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STAFF ANALYSIS OF CSSB 520 AND 521, AN ACT ESTABLISHING A STATE MENTAL HEALTH REHABILITATION CENTER AND MAKING A SPECIAL APPROPRIATION.

CSSB 520

SECTION 1: FINDINGS: ADDS THE NEW FINDING THAT THERE IS A NEED FOR ADDITIONAL RESIDENTIAL CARE TO SERVE THE NORTHERN REGION, THE DEVELOPMENT OF A COMMUNITY SUPPORT SYSTEM APPROACH TO DEALING WITH CHRONIC ADULT MENTAL ILLNESSES, AND A FACILITY TO SERVE THE LONG-TERM INPATIENT NEEDS OF THOSE YOUTHS WHO ARE CURRENTLY BEING SENT OUTSIDE OF THE STATE FOR MEDICAL AND EDUCATIONAL ATTENTION. FURTHER FINDS THAT THERE MAY BE A NEED FOR SEVERAL FACILITIES TO MEET THESE NEEDS. LOCATES ANY FACILITY OR FACILITIES IN FAIRBANKS.

SECTION 2: POWERS AND DUTIES OF THE DEPARTMENT: DIRECTS THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES TO CONSULT WITH LOCAL MENTAL HEALTH CARE PROVIDERS, HOSPITALS, PRIVATE CITIZENS GROUPS INVOLVED WITH MENTAL HEALTH AND THE DEPARTMENT OF EDUCATION AND DEVISE A PLAN TO MEET THE MENTAL HEALTH NEEDS OF STATE RESIDENTS. IN THE PLAN THE DEPARTMENT SHALL CONSIDER THREE NEEDS: (1) THE PROVISION OF ADDITIONAL RESIDENTIAL CARE, (2) THE PROVISION OF A COMMUNITY BASED COMPREHENSIVE SUPPORT SYSTEM TO DEAL WITH YOUNG ADULTS WHO NEITHER BELONG IN A LOCK-UP FACILITY BUT WHO CANNOT BE HELPED IN NORMAL RESIDENTIAL FACILITIES, (3) THE PROVISION OF LONG-TERM INPATIENT CARE TO ADDRESS THE LACK OF A FACILITY FOR YOUNG ADOLESCENTS WHO ARE CURRENTLY BEING SENT OUTSIDE OF THE STATE. THE BILL ALSO DIRECTS THE DEPARTMENT TO INVESTIGATE THE FEASIBILITY OF PRIVATE AS WELL AS STATE OPERATED FACILITIES WHERE APPROPRIATE.

SECTION 3: PURPOSE OF CENTER: LISTS A STRING OF SERVICES TO BE PROVIDED BY /NY CENTER OR MIX OF CENTERS.

SECTION 4: REPORT: REQUIRES THE DEPARTMENT TO SUBMIT A REPORT TO THE LEGISLATURE ON THE 10TH DAY OF THE FIRST SESSION OF THE 14TH ALASKA LEGISLATURE INCLUDING BUDGET RECOMMENDATIONS, CAPITAL AND OPERATING, TO IMPLEMENT THE PLAN AND PROVIDE AN ANALYSIS OF THE BILL'S IMPACT ON THE MENTAL HEALTH TRUST LANDS CASE (WEISS V. STATE OF ALASKA).

CSSB 521

CHANGES THE APPROPRIATED AMOUNT FROM \$30 MILLION TO \$3 MILLION. RATHER THAN CONSTRUCTION, THE BILL APPROPRIATES MONIES FOR THE DEVELOPMENT OF THE DEPARTMENT'S PLAN AND FOR THE DESIGN AND ENGINEERING FOR THE CONSTRUCTION OF THE MENTAL HEALTH REHABILITATION CENTER IN FAIRBANKS. LIMITS TO \$100,000 THE AMOUNT THE DEPARTMENT MAY USE IN THE DEVELOPMENT OF TITLED PLAN

Original sponsor: Resources Committee

1 IN THE SENATE

BY THE HEALTH, EDUCATION AND
SOCIAL SERVICES COMMITTEE

2 CS FOR SENATE BILL NO. 520 (HESS)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 THIRTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to the establishment of a state
7 mental health rehabilitation center; and providing
8 for an effective date."

9 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

10 * Section 1. FINDINGS. The legislature finds that children and adults
11 who suffer from chronic and debilitating psychiatric illness are among the
12 most underserved of all of the state's citizens. These persons are unable
13 to provide for their daily needs and require assistance to maintain them-
14 selves as functioning members of their communities. For some, acute and
15 crisis intervention services are needed. For others, long-term maintenance
16 care is required with on-going residential supervision and assistance,
17 including vocational rehabilitation, continuing education, special educa-
18 tion, psychotherapy, and opportunities for sheltered employment, in order
19 to participate as functioning members of society. The legislature further
20 finds that there is a need for an additional residential care facility to
21 serve the northern region of the state, community support system facilities
22 to provide comprehensive services to ^{adolescents} young adults; and a long-term inpa-
23 tient facility designed specifically to meet the medical and educational
24 needs of young Alaskans. Therefore, the legislature finds that there is a
25 need for a comprehensive mental health rehabilitation center or a mix of
26 facilities to meet these needs. The facility or facilities shall be
27 located in Fairbanks.

28 * Sec. 2. POWERS AND DUTIES OF THE DEPARTMENT. (a) The Department of
29 Health and Social Services shall, in consultation with local mental health

1 providers, local hospitals, private citizen groups involved with mental
2 health and the Department of Education, develop a plan to design and
3 construct a facility or facilities to meet the mental health needs of state
4 residents.

5 (b) The Department of Health and Social Services shall consider in
6 its plan

7 (1) the provision of ~~additional~~ residential ^{and community based} care ^{support programs} for the
8 chronically mentally ill adult population;

9 (2) the provision of ^{residential care and} a community-based comprehensive support
10 ^{Programs} ~~system~~ to deal with ^{adolescents} ~~young adults~~ who neither fit into an inpatient ^{psychiatric} ~~lock-up~~
11 facility nor can be placed into a normal educational facility; and

12 (3) the provision of ^{acute and} long-term inpatient ^{psychiatric} care to address the
13 state's lack of facilities for ~~young~~ adolescents whose needs cannot be met
14 by private in-state institutions or by residential care facilities and who
15 are currently being sent outside of the state to receive medical and
16 educational attention.

17 (c) The Department of Health and Social Services shall investigate
18 the feasibility of privately-operated facilities and state-operated facili-
19 ties.

20 * Sec. 3. PURPOSE OF CENTER. The purpose of the mental health rehabili-
21 tation center is to provide residential, inpatient and outpatient, psycho-
22 therapy, vocational rehabilitation, ^{life skills training} and educational services to emotionally
23 disabled persons in the state based upon referrals from state and private
24 referral agencies and school districts throughout the state.

25 * Sec. 4. REPORT. The department shall submit a report to the legisla-
26 ture by the 10th day of the First Regular Session of the Fourteenth Alaska
27 State Legislature. The report shall include specific budget recommenda-
28 tions to implement the plan developed under sec. 2 of this Act, including
29 capital and operational requirements. ~~The report shall also include an~~

1 ~~analysis of the impact of the plan on the resolution of the mental health~~
2 ~~trusts lands case. (Weiss v. State of Alaska)~~

3 * Sec. 5. This Act takes effect immediately in accordance with AS 01.-
4 10.070(c).

MSG 84-00634195 PRTY 1 04/11/84 16:49:16 ORIG: LAOB IN= 0011 OUT= 0010
FROM: ANCHORAGE/JACKI TO: TOM/FINAL STATS
TARGET: LHV SUBJ: (S) HESS, MENTAL HEALTH CENTERS, 4/11/84

LEGISLATIVE TELECONFERENCE NETWORK SIGN-IN SHEET

DATE: 4/11/84
SITE: ANCHORAGE, LISTEN ONLY
SPONSOR/SUBJECT: (S) HESS, MENTAL HEALTH CENTERS

...0..TESTIFIED	*****T/C STARTED: 3:00
...2..OBSERVED	*****T/C ENDED: 4:40
...2..TOTAL	

OBSERVED

1. KRISTI ANA BYRD, SEN. JOSEPHSON'S STAFF
2. ELIZABETH HICKERSON, SENATE ADVISORY COUNCIL

MSG 84-00034140 PRTY : 04/11/84 15:47:42 ORIG: LF05 IN= 0006 OUT= 0021
FROM: PAULA/FKS TO: TOM/JNU
TARGET: LJH6 SUBJ: MENTAL HEALTH FAC/SEN HESS T/C

MARSHA SCHNEIDER WOULD LIKE TO BE CALLED ON LATER ON IN THE
TELECONFERENCE AFTER SHE HAS HEARD OTHERS SPEAK.

DIANA CAMPBELL HAS A TIME CONSTRAINT, NEEDS TO SPEAK BY 4:15.

**SARRY TOM, DON'T KNOW WHAT HAPPENED TO THAT MICROPHONE ALL OF A SUDDEN.
I HAVE SWITCHED IT.***

MSG 84-00034077 PRTY 1 04/11/84 15:12:15 ORIG: LF05 IN= 0003 OUT= 0010
FROM: LYNDA/FBX TO: TOM/JNO
TARGET: LJH6 SUBJ: SEN HESS ON MENTAL HEALTH FAC

FBX OMNI #2

TO TESTIFY (CON'T)

9. LESLEY SALISBURY
10. PAULINE BENNET, O.T.R., AK OCCUPATIONAL THERAPY ASSOC.
11. MARTI CRANOR, FBX C.M.H.C.
12. B.J. STALEY, FBX CRISIS CLINIC FOUNDATION
13. KATHY WHITZELL, FBX MEM. HOSP & F.C.M.H.C.
14. AL AARON, MEMBER F.A.M.I. (MAY OR MAY NOT WISH TO SPEAK)
15. BLANCHE BRUNK, R.C.F.C.
16. PATTI KASTELIC
17. PHYLLIS VANAIRSDALE

PLUS ABOUT 6-8 OBSERVORS

MSG 84-00034120 PRTY 1 04/11/84 15:37:48 ORIG: LF05 IN= 0005 OUT= 0020
FROM: PAULA/FKS TO: TOM JNU
TARGET: LJH6 SUBJ: MENTAL HEALTH FAC/SEN HESS/TC

OMNI # 4

FBX

TO TESTIFY

- 20. GUY PATTERSON
- 21. TOM MOYER
- 22. ANN DENARDO

TO OBSERVE

- 12. JIM ORVIK
- 13. ROSE HOLLAND, FAMI
- 14. RUSS CUSACK, DUR

~~P.S. WE HAVE RESENT OTHER OMNIS TO LAXTC~~

MSG 84-00034064 PRTY 1 04/11/84 15:03:46 ORIG: LF05 IN= 0002 OUT= 0006
FROM: LYNDA/FBX TO: TOM/JNO
TARGET: LJH6 SUBJ: SEN HESS T/C

FORGOT TO TELL YOU I'M AT PRINTER LFH1. IF YOU COULD SEND OMNI'S HERE I'LL
BE SURE TO SEE THEM. THANKS.

TO TESTIFY:

- 1. ✓ SHERRY MCWHORTER, NO AK HEALTH RESOURCES ASSOC.
- 2. ✓ KAYE CORY BAKER *PAINFUL CASTLY*
- 3. ✓ MARSHA SCHNEIDER, AK CHAPTER NAT'L ASSOC OF SOCIAL WORKERS *will not speak*
- 4. ✓ NORMA LARSEN, *Spec - Special ED.*
- 5. ✓ RIKI SIPE, AK IC ALLIANCE
- 6. ✓ ALICE SIBBITT F.N.S.B. SCHOOL, SPEC ED.
- 7. ✓ RUTH LISTER, WICCA
- 8. ✓ TOM MINGEN, ABX HOSPITAL FOUNDATION

-----MORE IN A MINUTE

MSG 84-00034091 PRTY 1 04/11/84 15:17:59 ORIG: 'F05 IN= 0004 OUT= 0017
FROM: PAULA/FKS TO: TOM/JNU
TARGET: LJH6 SUBJ: MENTAL HEALTH FACILITY - SEN HESS T/C

OMNI † 3

TO TESTIFY:

- ✓ 18. ~~DIANA CAMPBELL~~
- 19. MARTON WURBOLD

TO OBSERVE:

- 1. JAN WHITE, CAMI, ICC COMMUNITY SVS
 - 2. COLLEEN BOHEN, FAMI
 - 3. JACQUELINE FAGON, FAMI
 - 4. ANNE SPINK, FKS MEMORIAL HOSP
 - 5. RALPH MATHEWS, SELF
 - 6. KATHY WHITZELL, FKS MEMORIAL HOSP
 - 7. TERI LYNN COLEMAN
 - 8. MARY MATHIS
 - 9. DANIEL MATHIS
 - 10. AL AARON, FAMI
 - 11. RANDY BROWN
-

PROFILES OF THE CHILDREN AND YOUTH
PRESENTLY RESIDING IN RESIDENTIAL CARE FACILITIES
OUTSIDE OF ALASKA

March 16, 1984

- Male, 17 years - in custody for six years; abandonment by parents; placement in Alaska failed; character disorder, poor behavioral controls; school unable to control; aggressive and sexual acting out towards women.
- Male, 15 years - long history of residential treatment; conduct disorder, unsocialized aggressive; attention deficit disorder with hyperactivity; mixed specific developmental disorder; mild mental retardation.
- Male, 18 years - delinquent; substance abuser; diagnosed psychotic and requires medication to maintain stability; bizarre ideation.
- Male, 12 years - foster and residential care in Alaska were unable to handle his problems. Hyperactive, injurious to self; bed-wetting; destruction of property; stealing; lying; cruelty to animals; sexual acting out.
- Female, 15 years - major seizure disorder; mild mental retardation; nonaggressive conduct disorder, characterized by chronic running away and extremely poor judgment.
- Female, 12 years - from a family where adult males were alcoholic and violent; sexually abused by grandfather; developed a pattern of lying, stealing, acting out sexually and self-destructive behavior.
- Female, 13 years - six failed foster placements in a year and a half; problems with lying, stealing, fire-setting; chronic runaway; inability to relate to peers or adults.
- Female, 17 years - sexually abused by father; chronic runaway; sexually acting out; suicide and homicide threats.
- Female, 14 years - two institutions in Alaska failed in making any charges; sexual abuse by stepfather; lying; stealing; troubled peer relationships; physically and verbally threatening; depressive; running away.
- Female, 17 years - delinquent, in McLaughlin for 11 months; out of control; alcohol abuse; truant; rebellious; conduct disorder; self-mutilation.

Female, 17 years - physically and verbally assaultive; extreme oppositionalism; stealing; chronic runaway; lying; very poor interpersonal relationships.

Female, 17 years - failed in two Alaska residential placements and in foster home; pathological lying regarding sexual abuse; multiple runaways; severe alcoholism; hostility to authority; acute anxiety and suicidal feelings.

Female, 13 years - sexually molested by father; had two residential placements and four foster home placements in Alaska; uncontrolled behavior; fighting; stealing; running; physical assaults on peers and a suicide attempt.

Male, 15 years - stealing; verbal threats of harm; suicide attempts; chronic runaway; drug abuse; conduct disorder.

Female, 13 years, sister to above - sexually abused by father; drug and alcohol abuse; chronic runaway; sexual acting out.

Male, 15 years - delinquent; theft; tortured a five year old girl with cerebral palsy; pre-psychotic.

Male, 15 years - violent, uncontrolled rages; destruction of property; drug and alcohol abuse; stealing.

Male, 16 years - delinquent; criminal mischief and burglary; emotionally disturbed; chronic substance abuser of gasoline, marijuana and alcohol; assaultive behavior.

Male, 15 years - runaway; fire setter; damaged property; drugs; sexual molestation of young children.

Male, 9 years - violent destructive behavior (destroying property, furniture, defacing walls); incontinent; attacking animals; fighting with other children.

Male, 8 years - fire setting; runaway; stealing; assaultive; hyperactive; probably brain damaged.

Male, 16 years - sexual acting out; stealing; fire setting; danger to others.

Male, 17 years - sexually abused by stepfather; running away; suicide attempts; drug and alcohol abuse.

FAMI
SR Box 30754
Fairbanks, Alaska 99701
452-3733

April 9, 1984

Senator Bettye Fahrenkamp
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Fahrenkamp:

The Fairbanks Alliance for the Mentally Ill (FAMI) supports the concept of a habilitation center, with a living component, for the Northern Region, to be built in Fairbanks. The quiet catastrophe of premature discharge from the Alaska Psychiatric Institute (API) into an unprepared community has created a social disaster. Without basic life support systems, the patient's survival in the community is marginal at best.

The need for long-term treatment exceeds the service capacity of Alaska's mental health system. In concert with this we seek an adequate long-term living facility, the entire concept to be developed toward quality care. Emphasis should be placed on patients' rights and family rights, with families being viewed as an integral part of the treatment process and not as obstacles to effective treatment.

Sitting in meetings on discharge planning at the API one understands the planner's dilemma: too few resources; too fragmented; and worst of all, no part of the system takes ultimate responsibility for discharged patients. That unsought role is assumed by the family, who quickly recognizes the comforting discharge plans bear only an accidental relationship to reality. The present reality of a non-system further discourages the patient into an eventual acceptance of a role as "an outsider".

The following conditions are of unquestioned value in promoting mental health. They constitute the basic components of an effective program.

- 1) A continuum of housing with proper supervision and support.
- 2) A constructive day activity (low-stress job, or training, or a supportive day program.)

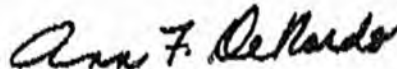
- 3) Medical care
- 4) Crisis intervention
- 5) A social network
- 6) Income
- 7) A core service agency that takes the ultimate responsibility when any of these six components fall apart or when the client has a relapse or disappears from sight.

We view the Greater Fairbanks Community Hospital Foundation's proposal as addressing the need for a core service agency. It should do what parents typically do until they die: be the place where the buck stops; the place that assumes full responsibility when anything goes wrong. It is not a 9 to 5 job. It would mean that once a client comes into their system, the agency retains life-long responsibility for that client. Alumni groups would assure that ex-residents could come back for varying levels of support. Follow-up outreach should be created including, when necessary, a mobile treatment team that carries treatment to the client wherever he/she is.

We would look for the core service agency to work much more closely with families which now are performing the core service role. An effective volunteer program would draw from the community, thus integrating and educating the two communities (facility and public).

With accountability and monitoring procedures built into its program, we view the proposal of the Fairbanks Community Hospital Foundation as a commitment to this ultimate responsibility to the long-term living problems and rehabilitation possibilities of our chronically mentally ill citizens.

Sincerely,



A. F. DeNardo
Chairperson, FAMI

northern alaska health resources association, inc.

March 03, 1984

Mark Boyer, Aide
c/o The Honorable Bettye Fahrenkamp
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Mark:

In accordance with your request, attached is a copy of the material that we have pieced together regarding mental health service needs for the northern region. Although necessarily a very hastily constructed report, the paper represents the consensus of the majority of the mental health service providers in Fairbanks.

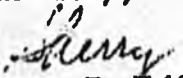
You will notice that the proposed service components are somewhat different from those originally outlined by Fairbanks Memorial Hospital. The experience of the providers indicated that this shift is appropriate. The bed needs by component also reflect the experience and expertise of the service providers, as well as their philosophy of normalization and appropriate treatment modalities.

We are all eager to see appropriate service development in the northern region of the nature outlined here. Everyone has basically three overriding concerns:

1. That services be developed which fit the needs of the people within acceptable treatment modalities and milieus and which do not create an "over-bedded" situation.
2. That maximum coordination occur with existing community programs and facilities to heighten quality and continuity of care while saving operating costs.
3. That the State ensure that long-range operating funds will be available to allow high staff-to-client ratios and other provisions essential to true treatment and rehabilitation (as opposed to custodial) services.

Please call if we can be of further assistance.

Sincerely,


Sherry E. McWhorter
Executive Director

SEM:flr

Enclosure

MENTAL HEALTH TREATMENT NEEDS

I. APPROPRIATE/NECESSARY COMPONENTS FOR THE NORTHERN REGION

A. Children and youth

1. Child guidance center, including family therapy, with inpatient short-term diagnostic capabilities.
2. Acute care/short-stay beds for children (short-stay for children is defined as four months or less).
3. Adolescent residential treatment unit(s).
4. Adolescent transitional care (structured group home).
5. Respite care capabilities.

B. Adults (chronically mentally ill)

1. Transitional supervised care (apartment-type and group home settings), with counseling and rehabilitation services. (Some of these adults may need day treatment and/or sheltered workshop services.)
2. Custodial long-term care with close supervision, medications monitoring, and sheltered workshop.
3. Outpatient services, day treatment, crisis intervention.
4. Respite care capabilities.

II. UNDERLYING PREMISES

- A. To be effective, the facilities must include well-qualified, well-paid staff with high staff-to-client ratios.
- B. Group homes, apartments, and other transitional facilities must be physically separated from any inpatient facility, ideally scattered throughout the community.
- C. The bill (SB 520) or other appropriate mechanism should require the State to develop standards and regulations concerning types and ratios of staff, quality of care, etc. Regulations should include provisions for a broad-based community board and for close interactions with community-based service providers.
- D. Residential services for children and youth must include provisions for schooling and must involve the Fairbanks North Star Borough School District in planning.

- E. Residential facilities for all age groups should include provisions for recreation; however, the programs should not duplicate major community facilities but rather should make maximum use of these facilities (e.g., swimming pools, ice rinks, ball fields, etc.).
- F. Adults, children, and youth should be physically separated from each other.
- G. Acute inpatient services for adults should continue to be housed within Fairbanks Memorial Hospital proper (a 20-bed unit is now under construction in the new tower to replace the existing 11-bed unit).
- H. Operating costs are a major concern. Some provision must be made by the State to cover these costs.

III. PERSONS WHO MIGHT RECEIVE SERVICES AT THE PROPOSED CENTER

- A. Chronically mentally ill adults - persons aged 18 and over with a history of repeated admissions to Alaska Psychiatric Institute or other inpatient settings and who are unable to cope effectively with normal activities of daily living without some degree of supervision because of psychiatric disturbance.
- B. Psychotic children and youth.
- C. Children and adolescents with severe behavior disorders.
- D. Children and youth with severe symptoms who are in need of diagnostic assessments.

IV. BED NEEDS BY TYPE

- A. Children and youth
 1. Child guidance center - beds for diagnostic stays and respite care - 5-bed unit.
 2. Pre-adolescent structured group home or residential treatment unit - 5 beds.
 3. Adolescent facility - 15 beds needed; arrangement of structured group home/residential treatment units to be determined.
- Total - 25 beds, sufficient for average annual occupancy not to exceed 80% through 1990.

B. Chronically mentally ill adults

1. Chronic, custodial care unit with respite care capabilities - 12 beds (assuming 2 reserved for respite care).
2. Transitional care -
supervised group homes - 2 6-bed cottages
supervised apartments - 20 2-bed apartments.
3. Acute hospital unit - to be taken care of through Fairbanks Memorial Hospital's 20-bed unit which is under construction in the new tower.

Total - 64 beds, sufficient for occupancy not to exceed 80% by 1990.

Note: This figure assumes close-out of a separate apartment program by the Fairbanks Community Mental Health Center.

V. RESIDENTIAL FACILITY/TREATMENT BEDS ALREADY IN NORTHERN ALASKA

- | | | |
|---|---|---------|
| A. Fairbanks Community Mental Health Center
Apartment Program | - | 8 beds |
| B. Presbyterian Hospitality House | - | 24 beds |
| C. North Star Children's Home, Dot Lake | - | 8 beds |
| D. Kotzebue Youth Group Home | - | 8 beds |
| E. Fairbanks Memorial Hospital Psychiatric
Unit (under construction) | - | 20 beds |
| F. Fairbanks Youth Facility Detention Center | - | 8 beds |
| G. Fairbanks Youth Facility Treatment Program | - | 12 beds |

VI. AGENCIES/ORGANIZATIONS WHO SHOULD BE INVOLVED IN PLANNING

- A. Fairbanks Community Mental Health Center.
- B. Tanana Chiefs Mental Health Program.
- C. Fairbanks Memorial Hospital.
- D. Fairbanks Rehabilitation Association.
- E. Women in Crisis - Counseling and Assistance.
- F. Resource Center for Parents and Children.

- G. Fairbanks Counseling and Adoption.
- H. Governor's Council for the Handicapped and Gifted.
- I. Northern Alaska Health Resources Association.
- J. Private psychiatrists and psychologists.
- K. University of Alaska Health and Counseling Center.
- L. Alaska Native Health Center, Fairbanks.
- M. Presbyterian Hospitality House.
- N. Fairbanks North Star Borough School District.
- O. Fairbanks Youth Facility Detention Center and Treatment Center.
- P. Juvenile Probation Office, Fourth Judicial District.
- Q. Fairbanks Health Center.
- R. Alaska Division of Family and Youth Services, Northern Region.
- S. Alaska Division of Mental Health and Developmental Disabilities, Northern Region.
- T. Family Focus/Fairbanks Native Association.
- U. Fairbanks Alliance for the Mentally Ill.
- V. Fairbanks Crisis Line.
- W. Fairbanks North Star Borough Department of Parks and Recreation.
- X. Manillaq Association.
- Y. North Slope Borough Health and Social Services Agency.
- Z. McGrath-Anvik Community and Family Services.
- AA. Upper Yukon Behavioral Health, Fort Yukon.
- BB. Tok Area Mental Health Center.
- CC. Yukon Tanana Mental Health Program, Tanana.
- DD. Yukon Koyukuk Mental Health Program, Galena.

POSITION PAPER

Senate Bill 520

"An Act relating to the establishment of a statewide mental health rehabilitation center; and providing for an effective date."

The apparent purpose of Senate Bill 520 is to create the statutory authority for a state-funded and state-operated residential facility for chronically mentally ill adults and children that require a variety of on-going social, educational, vocational, and health services in order to prevent their involuntary hospitalization at Alaska Psychiatric Institute as a result of recurring episodes of acute mental illness. This purpose is certainly commendable and is supported by the Division of Mental Health and Developmental Disabilities in the Department of Health and Social Services.

In developing the position of the Department of Health and Social Services on this bill, it has been necessary to examine its impact on the two categories of targeted patients separately as it is not programmatically possible to mix mentally ill adults with emotionally disturbed children in a way that will prove successful. The first section will be about adult residential care for the chronically mentally ill adult who requires residential care in order to remain free from the need of involuntary psychiatric hospitalization at the Alaska Psychiatric Institute. The second section in this position paper will be about the need for acute/chronic child or adolescent residential care for the emotionally disturbed, conduct disordered, substance abusing, or acting-out juvenile who is either in the custody of the Division of Family and Youth Services as a child in need of aid, or a delinquent child, or at risk of being in their custody as a result of these behaviors. These must be considered separately for purposes of understanding Senate Bill 520 and its potential effects on the Department of Health and Social Services.

Adult Residential Care

The adult residential care component of this proposal for a statewide mental health rehabilitation center is envisioned as a non-acute care facility for the chronically mentally ill adult who would benefit from out-of-home residential care and treatment. This is seen as a resource that would improve the quality of life for this group of persons, as well as possibly reducing the need for their periodic involuntary hospitalization at Alaska Psychiatric Institute as a result of episodes of acute psychiatric illness.

This may be especially effective if the statutes relating to involuntary outpatient commitment under A.S. 47.30.655-915 can be modified to make them more compatible with the need for a reduced standard of dangerousness to self or others for outpatient commitment of the mentally ill. Our experience has shown that by using the same standard for involuntary inpatient and outpatient commitment of the mentally ill, it is not practical to expect a community based, non-secure program to be able to accept and effectively treat the mentally ill persons under involuntary conditions. Frankly, they are simply

too sick to be able to cooperate with their treatment plan in an outpatient setting and present too great a risk of harm to themselves or others under the standard of dangerousness required for involuntary commitment.

By reducing the standard for involuntary outpatient commitment it would be possible to commit certain patients to this facility for residential care and treatment in an environment that is less restrictive than Alaska Psychiatric Institute.

In providing services for the chronically mental ill patient, the degree of illness and resulting danger to self or others varies over time. The amount and type of treatment that we are able to make available to these persons depends on the nature and extent of our statutory authority and the availability of our resources. The greater our ability to monitor and control the behaviors of these patients, the greater the chance of preventing episodes of acute distress and hospitalization.

Additionally, the facility will be available as a residential care center for the chronic mentally ill that voluntarily seeks placement. Such a facility as described in Senate Bill 520 would be capable of providing a comprehensive system of care, treatment, education, and training on a long term basis.

The concept of "community support systems" or "community case management" for the chronic patients is known to be an effective method of serving these patients. This bill would help to fill the extensive gap in that service system and will result in a greatly improved quality of life for the chronic mentally ill person and his family.

Acute/Chronic Child or Adolescent-Residential Care

The facility for the emotionally disturbed children and adolescents would have to be completely separate from the adult residential facility housing the chronically mentally ill. The facility for children and adolescents should be divided into two units. The first should be a short-term unit that would provide intensive mental health care for the acutely mentally ill child or adolescent. The second unit should be a residential or long-term unit for those emotionally disturbed children and adolescents who require a supervised residential/educational program in a structured setting.

The children and adolescents referred to these programs may be in the custody of the Division of Family and Youth Services as a child in need of aid or a delinquent child or they may be referred by their parents or guardian or some other agency such as a school district or court if the youth is involuntarily committed.

The long-term residential capacity of this facility will allow the approximately 40 children and adolescents currently in out-of-state facilities to be returned to Alaska for continued residential care and treatment closer to home. These children and adolescents have been sent out-of-state by the Department of Education for special education purposes and the Division of Family and Youth Services as delinquent children or children in need of aid. Most of these children are suffering from emotional disturbance and

require specialized resources for their care. They would be provided at this facility.

The following description of these children and their treatment is excerpted from the "Management and Treatment Philosophy on the Adolescent Unit" at Alaska Psychiatric Institute:

"Essentially, conduct disorder refers to youth who are acting out in a profound manner. The ordinary healthy and expected rebelliousness of adolescent years has turned to a severity that is obviously dangerous and inherently self and other destructive. The parents and family have lost control of their conduct disordered child in a major and agonizing way. Depression, anger, guilt, and fear have been released and are running rampant in the hearts of both child and parent. Such youngsters are generally using drugs and or alcohol, involved in sexual promiscuity, running away, and criminal behaviors. They are aggressive, violent, angry, frequently assaultive or homicidal, depressed and possibly suicidal. Some are living in the streets. Some are engaged in prostitution or pornography. Sexual molesting and fire setting behaviors are occasionally part of the picture.

Since most of these children are utilizing the defenses of projection, denial, and blaming, and are therefore unable to admit themselves to the hospital on a voluntary basis, the Alaska State mental health commitment law must be instituted in order for the hospital staff to be given the right to contain these youths in a locked setting—a critical component in their care in the initial stages of treatment since running escapist behavior is a keystone of this syndrome. Since these children are either homicidal, suicidal, or gravely disabled or some combination of these, it is not difficult to get a commitment. Nor is it difficult to convince a judge that the child's life was in grave danger, that the parents had lost control, and that the hospital would serve the purpose of temporary parent until the patient had obtained sufficient self knowledge to regain control and therefore security and safety. Indeed, inpatient treatment for behaviorally disordered teenagers represents one of society's last lines of defense against repeated failures of the community to hold youngsters long and safely enough until they can achieve mastery over the conflicts which beset them. Often, children arrive after having lost their place at home, in school, in group and foster care, and their

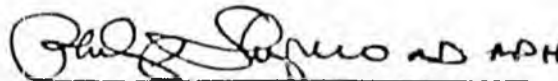
POSITION PAPER
Senate Bill 520
Page 4

choices are limited to hospital, jail, or streets. The first step then in the successful treatment of severe conduct disorder is to confine and contain the child behind a closed locked door. This serves to emphasize to the child and family that the individual is sick and is now a patient in a hospital as with any other severe life threatening illness. This is an important symbolic statement for the physician and treatment team to make as it may not be apparent to the family and patient that conduct disorder or extreme acting out is an illness and that it has a definitive treatment. In the initial interview the child is confronted with this in a clear manner not only with the and patient status in a hospital but with a verbal statement from the treatment team. The patients are told that they are ill, that the illness is severe, and that it is life threatening.

As can be seen from the description noted above, this is a group of disturbed young people that is extremely difficult to manage and treat. This is further complicated if the child or adolescent is not in the legal custody of the Department of Health and Social Services with a court order that authorizes institutional placement. In order for this facility to provide appropriate inpatient and residential care and treatment for periods longer than the 21 days currently allowed under the existing statute on a voluntary basis (A.S. 47.30.690), the law will have to be amended to permit voluntary admission on a longer term basis.

The Department of Health and Social Services supports the passage of Senate Bill 520 with the above noted recommendations.

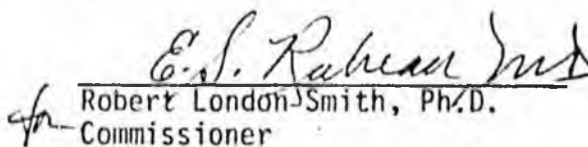
Recommended by:



Philip Shapiro, M.D., Director
Division of Mental Health and
Developmental Disabilities

Date: _____

Approved by:


Robert London-Smith, Ph.D.
Commissioner

Date: _____

March 30, 1984

PROFILES OF THE CHILDREN AND YOUTH
PRESENTLY RESIDING IN RESIDENTIAL CARE FACILITIES
OUTSIDE OF ALASKA

March 16, 1984

- Male, 17 years - in custody for six years; abandonment by parents; placement in Alaska failed; character disorder, poor behavioral controls; school unable to control; aggressive and sexual acting out towards women.
- Male, 15 years - long history of residential treatment; conduct disorder, unsocialized aggressive; attention deficit disorder with hyperactivity; mixed specific developmental disorder; mild mental retardation.
- Male, 18 years - delinquent; substance abuser; diagnosed psychotic and requires medication to maintain stability; bizarre ideation.
- Male, 12 years - foster and residential care in Alaska were unable to handle his problems. Hyperactive, injurious to self; bed-wetting; destruction of property; stealing; lying; cruelty to animals; sexual acting out.
- Female, 15 years - major seizure disorder; mild mental retardation; nonaggressive conduct disorder, characterized by chronic running away and extremely poor judgment.
- Female, 12 years - from a family where adult males were alcoholic and violent; sexually abused by grandfather; developed a pattern of lying, stealing, acting out sexually and self-destructive behavior.
- Female, 13 years - six failed foster placements in a year and a half; problems with lying, stealing, fire-setting; chronic runaway; inability to relate to peers or adults.
- Female, 17 years - sexually abused by father; chronic runaway; sexually acting out; suicide and homicide threats.
- Female, 14 years - two institutions in Alaska failed in making any changes; sexual abuse by stepfather; lying; stealing; troubled peer relationships; physically and verbally threatening; depressive; running away.
- Female, 17 years - delinquent, in McLaughlin for 11 months; out of control; alcohol abuse; truant; rebellious; conduct disorder; self-mutilation.

Female, 17 years - physically and verbally assaultive; extreme oppositionalism; stealing; chronic runaway; lying; very poor interpersonal relationships.

Female, 17 years - failed in two Alaska residential placements and in foster home; pathological lying regarding sexual abuse; multiple runaways; severe alcoholism; hostility to authority; acute anxiety and suicidal feelings.

Female, 13 years - sexually molested by father; had two residential placements and four foster home placements in Alaska; uncontrolled behavior; fighting; stealing; running; physical assaults on peers and a suicide attempt.

Male, 15 years - stealing; verbal threats of harm; suicide attempts; chronic runaway; drug abuse; conduct disorder.

Female, 13 years, sister to above - sexually abused by father; drug and alcohol abuse; chronic runaway; sexual acting out.

Male, 15 years - delinquent; theft; tortured a five year old girl with cerebral palsy; pre-psychotic.

Male, 15 years - violent, uncontrolled rages; destruction of property; drug and alcohol abuse; stealing.

Male, 16 years - delinquent; criminal mischief and burglary; emotionally disturbed; chronic substance abuser of gasoline, marijuana and alcohol; assaultive behavior.

Male, 15 years - runaway; fire setter; damaged property; drugs; sexual molestation of young children.

Male, 9 years - violent destructive behavior (destroying property, furniture, defacing walls); incontinent; attacking animals; fighting with other children.

Male, 8 years - fire setting; runaway; stealing; assaultive; hyperactive; probably brain damaged.

Male, 16 years - sexual acting out; stealing; fire setting; danger to others.

Male, 17 years - sexually abused by stepfather; running away; suicide attempts; drug and alcohol abuse.



The Greater Fairbanks
Community Hospital Foundation

POST OFFICE BOX 1396
FAIRBANKS, ALASKA 99707

April 3, 1984

Dear Senator Fahrenkamp:

Enclosed you will find a proposal which we are submitting for development and implementation of a total continuum of psychiatric care facilities for the interior of Alaska. The first portion of the proposal deals with an adult facility while the second portion of the proposal deals with a separate youth facility. The total cost of the two separate facilities is \$29,891,000.

It is the Greater Fairbanks Community Hospital Foundation's belief that it is totally inappropriate to combine youth and adult psychiatric care into one facility. Psychiatric care is a specialized medical science which deals with a number of different diagnostic categories. In attempting to combine those categories seen in adult patients with those categories seen in youth patients, we believe it is very inappropriate from a patient standpoint. If one looks at model psychiatric facilities throughout the country, they would find that youth psychiatric care is separated from adult psychiatric care because of the different needs presented by each group. We also believe that free-standing adult facilities with inpatient, outpatient, day treatment, apartment living and chronic care can financially stand on its own while a youth facility cannot from an operations standpoint and will have to be funded directly on an ongoing basis by the State of Alaska in order to maintain its operating viability. This operating viability will be discussed further under the youth facility.

We request your serious consideration of this proposal.

Sincerely,

The Greater Fairbanks Community
Hospital Foundation

APR 5 1984

PROPOSAL TO DEVELOP
A COMPREHENSIVE MENTAL HEALTH CENTER
FOR INTERIOR ALASKA

Submitted by

The Greater Fairbanks Community Hospital Foundation

Adult Comprehensive Mental Health Center

For many years the interior region of Alaska has been faced with the problems of developing adequate adult mental health facilities as well as coordinating services offered by numerous agencies serving the mentally ill. This proposal will try to identify and meet the needs of interior Alaska residents as well as providing continuity in mental health services offered in the northern region.

At the current time the following adult mental health services are offered in the Fairbanks area by one and/or more agencies: acute care, chronic care, outpatient care, day treatment program and apartment-type living. None of the programs listed above are connected or have continuity between segments.

The Greater Fairbanks Community Hospital Foundation is proposing to build a facility to house all segments of adult mental health care, including acute care, chronic care, outpatient care, day treatment, emergency screening services and apartment living.

Organization

It is proposed that in order for the Foundation to develop such a comprehensive mental health facility that the Foundation would require a grant from the

State of Alaska. The facility constructed would be owned by the Greater Fairbanks Community Hospital Foundation, a community-based organization currently involved in acute and long-term care in the Fairbanks area. The Foundation would sign a management contract with the Lutheran Hospitals and Homes Society, which currently manages both Fairbanks Memorial Hospital and Denali Center. The Lutheran Hospitals and Homes Society would be responsible to provide the accounting, administration, housekeeping, dietary, laundry and maintenance services for the facility while at the same time hiring a physician/director. The physician/director would be responsible for the adult acute and chronic care performed in the facility. The physician/director would also be a liaison for adult outpatient services offered by the Fairbanks Community Mental Health Center and other agencies which would lease space in the facility.

The purpose of the facility would be to draw together all agencies offering mental health services to interior residents so that a total, comprehensive approach could be taken towards treatment of residents regardless of whether it be acute care, chronic care, outpatient, day treatment or apartment living.

It is expected that once the facility is built Fairbanks Memorial Hospital will give up adult acute mental health care and will move such services to the new facility. It is also expected that Denali Center, which is currently performing adult chronic mental health services, will give up those services and will move those patients to the new center. By accomplishing these transfers, it will relieve both Fairbanks Memorial Hospital and Denali Center of acute overcrowding in addition to providing better services to mental health

patients through a coordination of efforts under one roof.

Organizations such as the Community Mental Health Center, Tanana Chiefs Mental Health Services and other agencies which would participate in the facility would retain their own identity and would only lease space in the facility in order to work towards a goal of developing the continuity of care throughout the system. ✓

The Greater Fairbanks Community Hospital Foundation and the Lutheran Hospitals and Homes Society would attempt to help facilitate the agencies located in community by working closely together for program continuity. It is projected that the facility would be configured in the following manner: (a) 20 acute care psychiatric beds; (b) 20 chronic care psychiatric beds; (c) 20 apartments and (d) 20,000 square feet of outpatient day program space. adult

Capital Funding

The best alternative for funding this project would be through a direct state grant of approximately \$16,533,000. Listed below you will find a construction cost breakdown for the facility by area. At the present time it is projected that 20 acute care beds will require approximately 20,000 square feet and 20 chronic care beds will require approximately 15,000 square feet. It is our understanding that both the acute and chronic units will be required to be built to somewhat higher standards than the remaining parts of the facility. This should not be a significant problem since the facilities can be connected by corridors and/or walkways. It is expected the cost of building the acute and chronic care areas will be approximately \$275 per square foot. In providing for 20,000 square feet of outpatient services,

we are projecting a cost of approximately \$130 per square foot and for the apartments we are projecting a square footage of 600 feet per apartment, or a total of 12,000 square feet. Again, it is estimated the apartment cost will be \$130 per square foot.

<u>Program Description</u>	<u>Square Feet Required</u>	<u>Cost Per Sq. Ft.</u>	<u>Total Cost</u>
20 Acute Care Beds	20,000	\$275	\$ 5,500,000
20 Chronic Beds	15,000	275	4,125,000
Outpatient Services	20,000	130	2,600,000
36 Apartments	21,600	130	2,808,000
Equipment and Furniture			<u>1,500,000</u>
Total	<u>76,600</u>		<u>\$16,533,000</u>

As listed above, the total cost of the facility, including equipment and furniture, will be \$16,533,000. It is projected in order to receive authorization from the State of Alaska to build such a facility, a certificate of need will be required. This has not been accomplished to date and will only be submitted should possible funding be received.

Operational Funding

The ongoing operational expenses of the facility would be funded from the following revenues:

- a. Adult acute care would be funded directly through private patient billings, third party billing or government agency billings for the services rendered.
- b. Adult chronic care would again be funded through patient billings, third-party billings and government billings.
- c. It is expected the apartment living would be funded through

renting apartments to prospective clients for a fixed rate per month.

- d. The outpatient space would be leased out to different community agencies interested in obtaining space in an adult comprehensive mental health center. These agencies would include the Community Mental Health Center, the Tanana Chiefs Mental Health Center, Vocational Rehabilitation, Fairbanks Rehabilitation, Crisis Line, Adult Protective Services and the Resource Center for Parents and Children.

It is projected that through these different operational funding mechanisms the facility would break even given the fact that no debt service would be required on the building.

Children and Adolescent Guidance Center

The Foundation's proposal to develop a separate youth mental health facility primarily comes from the lack of in-state resources for children and adolescents to receive appropriate care. Alaska has historically placed a significant number of children in residential facilities outside of the state. In a report prepared by Criminal Justice Planning Agency in July of 1981, it was noted that prior to 1979 the number of children placed in residential facilities outside of the state numbered nearly 100. Since then there has been a concerted effort to limit out of state placement. However, no new facilities have been developed to care for these children in state.

The majority of Alaska children who are placed in out of state programs have been categorized as severely emotionally disturbed. As of 1981 there were 39 residential facilities in the state; however, only two of those 39 accepted and provided treatment for children who had been diagnosed as severely emotionally disturbed. It is projected that the need for children and adolescents will continue to grow.

Organization

The Greater Fairbanks Community Hospital Foundation is proposing to develop a children and adolescent guidance center. In order to develop such a center the Hospital Foundation would require a grant from the State of Alaska. It is proposed the facility would be owned by the Greater Fairbanks Community Hospital Foundation, which currently is involved in the hospital and long-term care in the Fairbanks area. The Foundation would then have a management contract with the Lutheran Hospitals and Homes Society to provide the

administration, accounting, housekeeping, laundry, dietary and maintenance services for the facility. In addition, a director for the facility would be hired. The director would be responsible for all treatment occurring in the facility. It is imagined that the Foundation would recruit a physician/director who has extensive experience in the treatment of emotionally disturbed children and adolescents.

The purpose of the facility would be to draw all of the youth services together and provide them in a setting which would be conducive for the treatment of the youth in the interior of Alaska. It is expected the patients who are currently treated at Fairbanks Memorial, Denali Center and other places in the state such as API will be possible candidates for this center as well as Alaska residents who are currently being treated out of the state. We believe in order for this center to be successful, it will have to include office space and treatment space for other organizations which deal with emotionally disturbed youth in the community at the present time. Again, it is expected these organizations would retain their identity and would only lease space in the facility. It is projected these agencies would be combined under one roof in order to work towards a more uniform goal in continuity of care for children and adolescents.

It is projected the following services would be included in the facility: five evaluation acute psychiatric beds, ten acute children psychiatric beds and ten adolescent psychiatric beds. The total square footage would amount to approximately 20,000 square feet at \$275 per square foot or approximately \$5,500,000. Thirty residential beds would be provided with a square footage estimate of 15,000 square feet at \$200 per square foot or \$3 million. Also

outpatient day treatment and other services would be provided through lease of office space, with approximately 17,000 square feet available at \$130 per square foot or a total of \$2,210,000. In addition, approximately 12 group homes or apartments would be provided for adolescents under close supervision at approximately 800 square feet per apartment. This would total 9,600 square feet at \$130 per square foot or \$1,248,000. The total equipment for the facility, including furniture, would approximate \$1,400,000 or a total for the facility of \$13,358,000.

	<u>Square Feet</u>	<u>Cost Per Sq. Ft.</u>	<u>Total Cost</u>
Children and Adolescent Guidance Center			
Acute			
5 Evaluation)			
10 Children Treatment Beds)	20,000	\$275	\$ 5,500,000
10 Adolescent Treatment Beds)			
Residential Beds (30 beds)	15,000	200	3,000,000
Outpatient/Day Treatment	17,000	130	2,210,000
Group Homes (12 Apartments)	9,600	130	1,248,000
Equipment and Furniture			<u>1,400,000</u>
Total			<u><u>\$13,358,000</u></u>

It is again projected that in order to receive authorization from the State of Alaska to build such a facility, a certificate of need will be required. This has not been accomplished to date and will only be submitted should possible funding be received.

Operational Funding

The operational expenses of this facility would be primarily funded from a grant from the State of Alaska on an annual basis. Only the following services will be self-funded: (a) space leased to nonprofit agencies in

the community which would be combining their talents to provide a continuum of care; (b) acute treatment services which would be reimbursed through third-party insurance and Medicaid; (c) the remaining residential beds, outpatient day treatment and group homes would require funding from the state.

LEGISLATIVE TELECONFERENCE NETWORK SIGN-IN SHEET

APRIL 11, 1984 _____ DATE
 FAIRBANKS _____ SITE/LOCATION
 SENATE H.E.S.S. CHTE _____ SPONSOR/SUBJECT
 "50520 & 521" MENTAL HEALTH REHAB CENTER

TESTIFIED/PARTICIPATED:

1. TOM MINGEN, FBX HOSPITAL FOUNDATION, 1650 COWLES, FBX AK 99701 #456-2283
2. SHERY BEMHOFER, NO AK HEALTH RESOURCES ASSOC, 529 5TH AVE, FBX 99701 #454-2553
3. DAVE CORY BAKER, 21 MI. RICH HUY, BOX 53459, PO. POLE, AK. 99705 #480-2458
4. MARGA LARSEN, SR BOX 20062, FBX 99701 #479-6958
5. RITA SIFE, ARCTIC ALLIANCE, PO BOX 74711, FBX 99707 #479-7341
6. ALICE SIBBITT, F.H.S.G.SCHOOL, SPEC.ED, PO BOX 1267, FBX 99707 #452-2000
7. RUTH LISTER, WICCA, 702 10TH AVE, FBX AK 99701 #452-2293
8. LESLEY SALISBURY, BOX 90633, COLLEGE, AK 99708 #479-6449
9. STANA CAMPBELL, 1215 KENNICOTT, FBX AK 99701 #456-2914
10. PAULINE BENNET, C.T.R., 3605 ARCTIC BLVD, ANC, AK 99503 #456-6127
11. MARTI CRANOR, FBX C.M.H.C., 209 FORTY MILE AVE, FBX 99701 #452-1575
12. B.J. STALEY, FBX CRISIS CLINIC FOUNDATION, PO BOX 832, FBX 99707 #479-0166
13. KATHY MITCHELL, FBX MEM HOSP, 1450 COWLES, FBX 99701 #452-8181
14. BLANCHE FRANK, R.C.F.C., 809 COLLEGE, AK 99701 #454-2866
15. PHYLLIS VANDERDALE, 141 STEELHEAD, FBX 99701 #479-3271
16. MARTIN MURBOLD, PO BOX 60773, FBX 99701 #452-7603
17. GUY PATTERSON, FAMILY FOCUS, 1531 GILLAM, FBX 99701 #452-3733
18. ANN DENARDO, SR BOX 30754, FBX 99701 #452-3733

UNRECORDED:

1. MARGA SCHWEIDER, AK CHAPTER, NAT'L ASSOC. OF SOCIAL WORKERS, PO BOX 10430, FBX AK 99701 #456-5914
2. M. SARUM, I.A.N.J. MEMBER, PO BOX 74132, FBX 99701 #--
3. PATTY CASTELL, 4099 ANDERSON RD, FBX 99701 #479-5744
4. BOB WHITE, 315 NO CUSHMAN, FBX 99701 #456-4718
5. COLLEEN BOWEN, 1512 1RD AVE, FBX 99701 #452-8644
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8. DAN BEVIE, SR BOX 12352-A, FBX AK 99701 #477-6106
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10. RALPH MATHENS, SR BOX 40575, FBX 99701 #--
11. TERRY LYNN COLEMAN, 214 COLLEGE RD, FBX 99701 #452-6177
12. HARRY MATHIS, SR BOX 70660, FBX AK 99701 #108-6647
13. DANIEL MATHIS, SR BOX 70660, FBX 99701 #108-6647
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15. RUSSELL GUSACK, 375 7TH AVE, FBX 99701 #452-8191
16. LAWRENCE A. ROBLES, 9 MI STEECE, FBX 99701 #456-2976
17. JENNETTE GRASIO, SR BOX 20603, FBX 99701 #455-6212
18. DAVE MAYHE, 201 FIRST AVE, FBX 99701 #452-2446
19. TOM MOYER, CRISIS LINE, PO BOX 832, FBX AK 99707 #452-3733

STATS

18 TESTIFIED/ED
 19 OBSERVE/ED
 37 TOTAL

*****T/C STARTED:-----
 *****T/C ENDED:-----

HEALY VOLUNTEER SITE:

OBSERVED:

1. MARY VAN BLASCOM, RAILBELT MENTAL HEALTH ASSOC, PO BOX 2, HEALY AK #603-2442
2. GALT DURHAM, PO BOX 313, HEALY, AK #603-2777
3. SHELLEY USIBELLI, FBX COMMUNITY MENTAL HEALTH, POUCH 1, HEALY AK 99743
4. RAYMOND GANG, RAILBELT MENTAL HEALTH, BOX 41, HEALY 99743 #603-2651
5. B. MACFARLANE, AK COURT SYSTEM, BOX 12, HEALY, AK 99743 #603-2213

- ...TESTIFIED
- ...OBSERVED
- ...TOTAL

*In Anderson
Charlotte Thicketum testified*

=====EDM

Healy to observe

Person in FDX.

Mary VanBlarcom Walt Durham
Shelly Usibelli

Anderson

Eileen
to speak

Charlotte Thickstun

SOURCE: From Dependence to Independence, Western Interstate Commission on Higher Education, March 1981.

3. NEEDS OF THE CHRONICALLY MENTALLY ILL ADULT: IMPLICATIONS FOR MENTAL HEALTH SERVICES

by

JAMES H. WATERS, Ph.D.
Director, Intensive Treatment Team
Mental Health Center of Boulder County, Inc.

Editor's Preface: The author identifies the basic needs of the adult mentally ill and the psychological deficits which interfere with satisfaction of these needs. Skills and functions of key staff and the necessity for a multidisciplinary team approach to respond adequately to the multiple and divergent needs of the CMI are highlighted.

A thorough analysis of service needs for the adult mentally ill must begin with the awareness that, like the general population, the mentally ill need food, shelter, clothing, money, friends, transportation, medical care, education and recreation (2, 19). As adults, they must be able either independently to obtain these needs or in some way to arrange for others to provide these to them.

FUNDAMENTAL DEFICITS OF THE CHRONICALLY MENTALLY DISABLED

Mental illness characteristically results in a great vulnerability to decompensation under stress to a psychotic state, with severely disturbed thinking, mood and behavior (17, 19). In addition, however, and usually persisting beyond the episode of actual psychosis, serious psychological deficits are found in this population; these deficits markedly impair the abilities of such patients to meet their basic needs or to arrange for others to help them meet them. These deficits can be grouped into five general categories.

Attitudinal and motivational factors

In this population, decreased drive, impersistence and passivity are common, as are dependence (due to a perception of self as helpless (17)),

and resistiveness. Many who are experienced in the care of the adult mentally ill (1, 3; 18, 21) consider such features to be just as much basic characteristics of chronic mental illness, especially schizophrenia, as periods of psychosis. These traits result in a marked withdrawal from and inability to engage society. They also lead to tremendous frustration on the part of society's caregivers and the client's family.

Problems with judgment and impulse control

Reduced ego strength is reflected in imprudence and in impulsive "acting out." Commission of minor "crimes" and social transgressions may lead to contact with the legal system (including incarceration), to social and community rejection, and to the client's wasting of his already scarce resources (especially money) (19, 20, 21).

Impaired social skills

Client's in this population have weak ego boundaries and poor object relations and poor defenses to handle anger, anxiety, sexuality, and losses (3). Impaired empathy is characteristic. Also, these clients have chronic social anxiety (21). These psychological problems lead to marked social skill deficits resulting in social withdrawal or poor social integration, difficulty establishing close personal ties (17) and lack of a stable, enduring social support system (21).

Difficulty obtaining work, poor vocational adjustment, and poor job performance

These patients not only have poor work histories due to interruption of jobs as a result of psychotic decompensation under the stress of work, but they also often have deficits in or inadequate learning of job skills, poor work habits (slowness, especially), and have minimum job-seeking skills. Problems in the vocational sphere, because of our society's emphasis on the work ethic, lead to poor self-esteem and ostracism, to poverty, and to dependence on the (usually inadequate) welfare and disability payment systems.

Severe deficits in, and a limited repertoire of, everyday instrumental or coping skills

Many experts feel it is these deficits, and not psychotic symptoms or episodes per se, that lead either to institutionalization or to poor quality of life outside institutions (2, 6, 18). Problems with grooming, hygiene, health care, house cleaning and maintenance, shopping, budgeting, use of the banking system, cooking, and use of public transportation are a few of the crippling deficits frequently observed (6, 17, 18, 19). In addition these clients tend to be concrete in their thinking (17). Thus, learning and

adjustment obtained in one setting may not carry over to a new one when, as is common, the client's place of residence changes, for instance, as a result of hospitalization or incarceration.

Because of the extensiveness of their needs and the severity of their deficits, certain unique problems arise for the chronically mentally ill adult. In our society, financial, medical, legal, and educational services, for example, are each provided by separate agencies. Hence the client who has multiple service needs must approach and negotiate with many different bureaucratic systems. Community assistance is also needed, including support from "significant others" (2). Yet, because of the territoriality and complexity of the bureaucracies (5), the client may find coordinating these care systems very difficult (e.g., coordinating the welfare, medicaid and medical-care systems to get medical treatment). Lack of social skills and social withdrawal lead to difficulty establishing rapport with and enlisting the assistance of caregivers in these agencies. Therapists and caseworkers "burn out" due to the enormity of these clients' needs, to the limited gains observed and the difficulty forming a stable, comfortable alliance. Poor social skills, impaired judgment, and impulsive acting out may lead not just to lack of community acceptance, but to outright rejection, harassment, or scapegoating. In sum, the chronically mentally ill adult is very poorly equipped to survive in our complex, bureaucratic, demanding society.

SERVICE NEEDS IN THE MENTAL HEALTH SYSTEM

Comprehensive and effective service to the chronically mentally ill adult in the community requires a complex, sophisticated, extensive (and expensive) service delivery network. In what follows, I will outline some essential characteristics of such a network, using the assumption that it would be based in a comprehensive community mental health center. The components of the system can be roughly sorted into three categories: direct psychiatric interventions and psychosocial rehabilitation, case management and consultation, and administrative support. Again, there is some overlap of functions and characteristics between categories. After discussion of the components, some brief comments about the overall structure will follow.

PSYCHIATRIC INTERVENTION AND PSYCHOSOCIAL REHABILITATION

Psychiatric treatment of the chronically mentally disabled adult is supportive and rehabilitative. To this date there is no widely accepted, coherent theory explaining the etiology of schizophrenia or manic depressive illness, nor do we know how to "cure" these illnesses (1, 2, 17). We only know how to improve the symptoms and functioning of those suffering from these conditions. Appropriate goals of psychiatric treatment of the chronically mentally ill include helping the client achieve control over his situation and a feeling of mastery, i.e., symptom control, increased coping and instrumental skills, organization of life, increased responsibility and independence (1, 2, 5, 7, 17, 18).

ASSESSMENT

The treatment process begins with a good assessment. This includes not just formal diagnosis (required for administration of medication (4, 15, 24) and for establishing eligibility for social services assistance (11)); it also includes identification of strengths and weaknesses in the social and instrumental skills areas mentioned above (18).

Psychiatrists and nurses in this setting must be expert in psychopharmacological intervention. The psychochemical armamentarium now includes antipsychotics, anti-depressants, lithium, and stimulants (23). Recent research, however, indicates that discretion in the use of medications is essential because in some cases they may not only be unnecessary but even harmful (4, 13, 14, 15). Detection and management of side effects and of long-term toxicity (e.g., tardive dyskinesia) requires the psychiatrist (and nursing staff) working with the chronically mentally ill adult to be well trained, knowledgeable, and resourceful. They must also update knowledge constantly through reviewing current research and through continuing education. The psychiatrist must also know when and how to use (and when not to use) the hospital (3, 9, 17).

PSYCHOTHERAPY

There is a need for psychotherapy in the treatment of the chronically mentally ill. However, traditional psychotherapy training programs do not prepare therapists well to do the type of work needed. The therapist must understand his clients' pathology and dynamics and realize that the appearance of psychotic symptoms is a result of stress (5, 7, 17, 18). The attitude of the therapist must be hopeful, encouraging and supportive (12, 14, 17, 18, 21). Therapists must be comfortable with clients who are anxious or depressed, and who may show poor control over hostility and sexuality (14, 17, 18, 21). A directive, assertive approach is also necessary to counteract the client's passivity and withdrawal (18). The therapist must not be afraid to give direct advice (5, 7, 18) often thought of as taboo in traditional psychotherapy training. A primary task of the therapist is to support the client's ego functioning and increase reality contact and reality testing (5, 7, 12).

In terms of theoretical outlook, a traditional analytically-oriented approach might be of some value in understanding a client's psychodynamics, but for achieving behavior change a social learning perspective is likely to be more powerful (18, 24). Attention to and intervention in the psychosocial milieu is crucial. The therapist must use principles such as (external) social reinforcement including group support and encouragement, modeling, and coaching to change behavior. Inasmuch as the chronically mentally ill have concrete thinking and learning, interventions will have to be specific and direct. Therapists must be willing to teach basic skills rather than hoping that somehow addressing "underlying" conflicts or illness will result in general, overall improvement.

DIRECT TRAINING

For instance, vocational rehabilitation, which is crucial, requires direct training and skill-building. Clients may start learning work habits and skills in a sheltered workshop. However, as soon as feasible, placement in a regular work setting with special arrangements for continued training, encouragement, and support is advisable. Supervising staff in these placements will need to be familiar with the work to be done themselves so they can assist the clients in performing it (1). Eventually, clients may consolidate their efforts and run a business, reducing the need to work full time, which is often an unrealistic expectation. Special expertise in business management, however, will need to be taught specifically.

Group treatment is useful with this population. Participation in groups increases feelings of affiliation and mutual support, improves social skills and amount of socialization and may increase the likelihood of clients remaining in treatment (4, 13).

In view of the chronicity of deficits in this population, an ongoing, continuous model of treatment is more appropriate than a crisis or episodic model focused on "cure." Many of these clients have a lifelong disability; most follow up studies show that even when a program achieves success in improving clients' psychosocial functioning many of the gains disappear if support and involvement is not continued. Aftercare reduces recidivism (13, 18).

Treatment Settings

Therapists must balance the degree of support provided and dependence allowed against the therapeutic principle of normalization (22). The overall goal in treatment of the chronically mentally ill adult is the decrease of institutionalization (17).

Hospitals

Use of the hospital should be therefore kept to a minimum. Research indicates there is little need for hospitalization if adequate psychosocial alternatives are provided (14, 16). However, clients with organic mental impairment complicating a functional psychosis, or those with medical problems, may need hospitalization. Also, when a closed setting is needed to enforce civil involuntary commitment or to control violent behavior, hospitalization may be needed (3, 17). There is probably a residual population of clients who are not able to be placed out of hospitals due to chronic and severe behavior control deficits (public inappropriate sexuality, self-destructive behavior, aggression) and for these, hospitalization will continue to be needed. Exact numbers are difficult to estimate, but Lamb and Goertzel found fourteen such clients in a catchment area containing half a million people (9).

Use of non-hospital alternatives leads to less need of hospitalization in the future and to better psychosocial functioning. Clients treated without hospitalization are more likely to live independently, to have better jobs and more and better social relationships than matched controls (14, 16, 17).

An effective, responsive crisis intervention program, available twenty-four hours a day, is helpful in reducing need for hospitalization. Also adjustment can take place in the community if crisis work is done on an outreach, home basis, lessening the disruption of social, residential, and vocational ties and overcoming the problem of concreteness of learning (16). Nevertheless, for some clients, placement in a residential treatment facility, especially during psychotic episodes, will be necessary.

Residential Alternatives

Recommendations as to the nature of residential alternatives to inpatient care differ for recovery during acute episodes and for long-term rehabilitation of chronic clients, but in both cases attention to the psychosocial milieu is of paramount importance. Staff should be warm, nurturant, and accepting and convey positive expectations to clients that they will recover and improve (13, 14, 15, 16). For acute clients, however, small size and intensive staffing is important. Staff need to help clients limit their stimulation level. Stays of three to five months can be expected (13).

For long-term improvement chronic clients require a high degree of structure (clear guidelines for conduct, extensive daily plans) and organization and a practical, problem-solving, down-to-earth staff approach. High but realistic expectations for positive, concrete behavior change are important. Even though this may be stressful and the stress may lead at times to some shortlived decompensation and hospitalization, clients given higher expectations will eventually develop better psychosocial functions and will spend less time overall in the hospital (8, 13). A social learning approach is the most useful theoretical framework, and indefinitely long support (although not necessarily long residential placement) is necessary (2, 13, 15, 18). Emphasis on active participation in decision making by staff and clients and on cultivating a sense of autonomy is important (1, 4).

One should encourage "normalization" wherever possible. Clients should be expected to obtain work and seek recreation outside the residential setting as soon as possible and to take meals, sleep, and rise at normal hours (22). Clients should move to unsheltered residences -- not to boarding or nursing homes -- early. Sheltered residences imply a "license to be sick" (17) and discourage independence (8). Teaching of basic skills can be carried out best in a school classroom (6) or in the client's home when the skills to be learned are home skills such as cooking (18). They should not be taught in a community mental health center if other arrangements can be made. Any attempt to avoid a "total institution" atmosphere, where all needs are met in one setting, is positive (4, 17, 22).

CASE MANAGEMENT AND CONSULTATION

As noted above, the chronically mentally ill adult is likely over the course of treatment to require services from multiple agencies outside the mental health center and to be involved with more than one staff member or treatment setting within the mental health center. The task of the case manager is to tie together services to the client both within and outside the mental health center. Intake, assessment, planning, treatment, and referral to outside agencies (for housing, financial assistance, medical care, etc.) should be coordinated and systematically planned to help the client meet his needs and achieve his goals (2). If at all possible the case manager should be the client's therapist. He will need to know the client's pathology, strengths and weaknesses, and dynamics and establish an alliance (5). The case manager must also know other agencies and be able to work cooperatively with them. He must be able to communicate the client's needs, problems and characteristics effectively to these agencies, and provide consultation to them on how to help the mutual client (2, 5). Consultation to the family, including support and education, is essential for those family members must be able to assist their ill relatives who are at times stressful to live with due to their unpredictable, socially embarrassing, sometimes violent, or withdrawn behavior (4, 10, 13). The case manager must know how to impact the criminal justice system so that necessary treatment is continued if incarceration occurs, and so that that system is able to provide meaningful consequences for anti social, irresponsible behavior (18, 20, 21). Considerable effort is sometimes required to avert the legal system's tendency to relieve clients of their responsibilities as citizens by pressing for hospitalization for the mentally ill offenders as an "alternative" to punishment. Clients with high dependency needs (i.e., most clients) will learn to use this tendency to "arrange" hospitalization when feeling stressed, by acting out and getting arrested, if the case manager does not intervene to prevent this (18). Long jail stays for minor transgressions are not being recommended here, but a brief incarceration can increase the client's sense of responsibility.

Case management is at present a rather vaguely defined concept. Hence, other than the brief outline suggested above, it is difficult to define precisely the tasks, let alone the mix of knowledge, skills, and ability required of case managers (2).

ADMINISTRATIVE SUPPORT

Due to the size and complexity of the care delivery system, effective administration is a necessity in the modern mental health center. Of particular importance is a straightforward, informative clinical records-keeping operation to facilitate collection, communication, and availability of information about clients for clinical staff. Second, competent business management is needed to maximize collection of revenue (especially from complex systems such as state governments and Medicaid) and to minimize waste of scarce

financial resources. Finally, as civil commitment proceedings become ever more complex and strongly contested, good legal advice and administrative assistance in carrying out mental health law procedures will be increasingly essential. Mental health systems in the past have relied on the promotion of clinical staff (without administrative expertise or training) to fill administrative positions. This practice will become increasingly less defensible as administrative tasks become more complex and demand special skills and training.

OVERALL STRUCTURE OF THE SYSTEM

It is difficult to conceive of attempting to treat the chronically mentally ill adult in a community setting without using a multidisciplinary, team approach. Clearly, psychiatric expertise, behavioral techniques, knowledge of and ability to teach basic skills, ability to be comfortable with clients, awareness of laws governing treatment, and familiarity with a variety of social agencies will all be required in the case of these clients. In addition, this population is notorious for "burning out" service providers; the responsibilities and needs are great, the frustrations many, and the gains often limited and slow in coming. The multidisciplinary team allows for both pooling of specialties and for sharing of responsibility and frustrations, and for mutual support. The treatment staff of a comprehensive treatment agency will include psychiatrists, psychologists, psychiatric nurses, social workers, trained paraprofessionals, and residential care staff.

The exact nature of the skills, abilities, knowledge, and attitude mix required of particular staff in a given setting will vary according to staff arrangements, and from staff member to staff member, and across disciplines. What is essential is that the treatment team as a whole embody the skills, knowledge, abilities, and attitudes mentioned in the preceding sections. For instance, it is not necessary for the psychiatrist to be a skilled psychotherapist, providing he works closely with a primary therapist/case manager who is and providing the psychiatrist does not undermine the hopeful, directive approach of the therapist. Similarly, residential treatment shift coverage staff do not need to be familiar with the workings of the legal or social security systems, providing the case manager does or has administrative assistants who can deal with these systems. Even the number of clients a given therapist or psychiatrist can serve will vary according to the exact duties expected of the therapists and the abilities of other team members. In addition, training and utilization of volunteers is an important way for staff to increase services to clients. The efforts of non-core agency personnel (teachers, social services and welfare workers, the medical community, law enforcement) to help the chronically mentally ill adult may best be facilitated by vigorous, knowledgeable consultation from core agency personnel.

SUMMARY

The chronically mentally ill adult has difficulty surviving (meeting

basic needs) and achieving a reasonable quality of life outside an institution due to fundamental deficits in social and instrumental coping skills, deficits which persist beyond the period of overt psychosis. Successful treatment of such clients involves long-term supportive, rehabilitative, and training efforts, using the principles of normalization and social learning to structure and intervene in the psychosocial milieu. Hospitalization should rarely be necessary if a multidisciplinary team uses a system that provides appropriately structured social settings including residential care. Case management by a therapist who understands the client's dynamics, strengths and weaknesses and who can organize efforts within the service delivery team and arrange for non-core agencies to supply needed resources, is essential. The need for effective administration is great given the size and complexity of the care delivery system. The exact mix of skills and abilities required of particular staff will depend on the overall staffing patterns; however, the mental health agency as a whole should have the general characteristics described above.

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