Trust
Alaska Mental Health Trust Authority

3745 Community Park Loop, Suite 200
Anchorage, AK 99508
Tel 907.269.7960
www.mhtrust.org

MEETING AGENDA

Meeting: Program & Planning Committee
Date: April 23, 2020
Time: 8:30 AM
Location: online via webinar and teleconference
Teleconference: (844) 740-1264 / Meeting Number: 803 458 556 # / Attendee Number: #
https://alaskamentalhealthtrust.org/
Trustees: Verné Boerner (Chair), Rhonda Boyles, Chris Cooke, Laraine Derr, Anita Halterman, Ken McCarty, John Sturgeon

Thursday, April 23, 2020

		Page No.
8:30	**Call to order (Verné Boerner, Chair)** Roll Call / Announcements / Approve agenda / Ethics Disclosure Approval of Minutes: January 3, 2020	5
8:40	**CEO Update**	
9:00	**Shelter & Housing Interventions for Homeless Beneficiaries** • Daniel Delfino, Director of Planning, AHFC • Jennifer Smerud, Planner 1, AHFC • Kelda Barstad, Trust Program Officer	
	Break	
10:20	**Approvals** • MyPlace Housing Project – Fairbanks Rapid Rehousing • Home for Good – Anchorage Permanent Supportive Housing	 18 24
	Break	
11:30	**COMP Plan Update** • Jillian Gellings, DHSS Project Analyst • Rebecca Topol, DHSS Research Analyst • Autumn Vea, Evaluation & Planning Officer	31
12:15	**Lunch**	

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1:00	**FY22/23 budget process / focus area overview**	50
	Break	
	FY22/23 budget process / focus area overview – continued	
	Break	
	FY22/23 budget process / focus area overview – continued	
	Break	
3:30	**Costs of Drug and Alcohol Misuse in Alaska Update**	84
3:45	**Trustee Comments**	
4:00	**Adjourn**	

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Future Meeting Dates

Full Board of Trustee / Program & Planning / Resource Management / Audit & Risk / Finance

(Updated – March 2020)

• Finance Committee	April 22, 2020	(Wed)
• Resource Mgt Committee	April 22, 2020	(Wed)
• Program & Planning Committee	April 23, 2020	(Thu)
• Full Board of Trustee	May 20, 2020	(Wed) – TBD
• Program & Planning Committee	July 28-29, 2020	(Tue, Wed)
• Audit & Risk Committee	July 30, 2020	(Thu)
• Finance Committee	July 30, 2020	(Thu)
• Resource Mgt Committee	July 30, 2020	(Thu)
• Full Board of Trustee	August 26-27, 2020	(Wed, Thu) – Anchorage
• Full Board of Trustee	November 18-19, 2020	(Wed, Thu) – Anchorage
• Audit & Risk Committee	January 6, **2021**	(Wed)
• Finance Committee	January 6, **2021**	(Wed)
• Resource Mgt Committee	January 6, **2021**	(Wed)
• Program & Planning Committee	January 6, **2021**	(Wed)
• Full Board of Trustee	January 27-28, **2021**	(Wed, Thu) – Juneau

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Future Meeting Dates

Statutory Advisory Boards

(Updated – February 2020)

Alaska Mental Health Board / Advisory Board on Alcoholism and Drug Abuse

- Executive Committee – monthly via teleconference (First Wednesday of the Month)

Governor's Council on Disabilities and Special Education

- May 12, 2020 – Anchorage/ZOOM
- Sep. 29-30, 2020 – Anchorage/ZOOM
  (possible pre/post-meeting for Autism Ad Hoc and/or Workgroup on FASD)
- February 2021 Juneau/ZOOM

Alaska Commission on Aging

- February 10-13, 2020 – Board Meeting (Juneau)

ALASKA MENTAL HEALTH TRUST AUTHORITY

PROGRAM & PLANNING COMMITTEE MEETING
January 3, 2020
11:30 a.m.

Taken at:
3745 Community Park Loop, Suite 120
Anchorage, Alaska

Trustees Present:
Verne' Boerner, Chair
Anita Halterman
Mary Jane Michael
Ken McCarty
Chris Cooke
Laraine Derr (via Speakerphone)

Trust Staff Present:
Mike Abbott
Steve Williams
Miri Smith-Coolidge
Kelda Barstad
Luke Lind
Michael Baldwin
Carrie Predeger
Katie Baldwin-Johnson
Jimael Johnson
Valette Keller
Eric Boyer
Autumn Vea

Trust Land Office:
Wyn Menefee
Jusdi Doucet

Also participating:
Roy Scheller; Michelle Girault; Gennifer Moreau-Johnson; Jerry Jenkins; Aaron O'Quinn; Duane Harris; Lisa Nolan; Aaron Wolf; Leah Van Kirk (via Speakerphone); Rebecca Topol (via Speakerphone).

PROCEEDINGS

CALL TO ORDER

CHAIR BOERNER called the meeting to order and asked for any announcements.

TRUSTEE MICHAEL stated that it was her pleasure to acknowledge Roy Scheller's retirement.

She continued that they had met 42 years ago and that it had been a pleasure to watch his professional progress over the years. He was a champion for advocacy, the Key Campaign, over the years, and she thanked him for all he has done. She added that, as he transitions to retirement, the hope is to lead a wonderful life after this. She presented him with a plaque and asked for any other comments.

CHAIR BOERNER thanked Mr. Scheller for his years of service and dedication. The work he did is leaving a legacy and impacting those that have been helped, and the program will continue that work which will affect the next generation and the generations to come.

MR. WILLIAMS stated that it was a pleasure to work with Mr. Scheller and noted that he was always actively engaged in the budget-development process. He valued the perspective and participation of Hope, a large provider of services for the beneficiaries.

TRUSTEE MICHAEL introduced and welcomed Michelle Girault, the new CEO of Hope, who has also been there for 36 years.

TRUSTEE McCARTY talked about seeing the influence of Hope in Kodiak and the ripple effect, and thanked them for what was done.

MS. BARSTAD stated appreciation for Mr. Scheller's visionary leadership and that it was a pleasure to work with him and Hope. She continued that the agency has worked hard to ensure that people are living the lives they want to, promoting inclusion and independence in the community and across the state. She thanked him and wished him a well-deserved retirement.

MR. SCHELLER stated appreciation for the recognition and the good works. He continued that the Trust has been behind almost every single productive act that happened in the past decades. He applauded all for being very significant in helping people with intellectual disabilities have a full life. He added the hope to find meaning and purpose in his retirement by continuing many of his activities in support of people with developmental disabilities. He thanked all.

(Applause.)

CHAIR BOERNER moved to approval of the agenda.

APPROVAL OF AGENDA

MOTION: A motion was made to approve the agenda by TRUSTEE COOKE; seconded by TRUSTEE HALTERMAN.

There being no objection, the MOTION was approved.

CHAIR BOERNER asked for any ethics disclosures. There being none, she moved to approval of the minutes from the July 31, 2019, meeting.

APPROVAL OF MINUTES

MOTION: A motion to approve the minutes of July 31, 2019, was made by TRUSTEE COOKE, seconded by TRUSTEE MICHAEL.

There being no objection, the MOTION was approved.

CHAIR BOERNER moved to the CEO update.

CEO UPDATE

MR. ABBOTT noted that there have been no announcements from the Governor's office related to new trustee appointments. The Trust's application review was completed mid-December, transmitted to the Governor as required, and new appointees should be known in late December, early January. He thanked the representatives from the four advisory boards from the Alaska Native Health Board and from the Board of Trustees, the six entities that make up the application review process. He then commented on the recent release of Governor Dunleavy's FY21 budget proposal. The Governor actually consulted with the Trust personally, invited staff to present the budget to his leadership team and was grateful for the chance to do that and have a conversation about the role of the Trust and opportunities for the Trust and the Administration to work together. This showed a great indication of Governor Dunleavy's personal interest in the State budgeting process. He funded housing and homeless programs at FY20 at historic funding levels.

CHAIR BOERNER commended Governor Dunleavy for the invitation to have the conversation of the development of the budget and for, largely, the flat-funding of the behavioral health programs and behavioral health initiatives overall. She pointed out and noted that the Suicide Prevention Council budget was cut by 67.4 percent, which is about $400,000, including eliminating the school suicide program in a state with the highest levels of suicide in the nation. This is going to be an area of need because those that do attempt and commit suicide are Trust beneficiaries. She added that there are also reductions in the Energy Assistance Program and the WIC program, both areas of concern.

MR. WILLIAMS provided trustees with an update on the work that staff with the joint advisory boards have been doing in setting the joint advocacy priorities. He stated that there will be more information at the January Board meeting.

CHAIR BOERNER did an official roll call. Mr. Sturgeon was excused, and the other trustees were present. She moved on and thanked Eric Boyer for helping her with transitioning and taking on some of the responsibilities in the workforce development issues. She continued to the Porcupine building presentation, CHOICES, and Web, and recognized Katie Baldwin-Johnson.

MS. BALDWIN-JOHNSON recognized Duane Harris, the executive director of the Alaska Mental Health Consumer Web; Lisa Nolan, the newer executive director of CHOICES; and Dr. Aaron Wolf, all in the audience. She provided a frame for the partnership with these organizations in trying to identify better solutions for their facilities. Part of the beauty of these organizations is that they have the flexibility to adapt and meet the person where they are and invite them in, take the time to develop relationships, gain trust and really start identifying their needs to figure out how to better help them.

She continued with a brief overview of the beneficiary projects initiative and gave a history on the agencies represented. This initiative conceived of supporting beneficiaries and managing programs that focus on peer-to-peer support. The primary purpose was to develop safe, effective, and sustainable services for beneficiaries led by beneficiaries. This peer support

recovery model is used to really promote the recovery-oriented services that complement many of the clinical services. She added that many of the beneficiaries engaged with these agencies are unable or unwilling to receive services at the more traditional agencies. She explained that the peer support model is an evidence-based model. SAMHSA describes it as using a lived experience of someone in recovery to help support others navigating that path of recovery. She added that the State and the Trust have really embraced this model. She then moved to a brief overview of the services provided by the Mental Health Consumer Web. She stated that there is a handout that offers an overview of the recovery-based engagement and drop-in center, which provides a variety of services. The facility provides a critical safety-net service to the beneficiaries in the Anchorage Bowl and the reports from staff and beneficiaries are a testament to work they do, and the benefits provided. She asked Mr. O'Quinn to talk about the facilities.

MR. O'QUINN began with the old state building that formerly housed the Oil and Gas Conservation Commission, which has a public-use restriction and is valued at less than $400,000. He stated that the current facility for the Consumer Web is located at 13th and Gambell, and the CHOICES facility is directly across the street in the three-story office building. Both facilities have challenges, which he described. He then moved to and described the current available option at 3001 Porcupine Drive in Mountain View. The property has a deed restriction that limits it to a public purpose and is currently owned by the Heritage Bank, by the Municipality. It is appraised at $382,000, and is 12,300 square feet. He then walked through some of the anticipated costs to some modifications.

MR. WOLF stated that he has been involved with both programs and the present spaces are ill-conceived. He added that a lot of room will be saved by having the right kind of space.

MR. O'QUINN spoke to the budget for further evaluation and moved to the possibility of expanded services of beneficiaries based on having the facility more efficiently laid out.

MS. NOLAN stated the need for more recognition of CHOICES in the community to bring in more referrals and opportunities for volunteerism. She continued that she worked with Mr. O'Quinn and the architect on envisioning some spaces for more internship opportunities, which would benefit Anchorage and Alaska in the future for well-trained professionals that do not have to be imported from the Lower 48.

A discussion on the challenges of the site, the location limitation, and cost of repairs ensued.

MS. BALDWIN-JOHNSON asked Mr. Harris to address the potential for the Web in this new facility, and touch base on the bus access issue.

MR. HARRIS stated that they are looking to more effectively serve an increased number of beneficiaries on a daily basis. Currently, on average, 63 beneficiaries are being serviced daily; and the limitation is the configuration. The hope is having early childhood development, having staff placed in pods around the building for more effective monitoring and better input. He continued that the majority of the population are transient on foot. Because of the expense of bus rides, they are mostly pedestrians.

MR. ABBOTT stated that formal guidance is not being asked for, but there is the need for the trustees to continue being interested in providing a better situation for CHOICES and the Web.

He wanted to see if the trustees are interested in seeing a more fully developed proposal for how this facility could be owned by the Trust and then leased to these two entities going forward.

MR. McCARTY stated interest in hearing about the parameters and any other existing options.

MR. ABBOTT stated the plan for a fuller description of this geographic area, and we will make it part of subsequent information to be brought forward at another time.

CHAIR BOERNER breaks for lunch.

(Lunch break.)

CHAIR BOERNER called the meeting back to order and moved to the Comp Plan update. She asked Mike Baldwin to do some basic introduction.

MR. BALDWIN stated that a lot of good progress has been made on the Comp Plan. The last year was spent working with key partners and stakeholders to reinvigorate the Comp Plan and have a solid one out there. He then moved into the implementation phase, and asked Autumn Vea for an in-process update.

MS. VEA stated that the Comp Plan went live on July 1st, and still continues to receive positive feedback. It has been highlighted numerous times in the media and through interviews with our CEO. She continued that it is a lifespan perspective starting with early childhood and ending with the much needed workforce and data and funding elements. Since the last trustee update, the Comp Plan MOA has been addended. The progress report for the previous activities and deliverables were detailed, and were met all from that November 2018 MOA. The 2020 timeline was also updated to include the action plan and the scorecard. She moved to the first step of the MOA which is the action plan being led by Jillian Gellings; who is out on family medical leave. She continued the update on the Department's behalf on their action-planning effects for Ms. Gellings. She asked Ms. Leah Van Kirk, who was on the phone in Juneau, to talk about what the action plan has meant for DBH.

MS. VAN KIRK stated that she works for the Division of Behavioral Health and is the statewide suicide prevention coordinator in the prevention and early intervention section. She continued that part of her role is suicide prevention throughout the state, and then overseeing comprehensive behavioral health prevention and early intervention grantees. She added that they facilitate education throughout the state to teach communities how to respond to suicide, which can then prevent further suicide. She oversees a project with UAF in working on developing university- and college-level classes that will result in an occupational endorsement for behavioral health assistance. This project gave the framework, which is the Comp Plan, to really focus the planning efforts and really identify and take stock of what is already being done that supports the Comp Plan. She gave a short synopsis of what she did to come up with their action plan, identifying responsibilities and then identifying goals that were applicable to the work. She then reviewed and talked about some of those goals. She added that engaging partners integral with their work was helpful in identifying tactics or action items that were identified to work on. She stated that developing an action plan helped to think more strategically about the priorities, and it identified some of the gaps. She added that it was an excellent project to work on.

MS. VEA thanked Ms. Van Kirk, and introduced Rebecca Topol, who will talk about how she has been contributing to the scorecard.

MS. TOPOL stated that she works with Health Analytics and Vital Records, which used to be known as the Bureau of Vital Statistics. She continued that she had been working with the Mental Health Trust scorecard for about three years. She added that she helped coordinate the update to the scorecard document. She collects the most recent data, updates the document and then gets it out on the website. She explained that, currently, there are 23 indicators on the scorecard that have been stable over time. There is at least a decade's worth of data. She explained this is more detail and stated that the scorecard is being updated with 2019 data and is expected to be out in February of 2020. She added that the work based on Trust funding is maintained and updated to the current and new scorecard.

MS. VEA stated that the leadership group recently decided that there is still tremendous value in the use of the Alaska scorecard. She continued that this particular scorecard places a heavier emphasis on beneficiary-related health and social determinants of health versus indicators on the Healthy Alaskans 2030 that focuses on the health of all Alaskans. She added that it is important to have a standalone scorecard that highlights exactly what is impacting Trust beneficiaries specifically.

MS. TOPOL explained how the Trust recently used the scorecard in relationship to prevalence estimates, and then moved to updating the scorecard to reflect the current Comp Plan.

MS. VEA added that another big difference between the Alaska scorecard and Healthy Alaskans 2030 is the prevalence estimates. It helps Department leadership and the Trust predict where there will be growth. She continued that any particular beneficiary population helps to plan for the future to put funds and resources where they may be needed. She added that there is still a lot of valuable information on the existing scorecard as it stands. The efforts for updating are underway and the Trust will continue to be informed of the changes over the next few months.

MR. BALDWIN thanked and appreciated all of the partners and advisory boards that have been active and very spirited. He stated that a lot of really good dialog and collaboration around this has happened.

CHAIR BOERNER also thanked all for their presentations and for the comments to connect and augment how Healthy Alaskans 2030 helps create and provide a big-picture view of where these different pieces come together.

TRUSTEE McCARTY asked who was maintaining the scorecard.

MS. VEA replied that the Trust Funds Vital Health and Vital Analytics, and the Division of Public Health maintains it.

CHAIR BOERNER suggested identifying this discussion as a possible presentation for the future because there are so many different data sources. She thanked all for the presentation and moved to the Crisis Now agenda item.

MS. BALDWIN-JOHNSON provided a copy of the completed RI Alaska Crisis Now

consultation report and highlighted the work that the Trust has been doing with the partners, DHSS and others, to explore and look at opportunities of how to improve the continuum of care in the community. She stated that it is a complex issue. She moved to the highlights of the activities of the Crisis Now program in Phoenix, Arizona. She went into the Crisis Now model, talked about some of the potential adaptations for some of the urban communities and what aspects of that model may be beneficial in rural application.

MR. BOYER briefly talked about the core elements of the model and the work on crisis stabilization services. He talked about the traditional 911 services and making support or programs around the state to work synonymously with 911, especially for the ability to meet someone where they are with mental health/substance use services. The Crisis Now model is the best practice model being explored. One of the key things were that the first responders, police services, local PD, state troopers were the ones who were at the forefront pushing for these crisis-level services to be implemented. The collaboration and partnerships will be able to support law enforcement, hospital personnel, psychiatric care, whether outpatient or inpatient, and first responders.

MS. BALDWIN-JOHNSON stated that crisis, in terms of the Crisis Now model, is synonymous to 911 in that anyone receives that service at any time that it is needed. Obstacles like screening out or admission criteria or things that create barriers for people are not built in. A contract for a Crisis Now model kind of assessment here in Alaska was procured. RI was the successful respondent. Multiple folks engaged in community discussions and dialogues, taking a more holistic view of what is the system versus just communicating with the community behavioral health provider or local housing entity because the system tended to fragment and not start getting a better picture of the components that are or are not working all together. She continued that a report was wrapped up, and we had some good recommendations in this report which will be published publicly shortly. She added that it is important to approach this work from a place of engagement and partnership. This is an opportunity to think about how to mirror models like Crisis Now and the steps that would have to be taken in order for it to be possible.

MR. BOYER stated that the executive summary gave a snapshot of what went on and what the recommendations were.

TRUSTEE MICHAEL asked about funding.

MR. ABBOTT replied that it is primarily funded by Medicaid. There are supplemental contributions made by folks that see their workload reduced; contributions from hospitals and local governments. He continued that most of the services being provided are Medicaid-eligible expenses, and that is true in Alaska, too.

MS. MOREAU-JOHNSON stated that in the four prongs of the Crisis Now model, three of those are included in the 1115; one of which is currently being covered in the short-term crisis residential. She added that the one thing not covered at this time is the call center.

MR. ABBOTT stated that the Trust may be in a position to be a champion for this and asked the trustees if they thought this is something they would like to see brought forward.

CHAIR BOERNER had the trustees share their thoughts which were very positive. She called

for a break.

(Break.)

CHAIR BOERNER brought everyone back together and moved to the FY20 Change of Intent.

> **MOTION:** A recommendation that the Full Board of Trustees approve a change of intent for the FY20 Rural HCBS Coordinator project to convert it from FY20 MHTAAR funds allocated to the Department of Health and Social Services, Division of Senior and Disability Services to FY20 Authority Grant funds in the Housing and Long Term Services and Supports focus area titled HCBS Projects to be allocated at a later time was made by TRUSTEE MICHAEL; seconded by TRUSTEE HALTERMAN.

CHAIR BOERNER invited Ms. Barstad to provide some background.

MS. BARSTAD stated that the hope would be to put in place a rural HCBS coordinator, but the funds were not included in the FY20 budget for Senior and Disability Services. This project was not able to move forward. She continued that it is in the FY21 budget and was committed to as a two-year project. The funds and the Department of Health and Social Services are both in place for the next fiscal year. It was just not able to happen for FY20.

CHAIR BOERNER stated that the amount of this is $81,000.

MR. ABBOTT clarified that $81,000 is in the budget right now. The Department does not want to spend the money in the way it was proposed to be spent. This request is that it be repurposed. He explained that the action would simply be a recommendation to the full board to take action in a few weeks and then finalize this action so the money could be moved and put to use before the end of the fiscal year. He added that this money would convert to Authority Grant money.

CHAIR BOERNER called a roll-call vote:

> *TRUSTEE DERR, yes; TRUSTEE MICHAEL, yes; TRUSTEE COOKE, yes; TRUSTEE McCARTY, yes; TRUSTEE HALTERMAN, yes; TRUSTEE STURGEON, absent; TRUSTEE BOERNER, yes. The MOTION was approved.*

CHAIR BOERNER moved to the FY21 budget amendments and asked for a motion.

> **MOTION:** A motion that the Program and Planning Committee recommend that the Board of Trustees adopt the amendments to the FY21 budget as included in this memo. The amendments do not increase or decrease the FY21 budget as approved by the Board of Trustees on August 29th, 2019, was made by TRUSTEE DERR; seconded by TRUSTEE MICHAEL.

CHAIR BOERNER stated that there are various components of this and began with a request for the integration of pediatric primary care and behavioral health. The trustees previously approved $150,000 in FY21 Authority Grants funds to support capacity development for pediatric primary care and behavioral health integration in pediatric settings. She explained that this is for the prevention and early childhood intervention program serving young children to promote

resiliency, prevent and address trauma, and provide access to early intervention services. She asked for any questions.

MR. WILLIAMS pointed out that the request is to use $89,000 of that previously approved $150,000 that was described.

MR. ABBOTT clarified that this money is currently in a line item that says, "improve social determinants of health for families and young children." If this amendment is not adopted, the money will still be spent for the same purpose because it was in the approved budget. This will give a chunk of it to the Department of Health, the Mental Health Board staff to work on a specific element of it.

MS. JOHNSON stated that the beauty of the current design of this methodology is that it is linking existing data, and following these children in real-time. She asked Dr. Parrish to talk more about the design of this study.

DR. PARRISH explained that the Alaska Longitudinal Childhood Abuse and Neglect linkage project is a retrospective/prospective cohort study where the existing resources of the state through administrative data are leveraged; and the epidemiologic survey data is augmented. He stated that there is data for kids up to their tenth birthday, and we are already able to see educational outcomes from the data that has been linked looking at families that are in distress, where there may be mental health and substance use issues in the family. That can be directly mapped onto poor reading scores in third grade. He continued that this study would come to an end when the PFD is no longer funded because that is how the cohort is prospectively following the population, through that census taken on an annual basis. He added that prevention is something that occurs along a continuum, not one point in time.

MR. ABBOTT stated that these funds are currently allocated for this purpose to be used as Authority Grants. The proposal is to convert that to an MHTAAR allocation whereby the funds would be included in the State's FY21 budget and then spent for the same general purpose by the Department instead of by a grantee. The use of the money is not changing from what was authorized by the trustees five months ago. He added that the net change in Authority Grants would be a subtraction of $97,000, and there would be an increase of $97,000 of MHTAAR funds. The total $300,000 allocation for this function would not change.

TRUSTEE MICHAEL recommended moving forward with the rest of the motion, and then voting against the motion unless an amendment to the motion is wanted.

CHAIR BOERNER stated that the next item is on Housing and Long Term Services Support. The requested amendment is to change the current budget line item title to more accurately reflect the title and intent. The recommended new title is "Special Needs Housing Grant." There being no questions, she then moved to the next item under Beneficiary Employment and Engagement: "To utilize ongoing recovery including peer and family support services to reduce the impact of mental health and substance use disorders. Trustees previously approved $125,000 in FY21 Authority Grant funds for this project. The staff requested approval to change those funds from the Authority Grants to the FY21 MHTAAR Funds." There being no questions, the next item is Disability Justice. Increased Capacity, Training, and Competencies. Implement the CIT training courses, Anchorage and others, $200,000. "Trustees previously approved $200,000

in FY21 Authority Grant funds for the purpose of supporting Crisis Intervention Team training to law enforcement officers and other first responders." She continued that "The staff requests approving $80,000 of the previously approved $200,000 Authority Grant funds as FY21 MHTAAR funds to the Department of Public Safety Alaska State Troopers. These funds will be used to support the provision of CIT training to Alaska State Troopers." Further, No. 2, "Staff requests approving $80,000 of the previously approved $200,000 Authority Grants funds as FY21 MHTAAR funds to the Department of Public Safety Alaska Police Standards Council." And, again, to support CIT training. "And the remaining $40,000 of the previously approved FY21 Authority Grant funds will be used for continued support of the Anchorage Police Department CIT training courses. She continued that the next bullet is reentry/special needs housing, $150,000. The first request is to, "Rename the project or activity title to 'Reentry Transition Supports' to avoid confusion with the 'Special Needs Housing Grants.'" The second request is, "To remove the Alaska Housing Finance Corporation, AHFC, as the department/RDU/component (or recipient) of these funds. This will provide flexibility in granting these funds to identified communities or organizations such as the Anchorage, Fairbanks, Mat-Su, and Juneau reentry coalitions to assist Trust beneficiaries who are reentering society to obtain safe, transitional, or permanent housing."

TRUSTEE McCARTY asked if the AHFC granted funds or was that just put in there or did they just say they did not need the funds.

MR. WELCH replied that was the agency that was being worked with to disburse the funds. In working with them, they felt it would be better if we just did it directly rather than involving them in the process.

CHAIR BOERNER stated that was the final bullet and asked for any other comments or discussion. There being none, she did a roll-call vote.

> *TRUSTEE DERR, yes; TRUSTEE MICHAEL, yes; TRUSTEE COOKE, abstain; TRUSTEE McCARTY, yes; TRUSTEE HALTERMAN, yes; TRUSTEE STURGEON, absent; TRUSTEE BOERNER, yes. The MOTION was approved.*

CHAIR BOERNER moved to FY21 Developing Areas of Interest, and she recognized Mike Abbott.

MR. ABBOTT stated that in looking at the FY21 revenue estimates, on the current calculation, $3.8 million has not yet been allocated by the trustees for an FY21 expenditure. Proposed was an expenditure of approximately $29 million and change, but we have revenues of close to $33 million. He explained that was done intentionally last year because there were so many uncertainties around State policy choices relating to FY21. Essentially, about 10 percent of the spending authority or the available spending undesignated when the proposed budget was built at the end of August. He stated that there is no specific recommendation, but we want a brief conversation to get some guidance on moving forward. Two general areas have been identified where the Trust funds could be most impactful. First would be preparation for investment in the Crisis Now model that was just discussed. The second area is housing and homelessness. There are several opportunities for the Trust to invest in different types of housing and homelessness solutions that could make near-term impacts in FY21 and benefit Trust beneficiaries that are currently chronically homeless in a variety of communities around the state. The hope is to get

from the trustees a sense of whether those two areas of interest are shared by the trustees, or if there are other areas that the trustees would like to see or consider. He continued that the plan would be to bring the full board of trustees a recommendation for action at the January meeting for allocation of some or all of that unobligated or unutilized FY21 revenue. The recommendation would not be allocating all $3.8 million at this time, but to leave a contingency amount so late changes or needs could be met.

TRUSTEE DERR stated that she was excited to look at funding Crisis Now, which is really great. She continued that she had a bit of trouble with homelessness; the Trust has put a lot of money into homeless already. Several years ago one of the priorities in the state was alcoholism and drug abuse. A lot of money has been spent looking at what the needs are, and she feels that not much has been spent on solving the problem. She added the need to look at rehab, which seems lacking and is a crying need.

TRUSTEE MICHAEL stated that she would like to invest in the Crisis Now model rather than divert the energies to a lot of different things. If it takes more than a year to use $3 million, then it can be longer. It is important right now with all the issues around API to go all in.

TRUSTEE COOKE asked where that $3 million would come from.

MR. ABBOTT replied that, when the program-related investments were discussed last year, the trustees agreed to earmarking $3.6 million of reserves for that purpose. That was the fund source that is being planned to be used.

TRUSTEE COOKE agreed with the housing priority and also improving the mental health care continuum, the crisis is extremely important and an increasing need. He stated that there is also a need to have the Trust be more involved statewide with the beneficiaries, especially the rural areas. He would like to see the outreach continue and encouraged getting some grant proposals from providers in rural Alaska.

TRUSTEE McCARTY concurred with Trustee Michael and stated that Crisis Now will have a very systemic impact upon the state, and it is crucial. He added the need for a call center in Alaska to be developed to have that continuity of care data system.

TRUSTEE HALTERMAN stated support for Trustee Derr's recommendation to focus more on the Crisis Now model. There are too many issues with regard to housing and homelessness that are unaddressed. There are also questions of placement for many of the beneficiaries. Until those issues are sorted out, she is not inclined to put more money into housing and homeless solutions until there is a better understanding of what is being done with the existing populations of Trust beneficiaries.

CHAIR BOERNER stated that she was greatly impressed by the Crisis Now model, and crisis stabilization is an area that needs to be addressed. It is largely an urban program, and she appreciates Trustee Cooke's statement and recommendation to also look at some level between the urban and the rural. Having some direct impact with the rural communities is quite important. She talked about the housing and homeless issues, which she does support, but the crisis stabilization and the parody between urban and rural and addressing these issues are important.

MR. ABBOTT stated that this has been very helpful, and he can sense some consensus. There should be a recommendation from the staff for utilization of a significant amount of the unobligated funds for FY21 at the January trustee meeting in Juneau.

CHAIR BOERNER thanked Trustee Cooke for his brain child of allowing some trustee time to provide some thoughts and reflection. She invited Trustee Cooke to begin.

TRUSTEE COOKE stated that, in preparing for this meeting, it occurred to him that it was a long time since the last committee meeting of these three committees. He continued that in the past there were four committee meetings and one on the calendar for October which was not held this year and is also not on next year's schedule. Five-plus months is a long time, and he felt that the fall meeting should be a regular meeting.

MR. ABBOTT stated that it can be scheduled in the fall. He explained that in looking back at previous fall committee agendas they were pretty light and made a recommendation that committee meetings would not necessarily be required. He continued that, if the trustees are interested, staff is willing to support additional committee conversations and will work with the committee chairs and the board chair around adjustments to that. It can be put on the agenda for the January meeting.

TRUSTEE COOKE stated appreciation for the quarterly reports of the various grants that went out, and also the press release.

MS. BIASTOCK stated that there was a statewide media release announcing close to $1 million in Authority Grants in the last quarter. It was also posted on the Facebook page and the website. There will also be some follow-up done with the hope of generating some media along with the grantees around some of the work being done with those grants.

TRUSTEE COOKE suggested including an invitation for people to contact the Trust if they are interested in finding out more about how to obtain grants or the kinds of funds the Trust has available for various nonprofits.

TRUSTEE MICHAEL thanked the trustees for their willingness to participate in a one-day workshop with Catherine Wood in February, and we all will have interviews sometime in January. She stated that she is a great consultant. She also thanked staff and those that went on the trip, which was fun to hear about and gave a new perspective.

TRUSTEE McCARTY shared his experiences witnessing the homeless issue in Seattle and asking people in Cambodia and Thailand about their homeless situation and what they do. It is a big issue, with many reasons for why someone is homeless. He is excited about what the Trust is doing and thanked all for letting him be part of the team.

TRUSTEE HALTERMAN thanked all for their time and information. It was a great meeting. She appreciated the work being done and believes getting to the root of the problems will solve some of the homeless problems over time. She was glad to see recommendations being made to deal with the crisis situation, and added that the rest of it will come.

CHAIR BOERNER stated that she wanted to start the meeting wishing everyone a happy new year, a happy new decade and to just think about the promise and possibilities out there. She continued that she was thankful for and very honored and privileged to be a part of this body and working with everyone. She also thanked the staff for all the work; we are making a difference.

MOTION: A motion to adjourn the meeting was made by TRUSTEE COOKE; seconded by TRUSTEE HALTERMAN.

There being no objection, the MOTION was approved.

CHAIR BOERNER adjourned the meeting.

(Program & Planning Committed adjourned at 4:37 p.m.)

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MEMO

To: Verné Boerner, Chair - Program and Planning Committee
Date: April 15, 2020
Re: FY21 Partnership Grant Request
Amount: $250,000.00
Grantee: Fairbanks Rescue Mission Inc
Project Title: MyPlace Housing Project --Fairbanks Rapid Re-housing

REQUESTED MOTION:

Approve a $250,000 FY21 Partnership grant with the Fairbanks Rescue Mission for the MyPlace Housing Project – Fairbanks Rapid Re-Housing.

Assigned Program Officer: Kelda Barstad

STAFF ANALYSIS

The Fairbanks Rescue Mission (FRM) in conjunction with the Fairbanks Housing and Homeless Coalition (FHHC) seeks to continue a successful Rapid Re-housing (rapid rehousing) program that works exclusively with homeless individuals and families to promote consumer choice in the private rental market. The project employs the Coordinated Entry System (CES), landlord engagement, case management, and tapering financial support to transition program participants quickly from homelessness to becoming independent tenants and thriving members of the community.

The MyPlace Housing Project is a community Rapid Re-housing (rapid rehousing) project, hosted by the Fairbanks Rescue Mission, to quickly connect families and individuals experiencing homelessness to private market rentals.

This project is modeled after the National Alliance for Ending Homelessness (NAEH) and Supportive Services for Veteran Families (SSVF) benchmarks and standards for rapid rehousing programs. The NAEH/SSVF standards and benchmarks are evidence-based, national best practices with proven results of increasing rapid rehousing participants' independence and quality of life. Nationally, 80% of rapid rehousing participants exit the program stably housed in private market rentals and 85% of the stably housed participants are able to maintain long-term independence. This makes rapid rehousing the most successful and resource-efficient housing solution for people experiencing homelessness.

Trust beneficiaries are overrepresented in homeless populations with 49% of the homeless population in Fairbanks self-identifying as Trust beneficiaries. 78% of MyPlace residents identify as Trust beneficiaries.

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COMP PLAN IDENTIFICATION

Goal	Objective	Comments
Goal 3 Economic and Social Well-being	3.1 Housing	

PROJECT DESCRIPTION

The MyPlace Housing Project (MyPlace) follows the National Alliance for Ending Homelessness (NAEH) and Supportive Services for Veteran Families (SSVF) evidence based standards to center its focus on assisting participants to choose affordable rental units in the Fairbanks North Star Borough within 30 days of entering the program. The detrimental impacts of homelessness intensify based on overall length of times spent in homelessness and MyPlace seeks to limit the length of time spent without permanent housing and prevent relapses back into homelessness. In addition to following NAEH/SSVF standards, MyPlace was carefully designed to utilize the community's Coordinated Entry System (CES), filling the gap for rapid rehousing programs in Alaska's Balance of State Continuum of Care (CoC). With four major housing/homeless service agencies serving as assess points for CES and using the same standardized assessment tool, the Vulnerability Index -Service Prioritization Decision Assistance Tool (VI-SPDAT), MyPlace is able to pull participants directly from a community wide prioritization list regardless of where a homeless individual or family may be accessing services.

The prioritization list generated by the Coordinated Entry System is reflective of the populations served by Continuum of Care agencies, 49% of which qualify as Trust beneficiaries including individuals with mental illness (19%), Substance Abuse disorder (18%), developmental disabilities (13%), traumatic brain injuries (4.5%) and Alzheimer's disease or dementia (3%). MyPlace enrollment in its first funding cycle has exceeded these numbers with 78% of head of household members identified as Trust beneficiaries and 46% of head of household members experiencing mental illness.

MyPlace will also work closely with encampment outreach projects that directly serve unsheltered members of the community to reach individuals and families that may not currently be seeking or receiving services from the other housing/homelessness agencies in the community. Due to MyPlace utilizing dynamic prioritization (an evidence-based process used to move away from traditional static waiting lists), MyPlace is also able to assist households that do not fall into a rigid rapid rehousing scoring window and serve households that would be experiencing homelessness for an extended period of time on long waiting lists for public housing and permanent supportive housing units. MyPlace will continue to be a community led endeavor that constantly uses data, research and community needs to improve outcomes for participants.

EVALUATION CRITERIA

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The local Continuum of Care provides a structured referral network of community providers of homeless services. It also provides additional resources for monitoring, assessing, program implementation, and quality improvement issues. Documentation in the Homeless Management Information System (HMIS) is required. The Institute for Community Alliances conducts quarterly and annual data performance reviews of each program which includes number of clients served, demographics, length of enrollment in program, and outcomes such as increased income and decreased use of benefits.

MyPlace aims to meet the national standards for rapid rehousing programs of 85% successfully leaving homelessness within 30 days of enrollment, but may deviate slightly due to enrolling households with more barriers that fall outside of the strict rapid rehousing window due to dynamic prioritization.

Progress of program participants is evaluated on their Housing Stability Plans and through case notes. As a team, the case manager staff meets weekly to discuss and evaluate individuals who are having difficulty in meeting objectives, while also recognizing and learning from those that are in full compliance with the program. Exit letters and surveys are sent to participants after their official enrollment in the program has ceased to seek information to improve the quality of the program. The Program Manager monitors all participant outcomes and conducts periodic inspections of files. Additionally, the Executive Director will provide oversight by conducting review of program reports.

SUSTAINABILITY

MyPlace was started as a community project with 11 agencies coming together with the understanding of the need for a rapid rehousing program in the Fairbanks community. It continues to be a community effort with on-going consistent support of the Fairbanks Housing and Homeless Coalition.

The majority of service provider funds in Fairbanks come from local donations. This is also true for the Fairbanks Rescue Mission, with 49% of funds coming from donations and self-generated income. Long term sustainability of this project will depend upon the community identifying its success and being able to support it. Referrals are taken from a variety of agencies, including the school district, university, tribal organizations, etc., who are seeing the benefit of having this program in the community and may be able to give towards its continuation in the future. Additional partnerships with foundations and other grantors are developing as this program grows. For example, Rasmuson Foundation has expressed interest in being part of funding this project. The Balance of State Continuum of Care has become more competitive on a national level over the past three years and has been earning additional funds accordingly. The MyPlace program was awarded $38,741 of HUD funds in March 2020 and will continue applying for these funds.

WHO WE SERVE

The philosophy of MyPlace is not to merely house someone, but to assist participants in challenging barriers that create instability in their lives. The individual or family works with a

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case manager to create a life stability plan, which defines specific goals to achieving independence, such as access to mental health counseling, joining a program for domestic violence survivors, applying for a personal care attendant, attending job preparation classes, etc. The participant's success is attained through greater self-determination in challenging their barriers and diligently executing the action steps in their stability plan.

Fairbanks has sufficient availability of rentals in the private market (an average 16% vacancy rate in 2019), but many participants struggle to present themselves in a manner favorable to the landlords. Trust beneficiaries benefit from advocacy from staff members to explain past rent due, evictions, criminal background and other issues. Housed participants receive continued case management that has led them to seek increased income, apply for benefits, mental health counseling, treatment for physical health, and at times the pursuit of housing that is of lower cost to avoid a return to homelessness.

In its first funding cycle, 78% of MyPlace households were headed by Trust beneficiaries and 46% experienced mental illness. This exceeded the populations served by COC agencies, 49% of which qualify as Trust beneficiaries including individuals with mental illness (19%), Substance Abuse disorder (18%), developmental disabilities (13%), traumatic brain injuries (4.5%) and Alzheimer's disease or dementia (3%).

ESTIMATED NUMBER OF BENEFICIARIES SERVED EXPERIENCING

Mental Illness:	15
Developmental Disabilities:	8
Alzheimer's Disease & Related Dementias:	1
Substance Abuse	12
Traumatic Brain Injuries:	3
Secondary Beneficiaries(family members or caregivers providing support to primary beneficiaries):	2

BUDGET

Personnel Services Costs	$109,200.00
Personnel Services Costs (Other Sources)	$6,000.00
Personnel Services Narrative:	CEO oversight: $12,000 Trust Program manager: $49,000 Trust Case manager: $38,200 Trust Bookkeeper: $2,800 Trust Payroll taxes: $7,200 Trust The following are in-kind donations: Project Manager: $3000 City of Fairbanks Case Management: $3000 Partner Agencies

Travel Costs	$3,000.00

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Travel Costs (Other Sources)	$250.00
Travel Narrative:	Travel and training: $3,000 Trust The following are in-kind donations: Travel for project development: $250 City of Fairbanks

Space or Facilities Costs	$14,400.00
Space or Facilities Costs (Other Sources)	$1,000.00
Space or Facilities Narrative:	Office Space: $14,400 Trust The following are in-kind donations: rapid rehousing Presentation Venue: $500 Fairbanks Housing & Homeless Coalition rapid rehousing Planning Venues: $500 Partner agencies

Supplies Costs	$900.00
Supplies Costs (Other Sources)	$1,000.00
Supplies Narrative:	Office and program supplies: $900 Trust The following are in-kind donations: Office supplies: $1000 Fairbanks Rescue Mission

Equipment Costs	$0.00
Equipment Costs (Other Sources)	$2,200.00
Equipment Costs Narrative:	The following are in-kind donations: Internet/Phone Service: $1,200 Fairbanks Rescue Mission Furniture for households: $1000 Partner agencies

Other Costs	$122,500.00
Other Costs (Other Sources)	$43,200.00
Other Costs Narrative:	Temporary Financial Assistance: $122,500 Trust Temporary Financial Assistance: $38, 700 HUD COC The following are in-kind donations: Landlord discount for program: $4,500 Local landlords

Total Amount to be Funded by the Trust	$250,000.00
Total Amount Funded by Other Sources	$53,650.00

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Other Funding Sources	
Housing Urban Development CoC funds Secured	$38,700.00
City of Fairbanks Secured	$3,250.00
Fairbanks Housing and Homeless Coalition Secured	$500.00
Fairbanks Rescue Mission Secured	$2,200.00
Partner Agencies Secured	$4,500.00
Local landlords Secured	$4,500.00
Total Leveraged Funds	**$53,650.00**

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MEMO

To: Verné Boerner, Chair - Program and Planning Committee
Date: April 15, 2020
Re: FY21 Housing & Long Term Services and Supports Focus Area Allocation
Amount: $500,000.00
Grantee: United Way of Anchorage
Project Title: Home For Good

REQUESTED MOTION:

1. *Recommend that the full board of trustees approve allocation of $500,000 of unobligated funds to the FY21 Housing & Long Term Services and Supports focus area. These funds will be added to the "Beneficiaries have Safe Stable Housing with Tenancy Supports" strategy.*

2. *Recommend approval to the full board of trustees for a $500,000 FY21 Housing & Long Term Services and Supports focus area allocation to the United Way of Anchorage for the Home For Good Project.*

Assigned Program Officer: Kelda Barstad

STAFF ANALYSIS

Approximately 1,100 people experience homelessness in Anchorage. Between 300 and 400 of these are the most vulnerable, who cycle in and out of jail, suffer from mental illness and substance use disorders, require frequent police, fire and paramedic calls, strain homeless shelters and emergency rooms, and make camps of parks, trails, bus stops and doorways. These individuals are the hardest to serve and have the hardest time maintaining stable housing. The purpose of this project is to improve their lives and better use public resources to fund expansion of an effective solution—Permanent Supportive Housing (PSH).

By expanding permanent supportive housing in Anchorage, Home for Good aims to provide an effective, long-term solution for some of the Trust's most vulnerable beneficiaries—individuals who experience persistent homelessness. Without stable housing, individuals struggling with a substance use disorder, mental illness, developmental disability, or a traumatic brain injury are more likely to fall into a vicious cycle—moving from the streets, to the ER, to jail, without ever received the in-depth support needed to stabilize their condition or address the underlying problem.

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Providing Permanent Supportive Housing for this population will create a healthier community, including reduced calls for emergency medical personnel and police, allowing for greater focus on other community needs. Most importantly, it will improve the quality of life for individuals who are left behind by the status quo and who need effective, long-term support.

COMP PLAN IDENTIFICATION

Goal	Objective	Comments
Goal 3 Economic and Social Well-being	3.1 Housing	

The following is extracted from the prospective grantee's application.

PROJECT DESCRIPTION

The Home for Good pilot and 3-year pay-for-success project will serve Anchorage over four years, expanding permanent supportive housing by 150 units. The Alaska Mental Health Trust Authority's grant supports the service delivery components for the pilot, which is ramping up services for the first cohort of participants. This project was recommended for funding because it aligns with the focus areas of Housing and Long Term Services and Supports, and because it prevents the institutionalization of trust beneficiaries.

Absent this intervention, eligible individuals cycle through emergency-response systems. Most if not all face mental illness, substance use disorders, mental illness, and/or developmental disabilities. Permanent supportive housing is a proven intervention that disrupts the hospital, corrections, homelessness cycle to allow people to remain stably housed and to have the opportunity to engage in supportive services to meet their goals. The expected outcomes include housing stability (measuring continuous days/months in permanent housing), reduced recidivism, and reduced use of emergency health care services (e.g., emergency department visits, hospitalizations). Before the end of the pilot, the project aims to add up to 40 permanent supportive housing units. This forecast may be adjusted upward or downward—or extended further out—as the pilot continues to adjust to challenges in raising capital for the pay-for-success years, in ensuring that service providers achieve housing stability goals, and in the wake of disruptions to service provider capacity and housing markets caused by the COVID-19 pandemic.

The Trust beneficiary groups that are the focus of the project include individuals with mental illness, developmental disabilities, and/or chronic alcoholism or other substance-related disorders. The target population for permanent supportive housing eligibility—defined by the

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2016 HUD/DOJ grant that established the basic infrastructure for the project—includes individuals with high use of corrections (two stays in the last three years, including one in the last year), persistent homelessness, and a pattern of high-cost utilization of crisis services or significant health or behavioral health challenges. The project will serve many of Anchorage's most vulnerable people with behavioral health challenges, and it is anticipated that most, if not all, would be Trust beneficiaries.

For example, from a 25-person sample of pilot enrollees, the following Trust beneficiary groups were reported:

Alzheimer's Disease and Related Dementias..... 0
Intellectual or Developmental Disabilities 4
Traumatic Brain Injuries 4
Chronic Alcoholism or other Substance Use Disorder 21
Mental Illness 23
(Co-occurring Chronic Use Disorder & Mental Illness ..... 19)

In the current pilot, the project is led by a core collaboration between the United Way of Anchorage, the Municipality of Anchorage, and Social Finance, Inc., a national nonprofit focused on standing up and overseeing execution of pay-for-success interventions. Additional technical assistance is being provided by national advisors Corporation for Supportive Housing and by local contractors.

EVALUATION CRITERIA

In this project, payment is directly linked to outcomes achieved for beneficiaries, as measured by third party evaluation. The partners will know the extent to which participants are better off through clear, independent results that determine how many high-need individuals received housing and supportive services, whether they maintained housing, and what type of jail or healthcare interactions they experienced after being housed.

The project's evaluation will be led by Marny Rivera of NPC Research. The evaluation design will be finalized before transitioning from the pilot to the pay-for-success period. The project outcomes linked to payment will be selected and refined as outcome payers commit to the project; they will include measures such as housing stability (i.e., whether participants remained in permanent supportive housing), reduced recidivism (e.g., reduced jail days, fewer arrests), and reduced health care utilization (e.g., reduced emergency room visits). With appropriate data sharing protection, the evaluation may also assess other outcomes for the purpose of learning, including more detail on healthcare services used, participant satisfaction, and other survey measures. During the pilot, the project partners will track all of the key outcome metrics to

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assess early performance; however, the outcomes will not be linked to payment until the PFS years.

Outcomes will be documented through a rigorous reporting process, defined in the evaluation plan and the pay-for-success contracts. A series of data-sharing agreements will facilitate information-sharing between service providers and administrative data sources (including HMIS, and Municipality Police and Fire Departments) so that the evaluators can track project results on a quarterly basis. In addition, the project intermediaries will assess ongoing performance on programmatic measures including referrals and enrollment to ensure early operations are on track to meet these outcomes.

SUSTAINABILITY

The funding awarded previously by the Trust is being used to support the pilot. With support from the Corporation for Supportive Housing, a national expert on permanent supportive housing, the partners held a Request for Qualifications process in Fall 2018 and selected RurAL CAP, Southcentral Foundation, Daybreak, and CHOICES for consideration as service delivery providers, and selected NeighborWorks Alaska and Front Range Apartments for consideration as housing providers. By launch of the pilot, the team moved forward on agreements with RurAL CAP and Southcentral Foundation; it is housing some tenants at Front Range, in addition to at RurAL CAP and other scattered-site properties. The team is now also reviewing an updated proposal to deliver services from Anchorage Community Mental Health Services and is discussing housing options with Cook Inlet Housing Authority.

As the project transitions into the Pay For Success phase in late 2020, project partners may seek additional funding for new permanent supportive housing sites in Anchorage. At the end of the PFS project period, four years after service delivery began, the team aims to have in place ongoing support for sustained permanent supportive housing intervention, through an evergreen fund consisting of ongoing outcome payer contributions.

WHO WE SERVE

While the eligibility criteria for the target population is based on interactions with the homeless services, jail, and medical systems, studies of similar populations suggest that the individuals who meet these criteria overlap with one or more of the following Trust's beneficiary groups—those experiencing mental illness, chronic alcoholism and other substance related disorders, a developmental disability, or a traumatic brain injury. Many participants in the Alaska Housing First study (which has a similar, though distinct target population), reported significant behavioral health challenges at baseline—62% had PTSD, 33% were depressed or bipolar, and

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most had high alcohol consumption (86% typically had eight or more drinks per day). ["Evaluating Housing First Programs in Anchorage and Fairbanks, Alaska." (2017).]

Anchorage's Coordinated Entry system has been using the Vulnerability Index – Service Prioritization Decision Tool (VI-SPDAT), which assesses clients' vulnerability and matches them to the appropriate level of services. Although both Coordinated Entry and Home for Good are exploring more detailed assessment tools than VI-SPDAT, it may be useful to note that HFG will target individuals with high VI-SPDAT scores (9+). Clients who score this high often exhibit substance-related disorders, mental illness that match the Trust beneficiary population.

Note: the estimated number of beneficiaries is specific to the first year ramp-up year, as is the budget.

ESTIMATED NUMBER OF BENEFICIARIES SERVED EXPERIENCING

Mental Illness:	42
Developmental Disabilities:	6
Alzheimer's Disease & Related Dementias:	Unknown
Substance Abuse	48
Traumatic Brain Injuries:	11
Number of people to be trained:	15

BUDGET

Personnel Services Costs (AMHTA)	$489,400.00
Personnel Services Costs (Other Sources)	$235,651.00
Personnel Services Narrative:	The Trust's personnel services costs are fully dedicated to the personnel costs associated with the service delivery (i.e., supportive services and tenancy support). The remaining personnel services costs include housing personnel costs and transaction management personnel costs; these costs will be covered by other sources. Based on past provider budgets, we assume 79% of service delivery costs will be personnel, 39% of housing costs, and 100% of transaction management costs.
Travel Costs	$0.00
Travel Costs (Other Sources)	$11,184.00

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Travel Narrative:	Based on past housing provider budgets, the project anticipates costs associated with truck maintenance for travel for housing personnel (expected to be 3% of total housing costs).
Space or Facilities Costs	$10,600.00
Space or Facilities Costs (Other Sources)	$48,189
Space or Facilities Narrative:	The Trust's Space or Facilities Costs represent a portion of the expected costs specifically to service delivery. The remaining Space and Facility costs for service delivery and housing are covered by other sources. Based on past provider budgets, we assume 4% of service delivery costs will be spent on Space or Facilities and 35% of housing costs will be spent on Space or Facilities (includes maintenance and utilities).
Supplies Costs	$0.00
Supplies Costs (Other Sources)	$75,077.00
Supplies Narrative:	Based on past provider budgets, the project expects 11% of service delivery costs will be spent on supplies. These costs will be covered by other sources.
Other Costs	$0.00
Other Costs (Other Sources)	$610,828.00
Other Costs Narrative:	The project anticipates 7% of service delivery costs will be "other costs;" this includes insurance and indirect costs. We expect 23% of housing costs to be "other costs;" including reserves, the landlord mitigation fund, and other costs. This cost total also includes the overall project indirect costs ($125,456), the housing funds ($404,065). The project is requesting $1,000,000 capital budget for expected renovations to housing units. The

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	breakdown of these costs is pending contract negotiations with pilot housing providers.

Total Amount to be Funded by the Trust	$500,000.00
Total Amount Funded by Other Sources	$910,000.00

Other Funding Sources	
Rasmuson Foundation (secured)	$610,000.00
Municipality of Anchorage (pending)	$300,000.00

Strengthening the System:

Alaska's Comprehensive Integrated Mental Health Program Plan, 2020-2024

Statutory Responsibilities: DHSS and the Trust

AS 47.30.660. Powers and Duties of the Department of Health and Social Services: "The department shall prepare, and periodically revise and amend, a plan for an integrated comprehensive mental health program...; the preparation of the plan and any revision or amendment of it shall be made in conjunction with the Alaska Mental Health Trust Authority; be coordinated with federal, state, regional, local, and private entities involved in mental health services..."

AS 47.30.011. Alaska Mental Health Trust Authority: "The purpose of the authority is to ensure an integrated comprehensive mental health program."

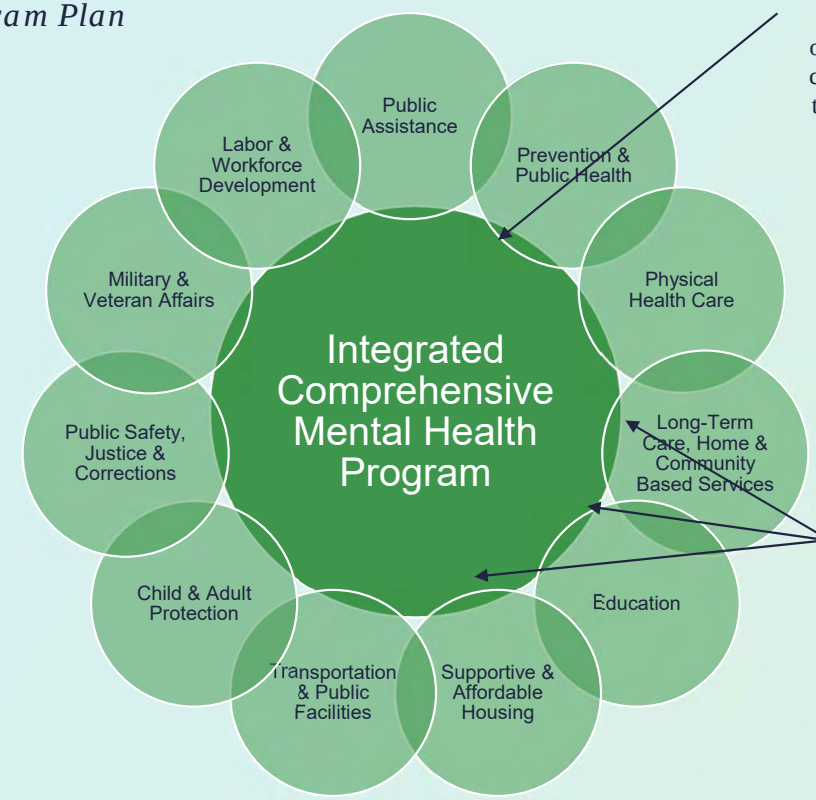
Benefits of a Comprehensive Integrated Mental Health Program

- Encompasses all beneficiary groups
- Bridges departments and divisions
- Endures administrations and legislatures
- Clearly delineates the Alaska's publicly-funded mental health program
- Establishes program-level vision and priorities
- Serves as the glue that connects reform efforts
- Evolves as the program evolves

Integrated Comprehensive Mental Health Program

State and Tribal plans inform and are informed by the Comprehensive Program Plan

COMPREHENSIVE MENTAL HEALTH PROGRAM PLAN

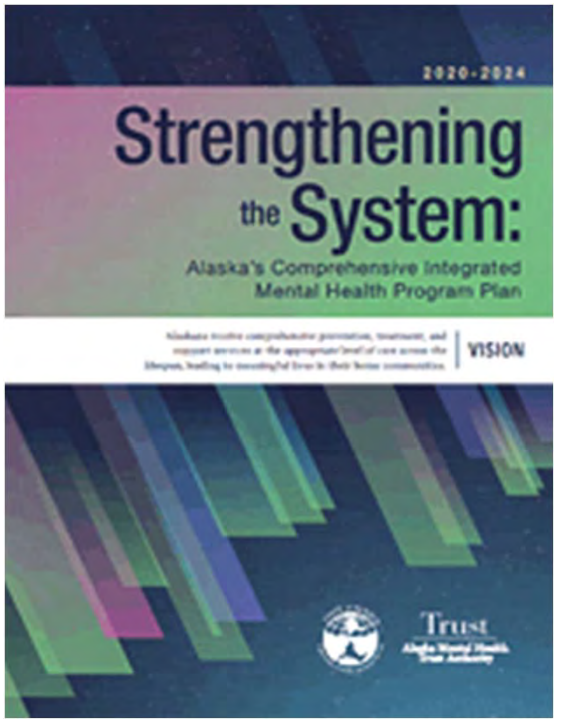


"Core": Programs supported with funds from the Mental Health Budget or State operating and capital funds clearly allocated to advance the Comprehensive Mental Health Program

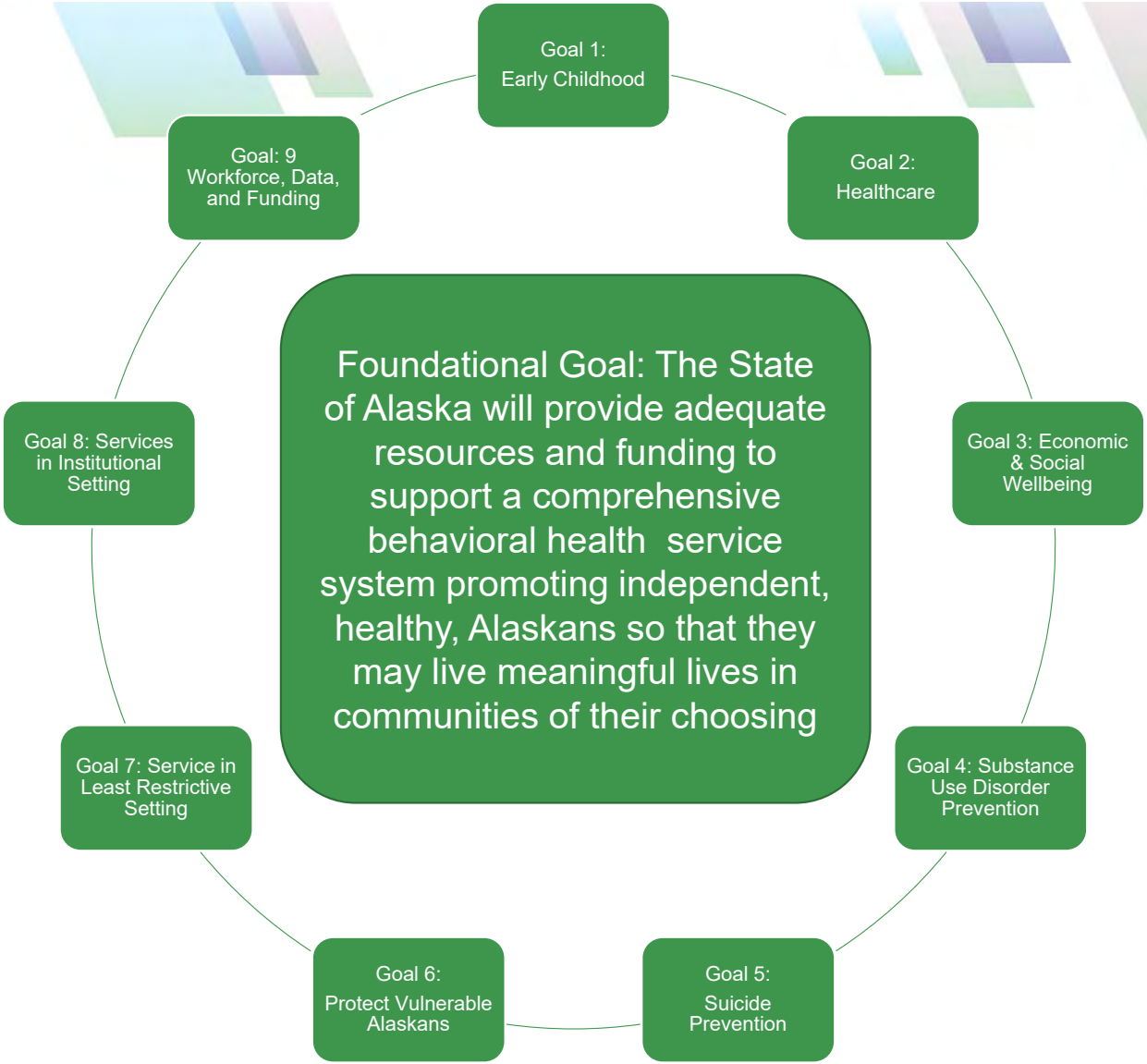
Integrated: Areas of Mission Overlap & Shared Responsibility

Plan Development

- DHSS Staff
- Trust Staff
- Advisory Board ED's & Planners
- Targeted Stakeholder Input
  - Advisory Boards
  - DOC, DOLWD, TRIBES, DEED,
- Public Comment



LIFESPAN: from the prenatal period through end of life



The plan can be found here: http://dhss.alaska.gov/Commissioner/Pages/MentalHealth/default.aspx

Goal 1: Early Childhood

1.1 Objective: Promote practice-informed, universal screening efforts and early intervention services.

a. **Strategy:** Establish standards of care that ensure developmental screenings and caregiver education is a normal part of the well-child check-up for all Alaska children.

b. **Strategy:** Create and utilize a centralized registry for collecting developmental screening data using a standardized, developmental screening tool.

c. **Strategy:** Provide early intervention for infants born with fetal alcohol spectrum disorders (FASDs) and neonatal abstinence syndrome (NAS) and their caregivers.

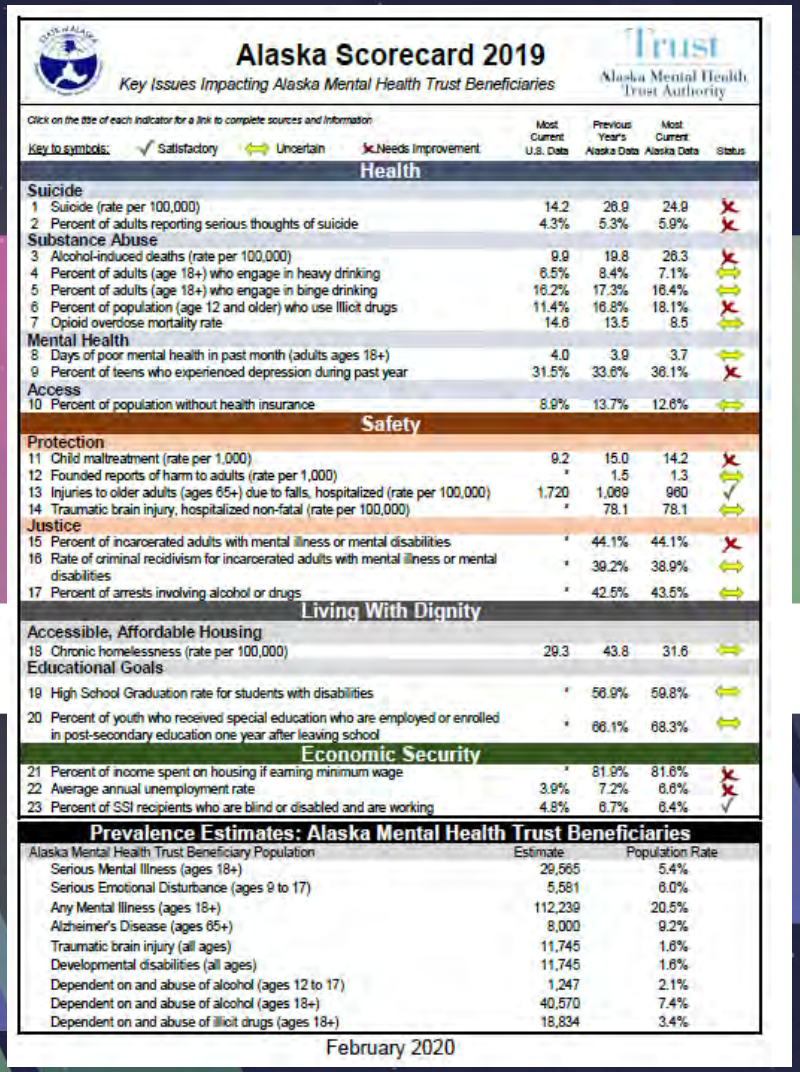
d. **Strategy:** Provide training and technical assistance on trauma-engaged strategies for providers serving young children to assess children and their caregivers for service needs.

e. **Strategy:** Promote training for pediatricians in a tiered screening process for neurodevelopmental disabilities.

Resources: Alaska Scorecard

Outcomes and Monitoring

http://dhss.alaska.gov/Commissioner/Documents/MentalHealth/resources.pdf



Alaska Scorecard 2019

Key Issues Impacting Alaska Mental Health Trust Beneficiaries

Trust — Alaska Mental Health Trust Authority

Click on the title of each indicator for a link to complete sources and information

Key to symbols: ✓ Satisfactory ⇔ Uncertain ✗ Needs Improvement

		Most Current U.S. Data	Previous Year's Alaska Data	Most Current Alaska Data	Status
Health					
Suicide					
1	Suicide (rate per 100,000)	14.2	26.9	24.9	✗
2	Percent of adults reporting serious thoughts of suicide	4.3%	5.3%	5.9%	✗
Substance Abuse					
3	Alcohol-induced deaths (rate per 100,000)	9.9	19.8	26.3	✗
4	Percent of adults (age 18+) who engage in heavy drinking	6.5%	8.4%	7.1%	⇔
5	Percent of adults (age 18+) who engage in binge drinking	16.2%	17.3%	16.4%	⇔
6	Percent of population (age 12 and older) who use Illicit drugs	11.4%	16.8%	18.1%	✗
7	Opioid overdose mortality rate	14.6	13.5	8.5	⇔
Mental Health					
8	Days of poor mental health in past month (adults ages 18+)	4.0	3.9	3.7	⇔
9	Percent of teens who experienced depression during past year	31.5%	33.6%	36.1%	✗
Access					
10	Percent of population without health insurance	8.9%	13.7%	12.6%	⇔
Safety					
Protection					
11	Child maltreatment (rate per 1,000)	9.2	15.0	14.2	✗
12	Founded reports of harm to adults (rate per 1,000)	*	1.5	1.3	⇔
13	Injuries to older adults (ages 65+) due to falls, hospitalized (rate per 100,000)	1,720	1,069	960	✓
14	Traumatic brain injury, hospitalized non-fatal (rate per 100,000)	*	78.1	78.1	⇔
Justice					
15	Percent of incarcerated adults with mental illness or mental disabilities	*	44.1%	44.1%	✗
16	Rate of criminal recidivism for incarcerated adults with mental illness or mental disabilities	*	39.2%	38.9%	⇔
17	Percent of arrests involving alcohol or drugs	*	42.5%	43.5%	⇔
Living With Dignity					
Accessible, Affordable Housing					
18	Chronic homelessness (rate per 100,000)	29.3	43.8	31.6	⇔
Educational Goals					
19	High School Graduation rate for students with disabilities	*	56.9%	59.8%	⇔
20	Percent of youth who received special education who are employed or enrolled in post-secondary education one year after leaving school	*	66.1%	68.3%	⇔
Economic Security					
21	Percent of income spent on housing if earning minimum wage	*	81.9%	81.6%	✗
22	Average annual unemployment rate	3.9%	7.2%	6.6%	✗
23	Percent of SSI recipients who are blind or disabled and are working	4.8%	6.7%	6.4%	✓

Prevalence Estimates: Alaska Mental Health Trust Beneficiaries

Alaska Mental Health Trust Beneficiary Population	Estimate	Population Rate
Serious Mental Illness (ages 18+)	29,565	5.4%
Serious Emotional Disturbance (ages 9 to 17)	5,581	6.0%
Any Mental Illness (ages 18+)	112,239	20.5%
Alzheimer's Disease (ages 65+)	8,000	9.2%
Traumatic brain injury (all ages)	11,745	1.6%
Developmental disabilities (all ages)	11,745	1.6%
Dependent on and abuse of alcohol (ages 12 to 17)	1,247	2.1%
Dependent on and abuse of alcohol (ages 18+)	40,570	7.4%
Dependent on and abuse of illicit drugs (ages 18+)	18,834	3.4%

February 2020

DRAFT Alaska Scorecard 2020

Trust — Alaska Mental Health Trust Authority

Strengthening the System: Alaska's Comprehensive Integrated Mental Health Program Plan, 2020-2024

Goal and Indicator	Goal	Most Current U.S. Data	Most Current Alaska Data	Alaska Change from Previous
Goal 1: Early Childhood				
Goal 2: Healthcare				
Goal 3: Economic and Social Well-Being				
Goal 4: Substance Use Disorder Prevention				
Goal 5: Suicide Prevention				
Goal 6: Protecting Vulnerable Alaskans				
Goal 7: Services in the Least Restrictive Environment				
Goal 8: Services in Institutional Settings				
Goal 9: Workforce, Data and Funding				

Value of the Scorecard

- Focuses on beneficiary related health and social determinants of health vs. indicators related to all Alaskans or national averages.
- Looking at the same indicators over expanded periods of time allows us to see how programs have made a + or – impact on the lives of beneficiaries.
- Most data sources are updated annually and after the data is published it's about one year in retrospection.
- Has been in existence since 2007.

2020 Updated Scorecard Process

- A workgroup is in the process of revising the indicators to align with the anticipated outcomes of Strengthening the System – new indicators!
- Workgroup includes DHSS public health & commissioner's office, Advisory Boards, Trust, and will likely include additional subject matter experts together to decide on a common indicator(s) as needed or necessary.
- Inventoried existing data sources, reviewing existing indicators from other plans, and evaluating new resources such as the Division OMB performance measures & corresponding data.

2020 Scorecard - Continued

- Workgroup is identifying gaps in data and exploring additional resources for the most accurate measurements.
- Measuring preventative goals with data is a challenge.
- Data – although important, is often older or point in time which does not give a broad overview.
- It is difficult to find US national comparable data for indicators potentially specific to Alaska and Trust Beneficiaries.
- Most data is specific rather than comprehensive – how to capture the whole picture.

DHSS Internal Action Plan

- Work is continuing on the internal action plan.
- Action plan tracks current programs and projects that fit under the Comp Plan within DHSS.
- The group plans to expand the focus to track other State of Alaska programs and projects as well as community stakeholder work .
- Focusing on alignment.

Objective 5.2: Support and improve the system to assist individuals in crisis.		
Strategies	Tactics	Responsible Agency
a. Maintain effective Careline Alaska services to all Alaskans in crisis.	• Continue to fund the Careline at appropriate staffing levels according to their accreditation through the American Association of Suicidology. • Evaluate Careline data to determine service needs of Alaskan's. • Assess the impacts of a possible 3-digit number (988) for mental health emergencies and implications regarding staffing and call volume.	
b. Provide public education on mental health and suicide.	• Support funding for Youth and Adult Mental Health First Aid, or other evidence based programs that are applicable to the needs of ~~for all~~ emergency responders, law enforcement, emergency room staff, direct service professionals, criminal justice staff, schools, and tribal providers. • Support the Department of Education and Early Development's efforts in developing and utilizing eLearning classroom lessons for students, including "Navigating Transitions: Promoting Wellness to Prevent Suicide Grades 5-12" • Support the Department of Education and Early Development's efforts to deliver and sustain the Suicide Awareness Prevention & Postvention Training delivered in eLearning format statewide to educators and any person requesting to complete the training.	
c. Ensure Alaskans who encounter the continuum of care are universally screened for behavioral health conditions and suicidal ideation.	• Implement the Zero Suicide framework, training and technical assistance to primary care and behavioral health providers utilizing an evidence based screening tool that screens for behavioral health conditions and suicidal ideation.	
d. Develop a continuum of community-based crisis intervention services to support beneficiaries in community settings whenever possible.	• Implement new services through the 1115 Behavioral Health Medicaid Waiver to provide for enhanced crisis intervention services. • Utilize the Administrative Services Organization to develop and maintain a program for growing regional provider capacity and support.	

Upstream shift

Strengthening the System 2020-2024 has shifted focus to included preventative care and early intervention.

By investing on preventative efforts, cost savings should be achieved by reducing the high cost services such as inpatient treatment at Alaska Psychiatric Institute or incarceration.

Similar success has been shown in early education.

Budget Recommendations

- Comp Plan guides and drives system change and service delivery for the Department & Trust.
- The Trust has been using the Comp Plan when reviewing Letters of Interest from partners to aid in deciding in recommendations for funding.
- The Trust's FY22/23 budget was evaluated and prioritized based on the Comp Plan's objectives/ and strategies.

Comp Plan Position

- A DHSS position to work on the Comp Plan was approved in the FY21 enacted Mental Health budget bill.
- The Comp Plan position will be in the DHSS Division of Public Health.
- Fully funded ($75.0 MHTAAR, $75.0 GF/MH).
- Position will work collaboratively with Trust staff, to build capacity within DHSS to facilitate, manage and coordinate DHSS resources needed to ensure the on-going implementation, evaluation, and monitoring of the Comp Plan.
- Position will take on the day to day project management and coordination within the department and with key partners like the Trust, and the Advisory boards.
- Point person will remain in the Commissioner's Office.

Thank You!

Alaska Scorecard 2020

Strengthening the System: Alaska's Comprehensive Integrated Mental Health Program Plan, 2020-2024

Goal and Indicator	Goal	Most Current U.S. Data	Most Current Alaska Data	Alaska Change from Previous
Goal 1: Early Childhood				
Goal 2: Healthcare				
2a. Percent of population without health insurance				
2b. Traumatic brain injury, hospitalized non-fatal (rate per 100,000)				
2c. Injuries to older adults (ages 65+) due to falls, hospitalized (rate per 100,000)				
Goal 3: Economic and Social Well-Being				
3a. Percent of people with and without disabilities who are employed				
3b. Percent of youth who received special education who are employed or enrolled in post-secondary education one year after leaving school				
3c. Percentage of residents of all ages living above the federal poverty level (adjusted for Alaska)				
3d. Average annual unemployment rate				
Goal 4: Substance Use Disorder Prevention				
4a. Percentage of high school students who felt so sad or hopeless every day for 2 weeks or more in a row that they stopped doing some usual activities in the past 12 months				
4b. Drug-induced mortality rate per 100,000 population				
4c. Alcohol-induced mortality rate per 100,000 population				
4d. Mean days of poor mental health in past month (adults ages 18+)				
Goal 5: Suicide Prevention				
5a. Rate of suicides by firearm				
5b. Suicide (rate per 100,000), all ages				
5c. Suicide (rate per 100,000), age 15-24 years				
Goal 6: Protecting Vulnerable Alaskans				
Goal 7: Services in the Least Restrictive Environment				
Goal 8: Services in Institutional Settings				
Goal 9: Workforce, Data and Funding				

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Focus Area: Housing and Long-Term Services & Supports

Program Officer: Kelda Barstad

The Trust's Housing and Long-Term Services & Supports (HLTSS) focus area was established in 2006. This focus area concentrates on ensuring beneficiaries have access to a continuum of services and supports that maximize independence in their home and community. Housing is a critical component to the continuum of care. Housing First, an evidence-based practice, identifies that a person must have the safety and security of a place to live before they can commit to consistent treatment of health and behavioral health conditions, reducing or eliminating substance use, obtaining employment or education, or meeting other goals. Equally important is having long-term services and supports that are person-directed to achieve maximum independence, autonomy and dignity. Long-term services and supports assist a person with their activities of daily living (e.g., eating, bathing, toileting) and instrumental activities of daily living (e.g., making phone calls, paying bills, managing medication) or support the person to become more independent and engaged in their community. Some populations require services that might relate to assisting people preparing for work or vocational training as well as continuing the recovery process. These activities may include assistance with personal organization, time management, social interactions and problem solving. Technology solutions have emerged as innovative options to provide environmental modifications, cuing, supervision, education, and connectedness.

Partners:
Housing: Trust staff partner with the two housing and homeless coalitions, the Alaska Housing and Urban Development regional office, Alaska Housing Finance Corporation, Alaska Association of Housing Authorities, local governments as represented by the housing coordinators, and members from local and regional housing and homeless coalitions. Partners provide homeless prevention and diversion services, outreach services, housing navigator services, shelter care, rapid rehousing interventions, transitional housing, permanent supportive housing and systems coordination and administration. The Trust is a member of the Homelessness Leadership Council in Anchorage, Alaska Council on the Homeless and the Built For Zero project in Anchorage.

Long Term Services and Supports: Trust staff partner with the Department of Health and Social Services, primarily the Divisions of Behavioral Health, Senior and Disabilities Services, and Alaska Pioneer Homes to work on projects and the overall service system to provide a robust continuum of care for beneficiaries who need long term

Comp Plan Strategy Alignment

Housing is a key social determinant of health that must be met so that individuals are able to spend their energy on recovery, health, and employment rather than using any means available to stay safe and warm. As such, this work aligns with:

> Goal 3, Objective 3.1: Alaskans have stable, safe housing with appropriate, community-based social supports to maintain tenancy.

While there are several goals and objectives that relate to long term services and supports, this objective speaks to the purpose of LTSS as well as the mission of the Trust – to support a robust service system across the state to avoid institutional care:

> Goal 7, Objective 7.2: Increase access to effective and flexible, person-centered, long-term services and supports in urban and rural areas to avoid institutional placement.

services and supports. Partners provide services that range from meals and transportation to direct care services to assisted living home care and systems coordination and administration. The Trust is a member of the Rural Elder Services Network, Alaska Traumatic and Acquired Brain Injury Advisory Council and regularly participates in meetings of AgeNET and the Statewide Independent Living Council and the Alaska Association on Developmental Disabilities.

Trust staff will continue to work with our advisory boards to identify other community, business, municipal, tribal, social services, and state/federal partners to further the work of this focus area.

Impact of Trust Supported Projects and Initiatives:

- The Juneau Forget Me Not Manor, a housing first congregate permanent supportive housing project, showed an emergency room usage decrease of 65% 6 months after the residents moved into housing, and a 72% decrease in contacts with the police. 100% of the residents are beneficiaries. Two years after moving in, 32% of residents reported two or fewer alcoholic drinks in the past 30 days. The Trust is a partner funder for this project.
- The Aging and Disability Resource Centers (ADRCs) served 14,246 people statewide, 21% of those served identified as beneficiaries. The leveraging of existing Trust funding to supplement state and federal funds opened ADRC offices in Fairbanks and Northwest Alaska. ADRCs are the access point for the Medicaid waiver programs, and provide information and referrals for the senior and disability services systems ensuring people are linked to services across the continuum of care.
- The Homeless Assistance Program and Special Needs Housing Grants served over 11,500 individuals through shelter care or housing programs. 30% of these individuals reported that they are Trust beneficiaries, however this number is considered low as national statistics would place that number closer to 41%, and the permanent supportive housing projects have 100% of residents who are beneficiaries. The Trust is a partner funder for these projects.

Current and future Strategies:

- Increase access to affordable and supportive housing.
- Implement additional rapid rehousing and permanent supportive housing projects.
- Participate in the Anchorage Built For Zero project, a community planning process used across the nation to end homelessness.
- Ensure the overall system of care is person directed.
- Build a robust continuum of care that supports autonomy, independence and inclusion.
- Work with partners to improve the system response and service array for people requiring complex care such as those returning from institutions, or who experience co-occurring disorders that must be served by different systems, such as an individual with cognitive and mental health diagnoses.
- Understanding the population prevalence and service needs of senior beneficiaries.
- Update the ADRD Roadmap to develop a path forward to serve individuals with ADRD and support their caregivers.
- Develop a state plan to support individuals with Traumatic and Acquired Brain Injuries.

Budgeting Considerations:

- Trustees approved a budget of approximately **$3,900,000** for strategies impacting Housing and Long-term Services and Supports for Trust beneficiaries for FY21.
- Over $1 million of those funds represent ongoing support for homeless shelters, rapid rehousing and permanent supportive housing.
- ew projects if the second half of the 1115 behavioral health waiver is implemented.

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Housing and Long Term Services and Supports

Supplemental Materials

1) This presentation, developed for the Alaska Public Health Association Conference, examines the number of Alaskans that will require long term services and supports, how much will it cost to serve them, and proposed Alaska strategies to promote health and independence for seniors and people with disabilities.

   Presentation: Promoting Health + Independence Across the Lifespan: Long Term Services and Supports in Alaska
   https://alaskamentalhealthtrust.org/wp-content/uploads/2020/04/Promoting-Health-Independence-Across-the-Lifespan-LTSS-in-Alaska-ALPHA-2014-photos-reduced-Copy.pdf

2) Evidence suggests that providing housing to certain high-need, high-cost patients can transform lives and have a very meaningful return on investment. Over the past three years, National Governors Association Center for Best Practices (NGA Center) has engaged in comprehensive technical assistance to 10 states, including Alaska, to develop statewide plans to establish or advance programs to improve outcomes and reduce cost of care for high-need, high-cost Medicaid enrollees.

   NGA's Full Report: Housing as Healthcare: Leveraging Housing Interventions that Improve Health Outcomes and Reduce Costs
   http://natlgovassoc.wpengine.com/wp-content/uploads/2018/07/1609HousingRoadmap.pdf

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Focus Area: Substance Abuse Prevention and Treatment

Program Officer: Katie Baldwin

In 2013, recognizing the magnitude of the negative impacts of alcohol and drug abuse on Alaskans, trustees approved a substance abuse prevention and treatment (SAPT) focus area. SAPT is focused on the full continuum of care for Trust beneficiaries, from prevention and early intervention to treatment and recovery.

The prevalence rates and negative consequences of alcohol and drug abuse upon Alaskans are substantial. Substance abuse and addiction constitute the largest preventable and costly health problem in the U.S. The long-term negative health effects of excessive alcohol and drug use among Alaskans is linked to any number of negative social, health and environmental consequences. According to a May 2018 State of Alaska Epidemiology report on Health Impacts of Alcohol Misuse in Alaska, 7.6% of all emergency medical transports in Alaska were attributed to alcohol consumption, and the child welfare system and criminal justice systems are substantially over-represented with alcohol and drug related impacts. Almost half of Alaska children in out-of-home placements were connected to homes with parental alcohol abuse, and between 2006 and 2016 roughly 18% of all criminal justice convictions were attributable to alcohol.

The economic cost of drug and alcohol misuse in Alaska is upwards of $3.5 billion annually, per the 2019 Update to the *Economic Cost of Drug Misuse in Alaska*. Access to treatment is of considerable concern to the Trust and our partners. Statewide treatment capacity and access to timely interventions are critical for persons seeking help, as is making sure that services are adequately funded to ensure stability in access over time. A 2016 Trust statewide assessment of services revealed that approximately one in nine adults were in need of treatment for an illicit drug or alcohol program, which equates to roughly 62,815 Alaskan adults. Reductions in grants, provider rate freezes, and disruptions in claims processing puts an already fragile system of service in jeopardy of reduced statewide capacity to serve Alaskans in need.

Partners:
Alaska Mental Health Board, Advisory Board on Alcoholism and Drug Abuse, Alaska Commission on Aging, Governors Council on Disabilities and Special Education, Alaska

Comp Plan Strategy Alignment

The core strategies of this area include changing social norms about addiction, reducing stigma associated with addiction, and enhancing access to needed interventions across a variety of settings. As such, this area aligns with:

> Goal 4: Prevention and treatment for drug and alcohol misuse is provided through collaborative, effective, and informed strategies.

Now that the work to improve the Crisis System of Care is included within the SAPT focus area, our work to implement the *Crisis Now* model also aligns with plan goals. Efforts to build out and optimize crisis response systems to include a robust crisis call line, dispatched mobile crisis teams, and 23 hour/short term crisis stabilization programs support these plan objectives:

> Goal 5, Objective 5.1: Coordinate prevention efforts to ensure that Alaskans have access to a comprehensive suicide prevention system, and

> Goal 5, Objective 5.2: Support and improve the system to assist individuals in crisis.

Behavioral Health Association, Alaska Tribal Behavioral Health Directors and Alaska Native Health Board, Alaska Department of Health and Social Services and Department of Corrections, as well as partner agencies and foundations including Recover Alaska, the Alaska Children's Trust, the Mat-Su Health Foundation, Rasmuson Foundation, and local community foundations.

Impact of Trust Supported Projects and Initiatives:

- Four A's Syringe Access Program (FASAP) is working to prevent the spread of blood-borne illnesses such as HIV and Hepatitis C (HCV), and to reduce the harm associated with injection drug use. With Trust support the program has implemented a new model to provide access to sterile syringes, rapid HIV and HCV testing, harm reduction counseling, and treatment referrals through mobile outreach to injection drug users in Anchorage and Mat-Su. This program uniquely increases access to evidenced-based harm reduction interventions for Trust beneficiaries.

- Volunteers of America's (VOA) treatment program offers critical services to children, adolescents, and families. As a primary provider of treatment services to youth and adolescents ages 13-24 impacted by addiction, the program benefited from Trust support during critical transitions in agency leadership and a decline in available funding. VOA has served approximately 270 youth from communities across Alaska. Trust funding enabled VOA to streamline operations, acquire evidence-based treatment models that support enhanced programming, and substantially reduce operating expenses to support long-term stability of the organization.

- The Trust contributed capital funding to Set Free Alaska to support development of a 16 bed men's residential addiction treatment center in Homer. Also supported by a grant from the Department of Health and Social Services Division of Behavioral Health, this project is focused on increasing statewide capacity to serve individuals impacted by addiction and mental health issues through expanded access to residential programming.

Current and Future Strategies:

- Targeting the negative impacts of alcohol and drug abuse of current and future beneficiaries by educating the public and policymakers regarding beneficiary needs; collaborating with partners on data collection, implementation of evidence based practices and primary care integration; supporting public awareness campaigns targeting social norms about alcohol/drugs; enhancing access to treatment; and improving state policy through statutory and regulatory revisions and development.

- Implementation of the 1115 behavioral health waiver services creates opportunities for the Trust to partner with organizations and/or communities as they move forward with implementation of the new and expanded treatment capacity proposed in the Substance Use Disorder portion of the waiver.

Budget Considerations:

To ensure ongoing Trust support to improve access to treatment interventions, trustees have authorized a budget of **$3,950** for this focus area for FY21. This includes $850.0 for substance abuse prevention and treatment, and $3,050.0 for crisis systems improvements.

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Substance Abuse Prevention and Treatment

Supplemental Materials

1) The Trust commissioned a 2019 update of two reports focused on the economic impact of drug and alcohol use in the state of Alaska. These reports provide data on the cost and harms to our state across a variety of sectors. Both reports are posted on the Trust website under the SAPT focus area and are also available at the following links:

   McDowell Reports- Economic Impact of Alcohol and Drug Use and
   The Economic Cost of Drug Misuse in Alaska, 2019 Update

   https://alaskamentalhealthtrust.org/wp-content/uploads/2020/01/McDowell-Group-Joint-Alcohol-and-Drugs-Summary-1.21.2020.pdf

2) Relevant materials related to the Trust's effort to improve the psychiatric crisis response system in Alaska are available on the Trust webpage:

   - Crisis Now Consultation Report, RI International, December 2019
   - White Paper: Transforming Services Is Within Our Reach, 2016 (Crisisnow.com)
   - Forensic Psychiatric Hospital Feasibility Study, Phase 2, 2019 (Agnew:: Beck for DHSS, partially funded by the Trust)
   - Acute Behavioral Health Improvement Project, 2019 (Agnew::Beck for ASHNA, funded by the Trust)
   - https://alaskamentalhealthtrust.org/news/trust-works-with-dhss-community-partners-to-improve-alaskas-psychiatric-crisis-continuum-of-care/

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Focus Area: Beneficiary Employment and Engagement

Program Officer: Jimael Johnson

The primary goal of the Beneficiary Employment and Engagement (BEE) focus area is to improve outcomes and promote recovery for beneficiaries through integrated, competitive employment, and meaningful engagement opportunities. The Trust promotes evidence-based strategies and best practices that increase opportunities and enable beneficiaries to achieve these outcomes.

Prior to the additional goal of Beneficiary Employment in 2014, the Beneficiary Project Initiatives (BPI) focus area originated in 2004 to help beneficiaries conceive and manage programs that focus on peer-to-peer support. The purpose of the focus area was to develop safe, effective services for beneficiaries using a peer support, recovery-based model. BPI funded agencies continue to serve exceptionally vulnerable beneficiaries using peer-support recovery oriented services. Many beneficiaries served by these agencies are unable or unwilling to receive services at traditional behavioral health agencies due to intensive and complex needs. BPI is retained as a primary strategy in the recently integrated BEE focus area.

Recent data reveals that only 40 percent of Alaskans with a disability are currently employed, compared to 80 percent of those without disabilities. For some Trust beneficiary groups, the rate of employment is even lower. For example, only 26 percent of Alaskans with a cognitive disability are employed. Work is viewed as an essential part of recovery for individuals with a serious mental illness and has a positive impact on self-esteem, life satisfaction, and reducing symptoms. Additionally, employment is a way out of poverty and a way to prevent people from entering the disability system. Further, meaningful community engagement opportunities reduce isolation and promote health and well-being. In 2014, Alaska passed legislation to become an "Employment First" state. Employment First means that employment in the general workforce should be the first and preferred option for individuals with disabilities receiving assistance from publicly funded systems. The Trust is actively working with stakeholders to further identify strategies and measures of progress to implement the Employment First philosophy into policy and practice.

Partners:
Primary partners include Trust advisory boards, as well as multiple state agencies such as Division of Behavioral Health, Division of Vocational Rehabilitation (DVR), and

Comp Plan Strategy Alignment

Employment and recovery support service (including peer support) themes emerged in the development of the plan. The two key objectives noted below illustrate alignment for topical focus areas related to Beneficiary Employment and Engagement:

Goal 3, Objective 3.2: Economic and Social Well-Being – Ensure that Competitive and integrated employment at part-time or full-time jobs pays minimum wage or above in integrated, typical work settings.

Goal 4, Objective 4.4: Substance Use Disorder Prevention – Utilize ongoing recovery support services to end the cycle of substance misuse.

the Department of Education and Early Development. Community based organizations are also critical partners, including those contemplating or implementing supported employment services, as well as the BPI agencies continuing to provide recovery-oriented and peer support services.

Impact:

- BPI grantees serve approximately 6,000 vulnerable beneficiaries statewide annually through a variety of peer support and recovery-oriented services.

- The Trust partners with DVR to provide flexible funding for pre-employment transition services (Pre-ETs) related training, outreach and student work experience, among other Pre-ETs investments. The Division of Vocational Rehabilitation reported more than 800 students with a disability receive Pre-ETs annually.

- Annually, an average of 15-20 Microenterprise grants are awarded to individual beneficiaries who own their own business or are looking to start their own business.

Current and Future Strategies:

The Trust supports varying strategies through both funding and advocacy that include integrated employment supports, meaningful activities, beneficiary and workforce training, and peer-based recovery support programs (i.e. peer and family support services).

- Data development and evaluation: engage stakeholders to identify common indicators and strategies to track progress and inform future employment related investment.
- Employment First Task Force: Advisory boards and state partners including the Departments of Labor and Health & Social Services have engaged with the Trust and national technical assistance to plan and promote implementation of the 2014 Employment First legislation, and to inform state agency and community partners of current resources and initiatives related to supported employment for people with disabilities.
- Evidence based & emerging employment practices
    - Continue statewide expansion of Individual Placements and Supports (IPS) model for beneficiaries experiencing mental illness, substance use disorder, and reentry populations
    - Increase reach and impact of Pre-ETs supports in collaboration with DVR and community partners.
- Beneficiary Project Initiatives: ongoing support of critical recovery-oriented agencies.
- Peer Support Certification: Ongoing support of DHSS and stakeholder efforts related to training and credentialing of peer support workforce.

Budgeting Considerations:

To ensure ongoing Trust support of key Beneficiary Employment and Engagement strategies, Trustees have authorized a budget of **$2,210,200** for this focus area in FY21.

APSE EMPLOYMENT FIRST STATEMENT

Adapted by Green Mountain Self Advocates and Self Advocates Becoming Empowered

All people with disabilities should have opportunities to work. Public dollars should be used to pay for supports for people to work in the community.

People with disabilities, their families, and their allies believe that:

Too many people with disabilities do not have a job. This is unacceptable.

All people should have opportunities for real jobs with real wages. It will get us out of poverty. We will be more independent. We will feel more included.

All people, with and without disabilities, can work in jobs together earning minimum wage or higher.

Like everyone else, people with disabilities should have access to supports that they need to work successfully.

All people, no matter what disability they have, have the right to work a job they choose that matches their skills and interests.

Public policies must support people with disabilities having real jobs. Money for services should be spent on people having jobs in the community.

Just calling your state an Employment First state is not enough. "Employment First" is when everyone who wants a job, has a job.

APSE Employment First Employment for All

GMSA Green Mountain Self-Advocates

Self Advocates Becoming Empowered

ThinkWork!

ICI UMass Boston

We will know Employment First policies are working when people with disabilities:

	Earn minimum wage or higher.		Are valued by employers.
	Have jobs with benefits.		Feel welcome when applying for a job.
	Own and run businesses.		Don't live in poverty.
	Choose employment as one of the big goals in life.		Get promoted.
	Are given the supports they need to work, no matter what type of disability they have.		Have all kinds of jobs based on their strengths and talents.
	Get to try out different jobs, starting when they are teenagers.		Have opportunities to change jobs and build a career.

If a person is not working in the community, this decision should be reviewed every year. A person's team must write a report describing why the person is not working.

Supported Employment

Promote competitive, integrated, and meaningful employment opportunities for Alaskans

Supported employment is founded on the belief that anyone can work if provided the right supports. Supported employment services help Alaskans with intellectual-developmental disabilities, behavioral health disorders, dementia, and traumatic brain injury, obtain and maintain employment in typical work settings, earning competitive wages and benefits, side-by-side with people who do not experience disabilities.

When Alaskans with disabilities are employed, they contribute positively in their communities, pay taxes, and experience meaningful engagement that reduces isolation and promotes health and well-being.

Sensible investment to grow a diverse workforce that includes people with disabilities, means directing resources for grant programs, vocational rehabilitation, university programs, peer support and mentorship, and more.

Alaska Mental Health Trust (Trust) beneficiaries[1] benefit from practices, policies, and funding that promote supported employment. The Trust and its partner advisory boards promote evidence-based strategies and best practices that increase opportunities for beneficiaries to gain integrated, competitive, and meaningful employment in their communities.

Employing People with Disabilities

Employment for people with disabilities is associated with better health and lower public costs. A 2013 University of Kansas study found that "participants with any level of paid employment had significantly lower rates of smoking and better quality of life; self-reported health status was significantly higher; and per person per month Medicaid expenditures were less."[2]

American Community Survey data from 2017 reveals that only 40% of Alaskans with a disability are currently employed, compared to 80% of people without disabilities. For some beneficiary groups, the rate of employment is even lower. For example, only 26% of Alaskans with a cognitive disability are employed.[3]

Employment is an essential part of recovery for many individuals with behavioral health disorders, offering positive impacts on life satisfaction, self-esteem, and reducing symptoms. Two-thirds (66%) of people with serious mental illness indicate they want to work, but only 15% are employed.[4]

Additionally, employment is a way out of poverty and a way to prevent people from becoming homeless or entering the disability or criminal justice systems.

Supported Employment in Alaska

Alaska is an *Employment First* state. *Employment First* is a national movement to promote employment in the general workforce as the preferred option for people with disabilities receiving assistance from publicly-funded systems. Alaska state agencies work together to support disability resource coordinators at job centers, public school

transition services, vocational rehabilitation, and more. Following are some of these efforts:

The Division of Vocational Rehabilitation (DVR) within the state Alaska Department of Labor and Workforce Development (DOLWD) helps Alaskans with disabilities prepare for and maintain employment. Vocational rehabilitation might include job counseling, referrals, training, placement services, and assistive technology.

The Division of Senior and Disabilities Services (SDS) provides individuals with intellectual and developmental disabilities (IDD), who are eligible for waiver long term waiver services, with opportunities for supported employment services. Within SDS, the Governor's Council on Disabilities and Special Education (GCDSE) leads a collaborative employer engagement group called the *Business Employment Services Team* which supports employers in hiring people with disabilities.[5]

The Division of Behavioral Health (DBH) within the Department of Health and Social Services (DHSS) promotes competitive grant funds and the *Individual Placement and Support* (IPS) program, an evidence-based model that promotes customized and transitional employment services for people with serious mental illness and substance use disorders.

The Department of Revenue (DOR) administers the Alaska *Achieving a Better Life Experience* (ABLE) program that helps Alaskans with disabilities save for qualified disability expenses without losing eligibility for certain public assistance programs.

Other statewide programs that offer supported employment resources, include the *Client Assistance Program*, *Alaska Tribal Vocational Rehabilitation Program*, *Disability Determination Services*, and *Ticket to Work.*

What Needs to Happen?

- ✓ Initiate a statewide *Alaska Work Matters* or *Employment First* taskforce to further implement Alaska's 2014 *Employment First* law concepts of competitive and integrated employment for Alaskans with disabilities, including *State as A Model Employer* (SAME) efforts;
- ✓ Support continued funding and grant opportunities for supported employment activities and programs in Alaska;
- ✓ Provide training and technical assistance to service providers to implement practices that support employment for people with all kinds of disabilities, at all levels;
- ✓ Enhance apprenticeship opportunities for Alaskans with disabilities, including people with behavioral health disorders;
- ✓ Reduce barriers in state policy, procedure, and regulations related to employment for people with disabilities across the lifespan.

The Trust and partner advisory boards support competitive, integrated, and meaningful employment opportunities for Alaskans with intellectual-developmental disabilities, behavioral health disorders, dementia, and traumatic brain injury.❖

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[1] *Alaska Mental Health Trust beneficiaries include Alaskans with mental illness, substance use disorders (SUD), Intellectual/Developmental Disorders (IDD) including fetal alcohol spectrum disorders (FASD), Alzheimer's disease and related dementia (ADRD), and Traumatic Brain Injury (TBI).*

[2] *Hall, J., Kurth, N., Hunt, S., Employment as a Health determinant for Working-age, Dually-eligible People with Disabilities, University of Kansas, 2013: https://kuscholarworks.ku.edu/handle/1808/11286?show=full*

[3] *Erickson, W., Lee, C., & von Schrader, S. (2019). 2017 Disability Status Report: Alaska. Ithaca, NY: Cornell University Yang-Tan Institute on Employment and Disability(YTI). http://www.disabilitystatistics.org/StatusReports/2017-PDF/2017-StatusReport_AK.pdf?CFID=21287273&CFTOKEN=1f758a616f571dc8-1AA49A94-0C14-2190-8A1E96E1F192CCA3*

[4] *Individualized Placement Support (IPS) Employment Center https://ipsworks.org/index.php/evidence-for-ips/*

[5] *For more resources on employment, visit the Council's Alaska Transition Handbook: Pathway to Adulthood and Employment. http://dhss.alaska.gov/gcdse/Documents/TransitionsHandbook.pdf*

For more information, go to: www.alaskamentalhealthtrust.org/jointadvocacy

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Focus Area: Disability Justice/Criminal Justice Reform and Reinvestment

Program Officer: Travis Welch

Since 2005, trustees have directed significant funding and staff resources towards criminal justice reform efforts in Alaska. In addition to reform efforts, the Trust has worked to address related issues affecting beneficiaries, including reducing beneficiary involvement and recidivism in the criminal justice system, and preventing the victimization of beneficiaries.

In 2014 the Trust funded a study of the prevalence and characteristics of Trust beneficiaries who entered, exited, or resided in an Alaska Department of Corrections (DOC) facility between July 1, 2008 and June 30, 2012. The study identified over 60,000 unique individuals, of which 30 percent identified as Trust beneficiaries. Additionally, Trust beneficiaries accounted for more than 40 percent of the incarcerations each year.

According to the 2018 Alaska Scorecard, DOC has become the largest provider of mental health services in the State of Alaska, and has the highest growth rate for incarceration per capita in the U.S. Since 2000, the average number of sentenced inmates in Alaska has increased each year by an average of 2.4% - higher than the national average.

Trust beneficiaries are at increased risk of involvement with the criminal justice system both as defendants and as victims. Limitations and deficiencies in community emergency response, treatment, and support systems make the criminal justice system the default emergency response to Trust beneficiaries experiencing a crisis as a result of their disorder. The median length of stay for Trust beneficiaries in a DOC facility is significantly longer than for non-Trust beneficiary offenders. Among those committing felonies, it is double; for misdemeanors, it is 150% longer.

The Alaska criminal justice system continues to be a top priority of the Alaska Legislature and the executive branch. Areas of emphasis center on offender diversion programs such as crisis stabilization and therapeutic courts, providing behavioral health services for persons who are incarcerated, and reentry services for returning citizens. The disability justice focus area strategies are well aligned with these priorities and the Trust FY21 budget provides support for partners who are engaged in these efforts.

Comp Plan Strategy Alignment

The disability justice focus's work with partner to ensure the criminal justice system effectively accommodates the needs of victims and offenders who are Trust Beneficiaries aligns with these plan objectives:

Goal 7, Objective 7.3 Reduce the number of Trust beneficiaries entering or becoming involved with Alaska's criminal justice system.

Goal 8, Objective 8.3 Enhance and expand access to clinical and case management resources for Alaskans who are incarcerated.

Partners:
The Trust disability justice focus area partners include the Trust Advisory Boards, community providers, tribal behavioral health partners, Alaska Department of Corrections (DOC), Alaska Court System, Alaska Justice Information Center, Law enforcement agencies, Alaska Office of Public Assistance (OPA), Alaska Public Defender Agency and Alaska Legal services, Alaska Division of Juvenile Justice (DJJ), University of Alaska Anchorage Center for Human Development, statewide prisoner Reentry coalitions.

Impact of Trust Supported Projects and Initiatives:

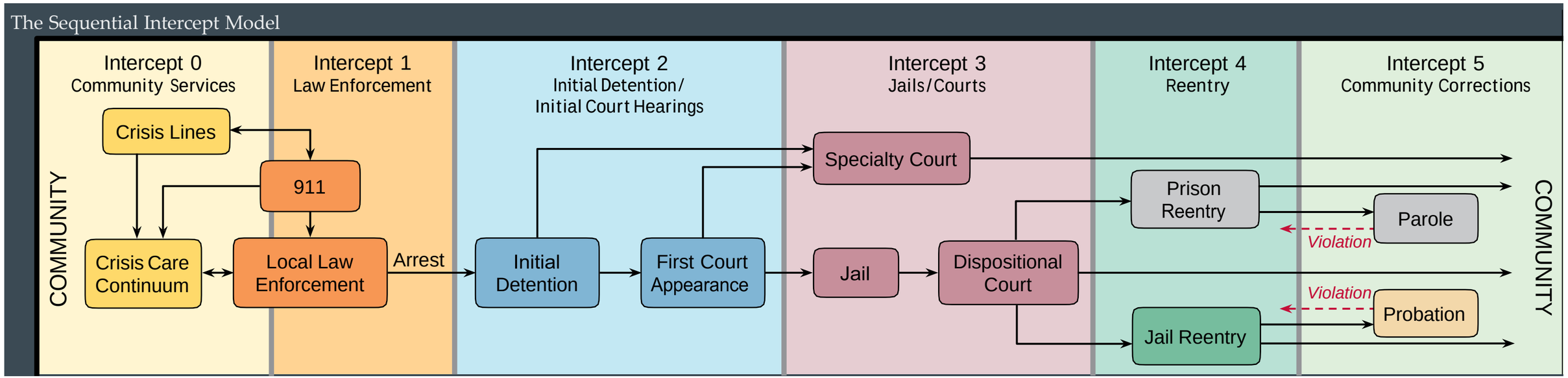
- Through the Trust disability justice focus area and other statewide efforts to reduce criminal justice recidivism, Alaska has achieved its lowest recidivism rate in the past 10 years. The percentage rate has dropped from the mid to high 60's to 59% for the 2016-2019 cohort of individuals being released from prison.
- The Bethel Holistic Defense project and therapeutic courts worked to divert beneficiaries out of the traditional court process and assist them with receiving services ranging from criminal defense and civil representation to mental health counseling and case management. The Bethel Holistic Defense project has served hundreds of beneficiaries since its inception in 2016, and is currently working to expand the project into Nome and Kotzebue.
- In 2019, the Trust-supported therapeutic court had an averaged utilization rate of 74% with 51 beneficiaries graduating the program. The overall state wide therapeutic court program had an average utilization rate of 94% with 131 beneficiary graduates over the same time period.

Current and Future Strategies:

- The Trust uses the Sequential Intercept Model (SIM) as the foundation for making funding and policy decisions in this focus area, with the overall goals being:
    1. Developing criminal justice and community behavioral health partnerships,
    2. Diverting Trust beneficiaries from the criminal justice system,
    3. Maintaining public safety by improving the health of beneficiaries and Alaska communities.
- To build upon the momentum of work already underway, the Trust will continue to support expansion of therapeutic courts, the holistic defense project, reentry coalitions and forensic peer support. The Trust will also focus on expanding programs which educate beneficiaries, providers, law enforcement officials, court staff, as well as policy makers and communities as a whole about justice involved beneficiaries.

Budgeting Considerations:
To ensure that the Trust can continue to provide funding for programs which serve beneficiaries involved in the criminal justice system or to prevent future involvement, Trustees have authorized a budget of $2,674,900 for this focus area in FY21.

Alaska Mental Health Trust Authority
Sequential Intercept Model
Disability Justice Focus Area
April 2020



Anchorage Reentry Coalition

Reentry Simulations

The Reentry Simulation is a community-driven activity that offers participants a hands-on opportunity to experience the challenges associated with reentry into the community after incarceration.

Simulations

9 Reentry Simulations in Anchorage to date in 2019-2020

6 Locations Used to Hold and Host Simulations

Technical Assistance and Support for Reentry Coalitions and Simulations in Juneau, Fairbanks, and the Mat-Su Valley

Co-hosts: UAA, College of Health; Alaska Native Justice Center; U.S. Attorney's Office, District of Alaska; Alaska Public Defender Agency; Alaska Dept. of Labor and Workforce Development; Reducing Recidivism & Reentry Conference

Reducing Recidivism & Reentry Conference

180 PEOPLE

BIGGEST SIMULATION IN AK

Participation

Total Attendees per Simulation	**45-180**
Total Unique "Reentrant" Participants	**+365**
Total Unique Simulation Volunteers	**112**
Volunteers That Participated +2 Times	**38%**

Satisfaction & Feedback

83%
Participants That Found the Simulation Either Very Impactful or Extremely Impactful

96%
Participants That Agreed or Strongly Agreed the Simulation was a Good Use of Their Time

95%
Participants That Would Recommend Participating in a Simulation to Another Person

"Extremely helpful in understanding reentry challenges. Will be useful in working with clients."

"I have had family and friends deal with these situations and I think its great you are raising awareness!"

"It helped me understand frustrations and biases and failure one would feel trying to stay afloat."

Thank you to the Alaska Mental Health Trust, the U.S. Attorney's Office, District of Alaska, NeighborWorks Alaska, and all the co-hosts, partner organizations, and volunteers that continue to make the reentry simulations such a success in Anchorage and around Alaska! Contact the Anchorage Reentry Coalition to learn more (reentry@nwalaska.org).

April, 2020 - V 1.0

Trust
Alaska Mental Health Trust Authority

ABADA Advisory Board on Alcoholism and Drug Abuse
AMHB Alaska Mental Health Board

GOVERNOR'S COUNCIL ON DISABILITIES & SPECIAL EDUCATION

Reducing Recidivism through Treatment and Reentry Supports

Promote rehabilitation practices and improved supervision to increase public safety

With 65% of Alaska's inmate population having a diagnosable mental health disorder,[1] the Alaska Department of Corrections (DOC) is, by default, the largest provider of mental health and substance use disorder services in the state.

According to an Alaska Mental Health Trust report published in 2014, Trust beneficiaries[2] are at increased risk for involvement with the criminal justice system and account for more than 40% of Alaska's incarcerations each year. Additionally, their median length (or mid-point) of stay is significantly longer than for other offenders. For beneficiaries who commit felonies, the length of stay is double that of a non-beneficiary, and for misdemeanors, it is 150% longer.[3]

The Trust and partner advisory boards believe that justice-involved beneficiaries are best served with access to treatment, housing, employment assistance, education, and training, so they are more likely to experience rehabilitation and less likely to commit new crimes.

Since about 95% of incarcerated Alaskans will serve their time and return to our communities,[4] funding for in-custody programs and community-based supports is a wise investment for improving public safety, reducing criminal recidivism, and creating safer, healthier communities.

Improved Practices Underway in Alaska

All Alaskans benefit when returning citizens have access to services and programs that help address the root causes of criminal behavior. Below are some of the improved efforts currently underway in Alaska:

Reentry Coalitions. Community coalitions have formed in Anchorage, Mat-Su, Fairbanks, Juneau, Kenai, Dillingham, Ketchikan, and Nome, to support individuals returning to the community after incarceration. Coalition efforts are helping to reduce barriers and improve community education and outreach. Alaska's reentry coalitions partner with profit and non-profit organizations, state agencies, and tribal, faith-based, and business organizations, to address barriers and promote practices that increase successful reentry and reduce recidivism.

Reentry Case Managers. Both DOC institutional probation officers and community case managers are partnering to provide early release planning 90-days before release for individuals at high-risk of recidivating. Reentry case managers provide transitional support for accessing housing, employment, training and education, healthcare, including behavioral health treatment, peer support, family reunification, and more, to increase the likelihood of stability and success after release.

Treatment inside prisons and halfway houses. Funding remains in place for mental health and addiction treatment inside prisons and halfway houses, with efforts to expand programming statewide. Treatment services can be the foundation of success after release from incarceration.

Improved prison population management practices. DOC prioritizes, when appropriate, separating low-level offenders from serious violent offenders, to prevent exposure to more serious anti-social and criminal behaviors. A large body of research shows that mixing low-level misdemeanants with high-level criminal offenders results in the low-level offenders returning to the community at higher risk for committing new crimes.

Strengthened community supervision during pretrial phase. DOC's Pretrial Enforcement Division provides improved supervision to defendants awaiting resolution of their criminal case, including connecting them to community resources that provide tools for long-term change and success, and increased likelihood of compliance with conditions of release.

Therapeutic Courts. Therapeutic courts offer court-supervised probation and rehabilitation support for people with mental illness, addiction, and other disorders. Specially-trained probation officers offer intensive case management and assistance for maintaining housing, employment, treatment, and recovery, while carrying out the obligations of their probation.

Access to limited driver's licenses. People convicted of a first felony DUI offense may receive a provisional driver's license if they: 1) participate in a therapeutic court program, or, if living where there isn't a therapeutic court, participate in a treatment program similar to a therapeutic court program, and 2) can prove he or she has been sober for 18 months.

Recidivism Reduction Fund. 50% of the revenue collected from the state's marijuana taxes has been invested into services and programs serving justice-involved individuals that include: 1) reentry services funded through DHSS for case managers who offer transitional planning and support; 2) substance use disorder treatment within DOC facilities; and 3) violence prevention programs through the Council on Domestic Violence and Sexual Assault.

The Trust and partner advisory boards support maintaining current efforts to enhance and expand services and programs that promote treatment and rehabilitation, improved public safety, and reduced criminal recidivism for justice-involved beneficiaries. ❖

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[1] *Trust Beneficiaries in Alaska's Department of Corrections, Hornby Zeller Associates (May 2014), pii). http://mhtrust.org/mhtawp/wp-content/uploads/2014/10/ADOC-Trust-Beneficiaries-May-2014-FINAL-PRINT.pdf*

[2] *Alaska Mental Health Trust beneficiaries include people with mental illness, substance use disorders (SUD), intellectual-developmental disabilities (IDD), including fetal alcohol spectrum disorders (FASD), Alzheimer's disease and related dementia (ADRD), and Traumatic Brain Injury (TBI).*

[3] *Trust Beneficiaries in Alaska's Department of Corrections, Hornby Zeller Associates (May 2014), pii). http://mhtrust.org/mhtawp/wp-content/uploads/2014/10/ADOC-Trust-Beneficiaries-May-2014-FINAL-PRINT.pdf*

[4] *Alaska Department of Corrections presentation to Alaska State Legislature, 2018.*

[5] *Division of Public Health, Alaska Bureau of Health Analytics & Vital Records.*

For more information, go to: www.alaskamentalhealthtrust.org/jointadvocacy

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Priority Area: Early Childhood Intervention & Prevention

Program Officer: Jimael Johnson

Beneficiaries come from all ages and all walks of life, including parents of young children (past and present) as well as infants and children themselves (present and future). Trust beneficiaries as defined in the Trust settlement include "all persons who are past, present, and future beneficiaries of the mental health lands trust" and Trust statutes highlight prevention services and work as one of many ways Trust resources can be deployed. It is this guidance as well as the expertise of our advisory boards and other key stakeholders that provides a framework for Trust work in this area.

The sooner beneficiary families including infants and young children are identified and connect with needed supports, the better their outcomes, as proven by decades of early intervention and brain development research. The Trust's "Bring the Kids Home" focus area initiative (2004-2012) highlighted the need for earlier identification and intervention of behavioral health supports for children and families to prevent the need for increasingly higher levels of care.

Part C of the federal Individuals with Disabilities Education Act (IDEA) provides funding to states to support early intervention systems for children age birth to three years with developmental delays or disabilities. Alaska's eligibility threshold for early intervention services is more limiting than many other states, meaning that many young beneficiaries are not able to access these high-quality supports at the most critical time in their development. The Trust works closely with Alaska's Part C program, also called the Infant Learning Program, to identify opportunities and improve access of these critical services for young beneficiaries and their families.

Additionally, the Trust recognizes the significance of trauma and Adverse Childhood Experiences (ACEs) and the fact that trauma is highly correlated with beneficiary groups, particularly those experiencing mental illness and substance use disorders. Alaska children are exposed to trauma early, with 1 in 3 (32%) reported to child welfare before their 7th birthday, according to the Alaska Longitudinal Child Abuse and Neglect (ALCAN Link) study. A report of harm to child welfare is an early indicator of problems and often predict family and child social and behavioral health support needs.

Comp Plan Strategy Alignment

Early childhood programs emerged as a primary focus in the plan. This focus area particularly aligns with the objectives of this goal:

Goal 1: Early Childhood – Programs serving young children promote resiliency, prevent and address trauma, and provide access to early intervention.

Goal 1, Objective 1.1: Promote practice-informed, universal screening efforts and early intervention services.

Goal 1, Objective 1.2: Provide ongoing support to ensure accurate identification and treatment of social-emotional needs for children and their caregivers, congruent with their cultural identification.

Goal 1, Objective 1.3: Reduce the instances and impact of Adverse Childhood Experiences (ACEs) through community engagement and by improving social determinants of health.

However, our current system does not usually intervene until children are at least school age (often late elementary) and can miss critical opportunities for optimally effective early intervention. Precise and targeted prevention occurring before birth and throughout childhood is needed to reduce or lessen the impact of negative childhood events that result in trauma (Alaska Division of Public Health, 2020).

Intervening early in childhood can alter the life course trajectory in a positive direction (Kellam et al., 2008; Kitzman et al., 2010). Substance abuse and other problem behaviors that manifest during adolescence have their roots in the developmental changes that occur earlier—as far back as the prenatal period. While early intervention can be effective at any age, it is especially powerful when applied early in a person's life, when development is most easily shaped and the child's life is most easily set on a positive course. Decades of research show the highest rate of economic returns comes from the earliest investments in children – up to a 13% return on investment for birth to age 5 five programs (Heckman, 2019).

Partners:
Primary partners include Trust advisory boards (Governor's Council on Disabilities and Special Education, Alaska Mental Health Board/Advisory Board on Alcoholism and Drug Abuse) and state agencies such as the Divisions of Behavioral Health and Public Health, Senior & Disabilities Services, Public Assistance Child Care Program Office, and the Department of Education and Early Development. Community partners are also critical, including the All Alaska Pediatric Partnership, thread, Head Start, Alaska Association for Infant and Early Childhood Mental Health, Association of Alaska School Boards, Rasmuson Foundation, Alaska Children's Trust and many others.

Impact of Trust Supported Projects and Initiatives:
The Trust continues to develop strategies and investments related to early childhood with promising results. Three recent investments with established or promising impact are highlighted below.

- Medicaid 1115 Behavioral Health Waiver: Anticipated impacts from the waiver include new services to increase early intervention and prevention supports for families and young children at-risk of experiencing mental health issues.
- Partnership Access Line – Pediatric Alaska (PAL-PAK): PAL-PAK offers child and adolescent mental health consultation services available to any Alaskan pediatric care provider in partnership with Seattle Children's Hospital and Help Me Grow Alaska. Consultation includes support for diagnostic clarification, medication adjustment, or treatment planning.
- Trauma-Informed Schools: The Trust has supported an intensive Juneau School District pilot of trauma-informed practice in three elementary schools. Preliminary evidence shows increased teacher capacity to handle challenging behaviors and improved student outcomes. Lessons learned from the pilot have been incorporated into a statewide trauma-informed schools framework.

Current and Future Strategies:

The Trust is poised to join the growing number of private and public foundations engaged in early childhood systems transformation. As a catalyst for change, the Trust is key influencer and able to build on past and current investments for this important beneficiary population. Early childhood investments promise profound benefits to beneficiaries, families, and communities.

- Screening and assessment: Early identification of developmental and other needs is critical to ensure young beneficiaries are well supported for maximum benefit reduced cost. Improved access to screening, assessment and appropriate service referrals in a range of child-serving settings is essential.

- Integration of behavioral health into primary care settings: Integrated care in a primary care setting has proven to improve access, reduce cost, and reduce stigma related to behavioral health needs for young children and their families.
- Enhanced home visiting supports: Through technology and innovative service delivery models, the Trust and partners seek to expand access to culturally relevant and effective early intervention services provided in home settings (i.e. Infant Learning Programs, Early Head Start, etc.)
- Trauma-engaged practice and behavioral health supports in educational settings: Partners statewide continue to prioritize enhanced trauma-engaged practice and behavioral health supports for students and consultants for staff in educational settings. Settings include early care and education, pre-school and K-12.
- Infant and early childhood mental health: The Trust is working with multiple partners to expand infant mental health workforce capacity. Workforce continues to be identified by advisory boards and partners as a high priority to implement new early intervention focused 1115 Medicaid waiver services designed for children and families. New services will require specialized training related to parent-child attachment and social-emotional development that is not widely available in Alaska today.
- Data development and evaluation: The Trust is partnering with stakeholders to monitor systems related issues such as maternal and infant mental health service access and childcare rates of expulsion and suspension. This work will also inform development of common indicators and strategies to track progress and inform future beneficiary related early childhood investment.

Budgeting Considerations:

To further develop partnerships and strategies related to early childhood intervention and prevention, Trustees have authorized a budget of **$880,000** for FY21 activities.

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The Importance of Early Intervention for Infants and Toddlers with Disabilities and their Families

July 2011

The Infants and Toddlers with Disabilities Program (Part C) of the Individuals with Disabilities Education Act (IDEA) was created in 1986 to **enhance the development** of infants and toddlers with disabilities, **minimize potential developmental delay**, and reduce educational costs to our society by minimizing the need for special education services as children with disabilities reach school age.[1] Part C provides early intervention (EI) services to infants and toddlers aged birth to three with developmental delays or a medical condition likely to lead to a developmental delay. Part C is not intended to be a stand-alone program. The intent is to **build interagency partnerships** among state agencies and programs in health, education, human services and developmental disabilities.

WHY INTERVENE EARLY?

Decades of rigorous research show that children's earliest experiences play a critical role in **brain development**. The Center on the Developing Child at Harvard University has summarized this research:[2,3]

- Neural circuits, which create the foundation for learning, behavior and health, are most flexible or "plastic" during the **first three years** of life. Over time, they become increasingly difficult to change.
- Persistent **"toxic" stress**, such as extreme poverty, abuse and neglect, or severe maternal depression can damage the developing brain, leading to lifelong problems in learning, behavior, and physical and mental health.
- The brain is strengthened by **positive early experiences**, especially **stable relationships** with caring and responsive adults, safe and supportive environments, and appropriate nutrition.
- Early social/ emotional development and physical health provide the foundation upon which **cognitive and language skills** develop.
- High quality early intervention services can **change a child's developmental trajectory** and improve outcomes for children, families, and communities.
- Intervention is likely to be **more effective** and **less costly** when it is provided earlier in life rather than later.

WHY ARE SERVICES ESSENTIAL?

Positive early experiences are essential prerequisites for later success in school, the workplace, and the community. Services to young children who have or are at risk for developmental delays have been shown to **positively impact outcomes across developmental domains**, including health,[3] language and communication,[4-7] cognitive development[8,9] and social/emotional development.[8,10] Families benefit from early intervention by being able to better meet their children's special needs from an early age and throughout their lives.[8,11] Benefits to society include reducing economic burden through a **decreased need for special education**.[8,9]

WHAT ARE THE UNMET NEEDS?

There is a **high need** for good quality Part C early intervention programs.

- **More children are in need of services** than are currently being served. In 2009, Part C served 348,604 children nationally, which represents 2.67% of the general population of children aged birth to 3.[12] However, research indicates that as many as 13% of birth to 3 year olds have delays that would make them eligible according to criteria commonly used by the states.[13]

nectac
The National Early Childhood Technical Assistance Center
919-962-2001 • phone 919-966-7463 • fax
www.nectac.org • web nectac@unc.edu • email

- There is a need to **serve children earlier**. Research has shown that at 9 months of age, only 9% of children who have delays that would make them eligible receive services; at 24 months of age only 12% of children who would be eligible receive services.[14]
- Research also suggests that there are **racial disparities** in the receipt of EI services,[13,14] with black children who would be eligible at 24 months of age being up to five times less like to receive services than white children.[14]
- Young children experiencing **homelessness** are more likely to have lower birth weights than other children, learning disabilities, developmental delays, emotional problems and behavior issues,[15-18] yet they are greatly **underrepresented** in early childhood programs.[15]
- There is a significant shortage of **well-trained professionals** with expertise in serving very young children with **behavioral or emotional** (e.g. depression, anxiety) problems[19,20] that negatively impact early learning, social interactions, and the overall well-being of an estimated 9% to 14% of children aged birth to five.[21,22]

IDEA requires referral to Part C for any child under the age of 3 who is identified as affected by illegal substance abuse, or is involved in a substantiated case of child abuse or neglect.[1]

- Approximately **10-11% of all newborns have prenatal substance exposure**,[23] a risk factor for poor developmental outcomes. An estimated **90-95% of these infants are sent home at birth without being identified or referred for services**.[23]
- In 2009, 702,000 children experienced **substantiated abuse or neglect**; 40% of these children received no post-investigation services; **one third were under age four**, and **infants under the age of one were the most likely to be victims**.[24] These young children often have **high rates of physical, cognitive, social-emotional, relational and psychological problems**.[25,26]

TAKE HOME MESSAGE

- There is an urgent and substantial need to identify as early as possible those infants and toddlers in need of services to ensure that intervention is provided when the **developing brain is most capable of change**.[1]
- High quality early intervention programs for vulnerable infants and toddlers can **reduce the incidence of future problems** in their learning, behavior and health status.[2,3]
- Intervention is likely to be **more effective** and **less costly** when it is provided **earlier in life** rather than later.[2,3]

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BUILDING STRONG FOUNDATIONS:
Advancing Comprehensive Policies for Infants, Toddlers, and Families

CLASP
policy solutions that work for low-income people

ZERO TO THREE
Early connections last a lifetime

Early Intervention: A Critical Support for Infants, Toddlers, and Families

Infants and toddlers with developmental delays or disabilities should be identified and receive early intervention services in a timely manner. Infants and toddlers learn a lot in the first three years of life: how to roll over, sit up independently, crawl, stand, walk, and use language to communicate with caregivers and peers.[1] However, sometimes children's developmental progress does not go as expected. Infants and toddlers with developmental delays and disabilities likely need extra help in the form of early intervention to meet their developmental milestones. "Early intervention" refers to a system of services—including assistive technologies; speech and language, occupational, or physical therapy; nursing or other medical services; and resources for parents to better understand and promote their child's development—that supports infants and toddlers with developmental delays or disabilities and their families.[2]

Early identification and intervention are critical for infants and toddlers who have or are at risk for delays and disabilities. When problems are identified early, timely intervention can mitigate or even eliminate the long-term effects on children's language, cognitive, motor, and social-emotional development,[3] while possibly reducing the need for intensive special education services later. One national study of children who participated in early intervention found that roughly one-third of infants and toddlers who received services did not have a disability at entry into kindergarten.[4] In an evaluation of Early Head Start, researchers found that low-income infants and toddlers who received early intervention services were more likely to catch up to their peers without delays or disabilities compared to children who were suspected of delay but did not receive services.[5] Early intervention services benefit parents as well by equipping them with the skills necessary to support their children's special needs.[6]

Part C of the federal Individuals with Disabilities Education Act (IDEA) provides grant funding to states to support early intervention systems.[7] States are required to operate a Child Find program as part of this system to identify children with developmental delays and disabilities and refer them to services. States must serve all eligible children younger than age 3 who meet the state-established criteria for developmental delay, or whose diagnosed condition is associated with a high probability of developmental delay. Providers develop an Individualized Family Service Plan (IFSP), which identifies the child's needs, developmental goals, and the services he or she will receive. By law, these services must be provided in children's "natural environments"—their homes, child care programs, or communities—to the maximum extent possible. States can impose fees on families but cannot deny services to families due to an inability to pay.

Despite the importance of early identification and intervention, many infants and toddlers with disabilities or developmental delays are not being identified and receiving early intervention. In federal fiscal year 2016, roughly 3 percent of children under age 3 received services through Part C,[8] yet experts estimate that as many as 13 percent of infants and toddlers could benefit from early intervention.[9] A significant proportion of children with unmet needs are probably in low-income families, as low-income children are more likely to be at risk of developmental delay or disability but less likely to receive services.[10] Some evidence also indicates that children of color with developmental delays are less likely to receive services compared to their White peers.[11] Accessing early intervention services is a multi-step process, and, unfortunately, families have many opportunities to fall through the cracks.

Overall, the rate of developmental screenings in the United States is low—just 31 percent of parents reported that their child aged 10 months to 5 years received a standardized developmental screening in the last 12 months.[12] Proper screening is an important first step in ensuring that problems with development are identified and further evaluated, and that children are referred for services.[13]

Even if all infants and toddlers were being screened, evaluated, and referred for services, early intervention systems would likely struggle to adequately serve all eligible infants and toddlers due to significant funding challenges. Federal appropriations for Part C have been mostly flat over the last decade and have declined in real dollars since 2003.[14] Notably, federal funding for Part C of IDEA is intended to support states in planning, developing, and implementing their early intervention systems, rather than to fully fund the provision of services.[15] Services are supported by a combination of state and other federal funds, and some states have local funding as well.[16] Medicaid is the largest federal funding source for early intervention services, comprising at least 20 percent of total funding.[17] Conversely, federal Part C funds comprise just 13 percent of total funding.[18] At present funding levels, federal support for Part C cannot even function as the "glue" for state early intervention systems as it was intended.

While federal regulations require that states serve infants and toddlers with developmental delays, states have the flexibility to define Part C eligibility criteria and can choose whether or not to serve those who are at high risk for delay.[19] At present, just five states serve children at risk for delay: Illinois, Massachusetts, New Hampshire, New Mexico, and West Virginia. States' methods for determining eligibility vary widely, and even those who serve children at risk define "risk" differently.[20] Consequently, the proportion of infants and toddlers served varies widely, from 1.72 percent in Mississippi to 9.05 percent in Massachusetts.[21] In the last decade, 20 percent of states narrowed their eligibility criteria in response to budgetary pressures,[22] which has resulted in lower enrollment rates.[23]

States also have the flexibility to determine how they will administer services. Year after year, states make adjustments to their programs to meet increasing demand with limited funding. Some states implement or increase fees for families; reduce reimbursement rates for providers; or require families to use private insurance.[24] States are also increasingly relying on Medicaid to provide early intervention to Medicaid-eligible infants and toddlers through the program's Early and Periodic Screening, Diagnostic, and Treatment benefit.[25] While these approaches are intended to help states better serve all eligible children, they may reduce the availability, frequency, or intensity of services available to families, particularly those who are uninsured or under-insured.[26]

Changes in funding levels and in how states administer programs also affect providers, who face decreasing reimbursement rates, increasing caseloads, and high staff turnover in some states.[27]

The first three years of children's lives set the stage for their developmental trajectories. Early intervention equips parents with the skills to support their children's special needs and enhances children's developmental progress, reducing the need for more intensive and costly services later. At present, too many infants and toddlers with delays and disabilities are going unidentified and are not accessing early intervention due to budget shortfalls. Significant federal and state investments in Part C are necessary to bolster states' Child Find efforts; improve service coordination and provision; and address provider availability, training, and oversight. Early intervention provides infants and toddlers with disabilities and delays the support they need to learn and grow, but will continue to fall short of serving all families in need until policymakers invest substantial resources.

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Trust
Alaska Mental Health Trust Authority

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Priority Area: Workforce Development

Program Officer: Eric Boyer

Since 2008, the Trust has used workforce development strategies to support recruitment and retention of healthcare employees across Alaska who provide in-patient and community-based care to our beneficiaries. To provide quality care for our beneficiaries we must have a robust health care system across Alaska's communities that can provide necessary care and on-going support. This level of care helps improve our beneficiary's quality of life, and with their ability to choose how and where they live. Focusing on the workforce is integral to supporting the 1115 Waiver services expansion, as well as projects like *Crisis Now* that will go hand-in-hand with these expanded services.

The AK Department of Labor and Workforce Development (DOLWD) predicts the health care industry will increase 21.4% by 2026, which equates to over 10,000 new jobs. At the same time, our workforce demographic, 18-64 year olds, is declining. This means we must focus not only on growing our own workers, but simultaneously recruit heavily from outside Alaska. According to DOLWD, 47 of Alaska's 50 fastest-growing occupations are in the healthcare sector, and the Alaska Healthcare Workforce Coalition is leading efforts to supporting that job growth. Furthermore, health care workforce development is essential to maintaining the state's overall economic health during this period of low oil prices, COVID-19 mandates, and associated impacts.

Partners:
The Alaska Health Workforce Coalition is a group of industry associations, tribal health, state departments, and universities who come together monthly to develop a coordinated, cohesive, and effective approach to addressing the critical needs for health workers in Alaska.

Impact of Trust Supported Projects and Initiatives:

- SHARP direct incentive/loan repayment program supported 349 provider loan-repayment contracts over last 10 years**.** With support from the Trust, the next SHARP enrollment period begins May 1 and runs through July 15, and will add up to 100 additional healthcare professionals to the workforce. 50% of patients seen by SHARP

Comp Plan Strategy Alignment

Making progress on the plan's goals and objectives requires a competent workforce that can carry out the services outlined in the plan. Therefore, it is imperative to engage, recruit, train, and retain the professionals that do this work.

> Goal 9, Objective 9.1: Strengthen workforce capacity with improved recruitment and retention to obtain and maintain knowledge and support innovation and modernization.

As the healthcare field is constantly evolving, and it takes a nimble group of organizations to meet this ever-changing field. A recent example of this necessity is the adaptation of practices and services to meet Medicaid expansion through the 1115 waiver. This idea is evident in this objective:

> Goal 9, Objective 9.2: Advance the competencies of the healthcare, behavioral health, and public health workforce.

clinicians were covered by Medicaid or Medicare. Currently, SHARP clinicians average over 500 patients seen per quarter.

- The Trust has long supported and partnered with the AK Training Cooperative, which is meeting the needs of direct service providers, training 4,000 individuals each year over the last five years. The AKTC continues to be a leader in the state in providing training and technical assistance for evidence-based practices including Screening, Brief Intervention, and Referral to Treatment (SBIRT), Safety Planning Intervention, MHFA, Question, Persuade, and Refer (QPR), Alternatives to Violence, and Crisis Intervention Training with our law enforcement officers.
- The Alaska Area Health Education Centers (AHEC) had 267 youth and teachers participate in Health Career Pathway Intensives, which is a collection of camps and academies designed to encourage students to consider healthcare professions. There are 80 more students projected to participate through the PATH academies during FY 20. Camps targeted the age group 15-19, and took place in Anchorage, Kodiak, Nome, Dillingham, Fairbanks, Akiak, Alakanuk, Juneau, and Bethel.

Current and Future Strategies:

- The Direct Service Professional (DSP) Career Pathway is a joint venture between the Southcentral AHEC and the AKTC to provide a 1-2 year career track and trainings needed to advance DSP competency to work in various social service settings.
- AKTC and provider partners will be providing peer support specialist training as the state moves into professionalizing this position through a certification body and approved training. The peer position will be integral to the implementation of the *Crisis Now* model.
- The state's growing 65 and over population will require a healthcare workforce to provide for their needs. One solution involves expanding the Path Academy model to address senior care. The Path Academy is piloting a three-week pre-apprenticeship training in healthcare - with an emphasis on working with the 65 and over demographic. Graduates of the program receive a stipend and are job-ready for a direct service provider position with agencies such as Access Alaska and the ARC of Anchorage.
- SHARP 3 is the program's latest iteration, and was created by state legislation passed in 2019. SHARP 3 will improve recruitment, retention, and distribution of health professionals in Alaska by expanding loan repayment, partnership funding, and administration fees. There will be a need to expand the financial support for participating agencies through collaborating with additional contributing funders.
- Health T.I.E (Testbed for Innovative Enterprises): Health T.I.E. is a project to create a structure for innovative approaches to challenging health and human service issues. A collaboration of the Trust, Matsu Health Foundation, the UAA Business Enterprise Institute (BEI), and Champney Consulting is building a business plan for an Alaskan-based accelerator focused on creating an ecosystem that encourages start-ups and innovative entrepreneurs to tackle "wicked problems" specific to health and human services, i.e., workforce shortages.

Budget Considerations:

Workforce is not a stand-alone focus area; rather it is embedded throughout the work of other focus areas and initiatives. Trustees authorized **$1,184,000** in FY21 for workforce related strategies/initiatives.

AT-A-GLANCE
2018 NATIONAL CORE INDICATORS® STAFF STABILITY SURVEY: RESULTS FROM ALASKA

NATIONAL CORE INDICATORS®
NASDDDS & HSRI

The National Core Indicators® (NCI®) Staff Stability Survey collects data from providers on the Direct Support Professional (DSP) workforce supporting adults (age 18 and over) who receive services from state developmental disabilities service systems.

The goal of the survey and the resulting data is to help states examine workforce challenges, identify areas for further investigation, benchmark their workforce data, measure improvements made through policy or programmatic changes, and compare their state data to those of other states and the NCI average.

In 2018, 26 states plus DC participated in the Staff Stability Survey.

This report shows state data along with the NCI weighted average. For more information on methodology, please see the 2018 Staff Stability Survey Report at www.nationalcoreindicators.org

This report was created by [STATE]

Alaska Provider Landscape

Of 95 eligible providers in the state, 69 are included in these results*.

Percentage of providers reporting the indicated number of DSPs on payroll:

	Numbers of DSPs on payroll			
	1-20	21-40	41-60	61+
Alaska	66.7%	8.7%	7.2%	17.4%
NCI Weighted Avg.	35.1%	12.5%	8.3%	44.1%

71% of providers in Alaska reported providing residential supports

60.9% of providers in Alaska reported providing in-home supports

75.4% of providers in Alaska reported providing non-residential supports

Types of support are not mutually exclusive

*represents a 6.20% margin of error

Alaska Turnover Rate is 35.8%

Participating states' turnover rates ranged from 30.7% to 62.7% with an NCI weighted Average of 51.3%

Full-Time Vacancy Rate: 7.6% (Weighted NCI Average: 11.9%)

Part-Time Vacancy Rate: 8.5% (Weighted NCI Average: 18.1%)

In Alaska among DSPs who were employed as of 12/31/18:

22.1% were employed less than 6 mos.

15.4% were employed 6-12 mos.

In Alaska among DSPs who **separated from employment** in 2018

24.9% had been employed less than 6 mos.

12.7% had been employed 6-12 mos.

Of all DSP separations in Alaska in 2018…

81.7% were voluntary separations

15.7% employment was terminated

2.6% don't know reason for separation

PERCENTAGE OF RESPONDING PROVIDERS REPORTING THAT THEY….

OFFER PAID TIME OFF TO SOME OR ALL DSPS:

Alaska: 47.8%

NCI: 77.5%

OFFER HEALTH INSURANCE TO SOME OR ALL DSPS:

Alaska: 36.5%

NCI: 70.6%

OFFER DENTAL INSURANCE TO SOME OR ALL DSPS:

Alaska: 40.0%

NCI: 66.1%

OFFER EMPLOYER SPONSORED RETIREMENT PLAN TO SOME OR ALL DSPS:

Alaska: 35.9%

NCI: 65.4%

MEDIAN HOURLY WAGES

Alaska: $16.00

NCI: $12.00

Alaska DSPs providing RESIDENTIAL supports: $15.12

NCI: DSPs providing RESIDENTIAL supports: $12.57

Alaska DSPs providing IN-HOME supports: $15.98

NCI: DSPs providing IN-HOME supports: $12.00

Alaska DSPs providing NON-RESIDENTIAL supports: $15.79

NCI: DSPs providing NON-RESIDENTIAL supports : $12.90

Trust
Alaska Mental Health Trust Authority

ABADA Advisory Board on Alcoholism and Drug Abuse
AMHB Alaska Mental Health Board

GOVERNOR'S COUNCIL ON DISABILITIES & SPECIAL EDUCATION

Workforce Development

Address workforce shortages for Alaskan healthcare professionals

Alaskans working in healthcare and social services are the foundation of a continuum of care for Alaska Mental Health Trust (Trust) beneficiaries.[1]

Healthcare professionals work for private and non-profit organizations, tribal, federal, local, and state entities, and contribute to a healthy workforce and strong Alaskan economy.

They provide "safety net" services that may include assisted living and personal care support, mental health and addiction treatment, case management, adult day and day habilitation programs, home-delivered and congregate meals, supported employment and job coaching, housing assistance, peer support and mentorship, and more.

Recruiting and retaining healthcare providers who serve Trust beneficiaries can be challenging. Work conditions are often stressful and physically challenging, and incentives to stay in-state or in the field are often limited. Lack of adequate pay, opportunities for full-time employment, benefits, mentorship and professional development are limited. Additionally, staff who leave their jobs under duress are less likely to return to the field, and with a generation of "baby boomer" workers retiring from the workforce, employers are losing seasoned professionals with knowledge and skills critically needed in healthcare in Alaska.

What is Alaska doing to build its healthcare workforce?

The Trust and partner advisory boards are working with both private and public agencies to address some of these challenges. Following are some of the statewide efforts currently underway:

The Alaska Training Cooperative (AKTC), administered under UAA, supports career development and training for healthcare providers that blends evidence-based practices with traditional knowledge. AKTC serves professionals engaged with Trust beneficiaries by ensuring that technical assistance and training is accessible and coordinated.

The Alaska Native Health Tribal Consortium (ANTHC) collaborates with the Alaska Department of Labor and Workforce Development, and the U.S. Department of Labor to promote apprenticeships through the *Behavioral Health Aide Registered Apprenticeship* program.

Licensed Marriage and Family Therapists (LMFT) and Peer Support Specialists are now Medicaid-reimbursable occupations, expanding the pool of professionals who can serve beneficiaries.

The University of Alaska is expanding health programs, including social work and behavioral health programs, based on regional health workforce assessments that identify local healthcare workforce needs.

The action agenda of the *Alaska Health Workforce Coalition*[3] contains systems change and capacity-building initiatives that address professional development, youth engagement, workforce policies, infrastructure, recruitment and retention, and evaluation and data.

The state's SHARP loan repayment program offers incentives for medical and mental health care professionals to seek and maintain employment in Alaska.

Initiatives focused specifically on Direct Support Professionals (DSP) include a DSP career and apprenticeship pathway for graduating high school students and displaced workers; creation of the Alaska Alliance of DSPs and a peer network focused on a strengthened workforce; and participation in the *National Core Indicators* survey to collect workforce data that will inform efforts and measure progress.

In addition, a healthcare innovation hub, *Health TIE*, will identify and support implementation of emerging technology to increase the capacity of the service system.

Who Are Alaska's Healthcare Professionals?

Direct Support Professionals (DSPs) *and* ***Personal Care Assistants (PCAs)*** provide long-term services that include assistance with daily living, systems navigation, non-clinical rehabilitation, transportation, and job coaching.

Case Managers assist in accessing services for personal care. ***Care Coordinators*** work across systems to coordinate an individual's healthcare plan, monitoring the delivery of services and fidelity of treatment and care.

Community Health Aides *and* ***Behavioral Health Aides*** offer primary, emergency, and behavioral healthcare in rural communities.

Behavioral Health Clinicians are licensed and non-licensed professionals who provide mental health and addiction treatment, assessments, recovery, and prevention.

Peer Support Specialists are people with lived experience of a disability or behavioral health disorder who serve as mentors, recovery coaches, and system navigators.

Psychiatrists, Geriatricians, Neurologists are physicians skilled in assessing and managing the specialized medical needs of people with disabilities, including people with behavioral health disorders.

How can we build our workforce?

- Adequate livable wages for direct care providers to better recruit and retain staff who work directly with beneficiaries;
- Adequately-trained professionals to provide supervision, mentorship, and oversight, and improve the stability and safety of both staff and clients in urban and rural communities;
- Adequate transition support for Alaskans returning to the community after institutional care (psychiatric hospitals, juvenile detention, foster care, residential behavioral health, nursing homes, prison);
- Specialized services that assist justice-involved Trust beneficiaries during pretrial, incarceration, and reentry phases of their justice involvement;
- Incentives to address high turnover, burn-out, and early departure from healthcare employment;
- Enhanced apprenticeship opportunities for Alaskans with disabilities; and
- Further implementation of Alaska's *Employment First* efforts, including ramping up *State as a Model Employer* (SAME) within Alaska state departments.

The Trust and partner advisory boards support resources to recruit, engage, train, and retain healthcare professionals, and address Alaska's shortage of professionals serving Alaskans with disabilities, including behavioral health disorders, across the lifespan. ❖

[1] *Alaska Mental Health Trust beneficiaries include Alaskans with mental illness, substance use disorders (SUD), Intellectual/Developmental Disorders (IDD) including fetal alcohol spectrum disorders (FASD), Alzheimer's disease and related dementia (ADRD), and Traumatic Brain Injury (TBI).*

[2] *Healthcare professionals who serve Trust beneficiaries include direct support professionals, personal care attendants, case managers and care coordinators, community behavioral health clinicians and aides, peer support specialists, psychiatrists, geriatricians, neurologists, and more.*

[3] *Alaska Health Workforce Coalition 2017-2021 Action Agenda.*

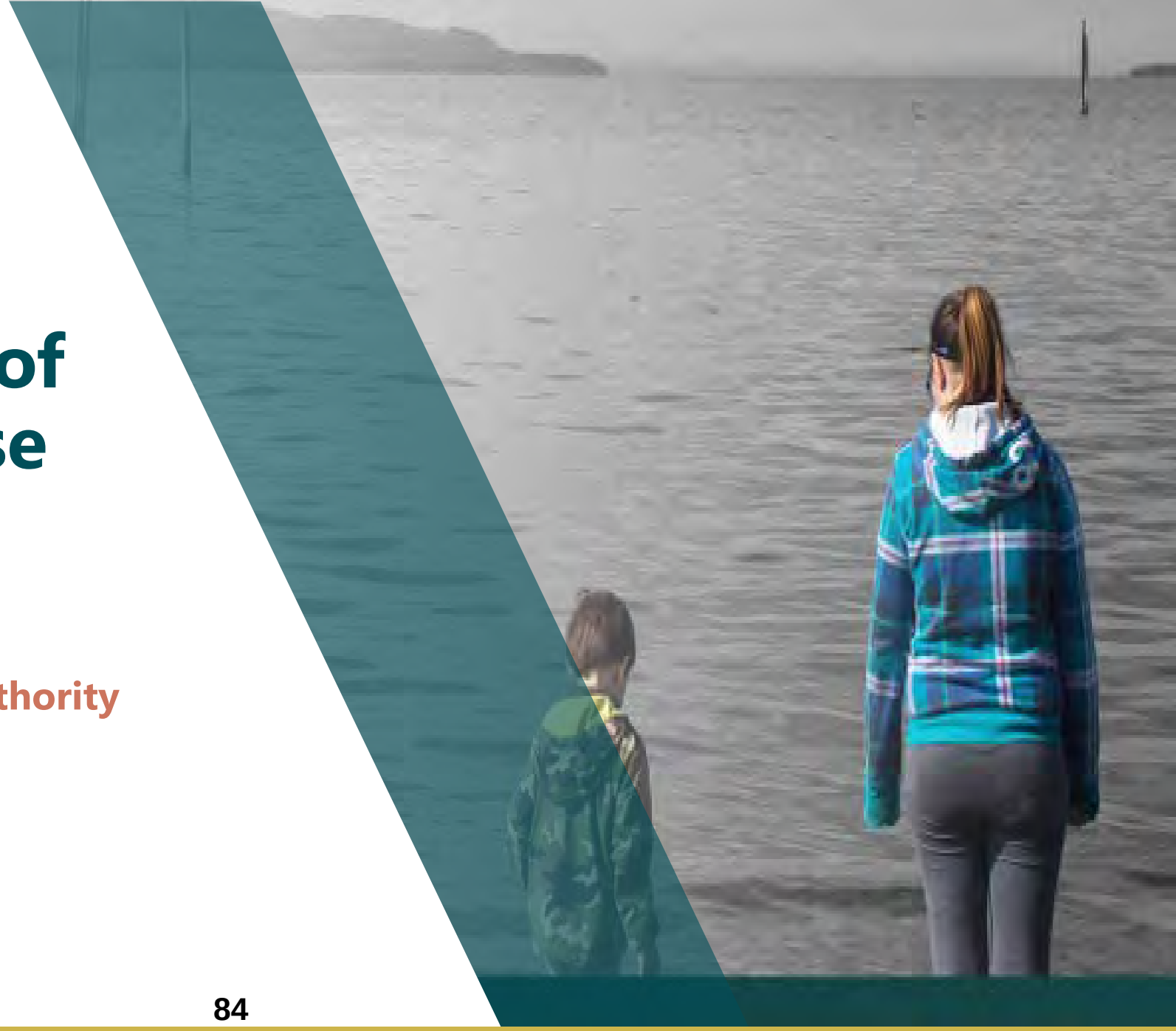
For more information, go to: www.alaskamentalhealthtrust.org/jointadvocacy

2020

Economic Costs of Substance Misuse in Alaska

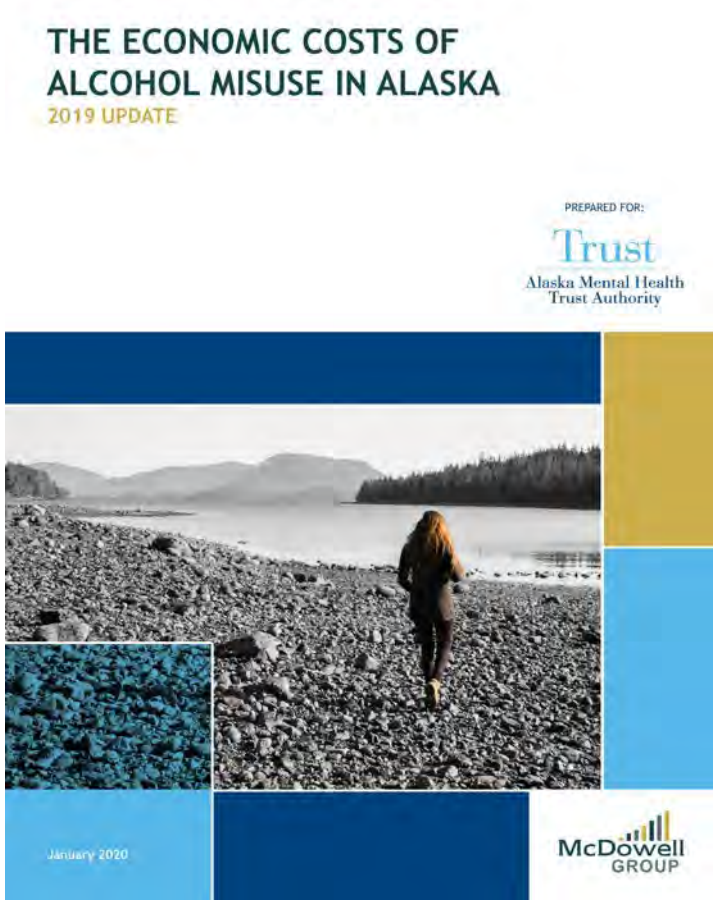
Prepared for
Alaska Mental Health Trust Authority

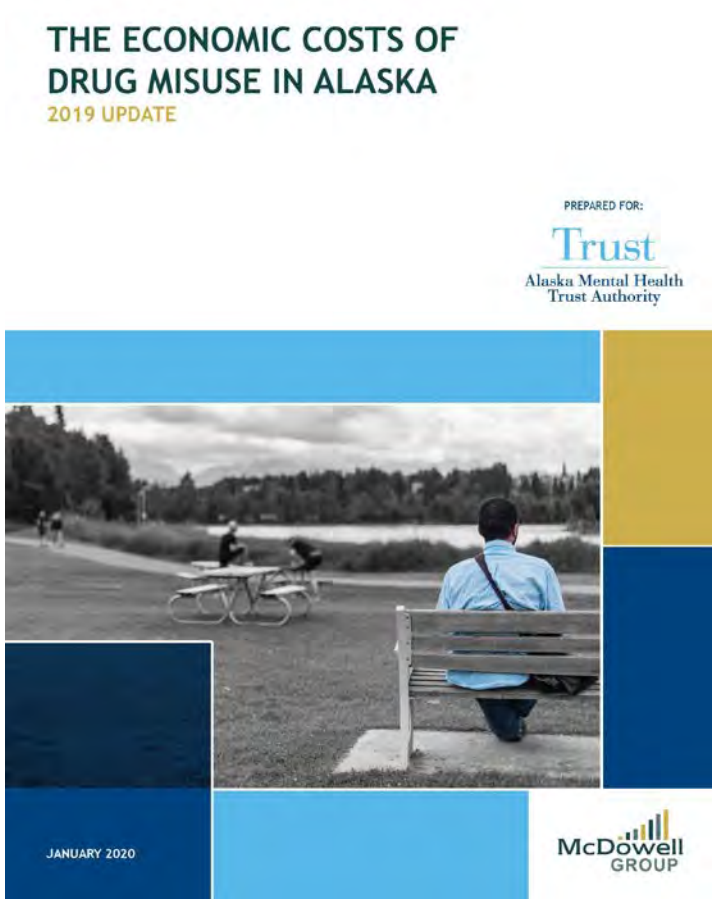
McDowell GROUP



Economic Costs of Alcohol & Drug Misuse Reports

5th Edition (2001, 2005, 2012, 2017)





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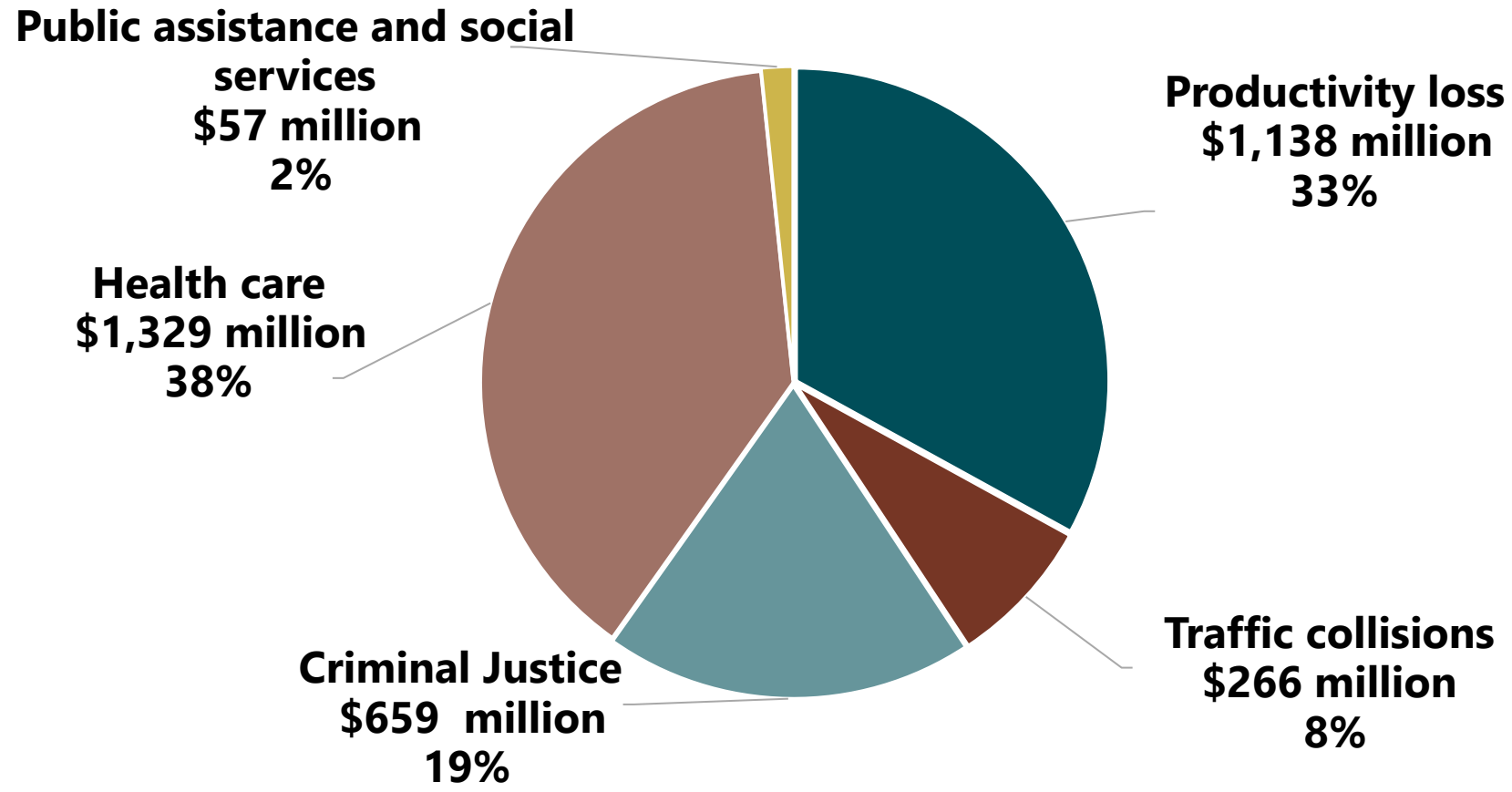
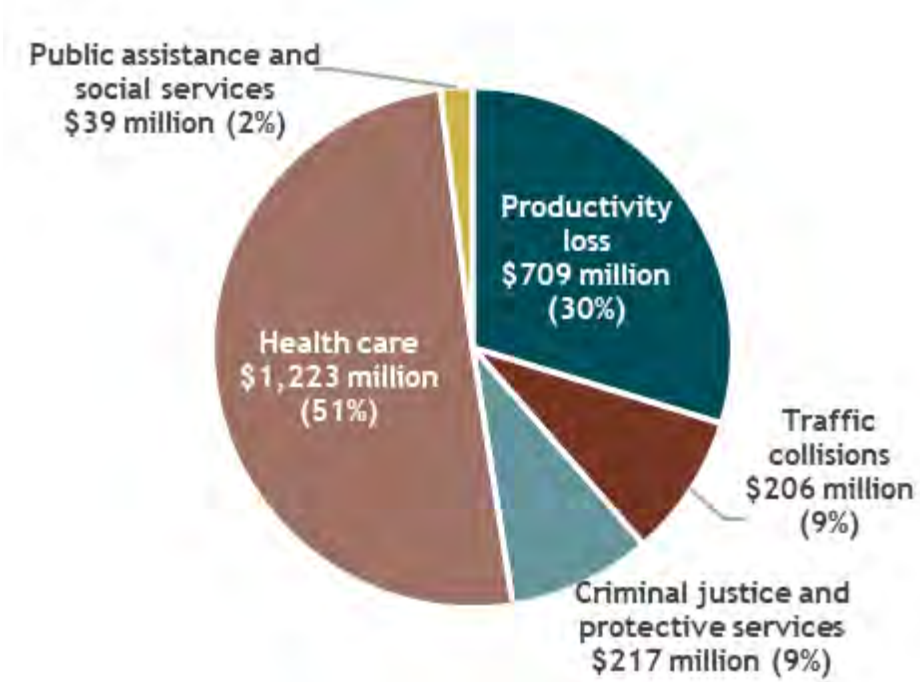
Total Economic Costs of Substance Abuse -- $3.45 Billion

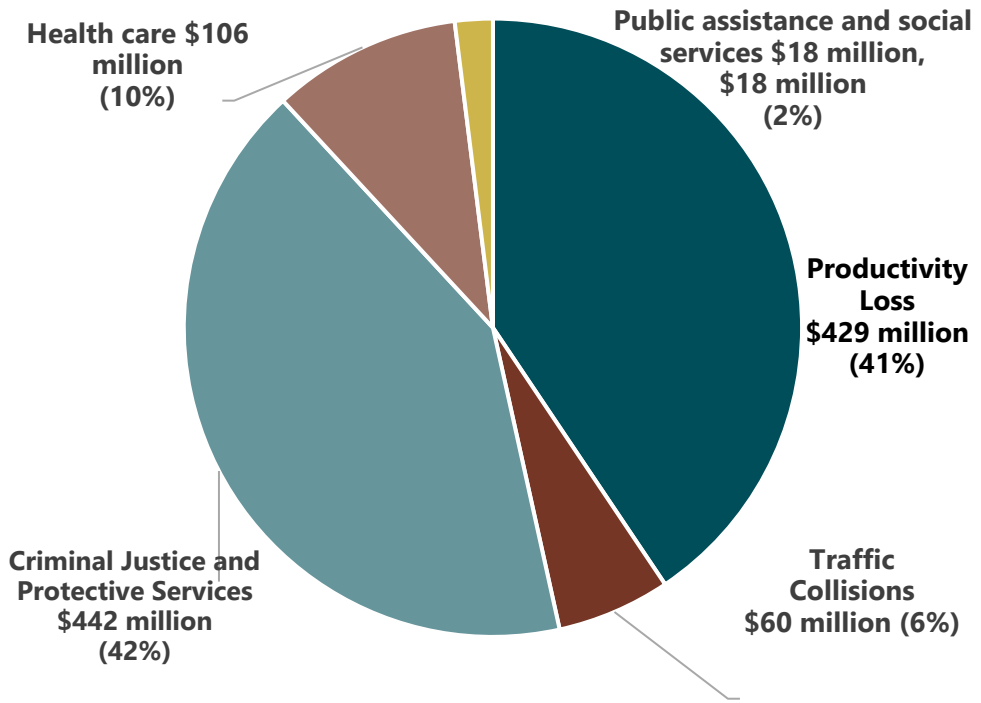


Substance Cost Breakout

Alcohol Misuse – $2.39 Billion



Drug Misuse -- $1.06 Billion



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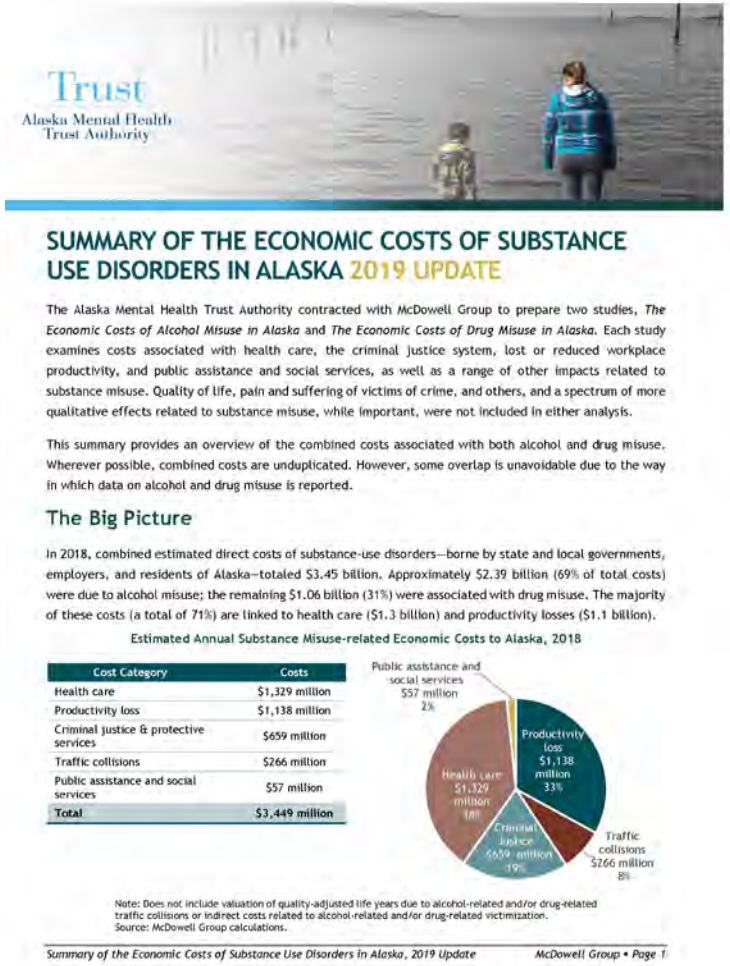
Want to know more?

www.alaskamentalhealthtrust.org



Trust
Alaska Mental Health Trust Authority

SUMMARY OF THE ECONOMIC COSTS OF SUBSTANCE USE DISORDERS IN ALASKA 2019 UPDATE

The Alaska Mental Health Trust Authority contracted with McDowell Group to prepare two studies, *The Economic Costs of Alcohol Misuse in Alaska* and *The Economic Costs of Drug Misuse in Alaska*. Each study examines costs associated with health care, the criminal justice system, lost or reduced workplace productivity, and public assistance and social services, as well as a range of other impacts related to substance misuse. Quality of life, pain and suffering of victims of crime, and others, and a spectrum of more qualitative effects related to substance misuse, while important, were not included in either analysis.

This summary provides an overview of the combined costs associated with both alcohol and drug misuse. Wherever possible, combined costs are unduplicated. However, some overlap is unavoidable due to the way in which data on alcohol and drug misuse is reported.

The Big Picture

In 2018, combined estimated direct costs of substance-use disorders—borne by state and local governments, employers, and residents of Alaska—totaled $3.45 billion. Approximately $2.39 billion (69% of total costs) were due to alcohol misuse; the remaining $1.06 billion (31%) were associated with drug misuse. The majority of these costs (a total of 71%) are linked to health care ($1.3 billion) and productivity losses ($1.1 billion).

Estimated Annual Substance Misuse-related Economic Costs to Alaska, 2018

Cost Category	Costs
Health care	$1,329 million
Productivity loss	$1,138 million
Criminal justice & protective services	$659 million
Traffic collisions	$266 million
Public assistance and social services	$57 million
Total	$3,449 million

Note: Does not include valuation of quality-adjusted life years due to alcohol-related and/or drug-related traffic collisions or indirect costs related to alcohol-related and/or drug-related victimization.
Source: McDowell Group calculations.

Summary of the Economic Costs of Substance Use Disorders in Alaska, 2019 Update *McDowell Group • Page 1*

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