ALASKA MENTAL HEALTH BOARD
ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE
431 NORTH FRANKLIN STREET, SUITE 200
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FY11 Budget Priorities

The Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse support increments in the Mental Health Budget (HB 302) that affect people with mental illness and addiction disorders. These requests were identified through extensive public input from treatment providers and other professionals, people with mental illness and addiction orders, family members, and public comment at board meetings and town hall meetings held statewide.

Rural Psychiatric Emergency Services
AMHB $300,000 (MHTAAR)
This funding is a continuation of a two-year recommendation for developing appropriate emergency services in rural hub communities. FY10 funds were used to connect a stabilization room at Central Peninsula Hospital to Alaska Psychiatric Institute (API) *via* video conferencing, and to assist Mat-Su Regional Hospital in developing local psychiatric emergency services – two regions from which most API admissions come. In FY11, funding will build upon this progress by providing safe and appropriate psychiatric emergency services in other bush communities.

Increased Access to FASD Treatment Services in Rural Alaska
AMHB $228,600 (GF/MH)
This funding will build services in communities with active FASD diagnostic teams so that children diagnosed with FASD can receive appropriate therapies and services as close to home as possible – with priority given to rural communities. Services may include occupational therapy, speech therapy, physical therapy, education supports and specialized mental health services. This funding will: 1) allow for immediate access of service upon diagnosis, rather than delay treatment, which could result in more costly out-of-state Residential Psychiatric Treatment Center (RPTC) care, 2) increase the availability of services in the home community, and 3) pay for services that are not reimbursed by Medicaid. This model is similar to the model used for providing services to youth with Severe Emotional Disturbance (SED) in the Bring the Kids Home initiative.

Substance Abuse Treatment for Pregnant Women
ABADA $500,000 (GF/MH)
This funding will make grant funds available to expand capacity for residential and/or intensive outpatient substance abuse treatment — followed by aftercare — to pregnant women. It would be prioritized as follows: 1) expand residential treatment capacity for pregnant women statewide (to alleviate the need to travel to Anchorage/Fairbanks), 2) encourage the expansion of existing family-based treatment models where children can reside at the facility with the mother in treatment, 3) expand intensive outpatient

treatment capacity for pregnant women statewide so that when space in a residential or a family-style program is not available, a pregnant woman can receive it, and 4) expand aftercare resources.

Rural Planning and Implementation of Community Detox

ABADA $100,000 (MHTAAR)

Funding would allow continuation of a two-year recommendation for bush communities working to find local solutions to chronic inebriate problems. This money will be targeted to communities with high levels of readiness and can be used to complement other sources of funding that implement community plans (once finalized), or to help initiate planning processes in communities ready to engage the issue.

See following pages for back-up…

Advisory Board on Alcoholism and Drug Abuse

Alaska Mental Health Board

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Support Rural Psychiatric Emergency Services

$300,000 (MHTAAR)

This funding request is a continuation of a two-year recommendation for Mental Health Trust Authority Authorized Receipts (MHTAAR) monies for developing appropriate emergency services in rural hub communities. FY10 funds were used to connect a stabilization room at the hospital in Kenai to API via video conferencing and to assist Mat-Su Regional Hospital develop local psychiatric emergency services. The FY11 recommendation will expand upon those efforts by providing safe and appropriate psychiatric emergency services in bush communities.

The intent is to better utilize the tele-behavioral health systems already in place by providing safe rooms and stabilization services as close to home as possible for people experiencing a mental health crisis. For this second year of funding, our express intent is that funding be used to encourage collaborations between local, state and tribal health care providers.

Outcomes are expected to include decreased API admissions and decreased completed suicides from regions in which local emergency psychiatric services are developed. Data from the Bureau of Vital Statistics, Alaska Trauma Registry and the API census will be used to monitor progress toward these outcomes.

The Problem
Rural hospitals are resistant to providing acute care due to the cost, facility requirements, staffing requirements, and perceived obstacles to reimbursement, seen by the recent closure of the Designated Evaluation Stabilization and Treatment (DES/DET) Program at Mt. Edgecombe Hospital in Sitka due to the costs and lack of adequate staffing.

API has been at least at 73% capacity since January 2007, and has been at over 90% capacity for 6 of the last 19 months. This chart, provided by API on August 4, 2008, shows admissions for 2007 and 2008:

- Division of Behavioral Health (DBH) Deputy Director Stacy Toner reported that the existing DES/DET budget is typically short $700,000 per year. This is what is needed to pay for the system we have, and prevent further losses like the beds recently closed at Mt. Edgecombe Hospital.
- DBH received a $330,000 increase to base funding for DES/DET during the 2008 legislative session, leaving a deficit of $370,000 to cover current costs of service.
- DBH staff report that costs of transportation from villages and rural communities to DES/DET facilities have increased by 17% in 2008, and they expect additional increases for a final rate of inflation in excess of 20%.

Consequences of not funding: Alaskans requiring emergency psychiatric services will continue to be held in unacceptable conditions pending transport to API. Transportation costs will continue to be a large proportion of the DES/DET budget. Rural communities will continue to experience high suicide rates.

Community Care = Cost Containment

Given the expected exponential growth in costs related to rural Alaskans accessing acute care through API, it is imperative that we not only shore up the foundations of our existing DES/DET system but also capitalize on our telemedicine assets to afford community-based acute care for psychiatric emergencies.

The same services now available through the limited DES/DET beds available can be offered by other rural hospitals through the use of telemedicine. API has expressed willingness to provide the on-call psychiatrist services to partner hospitals. While there is readiness is some communities, a concerted effort to build readiness in other rural communities will be necessary for long-term cost-containment. Some communities have technical and physical infrastructure already in place, making implementation of the pilot possible once staffing is sorted. Other communities may need financial and technical assistance to develop the technical and physical capacity to implement the pilot.

Public Comment

Public comment to the Alaska Mental Health Board this year has consistently shown that Alaskans experiencing psychiatric emergencies cannot receive adequate services in their community. The following statement was taken during public comment at one board meeting:

> *Six weeks ago my 17 year old son went to his clinician expressing feelings of personal harm and possibly harm to others. The clinicians got together and said he needed to go down to API . . . My son was told to go to the hospital so that an evaluation could be made there and then . . . he was escorted by police to the police department, to their break room. By this time he had settled down, he was quite calm, very rational, was not in any way shape or form going to hurt anybody, especially himself. [When] the evening flight arrived he was handcuffed and escorted to the airport. By this time he was calm and there was no need for handcuffs. To add insult to injury, the girls' basketball team was on the same flight . . . There were members of our congregation on the flight that were able to talk [to] my son and they assured me that my son was quite calm and rational, but still in restraints. ~ Reverend Ian MacInnis Green, Barrow (May 19, 2008)*

Support the $300,000 (MHTAAR) request in the Rural Psychiatric Emergency Services in the Mental Health Budget.

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Support Increased Access to FASD Treatment Services

$228,600 (GF/MH)

This funding will build services in communities with active Fetal Alcohol Spectrum Disorders (FASD) diagnostic teams, so that children diagnosed with FASD can receive appropriate therapies and services as close to home as possible – with priority given to rural communities. Services may include case management, occupational therapy, speech and language therapy, physical therapy, appropriate psychiatric testing, education supports, specialized mental health services, and FASD training for professionals in the community.

This funding will:

- Allow for immediate access of service upon diagnosis rather than delay treatment
- Increase services close to home and save costly travel expenses
- Pay for services that are not reimbursed by Medicaid

Outcomes are expected to include:

- Expanded support services in four communities (Sitka, Bethel, Kenai, Juneau) that will help children diagnosed with FASD develop and maintain appropriate life skills, a completed education, employability, ability to obtain and retain housing, social appropriateness, etc.
- Avoidance of secondary disabilities, such as mental health problems, disrupted school experience, criminal behavior, inappropriate sexual behavior, drug and alcohol abuse, problems with employment, problems with parenting, dependent living, etc.
- Increased utilization of occupational, physical, speech and language therapies, case management and education supports, and increased clinician competencies to deliver services to children diagnosed with FASD.
- Reduction in the number of children admitted to RPTCs

The Need

In 2009, 161 Alaskan children were diagnosed with FASD by seven active diagnostic teams statewide. After diagnosis, parents often report there are few or no services available in their community to assist with treatment, e.g. educational supports, speech and language therapy, occupational therapy, case management, family therapy. Without services near home, families must invest in costly travel to other locations, or go without services altogether. Children without early services are at a higher risk for developing secondary

disabilities, such as disrupted school experiences, mental health problems, criminal behavior, inappropriate sexual behavior, and substance abuse problems.

An additional gap in the current system is adequate training for behavioral health providers working with children diagnosed with FASD. To help address that gap, this recommendation includes funding sufficient to cover the costs of a mandatory training for all grantees so that clinical staff are equipped to best serve this population.

Funding Mechanism
The actual construct for use of the funds to benefit children diagnosed with FASD will be determined by the Division of Behavioral Health (DBH). Whether it follows an "individualized service agreement" (ISA) or other targeted funding mechanism, the intent is that resources will be available so that children receive the entire spectrum of needed services as close to home as possible, specific to the needs of the individual. This model is similar to the model used for providing services to youth with Severe Emotional Disturbance (SED) in the Bring the Kids Home Initiative. Funds may be used to complement the FASD Waiver and the resources for monitoring progress may include Medicaid billing information, data collection, client status reviews and consumer surveys.

What is FASD?
FASDs are a range of disabilities caused when a fetus is exposed to alcohol. These disabilities are a result of brain damage that can result in a variety of symptoms, including impaired mental function, learning disabilities, problems with memory, impulsiveness, poor judgment, severe emotional disturbance (SED), difficulty with problem solving, inability to control sexual urges, inability to apply consequence from past actions, difficulty with abstract concepts such as time and money, difficulty processing information, and more. Additionally, a person with an FASD without support has a high risk of becoming an alcoholic, suffering from depression, serving time in jail, or becoming homeless.

Research indicates repeatedly that with early diagnosis, knowledge, and support, a person with FASD can live a productive and healthy life without the costly services that result when a diagnosis goes without the necessary supports and services.

Additional consequences of not funding:

- Children with an FASD are at risk of dropping out of school, becoming an alcoholic or drug abuser, suffering from depression, serving time in jail, unable to sustain employment, becoming homeless and drinking during pregnancy.
- When children are not served in their own communities, the cost of travel to reach appropriate services is prohibitive.
- Children diagnosed with FASD who do not receive services may develop severe emotional disturbance (SED) resulting in "a need for the level and intensity of services" provided by an RPTC, when they will qualify for waiver services.

Support the Governor's request of $228,600 (GF/MH) for increased access to FASD treatment services.

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Support Substance Abuse Treatment for Pregnant Women

$500,000 (GF/MH)

This recommendation makes grant funds available to expand capacity to provide residential and/or intensive outpatient substance abuse treatment, followed by aftercare, to pregnant women. The increment addresses the limited capacity we have to serve this population.

Pregnant women are a "priority population," meaning that if there is an empty residential treatment bed and a pregnant woman is in need of that treatment, she gets the bed. However, this presumes there is a bed available. In November 2008, ABADA surveyed the system to see what resources were available to pregnant women.[1] There are 125 residential treatment beds available to pregnant women – but the average wait between assessment and admission is 23.3 days (almost an entire month of the pregnancy). The majority of these treatment beds are in Anchorage and Fairbanks. Most do not allow children to come with the mother, or allow them only under certain circumstances. There are 31 outpatient programs in Alaska providing specialized treatment services for pregnant women – the average wait between assessment and admission is 14 days.

Providers who shared data reported 97 pregnant women received substance abuse treatment in FY08. DHSS reports a prevalence rate of 15 children (1.5/1,000 live births) born each year with fetal alcohol syndrome and 163 children (16.3/1,000 live births) born each year affected by prenatal alcohol exposure. Thus, only 54% of the women who are estimated to have needed substance abuse treatment to prevent harm to their children *in utero* received care in FY08.[2]

The intent is that this funding would be prioritized as follows:

1. Expand residential treatment capacity for pregnant women statewide (to alleviate the need to travel to Anchorage/Fairbanks);
2. Encourage the expansion of existing family-based treatment models style treatment models where children can reside at the facility with the mother in treatment;

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[1] This survey was conducted by the Boards' research analyst. Substance abuse treatment providers were contacted by telephone and email and asked how many inpatient beds and outpatient spots were designated for pregnant women; what the wait time is (if any); whether and under what circumstances other children can reside with the mother in treatment; numbers seeking treatment; and numbers served.

[2] We also received comment that some physicians attempt (unsuccessfully) to use general hospitalization to provide care for pregnant women presenting with alcoholism or other addictions, further indicating the need for greater treatment capacity.

3. Expand intensive outpatient treatment capacity for pregnant women statewide so that, when space in a residential or a family-style program is not available, a pregnant woman who needs and seeks treatment can receive it; and
4. Expand aftercare resources.

While family-style programs are to be encouraged under this recommendation, we recognize that there will be communities and provider agencies that, very reasonably, cannot expand services in that way.

Outcomes are expected to include: A reduction in the number of children born with fetal alcohol syndrome and fetal alcohol spectrum disorders. If we expand treatment capacity so that the 46% of pregnant women thought to need treatment can access those services, we could achieve a significant reduction in children diagnosed with FASD. Data from the Alaska Birth Defects Registry and regional diagnostic teams will be used to monitor progress toward these outcomes.

Consequences of not funding: We will continue to have an FASD prevalence rate that is more than three times that of other states.[3]

Support the Governor's request for $500,000 (GF/MH) for substance abuse treatment for pregnant women.

[3] Of the prevalence rates reported by the five surveillance network states (CDC 1995-1997), Alaska had the highest rate: AK 1.5/1,000; AZ .3/1,000; CO .3/1,000; NY .4/1,000. Data available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5120a2.htm#tab2.

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Support Rural Planning and Implementation of Community Detox

$100,000 (MHTAAR)

This funding is a continuation of a two-year recommendation for Mental Health Trust Authority Authorized Receipts (MHTAAR) support for rural communities working to find local solutions to their chronic inebriate problems. This money will be targeted to communities with high levels of readiness and can be used to complement other sources of funding to implement community plans (once finalized) or to help initiate planning processes in communities ready to engage the issue.

Funds will be targeted for services to individuals committed under Title 47 only. Individuals choosing voluntary services after commitment would access other resources.

The Need
Urban communities are not the only places struggling to address the problem of chronic inebriates. Rural communities like Nome and Bethel continue to look for effective strategies to ensure the safety of chronically addicted individuals and to provide the detoxification, treatment and aftercare services needed. Because not every community's population of chronic inebriates presents with the same needs, or with the same needs of chronic inebriates in Alaska's urban centers, it is important that local solutions be developed with high levels of community involvement.

While the CSP and transfer stations, like those developed in Bethel, provide temporary intervention to promote the safety of individuals and the public, they are not designed to stop the downward spiral experienced by chronic inebriates.

There are rural communities ready to engage in developing community detoxification and treatment solutions. With the first year of this funding recommendation, the Wellness Coalition in Nome was supported in its planning process. Continued funded is needed to allow for meaningful planning that supports implementation of community solutions that will effectively address the problem of chronic inebriates in rural Alaska.

Implementation
The Division of Behavioral Health will make these funds available as grants to communities with high levels of readiness, to engage in planning for local community solutions tailored to the specific needs of the population of chronic inebriates in that community.

Outcomes are expected to include:

- Significant reduction in the number of Alaskans chronically abusing drugs and alcohol, to be measured by the numbers of individuals committed to treatment and successfully completing secure treatment, CSP/transfer station admissions, etc.
- Protection of Alaskan adults made vulnerable to harm (whether from the environment, self-harm or at the hands of others) due to chronic inebriation, to be measured by numbers of assaults, incidents of self-harm, and deaths resulting from conditions related to chronic inebriation.
- Reduction in the number of avoidable arrests, to be measured by number of arrests of individuals committed before and after treatment.
- Achieving sobriety through involuntary secure detox services means no more alcohol or drug related ER visits or arrests.

Consequences of not funding: Chronic inebriates will continue to overburden rural emergency departments and jails. The number of chronic inebriates who die due to exposure, violence, or neglect will not decrease.

Support the $100,000 (MHTAAR) request for rural planning and implementation of community detox in the Mental Health Budget.