1999
COMPREHENSIVE INTEGRATED MENTAL HEALTH PLAN

Tony Knowles, Governor
State of Alaska

Karen Perdue, Commissioner
Alaska Department of Health and Social Services

June 1999

Dear Alaskan:

I am pleased to present the 1999 Comprehensive Integrated Mental Health Plan (CIMHP). In mandating this plan, the Alaska Legislature envisioned a practical document that would guide program funding decisions. The 1999 CIMHP represents the mid-point of a five year effort to realize this vision using a results based budgeting approach. The 1999 CIMHP also marks a significant milestone because it is the first plan to be used as a basis for justifying requests for program funding.

The 1999 CIMHP reflects two major enhancements over the previous year's document. First, this document contains new sections on recommended strategies for achieving the desired results. These recommendations of the plan development team reflect new or expanded efforts that should be considered by the departments of the Executive Branch of State government, the Alaska Mental Health Trust Authority, the legislature and other agencies of State government in working to improve the health, safety, economic security and the quality of life of Alaskans. They do not reflect the policy of the Department of Health and Social Services. Second, a Data Development Agenda has been added to help identify and prioritize those steps that need to be taken to strengthen our ability to measure need and understand the results our programs achieve.

I am very grateful to the generous commitment of expertise, information and genuine concern that have been given by members of the public and the staff of many agencies and organizations. I would especially like to thank the multi-agency CIMHP Work Group which has worked with great deliberation to blend their diverse concerns into an increasingly more practical vision of how to improve the lives Trust beneficiaries.

A coordinated planning and evaluation process is essential to achieving the desired result

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INTRODUCTION

The Comprehensive Integrated Mental Health Program provides services and supports to Alaskans who are beneficiaries of the Mental Health Trust and to some individuals at risk of becoming beneficiaries. The beneficiaries include people with mental illness, developmental disabilities, Alzheimer's disease and related disorders, and chronic alcoholism with psychosis. During territorial days individuals with these conditions were often sent out of state for treatment provided for by the federal government. In 1956 Congress passed the Alaska Mental Health Enabling Act in 1956, which granted Alaska the administrative and fiscal authority to administer its own mental health program. This Enabling Act also included an endowment of a 1 million-acre Mental Health Lands Trust to address beneficiary needs.

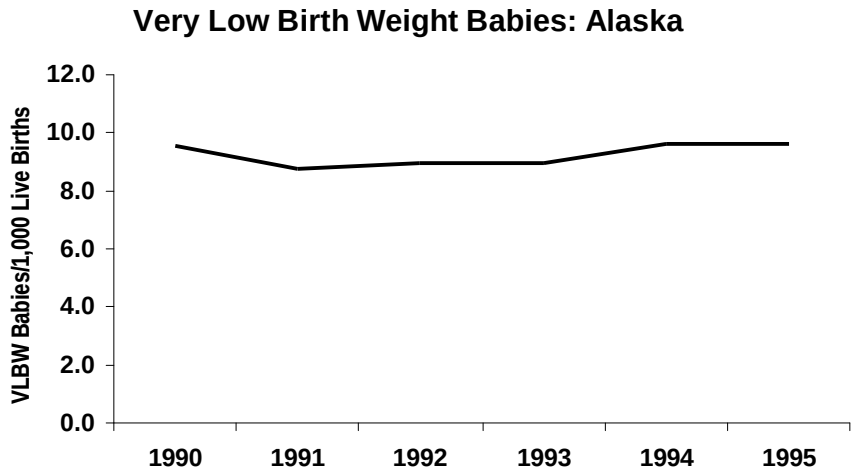
In 1994 the Alaska Legislature created the Alaska Mental Health Trust Authority. This act gives the Trust Authority responsibility to "submit to the governor and the Legislative Budget and Audit Committee a budget for the next fiscal year and a proposed plan of implementation based on the integrated comprehensive mental health program plan." The act assigned responsibility for the development of this plan, the CIMHP, to the Department of Health and Social Services in conjunction with the Trust Authority. In addition, the law assigns to Alaska Mental Health Board, Governor's Council on Disabilities and Special Education, Advisory Board on Alcohol and Drug Abuse, and the Alaska Commission on Aging the responsibility to contribute to the CIMHP.

The Department of Health and Social Services and the Alaska Mental Health Trust Authority have adopted a results based budgeting approach to the Comprehensive Integrated Health Plan. This approach which focuses on the effectiveness with which programs improve the lives of beneficiaries, is expected to require five years to fully implement. The 1999 CIMHP is the third year of this process. Prior year efforts have led to the identification of five broad result areas which provide focus and direction to a program for improving the lives of beneficiaries. These result areas are:

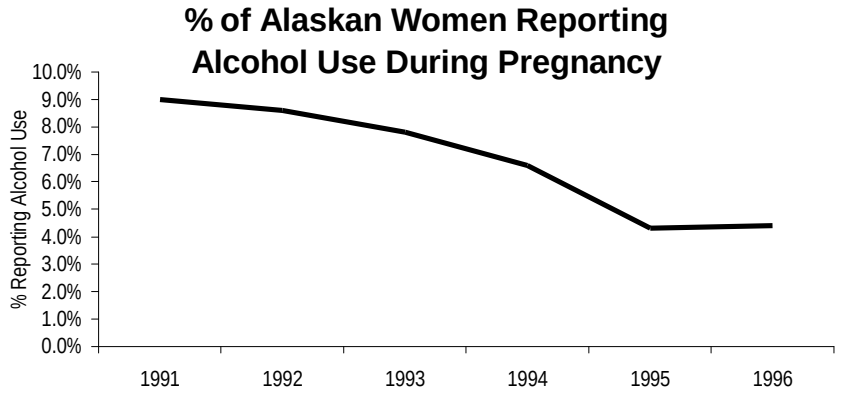
- Health
- Safety
- Economic Security
- Productively engaged, employed, contributing
- Living with dignity, to be valued members of society

Building on prior year efforts, this 1999 CIMHP presents an enhanced list of indicators that help monitor and measure the extent to which the overall program is achieving the desired results. Each set of indicators is accompanied by a discussion of the data and current efforts to achieve the desired results. The plan also outlines the expansion of existing strategies or the addition of existing strategies for consideration by departments of the Executive Branch, Alaska Mental Health Trust Authority and the Alaska State Legislature. These recommended strategies are do not reflect the current policy of the

Indicator Baseline:



Annual Reports (1988 - 1995), Alaska Bureau of Vital Statistics,
Alaska Department of Health and Social Services, Juneau, Alaska



Annual Reports (1988 - 1996), Alaska Bureau of Vital Statistics,
Alaska Department of Health and Social Services, Juneau, Alaska

The Story Behind the Baselines: Information on birth weight is collected from birth certificates by the Vital Statistics Section of the Department of Health and Social Services. Alaska has the lowest percentage of low birth weight babies in the nation. The percentage of babies born weighing less than 2,500 grams (5.5 pounds) was under 5.0% for the past ten years, although it has been increasing slightly each year since 1992. Children who are born with very low birth weights (<1,500 grams or 3.5 pounds) are at greater risk of experiencing developmental disabilities. In 1995, the Center for the Future of Children reported that very low birth weight babies experience the following long-term effects:

School Age Intelligence:	30% - IQ score of less than 85
Neurosensory Impairments:	14% - 17% (cerebral palsy, blindness, deafness, etc.)
Behavioral Outcomes:	28% experience behavior problems
Health Outcomes:	37% will have had at least one surgery by age 8

Drinking during pregnancy is strongly linked to Fetal Alcohol Syndrome and Fetal Alcohol Effects, which result in a range of physical and behavioral disabilities.

An encouraging trend can be seen in the percentage of women reporting alcohol use during pregnancy. Between 1991 and 1996, the percentage of women reporting alcohol use dropped by more than 50%, from 9.0% to 4.4%. It is not clear whether the decrease is due to an actual decline in drinking during pregnancy. Alcohol use is a self-reported item on the birth certificate so the decrease may also be in part due to the growing awareness of the dangers of drinking during pregnancy and the stigma this may now cause. Alaskan businesses that sell liquor were required to display signs warning about drinking during pregnancy in the early 1990s.

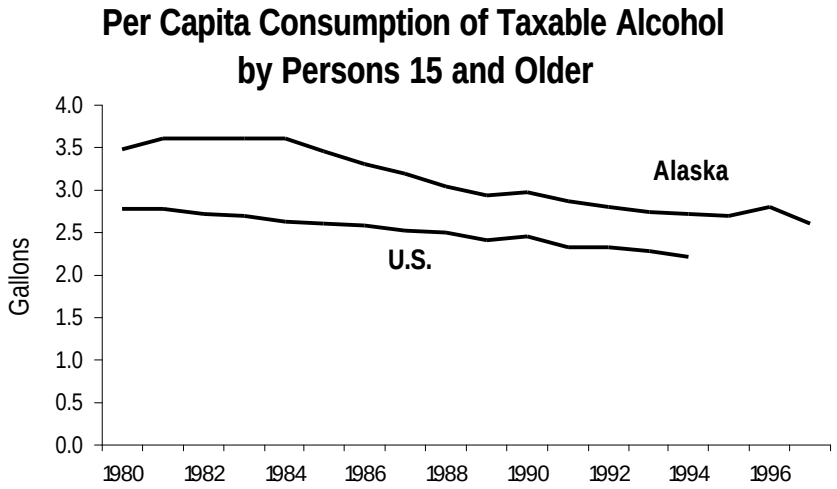
Current Efforts to Turn the Curve: Alaska has a number of programs that have been addressing these public health problems, including the FAS Prevention Project, Supplemental Food Program for Women, Infants and Children (WIC), Healthy Families Alaska, Medicaid (EPSDT), and Public Health Nursing. Recent expansions in Medicaid eligibility have made it possible for more women to get prenatal care. Programs for women at risk of alcohol use during pregnancy include alcohol in-patient and outpatient treatment programs, specialized treatment programs for pregnant

drinking or abusing drugs while pregnant or while trying to become pregnant.

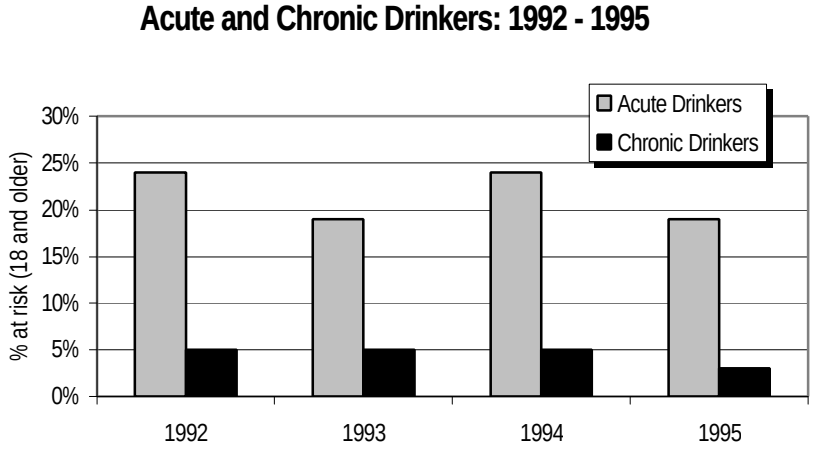
2. Education programs for physicians and other health care providers emphasizing the importance of talking to pregnant women about the dangers of drinking and abusing drugs while pregnant.

Result #1: HEALTH

Indicator Baselines:



Annual Report, State of Alaska Advisory Board on Alcoholism and Drug Abuse, 1997



The Story Behind the Baselines: Alcohol use in Alaska is higher than the national norm but the overall trend in consumption is downward. While there have been periodic upswings in total consumption, per capita consumption has dropped over the past twenty years. This decrease is surprising considering the growth of the tourism industry in Alaska (1.2 million visitors in 1996). Alcohol consumption figures are calculated using state population and in-state sales of alcoholic beverages. It is expected that this trend will continue through the year 2000.

"I tried to reach out to my family and tell them, "Look I have a problem, I need help." They blew me off. They said, "Oh well, you have a problem, deal with it."

Beneficiary
1998 Beneficiary Survey

The percent of Alaskans who are acute or binge drinkers seems to vary from one year to the next. Using 1992-1995 data on Alaskans who are acute or binge drinkers as a base, it appears that we can expect approximately 22% of Alaskans (18 and older) to fall into this category over the next five years. The percent of adults who are chronic drinkers remained at 5% from 1992 to 1994, then dropped to 3% in 1995. Data on acute and chronic drinkers is collected as part of the Behavioral Risk Factor Surveillance System (BRFSS). The purpose of BRFSS is to measure behavioral risk factors in the general population through a random sample telephone interview survey that is conducted monthly. The sample size is approximately 1,500 annually. In the BRFSS, acute drinking is defined as five or more drinks on an occasion, one or more times in the past month. Chronic drinking is defined as an average of 60 or more alcoholic drinks a month. Trends in acute and chronic drinking will become more apparent as more data is collected by the BRFSS.

"Public attitudes have changed. When I first came out here, if you talked about drinking or sobriety, people thought you called them something nasty and didn't want to hear about it. But now there are celebrations of sobriety and sober dances. And people are willing to talk about something that's a problem. But they talk - not just saying it's a problem and everything's bad, but this is something that can be solved."

Beneficiary
1998 Beneficiary Survey

In 1997 and 1998, the Gallup Organization conducted a household telephone survey for the Alaska Division of Alcoholism and Drug Abuse. More than 8,000 interviews were conducted. The study found that 9.7% of Alaskans 18 and older were dependent on alcohol and another 4.1% were alcohol abusers. In addition, the study found that there are differences in the level of alcohol abuse by region, as can be seen on the table below:

REGION	Alcohol Dependent	Alcohol Abusers
Urban	9.4%	4.1%
Gulf Coast	8.5%	3.9%
Southeast	10.5%	4.9%
Bush	11.9%	3.2%

The link between alcohol use and the development of chronic alcoholism is clear. Alcohol abuse is also associated with child abuse, crime, suicide, birth defects, occupational injury, accidental death, and the development of dementia. National mental health data indicates that more than 50% of

for alcohol and drug abuse can reduce post-release criminality and alcohol/drug abuse relapse. At the policy level, alcohol sales and consumption can be regulated to lower abusive drinking within the state or community. Strategies include prevention programs for young people (peer helpers, community suicide prevention programs, school health curriculum), alcohol taxation, and reducing alcohol-related problems by limiting access or availability of alcohol through pricing, zoning laws or license requirements.

Recommended Strategies:

New Initiatives

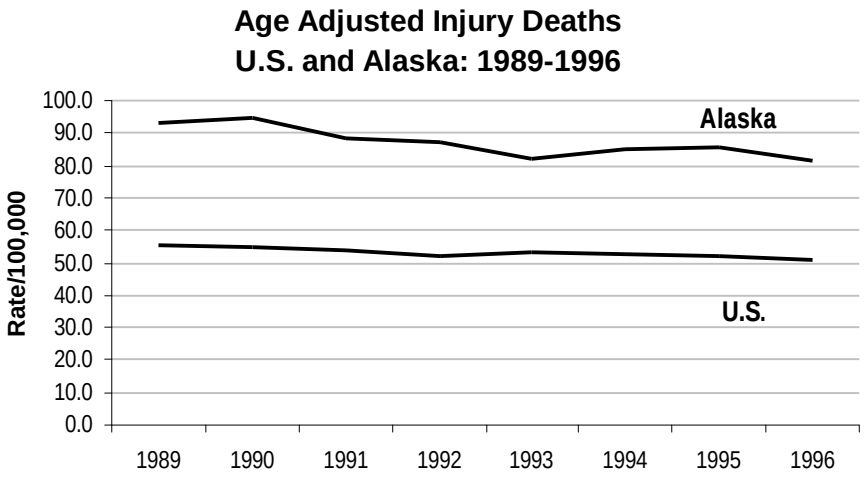
1. Require that tourism liquor licenses be seasonal unless it can be demonstrated that the year-round population of the community meets the population to license ratio established in Title 4.

2. Buy back licenses, as they go on the market, in communities where the number of licenses exceeds the number allowable based on population.

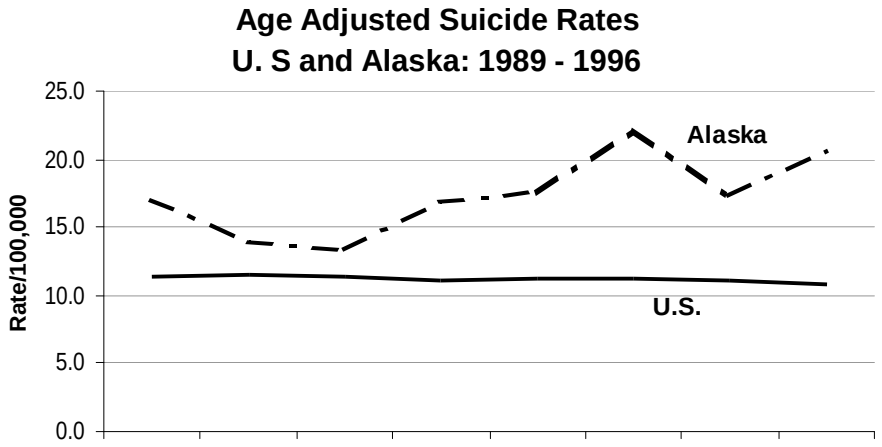
3. Increase state tax on alcohol sales.

Result #1: HEALTH

Indicator Baselines:



Injury Mortality Statistics, National Center for Injury Prevention and Control, http://www.cdc.gov/ncipc/osp/



The Story Behind the Baselines: Information on cause of death is collected and published annually by the Department of Health and Social Services Vital Statistics Section. Accidental deaths include motor vehicle accidents and all other accidents.

In Alaska, accidents are the leading cause of death for all age groups from one year up to 45 years. Children (between one and 14 years old) most often die due to motor vehicle accidents and drowning. The cause of death for adults is most frequently motor vehicle and air transport accidents. The Alaska age adjusted rate of death due to injury is consistently higher than the U. S. rate.

Accident survivors sometimes have life-long disabilities for which they will require support and services. In 1997, there were 621 traumatic brain injuries (TBI) in Alaska. TBI is often associated with long-term physical, emotional and financial costs.

Suicide was the fifth leading cause of death in Alaska in 1995. Suicide is the second leading cause of death for teenagers between the ages of 15 and 19. Accidents and suicides combined account for 60% of the deaths in this age group. The teen suicide rate is highest among young Alaska Native men. In 1995, the suicide rate dropped to 19.5 deaths per 100,000 population, down from 26.0 per 100,000 in 1994. This is the lowest age-adjusted suicide rate for Alaska since the beginning of the 1990s.

Information on cause of death for all Trust beneficiaries is not yet available.

Current Efforts to Turn the Curve: Some of the programs that are working to improve the safety of children are peer counselors and student assistance programs, community suicide prevention programs, mental health and substance abuse programs, and child protective services. Public health programs promoting, infant car seats, personal floatation devices, bicycle and motorcycle helmets, and other sports and outdoor safety gear, help reduce the number of children and adults who are injured or die in accidents. In communities, local Public Health Nurses, Community Health Aides and Public Safety Officers play an important role in community education and in responding to accidents, injuries or reports of harm.

attempting or committing suicide.

3. Expand peer helper programs in middle and high schools.

4. Increase the number of in-school clinics in high schools.

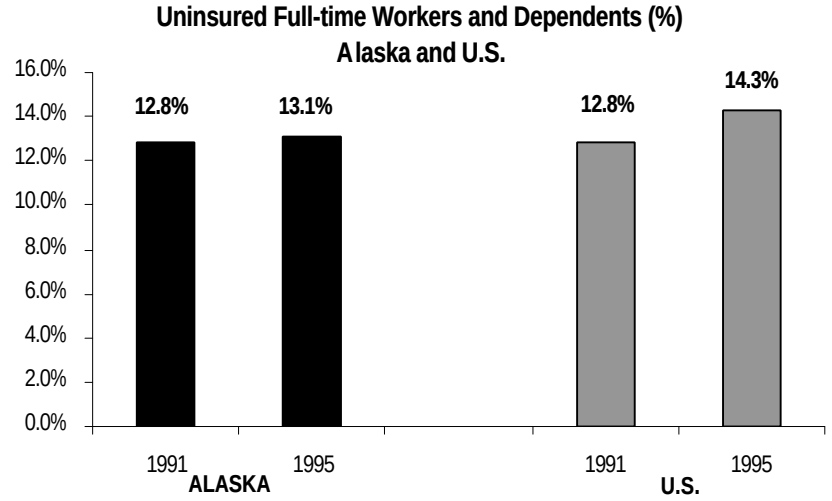
New Initiatives

1. Develop in-state traumatic brain injury programs to provide early and appropriate rehabilitation for adults and children.

2. Explore the feasibility of developing a Medicaid Waiver for people with traumatic brain injuries and chronic mental illness (TBI/CMI Waiver*)*

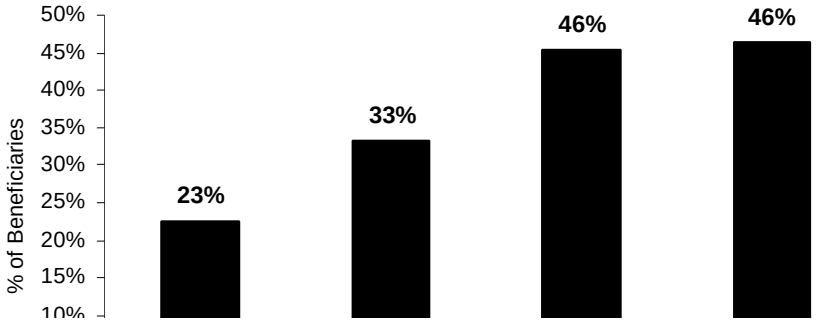
Result #1: HEALTH

Indicator Baselines:



Reforming the Health Care System: State Profiles 1997, Public Policy Institute, AARP, Washington, DC, 1997.

1998 Beneficiary Survey
(Self-selected Sample of 821 Alaska Mental Health Trust Beneficiaries)
Postponed or Gone Without Medical Care



The Story Behind the Baselines: Access to health care in Alaska is a complicated issue. In 1992, the Health Resources and Access Task Force reported to the Alaska Legislature that there were 90,000 uninsured Alaskans and that many of those with insurance had inadequate coverage. In 1995, 13.1% of Alaskan workers and their dependents did not have health insurance. Even with health insurance or Medicaid, access to health can be limited by other factors. Physicians often limit the number of Medicaid or Medicare patients they treat because the reimbursement for services does not meet the usual fee charged for the health care. Access is also sometimes limited by geographic factors. People living in remote areas of the state often have to fly to an urban area to get medical or dental care. Private insurers do not cover or adequately cover behavioral health and substance abuse services.

Medicaid is an important health care payment source for many Mental Health Trust beneficiaries. Even with medical coverage, beneficiaries often can not find physicians willing to treat them. While Medicaid pays for the full range of medical services, it only pays for acute dental service for adults.

Information on access to health care for Trust beneficiaries is not yet available. However, the Beneficiary Survey asked beneficiaries if they had postponed or gone without medical care in the previous 12 months. Mental health (46%) and alcoholics with psychosis (46%) beneficiaries were the most likely to have postponed or gone without care. Survey respondents with Alzheimer's or related dementia (23%) were the least likely to postpone medical services, probably because most of these beneficiaries are over 65 and eligible for Medicare.

Current Efforts to Turn the Curve: Medicaid income eligibility for children was recently expanded in Alaska through Denali KidCare. Other efforts that provide access to health care for beneficiaries are pro bono dental programs (Anchorage and Fairbanks), and sliding fee medical services through Section 330 Community Health Centers (Fairbanks and Anchorage). In 1999, a bill was introduced in the Legislature to provide for parity between physical and mental health coverage.

"Before, the argument was, if you got to see the doctor for free, everyone was going to see the doctor every other day. But now the argument is the opposite. A lot of people who need to see the doctor run out of money so they don't see the doctor when they need to, because they don't have any money to pay."

Consumer
1998 Beneficiary Survey

"We have no decent dental care. You can go get a tooth pulled if you are in pain. But to maintain, you can't get a teeth cleaning, you can't get caps."

Consumer
1998 Beneficiary Survey

"My health insurance pays for about 10% of my medical bills, and then they wonder why mental

preventive care.

New Initiatives

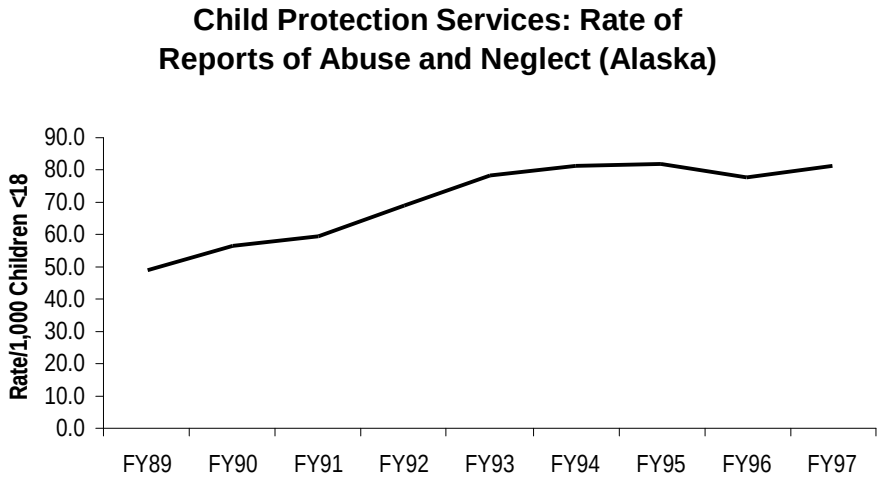
1. Monitor the expansion of Medicaid income eligibility for children's health services.

2. Develop affordable health plans for young adults who may not be in school or working.

3. Implement the recommendations of the Parity Task Force.

Result #2: SAFETY

Indicator Baselines:



Alaska Department of Health and Social Services, Division of Family and Youth Services, Juneau, AK

The Story Behind the Baselines: The Division of Family and Youth Services collects information on reports of harm to children. Reports of harm doubled between FY89 and FY97, increasing from 7,876 to 15,547. In 1997, there were 8,990 reports of neglected children, 4,123 reports of physical harm, 2,094 reports of sexual abuse and 340 'other' reports (abandonment and mental injury). A child may be the subject of more than one report of harm. Reports of neglect are continuing to increase while physical and sexual abuse reports began to level off in FY95. Abuse and neglect are major risk factors for emotional disorders, substance abuse, suicide and involvement with the correctional system. Many children who experience abuse and neglect repeat the pattern as adults by abusing and neglecting their own children. A recent study by the University of Alaska Justice Center (1998) shows that 82% of Alaska's long-term prisoner population reported that they experienced some form of sexual or physical abuse prior to their thirteenth birthday. Two-thirds (66%) reported being neglected as children. Another 1998 Department of Corrections study of the needs of female offenders found that 84% of women inmates experienced physical, sexual or emotional abuse at sometime in their lives. Information on reports of harm for Trust beneficiaries is not yet available.

"We need counseling services for the whole family, because anger comes into this a lot, because your whole life is gone, and now you're this other person. But counseling, because it's not only affecting you but it affects your kids, your significant other or husband, or your grandparents, or your aunts."

Consumer
1998 Beneficiary Survey

Current Efforts to Turn the Curve: The Healthy Families Program, supported parenting programs for people with developmental disabilities, and other early intervention programs are aimed at intervening with families at risk of child abuse and neglect. Other programs that can impact abuse and neglect of children are domestic violence programs, emergency medical services, Public Health Nurses, Community Health Aides and Public Safety Officers, and homemaker and chore services.

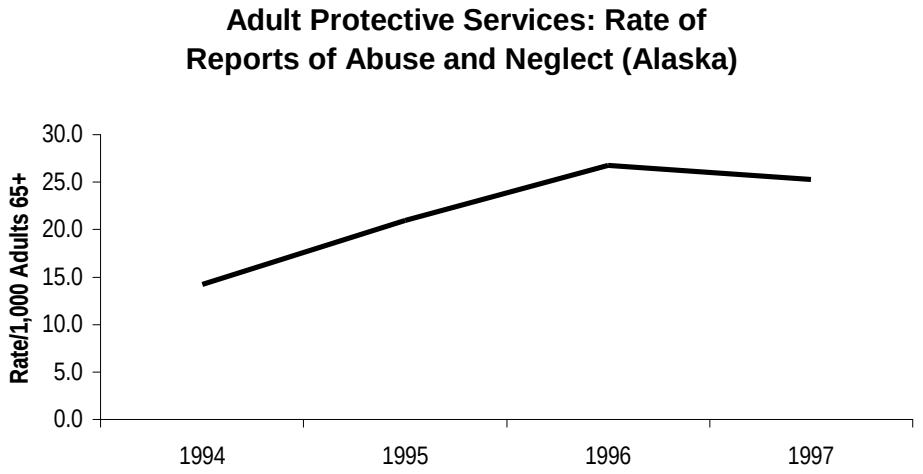
Recommended Strategies:

Expansion of Current Efforts

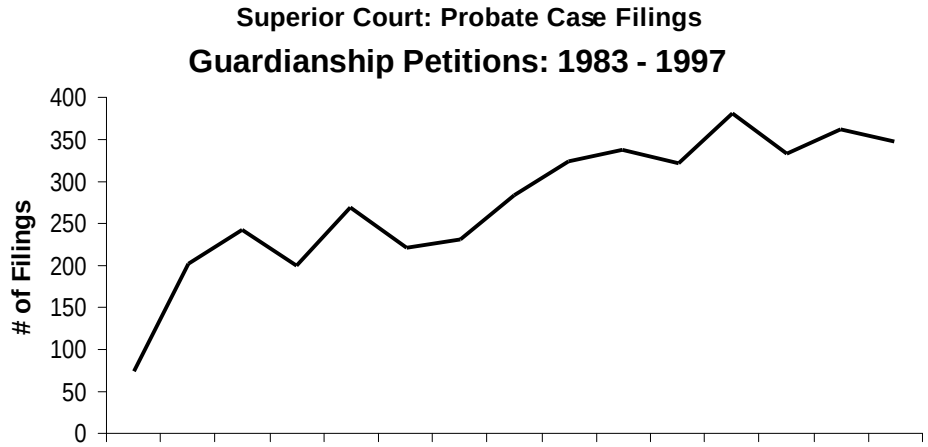
1. Increase the availability of in-home early intervention programs for at-risk families.
2. Increase the availability of parent training and support services.
3. Increase the availability of emergency respite care for children and adults.
4. Increase the availability of before and after school programs for children.

Result #2: SAFETY

Indicator Baselines:



Alaska Department of Administration, Division of Senior Services, Anchorage, AK



Services in the Department of Administration receives and tracks reports of harm to seniors and other dependent adults, including adult Alaska Mental Health Trust beneficiaries. The rate of reports increased from 14.3 reports for every 1,000 Alaskans 65 and older in 1994 to 25.3/1,000 in 1997. The increase can be attributed, to some extent, to the reorganization of Adult Protection Services in the Division of Senior Services in July 1994. The Division developed a public information campaign about elder abuse and was able to focus greater staff resources at responding to and following up on reports.

Information on reports of harm for Trust beneficiaries is not yet available.

In a 1998 study of the relationship between guardianship and safety by the McDowell Group, it is estimated that 95% of adults who have guardians are beneficiaries of the Mental Health Trust. The Alaska guardianship system serves an estimated 2,700 protected persons. Approximately 2,000 of these individuals have private guardians, usually family members. The study estimates that the major reasons for guardianship care for adults are:

Alzheimer's' and related dementia	40 - 50%
Mental illness	25 - 35%
Developmental disabilities	20 - 25%
Chronic substance abuse with psychosis	5 - 15%
Other	5 - 10%

"Legal Services and Disability Center is good, but there's not enough money to have them help us for all of the problems. There either needs to be more money for those agencies or ways that private attorneys would benefit, because they can only do so much pro bono."
Consumer
1998 Beneficiary Survey

"I don't want to be by myself, but I want to take care of my own money."
Consumer
1998 Beneficiary Survey

"I was so involved and so worn out by the time I went to get help that I think that I wasn't thinking things through very well. But it seemed like I would hear about one thing and would go to that agency and somehow they never made it clear what groups did what things."
Consumer
1998 Beneficiary Survey

Current Efforts to Turn the Curve: Programs that can impact abuse and neglect of seniors are domestic violence programs, emergency medical services, Public Health Nurses, Community Health Aides and Public Safety Officers, homemaker and chore services, care coordination, substance abuse services, and outreach services to seniors with mental illness.

Recommended Strategies:

Expansion of Current Efforts

1. Increasing respite care for caretakers of vulnerable adults.
2. Improve the quality of personal care and home health services through direct care provider training.

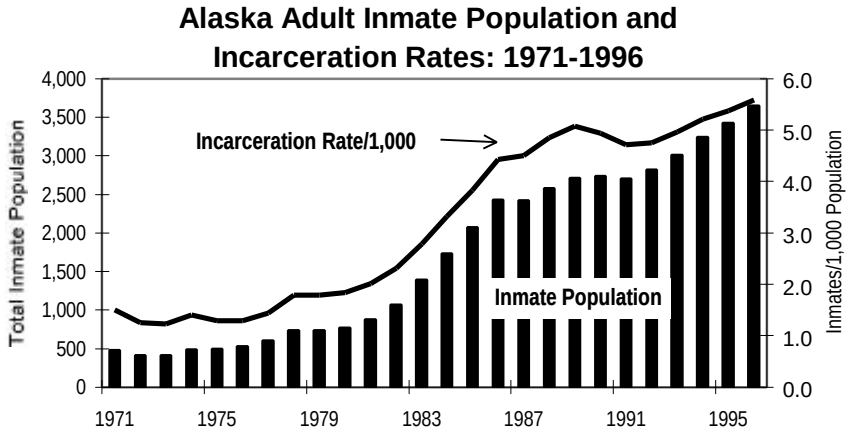
New Initiatives

1. Increase Personal Care Attendant (PCA) and assisted living rates, including augmented rates for people with mental illness or substance abuse problems.

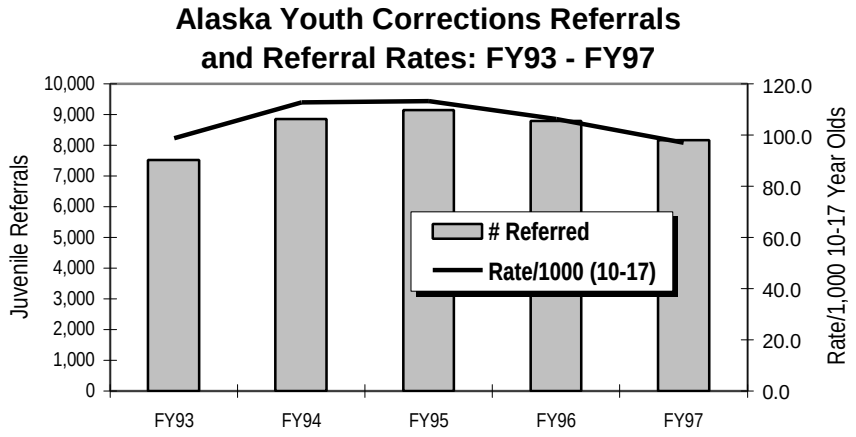
2. Provide treatment opportunities for those who abuse and neglect dependent adults.*)*

Result #2: SAFETY

Indicator Baselines:



Average Annual Populations and Incarceration Rates (1971-1996), Alaska Department of Corrections, Anchorage, AK



The Story Behind the Baselines: Alaska has one of the highest incarceration rates in the nation. In 1971, 1.5 of every 1,000 Alaskans was in prison. By 1996, the rate had more than tripled to 5.5 per 1,000. Between 1971 and 1996, the total incarcerated population increased from 482 to 3,648, or by 657%. Over this same period, the state population increased by only 104%. Some of the factors affecting the increase in the incarceration rate are:

- rise in the violent crime rate
- increases in police forces
- 1980 revision of the Criminal Code, including establishment of presumptive sentencing
- 1982 and 1983 Criminal Code revisions expanding presumptive sentencing
- mandatory minimum sentences for DWI offenders
- rise in serious juvenile crime and the 1994 juvenile waiver law requiring juveniles convicted of certain felonies be automatically waived to the adult system
- lack of emergency psychiatric services in the community to deal with violent mentally ill clients
- lack of transitional/supported housing in the community for displaced or discharged de-institutionalized mentally ill patients
- reduction in support services for ex-offenders

Alcohol abuse has a significant impact on incarceration rates in Alaska and nationally. The National Center for Addiction and Substance Abuse reported that 80% of the men and women behind bars in the nation's prisons are seriously involved in alcohol and drugs. In Alaska, the Criminal Justice Work Group reported in 1994 that alcohol is the primary or contributing factor in 80% to 95% of all criminal offenses committed.

In March through July 1997, the Division of Alcohol and Drug Abuse conducted interviews and collected urine samples from inmates at the Fairbanks, Bethel, Cook Inlet Pre-Trail Facility (CIPT), and 6th Avenue correctional facilities. The prisoners participating in the study were volunteers and had been arrested within 48 hours of their interview. The study found that 48% were abusing or dependent on alcohol, 18.5 on cocaine and 13.1% on marijuana.

In FY97, there were 8,163 juveniles (or 96.9 referrals per 1,000 youth aged 10 to 17) referred to the youth corrections program in the Alaska

"A few times my symptoms have been really bad, and I've called for help and the Juneau Police Department showed up at my door to take me in, and that's not what I needed. I just needed the support and help though. I didn't need the police there."

Consumer
1998 Beneficiary Survey

that are working to reduce adult and youth incarceration and recidivism are alternative sentencing and specialized probation officers, Community Residential Centers and electronic monitoring. Programs developed for Trust beneficiaries in the correctional system include treatment programs for prisoners with mental illness or alcoholism, diversion and the Institutional Discharge Program. Programs and activities aimed at preventing incarceration are Youth Court, Smart Start, alcohol and substance abuse treatment programs, community mental health programs, and child abuse and neglect programs.

Recommended Strategies:

Expansion of Current Efforts

1. Increase the availability of discharge programs, including transition planning, designed to support the transition of beneficiaries from the correctional system to the community.

2. Stricter interpretation and sanctions (including youth oriented alcohol treatment services) for young people charged with minor consuming.

3. School-based alcohol and drug support for adolescents.

New Initiatives

1. Increase the number of communities with Youth Courts and other diversion programs (including Mental Health and Drug Courts) for youth.

2. Provide misdemeanant diversion programs.

3. Pilot a community based, single point of entry for behavioral health emergencies as an alternative to placement in the correctional system.

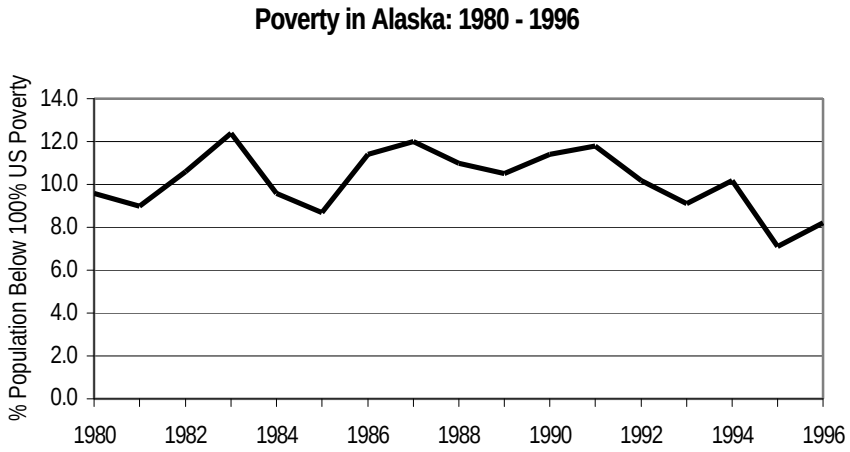
4. Provide support services and housing to youth transitioning from the juvenile correctional system.

5. Allow youth treatment programs flexibility in extending services past the youth's 18^{th} birthday.

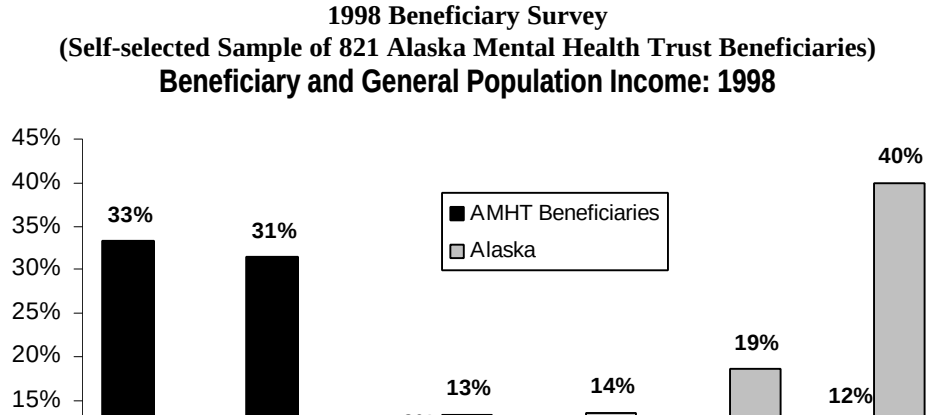
6. Provide early intervention services to high-risk youth, e.g. siblings of youth already in jail.

Result #3: ECONOMIC SECURITY

Indicator Baselines:



Government Information Sharing Project, Oregon State University, http://govinfo.kerr.orst.edu/



The Story Behind the Baselines: Income and poverty levels are measured every ten years as part of the federal census and updated annually by the US Census Bureau. The current method of determining the official poverty rate is based solely on income and family size. Families with incomes low enough to qualify for cash benefits also qualify for other programs that reduce their need for cash. Such families can receive subsidized housing at reduced rents, free medical care through Medicare and Medicaid, food assistance with Food Stamps, and childcare. As part of the planning process for the 2000 census, the US Census Bureau is considering including income and non-cash benefits in the determination of poverty.

According to the US Census Bureau, the Alaska poverty rate is equal to 125% of the U. S. poverty rate. The only source of Alaska poverty rate data is a special report prepared for the Division of Public Health by the Census Bureau from the 1990 Census, which included analysis of poverty by census area/borough, age group and ethnicity. Over the past 16 years, the percentage of Alaskans below 100% US poverty has varied from year to year, but averaged approximately 10% of the population. In 1990, nearly 30% of Alaska Natives were living at or below the poverty level. At the same time, nearly 1 in 5 children under 5 years old was living under the Alaska poverty level.

The US Census Bureau reported that in 1994-95, people with disabilities were at greater risk of having a low income than other Americans. They found that for people between the ages of 22 and 64, 13.3% of those who had no disability were classified as low income, compared to 19.3% of those with non-severe disabilities and 42.2% of those with severe disabilities. Consumer fraud of seniors is a national trend that is negatively impacting the limited incomes of people over 65.

The Beneficiary Survey, conducted by the Alaska Mental Health Trust Authority in 1998, asked beneficiaries for information about their household income. Survey participants reported incomes that contrast drastically with the household income for the general population. Nearly two-thirds (64%) of the beneficiaries participating in the survey reported household incomes of less than $20,000 while on 15% of Alaskan Households fell in this income group. Conversely, 59% of all Alaskan households reported incomes of more than $40,000, while only 19% of beneficiaries reported similar household incomes. Alaska Psychiatric Institute reported that 90% of adults admitted had income below $20,000 while 80% of adults receiving services from community mental health centers reported incomes below $40,000.

"On the housing programs and the Dividends, our rents should not go up. They're charging us one-third of our income, and if we have a child in the house, then they count it as income and raise the rent."

Beneficiary
1998 Beneficiary Survey

"They're doing a good job of keeping us at poverty level."

Beneficiary
1998 Beneficiary Survey

"We can't afford to go bowling, or to the movies, or out to dinner. We don't have the extra money to do any of these things."

Beneficiary
1998 Beneficiary Survey

for many beneficiaries. Senior employment programs provide many seniors with jobs as senior volunteers and help train seniors to acquire unsubsidized employment.

Recommended Strategies:

Expansion of Current Efforts

1. Educate seniors about consumer fraud.

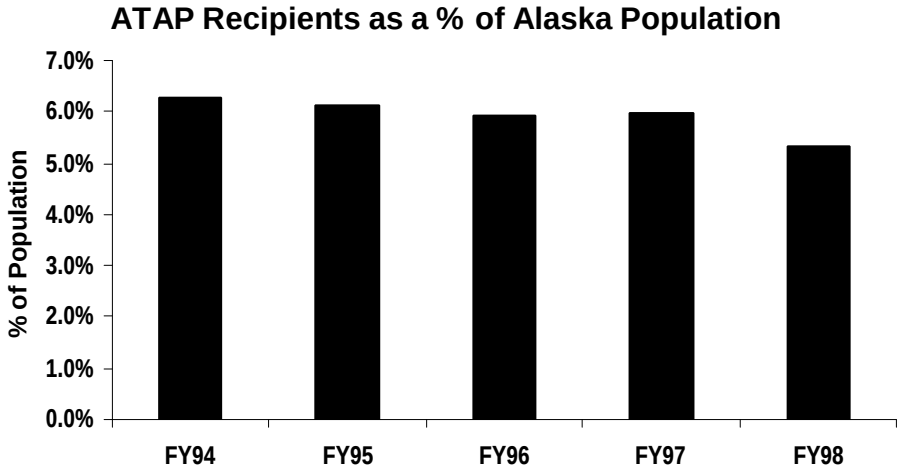
2. Increase respite or day care funding so that caregivers can continues working while caring for a beneficiary.

New Initiative

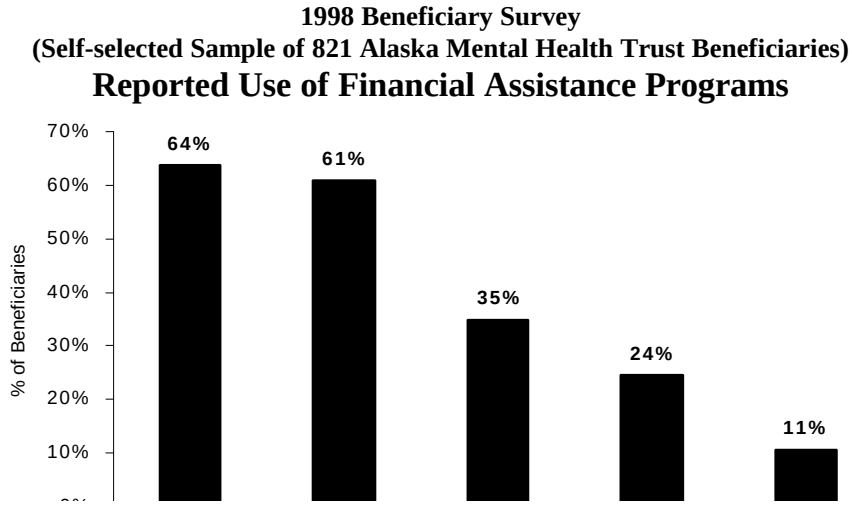
1. Establish a consumer credit union specifically for beneficiaries.

Result #3: ECONOMIC SECURITY

Indicator Baselines:



Alaska Division of Public Assistance, Department of health and Social Services, August 1998



The Story Behind the Baselines: The Alaska Temporary Assistance Program (ATAP) was signed into law in 1996. The goal of welfare reform is to: *move Alaskans from welfare to jobs so they can support their families, while maintaining a safety net for those truly in need.*

The first year of ATAP brought significant changes to the welfare caseload, including:

- The welfare caseload declined by 15%
- Welfare savings for FY98 were more than $24 million
- The welfare caseload dropped to under 11,000 for the first time since 1992

"I used to make more money in a day than I have in allowance for one week now, and I paid more taxes than I get in benefits today."

Beneficiary
1998 Beneficiary Survey

The Division of Public Assistance estimates that 5% to 10% of those receiving ATAP are Alaska Mental Health Trust beneficiaries. One of the most significant changes brought about by welfare reform is the five-year lifetime limit of ATAP benefits. Most of the people who came off the welfare rolls during the first year were the most ready-to-work. There is currently no safety-net for recipients who complete five years of ATAP benefits and who are unable or unwilling to work. There are an unknown number of beneficiaries on ATAP for whom the goal of employment is unrealistic.

"I'm a single parent with two kids at home. And it's hard. One of my children has a disability, and it's hard to try to go out and work without the support I need for my kids, the childcare."

Beneficiary
1998 Beneficiary Survey

Other financial assistance programs provide support for Mental Health Trust beneficiaries. Many of the beneficiaries who participated in the Beneficiary Survey reported that they receive assistance through Social Security (64%) and Medicaid (61%), Medicare (35%), housing assistance (24%) and tribal assistance programs (11%). Eight thousand (8,000) adults with disabilities receive Adult Public Assistance, about 45% of whom have a psychiatric disability.

Current Efforts to Turn the Curve: Some of the strategies that are proving effective at increasing the number of people leaving public assistance are child care subsidies, job readiness programs, job training, and case management.

and APA recipients.

3. Collect and analyze information collected about beneficiaries who use public assistance (disability, use of public assistance services, use over time)

4. Support legislation and funding for programs that provide beneficiaries with home and community based alternatives to institutional care.

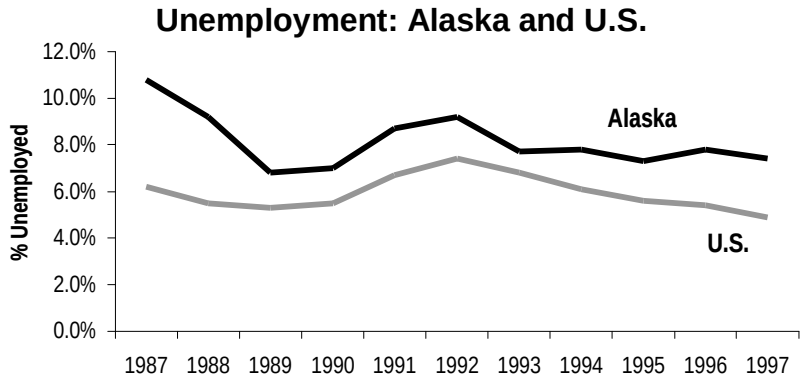
5. Increase access to guardians, conservators, representative payees and provide assistance with paperwork.

New Initiative

6. Develop strategies to assure beneficiaries access to public assistance services even if they have received Alaska Temporary Assistance Programs (ATAP) services for five years. (*New policy initiative)*

RESULT #4: PRODUCTIVELY ENGAGED, EMPLOYED,CONTRIBUTING

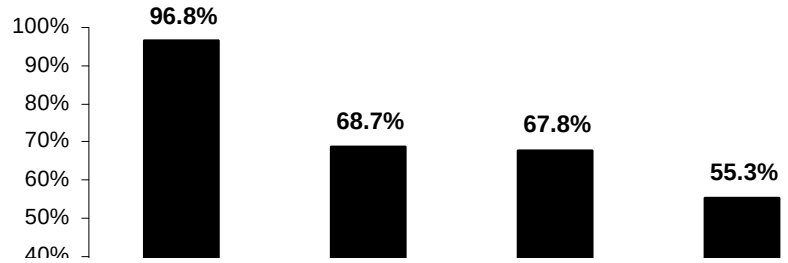
Indicator Baselines:



Government Information Sharing Project, Oregon State University, http://govinfo.kerr.orst.edu/

1998 Beneficiary Survey
(Self-selected Sample of 821 Alaska Mental Health Trust Beneficiaries)

Unemployment by Beneficiary Group



The Story Behind the Baselines: Data on employment, unemployment, hours and wages are collected and published monthly by the Alaska Department of Labor.

"That's the only reason why I haven't gone out to look for work--to keep my medical coverage."

Consumer
1998 Beneficiary Survey

Unemployment in Alaska varies greatly with the season. In 1996, the statewide rate of unemployment ranged from 9.7% in January to 5.5% in August. Unemployed rates also vary according to region or community. Traditional methodologies for determining unemployment do not work well in Alaska's smaller, more remote villages, where few jobs are available. Many people in these communities rely on a traditional subsistence lifestyle. Hunting, fishing and gathering wild foods form the basis of a non-cash economy. Often, people living in these communities have given up on actively seeking employment and are not counted in local or state statistics. In many of these communities, it is estimated that more than 75% of the adults are not working at cash jobs.

National sources estimate that up to 65% of adults with a variety of disabilities are unemployed. The Mental Health Trust Beneficiary Survey found similar rates of unemployment in Alaska. Of those who took part in the telephone survey, 69% of those with mental illness and 68% of those with developmental disabilities reported that they were unemployed. Fifty-five percent (55%) of alcoholics with psychosis and 97% of those with Alzheimer's or other dementia, most of whom are 60 or older, said that they were not employed.

"I refuse to quit (job). My four hour day is all I get, and that is the most wonderful thing in my whole life, besides my children."

Consumer
1998 Beneficiary Survey

Even when Trust beneficiaries are employed, they are often in part-time, low paying jobs. Beneficiaries may remain in these jobs because, if they worked longer hours or made more money, they would lose their eligibility for Medicaid, which is often their only source of health insurance. Loss of medical benefits was the most commonly cited reason given for not seeking work by unemployed beneficiaries. The cost of some psychotropic drugs which make it possible for mentally ill people to work can cost $900 per month. Other frequently cited reasons were discrimination, inability to find a job, and lack of training.

"Vocational Rehabilitation has helped me find a job."

Consumer
1998 Beneficiary Survey

Current Efforts to Turn the Curve: Some of the strategies that are proving effective at increasing employment opportunities for beneficiaries are employment training programs like those provided by the Division of Vocational Rehabilitation and the Private Industry Council. Developmental disability and mental health employment support programs provide on-the-job employment readiness training and support for workers. The Governor's Council on Disabilities and Special Education recently

Expansion of Current Efforts

1. Increase Division of Vocational Rehabilitation transition services to beneficiaries 18 to 21 years old, including those in alternative schools.
2. Increase the number of school districts that support beneficiaries in inclusive settings.
3. Increase the number of beneficiaries, including those in the juvenile justice system, who complete school and pass high school qualifying exams or complete a GED.
4. Provide access to educational resources to juveniles in the adult correctional system.

"Job coaching takes people out and helps people get a job; they are helpful. They give you good information. They help you out."

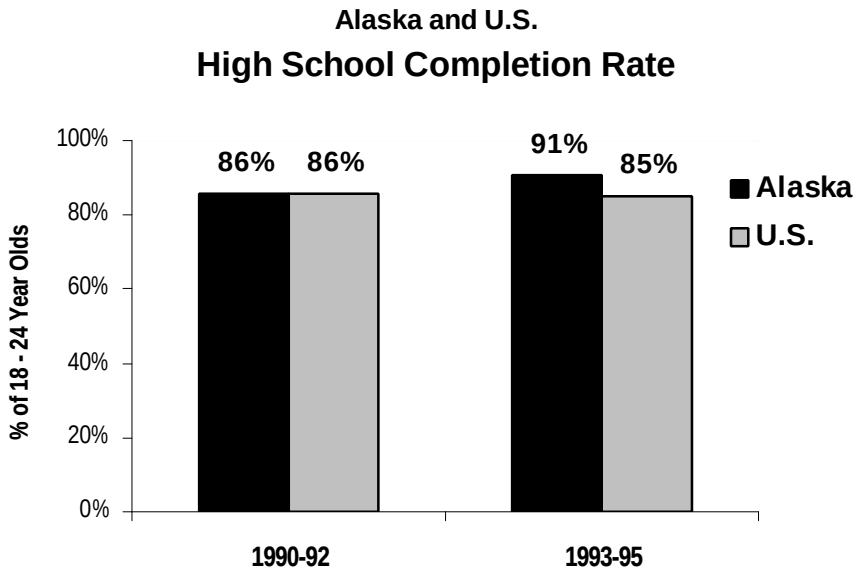
Consumer
1998 Beneficiary Survey

New Initiatives

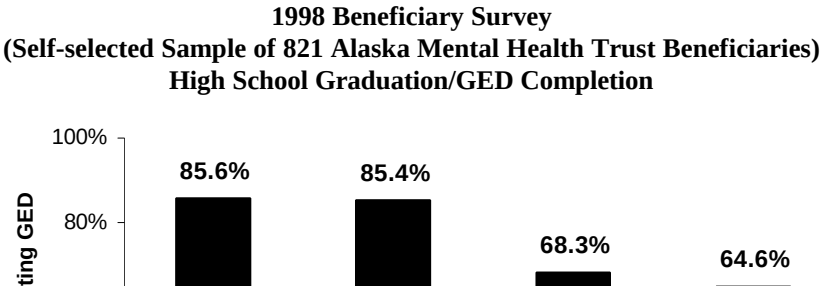
5. Provide cross-beneficiary job support services.
6. Create work opportunities for beneficiaries in the adult correctional system.
7. Monitor implementation of new employment initiatives, including Alaska Works and changes to Medicaid, to determine whether they provide expanded employment opportunities for beneficiaries.
8. Develop a strategic plan for the education of Trust beneficiaries.

Result #4: PRODUCTIVELY ENGAGED, EMPLOYED, CONTRIBUTING

Indicator Baseline:



Government Information Sharing Project, Oregon State University, http://govinfo.kerr.orst.edu/



The Story Behind the Baselines: Each October, the US Census Bureau conducts the Current Population Survey. Among the information collected is “high school completion rates for 18 through 24-year-olds not currently enrolled in high school”. This information is collected for each state and is computed based on data spanning three years. In the years 1993-95, the Alaska high school completion rate was 90.5%, compared to a national rate of 85.5%.

The Mental Health Trust Beneficiary Survey found similar rates for high school graduation or GED completion for two beneficiary groups, alcoholics with psychosis (85.6%) and those with mental illness (85.4%). Approximately two-thirds (68.3%) of the survey participants with developmental disabilities had graduated from high school or completed a GED. Beneficiaries who have Alzheimer’s or related dementia had the lowest high school completion rate (64.6%), which is probably a function of growing up at a time when many young people left high school to work or join the military.

The National Center for Education Statistics reported that in 1995, the percentage of young adults with disabilities (16 to 24 years) who dropout was 14.6%. The percentage of non-disabled young adults who dropped out was 11.8%. Students with mental illness are the most likely to dropout (56.1%), followed by those with mental retardation (31.1%), serious emotional disturbances (23.6%), and specific learning disabilities (15.8%). Learning disabilities were the most commonly reported disability in the study, affecting 2.2% of the population or one-third of the youths with disabilities in the age group.

"When I was going to high school, I had a teacher who said I wouldn't be able to graduate from high school. He said, "You'll never make it to college." I graduated from high school with honors, and I enrolled in college for an Associates degree. I have three more credits and I'll have an Associates degree."

Consumer
1998 Beneficiary Survey

Current Efforts to Turn the Curve: Some of the programs and initiatives proving to be effective at improving the educational outcomes for beneficiaries are education in regular classrooms, transition planning, mental health treatment services linked with special education programs, and support programs like peer counseling.

"We need more adult basic centers in villages for school; for GED, ABE (Adult Basic Education). They quit the ABE program in my village."

Consumer
1998 Beneficiary Survey

Recommended Strategies:

Expansion of Current Efforts

1. Increase the number of children in inclusive classrooms

4. Increase access to educational resources for juveniles in the adult and juvenile correctional systems.

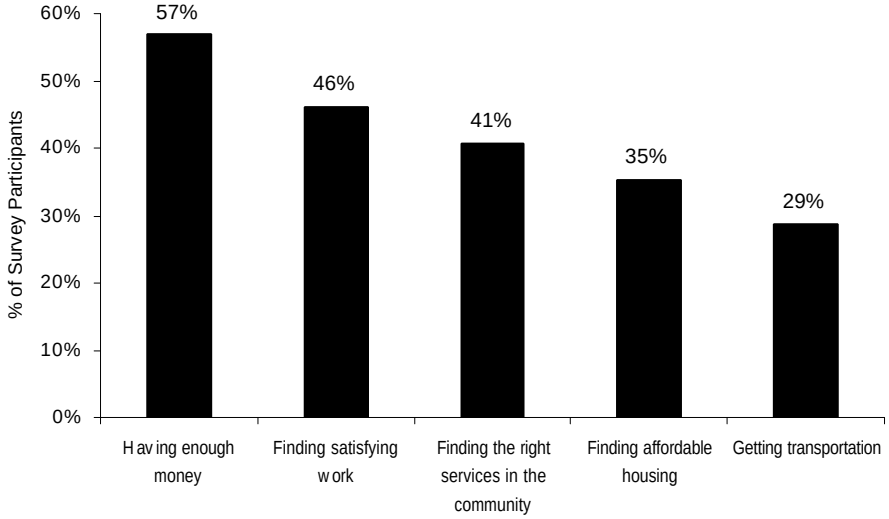
New Initiatives

1. Fund periodic audits of IEPs and make recommendations based on findings*)*
2. Develop an education strategic plan for beneficiaries.

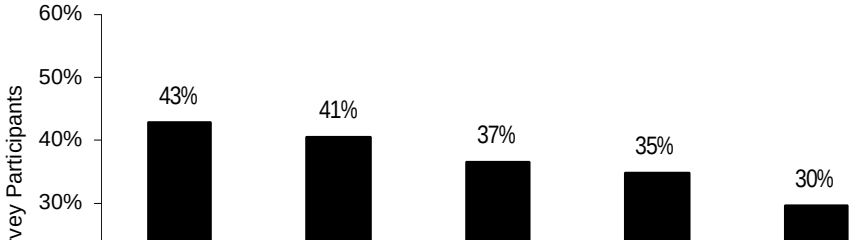
Result #5: LIVE WITH DIGNITY / VALUED MEMBERS OF SOCIETY

Indicator Baseline:

1998 Beneficiary Survey
(Self-selected Sample of 821 Alaska Mental Health Trust Beneficiaries)
Problems Encountered with Community Living



1998 Beneficiary Survey
(Self-selected Sample of 821 Alaska Mental Health Trust Beneficiaries)
Problems Encountered with Community Integration/Acceptance



The Story Behind the Baselines: Until recently, people with mental illness, developmental disabilities, chronic alcoholism and dementia were routinely removed from their homes and communities and placed in institutions. Until the late 1950s, hundreds of children and adults were sent to Morningside (Oregon) and other institutions thousand of miles from their homes and families. After statehood, beneficiaries received services in Alaska, but generally in centrally located institutions. As a result, people with disabilities were rare in communities and were often viewed with suspicion and mistrust. It is only in recent years, that local, community-based services have begun to spread across the state. Part of the mission of the Trust is to assist beneficiaries in becoming valued and contributing members of their communities.

Beneficiaries who participated in the Alaska Mental Health Trust Beneficiary Survey were questioned about problem areas they encountered in community living. Some of the problem areas noted were having enough money (57%), finding satisfying work (46%), finding the right services in the community (41%), finding affordable housing (35%), and getting transportation (29%).

Beneficiaries participating in the survey were also asked about some of the issues they faced in community integration and acceptance. The most common problems were having a decent social life (43%), feeling left out of things (41%), facing prejudice (37%), being able to control their own lives and making decisions (35%), and feeling unsafe when out (30%).

There is currently no comparable general population data.

Current Efforts to Turn the Curve: Some of the programs that have proven to be effective at providing beneficiaries with community living and home ownership support are HUD Section 8 and Supported Housing Programs, HUD 811 and 202 programs, the developmental disabilities and mental health housing grants, transitional housing and domicilary care, supported living, and in-home support programs. In addition, there are general relief and housing assistance programs for elders. Advocacy groups, such as NAMI Alaska, the Alzheimer's Association, and the Key Coalition play important roles in educating the public, changing attitudes, and advocating for community options for people with disabilities.

"Everyone should be guaranteed a place to live. Nobody should be homeless."

Consumer
1998 Beneficiary Survey

"I like having a roof over my head and money coming in. And I'm at a level that I'm feeling O.K. and can get back out in the community."

Consumer
1998 Beneficiary Survey

"I don't have things to do. I'm not a street roamer, I do not drink, and I am very isolated. I need friends."

Consumer
1998 Beneficiary Survey

"I like volunteering."

Consumer
1998 Beneficiary Survey

"I like to go drumming. One of my plans is working at a music store and being a drum teacher and beginning a band. And I'm really good. I was in the newspaper for Artist of the Week."

Consumer
1998 Beneficiary Survey

"Anything is possible. I

Consumer
1998 Beneficiary Survey

Recommended Strategies:

Expansion of Current Efforts

1. Ensure compliance with standards of care for facilities providing home and community based services for beneficiaries.
2. Provide training opportunities for community emergency services personnel (police, EMTs, hospital staff) on dealing with beneficiaries in crisis situations.
3. Support efforts to integrate beneficiaries into their communities.
4. Promote the participation of beneficiaries on policy-making boards and commissions.

New Initiatives

1. Re-capture the savings from the longevity bonus and reinvest it in senior services as a means of supporting seniors in their own homes and communities.
2. Explore a "universal" Medicaid waiver for home and community based care that is based on functional assessment rather than a specific disability.
3. Provide Alzheimer's and related dementia diagnostic and consultation services.

"I'd like to be able to get out more. Our transportation system only takes us to doctor's appointments but not anyplace else."

Consumer
1998 Beneficiary Survey

"Having knowledgeable family members makes a difference in how easily services are accessed or situations are handled."

Caregiver
1998 Beneficiary Survey

"We had a program with after hours that we could go to anytime--do crafts, and I liked that program. Everybody liked it. Then they cut that program. It's confusing."

Consumer
1998 Beneficiary Survey

"When you open up the newspaper, our Anchorage paper, there is, maybe once a week, an article about Alzheimer's in there, even if it's just a short little note. It's educating the general public."

Caregiver

Data Development Agenda

In Results Based Budgeting, results and indicators are used to establish baselines for the development of strategies and performance measures. Much of the information included in the Comprehensive Integrated Mental Health Plan (CMIHP) reflects the broader statewide population and are not specific to Mental Health Trust beneficiaries. Part of the CIMHP development process is identifying information gaps and moving forward with a data development agenda. The purpose of the data development agenda is to improve the quality and reliability of information on beneficiaries, thereby improving Department of Health and Social Services and AMHTA planning and budget development. The indicators below are currently not available. There are funding implications for most of the recommendations below. Each requires further analysis to determine the complexity, costs or potential legal barriers for each action or change.

Overarching Data Development Needs:

DATA	Why its important	Action or Cha
1. Consistent definition of beneficiaries across information systems (i.e. ARORA, DDIANA, PROBER, Senior Services, ADA, DOC, DOE, DVR, etc.).	It is important to compare the number of beneficiaries served by different programs and across systems.	Policy Change Addition/Revision to
2. Unduplicated count of beneficiaries to establish Alaska specific prevalence rates.	Current estimates of the number of beneficiaries are based on national prevalence data that may or may not be applicable to Alaska.	Survey Research - N Source
3. Consistent definition of descriptive data elements (income, ethnicity, educational attainment, living situation) across data systems.	Standardized method of describing beneficiaries.	Policy Change Addition/Revision to
4. New information systems funded by the Mental Health Trust Authority must include a determination of beneficiary status.	Standardized beneficiary count by program.	Policy Change
5. Regular survey of beneficiaries to determine income and living conditions.	It will be important to see how the status of beneficiaries changes over time.	Survey Research - N Source
6. Identify DHSS and other department information systems that collect information on beneficiaries and include them as sources of data for the data warehouse.	May provide a more complete picture of how beneficiaries use state-funded services.	Policy Change Addition/Revision to

Result #1: HEALTH DATA	**Why its important**	**Action or Cha**
1. # and rate of suicide attempts.	Indicator of need for mental health and substance abuse services.	New Primary Data S
2. % of low-birth weight babies with long-term disabilities.	Estimating future impacts on service systems.	Survey Research - N Source
3. Hospital discharge data by diagnosis as defined by ICD9 code.	Indicator of use of medical acute care facilities by beneficiaries.	Policy Change - Leg Addition/Revision to
4. Hospital emergency room data by diagnosis as defined by ICD9 code.	Indicator of use of medical emergency care facilities by beneficiaries.	Policy Change - Leg Addition/Revision to
5. % of beneficiaries who are uninsured (do not have a public or private third party payer).	Indicator of beneficiary access to health care.	Beneficiary Survey - Source
6. % of beneficiaries with health insurance that includes behavioral health coverage.	Indicator of beneficiary access to mental health and substance abuse treatment services.	Survey Research - N Source
7. % of beneficiaries who are unable to access needed medical, dental, mental health, long-term care or substance abuse treatment services.	Indicator of beneficiary access to health care and mental health treatment services.	Survey Research - N Source
8. % of physicians enrolled in and accepting Medicare/ Medicaid reimbursement.	Indicator of beneficiary access to health care and mental health treatment services.	Survey Research - N Source

Result #2: SAFETY

DATA	Why its important	Action or Cha
1. Retrospective studies: % of adults in correctional system, on Adult Public Assistance or in substance abuse treatment who were contacted by DFYS as children.	Indicator of future impacts on service systems and the need for future services.	Survey Research - N Source
2. # and percentages of beneficiaries in the correctional system.	Indicator of future impacts on correctional system and the need for future community services.	Addition/Revision to
3. Recidivism rate for beneficiaries involved in the correctional system.	Indicator of future impacts on service systems and the need for future services.	Addition/Revision to
4. # of beneficiaries with guardians, including reason for guardianship and type of guardian (guardians, conservators, representative payees).	Indicator of the level of support required by beneficiaries and provides a means of monitoring the guardianship services. Safety indicator.	New Information Sys
5. % of beneficiaries living in safe neighborhoods (based on neighborhood crime rates, existence of neighborhood watch programs, availability of alcohol through liquor licenses or local option, presence of law enforcement/VPSOs).	Quality of life indicator.	Survey Research - N Source

Result #3: ECONOMIC SECURITY

DATA	Why its important	Action or Cha
1. Income of beneficiaries.	Indicator of beneficiary quality of life - comparable to population.	Addition/Revision to Survey Research - N Source
2. Standardize methodology for collecting income information across databases.	Indicator of beneficiary quality of life - comparable to population.	Policy Change Addition/Revision to
3. Rate of employment for caregivers: before and after they become caregivers.	Indicator of care giver well-being and the availability of home and community services for beneficiaries.	Survey Research - N Source
4. Availability of affordable specialized, transitional and assisted living housing.	Indicator of access to services.	Survey Research - N Source
5. % of beneficiaries who are homeless.	Safety and quality of life indicator.	Survey Research - N Source

3.	Wages per hour for beneficiaries.	Indicator of the economic status of beneficiaries as compared to population.	Addition/Revision to Survey Research - N Source
4.	% of beneficiaries who receive a diploma or GED.	Indicator of the future economic status of beneficiaries.	Addition/Revision to
5.	% of juvenile offenders who are beneficiaries and who receive a diploma/GED.	Indicator of the future economic status of beneficiaries and recidivism potential.	Addition/Revision to

Result 5: LIVING WITH DIGNITY / VALUED MEMBER OF SOCIETY

	DATA	Why its important	Action or Cha
1.	Number of people living in nursing homes by age and diagnosis.	Indicator of the availability of community based alternatives to nursing home care.	Addition/Revision to
2.	% of seniors (60+) living in nursing homes.	Indicator of the availability of community based alternatives to nursing home care.	Addition/Revision to
3.	Number of complaints against nursing homes and assisted living homes.	Status of the service system and quality of care.	Addition/Revision to
4.	Number (or %) of beneficiaries using public transportation and para-transit (municipal or service provider)	Indicator of access to the community.	Addition/Revision to Survey Research - N Source
5.	% of beneficiaries living in the community or home of their choice.	Indicator of choice and quality of life.	Survey Research
6.	Community support or treatment service availability index	Method of comparing the availability of community capacity to provide home and community based services.	Analysis of Existing