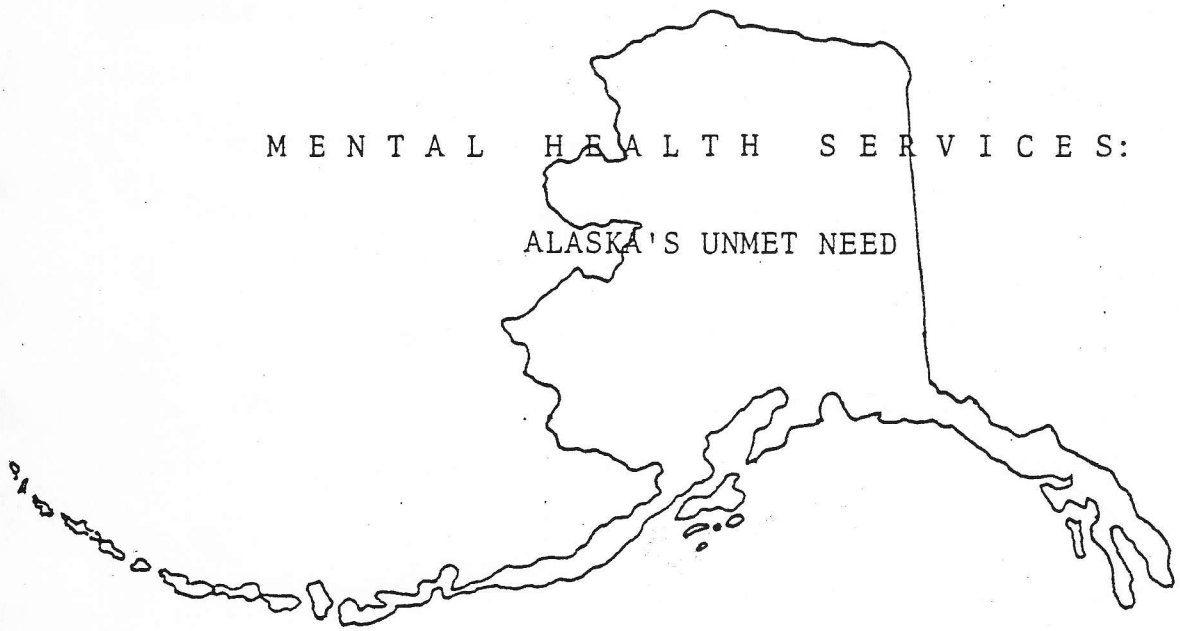
MENTAL HEALTH SERVICES:

ALASKA'S UNMET NEED



ALASKA MENTAL HEALTH ASSOCIATION

Fred Selkregg, President
Natalie Gottstein, Executive Director

CONTENTS

INTRODUCTION

In the past year alone, among numbers of acts of violence, three tragic events have impressed upon the Mental Health Association the need to speak out about the necessity to take some positive action. The lives of three people were needlessly lost.

A young woman, after several brief hospitalizations, committed suicide.

A young man with over ten admissions to the Alaska Psychiatric Institute was discharged because he needed less restrictive care murdered another young man while finding temporary shelter in a board and care facility.

The father of a young man with chronic mental illness of several years duration killed himself after an argument with his son.

These are just three of the many tragedies which are reported yearly by the press and which are indicative of the pressing need for the provision of services for a particularly vulnerable segment of the Alaskan population.

Mental health services in Alaska are grossly inadequate. In an effort to publicize the extent and the seriousness of the problem, the Alaska Mental Health Association, relying entirely on volunteer assistance, is publishing this document. We hope that these facts, which have been derived from a survey of key providers in the state, the 1980 Mental Health Annual Report, personal interviews, and other sources, will help to focus attention on this grave problem.

The Mental Health Association has for several years urged Alaska's representatives and administrations to meet its obligation to the mentally ill of our state. We feel this can best be accomplished by honoring the Mental Health Lands Trust obligation and through long

term planning. We trust this document will serve to inform government officials, as well as the public, that "necessary" mental health services for the people of Alaska are not being provided, nor has a determination of what those "necessary" services would include been made.

We hope that this document will stimulate the action needed to assess the problem, plan for its solution, and fund the necessary steps so that Alaska can have the kind of mental health program her people deserve.

Throughout the many years of Alaska's Territorial status, there were virtually no mental health programs available for the population. When an individual became mentally ill to the point of being either a public menace or a nuisance, he/she was apprehended and shipped to the Morningside Hospital in Portland, Oregon, for treatment under a contractural arrangement between the U.S. Department of the Interior and the hospital.

In 1956, prior to statehood, the citizens of Alaska petitioned the federal government for support in establishing programs for the mentally ill in Alaska. The federal government was generous and responded with a grant to build the Alaska Psychiatric Institute, a modern, 200 bed hospital for the mentally ill. In addition, the Territory was granted the privilege of selecting a million acres of land to be managed as a public trust. The income from this trust was to have been used to support the necessary expenses of the mental health program. Although the provisions of this trust were never honored (see appendix I), or perhaps even understood, some steps were taken to develop mental health services in Alaska.

The Division of Mental Health was established in 1957 as a function of the Department of Health and Social Services. A small, state operated mental health clinic was opened in 1959 and the Alaska Psychiatric Institute was constructed in 1962. 1963 was the year a federally funded statewide study to determine the need for mental health services was conducted and, as a result, additional outpatient mental health programs were initiated in Kodiak, Juneau, Ketchikan and Fairbanks.

In the early 1970's, serious problems began to emerge. The Alaska Psychiatric Institute was faced with a severe shortage of

qualified psychiatrists. The Division of Mental Health had had a series of short tenured Directors. The outpatient programs were understaffed and were serving impossibly large catchment areas. Salaries were inadequate and management and organizational problems abounded. The crisis was precipitated in 1972 when the state of Indiana refused to provide care for Alaska's mentally disordered offenders. The Alaska Psychiatric Institute was refusing admissions to many patients and the Commissioner of Health and Social Services appeared before an Anchorage Superior Court Judge to offer an explanation.

By 1973, the situation was untenable. A new Director of the Division of Mental Health was hired and sufficient financial and administrative support was made available to improve conditions. The Alaska Psychiatric Institute was developing as an active treatment facility with a full complement of psychiatrists. The Community Mental Health Enabling Act was enacted in 1975 and most of the 22 mental health planning districts in Alaska were funded for the development of community mental health services between 1975 and 1978. The Anchorage Community Mental Health Center was established in 1975 and was awarded a federal grant enabling the provision of services to the Anchorage/Mat-Su catchment area.

Although a statewide mental health system was beginning to emerge, much remained to be accomplished. However, the momentum started to diminish in 1979 when the Governor vetoed an expansion in delivery of community mental health services. Even as the Alaska Psychiatric Insitute continued to improve the quality of its services while it shortened the patients' length of stay, the admission rate continued to climb. Despite the cooperation between the Anchorage Community Mental Health Center and the Alaska Psychiatric Institute

to improve aftercare services, the number of clients requiring care gradually outstripped the supply of services.

Alaska adopted a new civil commitment code in 1981 which provided for a greater protection of patients' rights but which has also led to a marked increase in commitments to A.P.I. Notwithstanding the obvious need for alternatives to hospitalization to prevent unnecessary involuntary commitments, few if any, programs evolved.

A clear need has existed for private psychiatric hospital services in Anchorage for years, but Providence Hospital and Alaska Hospital have been reluctant to meet the need. Providence Hospital has designated an 11 bed unit for "medical-surgical patients needing psychiatric treatment" since 1977. The unit has been filled to capacity almost constantly for several years. The Southeast Regional Health Systems Agency Health Plan projects the need for 16 private acute psychiatric beds by 1990, a figure considered extremely conservative by psychiatrists in the private sector.

Although many chronic mental patients live within the state, there are no half-way houses for the mentally ill, no sheltered workshops, no intermediate care facilities, and only a handful of "board and care" private providers in Anchorage. The Division of Adult Protective Services developed a licensing procedure in 1978 for those establishments offering board and care for people requiring extended services. They conceived of several levels of services to the chronically mentally ill: Level I for those individuals needing relatively little supervision; Level II for those requiring more care and supervision, etc. It is no secret that not one Level II care facility is available in the State of Alaska. Persons needing this level are either retained at A.P.I. or place in Level I programs. The inadequacies of aftercare services and alternatives to institu-

tional care is evidenced by the fact that nearly 50 per cent of the readmissions to A.P.I. have been out of the hospital less than six months.

It is common knowledge to professionals working in the field in Alaska and to the families who have mentally ill family members, that a crisis is imminent. Mental health services are inadequate and no efforts are being made to improve the situation. In fact, the Governor has recently recommended an $800,000.00 reduction in the mental health budget, which will lead to the closure of some community mental health programs.

Even more alarming is the fact that neither the legislature nor the administration seems to recognize the seriousness of the situation. The "Mental Health Annual Report" has not been published since 1980. The results of seven years of community mental health program development have not been evaluated. The mental health needs of Alaska have not been assessed since 1973, when a legislative Interim Committee studied the problem.

FINDING: THERE IS A RAPIDLY EXPANDING NEED FOR INPATIENT PSYCHIATRIC TREATMENT.

The population of the state is growing at an astonishing rate and individuals who are in a transient status are especially at risk of developing mental illness. From March, 1981, to March, 1982, 126 patients were admitted to A.P.I. who had been residents of the state less than six months and 37 of them had been in the state less than one month.

The number of admissions to A.P.I. has increased at an annual rate in excess of five per cent. Admissions to the institution have doubled since 1974.

FINDING: AT PRESENT, ALL PUBLIC AND PRIVATE PSYCHIATRIC INPATIENT BEDS ARE BEING USED TO CAPACITY.

A.P.I.'s average daily census has soared to 93% of capacity. The increase in admissions was accommodated by A.P.I. by an increase in overall efficiency which resulted in the average length of stay being shortened from 60 days in 1973 to 30 days in 1979. This reduced length of stay has now plateaued, consequently, as the admissions rise, the facility will fill and then overflow.

The Providence Hospital Psychiatric Unit has operated at over 90% capacity for the last two years. In addition, many additional psychiatric patients are treated on medical-surgical units.

FINDING: A SIGNIFICANT PROPORTION OF ADMISSIONS FOR INPATIENT CARE RESULT FROM THE INADEQUACY OF AFTERCARE SERVICES AND THE ALMOST TOTAL LACK OF PROGRAMS WHICH PROVIDE ALTERNATIVES TO HOSPITAL CARE.

According to the 1980 "Mental Health Annual Report", 52.1 per cent of all admissions to A.P.I. were readmissions and four point six per cent of all the admissions to the hospital had been hospi-

talized at least ten times. Among the readmissions, 65.5 per cent were returned to the hospital within one year of their discharge and a startling 37.9 per cent of the readmissions occurred within a three month period following discharge.

FINDING: THE DEARTH OF MENTAL HEALTH SERVICES AND ADEQUATE MEDICAL SERVICES IN THE CORRECTIONAL SYSTEM RESULTS IN A LARGE PERCENTAGE OF ADMISSIONS TO A.P.I.

The 1980 "Mental Health Annual Report" shows that 32.7 per cent of the total admissions to A.P.I. came from the correctional system. Most of these patients were admitted for evaluations and/or treatment. The demand for these services became so high in 1982 that the judges and corrections system were requested to find other sources of care for these patients.

FINDING: THE NEED FOR BOTH PUBLIC AND PRIVATE INPATIENT SERVICES HAS NOT BEEN SYSTEMATICALLY ASSESSED AND PLANNING TO MEET THESE NEEDS IS FRAGMENTED.

The recent Southeast Regional Health Systems Agency health plan estimates the current need for additional inpatient beds to be 11, with a projected expansion to 16 by 1990. The State Division of Mental Health capital improvement budget forecasts the need for a 40-bed children's/adolescent unit to be constructed by 1984 as well as 40 additional adult beds to be completed in 1985. The Providence Hospital construction plan envisions an expansion of only nine acute psychiatric beds by 1990.

FINDING: NO AGENCY HAS EVEN ATTEMPTED TO EVALUATE THE NEED FOR LESSER LEVELS OF CARE THAN HOSPITALIZATION, AND NONE HAS CONSIDERED THE IMPACT OF SUCH SERVICES ON THEIR PROJECTED NEED FOR INPATIENT EXPANSION.

A number of states (California, Oregon, etc.) have recognized the importance of several levels of care which ranges from 24-hour hospitalization to infrequent outpatient visits. It is well known

that the absence of any one of any of these levels of care can have adverse effects upon other programs within the same system.

FINDING: ALTHOUGH THE EFFECTIVENESS OF THE REVISED STATE INVOLUNTARY COMMITMENT STATUTE DEPENDS UPON THE DESIGNATION OF REGIONAL MEDICAL HOSPITALS AS "EVALUATION FACILITIES", NO LOCAL HOSPITAL HAS ACCEPTED THAT DESIGNATION.

Alaska's sparse population and remote communities necessitates, if good medical care is to be given, that persons with mental disorders who need involuntary treatment should be evaluated as close as possible to their home communities. Although Alaska's new commitment statute provides for local evaluation, none of the hospitals has accepted this responsibility - in part because the incentives are inadequate and because continued state support is not assured.

FINDING: A DISPROPORTIONATELY HIGH PERCENTAGE OF THE ADMISSIONS TO THE ALASKA PSYCHIATRIC INSTITUTE WERE ALASKA NATIVES (32.7%).

The Alaska natives represent less than 32.7 per cent of the population of the state and the reasons for the high percentage of hospitalizations is unclear. Compounding the problem for the individual native and the system as a whole is the well known fact that once a native is sent from his home community for psychiatric treatment, he has a difficult time returning. These patients become disenfranchized from their home communities and tend to congregate in the larger cities. This same pattern is evident with the caucasian mentally ill. The inadequacies of services for both of these groups is exacerbated by the language problems and the unmet cultural needs of the native who is chronically mentally ill.

FINDING: THE ALASKA PSYCHIATRIC INSTITUTE HAS HAD PROBLEMS RECENTLY IN RECRUITING AND KEEPING WELL QUALIFIED PSYCHIATRISTS.

There may be many explanations for this problem. But it is obvious that the current high level of admissions (especially at

night and on the weekends), and the dramatic increase in salaries in the lower 48 states have resulted in employment in Alaska becoming less attractive for well qualified psychiatrists.

FINDINGS: COMMUNITY MENTAL HEALTH SERVICES

FINDING: THE MENTAL HEALTH ASSOCIATION 1982 SURVEY INDICATES AN ADDITIONAL 37.75 MILLION DOLLARS IN MENTAL HEALTH SERVICES IS REQUIRED TO FUND THE LEVEL OF PROGRAMMING NECESSARY TO MEET CURRENT NEEDS.

In March, 1982, the Alaska Mental Health Association surveyed the program directors and advisory board presidents in all 22 mental health districts in Alaska (see appendix II). Although one area reported that their services were adequate, most ackowledged there were numerous deficiencies in service delivery capabilities.

FINDING: A COMPREHENSIVE ASSESSMENT OF THE NEED FOR MENTAL HEALTH SERVICES FOR CHILDREN AND ADOLESCENTS HAS NEVER BEEN CONDUCTED.

In 1981, a Task Force studied the needs of severely emotionally disturbed children but did not attempt to study the overall problem. Incidentally, the study concluded that there were numerous gaps in service and some serious deficiencies which have resulted in many of Alaska's youth being placed out of state to receive treatment.

FINDING: OUTPATIENT MENTAL HEALTH SERVICES NEED TO BE EXPANDED TO PROVIDE SPECIALIZED SERVICES TO CHILDREN, ADOLESCENTS AND FAMILIES.

The survey indicates that 22 of the 24 respondents listed these services as needed. Although many small mental health clinics can provide a range of basic adult services, it is very difficult for one or two professionsal, who may not have had special training, to also provide specialized services to children and adolescents.

FINDING: COMMUNITY MENTAL HEALTH SERVICES FOR CHILDREN AND ADOLESCENTS ARE GENERALLY INADEQUATE.

In recent months, the Division of Family and Children's Services has limited its help to only those children who were abused or neglected. When young people are emotionally disturbed and need out

of home placement, there is frequently nothing available. The lack of a spectrum of services for children and adolescents which includes half-way houses, residential treatment programs for all ages, day treatment programs, is felt in all areas of Alaska. Our survey revealed that 14 planning districts identify these services as a priority at an estimated expenditure of $13,835,000.00 on a yearly basis.

FINDING: ALASKA'S MENTAL HEALTH SYSTEM PROVIDES ALMOST NO ALTERNATIVES TO INSTITUTIONAL CARE FOR THE CHRONICALLY MENTALLY ILL.

The only organized effort provide aftercare services to the ex-hospital patient is in Anchorage and it is grossly inadequate. No residential alternatives to board and care facilities exist. No sheltered workshop provides for ongoing employment. (A sheltered workshop is available for evaluation and training, but obviously not everyone will become skilled enough to compete in the open job market.) One day treatment program is in operation for a small number of clients. Outside of Anchorage, some outpatient aftercare services are provided, but no programs specifically for that purpose exist. Our survey revealed that 16 planning districts identified alternatives to institutional care in their districts as a necessary service, with an estimated annual cost of $23,915,000.00.

FINDING: NO LEVEL II ADULT CARE FACILITIES ARE AVAILABLE IN THE STATE OF ALASKA FOR THE CHRONIC DISABLED MENTALLY ILL.

Mental disease is an extemely chronic and disabling illness. It can be estimated that 25 per cent of those patients suffering a major mental disorder will be disabled for the rest of their lives. Many of these patients require long term, intermediate levels of care to assure them health and safety. It is obvious that a large number (50 to 100 in the Anchorage area alone) are not receiving care appropriate to their needs. Some of these patients are being treated in more expen-

sive levels of care and some in levels which do not provide adequate care and supervision.

FINDING: THE COMMUNITY MENTAL HEALTH PROGRAMS ESTABLISHED IN THE BUSH HAVE ENCOUNTERED SPECIAL PROBLEMS.

The bush mental health programs have been characterized by a rapid turnover of professional personnel, frustration with traditional service methodologies, and poor efficiency due to itinerant service delivery. Most of these programs have relied, to some extent, on para-professional personnel and have operated with inadequate medical support. The nature and extent of these difficulties was recently conceptualized in a paper presented by the Bush Mental Health Program Directors to the Mental Health Advisory Board and in several articles in the Winter issue of COPING. In spite of these known difficulties, no specialized training or orientation is provided people working in the bush and no program to train mental health para-professionals has been offered.

RECOMMENDATIONS

I: THE STATE OF ALASKA SHOULD ESTABLISH AND ANNUAL PROCESS FOR DETERMINING THE MENTAL HEALTH NEEDS OF ITS RESIDENTS.

Alaska's mental health system has experienced periods of feast and famine. This results from a funding process which is largely determined by political rather than management considerations. This erratic process continues in spite of the fact that Public Law 830, the federal law which granted Alaska one million acres of land to help support the mental health program, requires the state to determine the "necessary" costs of the program.

II: THE STATE OF ALASKA SHOULD HONOR THE TRUST OBLIGATION IN PUBLIC LAW 830 AND PROVIDE SUFFICIENT FUNDING FOR THE NECESSARY MENTAL HEALTH PROGRAMS.

Alaska's founding fathers were far sighted and recognized the obligation to provide a funding base for mental health services. Mental health services, when provided in a timely manner, can contribute significantly to the stability and strength of the citizenry.

III: THE STATE OF ALASKA SHOULD PROVIDE RESOURCES FOR PLANNING FOR MENTAL HEALTH SERVICES.

A state plan for the development of the necessary mental health services based on an adequate assessment of needs does not presently exist. The program cannot be expected to move forward without a plan which sets priorities and has a broad base of community support.

IV: STEPS SHOULD BE TAKEN IMMEDIATELY TO STRENGTHEN THE PROGRAM AT THE ALASKA PSYCHIATRIC INSTITUTE TO MAINTAIN THE QUALITY OF SERVICES AT ALASKA'S ONLY PUBLIC MENTAL HOSPITAL.

The Alaska Psychiatric Institute is the only hospital in the state which can accept involuntarily committed patients. The growth in population of the state, the lack of alternative services, and the new commitment law have all led to a high admission rate and

serious overcrowding.

V: THE DEVELOPMENT OF A COMMUNITY BASED SYSTEM OF "ALTERNATIVES TO INSTITUTIONAL CARE", INCLUDING HALF-WAY HOUSES, SHELTERED WORKSHOPS, SOCIAL ACTIVITY CENTERS, AND INTERMEDIATE CARE FACILITIES FOR THE CHRONIC MENTAL PATIENT MUST BE GIVEN THE HIGHEST PRIORITY.

The chronic mental patient in Alaska is receiving less than adequate attention. Some of these disabled native born Alaskans have been dependent upon state services for 20 to 30 years and will continue to be for the rest of their lives.

VI: FUNDS SHOULD BE PROVIDED TO STUDY THE PROBLEMS BEING ENCOUNTERED IN THE PROVISION OF MENTAL HEALTH SERVICES IN THE BUSH AND STEPS SHOULD BE TAKEN TO SUPPORT THESE PROGRAMS AND TO DEVELOP MORE CULTURALLY RELEVANT SERVICES.

Alaska's large bush area presents a unique challenge to the provision of mental health services encountered nowhere else in the United States. Alaska can profit from the experiences of other states in mental health service delivery in all areas except as it relates to the bush. Other states have rural programs, but nothing which even approximates the unique situation found in the Alaskan bush.

VII: A STUDY MUST BE MADE TO DETERMINE WHAT CONSTITUTES "CULTURALLY RELEVANT ALTERNATIVES TO INSTITUTIONAL CARE" FOR THE ALASKAN NATIVE WHO HAS A CHRONIC DISABLING MENTAL CONDITION.

The tendency for chronic mental patients to gravitate to large population centers is well known. When these patients are natives, born and raised in the bush, the lack of adequate services creates special problems. Although we know these services need to be cultually relevant, no one has planned or operated and board and care home or any other type of program specifically designed to fit the needs of the native population.

APPENDIX

A PUBLIC TRUST

When Alaska was in the process of achieving statehood in 1956, the United States Congress granted the Territory 1,000,000 acres of land to be managed as a public trust to provide funds for Alaska's mental health program. This grant represents a unique approach to the funding of mental health services in the United States, but the benefits of this legacy have never been realized by the mentally ill of Alaska.

The legislative language, when reviewed, seems to be fairly straightforward. The facts are as follows:

1956 Public Law 830, Title II, Sec. 202:

(a) "The Territory of Alaska is hereby granted and shall be entitled to select...not to exceed one million acres...

(b) "...The authority to make selections shall never be alienated or bargained away, in whole or in part...

(c) "All grants made or confirmed under this section shall include mineral rights...

(d) ...

(e) "All lands granted to the Territory of Alaska under this section, together with the income therefrom and the proceeds from dispositions thereof, shall be administered by the Territory of Alaska as a public trust and such proceeds and income shall first be applied to meet the necessary expenses of the mental health program of Alaska..."

In 1958, the Alaska Statehood Act was passed and confirmed the validity of this grant of land:

1958 Public Law 85-508, Alaska Statehood Act, Sec. 6:

(k) "Grants previously made to the Territory of Alaska are hereby confirmed and transferred to the State of Alaska upon its admission... for the purposes for which they were reserved;"

The lands were promptly selected and patented, but a trust fund was not established. The lands were sold, traded, leased; and the proceeds were placed in the General Fund. The lands were "managed" by the Division of Lands for the general public good, without specific reference to supporting the mental health program. As a consequence, Mental Health Land was placed in State Parks, the Auke Bay Community College, the Eagle River Correctional Center, fish hatcheries, church camps, etc., were built on Mental Health Land. Portions of this land were traded to municipalities and individuals.

These lands were of enormous value. They included miles of beach property in Southeast Alaska, thousands of acres of prime forest land, portions of Iron Mountain near Haines, six sections of the Beluga Coal Fields, and commercially valuable property surrounding Sitka, Juneau, Ketchikan, and other communities of Southeast Alaska. In fact, the value of these lands was so great, everyone wanted them for their own purposes.

A Mental Health Land Board was created in 1976. The Land Board's experience with the Division of Lands, the agency directly involved in managing the lands, was disappointing. The revenue from the lands amounted to about three dollars per acre because of the management philosophy. The Division of Lands could not provide the Board with adequate accounting of the lands. It was discovered that lands had been traded for other undesignated properties - which meant that the State "owed" some acreage to the Mental Health Lands. The Division had created a device called the "Interagency Land Management Agreement". It was learned that the University of Alaska was "managing" the Auke Bay property by building its facility on Mental Health Land -- rent free. It was a classic case of the "fox guarding the hen house". It became apparent in 1978, when the Native Claims were being finalized and municipalities were selecting properties, that a decision had to be made.

The Mental Health Land Board advocated the creation of a strong trust, with an administrative board with sufficient staff to be directly responsible for the management of the lands. The Board met with the leaders in the legislature, the Governor and his Commissioners, and other interested parties.

The solution the legislature agreed upon was to "redesignate and dispose" of all Mental Health Lands and to create a mental health trust fund, which would receive a percentage of the state's revenues.

1978 A NEW LAW IS PASSED -- Chapter 181:

Section 1.	Redesignation and Disposal of Mental Health Land...
Sec. 37.14.010	"Mental Health Fund Established."
Sec. 37.14.020	"Mental Health Advisory Board Created."
Sec. 37.14.050	"Contribution: -- The Commissioner of the Department of Revenue shall transfer to the fund, subject to legislative appropriation...a sum equal to one and one-half per cent of the total revenue derived from the management of State land..."

The result of the new law is as follows:

1979 -- No money -- No Board meeting

1980 -- No money -- No Board meeting

1981 -- No money -- No Board meeting

The University of Alaska, which also received a land grant in 1956

(150,000 acres), did not accept this new law and filed a limited lawsuit in 1978, which they won in 1980.

The University sued over the inclusion of some of their land in the Chugach State Park. (Mental Health Land was also included in this State Park.) The University was never compensated for this land and was prohibited from using it for University purposes. The fact of the case was never disputed. In the process, the State's basic position on all trust lands was revealed through this lawsuit. It argued that such lands can be used for other public purposes without paying compensation. The judge disagreed. As a consequence of this victory, the University is now in the process of a much larger suit to force the State to recognize the trust obligation it has ignored for the last twenty-five years.

In 1981, the Attorney General, Wilson L. Condon, stated in a formal opinion, "It can also be argued, perhaps even successfully, that Congress created a trust when it passed the Mental Health Lands Act ...But the legislature's appropriating the proper amount of money to a trust fund would cure any problem..." At the same time HBs 151 and 152 were introduced in an effort to finally begin to honor the state's obligation to the mentally ill. HB 152 appropriates $84,295,000.00 to the Mental Health Trust Fund, the sum deemed owed since the fund was created in 1978. The other bill, HB 151, provides for the oversight of this fund and its income. Senate companion bills, SB 710 and SB 711, were introduced by Senator Parr to help speed passage through the two houses. It is apparent at this time that none of the bills will get to floor votes and will, therefore, die in committee.

When this matter was reviewed by the administrative staff of the Anchorage Community Mental Health Center, they commented, "It is obvious that public officials who have been charged with responsibility for the Mental Health Trust Fund, in effect, have disinherited those who should now, and in the future, benefit from the trust." "This issue is more than an economic or political issue, it is a serious moral issue, which should be the concern of every thoughtful citizen of this state and of this nation."

The Alaska Mental Health Association has been actively working towards a solution of this problem since 1973. We don't believe it is possible for the mentally ill to be the recipients of a grant of such enormous value in 1956 and have nothing to show for it in 1981. The situation has become critical. Every year that passes results in more lost revenue and moves us closer to the point where Alaska will find it extremely painful to meet its obligation.

We feel we must have some progress towards a solution of this problem during this legislative session. At the very least, the one and one-half per cent of State revenues owed since 1978 should be appropriated to bring the fund up to date.

Our experience of the last twenty-five years has taught a lesson which we believe everyone should recognize. The original intent of the Mental Health Land Grant will never be realized if the oversight of this trust fund is left to the bureaucrats. We strongly believe that the governance of this fund and of the mental health program requires the involvement of a trust board with sufficient citizen in-

...

volvement to assure integrity and objectivity in their management. We believe this type of oversight to be acceptable and appropriate and would like to mention that the State of Texas has a similar board included in the administration of its mental health program.

(signed) The Alaska Mental Health Assn.

*Note: Since a version of the foregoing was presented to each of the legislators at the beginning of the 1982 session and there has been no vote on the floor of either house on a longstanding oversight of this Public Trust, it becomes the obligation of the Alaska Mental Health Association to file suit against the State of Alaska for a violation of its Trust Obligation.

The attached checklist is designed to allow you to simply indicate which type(s) of program(s) is/are needed in your area. We are not asking you to list what programs are currently in existance, but only what additional programs are needed. If you can provide us with some estimate of the number of clients to be served and the staff required, we can estimate the cost from experience elsewhere in the state. However, if you wish, a space has been provided for your estimate of the cost.

We have also provided additional space for programs we have failed to list. In addition, we have provided space for "remarks" - which we welcome - to enable you to add whatever qualifying comments you feel are necessary.

The results of this survey will be made available to you as soon as possible.

ULT

Outpatient Mental Health Services

	Program Element Needed	Program Size # of staff or # of patients to be served	Cost Estimate
1.	Medication supervision		
2.	Individual psychotherapy		
3.	Group psychotherapy		
4.	Family therapy		
5.	Marital therapy		
6.	Short-term crisis intervention		
7.	24 hour emergency/crisis intervention		
8.	Case management services to assure continuity of care		
9.	Forensic evaluation		
10.	Forensic treatment services		
11.			
12.			

Remarks

ULT

Inpatient Hospitalizations:

1.

2.

Alternatives to Institutionalization:

1. Day treatment programs
2. Short-term crisis residential alternative to hospitalization or transitional facility
3. Half-way house, short term, 2-3 months
4. Half-way house, long term, 6-12 months
5. Long term residential treatment program for persons requiring support for 2-3 years
6. Socialization centers
7. Sheltered workshop
8. Adult foster care
9.
10.

Program Element Needed	Program Size # of staff or # of patients to be served	Cost Estimate

Remarks

ILDREN - 6 - 12 years

	Program Element Needed	Program Size # of staff or # of patients to be served	Cost Estimate
Outpatient Mental Health Services:			
1. Medication supervision			
2. Individual psychotherapy			
3. Group psychotherapy			
4. Family therapy			
5. Specialized consultation to school district			
6.			
7.			
Inpatient Mental Health Services:			
1.			
2.			
Alternatives to Institutionalization:			
1. Foster home care			
2. Group homes			
3.			

Remarks:

)LESCENTS - 13 - 19 years:	Prog... Element Needed	... # of staff or # of patients to be served	Estimate
Outpatient Mental Health Services:			
1. Medication supervision			
2. Individual psychotherapy			
3. Group psychotherapy			
4. Family therapy			
5. Short-term crisis intervention services			
6. 24 hour emergency/crisis intervention services			
7. Case management services to ensure continuity of care			
8. Forensic evaluation			
9. Forensic treatment services			
10.			
11.			
Inpatient Hospitalization:			
1.			
2.			
Alternatives to Institutionalization:			
1. Adolescent day treatment programs			
2. Short-term crisis residential alternative to hospitalization or transitional facility			
3. Long term half-way home, 6-12 months			

Program Element Needed	Program Size # of staff or # of patients to be served	Cost Estimate
4. Long term residential facility		
5. Socialization Center		
6. Sheltered workshop and/or specialized educational services		
7. Specialized foster care		
8.		
9.		

Remarks:

ERIATRIC:

Specialized Outpatient Services		
Mental Health Consultation to other agencies		

Remarks:

COMMUNITY MENTAL HEALTH IN RURAL ALASKA

INTRODUCTION

In response to a request from the Governor's Mental Health Advisory Council, the rural Community Mental Health Center(CMHC) directors met to formulate a statement defining and describing rural/bush services and service delivery models. The committee consisted of the following CMHC program administrators: Nettie Scott, Susan Soule, Daniel Bill, Jeff Friedman, Boy Collier, Sharon Walluk, Evelyn Wiszinckas, and Michael Graf. The document is an attempt to identify specific issues and circumstances common to Alaska's rural and urban community mental health programs. It is hoped that this document will be adopted by the Council and the Division of Mental Health in developing orientation materials, in establishing funding criteria, in developing a more meaningful management information system format, in evaluating program effectiveness, and in preparing statewide planning documents.

MISSION STATEMENT

Community mental health programs in Alaska should provide a broad range of locally determined mental health services. These services should be accessible, responsive, adaptive, and should be founded upon a service philosophy, plan, and delivery system based upon local need. They should promote the well-being of the larger community, the family and the individual.

Planning, monitoring, and evaluating programs and services require criteria broad enough to encompass the various social and cultural contexts in which services are to be delivered, yet specific enough to provide clear direction. Following is a description of common rural community characteristics and a comprehensive listing of program functions, applicable not only to the rural program, but to more urban programs as well.

CHARACTERISTICS OF SMALL COMMUNITIES

Small Alaskan communities have important characteristics which differ substantially from those of larger urban settings. These characteristics are not totally unique to rural communities and exist to a lesser extent in urban areas. In rural communities, because they predominate, they play a large role in program development, service delivery, and overall program activities. These characteristics derive from the healthy need of a small community to survive independently and they are necessary and adaptive in allowing the small community to sustain itself. The generalized conservatism associated with these characteristics imposes certain unique demands on any program which has potential impact on the social structure and social functioning of the community. Some of these characteristics are:

1. A conservative social system in which there is a slowness to accept new persons and new ideas in the community.

2. A sense of tradition and resistance to rapid change.

3. An investment of trust in individuals rather than in roles or agencies.

4. Homogenity of life, people, activities and expectations.

5. A special relationship to the physical environment which may include a benign acceptance of natural phenomena.

6. A discrepancy between realistic lifestyle options of a small community and expectations aroused by exposure, often only media exposure, to urban styles and options.

7. Problems of transportation, communication, unavailability of materials, as well as the inaccessibility and high cost of goods and services.

8. A lack of employment opportunities.

9. No anonymity.

10. The ethic and historical necessity of community, familial and individual self-reliance.

Some of these general characterisitcs have clear implications for the acceptance of mental health services and interact with a variety of other specific characteristics, which include the following:

1. Conflicting and unclear expectations about services.

2. Frequently realistic expectations, based upon experience, that service may be erratic and providers transient.

3. Confusion about, and distruct of, mental health providers, agencies, and government organizations, based in part on past experience.

4. A proportionately greater stigma associated with the use of mental health services.

5. A lack of comprehensive or specialized services within the community or region.

6. Relative lack of access to services outside of the community or region.

7. Insufficient population to support community, district or regionally based specialized services.

rural services. Some of these factors are:

1. The program and its personnel must be prepared for a lengthy period of community scrutiny before being accepted. This process will be repeated with each change in program personnel.

2. Both the program and its personnel are faced with the task of offering diverse services. Although such services may or may not be typically regarded as community mental health services, they are critical to the ultimate acceptance of the program.

3. Service delivery must be informal and flexible if it is to succeed.

4. Professional staff members, particularly directors of one-person programs, must be willing and capable of accepting roles which include the following: visible and involved community member, outreach worker, broker, advocate, teacher, behavior changer, mobilizer, data manager, administrator, fiscal and personnel manager, secretary, grants-writer and grants manager, janitor, public relations officer, caregiver, community planner, consultant, and model.

5. The professional must be willing to develop and utilize both formal and personal community relationships as vehicles for change.

6. Professional and program staff must be capable of maintaining an effective program despite minimal ancillary services and limited levels of personal, social and material resources.

7. Program personnel must be prepared to cope with the length of time required to develop community relationships and the delays inherent in delivery of services on an itinerant basis.

RURAL COMMUNITY MENTAL HEALTH CENTER FUNCTIONS

Thus far, a descriptive set of community characteristics and factors has been presented which impinge upon community mental health program development. The nature of the situation in rural communities dictates the performance of certain service activities. The proportion of energy devoted to each activity varies according to the nature of the communities served as well as the program's current stage of development. For example, rural centers will devote more time to some activities than will urban centers.

Chart 1 on Page 6 graphically displays some of these differences in terms of the stage of development of a rural

CHART 1

AN ESTIMATE OF PROPORTIONATE PROGRAM EFFORT BY PROGRAM FUNCTION

Program Function	WEIGHT 1	2	3	4	5	6	7	8	9	10
Visibility	****	****	****	****	****	****	****	****	****	****
	+++									
	####	####	####	####	####	####	####			
Outreach	****	****								
	++++									
	####	####	####							
Brokerage/ Advocacy	****									
	++++	++++								
	####	####	####	####	####					
Assessment/ Evaluation	****	****								
	++++	++++	++++	++++	++++					
	####	####	####	####						
Teaching/ Educating	****	****	****	****	****	****	****			
	++++									
	####	####	####	####	####					
Community Resources Alternatives Devel.	****	****								
	++++									
	####	####	####	####	####	####	####			
Consultation	****	****	****	****	****					
	++++	++++	++++	++++	++++					
	####	####	####	####						
Individual Direct & Services Family	****	****	****							
	++++	++++	++++	++++	++++	++++	++++	++++	++++	++++
	####	####	####	####	####	####				
Data Management	****	****	****							
	++++	++++	++++	++++	++++					
	####	####	####	####						
Administration	****	****	****	****	****	****	****	****	****	****
	++++	++++	++++							
	####	####	####	####	####	####	####			

KEY: **** New Program - Rural
++++ Urban Program
+5-year Stage Rural Program

program and in comparison with a typical urban mental health center.

The functions that follow are presented not as an exhaustive listing of all possible service activities, but rather are a set of common CMHC functions. These CMHC functions include:

1. Outreach: Identifying and making purposeful contacts with people in need of mental health services.

2. Brokerage and Advocacy: Facilitating access to and usage of existing services; actively pursuing appropriate services, policies, rules and regulations; advocating and modeling healthy values, behaviors, attitudes and decisions. At times this may include such activities as assisting with tax and other business forms, filling grocery orders, etc.

3. Assessment and Evaluation: Assessing individual, family, and community needs, and providing evaluation services.

4. Teaching and Education: Providing a range of instructional and informational services. This includes developing and training local resource persons.

5. Community Resources/Alternatives Development: In collaboration with other community groups planning and developing needed programs and services; insuring the local availability of recreational, vocational, educational, and cultural activities and alternatives; promoting networking.

6. Consultation: Providing technical input to other providers and agencies concerning problems, needs, and programs.

7. Direct Service Provision: Providing counseling, psychotherapy, crisis intervention, and supportive services to identified persons and groups in need, sometimes of necessity such services are provided on an informal basis in an informal setting.

8. Data Management: Performing all aspects of data handling, gathering, tabulating, analyzing, and program monitoring.

9. Administration: Activities aimed at maintaining the agency or institution rather than activities directed to community or client services.

10. Visibility/Acceptability Promotion: Advertising the availability and promoting the acceptability of mental health services in the community through highly visible physical presence in the community, newletters, sponsorship of community functions and active participation in community life, not limited to professionally-related activities, etc.

PROGRAM MONITORING

The existing procedures for program monitoring do not adequately reflect what rural programs do, why they do it or how they do it. The following breakdown is a beginning effort at re-thinking one of these measures--the staff log. A workable, realistic procedure for program monitoring will require effort on the part of Division staff and program directors if the format is to be equitable to both rural and urban efforts.

A Categorical Break-Down by Service Function For Reporting and Measurement

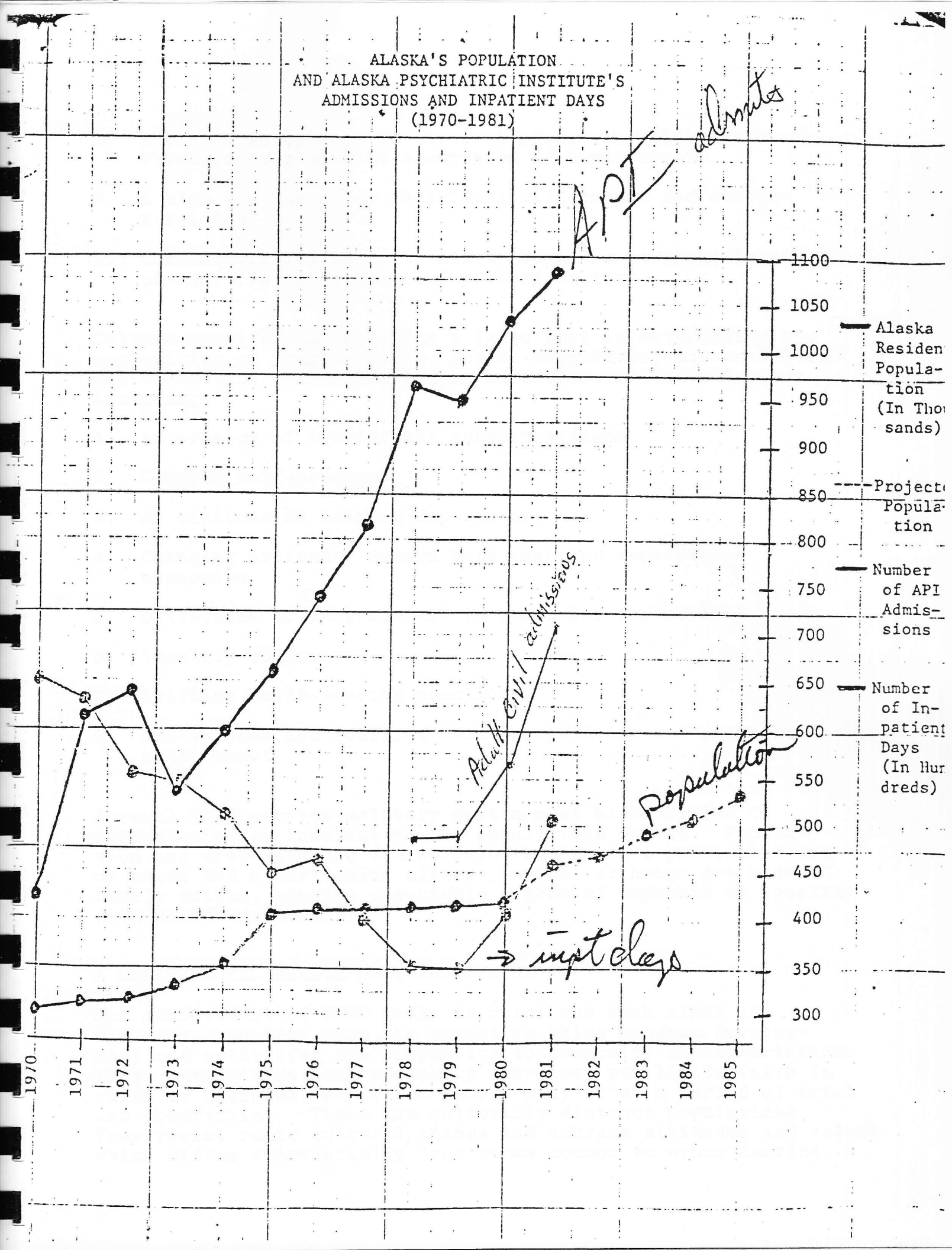
I. Services
   - A. Community-Oriented
     1. Community Resources/Alternative Development
   - B. Client/Community
     1. Evaluation
     2. Teaching/Education
     3. Consultation
   - C. Direct Client-Centered Services
     1. Brokerage/Advocacy
     2. Direct Treatment
     3. Outreach

II. Visibility/Acceptability Promotion

III. Administration
   - A. Data Management
   - B. Administrative Services

SUMMARY STATEMENT

In summary, a set of common CMHC functions has been identified which are readily applicable to the activities of both rural and urban programs. Characteristics of rural Alaskan communities have been presented. Program planning, monitoring, and evaluation as well as the selection, orientation and training of service providers can be enhanced by an appreciation of the factors discussed. These characteristics dictate that rural programs will differ substantially from more urban programs in the emphasis placed on the various program functions.


ALASKA'S POPULATION
AND ALASKA PSYCHIATRIC INSTITUTE'S
ADMISSIONS AND INPATIENT DAYS
(1970-1981)
API admits
Adult civil admissions
population
→ inpt days
1100
1050
1000
950
900
850
800
750
700
650
600
550
500
450
400
350
300
Alaska Residen Popula- tion (In Tho sands)
Project Popula- tion
Number of API Admis- sions
Number of In- patient Days (In Hur dreds)
1970
1971
1972
1973
1974
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985

8. A benign acceptance of physical phenomena which may be extended to a similar acceptance cf human events.

9. A high tolerance for individual differences and exccentricities.

10. Confidentiality as an intensely significant issue in small communities where personal privacy is rare.

Culture-specific factors play a large part in determining the necessities of program style, goals, objectives, and activities. Rapid cultural change has led in some communities to factors including:

1. An erosion of traditional support systems.

2. Lowered self-esteeem.

3. An attitude of learned dependency.

4. Changing attitudes toward both cash and subsistence economies.

5. Difference in language and in communication styles.

6. Identify confusion.

7. Shifting child-rearing practices.

8. Ambivalence and conflict about competition and individual achievement.

A rural CMHC service delivery system must be sensitive to characteristics inherent to the populations served. Population and area-specific characteristics create a particular set of needs and a particular climate, which, although not necessarily unique, require a variable degree of emphasis on locallly determined approaches.

A RURAL MENTAL HEALTH DELIVERY SYSTEM

The achievement of CMHC goals in rural and bush areas is directly dependent upon the extent to which program development and activities are responsive to community characteristics. These communities lack specialty services, put little faith in roles or agencies, admit new people only after a period of trial and observation. These are culturally distinct populations. They resist rapid cultural change and embrace attitudes and values which differ substantially from those common to urban America.

Such communities will neither use nor likely benefit from a case-oriented urban service model. They demand instead a community-oriented, personal-involvement approach. The community itself is the object of intervention.

The intervenor to a large extent is not a program or an expert, but an individual. Resistance to case-oriented treatment typically stems from:

1. Mistrust of professionals and outsiders.

2. Unclear expectations about services to be provided.

3. Stigma associated with the use of mental health services.

4. The ethic of self-reliance

5. The tendency to accept as natural events that in other environments would provide motivation for change.

6. An intense fear of gossip.

Further, the traditional case oriented model relies to a greater or lesser extent on the client's ability to develop new support systems and new patterns for spending time. A small rural community where destructive patterns of living may be community-wide phenomena does not readily offer new, positive support sys-
nor a wide variety of ways to spend time. Out of this latter characteristic comes the need for the community itself to be the object of intervention.

Finally, the mistrust of professionals, programs and persons from outside the community, coupled with the homogeneity of life, people and activities within the community leads to the need for the intervenor both to work at a personal level and to make efforts in terms of his or her own life-style to become a community member both in actions and in understanding.

Both in terms of adequate local client treatment and the prevention and reduction of "casualties", effective community interventions are clearly the treatment of choice. This requires not that rural CMHCs ignore the full range of accepted services, but that a priority be given to the development and maintenance of village networks, advocacy of healthy attitudes and behaviors. and other interventions. Because of the complex variables involved in this social and cultural milieu, this method of intervention requires a proportionately higher expenditure of time as compared with the more traditional case services. It should be stressed that rural programs, while providing some individual case services, cannot be expected to fit or to evolve into an urban-style delivery system.

Numerous factors must be taken into account in the delivery of