

# STATE OF ALASKA

## DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

TONY KNOWLES, GOVERNOR

P.O. BOX 110601  
JUNEAU, ALASKA 99811-0601  
PHONE: (907) 465-3030  
FAX: (907) 465-3068

November 2001

Dear Alaskan:

We are pleased to present *In-Step*, the comprehensive integrated mental health plan for fiscal years 2001-2006. Our vision is for everyone to have access to a full continuum of integrated care and services that are designed to assist Alaskans to live with dignity in their home communities.

*In Step* focuses on those Alaskans with mental and cognitive disabilities and/or substance use disorders. It incorporates work from the Healthy Alaskans 2010 public health plan and other statewide planning processes to offer guidance to policy makers for improvements to state services and to personal circumstances of persons with disabilities. Most importantly, it brings together the planning work of the four advocacy boards and commission:

- Alaska Mental Health Board
- Governor's Council on Disabilities and Special Education
- Advisory Board on Alcoholism and Drug Abuse
- Alaska Commission on Aging.

Alaska has worked hard to coordinate planning efforts and promote integrated services for people in community-based settings. The efforts and participation of Alaskans from government agencies, public and private entities, as well as individual advocates have contributed to continuous progress toward our goal to serve Alaskans in integrated settings.

Alaska closed its intermediate care facilities for the mentally retarded and downsized the Alaska Psychiatric Institute in order to promote community care and develop the necessary community infrastructure to make it possible. At the same time, we have significantly increased services and programs to allow individuals to live in their home community.

Planning is about people coming together in a cooperative process to set goals, implement strategies, and measure progress. This is the fourth comprehensive mental health plan. We have watched the process mature with each planning effort. We know there is still much work to do and we are committed to taking those steps necessary to realize our vision of making integrated community-based services available to all Alaskans.

Sincerely,



Jay Livey  
Commissioner

# The Plan - 2001

## Acknowledgments

Planning requires the participation of many individuals. We gratefully acknowledge and thank everyone who gave their time and expertise to make this plan possible. In particular, however, we want to recognize the staff of the departments of Health and Social Services, Corrections, Labor, and Education and Early Development. The plan process and development was orchestrated by the Comprehensive Plan Work Group. A subset of this group composed of staff from the advocacy boards and Trust drafted, compiled, and reviewed all sections of the document. Work Group membership changed during the course of this work, however, this list includes everyone who participated.

### Comprehensive Plan Work Group

John Pugh, Co-Chair, Trustee, Alaska Mental Health Trust

Russ Webb, Co-Chair, Deputy Commissioner, Department of Health & Social Services

Jane Demmert, Executive Director, Alaska Commission on Aging

Lynda Freeman, Executive Director, Alaska Commission on Aging

Richard Rainery, Executive Director, Alaska Mental Health Board

Millie Ryan, Executive Director, Governor's Council on Disabilities and Special Education

Pam Watts, Executive Director, Advisory Board on Alcoholism and Drug Abuse

John Malone, Trustee, Alaska Mental Health Trust

Caren Robinson, Chair, Alaska Mental Health Trust

Cristy Tilden, Planning Chair, Advisory Board on Alcoholism and Drug Abuse

Karl Brimner, Director, Division of Mental Health and Developmental Disabilities

Walter Majoros, Director, Division of Mental Health and Developmental Disabilities

Janet Clarke, Director, Division of Administrative Services

Ernie Turner, Director, Division of Alcohol and Drug Abuse

Marilee Fletcher, Regional Coordinator, Division of Alcohol and Drug Abuse

David Maltman, Program Administrator, Division of Mental Health and Developmental Disabilities

Kathryn Cohen, Plan Coordinator, Division of Administrative Services

Nick Coti, Planner, Division of Administrative Services

Paula Recchia, Planner, Alaska Commission on Aging

Jill Sandleben, Planner, Alaska Commission on Aging

Mara Rabinowitz, Planner, Department of Corrections

Mary Elizabeth Rider, Program Officer, Alaska Mental Health Trust

Anne Schultz, Research Analyst, Advisory Board on Alcoholism and Drug Abuse

Margo Waring, Planner, Alaska Mental Health Board



**In Step - The Plan  
2001-2006**

**Contents**

**Acknowledgments..... 1**

**Introduction ..... 7**

*Principles* ..... 8

*Themes* ..... 8

**Health..... 11**

**Mental Health Status ..... 11**

*Indicators*..... 11

        Self reported poor mental health days ..... 11

*Strategies*..... 12

**Early Life ..... 12**

*Indicators*..... 12

        Mothers and prenatal care ..... 12

        Premature infants ..... 13

        Alcohol during pregnancy ..... 13

*Strategies*..... 14

<b>Alcohol and Other Drugs .....</b>	<b>15</b>
<i>Indicators</i> .....	15
Per capita alcohol consumption .....	15
Acute and chronic drinking .....	16
Number of driving while intoxicated felony case filings .....	16
Motor vehicle injury and death rates .....	17
Alcohol related deaths .....	18
Alcohol use among high school students .....	18
Inhalant use among middle school and high school students .....	19
<i>Strategies</i> .....	19
<b>Suicide .....</b>	<b>20</b>
<i>Indicators</i> .....	21
Alaska’s suicide death rate compared to other states .....	21
Suicide rate of Alaskan youth .....	22
Suicide attempt rate per 100,000 population .....	22
<i>Strategies</i> .....	23
<b>Safety .....</b>	<b>25</b>
<b>Decriminalization .....</b>	<b>25</b>
<i>Indicators</i> .....	26
Title 47 non-criminal holds in community jails .....	26
Title 47 non-criminal holds in selected criminal facilities .....	27
Rates of Title 47 commitment filings and non-criminal holds per 100,000 adult population .....	27
Percentage of inmates in Department of Corrections institutions treated for mental illness .....	28
<i>Strategies</i> .....	29

<b>Safe Families .....</b>	<b>30</b>
<i>Indicators</i> .....	31
Number of reports of child harm .....	31
Number of reports and investigation results, fiscal years 1995-2000 .....	31
Number of children with reports of harm .....	32
Number of children in long-term state custody permanently placed in homes .....	32
Behavioral Risk Factor Survey (BRFSS) domestic violence data .....	33
Incidents of domestic violence .....	33
Adult Protective Services reports of harm and clients .....	34
Guardianship petitions .....	34
<i>Strategies</i> .....	35
<b>Safe Care.....</b>	<b>35</b>
<i>Indicators</i> .....	36
Proportion of consumers reporting satisfaction with public services .....	36
Number of complaints to the Long-Term Care Ombudsman. ....	36
Agencies with consumers on governing boards .....	37
<i>Strategies</i> .....	37
<b>Economic Security .....</b>	<b>41</b>
<b>Basic Economic Supports .....</b>	<b>41</b>
<i>Indicators</i> .....	42
Poverty rates for children in Alaska .....	42
Alaska’s per capita income compared to the rest of the United States .....	42
Alaska’s per capita income rank with and without the PFD .....	43
Public Assistance program participants as a percentage of the Alaska population .....	44
SSI/APA payment compared to Alaska poverty level .....	45
<i>Strategies</i> .....	45

**Employment ..... 46**

*Indicators*..... 46

Number of Medicaid recipients participating in the supported employment waiver program ..... 46

Number of Medicaid recipients who participate in the buy-in option ..... 47

*Strategies*..... 48

**Living With Dignity ..... 51**

**Housing ..... 51**

*Indicators*..... 52

Number of homeless people ..... 52

Number of patients discharged from API to homeless shelters ..... 53

Number of people with disabilities on wait lists for public housing or rental assistance ..... 54

Inventory of special needs and supportive housing ..... 54

*STRATEGIES* ..... 55

**Education and Training ..... 56**

*Indicators*..... 57

Number of children with mental and cognitive disabilities in public schools ..... 57

Percentage of students with emotional or developmental disabilities who complete their public education ..... 57

Passing rates on benchmark and high school graduation qualifying exam ..... 58

*Strategies*..... 59

**Educated Public ..... 59**

*Strategies*..... 60

**Next Steps ..... 63**

## Introduction

The Comprehensive Integrated Mental Health Plan provides policy direction intended to promote a continuum of care and service that foster individual well being, personal safety, economic security, and life with dignity for all Alaskans. The title, “In Step,” suggests common goals and a mutual awareness of our efforts to reach them. The plan will guide strategic, programmatic, and budget decisions for public services that comprise the behavioral health program.

This new edition of the comprehensive plan is divided into two documents. The first volume, “In Step - The Plan,” presents goals and quantitative measures to indicate progress toward them. It also suggests strategies to use. The second volume, “In Step - The Discussion,” provides background information, describes successful programs, and explains the rationale behind the strategies.

The Comprehensive Integrated Mental Health Plan guides the programs and services provided to Alaskans who are beneficiaries of the Alaska Mental Health Trust. Beneficiaries include people with:

- ❖ Mental illness
- ❖ Developmental disabilities
- ❖ Chronic alcoholism
- ❖ Alzheimer’s Disease and related disorders\*

Each beneficiary groups is defined in statute and is represented by one of four advocacy boards:

- ❖ Alaska Mental Health Board (mental illness)
- ❖ Governor’s Council on Disabilities and Special Education (developmental disabilities)
- ❖ Advisory Board on Alcoholism and Drug Abuse (chronic alcoholics)
- ❖ Alaska Commission on Aging (Alzheimer’s disease and related disorders)

The plan is a collaborative effort. The Department of Health and Social Services is responsible for developing the plan in conjunction with the Alaska Mental Health Trust.” The planning process integrates the comprehensive plan with other statewide plans such as those prepared by the three advocacy boards and commission, the Department of Corrections, and the Division of Public Health’s Healthy Alaskans 2010 plan. Plan development involves all of them as well as the Alaska Mental Health Authority, divisions within the Department of Health and Social Services, the Alaska Housing Finance Corporation, and others. All of their contributions are gratefully acknowledged.

Over the years, since its inception in 1996, the Comprehensive Integrated Mental Health Plan has become more comprehensive. It is a growing, changing document. The present plan will stand as a guiding document until 2006, with revisions and updates every two years.

---

\* AS 47.30.056 (b).

\*\* AS 47.30.660, Powers and duties of department.

## The Plan - 2001

The comprehensive plan focuses on services that improve the lives of Alaska Mental Health Trust beneficiaries. It is results-based, which means that it looks at “result areas,” each area including data based indicators to assist in measuring the results of services. The result areas are:

- ❖ Health
- ❖ Safety
- ❖ Economic Security
- ❖ Living with Dignity

### *Principles*

The vision is for all Alaskans to have access to appropriate behavioral health care and to participate in treatment and other services they need to live as independently as possible. To accomplish this, the public behavioral health system adheres to certain principles that govern state services. These principles are set in law and are found in separate Alaska statutes addressing services for people with mental or cognitive disabilities and substance use disorders.\* The principles are to:

- ❖ Provide ready and prompt access to care
- ❖ Inform consumers of their rights including confidentiality and treatment with dignity
- ❖ Provide services that are culturally appropriate and include multidisciplinary staffing
- ❖ Encourage consumers to participate in planning and evaluating their treatment
- ❖ Provide treatment in the least restrictive environment and as close to home as possible

The plan is results-oriented and stresses services that are:

- ❖ Innovative, encouraging imagination and forward thinking
- ❖ Integrated to increase efficiency, improve effectiveness, and enhance access
- ❖ Oriented toward prevention and early intervention
- ❖ Customer driven and addressing service system parity

### *Themes*

The themes of prevention and access to services thread throughout each result area in the plan. Prevention is the first step in care. Promoting mental well being has increasingly become part of public health campaigns. However, mental health has yet to receive the same level of attention as physical health. This is changing as science-based research identifies risk and resiliency factors that influence individual mental well being. Early identification of risk factors and early intervention to mitigate potential disorders appear repeatedly as strategies.

In an ideal world, people have access to the behavioral health services they need. Services are relatively close at hand and have the capacity, including trained staff, to serve everyone who needs help. Consumers can reach necessary services, receive appropriate care, and afford to pay for it. However, there are now significant disparities in access to care. Access is limited for those who are unemployed or disabled; for adolescents, children, those without adequate health insurance; for rural Alaskans. It is also limited for people who

\* AS 47.30.523, Community mental health program policy and principles; AS 47.37.150, Acceptance for treatment; AS 47.65, Service programs for older Alaskans and other adults; AS 47.80.110, Program principles.

may be culturally, physically, or educationally separated from behavioral health care services.

Alaskans confront substantial barriers to care due to geography, available expertise, and costs. In rural Alaska in particular, service delivery is problematic due to small numbers of consumers, vast distances, and a chronic shortage of staff. Administrative barriers such as state or federal law or policy, Medicaid reimbursement rules, payment and delivery systems, and confidentiality can also inhibit access to behavioral health services. The disproportionate number of people with mental illness and substance use disorders in Alaska's prisons is just one consequence of limited access to prevention and care.

Access to behavioral health care also is influenced by the availability of qualified staff. Behavioral health care workers come from many different educational backgrounds and include psychiatrists, social workers, clinicians, rural human services workers, personal care attendants, and volunteers. Rural areas are frequently understaffed due to low wages and difficult working conditions. Staff turnover is a significant problem throughout Alaska due to poor pay, isolation, and burnout.

In theory, all Alaskans have some access to behavioral health care. The State of Alaska, federal government, Native tribal entities, and private practitioners all provide geographically and organizationally overlapping opportunities for people to receive some care. These separate systems can fragment

scarce resources and allow people to slip between the cracks. State agencies are working with their counterparts in federal, Native health, and private practice to bridge gaps, fill in cracks, and otherwise ensure as much access to services as possible. However, there is still much to be done.

Those programs and projects that seem to work best share certain elements. They are consumer focused, cross artificial administrative barriers with collaborative and cooperative efforts, and address the whole person including his or her family. We tried to adopt an integrated, consumer perspective in this plan. Program and service gaps remain and this plan touches only on a few of these issues. Nonetheless, it does provide direction and some ways to measure our progress on the journey.

---



## Health

*“Health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity.” - World Health Organization*

The United States Surgeon General’s recent report on mental health emphasizes the fundamental importance of mental health to well being. The Surgeon General urges individuals and communities to prevent and mitigate mental illness, addiction, and cognitive disabilities. The human toll taken by these disorders is significant. Throughout our lives, we confront conditions that can profoundly impact our mental health. Twenty percent of all children are estimated to have mental disorders. Each year, one in five adults is affected by a mental health disorder.<sup>1</sup> An estimated 15 percent of adults with a mental disorder experience a co-occurring substance use disorder. Addiction disorders and suicide are among the health threats we face throughout our lives. As we age and our physical and mental health becomes more fragile, age-related dementia causes dependence and is the leading contributor to the need for long-term care.<sup>2</sup>

The Comprehensive Plan focuses on four health issues:

- ❖ Mental health status
- ❖ Early life
- ❖ Alcohol and other drugs
- ❖ Suicide

## Mental Health Status

*Goal: To enhance quality of life through appropriate services for people with mental and cognitive disabilities and substance use disorders.*

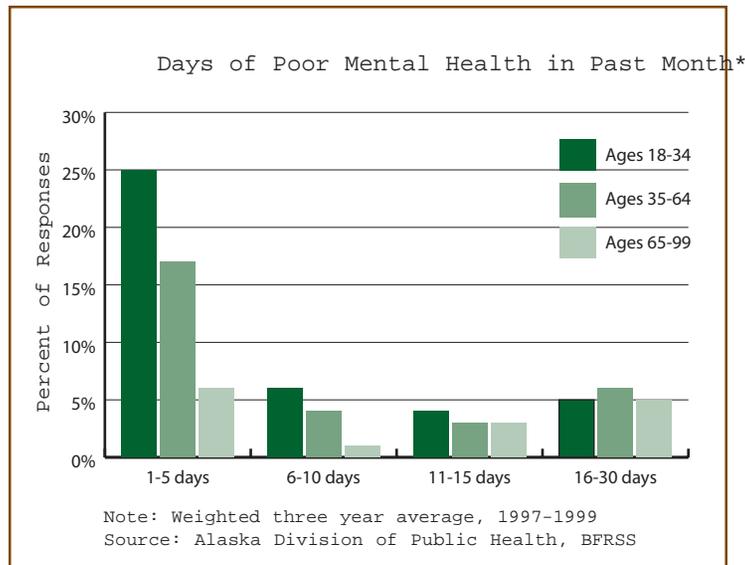
Good physical and mental health are common measures of an individual’s well being. One way to assess a population’s overall health is with a set of measures known as “Healthy Days.” Developed by the National Center for Disease Control, Healthy Days is one of the few population-based surveys of mental health status. It measures individuals’ self-evaluation of their physical and mental health within the past thirty days.

### Indicators

Self reported poor mental health days

Alaska survey results imply a need for preventive mental health care. Thirty percent of survey respondents reported experiencing some poor mental health during the preceding month. Fourteen percent reported more than five days of poor mental health. The percentage of young adults reporting from 1 to 15 days of poor mental health is consistently higher than in other age groups (Figure H-1).

Figure H-1



*Strategies*

1. Coordinate prevention among government agencies to increase the effectiveness of those efforts.
2. Train physical health care providers such as public health nurses, paraprofessionals, and medical providers to screen patients for mental and cognitive disabilities and substance use disorders, and to provide appropriate referral for treatment.

**Early Life**

*Goal: To promote healthy births and encourage early childhood interventions to reduce the risk of disability.*

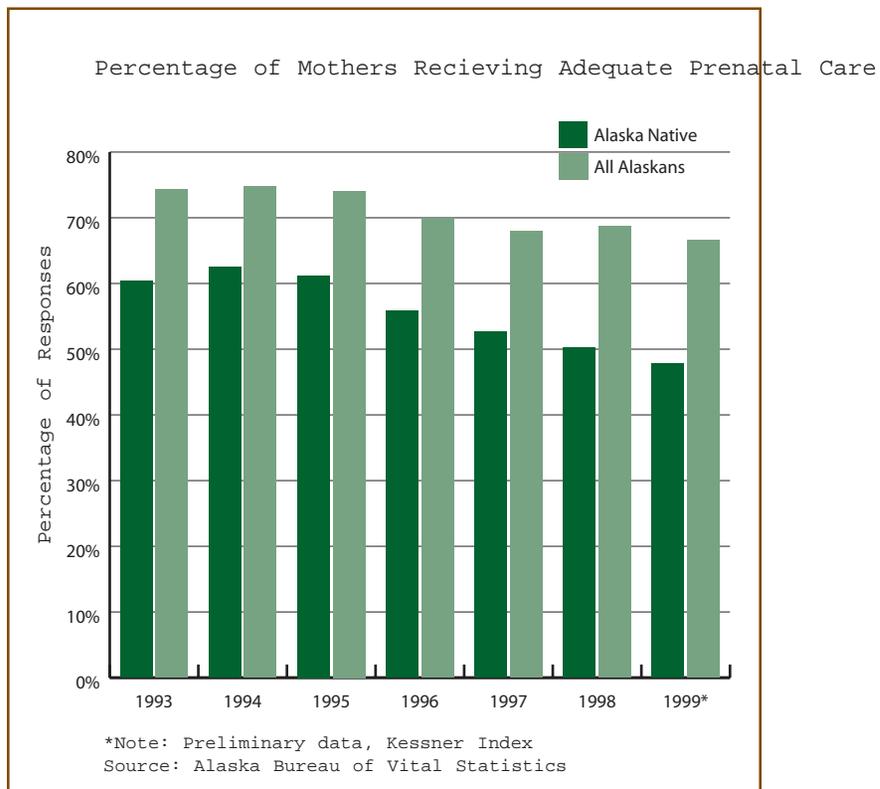
Alaskan families, like those everywhere, strive to have healthy babies and to provide good homes for their children. The first three years of a child’s life are a time of extraordinary growth physically, mentally, emotionally, and socially. We know that environmental factors have a profound influence on the brain. Recent research confirms that many children’s mental health problems are related to family violence, parent’s chemical addiction, mental illness, and poverty.<sup>3</sup> Often a number of identifiable stresses combine to create family dysfunction and to compromise the children’s development and health.

*Indicators*

**Mothers and prenatal care**

Prenatal care can help reduce perinatal illness, disability, and death by identifying and mitigating physical and environmental risks. However, the percentage of Alaskan mothers who report receiving adequate prenatal care is declining. Between 1993 and 1999, this percentage dropped an estimated 8 percent for all Alaskans and 15 percent for Alaska Natives (Figure H-2).

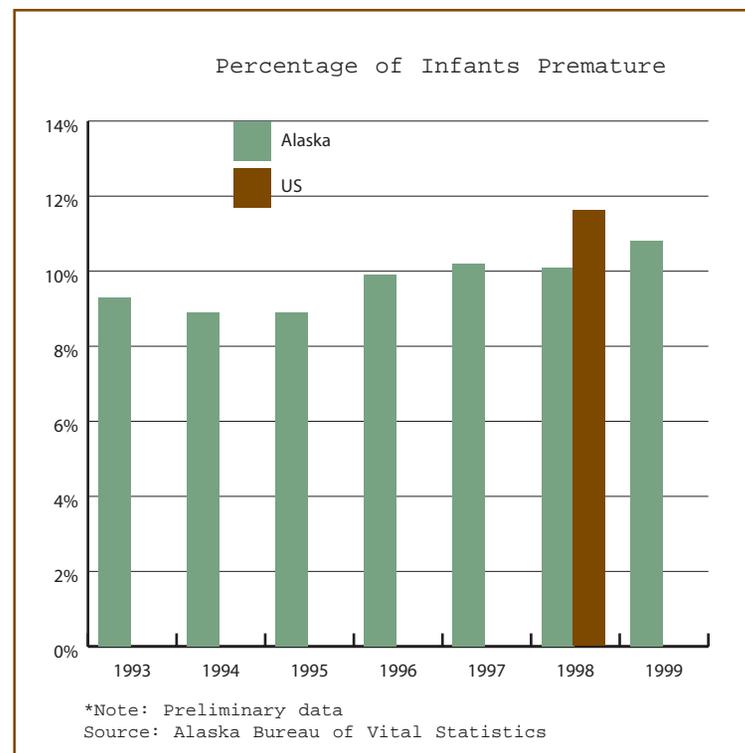
Figure H-2



### Premature infants

The percentage of premature births in Alaska has increased by 1 percent since 1996 although this percentage is still lower than the nationwide figure of 11.6 percent (Figure H-3). The relative difference in the number of premature births in 1996 and 1999 is less than 10 percent. Premature birth and related low birth weight increase the risk of an infant's developing a mental disorder and/or experiencing problems in social development. Pre-term birth is associated with environmental

Figure H-3



risk including use of alcohol, tobacco, and other drugs during pregnancy.

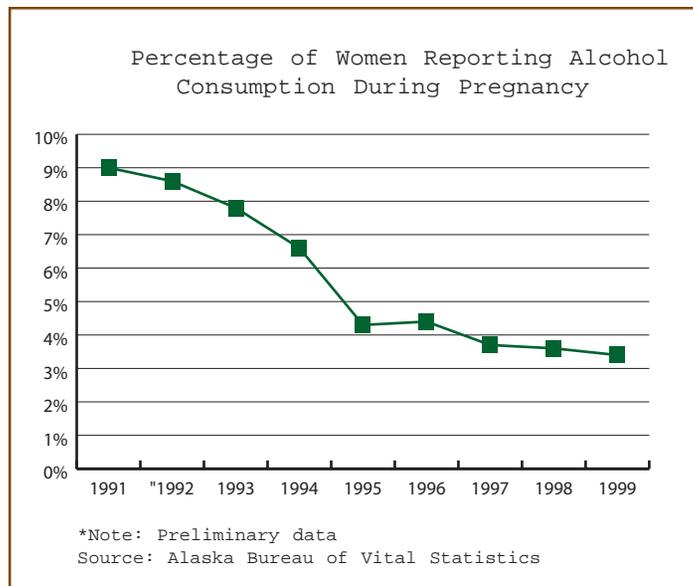
### Alcohol during pregnancy

One of the most significant and preventable risks to unborn children is the use of alcohol or other drugs during pregnancy. A parent's substance use can cause low birth weight, growth abnormalities, developmental disabilities, fetal alcohol syndrome (FAS), and fetal death. To compare the

## The Plan - 2001

prevalence of the problem in Alaska with that in other states is difficult because of differences in the way various states gather information. Alaska's FAS prevalence rate is estimated at 1.0 to 1.4 births per 1,000.<sup>4</sup> This is at least double the national rate of .1 to .7 per 1,000 births. Alaska Bureau of Vital Statistics birth data indicates a 5 percent decrease in reported alcohol use between 1991 and 1999 (Figure H-4). This is a relative drop of 61 percent between 1991 and 1999. However, the data may not reflect a real change in

Figure H-4



behavior so much as a growing reluctance to report consumption because of social disapproval of alcohol use during pregnancy.

### Strategies

1. Maintain Denali Kid Care program.\*
2. Continue to research effectiveness of and expand access to programs designed to prevent disabling conditions and provide support to high-risk families.
3. Eliminate the Infant Learning Program\*\* wait list and expand service capacity to assure available services.
4. Provide training to help early intervention workers and child care providers work more effectively with children who have behavioral health problems.
5. Expand screening, referral, and service capacity to provide behavioral health care services for young children, including infants and toddlers.
6. Support training to enable health care providers to regularly screen for alcohol, tobacco, and other drug use disorders in women of reproductive age, especially during pregnancy and lactation.

\* Initiated in March of 1999, Denali KidCare is part of the governor's Smart Start for Alaska's Children. The legislature incorporated the federal Children's Health Insurance Program (CHIP) into state law as Denali KidCare, an expansion of Medicaid. The program covers the costs of prenatal care and delivery to families with an income of up to 200 percent of poverty.

\*\*The Infant Learning program is an early intervention program designed to mitigate long-term impacts of developmental delays and other health conditions.

7. Eliminate waiting lists for alcohol and other drug treatment programs and increase the availability of mental health treatment for women and children.

## Alcohol and Other Drugs

*Goal: To reduce the abusive use of alcohol and other drugs to protect Alaskans' health, safety, and quality of life.*

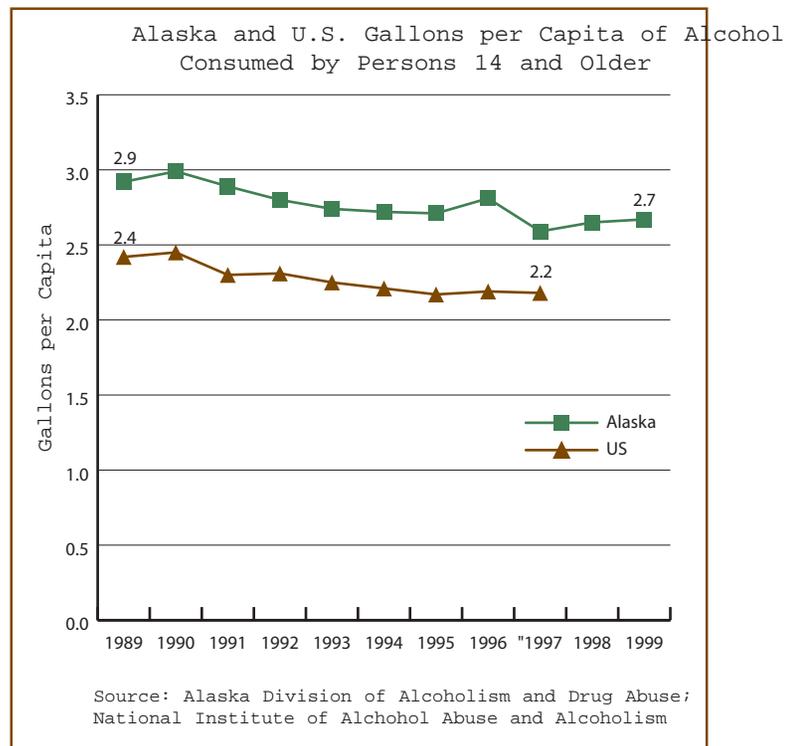
Alcoholism is epidemic in Alaska. Historically and currently, the abuse of alcohol is pervasive within our communities and families. The social cost of alcohol abuse is seen in rates of related injuries, chronic disease, and deaths. National research indicates substance abuse is implicated in 70 percent of all cases of child abuse and that 80 percent of the men and women behind bars are there because of drug or alcohol related crime.\*

According to data gathered between 1991-1993, when compared with other states, Alaska ranked first in the number of deaths with alcohol involvement, second in the percentage of residents who are chronic drinkers, and fifth in the nation for severity of alcohol problems.\*\* More recent national data indicates little change. In 1999, with 7.3 percent of its 12-and-older population considered dependent

on alcohol and/or illicit drugs, Alaska again had the highest percentage of people with addiction disorders in the nation.<sup>5</sup>

### Indicators

Figure H-5



### Per capita alcohol consumption

Alcohol consumption rates reflect the prevalence and severity of alcohol related problems. There is some good news. Nationally, per-capita alcohol consumption decreased by

\* National Center on Addiction and Substance Abuse at Columbia University, <http://www.casacolumbia.org>

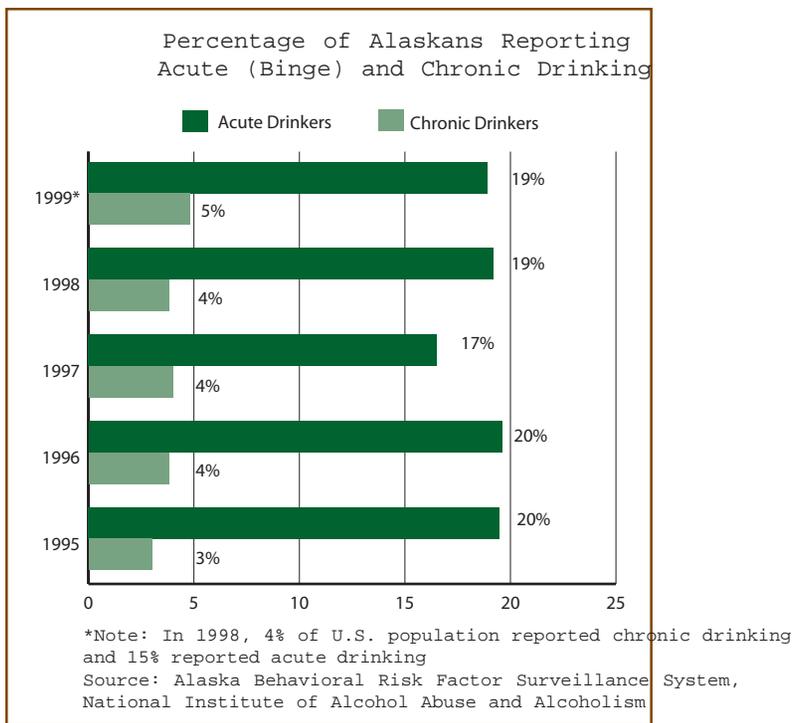
\*\* The Alcohol Problem Index is based on deaths with explicit mention of alcohol, drunken driving arrests, and alcohol-only clients.

# The Plan - 2001

about 9 percent between 1989 and 1999.<sup>6</sup> Over the past ten years in Alaska, the consumption rate also slightly declined (Figure H-5). But consumption in Alaska remains higher than in the rest of the nation. There is some speculation that our high consumption rates may, in part, reflect the ever-expanding number of summer visitors.

## Acute and chronic drinking

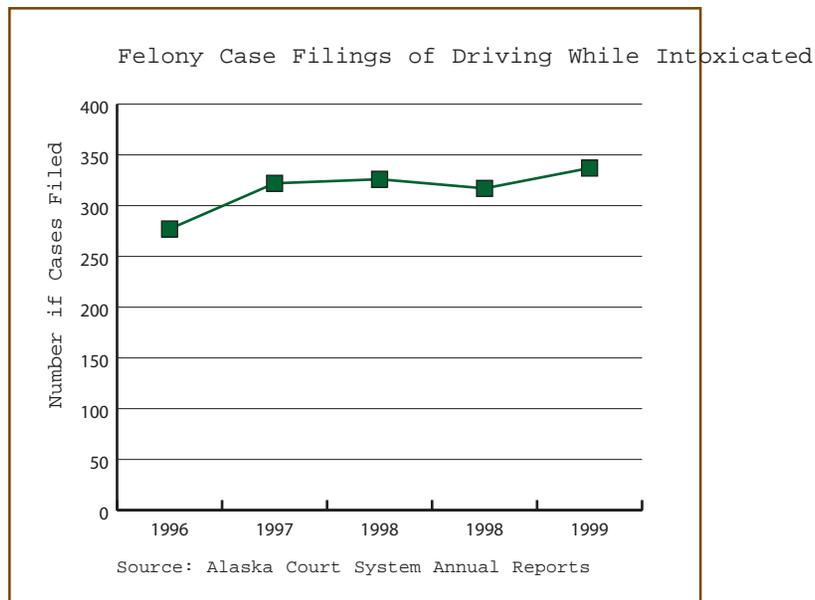
Figure H-6



Another indication of the pervasiveness of alcohol abuse is the percentage of Alaskans who report acute (binge) and chronic drinking. The percentage of Alaskans identified as acute drinkers dropped slightly between 1995 and 1999; however, the percentage of chronic drinkers increased (Figure H-6). Nationally, in 1998, 16.6 percent of adults reported acute or binge drinking as compared with 19.2 percent of Alaskan adults.<sup>7</sup> In 1999, the reported proportion of acute drinkers in Alaska (19 percent) was four percentage points higher than the national median of 15 percent.\*

## Number of driving while intoxicated felony case filings

Figure H-7



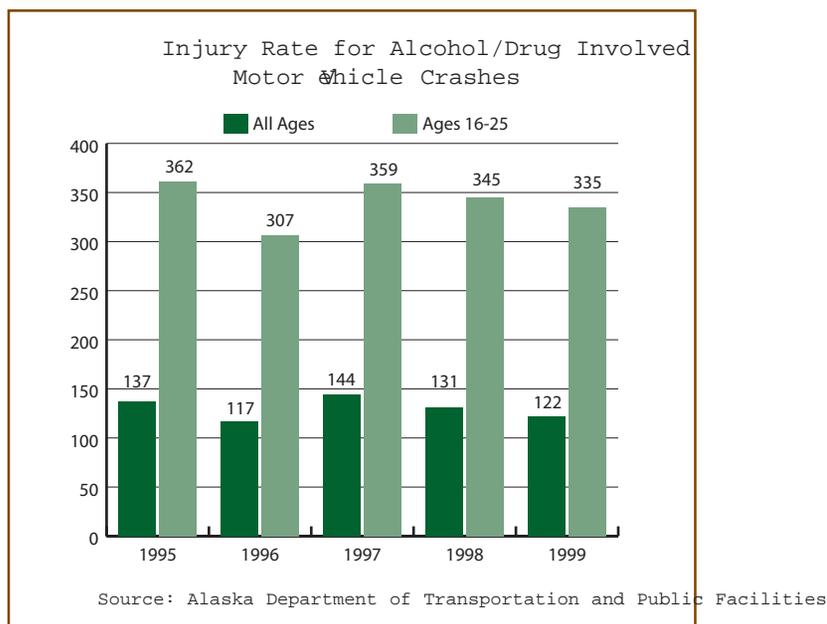
\* Data is from the Alaska Behavioral Risk Factor Survey, an annual telephone survey administered nationally. Acute or binge drinking is defined as drinking five or more drinks on one occasion within a 30-day period. Chronic drinking is defined as drinking an average of 60 or more alcohol drinks in the month preceding the survey.

The number of felony court filings for the crime of Driving While Intoxicated (DWI) has gradually increased over the past five years (Figure H-7). A defendant is charged with a felony when he or she has had three DWI convictions within a five-year period. Therefore, these filings represent repeat offenders. An increase in filings may reflect better law enforcement. It may also indicate an increase in public safety as DWI drivers are taken off the roads.

### Motor vehicle injury and death rates

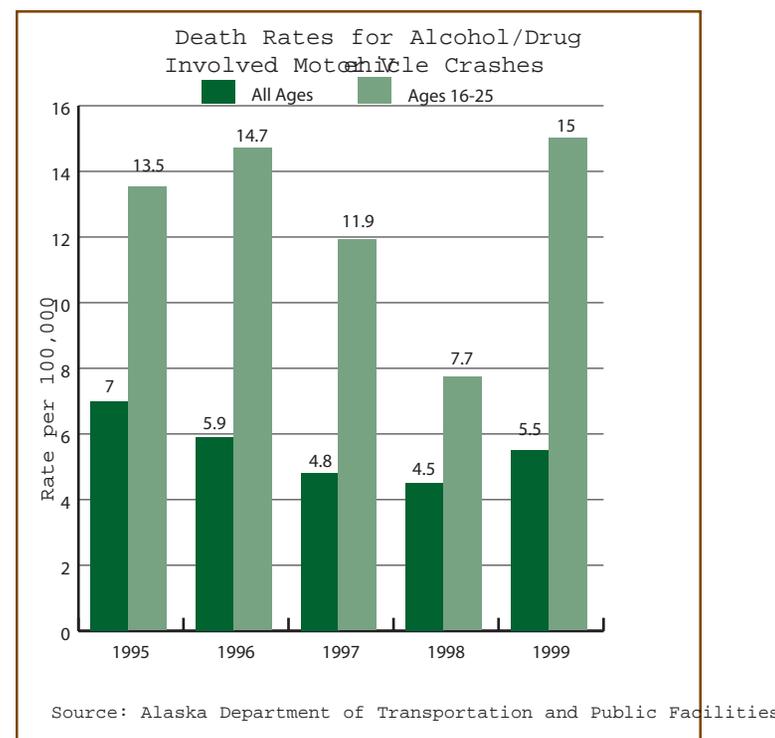
A dramatic example of the negative impact of alcohol and drugs is the number of traffic accidents in which alcohol is

Figure H-8



involved. In 1999, alcohol was implicated in 38 percent of all fatal traffic accidents and seven percent of all vehicle crashes in the nation.\* In Alaska, seven percent of all traffic accidents and 44 percent of all traffic fatalities occurred in alcohol related vehicle crashes.<sup>8</sup> The rate of injury and death and the proportionately high number of youth injured and killed in alcohol/drug involved accidents is alarming (Figures H-8 and

Figure H-9



\*The National Highway Traffic Safety Administration defines a fatal traffic crash as being alcohol related if either a driver or a pedestrian had a blood alcohol concentration of 0.01 grams per deciliter or greater.

<sup>8</sup>Motor vehicle crashes include traditional highway vehicles, pedestrians, pedecyclists, all-terrain vehicles, snowmachines, and motorcyclists.

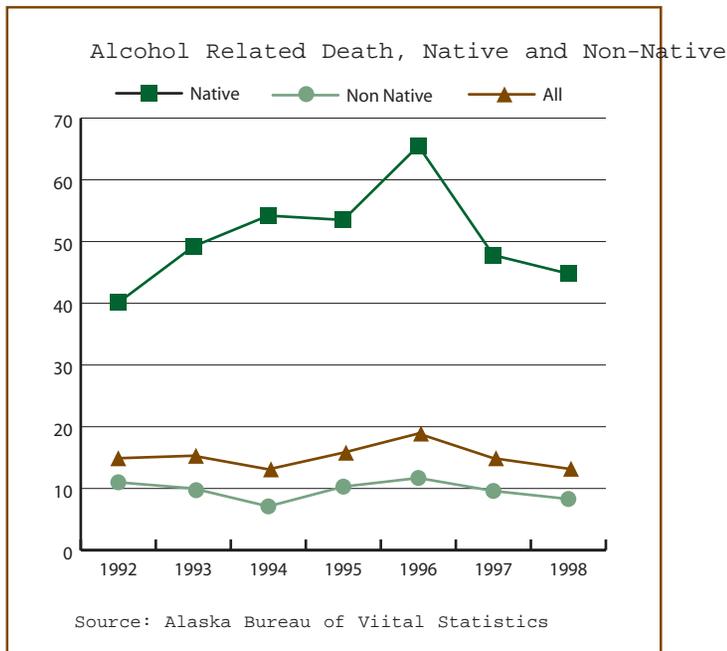
# The Plan - 2001

H-9). \*\* The rate of youth killed in alcohol/drug involved vehicle accidents almost doubled between 1998 and 1999 (Figure H-9).

## Alcohol related deaths

When death from alcohol related disease and injury are combined, the death rate per 100,000 population in Alaska rises to more than 13.2, making alcohol use the seventh leading cause of death in 1998. Between 1996 and 1998, however, the trend line dipped (Figure H-10).\* The number of Alaska Native deaths attributable to alcohol is substantially greater than the number of non-Native deaths. The alcohol-related death rate in 1998 for Alaska Natives was

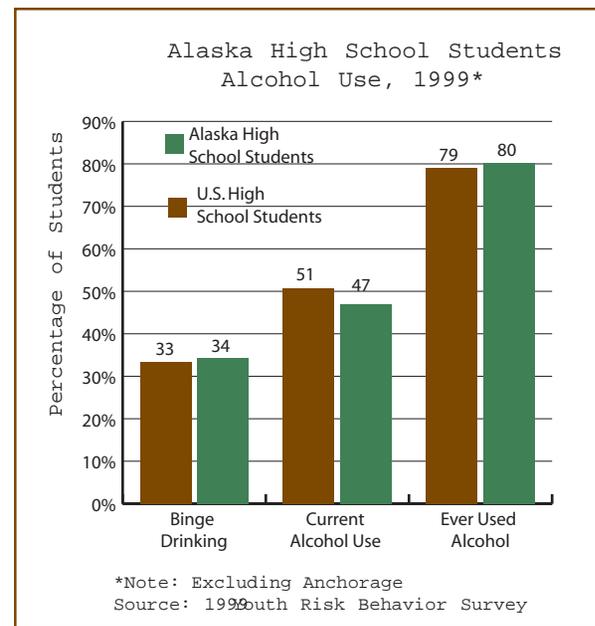
Figure H-10



\*Alcohol deaths are defined as those with ICD 9 codes 291, 303, 305.0, 357.5, 535.3, 790.3, 425.5, 571.0-571.3, and E860.

\*\*The Alaska Youth Risk Behavior Study provides descriptive data for students attending school outside the Anchorage school district. The high school results were weighted and prevalence estimated for students enrolled in eligible schools. The survey does not include correspondence, home study, alternative, and correctional schools.

Figure H-11



44.8 per 100,000 population. Although this rate has dropped from a high of 65.5 in 1995, it still is 5.5 times higher than the rate for non-Native Alaskans.

## Alcohol use among high school students

The Alaska Division of Public Health administered the Alaska Youth Risk Behavior Survey in 1999.\*\* The survey gathered information regarding the depth of the alcohol and drug abuse problem among adolescents who live outside the Anchorage school district. Results can be cautiously compared to the results of the national Youth Risk Behavior

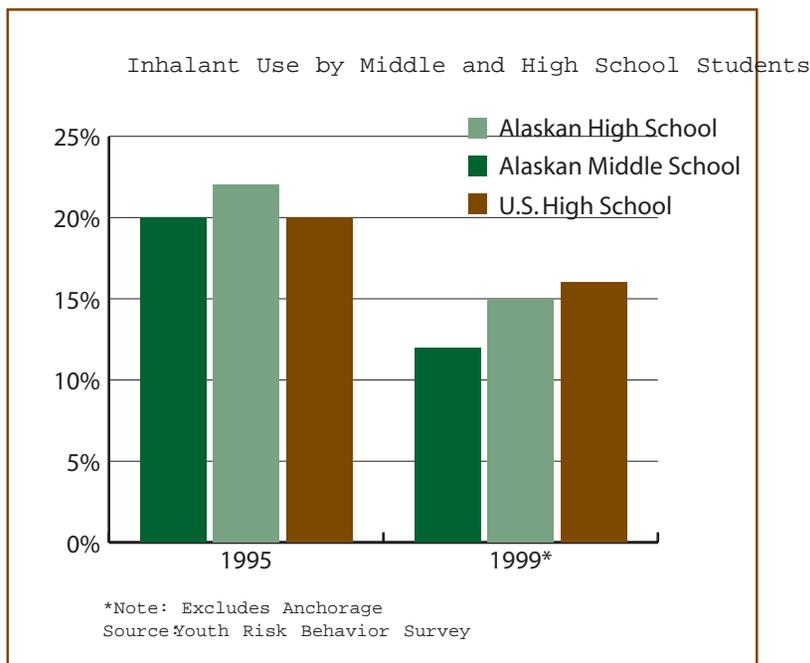
Survey conducted in 1997. The Alaska high school use closely matches the percentages in the US student population overall. More than one third of students surveyed engaged in binge drinking and almost half of these students consumed some alcohol during the month prior to the survey (Figure H-11).

### Inhalant use among middle school and high school students

Inhalants are primarily used by children. Inhalants cause permanent damage to the brain, heart, kidneys, and liver, and can cause death. Inhalants abuse is reported to reach its

peak during seventh through ninth grades.<sup>9</sup> According to the Youth Risk Behavior Survey, the most common drugs used by high school students in Alaska (excluding Anchorage) are marijuana and inhalants (glues, paints, and sprays). In 1995, 22 percent of Alaska high school students reported that they had sniffed an inhalant to get high (Figure H-12). This percentage dropped by seven percent in 1999. But this change should be viewed with skepticism because it may be the result of a change in the sample. Anchorage was not part of the 1999 survey. However, inhalant abuse continues to be a problem. The Yukon-Kuskokwim Health Corporation recently opened the only inhalant treatment program in Alaska.

Figure H-12



### Strategies

1. In partnership with the Department of Education and Early Development, local school districts, the Alaska Association of School Boards, and advocacy agencies support age-appropriate education and skill building to prevent substance abuse by preschool and public school students.
2. Support the Alaska Native wellness (sobriety) movement and the implementation of local option laws.
3. Advocate for an alcohol tax increase to reduce alcohol consumption and raise revenue for treatment programs.
4. Provide a mechanism for the Divisions of Public Health,

Public Assistance, Juvenile Justice, and Family and Youth Services to provide substance abuse and mental health screening for adults and youth served by their programs.

5. Restore and stabilize statewide funding for early intervention programs such as the Alcohol Safety Action Program.\*

6. Work toward implementing a juvenile safety action program that provides appropriate screening and follow-up for minors cited for underage drinking or driving while intoxicated.

7. Support and promote collaborative efforts between the judicial, correctional, and social service systems, such as therapeutic courts.

8. Eliminate the waiting list for people seeking outpatient and inpatient alcohol and other drug treatment.

9. Encourage implementation of best practices in treatment programs targeting pregnant women, women with children, adolescents, people with co-occurring mental health and substance use disorders, older Alaskans, people with developmental or other disabilities, and inmates in correctional facilities.

10. Expand the capacity of culturally relevant substance abuse prevention, early intervention, treatment, and after-care programs in both rural and urban areas.

11. Encourage comprehensive alcohol and other drug treatment services that address the needs of the whole person through a continuum of care including appropriate after-care.

## Suicide

---

*Goal: To reduce the number of suicides in Alaska.*

Suicides and suicide attempts occur in Alaska with unusually high frequencies. All Alaskans are affected — male, female, Alaska Native, non-Native, rural, and urban residents. Suicide tends to occur among people who have experienced stressful life events and physical illness. It is a symptom of major depressive disorders and is common among people with severe psychotic symptoms and co-occurring mental and addictive disorders.\*\* Between 1990 and 1998, more than 180 Alaskan communities were affected by suicide, with at least one suicide occurring in 50-60 communities each year. Surviving friends and loved ones suffer from the traumatic emotional effect of suicide. The impact is even greater in small villages because of the face-to-face nature of social relations and strong traditional values of interdependence. Everyone in the community is affected emotionally, physically, socially, politically, economically, and spiritually. Suicide attempts, like completed suicides, reflect the poor mental health of individuals and communities.

\* The Alcohol Safety Action Program coordinates the state-wide court ordered misdemeanor addiction treatment services, provides case management and operates as a neutral link between the justice system and the treatment delivery system.

\*\* All Alaskans who have committed or attempted suicide are considered to be or to have been Alaska Mental Health Trust Beneficiaries as defined in AS 47.30.056.

Indicators

Alaska's suicide death rate compared to other states

Suicide was the fifth leading cause of death in the state and the ninth leading cause of death in the nation. Alaska averages 130 suicide deaths per year. Alaska had a rate of 21.5 suicide deaths per 100,000 population in 1998. Nevada, with a rate of 23 deaths per 100,000 population, is the only state with a suicide death rate higher than Alaska (Figure

H-13). Nationally, the growing alarm regarding suicide motivated the Surgeon General to introduce a public health blueprint for addressing suicide.<sup>10</sup> An important blueprint recommendation is for prevention activities to address undetected and under-treated mental and substance use disorders, primary risk factors associated with suicide.

Figure H-13

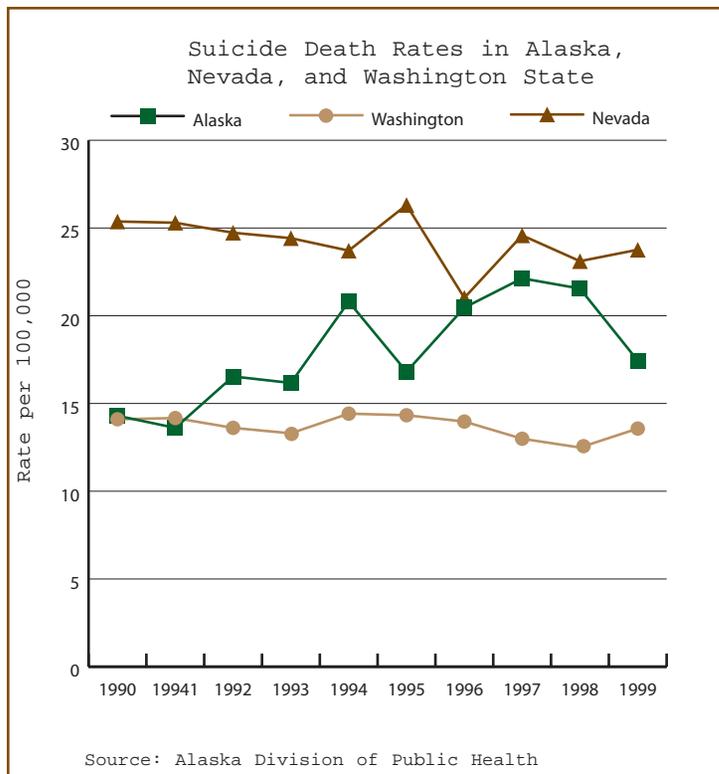
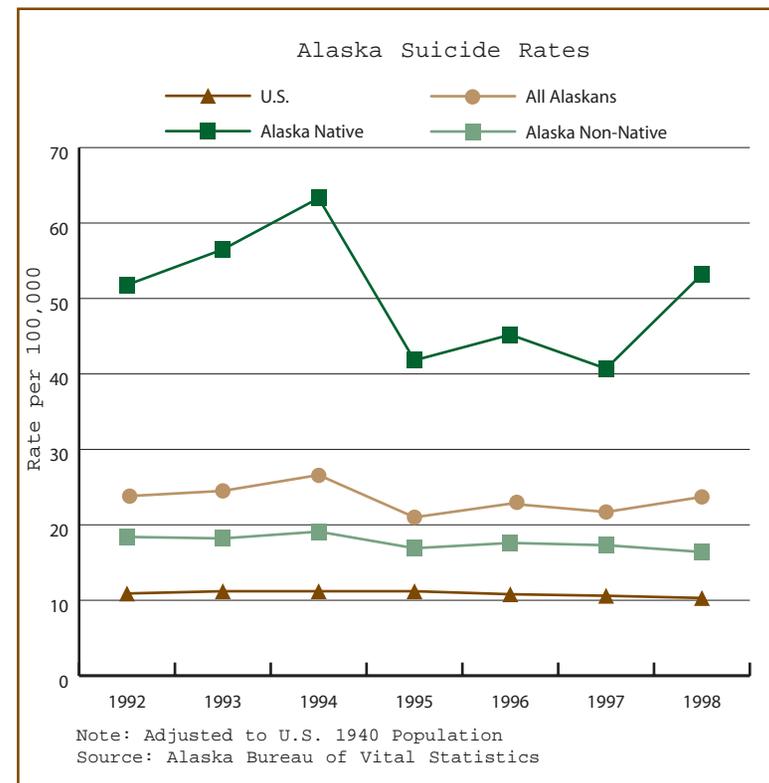


Figure H-14



# The Plan - 2001

## Age adjusted Alaska suicide rates

Suicide rates in Alaska are twice those for the United States as a whole (Figure H-14). Alaska Native males between the ages 15 and 39 are at the greatest risk. From 1992 through 1998, the all-Alaskan rate remained at levels twice the national average. In 1994, the Alaska Native suicide rate peaked at five times the national average. The Alaska Native rate declined in the late 1990s, but has remained consistently much higher than the rates for all of the other populations.

## Suicide rate of Alaskan youth

The suicide rate for young Alaskans is 37.8 deaths per 100,000 population – a rate almost four times greater than the

national rate (Figure H-15). More than one-fourth of all suicides were committed by youth between the ages of 15 and 24. Alaska Native men, at the rate of 210 suicides per 100,000 people, committed about half of these suicides during the most recent five-year period.<sup>11</sup> This translates into an average of 35 deaths per year.

## Suicide attempt rate per 100,000 population

Demographic patterns revealed in an analysis of suicide attempts underscore the need for prevention and early intervention focused on high-risk groups (Figure H-16). Only suicide attempts that resulted in hospital admission are included. Several patterns emerge to identify the groups at highest risk. First, the rate of suicide attempts is higher for females than males in every age group, regardless of race. Second, within both the male and female groups, Alaska Natives are at higher risk of suicide attempts than are non-Natives. Finally, while suicide attempts may occur in any age group, attempts are most common among youth and young adults between the ages of 10 and 39. Young female prevalence rates are substantially higher than male. Young Alaska Native women have the highest rate of suicide attempts. The highest rate among males occurs later, in the 20-29 age group.

Figure H-15

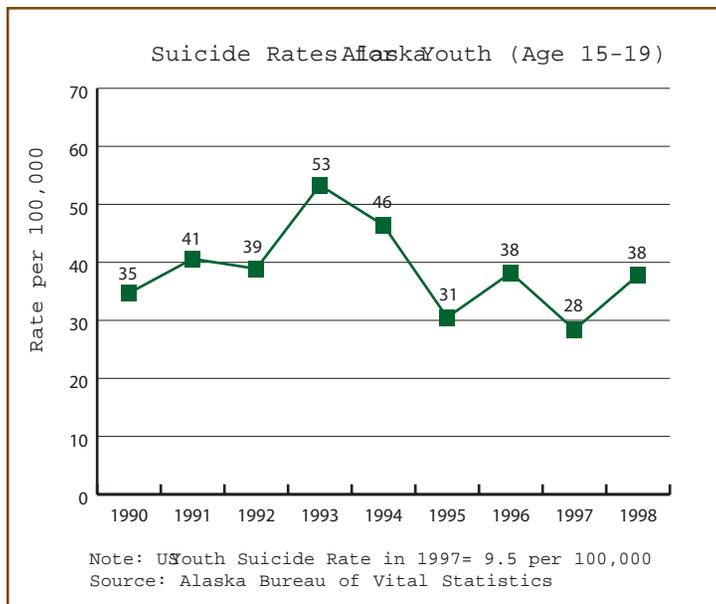
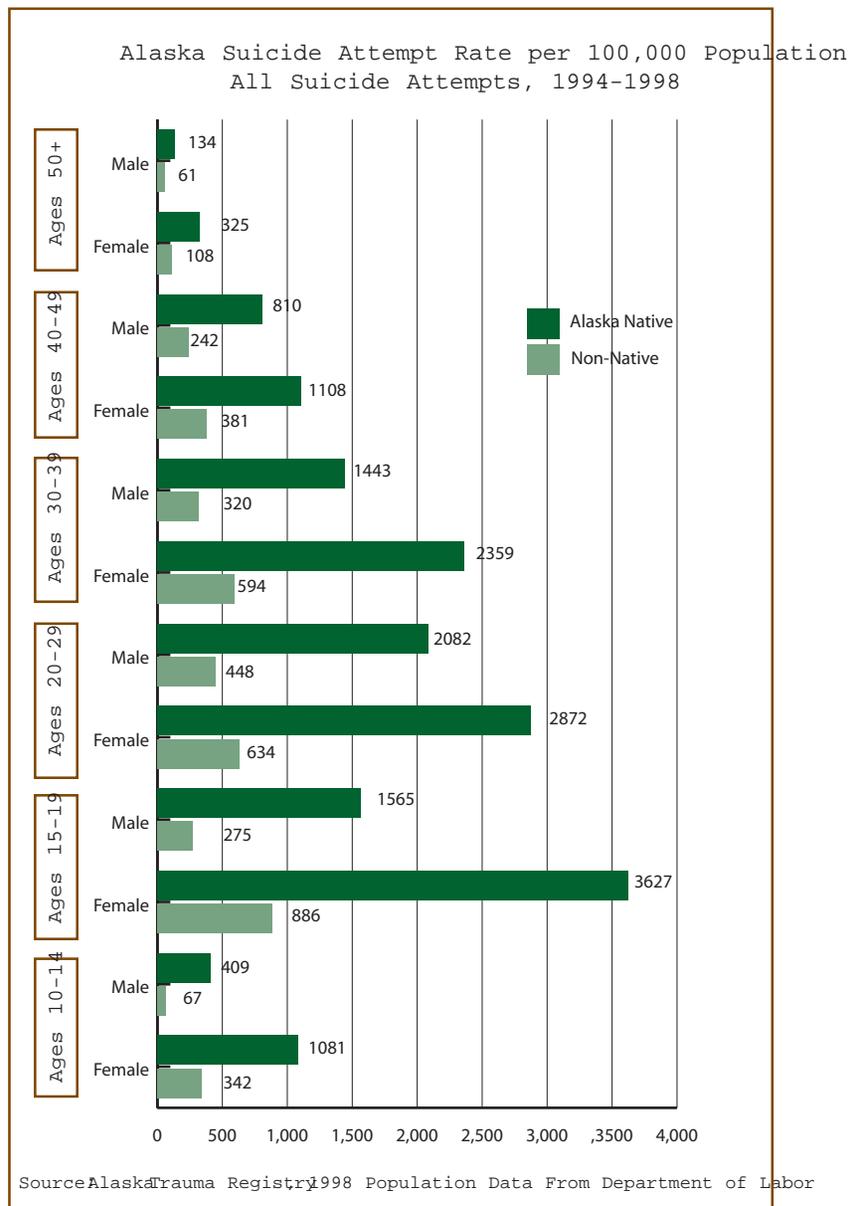


Figure H-16



Strategies

1. Support the statewide suicide prevention council in developing and implementing a statewide suicide prevention plan and in disseminating suicide-related research.
2. Improve the understanding of suicide issues and increase early intervention skills in the general population, especially those likely to come into contact with individuals at high risk.
3. Expand the Rural Human Services System Project and the Community-Based Suicide Prevention Program grants\* to reach more communities.
4. Support suicide research, particularly in association with the University of Alaska, including follow-back studies and comparative community studies to increase our understanding of the characteristics of individuals and communities most at risk.
5. Train health care and social services providers, law enforcement officers, and rural human service providers to use appropriate screening tools to identify and treat risk factors for suicide.
6. Ensure that emergency services are readily accessible throughout the state including, rural communities. Services should include procedures and protocols for identification, screening, and referral of adults and youth at risk of suicide.

\*The Rural Human Services System Program provides funds to human services agencies in rural Alaska to hire, train, supervise and support village-based counselors. Currently there are RHSSP trained counselors working in over 80 villages. The Community-Based Suicide Prevention Program provides grants to smaller communities to design and implement their own projects to reduce suicide and increase individual, family and community health.

7. Support training for emergency room staff and health aides on how to talk with parents of suicide attempters and advise them on creating a safer environment for their child.
  8. Support ongoing training of juvenile and adult correctional and jail personnel in identification of suicide risk, elimination of suicide means, and referral for treatment.
  9. Support public education efforts related to suicide means restriction and safe gun storage.
  10. Encourage the development of effective survivor networks.
  11. Promote development of community-wide crisis services for communities experiencing the consequences of suicide, especially rural communities.
  12. Support public school efforts to develop crisis response plans to deal with the impact of peer suicides and suicide attempts.
- 

### End Notes

<sup>1</sup> *About Mental Illness and Mental Health*, National Institute of Mental Health, <<http://www.nimh.nih.gov/strategic/abmental.cfm>>.

<sup>2</sup> *Mental Health: A Report of the Surgeon General*, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

<sup>3</sup> *Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Protection*, US Department of Health and Human Services, April 1999.

<sup>4</sup> "Fetal Alcohol Syndrome, Alaska's Number One Preventable Birth Defect," 2000 Status Update, in *Alaska's Response to Fetal Alcohol Syndrome*, Alaska Department of Health and Social Services, Office of FAS, Juneau, November 2000.

<sup>5</sup> *Summary of Findings from the 1999 National Household Survey on Drug Abuse, Department of Health and Human Services*, Substance Abuse and Mental Health Services, Office of Applied Studies, Rockville, August 2000.

<sup>6</sup> *1999 National Household Survey on Drug Abuse*.

<sup>7</sup> "Health Risks in Alaska among Adults," in *Alaska Behavioral Risk Factor Survey: 1998 Annual Report*, Department of Health and Social Services, Division of Public Health, Juneau, August 2000.

<sup>8</sup> *1999 Alaska Traffic Accidents*, Alaska Department of Transportation and Public Facilities, Division of Statewide Planning, Juneau, December 2000.

<sup>9</sup> "Substance Abuse Letter, An Independent Report on Prevention and Treatment Issues", Volume 6, Number 23, July 2000.

<sup>10</sup> *The Surgeon General's Call to Action to Prevent Suicide*, 1999, <<http://www.surgeongeneral.gov/library/calltoaction/calltoaction.htm>>.

<sup>11</sup> "Suicide in Alaska: A Walk through Data on Age, Sex and Race Group Statistics", Alaska Department of Health and Human Services, Division of Public Health, Juneau, March 15, 2001.

## Safety

Most people feel secure and live in safety. Not so those made vulnerable by mental illness or addiction. To protect all its citizens, Alaska enacted a set of laws collectively known as Title 47.\* Those laws were intended to ensure appropriate treatment for those incapacitated by mental illness or substance use disorders. However, in Alaska as across the United States, adequate treatment is not always available. “Our nation’s jails and prisons have become, by default, the psychiatric warehouses of the new millennium.”\*\*

One’s own family sometimes threatens personal safety. Family violence can cause permanent damage to the mental health of children exposed to it, whether as victims or witnesses. Physical abuse and psychological maltreatment of children results in insecure attachment to others and psychiatric disorders such as post-traumatic stress syndrome, conduct disorders, depression, delinquency, and impaired social and cognitive functioning.<sup>1</sup> Family violence is a major factor contributing to mental disorders and addiction among women. In addition, rates of elder abuse appear to be increasing and recent research indicates that in 90 percent of the cases, the perpetrator is a family member.<sup>2</sup>

Safe care is a public trust. When the public system steps in to help people to live in safety, the care and treatment provided must be appropriate and do no harm. Quality assurance, carefully conducted provider reviews, and consumer satisfaction surveys are among the ways of making sure that the appropriate standards are met.

The Comprehensive Plan Steering Committee identified three focus points related to Safety:

- ❖ Decriminalization
- ❖ Safe families
- ❖ Safe care

---

## Decriminalization

*Goal: To provide appropriate referral and treatment for mental illness and substance use disorders as an alternative to inappropriate incarceration.*

People with mental illness, substance use disorders, developmental disabilities, and other cognitive disorders need appropriate treatment. The legislature designed Title 47 commitment laws to protect incapacitated people from becoming victims and from hurting themselves or others. But as yet, no Alaskan community has services adequate to meet the needs of all those persons at risk. Lack of adequate community treatment frequently means that people who are mentally incapacitated due to psychiatric or substance abuse are placed in jail for their own protection.

The problem intensifies when people, as a result their illness, commit misdemeanors and become entangled in the criminal justice system. In the past, many of these people would have been sent to state hospitals. Now, these offenders are going by default into correctional facilities ill equipped to provide appropriate treatment or protective care. We know

\* Title 47 refers to Alaska Statutes AS. 47.37 Uniform Alcoholism and Intoxication Treatment Act, AS. 47.30, Mental Health subsections 670 - 725 concerning commitments.

\*\*Michael Faenze, NMHA, September 21, 2000

# The Plan - 2001

that nationally, the shift of persons with mental illness from psychiatric hospitals to correctional facilities has reached crisis proportions.<sup>3</sup>

## Indicators

### Title 47 non-criminal holds in community jails

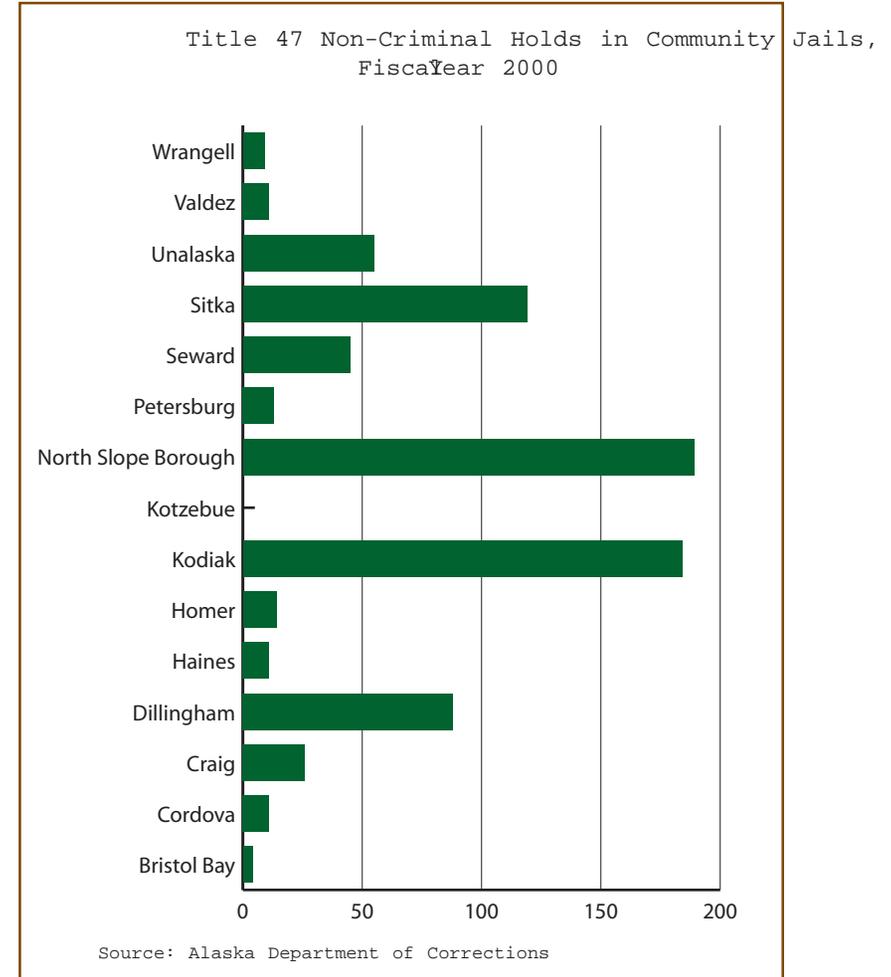
Under Title 47, people who have not been charged with a crime but who are under the state’s protective custody may be temporarily placed in a correctional facility or local jail. There are two kinds of non-criminal holds. One is for mental health emergencies<sup>4</sup> and the other for persons incapacitated by intoxication.<sup>5</sup> The majority (89 percent) of non-criminal holds in community jails are due to intoxication. Intoxicated individuals can be taken into protective custody at state or municipal detention facilities for up to 12 hours or until an appropriate treatment facility is available. Likewise, in mental health emergencies, a person may be placed in a jail or other correctional facility while awaiting a psychiatric evaluation or transportation to a treatment facility.

When used appropriately in combination with access to treatment facilities, Title 47 laws can be effective and keep incapacitated people safe. However, the number of non-criminal holds reflects a problem with access to appropriate treatment facilities. In fiscal year 2000, people were held in community jails under the Title 47 non-criminal holds on 779 occasions (Figure S-1) in 15 communities\*.

### Title 47 non-criminal holds in selected criminal

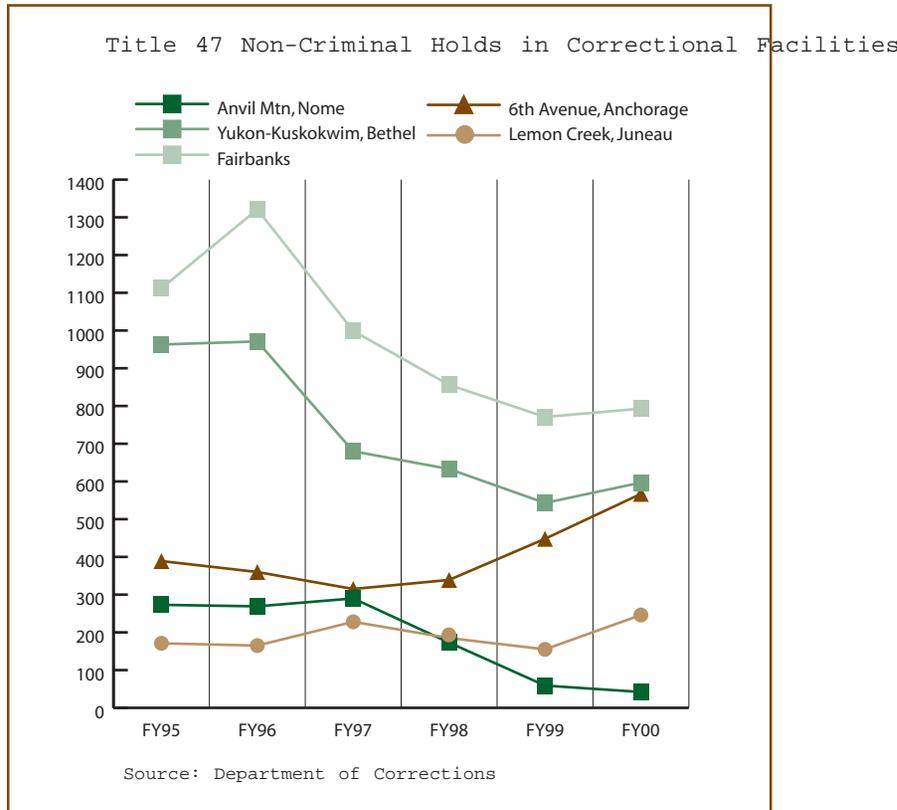
This number is only a fourth of the statewide total of more than 3,100. In the same year, 2,322 people needing protective custody were placed in Department of Corrections facilities.

Figure S-1



\* Community jails, once called contract jails, are operated by local government with some funding from the Department of Corrections. There are 15 of these jails. There are also locally funded and operated jails that accept non-criminal holds. These are not included in this count.

Figure S-2



facilities

The total number of Title 47 non-criminal holds in Fairbanks, Bethel, and Anvil Mountain (in Nome) has dropped 39 percent, from 2,348 in 1995 to 1,432 in 2000 (Figure S-2). During this same period, holds at Lemon Creek in Juneau and the Anchorage Sixth Avenue Correctional Center almost doubled. The decrease in holds may be the result of local

agencies such as police, hospitals, and treatment facilities working together intensively to increase appropriate placement of people in protective custody. It appears this cooperative effort paid off. For example, in Fairbanks in fiscal year 1996, there were 1,321 non-criminal holds. In fiscal year 2000, the number dropped to 793.<sup>6</sup>

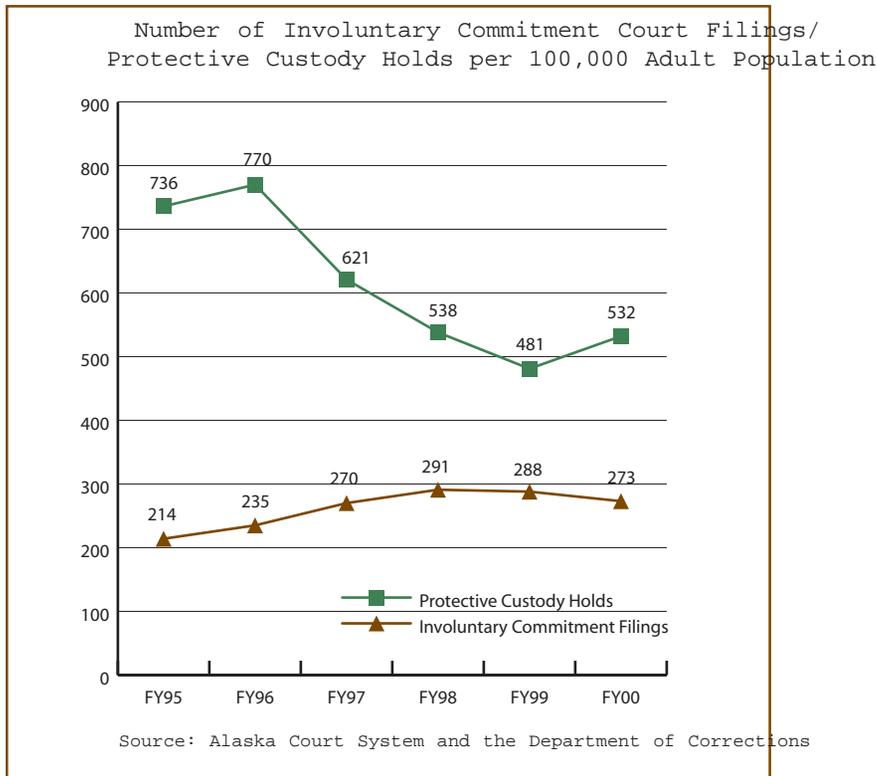
Rates of Title 47 commitment filings and non-criminal holds per 100,000 adult population

Title 47 involuntary commitment requires an individual to receive treatment.<sup>7</sup> This is not true for non-criminal holds. People who are placed in criminal facilities as non-criminal holds are often released without treatment only to be picked up and held again. In an effort to solve the problem of the revolving door for people with addictions, the Advisory Board on Alcoholism and Drug Abuse urged treatment providers to commit clients picked up repeatedly as non-criminal holds. Between fiscal years 1996 and 1999 (Figure S-3, the rate of involuntary commitments (both alcohol-related and psychiatric) increased by 22 percent, and the rate of non-criminal holds decreased by 38 percent. The increase in commitments and decrease in holds coincides with a substance abuse provider education effort on use of Title 47 statutes for alcohol commitments. The Advisory Board on Alcoholism and Drug Abuse notes that as “treatment programs work with communities to provide more appropriate services and timely interventions, the number of protective custody holds decreases.”<sup>8</sup> However, the number of non-criminal holds appears to, once again, be on the rise.

Percentage of inmates in Department of Corrections

# The Plan - 2001

Figure S-3

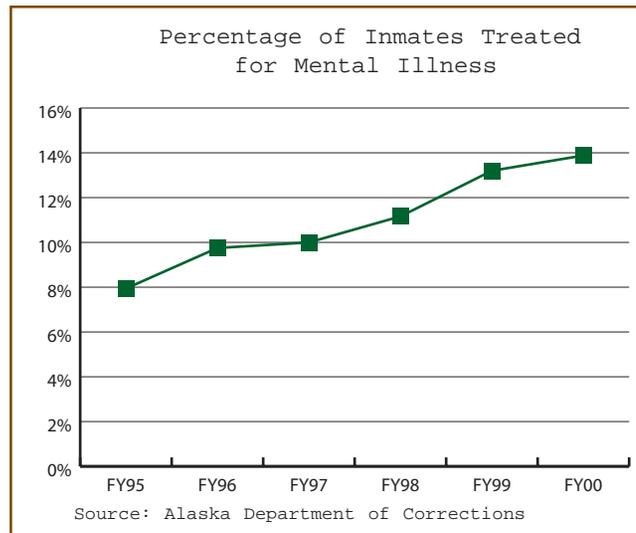


## institutions treated for mental illness

The Department of Corrections (DOC) houses a substantial number of people with mental or cognitive disabilities and substance use disorders. Although only a small proportion of inmates with mental or cognitive disabilities and substance use disorders actually receive treatment, the percentage of these inmates who receive some treatment is increasing (Figure S- 4).

The number of people in the Department of Corrections who experience mental illness or substance use disorders shows the gaps in Alaskan’s system of behavioral health care. Many of those arrested are homeless or incapacitated by psychiatric illness or alcohol. An information system initiated two years ago has provided the first full year of data on people incarcer-

Figure S-4



ated with serious mental illness and served by the Corrections Mental Health staff. In fiscal year 2000, DOC Mental Health staff served 2,556 inmates with serious mental illness. Of this population, at the time of arrest, 22 percent were homeless, 20 percent had stopped taking their medication before their crime, and 17 percent were suicidal. Other grim statistics tell us that 68 percent were intoxicated during their crime; 77 percent had a co-occurring substance use disorder, 19 percent a history of special education, and 16 percent a below average

IQ. In addition, 30 percent had prior psychiatric hospitalization and 28 percent had attempted suicide.<sup>9</sup>

People with psychiatric disabilities and/or substance use disorders are often incarcerated because of crimes resulting from their illness. Treatment and services are limited to those in crisis. In 1997, DOC conducted a study to determine the prevalence rates for inmates with mental illness, developmental disabilities, substance use disorders, or age related dementia. Results indicated that on January 15, 1997, 37 percent of the inmates in institutions were either mentally ill, chronic alcoholics, and/or developmentally disabled.<sup>10</sup>

### *Strategies*

1. Replace the aging Alaska Psychiatric Institute with a psychiatric hospital that has an improved therapeutic environment, expand community designated evaluation and treatment hospital alternatives for emergency psychiatric care, and strengthen community services to prevent inappropriate hospitalization and/or incarceration.

2. Increase the availability of emergency service for people incapacitated by alcohol or other drug abuse including emergency service patrols, detoxification, and enhanced detoxification.

3. Support construction of health clinics that include space

for comprehensive behavioral health care through the Denali Commission.

4. Continue to explore ways to use technology to access such services as telepsychiatry and computer assessments.

5. Ensure appropriate protective intervention for people incapacitated due to psychiatric illness or substance use disorders through continuing education and training for public safety personnel, health care providers, mental health clinicians, and chemical dependency treatment professionals.

6. Work with the Alaska Court System and the Department of Corrections to expand the therapeutic court model for alcohol and other drug addicted offenders to other communities based on the results of the pilot program in the communities of Anchorage and Bethel, including the development of complementary behavioral health services.

7. Continue to support Court Coordinated Resources (Mental Health Court) and Jail Alternative Services (JAS) projects designed to divert non-violent, low risk, mentally and developmentally disabled misdemeanants from jail into behavioral health treatment by providing appropriate and accessible programs and services.

8. Support efforts to have juvenile offenders with behavioral disorders diverted into treatment as a sentencing option, and provide appropriate and accessible services.

9. Support the efforts of the Department of Corrections to provide appropriate care for people with mental, cognitive, and/or substance use disorders who are incarcerated.
10. Ensure that juvenile offenders with behavioral disorders receive appropriate treatment within juvenile correctional facilities.
11. Review Alaska's laws regarding outpatient commitment to determine whether these laws should be modified to enhance safety and encourage consumer participation in community based treatment.
12. Support efforts to screen repeat offenders for cognitive, substance use, or mental disorders that may contribute to recidivism in the criminal justice system.

---

### Safe Families

*Goal: To protect children and vulnerable adults from abuse, neglect, and exploitation.*

To most people, the word "family" is synonymous with trust and security. That may be why for many years, family violence was considered a private matter. Today, family violence is recognized as a public health problem and a commu-

nity responsibility. Recent research links family violence to developmental delays, behavioral disorders, juvenile crime, and substance abuse.<sup>11</sup> Research in Alaska revealed that 50 percent of long-term prison inmates reported some form of physical abuse from a family member.<sup>12</sup> Because definitions and reporting standards vary from state to state, it is hard to compare the data on child abuse. However, in 1996, Alaska reported the highest rate in the nation (41 of 1,000 children) with substantiated or indicated reports of child abuse or neglect.\* Alaska also showed the highest percentage (92 percent) of those children with substantiated reports.

Domestic violence and sexual assault also are significant problems in our state. As with child abuse data, the reporting of national and state-specific data on domestic violence and sexual assault has not been standardized. We do know that in fiscal year 2000, approximately 2 percent of the total state population received services directly related to domestic violence and sexual assault. We also know that Alaska ranks first in the nation for sexual assault with a rate of 68.6 rapes per 100,000 residents in 1998.<sup>13</sup>

Disabled and elderly people are more vulnerable than others to abuse. Often, the frail elderly become victims of family violence. A national study completed in 1998 confirmed the seriousness of the elder abuse problem in domestic settings.<sup>14</sup> The study also revealed that women are abused at a higher rate than men and that the oldest people (over 80 years of age) are abused at two or three times their proportion in the elderly population. In nine out of ten cases, the perpetrator was a family member.

---

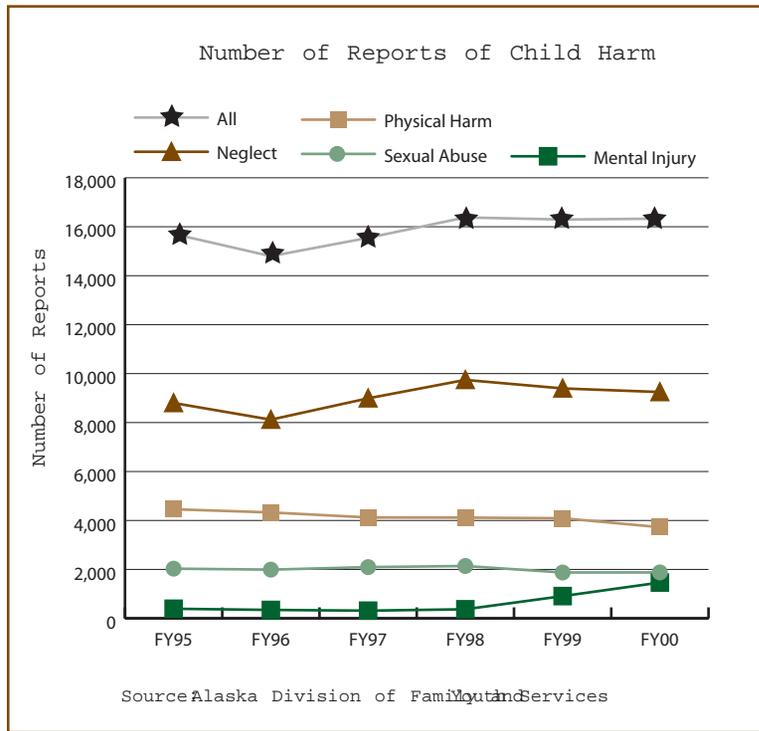
\* Child reports of harm and reports of domestic violence are not consistent between states because of different state definitions and standards. For example in Alaska the child reports of harm numbers include all investigated reports. In other states, the report number may only include those cases found to be substantiated. In this instance, Alaska's numbers would be larger.

Indicators

Number of reports of child harm

Overall, the total number of reports of harm has remained relatively constant during the past three years following a steady rise of approximately 5 percent from fiscal year 1996 through fiscal year 1998 (Figure S-5). Over this same period, the number of reports of neglect, physical harm, and sexual abuse have decreased or remained stable. This is

Figure S-5

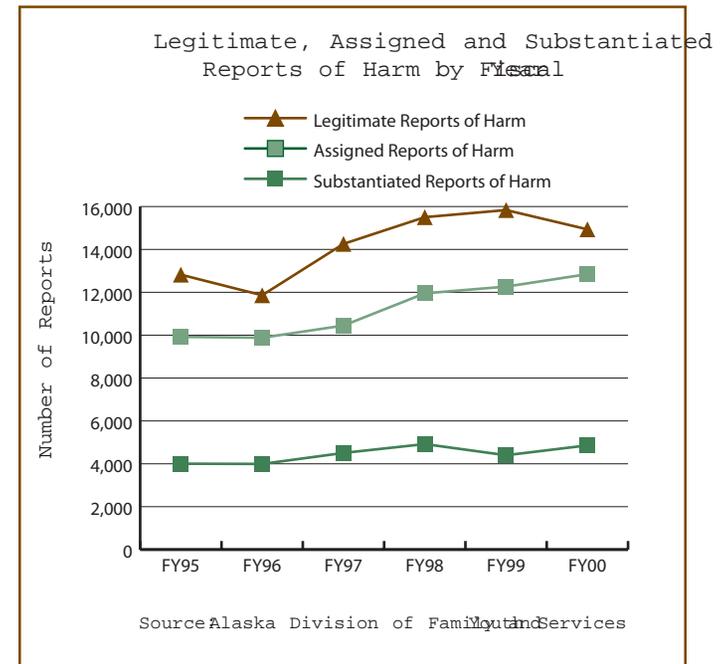


good news. However, the number of reports of mental injury has gone from 372 to 1463, almost quadrupling since fiscal year 1998.\* This increase may be attributable to the 1998 state law change that more clearly defines what constitutes mental injury.<sup>15</sup>

Number of reports and investigation results, fiscal years 1995-2000

The number of legitimate reports of harm dropped by 6 percent between fiscal years 1999 and 2000 (Figure S-6).\*\* At the same time, Alaska was working hard to increase social worker response to legitimate reports. The number of

Figure S-6



\* The Child Welfare League of America defines child abuse and neglect as any recent act or failure to act on the part of a parent or caretaker that results in death, serious physical or emotional harm, sexual abuse or exploitation, or presents an imminent risk of serious harm to a child under 18.

\*\* Although the total number of all reports has remained fairly stable during the past three years (Figure S-5), the number of legitimate reports has decreased by 5.6 percent from 15,835 to 14,937.

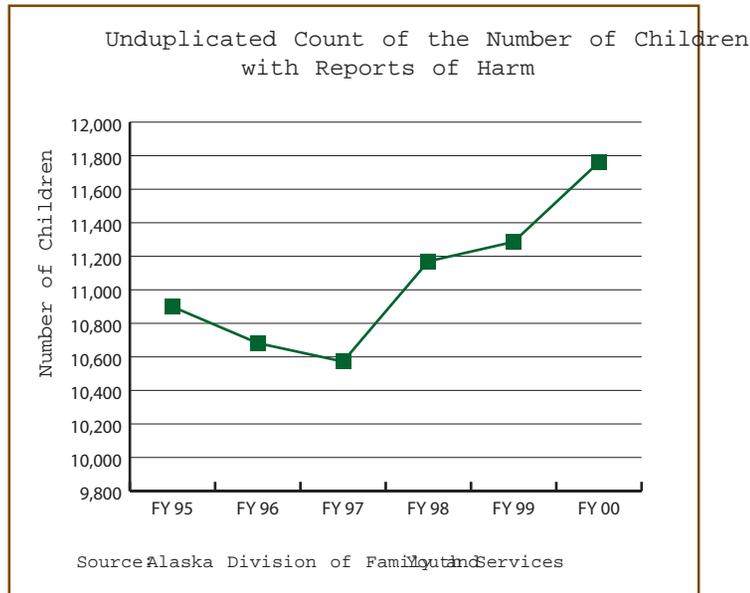
# The Plan - 2001

reports assigned increased by 5 percent and the number of reports substantiated increased by 10 percent. One possible reason for the decrease in reports may be that due to the swifter response by the Division of Family and Youth Services, there are fewer multiple reports for the same families.

## Number of children with reports of harm

The number of children who are the subjects of reports of harm has steadily increased since 1997 from 10,572 to 11,761 children in 2000 (Figure S-7). This is an 11 percent increase at a time when the state population of children decreased by 1.3 percent.\*

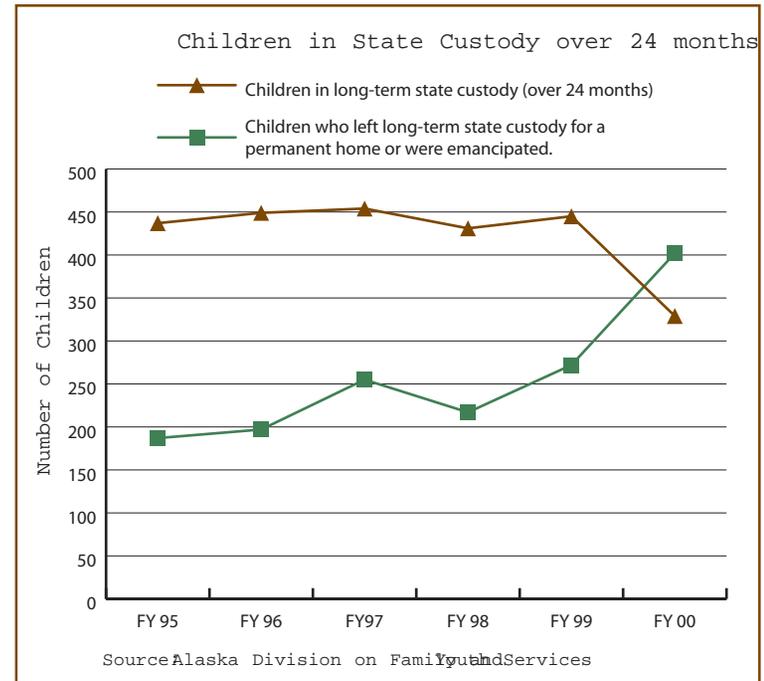
Figure S-7



## Number of children in long-term state custody permanently placed in homes

Between fiscal years 1998 and 2000, the number of long-term state custody children who found permanent homes increased by 85 percent and the number of long-term state custody children dropped by 24 percent (Figure S-8). In 1999, the legislature and Department of Health and Social Services worked together to focus attention on children who had been in state custody from 22 months to more than ten years. This became "The Balloon Project." The project was initiated because although most children taken into state custody are

Figure S-8



\*According to DOL, there were 193,176 children between the ages of 0 and 17 in 1997. This number was 190,717 in 2000.

returned to their families within a few months, some children remain in state custody much longer. However, as a result of successful collaborative work between state departments and partner agencies, this picture is improving.

### Behavioral Risk Factor Survey (BRFSS) domestic violence data

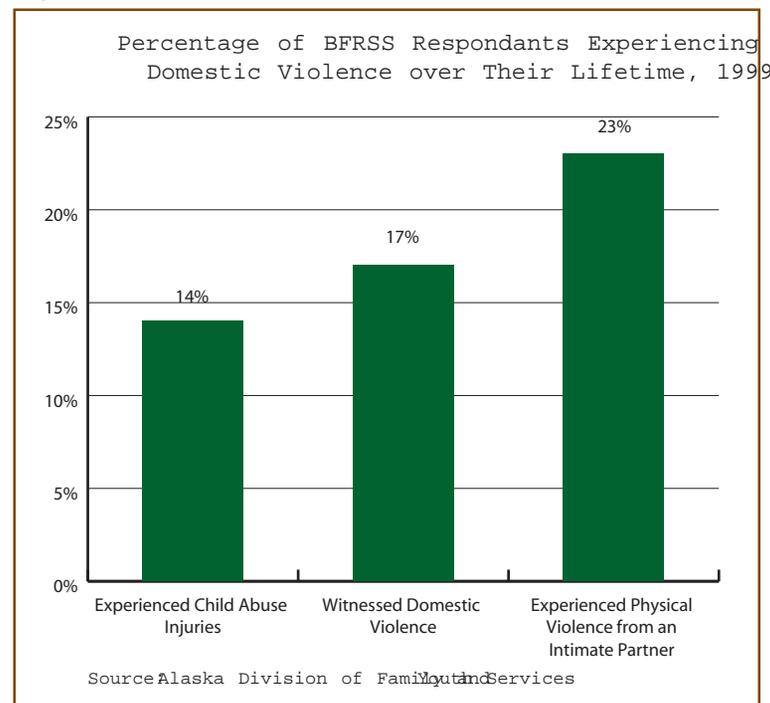
Victims of domestic violence suffer increased risk of physical and mental disorders. Common mental health problems include depression, post traumatic stress disorder, and substance use.<sup>16</sup> Almost one quarter of Alaskans responding to the 1999 BRFSS survey indicated that they had personally experienced physical violence from an intimate partner (Figure S-9). In an effort to collect population-based domestic violence data that would be comparable to other states and across years, ten questions were added to Alaska's Behavioral Risk Factor Surveillance System (BRFSS) survey in 1999. This data comports with National Violence against Women Survey Report data indicating that nearly 25 percent of surveyed women were physically assaulted at some time by a current or former spouse, cohabiting partner, or date.<sup>17</sup> This does not include other common forms of domestic violence including emotional abuse, threats, economic abuse, or restriction of personal freedom.

### Incidents of domestic violence

There were more than 17,500 incidents of domestic violence serious enough to require refuge in a domestic violence shelter in Alaska in fiscal year 2000 (Figure S-10). A new data system developed and implemented in fiscal year 2001

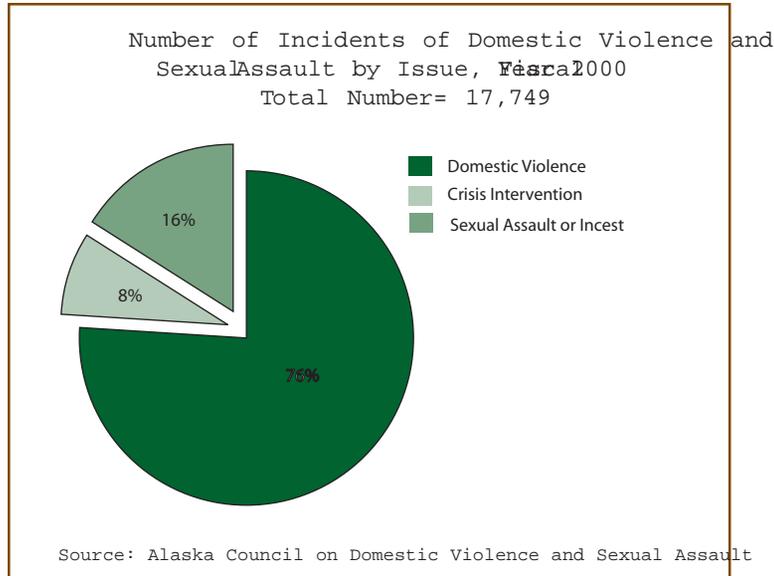
indicates that an estimated 7,500 to 8,000 Alaskans were victims of domestic violence. This is the first unduplicated count of people served by the network of domestic violence and sexual assault shelters. In the future, the data about this population will improve because the Alaska Council on Domestic Violence and Sexual Assault has initiated a new management information system.

Figure S-9



# The Plan - 2001

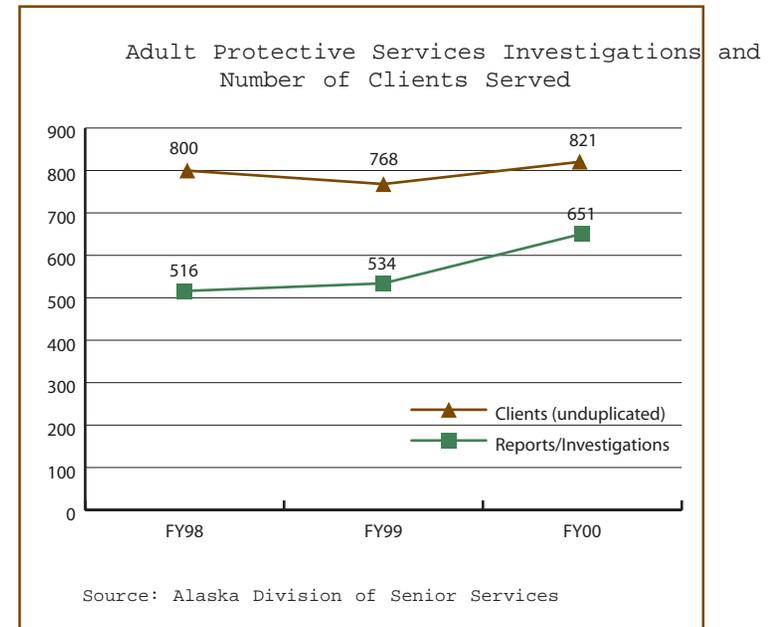
Figure S-10



## Adult Protective Services reports of harm and clients

The number of reports received and investigations increased by 26 percent between fiscal years 1998 and 2000; however, the number of clients increased by only 3 percent (Figure S-11). Alaska law defines vulnerable adults as persons 18 years of age or older who, because of a physical or mental impairment or condition, are unable to meet their own needs or to seek help without assistance.<sup>18</sup> Harm includes abandonment, abuse, exploitation, and neglect. Adult Protective Services in the Department of Administration receives and investigates reports of harm. Neglect is the most common report. More than half of the clients are female.

Figure S-11

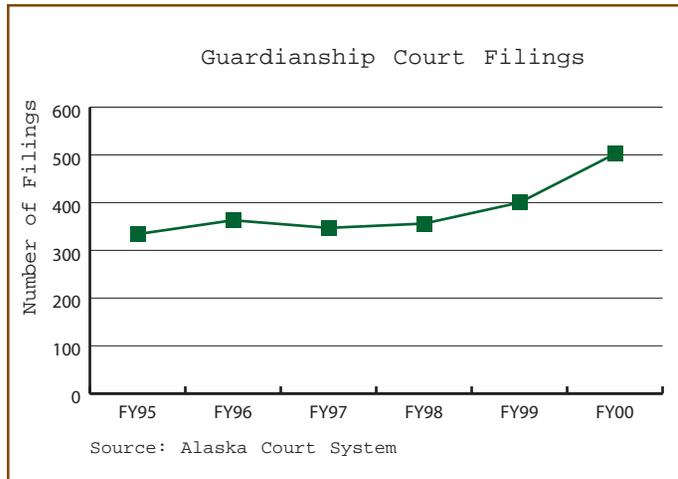


## Guardianship petitions

There has been a gradual increase in the number of court filings for guardianship for both children and adults over the past five years (Figure S-12). The number of filings increased by 33 percent between fiscal years 1995 and 2000. Decision-making capacity is the most common problem presented by vulnerable adults who become clients of Adult Protective Services. As the Alaskan population ages, this will continue to be a significant issue. For example, in fiscal year 2000, decision-making was an issue with 86 percent of the clients compared with 63 percent in fiscal year 1999. When adults are incapable of making critical decisions about their health and safety, a guardian may be appointed. Guard-

ianship is a legal process and guardian appointments go through the Superior Court.

Figure S-12



*Strategies*

1. Increase support for programs that strengthen and reunite families and reduce the number of out-of-home placements.
2. Support resources necessary to maintain a 90 percent reports of harm investigation rate in line with the governor’s zero tolerance policy for child abuse and neglect.
3. Continue to move children quickly from long-term state custody into safe, quality homes with programs such as

the Balloon Project, and to move children more quickly from foster care into permanent homes.

4. Assure that victims or witnesses of domestic violence and sexual assault have access to appropriate behavioral health care through the cooperative efforts of domestic violence programs and public behavioral health care providers.
5. Assist in strengthening adult protective services including seeking the resources needed to increase responses to reports of harm and public education about abuse of vulnerable adults.
6. Support efforts of the Office of Public Advocacy, Public Guardian Section, to assure that all individuals (children and adults) with cognitive disabilities who need a competent substitute decision-maker are assigned a guardian/conservator and/or representative payee.

---

**Safe Care**

*Goal: To improve the quality of behavioral health care provided to the public.*

The public behavioral health system is responsible for providing safe and effective care. During the past decade, consumers have become increasingly involved in choosing the type of treatment and other services they receive. This has changed

## The Plan - 2001

the system. Today, many agencies include consumers on their boards of directors. Consumers participate in quality assurance reviews for mental health, developmental disabilities, and early intervention/infant learning programs. Consumer satisfaction surveys are included in most provider reviews conducted by the Department of Health and Social Services.

### Indicators

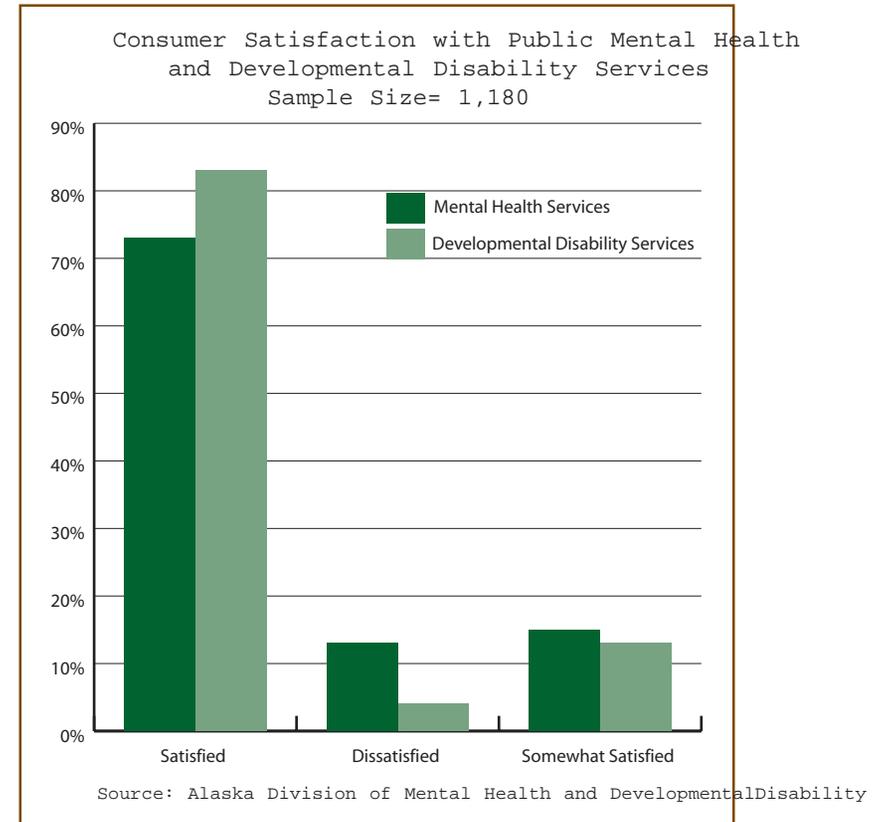
■ Proportion of consumers reporting satisfaction with public services

Data collected from more than 1,180 consumer interviews during 56 program reviews indicate that a majority of consumers were satisfied with the publicly funded mental health and developmental disabilities services they received in fiscal years 1999 and 2000 (Figure S-13). The Division of Mental Health and Developmental Disabilities recently incorporated a set of consumer satisfaction standards into the integrated quality assurance review process.

■ Number of complaints to the Long-Term Care Ombudsman.

The number of complaints and requests for assistance received by the Long-Term Care Ombudsman has risen by 53 percent, from 697 in Fiscal Year 1997 to 1,071 in Fiscal Year 1999 (Figure S-14).<sup>19</sup> Between 60 and 70 percent of the complaints are against assisted living homes. This is of concern because Alaska has the nation's fastest growing cohort of people 65 and older. Between 1990 and 1999, the number of seniors grew 52 percent.<sup>20</sup> Many are consumers of long-term care services. Because of their vulnerability,

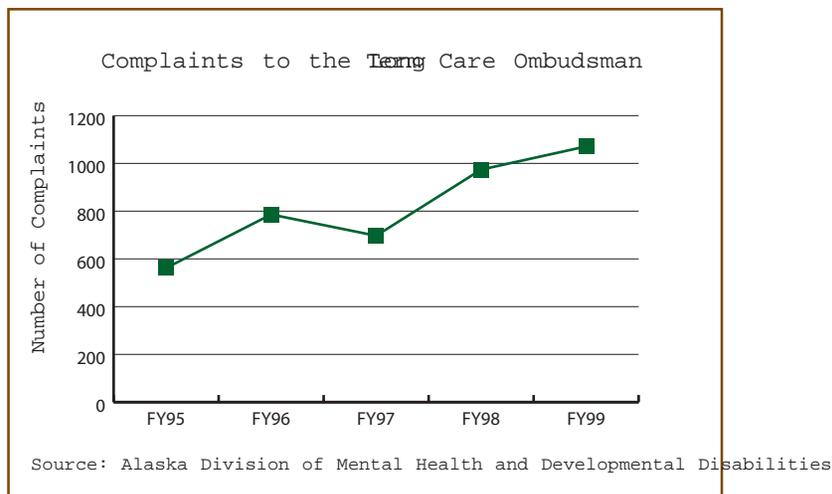
Figure S-13



the legislature created the Long-Term Care Ombudsman Office in 1988.<sup>21</sup> The ombudsman investigates complaints about nursing homes, assisted living homes, and senior housing units as well as concerns about individuals' care and circumstances. Consumers, family members, administrators, and facility staff can make complaints regarding the health, safety, welfare, or rights of a long-term care resident. Re-

cently the ombudsman office was transferred from the Division of Senior Services to the Alaska Mental Health Trust Authority.

Figure S-14

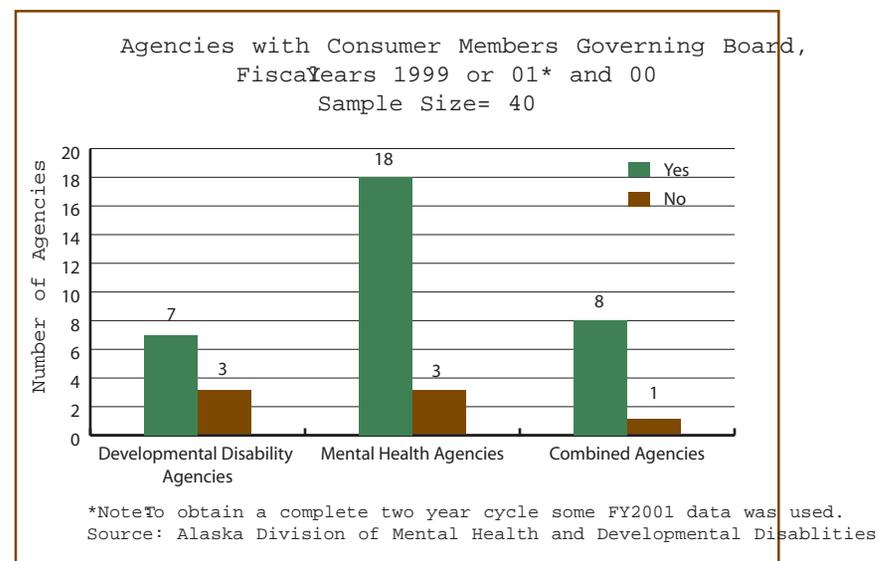


### Agencies with consumers on governing boards

A majority of the mental health and developmental disability agencies now include consumers on their governing boards. Out of forty agencies reviewed as part of the integrated quality assurance site review process, 82 percent met the review standard of having consumers or family members in sufficient numbers on the agency governing body or board to ensure their meaningful participation (Figure S-15)\*. Consumers of publicly funded mental health and developmental

disabilities services demand increased involvement in their treatment and care. Consumers or family members of consumers also sit on the each of the four statewide advocacy boards and commission.

Figure S-15



### Strategies

1. Ensure that consumers and family members have the opportunity to participate in policy development, planning, and evaluation of services involving mental health, substance abuse, developmental disabilities, and older Alaskans.

\* Program reviews are conducted every other year. This process was initiated in the middle of Fiscal Year 1999; therefore this data represents only a partial year. To compensate, the data in the Figure S-13 includes some FY 2001 data.

2. Develop and integrate the automated management information systems that support state-funded substance abuse treatment providers, community mental health providers, and the Alaska Psychiatric Institute.
  3. Develop and adopt research-based, clinically appropriate program standards and data collection for Department of Health and Social Services treatment programs.
  4. Promote the development of a coordinated approach for investigation and data collection that spans the efforts of the Long Term Care Ombudsman, Adult Protective Services, Division of Senior Services, and the Division of Mental Health and Developmental Disabilities.
  5. Ensure that the divisions of Mental Health and Developmental Disabilities, Alcoholism and Drug Abuse, Juvenile Justice, and Family and Youth Services have the resources to implement and maintain programs that assure safe and high quality care.
  6. Support the efforts of the Department of Administration, Division of Senior Services, and the Department of Corrections to obtain resources needed to implement and maintain quality assurance programs.
  7. Increase the number of assisted living homes and quality of care provided through increasing available resources dedicated to the assisted living home licensing programs in the departments of Administration and Health and Social Services.
  8. Increase support and education for family caregivers of people with dementia to reduce caregiver stress and delay placement of people in long-term care facilities.
  9. Help providers to hire and retain quality staff to serve people with mental illness, developmental disabilities, substance use disorders, and Alzheimer's disease and related disorders.
  10. Collaborate with provider agencies and the University of Alaska to expand recruitment, develop continuing education programs, and promote retention of personal care attendants and paraprofessional rural human service workers.
  11. Enhance the use of advance directives for mental health and other long-term care consumers to assure that individual choices are respected.
  12. Ensure appropriate placement, effective treatment, timely discharge, and aftercare for children in state custody who are placed in residential treatment programs and psychiatric hospitals in and out of state.
- 

## END NOTES

<sup>1</sup> Mental Health: A Report of the Surgeon General, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999

<sup>2</sup> National Elder Abuse Incidence Study Final Report, by the National Center of Elder Abuse, Department of Health and Human Services Administration for Children and Families and the Administration on Aging, September 1998.

<sup>3</sup> Homeless, Incarceration, Episodes of Violence: Way of Life for Almost Half of Americans with Untreated Severe Mental Illness, <<http://www.psychlaw.org/generalresources/fact2.htm> >.

<sup>4</sup> AS 47.30.705, ~~Emergency~~ detention for evaluation.

<sup>5</sup> AS. 47.37.170 Treatment and services for intoxicated persons and persons incapacitated by alcohol or drugs.

<sup>6</sup> Department of Corrections, Title 47 Holds in DOC Correctional Facilities by Fiscal Year.

<sup>7</sup> AS 47.30.670-803

<sup>8</sup> Results from Our Research: Alaska State Planning and Drug Abuse Services 1999-2003 Advisory Board on Alcoholism and Drug Abuse, Juneau, 1999.

<sup>9</sup> Personal communication from Dr. Sperbeck, DOC, to Kathryn Cohen, DHS August 9, 2001.

<sup>10</sup> Mental Health Needs Assessment for Offenders in Custody and Under Supervision of the Alaska Department of Corrections Department of Corrections, Juneau, 1997.

<sup>11</sup> Child Abuse and Neglect, A Look at the States: 1999 CWLA State Book Petit, Michael et al. Pres. CWLA, Washington, DC.

<sup>12</sup> Results from the Long-term Inmate Survey: Focus on Child Histories, Report Alaska Department of Corrections, Justice Center University Alaska Anchorage, June 1998.

<sup>13</sup> Safe City Program, In-Dependent Prevention Team rankings based on information in the Uniform Crime Reports (UCR), 1976-1998, Federal Bureau of Investigation.

<sup>14</sup> The National Elder Abuse Incidence Study; Final Report, by The National Center on Elder Abuse at The American Public Human Services Association in Collaboration with Westat, Inc., former American Public Welfare Association; prepared for the Administration for Children and Families and the Administration on Aging, the Department of Health and Human Services, September 1998.

<sup>15</sup> AS 47.10.101 Children in need of aid.

<sup>16</sup> Factors Moderating Physical and Psychological Symptoms of Battered Women, Journal of Family Violence Follingstad, D.R. et al; 1991; 6:81-95.

<sup>17</sup> National Violence Against Women Survey Report; US DOJ, July 2000.

<sup>18</sup> AS 47.24.010-900

<sup>19</sup> Alaska Commission on Aging Annual Reports, Fiscal 1997, 1998, 1999; Department of Administrative Services, Division of Senior Services.

<sup>20</sup> Long Term Care Services Study and Recommendations for Change to Alaska Long Term Care Certificate of Need Regulation Department of Health and Social Services, Administration, October 2000, Juneau.

<sup>21</sup> AS 44.21.231.



## Economic Security

*“Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age, or other lack of livelihood in circumstances beyond his control.” — Article 25, United Nations Universal Declaration of Human Rights*

Economic security means that people are able to provide basic necessities for themselves and their families. Economic security may involve working for wages or a combination of paid work and subsistence activities. However, there are some people whose disabilities make it difficult to work for wages, but who can participate in community life and contribute to society in other ways. There also are families who live either in temporary or permanent poverty, unable to maintain an adequate standard of living. For many of them, the challenge of economic self sufficiency is complicated by family mental illness, cognitive disorders, or substance abuse problems.

Poverty does not cause mental illness, substance abuse, developmental disabilities, or cognitive disorders. However, there is an association between the social and emotional stress produced by poverty and the onset of mental and physical disease. Children who grow up in poverty are more likely to suffer from poor physical health and developmental

delays.<sup>1</sup> The recently released Surgeon General’s report on mental health asserts “that both biological and social factors contribute to the causes, manifestations, course, and outcome of health and disease, including mental disorders.”

Paid employment is often the basis of an individual’s or family’s economic security. However, for people with physical or mental disabilities, finding and keeping a job can be difficult. A survey of Alaska Mental Health Trust beneficiaries conducted in 1998 revealed that only 30 to 35 percent of adults with mental illness or developmental disabilities and 45 percent of those with substance use disorders were employed.<sup>2</sup> Those who were usually worked in low paying or part time jobs. Almost two-thirds of all survey respondents reported a household income below \$20,000, and only 19 percent reported an income over \$40,000.

The Comprehensive Plan focuses on two major issues related to economic security:

- ❖ Basic economic supports
- ❖ Employment

---

### Basic Economic Supports

*Goal: To make it possible for all Alaskans to live in dignity with adequate food, shelter, and medical care.*

# The Plan - 2001

Many Alaskans live in poverty because of circumstances beyond their control. The State of Alaska mediates some effects of poverty by providing basic economic assistance on a temporary or permanent basis. Alaska's most vulnerable families can rely on an economic safety net composed of public assistance programs. Publicly funded programs offer basic supports to Alaskans who cannot meet their essential needs. In the absence of these programs, many Alaskans would be hungry, homeless, or institutionalized. Still, some people fall through the safety net. For example, there are few economic supports available to adults with multiple low-level disabilities that create barriers to economic success.

Direct cash support programs include the Alaska Temporary Assistance Program (ATAP) that helps families during times of transition; the Adult Public Assistance program (APA) that provides long term assistance to individuals experiencing disabilities or over age 65; and General Relief Assistance (GRA) that focuses on individuals facing extreme financial crisis. The state's Food Stamp and Heating Assistance programs supplement these sources of economic aid.

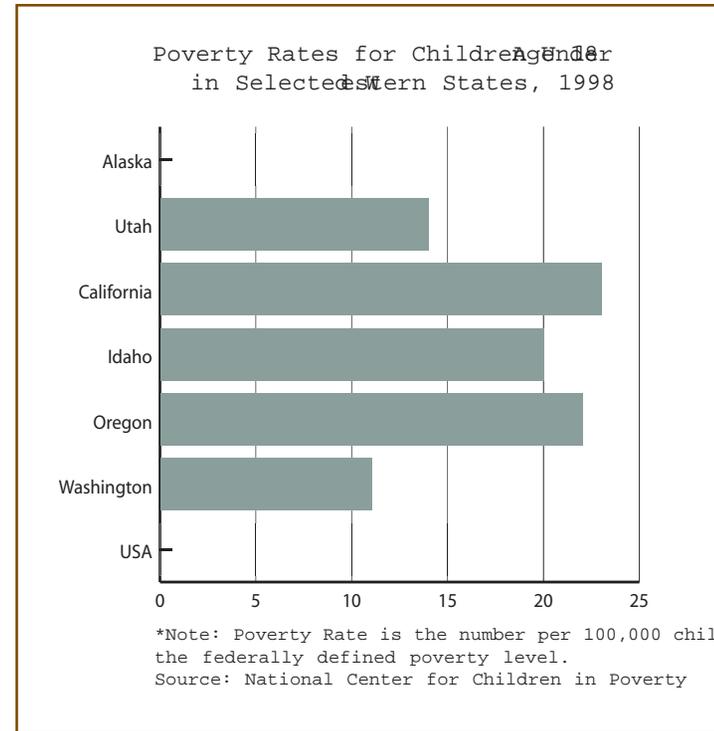
### Indicators

#### Poverty rates for children in Alaska

Ten percent of Alaska's children were considered poor in 1998. In 1999, an estimated 17 percent of Alaskan children five years old or younger lived in families whose income was low enough to make them eligible for Temporary Assistance.<sup>3</sup> Although the poverty rate for children in Alaska compares favorably with that for the US and other western

states, poverty is particularly harmful to children (Figure E-1). Childhood poverty can have a destructive impact on normal child development as a result of poor nutrition and the family dysfunction often associated with poverty.

Figure E-1

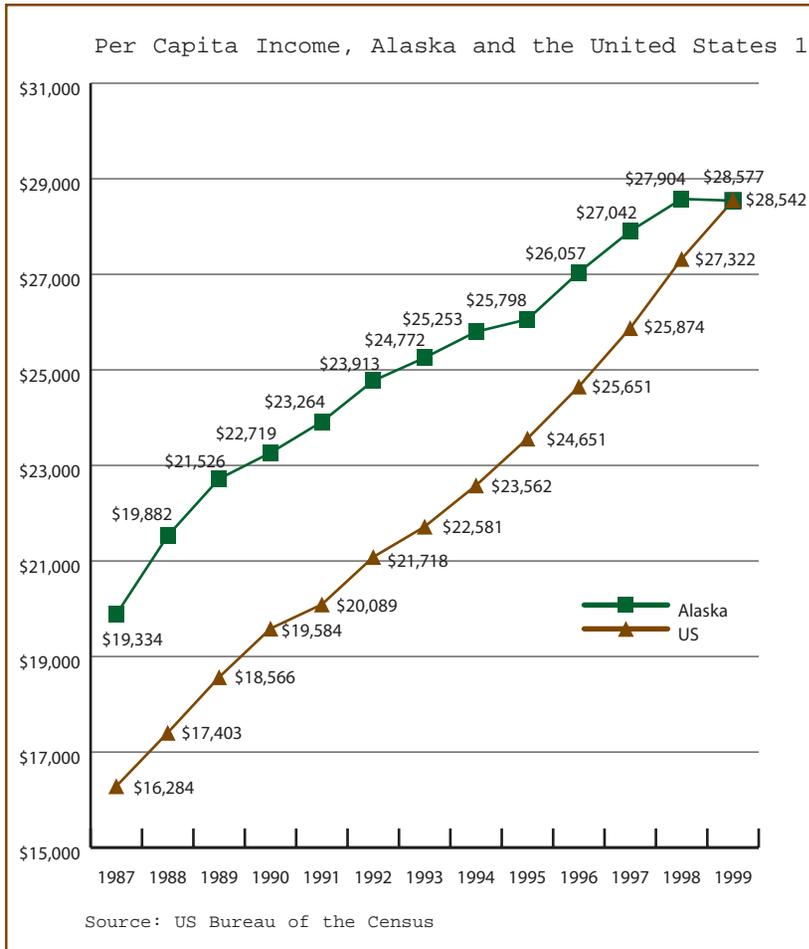


#### Alaska's per capita income compared to the rest of the United States

Nationally, the U.S. Census Bureau reports increases in income and declines in poverty. Alaska's income has contin-

ued to grow, but not as fast as the rest of the United States (Figure E-2).<sup>4</sup> While Alaska's per capita income was eight percent higher than that of the U.S. in 1987, by 1999, the rest of the nation had closed the income gap.<sup>5</sup> The rate of inflation in Alaska has also dropped when measured with the Anchorage Consumer Price Index, the only "Alaska" infla-

Figure E-2

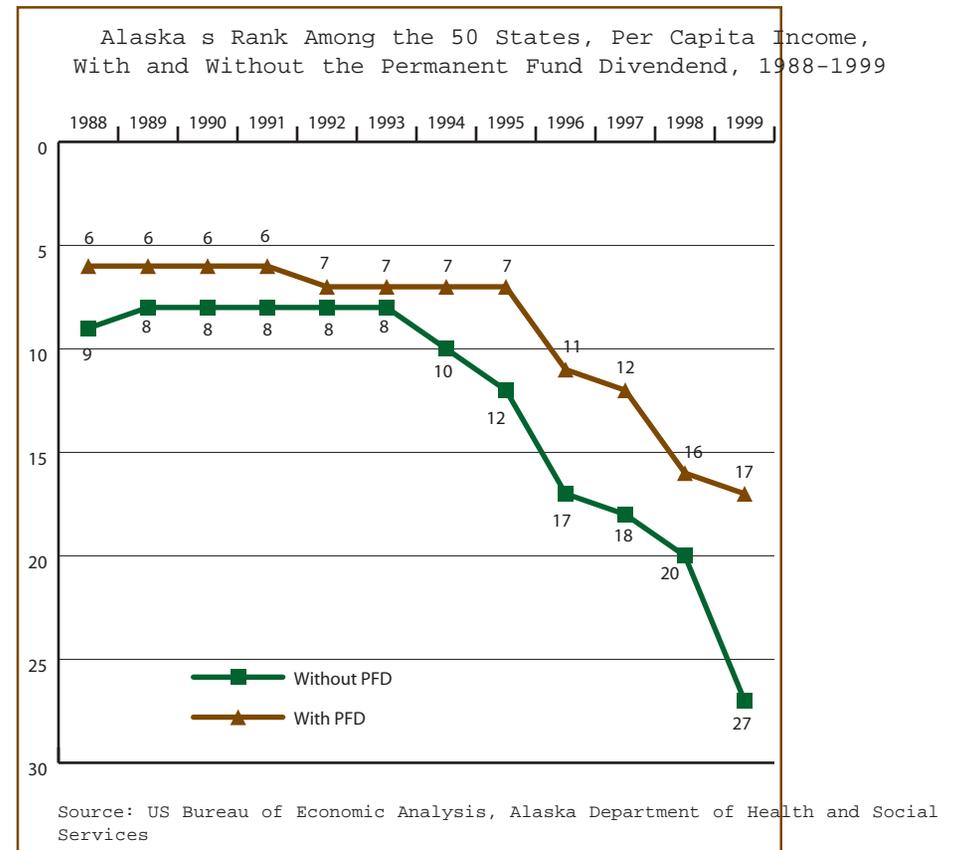


tion measure. Since 1960, the rate of inflation in Anchorage has been significantly lower than in the rest of the nation.<sup>6</sup>

Alaska's per capita income rank with and without the PFD

When the Alaska Permanent Fund (PFD) is removed from the per capita income calculation, Alaska's rank among the

Figure E-3



# The Plan - 2001

rest of the states drops precipitously (Figure E-3). Alaska's annual Permanent Fund Dividend has lifted many Alaskans over the poverty threshold.

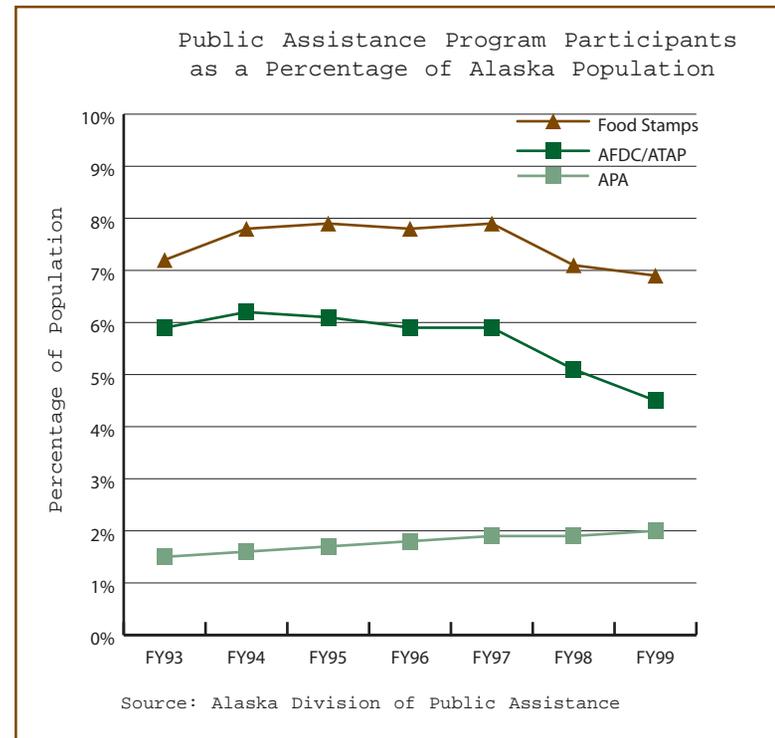
## Public Assistance program participants as a percentage of the Alaska population

Many Alaskans rely on public assistance programs during times of crisis or when chronic conditions such as disability or old age and absence of economic alternatives make assistance a necessity. Since 1997, the proportion of Alaskans who participate in two of the largest public assistance programs, the Alaska Temporary Assistance program and Food Stamps, has decreased while Adult Public Assistance program participation has increased (Figure E-4).

The Alaska Temporary Assistance program has a five-year lifetime limit on benefits, posing a problem for families that include adults with non-severe mental and cognitive disabilities or substance use disorders.<sup>7</sup> Studies in other states indicate a prevalence rate as high as 35 percent for those disorders. Although there are some exceptions to the time limit for families with extenuating circumstances, exceptions are limited to 20 percent of the annual caseload. A smaller caseload means fewer families have access to the extension benefit.

The Food Stamp program is also time limited. Basic nutrition is essential to achieving and maintaining health, and many poor Alaskans rely on the Food Stamp program to help them buy food and related items. Work is required to qualify

Figure E-4



for Food Stamps and there is a three-month limit every three years unless the individual is working full-time or has another exemption. Program eligibility is based on income and resources. In September, the maximum monthly benefit for a single person was between \$160 and \$249 dollars depending on whether the person lived in an urban or rural community.

Alaska’s Adult Public Assistance (APA) program is designed to supplement the federal Supplemental Security Income (SSI) program. The APA/SSI program helps keep people in their own homes and out of institutions. As a result of this program and others, the state has been able to close the Harborview Developmental Center and downsize the Alaska Psychiatric Institute. However, the number of SSI/APA program participants has increased an average of 9 percent per year during the past ten years. This increase is expected to continue as the baby boomer population ages.<sup>8</sup>

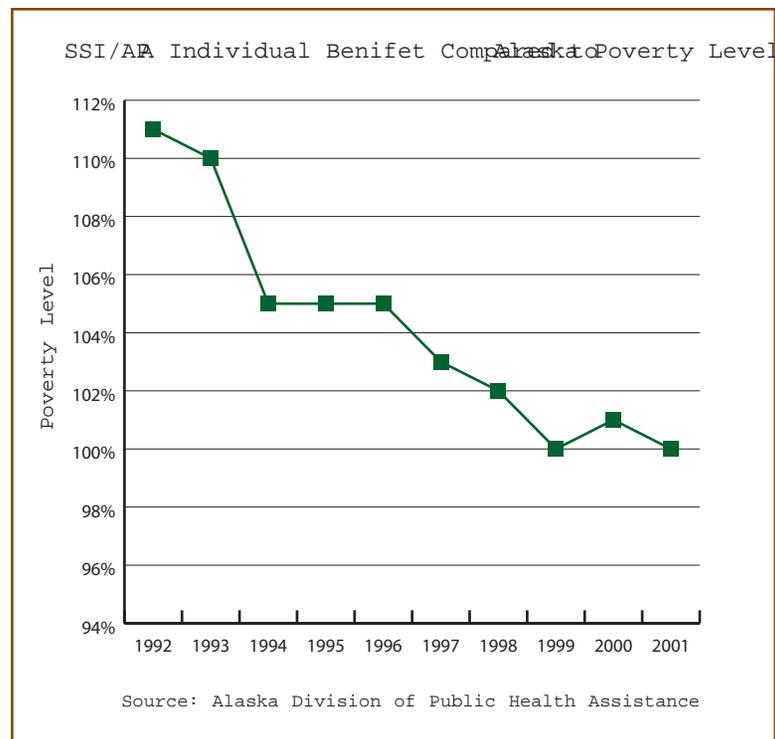
### SSI/APA payment compared to Alaska poverty level

The SSI/APA cash benefit for people with disabilities has eroded over the years in relation to the definition of poverty (Figure E-5). In Alaska, the SSI/APA programs combine to provide minimal cash assistance of \$892 dollars a month to elderly, blind, or disabled individuals. The SSI payment is adjusted every year to take inflation into consideration, but the APA payment is legally capped and therefore diminishes every year due to inflation.

#### Strategies

1. Assure reasonable safety net programs designed to meet basic needs of all vulnerable Alaskans by protecting Adult Public Assistance, Temporary Assistance, Food Stamps, General Relief Assistance, Medicaid, and Foster Care programs from benefit reductions.

Figure E-5



2. Review purchasing power of current public assistance benefits in Alaska’s economy and, if appropriate, recommend a cost of living adjustment.
3. Promote screening, assessment, and referral services to identify Temporary Assistance participants with mental illness, substance use disorders, or developmental disabilities; and, when appropriate, provide necessary services to help them achieve economic self sufficiency.

4. Develop and implement safety net services for families with behavioral health and cognitive disorders who are impacted by the 60-month time limit on Alaska Temporary Assistance.
5. Increase the capacity to serve people with disabilities who need mental health and substance abuse services.
6. Maintain current Medicaid service levels for people with mental illness, cognitive disorders, developmental disabilities, substance use disorders, and/or dementia.
7. Expand Medicaid coverage for dental services to adults who are mentally and/or cognitively disabled, chemically addicted, and/or elderly with dementia.
8. Expand the Medicaid program to include health care services for people with Alzheimer's disease and related disorders to allow them to remain in their homes for as long as possible.
9. Support legislation to require that health insurers provide behavioral health care coverage on parity with physical health care coverage.

---

## Employment

*Goal: To increase work opportunities for Alaskans with disabilities or cognitive disorders.*

A consumer of mental health services defined recovery as, “good health, good food, and a decent place to live, all supported by an adequate income that is earned through meaningful work.”<sup>9</sup> Mental disorders, including mental illness and developmental disabilities, are the leading causes of disability in America.<sup>10</sup> Mental illness is the largest single category of major disability (33 percent) for individuals who receive SSI/APA, followed by developmental disabilities (15 percent).<sup>11</sup> In addition to the limits mental illness places on employment, the necessary medical care is usually costly.

Earning an adequate income remains beyond the reach of many individuals with disabilities. People with disabilities are poorer and more likely to be unemployed than are people without disabilities. As of March 1998, only 2.8 percent (491) of the disabled SSI recipients in Alaska were working.<sup>12</sup> For those working, the average earnings were \$856 a month. In a 1998 survey of 1,000 Alaskan Medicaid recipients with disabilities,<sup>13</sup> more than half (59 percent) of the respondents said they would like to work if employment did not affect their eligibility for needed medical benefits. Within this group, 35 percent wanted to work full time and 44 percent, part time.

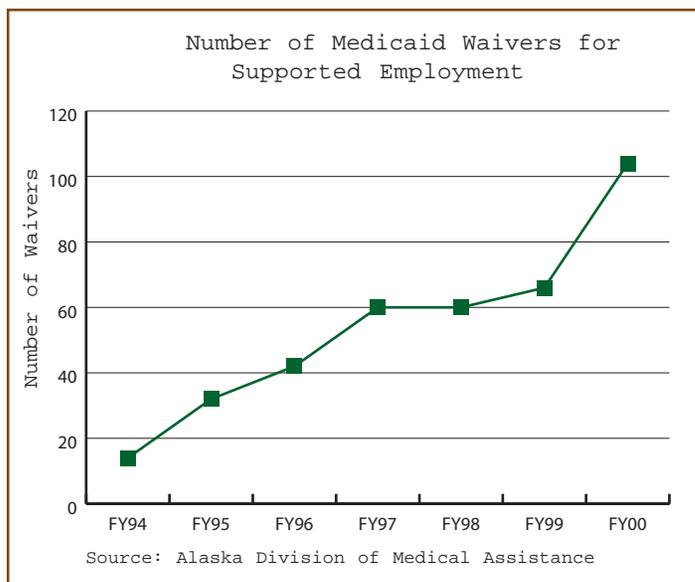
### *Indicators*

Number of Medicaid recipients participating in the supported employment waiver program

The number of participants in the Medicaid supported employment waiver program has steadily increased since the

program was initiated in 1994 (Figure E-6). This may reflect the increased emphasis on employment within the disabled community. That emphasis includes “supported employment,” that is paid employment for persons with developmental disabilities for whom competitive employment at or

Figure E-6

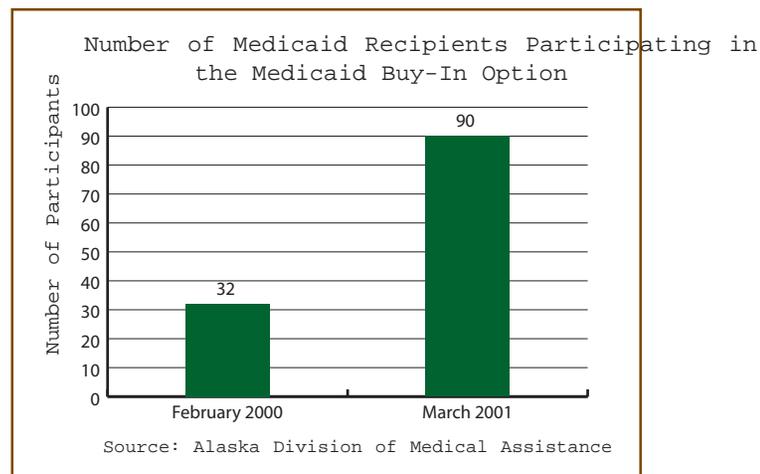


above the minimum wage is unlikely and who, because of their disabilities, need intensive ongoing support, including supervision and training, to perform in a work setting.<sup>14</sup> Medicaid covers the costs of supported employment for people with developmental disabilities, allowing participants to contribute to the community and to their own sense of self-esteem through work.

### Number of Medicaid recipients who participate in the buy-in option

To combat the fear of losing medical benefit if someone with disabilities becomes employed, Medicaid offers a new buy-in program. Since its introduction in July 2000, the number participating has almost tripled (Figure E-7).<sup>15</sup> Alaska was the first state to pass legislation that provides for this new program. The intent is to encourage people with disabilities to work by continuing their access to Medicaid healthcare coverage. To participate in the new buy-in program, family income cannot exceed 250 percent of federal poverty guidelines for Alaska, and the individual’s earned income cannot exceed \$984 per month. The number of people participating should continue to increase as knowledge about this option is coupled with the Alaska Works Project, a statewide initiative designed to remove barriers to employment confronted by people with disabilities.

Figure E-7



### Strategies

1. Embed an employment and job retention component into all adult mental health, developmental disabilities, and substance abuse treatment programs to assist clients to find and retain wage paying jobs.
2. Increase education and training opportunities to support people in their return-to-work efforts including pre-employment and vocational services for people with serious mental illness, substance use disorders, or developmental disabilities.
3. Develop the state Medicaid program including Medicaid buy-in and other health insurance options to better support those people with disabilities who return to work.
4. Support Division of Vocational Rehabilitation efforts to provide technical assistance to employers who want to hire individuals with disabilities.
5. Continue to participate as a member of the Alaska Consortium in the federally funded Alaska Works Initiative designed to address major barriers that keep people with disabilities from success in the workplace.
6. Continue to use funding available through federal employment initiatives such as Ticket to Work and the Work Incentives Improvement Act to promote employment and self-sufficiency for people with disabilities.

7. Encourage and support employment opportunities for youth at risk of or experiencing behavioral disorders.
8. Promote the coordination of programs providing human service related transportation, look for new funding sources, and educate service providers and consumers about transportation alternatives.

---

### ENDNOTES

<sup>1</sup> “One in Four: America’s Youngest Poor, December 1996” <<http://cpmcnet.columbia.edu/dept/nccp/oiftext.html>>.

<sup>2</sup> “A Marketing Research Report for Alaska Mental Health Trust Authority,” Craciun & Associates, Anchorage, February 1999.

<sup>3</sup> Estimate based on information from *Alaska Population Overview, 1999 Estimates*, Alaska Department of Labor and Workforce Development, Juneau, Alaska, May 2000, and the Division of Public Assistance.

<sup>4</sup> Per capita income is the mean income computed for every man, woman, and child in a particular group. The Census Bureau derived per capita income by dividing the total income of a particular group by the total population in that group (excluding patients or inmates in institutional quarters).

<sup>5</sup> This graph has not been adjusted for cost of living or inflation.

<sup>6</sup> “The Cost of Living in Alaska” in *Alaska Economic Trends*, Alaska Department of Labor and Workforce Development, June 2001, Volume 21, No. 6.

<sup>7</sup> The Alaska Temporary Assistance for Needy Families (TANF) program replaced the Aid to Families with Dependent Children (AFDC) as part of federal welfare reform in 1996.

<sup>8</sup> “Executive Summary, Review of Alaska-Specific Disincentives to Work for Individuals with Significant Disabilities,” Governor’s Council on Disabilities and Special Education, Anchorage, 1998.

<sup>9</sup> *Mental Health: A Report of the Surgeon General*; U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999 (p. 99).

<sup>10</sup> *Mental Health: A Report of the Surgeon General, Executive Summary*, US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, Washington, DC, 1999.

<sup>11</sup> “Adult Public Assistance Fact Sheet” Department of Health and Social Services, Division of Public Assistance, February 2001.

<sup>12</sup> “Executive Summary: Review of Alaska-specific Disincentives to Work for Individuals with Significant Disabilities,” Alaska Governor’s Council on Disabilities and Special Education, Anchorage, 1998.

<sup>13</sup> “Transitioning to Economic Independence: An Employment Initiative for People with Severe Disabilities,” Alaska Governor’s Council on Disabilities and Special Education; Anchorage, 1999.

<sup>14</sup> 7 AAC 43.1110 (29).

<sup>15</sup> Families with a disabled adult are eligible for this buy-in program. Although the majority of participants are individuals with disabilities, there are some participants who are not disabled but who have adult family members who are disabled.



## Living With Dignity

*“Living with Dignity means being valued and appreciated by others for the choices and contributions one makes and being able to take advantage of the opportunities available to all Alaskans.” - Alaska Governor’s Council on Disabilities and Special Education*

People measure their individual value through their interaction with their families and community. People perceive their own merit through society’s eyes as reflected in the mass media, entertainment, and language. To be part of a neighborhood, live in acceptable housing and attend the public school are marks of community membership. Social stigma and prejudice keep many people from participating in community activities. Stigma also prohibits individuals from pursuing treatment and services necessary to become fully contributing members of their community.

People’s self-esteem is tied to their sense of belonging. Alaskans experiencing mental illness, substance use disorders, developmental disabilities, and age-related dementia need to engage with family, friends, and neighbors and to participate in their communities. Social contributions can include volunteer or paid work, subsistence activities, active membership in spiritual and other community organizations, and successful school attendance.

The Comprehensive Plan focuses on three issues related to life with dignity:

- ❖ Housing
- ❖ Education and Training
- ❖ Educated Public

## Housing

*Goal: To enable people to live in appropriate housing in the community.*

There is not enough safe, comfortable, appropriate, and affordable housing to meet the needs of Alaskan residents.<sup>1</sup> The impact of this scarcity is strongly felt by the vulnerable people with mental illness, developmental disabilities, substance use disorders, and Alzheimer’s disease or related disorders. Because they generally have low incomes and often face discrimination in the housing market, people who are the most disabled are the most vulnerable to homelessness. Misperceptions about people with these disabilities, create stigmas that make it even harder for them to find housing.

Nationally during the past two decades, homelessness has increased due to the combination of a shortage of rental housing and an increase in poverty.\* Housing absorbs a high

## The Plan - 2001

proportion of income, and when a family reaches an economic crisis due to health issues or job loss, housing is easily lost. Other risk factors associated with homelessness include a lack of health care, domestic violence, mental illness, and substance use disorders.<sup>2</sup> In short, “homelessness results from a complex set of circumstances which require people to choose between food, shelter, and other basic needs.”<sup>3</sup> For people with psychiatric illness or chronic addiction disorders, homelessness can be symptomatic of their disability and unsatisfied treatment needs.

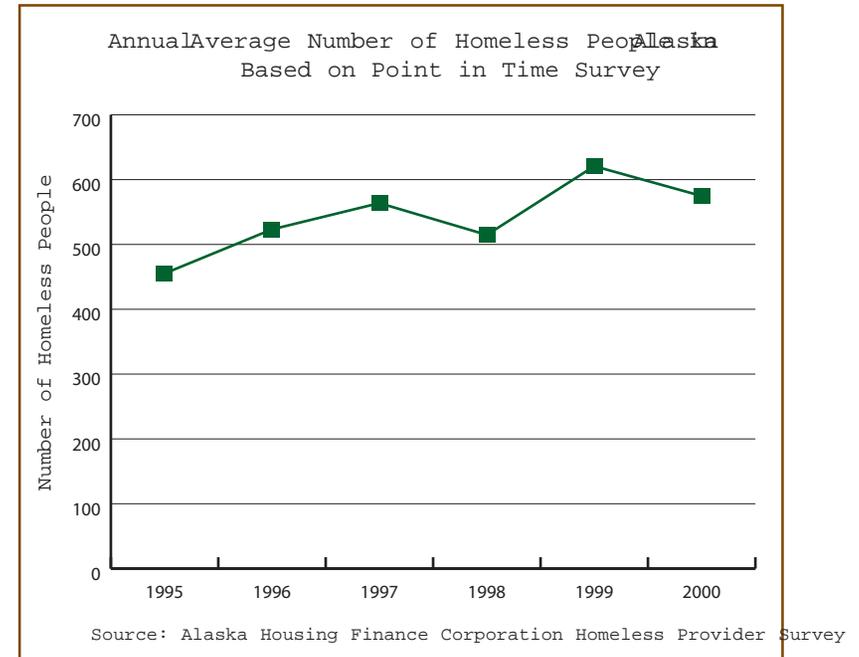
A number of governmental programs provide housing assistance for people with low incomes and disabilities. In Alaska, the primary agencies addressing housing needs are the federal Department of Housing and Urban Development (HUD), the federal Department of Agriculture (USDA), regional housing authorities, the Alaska Housing Finance Corporation (AHFC), and Alaska’s Tribally Designated Housing Entities (TDHEs).

### Indicators

#### Number of homeless people

The number of homeless people reported in the Alaska Housing Finance Corporation’s Homeless Survey increased 26 percent between 1995 and 2000 (Figure L-1). Providers of services for homeless people semiannually complete the survey on a predetermined day. It is a voluntary survey with a return rate from providers that varies from 50 to 79 percent. It depends on self-disclosure concerning substance abuse or mental illness. Although the survey has many

Figure L-1



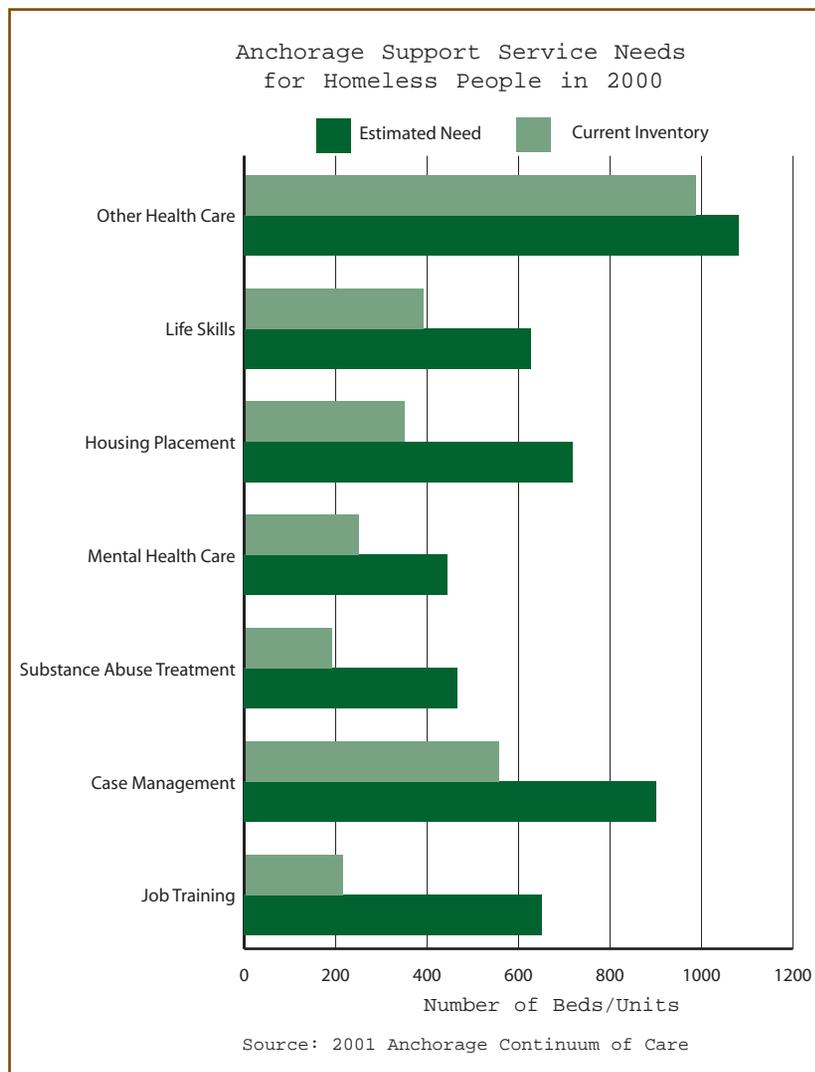
limitations, it does provide some idea of the number of homeless people and their characteristics.

#### Supportive services for homeless people

Anchorage conducted research on the kinds and availability of services needed by the Anchorage homeless population. The study found that need exceeded supply, especially for job training, housing placement, and case management (Figure L-2). These support services accompanying publicly funded special needs and supportive housing help homeless

<sup>2</sup> A homeless individual is defined in 42 USCS 11302 (2001) as either someone who lacks a fixed, regular, and adequate nighttime residence or is an individual who has a primary nighttime residence that is in a shelter designed to provide temporary living accommodations (including congregate shelters, and transitional housing for the mentally ill); an institution that provides a temporary residence for individuals intended to be institutionalized; or a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation.

Figure L-2

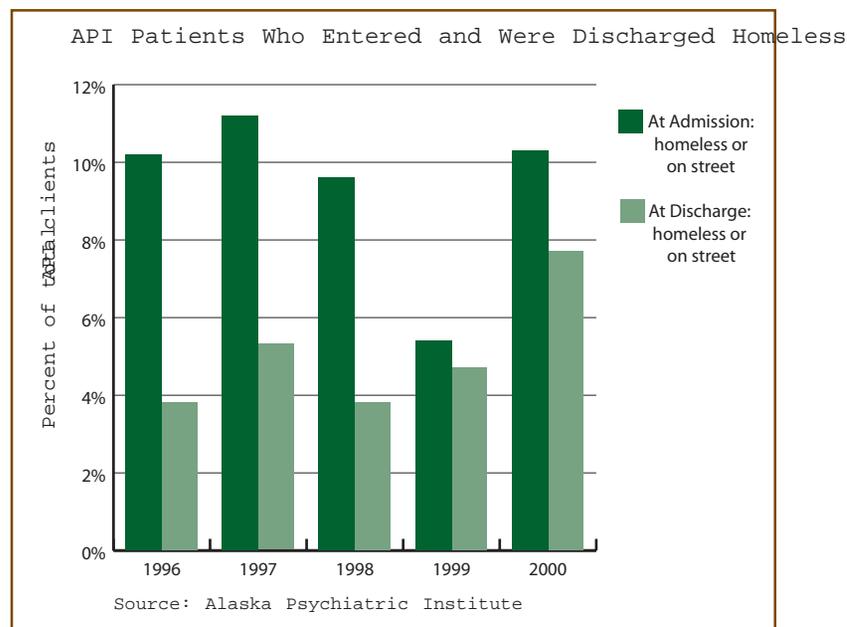


people and well as people with cognitive and mental disabilities and/or substance use disorders find and keep permanent homes.

### Number of patients discharged from API to homeless shelters

Between 1996 and 2000, the percentage of API patients who arrived homeless and who were discharged homeless ranged between 4 and 11 percent (Figure L-3). When API patients return to their home community, appropriate living arrangements are made whenever possible. There are fewer homeless individuals at the time of discharge than at admission, reflecting some success in finding housing. Those who are homeless at discharge are typically referred to shelters in the community. The number of API patients discharged as homeless has increased from 45 in 1996 to 111 in 2000, indicating a need for more housing for this population.

Figure L-3

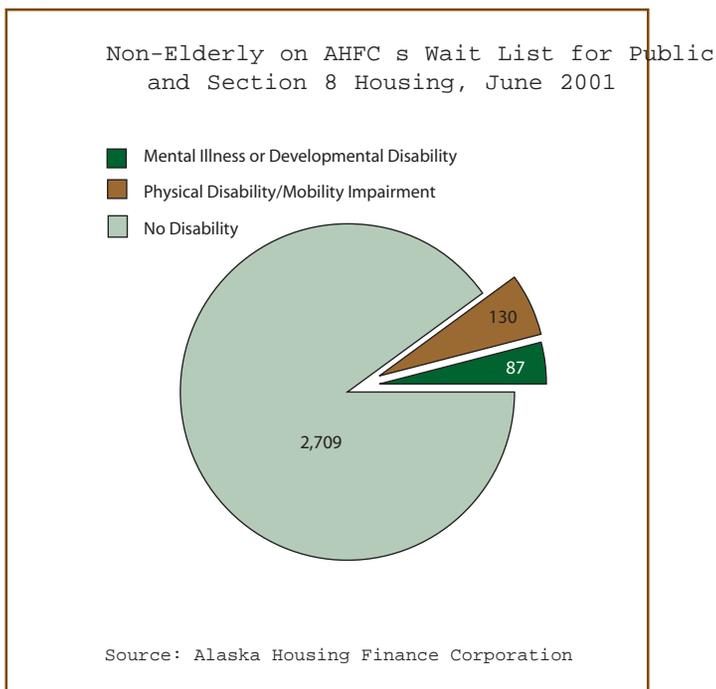


# The Plan - 2001

## Number of people with disabilities on wait lists for public housing or rental assistance

AHFC provides some public housing preference for persons who are disabled, homeless or who are paying more than 50 percent of their income for rent, on the waiting lists for the Section 8 Voucher program<sup>4</sup> and the public housing program. However, only 10 percent of the non-elderly people on AHFC's wait list for public housing are people with disabilities (Figure L-4). Anecdotally, AHFC believes there are many more people who could and should be on the wait list than at present because of the way the list is managed. AHFC

Figure L-4



recommends more education and training for service providers and consumers to inform them about housing preferences and what it is that they must do in order to receive AHFC housing help.

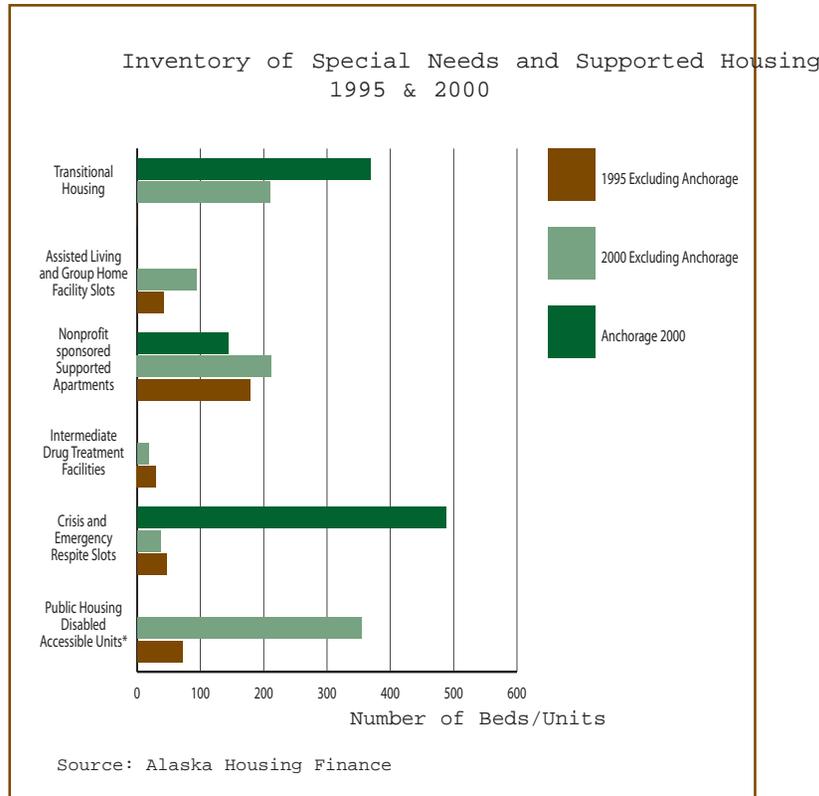
## Inventory of special needs and supportive housing

Housing terminology can be confusing and varies depending on the agency and population served. The following definitions apply to this inventory. Public housing and accessible units refer to permanent housing operated by AHFC. Crisis and emergency respite slots are in facilities that offer emergency shelter and supportive services to people with disabilities. The number of slots is the facility capacity. Intermediate drug treatment facilities are residential drug treatment options in the community. Non-profit sponsored supported apartments are housing units owned and operated by non-profit entities such as local Community Mental Health Centers. An assisted living or group home is housing coupled with services to assist individuals with some activities of daily living. Group home facilities accommodate more than one unrelated person with a disability and provide a full-time supervised setting. Transitional housing refers to housing that bridges the gap between homelessness and permanent housing.

According to the AHFC inventory in 1995 and 2000, the number of available slots for special needs and supportive housing increased, but crisis and emergency respite slots and those for intermediate drug treatment facilities slightly decreased (Figure L-5). One of the requirements of supportive housing is provision of associated supportive services that

allow people to remain in their own homes. These services often are covered by Medicaid.

Figure L-5



*Strategies*

1. Work with consumers, USDA, HUD, AHFC, and TDHEs plus other private and public entities to assure that people with mental illness, substance use disorders, developmental disabilities, and Alzheimer's disease or related disorders have choices of accessible, affordable, and safe homes in the community.
2. Support development of permanent and transitional housing with associated supportive services for adults and juveniles completing substance abuse or mental health treatment programs; transitioning out of API, nursing homes or other institutions; and returning to the community.
3. Collaborate with AHFC, the Trust, USDA, HUD, TDHEs and other agencies to determine the most effective way to increase the housing options and coordinate funding streams to benefit people with mental or cognitive disorders, chemical addictions, and Alzheimer's disease and related disorders.
4. Support the Alaska Commission on Human Rights, Anchorage Equal Rights Commission, AHFC, and federal agencies in their education of public and private landlords and local governments about compliance with fair housing laws and the Americans with Disabilities Act.

5. Support resources necessary to maintain housing specialist positions within public agencies to develop funding sources for housing programs.
  6. Promote recruitment and licensing of assisted living homes, particularly in rural communities, to allow people to remain in their own communities.
- 

### Education and Training

*Goal: To assure that all Alaskans have the opportunity to complete their education and become productively engaged.*

People identify themselves with their accomplishments. Participation in community events and neighborhood life, playing team sports, and completing high school all help people define and value themselves. For most adults, the groundwork for healthy community interaction is laid in school as part of their education. Participation in the community by all its residents is promoted by the educational policy to include children with disabilities in public school classrooms whenever possible.

The Individuals with Disabilities Education Act (IDEA) is the primary law that entitles children with disabilities to a free and appropriate education. IDEA requires states to

provide special education and related services to students who meet eligibility requirements. Children must be taught in the least restrictive environment and among non-disabled children to the maximum extent appropriate. To be eligible, a student must meet disability criteria established by the state and the disability must adversely affect his or her educational performance.

National estimates indicate that children and adolescents with mental disorders make up from 17 to 22 percent of the population.<sup>5</sup> Children with these disorders are at high risk of dropping out of school and never becoming fully functional members of society. Our children need the benefits of collaboration and cooperation between public schools and publicly funded mental health professionals. Although the schools could provide a place where children with emotional disturbance are recognized and referred for appropriate care, the lack of trained staff combined with limited options for referral prohibit this possibility.<sup>6</sup>

There are other children who do not meet the criteria for special education but who show symptoms of depression or behavioral disorder. These children are at significant risk of becoming seriously emotionally disturbed as well as dropping out of school. A study conducted in 1992 indicated that Alaska's children follow the disturbing national trend for earlier occurrences of depression and serious emotional disturbance.<sup>7</sup> Although some school districts have counseling programs, many do not.

*Indicators*

Number of children with mental and cognitive disabilities in public schools

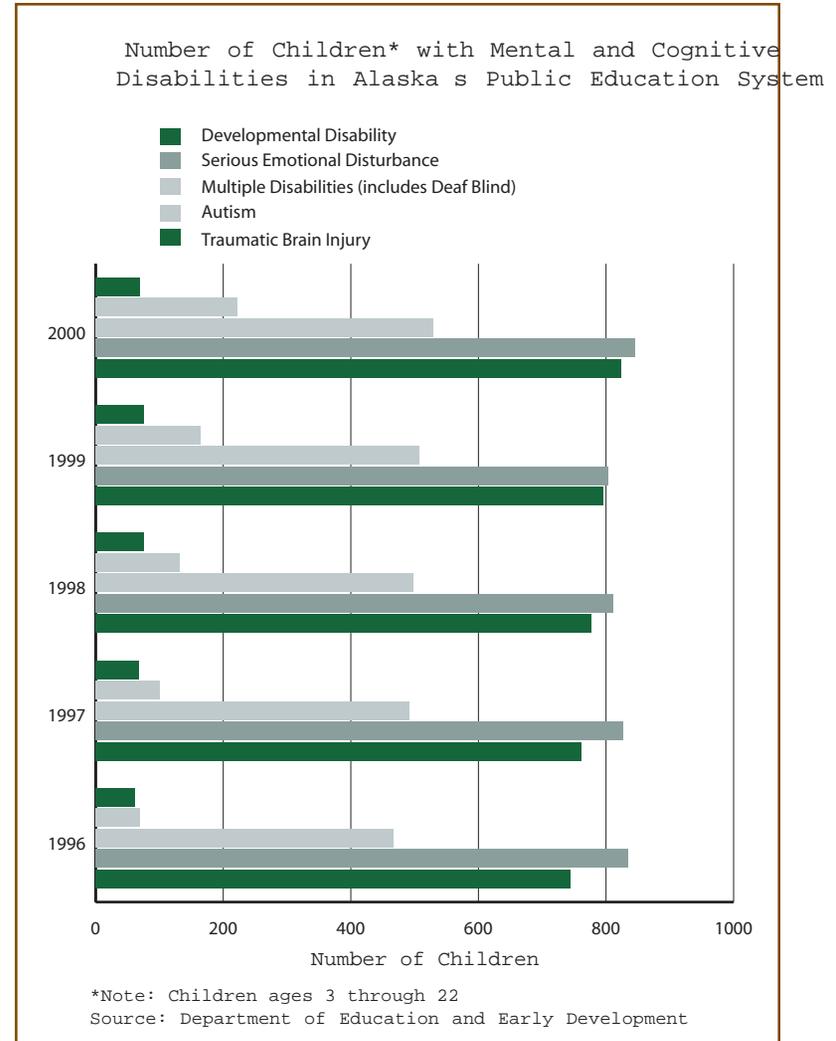
There are more than 2,000 children between the ages of 3 and 22 with mental or cognitive disorders in Alaska’s public education system (Figure L-6). This is about 13 percent of the total number of children in special education. Although the actual number is gradually increasing as the state population increases, the proportion has remained relatively constant ranging from 1.6 percent in 1996 to 1.8 percent in 2000.

The Department of Education and Early Development (DEED) provides individualized special education services to children in the public schools. Local school districts identify the children, assess their needs and provide additional personnel and in-service training for teachers and other staff. These services are provided to children with disabilities from pre-school to 21 years of age.

Percentage of students with emotional or developmental disabilities who complete their public education

The percentage of students with disabilities who completed high school by receiving a diploma or certificate between 1995 and 2000 has ranged between 60 and 66 percent (Figure L-7). There are, however, concerns about a decrease in this percentage with the implementation of the high

Figure L-6

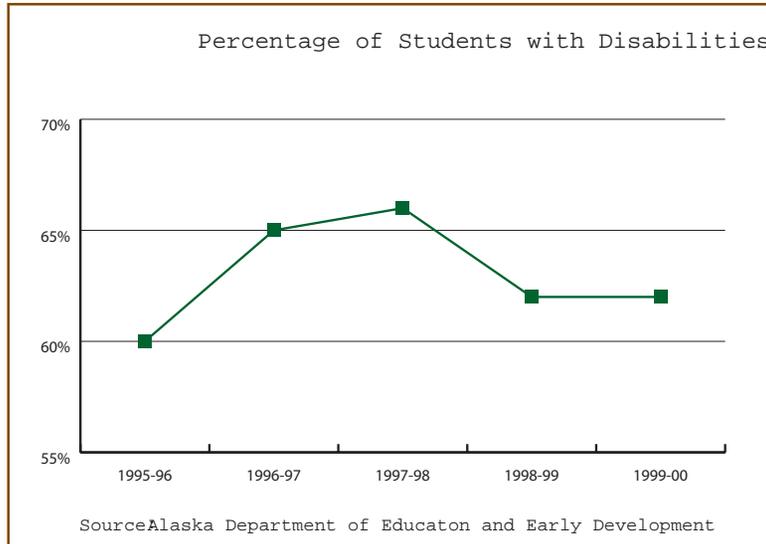


school qualifying exam. This will require all Alaska high school students to pass an examination in reading and writing beginning with the graduating class of 2004, and in mathematics for the graduating class of 2005.

# The Plan - 2001

IDEA requires schools to provide necessary accommodations for special education students to participate in the high school exit examination as identified in each student's required Individual Education Plan. This accommodation includes development of an alternate assessment for students with significant disabilities.<sup>8</sup> In addition, DEED has started work on an optional assessment with some guidelines and parameters for children with disabilities. The student's Individualized Education Plan Team will determine whether the child will participate in this assessment. There are questions about whether these students will receive a regular or special high school diploma. Regardless, it is critical for children to participate in school and complete a high school course of study as part of their preparation for a life as independent as possible.

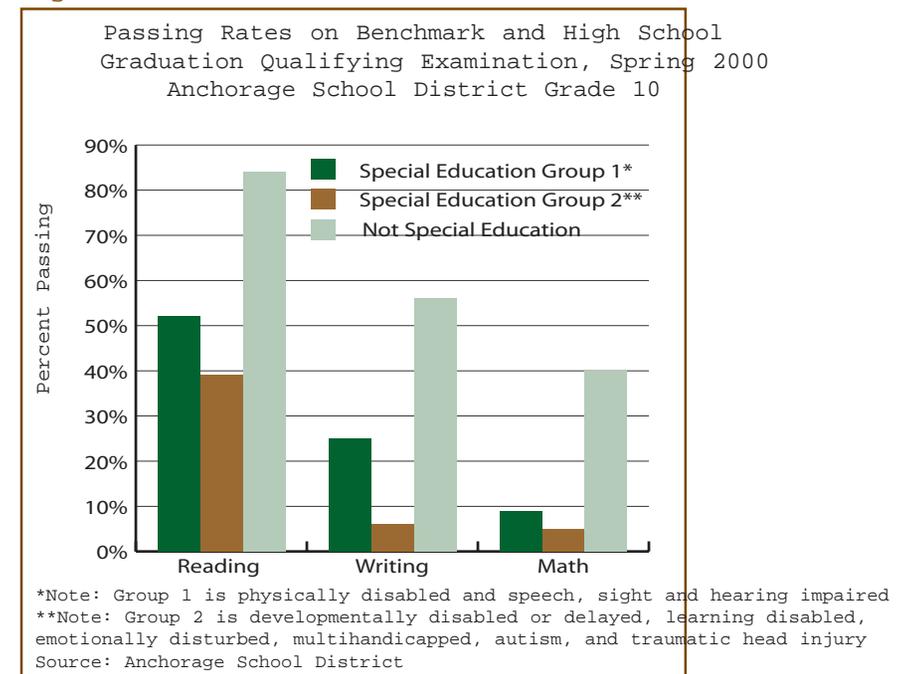
Figure L-7



## Passing rates on benchmark and high school graduation qualifying exam

A recent trial of the qualifying exam administered in the Anchorage School District showed dramatically lower passing rates for Special Education students (Figure L-8). The purpose of the trial was to determine how well children experiencing disabilities performed on the test as compared to the rest of the student population. District results indicate the need for alternative assessments to determine these students' school success.

Figure L-8



### *Strategies*

1. Collaborate with the Department of Education and Early Development to increase the numbers of youth with developmental disabilities or serious emotional disorders who complete high school.
2. Promote the development of more school-based counseling programs to identify and provide services to children with emotional disorders and developmental disabilities.
3. Support efforts to assist Special Education students' transition from schools to other productive activities.
4. Assist in the developing and implementing a comprehensive statewide plan for Alaska's system of recruitment, retention, and training of para-educational and professional personnel.

---

## **Educated Public**

*Goal: To reduce stigma associated with mental illness, substance abuse, developmental disabilities, and age related dementia.*

People disabled by mental illness, addiction, developmental disabilities, or dementia often are stigmatized by a society that erroneously attributes their condition to character flaws. The symptoms of the disabling condition may be ridiculed or result in violence. “We believe the person with a stigma is not quite human.”<sup>9</sup> The individual experiences both the symptoms of the disease and social barriers raised by stigma.

Individuals can internalize society's misperceptions, losing their confidence and self esteem. As a result, they may not seek treatment or other services they need. For example, according to a national survey of the needs of women in addiction recovery, 82 percent of the 200 survey respondents identified shame as the most common barrier to treatment.<sup>10</sup> The social consequences of non-treatment impact everyone. We know that people with untreated serious mental or cognitive disorders make up at least 10 percent of the nation's total jail and prison population.<sup>11</sup>

Public ignorance gives rise to social stigma and can keep people stigmatized from participating fully in community life. People may not receive services they need because health care providers, educators, police officers, and social service agencies are unable to identify and refer for treatment people they serve who may experience mental or cognitive disabilities or substance use disorders. Employers are reluctant to hire people with disabilities because of concerns about their ability to do the work. Housing is difficult to find because of public fears about mental illness and violence.

## The Plan - 2001

Advocacy groups have worked to change public attitudes about behavioral health disorders. The National Alliance for Mentally Ill and the National Council on Alcoholism and Drug Dependence continue to campaign against stigma and promote education about these disabling conditions. There has been some success. In a recent study of the changes in public perception about mental illness, researchers found that the public has acquired some understanding of the physical causes of mental illness and supports the use of medication for the treatment of depression and schizophrenia.<sup>12</sup> There also appears to be recognition that serious mental illness will not get better without treatment. Public opinion research on addictions in 1999 reported 73 percent of those surveyed believe addiction is a disease. Sixty-nine percent knew a friend or acquaintance with an alcohol or other drug problem and 59 percent indicated a problem in their family.<sup>13</sup>

On the negative side, for both mental illness and addiction disorders, many members of the public have yet to accept the biological basis for these diseases. For example, in a survey regarding the causes of mental illness, almost 75 percent of those surveyed thought mental illness was caused by emotional weakness, 65 percent blamed bad parenting, 35 percent thought it was due to sinful or immoral behavior, and 43 percent thought people caused it themselves.<sup>14</sup>

There is still a public perception that people with mental illness, especially people with psychosis, are violent. Although there is some cause for concern, the risk of violence is low. The greatest risk is from people with co-occurring disorders or

with severe mental disorder who are noncompliant with their medications. Even so, the risk is much higher for a family member than for a stranger. According to the recent Surgeon General's Report, "To put this all in perspective, the overall contribution of mental disorders to the total level of violence in society is exceptionally small."<sup>15</sup> There are still fears, however, attributed in part to media reporting and portrayals in mass entertainment of people with mental illness as violent. These images reinforce the stereotype of people with mental illness. There is still much work to do.

### *Strategies*

1. Support efforts by advocacy boards and the commission to promote public education about mental illness, substance use disorders, developmental disabilities, and Alzheimer's disease and related disorders to reduce stigma that hinder access to treatment and services.
  2. Work with advocacy boards and the commission to develop educational initiatives about mental health and alcohol and drug problems and to promote dignity and reduce stigma and discrimination against people with these disorders.
-

## End Notes

<sup>1</sup> “Executive Summary, The House: What a Wonderful Thought,” edited to include July 2000 comments from AHFC and Trust staff on activities since 1997,” Alaska Mental Health Trust Authority, Anchorage, Alaska.

<sup>2</sup> “Homelessness: Programs and the People They Serve - Highlights Report,” <[www.huduser.org/publications/homeless/homelessness/highrpt.html](http://www.huduser.org/publications/homeless/homelessness/highrpt.html)>.

<sup>3</sup> National Coalition for the Homeless Fact Sheets, National Coalition for the Homeless, June 1999; <[www.nationalhomeless.org/causes.html](http://www.nationalhomeless.org/causes.html)>.

<sup>4</sup> Section 8 Housing is a voucher program to provide qualified individuals with rental assistance for privately owned rental housing.

<sup>5</sup> “Report of the Surgeon General’s Conference on Children’s Mental Health: A National Action Agenda,” Department of Health and Human Services, December 1999, <<http://www.surgeongeneral.gov/cmh/childreport.htm>>.

<sup>6</sup> *Mental Health: A Report of the Surgeon General*, US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

<sup>7</sup> *1993 Alaska Youth Mental Health Needs Assessment, A Pilot Study of the Prevalence of Seriously Emotionally Disturbed Youth in Alaska*, Department of Health and Social Services, Division of Mental Health and Developmental Disabilities, Juneau, August 31, 1993.

<sup>8</sup> “Alaska Special Education Handbook,” Department of Education and Early Development, September 1999, <<http://www.eed.state.ak.us/tls/sped>>.

<sup>9</sup> *Changing the Conversation, the National Treatment Plan Initiative*, US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, November 2000, <<http://www.samhsa.gov>>.

<sup>10</sup> “Substance Abuse Letter, An Independent Report on Prevention and Treatment Issues,” Pace Publications, Vol. 6, no. 23, 2001.

<sup>11</sup> “Consequences of Non-Treatment,” <<http://www.psychlaws.org/GeneralResources/Fact1.htm>>.

<sup>12</sup> *American’s View of Mental Health At Century’s End, Continuity and Change*, Indiana Consortium for Mental Health Services Research, Indiana University, 2000.

<sup>13</sup> *Changing the Conversation, the National Treatment Plan Initiative*, US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, November 2000, <<http://www.samhsa.gov>>.

<sup>14</sup> “Forgotten Policy: An Examination of Mental Health in the U.S., A Series of Community Voices Publications,” W.K. Kellogg Foundation, May 2001, <<http://www.communityvoices.org>>.

<sup>15</sup> *Mental Health: A Report of the Surgeon General*, US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.



## Next Steps

Comprehensive Integrated Mental Health Plan sets goals, suggests strategies for reaching them, and identifies ways to measure progress on the journey. The two themes that reoccur throughout the plan are the hope of prevention and the call for access to care. They spotlight the need for Alaska's public behavioral health system to expand its service capacity, recruit, and train workers and offer affordable care and services. Strategies supporting these themes stress collaboration and cooperation across the artificial clinical, administrative, and funding barriers that keep people from receiving integrated and comprehensive services. Prevention efforts and service access for everyone will improve with better understanding of racial and ethnic groups, their histories, traditions, beliefs, and value systems.

To measure results of our programs and progress toward our goals, we must have reliable databases that let us see if the programs make a difference to the people they serve. The public behavioral health system is still struggling to develop adequate information systems that collect necessary data on individuals and programs, talk to each other to allow comprehensive analysis, and protect consumer confidentiality. We still have trouble answering the fundamental question: "Does any given program help people function as successfully and independently as possible?"

Equally important are population-based surveys conducted on a regular schedule to measure the public's well being. Surveys such as the Behavioral Risk Factor Survey and the Youth Risk Behavioral Survey allow us to gather Alaska-specific information to compare to other states and the nation. These surveys have time depth and meet national standards for reliability.

To provide the most fiscally responsible, effective care and services, we must continue to support the science-based research needed to evaluate existing programs and to develop new and more effective solutions.

Failure to provide behavioral health care is seen in the devastating consequences of non-treatment - in loss of health, homelessness, suicide, victimization, family dysfunction, worsening of disease symptoms, violence, and incarceration. The number of people with mental illness, untreated addiction, and developmental disabilities reflects the scarcity of services available in many Alaskan communities. Evidence of the need for more effective prevention programs and integrated services is revealed in assessment research, program evaluations, and in public testimony to the Alaska Mental Health Board, the Advisory Board on Alcoholism and Drug Abuse, Alaska Commission on Aging, and Governor's Council on Disabilities and Special Education.

This is the fourth iteration of the comprehensive integrated mental health plan. Each planning process has improved the plan as a framework for policy and funding decisions. As awareness of the comprehensive plan grows and understanding of the plan purpose deepens, there will be an increase in public resolve and a stronger call for action to move the public behavioral health system closer to our vision of a comprehensive, integrated system of prevention and care. Please see "In Step: The Discussion" for additional information and examples of what has and what might work to improve the lives of Alaskans.

The horizon for this comprehensive integrated mental health plan is five years, from 2001 to 2006. The plan process, however, is continuous. Updates about specific issues or shifts in focus will be prepared biennially. Please contact Kathryn Cohen, Plan Coordinator, at (907) 465-3644 or [kathryn\\_cohen@health.state.ak.us](mailto:kathryn_cohen@health.state.ak.us), with your thoughts and concerns about further comprehensive planning efforts.

This document was released by the Department of Health and Social Services and was produced at a cost of \$5.98 per copy in order to provide a plan for a comprehensive integrated mental health program as defined in AS 47.30.056(i). It was printed in Anchorage, Alaska. For information on alternative formats for this and other department publications, please contact the department ADA Coordinator, at (907) 465-1637, (TDD) or (907) 465-3196.

