State of Alaska
FY2014 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.

Major RDU Accomplishments in 2012

The Alaska Psychology Internship Consortium (AK-PIC)

- The primary goals of the Alaska Psychology Internship Consortium focus on providing a means for University of Alaska Anchorage/University of Alaska Fairbanks psychology doctoral students to complete their training in state, to recruit psychologists from out of state, and to positively impact the behavioral health system of Alaska by addressing critical workforce shortages.
    - Intern Recruitment: In its first three years of existence, the Alaska Psychology Internship Consortium has provided an opportunity for over 90% of the internship-ready University of Alaska Anchorage/University of Alaska Fairbanks psychology doctoral students to complete their training in state, and has recruited eight new pre-doctoral psychology interns into the state.
    - Expansion: Five in year one and seven in year two -- the training sites at the Alaska Psychiatric Institute and the Alaska Family Medicine Residency at Providence Hospital each expanded to two slots, while the remaining three training sites retained one slot each.
    - In-State Retention: Of the twelve Alaska Psychology Internship Consortium graduates to date, ten have remained in state to begin their professional careers in behavioral health. Of those ten, nine have obtained employment in behavioral health agencies. One is taking time to complete her dissertation, and plans to seek employment within the state in the near future.

Tribal/Rural System Development

- The team provided a gap analysis on business practices for all interested tribal grantees and that allowed us to target training to their behavioral health agency staff on the following range of issues:
    - Behavioral Health integrated regulations; specifically in relation to clinical documentation
    - Medicaid billing
    - Medicaid enrollment
    - Developing ongoing quality assurance programs within agencies
    - Assisting agencies in developing ongoing training efforts
    - Assisting agencies in developing policies and procedures
    - Developing a comprehensive documentation handbook
- Plans are currently underway to solicit a second technical assistance contract that will focus on the Behavioral Health Aide services provided in the village and assist tribal behavioral health agencies in developing culturally relevant therapies that will meet the definitions of rehabilitation therapies within the regulations.

Tobacco Enforcement and Education

- Since 1996 when Alaska first began its Tobacco Enforcement and Education Program, youth access to tobacco products has dropped from a 2001 high of 36% of retailers selling tobacco to youth under 19, to **a 2012 low of 6.5% of retailers selling tobacco to youth**—a reduction of almost 30 percentage points. Keeping tobacco products out of the hands of our youth has also helped decrease the number of Alaska high school youth who smoke, from 37% in 1995 to 14% in 2011 (according to the Alaska Youth Risk Behavior Survey). The success of this effort is due to the combined activities of our federal, state, local, and community partners; everyone working collectively toward a common goal—healthier Alaskan youth.

Integrated Regulations

- The Division implemented the Integrated Behavioral Health Services Regulations on October 1, 2011. A full systems implementation occurred on December 1, 2011. This created a single set of Behavioral Health reimbursement rates for Medicaid Services, and a single set of service guidelines for mental health, substance abuse, and co-occurring disorders. Changes and results from these integrated regulations include the following:
    - Promote an expectation and increased capacity to deliver integrated services to individuals with co-occurring mental health and substance use disorders.
    - National program accreditation will play a role in the overall system of standards.
    - The behavioral health system will continue movement toward a continuous quality improvement model.
    - A fundamental shift in policy direction of program approval and oversight in Alaska.
    - A continued emphasis on a management strategy that is outcome and performance based.
    - Implementation of a service authorization system for community-based Medicaid services using defined clinical criteria.

Office of Integrated Housing

- Working collaboratively during FY2012, the Office of Integrated Housing was able to provide technical assistance related to housing and supportive services development to many agencies and individuals statewide.
    - Contributed to the acquisition of a structure and in development of services for large “Housing First” project in Fairbanks.
    - Participated in the development planning for a large (54 person) facility to house some of the most challenging and unstable clients in Anchorage.
    - Provided technical assistance to special needs housing grant recipients statewide.
    - Managed grants to agencies serving beneficiaries to ensure continued high quality service in a cost effective manner.
    - Provided technical assistance for rural providers seeking help finding resources for high needs clients.
    - Worked with the Alaska Psychiatric Institute to develop housing and service-related resources for high-risk, high-needs clients.
    - Managed a program which provides for residence in assisted living homes for approximately 150 persons.
    - Served on panels and workgroups to develop services for clients needing a high level of support to maintain residences.

Pre-development of the Sobering Center for Nome

A new chief executive officer assumed the helm of the Norton Sound Health Corporation in FY2012 and continued the project plan to develop the full range of substance use disorder treatment services for the region – sobering center, Intensive Outpatient Program, and Outpatient Program with safe/sober housing. The program will be located in the old hospital facility. A sustainability plan is in development. The current plan is to open the facility and provide services by the fourth quarter of FY2013.

Sobering Center Operations in Bethel

The Yukon Kuskokwim Sobering Center achieved the stated goals of reduced census at the Yukon-Kuskokwim Health Corporation Emergency Department and the Yukon Kuskokwim Correctional Center’s jail. The goals of harm reduction for individuals were further met by the safe and respectful nature of the Sobering Center. Application of Screening, Brief Intervention, and Referral to Treatment (SBIRT) protocols has provided education on the health risks and costs of alcohol use to individuals seen at the facility with follow-up referrals to Yukon-Kuskokwim Health Corporation Behavior Health outpatient for further alcohol use assessment. Midway through the fiscal year, the program received additional funding to provide 24/7 operations. This program is seen as a model for other communities who are building similar services – as referenced above – in Nome.

Family Wellness Warriors

- The SouthCentral Foundation Family Wellness Warriors Initiative began its second year of a three-year program with the community of Bethel. Year two began with a great deal of tension and miscommunication among the participating agencies in the Bethel area. There was concern among two of the three major

community partners (Yukon Kuskokwim Health Corporation, Orutsararmiut Native Council, and Association of Village Council Presidents) that the initiative had not been agreed upon by all community agencies and that the Family Wellness Warriors Initiative approach was not appropriate for the Bethel-Yukon Kuskokwim region. Through a deliberate and thoughtful process, the Family Wellness Warriors Initiative staff stepped back, and worked with all three agencies to re-open communications, bring all interested parties to "the table" and worked through the misunderstandings and miscommunication that had occurred. While certain staff of all three agencies had agreed to the introduction of Family Wellness Warriors Initiative into the Bethel community, internal communication had not reached all necessary staff. This created a community-wide misunderstanding about the intended outcome and role of the Family Wellness Warriors Initiative staff. By allowing the Bethel community additional time to process, meet and agree upon next steps, the Family Wellness Warriors Initiative process is now proceeding into year three with all three agencies working in partnership.

Trauma Informed Training

- Three Regional Trauma Institutes were held in FY2012 in Anchorage, Juneau, and Fairbanks. Staff from community behavioral health agencies and Council on Domestic Violence and Sexual Assault grantee agencies were flown in for the sessions and a total of 825 people were trained. This two-day institute reached providers from across Northern and Western Alaska. Participants included providers from community mental health, infant learning, substance abuse treatment, education, and tribal health.
- The Institute included training on the impacts of trauma, science-based intervention, and putting trauma-informed care into practice. Additionally, the project provided training on advanced trauma treatment (using evidence-supported practice) to 94 providers. The project also provided five additional training on the impacts of trauma, an example being the provision of training on the impact of witnessing domestic violence for the Children's Mental Health Awareness Day event.
- The Trauma 101 curriculum was developed in response to the need for a consistent, coherent training for both clinical and non-clinical providers that could be disseminated statewide. The curriculum was developed by the Alaska Child Trauma Center in collaboration with the University of Alaska, Anchorage School of Social Work and the Co-Occurring Disorders Institute. A diverse advisory board representing juvenile justice, substance abuse treatment, domestic violence and sexual assault victims, and tribal health providers gave input and provided guidance in the development of the curriculum.

Treatment Capacity

- Thirty new community-based mental health programs have been developed statewide to provide:
  - home-based family services
  - community and school-based treatment services
  - develop rural treatment resource homes
- Additional residential capacity to serve children and youth with co-occurring disorders was developed.
- Transitional planning and accessing adult services continues to be addressed through Home and Community Based and Comprehensive Grants. Transitional housing is limited for children aging out of the State's custody and is available mainly in urban areas.
- Final roll-out in January 2012 occurred for the significantly revised Alaska State Court System forms that pertain to the emergency detention, evaluation, and involuntary commitment of persons experiencing a mental health crisis.
- Eighty clients released from Department of Corrections were housed through the Discharge Incentive grant, most of whom would have been otherwise homeless.

Family Focused Treatment Services

- The "Parenting with Love and Limits" (PLL) contract provides bi-weekly telephonic supervision to clinicians who have been trained in seven sites in Kenai Peninsula, Anchorage, Fairbanks, Kodiak, Mat-Su, and Ketchikan. A total of 141 youth and families were served in FY2012, including youth returned to the home from in state and out of state residential treatment and in state Division of Juvenile Justice facilities. During FY2012, 29 staff were fully trained in "Parenting with Love and Limits." Outcomes are demonstrating that the

investment of the state in “Parenting with Love and Limits” is effective in serving the target population and keeping them in their home communities with their families.

- A Transitional Aged Youth contract using the Transition to Independence Process (TIP) model included site visits to Anchorage, Sitka, Juneau, Fairbanks and Mat-Su in which community-wide stakeholder training occurred in addition to grantee focused Transitional Aged Youth training specifically with program managers and peer facilitators. 206 transitional aged youth and families were served and positive outcomes resulted. The numbers of youth served in all sites met the anticipated outcomes. During FY2012 there were 91 unique staff fully trained in Transition to Independence Process.

Critically Mentally Ill Adults

- 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 more effective use of community services, appropriate interventions, and housing stability through the Bridge-Home Pilot program and the Department of Corrections Discharge Incentives programs, to name two. 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 Seriously Mentally Ill adults with no benefits or other resources.

Bridge Home Program

- In FY2012 the Bridge Home program continued to demonstrate the effectiveness of the “housing first” model of intervention and care with persons having extensive histories of the use of inpatient psychiatric services and of the jail system. Of the 56 unduplicated clients served in FY2012, most had been stabilized in the program during FY2011 and remained stable during FY2012 while working toward a goal of finding independent housing. Consequently, the research data for FY2012 focused on the 14 new clients who entered the program during the FY2012 year. Data indicates that for this group the use of the Alaska Psychiatric Institute and Department of Corrections during the year prior to entering the Bridge Home program was significantly higher (Alaska Psychiatric Institute - 224 days and Department of Corrections - 704 days) while in supportive services during FY2012, this same group were in the Alaska Psychiatric Institute (58 days) or jail (80 days).

Mental Health Web

- During FY2012, 1,906 unduplicated persons were served by the Mental Health Web, a peer operated program serving a population with high representation of Alaska Natives. The program was originally started as a drop in center to provide a safe and welcoming environment for “street people” having a mental illness. It has expanded to being a major referral hub to many different types of services and resources, including employment and housing.

Individualized Service Agreement (ISA)

- Eleven agencies utilized Adult Individualized Services Agreements to provide targeted services to 761 consumers at risk of hospitalization or de-compensation.

Education / Training

- The January 2012, Division-sponsored Change Agent Conference focused specifically on issues related to the State’s emergency services delivery and response system.

- Crisis prevention and intervention training for the staff of two hospitals (PeaceHealth Ketchikan Medical Center and South Peninsula Hospital) and for the staff of these two communities’ associated behavioral health centers, was provided with the goal of helping the staff at these local entities feel more competent in working with difficult, aggressive, acting-out patients.

- During academic year 2012, 25 Rural Human Service students graduated from the three campus programs: Kuskokwim Campus —12 students graduated and Interior Aleutians Campus (Fairbanks and Anchorage) —13 students graduated, receiving their 32 credit Rural Human Services Certificate. Twenty-four (24) new students registered for fall Rural Human Service classes that began in September 2012 (or academic year 2013); 10 registered through the Kuskokwim Campus and 14 for the Interior Aleutians Campus.

Alaska Psychiatric Institute

- Significant progress was achieved in making the results of the University of Alaska Anchorage/Alaska Psychiatric Institute Data Project available to behavioral health agencies invested in the State’s emergency

services delivery system.

- Coordination significantly increased between the Division and the Alaska State Hospital & Nursing Home Association (ASHNHA) and its member hospitals around mutual areas of interest within the State's behavioral health emergency services system, with a focus on the impact on hospital emergency departments when the Alaska Psychiatric Institute (API) is at, or over, its bed capacity and persons committed to the Alaska Psychiatric Institute must be held in local hospital emergency departments awaiting bed availability at the Alaska Psychiatric Institute.
- Alaska Psychiatric Institute transitioned to an acute care inpatient treatment model.
- Alaska Psychiatric Institute optimized inpatient bed utilization and eliminated the wait list for inpatient beds.
- Alaska Psychiatric Institute enhanced recruitment and retention efforts with the Psychiatric Residency Rotation Program.
- Alaska Psychiatric Institute hired six permanent full-time licensed independent practitioners and substantially reduced dependence on locum tenens agencies and continues to evolve as a major teaching and training center for behavioral health and psychiatry.
- A peer support specialist from a community based peer provider agency meets with hard-to-engage Alaska Psychiatric Institute patients prior to discharge in an effort to engage them in support services as they return to the community. The final report from the agency for FY2012 indicates a total of 508 documented unduplicated engagements.

Alaska Psychiatric Institute (API) Board

- The Board implemented recovery-based training delivered by Peer Support Consortium.
- The Board implemented Wellness Recovery Action Plan (WRAP) services.

Alcohol Safety Action Program and Courts

- The Alcohol Safety Action Program is now also part of the Juneau Therapeutic Courts, providing an Alcohol Safety Action Program probation officer II who is responsible for the case management and community supervision for all participants of that project.
- The continued funding for the Partners for Progress provided the agency with the ability to continue providing support services to the Anchorage Wellness Court, as they had in the past through federal funding that ended in FY2011. These funds did not provide an increase in resources or program services, but maintained existing services.
- The addition of the Therapeutic Court supervisor has allowed for more effective clinical oversight, training, and supervision of all of the Therapeutic Court staff. The addition of the Alcohol Safety Action Program supervisor has also allowed for more effective oversight and training efficiencies for the Anchorage Alcohol Safety Action Program staff as well as the Alcohol Safety Action Program grantees throughout the state.
- The implementation of the Alaska Automated Information Management System e-courts module in all of the Therapeutic Courts provides an opportunity for each court to align procedurally and collect consistent data throughout the system. This data will allow us to operate more effectively resulting in better outcomes for our participants.
- During FY2012, the Alcohol Safety Action Program office continued to embrace and utilize the practice of Motivational Interviewing (MI) and Screening, Brief Intervention, and Referral to Treatment (SBIRT). The original intent of training all state Alcohol Safety Action Program staff and Alcohol Safety Action Program grantee staff in the use of Motivational Interviewing and Screening Brief Intervention and Referral to Treatment was to begin a deliberate shift from an exclusive model of enforcement and monitoring of court requirements, to a model of motivating clients to make positive life choices and life-long changes in their use and misuse of alcohol. Continuing and advanced training occurred throughout FY2012 and will continue in FY2013. The outcome we hope to see in the near future is a reduction in recidivism and a decrease in risk-taking, alcohol-related behavior.

Fetal Alcohol Spectrum Disorder (FASD) Diagnostic Teams

- During FY2012, the Fetal Alcohol Spectrum Disorder diagnostic teams conducted 134 diagnoses, a reduction from our high of 179 diagnoses in FY2011. This reduction is the result of the delay of new Provider Agreements being finalized and closure of three teams. Between 2000 and 2012 we completed a total of 1,817 diagnoses or an average of 151 diagnoses per year.

Community Action Planning (CAP)

- Coordination of Community Action Planning (CAP) teams among provider agencies including 16 newly trained and certified individuals throughout Alaska to implement the National Alliance on Mental Illness (NAMI) suicide postvention training model – *Connect*.
- Further development of Community Action Plan team technical assistance and training will be necessary in order to create a well defined system that will reach all communities in Alaska and will continue in FY2013, building on the accomplishments of FY2011 and FY2012.

Prevention Grants Program

- FY2012 began a new three-year competitive funding cycle for our Comprehensive Behavioral Health Prevention grant programs. The Division of Behavioral Health received 46 proposals, requesting over $11 million dollars in grant funds; the amount available for distribution was $4.6 million. 41% of the applications were from new agencies (not previously funded through this grant program). Competition for these prevention grant funds was very high; we divided proposals into three categories to make sure like agencies were being compared to like agencies. A total of 25 agencies received a grant award for the FY2012-2014 grant cycle —seven Building Capacity grants; 10 Implementation grants for communities under 20,000 population; and eight Implementation grants for communities over 20,000 population. During the FY2009-2011 grant cycle a total of 38 agencies received grant awards. This reduction in total grant awards was not due to reduced category funding, but a decision to provide more robust funding to each grantee instead of funding more agencies, but with less funding.
- During FY2012 we completed a database project to better collect the outcome data for our last three-year grant cycle and to develop a prevention program outcomes report utilizing the outcomes and results from strategies and interventions conducted across the state during FY2009-FY2011.

Domestic Violence/Sexual Assault Programming

- Domestic Violence and Sexual Assault Rural Pilot Project grants were awarded in February 2011. Four communities received these grants, as part of the Governor's Domestic Violence and Sexual Assault Initiative. Communities receiving grants are Dillingham, Bethel, Kodiak, and Sitka. The grant programs continued into FY2012 with one implementation grant awarded at $800,000 (Dillingham) and three building capacity grants awarded at $200,000 each for Bethel, Kodiak, and Sitka. Key accomplishments in FY2012 include the completion of three additional regional service area Alaska Victimization Surveys in Sitka, Bethel, and Kodiak. Additionally, a statewide initiative to implement the Green Dot By-Stander participation program; the continuation of Undoing Racism training in Bethel; and a number of youth leadership programs in Bethel, Kodiak, Dillingham and Sitka occurred. The four programs also met to begin mapping our three shared measurements:
    - Increased youth participation in activities to reduce domestic violence and sexual assault;
    - Enhanced local services to improve victim and family services to improve domestic violence and sexual assault;
    - Change in public norms and acceptance of domestic violence and sexual assault.

Alaska Mental Health Board / Advisory Board on Alcohol and Drug Abuse (AMHB / ABADA)

- The boards continued to participate in a statewide anti-stigma campaign targeting the general public with the message "You Know Me." The boards implemented a complementary anti-stigma campaign with the message "We Are All Alaskans."
- The boards have continued to staff the Alaska Fetal Alcohol Spectrum Disorder Partnership as a statewide coalition for individuals diagnosed with Fetal Alcohol Spectrum Disorder and their families, service providers, and other interested community members. The Alaska Fetal Alcohol Spectrum Disorder Partnership is governed by a member-staffed Steering Committee and includes over 70 individual and agency members. Members of the partnership engaged in educational and advocacy events throughout 2012, with special focus on including individuals experiencing Fetal Alcohol Spectrum Disorder and their families/caregivers as advocates.
- Board members and staff solicited public comment from consumers, families, and community members at board meetings in Juneau, Nome, and Talkketna, as well as at two community inclusion meetings in Anchorage, providing significant public input used in the boards many efforts related to the behavioral health

system.

- Board staff made significant contributions to the Division of Behavioral Health's data development activities: the Outcomes Identification and Systems Performance Project Committee, Strategic Prevention Framework State Incentive Grant workgroups, the Complex Behaviors Collaborative steering committee, and Comprehensive Integrated Mental Health Data and Planning Group.
- As part of the Bring the Kids Home project, the boards have coordinated "Family Voice," a grant to provide travel and support for families and youth to participate in policy making and advocacy. A Youth Policy Summit was held in 2012 for which 18 youth from Alaska communities statewide came to Juneau to participate in education and advocacy activities with legislators and policymakers.
- The boards strengthened their advocacy efforts through their ongoing work with a statewide, grassroots advocacy network. The boards will continue to emphasize the education and empowerment of stakeholders as self-advocates. Since 2005, nearly 300 consumers and self-advocates have received advocacy training.

Statewide Suicide Prevention Council

- The Council coordinated with community advocates to secure passage of a legislative mandate for suicide prevention and awareness training for certain teachers, as well as funding for school-based suicide prevention efforts.
- The Council launched a three-year pilot program offering evidence-based suicide prevention training to high school teachers, administrators, and staff in September 2012. This training, Kognito At-Risk, is a nationally recognized training and is made available at no charge to teachers and school districts, due to state support of the pilot.
- The Council and the Department of Health and Social Services hosted training for regional suicide prevention teams in January 2012 to learn about the state suicide prevention plan goals and strategies and develop localized action plans.
- The Council has engaged in traditional media-based prevention and education, with special emphasis on social media as a way of raising public awareness and reducing stigma.
- The Council members and staff solicited formal public comments at meetings in Anchorage. The Council solicited informal comment through presentations and booths at events like the annual Elders and Youth Conference.
- The Council supported Alaska representation at national suicide prevention conferences by sharing lessons learned in Alaska and bringing back new information about effective interventions and prevention strategies.
- The Council delivered an annual implementation report based on statewide activities within the context of the five-year statewide suicide prevention plan.

Key RDU Challenges

- **Legislative and Policy Development**
  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** has the potential to have major impact on the current behavioral health system of care. At the States' discretion in January 2014, Medicaid eligibility criterion may be expanded 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 would result in a significant increase in enrollment. Previously uninsured citizens would obtain access to care through insurance reform and coverage expansion. If instituted, demand for behavioral health services is estimated to increase by as much as 30%. This would have 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 would challenge and strain the current behavioral health treatment system.
    - **Health Information Technology for Economic and Clinical Health 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 information technology network. At the core of interoperability is the requirement for electronic health records 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 electronic health records application, i.e., the Alaska Automated Information Management 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 electronic health records applications.

- **International Classification of Diseases and 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 International Classification of Diseases-9 system to an expanded International Classification of Diseases-10 version to be implemented by October 1, 2013. In addition, the government has also mandated an upgrade of the nine Health Insurance Portability and Accountability Act transaction formats for electronic data transmission from the initial 4010 version to version 5010. 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.

- **Partnerships: Coordination of Behavioral Health with Other Non-Traditional Provider Settings**
The landscape of behavioral health service delivery is becoming more integrated and coordinated, and challenges the historical silos of designated treatment settings. These efforts at "cross coordination" with behavioral health include: primary care, medical home models, corrections, therapeutic courts, and domestic violence/sexual assault providers. This cross coordination will require changes in business and clinical practice, with new resources and skills, including business modeling that balances fiscal, revenue and clinical management and results in maximum service capacity and delivery of quality care, with meaningful outcomes.

- **Resource Eligibility, Service Capacity, and Access**
Insuring access to appropriate services and determining sufficient treatment capacity is a complex challenge. While we anticipate a potential increase in need for services due to the optional expansion of Medicaid, we also anticipate decreased federal financial support. These changes highlight the need for the development of 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; and
  - Measurement and monitoring capacity to ensure resource eligibility results in access of care and targets disparity of care (ex. the historical lack of Medicaid coverage for substance use disorder services and the lack of coverage as the number one cause of not accessing substance use disorder treatment.).

- **Performance Management System: Use of Data**
The Division of Behavioral Health continues to refine a performance management system to insure an efficient, equitable, and effective system of behavioral health care for Alaskans. The Division is applying the Results Based Accountability framework to inform this performance management system. This includes the development of a scorecard, with targeted performance measures in the following areas: acute care volume, access to treatment, emergency medical services volume, engagement and retention, treatment quality, and outcomes. The Division of Behavioral Health is developing formal feedback loops via processes and policies on the application of data to monitor the treatment system. Related challenges involve budgeting for appropriately skilled research staff in order to maximize the necessary data collection, analysis, reporting, and application to business and service delivery practices. This system realignment absorbs a significant amount of leadership time and energy that limits our resources for timely analysis of emerging issues.

- **Statewide Behavioral Health Psychiatric Emergency Services System**

Psychiatric Emergency Services is a critical element of the prevention and treatment system of care. This can, and often involves the coordination between three separate service components: (1) the community behavioral health providers; (2) Designated Evaluation & Stabilization and Designated Evaluation & Treatment (DES / DET) service providers, and (3) the Alaska Psychiatric Institute (API). Challenges specific to each component have corresponding and compounding impacts on the others:

- Communities statewide, but especially in more isolated rural areas, face significant workforce issues; local behavioral health programs in particular have great difficulty recruiting and retaining psychiatrists, advanced nurse practitioners (ANPs) or registered nurses with psychiatric specialties, licensed clinical psychologists, and licensed masters in social work (MSW). Rural social service programs routinely experience workforce shortages and high turnover in other behavioral health professions and positions.
- Maintaining functioning partnerships between local hospitals and community behavioral health providers and other key social service agencies, in order to facilitate efficient and effective shared responses to local behavioral health emergencies, is a significant, continuing challenge.
- The development of quality local Psychiatric Emergency Services throughout the State, as well as the development of alternatives to hospitalization (such as crisis respite beds), is needed to minimize admissions to Alaska Psychiatric Institute - the State psychiatric hospital - which has very limited capacity (80 total beds, with only 50 acute adult beds) and has experienced a significant census increase in recent years.

- **Designated Evaluation and Stabilization/Designated Evaluation and Treatment** (**DES/DET)**
  - Clear expectations need to be established and supported through ongoing orientation, training, technical assistance, and continuing quality improvement processes, in order to develop and sustain Designated Evaluation and Stabilization services in those communities fortunate enough to have both a small, critical access hospital and a comprehensive behavioral health center program.
  - It is anticipated that Designated Evaluation & Stabilization and Designated Evaluation & Treatment facilities and local community behavioral health centers will continue to struggle with workforce issues, including shortages and turnover in psychiatrist, advanced nurse practitioner, psychiatric nurse, and other behavioral health clinician positions. Fluctuations in staffing at any of the partners involved in the provision of behavioral health emergency services (including transportation) can render the Designated Evaluation and Stabilization/Designated Evaluation and Treatment delivery system ineffective.
  - The inability to successfully recruit and fund new hospitals to provide Designated Evaluation and Stabilization and Designated Evaluation and Treatment services in the Mat-Su Valley and Anchorage bowl, (areas that are the source of over 80% of the Alaska Psychiatric Institute's annual admissions) increases the need for the Division to develop communications and placement strategies in order to respond when the census pressure on Alaska Psychiatric Institute creates a backlog of committed patients awaiting transfer to Alaska Psychiatric Institute from hospital emergency rooms statewide.

- **Alaska Psychiatric Institute** (**API)**
  - 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 the Alaska Psychiatric Institute 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.
  - At the Alaska Psychiatric Institute, 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.
  - 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.
  - With the adoption of revised Alaska Court System forms related to the processes involved in the emergency detention and involuntary commitment of persons experiencing a behavioral health crisis, the Division of Behavioral Health now faces significant pressure (both monetary and legal) to arrange

transport of those persons subject to court-ordered involuntary 72-hour evaluation holds *within 24 hours* of the time and date of the court order

- **Family Based Treatment**
  At any given time, children/youth comprise approximately 25% of all clients served (publicly funded) at clinics and for rehabilitation services. However, the majority of services delivered target only the child/youth, without their families. An analysis of Medicaid data indicated that 62% of all youth served did not receive any family services. Of the 38% who did, it only resulted in an average of 5.8 hours per year. Family systems theory recognizes and values the role and impact families have on children/youth with mental health and substance use disorders. This approach regards the family, as a whole, as a unit of treatment. The Division has growing concerns that the level of family based treatment is minimal at best, and reflects a lack of adequately trained behavioral health professionals to provide this skilled service. By default this results in unintended consequence of institutional parenting of children and reinforces a dependency on treatment providers, and undermines the potential for good treatment outcomes for children and their families.

- **Bring the Kids Home (BTKH) – The Next Phase**
  The *Bring the Kids Home* Initiative is transitioning from the "active-execution" phase to "benefits gained" and aligning with the regular business and clinical practices of the children's treatment system (children and adolescents with Severely Emotionally Disturbed and/or Substance Use Disorder). The Division of Behavioral Health has implemented 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 inform 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).

- **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 care providers 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 among 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 ensure that behavioral health services are not diminished or overshadowed as a result of integration.

- **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 the Division of Behavioral Health currently has multiple grant programs to distribute public funds for behavioral health treatment services (seriously mentally ill adults, severely emotionally disturbed children, and substance use disorder adults and adolescents). As new funding has become available for expansion of service capacity or to promote systems change, additional grant programs were created to manage and monitor expected program outcomes. Over time the volume of individual grant programs has increased, resulting in greater administrative burden for the Division, as well as provider grantees.

  We will be developing a new model to align all adult services and all children/youth services into 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 potential 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.

Significant Changes in Results to be Delivered in FY2014

- **Behavioral Health Grants: Comprehensive Behavioral Health Treatment & Recovery Grant Solicitation**
  In late FY2013 the Division will solicit agency applications through a competitive request for proposal process. FY2014 is the first year of a three-year funding cycle for delivery of substance abuse treatment services. The Request for Proposal is an opportunity to increase the standards for service delivery, requiring the use of more evidence-based practices, targeted services for pregnant women, and families involved with the Office of Children's Services. This new procurement will place an increased emphasis on performance measures for all types of services and levels of care. It will also be a vehicle to enhance integration of services to children, youth, and families with mental health co-occurring disorders.

- **Veterans' Access to Care**
  The Division is involved in increasing access to care for veterans and their families. This access is being enhanced through the use of tele-health and training events for agency staff to better understand and meet the needs of veterans and their families.

- **Behavioral Health Client Follow-Up and Re-engagement Pilot Project**
  The purpose of this pilot project is to evaluate methodologies to measure behavioral health treatment outcomes following the discontinuance of services and provide an opportunity to re-engage clients when appropriate. Currently Client Status Review outcome data are collected routinely on active treatment clients, but there is no Client Status Review tracking after active treatment has stopped. The pilot project will result in a report shared with stakeholders that assists in determining rates of recovery for various subpopulations of behavioral health clients, including those that leave early from treatment. The follow-up survey is expected to extend into FY2014.

- **Severely Emotionally Disturbed Children/Youth**
  - Basic infrastructure and innovative, integrated village-based programs are needed to achieve a continuum of care for mental health services in rural Alaska. Efforts will continue in FY2014 to address unmet needs:
    - Clinicians, staff support, office space, equipment, supplies, and travel funds to provide sustainable psychiatric emergency services and basic outpatient mental health services by the smallest community mental health agencies.
    - Development of personal computer-based in-home technology will help connect behavioral health aides with their supervisors and clinical support teams.
    - In-home or in-community supports for children and youth returning from residential or out of community care to create successful transitions.
    - Funding and training to create and sustain a viable and effective village-based system that can effectively deliver behavioral health services and that can recoup Medicaid funding for beneficiaries.

- Implementation of Early Childhood Behavioral Services in Primary Care and Infant Learning Settings
- Implementation of a level of care/service intensity tool for the entire system for severely emotionally disturbed (SED) youth.

- **Severely Mentally Ill Adults**
  - **Alaska Complex Behavior Collaborative**
    Depending on prior year outcomes, the Division will investigate expansion of the Alaska Complex Behavior Collaborative model to provide brief stabilization and other individualized supports.
  - **Bridge Home**
    Continuation funding will assure support for the successful Bridge Home project located in Anchorage, which provides transitional housing and services for clients who have failed in other placements and would otherwise likely be incarcerated or hospitalized due to their difficult and challenging behaviors. Continued funding will also allow further development and support of the assertive community treatment program initiated in FY2013 to better engage and serve the high needs, complex, seriously mentally ill population in Anchorage.
  - **Alaska Housing Finance Corporation Demonstration Program**
    The Division of Behavioral Health, Senior and Disability Services, Alaska Housing Finance Corporation, and Alaska Mental Health Trust collaborated in an application to the Department of Housing and Urban Development which would provide project-based rental assistance in the development of supportive housing for extremely low income persons with disabilities. If funded, this project would address the disproportionate number of individuals who are disabled and who reside in institutional settings such as Assisted Living Homes, and transition them to permanent supportive community housing.

- **Psychiatric Emergency Services**
  - Using the data collected in FY2012 and FY2013, the Division will redirect resources in the FY2014 four-year Comprehensive Behavioral Health Treatment and Recovery grant solicitation to maximize efficiencies and effectiveness, so that the right service to the right person is at the right time and at the right cost.
  - We expect the implementation of the recommendations from a consultant's FY2013 report identifying issues and preliminary recommendations regarding the current operational status of the Division's DES/DET Mental Health Treatment Assistance Program and its Secure Patient Transport Program to improve the overall efficiency and effectiveness of these two key Psychiatric Emergency Services programs by and through FY2014.
  - The Division will expand statewide crisis prevention and intervention training to include sessions for emergency transport providers (like municipal ambulance services, emergency medical services, or air ambulance services, as well as any potential new secure transport providers and all existing providers). This will result in improvement in the administration of the emergency services system, statewide.

- **Designated Evaluation and Treatment** (**DET)**
  Should the roll out of the federal Health Care Reform law happen in 2014, the current and primary funding source for Alaska's Designated Evaluation and Treatment (DET) services, Disproportionate Share Hospital (DSH) funds, may be curtailed, declining between 2014 and 2020, thereby reducing over time the capacity of Alaska to use its Disproportionate Share Hospital funding to support the provision of Designated Evaluation and Treatment services at Bartlett Regional Hospital and Fairbanks Memorial Hospital (Alaska's only two Designated Evaluation and Treatment facilities). Determining the actual impact of any reduction in Disproportionate Share Hospital funding is a significant issue for the Division of Behavioral Health, one that requires advance planning and forward-funding decisions once the State has a better understanding of the impact of the Affordable Care Act on Disproportionate Share Hospital payments to states.

- **Alaska Psychiatric Institute**
  - Develop subject matter expertise to sustain evidence based clinical practice and systems transformation integrating primary care and behavioral health via the Tele-behavioral Health Program

- Optimize use of electronic health records and deploy a scanning and archiving system
- Standardize hospital clinical and business operations consistent with best practices and meet the challenges of healthcare reform
- Stabilize professional workforce with psychiatry, nurse practitioners, and psychiatric nurses

- **Alaska Psychiatric Institute (API) Board**

New Performance Measures for FY2014

In FY2013, the department implemented a results-based management framework which led to:
- a refinement of overarching priorities
- the development of core service areas and agency performance measures
- the alignment of division-level performance measures

This process set in motion an agency-wide shift in how we measure our impact on the health and well-being of Alaskan individuals, families and communities and how we align our budget. With this shift, it is the intent of the department to deliver quality service (effectiveness) while making the best use of public resources (efficiency). At an agency glance, this framework allows department level measures to cascade to divisions and division measures to more strategically align upward towards meaningful outcomes.

To that end, the following measures reflect this division's contribution to the department performance measure structure for FY2014.

PRIORITY I. HEALTH & WELLNESS ACROSS THE LIFESPAN	
CORE SERVICE A. PROTECT AND PROMOTE THE HEALTH OF ALASKANS.	
OUTCOME 1. Alaskans are healthy	
EFFECTIVENESS MEASURE	**Percent of Alaskans who demonstrate improved health status.***
EFFICIENCY MEASURE	**Cost per percentage of improved health.***
	***AGGREGATE DIVISION MEASURES - (Percent of Alaskans who demonstrate improved health status).**
EFFECTIVENESS MEASURE	Percent of Alaskans who are immunized.
EFFICIENCY MEASURE	Cost per immunization.
OUTCOME 2. Alaskans are free from unintentional injury	
	ALIGNING DIVISION LEVEL MEASURES
EFFECTIVENESS MEASURE	Percentage of medication errors for Alaskans in the care/custody of HSS.
EFFICIENCY MEASURE	Number of hospitalizations due to medication errors. (HCS)
EFFICIENCY MEASURE	Cost of medical services in facilities. (DJJ)
EFFECTIVENESS MEASURE	Percent of facilities with deficiencies.
EFFICIENCY MEASURE	Percent of decrease in facilities with deficiencies.
EFFICIENCY MEASURE	Percent of complaints investigated within established timeframes.
OUTCOME 3. Alaskans are free from substance abuse and dependency	
EFFECTIVENESS MEASURE	**Percent of Alaskans discharged from substance abuse treatment services who successfully completed treatment.**

EFFICIENCY MEASURE	**Cost of treatment per completion.**
	ALIGNING DIVISION LEVEL MEASURES
EFFECTIVENESS MEASURE	Percent of disenrollments from substance abuse treatment programs indicating that the client successfully completed the program.
EFFICIENCY MEASURE	Percent of adults receiving substance abuse outpatient service who report a positive evaluation of treatment outcomes.

CORE SERVICE B. PROVIDE QUALITY OF LIFE IN A SAFE LIVING ENVIRONMENT FOR ALASKANS.

OUTCOME 4. Alaskans with behavioral issues report improvement in key life domains.

EFFECTIVENESS MEASURE	**Percent of Behavioral Health clients who report improvement in quality of life between their initial Client Status Review and first subsequent review.**
EFFICIENCY MEASURE	**Average cost of care for those who report improved quality of life vs. those who do not report improved quality of life.**

PRIORITY II. HEALTH CARE ACCESS, DELIVERY AND VALUE

CORE SERVICE A. MANAGE HEALTH CARE COVERAGE FOR ALASKANS IN NEED.

OUTCOME 1. Each Alaskan has a primary care provider.

EFFECTIVENESS MEASURE	**Percent of individuals served by the department who have a primary care provider.***
EFFICIENCY MEASURE	**Cost per recipient served by the department who has a primary care provider.***
	***AGGREGATE DIVISION MEASURES - (Percent of individuals served by the department who have a primary care provider).**
EFFECTIVENESS MEASURE	Percent of clients with access to a regular primary care provider.
EFFICIENCY MEASURE	Cost to provide health care services per client.
	ALIGNING DIVISION LEVEL MEASURES
EFFECTIVENESS MEASURE	Percentage of Medicaid recipients served.
EFFICIENCY MEASURE	Average cost per recipient. (APH, DBH, DPH, OCS, SDS)

CORE SERVICE B. FACILITATE ACCESS TO AFFORDABLE HEALTH CARE FOR ALASKANS

OUTCOME 1. Alaskans have access to health care.

EFFECTIVENESS MEASURE	**Percent of Alaskans in urban communities that can access care.***
EFFICIENCY MEASURE	**Department cost per percent of Alaskans with access to care.***
	***** AGGREGATE DIVISION MEASURES - (Percent of Alaskans in urban communities that can access care).**
EFFECTIVENESS MEASURE	The percentage of the estimated need for behavioral health services are met through community-based services.
EFFICIENCY MEASURE	Percent of clients whose wait time to access treatment is less than 7 days.
EFFICIENCY MEASURE	Percent of substance abuse residential treatment providers with a bed utilization rate of 85% or higher.

PRIORITY III. SAFE & RESPONSIBLE INDIVIDUALS, FAMILIES AND COMMUNITIES

CORE SERVICE B. PROTECT VULNERABLE ALASKANS.

OUTCOME 2. Alaskan adults at risk of maltreatment are protected from abuse, neglect and exploitation.

	ALIGNING DIVISION LEVEL MEASURES
EFFECTIVENESS	Number of transports for psychiatric emergency commitments (i.e., Title 47 Transports)

	MEASURE EFFICIENCY MEASURE	Cost per transport for psychiatric emergency commitments (i.e., Title 47 Transport)

CORE SERVICE C. PROMOTE PERSONAL RESPONSIBILITY AND ACCOUNTABLE DECISIONS BY ALASKANS.

OUTCOME 1. Alaskan communities support tobacco enforcement.

EFFECTIVENESS MEASURE	**Vendor compliance rate with laws regulating the sale of tobacco products to youth (i.e., based on Syntar retailer violation rate).**
EFFICIENCY MEASURE	**Percent of youth-accessible tobacco vendors that receive an educational visit from Tobacco Enforcement staff.**

OUTCOME 3. Alaskans with health conditions practice self-management.

EFFECTIVENESS MEASURE	**Percent of clients with chronic disease enrolled in self-management programs.**
EFFICIENCY MEASURE	**Cost per client for self-management services.**

Contact Information

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Behavioral Health
RDU Financial Summary by Component

All dollars shown in thousands

	FY2012 Actuals				FY2013 Management Plan				FY2014 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	1,373.9	0.0	0.0	1,373.9	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	1,135.5	272.0	3,503.2	2,297.1	1,783.0	310.1	4,390.2	2,297.1	1,783.0	310.1	4,390.2
Behavioral Health Grants	24,438.2	1,715.7	2,971.6	29,125.5	35,195.8	1,696.5	3,432.2	40,324.5	26,620.8	1,740.7	3,532.2	31,893.7
Behavioral Health Administration	7,295.3	449.8	1,830.2	9,575.3	8,083.6	894.1	2,237.7	11,215.4	8,135.5	667.1	2,887.9	11,690.5
CAPI Grants	2,003.5	1,400.0	2,697.3	6,100.8	2,069.1	1,600.0	3,522.4	7,191.5	2,069.1	1,600.0	3,522.4	7,191.5
Rural Services/Suicide Prevent'n	2,999.1	4.9	334.8	3,338.8	3,068.2	0.0	412.1	3,480.3	3,056.2	0.0	412.1	3,468.3
Psychiatric Emergency Svcs	7,827.9	183.0	0.0	8,010.9	8,809.0	0.0	0.0	8,809.0	8,316.1	0.0	0.0	8,316.1
Svcs/Seriously Mentally Ill	14,978.4	1,150.0	906.9	17,035.3	15,334.8	1,275.0	972.0	17,581.8	15,772.8	850.0	972.0	17,594.8
Designated Eval & Treatment	3,248.6	0.0	0.0	3,248.6	3,156.4	0.0	0.0	3,156.4	3,286.3	0.0	0.0	3,286.3
Svcs/Severely Emotion Dst Yth	13,826.4	1,311.7	0.0	15,138.1	15,179.9	1,391.8	0.0	16,571.7	15,089.9	716.8	0.0	15,806.7
Alaska Psychiatric Institute	8,067.3	24,145.8	0.0	32,213.1	7,322.0	24,905.2	0.0	32,227.2	7,330.7	25,080.8	0.0	32,411.5
API Advisory Board	8.1	0.0	0.0	8.1	9.0	0.0	0.0	9.0	9.0	0.0	0.0	9.0
AK MH/Alc & Drug Abuse Brds	467.2	508.1	14.8	990.1	532.0	522.6	99.3	1,153.9	532.4	494.0	99.3	1,125.7
Suicide Prevention Council	123.6	0.0	0.0	123.6	588.9	0.0	0.0	588.9	600.9	0.0	0.0	600.9
Totals	**88,753.2**	**32,004.5**	**9,027.6**	**129,785.3**	**103,319.7**	**34,068.2**	**10,985.8**	**148,373.7**	**94,790.7**	**32,932.4**	**11,736.0**	**139,459.1**

Behavioral Health
Summary of RDU Budget Changes by Component
From FY2013 Management Plan to FY2014 Governor

All dollars shown in thousands

	Unrestricted Gen (UGF)	Designated Gen (DGF)	Other Funds	Federal Funds	Total Funds
FY2013 Management Plan	**83,726.1**	**19,593.6**	**34,068.2**	**10,985.8**	**148,373.7**
Adjustments which will continue current level of service:					
-Behavioral Health Grants	-8,775.0	0.0	-275.0	0.0	-9,050.0
-Behavioral Health Administration	1.9	0.0	-452.0	0.2	-449.9
-Rural Services/Suicide Prevent'n	-12.0	0.0	0.0	0.0	-12.0
-Psychiatric Emergency Svcs	-492.9	0.0	0.0	0.0	-492.9
-Svcs/Seriously Mentally Ill	38.0	0.0	-1,275.0	0.0	-1,237.0
-Designated Eval & Treatment	129.9	0.0	0.0	0.0	129.9
-Svcs/Severely Emotion Dst Yth	-360.0	0.0	-1,275.0	0.0	-1,635.0
-Alaska Psychiatric Institute	8.7	0.0	100.6	0.0	109.3
-AK MH/Alc & Drug Abuse Brds	0.4	0.0	-477.2	0.0	-476.8
-Suicide Prevention Council	12.0	0.0	0.0	0.0	12.0
Proposed budget increases:					
-Behavioral Health Grants	200.0	0.0	319.2	100.0	619.2
-Behavioral Health Administration	50.0	0.0	225.0	650.0	925.0
-Svcs/Seriously Mentally Ill	400.0	0.0	850.0	0.0	1,250.0
-Svcs/Severely Emotion Dst Yth	270.0	0.0	600.0	0.0	870.0
-Alaska Psychiatric Institute	0.0	0.0	75.0	0.0	75.0
-AK MH/Alc & Drug Abuse Brds	0.0	0.0	448.6	0.0	448.6
FY2014 Governor	**75,197.1**	**19,593.6**	**32,932.4**	**11,736.0**	**139,459.1**