

**ALASKA STATE LEGISLATURE**  
**HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE**

February 10, 2015

3:03 p.m.

**MEMBERS PRESENT**

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

**MEMBERS ABSENT**

Representative Liz Vazquez, Vice Chair

**COMMITTEE CALENDAR**

PRESENTATION: ALASKA MENTAL HEALTH TRUST AUTHORITY

- HEARD

PRESENTATION: NAMI

- HEARD

**PREVIOUS COMMITTEE ACTION**

No previous action to record

**WITNESS REGISTER**

JEFF JESSEE, Chief Executive Officer  
Alaska Mental Health Trust Authority  
Department of Revenue  
Anchorage, Alaska

**POSITION STATEMENT:** Presented an overview PowerPoint on the Alaska Mental Health Trust Authority.

DOV GARTENBERG, Executive Director  
National Alliance on Mental Illness (NAMI) Juneau  
Juneau, Alaska

**POSITION STATEMENT:** Testified during a presentation by NAMI.

SHIRLEY HOLLOWAY, President  
National Alliance on Mental Illness (NAMI) Alaska  
Anchorage, Alaska

**POSITION STATEMENT:** Testified during a presentation by NAMI.

JOHN HARTLE, Board Member  
National Alliance on Mental Illness (NAMI) Juneau  
Juneau, Alaska

**POSITION STATEMENT:** Testified during a presentation by NAMI.

CRYSTAL BORLAND, Incoming Executive Director  
National Alliance on Mental Illness (NAMI) Juneau  
Juneau, Alaska

**POSITION STATEMENT:** Testified during a presentation by NAMI.

#### **ACTION NARRATIVE**

[3:03:20 PM](#)

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

#### **PRESENTATION: Alaska Mental Health Trust Authority**

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CHAIR SEATON announced that the first order of business would be a presentation by the Alaska Mental Health Trust Authority.

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JEFF JESSEE, Chief Executive Officer, Alaska Mental Health Trust Authority, Department of Revenue, presented a PowerPoint titled "Trust." He directed attention to slide 1, "Trust Beneficiaries," and listed people with mental illness, developmental disabilities, chronic alcoholism, substance related disorders, Alzheimer's disease, dementia, and traumatic brain injury as beneficiaries of the trust. He stated that prevention was a big part of the work by the Trust with a hope to avoid many of these conditions. He moved on to slide 2, "Established Focus Areas," and shared that the five focus areas were disability justice, substance abuse prevention and treatment, beneficiary employment and engagement, workforce

development, and housing and long-term services and support. He listed the current priorities in this legislative session to include: restore funding for the homeless assistance program as this was a true safety net for the homeless; and, work on Medicaid expansion and its reform in order to fundamentally alter the trajectory of the program to make it more sustainable, slide 3, "Current Priorities." He expressed his belief that Medicaid expansion could be a catalyst for Medicaid reform, and a more sustainable budget over time. He shared that he had explained to the Senate Finance Committee that the mental health bill would start to review the budget in a broader context, and not review each department and program in its own "stovepipe." He offered an example of the Behavioral Health program, noting that it had an impact on recidivism, and hence was a part of the Department of Corrections (DOC) budget. He pointed out that many problems with recidivism were not controlled by DOC, but were in the Department of Health and Social Services (DHSS) budget. He laid the responsibility for this "stovepipe" approach on the finance sub committees, as they did not review budgets in conjunction with each other. He offered his belief that the House Finance Committee initiated the separation of departments, and instead the budgets should be reviewed as a whole.

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CHAIR SEATON asked that he speak about the way in which the mental health trust fund worked, its structure, and its independence and relationship with the legislature.

REPRESENTATIVE TARR reflected on an interagency working group as a means to share the budgetary information, and asked whether there was an existing model for an infrastructure to facilitate this coordination.

MR. JESSEE replied that interagency collaborative groups did exist, and he listed the Criminal Justice Working Group, which includes the Department of Administration, Department of Public Safety, Department of Corrections, Department of Labor & Workforce Development, and Department of Health and Social Services. He reported that both legislative bodies included intent language in the budget for agencies to continue working together in the development of a recidivism reduction plan, which includes the Department of Corrections, Department of Public Safety, the Alaska Court System, Department of Health and Social Services, Department of Labor & Workforce Development,

Alaska Housing Finance Corporation, and the Alaska Mental Health Trust Authority.

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MR. JESSEE spoke about the Alaska territorial days when anyone with a mental disability was convicted for being "an insane person at large" and was sent to Morningside Hospital in Oregon. At statehood, Alaska would have needed to begin payment to Morningside Hospital and, as there was not any means to support this unpopular program, the Mental Health Enabling Act was passed. This act provided money for the first wing of Alaska Psychiatric Hospital, an in-state mental hospital, and bought a motel in Valdez to house people with developmental disabilities. He explained that this act also provided some federal money, which was reduced over a few years, and created a one million acre land trust for the state to generate additional revenue. He offered an anecdote, sharing that the original proposed land trust was for one half million acres, but while the proposed bill was in committee, the Representative from Nebraska complained about the idea and mockingly suggested offering one million acres, with the idea that the proposed bill would then be defeated. He shared that the land trust had originally selected some of the most valuable land in the state however, almost half of that land had been passed on for less than face value. He reported that this generated a law suit, which was finally settled in 1995, with the re-creation of the mental health trust and a return of some substitute land to replenish the one million acres. He noted that these lands were developed by the Alaska Mental Health Trust Land Office in the Department of Natural Resources. He relayed that there was also a cash endowment of \$200 million that had grown to \$500 million. He declared that the most important part was a Board of Trustees who were able to oversee management of these assets and spend the revenue from these assets to improve the mental health program, without any legislative approval except for the administrative budget. He declared that the majority of funding came through state government, in order to create a comprehensive, integrated mental health program, instead of a separate grant system.

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CHAIR SEATON asked about the relationship of the mental health trust budget during the legislative budget process.

MR. JESSEE explained that the mental health budget, as opposed to the capital budget or the operating budget, was designed to look at the mental health program in aggregate in order to view the budget's interrelationship and find efficiencies and effectiveness changes to the system. He stated that the finance committees deconstructed the mental health budget into departmental components, and reviewed the interrelationships before reconstructing it for a sustainable budget. He likened the mental health trust as venture capital for the state mental health program. He pointed out that the Trust spends about \$25 million each year for the mental health program. He mentioned the Bring the Kids Home program for reducing the number of kids sent out of state from 437, at a cost of \$45 million each year. Currently there are only 88 kids housed out of state, and the money has been re-invested for in-state services. He reported that the Trust spent about \$16 million of its funds to help organize, start pilot projects, and facilitate the re-investment of outside dollars into in-state services.

MR. JESSEE moved on to slide 4, "Prevention & Early Intervention."

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REPRESENTATIVE STUTES asked about the means of access to these funds. She shared that people in rural Alaska were aware of the Trust but did not know of any way to access or utilize the benefits.

MR. JESSEE replied that two thirds of the Trust funding was spent through state government, and offered an example for money allocated to the Department of Health and Social Services for a program which was then distributed to grantees in the community. He mentioned start-up funding for the Bethel Sobering Center to help inebriates from the streets in Bethel. He noted there were also some individual grants for up to \$2,500 for things to improve their quality of life.

REPRESENTATIVE STUTES asked who the trust providers were.

MR. JESSEE explained that the providers were anyone who received a grant from the various agencies who were partners for services.

REPRESENTATIVE STUTES offered an anecdote for an explanation as to determining who was a provider.

MR. JESSEE explained that, as the Trust was venture capital for the program, they did not provide base funding to provider agencies. He offered an anecdote to explain who an individual would visit if they need services. He stated that these programs and systems for care were developed with funding from the Trust, but that the Trust only offered indirect participation for mental health services.

REPRESENTATIVE STUTES asked for an example regarding an individual who was not eligible for any benefits. She referenced an earlier House Health and Social Services Standing Committee presentation for tele-medicine, noting that the tele-medicine provider did not facilitate any further connections for help.

MR. JESSEE said that in many parts of Alaska tele-psychiatry was the number one use of tele-medicine. He explained that an individual who was not eligible for tribal services may have to pay or find a private provider. That individual would either need insurance, be eligible for Medicaid, or have money, in order to pay. He stated that without any of these, the individual would be "in big trouble" as they would have a hard time accessing services. He declared that this was "why we're talkin' about Medicaid expansion."

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REPRESENTATIVE TARR asked for examples of direct service provider groups that were offered grants.

MR. JESSEE offered RuralCap, NAMI, and Tanana Chiefs Conference as groups which the Trust had offered grants, noting that the Trust provided about 175 grants.

REPRESENTATIVE TARR suggested that a referral to one of these agencies was another way for individuals to access services.

MR. JESSEE offered another example of the network of community health aides in the tribal health system. He shared that behavioral health aides were now being trained for behavioral health services in rural clinics, and that a training manual and handbook was necessary for this training. As this manual was an expensive endeavor, the Trust funded that manual because it enhanced the program.

REPRESENTATIVE WOOL asked whether the Trust only worked through the tribal health network.

MR. JESSEE replied that, although the behavioral health aide program was through the tribal health network, they did not only work with tribal health agencies.

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MR. JESSEE returned attention to slides 5 - 6, and the impact of adverse early childhood experiences. He stated that the more of these experiences stacked up in childhood the worse the outcomes were over time, such as: physical abuse and neglect, emotional abuse and neglect, sexual abuse, alcohol or drug user in the household, an incarcerated household member, chronic depression, or one or no parents. He stated that some of these outcomes were fairly obvious, pointing out that the odds ratio of suicide attempts correlated with these adverse childhood experiences, slide 7. This pattern followed very consistently and, he pointed out the correlations of adverse experiences with heart disease, asthma and other physical ailments were not quite as obvious. He reported that it was necessary to build a sustainable budget so that attention could be focused on these adverse experiences. He lamented that these programs were often not addressed until it was a struggle to find the money to invest in these programs.

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[Chair Seaton passed the gavel to Representative Talerico]

MR. JESSEE moved on to slide 10, "Prevention Programs." He asked how it was determined for what was the "best bang for the buck." He spoke about the nurse family partnership for low-income families, which identified at-risk families at the time a child was born, and set up a nurse partnership. He declared that this was a very cost effective program, and cited the Washington State Institute for Public Policy studies on early intervention strategies. He stated that the early intervention and prevention programs were some of the best returns on investment, as they headed off the problems at the front end so they were not being paid for later. He reported that the cost per family was about \$9,800 but the benefit was about \$26,000. He stated that the early childhood education program had an even stronger cost benefit.

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MR. JESSEE shared slide 11, "Juvenile Offenders," and directed attention to the success of the various strategies. He spoke about the Scared Straight program, describing it as a program that took kids to the jail and walked them around, while telling them that this was the result of their current actions. He declared that not only did this not work, it was counterproductive and had a one percent chance for any positive outcome. He explained, in that kids have an inherent fear of the unknown, once they were made aware of the inside of jail, they were no longer as deterred by it. He suggested that it might be better not telling them what jail would be like. He spoke about the DARE program, which brought police officers in uniform into the schools to talk with young students about the evils of drugs and alcohol. He stated that although teachers, kids, principals, and the police all loved this program, it did not work. He opined that it was unclear why it did not work, but offered his belief that as the young students aged, they no longer listened to any authority figures. He emphasized that a program that did work brought recovering teen-age addicts into the classroom to speak. He acknowledged that the offer to principals for eliminating the police officer visits in lieu of visits by addicts was often a challenge.

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MR. JESSEE moved on to slide 12, "Recidivism," and declared that something had to change in order "to turn the curve on the corrections population," or it would be necessary to build an additional \$300 million prison with a \$50 million annual operating budget. He declared that this was not a path to sustainability. Moving on to slide 13, "Monetary Benefits and Costs of Evidence-Based Public Policies that Affect Crime," he explained that Case Management with swift and certain graduated sanctions was very effective and had a good return on investment. He pointed out that the same case management without swift and certain penalties was less effective, but cost the same. He explained that a current program, Probationer Accountability with Certain Enforcement (PACE), had been piloted in Alaska and was ready for expansion if there was funding. He explained that the PACE program did not wait for someone on probation to do a series of little things with no penalties until a larger, more serious violation; instead, a small but certain penalty, 24 hours in jail, was applied the first time they stepped out of line. He declared that this program was very effective. He stated that the budget could be brought under control with smart investment in these strategies, that it

was necessary to use the data, keep track of the data, and stop funding the programs that were not accomplishing expectations.

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REPRESENTATIVE TARR asked about the McDowell study.

MR. JESSEE, in response to Representative Tarr, shared that the McDowell Group had studied the cost of excessive use of alcohol to the state. The report had listed the cost to be \$1.2 billion, including: criminal justice costs, Office of Children's Services, the court systems, public safety, and lost productivity. He pointed out that, although there was a \$1.2 billion cost to the state, the alcohol industry only paid about \$40 million in taxes. He offered his belief that no other industry would be allowed to leave a "\$700 million mess in the community."

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REPRESENTATIVE WOOL, suggesting that the program solutions "sound a little counter intuitive," asked whether there were any problems with convincing others that these worked.

MR. JESSEE replied that it was only necessary to review the data. He offered an example of Housing First, which housed homeless people with chronic alcohol problems. He pointed out that there had been initial resistance to the program. He stated "homelessness is not cheap," listing costs for health care through the emergency room, police, fire, and court costs. He referenced an article about "Million Dollar Murray," in which the author followed a homeless man in San Diego, and recounted the costs to the community, which were \$1 million. He reported that housing allowed for improved health and reduced pick-ups by the police, resulting in savings for the community. He shared a story about Anchorage assembly persons being shown a similar housing for homeless program in Seattle, which was highly touted. He stated "you gotta look at the data."

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REPRESENTATIVE TARR asked about an update to the development of the Fairview program which received a \$4 million appropriation during the past year.

MR. JESSEE, in response, stated that there were meetings between the Fairview community and the Division of Behavioral Health.

He reported that the division was developing an assertive community treatment program, which would immediately follow up on patients who missed an appointment to help maintain stability and keep them from cycling through the other expensive systems.

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REPRESENTATIVE STUTES expressed her alarm over an earlier comment that an individual was "just out of luck" if they were "not eligible for native care, and you don't have Medicaid, and you don't have any money." She stated that these were exactly the people who most needed the benefits.

MR. JESSEE expressed his agreement, stating that he was not making light of this, or saying that this was alright. However, this was a fact for the current system of health care. If a person was not insured, was not eligible for tribal health care, did not have enough money to pay, and the public system did not have the capacity to serve them, then it would be very difficult to access the services.

REPRESENTATIVE STUTES questioned whether this was the reason for the mental health trust fund. She offered her belief that, as this was a public, state owned fund, there had to be an avenue of access to treatment for the people who did not have medical insurance, Medicaid, or money.

MR. JESSEE replied that he would totally agree. He explained that the Trust had \$20 - \$25 million to spend annually for improvement to the program, whereas the entire mental health program budget, including Medicaid, was over \$300 million. He pointed out that placement of every dollar from the Trust into additional capacity in the service system would only be "a drop in the bucket." He shared that the Trust focused the use of its dollars in a way to enhance the overall system and allow service to more people than by using those dollars directly. He pointed to support for Medicaid expansion, as it was estimated that 5,000 more behavioral health beneficiaries would become eligible with Medicaid expansion. He stated that it would not be possible for the Trust to serve those 5,000 people if it spent all of its money on direct services. He offered his belief that it was possible, should the Trust spend its annual \$25 million for direct services, for the legislature to back out \$25 million of general funds. There would not be any more services, and the Trust money would be locked up. Also, there would no longer be any Trust money for investment as venture capital, which could include money for mental health courts, Housing First, and other

programs. He explained that venture capital dollars invested in any public system of care were no longer available, except upon rare occasion. He declared that the Trust money was a "unique tool." He emphasized that the Trust could not provide the direct services, but it could help with investments to serve a greater number of people.

REPRESENTATIVE STUTES expressed her understanding.

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REPRESENTATIVE TARR asked about individuals seeking behavioral health services through emergency rooms, noting that emergency rooms were not equipped for these services. She acknowledged that, as this was the last resort for many people, they would not be turned away but would not receive service from the appropriately trained personnel.

MR. JESSEE expressed his agreement. He noted that the original plan during the recent rebuilding of Alaska Psychiatric Institute (API), had been for a 200 bed hospital; however, the Trust had expressed its preference for more community based care. He shared that a psychiatric emergency room was then developed at Providence Alaska Medical Center in Anchorage, which could be used in lieu of API. He reported that the local hospitals in Juneau and Fairbanks also had mental health units for psychiatric emergencies, although the Mat-Su Regional Medical Center did not have this capacity. He declared that emergency mental health care was very important.

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The committee took an at-ease from 3:48 p.m. to 3:51 p.m.

**PRESENTATION: NAMI**

[3:51:47 PM](#)

REPRESENTATIVE TALERICO announced that the next order of business would be a presentation by the National Alliance on Mental Illness (NAMI).

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DOV GARTENBERG, Executive Director, National Alliance on Mental Illness (NAMI) Juneau, stated that the NAMI organization had 1,100 national affiliates and that NAMI Juneau served Southeast

Alaska. He reported that there had been up to 11 affiliates in Alaska, and that it had started in the 1970s, when large mental hospitals were closing down and adult children were returning to their homes. The national organization was developed as a grass roots organization when local groups were formed to respond to this situation.

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SHIRLEY HOLLOWAY, President, National Alliance on Mental Illness (NAMI) Alaska, briefly shared her first contact with NAMI, about 4 years ago, when her mentally ill daughter committed suicide. She had then contacted Jeff Jesse, asking him for suggestions for organizations to work with, and he introduced her to NAMI. She lauded that NAMI offered immediate support to her family, meeting with her daughter's children, her siblings, and her parents. She touted that NAMI provided a level of support "that was unbelievable" and for which she was still grateful. Subsequently, she became the Vice President of NAMI Anchorage, and now, she is the President of NAMI Alaska. She declared that her mission is for NAMI to provide a service to families not available through any other agencies. She detailed that her experiences with experts during her daughter's mental illness never suggested there was a program in support of families living with an individual with mental illness. She offered her desire to have trained NAMI staff everywhere in Alaska to support and advocate for families, so that other families did not have to suffer as her family had suffered. She offered her belief that this is "one of the most cost effective programs you'll ever hear about." She acknowledged the fiscal challenge to the state, and offered for NAMI to be a part of the solution.

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JOHN HARTLE, Board Member, National Alliance on Mental Illness (NAMI) Juneau, shared that he became involved with NAMI when a family member was suffering from a mental disability. He reiterated the cost effectiveness of the NAMI program, and noted that it received some funding through the TRUST. He stated that NAMI offers courses to family members, taught by volunteers and are free to families. These courses and the course materials were developed by the national organization to teach family members about the course of treatment for mental illness, the medications, the symptoms, and expectations for outcomes. He declared that this was a "life ring thrown to me in the middle of the sea." He shared that he had no idea where to turn during this family member crisis. He stated that NAMI was a statewide

volunteer organization, and had hopes for funding from RFPs through the Division of Behavioral Health, in the Department of Health and Social Services. He asked that the committee be supportive. He pointed out that NAMI was unique as it provided services and information to family members, whereas other mental health providers would not ever return his phone calls, as they were terrified of the Health Insurance Portability and Accountability Act (HIPPA). He declared that services were needed for family members in order to provide support to the individuals suffering from mental illness. He stated that this support was very effective in providing better outcomes.

[4:01:25 PM](#)

CRYSTAL BORLAND, Incoming Executive Director, National Alliance on Mental Illness (NAMI) Juneau, offered an overview of some of the NAMI programs, referring to the handout titled "Improving Lives:" [Included in members' packets]. She directed attention to a 12 week course, Family to Family, which was taught by peers with an evidence based, nationally based, curriculum. She relayed that it touched on medications, treatment options, coping strategies, and diagnosis of mental illness, and it showed the family how to communicate better and more effectively with their loved one. She shared that once the individuals were able to cope and communicate with their loved one, they would become better advocates. She stated that the program, along with support from the family and the community, also worked to keep people out of institutionalized care, which was a cost savings. She listed some of the other program offerings, which included NAMI Basics and support groups for both families and people living with mental illnesses.

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MR. GARTENBERG relayed that NAMI was a peer support organization, and not a direct service organization. He stated that NAMI Anchorage and NAMI Juneau continues to receive grants, as well as raising money from other sources. He relayed that the Trust had stepped in for support when the state funding ended. He offered his belief that, as much of the state was under served, a NAMI presence statewide had early intervention possibilities. He said that NAMI had motivated individuals for getting the word out and connecting with providers and leaders in the communities to ensure there was education and support in the local community. He shared that the NAMI training standards required presentation of information and connection with people. He explained that the peer support nature of the organization,

its great strength, required funding for training and the creation of affiliates in other areas. He declared that NAMI did not have the resources to expand with other affiliates, although the TRUST had indicated it would work with the state for expansion. He reiterated that the cost benefits to the family and to the state from early intervention were enormous. He shared an anecdote about the NAMI Basics program for parents with adolescents who were showing signs of early onset mental illness, although still undiagnosed.

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MS. HOLLOWAY thanked the committee and pointed out that most states provided state funding for NAMI, whereas in Alaska, NAMI was only receiving money from the Trust. She said that NAMI had been able to raise some money for training, and was able to train 14 people from communities throughout the state. She pointed out that this training offered the potential for these people to return to their communities and provide that same level of support and training to people in their communities. She reported that NAMI was also working with GCI for a more cost effective on-line delivery. She expressed her hope for any support to the program.

REPRESENTATIVE TARR expressed her appreciation, especially for the use of community volunteer programs.

[4:10:28 PM](#)

#### **ADJOURNMENT**

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 4:10 p.m.