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YUKON-KUSKOKWIM HEALTH CORPORATION
"Fostering Native Self-Determination in Primary Care, Prevention and Health Promotion"

Behavioral Health

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Yukon Kuskokwim Health Corporation

Behavioral Health Services

Business Plan

Annual Report

February 2001

Yukon Kuskokwim Health Corporation
Behavioral Health Business Plan

Executive Summary

Through a cooperative effort of the Yukon Kuskokwim Health Corporation Administration and the Divisions of Mental Health/Developmental Disabilities and Alcohol and Drug Abuse within the Department of Health and Social Services for the State of Alaska; we will design and implement a program which combines the Yukon Kuskokwim Health Corporation's Mental Health and Substance Abuse services into a single integrated behavioral healthcare service delivery system. This Behavioral Health project will provide an enhanced community system of mental health and substance abuse interventions in a culturally based environment that blends both contemporary and traditional practices.

Highlights of the project include:

A. An agreement between the Yukon Kuskokwim Health Corporation and the State of Alaska which addresses both implementation of the project and management of mutual programmatic concerns in regard to the implementation.
B. Strategic reallocations of resources within the region to case manage children and families in order to deter acute mental health or substance abuse crisis development.
C. Utilization of community based early outreach and case management to prevent or reduce the number of out of home placements for children in need of treatment.

1.1 Program Abstract

The Yukon Kuskokwim Health Corporation's Mental Health and Substance Abuse Services are proposing a cooperatively administered community based program focused on care at the village level. Clients may receive a multi-disciplinary assessment, which can include a medical examination, psychological testing, psychosocial assessment, substance abuse assessment, family assessment, and behavioral observations. Through the needs identified in this process a treatment team is assembled by the field supervisor whose participants may include: physicians, psychologists, social workers, health aides, clinicians, educators, tribal social services, along with the client and their family, the village counselor and family advocate. This team will design an individual treatment plan for the client. The interventions specified in the treatment plan will primarily be implemented by the Village Wellness Counselors in the villages with the clinical direction of Village Clinicians directly supervised by Field Supervisors. Specialty services are available if needed at the regional level.

Through the provision of village-based counseling and support services, the client can receive treatment at home. The village behavioral health staff can also provide crisis intervention services, which may prevent the client having to leave

the village should symptoms exacerbate. Itinerant clinicians and psychiatrists available in the villages to provide assessment, diagnostics and support also assist in preventing clients and families from having to leave their homes to access services.

This program expands the services that are available without unnecessary duplication of organization structures. In an environment of critically scarce options, this is the most effective utilization of the resources available.

1.2 Mission

Yukon-Kuskokwim Health Corporation Mission:
To achieve the greatest possible improvement in the health status of the people of the Y-K Delta region of Alaska. YKHC is committed to the development of culturally relevant programs for primary care, prevention, and health promotion in a setting that fosters Native self-determination in the control and management of health delivery.

As the Yukon Kuskokwim Health Corporation's Mental Health Services and Substance Abuse Services began the process of integrating service delivery the joint teams met and determined the following goals and values to use as evaluation guidelines to determine whether the process enhances the potential for increasing the desired client outcomes identified by the clinical staff.

Goals

- Improve health/life
- To promote self-determination
- Reduce deviation to pre-crisis
- Family preservation
- Remembering/returning to the full meaning of life through spiritual values

Yukon Kuskokwim Health Corporation – Behavioral Health Services
Mission Statement

In accordance with the mission the Yukon Kuskokwim Health Corporation; we provide an array of holistic, life enhancing, culturally based behavioral health services for the people of the Yukon Kuskokwim Delta

2.0 Program Services

The Yukon Kuskokwim Health Corporation integrated service delivery system is comprised of four service components. Each component aligns similar services to allow for ease of communication and administration. The result sought is clearer lines of supervision while avoiding duplications. The four components are ***Emergency Services, Village Services, Specialty Services, and Support Services.***

During program implementation the service delivery components became clearly defined. Support Services is no longer a separate component, but is integrated throughout the service delivery system in order to enhance communication. Specific clinical support services have moved directly into the administrative function of the department.

Behavioral Health Administration –

Behavioral Health Administration is overseen by the Behavioral Health Administrator. This person serves as the corporate liasion to YKHC Administration, the Health Services Management Team, the Full Board of Directors, the Behavioral Health Advisory Board and all State and Federal funding agencies.

Program Evaluation is a primary responsibility of Behavioral Health Administration. Behavioral Health Services at YKHC has established several mechanisms to ensure its programs are continuously evaluated and that these evaluations serve as a basis for improvement throughout its service delivery system. Currently, a ***Program Evaluator*** has been directly hired by the department to coordinate its multiple evaluation activities. Development of internal evaluation capacity has been elevated to a departmental priority for Behavioral Health Services. The ability of the program to comprehensively evaluate and improve its services internally is a demonstration of self-determination. Behavioral Health Services has 4 contracts with the UAA- Institute of Circumpolar Health Studies for external evaluation. Further, the department reports 6 Oryx indicators to JCAHO quarterly, submits Baseline Measures to IHS quarterly, and submits fourteen quarterly reports to the State of Alaska and SAMHSA.

Rural Human Services Coordinator manages the overall operation of the Rural Human Services (RHS) program from recruitment of students through their successful completion of the two-year certificate program at the Kuskokwim Campus of the University of Alaska - Fairbanks. In May, 2000, 15 students received RHS certificates. In September, 2000, 18 new students enrolled and began the RHS program in Bethel. To date, 30 graduates of the RHS program are employed in positions of counselors or counselor supervisors by the Yukon Kuskokwim Health Corporation. In June, 2000, the RHSII program enrolled its first group of 16 students from across the state at the Bethel campus. Eight of those RHSII students are employed by the Yukon Kuskokwim Health Corporation.

Elder Activity Coordinator facilitates elder participation in various YKHC programs by maintaining contacts with elders throughout the region, notifying them of upcoming events and assisting them with planning. In July, 2000, five additional elders from the region received ***Lifetime Traditional Counselor*** certification from the State of Alaska. Louie Andrew retired from this position in January, 2001, and YKHC is currently recruiting for a new coordinator.

Quality Improvement Coordinator is position is currently vacant and is being evaluated to determine whether this utilization review and auditing function would be better suited to move to Health Information or remain an Administrative function.

Emergency Services –

The ***Emergency Services*** component is directly administered by the ***Director of Emergency Services.***

Emergency On-Call Responders-Emergency Services Clinicians and Complex Care Managers are available twenty-four hours per day to respond to behavioral health crisis. The Emergency Services team was recruited and hired in October, 1999. Since that time one clinician has moved from the region and one was hired to replace him in March, 2000. The stability of the team while adding the ability to provide effective case management principles to the high frequency users of the system has contributed to the phenomenal decrease of 16% in emergency calls during the last year.

One statistic that has remained higher than the national average is the suicide rate in the Y-K Delta. While, behavioral health promotion and social marketing campaigns have been initiated to increase awareness of the problem and warning signs it remains that greater than 95% of all those completing suicide in the region have never had a contact with a counselor or clinician.

YKDRH Hospital Evaluation Services –YKDRH and Pathways together have developed a system for inpatient hospital evaluation for up to seventy–two hours. This program is a designated evaluation bed for the State of Alaska that allows for involuntary commitment. The YKDRH has in the last quarter of calendar year 2000 has transferred the responsibility for management of the on-call attendant pool to the Nurse Manager of North Wing from the Behavioral Health Emergency Service. The goal is to provide for continuity in the attendants who are with clients who are involuntarily admitted to the evaluation bed. The attendants will report directly to the charge nurse on duty and will be scheduled regular shifts at the hospital versus on-call.

Crisis Respite Center **(CRC)** is a program that provides emergency support services for individuals experiencing a life crisis so disruptive it cannot be managed in an outpatient setting. During calendar year 2000, the Crisis Respite Center admitted an average of 23 clients per quarter with an average length of stay of 7 days per client. The overall API diversion rate was 55 – 60 clients during this calendar year.

Residential Diagnostic Treatment Center **(RDT)** provides evaluation and short-term residential treatment for children experiencing a life crisis so disruptive it cannot be managed in an outpatient setting. During calendar year 2000, the Crisis Respite Center admitted an average of 23 clients per quarter with an average length of stay of 11 days per client. The overall hospitalization diversion rate was 80 clients during this calendar year.

Village Services –
The ***Children's Special Projects Director*** reports to the Behavioral Health Administrator. The primary focus of the five year Child Mental Health Initiative project is to increase access to services for children and their families by building an enhanced system of care which addresses the needs of children and their families region-wide.
In October, 2000, this project was extended by the Federal government and will now be funded for ***six*** years. Primary accomplishments of the project in 2000 include –
Facilitation of multiple Memoranda of Agreement with other child serving agencies across the region including school districts, head start programs, other mental health and substance abuse providers, and DFYS.
Introduction of the Wrap Around concept to the Behavioral Health Service and other regional agencies.
Establishment of a voice for families in the Y-K Delta by hiring a Family Support Coordinator, 7 Family Advocates, and hosting a first ever regional retreat for families of Severely Emotionally Disturbed children.

All service delivery aspects of the ***Village Services*** component are administered by the ***Director of Village Services.***

Family Spirit Project this highly successful project worked with DFYS to hold Family Spirit gatherings in Napaskiak and Tuluksak in 2000. Hundreds of people in each of these villages attended these mutli-day gatherings and participated in the educational programs. Programs on substance abuse treatment, grief and healing, positive parenting, and gender-specific healing circles remain the most requested at the gatherings. Follow-up in these villages continues to be reported as positive by the village wellness teams and the DFYS social workers. In the remainder of FY 2001, gatherings are scheduled for Emmonak, Toksook Bay, Chuathbulak, Tuntutuliak, and Bethel. The original model and workbook is continuously edited and applied at each subsequent site.

Community Holistic Development provides technical assistance to Y-K Delta communities in the area of holistic health and prevention of substance abuse. They have provided leadership to the Family Spirit Gatherings and the Inhalant Prevention Conference. This continues to remain as one of the most requested services by the villages. Working with large groups particularly to promote healing after a tragedy has been the most successful service of this program.

Core Service Teams are the heart of the village based service delivery system. These teams have members who fulfill both the needs of the client and their family and the

needs of the service delivery system to ensure appropriate care is provided. The YKHC team members are –

Field Supervisors provide direct supervision, develop training plans and offer technical assistance to the Village Clinicians, Village Wellness Counselors, Elder Counselors and Family Advocates.

Village Clinicians work closely with the ***Village Wellness Counselors,*** clients, family and other providers to complete a holistic intake and develop treatment plans for implementation by the village based service providers and families.

Village Wellness Counselors are helpers whose skills allow them to recognize and respond to a wide variety of human needs including crisis intervention, assessments, outpatient counseling and aftercare.

Elder Counselors and Traditional Counselors work in coordination with Village Wellness Counselors to provide requested traditional counseling services and consultation to clients and their families.

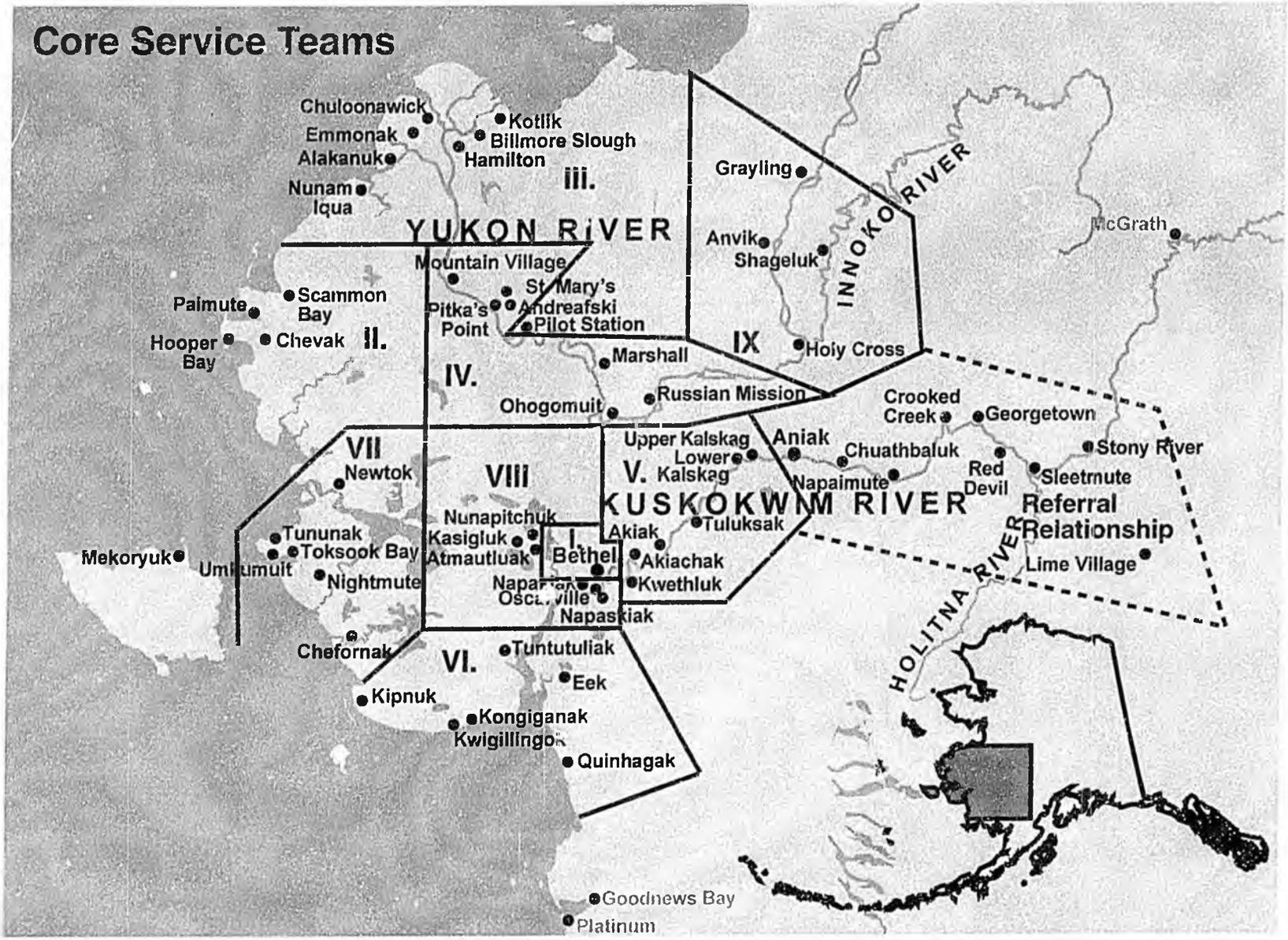
Family Advocates are regional positions with two primary purposes. First, to ensure support for the role of the family in the treatment planning process, and second, to provide assistance and input into the process of the evaluation of services.

There are nine specific teams planned to provide services across the Y-K Delta. The following chart shows the current level of development of these teams.

	Core Team	Wellness Counselors
Team II	*Tim Kaganak* -Field Supervisor Scammon Bay *(907) 558-5856* Arleata Snell-Family Advocate- Chevak Jack Brandon -Village Clinician-Bethel Suzanna Paniyak-Elder (Chevak) Neva Rivers-Elder (Hooper Bay)	Martha Simeon-Hooper Bay Aaron Kaganak-Scammon Bay Elias Stone-Hooper Bay Al..ed Ulroan- Chevak Darlene Joe-Hooper Bay Samuel Smith-Mekoryuk
Team III	*Virginia Moore*-Field Supervisor Alakanuk *(907) 949-1572* Kevin George-Family Advocate (Alakanuk) Lambert Lukudak-Elder (Emmonak) Village Clinician - Vacant Fred Augustine -Elder (Alakanuk)	Priscilla Ed nund-Alakanuk Rev. Stan Heckman-Pilot Station Emma Mathias -Kotlik
Team IV	*Ethel Ephamka* -Field Supervisor *543-6088 Bethel* Theresa Kelly-Family Advocate (St. Mary's) Vacant-Village Clinician Vacant-Elder	Maggie Paukan- St. Mary's Alice Keyes-Mt. Village
Team V	*Stella Wassillie* -Field Supervisor *543-6742 Bethel* Sarah Jasper-Family Advocate (Akiak) Village Clincal Supervisor - Daniel Bill Vacant-Elder	Nick Ayapan- Kwethluk Olga Kinegak-Tuluksak Nastasia Levi-Lower Kalskag Andrew Jasper-Akiak

Team VI	*Annie Wassilie*-Field Supervisor *543-6741 Bethel* Steven Mann-Family Advocate (Kipnuk) LKSD MOA pending-Village Clinician Vacant-Elder	Grace Friendly-Quinhagak Vacant- Kwigillingok Vacant-Kipnuk
Team VII	*Annie Wassilie (interim)*-Field Supervisor *543-6741 Bethel* Raymond Therchik-Family Advocate (Toksook) LKSD MOA pending-Village Clinician Vacant-Elder	Jonathan Lewis- Chefornak Florence Therchik-Toksook Bay Simeon John-Toksook Bay Felix Albert- Tununak
Team VIII	*Sam Oscar*-Field Supervisor *543-6740 Bethel* Anna Larson-Family Advocate (Napakiak) LKSD MOA pending-Village Clinician Vacant-Elder	Ida Kernak-Napakiak Sophie Jenkins-Napaskiak Fr. Victor Nick-Kasigluk Melvin Pavilla-Atmautluak
Team IX	*Mike Cutter*-Field Supervisor *543-6725 Bethel* Vacant-Family Advocate Israel Nelson (4Rivers MOA)-Village Clinician Vacant-Elder	Marlene Benjamin- Shageluk Marvin Deacon-Grayling Thomas Maillelle-Grayling David Walker-Holy Cross

Team service delivery will begin in April, 2001, in the villages of and surrounding villages of Hooper Bay, Emmonak, and St. Mary's. Teams in the Upper Yukon region and the village of and surrounding villages of Kwethluk will be operational by June, 2001. The final teams are scheduled to be functional by December, 2001.


Core Service Teams
Chuloonawick
Emmonak
Alakanuk
Nunam Iqua
Kotlik
Billmore Slough
Hamilton
iii.
YUKON RIVER
Mountain Village
St Mary's
Andreafski
Pitka's Point
Pilot Station
Scammon Bay
Palmute
Hooper Bay
Chevak
II.
IV.
Marshall
Russian Mission
Ohogomuit
Grayling
Anvik
Shageluk
INNOKO RIVER
McGrath
IX
Holy Cross
Crooked Creek
Georgetown
Stony River
Upper Kalskag
Lower Kalskag
Aniak
Chuathbaluk
Red Devil
Napaimute
Sleetmute
VII
Newtok
VIII
V.
KUSKOKWIM RIVER
Referral Relationship
Lime Village
Nunapitchuk
Kasigluk
Atmautluak
Tuluksak
Akiak
I.
Bethel
Akiachak
Kwethluk
Napaskiak
Tununak
Toksook Bay
Umkumiut
Nightmute
Mekoryuk
Chefornak
VI.
Tuntutuliak
Eek
Kipnuk
Kongiganak
Kwigillingok
Quinhagak
HOLITNA RIVER
Goodnews Bay
Platinum

Specialty Services comprise the regional services that are available to the individual who needs are greater than can be addressed in the village, or who need more specific diagnostic assessment. All services in the Specialty Services component of the Behavioral Health system report to the ***Director of Specialty Services.***

Clinical Services

Integrated Outpatient Clinic –

Services available in the Integrated Outpatient Clinic are:

Psychiatric Services – the Yukon Kuskokwim Health Corporation employs three Psychiatrists on a part time basis. They provide regional psychiatric services by holding specialty clinics in Bethel, as well as, traveling to villages as frequently as ninety times per year to see clients closer to home. Further, the Yukon Kuskokwim Health Corporation employs a full time Psychiatric Nurse Practitioner who is located in Bethel to assist with medication management for clients region-wide.

Psychological Services – the Yukon Kuskokwim Health Corporation employs a Licensed Clinical Psychologist who provides psycho-metrics and interpretive reports to assist in the provision of comprehensive diagnostics to specific clients in the region. In FY 2001, additional psychological services will be available to children in the region through the Child Mental Health Initiative and the Inhalant Project.

Children's Specialty Diagnostic Services – provide clinicians who through training and experience work directly with children to ensure appropriate diagnosis particularly when multiple contributing factors (including abuse issues, FAS/FAE) must be considered. The FAS team will train additional clinicians in FY 2001 in order to enhance and expand this clinical diagnostic service.

Assessors – In 2000, the Behavioral Health Service has established an assessors office with two full time positions in the integrated clinic. These positions serve as the single point of entry in the Bethel office and can provide immediate and scheduled screening for mental health and substance abuse issues. The assessors through a decision tree process help the individual enter into the array of services available in the Behavioral Health Service. The Wellness Counselors perform the same level of assessments at the village level. The assessors office facilitates the case review process on a daily basis and maintains the wait list for admission to substance abuse treatment services.

Outpatient Counseling Services – are available in the regional clinic as well to supplement services especially to Bethel residents. Two full-time counselors are employed in this capacity.

Bethel Alcohol Safety Action Program is a program that provides for screening for court referred clients and monitors treatment programs for compliance for these clients who have current misdemeanor charges against them both within the State of Alaska and those individuals that have relocated to our region from other states. In the current calendar year, YKHC is evaluating the potential of enhancing substance abuse services available to include a therapeutic court program.

Phillips Ayagnirvik is a residential treatment and recovery program for regional and statewide referrals suffering from the disease of substance abuse. The Phillips program adopted the cohort model in November of 2000 and has completed two cycles of the program to date. Client satisfaction surveys indicate individuals receiving services at the program prefer the cohort model versus open admissions. The treatment program served 3740 inpatient days in the twelve month period from July 1, 1999 through June 30, 2000. In order to duplicate this number of patient days at Phillips the new cohort model would have to be filled to 80% capacity for each group. We have demonstrated with the last cohort we can admit to 100% of the beds in this model and successfully complete 94% of those admissions. The program will during this year increase the number of annual treatment days, and also increase the number of persons successfully completing treatment. The Program has recently hired a new clinical supervisor with many years of residential treatment experience and has added a Master's level clinician to staff.

Inhalant Intervention Project was funded for construction of the facility by the Health Resources Services Administration (HRSA) and for operations by the Center for Substance Abuse Treatment (CSAT) during 2000. The planning and design of the facility was completed in the Spring with the assistance of a Statewide survey and input from a newly established Statewide Advisory Board. The program operations received funding in October and implementation started immediately. Outreach to people statewide to educate them about the issue and concerns related to inhalant abuse included presentations at the Children's Mental Health Conference, the Prevention Symposium, and the Public Health Summit. Further, the project had representation at the National Inhalant Summit in Washington, DC, as well as, the Quarterly Inhalant Director's Meeting in Ontario. The project has numerous community trainings and presentations scheduled early in 2001 and the residential treatment center grand opening is scheduled for August 31, 2001.

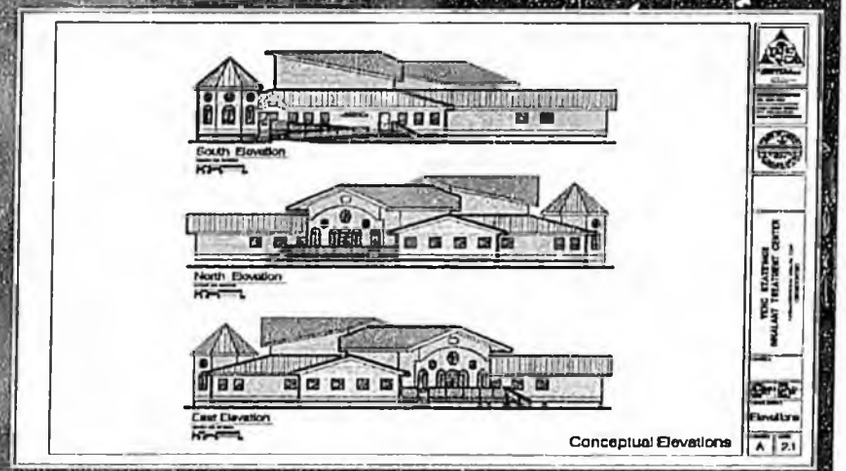
Inhalant Abuse Treatment Project

Serving the State of Alaska

Information Sessions and Provider Training

Early Intervention "CACHE"

Residential Treatment



Rehabilitative Services

Delta Supportive Living provides intensive family preservation services. In 2000, five families were served by this program. Working specifically with the parents to ensure the families remained intact avoided up to ten children having to be placed outside of the family in state supported foster care.

Alaska Youth Initiative is a comprehensive case management program that provides individualized "wrap-around" services to severely emotionally disturbed youth that are at risk of out-of-state placement. Five clients in the Y-K region received services through the AYI program in 2000.

Morgan Transitional Living is a program which provides housing for the mentally or socially-challenged individuals from the regional community, and teaches them daily living, job seeking and independence skills by providing a temporary living arrangement while the client seeks transitioning "back" into the community. This program serves five adults at all times. This program received an additional $150,000 in federal HUD funds this year in order to provide additional case management services to the assist in the transitioning process to the community.

Camai Case Management is the YKHC program which transferred from Bethel Community Services at the end of FY 2000. This program has been expanded to current eighteen client case load. These individuals live either in the Camai house or in private homes in the community. This program has received funding this year to build two duplexes which will provide four single independent living units in the community for these clients to live.

3.0 Implementation Plan

The Implementation Plan identifies goals and objectives to be accomplished in moving from distinct, separate and non-communicative service delivery programs into a single integrated system of service delivery for Behavioral Health in the Y-K Delta. The dates reflect both milestones that are completed and projections for accomplishing others.

2001 Update

The following goals and objectives have been analyzed for completion. The dates prior to January 2000 were documented milestones in the process. Dates including January 2000 and forward have their status documented in parentheses and italics.

3.1 Clarify with the Joint Mental Health and Substance Abuse Teams, participating State of Alaska and other outside agencies, an the Combined Advisory the Mission, Goals and Values of the Behavioral Health System

Meeting with Joint Mental Health and Substance Abuse Management Team to develop Mission, Goals and Values of the Behavioral Health plan

July 1998, August 1998, March 1999, April 1999, August 1999, September 1999, October 1999

3.1.1 Meeting with Village Based Counselors to obtain input and orient to elements of the Behavioral Health Plan

May1999, August 1999, October 1999, May 2000*(completed)*

3.1.2 Meeting with State of Alaska workgroup to define specific elements of the Behavioral Health plan

July 1999, October 1999

3.1.3 Meeting with Advisory Board regarding the Behavioral Health Plan

August 1998, March 1999, June 1999, August 1999, December 1999

3.2 Design an integrated service delivery system for mental health and substance abuse treatment services for the Yukon Kuskokwim Health Corporation

3.2.2 Delineate the Organizational Structure of the Integrated Service Delivery System

November 1999

3.2.3 Define the Role of Programs within the System

November 1999

3.2.4 Identify Funding to be Re-Directed within the System

November 1999

3.2.5 Identify Positions to be Re-Assigned to fulfill the requirements of the System

November 1999

3.2.6 Develop individual education plans that evaluate ability to meet requirements of specific competencies of the re-assigned positions in the Behavioral Health system and address how identified educational needs will be meet.

January 2000*(completed May 2000)*

3.2.7 Identify core service team hubs in the region and evaluate current levels of service delivery in each

November 1999

3.3 Recruit an Experienced Administrative Team to organize and implement the integrated service delivery system

3.3.2 Evaluate and hire Behavioral Health Administrator

April 1999

3.3.3 Evaluate capacity of and promote current staff to Administrative level positions as appropriate

October 1999

3.3.4 Recruit and Hire staff for vacant Administrative positions

March 2000*(completed March 2000)*

3.4 Ensure Natural Native Supports and Traditional Native Methods of Healing along with Modern Best Practices are Incorporated into all

levels of the Behavioral Health Service Delivery System

3.4.2 Develop educational curriculum for all staff that teaches cross cultural communication and understanding specific to populations served in the Y-K Delta region.

January 2000*(completed March 2000)*

3.4.3 Plan and implement schedule of ongoing training for all staff that teaches utilization of traditional native methods of healing in clinical practice

March 2000, ongoing*(July 2000, May 2001)*

3.4.4 Utilize existing and expanded Rural Human Service program for clinical training of Village Based Counselors

Ongoing

3.4.4 Provide continuing education opportunities focusing on training for Best Practices in Mental Health and Substance Abuse treatment for all staff upon completion of required educational plans.

Ongoing

3.5 The Behavioral Health system will include a plan for education of staff regarding implementation of the integrated service delivery system as well as on-going education to meet the service delivery needs of the region.

3.5.1 Develop a plan of orientation to the integrated service delivery system for existing staff.

November 1999

3.5.2 Develop a plan of orientation to the integrated service delivery system for all new staff hired to the program.

January 2000, ongoing*(monthly)*

3.5.3 Evaluate individual needs for cross training for all existing staff and develop individual education plan to address any identified needs.

March 2000*(completed May 2000)*

3.5.4. Develop and implement a plan of Yup'ik specific orientation for new hires and annual training for all staff on cultural issues, values and beliefs.

March 2000, ongoing*(July 2000, May 2001)*

3.6 Develop a schedule of organization and implementation of the core service teams throughout the region.

3.6.1 Define geographical boundaries of nine core service teams.

November 1999

3.6.2 Evaluate existing resources within each geographical boundary and assess needs to implement full teams.

November 1999

3.6.3 Develop a schedule of full implementation of all teams within two-years.

November 1999

3.7 Quality Assurance and Evaluation

3.7.1 Develop subcommittee to design a pilot single site review plan for the State of Alaska DMH/DD and ADA.

December 1999

3.7.2 Orient YKHC's Quality Improvement Coordinator to both State of Alaska site review processes.

June 2000*(Pending MOA)*

3.7.3 Develop a plan for and educate staff regarding the standards and methodology of the integrated single site review.

January 2001*(Pending MOA)*

3.7.4 Implement and Evaluate Effectiveness of Integrated Single Site Review plan at YKHC.

September 2001*(Pending MOA)*

3.8 Integrate health information systems for mental health and substance abuse services into a single clinical record

3.8.1 Evaluate existing health information and reporting systems for efficiency and effectiveness in promoting access for the client.

June 2000*(Pending MOA)*

3.8.2 Design a plan of integration of mental health and substance abuse services records into one health information system.

September 2000*(Pending MOA)*

3.8.3 Develop a plan for and educate staff regarding the record integration system.

December 2000*(Pending MOA)*

3.8.4 Complete integration of records

June 2001*(Pending MOA)*

3.9 Develop a financial plan that identifies costs associated with implementation and continuation of the Behavioral Health plan.

3.9.1 Analyze impact of new Medicaid regulations

March 2000*(ongoing)*

3.9.2 Analyze cost of services

March 2000*(Pending MOA)*

3.9.3 Identify additional sources of funding

June 2000*(Pending MOA)*

3.9.4 Develop reimbursement strategy to include cost of services.

September 2000*(Pending MOA)*

5.0 Program Administration

5.1 Corporate Line of Authority

Behavioral Health Services for the Yukon Kuskokwim Health Corporation is administered within the Health Services Division of the organization. Health Services Division of YKHC was formed in October, 2000 with the integration of the Hospital Services Division and Community Services Division. The ***Vice-President of Health Services*** directly supervises the Behavioral Health Administrator. Further, the Behavioral Health Administrator works directly with the ***Community Services Finance Administrator*** regarding all financial issues of the program including budgeting, reimbursements, and utilization of financial resources.

5.2 Behavioral Health Services Administration

2001 Update on Behavioral Health Administration –

Sandra Mironov, Behavioral Health Administrator has held this position since April 1999. She has lived in Bethel and worked for YKHC since 1995. Her background is in Nursing and Psychology and she has had extensive experience in program design and implementation in both mental health and substance abuse programs.

Vince Weber, Director of Emergency Services, has held this position since October, 1999. Vince transferred from the Clinical Supervisor position of the Mental Health system. He has worked with the RSAS program for several years providing oversight to treatment planning. Vince has lived in Bethel and worked for YKHC since 1988.

Ray Watson, Director of Village Services, has held this position since October, 1999. Ray transferred from the position of Clinical Supervisor at Phillips Ayagnirvik. Ray has lived in Bethel his entire life and he has worked for RSAS since 1992.

Laura Baez, Child Special Project Director, has held this position since October, 1999. Laura transferred to this position from the Child Services Coordinator for Mental Health Services. She has lived in Bethel and worked for YKHC since 1997.

The Director of Specialty Services position was vacated in February, 2001 and we are currently evaluating the best approach to providing supervision for these services.

All administrators for Behavioral Health Services hold clinical licensure and/or certification in their field of expertise.

5.3 Personnel

Each Administrator has the responsibility of recruiting and hiring adequate staff to implement the plan described here within availability of funding defined by corporate administration.

The types, numbers and qualifications of personnel to staff the service delivery system was described in the original plan dated January, 2000. Following is a list of the current numbers of staff by position including a review of their current qualifications and job specific training offered in 2000.

Job Title	#of staff	Vacancies	RHS or above*	Enrolled in RHS	Licensed or Certified in Field
Emergency Services -					
Emergency Clinician*	3	0	100%		67%
Complex Care Manager	3	0	100%		100%
CRC Coordinator	1	0	100%		
SR Crisis Management Specialist	2	0			
Crisis Management Specialist I	9	0	36%		
RDT Coordinator	1	0	0	100%	
RDT Clinician*	1	0	100%		100%
Youth Counselor	4	0	0		
Village Services -					
Child Project Evaluator*	1	0	100%		
Technical Assistance Coordinator	1	0	100%		
Family Spirit Project Coordinator	1	0	100%		
Field Supervisor	6	1	100%		100%
Village Services Clinical Director*	1	0	100%		100%
Village Clinician*	0	3	100%		
Village Weliness Counselor	28	3	53%	44%	82%
Elder Counselor	4	4	N/A	N/A	
Family Advocate	7	1	14%		
Substance Abuse Educator	1	0	100%		100%
Community Holistic Mgr	1	0	100%		
Specialty Services-					
Psychiatrist*	3	0	100%		100%
Psychiatric Nurse Practitioner*	0	1	100%		
Clinical Psychologist*	1	0	100%		100%
Child Mental Health Clinician*	2	0	100%		100%

Clinician*	1	0	100%		
Assessor	2	0	50%	50%	
Outpatient Counselor	2	0	100%		100%
Aftercare Counselor	1	0	0		100%
Clinical Supervisor, Substance Abuse*	1	0	100%		100%
Residential Counselor	1	2	100%		100%
Counselor Trainee	3	1			
BASAP Coordinator	1	0	100%		
Transitional Living Coordinator	1	0	100%		
Transitional Living Skills Trainer	4	0	25%		
Family Services Coordinator *	1	0	100%		100%
Family Services Trainer	2	0	50%		
Rehabilitation Training Coordinator	1	0	100%		
Supportive Living Coordinator	1	0	100%		

**All clinician positions are filled by Master's Level or Above*

Vacancy Rate The Behavioral Health Services overall vacancy rate to date is 14.5%. This represents 17 current vacancies on staff. The number is inflated due to 10 or 8.5% of these positions being new expansion positions budgeted for the first time in FY 2001, thus the actual vacancy rate of 6% represents a clearer picture of vacancies in the program. These positions are being actively recruited and we have offered positions to three new clinicians to work in the villages.

Promotion Rate During the past year, eleven (100% native)Behavioral Health Services staff have accepted promotions to positions of supervisory responsibility within the integrated service delivery system for a promotion rate of 9.6%.

Attrition Rate For the year 2000, the BHS has had an overall attrition rate of 7.7%. The following is a summary of staff of how staff have left the services:

Termination	1	(there has been one additional termination in 2001).
Resignations	7	(three of these were due to the staff being ineligible to work in a child contact position due to ICWA, two of these people have returned to work at YKHC)
Educational LOA	2	(one of these people will return to work in March 2001)

Training opportunities for Behavioral Health staff in 2000 –

- ***JCAHO Leadership Seminar, (2days) Bethel 6 participants***
- ***Rural Human Services, UAF-Kuskokwim Campus, Bethel***
  15 graduates May, 2000 14 enrolled September, 2000
- ***RHS II, UAF-Kuskokwim Campus, Bethel***
  8 enrolled Summer, 2000
- ***RHS Supervisor Training, Fairbanks 8 participants***
- ***25th Annual Indian School on Addictions, (5 days)Albuquerque 6 participants***
- ***RADACT Counselor Academy, Anchorage (3 weeks) 12 graduates***
- ***Annual School of Addictions, Anchorage (4 days) 16 participants***
- ***On-Site ASAM-PPCII training, Bethel (2 days) 30 participants***
- ***Child Mental Health, Georgetown Institute, (2 weeks) New Orleans***
  12 participants
- ***Child Mental Health Conference, Anchorage (4 days) 20 participants***
- ***Prevention Symposium, Anchorage (3 days) 10 participants***
- ***2nd Annual Counselor Traditional Modalities Training, (5 days) St. Mary's 35 participants***
- ***SAMHSA Conference on Women, San Diego (5 days) 2 participants***
- ***3rd Annual Inhalant Conference, Bethel, (3 days) 40 participants***
- ***Tribal Gathering – Traditional Healing Methods, Bethel, (3 days)***
  15 participants
- ***Inhalant Best Practices, (5 days) Anchorage 20 participants***
- ***Therapeutic Milieu Development, (6 days) Bethel 8 participants***
- ***Wraparound training (2 days) Bethel 20 participants***
- ***Native "Wraparound" Training, (4 days) Albuquerque 6 particpants***
- ***Numerous Individual Continuing Education seminars to maintain licensure and certifications***

Reassignments of Job Positions in Integration of Mental Health and Substance Abuse Services

During the integration process many employees have stated their greatest fear is the potential loss of their employment at YKHC. The administration has assured all mental health and substance abuse treatment staff they would not lose their employment as a result of the realignment of the two departments into one. Therefore, it is necessary to reassign certain positions to increase capacity and productivity within the system. Many staff will have new supervisors as a result of the integration and others will have new roles and job titles. Efforts have been made whenever possible to include staff in the reassignment planning process. Most staff are reassigned to positions that build upon their individual strengths. Reassignments may be immediate due to demand for essential services as in Emergency Services or they will occur at the time of employee evaluation with all reassignments complete by July 1, 2000.

2001 Update

The integration of the mental health services and substance abuse services required substantial integration of some positions in the organization, particularly those which were village based. While the job titles are completely integrated at this point it is important to remember staff integration of responsibilities is a dynamic process and will vary from individual to individual. YKHC has offered several opportunities in the past year for village based staff to gather as a whole to facilitate this integration. Dates of these gatherings in were

December, 1999
May, 2000
July, 2000
January, 2001.

Each opportunity focused on orientation, answering questions, team building and applying counseling principles to all clients.

The January 2001 meeting was successful due to the staff evaluations 100% identify themselves as members of a cohesive team serving all behavioral health clients from across the Delta.

6.0 Information Infrastructure

Currently, the Yukon Kuskokwim Health Corporation has two completely separate client record systems for mental health and substance abuse services. If a client is seen by both services, they have two complete separate records that contain many duplications of the information for one individual. Part of the system uses the IHS RPMS electronic client record to store progress information and part of the system does not. Records are stored on site for seven years then one service archives records using the IHS protocols and the other service destroys records. Reporting of services to the State of Alaska data system is done by two separate methods one manual for the counselors and the other through and electronic crosswalk from the clinical record.

In addressing challenges to developing an effective and efficient record keeping system the following adjustments to existing systems are considerations to be addressed:

(a) One method of maintaining records for clients who have not received services in seven or more years needs to be established.
(b) Can the State of Alaska establish one method of receiving demographic data for planning, budgeting purposes from the electronic client system of record keeping utilized by YKHC?
(c) Are 100% of staff activity reporting of substance abuse counselors required for planning purposes by the State of Alaska?
(d) The Yukon Kuskokwim Health Corporation needs to obtain the list of simplified direct service codes for substance abuse providers developed by the Rural Human Services program.
(e) Methods of streamlining documentation for Village based providers need to be developed and implemented.

2001 Update

Initial training on using the RPMS system by village based counselors has been accomplished. Changes which were discussed in the State of Alaska systems have not been implemented at this time.

7.0 Quality Management

Upon integration into a single service delivery system, the current State of Alaska system of reviewing a provider for mental health and substance abuse services is no longer appropriate. A single integrated review model will have to be developed in order to adequately review YKHC's service delivery.

YKHC is requesting for the Behavioral Health system's Quality Improvement Coordinator to accompany and participate in several mental health and substance abuse services site reviews over the first six months of 2000. This will orient this individual to the requirements of both systems then internal reviews can more accurately reflect the intent of regulations in both areas.

Following this orientation, the Behavioral Health implementation plan calls for the development of a sub-committee who will design a pilot single site review process to be used to evaluate the Yukon Kuskokwim Health Corporation in September 2001. The project development sub-committee should include site reviewers from both departments of the State, YKHC's Quality Improvement Coordinator, consumer representation and clinician participation. This model could be utilized in other areas of the state with integrated providers thus reducing duplications of processes among the separate departments.

2001 Update

YKHC remains committed to assisting in the development of a single site review for integrated service delivery systems.

In the year 2000, YKHC Behavioral Health Services received its initial JCAHO accreditation. Accreditation was achieved with a Behavioral Health score of "96" resulting in Accreditation with Commendation. YKHC has requested a waiver of compliance with Alcohol and Drug Abuse standards based on its accreditation by JCAHO. Mental Health services has not established a similar waiver process for those providers seeking independent accreditation.

last year, and the transitional living support program has received preliminary approval for an additional three years of funding.

8.3.6 Availability of Yukon-Kuskokwim Health Corporation Funds

Federal funds provided under the Yukon-Kuskokwim Health Corporation's P.L.93-638 compact are subject to annual negotiation. Contract support funds are provided under separate congressional authority and a separate determination of the amount awarded.

IMPROVING SUBSTANCE ABUSE TREATMENT: THE NATIONAL TREATMENT PLAN INITIATIVE

Changing the **Conversation**

NOVEMBER 2000

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

I. Executive Summary

Panel members focused on identifying ways to close the "gap" in alcohol and drug treatment, defined as the difference between individuals requiring treatment and those receiving treatment. This report discusses a number of underlying issues surrounding the treatment gap and proposed recommendations for filling the gap.

Substance abuse and dependence is a "biopsychosocial" disorder, which means that the nature of the disorder is influenced by a combination of biological, medical, psychological, emotional, social, and environmental factors. The disorder is progressive, chronic, and relapsing. Often, substance abuse dominates an individual's life, with a profoundly negative impact on the individual and those around him or her.

Substance abuse disorders afflict approximately 13 million individuals. Of those 13 million individuals, only about 3 million are receiving treatment, leaving approximately 10 million people stranded in the treatment gap. To fill this gap, the Panel strongly recommends a "no wrong door" strategy to assure effective and appropriate care for all individuals in need of treatment, regardless of demographic or other factors that might impede their access to care. The Panel considered approaches that would reflect the needs and concerns of all individuals who might use the substance abuse system or other overlapping systems. They sought to understand the factors that impact individuals and their families and friends.

Although it is now well established that treatment is effective to counter substance abuse, the Panel identified significant barriers to treatment: societal, organizational, and individual factors; access to appropriate treatment; the use and allocation of resources and adequate financing of programs and services; and issues surrounding the quality of care and treatment outcomes.

To address these barriers, the panel developed recommendations in three areas: Access and inter-State linkages; resource allocation and financing; and quality care and outcome measures.

ACCESS AND INTER-SYSTEM LINKAGES emphasizes the benefit of multiple systems working together to ensure that appropriate, effective care is available to all individuals in need of treatment.

1. Develop a plan to create a nationwide expectation for alcohol and drug treatment such that no matter where in the human services, health, or justice system an individual appears, his or her alcohol or drug problem will be appropriately identified, assessed, referred, or treated.

RESOURCE ALLOCATION AND FINANCING focuses on improving public and private insurance benefit packages, increasing the resources in the system, and using system resources more effectively.

2. Increase total resources available for substance abuse treatment (i.e., Federal, State, local, and private) in order to reduce associated health, economic, and social costs.

3. Develop a standard insurance benefit for substance abuse treatment that provides for a full continuum of appropriate and continuing care to meet the needs of persons with substance abuse disorders.

4. Provide sustained support to increase State and local capacity to identify, assess, determine, and monitor need for treatment at the local/community level.

5. Organizations and payors that want to engage in delivery of services for substance abuse screening, assessment, and/or treatment should: (1) use evidence-based treatment protocols; and (2) continuously monitor quality of care (structure, process, and/or outcomes) using common methods and measures adopted by the field through a consensual process. This should apply to both public and private providers and payors, operating in the substance abuse, primary health, social service/welfare, justice, education, or other fields.

QUALITY CARE AND OUTCOMES MEASURES centers on improving the quality and appropriateness of care provided and creating an ongoing monitoring process for maintaining a high level of care.

6. Define and help support processes to reach cross-system consensus on evidence-based standards for quality of care and practices that apply to all systems and payors.

7. Facilitate cross-system consensus on critical data elements to measure quality of care and treatment outcomes.

Viewed collectively, these recommendations provide the strategic base to ensure that those in need of treatment actually receive treatment, that sufficient public and private resources are available and appropriately employed to deliver the "quantity" (frequency, duration, intensity) of treatment, and that the types and levels of care needed are available.

II. Defining the Treatment Gap

Substance abuse and dependence is a complex disorder, with associated biological, psychological, and social causes and effects. Historically, this disorder has been treated as a social problem while the psychological and biologic aspects largely have been ignored. However, the deterioration of functionality within each of these aspects of the disorder requires that treatment and intervention address the entire biopsychosocial continuum. In addition, substance abuse and dependence is a chronic, relapsing illness. Although many of the symptoms and associated illnesses require that a client receive specialized or acute care, these systems might not be prepared to treat the chronic elements of the illness.

In this report, people with alcohol and drug abuse disorders are defined as individuals who meet diagnostic criteria for receiving treatment whether the nature of their presenting symptoms is biological, social, or psychological. These individuals have progressed to the point where they require intervention and treatment. However, given the social aspects of this disorder, the ramifications and possibly the causes of substance abuse extend beyond the individual experiencing the problem to affect those around him or her, as well. Thus, it is also important to address the treatment needs of family and friends closely affected by this disorder.

Many organizations and agencies have published estimates of the number of people experiencing problems with drugs and/or alcohol in the United States. Across studies, the findings consistently demonstrate that there are more individuals in need of treatment than can be accommodated by the system. In most reports, alcohol and drug abuse are studied separately. The Office of National Drug Control Policy (ONDCP) focuses on drug problems, and many of its findings are cited in this report. The National Institute of Health (NIH) focuses on alcohol and drug abuse in two separate institutes, the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). The separate statistical representation of alcohol and drug use means that attempts to combine the numbers provide only rough estimates because double counting may occur. The fact is that approximately half of people with drug problems also suffer from alcohol disorders. The disparity in survey methodologies and access to data also produces many of the numeric differences. Nonetheless, the numbers presented below paint a broad picture of the size of the treatment gap.

According to the ONDCP's *1999 National Drug Control Strategy*, there are approximately 4 million chronic drug users in the United States. This closely aligns with the *1998 National Household Survey on Drug Abuse*, which found that 4.1 million people were in need of drug treatment. The NIAAA report, *Improving the Delivery of Alcohol Treatment and Prevention Services*, estimates that there are 14 million alcohol abusers, whereas the *1998 National Household Survey on Drug Abuse* finds approximately 9.7 million people in need of alcohol treatment. Regardless of the source, a conservative estimate of those in need of substance abuse treatment is between 13 and 16 million people. In contrast, both the 1997 Institute of Medicine (IOM) report, *Managing Managed Care*, and the 1998 *National Household Survey* conclude that approximately 3 million people receive care for alcohol or drugs in one year. Although, as previously stated, neither the estimates of those in need nor the estimates of those in treatment are all inclusive, the picture remains the same — more than 10 million people who need treatment each year are not receiving it.

To move toward closing the treatment gap, a clear understanding of how treatment is defined is necessary. Panel members agreed that for this report, treatment would be defined as follows:

> *"Treatment refers to the broad range of [primary and supportive] services — including identification, brief intervention, assessment, diagnosis, counseling, medical services, psychiatric services, psychological services, social services, and follow-up, provided for persons with alcohol [and/or other drug] problems. The overall goal of treatment is to reduce or eliminate the use of alcohol [and/or other drugs] as a contributing factor to physical, psychological, and social dysfunction and to arrest, retard, or reverse the progress of any associated problems" (IOM, 1990a).*

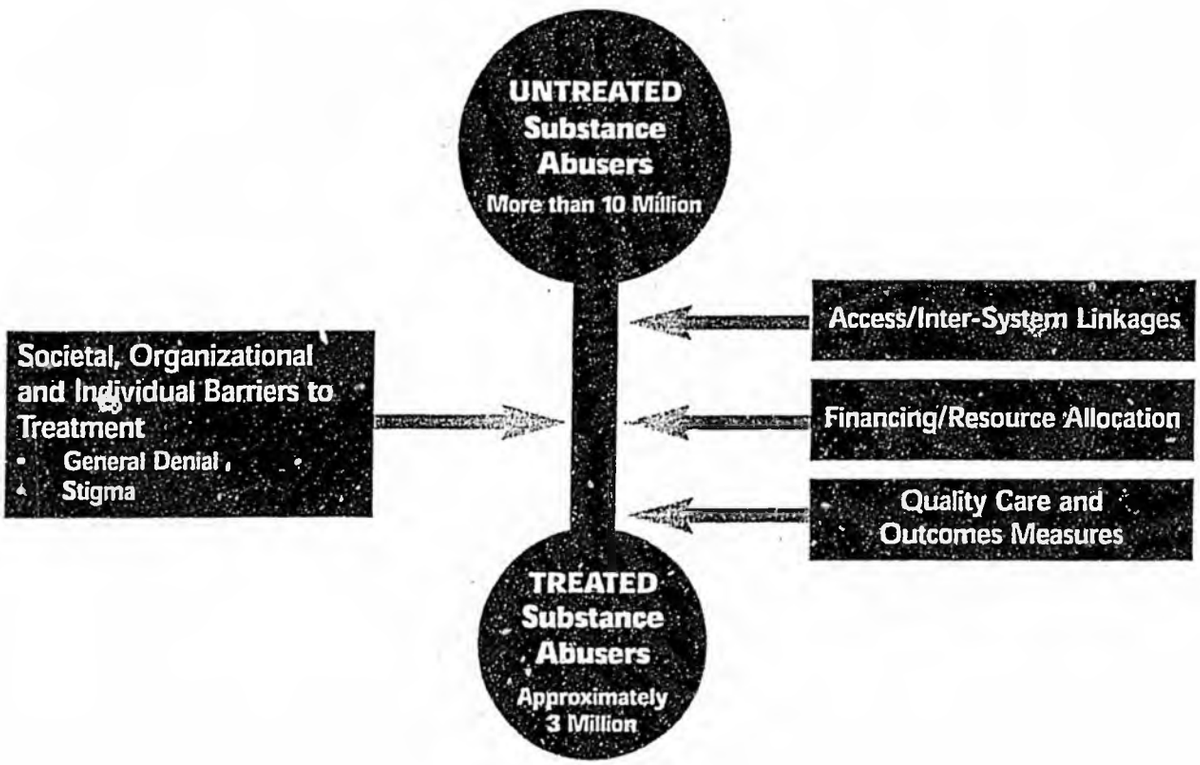
It is becoming increasingly evident that treatment is effective in addressing substance abuse. For example, the ONDCP 1995 National Drug Control Strategy stated that "studies and statistics indicate that the fastest and most cost effective way to reduce the demand for illicit drugs is to treat chronic hard core drug users." The ONDCP used this empirical evidence to buttress its plan for more effective use of available Federal treatment grant funds to move individuals into treatment and the increased use of justice system resources to treat chronic users under their authority. Other studies have also supported this view.

> *"Research has shown that drug abuse treatment is both effective and cost effective in reducing not only drug consumption but also the associated health and social consequences. . . .Treatment gains are typically found in reduced intravenous and other drug use, reduced criminality, and enhanced health and productivity" (IOM, 1996).*

III. Understanding the Problem

The next step is to understand what factors are contributing to the gap and interfering with effective treatment. The Panel separated the treatment gap into four main discussion areas: Societal, Organizational, and Individual Barriers to Treatment; Access and Inter-System Linkages; Financing/Resource Allocation; and Quality Care and Outcomes Measures (see Figure I.1).

Figure I.1 Major Access Barriers in Substance Abuse Treatment



A. SOCIETAL , ORGANIZATIONAL, AND INDIVIDUAL BARRIERS TO TREATMENT

There are many reasons why individuals fail to get treatment, including stigma associated with the disorder; cost of treatment; unavailability of support services, such as child-care or transportation; and failure of systems to effectively identify individuals and direct them into treatment.

These issues intensify for individuals categorized as "special" populations. The treatment system often does not provide well for population groups such as women, children and adolescents, the aging and disabled, ethnic groups, and rural populations. Historically, programs have been aimed at men; thus, there are a limited number of women- or juvenile-oriented programs. Because access issues due to pregnancy and child-care are prevalent within these groups, the result is impaired access to care. Gender and age are not the only barriers; ethnic and racial differences frequently prevent individuals from accessing treatment due to language or other cultural barriers.

Furthermore, geography poses a problem in many rural areas because an insufficient number of programs are spread across different regions. These scattered programs pose problems for accessibility (e.g., long travel times or lack of transportation), especially for individuals in need of on-going care. Location of care, type of care available, hours of operation, and other program characteristics often limit client access to care. In addition to these barriers, some individuals who have access to treatment do not choose to use it. Many people fail to accept the magnitude of their specific problem, or have a fear of the public perception associated with treatment. Their "denial" increases the importance of rigorous screening across systems and facilitating access to treatment for resistant individuals.

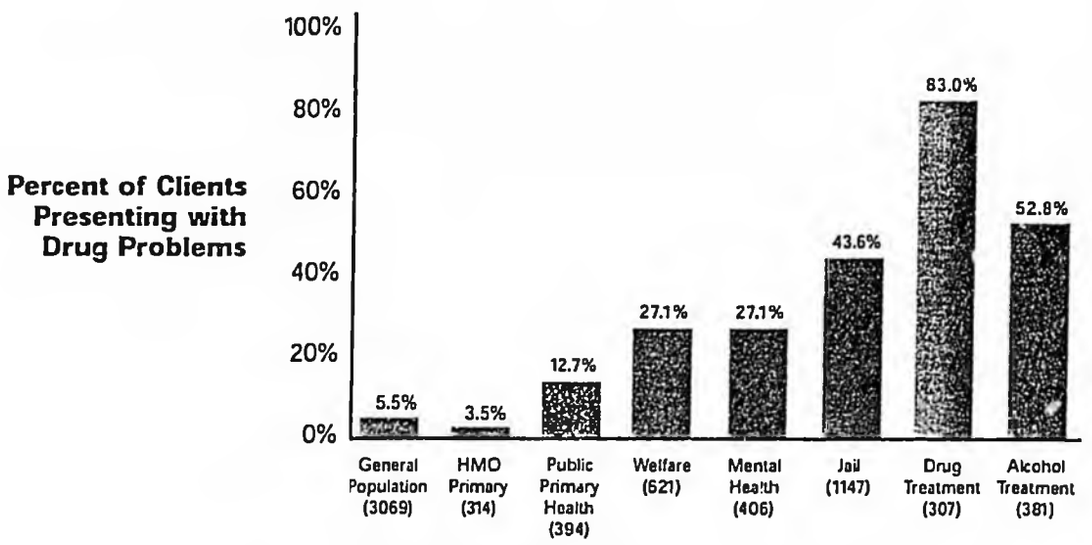
B. ACCESS AND INTER-SYSTEM LINKAGES

Because of the nature of the disorder, individuals in need of treatment might appear in various settings, including healthcare, the justice system, mental health, welfare and social services, and juvenile or educational systems. Often they are not effectively screened and diagnosed to facilitate movement into treatment. Different systems function independently, often failing to use inter-system linkages that could increase the number of individuals able to receive treatment as well as the resources available for treatment.

Additionally, the lack of cohesive interaction among systems interferes with the ability of the treatment system to provide a high quality continuum of care. The disconnection between overlapping systems does not foster effective identification and maximization of the resources (financial or otherwise) available across systems. The development of an interactive system that matches care to need, regardless of point of entry, is crucial to establishing inter-system linkages and improving success.

A recent study (Weisner, 1999) of new admissions of weekly drug users across population and community agency systems shows the prevalence of drug users located in other systems (see Figure I.2).

Figure I.2 Distribution of Drug Users Across Health, Social Service, Justice, and Other Sectors of the Community



Source: Weisner (1999)

The justice system poses one of the greatest challenges for improving access. One study estimates that approximately 1.4 million or 80 percent of the people who are incarcerated have a history of alcohol and/or drug abuse (Culpepper Foundation, 1998). Furthermore, many of the incarcerated individuals who are in need of treatment do not have access to treatment. A report from Join Together (1996) indicates that only seven percent to15 percent of incarcerated persons receive treatment. Additionally, the problem extends beyond the walls of the correctional facility. Substance abuse is equally a problem among juvenile justice populations and parole and probation populations and can also be an issue in civil proceedings. In a 1995 survey of adults on probation, nearly 70 percent reported past drug use, and 32 percent admitted to illegal drug use in the month before their arrest (Bureau of Justice Statistics, 1997).

Inability to effectively deal with persons in need of treatment is not limited to the justice system. For instance, studies show that primary and urgent care physicians treat a substantial number of

individuals in need of substance abuse treatment (Join Together, 1998). Often health care providers are unable to identify the treatment needs of their patients and are not linked into the appropriate system to effectively guide patients into treatment.

The inter-system disconnect is also common between the mental health and substance abuse treatment systems. A joint report by the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and the National Association of State Mental Health Program Directors (NASMHPD) indicates that there are 10 million persons with at least one co-occurring mental health and substance abuse-related disorder. Patients with mental, drug, or alcohol disorders appear in both systems and often are missed or misdiagnosed (NASMHPD and NASADAD, 1999). Additionally, differences in insurance coverage and differences in funding mechanisms between systems fuel the disconnect between systems because diagnoses might not be covered from one payor to another.

There is also a substantial disconnect between the social service system and the substance abuse treatment system. In the welfare system, caseworkers have limited clinical training and few standards for screening and assessing individuals who might be in need of treatment. This lack of training makes it difficult to identify patients who are in need of treatment, and nearly impossible to ensure that they are referred into treatment (IOM, 1997a; National Association of Alcohol and Drug Abuse Counselors [NAADAC], 1998).

Inter-system issues that contribute to the treatment gap are not limited to the inability of systems to identify and move individuals toward appropriate treatment. They also include the difficulty associated with transferring patient-specific information from one system to another. For systems to interface effectively, they must share relevant data. Currently systems with overlapping clients often do not exchange data. These systems frequently lack updated information systems, standard reporting requirements, and consistent and clear communication processes. The lack of collaboration and communication between systems can be attributed to the territorial nature of some agencies and systems, whereas in other cases, conflicting or different organizational missions make collaboration, even for the greater good, more difficult.

Another challenge associated with the effects of substance abuse that systems must address is the impact of the problem on those not directly involved. Treatment tends to focus on the individual experiencing problems and not on the families, friends, and others affected by the disorder who are not actively involved in substance abuse. The Panel believes that the ability to work with children and family members of the client is critical and must be considered by all systems interacting with persons experiencing problems with alcohol or other drugs.

C. RESOURCE ALLOCATION AND FINANCING

Resources as defined in this context include the financial, infrastructure, and other resources that support and sustain the provision of substance abuse treatment. The adequacy of resources addresses the amount of resources currently available in the system, and the effective use of resources addresses the ability to use and deliver better results with limited funds. These financing and resource allocation issues directly determine the ability of an individual to access treatment.

Despite the many factors that contribute to the gap, the Panel agrees with many in the field that inadequate funding for substance abuse treatment is a major part of the problem. Over the last decade, spending on substance abuse prevention and treatment has increased, albeit more slowly than overall health spending, to an estimated annual total of $12.6 billion in 1996 (McKusick, Mark, King, Harwood, Buck, Dilonardo, and Genuardi, 1998). Of this amount, public spending is estimated at $7.6 billion (McKusick, et al., 1998). The public spending includes dollars from Medicaid and Medicare, as well as other Federal funds from the Department of Defense, the Department of Veterans Administration, the Department of Justice, and the Substance Abuse Prevention and Treatment (SAPT) Block Grant. The SAPT Block Grant provides Federal support to addiction prevention and treatment services nationally through State and local governments. Private spending includes individual out-of-pocket payment, insurance, and other nonpublic sources, and is estimated at $4.7 billion (McKusick, et al., 1998).

One of the main reasons for the higher outlay in public spending is the frequently limited coverage of substance abuse treatment by private insurers. Although "70 percent of drug users are employed and most have private health insurance, 20 percent of public treatment funds were spent on people with private health insurance in 1993, due to limitations on their policy" (ONDCP, 1999b). In the view of the Panel, private insurers should serve as the primary source of coverage, with public insurance serving as the safety net.

Despite the $12.6 billion spent on substance abuse treatment, the system possesses limited resources. Several issues have an impact on the effective allocation of resources. Because financing is not based on the effectiveness of programs, inefficient allocation and use of resources is common. Clients often enter treatment based on the geographic and financial factors that affect their ability to access care. An individual's course of treatment frequently is decided based on the program to which he or she has access rather than on his or her specific needs. Often a patient's gender, culture, or other individual factors are not considered in the treatment plan. Thus, the needs of special populations such as women, children, and minorities who require additional or different services might not be addressed.

Not only are treatment resources limited, but eligibility requirements associated with different Federal funding streams are often inconsistent, making funding somewhat inflexible. The Panel

believes that the stringency of these requirements enables ineffective methods for allocating resources.

The Institution for Mental Disease (IMD) exclusion in Medicaid can be one such hindrance to treatment. The IMD exclusion, unless otherwise amended by a waiver, prohibits inpatient or residential settings with more than 16 beds from using Medicaid dollars to cover that care. Through statutory language and regulations promulgated by the Health Care Financing Administration (HCFA), no residential facility that has more than 16 beds may receive reimbursement for alcohol and drug treatment. However, effective financing and treatment for substance abuse and dependence requires the flexibility to use residential care when needed.

Other issues related to resources that are affecting the treatment system — such as low resources relative to the number of clients treated, low wages, erosion of dollars per client, staff burnout, and other provider issues — make it difficult to provide a full continuum of appropriate care. Further exacerbating the gap is the poor condition of many structural facilities and the lack of resources available to maintain or improve existing facilities or to build new ones (see Panel III Report).

D. QUALITY CARE AND OUTCOMES MEASURES

Substance abuse treatment lacks generally accepted standards of care and quality improvement protocols. Because care is frequently defined differently across different payors and providers, the care provided might vary for the same diagnosis, making some courses of treatment ineffective. This variation is compounded by cost reduction strategies of third-party payors that might affect clinical decisions and drive treatment decisions. This situation often leads to the provision of care that does not match the specific needs of the individual, and results in less effective treatment.

The lack of basic standards can also result in overuse and underuse of treatment. The Panel believes that specific areas without generally accepted standards include screening and assessment and quality assurance. In a system in which the point of entry determines the type of treatment received, the result of inconsistent screening and assessment approaches can be treatment that does not meet individual needs. To provide effective care, the standards must be structured so that providers can identify the level of care necessary and match it with the correct provider possessing both the resources and availability to treat the individual at the appropriate level of care. Currently the system does not require a set of standards across all types of providers within the system; until that is the norm, system inefficiencies that result in lower quality of care will persist.

In many cases, people experiencing problems with alcohol and/or drugs do not have access to the appropriate level of care, and the care they do receive may fall short of their needs. A continuum of care should include prevention, intervention, assessment, treatment, and maintenance. The general unavailability of an adequate continuum of care is evident in the limited funding available for brief

interventions, where the purpose is to screen and provide quick therapeutic interventions. Further, the full continuum of care should include services needed by families and others affected by an individual's substance abuse disorder.

IV. Themes from the Public Hearings

To ensure the incorporation of community perspectives in this effort, the Center for Substance Abuse Treatment (CSAT) held six public hearings across the nation. More than 400 testimonies were heard from individuals from 31 States and included representatives from the recovery community, State and local agencies, treatment providers, educators, and researchers.

Considerable testimony was presented around the need for an increase in funding to support the improvement of treatment. These areas included: (1) services to individuals with co-occurring disorders, (2) treatment facilities (e.g., residential, long-term, women, youth, and hearing impaired settings), and (3) wraparound services for clients and their families (e.g., education programs, independent living skills, vocational training). Additionally, the need for integration with other systems such as primary care, child welfare, justice, and social services was often identified as critical.

Other testimonies expressed a need for:

- The development of a continuum of care;
- Parity for substance abuse treatment services;
- The system to be better equipped to address the diverse needs of its clients; and
- The consideration of treatment as an alternative to incarceration for non-violent offenders.

Panel members used the issues raised during the public hearings both to guide and to supplement their areas of discussion.

V. Recommendations

To address these problems, Panel members developed a series of recommendations focusing on three areas: inter-system relationships, resource allocation, and quality care and outcome measures.

A. ACCESS AND INTER-SYSTEM LINKAGES

1. Develop a plan to create a nationwide expectation for alcohol and drug treatment such that no matter where in the human services, health, or justice system an individual appears, his or her alcohol or drug problem will be appropriately identified, assessed, referred, or treated.

This recommendation calls for a "no wrong door" approach to effective treatment. It requires that there be access to treatment through all systems, regardless of point of entry, and that any treatment provided meets specific standards of quality. Due to the nature of substance abuse disorders, individuals may present in many different venues. The goal for each system is to be able to refer clients or provide effective treatment. Development of inter-system collaboration to maximize available services and resources is critical to provision of effective treatment. Because it is impossible for all systems to provide comprehensive effective treatment services, creation of integrated identification, screening, referral, and care management processes is essential to successful treatment outcomes.

Panel members believe that there are three main strategies for the implementation of this recommendation: (1) CSAT should serve as the lead agency for developing the plan; (2) CSAT should support the development of standards for treatment for those agencies outside the substance abuse treatment system, provide technical assistance, facilitate intergovernmental links, and coordinate with the ONDCP and the Substance Abuse and Mental Health Services Administration (SAMHSA) to promote implementation; and (3) protocols for providing evidence-based treatment may be attached to State and local funding streams to ensure effective treatment, regardless of point of entry.

Discussion

The negative impact that substance abuse has on health, crime, employment, education, and every other facet of life speaks directly to the benefits of providing treatment to those experiencing problems with alcohol or drugs. Treatment has been shown, among other things, to significantly lower drug and alcohol use, lower healthcare costs, reduce crime, and increase productivity. Thus, ensuring that the client experiencing problems with alcohol or other drugs receives treatment will help that individual recover from his or her disorder and also produce results for all of these systems.

STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF ALCOHOLISM AND DRUG ABUSE

P.O. BOX 110607
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December 14, 1998

Dear Reader:

The Division of Alcoholism and Drug Abuse is pleased to present this final report on the outcomes of treatment services provided in Alaska. The findings from this study show that Alaskans who complete a treatment program are staying sober, securing and keeping jobs, and are less likely to be involved in legal actions relating to alcohol and substance abuse.

The study for the Division of Alcoholism and Drug Abuse was conducted by New Standards, Inc., a nationally recognized authority in studying treatment programs. Under the study, some 1,600 residential patients and outpatients have been followed from their admission to a treatment program to one year following admission.

Findings from the study show that treatment does work. The study also confirms our belief that continuing care is very important. Information derived from this study will assist us in designing the best treatment and after care program for Alaskans.

The State of Alaska's treatment programs care for approximately 2,500 residential and 5,500 outpatients a year. Treatment services are provided by 45 programs in the State.

This study followed patients from treatment centers in Anchorage, Barrow, Bethel, Craig, Dillingham, Fairbanks, Healy, Juneau, Kenai, Ketchikan, Mat-Su, Nenana, and Nome.

We encourage you to read and study this report. If you have any questions, please contact the Division.

Sincerely,

Loren A. Jones
Director

Chemical Dependency Treatment Outcome Study
Executive Summary

Results from a study of Alaska's chemical dependency treatment programs show that the state's efforts are succeeding on several fronts. Follow-up interviews with participants in both inpatient and outpatient treatment programs indicate that, after one year, arrests and hospitalization decreased, while participants' employment rates and work attendance increased.

The Alaska Division of Alcoholism and Drug Abuse commissioned the treatment outcome study to measure the effectiveness of publicly funded residential and outpatient treatment programs. Beginning in February 1994, the study surveyed 1024 residential/step-down patients and 510 outpatients who consented to assessments at admission, discharge, and six and 12 months after admission to treatment. The findings were collected by New Standards Inc., a Minnesota-based authority in studying treatment programs.

The study will provide information to help policymakers design the best treatment and after-care programs for Alaskans.

The outcome study found:

- Of Alaskan patients surveyed, 56 percent of those in outpatient programs abstained from alcohol for one year after treatment, compared to 42 percent of residential patients. Outpatients in the study received an average of 59 hours of care, while patients in residential programs received an average of 39 days of inpatient care.

- The study also found there is a strong association between abstinence rates and post-treatment levels of care and peer support groups like Alcoholics Anonymous. For 75 percent of residential patients, formal aftercare taken for a year resulted in a year of sobriety. Formal aftercare during the first six months appears to have the strongest impact on recovery among outpatients, with 71 to 77 percent reporting sobriety.

- Both residential and outpatient program participants reported substantial decreases in legal problems one year posttreatment. Criminal arrests, traffic arrests and motor vehicle accidents dropped. This yields overall societal benefits as a result of chemical dependency treatment by easing demands on already overburdened legal and insurance systems.

- Documented reductions in hospitalizations and emergency care and outpatient care for chemical dependency program patients support the notion that, following treatment there is a shifting away from costly hospital and emergency room "crisis" or urgent care, toward more timely and appropriate preventive or routine outpatient treatment.

- Employment rates changed dramatically from pretreatment through one year after treatment. Full-time employment increased from 30 percent before treatment to 45 percent at 12 months. Conversely, unemployment rates dropped from 45 percent to 24 percent.

- Both residential and outpatients reported significant reductions in tardiness and missing work. Outpatients in particular reported fewer problems with supervisors and fewer mistakes on the job.

- A significant number of patients surveyed reported sexual and physical abuse; 10 percent of the residential patients and 8 percent of the outpatients indicated incest by a male relative. Twenty-eight percent of the outpatients and 29 percent of the residential patients reported physical abuse prior to age 18.

Alaska Division of Alcoholism and Drug Abuse
Chemical Dependency Treatment Outcome Study

Clinical Fact Sheet 1
July 1998

A Brief Summary of Methods

The State of Alaska's Division of Alcoholism and Drug Abuse determined in late 1993 that objective and empirical outcome data on publicly funded chemical dependency treatment patients was needed to *make informed treatment policy and financial decisions based on empirical data rather than qualitative judgments without data.*

The Sample

Beginning in January 1994, the study assessed over 1500 consenting patients at admission, discharge, and six and twelve months after admission to treatment. At the end of this study, there are 1024 residential/step-down patients and 510 outpatients who have consented to participate in the study.

These 1534 consenting patients from 13 facilities were chosen to be representative of a consecutive admission convenience sample of all ethnicities (both Alaska native and non-native) of people seeking publicly-funded chemical dependency treatment in Alaska. These 13 facilities are from geographically representative areas of Alaska and include treatment facilities from the Anchorage, Barrow, Bethel, Craig, Dillingham, Fairbanks, Healy, Juneau, Kenai, Ketchikan, Nome, and Wasilla areas.

The residential/ step-down treatment group is made up of patients who received only residential chemical dependency treatment, and/ or some combination of residential and outpatient/day hospital treatment. The outpatient treatment group is made up of patients who received only day or evening outpatient, or day hospital treatment, but no residential treatment.

The Study Designs, Methods, and Measures

The Alaska Outcome Study (AOS) was designed to assess any change in various areas of patients' lives that may be due to the chemical dependency treatment they received. To achieve this, Intake, Admission and History forms were designed to provide comprehensive pretreatment baseline assessments of many different key sociodemographic, clinical (including substance use, antisocial and depressive) symptom profile and severity, vocational functioning, health care utilization, and legal factors. These measures were necessary to provide a starting point against which to measure improvements in functioning assessed from data gathered at the follow-up interviews six and twelve months after admission to treatment. A Discharge form measures key treatment process variables such as treatment completion, length of stay, chemical use during treatment, family participation in treatment, and postdischarge referrals.

Finally, at six and twelve months after admission to treatment, the patient receives a phone call from professionally-trained phone surveyors at NSI in St. Paul, Minnesota. Each of these phone interviews is between 5 and 10 minutes long and contains information about patient satisfaction with treatment, the patient's sobriety status and chemical use in the past six months, the obstacles to the patient's recovery, vocational functioning, health care utilization, legal problems, and depressive symptoms.

If, for some reason, interviewers were unable to contact the patient for the six-month interview, attempts were still made to contact the patient for the twelve-month interview.

The initial baseline data collection began in February 1994 and was extended through March 1997.

Final Status of the Study

As of April 1996, 1024 residential patients and 510 outpatients had consented to the follow-up study. NSI successfully contacted 42% of the eligible residential patients and 54% of the eligible outpatients one year after admission to treatment. These contact rates are consistent with other CATOR studies involving largely rural, publicly-funded populations.

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. These outcomes are comparable to those of other publicly funded programs.

Alaska Division of Alcoholism and Drug Abuse
Chemical Dependency Treatment Outcome Study

Clinical Fact Sheet 2
July 1998

Summary of Contact Bias

The State of Alaska's Division of Alcoholism and Drug Abuse determined in late 1993 that objective and empirical outcome data on publicly funded chemical dependency treatment patients was needed to *make informed treatment policy and financial decisions based on empirical data rather than qualitative judgments without data.*

The Sample

Beginning in January 1994, the study assessed over 1500 consenting patients at admission, discharge, and six and twelve months after admission to treatment. At the end of this study, there are 1024 residential/step-down patients and 510 outpatients who have consented to participate in the study.

These 1534 consenting patients from 13 facilities were chosen to be representative of a consecutive admission convenience sample of all ethnicities (both Alaska native and non-native) of people seeking publicly-funded chemical dependency treatment in Alaska. These 13 facilities are from geographically representative areas of Alaska and include treatment facilities from the Anchorage, Barrow, Bethel, Craig, Dillingham, Fairbanks, Healy, Juneau, Kenai, Ketchikan, Nome, and Wasilla areas. The residential/ step-down treatment group is made up of patients who received only residential chemical dependency treatment, and/ or some combination of residential and outpatient/day hospital treatment. The outpatient treatment group is made up of patients who received only day or evening outpatient, or day hospital treatment, but no residential treatment.

Contact bias for the 6-month and 12-month interviews was minimal. Among other publicly funded programs in general, contact bias has ranged from minimal to substantial. The fact that the contact bias is minimal for the current study suggests that the outcomes measured through the follow-up interviews are representative of the entire population that originally consented to participate.

The following table presents a demographic comparison of patients who were not contacted with those who were contacted at 6 and 12 months.

	No Contact	6 Months	12 Months
Gender			
Male	66%	62%	61%
Female	34%	38%	39%
Age			
20 & Younger	4%	6%	5%
21 – 40	75%	76%	76%
41 – 60	20%	18%	19%
61 & Older	1%	1%	1%
Degree			
None	26%	24%	23%
Diploma/GED	54%	56%	57%
Vo-Tech	14%	15%	15%
Associate	4%	4%	3%
Bachelor	3%	2%	2%
On Disability or Welfare			
No	76%	76%	77%
Yes	24%	24%	23%
Ethnicity			
Caucasian	46%	45%	47%
African American	7%	5%	3%
American Indian	3%	2%	3%
Athabascan	8%	7%	7%
Tlingit	3%	5%	4%
Haida	1%	1%	1%
Aleut	4%	5%	5%
Inupiat	12%	12%	12%
Yupik	8%	12%	9%
Tsimshian	1%	1%	1%
Other AK Native	2%	2%	2%
Other	4%	3%	4%
Occupational Status			
Professional/Technical	8%	7%	7%
Manager/Admin/Buss	3%	3%	3%
Sales	5%	4%	5%
Clerical/Office Worker	8%	10%	9%
Craft/Skilled/Guide	17%	15%	16%
Transp/Equip Operator	4%	5%	5%
Non-Farm Labor	25%	23%	25%
Domestic Worker	6%	5%	6%
Service Worker	9%	10%	9%
Farm Labor	0%	0%	0%
Military Service	1%	0%	0%
Subsistence	3%	4%	4%
Other	11%	13%	13%
Chemical Dependency Hierarchy			
Ungrouped	26%	24%	26%
Alcohol Only	37%	41%	42%
Prescription Drugs	1%	0%	1%
Marijuana	15%	15%	15%
Stimulants	1%	0%	0%
Cocaine	19%	17%	14%
Opiates	2%	1%	1%

Note: The category "Ungrouped" in the Chemical Dependency Hierarchy represents those patients who did not endorse sufficient symptoms to suggest dependence on a particular substance.

Alaska Division of Alcoholism and Drug Abuse
Chemical Dependency Treatment Outcome Study

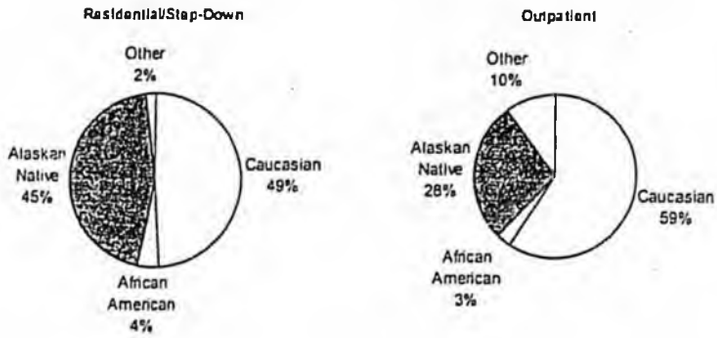
Clinical Fact Sheet 3
July 1998

Demographic and Clinical Profile

The Alaska Division of Alcoholism and Drug Abuse treatment outcome study, designed to measure the effectiveness of publicly-funded residential and outpatient treatment began in February 1994. This study assessed 1024 residential/step-down patients and 510 outpatients who consented to assessments at admission, discharge, and six and twelve months after admission to treatment.

Demographic Profile of Patients

The outpatient sample contained a higher proportion of Caucasians than the residential/step-down program; the residential/step-down program included a higher proportion of Alaska Native Peoples (primarily Yupik and Inupiat).



English was the primary language of both samples (89% residential/step-down and 90% outpatient). A higher proportion of outpatients were male (69% vs. 56%), married (23% vs. 18%), educated past high school (24% vs. 16%), and employed full-time (49% vs. 20%) than residential/step-down patients. Outpatients were also slightly older, with 21% vs. 18% falling in the 41-60 year range.

A lower proportion of outpatients were unemployed (30% vs. 50%), received disability compensation (5% vs. 8%), and welfare (17% vs. 22%) than residential/step-down patients.

The largest percentage within both the residential/step-down sample (19%) and the outpatient sample (25%) listed their primary job as a non-farm laborer. Fifty-five percent of the outpatients had a family income below $20,000, as did 58% of the residential /step-down patients.

Referral sources also differed between residential/step-down patients and outpatients. Whereas 62% of outpatients were court ordered, only 45% of residential/step-down patients were. At the same time, 49% of residential step-down patients were self-referred compared to only 27% of the outpatients.

The proportions of self-paying patients were comparable (64% residential/step-down vs. 65% outpatient).

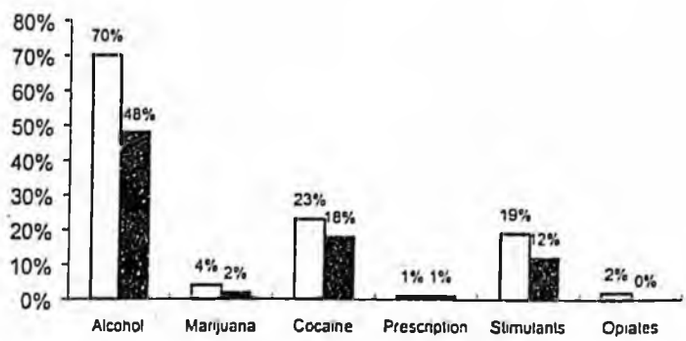
Forty-five percent of the outpatients reported entering treatment because they were arrested for DWI/DUI. This compares with only 28% of the Residential/Step-Down patients.

Clinical Profile of Patients

In general, the residential/step-down patients enter treatment with higher levels of chemical use symptom severities, illicit drug use and other co-existing problems than the outpatient sample.

Sixty-three percent of the outpatients were classified as low in severity, compared to 56% of the residential/ step-down patients. Twenty-four percent of the residential/step-down patients were classified as either moderately high or high, compared to only 14% of the outpatients.

Alcohol dependence was reported among 70% of the residential/step-down patients and 48% of the outpatients. Twenty-three percent of residential/ step-down clients were marijuana dependent compared to 18% of outpatients. Nineteen percent of residential/ step-down patients were dependent on cocaine compared to 12% of outpatients.



A higher proportion of residential/step-down patients received prior treatment for chemical dependency (62% vs. 48%) and depression (27% vs. 19%) than outpatients.

A significant proportion of each sample reported physical and sexual abuse; 10% of the residential/step-down patients and 8% of the outpatients reported incest by a male relative. Twenty-eight percent of the outpatients and 29% of the residential/stepdown patients reported physical abuse prior to age 18.

Alaska Division of Alcoholism and Drug Abuse
Chemical Dependency Treatment Outcome Study

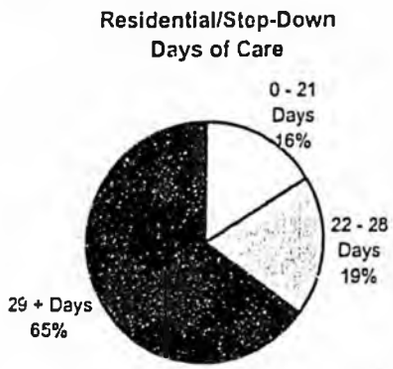
Clinical Fact Sheet 4
July 1998

Treatment Profile

The Alaska Division of Alcoholism and Drug Abuse treatment outcome study, designed to measure the effectiveness of publicly-funded residential and outpatient treatment began in February 1994. This study assessed 1024 residential/step-down patients and 510 outpatients who consented to assessments at admission, discharge, and six and twelve months after admission to treatment.

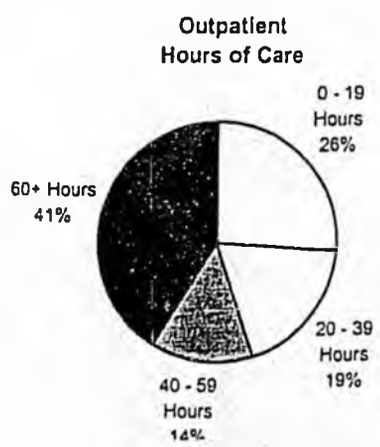
Inpatient and Outpatient Care

Residential/Step-Down patients received an average of 39 days of inpatient care.



Approximately 50% of the patients received at least this amount. In all, 65% received more than the 28 days of care historically found in traditional inpatient programs. Of those who received more than 28 days, 44% remained abstinent for a full year following treatment.

The vast majority of Residential/Step-Down patients did not receive outpatient care (94%). Of those who did, 38% received less than 10 hours of outpatient care either before or after residential treatment.

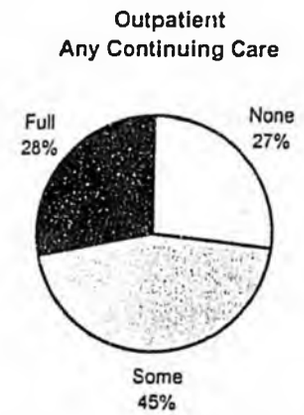


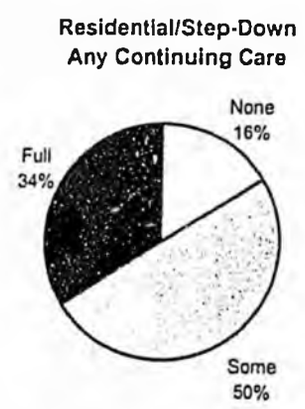
Outpatients received an average of 59 hours of care. Forty-one percent received more than 59 hours, with most (35%) receiving 70 hours or more. Seventy-nine percent of those with 70 or more hours of care were abstinent for a full year following treatment.

Continuing Care

Thirty-eight percent of outpatients and 55% of residential/step-down patients report attending some formal aftercare program over the full year.

At the same time, 70% of outpatients attended some form of peer support group (e.g., AA, etc.) at least sporadically throughout the first year after treatment, as did 79% of Residential/Step-Down patients.





In all, 73% of the outpatients and 84% of the Residential/Step-Down patients reported attending some form of continuing care during the year following treatment. Among those with full attendance, 64% of residential/stepdown patients and 74% of outpatients were abstinent for a full year following treatment.

Job Cost-Offsets

The Alaska Division of Alcoholism and Drug Abuse treatment outcome study, designed to measure the effectiveness of publicly-funded residential and outpatient treatment began in February 1994. This study assessed 1024 residential/step-down patients and 510 outpatients who consented to assessments at admission, discharge, and six and twelve months after admission to treatment.

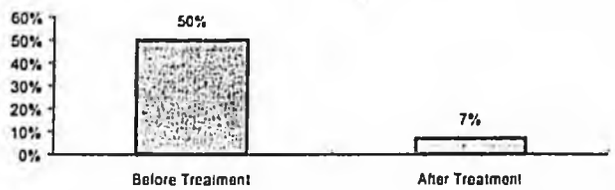
Employment rates changed dramatically from pretreatment through one year after treatment. Full-time employment increased from 30% before treatment to 45% at twelve months. Conversely, unemployment rates dropped from 45% to 24%. *Patients from both the Residential/Step-Down program and the Outpatient program improved in job functioning one year posttreatment*

Residential/Step-Down Patients

Residential/Step-Down patients improved in all areas of job functioning, with the exception of making mistakes and getting injured at work. With the significant drop in missed days of work, patients had greater opportunity to experience other types of job problems. For example, injury rates increased slightly from 4% to 9%, and making mistakes remained constant at 16% before and after treatment.

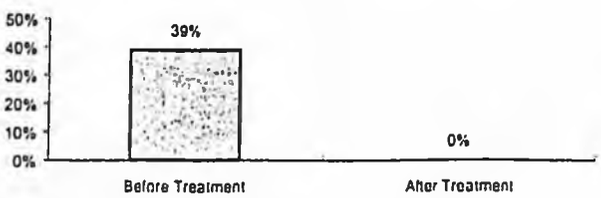
As shown in the figures, working while under the influence decreased dramatically one year

Working While Under the Influence
Residential/Step-Down Patients



posttreatment.

Working While Under the Influence
Outpatients



Job Functioning One Year Posttreatment

	Residential/Step-Down	
	Before Treatment	One Year Posttreatment
Problems With Supervisor	18%	13%
Problems Getting Job Done	11%	9%
Making Mistakes	16%	16%
Missing Work	35%	10%
Being Late to Work	30%	11%
Absent During the Past Month	33%	14%
Injured at Work	4%	9%

Outpatients

Outpatients also improved dramatically in terms of working while under the influence, as shown in the figure below. Outpatients improved in all areas of job functioning except getting injured at work and being absent from work.

Four percent of the patients in this sample reported getting injured on the job before treatment; six percent reported getting injured in the year after treatment. This slight increase may be attributable to any number of external factors, including seasonal variations in jobs.

Job Functioning One Year Posttreatment

	Outpatients	
	Before Treatment	One Year Posttreatment
Problems With Supervisor	16%	8%
Problems Getting Job Done	16%	4%
Making Mistakes	14%	6%
Missing Work	10%	2%
Being Late to Work	16%	2%
Absent During the Past Month	16%	16%
Injured at Works	4%	6%

These results support the notion that substance abuse exacts a heavy toll in terms of workplace productivity and directly translates into dollars lost by the employer. They further suggest that successful treatment is strongly associated with an enduring reduction in those workplace costs related to substance abuse.

Alaska Division of Alcoholism and Drug Abuse
Chemical Dependency Treatment Outcome Study

Clinical Fact Sheet 6
July 1998

Medical Cost-Offsets

The Alaska Division of Alcoholism and Drug Abuse treatment outcome study, designed to measure the effectiveness of publicly-funded residential and outpatient treatment began in February 1994. This study assessed 1024 residential/step-down patients and 510 outpatients who consented to assessments at admission, discharge, and six and twelve months after admission to treatment.

Patients from both the Residential/Step-Down and Outpatient programs improved in medical utilization one year posttreatment

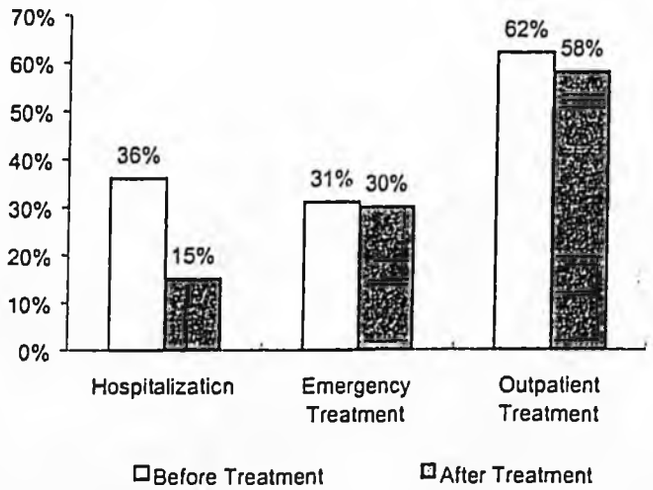
Overall, females tend to utilize more medical services. This is most pronounced with outpatient medical services. Females also tended to report larger reductions in all types of medical care utilization as compared to males on year post-treatment.

Residential/Step-Down Patients

Among residential/step-down patients, hospitalization rates one year after treatment were substantially lower as compared to before treatment. However, as shown in the figure below, there was effectively no decrease in emergency care utilization (males decreased from 31% to 27%, while females increased from 29% to 33%), and the change in outpatient healthcare utilization was slight.

Overall, male patients reported less utilization in all service areas following treatment. With the exception of emergency services, females reported similar decreases in healthcare utilization.

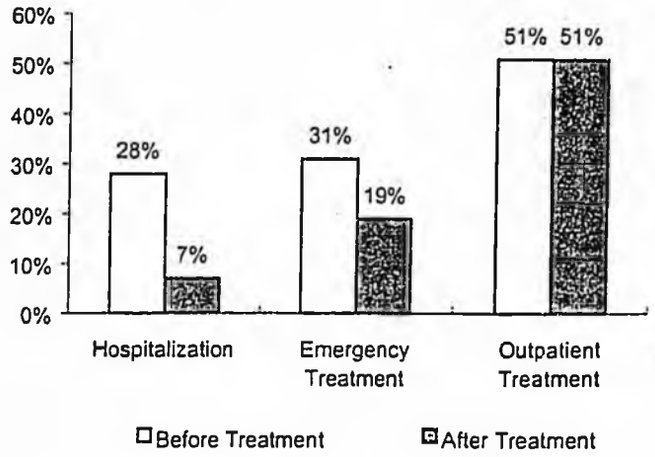
Medical Utilization Cost-Offsets
Residential/Step-Down Patients



Outpatients

There were substantial reductions in hospitalizations and emergency care among patients who received outpatient chemical dependency treatment. There was a slight increase in outpatient healthcare utilization among males (46% before treatment to 48% after treatment) and a slight decrease among females (62% before treatment to 59% after treatment).

Medical Utilization Cost-Offsets
Outpatients



The slight reductions in outpatient healthcare utilization accompanied by dramatic reductions in hospitalizations and emergency care support the notion that following treatment there is a laudable shifting of medical utilization away from costly hospital and emergency room "crisis" or urgent care, towards more timely and appropriate preventive or routine outpatient treatment.

Alaska Division of Alcoholism and Drug Abuse
Chemical Dependency Treatment Outcome Study

Clinical Fact Sheet 7
July 1998

Legal Cost-Offsets

The Alaska Division of Alcoholism and Drug Abuse treatment outcome study, designed to measure the effectiveness of publicly-funded residential and outpatient treatment began in February 1994. This study assessed 1024 residential/step-down patients and 510 outpatients who consented to assessments at admission, discharge, and six and twelve months after admission to treatment.

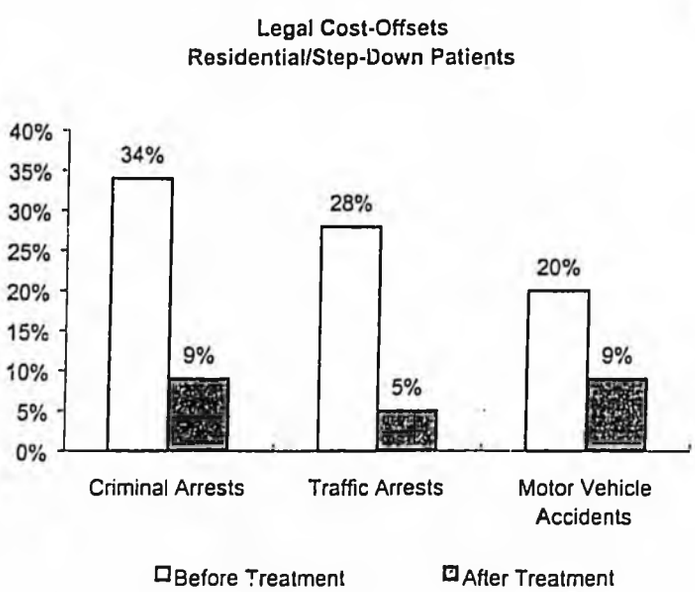
Both the Residential/Step-Down and Outpatient program patients reported reductions in legal problems one year posttreatment.

Aggregate CATOR analyses have documented substantial post-treatment changes or reductions in legal involvement. These changes were found to hold for Alaska patients as well.

These measures of legal involvement are reflective of the impact alcohol and drug use has on public safety; thus any declines are beneficial not only to the patients themselves, but also members of the community at large.

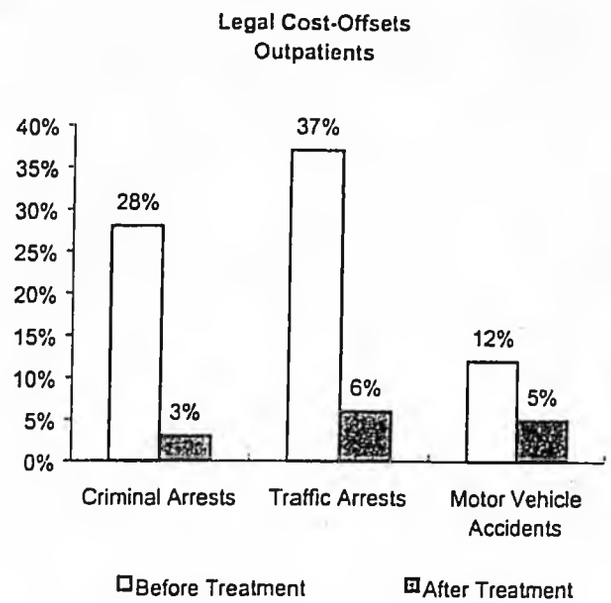
Residential/Step-Down Patients

Residential/step-down patients decreased utilization of the legal system in three specific areas one year posttreatment: Arrests for criminal offenses, arrests for traffic violations, and motor vehicle accidents.



Outpatients

Legal problems also decreased for outpatients one year posttreatment, most notably in arrests for criminal offenses and traffic violations.



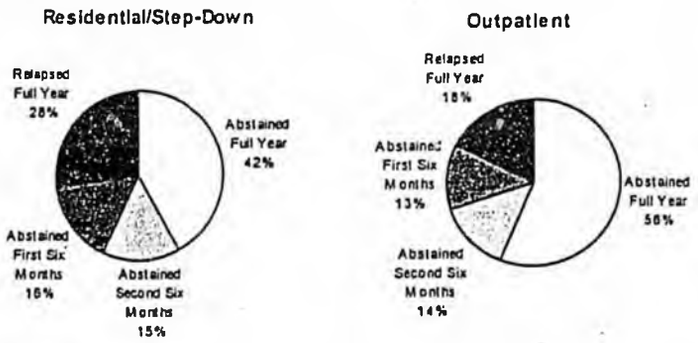
In sum, any decreases in legal involvement yield societal benefits through an easing of demands on already overburdened legal and insurance systems.

Legal fees, court costs and auto insurance premiums should be factored into the "cost" of the above legal problems, and they should be factored into the "benefits" of their reduction associated with chemical dependency treatment.

Abstinence Rates

The Alaska Division of Alcoholism and Drug Abuse treatment outcome study, designed to measure the effectiveness of publicly-funded residential and outpatient treatment began in February 1994. This study assessed 1024 residential/step-down patients and 510 outpatients who consented to assessments at admission, discharge, and six and twelve months after admission to treatment.

The overall one-year abstinence rate for residential/step-down patients was 42%, compared to 56% of the outpatients. A total of 57% of the residential/step-down patients and 70% of the outpatients reported full abstinence during the six months prior to the one-year follow-up. Twenty-eight percent of residential/step-down patients relapsed the entire year after treatment, whereas only 18% of the outpatients relapsed the entire year. These rates are comparable to those of similar rural, publicly funded populations.



Patient Characteristics and Abstinence

Male outpatients were more likely to abstain one year posttreatment than female outpatients (59% vs. 49%) while female residential/step-down patients were slightly more likely to abstain all year than their male counterparts (46% vs. 39%).

Among residential/step-down patients, those classified as low in severity were most likely to abstain all year (49%). Among outpatients those classified as moderately low in severity were most likely to abstain (61%). Fifty-seven percent of the outpatients dependent on alcohol remained abstinent one year after treatment compared to only 34% of the residential/step-down patients. Seventy-one percent of outpatients dependent on cocaine remained abstinent compared to only 29% in the residential/step-down programs. This finding may, in part, be due to the fact that those who are most severely dependent (and therefore less likely to remain abstinent) are placed in residential treatment.

Treatment Characteristics and Abstinence

Forty-nine percent of the inpatients with a length of stay between 22 and 28 days abstained all year, as did 44% of those with a length of stay of more than 29 days. Seventy-one percent of the outpatients with more than 40 hours of service remained abstinent for a full year as compared to 46% of those with 40 or less.

Continuing Care and Abstinence

CATOR aggregate analyses over the past decade have consistently documented a strong association between abstinence rates and post-treatment levels of program aftercare participation and peer support group attendance.

While, overall, attendance in continuing care programs among Alaska patients is generally lower than among CATOR facilities, the pattern still holds. Among the Residential/Step-Down patients, Formal Aftercare fully attended for a full year has the strongest impact on abstinence with 75% reporting a full year of sobriety.

Formal aftercare during the first 6 months appears to have the strongest impact on recovery among outpatients with 71-77% who reporting sobriety.

Continuum of Care and Abstinence Rates

	Residential/ StepDown	Outpatient
Formal Aftercare Attendance (Months 1-6)	**Fully Abstained**	**Fully Abstained**
None	31%	49%
Some	43%	77%
Full	69%	71%
Formal Aftercare Attendance (Full Year)	**Fully Abstained**	**Fully Abstained**
None	27%	49%
Some	51%	68%
Full	75%	63%
Peer Support Group (AA) Attendance (Months 1-6)	**Fully Abstained**	**Fully Abstained**
None	19%	56%
Sporadic	39%	53%
Regular	51%	66%
Peer Support Group (AA) Attendance (Full Year)	**Fully Abstained**	**Fully Abstained**
None	30%	33%
Sporadic	21%	63%
Regular	62%	68%
Aftercare or Peer Support Group Attendance (Months 1-6)	**Fully Abstained**	**Fully Abstained**
None	20%	43%
Some	38%	47%
Full	51%	67%
Aftercare or Peer Support Group Attendance (Full Year)	**Fully Abstained**	**Fully Abstained**
None	29%	28%
Some	32%	61%
Full	64%	74%

ACCESS TO TREATMENT

How do individuals get into treatment for substance use disorders? These are a few ways people are motivated to enter treatment.

DWI OR OTHER ALCOHOL RELATED OFFENSES

COURT OR PROBATION REFERRAL

POLICE/PUBLIC SAFETY

EMPLOYER/EAP INTERVENTION

DIVISION OF FAMILY AND YOUTH SERVICES

FAMILY AND FRIENDS

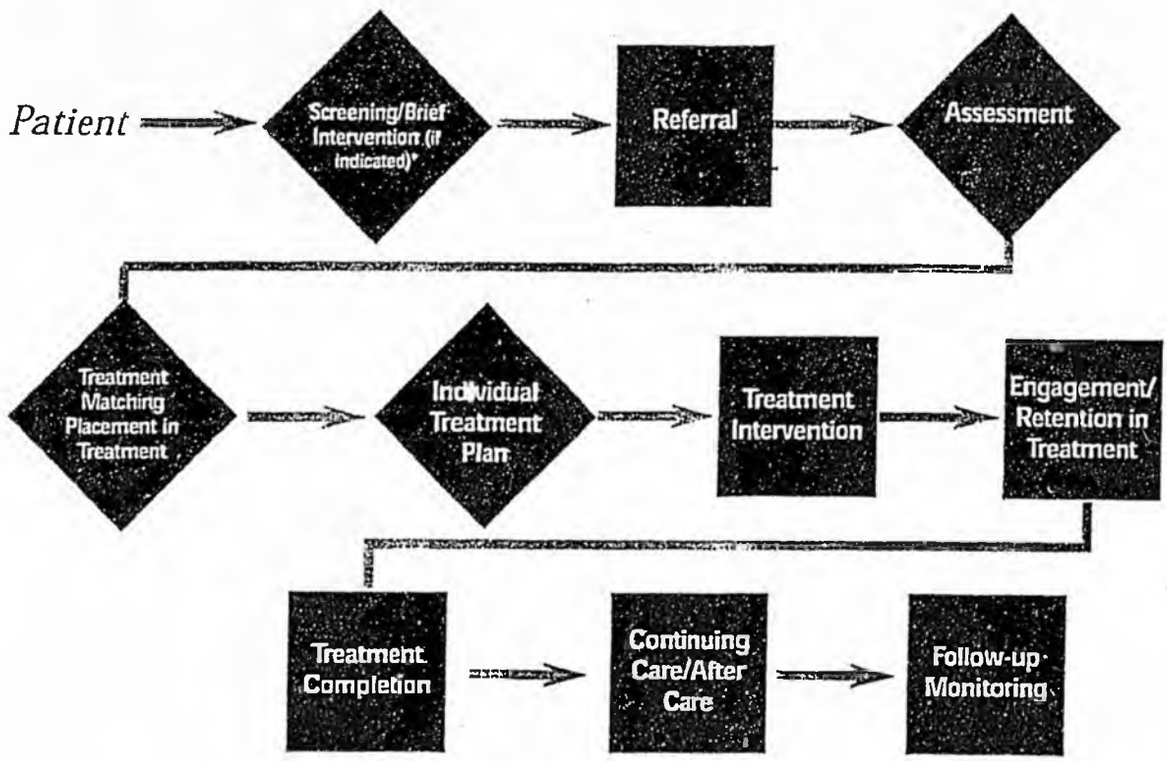
EMERGENCY MEDICAL AND OTHER HEALTHCARE PROVIDERS

CHURCH

WELFARE

AGENCIES SUCH AS MENTAL HEALTH, PUBLIC HEALTH

Figure III.3. Treatment Process



*Screening, brief intervention, and referral might occur in a number of sectors outside the substance abuse treatment system such as the justice system, the school systems, the public health systems, the welfare system, and the workplace.

The Panel recommends that groups such as the American Society of Addiction Medicine (ASAM), the National Association of State Alcohol and Drug Abuse Directors (NASADAD), CSAT, the Office of Applied Studies (OAS), NIDA, NIAAA, and others should be involved in developing the taxonomy.

The Panel examined numerous reports and studies that have addressed the need for improving treatment systems (see Selected Bibliography). The Panel's recommendation on treatment planning and, more specifically, on the development of a client-focused model in many ways encapsulates that body of previous work and sets a specific, practical agenda for producing the proposed changes.

Recommended Action Steps

The Panel suggests that after the release of the National Treatment Plan Iniative (NTP), CSAT should convene a group of national stakeholders to identify the tools, protocols, and practices required to facilitate and evaluate implementation of individualized programs of care. To support this and to promote the individualization of treatment, CSAT should analyze and compare current technologies for assessment, placement, treatment planning, and treatment implementation.

Panel members discussed and developed a series of activities that, if completed, will assist in the implementation of the recommendation. These activities include the following:

- State substance abuse authorities and other payors should phase in requirements for individualized treatment planning, recognizing that public and private systems of care must develop the capacity and infrastructure to support the adoption of these tools and practices.
- State accrediting and licensing authorities should incorporate requirements for individualized treatment planning into operational policies and accrediting standards.
- Treatment practitioners should be trained to implement individualized treatment planning and should use the tools and practices required to support the individualization of treatment.

FINANCING AND REIMBURSEMENT

Many community treatment programs struggle to survive because funding and resources are limited. Without adjustments in the level of reimbursement to support a full continuum of care, many providers may be unable to continue or simply will fall short of serving the community's needs (see Panel I Report). To address this problem the Panel recommends the following:

2. Reimbursement mechanisms should be aligned with treatment goals and should incorporate performance measures and outcome standards to guide resource allocation, as well as rates sufficient to cover both reasonable costs and a surplus to support reinvestment.

Discussion

This recommendation encourages a flexible approach to reimbursing treatment to address the undercapitalization of the treatment system. The current negative attitude toward profit within the treatment system makes it difficult for many organizations to compete in the market and effectively reinvest in their organizations. Combined with insufficient reimbursement rates, this attitude makes it nearly impossible for organizations to operate effectively or efficiently.

This recommendation takes a three-point approach aimed at addressing some of the problems of the current reimbursement system. First, it calls for the creation of a reimbursement system that aligns financing with desired clinical processes and outcomes. The revised system should account for variations in patient severity.

The second component of the recommendation is the establishment of rate-setting methodologies that account for total cost of treatment and infrastructure. A fair and equitable payment system might involve the sharing of risk so that reimbursement adequately covers costs.

SCREENING

WHAT IS SCREENING? – An initial review of symptoms to determine whether drinking or other drug use is out of bounds

WHO SCREENS?

- Alcohol Safety Action Programs
- Employee Assistance Programs
- Chemical Dependency Service Providers
- Judges
- Public Safety Personnel
- Social Service Providers
- Mental Health Providers
- Emergency Rooms
- Village Health Aides
- Rural Human Services Workers
- Doctors
- Nurses
- Clergy

Screening instruments are used to rapidly distinguish between those who are exceedingly likely to have a problem with substance use and those who are unlikely to have a problem. Screening for alcohol problems should be routine in any counseling or health care setting.

The ability to intervene with an alcohol problem depends first, on the problem being identified and secondly, on an adequate assessment to determine the extent and nature of the problem.

ASSESSMENT AND PLACEMENT

WHAT IS ASSESSMENT? Gathering and evaluating information to diagnose substance use disorders and develop treatment plans that address the problems identified in the assessment. This includes making referrals for appropriate levels of treatment.

The American Society of Addiction Medicine, Patient Placement Criteria, Second Edition, (ASAM PPC-2) is the standard used by the Division of Alcoholism and Drug Abuse in making appropriate placement recommendations for individuals needing treatment.

The levels of service include:

- Level 0.5: Early Intervention
- Level I: Outpatient Services (which can include aftercare/continuing care services)
- Level II: Intensive Outpatient/Partial Hospitalization Services
- Level III: Residential/Inpatient Services
- Level IV: Medically Managed Intensive Inpatient Services

HOW ARE INDIVIDUALS PLACED IN TREATMENT SETTINGS?
The following problem areas are identified as those most commonly addressed in making placement decisions. Subsequent formulation of individual treatment plans. Each of these areas is evaluated in a complete assessment:

- 1. Acute Intoxication and/or withdrawal potential
- 2. Biomedical conditions and complications
- 3. Emotional/Behavioral conditions (e.g. psychiatric conditions, psychological or emotional/behavioral complications of known or unknown origin, poor impulse control, changes in mental status, or transient neuropsychiatric complications)
- 4. Treatment acceptance/resistance
- 5. Relapse/continued use potential
- 6. Recovery/living environment

Each of the above "dimensions" is evaluated, including assessment of severity of symptoms in each category. The ASAM PPC-2 outlines specific criteria for admission and discharge to and from appropriate levels of care for adults and adolescents. Referrals may be specific to target populations such as pregnant women, women with young children, those with co-occurring mental illness and substance use disorders, the developmentally disabled (including those with fetal alcohol syndrome), institutionalized offenders, non-institutionalized offenders, or late-stage chronic alcoholics.

WHAT IS TREATMENT?

- Based on a plan of action for addressing specific problems identified in each of the assessment categories.

- It generally includes:

  > education about alcohol and other drug addiction

  > life skills development in areas such as:

  Anger management, stress management, problem solving, nutrition, communication skills, time management, conflict resolution, family issues, personal responsibility, use of community recovery support groups such as aa/na and natives for sobriety; planning to avoid returning to drinking/using, called relapse prevention

- It may include drug assisted therapy such as:

  Naltrexone
  Antabuse
  Acamprosate
  Methadone

- Or it may include detoxification in:
  >a medical setting using a drug such as librium to prevent life threatening withdrawal for severe cases
  >or social detox for less severe cases

- It may include longer term care for late stage chronic alcoholics/addicts who need more time to recover

- Treatment for mental illness in the "dually diagnosed" client

- Parenting skill development

- G.e.d. support

- Employment preparation

CONTINUING CARE

Following primary treatment, individuals need continuing support, sometimes known as Aftercare, or Continuing Care, to reinforce the gains made in treatment. Without such support, the chances of successful recovery are significantly decreased.

The New Standards Chemical Dependency Treatment Outcome Study (pub. 1998) in Alaska reported that for 75 percent of residential patients, formal aftercare taken for a year resulted in a year of sobriety. Formal aftercare during the first six months appears to have the strongest impact on recovery among outpatients, with 71 to 77 percent reporting sobriety. Keep in mind, persons referred to residential care are the more severely affected alcohol-dependent individuals.

CONTINUING CARE MAY INCLUDE:

- Reinforcement of recovery life skills
- Counseling to support coping with life problems as a sober person
- Help to "clean up the wreckage" from drinking/using
- Help to deal with family and parenting issues
- Reinforcement of continuing contact with community recovery support groups such as 12-step programs, Natives for Sobriety, and others.
- Urinalysis Testing
- Relapse Prevention

AFTERMATH OF TREATMENT

INCREASED EMPLOYABILITY

REUNIFICATION OF FAMILIES

REMOVAL OF COURT SANCTIONS

FINANCIAL ACCOUNTABILITY

REDUCTION IN NEED FOR EMERGENCY MEDICAL SERVICES

REDUCED RECIDIVISM IN THE CRIMINAL JUSTICE SYSTEM

REDUCED INCIDENTS OF CHILD ABUSE AND NEGLECT

REDUCED INCIDENTS OF DOMESTIC VIOLENCE

FULL CITIZENSHIP

Alcohol Safety Action Program (ASAP)

Purpose

Alcohol Safety Action Programs (ASAP) provide alcohol screening and case management of criminal justice cases. The basic ASAP function is accountability and case management for DWI and other alcohol/drug related misdemeanor cases. ASAP operates as a neutral link between the justice and the health care delivery systems. This involves screening cases referred from the district court into drinker classification categories, as well as managing and monitoring cases throughout education and/or treatment requirements.

A close working relationship among all involved agencies listed below is required:

- judiciary
- licensing
- probation
- legislature
- corrections
- prosecution
- enforcement
- rehabilitation
- traffic records
- public information/education

To qualify for ASAP services, individuals must have a current or pending criminal justice case. Most clients are referred directly from the court as a condition of their sentence, although they may be assigned prior to their conviction as a condition of release.

The screening procedure itself requires about an hour in the office where the client completes a questionnaire and structured interview. The blood alcohol count (BAC) at the time of arrest and prior criminal/traffic record is obtained and incorporated. Those individuals classified as non-problem drinkers are referred to an alcohol information school (AIS) approved by the Department of Public Safety. Problem drinkers are referred to alcohol/drug treatment providers approved by the Division of Alcoholism & Drug Abuse (ADA). All clients are given an opportunity to choose the agency that they wish to attend, as long as the agency provides the required services.

If clients fail to complete their required assignment(s), a noncompliance affidavit is filed with the prosecution. This may result in a **Petition To Revoke Probation** being filed with the court. Once filed, the magistrate/judge may issue an order to show cause or a bench warrant, and require further hearings to determine the appropriate sanctions (e.g., reassignment to ASAP, reimposition of jail time and/or fine, etc.)

Goals and Objectives

The goal of each community ASAP is to provide reliable early identification of problem drinkers and appropriate intervention services for DWI and other alcohol/drug related cases.

The objectives are to:

- Serve as community resource for DWI and related statistics.
- Provide timely notification of noncompliance to the referring authority
- Process routine self-referrals for DWI and other alcohol/drug related cases
- Monitor offender's compliance with alcohol/drug education or treatment referrals
- Process routine court referrals involving DWI and other alcohol/drug related cases
- Provide monthly reports and/or information regarding program activities as required
- Investigate backgrounds on all referrals for the early identification of problem drinkers
- Provide alcohol/drug referrals for education/treatment assignments as a condition of probation
- Provide overall program management to enhance service delivery with the Alaska Court system, the Department of Public Safety, and health care providers.

RETURN TO ADA HOME PAGE
GO TO ASAP LIST OF OFFICES

ALASKA ASAP OFFICES

- **Anchorage ASAP Misdemeanor Services**
  Ronald Taylor, Social Services Program Coordinator
  303 K Street
  Anchorage, AK 99501
  907-264-0735 FAX # 907-264-0786

- **Bethel ASAP**
  Pepsi Thomas, Administrator
  P.O. Box 1087
  Bethel, AK 99559
  907-543-6720 or 1(800)478-2128 Fax # 907-543-6712

- **Dillingham ASAP**
  Carla Akelkok, Administrator
  P.O. Box 130
  Dillingham, AK 99576
  907-842-5130 Fax # 907-842-1482

- **Fairbanks ASAP**
  Steve Melton, Administrator
  911 Cushman Street #205
  Fairbanks, AK 99701
  907-52-6144 Fax # 907-452-7845

- **Homer ASAP**
  Elaine Olson, Administrator
  3858 Lake Street, Suite #10A
  Homer, AK 99603
  907-235-4050 Fax # 907-235-7294

- **Juneau ASAP**
  Cheri Cadiente, Administrator
  211 4th Street, Suite 102
  Juneau, AK 99801
  907-463-4410 Fax # 907-463-2539

- **Kenai ASAP**
  Bill Goblet, Administrator
  150 North Willow, Suite 44
  Kenai, AK 99611
  907-283-6586 Fax # 907-283- 4029

- **Ketchikan ASAP**
  Ken Goodrich, Administrator
  415 Main Street, Rm 303, SOB.
  Ketchikan, AK 99901
  907-225-4050 Fax # 907-225-4050

- **Kodiak ASAP**
  Terri Ensley, Administrator
  115 Mill Bay Road
  Kodiak, AK 99615
  907-486-3535 Fax # 907-486-7689

- **Kotzebue ASAP**
  Carlos Salazar, Administrator
  P.O. Box 256
  Kotzebue, AK 99752
  907-442-7606 Fax # 907-442-7822

- **Mat-Su ASAP**
  Seere Thompson, Administrator
  348 S. Denali Street
  Palmer, AK 99645
  907-745-0555 Fax # 907-745-1913

- **Seward ASAP**
  Fred Wemarck, Administrator
  P.O. Box 1045
  Seward, AK 99664
  907-224-5257 Fax # 907-224-7081

Return to ASAP Overview
Back to DADA

Understanding Alcoholism and the Treatment of Alcoholism -- An Overview

Ernie Turner, Director

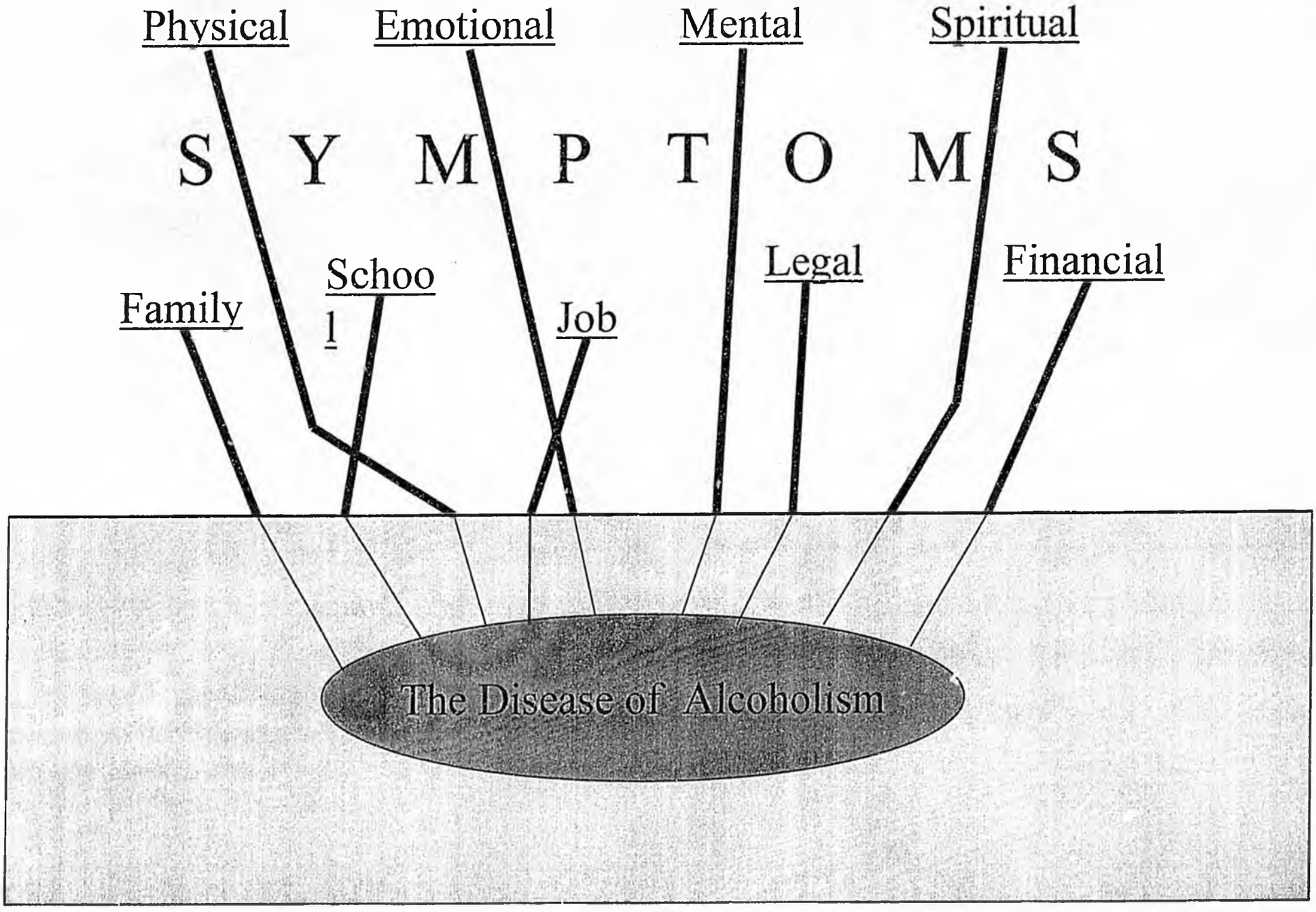
Alcoholism and Drug Abuse Division,
Department of Health and Social Services

March, 2001

Alcoholism: a clinical definition

Alcoholism is a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal.

It is characterized by continuous or periodic impaired control over drinking, preoccupation with alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic.


Physical
Emotional
Mental
Spiritual
S Y M P T O M S
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The Disease of Alcoholism

It all adds up.

Alcohol is implicated in…

65% of suicide attempts

83% of child abuse investigations

60% of domestic violence reports

63% of sexual assaults

53% of fatal automobile crashes

45% of fatal fires

46% of homicides

- 1998: 1,047 alcohol-related injuries requiring hospitalization
- In FY99, 2,109 people held in protective custody for up to 12 hours at State correctional facilities or community jails because they were alcohol-incapacitated.

- For FY2000, Alaska Court System data show approximately 5,300 arrests for DWI.
- Of these, about 75% (3,969) were convicted and referred to Alaska Alcohol Safety Action Program (ASAP), which monitors offenders referred by the courts to ensure that they complete required treatment.
- The remaining were either dismissed, convicted as a felony DWI, or convicted where there was no local ASAP for referral.

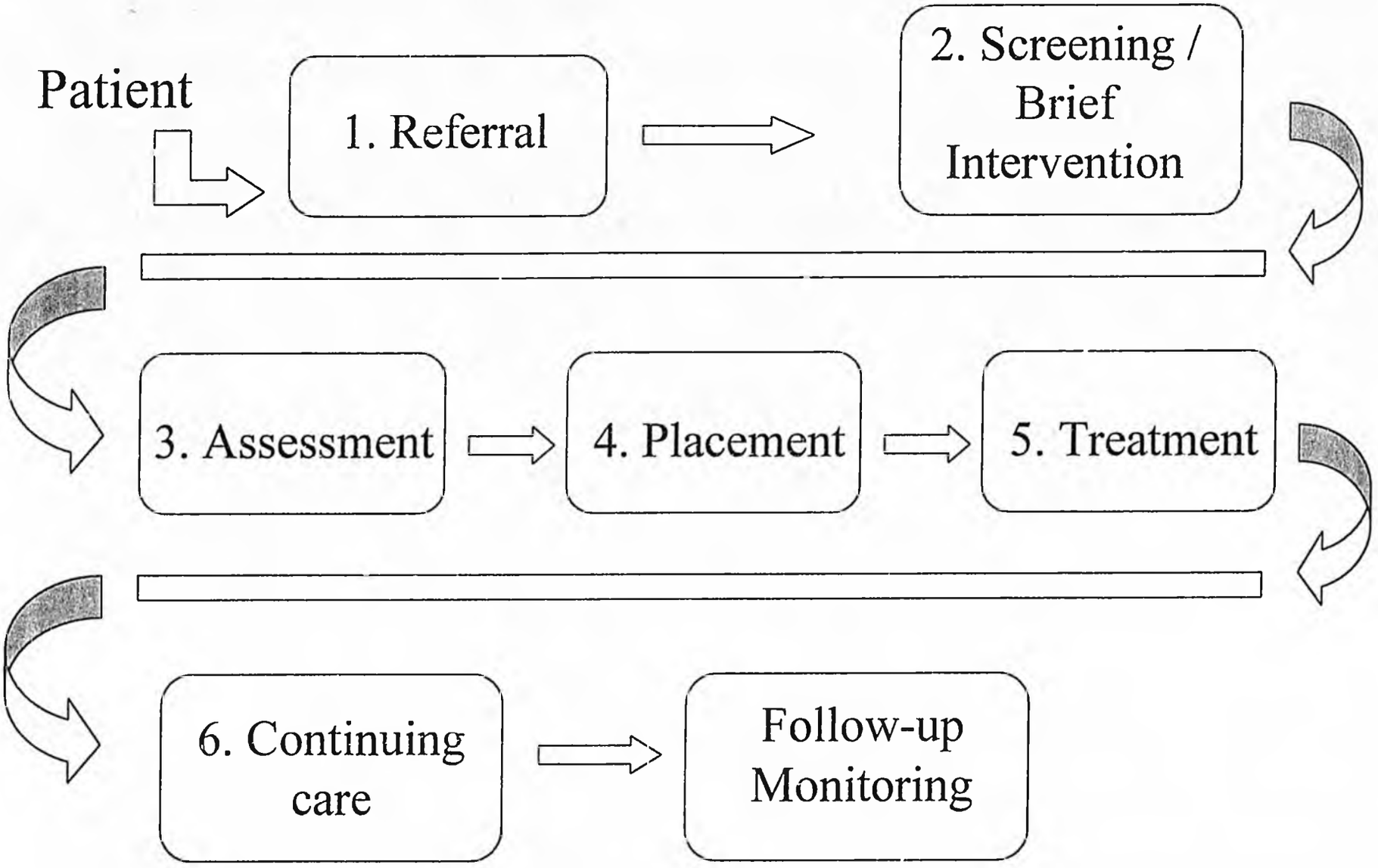
About 58,000 Alaskans misuse, abuse, or are addicted to alcohol.

9.7 percent of Alaskans ages 18 and over are alcoholics -- they meet the criteria for "alcohol dependence" This is more than double the national average, 4.38 percent.

How do we respond to alcoholics?

- Lock 'em up: emergency medical services, 12-hour protective custody, arrest, incarceration
- Clean up after 'em: welfare, child protective services, family and youth services
- Respond to the symptoms: health care for chronic illnesses related to alcoholism, accidents, traumas, etc.
- Treat the cause: respond directly to the root of the disease

Treatment Process



1. Referral

People usually enter the treatment system at the urging of family, friends, their spiritual community, employers, teachers, doctors, family protection and public assistance workers, or on the order of the court.

Some people feel that patients can only be successful when they enter treatment without coercion. But very few patients enter treatment on their own initiative, and those who do are no more successful than those who don't.

2. Screening

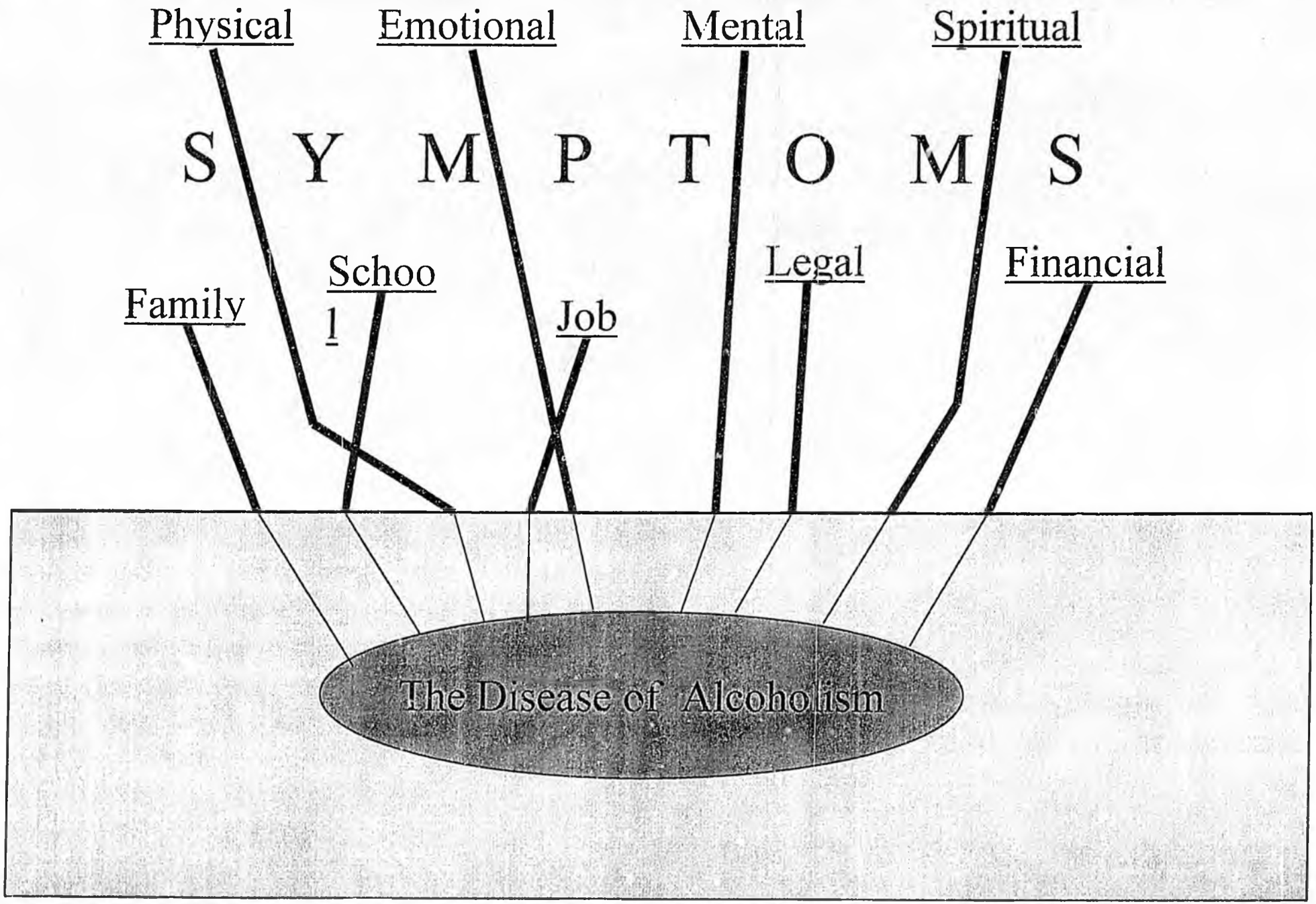
- Screening is an initial review of symptoms to determine whether drinking or other drug use is out of bounds.
- Screening is used to rapidly distinguish between those who need education and those who need treatment.

CAGE diagnostic screening tool

- *Concern*
- *Anger*
- *Guilt*
- *Eye-opener*

3. Assessment

- Assessment is gathering and evaluating information to diagnose substance abuse disorders and develop treatment plans that address the problems identified in the assessment. This includes making referrals for appropriate levels of treatment.


Physical
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The Disease of Alcoholism

4. Placement

- The American Society of Addiction Medicine, Patient Placement Criteria, Second Edition, (ASAM PPC-2) is the standard used by the Division of Alcoholism and Drug Abuse in making appropriate placement recommendations for individuals needing treatment.

5. Treatment

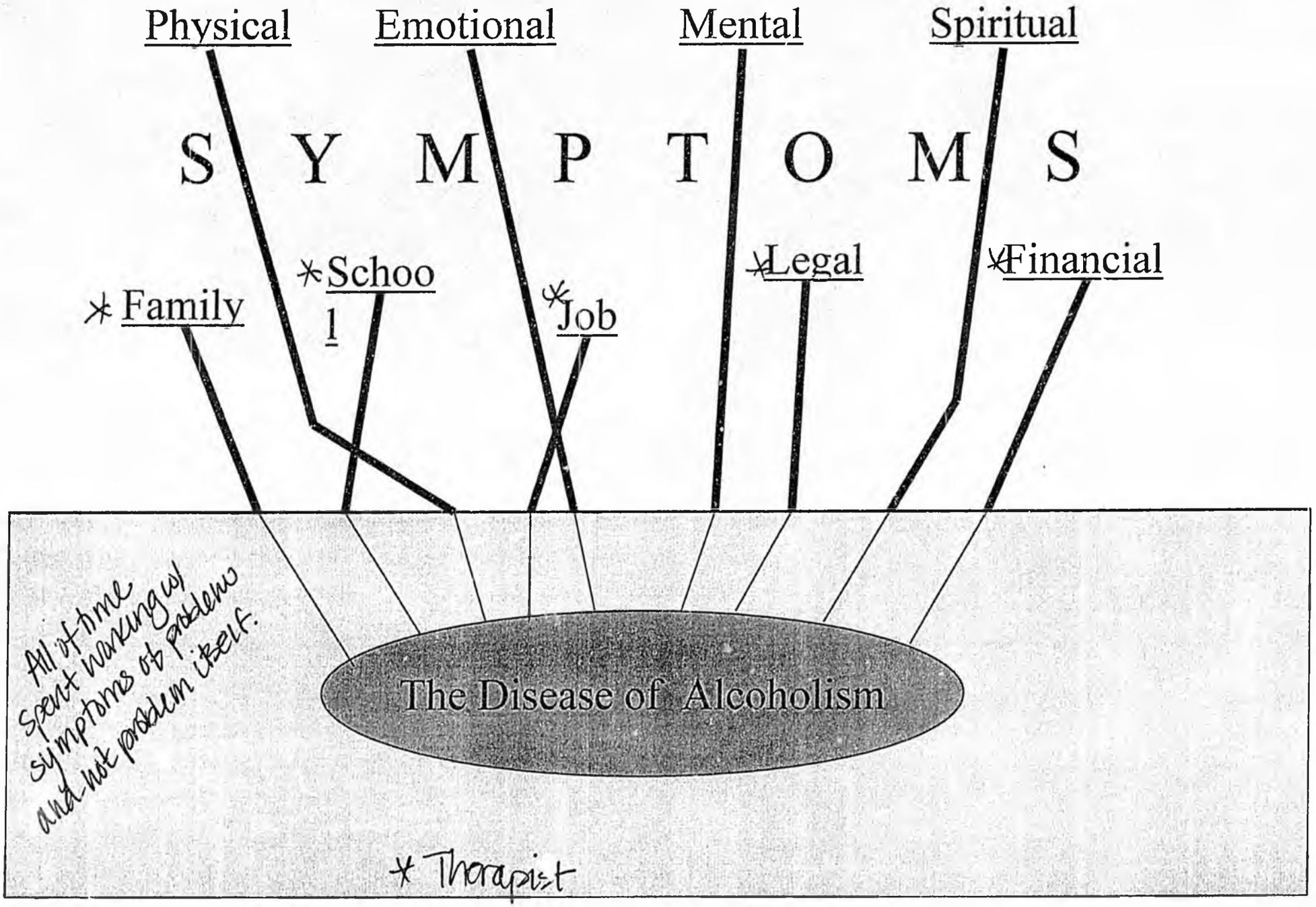
Treatment can take many forms, depending upon the severity and progression of the disease in a given patient.

- It may include **detoxification** in a medical setting using a drug such as librium to prevent life threatening withdrawal for severe cases, or in a social setting for less severe cases.
- It may include **drug assisted therapy** such as Naltrexone, which reduces the craving.
- It may also include **longer term care** for late stage chronic alcoholics/addicts, and **treatment for mental illness** in the "dually diagnosed" client.

1/12 die from seizures
1/12 die from DTs (accidents)

What else might treatment include?

- **Education** about alcohol and drugs
- Various **strategies** to help the patient break through denial
- Introduction to a **support group** such as AA/NA and Natives for Sobriety
- **Relapse prevention skills development**
- **Recovery life skills** development, such as: stress management, problem solving, nutrition, communication skills, conflict resolution, famiiy issues, personal responsibility


Physical
Emotional
Mental
Spiritual
S Y M P T O M S
* Family
* Schoo l
* Job
* Legal
* Financial
The Disease of Alcoholism
All of time spent working w/ symptoms of problem and not problem itself.
* Therapist

6. Continuing care

Studies show that participation in continuing care is the best predictor of positive treatment outcomes at one-year follow-up.

1994-1998 study

these pl. have more chronic problems to begin with

Attend Aftercare Or Peer Support Full Year	Abstain Full Year	
	Residential	Outpatient
None	29%	28%
Some	32%	61%
Full Year	**64%**	**74%**

A recent study of Alaska treatment outcomes shows 56% of outpatients and 42% of inpatients abstained from alcohol for a year after treatment. The study also showed:

- Unemployment rates dropped from 45% before treatment to 24% at 12 months.
- Criminal arrests, traffic arrests, and motor vehicle accidents dropped. Legal problems substantially decreased.
- Patients shift away from costly hospital and emergency room "crisis" or urgent care, toward more timely and appropriate preventive or routine outpatient treatment.