

# Alaska Mental Health Board

## 1999 Report

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# ALASKA MENTAL HEALTH BOARD

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TONY KNOWLES, GOVERNOR  
STATE OF ALASKA

431 N. Franklin, Suite 200  
Juneau, Alaska 99801  
Office: (907) 465-3071  
Fax: (907) 465-3079

March 13, 2000

Concerned Alaskans  
Governor Knowles  
Members, 21st Alaska Legislature

Dear Alaskans, Governor Knowles, and Legislators:

The Alaska Mental Health Board is pleased to present its 1999 Annual Report. Created in 1987, the Board has as its primary mission assisting Alaskans to develop and maintain an integrated, comprehensive state mental health program.

During 1999, the Board continued to press for the development of a service system based on the values and needs of consumers. We can report substantial progress on several initiatives key to this fundamental goal:

- ◆ quality assurance for community and inpatient services
- ◆ strategic system planning
- ◆ consumer involvement in policy development and decision-making
- ◆ community services to support a smaller Alaska Psychiatric Institute

The Board again identified three service sectors as needing enhancement: 1) children and youth, 2) rural, and 3) diversion from the criminal justice system. We also believe that safe, affordable housing for Alaskans experiencing mental illness remains a critical necessity.

We intend this report to be informative and useful. Please contact us if you have comments or would like additional information concerning Board activities.

Sincerely,

*Susan Humphrey-Barnett*

Susan Humphrey-Barnett  
Chair

## Introduction

**T**his annual report records the 1999 goals and accomplishments of the Alaska Mental Health Board (AMHB) and of the state mental health system. This report also sketches a rough portrait of the state mental health system in Alaska—the services and the people that use those services. We highlight the Board’s work in several key domains, including:

- ◆ advocacy for Alaskans experiencing mental illness
- ◆ system development
- ◆ collaboration among system stakeholders
- ◆ designing the system of the future

The Board intends that this report proves useful to readers and sparks participation in the process of building and strengthening the state mental health system. The AMHB relies on all Alaskans to guide it in this work. We invite you to attend any of the Board’s meetings held in communities across the state or to contact us concerning your views on the state mental health system and service to Alaskans. Visit the AMHB web site ([www.amhb.org](http://www.amhb.org)) for current information on Board activities and initiatives.

### **Alaska Mental Health Board**

431 North Franklin St.,  
Suite 200

Juneau, Alaska 99801

- ◆ 907/465-3071
- ◆ 907/465-3079 (fax)
- ◆ [amhb@alaska.net](mailto:amhb@alaska.net)

## Special Section

### The Surgeon General's Report on Mental Health

**D**ecember 1999 witnessed a signal event in the history of public health in the United States—the release of the Surgeon General's Report on Mental Health. The report is one of only seven the Surgeon General has published on subjects other than tobacco and the first to focus on mental health. The report assesses our nation's response to mental illness, identifies serious barriers faced by persons with mental illness, and makes recommendations for a more positive, proactive response to mental illness. The report stresses the importance of information, policies, and actions that will reduce and eventually eliminate the stigma America attaches to mental illness. Hundreds of mental health consumers, providers, and others were involved in the design and creation of the report.

#### An Historic Event

*The Surgeon General's Report on Mental Health is an historic milepost in American public health.*

The Surgeon General has pointed the way to answering key questions about mental health and mental illness in America by:

- ◆ Assessing the nation's response to mental illness
- ◆ Identifying barriers to addressing mental illness
- ◆ Informing future policy development
- ◆ Calling the nation to action to improve its mental health.



#### Mental Health: A Public Health Issue

One of fundamental points the Surgeon General makes is the importance of treating mental health as a public health issue. The report emphasizes that the nation must recognize that:

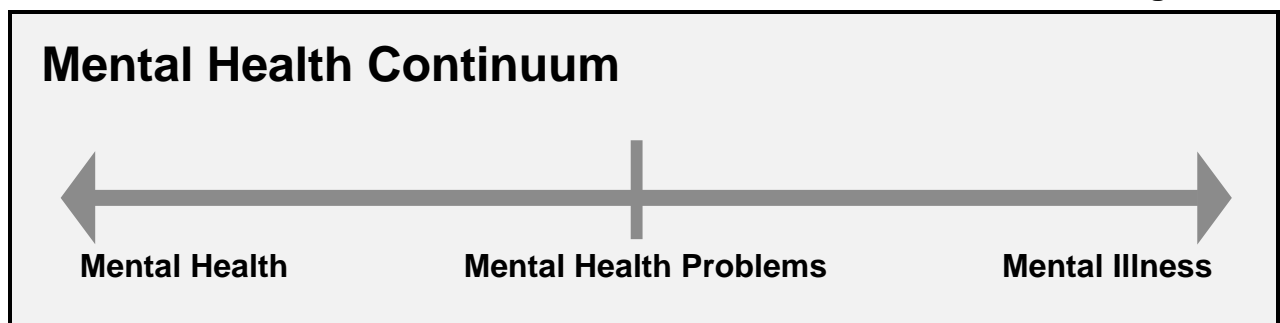
- ◆ Mental health is fundamental to overall health. The qualities of mental health are essential to a healthy life. Mental health is indispensable to personal well being. As a country, we must assign the same priority to good mental health as we do to good physical health.
- ◆ Mental disorders are real health conditions. Mental disorders have an immense impact on a person's health and can be extremely disabling. There is a growing recognition of mental illnesses as brain disorders that can be treated as effectively as any health condition.

- ◆ Mental health and physical health are inseparable. Just as the mind and body interact, mental conditions and physical conditions interact and affect one another. For example, clinical depression has a great impact on physical health. Similarly, serious physical diseases have a great impact on a person’s mental health. We must treat physical and mental health as major components of overall health.

Mental health and mental illness may be thought of as points on a continuum (Figure S-I). In this light, we may see that the continuum applies to us all. But what do we mean by the terms “mental health,” “mental health problems,” and “mental illness”?

- ◆ *Mental Health* refers to positive mental functioning characterized by productive activities, positive relationships, and ability to adapt/cope with adversity. Mental health is not static but changes over time and with circumstances.
- ◆ A *Mental Health Problem* is a situational or developmental condition causing short-term distress and impaired functioning. Difficult periods in life (divorce, death of a loved one, loss of job, etc.) often trigger mental health problems.

Figure S-I



- ◆ *Mental Illness* is a health condition including alterations in thinking, mood, or behavior that leads to more severe, longer-term distress and impaired functioning. In its most severe form, mental illness can produce major life-long disability.

What do these definitions mean in terms of the mental health/mental illness continuum? Everyone falls somewhere along the continuum, often at different places at different times in life. Almost everyone has experienced mental health problems with some of the signs and symptoms of mental disorders.

Conditions become more disabling further to the right on the continuum, culminating in the severe distress and impaired

functioning of chronic and severe mental illness. Different points on the continuum call for different interventions—from prevention/informal support, to targeted treatment, to comprehensive long-term treatment and supports. The cost of services also goes up as we move along the continuum toward severe, chronic mental illness.

<b>Overall Years of Life Lost to Illness</b>	
<b>Cause</b>	<b>% of Disease Burden</b>
Cardiovascular conditions	18.8
Mental illness	15.4
Malignant disease (cancer)	15.0
Respiratory conditions	4.8
Alcohol use	4.7
Infectious and parasitic disease	2.8
Drug use	1.5

**Table S-I**

Put in the context of the overall burden of illness experienced by Americans, the weight of mental illness may come as a surprise to many. Mental illness accounts for nearly a sixth of all the years of

life lost to disease, more than all cancers combined (see Table S-I). Only heart disease is a greater public health burden to Americans.

Other data reinforce the status of mental illness as a major challenge to the health of the nation and, conversely, the importance of mental health to Americans.

- ◆ Conditions caused or exacerbated by mental health problems prompt up to half of all visits to primary care physicians.
- ◆ Approximately 15% of all adults who have a mental disorder in a year have a co-occurring substance abuse disorder. As many as half of people with serious mental illnesses develop alcohol or drug abuse problems at some point in their lives.
- ◆ One in five children have a diagnosable emotional disorder.
- ◆ The incidence of suicide among 15-24 year olds has tripled since 1960.
- ◆ Nearly half of those with severe mental illnesses do not seek treatment.



**Treatment Works**

Despite the devastating impact of mental illness, the Surgeon General reminds us that we have cause for hope. Many who have experienced mental health problems or illnesses have succeeded through effective treatment. More people with mental illnesses are living successfully in their communities.

Science demonstrates that effective treatment is not only possible, but also as effective as treatments for other medical conditions. Research continues to lead to great leaps in understanding of how the brain regulates thought, behavior, and emotion in both health and in illness.

Advances in the efficacy of medications have been particularly noteworthy. Early medications for mental illness often had serious or permanent side effects. Newer medications control symptoms of mental illness more effectively with fewer ill effects, allowing people with mental illnesses more control over their lives.

Perhaps the real tragedy of mental illness in America is that nearly half of all people with severe mental illnesses do not seek treatment. As the effectiveness of treatment increases, we must find ways to increase the number of people treated. One of the key recommendations in the Surgeon General's report is "Seek help if you have a mental health problem or think you have the symptoms of a mental disorder!"



## The Obstacles

To encourage people with mental illnesses to seek help; America must tackle some real barriers to mental health and foster more positive responses to mental illness.

### Stigma

*If I had a heart attack, people would be concerned about me, but since I have a mental illness, people laugh at me.*

This statement by an Alaskan consumer underscores the negative stereotyping, fear, or outright discrimination that people with mental illnesses face daily. This pervasive social stigma (reinforced on a regular basis by the popular media) prevents many people with mental illnesses from seeking help. As long as America tolerates stigma, people will hesitate to seek help.

### Culture/Ethnicity/Gender/Age Factors

The needs of mental health consumers vary according to age, gender, race, and culture. All these factors must be considered in identifying individual needs. For example, the elderly population in the U.S and Alaska is increasing at a dramatic rate. Alzheimer's disease and related dementias, depression, and high suicide risk are just a few of the principal mental health issues facing the elderly.

### The Obstacles

*Three chief barriers stand in the way of improving the mental health of the United States and Alaska.*

- ◆ *Stigma*
- ◆ *Diversity of need*
- ◆ *Cost of care*

## Financial Barriers

The organization and financing of mental health services has been a significant barrier to many consumers. For example, managed care has often been used as a tool to cut costs and reduce access and services to people with mental illnesses. In addition, many health consumers do not have private insurance that covers mental health needs. Ninety percent of all health insurance policies provide less coverage for mental illness than for physical illness.



## The Surgeon General's Call to Action

The Surgeon General called Americans to action to take up the challenges presented by the barriers to mental health. Eight fundamental tools will allow us to dismantle these obstacles.

- ◆ **Build the science base:** We must continue to seek to advance our knowledge of the brain and its chemistry.
- ◆ **Overcome stigma:** We must adopt a zero tolerance for stigma and dispel the myths and stereotypes that surround mental illness. We must increase efforts to educate others and ourselves about mental illness.
- ◆ **Improve public awareness of effective treatment:** We must make people aware of the large range of effective mental health interventions.
- ◆ **Ensure accessibility to services:** We must make mental health services available when and where people need them, particularly in rural communities.
- ◆ **Ensure delivery of state-of-the-art treatment:** We must translate the continuing advances of research and science into actual treatment services for people with mental illnesses.
- ◆ **Deliver individualized treatment:** We must create diagnostic and treatment frameworks that recognize individual age, gender, race, cultural, and other characteristics.
- ◆ **Facilitate entry into treatment:** We must provide and publicize multiple access points to treatment services.
- ◆ **Reduce financial barriers:** We must continue to advocate for parity in private insurance for mental health with physical health to reduce financial barriers to treatment for people with mental illnesses.



# A Brief Status Report

**A**laska's public mental health system represents a singular constellation of people, services, and plans. As a result of the Alaska Mental Health Trust settlement, services to Alaskans experiencing mental illness are planned and funded through a unique public process. The Alaska Mental Health Board (AMHB) represents Trust beneficiaries with mental illnesses in this process.

The AMHB plans and coordinates state mental health services, advocates for people with mental illness, and evaluates the state mental health program. The Board collaborates with state agencies that deliver or fund mental health services, the Alaska Mental Trust Health Authority (AMHTA), and service consumers and providers to develop an integrated and comprehensive mental health program.



## 1999 Accomplishments

1999 marked another year of continued achievement and progress toward the AMHB's principal goal, the redefinition of Alaska's public mental health services as a consumer-centric system. The Board continued to stress cooperation and consensus among all stakeholders, while advocating consumer leadership.

1999 saw several AMHB initiatives come to fruition or make significant strides toward that end. Taken as a whole, these efforts will lead to a more integrated, outcomes-based, and consumer-focused system. Key AMHB accomplishments, most in concert with many other stakeholders, included:

- ◆ Released *A Shared Vision II*, the strategic plan for the state's mental health system. Scores of stakeholders representing all perspectives contributed to this renewed blueprint for a consumer-centered mental health system.
- ◆ Advocated for passage of HB 149, which eliminates health insurance discrimination against persons with mental illness and with substance abuse disorders.
- ◆ Helped guide the creation of a Mental Health Court in Anchorage (one of only three nationwide). The court complemented the operation of the Jail Alternatives Services (JAS) project, which diverts misdemeanants charged with crimes directly resulting from behavior associated with their mental illnesses from prison to treatment programs. JAS

### Key AMHB Duties

- ◆ *Prepare the state mental health plan*
- ◆ *Advocate for Alaskans with mental illnesses*
- ◆ *Recommend a mental health program budget*
- ◆ *Assist in developing a comprehensive plan*
- ◆ *Evaluate state mental health program*

results show reduced recidivism among those diverted to treatment.

- ◆ Initiated a process that will establish supported housing for dually diagnosed Department of Corrections and Alaska Psychiatric Institute (API) clients. Lack of this resource has long been a crucial obstacle in efforts to re-integrate Trust beneficiaries into their communities.
- ◆ Pushed the continued growth of community services that will allow the state to reduce the number of beds at API. Five long-term patients moved from API to supported housing units. API subsequently removed those beds from service.
- ◆ Participated in the development of program standards for a new integrated quality assurance review process for community mental health programs. The signal achievement was the focus of these IQA reviews on consumer quality of life and engagement in grantee governance. The AMHB participated in several of these reviews. The Board thereafter undertook an analysis of the process and identified several areas requiring continued development or re-evaluation.
- ◆ Completed the API Quality Assurance Report and subsequent endorsement of the majority of the report's recommendations by the DHSS commissioner. The end result will be to expand consumer and family member involvement in treatment, quality assurance, and governance at API.
- ◆ Published a report on performance measures and unified the Board's effort to establish a system of performance measures for mental health services with a comparable effort in DHSS.
- ◆ Supported the approach developed by the Children's Mental Health Coordinator to move in concert with DHSS towards a unified system of mental health care for children and youth.
- ◆ Spearheaded the creation of a DHSS Consumer Affairs position, intended to augment the voice of consumers in Alaska's mental health policy and decision-making.
- ◆ Collaborated with the Alaska Commission on Aging to found a joint committee on mental health and aging. The committee will pursue several goals: assessing senior mental health needs, recruiting geriatric expertise in the community mental health system, and establishing geriatric mental health training in the human services and health curricula of the state's universities.
- ◆ Played a key role in the establishment of the Basic Supports Coalition. Over 120 communities, service providers, and advocacy organizations came together to lead the effort to protect funding levels for essential state support programs for disabled and vulnerable Alaskans.

### **Moving The Agenda**

*The AMHB and system stakeholders made real progress on over a dozen major issues during 1999.*

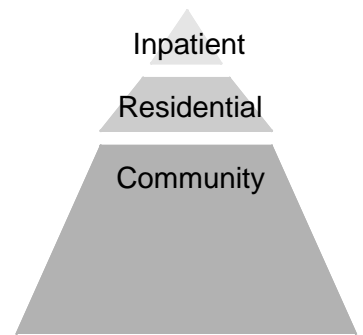
- ◆ Participated in the first high-level collaborative planning effort for rural mental health. The effort engendered the first-ever statewide rural mental health conference (to take place in April 2000) and initiated work to integrate substance and mental health services and to develop consulting and support services for rural communities.



### Work Still Ahead

The ideal mental health service array is a pyramid, with most services provided on a decentralized, local, community-based, and low-intensity basis. A much smaller capacity would consist of higher intensity services offered by local or regional residential providers. Finally, the tip of the pyramid represents centralized, institutional inpatient care, an ever-decreasing share of capacity as Alaska progresses toward a community-based, consumer-centered system of care. *A Shared Vision II* defines a complete, consumer-centered system. The differences between AMHB vision and Alaskan reality are most striking in four critical areas.

- ◆ **Rural services:** Two mental health systems exist in Alaska. Urban Alaska possesses full-service systems. Most rural Alaskan communities have limited or no local services. Expanding and spreading innovative, integrated local services will be a vital step in achieving a statewide continuum of care and reducing reliance on more costly programs near the apex of the pyramid. During 1999, the AMHB Rural Initiative helped to define priorities and outline strategies to enhance rural mental health services.
- ◆ **Criminalizing mental illness:** State correctional institutions (including youth corrections) house large populations with mental illnesses. Many non-violent misdemeanants could be more effectively treated in community settings. The AMHB continues to work to strengthen the relationship between the criminal justice and community mental health systems and to make available an adequate correctional continuum of care.
- ◆ **Children’s service system:** The AMHB advocates and is working to coordinate efforts to address issues such as:
  1. Services for youth transitioning to adult services
  2. Out of home placements for the increasing numbers of children and youth in state custody



**Four Challenges**

*The AMHB’s main focuses in 1999 were:*

- ◆ *Rural services*
- ◆ *Criminalization*
- ◆ *Children’s services*
- ◆ *API/community transition*

3. Coordination with DFYS and other service agencies to develop a more coordinated system of care

- ◆ **API-Community Services Coordination:** Mental health stakeholders have designed a system based on augmented community resources, which will lead to the reconfiguration of Alaska Psychiatric Institute (API) into a smaller, more specialized component of the overall system.



### Who We Represent

**Table S-2**

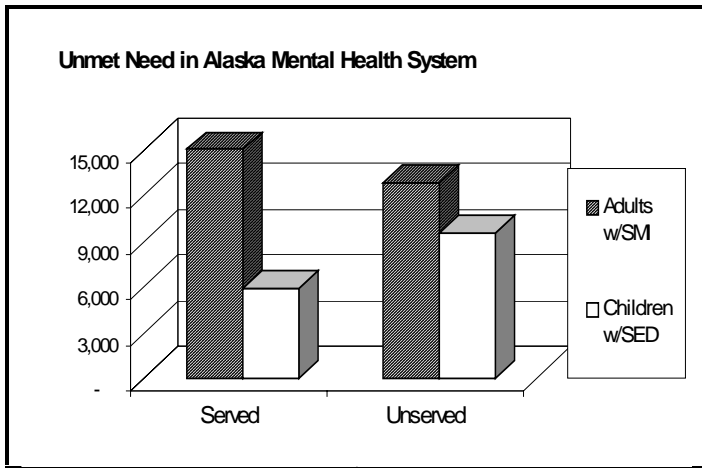
<b>Mental Illness In Alaska, 1998</b>	
1998 Alaska Population	621,400
Total SMI/SED population	43,200
Children and Youth (age 5-18)	15,400
Adults (age 19 and over)	23,600
Institutional/homeless	4,200

We estimate that 6.2% of Alaska’s adult population under age 55 and 3.9% over 55 experience *severe mental illness* (SMI) over the course of a typical year. Similarly we believe that children and youth with *severe emotional disturbances* (SED) number about 10% of Alaska’s age 5-18 population. These figures are adopted from national estimates and count only individuals whose mental illness causes significant functional impairments in daily

living. Table S-2 displays our 1998 SMI and SED estimates, about 7% of Alaska’s population.

The State of Alaska is the primary funder of mental health services

in the state, funding 80% to 90% (including Medicaid) of services for Alaskans with mental or emotional disorders. We estimate that about 22,000 Alaskans used state-funded community services during 1998—just about half of all Alaskans experiencing SMI or SED, as shown in Chart S-1. This mirrors national data indicating that about one-half of adults with severe mental illness and one-third of children and youth with severe emotional disturbances receive public mental health services.



**Chart S-1**

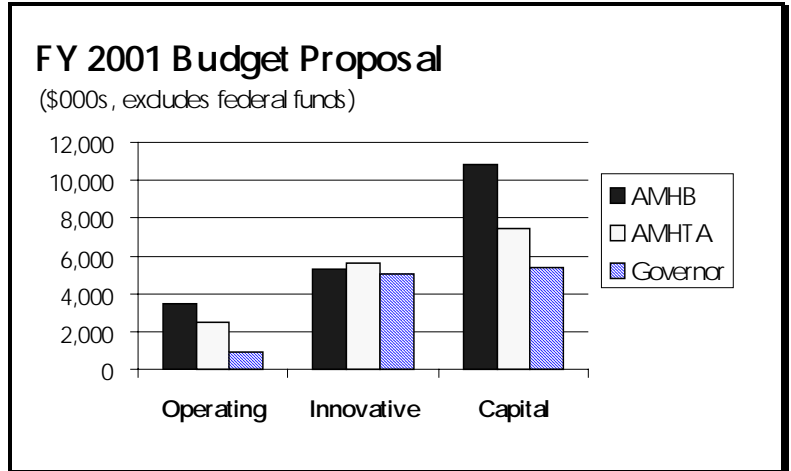


### How We Would Build the System

The AMHB’s goal is a budget linked to program effectiveness. Stakeholder input guided construction of FY 2001 budgets. Chart 2 displays aggregate FY 2001 operating, capital, and innovative project budgets. The three columns in each category show the

reshaping of the AMHB budget by AMHTA and the Governor. While all three parties substantially agreed on innovative projects, major differences marked the other budgets. Our FY 2001 budgets target key services, such as:

- ◆ Replacing the API facility and expanding area community capacity.
- ◆ Upgrading rural facilities and expanding rural service capacity.
- ◆ Enhancing emergency services outside the API project area.
- ◆ Creating services to aid the transition from youth to adult services.
- ◆ Augmenting assisted living and other housing options.
- ◆ Enhancing services in the Department of Corrections.



**Chart S-2**



# 1. The AMHB and System Change

**W**ith the 1994 settlement of the Mental Health Trust litigation, the role of the Alaska Mental Health Board (AMHB) changed significantly. Since then, the AMHB has focused on planning and advocating for Alaskans with mental disorders. The AMHB stresses stakeholder collaboration and consensus as the keys to building a fully integrated, community-based care system. In so doing, we strongly advocate for an increasingly prominent role for consumers and Trust beneficiaries. This chapter sums up recent AMHB work to build an integrated, community-based system and strengthen the role of consumers in that system.



## System Planning

Planning for a comprehensive public mental health system is a central purpose of the AMHB. Planning provides the blueprint for AMHB advocacy, program review, and system-building efforts. We describe recent and ongoing planning projects in this section.

- ◆ **Comprehensive Integrated Mental Health Plan:** State law calls for the Department of Health and Social Services (DHSS), in conjunction with the Alaska Mental Health Trust Authority (AMHTA), to develop a “comprehensive integrated mental health plan”. During 1998-99 the Comprehensive Plan team worked to further refine results desired for program recipients and the data that will show whether those results have been achieved. The AMHB continues to assist in developing mental health elements of the plan.
- ◆ **Strategic Mental Health Plan:** The AMHB adopted *A Shared Vision II*, a strategic plan for mental health services, in January 1999. Since adoption, Planning Committee efforts have focused on implementing goals and strategies identified in the plan. Some efforts are solely within the oversight of the AMHB, but most involve working cooperatively with other agencies to achieve goals. For example, the AMHB works closely with DHSS, the AMHTA, and the Alaska Housing Finance Corporation to develop more housing options for Alaskans with mental illness.
- ◆ **Federal Block Grant:** The AMHB also was a key player in developing the state’s plan for the use of federal community mental health services block grant funds.

### ***A Shared Vision II***

*The new strategic plan is the first complete revision of the plan since 1991.*

### **A Consensus Plan**

*A Shared Vision II rests on stakeholder consensus. Implementation will be a collaborative effort.*

Other AMHB planning work encompassed:

- ◆ participating in development of a new quantitative approach to mental health system planning;
- ◆ initiating strategies to improve emergency psychiatric services throughout Alaska;
- ◆ making recommendations for a system of mental health performance measures;
- ◆ working to improve rural mental health care; and
- ◆ recommending priorities as part of the FY 2001 budget development process.

The ideal array of mental health services describes a pyramid. The base of the pyramid consists of low-intensity services provided in the community. A much slimmer layer comprises higher intensity services, often residential in nature, offered by local or regional providers. Finally, the peak of the pyramid represents centralized institutional inpatient care. This last level will shrink as a share of capacity as Alaska continues to move toward a local, community-based, consumer-centered system of care.

*A Shared Vision II* describes a comprehensive, consumer-centered system. The differences between the system as we experience it on the ground in Alaska and the comprehensive system of *A Shared Vision II* identifies service needs. The most critical differences between the actual and comprehensive systems appear in four major areas:

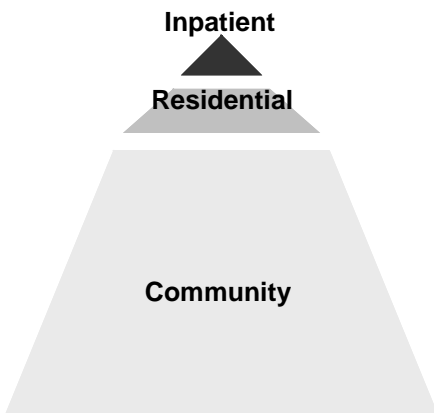
- ◆ Rural care continuum.
- ◆ Children's service system.
- ◆ Criminalizing mental illness.
- ◆ API-community care transition.

The AMHB has concentrated its energies in recent years to narrowing the gap between the actual and the comprehensive in these service sectors. We devote most of the remainder of this chapter to considering each of these in turn.



### **Rural Services**

Alaska continues to encompass essentially two separate mental health systems. Urban areas and large communities possess a more or less full-service care system. A second system exists in rural





Alaska. Perhaps 175 villages have no local mental health services other than the occasional itinerant provider. Another 85 or so communities have a local worker providing part-time services (while these people may be paid for part-time work, they are on call full-time) for any and all with mental, emotional, substance abuse, and other problems. Finally, regional centers such as Dillingham or Kotzebue have community mental health centers with a range of services.

Village providers are the first line of prevention and intervention in an environment far removed from crisis respite facilities, community mental health centers, and case managers. They work with individuals, not diagnoses, supplying truly integrated services. The existing network of village-based mental health workers contains gaps that remain to be bridged, despite some progress.

During 1999, some limited, but real, enhancements to rural services occurred as a consequence of joint initiatives by the AMHB and the Advisory Board on Alcoholism and Drug Abuse (ABADA). Rural Human Services (RHS) grants to three unserved regions, Bering Straits, Maniilaq, and Eastern Aleutians, resulted in about 25 new counselors joining the existing 60. In addition, a number of RHS personnel, some new and others existing, were trained. Those numbers will be augmented during FY 2000.

Despite the progress in 1999, serious gaps still exist. Although most regions now have some local human service presence, much of the state remains unserved on a regular basis. For example, 20 of 49 villages of the Yukon-Kuskokwim Delta have no local worker. In Bristol Bay, just 15 of 32 villages have part-time local services.

Training is crucial to create and sustain a viable and effective village-based system. Local workers should have the opportunity to attend periodic training at the University of Alaska (UA) or similar programs. The UA program has been pared back. Continuing education, along with qualified clinical supervision, is essential as village workers gain experience and knowledge. Without sufficient training resources, expanding or simply maintaining local service levels is problematic.

The Community Based Suicide Prevention Project (CBSPP) is another core village-based service. 61 communities have CBSPP grants, but many more do not. Current grants provide inadequate resources for key elements such as training in early intervention, crisis intervention and follow-up, or grief and healing.

### **The Rural Challenge**

*Rural providers must be creative and integrate service delivery because the resources common to larger communities do not exist in rural Alaska.*

Expanding and spreading innovative, integrated village-based service delivery remains a vital step in achieving a statewide continuum of care. These programs, at a bargain price, reduce reliance on more costly services at the apex of the pyramid of care.

On the planning front, major advances were recorded during the year. During October 1999, the AMHB and DMHDD sponsored a rural mental health planning meeting, which was attended by rural providers from across the state. Three separate initiatives were developed during the meeting:

- ◆ A contractor will evaluate mental health consultation services provided to rural communities over the past five years and make recommendations for enhancing these services in FY 01 and beyond, including the use of telepsychiatry.
- ◆ A training conference for rural mental health providers will take place in April 2000. The conference will focus on such areas as: current successful approaches to service provision; an orientation to API; and a report on the evaluation of prior mental health consultation services.
- ◆ A plan was developed to establish a steering committee to move more towards integrated mental health and substance abuse services in rural communities. The AMHB, DHSS and the Alcoholism and Drug Abuse Advisory Board will negotiate the structure, scope and membership of the committee.

### **Rural Conference**

*The first ever conference geared to rural Alaska's unique mental health issues will take place during 2000.*

The AMHB and the ABADA participated in a December 1999 planning meeting for the RHS program. An action plan was developed to further enhance the RHS program, which the AMHB considers a model. Once this plan is put in writing, the AMHB will work with the ABADA and other stakeholders to help implement its key elements.



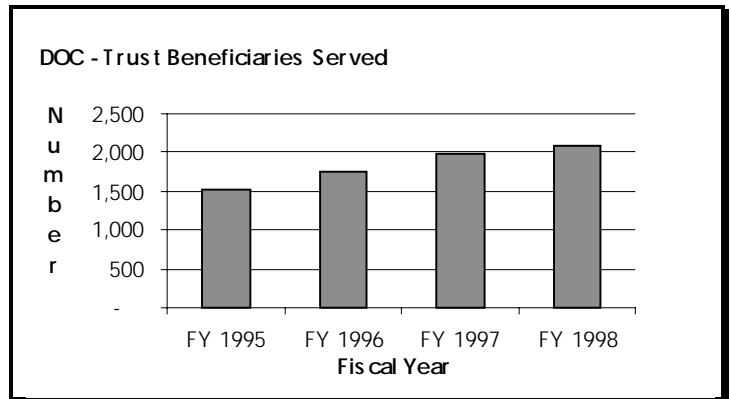
### **Criminalizing Mental Illness**

The Department of Corrections (DOC) remains Alaska's largest institutional provider of mental health services. Some telling statistics illustrate the mounting influx of men and women with mental disorders into correctional facilities and programs.

- ◆ A 1997 assessment identified 29% of Alaska's prison population as AMHB beneficiaries, twice the 10%-15% of prison inmates with severe mental illnesses nationally.

- ◆ DOC serves about 2,100 adults with serious mental illnesses annually (Alaska Psychiatric Institute serves about 1,200).
- ◆ The DOC beneficiary population is growing at a rapid rate, up 36% in FY 98 over FY 95, as shown in Chart 1.
- ◆ The rate of incarceration for adults with severe mental illnesses far outstrips the rate for adults from the total population as incarceration rates per 100,000 demonstrate. On January 15, 1997, the rate of incarceration in state correctional facilities for Alaskan adults without a serious mental illness was about 570 per 100,000. The rate for adults with a serious mental illness was 3,500. Adults with a serious mental illness were over six (6) times as likely to be incarcerated as were all other adults.
- ◆ Youth with mental or emotional disorders are at higher risk as well. Youth corrections facilities house many with mental or emotional disorders—in January 1998 about 17% of McLaughlin Youth Center residents had a diagnosis of severe mental illness. According to SAMHSA, 20% of students with serious mental disorders will be arrested at least once before leaving school, compared to 6% of all students.

**Chart 1**



We continue to ask the key question—*Is imprisonment an effective, humane, and cost-effective, means of treating this population?* This question encompasses both the larger issue of criminalizing mental illness and the narrower subject of the efficacy of corrections mental health programs. Many, if not most, incarcerations in adult and youth corrections were the direct result of individuals’ disorders. The AMHB rejects the notion that incarceration is an effective or efficient means of treating mental illness. While some inmates with mental illnesses are felons, most are misdemeanants, many of whom could be more effectively and inexpensively treated in other settings. While incarceration may be required in many cases, it should never be confused with treatment.

**Criminalizing Illness**

*Adults with a serious mental illness are six times as likely to end up in prison than are all other adults.*

During 1999, AMHB efforts focused on pilot projects that support goals in *A Shared Vision II* related to decriminalizing mental illness.

- ◆ The AMHB sponsored a pilot project in Anchorage called Jail Alternative Services (JAS). JAS diverts from prison time those misdemeanants with mental illnesses that would be better

### **Diversion Works**

*Misdemeanant diversion reduces both ensuing API commitments and re-arrests among JAS participants.*

served in a community setting. Initial experience showed JAS participants with substantially fewer re-arrests and API commitments than non-participants. The Board seeks to implement recommendations from a JAS project evaluation. The key piece spearheaded by the AMHB is a multi-stakeholder planning process addressing the need for supported housing services for offenders with co-occurring mental and substance abuse disorders. These efforts have resulted in funding from the Trust to develop a pilot project. The DHSS and DOC commissioners are currently reviewing this situation and we expect services to begin in FY 01.

- ◆ The AMHB also advocated for establishment and financial support for a Mental Health Court in the Anchorage Judicial District that offers coordinated legal resources and community placement alternatives for misdemeanants.
- ◆ The group supporting both the JAS project and the Mental Health Court worked as a sub-committee of the Criminal Justice Assessment Commission, providing detailed recommendations for ways to reduce the use of prisons as destinations for individuals with mental disorders. The group recommended a variety of strategies including housing, professional training, court administration, and case management. Some of these recommendations were then embodied in funding requests to the federal Bureau of Justice Assistance.

All of these efforts have received significant and favorable media attention in Alaska, helping the public understand issues related to criminalization of mental illness.

The AMHB was also instrumental in an evaluation of emergency services in Fairbanks that had repercussions for the correctional system. This review highlighted the need for alternative transportation for civilly committed individuals to API to reduce time awaiting transport, usually in jail. A new transportation provider and enhanced emergency services significantly reduced the civilly committed individuals in Fairbanks Correctional Center.

In 1999 the DOC completed its first plan for services for inmates with mental illnesses. AMHB staff worked closely with DOC staff to assure that issues of institutional care, as well as discharge planning and integration into community care were identified and discussed. DOC's plan and recommendations were forwarded to the AMHB.

Other DOC actions deserve note. The Department's telepsychiatry project is an innovation with fiscal and therapeutic benefits. Telepsychiatry extends psychiatric expertise to rural facilities at minimal cost. DOC has trained prison and jail staff in suicide prevention strategies. To assure quality of care, DOC developed an innovative uniform assessment instrument for new inmates with mental illnesses. The assessment instrument is on hand-held computers and can be used by a variety of mental health professionals and paraprofessionals.

The AMHB has a two-fold response to the criminalization of mental illness. First, the Board will continue to work for a full continuum of care in correctional systems. Services remain limited in youth corrections—few specialized services are available. Despite recent additions to the adult care continuum, those resources do not approach adequacy.

Second, the Board will promote increased collaboration between the criminal justice system and community mental health services. The Institutional Discharge Program has helped to reintegrate offenders with mental illnesses back into the community and reduce recidivism; no similar program, however, exists for youth. The critical missing pieces in the transition of offenders back to the community remain the general lack of appropriate services and, in particular, supported transitional housing.

### **No Place to Go**

*A lack of services, chiefly supported housing, impede transition from corrections to the community.*



## **Children and Youth Services**

Since 1994 the AMHB has identified expanded and improved services for children and youth as Alaska's most critical mental health need. The 1994 issues continue to demand remedy in 1998:

- ◆ limited emergency and crisis respite services;
- ◆ inadequate residential and diagnostic services;
- ◆ high suicide, violence, and substance abuse rates;
- ◆ poorly coordinated transition to adult services;
- ◆ scarce prevention and early intervention services;
- ◆ insufficient collaboration and integration of the special education and mental health systems; and
- ◆ limited mental health services for incarcerated youth.

Over the last several years, the Board has intensified efforts to bring children's issues to the forefront. Building the continuum of care for children and youth outlined in *A Shared Vision II* is the

AMHB's ultimate goal. The AMHB's children's subcommittee takes the lead in Board efforts. Since 1998, the Children's Mental Health Coordinator, a Trust-funded position shared by the AMHB and DMHDD, has assumed a pivotal role in promoting cooperative initiatives to reform and enhance children's services. The coordinator's focus areas, as agreed upon by DMHDD and AMHB, include:

- ◆ transitional services for youth entering adult services;
- ◆ the number of youth, including those in state custody, requiring residential or institutional placements, in Alaska or out of state;
- ◆ enhancement of children's services resources;
- ◆ coordination with the Division of Family and Youth Services (DFYS) on issues concerning children in state custody; and
- ◆ development of an overall action plan for children's services.

### **Children's Coordinator**

*The Children's Mental Health Coordinator focuses cooperative efforts to reform service delivery.*

The Children's Mental Health Coordinator position assists in developing a more unified system of care for children's services. The Coordinator will facilitate more integrated service delivery by coordinating major planning and implementation activities for children's services across the multiple systems of care affecting children's mental health.

During 1999, the Children's Mental Health Coordinator made significant contributions as the State continued to move towards the goal of a more unified system of care. The Coordinator helped facilitate several efforts to integrate children's services:

- ◆ Crafted a DMHDD work plan for children's services;
- ◆ Staffed several meetings chaired by the DHSS Deputy Commissioner to address cross-divisional and department initiatives relating to children's mental health;
- ◆ Drafted a memorandum of agreement among DHSS divisions to act jointly in determining residential placement of children;
- ◆ Helped facilitate consensus on using psychiatric nurses within DFYS to improve residential placement decision-making;
- ◆ Staffed the AMHB Children's Subcommittee and monthly teleconferences with children's mental health stakeholders to discuss and act upon children's mental health priorities.
- ◆ Continued planning for a possible FY00 response to the federal Substance Abuse and Mental Health Services Administration – Child Mental Health Initiative.
- ◆ Staffed the Children's Work Group and the Transition Services Task Force. The Children's Work Group issues include out of state placement and data collection, integration of services,

transition services for children entering the adult service system, and rural issues.

During 2000, children's mental health services will focus on designing and implementing the Mental Health Stabilization Homes, for which the AMHB successfully advocated for Trust funding. This will increase residential services to children in state custody. As well, efforts to develop an effective transitional system for children entering adult services and participation in the Maternal, Child and Family Health Young Child Behavioral Health Initiative will be key efforts. Other focuses will include several prevention and early intervention initiatives with the Division of Public Health. The Coordinator will organize the Children's Mental Health Conference: "Ways to Care – Connections to Make" to take place in October 2000.

The Transition Services Task Force will draft recommendations to the Director of the Division of Mental Health and Developmental Disabilities for consideration. These recommendations will include a definition of an effective transitional system.



### **Community Services and API 2000**

The AMHB is partnering with DHSS and the Trust in the Community Mental Health/API 2000 Project. The "Project" aims at better serving consumers facing mental health crises by developing a network of local, private services, and replacing the aging API with a new, smaller facility. The overall strategy calls for shifting resources and responsibility for emergency mental health care from API to private providers, including local hospitals. Consumers, providers, advocates and the State have worked together to develop the project plan.

The 37 year-old API has been functionally obsolete for more than a decade. The new hospital will provide consumers with quality treatment, safety, and privacy in a therapeutic environment. The new system will reduce Alaska's use of public psychiatric beds to among the lowest in the country, while ensuring that appropriate services are available in the community.

The Project centerpiece is an integrated system of private mental health and substance abuse services in the Anchorage area. The Project service area covers the Anchorage/Southcentral Alaska, source of nearly 90% of API admissions during FY 99. Some of

**Shifting the Burden**  
*The Anchorage emergency care system will rely on private services. Alaska's use of public psychiatric beds will be among the lowest in the country.*

these services will be new and others enhancements of existing services. The new service system will include the following:

- ◆ A single point of entry for persons in mental health crises or co-occurring mental health/substance abuse crises.
- ◆ A detox facility for stabilizing intoxicated persons with mental illness and a “dual diagnosis” treatment program for those suffering from both mental illness and chemical dependency.
- ◆ Designated evaluation and treatment (DET) hospital care for individuals in crisis and in danger of harming themselves or others or who are gravely disabled.
- ◆ Respite care for consumers who can be evaluated, assessed and stabilized outside of a hospital setting.
- ◆ A “Utilization Review Team” to increase the accountability of the system through concurrent review of decisions for emergency care and treatment.
- ◆ Enhancement of residential mental health and substance abuse treatment services to ensure success in the community for those needing long-term support.

1999 saw a number of changes directly affecting publicly funded inpatient care and API.

- ◆ The AMHB actively worked for the passage of SB 97—a bill that clarified the state’s responsibility to provide designated evaluation and treatment services to indigent persons in the state’s acute care hospitals.
- ◆ The project succeeded in moving 5 long-term care patients at API into supported housing services. These patients had been at API from two to 18 years.

### **Community Homes**

*Five patients who had been at API from 2 to 18 years moved to community housing in 1999.*

The AMHB was a primary catalyst in developing *Transforming API: A New Vision of Alaska’s Mental Health System*. This report sets forth multiple recommendations for API to improve quality, maintain excellence, and increase the role of consumers, family members, and advocates in all aspects of the hospital’s operations. DHSS has endorsed most of the recommendations in the report and they have been included in the *Community Mental Health/API 2000 Project* work plan.

The Project has now been redefined to include three elements: enhanced community based services, a new physical plant for API and quality services at API. The new community services will be implemented in FY 00 and FY 01; the exact configuration of services may be modified to accommodate the response of community based service providers and other stakeholders. It is expected that a decision on a new site for API will be made in the



near future. In the meantime, the Project work plan also now includes quality assurance recommendations for API contained in *Transforming API: A New Vision of Alaska's Mental Health System*. The AMHB maintains its position that all three elements of the Project must advance simultaneously and in concert to ensure that the needs of mental health consumers are addressed in a positive manner.



## **AMHB Initiatives**

The AMHB initiated or participated in several efforts intended to reshape the public mental health system that fell outside the four critical spheres discussed up to this point. In each case, the AMHB worked with other system stakeholders (consumers, advocates, providers, and the State) to define critical issues and build consensus on actions to address critical issues. The result was that our collective vision for the mental health system came into a sharper focus and the commitment to work collaboratively towards common goals grew stronger.

### **Advocacy**

As keepers of the plan for the state mental health program, the AMHB advocates its implementation. Key to this advocacy role is bringing a consumer/beneficiary focus to the process and system. Recent advocacy endeavors have been several.

- ◆ The Internet is a key and growing medium of communication for people experiencing mental illness. The Board continued to expand the utility of its web site during 1999. Originally containing basic information concerning the Board's mission, structure, and membership, the site now offers access to *A Shared Vision II*, annual reports, and other key documents, as well as posting updates on board meetings and important events and issues.
- ◆ The AMHB was one of the founding members of the "Coalition for Basic Supports". The Coalition was formed in direct opposition to HB 161, a bill that would require state agencies administering basic support programs to *pro rate* benefits depending on the amount the Legislature provides for each benefit program. The AMHB, along with other Coalition members, believes that this legislation, if passed, would significantly reduce the "safety net" for Alaska's most needy citizens. Basic support programs provide many Alaskans a consistent means to meet fundamental living expenses such as

### **AMHB on the WWW**

*Visit the AMHB on the Worldwide Web at [www.amhb.org](http://www.amhb.org) to learn about the Board and to keep current on system developments.*

food, shelter, clothing, medical care and transportation. Basic supports allow vulnerable citizens to live as independently as possible and with dignity in the communities of their choice.

- ◆ The AMHB assumed a strong advocacy role in working to enhance emergency mental health services throughout the state. This included co-sponsoring a special assessment of mental health services in Fairbanks and developing an emergency services initiative for the Board.

### **Discrimination**

*90% of health insurance policies restrict mental health coverage. 29 states have taken steps to end this discrimination.*

### **Mental Health Parity**

Approximately 90% of health insurance policies restrict mental health coverage to levels well below that of physical health coverage. Through the advocacy of the AMHB, the Building Bridges Campaign, and others, the Mental Health Parity Task Force was established during the 1998 legislative session. The main charge of the Task Force was to identify the differences in mental health and physical health coverages and make recommendations that address current inequities to the Legislature. The Task Force issued its final report in February 1999, and House Bill 149 was introduced in March 1999 to implement the task force recommendations. HB 149 would do the following:

- ◆ Assure that people needing treatment for mental illnesses and substance abuse disorders have insurance benefits equal to those of people with physical illnesses.
- ◆ Exempt employers with fewer than 20 employees.
- ◆ Make mental health coverage mandatory – rather than voluntary – for employers who offer health insurance to their employees.

HB 149 remains in the House HESS Committee. The AMHB will continue to work with legislators and other stakeholders to ensure the adoption of parity legislation so Alaska can join the 29 states that have done so already. Full parity will allow more people with mental illnesses to maintain employment, live successfully within the community, and reduce dependence on public assistance.

### **Measurable Outcomes**

During 1999, the AMHB reviewed the multiplicity of efforts undertaken at federal, state, and local levels to define performance measures for the state's mental health services. With the assistance of a contractor, the AMHB identified those data sets required by funding and oversight organizations and data sets recommended and used by other states. Ultimately, the AMHB recommended a set of performance measures in the areas of access to care,

appropriateness of care, and management, which could tell us about the extent, and quality of public mental health care in Alaska. A group of stakeholders was brought together to review the list of measures and, working in sub-committees, identify implementation issues and solutions and the resources needed to collect relevant data. A draft report on this data set is expected in August 2000, with a final report projected for December 2000.



### **Measurable Outcomes**

*The public mental health system will adopt measurable outcomes that ensure accountability for services delivered.*

## **Program Review**

Review of programs composing the state mental health system constitutes a key element of the AMHB mission. Historically, the Program Evaluation and Review Committee (PERC) has acted as the Board's vehicle for program reviews. From its inception, PERC scrutinized state-funded community and inpatient programs to evaluate service quality and efficacy. The AMHB approach to program evaluation has changed of late, in concert with a changed approach throughout the system, as a focus on quality assurance takes hold in Alaska.

## **Quality Assurance**

Service accountability depends upon effective quality assurance mechanisms. The AMHB contributed to two efforts reshaping quality assurance for mental health services. First, the AMHB joined with DMHDD and other stakeholders on a steering committee that developed an integrated quality assurance (IQA) program for community-based mental health, developmental disabilities, and infant learning services. The resulting program standards combined quality of life and consumer satisfaction. The review program itself integrated these standards with Medicaid and licensing reviews for community agencies providing these services. Standards in hand, teams began conducting reviews of programs throughout the state in early 1999. Teams included consumers, family members, providers, AMHB members (in selected instances), and DHSS staff.

The second effort targeted quality assurance at API. The AMHB and DMHDD agreed in February 1998 to enhance API treatment, quality assurance, and governance and established a steering committee dedicated to the pursuit of several goals:

- ◆ Expand consumer, family, and advocate involvement in treatment and quality assurance efforts.

- ◆ Place greater emphasis on individualized services that increase the ability of consumers to function in the least restrictive environment.
- ◆ Strengthen the governing body's policy-making role.
- ◆ Increase consumer representation and ensure broad-based cultural and stakeholder representation on the governing body.

The committee completed its report in early 1999, recommending means to accomplish these goals. The Department of Health and Social Services endorsed most of the committee's recommendations, which have been incorporated into the Community Mental Health/API 2000 project.

The next challenge will be to integrate community and inpatient quality assurance elements under the aegis of a single program. The first step will be to analyze the program standards developed for community mental health programs to determine which of these standards are applicable to inpatient care. Once this analysis has been completed, the community and inpatient quality assurance systems will begin to merge.

PERC continues its review function by surveying IQA review reports for evidence of system-level service quality and effectiveness. In late 1999 the committee published an evaluation of the IQA program and a synthesis of IQA findings based on the program's first half-fiscal year of operation. PERC found that three issues rose to the surface in the initial round of IQA reviews:

- ◆ Local mental health grantees had uneven records of compliance with consumer and community-oriented standards.
- ◆ Scoring disparities suggest that standards suitable for large, urban grantees may not be so for smaller, rural programs.
- ◆ Low overall compliance with both administrative and medical necessity standards suggests that both sets of standards may need review or that grantees may need technical assistance.

### **IQA Issues**

*An AMHB review of the IQA process revealed key areas requiring possible revision of standards.*

The advent and improvement of quality assurance review processes will allow the AMHB to refocus its program review mission during 2000. The committee will devote more energy to system-level issues, such as the availability of emergency services and the establishment of a quality assurance process for the Department of Corrections as it steps away from reviewing individual programs. The AMHB made, at least temporarily, one exception to the decision to end program reviews.

PERC will continue the annual on-site review of API, which focuses on institutional policies, quality of care, and coordination with other mental health providers. While other agencies routinely review API, none provides the consumer-oriented perspective of the AMHB. The 1998 formation of the API Quality Assurance Steering Committee prompted the AMHB to suspend reviews of API. Once it became clear that it would take considerable time to develop a new consumer-oriented review process, the AMHB (with DMHDD and API concurrence) determined to resume its annual reviews during 2000 as an interim measure pending the creation of a new API quality assurance mechanism.

Finally, a parting note concerning AMHB reviews of state community mental health grantees. For the better part of a decade, PERC reviewed local programs, focusing on contributions to the goals of *A Shared Vision*. With the adoption of Integrated Quality Assurance (IQA) standards in late 1998, PERC brought to a close its grantee review function. The committee, on behalf of the AMHB, negotiated a memorandum of agreement with DMHDD that provides for AMHB participation in selected IQA reviews, preserving Board role in the review of state-funded programs. AMHB members participated in several IQA reviews during 1999.



## Consumer Leadership and Work

The AMHB commitment to consumer involvement and leadership in all aspects of the mental health system took a significant step toward fruition in 1999. Consumers' primary role in shaping the policies that affect the future of the mental health system was enhanced by the filling of the DMHDD Consumer Affairs position. The AMHB, in cooperation with other advocates, worked diligently to obtain Trust funding for the pilot position, part of the senior management team at DMHDD. The position helps ensure a greater consumer voice in shaping both public mental health policy and decisions. To ensure external accountability, the position also reports to the AMHB Consumer Advisory Committee. The position does not displace other consumer involvement mechanisms of the DMHDD, the AMHB, or elsewhere in the mental health system. Instead, its purpose is to focus and integrate many of these efforts within the state policy-making arena.

Few Americans (or Alaskans) with severe disabilities, whether physical, mental, or emotional, are able to work, but not for the reasons most of us might assume to be the case. In fact, regulatory, social, or institutional obstacles prevent most people with

### A New Role

PERC will refocus its efforts on systemic issues as it cedes responsibility for grantee reviews.

### Consumer Leaders

*Consumers must have a primary role in shaping public mental health policy.*

disabilities who want to work from doing so. According to a 1998 Harris Poll, 72% of people with severe disabilities want to work. Less than 1% on federal disability rolls actually do. The principal barrier to employment for those with mental or emotional disorders is the loss or lack of health care coverage. Medicaid covers most health care needs of these people. In most cases, going to work means a loss of Medicaid eligibility with no substitute health care, a choice few with severe disabilities can risk.

### **The Will to Work**

*Although 72% of people with severe disabilities want to work, only 1% actually does.*

The AMHB, with DHSS, the Division of Vocational Rehabilitation, and the Governor's Council on Disabilities and Special Education (the project lead), has worked for two years on a Trust-funded project to identify and reduce barriers to employment. During 1999, the group developed recommendations to dismantle employment barriers and brought these to high-level state policymakers. A pilot project continued its success helping individuals with disabilities make the transition from public assistance to paid employment. In the future, research findings and pilot project experience will be combined to develop training and other resources for provider agencies to help surmount the barriers to employment.

## 2. Who Does the AMHB Serve?

**T**he Alaska Mental Health Board represents one of the four categories of Trust beneficiaries. State law (AS 47.30.056) defines the AMHB beneficiary group as Alaskans diagnosed with ten types of mental disorders (see box). The Board's principal functions are twofold. First, it is the state planning and coordinating agency under federal and state mental health laws. Second, the AMHB represents Alaskans with mental illness in the development of an integrated and comprehensive public mental health program. To fulfill these duties, the AMHB:

- ◆ Prepares and maintains the state's comprehensive mental health service plan.
- ◆ Proposes annual plans to implement the state plan.
- ◆ Provides a public forum for mental health issues.
- ◆ Advocates for Alaskans with mental illness to the Governor, Legislature, state agencies, and public.
- ◆ Advises the Legislature, Governor, AMHTA, and state agencies in matters affecting beneficiaries.
- ◆ Assists the AMHTA in developing an integrated mental health program for all beneficiaries and recommends uses of mental health trust income.
- ◆ Evaluates the state mental health program.

In 1996, the Board specifically identified those Alaskans qualified as beneficiaries by spelling out diagnostic criteria associated with the mental disorders listed in state law.



### How Many Alaskans Experience Mental Illness?

The first step in planning and advocating for a group is estimating its numbers. We must estimate the numbers of Alaskans with mental or emotional disorders because no actual census of these populations exists. Few states have attempted such counts, which require complex and expensive epidemiological work. The AMHB employs a two-part process to calculate first how many Alaskans experience mental illness and, second, how many of those Alaskans are Trust beneficiaries.

We rely on methodologies developed by the federal Center for Mental Health Services (CMHS) to estimate the prevalence of serious mental illness (SMI) and severe emotional disturbance (SED) among Alaskan adults and children, respectively. CMHS

### Beneficiary Disorders

1. *Schizophrenia*
2. *Delusional disorders*
3. *Mood disorders*
4. *Anxiety disorders*
5. *Somatoform disorders*
6. *Organic mental disorders*
7. *Personality disorders*
8. *Dissociative disorders*
9. *Other severe and persistent disorders*
10. *Childhood disorders*

### How Many?

*Like most states, Alaska has no direct mental illness prevalence data.*

**Adult Mental Illness**

*Nationally, about 6.2% of adults under age 55 face serious mental illness in a year, for adults 55 and older, the figure is 3.9%.*

definitions of SMI and SED encompass only individuals that *suffer from a disorder that significantly impairs daily functioning.*

Previously, CMHS synthesized state by state SMI estimates. In 1998, it stepped back from these state estimates, instead adopting national estimates of 6.2% for adults to age 54 and 3.9% for adults 55 or older. We follow the CMHS lead and adopt these estimates (previously we used an Alaska specific 6.3% figure for all adults). Data we have collected from DMHDD and Alaska providers indicate that about 85% of Alaska’s SMI adults qualify as Trust beneficiaries.

CMHS also revised its SED methodology in 1998, although the practical outcome does not affect our approach. CMHS continues to identify 9%-13% of children ages 9-18 as seriously emotionally disturbed, depending upon a state’s poverty rate. Given Alaska’s low overall poverty rate (even at 150% of federal guidelines), we believe that Alaska SED prevalence is likely about 10%. All children identified as SED qualify as Trust beneficiaries as a consequence of the risk childhood disorders pose as the source of chronic adult disorders.

Table 1 displays AMHB prevalence calculations. Some 43,200 Alaskans experienced serious mental or emotional disorders during

1998. Distilling this number down to Trust beneficiaries, we estimate the number to have been 39,600. A key aspect of our estimate is that while children compose about 33% of Alaska’s population, they represent about 39% of beneficiaries. If we consider this circumstance in combination with recent population projections, the implications should interest and perhaps alarm mental health planners and policy makers.

If we examine recent Alaska Department of Labor population projections, we will discover that the picture of general situation depicted in Table 1 is likely to change dramatically over the next two decades. As portrayed in Chart 2, which projects SED/SMI population by age cohort, overall population trends, should they

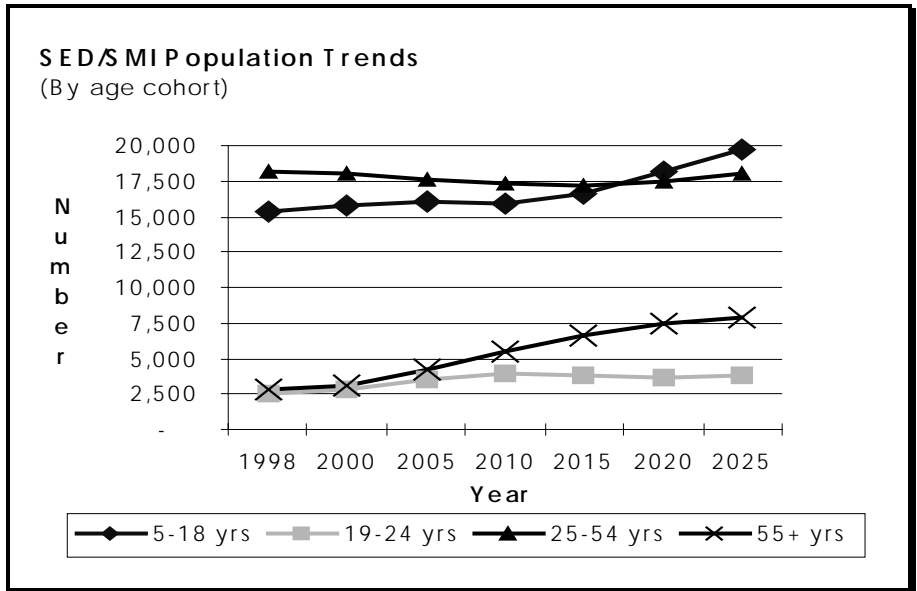
**Table 1**

<b>1998 SED/SMI Prevalence in Alaska</b>	
<b>1998 Alaska Population</b>	<b>621,400</b>
<b>Total SED/SMI population</b>	<b>43,200</b>
Children and Youth (age 5-18)	15,400
Adults (age 19 and over)	23,600
Institutional/homeless	4,200
<b>Beneficiary population</b>	<b>39,600</b>
Children and Youth (SED)	15,400
Adult (SMI)	20,000
Institutional/homeless	4,200



come to pass, will produce significant repercussions for the public mental health system as we know it over the coming decades.

The largest segment of Alaska's SED/SMI population in 1998 was adults ages 25 to 54. This cohort's numbers are declining now and though predicted to begin to rise again by 2015, will still be about 5% below 1998 levels in 2025. Children ages 5-18 will surpass adults as the largest segment of the SED/SMI population shortly after 2015. This cohort's size should rise 28% from 15,400 to nearly 20,000 by 2025.



**Chart 2**

Growth rates projected for two other age cohorts should also attract our attention. Young adults, ages 19-24, will increase in number by about 50% by 2010, even though at age 19 the estimated prevalence for this group magically drops from 10% to 6.2% as they cross the arbitrary threshold to adulthood. Meanwhile the older (over 55) adult population will register huge increases, nearly tripling in size from less than 3,000 in 1998 to 8,000 in 2025, despite presumed lower SMI prevalence. These trends reflect the inexorable aging of Alaska's population.

In closing the prevalence issue, we note that for several reasons, we suspect that our numbers may understate the true picture.

- ◆ Statewide SED/SMI prevalence rates likely mask higher rural Alaska prevalence rates. Socio-economic status inversely associates with mental illness; that is, low income equates with increased risk. Rural Alaska's elevated substance abuse and suicide rates also suggest higher SMI/SED prevalence
- ◆ Alaska's urban population is increasing as a portion of the total population over time. Urban density is a predictor of serious mental illness among adults, and Alaska should expect added upward pressure on prevalence rates as urban populations rise.
- ◆ Younger people are more likely to suffer mental disorders. Because Alaska's Native and African-American populations

**Reality Masked**

*Our estimates likely mask actual Alaska prevalence for several reasons.*

are both substantially younger than the population at large, it is likely these groups experience disproportionate prevalence.

- ◆ We believe that 5,000 to 6,000 Alaskans suffer from organic brain syndrome (OBS). Individuals with OBS may have co-occurring mental illnesses, but most receive no services and thus few are directly counted.



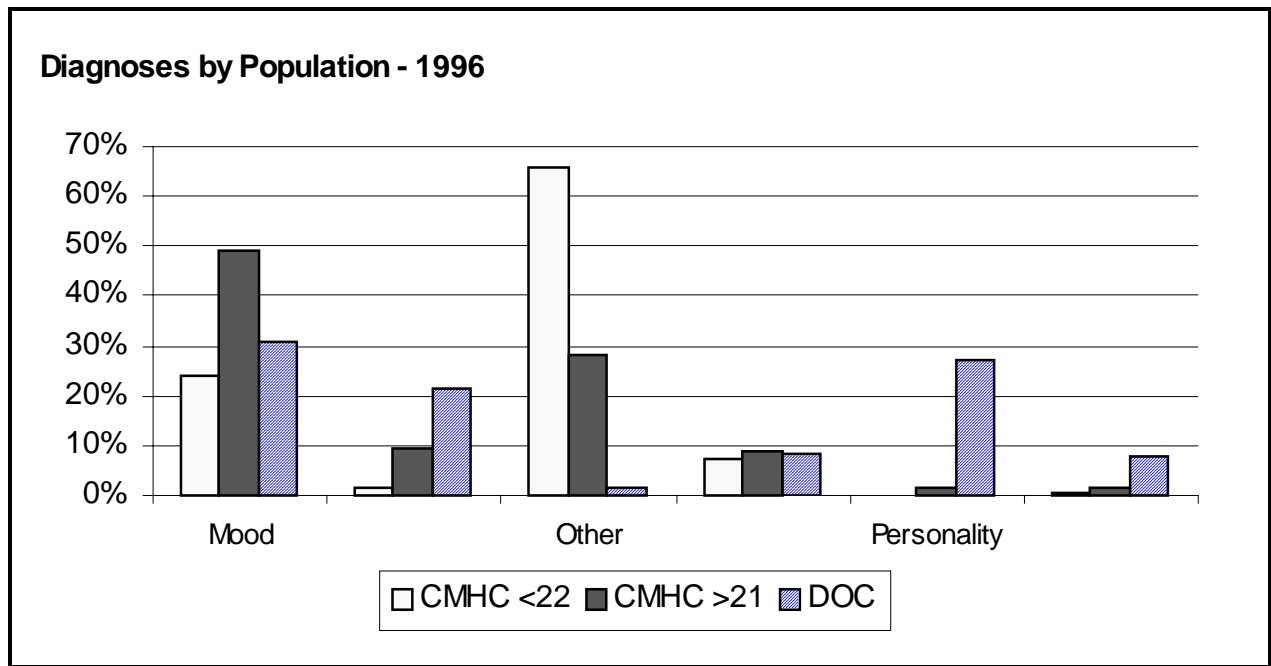
### Beneficiary Profiles

Profiling a typical Alaskan with a mental or emotional disorder entails some difficulty. Several very distinct populations exist, at least according to service-related data. To illustrate, Chart 3 depicts variations among three populations' 1996 diagnoses:

- ◆ Department of Corrections inmates
- ◆ Adult community mental health center (CMHC) admissions
- ◆ Child and youth CMHC admissions

The three diagnostic profiles diverge radically. Chart 3 displays portions of the three populations with the six major diagnoses (those with at least a 5% share of any population). For only one diagnosis (anxiety) did the groups have similar segments. All others varied widely. For example, 66% of children and youth admitted to CMHCs ("CMHC <22" in the chart) had "other" diagnoses, compared to less than 29% for adult CMHC admissions ("CMHC >21") and 2% for inmates (DOC). Comparable disparities appear for all other diagnostic categories.

**Chart 3**



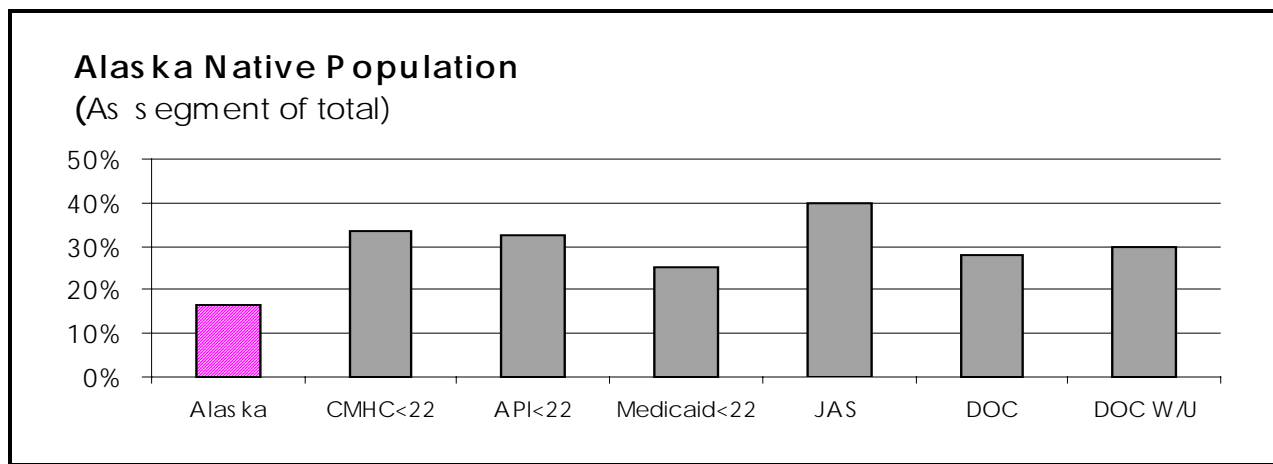
So as we discuss systems of care and service needs throughout this report, be aware that even as we refer to integrated services, we are still talking about unique groups of people with unique needs. Those unique populations will require unique service resources.

Demographic data reveals key differences between Alaskans at large and AMHB Trust beneficiaries. These differences illuminate AMHB policy initiatives and budget proposals discussed in following chapters.

A core issue for the AMHB is the disproportionate number of Alaska Natives among mental health clients compared to the state population at large. Chart 4 shows a representative sample of that disparity. Alaska Natives (including Native Americans) make up about 16% of the state’s population, but substantially larger segments of AMHB beneficiaries in the populations (using the latest reliable data available in each case) highlighted in the chart, youth and offenders. For example, for Alaska Natives exceeded 30% of total CMHC and API admissions under age 22. Natives comprise 30% of the populations of all inmates with serious mental illnesses (DOC) and of the residents of the women’s psychiatric unit at Hiland Mountain Correctional Center (DOC/WU). Fully 40% of Jail Alternatives Services (JAS) participants are Alaska Natives. This across the board over-representation greatly concerns the AMHB and should be examined in depth.

**Natives in the System**  
*Disproportionate numbers of Alaska Natives across the mental health system acutely concerns the AMHB.*

**Chart 4**



The social and economic circumstances of Alaskans with mental disorders and Alaskans at large differ in other respects as well. We highlight a few of these (using single year data as a snapshot).

### **A Different Life**

*Mental illness often severs or precludes family, social, and economic supports vital to community integration.*

- ◆ **Income:** Four of five beneficiaries have median household incomes under 80% of the median income for all Alaskans.
- ◆ **Education:** Nearly 58% of adult beneficiaries' education ends with a high school diploma, compared to 42% of other Alaskan adults.
- ◆ **Employment:** Beneficiaries are less likely to work than are other Alaskans. About two-thirds of Alaskans over age 16 work. Only one of four adult beneficiaries admitted to CMHCs are employed full-time (13% report part-time or subsistence/seasonal work).
- ◆ **Marital Status:** Alaskans at large and Alaskans with SMI present opposite images. About 60% of adult Alaskans are married, compared to 29% of CMHC admissions, 18% of API admissions, and 15% of DOC inmates with SMI.

AMHB beneficiaries lead lives different than other Alaskans. Employment, living situation, income, domestic relations, ethnic composition, and educational attainment—the standards and conditions of the AMHB beneficiary population all differ markedly from those of the larger population.

### 3. Service Delivery

**A**laskans with mental illness seek services from a diverse array of providers. These providers are members of two somewhat overlapping service constellations—the public and the private (the margin box displays the major components of Alaska’s public mental health system). Presenting a coherent picture of services delivered and needed requires piecing together data from many sources, with attendant gaps and inconsistencies.

- Public Mental Health System Components**

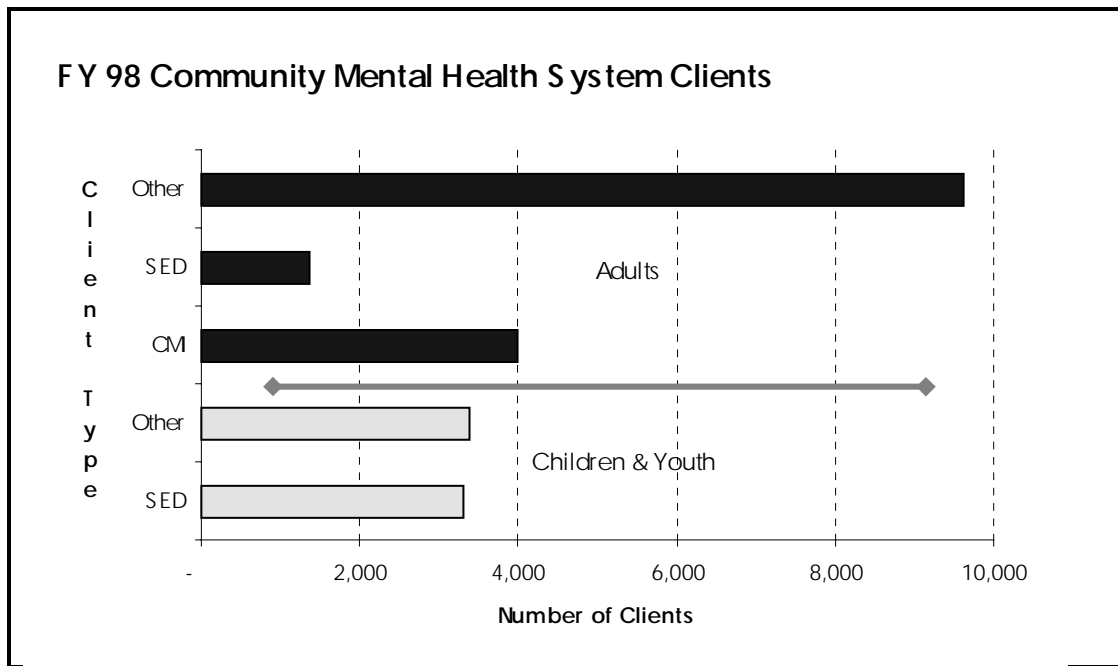
  - ◆ *Community mental health grantees*
  - ◆ *API*
  - ◆ *Medicaid providers*
  - ◆ *Local hospitals*
  - ◆ *DFYS providers*
  - ◆ *Dept. of Corrections*
  - ◆ *School special education*
  - ◆ *Rural human services*
  - ◆ *Indian Health Service*



#### Public Mental Health Services and Users

Chart 5 displays state-funded community mental health service client counts, based on a 1998 Division of Mental Health and Developmental Disabilities (DMHDD) survey of providers. Community providers served about 22,000 Alaskans. We estimate that over 43,000 Alaskans experience SMI and SED. It would appear then about half as many Alaskans that we estimate as experiencing SMI and SED actually received services funded by the State. Note that not all those served were necessarily among the SMI or SED population (although the DMHDD SED and SMI definitions differ from our own, making direct comparison to beneficiary counts imprecise). Many of those receiving inpatient services also received community services and appear in that count as well.

**Chart 5**



State-funded community mental health client services fall into four major categories.

1. **Psychiatric Emergency Services (PES):** All 32 community mental health centers in Alaska offer some type of round the clock emergency services. During FY 98, about 15,000 Alaskans used crisis services as CMHCs responded to 30,000 crisis contacts.
2. **Services for Adults with Chronic Mental Illness (CMI):** All community mental health centers and some limited service providers offer community support programs for adults with chronic disorders.
3. **Services for Youth with Severe Emotional Disturbance (SED):** All community mental health centers and five limited service providers serve SED children and youth. Services for youth with the most severe problems are provided through the Alaska Youth Initiative (AYI), an individualized wrap-around program serving about 150 youth annually.
4. **General Mental Health Services (GMH):** 16 community mental health centers and two limited service providers serve people experiencing depression, suicidal ideation or behavior, or other serious individual or family psychiatric dysfunction.

### Variety and Limits

*While Alaskans can obtain a variety of services, these have, by and large, limits in their scope, quantity, and accessibility.*

In addition to community organizations, the State provides inpatient care at Alaska Psychiatric Institute and local hospitals, as described below. About 1,500 Alaskans receive inpatient services (excluding those served in correctional institutions) at Alaska Psychiatric Institute or a local hospital annually.

- ◆ **Designated Evaluation and Treatment (DET):** Certain community hospitals provide inpatient services for individuals involuntarily committed under Alaska law and for voluntary patients who meet commitment criteria. Community hospitals evaluated 94 clients and treated 39 during FY 98.
- ◆ **Alaska Psychiatric Institute (API):** API provides inpatient care to adults and adolescents whose needs exceed local service capacity and evaluates and treats patients referred by the criminal justice system. FY 98 API admissions totaled 1,354.

In addition to this data, the AMHB surveys other agencies that serve beneficiaries. This latter data originates with independent sources and, as a result, comparison and aggregation are problematic. Prudence dictates that we do not use this data to calculate a total count of those served. We present it in the interests of expanding general knowledge.

- ◆ Rural Services grants now number ten, compared to seven in FY 97. Local workers counsel individuals, respond to crises,

conduct outreach, and present community information, education, and skill building activities.

- ◆ The Office of Public Advocacy (OPA) provides guardianship and conservatorship services; its caseload included 225 individuals with mental illness in FY 98, 220 were Trust beneficiaries.
- ◆ The Division of Vocational Rehabilitation offers rehabilitation and training to people with disabilities and carries about 500 cases for individuals with psychosis, neurosis, and other mental and emotional disorders (some 425 beneficiaries).
- ◆ The Department of Corrections (DOC) housed 1,988 AMHB beneficiaries in correctional facilities during FY 98. On a given day as many as 900 beneficiaries may be incarcerated and 600 residing in community residential centers or on probation. DOC services focus on those with chronic or acute mental illnesses or severe personality disorders presenting behavior and management problems.
- ◆ Local school districts provide special education to students with SED. Including preschool ages 3 to 5, local schools served about 920 children and adolescents during the 1997-98 school year.
- ◆ 15 hospitals (excluding API) supply the vast majority of psychiatric inpatient care, reporting some 2,664 admissions (2,400 beneficiaries) during FY 98.
- ◆ The Healthy Families Alaska program serves about 300 families with children from birth to age 5 at risk of neglect and abuse in seven communities. Services include prevention and early intervention for mental health and substance abuse issues.
- ◆ Housing is a critical necessity for Trust beneficiaries. 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.



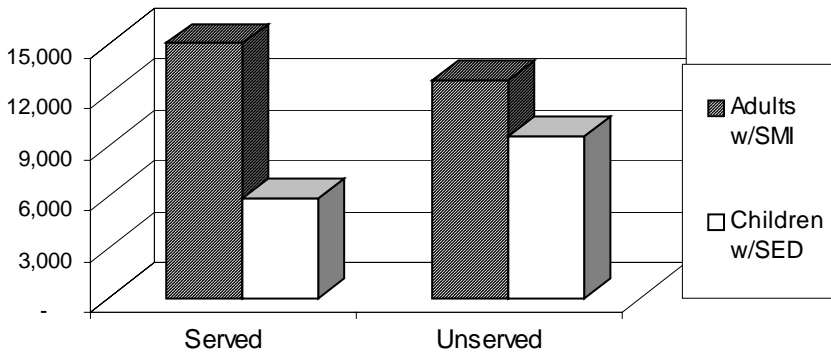
## The Big Picture

Table 2 displays the number of beneficiaries served by agencies from which we were able to secure data. The nature of the data (inconsistent formats and duplicated client counts) enjoins any attempt to aggregate it. These data fragments reinforce two enduring characteristics of the public mental health program. First, it encompasses varied and valuable resources, many of which are outside what most of us consider the mental health system. Second, as a consequence, the overall system may not be ideally cohesive or coherent.

### The 21st Century

*Over 50,000 Alaskans will experience serious mental illness each year by 2010.*

**Unmet Need in Alaska Mental Health System**



**Chart 6**

The information outlined in this chapter suggest leads us to believe that Alaska’s mental health system reaches roughly the same proportion of adults with SMI and children ages 5 through 18 with SED as do mental health systems across the nation. Chart 6 presents our estimate of the unmet need, which consists of nearly 13,000 adults and about 9,500 children and youth. Again, we count

only those individuals with significant impairments to routine daily activities as defined in our prevalence discussion. Over 43,000 Alaskans experience serious mental or emotional disorders, about 7.0% of the state’s 1998 population. We expect these numbers to increase at a pace at least equaling overall population growth, exceeding 50,000 by 2010.

Overall service data suggest that Alaska’s community mental health system serves slightly more than half the state’s adults experiencing serious mental illnesses; CMHS estimates that 48.5% of adult Americans with SMI receive some service. About 38% of Alaskan SED children and youth receive services, compared to

about one-third nationally.

**Table 2**

**Beneficiaries Served in 1998 (selected programs)**

<b>Service Component</b>	<b>Number</b>
Community Mental Health Grantees	20,500
Medicaid/CMHC	7,056
Private Hospitals	2,664
Medicaid/DFYS	2,067
Department of Corrections	1,988
Alaska Psychiatric Hospital	1,354
Local School Districts	920
Rural Human Services Providers (2 reporting)	500
Division of Vocation Rehabilitation	500
Office of Public Advocacy	220
Disability Law Center	75

This report’s service and prevalence data fail to illustrate key facts of AMHB beneficiary status:

- ◆ They are the largest of the four beneficiary groups.
- ◆ More AMHB beneficiaries are served by public programs than are any of the



other three beneficiary groups.

- ◆ The number of unserved AMHB beneficiaries is also the largest among the four beneficiary populations.



## Where This Leads Us

The AMHB identified three years ago four critical need spheres. These four spheres, noted at right, remain the Board's FY 2001 planning and advocacy priorities and drive our FY 2001 budget proposal.

### Rural Services

Over the decade of its existence, the AMHB has heard testimony numerous times describing the unique needs of rural consumers and communities. The AMHB meets at least once a year in a rural setting to facilitate information exchange and to maintain awareness that rural social, cultural, and service delivery issues and needs differ fundamentally compared to urban issues. The challenges presented by lack of resources and the difficulties in recruiting, training, and retaining qualified personnel are constant themes in the Board's dialogue and interaction with rural stakeholders. Rural services are one of the major areas addressed within *A Shared Vision II*. The key issues and needs identified within this planning process include:

- ◆ inadequate information exchange when rural consumers are treated outside communities of origin;
- ◆ lack of culturally-based service models;
- ◆ inequitable distribution of resources to rural communities;
- ◆ lack of support for and isolation of rural service providers;
- ◆ insufficient resources;
- ◆ interrelationship of mental health, domestic violence, sexual assault, suicide and alcoholism;
- ◆ absence of crisis respite services in most rural communities;
- ◆ lack of Title 47 evaluation services in most rural communities;
- ◆ impact of welfare reform.



### Critical Spheres

- ◆ *Rural Services*
- ◆ *Children's Services*
- ◆ *Criminalizing Mental Illness*
- ◆ *API-Community Care Continuum*

### DOC Trends

*The number of AMHB beneficiaries served in DOC institutions rose 36% from FY 95 to FY 98.*

### Gaps and Fragments

*Children's mental health care is fragmented and riddled with serious gaps.*

## Criminalizing Mental Illness

The Department of Corrections (DOC) is Alaska's largest institutional provider of mental health services. DOC serves a growing population of AMHB beneficiaries (up 36% from FY 95 to FY 98). As much as nearly 30% of DOC's institutional population and 15% of its probation and community program populations are AMHB beneficiaries. Youth correctional facilities also house many beneficiaries.

The AMHB has identified the following needs related to the criminalization of mental illness:

- ◆ **A full continuum of care for incarcerated beneficiaries:** This continuum does not exist in the youth corrections system: few specialized services are available to youth. Adult services are limited, particularly for those not experiencing chronic or acute illnesses. DOC has identified the need for a sub-acute care unit for men as well as enhanced services for women without chronic or acute care needs.
- ◆ **Collaboration between the criminal justice and community mental health systems:** The IDP+ program has successfully helped reintegrate offenders into the community. Jail Alternative Services is diverting misdemeanants in Anchorage to community programs in conjunction with a nationally recognized mental health court which coordinates judicial, legal, and social resources. These programs provide a key alternative to incarceration and place more offenders in community settings.
- ◆ **Expanding specific community services that prevent incarceration:** Supported housing has been identified as a key resource in the effort to decriminalize mental illness. Housing options are needed for both individuals being released from incarceration and those diverted from jail.



## Child and Youth Services

Children's mental health services in Alaska are provided in various treatment modalities ranging from less restrictive environments to very restrictive. While many examples of excellent children's programs exist across Alaska, the overall system remains fragmented and characterized by serious service gaps. It has become clear a unified system of care will better serve children experiencing SED and their families.

The AMHB, DHSS, consumers, and stakeholders are working to develop a more unified system of care for children and their families. This group drafted a mission statement, core values, and guiding principles, which were adopted by the AMHB in 1999.

- ◆ Mission: Improve the mental health and well being of Alaskan children by ensuring ready access to coordinated and comprehensive care. Such care is best provided through an integrated system of care, which includes mechanisms for the development, implementation, coordination, and evaluation of services.
- ◆ Core Values: Child centered and family focused; community based; consumer leadership; culturally responsive; cost effective; outcome based systems.
- ◆ Guiding principles: Access to services; individualized services; least restrictive environment; families as full participants; nurturing relationships; integrated services; comprehensive service system; advocacy; quality care.

The mission, core values, and guiding principles provide the framework for future activities to develop a more unified system of mental health care for the children and youth of Alaska.



### **Community Services to Support a Smaller API**

Mental health consumers have consistently told the AMHB that they wish to receive services in the most normative and least restrictive community-based settings possible. With this goal in mind, the AMHB has strongly supported and participated in the Community Mental Health/API 2000 project (the Project). The Board has affirmed that continued support for the Project is contingent upon factors delineated in written policy statements. These factors emphasize protecting consumers from harm during the transition to a smaller API. We highlight below the most significant elements of the AMHB's policy position on the Project:

- ◆ Address API facility, community services implementation, and API quality assurance as a package to ensure that the Project is integrative and comprehensive;
- ◆ Secure sufficient funding to implement the full array of proposed community services within the Project;
- ◆ Establish shared responsibility and collaboration on Project oversight among the AMHB, AMHTA, and DHSS;
- ◆ Build consensus with consumers and providers in all aspects of Project implementation; and

#### **The AMHB on API**

*Support for the API project hinges on several factors that include integrated, comprehensive services, adequate funding, shared oversight, and stakeholder consensus.*

- ◆ Implement consensus recommendations of the API Quality Assurance Steering Committee to the full extent possible.



### **Non-State Mental Health Services**

Federal programs and private providers comprise key components of Alaska's mental health system. Federal programs represent the smaller of the two. Many Native Alaskans who are Indian Health Service eligible are served by state mental health grantees. Federal program data is unavailable. Private providers (hospitals, residential centers, clinics, physicians, psychiatrists, and others) provide most mental health services in Alaska. A large part of such services are publicly funded (via community mental health grants and Medicaid). Data concerning services paid from other sources (private insurance, personal funds, etc.) remain unavailable. CMHS data indicates that about 75% of services nationally are publicly funded. We believe that grants and Medicaid account for 80%-90% of all services in Alaska.

## 4. FY 2001 Mental Health Budget

**E**ach year the Alaska Mental Health Board, as do the three other Trust boards, develops a budget proposal for programs serving the Alaskans it represents. Each board presents its budget to the Alaska Mental Health Trust Authority. This chapter looks in turn at the three components of the budget (operating, capital, and innovative projects) as proposed by the Alaska Mental Health Board and how those proposals stand with the AMHTA and the Governor.



### FY 2001 Operating Budget

Mental health operating budget allocations go to five departments, the court system, and the University of Alaska. Scores of grantees and other providers deliver services via about fifteen grant programs. As this report is written, the state's operating budget (FY 2000 General Fund/Mental Health or GF/MH) for services to Alaskans with mental or emotional disorders totals roughly \$39 million (excluding the state share of Medicaid).

The AMHB's FY 2001 operating budget proposal targets key service spheres. Chart 7 displays the GF/MH increment (additions to the operating budget) amounts proposed by the AMHB, comparing that to the increment level recommended by the AMHTA to the Governor, and the amount finally included in the Governor's budget. The AMHB proposed 14 increments totaling \$3 million for existing and new services. Key AMHB GF/MH proposals include:

- ◆ Department of Corrections: completing the transition of the DOC women's psychiatric unit to ongoing funding and creating a men's sub-acute care unit;
- ◆ Rural services: preserving existing service levels of the Rural Human Services program and extending the program to unserved communities;
- ◆ Children's Services: transitional services for youth entering the adult service system; and
- ◆ Assisted living: increased state reimbursement for services for residents of assisted living homes.

As Chart 7 suggests, few AMHB GF/MH proposals survived as far as the Governor's budget. The only significant proposal adopted

### The Process

*The AMHB budget work extends over several months and involves all system stakeholders that wish to participate.*

by the Governor was the final increment for the women's psychiatric unit (part of a commitment agreed to two years ago).

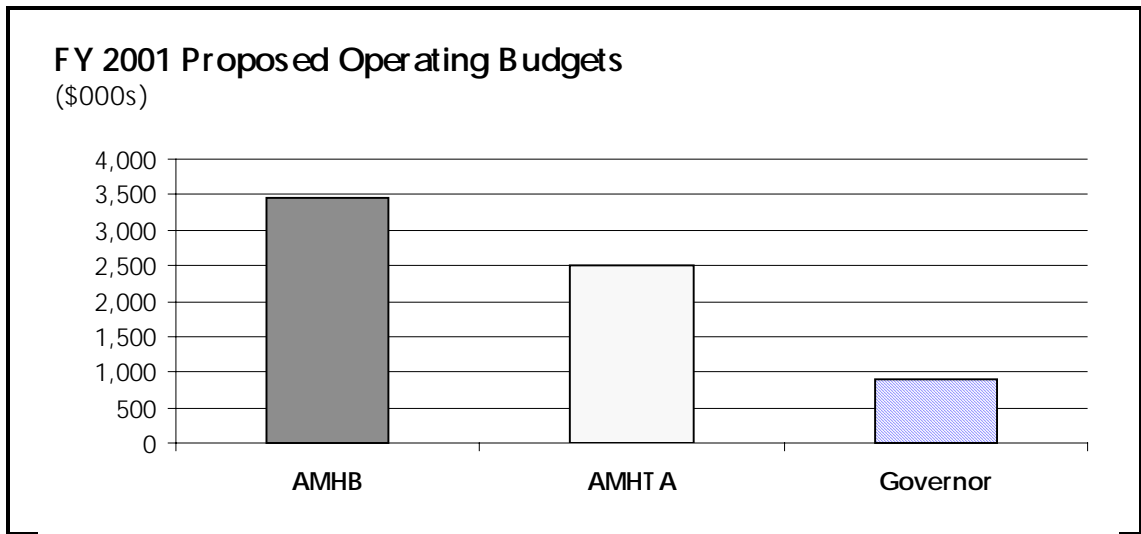


Chart 7



### FY 2001 Capital Budget

For FY 2001, the AMHB proposes seventeen capital projects total just less than \$11 million dollars (see Chart 8). Most of these projects directly support the AMHB's critical service areas.

- ◆ Rural services: the Board focused on the critical need facing rural providers, making funds for planning, design, renovation, and construction of rural facilities its top priority. It also recommended a coordinated telepsychiatry project, linking rural communities to service resources (for both correctional and community services) in urban areas.
- ◆ Beneficiary housing options (including housing modifications and homeless programs) have remained among the AMHB's top priorities for capital funding for several years now.
- ◆ API 2000/Community Services: funds for the replacement of the existing API facility also top the AMHB list.

The Governor significantly reduced or eliminated key AMHB capital priorities, despite general agreement with our approach on the part of the AMHTA. While housing funding was among the top priorities at all levels of the budget process, the AMHB's desire to begin rebuilding rural Alaska's inadequate and deteriorating service delivery infrastructure was not.

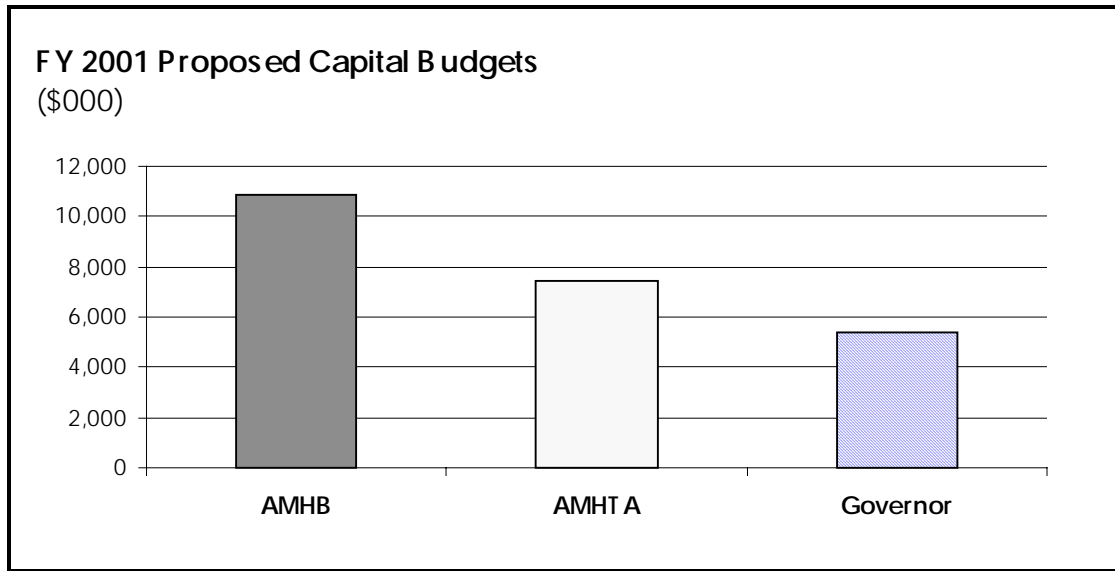


Chart 8

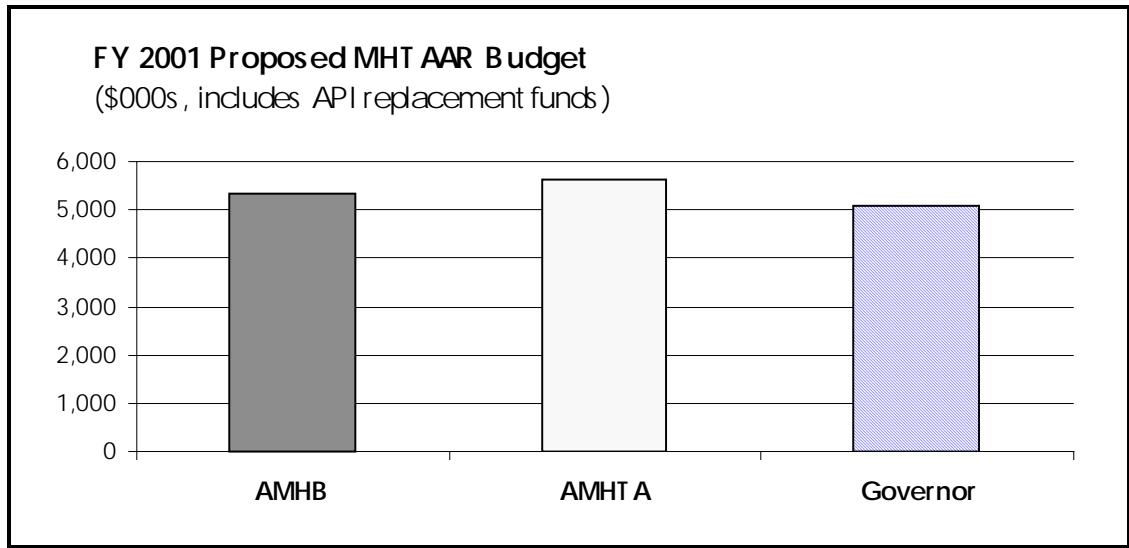


### FY 2001 Innovative Projects

Chart 9 displays aggregate cost of innovative projects recommended by the AMHB. These projects, designed to bring new approaches to service delivery, are funded with Mental Health Trust Authority Authorized Receipts (MHTAAR). Several aspects of our innovative project package deserve emphasis.

- ◆ The AMHB proposes to continue nine projects first funded in previous years. These projects involve services including alternatives to incarceration, coordination of children’s services, consumer empowerment, and quality assurance, as well as community services associated with the API 2000.
- ◆ We offer nine new projects for FY 2001, attaching top priorities to services for offenders with co-occurring disorders, rural emergency services, children’s residential services, and services for seniors with multiple disorders.
- ◆ Several small proposals targeting collaboration between the AMHTA and other beneficiary boards developed out of joint discussions.

All of the AMHB’s ongoing projects were endorsed by the AMHTA and appear in the Governor’s budget. Most of the new initiatives proposed by the AMHB live on in the Governor’s budget as well.



**Chart 9**

The mental health budget rests in the hands of the Legislature at this writing. The fate of AMHB proposals remains unknown until the Legislature finishes its budget work later this year.