENCY SERVICES			
Crisis/Respite	Yes	Fbks - 5, TCC - 8	4 Rivers has services, but no beds
Acute Care Hospital	Yes	FMH - 166, Bassett Army - 80	
Acute Care Hospital - evaluation	Yes	FMH	
Acute Care Hospital - treatment	Yes	FMH	not paid for by DMHDD
CMHC Emergency Services	Yes	Frbks, Railbelt, Yukon -Tanana,	4 Rivers, Yukon Flats. 800 # most villages, except Yukon-Koyukuk
Detox Facility	Yes	Fbks	FMH, FNA, RCAOA
Suicide Prevention Grants	Yes	Allakaket, Hughes, Anderson, Huslia	Koyukuk, Nulato, Nenana, Ruby, Ft. Yukon
CHILDREN AND YOUTH SERVICES			
DFYS Residential	Yes	Fbks - 15 beds	Hospitality House - in 3 units
Day Treatment (Youth Educ. Support Srvcs.)	Yes	Fbks - FCSA	15 SED youth
DFYS Family Centered Srvcs	Yes	Fbks	FCA, FNA, RCPC
Therapeutic Foster Homes	Yes	FCMHC - 10; FCSA-17; Private - 10	FCSA + AYI youth
AYI & Rural Initiative	Yes	Fbks-FCSA	Plus rural initiative
Outreach to Homeless Youth	N/R		
Abuse, Neglect, Domestic Violence Program/Outreach	Yes		Yukon-Koyukuk, TCC Family Services
DMHDD SED Grant	Yes	Galena - $2,800; FRA - $91,600; FMH - $982,400	FCSA-$181,900, Tok - $31,100, 4 Rvrs-$49,700; Railbelt-$51,600
Residential Diagnostic and Treatment Center	No		
Peer Helper Program	Yes	Fbks-2, Delta Jct.	Ft. Yukon, Tok (private funded)

Service type	Yes/No	Extent/location	Comments
Other School-based Mental Health Services	Yes	RMHA, FCSA	Yukon-Koyukuk, Yukon Flats School District, Nenana, Cantwell, Anderson, Healy; FCSATIC Brown pilot prj., YESS & FNSBSD
emergency crisis/respite & planned respite	Yes	Frbks-FCSA	AYI & Pathfinder FCSA's consumers & families
MH & DD dual diagnosis	Yes	Frbks FCSA, FRA, FCMHC	Young adult transition project
ADULT SERVICES			
Adult Foster Homes	Yes	Fbks 2, 11 elsewhere	
Residential	Yes	3	
CSP-Day Treatment	Yes	Fbks	FCMHC "Clubhouse" model
CSP-Vocational Rehab, Training, or Work Support	Yes	Fbks	FCMHC
CSP-Supervised Apts	Yes	Fbks 41	FCMHC
Homeless Shelter or Outreach	N/R		FCMHC
CSP-Group Homes	Yes	Denardo Ctr-9 beds, Paul Williams House-6	
CSP-Board & Care Homes	No		
GMH - Outpatient	Yes	Tok-$1,400; Nenana $1,200;	4 Rivers-$1,500; Yukon Yoyukuk-$4,600; Yukon Flats/Ft. Yukon
GMH Itinerant Outpatient	Yes	McGrath, Railbelt, Tok, Ft. Yukon,	Galena. Each covers some or all villages.
FORENSIC SERVICES			
MIO Transitional Housing	No		
Community Holding Facility or Jail	No		
DOC Institutional MH Services	Yes	Fbks CC	
DOC CRC MH Services	Yes	Fbks - Northstar Ctr - 99 beds	

Service type	Yes/No	Extent/location	Comments
SENIOR SERVICES			
Geriatric Mental Health Program or Outreach	No		
Adult Day Services	Yes	Fbks - 43 served	
Respite Services	Yes	Fbks, Delta, Minto, Ft. Yukon,	Northway, Nenana, Alatna
STAFFING			
Numbers of Grant Funded FTEs and of Total FTEs	Yes	FCMHC-76.36, 4 Rvrs-4.5, Tok-2, Tanana-4.2; Paul Williams House 4.1; Y-T 4.2;	TCC Counseling Center 4; Railbelt-2, Galena-9, Ft. Yukon 2 st. funded & 3 IHS, Yukon FCSA-138 FTE (125 Medicaid funded) ALL TOTALS
Number of Psychiatrist FTEs	Yes	Tok 2 days/6 wks, FCMHC-2.0 + 1.0 ANP, Rlbelt-12 visit/yr, FCSA-1	TCC-3 contract(3days/wk in Fbks &3 wks/qtr. in villages, McGrath-1day/qrtr. None Y-K; FNA 2/mo.
Child Interagency Team	Yes	Y-Koyukuk	
Mobile Crisis/Respite Team	Yes	Frbks-AYI/Pathfinders	FCSA consumers & families (3 FTE)
Itinerant PHS Psychiatrist	No		Ft. Yukon, Yukon Flats, Venetie: 1 day/quarter
Tribal, Health Corp., Local Gov't Behavioral Aides	Yes	McGrath-2/8 villages, Ft. Yukon - 3/8 villages,	Yukon Tanana-3/10 villages,
Rural Human Services Workers	Yes		Galena-5/6 villages
TRANSPORTATION			
Public Transportation	Yes/No		Fairbanks/villages. Tok: 2/wk to Frbks. & Anch.
Coordinated Human Services Transportation	Yes/No		Fairbanks/villages
Dedicated Transportation for Mentally Ill	Yes/No		Fairbanks/villages

Service Area 5: Yukon Kuskokwim	**1997 Population: 22,507**	**Area: 62,796 sq. miles**	**DMHDD Grantees: YKHC, KNA Community Counseling Center, Bethel Community Services, Asa'carsarmiut Tribal Council**
Service type	**Yes/No**	**Extent/location**	**Comments**
EMERGENCY SERVICES			
Crisis/Respite	Yes	Bethel - 7 beds	BCS Camai House- 6; YKHC CRC-6
Acute Care Hospital	Yes	Bethel-51 beds	
Acute Care Hospital - evaluation	Yes	Bethel - 1	
Acute Care Hospital - treatment	No		
CMHC Emergency Services	Yes	YKHC	Areawide 800/478-2642
Detox Facility	No		
Suicide Prevention Grants	Yes	Eek, St. Mary's, Aniak, Alakanuk, Kwethluk, Kotlik,	Toksook Bay, Emmonak, Lower Kalskag, Chefornak, Tuntutuliak, Russian Mission, Chuathbaluk
CHILDREN AND YOUTH SERVICES			
DFYS Residential	Yes	Bethel - 13 beds	Bethel Group Home and AVCP
Day Treatment	No		
DFYS Family Centered Srvcs	Yes	Bethel	Orutsararmiut NC FS/FP
Therapeutic Foster Homes	No		
AYI	Yes	BCS - 5, Asa'carsamiut - 1	
Outreach to Homeless Youth	N/R		
Abuse, Neglect, Domestic Violence Program/Outreach	N/R		
DMHDD SED Grant	Yes	Aniak - $15,600; YKHC - $490,700	
Residential Diagnostic and Treatment Center	Yes	Bethel- 5 beds	YKHC

Service type	Yes/No	Extent/location	Comments
Peer Helper Program	Yes	KNA	
Other School-based Mental Health Services	No		
ADULT SERVICES			
DFYS Licensed Adult Foster Homes	No		
Residential	Yes	Bethel-42	Bautista House - 12
CSP-Day Treatment	Yes	Bethel	
CSP-Vocational Rehab, Training, or Work Supports	Yes	Bethel	
CSP-Supervised Apts	Yes	Bethel-12	YKHC (Delta Supportive Living)-5, Camai House - 8; YKHC Transitional Living-5
CSP-Group Homes	No		
Homeless Shelter or Outreach			
CSP-Board & Care Homes	No		See residential
GMH - Outpatient	Yes	Aniak-$1,300	
GMH Itinerant Outpatient	No		Not regular-see psychiatrist
FORENSIC SERVICES			
MIO Transitional Housing	No		
Community Holding Facility or Jail	Yes		
DOC Institutional MH Services	Yes	YKCC	
DOC CRC MH Services	Yes	Bethel - 85 beds	YKCC
ELDERLY SERVICES			
Geriatric Mental Health Program or Outreach	Yes (?)	Bethel	2 elder counselors
Adult Day Services	Yes	Bethel	
Respite Services	No		

Service type	Yes/No	Extent/location	Comments
STAFFING			
Numbers of Grant Funded FTEs and of Total FTEs	Yes	24.6	BCS-3.8
Number of Psychiatrist FTEs	Yes	Bethel - .5, Aniak - qtrly	Dr. Ondige (BCS 6 times/year, YKHC 6x/yr);Dr.Huffman YKHC FT; Dr. Jackman YKHC 4 clinics; Aniak-Dr. Huffman
Child Interagency Team	Yes	Bethel, Aniak	Bethel- also for adults; Aniak has child protection team
Mobile Crisis/Respite Team	No		
Itinerant PHS Psychiatrist	Yes	Bethel	Quarterly visits to 10 villages
Tribal, Health Corp., Local Gov't Behavioral Aides	No		
Rural Human Services Workers	Yes		
TRANSPORTATION			
Public Transportation	No		
Coordinated Human Services Transportation	No		
Dedicated Transportation for Mentally Ill	No		

Service Area 6/7: Southcentral	**1997 Population: 307,307**	**22,450 sq. miles**	**DMHDD Grantees: Life Quest, ACF, Southcentral Counseling Center, Southcentral Foundation, ASETS, ARC of Anch., ACS, AYPF, Alternatives, Hope Cottages, Daybreak, SELS**
Service type	**Yes/No**	**Extent/location**	**Comments**
EMERGENCY SERVICES			
Crisis/Respite	Yes	SCC - 8, ARC - 1, Wasilla-10(adult)	
Acute Care Hospital	Yes	Prov.-303 acute AK Reg.-238 acute	Valley-36 acute, 4 swing ANMC-170 acute
Acute Care Hospital - evaluation	Yes	Providence	
Acute Care Hospital - treatment	Yes	Providence	
CMHC Emergency Services	yes	SCC; Alternatives	SCC:24 hour mobile assessment; SCF: day time on-call.
Detox Facility	Yes	Anchorage, Wasilla - 2 beds (Nugen's)	
Suicide Prevention Grants	No		
CHILDREN AND YOUTH SERVICES			
DFYS Residential	Yes	Anchorage - 83 MatSu - 7	
Day Treatment	Yes	Anchorage - 13, Life Quest- 60, ACF 12, Alternatives-45	Life Quest - Early childhood, children & adolescent programs
DFYS Family Centered Services	Yes	ACF, Booth, AYPF, SCF, Valley WRC	Family Support/Family Preservation
Therapeutic Foster Homes	Yes	ACS-12; ARC-12; ASETS-17 Private-6	MatSu through AYI; SCF - 2 (teen sex offender)
AYI	Yes	MatSu, ASETS, ARC, ACS, AYPF,	SELS, Alternatives, LifeQuest, Hope Cottages
Outreach to Homeless Youth	Yes	Anchorage	ACF-homeless; AYPF peer counselors-HIV/AIDS & fam. plan.
Abuse, Neglect, Domestic Violence Program/Outreach		ACF; SCF	SCF: prevention & outreach

Service type	Yes/No	Extent/location	Comments
DMHDD SED Grant	Yes	SCC - $832,200; SCF - $40,000	ACF - $293,700; LifeQuest - $378,143
Residential Diagnostic and Treatment Center	Yes	ACS-6	
Peer Helper Program	Yes	Wasilla	
Other School-based Mental Health Services	Yes	Wasilla	Alternative Placement
ADULT SERVICES			
DFYS Adult Foster Homes	Yes	Anchorage-2, MatSu-1	Eagle River - 1 ASETS also
Residential	Yes	ARC-10, SCC-118	Private apts - Sect 8 public housing. I client home
CSP-Day Treatment	Yes	SCF Clubhouse. LifeQuest	Psychosocial Rehabilitation. Case management.
CSP-Vocational Rehab, Training, or Work Supports	Yes	LifeQuest, SCC; ASETS-29	Psychosocial rehab also - SCC
CSP-Supervised Apts	Yes	SCC-64; ASETS-3; ARC-6; LifeQuest-39	MH Housing pgm - 15, ASETS also
CSP-Group Homes	Yes	ARC - 6	MH Housing pgm; SMI/sub. abuse
Homeless Shelter or Outreach	Yes	Anch: Crossover House; ASETS-7	
CSP-Board & Care Homes	Yes	Anchorage - 105; LifeQuest - 15; ASETS -12	ASETS - assisted living
GMH - Outpatient	Yes	LifeQuest-$28,200; SCC - $384,700; SCF	
GMH Itinerant Outpatient	No		
FORENSIC SERVICES			
MIO Transitional Housing	Yes	SCF; SCC-25	SCC - IDP+; SCF-$180,000 for CMI transitional living thru IDP+
Community Holding Facility or Jail	No		
DOC Institutional MH Services	Yes	CIPT, HMCC, PCC, MSPT, ACO, 6th Ave	
DOC CRC MH Services	Yes	Akeela - 17; Cordova Ctr - 178;	Glenwood - 90; Parkview - 112

Service type	Yes/No	Extent/location	Comments
SENIOR SERVICES			
Geriatric Mental Health Program or Outreach	Yes	Wasilla	
Adult Day Services	Yes	Anchorage - 96 served	
Respite Services	Yes	Anchorage, MatSu	
STAFFING			
Numbers of Grant Funded FTEs and of Total FTEs	Yes	SCC - 107 (184 Total) SCF-2.4 (24 total)	MatSu - 93.8 total, ACS - 125 total, ASETS - 69.5 total, ARCA-4.82, Alternatives+52 Total FTE
Number of Psychiatrist FTEs	Yes	SCC - 2.35, MatSu - 3, Alternatives-1; SCF-PT	SCC - 3.1 ANP's, as well as consultants; DFYS - contract for MYC and court
Child Interagency Team	Yes	MatSu; ACS	
Mobile Crisis/Respite Team	Yes	SCC	
Itinerant PHS Psychiatrist	No		
Tribal, Health Corp., Local Gov't Behavioral Aides	No		
Rural Human Services Workers	No		
TRANSPORTATION			
Public Transportation	Yes	Anchorage	
Coordinated Human Services Transportation	No		
Dedicated Transportation for Mentally Ill	No		

Service Area 8: Copper River	**1997 Population: 10,431**	**Area: 28,572 sq. miles**	**DMHDD Grantees: Cordova MHC, Valdez MHC, Copper River MHC, Mt. Sanford Tribal Consortium**
Service type	**Yes/No**	**Extent/location**	**Comments**
EMERGENCY SERVICES			
Crisis/Respite	Yes	Cordova	Crisis intervention
Acute Care Hospital	Yes	Cordova-13 acute, 10 LTC, 4 swing	Valdez - 15 acute, 4 swing
Acute Care Hospital - evaluation	No		
Acute Care Hospital - treatment	No		
CMHC Emergency Services	Yes		
Detox Facility	Yes	Cordova	Cordova Hospital
Suicide Prevention Grants	Yes	Tatitlek, Mentasta, Chistochina,	Kluutikaah
CHILDREN AND YOUTH SERVICES			
DFYS Residential	No		
Day Treatment	No		
DFYS Family Centered Srvcs	Yes	Copper Center, Valdez, Cordova	FS/FP
Therapeutic Foster Homes	No		
AYI	No		
Outreach to Homeless Youth	No		
Abuse, Neglect, Domestic Violence Program/Outreach	Yes	Cordova, Valdez	Cordova: Women's Support Grp Domestic Violence Batters' Txt Grp Valdez: Anger Mgmt.
DMHDD SED Grant	Yes	Copper Ctr-$5,700; Cordova - $13,600	
Residential Diagnostic and Treatment Center	No		

Service type	Yes/No	Extent/location	Comments
Peer Helper Program	Yes	Valdez	High school, junior high in 1995
Other School-based Mental Health Services	Yes	Valdez	Elem. Jr. HS counselor on site 20 hrs/wk (contract)
ADULT SERVICES			
DFYS Adult Foster Homes	No		
Residential	Yes	Valdez - 7	
CSP-Day Treatment	Yes		Copper River Voc Rehab thru MatSu & on site quarterly visits
CSP-Vocational Rehab, Training, or Work Supports	Yes		Copper River Voc Rehab thru MatSu & on site quarterly visits
CSP-Supervised Apts	No		
CSP-Group Homes	No		
Homeless Shelter or Outreach	N/R		
CSP-Board & Care Homes	No		
GMH - Outpatient	Yes		
GMH Itinerant Outpatient	Yes	Tatitlek & Chenega Bay fr. Cordova; Chugach - villages	Unknown frequency or number; Provides to all region
FORENSIC SERVICES			
MIO Transitional Housing	No		
Community Holding Facility or Jail	Yes	Cordova, Valdez	Cordova - 7 days; Valdez - 30. Glennallen AST for Copper River
DOC Institutional MH Services	No		
DOC CRC MH Services	No		
SENIOR SERVICES			
Geriatric Mental Health Program or Outreach	Yes	Cordova, Valdez	Cordova: Senior Specialist. Valdez: serve swing bed patients
Adult Day Services	No		
Respite Services	No		

Service type	Yes/No	Extent/location	Comments
STAFFING			
Numbers of Grant Funded FTEs and of Total FTEs	Yes	Cordova-3.70 total Valdez-2.95 total; CRNA-2.5	
Number of Psychiatrist FTEs	Yes	Cordova, Valdez - 12 visit/yr	Contract with Langdon; Copper River contract with Dr. Pollock
Child Interagency Team	Yes		Cordova Child Abuse Response Team
Mobile Crisis/Respite Team	No		
Itinerant PHS Psychiatrist	No (?)		
Tribal, Health Corp. , Local Gov't Behavioral Aides	Yes	Copper Center	
Rural Human Services Workers	Yes	Copper River	1.5 FTE
TRANSPORTATION			
Public Transportation	No		
Coordinated Human Services Transportation	Yes	Copper River	
Dedicated Transportation for Mentally Ill	Yes	Copper River	

Service Area 9: Bristol Bay	**1997 Population: 7,571**	**Area: 40,101 sq. miles**	**DMHDD Grantees: BBAHC**
Service type	**Yes/No**	**Extent/location**	**Comments**
EMERGENCY SERVICES			
Crisis/Respite	Yes	Dillingham - 6 beds	Our House crisis/respite
Acute Care Hospital	Yes	Dillingham-10 acute	
Acute Care Hospital - evaluation	No		Evaluation designation pending
Acute Care Hospital - treatment	No		
CMHC Emergency Services	Yes		800 # during working hours; 24 hr dispatch thru DLG Police Dept.
Detox Facility	No		
Suicide Prevention Grants	Yes	Igiugig, Iliamna, Levelock,	So. Naknek, Newhalen, New Stuyahok, Nondalton, King Salmon, Naknek
CHILDREN AND YOUTH SERVICES			
DFYS Residential	No		
Day Treatment	No		
DFYS Family Centered Srvcs	Yes	Dillingham, King Salmon	Family Services and Youth Services offices.
Therapeutic Foster Homes	Yes		
AYI	Yes	Bristol Bay	Designated AYI provider but no funds allocated
Outreach to Homeless Youth	N/A		Would offer if requested or need identified
Abuse, Neglect, Domestic Violence Program/Outreach	Yes	Dillingham	Regional services provided by S.A.F.E
DMHDD SED Grant	Yes	$17,500	FY 98
Residential Diagnostic and Treatment Center	Yes	Dillingham	BBAHC Jake's Place
Peer Helper Program	Yes	5 school districts	13 programs
Other School-based Mental Health Services	Yes	BB Borough, Togiak, Chignik Lake, Dillingham,	Goodnews Bay, Levelock, Manokotak, Newhalen, New Stuyahok, Nondalton, Perryville

Service type	Yes/No	Extent/location	Comments
ADULT SERVICES			
DFYS Adult Foster Homes	No		
Residential	No		
CSP-Day Treatment	No		
CSP-Vocational Rehab, Training, or Work Supports	No		
CSP-Supervised Apts	No		
CSP-Group Homes	No		
Homeless Shelter or Outreach	No		
CSP-Board & Care Homes	No		
GMH - Outpatient	Yes	$4,300	FY 98
GMH Itinerant Outpatient	Yes	4-6 visits per year each of 32 villages	Minimum number of visits
FORENSIC SERVICES			
MIO Transitional Housing	No		
Community Holding Facility or Jail	Yes	Dillingham - 8, Bristol Bay - 4	Dillingham - 20 days detention, Bristol Bay - 15 days
DOC Institutional MH Services	No		
DOC CRC MH Services	No		
SENIOR SERVICES			
Geriatric Mental Health Program or Outreach	No		
Adult Day Services	No		
Respite Services	Yes	Chignik Bay, Naknek, Iliamna, Tuluksak,	Dillingham, Manokotak, New Stuyahok, Nondalton, Port Heiden, Togiak

Service type	Yes/No	Extent/location	Comments
STAFFING			
Numbers of Grant Funded FTEs and of Total FTEs	Yes	27.0 FTE TOTAL	6.8 state grant funded
Number of Psychiatrist FTEs	Yes	.05 FTE	Contract - 4 visits per year
Child Interagency Team	No		
Mobile Crisis/Respite Team	No		
Itinerant PHS Psychiatrist	No		Provided through ANMC
Tribal, Health Corp., or Local Gov't Behavioral Aides	Yes	27 Children's Services Workers	BBNA - Tribal - regionwide
Rural Human Services Workers	Yes	11- Togiak, Pilot Pt., Goodnews Bay, Ekwok, Nondalton	Manokotak, Kokhanok, Chignik Bay, Port Heiden (2 sites undetermined)
TRANSPORTATION			
Public Transportation	No		
Coordinated Human Services Transportation	No		
Dedicated Transportation for Mentally Ill	Yes	Our House	while in residence

Service Area 10: Kenai Peninsula	**1997 Population: 48,098**	**Area: Approx. 25,000 sq. miles**	**DMHDD Grantees: South Peninsula MHC, Seward Life Action Council, Central Peninsula MHC, Kenai Community Care Center**
Service type	**Yes/No**	**Extent/location**	**Comments**
EMERGENCY SERVICES			
Crisis/Respite	Yes	Homer-2, Kenai-4	no longer available in Seward
Acute Care Hospital	Yes	So. Penin.-20 acute, 18 LTC,	Seward-4 acute, 2 swing, Cent. Pen. -46 acute, 16 ch dep, 4 swing
Acute Care Hospital - evaluation	Yes	Kenai, Homer	
Acute Care Hospital - treatment	No		
CMHC Emergency Services	Yes	SPH, Homer jail, Homer CMHC,Seward	Seward 24 hr crisis line by multi-service staff
Detox Facility	No		
Suicide Prevention Grants	No		
CHILDREN AND YOUTH SERVICES			
DFYS Residential	Yes	Kenai Care Center-15 beds	5 emergency, 5 sex offender, 5 community care
Day Treatment	No		
DFYS Family Centered Srvcs	Yes	Kenai, Seward	FS/FP
Therapeutic Foster Homes	Yes	Homer	
AYI	Yes	Kenai-2, Homer-1	
Outreach to Homeless Youth	N/R		
Abuse, Neglect, Domestic Violence Program/Outreach	Yes	Homer, Seward	Seward: SLAC
DMHDD SED Grant	Yes	Homer $95,4000; Kenai-$176,500	$0 Seward
Residential Diagnostic and Treatment Center	No		

Service type	Yes/No	Extent/location	Comments
Peer Helper Program	No		
Other School-based Mental Health Services	Yes	Homer	
ADULT SERVICES			
DFYS Adult Foster Homes	Yes	Homer-1, Kenai-5	
Residential	Yes	Private apt (T27): Homer-9, Kenai-5	Public Housing (T20): Homer 6, Seward-1, Kenai-1
CSP-Day Treatment	No		
CSP-Vocational Rehab, Training, or Work Supports	Yes	Kenai, Homer	
CSP-Supervised Apts	Yes	Homer-13, Kenai-30, Seward-4	
CSP-Group Homes	Yes	Seward-5, Homer 1	
Homeless Shelter or Outreach	N/R		
CSP-Board & Care Homes	No		
GMH - Outpatient	Yes	Homer, Kenai, Seward	
GMH Itinerant Outpatient	Yes	Homer	
FORENSIC SERVICES			
MIO Transitional Housing	No		
Community Holding Facility or Jail	Yes	Seward - 14 beds, Homer - 7 beds	Seward - 30 days detention; Homer - 10 days
DOC Institutional MH Services	Yes	Seward, Kenai	SPCC, WCC, & WPTF
DOC CRC MH Services	No		
SENIOR SERVICES			
Geriatric Mental Health Program or Outreach	Yes	CPC- 1 clinician	
Adult Day Services	Yes	Kenai, Homer	
Respite Services	Yes	Anchor Point, Clam Gulch, Kenai	Homer Ninilchik, Port Graham, Seward

Service type	Yes/No	Extent/location	Comments
STAFFING			
Numbers of Grant Funded FTEs and of Total FTEs	Yes	Seward-4.7, Homer-33, Kenai-31.8	Seward+10.8 all FTE
Number of Psychiatrist FTEs	Yes	Homer 2/5 T	
Child Interagency Team	Yes	Seward, Homer, Kenai	
Mobile Crisis/Respite Team	No		
Itinerant PHS Psychiatrist	No		
Tribal, Health Corp., Local Gov't Behavioral Aides	No		
Rural Human Services Workers	No		
TRANSPORTATION			
Public Transportation	No		
Coordinated Human Services Transportation	No		
Dedicated Transportation for Mentally Ill	No		

Service Area 11: Kodiak	**1997 Population: 13,547**	**Area: 7,156 sq. miles**	**DMHDD Grantees: Kodiak Borough MHC**
Service type	**Yes/No**	**Extent/location**	**Comments**
EMERGENCY SERVICES			
Crisis/Respite	No		Closed due to lack of funding
Acute Care Hospital	Yes	25 acute, 19 LT, 4 swing	
Acute Care Hospital - evaluation	Yes		72 hour evaluation
Acute Care Hospital - treatment	No		
CMHC Emergency Services	No		
Detox Facility	Yes	Kodiak	Kodiak Island Hospital-PRN (detox closed in 1993)
Suicide Prevention Grants	Yes	Larson Bay, Port Lions, Old Harbor,	Ouzinkie
CHILDREN AND YOUTH SERVICES			
DFYS Residential	No		Closed in 1996
Day Treatment	No		
DFYS Family Centered Srvcs	Yes	Kodiak	Family Service & Youth Service office, little foster placement
Therapeutic Foster Homes	No		
AYI	Yes	KIB	1 served, lack funds for others
Homeless Youth Outreach	No		
Abuse, Neglect, Domestic Violence Program/Outreach	Yes		Kodiak Women's Resource Center
DMHDD SED Grant	Yes	Kodiak-$56,600	
Residential Diagnostic and Treatment Center	No		
Peer Helper Program	No		
Other School-based Mental Health Services	Yes		MHC=3.0 FTE in school, others from school district

Service type	Yes/No	Extent/location	Comments
ADULT SERVICES			
DFYS Adult Foster Homes	No		
Residential	Yes	Kodiak-9	Transitional housing apartments
CSP-Day Treatment	No		
CSP-Vocational Rehab, Training, or Work Supports	No		
CSP-Supervised Apts	Yes	Kodiak-9	
CSP-Group Homes	No		
Homeless Shelter or Outreach	Yes		2 evenings/week at Brother Francis Shelter
CSP-Board & Care Homes	No		
GMH - Outpatient	Yes		
GMH Itinerant Outpatient	Yes		
FORENSIC SERVICES			
MIO Transitional Housing	No		
Community Holding Facility or Jail	Yes	Kodiak - 16 beds	10 days detention
DOC Institutional MH Services	No		
DOC CRC MH Services	No		
SENIOR SERVICES			
Geriatric Mental Health Program or Outreach	No		
Adult Day Services	No		
Respite Services	No		

Service type	Yes/No	Extent/location	Comments
STAFFING			
Numbers of Grant Funded FTEs and of Total FTEs	Yes	Kodiak -15	10.5 at center
Number of Psychiatrist FTEs	Yes	1	
Child Interagency Team	Yes	Kodiak - 4.5 FTE	Staff in schools
Mobile Crisis/Respite Team	No		
Itinerant PHS Psychiatrist	No		
Tribal, Health Corp., Local Gov't Behavioral Aides	Yes	Number unknown-Villages	Kodiak Area Native Association has mental health aides in villages
Rural Human Services Workers	Yes		Kodiak Area Native Assoc. has CHA and CHR
TRANSPORTATION			
Public Transportation	No (?)		Projected for 1/98
Coordinated Human Services Transportation	No		
Dedicated Transportation for Mentally Ill	No		

Service Area 12/13/14: Southeast	**1997 Population: 74,217**	**Area: 34,936 sq. miles**	**DMHDD Grantees: Wrangell MHC, JCMHC, JAMI, JYS, Sitka MHC, SEARHC, COHO MHS, Gateway, LCCC, Comm. Connections, Petersburg MHC**
Service type	**Yes/No**	**Extent/location**	**Comments**
EMERGENCY SERVICES			
Crisis/Respite	Yes	Juneau - 5 beds Ketchikan - 2 beds	JAMI - 5 crisis/respite & transitional beds
Acute Care Hospital	Yes	Bartlett -51, Ketchikan - 46 acute, 46 LTC, Mt. Edgecumbe - 178	Wrangell - 9 acute, 14 LTC, 4 swing, Petersburg - 11 acute, 14 LTC, 4 swing, Sitka Comm - 24 acute, 25 swing
Acute Care Hospital - evaluation	Yes	Bartlett, Ketchikan, Sitka, Mt. Edgecumbe	Not paid by DMHDD
Acute Care Hospital - treatment	Yes	Bartlett, Mt. Edgecumbe	Bartlett not paid by DMHDD
CMHC Emergency Services	Yes	Ketchikan, Sitka	Kkn:24 hr. availability
Detox Facility	Yes	Ketchikan, Juneau	
Suicide Prevention Grants	Yes	Hoonah, Kake, Angoon, Saxman,	Yakutat
CHILDREN AND YOUTH SERVICES			
DFYS Residential	Yes	Juneau -20; Sitka - 6: Ketchikan - 11	Juneau includes 5 emergency & 5 sex offender, Kkn - 5 emergency
Day Treatment	Yes	Juneau	50 slots
DFYS Family Centered Srvcs	Yes	Juneau, Ketchikan, Sitka, Wrangell	FS/FP
Therapeutic Foster Homes	Yes	Juneau - 4 beds	
AYI	Yes	Ketchikan, Sitka, Juneau	
Outreach to Homeless Youth	No		
Abuse, Neglect, Domestic Violence Program/Outreach	Yes	Region	Women in Safe Homes (WISH) shelter & outreach; SAFV
DMHDD SED Grant	Yes	CBJ - $157,200; JYS - $241,100; COHO - $31,600	Petersburg - $33,800; Wrangell $31,900; Sitka - $19,300; Ketchikan - $258,900

Service type	Yes/No	Extent/location	Comments
Residential Diagnostic and Treatment Center	No		
Peer Helper Program	Yes	Sitka, Wrangell, COHO*, Ketchikan	*Selected villages on POW Island
Other School-based Mental Health Services	Yes	Sitka, Ketchikan, SEARHC*	Sitka - SMHC; *Angoon, Haines, Kake, Hydaburg, Klawock, Klukwan. Ketchikan HS students are "special friends" to elementary pupils.
ADULT SERVICES			
DFYS Adult Foster Homes	Yes	Juneau - 7 (?)	
Residential	Yes	JAMI-4, CBJ-29	All in own homes. JAMI - 9 in public housing
CSP-Day Treatment	Yes	JAMI, Sitka	
CSP-Vocational Rehab, Training, or Work Supports	Yes	Ketchikan, JAMI, Wrangell	
CSP-Supervised Apts	Yes	Jnu-87, Sitka-5 beds, Ketchikan-3	Ketchikan - 2 semi-supervised rooms in house w/respite beds
CSP-Group Homes	Yes	Jnu - 8, Sitka-3	
Homeless Shelter or Outreach	Yes	Ketchikan	
CSP-Board & Care Homes	No		
GMH - Outpatient	Yes	COHO - $1,700, LCCC - $13,000, CBJ - $69,700	Ketchikan - $102,200, Petersburg - $3,900, Sitka - $3,100, Wrangell - $4,900
GMH Itinerant Outpatient	Yes	Hollis, Thorne Bay, Hydaburg,	SEARHC (selected villages), COHO, Ketchikan, Klawock
FORENSIC SERVICES			
MIO Transitional Housing	No		
Community Holding Facility or Jail	Yes	Sitka, Haines, Petersburg, Craig, Wrangell	Craig & Petersburg - 15 days; Haines - 14; Sitka - 10, Wrangell - 30
DOC Institutional MH Services	Yes	Juneau, Ketchikan	
DOC CRC MH Services	Yes	Juneau - 60	

Service type	Yes/No	Extent/location	Comments
SENIOR SERVICES			
Geriatric Mental Health Program or Outreach	Yes	Ketchikan - 1 PT	Jnu-1 clinician supporting peer counselors. Ketchikan. consult to Pioneers Home
Adult Day Services	Yes	Juneau, Ketchikan	
Respite Services	Yes	Craig, Haines, Hoonah, Sitka, Juneau, Kake,	Ketchikan, Klawock, Metlakatla, Petersburg, Saxman, Wrangell, Hydaburg
STAFFING			
Numbers of Grant Funded FTEs and of Total FTEs	Yes	CBJ-25.16, LCC - 3, Wrangell - 3.25, Sitka -8	Petersburg - 2, COHO - 3.2, Ketchikan - 20, JAMI - 26, JYS - 23.25,
Number of Psychiatrist FTEs	Yes	Bartlett-2, CBJ-.5, JYS-1, JAMI-1, SEARHC-3	Wrangell-qtrly, COHO-bimonthly, Petersburg-quarterly, Ketchikan-7 days/mon
Child Interagency Team	Yes	Juneau, Sitka, Ketchikan	
Mobile Crisis/Respite Team	No		
Itinerant PHS Psychiatrist	No		
Tribal, Health Corp., or Local Gov't Behavioral Aides	Yes	Angoon 2; Haines 2; Hydaburg 1; Kake 1; Klawock 1; Klukwan 1/2	SEARHC
Rural Human Services Workers	No		
TRANSPORTATION			
Public Transportation	Yes	Ketchikan, Juneau	
Coordinated Human Services Transportation	No		
Dedicated Transportation for Mentally Ill	Yes	Sitka	thru CSP at SMHC

Service Area 15: Aleutians	**1997 Population: 7,604**	**Area: 11,137 sq. miles**	**DMHDD Grantees: Eastern Aleutians Tribes MHC, Illiulak MHC**
Service type	**Yes/No**	**Extent/location**	**Comments**
EMERGENCY SERVICES			
Crisis/Respite	Yes	Cold Bay, Akutan, King Cove, Sand Pt., Unalaska	No respite capacity
Acute Care Hospital	No		
Acute Care Hospital - evaluation	No		
Acute Care Hospital - treatment	No		Emergency evaluations for hospital
CMHC emergency services	Yes	Unalaska-24 hr. on call MH professional	Regionwide 800 #
Detox Facility	No		
Suicide Prevention Grants	Yes	Akutan, False Pass, St. Paul	Managed by APIA, Managed by tribal council
CHILDREN AND YOUTH SERVICES			
DFYS Residential	No		
Day Treatment	No		
DFYS Family Centered Srvcs	Yes	St. Paul & Unalaska	Family & Youth itinerant service - Naknek & Dillingham.
Therapeutic Foster Homes	n/a		
AYI	n/a		
Outreach to Homeless Youth	no		
Abuse, Neglect, Dom. Violence Program/Outreach	Yes	Victim shelter also	Managed by Unalaskans Against Family Violence & Sexual Assault
DMHDD SED Grant	Yes/No	Iliuliuk-$16,700, EA-$33,900	Funds not available for Unalaska
Residential Diagnostic and Treatment Center	No		
Peer Helper Program	Yes		
Other School-based Mental Health Services	No		

Service type	Yes/No	Extent/location	Comments
ADULT SERVICES			
DFYS Adult Foster Homes	No		
Residential	No		
CSP-Day Treatment	No		
CSP-Vocational rehab, training, or work supports	No (?)		Service unofficially available
CSP-Supervised Apts	No		
CSP-Group Homes	No		
Homeless Shelter or Outreach	No		
CSP-Board & Care Homes	No		
GMH - Outpatient	Yes		Very limited
GMH Itinerant Outpatient	Yes	Nelson Lgn & False Pass-2/mon, St. George-1 wk/mon	Unalaska & St. Paul, regular schedule. Atka & Nikolski 4x/yr. All others on regular schedule
FORENSIC SERVICES			
MIO Transitional Housing	No		
Community Holding Facility or Jail	Yes	Unalaska - 10 beds	30 day detention limit
DOC Institutional MH Services	No		
DOC CRC MH Services	No		
SENIOR SERVICES			
Geriatric Mental Health Program or Outreach	Yes		Unalaska has no funding but provides outreach
Adult Day Services	No		
Respite Services	No		

Service type	Yes/No	Extent/location	Comments
STAFFING			
Numbers of Grant Funded FTEs and of Total FTEs	Yes	AW-4.25, EA-4.90	Total
Number of Psychiatrist FTEs	Yes	AW - .40, EA - .40	
Child Interagency Team	No		
Mobile Crisis/Respite Team	No		
Tribal, Health Corp. or Local Gov't Behavioral Aides	No		
Rural Human Services Workers	No		
Itinerant PHS Psychiatrist	?		
TRANSPORTATION			
Public Transportation	No		
Coordinated Human Services Transportation	No		
Dedicated Transportation for Mentally Ill	No		

CHILDREN AND YOUTH SERVICES

Introduction

Facts About Children and Youth and Mental and Emotional Disorders

- Mental illness affects one in every five young people at any given time. To reduce the risk for developing disabilities, all these children should be identified and receive the help they need to develop normally.
- One in ten Alaskan young people experience emotional problems so severe that their functioning is impaired.
- In 1992, an estimated two-thirds of Alaskan young people with mental health problems were not getting the help they needed.
- Many of the children under 18 with a serious emotional disturbance who receive mental health services may be receiving inappropriate services.
- Between 14,000 and 15,000 Alaskan young people experience serious emotional disorders, but only 5,500 receive treatment.
- Alaska has one of the highest rates of substantiated cases of child abuse and neglect in the nation.
- Alaska's teen suicide rate is the fourth highest in the nation.
- In the past ten years, arrests of Alaskan juveniles for violent crimes have increased 268 percent.

Members of the Alaska Mental Health Board, parents, advocates, providers and representatives of state agencies came together to write *A Shared Vision II*, Children and Youth Services section, with a sense of commitment and energy to produce a plan that not only provides philosophical guidance but actual strategies to achieve goals. Participants in this process acknowledge that to date we have not formed a unified vision of where we would like to be in five years; however, we are more aware of the steps we need to take to get there and are committed to expanding the system of care and improving and extending access for families and children to quality mental health care in Alaska.

Nationally, research into the causes and treatment of mental disorders has been advancing rapidly since 1980. These advances are attributed to

the synergy of multi-disciplinary research which has resulted in the rapid development of new research techniques and technologies. This research has produced a better understanding of the complex interaction between the brain, endocrine and immune systems and the complex role in brain development of interactions between genetics, the biological systems, behavior, and the environment. Biology modifies behavior and behavior modifies biology.

While a very complex series of interactions is involved in brain development and the development of mental disorders, this also opens many points at which interventions can interrupt the development of mental disorders. The Institute of Medicine recommends adopting risk reduction programs that include universal preventive interventions for the whole population, including preconception and prenatal care, immunizations, and protection from heavy metals and head injury; selective prevention interventions targeted to individuals or population subgroups whose risk of developing mental disorders is significantly higher than average (Headstart and Healthy Families, for example); and indicated preventive interventions targeted to high risk individuals who are identified as having minimal, but detectable, symptoms or biological markers. Alaska lacks well developed programs for universal and selective preventive interventions.

The American Academy of Child and Adolescent Psychiatry has age appropriate screening tools for use in schools for children age three to eighteen and guidelines for identifying infants and toddlers with mental health needs. Federal laws (Individuals with Disabilities Education Act) require schools to identify all students with mental disabilities and to encourage the treatment of infants and toddlers prior to occurrence of developmental delays. While risk reduction programs have proven cost effective, states need incentives to change their existing programs. To help pay for new programs, the federal share of Medicaid has been increased. The National Governor's Association co-sponsors the "I am Your Child" campaign to focus public attention on the importance of the early childhood years in reducing the risks of mental disorders. The challenge facing state agencies and planning boards is to translate the science of prevention into cost effective programs.

More effective tools are now available for early identification and treatment programs. The American Academy of Pediatrics has developed the DSM-PC to help family physicians and other primary care providers identify children who should be referred to professionals trained in the

diagnosis and treatment of childhood mental and emotional disorders. Additionally, age appropriate screening tools have been developed to help pre-school and school teachers and parents identify children who need further assessment by mental health professionals. Early intervention programs greatly improve outcomes for children. Of special note is the progress reported in reducing life-long disabilities among people who are treated for schizophrenia within six months of onset.

The federal Center for Mental Health Services (CMHS) was established to focus services research on more effective treatment programs, especially for children with serious emotional disturbances. The CMHS demonstration grant program has encouraged innovative approaches to improving service delivery for children and their families who receive services from more than one service system. The demonstration grants have also encouraged innovative managed care practices to improve cost effective service systems. Children ages zero to three are an emerging area of research focus. Programs for this age group have demonstrated cost effective results in reducing neglect and abuse, improving intellectual and cognitive functioning and helping infant brain development.

In Alaska and nationally, public awareness of the extent of mental illness/emotional disturbance in children has been growing, with a concomitant realization of the need for services to address those problems. The federal CMHS has focused attention on best practices in providing services for children (*Making It Happen*, 1997) and federal funds have been made available on a competitive basis for several years. The consumer movement has also begun to target the needs of emotionally disturbed children.

At the request of state governors, more freedom has been given to states to use innovative funding practices: the waiver process for Medicaid has been liberalized; states are allowed to blend funding streams to eliminate many federal funding limitations and to re-focus funding into early interventions. Also, on the national level, additional funds have been provided for Early Periodic Screening Diagnosis and Treatment and the Child Health Insurance Program.

When *A Shared Vision I* was written in 1991, recommendations were made to increase use of federal funds to augment state funds. We must also look to optimum use of all public and private economic and human resources, if we are to meet the mental health needs of Alaska's children and youth.

Since *A Shared Vision I*, public awareness has grown in distinguishing the variety of mental health needs of children. While some children are born with neuro-biological disorders that require mental health interventions, other children develop emotional disorders in response to environments which do not provide the care, love, safety and predictability that children need. For those whose illnesses are biological, cost effective programs can reduce the disabilities associated with untreated illnesses. Some children, such as those experiencing Fetal Alcohol Syndrome/Fetal Alcohol Effects develop "secondary disabilities" of emotional disorders because their very different learning and interpersonal needs are not met. Advocates and providers (and the Alaska Mental Health Board) struggle to allocate appropriate attention to those children whose needs begin at birth and those whose needs might have been prevented. Any child may have mental health needs that should receive attention, including occasional counseling, and in such areas as skill development or "emotional literacy," and better interpersonal and decision making skills.

Mental health services in Alaska have mirrored the national history of a focus on adult needs and earlier development of a system of care for adults. However, as children are very different from adults, their needs were not readily met by the adult service system. It has taken considerable national effort to identify what works for children and their families. This knowledge has developed within the context of the national consumer advocacy movement which has stressed the importance of meeting the needs of children and their families, through family centered services and treatment of the child in a holistic manner. Following are the core values which the Children and Youth Action Team and the Alaska Mental Health Board support in developing a complete system of care for children's mental health needs in Alaska.

Core Values

- The system of care is family centered, with the needs and strengths of the child or youth, family and community driving the types and mix of services provided.
- The system of care should be community based, with the locus of services at the community level. The management and decision making responsibility rests with the family and is shared by the community, region, and state.

- Children and youth needing help should be identified and services provided as early as possible under the direction of professionals trained in the diagnosis and treatment of childhood mental and emotional disorders.
- When mental health services and support are needed for families:
  - Families are full partners with professionals in planning for and evaluating the effectiveness of services.
  - Services and supports are consistent with each family's beliefs, values and culture.
  - Services and supports are individualized, consistent, continuous, respond to the unique and changing needs of each child or youth and family as they evolve over time, and are focused on re-establishing independence.
  - Services are accessible and seamless from the perspective of the child or youth and family.
  - Services are integrated and blended with other community and natural resources in a manner that is least restrictive and that supports the child or youth and family in their community.
  - Children and their families deserve the protection of their rights and effective advocacy.
  - Families are treated with respect and dignity.

Approach of *A Shared Vision II* Children and Youth Section

The challenge faced by the Children and Youth Action Team that developed this section of the *A Shared Vision II* was how to concentrate on these many needs, while maintaining a focus on the whole child and to do so in a fiscally responsible manner. Following are approaches which were selected.

1. Efficient and effective interventions are possible when agencies collaborate and coordinate service delivery at both the state and local community level.
2. Care for children and youth can be strengthened by integrating physical and mental health care delivery systems.
3. Assessment and delivery systems need to focus their attention where children spend most of their time--in homes and in schools.
4. Early intervention pays, cutting the huge human, social and economic costs of untreated mental illnesses.

5. Aggressive screening and appropriate diagnosis by professionals trained in childhood mental and emotional disorders is essential for successful early intervention.
6. Some groups of children and youth are at high risk or have need for intensive services. We should focus on their treatment needs. These under-served groups include children living in rural areas, in poverty, in families in crisis, or substance abusing families, or who have physical illnesses or disabilities.
7. Treatment and services should be available in the child's or youth's home community or as close as possible within Alaska, recognizing that some highly specialized services may only be available outside the state.

The Children and Youth Action Team envisions a system of care that links children and youth and their families to a wide variety of family focused, community based and culturally appropriate services that are organized to work together. Effective interagency partnerships between consumers, mental health providers, child welfare, education, substance abuse, domestic violence, physical health and juvenile justice, can help establish appropriate individualized service plans that build on family strengths and needs.

System of Care

Since the first edition of *A Shared Vision*, many changes have occurred in children's mental health services, especially in services for serious emotional disorders. Alaska has mirrored the rest of the country in focusing on the need for an integrated network of services that is consumer driven and delivered in the least restrictive setting. Efforts by the Alaska Mental Health Board, Department of Health and Social Services, providers, consumers and advocacy groups have targeted development of appropriate intensive services and new service delivery models. However, stakeholders agree that in mental health services for children and youth a gap exists between the needs of consumers and the availability of services.

The components of services for children and youth should include:

- Mental health services (respite, emergency, therapeutic foster care).
- Prevention services and early intervention.
- Educational services.
- Cultural services.

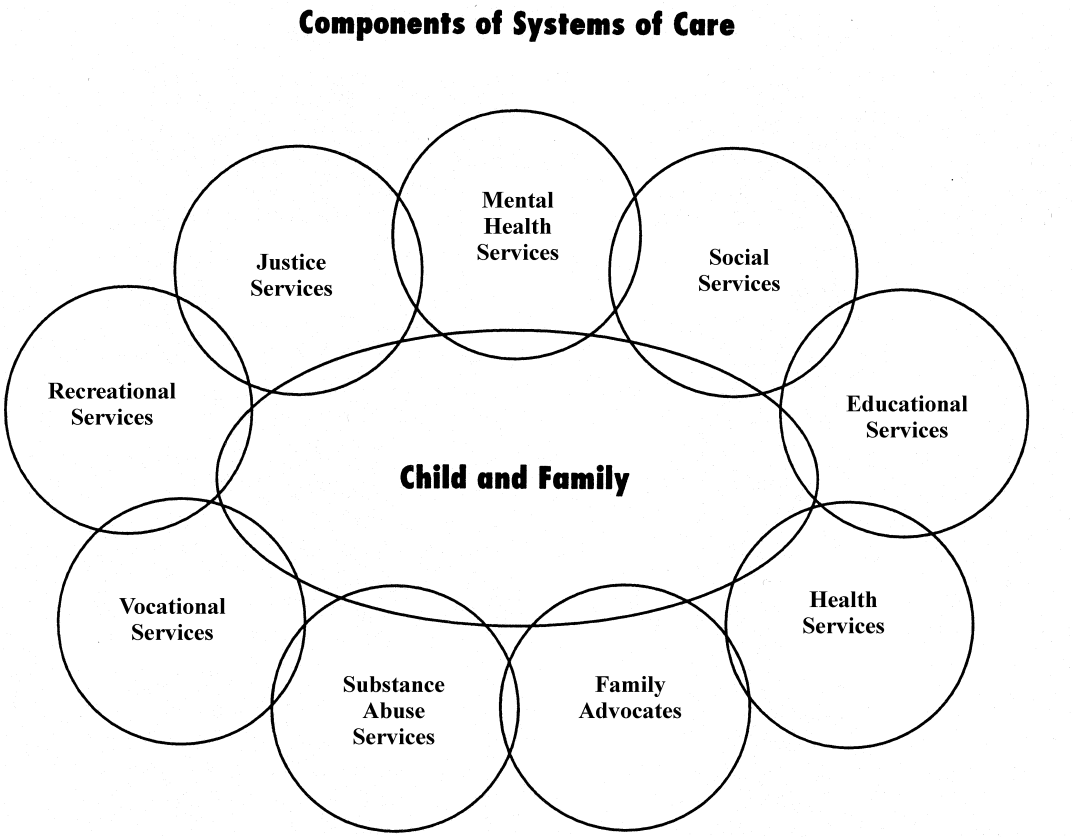
- Physical health services.
- Substance abuse services.
- Social services.
- Child protection.
- Youth Corrections.
- Transition and vocational services.
- Recreational services.
- Support services (e.g., case management, family support and self help groups, advocacy, legal services, transportation, etc.).

Non-residential mental health services include:

- Prevention.
- Early identification and intervention.
- Assessment: psychological, psychiatric and neurological evaluations.
- Outpatient therapy: individual, family, group therapy, activity therapy, socialization therapy, living skills therapy.
- Crisis services.
- Case management.
- Respite care.
- Medication management.
- Home based services.
- School based services.
- Day treatment.
- Emergency services, evaluation and referral.
- Support services.
- Skill building.

Residential services are a component of the network of services that should be available, including:

- Crisis respite residential services/planned respite.
- Therapeutic foster care.
- Therapeutic group care.
- Therapeutic camp services.
- Residential treatment services.
- Inpatient hospitalization.
- Transition services.



The Challenge

The challenge facing the Alaska Mental Health Board and other advocates is to work together to develop and implement a unified vision for children's mental health services in Alaska. We recognize that this document is a step along the way toward this shared goal.

Issue 1: The System Fragmentation and Gaps

Goal: Create an integrative, collaborative system of care for children and youth with mental and emotional disorders.

Discussion

As the Children and Youth Action Team met to determine the needs and outcomes of mental health service provision for children and youth and their families, one theme recurred. To effectively work with a child or youth and that individual's family, systems must commit to the

elimination of all barriers and boundaries. Access should be obtained without delay and appropriate services should be made available immediately. Respite for families and parents should be regularly scheduled to proactively maintain placements. Children and youth with conduct disorders should be included in regular classrooms by teaching classroom and special education teachers how to use state-of-the-art behavioral techniques to control disruptive and aggressive student behavior. Parents must become partners in the purest sense of determining appropriate services based on their family's strengths. A child's well being and health will only thrive with the systems working together. This holistic approach will positively affect not only the children and youth and families being served but also the communities in which they live.

Objective A: Assure mental health stakeholders are active collaborators in the mental health service system in order to provide the best possible system of care.

Discussion

As noted in the introduction to this section, advocates, consumers and family members are encouraged to become full participants in the mental health system, from policy making, planning and evaluation to individual treatment planning. Established agencies can facilitate this level of consumer and advocacy participation.

Actions

1. Encourage the participation of consumers and family members in all levels of service delivery, including policy making, planning and service design and evaluation. Explore compensation for consumer participants on official committees, for example, for child care expenses.
   Responsible party: Alaska Mental Health Board, Department of Health and Social Services, Department of Education, Alaska Mental Health Trust Authority and other agencies
2. A children's specialist position will work with consumers, advocates and providers to identify a vision of system change for Alaska's mental health services for children which will be the basis for efforts to seek federal and other grant resources.
   Responsible party: Alaska Mental Health Board, Division of Mental Health and Developmental Disabilities
3. Managed care contracts for private and public mental health services should include provisions for parent training, family support, and

appeals and grievance procedures.
Responsible party: Department of Health and Social Services, Alaska Mental Health Board

4. Advocacy groups will provide tools to schools for awareness training to reduce stigma and as a resource for community education.
Responsible party: Advocacy groups
5. Assure that consumers and family members become a part of the mental health treatment system by employing trained consumers and family members as advocates within the system.
Responsible party: Division of Mental Health and Developmental Disabilities and service providers
6. Assure that family involvement in treatment is supported by policies and funding, for example, for family counseling.
Responsible party: Division of Mental Health and Developmental Disabilities, Division of Medical Assistance

Objective B: Assure effective collaboration among planning boards.

Discussion

Under Alaska's statutes, planning and advocacy responsibilities for children and youth with emotional disturbances is shared by the Alaska Mental Health Board, the Governor's Council on Disabilities and Special Education (GCDSE) and the Governor's Advisory Board on Alcohol and Drug Abuse (ABADA). The Governor's Council shares responsibility for seriously emotionally disturbed children and youth who receive special education services. The Advisory Board focuses on services that prevent and treat substance abuse in children and youth. Many of the children and youth at risk of substance abuse have emotional disturbances.

Actions

1. Alaska Mental Health Board, Governor's Council on Disabilities and Special Education, and Governor's Advisory Board on Alcoholism and Drug Abuse will identify areas of common responsibility and develop mechanisms for joint policy development, planning and budgeting efforts with the Alaska Mental Health Trust Authority.
Responsible party: Alaska Mental Health Board, Governor's Council on Disabilities and Special Education, Governor's Advisory Board on Alcoholism and Drug Abuse

Objective C: Assure that the Department of Health and Social Services, the Department of Education and school districts are active, collaborative partners in providing for mental health needs of students.

Discussion

Children and youth with serious emotional disturbances (SED) are eligible for special education services if they meet criteria created by the federal Individuals with Disabilities Education Act (IDEA), and their disabilities interfere with their ability to learn. These children and youth must be provided with special education and related services in a manner set forth in an "Individualized Education Plan" (IEP) which is developed by the student's parents and the school.

The criteria for certification for special education services exclude children and youth who are "socially maladjusted." In practice, this means that children and youth who have a diagnosis of "conduct disorder" are often unable to obtain special education and related services, even when these behaviors are severe. However, some children and youth with diagnoses of conduct disorder will meet the functional definition of disability under Section 504 of the Rehabilitation Act of 1973. This law requires school districts to provide reasonable accommodations to students with disabilities.

Other children and youth with less severe disorders may not qualify for special education services. Some school districts have counseling services, but many do not. Community mental health centers and certain other grantees of the Division of Mental Health and Developmental Disabilities provide services to children and youth with emotional disturbances and conduct disorders.

There is evidence that in Alaska and nationwide, children and youth with emotional disturbances may be inappropriately segregated from other children and youth. Anecdotal evidence indicates that many schools exclude children and youth with emotional disabilities after failing to develop appropriate individualized behavior management plans for them.

Advocates for children and youth with emotional disabilities are concerned about the lack of coordination between schools and mental health providers. There is also concern that children and youth in state custody with emotional impairments do not receive coordinated services

from their schools and their legal custodian due to lack of Division of Family and Youth Services input into the special education process.

Interventions at school can have major impacts on a child's functioning in other areas of his or her life. Cooperation among service providers is vital, and is required by the 1997 amendments to the Individuals with Disabilities Education Act.

Actions

1. The Department of Health and Social Services and the Department of Education will promote opportunities for children and youth with serious emotional disturbances (SED) to receive mental health services in school settings.
   Responsible party: Department of Health and Social Services, Department of Education
2. Enhance networking capacity between the departments of Health and Social Services and Education through development of a Memorandum of Agreement (MOA) regarding collaborative services for serious emotionally disturbed children and youth, including: a commonly understood vocabulary for education and mental health services staff; a review of policy and procedure manuals and other departmental guidance documents to identify barriers to collaborative services and means to enhance integration of services; and an implementation plan for review and approval by the commissioners. The MOA will address the possibility of merged funding streams for SED support services and protocols for a Memorandum of Agreement template for use at the local level that spells out Individual Education Program responsibility between school districts and mental health agencies.
   Responsible party: Department of Heath and Social Services, Department of Education
3. Enhance the networking capacity between the departments of Health and Social Services and Education by creating a means to share and distribute information about significant children and youth's mental health issues and activities. This will be accomplished by a Department of Education grant to the Governor's Council on Disabilities and Special Education or the Alaska Mental Health Board for collection and dissemination of information regarding prevention activities, research, and innovative practices in services to serious emotionally disturbed children and youth, with an advisory group to identify objectives and annual implementation tasks for

staff.
Responsible party: Department of Education

4. The Department of Education, Alaska Mental Health Board, Governor's Council on Disabilities and Special Education, Division of Mental Health and Developmental Disabilities and Disability Law Center will research school district practices that adversely effect serious emotionally disturbed children and youth, for example: misuse of "conduct disorder" label to avoid special education services; numbers of SED children and youth suspended or dismissed from school; numbers of SED children and youth who drop out of school and reasons for leaving; etc.
   Responsible party: Task group
5. The Division of Mental Health and Developmental Disabilities, Department of Education and Alaska Mental Health Board will identify opportunities to provide mental health consultation to Headstart, and other early childhood intervention programs, including Healthy Families.
   Responsible party: Division of Mental Health and Developmental Disabilities, Department of Education, Alaska Mental Health Board
6. The mental health system will provide training to schools in the use of age appropriate screening tools for use by teachers and parents, and by school nurses/counselors, (where school districts have this personnel) and encourage offering social and family skills training.
   Responsible party: Division of Mental Health and Developmental Disabilities and grantees
7. The Department of Education in consultation with the Division of Mental Health and Developmental Disabilities will provide training for teachers regarding class room adaptations to the learning needs of children and youth with emotional and mental disorders and how to work effectively with mental health case managers.
   Responsible party: Department of Education
8. The Department of Education will provide training to educators in the development and implementation of behavior plans for students with behavior disorders/challenging behaviors and in working effectively with a treatment team.
   Responsible party: Department of Education
9. The Division of Mental Health and Developmental Disabilities will provide to the Department of Education information regarding disorders which may affect student performance.
   Responsible party: Division of Mental Health and Developmental Disabilities

10. The Division of Mental Health and Developmental Disabilities will identify conflict resolution and emotional literacy materials and programs for use by schools.
    Responsible party: Division of Mental Health and Developmental Disabilities
11. Work with the Department of Education in the development of the plan for service integration required under the 1997 amendments to Individuals with Disabilities Education Act.
    Responsible party: Alaska Mental Health Board, Governor's Council on Disabilities and Special Education, Department of Education

Objective D: Assure that children and youth receive integrated, individualized mental health services appropriate for their needs in the least restrictive setting through collaboration within the Department of Health and Social Services.

Discussion

The Department of Health and Social Services has increased integration of planning and problem-solving regarding services provided by the Department. Current areas of focus include:

- Supporting those children and youth in the Department's custody and their families.
- Developing regional and local solutions to support children and youth in need of mental health and substance abuse services. The divisions of Mental Health and Developmental Disabilities and Alcohol and Drug Abuse are coordinating closely with the Division of Family and Youth Services to develop new ways to provide mental health and substance abuse services to children and youth in custody.
- Evaluating the Alaska Youth Initiative.
- Identifying systemic inefficiencies that limit access and timely provision of services, and developing recommendations to improve the delivery of individualized services to severely emotionally disturbed youth.
- Establishing Department policy regarding the screening of youth at risk of placement into treatment facilities in other states and monitoring of those placements. Over forty children and youth, and youth in state custody, are currently in out-of-state residential facilities. Close monitoring of these cases and screening of potential new referrals will ensure that all local options have been reviewed

and will provide information about service needs in Alaska. The Department can then more closely identify what residential treatment needs exist, and whether there are specialized service needs that cannot be feasibly provided in Alaska.

The Department should continue to strive toward establishing a seamless system of service delivery for children and youth with mental and emotional disorders by integrating services within the department and by collaborating with other stakeholders. These efforts need to involve families, planning boards, consumer advocacy groups, and providers. Barriers to services and barriers that create fragmentation of services need to be eliminated. Collaboration will avoid duplication of services and help assure cost effective services.

Actions

1. Identify resources to support comprehensive, integrated mental health services for seriously emotionally disturbed children and youth including crisis respite and residential alternatives to institutional care.
   Responsible party: Division of Mental Health and Developmental Disabilities
2. The Alaska Mental Health Board and Division of Mental Health and Developmental Disabilities will develop a strategic plan to assure reduction in barriers to mental heath services for children and youth at risk of placement into state custody and their families, including examining the possibility of giving priority to mental health treatment of abused children and youth, children and youth who have witnessed violence, and children and youth of substance abusing parents.
   Responsible party: Division of Mental Health and Developmental Disabilities
3. The Department of Health and Social Services will develop a plan and assure funding for providing seamless services for children and youth with serious emotional disturbance who receive services from more than one agency within DHSS.
   Responsible party: Department of Health and Social Services
4. Review Department of Health and Social Services' structures, plans, and service delivery to identify ways to enhance coordination and integration of service delivery, including: mental health and substance abuse services; mental health and social services; and Department of Health and Social Services physical and mental

health services. Whenever possible, such public health services as Early Periodic Screening Diagnosis, and Treatment and maternal and child health services, should provide a focus on behavioral and emotional health and identification and early intervention.
Responsible party: Task group

5. The Division of Mental Health and Developmental Disabilities and Division of Alcoholism and Drug Abuse will identify barriers to simultaneous services for children and youth with mental and emotional disorders and co-occurring substance abuse problems and eliminate those barriers to simultaneous care.
Responsible party: Division of Mental Health and Developmental Disabilities, Division of Alcoholism and Drug Abuse
6. Assure careful input by advocates and mental health professionals into the development of regulations for secure and semi-secure treatment facilities licensed by the Division of Family and Youth Services. Program data should be reviewed by an intra-departmental and Alaska Mental Health Board workgroup to assure appropriate use of secure and semi-secure treatment facilities.
Responsible party: Division of Family and Youth Services
7. The Alaska Mental Health Board will use research findings from the Center for Mental Health Services, National Institute of Mental Health and other multidisciplinary research sources to plan for Alaska's children.
Responsible party: Alaska Mental Health Board
8. The Alaska Mental Health Board will invite the Director of Division of Family and Youth Services to sit *ex officio* on the Board.
Responsible party: Alaska Mental Health Board

Issue 2: Need for Appropriate Care, Earlier Intervention and Accurate Diagnosis

Goal: Provide appropriate care for children and youth with mental and emotional disorders, emphasizing accurate diagnosis, early intervention, prevention and effective treatment.

Objective A: Provide for the treatment needs of special populations of children and youth with mental and emotional disorders.

Discussion

Child Abuse Victims: Being a victim of child abuse, including sexual abuse, frequently leads to a variety of severe mental health problems which can significantly impact the child's life in a variety of different ways. It can lead to dissociative disorders, post traumatic stress disorder, substance abuse, suicide, health problems and other serious disorders. Some victims may become perpetrators or otherwise involved in the juvenile correctional system. Treatment for child victims needs to be adequately funded and mental health providers need to have the skills to provide the treatment. Services need to be available statewide.

Actions

1. Develop closer collaboration between the Division of Family and Youth Services and mental health service providers to ensure child sex abuse victims get needed treatment.
   Responsible party: Division of Family and Youth Services, Division of Mental Health and Developmental Disabilities
2. The Department of Health and Social Services and the Department of Corrections will work together to minimize the numbers of sex offenders who repeat their offenses against children and youth.
   Responsible party: Division of Family and Youth Services, Department of Corrections
3. Mental health providers must be trained to identify child sex abuse victims and to work with these children and youth. Their care should be considered an emergency need under the Division of Mental Health and Developmental Disabilities' grants to community mental health centers and other service providers.
   Responsible party: Division of Mental Heath and Developmental Disabilities
4. Research the relationship between child sexual abuse and youth/adult mental health, substance abuse problems and criminal system involvement.
   Responsible party: Children's Mental Health Work Group
5. Seek funding for a pilot project to target child sex abuse victims for intensive mental health services and to provide longitudinal data.
   Responsible party: Division of Mental Health and Developmental Disabilities, Alaska Mental Health Board
6. Consider funding pilot programs to mobilize sex abuse intervention teams to work with domestic violence shelters, homeless shelters, emergency shelters and schools.
   Responsible party: Alaska Mental Health Board

Discussion

Sexually Assaultive Behavior: Historically, sexually aggressive or exploitive behaviors in childhood have not been dealt with in an accountable manner. Too often, common adult responses have been non-specific disciplinary, punitive or minimizing measures which have failed to confront exploitive behaviors or to teach appropriate behaviors. Many responses to childhood sexuality, as well as aggressive or exploitive sexuality, have not prompted communication or understanding at a cognitive level but rather have led to secrecy at a behavioral level. Many adult and adolescent sexual offenders have recalled that society often minimized the existence or importance of early offending behavior, as much as they did themselves. Sexual learning prior to puberty often occurs without the influence of societal norms. A variety of factors seem to put children and youth at risk of developing deviant sexual behaviors. These factors have been identified retrospectively in work with adolescent and adult sex offenders.

Actions

1. Develop a system of service delivery which is goal directed and enhanced by greater coordination of efforts and treatment interventions supported by a common treatment philosophy across all child serving systems.
2. Arrange for an intensive training agenda that is designed to prepare a variety of service providers with skills in early identification and treatment recommendations and interventions for children as young as three years old.

   Responsible party (actions 1-2): Division of Mental Health and Developmental Disabilities, Division of Family and Youth Services

Discussion

Runaway Youth: Runaway youth remain a chronic problem in Alaska. Often fleeing homes with patterns of abuse or dysfunctional relationships, these youth place themselves at risk of harm and may, in time, slip into the offender population. An unknown percentage may be mentally ill and need treatment. Sometimes the Division of Family and Youth Services and parents place runaway youth in psychiatric hospitals for lack of alternative placements. Regretfully, no analysis of the runaway problem has been conducted in Alaska since 1983. While the federally-funded runaway shelters managed by Juneau Youth Services, Fairbanks Native Association and Anchorage's Alaska Youth and Parent Foundation do

maintain some statistics, there is no provision for collection of statewide statistics on runway and homeless youth. These youth fall outside the child protective service system and the youth corrections system unless there are other circumstances and charges unrelated to their runaway status that would bring them within those systems.

Actions

1. Strengthen communication between state, federal, and privately funded agencies that serve Alaska's runaway population.
2. Use updated state data and existing data to allocate resources where the need is greatest.
3. Train runaway youth providers to identify child abuse, mental health, sex offender and domestic violence issues.
4. Develop closer relationships between runaway youth programs and the Division of Family and Youth Services, the Division of Mental Health and Developmental Disabilities and law enforcement agencies to facilitate service delivery and family reunification, and to reduce institutional placement.
5. Seek funding to conduct a statewide needs assessment to determine the service needs of this population.
6. Monitor and evaluate existing locally based runaway initiatives to determine best practices for creating safe environments for runaway youth and best practices for linking youth with psychiatric disorders with needed services.
7. Coordinate funding and resource availability with private, school district, state and other government agencies to ensure continuing and expanded services for runaway youth.
8. Assure advocates and mental health professionals have adequate input into Division of Family and Youth Services regulations governing the licensure of secure and semi-secure treatment facilities.

   Responsible party (actions 1-8): Division of Family and Youth Services

Discussion

Mentally Ill and Emotionally Disturbed Youth in Detention Facilities: Delinquent mentally ill and emotionally disturbed youth in detention facilities pose significant management issues because they need more intensive and specialized staffing as well as different kinds of treatment than is needed by other delinquent youth. Most common diagnoses for these residents include: major depression with suicidal

ideation, defiant disorder, schizophrenia and borderline personality disorder. Mentally ill delinquents are almost always in the facility more as a function of their emotional or psychiatric disorders than their actual delinquency. Their history often includes multiple admissions to psychiatric hospitals. Alaska has not provided adequate services to these adolescents and they have defaulted into the juvenile correctional system. Correctional facilities are not currently staffed to meet the needs of emotionally disturbed and mentally ill adolescents or to provide for their care on discharge.

Actions

1. Develop programs that treat mentally ill and emotionally disturbed youth in detention (see Goal I, Objective D; Goal II, Objective B).
   Responsible party: Division of Family and Youth Services
2. The Department of Health and Social Services and The Alaska Mental Health Board will request funds for adequate staffing of juvenile detention facilities to assure that juveniles receive assessment, diagnosis and treatment appropriate to their conditions.
   Responsible party: Department of Health and Social Services, Alaska Mental Health Board
3. Assure careful input by advocates and mental health professionals into the development of regulations for secure and semi-secure treatment facilities licensed by the Division of Family and Youth Services. Program data should be reviewed by an intra-departmental and Alaska Mental Health Board workgroup to assure appropriate use of secure and semi-secure treatment facilities.
   Responsible party: Division of Family and Youth Services, Alaska Mental Health Board

Discussion

Children with Fetal Alcohol Syndrome/Fetal Alcohol Effects (FAS/FAE): Nationally, secondary emotional/psychiatric disabilities are highly correlated to FAS/FAE, in the 90% and above ranges. Since Alaska has so many FAS/FAE children and youth, we need to focus on prevention of these secondary disabilities, many of which appear to be a result of or related to the inappropriate expectations we have of these children and youth, many of whom appear "normal." Frustration, anger, hurt, etc. can be a potent mix that lead to emotional disorders and encounters with the juvenile justice system. Preventive care will take the efforts of a wide range of professionals, including teachers who have developed expertise in

working with FAS/FAE children and youth, mental health professionals who have similar expertise, and other helping professions.

In Alaska's government planning and advocacy system, responsibility for children and youth with neurological disorders is shared by the Governor's Council on Disabilities and Special Education, the Advisory Board on Alcoholism and Drug Abuse and the Alaska Mental Health Board. The first joint board meeting, held in response to *A Shared Vision I*, targeted the needs of Fetal Alcohol Syndrome/Fetal Alcohol Effects children and youth for particular coordinated approaches. Since that time, the Boards sponsored a Summit on FAS/FAE where representatives came to agreement on future actions that need to be taken.

Actions

1. State and community providers will ensure that children and youth with Fetal Alcohol Syndrome/Fetal Alcohol Effects (Alcohol Related Neurological Deficits) and other neurological disorders receive appropriate early diagnosis, support, and treatment, by: increasing in-state diagnostic capability; training physicians in the diagnosis and management of FAS/FAE and other neurological conditions; and providing training opportunities for mental health providers, educators, and members of the legal and justice systems.
2. Agencies will explore development of programs to support the parenting skills of Fetal Alcohol Syndrome/Fetal Alcohol Effects individuals when they become parents.
3. Implement the recommendations of the Fetal Alcohol Syndrome Summit as stated in Fetal Alcohol Syndrome: A Time for Action, February 1998.
   Responsible party (actions 1-3): Fetal Alcohol Syndrome/Fetal Alcohol Effects Coordinator, Department of Health and Social Services

Discussion

Adolescents in Transition to Adult Services: The Alaska Mental Health Board has been concerned for several years about the need for adequate transition between the child, youth and adult mental health treatment systems. The AMHB's Children and Youth Task Force authored a paper on transition which was given wide distribution within the Department of Health and Social Services and among mental health stakeholders. School districts are required by law in Special Education Individualized Education Plans to plan for transition for 14-22 year olds. However, for most 18-22 year olds, transition does not occur and the adult

system is not ready to receive youth who have become ill as children. It is difficult for normal 18-22 year olds to transition into adulthood; it is dangerous for mentally ill and emotionally disturbed youth to transition without support. Without adequate support many mentally ill and emotionally disturbed adolescents transition into the criminal justice system.

Planning for transition to adult services should begin several years before a child becomes an adult. For children and youth classified as serious emotionally disturbed in school, Special Education laws require that transition begin no later than age 16. There is also a need for transition planning for those adolescents who are not receiving services under an Individualized Education Plan.

Actions

1. Promote and support collaboration between state and local government, schools, mental health agencies (child and adult), courts, criminal justice, etc. that will integrate federal/state Individuals with Disabilities Education Act guidelines for transition services through Individualized Education Plans.
2. Increase awareness and build support by educating all levels of the provider community regarding the needs and benefits of transition services.
3. The Department of Health and Social Services will implement the Children and Youth Task Force Transition Paper recommendations that all youth with brain disorders leave school and the children's mental health system with the skills, support and knowledge required to help them participate in adult life, including being able to work, learn and live in the area of their choice.
4. Clarify confidentiality laws and regulations pertaining to youth and adult service systems.
5. Train child/adult agencies and providers, together, to provide seamless transition services.
6. Establish a statewide policy (standards of care) for transition age youth.
7. Empower youth (young adults) and their families to be active in planning and implementing individualized transition services.
8. Coordinate funding sources, including finding grants that are specifically intended for transition services for education, housing, etc.
9. Involve adult service agencies early, as transition plans are being made.

10. Ensure that transition services are geared to the need of the individual and ensure success rather than arbitrary age or categorical "cut off."
11. Make certain that the process for transition planning is automatic for every child (not just per request).
12. Begin the transition process early (14-16 years of age).
    Responsible party (actions 1-12): Department of Health and Social Services, Department of Education

Discussion

Children with Mental/Emotional Disorders and Substance Abuse Treatment Needs: Neither the mental health nor the alcohol treatment systems accept full responsibility for children and youth who have mental and emotional disorders and substance abuse treatment needs. However, these issues are very interrelated. Funding is often categorical and mutually exclusive, i.e., alcohol funding cannot be used for mental health treatment. Accreditation and licensing are restrictive to the extent that substantial redundancy must be tolerated to be licensed/accredited in both areas.

Research indicates that children are beginning to experiment with alcohol and other drugs at younger ages. This experimentation, coupled with mental health issues for severely emotionally disturbed children, illustrates the need for combined mental health/substance abuse treatment.

National organizations and research support the importance of integrating these services. Since children and youth with mental and emotional disorders are over-represented in substance abuse programs, the National Institute of Mental Health recommends early intervention for children and youth with mental and emotional disorders as a promising primary prevention program for substance abuse.

Actions

1. Obtain support/validation from advocacy groups who have traditionally supported only one area (mental health or substance abuse).
2. Develop a planning/collaboration/communication process between the Division of Mental Health and Developmental Disabilities, the Division of Alcohol and Drug Abuse, the Alaska Mental Health Board and Governor's Advisory Board on Alcoholism and Drug Abuse on

planning issues.
Responsible party (actions 1-2): Alaska Mental Health Board

3. Develop a planning/collaboration/communication process between providers of children and youth's mental health and substance abuse services.
4. Identify funding sources within both divisions (or other resources) which do not carry specific categorical service restrictions. With a portion of these funds issue requests for proposals (RFPs) for joint pilot projects.
5. With a portion of these funds (identified in Action 4), develop an educational program which identifies and validates the overlap of these co-occurring conditions.
Responsible party (actions 3-5): Division of Mental Health and Developmental Disabilities, Division of Alcohol and Drug Abuse

Discussion

Children and Youth in Out-of-State Placements: In 1985 the Alaska Youth Initiative (AYI) was developed by the Department of Health and Social Services and the Department of Education in response to the increasing practice of sending seriously emotionally disturbed youth out of state for services. AYI's goal was to bring children and youth back to Alaska and prevent future out-of-state placements by providing in-state treatment alternatives. Since 1995, this problem has re-surfaced, with at least 40 youth currently in state custody placed in out-of-state treatment facilities. Scores of other children and youth are in out-of-state foster care and many children and youth not in state custody are also in out-of-state placements. Work on this issue has identified inconsistent state statutes and regulations regarding prioritization of mental health services for children and youth, leading to service gaps and confusion at the service delivery level. The work also found: inadequate review processes for cases under consideration for out-of-state placement; inadequate in-state treatment resources; less costly out-of-state services; long waiting times for admission to AYI; and inadequate access to crisis services.

Actions

1. Conduct an in-depth analysis of children and youth in out-of-state placement to identify services needed in Alaska.
2. Conduct a formal review of Alaska Youth Initiative, including its ability to prevent out-of-state placements.
3. Develop a standardized system to identify children and youth needing services not available in Alaska and to review their cases prior to a placement decision.

4. Develop treatment protocols/approaches for children and youth with difficult-to-serve mental disorders who are at risk for out-of-state placement.
5. Identify funding for mental health services for youth in detention facilities and for delinquent youth in state custody, and their families.
6. Investigate the ability of the Children's Service Delivery Model Pilot Project to prevent out-of-state placements.
7. Develop specific training for community mental health services staff, focusing on best practices to reduce out-of-state and out-of-community placement.
8. Investigate the feasibility of a form of secure residential care as an alternative to out-of-state placement for some children and youth.
9. Explore the development of Department of Health and Social Services' regulations to facilitate the integration of children and youth's services provided by more than one departmental division.
10. Support the development of a full system of care for mental health and medical care needs of children and youth in Alaska, with emphasis on the least restrictive alternative.
11. Assure that families are supported when children and youth are returned to home and that this support continues.
12. Assure full participation of the Department of Education in Alaska Youth Initiative and out of state placement decisions, as well as in development of treatment plans.
13. Develop and distribute residential selection guidelines for use by parents of children and youth who are not in state custody.
14. Develop additional needed policies and procedures to prevent unnecessary out-of-state placements.

    Responsible party (actions 1-14): Division of Mental Health and Developmental Disabilities, Division of Family and Youth Services, Alaska Mental Health Board

Discussion

Culturally Appropriate Treatment: Alaska's children and youth come from many different ethnic backgrounds. Service providers need to be familiar with and sensitive to each family and culture. In addition, special emphasis needs to be placed on Alaska Native youth receiving mental health services in both rural and urban areas that is consistently culturally respectful. Many urban youth have significant cultural ties and strong tribal identity which can serve as a strength or natural support, yet is minimized or overlooked when they reside in an urban area.

Cultural appropriateness of treatment is a particular issue for youth sent from rural areas to urban centers for treatment, and is also an issue for some "urban" Alaska Native youth who lived in rural areas before relocating to an urban center. A treatment goal is often to return to the community of tie where there may be family support, or the youth may reach 18 and decide to return to his/her community of tie.

Actions

1. The Division of Mental Health and Developmental Disabilities will structure grants to address rural and urban agencies' plans for cross cultural training, employment of Alaska Native staff and consultants and other minority staff appropriate to the locale. Quality Assurance standards will ensure mental health practitioners provide culturally relevant treatment. Follow up for compliance will occur during scheduled quality assurance reviews.
   Responsible party: Division of Mental Health and Developmental Disabilities

Objective B: Provide adequate and effective diagnosis and treatment for children and youth with mental and emotional disorders.

Discussion

The mental health services system for children and youth has, in recent years, focused attention on developing standards of care for mental health services in Alaska. The Division of Mental Health and Developmental Disabilities convened a Quality Assurance Steering Committee with representatives of several agencies including the Governor's Council on Disabilities and Special Education, community mental health providers, Alaska Mental Health Board, Division of Public Health, University of Alaska, consumers, and the Alaska Mental Health Trust Authority, to focus on and articulate treatment standards for mental health services for children and youth and adults. These standards need to be expanded to include best practices for mental health treatment based on national research. On the national level, the Center for Mental Health Services, National Institute of Health, professional organizations and major university research centers have reviewed services research to articulate best treatment practices for a variety of diagnoses and services for children and youth.

Actions

1. The Quality Assurance Committee or a similar multi-disciplinary group will review national research data to develop specific best practices for use in Alaska.
2. The Quality Assurance Committee will access technical assistance from the Center for Mental Health Services and other sources on best treatment practices and incorporate this information into a draft document.
3. The best practices draft document will be distributed to providers, consumers and managed care authorization agencies for review and comment.
4. Assertively provide mental health services as soon as children and youth have been identified as victims of emotional, physical or sexual abuse.
5. Provide training to care providers in diagnosis and treatment interventions for childhood disorders.
   Responsible party (actions 1-5): Division of Mental Health and Developmental Disabilities

Objective C: Provide adequate and effective prevention and early identification for children and youth with mental and emotional disorders.

Discussion

Mental illness/emotional disorders affect one in every five young people at any given time. To reduce the risk for developing disabilities, all of these children and youth should be identified and receive the help they need to develop normally. Early treatment works to minimize development of disabilities. Left untreated, childhood mental illness leads to chronic disabilities. Children and youth with emotional disorders are over represented in the juvenile justice system, substance abuse programs, school drop outs, teen pregnancy and suicide rates.

The Children and Youth Action Team urges that Alaska's mental health service system give higher priority to prevention, accurate diagnosis and early treatment interventions.

Prevention: Not all causes of mental health problems in children and youth are known. Both environment and biology are often involved. Biological causes include chemical imbalances, genetics, and damage to the central nervous system. These are considered to be neurobiological

brain disorders, according to the medical community. To address these factors, the National Institute of Medicine gives the following recommendations which include the universal prevention steps: prenatal care, immunizations, head protection, and protection of young children from heavy metals. For some of these disorders, there is no known prevention.

Environmental factors placing children and youth at risk for mental health problems include: experiencing violence, abuse, neglect; loss of loved ones through death, divorce, or broken relationships; and such physical risks as lead poisoning and brain traumas. Social rejection as a result of race, sexual orientation, poverty or physical appearance or behavior also potentially influence the risk of mental health problems for youth. Undiagnosed and untreated learning disabilities are also a risk factor for emotional disorders in children and youth.

Additionally, according to the Casey Family Program, "it is estimated that up to 80% of children's distress is related to the combination of substance abuse, child abuse, and/or mental illness in the family." Prevention, therefore, must actively address family issues that increase risk factors for children.

Early identification/intervention: According to the national Center for Mental Health Services, 25% of children and youth have a diagnosable mental illness. And, at least 20% of these children and youth have a serious emotional disturbance that disrupts his or her ability to function. Without intervention, these disorders can lead to school failure, alcohol and other drug abuse, family discord, violence, or suicide. Suicide is a particularly critical issue for Alaska's youth. According to 1994 vital statistics data for the State of Alaska, the suicide rate in this state for 15 to 19 year old youth is 41.3 per 100,000, almost four times the national average.

Data suggests that one in five school age children have developed such serious disabilities that they qualify as "seriously emotionally disturbed" by national standards. Even higher rates are experienced among children ages 9 to 17. In 1992, a study by Dr. Norm Dingus for the Division of Mental Health and Developmental Disabilities estimated that two-thirds of Alaskan school children with a serious emotional disorder are not receiving help. Diagnosis of children is complex, due to developmental and other factors. When children receive inaccurate diagnoses, they receive

inappropriate services that are costly and ineffective. Treatment delays may result in permanent disabilities.

Mental illness in children encompasses the full range of emotional and behavioral conditions affecting adults. Left untreated, the child may develop poor patterns of behavior and responses to family, teachers, and other children. Because of the lack of normal experience and the long time available to develop maladaptive behavior, childhood onset of mental illness may lead to more severe disabilities than adult onset disorders.

Children must have access to screening and diagnosis of mental health issues that include comprehensive medical, family, social, and psychological assessments, including strengths and impact on all life domains. Currently, evaluations are often uni-dimensional and more oriented to admitting or denying admissions to a particular program. There should be a screening process that identifies children who need medical and neurological assessments.

Fortunately, children's disorders may be more malleable than adult conditions because of the potential to intervene earlier in the development of the disorder. Hence, early identification programs are urged to prevent substance abuse and mental/emotional disorders and to reduce the huge human, economic, and social costs of these disorders. Mental illness should be identified as early as possible, and those whose onset are in early childhood should receive appropriate treatment. Early identification programs need to include teachers and parents. Diagnosis and treatment planning needs to be done by professionals trained in childhood mental and emotional disorders. Accurate diagnosis and early treatment can reduce the severity of illness. For example, early treatment of manic depression, an illness with frequent adolescent onset, has long been recommended because of the "kindling effect;" each episode causes physical changes in the brain that makes future episodes more likely and severe.

Early intervention is cost-effective. Research clearly shows that early intervention increases the developmental and educational gains for the child, improves the functioning of the family, and reaps long-term benefits for society. In addition, a recent federal study showed a high correlation among adolescent girls with mood disorders and teen pregnancy. Children whose family lives are disrupted by substance abuse or have been victims of emotional, physical or sexual abuse are at high risk for emotional disorders, suicide, teen pregnancy and substance abuse.

Actions

1. The Alaska Mental Health Board will work in conjunction with a Department of Health and Social Services working group to identify mental disorder prevention opportunities and define a plan for increasing current efforts.
2. The Alaska Mental Health Board will work in conjunction with a Department of Health and Social Services working group on early identification and intervention opportunities and develop a plan for increasing current efforts.

   Responsible party (actions 1-2): Alaska Mental Health Board, Department of Health and Social Services
3. Parents and teachers should receive training in the use of tested screening tools that can identify children and youth who need referral to mental health professionals trained in diagnosis and treatment of childhood mental and emotional disorders.
4. The Department of Education will provide school districts with information about mental disorder screening tools and information about common disorders and their symptoms.
5. The Department of Education and children's advocates will encourage early diagnosis by multiple disciplines and early remediation of learning disabilities.

   Responsible party (actions 3-5): Department of Education
6. Explore the potential for screening and assessment and referral conducted by the Division of Public Health in regional diagnostic clinics.
7. Expand Healthy Families, Headstart, and similar programs which offer proven in-home programs which can prevent early childhood emotional disorders.
8. Explore expansion of the Infant Learning Program to include children at risk of mental and emotional disorders.
9. Fully utilize Early Periodic Screening Diagnosis and Treatment and Child Find to identify emotional and behavioral disorders and refer them for appropriate treatment.

   Responsible party (actions 6-9): Division of Public Health
10. The All Alaska Pediatric Partnership and others will be enlisted to provide training to private acute care medical practitioners in early identification and referral for childhood emotional disorders.

    Responsible party: All Alaska Pediatric Partnership

Addendum

Collaboration Between the Governor's Council on Disabilities and Special Education and the Alaska Mental Health Board

The Governor's Council on Disabilities and Special Education and the Alaska Mental Health Board (AMHB) share planning responsibility for services to children with serious emotional disturbances. The focus for the Governor's Council is school based. In the past, the AMHB's focus has been more on services outside school settings. To treat the child as a whole, we acknowledged the need to combine these approaches and to look at services in all environments used by children and their families. In Fiscal Years 97-98, for the first time, the AMHB and the Governor's Council jointly agreed to plan for areas of overlapping responsibility. Members of the AMHB served on the Governor's Council's team to develop a *Plan for Improving Services for Students with Severe Emotional Disturbances* (February, 1997). The Children's Action Team for *A Shared Vision II* reviewed and recommended adoption of the goals contained in the Governor's Council plan. Re-formatted, these appear below. Fuller discussion of each of the goals appears in the Governor's Council document. Additional proposed actions are found in other places in the Children's Services section.

Goal 1: Eliminate inappropriate assessment and diagnosis bound services.

Discussion

Federal and state laws and regulations contain varying and incompatible definitions of "seriously/severely emotionally disturbed" children and youth, especially for those services provided by the Department of Education for special education services, the Division of Mental Health and Developmental Disabilities for mental health services, the Division of Medical Assistance for Medicaid payment for services and the Alaska Youth Initiative for intensive coordinated services. These varying definitions cause problems between the education community and mental health service providers in identifying and providing collaborative and comprehensive services for children with serious emotional disturbances.

Actions

1. The Governor's Council will work closely with the Division of Medical Assistance to develop a comprehensive and compatible definition of "seriously emotionally disturbed."
2. The Department of Education, Division of Family and Youth Services, Division of Mental Health and Developmental Disabilities, and Division of Medical Assistance will work with Alaska Youth Initiative providers to develop eligibility criteria which clearly incorporate the new Division of Medical Assistance definition of serious emotional disturbances while maintaining other necessary eligibility criteria.
3. The Governor's Council, school districts and the Alaska Department of Education will work together to modify, if possible, the definition of serious emotional disturbances as it appears in Alaska's Special Education regulations.

Goal 2: Comprehensive and collaborative systems will provide services to meet the needs of children, youth, and adults with and at risk of developing serious emotional disturbances.

Discussion

Alaska has services to support people with serious emotional disturbances. However, access can be problematic. Complex service systems and eligibility requirements can be confusing and intimidating. Services available from schools, agencies and other organizations may overlap or appear fragmented. In some communities, services may not exist or cannot be reached because of transportation difficulties.

Traditional systems approach clients as problems in need of treatment. Available services may not meet an individual's needs. Providers may be unaware of additional services being received by the client and family. Inefficiencies and overlap can be avoided through comprehensive and collaborative care that is community based. Partnerships need to be created across schools, families, service agencies, churches, businesses, local governments and other organizations. Members need to collaborate by communicating, sharing human resources, and/or co-funding activities. The outcome is that partners develop and implement comprehensive strategies to meet local needs in a more effective and cost efficient manner.

A comprehensive and collaborative system is also family centered. Family needs are shared with providers and are addressed by strategies developed by community partnerships. These services meet needs across the variety of major life activities.

Many projects and agencies exist with various service delivery models and various levels of community and cross discipline involvement. Improved communication and coordination are keys in achieving services that are comprehensive and collaborative.

Actions

1. The Alaska Mental Health Board, Governor's Council on Disabilities and Special Education and Alaska Mental Health Trust Authority will advocate for full funding of the continuum of services.
2. The Department of Health and Social Services and Department of Education will explore and implement a case manager model.
3. The Department of Health and Social Services and Department of Education will establish centralized communication and coordination strategies.
4. The Department of Health and Social Services and Department of Education will examine interpretations of laws and regulations to remove barriers to creating needed flexibility.
5. The Department of Health and Social Services and Department of Education will remove unnecessary barriers to accessing relevant client information while preserving needed confidentiality.
6. Local agencies and school districts will examine the current continuum of care to focus on early intervention.
7. Increase access to foster care and other care options, social and recreational activities, and programs for drug and violence-free communities.
8. Local communities and organizations will ensure parent involvement in and supervision of their children by educating families regarding the benefits of parent involvement and by supporting families in creating time with their children.
9. Develop understandable guide materials for parents, families and advocacy groups.

Goal 3: Expand treatment models available to school districts.

Actions

1. Use comprehensive, coordinated, collaborative service models that are school based, use mental health staff in schools and coordinate social services.
2. Make social skills training part of the regular school curriculum.
3. The Department of Education will train teachers to make more effective use of behavior plans.
4. The Department of Education will assist schools in using intervention assistance teams as an initial step in school behavior problem referrals.
5. The Department of Education, Division of Mental Health and Developmental Disabilities and Alaska Mental Health Board will support student directed interventions in schools (e.g., conflict mediation, peer counseling, student court).
6. The Alaska Department of Education, school districts and Project Spruce will train school counselors and school psychologists to be more effective in prevention, early intervention, consultation and staff development regarding serious emotional disturbances in children.

Goal 4: Expand resources available to parents and providers of services for children with serious emotional disturbances and their families.

Actions

1. The Alaska Mental Health Board, Governor's Council and advocacy groups will provide comprehensive formatted information for families accessing services.
2. Advocacy and professional groups will provide training for parents of children with serious emotional disturbances and the Alaska Mental Health Board will advocate for a requirement that this training be a part of any public managed care system.
3. The Alaska Department of Education will encourage the creation of school social worker positions or other positions to work on social skills training, designing behavior plans for children, etc.
4. Provide training on serious emotional disturbances issues and networking for school psychologists in isolated districts through Project SPRUCE.

5. The Alaska Department of Education will provide training activities for school district staff and administrators to encourage schools to offer varied treatment options for students with behavior problems.
6. Local communities and providers will increase parenting skills by creating incentives to parents to take classes and courses and form parent peer groups.

Goal 5: Encourage more collaborative service delivery models for serious emotionally disturbed children and their families.

Actions

1. The Governor's Council, Alaska Mental Health Board, Alaska Department of Education and others will support combining school and community mental health jobs, creating school social worker positions, and redirecting school psychologists and counselors to a greater prevention and behavioral intervention focus, especially through sharing information with school districts about successful projects.
2. The Alaska Department of Education will ensure through awareness training that school and school-service agency collaboration involves parents as members of the service team.
3. School personnel and service providers will receive needed training in collaborative interagency efforts.
4. The Alaska Mental Health Board, Governor's Council on Disabilities and Special Education, Division of Mental Health and Developmental Disabilities, Division of Family and Youth Services and Alaska Department of Education will explore ways to: reduce delays in records transfer when children move or change programs; standardize forms and intake procedures among programs; and provide continuity of services when children lose eligibility for specific programs.

Goal 6: Increase resources available to teachers and service providers who work with serious emotionally disturbed students.

Actions

1. Provide teachers with directories of community mental health resources and the time to access resources.
2. Encourage collaboration regarding services to children with serious emotional disturbances and their families on the state departmental levels and within communities.

3. Provide joint conference opportunities and shared in service training for teachers of children with serious emotional disturbances and mental health providers.
4. Evaluate and, when appropriate, expand the work of the Special Education Service Agency which is working on community prevention models to reduce the incidence of serious emotional disturbances on a community by community basis.

Children and Youth Services Action Team Members

Kathy Craft, Chair, Alaska Community Mental Health Services Association
Tom Begich, Division of Family and Youth Services
Kate Cross-Das, National Alliance for the Mentally Ill, Fairbanks
Nancy Dodge, Whaley School
Dave Fleurant, Disability Law Center
Mishal Goade, Tanana Chiefs Conference
Sandra Juneby, Alaska Mental Health Board
Maggie Knowles, Bureau of Indian Affairs
Sarah McConnell, Children and Youth Task Force
Gina Macdonald, Division of Mental Health and Developmental Disabilities
Jan McGillivary, Alaska Mental Health Association
Jim Maley, Alaska Association of Homes for Children
Larry Michael, Special Education
Laura Rorem, Alaska Mental Health Board
Millie Ryan, Governor's Council on Disabilities and Special Education
Claudia Shanley, Maternal, Child and Family Health, Division of Public Health
Pamela Simpson, Special Education Service Agency
Richard Smiley, Alaska Department of Education
Dave Williams, Division of Medical Assistance
Dick Wilson, National Alliance for the Mentally Ill, Sitka
Staff: Margo Waring, Alaska Mental Health Board

Alaska Mental Health Board Children's Sub-Committee

Sheila Gaddis, Chair
Daniel Bill
Karl Brimmer
Jan MacClarence

RURAL SERVICES

Introduction

Many factors require unique consideration of rural mental health issues. All of these factors point to a much different reality than that of more urban counterparts and many of the factors relate to geography. A myriad of issues surround geography including: separation from road systems, creating access barriers for most goods and services; higher cost for transportation, goods and services; and the isolation experienced by rural Alaskans.

Mental health service provision in villages and rural communities is very different than in urban Alaska. Mental health services are more scarce, with many villages having no mental health-related services or a single paraprofessional to address all human service needs. Rural and village mental health service providers feel enormous responsibility for community wellbeing, yet are often cut off from outside forms of support. Efforts to increase mental health services through Medicaid refinancing have not been effective and applicable to rural Alaska, which has increased concerns about the inequitable distribution of resources to rural Alaskan communities.

Special efforts are needed to address the unique mental health needs of rural Alaska. Efforts should based on a strengths perspective, emphasize culturally-based service models and enhance programs that have demonstrated success, such as the Rural Human Services Worker Program. At the same time, the extent and interrelation of significant social issues (domestic violence, sexual assault, mental health, alcoholism/drug abuse, suicide) in rural communities needs to be recognized; integrated program approaches that address the interrelation of these issues need to be promoted and enhanced. When these approaches are combined with adequate resources and more effective networking between rural and urban communities, significant improvements will result in the mental health of rural Alaska.

Issue 1: The Inadequate Exchange of Treatment-Related Information When Rural Consumers Leave Their Community of Origin for Treatment

Goal: Enhance ways of sharing client-specific information among agencies assisting persons with mental illness.

Discussion

It is critical that there be a balance between confidentiality and collaboration regarding treatment-related services to persons with mental illnesses. Mental health consumers have fundamental rights regarding confidentiality which are set out through various laws and regulations. It is essential that these confidentiality rights be acknowledged and respected, particularly in rural communities where it is often difficult to maintain a sense of personal privacy, and where community ties may be stronger than in urban areas.

At the same time, to ensure continuity of care, it is essential that there be adequate collaboration and information sharing among providers, particularly when rural consumers receive services outside their home communities. Evidence indicates that this collaboration is seriously lacking at this time, and that confidentiality rules unintentionally delay, impede and obstruct routine service delivery to rural consumers.

Rural mental health providers frequently have difficulty receiving and/or obtaining from other programs routine discharge information such as discharge summaries, treatment recommendations and current medications. This typically results when rural consumers leave out-of-community programs and do not sign releases to forward information, or do not acknowledge that they will be seeking services in a rural community. Even when local programs are identified and an information release is obtained, information usually arrives long after the client has returned to the village.

The circumstances described above create great barriers to service provision for rural consumers. Rural mental health providers must often go to extraordinary lengths to obtain even routine information from out-of-community providers. This labor typically involves contacting the previous program, seeking and obtaining the client's written consent to the release, faxing the release (if this is acceptable to the program), contacting the program, and finding the appropriate individual with whom to discuss the case. If medication is an issue, the situation is more complex since the

rural provider must also obtain or assist the client in obtaining the recommended medication.

Actions

1. Enhance the use of/develop the following protocols to facilitate client-related communication between rural providers and out-of community providers:
   a. Two-way information releases that can be initiated either before a client leaves a rural community to receive treatment or prior to the client's release from an out-of-community program.
   b. Mechanisms for multi-agency releases and enhanced case conferencing among mental health and other service providers.
   c. Guidelines for enhanced communications between mental health and school personnel regarding children and youth who leave their communities to receive mental health services.

   Responsible party: Division of Mental Health and Developmental Disabilities, Department of Education, Alaska Mental Health Board, Alaska Community Mental Health Services Association, Rural Alaska Program Directors Association
2. Provide a brochure or written instructions to programs impacted by the new information sharing protocols.
   Responsible party: Division of Mental Health and Developmental Disabilities
3. Provide training to all affected provider organizations impacted by the newly developed protocols.
   Responsible party: Division of Mental Health and Developmental Disabilities
4. Investigate the feasibility of law or regulations changes to require treatment programs to pursue front-end releases from clients prior to discharge.
   Responsible party: Alaska Mental Health Board, Division of Mental Health and Developmental Disabilities, Department of Law

Issue 2: Lack of Culturally-based Service Models

Goal: Support the development of more culturally-based service models that are locally determined and have broad-based community involvement.

Discussion

Traditional healing seeks a sense of wholeness with people, cultures and communities. Before contact with Western civilization, the indigenous

people of Alaska depended on a knowledge of anatomy, herbal medicine and other healing practices for health maintenance. Generally, traditional healing focused on the person in the context of their community, rather than on a discreet biomedical illness. The emphasis was on health, not disease. Disease and illness, including mental illness, were not perceived as items to be conquered and removed from life, but as natural parts of the person and life itself.

In many Native nations, the power of healing came from a spiritual source and was given to the people. This power was seen as a renewable resource--the more healing was received, the more there was to give. Healing became continually available to all as a gift to be shared, seeking to empower people and liberate them from obstacles to their well being.

In the 1900's, Western-trained medical practitioners became an increasingly important source of health care for Alaska Natives. This occurred simultaneously with the discouragement of traditional beliefs and practices by Native persons. In this way, a healing-oriented social system that had been ideally suited to its purpose, was replaced by another system which was ill suited to the social, physiological and psychological needs of Alaska Natives.

To ensure greater local ownership of mental health issues, there is a need to support rural communities in validating their cultural framework, and applying this framework to the development of service models and prevention efforts. Traditional practices such as mentoring relationships with elders can be an especially effective prevention and early intervention strategy. Each community must establish and maintain a process for broad-based community involvement to define its approach to mental health issues. In many communities, this process has already begun.

At the same time, it is important to recognize that traditional culture is stronger in some communities than in others. The extent and form of culturally-based service and prevention models should be determined through the coordinated input of village councils, elders, community leaders, mental health and substance abuse service providers, legal personnel, school officials, health practitioners, etc. In this way each community can decide for itself how traditional its approaches to prevention and mental health service provision will be.

Actions

1. Sponsor regional and statewide forums to highlight and validate current village-based cultural approaches to mental health service provision.
   Responsible party: Alaska Mental Health Board, Division of Mental Health and Developmental Disabilities, Division of Alcoholism and Drug Abuse, regional health corporations
2. Increase cultural awareness training for providers of mental health services to rural communities; whenever possible, this training should be provided by rural community members.
   Responsible party: Division of Mental Health and Developmental Disabilities, Division of Alcoholism and Drug Abuse
3. Provide technical assistance/funding incentives to rural communities that demonstrate a commitment to broad-based community involvement in addressing mental health-related issues.
   Responsible party: Division of Mental Health and Developmental Disabilities, Division of Alcoholism and Drug Abuse, Division of Family and Youth Services, Alaska Mental Health Board, Alaska Mental Health Trust Authority
4. Work with the Department of Social Work, School of Nursing and other pertinent University programs to increase the enrollment of rural students, enhance distance delivery of degree programs, and maximize curriculum emphasis on culturally-responsive service provision.
   Responsible party: University of Alaska (especially the College of Rural Alaska), Alaska Mental Health Board

Issue 3: The Equitable Distribution of Resources to Rural Communities

Goal: Examine and implement differential funding mechanisms for rural mental health services.

Discussion

Community mental health programs throughout the state are predominately funded through Division of Mental Health and Developmental Disabilities grants, Medicaid and other third party sources. While grant funds have been reduced in recent years, there has been a substantial increase in Medicaid funding for mental health services. This growth in Medicaid has occurred primarily within the more

urban areas of Alaska. An unintended consequence of cost-shifting from grants to Medicaid is that most rural communities are not full participants in Medicaid refinancing, and are therefore not receiving adequate financial support to address pressing and fundamental mental health needs.

Though many rural mental health programs may be eligible for third party and Medicaid reimbursement for services, these revenue sources have proven to be insufficient and unreliable in supporting program operations. In many cases, the pool of Medicaid and third party clients is small in rural communities, which creates a disincentive for pursuing these reimbursement options. In addition, rural programs often lack the personnel resources and administrative infrastructure to capture Medicaid reimbursement, and are reluctant to divert scant existing resources away from direct client services. It is also difficult to receive Medicaid and third party reimbursement for prevention and early intervention efforts, which are perceived as essential in rural communities.

The advent of managed behavioral health care presents another potential threat to an already eroding funding base for rural mental health services. Under typical managed care arrangements, providers enter into fee-for-service arrangements with managed care organizations which function as intermediaries between funding agencies and the service providers. Many rural programs would not be able to maintain their current base of services in conventional managed care arrangements due to the remoteness of their programs, limited personnel, and small client populations.

The combined impact of diminishing grant funds, Medicaid inaccessibility and expectation to implement managed care strategies threaten the ability of rural mental health programs to respond to pressing community needs. In contrast to urban areas where there are often choices among services and service providers, rural mental health programs are often the only programs available to address a variety of mental-health related issues. To maintain this basic safety net, it is essential that there be discrete funding alternatives for rural communities to address fundamental community mental health needs.

Actions

1. Maintain/increase the grant-in-aid funding process for rural programs.
2. Monitor combined grant and Medicaid funding to programs or regions and adjust grant funding as Medicaid revenues increase or decrease.
3. Require that rural representatives be appointed to all grant review and funding decision processes for community mental health services.
4. Determine which rural programs have potential for greater participation in the Medicaid program.
5. For those programs identified under #4, establish specific mechanisms to enhance capacity for Medicaid reimbursement, e.g., assistance/resources with Medicaid billings.
6. Ensure that funding decisions fully recognize and respond to the higher cost of travel and other aspects of service provision in rural communities.

   Responsible party (actions 1-6): Division of Mental Health and Developmental Disabilities, Division of Alcoholism and Drug Abuse, Division of Family and Youth Services, Alaska Mental Health Board, Governor's Advisory Board on Alcoholism and Drug Abuse, Alaska Mental Health Trust Authority
7. Explore the feasibility of establishing a greater structural focus within the Department of Health and Social Services on rural health services, including rural mental health programs, e.g., a division or office focusing on rural issues.

   Responsible party: Department of Health and Social Services Commissioner's Office
8. Assist rural communities in determining which programs could successfully implement and sustain managed mental health care approaches to service provision.
9. If managed care is implemented for rural programs, ensure that adequate resources are available for responding to the needs of high-risk clients.

   Responsible party (actions 8-9): Division of Mental Health and Developmental Disabilities, Division of Medical Assistance, Alaska Mental Health Board

Issue 4: Lack of Support Network and Isolation of Rural Providers

Goal: Develop, enhance and fund models and support systems that maximize the use of indigenous rural resources and the coordination of internal and external resources.

Discussion

Due to complex situational demands and social pressure, rural mental health providers feel alone, isolated and estranged from peer support. They often feel an extreme sense of responsibility for addressing mental health-related needs in their communities. These factors combine to create a sense of powerlessness and burnout, and result in increased turnover among rural providers.

Most rural mental health providers work in isolated communities which range in population from a few hundred to a few thousand residents, and are typically accessible only by air. Rural mental health programs have limited professional, paraprofessional and program support personnel. Rural program expenditures are also higher than their urban counterparts due to high transportation, facility, shipping and utility expenses.

Rural mental health workers, at both the village and rural hub level, must be available on a 24-hour per day, seven days per week basis to respond to various types of crises. In addition, rural paraprofessional and professional providers are expected to participate in numerous community events ranging from celebrations to gatherings regarding community tragedies.

In larger rural communities, the mental health programs are generally the only mental health resource in the area and have little or no back-up professional support during times of crisis. Rural hub providers are often perceived as a clearinghouse for many social services, in addition to mental health services, and experience extraordinary demands on their time and energy.

At the village level, paraprofessional workers may have access to a professional program director in a rural hub community for guidance and support. At the same time, these village workers are often perceived by their communities as the only mental health resource and feel an

increased burden of responsibility for community well being. Since the village paraprofessionals are community members themselves, they have multiple roles and the line between community member and community helper often becomes blurred.

Of particular concern are the tragedies which occur in small communities. When a sudden, unexpected death occurs, the whole community is overwhelmed and shocked with the event, and must address feelings of disbelief, loss and grief. The rural mental health provider, who shares these emotional responses, is also expected to provide comfort and support to both the community and individual community members. Village paraprofessionals often feel an additional sense of responsibility for the loss and lack a support system to process their own feelings.

Actions

1. Work in concert with Native corporations to identify and strengthen cultural and familial support networks in rural communities; these support systems should include village elders whenever possible.
   Responsible party: Division of Mental Health and Developmental Disabilities, Division of Alcoholism and Drug Abuse, Division of Family and Youth Services, Alaska Mental Health Board, Governor's Advisory Board on Alcoholism and Drug Abuse
2. Establish and publicize a 24-hour per day, seven day per week, support system for rural providers to access in times of emergency or when clinical consultation is needed.
3. Provide updated telecommunication technologies to rural mental health workers including telemedicine services, E-mail and Internet access, and provide training in use of new technologies. The use of telemedicine as a tool in screening, assessment, evaluation and treatment should be explored.
4. Enhance and strengthen the linkage between Alaska Psychiatric Institute and rural providers (including rural hospitals) by offering orientation programs for new rural providers and ongoing staff development for existing rural paraprofessional and professional providers.
5. Strengthen the relationship between urban community mental health centers and rural providers by offering orientations and network building at the urban centers.
   Responsible party (actions 2-5): Division of Mental Health and Developmental Disabilities, Alaska Mental Health Board, Alaska Community Mental Health Services Association, Rural Alaska Mental Health Directors Association, Alaska Mental Health Trust Authority

6. Ensure adequate funding for rural paraprofessionals and supervisors to attend the Rural Human Services Training Program through the University of Alaska to enhance skill development and increase peer support networks.
7. Provide funding for periodic rural mental health conferences to address the staff development and networking needs of mental health professionals and paraprofessionals in rural communities.

Responsible party (actions 6-7): Division of Mental Health and Developmental Disabilities, Alaska Mental Health Board, Division of Alcoholism and Drug Abuse, Governor's Advisory Board on Alcoholism and Drug Abuse, University of Alaska, Alaska Mental Health Trust Authority

Issue 5: Rural Human Services Worker Program

Goal: Provide greater support, recognition and funding for the Rural Human Services System Program (RHSSP).

Discussion

The Rural Human Services System Project began in 1992 as a way to increase the number of rural communities with resident, appropriately trained, generalist human service providers. It offers grants to qualified agencies, including Native Health Corporations and non-profit organizations, to hire, train and supervise village-based human service workers. Currently, about 50 Alaska villages have village-based human service workers wholly or parted supported with RHSSP grant funds.

The Rural Human Services System Project includes both educational and direct service components. For the educational component, the RHSSP worked closely with the University of Alaska to develop a training program which is fully accredited, articulates with more advanced degree programs and incorporates both Native and Western healing skills and knowledge. The 30-credit program is guided by a statewide Alaska Native Coordinating Council and is taught through both the Interior-Aleutian (based in Fairbanks) and Kuskokwim campuses of the College of Rural Alaska.

For the direct services component, Rural Human Services System Project village workers are providing a broad range of prevention, treatment and aftercare services. Each community defines and prioritizes its unique

service needs; the specific array of RHSSP services therefore varies from community to community.

By all measures, the Rural Human Services System Project is successful. Agencies employing RHSSP trained village workers report that the village staff are effectively intervening in behavioral health emergencies and reducing the number of crisis transports outside the community. In addition, increasing numbers of the RHSSP training program graduates are choosing to continue their education by pursing AA, BA and MA degrees. Partly due to this heightened interest, several University programs are coordinating to make it easier for rural Alaskans to pursue advanced degrees in social work, psychology and human services without needing to leave their communities for extended periods.

Despite this track record of success, there are still many limitations associated with the Rural Human Services System Project program. These limitations include: inadequate funds to serve more communities through RHSSP workers; lack of funds to address the ongoing training and supervision needs of the village workers; difficulties in establishing a career ladder for RHSSP workers and the need for greater peer support for the village human service workers. To adequately address the human service needs in rural Alaska, there is a need to build upon the successes of the RHSSP and address current program deficiencies.

Actions

1. Establish a joint mental health and substance abuse advisory process to assist with planning and policy development for the Rural Human Services System Project.
   Responsible party: Division of Alcoholism and Drug Abuse, Alaska Mental Health Board, Division of Mental Health and Developmental Disabilities, Governor's Advisory Board on Alcoholism and Drug Abuse, University of Alaska
2. Provide funding to increase the number of communities served through the Rural Human Services System Project program; an emphasis should be placed on funding strategies which promote greater self-sufficiency through such means as Indian Health Service Medicaid billings.
3. Provide funding designated specifically to address the ongoing training needs of Rural Human Services System Project village workers; current funding is limited to the basic certification training.

4. Ensure that Rural Human Services workers have adequate supervision by an appropriate mental health professional who has experience in long distance supervision.
5. Provide funding for a Rural Human Services System Project conference to address such issues as: identifying current program needs, promoting alternative revenue sources, sharing program successes and developing educational and career advancement.
   Responsible party (actions 2-5): Division of Alcoholism and Drug Abuse, Alaska Mental Health Board, Governor's Advisory Board on Alcoholism and Drug Abuse, Alaska Mental Health Trust Authority
6. Add a mental health presence to the current University efforts to expand opportunities for rural residents to obtain human service and/or social work degrees without relocating to urban settings.
   Responsible party: Division of Mental Health and Developmental Disabilities, Alaska Mental Health Board, Rural Alaska Mental Health Directors Association, University of Alaska
7. Encourage agencies that employ Rural Human Services System Project village workers to develop career ladders and other forms of career advancement for the RHSSP workers.
   Responsible party: Division of Alcoholism and Drug Abuse
8. Support the development of the Professional Association of Rural Counselors of Alaska; the group is being formed to provide peer support for Rural Human Services System Project program graduates and to develop standards and procedures for rural counselor certification.
   Responsible party: Governor's Advisory Board on Alcoholism and Drug Abuse, Alaska Mental Health Board, Alaska Mental Health Trust Authority
9. Collect and analyze data on the location, training and tasks of paraprofessional human service workers in rural Alaska to explore opportunities for cross training, joint supervision and efforts to avoid duplication of services.
   Responsible party: University of Alaska Department of Social Work, Alaska Mental Health Board

Issue 6: Interrelationship of Mental Health, Domestic Violence, Sexual Assault, Suicide, and Alcoholism

Goal: Assist rural communities in addressing the interrelationship of these problems through a combination of community approaches and outside assistance and support.

Discussion

Anecdotal and research data indicate an interrelationship between substance abuse, mental health problems, various forms of interpersonal violence and abuse, and self destructive behavior, including suicide. There is an intergenerational pattern to these behaviors; for Alaska Natives, these behavior patterns have been linked to multigenerational, post traumatic stress stemming from losses suffered in the epidemics of the early 1900's. The dramatic changes in lifestyle due to settlement by miners, traders and missionaries, combined with the change from a barter to money-based economy created additional stressors which have contributed to these major social problems in many Alaskan communities.

Despite general recognition of the interrelationship of these problems, services designed to prevent and treat the problems continue to be fragmented. Differences in professional training and education of providers coupled with differences in funding sources, philosophies and program requirements contribute to the fragmentation of services. Special projects designed to enhance collaboration do not appear to have substantially altered the fragmented nature of the basic service system.

The interrelationship among major social problems and lack of integrated service delivery, while true for communities of all sizes, is particularly devastating for smaller, rural communities. For example, high rates of suicide and suicide attempts, especially among young Alaska Native men, cause great pain in rural Alaska communities. It is important to recognize that substance abuse, self destructive behavior, and interpersonal violence/abuse are not isolated acts, but rather actions taken by individuals in the context of family, community and culture. These problems require an interdisciplinary approach to address the multiple psychological, social, economic and cultural factors which contribute to their existence.

There is mounting evidence that integrated, culturally-based approaches to social problems are best addressed from within, i.e., by the community

itself. Communities cannot address these issues successfully, however, without support from outside entities that can provide technical assistance and financial resources. The Community-Based Suicide Prevention Program is an example of a partnership between rural communities and outside agencies. This program provides small grants to rural Alaskan communities and assists communities in designing and implementing strategies to reduce suicide and other self-destructive behavior. Data indicates that, as a group, the communities that have sustained suicide prevention projects for three or more years have reduced the rate of suicide at a greater rate than other Alaska communities.

Actions

1. Increase funding for the Community-Based Suicide Prevention Program to enhance services and training for existing communities and to allow additional communities to participate in the program. (Since the program's inception in FY 89, the average grant award has actually declined from $15,000 to $13,000.)
   Responsible party: Governor's Advisory Board on Alcoholism and Drug Abuse, Division of Alcoholism and Drug Abuse, Alaska Mental Health Board, Alaska Mental Health Trust Authority
2. Provide training funds for communities wishing to develop integrated, community-based teams to address behavioral and social problems. Training should focus on cross training among program disciplines and general skills and strategies related to community problem solving, and project organizing, planning and implementation.
3. Provide training to regional mental health, substance abuse and social service agencies in how to best support integrated, community-based programs.
4. Enhance the ability of communities to share experiences and knowledge regarding integrated community programs through such mechanisms as newsletters, web pages and Internet user groups.
   Responsible party (actions 2-4): Governor's Advisory Board on Alcoholism and Drug Abuse, Division of Alcoholism and Drug Abuse, Alaska Mental Health Board, Division of Mental Health and Developmental Disabilities, Division of Family and Youth Services, Alaska Mental Health Trust Authority
5. Explore funding options to develop a Community-Based Behavioral and Social Health Program to address behavioral and social problems in an integrated manner, including:
   a. Merging of existing funding streams to develop pilot projects in local communities.

b. Funding for new grants to develop integrated local projects.
Responsible party: Governor's Advisory Board on Alcoholism and Drug Abuse, Division of Alcoholism and Drug Abuse, Alaska Mental Health Board, Division of Mental Health and Developmental Disabilities, Division of Family and Youth Services, Division of Public Health, Division of Public Assistance, regional health corporations

Issue 7: The Absence of Crisis Respite Services in Most Rural Communities

Goal: Increase crisis respite capacity in rural regions throughout the state.

Discussion

Crisis respite services play a vital role in the continuum of care for children, adolescents and adults. In a crisis respite setting, clients receive stabilization and safety monitoring services which may prevent and forestall more costly and restrictive institutional and out-of-community care. In addition, crisis respite is an important service for youth and adults who are transitioning back to less restrictive care after receiving intensive institutional services. Increased grant funding for local crisis respite services has been a long-standing Alaska Mental Health Board priority and has been universally endorsed as an essential service by consumers, families, advocates and providers.

Current crisis respite services exist primarily in urban communities, with a limited number of crisis respite beds available in rural hub communities. The need for crisis respite services, however, is particularly acute in rural Alaska, due to the lack of other available mental health services. In many cases, a person with a mental health crisis in a rural village has no other service option other than respite care or psychiatric hospitalization in an urban community. In some cases, clients are transported in restraints to urban hospitals (including Alaska Psychiatric Institute) and then are not admitted because they no longer meet the criteria for civil commitment or the crisis has otherwise diminished. This disruption, additional anguish, and transportation cost could be avoided or decreased if respite care were more readily available in rural communities.

There are two basic models of crisis respite care. The first model is a traditional crisis respite program which is facility-based and has staffing on a 24-hour per day, seven day per week basis. This model is more appropriate in urban communities where the number of clients needing respite care justifies the full time nature of the program.

The second model is "client and family centered" crisis respite care which maximizes the use of existing community services. This model promotes innovative approaches including respite within emergency foster care homes, small facility-based crisis respite in rented homes with on-call staff, and adding a crisis respite component to existing community residential programs (substance abuse, women's shelters, youth homes, etc.); this last approach has been successfully implemented in Kotzebue. In smaller villages, respite care could take the form of a paid attendant to provide 24-hour support to residents experiencing mental health crises.

Due to its emphasis on using existing community and family resources, the client and family centered care model is a much more appropriate model for rural Alaska communities. This model allows the possibility of expanding crisis respite services in rural hub communities as well as providing respite care directly in appropriate village settings.

Actions

1. Expand existing crisis respite services in rural hub communities to function as an intermediate step between villages and urban centers.
2. Provide funding for client and family centered crisis respite services in villages and rural hub communities.
3. Provide training and technical assistance to rural communities in the development of client and family centered crisis respite services.
   Responsible party (actions 1-3): Division of Mental Health and Developmental Disabilities, Alaska Mental Health Board, Alaska Mental Health Trust Authority
4. Ensure that Medicaid funds are appropriately used as a funding source for crisis respite services for eligible clients.
   Responsible party: Division of Mental Health and Developmental Disabilities, Division of Medical Assistance

Issue 8: The Lack of Title 47 Evaluation Services in Most Rural Communities

Goal: Develop statewide Title 47 evaluation services in hospitals throughout Alaska.

Discussion

In most cases, rural communities are inadequately equipped to respond to client situations requiring evaluation for involuntary commitment under Title 47. The law requires that the evaluation take place within a hospital setting. Presently there are very few rural hospitals that are actually providing Title 47 evaluation services. Many clients are therefore detained in jails, alongside criminal detainees, until they can be transferred to an urban hospital or Alaska Psychiatric Institute for evaluation.

The net result is that the primary respondents to acute, mental health crises in rural areas are usually law enforcement officers with little or no mental health support. Rural hospitals, clinics and community mental health aides are currently unable to provide necessary screening and evaluation services or safe, alternative detention while awaiting transfer of the client to an available evaluation facility.

Encouraging rural hospitals to function as Title 47 evaluation facilities will allow rural consumers to remain closer to their communities and families while reducing the burden on urban facilities to accept additional patients. Recently, Bethel has begun to provide Title 47 evaluation services on a routine basis within its local hospital. The impediments to developing psychiatric evaluation services in other rural hospitals should be more fully explored and resolved.

It is also important to note that the effectiveness of rural hospital psychiatric evaluation services is in part dependent on the availability of crisis respite services in local communities. Crisis respite may be needed prior to hospital-based evaluation and as a discharge option for transition to less restrictive community care. It is therefore important that there be concurrent planning for rural crisis respite and Title 47 evaluation services.

Actions

1. Review psychiatric admission data for Alaska Psychiatric Institute and other hospitals to determine those rural communities with the greatest need for local/regional evaluation services.
2. Conduct meetings with representatives of rural hospitals to better understand the impediments to providing Title 47 evaluation services.
   Responsible party (actions 1-2): Alaska Mental Health Board, Division of Mental Health and Developmental Disabilities
3. Explore the possibility of limiting liability for hospitals agreeing to work with Title 47 patients.
   Responsible Entities: Division of Mental Health and Developmental Disabilities, Department of Law
4. Publicize and enhance the availability of Alaska Psychiatric Institute's 24-hour psychiatric back-up consultation to local hospitals.
5. Explore the possible use of telemedicine for consultation and/or screening and evaluation in relationship to Title 47 services.
6. Continue and enhance technical assistance efforts to rural hospitals that are providing Title 47 evaluations or are considering adding this service.
   Responsible party (actions 4-6): Division of Mental Health and Developmental Disabilities/Alaska Psychiatric Institute
7. Provide funding for any renovations necessary to accommodate Title 47 evaluations within rural hospitals.
8. Implement pertinent recommendations from the Alaska Mental Health Board's regional planning process for inpatient psychiatric services. (Under this process, local hospitals and community mental health centers within pre-defined regions received planning grants to assess the need for regional inpatient psychiatric services.)
   Responsible party (actions 7-8): Alaska Mental Health Board, Division of Mental Health and Developmental Disabilities, Alaska Mental Health Trust Authority

Issue 9: Welfare Reform

Goal: Assess the unique impact of welfare reform on rural Alaska and develop collaborative strategies to mitigate any negative impact.

Discussion

There is a need to assess the unique impact of welfare reform on rural communities. These communities may not have the necessary resource base to successfully implement the changes required under welfare reform. As a result, the ability of rural residents to meet basic life needs may be seriously and negatively impacted by welfare reform.

The Alaska Temporary Assistance Program and corresponding federal Temporary Assistance for Needy Families Program, require a shift from public assistance to work activities for current and future welfare recipients. There may not be adequate jobs available in rural communities, however, to accommodate welfare to work requirements. Some residents may need to relocate from villages to rural hub communities and urban centers to find jobs. In addition, there is a lack of child care resources in rural areas to support the move from welfare to work; this will place an increased burden on extended families in rural communities to provide needed child care services.

Other aspects of welfare reform will also impact rural communities. Many rural residents, including immigrants, children with serious emotional disorders, and people with alcohol/drug disabilities, have lost Social Security Insurance assistance due to recent changes in this federal program. In many cases, the affected groups have also lost Adult Public Assistance support and Medicaid coverage. Some rural residents have also lost eligibility for the federal Food Stamp program.

There is a great concern about the potential cumulative impact of welfare reform initiatives on rural communities. A substantial number of rural residents will experience the stress of losing their current economic safety net, combined with increased pressure to find work which may not be available in their home communities. With less formalized support services than in urban areas, rural communities will be forced to rely more heavily on families and informal community supports to accommodate the changes required by welfare reform. There is a strong possibility that this increased family and community stress will lead to higher rates of family violence, sexual assault, alcoholism and suicide. There will also likely be a much greater need and demand for mental

health services to assist community members in coping with these increased life stresses.

Actions

1. Conduct an assessment/study of the differential impact of welfare reform on rural communities, including the following elements:
   a. A review of Social Security Insurance data to determine the geographic distribution of persons receiving and losing Social Security Insurance benefits.
   b. A review of Alaska Temporary Assistance Program data to determine program participation patterns throughout the state and relative success rates in transitioning from welfare to work activities.
   c. An analysis of migration patterns resulting from welfare reform activities, including the number of persons displaced from their communities of origin.
   d. A statewide analysis of any major changes in the demand for mental health, domestic violence/sexual assault and substance abuse services as a result of welfare reform.
   e. An analysis of the system used to determine who will be eligible for the exception from the five-year limit on financial assistance under Alaska Temporary Assistance Program.

   Responsible party: Division of Public Assistance, Division of Alcoholism and Drug Abuse, Division of Family and Youth Services, Division of Mental Health and Developmental Disabilities, Council on Domestic Violence and Sexual Assault
2. Pursue funding from the Alaska Mental Health Trust Authority to conduct the above study.

   Responsible party: Department of Health and Social Services, Alaska Mental Health Board
3. Based on the results of the study, implement specific strategies to address the impact of welfare reform on rural communities. These strategies might include:
   a. Adjustments in funding for mental health, substance abuse and domestic violence/sexual assault programs to address any increased demand.
   b. Changes in Alaska Temporary Assistance Program program policies to address areas of concern and to target program resources to communities and regions that are most in need.
   c. Possible statutory, regulatory and policy changes to help enhance the economic well-being of rural communities impacted by welfare reform.

Responsible party: Division of Public Assistance, Division of Alcoholism and Drug Abuse, Division of Family and Youth Services, Division of Mental Health and Developmental Disabilities, Council on Domestic Violence and Sexual Assault

4. Provide increased educational information to rural communities on the scope and details of welfare reform changes. An emphasis should be place on building partnerships between state, regional and local entities in planning and providing the training activities.
Responsible party: Division of Public Assistance, regional Native corporations, local governments and tribal councils

Rural Action Team Members

John Battaglia, Division of Mental Health and Developmental Disabilities
James Berner, Alaska Area Native Health Services
Daniel Bill, Alaska Mental Health Board
Charlene Fisher, Council of Athabascan Tribal Governments
Marilee Fletcher, Division of Alcoholism and Drug Abuse
Glen Herbst, Police Department, Unalaska
Sandra Juneby, Alaska Mental Health Board
Robert Morgan, Alaska Native Foundation
Agnes Rychnovsky, Alaska Mental Health Board
Susan Soule, Division of Alcoholism and Drug Abuse
Mark Snipes, Rural Mental Health Directors Association
Staff: Walter Majoros, Alaska Mental Health Board

ADULT SERVICES

Introduction

Based on methods developed by national experts, the Alaska Mental Health Board estimates that 6.3% of Alaska's adult population experiences severe mental illness over the course of a typical year, the seventh highest rate in the nation. These figures represent only individuals whose mental illness results in significant functional impairments in daily living. In 1996, the prevalence rate means that 25,200 adults over age 19 experienced significant mental illness.

People experiencing psychiatric disorders need treatment/rehabilitation for their illness and may need supports in various aspects of their lives--employment, housing, transportation, social life. Participation by the person, family, natural support network and peers is vital to the treatment and recovery process. Many adults have their treatment and rehabilitation needs addressed by public (state and federal) service providers. Private service providers are also a vital element of mental health care in Alaska. These services may be financed by individuals, private health insurance or Medicaid reimbursement.

A focus for adult services in Alaska has been the down-sizing and redefining of the Alaska Psychiatric Institute (API) and the development of community resources to complement a smaller API. The development of community resources is only one change in the shape of adult psychiatric services in Alaska. Mental health advocates also see the need to move into the current managed care environment in ways that emphasize community values, equity principles and service quality, in addition to cost effectiveness and containment. Greater access to mental health care can be achieved by expansion of private health insurance coverage. Thus, the Alaska Mental Health Board and advocates have urged greater "mental health parity" in health insurance coverage on the state level, to complement federal legislative changes.

Since the Alaska Mental Health Board first developed *A Shared Vision* in 1992, the needs of people with psychiatric disabilities have been greatly furthered by a strong consumer movement advocating for adequate

funding of quality services and educating the public about psychiatric recovery. We are committed to assisting in these efforts.

Mental Health Services Issues

Context

The elements that constitute the comprehensive integrated mental health program are legally defined as those "public health programs and services that, on December 16, l994, are separately recognizable and administered, without regard to the administrative unit directly responsible for the delivery of the service; among the services included are services for the mentally ill, community mental health services, services for the developmentally disabled, alcoholism services, and services for children, youth, adults, and seniors with mental disorders; . . ." (See AS 47.30.056(2)(I)(1)). There is a minimum set of services specified in the statute that provides the framework for a continuum of care for adults (See AS 47.30.046):

- Emergency services on a 24-hour basis.
- Screening, examination, and evaluation services required to complete the involuntary commitment process.
- Inpatient care.
- Crisis stabilization services.
- Treatment services.
- Case management.
- Daily structure and support.
- Residential services.
- Vocational services.
- Outpatient screening, diagnosis, and treatment services.
- Prevention and education services.

The Community Mental Health Services Act's policy and principles guide the development and delivery of these services (See AS 47.30.523). The policy emphasizes integration and coordination of services between providers. It requires the community mental health program to:

- Provide a comprehensive and integrated system of community-based mental health services to persons most in need of these services, and

- Coordinate with programs established by the following three statutes: Alcoholism and Intoxication Treatment Act, Service Programs for Older Alaskans and Other Adults, and Persons with Disabilities; and with other programs affecting the well being of persons in need of mental health services.

The Legislature requires the Alaska Mental Health Trust Authority to follow certain guidelines regarding provision of services within the program that are paid for from the Trust. These services shall be "provided to recipients as close to the recipient's home and family as practical with due consideration of demographics, mental health service requirements, use of mental health services, economic feasibility, and capital expenditures required for the provision of minimum levels of service; . . ." (See AS 47.30.046(b)(5)).

Service Principles

Community Mental Health Services Act	Programs for Persons with Handicaps
Access	
Have ready and prompt access to necessary screening, diagnosis, and treatment.	Make services available at time and locations that enable residents of the provider's service area to readily obtain services.
Client Rights	
Be informed of all their rights, including the right to confidentiality and to treatment with dignity.	Ensure each client's right to confidentiality and treatment with dignity.
Qualified Staff	
Be provided services by trained competent staff who are sensitive to cultural and social differences.	Establish staffing patterns that reflect the cultural, linguistic, and other social characteristics of the community, and which incorporate multidisciplinary professional staff to meet client functional levels and diagnostic and treatment needs.
Treatment Planning	
Clients to be informed of and encouraged to participate in planning, delivering, and evaluating their treatment services; receive services designed to maximize individual potential and minimize institutionalization.	Promote client and family participation in formulating, delivering, and evaluating treatment and rehabilitation; design treatment and habilitation to maximize individual potential and minimize institutionalization.
Least Restrictive Setting	
Be treated in the least restrictive environment as close to home as possible.	Provide services in the least restrictive setting, enabling a person to live as normally as possible within the limitations of the handicap.

Issue 1: Early Intervention

Goal: Individuals with psychiatric illnesses will have access at the earliest possible time to recognized effective treatment, including treatment for those who are dually diagnosed with mental illness and substance abuse.

Discussion

Recent research indicates that early intervention and treatment dramatically impact the course of mental illness and that many people can go on to live normal and productive lives with appropriate treatment. Early diagnosis and treatment of psychiatric illness (early intervention) may diminish the disabling nature of mental illness. Early intervention is cost effective, as people will require fewer services over the course of their lives. This humane and simple goal frequently eludes us, meaning that adults who experience mental illness often wait for accurate diagnoses. Newly diagnosed patients are frequently given pharmacological interventions that are less than ideal, as cost savings measures, since the newest and most effective drugs are expensive. This approach is "penny wise and pound foolish."

People experiencing co-occurring mental illness and substance abuse problems have historically found access to services limited and fragmented. Coordinated and concurrent treatment for persons who experience both mental illness and substance abuse problems has been lacking. Yet, recent studies have found that 75% of people experiencing psychiatric disorders have a co-occurring substance abuse problem. Researchers believe that this often begins with attempts by mentally ill people to treat the symptoms of their illness with "self medication." Addictions and chronic disease develop over time. The federal Center for Mental Health Services stresses the need for mental illness and substance abuse to be treated simultaneously--not sequentially or in parallel systems. The current division of efforts provides a dramatic disservice to both populations. Optimum treatment cannot occur unless the barriers between providers are broken down.

Actions

1. Enhance collaboration between: the Division of Mental Health and Developmental Disabilities and the Division of Alcohol and Drug Abuse to provide simultaneous service delivery; the Alaska Mental Health Board and Alcoholism and Drug Abuse Advisory Board; and on the local level to enhance the response to people with co-occurring

disorders.
Responsible party: Division of Mental Health and Developmental Disabilities, Alaska Mental Health Board

2. The Alaska Mental Health Board will advocate with the Department of Health and Social Services and the Alaska Mental Health Trust Authority to eliminate the barriers between delivery of simultaneous mental health and substance abuse services.
Responsible party: Alaska Mental Health Board
3. The Alaska Mental Health Board, Alaska Mental Health Trust Authority, Governor's Council on Alcoholism and Drug Abuse and the Department of Health and Social Services will encourage cross training of mental health and substance abuse workers so that simultaneous services can be delivered.
Responsible party: Alaska Mental Health Board, Alaska Mental Health Trust Authority, Governor's Council on Alcoholism and Drug Abuse, Department of Health and Social Services
4. The Department of Health and Social Services will encourage grantees to deliver both mental health and substance abuse services and will seek more combined service providers.
5. The Department of Health and Social Services will develop internal processes to facilitate simultaneous service delivery.
6. The Department of Health and Social Services will work to ensure pooled funding for simultaneous substance abuse and mental health services.
7. Providers will be trained to treat substance abuse and mental illness simultaneously.
8. Managed care in the public and private sectors will act on the knowledge that early and appropriate interventions for mental illness and simultaneous treatment of co-occurring disorders are cost effective. Department of Health and Social Services staff will work with the state's insurance division and industry to promote these principles in private insurance.
Responsible party (actions 4-8): Department of Health and Social Services
9. Encourage greater public education, assessment, and outreach efforts to identify individuals with mental illness and encourage them to seek treatment.
Responsible party: Alaska Mental Health Board, Division of Mental Health and Developmental Disabilities, advocacy groups

Issue 2: Crisis Services

Goal: Ensure that crisis intervention services are readily accessible throughout the state.

Discussion

An adequate continuum of care for mentally ill adults must contain widely distributed access to crisis respite services. Crisis respite services are a "first line" effort to prevent hospitalization and a service which, after brief hospitalization, can minimize the need for extended hospitalization. Without adequate crisis respite services available, people in crises will be sent to hospitals first. However, Alaska's public psychiatric hospital, Alaska Psychiatric Institute (API), has been decreasing its bed capacity for nearly a decade. Plans call for the future API to divert more acute patients to regional hospitals for evaluation and treatment and to crisis beds, when this is determined to be the most appropriate level of care. Unless we fund adequate crisis respite services, we will overuse more costly hospital care.

Although good community support services reduce remission crises, there will be times when acute care and crisis stabilization services are required. Local hospital resources throughout Alaska could provide psychiatric evaluation services. Frequently, even a short stay for evaluation can provide enough support that a person can avoid further hospitalization, especially if crisis respite services are available upon discharge. In addition, strides have been made to use alternative facilities for the detox/evaluation needs of those who are intoxicated and threatening to harm themselves, rather than hospital level care. As API re-directs its mission toward tertiary care, more regional psychiatric treatment capacity will be needed to address acute care needs. This care will be closer to clients' homes and families and may be less costly than centralized care. However, system changes will be necessary for this new configuration of services to succeed. Some of the costs for decentralized care may be paid for by decreased use of centralized hospital services, as proposed in the October, 1997 *Alaska Psychiatric Institute Community Implementation Plan.*

Actions

1. The Alaska Mental Health Board, Department of Health and Social Services, and the Alaska Mental Health Trust Authority will advocate for increases in the availability of crisis respite services throughout the state.

2. Explore the possibility of joint/shared crisis facilities in rural areas.
3. Implement the *Alaska Psychiatric Institute Community Services Implementation Plan* regarding an emergency services system for the Anchorage area, especially for increased crisis respite services, including care for those who have a history of aggressive behavior.
4. The Alaska Mental Health Board, Department of Health and Social Services, and the Alaska Mental Health Trust Authority will advocate for adequate funding to meet the psychiatric in-patient evaluation and treatment needs of involuntarily committed individuals, as well as those who seek care "in lieu" of involuntary commitment, that is, who meet the commitment standards.
   Responsible party (actions 1-4): Alaska Mental Health Board, Department of Health and Social Services, Alaska Mental Health Trust Authority
5. The Alaska Mental Health Board and Division of Mental Health and Developmental Disabilities will review the current "indigency standard" and options, such as sliding fee scales, for user participation through sliding fee scales in paying for in-patient care.
   Responsible party: Alaska Mental Health Board and Division of Mental Health and Developmental Disabilities
6. The Division of Mental Health and Developmental Disabilities' regulations will provide that all hospitals and other facilities that come in contact with individuals who are substance abusers and have mental disorders refer those individuals for substance abuse services, at a minimum, upon discharge.
7. Alaska Psychiatric Institute will provide outreach to hospitals providing psychiatric evaluation and designated treatment with 24 hour psychiatric consultation on request.
8. The Division of Mental Health and Developmental Disabilities will work with regional hospitals to ensure additional evaluation and designated treatment sites.
9. The Division of Mental Health and Developmental Disabilities will develop processes to assure consistent quality care among providers of psychiatric in-patient services.
   Responsible party (actions 6-9): Division of Mental Health and Developmental Disabilities

Issue 3: Consumer and Family Involvement in the Treatment Process

Goal: Enhance collaboration between consumers, family members, and professionals in the treatment process and provide needed family supports.

Discussion

Consumers and families should be an integral part of the treatment team and should be provided with sufficient education in all facets of the illness to allow them to be effective. Research shows that when families are informed and take an active part in treatment decisions, consumer outcomes are better. While families do not cause neuro-biological disorders, their knowledge of and relationship with the consumer is unique and can be a significant help in determining and implementing the best course of treatment. In other types of mental illness, the consumer and professionals will identify those persons appropriate for involvement to advance positive treatment outcomes.

Family support is an integral part of the community support service system. Families provide basic support for many individuals with severe mental illness. Often by default families are the primary care providers and will continue to share in the care of their family member into the indefinite future. Due to misinformation in the past, families were often blamed for the illness. Assistance to families helps them recognize their many important roles. Assistance to families also includes: accurate education about the nature of the illness; counseling on appropriate techniques for dealing with day to day problems and crisis situations; and the opportunity to participate in family support groups and advocacy organizations. When individuals with severe mental illness reside with their families, information on entitlements and opportunities for respite care and other support and training services should be provided.

Actions

1. The Department of Health and Social Services will ensure that grantee agencies meet a standard for consumer and family involvement in treatment.
2. Managed care in the public and private sectors will assure consumer and family involvement in treatment.
3. Public mental health services, including managed care, will provide opportunities for family education.

4. The Department of Health and Social Services and mental health stakeholders will develop standards that embody desired consumer outcomes that will become part of the Department of Health and Social Services quality assurance program.
   Responsible party (actions 1-4): Department of Health and Social Services
5. The Department of Health and Social Services and Alaska Mental Health Board will develop performance measures for services which focus on consumer outcomes.
   Responsible party: Department of Health and Social Services, Alaska Mental Health Board
6. Training will be provided to consumers and families by advocacy groups to enhance their collaboration in the treatment process.
   Responsible party: Advocacy groups

Issue 4: Consumer Support Services

Goal: Ensure that consumer support services are an integral part of the adult mental health services program in Alaska.

Discussion

Consumer support services should be an integral part of a continuum of care for persons with psychiatric disabilities. Self-help groups and consumer operated services which are self-defined and consumer controlled are at work in some communities. These services are voluntary and based on choice, shared power, and peoples' needs for survival, friendship, and a sense of community. The services supplement the formal mental health system by meeting a variety of social and life support needs. Many are associated with employment which has been indicated as a top priority of Alaskans with mental illness.

Actions

1. Advocacy groups will provide opportunities for peer-support groups that meet regularly to share ideas, information, and provide mutual support.
   Responsible party: Advocacy groups
2. The Division of Mental Health and Developmental Disabilities, Alaska Mental Health Board and advocacy groups will support drop-in centers or social clubs for individuals to socialize and build a support community.

3. The Division of Mental Health and Developmental Disabilities, Alaska Mental Health Board and advocacy groups will support independent living programs that provide services such as assisting individuals to obtain financial benefits, housing, counseling and referral, independent living skills training, job counseling, and employment.
4. The Division of Mental Health and Developmental Disabilities, Alaska Mental Health Board and advocacy groups will support consumer-run housing, businesses, respite care, or crisis assistance services.
5. The Division of Mental Health and Developmental Disabilities and advocacy groups will support community education on mental illness and the potential of individuals with mental illness to lead productive, satisfying lives and contribute to the community in which they live.

   Responsible party (actions 2-5): Division of Mental Health and Developmental Disabilities, Alaska Mental Health Board, advocacy groups

Issue 5: Gaps in Community Care/Continuity of Care

Goal: Ensure that the minimum set of services, specified in statute (AS47.30.046), are available in all areas of the state on either an individual or community level.

Discussion

A large portion of Alaska's population lives in very small population centers with minimal mental health services. This makes it very difficult to provide a continuum of care to individuals who suffer from psychiatric disorders. One way of providing that continuum is by training providers in home communities to provide individualized, wrap-around services for the beneficiary population. This care is expensive, but less expensive than trying to establish programs in rural settings. The system would have to adopt a payment method that allows the funds to follow the individual.

The Alaska Mental Health Board believes optimal treatment, favorable outcomes, and recovery are most likely to occur when comprehensive community support programs are provided in an atmosphere of respect, acceptance, and hope.

People with psychiatric disorders may require a variety of services from different providers. Continuity of care can best be achieved through case management. The case manager is responsible for the coherence and appropriateness of services. The level of service needed is directly related to the level of acuity of the person's illness. Every person should have a single service manager or management team who keeps informed about every aspect of the treatment and informs the consumer and others who need to know. When an individual is hospitalized, the manager should be kept informed and should communicate frequently with the inpatient treatment team. Whenever residence in a community is interrupted for any reason, continuity of care requires that the same service manager or management team retain responsibility for the individual's treatment unless the consumer or other members of the treatment team desire a change.

Actions

1. Ensure that funding is available for individualized care for individuals living in rural areas without necessary services.
2. Ensure that funding is available for programs to provide a minimum set of services in all smaller communities.
3. Training funds should be available for all publicly-funded community service providers to restructure their systems to: incorporate proven research finding with innovative models of care; provide access to services that consumers need; provide oversight and advocacy through well-trained care managers; and use an integrated consumer-centered systems approach that includes providing services in settings that are comfortable for the consumer.
4. Ensure that technical assistance is available to work with the home communities of individuals with psychiatric disorders to help develop needed services.
   Responsible party (actions 1-4): Division of Mental Health and Developmental Disabilities, Alaska Mental Health Board
5. The Alaska Mental Health Board will advocate for client choice in case management, so that if available and desired, clients can select independent case managers.
6. The Alaska Mental Health Board will advocate for a comprehensive array of consumer services to be available for individuals who meet the priority definition and either have a Global Assessment Functioning scale score of 50 or below or who are at risk of declining to this level. These must include "new generation" medications, inpatient treatment, outpatient treatment with mobile capability, residential support services, transportation services, intensive case

management, psychosocial rehabilitation, peer support, consumer-run services, and round-the-clock crisis services that are available seven days a week.
Responsible party (actions 5-6): Alaska Mental Health Board

Issue 6: Homelessness

Goal: Ensure that homeless mentally ill persons are identified, have individualized plans, and receive the range of services needed for successful community living.

Discussion

The Alaska Mental Health Board advocates for the right treatment for persons with psychiatric disorders who are homeless or at risk of becoming homeless. These citizens have the same needs and rights to shelter and treatment as all other persons with psychiatric disorders. The AMHB seeks to ensure that homeless persons with psychiatric disorders have individualized treatment plans that are integrated into existing systems of care and related health and human service systems. Service providers, professionals and other helpers need to maintain their commitment to treating homeless persons with psychiatric disorders and their families with compassion, courtesy and respect. The AMHB deplores the commonplace use of jails and prisons to warehouse homeless persons with psychiatric disorders.

Twice a year the Alaska Housing Finance Corporation surveys the homeless population served at social services agencies around the state. Based on self report over the past 3 years, between 9% and 22% of the survey participants stated that they experienced a severe mental illness. It is generally accepted that these statistics under-report the actual number of homeless mentally ill persons. Seriously mentally ill persons should have adequate support systems available to them to prevent homelessness. In the event that homelessness occurs, services should be coordinated to remedy the situation as soon as possible.

Actions

1. Increase public and service sector education aimed at preventing and reducing the risk of homelessness for persons with psychiatric disorders.

2. Develop more constructive alternatives than the current use of the correctional system to be provided to homeless persons with psychiatric disorders.
3. Make training available to providers of services to homeless people with mental illness on the provision of respectful, family sensitive care.

Responsible party (actions 1-3): Advocacy groups, Alaska Mental Health Board, Division of Mental Health and Developmental Disabilities

Issue 7: Persons with Organic Brain Disorders

Goal: Ensure that people with organic brain disorders receive appropriate services and supports.

Discussion

Organic Brain Syndrome (OBS) occurs in people who have survived traumatic brain injury and other accidents, progressive, degenerative and other diseases, and congenital anomalies that cause brain damage. People with OBS may experience life altering behavioral and personality changes, anger, impulsive responses, memory lapses, and depression. They also may have mental illness. They are often unable to secure and maintain employment, a home, and a family. Their problems are often preceded by and/or exacerbated by drug and alcohol abuse.

The University of Washington estimates that between 5,000--6,000 Alaskans have some form of organic brain disorder. Depending on the cause of the brain damage, a person may be served by several different service systems. When the problem started before the age of 18, services may be under the pervue of the Governor's Council on Disabilities and Special Education. For adults, care and services are often inaccessible or inconsistent, with many adults unable to find any service providers. Many community mental health care providers will assist only if the person with Organic Brain Syndrome also has another major mental illness. Mental health care is available to mentally ill offenders in Department of Corrections custody who have OBS. On release, however, it is difficult to find community placements for these individuals.

Actions

1. The beneficiary boards will urge the Alaska Mental Health Authority to convene a "summit" to reconfigure and rationalize the State's services for people with Organic Brain Syndrome.
2. Advocate that the responsible agency for services to people with Organic Brain Syndrome be clearly defined.
3. Establish a multi-agency steering group to address pooled funding, community based, individual centered services and wider use of screening tools for client identification.
4. Support training of professionals specializing in treating and educating persons with brain disorders in scientifically based knowledge about these disorders.
5. Develop a guide for Organic Brain Syndrome services that identifies funding sources for treatment, rehabilitation, and care.
   Responsible party (actions 1-5): Alaska Mental Health Board, Governor's Council on Disabilities and Special Education, Alaska Commission on Aging, Governor's Advisory Board on Alcoholism and Drug Abuse, Alaska Mental Health Trust Authority

Issue 8: Long Term Care

Goal: Long term care must be available for the small percentage of people with psychiatric disorders who are unable to live in their communities.

Discussion

One of the trends in modern mental health services has been to "deinstitutionalize" those who frequently spent much of their lives in state mental institutions. However, we have failed to adequately provide for the needs of those whose severe illnesses make sustained community living impossible. For some time, numbers of people with long term treatment needs received services at Alaska Psychiatric Institute and at Harborview Development Center (HDC). HDC has been closed and the bed census at API reduced. Community residential placements have been found for many of those who received treatment at these institutions. Many people with long term treatment needs, absent the services, intensive rehabilitation, intensive supports and supervision they need, become homeless or involved with the criminal justice system. For those without these services, prison often becomes their long term institution. Humane care requires that we develop alternative long term care.

Actions

1. The Division of Mental Health and Developmental Disabilities will work with mental health providers to identify opportunities to develop community long term care for people with psychiatric disorders.
2. The Division of Mental Health and Development Disabilities will work with other state agencies providing long term care to maximize and integrate long term care services. Explore mechanisms for longer term funding for rehabilitation and intensive services through community mental health centers.
   Responsible party (actions 1-2): Division of Mental Health and Developmental Disabilities
3. The Division of Mental Health and Developmental Disabilities and Alaska Mental Health Board will research this subject to determine best models and approaches that have been used nationally, including approaches that look at long term care needs across divisions, departments, and providers.
   Responsible party: Division of Mental Health and Developmental Disabilities, Alaska Mental Health Board
4. The Alaska Mental Health Board will advocate for this service and use the budget process to highlight the need.
   Responsible party: Alaska Mental Health Board

Issue 9: Individual Service Outcomes

Goal: A partnership of consumers/family members, providers, case managers, and researchers will participate in the development of outcome measurement systems. The state system of mental health care will have both internal and external continuous quality assurance processes to certify that their outcome measurement system meets the minimum operational standards.

Discussion

In many cases, price is often the determinant of quality for managed care. As a result, purchasers are able to adjust price with little regard to quality. There are some good efforts at developing practice or outcome standards which will provide system accountability, and hold providers responsible for the efficacy and quality of the services they offer. These are discussed in the "systems" section of Adult Services. While every system of care needs an outcome measurement system, all outcome systems will not be identical across programs. Careful attention needs to be paid to efforts

such as the *Outcomes Roundtable Principles for Consumer Outcome Assessment Systems.* (National Alliance for the Mentally Ill, 1995)

Actions

1. Partner in the work of the Division of Mental Health and Developmental Disabilities Quality Assurance Steering Committee regarding the development of new program standards and continuous quality improvement.
2. Ensure that standards developed include clearly defined outcome measures set as benchmarks for evaluating program and personnel performance.
3. Ensure that outcome assessments be conducted with each consumer on at least an annual basis and on hospital discharge and incarceration, including measures of consumer and family satisfaction and dissatisfaction with services.
4. Ensure that a component of program performance evaluations be conducted by a neutral unbiased party not affiliated with either the Division of Mental Health and Developmental Disabilities or the program being evaluated.
5. Develop a partnership of consumers, family, providers, case managers and researchers to review the quality of publicly provided mental health inpatient services.
   Responsible party (actions 1-5): Division of Mental Health and Developmental Disabilities, Alaska Mental Health Board

Life Domain Issues

Context

It is important to recognize that persons with mental illnesses have fundamental life needs in addition to the need for mental health services. These fundamental needs exist in such areas of housing, employment, health care, transportation, education, and community support activities. Persons who experience mental illnesses have the same basic life needs as anyone else in our society. Similarly, mentally ill persons have the same right to have these needs met as other members of society.

Unfortunately, many persons with mental illness, especially the chronically mentally ill, experience great deficiencies in these areas of basic life needs. The inability of our present system to adequately address these needs creates environmental stresses which exacerbate the debilitating aspects of mental illness. On a more positive note, those

individuals who receive adequate support in addressing life domain issues are more successful in adapting to and managing their mental illnesses.

The Alaska Mental Health Board's recent survey of mental health consumers indicates that housing, transportation and employment/job training are extremely high-level needs that must be addressed in their lives. Unless and until these needs are met, persons with mental illness will not maximize the potential for self-sufficiency and productivity within their lives.

Issue 10: Employment and Training

Goal: Ensure that mental health consumers have equal opportunities for employment and training, without sacrificing health care benefits or other basic life maintenance services.

Discussion

Being a contributing member of the community is a goal for most people with psychiatric disorders. To the extent that this contribution can be as an employed worker, the individual and society benefits. There are obstacles to achieving this goal however, including the nature of the disability, the need for adequate training and support, concern about losing a job when an acute episode occurs, and the fear of losing medical insurance once an individual leaves public assistance. For many individuals, the value of assistance with psychiatric services and medications outweighs the feasibility of working, especially if that work is often at minimum wage. For those with education and skills prior to the onset of mental illness, the task of obtaining appropriate employment is even more challenging and frustrating.

Employment issues for adults with serious mental illnesses are a component of an initiative spearheaded by the Governor's Council on Disabilities and Special Education, in which the Alaska Mental Health Board is participating as a steering committee member. The Division of Vocational Rehabilitation in the Department of Education is the lead agency. The initiative, known as the Work Incentives Project, has been funded by the Alaska Mental Health Trust Authority for three years; it serves individuals with developmental, mental, and physical disabilities. The project consists of three components which are described in actions 1 through 3 below.

Actions

1. Disincentives to employment: Complete a study to identify barriers to employment faced by people with disabilities, including: fear of losing health benefits; financial disincentives; fragmented systems; lack of knowledge of Social Security work incentives; lack of vocational services; and limited work opportunities. The contractor will look at work incentive programs elsewhere and identify specific disincentive in Alaska. The contractor will assess the population looking to work and their experience with disincentives. A program of incentives for all stakeholders including people with disabilities, employers, and public and private insurers will be recommended. Changes at the state and federal level will be identified and pursued. System cost analyses will be part of the project.
2. Pilot project: Complete a project to develop and implement specialized vocational rehabilitation services. Services include benefits counseling, career planning, education, training, job development, and placement. The Division of Vocational Rehabilitation is funding training, job accommodations, and other services needed by individuals to reach vocational goals.
   Responsible party (actions 1-2): Governor's Council on Disabilities and Special Education
3. Training and pilot in additional communities: Based on the pilot project, training and assistance will be provided to additional pilot grantees in rural and remote areas to implement similar services. In addition, training will be offered to individuals including those with disabilities, vocational rehabilitation counselors, public assistance workers, case managers, policymakers, and others.
   Responsible party: Division of Vocational Rehabilitation
4. The Alaska Mental Health Board and other advocates will seek changes in state law to allow Medicaid recipients to maintain health insurance coverage if affordable coverage is not available through employment.
   Responsible party: Alaska Mental Health Board, Disability Law Center
5. Mental health advocacy groups will seek enhancements to federal parity legislation which will allow mental health consumers to have greater access to mental health services through employer insurance policies.
   Responsible party: Alaska Mental Health Board, Building Bridges Campaign, advocacy groups
6. The Division of Vocational Rehabilitation, Division of Mental Health and Developmental Disabilities and advocacy groups will establish

educational programs aimed at increasing employer awareness of mental illness and eliminating barriers to employing persons with mental illnesses.
Responsible party: Division of Vocation Rehabilitation

7. Service providers and advocacy groups will work with community organizations to find volunteer opportunities for individuals with psychiatric disorders.
Responsible party: Service providers, advocacy groups
8. The Department of Health and Social Services will ensure that all state funded case management services for mental health consumers include employment and training as an element of individual case plans.
Responsible party: Department of Health and Social Services
9. Explore ways for Division of Vocational Rehabilitation to extend services beyond the current restrictive time limits for mental health consumers who require additional supports.
Responsible party: Division of Vocational Rehabilitation

Issue 11: Housing Services

Goal: Alaskans with psychiatric illnesses must be able to secure accessible and affordable housing in their communities.

Discussion

Accessible, available and affordable housing is key to the independence and full participation of Alaskans with psychiatric disorders in their local communities. Historically, some people with mental illness led "out of sight, out of mind" lives in segregated institutions. Despite recent downsizing of institutions, freedom of choice in where to live remains an elusive goal for many Alaskans with psychiatric disabilities.

Mental health consumers need a place to live for recovery to begin. Some mentally ill people live in shelters and on the streets. Young people with mental illness are in transition from their parents' residences to their own. Others experience late onset of a mental illness and need assisted living care; those with medical complications require skilled nursing care. Wherever a person enters the system, regular, safe, decent, sanitary housing is necessary to begin a rehabilitation program.

Key issues in housing for people with mental illness include: housing for the elderly with mental illness; recognition that children may become homeless due to a parent having a mental illness; and housing for adults

who may have additional diagnostic issues such as substance abuse, criminal behaviors or correctional system involvement. Support services and advocacy may be needed for the percentage of mentally ill people whose conditions result in behaviors that make them less desirable tenants.

Multiple obstacles prevent people with psychiatric disorders from securing adequate housing in the community. To start with, low income levels make rent payments unaffordable or limit access to mortgage loans; even when people with disabilities secure government assistance, they are the group most likely to live in severely inadequate housing.

For some Alaskans with mental disabilities, the choice of where to live is limited by funding agencies or service providers. Funding for support services is often tied to congregate living situations or service providers are only able to provide support service within a group setting. Service providers rather than people with mental disabilities own the homes where services are provided. Developing a community-based support structure independent of housing programs requires considerable redirection of funds and extensive program development time.

A Shared Vision I gave direction to successful efforts to increase access to housing for people with mental illness. Funds were made available to assist providers with grant writing for the federal Department of Housing and Urban Development and the Alaska Housing Finance Corporation that increased the number of units available to consumers. Purchase, renovation, and new construction were funded under these initiatives. Leveraged resources to increase the number of Section 8 vouchers targeted persons with psychiatric disabilities. Recently, the Alaska Mental Health Trust Authority has taken an active leadership role in working with other agencies to expand access to housing for their beneficiaries.

Actions

1. The Division of Mental Health and Developmental Disabilities will work with the Alaska Housing Finance Corporation and providers to adjust program rules to be more consumer friendly, for example, assuring that no individual with a psychiatric disorder should lose his or her housing in the community during short periods of inpatient treatment.
   Responsible party: Division of Mental Health and Developmental Disabilities

2. The Alaska Mental Health Board recommends that an equitable portion of federal and state housing funds be designated for persons with psychiatric disorders. The funds should be integrated to finance the housing component of a unified system of treatment, services and supports for persons with psychiatric disorders.
3. The Alaska Mental Health Trust Authority will work with Alaska Housing Finance Corporation to assure that special needs housing funds are available for residential treatment facilities.
   Responsible party (actions 2-3): Alaska Mental Health Trust Authority
4. The Division of Mental Health and Developmental Disabilities will work with providers to assure as much consumer choice as possible in types of housing arrangements and those with whom housing is shared.
5. The Division of Mental Health and Developmental Disabilities will continue to provide grant writing and other technical assistance to service providers on accessing available state and federal funds for housing.
   Responsible party (actions 4-5): Division of Mental Health and Developmental Disabilities
6. The Alaska Mental Health Trust Authority, Department of Health and Social Services and advocates will develop initiatives to ensure affordable housing (e.g., home modification programs, requiring that housing vouchers be considered as income by rental agents, building owners, banks and mortgage companies).
   Responsible party: Alaska Mental Health Trust Authority, Department of Health and Social Services
7. Regional Housing Authorities and communities will be encouraged to develop housing plans that include provision of housing for people with disabilities.
   Responsible party: Regional Housing Authorities
8. Fully fund the Alaska Housing Finance Corporation's proposed budgets to expand special needs housing, especially mental health consumers'housing alternatives.
   Responsible party: Alaska State Legislature
9. Target state housing funds towards rural communities which are not eligible for federal housing funds.
   Responsible party: Alaska Housing Finance Corporation
10. Redirect housing funding away from separate housing or housing that requires special terms or conditions and toward housing in the most inclusive settings with maximum control by people with

disabilities.
Responsible party: Alaska Housing Finance Corporation

11. The Division of Mental Health and Developmental Disabilities and advocates will supply information regarding numbers and extent of need to the legislature, the Alaska Mental Health Trust Authority and the Alaska Housing Finance Corporation.
Responsible party: Division of Mental Health and Developmental Disabilities
12. Advocacy groups will request training from Alaska Housing Finance Corporation on ways to acquire state and federal funds for people with disabilities to own their own homes and develop initiatives for individual home ownership.
Responsible party: Advocacy groups

Issue 12: Transportation

Goal: Ensure that accessible transportation is available to all Alaskans with psychiatric illnesses.

Discussion

Accessible transportation is one of the keys to employment and community participation for people with disabilities. Only a few Alaskan communities have public transportation. Where it does exist, public transportation is limited. When special transportation is provided to disabled people, uncoordinated transportation systems create additional barriers in some communities, e.g., eligibility restrictions or limited hours of service. Many people with disabilities do not live in areas served by pubic transportation and thus rely on private vehicles. However, buying a car may be difficult because of the general low income level of people with disabilities. In addition, people with mental illness may have to use public transportation systems due to limitations on driving resulting from psychotropic medications.

Actions

1. Provide training targeted toward transportation operators and related service personnel. That training should emphasize the operators'and service personnels' role in reducing stigma and basic information about psychiatric disorders.
2. Continue efforts to provide joint planning and funding of transportation projects for people with disabilities by the Department of Transportation and Public Facilities, the Department of Health and Social Services and the Alaska Mental Health Trust Authority.

Responsible party (actions 1-2): Alaska Mental Health Trust Authority, Department of Transportation and Public Facilities

Issue 13: Physical Health Care

Goal: Alaskans with psychiatric illness will have access to adequate physical health care.

Discussion

Accessible, affordable and comprehensive health care often eludes people with psychiatric disorders. Several factors account for this deficit. Many people with mental illnesses are unable to secure health insurance. People with psychiatric disorders are often low income and must rely on Medicaid, a system that often focuses on acute care, rather than on care for the chronic conditions they frequently experience. The side effects of medications used for the treatment of psychiatric disorders can increase the individual's health care needs.

Actions

1. Maintain restoration of Medicaid funding for vision, hearing, acute dental care and physical therapy services for adults with psychiatric disorders.
2. Enact legislation limiting preexisting-condition exclusions and improving portability and renewability of private insurance coverage.
   Responsible party (actions 1-2): Alaska State Legislature
3. Provide training to enable people experiencing mental illness to become more informed consumers of health care services.
   Responsible party: Advocacy groups
4. Ensure that public managed care initiatives integrate physical and mental health services and require collaboration between physical and mental health care providers.
   Responsible party: Alaska Mental Health Board, Department of Health and Social Services
5. Develop legislation which provides for mental health parity in private insurance.
   Responsible party: Alaska Mental Health Board, Building Bridges Campaign, advocacy groups
6. Advocate for state Medicaid changes to allow people with psychiatric disabilities to retain Medicaid coverage when they find low wage employment.
   Responsible party: Disability Law Center, Alaska Mental Health Board

Issue 14: Community Inclusion and Supports

Goal: Advocate that individuals with psychiatric disabilities have the same community resources to live, learn, work and play as do non-disabled persons.

Discussion

Individuals with psychiatric disabilities should use the same community resources to live, learn, work and play as non-disabled persons and participate in the same local communities activities as non-disabled persons.

As long as people with disabilities remain segregated, non-disabled people do not get to know them. Segregation - whether the result of stairs or attitudes - creates harmful myths and stereotypes or worse, sets up a self-fulfilling prophecy for failure. Among many people, there is still a "stigma" attached to having a psychiatric disability. As a society we have made progress in accepting people with physical disabilities, however, we have much to do to eradicate the stigma that follows those who have psychiatric disorders.

Actions

1. Fully support anti-stigma and anti-discrimination programs such as those of National Association for the Mentally Ill and the National Mental Health Association.
   Responsible party: All mental health stakeholders
2. Enforce existing anti-discrimination laws such as the Americans with Disabilities Act.
   Responsible party: Department of Health and Social Service, Disability Law Center, advocacy groups

Issue 15: Substitute Judgement Decision Making

Goal: All individuals with a mental illness who are determined by the court to be incapacitated will have a competent and effective substitute decision maker.

Discussion

Currently there are not enough alternative decision makers available to make competent and effective decisions for individuals in need of such support. The Office of Public Advocacy's Public Guardian Program has six public guardians who provide guardianship services to 540 incapacitated Alaskans. The average caseload of 90 individuals exceeds those of other states by two to three times. Caseloads of this size impact the ability of the public guardians to provide individualized, quality, or timely services.

Private guardianship is available only to individuals who can pay for such services. Public and private guardianship, and alternative representative payee programs, which provide only financial assistance, lack oversight, regulations or licensing.

Families that attempt to provide alternative decision making for their family member may lack support or information to most effectively carry out their duties. Existing protections for wards may inadvertently pose barriers to guardians in ensuring necessary mental health care. Specifically, Alaska Statutes apparently do not permit guardians to arrange for voluntary psychiatric hospitalization for a mental health consumer. Waiting for an incapacitated mentally ill person to decompensate so thoroughly that involuntary commitment is possible may jeopardize the life and ultimate functional capability of that person.

Actions

1. Promote excellence in public and private guardianship programs and representative payee programs through effective monitoring, regulations, and program evaluation and funding that include consumer satisfaction measures and consumer/family review.
2. Review the current programs that provide guardianship, conservatorship, and representative payee programs to determine strengths and areas for improvement.
3. Advocate for necessary changes in statutes, regulations, and programs to insure access to assistance is available to all individuals who require service.

4. Develop training and assistance programs for consumers and families regarding substitute decision making.
   Responsible party (actions 1-4): Office of Public Advocacy, Alaska Mental Health Trust Authority, Department of Health and Social Services

System Level Issues

Introduction

Descriptions of the ideal mental health system contain certain common characteristics, which taken together, may be used to form a basis for a comprehensive program. According to these descriptions, an ideal system is:

- Integrated and collaborative.
- Preventive.
- Appropriate and comprehensive.
- Culturally competent.
- Outcomes oriented.
- Family centered.
- Cost effective.

An integrated system makes it easier for individuals and families to receive the help they need and ensures efficient use of providers' time and resources. A system that is fragmented is troublesome for those individuals or families who have multiple needs that are often related to each other in complex causal chains. No matter which aspect of the system they enter, they often find someone who can respond to only one piece of their problem.

An ideal system is geared toward preventing problems rather than reacting to them. A focus on prevention ensures that the need to provide intensive treatment and crisis-oriented services is balanced with an investment in preventive and early intervention services for individuals and families.

An appropriate and comprehensive service system provides a variety of opportunities and services to respond to the full range of individual and family needs. This service system works to help people develop activities which advance their talents, and allows them to pursue their interests

and participate in community life. Services are not static; plans are responsive to functional status, age, and other individualized conditions.

Respect for cultural differences is reflected in system-wide policy and practice; this respect is evident in all levels of the system. Representatives from key cultural groups are consulted and invited to participate in policy-making, program planning, program administration, and service delivery. A number of elements have been identified as system characteristics that contribute to a system's ability to be responsive to cultural diversity. A system must:

- Value diversity;
- Have the capacity for cultural self-assessment;
- Understand the dynamics inherent when cultures interact; and
- Be able to use institutionalized cultural knowledge to enhance services.

If these elements are present at every level of the system, they contribute to a total system of care that is effective across cultures.

Measuring success by improved outcomes for individuals and families paves the way for more client-centered services. Service providers help families to set reasonable goals and share responsibility for attaining them. More sensible and fruitful outcome measures can be viewed as an accountability mechanism that affects the system at both the state and community levels. Outcomes need to be consumer oriented in addition to system oriented.

The service system must recognize that every family has strengths. As a result, individuals and families have a major voice in setting goals and deciding what services they need to meet those goals. Hours and location of services serve the individual's and family's needs rather than organizational preferences.

Issue 16: Financing of Treatment and Services

Goal: Ensure that care for all persons with psychiatric disorders is affordable, nondiscriminatory, and includes coverage for effective and appropriate treatment.

Discussion

The Alaska Mental Health Board supports the establishment of provisions

to ensure the financing of basic health care for every Alaskan at costs affordable to individual citizens and families. It is critical that coverage of psychiatric disorders be equal in scope and duration to coverage of other illnesses and without more restrictive limits than for other diseases. During the 1997 legislative session, the AMHB supported a resolution to establish a task force to study the differential treatment of psychiatric disorders versus physical disorders in insurance practice and make recommendations for changes to the legislature. While the AMHB supports recently passed federal parity legislation, we recognize that this legislation is restrictive and needs to be expanded through state legislation. In addition, if adequate mental health care is to be provided to Alaskans, private-sector health plans must cover all proven-effective modes of treatment; the cost of not treating psychiatric disorders greatly exceeds the cost of treating them.

Public funding for services to persons with psychiatric disorders who are unable to care for themselves is the responsibility of society. Local, state and federal governments have the responsibility to develop an integrated system of care and to fund this system adequately. The most basic needs of mentally ill persons when they are at their most vulnerable are for shelter, food, clothing, medical and social supports, and assistance toward self-sufficiency. Government has met such needs principally through programs for income maintenance, medical treatment, medical insurance, other health and social services, shelter and housing, education, transportation assistance, legal assistance, advocacy, training and employment. When funding patterns change, we risk treating only those whose needs are addressed by categorical funds. In recent years, Alaska has seen a marked increase in mental health services to Medicaid patients and a decline in services for those whose needs are met through mental health grant funds.

Federal funds have supported hospitals that provide psychiatric care to those under 18 and those over age 65. Congress has enacted legislation to substantially reduce this support over the next several years. This legislative change presents new opportunities and challenges in planning for mental health services.

Actions

1. Continue the work of the Parity Task Force to develop Alaskan legislation supporting parity between mental health and physical health care in insurance coverage.

2. Advocate with the legislature for parity legislation.
   Responsible party (actions 1-2): Alaska Mental Health Board, Building Bridges Campaign, advocacy groups
3. The Alaska Mental Health Board will advocate for full funding of mental health programs to meet consumers' mental health needs.
4. The Alaska Mental Health Board will advocate for maximum funding for both biomedical and services research for psychiatric disorders and for federally-funded treatment and services for individuals with psychiatric disorders.
5. The Alaska Mental Health Board will participate in API 2000 planning to ensure that services offered in the future are appropriately funded.
6. The Alaska Mental Health Board calls upon the United States Congress to adopt uniform standards of Medicaid eligibility based upon individual resources and the need for services, rather than upon the location in which services are provided or the residence of the recipient.
7. The Alaska Mental Health Board will work with Department of Health and Social Services' senior staff to explore pooling funding sources, including grant funds and Medicaid to provide for integrated care, especially for co-occurring disorders.
   Responsible party (actions 3-7): Alaska Mental Health Board

Issue 17: Managed Care

Goal: To develop a managed care or equivalent resource management system where stakeholder values, positive outcomes and quality services are on a par with cost containment and effectiveness.

Discussion

Developments within and outside Alaska have converged to require an analysis of the application of managed care to mental health services within the state. Nationally, managed care systems are sweeping through state and local public mental health systems, often touted as a way to curb skyrocketing entitlement and service provision costs. At the state level, the Legislature and other stakeholders are demanding greater accountability and cost effectiveness for public mental health services in an era of declining oil revenues.

The Alaska Mental Health Board seeks to avoid the mistakes made in many other states where managed care has been used strictly as a cost control mechanism. In many of these cases, managed care organizations

have reduced client services and removed funds from the mental health system in the form of profits.

The Alaska Mental Health Board is now exploring whether the principles of managed care can be used to both improve care and control costs. For managed care to work in Alaska, cost considerations must be addressed concurrently with concerns for values, outcomes and quality services. In addition, there needs to be a process to involve consumers/families, providers and other stakeholders in the planning and development of a managed care system in Alaska.

To ensure this more balanced approach, the Alaska Mental Health Board has overseen two separate studies regarding managed mental health care and is considering the information in these reports in light of future policy and program development. The Board has also convened a broad-based Steering Committee to assist in overseeing the development of managed mental health care in Alaska.

Actions

1. The Alaska Mental Health Board will ensure that any future development adheres to the Board's December 12, 1997 position regarding the first managed care report, including the following principles for improving the mental health system:
   a. Design and delivery of care must be based on consumers' goals, needs and preferences.
   b. Any future arrangement must be built on current consumer, provider, departmental and system strengths.
   c. A new system must organize around desired outcomes.
   d. Desired outcomes should be promoted through risk and reward polices and actions.
   e. Clinical and financial authority/responsibility must be more clearly aligned and responsive to the individualized needs of mental health consumers and their families.
2. The Managed Care Steering Committee and the Alaska Mental Health Board will review and develop positions on the second managed care report, received April 30, 1998.
3. The Alaska Mental Health Board, Department of Health and Social Services and other stakeholders will work together to consider and implement recommendations put forth by the Alaska Mental Health Board and the Managed Care Steering Committee.

   Responsible party (actions 1-3): Alaska Mental Health Board, Department of Health and Social Services

Issue 18: Case Management

Goal: Ensure that appropriate, coherent services are available for each client through case management.

Discussion

The role of case managers in providing continuity of care is addressed in the Treatment section of this plan. In addition, in well managed mental health systems, case managers function as the responsible entity to assure appropriate quality of care for individuals as they move through the system. An acceptable definition of case management appears in the federal publication *Adults with Severe and Persistent Mental Illness*. "Case management is a practice in which the service recipient is a partner, to the greatest extent possible, in assessing needs, obtaining services, treatments and supports, and in preventing and managing crisis. The focus of the partnership is recovery and self management of mental illness and life. The individual and the practitioner plan, coordinate, monitor, adjust, and advocate for services and support directed toward the achievement of the individual's personal goals for recovery and self management of mental illness and life. The individual and the practitioner plan, coordinate, monitor, adjust and advocate for services and supports directed toward the achievement of the individual's personal goals for community living."

All persons who have a severe and persistent mental illness should have a case manager. The intensity of case management services should be tied to the level of acuity of the illness. There is concern that when case management services are provided by the service provider, adequate planning, monitoring, adjustment and advocacy may not occur. Independence of case management may mitigate these difficulties. In the Alaska Mental Health Board's research into long term care, recommendations were adopted to explore the possibility of multiple state agencies supporting independent case management service agencies.

Actions

1. The Division of Mental Health and Developmental Disabilities and Alaska Mental Health Board will support consumer choice of case management services, when appropriate.
2. The Department of Health and Social Services, Alaska Mental Health Board, and Department of Administration will investigate the possibility of supporting single case management service providers, regardless of the disabling condition and from whom they receive

treatment services.
Responsible party (actions 1-2): Division of Mental Health and Developmental Disabilities, Alaska Mental Health Board

3. The Alaska Mental Health Board will advocate for inclusion of client choice in case management services in Division of Medical Assistance regulations and in public managed care.
Responsible party: Alaska Mental Health Board

Issue 19: API 2000 Community Implementation Process

Goal: Ensure that integrated, community-based services are implemented and maintained to accommodate a smaller Alaska Psychiatric Institute.

Discussion

As Alaska's only state psychiatric hospital, Alaska Psychiatric Institute has played a key role in the mental health services in Alaska. The need for a new building for API was identified over ten years ago. Initially conceived as a 114-bed facility, the size of the planned facility has been dictated more by financial constraints rather than underlying service needs. Concurrently, consumers and advocates have maintained that comprehensive, integrated community services can significantly reduce the number of beds needed at Alaska Psychiatric Institute.

In January, 1997, a state-funded study presented several scenarios for a downsized Alaska Psychiatric Institute. A follow-up study in October, 1997 examined the considerations and steps necessary to implement a 54-bed hospital model. The report concluded that the 54-bed model is both desirable and affordable, and outlined the essential elements of the API Community Implementation Plan. The Plan shifts public hospital resources and maximizes third party revenues to build comprehensive community services which are closer to home and in less restrictive environments. Alaska Psychiatric Institute's 54 beds will be used to serve clients whose needs cannot be effectively addressed at the community level.

A project structure with broad-based stakeholder involvement is now being established to guide the development of services under the Community Implementation Plan. It is estimated that the phase-in process for community based services under the Plan will take a minimum of two years.

Actions

1. The Alaska Mental Health Board will ensure that enforceable agreements are in place regarding needed community services to complement a smaller Alaska Psychiatric Institute.
   Responsible party: Alaska Mental Health Board
2. The Alaska Mental Health Board, the Alaska Mental Health Trust Authority and the Department of Health and Social Services will ensure that the Community Implementation Plan includes the following elements:
   a. A single point of entry system for behavioral health emergencies in the Anchorage area.
   b. Enhanced acute-care diversion services in South Central Alaska including 23-hour crisis stabilization, crisis respite, designated evaluation and treatment beds, and residential detoxification services for dually diagnosed clients.
   c. Enhanced assisted living and/or nursing home services and psychiatric consultation for persons with long-term care needs.
   d. A plan for addressing the inpatient/residential care needs of adolescents with an emphasis on community based alternatives to the adolescent unit at Alaska Psychiatric Institute.
   e. A detailed budget plan for financing the phase-in of community-based services and managing the transfer of resources from Alaska Psychiatric Institute to the community.
3. The Alaska Mental Health Board, the Alaska Mental Health Trust Authority and the Department of Health and Social Services will ensure that all major stakeholders are represented in the community implementation process and that any deviations from the Plan are developed through stakeholder consensus whenever possible.
   Responsible party (actions 2-3): Alaska Mental Health Board, Department of Health and Social Services, Alaska Mental Health Trust Authority

Issue 20: Cultural Diversity

Goal: Ensure that cultural, racial, ethnic and linguistic differences are addressed within mental health services and governance structures of mental health programs.

Discussion

Persons of cultural, racial, religious, and ethnic diversity and those for whom English is not the primary language have unique characteristics that sometimes impede their ability to benefit fully from existing

treatment, training, and rehabilitation programs. The Alaska Mental Health Board believes that providers must have training in and sensitivity to cultural diversity. This can be assured by hiring service providers from minority groups and by training majority group members in the provision of culturally sensitive services.

The higher rates of involuntary commitment and incarceration in correctional facilities that occurs among minorities with psychiatric disorders may be symptomatic of lack of cultural sensitivity. The Alaska Mental Health Board urges the incorporation of ethnic and cultural perspectives and competence into the design and implementation of programs and procedures for persons with psychiatric disorders so that diagnostic evaluations, consumer and family communications, and the provision of treatment and services will be free from bias and cultural impediments.

Actions

1. The Alaska Mental Health Board will advocate for expanded efforts toward recruitment and training of professionals from diverse groups.
2. The Alaska Mental Health Board will advocate for the development and distribution of materials in appropriate languages for use in education.
3. The Alaska Mental Health Board will advocate for encouragement of participation of minority groups in programs and services.
4. The Alaska Mental Health Board will advocate for outreach efforts targeted to under-served groups.
5. The Alaska Mental Health Board will advocate for actions to increase minority representation on all mental health policy and governance structures.
6. The Alaska Mental Health Board will advocate for and seek funds for distance delivery of University of Alaska educational programs which encourage indigenous providers.

   Responsible party (actions 1-6): Alaska Mental Health Board

Quality Assurance and Outcomes

Issue 21: Alaska Psychiatric Institute Treatment/Quality Assurance

Goal: To enhance quality and treatment at Alaska Psychiatric Institute through a consensus building planning process.

Discussion

The API 2000 process is an opportunity to review and redesign the way that services are provided across the continuum of care to persons with mental illnesses. A stronger partnership needs to be developed between Alaska Psychiatric Institute and other care providers, including families and other natural support systems. A rigorous approach is being undertaken to examine and redesign community-based services through such mechanisms as the API Community Implementation Plan, enhanced quality assurance and managed care planning efforts. A reexamination of API's treatment and quality assurance efforts needs to be addressed with the same level of rigor.

To this end, the Alaska Mental Health Board and the Department of Health and Social Services developed a letter of agreement regarding quality assurance and treatment at Alaska Psychiatric Institute. The agreement established the API Quality Assurance and Treatment Committee composed of consumer, family, advocate, and state representatives. The Committee's goal is to develop report(s) addressing the following areas at API: treatment issues; quality assurance; involvement of consumers, families and advocates; and the API governing structure. The Committee has begun to meet and hopes to complete its work by December, 1998.

Actions

1. The Alaska Mental Health Board and Department of Health and Social Services will ensure that the Alaska Psychiatric Institute Quality Assurance Committee addresses the following issues included in the memorandum of agreement:
   a. That treatment services be fully responsive to consumers' individualized needs.
   b. That treatment services maximize the ability of consumers to function as independently as possible within the least restrictive environment.

c. That the quality assurance program include review by an entity independent of Alaska Psychiatric Institute.
d. That the policy making role of the Alaska Psychiatric Institute Governing Board be maximized.
e. That consumers, family members and other stakeholders have maximum involvement in treatment, quality assurance and governance at Alaska Psychiatric Institute.

2. The Alaska Mental Health Board and Department of Health and Social Services will ensure that Committee recommendations are considered and implemented to the greatest extent possible.
3. The Alaska Mental Health Board and Department of Health and Social Services will ensure that the work of the Committee is integrated with other major efforts including the Alaska Mental Health Board's review of Alaska Psychiatric Institute, community quality assurance efforts, and the Alaska Psychiatric Institute Community Implementation Plan.
Responsible party (actions 1-3): Alaska Mental Health Board, Department of Health and Social Services

Issue 22: Quality Assurance for Community-Based Mental Health Programs

Goal: Fully implement and maintain an integrated quality assurance program for community-based mental health, developmental disabilities and infant learning programs.

Discussion

The Division of Mental Health and Developmental Disabilities has begun to develop of an integrated quality assurance program covering mental health, developmental disabilities and infant learning services. A Steering Committee with representatives from consumers, providers, advocacy organizations and the State has overseen the development of integrated program standards. The standards include both general administrative standards that apply equally to mental health, developmental disabilities and infant learning, and specific service delivery standards that apply uniquely to each program area.

The next stage in the integrated community quality assurance effort will be to implement the actual program site reviews. Review teams consisting of a contract facilitator and consumer, State, advocate and provider

representatives will conduct reviews of programs throughout the state. The program standards will provide the foundation for the reviews, and the reviews will include interviews with consumers, family members, staff and interagency personnel, in addition to a review of agency records. A primary focus of both the reviews (and the standards) will be consumer and family member satisfaction with various aspects of service provision.

Reviews will occur a minimum of every other year and whenever possible, the review team will review the mental health, infant learning and developmental disabilities programs within the given community during a single site visit. Medicaid compliance will also be incorporated into the site review process. Upon completion of the program review, the program will be given a written report detailing its strengths and weaknesses in relationship to the program standards, and will have an opportunity to respond and propose actions to ensure future compliance. An emphasis will also be placed on arranging and/or providing technical assistance to programs to address any major areas of deficiency in relationship to the standards or other concerns identified in the review process.

Actions

1. Initiate and maintain program reviews with the broad-based representation described above. The inclusion of consumers, family members and advocates as part of the review teams is particularly important.
2. Ensure that the program reviews address the concerns and perspective of consumers who receive services from the program, and their family members.
3. Through the review process, identify key issues for training and technical assistance and provide resources to address major areas of concern. Depending on the issue, training and technical assistance may be provided at the community, regional or statewide level.
4. Maintain the Steering Committee for the integrated community quality assurance effort to assist in overseeing implementation of the program review process.
5. Begin integration of the community quality assurance effort with the API quality assurance effort (described in Issue 21 in this section). An emphasis should be placed on developing a unified, overall quality assurance system that addresses both community-based and institutional services.
6. Ensure that any identified system-level concerns relating to consumers and family members are communicated with the Consumer Affairs position to be located within the Division of Mental

Health and Developmental Disabilities.
Responsible Party (actions 1-6): Division of Mental Health and Developmental Disabilities

Issue 23: Legal Concerns (Part 1)

Goal: Alaskans with psychiatric disorders will have access to adequate legal, administrative and case management representation.

Discussion

The criminal, civil and administrative systems and the rights and responsibilities associated with them can be incomprehensible to mental health consumers. Therefore, when individuals interface with the police, courts, and civil and administrative systems, they need increased support to deal with these difficult issues, including someone to act on their behalf. In addition, mental health consumers, like other Alaskans, have civil legal issues which require legal representation. Low income limits their access to needed legal representation in such areas as family law.

Actions

1. The Department of Health and Social Services and advocates will educate all systems on behalf of people with psychiatric disorders regarding their special needs.
2. Advocates and service providers will intervene on behalf of consumers to assure adequate and prompt representation.
3. Address the training needs of providers in the civil, criminal and administrative systems to recommend helpful responses when working with people with psychiatric disorders.
   Responsible party (actions 1-3): Division of Mental Health and Developmental Disabilities, advocates
4. The Alaska Mental Health Board will advocate with the Alaska Mental Health Trust Authority for additional funding to Alaska Legal Services for family law services for Trust beneficiaries.
   Responsible party: Alaska Mental Health Board, Alaska Mental Health Trust Authority

Issue 24: Legal Concerns (Part 2)

Goal: Enhance the use of advance directives for mental health consumers.

Discussion

Consumer driven mental health treatment is enhanced by the person's advance directives through the "Declaration for Mental Health Treatment." Consumers have often been at the mercy of their illness and subject to crisis planning. In 1996, the Legislature passed a law establishing the ability of consumers to develop "advance directives." These directives allow consumers to make choices in advance when they are more stable and able to make clearer treatment choices. The Alaska Mental Health Board and advocacy groups recognize the value of having consumers' rights presented to each person at several points in their life, i.e., at intake into a community mental health program, followed by a yearly review and upon discharge from the Alaska Psychiatric Institute. These would be optimal times for caregivers and service providers to work collaboratively with the mentally ill person to establish advance directives.

Actions

1. Through regulatory changes, establish points where advance directives are routinely discussed with consumers, that is, at intake into a community mental health program, with a yearly review and upon discharge from hospitalization.
2. Service providers will work collaboratively with consumers to establish advance directives and to make them a part of treatment planning.
3. Provide funds for routine training of providers and consumers regarding advance directives.
   Responsible party (actions 1-3): Division of Mental Health and Developmental Disabilities and advocacy groups

Issue 25: Criminalization of the Mentally Ill

Goal: Reduce the number of individuals with psychiatric disorders entering the criminal justice system.

Discussion

The number of individuals with psychiatric disorders in Alaska's correctional system has been steadily increasing. This is indicative of a system failure to identify and serve psychiatric disordered individuals with community based services. The Alaska Mental Health Board is committed to seeing this trend reversed. This will require cooperative efforts between the Departments of Law, Corrections and Health and Social Services. Readers are referred to the Mentally Ill Offenders Services Section of this plan for additional details. A summary of recommended actions follows; however, detailed steps are proposed in the Mentally Ill Offenders Services Section.

Actions

1. Ensure that a pilot diversion program is developed for mentally ill offenders. That includes, at a minimum, assessment and referral services.
2. Ensure that adequate mental health services exist for those mentally ill individuals who are incarcerated.
3. Ensure that adequate supervised living arrangements exist for mentally ill offenders leaving correctional facilities.
4. Ensure that adequate community programs exist that focus on prevention of recidivism.

   Responsible party (actions 1-4): Department of Corrections, Alaska Mental Health Board, Alaska Mental Health Trust Authority

Issue 26: Consumer Participation

Goal: Assure that consumers and family members participate at all levels of mental health policy development, planning, and evaluation of services.

Discussion

To assure that Alaska's mental health system is responsive to the needs of mental health consumers, consumers and family members must participate in all levels of decision making that affect them. On the

individual level, this means that consumers must be partners in the development of their own treatment plans. On the system level, full participation means that consumers and family members must be partners in policy development, planning, budget development and program evaluation. The Alaska Mental Health Board and the Division of Mental Health and Developmental Disabilities are committed to continuing and expanding opportunities for consumer and family member participation.

Actions

1. The Alaska Mental Health Board will ensure that adequate resources exist to promote consumer and family member participation in all phases of policy development, planning, budget development and evaluation.
2. The Alaska Mental Health Board will examine the possibility of compensation for consumers officially serving on committees and/or of reimbursement of consumers' expenses, such as child care, while serving on such committees.

Responsible party (actions 1-2): Alaska Mental Health Board

Adult Services Action Team Members

Vicki Turner Malone, National Association for the Mentally Ill, Alaska, chair
John Bajowski, Division of Mental Health and Developmental Disabilities
Kelly Behen, Alaska Mental Health Board
Barbara Bennett, Alaska Coalition on Housing and Homelessness
Mike Boyd, Alaska Community Mental Health Services Association
Randall Burns, Alaska Psychiatric Institute
Pat Clasby, Alaska State Hospital and Nursing Home Association
Dorcas Jackson, Office of Public Advocacy
Robyn Henry, National Association for the Mentally Ill, Alaska
Jan MacClarence, Alaska Mental Health Board
Pat Murphy, Alaska Mental Health Board
Mary Elizabeth Rider, Alaska Mental Health Trust Authority
Ann Schultz, Governor's Advisory Board on Alcoholism and Drug Abuse
Dave Wagner, Mental Health Consumers of Alaska
Staff: Margo Waring, Alaska Mental Health Board

SENIOR SERVICES

Introduction

The elderly are not an isolated, marginal group of people. They are what each of us becomes over the natural course of life. How we attend to and value them now determines to a great extent how we each will live out our own lives as well. This is the heart of good mental health.

Issue 1: Identify Mental Health Needs Of Geriatric Population

Goal: Determine the mental health needs of the geriatric population, including aspects of prevention and intervention.

Discussion

Alaska is on the brink of significant sociologic, economic, and public health change related to the rapidly increasing proportion of older people in the population. The conservative projection suggests a doubling of the number of persons over 65 between 1990 and 2015 (up to 42,000), and the extreme projection suggests the number could go as high as 100,000 in the same time period. In either case, Alaska's senior population growth is among the highest in the country. Why this is so is less important than how our public and private systems respond to its impact.

While most seniors adapt to and capably manage the changes in their lives, inevitable losses associated with advancing age will require many of them (and their families) to call upon a wide variety of services for assistance. Not the least among these services is mental health care. The incidence of certain kinds of mental, emotional and behavioral problems among persons over 60 years of age is at least as great, and in some categories (e.g., depression, anxiety, suicide risk, dementia) much higher than in the population as large. Depression among the elderly significantly increases overall health care costs. Nationally, suicide rates among those over 65 are the highest in the country and rising. Worldwide, elderly mental illness rates are triple those for middle-aged people. Nothing suggests Alaskan immunity to these trends.

The risk factors for mental illness are clear for all to see:

- Loss of income, meaningful activity, and social status through retirement.
- Development of chronic health and perceptual problems.
- Compounded bereavement at the deaths of friends and significant others.
- Loss of mobility and increased social isolation.
- Increased risk for relocation or displacement.

While all these could happen to an individual at any stage of life, the increasing frequency with which they occur after age 60 requires seniors to be as mentally and emotionally fit as can be to avoid over-dependence on others, and to maintain a sense of personal meaning and well-being to the end of life.

Because so many more people now choose to remain in Alaska after retirement than previously, and because many more are choosing to move here in later life, it is time that systematic determination of needs and services is commenced in the area of mental health. The past decade has seen the development of an infrastructure, primarily in the urban areas of Alaska, that provides for many of the essential services older people tend to require (e.g., transportation, nutrition, primary health care, caregiver support). The mental health needs of Alaska's seniors, however, have not been addressed, with the exception of Alzheimer's Disease and related dementias. Demographic trends no longer allow Alaska to ignore senior mental health. We are all aging, and thus have a vested interest in a state with a vision to know its people and their needs, no matter their age.

Actions

1. Identify and assess specific mental health needs of the geriatric population and current status of services to that population.
2. Identify specific groups who are at higher risk of mental health problems (e.g., caregivers, homebound).
3. Collect specific data (including determining specific indicators such as suicide and substance abuse rates) to identify extent of need.
4. Determine specific housing needs, including crisis/respite and capacity to accommodate medical needs, of the geriatric population with mental health needs. Develop a plan to address housing needs that identifies potential funding resources.
5. Identify a senior mental health continuum of care, from prevention to acute and chronic care.

Responsible party (actions 1-5): Professional Services Contract (Mental Health Trust Authority Revenue) administered by Alaska Mental Health Board and Alaska Commission on Aging

6. Support ongoing research and evaluation of senior mental health needs.
   Responsible party: Division of Senior Services, Alaska Mental Health Board
7. Appoint a Senior Mental Health Advisory Committee to advise and assist the Alaska Mental Health Board in geriatric mental health matters.
   Responsible party: Alaska Mental Health Board

Issue 2: Developing Geriatric/Mental Health Expertise

Goal: Establish a collaborative approach to developing expertise to meet the mental health needs of the elderly in all levels of care.

Discussion

What is required to be of help to an older person? This is not an easy question to answer, often because aging is something most people would like to avoid. That both the client and the helper are aging at the same rate requires first and foremost that the helper be comfortable with this indisputable fact. Otherwise, our interventions will be guided by myth and prejudice and will not be helpful.

To be of help also requires time. The problems presented by older clients are invariably multifaceted and complex. Mental illness and its treatment must be understood in the context of multiple losses across all life domains, with recognition of a lifetime of behavior patterns, interpersonal relationships, social roles and expectations, personal resources, functional capacity, and attitudes toward self and others. Cursory assessment of mental health is incomplete if it is done without a comprehensive understanding of the larger picture of a person's life situation.

To be of help, one must also recognize the unique aspects of old age. Psychological and developmental theories and approaches typically do not do so. We accept that aging brings physical changes. Less is known about how older people respond to stress, loss, or other emotional demands. Each person retains their individuality over time, despite popular images of the elderly as fitting into a common mold. Carl Jung wrote of aging that "what was true in the morning by afternoon has become a lie." All who

seek to help older people must accept them as individuals with unique developmental and emotional circumstances.

Alaska has minimally (at best) incorporated aging into educational curricula, professional development conferences, and field training for students and workers in the helping professions. Specialized treatment facilities and programs are scarce for older people with mental health problems. Psychiatric problems often go unrecognized, or are inappropriately treated (e.g., over-prescription of psychotropic medication) by non-psychiatrically trained physicians. Many mental health problems of the elderly are by default managed on a daily basis by persons with little or no specialized training, such as in-home care workers, nursing home personnel, or family caregivers. With the burgeoning population of older people in Alaska, the recruitment and retention of specialized geriatric practitioners is increasingly urgent.

Alaska's vast rural areas present another great challenge to the provision of competent mental health care. The residents of more than 200 remote villages receive health care primarily from health corporations located in regional centers. The regional hospitals and community mental health centers serving rural Alaska provide varying degrees of mental health services. Professionals in rural areas have few opportunities for continuing education and must rely on telecommunications to collaborate with others in the mental health field. Alaska must develop ways to expand access to mental health services in rural areas, assisting rural providers in developing flexible programs and collaborative opportunities so that elders can remain in their home communities. Existing training programs, such as the University of Alaska Fairbanks Rural Human Services program, do not offer specific senior mental health tracks.

Actions

1. Recommend and encourage higher education institutions to include geriatric mental health training in all human service and health science curricula. A position paper outlining the Alaska Mental Health Board position should be forwarded to those institutions. *Responsible party: Alaska Mental Health Board, Senior Mental Health Advisory Committee*
2. Promote the recruitment and hiring of psychiatrists and other mental health professionals with geriatric knowledge within the community mental health system by requiring community mental health grantees to identify how they plan to respond to needs of seniors in their catchment area.

Responsible party: Division of Mental Health and Developmental Disabilities

3. Develop a distance education program on geriatric mental health that could result in a competency based geriatric mental health certification.
   Responsible party: Division of Mental Health and Developmental Disabilities, University of Alaska Anchorage, Alaska Community Mental Health Services Association, Rural Mental Health Directors Association, Senior Mental Health Advisory Committee
4. Contact the Northwest Geriatric Institute and other qualified organizations and individuals to encourage them to provide Alaska based mental health training.
   Responsible party: Alaska Mental Health Board
5. Assess and compile resources available for training and education in geriatric mental health issues and distribute to community mental health centers and senior service agencies. Develop a directory of available services and establish a clearinghouse to keep information current.
   Responsible party: Professional Services Contract (Mental Health Trust Authority Revenue project), administered by Alaska Mental Health Board and Alaska Commission on Aging
6. Educate primary care providers, through professional associations (such as Alaska Medical Association, National Association of Social Workers and Alaska Psychological Association), regarding mental health needs of the geriatric population. Encourage the establishment of continuing education units on geriatric mental health. Contact coordinators for statewide geriatric conferences to encourage inclusion of mental health issues.
   Responsible party: Alaska Mental Health Board, Alaska Commission on Aging, Senior Mental Health Advisory Committee

Issue 3: Service Delivery And Access

Goal: Ensure that aging and mental health service delivery systems provide coordinated comprehensive approaches to meeting the broad mental health needs (including Alzheimers Disease and Related Dementias, dual diagnosis, chronically mentally ill, etc.) of the elderly regardless of living situation or geographic location.

Discussion

Despite the growing number of older people in Alaska, and despite the prevalence of diagnosable mental disorders, utilization of Alaska Psychiatric Institute and community mental health center services statewide by Alaskans age 60 and over has remained constant at 1-2% of admissions, which is half the national utilization rate for seniors. This suggests the need to examine types and availability of services, as well as service accessibility.

Many seniors view mental health care with stigma and fear. Today's seniors are not accustomed to discussing their problems and feelings with others. Moreover, the fear of being regarded as incompetent or of having a serious dementing illness leads to psychological denial and avoidance of assistance. Because many mental health problems present as physical complaints, the issues are often not correctly identified by family members, practitioners, or even the older individuals themselves. Aggressive public education could help normalize treatable mental disorders and foster a greater openness regarding problems and solutions.

Even when an older person is aware of problems and receptive to help, it does little good if no help is available, or there is no practical way to get to help. Many seniors are unable to drive, or are homebound, and require such service to come to them. Development of outreach programs for psycho-education and treatment creates advantages for both access and comprehensive assessment. Access to services in rural Alaska is another issue and revolves more around the lack of services than in urban settings.

Cost of services is problematic as well, due to poor third-party support through Medicare, Medicaid, and other insurance. Indeed, specialized services are unlikely without viable financial incentives for clinics, hospitals, and practitioners. The irony, of course, is that prevention and early intervention can delay or avert much costlier acute and long term care and preserve an individual's independence and life satisfaction.

Coordinated advocacy and planning efforts are needed to integrate mental health services into the continuum of existing community-based services for older people. Such efforts must be initiated by consumers, their caregivers, and providers alike. Broad-based community education that prepares today's middle-agers for retirement and encourages long-range life planning will also help create a more informed inter-generational life perspective.

Actions

1. Develop effective outreach and identification methods.
   Responsible party: Division of Mental Health and Developmental Disabilities, Division of Senior Services, National Alliance for the Mentally Ill, Alaska, Alaska Mental Health Association, Health Consumers of Alaska, Senior Mental Health Advisory Committee
2. Ensure the availability of psychiatric or other proper consultation for seniors with mental health needs regardless of living situation or geographic location.
   Responsible party: Division of Mental Health and Developmental Disabilities, Division of Senior Services
3. Develop geriatric mental health expertise within the Division of Mental Health and Developmental Disabilities and Division of Senior Services.
   Responsible party: Division of Mental Health and Developmental Disabilities, Division of Senior Services
4. Include mental health resources in appropriate senior services directories and web sites.
   Responsible party: Alaska Commission on Aging
5. Establish a link between the Alaska Mental Health Board and the Alaska Commission on Aging regarding service to people with Alzheimer's Disease and Related Dementias.
   Responsible party: Alaska Mental Health Board, Alaska Commission on Aging
6. Analyze Medicaid reimbursement issues and develop a plan to address barriers.
   Responsible party: Division of Medical Assistance, Division of Senior Services, Division of Mental Health and Developmental Disabilities
7. Explore third party reimbursement issues.
   Responsible party: Division of Senior Services
8. Explore avenues for developing individual and system-level consumer advocacy and mediation methods.
   Responsible party: Alaska Mental Health Board, Alaska Commission on Aging, National Alliance for the Mentally Ill, Alaska, Alaska Mental Health Association, Mental Health Consumers of Alaska
9. Develop short term critical incident/crisis intervention plans in conjunction with the community mental health system, senior service system and community emergency services system.
   Responsible party: Division of Mental Health and Developmental Disabilities, Division of Senior Services

Senior Action Team Members

Dr. Beverly Bailey, LifeQuest Mental Health Center
Mike Boyd, Alaska Community Mental Health Services Association
Kay Branch, Bristol Bay Native Association
Kay Burrows, Division of Senior Services
Dr. Lucy Curtiss, Southcentral Counseling Center
Ken Fallon, Division of Mental Health and Developmental Disabilities
Jane Hanna, Juneau Mental Health Advisory Committee
Ken Helander, Daybreak Adult Day Center
Sylvia Matthews, National Association for the Mentally Ill, Alaska
Jill Sandleben, Alaska Commission on Aging
Roberley Waldron, Alaska Mental Health Board
Staff: Richard Rainery, Alaska Mental Health Board

MENTALLY ILL OFFENDERS' SERVICES

Introduction

The Department of Corrections is the largest provider of institutional mental health services in Alaska. This has happened over the last decade as a result of a number of system changes, some of which are mirrored in other states and some of which are more "Alaskan." Alaska came to deinstitutionalization of its hospitalized mentally ill patients later than most other states in the U.S. In the mid-1980's, the Alaska Psychiatric Institute began the process of decreasing its bed capacity, a process still underway. Funding decreases and the patient advocacy movement triggered this trend, but deinstitutionalization has had its own momentum. The net effect has been that API has gone from a facility with a 200+ bed capacity to a proposed facility that will have 54 beds. This has reduced both the number of patients that can be treated at a time, and the length of stay. Community services have not kept pace or been adequate to assist people who could no longer receive treatment in API. This has caused an increase in the number of mentally ill people in homeless shelters and, especially, in correctional facilities. Many chronically mentally ill people whose disability had previously placed them in hospital settings for extended periods were displaced into relatively unsupervised settings in the community. Without adequate monitoring, structure and the means to ensure treatment compliance, a portion of these consumers suffered a decompensation in mental status, often resulting in their arrest on misdemeanor or felony charges.

At about the same time deinstitutionalization was gaining momentum, a process of reinstitutionalization was occurring. In 1982, the Alaska Legislature effectively eliminated the Not Guilty by Reason of Insanity defense in Alaska, by passing restrictive amendments. Instead, they substituted a new designation, the Guilty But Mentally Ill verdict, which is seldom used. Those found Guilty But Mentally Ill are committed to the custody of the Department of Corrections and serve their entire sentences in correctional facilities while undergoing psychiatric treatment. In actual fact, "guilty but mentally ill" offenders serve more time in correctional facilities than individuals found guilty of the same offense, due to specific statutory language prohibiting furlough and parole eligibility. Consequently, increasing numbers of severely mentally ill offenders who

might otherwise have been in hospital settings in other states have become reinstitutionalized in Alaska's prisons for lengthy periods of incarceration.

Other states have recently passed statutes which require the commitment and treatment of persons defined as highly dangerous sexual offenders following completion of their original sentence. If enacted in Alaska, such a law could increase the number of individuals civilly committed for treatment in locked facilities. Housing and treatment for such persons could impact bed space and resources available to treat the mentally ill, and potentially divert resources to a population that has not been considered mentally ill by Alaska's mental health treatment agencies.

Arrest and incarceration have become a common form of emergency respite care and long-term reinstitutionalization for chronically mentally ill Alaskans. Unfortunately, this is an expensive moral and financial price to pay for public protection and individual treatment.

The documented burden placed on the correctional system is enormous. In 1996, Department of Corrections mental health clinicians saw 1,741 unduplicated mentally ill individuals in Alaska's correctional facilities. According to a recently completed mental health needs assessment, on one snapshot day (1/15/97), 883 individuals, or 29% of the 3091 individuals incarcerated in Department of Corrections correctional facilities, were identified as having some mental illness as defined by AS 47.30.056, and suffering from conditions which require some special care from mental health staff. Of these, 373 individuals (337 males and 36 females), 12% of the total incarcerated population, were suffering from a major mental illness. Seventy-eight individuals, or 38% of the 203 incarcerated females, were identified as mentally ill. (Data is taken from the 1997 report by Care Systems North entitled a *Mental Health Needs Assessment for Offenders in Custody and Under Supervision of the Alaska Department of Corrections.)*

Intensive community treatment for mentally ill individuals is more humane, effective, and often less expensive than incarceration or hospitalization at Alaska Psychiatric Institute. For example, continued care in community settings averaged $6,650 in FY 96. Actual costs depend on the level of services required by the mentally ill individual, based on the severity of the person's illness and amount of supervision or enhanced services needed. The average total cost for housing and clinical services combined is $9,984 per year. Actual community housing costs ranged from

$4,020 per year for rental assistance only, to $4,332 per year for individuals living in adult assisted living homes. Clinical and rehabilitation services for adult assisted living clients averaged $5,652 per year. Mentally ill individuals living in permanent supported housing with daily intensive clinical and rehabilitation services on average range from $20,000 to $30,000 per year. The highest cost can range up to $70,000 or more for a severely disturbed individual who requires 24 hour intensive individual services. API cost $758.48 per day in FY 98 (which if an individual stayed for a year would be $274,000 per year). The average statewide daily rate for a Department of Corrections bed in FY 97 was $105.27 per day ($38,520 per year); court costs and other costs involved in prosecution are not included. All incarceration costs are borne by the State of Alaska. Fifty percent of API costs are borne by the State of Alaska while the rest are covered by the federal government or other third party payers. Mentally ill individuals in community care may receive Medicaid and other federal funds to support their care in the community. When we use a system approach to costing out alternatives, clearly, the community and the individual are better served by intensive and appropriate treatment in a community setting. Clinical and legal recidivism rates for people in intensive community treatment settings are lower than for those without adequate community supports.

In the long term, ways need to be found to divert mentally ill offenders whose crimes result from their illness, especially misdemeanants, from the criminal justice system and correctional facilities to effective community care. In large communities, a "single point of entry," one place where police can bring people experiencing mental difficulties, may be a solution. In all communities, coordination between the criminal justice system and mental health providers and advocates is important.

Mentally ill offenders are required by law and simple humanity to receive treatment while incarcerated. In addition, care for these individuals and public safety concerns require attention to relapse prevention. What needs to be done to meet these twin needs?

The Mentally Ill Offenders Action Team recommends several objectives which seek to implement the goal of expanding and improving the continuum of care for mentally ill offenders. These objectives encompass prevention of imprisonment by enhancing community supports, promoting adequate care for those who are incarcerated, and emphasizing relapse prevention after release.

Continuum of Care for Mentally Ill Offenders
Spectrum of Services Depending on Acuity of Need

The following is a proposed Continuum of Care. Underlined items are currently missing from the delivery system. The effectiveness of the proposed continuum, and efforts to divert and successfully treat and maintain mentally ill individuals in the community, will rely on all pieces of the continuum being operational.

I. Initial Contact with Law Enforcement

A. Dependent on the nature of the offense and the presenting mental status and behavior of the individual that comes to the attention of the law enforcement officer, the officer may:
   1. Make a decision to charge.
   2. Consider pre-arrest diversion.
      a) Obtain screening, assessment, and referral by community service gatekeeper in large communities.
      b) Directly transfer the individual for assessment by outpatient mental health providers, hospital or detox facility.

II. Intake into Department of Corrections facilities

A. Mental health status screening conducted by nursing staff shortly after intake (within 24 hours) on new remands to Department of Corrections.

B. If indicated, referral to Department of Corrections mental health staff for further assessment, diagnosis, and treatment recommendations. If indicated:
   1. Recommendations to institutional staff regarding behavioral management.
   2. Mental health treatment.

C. Identify potential candidates for misdemeanant diversion.
   1. Coordination between court and legal system on case prosecution and sentencing.
   2. Once stabilized, release mentally ill misdemeanant offender to community on court ordered intensive probation with coordinated mental health follow-up.

III. Department of Corrections Treatment Programs

A. Individual treatment plan to include:

1. Medication prescription and monitoring.
2. Individual and group counseling.
3. Specialized programs e.g., anger control, life skills, substance abuse treatment, sex offender treatment, values clarification, thinking errors, cognitive skills.
4. Housing placement determination based on acuity:
    a) Psychiatric hospital care available when needed.
    b) Acute care (24 hour intensive monitoring, treatment and protection), makes it possible to deliver frequent therapeutic interventions for people experiencing psychotic or similar symptoms. (Currently Cook Inlet Pre-Trial Facility Mike Module is available for men. A psychiatric assessment and treatment unit for women is critically needed. A women's psychiatric unit is scheduled to open in 1998 with initial funding provided by the Alaska Mental Health Trust Authority; continued funding by the Legislature is critical).
    c) Sub-acute care--residual symptoms and impaired functioning prevents person from being mainstreamed with general population (currently provided in Cook Inlet Pre-Trial Facility-Mike Mod).
    d) Sheltered living--separate from general population (e.g., Hiland Mountain Correctional Center special needs wing for men).
    e) Crisis bed--short-term use of mental health segregation bed monitored by correctional officers and mental health staff.
    f) Transitional housing in preparation for release, i.e. furlough.
5. Contact with community mental health centers regarding mentally ill inmates in custody:
    a) Occurs regarding their clients at time of arrest.
    b) Referral made to community mental health centers during incarceration. Intervention/involvement of outpatient providers periodically occurs during incarceration for continuity of care.
    c) Formal transfer of patient care at release.

IV. Post Release Treatment and Services

A. Specialized probation officers for mentally ill male and female felons, and probation officer or some other form of monitoring for misdemeanants.

B. Options in housing ranging from 24 hour structured supervised housing, to group homes, to independent apartments with case management.

C. Programs that provide daily structure, support, rehabilitation, treatment, and supervision. These could include partial hospitalization, specialized work programs, clubhouses, therapeutic/recreational activities, life skills, and anger management, as needed by the patient.

D. Special substance abuse treatment for the mentally ill (emphasizing relapse prevention), including residential, outpatient, transitional, and long-term specialized housing.

E. Option of intensive case management with daily outreach contact.

F. Specialized sex offender treatment for mentally ill offenders (modified relapse prevention model).

V. Prevention

A. Community mental health center programs ranging from emergency care to outpatient support to intensive 24-hour supervised care in the community, including a full range of housing options.

B. Access to hospital treatment beds.

C. Mentally ill inpatient stay at hospital long enough to be stabilized.

D. Long term or tertiary care in structured setting for severely chronically mentally ill.

E. Specialized substance abuse treatment for the mentally ill emphasizing relapse prevention to be offered in the community.

VI. Notes to the Continuum of Care: Potential Legal Issues

A. There is a systematic relationship between Alaska Psychiatric Institute admissions criteria, bed capacity, length of stay, and patient stability. If people are not admitted when necessary or do not receive adequate lengths of stay, they may become involved with the criminal justice system. The involuntary

commitment statute should be reexamined to determine if a change is needed to insure access to psychiatric care.

B. Persons who are hospitalized under Title 12 whose charges are dropped may need continued psychiatric care under Title 47. Present Alaska statutes and procedures should be re-examined to determine if this transition can be streamlined to effectively insure adequate psychiatric care for the individual.

C. The guardianship statute, A.S. 13.26.150 (e) (1), prohibits voluntary admissions to Alaska Psychiatric Institute for mentally ill persons who have a court-ordered public guardian. Admission is by formal commitment proceeding only. Mentally ill individuals who have a guardian must severely decompensate in their illness before they are able to obtain inpatient hospital care. Legal change is needed to make it possible for these individuals to have earlier access to appropriate psychiatric hospital care.

D. Criminalization of the mentally ill is an increasing problem. Alaska lacks a system of diversion from jail into community based mental health programs. Jail should not be used as intake into the mental health system. Diversion of mentally ill offenders arrested on misdemeanant charges is needed to reduce criminalization of the mentally ill. A system for diversion of mentally ill misdemeanant offenders needs to be developed. It is expected it will include close coordination between the court, defense and prosecuting attorneys, correctional and community mental health staff, and when funded, a misdemeanant case coordinator to monitor treatment compliance in hopes of reducing clinical and legal recidivism. Ultimately, a single point of entry mechanism to ensure assessment of the individual is needed in large communities.

E. In June, 1997, the U.S. Supreme Court upheld the constitutionality of civil commitments of dangerous sexual predators after they have served their prison sentences. If enacted in Alaska, such a law could have negative consequences for people with mental illnesses and for the public mental health system. Sexual predator legislation could potentially increase the number of individuals needing locked facilities. Increased resources would be required to manage this population without negatively impacting public mental health and correctional services.

F. Confidentiality issues need to be addressed to allow for exchange of information to identify mentally ill individuals who come in contact with the criminal justice system and will be in need of increased coordination between members of the legal community and mental health providers. Management information systems could be designed to address both the need to identify individuals entering each system and those common to both systems.

Issue 1: Access to Mental Health and Related Services

Goal: Increase access to appropriate and quality mental health services in a continuum of care for mentally ill offenders.

Objective A: Develop a Department of Corrections psychiatric assessment and treatment unit for female mentally ill offenders.

Discussion

Mentally ill females incarcerated in Department of Corrections facilities are housed either with the general population or in "segregation" beds. They do not have access to 24 hour care (psychiatric assessment, supervision, and appropriate mental health treatment and programming). Although medications are available, adequate treatment services are not available for these consumers. Any mental condition will be exacerbated by spending 23 hours a day in solitary confinement. A female unit needs to be established that will meet the Cleary standards which defined the current services for male inmates.

Actions

1. The Department of Corrections will continue to work with the Alaska Mental Health Board, Alaska Mental Health Trust Authority and the Legislature to fund a mental health unit for female offenders.
   Responsible party: Department of Corrections

Objective B: Increase the number of housing alternatives (including group homes, supervised apartments and 24 hour structured housing) for the mentally ill who are leaving correctional facilities.

Discussion

People released from Department of Corrections facilities have limited housing options, often being released to the streets or homeless shelters, without supervision or structure to their days. This contributes to relapse, re-offense, decompensation and re-incarceration. The ability of the Department of Corrections to impose conditional early release is limited by the housing available. Twenty-four hour supervision is critical to making a successful transition to the community for some of these severely mentally ill individuals.

Actions

1. Division of Mental Health and Developmental Disabilities staff will work with their grantees, Alaska Mental Health Trust Authority, and Alaska Housing Finance Corporation to identify community needs, develop alternatives to meet those needs, and explore federal grants with Alaska Housing Finance Corporation participation.
   Responsible party: Division of Mental Health and Developmental Disabilities

Objective C: Long term psychiatric care will be met in an appropriate setting.

Discussion

Many complex, chronically mentally ill people in Alaska have not had access to needed high levels of psychiatric care. Without this care, some mentally ill persons become offenders in the custody of the Department of Corrections. If this service were available, more chronically mentally ill Alaskans would become stabilized and, therefore, less likely to become involved with the criminal justice system.

Actions

1. The Alaska Psychiatric Institute planning process will identify an Anchorage location for tertiary care.
   Responsible party: Alaska Mental Health Board
2. The Department of Corrections will use Alaska Psychiatric Institute as tertiary care with a corrections transfer capacity.
   Responsible party: Department of Corrections

3. The Alaska Mental Health Board, Division of Mental Health and Developmental Disabilities and Department of Corrections will identify an appropriate tertiary care venue for mentally ill offenders.
   Responsible party: Alaska Mental Health Board

Objective D: Enhance funding levels to assure effectiveness of existing community programs.

Discussion

Rates of incarceration and recidivism indicate that community mental health programs do not always have adequate funding resources to monitor mentally ill offenders post release and, therefore, to adequately protect the individual and society. Cost can range considerably, up to significant levels for persons in the Institutional Discharge Plus program.

Actions

1. The Alaska Mental Health Board will annually assess the need for funding for community programs.
2. The Alaska Mental Health Board will request needed enhancements in budget requests.
   Responsible party (actions 1-2): Alaska Mental Health Board

Objective E: Expand community services to include more post release options.

Discussion

Post incarceration treatment options do not include adequate day treatment, vocational rehabilitation, anger management, social skills development, substance abuse treatment, work options. etc. Lack of focused time and supervision often leads to repeat offenses and probation is less likely to be successful.

Actions

1. The Division of Mental Health and Developmental Disabilities and Department of Corrections will work with the Alaska Mental Health Board to request funds from the Alaska Mental Health Trust Authority for intensive daily activities for Anchorage mentally ill offenders released to the community, including anger management, social and living skills, mentally ill/chemical abuse treatment, sex offender treatment, vocational training and job placement. The program should be run by the community mental health center or in

combination with Department of Corrections and Institutional Discharge Plus staff.

2. If this pilot project is successful, funds will be requested to replicate it in other communities.

Responsible party (actions 1-2): Division of Mental Health and Developmental Disabilities, Department of Corrections, Alaska Mental Health Board

Objective F: The Department of Corrections will have access to psychiatric hospital services for mentally ill forensic patients.

Discussion

Currently, Alaska Psychiatric Institute has only 10 beds that are reserved for court ordered mental status evaluations and for competency evaluations and training for those found to be incompetent to stand trial. Correctional transfer capability for the Department of Corrections to a psychiatric hospital needs to exist when and for as long as the individual needs this care. The Department of Corrections will continue to operate a men's mental health unit to provide psychiatric assessment and treatment for mentally ill inmates. As of January, 1998, the Department of Corrections will begin operation of a women's psychiatric assessment and treatment unit, using Alaska Mental Health Trust Authority initial funding. Continued development and funding for this service are necessary.

Actions

1. The Division of Mental Health and Developmental Disabilities will continue to explore other models for providing court ordered evaluations, e.g., out-patient evaluations with experts sent to the prison, court clinic model, licensing of private practitioners for forensic evaluations.
2. The Division of Mental Health and Developmental Disabilities and Department of Corrections will coordinate where to house those individuals ordered by the court to have psychiatric evaluation; and the Division of Mental Health and Developmental Disabilities will provide for staff for the evaluations.
3. Assure that the future Alaska Psychiatric Institute (API) has space for correctional transfers; the Department of Corrections will coordinate with API to determine treatment needs and anticipated lengths of stay for correctional transfers to API.

4. Assure that the Department of Corrections has access to forensic hospital services for mentally ill offenders as needed.
   Responsible party (actions 1-4): Division of Mental Health and Developmental Disabilities
5. The Alaska Mental Health Board will advocate for continued funding for the women's mental health unit.
   Responsible party: Alaska Mental Health Board

Objective G: Develop treatment programs for mentally ill sex offenders during incarceration and post incarceration, including relapse prevention.

Discussion

Current treatment services are provided primarily to non-mentally ill sex offenders. Additional funding is needed to create a specialized program to treat mentally ill sex offenders whose ability to participate in treatment is complicated by chronic mental illness. Sex offender treatment will serve to protect the public by targeting relapse prevention.

Actions

1. The Department of Corrections will explore funding from the Alaska Mental Health Board and the Alaska Mental Health Trust Authority to establish a pilot sex offender project in Anchorage for incarcerated mentally ill offenders and mentally ill offenders on parole/probation which emphasizes relapse prevention.
2. If program outcomes indicate, the Department of Corrections and the Alaska Mental Health Board will request funding to expand to such locations as Bethel, Fairbanks, and Southeast Alaska.
   Responsible party (actions 1-2): Department of Corrections

Objective H: Assess and treat the "organic brain syndrome" population.

Discussion

Many people with organic brain disorders in Alaska have no source of treatment and long term support. An increasing number of individuals with organic brain syndrome (organic brain malfunctions due to trauma, substance abuse, disease) are showing up in correctional facilities.

Actions

1. The Alaska Mental Health Trust Authority will be asked to work with the "beneficiary boards" and the Department of Health and Social Services to identify an agency that will assume responsibility

for assessment and long term support services for clients with organic brain syndrome, regardless of the cause of disability.
Responsible party: Alaska Mental Health Board

Objective I: Maximize the number of mentally ill misdemeanants who are diverted from the criminal justice system to the mental health system.

Discussion

Many mentally ill people, especially those who are not currently supported by community programs, may be picked up by police for violation of misdemeanor laws. Jail is often seen as the easiest, and frequently the only available placement by the police, but this is not a placement or process that brings people into contact with community mental health service providers. If diversion were available for appropriate mentally ill misdemeanants, many of those who now become involved with the costly criminal justice system could be diverted to an alternative which would provide psychiatric assessment, treatment, medication and monitoring. Ultimately, fewer people would become repeat law breakers. One alternative focus is to establish a place other than jail for police to bring people. In addition, adjudicated misdemeanants could be diverted from jail time to court probation and treatment in community programs.

Actions

1. In Anchorage, as a pilot project, a Task Force will establish a system to identify and link mentally ill misdemeanants to community mental health and support providers, and track the effectiveness of care and compliance with bail or probation requirements.
   Responsible party: Task Force
2. The Alaska Mental Health Board/Alaska Mental Health Trust Authority will request funding to implement the pilot project.
   Responsible party: Alaska Mental Health Board, Alaska Mental Health Trust Authority
3. The Alaska Mental Health Board and Department of Corrections will evaluate the pilot project for replication in other areas of the state.
   Responsible party: Alaska Mental Health Board

Issue 2: Title 47 Revisions

Goal: The language and procedures in Title 47 will be re-examined for improvements.

Discussion

Many changes have occurred in our mental health system since our current civil commitment law was passed. Other changes have been proposed but not enacted. In addition, the civil commitment statute is applied differently in different areas of the state. Changes may be possible which will better serve the needs of mentally ill Alaskans, while assuring protection of their civil liberties.

Actions

1. The Alaska Mental Health Board will provide an analysis of identified legal issues and recommend possible statutory revisions, including streamlined re-commitment and out-patient commitment. The analysis will also address the inability of public guardians to arrange for voluntary hospitalization, while insuring protection of civil rights.
   Responsible party: Alaska Mental Health Board
2. The Division of Mental Health and Developmental Disabilities will review interpretation of AS 47.30 regarding admissions to Alaska Psychiatric Institute to ensure that those in need of care receive admission.
   Responsible party: Division of Mental Health and Developmental Disabilities

Issue 3: Management Information Systems

Goal: Develop tracking systems to rapidly identify mentally ill offenders and ensure appropriate services within the criminal justice and mental health systems, and to allow coordination of services across these systems.

Discussion

Confidentiality issues need to be addressed to allow for exchange of information to identify mentally ill individuals who need increased coordination between the legal community and mental health providers. Management information systems could be designed to address both the

need to identify individuals entering each system and those common to both systems.

Actions

1. The Department of Health and Social Services, Department of Law, Alaska Mental Health Board, Department of Corrections, and advocacy groups will explore methods to address the problem of protecting privacy rights while assuring agencies adequate access to records and tracking information.
   Responsible party: Department of Health and Social Services

Mentally Ill Offenders Action Team Members

Colleen Patrick Riley, Department of Corrections, Chair
Barbara Brink, Public Defender
Randall Burns, Alaska Psychiatric Institute
Mike Campbell, Division of Mental Health and Developmental Disabilities
Cindy Cooper, Deputy Attorney General, Criminal Division
Cindy Drinkwater, Disability Law Center of Alaska
Jeff Duncan, Southcentral Counseling Center
James Gay, Department of Corrections
Bob Galea, Akeela Treatment Services
Lt. Bob Gorder, Alaska State Troopers
Leslie Hiebert, Office of Public Advocacy
Michael Logue, Gorton and Associates
Mark Mew, Deputy Chief, Anchorage Police Department
Susan Parkes, District Attorney
Judge Stephanie Rhoades, Third Judicial District
John Richard, Anchorage Municipal Prosecutor
Mara Rabinowitz, Department of Corrections
David Sperbeck, Department of Corrections
Ron Taylor, Alcohol Safety Action Program Coordinator
Scott Wheat, National Alliance for the Mentally Ill, Alaska
Staff: Margo Waring, Alaska Mental Health Board