ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
January 29, 2015
3:03 p.m.

MEMBERS PRESENT

Representative Paul Seaton, Chair
Representative Liz Vazquez, Vice Chair
Representative Neal Foster
Representative Louise Stutes
Representative David Talerico
Representative Geran Tarr
Representative Adam Wool

MEMBERS ABSENT

All members present

COMMITTEE CALENDAR

PRESENTATION: THE STATEWIDE SUICIDE PREVENTION COUNCIL

- HEARD

PRESENTATION: BECOMING A TRAUMA INFORMED SYSTEM~ DIVISION OF JUVENILE JUSTICE

- HEARD

PRESENTATION: 24/7 SOBRIETY MONITORING PROGRAM

- HEARD

OVERVIEW: DIVISION OF BEHAVIORAL HEALTH

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

KATE BURKHART, Executive Director
Statewide Suicide Prevention Council
Division of Behavioral Health

Department of Health and Social Services
Juneau, Alaska
POSITION STATEMENT: Presented a PowerPoint entitled "The Statewide Suicide Prevention Council."

KAREN FORREST, Director
Division of Juvenile Justice
Department of Health and Social Services
Juneau, Alaska
POSITION STATEMENT: Introduced the trauma-informed care program.

SHANNON CROSS-AZBILL, Clinical Director
Division of Juvenile Justice
Department of Health and Social Services
Anchorage, Alaska
POSITION STATEMENT: Introduced a PowerPoint entitled "Becoming a Trauma Informed System."

BERNARD GATEWOOD, Superintendent
Fairbanks Youth Facility
Youth Facilities
Division of Juvenile Justice
Department of Health and Social Services
Fairbanks, Alaska
POSITION STATEMENT: Testified during the discussion on trauma-informed care systems.

TONY PIPER, Coordinator
Alcohol Safety Action Program (ASAP)
Division of Behavioral Health
Department of Health and Social Services
Anchorage, Alaska
POSITION STATEMENT: Testified during discussion of the 24/7 sobriety monitoring program.

ALBERT WALL, Director
Central Office
Division of Behavioral Health
Department of Health and Social Services
Juneau, Alaska
POSITION STATEMENT: Answered questions during discussion on the 24/7 sobriety monitoring program and presented a PowerPoint overview of the Division of Behavioral Health.

ACTION NARRATIVE

3:03:21 PM

CHAIR PAUL SEATON called the House Health and Social Services Standing Committee meeting to order at 3:03 p.m. Representatives Seaton, Tarr, Wool, Vazquez, and Foster were present at the call to order. Representatives Talerico and Stutes arrived as the meeting was in progress.

PRESENTATION: THE STATEWIDE SUICIDE PREVENTION COUNCIL

3:03:52 PM

CHAIR SEATON announced that the first order of business would be a presentation by the Suicide Prevention Council.

3:04:56 PM

KATE BURKHART, Executive Director, Statewide Suicide Prevention Council, Division of Behavioral Health, Department of Health and Social Services, reported that the council was established by the Alaska State Legislature in 2001, slide 1, in response to a large spate of deaths by suicide. She noted that the council had 13 volunteer members appointed by the governor and 4 ex-officio members appointed by the Legislature. She said that the council offered guidance and advice related to suicide to the executive and legislative branches, as well as communities. She listed the responsibilities of the council to include: improving health and wellness by reducing suicide, broadening awareness of suicide and the role of risk and protective factors, enhancing suicide prevention services and programs, developing healthy communities through comprehensive, collaborative, community and faith-based approaches, developing and implementing a statewide suicide prevention plan, and strengthening and building new partnerships between public and private entities to advance suicide prevention efforts. As this was a massive responsibility, in 2010 and 2011, the council reevaluated its approach to the work, and focused on greater collaboration and coordination of effort with communities for a more effective suicide prevention program.

3:08:56 PM

MS. BURKHART directed attention to slide 2, "coordinate," stating that coordination was "a huge part of what the suicide prevention council does." She shared that the plan, now in its third year, was not a typical state health program plan, but was

based on an intensive, participatory process from 150 - 200 Alaskans, including clergy, Village Public Safety Officers (VPSOs), suicide attempters, young people, business owners, and the clinicians providing services. This process created a plan and strategy that was fully endorsed by those who were served, hence it became self-implementing. The council ensured that communities were connected with each other and with the necessary resources to effectively implement the strategies in the plan. She shared the Wall of Hope, which offered resilience to young people for navigating difficult situations and a place to seek help during a crisis. She reported that the council worked with school districts to organize and report on these events.

3:11:09 PM

MS. BURKHART shared slide 3, "collaborate," and offered examples which included a long standing media campaign with the Iron Dog race. She shared the background for the campaign. She pointed out that the word suicide was not usually used in these campaigns, but instead there were references such as: reasons to live, working together, or life is a team effort. She noted that the downtown Anchorage Rotary Club had identified suicide prevention as a priority for the organization, and had developed a training regimen for gatekeeper suicide prevention available to all statewide Rotary Clubs. She acknowledged the importance of this for the foundation of the state suicide prevention plan that every Alaskan take responsibility for preventing suicide by identifying when someone was in crisis and helping get them connected to help. She spoke about a peer suicide prevention program for high school students, "You are not alone."

3:14:19 PM

MS. BURKHART moved on to slide 4, "communicate," and explained that the council had developed a suicide prevention portal which allowed information to be presented at the community level, and minimized the costs of hosting websites. She reported that the statewide website was stopsuicidealaska.org. She mentioned that the council also partnered with the state crisis intervention line, Careline, which was located in Fairbanks and staffed by Alaskans trained to talk with people in crisis. Careline also provided follow up to people who had called and needed additional connection. She pointed out that Careline received state funding and was an integral part of the suicide prevention efforts. Its partnerships with Alaska Native Tribal Health Consortium, Department of Health and Social Services, community

coalitions, and the council allowed for advertising and outreach, with its resources reserved for services.

3:16:10 PM

MS. BURKHART addressed slide 5, "warning signs," and listed some of the signs, which included: threatening to hurt or kill themselves; looking for ways of suicide; talking or writing about death, dying, or suicide; acting recklessly; dramatic mood changes; and, expressing feelings of purposelessness or hopelessness. She shared a report that stated firearms and suffocation were the two predominant means of suicide.

3:18:56 PM

MS. BURKHART remarked that the state suicide prevention plan was a plan of action, instead of aspiration, slide 6, "casting the net upstream."

3:19:42 PM

MS. BURKHART directed attention to slide 7, "goals," and listed the goals to include: Alaskans accept responsibility for preventing suicide; respond effectively and appropriately to people at risk of suicide; communicate, cooperate, and coordinate suicide prevention efforts; have immediate access to the necessary prevention, treatment, and recovery services, as access to health care was critical; and support survivors in healing. She shared that there was quality data and research available for use in planning, implementation, and evaluation of the suicide prevention efforts.

3:21:14 PM

MS. BURKHART explained that the council had created six regional suicide prevention teams, which allowed the work to be aligned most closely with each community's values and needs, slide 8, "regional teams." Each regional team could decide which of the aforementioned goals were most appropriate for its efforts. Every other year, a statewide summit with all of the regional teams allowed for each plan to be refined.

3:21:55 PM

MS. BURKHART said that the data collected by the Bureau of Vital Statistics revealed that the suicide rate in Alaska had remained steady for many years, slide 9, "suicide data." She stated that

Alaska was now only the fourth highest rate of suicide in the US. She opined that this steadiness could reflect that the prevention efforts were "something right in that we have held steady while other similarly situated states have experienced a rise in their rate." She shared that there was also data collected for veterans' deaths.

3:23:37 PM

MS. BURKHART shared some of the strategies under the state plan, which included that Alaskans know about Careline and other community crisis lines, and that the information is shared, slide 10, "crisis intervention." She pointed out that every strategy had a performance indicator for measurement of progress toward the goals, and that this was measured by looking at the numbers of calls to Careline. She said that the calls to Careline had risen from about 6,000 in 2013 to more than 10,000 in 2014. She noted that, should all the responders on Careline be busy, the calls would roll over to a nationally accredited member of the suicide prevention lifeline network, ensuring a trained response. She stated that more than 80 percent of the callers disclosed a current mental health or substance use disorder.

3:25:19 PM

MS. BURKHART shared that another plan strategy was for the State of Alaska and its partners to make training in evidence based suicide prevention and intervention models accessible to all interested Alaskans, slide 11, "training." She reported that, in 2014, over 5000 people were trained, as training was now available to educators and school district staff through the Department of Education and Early Development.

3:26:38 PM

MS. BURKHART lauded Dr. Jay Butler for coining the term, "web of causality," slide 12. She said that this term offered a description for the many factors which lead to the contemplation or attempt of suicide, pointing out that there were also social and economic factors. She shared that suicide was not the result of one factor.

3:27:52 PM

MS. BURKHART explained "childhood trauma" and its impact, slides 13 - 15. She reported that the data collected came from the

Adverse Childhood Experiences (ACEs), those traumatic events, such as abuse, neglect, domestic violence, mental illness, substance abuse, incarceration, or divorce within a household, which occurred to individuals or their immediate family, while young. The Behavioral Risk Factor Surveillance Survey (BRFSS) data on ACEs offered a more specific understanding for how many Alaskans were dealing with the ramifications of this childhood trauma. This survey showed that 64 percent of Alaskan adults had at least one of these experiences, and 27.4 percent had three or more of these experiences. She declared there was a correlation between the number of these adverse experiences (ACEs) and the likelihood of negative health and social experiences later in life; the higher the ACEs number, the higher the likelihood of risks for suicide attempts. She shared that a complete analysis of this BRFSS data was on-line, and that research at the national level showed this increase to be exponential. She said that nearly two thirds of suicide attempts among adults were attributable to adverse childhood experiences (ACEs). She directed attention to a graph depicting the exponential increase of risks per suicide, slide 15.

3:30:44 PM

MS. BURKHART shared that there was a lot of success for the school based suicide prevention efforts, slides 16 - 18, "what's working." She referenced the Teck-John Baker Youth Leaders Program in the Northwest Arctic, modeled after an evidence based natural helper's model, but refined to include Inupiaq traditions and values for greater cultural relevance to the local students. She said that they had greater success for preventing adolescent suicide than most other communities. There was a focus on the strength and the resiliency of the youth, and the youth were connected with adult mentors who taught their heritage and culture. She reported that the council partnered with the Department of Education and Early Development to fund grants for school based suicide prevention and that there were currently 10 grantees, all offering evidence based suicide prevention training and access to mental health services. She shared that at risk students were most often attending alternative schools. In Juneau, the local suicide prevention coalition partnered with the school district for a peer leadership model, Sources of Strength. She shared that this program also had successes similar to the aforementioned program in the Arctic. She reported on a program in the Lower Kuskokwim School District which had a very successful program, as well. She stated that, as access to mental health care services was integral to preventing suicide, the State had

supported the development of culturally relevant programs to ensure that indigenous people had access to meaningful suicide prevention. She spoke about "Doorway to a Sacred Place," a traditional healing model funded by the Department of Health and Social Services.

3:34:01 PM

REPRESENTATIVE FOSTER declared that he was a big supporter of the Qungasvik Project in the Lower Yukon area. He asked if the intent was for these programs, if successful, to be used in other regions. He suggested that both funding and awareness was necessary, and he asked if Department of Health and Social Services was helping to get the word out.

MS. BURKHART replied that these projects had an organic quality that was culturally relevant to the area. She reported that the funding organization had been invited in by the community, and after a long, very careful process, a model was developed that was effective in that community and in that culture. Because of this success, the state had allocated resources to the Yukon-Kuskokwim Health Corporation to help spread this model throughout that area of cultural relevance. She expressed concern for the availability of state resources to develop a similar organic process in another part of the state.

3:36:22 PM

MS. BURKHART concluded with slide 19, "what's next." She said that they would continue to develop and support increased access to evidence based suicide prevention training. She noted that more Alaskans understood the importance of Careline. She stated that there was not a robust curriculum or training in helping professions, and that suicide prevention was not a major component in many mental health curriculums. The council was working to make evidence based training available on line for continuing education credits for social workers, psychologists, and nurses. They would continue to encourage suicide screening and intervention in primary care practices and would encourage support services and resources for parents and families to ensure that all Alaskan children grow up in healthy and stable environments. The council wanted to expand the suicide knowledge and research base in Alaska, and refine its communication strategies to take advantage of emerging outlets. She declared that it would be necessary in the next few years to sit down and evaluate its progress so that the next planning phase would build on what was successful.

3:39:44 PM

CHAIR SEATON expressed his appreciation for casting the net upstream to relate to underlying health issues. He asked about the 2013 US military study on suicide, which found that the likelihood for suicide was doubled when Vitamin D levels were below 15 ng/ml. He asked if the council had considered this for any recommendations.

MS. BURKHART replied that the council had read the study and acknowledged the need for more research, as there was a clear association between Vitamin D deficiencies and depression. She pointed out that it was unclear whether this was causative, as all the subjects in the military study had been deployed. She pointed out that women and people living in poverty were also populations that tended to have lower Vitamin D. She acknowledged this association and that this information was in conversations by the council. She stated that the council, as it wanted communities to address suicide in a way that fit with what they were seeing, tended to not tell the communities how to deal with it. She compared studies of Vitamin D to studies on sugar in various population groups. She mentioned the disruptions in light and time caused by daylight savings time, and its relationship to the risk of suicide.

3:43:20 PM

REPRESENTATIVE WOOL asked whether the number of suicides in Alaska during 2014 had decreased.

MS. BURKHART replied that this was still unknown, as the Bureau of Vital Statistics collected the information, but there was a delay for the notification of Alaskans dying outside of Alaska. This resulted in a nine month lag for the release of the final data.

3:45:04 PM

The committee took an at-ease from 3:45 p.m. to 3:47 p.m.

3:47:36 PM

PRESENTATION: BECOMING A TRAUMA INFORMED SYSTEM, DIVISION OF JUVENILE JUSTICE

CHAIR SEATON announced that the next order of business would be a presentation on trauma informed care.

3:48:04 PM

KAREN FORREST, Director, Division of Juvenile Justice, Department of Health and Social Services, explained that Division of Juvenile Justice had been working on trauma-informed care for several years, since a successful pilot project at the McLaughlin Youth Center in Anchorage had resulted in a significant drop in youth isolation and youth restraint due to behaviors. She explained that a trauma informed agency was one which: realized the wide spread impact of trauma, noting the importance in the Division of Juvenile Justice as so many of its youth had adverse childhood experiences; recognized the signs of trauma in its youth, as well as its staff, who could experience secondary trauma from working with these youth; and, adopted policies, programs, and procedures which take into account the trauma and adverse life experiences. She stated that the division had a better understanding of how to intervene, and had a better relationship with youth. She pointed out that youth felt safer and were able to develop coping skills to address the traumatic stress reactions. She stated that this care could improve the overall outcomes and decrease the recidivism rate. She shared that Department of Health and Social Services was working on this care through the Office of Children's Services and the Division of Behavioral Health.

3:53:11 PM

SHANNON CROSS-AZBILL, Clinical Director, Division of Juvenile Justice, Department of Health and Social Services, explained that its youth population had experienced many of the aforementioned 10 points of the Adverse Childhood Experiences (ACEs), as well as other traumas including homelessness and bullying. She presented slide 1, "Trauma Informed Care," from a PowerPoint titled, "Becoming a Trauma Informed System." She declared that this was a process, a culture change, and not a program. She allowed that although anyone can be trauma informed, it was necessary to take the information and utilize it. She said that Division of Juvenile Justice (DJJ) was working through a change in its program from isolation to relationship based. She emphasized that forming the relationship was the most important aspect of trauma informed care, as a therapeutic relationship allowed for accountability and safety.

3:57:33 PM

MS. CROSS-AZBILL moved on to slide 2, "First and Foremost: Support From Administration," and declared that, without this support, everything would be very difficult. She pointed to slide 3, "Becoming a Trauma Informed System..." which was a reminder that two steps forward and one step back was still one step forward. She offered an anecdote of the difficulty she had faced with the distribution of coping toys to one of her patients, noting that this was now an accepted tactic.

4:00:59 PM

MS. CROSS-AZBILL addressed slide 4, "Why Learn About Trauma?" She stressed that it was now accepted that traumatic experiences did impact a person's brain and body. She compared pictures of brains that had and had not been exposed to neglect, similar to the development of brains exposed to alcohol. She reported, as staff now better understood the physiological, emotional, and neurological impact of traumatic experiences that relationships could be enhanced and treatment could be improved.

4:01:58 PM

MS. CROSS-AZBILL shared slide 5, "Long-Term Impact of Trauma," and pointed out that the long term impacts from trauma included mental health issues, substance abuse, and physical health issues such as diabetes, heart attacks, and cancer.

MS. CROSS-AZBILL moved on to slide 6, "Safety," and declared that this was the most important aspect of any service system that worked with violence and trauma. She shared that improvement to facilities and youth required review for trauma informed care to enhance safety. Directing attention to slides 7 - 8, she reiterated that good relationships allowed for better accountability. She said that they created safety and provided structure and consistency to help create the environment in the TIC.

MS. CROSS-AZBILL introduced slide 9, "Training and Professional Development," which listed the staff trainings. She stated that the staff pairings were inter-departmental so it would not appear to be just "a mental health thing," and this had also helped to build those relationships. She said that the clinicians had worked on trauma focused therapies, and that secondary trauma training was enhanced to better help the staff. She referenced the integrated life story assessment (ILSA),

similar to a time line of the subject's life, slide 10, which was also used by the probation staff. She declared the need to focus on strengths and the necessity to implement those when moving forward.

MS. CROSS-AZBILL directed attention to slide 12, "Disrupted Brain Development from Childhood Neglect," noting that these were pictures of the two brains she had mentioned earlier. Focusing on slide 14, "ACEs and suicide attempts," she offered an anecdote about a youth detainee who had attempted suicide, was then sent to Alaska Psychiatric Institute, and then returned to the Anchorage youth facility where he had made other suicide attempts. She relayed that staff viewed this behavior as conduct disorder, whereas the clinicians declared that this was post-traumatic stress disorder with a bi-polar diagnosis. This brought discussion and disagreement for the means of treatment. When the ACE diagnosis was assessed, it was discovered that he had experienced six of the ten adverse childhood experiences. She directed attention to the corresponding data, which showed that this would increase the risk for suicide attempts by 28 times. She pointed out that it was inconsequential for the reasons to the suicide attempts; that it was more important to look at the basics of what happened to him, build on his strengths, and work on the relationships. She offered an anecdote for recent interactions with this same youth.

4:14:13 PM

BERNARD GATEWOOD, Superintendent, Fairbanks Youth Facility, Youth Facilities, Division of Juvenile Justice, Department of Health and Social Services, reported that he had introduced trauma informed care into the Fairbanks youth facility. He declared that, as he always wanted to make the facility better and that everyone had the right to be treated with dignity and respect, it was necessary to focus on respect when forming the relationship. He stated that the kids still had the ability to bounce back and be productive citizens, although they often needed some help. He shared that it was necessary to take a step back, review what happened to cause these actions, and look at the kids as human beings. He opined that it was from this point that progress would begin. He shared that all of the staff, including teachers, maintenance, and nurses, were trained in the introduction phase of the TIC program, so that all the staff understood trauma and its effects on the clients in the facility. He said that TIC allowed people to focus on their own triggers, better understand their own reactions, and develop better coping skills, so there would be better relationships.

4:19:13 PM

CHAIR SEATON asked how the numbers on an ACEs assessment were used in the treatment decision.

MR. GATEWOOD replied that the number was irrelevant, that it was important to know the traumatic events which lead to the current state. It was most important to treat the person with respect, build relationships, and work on resilience.

CHAIR SEATON reflected on past testimony about the importance of ACEs, which seemed to focus on the numbers.

REPRESENTATIVE WOOL asked about the aforementioned point system that was no longer in use.

MR. GATEWOOD replied that this system had been based on points for behavior. He opined that, although points were artificial as there were not points in the real world, points gave both kids and staff a barometer, and something was necessary if points were going to be replaced.

4:22:07 PM

MS. CROSS-AZBILL explained that it was necessary to recognize the traumas and adverse experiences, and then look at how they earn points to help them become successful.

PRESENTATION: 24/7 SOBRIETY MONITORING PROGRAM

4:22:39 PM

CHAIR SEATON announced that the next order of business would be a presentation on the 24/7 sobriety monitoring program.

4:23:55 PM

TONY PIPER, Coordinator, Alcohol Safety Action Program (ASAP), Division of Behavioral Health, Department of Health and Social Services, said that the 24/7 sobriety monitoring program was one of the smart justice evidence based initiatives passed the previous legislative session, through Senate Bill 64. As this concept had been successfully used in several areas around the country, the 24/7 sobriety monitoring program was modeled on these other programs. He explained that the program allowed qualified participants to be actively involved in their

community, and to take care of their obligations instead of sitting in an institution. He reported that, as the participants were tested twice daily for alcohol with a breath analysis every 12 hours, the public was also safe. If there were any action that was not positive, there was an immediate follow up action, which most often resulted in immediately being remanded to the institution. He shared that Senate Bill 64 allowed this 24/7 program to be used in a variety of ways, including bail, probation, parole, and children in need of aid programs. He noted that the program had started in July, and shortly thereafter a tour for judges and attorneys had been instrumental in spreading the program information and increasing the referrals. He reported that there had been 218 participants through the end of December, with 89 active participants. He said there had been more than 11,000 successful breath tests, with only 26 failed breath tests. He shared that there had been more than 1300 successful drug tests, with only 16 failures. These failure rates were lower than those in other areas with similar programs. He pointed out that all of the 42 patients who had failed, were now re-entered into the program, and were currently successful. He explained that participants were released to the program, with instructions for where to go and how the program worked. He reported that drug testing was randomly done two or three times each week, with participants calling in each morning. The alcohol testing was conducted in both the morning and the evening and attendance was mandatory. He allowed that some adjustments to the timing had been made to allow for bus schedules. He reported that 64 people had now completed the program with no violations. He said that the program was now being expanded into Fairbanks and the Kenai. The per person cost for participation in the program was $5 each day for the breath test, and between $10 and $50 for the drug test, dependent on the number of drugs and the frequency of testing. He shared that facial recognition software was also available for those unable to go to the testing facilities, and were testing at home.

4:29:26 PM

REPRESENTATIVE STUTES asked about the random scheduling for drug testing.

MR. PIPER explained that the individual would call in every day and be advised whether they were scheduled to come in that day.

REPRESENTATIVE STUTES offered her understanding that, with advance warning, there was the ability to mask the results.

MR. PIPER replied that current drug tests had precautions that would show tampering or dilution for the normal urine sample. He added that these tests were witnessed by a representative of the program.

4:31:10 PM

REPRESENTATIVE STUTES opined that people can ingest "whatever it is they take" to produce a normal urine sample. She expressed confusion for the program offering an advance warning.

CHAIR SEATON asked that Representative Stutes research this further, to identify the chemical and whether this would show up as a normal sample.

4:33:07 PM

REPRESENTATIVE WOOL asked for the type of offenders in the program.

MR. PIPER, in response, shared that the bill listed the qualifying offenses, "more or less misdemeanor offenders," which included driving under the influence (DUI) and drug offenders.

REPRESENTATIVE WOOL asked if this included first time DUI offenders.

MR. PIPER replied that a first time offender could be in the program, though more often it was second and third time offenders.

REPRESENTATIVE WOOL asked for more information about the ankle bracelet monitoring system.

MR. PIPER acknowledged the availability of a bracelet, which was going to be used in the Fairbanks area. He offered his belief that Department of Corrections used the Sober Link bracelet, although it was only capable of alcohol testing.

REPRESENTATIVE WOOL opined that the bracelet could eliminate the need to go twice daily to a facility.

MR. PIPER concurred.

REPRESENTATIVE VAZQUEZ asked about the time lag between the call-in and testing.

MR. PIPER explained that there was a short time window in the morning, the call in period began at 6 a.m. and the testing had to be completed prior to 9 a.m.

REPRESENTATIVE VAZQUEZ asked if there was a designated lab.

MR. PIPER replied that there was a designated facility.

CHAIR SEATON opined that outside monitoring was an added efficiency for the justice system, as it reduced the cost of incarceration, it kept earnings going to the family, and it maintained engagement with the community. He declared that he was encouraged by the 11,000 positive test results, with only 26 failed tests. He offered his belief that there was a stronger learning path for learning how to not abuse alcohol out-of-jail versus in-jail. He expressed his support for the program and for an increase to the number of non-violent offenders able to be "back into life, but on that right path."

4:38:05 PM

REPRESENTATIVE VAZQUEZ asked who supervised the program.

MR. PIPER replied that the Department of Health and Social Services and the Alcohol Safety Action Program (ASAP) office were overseeing the program. In response to Representative Vazquez, he added that he was the program manager. He explained that the current results only reflected the program since its inception in August, although the South Dakota program had demonstrated results for a much longer period of time.

4:39:38 PM

ALBERT WALL, Director, Central Office, Division of Behavioral Health, Department of Health and Social Services, said that the department would provide the data.

4:39:56 PM

REPRESENTATIVE STUTES asked if, as this was a court mandated sobriety or drug testing program, there was any time delay or requirement before an individual would begin the program.

MR. PIPER explained that program participants were given instructions immediately upon their release from court, which allowed 12 hours to appear. These instructions included the

testing times, the directions to the facility, and bus routes to the facility. He said that anyone who took longer than 12 hours to appear at the testing agency was tested for the length of time since their court appearance. He shared that, as his office was immediately notified upon an individual's release from the court, the testing agency was expecting the individual within the next 12 hours.

A short video about the program was presented.

4:44:45 PM

MR. WALL explained that the program represented a response by the Department of Health and Social Services and its collaborative partners to comply with Senate Bill 64. It was based on a model that had shown results and had a consistent 100 percent accountability. He pointed out that the program offered a savings to the system. It addressed the addictive behavior, while holding the individual accountable and showing them an alternative way to move forward with their lives.

OVERVIEW: DIVISION OF BEHAVIORAL HEALTH

4:45:43 PM

CHAIR SEATON announced that the final order of business would be an overview of the Division of Behavioral Health.

4:46:27 PM

ALBERT WALL, Director, Central Office, Division of Behavioral Health, Department of Health and Social Services, presented a PowerPoint titled, "House Health & Social Services| Division Overview." Directing attention to slide 2, "Behavioral Health Overview," he said that the division existed to "manage and integrated and comprehensive behavioral health system based on sound policy, effective practices, and open partnerships." He said there were 348 full time positions in the division, and that the operating budget was about 5.2 percent of the overall Department of Health and Social Services budget, almost $142 million. The division served about 32,854 people, which did not include the prevention population.

4:47:49 PM

MR. WALL addressed slide 3, "Organization Chart," which showed the division structure and a breakout of personnel in each area.

He pointed to the Alaska Psychiatric Institute (API), which he described as "the anchor of acute care for behavioral health in the state." He noted that API was located in Anchorage and was an in-patient facility with 246 staff. API cares for people with the most extreme need and was based on a therapeutic and restorative model to return people to their community. Next, he pointed to the Prevention & Early Intervention Section, which primarily ran program management for grants, including fetal alcohol spectrum disorder (FASD) and suicide prevention. Although this section was primarily housed in Juneau, the grants were distributed statewide. He moved on to another grant section, the Treatment & Recovery Section, which represented the largest financial section after API, and handled grants in four categories. He referenced the Medicaid & Quality Section, which had quality oversight and assessment for Medicaid billing for behavioral health and for the Medicaid providers to behavioral health. He explained that the Policy & Planning Section handled the proprietary data base system where grantees entered reports, which allowed for tracking the information. This section also performed the research for the division. He noted the Administrative Support Team, as well as the three boards: the Alaska Mental Health Board, the Advisory Board on Alcohol & Drug Abuse, and the Statewide Suicide Prevention Council.

4:50:37 PM

MR. WALL presented slide 4, "Division Core Service Alignment," and stated that the division, similar to the department, was core service driven, and he explained how the core services of the division fed into the three priorities. He said that the first core service identified behavioral health needs by population and geography and developed and implemented a statewide strategy to meet those needs. He said that the second core service was to develop and maintain a stable, accessible, and sustainable system of behavioral healthcare for Alaskans in partnership with providers and communities. He said that it was extremely critical for behavioral health services to work collaboratively with its providers, as the system was designed and dependent on working together with other groups. He stated that the third core service was to protect and promote the improving behavioral health of Alaskans. The fourth core service was to provide accessible, quality, active inpatient treatment in a safe and comfortable setting, and the fifth core service was to provide and coordinate interagency behavioral healthcare.

4:52:57 PM

MR. WALL presented slide 5, "Continuum of Care," and explained that the continuum flow began with the prevention and early intervention efforts, which cost little per contact but had great value, such as suicide prevention, domestic violence and FASD. Moving along the continuum, he pointed to the treatment and recovery services, divided among mental health, such as mental illness, and behavioral health, such as substance issues. He noted that the treatment and recovery grants were most often found in the middle of the continuum. He pointed out that some of these services received grant dollars, as well as billing for Medicaid reimbursement for some of the population. Continuing along the continuum, he spoke about the more intensive services which included acute psychiatric help, and those high associated costs. The continuum concluded with the long term residential psychiatric treatment centers, the most expensive service.

4:55:23 PM

MR. WALL moved on to slide 6, listing the age groups, with the bulk of service for adults between ages 18 - 64. Presenting slide 7, "Collaboration," he emphasized the importance of the collaborative effort across the continuum of care. He declared that he was impressed with the relationships built with the care providers. He listed many of the organizations which represented groups of providers and their representation at conferences and workshops to ensure the necessary care. He read from a prepared statement:

> The purpose of the Division of Behavioral Health is to manage an integrated and comprehensive behavior health system based on sound policy, effective practices, and open partnerships. This is accomplished through either performing or providing for mental health and substance use disorder services, ranging from prevention to screening, out-patient treatment, and acute psychiatric care. Those services are specifically focused on individuals who cannot access behavioral health services without some form of assistance and are targeted to the following specific population groups: these are individuals in severe psychiatric crisis or in need of de-toxification; severely emotionally disturbed children and youth; severely mentally ill adults; substance use disordered adults and youth; and, or, adults and youth in the community, specifically services to prevent health risk factors.

MR. WALL concluded by stating that the division did, in some ways, provide direct service to some programs. However, most of the services were indirect, through the provider groups in the communities, either through grant funding or Medicaid services. He reported that, in order to accomplish its purpose, the division provided ongoing prevention and early intervention for behavioral health issues through grant programs and management, and he listed many of these programs, which included suicide awareness, fetal alcohol syndrome, domestic violence, and drug and tobacco use. He noted that direct care was provided through the therapeutic courts, the alcohol program, and API. The division provided for on-going, comprehensive behavior health treatment and recovery, as well as psychiatric emergency services for severely disturbed children and youth, severely mentally ill adults, and substance use disordered youth and adults. He pointed out that the division provided statewide access to behavior health care through management and quality assurance of the behavior health Medicaid system.

5:00:22 PM

CHAIR SEATON noted that, although only 2.5 percent of the service population was 65 and older, there seemed to be an increase in dementia and Alzheimer's. He asked whether this population received much service.

MR. WALL replied that he was working with the Division of Senior and Disabilities Services, as this was a growing area of concern.

CHAIR SEATON said that he was supportive of an upstream net and moving into prevention to delay the onset of Alzheimer's, as it was a disruption of lives throughout the state.

MR. WALL said that a committee had been formed, as this was a concern, and it was in on-going discussions.

5:03:00 PM

REPRESENTATIVE VAZQUEZ referred to slide 5, "Continuum of Care," and asked about the reference to Acute Psych (Non-API).

MR. WALL explained that some of this population was served by hospitals in-state and out-of-state. He directed attention to the Designated Evaluation, Treatment, and Stabilization box, and explained that this was also done in hospitals.

CHAIR SEATON asked whether Alzheimer's fits into any of these sections for long term care.

REPRESENTATIVE VAZQUEZ shared that it was a separate waiver.

MR. WALL explained that these were normally cared for under the Senior and Disabilities waiver.

MR. WALL, in response to Representative Vazquez, explained that the residential psychiatric treatment centers were long term care for children with serious emotional disturbance, and that many of these were located out of state.

REPRESENTATIVE VAZQUEZ asked for a breakdown of the aforementioned out of state and in-state program expenses.

MR. WALL said that he would provide this.

REPRESENTATIVE VAZQUEZ, referring to slide 5, asked what prevention services were being offered in this category.

MR. WALL explained that this category included advertisements on television and radio, as well as printed material, for a variety of subjects, including under-age drinking, tobacco use, suicide awareness, and FASD.

REPRESENTATIVE VAZQUEZ asked whether there was any effort to include nutrition and vitamins as prevention measures, as a lot of research indicated that severe deficiencies of vitamins could show up as diseases. She requested more effort in that direction.

MR. WALL replied that he was unaware of any effort in the Division of Behavioral Health, although there could be in Department of Health and Social Services. He would forward that information.

REPRESENTATIVE VAZQUEZ added that there were studies on the effects of color on patients and their moods. She stated that it was necessary "to start thinking out of the box, instead of taking the most expensive options we have." She suggested that there were cheaper options to help the healing process.

5:08:48 PM

CHAIR SEATON announced that there would be sessions specifically to address prevention and strategies to lower costs while improving the health status of Alaskans.

5:09:14 PM

ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 5:09 p.m.