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d) Fewer young people are progressing into the system as a result of these efforts.

What comes next?

As proud as we are to be here, we're also here to say that what we've accomplished is only a start. There is so much more to be done. We came today to let you know that there are tens of thousands of other young people, families and communities grappling with addictions, as well as crime and all its associated problems. We believe that Reclaiming Futures is ready to expand and disseminate across the United States, and we are preparing our next steps to serve as a national resource center to help other communities do just that.

Now that our colleagues in Anchorage have helped to both develop and test this proven approach, we are very excited that there is interest here in Juneau and other communities in adopting the Reclaiming Futures model. You could not make a more important investment in a successful approach that will allow you to reap numerous rewards for many years to come.

Thank you again for the wonderful opportunity to present before this important body, your undivided attention – and for your support and leadership of this national movement.

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reclaiming NEWSLETTER review

Spring 2007

RECLAIMING FUTURES
ANCHORAGE, ALASKA

in this issue . . .

- "When You Were 15" launches
- Caddell retires
- Project Trip to Juneau
- Glacier Awards Announced

Juvenile Probation Officers Call For New Responses to Teen Drug and Alcohol Use in New Report

Reclaiming Futures Anchorage Justice Fellow Linda Moffitt is one of several juvenile justice leaders who is recommending a ground-breaking approach to help teens in trouble with drugs, alcohol and crime. Moffitt and other juvenile probation officers involved in the Reclaiming Futures initiative released a new report in February titled *Juvenile Probation Officers Call for New Responses to Teen Drug and Alcohol Use and Dependency*.

The report outlines practical steps for other juvenile probation officers to follow to make changes in their own juvenile justice systems. The findings are based on the Reclaiming Futures model tested in ten communities, including Anchorage,

Juvenile continued on page 5 . . .

Reclaiming Futures Anchorage Launches When You Were 15 Campaign

Reclaiming Futures Anchorage launched the "When You Were 15" campaign in January on Thank Your Mentor Day. The campaign encourages adults to become mentors for teens, including those who are struggling with drugs, alcohol, and crime.

The campaign features adults and young people in Alaska who recall their own lives at 15 and the adults who helped them get through tough times. Community members are encouraged to log on to www.whenyouwere15alaska.org to read story entries, write their own story, and find out how they can help teens in their community.

Ultimately, When You Were 15 Campaign

Campaign continued on page 5 . . .

Who We Are

Reclaiming Futures is a $21 million initiative of the Robert Wood Johnson Foundation located in Anchorage, as well Santa Cruz, Calif., Chicago, Ill., four counties in Southeastern Kentucky, Marquette, Mich., the state of new Hamphire, the Lakota Reservation in Rosebud, South Dakota, Dayton, Ohio, Portland, Ore., and Seattle, Wash. In its fifth year, an evaluation conducted by the Urban Institute and the University of Chicago indicates that Reclaiming Futures has significantly improved the quality of juvenile justice and substance abuse treatment services across the ten communities. Learn more about the national initiative at www.reclaimingfutures.org and Reclaiming Futures Anchorage at www.reclaimingfuturesanc.org

3350 Commercial Drive, Suite 100 Anchorage, AK 99501-3057 (907) 277.4177
www.reclaimingfuturesanc.org

Project Connect Educates Alaska Legislators

A mid-February "Project Connect" trip to Juneau by several members of the Reclaiming Futures Anchorage team resulted in more than 25 formal visits with Senators and members of the House and valuable discussions on the importance of treatment for juvenile offenders who have alcohol or substance abuse problems.

Highlights of the trip included an introduction on the House floor, one-to-one meetings with 18 lawmakers and a reception that was widely attended by legislators and staffers, as well as Alaska Department of Corrections and Health & Social Services officials.

"On a scale of 1 to 10, I'd rank the meetings in Alaska a 12," said Robert Wood Johnson Foundation (RWJF) representative Mitch Patterson, who helped to organize and coach the Reclaiming Futures team prior to the Project Connect visit.

Reclaiming Futures Anchorage received additional funding from RWJF late last year to support efforts to provide information to Alaska policy leaders about the importance of RF efforts in reducing substance use and building a stronger and more effective treatment system.

"We see this as a critical time to get policymakers up-to-speed on juvenile justice issues and the impact teen substance abuse has on society," said Reclaiming Futures Anchorage Project Director Tom Begich. "With a new governor in office, changes in various state positions and increased awareness of the need to find better ways to keep young people out of the justice system, the timing of our State Connect visit could not have been better."

Reclaiming Futures Anchorage staff will be following up with everyone who met with the team in February, to provide additional information about the Reclaiming Futures initiative and to answer specific questions posed during the visits. Another trip to the state capital is scheduled for April, when Reclaiming Futures and RWJF representatives are expected to have the opportunity to testify at special Senate and House Health and Social Services hearings.

Anchorage and Other Reclaiming Futures Sites Receive Two More Years of Funding

The Robert Wood Johnson Foundation (RWJF) recently announced its board has approved funding to support Reclaiming Futures Anchorage for two more years. The board also approved funding for a national expansion of the Reclaiming Futures initiative.

"We were already working on funding for sustainability of the initiative in Anchorage, so this is just icing on the cake," said Reclaiming Futures Anchorage Project Director Tom Begich. "We look forward to continuing the work here in Anchorage, and sharing what has been learned with new cities across the U.S."

Overall, the RWJF board approved $6.5 million to support ten pilot sites for two more years, which includes Reclaiming Futures Anchorage. The money also will be used to help seven additional new sites implement the Reclaiming Futures model over the next four years. A national resource center will be created to provide data, case studies and other information to additional communities seeking to improve drug and alcohol services for justice-involved youth. Reclaiming Futures will invite applications from communities interested in participating as one of the seven new pilot sites on its web site this spring, and expects to select the winning cities by summer 2007. The new Reclaiming Futures sites will receive technical assistance, on-site coaching, educational materials and invitations to national conferences and workshops.

Catch HBO Addiction Focus in March

Be sure to tune your television to HBO in March for its multi-platform campaign on "Addiction." Join Together, Community Anti-Drug Coalitions of America (CADCA) and Faces & Voices of Recovery, all of which have been supported by the Robert Wood Johnson Foundation (RWJF), are uniting to help communities make the most of a powerful opportunity to bring the message of addiction treatment and recovery to millions of Americans. From March 15-18, HBO will launch the Addiction Project, a groundbreaking multi-media campaign to help Americans understand addiction as a treatable brain disease, spotlight new treatment advancements and provide hope for long-term recovery. The 14-part series will air during a free HBO preview weekend and kicks off with a March 15 broadcast of the documentary ADDICTION at 5 p.m. Alaska time. To find out more about HBO's addiction project, visit www.AddictionAction.org

Glacier Awards Recognize Those Who Have Persisted With Reclaiming Futures Anchorage Work

If you've been working on the Reclaiming Futures Anchorage (RF) project for very long, you've undoubtedly heard it a dozen times – "systems change takes time." Many of the people involved with RF have been working for years, even before the project got its official funding from the Robert Wood Johnson Foundation. In January, many of those people were officially recognized with a 2006 Reclaiming Futures Glacier Award.

The number of Alaskans who have worked to make the Reclaiming Futures Anchorage project a success is impressive. The list of people recognized also was longer than most knew. They were invited to a catered lunch and heard a little about some of the other "team" members, many of whom they've never met. It was perhaps the first time that those involved in the project got to see how widespread the team is, and to hear how many people are making a difference through their day-to-day efforts on the job.

"The one thing that has kept Reclaiming Futures going, through the good times and the bad, has been the persistence and dedication of each of you," RF project director Tom Begich told a packed room of people at the Volunteers of America (VOA) offices. "We thank each of you for that diligence."

Glacier Awards, small acrylic plaques that resemble the ice of a slow-moving, yet powerful glacier, were handed out to more than 30 people. At the same time, stories about how different people got involved, or the role that team members played were revealed as each person was called up to receive his or her award. Recipients of the 2006 Glacier Awards include:

Barb Henjum, McLaughlin Youth Center
Chris Aquino, Alaska Initiative for Community Engagement
Debbie Bogart, Anchorage's Promise
Diane DiSanto, Mayor's Office
Elaine Dahlgren, Volunteers of America
Fred Jenkins, retired, United Way of Anchorage
Gary Caddell, Division of Juvenile Justice
Jerry Shough, Volunteers of America
Karin Schaff, Volunteers of America
Lee Post, McLaughlin Youth Center
Leslie Wenderoff, McLaughlin Youth Center
Lisa Wilson, Public Defender Agency
Lori Destefano, Volunteers of America
Michael Kerosky, Anchorage School District, Safe & Drug Free Schools
Molly Evans, student researcher
Nelson Page, Burr, Pease & Kurtz
Nine Volkova, Volunteers of America
Steve McComb, Division of Juvenile Justice
Tony Piper, Dept. of Health & Social Services
Master William Hitchcock, Alaska Court System
Kathy Day, Kathy Day Public Relations (KD/PR)
Allen Blair, Denali Family Services
Barbara Malchick, Office of Public Advocacy
Currey Cook, Office of Public Advocacy
Carol Comeau, Anchorage School District
Jayson Smart, Stone Soup Group
Sharon Chamard, UAA Justice Center
Travis Erickson, Office of Children's Services
Linda Moffitt, Division of Juvenile Justice
Linda Wilson, Public Defender Agency

Members of the Reclaiming Futures Anchorage executive committee accept their Glacier Awards from Project Director Tom Begich. (Left to right): Elaine Dahlgren, Michael Kerosky, Tony Piper, Barb Henjum, Lisa Wilson, June Sobocinski, Karin Schaff, Master William Hitchcock and Tom Begich.

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Never Giving Up Kept Caddell Motivated Over 30 Year Career

When Gary Caddell started working in the Division of Juvenile Justice (DJJ) in 1978, he never dreamed he'd still be there 30 years later. But that's exactly what happened. As Caddell prepares to retire this April, he knows why he remained in this field of work.

"The people I have worked with over all of these years really believe that what they do makes a difference in young people's lives," says Caddell. "There is a certain core of people in the community who you see always involved, caring and never giving up on that vision. And DJJ has been blessed with more than its share of that type of individual."

"We really have had some innovative approaches, and in some cases, led the country in thinking differently about how to implement programs that work for the benefit of the juveniles and the community, it's definitely something that has kept me challenged and motivated."

-Gary Caddell

That statement also rings true for Caddell himself. When he retires as a district supervisor with Anchorage Juvenile Probation, he will be remembered as one of many people who have never given up on the Reclaiming Futures project. He's been there from the beginning and has given important input all along the way.

Caddell started his career as a counselor at McLaughlin Youth Center for just over four years before receiving a promotion to a juvenile probation officer position in the Anchorage Probation Office. He worked up the ladder at DJJ from a line officer to probation supervisor. Many credit Caddell's work over those years as essential to the success of some of Reclaiming Future's systems today. One of his first efforts was an active interagency collaboration through his work on the Serious Habitual Offender Comprehensive Action Plan (SHOCAP), a federally sponsored program to locally define, identify, track and supervise a small portion of offenders who commit most of the serious and violent juvenile crimes, SHOCAP sought to improve public safety by focusing attention on serious habitual offenders through information sharing, unheard of among agencies working with juveniles in those days. He also is proud of his role in creating a school-based probation in the mid 1980s and re-implemented in the late 90's, and work to get the Anchorage School District more involved in the juvenile justice process. These are just three of a long list of innovative approaches Caddell has had a role in developing.

His goal has always been to streamline systems so services reached kids quicker and to open up communication lines between agencies.

"My bosses always told me if I saw a need, to figure out how and go fix it," says Caddell. "We really have had some innovative approaches, and in some cases, led the country in thinking differently about how to implement programs that work for the benefit of the juveniles and the community, it's definitely something that has kept me challenged and motivated."

Caddell admits the Reclaiming Futures Anchorage program today still isn't exactly what he and probably many others envisioned five years ago, but he feels it has come a long way. Despite his departure, he is confident the work will continue to bring in more community agencies and build that seamless network of provider services.

Although his retirement plans are pretty loose at this point, since his wife wants to continue working, Caddell says he'll definitely be staying in Anchorage for now and hopes to remain involved in the Reclaiming Futures Initiative in some capacity. He will begin shopping for a motorhome that will lead to more travel, and possibly a home in Washington State near family. He also is looking forward to "playing" with ultra-light airplanes and enjoying time with his adult children and (someday) grandkids.

Campaign continued . . .

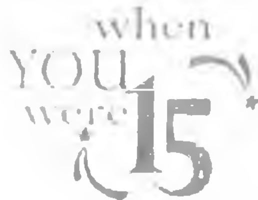
organizers will collaborate with Anchorage Youth Development Coalition and Anchorage Mentoring Alliance to publish an anthology of stories titled, "What Chapter In Your Life". In conjunction with the web site, a public education campaign has been launched to raise community awareness about the need for more mentors, especially for teens in the justice system. The campaign includes bus signs, posters, advertising in the Anchorage Daily News and radio public service announcements (PSAs). Students from the Public Relations Student Society of America (PRSSA) chapter at the University of Alaska are collecting audio and video stories that will be used for the PSAs and posted on the web site.

Big Brothers/Big Sisters Executive Director Peggy Owens looks on as one of the agency's Big Brother and Little Brother matches talk about how important their friendship has been to them. Many mentors and their mentees shared their stories and thanked those who have made a difference in their lives at the Thank Your Mentor Day held at the Cook Inlet Tribal Council building in

"Most people can think back to a time in their teenage lives when they were having a tough time and recall one adult who had a particularly positive influence on them," said Tom Begich, project director for Reclaiming Futures Anchorage. "With this campaign, we want to encourage people to become a mentor or natural helper, or to provide opportunities for teens to engage in healthy and positive community and social activities."

Reclaiming Futures, an initiative of the Robert Wood Johnson Foundation, is committed to getting more help for teens in the justice system who have drug and alcohol problems. A key element of the Reclaiming Futures model is to involve more adults as positive role models in the lives of these teens.

"When You Were 15" was piloted at the Reclaiming Future's site in Multnomah County in Portland, Oregon, where it recently received the Oregon Governor's Council on Alcohol & Drug Abuse Clark Campbell Media Award.



Other Reclaiming Futures sites launching similar campaigns in their communities are Southeastern Kentucky and Seattle, Wash. Future launches are planned in Chicago, Ill., Dayton, Ohio. Marquette, Mich. and the Lakota Reservation in Rosebud, South Dakota.

Juvenile continued . . .

over the last five years. The approach includes screening each teen who enters the juvenile justice system for drug and alcohol problems, assessing the severity of their use and providing prompt access to a treatment plan coordinated by a service team. Reclaiming Futures also connects teens with employers, educational opportunities, mentors and volunteer service projects.

The report offers ten specific recommendations for juvenile justice practitioners including: collaborating with mental health providers, alcohol and drug treatment professionals, school administrators and community partners; knowing which services are available and appropriate for drug-involved youth; tailoring interventions based on the teen's strengths, risk and needs; supporting staff to continue to learn about effective substance abuse treatment; promoting funding for family advocacy; wrap-around services and mentoring; and, collecting and sharing data to help all agencies involved in the effort.

For a complete copy of Juvenile Probation Officers Call for New Responses to Teen Drug and Alcohol Use and Dependency, visit www.reclaimingfutures.org

RECORDS CERTIFICATION

I, the undersigned, an employee of the State of Alaska, do hereby certify that the microfilm images on this microform are accurate reproductions of the original records of the State of Alaska as accumulated during the regular course of business, and that it is the established policy and practice of this State to microfilm its records and to dispose of the original documents after microfilm reproductions have been made.

Stan Hubbard
Signature of Camera Operator

5-29-2009
Date

Certification Rev 7/98

2/5/08 PRESENTATION: TRAUMATIC BRAIN INJURY & MILITARY VETERANS

3745 Community Park Loop, Ste. 240
Anchorage, Alaska 99508
office: (907) 274-2824 fax: (907) 274-2826
www.alaskabraininjury.net

To: House HESS Committee Members
From: Jill Hodges, Executive Director, Alaska Brain Injury Network, Inc.
Date: Tuesday, February 5, 2008
Subject: Traumatic Brain Injury Presentation

Thank you for the opportunity to share Alaska-related TBI issues and highlighting the needs of Alaskans and returning service members experiencing traumatic brain injury.

There is a solution to 'a long-forgotten blow to the head.' The solution is the same for those who recently experienced a brain injury including children, civilian adults, and soldiers. And the solution lies in Alaska's ability to recognize the "common thread running through many cases of seemingly unrelated social problems." Brain Injury.

A coordinated system of care here in Alaska is possible, research shows it is essential, and the time is now. The many thousands of Alaskans who live with this disability (and their family members) will tell you that everyday living is WORK. Alaska can create the essential brain injury services that allow these same individuals the opportunity to redirect their energy...AWAY from the frustrating forgetful behavior, the substance abuse, and the suicidal thoughts...and TOWARDS providing for their families, paying taxes, and improving their communities.

We can all agree that it is very possible for any of us to 'hit our head'; that in an instant, our life or a family member's success in life will be dependent on our knowledge of brain injury.

Alaska has one of the highest rates of brain injury in the Nation. This is currently being compounded by the number of Alaskans returning from the OIF/OEF wars with brain injury due to improvised explosive devices and trauma.

There are standard services for brain injury, let's continue to develop them in Alaska. Let's create a system that supports Alaskans living with brain injury and their families as they relearn life and create identities that are manageable, productive, and meaningful.

Presentation messages:

- Brain Injury in Alaska is epidemic
- The epidemic is being compounded by soldiers and veterans returning to Alaska from OIF/OEF wars.
- TBI has higher incidence rates relative to other disabilities; however, there are comparatively fewer services

- TBI infrastructure is standard in other states, Alaskans are asking for services close to home.
- The disjointed TBI system is putting excess pressure on other resources by producing high numbers of TBI survivors that are abusing alcohol, creating violence, practicing unlawful behavior, destroying family infrastructure, and committing suicide.
- Need support and funding to create a continuum of care for survivors of brain injury and their families to live manageable, productive, and meaningful lives.

Recommendations:

- A coordinated rehabilitation system between community providers, military, and state services.
- A multi-disciplinary approach where all treatment providers are talking to each other regularly.
- TBI educational materials to be distributed to families and the individual regarding what is traumatic brain injury, symptoms and behaviors related to the injury, and the role treatment plays in the individual's recovery.
- A liaison between the military and the community providers to communicate to both parties and the individual accessing the services.
- Case management for the survivor to organize the treatment teams; provide access to financial supports, family supports, and community programs; and to follow up with the individual, confirming that he/she is making it to their appointments.
- Clubhouses/Day Programs for survivors who are not yet able to work to be in a productive/social environment; encourages vocational and volunteer activities, and appropriate social skills.
- Specialized vocational rehabilitation and employment services for person with traumatic brain injury.
- Workforce development and training to increase the number of providers in Alaska that can serve people with brain injury using evidence-based brain injury practices.
- Develop brain injury screening requirements among various State Departments and Divisions. In addition, create volunteer screening opportunities for military service members that may not have been identified in the system.

I hope you find the presentations informative and useful. I have included a packet of materials and articles for education and reference. The Alaska Brain Injury Network looks forward to working with the Alaska legislature in continuing to plan for Alaska's traumatic brain injury survivors and their families.

For more information on the Traumatic Brain Injury Task Force Report to the Army Surgeon General: (123 pages)
http://www.armymedicine.army.mil/news/reports/TBITaskForceReportJanuary2008.pdf

Alaska Brain Injury Network, Inc. mission to educate, plan, coordinate, and advocate for a comprehensive service delivery system for survivors of traumatic brain injury and their families.

Presenters contact information:

JILL HODGES
Executive Director
Alaska Brain Injury Network, Inc.
Phone: 907 274 2824
Fax: 907 274-2826
jill@alaskabraininjury.net

SERGEANT TANNER AND STEPHANIE TANNER
TBI survivor and his wife
Ft. Richardson, AK
Phone: 630-888-7166
Scott.tanner1@us.army.mil

Alaska Brain Injury Network, Inc. mission to educate, plan, coordinate, and advocate for a comprehensive service delivery system for survivors of traumatic brain injury and their families.

Traumatic brain injury (TBI) has been described as the signature injury of the Iraq and Afghanistan wars. It has been an Alaska public health issue for several decades, with surveillance beginning in 1991. The Alaska Brain Injury Network has identified several fiscal and policy recommendations that will help solve the issues facing Alaskans with traumatic brain injury.

Please support:

1. Legislative Resolution
   Traumatic Brain Injury Awareness Month, March 2008

2. FY09 GF/MH Governor's Budget
   $100.0 Brain injury training for providers
   $10 million Housing Trust

Recommendations for additions to the FY09 GF/MH Legislative Budget

Priorities in the FY09 GF/MH Alaska Mental Health Trust Authority budget included:

$200.0	Brain injury services development: LT rehab support
$175.0	Brain injury training for providers (not fully funded)
$25.0	Brain injury outreach

ABIN recommends that there be increased funding for brain injury prevention and brain injury services. We are working with the Department of Health and Social Services on the implementation and prioritization of successful brain injury state-funded programs.

ABIN GF/MH Budget recommendations include:

$200.0	Brain injury prevention
$2 million	Brain injury services (to serve 1000 Alaskans)

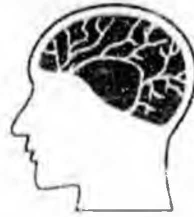
Brain Injury Program Recommendations

1. In-State Brain Injury Post-Acute Rehabilitation
2. Targeted Case Management
3. Clubhouse and Day Programs
4. Vocational Rehabilitation Services for Person with TBI
5. Workforce Development and Training
6. Brain injury Screening, Referral, Assessment, and Treatment Protocol

The budget and program recommendations will benefit both the Civilian and Military populations. The issues we are working to solve are: quality of life, health, and safety for the TBI survivor, family, and community. Every recommendation is based on improving the lives of Alaskans and reducing fiscal and indirect costs.

Alaska Brain Injury Network, Inc., mission is to educate, plan, coordinate, and advocate for a comprehensive service delivery system for Alaskans with brain injury and their families.

For contact information visit www.alaskabraininjury.net



Every 15 seconds someone sustains a traumatic brain injury (TBI) in the U.S.

Thirty years ago, only half of all people with brain injury survived; now 78% survive. This means that many individuals now live with significant disability requiring a full range of services.

Every year the Alaska Department of Health & Social Services reports about 800 traumatic brain injury (TBI) cases resulting in hospitalization or fatality. The Alaska TBI rate is 28% higher than the national average. The TBI rate in rural Alaska is one of the highest in the nation.

It is estimated that at least 10,000 Alaskans are living with brain injury today. The number keeps accumulating. Brain Injury can be a life-long disability

The Alaska Brain Injury Network, Inc. (ABIN) is a non-profit organization dedicated to Alaskans whose lives have been changed by brain injury.

ABIN's Board of Directors represent all regions of Alaska and the extended brain injury community – survivors, family members, service providers, health educators, researchers and those who write laws and policy.

ABIN works with the Alaska Mental Health Trust Authority, Department of Health and Social Services, and partner boards to advocate for policy changes, programs, and facilities to better serve the brain injury population.

ABIN connects survivors and family members with others. Please contact us to learn about brain injury programs in your region.

The goal for every brain injury survivor is the best possible recovery for a fulfilling and productive life. Achieving that goal requires full range of services close to home. This includes...

- Prevention
- Early identification and intervention
- Access to skilled specialists
- Community-based post injury services
- Continuing rehabilitation
- Brain injury support groups and in-state resources

What you can do...

- **Be aware of the fiscal and social burden of brain injury nationally and to the state of Alaska**
- **Become familiar with ABIN Priorities in the Governor's FY09 GF/MH Budget: Brain Injury Training for Providers.**
- **Support the Housing Trust,** www.akhousingtrust.com
- **Join Alaska Brain Matters listserve to meet Alaskans who have been touched by traumatic brain injury.**

ABIN Priorities

In-state rehab facility – many Alaskans are left in a hospital setting because there is no post-acute rehabilitation option in the State. Others are sent out of State. It is time for Alaskans to have treatment for their brain injury. Research shows outcomes improve with quality rehabilitation.

Brain Injury Waiver - recommendations for the current Medicaid waiver system to accommodate the services needed by brain injury survivors: neuropsychological assessment, cognitive and functional therapy, case management, counseling, home modifications, transportation, respite care, and more.

www.alaskabraininjury.net
3745 Community Park Loop, Ste 240
Anchorage, AK 99508
(907) 274-2824

Alaska Brain Injury Network, Inc. helps identify, develop, implement, and sustain needed programs and resources that promote prevention and expand treatment and service delivery to Alaskans who experience TBI and their families.

You KNOW us...

The Public Health Burden of Brain Injury (prevalence)

5.3 million Brain Injuries
5 million persistent Mental Illness
4 million Alzheimer's
3 million Stroke
2 million Epilepsy
900,000 HIV/AIDS
500,000 Cerebral Palsy
400,000 Spinal Cord Injury

Brain injury accounts for more years of lost productivity than any other injury.

The Financial Burden of Brain Injury

- It is estimated that over a lifetime, it can cost between $600,000 and $1,875,000 to care for a survivor of severe TBI.
- Direct medical costs and indirect costs of TBI such as lost productivity totaled an estimated 60 billion dollars in the United States in 2000. *(Centers for Disease Control and Prevention)*
- Every dollar used for brain injury rehabilitation saves up to $35 in future medical costs. (Rhode Island Brain Injury Association)

Prevention is the only cure for Brain Injury

- The three leading causes of brain injury nationally and in Alaska are:
  1) motor vehicle crashes 2) falls and 3) assaults.
- One-third of all TBIs recorded in the Alaska Trauma Registry were alcohol related.
- The use of safety belts is the single most effective measure to prevent traumatic brain injuries.
- Helmets are estimated to be 37% effective in preventing fatal injuries to motorcyclists. (*National Highway Traffic Safety Administration)*
- Bicycle helmets are 85-88 percent effective in mitigating head and brain injuries. Every dollar spent on a bike helmet saves $40 in direct medical costs and other costs to society. *(National Highway Traffic Safety Administration)*
- 60-67% of injured U.S. soldiers sent from Iraq to Walter Reed Army Medical Center have a TBI from blasts, severe falls and motor vehicle accidents. *(United Press International, July 2004).* These soldiers are now returning home to Alaska for continuing treatment and rehabilitation.

Traumatic Brain Injury is a beneficiary group participating in the Alaska Mental Health Trust Authority "You Know Me" Anti-Stigma Campaign.

SUCCESS STORY: Mr. L

Injury

Mr. L was working as a reserve deputy sheriff when he and his partner became involved in a high-speed chase. Their cruiser overturned on some loose gravel, ejecting Mr. L. He suffered a traumatic brain injury in addition to numerous fractures and lacerations as he slid approximately 200 feet along the asphalt and was then run over by his own vehicle. Paramedics flew him to a local trauma center where doctors told his wife he might not live another hour.

Medical Care

After 2 months in a coma, and 6 months on life-support, Mr. L was discharged home to 24-hour attendant care, unable to perform self-care activities. He was confined to a wheelchair, unable to stand even with a walker. He was unable to drive and required extensive home and vehicle modifications. At the age of 52 Mr. L had a reasonable life expectancy of 22 years.

Cost/Benefit Analysis

At the request of the insurance representative, a cost/benefit analysis was done to evaluate the decision to invest in further rehabilitation. Centre For Neuro Skills (CNS) in Dallas, Texas was contacted to assist in this analysis. CNS has specialized in the rehabilitation of persons suffering from traumatic brain injury for over 25 years. Both the insurance carrier and CNS determined that without an investment in further rehabilitation services, Mr. L's annual lifecare costs would exceed $200,000. (See Appendix A)

Rehabilitation

Mr. L was admitted to CNS - Dallas in February, 2001. He participated in an intensive, interdisciplinary rehabilitation program for approximately eight months. The treatment goals were to improve coordination, overall strength and endurance and range of motion. His therapy team addressed ongoing depression and psychological issues as well as improving cognitive functioning. The focus was to improve his ability to live independently and participate in work activities.

Outcome

In October, 2001, Mr. L was discharged home with his wife completely independent in all activities of daily living. He regained functional ambulation with a straight cane and is now able to operate a motor vehicle. He began a volunteer position with the local sheriff's department and is enrolled in an Associate Degree program at a local college. No attendant care or nursing is necessary. Discharge recommendations were for continued physical therapy, 3 times a week for 3 to 6 months, and counseling twice a week for 6 weeks.

Table 1

Annual Lifecare Costs	
Prior to CNS Admission	$207,267
Following CNS Discharge	$8,452
Savings per year:	**$198,815**
$198,815 X 22 years =	$4,373,930
Total Lifetime Dollars Savings =	**$4,373,930**

Appendix A

Annual Lifecare Costs without a Postacute Admission

Item	Cost
Attendant Care (24/hr)	$157,248
Additional Hospitalizations	19,272
Allied Health Consultations	10,858
Medications	2,000
Van Modifications	4,350
Home Modifications	2,727
Medical Specialists	2,220
Case Management	5,000
Equipment	3,592
Total:	**$207,267**

Annual Lifecare Costs with a Postacute Admission

Item	Cost
Re-evaluation (continued therapy)	$1,250
Medications/Supplies	1,702
Equipment	2,500
Additional Surgery	2,000
Physician Visits	1,000
Total:	**$8,452**

HIDDEN TRAUMA

Studies Cite Head Injuries As Factor in Some Social Ills

Brain Researchers Link Mental Woes, Alcoholism To Long-Ago Blows

By THOMAS M. BURTON

January 29, 2008; Page A1

Researchers studying brain injury believe they've found a common thread running through many cases of seemingly unrelated social problems: a long-forgotten blow to the head.

They've found that providing therapy for an underlying brain injury often helps people with a variety of ills ranging from learning disabilities to chronic homelessness and alcoholism. If broadly verified, the findings could have a significant impact in dealing with such intractable difficulties.

That severe head injuries can lead to cognitive and behavioral problems is widely accepted. The U.S. Centers for Disease Control and Prevention estimates 5.3 million Americans suffer from mental or physical disability that is due to brain injury.

What's new is the contention of some researchers that there are many other cases where a severe past blow to the head, resulting in unconsciousness or confusion, is the unrecognized source of such problems. "Unidentified traumatic brain injury is an unrecognized major source of social and vocational failure," says Wayne A. Gordon, director of the Brain Injury Research Center at Mount Sinai School of Medicine in New York, where much of the research is being done.

Research by his team has consistently found high rates of "hidden" head trauma when screening various populations in New York schools, addiction programs and the general population. The CDC acknowledges its 5.3 million estimate is an undercount based on hospital admissions; it doesn't include people who sought no treatment for a severe blow to the head or who were sent home from a doctor's office or emergency room with little treatment.

UNDERLYING CAUSE

• **New Findings:** Researchers say a blow to the head years earlier may be linked to problems later in life, such as learning disabilities, homelessness and alcoholism.
• **Early Identification:** Some schools are trying to identify children who may have had head injuries to provide special help in education.
• **The Impact:** The findings are offering new hope to adults coping with the onset of disorders such as losing the ability to read or concentrate.

Causes of brain injury can include bike and car accidents, sports concussions such as those suffered by professional football players, and abuse and falls that can date back to childhood.

Doctors say about 85% of common falls in infancy don't produce long-term deficits, but that some do.

To be sure, it's difficult to connect with any certainty a long-ago blow to the head to memory and cognition problems years later. Other researchers point out that many people do recover completely from severe head injury, and mental problems arise from other causes. Moreover, Mount Sinai's findings haven't all been published, nor have they been widely evaluated at other institutions.

Lost Ability to Read

Mount Sinai's research involves people like Kate Gleason, a business-college instructor who over the course of a year lost her ability to read, keep her home orderly and even maintain friendships.

In 1998, Ms. Gleason tried to open a window in her New York apartment building's hallway, but the heavy top window fell and bashed her on the head. She was treated by doctors at a local hospital, who she says let her walk home and told her she'd be fine. But on the way back, she was still so confused she had to hang onto lampposts and buildings to keep from losing her way.

A slim, auburn-haired woman then in her mid-40s, Ms. Gleason kept teaching, but found that the bright lights and hectic office were overwhelming. She says she confided in a boss about her troubles and soon lost her job. After that, she made ends meet by returning to proofreading work, but she slowly withdrew socially.

She didn't pay bills on time. Her house was a mess. "Years and years went by, and I had lots of problems," she says. "I didn't know it was from the head injury. I just thought I had a clutter problem." By 1999, Ms. Gleason, who has a master's from Columbia University, was "so bad on the level of functioning as a college grad that I wanted to die." She had no idea why.

Then about two years ago, she got a strange letter from Mount Sinai: It asked if she was having trouble thinking or solving problems or if she became easily overwhelmed. It turned out Mount Sinai doctors were reaching out to people whose medical records showed a blow to the head. Ms. Gleason responded, and when researchers interviewed her, she began to sob, saying, "Life is just so hard."

On what was to be the first day of an attention and memory program, Ms. Gleason got lost in the maze of hospital hallways and began crying again. Once she found the site, she discovered she wasn't the only patient who got lost a lot, or who cried.

For five days a week for six months, she worked through five hours of attention exercises, reading articles to explain the main idea, interpreting charts and graphs, taking classes on how to take apart a problem and reduce it to smaller steps, writing mock "advice columns" on how to handle life issues.

At first, she found the work so intense she needed a break every 15 minutes. By a week later, she could concentrate a little longer. She completed the program in August 2006, eight years after

the window struck her. Now she's studying to be a church-based counselor. "That program gave me my life back," she says.

A group for whom the research on undiagnosed head injuries could be especially relevant is the homeless. Assessments by Mount Sinai researchers of about 100 homeless men in New York found that 82% had suffered brain injury in childhood, primarily as a result of parental abuse.

An epidemiological study in 2000 was larger. Researchers went door-to-door in New Haven, Conn., interviewing 5,000 people, 7.2% of whom recalled a past blow to the head that was followed by unconsciousness or a period of confusion. In follow-up testing, the researchers found that those who reported such injuries had more than twice the rate of depression and of alcohol and drug abuse as others.

Wayne A Gordon

They also had sharply elevated rates of panic disorder, obsessive-compulsive disorder and suicide attempts, say the researchers, led by Jonathan Silver of New York University.

Such research began in the late 1980s with Mount Sinai's Dr. Gordon and Mary Hibbard, both Ph.D. psychologists specializing in rehabilitation and neuropsychology. In questioning patients referred to them, they were struck by how often they turned up a history of a brain injury that wasn't in the patients' medical records.

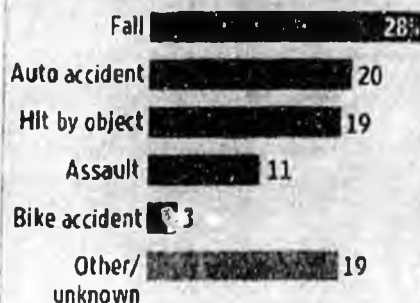
Using a questionnaire they devised, they tried to determine how many children in the city school system had head injuries that were followed by cognitive difficulties. At one school, 10% of students told of having once had a significant head injury. Later testing of these children frequently "was suggestive of impairments," Dr. Hibbard says.

Mary Hibbard

Next, with a grant from the U.S. Department of Education, they set out to determine how many pupils enrolled in programs for children with learning disabilities had ever suffered a hard blow to the head. The results were startling: About 50% had.

"The accident can be three months ago, but by the time the symptoms happen, the accident is forgotten. Nobody puts it together," says Tamar Martin, a psychologist in the program. The team worked with about 400 children, finding that many children who'd had brain injuries were lost in regular learning-disabilities classrooms.

They have trouble with their memory from day to day, and teachers can assume they're not trying hard, Dr. Martin says. They need more breaks between topics. But their performance varies greatly from day to day, and a teacher can also erroneously perceive this fluctuation as lack of initiative.



Just giving such children more time often helps, she says, as do special prompts from teachers. For instance, Dr. Martin says, a teacher may say, "In a couple of minutes, I am going to ask you about problem No. 10," and give the child time to prepare before officially asking.

High Intellect

One 14-year-old girl had a high intellect, but after she was hit by a car, she suddenly couldn't do outlines or organize her time, her mother says in an interview. "Her processing was slower," adds Michelle Kornbleuth, another psychologist in the Mount Sinai program. "She was frustrated, and her scores came out in the average range."

With Dr. Kornbleuth's help, the girl was allowed to take exams privately in an office and could concentrate better. With such accommodations, she completed high school and went on to graduate from prestigious Smith College.

Kansas systematically tries to identify brain injuries among the "learning disabled." School social workers and teachers with special training across the state show other teachers how to recognize and work with the brain-injured, says Janet Tyler, director of a neurologic-disabilities project in the state education department.

"When you look at children with learning disabilities or behavior problems, there's often an underlying high percentage of children with traumatic brain injury. We're looking at about 20%," she says.

In Mulvane, Kan., Sandy Baca's son Timothy, who was hit by a car at age 2, struggled in school for years. Ms. Baca says that once teachers understood the difference between brain injury and other disability, "they found ways for him to be successful. If he couldn't do the work one day, they would lower expectations for the day." Ultimately, he finished high school.

The Mount Sinai team evaluates people via a battery of "neuropsych" tests lasting up to nine hours. They are shown pictures of objects, then asked minutes later what they saw. They see a complex geometric design with triangles, lines and circles and are asked to draw it from memory. They're shown a series of multiple random letters and asked to cross out, say, the "c" and "e" every time they see one.

On a recent morning, a 44-year-old manager at a New York investment firm was working on attention training with a postdoctoral fellow. He had sustained several sports concussions as a younger man and then in recent years twice banged his head hard. Lately, he had been feeling confused. Commuting between New York City and Long Island, he boarded the wrong train three days in a row.

In the first of several exercises, the patient was asked to read a page of text while crossing out all words ending in "ing," and then to answer questions about what he'd read. The first time through, he caught only seven of 12 "ing" words. A second test asked him to choose a word that didn't

belong in a group of five, while listening to other words and pressing a buzzer when he heard words with four letters.

About five years ago, the Mount Sinai team began looking at residents of New York centers for alcoholism and drug abuse. They evaluated 845 patients and determined that 54% had once suffered a hard blow to the head. Of course, some had injuries after they began drinking, so there is a certain chicken-and-egg problem with that number.

Link to Addiction

Steven Kipnis, medical director of a New York state agency for alcoholism and addiction, says his work with counselors convinces him that many of the patients became alcoholic or addicted in part because of a head injury, and knowing about it helps in treatment.

"Someone can get hit in the head with a softball and still be working. They tend to be in denial. They get mood swings, they yell at a spouse. It's a slow downward spiral, and that's when alcohol and drugs" become an option, he says.

The agency has a program specifically for the brain-injured at the R.E. Blaisdell Addiction Treatment Center in Orangeburg, N.Y. A counselor there, Steve Oswald, tells of one patient who dropped out of a general alcoholism program three times before the program for the brain-injured began, and then successfully completed the program.

In 2006, Mount Sinai's Dr. Gordon began to work with Common Ground, a New York nonprofit that builds housing for the homeless. About 70% of 100 homeless people they tested came out in the 10th percentile or lower for memory, language or attention, says the group's director of psychiatric services, Jennifer Highley. Questioning uncovered that 82% had a significant blow to the head prior to becoming homeless, usually from severe parental abuse during childhood.

"People get abused as kids, making them inattentive in school and sometimes unable to learn," says Ms. Highley. She says head injury and the emotional fallout from abuse can lead to alcoholism and addiction, and "that combination creates the inability to function and often leads to homelessness."

Write to Thomas M. Burton at tom.burton@wsj.com[1]

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(1) mailto:tom.burton@wsj.com

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Mild Traumatic Brain Injury in U.S. Soldiers Returning from Iraq

Charles W. Hoge, M.D., Dennis McGurk, Ph.D., Jeffrey L. Thomas, Ph.D., Anthony L. Cox, M.S.W., Charles C. Engel, M.D., M.P.H., and Carl A. Castro, Ph.D.

ABSTRACT

BACKGROUND

An important medical concern of the Iraq war is the potential long-term effect of mild traumatic brain injury, or concussion, particularly from blast explosions. However, the epidemiology of combat-related mild traumatic brain injury is poorly understood.

METHODS

We surveyed 2525 U.S. Army infantry soldiers 3 to 4 months after their return from a year-long deployment to Iraq. Validated clinical instruments were used to compare soldiers reporting mild traumatic brain injury, defined as an injury with loss of consciousness or altered mental status (e.g., dazed or confused), with soldiers who reported other injuries.

RESULTS

Of 2525 soldiers, 124 (4.9%) reported injuries with loss of consciousness, 260 (10.3%) reported injuries with altered mental status, and 435 (17.2%) reported other injuries during deployment. Of those reporting loss of consciousness, 43.9% met criteria for post-traumatic stress disorder (PTSD), as compared with 27.3% of those reporting altered mental status, 16.2% with other injuries, and 9.1% with no injury. Soldiers with mild traumatic brain injury, primarily those who had loss of consciousness, were significantly more likely to report poor general health, missed workdays, medical visits, and a high number of somatic and postconcussive symptoms than were soldiers with other injuries. However, after adjustment for PTSD and depression, mild traumatic brain injury was no longer significantly associated with these physical health outcomes or symptoms, except for headache.

CONCLUSIONS

Mild traumatic brain injury (i.e., concussion) occurring among soldiers deployed in Iraq is strongly associated with PTSD and physical health problems 3 to 4 months after the soldiers return home. PTSD and depression are important mediators of the relationship between mild traumatic brain injury and physical health problems.

From the Division of Psychiatry and Neuroscience, Walter Reed Army Institute of Research, U.S. Army Medical Research and Materiel Command, Silver Spring, MD (C.W.H., D.M., J.L.T., A.L.C., C.A.C.); and the Deployment Health Clinical Center and Uniformed Services University of Health Sciences, Washington, DC (C.C.E.). Address reprint requests to Dr. Hoge at the Division of Psychiatry and Neuroscience, Walter Reed Army Institute of Research, 503 Robert Grant Ave., Silver Spring, MD 20910, or at charles.hoge@us.army.mil.

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More than 1.5 million U.S. military personnel have deployed to Iraq or Afghanistan since the start of military operations in 2001. Because of improved protective equipment, a higher percentage of soldiers are surviving injuries that would have been fatal in previous wars.[1] Head and neck injuries, including severe brain trauma, have been reported in one quarter of service members who have been evacuated from Iraq and Afghanistan.[1,2] Concern has been emerging about the possible long-term effect of mild traumatic brain injury, or concussion, characterized by brief loss of consciousness or altered mental status, as a result of deployment-related head injuries, particularly those resulting from proximity to blast explosions.[3-5] Traumatic brain injury has been labeled a signature injury of the wars in Iraq and Afghanistan.[4,5]

The exact proportion of troops who have mild traumatic brain injury is not known, although it has been reported to be as high as 18% in news articles citing army medical officials.[6] Many troops reportedly have persistent postconcussive symptoms, such as irritability, memory problems, headache, and difficulty concentrating. As a result, the Department of Defense and the Department of Veterans Affairs are implementing new population-screening procedures for mild traumatic brain injury.[7-9]

Despite these steps, little is known about the epidemiology of mild traumatic brain injury during deployment and its association with adverse health outcomes after deployment. The bulk of the literature on mild traumatic brain injury has been based on civilian patients treated in clinics or hospitals, has not been population-based, and has lacked adequate comparison groups, such as persons with other types of injuries.[10,11] It is not known whether population screening for mild traumatic brain injury could improve health outcomes,[12] and there are conflicting guidelines for treating mild traumatic brain injury.[13,14]

The case definition of mild traumatic brain injury that is being adopted by the new Department of Defense and Department of Veterans Affairs screening programs[8,9] is consistent with national surveillance definitions.[11,15] However, the use of this definition for clinical screening weeks or months after concussive events, such as during the period after deployment, has not been evaluated. The definition may not be sufficiently specific for the combat environment, where acute signs of concussion, such as alteration of mental status (e.g., being dazed or confused), may overlap with dissociative symptoms of acute stress disorder, or for the postcombat period, during which postconcussive symptoms may overlap with symptoms of post-traumatic stress disorder (PTSD) and other disorders.[16]

This epidemiologic study assesses the prevalence and significance of a self-reported history of combat-related mild traumatic brain injury, based on the accepted case definition, among soldiers after a yearlong deployment to Iraq. The purpose is to provide information to advance prevention and treatment strategies and inform public health policies.

METHODS

In 2006, we conducted an anonymous survey of 2714 soldiers from two U.S. Army combat infantry brigades — one Active Component and one Reserve Component (Army National Guard) — 3 to 4 months after their return from a yearlong deployment in Iraq. The units saw high levels of combat, similar to those of other infantry units.[17-19] The 3-to-4-month time point was chosen to minimize recall bias and for its appropriateness for assessing persistent postconcussive symptoms.[20,21]

RECRUITMENT

Unit leaders provided time for all their soldiers who had deployed to Iraq and were on duty to attend a recruitment briefing by study investigators. Written informed consent was obtained under a protocol approved by the institutional review board of the Walter Reed Army Institute of Research. Of 4618 soldiers in the two brigades, 2714 (59%) completed the questionnaire. Lack of availability of soldiers to complete the questionnaire was mostly due to normal transfers to other units, training, or attendance at military schools. More than 98% of soldiers who attended the recruitment briefings agreed to participate. However, up to 7% of the values for some variables were missing.

INJURIES AND COMBAT EXPERIENCE

The questionnaire asked soldiers whether they had been injured during their deployment by a blast or explosion, a bullet, a fragment or shrap-

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ne, a fall, a vehicle accident, or other means and whether the injury involved the head. A soldier was considered to have had a mild traumatic brain injury if any of three questions — regarding "losing consciousness (knocked out)," "being dazed, confused, or 'seeing stars,'" or "not remembering the injury" — elicited a positive response. These questions were based on definitions from the Centers for Disease Control and Prevention and the World Health Organization that were adapted by the Defense and Veterans Brain Injury Center working group for military-wide use.[8,9,11] The question regarding loss of consciousness was analyzed separately to determine whether it was a stronger predictor than the two other questions pertaining to altered mental status, the results of which were combined. Soldiers who reported any injury that did not involve altered mental status or losing consciousness served as the reference group for all analyses.

Combat intensity was measured with the use of 17 of the 18 questions from the Combat Experiences Scale[17] (range, 0 to 17, with higher scores indicating a greater number of different combat experiences on one or more occasions). The 18th question, concerning being wounded, was excluded because it was covered in the questions about injuries. Of the 17 experiences, soldiers had a median of 9 (interquartile range, 6 to 11) during the deployment. The Cronbach alpha for the 17 dichotomized questions was 0.85.

MEASURES OF PHYSICAL HEALTH

Soldiers were asked how they rated their overall health (from "poor" to "excellent"), how many primary care ("sick call") appointments they had attended, and how many days of work they had missed in the past month because of illness. Physical symptoms were measured by the Patient Health Questionnaire 15-item somatic symptom severity scale (PHQ-15).[22] This scale normally has a range of 0 to 30, with higher numbers indicating a greater number and severity of symptoms. For this study, the range was 0 to 28 because a question on menstrual cramps was excluded owing to the low number of women. High severity of symptoms was defined as a score of at least 15.[22,23] Five additional questions, which were not part of the PHQ-15, were asked regarding important postconcussive symptoms that concerned memory, balance, concentration, ringing in the ears, and irritability.

MEASURES OF DEPRESSION AND PTSD

Current symptoms (i.e., symptoms during the past month) of major depressive disorder and PTSD were assessed by the 9-question depression-assessment module of the Patient Health Questionnaire[24] and the 17-item National Center for PTSD Checklist, respectively, which are based on well-validated case definitions used in veteran and military populations.[17,25,26] For major depression, subjects had to meet the criteria of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV), and report impairment in work, home, or interpersonal functioning at the "very difficult" level.[17,24] For PTSD, subjects had to meet the DSM-IV criteria (one intrusion symptom, three avoidance symptoms, and two hyperarousal symptoms) and have substantial distress, as measured by a total score of at least 50 (range, 17 to 85, with higher scores indicating a greater number and severity of symptoms).[17,26]

STATISTICAL ANALYSIS

Surveys were scanned with the use of ScanTools (National Computer Systems), with quality control verifying error rates below 0.25%. SPSS software (version 12.0) was used for data analysis, including chi-square and analysis-of-variance testing for univariate analyses. Multivariate analyses were conducted with the use of multiple logistic regression with SPSS software (version 12.0), including goodness-of-fit testing of all models.

RESULTS

SUBJECTS

Of 2714 soldiers, 149 (5.5%) were excluded because of missing data from the questions about injuries, and 40 (1.5%) were excluded because they reported having had a head injury without loss of consciousness or altered mental status. The demographics of the study population were similar to those of infantry soldiers deployed to Iraq[17,19]; 95.5% were male, 55.5% were under the age of 30 years, and 47.5% were of junior enlisted rank.

INJURIES

Of the 2525 soldiers included in the study, 124 (4.9%) reported an injury with loss of consciousness (most often lasting between a few seconds and 2 or 3 minutes), and 260 (10.3%) reported an injury with altered mental status not involving

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Table 1. Characteristics of the Study Population.*

Characteristic	Injury with Loss of Consciousness (N=124)	Injury with Altered Mental Status (N=260)	Other Injury (N=435)	No Injury (N=1706)	P Value for Loss of Consciousness vs. Other Injury	P Value for Altered Mental Status vs. Other Injury
Female sex — no./total no. (%)	1/123 (0.8)	3/258 (1.2)	21/431 (4.9)	88/1692 (5.2)	0.04	0.01
Age <30 yr — no./total no. (%)	79/123 (64.2)	149/257 (58.0)	206/431 (47.8)	958/1698 (56.4)	0.001	0.01
High-school education or less — no./total no. (%)	53/122 (43.4)	103/253 (40.7)	172/429 (40.1)	719/1683 (42.7)	0.51	0.87
Rank — no./total no. (%)					0.04	0.86
Junior enlisted (E1–E4)	73/122 (59.8)	127/256 (49.6)	202/426 (47.4)	780/1684 (46.3)		
Midlevel enlisted (E5–E6)	40/122 (32.8)	97/256 (37.9)	168/426 (39.4)	615/1684 (36.5)		
Senior enlisted and officers	9/122 (7.4)	32/256 (12.5)	56/426 (13.1)	289/1684 (17.2)		
Marital status — no./total no. (%)					0.30	0.06
Single	32/108 (29.6)	76/245 (31.0)	100/403 (24.8)	528/1595 (33.1)		
Married	67/108 (62.0)	149/245 (60.8)	250/403 (62.0)	933/1595 (58.5)		
Divorced, separated, or other	9/108 (8.3)	20/245 (8.2)	53/403 (13.2)	134/1595 (8.4)		
Mechanism of injury — no. (%)†					<0.001	<0.001
Blast or explosion	98 (79.0)	189 (72.7)	101 (23.2)			
Bullet	6 (4.8)	2 (0.8)	7 (1.6)			
Fragment or shrapnel	31 (25.0)	48 (18.5)	35 (8.0)			
Fall	38 (30.6)	73 (28.1)	190 (43.7)			
Vehicle accident	38 (30.6)	47 (18.1)	58 (13.3)			
Other	16 (12.9)	23 (8.8)	147 (33.8)			
Improvised explosive device exploded near soldier on ≥2 occasions (with or without injury) — no./total no. (%)	106/122 (86.9)	231/258 (89.5)	281/434 (64.7)	938/1690 (55.5)	<0.001	<0.001
Hospitalized while deployed — no./total no. (%)	50/124 (40.3)	44/259 (17.0)	59/433 (13.6)	89/1701 (5.2)	<0.001	0.23
Quartile of combat intensity — no./total no. (%)‡					<0.001	<0.001
1	2/124 (1.6)	8/259 (3.1)	74/435 (17.0)	452/1705 (26.5)		
2	15/124 (12.1)	29/259 (11.2)	95/435 (21.8)	467/1705 (27.4)		
3	21/124 (16.9)	53/259 (20.5)	97/435 (22.3)	376/1705 (22.1)		
4	86/124 (69.4)	169/259 (65.3)	169/435 (38.[illegible])	410/1705 (24.0)		

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Mental health problems						
PTSD — no./total no. (%)§	54/123 (43.9)	71/260 (27.3)	70/433 (16.2)	155/1701 (9.1)	<0.001	<0.001
Major depression — no./total no. (%)¶	27/118 (22.9)	21/250 (8.4)	28/423 (6.6)	55/1673 (3.3)	<0.001	0.39
Score on Post-Traumatic Stress Disorder Checklist§	46.8±19.0	39.8±16.3	35.0±15.0	29.1±13.2	<0.001	<0.001

* Complete data regarding some of the characteristics were not available for all subjects. P values were calculated with the use of the chi-square test except where indicated. PTSD denotes post-traumatic stress disorder.

† Mechanisms of injury are not mutually exclusive.

‡ Combat intensity was measured with a 17-question scale representing the number of different combat experiences. Scores range from 0 to 17, with higher values indicating a greater number of experiences. Scores of 0 to 5 constitute quartile 1, 6 to 8 quartile 2, 9 and 10 quartile 3, and 11 to 17 quartile 4.

§ PTSD was measured with the Post-Traumatic Stress Disorder Checklist, which has a range from 17 to 85, with higher scores indicating a greater number and severity of symptoms. All subjects who met the psychiatric-symptom criteria of the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV), and who had a total score on the Post-Traumatic Stress Disorder Checklist of at least 50 were classified as having PTSD. Plus–minus values are means ±SD. P values for the score on the Post-Traumatic Stress Disorder Checklist were calculated with the use of analysis of variance.

¶ Major depression was measured with the Patient Health Questionnaire. Subjects who were classified as having major depression had to meet the psychiatric criteria according to DSM-IV and report functional impairment at the "very difficult" level.

loss of consciousness (253 said they had been "dazed, confused, or seeing stars"). Four soldiers reported loss of consciousness lasting longer than 30 minutes. Although technically they were considered to have had moderate traumatic brain injury, they were not excluded because the number was low and it was not possible to verify the self-reported data from any of the subjects. An additional 435 soldiers (17.2%) reported some other injury during the deployment with no loss of consciousness or altered mental status, most commonly resulting from a fall or other incident (e.g., handling heavy equipment or injuring oneself during training) (Table 1). This was the reference group for all analyses (Tables 1, 2, and 3). Also shown in Tables 1 and 2, for comparison purposes, are the characteristics of the remaining 1706 soldiers who reported no injury.

As compared with soldiers who had other injuries, soldiers who reported mild traumatic brain injuries were significantly more likely to report high combat intensity, a blast mechanism of injury, more than one exposure to an explosion, and hospitalization during deployment (Table 1). Soldiers who reported mild traumatic brain injuries were also significantly younger, more likely to be junior in rank, and more likely to be male than were soldiers who had other injuries.

PTSD AND MILD TRAUMATIC BRAIN INJURY

PTSD was strongly associated with mild traumatic brain injury. Overall, 43.9% of soldiers who reported loss of consciousness met the criteria for PTSD, as compared with 27.3% of those with altered mental status, 16.2% of those with other injuries, and 9.1% of those with no injuries (Table 1). In a logistic-regression model that included age, military rank, sex, hospitalization or no hospitalization, mechanism of injury (blast or other mechanisms), level of combat intensity, exposure or nonexposure to multiple blasts from improvised explosive devices, and type of injury (loss of consciousness vs. other injuries), only loss of consciousness and combat intensity remained significantly associated with PTSD (odds ratio for loss of consciousness, 2.98; 95% confidence interval [CI], 1.70 to 5.24; odds ratio for top quartile of combat intensity vs. lowest quartile, 11.58; 95% CI, 2.99 to 44.83) (see Supplementary Appendix 1, available with the full text of this article at www.nejm.org). Injury with loss of consciousness was also independently associated with ma-

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Table 2. Physical Health Status after Deployment According to Type of Injury during Deployment.*

Physical Health during the Past Month	Injury with Loss of Consciousness (N = 124)	Injury with Altered Mental Status (N = 260)	Other Injury (N = 435)	No Injury (N = 1706)	P Value for Loss of Consciousness vs. Other Injury	P Value for Altered Mental Status vs. Other Injury
	no./total no. (%)					
Poor overall health	15/119 (12.6)	17/257 (6.6)	29/422 (6.9)	38/1665 (2.3)	0.04	0.90
≥2 Missed workdays due to illness	28/120 (23.3)	40/256 (15.6)	61/419 (14.6)	122/1671 (7.3)	0.02	0.71
≥2 medical visits for physical condition	51/120 (42.5)	84/256 (32.8)	123/426 (28.9)	331/1678 (19.7)	0.005	0.28
PHQ-15 score of ≥15†	30/121 (24.8)	41/254 (16.1)	48/426 (11.3)	85/1683 (5.1)	<0.001	0.07
Physical symptoms included in PHQ-15‡						
Stomach pain	14/120 (11.7)	20/249 (8.0)	37/421 (8.8)	71/1674 (4.2)	0.34	0.73
Back pain	40/121 (33.1)	78/253 (30.8)	122/424 (28.8)	311/1678 (18.5)	0.36	0.57
Arm, leg, or joint pain	45/121 (37.2)	105/252 (41.7)	168/423 (39.7)	387/1673 (23.1)	0.62	0.62
Headache	39/121 (32.2)	45/254 (17.7)	51/421 (12.1)	141/1674 (8.4)	<0.001	0.04
Chest pain	17/121 (14.0)	7/253 (2.8)	20/425 (4.7)	40/1675 (2.4)	<0.001	0.21
Dizziness	10/120 (8.3)	15/254 (5.9)	13/425 (3.1)	31/1680 (1.8)	0.01	0.07
Fainting spells	5/120 (4.2)	2/253 (0.8)	8/423 (1.9)	7/1678 (0.4)	0.17	0.34
Heart pounding or racing	23/120 (19.2)	25/253 (9.9)	21/425 (4.9)	62/1679 (3.7)	<0.001	0.01
Shortness of breath	17/120 (14.2)	19/254 (7.5)	30/421 (7.1)	54/1675 (3.2)	0.02	0.86
Constipation, loose bowels, or diarrhea	26/120 (21.7)	31/253 (12.3)	50/424 (11.8)	115/1681 (6.8)	0.006	0.86
Nausea, gas, or indigestion	22/120 (18.3)	34/253 (13.4)	65/423 (15.4)	132/1677 (7.9)	0.43	0.49
Pain or problems during sexual intercourse	10/120 (8.3)	8/253 (3.2)	16/425 (3.8)	16/1673 (1.0)	0.04	0.68
Fatigue	59/111 (53.2)	92/232 (39.7)	136/393 (34.6)	388/1542 (25.2)	<0.001	0.21
Sleep disturbance	63/117 (53.8)	111/247 (44.9)	157/422 (37.2)	402/1666 (24.1)	0.001	0.05
Other postconcussive symptoms§						
Memory problems	29/118 (24.6)	41/253 (16.2)	58/422 (13.7)	124/1680 (7.4)	0.005	0.38
Balance problems	10/120 (8.3)	17/254 (6.7)	12/424 (2.8)	26/1677 (1.6)	0.02	0.02
Ringing in the ears	28/119 (23.5)	45/251 (17.9)	59/422 (14.0)	99/1675 (5.9)	0.01	0.17
Concentration problems	37/118 (31.4)	65/250 (26.0)	76/420 (18.1)	170/1667 (10.2)	0.002	0.02
Irritability	67/118 (56.8)	118/248 (47.6)	154/419 (36.8)	409/1659 (24.7)	<0.001	0.006

* Complete data regarding the physical health categories were not available for all subjects.

† PHQ-15 refers to the Patient Health Questionnaire 15-item somatic symptom scale (range in this study, 0 to 28, with higher numbers indicating a greater number and severity of symptoms).

‡ The numbers and percentages of persons reporting "bothered a lot" (for all symptoms except fatigue or sleep disturbance) or "more than half the days" (for fatigue and sleep disturbance) are shown. One symptom from the PHQ-15 pertaining to menstrual cramps was not included, since there were so few women in the study.

§ The numbers and percentages of persons reporting "bothered a lot" (for memory problems, balance problems, and ringing in the ears) or "more than half the days" (for concentration problems and irritability) are shown.

for depression (odds ratio, 3.67; 95% CI, 1.65 to 8.16). Similarly, injuries associated with altered mental status (as compared with other injuries) and combat intensity were significantly associated with PTSD (but not with depression) (odds ratio for injuries with altered mental status, 1.78; 95% CI, 1.13 to 2.81; odds ratio for combat intensity, 6.63; 95% CI, 2.23 to 19.76).

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ADJUSTED AND UNADJUSTED ANALYSES OF PHYSICAL HEALTH

Tables 2 and 3 show the association of the type of injury with measures of physical health. Soldiers who had lost consciousness were significantly more likely to report poor general health, more missed workdays, and a higher number of medical visits in the past month than were soldiers with other injuries. Soldiers who had lost consciousness also had significantly higher scores on the PHQ-15 and significantly higher rates of nine of the PHQ-15 physical symptoms and all five of the other postconcussive symptoms (Table 2). Multivariate logistic-regression analysis was then conducted to assess whether PTSD and major depression mediated the relationship between loss of consciousness and physical health outcomes (Table 3).[27] When PTSD and depression were included in the analyses, the associations between loss of consciousness and the multiple physical health outcomes disappeared, except for two symptoms (headache and heart pounding). For example, when loss of consciousness was compared with other injuries, the odds ratio for having a high PHQ-15 score fell from 2.60 (95% CI, 1.56 to 4.33) in the unadjusted comparison to 0.92 (95% CI, 0.46 to 1.82) after adjustment for PTSD and depression (Table 3). In contrast, the odds ratio for having a high PHQ-15 score in this adjusted equation for PTSD was 7.86 (95% CI, 4.09 to 15.10), and the odds ratio for major depression was 7.47 (95% CI, 3.53 to 15.78) (see Supplementary Appendix 2). Further adjustment to include all significant variables from Table 1 did not change the results appreciably; the odds ratio for having a high PHQ-15 score dropped to 0.76 (95% CI, 0.31 to 1.84), and the association with heart pounding became nonsignificant (Table 3). Of all physical health outcomes associated with loss of consciousness in the unadjusted analysis, only headache remained significant after adjusting for PTSD and depression. In contrast, PTSD, depression, or both were strongly associated with all the physical health outcomes in these adjusted models.

A similar analysis compared altered-mental-status injuries with other injuries (Tables 2 and 3). Initially, altered mental status was associated with only three of the physical symptoms and three of the other postconcussive symptoms. The associations disappeared when PTSD was included in the analyses, and there was no change with further adjustment for demographic and combat variables. Depression was not included, since there was no association between altered mental status and depression (Table 1).

The following example illustrates how cases were distributed and why the association between mild traumatic brain injury and high symptom-severity scores did not persist after adjustment for PTSD. The high PHQ-15 scores occurred almost exclusively in soldiers who had PTSD. Of soldiers with PTSD, there were no significant differences in the proportion with a high PHQ-15 score according to type of injury: 27 of 53 with loss of consciousness (50.9%), 28 of 67 with altered mental status (41.8%), and 29 of 69 with other injuries (42.0%) had a high PHQ-15 score. Of soldiers without PTSD, the proportion with a high PHQ-15 score was much lower and also showed no significant differences according to type of injury: 3 of 67 with loss of consciousness (4.5%), 13 of 187 with altered mental status (7.0%), and 19 of 356 with other injuries (5.3%). (The denominators differ slightly from those in the tables because of missing values.)

DISCUSSION

In this study, nearly 15% of soldiers reported an injury during deployment that involved loss of consciousness or altered mental status. These soldiers, defined as having mild traumatic brain injury, were significantly more likely to report high combat exposure and a blast mechanism of injury than were the 17% of soldiers who reported other injuries. Soldiers with mild traumatic brain injury reported significantly higher rates of physical and mental health problems than did soldiers with other injuries. Injuries associated with loss of consciousness carried a much greater risk of health problems than did injuries associated with altered mental status.

Although this study was based on a nonrandom sample from two brigades, the sample is likely to be representative of soldiers serving in ground-combat units in Iraq. The demographic characteristics and rates of combat experience of the subjects are consistent with those in other studies.[17-19] The unavailability of soldiers was mostly due to work schedules, which would be unlikely to introduce bias. One bias is that on the survey days, soldiers who were ill, at medical appointments, or more seriously injured did

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Table 3. Unadjusted and Adjusted Odds Ratios for Each Postdeployment Physical Health Outcome According to Type of Injury during Deployment.*

Physical Health during the Past Month†	Injury with Loss of Consciousness vs. Other Injury‡			Injury with Altered Mental Status vs. Other Injury§		
	Unadjusted	Adjusted for PTSD and Depression	Adjusted for PTSD, Depression, and Other Variables	Unadjusted	Adjusted for PTSD	Adjusted for PTSD and Other Variables
	odds ratio (95% confidence interval)					
Poor overall health	1.96 (1.01–3.78)¶	0.92 (0.43–1.99)	1.43 (0.50–4.07)	0.96 (0.52–1.78)	0.76 (0.40–1.44)	0.97 (0.44–2.16)
≥2 Missed workdays due to illness	1.79 (1.08–2.95)¶	1.31 (0.75–2.27)	1.76 (0.85–3.65)	1.09 (0.71–1.68)	1.00 (0.64–1.55)	0.93 (0.54–1.60)
≥2 Medical visits for physical condition	1.82 (1.19–2.77)‖	1.31 (0.82–2.07)	1.28 (0.72–2.28)	1.20 (0.86–1.68)	1.11 (0.79–1.57)	1.08 (0.71–1.63)
PHQ-15 score of ≥15**	2.60 (1.56–4.33)††	0.92 (0.46–1.82)	0.76 (0.31–1.84)	1.52 (0.97–2.38)	1.13 (0.69–1.87)	1.31 (0.71–2.41)
Physical symptoms included in PHQ-15**						
Stomach pain	1.37 (0.72–2.63)	0.70 (0.32–1.50)	0.67 (0.25–1.82)	0.91 (0.51–1.60)	0.[illegible] (0.43–1.40)	1.21 (0.58–2.51)
Back pain	1.22 (0.79–1.89)	0.84 (0.52–1.36)	0.87 (0.48–1.57)	1.10 (0.79–1.55)	0.96 (0.68–1.37)	0.97 (0.64–1.47)
Arm, leg, or joint pain	0.90 (0.59–1.36)	0.62 (0.39–0.98)	0.79 (0.44–1.39)	1.08 (0.79–1.49)	0.97 (0.70–1.35)	1.28 (0.86–1.92)
Headache	3.45 (2.13–5.58)††	2.10 (1.22–3.61)‖	2.38 (1.12–5.07)¶	1.56 (1.01–2.41)¶	1.34 (0.85–2.10)	1.63 (0.92–2.90)
Chest pain	3.31 (1.67–6.54)††	1.58 (0.72–3.49)	1.84 (0.61–5.52)	0.58 (0.24–1.38)	0.48 (0.20–1.17)	0.52 (0.18–1.54)
Dizziness	2.88 (1.23–6.75)¶	1.19 (0.45–3.15)	4.00 (0.96–16.62)	1.99 (0.93–4.25)	1.54 (0.70–3.38)	2.15 (0.83–5.56)
Fainting spells	2.26 (0.72–7.03)	1.02 (0.30–3.52)	1.11 (0.22–5.60)	0.41 (0.09–1.96)	0.31 (0.06–1.50)	0.27 (0.05–1.62)
Heart pounding or racing	4.56 (2.43–8.58)††	2.14 (1.04–4.41)¶	1.90 (0.71–5.09)	2.11 (1.56–3.85)¶	1.64 (0.87–3.10)	1.75 (0.79–3.84)
Shortness of breath	2.15 (1.14–4.05)¶	1.02 (0.49–2.13)	0.77 (0.30–1.99)	1.05 (0.58–1.91)	0.82 (0.44–1.53)	0.72 (0.34–1.54)
Constipation, loose bowels, or diarrhea	2.07 (1.22–3.49)‖	1.42 (0.80–2.53)	1.55 (0.74–3.24)	1.05 (0.65–1.68)	0.88 (0.53–1.44)	1.20 (0.67–2.17)
Nausea, gas, or indigestion	1.24 (0.73–2.11)	0.74 (0.40–1.36)	0.65 (0.31–1.38)	0.86 (0.55–1.34)	0.75 (0.47–1.18)	1.06 (0.60–1.85)
Pain or problems during sexual intercourse	2.32 (1.03–5.26)¶	0.80 (0.31–2.07)	0.98 (0.27–3.51)	0.84 (0.35–1.98)	0.58 (0.24–1.42)	0.81 (0.26–2.54)
Fatigue	2.14 (1.40–3.29)††	1.15 (0.68–1.94)	1.24 (0.66–2.34)	1.24 (0.89–1.74)	1.03 (0.72–1.49)	1.25 (0.79–1.96)
Sleep disturbance	1.97 (1.30–2.98)‖	1.14 (0.70–1.85)	1.13 (0.63–2.03)	1.38 (1.00–1.90)¶	1.19 (0.84–1.67)	1.23 (0.81–1.85)
Other postconcussive symptoms						
Memory problems	2.05 (1.24–3.38)‖	1.06 (0.59–1.90)	1.79 (0.85–3.79)	1.21 (0.79–1.87)	0.97 (0.61–1.54)	1.23 (0.70–2.15)
Balance problems	3.12 (1.31–7.41)¶	1.66 (0.63–4.36)	1.58 (0.41–6.08)	2.46 (1.16–5.25)¶	2.07 (0.96–4.48)	1.40 (0.51–3.82)
Ringing in the ears	1.89 (1.14–3.14)¶	1.30 (0.75–2.26)	0.78 (0.39–1.55)	1.34 (0.88–2.05)	1.19 (0.77–1.83)	0.76 (0.45–1.27)
Concentration problems	2.07 (1.30–3.28)‖	0.83 (0.45–1.55)	0.92 (0.42–2.00)	1.59 (1.09–2.32)¶	1.29 (0.84–1.96)	1.59 (0.94–2.69)
Irritability	2.26 (1.49–3.42)††	1.33 (0.82–2.16)	1.17 (0.65–2.11)	1.56 (1.14–2.15)‖	1.32 (0.93–1.89)	1.46 (0.95–2.24)

* PTSD denotes post-traumatic stress disorder.
† All dependent variables (physical health problems or symptoms 3 to 4 months after deployment) are shown.
‡ Two adjusted analyses were conducted by logistic regression. The first was adjusted for PTSD and depression, and the second was adjusted for PTSD, depression, sex, age, rank, mechanism of injury, exposure or nonexposure to multiple blasts from improvised explosive devices, hospitalization or no hospitalization, and combat intensity.
§ Two adjusted analyses were conducted by logistic regression. The first was adjusted for PTSD, and the second was adjusted for PTSD, sex, age, rank, mechanism of injury, exposure or nonexposure to multiple blasts from improvised explosive devices, hospitalization or no hospitalization, and combat intensity.
¶ P=0.01 to <0.05.
‖ P=0.001 to 0.009.
** PHQ-15 denotes the Patient Health Questionnaire 15-item somatic symptom severity scale (range in this study, 0 to 28, with higher numbers indicating a greater number and severity of symptoms).
†† P<0.001.

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not have the opportunity to participate, possibly resulting in an underestimate of prevalence rates.

In this study, mild traumatic brain injury was significantly associated with psychiatric symptoms, notably PTSD, and the association remained significant after combat experiences had been controlled for. More than 40% of soldiers with injuries associated with loss of consciousness met the criteria for PTSD. The data indicate that a history of mild traumatic brain injury in the combat environment, particularly when associated with loss of consciousness, reflects exposure to a very intense traumatic event that threatens loss of life and significantly increases the risk of PTSD.[28]

The principal limitation of the study is the cross-sectional design based on self-reported data, and thus causality can only be inferred and recall bias is possible. However, the consistency of the results obtained with the use of validated clinical instruments supports the validity of the methods. The analyses suggest that the high rates of physical health problems reported by soldiers with mild traumatic brain injury 3 to 4 months after deployment are mediated largely by PTSD or depression. When these mental disorders were included in the analyses, mild traumatic brain injury was no longer associated with any of the physical health problems, except for headache among those who had lost consciousness. Both PTSD and depression have been associated with a wide range of physical health problems,[23,29,30] including persistence of postconcussive symptoms.[31,32]

The mechanisms of these relationships are complex. Studies have not confirmed any direct link between PTSD and injury to brain tissue from the concussion itself, although this is an important area of research that makes use of new technology, such as diffusion tensor imaging.[33,34] There is evidence that implicit processing of traumatic memories and fear conditioning, both mechanisms for the development of PTSD, occur even in persons with severe traumatic brain injury who are amnesic for the traumatic event.[30] Mechanisms that are likely to underlie both the onset of PTSD after traumatic brain injury and the physical symptoms related to PTSD and depression include biologic processes associated with exposure to extreme stress, activation of the hypothalamic–pituitary–adrenal axis, autonomic reactivity, reactive cell-mediated immune responses, disturbed sleep physiology, and altered perception of symptoms.[16,28,29,35]

Despite the complexity associated with attribution of physical health symptoms in the postdeployment period, these data should not be construed as suggesting that mild traumatic brain injury is not a serious medical concern. Soldiers who reported mild traumatic brain injury events, particularly loss of consciousness, were at very high risk for physical and mental health problems. Multiple concussions are associated with a longer recovery period,[36] which increases the risk for soldiers who have more than one episode during deployment. However, the relationship between concussion and persistent postconcussive symptoms is poorly understood. Postconcussive symptoms, which usually resolve rapidly (within several days or weeks),[20,21] are not specific to traumatic brain injury.[37] One recent study showed that the prevalence of postconcussive symptoms after injury was identical among patients with mild traumatic brain injury and patients with non-head traumas.[37] There is a theoretical concern about the neurologic effects of primary-blast overpressure (as distinct from the mechanical injuries caused by secondary or tertiary blast effects).[3,38] However, there is no evidence that a brief period of unconsciousness from a blast explosion is different clinically from an equivalent duration of unconsciousness caused by any other mechanism. With the absence of meaningful data on the effects of primary blast exposure on the brain, speculation by clinicians and the surrounding publicity[39] may unnecessarily increase patients' anxieties about the nature of their symptoms.[40]

From a diagnostic and treatment perspective, postconcussive symptoms are indistinguishable from symptoms of various disorders, including other symptom-based conditions described by soldiers returning from war.[40-42] The persistence of postconcussive symptoms has also been shown to be associated with medical disability and compensation proce[illegible] well as the expectations and beliefs that patients have about their injuries.[10,43] Evidence-based interventions for the treatment of persistent postconcussive symptoms are lacking,[13,14] and the results of diagnostic procedures (neuroimaging or neuropsychological testing) for mild traumatic brain injury or deployment-related cognitive effects are often inconclu-

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sive and difficult to interpret.[35,39,44] Management focuses largely on alleviating symptoms, yet the most compelling efficacy data highlight the importance of education to normalize symptoms and provide expectation of rapid recovery.[13,14,43,45] Toward this goal, the use of the term "concussion" is encouraged instead of "mild traumatic brain injury." Validated risk-communication approaches, education strategies, and evaluation procedures are needed.

A public health policy implication of this study relates to the sheer number of service members and veterans likely to be referred for further evaluation after being screened under new Department of Defense and Department of Veterans Affairs policies. This study suggests that a self-reported history of mild traumatic brain injury during deployment, particularly when associated with altered mental status without loss of consciousness, lacks specificity in predicting postdeployment physical health problems among injured soldiers. No empirical validation of the screening questions by means of clinical interviews has been done, with the exception of one widely quoted study that had no control group.[9,46] Almost two thirds of the mild traumatic brain injuries in this study sample were identified on the basis of a question that asked soldiers whether they were dazed or confused at the time of the injury. The question proved to have poor correlation to physical health outcomes, even without adjustment for PTSD. Screening for mild traumatic brain injury months after the injury is likely to result in the referral of a large number of persons for evaluation and treatment of nonspecific health symptoms attributed to brain injuries, with potential unintended iatrogenic consequences.[12,40,47,48] Evaluation of the screening programs for traumatic brain injury is needed to ensure that the risks do not outweigh the benefits and that screening is conducted within an effective structure of care.

The strong associations between mild traumatic brain injury, PTSD, depression, and physical health symptoms in combat veterans reinforce the need for a multidisciplinary approach centered in primary care. Evidence-based studies of the management of symptom-based disorders and collaborative care approaches to the evaluation and treatment of coexisting mental disorders in primary care settings are important in designing intervention strategies.[30,40,41,45,48-51]

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REFERENCES

1. Okie S. Traumatic brain injury in the war zone. N Engl J Med 2005;352:2043-7.
2. Xydakis MS, Fravell MD, Nasser KE, Casler JD. Analysis of battlefield head and neck injuries in Iraq and Afghanistan. Otolaryngol Head Neck Surg 2005;133:497-504.
3. Warden D. Military TBI during Iraq and Afghanistan wars. J Head Trauma Rehabil 2006;21:398-402.
4. Independent Review Group. Rebuilding the trust: report on rehabilitative care and administrative processes at Walter Reed Army Medical Center and National Naval Medical Center. Alexandria, VA, April 2007. (Accessed January 4, 2008, at http://www.ha.osd.mil/dhb/recommendations/2007/IRG-Report-Final.pdf.)
5. An achievable vision: report of the Department of Defense Task Force on Mental Health, June 2007. (Accessed January 4, 2008, at http://www.ha.osd.mil/dhb/mhtf/MHTF-Report-Final.pdf.)
6. Carson study: 1 in 6 shows TBI symptoms. Associated Press. April 11, 2007.
7. Department of Veteran Affairs, Veterans Health Administration. VHA Directive 2007-013. Screening and evaluation of possible traumatic brain injury in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans. Washington, DC: April 13, 2007. (Accessed January 4, 2008, at http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1556.)
8. Defense and Veterans Brain Injury Center Working Group on the Acute Management of Mild Traumatic Brain Injury in Military Operational Settings. Clinical practice guidelines and recommendations. December 22, 2006. (Accessed January 4, 2008, at http://www.pdhealth.mil/downloads/clinical_practice_guideline_recommendations.pdf.)
9. 3 Question DVBIC TBI screening tool instruction sheet. Washington, DC: Defense and Veterans Brain Injury Center. (Accessed January 4, 2008, at http://www.dvbic.org/pdfs/3-Question-Screening-Tool.pdf.)
10. Carroll LJ, Cassidy JD, Peloso PM, et al. Prognosis for mild traumatic brain injury: results of the WHO Collaborating Centre Task Force for mild traumatic brain injury. J Rehabil Med 2004;43:Suppl:84-105.
11. National Center for Injury Prevention and Control. Report to Congress on mild traumatic brain injury in the United States: steps to prevent a serious public health problem. Atlanta: Centers for Disease Control and Prevention, 2003.

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12. Rona RJ, Hyams KC, Wessely S. Screening for psychological illness in military personnel. JAMA 2005;293:1257-60.

13. Peloso PM, Carroll LJ, Cassidy JD, et al. Critical evaluation of the existing guidelines on mild traumatic brain injury. J Rehabil Med 2004;43:106-12.

14. Borg J, Holm L, Peloso PM, et al. Non-surgical intervention and cost for mild traumatic brain injury: results of the WHO Collaborating Centre Task Force on Mild Traumatic Brain Injury. J Rehabil Med 2004;43:Suppl:76-83.

15. Borg J, Holm L, Cassidy JD, et al. Diagnostic procedures in mild traumatic brain injury: results of the WHO Collaborating Centre Task Force on Mild Traumatic Brain Injury. J Rehabil Med 2004;43:Suppl:61-75.

16. Bryant RA. Posttraumatic stress disorder and mild brain injury: controversies, causes and consequences. J Clin Exp Neuropsychol 2001;23:718-28.

17. Hoge CW, Castro CA, Messer SC, McGurk D, Cotting DI, Koffman RL. Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. N Engl J Med 2004;351:13-22.

18. Hoge CW, Auchterlonie JL, Milliken CS. Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. JAMA 2006;295:1023-32.

19. Vasterling JJ, Proctor SP, Amoroso P, Kane R, Heeren T, White RF. Neuropsychological outcomes of Army personnel following deployment to the Iraq war. JAMA 2006;296:519-29.

20. McAllister TW. Mild brain injury and the post-concussive syndrome. In: Silver JM, McAllister TW, Yudofsky SC, eds. Textbook of traumatic brain injury. Washington, DC: American Psychiatric Publishing, 2005:279-308.

21. McCrea M, Guskiewicz KM, Marshall SW, et al. Acute effects and recovery time following concussion in collegiate football players: the NCAA Concussion Study. JAMA 2003;290:2556-63.

22. Kroenke K, Spitzer RL, Williams JBW. The PHQ-15: validity of a new measure for evaluating the severity of somatic symptoms. Psychosom Med 2002;64:258-66.

23. Hoge CW, Terhakopian A, Castro CA, Messer SC, Engel CC. Association of posttraumatic stress disorder with somatic symptoms, health care visits, and absenteeism among Iraq War veterans. Am J Psychiatry 2007;164:150-3.

24. Spitzer RL, Kroenke K, Williams JB. Validation and utility of a self-report version of the PRIME-MD: the PHQ primary care study. JAMA 1999;282:1737-44.

25. Bliese PD, Wright KM, Adler AB, Cabrera O, Castro CA, Hoge CW. Validating the PC-PTSD and the PTSD Checklist with soldiers returning from combat. J Consult Clin Psychol (in press).

26. Kang HK, Natelson BH, Mahan CM, Lee KY, Murphy FM. Post-traumatic stress disorder and chronic fatigue syndrome-like illness among Gulf War veterans: a population-based survey of 30,000 veterans. Am J Epidemiol 2003;157:141-8.

27. Baron RM, Kenny DA. The moderator-mediator variable distinction in social psychological research: conceptual, strategic, and statistical considerations. J Pers Soc Psychol 1986;51:1173-82.

28. Nemeroff CB, Bremner JD, Foa EB, Mayberg HS, North CS, Stein MB. Posttraumatic stress disorder: a state-of-the-science review. J Psychiatr Res 2006;40:1-21.

29. Boscarino JA. Posttraumatic stress disorder and physical illness: results from clinical and epidemiologic studies. Ann N Y Acad Sci 2004;1032:141-53.

30. Kroenke K. Patients presenting with somatic complaints: epidemiology, psychiatric co-morbidity and management. Int J Methods Psychiatr Res 2003;12:34-43.

31. Bryant RA, Harvey AG. Postconcussive symptoms and posttraumatic stress disorder after mild traumatic brain injury. J Nerv Ment Dis 1999;187:302-5.

32. Rapoport MJ, McCullagh S, Shammi P, Feinstein A. Cognitive impairment associated with major depression following mild and moderate traumatic brain injury. J Neuropsychiatry Clin Neurosci 2005;17:61-5.

33. Bazarian JJ, Blyth B, Cimpello L. Bench to bedside: evidence for brain injury after concussion — looking beyond the computed tomography scan. Acad Emerg Med 2006;13:199-214.

34. Taber KH, Hurley RA. Traumatic axonal injury: atlas of major pathways. J Neuropsychiatry Clin Neurosci 2007;19:iv-104.

35. Katon WJ, Lin EHB, Kroenke K. The association of depression and anxiety with medical symptom burden in patients with chronic medical illness. Gen Hosp Psychiatry 2007;29:147-55.

36. Guskiewicz KM, McCrea M, Marshall SW, et al. Cumulative effects associated with recurrent concussion in collegiate football players: the NCAA Concussion Study. JAMA 2003;290:2549-55.

37. Meares S, Shores EA, Taylor AJ, et al. Mild traumatic brain injury does not predict acute postconcussion syndrome. J Neurol Neurosurg Psychiatry (in press). (Accessed January 4, 2008, at http://jnnp.bmj.com/cgi/content/abstract/jnnp.2007.126565v1.)

38. Taber KH, Warden DL, Hurley RA. Blast-related traumatic brain injury: what is known? J Neuropsychiatry Clin Neurosci 2006;18:141-5.

39. Glasser R. A shock wave of brain injuries. Washington Post. April 18, 2008:B01. (Accessed January 4, 2008, at http://www.washingtonpost.com/wp-dyn/content/article/2007/04/06/AR2007040601821.html.)

40. Barsky AJ, Borus JF. Functional somatic syndromes. Ann Intern Med 1999;130:910-21.

41. Engel CC, Katon WJ. Population and need-based prevention of unexplained symptoms in the community. In: Joellenbeck LM, Russell PK, Guze SB, eds. Strategies to protect the health of deployed U.S. forces: medical surveillance, record keeping, and risk reduction. Washington, DC: National Academy Press, 1999:173-212.

42. Jones E, Hodgins-Vermaas R, McCartney H, et al. Post-combat syndromes from the Boer War to the Gulf War: a cluster analysis of their nature and attribution. BMJ 2002;324:321-4. [Erratum, BMJ 2002;324:397.]

43. Ferguson RJ, Mittenberg W, Barone DF, Schneider B. Postconcussion syndrome following sports-related head injury: expectation as etiology. Neuropsychology 1999;13:582-9.

44. Hoge CW. Deployment to the Iraq war and neuropsychological sequelae. JAMA 2006;296:2678-9.

45. Mittenberg W, Tremont G, Zielinski RE, Fichera S, Rayls KR. Cognitive-behavioral prevention of postconcussion syndrome. Arch Clin Neuropsychol 1996;11:139-45.

46. Schwab KA, Ivins B, Cramer G, et al. Screening for traumatic brain injury in troops returning from deployment in Afghanistan and Iraq: initial investigation of the usefulness of a short screening tool for traumatic brain injury. J Head Trauma Rehabil 2007;22:377-89.

47. Fisher ES, Welch HG. Avoiding the unintended consequences of growth in medical care: how might more be worse? JAMA 1999;281:446-53.

48. Engel CC, Hyams KC, Scott K. Managing future Gulf War syndromes: international lessons and new models of care. Philos Trans R Soc Lond B Biol Sci 2006;361:707-20.

49. Clinical Practice Guideline for Post-Deployment Health Evaluation and Management. Washington, DC: Department of Defense, Veterans Health Administration, February 2001 (updated December 2001). (Accessed January 4, 2008, at http://www.oqp.med.va.gov/cpg/PDH/G/PDH_cpg.doc.)

50. Gilbody S, Bower P, Fletcher J, Richards D, Sutton AJ. Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes. Arch Intern Med 2006;166:2314-21.

51. Katon WJ, Zatzick D, Bond G, Williams J Jr. Dissemination of evidence-based mental health interventions: importance to the trauma field. J Trauma Stress 2006;19:611-23.

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DRAFT

Promising Practices

State Systems of Coordinated Services and Supports for Individuals with Traumatic Brain Injury and Their Families

Do I know someone who's had a Traumatic Brain Injury?

A bus sideswiped Melissa as she was driving her car to work. She moved in and out of consciousness during the ambulance ride, but was coherent when she arrived at the hospital. She was treated for cracked ribs and a ruptured spleen and was given an MRI which showed no apparent brain injury. Several months later she began having memory problems and serious depression. She began drinking heavily to deal with the depression and lost her job as a legal secretary. She is attempting to live off of unemployment insurance.

A babysitter shook Alfred when he was 6 months old. He was in a coma for 7 days and diagnosed with Shaken Baby Syndrome. Alfred walked and talked much later than other children his age. He was evaluated for developmental disability services and enrolled in special education when he started school.

R[illegible]

Despite their outward differences, all of these people have experienced a Traumatic Brain Injury (TBI). These examples provide a glimpse into the complex and unique nature of TBI and its effects . . .

Chances are ....

It may have been called by a different name: a concussion, Shaken Baby Syndrome, head injury, or anoxia due to trauma. These are just a few of the other names for Traumatic Brain Injury (TBI), but all of them have the potential to kill or leave an individual with life long disabling conditions.

STATISTICS

One million Americans sustain a TBI and of these, more than 50,000 die and 80,000 experience the onset of long-term disabling conditions following the TBI. Current estimates from the Centers for Disease Control (CDC) state there are 5.3 million Americans living with a disability as a result of TBI. At greatest risk are adolescents, young adults and those older than 75.

TBI occurs 8 ½ times more frequently than breast cancer, 35 times more than HIV/AIDS, 137 times more than spinal cord injury, and 144 times more than multiple sclerosis. The numbers of individuals living with TBI have steadily increased over the past 25-30 years, so to have the challenges of accessing existing systems of supports and services that are available, appropriate, and acceptable.

COSTS

The annual costs of TBI are estimated to be $48.3 billion with hospitalization accounting for $31.7 billion, and fatal brain injuries costing the nation $16.6 billion. What the long term costs are to provide supports and services is unknown, but it is an issue that needs our attention.

RISK FACTORS

TBI occurs regardless of age, gender, ethnicity, socio-economic status, or education. Anyone has the potential for being involved in an event resulting in a TBI. TBI is a significant public health issue that must be addressed. HRSA's MCHB grants to the States are helping to address the needs of Individuals with Traumatic Brain Injury and Families by assisting States as they define and build Coordinated State Systems of Services and Supports.

Promising Practices for State Systems of Coordinated Services and Supports[1] for Individuals with Traumatic Brain Injury and Their Families

BACKGROUND

The TBI Act of 1996

Resulting from uncontrolled costs and inadequate access to services, in July 1996 Congress enacted the Traumatic Brain Injury Act, Public Law 104-166: "to provide for the conduct of expanded studies and the establishment of innovative programs with respect to traumatic brain injury (TBI)". Under the Law, the Health Resources and Services Administration (HRSA), is charged with implementing a State Grant Program to improve access to health and other services for individuals with TBI and their families.

All HRSA TBI Grants to States address one or more of the following Healthy People 2010 goals:

1. Improve access to comprehensive, high quality health care services.
2. Increase the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and improve health and quality of life.
3. Ensure that Federal, Tribal, State, and local health agencies have the infrastructure to provide essential public health services effectively.

The National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) were also delegated responsibilities in the areas of research, and prevention and surveillance respectively. CDC has additional public awareness and education responsibilities.

Consensus Statement

In 1998, the NIH convened a consensus conference on TBI Rehabilitation Methods. The panel concluded that individuals with TBI have the best chances for rehabilitation if they have access to individualized treatment programs that combine a wide range of components . . . "the consequences of TBI are rarely limited to one set of symptoms. Rather, they typically affect many facets of a person's life..."

In September 2000, the Brain Injury Association of America (BIA) held a Resource Facilitation Summit. Supported by HRSA/MCHB, the Summit outlined "Principles and Best Practices to Guide Program Development and Operations in Brain Injury" targeted to programs that are administered by State government agencies or contracted to state BIA's. This Summit recognized the great need to build partnerships that help individuals and communities access information, supports, and services.

In October 2000, the CDC convened an Expert Working Group to identify preliminary models of key domains in assessing longer-term outcomes of TBI in Children and Youth. The Work Group

[1] Services and Supports are defined as any and all of the medical, therapeutic, rehabilitative, community based, psycho-social, economic, educational, vocational, or other needs to necessitate the individual with TBI's ability to function in the community of choice as independently and productively as possible.

recognized that appropriate services for children and youth with TBI are severely lacking. They concluded that an additional dimension to existing models was needed: "Studies of outcomes of TBI in this population should document the needs for services and the barriers to receiving them." Therefore, the Work Group developed a separate Operational Model specifically for these issues.

In April 2001, HRSA's/MCHB's Traumatic Brain Injury Technical Assistance Center (TBI TAC) sponsored a Service Coordination Work Group comprised of individuals from States with TBI grants, including Alabama, Iowa, Minnesota, Michigan, South Carolina, Colorado, Washington, Kentucky, as well as representatives from the BIA, the National Association of State Head Injury Administrators (NASHIA) and TBI TAC Staff.. This group was charged with the responsibility of identifying the key elements needed for State Systems of Coordinated Services and Supports. The expertise each State brought to the discussions resulted in the recognition of two key factors: (1) State service delivery systems are fragmented and (2) lack coordination and the points of entry into the States' systems are neither readily identified nor accessible. The States represented in this Work Group have been working to develop mechanisms and methods to coordinate, change, and improve their existing systems of services and supports.

STATEMENT OF NEED

The conclusions from these distinct meetings have recognized: **It is imperative that coordinated, accessible, appropriate, and acceptable TBI services and supports must be available throughout an individual's life as TBI is complex, variable, personal, and can have life-long effects.** TBI is underdiagnosed as it is easily misdiagnosed or goes undiagnosed altogether. Individuals' lives are being saved: we must have systems to support individuals in living their lives after TBI.

This document proposes there are six Critical Indicators every State needs to address as State Systems of Coordinated Services and Supports are developed, enhanced or sustained. The Critical Indicators will be used to measure a State's success in achieving coordinated systems and as the basis for the core outcomes, described later, to be achieved for children, youth, and adults with TBI and their families.

PROGRAM DESCRIPTION

Critical Indicators Needed to Build State Systems of Coordinated Services and Supports

System Entry or Access

Service Needs are often not identified until the service system has been entered. Early and correct diagnosis of a TBI is essential as a missed diagnosis or a misdiagnosis leads to absent, inappropriate or denied services and supports. Once a TBI and the ensuing service needs have been identified, it is crucial that families and individuals with traumatic injury have straightforward and readily available information. This information must identify both the point of entry into the State's existing delivery system of services and supports and be user friendly[2].

[2] This may include, but not limited to the identification of the physical location, assistance for literacy, language, and cognitive needs, cultural sensitivity, and forms that are easy to use and are not redundant.

Additionally, the assessment tool used by State agencies for in-take, identification of service needs, and/or referral must be consistent or uniform across agency lines.

Assistance in Coordination

Individuals with TBI frequently require a spokesperson or advocate for assistance in navigating State systems and for articulating their service needs. Issues resulting from TBI are often complex and frequently develop or change over time therefore a coordinated State system of services and supports needs to be flexible, creative, and cost effective in the approaches to service delivery. Providers of services[3] must work closely with the individual and family in developing a plan to meet those needs. Providers of services and supports can be instrumental in helping individuals and families develop self-advocacy skills that will be utilized throughout the individual's life.

Partnership Approach to Service and Support Provision

All providers[4] of TBI services and supports must recognize that coordination of services and supports begin at the scene of the injury and may continue indefinitely, as individual needs dictate. There may be a multiplicity of providers, both professional and para-professional, called upon to use their expertise and knowledge with fluctuating levels of involvement and for indeterminate periods of time. A Partnership Approach expects that all providers of services recognize there are many providers working on behalf and with the individual and the family. Therefore, the individual and family are full partners in the decision making and service delivery process. Each participant's contribution is significant as it serves to build the service coordination efforts, document data about TBI issues, provide an environment supportive of the individual and the family within the context of their choices, needs, life roles, and community, as well as raise the awareness of issues stemming from TBI.

Education and Training

Education and training about TBI is the core of a coordinated system of services and supports. Families and individuals with TBI are thrown into the world of TBI with little if any prior knowledge. Information about TBI, its effects, and where to access available services within the State must be readily available. Frequently, families or individuals with TBI seek this information from their medical providers. It cannot be assumed that comprehensive education and training about TBI is included in under-graduate or graduate studies and specialized training such as medical school, teacher preparation, or allied health training. The long term effects and issues resulting from TBI are frequently not included in these curricula. Accurate, comprehensive, and timely educational[5] and training opportunities from multiple sources and perspectives for providers of services, policy makers, families, and individuals with TBI will produce the foundation for Accessible, Available, Appropriate, Acceptable, and Affordable coordinated services and supports for individuals with TBI and their families.

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[3] Includes but not limited to both private and public, e.g., state agency service delivery systems, community based providers, medical and rehabilitative services, schools, managed care.

[4] Examples include but are not limited to: medical, rehabilitative, and other direct care providers, case managers/coordinators, life-skills attendants, family members, individuals with TBI, peer counselors - all providers from every discipline, role, and location.

[5] Training that is approved for CEU's, CME's, or other licensing or certification requirements.

Flexible and Coordinated Long Term Services and Supports

Individuals with TBI and their families may need life-long services and supports, however the level of intensity at which services are needed varies. The long-term effects of TBI may manifest over time, therefore systems must be designed with the flexibility of allowing individuals to take recesses and then be able re-enter as needs are identified. TBI services may be provided by many agencies within a State's system, but these may not be the appropriate service delivery systems to meet the individual's needs. To increase the efficiency, effectiveness, and cost sharing, agencies must develop a mechanism for case finding[6], resource identification, tracking the individual's progress, and collaboration in order to maximize existing resources. No one State agency can be expected to shoulder the responsibility of being the sole provider of services and supports within the State. Accessibility, Availability, Appropriateness, Acceptance, and Affordability[7] for individuals with TBI must become the norm as it provides an environment supportive of the individual and the family within the context of their choices, needs, life roles, and their community of choice.

Using Data for Policy Development

Accurate and current data are critical for making informed policy decisions that affect systems change. States should recognize there are multiple potential data sources and build data linkages between agencies and other credible data sources[8] as individuals with TBI frequently are receiving services for secondary conditions resulting from the TBI. Therefore, a comprehensive picture of TBI issues, needs, and resources will be identified as individuals with traumatic injury access services across the spectrum of service delivery systems. The data picture should include incidence, prevalence, costs, cost benefits, and results of case-finding: the "Hard" data. The "Heart" data: are the stories and experiences from the individuals who are living with effects of TBI. Heart data can serve to be a measuring stick of how well the State's systems are functioning. Both types of data are necessary when building an accurate picture to support policy for the coordination of services and supports in the State.

ROLES and RESPONSIBILITIES

All TBI stakeholders need to become collaborative partners in developing a coordinated system of services and supports in every state. As you work towards achieving these outcomes, each partner in this process must contribute to creating or enhancing the existing service systems as well as documenting the results of these efforts.

Individuals with TBI and their Families have the best perspective respect to systems' accessibility, availability, appropriateness, acceptability, and affordability. As such, families of all types, cultures, and socioeconomic levels must be able to participate in all aspects and at all levels of coordinating efforts and in the measuring of success of these Promising Practices.

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[6] Many people with TBI access non-TBI services, finding and identifying these individuals for appropriate supports and services is critical. Many people with TBI are not seen in a hospital, but a doctor's office .. these individuals need to be identified in the event they are in need of supports and services

[7] Affordability means affordable by the individual/family with TBI, by service coordinators who looking for affordable options, by funding sources who need to pay for the most cost effective measures to meet the needs, and for providers, be they public or private as to whether they can afford to deliver said services for the amount reimbursed.

[8] Data from the State BIA, ILC, UAP, counties, or other points of entry or service delivery

Communities[9] are frequently the entry points into the State's system as well as the point of service delivery, therefore, communities must make entry points and available services and supports known. Because communities are the front line of entry and service delivery, it is essential that they participate in collaborative efforts to build State systems of coordinated services and supports. This includes documenting the efficacy of accessibility, availability, appropriateness, acceptability, and affordability of services and supports and the degree to which individuals with TBI and their families participate at all levels of decision making. Communities must examine the resources available and establish goals to increase their capacity for assisting individuals with integrating into the mainstream of community life. Additionally, communities must collect data on the six key indicators in ways that allow for a common measurement across communities.

Employers and Educators need to evaluate and improve their existing systems and to document their efforts in building environments for individuals with TBI and their families as individuals enter or return to work or school post TBI. Employment and educational settings are frequently the front line of community re-entry, therefore it is essential to coordinate needed services and supports and to document costs as well as cost benefits when individuals successfully return to work or school.

Service Providers[10] should maximize a Partnership Approach by working to coordinate the systems of delivery of services and supports. Service providers should document and evaluate the systems of identification and referral to promote data systems that are linked and coordinated. This will produce more effective and technologically appropriate methods of identification of TBI. Data systems need to be responsive to the complex issues of confidentiality and privacy while preserving ways to share data. As key stakeholders in the service system, all providers, including those in acute medical, rehabilitation, community based services, education, employment, and long-term supports can provide data for policy development that documents the range, the efficacy, and the coordination of services for individuals with TBI and their families.

Brain Injury Association of America State Affiliates and other grass roots organizations play a key role in promoting self-advocacy and representing the experiences and views of individuals with TBI and their families. To do so they must share their information and referral data collection efforts across the country. These organizations have data that is not otherwise available through established systems or registries. The data captures the immediate and life long needs of individuals with TBI as well as their satisfaction with the system's services and supports. Incorporating the data from these sources into policy decisions will facilitate policy development from a real life perspective. BIA's and other grassroots organizations should also build partnerships with other groups representing individuals who share similar needs for services and supports as a way to build a more responsive service delivery system for all people.

Members of National Association of State Head Injury Administrators (NASHIA) assist state governments in promoting partnerships and in building systems to meet the needs of individuals with TBI and their families. NASHIA members must exercise their unique opportunity of providing information and data that supports coordinated State system of services and supports and assist in the development of TBI policy as a national body and individually in member States.

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[9] Communities include taxable frameworks e.g., counties, cities, towns, villages, parishes, boroughs

[10] Includes both private and public; e.g., state agency service delivery systems, community based providers, medical and rehabilitative services, schools, managed care

Funding Sources[11] are vital players in fostering system coordination efforts and funding appropriate brain injury services and supports that deliver coordinated services and supports. In doing so, this serves as a source of information regarding insurance coverage, costs, and cost benefits - the appropriate utilization and types of services provided to individuals with TBI and their families. It is critical for funding sources to build linkages with other data systems, address confidentiality issues, and assure early and accurate diagnosis or identification of TBI within the variety of delivery systems and examine cost reimbursement mechanisms. This will provide the documentation necessary to capture the real costs of TBI and the efficacy of service coordination that is needed to build accurate funding decisions in states.

State Governments should use the four core components[12] as the baseline for building and maintaining coordinated State systems of services and supports for individuals with TBI and their families. States should also be sensitive and responsive to the needs of individuals with TBI and their families when addressing policy and funding decisions as well as establishing measures to address costs, promote cost benefits, establish and oversee standards of care, and to maintain efficacy and customer satisfaction of the State's services and supports. States have the unique opportunity of partnering with a variety of agencies, organizations, associations, individuals, and families all leading to ensure systems that are truly responsive to the needs of individuals with TBI and their families.

Federal Partners will help in providing the national picture of TBI and providing the data and information on progress being made in establishing coordinated services and supports in every state. This ongoing process of measuring the state's success in achieving their outcomes will narrow the gap between the vision of coordinated systems and reality. It must be coordinated at the national level.

EVALUATION

In a Coordinated System in which health care and long-term services and supports are to be provided for individuals with TBI and their families, the stated "Promising Practices" for service coordination builds upon the experiences and successes of the State grantees in the TBI Program. By doing so it will assure that programs and policies are established to guarantee that:

- All individuals with disabilities resulting from TBI and their families have access to relevant information, quality health care, protection and advocacy, and services and supports to meet lifelong needs emanating from the effects of TBI.
- Services are coordinated.
- Providers are adequately trained.
- Individuals with TBI and their families actively participate in how services are chosen and provided.
- Individuals with TBI are prepared to function in the community and to lead productive lives.
- Financing issues are equitably addressed.

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[11] Includes public and private insurance, state service delivery systems funded by Medicaid option dollars, waivers, state general revenue, trusts, agency budgets

[12] State TBI Advisory Board/Council, Lead Agency, Current Needs and Resource Assessment, and State TBI Action Plan

These changes must occur in ways that will provide optimal outcomes for individuals with TBI and their families. As the next step in the implementation of these "Promising Practices", six national outcomes have been selected by the TBI TAC Service Coordination Work Group as critical to guide efforts within States to supporting a coordinated system of services and supports.

Core Outcomes to be achieved:

All individuals with TBI and their families will:

1. Have the TBI diagnosed or identified in a timely and expeditious manner, with appropriate documentation.

2. Be able to access services through easily identified points of entry that are user friendly.

3. Receive coordinated ongoing services and supports within their community of choice.

4. Have services and supports that are carefully planned, culturally sensitive, cognitively and life-stage appropriate, and necessary for making successful transitions to school, work, and independence as needed throughout the individual's life.

5. Partner in decision making at all levels, and express satisfaction with the services required to achieve the planned outcomes.

6. Have adequate private and/or public funding (including insurance) to pay for the services they need.

CONCLUSION

Through collaborative action, we will establish State systems of coordinated services and supports that meet the long-term needs of individuals with TBI and their families. We will be able to communicate the value in developing such systems as we will be focusing our activities on Accessible, Available, Appropriate, Acceptable, and Affordable services and supports while maximizing cost effectiveness and long-term benefits.

Alaska Native Health Board
MEGA Meeting

Tuesday, February 12, 2008
Centennial Hall ~ Juneau, Alaska

DRAFT AGENDA

9:00 a.m. **Welcome**
Invocation
Introductions

9:15 a.m. **Agency Updates**

~Alaska Area Native Health Service	Dr. Ken Glifort, Acting Director
~Alaska Dept. of Health and Social Services	Karleen Jackson, Commissioner
~Alaska Native Health Board	Andrew Jimmie, Chairman
~Alaska Native Tribal Health Consortium	Paul Sherry, CEO

10:15 a.m. **Break**

10:30 a.m. **Alaska Tribal Medicaid Reform Initiative**

Introductory Remarks: Senator Lyman Hoffman
Senator Donald Olson

Panel Discussion:
Jerry Fuller, DHSS Medicaid Director
Deb Erickson, ANTHC TMRI Project Manager
Valerie Davidson, ANTHC L&IA
Paul Hansen, Maniilaq (Long Term Care) *(invited)*
Victor Joseph, TCC (Behavioral Health) *(invited)*
Frank Sutton, Medicaid Task Force Chair

12:00 p.m. **Lunch** (on your own)

1:00 p.m. **Alaska e-Health Initiative: Electronic Health Records/Health Information Exchange**

Panel Discussion:
Paul Sherry, ANTHC CEO
Rebecca Madison, Project Manager
Dr. Jay Butler, DHSS Chief Medical Officer
Bill Streur, DHSS, MMIS Project

2:00 p.m. **Recommendations of the Governor's Health Care Strategies Council**

Panel Discussion:
Don Kashevaroff, Council member *(telephonic)*
Karleen Jackson, DHSS Commissioner
Representative Peggy Wilson *(invited)*

2:30 p.m. **2008 Alaska State Legislature: Health-related Bills under Consideration**

Panel Discussion: Pat Jackson, State Liaison
Sherry Hill, DHSS
Alaska Legislators

3:30 p.m. **Adjournment**

4:00 p.m. **ATHS Presentation to Bush Caucus** (Capitol Building)

~ Introduction to the ATHS
~ ANHB State Priorities

1. Medicaid
2. Electronic Health Record
3. Behavioral Health Grants
4. Other Priorities
5. Village Safe Water

5:30 – 8:00 p.m. **Reception: In Honor of Paul Sherry, ANTHC CEO**
Home of Myra M. Munson

RECORDS CERTIFICATION

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2/14/08 PRESENTA-TION: OFFICE OF CHILDREN'S SERVICES

OFFICE OF CHILDREN'S SERVICES

Ten-Year Review

Draft

Representative John Coghill & Staff
January 29, 2008

EXECUTIVE SUMMARY

One of the key motivations for me to enter the political arena in 1998 was my belief that parental rights were being ignored in the child protection world. I strongly believe that our children do not belong to the government. Since I came to the legislature in January of 1999, I have slowly and deliberately moved forward on parental rights reform with the firm belief that government should work at preserving families and keeping children with family members as a preference over placement with strangers.

In March of 1998, as an Alaskan citizen, I sat in the Fairbanks LIO for three days waiting to testify against House Bill 375, an omnibus bill embracing federal guidelines for child protection and government intervention of child custody. The bill, which passed with only two dissenting votes, implemented a standard of preponderance of evidence for state intervention into a family's life.

Since the passage of HB 375, I and other legislators have dealt with parents finding themselves involved with the Division of Family and Youth Services (DFYS). Ten years ago reuniting children with their parents once they had been removed from the home was virtually an impossible task. Regional offices of DFYS received little supervision by the statewide director and front line workers were making policy calls that left permanent scars on Alaskan families.

Many legislators have spent the last ten years undoing some of the unintended consequences of HB 375. To better understand the changes made in the child protection laws in the last decade, later in this report we will summarize legislation introduced by legislators and the governor in the last ten years.

In 2003, the Murkowski Administration, under the direction of Commissioner of Joel Gilbertson of Health and Social Services, restructured the department. DFYS was renamed as Office of Children's Services (OCS) and the office was elevated to a deputy commissioner level. With the new name and Marcia Kennai being appointed deputy commissioner, family preservation was injected into the philosophy of the department. However, the division still had problems and high profile cases from the Anchorage area were catching the attention of the news media.

During the 18 months Marcia Kennai ran OCS, she submitted to the federal government and implemented a Program Improvement Plan (PIP) as a response to a 2002 federal audit. The PIP put measurements in place to improve the child protection system. Also under Kennai's direction a new child protection data management system, the Online Resources for the Children of Alaska (ORCA, was put into place. While it took several years to perfect the system, data is now easily retrieved and updated with the ORCA system.

Joel Gilbertson and legislators discuss HB 53 with press.

Gilbertson appointed Tammy Sandoval as the new deputy commissioner for OCS. Tammy came to OCS in early 2004 with 20 years of extensive social work experience. Before coming to Alaska, Tammy worked for the National Resource Center on Maltreatment assisting child welfare agencies across the nation with child protection planning and programming. Before being appointed deputy commissioner Sandoval served as the OCS Systems Reform Administrator.

In early 2005, Joel Gilbertson and Tammy Sandoval attended a meeting I arranged with other legislators who had legislation introduced addressing concerns with OCS and legislators who were anticipating introducing legislation. The end result of the meeting was the decision that House Bill 53, a bill I introduced in the House making statutory changed to OCS, would be the vehicle for an omnibus bill including reform provisions from bills filed by Governor Murkowski and Representatives Rokeberg, Neuman, Harris, Chenault, and McGuire. Tammy Sandoval attended every committee hearing and openly engaged in the discussion of child protection reform to promote family preservation and opening child protection proceedings to transparency.

In 2006, Sandoval contracted with an outside consultant, ACTION for Child Protection, Inc., to study and evaluate internal operations of OCS. The consultant evaluated the operations of the OCS within four functions: organizational structure, community relationships, effectiveness of policy and procedures, and training curriculum. Recommended changes included competing the implementation of the new child protection information management system (ORCA), training staff in and implementing a new safety assessment model for child abuse investigations, and successfully completing a (PIP) with federal partners.

When gauging OCS's performance and improvements, we have to consider the statistics available, however, one way for a legislator to grade the bureaucracy is the number of constituent complaints our office receives about a state agency. My office has been fielding complaints from all over the state about OCS for ten years now.

I can honestly say when HB 53 passed out our workload increased because of increased awareness by grandparents and relatives of their rights. The first year of implementation was hampered by a lack of knowledge of the new laws by courts and attorneys at Department of Law. One judge in Kenai continued to keep court proceedings closed months after HB 53 was enacted. Now constituent complaints are almost non-existent, but we still find caseworkers using old rules and procedures.

Areas of concern I continue to have are worker recruitment and retention, supervisor training, foster care training, modifying the Interstate Child Placement Compact without waiving sovereignty, replacing federal dollars funding Child Advocacy Centers, increasing public awareness of the grievance process, and strengthening an atmosphere within OCS for family preservation.

In this report, we will give a brief history of the reform to child protection over the past ten years, discuss increases in funding during the last three years to help OCS implement some of the changes the legislature has made. We will also make some broad comments on improvements to the system where attention is still needed.

SUPERVISOR TRAINING

While the legislature has provided over $1 million for training of front line workers in the past three years, there is still a need to provide training for supervisors to the front line workers. The quality of supervisory staff is a key element to properly teaching family preservation policies to the support staff.

MODIFYING THE INTERSTATE CHILD PLACEMENT COMPACT

Last year, we introduced HB 50 as a mechanism to weigh in on the amendment of the Interstate Child Placement Compact. Everyone agrees the existing compact doesn't work. However, sixteen states have expressed concerns about the power of the Interstate Commission being given the authority to promulgate rules and regulations that would supersede state law.

The areas of the compact that are being questioned are as follows:

1. **Article VI (B)** – a state has **no due process** when it disagrees with the placement authority of the Interstate Commission.

2. **Article IX (A), (C), & (D)** – allows the Interstate Commission to promulgate, interpret, and enforce rules that **supersede "state law**, rules or regulation".

3. **Article XI (A), (D), & (H)** – Gives the Interstate Commission authority to promulgate rules that have the "force and effect of statutory law and shall superseded any state law, rule or regulation to the extent of any conflict". If adopted by a state, this provision relinquishes the sovereignty of state law.

4. **Article XII (A)(2)** – Gives the compact sovereignty over the states adopting the compact.

5. **Article XII (C)(c)** – Gives the Interstate Commission authority to bring legal action against any state adopting the compact.

6. **Article XIII (B)** – Gives the Interstate Commission authority to assess fees on states and allows the commission to promulgate rules to bind the states to the fees. The Alaska State Legislature has appropriation powers and this clause would, in effect, waive that authority.

It should be noted that the Attorney General's Office has advised OCS Director Tammy Sandoval and Heath & Social Services Commissioner Karleen Jackson not to agree to the Compact in its current form.

On On February 13th, Marcia Pickering from OCS sent us the final draft of the compact We are now reviewing the draft to see how the language has been altered to address our concerns about a compact between states superseding state law.

CHILD ADVOCACY CENTERS (CACs)

As mentioned earlier in this report, OCS and law enforcement agencies are now required by state law to use CACs in Alaska when available.[1] Most professionals recognize the advantages to using the centers for the sake of the children to be interviewed and for the sake of preserving important evidence in child abuse cases. While no firm numbers are available, the consensus is the centers do save the state money. One large factor in savings for prosecutors is evidence obtained through an interview at a CAC is more likely to cause someone charged with the crime to plea bargain. Senator Stevens has been providing funding for the CACs for the last five years through the Office of Juvenile Justice, but there will be no federal funding for the centers in FY'09. The department is asking for $2,423,500 in funding. There is $1,123,500 in federal dollars remaining to use in next years funding, which leaves a $1,300,000 gap for funding with general fund money.

Alaska Children's Alliance recently published the following charts showing the benefits of utilizing Child Advocacy Centers.

CAC Research – Crimes Against Children Research Center University of New Hampshire

1,000 cases of CSA studied at four CACs and four communities without CACs showed:

More coordination of interviews at CACs – more police involvement in cases

- **Children at CAC less fearful when interviewed**
- **Higher satisfaction among parents / caregivers when CAC used**
- **More referrals for mental health services through CACs**
- **More forensic medical exams when CAC used**

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[1] See pages 8 – 9.

Cost Benefit Analysis

Analysis done by the National Children's Advocacy Center

Use of CACs showed a cost savings of 36%, or $1,047 per case.

- **Without a CAC: $3,949**
- **With a CAC: $2,902**

COST SAVINGS

Community	FY 07 Children Seen	FY 07 Cost Savings	Total Children Seen Since CAC Open	TOTAL SAVINGS
Anchorage	722	$ 755,934	6,373	$ 6,672,531
Wasilla	152	$ 159,144	1,167	$ 1,221,849
Fairbanks	139	$ 145,533	521	$ 545,487
Juneau	100	$ 104,700	772	$ 808,284
Bethel	140	$ 146,580	674	$ 705,678
Dillingham	38	$ 39,786	115	$ 120,405
Nome	21	$ 21,987	130	$ 136,110
Kotzebue	28	$ 29,316	47	$ 49,209
Kenai Peninsula	37	$ 38,739	37	$ 38,739
TOTALS	1,377	$1,441,719	9,836	$10,298,292

GRIEVANCE PROCESS

Parents are still intimidated about filing grievances and continue to tell us they avoid filing a grievance because they are afraid of retaliation and making their chances of regaining custody of their children. OCS needs to educate parents on the grievance process and let them know there are legitimate reasons to file a grievance. The main reason for filing a grievance is to elevate the case to a higher level of decision –meaning when a parent believes a caseworker is making decisions which should be made at a higher supervisory level.

STRENGTHENING FAMILY PRESERVATION PROGRAMS

OCS should get high marks for starting from the first contact with a family to look at what has to be done to keep the child or the children in the home with the parents. While there are still differences of style in management by regions of Alaska, overall there is improvement in efforts to keep families united. Reductions in federal dollars for family preservation programs will continue to be a challenge for OCS.

The University Lake Multi-Disciplinary Center deserves mention as an improvement in family services for families where sexual or physical abuse has occurred. The consolidation of all the stakeholders in a CINA case will reduce trauma for the family, improve delivery of services to the family, and make it less likely that a family falls through the cracks while working with OCS.

TEN-YEAR HISTORY OF LEGISLATIVE REFORM OF OCS

21st Legislature - 1999 - 2000

FAMILY RIGHTS LEGISLATION 1999 – 2000

BILL	SHORT TITLE	PRIME SPONSOR	CURRENT STATUS
HB 34	REPORTING CRIMES AGAINST CHILDREN	DYSON	CHAPTER 62 SLA 99
HB 256	RECORDING OF INTERVIEWS WITH CHILDREN	COGHILL	(H) HES
HB 259	PUBLIC DEFENDER CHILDREN' PROCEEDINGS	COGHILL	CHAPTER 67 SLA 00
HB 269	VIDEOTAPING OF INTERVIEWS WITH CHILDREN	THERRIAULT	(H) HES
HB 288	CHILDREN WITNESSING DOMESTIC VIOLENCE	RLS BY KOTT	CHAPTER 67 SLA 00
HB 321	CONFIDENTIALITY OF CINA HEARINGS & RECORD	REQUEST OF THE GOVERNOR	(H) HES
HB 328	REPORTS RELATED TO CHILD IN NEED OF AID	COGHILL	(H) HES
HB 389	EDUCATIONAL NEGLECT FOR CINA PROCEEDINGS	BRICE	(H) HES
HB 409	GRANDPARENTS' RIGHTS REGARDING CINA	DYSON	(H) FIN
HB 413	INTENSIVE FAMILY PRESERVATION SERVICES	CISSNA	(H) FIN
SB 224	CONFIDENTIALITY OF CINA HEARINGS & RECORD	RLS BY REQUEST OF THE GOVERNOR	(S) JUD

HB 34 - REPORTING CRIMES AGAINST CHILDREN – Dyson

This legislation made it a class A misdemeanor for an adult to fail to come to the aid of a child or fail to report a violent crime against a child. Representative Dyson introduced the legislation because of a case that occurred in Nevada. A seven-year old child was molested and murdered in a casino restroom and a witness to the incident did not come to the aid of the child and, in fact, gave the murderer a ride back to California.

HB 256 & 269– RECORDING INTERVIEWS WITH CHILDREN – Coghill & Therriault

On January 10, 2000, HB 256 was introduced and required all official interviews with children who are alleged to have been abused or neglected to be videotaped. Because the Knowles Administration said the fiscal notes for the bill would be prohibitive, the bill never received a hearing. Fiscal notes in past legislation have been based on outdated videotaping methods. They have not taken into account new technology for videotaping, nor have they taken into consideration the savings to be realized by the State of Alaska. Representative Coghill argues mandatory videotaping would reduce numbers of interviews, reduce determinations of CINA cases, reduce costs for foster care and medical expenses, and reduce workloads for the attorney general's, public defender's, and Office of Public Advocacy's offices.

Reasons for mandatory videotaping:

- Reduces trauma to the child because the videotaped interview can be used in place of multiple interviews by social workers, school officials, guardian ad litems, attorney general's office and the public defender's office.

- The videotape will contain information that the judge can review at the 48-hour-hearing to determine if the child is in need of aid without subjecting the child to yet one more interview.

- Videotaping increases the quality of the interview because the interviewer knows his or her method of interviewing the child will be scrutinized by all parties

The Courts and the Attorney Generals working on CINA cases also saw several advantages to mandatory videotaping in CINA cases and believed such a requirement would benefit all parties in a CINA case, especially the victim.

Their reasons for wanting mandatory videotaping were numerous but the pluses echoed by all were the following:

- Once a child has been interviewed on videotape, it is harder for he or she to recant what was said. It is also easier for the court to determine if the child was manipulated into answering questions a certain way.

- Prosecutors claim a person accused of child abuse is more likely to confess if he or she views a videotaped interview.

- Expert witnesses can review the videotape and give testimony on their findings.

- Videotapes often refresh the victim's memory which may fade with time in cases where months or years pass before a case is tried.

Then Representative Gene Therriault also introduced a mandatory videotaping bill, HB 269, which received a hearing but was held in committee. Therriault's bill called for a pilot program in Fairbanks to see how mandatory videotaping would work. Representative Coghill kept the discussion and debate alive until the concept was passed in HB 53 in 2005.

HB 259 – PUBLIC DEFENDER CHILDREN'S PROCEEDINGS – Coghill

Previous to his time in the legislature Representative Coghill had worked with parents who had been entrenched in the process of DFYS removing children from their custody and found a pattern of helplessness on the part of those parents. When he introduced HB 259 in February of 2000, Representative Coghill proposed providing legal counsel to parents immediately when their child was placed in physical custody of the State and the parents were awaiting the 48-hour hearing at which the court determines whether probable cause exists to deem the child a "Child In Need of Assistance" (CINA).

Representative Coghill argued "when a child is removed from the family home, the effects can be traumatic; so much so that the parents are unaware of what has just happened, why it has happened, and what should be done next. The common situation is that the parents are distraught because their child has been removed by the state and feel intimidated by the judicial process for CINA determinations. They don't even know they can ask the judge for a continuance to seek legal advice."

The argument was made that this legislation will result in added expenses to the State, but Representative Coghill countered this legislation would actually reduce the cost of CINA cases in Alaska. He said that by providing all the information in a professional manner at the first hearing of determination, the number of children in state custody for 90 days to six months then returned to their family would be reduced. This meant a reduction in foster care, caseworker, and health care costs, as well as, long-term public defender, guardian ad litem, and AG expenses. Both Office of Public Advocacy (OPA) and the Public Defender submitted zero fiscal notes for the bill.

HB 259 amended the law that a person did not qualify for assistance from the public defender's office until indigence is determined. Parents were going to court not knowing their rights or the process because they can not find legal assistance in time for the 48-hour hearing. HB 259 as enacted allows any parent or guardian to get legal assistance from the Public Defender's office for the 48-hour CINA hearing regardless of whether or not they are indigent.

HB 288 – CHILDREN WITNESSING DOMESTIC VIOLENCE – Kott

This bill expanded the list of aggravating factors in mitigating the severity of the domestic violence crime and determining the sentence for the crime of domestic violence to protect the special vulnerability of children. Committing domestic violence in the presence of a child became a major factor in determining the severity of the crime and the resulting sentence.

HB 321 & SB 224 – CONFIDENTIALITY OF CINA HEARINGS & RECORDS - Governor

This bill was the first attempt by Department of Law to open CINA proceedings to the public under certain circumstances. The bill was the product of a special task force appointed by then Governor Tony Knowles to address concerns about accountability on the part of DFYS during a period of time when DFYS was receiving mass criticism about how they operated. The task force made three recommendations:

"(1) Court Proceedings. With limited exceptions, all proceedings involving child protection matters should be open. The exceptions are the initial proceeding should be closed, the subsequent proceeding would be closed if a party has not had the opportunity to obtain legal counsel, or a court could choose to close all or a part of a proceeding so far as necessary to protect the interest of the child. The court would be required to make a specific finding before the proceeding would be closed to avoid the situation of it becoming a blanket order in certain courts, that regardless of the statute, the matter would be closed.

(2) Court Records. Those records are today closed. For cases that would be prosecuted or pursued after the enactment of the statute, certain of those records would be made public, but others would remain closed. In essence there would be a confidential record in the court system as well as the public record. A member of the public or press would be able to see what the basic procedure is and what the basic controversy is, but such records as psychological reports would be kept confidential. Children will be better protected in an open atmosphere rather than a closed one.

(3) Agency Records. These records would continue to be closed; however, it would not preclude the publication of summaries of reports of harm. If the public wished to view how the state is doing its job, it would be pointed to the public court proceedings and to the records of the court system."

HB 321 narrowed down the task forces' recommendations and the bill opened records under three circumstances:

1. when there is a child fatality or near fatality[2];
2. for a fair comment proceeding when parents speak publicly about the case;
3. when there is a companion criminal case.

Representative Dyson thought the bill would require more deliberation than one session could provide, and the bill was not moved out of House HESS.

HB 328 – REPORTS RELATED TO CHILD IN NEED OF AID - Coghill

Also in 2000, Representative Coghill introduced his first attempt to establish accountability on the part of DFYS. This legislation made a state employee civilly liable to parents who are victims of false allegation for damages for defamation. The legislation also made a state employee convicted of inappropriately disclosing confidential CINA files guilty of a class B misdemeanor. The bill never received a hearing but opened up a six year debate over duties and standard of care by the state to both the children and the parents.

HB 389 – EDUCATIONAL NEGLECT FOR CINA PROCEEDINGS – Brice

This legislation would have made a child under 16 years of age whose parents knowingly violated the compulsory attendance statute a child in need of aid.

HB 409 – GRANDPARENTS' RIGHTS REGARDING CINA – Dyson

This bill had provisions that would require the grandparents to be notified of all proceedings that could lead to the termination of parental rights. This was the first bill to recognize that CINA proceedings need to recognize a CINA case involves the entire family, not just the parents. The bill was reintroduced by Dyson in 2001 and was passed into law that year.

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[2] Federal law already requires disclosure when there is a child fatality or near fatality.

HB 413 – INTENSIVE FAMILY PRESERVATION SERVICES - Cissna

This bill was Representative Cissna's first attempt to create an intensive intervention just before the removal of children from their parents into state custody. The proposal was based on a model, called Homebuilders, which has been successfully used by Washington State since 1974. In 2000, 30 other states had implemented the intensive family preservation model. Representative Cissna said the program is successful because, even though the family may have received similar services prior to the imminent removal of their children, the family is truly in crisis. At this juncture, families are searching for a way to safely keep their children at home. The bill laid out the program and steps that would be necessary to implement the proposal. Representative Cissna reintroduced the bill in 2001, but the bill failed to pass.

Since reorganization of DFYS to OCS in 2003 and with the appointment of Tammy Sandoval as head of OCS, intensive family preservation is a recognized practice.

22nd Legislature 2001 – 2002

FAMILY RIGHTS LEGISLATION 2001 - 2002

BILL	SHORT TITLE	PRIME SPONSOR(s)	CURRENT STATUS
HB 23	INTENSIVE FAMILY PRESERVATION SERVICES	CISSNA	(H) HES
HB 25	EDUCATIONAL NEGLECT FOR CINA PROCEEDINGS	HAYES	(H) HES
HB 164	GRANDPARENTS' RIGHTS REGARDING CINA	DYSON	CHAPTER 43 SLA 01
HB 252	CHILDREN IN NEED OF AID: SERVICES & LIAB.	COGHILL	(S) RLS
HB 261	TERMINATION OF PARENTAL RIGHTS	COGHILL	(H) HES
HB 280	VISITATION COST WHEN PARENT MOVES	DYSON	(H) HES
HB 301	NONCASH CONTIRBUTIONS FOR CHILD SUPPORT	COGHILL	(H) HES
HB 309	INTERSTATE PLACEMENT OF CHILDREN	CHENAULT	(H) HES
HB 465	CINA AND FOSTER CARE AMENDMENTS	CHENAULT	(H) HES
HB 469	CHILD AND FAMILY OMBUDSMAN	CHENAULT	(H) HES

HB 23 - INTENSIVE FAMILY PRESERVATION – Cissna

Representative Cissna reintroduced this bill to recognize that DFYS should first attempt to preserve the family before removing a child or children from the family. Language from this bill was added to HB 252, which died in Senate Rules the last day of session in 2002.

HB 25 – EDUCATIONAL NEGLECT FOR CINA PROCEEDINGS – Hayes

This legislation would have made a child under 16 years of age whose parents knowingly violated the compulsory attendance statute a child in need of aid.

HB 164 - GRANDPARENTS RIGHTS REGARDING CINA – Dyson

This bill passed in 2001 and enacted provisions that require the grandparents to be notified of all proceedings that could lead to the termination of parental rights. This was the first bill to recognize that CINA proceedings need to recognize a CINA case involves the entire family, not just the parents.

HB 252 - CHILD IN NEED OF AID: SERVICES AND LIABILITY – Coghill

This bill created a duty and standard of care for OCS caseworkers. It died in Senate Rules on the last day of the second session. While the bill ran out of time in the 22nd Legislature, the committee process brought the issue of duty and standard of care to a new level of awareness both on the part of legislators and people working for DFYS.

HB 261 - TERMINATION OF PARENTAL RIGHTS – Coghill

This legislation would have raised the standard for termination of parental rights to beyond a reasonable doubt from the existing standard of a preponderance of evidence. Such a change would have put all parents on an equal playing field and "beyond a reasonable doubt" is the standard for parents governed by the Indian Child Welfare Act. While the bill didn't pass, the discussion continued about how to draw a brighter line for civil actions based on accusations of wrongdoings that would be, if criminal charges were filed, judged at a higher standard.

HB 280 – VISITATION COST WHEN PARENT MOVES – Dyson

When the parent with primary physical custody of a child moves away from the other parent with joint legal custody of the child, visitation can be made difficult because of the travel expenses created for the other parent. This legislation would have allowed the court to issue a separate order for the parent with primary physical custody to pay travel expenses for the child to relocate for visitation if the move was fifty mile or more from the other parent.

HB 301 – NONCASH CONTRIBUTIONS FOR CHILD SUPPORT - Coghill

This legislation recognized the dignity of self-sacrifice in a parent providing for children even when cash is not available as there are other means of support outside cash payments. If a person can provide firewood, fish, labor or game meat that is significant support for family needs, this should be recognized as real child support.

HB 309 – INTERSTATE PLACEMENT OF CHILDREN – Chenault

This bill would have required original copies of court orders and custody orders to accompany a child being moved from one state to another under the Interstate Compact for Placement of Children (ICPC). It also imposed sentences and penalties for people who violate the ICPC with each day being a separate violation. An example given during testimony in committee on the bill was a child who was out of the state for 10 days in violation of ICPC. The parent who violated the law could have been sentenced to 1,800 days in jail and fined up to $10,000. The bill also required all ICPC agreements to be copied to the court file on the case.

HB 309 had two hearings in House HESS Committee but was not moved out of committee.

HB 465 – CINA AND FOSTER CARE AMENDMENTS – Chenault

This legislation required notice to grandparents of CINA proceedings including the possibility of termination of parental rights. It also prevented the State from using state or federal funds for medical treatment of a child in state custody the child is not otherwise eligible for such coverage from Indian Health Service or Medicaid. It also more clearly defined advance notice for proceedings to mean 10 days and made the disclosure of confidential information by a state employee in a CINA case a misdemeanor criminal offense. Lastly, the bill required to department to remove a child from a foster home and make placement with a relative if a relative is located. Many provisions of this bill were eventually enacted with HB 53.

HB 469 – CHILD AND FAMILY OMBUDSMAN – Chenault

This bill established a new office called the Office of the Child and Family Ombudsman within the legislative branch of state government to investigate complaints filed by children and families about OCS. The bill did not pass.

23rd Legislature 2003 - 2004

BILL	SHORT TITLE	PRIME SPONSOR(s)	CURRENT STATUS
HB 17	JURY TRIAL FOR ENDING PARENTAL RIGHTS	COGHILL	(H) JUD
HB 176	NONCASH CHILD SUPPORT	COGHILL	(H) FIN
HB 197	INTENSIVE FAMILY PRESERVATION SERVICES	CISSNA	(H) HES
HB 231	PARENTAL RIGHTS; SUPPORT ARREARAGES	HARRIS	(H) HES
HB 316	CHILDREN IN NEED OF AID: SERVICES & LIAB.	COGHILL	(H) HES
SB 288	TEMPORARY CHILD CUSTODY HRNGS/PLACEMENT	GREEN	CHAPTER 117 SLA 04

HB 17 – JURY TRIAL FOR ENDING PARENTAL RIGHTS – Coghill

Termination of Parental Rights proposed allowing parents the right to a jury trial and a day before their peers. The bill never received a hearing because of the fiscal impact of providing a jury for termination cases. In 2004, the Court System was receiving approximately 1,200 new CINA cases and 200 petitions to terminate parental rights annually.

HB 176 – NONCASH CONTRIBUTIONS FOR CHLD SUPPORT - Coghill

Rep. Coghill reintroduced his non cash child support bill in 2003. He was contacted by Tanana Chiefs Conference and informed they were going to implement a policy for noncash contributions with their enforcement of child support orders. They said they recognize that a person may be working hard to provide for their children even

though a cash payment is the only thing CSSD recognizes. One of the impediments to getting this legislation passed was concerns about how to place a value on noncash contributions and the unintended consequences to placing a value on things accumulated though subsistence activities.

HB 197 - INTENSIVE FAMILY PRESERVATION – Cissna

Representative Cissna reintroduced this bill in the 23rd legislature. She said she continues to believe children are being removed from their homes, placed in foster homes and not getting the services needed to be returned to their family.

HB 231 – TERMINATION OF PARENTAL RIGHTS FOR CHILD SUPPORT ARREARAGES – Harris

This bill would allow the custodial parent of a child who lives in Alaska to file an action to terminate the parental rights of a noncustodial parent if that parent is not in "substantial compliance" with the custody order. "Substantial compliance" would mean no arrearage, an arrearage in an amount not more than twelve times the monthly obligation, or the court has found the noncustodial parent "making the best efforts." The bill did not pass.

HB 316 – CHILD IN NEED OF AID: SERVICES AND LIABILITIES - Coghill

This piece of legislation drew huge resistance from the Department of Law. The bill included construction language that CINA laws "recognize that parents possess inherent, individual rights to direct and control the education and upbringing of their children". The section objected to by DOL was a new section of law, AS 47.10.961, Duty and standard of care regulation:

The department shall adopt regulations that establish the scope of the duty owed and the standard of care that must be met by the department's employees with regard to the children and families being served under this chapter. The regulations must be consistent in all relevant respects with the code of professional ethics and the standards of practice for social work adopted by the Board of Social Work Examiners under AS 08.95."

It was during the debate between Representative Coghill and the Department of Law on this legislation that he began to advocate for more training for social workers and more accountability for their actions.

SB 288 – TEMPORARY CHILD CUSTODY HEARINGS & PLACEMENT – Green

This bill was a housekeeping measure to capture more federal dollars to care for children placed in state custody. Current state law provides that the courts determine within 48 hours of removing a child whether or not it is "contrary to the welfare of the child to remain in the home of the parent." Varying language is used to express this, but if the judge does not say it is "contrary to the welfare of the child" the child would not be eligible for Title IV-E funding for the duration of the child's life in the system. Because the language is so critical, Senator Green decided to put in statute that it is "contrary to the welfare of the child to remain in the home of the parent." It is estimated that the State lost $500,000 in federal receipts in FY '05 because judges failed to use the correct terminology in their court orders. In 2004, when Green introduced the bill about 5% of the statewide cases under review did not use that language in the initial hearing and did not receive the funding. About 26% of cases in Anchorage did not qualify, even though the judges had received training. The bill passed and was enacted.

24th Legislature 2005 - 2006

BILL	SHORT TITLE	SPONSOR(s)	STATUS	DATE
HB 17	CINA; ADOPTION; FOSTER CARE	ROKEBERG, GATTO	(H) HES	01/10/05
HB 53	CHILDREN IN NEED OF AID/ADOPTION/GUARDIAN	COGHILL	CHAPTER 64 SLA 05	06/30/05
HB 112	CHILD PROTECTION INTERVIEW/TRANSPORT	RLS BY REQUEST OF THE GOVERNOR	(H) HES	01/26/05
HB 113	CHILD PROTECTION CONFIDENTIALITY	RLS BY REQUEST OF THE GOVERNOR	(H) HES	01/26/05
HB 114	TERM. PARENTAL RTS/CINA/DELINQUENCY CASES	RLS BY REQUEST OF THE GOVERNOR	(H) HES	03/23/05
HB 346	CHILD ABUSE INVESTIGATIONS	NEUMAN, LYNN	(H) JUD	04/06/06
HB 408	CHILD ABUSE AND NEGLECT/DISCLOSURE/PFDS	RLS BY REQUEST OF THE GOVERNOR	CHAPTER 20 SLA 06	05/03/06
SB 82	CHILD PROTECTION INTERVIEW/TRANSPORT	RLS BY REQUEST OF THE GOVERNOR	(S) JUD	02/18/05
SB 83	TERM. PARENTAL RTS/CINA/DELINQUENCY CASES	RLS BY REQUEST OF THE GOVERNOR	(S) RLS	02/28/05
SB 84	CHILD PROTECTION CONFIDENTIALITY	RLS BY REQUEST OF THE GOVERNOR	(S) FIN	03/04/05
SB 252	DEFINITION OF CHILD ABUSE AND NEGLECT	RLS BY REQUEST OF THE GOVERNOR	(S) JUD	02/09/06

The Twenty-Fourth Legislature was focused on OCS issues. A high profile case in the Mat-Su Valley put OCS on the front page of nearly every newspaper in the State and the legislature and the public were asking hard questions. While OCS wanted to tell their side of the story, Department of Law advised them that they couldn't disclose confidential information; therefore, the criticism of OCS went unanswered.

The Murkowski Administration had reorganized the Department of Health & Social Services, changed DFYS to OCS, elevated the director of OCS to a deputy commissioner position, and filed four pieces of legislation in the House and the Senate that would make changes to the way OCS did business. Representative Coghill was just one of several legislators, Representatives Rokeberg, Neuman, Lynn, Chenault, Harris, and McGuire, who introduced bills addressing concerns with OCS in 2005.

Representative Coghill organized a meeting with all the legislators working on legislation and the governor's office to discuss an omnibus bill that would address everyone's concerns without creating chaos in the system.. It was decided that HB 53 would be the bill used as the vehicle for an omnibus bill to make amendments to AS 47.10 CINA laws. The bill which included 67 sections of amendments to the CINA laws became know as the Family Rights Act.

Governor Murkowski's part of the legislation focused on confidentiality in child protection cases. This legislation improved transparency in the child protection system by allowing the Department of Health and Social Services Office of Children's Services to share information with the public about department actions in certain child abuse and neglect cases.

As a result of passage of HB 53, two key areas changed in the child protection confidentiality statutes:

- CINA court hearings would be open to the public except in certain circumstances. Before HB 53, these hearings were closed to the public.
- OCS would be able to publicly respond to inquiries surrounding child abuse and neglect cases, disclosing agency actions in CINA proceedings under three circumstances, if:
    - a parent has discussed their OCS case with the media,
    - an alleged perpetrator has been charged with a crime relating to the abuse or neglect of a child under their care, or
    - a report of harm has resulted in the fatality or near fatality of a child.

Other changes House Bill 53 made in CINA law include:

CREATES A DUTY AND STANDARD OF CARE

The bill eliminated from the law language that implies there is no duty and standard of care for social workers making decisions for children in state custody. Representative Coghill believed the Alaska Supreme Court's ruling in *Karen L. v Alaska DFYS*, 953 P.2d 871 (Alaska 1998) did create a duty to children in state custody and believed there is a civil liability for wrongdoing. He introduced his first bill to accomplish this in 1999. (Sec. 29) Coghill

In an effort to establish a duty and standard of care, Representative Coghill said "to protect vulnerable children the government requires parents to raise their children by certain standards, and I believe government should be held to those high standards when they take children into their custody. Dealing with the Office of Children's Services should have good due process and should be transparent so that everyone involved knows what the rules are and what is required of them."

STRENGTHENS FAMILIES

HB 53 also strengthens the rights of adult family members (including grandparents), especially those who have already been instrumental in raising the child. Many times when parents run awry of OCS, grandparents or other adult relatives get placement of the child. If parental rights are terminated, those raising the child should have preference for adoption. (Sec. 3) Coghill

Other relatives or family friends should also be considered for placement before a child is placed with a stranger. Other adult family members and grandparents also gain accessibility to information and hearings in CINA cases through this legislation. (Sec. 10) Governor

It provides for the least restrictive placement in close proximity of the parents for reunification purposes. The preference for placement is: (Sec. 33) Coghill

1. an adult family member
2. a family friend
3. a licensed foster home
4. an institution

It requires OCS to do everything possible to provide parental and family visitation for children, and if OCS denies visitation they must provide a reason. The family members will be informed of their right to a hearing if denied. (Sec. 13) Rokeberg

It establishes that poverty is not a reason to deny placement with relatives. (Sec. 37) Department of Law Amendment

It established that parental rights cannot be terminated solely on the basis that the parent did not get treatment if the treatment was not available and OCS did not provide treatment. (Sec. 14) Coghill

The bill encouraged OCS to provide the training for foster parents to become mentors to encourage family reunification without placing foster homes at risk. (Sec. 14) Coghill

HB 53 amended the definition of "major medical treatment to include medication used to treat a diagnosed mental health disorder." (Sec. 15) Governor

MAKE THE PROCESS TRANSPARENT

The bill creates a transparent process by making previously unavailable confidential information available to certain people and making court proceedings open to the public. (Sec. 9) Governor

There are sideboards for such proceedings: (Sec. 10)Governor

1. If a child could be stigmatized or emotionally damaged

2. If it would interfere with a criminal investigation

3. If disclosure would violate state or federal law

When a person attends a CINA hearing the court issues an order for confidentiality outlining what information can be revealed to the public and what the sidebars are. The Finance Committee strengthened sanctions if a person violates the court order. Now those persons are subject to sanctions that include being barred from any future CINA proceedings regardless of who the parties are. (Sec. 10) Governor

A grievance process is established in law and the department is required to provide to each parent a copy of the grievance procedures. (Sec. 28) Coghill

Fred Van Wallinga from Citizens Review

An additional safeguard to transparency and due process is the establishment of a state review panel that will adopt policies and procedures by regulation, compile reports, report to the governor annually, and conduct hearings on complaints filed against OCS. The panel is subject to the Open Meetings Act and will have the ability to meet in executive session. (Sec. 38 – 44) Coghill

VIDEOTAPING & CHILD ADVOCACY CENTERS

HB 53 encourages the use of Child Advocacy Centers (CAC) in areas they are available and requires audio recordings for all other interviews of children believed to be children in need of aid (CINA). This creates accountability in interviewing and protects the child from multiple interrogations. It requires mandatory videotaping of suspected victims of sexual abuse. (Sec. 49) Coghill

The bill defines Child Advocacy Centers in state statute. The definition is language agreed upon by the Department of Law, OCS, and the Child Advocacy Centers. (Sec. 49) Coghill

Established criteria for schools to follow when a child is to be interviewed and directs OCS to work with law enforcement and schools in establishing procedures for interviewing. (Sec. 26) Governor

Provides that the videotape of a sexual abuse interview of a minor under the age of sixteen can be admissible evidence in a criminal case if the witness is available for cross examination. (Hollis French Amendment on the floor of the Senate)

RESPONSIVE TO THE PUBLIC

It requires OCS to within 20 days respond to a voluntary reporter whether or not OCS has opened a case. (Sec. 47) Rokeberg

Requires OCS to work with legislative offices and the Ombudsman's Office when dealing with constituent cases. (Sec. 20) Rokeberg

Provides that legislative offices can remain a non-party participant of a case even when the parental rights have been terminated. (Sec. 21) Coghill

In 2006, OCS came to Representative Coghill to carry House Bill 408 which was a catch all for some final tweaks to AS 47.10.

In an effort to ensure that more parents are receiving family support services, OCS must now provide to the court "clear and convincing evidence" that the parent should not receive those services.

1. Parent has subjected child to substantial risk through abandonment, sexual abuse, torture, chronic physical or mental injury;
2. Committed, abetted, attempted, conspired or solicited homicide
3. Felony assault that results in injury of a child;
4. Failed to comply with a court order in a twelve month period

HB 408 raised the bar from preponderance of evidence to "clear and convincing evidence" to terminate parental rights. This was retroactively applied to CINA cases pending before the court, on appeal, and for which the time of appeal has not expired on the day the bill became law.

Language from Representative Chenault's HB 327 was added to HB 408. It requires departments to respond to inquiries from public officials within five working lays.

A Coghill amendment clarified that once one of the three triggers for OCS to publicly discuss a ROH, OCS has the flexibility to disclose confidential information on all reports of harm in the family's history with OCS.

The bill preserves Permanent Fund Dividends applied for and placed in a trust by OCS for children in state custody. The PFD's remain in the trust until the child turns 18, the child is returned to biological parents or the child is adopted. The only other way the money can be released is if a court determines a guar 'ian has a legitimate use of the funds. This law was changed as a result of a guardian in Representative Coghill's district getting several years of PFD's for two children and the placement did not work out.

Finally, the bill requires health care providers to report children they suspect are adversely affected by a controlled substance or alcohol and clarifies controlled substance does not include prescribed medication.

25th Legislature 2007 - 2008

Letting the administration get its hands around the family rights reforms of 2005 and 2006, the legislature took a hiatus from Title 47.10 in 2007. Legislators did work on funding for increased numbers of frontline workers, more training funds, and getting ORCA to the stage of benefit for everyone.

This year Representative Coghill will be introducing a piece of legislation for OCS. The legislation transfers from the commissioner to the department the authority to adopt regulations to determine the amount and duration of subsidy payments for hard-to-place children. The bill also provides to OCS the same ability to get support changes orders as parents by adding administrative orders as an option to going to court for a change of order. Lastly, the bill clarifies that if a state employee of public officials discloses confidential or privileged information provided to them under AS 47.10.092 that person could be found guilty of a misdemeanor, could be fined $500 and could serve not more than one year of imprisonment.

FUNDING INFORMATION FROM FY '06 - PRESENT

FY '06 BUDGET INCREMENTS FOR INCREASES:

Frontline workers increase GGU	$ 943,500
Training for front line staff	$ 409,200
ORCA maintenance & help desk support	$ 591,900
Bargaining Unit Contracts	$ 2,080,900
3 new PCNs	$ 177,200
Retirement Systems Increases	$ 95,600
Family Preservation Funding	$ 1,351,000
Front line worker expansion	$ 4,613,700
Subsidized adoptions	$ 1,978,700
TOTAL INCREASES FY '06	$12,241,700

Reductions in funding in FY '06:

Foster care base rate	76,600
Foster care special needs	460,000

FY 07 BUDGET INCREMENTS FOR INCREASES:

Bring the Kids Home Expand Behavioral Rehabilitation Services	$ 2,500,000
Medicaid Behavioral Rehabilitative Services Rate Increase to fully reimburse providers for Kids in Custody	$ 2,214,000
Medicaid Behavioral Rehabilitative Services Rate Increase for Non-Custody Kids	$ 580,000
Continue FY 06 enhance training capacity for front line workers	$ 409,200
Wage and benefit increases for frontline workers	$ 2,620,800
Wage and benefit increases for children's services management	$ 189,500
Other wage and benefit increases	$ 78,900
Citizen's Review Panel operating costs	$ 35,700
TOTAL FY '07 INCREASES	$ 8,628,300

FY '07 Increases requested OCS but not funded:

ORCA upgrade	750,000
BTKH gate keeping committee	200,000
Enhanced post adoptive services especially in rural areas	230,000
Expand contracts with Catholic Social Services & Fairbanks Counseling and Adoption	147,300
TOTAL	$ 1,327,300

FY '07 Loss of Revenues:

Loss of MHTAAR funding for OCS Parental Support Services	**$ 150,000**

FY '08 BUDGET INCREMENTS FOR INCREASES:

Replace federal dollars for front line workers	$ 1,872,600
Replace federal dollars for Children's Services Management	$ 652,100
Replace federal funding for Children's Services training	$ 223,600
Replace federal funding for Family preservation	$ 650,000
Replace federal funding for foster care special needs	$ 341,000
Replace federal funding for residential child care	$ 105,500
Increase Early Childhood Comprehensive System Grants	$ 100,000
Increase Behavior Intervention and Supports Early Childhood	$ 80,000
TOTAL – FY '08 INCREASES	**$ 4,024,800**

FY '09 BUDGET INCREMENTS FOR INCREASES:

FMAP Increases - GF	$	355,600
Basic Training and Development - $369.1 GF	$	427,000
Implement Front line worker recommendations - $600.0 GF	$	860,900
Replaces federal dollars for Private Proshare Refinancing-Family Preserve	$	322,400
Transfer of Proshare GF from Health Care Services to OCS	$	76,900
Child Advocacy Centers – replace federal dollars - GF	$	1,488,200
Foster parent and parent srvcs: recruit, train, support - $75.0 GF/$75 MH	$	150,000
IV-E Federal participation foster care base rate change – GF replace	$	57,100
Increase receipt support services for CSSD collection - RSS	$	600,000
IV-E Foster Care Augmented Rate change – GF replace	$	7,700
Increase child care benefits for CPS – I/A	$	1,295,100
IV-E Special Needs Fed participation change – GF replace	$	13,700
Increase legal fees for adoption – GF	$	277,500
IV-E Residential Child Care fed participation change – GF	$	12,200
MH Trust: Behavior Intervention and support-early childhood system	$	80,000
MH Trust: Early Childhood comprehensive grant system grants	$	75,000
MH Trust: Early childhood mental health learning network & coordinator - $ 100.0 GF/MH and $ 100.0 MHTAAR funds	$	200,000
TOTAL FY'09 INCREMENT INCREASES	**$**	**6,299,300**

FY '09 FUNDING TRANSFERS

Transfer out permanency funding to subsidized adoptions-legal services	$	227,500

FY '08 SUPPLEMENTAL REQUEST:

Foster Care Base Rate due to increased Protective Services Reports	$	656,300
Foster Care Special Needs Funding – 240 additional children	$	622,800

ALLEGATIONS

	Mental Injury	Neglect	Physical Abuse	Sexual Abuse	Unknown	Total
Nov 2007	227	1,271	299	151	1	1,949
Nov 2006	355	1,115	287	181	0	1,938
Nov 2005	349	974	331	157	0	1,811

A Protective Services Report may contain one or more allegations of child abuse or neglect. The table above shows the number of allegations in the PS reports counted by the type of harm alleged. Total PS reports in Nov. 2007 - 892; Nov. 2006 - 915; and Nov. 2005 - 823.

ASSESSMENT COMPLETED

	Substantiated	Not Substantiated	Closed without finding	Total
Nov 2007	154	227	53	434
Nov 2006	183	260	31	474
Nov 2005	199	212	27	438

Substantiated: the available facts indicate the child was abused or neglected;

Not substantiated: based on the available facts, OCS is unable to determine if a child was abused or neglected, or there are no facts to support the allegation of child abuse or neglect;

Closed without finding: no determination made because, for example, the family cannot be located.

Source of charts: http://hss.state.ak.us/ocs/Statistics/default.htm

RECORDS CERTIFICATION

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Stan Hubbard
Signature of Camera Operator

5-29-2009
Date

Certification Rev 7/98

2/21/08 PRESENTA-TION: CIVIC EDUCATION TASK FORCE FINAL REPORT

CITIZEN'S ADVISORY TASK FORCE ON CIVICS EDUCATION POLICY

A Task Force established by the Alaska State Legislature

Mary Bristol, Chair
3305 Glenn Don Anchorage, AK 99504
907-333-6725 akbristol@gci.net

Senator Lyda Green
President of the Senate
Alaska State Legislature
State Capitol, Room 111
Juneau, AK 99801-1182

Rep. John Harris
Speaker of the House
Alaska State Legislature
State Capitol, Room 208
Juneau, AK 99801-1182

Dear President Green and Speaker Harris:

I'm pleased to present to you the enclosed *Final Report & Recommendations* of the Alaska Legislature's Citizen's Advisory Task Force on Civics Education Policy. As you know, the legislature established the task force last year to recommend ways to strengthen civic education for young people in our state, by reviewing content standards, curricula and professional development strategies. The task force was also charged with exploring ways to implement the recommendations of the Alaska Civic Learning Assessment [ACLA] Project, which were contained in the 2006 ACLA report, *Advancing Civic Learning in Alaska's Schools.* This report represents the culmination of several months of effort by task force members to identify practical, feasible and cost-effective steps for achieving these goals.

As a group of diverse educators, elected officials, civic leaders, students, and members of the legal community, task force members recognize that "(f)ailure to educate young people about the principles on which our government is founded poses a serious threat to the institutions they will inherit." Schools play a vital role in ensuring that this education takes place. However, schools carry a heavy burden already and cannot be expected to shoulder responsibility for civic learning alone. Notably, the task force does not recommend the adoption of mandatory curricula or testing for civics at this time. Instead, the consensus of the group is that greater coordination, creativity and support for civic learning at a statewide level has a better chance of fostering real improvement than more requirements placed on schools.

Accordingly, our recommendations envision a two-prong approach to fostering civic education. The first would address civics standards, curricula, professional development and other factors directly related to schools by creating and funding a Coordinator for Civic Learning in the Department of Education and Early Development. The second would address the broader government and