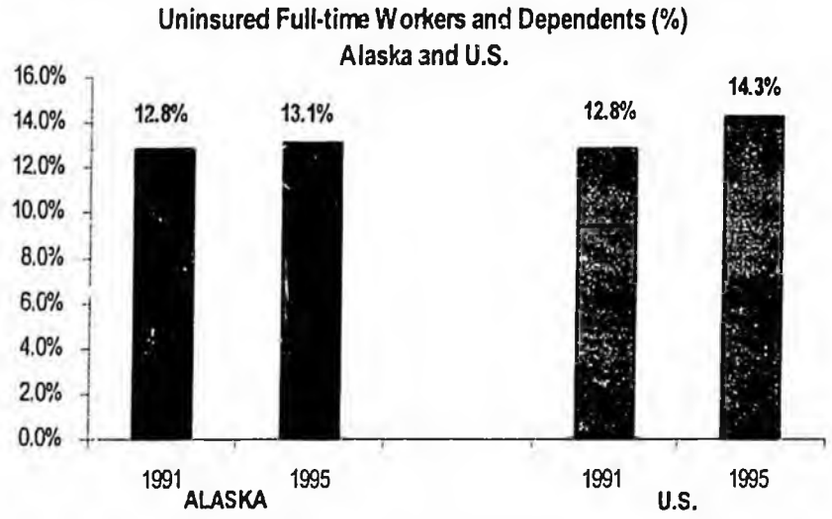
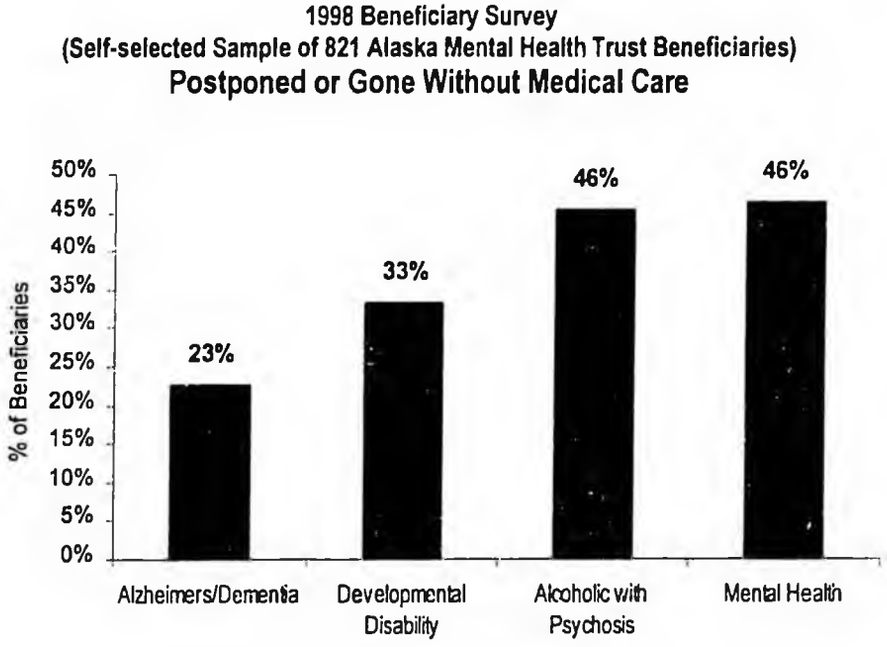
Result #1: HEALTH

Indicator Baselines:



Reforming the Health Care System: State Profiles 1997, Public Policy Institute, AARP, Washington, DC, 1997.



The Story Behind the Baselines: Access to health care in Alaska is a complicated issue. In 1992, the Health Resources and Access Task Force reported to the Alaska Legislature that there were 90,000 uninsured Alaskans and that many of those with insurance had inadequate coverage. In 1995, 13.1% of Alaskan workers and their dependents did not have health insurance. Even with health insurance or Medicaid, access to health can be limited by other factors. Physicians often limit the number of Medicaid or Medicare patients they treat because the reimbursement for services does not meet the usual fee charged for the health care. Access is also sometimes limited by geographic factors. People living in remote areas of the state often have to fly to an urban area to get medical or dental care. Private insurers do not cover or adequately cover behavioral health and substance abuse services.

"Before, the argument was, if you got to see the doctor for free, everyone was going to see the doctor every other day. But now the argument is the opposite. A lot of people who need to see the doctor run out of money so they don't see the doctor when they need to, because they don't have any money to pay."

Consumer
1998 Beneficiary Survey

Medicaid is an important health care payment source for many Mental Health Trust beneficiaries. Even with medical coverage, beneficiaries often can not find physicians willing to treat them. While Medicaid pays for the full range of medical services, it only pays for acute dental service for adults.

"We have no decent dental care. You can go get a tooth pulled if you are in pain. But to maintain, you can't get a teeth cleaning, you can't get caps."

Consumer
1998 Beneficiary Survey

Information on access to health care for Trust beneficiaries is not yet available. However, the Beneficiary Survey asked beneficiaries if they had postponed or gone without medical care in the previous 12 months. Mental health (46%) and alcoholics with psychosis (46%) beneficiaries were the most likely to have postponed or gone without care. Survey respondents with Alzheimer's or related dementia (23%) were the least likely to postpone medical services, probably because most of these beneficiaries are over 65 and eligible for Medicare.

"My health insurance pays for about 10% of my medical bills, and then they wonder why mental health people are not getting their medical care. They wonder why we don't get better. I never did have Medicaid."

Consumer
1998 Beneficiary Survey

Current Efforts to Turn the Curve: Medicaid income eligibility for children was recently expanded in Alaska through Denali KidCare. Other efforts that provide access to health care for beneficiaries are pro bono dental programs (Anchorage and Fairbanks), and sliding fee medical services through Section 330 Community Health Centers (Fairbanks and Anchorage). In 1999, a bill was introduced in the Legislature to provide for parity between physical and mental health coverage.

Recommended Strategies:

Expansion of Current Efforts

1. Include screening for mental health disorders in EPSDT screenings.
2. Expand Medicaid coverage of dental services for adults to include preventive care.

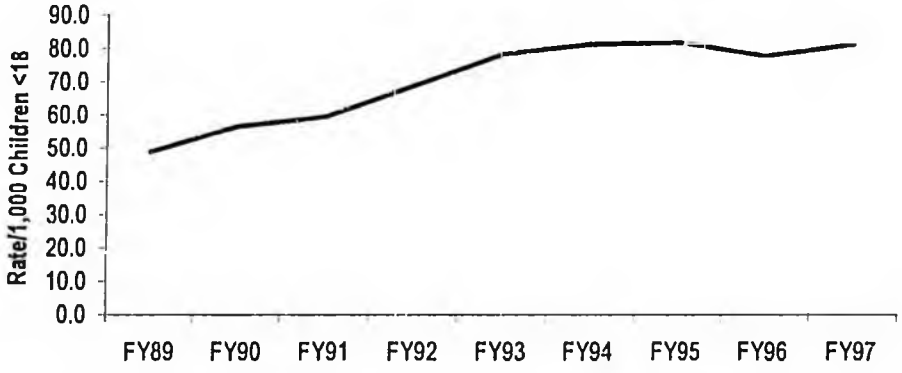
New Initiatives

1. Monitor the expansion of Medicaid income eligibility for children's health services.
2. Develop affordable health plans for young adults who may not be in school or working.
3. Implement the recommendations of the Parity Task Force.

Result #2: SAFETY

Indicator Baselines:

Child Protection Services: Rate of Reports of Abuse and Neglect (Alaska)



Alaska Department of Health and Social Services, Division of Family and Youth Services, Juneau, AK

The Story Behind the Baselines: The Division of Family and Youth Services collects information on reports of harm to children. Reports of harm doubled between FY89 and FY97, increasing from 7,876 to 15,547. In 1997, there were 8,990 reports of neglected children, 4,123 reports of physical harm, 2,094 reports of sexual abuse and 340 'other' reports (abandonment and mental injury). A child may be the subject of more than one report of harm. Reports of neglect are continuing to increase while physical and sexual abuse reports began to level off in FY95. Abuse and neglect are major risk factors for emotional disorders, substance abuse, suicide and involvement with the correctional system. Many children who experience abuse and neglect repeat the pattern as adults by abusing and neglecting their own children. A recent study by the University of Alaska Justice Center (1998) shows that 82% of Alaska's long-term prisoner population reported that they experienced some form of sexual or physical abuse prior to their thirteenth birthday. Two-thirds (66%) reported being neglected as children. Another 1998 Department of Corrections study of the needs of female offenders found that 84% of women inmates experienced physical, sexual or emotional abuse at sometime in their lives. Information on reports of harm for Trust beneficiaries is not yet available.

"We need counseling services for the whole family, because anger comes into this a lot, because your whole life is gone, and now you're this other person. But counseling, because it's not only affecting you but it affects your kids, your significant other or husband, or your grandparents, or your aunts."

Consumer
1998 Beneficiary Survey

Current Efforts to Turn the Curve: The Healthy Families Program, supported parenting programs for people with developmental disabilities, and other early intervention programs are aimed at intervening with families at risk of child abuse and neglect. Other programs that can impact abuse and neglect of children are domestic violence programs, emergency medical services, Public Health Nurses, Community Health Aides and Public Safety Officers, and homemaker and chore services.

Recommended Strategies:

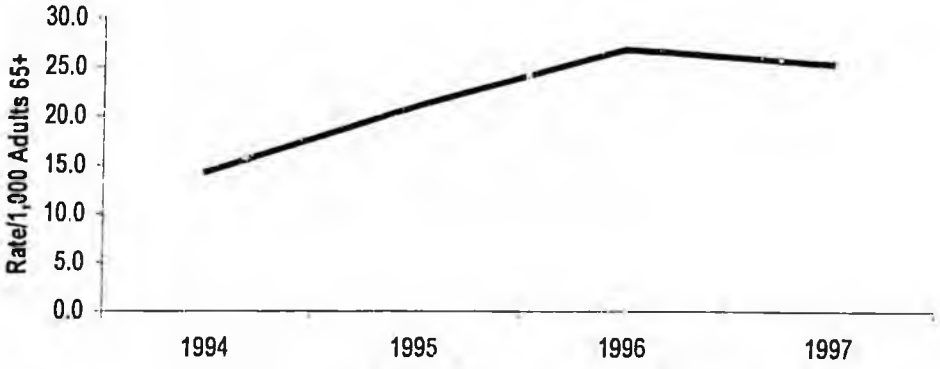
Expansion of Current Efforts

1. Increase the availability of in-home early intervention programs for at-risk families.
2. Increase the availability of parent training and support services.
3. Increase the availability of emergency respite care for children and adults.
4. Increase the availability of before and after school programs for children.

Result #2: SAFETY

Indicator Baselines:

Adult Protective Services: Rate of Reports of Abuse and Neglect (Alaska)



Alaska Department of Administration, Division of Senior Services, Anchorage, AK

Superior Court: Probate Case Filings

Guardianship Petitions: 1983 - 1997

The Alaska Guardianship System, The McDowell Group, September 1998.

The Story Behind the Baselines: The Division of Senior Services in the Department of Administration receives and tracks reports of harm to seniors and other dependent adults, including adult Alaska Mental Health Trust beneficiaries. The rate of reports increased from 14.3 reports for every 1,000 Alaskans 65 and older in 1994 to 25.3/1,000 in 1997. The increase can be attributed, to some extent, to the reorganization of Adult Protection Services in the Division of Senior Services in July 1994. The Division developed a public information campaign about elder abuse and was able to focus greater staff resources at responding to and following up on reports.

"Legal Services and Disability Center is good, but there's not enough money to have them help us for all of the problems. There either needs to be more money for those agencies or ways that private attorneys would benefit, because they can only do so much pro bono."

Consumer
1998 Beneficiary Survey

Information on reports of harm for Trust beneficiaries is not yet available.

In a 1998 study of the relationship between guardianship and safety by the McDowell Group, it is estimated that 95% of adults who have guardians are beneficiaries of the Mental Health Trust. The Alaska guardianship system serves an estimated 2,700 protected persons. Approximately 2,000 of these individuals have private guardians, usually family members. The study estimates that the major reasons for guardianship care for adults are:

"I don't want to be by myself, but I want to take care of my own money."

Consumer
1998 Beneficiary Survey

Alzheimer's' and related dementia	40 - 50%
Mental illness	25 - 35%
Developmental disabilities	20 - 25%
Chronic substance abuse with psychosis	5 - 15%
Other	5 - 10%

"I was so involved and so worn out by the time I went to get help that I think that I wasn't thinking things through very well. But it seemed like I would hear about one thing and would go to that agency and somehow they never made it clear what groups did what things."

Consumer
1998 Beneficiary Survey

Current Efforts to Turn the Curve: Programs that can impact abuse and neglect of seniors are domestic violence programs, emergency medical services, Public Health Nurses, Community Health Aides and Public Safety Officers, homemaker and chore services, care coordination, substance abuse services, and outreach services to seniors with mental illness.

Recommended Strategies:

Expansion of Current Efforts

1. Increasing respite care for caretakers of vulnerable adults.
2. Improve the quality of personal care and home health services through direct care provider training.

3. Provide family support and counseling services to families supporting vulnerable adults.)

4. Increase the number of public guardians.

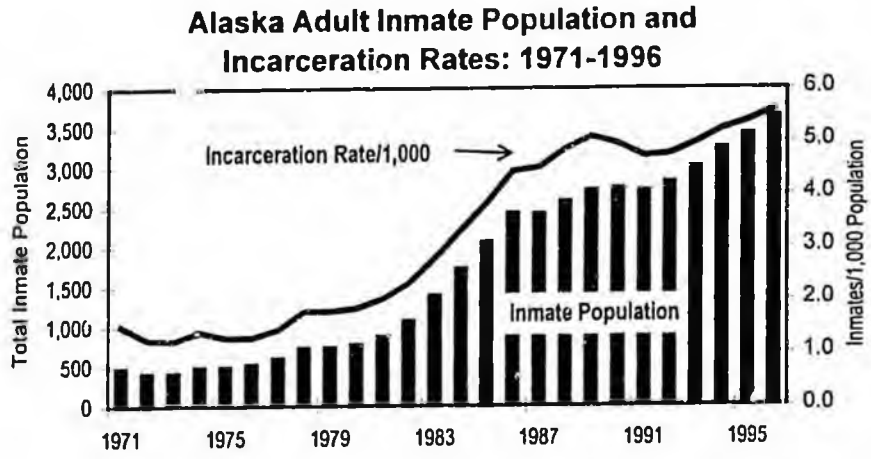
New Initiatives

1. Increase Personal Care Attendant (PCA) and assisted living rates, including augmented rates for people with mental illness or substance abuse problems.

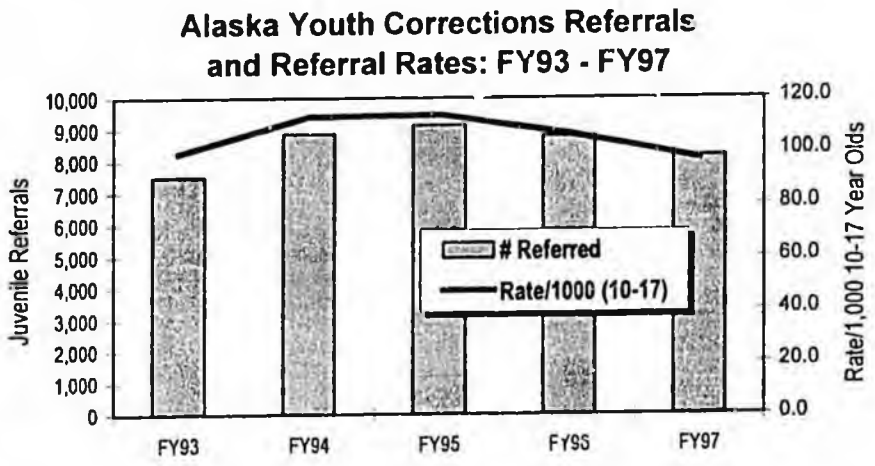
2. Provide treatment opportunities for those who abuse and neglect dependent adults.)

Result #2: SAFETY

Indicator Baselines:



Average Annual Populations and Incarceration Rates (1971-1996), Alaska Department of Corrections, Anchorage, AK



Referral Summary (FY93 - FY97), Alaska Department of Health and Social Service, Division of Family and Youth Services

The Story Behind the Baselines: Alaska has one of the highest incarceration rates in the nation. In 1971, 1.5 of every 1,000 Alaskans was in prison. By 1996, the rate had more than tripled to 5.5 per 1,000. Between 1971 and 1996, the total incarcerated population increased from 482 to 3,648, or by 657%. Over this same period, the state population increased by only 104%. Some of the factors affecting the increase in the incarceration rate are:

- rise in the violent crime rate
- increases in police forces
- 1980 revision of the Criminal Code, including establishment of presumptive sentencing
- 1982 and 1983 Criminal Code revisions expanding presumptive sentencing
- mandatory minimum sentences for DWI offenders
- rise in serious juvenile crime and the 1994 juvenile waiver law requiring juveniles convicted of certain felonies be automatically waived to the adult system
- lack of emergency psychiatric services in the community to deal with violent mentally ill clients
- lack of transitional/supported housing in the community for displaced or discharged de-institutionalized mentally ill patients
- reduction in support services for ex-offenders

"A few times my symptoms have been really bad, and I've called for help and the Juneau Police Department showed up at my door to take me in, and that's not what I needed. I just needed the support and help though. I didn't need the police there."

Consumer
1998 Beneficiary Survey

Alcohol abuse has a significant impact on incarceration rates in Alaska and nationally. The National Center for Addiction and Substance Abuse reported that 80% of the men and women behind bars in the nation's prisons are seriously involved in alcohol and drugs. In Alaska, the Criminal Justice Work Group reported in 1994 that alcohol is the primary or contributing factor in 80% to 95% of all criminal offenses committed.

In March through July 1997, the Division of Alcohol and Drug Abuse conducted interviews and collected urine samples from inmates at the Fairbanks, Bethel, Cook Inlet Pre-Trail Facility (CIPT), and 6th Avenue correctional facilities. The prisoners participating in the study were volunteers and had been arrested within 48 hours of their interview. The study found that 48% were abusing or dependent on alcohol, 18.5 on cocaine and 13.1% on marijuana.

In FY97, there were 8,163 juveniles (or 96.9 referrals per 1,000 youth aged 10 to 17) referred to the youth corrections program in the Alaska Department of Health and Social Services. A 1996 survey at the McLaughlin Youth Center in Anchorage indicated that 65% of residents had a DSMIII/IV diagnosis and 9% had severe emotional disorders. The New York Times recently reported that nationally up to 20% of incarcerated juveniles are seriously emotionally disturbed and that,

often, going to jail is the only way for many to get treatment.

Current Efforts to Turn the Curve: Some of the programs that are working to reduce adult and youth incarceration and recidivism are alternative sentencing and specialized probation officers, Community Residential Centers and electronic monitoring. Programs developed for Trust beneficiaries in the correctional system include treatment programs for prisoners with mental illness or alcoholism, diversion and the Institutional Discharge Program. Programs and activities aimed at preventing incarceration are Youth Court, Smart Start, alcohol and substance abuse treatment programs, community mental health programs, and child abuse and neglect programs.

Recommended Strategies:

Expansion of Current Efforts

1. Increase the availability of discharge programs, including transition planning, designed to support the transition of beneficiaries from the correctional system to the community.
2. Stricter interpretation and sanctions (including youth oriented alcohol treatment services) for young people charged with minor consuming.
3. School-based alcohol and drug support for adolescents.

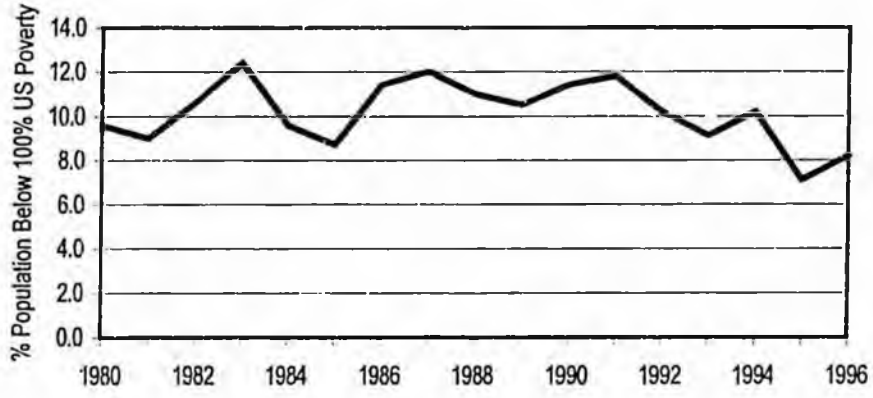
New Initiatives

1. Increase the number of communities with Youth Courts and other diversion programs (including Mental Health and Drug Courts) for youth.
2. Provide misdemeanant diversion programs.
3. Pilot a community based, single point of entry for behavioral health emergencies as an alternative to placement in the correctional system.
4. Provide support services and housing to youth transitioning from the juvenile correctional system.
5. Allow youth treatment programs flexibility in extending services past the youth's 18th birthday.
6. Provide early intervention services to high-risk youth, e.g. siblings of youth already in jail.

Result #3: ECONOMIC SECURITY

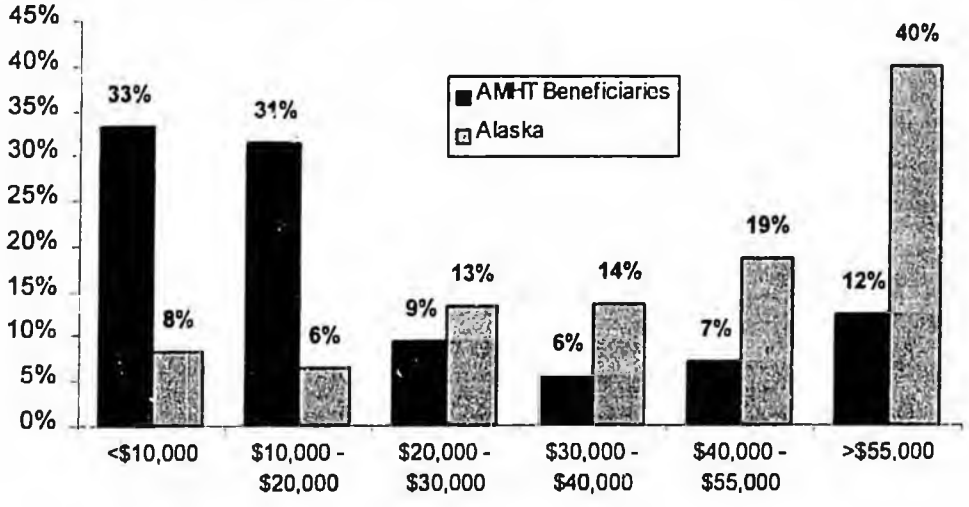
Indicator Baselines:

Poverty in Alaska: 1980 - 1996



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

1998 Beneficiary Survey
(Self-selected Sample of 821 Alaska Mental Health Trust Beneficiaries)
Beneficiary and General Population Income: 1998



The Story Behind the Baselines: Income and poverty levels are measured every ten years as part of the federal census and updated annually by the US Census Bureau. The current method of determining the official poverty rate is based solely on income and family size. Families with incomes low enough to qualify for cash benefits also qualify for other programs that reduce their need for cash. Such families can receive subsidized housing at reduced rents, free medical care through Medicare and Medicaid, food assistance with Food Stamps, and childcare. As part of the planning process for the 2000 census, the US Census Bureau is considering including income and non-cash benefits in the determination of poverty.

"On the housing programs and the Dividends, our rents should not go up. They're charging us one-third of our income, and if we have a child in the house, then they count it as income and raise the rent."

Beneficiary
1998 Beneficiary Survey

According to the US Census Bureau, the Alaska poverty rate is equal to 125% of the U. S. poverty rate. The only source of Alaska poverty rate data is a special report prepared for the Division of Public Health by the Census Bureau from the 1990 Census, which included analysis of poverty by census area/borough, age group and ethnicity. Over the past 16 years, the percentage of Alaskans below 100% US poverty has varied from year to year, but averaged approximately 10% of the population. In 1990, nearly 30% of Alaska Natives were living at or below the poverty level. At the same time, nearly 1 in 5 children under 5 years old was living under the Alaska poverty level.

"They're doing a good job of keeping us at poverty level."

Beneficiary
1998 Beneficiary Survey

The US Census Bureau reported that in 1994-95, people with disabilities were at greater risk of having a low income than other Americans. They found that for people between the ages of 22 and 64, 13.3% of those who had no disability were classified as low income, compared to 19.3% of those with non-severe disabilities and 42.2% of those with severe disabilities. Consumer fraud of seniors is a national trend that is negatively impacting the limited incomes of people over 65.

"We can't afford to go bowling, or to the movies, or out to dinner. We don't have the extra money to do any of these things."

Beneficiary
1998 Beneficiary Survey

The Beneficiary Survey, conducted by the Alaska Mental Health Trust Authority in 1998, asked beneficiaries for information about their household income. Survey participants reported incomes that contrast drastically with the household income for the general population. Nearly two-thirds (64%) of the beneficiaries participating in the survey reported household incomes of less than $20,000 while on 15% of Alaskan Households fell in this income group. Conversely, 59% of all Alaskan households reported incomes of more than $40,000, while only 19% of beneficiaries reported similar household incomes. Alaska Psychiatric Institute reported that 90% of adults admitted had income below $20,000 while 80% of adults receiving services from community mental health centers reported incomes below $40,000.

Current Efforts to Turn the Curve: Some of the strategies that are proving effective at increasing the incomes of 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. On-going support after acquiring employment is a determining factor in job retention for many beneficiaries. Senior employment programs provide many seniors with jobs as senior volunteers and help train seniors to acquire unsubsidized employment.

Recommended Strategies:

Expansion of Current Efforts

1. Educate seniors about consumer fraud.
2. Increase respite or day care funding so that caregivers can continues working while caring for a beneficiary.

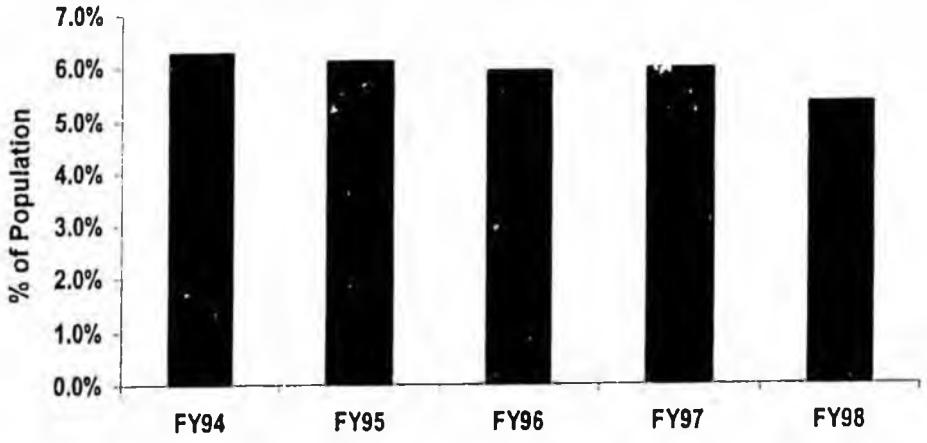
New Initiative

1. Establish a consumer credit union specifically for beneficiaries.

Result #3: ECONOMIC SECURITY

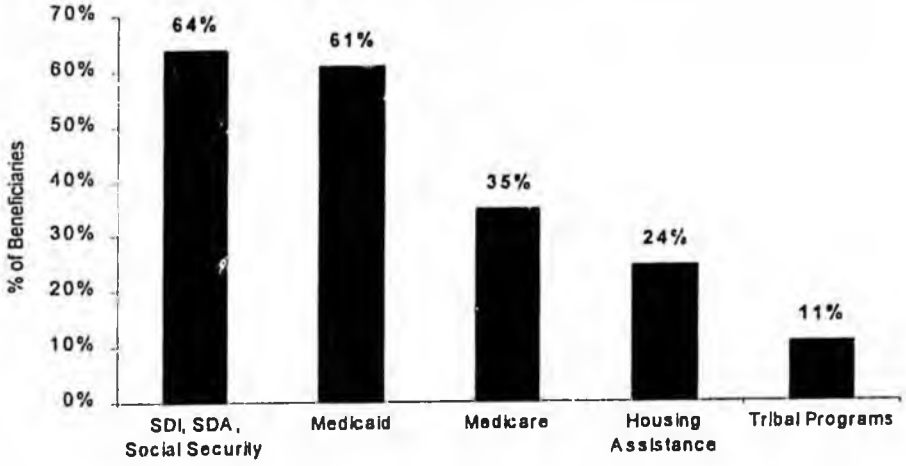
Indicator Baselines:

ATAP Recipients as a % of Alaska Population



Alaska Division of Public Assistance, Department of health and Social Services, August 1998

1998 Beneficiary Survey
(Self-selected Sample of 821 Alaska Mental Health Trust Beneficiaries)
Reported Use of Financial Assistance Programs



The Story Behind the Baselines: The Alaska Temporary Assistance Program (ATAP) was signed into law in 1996. The goal of welfare reform is to: *move Alaskans from welfare to jobs so they can support their families, while maintaining a safety net for those truly in need.*

"I used to make more money in a day than I have in allowance for one week now, and I paid more taxes than I get in benefits today."
Beneficiary
1998 Beneficiary Survey

The first year of ATAP brought significant changes to the welfare caseload, including:

- The welfare caseload declined by 15%
- Welfare savings for FY98 were more than $24 million
- The welfare caseload dropped to under 11,000 for the first time since 1992

"I'm a single parent with two kids at home. And it's hard. One of my children has a disability, and it's hard to try to go out and work without the support I need for my kids, the childcare."
Beneficiary
1998 Beneficiary Survey

The Division of Public Assistance estimates that 5% to 10% of those receiving ATAP are Alaska Mental Health Trust beneficiaries. One of the most significant changes brought about by welfare reform is the five-year lifetime limit of ATAP benefits. Most of the people who came off the welfare rolls during the first year were the most ready-to-work. There is currently no safety-net for recipients who complete five years of ATAP benefits and who are unable or unwilling to work. There are an unknown number of beneficiaries on ATAP for whom the goal of employment is unrealistic.

Other financial assistance programs provide support for Mental Health Trust beneficiaries. Many of the beneficiaries who participated in the Beneficiary Survey reported that they receive assistance through Social Security (64%) and Medicaid (61%), Medicare (35%), housing assistance (24%) and tribal assistance programs (11%). Eight thousand (8,000) adults with disabilities receive Adult Public Assistance, about 45% of whom have a psychiatric disability.

Current Efforts to Turn the Curve: Some of the strategies that are proving effective at increasing the number of people leaving public assistance are child care subsidies, job readiness programs, job training, and case management.

Recommended Strategies:

Expansion of Current Efforts

1. Case management to assist with access to public assistance and services.
2. Provide employer incentives for training and hiring hard to place ATAP and APA recipients.
3. Collect and analyze information collected about beneficiaries who use public assistance (disability, use of public assistance services, use over time)
4. Support legislation and funding for programs that provide beneficiaries with home and community based alternatives to institutional care.
5. Increase access to guardians, conservators, representative payees and provide assistance with paperwork.

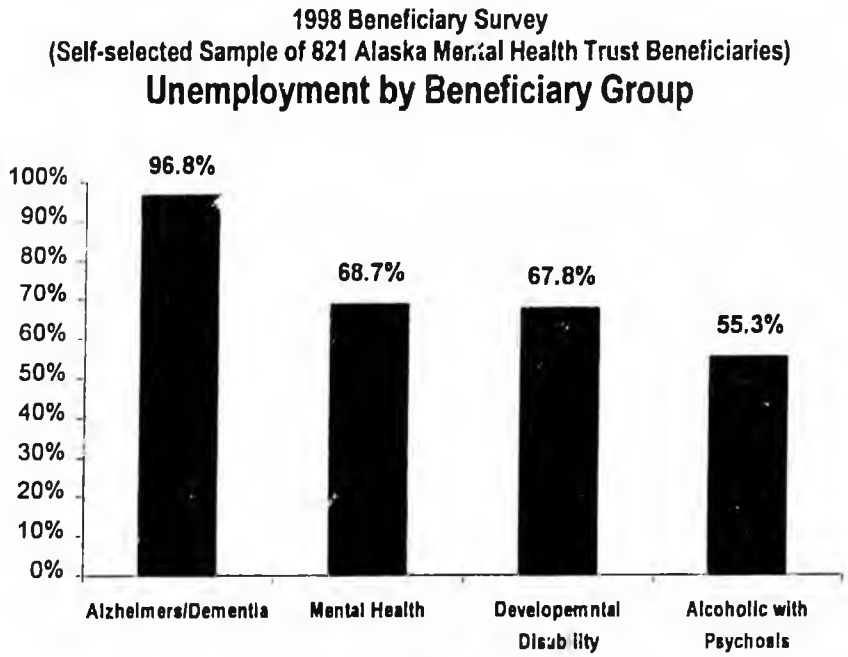
New Initiative

6. Develop strategies to assure beneficiaries access to public assistance services even if they have received Alaska Temporary Assistance Programs (ATAP) services for five years. (*New policy initiative)*

RESULT #4: PRODUCTIVELY ENGAGED, EMPLOYED,CONTRIBUTING

Indicator Baselines:

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



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

"That's the only reason why I haven't gone out to look for work--to keep my medical coverage."

Consumer
1998 Beneficiary Survey

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.

"I refuse to quit (job). My four hour day is all I get, and that is the most wonderful thing in my whole life, besides my children."

Consumer
1998 Beneficiary Survey

National sources estimate that up to 65% of adults with a variety of disabilities are unemployed. The Mental Health Trust Beneficiary Survey found similar rates of unemployment in Alaska. Of those who took part in the telephone survey, 69% of those with mental illness and 68% of those with developmental disabilities reported that they were unemployed. Fifty-five percent (55%) of alcoholics with psychosis and 97% of those with Alzheimer's or other dementia, most of whom are 60 or older, said that they were not employed.

Even when Trust beneficiaries are employed, they are often in part-time, low paying jobs. Beneficiaries may 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. Loss of medical benefits was the most commonly cited reason given for not seeking work by unemployed beneficiaries. The cost of some psychotropic drugs which make it possible for mentally ill people to work can cost $900 per month. Other frequently cited reasons were discrimination, inability to find a job, and lack of training.

"Vocational Rehabilitation has helped me find a job."

Consumer
1998 Beneficiary Survey

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. The Governor's Council on Disabilities and Special Education recently received federal funding for a five-year employment initiative (Alaska Works). Senior employment programs provide many seniors with jobs as senior volunteers and helps train

seniors to acquire unsubsidized employment. During their 1998 session, the Alaska Legislature passed 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.

"Job coaching takes people out and helps people get a job; they are helpful. They give you good information. They help you out."

Consumer
1998 Beneficiary Survey

Recommended Strategies:

Expansion of Current Efforts

1. Increase Division of Vocational Rehabilitation transition services to beneficiaries 18 to 21 years old, including those in alternative schools.
2. Increase the number of school districts that support beneficiaries in inclusive settings.
3. Increase the number of beneficiaries, including those in the juvenile justice system, who complete school and pass high school qualifying exams or complete a GED.
4. Provide access to educational resources to juveniles in the adult correctional system.

New Initiatives

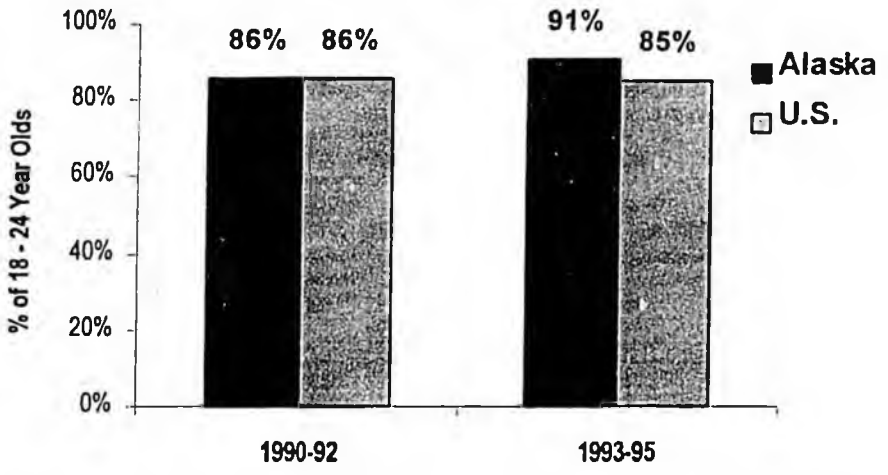
5. Provide cross-beneficiary job support services.
6. Create work opportunities for beneficiaries in the adult correctional system.
7. Monitor implementation of new employment initiatives, including Alaska Works and changes to Medicaid, to determine whether they provide expanded employment opportunities for beneficiaries.
8. Develop a strategic plan for the education of Trust beneficiaries.

Result #4: PRODUCTIVELY ENGAGED, EMPLOYED, CONTRIBUTING

Indicator Baseline:

Alaska and U.S.

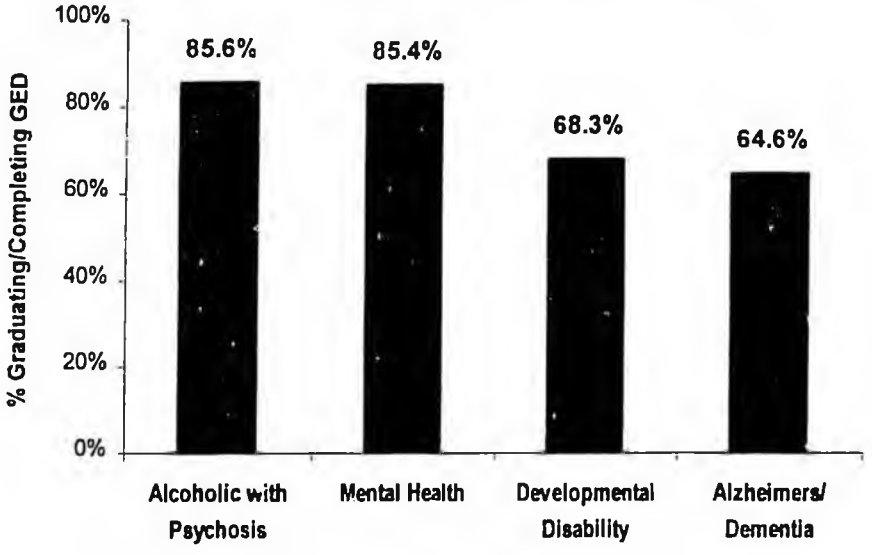
High School Completion Rate



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

1998 Beneficiary Survey
(Self-selected Sample of 821 Alaska Mental Health Trust Beneficiaries)

High School Graduation/GED Completion



The Story Behind the Baselines: Each October, the US Census Bureau conducts the Current Population Survey. Among the information collected is "high school completion rates for 18 through 24-year-olds not currently enrolled in high school". This information is collected for each state and is computed based on data spanning three years. In the years 1993-95, the Alaska high school completion rate was 90.5%, compared to a national rate of 85.5%.

The Mental Health Trust Beneficiary Survey found similar rates for high school graduation or GED completion for two beneficiary groups, alcoholics with psychosis (85.6%) and those with mental illness (85.4%). Approximately two-thirds (68.3%) of the survey participants with developmental disabilities had graduated from high school or completed a GED. Beneficiaries who have Alzheimer's or related dementia had the lowest high school completion rate (64.6%), which is probably a function of growing up at a time when many young people left high school to work or join the military.

"When I was going to high school, I had a teacher who said I wouldn't be able to graduate from high school. He said, "You'll never make it to college." I graduated from high school with honors, and I enrolled in college for an Associates degree. I have three more credits and I'll have an Associates degree."
Consumer
1998 Beneficiary Survey

The National Center for Education Statistics reported that in 1995, the percentage of young adults with disabilities (16 to 24 years) who dropout was 14.6%. The percentage of non-disabled young adults who dropped out was 11.8%. Students with mental illness are the most likely to dropout (56.1%), followed by those with mental retardation (31.1%), serious emotional disturbances (23.6%), and specific learning disabilities (15.8%). Learning disabilities were the most commonly reported disability in the study, affecting 2.2% of the population or one-third of the youths with disabilities in the age group.

"We need more adult basic centers in villages for school; for GED, ABE (Adult Basic Education). They quit the ABE program in my village."
Consumer
1998 Beneficiary Survey

Current Efforts to Turn the Curve: Some of the programs and initiatives proving to be effective at improving the educational outcomes for beneficiaries are education in regular classrooms, transition planning, mental health treatment services linked with special education programs, and support programs like peer counseling.

Recommended Strategies:

Expansion of Current Efforts

1. Increase the number of children in inclusive classrooms.
2. The Department of Health and Social Services and the Alaska Mental Health Trust Authority develop collaborative relationship with the Department of Education.

3. Increase the number of beneficiaries, including those in the juvenile justice system, who complete school and pass high school qualifying exams or complete a Graduate Equivalency Diploma (GED).
4. Increase access to educational resources for juveniles in the adult and juvenile correctional systems.

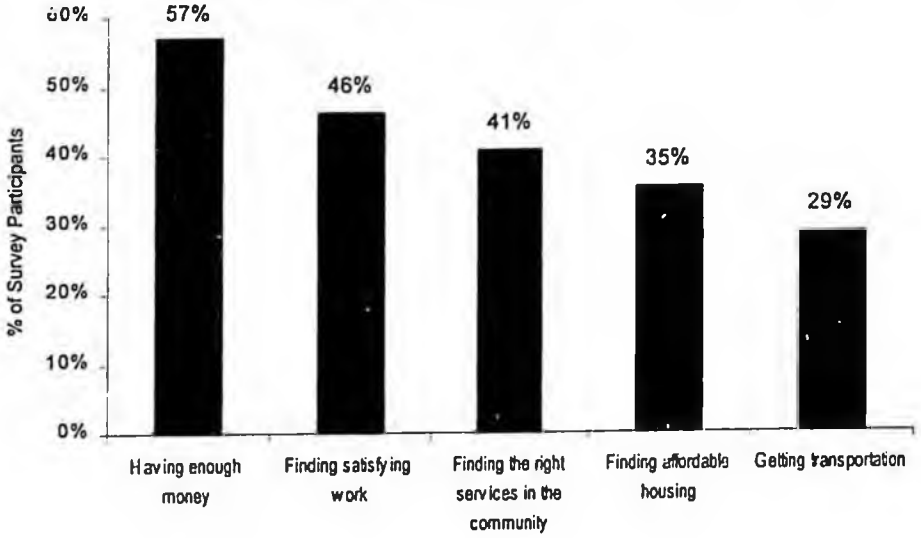
New Initiatives

1. Fund periodic audits of IEPs and make recommendations based on findings)
2. Develop an education strategic plan for beneficiaries.

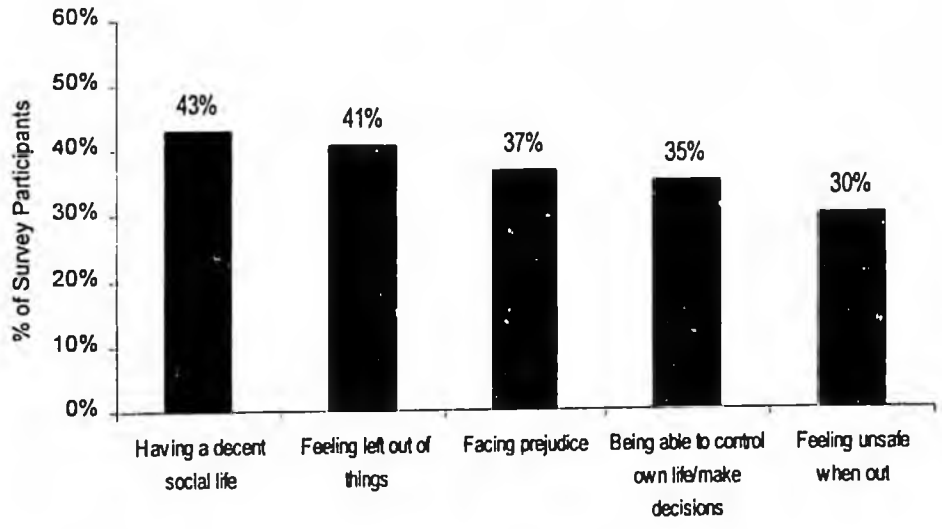
Result #5: LIVE WITH DIGNITY / VALUED MEMBERS OF SOCIETY

Indicator Baseline:

1998 Beneficiary Survey
(Self-selected Sample of 821 Alaska Mental Health Trust Beneficiaries)
Problems Encountered with Community Living



1998 Beneficiary Survey
(Self-selected Sample of 821 Alaska Mental Health Trust Beneficiaries)
Problems Encountered with Community Integration/Acceptance



The Story Behind the Baselines: Until recently, people with mental illness, developmental disabilities, chronic alcoholism and dementia were routinely removed from their homes and communities and placed in institutions. Until the late 1950s, hundreds of children and adults were sent to Morningside (Oregon) and other institutions thousand of miles from their homes and families. After statehood, beneficiaries received services in Alaska, but generally in centrally located institutions. As a result, people with disabilities were rare in communities and were often viewed with suspicion and mistrust. It is only in recent years, that local, community-based services have begun to spread across the state. Part of the mission of the Trust is to assist beneficiaries in becoming valued and contributing members of their communities.

Beneficiaries who participated in the Alaska Mental Health Trust Beneficiary Survey were questioned about problem areas they encountered in community living. Some of the problem areas noted were having enough money (57%), finding satisfying work (46%), finding the right services in the community (41%), finding affordable housing (35%), and getting transportation (29%).

Beneficiaries participating in the survey were also asked about some of the issues they faced in community integration and acceptance. The most common problems were having a decent social life (43%), feeling left out of things (41%), facing prejudice (37%), being able to control their own lives and making decisions (35%), and feeling unsafe when out (30%).

There is currently no comparable general population data.

Current Efforts to Turn the Curve: Some of the programs that have proven to be effective at providing beneficiaries with community living and home ownership support are HUD Section 8 and Supported Housing Programs, HUD 811 and 202 programs, the developmental disabilities and mental health housing grants, transitional housing and domicilary care, supported living, and in-home support programs. In addition, there are general relief and housing assistance programs for elders. Advocacy groups, such as NAMI Alaska, the Alzheimer's Association, and the Key Coalition play important roles in educating the public, changing attitudes, and advocating for community options for people with disabilities.

"Everyone should be guaranteed a place to live. Nobody should be homeless."
Consumer
1998 Beneficiary Survey

"I like having a roof over my head and money coming in. And I'm at a level that I'm feeling O.K. and can get back out in the community."
Consumer
1998 Beneficiary Survey

"I don't have things to do. I'm not a street roamer, I do not drink, and I am very isolated. I need friends."
Consumer
1998 Beneficiary Survey

"I like volunteering."
Consumer
1998 Beneficiary Survey

"I like to go drumming. One of my plans is working at a music store and being a drum teacher and beginning a band. And I'm really good. I was in the newspaper for Artist of the Week."
Consumer
1998 Beneficiary Survey

"Anything is possible. I went skydiving a year and a half ago."
Consumer
1998 Beneficiary Survey

"Maybe I'd think about getting married and finding a girlfriend someday."
Consumer
1998 Beneficiary Survey

Recommended Strategies:

Expansion of Current Efforts

1. Ensure compliance with standards of care for facilities providing home and community based services for beneficiaries.
2. Provide training opportunities for community emergency services personnel (police, EMTs, hospital staff) on dealing with beneficiaries in crisis situations.
3. Support efforts to integrate beneficiaries into their communities.
4. Promote the participation of beneficiaries on policy-making boards and commissions.

New Initiatives

1. Re-capture the savings from the longevity bonus and reinvest it in senior services as a means of supporting seniors in their own homes and communities.
2. Explore a "universal" Medicaid waiver for home and community based care that is based on functional assessment rather than a specific disability.
3. Provide Alzheimer's and related dementia diagnostic and consultation services.

"I'd like to be able to get out more. Our transportation system only takes us to doctor's appointments but not anyplace else."

Consumer
1998 Beneficiary Survey

"Having knowledgeable family members makes a difference in how easily services are accessed or situations are handled."

Caregiver
1998 Beneficiary Survey

"We had a program with after hours that we could go to anytime--do crafts, and I liked that program. Everybody liked it. Then they cut that program. It's confusing."

Consumer
1998 Beneficiary Survey

"When you open up the newspaper, our Anchorage paper, there is, maybe once a week, an article about Alzheimer's in there, even if it's just a short little note. It's educating the general public."

Caregiver
1998 Beneficiary Survey

Data Development Agenda

In Results Based Budgeting, results and indicators are used to establish baselines for the development of strategies and performance measures. Much of the information included in the Comprehensive Integrated Mental Health Plan (CMIHP) reflects the broader statewide population and are not specific to Mental Health Trust beneficiaries. Part of the CIMHP development process is identifying information gaps and moving forward with a data development agenda. The purpose of the data development agenda is to improve the quality and reliability of information on beneficiaries, thereby improving Department of Health and Social Services and AMHTA planning and budget development. The indicators below are currently not available. There are funding implications for most of the recommendations below. Each requires further analysis to determine the complexity, costs or potential legal barriers for each action or change.

Overarching Data Development Needs:

DATA	Why its important	Action or Change Required
1. Consistent definition of beneficiaries across information systems (i.e. ARORA, DDIANA, PROBER, Senior Services, ADA, DOC, DOE, DVR, etc.).	It is important to compare the number of beneficiaries served by different programs and across systems.	Policy Change Addition/Revision to Existing Systems
2. Unduplicated count of beneficiaries to establish Alaska specific prevalence rates.	Current estimates of the number of beneficiaries are based on national prevalence data that may or may not be applicable to Alaska.	Survey Research - New Primary Data Source
3. Consistent definition of descriptive data elements (income, ethnicity, educational attainment, living situation) across data systems.	Standardized method of describing beneficiaries.	Policy Change Addition/Revision to Existing Systems
4. New information systems funded by the Mental Health Trust Authority must include a determination of beneficiary status.	Standardized beneficiary count by program.	Policy Change
5. Regular survey of beneficiaries to determine income and living conditions.	It will be important to see how the status of beneficiaries changes over time.	Survey Research - New Primary Data Source
6. Identify DHSS and other department information systems that collect information on beneficiaries and include them as sources of data for the data warehouse.	May provide a more complete picture of how beneficiaries use state-funded services.	Policy Change Addition/Revision to Existing Systems

Result #1: HEALTH

DATA	Why its important	Action or Change Required
1. # and rate of suicide attempts.	Indicator of need for mental health and substance abuse services.	New Primary Data Source
2. % of low-birth weight babies with long-term disabilities.	Estimating future impacts on service systems.	Survey Research - New Primary Data Source
3. Hospital discharge data by diagnosis as defined by ICD9 code.	Indicator of use of medical acute care facilities by beneficiaries.	Policy Change - Legislation Addition/Revision to Existing Systems
4. Hospital emergency room data by diagnosis as defined by ICD9 code.	Indicator of use of medical emergency care facilities by beneficiaries.	Policy Change - Legislation Addition/Revision to Existing Systems
5. % of beneficiaries who are uninsured (do not have a public or private third party payer).	Indicator of beneficiary access to health care.	Beneficiary Survey - New Primary Data Source
6. % of beneficiaries with health insurance that includes behavioral health coverage.	Indicator of beneficiary access to mental health and substance abuse treatment services.	Survey Research - New Primary Data Source
7. % of beneficiaries who are unable to access needed medical, dental, mental health, long-term care or substance abuse treatment services.	Indicator of beneficiary access to health care and mental health treatment services.	Survey Research - New Primary Data Source
8. % of physicians enrolled in and accepting Medicare/ Medicaid reimbursement.	Indicator of beneficiary access to health care and mental health treatment services.	Survey Research - New Primary Data Source

Result #2: SAFETY

DATA	Why its important	Action or Change Required
1. Retrospective studies: % of adults in correctional system, on Adult Public Assistance or in substance abuse treatment who were contacted by DFYS as children.	Indicator of future impacts on service systems and the need for future services.	Survey Research - New Primary Data Source
2. # and percentages of beneficiaries in the correctional system.	Indicator of future impacts on correctional system and the need for future community services.	Addition/Revision to Existing System
3. Recidivism rate for beneficiaries involved in the correctional system.	Indicator of future impacts on service systems and the need for future services.	Addition/Revision to Existing System
4. # of beneficiaries with guardians, including reason for guardianship and type of guardian (guardians, conservators, representative payees).	Indicator of the level of support required by beneficiaries and provides a means of monitoring the guardianship services. Safety indicator.	New Information System
5. % of beneficiaries living in safe neighborhoods (based on neighborhood crime rates, existence of neighborhood watch programs, availability of alcohol through liquor licenses or local option, presence of law enforcement/VPSOs).	Quality of life indicator.	Survey Research - New Primary Data Source

Result #3: ECONOMIC SECURITY

DATA	Why its important	Action or Change Required
1. Income of beneficiaries.	Indicator of beneficiary quality of life - comparable to population.	Addition/Revision to Existing System Survey Research - New Primary Data Source
2. Standardize methodology for collecting income information across databases.	Indicator of beneficiary quality of life - comparable to population.	Policy Change Addition/Revision to Existing Systems
3. Rate of employment for caregivers: before and after they become caregivers.	Indicator of care giver well-being and the availability of home and community services for beneficiaries.	Survey Research - New Primary Data Source
4. Availability of affordable specialized, transitional and assisted living housing.	Indicator of access to services.	Survey Research - New Primary Data Source
5. % of beneficiaries who are homeless.	Safety and quality of life indicator.	Survey Research - New Primary Data Source

Result 4: PRODUCTIVELY ENGAGED, EMPLOYED, CONTRIBUTING

DATA	Why its important	Action or Change Required
1. # of beneficiaries on ATAP and % nearing 5 year limit.	Indicator of the # of beneficiaries who may need alternatives to ATAP at some point.	Addition/Revision to Existing Systems
2. Hours worked per week for beneficiaries.	Indicator of the economic status of beneficiaries as compared to population.	Addition/Revision to Existing Systems Survey Research - New Primary Data Source
3. Wages per hour for beneficiaries.	Indicator of the economic status of beneficiaries as compared to population.	Addition/Revision to Existing Systems Survey Research - New Primary Data Source
4. % of beneficiaries who receive a diploma or GED.	Indicator of the future economic status of beneficiaries.	Addition/Revision to Existing Systems
5. % of juvenile offenders who are beneficiaries and who receive a diploma/GED.	Indicator of the future economic status of beneficiaries and recidivism potential.	Addition/Revision to Existing Systems

Result 5: LIVING WITH DIGNITY / VALUED MEMBER OF SOCIETY

DATA	Why its important	Action or Change Required
1. Number of people living in nursing homes by age and diagnosis.	Indicator of the availability of community based alternatives to nursing home care.	Addition/Revision to Existing Systems
2. % of seniors (60+) living in nursing homes.	Indicator of the availability of community based alternatives to nursing home care.	Addition/Revision to Existing Systems
3. Number of complaints against nursing homes and assisted living homes.	Status of the service system and quality of care.	Addition/Revision to Existing Systems
4. Number (or %) of beneficiaries using public transportation and para-transit (municipal or service provider)	Indicator of access to the community.	Addition/Revision to Existing Systems Survey Research - New Primary Data Source
5. % of beneficiaries living in the community or home of their choice.	Indicator of choice and quality of life.	Survey Research
6. Community support or treatment service availability index	Method of comparing the availability of community capacity to provide home and community based services.	Analysis of Existing Service System

DEPARTMENT OF HEALTH & SOCIAL SERVICES

Highlights

Down

- Infant mortality: neonatal and post-neonatal
- Teen pregnancy rates
- Juvenile crime
- Welfare dependency for able-bodied people
- Per capita consumption of alcohol, almost a gallon per person in 20 years
- Number of people who live in institutions for the mentally retarded to zero
- Number of people being hospitalized for long periods for mental illness

Up or Even

- Immunization rates for 2-year-olds
- Number of children who have health insurance
- Health of babies being born (higher birth rate)
- Number of child abuse reports have leveled off

Challenges

- Rate of children dying in Alaska is still one of the highest in the nation: intentional injuries and accidents, drowning, fire, dog bites, firearms, child abuse
- Levels of physical activity
- Obesity
- Tobacco use

Department Mission

To promote and protect the health and well-being of Alaskans.

Key Performance Measures

Division of Juvenile Justice

Mission: To protect and restore communities and victims while holding juvenile offenders accountable for correcting their behavior.

Measure: Youth and Justice - The percentage of restitution paid will be at least 82% of the amount ordered. The number of community work service hours will be 92% of the amount ordered.

Current Status:	In FY 99, 86% of the amount of restitution ordered was collected from juvenile offenders and paid to victims. During the same period, 95% of the community work service hours ordered was completed.
Benchmark:	Baseline used is the 1st quarter for FY1999. Restitution paid 79% and community work service 83%.
Background and Strategies:	It is the belief of DJJ that an essential aspect of rehabilitation of juvenile offenders is being held accountable for their actions, and making amends to the victim.

Highlights

- Juvenile arrests down
- Relieving facility overcrowding
- Accreditation
- Youth Courts/Community Response

Division of Family & Youth Services

Mission: To protect children who are abused and neglected or at risk of abuse and neglect.

Measure: The percentage of child protective services legitimate reports of harm assigned for an investigation will increase to 90% for FY2001.

Current Status:	FY2000: From July 1 through October 31, 1999, the total number of legitimate reports of harm assigned for investigation was 90%. Note: Due to the seasonality involved in Reports of Harm, data for a full fiscal year will be used for comparison purposes.
Benchmark:	In FY1997, 73.6% of legitimate reports of harm were assigned for investigation.
Background and Strategies:	Increased number of child protection workers to respond to more reports; better training and less turnover among these workers. FY1997: 73.6% of legitimate reports of harm were assigned for investigation FY1998: 77.3% of legitimate reports of harm were assigned for investigation FY1999: 78.1% of legitimate reports of harm were assigned for investigation. Set targets for assigning reports.

Highlights

- More Response to Reports Of Harm (ROH)
  - Dual track
- Work Force Issues
  - Training
  - Safety still an issue
  - Turnover

- Children in Custody Longest are Moving into Permanent Homes
  - Adoption

- Foster Care Improvements
  - Foster-a-Future
  - Safety still an issue

- Residential Care Improvements
- Legal system for permanent placement is working
- Risk assessment tool

Division of Public Health

Mission: To preserve and promote the state's public health.

Measure: Child Health Improvements - Increase the number of 2-year-olds fully immunized to 90% by the year 2001.

Current Status: The percentage of fully immunized 2-year-olds for calendar year 1998 was 81.3%. This is up from 69% in 1996 and 75% in 1997.

Benchmark: The department has gone from 48th to 22nd in ranking for the nation from 1997 to 1999.

Background and Strategies: In 1997, the Department launched a major initiative to increase the rate of fully immunized two-year-olds. In two years we have gone from 48th to 22nd in the ranking for the nation. This comprehensive public-private initiative to increase the awareness of the need for immunizations and ensure access for families to the needed immunizations will be extended through 2000, in order to obtain the highest level of immunizations possible by the end of the Year 2000, hopefully the 90% goal. After this date, immunization activities will remain a priority to ensure the rate does not fall as new children are born or move to the state.

Measure: Child Health Improvements - Reduce youth smoking and smokeless tobacco use rates by 10% by the end of FY2001.

Current Status: Preliminary results from the Youth Risk Behavior Survey (YRBS) suggest that youth smoking has decreased, especially among younger youth.

Benchmark: Percent of participants in the Youth Risk Behavior Survey sponsored by Centers for Disease Control and Prevention and co-administered by the State of Alaska and individual school districts.

Background and Strategies: The YRBS is a random, anonymous school survey, sponsored by Centers for Disease Control and Prevention (CDC) and co-administered by the State of Alaska and individual school districts. In 1995, 36.5% of Alaskan high school students reported current cigarette use and 72.1% reported that they had ever smoked a cigarette. Middle school student cigarette use in 1995 was reported at 58.3% ever smoked and 24.8% current cigarette use. Preliminary results from the 1999 YRBS suggest that youth smoking has decreased, especially among younger youth. The differences do not reach statistical significance, and it will take several years of data collection to be sure that smoking is declining among youth.

Research indicates that a comprehensive approach is the most effective method of reducing youth tobacco use rates. Therefore Alaska's Tobacco Prevention and Control Program is targeting both adults and youth.

Highlights

- Child Death Investigations/Medical Examiner
- Denali KidCare
- Emergency Medical Services
- Breast and Cervical Cancer
- New Public Health Lab, Kenai Health Center
- Healthy Alaskans 2010

Volume 6, Number 1 February 1998

Alaska's Behavioral Risk Factor Surveillance System

Tony Knowles
Governor

State of Alaska
Department of Health and Social Services

Karen Perdue
Commissioner

1991-1996

Alaska's Progress Towards the Goals of Healthy People 2000

About half of all deaths occurring annually can be attributed to modifiable behavioral risk factors (McGinnis and Foege, 1993). These risk factors are associated with lifestyle and include such things as poor diet, physical inactivity, smoking, overweight, not using safety belts and not taking preventive health measures. Many diseases and premature deaths could be prevented through modified behavior and lifestyle.

In 1991, the publication Healthy People 2000: National Health Promotion and Disease Prevention Objectives was produced. This document outlines a national strategy to reduce the risks associated with disease and premature death and improve the nation's health by the year 2000.

The Behavioral Risk Factor Surveillance System

The Alaska Department of Health and Social Services implemented the Behavioral Risk Factor Surveillance System (BRFSS) in 1990 in cooperation with the Federal Centers for Disease Control and Prevention. The system gathers information about the health related lifestyle choices of Alaskan adults related to leading causes of death such as heart disease, cancer and injury. The program is part of an ongoing national data collection system. Results are analyzed each year to improve our understanding of Alaskan health habits and to measure progress toward national and state health objectives.

In Alaska, 128 health interviews are conducted each month utilizing a standardized BRFSS questionnaire. The interviews are conducted over the telephone using randomly selected telephone numbers. Respondents are randomly selected from the adult members of the household (18 years of age and older). A total of 1,536 interviews are completed annually. These data are analyzed by the Centers for Disease Control and Prevention and weighted to adjust the sample to represent the state population.

This report summarizes survey findings from 1991 to 1996 and compares the results to selected national health objectives presented in the Healthy People 2000 publication.

Overweight

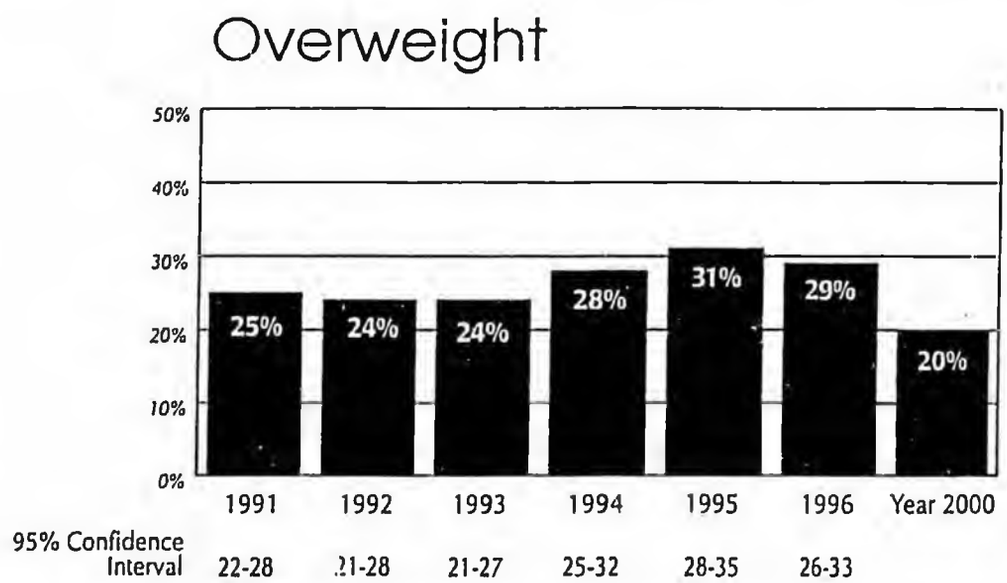
Healthy People 2000 Objective 1.2 – not met

Reduce the prevalence of overweight to a prevalence of no more than 20 percent among people aged 20 and older.

Overweight people are at increased risk for heart disease, diabetes and for certain types of cancer.

Survey results indicate that Alaska has not met this goal and that typically more than 20% of Alaskan adults are overweight.

*Definition used for this survey: Body Mass Index (BMI): Females with body mass index (weight in kilograms divided by height in meters squared (w/h **2)>=27.3 and males with body mass index >= 27.8.*



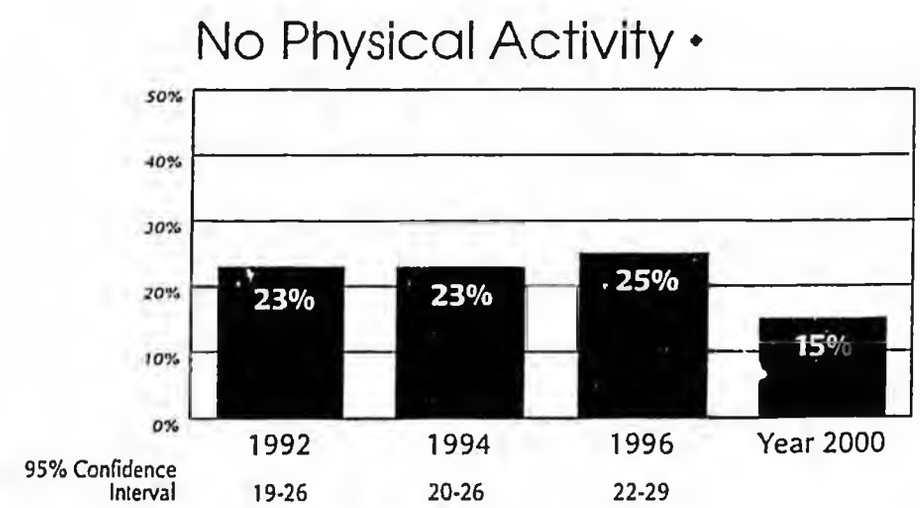
Physical Activity

Healthy People 2000 Objective 1.5 – not met

Reduce to no more than 15 percent the proportion of people aged 6 and older who engage in no leisure-time physical activity; reduce to no more than 22 percent the proportion of people aged 65 and older who engage in no leisure-time physical activity.

The Surgeon General recommends regular (preferably daily) physical activity for better health. Regular physical activity reduces the risk of premature death and enhances health.

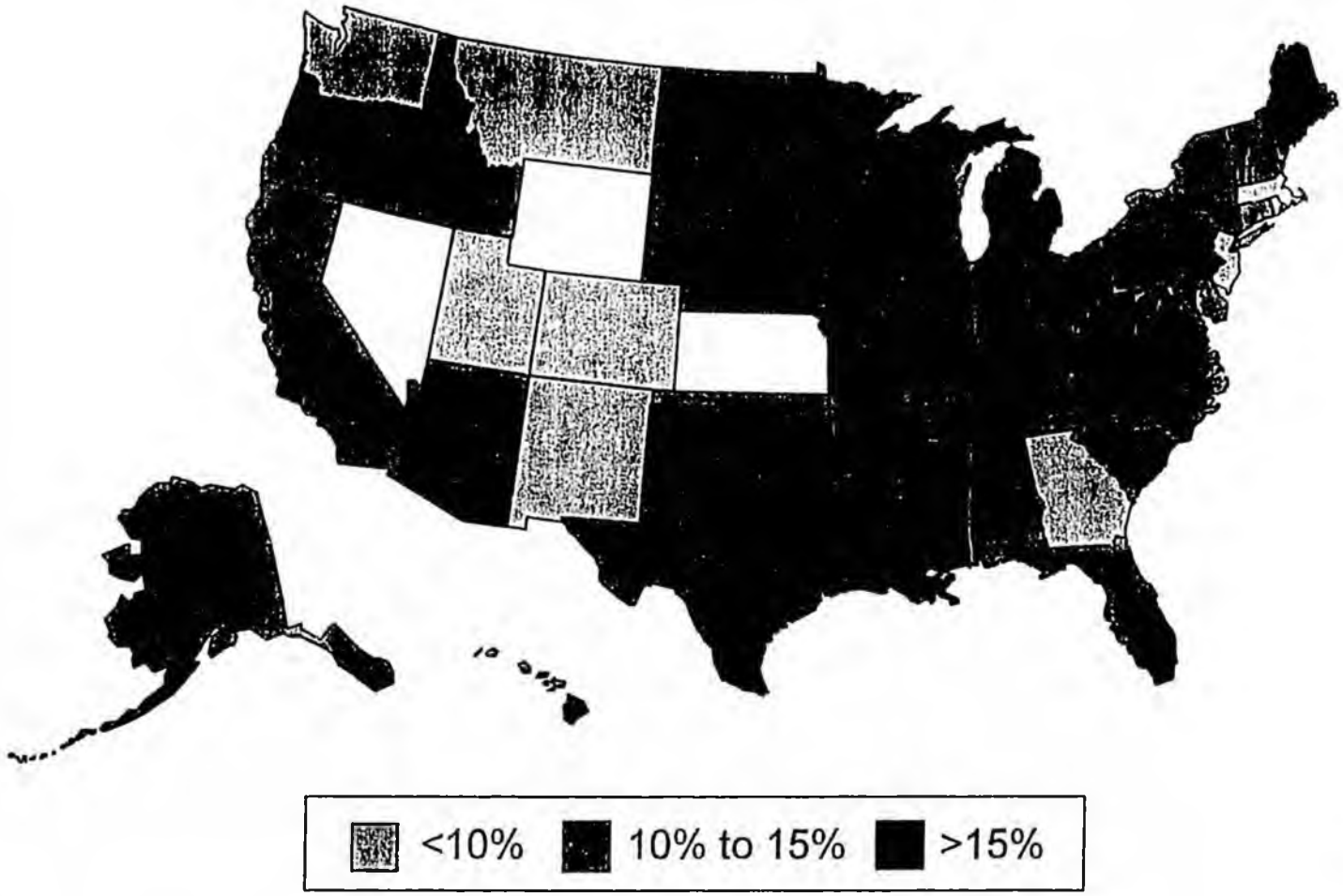
The proportion of Alaskan adult respondents who report no leisure time activity has remained unfavorably above the Year 2000 goal of 15%.



• *data not collected during missing years*

Prevalence of Obesity* among U.S. Adults
BRFSS, 1991

(*Approximately 30 pounds overweight)



Source: Mokdad AH, et al. *J Am Med Assoc* 1999;282:16.

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

Prevalence of Obesity* among U.S. Adults
BRFSS, 1998

(*Approximately 30 pounds overweight)

Source: Mokdad AH, et al. *J Am Med Assoc* 1999;282:16.

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System. 1999.

Leading Health Indicators

The Leading Health Indicators reflect the major public health concerns in the United States and were chosen based on their ability to motivate action, the availability of data to measure their progress, and their relevance as broad public health issues.

The Leading Health Indicators illuminate individual behaviors, physical and social environmental factors, and important health system issues that greatly affect the health of individuals and communities. Underlying each of these indicators is the significant influence of income and education (see Income and Education, page 12).

The process of selecting the Leading Health Indicators mirrored the collaborative and extensive efforts undertaken to develop Healthy People 2010. The process was led by an interagency work group within the U.S. Department of Health and Human Services. Individuals and organizations provided comments at national and regional meetings or via mail and the Internet. A report by the Institute of Medicine, National Academy of Sciences, provided several scientific models on which to support a set of indicators. Focus groups were used to ensure that the indicators are meaningful and motivating to the public.

Leading Health Indicators

- Physical activity
- Overweight and obesity
- Tobacco use
- Substance abuse
- Responsible sexual behavior
- Mental health
- Injury and violence
- Environmental quality
- Immunization
- Access to health care

For each of the Leading Health Indicators, specific objectives derived from Healthy People 2010 will be used to track progress. This small set of measures will provide a snapshot of the health of the Nation. Tracking and communicating progress on the Leading Health Indicators through national- and State-level report cards will spotlight achievements and challenges in the next decade. The Leading Health Indicators serve as a link to the 467 objectives in *Healthy People 2010: Objectives for Improving Health* and can become the basic building blocks for community health initiatives.

Division of Mental Health & Developmental Disabilities

Mission: To improve and enhance the quality of life for consumers impacted by mental disorders or developmental disabilities.

Measure: API 2000 Community Implementation Plan--Decrease the number of psychiatric hospital days used per person that are publicly funded.

Current Status:	As of first half of FY1999, 12 days expresses the average number of days per person that are publicly funded.
Benchmark:	The benchmark is 13 days based on the second half of FY1998.

Highlights

- API 2000/Community Psychiatric Services
- Developmental Disabilities waiting list
- Comprehensive Integrated Plan

Division of Alcoholism & Drug Abuse

Mission: To reduce alcoholism and substance abuse.

Measure: Reduce the annual per capita alcohol consumption by people aged 14 and over from 2.55 to 2.25 gallons by FY2001.

Current Status: The numbers currently indicate that Alaska's consumption rate is declining. Since FY90 Alaska has experienced a steady decline with the most recent years rates of 2.64 and 2.51 gallons per capita for FY97 and FY98 respectively.

Benchmark: Annual per capita alcohol consumption for ages 14 and over was 3.46 gallons in FY85.

Background and Strategies: 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 but does not acknowledge the state's significant (and increasing) visitor population. 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. In relation to this strategy the department advocates for positive change through legal and regulatory initiatives. Other strategies include but are not limited to: encourage activities and initiatives that will change community standards and emphasize healthy lifestyles; encourage traditional and alternative social activities that are alcohol and drug free.

This age group was selected by the Division in order to have a valid comparison of the state's consumption levels with the national level.

Highlights

- Progress toward outcomes/audit issues
- Title 47

A Summary of Recent Findings Regarding Substance Abuse in Alaska

The Division of Alcoholism and Drug Abuse (ADA) is about to make public a report which summarizes six recently-completed research reports. These research findings, developed with the collaboration of the Division of Public Health's Section of Epidemiology, provide science based information related to the success of treatment and intervention as well as information about the prevalence of alcohol and drug abuse in Alaska.

Among the information learned from this research are:

- Of Alaskan outpatients surveyed, 56 percent abstained from alcohol for one year after treatment.
- Of Alaskans in residential programs surveyed, 42 percent abstained from alcohol for one year after treatment.
- 36 percent of Alaskan residential clients surveyed were hospitalized before treatment and 15 percent after treatment.
- 28 percent of Alaskan outpatient clients surveyed were hospitalized before treatment and 7 percent after treatment.
- 66 percent of the misdemeanor offenders referred to the ASAP did not re-offend during a subsequent 3 year period.
- A total of 13.85 percent of Alaskans are in need of treatment for alcohol and/or substance abuse. The studies show that 12.6 percent of Alaskan residents are in need of treatment for dependence upon or abuse of alcohol. An additional 1.2 percent of Alaskan residents need treatment for drug abuse or dependence and .05 percent of Alaskan adults are in need of treatment for drug abuse or dependence only.
- Survey respondents to Substance Abuse Need for Treatment Among Arrestees Survey showed that 37.3 percent of this population are in need of treatment. Of this total 32.9 percent are male and 50 percent are female.

If you are interested in complete copies or other information regarding these reports please contact ADA at 1-800-478-2072 or the Division of Public Health's Section of Epidemiology at (907)269-8000.

Division of Public Assistance

Mission: To provide basic living expenses and self-sufficiency services to Alaskans in need.

Measure: Move 50% of welfare recipients into work activities by the end of FY20001.

Current Status: The percentage of all Temporary Assistance families participating in federally countable work activities was 45% in January 1999.

Benchmark: Federal law requires that states meet work participation requirements:

FFY1997 25% of all families

FFY1998 30%

FFY1999 35%

FFY2000 40%

FFY2001 45%

FFY2002 50%

Background and Strategies: The Temporary Assistance program is a work-focused program to help Alaskans plan for self-sufficiency and to make a successful transition from welfare-to-work. Federal welfare reform law requires the state to meet work participation requirements. Failure to meet federal participation rates results in fiscal penalties. In FY2001 federal law requires 45% of all families and 90% of all two parent families to participate in a defined "work activity".

Highlights

- Adult Public Assistance

Division of Medical Assistance

Mission: To maintain access to quality health care for all Alaskans and to provide health coverage for Alaskans in need.

Measure: Percentage of Alaskan providers participating in the Medical Assistance program, by type and region.

Current Status: FY 1999 Summary Data

	Enrolled	Participating
Physicians	84.9%	52.5%
Dentists	82.8%	59.0%
Pharmacies	75.8%	75.0%
Hospitals	100.0%	95.7%
Nursing Homes	100.0%	100.0%

Benchmark: The Division has measured participation by physicians, pharmacies, dentists, inpatient hospitals, and nursing homes during FY1999. Participation rates compare licensed Alaskan providers with Medicaid enrolled and participating providers (i.e., those providers reimbursed for services).

Department Goals and Strategies for FY 2001

Help children stay healthy and safe.

- Improve the state's response to child abuse and neglect by responding to more reports of harm, ensuring that children in state care are placed in safe, quality homes, and moving children in foster care to permanent homes more quickly.
- Develop a system to improve surveillance, treatment and prevention of alcohol-related birth defects.
- Fully implement Denali KidCare - health care coverage for low-income children and pregnant women.
- Implement strategies to reach statewide immunization target: 90 percent of all 2-year-old children.
- Improve access to pediatric dental services.

Help Alaskans live healthier and have access to basic health care to reduce chronic and preventable disease.

- Improve access to health care for Alaskans in rural areas.
- Assist in the efficient development of telemedicine in Alaska.
- Efficiently manage the Medicaid program and gain the necessary federal and state resources to deliver a comprehensive program.

Assist Alaskans who experience developmental disabilities and/or mental illnesses to live independently and remain economically secure.

- Refine Comprehensive Integrated Mental Health Plan in conjunction with consumers, policy boards and the Alaska Mental Health Trust Authority.
- Promote self-sufficiency for adults with disabilities through work incentives.
- Replace aging Alaska Psychiatric Institute, improve treatment services at new API, and strengthen community services to prevent inappropriate hospitalization.
- Review status and operation of adult assisted living homes and the clients they serve. Assist in strengthening guardianship and adult protective services.
- Develop and implement a plan for improving services for special needs children.
- Continue mental health program improvements.
- Eliminate the waiting list for infants needing diagnosis and treatment of developmental disabilities or delays.

Increase incentives and opportunities for communities to collaborate with the department to improve results for children and families

- Implement tribal Temporary Assistance for Needy Families (TANF) partnerships.
- Promote self-sufficiency for families on public assistance.
- Continue collaboration with communities and private organizations on service integration projects.
- Improve regulatory framework and processes for awarding, monitoring and implementing departmental grants for services to assist Alaskans.

Establish an integrated statewide system for data collection, analysis and reporting that improves services to Alaskans

- Continue to link and integrate data from a variety of existing systems, including state and grantee client and management information systems.

- Develop and refine a system to evaluate welfare reform outcomes.

Promote efficient streamlined systems where employees value their work and meet customers needs

- Continue effort to integrate systematic performance measurement into the department's program planning, budgeting and ongoing operations.

- Improve process for internal and external communications.

Major Department Accomplishments for FY1999

- Launched Denali KidCare, expanding health care coverage to uninsured children and pregnant women. As of September, the program had reached its goal of enrolling nearly 12,000 children and was close to reaching its goal of signing up 800 pregnant women.

- Improved the response to reports of child abuse and neglect.

- Completed first full year of operation of Family Services Training Academy; all new workers trained before receiving caseloads; more than 260 social workers trained in first year.

- Increased training for child protection workers; reduced staff turnover; successfully filled approximately 22 vacant positions to provide increased protection.

- Launched statewide "Foster a Future" foster care recruitment campaign. Added more than 200 foster homes since FY 97.

- Provide services to additional 169 consumers who had been on the developmental disabilities waitlist for services, and provided developmental disability services to a total of 1,900 persons.

- Reduced overcrowding in juvenile detention and treatment facilities by opening a new 22-bed treatment unit addition to the existing Johnson Youth Facility in Juneau and adding 20 new detention beds at McLaughlin Youth Center in Anchorage.

- Implemented an aggressive immunization campaign at the state and local level, that simultaneously increased dramatically the number of two year olds who are adequately immunized, ensured that all Alaskan school age children are adequately immunized against measles to prevent another measles outbreak from occurring and significantly increased the immunization levels for young children against Hepatitis A and B.

- Reduced Temporary Assistance caseload to 8,721 families, the lowest point since 1991 when two-parent families were added to the old AFDC program, 34% below the historical peak in 1994.

- Reduced expenditures for Temporary Assistance payments from $90.9 million in FY98 to $74.3 million in FY99. This 18% saving contributes to a 35% saving over the past two years. These savings are from reduced payments due to earnings and from case closures.

- Initiated a successful program to assure that all "mission-critical" systems are Y2K compliant.

- Expanded state's response to fetal alcohol syndrome by conducting more than 200 medical chart reviews as part of FAS Surveillance Project and by establishing and training three FAS Multidisciplinary Community Teams - in Bethel, Dillingham and Copper Center.

A Summary of Recent Findings Regarding Substance Abuse in Alaska

Prepared by the Division of Alcoholism and Drug Abuse
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December, 1999

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Overview

Since 1994 the State of Alaska, Division of Alcohol and Drug Abuse has been conducting and participating in a significant level of federal and state funded research, with resources provided by the Department of Health and Human Services, Center for Substance Abuse Treatment Agency as well as by the State.

The federally funded research efforts, or needs assessment, have been designed to determine the prevalence, severity and needs for treatment of Alaska's substance abuse problems. This research has been conducted by the Division of Alcoholism and Drug Abuse in close collaboration with the Division of Public Health, Section of Epidemiology. The needs assessment research has assessed the situation State-wide, as well as among demographic and geographic groupings within the State. We have also compared findings from this research with findings from similar research efforts conducted by or about other states. While our needs assessment efforts are still ongoing a key finding has been the limits imposed by many of our current data sources, and while the on-going research includes efforts to address these data source constraints it is important to note that the findings mentioned herein are preliminary in nature. However, our efforts so far have produced results that either (a) appear to be confirmed from several sources or (b) raise questions that point toward further investigation.

Additionally, this report summarizes state funded research conducted by the University of Alaska Anchorage, Institute for Circumpolar Health Studies, on the Alcohol Safety Action Program, as well as a chemical dependency treatment outcome study conducted by New Standards, Inc. on over 1600 Alaskan residential and outpatient clients. The intent of the Alcohol Safety Action Program study was to measure the effectiveness of the program in reducing the number of re-offenses of alcohol related offenders. The outcome study provides information about the State's residential and outpatient clients from their admission to a treatment program to one year following admission.

While we summarize our research efforts of the last 5 years in this publication, researchers and others interested in complete copies of these reports should contact the Division of Alcoholism and Drug Abuse at 1(800)478-2072 or the Division of Public Health's Section of Epidemiology (907)269-8000.

Needs Assessment Data Sources and Research Methods:

Needs assessment information has been compiled from two broad categories of data: interstate data sources that are available regarding all or many states, and intrastate data sources that have been collected solely for Alaska's analytic and program planning purposes. Both categories relied upon data sources presumed to have high face validity. As we have proceeded through our analyses, we have discovered some limits to these assumptions that are inherent to the data; these limits will be noted.

Interstate data sources to date have included:

(i) the National Drug and Alcohol Treatment Unit Survey (NDATUS) to determine persons in treatment;

(ii) the National Institute of Alcoholism and Alcohol Abuse (NIAAA) County Alcohol Problem Indicators to determine mortality, using data with specific mentions of alcohol as a cause of death;

(iii) the Center for Disease Control's Behavioral Risk Factor Survey (BRFSS) and

(iv) the FBI's Uniform Crime Reporting (UCR) Arrest Statistics for all drug abuse violations and for arrests for driving under the influence of alcohol.

Intrastate substance abuse and dependence research to date has included

(i) a statewide residential telephone survey of 8,167 households over an approximately four month span of time;

(ii) a voluntary survey and urinalysis of 658 arrestees from four booking sites in Anchorage, Fairbanks and Bethel, and

(iii) a review of existing state databases for treatment, mortality and arrest data from 1990-95 regarding alcohol and drug arrests, accident injury and mortality, and treatment.

(iv) A small area (borough level) estimates of substance abuse prevalence and dependence based on synthetic estimates from the household telephone survey data.

This research summary includes an Interstate Substance Abuse Indicator Chartbook that compares Alaska Statewide data with that of other states, and executive summaries from the four intrastate studies described above.

Please note that due to limits in data availability from the several states the interstate data is several years older than, and different from, much of the intra-state data. It also should be mentioned that our recent in-State studies have used nationally accepted operational definitions for substance dependence or abuse used by other states in similar research efforts. In our interview studies for example, an individual is defined as having a lifetime diagnosis of substance dependence or abuse who has both used and had a symptom as defined by DSM-III-R within the last eighteen months. These particular study respondents have also been considered persons who may have needed treatment within the last year.

Independent reviews of the various studies have found their methods and conclusions sufficient to support the major findings presented in the attached executive summaries. Highlights from the reports can be briefly describes as follows:

I. Prevalence Findings:

A. Alcohol:

"Need for substance abuse treatment" is defined as being in a state of substance abuse or dependence, and requiring help to stop or reduce substance use, to prevent relapse, or to recover from the effects of abuse. The operational definition of treatment need is a diagnosis of a substance use disorder, either abuse or dependence. According to these definitions, the survey found 12.6 % of residents in need of treatment for dependence upon or abuse of alcohol, with an

additional 1.2% also in need for treatment for drug abuse or dependence. In comparison, the survey finds 0.5% of adults are estimated to be in need for treatment of drug dependence or abuse only.

Data from all other studies support the finding that alcohol is Alaska's problem substance of choice. Interstate comparative data is consistent with these findings. The attached interstate indicator analysis finds that Alaska is among the states with the nation's most severe rates of alcohol problems; with problems of alcohol abuse and dependence and need for treatment far exceeds the problems of dependence, abuse and need for treatment associated with all other drugs. According to this data Alaska experiences the fifth most severe rate of alcohol problems in the nation, based on death, arrest and treatment data. Alaska holds the dubious distinction of being ranked first in deaths with an explicit mention of alcohol, and thirteenth for deaths due to alcoholic cirrhosis. Alaska ranked tenth nationally in DUI arrests, and thirteenth in motor vehicle fatalities with blood alcohol levels greater than .10%. The 1993 BRFSS Alaska survey data used for national comparisons among states found Alaska to rank first nationally in mothers of newborns who admitted to having 3-4 drinks per week; fourth in "binge drinking" (5 or more drinks at least once in the past month); and second in "chronic" drinking (60 or more drinks per month).

While it is to early to determine if there is a trend it is encouraging that more recent BRFSS survey data includes: an estimate that over the 1993-95 time period Alaska adults estimated to be at risk for chronic drinking declined from 5.3% to 2.9% (national median = 2.77%); the percent of Alaska adult males who reported having 60 or more drinks in the month prior to the survey declined from 8.6% to 4.6% over the 1993-95 time period and among adult Alaska females the reported decline was from 1.6% to 1.1%; the per cent of Alaska adults who reported they had been drinking and driving in the month prior to the survey declined over the 1993-95 time period from 2.5% to 1.3%

Our recent telephone survey has produced an estimate of 9.7% of all Alaska adults as having a lifetime alcohol dependency, with another 4.1% identified as alcohol abusers. The need for treatment appears greatest among adults from 25 to 44 years of age. Alcohol and dependency problems appear to be most severe in the BRFSS regions identified as Southeast and Bush Alaska. Alcohol dependency and abuse rates are found to be twice as high among men as among women, and lifetime dependency is estimated as approximately 50% higher among Alaska Natives and Native Americans than among whites.

The substance abuse indicator analysis of five available States data indicators show that while the problems remain extremely severe, overall the alcohol and drug abuse problem in Alaska showed some significant improvement by the mid-1990s compared to the early 1990s. Overall treatment admissions increased, at the same time that mortality rates and injury rates from accidents declined. While difficulties with the data are noted within the full reports, as well as in the attached review of the reports, nonetheless this can be regarded as an indicator of progress in providing treatment identified in the reports as clearly needed.

B. Controlled Drugs:

Alaska, according to interstate indicator data from 1991-93, is among the states with the lowest rates of controlled drug problems (ranked 40th according to the "Drug Problem Index" described in the included Interstate Substance Abuse Chartbook, among the 50 states). This finding is supported through the household telephone survey and the urinalysis results from our arrestee study. Dependence on controlled substances seems most problematic among the two youngest age groups of Alaska adults (18-24 and 25-44 years of age). Among controlled substances marijuana dependence is, by far, the controlled substance most subject to user dependence in Alaska according to the household telephone survey. Marijuana dependence appears to be most pronounced in the roadless areas of the State described as "the Bush" region – one of the four Alaska demographic subdivisions used for studies routinely conducted for the Center for Disease Control and other agencies by the Alaska Section of Epidemiology. (The other regions are described as "Urban", Gulf Coast" and Southeast". However, the substance abuse indicator study found arrest rates for controlled substances to be greatest in the Gulf Coast region. The survey found approximately 2.5% of Bush residents can be described as having a lifetime diagnosis of marijuana dependence or abuse, while Statewide the diagnosis is estimated to apply to 1.1% of the population. (It should be noted that the "lifetime" diagnosis includes anyone who both used a controlled substance and had a symptom as defined by DSM-IIIR diagnostic criteria within the last 18 months prior to the household telephone survey.)

The marijuana problem is most pronounced among the 18-24 year age group (4.2% estimated as dependent, and an additional 1.0% as abusers), and is three times as likely to be found among men (1.7%) than among women (0.5%). Race and ethnicity also appear to impact the diagnosis: Alaska Natives and Native Americans evidenced marijuana dependency (1.9%) at a rate nearly double that of whites (1.0%). These demographic results were generally supported through urinalysis findings of the arrestee study, and through the NDATUS Alaska marijuana treatment data (Alaska ranked 8th in per capita persons receiving marijuana treatment, with 1.3 times more persons being treated than arrested).

Cocaine was identified by the household survey as the second most serious controlled substance subject to abuse and dependence among adult Alaskans. However, the number of individuals so diagnosed is small, with 0.2% receiving a current dependency diagnosis, the largest proportion (0.3%) in the urban part of the State, and with men predominating in this diagnosis by four to one over women. However, in the arrestee study, 18.5% of those volunteering for the study were diagnosed as abusing or dependent upon cocaine, and women were more likely than men to be diagnosed with cocaine dependence or abuse. Among Alaska's arrestees, whites were diagnosed with cocaine dependency at a rate more than twice as great as found among Alaska Natives while the survey data indicated a prevalence among whites only about 50% greater than that found among Alaska Natives. The majority of those identified as dependent were found to be severely dependent.

A caution regarding drug-related disease findings should be noted: Homelessness and the levels of four contagious diseases- HIV-AIDS, TB, hepatitis and syphilis- are associated with drug use. Their levels frequently correlate well with the levels of drug dependency and abuse estimated from survey, treatment and arrest data. This is not the case in Alaska. No HIV-AIDS data is

available from Alaska, but Alaska's TB rates are very high, and hepatitis-B rates are higher than would be expected according to drug-related data. This may result from (a) the inherent constraints imposed by a household telephone survey that will not reach the homeless or those without telephones, or (b) non-drug factors associated with public health or geographic conditions that may account for the contagious disease variance.

The household survey found 0.1% of adult household residents Statewide evidenced a dependency on amphetamines, and 0.1% on hallucinogens, with dependence concentrated among the 18-24 year age group. Among this group 0.6% were diagnosed as dependent upon amphetamines, except for a lower rate in the Bush region, and 0.3% were diagnosed for hallucinogen dependence - except in the Gulf Coast region where the prevalence was indicated to be 0.9%). Although the percentage is small, Native Alaskans showed a prevalence of amphetamine dependency four times greater than among whites.

C. Need For Treatment

Findings from these studies as well as on-going studies are intended to be used for policy planning and program adjustment purposes. Among the key findings revealed through the survey regarding the need for treatment are that while need exceeded 14% among adults in all four BRFSS regions of the State, the estimated need for alcohol and drug treatment are greatest in the Bush and Southeast BRFSS regions. These regions are where in excess of 16% of the adult population is in need of treatment. Again, the greatest need for treatment among adults was found to be for alcohol dependency and abuse. Statewide 12.6% of adults are estimated to be in need of treatment for alcohol dependency or abuse, while only 0.5% are estimated to be in need of treatment for drug dependency; and an additional 1.2% in need of treatment for both alcohol and drug dependency. The need for drug or combined dependency treatment appears to be greatest in the Bush BRFSS regions, in which 1.1% of the adult population is estimated to need treatment for combined or drug dependency or abuse. A diagnosis of marijuana dependence contributed significantly to the formulation of this Bush regional estimate, as the estimated marijuana dependence/abuse rate of 1.3% was more than double that found in any other region of the State.

State funded research conducted by the Institute for Circumpolar Health Studies assisted the Division of Alcoholism and Drug Abuse in measuring the effectiveness of the ASAP program in reducing the number of re-offenses of alcohol/drug related offenders in several sites throughout the state - Juneau, Anchorage, Fairbanks & Mat-Su. A significant finding of the study was that 65-66 percent of the clients referred to the ASAP program on their first DWI did not re-offend during a subsequent 3 year period.

The chemical dependency treatment outcome study, or New Standards report, provides data on 1024 residential patients and 510 outpatients who consented to the follow-up study. The researchers were successful in contacting 42% of the eligible residential patients and 54% of the eligible outpatients one year after admission to treatment. The one-year outcome results provide a psychosocial and clinical profile of the residential and outpatient groups, as well as important job, medical, and legal cost-offsets impacted by treatment.

The attached executive summaries and reviews, along with the accompanying Interstate Substance Abuse Indicator Chartbook, provide a clear, detailed overview of the condition of

substance abuse and the needs for treatment within the State. The cooperation received in the data collection efforts from Alaska's public treatment programs, the Department of Public Safety, and the Department of Corrections were crucial to the accomplishment of these reports, and is greatly appreciated.

EXECUTIVE SUMMARY:

TECHNICAL REPORT

ALASKA ADULT HOUSEHOLD TELEPHONE SURVEY STATEWIDE and SUBSTATE PLANNING REGIONS

Submitted to:

Alaska Department of Health and Social Services

Division of Alcohol and Drug Abuse and to the Section of Epidemiology of the Division of Public Health

Submitted by:

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March 1998

EXECUTIVE SUMMARY

The resources that have been made available by the Center for Substance Abuse Treatment (CSAT) and the Alaska Department of Health and Social Services, Division of Alcoholism and Drug Abuse (ADA), for conducting the Alaska adult household survey have expanded needs assessment efforts in Alaska during the 1997-1998 time period. The Gallup Organization has been pleased to join ADA in collecting data for a statewide adult household survey, administered by telephone in the state of Alaska, as part of Alaska's family of studies to develop needs assessment capabilities in the area of substance abuse and need for treatment. Substate planning regions in Alaska are the Urban, Gulf Coast, Southeast, and Bush regions.

The purpose of the adult household telephone survey was: To provide information on substance dependence, abuse, prevalence and the extent of unmet need and demand for substance abuse treatment services for adults in Alaska at the state and substate planning region level.

Sample Methodology

For the purpose of sampling, the adult population was stratified into four regions. Sampling was accomplished independently within each region using the truncated Casady-Lepkowski method of telephone sampling. The goal of Gallup's sampling scheme was to estimate treatment needs for adult alcohol and other drug users aged 18 and older. Gallup also oversampled persons in the 18 to 44 age group by substate planning region since this is the age group with relatively higher rates of illicit drug use. Specific efforts were made to estimate treatment needs for alcohol and other drugs among injection drug users and women of childbearing age.

Maximization of Data Quality

Two critical aspects of maximizing data quality for this project were maintaining respondent confidentiality and maintaining quality control over interviewers' work. In order to ensure confidentiality: 1) all Gallup personnel who worked on this project signed a statement promising that they would maintain the confidentiality of all survey data; and 2) no personal identifying information was delivered to ADA with the final adult survey data set. To maintain quality control over interviewers' work, supervisors silently monitored the interviewers' work and checked interviewers' completed work for accuracy and completeness.

Characteristics of the Sample

Demographic data for persons who participated in the study provide the following information about the sample by county:

- 68.3% of the respondents were ages 18-44 with slightly more than half (55.9%) of the respondents found in the 25 to 44 years of age category.

- In all regions over 64% of the respondents were 18-44 years of age. This was due to the oversampling of persons of this age group.

- Females comprised 54.1% of the sample. For all regions, over half of the sample was female.

- More than seven in ten (72.7%) of the sample was white and 21.1% was Native American or Alaskan Native. "Other races" made up 6.2% of the sample.

- Most of the respondents had a high school education or greater (92%).

- 42.3% reported an income of less than $40,000.

SUBSTANTIVE ANALYSIS AND FINDINGS

Diagnosis Estimates for Dependence and Abuse

To determine whether a person should be diagnosed as dependent on or abusing a particular substance, the diagnosis criteria of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 3rd revised edition (DSM-III-R), was used. To make a diagnosis, a respondent is asked a series of nine questions about his or her use of alcohol or a particular drug. A diagnosis of substance dependence requires meeting three of the nine DSM-III-R criteria and having some of the symptoms of disturbance that have persisted for at least one month, or have occurred repeatedly over time. The three criteria for dependence measure: 1) undesired excessive use, including resulting tolerance and withdrawal sickness; 2) problems in the critical realms of a person's life that are a result of excessive use; and 3) failed attempts to control substance use without help.

A diagnosis for substance abuse requires that two criteria are met: 1) continued use despite having recurrent social, occupational, psychological or physical problems exacerbated by it; and 2) recurrent use in situations where it is physically hazardous. Summary Tables 1a-3 present lifetime and current dependence and abuse estimates as well as estimates of lifetime treatment needs. All estimates are based on current (1997) estimates of census data. The weighting of the Alaska household survey data was done in early 1998, and the Claritas 1997 estimates were the most current estimates at the time.

Analysis of the Alaska adult household survey data produced the following lifetime diagnosis estimates for dependence and abuse.

- 9.7% (approximately 41,108) of adult Alaska residents were dependent on alcohol, and another 4.1% (approximately 17,294) were alcohol abusers.

- The proportion of alcohol dependence varied across all regions ranging from 8.5% to 11.9% for the Gulf Coast and Bush regions respectively.

- Alcohol abuse estimates ranged from 3.2% for the Bush region to 4.9% in the Southeast region.
- Diagnosis estimates of alcohol dependence and abuse were twice as high among men compared to women.
- Native Americans and Alaskan Natives had the highest lifetime estimates of alcohol dependence (14.9%) while the estimate for whites was 9.2%.
- The rate of marijuana dependence (1.1%) was about one-tenth of the estimated alcohol dependence (9.7%) Abuse of marijuana was low (0.4% at approximately 1,761 adults).
- Low rates of hallucinogen, cocaine, and amphetamine dependence (0.1%, 0.2%, and 0.1% respectively) were found in Alaska.
- No respondents were diagnosed as dependent on heroin or inhalants.
- Statewide abuse of hallucinogens was 0.1%, while no respondents were diagnosed as abusers of cocaine, heroin, inhalants, or amphetamines.
- Adults under 65 years of age were much more likely than those 65 or older to be dependent on or abusing drugs and alcohol.

Summary Table 1: Lifetime Estimates of Dependence and Abuse of Alcohol and Illicit Substances, Statewide and by Substate Planning Region

		Substate Planning Region			
	Alaska	*Urban*	*Gulf Coast*	*Southeast*	*Bush*
	N=423,997	N=277,071	N=50,796	N=52,538	N=43,592
Percentage diagnosed as	(n=8,167)	(n=2,543)	(n=1,587)	(n=2,017)	(n=2,020)
Dependent on:					
Alcohol	9.7	9.4	8.5	10.5	11.9
Marijuana	1.1	1.0	1.0	1.1	2.5
Hallucinogens	0.1	0.0	0.1	0.1	0.1
Cocaine	0.2	0.3	0.1	0.2	0.1
Heroin	0.0	0.0	0.0	0.0	0.0
Inhalants	0.0	0.0	0.0	0.0	0.0
Amphetamines	0.1	0.1	0.2	0.1	0.0
Abusing:					
Alcohol	4.1	4.1	3.9	4.9	3.2
Marijuana	0.4	0.4	0.5	0.4	0.2
Hallucinogens	0.1	0.1	0.0	0.0	0.0
Cocaine	0.0	0.0	0.0	0.0	0.0
Heroin	0.0	0.0	0.0	0.0	0.0
Inhalants	0.0	0.0	0.0	0.0	0.0
Amphetamines	0.0	0.0	0.0	0.0	0.0

Summary Table 2: Current Estimates of Dependence and Abuse of Alcohol and Illicit Substances, Statewide and by Substate Planning Region

		Substate Planning Region			
	Alaska	*Urban*	*Gulf Coast*	*Southeast*	*Bush*
Percentage diagnosed as	N=423,997 (n=8,167)	N=277,071 (n=2,543)	N=50,796 (n=1,587)	N=52,538 (n=2,017)	N=43,592 (n=2,020)
Dependent on:					
Alcohol	5.2	5.2	3.5	5.1	6.8
Marijuana	0.4	0.4	0.1	0.3	1.1
Hallucinogens	0.0	0.0	0.0	0.1	0.1
Cocaine	0.1	0.1	0.1	0.1	0.0
Heroin	0.0	0.0	0.0	0.0	0.0
Inhalants	0.0	0.0	0.1	0.0	0.0
Amphetamines	0.1	0.1	0.1	0.1	0.0
Abusing:					
Alcohol	2.1	1.9	1.8	3.5	2.0
Marijuana	0.1	0.1	0.1	0.2	0.1
Hallucinogens	0.0	0.0	0.0	0.0	0.0
Cocaine	0.0	0.0	0.0	0.0	0.0
Heroin	0.0	0.0	0.0	0.0	0.0
Inhalants	0.0	0.0	0.0	0.0	0.0
Amphetamines	0.0	0.0	0.0	0.0	0.0

Treatment Needs Based on Diagnoses

"Need for treatment" is defined as being in a state of substance abuse or dependence and requiring help to stop or cut down on substance use, to prevent relapse, or to recover from the effects of use. The operational definition of treatment need is a diagnosis of a substance use disorder, either abuse or dependence. Indeterminate diagnoses were not included in the definition of the need for treatment. Using the diagnoses for dependence and abuse of substances, the number of persons who need treatment for alcohol only, drugs only, and both alcohol and drugs were determined.

- 12.6% of adults (about 53,268 persons) in Alaska need treatment for alcohol only. Another 1.2% (approximately 5,134 persons) need treatment for both drugs and alcohol. 0.5% (approximately 2,270 persons) need treatment for drugs only.

- The proportion of persons who need alcohol treatment varies across the substate planning regions.

- The estimated need for alcohol treatment was found primarily in the 18-64 year old segment of the population (more than 10%). About half this rate, 5.1%, was reported by the 65 and older age group.

- A pronounced need for alcohol treatment only (48%) as well as both drug and alcohol treatment (14.5%) was found among injection drug users.

Summary Table 3: Lifetime Estimates of Need for Alcohol and Other Drug Treatment, Statewide and by Substate Planning Region

		Substate Planning Region			
Need for:	*Alaska* N=423,997 (n=8,167)	*Urban* N=277,071 (n=2,543)	*Gulf Coast* N=50,796 (n=1,587)	*Southeast* N=52,538 (n=2,017)	*Bush* N=43,592 (n=2,020)
Alcohol Treatment Only	12.6	12.3	11.3	14.4	13.5
Drug Treatment Only	0.5	0.4	0.7	0.6	1.1
Both Alcohol and Drug Treatment	1.2	1.2	1.0	1.0	1.6

Unmet Demand for Self-Reported Treatment Needs

For policy planning purposes, the measurement of unmet demand is a key objective of needs assessment. "Unmet demand" is defined as the number of people who need and want treatment, but who have not received it because it was unavailable. Presumably, unmet demand is the prime reason for seeking additional funds, changing allocations of existing funds, and developing new programs that are appropriate for underserved populations. In the adult household survey, respondents were asked if they received treatment in the last year and, if so, what kind they obtained and if they had a desire for more treatment. For those who did not receive treatment in the past year, respondents were asked whether they needed treatment in the past year, whether they would have obtained treatment if it had been available, what type of treatment they would have wanted, and what obstacles, if any, prevented them from receiving treatment.

Among those who received treatment in the past 12 months and desired more treatment...(N=1,093)

The vast majority of Alaska adults who desired more treatment for their substance use problem were found to be aged 25 to 44 (79%). These persons were residents of all regions.

- 50.3% of the persons who desired more treatment for their substance use problem were women. Again, these persons were residents of all regions, with the largest proportions in the Urban and Southeast regions (55.4% and 54.7% respectively).
- Over two-thirds (72.8%) of the persons who desired more treatment were white.
- Among women of childbearing age, 50.3% desired additional treatment. These women were found in all regions except the Gulf Coast.
- Among injection drug users, 21% desired more treatment. These individuals were found in all regions, with the largest proportion (26.9%) in the Urban region.

Among those who desired treatment but did not obtain treatment in the past 12 months...(N=1,622)

- All adults (100%) who desired treatment but had not obtained treatment in the past 12 months were ages 18 to 64. More than three-quarters (79%) of the adults who desired treatment were ages 25 to 44.

- 59.6% of the adults who desired treatment but had not obtained treatment in the past 12 months, were men. This proportion of men was not uniform throughout the state. It ranged from 59.0% in the Urban region to 90.4% in the Bush region.

- More than two-thirds of adults who desired treatment but had not received treatment were white.

- Among those who did not receive treatment in the past 12 months, but desired treatment, the largest proportion were women of childbearing age (40.4%).

- Of the adults who desired treatment, 12.7% were injection drug users, and all of these drug users were in the Urban region.

Obstacles to Treatment

Among those who received treatment in the past 12 months and desired more treatment...(N=1,093)

Adults who received treatment in the past 12 months and who cited obstacles to receiving more treatment were found in all regions. The following obstacles were reported by 25% or more of these respondents on a statewide basis:

- Lack of insurance or other means to pay for treatment
- Specific treatment type was not available
- Program did not have the special services they needed.

Among those who desired treatment but did not receive treatment in the past 12 months...(N=1,622)

Adults who cited obstacles to obtaining treatment in the past 12 months were found in all regions. The following obstacles were reported by 25% or more of these respondents on a statewide basis:

- Lack of insurance or other means to pay for treatment
- Programs put them through too much red tape
- Long distance between them and the nearest treatment facilities
- Treatment facilities were full, and
- Could not get the type of treatment they wanted.

Conclusions

- 9.7% of adult Alaska residents were dependent on alcohol and another 4.1% were diagnosed as alcohol abusers. This translates into approximately 58,402 adult Alaska residents in need of treatment for alcohol.

- Looking at persons who are abusing or dependent on drugs only, 0.5% percent are in need of treatment. This translates into 2,270 persons needing treatment for drugs only.

- Among the defined age groups, the need for alcohol treatment is most pronounced in adults ages 25 - 44 (14.9%).

- 21% of the persons who had received treatment in the past 12 months and desired more treatment were injection drug users.

- The major obstacles to receiving treatment reported by persons who had received treatment in the past 12 months and desired more treatment were: lack of insurance or other means to pay, specific treatment type was not available, and the programs did not have the special services they needed.

- 40.4% of persons who desired treatment but had not received treatment in the past 12 months were women of childbearing age. Slightly more than one in eight (12.7%) were injection drug users.

- Obstacles to receiving treatment cited by those who desired it but had not received any treatment in the past 12 months included: lack of insurance or other means to pay, the programs put them through too much red tape, the nearest treatment facilities were too far away, the treatment programs were full, and respondents could not get the type of treatment they wanted.

- The data show that alcohol treatment needs varied across the four defined substate planning regions in Alaska.

EXECUTIVE SUMMARY:

TECHNICAL REPORT

SUBSTANCE ABUSE INDICATOR STUDY FOR TREATMENT RESOURCE ALLOCATION

Submitted to:

Alaska Department of Health and Social Services

Division of Alcohol and Drug Abuse and to the Section of Epidemiology of the Division of Public Health

Submitted by:

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The Gallup Organization
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December 1998

Executive Summary

The Alaska Substance Abuse Indicator Study (SAIS) was designed to allow the Alaska Division of Alcohol and Drug Abuse and Division of Public Health (ADA /DPH) to coordinate and compile related data within the state of Alaska on substance abuse; to develop substance abuse indicator models for application to allocate treatment service resources in the state of Alaska; and to understand the context of substance use in the state by looking at the trends of common indicators. In addition, the SAIS was also expected to improve communication linkages between ADA /DPH and those public and private agencies which monitor direct and indirect substance abuse indicators in order to further expand the utility of existing information.

Background

ADA /DPH currently takes into consideration the existing substance abuse indicator data at best marginally when determining substance abuse treatment resource allocation. ADA /DPH attempts to put core substance abuse services in each region. ADA /DPH requires needs assessment data to assess the proportion of the population in need of treatment which is able to receive treatment and the number of persons still in need of treatment in order to guide planning efforts. The division guides its treatment services resource allocation decisions on the basis of the population size, substance abuse prevalence and the need for core services in each region. ADA /DPH sought to address scientifically treatment planning needs, and received funding by the Center for Substance Abuse and Treatment (CSAT) to contract with The Gallup Organization (Gallup) to explore alternative approaches for resource allocation decisions.

The SAIS compared and contrasted three categories of treatment resource allocation models: 1) *population-based model*, 2) *indicator-based model*, and 3) *household survey-based model*.

The population-based model typically considers only the population size of the geographic unit in allocating resources. This approach may consider the variations in local cost index, but would hardly consider the data on local treatment service need.

The household and indicator-based models, in contrast to the population-based model, consider the local treatment need in allocating treatment resources. The household survey-based model considers the locally estimated need for treatment services. Treatment need, as measured in the latest Gallup adult household survey, is defined as those adults who were diagnosed as dependent on alcohol, drugs, or both drugs and alcohol, and those diagnosed as abusing one or more substances, as measured by the Diagnostic Statistical Manual (DSM-III-R) criteria. The main limitation in assessing treatment need with the household survey is that the data are expensive to collect and are not collected routinely by the state.

The indicator-based model offers a promising alternative approach, which is not only less costly but also promotes using the existing data from other state agencies. The indicator-based model The indicator-based model offers a promising alternative approach, which is not only less costly but also promotes using the existing data from other state agencies. uses the secondary data to determine the prevalence of substance abuse at the region level.

Method

The study was implemented from July 1996 to December 1998 in three phases: 1) data collection and coordination, 2) indicator selection and validation, and 3) modeling and resource allocation. Gallup, with assistance from ADA /DPH, collected substance abuse indicator data for the five year period of 1990 to 1994. The data were subjected to modeling efforts in a series of steps:

Step 1: Data on the substance abuse indicators were described as the *rates* (per 100,000 population) to allow for comparisons across the boroughs. The *rates* were calculated by using the region level data on each substance abuse indicator (such as number of arrests, mortality etc.) as the *numerator* and the six year (1990-95) average of Alaska Population or 1995 Alaska Population as the *denominator.*

Step 2: These rates were used to calculate the *severity indices* for each indicator and each region. Severity Indices were expressed on a scale of 0 to 100, where score of 100 fixes the top of the range of substance abuse problem. A region with the highest rate on a given indicator will have 100 as its severity index for that indicator. All other severity indices within a given region are expressed as a percentage of the largest problem.

Step 3: Severity indices were combined to develop a *composite severity index* (CSI) for each region. The CSIs score remains on a scale of 0 to 100 and is derived by taking an average of all severity indices for each region.

Step 4: The CSIs were multiplied with the adult region population to estimate the region's *problem size.* The problem size is an estimate of the substance abuse problem derived by multiplying the CSI with the region's five (1990-94) year population average.

Step 5: *Allocation factors*, in proportion to the region's problem size, were established to guide the treatment resource allocation decisions. The sum of the problem sizes of each region represents the total problem size for the state of Alaska and was used to establish the proportional resource allocation factor for each region in the state of Alaska.

Limits of the Data

The data on arrests and treatment cover the period 1990 to 1994, while the data on accident injuries accident fatalities, and mortality cover the period 1991-1995. In addition to different dates for the indicator data, two of the indicator data sets -- for accident injuries and accident fatalities -- do not include either the race or geographical variables.

The lack of a geographical variable is particularly important when considering the modeling to determine resource allocation. The purpose of resource allocation is to assess what proportion of resources are needed in each of the four regions in Alaska, and thus the lack of the geographical

variable for two of the indicators means that those indicators cannot be used to make those resource allocation estimates.

Trends in Rates of Treatment, Arrests, Mortality, Accident Injuries and Accident Fatalities

A comparison of the five indicators across the five years for which they are available shows that overall the alcohol and drug abuse problem in Alaska showed some significant improvement by the mid-1990s compared to the early 1990s. Overall treatment increased, at the same time that mortality rates and injury rates from accidents declined. There was little change in accident fatality rates, however, which were quite low. Arrests related to alcohol and drug abuse increased slightly across the state as a whole over the five-year period.

Alaska Treatment Resource Allocation Model

Of all the substance abuse indicator data elements included in the Alaska SAIS database, only two were chosen for modeling purposes because complete data grouped by region, race, gender were available. Others (accidents and injuries data) could not be included because of incomplete data sets. The two indicators chosen for modeling were the following:

- Total alcohol and drug related arrests
- Total drug and alcohol related mortality

Gallup's analysis showed that the indicator-based model emerges as a promising approach for allocating treatment resources among boroughs. Gallup developed two indicator-based models, a telephone survey model, and a population model for ADA /DPH to guide its treatment resource allocation decisions. ***Model One*** includes both the indicators but calculates the rates using the average of 1990-95 populations. ***Model Two*** considers both the indicators but calculates the rates based on the 1995 Alaska population. ***Model Three*** is based on the results of the telephone survey, while ***Model Four*** is based on the size of population. The treatment resource allocation factors, using these models, are shown in Table 1.

Table 1. Treatment Resource Allocation Factors Among the Various Models

	Urban Region	Gulf Coast Region	Southeast Region	Bush Region
Indicator Model #1	57.6%	13.8%	13.5%	15.1%
Indicator Model #2	58.0%	14.1%	13.4%	14.5%
Telephone Survey Model	63.7%	10.4%	13.9%	12.0%
Population Model	64.4%	11.6%	12.3%	11.7%

Recommendations

Gallup believes that the experience gained by ADA /DPH in designing and implementing the SAIS produced promising results. Gallup's recommendations focus on using the indicator-based model, updating the SAIS database, and meeting methodological challenges.

Using Indicator-Based Model

Gallup believes that ADA /DPH can achieve cost-effectiveness in resource allocation by guiding its decisions with the indicator-based model presented in this report. This approach not only takes into account the size of the population, but also the severity of the substance abuse problem in the region.

Updating the SAIS Database

Gallup encourages ADA /DPH to make arrangements to update the 1990 to 1994 SAIS database from cooperating agencies on an annual basis. In this way, any changes in the statistical relationships within and among social indicators can be determined. This would allow ADA /DPH to provide timely social indicator information to other public and private organizations with an interest in substance abuse prevention, treatment and related activities.

EXECUTIVE SUMMARY:

TECHNICAL REPORT

ALASKA SMALL AREA ESTIMATION STUDY

Submitted to:

Alaska Department of Health and Social Services

Division of Alcohol and Drug Abuse and to the Section of Epidemiology of the Division of Public Health

Submitted by:

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December 1998

EXECUTIVE SUMMARY

Introduction

The small area estimation study for the state of Alaska was undertaken as a follow-up task of the statewide Adult Household Survey conducted by the Gallup Organization in 1997-98. The main objective of the small area estimation study was to improve the overall precision of some of the key household study estimates at the 'small area' level. The resources provided by the Center for Substance Abuse Treatment (CSAT) and the Alaska Department of Health and Social Services, Division of Alcoholism and Drug Abuse (ADA) have expanded needs assessment efforts in Alaska during the 1997-1998 time period. The goal of the adult household survey was to provide information on substance dependence, abuse, prevalence and treatment needs for adults in the state of Alaska mainly at the state and the sub-state planning region level. For small areas, however, the traditional direct survey estimators based solely on the household study may have relatively large standard errors because of inadequate sample size at the 'small area' level. The objective of the small area estimation task, therefore, was to improve the precision of such small area estimates by taking advantage of relevant information at the small area level.

Methodology

In the state of Alaska, the boroughs within each sub-state planning region were chosen as 'small area' for the purpose of this small area estimation analysis. Estimates were computed to provide information on dependence, abuse, severity and treatment need for Alcohol, Marijuana and other drugs. Estimates for both lifetime and current diagnosis were derived. The analysis was carried out following the methodology proposed by Chattopadhyay et al. (1996). A detailed description of the estimation method is discussed in Section 2 of this report. Empirical Bayes estimates were computed at the small area (borough) level. In order to evaluate the appropriateness of the small area estimation methodology, Section 3 tables also include both the direct survey estimates (based on adult household survey data) and the small area estimates at the borough level. As expected, the small area estimates were, in general, found to be more precise than the direct survey estimates at the borough level.

Section 3 of this report presents the small area estimates for each borough. The estimates were computed for the following variables: (i) Diagnosis of alcohol dependence, abuse, and severity of alcohol dependence (ii) Diagnosis of marijuana dependence, abuse, and severity of marijuana dependence and (iii) Diagnosis of other drugs dependence, abuse, and severity of other drugs dependence. The 'other drugs' included the following five drugs: Hallucinogen, Cocaine, Heroin/Opiate, Amphetamine and Inhalants. Since very few respondents were diagnosed as dependent or abusers of these drugs particularly at the borough level, these drugs were put together in the 'other drugs' category. Respondents with diagnosis of dependence on any one of the five drugs, for example, were treated as diagnosed for dependence on 'other drugs.' For the severity variable, all respondents with diagnosis of severe dependence (on alcohol, marijuana or other drugs) were treated as being diagnosed for severity. The remaining (no severity, mild severity or moderate severity) were treated as being not diagnosed for severity. Besides the lifetime diagnosis variables mentioned above, small area estimates were also computed for

current diagnosis variables for alcohol, marijuana and other drugs. Using the diagnoses for dependence and abuse of substances, small area estimates of the percentage of adults who need treatment for alcohol only, drugs only, and both alcohol and drugs were also derived at the borough level. The definitions of diagnosis of dependence, abuse or severity according to the DSM-IIIR are available in the adult household study report.

The small area estimation analysis was based on the Alaska adult household survey data and current census data. For details of the methodology, definition of terms and data collection procedures used in the adult household study, please refer to the adult household survey report (1998) submitted by the Gallup Organization. The current estimates of the census data were obtained from the on-line database called CLARITAS if Ithaca, New York.

Major Findings

The small area estimation was carried out using the sample data of the Alaska Adult household Study. The sample size (# of completed interviews) at the borough level varied significantly. The maximum sample size was (1534) in Anchorage whereas the minimum size (49) was in Bristol Bay and Lake and Peninsula. Besides Anchorage, the boroughs with relatively higher sample size were Kenai Peninsula (1062), Juneau (855), Fairbanks Northstar (548), Bethel (483) and Ketchikan Gateway (412). Some other boroughs with relatively smaller sample size were Haines (67), Aleutians East (77) and Aleutians West (99). Use of small area estimation techniques become particularly important for the boroughs with smaller sample size.

As explained in this report, the boroughs were chosen as the 'small areas' for this analysis. It is found that the proposed small area estimates (the empirical bayes estimates) are more reliable (in terms of sampling error or precision) as compared to the direct survey estimators (based on the adult study) at the borough level. The empirical bayes estimates are, therefore, recommended at the borough level particularly for boroughs with smaller sample size.

The following findings are based on data presented in Table1 through Table 15 of Section 3 of this report.

Lifetime Diagnosis of Alcohol Dependence: The estimated percentage of adults with lifetime diagnosis of alcohol dependence varied across boroughs. Based on the empirical bayes estimates, the percentages ranged from 7.75 to 13.78. The top three boroughs were Yukon-Koyukuk (13.78), North Slope (13.78), Bethel (12.94). The bottom three boroughs were Kodiak Island (7.75), Kenai Peninsula (8.47), Matanuska-Susitna (8.96). The sampling error as measured by the square root of mean square error (mse) for the estimates were in the range of 0.75 to 2.76. The margin of error (precision) calculated as 1.96 times the square root of mse is always found to be less than 5 percent.

Lifetime Diagnosis of Alcohol Abuse: The estimated percentage of adults with lifetime diagnosis of alcohol abuse varied across boroughs. Based on the empirical bayes estimates, the percentages ranged from 2.33 to 6.67. The top three boroughs were Aleutians West (6.67), Prince of Wales (5.75)and Juneau (5.18). The bottom three boroughs were Bethel (2.33), Dillingham (2.83) and Wade Hampton (2.86). The sampling error as measured by the square root of mean square error (mse) for the estimates were in the range of 0.52 to 1.54. The maximum

margin of error (precision) calculated as 1.96 times the square root of mse is found to be only about 3 percent.

Lifetime Diagnosis of Marijuana Dependence: The estimated percentage of adults with lifetime diagnosis of marijuana dependence varied across boroughs. Based on the empirical bayes estimates, the percentages ranged from 0.59 to 2.88. The top three boroughs were North Slope (2.88), Wade Hampton (2.81) and Northwest Arctic (2.70). The bottom three boroughs were Matanuska-Susitna (0.59), Sitka (0.85) and Haines (0.85). The sampling error as measured by the square root of mean square error (mse) for the estimates were in the range of 0.25 to 0.89. The maximum margin of error (precision) calculated as 1.96 times the square root of mse is only about 1.74 percent.

Lifetime Diagnosis of Marijuana Abuse: The estimated percentage of adults with lifetime diagnosis of marijuana abuse did not vary much across boroughs. Based on the empirical bayes estimates, the percentages ranged from 0.13 to 0.59. The top three boroughs were Kodiak Island (0.59), Valdez-Cordova (0.53) and Kenai Peninsula (0.51) where as the bottom three boroughs were Wade Hampton (0.13), Northwest Arctic (0.14) and Bethel (0.14). The sampling error as measured by the square root of mean square error (mse) for the estimates were in the range of 0.05 to 0.23. The maximum margin of error (precision) calculated as 1.96 times the square root of mse is less than .5 percent.

Lifetime Diagnosis of 'Other drugs' dependence and abuse: The estimated percentage of adults with lifetime diagnosis of dependence or abuse on 'other drugs' did not vary much across boroughs. There were very few cases reported in these categories and the maximum percentage estimate for dependence and abuse was only about 0.59 and 0.12 percent respectively. The margin of error (precision) calculated as 1.96 times the square root of mse was also very small (less than 0.5 percent).

Any Current Alcohol Diagnosis: The estimated percentage of adults with any current alcohol diagnosis varied across boroughs. Based on the empirical bayes estimates, the percentages ranged from 5.07 to 10.03. The top three boroughs were Prince of Wales (10.03), Lake and Peninsula (9.90) and Nome (9.54). The bottom three boroughs were Kenai Peninsula (5.07), Valdez-Cordova (5.23) and Kodiak Island (5.52). The sampling error as measured by the square root of mean square error (mse) for the estimates were in the range of 0.66 to 2.15. The maximum margin of error (precision) calculated as 1.96 times the square root of mse is always less than 5 percent.

Any Current Marijuana Diagnosis: The estimated percentage of adults with any current marijuana diagnosis did not vary significantly across boroughs. Based on the empirical bayes estimates, the percentages ranged from 0.24 to 1.40. The sampling error as measured by the square root of mean square error (mse) for the estimates were in the range of 0.10 to 0.47. The maximum margin of error (precision) calculated as 1.96 times the square root of mse is less than 1 percent.

Any Current Other Drug Diagnosis: The estimated percentage of adults with any current 'other Drugs' diagnosis did not vary significantly across boroughs. There were very few cases reported in this category and the percentages ranged from 0.05 to 0.37. The margin of error (precision)

calculated as 1.96 times the square root of mse was also very small (less than 0.5 percent).

Need for Alcohol Treatment only: The estimated percentage of adults needing alcohol treatment only varied across boroughs. Based on the empirical bayes estimates, the percentages ranged from 10.04 to 17.77. The top three boroughs were Prince of Wales (17.77), Aleutians West (16.95) and Ketchikan Gateway (15.59). The bottom three boroughs were Wade Hampton (10.04), Valdez-Cordova (10.95) and Kodiak Island (11.12). The sampling error as measured by the square root of mean square error (mse) for the estimates were in the range of 0.85 to 3.08. The margin of error (precision) calculated as 1.96 times the square root of mse is found to be about 6 percent.

Need for Drug Treatment only: The estimated percentage of adults needing drug treatment only did not vary significantly across boroughs. Based on the empirical bayes estimates, the percentages ranged from 0.34 to 1.30. The sampling error as measured by the square root of mean square error (mse) for the estimates were in the range of 0.10 to 0.56. The margin of error (precision) calculated as 1.96 times the square root of mse is found to be only about 1 percent.

Need for both Alcohol and Drug Treatment: The estimated percentage of adults needing both alcohol and drug treatment did not vary significantly across boroughs. Based on the empirical bayes estimates, the percentages ranged from 0.77 to 2.01. The sampling error as measured by the square root of mean square error (mse) for the estimates were in the range of 0.24 to 0.57. The margin of error (precision) calculated as 1.96 times the square root of mse is found to be only about 1 percent.

In summary, the number of adults diagnosed for dependence or abuse was significantly higher for alcohol as compared to other drugs. Among drugs excluding alcohol, marijuana had the maximum number of diagnosed cases. There were very few cases of diagnosis for other drugs consisting of Hallucinogen, Cocaine, Heroin/Opiate, Amphetamine and Inhalants. The pattern was similar for both lifetime and current diagnosis variables. The number of adults needing treatment was also much higher for alcohol as compared to other drugs.

EXECUTIVE SUMMARY:

TECHNICAL REPORT

ALASKA
SUBSTANCE ABUSE NEED for TREATMENT
Among ARRESTEES (SANTA)

Prepared by
Johnson, Bassin &Shaw

Submitted to:

Alaska Department of Health and Social Services

Division of Alcohol and Drug Abuse and to the Section of Epidemiology of the Division of Public Health

December 4, 1998

EXECUTIVE SUMMARY

The Federal Center for Substance Abuse Treatment (CSAT) provided several State agencies with funding to perform a family of studies to estimate statewide need for substance abuse and dependency treatment. One member of the family of studies is the Substance Abuse Need for Treatment among Arrestees (SANTA). As its name implies, SANTA is designed to provide preliminary estimates of treatment need among arrestees. Arrestees are targeted for special study because substance use and abuse are especially high in this population and because substance use is often associated with the commission of other crimes. The six objectives of the Alaska SANTA study were to: (1) profile arrestees who met DSM-III-R diagnostic criteria for substance abuse or dependence; (2) profile arrestees whose urinalyses were positive for at least 1 of 10 drugs tested; (3) compare results of self-report data and urinalyses; (4) describe the substance abuse treatment histories of arrestees who had positive urinalyses as well as treatment histories of arrestees with DSM-III-R substance abuse/dependence diagnoses; (5) identify factors associated with chemical detection and DSM-III-R diagnoses of substance abuse or dependence; and, (6) compare current SANTA results with previous Drug Use Forecasting (DUF) survey results.

The study participants were 658 adult arrestees from four jails at three sites: Anchorage, Fairbanks, and Yukon/Kuskokwim. Sites were selected for ethnic diversity, degree of urbanicity, high flow rates, and relatively high numbers of female arrestees. Participants were asked to complete a modified DUF interview, which measures DSM-III-R substance abuse and dependence diagnostic criteria, treatment history, and demographics. Participants also were asked to provide a urine sample, which provided chemical evidence of recent ingestion of 10 drugs. Eligibility requirements included arrest within the previous 48 hours, so that urinalysis results would indicate whether the arrestee was under the influence at the time of arrest.

Interviews were conducted by local college students with criminal justice or social science training or other relevant experience. Interviewers were trained by staff from the Center for Substance Abuse Research (CESAR). Urinalysis was conducted by Quest Diagnostics, Inc. Data were analyzed by JBS. More than half of study participants received a substance abuse or dependence diagnosis. Also, more than half tested positive for at least one drug. Alcohol was the substance most frequently associated with an abuse/dependence diagnosis. Cocaine was the illicit drug most frequently associated with a DSM-III-R substance abuse/dependence diagnosis, followed by marijuana. Marijuana was the illicit drug most frequently associated with a positive urine test, followed by cocaine. Males were more likely than females to be diagnosed with marijuana abuse/dependence or test positive for marijuana. Females were more likely than males to be diagnosed with cocaine abuse/dependence or test positive for cocaine. Arrestees who were older were more likely than those who were younger to receive an alcohol or cocaine abuse/dependence diagnosis. Older arrestees were also more likely than younger ones to have a urine test indicating cocaine use. Younger arrestees were more likely than older ones to test positive for marijuana or to be diagnosed as abusing or dependent on marijuana. Alcohol abuse and dependence were more prevalent among Alaskan Natives than other ethnic groups, while Alaskan Natives were less likely than other ethnic groups to be diagnosed with cocaine abuse/dependence.

For marijuana and cocaine there was a higher rate of positive urinalysis than DSM-III-R diagnosis. This indicates that some arrestees who use these drugs either do not currently meet the criteria for an abuse/dependence diagnosis, or that they are not honestly reporting their symptoms. For narcotics and amphetamines, more arrestees were diagnosed with abuse/dependence than tested positive. Thus, many arrestees who are in need of substance use treatment for narcotics or amphetamine abuse/dependence either had not used their problem substance recently before arrest, or received a false negative urine test.

Urinalysis results and self-reports of last 3 days' use were often discrepant. With the exception of amphetamines, most arrestees who tested positive denied using the corresponding drug. In the case of amphetamines, the same proportion who tested positive reported using them within the last 3 days. Discrepant results may be due to resistance to giving socially undesirable responses, misunderstanding or procedural errors during the interview, or measurement error in the interview or urine tests.

Nearly three-fourths of those who tested positive for drug use had not received treatment within the past year. Over 60 percent of those with positive urinalyses who had not received treatment within the past year also did not perceive that they needed treatment for their substance use, indicating that this population is unlikely to seek or participate in treatment voluntarily. Just over 70 percent of arrestees with DSM-III-R substance abuse/dependence diagnoses did not report that they had received substance abuse treatment during the past year. Just under half of those with diagnoses who had not received treatment also did not perceive that they needed treatment. These findings suggest that efforts to treat this problem should include not only providing adequate treatment slots, but also outreach efforts to encourage participation.

Need for treatment may be predicted by ethnicity, sex, and type of crime committed. Logistic regression results indicate that white arrestees are more likely than others to test positive for drug use. A DSM-III-R diagnosis of illicit drug abuse/dependence was predicted by being white, female, or a felon. A DSM-III-R diagnosis of alcohol abuse/dependence was predicted by being non-white, over 25 years old, or a non-felon. DSM-III-R diagnoses of abuse or dependence on both alcohol and drugs were predicted by being white.

In general, Alaska SANTA study participants were less likely to test positive for drug use than 1996 DUF study participants. This was especially true for cocaine, opiates/narcotics and multiple drugs.

Current results are derived from a convenience sample, and therefore cannot be generalized to Alaska's population of adult arrestees. More precise estimates can be derived from further research on the number of arrestees in the State, and from estimates of need among a random, representative sample of arrestees.

The current preliminary finding that a total of 397 (60.3%) out of 658 arrestees meet criteria for a DSM-III-R diagnosis of substance abuse/dependence suggests that a large proportion, possibly the majority, of arrestees in Alaska may be in need of substance abuse treatment services

Alaska's Treatment Needs Assessment:

Critical Review of Conducted Studies and Preparation of Information for Systems Planning

Submitted to:
The Division of Alcoholism and Drug Abuse
State of Alaska, Department of Health and Social Services

By:
The North Charles Research and Planning Group of North Charles, Inc.

March 11, 1999

Introduction

This report provides a summary of the study conducted by the North Charles Research and Planning Group (NCRPG) that produced the appended critical reviews of treatment needs assessment studies conducted for the State of Alaska. The State invested its State Treatment Needs Assessment Project (STNAP) round one support in three studies: 1) a survey of substance abuse treatment needs in the general household population, 2) a survey of recent arrestees that featured a computer-assisted personal interview concerning treatment needs and collected urine specimens to confirm the self-reported use of illicit drugs, and 3) a substance abuse indicator study. The substance abuse indicator study also included the use of a new methodology for distributing survey information compiled for four large geo-political groups of Alaska communities to smaller areas within the major groups. The survey contractors submitted draft final reports for the household survey (The Gallup Organization, Inc.), the Substance Abuse and Need for Treatment among Arrestees (SANTA) study (JBS, Inc.) and a Substance Abuse Indicator Study for Treatment Resource Allocation (Gallup). The contractors also submitted the data sets resulting from completed interviews in the household and arrestee studies along with information describing the process of the studies. The data collected from reporting agencies that were used in the indicator study were provided to NCRPG.

Alaska contracted with NCRPG to help evaluate the work of the contractors and to insure that the studies' methodologies and data are in adequate condition for the comprehensive substantive analyses that NCRPG will perform in round two of Alaska's STNAP. It is very important that these checks be conducted soon after the data collection is completed. If there are problems in the data sets, fixing those problems may be possible if they are discovered immediately. The evaluation of the materials delivered by the contractors will help assure that the contractors were compliant with the conditions of their contracts with Alaska. NCRPG evaluated the quality of the data and the adequacy of the documentation of the data and data collection procedures.

In many other fields, it is commonplace to have an independent expert advise the project sponsor regarding the technical adequacy of the work being completed. NCRPG used its unique background and general technical expertise to evaluate the studies conducted under contract with Gallup and JBS. As the CSAT technical assistance contractor for five years, NCRPG designed the data collection studies conducted by Alaska's contractors. NCRPG also reviewed final reports from many states with similar studies conducted by Gallup and JBS as well as by other state contractors. Frequently, NCRPG advised states about the technical adequacy of the finished product.

Household Survey

NCRPG evaluated the household telephone survey by reviewing analyzing the survey database and the adequacy (e.g., completeness) of the draft final report and the data collection procedures and outcome. The evaluation is included as Appendix A to this final report. The evaluation focused on the major concerns of how the response rate was defined, the components of the response rate including process measures such as the success in converting respondents who initially refused to participate into completed interviews, the sampling design, and procedures for weighting the sample to the population of the state.

NCRPG's overall evaluation of the telephone survey was that the information base accurately describes the current need for substance abuse treatment among people living in Alaskan households. Some of the strengths of the household survey conducted for Alaska include a satisfactory response rate, the use of an effective procedure for allocating more interviews to geographic areas where problems with substances were more prevalent, and estimates of the level of need for treatment that were consistent with estimates from other sources including the NCRPG substance abuse problem index and current levels of met demand for treatment. The information produced by the survey should make an important contribution to further efforts by ADA to improve treatment services.

The review pointed out the need for further processing of the data set that would recode responses now designated as "additional responses" that should be included into existing response categories. A number of interviews identified by the interviewers as of poor quality or self-reported by the respondents to be less than truthful needed to be examined and the results of the survey adjusted for any impact these cases might have on the outcomes. The procedure for weighting survey results to represent the population of Alaska needed to be better defined in the report, but we concluded that the method used fewer than the necessary number of age groups to compute population weights. NCRPG's review yielded several suggestions for improving Gallup's report of survey outcomes including the need to present need estimates based on the actual survey sample as well as after the survey statistics were applied to the state population.

SANTA Study

The evaluation of the SANTA study included topics similar to those used for the evaluation of the household survey, e.g., the quality of the data, and topics that are unique to SANTA studies. The evaluation of the SANTA study is included as Appendix B of this report. Among the concerns unique to SANTA studies that were considered in NCRPG's evaluation was the contractor's success in obtaining biological specimens (urine) for testing, the length of time between arrest and acquisition of a urine sample, the completeness of the report of the SANTA study with respect to documenting differences among sites, across arrest types, by the day and time of the arrests, and the differences between respondents who provided specimens and those who did not.

NCRPG's review of the draft report and inspection of the collected information set indicated that the SANTA study was conducted using procedures that were consistent with the study protocol. The information base resulting from the study seemed to be devoid of major flaws. We did find errors in the data definitions that suggested the need for a careful review of the data dictionary. Despite a high rate of refusal to provide biological samples and a high rate of underreporting of drug use (e.g., 60% of the arrestees who denied using marijuana in the last three days tested positive for the drug and 47% of arrestees who denied using cocaine had traces in their urine) the findings from the SANTA study show rates of recent drug use that are much higher than rates observed in the general population. For example, 58% of the SANTA respondents who submitted a urine sample tested positive for at least one drug.

The practical uses of the SANTA data primarily involve the criminal justice system. Features of the SANTA study design and questionnaire limit the study's ability to add to Alaska's knowledge about the statewide prevalence of current need for treatment. However, the SANTA

study outcomes could be profitably used to alert constituencies of the need to develop policies and strategies that would incorporate substance abuse treatment into the criminal justice system at the point of arrest. Providing treatment instead of or as part of imprisonment has become a major national agenda. The economy of providing treatment rather than incarceration merits further efforts in this area. The SANTA data on treatment need outcomes can be used to demonstrate just how large that economy might be in Alaska

Substance Abuse Indicator Study

The substance abuse indicator study was subjected to a review that focused on the selection of variables used in the estimation model, the documentation of the data, the quality of the data in the database, and the contractor's methods for determining reliability and validity for the estimation model. The review of the substance abuse indicator study is included in this report as Appendix C.

Gallup produced a social indicator model that estimated need for combined alcohol and drug treatment in four geo-political areas of Alaska using alcohol- and drug-related arrests and alcohol- and drug-related deaths. NCRPG concluded that other indicators besides those two could have been used profitably in the study. Using just the four major regions as the unit of analysis instead of the smaller census boroughs reduced the usefulness of the needs estimates for planning. Similarly, Gallup used demographic variables aggregated to the regional level with the result that demographic characteristics have little variance across regions. NCRPG's review of the Gallup study was critical of the lack of separate models for alcohol and drug treatment needs. We also noted that Gallup performed no tests of the validity or reliability of the social indicator model. Our review strongly suggested Gallup should give more attention to its report presentation. The graphs were hard to read and the formatting of tables included a confusing use of line numbers. In many displays, numbers were expressed in tens rather than units, but not labeled as such; no reason was provided for using a non-standard metric. There were many syntactical errors and inconsistencies in the body of the report. The explications of such key points as variable selection procedures and the current allocation criteria should have been clearer than they were.

In addition to the social indicator analysis, Gallup included a smaller study that applied a statistical method for using survey information available from large areas to estimate values in communities whose populations were too small to provide enough observations for reliable information. The discussion of the small area estimation procedure at the contractors conference in January concluded that the procedure, when applied to the unique geography of Alaska and the structure of Alaskan communities, did not produce small area estimates that were consistent with other models and experiential evidence.

The State of Alaska recognized the need for an effective method of projecting treatment need information across both time and communities. The initial effort to produce a social indicator based model was informative, particularly in pointing out the information needs of an effective model and the level of commitment necessary to develop a social indicator system that can be applied year after year. The Alaska STNAP studies funded by CSAT include the development of a permanent Alaska-based social indicator system.

Interstate Analysis

In addition to reviewing the reports of studies conducted in round one of the STNAP program, Alaska asked NCRPG to compare the preliminary results of the studies with similar findings from other states. The household survey review (Appendix A) and the SANTA study review (Appendix B) both include comparisons between Alaska's results and those observed in other states. The comparison among states of surveys of the general household population does help to place Alaska's substance abuse treatment needs in a state-level framework. For example, we found that Alaska had higher substance use rates than Montana and North Dakota, even though the demographic characteristics of the three states are similar in many respects. Marijuana treatment need estimates for Alaska were slightly lower than the estimates for Montana but much higher than the estimates for North Dakota. Comparisons among SANTA surveys do not support meaningful comparisons because the SANTA studies lack comparable methodologies for sampling and data collection. We reported the results of the severity of substance use related problems among arrestees in a number of other states in our SANTA study review (Appendix B) with a caution against over-interpreting differences between Alaska and other states.

The State wanted to know how Alaska compares to other states with regard to deaths, arrests, diseases, and treatment services related to substance abuse. Most of the funds for treatment services in Alaska come from State, rather than federal, sources. By documenting that Alaska's problems are especially severe and that other states may be doing more to combat the problems, planners can advise the legislature that more resources are needed. Alaska felt that the state-level comparative analyses should be done as soon as possible to spark interest in Alaska's STNAP and to open discussions among decision makers about changes in the amount of resources available and how the resources should be allocated. NCRPG included an interstate analysis in this small contract. That analysis, "How Does Alaska Stack Up? An Interstate Substance Abuse Indicator Analysis" is provided as Appendix D of this report.{EDITOR"S NOTE: This document has been replaced by an updated "Interstate Substance Abuse Indicator Chartbook" provided herein}

Contractors Conference

The Division of Alcoholism and Drug Abuse (ADA) accelerated the project schedule in order to be able to take advantage of opportunities in January and February to present information on the progress of the STNAP studies and findings from those studies to other agencies and governing bodies. In November, ADA requested that preliminary reviews of all the round one studies would be presented at a conference with the contractors that would take place on January 7th and 8th in Anchorage. NCRPG agreed adjust its schedule to satisfy ADA 's request.

At the meeting in Anchorage, the contractors presented their preliminary final reports of the studies to representatives of ADA and the Epidemiology Group of the Department of Health and Social Services. The Gallup Organization was present at the meeting to discuss the household survey and the substance abuse indicator study. JBS staff participated by telephone. NCRPG's critical review of the preliminary final reports was represented by Dr. Richard LaBrie. The ensuing discussion provided clear direction to the contractors regarding how the reports needed to be revised to achieve an accurate and complete documentation of the study materials for transfer to ADA .

NCRPG also presented the results of their interstate analysis at this meeting. The demonstration of how Alaska compares to other states on important indicators of need for alcohol and drug treatment, how the contrasts among states can be clearly expressed using models that produce comprehensive indexes of both alcohol and drug treatment need, and how Alaska's treatment system is responding to the need for treatment were very well received. It was agreed at that meeting that NCRPG would make available the raw data used in the interstate analysis to assist ADA in its presentations of the STNAP program.

Summary of Tasks and Deliverables

NCRPG completed all of the tasks defined in the study protocol and submitted all the deliverables itemized in its agreement with ADA . NCRPG expended effort and resources in order to satisfy requests made by ADA . The major adjustments to ADA 's interests and needs were, 1) accelerating the reviews of preliminary reports of round one studies in order to present the reviews at the beginning of January, 2) traveling to Anchorage to attend the two-day contractors meeting, 3) expanding the comparisons of round one studies to results from other states to include a separate interstate model of alcohol and treatment need and met demand for services, and 4) providing the detailed state-level information used in the interstate model to ADA to assist in their presentations.

The following is a brief summary of the study activities organized as list of benchmark events.

Date	Benchmark Event
9/11/98	Contract between Alaska ADA and North Charles signed by both parties.
10/5/98	Conference on study tasks: NCRPG, Clay McDowall, and Loren Jones (by phone)
10/19/98	Monthly report sent to ADA .
11/2/98	Revised tasks, timeline, and deliverables defined.
11/3/98	Monthly report sent to ADA .
11/9/98	Study protocol sent to ADA .
11/10/98	January meeting date set and preliminary agenda defined.
12/1/98	Monthly report sent to ADA .
12/7/98	SANTA preliminary report received by NCRPG and ADA .
12/8/98	SANTA questionnaire and data dictionary received by NCRPG and ADA .
12/10/98	Substance abuse indicator study preliminary report received by NCRPG and ADA .
12/31/98	Final agenda for January meeting.
1/4/99	Draft review of household survey completed and sent to ADA .
1/5/99	Draft review of substance abuse indicator study completed and sent to ADA .