

2/17/99

Overview:

Mental

Health

Trust

**HFIN**

**FILE**

## *The bottom line – results*

In establishing budgets, the Board of Trustees looks closely for program and service results. They use a results based budgeting approach that looks for improved services for beneficiaries and cost savings. Trustees also have required a higher than usual level of reporting on projects funded within the General Fund/Mental Health base, including new methods of accountability reporting. This approach ensures cost effective services to improve the lives and circumstances of Trust beneficiaries.

### Trust Authority Board of Trustees

**Nelson G. Page**  
Chair

**John Pugh**  
Vice Chair and chair of the Budget Committee

**Tom Hawkins**  
Secretary and co-chair of the Asset Management Committee

**John Malone**  
Chair of Program and Planning Committee

**Caren Robinson**  
Comprehensive Integrated Mental Health Plan

**Phil A. Younker, Jr.**  
Co chair of the Asset Management Committee

**Susan LaBelle**  
Rural Outreach

## *Small projects funding*

Three times each year The Trust awards small project grants. These are projects solely administered by the Trust Authority and are funded with Trust income. Under the settlement, the Trustees may spend Trust income without a legislative appropriation. This amounts to approximately \$105,000 each year. These grants average \$5,000 each to non government organizations providing grass roots services to beneficiaries.

### Trust Authority Staff

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*The* TRUST

The Alaska Mental Health Trust Authority

## *Funding Alaska's*

# Comprehensive Integrated Mental Health Program

*A guide to the  
Alaska Mental Health  
Trust Authority  
and the legislative  
budget process.*

*The* TRUST

The Alaska Mental Health Trust Authority

## *Who we are and how we came to be*

The Alaska Mental Health Trust Authority (The Trust) occupies a unique niche in state government. The Trust provides leadership in shaping a Comprehensive Integrated Mental Health Program to help the most vulnerable Alaskans. These beneficiaries of The Trust include Alaskans who experience a mental illness; mental retardation or similar disability; Alzheimer's disease or related dementia; or chronic alcoholism with psychosis.

When the Alaska Legislature established The Trust in 1994, it brought an end to more than 10 years of protracted legal battles. At issue was what the state did with land it was given by the federal government in 1956, land that was to have been managed as a public trust for the benefit of mental health programs in Alaska. While the settlement of \$200 million in cash and nearly one million acres of land ended the legal action, it marked just the beginning of a coordinated effort to improve the lives and circumstances of Trust beneficiaries.

## *Our mission and how we operate*

The seven-member Board of Trustees, appointed by the governor subject to legislative confirmation, adopted a vision and mission for The Trust. They are:

*The Alaska Mental Health Trust Authority administers the Mental Health Trust established in perpetuity. It has a fiduciary responsibility to its beneficiaries to enhance and protect the trust and to provide leadership in advocacy, planning, implementing and funding of a comprehensive integrated mental health program to improve the lives and circumstances of its beneficiaries.*

To accomplish its mission, The Trust works in partnership with three boards and a commission, consumers and family members, various state agencies, the Governor's office, the Alaska Legislature, and private non-profit service providers. In shaping the Comprehensive Integrated Mental Health Program, the Trustees review the budget recommendations developed by three governor-appointed boards and a commission that advocate for Trust beneficiaries. They are the:

- Advisory Board on Alcoholism and Drug Abuse
- Alaska Commission on Aging
- Alaska Mental Health Board
- Governor's Council on Disabilities and Special Education

## *The budget process – a separate appropriation bill*

By statute, the Trust each year forwards a capital and operating budget that provides for services to beneficiaries within the Comprehensive Integrated Mental Health Program. Money spent on the program also funds preventive and early intervention services for all Alaskans. This budget is due by Sept. 15th of each year. The statute requires that this budget be identified in a separate appropriation bill each legislative session. If the governor or the legislature changes this budget, they must explain the difference in writing. The governor's budget recommendations are due on Dec. 15th.

The separate appropriation bill for the Comprehensive Integrated Mental Health Program includes several components. They are:

### 1. General Fund/Mental Health Base (GF/MH Base)

This is the amount established by identifying the mental health services funded within the state's general fund budget. The Trustees calculated that amount to be \$108 million for fiscal year 1999. These general funds are designated as general fund/mental health dollars, or GF/MH base. The final budget from the previous fiscal year establishes the GF/MH base.

### 2. Adjustments to the Base

As The Trust and the associated boards and commission further refine the definition of beneficiaries and accurately track funds for the Comprehensive Integrated Mental Health Program, the Trustees suggest adjustments to the base each year.

### 3. GF/MH Increments

When the Trustees identify better and more cost-efficient ways of providing on-going services or providing for unmet needs, they make recommendations in the form of GF/MH increments.

### 4. Mental Health Trust Authority Authorized Receipts (MHTAAR)

The Trustees usually choose to have existing state agencies administer Trust funds, MHTAAR. These state agencies must have legislative approval to receive and spend Trust funds.

### 5. Capital Budget

The separate appropriations bill includes that portion of the state's capital budget that funds mental health projects. This often includes funds from the Alaska Housing Finance Corporation to provide housing for beneficiaries as part of the Comprehensive Integrated Mental Health Program.



# REPRESENTATIVE ELDON MULDER

CO-CHAIR HOUSE FINANCE

ALASKA STATE LEGISLATURE • HOUSE OF REPRESENTATIVES

DISTRICT 23 • MULDOON & FORT RICHARDSON

CAPITOL BUILDING, #507 • JUNEAU, ALASKA 99801 • PHONE (907) 465-2647 • FAX: (907) 465-3518

E-MAIL: REPRESENTATIVE\_ELDON\_MULDER@LEGIS.STATE.AK.US

## MEMORANDUM

**DATE:** FEBRUARY 17, 1999  
**TO:** BUDGET SUBCOMMITTEE CHAIRMEN  
**FROM:** REPRESENTATIVE ELDON MULDER

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### 1. Supplemental Budget Items

Subcommittee Chairs should:

- a. Be responsible for getting information from the department (informally or in a subcommittee meeting) regarding each supplemental request.
- b. Get information and a recommendation from your fiscal analyst.
- c. Ask whether any other division or program within the department can pay for this.
- d. Determine whether the expenditure was extraordinary or whether the department merely exceeded their appropriation (poor management of their appropriation).
- e. Be ready to discuss and ask questions of the department at the Finance Committee meeting within approximately one week.
- e. Be ready to discuss the supplemental requests for your departments at Caucus next week.

### 2. Subcommittee Work-Missions and Measures

1. Goal: Complete drafting of missions of the department and all divisions.

2. Discuss and draft mission statements with commissioners or, at minimum, the Division Directors. (Mission statements should align with the constitutional purpose and enabling statutes of the particular department and division.)
3. Alignment of missions with department mission: If the division's mission does not align with the department's division, consider making a recommendation to move the division to a different department or propose elimination of the division.
4. When your mission statements are completed, prioritize the functions of the department by division. At minimum, identify which functions are life, health, safety related. Make a list of all the life, health, safety functions in the department that would be considered essential services.

### **3. Subcommittee Work-Efficiencies**

1. If you had to eliminate a program or service in your department, tell me which one it would be and why it should go rather than any other program or service in the department.
2. If you had to integrate services or functions in your department or across departments, which one(s) would you integrate.

### **4. Subcommittee Work-Suggestions**

In addition to the analysis you and your staff are performing, please consider the following:

- a. Wherever you see federal money, check to be sure the state is not "overmatching" it. Verify the match rate. If we are overmatching federal funds, consider cutting G.F. to the minimum match amount.
- b. Determine whether the department is missing any opportunity to use federal funds or other funds instead of G.F.
- c. Review the department's data and detail books from past years to determine whether they are being consistent with their figures and estimates.
- d. Ask the commissioner of each department (in an informal setting) whether they will work with you on budget reduction scenarios. Beware the Washington Monument play, but give the departments a chance to be forthcoming by working informally with them.

cc:           Rep. Davies  
              Rep. Grussendorf  
              Rep. Moses

**FY99 / FY00 ALL FUNDS FISCAL SUMMARY**

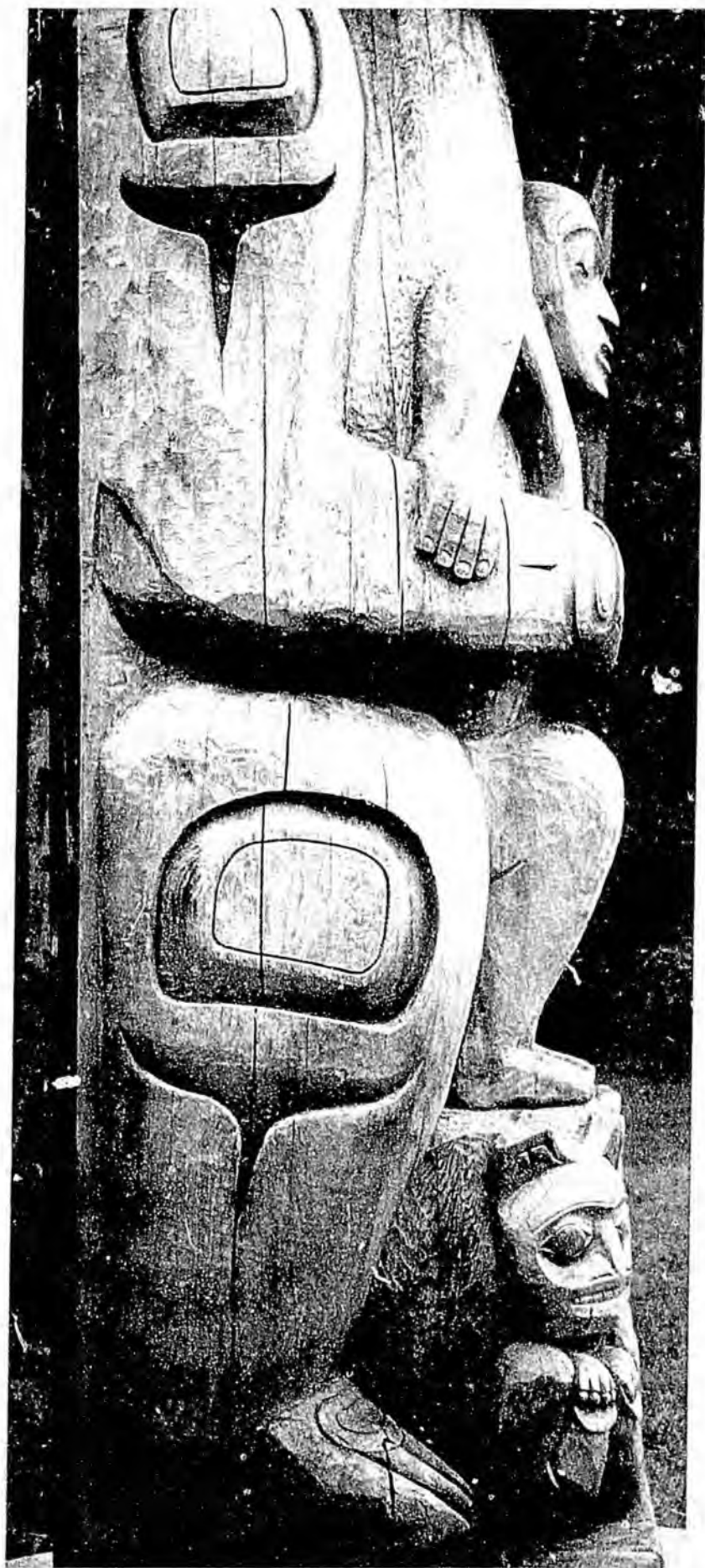
(\$ millions)

	FY99 Authorized				FY00 Governor			
	GF/CBRF/ ILTF	Federal	Other	Total	GF/CBRF/ ILTF	Federal	Other	Total
<b>REVENUES</b>								
Unrestricted GF Fall 98 Forecast Update	1,287.0			1,287.0	1,299.0			1,299.0
Revenue Adjustments	-63.5			-63.5	-17.7			-17.7
AIIDEA Transfer to General Fund	16.0			16.0	0.0			0.0
Federal and Other Funds		1,470.2	2,859.6	4,329.8		1,581.0	2,558.4	4,139.4
<b>TOTAL AVAILABLE</b>	<b>1,239.5</b>	<b>1,470.2</b>	<b>2,859.6</b>	<b>5,569.3</b>	<b>1,281.3</b>	<b>1,581.0</b>	<b>2,558.4</b>	<b>5,420.7</b>
<b>EXPENDITURES</b>								
Operating (1)	2,159.4	864.7	1,001.3	4,025.4	2,232.2	924.6	1,046.4	4,203.3
Agency Operations (Non-Formula)	1,095.0	475.1	844.1	2,414.2	1,144.1	509.0	891.5	2,543.5
Formula Programs	1,064.4	389.6	157.3	1,611.2	1,088.2	416.7	155.0	1,659.8
Debt Service	46.0	0.0	30.7	76.7	5.7		59.9	65.6
Capital including Mental Health	85.4	586.4	530.9	1,202.7	112.9	640.9	185.6	939.4
Loan Fund Capitalization	3.8	19.1		23.0	3.1	15.5		18.6
Special Appropriations & Fund Transfers	17.2		9.4	26.6	16.6		14.0	30.6
Permanent Fund Dividends/Inflation Proofing			1,287.3	1,287.3			1,252.5	1,252.5
Supplementals (2)	16.5			16.5	15.4			15.4
New Legislation (3)								0.0
<b>TOTAL APPROPRIATIONS (4)(5)</b>	<b>2,328.4</b>	<b>1,470.2</b>	<b>2,859.6</b>	<b>6,658.2</b>	<b>2,386.0</b>	<b>1,581.0</b>	<b>2,558.4</b>	<b>6,525.4</b>
Less Duplicated Expenditures			-434.7	-434.7			-484.8	-484.8
<b>UNDUPLICATED EXPENDITURES</b>	<b>2,328.4</b>	<b>1,470.2</b>	<b>2,424.9</b>	<b>6,223.5</b>	<b>2,386.0</b>	<b>1,581.0</b>	<b>2,073.6</b>	<b>6,040.6</b>
From Constitutional Budget Reserve (6)	1,088.9			1,088.9	1,104.7			1,104.7

Revenue Assumptions:	Price \$/BBL	Production MMbd
FY99 Updated Fall 98 Forecast	11.58	1.177
FY00 Updated Fall 98 Forecast	12.50	1.117

**Notes:**

- (1) Shared Taxes and Fishery Enhancement Tax Receipts are not included-these items are off-budget.
- (2) Supplemental figures are estimates. Note that the \$16.5 million estimate of FY99 general fund supplemental needs appears to be unrealistically low. The footnotes to the "Governor's Budget Comparison for FY99 - FY00" state that the administration's estimate of FY99 supplemental needs is \$35 million plus an unspecified amount for the Y2K compliance effort.
- (3) The "Governor's Budget Comparison for FY99-FY00" includes a reduction of \$5.3 million in general funds resulting from the estimated cost of selected pieces of legislation that the Governor intends to sponsor. We will incorporate the costs of the Governor's legislation as it is introduced and fiscal notes are prepared.
- (4) Total appropriation figures do not include RPI.s.
- (5) FY00 total appropriations figures do not include the \$15.0 million in general fund budget reductions reflected in the "Governor's Budget Comparison for FY99 - FY00". We will incorporate those reductions into this document as specific amendments to the budget and/or legislation are proposed.
- (6) Further legislative action will be required to withdraw any amount greater than \$700 million from the CBR for FY99.



# RESULTS WITHIN OUR REACH

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Alaska  
State Plan for  
Alcohol and  
Drug Abuse  
Services

1999-2003

COVER PHOTO

WITH THANKS AND GRATEFUL ACKNOWLEDGEMENT TO  
STAN MARSDEN AND THE PEOPLE OF CRAIG, ALASKA.

THEIR UNIQUE PARTNERSHIP IN CREATING  
THE HEALING HEART TOTEM

OFFERS HOPE AND INSPIRATION TO ALL ALASKANS.

(PHOTO BY ANNE SETIULIZ)

State of Alaska  
ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE  
240 MAIN STREET, SUITE 101  
JUNEAU, AK 99801  
907 465-8920 ♦ 888 464-8920



## Message from the Chair

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DT: January 1999

TO: Fellow Alaskans

FR: Cheryl Mann, Chair  
Advisory Board on Alcoholism and Drug Abuse

RE: Partnerships for a Healthy Alaska

There is no greater foundation for the implementation of this new state plan for delivery of alcohol and drug abuse services than partnerships at the local, regional or state level. You will find the creation of partnerships and the nurturing of new coalitions to be a common thread throughout this plan.

One of the enduring values of partnership development is that frequently more intangible resources are required than funding resources. Commitment, time and sharing of leadership are some of the most vital requirements. When Alaskans give freely of these assets, from themselves and their organizations, we will be able to stretch existing resources and focus new resources on our most urgent needs in the most beneficial and cost effective ways.

The Advisory Board can take great pride in its ground-breaking work in establishing treatment outcomes and raising awareness among providers and allied health professionals. Over the next decade we will continue to firmly embrace our mission to significantly reduce the devastating consequences of substance abuse on individual Alaskans, families and communities.

We invite each of you to find ways in which you can be a partner in achieving that desired result. If we can help you to identify other individuals and organizations that share your concerns please be sure to ask for our assistance.

Advisory Board on Alcoholism and Drug Abuse  
PO Box 110608  
Juneau AK 99811-0608

The Advisory Board's toll free telephone number is 1-888-464-8920. Assistance may also be requested by e.mail to [Anne\\_Schultz@health.state.ak.us](mailto:Anne_Schultz@health.state.ak.us)

## Advisory Board Roster

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As of January 1999, the Advisory Board on Alcoholism and Drug Abuse is composed of the following members, appointed by the Governor:

Cheryl Mann, Anchorage CHAIR

Gerry Kasiak, Ketchikan CHAIR-ELECT

Delfin Lopez, Sterling RECORDER-TREASURER

Sebastian Cowboy, St. Marys

C. Joe DiMatteo, Anchorage, appointed December 1998

Donna R. Galbreath, Fairbanks

Alice Johnstone, Sitka

Loren Jones, Juneau

Anne Kinter, Juneau, appointed December 1998

Banarsi Lal, Fairbanks

Henrietta Nugen, Wasilla

Don Peter, Fort Yukon

Valerie M. Therrien, Fairbanks

Eric Tomasino, Palmer

Cristy Willer Tilden, Dillingham

The Advisory Board acknowledges the contributions made to the strategic planning process by members whose terms expired or who moved from Alaska before the plan was completed: Roseanne Turner, Anchorage; and Suzanne Drapeaux, Juneau.

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## Mission and Guiding Principles

### MISSION

In partnership with the public, the Advisory Board on Alcoholism and Drug Abuse plans and advocates for policies, programs and services that help Alaskans achieve healthy and productive lives, free from the devastating effects of the abuse of alcohol and other substances.



### GUIDING PRINCIPLES

The philosophy of the Advisory Board on Alcoholism and Drug Abuse is to create an environment in which individuals can explore and expand their human potential by recognizing that:

1. Alaskans have the right to seek a life free of the devastating effects of alcohol and substance abuse.
2. The fatal diseases of alcoholism and drug addiction are both preventable and treatable.
3. Sobriety is a positive lifestyle choice for Alaskans.
4. Prevention is as important a public health concern as treatment is.
5. Services must respect personal and community needs in a holistic way that acknowledges cultural and gender differences.
6. Rights and dignity of the client must be respected at all times.
7. Best practice standards must be used by those who provide treatment and prevention services.
8. Success will be measured by improvement in health and well-being and by the elimination of substance abuse and the harm it causes.
9. Partnerships between communities, public and private organizations, families and individuals are the key to success in fulfilling our mission.
10. All decisions and actions must focus on positive impacts on future generations.

## Executive Summary

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**R**esults that will significantly reduce the negative consequences of alcohol use by Alaskans is the focus of **Results Within Our Reach**, the Alaska state plan for alcohol and drug abuse services. The plan covers the years 1999-2003.

A statewide work group with expertise from many disciplines joined the Advisory Board as stakeholders in this planning effort. They brought commitment and urgency to the development of this plan. The group was able to build upon the solid foundation laid in **Meeting the Challenge**, the strategic plan for the Division of Alcoholism and Drug Abuse published in 1994.

This plan reflects the Advisory Board's commitment to results-based service delivery. It incorporates the use of indicators, strategies and performance measures that will help to monitor service delivery effectiveness.

The Advisory Board framed the process by identifying its mission and guiding principles. These emphasize the necessity for public awareness of the scope of the problem, a broad range of partnerships and personal responsibility. To ascertain attitudes of key informants throughout the state, the Advisory Board asked more than 1,000 stakeholders to indicate their level of agreement with statements about alcohol and drug abuse issues. More than fifty percent responded, with remarkably favorable levels of agreement. The Board is confident that this plan is well grounded and reflects community awareness of the scope of the problem it seeks to remedy.

**T**his plan focuses on the overarching result desired for all Alaskans: that they live free from the negative consequences of alcohol and other drug use. It identifies six indicators that will be used to track progress over the coming years. Each is supported by sufficient data collection to calculate trends over time. The Advisory Board looked to staff of the Division of Alcoholism and Drug Abuse for the collaborative development of strategies and performance measures with which to implement the plan. Public testimony was solicited. Eighteen strategies emerged, each with a set of performance measures. The strategies recognize the essential role partnerships play in changing attitudes, behaviors, and community norms. The strategies identify special populations that require greater service capacity, accessibility and intensity. A specific strategy addresses the needs of chronic alcoholics with psychosis, who are beneficiaries of the Alaska Mental Health Trust.

In order to walk the talk that is talked about in the plan, continuous attention must be paid to data development. The Data Agenda section gives a comprehensive review of the benefits and constraints of data collection and spells out the additional

data that will be required in the future. This ongoing data collection effort is imperative if the plan is to achieve its desired level of accountability.

The prevention and treatment strategies identified in the plan will be implemented by the Division of Alcoholism and Drug Abuse, which has responsibility for managing service delivery in Alaska. The Division's Request for Proposals (RFP) process will incorporate strategies implementation into funding allocation decisions. Successful grantees will develop proposals that reflect the Division's guidelines and this plan.

**B**oth the Advisory Board and the Division will work assertively to ensure wide distribution of the plan during the coming months.

The Division will monitor performance measures to assess the level, quality and effectiveness of effort. Over the next several years the Division and the Board will be able to ascertain the effectiveness of selected strategies. This monitoring will guide course corrections during the updating of the plan as the year 2003 approaches.

**E**ach year the Advisory Board will collect the required indicator data to determine the extent to which the strategies have influenced desired results. The Board undertakes this process being mindful that it will be necessary to view data over time before definitively assessing effectiveness over the long term.

The Advisory Board will work with the Department of Health and Social Services, Alaska Mental Health Trust Authority and the Trust's other beneficiary advocacy boards to ensure an effective integration of this plan into the Comprehensive Integrated Mental Health Plan for the state.

## Background

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Strategic planning is an ongoing process. Each phase builds on previous work and lays the foundation for future planning efforts. In 1994, the Alaska Division of Alcoholism and Drug Abuse published a comprehensive strategic plan, Meeting the Challenge: A Strategic Plan for the Division of Alcoholism and Drug Abuse. This plan identified trends in the external environment as well as goals and strategies for the Division in the 1990s.

The 1994 plan focused on four major trends that would affect the Division and service delivery through the end of the decade.

- Level and extent of alcohol, other drug, and inhalant abuse in Alaska;
- Special needs and barriers for specific populations such as rural residents, pregnant women, persons with co-existing mental illness, and women with dependent children;
- Funding sources and restrictions; and
- Increased emphasis on service delivery outcomes.

A series of strategies and goals were developed to address the needs of Alaskans within the context of these trends. As predicted, these trends have played a major role in program development and service delivery in the latter part of the decade. Furthermore, these factors are predicted to play an even greater role in the future.

Of the four major trends, the emphasis on outcomes is a pivotal factor in both program development and funding allocation. In 1996, the Division of Alcoholism and Drug Abuse and the Advisory Board on Alcoholism and Drug Abuse brought together a workgroup to identify desired outcomes for both treatment and prevention efforts. In the Request For Proposals (RFP) issued in 1997, the Division mandated the use of outcome targets along with more traditional process measures. To support this move, standardized outcome measures were developed. They are currently being incorporated into the Division's management information system (MIS).

In 1994, the Mental Health Lands Trust claims were settled after years of litigation. The Alaska Mental Health Trust Authority was formed. Its Trustees are charged by statute with managing the assets of the Trust, and providing resources for services to beneficiaries. Trust beneficiaries are defined as Alaskans who experience one or more of the following:

- a mental illness;
- mental retardation or similar disability;
- Alzheimer's disease or related dementia;
- chronic alcoholism with psychosis.

Four boards are responsible for addressing the needs of these beneficiary groups: the Alaska Mental Health Board, the Governor's Council on Disabilities and Special Education, the Alaska Commission on Aging and the Advisory Board on Alcoholism and Drug Abuse.

The Advisory Board on Alcoholism and Drug Abuse plans and advocates for the needs of chronic alcoholics with psychosis. It also plans and advocates for substance abuse service needs of all Alaskans. To fulfill these responsibilities, the Advisory Board has completed this 12-month strategic planning effort. Many Alaskans have made valuable contributions to the process.

First, the Board invited a group of 25 Alaskans with special interest and expertise in substance abuse issues to participate in the Strategic Planning Work Group. They met initially in September 1997 for orientation to the Advisory Board's guiding principles and mission, and to become acquainted with the results-based model developed by Mark Friedman. Mr. Friedman is a policy consultant to the Alaska Legislature, the Office of Management and Budget, and the Alaska Mental Health Trust Authority. The work group participants are gratefully acknowledged in Appendix A.

To test the assumptions on which to base the revised plan, the Advisory Board sent a fifteen-question survey to more than 1,000 key informants throughout the state. With a response rate of 51%, the results indicated an overwhelming sense that substance abuse, particularly alcoholism, is the most pressing health problem in the state.

The Work Group formed three teams: the Results Team, the Indicators Team, and the Strategies and Performance Measures Team. Over a seven-month period, the teams developed a set of desired results and indicators, each team building on the work of the previous group. In July 1998, the full Advisory Board, Division of Alcoholism and Drug Abuse staff, and other key stakeholders jointly developed strategies and performance measures.

In this manner, the desired results, indicators of their achievement, strategies for success and performance measures were identified. With these key elements in place, sources of reliable data were examined and baseline data collection began. The draft plan was reviewed by the original Work Group in September 1998. Public testimony and comment were received in November and December 1998. This final document reflects the Advisory Board's plan based on those thoughtful and collaborative efforts.

## About this plan...

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This strategic plan will serve a number of purposes over the next four years. Most importantly, it will guide the Advisory Board and the Division in planning efforts to eliminate the negative consequences of alcohol and other drug use. It is the framework for continuing assessment of service needs throughout Alaska. It will help track the extent and quality of our efforts. Finally, it offers strategies that encourage stakeholders, clients, and communities to address issues forthrightly in ways that will achieve and sustain local benefits.

This plan is organized in the following manner:

**The Model.** The model was developed by Mark Friedman, of the Fiscal Policy Institute, Baltimore, Maryland. One of the compelling reasons for using this model is that it is also being used by other State agencies and the Legislature as a method for developing budgets and programs based on desired results.

**Results and Indicators.** Desired results are in this section. The indicators will measure progress toward achieving these results. Each indicator includes a graphic representation of recent trends and the source of the data used to create the chart or graph.

**Strategies and Performance Measures.** The strategies that have been selected to move us toward desired results are in this section. Each strategy includes a series of performance measures that will help chart progress.

**Data Agenda.** Some valuable data are not available. The data agenda identifies desirable data that support existing indicators and data that would support other potentially advantageous indicators.

**Implementation.** This section identifies the four distinct implementation efforts that are required in order for the plan to remain a useful tool over time.

## **Results and Indicators<sup>1</sup>**

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The beginning point for development of the strategic plan for alcohol and drug abuse services is to identify the desired results or outcomes. Appropriate strategies and performance measures flow from those results.

*Results are conditions of well being in individuals, families, and communities,* according to Friedman. Desired results are abstract and not easily measurable. They are also of an enduring nature. They are not expected to change quickly. These desired results will be the focus for the planning and service delivery effort at the state level over a period of years.

*Indicators are markers that give some distinct indication of progress.* These are measures for which data are readily available. While there are many sources and types of available data, only those measures that score high in data power, proxy power, and communication power are used.

*Data power* is an indication of the accuracy, availability, and consistency of data across the diverse regions of the state. It also takes into account the regularity with which the data is collected.

*Proxy power* is an indication of how well the data says something of central importance about the result.

*Communication power* is an indication of how well the indicator is understood by the desired audience. When the indicators are published, decision-makers as well as the general public must be able to make the connection between the results that are desired and the data reported.

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<sup>1</sup> Mark Friedman, Fiscal Policy Institute, Turning the Curve, 1996

## Desired Results

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*Alaskans live free from the negative consequences of alcohol and other drug use.*

The Advisory Board's vision of a healthy, productive, and happy society is one that is free from the negative consequences of alcohol and other drug use. The foundation of this plan rests on the Board's commitment to significant reduction in those negative consequences. The consequences are apparent in per capita consumption, DUI convictions, alcohol or drug related convictions, alcohol-related injuries, 12-hour protective custody holds and the rate of binge or chronic drinking by adults.

### Other desired results:

- *Alaskans are physically, mentally, spiritually, and emotionally healthy and are engaged in health lifestyles to sustain well being.*
- *Alaskans are safe in their homes and communities.*
- *Alaskans achieve their highest possible level of self-sufficiency.*
- *Alaskans live with dignity and respect as valued members of their families and communities.*

## Indicator One

### Per capita consumption of alcohol.

The rate of consumption per person, 14 years and older, based on excise taxes collected at the wholesale level.

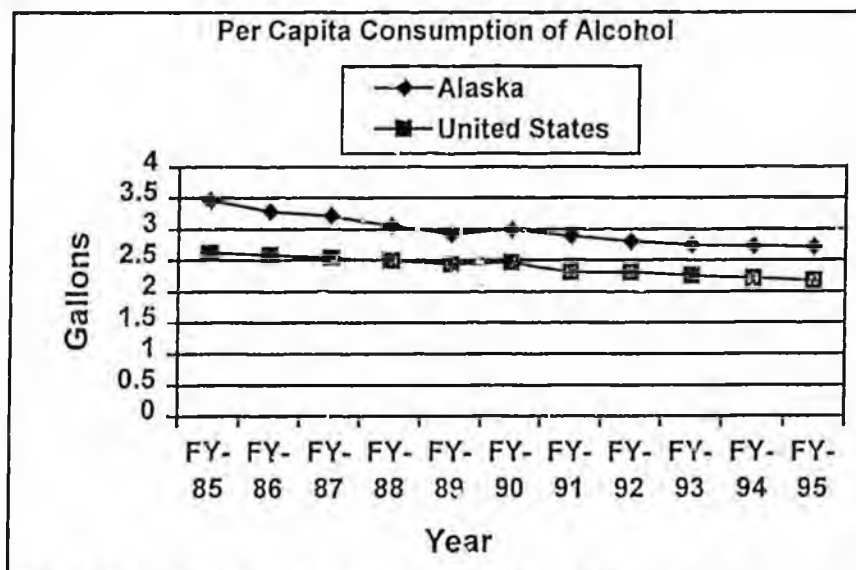


Figure 1 Source: Division of Alcoholism and Drug Abuse

### The story behind the indicator headline...

The prevalence and severity of alcohol-related problems among Alaskans is directly related to the amount of alcohol consumed. The data, as collected, are based on total alcohol purchased at the wholesale level and the number of Alaskans who are 14 years of age and older. If this number were adjusted downward to remove those who completely abstain from alcohol, then per capita consumption would be greater. Although the figure for Alaska is higher than the national average, both sets of data indicate that consumption is decreasing. The population data does not acknowledge the state's significant visitor population. The consumption decrease by Alaska residents may be even greater than shown. The strategies that impact this indicator most readily are those that address public policy issues such as the number of licensed outlets and their hours of operation.

## Indicator Two

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### Number of convictions for Driving Under the Influence of alcohol (DUI).

The number of convictions in state district and superior courts on charges of driving while under the influence of alcohol.

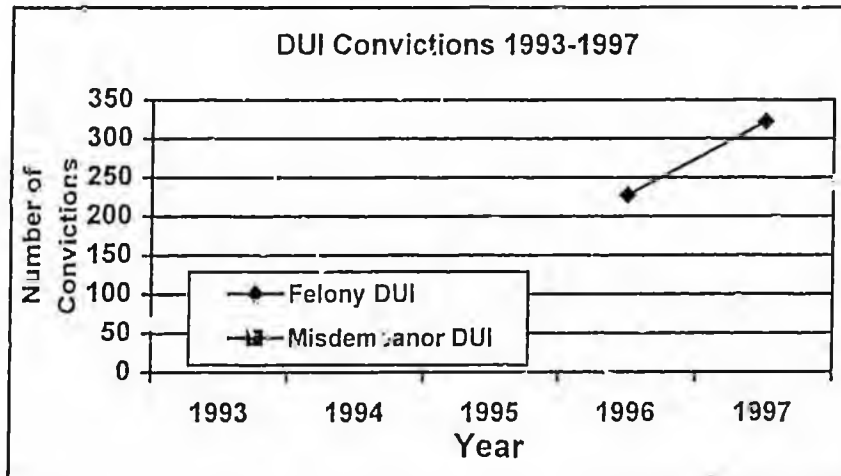


Figure 2 Source: Alaska Court System

### The story behind the indicator headline...

Driving while under the influence of alcohol is one of the strongest indicators of the negative consequences associated with alcohol misuse. Data for 1997 show that 30 percent of all automobile accident fatalities had alcohol or drugs as the major contributing factor<sup>2</sup>. There are many variables that impact this data, including enforcement effort and prosecutor case loads. The data correlate with successful prevention efforts, particularly in terms of public awareness of the consequences of Driving Under the Influence (DUI). Driving under the influence of alcohol impacts lives, not only in accidents, injuries, and deaths, but also in family suffering, employment problems, and social functioning. Persons convicted of DUI also represent one of our most well defined target populations: individuals whose use of alcohol has directly caused negative consequences. DUI convictions are categorized by both felony and misdemeanor offenses.

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<sup>2</sup> Alaska Department of Transportation and Public Facilities, 1997 Alaska Traffic Accidents, July 1998

## Indicator Three

Number of state criminal convictions on alcohol or drug-related charges.

The number of convictions on charges which include possession or distribution of drugs, misconduct involving alcohol or other drugs, and failure to take a breath test. The indicators are based on data published by the state court system and do not include arrest data that does not result in convictions.

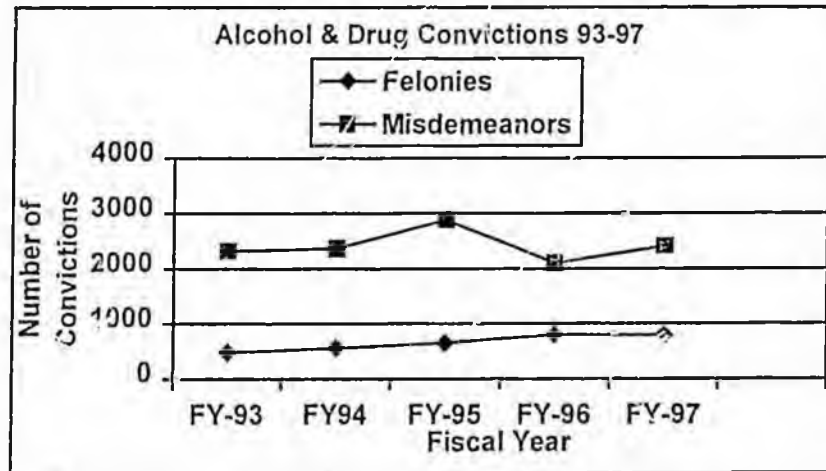


Figure 3 Source: Alaska Court System

The story behind the indicator headline...

Convictions for drug and alcohol-related offenses, like DUI convictions, offer a clear picture of the negative consequences of use of alcohol and other drugs. Between fiscal years 1993 and 1997, felony convictions increased from 478 to 791. Misdemeanors have varied but show no clear increase or decrease trends. There are a number of factors that may impact this indicator including State Trooper and local police department enforcement, changes in laws, and prosecution efforts. Intervention and treatment services play a major role in decreasing the amount of alcohol and drug-related crime. Collaborative efforts have demonstrated that early intervention and appropriate, timely treatment for offenders can reduce the number of alcohol and drug-related crimes.

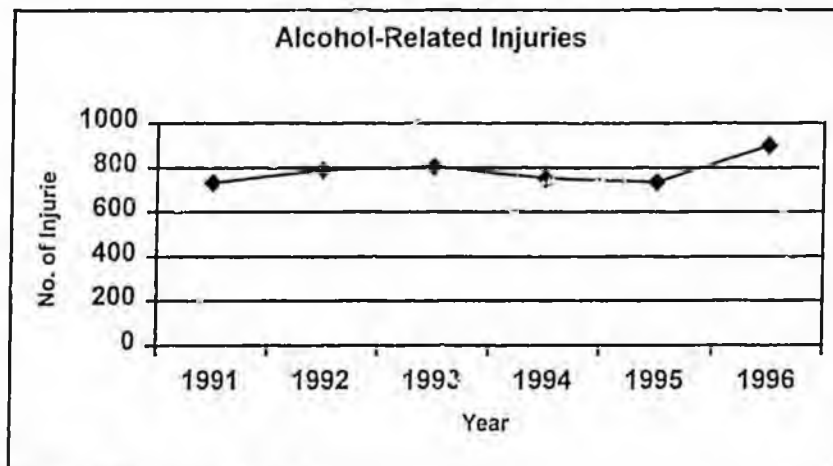
## Indicator Four

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### Alcohol-related injuries requiring hospitalization.

Injuries treated in a hospital for which alcohol was determined to be a contributing factor.

Figure 4



Source: Alaska Trauma Registry

### The story behind the indicator headline...

Injuries involving the use of alcohol represent a significant and costly negative consequence. The Alaska Trauma Registry, which collects information from every hospital in the state, tracks all injuries requiring hospitalization. It has special fields within its database to indicate the involvement of alcohol. The number of injuries seemed to peak in 1993 and start a downward trend. However, the number of injuries in 1996 showed a sharp increase. These injuries typically involve young people. They affect the injured individuals, families, and sometimes entire villages. They require the most expensive level of medical care: that provided in an emergency department or trauma center. The efforts that are most likely to impact this indicator are those which seek to restrict access to alcohol or other drugs through public policy advocacy. A recent study indicated that Alaska Natives living in "wet" villages were almost three times more likely to die from an alcohol-related injury than those living in "dry" villages<sup>3</sup>. Early intervention and treatment services have also been shown to have a positive impact on this indicator.

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<sup>3</sup> Alaska Child Protection Review Team, Report to the Governor, 1997

## Indicator Five

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The number of 12-hour protective custody holds.

The number of alcohol-incapacitated persons held in protective custody for up to 12 hours at State correctional facilities or community jails.

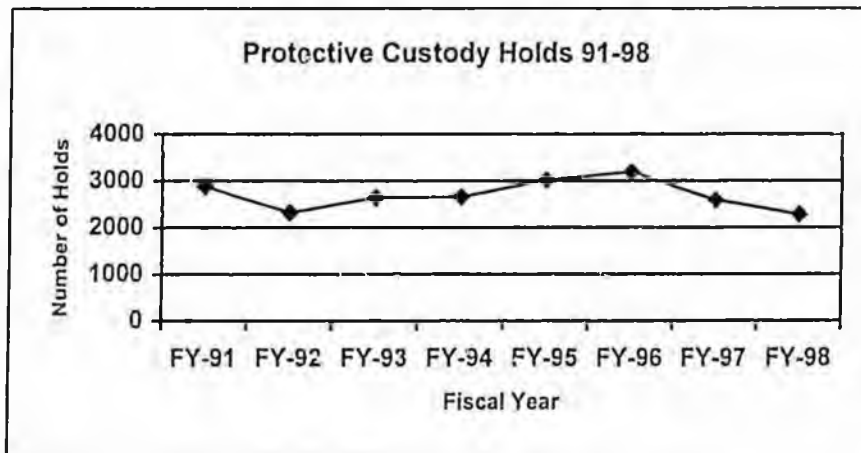


Figure 5 Source: Alaska Department of Corrections

### The story behind the indicator headline...

Alaska Statute 47.37 provides that persons incapacitated by alcohol may be taken into custody in order to protect them and others from the negative consequences of their incapacitation. If suitable detoxification facilities are not available, they are taken to Department of Corrections facilities. They are held until protective custody is no longer necessary or up to twelve hours. As treatment programs work with communities to provide more appropriate services and timely interventions, the number of protective custody holds decreases. During 1995 and 1996, the Division of Alcoholism and Drug Abuse began to place more emphasis on early intervention for late stage, chronic alcoholics. This is the population most likely to require protective custody. Additional resources for detoxification have expanded community response. As a result, the number of protective custody holds has begun to decrease. During this period, the Advisory Board conducted training on the use of involuntary commitment of persons whose alcoholism is life-threatening. Community partnerships, resource expansion and community training in involuntary commitment procedures are contributing to the reduction in 12-hour protective custody holds.

## Indicator Six

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The rate of binge or chronic drinking by adults.

The percentage of Alaskans who self report acute or binge drinking in response to the annual Behavior Risk Factor Survey.

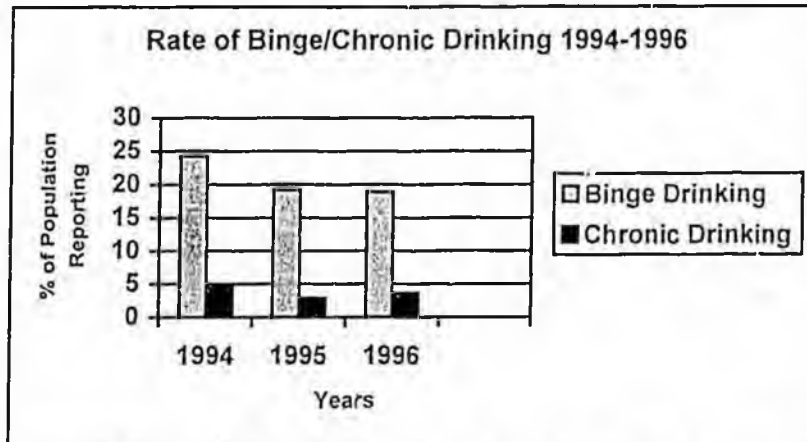


Figure 6 Source: Alaska Behavioral Risk Factor Surveillance System

### The story behind the indicator headline...

Each year, the State of Alaska conducts a telephone survey to obtain information on behavioral risks prevalent among Alaskans. The interviews are conducted with a random sample of 1,535 residents, 18 years of age or older. One of the categories is the percentage of population engaged in binge or chronic drinking. **Binge drinking**, for purposes of this survey, refers to drinking five or more drinks on one occasion, at least once in the month preceding the survey. **Chronic drinking** refers to drinking an average of 60 or more alcoholic drinks in the month preceding the survey. There is a high correlation between these drinking patterns and many of the negative consequences associated with alcohol abuse – particularly medical, family, and employment problems. The strategies that will have the most immediate impact on this indicator will be those that provide intervention and treatment services to chronic, late stage alcoholics. Early intervention services are also required to impact individuals whose disease progression has not reached the point of chronic or binge drinking.

Three sets of strategies converge to drive the plan's implementation. No single strategy is most important. The overarching focus is on partnerships, both community-based and statewide. Partnerships play a key role in the delivery of both prevention and treatment services. There is a major commitment to decreasing the negative consequences of alcohol and drug abuse by ensuring access to the appropriate range of quality treatment services for all Alaskans who need them. Additionally, we know that multiple strategies consistently targeting various populations over periods of time are more effective than strategies with a single focus.

## Strategy One

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Support community-based processes that build partnerships and provide more effective prevention and treatment services.

### What this means...

Partnerships and collaboration are the keys to success in achieving desired results. If partnerships and collaboration are to become more than lofty goals, then communities must provide processes that nurture them. These processes include needs assessments, planning for services, integrated activities, and broad-based evaluation. Programs and activities must be relevant to the particular community. They must be conducted in a manner that respects community norms and values.

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### How will we measure our performance?

- |                               |                                                 |
|-------------------------------|-------------------------------------------------|
| <u>Performance Measure 1:</u> | Number of agencies and groups participating.    |
| <u>Performance Measure 2:</u> | Extent of participation in effort.              |
| <u>Performance Measure 3:</u> | Number of new initiatives.                      |
| <u>Performance Measure 4:</u> | Percentage change in desired community results. |

## Strategy Two

---

Encourage activities and initiatives that will change community standards and emphasize healthy lifestyles.

### What this means...

Community behaviors and activities usually reflect local standards and attitudes. These are "unwritten rules" that define what is appropriate or tolerable. Shaping these norms and values is an evolutionary process. One of the most familiar results of such a strategy is the decline in tolerance for driving under the influence of alcohol. Mothers against Drunk Drivers (MADD) started out as a small local advocacy group. Thousands of local initiatives have brought about sustained positive change because of MADD's vision and persistence. The Advisory Board will support and nurture programs that seek to influence the standards and attitudes of communities by encouraging and promoting sobriety as a healthy lifestyle choice.

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### How will we measure our performance?

- |                               |                                                                                 |
|-------------------------------|---------------------------------------------------------------------------------|
| <u>Performance Measure 1:</u> | Number of agencies, groups, and individuals involved in proactive partnerships. |
| <u>Performance Measure 2:</u> | Extent of participation in effort.                                              |
| <u>Performance Measure 3:</u> | Number of new initiatives and diversity of support.                             |
| <u>Performance Measure 4:</u> | Percentage change in desired community results                                  |

## Strategy Three

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Distribute useful and effective information to targeted populations.

### What this means...

The Advisory Board will encourage distribution of accurate and relevant information to help policy makers, individuals, families, and communities make wise decisions. All available research indicates that for information to be effective its message must address a specific audience. It must be relevant for particular age groups and cultures. It must be developed with a clear understanding of the desired response. Examples of this strategy are distribution of new research findings and outcome information to policy makers, promotion and advertising of available treatment services, and public information campaigns targeted to women of childbearing age.

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### How will we measure our performance?

<u>Performance Measure 1:</u>	Quantity of material developed and/or distributed.
<u>Performance Measure 2:</u>	Quality of material for a particular target audience.
<u>Performance Measure 3:</u>	Number of target group members reached.
<u>Performance Measure 4:</u>	Percent of target group with increased awareness.

## Strategy Four

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Promote the benefits of treatment, recovery, and sober lifestyle.

### What this means...

Despite best efforts and positive outcomes for treatment services, members of the general public often have negative attitudes about the value and appropriateness of chemical dependency treatment. The Advisory Board will support efforts and strategies that raise public awareness of the positive benefits of chemical dependency treatment, recovery, and a life of sobriety. The Board will work to eliminate stigma and denial. Examples of these strategies include program alumni organizations, public awareness campaigns, and advocacy for recognition of the contribution the sober lifestyle makes to the welfare of all Alaskans.

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### How will we measure our performance?

- |                               |                                                                                                                      |
|-------------------------------|----------------------------------------------------------------------------------------------------------------------|
| <u>Performance Measure 1:</u> | Number of self-referrals.                                                                                            |
| <u>Performance Measure 2:</u> | Increased number of advocacy groups.                                                                                 |
| <u>Performance Measure 3:</u> | Cost-benefit data.                                                                                                   |
| <u>Performance Measure 4:</u> | Positive benefits of treatment –<br>in life domain areas of health,<br>family, self-sufficiency, and transportation. |

## Strategy Five

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Encourage traditional and alternative social activities that are alcohol and drug free.

### What this means...

Alaskans are frequently encouraged to consume alcohol and other substances at social, athletic and other community events. In addition to providing safer and healthier alternatives for youth, alcohol and drug free activities can also help redefine community norms and values to those that support sobriety. The Advisory Board will support efforts that offer organized alcohol-free and drug-free activities involving a broad spectrum of the community.

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### How will we measure our performance?

<u>Performance Measure 1:</u>	Number of alternative activities developed and delivered.
<u>Performance Measure 2:</u>	Percent of target population participating.
<u>Performance Measure 3:</u>	Number of target group involved in planning and implementation.
<u>Performance Measure 4:</u>	Percent of activities initiated and/or led by target group.

## Strategy Six

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Advocate for positive change through legal and regulatory initiatives.

What this means...

All available research points to the conclusion that public policy decisions regarding alcohol and other substances have a major impact on the prevalence and severity of substance abuse problems in communities. Examples of such policy decisions are raising the minimum legal drinking age to 21 and lowering blood alcohol legal limits for drivers. Other legal and regulatory initiatives include limiting bar and tavern hours, restricting the number of alcoholic beverage outlets in an area, supporting enforcement of existing laws, and consistent consequences for youth who engage in use of alcohol or other drugs. A less obvious benefit of these strategies is the positive impact on community norms and values. As these initiatives impact public policy decisions, communities become more aware of the negative consequences associated with alcohol and drug abuse.

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How will we measure our performance?

- |                               |                                                                                                        |
|-------------------------------|--------------------------------------------------------------------------------------------------------|
| <u>Performance Measure 1:</u> | Number of initiatives introduced as legislation or local ordinances.                                   |
| <u>Performance Measure 2:</u> | Variety of responses that indicate support, such as public opinion messages, letters, telephone calls. |
| <u>Performance Measure 3:</u> | Number of such initiatives passed.                                                                     |
| <u>Performance Measure 4:</u> | Percentage change in desired community results.                                                        |

## Strategy Seven

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Ensure the delivery of quality services by offering appropriate continuing education and training for chemical dependency treatment professionals.

### What this means...

High quality service delivery depends on recruitment and retention of well-qualified treatment professionals. The Advisory Board will support funding for training programs, a statewide training coordination agency, programs which provide training components, and annual training events. The Board will support the certification process for chemical dependency professionals to ensure that persons providing services hold the highest qualifications. The Board will also support an accreditation process for programs which mandates high levels of qualification for professional staff.

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### How will we measure our performance?

<u>Performance Measure 1:</u>	Increase in the number of certified counselors in Alaska.
<u>Performance Measure 2:</u>	Increase in the number of certified counselors working in the field.
<u>Performance Measure 3:</u>	Salaries for chemical dependency professionals that are comparable to others performing comparable work.
<u>Performance Measure 4:</u>	Reduction in rate of staff turnover.
<u>Performance Measure 5:</u>	Increase in staff training opportunities.
<u>Performance Measure 6:</u>	Greater collaboration with post-secondary and other training systems.

## Strategy Eight

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Expand awareness of substance abuse issues for allied health professionals, educators and other helping agents.

### What this means...

If related service or education providers are to deliver consistent, appropriate, and accurate information to target populations, they must first receive the most recent factual information. Programs to implement this strategy range from an organized regimen of in-service training to carefully designed formal course curricula for professionals. With a strong emphasis on collaboration, it is critical to consider a wide diversity of professionals including

- medical staff and other health care professionals;
- domestic violence advocates;
- educators, teachers and aides
- mental health professionals;
- senior services providers;
- disability services providers;
- public assistance caseworkers and employment specialists
- juvenile and adult corrections staff;
- family service workers.

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### How will we measure our performance?

<u>Performance Measure 1:</u>	Number of target group participating in training.
<u>Performance Measure 2:</u>	Percentage of target group completing training.
<u>Performance Measure 3:</u>	Number of target group showing increased knowledge and awareness.
<u>Performance Measure 4:</u>	Percent of target group positively impacted as shown by pre/post tests.

## Strategy Nine

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Use education strategies to help youth improve critical life and social skills.

### What this means...

Research indicates that development of life and social skills is more effective than didactic drug and alcohol education in helping young people avoid high risk behaviors. The Advisory Board will support programs that offer education and skill-building activities targeted to youth. These programs will help youth make appropriate decisions and avoid activities and behaviors with negative consequences. Multiple strategies that are age, culture, and gender specific are more effective than single, broad strategies. The education, information and messages targeted at youth must evolve with them as they mature.

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### How will we measure our performance?

<u>Performance Measure 1:</u>	Number of target group participating.
<u>Performance Measure 2:</u>	Number of target group completing.
<u>Performance Measure 3:</u>	Number of target group showing positive change or decrease in risk factors/increase in protective factors.
<u>Performance Measure 4:</u>	Percent of target group learning new skills, as shown by pre/post tests.

## Strategy Ten

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Identify people with problems as early as possible and refer them for appropriate services.

### What this means...

This strategy is based on the premise that early problem identification and prompt action greatly enhances the likelihood of successful intervention. Programs that support this strategy would be located within organizations and agencies that are most likely to contact "at-risk" individuals at an early stage. Examples are schools, places of employment, and family and youth services. In these programs, individuals who are identified as "at-risk" for developing problems, or are engaging in behaviors that produce negative consequences, will be assessed and referred for appropriate services.

---

### How will we measure our performance?

<u>Performance Measure 1:</u>	Number of at-risk individuals identified.
<u>Performance Measure 2:</u>	Percent of target group contacted.
<u>Performance Measure 3:</u>	Number of appropriate referrals made.

## Strategy Eleven

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Improve interdisciplinary coordination and collaboration at local, regional and statewide levels.

### What that means...

Substance abuse professionals have a great stake in early problem identification. They recognize that they are usually not in the best position to identify these problems and intervene early. They depend on the abilities and collaboration of community members, helping agents, and other professionals to recognize the behaviors and symptoms and make prompt appropriate referrals. The Advisory Board will support efforts that foster collaboration among the various groups of professionals and programs in communities. These efforts will lead to earlier intervention and more appropriate treatment plans for clients.

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### How will we measure our performance?

<u>Performance Measure 1:</u>	Increase in number of referrals to and from providers.
<u>Performance Measure 2:</u>	Increase in number of referral services to and from providers.
<u>Performance Measure 3:</u>	Referral sources report improved outcomes.

## Strategy Twelve

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Support a continuum of care for chronic alcoholics with psychosis that focuses on intervention, treatment and the client's long term life domain requirements.

### What that means...

Chronic alcoholics with psychosis are beneficiaries of the Alaska Mental Health Trust, established in Alaska Statute 47.30.056(b)(3). The Advisory Board on Alcoholism and Drug Abuse has a special responsibility to this group, described in AS 44.29.140. The Advisory Board must provide the Alaska Mental Health Trust Authority with specific recommendations to ensure that the service needs of chronic alcoholics with psychosis are met.

Chronic alcoholism is a problem that pervades every part of Alaskan life. It places an excessive burden on scarce medical, legal and public safety resources. Use of alcohol by chronic alcoholics with psychosis destroys their physical health and emotional and spiritual well-being. It seriously damages family and community life. This population has traditionally been underserved by health and social service agencies. The state has both a legal and moral responsibility to provide comprehensive and coordinated services for this population. These services must be delivered with respect for clients and their families, in a manner that ensures positive, measurable results.

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### How will we measure our performance?

- |                               |                                                                                                                                    |
|-------------------------------|------------------------------------------------------------------------------------------------------------------------------------|
| <u>Performance Measure 1:</u> | Increase in treatment capacity and services for chronic alcoholics with psychosis.                                                 |
| <u>Performance Measure 2:</u> | Increase in admissions to treatment for chronic alcoholics with psychosis.                                                         |
| <u>Performance Measure 3:</u> | Improved treatment retention and outcomes for chronic alcoholics with psychosis.                                                   |
| <u>Performance Measure 4:</u> | Increased availability of long term support services in life domain areas of health, housing, transportation and self-sufficiency. |

## Strategy Thirteen

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Develop sufficient resources to meet community needs for appropriate levels of treatment for adults, youth and special populations.

### What that means...

It is not possible to deliver every service component in every community. However, it is possible to have access to all components in a full continuum of care. Effective service delivery at the community level is determined by problem prevalence, demand, and service utilization. Examples of this strategy include establishment of detoxification facilities in hub communities, strategic placement of long term and domiciliary care facilities around the state, and development of special programs such as inhalant abuse treatment where appropriate. It is also critical that all providers understand the entire service delivery system and utilize the available resources in the best interests of clients and their families.

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### How will we measure our performance?

Performance Measure 1:

Increase in new services developed where needed.

Performance Measure 2:

Increase in number of communities seeking additional resources or services (financial or otherwise) using innovative approaches.

## Strategy Fourteen

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Identify and remove barriers that prevent clients from entering treatment.

What this means...

While some people are unwilling to seek treatment, many barriers prevent others from receiving the services that they want and need. Some of these barriers are present for all clients, such as waiting lists and financial resources. Other barriers reflect the lack of programs to address the needs of special populations. The Advisory Board will support those programs that implement strategies designed to remove barriers for those seeking treatment. Examples of these efforts include streamlined intake procedures, increased capacity based on prevalence and demand, and special programs where indicated.

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How will we measure our performance?

Performance Measure 1:

Improved access, as reported in client satisfaction surveys.

Performance Measure 2:

Decreased time between first contact and admission to treatment.

Performance Measure 3:

Capacity to ensure that everyone who asks for treatment receives it.

Performance Measure 4:

Increased number of client admissions.

## Strategy Fifteen

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Support community efforts to establish involuntary commitment procedures and to use them when appropriate.

### What this means...

For a small number of chemically dependent persons, timely and intensive services are necessary in order to prevent death. For this special population, involuntary commitment to treatment is the only remaining alternative. In order to use the involuntary commitment procedures defined by Alaska Statute 47.37, communities need to work together in collaborative partnerships. The Advisory Board will continue to support community efforts to organize and develop local plans and procedures for initiating involuntary commitments. These efforts include community training, funding for legal assistance, travel and transportation assistance, and technical assistance.

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### How will we measure our performance?

- |                               |                                                                                        |
|-------------------------------|----------------------------------------------------------------------------------------|
| <u>Performance Measure 1:</u> | Increased number of involuntary commitments.                                           |
| <u>Performance Measure 2:</u> | Improved treatment outcomes for those committed involuntarily.                         |
| <u>Performance Measure 3:</u> | Increased number of communities using involuntary commitment procedure when necessary. |
| <u>Performance Measure 4:</u> | Measurable reduction in inappropriate emergency services for public inebriates.        |
| <u>Performance Measure 5:</u> | Reduction in number of 12-hour protective custody holds.                               |

## Strategy Sixteen

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Provide appropriate services for underserved Alaskans.

What that means...

There are a wide variety of programs that address the chemical dependency treatment needs of Alaskans. However, a substantial number of special populations are not adequately served. These groups include:

- Alaska Natives;
- youth;
- women with children;
- seniors;
- dually-diagnosed clients;
- clients with disabilities.

Treatment success with these populations depends on program design uniquely appropriate to their needs. Examples of such programs include special services for poly-diagnosed clients, special programs for women with children, and Alaska Natives.

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How will we measure our performance?

<u>Performance Measure 1:</u>	Increased capacity for underserved Alaskans.
<u>Performance Measure 2:</u>	Increased admissions of underserved Alaskans.
<u>Performance Measure 3:</u>	Improved treatment outcomes for underserved Alaskans.

## Strategy Seventeen

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Use relevant research to identify and incorporate key variables that contribute to successful treatment outcomes.

### What this means...

It is often difficult to predict how any particular individual with chronic disease will respond to treatment. For many clients, certain variables are significant indicators for success. Examples of such variables are a strong post-treatment support system, employment opportunities, and alcohol/drug free housing. Monitoring emerging research and assessing the client with regard to key variables will increase the probability of client success. This strategy will require collaborative relationships with other helping professions. Many of the variables involve services and issues not directly provided by chemical dependency treatment programs. Examples of these efforts include drug and alcohol-free transitional housing, vocational and educational referrals, and services designed to strengthen families.

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### How will we measure our performance?

Performance Measure 1:

Decrease in relapse rates.

Performance Measure 2:

Percentage of clients with improvement in life domains.

## Strategy Eighteen

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Address the treatment needs of persons in the criminal justice system.

### What this means...

All available data and research indicate that drugs and alcohol are prevailing factors in crime in Alaska. The vast majority of the incarcerated population has drug and/or alcohol problems. In order to decrease recidivism in this population, drug and alcohol treatment needs must be addressed. Drug courts and other diversion strategies identify and provide appropriate services to individuals before they are incarcerated. Depending on the nature of the offense, treatment can be ordered in lieu of incarceration. This approach leads to a more appropriate allocation of scarce corrections resources.

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### How will we measure our performance?

<u>Performance Measure 1:</u>	Increased percent of offender population with substance abuse problems accessing treatment services.
<u>Performance Measure 2:</u>	Decreased recidivism among alcohol and drug-related criminal offenders.
<u>Performance Measure 3:</u>	Increased number of inmates in treatment programs.
<u>Performance Measure 4:</u>	Increased number of treatment options for offender population.
<u>Performance Measure 5:</u>	Increased percentage of treatment completion and improvement in treatment outcomes
<u>Performance Measure 6:</u>	Increased number of drug courts and other diversion programs.

## Data Agenda

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- I. **Introduction.** Consistent and reliable data are a key element in the planning process. Information about existing conditions helps to develop baselines or reference points. As this plan is implemented, reliable and consistent data will be used to measure performance and results. Careful analysis of indicator and performance measure data will help decision-makers modify strategies to achieve the best results.
  
- II. **General Data Agenda.** There are a number of issues regarding data collection and analysis that apply to the entire planning process.
  - A. **Timeliness of Data.** Much of the data to be used as indicators is collected and published annually by state agencies. While this makes data collection somewhat straightforward, effectiveness is compromised by the time lag between events and data publication. Most data is typically available two years after the fact. Efforts will be made to obtain the data prior to its normal publication schedule whenever possible. Patience will be required. Data that indicate effectiveness will not be available until at least two years after the implementation of a strategy. For some strategies that seek to impact community norms and values, this time period may be even longer.
  
  - B. **Data Storage and Maintenance.** Planning is an ongoing process. Data must consistently support this process. There must be an organized, reliable system for data storage and maintenance. The data, if properly maintained, will be useful in the ongoing strategic planning process and in the annual planning processes of the Advisory Board and the Division. The greater the detail of collected data, the more diverse and useful its applications will be.
  
  - C. **Data Analyses.** The degree of effort required to collect, store, and maintain data will be driven, in large part, by the analyses desired. The use of spreadsheets, databases, or statistical programs to analyze data requires rigorous formatting. The effort is even greater if data from different sources are to be integrated for analyses. During the first year of this plan a data collection, maintenance and analysis plan will be developed to support this effort. This plan will identify data sources and format, integration and analyses desired and appropriate computer software applications.

III. **Indicator Data Agenda.** Each of the six headline indicators is supported by data that rate high in proxy, data, and communication power. Despite this, each of the indicator data sets has variables that should be acknowledged during the analysis.

A. **Per Capita Consumption of Alcohol.** The per capita consumption of alcohol data is straightforward. There are some factors, however, which diminish its usefulness.

1. **Age Applicability** – The per capita consumption data are based on total population, 14 years of age and older. They do not account for drinking by youth under age 14.
2. **Persons Who Abstain from Alcohol** – The data do not take into account those individuals who choose to abstain from alcohol. As this population segment grows, it will lower per capital consumption. It is possible that those who drink alcoholic beverages may be drinking more while the data indicates a decrease in per capita consumption.
3. **Consumption by Visitors** – The per capita consumption data are based on state population. If visitors significantly impact the amount of alcohol consumed, the per capita consumption data could show an increase when, in fact, there was no increase in consumption by Alaska residents.
4. **Effects of Wholesale Distribution vs. Consumption** – The per capita consumption data are based on state excise tax collected at the wholesale point in the alcohol distribution chain. While this is considered a good surrogate marker for consumption, there are sales that do not result in Alaska consumption. Some residents purchase Alaska-brewed beer as gifts that are shipped out of state. Although this is probably not significant, we do not know the exact extent of this practice.

B. **DUI Convictions.** Driving Under the Influence (DUI) conviction data are collected and maintained by the State of Alaska Court System. Felony DUI data are included as a separate conviction category in regularly published reports. Misdemeanor DUI conviction data, however, are included with other misdemeanor traffic violation convictions. In order to obtain these data, a special request must be made to the Court System. An agenda item for the first year of this plan is to ask the Court System to begin separating misdemeanor DUI convictions in their published reports. Another problem with these data is that they do not include arrests that do not result in convictions. Enforcement effort, prosecution workload and strategies, and trends toward plea bargains for other charges also impact these data.

- C. **Drug and Alcohol Related Convictions.** This data set has some of the same limitations present in DUI conviction data. It does not reflect arrests for which there is no conviction, or plea bargains to other charges. An additional complication is that many drug charges are prosecuted in federal court as violations of federal law. Regularly published reports show drug and alcohol convictions at the national level and overall federal convictions at the state level. Specific drug and alcohol conviction data for specific states require a special data run at the federal level. A data agenda item will be to work with the federal court system to encourage reporting of data in a useful format.
- D. **Alcohol Related Injuries.** The State of Alaska Emergency Medical Services Section maintains the Alaska Trauma Registry. The registry collects data relating to injuries that are treated at hospitals throughout the state. There are fields within the registry that identify whether or not alcohol was involved. Although there is not a standard published report, the staff that maintains the registry can produce a custom report that includes desired information. Injuries that are not treated in an emergency room are not included in the registry. The data agenda item relating to this indicator is to determine exactly what information is desired from the registry each year and to work with the Emergency Medical Services staff to obtain that data.
- E. **12-Hour Protective Custody Holds.** Data for 12-hour protective custody holds are collected by the State Department of Corrections. These data reflect the number of Title 47 non-criminal holds in state correctional facilities. At present, community jails, operated by municipalities and boroughs, are not contractually required to record data on 12-hour protective custody holds. The data agenda item for this indicator is to work with the Department of Corrections to develop a standard annual report that includes all Corrections facilities and community jails.
- F. **Rate of Binge/Chronic Drinking.** The percentage of Alaskans reporting binge or chronic drinking is obtained from the annual Behavior Risk Factor Surveillance Survey. It is conducted using a random sample of 1,535 adult Alaskans. The survey results are published annually by the Alaska Division of Public Health. One of the contributing factors to the reliability of this data set is that the survey questions were rigorously developed at the national level. These same questions are also used in a national survey. This indicator can be tracked over time for trend analysis.

- IV. **Performance Measures.** Each strategy selected by the strategic planning work group has a series of measures for evaluating performance. The data for these measures are collected and analyzed by the Division of Alcoholism and Drug Abuse and used to assess the level and quality of effort. Most of the data will be collected from grantees that are required to submit data relevant to their programs. The data from individual grantees will be consolidated to provide an assessment of statewide effort. Most data come from two sources: quarterly reports on goals and objectives and program reports to the Division's Management Information System (MiS). Despite this effort, there are some measures for which data are not now readily available. The data agenda for the Division of Alcoholism and Drug Abuse over the next two years is to examine these specific measures and explore means for obtaining supporting data.
- V. **Other Data Agenda.** Beyond those indicators selected to measure progress toward results and the performance measures for strategies, there are other data and information that would be useful in assessing needs and evaluating program performance. For a variety of reasons those data are not useable at present. This provides yet another set of issues for the data agenda.
- A. **Youth Behavior Risk Survey.** Every two years, the State of Alaska of conducts a survey in the education system to assess attitudes and behaviors that constitute risks to health. While this survey provides useful data, it is not administered in all areas of the state. Participation is determined by local School Boards and is voluntary. The areas not participating are significant enough that the results may not be generalized to the entire state. The data agenda for the next two years is to advocate with the Legislature and the Department of Education to require statewide participation in this valuable survey effort.
- B. **Prevalence Studies.** During 1997 and 1998 the Division of Alcoholism and Drug Abuse participated in a federally-funded comprehensive effort to measure prevalence of alcoholism and alcohol abuse in the general population. This massive, expensive effort involved random sample telephone surveys using rigorously developed survey instruments. The results obtained from this effort have proven extremely valuable in assessing needs and barriers to meeting those needs. Although it is not practical to undertake every year, such a survey conducted at five-year intervals would be very useful in assessing results. The data agenda item for this issue is to advocate at both state and federal levels for consistent periodic surveys of this nature.

- C. **Consumption of Alcohol by Pregnant Women.** The Alaska Division of Public Health, Section of Maternal and Family Health, conducts an annual survey of women who give birth during the year. This survey uses an instrument developed by the U. S. Centers for Disease Control. The survey is conducted by mail using a stratified random sample methodology. The response rate for this survey has traditionally been extremely high, which makes it a valuable tool. Among the questions in the survey are a series on alcohol use during pregnancy. Given the significant negative consequences associated with drinking during pregnancy (Fetal Alcohol Syndrome and Fetal Alcohol Effect), the trends in this area would be most useful in assessing prevention efforts. Although routine reports are not published, the staff responsible for this effort is able to produce custom reports. The data agenda item for this issue is to work with the Section of Epidemiology to identify key information from the survey that can be provided annually.
- D. **Alcohol-Related Deaths.** Consistent data on alcohol-related deaths is not readily available. This is primarily because of the many ways in which alcohol and other drugs can cause death. The cause of death usually associated with alcohol consumption is cirrhosis of the liver. However, there are other fatal medical conditions related to alcohol consumption such as heart disease and esophageal cancer. Many accidents and homicides are also associated with alcohol abuse. This is compounded by the fact that these causes of death are associated with other factors as well as alcohol consumption. The same difficulties are present with consumption of other drugs. The State of Alaska Bureau of Vital Statistics reports on causes of death annually. In 1996, for example, the Bureau of Vital Statistics reported a total of 110 deaths due to alcohol use or abuse<sup>1</sup>. The Bureau also reports separately for deaths due to cirrhosis and other diseases. The data agenda item for this issue is to work with the Bureau of Vital Statistics over the next five years to develop a useable method of identifying death due to alcohol or other drug consumption.
- E. **Department of Health and Social Services Data Warehouse.** The Alaska Department of Health and Social Services is currently working on a project to provide easier access to data across Divisions. The Advisory Board on Alcoholism and Drug Abuse will monitor these efforts and assist as appropriate in developing a system that will meet the data needs of the State and providers as well as protecting the privacy and confidentiality of consumers.

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<sup>1</sup> Alaska Bureau of Vital Statistics, 1996 Annual Report, 1998

## Implementation

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This strategic plan will succeed to the extent that it is consistently implemented and updated. Four distinct implementation efforts are required in order for the plan to remain a useful tool over time.

- 1. Implementation of Strategies.** The prevention and treatment strategies identified in this plan will be implemented by the Division of Alcoholism and Drug Abuse, which has responsibility for managing service delivery in Alaska. The Advisory Board on Alcoholism and Drug Abuse and the Division will share responsibility for implementation of strategies that address public policy, advocacy and legal/legislative initiatives. The implementation of service delivery strategies will be accomplished primarily through the Request for Proposals (RFP) process. This process leads to funding allocation to support specific strategies. Successful grantees will develop proposals that reflect the Division's guidelines and this plan. Future Requests For Proposals (RFPs) from the Division will incorporate experience and knowledge gained by monitoring indicators and performance measures as well as emerging research. Both the Division and the Advisory Board will share responsibility for wide distribution of the plan. Each will work assertively to educate providers, stakeholders, and the public about the plan's contents and significance in reducing negative consequences of alcoholism and drug abuse for all Alaskans.
- 2. Monitoring of Performance.** As strategies are implemented, the Division will monitor performance measures to assess the level, quality, and effectiveness of effort. The data required for monitoring performance will be reported by programs and collected independently by the Division. By monitoring performance in a timely manner, the Division and the Advisory Board will be able to gauge whether the selected strategies are the right ones and whether the level of effort is sufficient to impact the indicators as desired.
- 3. Monitoring of Indicators.** Each year, the Advisory Board will collect the required indicator data to determine the extent to which the strategies have influenced the desired results. There are several confounding factors in this task. First, indicator data are impacted by variables beyond the control of the Division or the Advisory Board. Care must be exercised when deciding how much the data have been impacted by the strategies and how many intervening variables have impacted them. Second, the data reflected in the indicators are often one to two years old before publication. There could be a lag of three or four years after the implementation of a strategy before indicator data are available from which to draw conclusions. Once the data

are available, it will be necessary to view several years of data before assessing effectiveness.

4. **Ongoing Planning.** Only one desired result was examined during this planning phase. The planning work group identified four other desired results for all Alaskans. The ongoing planning effort will follow two parallel tracks. The first track focuses on review of the performance measure and indicator data and refinement of the strategies as necessary. The second track focuses on developing indicator data, strategies and performance measures for the other results. It is recommended that the planning work group convene every third year to update the plan, building on the ongoing efforts indicated above.
5. **Integration into the Comprehensive Integrated Mental Health Plan.** The Advisory Board will work with the Department of Health and Social Services, the Mental Health Trust Authority, and the three other beneficiary boards to ensure a smooth integration of this plan into the Comprehensive Integrated Mental Health Plan.

## Strategic Planning Work Group

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## Glossary

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**Abuse of alcohol, other drugs, or inhalants:** A persistent pattern of use of alcohol, other drugs or inhalants with which health consequences and/or impairment in social functioning are associated. This is different from dependence, which has such manifestations as craving, tolerance and physical dependence. Abuse is any use of a legal or illegal drug or substance that causes physical, mental, emotional or social harm, whether mild or severe.

**Accountability:** Responsibility for performance and results; holding political leaders and agency managers accountable for results according to agreed upon performance standards.

**Addict:** A person who is physically dependent on one or more psychoactive substances, whose chronic use has produced tolerance, who cannot control his or her intake, and who would have withdrawal symptoms if drug use were discontinued.

**Alaska Mental Health Trust Authority (AMHTA):** The Alaska Mental Health Trust Authority administers the Mental Health Trust established in perpetuity. It has a fiduciary responsibility to its beneficiaries to enhance and protect the Trust and to provide leadership in advocacy, planning, implementing, and funding of a comprehensive integrated mental health program to improve the lives and circumstances of its beneficiaries.

**Alcohol:** The active ingredient in beer, wine and distilled spirits; ethyl alcohol or ethanol.

**Alcohol Dependence:** A psychic and usually physical state resulting from taking alcohol. It is characterized by behavioral and other responses that always include compulsion to take alcohol on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence. The person may or may not have developed a tolerance for alcohol. A person may be dependent on alcohol and other drugs. "Alcohol dependence" is often used interchangeably with the term "alcoholism."

**Alcoholism:** A primary, chronic disease with genetic, psychosocial and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic.

- **Primary** refers to the nature of alcoholism as a disease entity, in addition to, and separate from other pathophysiologic states which may be associated with it. It suggests that alcoholism, as an addiction, is not a symptom of an underlying disease state.
- **Disease** means an involuntary disability. It represents the sum of the abnormal phenomena displayed by a group of individuals. These phenomena are associated with a specific common set of characteristics by which these individuals differ from the norm, and which places them at a disadvantage. Use of the term involuntary in defining disease is descriptive of this state as a discrete entity that is not deliberately pursued. It does not suggest passivity in the recovery process nor does use of the term imply the abrogation of responsibility in the legal sense.
- **Often progressive and fatal** means that the disease persists over time with physical, emotional, and social changes that are often cumulative and may progress as drinking continues. Alcoholism causes premature death through overdose, organic complications involving the brain, liver, heart and many other organs, and by contributing to suicide, homicide, motor vehicle crashes and other traumatic events.
- **Impaired control** means the inability to limit alcohol use or to consistently limit, on drinking occasions, the duration of the drinking episode, the quantity of alcohol consumed, and/or the behavioral consequences.
- **Preoccupation** used in association with alcohol use indicates excessive, focused attention given to the drug alcohol, its effects, and/or its use. The relative value thus assigned by the individual often leads to a diversion of energies away from important life concerns.
- **Adverse consequences** are alcohol-related problems or impairments in such areas as physical health (e.g., alcohol withdrawal syndromes, liver disease, gastritis, anemia, and neurological disorders,) psychologic functioning (e.g., impairments in cognition, changes in mood and behavior,) interpersonal functioning (e.g., marital problems, child abuse, troubled social relationships,) occupational functioning (e.g., scholastic or job problems,) and legal, financial or spiritual problems.
- **Denial** is used here not in the psychoanalytic sense of a single psychological defense mechanism disavowing the significance of events, but more broadly to include a range of psychological maneuvers that decrease awareness of the fact that alcohol use is the cause of a person's problems rather than a solution to those problems. Denial becomes an integral part of the disease and is nearly always a major obstacle to recovery.

**ASAM:** The American Society of Addiction Medicine, a national medical specialty society of physicians dedicated to improving the treatment of alcoholism and other drug dependencies.

**ASAM Placement Criteria:** American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders, a clinical guide for matching patients diagnosed as having a substance use disorder to appropriate levels of care based on an assessment of:

1. acute intoxication and/or withdrawal potential;
2. biomedical conditions and complications;
3. emotional/behavioral conditions and complications;
4. treatment acceptance/resistance;
5. relapse potential;
6. recovery environment.

**Beneficiary (AMHTA):** The beneficiaries of the Alaska Mental Health Trust Authority are Alaskans who experience mental illness; mental retardation or similar disabilities; chronic alcoholism with psychosis and/or Alzheimer's disease or related dementia.

**Binge Drinking:** Having five or more drinks on an occasion one or more times in the past month.

**Chemical Dependency:** Physiological or physical dependence on a psychoactive substance.

**Chronic Alcoholic with Psychosis:** As defined in AS 47.30.056(b)(3), this group includes persons with the following disorders:

1. alcohol withdrawal delirium (delirium tremens);
2. alcohol hallucinosis;
3. alcohol amnesiac disorder;
4. dementia associated with alcoholism;
5. alcohol-induced organic mental disorder;
6. alcoholic depressive disorder;
7. other severe and persistent disorders associated with a history of prolonged or excessive drinking or episodes of drinking out of control and manifested by behavioral changes and symptoms similar to those manifested by persons with disorders listed in this subsection.

**Chronic Drinking:** An average of 60 or more drinks a month.

**Culturally Sensitive:** Awareness of unique aspects and nuances of one's own culture and of other cultures.

**Detoxification:** Treatment to restore physiologic function after it has been seriously disturbed by the overuse of alcohol or other drugs.

**Drug Dependence:** A psychic and sometimes physical state resulting from taking a drug. It is characterized by behavioral and other responses. These always include a compulsion to take a drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence. The person may or may not have developed a tolerance for the drug. A person may be dependent on more than one drug.

**Dually-Diagnosed:** Persons suffering from co-existing mental illness and alcohol or drug dependence.

**Early Intervention:** Services designed to identify individuals who are at high risk for developing alcohol or other drug-related problems. These services are also directed toward persons who are experiencing adverse effects of alcohol or other drug use but are not dependent. Services seek to modify alcohol or drug use behaviors and attitudes.

**Fetal Alcohol Syndrome (FAS):** Fetal Alcohol Syndrome and other alcohol-related birth defects refer to a group of physical and mental birth defects resulting from a woman's alcohol consumption during pregnancy. FAS is the leading known cause of mental retardation and is 100 percent preventable.

**Fetal Alcohol Effect (FAE):** FAE is similar to FAS but lacks the physical symptoms of FAS. FAE neurological abnormalities, development delays, intellectual impairments and learning/behavior disabilities are similar to, and sometimes more severe than, those of FAS.

**Guiding Principles:** These define what the organization stands for and are used as the foundation on which to develop a strategic plan of action.

**Inhalants:** Any volatile substance that can produce an intoxicating state when inhaled. A volatile substance becomes a gas at normal room temperature. Examples include common household products such as fast-drying glues and cements; paints, lacquers and varnishes; thinner and removers; lighter and dry cleaning fluids; kerosene, gasoline, lantern and stove fuel; fingernail, shoe and furniture polish; typewriter correction fluids; felt-tip pens; aerosol products; refrigerants such as freon.

**Involuntary Commitment:** A legal process defined in Alaska law (AS 47.37.190) whereby a person addicted to alcohol may be committed to a treatment facility without the person's permission if the person lacks self control in using alcohol and presents a danger to others or is incapacitated by alcohol.

**Indicator or Benchmark:** A measure, for which data is available, that helps to quantify the achievement of a desired result or outcome.

**Mission Statement:** This states the purposes served by an organization's mission. By defining its mission, an organization can decide upon appropriate outcomes and performance measures.

**Misuse of alcohol, drugs or inhalants:** Use of alcohol, other drugs, or inhalants in a way that is illegal or deviates from medically accepted use.

**Performance Measure:** A measure of effectiveness of agency or program service delivery.

**Results-oriented Government:** A government that values results and qualitative outcomes over expenditures and inputs. It is concerned with accountability and performance measurement.

**Result or Outcome:** A condition of well-being for children, families or communities.

**Sobriety:** A positive, healthy and productive way of life, free from the negative effects of alcohol or other drug misuse or abuse.

**Strategic Planning:** A process of defining the vision, mission, goals and objectives of an organization. Through the planning process the organization identifies the results it see<sup>1</sup> to achieve through its programs and the specific means by which it intends to achieve these results.

**Tolerance:** Physiologic adaptation to the effect of a drug, diminishing the effect of constant dosages.

**Treatment Capacity:** The amount of substance abuse services that are readily accessible.

**Vision:** The ideal mission of a governmental jurisdiction and/or agency, and the ideal way it must operate to accomplish its mission and best serve its clients.

## **Selected Resources and References**

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The following are only a few the very broad range of references and resources available to those with an interest in eliminating the negative consequences of alcohol and drug abuse.

**Advisory Board on Alcoholism and Drug Abuse.** Annual reports of the Advisory Board's activities, and selected reports on programs and projects, as well as additional copies of this plan. (907) 465-8920 or 1-888-464-8920.

**Alaska State Library bibliography on Alcohol and Drug Abuse Treatment.** Call 907 465-2916 to request a free copy. Also available from <http://www.educ.state.ak.us/lam/library.html>.

**Alcoholics Anonymous.** <http://www.alcoholics-anonymous.org/>

**Center for Science in the Public Interest "Booze News"** <http://www.cspinct.org>

**Center for Substance Abuse Prevention** maintains a Clearinghouse on Alcohol and Drug Information at 1-800-729-6686. Its website may be reached at <http://www.health.org>.

**Division on Alcoholism and Drug Abuse.** In the coming months, the final reports of federally-funded research projects relating to prevalence in Alaska will become available. (907) 465-2071 or 1-800-478-2072.

**Dual Diagnosis Website,** focuses on mental illness, drug addiction and alcoholism. <http://www.erols.com/ksciacca/>

**Higher Education Center for Alcohol and other Drug Prevention,** sponsored by the U. S. Department of Education. <http://www.edc.org/hec/>

**Join Together Online Organizations** working together to combat substance abuse and violence. <http://www.jointogether.org/>

**National Institute on Alcohol Abuse and Alcoholism.** Offers a wealth of information, publications and databases on both treatment and prevention. <http://silk.nih.gov/niaaa1/>

**The National Library of Medicine, PubMed.** A very large range of medical topics, including Clinical Alerts of the National Institutes of Health, a journal database browser and links to many other sources. <http://www.ncbi.nlm.nih.gov/pubmed/>

**National Organization for Fetal Alcohol Syndrome.** <http://www.nofas.org/>

Printed in Juneau, Alaska.  
at a cost of \$1.81 per copy.

Additional copies are available upon request.  
Please call 907 465-8920 or 1-888-464-8920.

*The* T  
TRUST

Alaska Mental Health Trust Authority

HB51

presentation to the

House Finance Committee

February 17, 1999

## The Trust's Beneficiaries

- *People with mental illness*
- *People with mental retardation and similar disabilities*
- *Chronic alcoholics with psychosis, and*
- *People with dementia*

## Key Terms of Settlement

- Mental Health Trust Lands and associated state lands released for development
- Trust Authority free to use Trust resources to act as a catalyst for change
- Trust Authority funding recommendations considered in a single appropriation bill
- Trust Authority to aid in comprehensive planning for mental health

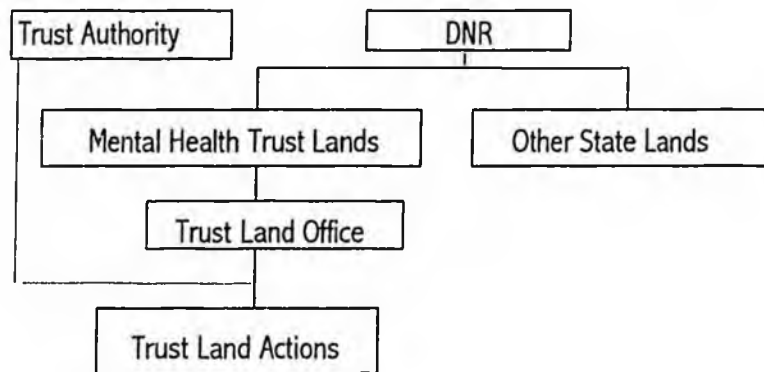
## Mission and Vision

*The Alaska Mental Health Trust Authority administers the Mental Health Trust established in perpetuity. It has a fiduciary responsibility to its beneficiaries to enhance and protect the Trust and to provide leadership in advocacy, planning, implementation, and funding of a comprehensive integrated mental health program to improve the lives and circumstances of its beneficiaries.*

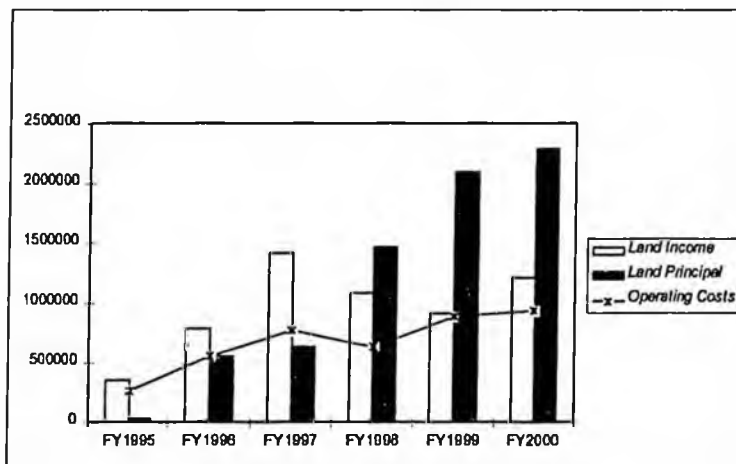
## Trust Responsibilities

- *Manage the land and cash assets of the Trust in perpetuity*
- *Provide leadership & advocacy for beneficiaries*
- *Recommend the state's budget for the Comprehensive Integrated Mental Health Program*

## Trust Land Management Framework



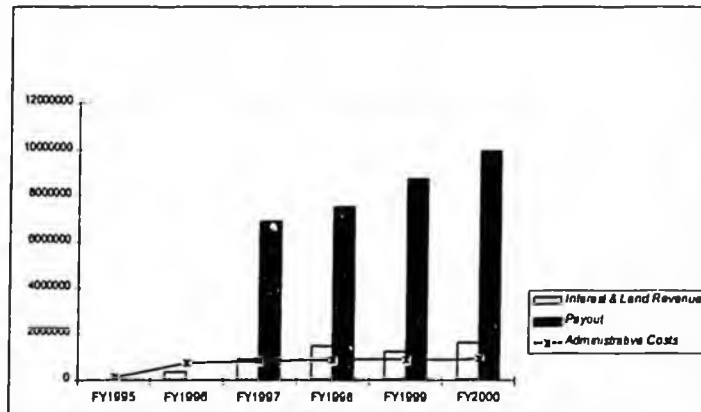
## Trust Land Revenue vs. Operating Costs



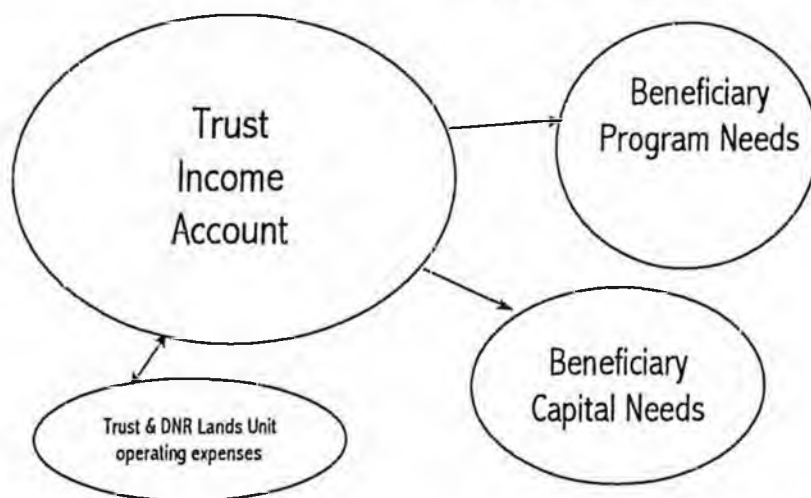
## Cash Assets FY99

Total Fund	\$293,215,778
Principal	\$246,620,844
Principal Reserve	\$34,817,06
Net Income (obligated)	\$11,777,87

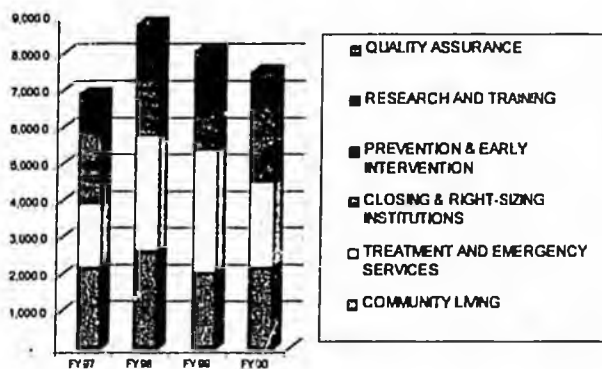
## Trust Authority Revenues, Payout and Administrative Costs



## Where the funds go



## Trust Income Expenditures by Category



## Changing the Culture

- Accountability. We all must agree on results we seek.
- Consistency in purpose and direction. Needs to be a way of life, a way of thinking.

### *What we have done*

- Trained boards & departments in results-based planning.
- Agreed on some basic language & results in the CIMHP process.

## Results we are looking for

- Are Trust beneficiaries healthy?
- Are they safe?
- Are they economically secure?
- Are they productively engaged or in school?
- Are they living with dignity, as valued members of their communities?

## Examples of indicators

- To see if Alaskans are healthy, look for
  - rates of alcohol consumption & alcohol-related deaths
  - rate of hospital admission for mental illness, substance abuse, disability, or aging problems
  - rate of preventable birth defects
- To see if beneficiaries are healthy compared to all Alaskans, look for
  - chronic alcohol use
  - rate of admission to hospitals
  - rates of disabling conditions

## Requesting Funding Recommendations

*Four boards recommend funding to the Trust:*

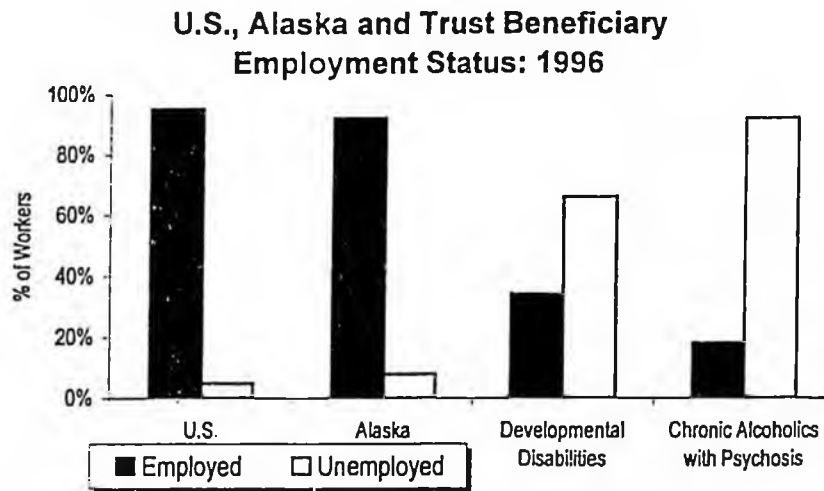
- Budget recommendations to the Trust should be result-oriented.
- Boards describe their overall strategies.
- Boards explain how budget recommendations help Trust beneficiaries.
- Boards help track progress of programs we fund.

## RESULT #4: PRODUCTIVELY ENGAGED, EMPLOYED, CONTRIBUTING

### Indicator Baselines:



Government Information Sharing Project, Oregon State University, <http://govinfo.kerr.orst.edu/>



Government Information Sharing Project, Oregon State University, <http://govinfo.kerr.orst.edu/>  
Response to Mental Health Trust Authority Request for Recommendations, Advisory Board on Alcoholism and Drug Abuse, June 1996  
Alaskans with Developmental Disabilities: A Report to the Mental Health Trust Authority on the Status and Living Conditions of the Beneficiaries, Governor's Council on Disabilities and Special Education, July 1996

**The Story Behind the Baselines:** Data on employment, unemployment, hours and wages are collected and published monthly by the Alaska Department of Labor.

Unemployment in Alaska varies greatly with the season. In 1996, the statewide rate of unemployment ranged from 9.7% in January to 5.5% in August. Unemployed rates also vary according to region or community. Traditional methodologies for determining unemployment do not work well in Alaska's smaller, more remote villages, where few jobs are available. Many people in these communities rely on a traditional subsistence lifestyle. Hunting, fishing and gathering wild foods form the basis of a non-cash economy. Often, people living in these communities have given up on actively seeking employment and are not counted in local or state statistics. In many of these communities, it is estimated that more than 75% of the adults are not working at cash jobs.

There is currently limited data available on the employment status of beneficiaries of the Alaska Mental Health Trust Authority. The Advisory Board on Alcoholism and Drug Abuse reported that 92% of the chronic alcoholics with psychosis who receive state funded substance abuse services are unemployed. Approximately two-thirds (66%) of adults with developmental disabilities in state services are unemployed.

National sources estimate that up to 65% of adults with a variety of disabilities are unemployed. Even when Trust beneficiaries are employed, they are often in part-time, low paying jobs. Beneficiaries remain in these jobs because, if they worked longer hours or made more money, they would lose their eligibility for Medicaid, which is often their only source of health insurance.

**Current Efforts to Turn the Curve:** Some of the strategies that are proving effective at increasing employment opportunities for beneficiaries are employment training programs like those provided by the Division of Vocational Rehabilitation and the Private Industry Council. Developmental disability and mental health employment support programs provide on-the-job employment readiness training and support for workers. Senior employment programs provide many seniors with jobs as senior volunteers and helps train seniors to acquire unsubsidized employment. The Alaska Legislature is currently considering a bill that would allow people with disabilities to retain Medicaid coverage while working. Programs like elder care and respite make it possible for caregivers of people with Alzheimer's Disease to continue working.

# GOVERNOR'S COUNCIL ON DISABILITIES AND SPECIAL EDUCATION

## INVESTING IN RESULTS OUTCOME BASED DECISION MAKING

Alaskans who experience developmental disabilities want results, not activities, from programs. They also want outcome measures in place so they can determine if their desired results are being achieved. The results that Alaskans with disabilities want and some proposed outcome measures are presented below across the six major life domains: community living, education, employment, health care, housing and transportation.

### COMMUNITY LIVING

Results	Outcome Measures
Every individual is a valued, participating member of his or her community.	<ul style="list-style-type: none"> <li>• Number and percent of people who are registered voters</li> <li>• Decrease in funds expended for services provided in institutions (e.g. API, hospitals, nursing homes or jail)</li> </ul>
People receive prevention and early intervention services.	<ul style="list-style-type: none"> <li>• Number and percent of people, especially infants and toddlers, who need fewer specialized services</li> <li>• Decrease in the incidence of high cost crisis situations</li> </ul>

### EDUCATION

Results	Outcome Measures
Students reach their educational goals and potential.	<ul style="list-style-type: none"> <li>• Number and percent of students who graduate from high school with jobs or post-secondary education plans in place</li> <li>• Number and percent of students who are making progress in classrooms with children who do not have disabilities</li> <li>• Number and percent of students who meet or exceed performance standards</li> </ul>

### EMPLOYMENT

Results	Outcome Measures
People get and keep employment consistent with their interests, abilities and needs.	<ul style="list-style-type: none"> <li>• Number and percent of people who maintained employment at 6, 12, 24 and 36 months</li> <li>• Number and percent of people who own their own businesses</li> <li>• Number and percent of people who are employed in jobs with health care benefits</li> </ul>

## HEALTH CARE

Results	Outcome Measures
People are healthy and benefit from the full range of needed health care services.	<ul style="list-style-type: none"><li>• Decrease in the utilization of high cost acute care or emergency room services</li><li>• Number and percent of low birth-weight babies</li><li>• Number and percent of survivors of head injuries or spinal cord injuries</li></ul>

## HOUSING

Results	Outcome Measures
Adults choose where and with whom they live.	<ul style="list-style-type: none"><li>• Number and percent of people who own their own homes</li><li>• Number and percent of people who are living safely in the community</li></ul>

## TRANSPORTATION

Results	Outcome Measures
People are able to get to where they want to go when they want to go.	<ul style="list-style-type: none"><li>• Increase in the availability of accessible transportation</li><li>• Number and percent of people who use less expensive fixed route systems as compared to those who use paratransit systems</li></ul>

The results presented here are not unique to people who experience developmental disabilities. However, Alaskans who experience disabilities are less likely to achieve these results than the average Alaskan. People who experience disabilities have identified a number of reasons for this discrepancy, including:

1. their unique needs for physical accessibility, access to transportation, assistive technologies, and individualized and family supports;
2. the general lack of public awareness about the needs, rights and responsibilities of people who experience disabilities; and
3. limited incomes, which further prevent their full participation in community life.

## Harborview Developmental Center

### *What we said we would do*

- Close HDC.
- Move residents to community.
- Re-allocate funds to more effective programs.

### *What we did*

- Partnered with AHFC & DHSS for special needs housing.
- Subsidized cost of HDC for 3 fiscal years.
- Supported development of necessary community services.

### *How well we did*

- HDC closed 12/31/97.
- Everyone moved to community
- Services funded to meet individual needs.

### *Strategies: Rewarding success*

- Re-distribute HDC funds to DD services
  - serve people waiting longest
  - minimal "core" services
  - small safety net

### *Validating & monitoring investment*

- Funded a deinstitutionalization study.

## Hope Cottages ICFs-MR

### *What we said we would do*

- Close the ICFs-MR.
- Move residents to smaller community settings.
- Re-allocate funds to more effective programs.

### *What we did*

- Partnered with AHFC & DHSS for special needs housing.
- Supported development of necessary community services.

### *How well we did*

- ICFs-MR closed 7/1/96.
- Everyone moved to community settings of their choice.
- Services funded to meet individual needs.

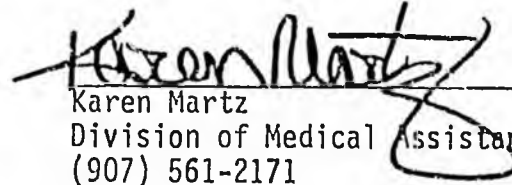
### *Strategies: Rewarding success*

- Re-distribute ICF-MR funds to DD Waiver services

ICF/MR and IMH Census

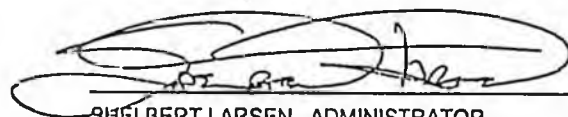
Psychiatric Beds	Per Diem Rate	Certified Beds	Current Occupancy			Non-Medicaid	Current Census	Vaca Bed
			Total	Medicaid Under 22	Over 65			
Alaska Psychiatric Institute, Anchorage	252.24	174	17	16	1	100	117	57
Charter North Anchorage	N/A	60	18	18	-0-	38	56	4

ICF/MR Beds	Per Diem Rate	Certified Beds	Current Occupancy		Total Census	Vacant Beds
			Medicaid	Non-Medicaid		
Harborview Developmental Center, Valdez	302.00	64	56	2	58	6
Hope Cottages, Anchorage	261.49	40	40	-0-	40	-0-


 Date 5/10/88  
 Karen Martz  
 Division of Medical Assistance  
 (907) 561-2171

PSYCHIATRIC BEDS	PER DIEM RATE	CERTIFIED BEDS	CURRENT OCCUPANCY			TOTAL CENSUS	VACANT BEDS
			MEDICAID		NON-MEDICAID		
			UNDER 21	65 & OVER			
ALASKA PSYCHIATRIC INSTITUTE Anchorage	\$758.48	114	2	0	70	72	42
CHARTER NORTH HOSPITAL Anchorage	N/A	74	17	0	11	28	46
NORTH STAR HOSPITAL Anchorage	N/A	34				0	34

ICF/MR BEDS	PER DIEM RATE	CERTIFIED BEDS	CURRENT OCCUPANCY		TOTAL CENSUS	VACANT BEDS
			MEDICAID	NON-MEDICAID		

  
 \_\_\_\_\_  
 SHELBERT LARSEN, ADMINISTRATOR  
 DIVISION OF MEDICAL ASSISTANCE (907) 561-8081  
 HEALTH FACILITIES LICENSING & CERTIFICATION

1/7/98  
 \_\_\_\_\_  
 DATE

## Housing

### *What we said we would do*

- Partner with AHFC on institution closure.

### *What we did*

- Closed Harborview & Hope ICFs.
- Special Needs Housing with AHFC, DHSS, & DSS.

### *How well we did*

- Institution residents now in community.
- People can stay home with housing modifications.

### *What we are doing*

- Moving long-term API residents into community-based housing.
- Domiciliary care for chronic alcoholics.
- Pioneer Homes renovations.
- Facility & ADA upgrades.
- AHFC loan program changes.

### *Strategies: rewarding success*

- Include AHFC funding in MH budget.
- Homeless Assistance Program.
- Match for Federal & Other Grants for transitional housing programs.
- Special Needs Housing: first at DHSS, now at AHFC.

### *Validating & monitoring investment: Look for*

- AHFC training for communities on accessing housing finance for vulnerable populations
  - Clarifying roles for housing & supports

## Alcohol and Drug Abuse

### *Culture change predates the Trust*

- Leg Audit promoted change

### *What we did*

- Learned from the data.
- Funded domiciliary program in Fairbanks, in partnership with AHFC's Special Needs Housing.
- Funded case management and day treatment for people with dual diagnosis.
- Funded trauma study with Providence
- Funded enhanced detox beds at Clitheroe.

### *Strategies*

- Increase enhanced detox: API community implementation project.
- Fund women's services in places their children can also stay.
- FAS prevention.

### *Validating & monitoring investment*

- Educate providers on leveraging funds for domiciliary care.
- Watch Homeward Bound Project.

## Department of Corrections

### *What we said we would do*

- Fund a study of Trust beneficiaries in DOC custody.
- Fund a planner at DOC to ensure collaboration on behalf of beneficiaries.

### *What we learned*

- 19% of people at DOC have mental illness & 29% have significant drug or alcohol problems.
- 38% of women at DOC have mental illness.
- No services for women with mental illness.

### *What we did*

- With LB&A & DOC, developed a strategy to create & fund a women's mental health unit.
- Fully funded women's unit for FY98.
- Funded the planner.

### *How well we did*

- Women's unit opened late 1/98.
- Integrated DOC & mental health planning.

### *Strategies*

- Fund 2/3 of the women's unit for FY99.
- Increased 6th Ave. jail mental health staff.
- Hired UW psych interns.
- Funded misdemeanor diversion project.

### *Validating & monitoring investment*

- Improvement in mental health status of individuals with mental illness at DOC.
- # of people diverted by misdemeanor project.

## Healthy Families

### *What we said we would do*

- Fund pilot program that offered results-based services.

### *What we did*

- Fund expanded pilot program FY97, 98, and 99.

### *How well the program did*

- Serving 303 families in 8 communities as of 9/30/97.
- decreased child abuse rates for participants.
- increased employment rates.

### *Strategy:*

#### *Validating & measuring investment*

- Fund the program evaluation in FY99 and FY00.
- 94% of families had no abuse or neglect, when 30% would have (statistically validated instruments used on Lower 48 groups).
- Estimated DFYS cost savings of \$169-225,000 (DHSS, DPH, MCFH).

## Seniors

### *What we said we would do*

- Pilot for mental health needs of elderly
- Develop data system to track senior service use

### *What we did*

- Dementia training kit & distance education.
- Increased care coordination for seniors.
- Pioneer Homes renovations
- Construct adult day care in Chugiak & Palmer

### *How well we did*

- Dementia training across the state.
- Care coordination promotes better use of community resources.

### *What we are doing now*

- Identifying beneficiaries in senior services.

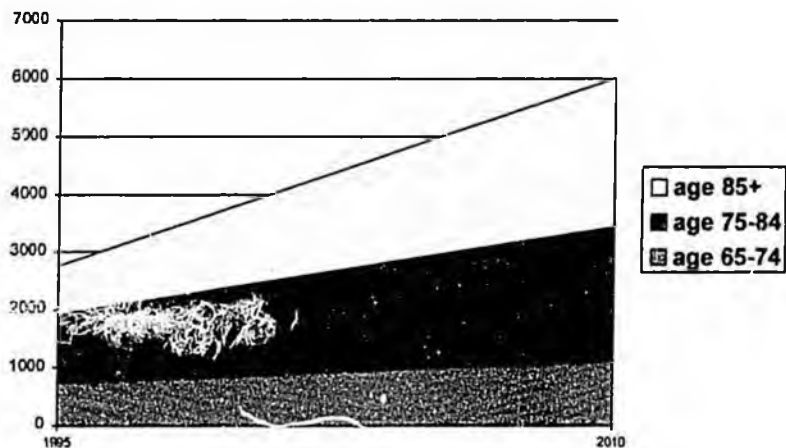
### *Strategies*

- Hire Pioneer Home Aides.
- Build capacity: riding the wave.
- Re-invest savings from the Longevity Bonus to senior programs.
- Supplement General Relief--long term care funding.

### *Validating & monitoring investments*

- Assisted Living Rate Study
- Re-engineering the Guardianship system.
- Adult Protective Services/General Relief data system.
- *Look for ACoA Data base systems to tell how many people used services.*

## Dementia growth 1995-2010



## Alaska Psychiatric Institute

### *What we said we would do*

- Address the API replacement problem

### *What we did*

- Community implementation plan.
- Due diligence review of property.
- Established removal costs for the old building.
- Confirmed need for hospital: 54-72 beds.

### *What we are doing now*

- Completing a coordinated package: buy new building, remove old building, pay for community services before federal rate changes cost the state millions more.

### *Strategies*

- Implement community service plan.
- Negotiate location & cost of replacement hospital with 54-72 beds.
- Emergency psych care in local hospitals.
- Detox for drinking mentally ill people.
- Single point of entry.
- Psychiatric assisted living for people who now live in API.
- Re-allocate savings from API to community services.

### *Validating & monitoring investment: Look for*

- Decreased admissions to API.

## Mental Health

### *What we said we would do*

- Divert people from hospitalization.
- Move individuals from Sourdough at Harborview into community.
- Pilot an independent care coordination model for disturbed children.

### *What we did*

- Funded diversion & crisis respite.
- Closed Harborview.

### *How we did*

- Hospitalizations are down.
- Individuals from Sourdough are in communities.
- Independent care coordination is hard to implement.
- Community mental health Medicaid costs are stabilizing.

### *What we are doing now*

- Quality Assurance audits.
- Developing a QA program.
- Developing program standards.
- Managed mental health care study.

### *Strategies*

- Closely track Medicaid expenditures for mental health services.
- Managed care review--best uses of mental health funds.
- Enhanced services to people who have mental illness and who are drinking.

### *Validating & monitoring investment*

- Community services should result in decreased hospital need.
- Are consumers healthier? Safer? More economically independent?

## Mental Health Quality Assurance

- *Consumer Satisfaction/Quality of Life* An increase in consumer satisfaction and positive outcomes from services.
- *Quality of Services* Development of combined integrated administrative standards (MH/DD/ILP) and refinement of specific direct service delivery standards.
- *Fiscal Accountability* The need to monitor the use of State dollars (both Medicaid and grant funds) used by grantees of DMHDD.
- *Follow-up/Plan of Improvement* To ensure that corrective action is taken when the need for change is identified.
- *Cost Effectiveness of Site Reviews* A consolidated review process that is efficient and useful to service providers, consumers, and the State while costing less than multiple fragmented reviews.
- *Combined and Strengthened On-Site Reviews with minimal disruption* Consolidate the strengths of the various past site review processes coupled with combined team to minimize community disruption (number of site visits) associated with multiple site reviews.

## Economic Security

### *What we said we would do*

- Help Trust beneficiaries at risk of losing SSI, APA, & Medicaid because of federal rule changes.

### *What we did*

- Funded SSI re-determination for alcoholics with psychosis & children with disabilities.

### *How well we did*

- Estimated 1,000 beneficiaries would lose benefits; about 150 actually lost SSI and Medicaid.

### *What we are doing now*

- Funding an Economic Development Consortium using existing small business development sources.

### *Strategies*

- Analysis of economic impacts on seniors of declining income, learning how seniors pay their way.

### *Validating & monitoring investment*

- Funding a cooperative effort on Employment Initiatives
  - finding out what helps beneficiaries stay employed.

## Better use of existing resources

- Mental Health Managed Care Study
  - emerging indicators: housing, employment
- Waiver Review
  - 5 years of DD waivers
- Coordinated transportation
  - leverages federal funds
- Data integration
  - comparing info across systems
- Assessment of facilities
  - prioritizing upgrades
- Task force on insurance coverage for mental health and substance abuse services
- Guardians for vulnerable adults

## FY00 Operating & Capital Recommendations

GF/MH Base	\$118,077.6
Adjustments to GF/MH Base	\$4,045.5
GF/MH (w/o API capital)	\$9,365.0
AHFC	\$3,562.5
Trust funding	\$9,038.0

**Alaska Mental Health Trust Authority**

**FY00 Operating Recommendations (Approved 9/11/98)**

*Continues onto next page*

AMHTA #	Dept/BRU/ Component (DHSS unless otherwise specified)	Descriptions	MHTAAR*	GF/MH**
10010075	DOA/DSS/HCB	Mental Health Needs of Elderly (Yr 3 of 3)	300.0	
10010201	DOA/DSS/HCB	Respite Care for ADRD Seniors	300.0	
10020219	DOA/DSS/HCB	Adult Day Grants		500.0
10020221	DOA/DSS/HCB	Care Coordination Expansion		400.0
10010081	DOA/DSS/PCSA	Rural LTCare Development & Training (Yr 2 of 2)	130.0	
10010218	DOA/DSS/PCSA	Data Development – Div of Senior Services	50.0	
10020079	DOA/DSS/PCSA	LTCare Ombudsman Volunteer Coordinator		70.0
10020220	DOA/DSS/PCSA	Data Management – Div of Senior Services		50.0
10020222	DOA/DSS/PCSA	Assisted Living Rate Increase (DOA)	300.0	480.0
10010076	DOC/StwSvcs/Inm Hlth	Women's Psychiatric Unit (Yr 3 of 3)	200.0	200.0
10010131	DOC/StwSvcs/Inm Hlth	Dept of Corrections Planner (Yr 3 of 3)	30.0	30.0
10010157	DOC/StwSvcs/Inm Hlth	Jail Alternative Services (Yr 2 of 3)	130.0	
10010207	DOC/StwSvcs/Inm Hlth	Women's Resid Substance Abuse Trtmt (Yr 2 of 3)	51.2	
10020154	PrchSv/RsChldCare	Comm Resid Alternatives for SED Yth (Yr 2 of 2)	150.0	50.0
10010208	StHlthSv/HlthFam	Healthy Families Control Group Study (Yr 2 of 3)	100.0	
10010232	StHlthSv/ILPGrants	Institutional Prevention & Quality Assurance-ILP		429.2
10020225	ADA/ADAAdmin	Youth Education, Assessment & Referral Program		50.0
10010010	ADA/Grants	Day Trtmt Dually Diag (MI&Alc) - Ketch (Yr 3 of 3)	63.3	
10010006	ADA/Grants	Trauma Victim Study – Providence ER (Yr 3 of 3)	18.7	
10010026	ADA/Grants	Chronic Alcoholic Domiciliary LT Care (Yr 3 of 3)	100.0	
10010009	ADA/Grants	Program for Dually Diag (MI & Alc) Anch (Yr 3 of 3)	370.0	
10020067	ADA/Grants	Program for Dually Diag - (MI&Alc) Anch/MatSu		350.0
10020226	ADA/Grants	Long-term Care Substance Abuse Treatment		200.0
10020183	ADA/Grants	Residential Svcs for Women/Children		600.0
10010229	ADA/Grants	Women & Children Collaboration Project (Yr 1 of 3)	50.0	
10020224	ADA/Grants	Youth Residential Service Capacity Expansion		50.0
10020227	ADA/Grants	Spirit Camp Replication		63.0
10010007	ADA/PrimaryPrev	Local Option Law "How To" Manual (Yr 3 of 3)	79.7	
10010071	ADA/PrimaryPrev	Fetal Alcohol Syn/ARBD/ARND Prev (Yr 3 of 4)	300.0	
10020182	ADA/RHSvcsGrnts	Increase Rural Human Services	150.0	465.0
10010011	CMHG/GCMHG	Mental Health Consumer & Family Conference	43.7	
10010059	CMHG/GCMHG	API-Related Community Services Implementation	2,000.0	
10010216	CMHG/GCMHG	Implement Integrated Quality Assurance Process (DD/MI/ILP) (Yr 2 of 2)	225.0	
10010156	CMHG/CMHG	Rural Svcs for the Deaf/Hearing Impaired (Yr 2 of 2)	189.9	
10020223	CMHG/CMI	Assisted Living Rate Increase (DHSS)		454.0
10020235	CMHG/PsychEmrg	Emergency, Respite & DET Outside API 2000 Area		500.0
10010012	CMHG/SEDYth	Children's Service Delivery Model (Yr 1 of 3)	390.0	
10020236	CMHG/SEDYth	SED Youth Transition/Family Support Services		146.0
10010113	CDDG/CDDG	Amer Disab Act Comm Prgm Accessibility (Yr 2 of 2)	100.0	
10020228	CDDG/CDDG	Earn as You Learn Program (Yr 1 of 3)	100.0	
10020231	CDDG/CDDG	Substance Abuse Services for People w/Multiple Diagnoses		240.0
10020233	CDDG/CDDG	Institutional Prevention & Quality Assurance-DD		965.8
10020234	CDDG/CDDG	Intensive Inclusive Childcare Training		77.0
10010112	MHTBds/GCDSE	Economic Development Alliance (Yr 2 of 3)	200.0	
10010110	MHTBds/GCDSE	Employment Initiatives (Yr 3 of 3)	308.0	

**Alaska Mental Health Trust Authority**

AMHTA #	Dep/BRU/ Component (DHSS unless otherwise specified)	Descriptions	MHTAAR*	GF/MH**
10010114	MHTBds/GCDSE	DD Medicaid Waiver Study Implementation (Yr 2of2)	50.0	
10010211	Inst&Ad/API	API Quality Assurance (Yr 2 of 2)	20.0	
10010217	Inst&Ad/MHDDAdm	Mental Health Consumer Affairs Position (Yr 2 of 2)	90.0	
10010018	AdSvcs/Pln&Facil	Comprehensive Integrated Mental Health Plan	50.0	
<b>SUBTOTAL</b>			<b>\$6,639.5</b>	<b>\$6,370.0</b>
30010165	Trust Administered	Trust Small Projects Funding (3 times/year)	105.0	
30010215	Trust Administered	Rural Outreach Project	25.0	
30010237	Trust Administered	Board Collaboration	20.0	
30010238	Trust Administered	Telepsychiatry	25.0	
30010239	Trust Administered	Miller Trust Project	25.0	
<b>TOTAL RECOMMENDATION by Source</b>			<b>\$6,839.5</b>	<b>\$6,370.0</b>

**FY00 Adjustments to the GF/MH\*\* Base**

KEY	Dep/BRU/ Comp	Description	From	To	Amount
40020247	DOA/AKL/PioHms	Pioneer Homes	GF	GF/MH	\$3,480.7
40020248	DOA/Legal& Advocacy/OPA	Office of Public Advocacy	GF	GF/MH	564.8

**FY00 Trust Administration and Natural Resource Management**

KEY	Dept/BRU/ Comp	Description	MHTAAR *	MHT Admin ****	TOTAL
10010162	DOR/ MHTA	Trust Authority Administration (8.9% of total MHTAAR)		\$924.9	\$924.9
10010163	DNR/MHT Land Office	Mental Health Trust Land Office and Natural Resource Management	\$938.5		938.5
<b>TOTAL Trust Administration &amp; Natural Resource Development</b>			<b>\$938.5</b>	<b>\$924.9</b>	<b>\$1,863.4</b>

\*MHTAAR = Mental Health Trust Authority Authorized Receipts    \*\*GF/MH = General Fund/Mental Health  
 \*\*\*\*MHT Admin = Mental Health Trust Authority Administration

**Alaska Mental Health Trust Authority**

**FY00 Capital Budget Recommendations** (Approved 9/11/98)

KEY	Dept	Description	MHTAAR*	GF/MH**	AHFC***	Fed'l & Other	TOTAL
20030198	DOA	Pioneer Homes Renovations			262.5		262.5
20010241	DOA	Data Development-DSS (Capital)	\$100.0	\$100.0			200.0
20020242	DOA	Juneau Adult Day Center		50.0			50.0
20010240	DHSS	Program Facilities: Deferred Maintenance & American Disabilities Act Upgrades	250.0	250.0			\$500.0
20010034	DHSS	Program Equipment	100.0	100.0			200.0
20020191	DHSS	API Repair & Maintenance		225.0			225.0
20030245	DHSS	API Replacement of Existing Facility		14,000.0		15,000.0	29,000.0
20020243	DHSS	Ketchikan Residential Diagnosis & Treatment Center		1,200.0			1,200.0
20020244	DHSS	Rural Human Services Facilities Upgrades		500.0			500.0
20020246	DHSS	Housing Modifications for People with Special Needs		420.0	500.0		920.0
20030035	DOR/AHFC	Beneficiary and Special Needs Housing Program			2,000.0		2,000.0
20030196	DOR/AHFC	Homeless Assistance Program (HAP)	200.0		800.0		1,000.0
20010199	DNR	Trust Land Office - Land & Resource Enhancement	660.0				660.0
20010033	DOT/PF	Coordinated Transportation & Vehicles	150.0	150.0			300.0
		MHTAAR	\$1,460.0				
		GF/MH		\$16,995.0			
		AHFC			\$3,562.5		
		Federal & Other				\$15,000.0	
		TOTAL					\$37,017.5

\*MHTAAR = Mental Health Trust Authority Authorized Receipts

\*\*GF/MH = General Fund/Mental Health

\*\*\*AHFC = Alaska Housing Finance Corporation Receipts