State of Alaska
FY2013 Governor's Operating Budget

Department of Health and Social Services
Behavioral Health
Results Delivery Unit Budget Summary

Behavioral Health Results Delivery Unit

Contribution to Department's Mission

Improved quality of life through the right service to the right person at the right time.

Core Services

- Provide for a continuum of statewide mental health and substance use disorder services ranging from prevention, early intervention, treatment, and recovery, including inpatient psychiatric hospitalization and operation of the Alaska Psychiatric Institute.

Results at a Glance

(Additional performance information is available on the web at http://omb.alaska.gov/results.)

End Result A: The quality of life for Alaskans experiencing a serious emotional disturbance (SED), a serious mental illness (SMI) and/or a substance use disorder (SUD) is enhanced.

Target #1: At least 75% of individuals who receive Behavioral Health community-based services will report "functioning well" for each of six life domains (Basic Needs, Housing, Activities/Employed, Mental Health, Physical Health, & Thoughts of Self Harm).

Status #1: The target of at least 75% of individuals who receive Behavioral Health community-based services reporting "functioning well" in life domains was met for four of six domains. In FY2008, FY2009, and FY2010, at least 75% of individuals who received Behavioral Health community-based services and completed a follow-up Client Status Review reported "functioning well" for the following four life domains: Financial/Basic Needs, Housing Situation, Physical Health, and Thoughts of Self Harm. Less than 75% of individuals reported "functioning well" for two life domains: Meaningful Activities/ Employment and Mental/Emotional Health.

Target #2: Maintain or increase successful treatment completion by individuals who receive substance abuse treatment services.

Status #2: From FY2009 to FY2011, the percent of individuals who were unenrolled from substance abuse treatment services who successfully completed treatment has remained steady at approximately 50%.

Strategy A1: Improve and enhance the quality of life of children experiencing a serious emotional disturbance through treatment services that meet their clinical needs close to their home communities.

Target #1: Reduce the number of children in out-of-state residential psychiatric treatment centers (RPTCs) by 10% each year.

Status #1: Status: From FY2010 to FY2011, there was a 13% decrease in the number of distinct out-of-state residential psychiatric treatment centers (RPTC) recipients of care (from 221 in FY2010 to 192 in FY2011).

Strategy A2: Improve and enhance the quality of life of Alaskans who experience serious behavioral health disorders by implementing a Performance Management System that promotes process improvement and fosters partnerships to improve the quality of services provided.

Target #1: At least 75% of individuals (including adults, parents/caregivers of youth, and adolescents) who complete the Annual Behavioral Health Consumer Survey for mental health outpatient services will report a positive overall evaluation of services.

Status #1: In FY2011, 78% of adults, 78% of parents/caregivers of youth, and 75% of adolescents who completed the Annual Behavioral Health Consumer Survey for mental health outpatient services reported a positive overall evaluation of services.

Target #2: At least 75% of individuals (including adults, parents/caregivers of youth, and adolescents) who complete the Annual Behavioral Health Consumer Survey for substance use disorder outpatient services will report a positive overall evaluation of services.

Status #2: In FY2011, 78% of adults, 69% of parents/caregivers of youth, and 66% of adolescents who completed the Annual Behavioral Health Consumer Survey for substance use disorder outpatient services reported a positive overall evaluation of services.

Strategy A3: Improve and enhance the quality of life of Alaskans who experience serious behavioral health disorders by assuring them access to a comprehensive, integrated Behavioral Health Service System.

Target #1: Increase the number of youth experiencing serious emotional disturbances (SED) and adults experiencing serious mental illness (SMI) who receive community-based mental health services.
Status #1: From FY2010 to FY2011, the number of youth experiencing serious emotional disturbances (SED) who received community-based mental health services increased 6.9%, from 3,735 in FY2010 to 3,994 in FY2011. The number of adults experiencing serious mental illness (SMI) who received community-based mental health services increased 3.1%, from 7,532 in FY2010 to 7,767 in FY2011.

Target #2: Increase the number of adults experiencing a substance use disorder who receive community-based substance abuse treatment services.
Status #2: From FY2010 to FY2011, the number of adults experiencing a substance use disorder who received community-based substance abuse treatment services increased 1.4%, from 6,255 in FY2010 to 6,344 in FY2011.

End Result B: Alaskans live free from the negative impacts of alcohol and drug use.

Target #1: Reduce the number of alcohol-related motor vehicle fatal crashes.
Status #1: From 2009 to 2010, the number of alcohol-related motor vehicle fatal crashes decreased 22.7%, from 22 in 2009 to 17 in 2010.

Target #2: Reduce the incidence of Fetal Alcohol Spectrum Disorder (FASD) in Alaskan children.
Status #2: The target to reduce the incidence of Fetal Alcohol Spectrum Disorder (FASD) in Alaskan children was met. From 2002 to 2003, the prevalence of FASD decreased 23%, from 128.7 per 10,000 live births in 2002 to 99.1 per 10,000 live births in 2003.

Target #3: Reduce the rate of alcohol-induced deaths.
Status #3: The target to reduce the rate of alcohol-induced deaths was not met. From 2008 to 2009, the number of alcohol-induced deaths per 100,000 population remained relatively steady at 21.7 in 2008 and 21.9 in 2009.

Strategy B1: Prevent and reduce substance use and abuse.

Target #1: Reduce the percent of women consuming alcohol during pregnancy.
Status #1: From 2007 to 2008, the percent of women consuming alcohol during the last three months of pregnancy increased slightly from 5.1% to 6.1%.

Target #2: Reduce the percent of male and female adults ages 21-64 who engage in binge drinking.
Status #2: From 2009 to 2010, the percent of adult males ages 21-64 who engaged in binge drinking during the past 30 days increased from 26.6% to 30.5%; the percent of adult females ages 21-64 who engaged in binge drinking during the past 30 days remained steady at 13.5% both years.

Target #3: Reduce the percent of male and female adults ages 21-64 who engage in heavy drinking.
Status #3: From 2009 to 2010, the percent of adult males ages 21-64 who engaged in heavy drinking during the past 30 days increased slightly from 6.8% to 7.7%; the percent of adult females ages 21-64 who engaged in heavy drinking during the past 30 days decreased from 7.0% to 4.5%.

Target #4: Reduce the percent of high school students who use alcohol.
Status #4: From 2007 to 2009, the percent of high school students who used alcohol during the past 30 days decreased from 39.7% to 33.2%.

End Result C: The mental health of Alaskans is optimized.

Target #1: Reduce the rate of suicide deaths to 10.6 deaths per 100,000 population.
Status #1: The target to reduce the rate of suicide deaths to 10.6 deaths per 100,000 population was not met; however, from 2008 to 2009, the rate did decrease from 24 to 19.6 deaths per 100,000 population.

Target #2: Reduce the percent of adults who experience poor mental health.
Status #2: From 2009 to 2010, the percent of adults who experienced poor mental health during the past 30 days

increased slightly from 7.4% to 8.6%.

Target #3: Reduce the percent of teens who experience depression.
Status #3: During 2003, 2007, and 2009, between 25% and 27% of high school students experienced depression during the past 12 months.

Key RDU Challenges

- **Alaska Psychiatric Institute (API) Transition to an Acute Care Model**
  Over the past year and half, Alaska Psychiatric Institute - Alaska Recovery Center (API) has transitioned to an acute care psychiatric inpatient treatment center. This brings the hospital into alignment with the initial Certificate of Need to establish short-term psychiatric inpatient hospitalization for mentally ill adults and seriously/emotionally disturbed youth. It also achieves the following:
  - o Alignment with healthcare reform to limit long and unnecessary hospitalizations
  - o Alignment with the state's vision of home and community based treatment services
  - o Greater access to available psychiatric inpatient acute care beds

  API treats the most acute phase of a psychiatric illness when hospitalization is medically necessary. The treatment focus is on the resolution of acute symptoms which interfere with daily functioning and the precipitating psychosocial stressors that preceded the need for hospitalization. As the individual has optimized treatment, proactive discharge planning assures the return to community living and treatment.

  The hospital is staffed seven days a week to provide acute care. Active treatment with admissions and discharges occurring on a daily basis presents numerous challenges for the leadership team at the hospital, as well as to the community behavioral health system. The workforce shortage of qualified psychiatrists in the state and at API requires the hospital to contract with Locum Tenens agencies at a cost **twice as much as** a state employed physician. This creates budgetary as well as continuity of care issues. Another challenge is the role of API with the greater Anchorage metropolitan area including the Palmer-Wasilla region. As the only hospital with psychiatric acute care inpatient capacity serving a metropolitan area greater than 425,000 people, demand for bed utilization sometimes exceeds capacity. The system is challenged to create additional capacity in the private sector. Finally, working collaboratively with Behavioral Health's Emergency Services Steering Committee, it will be critical to revitalize crisis services and emergency services around the state and integrate substance abuse into the system.

- **Broadening the Vision of Prevention**
  Nationwide, as well as locally, there is a movement to broaden the vision of prevention to include promotion of mental health, physical health and wellness in addition to the traditional prevention strategies, recognizing the need to act earlier and to incorporate all aspects of health into our state and community health planning. Within the Division of Behavioral Health we oversee a continuum of care that includes prevention of substance abuse, early intervention services for those at risk for substance use or mental health concerns, treatment of both substance use disorders and mental health disorders, and recovery and maintenance following specific treatment services. The piece that has been missing is promotion of good mental health, physical health and overall individual, family and community wellness that can stop the need for future interventions along the continuum of care. In addition, mental health has never been part of the "prevention" services and we are now recognizing there are many strategies and interventions that can be employed to delay onset and reduce severity of many mental health conditions. The Division of Behavioral Health is committed to expanding our vision of prevention. The climate is right for change, as the value of prevention, across disciplines, is gaining momentum. There is now a clear recognition that the social and health problems we are working to minimize are all interconnected, and our efforts across the continuum of care must start earlier, be broader in our reach, and be coordinated across disciplines and service types.

- **Affordable Housing**
  There is a deepening crisis in Anchorage and statewide due to the freeze in subsidized housing vouchers through Alaska Housing Finance Corporation. This is a hardship for hundreds of individuals with serious mental illness. It can potentially cause destabilization, a risk of movement to higher levels of care, preventing transitions to independence from Assisted Living Homes, and an inability to transition out of homelessness.

- **Grant Streamlining**

The treatment and recovery section for DBH currently has multiple grant programs to fund behavioral health treatment for seriously mentally ill adults, severely emotionally disturbed children and substance use disorder adults and adolescents. The reasons for this relate to service expansion that has occurred through new funding coming into the system to promote change: In order to track these services as they were implemented, we kept them separate. Now we have an overwhelming burden of small grant programs that are hard for us to manage and create additional administrative burden for our grantees.

We will be developing a new model to align all adult services and all children/youth services into two distinct programs that will encompass all behavioral health (integrated mental health and substance abuse) treatment services with responsibilities for emergency crisis support for people within Community Service Planning Areas. This will provide the opportunity to blend all of the outlier grant programs into a cohesive system. The additional intent of streamlining is to integrate Medicaid and grant oversight to be better able to verify that the expansion of services we anticipate in 2014 will be targeted effectively to those individuals who are joining the system. We anticipate additional coordination with our behavioral health treatment providers and their primary care providers to partner in development of medical home models for our behavioral health clientele.

- **Service Capacity**
  Insuring access to appropriate services and determining sufficient treatment capacity is a complex responsibility. While we anticipate an increase in need for services due to the expansion of Medicaid, we also anticipate decreased federal financial support. These changes highlight the need for program management strategies necessary to control the system. Projects addressing these multifaceted issues include: establishment of a methodology to determine the capacity of the behavioral health system; identification of system gaps and recommendations for improvement including a review of payment systems to insure a reasonable reimbursement for quality services; changes in infrastructure, coverage, workforce, and information exchanges; development of continuous improvements to the performance management system that optimize data collection, reporting, and analysis that informs and modifies program and clinical practice for improved outcome measurement.

- **Regulations – Ongoing Improvement**
  In support of on-going program improvement, Behavioral Health has identified several areas where regulation changes are required or should be considered. These include: revise Medicaid Residential Psychiatric Treatment Centers (RPTC) coverage regulations to ensure standardization in licensure and national accreditation requirements for out-of-state facilities; revise regulations covering methadone programs to align with current national coverage standards; adopt a standardized level of care instrument to support continuum of behavioral health services; define standards outlining mandatory critical incident reporting requirements; add specialized early childhood Medicaid services; revise authorization criteria for admission to psychiatric hospital and RPTC services; define coverage for behavioral health aides; consider revising services included in the daily rate for RPTC services; revise Medicaid service coverage for psychologists; expand disenrollment and sanction authorities; and consider reimbursement for prevention.

- The national landscape includes emerging issues that will have significant implications and challenges for the Division of Behavioral Health. These include:
  - **The Affordable Care Act** will have major impact on the current behavioral health system of care. For example, by 2014, Alaska's Medicaid eligibility criterion will expand to include all citizens, including children, who fall under 133% of the federal poverty rate. Additionally, foster care children will be covered up to age 26. This will result in a significant increase in enrollment. Previously uninsured citizens will obtain access to care through insurance reform and coverage expansion. Demand for behavioral health services is estimated to increase by as much as 30%. This has significant implications for the manner of access to services, service delivery, workforce development, and challenges to the management and oversight of multiple service systems. This expansion of coverage and the anticipated increased demand in access to services will challenge and strain the current behavioral health treatment system.
  - **HITECH Act:** The Health Information Technology for Economic and Clinical Health Act (HITECH Act) is rapidly reshaping the arena of electronic health records (EHR) requiring an interoperable health IT network. At the core of interoperability is the requirement for EHR applications to meet certification standards of "meaningful use." The arena of behavioral health was excluded from federal legislation that would have assisted in accessing financial resources to support the expense of achieving meaningful use certification. The Division functions as a vendor of an EHR application, i.e. the AKAIMS system, and must absorb this additional programming expense and obligations for long term future maintenance costs as well. Behavioral

health treatment service providers will be challenged to reevaluate current clinical and business practices to align with EHR applications.

- **ICD & 5010:** Most world healthcare systems follow the World Health Organization (WHO) International Classification of Diseases (ICD). This coding scheme is used to classify morbidity and mortality data for vital statistics tracking and for health insurance claim reimbursement. The federal government mandates the move from the ICD-9 system to an expanded ICD-10 version to be implemented by October 1, 2013. In addition, the government has also mandated an upgrade of the nine HIPAA transaction formats for electronic data transmission from the initial 4010 version to version 5010. The deadline for this implementation is January 1, 2012 to accommodate the expanded ICD-10 codes. Developing an effective consecutive implementation for these two major changes will require strategic planning to include training, interaction with vendor systems, changes to internal legacy systems, benefit and provider contractual changes, and testing to ensure a transparent changeover.

- **Integrating Behavioral Health and Primary Care Services**
  Over the past twenty-five years many studies have found correlations between physical and behavioral health-related problems. Individuals with serious physical health problems often have co-morbid mental health and substance abuse problems. While patients typically present with a physical health complaint, data suggest that underlying mental health or substance abuse issues often trigger these visits. These realities explain why increased integration of behavioral health and healthcare services is a priority amongst policymakers, planners, and providers of physical and behavioral health care across the United States. The challenges we face in Alaska include:
  - Identification, facilitation and support of behavioral health providers and primary care providers that are willing to enter into partnerships to develop and operate a full continuum of healthcare services. The implications for system-wide duplication and competition for scarce resources are significant.
  - Development of new ancillary resources such as healthcare homes to support the integrated services.
  - Monitoring and oversight to assure that behavioral health services are not diminished or overshadowed as a result of integration.

Significant Changes in Results to be Delivered in FY2013

- **Substance Abuse Treatment for Unresourced Individuals**
  This increment would make grant funds available to expand capacity to provide medical detox, residential, and/or intensive outpatient substance abuse treatment – followed by aftercare – to unresourced adults. It addresses the fact that demand for residential treatment, intensive outpatient, and aftercare continues to exceed the substance abuse treatment system's capacity. It is also designed to reinforce the existing treatment capacity in the face of a potential increase in demand for services. If the 30,000 uninsured Alaskans living at or below 133% of the federal poverty index become eligible for publicly funded health insurance after 2014 (based on 2006 prevalence estimates), at least 2,800 of these adults can be expected to experience a substance use disorder requiring treatment.

  This recommendation to expand substance abuse treatment capacity supports the efforts of the Domestic Violence and Sexual Assault prevention initiative by improving access to treatment. Without this funding, individuals experiencing substance use disorders – especially in non-priority groups – will continue to be disproportionately represented among prison, homeless, unemployed and other disadvantaged populations. Their families and communities will continue to endure the consequences of their untreated addiction and dependence. Waitlists will become untenable as more Alaskans become eligible for publicly funded services, creating even greater burden on the already taxed substance abuse treatment system.

- **Tele-Health Strategic Capacity Expansion**
  The entire state of Alaska is a Workforce Shortage Area for Behavioral Health Professionals. There are a limited number of psychiatrists in Alaska. Most of our communities have *no* psychiatric coverage and shortages of behavioral health clinicians and direct service workers resulting in inadequate access to behavioral health services. Lack of availability results in costly travel to access care, and the care is often at higher, more costly levels than necessary. One of the strategies we have used in the private, tribal and public sectors is implementation of tele-health solutions. However, the current tele-health solutions focus on agency to hub area connectivity using high end equipment and expensive T-1 line connectivity. Technological solutions have

advanced that include a PC based application of tele-health to a home-based model that is less expensive and has more comprehensive application.

This increment requests funding to: (1) assess readiness of the DBH provider network to pilot such a demonstration project; (2) review potential vendors and telecommunications carriers to work collaboratively with the Division for a custom application; and (3) identify specific hub areas for linkage to appropriate services for home-based treatment.

Positive potential benefits include: increased access to behavioral health services by getting services into homes via case managers, behavioral health aides, and others; decreased travel costs for treatment and court appearances; increased integration with primary care; and increased productivity.

- **Trauma Informed Behavioral Health Care**
  This increment would ensure access to trauma-informed behavioral health services for victims of domestic violence, sexual assault, and other forms of interpersonal violence. It builds upon DBH efforts in the previous two fiscal years to train behavioral health providers in trauma informed care practices. This increment supports direct services for adult victims of violence.

  For a victim of domestic violence experiencing a generalized mental health issue or moderate alcohol dependence, treatment services are out of reach unless the person has private insurance. Rather than wait until that person's condition worsens to become one of the Medicaid priorities for treatment services, this increment would ensure access to treatment and early intervention services to address the behavioral health issue **before** it becomes a serious, incapacitating (and expensive) disorder.

  Services will be accessed through existing Network on Domestic Violence and Sexual Assault providers who have operating agreements with their local Comprehensive Behavioral health Treatment & Recovery Grant provider so that individuals who have Medicaid will be able to pay for their treatment services via that method. Non-resourced clients will be able to access care through the grant funds that this increment provides.

- **Early Childhood Screening and Brief Behavioral Services Package**
  Brief behavioral services are expected to become available for young children and their families in primary care offices and community mental health centers in FY2013. These services will be effective interventions for children and families experiencing the consequences of domestic violence. By encouraging providers to perform early and regular screenings for developmental and social-emotional delays/disabilities, we can ensure that Alaskan children who have witnessed or suffered domestic violence receive the services they need to grow up healthy.

  The impact of child maltreatment (abuse, neglect, and witnessing domestic violence) on brain development, as well as cognitive and emotional development, has been well-documented. Depression, disassociation, post traumatic distress disorder (PTSD), maladaptive behaviors, language deficits, altered brain maturation and other neuropsychological outcomes can all result from being a childhood victim or witness to domestic violence. Standardization of early childhood screenings (i.e. Early Periodic Screening, Diagnosis, and Treatment - EPSDT) to identify and intervene with early childhood behavioral and developmental concerns will help to connect these children and families to services needed to promote healthy development.

  The increment would fund outreach, training, and technical assistance to encourage more providers to administer EPSDT screenings, to use a standardized screening tool, to inform them about services available and to provide information necessary for meaningful referral to services. This increment would also fund education and outreach to parents about the EPSDT program and the services available to them – while also stressing how important it is that children not only be kept safe from harm, but also to receive services early to address the harm that results from living in a violent household.

- **Bring the Kids Home (BTKH) – The Next Phase**
  Plans for transition of the BTKH Initiative service array into the regular business of the seriously emotionally disturbed youth and children and adolescents with substance use disorders will require focus and clear direction so we do not lose momentum. We are targeting a more effective on-going review of all children and youth in Residential Psychiatric Treatment Center (RPTC) care to shorten their length of stay and reintegrate them into their family and community earlier with more success. This will require that we realign funding within the initiative

to support in-state service expansion and a renewed focus on treating the whole family together. The goal is to sustain the forward progress achieved by this very successful endeavor and implement strategies that will imbue the entire children's system with the values of the initiative:

- Kids belong in their homes (least restrictive, most appropriate setting, community based).
- Strengthen families first (strength based, preventative).
- Families and youth are equal partners (family driven, youth driven).
- Respect individual, family and community values (culturally competent, individualized care, community-specific solutions).
- Normalize the situation (meet the child where they are, respect normal life cycles, promote normal and healthy development).
- Help is accessible (coordinated and collaborative).
- Consumers are satisfied and collaborative meaningful outcomes are achieved (emphasis on research, evidence, quality improvement, accountability).

The system will also be stretching to absorb the early childhood behavioral health service expansion with the intention of limiting the number of children who access the deeper end of the service array by catching them early, treating them within the family context so we are building stronger families for these at-risk children.

Major RDU Accomplishments in 2011

- **Prevention Programs and Initiatives**
  - FY2011 was the final year of a 3-year grant cycle for our Comprehensive Behavioral Health Prevention & Early Intervention grants. We are beginning to collect the data for the last three years to develop a prevention program outcomes report from strategies and interventions conducted across the state.
  - In January of FY2011 DBH received approval of our federal Strategic Prevention Framework State Incentive Grant (SPF SIG) Strategic Plan, where we identified youth alcohol use and adult heavy and binge drinking as Alaska's top priority consumption pattern, based on a review and analysis of our state's substance use data. In February we released a Request for Proposals, based on the approved strategic plan. Grants were awarded in FY2012.
  - Alaska Fetal Alcohol Syndrome (FAS) prevalence rates were released showing an overall 32% decrease in FAS births prevalence from 19.9 to 13.5 per 10,000 live births and a 49% decline among Alaska Native births, from 63.1 to 32.4 per 10,000.
  - In FY2011 two new FASD diagnostic teams were added in Anchorage and Glennallen/Copper Center. The number of diagnoses conducted in Alaska increased from 133 in FY2010 to 179 diagnoses in FY2011. We completed a total of 1,683 diagnoses or an average of 153 diagnoses per year between 2000 and 2011
  - All therapeutic court funds were combined and moved to the Alaska Court System budget in an effort to streamline and better coordinate the State's Therapeutic Court System.
  - In the Spring of FY2011, a coverage study was conducted to document tobacco retailers across the state that are conducting business and to verify that those conducting business have a tobacco endorsement. The results of that study are currently being analyzed and will be available in the fall of FY2012. It appears there are no significant concerns, but the information collected will assist us in determining additional educational and compliance tools retailers need to continue to improve our state's youth tobacco sell rate. We have seen consistently decreasing sell rates over the past three years.

- **Services for Severely Emotionally Disturbed Youth**
  - There are currently thirty community-based mental health programs throughout the state that are providing a comprehensive spectrum of outpatient services including rehabilitation services delivered in the home, community, or school settings to develop an expansive, flexible, community-based system of care.

  - The **"Parenting with Love and Limits" (PLL)** contractor completed site visits to agencies on the Kenai Peninsula and in Anchorage delivering intensive training to direct care staff on PLL. Bi-weekly telephonic supervision was provided to three Kenai Peninsula sites and Anchorage Division of Behavioral Health and Division of Juvenile Justice sites for care review and supervision for family group cohorts. During FY2010 and FY2011 192 youth and families were served, and as a result many youth were brought home early from treatment and served in the home with their family. In other situations, PLL was effectively used to divert potential out-of-home placement. During the contract period 28 staff members were fully trained in PLL. Outcomes are demonstrating that the investment of the state into PLL is effective in serving the target population and keeping them in their home communities with their families.

- The **Transition to Independence Process (TIP)** contractor completed site visits to Anchorage, Sitka, Fairbanks and Mat-Su providing community-wide stakeholder trainings, intensive grantee focused training specifically with program managers and peer facilitators, and monthly telephonic support to ensure TIP services are moving forward as projected. During FY2010 and FY2011 168 total transitional aged youth and families were served in which we saw youth returned to the home from in-state and out-of-state residential treatment while also identifying youth who were at risk of going into residential treatment and working with families to avoid placement. The numbers of youth served in all sites met the anticipated outcomes. During the contract period there were 114 staff fully trained in TIP.

- **Residential Child Care Related**
  - During FY2011, Residential Care grantees began using AKAIMS for reporting, the Alaska Screening Tool (AST) is being used by residential programs to screen for substance abuse, mental illness, co-occurring substance abuse and mental illness, traumatic brain injury (TBI), and Fetal Alcohol Spectrum Disorders (FASD), and the Client Status Review (CSR) to measure success in treatment and recovery.
  - During the fiscal year, several rural shelters were made eligible to provide longer term services when appropriate for youth. This allows youth to stay in their home community when possible and may aid rural shelters to remain financially viable.

- **Behavioral Health Emergency Services System**
  During FY2011, the division hired a statewide Emergency Services Program specialist. FY2011 accomplishments include:
  - Creation of the Community Emergency Services System Steering Committee with six workgroups: Administration, Financing, Collaboration, Behavioral Health Services, Community Resources, and Peer & Family Supports.
  - Coordination between the Alaska Court System, the Public Defender Agency, the Department of Law, and the Division regarding revisions to the Alaska State Court System forms that pertain to the emergency detention, evaluation and involuntary commitment of persons experiencing a mental health crisis.
  - Initiation of the UAA / API Data Project with the goal of reviewing API admissions and discharge data in order to help explore potential ways to reduce census pressures on API.
  - South Peninsula Hospital in Homer to complete an agreement to provide Designated Evaluation and Stabilization (DES) services to the south Kenai Peninsula region by the end of 2011.
  - Long-promised crisis prevention and intervention training provided to the staff of two of Alaska's three DES hospitals (PeaceHealth Ketchikan Medical Center and South Peninsula Hospital), as well as to the staff of these two communities' associated behavioral health centers, meeting the Division's goal of helping the staff at these facilities feel more competent in working with difficult, aggressive, acting out patients.
  - Revised DSH agreements to be completed, as well as separate agreements with all DES and DET hospitals for the reporting of information regarding the admissions to these facilities of persons seeking payment of their treatment services under the State's Mental Health Assistance Program (MHAP).
  - A substantially revised Provider Agreement (PA) for Secure Transport Services was completed, including increases to the fee structure. The new fee structure was sufficient to encourage the existing two secure transport companies to remain in the business, and DBH was also able to recruit a new start-up company into the business, which greatly relieved stress on the system and quieted service complaints.

- **Housing and Discharge Incentives Programs**
  The focus of care continued to be a reduction of use of the Alaska Psychiatric Institute (API) and Department of Corrections (DOC) facilities through a concurrent increase in community supports, appropriate interventions and housing stability. The Bridge Home Pilot program and the DOC Discharge Incentives program continue to deliver results consistent with their missions. In FY2011, there was a shift in focus in that the DOC program is attempting to serve mentally and behaviorally complex adults who formerly were sent out of state for residential care and the Bridge Home program is working with clients having more severe issues than previously. The reporting requirements for the programs have been revamped to be more outcome and results-oriented rather than purely quantitative. The Adult Individualized Services (ISA) program was established and began funding services for the hard to serve population of SMI adults with no benefits or other resources. Specific accomplishments include:
  - 50 Bridge Home clients with histories of high utilization of the Alaska Psychiatric Institute (API) and Department of Corrections (DOC) resources and history of housing instability were served by the program. Those admitted to the Bridge Home since July 1, 2010 spent 766 days in jail and 78 days in API in the year

preceding their involvement. Through the end of the 4th quarter of FY2011, these same had spent no time in API and 35 days in jail.
- 74 clients released from DOC were housed through the Discharge Incentive grant, most of whom would have been otherwise homeless.
- During the fourth quarter of FY2011, 823 unduplicated persons were served by the Mental Health Web, a peer operated program serving a population with high representation of Alaska Natives. A client satisfaction survey done during the fourth quarter of FY2011 shows that 91% of clients reported an improvement in their functioning or quality of life.
- A peer support specialist from a community based peer provider agency meets with hard-to-engage API patients prior to discharge in an effort to engage them in support services as they return to the community.
- 12 agencies utilized Adult Individualized Services Agreements with 12 agencies to provide services to unresourced consumers.
- Services were provided to 10,752 seriously mentally ill adults statewide.
- Technical Assistance related to housing inventories was provided to Fairbanks Community Behavioral Health Center and Kenai Peninsula Housing Initiatives.
- Participated in successful conditional use permit process for the 48 unit Karluk Manor, a Housing First project in Anchorage for people who are chronically homeless.
- Brokered cooperation between service providers and ecumenical groups for the purpose of moving a Fairbanks Housing First project forward in a 102 unit former hotel.
- Initiated investigation of AKAIMS data to provide housing needs indicators from Living Situation and Household Code data.
- The Assisted Living Home Training & Targeted Capacity for Development project provided training to a total of 191 behavioral health and other assisted living home staff trained during FY2011. There were a total of 21 trainings provided. Communities served were: Anchorage, Fairbanks, Wrangell, and Seward. The training planned for Bethel had to be cancelled. Information gathered during the year shows a 400% increase in use from FY2010 to FY2011. Pre and post test results indicate there were significant changes for all 19 levels of knowledge.

- **Sexual Assault and Domestic Violence Prevention**
  In early December of 2009, the Governor announced an initiative to “eliminate the epidemic of sexual assault and domestic violence within a decade.” Via an RSA from the Governor’s Office, Behavioral Health received funding for the following projects during FY2011.

  - **Trauma Informed Training for Behavioral Health Providers:** DBH worked with the Anchorage Community Mental Health Center to develop the Trauma 101 curriculum. The development committee included 5 trauma content experts, a lead curriculum developer and curriculum designer. Eighteen trainings reaching 600 providers have been provided to date. These trainings have ranged from brief (two to four hours) trainings aimed at building basic trauma-awareness and knowledge for broad audiences (Annual School on Addictions and Early Childhood Mental Health Institute) to more intensive multi-day trainings aimed at systematic trauma-informed care implementation (four days of training on evidence-based trauma-informed care for Division of Juvenile Justice staff, two days of training for teachers and school nurses and two days of training for 12 agencies in Haines) and blended trainings that are aimed at building foundational knowledge for a targeted audience (on-site training for Covenant House staff).

  - **Family Wellness Warriors:** The Family Wellness Warriors project is a three-year community commitment to development of a sustainable, community-owned and driven process to increase health and wellness and decrease all forms of interpersonal violence and other contributing factors such as substance abuse. Year one of the initiative included a project in Dillingham that was concluded at the end of FY2011.

  - **Multi-disciplinary Rural Community Pilot Project:** In FY2011 four communities received these grants. Dillingham received $800,000 for an implementation grant. Kodiak, Bethel and Sitka each received $200,000 for capacity building projects. Each of these grant programs were initially funded in February 2011, thus having only a partial first year of funding. Key accomplishments in FY2011 include the completion of the Dillingham service area Alaska Victimization Survey, the introduction of the Green Dot By-Stander participation program in three of the four communities; the completion of Undoing Racism training in Bethel; the completion of a community Choose Respect mural in Sitka; and a number of youth leadership programs in Bethel and Sitka.

- **Treatment and Recovery Services**
  - **The Secured Treatment Unit at the Salvation Army Clitheroe Center**: Despite a program closured in FY2011 the program provided 1,093 nights of services and is operating at full capacity with 6 Detox beds.

  - **Numbers served in the publicly funded Substance Abuse treatment system in Alaska**: 694 youth experiencing substance use disorder (SUD) and 6,344 adults experiencing SUD.

  - **Substance Abuse Treatment Capacity for Pregnant Women**. The division made grant funds available to expand substance abuse treatment capacity for pregnant women, targeting communities outside of Anchorage and Fairbanks. The substance abuse treatment projects began delivering services January 2011. A third project is targeted to begin in January 2012. These projects worked in close collaboration with the Office of Children's Services and other agencies that provide services or interact with pregnant women, such as Public Health Nursing.

  - **Sobering Center Operations in Bethel:** The Yukon Kuskokwim Correctional Center reports that the Sobering Center activity has reduced the number of Title 47 12-hour protective custody holds by 66% in the fourth quarter of FY2011. Sobering Center staff are offering and administering the Screening, Brief Intervention and Referral to Treatment screen tool. Based on the assessment, the appropriate referral to behavioral health and/or substance abuse treatment services is made. The Sobering Center is not just a place to "sleep it off." People are treated with respect and staff members engage the clients in change toward sobriety.

- **Pre-development Activities for Developing Sleep-Off Alternatives in Targeted Communities (Nome)**: The project established two activities which led to the development of culturally appropriate treatment for the region. The first was the establishment of the Cultural Committee made up of local community recovering substance abusers, current behavioral health aides from several villages and the connection with the region-wide Wellness Forum which provides input from various representative groups from around the region including the villages as well as service agencies. The second activity was to work with each Indian Reorganization Act (IRA) village council to select Elder representatives from each village to provide input on traditional values and healing practices which will then be incorporated into the treatment services provided. No clients were served during FY2011, but the results of the community meetings and the input from communities and individuals has demonstrated the concern and willingness of the residents of the region to start making some changes in how their services are provided and in a way that is acceptable to the people of the region.

- **Workforce Development**
  - **Alaska Psychology Internship Consortium (AK-PIC)**. The goal of this project was to train psychologists to help meet Alaska's behavioral health workforce needs. AK-PIC is a pre-doctoral internship program that is partially affiliated with the joint University of Alaska Anchorage and Fairbanks PhD program in Clinical-Community Psychology. In June of 2011, AK-PIC graduated its first class of interns. Of the five AK-PIC graduates, three are now employed by behavioral health agencies in Alaska. One is completing his dissertation, and plans to seek employment within the state in the near future. One of the five interns from AK-PIC's inaugural cohort has sought employment outside the state of Alaska. The unique nature of the internships both in content (mental health and addictions, trans-cultural focus), location, and creative use of technology (web portal and videoconferencing) are gaining national attention.

  - **PhD Student Partnership.** The doctorate program in Clinical Community Psychology at the University of Alaska was designed with a rural indigenous emphasis to prepare doctoral level scientist-practitioners who join theory, practice and research to meet behavioral health needs and to improve the wellbeing of Alaskans and their communities. Two graduate research students worked to maximize the clinical utility of the Alaska Screening Tool and Client Status Review outcomes instrument. Funding for this project ended in June, 2011.

  - **Tribal Rural System Development:** This project focuses on the development of services and strategies specific to tribal systems to expand health service delivery and improve funding mechanisms, as recommended by Senate Bill 61 (CH10, SLA 2007) (Medicaid Reform report). There are two major components to this initiative: 1) a contract for gap analysis and 2) an amendment to the MMIS Contract. The gap analysis contractor has completed 11 of the 12 on-site evaluations of programs. Final reports have been

completed for seven agencies. The remaining reports are in review status and will be finalized after agency feedback has been received. The contractor has completed a summary report listing common issues. To date the contractor for the amendment to the MMIS contract has developed an introductory video, five training tutorials including workbooks and three job aids. They are completing work on two additional modules and two job aids. The on-line system has been installed and is currently being pilot tested by three tribal agencies.

- **Alaska Mental Health Board and Advisory Board on Alcohol and Drug Abuse (AMHB/ABADA)**
  During FY2011, the Boards' specific advocacy and public information campaigns included:
  - Participated in the statewide anti-stigma campaign targeting the general public with the message "You Know Me" and ran the complementary campaign with the message "Treatment Works, Recovery Happens."
  - Coordination of Fetal Alcohol Spectrum Disorders (FASD) Awareness Day and Recovery Month events in Juneau, Anchorage, and other communities.
  - Members of the Alaska FASD Partnership engaged in educational and advocacy events throughout 2011, with special focus on including individuals experiencing FASD and their families/caregivers as advocates.
  - A Youth Policy Summit was held in 2011, at which youth from several Alaska communities came to Juneau to participate in education and advocacy activities with legislators and policymakers.
  - Since 2005, nearly 250 consumers and self-advocates have received advocacy training.

- **Statewide Suicide Prevention Council**
  - In FY2011 the Council, with the Iron Dog, DHSS, Alaska Native Tribal Health Consortium, Alaska Mental Health Trust Authority, and Alaska Brain Injury Network, developed a highly regarded education and awareness campaign featuring the 2010 and 2011 winners of the Iron Dog Race. This partnership grew to include the Alaska State Troopers, who helped deliver the message in villages along the race route.
  - Over 100 stakeholders were engaged by the Council in developing the five-year State Suicide Prevention Plan.

Contact Information

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Behavioral Health
RDU Financial Summary by Component

All dollars shown in thousands

	FY2011 Actuals				FY2012 Management Plan				FY2013 Governor			
	UGF+DGF Funds	Other Funds	Federal Funds	Total Funds	UGF+DGF Funds	Other Funds	Federal Funds	Total Funds	UGF+DGF Funds	Other Funds	Federal Funds	Total Funds
Formula Expenditures												
None.												
Non-Formula Expenditures												
AK Fetal Alcohol Syndrome Pgm	1,363.4	0.0	0.0	1,363.4	1,673.9	0.0	0.0	1,673.9	1,673.9	0.0	0.0	1,673.9
Alcohol Safety Action Program	2,095.7	1,063.7	264.1	3,423.5	2,154.3	1,770.6	310.1	4,235.0	2,183.0	1,766.4	310.1	4,259.5
Behavioral Health Grants	24,450.4	1,358.1	3,309.6	29,118.1	25,250.8	1,896.5	3,432.2	30,579.5	26,300.8	1,696.5	3,432.2	31,429.5
Behavioral Health Administration	7,160.8	529.6	2,950.9	10,641.3	7,935.8	982.1	2,376.5	11,294.4	8,205.2	939.7	2,424.3	11,569.2
CAPI Grants	2,454.2	1,660.8	1,088.0	5,203.0	2,069.1	1,400.0	3,247.9	6,717.0	2,069.1	1,600.0	3,247.9	6,917.0
Rural Services/Suicide Prevent'n	2,557.0	0.0	368.8	2,925.8	3,068.2	0.0	500.0	3,568.2	3,068.2	0.0	500.0	3,568.2
Psychiatric Emergency Svcs	7,145.7	2.0	0.0	7,147.7	8,809.0	0.0	0.0	8,809.0	8,809.0	0.0	0.0	8,809.0
Svcs/Seriously Mentally Ill	14,629.9	1,100.0	890.1	16,620.0	15,019.8	1,150.0	972.0	17,141.8	15,044.8	950.0	972.0	16,966.8
Designated Eval & Treatment	3,134.2	0.0	0.0	3,134.2	3,156.4	0.0	0.0	3,156.4	3,156.4	0.0	0.0	3,156.4
Svcs/Severely Emotion Dst Yth	12,021.6	1,038.1	0.0	13,059.7	14,234.9	1,321.8	0.0	15,556.7	15,284.9	1,391.8	0.0	16,676.7
Alaska Psychiatric Institute	9,715.3	22,551.8	0.0	32,267.1	7,152.7	24,454.9	0.0	31,607.6	7,310.4	24,875.2	0.0	32,185.6
API Advisory Board	2.8	0.0	0.0	2.8	9.0	0.0	0.0	9.0	9.0	0.0	0.0	9.0
AK MH/Alc & Drug Abuse Brds	485.2	377.2	19.4	881.8	471.7	513.0	97.8	1,082.5	537.0	493.6	99.3	1,129.9
Suicide Prevention Council	128.0	0.0	0.0	128.0	130.9	0.0	0.0	130.9	584.9	0.0	0.0	584.9
Totals	**87,344.2**	**29,681.3**	**8,890.9**	**125,916.4**	**91,136.5**	**33,488.9**	**10,936.5**	**135,561.9**	**94,236.6**	**33,713.2**	**10,985.8**	**138,935.6**

Behavioral Health
Summary of RDU Budget Changes by Component
From FY2012 Management Plan to FY2013 Governor

All dollars shown in thousands

	Unrestricted Gen (UGF)	Designated Gen (DGF)	Other Funds	Federal Funds	Total Funds
FY2012 Management Plan	**71,569.7**	**19,566.8**	**33,488.9**	**10,936.5**	**135,561.9**
Adjustments which will continue current level of service:					
-Alcohol Safety Action Program	21.1	7.6	-4.2	0.0	24.5
-Behavioral Health Grants	0.0	0.0	-675.0	0.0	-675.0
-Behavioral Health Administration	175.2	19.2	-367.4	47.8	-125.2
-CAPI Grants	0.0	0.0	-1,400.0	0.0	-1,400.0
-Svcs/Seriously Mentally Ill	-325.0	0.0	-1,150.0	0.0	-1,475.0
-Svcs/Severely Emotion Dst Yth	0.0	0.0	-1,205.0	0.0	-1,205.0
-Alaska Psychiatric Institute	157.7	0.0	345.3	0.0	503.0
-AK MH/Alc & Drug Abuse Brds	15.3	0.0	-454.4	1.5	-437.6
-Suicide Prevention Council	4.0	0.0	0.0	0.0	4.0
Proposed budget decreases:					
-Alcohol Safety Action Program	0.0	0.0	-85.0	0.0	-85.0
Proposed budget increases:					
-Alcohol Safety Action Program	0.0	0.0	85.0	0.0	85.0
-Behavioral Health Grants	1,050.0	0.0	475.0	0.0	1,525.0
-Behavioral Health Administration	75.0	0.0	325.0	0.0	400.0
-CAPI Grants	0.0	0.0	1,600.0	0.0	1,600.0
-Svcs/Seriously Mentally Ill	350.0	0.0	950.0	0.0	1,300.0
-Svcs/Severely Emotion Dst Yth	1,050.0	0.0	1,275.0	0.0	2,325.0
-Alaska Psychiatric Institute	0.0	0.0	75.0	0.0	75.0
-AK MH/Alc & Drug Abuse Brds	50.0	0.0	435.0	0.0	485.0
-Suicide Prevention Council	450.0	0.0	0.0	0.0	450.0
FY2013 Governor	**74,643.0**	**19,593.6**	**33,713.2**	**10,985.8**	**138,935.6**